AAFP, ADFM, AFMRD, AND STFM RELEASE JOINT STATEMENT REGARDING DUKE RESIDENCY

THE SHELL GAME AND YOUR PRACTICE RETIREMENT PLAN
The 2006 American Academy of Pediatrics report on optimizing bone health supports dairy’s role in the bone health of children and adolescents.

Talk to your patients about including three servings of dairy a day (milk, cheese or yogurt) to help build stronger bones.

- **Assess Calcium Intake:**
  The AAP suggests periodically assessing calcium intake and risk factors for suboptimal bone health at 2 or 3 years of age, after the infant is no longer taking human milk or formula; during preadolescence (8-9 years of age); and during early adolescence, when peak accumulation of calcium occurs. Refer to the AAP report, “Optimizing Bone Health and Calcium Intakes of Infants, Children, and Adolescents” for an assessment questionnaire.

- **Share Bone Building Tips:**
  Most people can achieve the recommended dietary intake of calcium by eating three servings of milk, cheese, or yogurt each day. Low-fat and fat-free versions are encouraged. Non-dairy food sources and supplements are an alternative, but these products do not offer the same nutrient benefits of dairy foods.

- **Model Healthy Habits:**
  All family members should evaluate their calcium intake and consider three servings of dairy a day (4 for adolescents) for building stronger bones.

- **Be Active:**
  Encourage physical activity, primarily weight-bearing exercise as part of an overall healthy bone program.

Visit [www.nationaldairycouncil.org](http://www.nationaldairycouncil.org) to download a calcium assessment questionnaire for use with patients and [www.aap.org](http://www.aap.org) for additional resources.

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<table>
<thead>
<tr>
<th>Kids/Adolescents</th>
<th>Calcium Intake, mg/day</th>
<th>Servings of Dairy per Day</th>
</tr>
</thead>
<tbody>
<tr>
<td>1-3 years</td>
<td>500</td>
<td>3</td>
</tr>
<tr>
<td>4-8 years</td>
<td>800</td>
<td>3**</td>
</tr>
<tr>
<td>9-18 years</td>
<td>1300</td>
<td>4**</td>
</tr>
</tbody>
</table>

* Age-appropriate servings
** One serving equals 8 ounces of milk or milk equivalent

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7 out of 10 boys and 9 out of 10 girls don’t get the calcium they need.\(^1\,\,^2\)

Pediatricians Call for Calcium Check-up

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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.
I write this column in the midst of the Academy’s dialogue with Duke University about the future of the Family Medicine Residency Program. Although we have been aware of some difficulties in that program over the last 3 or 4 years especially, and have made some efforts to assist the Department in resolving them, it is fair to say we did not see this coming. Dismay, shock, anger, confusion – all reactions that have now given way to a sense of resolve to engage the Duke community in an attempt to understand this decision and reach a mutually successful outcome. We still believe that the Department of Community and Family Medicine should engage itself in training Family Medicine resident physicians and hope to reach a conclusion that will allow Duke to continue the nearly 35 year tradition of providing new family physicians for North Carolina. Many communities in our state would have more serious access-to-care issues if not for the Duke trained physicians serving them; many academic departments of Family Medicine would be poorer for not having the leadership of Duke trained family physicians.

The outpouring of support from many of our members has encouraged me. The vast majority of messages I have received have been supportive of the Academy’s position. Many of you have written to express your dismay and disappointment at this decision. I have particularly been impressed at the passionate replies from graduates of the Duke program. If you share these sentiments and have not already sent your message to Dr Brodhead and Dr Dzau, I encourage you to do so now. Dr Brodhead’s email address is richard.brodhead@duke.edu and Dr Dzau’s is victor.dzau@duke.edu

I must admit that there is a small minority of members who have said, in essence, good riddance. They feel that Duke has never treated family medicine with the respect and support that it deserved, and there is little need for us to use the valuable resources of the Academy in trying to save a program in a University system that doesn’t value our contributions. One member related his sense that this battle between family physicians and the rest of medicine had been ongoing for the 50 years of his career and that it made little sense to try and change what is unchangeable. I could not help but think of Don Quixote as I read his email – are we madmen tilting at windmills, pursuing an idealistic, impractical goal?

Cervantes criticized life dominated by greed, pride, and violence while defending the ideals of goodness, justice, truth and beauty. Perhaps, like Quixote we are pursuing an idealistic goal in a hostile environment. I disagree with the contention that it is an impractical goal we pursue. There is ample evidence in the literature that health systems that are primary care-based have better outcomes and lower costs. We do not ask that the specialty training and research at Duke go away or suffer any losses to maintain the family medicine residency. We need the specialists, and the Future of Family Medicine report showed us that the majority of specialists outside of academic medical centers see that they need us as well. We aren’t tilting at windmills; we are pursuing our ideals, sharing a vision, and seeking a practical solution to real needs in our society.
As we pursue our goals, we would do well to remember to avoid the trap of Jackson Browne’s song: seeing the years and fears go by without crying. I really can’t say it any better than Rachel Remen in *Kitchen Table Wisdom:*

“One of the most common experiences in the practice of medicine is the experience of loss and disappointment… Protecting ourselves from loss rather than grieving and healing our losses is one of the major causes of burnout. Very few of the professionals I have treated for burnout actually came in saying that they were burned out. I don’t think most of them knew. The most common thing I’ve been told is, “There is something wrong with me. I don’t care anymore. Terrible things happen in front of me and I feel nothing.”

Yet people who really don’t care are rarely vulnerable to burnout. Psychopaths don’t burn out. There are no burned out tyrants or dictators. Only people who do care can get to this place of numbness. We burn out not because we don’t care, but because we don’t grieve. We burn out because we have allowed our hearts to become so filled with loss that we have no room left to care….

Grieving is a way of self-care, the antidote to professionalism.

The bottom line is that grieving is not meant to be of help to any particular patient. You grieve because it is of help to you. It enables you to go forward after loss. It heals so that you are able to love again. “On to the next” is a denial of common humanity, an assertion that someone can die in front of us without touching us. It is a rejection of wholeness, of a human connection that is fundamental. It makes no sense at all when you say it out loud.”

“Grieving is a way of self-care, the antidote to professionalism.”

Find a trusted colleague, create a Meaning in Medicine group, seek help from a professional – the Center for Professional Well-Being in Durham or the Sotile’s in Winston-Salem would be a great place to start. Call me – 919.562.2288 – and let’s talk.

We are idealists. We can be pragmatic. Our goals are not impractical. Grieve your losses so you can still see the sky. We can and must make a difference, in our own lives, the lives of our communities, and the healthcare system whose morals sometimes seem as incompatible with our morals as Don Quixote’s and 16th century Spain’s were. Thank you for what you do everyday – it makes a difference!! I’m proud to be a Family Physician!!


Many priorities adopted by the Academy’s Government Affairs Advisory Council have seen action in this year’s “short session” of the N.C. General Assembly. Of particular interest has been the effort to increase funding for Early Intervention initiatives and increased reimbursement to physicians by Medicaid.

At press time, both of these initiatives showed promise for being funded in the 2006-07 fiscal budget.

The proposed Senate budget increased funding for Early Intervention programs by $7 million and the House version increased funding by $8 million. The additional funds are needed due to the tremendous growth in referrals to Early Intervention services.

The House version of the budget also allocated $20 million to provide inflationary increases for Medicaid reimbursement. Efforts are underway to get both the House and Senate to agree to these increases as the Budget goes to conference committee in late June.

Look for additional information on both these initiatives and others undertaken by the Academy’s Government Affairs Advisory Council in future editions of the e-newsletter, NCAFPNotes or on the Academy’s website at www.ncafp.com.
The Shell Game and Your Practice Retirement Plan

Remember watching magician tricks when you were young? One of my favorites was the shell game. Essentially, a magician would display a small ball, hide it under one of three shells, then - through fast moving hands - move the three shells around so you could not follow the shell containing the ball. After recent experiences reviewing group practice retirement plans, it seems the shell game has found a new home.

In medium and large-sized group practices, practice managers struggle to understand the cost elements in their retirement plan. With smaller practices, this effort falls to one of the physician - owners. In either case, despite sometimes valiant efforts, the person attempting to understand the current plan costs and fees frequently is frustrated by the lack of clarity, an inability to understand what the costs mean, and an inability to know whether all costs have been captured. Indeed I have witnessed situations where numerous conversations over a period of weeks is required to receive information from a plan provider that should already have been provided (and certainly assembled within a day or two otherwise). The core of the problem is a lack of disclosure provided by the plan advisor.

We ask the physician-owner or practice administrator (as the case may be) if they understand:

- every cost and fee associated with their plan;
- who is receiving the fees;
- how the fee is earned (what services are being provided);
- the liability that may arise from conflicts of interest their plan provider may have.

Usually, the reply is they believe they are "getting a good deal" from their plan advisor, but they don't know the details. I recently assisted a practice in understanding their existing plan cost structure. The existing plan provider indicated the client's current plan was "such a good deal, they could not offer it to new clients". When I learned this, I became uncomfortable, and felt transported back to the magician experience. It is at this point we sometimes see a difference in the actions of the physician-owner vs. practice manager. The physician owner knows that liability and much (if not all) the costs of the plan are going to rest with them (therefore most of any savings will benefit them as well). The practice manager knows they have little if any liability (depending on their role), don't pay the plan costs, but most of all - will have to assume the workload of analyzing, migrating, and implementing a new plan. So there is a clear divergence in the alignment of interests. Sadly this may result in a practice manager being less than fully motivated to do the due diligence required to understand the current situation in detail. As a result, the status quo sometimes becomes attractive to the practice manager.

In many instances, practice retirement plans use a broker working for a bank, brokerage or insurance company. As such, they have an obligation to ensure the funds selected for a given plan are merely appropriate / suitable. They are not held to the standard of care of your CPA, CFP, Attorney, or RIA - that of a Fiduciary. If they were, they would not only have to disclose conflicts of interest, but more importantly, avoid them. Brokers are not subject to the Investment Advisor Act of 1940, so they're not held to the same high standard of care. Registered Investment Advisors (RIAs) are subject to the Advisor act which means they must act in a manner incumbent of a Fiduciary i.e., act in the best interest of the client. To the owner-physician, working with an RIA should translate into having a readily understandable document explaining the process of fund selection, as well as every cost and fee associated with the plan. An example is provided that approximates recent findings in working with group practices.

**Exampl of Two Plans. Which one would you like?**

<table>
<thead>
<tr>
<th>Fee / Cost</th>
<th>Original Plan</th>
<th>New Plan</th>
</tr>
</thead>
<tbody>
<tr>
<td>annual advisor fee *</td>
<td>1.15%</td>
<td>0.60%</td>
</tr>
<tr>
<td>average annual mutual fund / ETF fee *</td>
<td>1.00%</td>
<td>0.30%</td>
</tr>
<tr>
<td>mutual fund 12B-1 fee *</td>
<td>0.25%</td>
<td>0.00%</td>
</tr>
<tr>
<td>average annual cost of internal fund trading *</td>
<td>0.50%</td>
<td>0.10%</td>
</tr>
<tr>
<td>commissions paid from loaded funds *</td>
<td>1.00%</td>
<td>0.00%</td>
</tr>
<tr>
<td>Third Party Administrator annual fee *</td>
<td>0.00%</td>
<td>0.10%</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>3.90%</strong></td>
<td><strong>1.10%</strong></td>
</tr>
</tbody>
</table>

Believe it or not, the plan on the right (at less than one third the cost) may have better liability protection for the owners assuming the advisor cannot/ does not provide substantial disclosure on the process of fund selection including 12B-1 fees and those with loads / commissions.

**Assumptions:**

- Advisor fees frequently reduce (on a % basis) as plan assets accumulate. e.g., an advisor fee for a plan with $6M in assets may charge 0.6%, whereas one with $2M might charge 0.9%.

- Mutual fund fees for actively traded equity funds average 1.5% (source: Morningstar). Combined equally with bond fund fees of 0.5%, leaves an average of 1.0%. Many passively managed mutual funds and exchange traded funds have annual fees in the 0.2- 0.4% range. We used 0.3% here.

- 12B-1 fees are lowest (0.25%) when applied to front end (A class) mutual funds.

- Undisclosed but real costs incurred by the mutual fund for brokerage charges to buy & sell stocks can easily be 0.5% (source: Zero Alpha Group). Passively managed funds often have internal trading costs around 0.1%. Exchange Traded Funds may have 0.0% internal fund trading costs.

- Many front end sales loads are 5.75%. Assuming the investor held the fund for a period of approx. 5 years (very generous), we express this cost as approximately 1%/yr.

- We are breaking out a reasonable fee for IRS testing by the Third Party Administrator instead of bundling it into a brokerage fee. This depends on the type of plan and assets within the plan.
Recommendations:
1. Owner-Physicians need to stay involved in the process of understanding their current plan, and not merely delegate the analysis to an employee because 1) employees do not have the same liability - especially ERISA, 2) they may not be paying the bill for plan advisor fees; 3) they may not be looking forward to the work involved in managing the process of moving to a new plan provider.

2. Obtain a thorough and accurate representation of all fees, costs and commissions from the advisor - and get it in writing. Have the advisor explain everything in plain English – not industry technical jargon.

3. Obtain a written statement from the plan advisor disclosing any conflicts of interest & all associations and affiliations. Conflict of interest reduces their ability to assume liability - and shifts it back to the owner – physician.

4. Understand: does the advisor work for a bank, brokerage, insurance company or mutual fund. Is the advisor a broker or investment advisor representative (someone who works for a Registered Investment Advisor). Is the advisor a CFP certificant?

5. Obtain and understand the written policy of fund selection. If any funds have 12B-1 fees, ask the advisor how this fund necessarily is in the best interest of the plan participants vs. other funds with no 12B-1 fees. The same is true for any funds with loads (commissions).

6. If your plan advisor does not have the ability to explain the tax ramifications of plan investing, speak to your CFP or CPA. For example, plan participants are paying more tax than they could by holding equity mutual funds inside their 401k account. This is because equity mutual funds only pay 15% tax on long term capital gains and dividends when in a taxable account, but are subject to (higher) personal income tax rates when withdrawn from a tax deferred account (401k).

continued on page 13
The NCAFP Foundation has been awarded a $360,000 grant from the N.C. Health and Wellness Trust Fund Commission as part of an effort designed to help eliminate health care disparities across the state. The Trust Fund selected the NCAFP Foundation and 22 other grantees from 108 applicants for funding.

The NCAFP grant is designed to help the Academy’s Health Disparities Council implement a comprehensive effort to increase physician knowledge of the national “Culturally and Linguistically Appropriate Services (CLAS)” standards and to help provide physicians the tools to better care for a diverse patient population. The goals of the project are to:

- Increase physician knowledge of risk factors of disparate population groups that may result in different patient-care decisions (i.e., recommended screening times, etc.) directly related to cancer, diabetes and cardiovascular diseases;

- Increase physician understanding and awareness of cultural differences and how these differences may impact adherence to best practices, and patient behavior, and working with physicians to determine successful strategies to enhance physician-patient communication through culturally and linguistically appropriate services; and

- Identify, highlight and pilot models of successful physician collaboration with disparate populations groups related to health behavior changes in order to increase the level and effectiveness of collaboration and physician outreach.

NCAFP Board Chair and Health Disparities Council Chair Karen L. Smith, MD, will serve as the senior medical advisor for the project. Outside collaborators include: the Carolinas Center for Medical Excellence, Community Care of North Carolina, Sandhills Community Care Network, the UNC Department of Family Medicine, N.C. Cooperative Extension Service, the AHEC Digital Library, and the Justus-Warren Heart Disease and Stroke Prevention Task Force, among others.

Key activities of the project will include:

- Developing and implementing a comprehensive educational curriculum to improve physician knowledge and understanding of health disparities and how to provide culturally and linguistically services. These educational initiatives will be delivered through lectures and special workshops in conjunction with the Academy’s Winter and Spring Meetings during each year of the grant.

- Utilizing an Online Cultural Competency in Health Care Curriculum developed by the National Office of Minority Health and administered through the Carolinas Center for Medical Excellence. Academy members will be recruited to participate in this nine-hour online curriculum, entitled “A Family Physician’s Practical Guide to Culturally Competent Care.”

- Developing targeted practice-based initiatives at the local level in five to six family medicine practices. This effort will include working with the physicians to develop relationships and collaborations with other local organizations representing minority populations in order to address health literacy and behavior at the community level.

If you are interested in becoming involved in this project or would like more details, please contact Greg Griggs, Director of Professional Services, at ggriggs@ncafp.com or (919) 833-2110.

MAKE A SPECIAL GIFT

You can honor our 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!
NCAFP FOUNDATION SILENT AUCTION MOVING INTO ITS SECOND DECADE

We’ve passed the 10-year mark! The NCAFP Foundation is proud to announce that the 2006 Silent Auction is going into its 11th year! Once again we’re putting the “fun” into “fun”draiser and holding our Silent Auction during the Winter Family Physicians Weekend at The Grove Park Inn Resort & Spa in breathtaking Asheville, November 29 – December 3. Don’t be left out – help us out! Do you know of a hotel or charming bed & breakfast that you want to share with us? Or perhaps you have a special talent, such as woodworking, quilting, painting? Maybe you’ve got that “dark horse” tucked away in your attic that you’d like to donate? You might want to contact your college for sports memorabilia. All donated auction items are tax deductible, and the proceeds go towards the various NCAFP Foundation programs and projects.

Join in the fun! If you want to donate an item (or two!), contact Marlene Rosol, Development Coordinator, at (919) 833-2110, (800) 872-9482 [NC only], or mrosol@ncafp.com. Thank you!

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 2006 Corporate Members – we couldn’t do it without you!!

THANK YOU TO OUR 2006 CORPORATE MEMBERS!!
WE COULDN’T DO IT WITHOUT YOU!

Grand Patrons:
NC Academy of Family Physicians, Raleigh, NC*

Supporters:
MAG Mutual Insurance Company, Atlanta, GA*
MedCost, LLC, Winston-Salem, NC*
Rudy L. Snow, Menzies-Med, Granite Falls, NC*

CONGRATULATIONS TO OUR FOUNDATION SCHOLARSHIP WINNERS

Hearty congratulations to our Foundation Student Scholarship winners! Cherrie Crowder and Jessica Triche of East Carolina University are the proud recipients of the NCAFP Foundation’s yearly scholarships that are awarded to NC medical students.

The awards remain scholarships under the condition that the students successfully complete their residency training in the specialty of Family Medicine. If, however, residency training is not completed in this specialty, the scholarship converts into a loan and payment requirements commence.

We encourage all students registered at the four NC medical schools to apply for scholarships. For more information on student scholarships, or how you can make a donation to the Scholarship Program, please contact Marlene Rosol, Development Coordinator, at (800) 872-9482 [NC only], (919) 833-2110, or mrosol@ncafp.com.

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FAMILY MEDICINE NEEDS YOUR SUPPORT

The specialty of Family Medicine and the people of North Carolina need your support! With your help, we can continue to fulfill our mission of providing quality healthcare to the people of North Carolina. Our Adolescent Obesity & Inactivity Project reaches at-risk adolescents and their families … Tar Wars motivates 5th & 6th graders to choose a healthy lifestyle … our Family Medicine Interest Groups, Student Scholarships, Externship Program, and Student Elective Rotation are key elements in showing medical students that the specialty of Family Medicine is a worthwhile choice. Please think about making a contribution to the NCAFP Foundation!. For more information on how you can make your contribution to the NCAFP Foundation, contact Marlene Rosol, Development Coordinator, at (919) 833-2110, (800) 872-9482 [NC only], or mrosol@ncafp.com. You can also visit the NCAFP Foundation at www.ncafp.com. Thank you for your support!
North Carolina Academy of Family Physicians

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Call Donna Freeman at 1-800-295-5120 for a free, no-cost, no-obligation review of your current personal insurance coverage. We’ll make insurance simple.

Raleigh, NC, June 14, 2006— Lauren Bice of Hendersonville has been named the 2005-06 North Carolina winner for the National Tar Wars Poster. Bice will represent North Carolina in the national competition in Washington in July.

Tar Wars is an educational program and poster contest that discourages tobacco use among the country’s youth. Sponsored by the American Academy of Family Physicians, Tar Wars focuses on attitudes about tobacco use, the effects of tobacco on the body, and how different messages in tobacco advertising influence people.

Tar Wars was developed in 1988 by the Hall of Life at the Denver Museum of Natural History and Doctors Ought to Care. The AAFP has overseen the program since 1996. The program has been implemented in all 50 states and some territories and internationally, and it has reached more than 2.5 million children. To date, Tar Wars has reached over 22,000 North Carolina fourth- and fifth-graders and been implemented in nearly 500 elementary schools across North Carolina since the program began in 1999.

Lauren is the daughter of Blain and Suzanne Bice of Hendersonville and attends Glenn Marlow Elementary School.

Glenn Marlow Elementary Student wins State Tar Wars® Poster Contest

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Have you wanted to help get kids in your community become more active? Have you wondered how to make a difference in the rising obesity trends in kids? If so, consider starting a fitness renaissance program in your local elementary school(s).

What is this fitness renaissance? It is an awards program designed for kids in grades k-5 that rewards them for achieving fitness goals during the school year. Modeled after the popular reading renaissance program, fitness renaissance has been endorsed by the ncafp board for implementation across the state with family physicians taking the lead.

The basics of a fitness renaissance program are simple. PE teachers in your elementary school(s) use a focused activity each nine week grading period for kids to strive to beat their goal. The activities include those used in the president's physical fitness awards, such as shuttle run, pullups, v sit reach, etc. Each child is tested on the activity at the beginning of the grading period, and is assigned an individual goal by the teacher to achieve by the end of that period. During PE, the teachers will assist the students in practicing to reach the goal. If the child achieves his/her goal before the end of the period, he/she receives an award at the next awards assembly for the school, typically at the end of each grading period. In addition, at the end of the school year, special gold, silver and bronze awards are presented to students who have achieved their goals more than one grading period.

What is your role as a family physician in this? You would serve as an advocate for the children and help to coordinate the program along with school officials and local civic clubs, who will support the program thru contributions. In fact, Kiwanis clubs of NC/SC is set to endorse fitness renaissance as a sponsored program, meaning seed funding will be available from these clubs all over north and South Carolina.

Fitness renaissance began as a collaborative venture in Clinton, NC among the school system, numerous civic clubs, and Dr. Tommy Newton, a past president of NCAFP. It has been immensely successful there, with all children in grades k-5 participating in the program. In addition, close to 75% of all children who have participated thus far have received at least one award. Multiple civic and church groups, along with businesses, have supported this program to date.

Further, after its first year, there was a 12% decrease in the number of kids in the second grade who measured in the “obese or at risk for overweight category” (>85 percentile BMI). Nutritional initiatives in Clinton city schools also helped contribute to these numbers.

So, consider using the Clinton model, and developing a fitness renaissance program in your community and school system. You'll be glad you did, as a lot of kids will become more active as they strive to achieve their goals. Further advice on starting your own program will be shared in future newsletters, and at the winter NCAFP meeting in December 2006. If you want info on fitness renaissance before then, contact Jenni Fisher at the NCAFP office, or dr. Tommy Newton at 910-592-6011.
Reelection News

The NCAFP is proud to announce 100% reelection for the period January 1, 2002 - December 31, 2005! We congratulate our members who fulfilled their CME requirements for this period.

For our members who were last reelected in 2004, you have until the end of 2006 to report 150 hours of CME in order to maintain your Academy membership. Requirements include at least 75 AAFP prescribed credit hours, a minimum of 25 group learning activities, no more than 25 from enrichment activities, plus caps on other activities. Hours reported should be obtained between January 1, 2004 through December 31, 2006.

For further details, review the AAFP CME Requirements for Members reprint 101 or visit www.ncafp.com or www.aafp.org. You can also call the AAFP at 800-274-2237 or the NCAFP at 919-833-2110 or 800-872-9482 [NC only].

Welcome to our new Academy Members

We would like to extend a hearty welcome to all our new NCAFP members! We’re pleased that you have chosen to join our Academy and look forward to getting to know you. We invite you to visit our website at www.ncafp.com to learn more about the NCAFP’s various CME programs, our Foundation’s projects, legislative issues, and other information pertinent to the specialty of Family Medicine.

CME MEETINGS NEWS

Live - CME from the Journals Your Trust
July 28, 2006 at the Marriot Crabtree, Raleigh.
Join the AAFP for a day of quality, practical education for the whole primary care team on hyperlipidemia, diabetes, COPD, child and adolescent immunizations and depression. For more information or to register, visit www.antidotecme.com/journal-live.

Second EHR Vendor Showcase Planned for Late Summer/Early Fall in Raleigh

The NCAFP is preparing to present another EHR Vendor Showcase. This full day seminar has been designed to educate participants on issues related to the adoption and utilization of electronic health records (EHRs). The NCAFP has partnered with the Carolinas Center for Medical Excellence in recognizing the opportunities available to primary care physicians with the DOQ-IT program.

The Showcase will enable the primary care physicians an opportunity to evaluate and select EHRs for their practice and to gain a better understanding of the features and functions currently available. The conference will also work to help improve the understanding of costs and benefits of using EHRs. All attendees will have the opportunity to visit an array of system vendors in the showcase’s exhibit hall, as well as get a rare opportunity to participate in 30-minute demonstrations in the lecture hall.

ANNUAL NCAFP WINTER MEETING
November 30 – December 3, 2006. The Academy’s annual winter meeting in Asheville promises to be one of our best ever! Come and enjoy the festive beauty in the mountains this holiday season for our 2006 Winter Extravaganza. Program Chair Dr. Kevin Burroughs has planned an outstanding program full of variety and issues faced by most family physicians in practice today. The official meeting website, along with online registration, is available at http://www.ncafp.com/wfpw. Look for additional information on the meeting in the coming months. The early bird registration is
7. Intelligent plan design. Not only should your plan advisor thoroughly explain why the type of plan was selected e.g., 401(k), but they should also be able to advise you on whether the new Roth feature would be beneficial. Also, you should be advised on whether an age-based or cross-tested profit share plan might be an appropriate addition to the 401(k). In many cases, physician-owners will benefit from having an age-based or cross-tested profit share plan added to the 401(k). This may allow physician-owners to maintain employer contributions to non-owner employees (or even reduce), while increasing contributions to their own accounts.

As of the date writing this article (February 2006), the Securities Exchange Commission (SEC) has implemented new rules (January 2006) whereby brokers that wish to retain accounts with financial planning services or discretionary authority must become licensed as an Investment Advisor Representative. As such, these broker-advisors will be subject to the Investment Advisor Act of 1940 for the first time. Unfortunately, these individuals are only subject to the higher standard of care (of the Advisor Act 1940) when acting on accounts with discretionary authority or when offering financial planning services. This may not be when they are working with your practice to provide a group retirement plan. When not acting as an advisor, the broker must provide a disclosure statement indicating that the interests of the brokerage and the client may not always be the same. My apologies for the confusion. You may wish to contact the SEC for further insight. Perhaps a good question might be – who benefits from confusion with this new rule? I’m fairly confident confusion does not benefit the investing public.

Jeff Seymour is Managing Director of Triangle Wealth Management. His practice works solely with Physicians and Dentists in ERISA consulting, practice retirement plan implementation, private wealth management, asset protection, and procurement consulting. He may be reached at www.doctorwealth.com, or 919-469-3600.
Our organizations strongly believe that academic family medicine departments should create clinical environments where innovation, quality improvement and effective medical education take place concurrently. Most respected family medicine departments across the nation, including those at other top-tier private universities, have been able to balance the priorities of patient care, research and teaching while maintaining the integrity of their residency training programs. It is also critical that medical students have the opportunity to observe what the future of family medicine has to offer -- innovations in practice, research that aims to improve the health of patients and communities -- and excellent residents. The closure of the residency at Duke means that that important contribution to the people of North Carolina and beyond will come to an end.

The press release cites “declining interest in family medicine” as a major reason for the closure. Interest in family medicine residencies among fourth year U.S. medical students has indeed dropped substantially, despite much evidence for the need of the discipline. This is part of a trend defined by increased interest in more highly paid specialties, many of which also allow a perceived easier lifestyle. Decline of interest has been even more dramatic in general internal medicine, in which a recent study has documented that only 10% of interns in internal medicine now expect to go into general internal medicine. For family medicine, at least, the decline has stabilized and there are signs that interest is beginning to increase. There is no doubt, however, that these have been difficult times for residency programs. The challenge for educators like those at Duke is to innovate -- to create training programs that are attractive to students and can convince prospective residents that the new model of family medicine is worth the investment of a career.

We also believe that it is important to continue training family physicians. There is clear and compelling evidence that primary care physicians, especially family physicians, are central to optimal and cost effective healthcare for the American public. Family physicians are essential to a health care delivery team that forms the foundation of patient-centered, technologically enhanced, community-based care for the 21st century. As one of the early family medicine residencies established in the nation in 1972, the Duke program itself has been evidence of the importance of family medicine, producing more than 350 family physicians for North Carolina and the nation, many of whom have gone on to distinguish themselves in academia and organized medicine. Closing the program means that that important contribution to the people of North Carolina and beyond will come to an end.

In 2004, the Robert Graham Center for Policy Studies in Family Medicine and Primary Care prepared a report on the role of family physicians in the U.S. healthcare workforce. That report was inappropriately cited by Duke as one justification for the decision to close its residency program. The Graham Center has expressed dismay that its work, which clearly does not espouse a reduction in the production of family physicians, should be used to justify, even in part, the closure of this family medicine residency.

We wish to re-affirm our commitment to the students, residents and sponsoring institutions of family medicine graduate education. As the nation’s need and demand for family physicians continues to grow, we stand firm in our dedication to develop, maintain, and grow those training programs committed to quality in care and education. Our organizations work diligently to ensure that every young physician who aspires to become a family physician has both the opportunity and support to achieve that goal. We look forward to further dialogue with Duke University's leadership.

Organizational Contacts:
American Academy of Family Physicians
Larry S. Fields, M.D., President

Association of Departments of Family Medicine
Warren Newton, M.D., M.P.H., President

Association of Family Medicine Residency Directors
Samuel M. Jones, M.D., President

Society of Teachers of Family Medicine
Caryl Heaton, D.O., President
ACADEMY SELECTED TO PARTICIPATE IN MOVE MORE SCHOLARS INSTITUTE

The NCAFP’s Adolescent Obesity Initiative Project Coordinator, Jenni Fisher, MPH, was selected to participate in the first North Carolina Move More Scholars Institute (MMSI). MMSI is modeled after the National Physical Activity and Public Health course. The national program is in its 12th year and has been highly successful in training physical activity professionals throughout the country. North Carolina is the first state to adapt the national course curriculum to fit their state level physical activity needs.

MMSI is offered by the Physical Activity and Nutrition Branch of the North Carolina division of Public Health and sponsored by Get Kids in Action, a partnership between the University of North Carolina at Chapel Hill and the Gatorade Company. The goal of MMSI is to increase the capacity of physical activity professionals to intervene at the community level to promote and support physical activity to North Carolina Families.

The course ran for four days and 28 physical activity professionals throughout the state attended. The majority of the first day consisted of all attendees presenting on one program they are involved in that promotes physical activity. A dinner and reception followed with an inspiring talk from keynote speaker Sig Hutchinson, the “2005 Wake County Volunteer of the Year.” The second day included sessions from professionals at the Centers for Disease Control and Prevention and the University of North Carolina at Chapel Hill about physical activity recommendations, understanding data and using evidence-based interventions. The third day moved forward from implementing interventions to effectively evaluating them. Most of the day was spent working on assessing and designing healthy communities. On the last day, the future of obesity prevention and integrating and working with partnerships was discussed.

The 28 scholars from across the state included health department health educators, cooperative extension family and consumer science agents, nutritionists, parks and recreation consultants, disability services physical activity coordinator and city wellness coordinators. For more information about the NCAFP’s Adolescent Obesity Initiative, go to www.ncafp.com/aoi and for North Carolina specific physical activity resources go to www.eatsmartmovemorenc.com.

MARK ROBINSON, MD, CHOSEN AS PRESIDENT-ELECT OF THE ASSOCIATION OF FAMILY MEDICINE RESIDENCY DIRECTORS AND BOARD OF DIRECTORS

Leawood, KS — Mark Robinson, M.D., a family physician in Concord, NC, has been chosen as President-Elect to the Board of Directors of the Association of Family Medicine Residency Directors (AFMRD). The AFMRD represents more than 460 family medicine program directors nationwide. Robinson was elected in early June 2006 by the AFMRD membership.

Robinson works in family medicine in Concord, NC at the Cabarrus Family Medicine Residency Program, sponsored by Northeast Medical Center. In 1995 Robinson helped start the family medicine residency program at Cabarrus, and has served as program director since 2001. Dr. Robinson oversees a residency training program within the private practice of Cabarrus Family Medicine, PA that cares for over 70,000 patients from this region.

After receiving his bachelor’s degree from Brown University, Robinson earned his medical degree at the University of Pennsylvania on an Army Health Professions scholarship. Robinson completed his residency in family medicine at Madigan Army Medical Center in Tacoma, WA, where he served as chief resident, and won the Society of Teachers of Family Medicine (STFM) teaching award.

Following residency, Robinson began his career in medicine at Fort Gordon, GA where he was a member of the faculty of the family medicine residency program at Eisenhower Army Medical Center. After completing the Faculty Development Fellowship in 1989 at the University of North Carolina-Chapel Hill, Robinson joined the family medicine faculty at Carolinas Medical Center in Charlotte, NC. He taught family medicine residents and conducted clinical research at CMC until joining Cabarrus Family Medicine in 1995.

In 2001 Robinson completed the National Institute for Program Directors’ Development (NIPDD), a fellowship designed for family physician educators who want to enhance and develop leadership skills in order to become better prepared as effective directors of residency programs.

Growing up in northeastern Connecticut with a family physician as a father, Robinson learned the basic principles of family medicine from his father’s example. The lessons learned by observing his father’s dedication to his patients and community provided Robinson the foundation upon which to build his own career in family medicine. Robinson looks forward to providing servant leadership to an organization that works to enhance the specialty to which he has dedicated his life.
25% of physician practices in North Carolina have an EHR...

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