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## NCAFP Strategic Plan

### Vision Statement

The vision of the North Carolina Academy of Family Physicians is to be the leader in transforming healthcare in NC to achieve optimal health for all people of NC.

### Mission Statement

The mission of the North Carolina Academy of Family Physicians is to improve the health of patients, families, and communities by serving the needs of members with professionalism and creativity.

### Strategic Objectives

1. **Health Promotion & Disease Prevention (Health of the Public):** Assume a leadership role in improving the health of North Carolina’s citizens by becoming proactive in health promotion, disease prevention, chronic disease management and collaborating in other public health strategies.

2. **Advocacy:** Shape healthcare policy through interactions with government, the public, business, and the healthcare industry.

3. **Workforce:** Ensure a workforce of Family Physicians which is sufficient to meet the needs of patients and communities in NC.

4. **Education:** Assure high-quality, innovative education for family physicians, residents, and medical students that embodies the art, science, and socioeconomics of family medicine.

5. **Technology & Practice Enhancement:** Strengthen members’ abilities to manage their practices, maintain satisfying careers, and balance personal and professional responsibilities.

6. **Research:** Develop and promote new medical knowledge and innovative practice strategies through information technology, primary care research and assessment of the practice environment.

7. **Communications:** Promote the unique role and value of family medicine, family physicians and the NCAFP to the public, business, government, the healthcare industry and NCAFP members.
Life is what it is all about. We are born to live and eventually die. Life is what happens in the interim of these two miraculous events. As a physician I must wonder if our daily teaching really makes a difference. The statistics give us the data to support discussing healthy lifestyle topics. The challenge becomes in transmitting this knowledge in such a way allowing the patient to truly act toward implementing a change. One must wonder, why a person would not follow the advice of their trusted physician? This question is one which leads me to review the notion of resistance to preventive health care in the general population. Is it truly resistance or merely ignorance which allows us to not live our lives in a healthful manner? I wish to explore the existence of resistance, interferences to initiating a healthy lifestyle, the responsible parties, and finally, activities which the NCAFP has developed to assist in this very important task.

This past week was very tumultuous in our office. Our team transitioned to a facility designed for a full computerized record-keeping system. This technology is one which should allow the doctor to spend more quality time listening and offering advice to our patients. I was quite proud of the accomplishment but quickly learned that electronic health records does not solve all problems, as noted by a most recent experience. Late Friday afternoon one of our seniors entered for her usual visit. Her concern is always that of the “ticker.” During the interview the topic of diet was reviewed. She assured me that for the most part she ate healthy foods, but this past week she had a taste for a pork barbecue sandwich. Unfortunately, her blood pressure revealed some loss of control on this visit. Upon providing the usual response for need to maintain a cardiac prudent diet, her response was, “Doctor, I only live once and I want to enjoy it while I am still here.” How does one respond? A smile and recognize a good point is made? Is that the end of the encounter or is it an invitation for debate? Perhaps one could take the patriarchal approach and insist that the patient follow the physician’s advice or terminate the relationship. There are other issues which arise, including poor outcome for this patient, including risk of death, physician’s responsibility to document the response, acknowledging non-compliance, requirement of documenting the management plan for this new problem. Anyone providing advice encountering responses contrary to the message attempted to be conveyed. Preventive medicine topics are the bane of my day; yet this is the area in which family physicians can have a great impact if successful. Perhaps reviewing other resistant responses will allow us some insight into what people are thinking about.

In an effort to prepare for this review I sought the input from my most trusted advisors - my husband and kids. I asked them to give me some reasons why they do not do as the doctor requests. This is the aggregated list: “I only have one life to live, so why waste it,” “I will start tomorrow,” “My grandmother/grandfather did it this way and they lived to be one hundred.” “It tastes/feels so good, just a little won’t hurt,” “I am going to die of something anyway,” “I know of someone who did everything right and they died anyway,” “My doctor does not exercise or eat right or smokes or drinks,” “I will quit when I get older,” “Those problems are not in my genes,” “Everybody else does it,” “My medical problems will not allow me to exercise,” “It costs too much money to buy healthy foods,” “I don’t have time to plan meals or exercise.” The list goes on and I encourage you to review your own encounters.

In order to provide a response to excuses for not living optimally, perhaps we need to understand some of the pressures people must deal with, adding to resistance for change. The easiest response is echoed by Flip Wilson’s words, “The devil made me do it.” The better response may be found in the media. The role of radio, television, billboards, posters, magazines, and the Internet is a very important contributor to this American problem. Famous people, such as John Wayne, were legends in their own time more than we ever recognized. “Invisible mentors” of this nature play a role in establishing behaviors which may be deceptive from a healthy standpoint. I must relate my experience when searching for a small burger, since I only desired a taste. I pulled into the driveway of a fast food restaurant and requested a small hamburger. Of course cheese was offered for an additional amount, which I declined. I went to the pickup window and received a very lightweight bag. Upon opening it, I discovered a burger just a little larger than a silver dollar. What was this and where is the beef? Since I was thinking healthy this particular day, does smaller mean better dietary choice or an opportunity to eat more of them? Anyone in New York knows you must order at least a half dozen of White Castle burgers in order to satisfy the taste. The same goes for doughnut holes, chicken nuggets, spacedots ice cream, etc. The media campaigns are widespread and have strong financial implications. The challenge for the physician to overcome interference of this nature will be great. I must surmise to say the job is far beyond the action of one, but will require the concerted efforts of many.

Implementing change toward a healthy lifestyle will not only involve our state and federal government campaigns, but also require educating the educated."
require educating the educated. It will be necessary for the physician, the teacher, the dietician, the social worker, the preacher, and all who have been instructed in formal education, to learn a new approach. This change must be perceived not as an addition to living, but fully integrated as a lifestyle starting early in childhood. Family physicians are essential in educating the public, and the NCAFP is taking a lead role for the state of North Carolina. The NCAFP has projects designed for members and supporting organizations to utilize in the day-to-day contact with people in the communities we serve. Projects such as Tar Wars for prevention of smoking are targeted to third-graders; Into The Mouths of Babes dental varnish project, and the Adolescent Obesity and Inactivity Project, are developed for use in the office or classroom setting. If each member or supporting group highlighted a selected project to implement in their community this year, then North Carolinians as a whole would benefit. The emphasis this year is on childhood obesity. This project is designed to work in collaboration with the NC Cooperative Extension Service. We are asking our members to take the initiative and to contact the NCAFP in order to link you with a participating NC Cooperative Extension agent in order to get started in your community. Working with the kids is a good place to start lifestyle changes.

It is clear that many factors play a role in resistance to change. The individual physician may certainly find the task of counteracting external influences as an insurmountable problem. The joint effort of practices and the NCAFP will lead to success in creating a healthier and happier population. I look forward to working with each of you in this endeavor in order that we actively assimilate preventive health measures in each encounter.

Over 100 Physicians Enjoy Spring Meeting in Wrightsville Beach

The Holiday Inn SunSpree Resort in Wrightsville Beach, NC provided a beautiful backdrop for the NCAFP's annual Spring Family Physicians Weekend on April 7-10. Over one hundred physicians were on hand to hear lectures on a range of clinical topics. On Friday, Lieutenant Governor Beverly Perdue was presented with an Academy Distinguished Service Award after a brief awards ceremony. Perdue was recognized for her leadership of the NC Health and Wellness Trust Fund Commission and its various programs.

In addition to the meeting's CME sessions and exhibition, the Academy also conducted a full agenda of business meetings. All Academy councils met during the weekend, including the newly-formed Health Disparities Council.

Second Stop on the EHR Roadshow a Success!

The second stop of the NCAFP and the North Carolina Pediatric Society (NCPS) EHR Roadshow was held in Greensboro, NC on March 12, 2005 at the Grandover Resort and Conference Center. The event consisted of a day long educational conference with expert panel discussions and presentations on electronic health records. Two expert panel presentations - one on Implementation (contracting, cost considerations and financing) and the other on Maintenance (long-term services and long-term advantages), were presented, along with presentations on electronic health records. The activities were particularly informative for attendees and there were plenty of opportunities to get questions answered by the experts. There is one more stop on the EHR Roadshow in Wilmington this Fall - September 17, 2005. Please check our website for the most up-to-date information.

Gear Up for Our Mid-Summer Meeting

Myrtle Beach on the fourth of July equals summertime fun! It's the perfect place to bring your family for a week of fun, relaxation and convenient half-day sessions of CME. Program Chair, Christopher Snyder, MD has an outstanding program planned that's full of variety and information about issues facing family physicians in practice today.

The meeting will present great activities for the entire family to enjoy. On Monday evening NCAFP will host our annual Summer Fun Pig Pickin'. On Wednesday, plan to hit the links with our fun NCAFP Golf Challenge. And Thursday features Dolly Parton's Dixie Stampede - a fun-filled, action-packed dinner and show extravaganza for everyone! Great fun and superior accommodations await you and your family!

In a break from the past, all registrants will receive an electronic syllabus on CD ROM that will contain all lecture handouts and meeting materials. These will be made available for download/printing prior to the meeting. A limited-number of printed versions of the syllabus will be available for $20.

Pre-registration is required. To register, mail or fax your registration form with your credit card number or check made payable to the NCAFP. Registration can also be completed online at http://www.ncafp.com/cme. Refunds (less a $75 administrative fee) will be made only upon receipt of a written request. No refunds will be made after June 1.
Why should family physicians identify developmental delays in children?

a) Because Medicaid now requires it

b) Because identification and treatment of developmental delays can make an enormous difference in children’s lives by enabling them to meet their potential

Both answers are correct, but ‘b’ should be particularly compelling. The fact that Medicaid now requires screening is a fortunate convergence of rules with good medicine.

Overall, about 16% of children have some kind of developmental disability. When psychosocial problems are also considered, between 20% and 25% of children have some kind of developmental or behavioral problem. This has been referred to as the “new morbidity” in pediatrics.

You probably find this corresponds to your experience. Public health and medicine have advanced so that relatively few children suffer from the serious illnesses of the past, such as mastoiditis and meningitis.

Much of what children now suffer from are developmental delays and learning disabilities, leading to poor school performance and low self-esteem; as well as behavioral problems such as ADHD, depression, and anxiety.

You may have had children in your practice like Charles, who entered kindergarten with no preschool experience and without identification of his severe delays. His lack of understanding of the expectations for him resulted in behavior and emotional problems - and was hard on his classmates, teacher, and parents. In contrast, Michael was identified at 3 with both developmental and behavioral problems. By the time he entered kindergarten, he had made significant progress. He was put in a class appropriate for his needs -2 days a week in a special program and 3 days in regular kindergarten. Not only was he happy there, but his mother was thrilled at his improvement.

Can we make a difference? Absolutely.

Early intervention for developmental problems can produce the following benefits: developmental gains, prevention of some disabilities, reduction of family stress, reduction of the need for special education, and financial savings. Each dollar spent is estimated to save $7. Of course, early intervention can take place only if developmental problems are identified.

How do we identify developmental delays?

Two time-honored methods are no longer state of the art. The most common form of “screening” has been “clinical judgment” or “I know one when I see one.” The screen that many of us learned we should use is the Denver, but most of us don’t use it because it is cumbersome. Although we learned it was the standard, the Denver has low sensitivity and specificity.

With current practice, less than half of developmental delays are identified before school entry.

The screens currently recommended for office practice are based on information supplied by parents. These are considerably easier and faster to administer than the Denver and can be integrated into an office protocol for well child visits. The two major screening tools currently used and recommended are Ages and Stages and PEDS.

Ages and Stages (ASQ) consists of 19 different questionnaires, each for a different age between 4 and 60 months. Each survey asks specific questions about what the parent has observed the child to do (e.g., “does your baby pick up a toy and put it in his mouth?”), is about 4 pages, and takes about 7 minutes to administer. It is easy to score and may be reproduced.

Parents’ Evaluation of Developmental Status (PEDS) is a single page of 10 questions administered to parents of children ages 0-8. The questions elicit parental concerns.

(E.g., “do you have any concerns about how your child talks and makes speech sounds?”) It takes about 2 minutes to fill out. There are 5 possible scoring outcomes. One requires a second screen, so, if you use PEDS, you need to have access to another screening instrument, either in your office or by referral. PEDS may not be reproduced.

Both ASQ and PEDS can be scored rapidly. Both have sensitivities and specificities of about 75%. Although this is much improved from the Denver or “clinical judgment,” this still means that about 1 in 4 is missed on each screen. (Repeated screening decreases this number.) Continue to be alert for delays not identified by the parent and to pursue other testing if indicated. For
instance, one mother filled out her PEDS with no concerns, but, when I noted that her 3-year-old’s speech was unclear, she said, “He can’t pronounce some of his letters.” Of course, I referred him for speech evaluation despite an apparently negative screen.

Medicaid now requires a formal screening tool, and either PEDS or ASQ is acceptable. Children must be screened at their 6, 12, 18 or 24 months, and 3, 4, and 5-year Healthcheck appointments. You may elect to screen at more ages. The developmental screen is now coded separately as 96110-EP.

Integrating developmental screens into your well-child checks is not difficult. It requires an initial investment of time for developing a process. Pick a screening tool (and, if you select PEDS, a back-up for those children who need a 2nd screen). Decide on the ages for testing. Determine when the parent will receive the tool (e.g., in the waiting room or exam room), who will give it, who will score it, when it will be reviewed with the parent, and how referrals will be handled. Chart the process, including which staff are responsible for each step.

These tools are screening tests, not diagnostic instruments. They identify children who need further evaluation.

Interpreting the results tactfully and accurately is critical. Neither overstate (which will cause undue worry) nor understate (which may lead the family to neglect the follow-up) your findings. Discuss the child’s strengths as well as his weaknesses. Do not give diagnoses. For instance, say, “Will is a happy baby with a good disposition. I am concerned that he is not yet doing some things that other babies his age do.” Note that there is a range over which children achieve skills and that the child is likely to develop the skills in question at some point.

If you are making a referral, be sure to describe the referral program and how it will benefit their child. The more that you, their family doctor, are able to assure them that you are referring them to a place you trust, which will look after the best interests of their child and family, the more likely they are to follow through. And be sure that they know that you will continue to take care of their child.

Developmental assessment and treatment is covered by IDEA, the Individuals with Disabilities Education Act. This is different from most medical conditions that we see. Your patients don’t have a federal right to treatment of their strep throats, but they do for their developmental problems.

In North Carolina, the key resource for young children with developmental delays is the local CDSA, Children’s Developmental Service Agency (formerly the Developmental Evaluation Center). Children aged 0-3 who need evaluation should be referred there. All children are eligible for free evaluation by their CDSA, irrespective of family income. Children who qualify will be entered into the infant-toddler program. Children are eligible for the program not only if they have documented developmental delay (>20%), but if they are high-risk for delay (e.g., if they have a condition such as neurofibromatosis which puts them at risk, even if they are not currently delayed) or if they have atypical development (e.g., hyperactivity or separation difficulties). CDSAs provide or refer for a wide variety of services, including physical therapy, occupational therapy, nutrition, and family therapy.
Another important resource is Child Service Coordination. This program is administered by the health department and is available to privately insured as well as Medicaid patients. Child service coordinators do home visits on children at risk, and perform developmental assessments. The exact guidelines may vary according to region, but, in general, they are particularly useful in following children about whom you have concerns, but who have not manifested clear delays.

According to IDEA, children aged 3 or over are the responsibility of the school system. Referrals go to an intervention team, which determines what testing is needed. For school-aged children, you should make the referral to the child's school. For children 3-5, contact your school system to find out where to make these referrals. Some more complex children may be evaluated at the CDSA, but the school system will determine these criteria. You will find it helpful to build a relationship between the preschool contact and the medical community so that everyone completely understands the referral process.

Children over the age of 3 are eligible for services only if their disability affects their educational performance. In other words, the criteria are stricter than for younger children, and some children who are eligible as toddlers are no longer eligible after 3.

Knowing your community resources is key. Screening will benefit the children in your practice only if you make the appropriate referrals when indicated.

As you work with these children, remember that psychosocial problems and maternal depression are risk factors for developmental and behavioral problems in children. As family practitioners, we have a unique role to play. Identifying a child with problems is an opportunity to see other family members and screen for related problems - or discuss the stress of having a child with a disability.

Why should family physicians identify developmental delays in children?

Becoming competent at developmental screening takes a relatively small investment of money and time, and the return is large. It provides us a perfect opportunity to interact with other community agencies that share our interest in improving the lives of our patients. And it is a way to participate in addressing the major challenges that confront children today and look forward to the time when untreated developmental delays are as rare as mastoiditis.

Resources
Developmental Screening Tools
ASQ - www.brookespublishing.com
PEDS - www.pedstest.com

For more information about setting up screening in your practice:
The American Academy of Pediatrics Section on Developmental and Behavioral Pediatrics - www.dbpeds.org
Go to “Practice”, then “Screening” for information on screening tools and implementing screening.
The North Carolina Pediatric Society - www.ncpeds.org
Includes Developmental and Behavioral Screening and Surveillance-step-by-step directions to start screening in your practice (PowerPoint presentation)
Sherry.Hay@ncmail.net can provide “Getting Started” worksheets, office resource guides and expertise on implementing screening in practice
To find your CDSA and for other early intervention information:
Together We Grow - North Carolina Early Intervention Services www.ncei.org

TAR WARS UPDATE

Busy! That is the best word to describe the numerous Tar Wars presenters across the state. Requests for giveaways and questions about the May 11, 2005 poster submission are hot topics for the program coordinator.

Various groups and individuals have decided to implement Tar Wars in their towns. Thanks to NCAFP member, Dr. Kia Jeanell, a Durham chapter of the Kappa Alpha Psi fraternity is using Tar Wars as part of their mentoring program.

In an adjacent town, Katie Chwastiak and the UNC FMIG have taken the Tar Wars program to all of the elementary schools in the Chapel Hill - Carrboro district. Presenting to over 825 fourth- and fifth-graders kept the UNC medical students moving during the months of January and February. The feedback from the principals, school nurses, teachers and students has been extremely positive.

Moving to western North Carolina, Dr. Joseph Antinori and his colleagues in Burnsville officially signed on to present Tar Wars in Yancey County and over 250 students will learn about the short-term effects of using tobacco. Once again, the Alleghany physicians, including Dr. Beth Lyon-Smith, are making their mark in the home of the 2004 National Tar Wars Poster Contest Winner.

If you would like to present Tar Wars in your community, please visit www.ncafp.com/tarwars or send an email to tsingletary@ncafp.com. It is a fun and easy interactive presentation; just ask the Ahoskie high school presenters and their trainer, Michelle Warren, RN!
North Carolina Match Improves in 2005

Preliminary information available from the National Resident Matching Program (NRMP) indicates that the 2005 national fill rate for family medicine residency positions is 2,292 positions filled out of 2,782 positions offered (82.4%). In NC, the fill rate was 83.5% up from 80% last year.

This represents an increase in the percentage of family medicine residency positions filled through the NRMP over 2004. [Included in this category are family medicine-psychiatry and internal medicine-family medicine.] One-hundred and two fewer family medicine positions (3.5%) were offered in 2005 than in 2004. Of U.S. seniors participating in the 2005 NRMP, 7.7% matched in family medicine compared with 8.2% in 2004. Similarly, of U.S. seniors matching, 8.2% matched in family medicine compared with 8.8% in 2004. 2005 is the eighth consecutive year since 1998 that a smaller percentage of U.S. seniors, participating and matching through the NRMP, matched in family medicine than the previous year. Medical students in 2005 continue to demonstrate a preference for medical subspecialties over primary care when compared with data from the past several years. Declining interest in primary care careers, including family medicine, continues.

While fill rates have improved slightly, some of the increase is attributable to a reduction in the number of positions offered and to stronger interest among international medical graduates, many of whom will return to their country of origin following their medical training. Prepared by the AAFP Division of Medical Education: Data Source: National Resident Matching Program.

### 2005 Match Results by Program

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<td>-</td>
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</tr>
</tbody>
</table>

* 1 filled prematch DO candidate who did not want to participate in the Match, for a total of 6 of 8 slots filled.
** 1 filled prematch DO candidate who did not participate in the Match, for a total of 6 of 8 slots.
Welcome To New Academy Members

The Academy wishes to extend a warm welcome to all new members. If you have any questions regarding membership, please contact Tish Singletary at (919) 833-2110 or via email at tsingletary@ncafp.com

Active Members
Victor M. Alvarez, MD (Charlotte)
Paul D. Collins, MD (Wilmington)
Jason Douglas Creel, DO (Franklin)
Dawod A. Dawod, MD (Raleigh)
Stacey E. Devine, MD (Charlotte)
Steven P. Dzialas, MD (Almond)
Dane R. Flöberg, MD (Charlotte)
James E. France, MD (Clemmons)
Brian H. Halstater, MD (Durham)
John M. Hemmersmeier, MD (Durham)
Raghu R. Katuru, MD (Jacksonville)
Daniel G. Koch, MD (Lincolnton)
David N. LaMond, DO (Hendersonville)
Susan M. S. Lester, MD (Waxhaw)
William M. Lester, MD (Waxhaw)
Kenneth M. MacKinnon, MD (Fletcher)
Charlita Rose Mangrum, MD (Hamlet)
Kenneth R. McElvain, MD (Morehead City)
Matthew Scott McGlothlin, MD (Oxford)
James A. Mitchell, MD (Fayetteville)

Susan R. Pittman, MD (Locust)
John E. Reaves, Jr., MD (Mount Holly)
Sarita Sharma, MD (Durham)
James Harrison Shepherd, MD (Mooreville)
David M. B. Smith, MD (Franklin)
Mark K. Stephenson, MD (Charleston, WV)
Vyyvan Y. Sun, MD (Greensboro)
Grace Tang, MD (Raleigh)
Joseph Jack Umesi, MD (Raleigh)
Gloria Vreeland, MD (Leland)
Michael Wang, MD (Wendell)

Inactive Members
Hilary L. Canipe, MD (Murfreesboro)
Michael M. McLeod, Jr., DO (Greenville)

Resident Members
Pamela M. Binns, MD (Charlotte)
Genevieve N. Brauning, MD (Charlotte)
Katherine M. Walker, MD (Greensboro)

Student Members
Mr. Adam J. Froyum Roise (Raleigh)
Ms. Anne Lachiewicz (Chapel Hill)
Mr. Kyle Mills (Chapel Hill)
Ms. Crystal M. Pressley (Carrboro)
Ms. Sarah Rogers (Chapel Hill)
Mr. James G. Wallace, Jr., MPH (Chapel Hill)

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**MAKE A SPECIAL GIFT**

You can honor or memorialize a colleague, friend or family member with a gift to the NCAFP Foundation. By making a special designation, the Foundation will send a card to the family of the deceased, individual or organization being honored. The card will show your name as the donor, but not the amount of the contribution. To make your special, tax-deductible gift, contact Marlene Rosol, Development Coordinator, NCAFP Foundation, (919) 833-2110, (800) 872-9482 [NC only], or mrosol@ncafp.com. Thank you!

**FOUNDATION SCHOLARSHIP PROGRAM**

The NCAFP Foundation wants to help our North Carolina medical students! All NC medical students are eligible to apply for one of four scholarships in 2004. Applications are due in the Foundation office by May 3, 2005. There is still time for you to apply for a scholarship. Applications are available through the four FMIG programs or you can download them on the NCAFP website (www.ncafp.com). For more information on student scholarships, or how you can make a donation to the Scholarship Program, please contact Christy Ayscue, Programs Coordinator, at (800) 872-9482 [NC only], (919) 833-2110, or cayscue@ncafp.com.

**VISIT THE FOUNDATION ON THE WEB!**

Pay a visit to our web site at www.ncafp.com and discover more about the NCAFP Foundation. You’ll be able to read all about our programs and projects, and how you can get involved!

**THE FOUNDATION VALUES ITS CORPORATE MEMBERS!**

The NCAFP Foundation’s Corporate Members are important to us! Their participation and support are crucial to what we do, and we are proud to include them as part of our Foundation family.

**Thank you to our 2004 Corporate Members! We couldn’t do it without you!**

**Grand Patrons:**
- First Citizens Bank, Raleigh, NC*
- NC Academy of Family Physicians, Raleigh, NC*

**Patrons:**
- Novant Health, Winston-Salem, NC**
- UNC Hospitals, Chapel Hill, NC**

**Supporters:**
- ECR Pharmaceuticals, Richmond, VA**
- MedCost, LLC, Winston-Salem, NC*
- Moses Cone Health System, Greensboro, NC*

*Corporate Members - Unrestricted    **Corporate Members - Restricted
Family Medicine Interest Group Dinners
Each year, the Family Medicine Interest Groups (FMIG) at each of the four NC medical schools holds a dinner towards the end of the school year. The purpose of the FMIG Annual Dinner meetings is to bring students, residents, and family physicians together on an informal basis to discuss issues pertinent to the field of family medicine. Over 100 medical students, family medicine residents, faculty and community physicians are expected to attend the dinners this year.

Brody School of Medicine at East Carolina University: Wednesday, April 13, 2005
University of North Carolina at Chapel Hill: Tuesday, April 26, 2005
Duke University: Thursday, April 28
Wake Forest University: Thursday, May 12

Get Ready for Fellowship and Learning in Kansas City
The 2005 National Conference of Family Practice Residents and Medical Students will take place July 27 - 30 in Kansas City, MO. For thirty-two years, this meeting has been planned exclusively for residents and medical students and is the largest gathering of its kind in the country.

The theme of this year’s meeting is Your Voice Counts - Who Do You Speak For? Attendees will learn about policy development, lobbying, helping patients navigate the health care system and how to maximize their medical school and residency experience. You can attend clinical workshops, learn how to use the latest medical technology equipment, network with fellow students and physicians and tour the large exhibit hall of family practice residency programs and practice opportunities. Scholarship opportunities are available from the AAFP. Visit the AAFP’s website for more detailed meeting information and to apply for the scholarships: www.aafp.org/conference.xml

Practice Management Conference and Opportunities Fair
The Practice Management Conference was held Friday, March 18. A total of 55 second-year family medicine residents attended the meeting to explore issues of practice management, legal issues and career choices. Residents were able to interact with local hospital systems recruiting family physicians and other vendors in the exhibit hall.

Sign up for the New Student Mentoring Program
Many of you have already shown support of student members of the NCAFP by providing student buddy money, allowing students to use the money to either become a member of the NCAFP or to fund the registration for attending the conference. For this, the students are very grateful. This is another opportunity for you to get more involved with the students and serving as their link to this wonderful profession.

In an effort to increase student interest in family medicine, NCAFP student members would like to create a mentoring program. The goal of this system will be to provide a contact person for students interested in family medicine so that they may gain a better understanding of what family physicians do and answer any questions that they may have. Hopefully by creating this link, those students who are interested in family medicine will stay interested.

If you want to become a student mentor, please send your name, address, phone number, and email address to Kimberly_bennett@med.unc.edu.
In order to equip yourself with the knowledge you need to make informed decisions regarding the Electronic Medical Records solution that’s right for you, you should understand the various capabilities of EHR products. Not all EHR products are created equal. The following EHR Checklist contains some of the more important factors you should consider when deciding whether or not to give a vendor and their product a second look. Keep in mind that a vendor’s appearance on paper is only part of the evaluation process. Be sure to ask each company for a demonstration of their product, and be sure it is, or can be, customized for your specialty and the way you do business.

1. Workflow Efficiency: Does the EHR have a flexible configuration that won’t hinder my current workflow?
2. Specialty Content: Does the EHR system have clinical content tailored for my specialty?
3. User Flexibility: Does the vendor mandate that every clinician document the same way using templates, or can some clinicians continue to dictate?
4. Implementation Flexibility: Is the EHR sold modularly, or does it need to be purchased/implemented as a set package? Can I add functionality later as my needs grow?
5. Clinically-Driven Product Design: Was the EHR system developed with input from actual clinicians physicians, nurses and other caregivers?
6. Return On Investment: Can the EHR help generate revenue for my practice, reduce inefficiency and help me provide excellent patient care?
7. Product Integration: Will the EHR work with my existing practice management system? Does the company sell a practice management system, as well, so I can take advantage of an integrated system?
8. Installation, Training & Support: Does the vendor install their systems? Provide in-depth, on-site training to the practice? Have a dedicated support team available after installation is complete or offer other value-added services?
9. Vendor Stability: Will the vendor be around to support me in the long run?
10. Commitment to Product Development: Will the functionality and feature-set of the EHR continue to grow? How frequently does the company release updates/new versions of the product?

Workflow
The best EHR solutions don’t completely change the way your practice runs - instead, they are flexible enough to fit into your existing workflow while also improving, streamlining and smoothing the rough edges in your work processes.

Consider how your practice works and look for an EHR solution that contains features that can best help improve your office’s workflow.

Examples of features might include:

- The use of specialty-specific templates to quickly record chart notes
- Electronic patient check-in to improve efficiency
- Electronic results sign-off to save staff time and allow quicker turnaround for the patient
- Real-time access to patient charts, day or night
- Instant messaging to improve office communication (especially beneficial for practices with multiple locations)
- A flexible transcription tool
- A customizable patient summary screen for viewing data the way you want to see it

Content Tailored to Your Specialty
Some systems come equipped with templates specific to your specialty, reducing the amount of manual data entry required to get the system up and running. Others don’t. It’s important to keep in mind how much time you and/or your staff want to spend customizing your system when evaluating products.

Be sure to ask the vendor if their templates were created with input from clinicians in your specialty. Further, ask vendors if other users of their product trade or sell their templates - another option that can save you customization time.

Documentation Flexibility
Some EHR systems take an “all or nothing” approach with documentation. They require that every physician in the practice use only templates, and sometimes only one type of template can be used throughout the practice. This shuts out, for example, anyone at the practice who wants to continue handwriting notes or dictating. Depending on your practice’s needs, you may want to look for an EHR system that allows more than one form of documentation.

Flexible Implementation
Consider your practice’s needs, budget and capabilities when researching a vendor’s implementation options. For example, do you need an entire EHR solution now, or would you prefer to purchase and implement specific components incrementally? Some practices might want to add transcription or document imaging in the early phases, while waiting until later to implement point-of-care charting and charge passing. This modular approach may be more affordable, and it allows your staff the flexibility and time to master specific components before new ones are implemented. On the other hand, if your practice is on a more accelerated timeframe, a modular approach may not work - you’ll want to look for a vendor that can help you become fully operational from the start.

No matter which implementation option you choose, be sure to find out from the vendor if you can add functionality later as your needs grow.

Clinically-Driven Design
Consider EHR systems developed with input from actual clinicians: physicians, nurses and other caregivers who fully understand how medical practices operate. The best EHR providers have clinicians who help drive the direction of products - improvements, advancements and needed innovations. They also have physician groups who advise and guide product development, and a client base of physicians who are able to provide input. These EHR providers have the clearest vision and the best understanding of what clinicians want and need.

Return On Investment
An important factor in choosing an EHR solution is finding one that can maximize your return on investment by generating revenue, reducing inefficiencies and improving patient care. A user-friendly EHR system can provide a wide variety of benefits to practices, including, for example, the ability to add another physician without adding new support staff. Growth then comes at practically no increased staffing costs.

Ways an EHR system can provide a return on investment, either financial or otherwise:

- Eliminate costs associated with creating and maintaining paper charts
- Reduce or eliminate chart storage
- Increase revenue through added exam rooms as chart rooms are converted
- Code more accurately through the use of templates and coding features
- Add doctors without adding ancillary staff
- Increase efficiency through streamlined processes
- Go home earlier each day without compromising the quality of care
Integration With Another Vendor’s Practice Management Software

If your goal is a seamless flow of data between your practice management and EHR systems, that is usually best accomplished when the two are completely integrated through one vendor.

However, some EHR companies will offer to write an interface so that your practice management system and their EHR system can exchange data. This is a viable and often affordable solution, but it can also create some unique challenges. For example, which vendor do you call for support if the interface experiences problems? What happens during software upgrades - will the interface continue to operate?

You may also want to ask the vendors you are considering about product integration beyond the practice management system. Will the EHR allow you to share patient data across multiple medical care settings? A strong EHR product will continuously evolve, not only meeting your current challenges, but addressing your future needs.

Training and Support

Perhaps one of the most important, yet underestimated, parts of an EHR purchase revolves around training and support. When you evaluate support capabilities, be sure that the EHR company has the staffing, business hours and locations to provide you with answers when and where you need them.

Find out if ongoing training is available via several venues (on- and off-site, users group, Web, phone, etc) and if you have to pay trainers’ travel expenses. Ask if the trainers are company employees or subcontractors. Check on the customer support hours of operation and if on-site support is available.

Vendor Stability

Considering the company as well as the product is important when choosing an EHR solution. You must be sure the company you choose today will still be around tomorrow to provide you with support and product enhancements.

Find out:
- How long has the company been in business?
- What are the company’s recent revenues, and what have they been for the past few years? Is there a pattern of growth?
- How many EHR clients does the vendor have?
- Does the vendor serve other practices in your specialty? If so, how many?
- What do the vendor’s references have to say about the product? Or about the customer service?

Ongoing Product Development

How is the vendor you choose working to improve your EHR system so that your feature set and functionality keeps growing?

One way to tell is by getting the actual dollar amount it spends annually on research and development. Top EHR companies re-invest a substantial amount of profits in their products, which means they are literally invested in you and your continued success.

Conclusion

Selecting an EHR system can be a difficult decision, but using an EHR checklist can help you compare “apples to apples” and determine the right product for your practice. Choosing an EHR system also means choosing a reliable partner, one that will be there to provide you with product enhancements and continued support. Also, consider the overall feeling you have for a particular vendor, as well as your impression of the company’s executives, sales representatives and support team. The right company will have a quality product, people and a commitment to the long-term success of your practice.

About the Authors

Ms. Ellis is Manager of Sales Application Support and Ms. Moulton is a marketing specialist at Raleigh-based Misys Healthcare Systems. They have a combined 13+ years in the healthcare IT industry.

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Medicaid Dental Providers

As we all know it is often difficult to locate a dentist to provide treatment for Medicaid-covered children under age 3. Did you know that there are 3 privately-owned dental clinics in NC that see Medicaid children exclusively, from birth to age 20? The clinics are owned and operated by Dr. Tish Balance, and are located in Charlotte (704.393.3911), Raleigh (919.733.3002), and Winston-Salem (336.777.1272). If you need more information, such as address or driving directions, please call the individual clinic at the above number. While this is not an option for everyone, it may be helpful for patients living in the surrounding areas.

The NC Division of Medical Assistance also posts a Medicaid dental provider list by county on their website. This list contains “significant” providers, or those accepting at least 10 new Medicaid patients during the previous quarter. Providers are classified as a ‘general dentist’, as a health department or community health center, or by their specialty. Medicaid reports that although this information is not guaranteed, these are the providers more likely to accept Medicaid as payment.

For more information go to:
www.dhhs.state.nc.us/dma/dental/dentalprovlistnew.xls
Many activities have taken place across the state as the Adolescent Obesity & Inactivity pilot county participants began to implement their plans. Examples of the activities are many, yet the common theme has been the collaboration between family physicians and Cooperative Extension agents. The momentum that has been generated can only reflect the desire to address the rising rates of childhood obesity and inactivity that seems to have entrenched itself in every county across the state.

Many of you have seen or heard the FitTogether advertising campaign that directs individuals to www.fittogethernc.org. This site encompasses a health risk assessment, directory of community resources and agencies and tips for incorporating more activity and better eating into one’s lifestyle. Take a moment to visit the site and tell us what you think?

You see individuals on a daily basis that can use some additional information to obtain or maintain healthier lives. Do you believe this website offers enough ideas to serve as an additional resource for your patients? Can you share some of the tools that you use? Have you built a coalition within your community with the intent of making environmental changes similar to more walking trails or sidewalks in town? What do you think it will take to make a difference?

Perhaps a primary example of making a change in your community is the Fitness Renaissance story. Aware that healthy habits begin early, Dr. Tommy Newton, working with a team of school administrators in Clinton, NC, decided to develop a physical activity program that would start with kindergarten through grade five students. The objective of Fitness Renaissance is to have children work on an individualized activity goal for a nine-week period. Upon completion of the first time-period, children that have achieved their goal are then awarded with incentives that reinforce their experience.

Last November, Dr. Newton made a presentation to the Clinton City School Board, who endorsed the programs concept. Since its implementation, over 1000 students at Kerr and Butler Avenue Elementary Schools have been through the first nine-week module and received awards in January. According to Dr. Newton, “Students have displayed persistent excitement about both the selected activities and their own prospects for accomplishing their goal, thus receiving an award.”

The program has received newspaper coverage on a local and regional basis as an example of community collaboration and efforts to help children in living healthier and more active lives. Several Clinton City civic clubs, including the Kiwanis and American Business Women’s Association, have contributed to Fitness Renaissance.

In December of 2004, the NCAFP Board of Directors voted to endorse the use of Fitness Renaissance as an Academy Project. For more information about the program and how you can begin in your community, please contact the NCAFP at 919-833-2110 x 114 or tsingletary@ncafp.com.
That’s healthy advice for many of your African-American patients.

- A new report by the National Medical Association† recommends African Americans consume 3-4 servings of low-fat dairy foods daily to reduce the risk of chronic diseases, such as obesity and hypertension.¹
- Nearly half of all African Americans consume less than one dairy serving daily¹ which may lead to inadequate intake of important nutrients.
- The newly released Dietary Guidelines for Americans recommend people consume 3 servings of fat-free or low-fat milk or milk products every day as part of a healthy diet, and lactose-free milk or yogurt for individuals who are lactose intolerant.²

People who are sensitive to lactose can still enjoy dairy foods’ great taste and health benefits. Here are a few tips to consider.

Drink lactose-free milk, such as LACTAID® Milk, which offers all the nutrients of regular milk, but is easier to digest and tastes great.

Aged cheeses like Cheddar and Swiss are naturally low in lactose.

Introduce milk and other dairy foods into the diet slowly. Start with small portions with meals or snacks and gradually work up to 3 servings a day.

Remember LACTAID® Fast Act Dietary Supplements with the first bite or sip of dairy to help break down lactose so patients can enjoy milk and other dairy foods.

Yogurt is good. Cultured dairy foods like yogurt contain friendly bacteria that help digest lactose.

Visit www.nationaldairycouncil.org for more information about dairy’s role in weight loss and to download a free African-American health education kit, including patient education materials.

For information on LACTAID® Products and lactose-free recipes visit www.lactaid.com or call 1-800-LACTAID.

¹ Research indicates that including 3 servings of dairy each day in a reduced-calorie diet may help support healthy weight loss.
² The National Medical Association is the leading national organization representing African-American physicians and health professionals.