BANGLADESH MEDICAL ASSOCIATION OF NORTH AMERICA CAROLINA CHAPTER

A Publication for Members and Friends of the Carolina Chapter of BMANA

2018

annual conference

Promoting Health, Education, Culture, Fraternity, and Charitable Work Within Bangladeshi Medical Professionals and the Global Community

Executive Committee 2017-2019		
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Bangladesh Medical Association of North America-Carolina Chapter (BMANA-CC)

2018 BMANA-CC 16TH ANNUAL CONVENTION--AGENDA AT A GLANCE

Embassy Suites By Hilton, 201 N Harrison Oaks Blvd, Cary NC 27513

Date:	**March 30 THROUGH APRIL 1**

FRIDAY-MARCH 30, 2018

Start	End	Time HRs	Program Description	Room Location or Contact
6:00:00 PM	9:30:00 PM	3:30	FAMILY NIGHT--Session 1	Smith Room
9:30:00 PM	10:00:00 PM	0:30	Break	Blowing Rock/Chimney Rock
10:00:00 PM	11:30:00 PM	1:30	FAMILY NIGHT--Session 2	Smith Room
Total Friday Hours		**5:30**		

SATURDAY-MARCH 31, 2018

Start	End	Duration-hrs	Program Description	Room Location or Contact
8:00:00 AM	9:00 AM	1:00	Special Breaskfast	Smith Room
8:30:00 AM	12:30:00 PM	4:00	Scientific Session and Exhibits	Smith Room
12:30:00 PM	2:00:00 PM	1:30	Lunch	Blowing Rock/Chimney Rock
2:00:00 PM	4:00:00 PM	2:00	Business Meeting	Smith Room
4:00:00 PM	5:30:00 PM	1:30	BREAK AND SOCIAL (SAJA GUJA)	Individual Guest Rooms
5:30:00 PM	7:30:00 PM	2:00	Dinner	Blowing Rock/Chimney Rock
7:30:00 PM	8:00:00 PM	0:30	Prayer Break	Cameron Room
8:00:00 PM	10:30:00 PM	2:30	Cultural Program--First Session	Blowing Rock / Chimney Rock
10:30:00 PM	11:00:00 PM	0:30	Break/Shingara	Blowing Rock/Chimney Rock
11:00:00 PM	1:00:00 AM	2:30	Cultural Program--Second Session	Blowing Rock/Chimney Rock
Total Saturday Hours		**18:00**		

SUNDAY-APRIL 1, 2018

Start	End	Time	Program Description	Room Location or Contact
11:00:00 AM	1:00:00 PM	2:00	Member's day Planning Meeting.	Smith Room
Total Sunday Hours		**2:00**	**Brunch and Member's day Planning Meeting.**	

WakeMed
WakeMed Health & Hospitals

3000 New Bern Avenue
Raleigh, North Carolina 27610
www.wakemed.org

Dear Friends,

As you gather with your colleagues for the 16th Annual BMANA-CC convention, I am honored to be here once again and have the opportunity to speak about leadership and the changing health care environment.

Your participation in this conference is not only evidence of your dedication to continuous learning in your respective medical disciplines but also your commitment to promoting health, education, culture, fraternity and charitable work with Bangladeshi medical professionals and the broader community.

On behalf of WakeMed and the communities we serve, I want to thank you for this commitment and look forward to working together toward our shared missions of improving the health and wellbeing in our community.

Respectfully,

Donald Gintzig
President & CEO
WakeMed Health & Hospitals

2017-2018 BMANA-CC Active Member's List *

PHYSICIANS NAME	SPECIALITY	RESIDENT CITY
A.B.M.Enayet Ullah, MD	Internal Medicine	Cary
Abdul Malek, MBBS	Non-Practitioner	Cary
Abu Ahmed Zahidur Rahman, MD	Internal Medicine	Cary
Abu Salahuddin, MD	Internal Medicine	Fayetteville
Abu Sharifuzzaman, MD	Internal Medicine	Raleigh
Abul K. Azad, MD	Internal Medicine	Fayetteville
Abul F. Imam, MD	Internal Medicine	Raleigh
Ashraful Hannan, MD	Internal Medicine	Fayetteville
Asif Wahid, MD	Cardiology	High Point
Dabiruddin Humayun, MD	Internal Medicine & Pediatrics	Raleigh
Farida Yasrmin, MBBS	Non-Practitioner	Fayetteville
Fatima Hossain, MD	Internal Medicine	Cary
Ferdousi Chowdhury, MBBS	Non-Practitioner	Fayetteville
Habib A Masood, MD	Internal Medicine	Cary
Humayun Kadir, MD	Family Practice & Geriatrics	Cary
Khwaja Hussain, MD	Family Practice	Goldsboro
Kishore R. Chowdhury, MD	Internal Medicine	Kinston
Ishtiaque Mohiuddin, MD	Cardiology	Cary
Mahfuzul Haque, MD	Gastroenterology	Durham
Maleka Z Ahmed, MD	Hematology/Oncology	Eastover
Mamum Shahrier, MD	Gastroenterology	Raleigh
Md. Abu Zahid Karim, MD	Internal Medicine	Fayetteville
Mizanur Rahman, MD	Psychiatry	Fayetteville
Mohammad A. Khan, MD	Internal Medicine	Raleigh
Mohammad D Hossain, MD	Internal Medicine & Pediatrics	Raleigh
Mohammad Sabur Naseri, MD	Pediatrics	Fayetteville
Mohammed A. Khasru, MD	Neurology	Fayetteville
Najmul Chowdhury, MBBS, MPH	Public Health Epidemiology	Knightdale
NurJahan Begum, MBBS	Non-Practitioner	Morrisville
Nusrat Ara, MBBS	Non-Practitioner	Cary
Nusrat Mujib, MD	Internal Medicine	Cary
Paritosh Chowdhury, MD	Psychiatry	Kinston
Razia Hafiz, MD	Family Practice & Geriatrics	Cary
Riaz Chowdhury, MD	Gastroenterology	Raleigh
S. M. Jafrul Islam, MD	Anesthesiolgy	Fayetteviile
Sabina Hannan, MBBS	Non-Practitioner	Fayetteville
Sagir Ahmed, MD	Cardiology	Cary
Salma Syed, MD	Pediatrics	Greenville
Sayeed Hossain, MD	Pulmonology	Greenville
Shabbir Chowdhury, MD	Psychiatry	Fayetteville
Shah Alam, MD	Nephrology	Shelby
Shahnaz Ilias, MBBS	Non-Practitioner	Grensboro
Shamsul A. Khan, MD	Pediatrics	Rockingham
Shireen Islam, MBBS	Non-Practitioner	Raleigh
Shyamal Palit, MD	Nephrology	Fayetteville
Sufia Siddique, MD	Family Practice	Cary
Tahmida Jahangir, MD	Pediatrics	Fayetteville
Tapon K. Gayen, MD	Internal Medicine	Winterville
Tarek Aziz, MD	Psychiatry	Greensboro
Taslim Ahmed, MBBS, MPH	Public Health-Health Administration	Knightdale
Tasneem Israt Islam, MBBS	Non-Practitioner	Cary
Waliur Rahman, MD	Internal Medicine & Geriatrics	Fayetteville
Zakia Karim, MD	Pediatrics	Fayetteville

* If your name is not listed here or you wish to make any changes, please contact the President of BMANA-CC

President's Message

It is my pleasure and honor to welcome you to our 16th Annual Convention at Cary, North Carolina. I would like to thank all the members of BMANA-CC for making this convention a successful one.

All members of the Executive Committee and Convention committee worked hard to present this wonderful event. Thanks to Dr. Mamun Shahriar, our Education Secretary, for organizing a high quality scientific session; Dr. Jafrul Islam for showcasing a colorful cultural event; and Dr. Najmul Chowdhury for assisting me with convention activities, real-time web-updates, and developing a unique, spectacular Convention Souvenir.

Special Thanks goes to Dr. Abul Imam, our founding President and Co-Convener for his guidance and continuous support. Drs. Asif Wahid, Taslim Ahmed, Humayun Kadir, Farida Yasmin, Shyamal Palit, Sabina Hannan, Mahfuzul Haque and Nusrat Ara who performed their assigned jobs well. I appreciate all that you have done for this event and for our beloved organization. Thanks to Drs. Dabiruddin Humayun, Habib Masood, Ishtiaque Mohiuddin, Sufia Siddique, Waliur Rahman, Muhammed Khasru and Sagir Ahmed for offering their precious time to get fund-raising/sponsorship. I am grateful to our sponsors for supporting our event, which helped us to do everything smoothly.

I am privileged to have the responsibility of leading this organization for the past year. With generous donations from our members we were able to do the philanthropic activities both at home and abroad and we accomplished a lot. We donated 10,000 dollars for the Syrian Crisis: 5,000 dollars to White Helmet, also called the Syrian Civil Defense, who were nominated for Nobel Peace Prize during 2017; another 5,000 dollars to Doctors Without Borders (1999 Nobel Peace Prize winner). We also donated 10,000 dollars for Bangladesh Floods through Ankur International, and 4,500 dollars to Red Cross for US Hurricanes (Hurricanes Harvey/Irma/Maria). We donated 10,000 dollars to NABIC for the Rohingya Crisis in Bangladesh, and then 4,000 dollars to the BMANA Disaster Fund to help with the purchase of an ambulance by Hope Foundation.

Last but not least, I am grateful to all our members, as the conference itself would not have been possible without their support and contributions. We are proud of our members and of our glorious achievements.

Once again, on behalf of the Executive Committee Members and Convention Committee Members, I welcome you and your families to this great event.

Best wishes,

Abu Sharifuzzaman,MD

Abu Sharifuzzaman,MD
Convention Convener and President

General Secretary's Message

It is a great honor to welcome all of our members and their supportive families to the annual BMANACC convention. Every year, we host an educational, informative event that celebrates not only medicine and healthcare but the rich culture from which we come.

This event would not be possible without the help of our leadership and engaged members every year to make sure that we have enlightening scientific sessions, an excellent and entertaining cultural program, and a well-put together and well-designed souvenir. I would like to thank all of you for making this a successful convention.

I hope that you thoroughly enjoy the programs and festivities planned for this weekend, and I am grateful to all of you for your attendance and dedication to this convention.

May the 2018 BMANACC convention be the highlight of the start of your spring, and once, again, I extend a warm welcome to all of you on behalf of the Executive Committee.

With warmest regards,

Asif Wahid, MD
General Secretary
BMANACC

Second Victim Phenomenon

Maleka Z. Ahmed, MD
Assistant Professor of Medicine,
Duke Cancer Network, Duke Health

Second victim phenomenon after an adverse event in health care setting was first described by Albert Wu et al., in 2000 published in the *British Med Journal, 2000; 320:726-727.* He addressed the issue of medical error causing adverse events. He raised the issue of need for support of the health care professional who made the mistake. The first victim is of course the patient and family and the second victim are the involved health care professional. The unanticipated adverse event may or may not be related with a medical error.

Second victims were officially defined in 2009 by Scott et al. in *Joint Commission journal on quality and patient safety 36 (5), 233-240, 2010. 141, 2010.* They also described the natural history of recovery for the second victims, after interviewing 31 second victims. The participants experienced symptoms that was not any different on different sexes or professional group.

They described six stages of the process.

1. Chaos and accident response.
2. Intrusive reflections.
3. Restoring personal integrity.
4. Enduring the inquisition.
5. Obtaining emotional first aid.
6. Moving on.

They recommended institutional interventions to screen at risk professionals after an adverse event to expedite recovery and mitigate adverse career outcome.

The Institute of Medicine *Committee* on the *Quality* of *Health Care in America* report- *Corrigan et al 2000"* To Err is Human: Building a Safer Health System" described high number of projected deaths each year as a result of preventable medical errors.

Most of the time, post event investigations often show experienced well-intentioned health professionals who are involved. They are usually surrounded by complex clinical situations, poorly designed processes and suboptimal communication patterns. These events leave a devastating personal and professional toll.

Some has described this as post-traumatic stress disorder.

Why Understanding and Recognizing this Second Victim Phenomenon is important?

Prevalence of second victims after an adverse health care event may range from 10.4 to 43.3% depending on the literature. University of Missouri health Care did an enquiry as part of internal patient survey of 1160 health care professionals.

One in seven reported a patient safety event in past one year which has caused personal problems such as anxiety, depression or concerns about the ability to perform one's job. 68% reported getting no help from the institution. People reported need for support.

In 2009, John Hopkins Hospital has come up with the RISE program (Resilience in Stressful Events) as an organizational response to an unanticipated adverse event in health care. Two third of the responders in a patient safety summit survey reported emotional distress after an unanticipated adverse event and half of them had reached out for support from a peer. They agreed for the need for hospital sponsored peer support program. This is a multidisciplinary peer support program.

They started in pediatrics department and eventually has expanded to hospital wide. After an adverse patient related event such as medical error, death, unexpected outcome or non-accidental trauma, the health care worker activates RISE call by paging the RISE pager. 'The peer responder calls back within 30 minutes and plans a meeting with 12 hours. The responder actively listens to the second victim and gives psychological first aid and emotional support. The responder mainly focuses on the emotions of the second victim rather than details of the incident. Also, provide list of organizational support resources. The interaction is confidential, except in the case that the caller indicates potential harm to self or others. After the encounter the peer responder does debriefing to the RISE to provide learning opportunity for the other members. The investigation on the medical event of course goes on as usual.

John Hopkins group reported 4-year follow-up in BMJ,2016, vol6 issue 9, Hanan, et al. They reported 56% of the calls requested group support for patient death unrelated to medical errors. Majority of responders recommended additional resources for support. A few of these were medical errors, but majority were simply related to extra ordinary stresses I at the job.

They stressed the fact that unless there is recognition of the problem and clear support in workplace is present, further adverse event and more patient harm will be done. Institution should give more support to health care providers to prevent burnout or leaving their professions.

In 2018 Article published in J Ped Nursing by Dukhanin et al, a survey showed 93% respondents were very likely to recommend the program to others. The finding suggested an important role of organizational culture in second victim support program implementation.

We should acknowledge and recognize the second victim phenomena to prevent burnout and ruining of carrier or permanent emotional issues including substance abuse, even suicide among health care professionals.

2017 ACCOMPLISHMENTS

Our Mission: To promote health, education, culture, fraternity, and charitable work within Bangladeshi medical professionals and the wider community.

Donations:

- **10,000** dollars for Syrian Crisis, (**5,000** dollars to White Helmet, also called Syrian Civil Defense (who were nominated for Nobel Peace Prize on 2017) and another **5,000** dollars to Doctors Without Borders 1999 Nobel Peace Prize winner).
  10,000 dollars for Bangladesh Floods through Ankara International
- **4,500** dollars to Red Cross for US Hurricanes (Hurricanes Harvey/Irma/Maria)
- **10,000** dollars to NABIC for Rohingya Crisis in Bangladesh,
- **4,000** dollars to BMANA Disaster Fund to help purchase of Ambulance by Hope Foundation.

Academic:

- Conducted Annual educational event. Dr. Riaz Chowdhury, one of our past presidents has been contributing to train physicians in Bangladesh in advanced GI Procedures. He was elected as president of Bangladesh Medical Association of North America.
- Dr. Chowdhury as BMANA president signed an MOU with presidents of AAPNA, AAPI to make an alliance for south Asian Physicians Group.

Cultural and Diversity:

- Very high quality cultural events are presented by our members every year to enrich the culture and customs of society.

ECHO News Brief
Be connected. Be heard. Be informed.®
March 8, 2018

Joint Coalition of Physicians in South Asia Region

APPNA (Association of Physicians of Pakistani Descent of North America), **AAPI** (American Association of Physicians of Indian Origin) and **BMANA** (Bangladesh Medical Association of North America) have joined forces to expand and support physicians globally with an emphasis on the South Asia region. APPNA reports that this coalition of more than 130,000 South Asian Physicians of North America (**SAPNA**) constitutes about 15% of the physician workforce in the United States. https://www.ecfmg.org/echonews/issue34.html#a2

The coalition will focus on:

- increasing the residency slots for foreign medical graduates,
- visa issues, and
- health care issues of South Asian people in North America and South Asia.

A memorandum of understanding was signed by (L-R) Dr. Riaz Chowdhury, President BMANA; Dr. Iqbal Zafar Hamid, President APPNA; and Dr. Gautam Samadder, President AAPI

Indian, Pakistani and Bangladeshi-American doctors groups form coalition

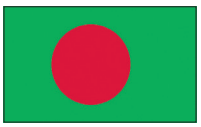
WASHINGTON, D.C. — The American Association of Physicians of Indian Origin and the medical associations representing Pakistani- and Bangladeshi-American physicians convened on Jan. 27 and signed a memorandum of understanding to advance their common professional, humanitarian and policy issues, including U.S. health care reform.

AAPI's meeting with the Association of Physicians of Pakistani Descent of North America (APPNA) and the Bangladeshi Medical Association of North America (BMANA) at the Hyatt Regency Hotel in downtown Miami laid the groundwork for a grouping that could provide South Asian-American physicians a seat at the table in both organized medicine and mainstream policy discussions.

Dr. Naresh Parikh, AAPI's president-elect called it a "first step that has potential for opening many new opportunities for South Asian physicians and the population they serve." Dr. Chowdhury said that the three organizations together represent more than 100,000 practicing physicians in the U.S. — or about 15 percent of all practicing physicians nationwide.

Initiatives are expected to include promoting the research and education programs of the three organizations, instituting a research protocol to explore the cardiovascular health status among the South Asians in North America and cancer statistics at home and abroad.

BANGLADESH



Population: 156 594 962 • Income group: Low • Gross national income per capita: US$ 1 010

INSTITUTIONAL FRAMEWORK

Lead agency	National Road Safety Council (NRSC)
Funded in national budget	No
National road safety strategy	Yes
Funding to implement strategy	Partially funded
Fatality reduction target	50% (2011–2020)

SAFER ROADS AND MOBILITY

Formal audits required for new road construction projects	Yes
Regular inspections of existing road infrastructure	Yes
Policies to promote walking or cycling	No
Policies to encourage investment in public transport	Yes
Policies to separate road users and protect VRUs	No

SAFER VEHICLES

Total registered vehicles for 2014	2 088 566
Cars and 4-wheeled light vehicles	547 423
Motorized 2- and 3-wheelers	1 336 339
Heavy trucks	141 850
Buses	59 500
Other	3 454
Vehicle standards applied[a]	
Frontal impact standard	No
Electronic stability control	No
Pedestrian protection	No

[a] UNECE WP29.

POST-CRASH CARE

Emergency room injury surveillance system	No
Emergency access telephone numbers	None
Permanently disabled due to road traffic crash	—

DATA

Reported road traffic fatalities (2012)	2 538[b] (57% M, 17% F)
WHO estimated road traffic fatalities	21 316 (95%CI 17 349–25 283)
WHO estimated rate per 100 000 population	13.6
Estimated GDP lost due to road traffic crashes	1.6%[c]

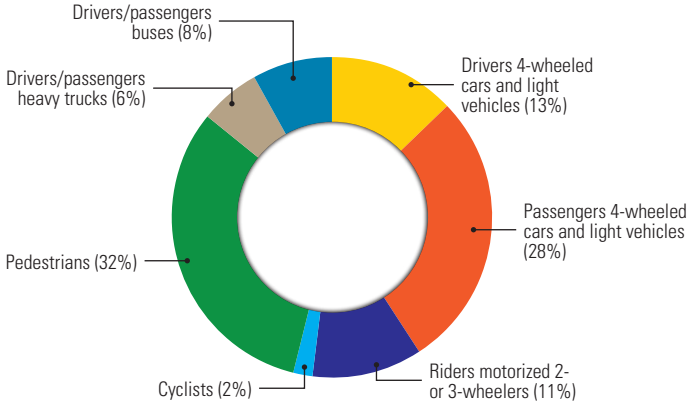
[b] Police First Information Report (FIR). Defined as died at scene of crash.
[c] Transport Research Laboratory, UK (data from 2003).

SAFER ROAD USERS

National speed limit law	Yes
Max urban speed limit	No
Max rural speed limit	~112 km/h
Max motorway speed limit	No
Local authorities can modify limits	No
Enforcement	0 1 2 ③ 4 5 6 7 8 9 10
National drink–driving law	Yes[d,e]
BAC limit – general population	—
BAC limit – young or novice drivers	—
Random breath testing carried out	No
Enforcement	0 1 ② 3 4 5 6 7 8 9 10
% road traffic deaths involving alcohol	—
National motorcycle helmet law	Yes
Applies to drivers and passengers	Yes
Law requires helmet to be fastened	No
Law refers to helmet standard	Yes
Enforcement	0 1 2 3 ④ 5 6 7 8 9 10
Helmet wearing rate	—
National seat-belt law	No
Applies to front and rear seat occupants	—
Enforcement	—
Seat-belt wearing rate	—
National child restraint law	No
Restrictions on children sitting in front seat	No
Child restraint law based on	—
Enforcement	—
% children using child restraints	—
National law on mobile phone use while driving	No
Law prohibits hand-held mobile phone use	—
Law also applies to hands-free phones	—
National drug-driving law	Yes

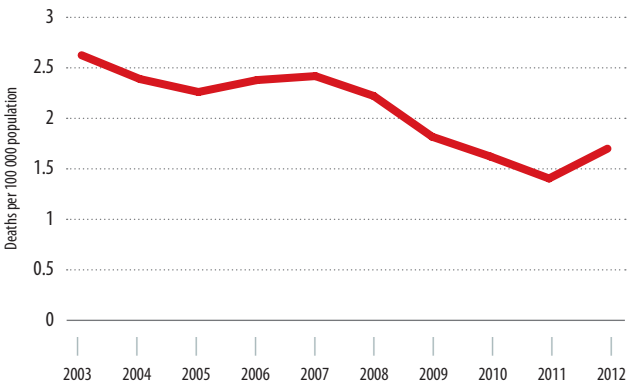
[d] Not based on BAC.
[e] Alcohol consumption legally prohibited.

DEATHS BY ROAD USER CATEGORY



Source: Road Transport Authority Annual Report (data from 2012).

TRENDS IN REPORTED ROAD TRAFFIC DEATHS



Source: Road Transport Authority Annual Report (data from 2012).

Legislative review conducted by WHO. Vehicle safety data from UNECE WP29. Other data collected by questionnaire and cleared by National Institute of Traumatology and Orthopaedic Rehabilitation (NITOR).

Bangladesh: WHO statistical profile

Basic statistics

Indicators	Statistics	Year
Population (thousands)	156595	2013
Population aged under 15 (%)	30	2013
Population aged over 60 (%)	7	2013
Median age (years)	25	2013
Population living in urban areas (%)	33	2013
Total fertility rate (per woman)	2.2	2013
Number of live births (thousands)	3137.7	2013
Number of deaths (thousands)	886.2	2013
Birth registration coverage (%)	31	2011
Cause-of-death registration coverage (%)	…	
Gross national income per capita (PPP int $)	2810	2013
WHO region	South-East Asia	2013
World Bank income classification	Low	2013

... Data from 2007 onwards not available.

Source:
Country statistics and global health estimates
by WHO and UN partners

For more information visit the Global Health Observatory
(http://www.who.int/gho/en/)

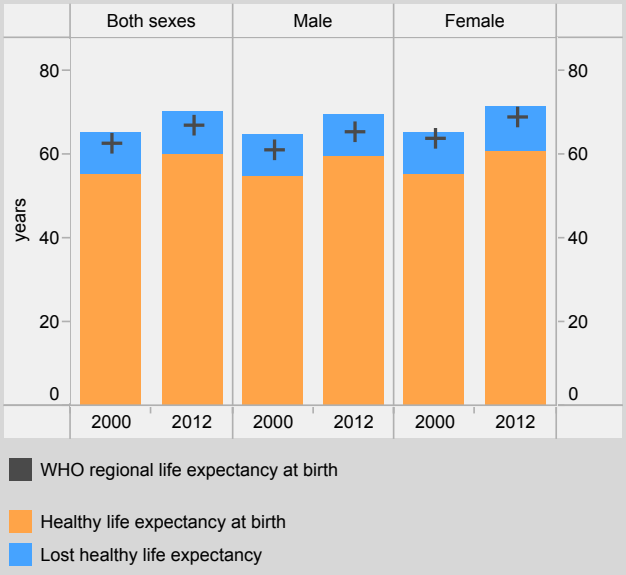
Last updated: January 2015

Life expectancy (years), 2012

		Country	WHO region	World Bank income group
Life expectancy	At birth	70	67	62
	At age 60	18	17	17
Healthy life expectancy	At birth	60	59	53

Life expectancy at birth for both sexes increased by 5 year(s) over the period of 2000-2012; the WHO region average increased by 5 year(s) in the same period.

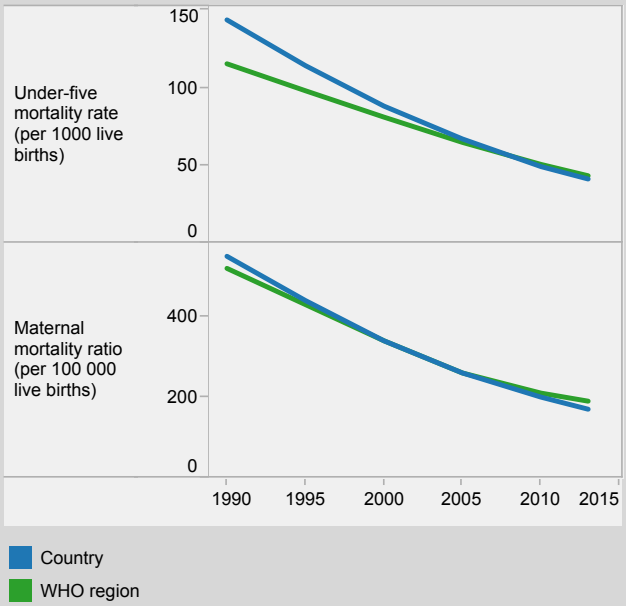
In 2012, healthy expectancy in both sexes was 10 year(s) lower than overall life expectancy at birth. This lost healthy life expetancy represents 10 equivalent year(s) of full health lost through years lived with morbidity and disability.



Millennium Development Goals (MDGs)

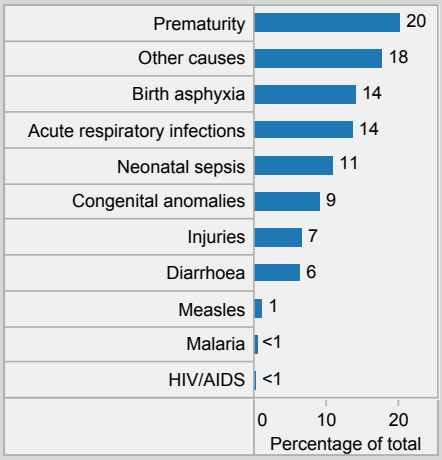
Indicators	Statistics: Baseline*	Statistics: Latest**
Under-five mortality rate (per 1000 live births)	144	41
Maternal mortality ratio (per 100 000 live births)	550	170
Deaths due to HIV/AIDS (per 100 000 population)	0.1	0.3
Deaths due to malaria (per 100 000 population)	1.9	0.9
Deaths due to tuberculosis among HIV-negative people (per 100 000 population)	74	51

*1990 for under-five mortality and maternal mortality; 2000 for other indicators
**2012 for deaths due to HIV/AIDS and malaria ; 2013 for other indicators

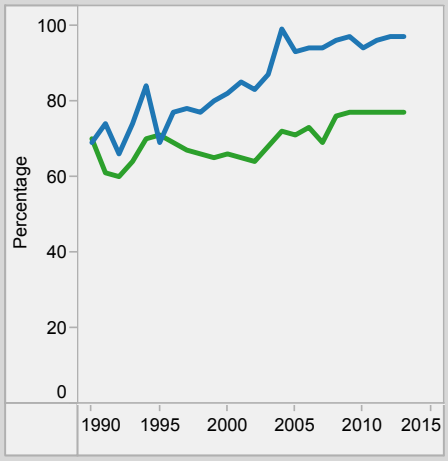


Bangladesh: WHO statistical profile

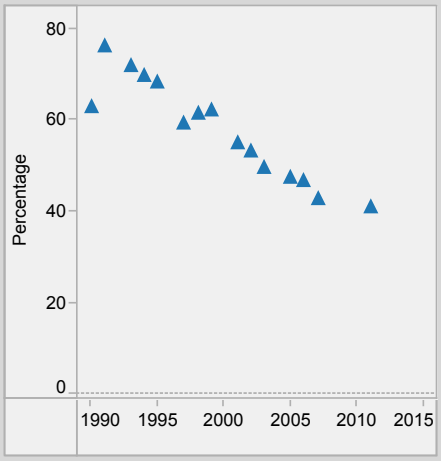
Distribution of causes of deaths in children under-5, 2013



DTP3 immunization among 1-year-olds



Children aged under-5 stunted

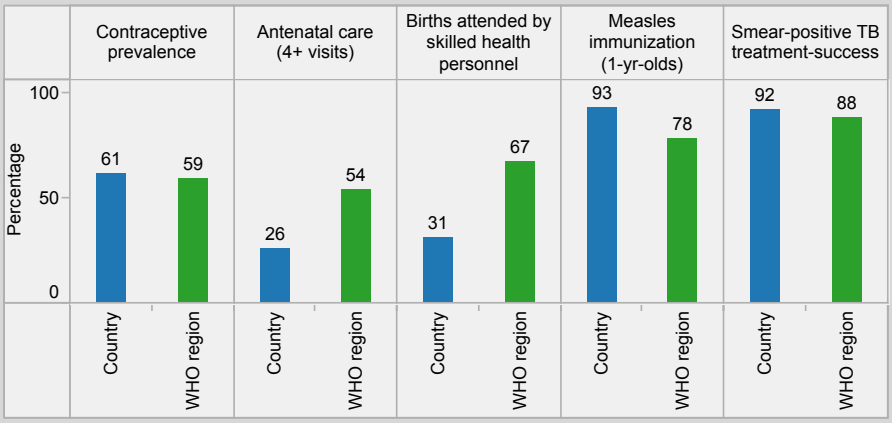


Country
WHO region

Source: Country statistics and global health estimates by WHO and UN partners
For more information visit the Global Health Observatory (http://www.who.int/gho/en//)
Last updated: January 2015

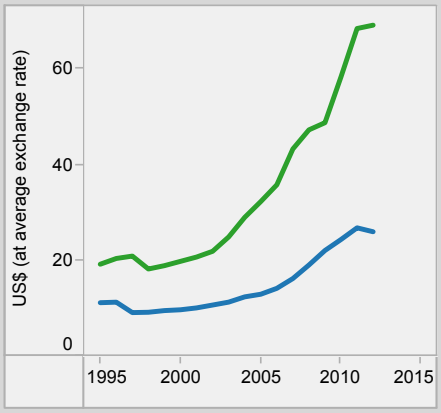
Utilisation of health services*

*Data refer to the latest year available from 2007.

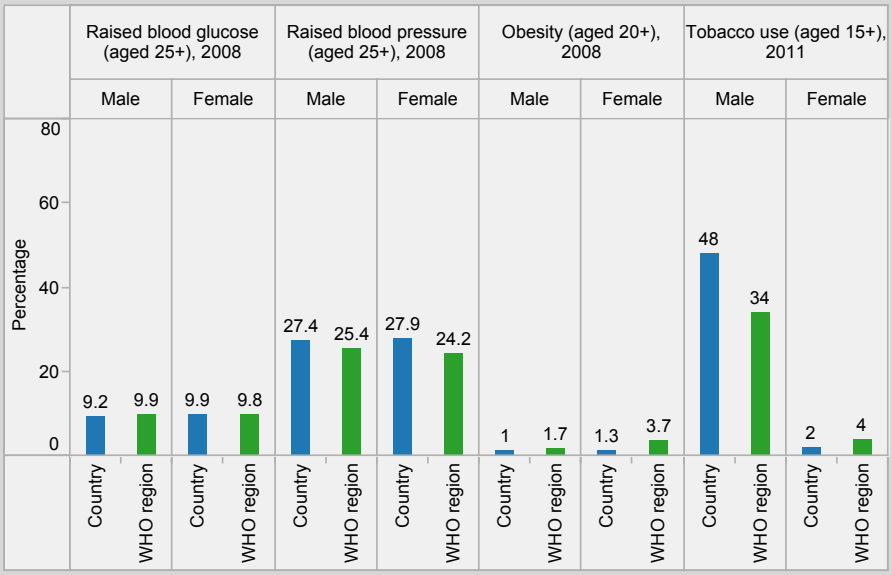


... Data not available or applicable.

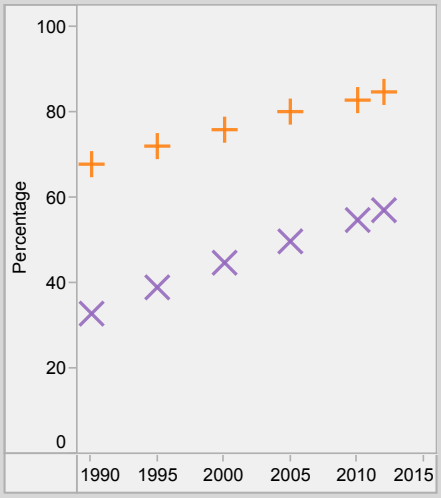
Per capita total expenditure on health



Adult risk factors



Population using improved water and sanitation

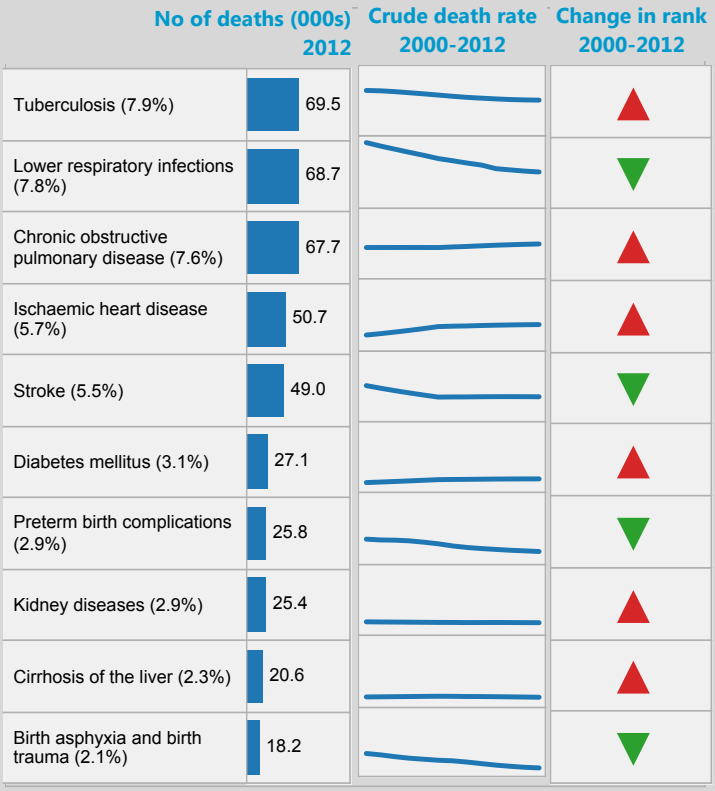


+ Improved drinking-water sources
× Improved sanitation facilities

Bangladesh: WHO statistical profile

Top 10 causes of death

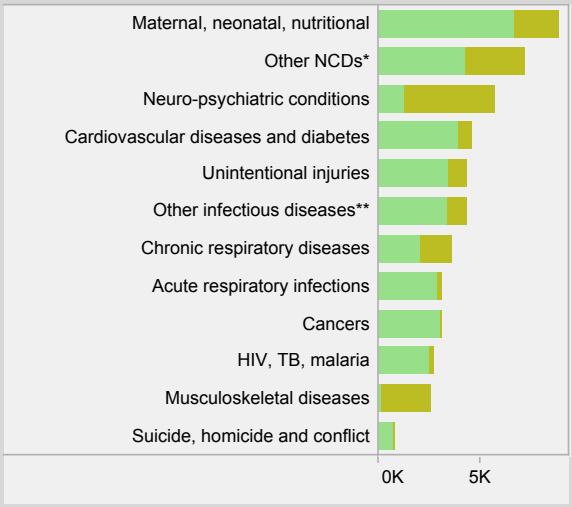
Tuberculosis was the leading cause of death, killing 69.5 thousand people in 2012



Burden of disease, 2012

Disability-adjusted life years (DALYs) are the sum of years of life lost due to premature mortality (YLL) and years of healthy life lost due to disability (YLD).

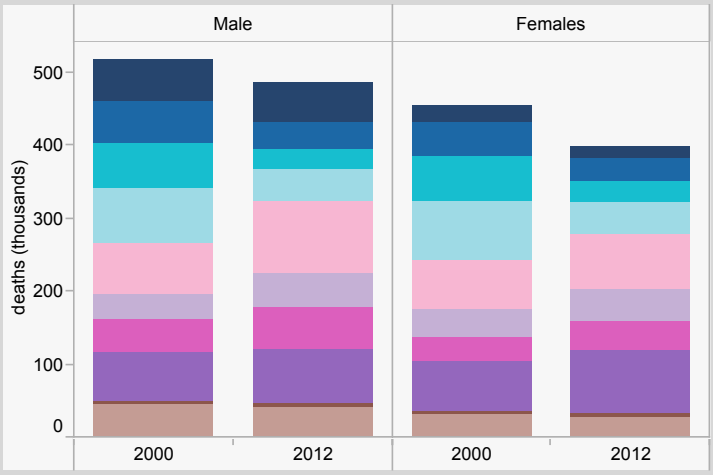
DALYs, YLL and YLD (thousands) by broad cause group



*Other noncommunicable diseases (NCDs) including non-malignant neoplasms; endocrine, blood and immune disorders; sense organ, digestive, genitourinary, and skin diseases; oral conditions; and congenital anomalies.

** Infectious diseases other than acute respiratory diseases, HIV, TB and malaria.

Deaths by broad cause group



Causes

- HIV, TB, malaria
- Acute respiratory infections
- Other infectious diseases
- Maternal, neonatal, nutritional
- Cardiovascular diseases and diabetes
- Cancers
- Chronic respiratory diseases
- Other NCDs
- Suicide, homicide and conflict
- Unintentional injuries

Probability of dying, 2012

Probability of dying between relevant exact ages, for a person experiencing the 2012 age-specific mortality risks throughout their life.

Before age 15, all causes	Male	18%
	Female	15%
Before age 70, all causes	Male	59%
	Female	53%
Between ages 15 and 49, from maternal causes	Female	4%
Between ages 30 and 70, from 4 major noncommunicable diseases (NCDs)~	Both sexes	18%

~Cancers, cardiovascular diseases, chronic respiratory diseases and diabetes

Source: Country statistics and global health estimates by WHO and UN partners

For more information visit the Global Health Observatory (http://who.int/gho/mortality_burden_disease/en/)

Last updated: January 2015

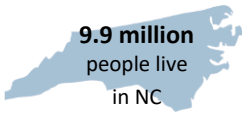
THE HENRY J. KAISER FAMILY FOUNDATION

MEDICAID IN NORTH CAROLINA

June 2017

Medicaid and the Children's Health Insurance Program (CHIP) provide health and long-term care coverage to more than 2.0 million low-income children, pregnant women, adults, seniors, and people with disabilities in North Carolina. Medicaid is a major source of funding for safety-net hospitals and nursing homes. The American Health Care Act (AHCA) would fundamentally change the scope of the program and end the guarantee of federal matching funds.

Snapshot of North Carolina's population

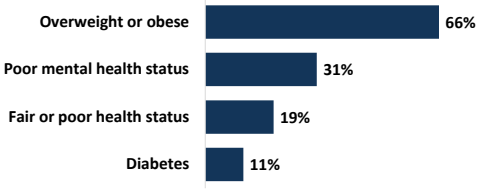


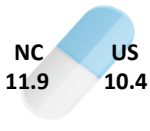
9.9 million people live in NC

35% of NC's population is low-income

Low-income: <200% FPL or $40,840 for a family of 3 in 2017

Adults in NC reporting:





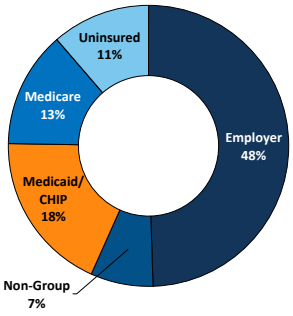
Opioid Deaths

HIV Diagnoses

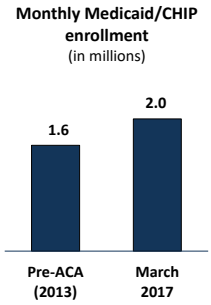
Per 100,000 population in 2015

How has Medicaid affected coverage and access?

In 2015, 18% of people in NC were covered by Medicaid/CHIP.



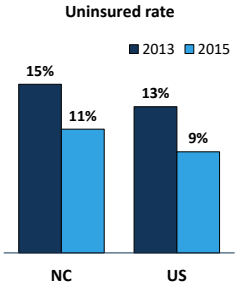
Since implementation of the Affordable Care Act (ACA), Medicaid/ CHIP enrollment has increased in NC.



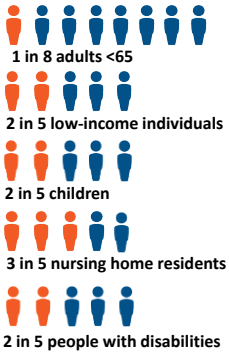
Did NC expand Medicaid through the ACA?

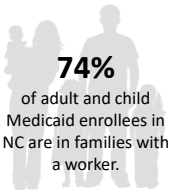
0 adults
in the expansion group in Q1 of 2016

The uninsured rate in NC has decreased.



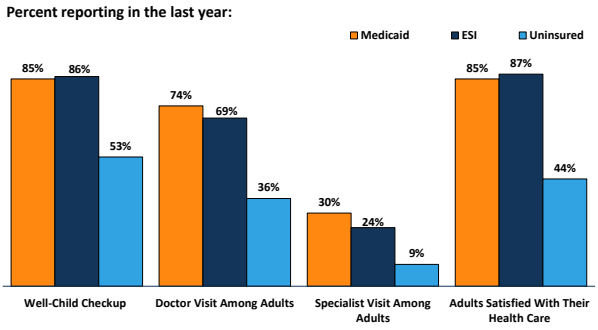
In NC, Medicaid covers:





74%
of adult and child Medicaid enrollees in NC are in families with a worker.

Nationally, Medicaid is comparable to private insurance for access and satisfaction – the uninsured fare far less well.



Medicaid coverage contributes to positive outcomes:

- Declines in infant and child mortality rates
- Long-term health and educational gains for children
- Improvements in health and financial security

And…

>85%
of the public would enroll themselves or a child in Medicaid if uninsured.

How does Medicaid work and who is eligible?

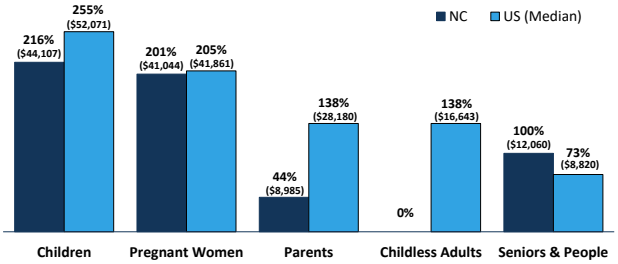
Each Medicaid program is unique:

Federal government sets core requirements, but states have flexibility regarding:

- **Eligibility** - All states have taken up options to expand coverage for children; many have opted to expand coverage for other groups.
- **Benefits** – All states offer optional benefits, including prescription drugs and long-term care in the community.
- **Delivery system & provider payment**– States choose what type of delivery system to use and how they will pay providers; many are testing new payment models to better integrate and coordinate care to improve health outcomes.
- **Long-term care** – States have expanded eligibility for people who need long-term care and are increasingly shifting spending away from institutions and towards community-based care.
- **State health priorities** – States can use Medicaid to address issues such as the opioid epidemic, HIV, Zika, autism, dementia, environmental health emergencies, etc.

Eligibility levels are highest for children and pregnant women.

Eligibility Level as a Percent of FPL, as of January 1, 2017



Eligibility levels are based on the FPL for a family of three for children, pregnant women, and parents, and for an individual for childless adults and seniors & people w/ disabilities. Seniors & people w/ disabilities eligibility may include an asset limit.

How are Medicaid funds spent and how is the program financed?

Medicaid plays a key role in the U.S. health care system, accounting for:

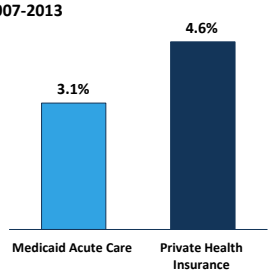
$1 in $6 dollars spent overall in the health care system

More than $1 in $3 dollars provided to safety-net hospitals and health centers

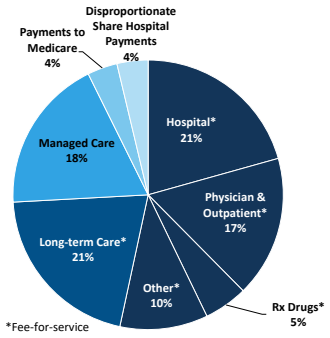
$1 in $2 dollars spent on long-term care

On a per enrollee basis, Medicaid spending growth is slower than private health care spending, in part due to lower provider payments.

Per enrollee spending growth in the US, 2007-2013



In FY 2016, Medicaid spending in NC was $12.4 billion.

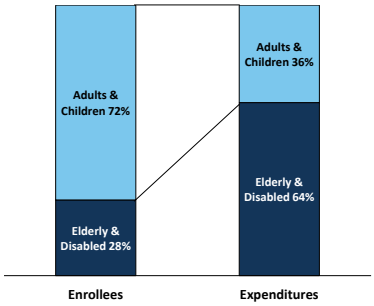


0.79
is the Medicaid-to-Medicare physician fee ratio in NC.

56%
of long-term care spending in NC is for home and community-based care.

80%
of beneficiaries in NC are in primary care case management.

In 2014, most Medicaid beneficiaries in NC were children and adults, but most spending was for the elderly and people with disabilities.



335,100
Medicare beneficiaries (22%) in NC **rely on Medicaid** for assistance with Medicare premiums and cost-sharing and services not covered by Medicare, particularly long-term care.

31%
of Medicaid spending in NC is for Medicare beneficiaries.

Federal matching funding to states is guaranteed with no cap and rises depending on program needs.

In NC the federal share (FMAP) is 66.9%. For every **$1** spent by the state, the Federal government matches **$2.02**.

Expansion states receive an increased FMAP for the expansion population. NC did not expand Medicaid and did not receive additional federal funds.

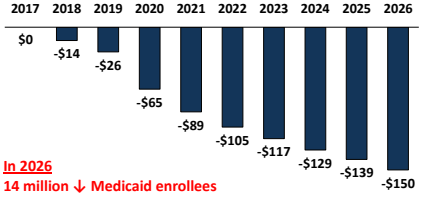
17%
of state general fund spending in NC is for Medicaid.

67%
of all federal funds received by NC is for Medicaid.

What are the implications of reduced federal financing in a Medicaid block grant or a per capita cap?

The American Health Care Act (AHCA) would reduce federal Medicaid funding through ACA repeal and federal caps.

The CBO estimates that the AHCA would reduce federal Medicaid spending by **$834 billion** nationally over the 2017-2026 period.



In 2026
14 million ↓ Medicaid enrollees
24% ↓ in federal funds
23 million ↑ in uninsured → 51 million uninsured

However,
71%
of Americans think Medicaid should continue as it is today

Reducing federal funds through a per capita cap or block grant:

Shifts costs and risks to states, beneficiaries, and providers if states restrict eligibility, benefits, and provider payment.

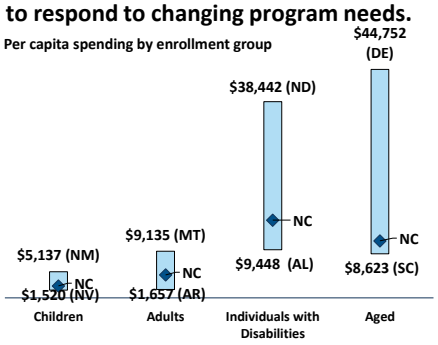
Locks in historic spending patterns and have an even greater impact on states that expanded Medicaid.

Limits states' ability to respond to rising health costs, increases in enrollment due to a recession, or a public health emergency such as the opioid epidemic, HIV, Zika, etc.

Leads to more low income uninsured Americans.

A per capita cap would lock in state spending patterns and limit states' ability to respond to changing program needs.

Per capita spending by enrollment group



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ALZHEIMER'S STATISTICS
NORTH CAROLINA

U.S. STATISTICS

*Over **5 million Americans** are living with Alzheimer's, and as many as **16 million** will have the disease in 2050. The cost of caring for those with Alzheimer's and other dementias is estimated to total **$236 billion** in 2016, increasing to **$1.1 trillion** (in today's dollars) by mid-century. Nearly **one in every three seniors** who dies each year has Alzheimer's or another dementia.*

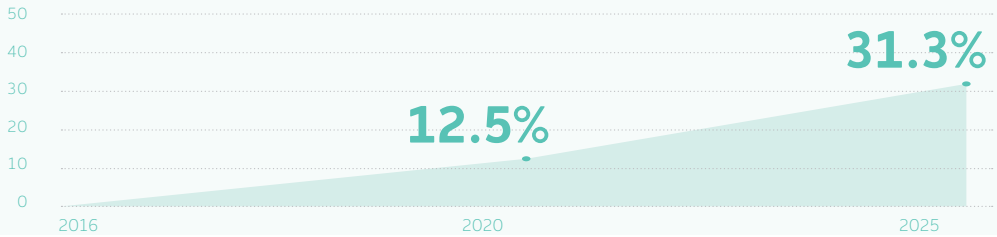
For more information, view the 2016 *Alzheimer's Disease Facts and Figures* report at alz.org/facts.

65+ Number of people aged 65 and older with Alzheimer's by age*

Year	65-74	75-84	85+	TOTAL
2016	26,000	70,000	64,000	160,000
2020	31,000	79,000	69,000	180,000
2025	35,000	100,000	77,000	210,000

** Totals may not add due to rounding*

Percentage change from 2016



Medicaid costs of caring for people with Alzheimer's, 2016

$1,094 MILLION

Number of deaths from Alzheimer's disease in 2013

- *6th leading cause of death in North Carolina*

2,872

Number of Alzheimer's and dementia caregivers, hours of unpaid care, and costs of caregiving

Year	Number of Caregivers	Total Hours of Unpaid Care	Total Value of Unpaid Care	Higher Health Costs of Caregivers
2013	442,000	504,000,000	$6,272,000,000	$252,000,000
2014	448,000	510,000,000	$6,208,000,000	$263,000,000
2015	454,000	516,000,000	$6,327,000,000	$275,000,000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Bangladesh Medical Association of North America-Carolina Chapter (BMANA-CC)

2018 BMANA-CC 16TH ANNUAL CONVENTION--SCIENTIFIC SESSION

Embassy Suites By Hilton, 201 N Harrison Oaks Blvd, Cary NC 27513

SATURDAY-MARCH 31, 2018

Agenda for Scientific Session of BMANACC 2018 CONFERENCE

Time			Clinical Area, Clinical Topic, and Speaker	
8:00:00 AM	8:30:00 AM	0:30	**Breakfast--Opening and Welcome Remarks** Dr. Mamun Shahrier	
8:30:00 AM	9:00:00 AM	0:30	NEUROLOGY	CVA and Update on Neurology Dr. Muhammed Khasru
9:00:00 AM	9:30:00 AM	0:30	DIABETES	Long Term Results with Invokana across a Broad Range of Patients with Type 2 Diabetes Dr. Corey Berlin
9:30:00 AM	10:00:00 AM	0:30	PEDIATRIC GI	Management of Ingested Foreign Bodies in Children Dr. Tanbeena Imam
10:00:00 AM	10:30:00 AM	0:30	BREAK AND CLINICAL NETWORKING BOOTH EXHIBIT AREA	
10:30:00 AM	11:00:00 AM	0:30	PULMONOLOGY	Pulmonary Fibrosis Dr. Sayeed Hossain
11:00:00 AM	11:30:00 AM	0:30	DIABETES	DUALING with Type 2 Diabetes:Xultophy 100/3.6 Dr. Nilay Desai
11:30:00 AM	12:00:00 PM	0:30	HEMATOLOGY - ONCOLOGY	Thromboembolism: How long to treat? Prof. Maleka Ahmed, MD. Duke University
12:00:00 PM	12:30:00 PM	0:30	CLINICAL NETWORKING AND BOOTH EXHIBIT	
Total Scientific Session Hours		4:00		

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