2010 Legislative Affairs Agenda -

In A Year With So Many Legislative Issues, We Have To Stay Focused
Fantastic Schedule for CME Lectures & Optional Seminars!

4 Half-Day CME Sessions from Mon., July 5th to Thurs., July 8th, 2010
3 Optional Workshops on Fri., July 9th and Sat., July 10th, 2010

Complete meeting information is online at www.ncafp.com/msfmd

Register Online - Fast & Easy
2009-2010 NCAFP Board of Directors

NCAFP Executive Officers
President: R.W. 'Chip' Watkins, MD, MPH, FAAFP
President-Elect: Richard W. Lord, Jr., MD
Vice President: Brian R. Forrest, MD
Secretary/Treasurer: Shannon B. Dowler, MD
Board Chair: Robert Lee Rich, Jr., MD
Executive Vice President: Gregory K. Griggs, MPA, CAE
Past President (w/voting privileges): Christopher Snyder, III, MD

The District Directors
District 1: R. Kevin Talton, MD
District 2: Connie Brooks-Fernandez, MD
District 3: Scott E. Konopka, MD
District 4: Timothy J. McGrath, MD
District 5: Rhett L. Brown, MD
District 6: James W. McNabb, MD
District 7: Thomas R. White, MD
At-Large: George L. Saunders, MD
At-Large: William A. Dennis, MD

IMG Physicians Constituency: Nalin S. Bajinaith, MD
Minority Physicians Constituency: Enrico G. Jones, MD
New Physicians Constituency: Jana C. Watts, MD
FM Department Constituency: Kenneth K. Steinweg, MD
FM Residency Directors: Gary E. Levine, MD
Resident Director: Meshia Q. Todd, MD (Duke)
Resident Director-Elect: Nicole Shields, MD (SR-AHEC)
Student Director: Kathryn Norfleet (UNC)
Student Director-Elect: Sohale Vu (ECU)

AAFP Delegates and Alternates
AAFP Delegate: Mott P. Blair, IV, MD
AAFP Delegate: Karen L. Smith, MD, FAAFP
AAFP Alternate: L. Allen Dobson, MD
AAFP Alternate: Michelle F. Jones, MD

FP Department Chairs and Alternates
Chair (EUI): Kenneth Steinweg, MD
Alternate (Duke): J. Lloyd Michener, MD
Alternate (UNC): Warren P. Newton, MD, MPH
Alternate (WFU): Michael L. Coates, MD

NCAFP Editorial Committee
Chair: William A. Dennis, MD

NCAFP Council Chairs
Advocacy Council: Brian R. Forrest, MD
Continuing Medical Education Council: Richard Lord, Jr., MD
Health of the Public Council: James McNabb, MD
Practice Enhancement Council: Jennifer Mullendore, MD

The NCAFP Strategic Plan

Mission Statement: to advance the specialty of Family Medicine, in order to improve the health of patients, families, and communities in North Carolina.

Vision Statement: Family physicians will be universally valued for their role in providing high quality care to the people of North Carolina.

Core Beliefs:
- We believe that Family Medicine is essential to the well-being of the health of North Carolina, and that Family Medicine is well-suited to improve the health of the residents of our state.
- We believe in a healthcare system that is primary care driven. We believe there is an inherent value in a primary care medical home—providing quality, access and affordability.
- We believe in a healthcare system that is fair, equitable and accessible. We believe in the elimination of health disparities and barriers to access to healthcare for North Carolina.
- We believe in a comprehensive approach to patient care, and value the health and well being of patients, families and communities.
- We value collaborative communication with all parties concerned with healthcare delivery, and advocate for a positive practice environment to nourish the specialty of family medicine.
- We value the professional and personal well being of our members.

Core Values:
- Quality, evidence-based, timely education.
- Professional excellence and integrity.
- Fiscal responsibility, organization integrity and viability.
- Creativity and flexibility.
- Member-driven involvement in leadership and decision making.

Additional details on the strategic plan are located at www.ncafp.com/home/academy/mission
Health Care System Reform Needs to Recognize Primary Care

The 2010 Presidential Address Conclusion

The following is the conclusion of Dr. R.W. Watkins’ Presidential Inaugural Address delivered to members on Saturday, December 4, 2009, in Asheville, NC. The first part of his address was published in the Winter edition on this magazine (Vol. 6, No. 1).

Programs like CCNC do address the deeper issues of containing costs AND provide quality initiatives by putting the primary care doctor in charge and paying them on a PMPM basis which changes the incentives from sick-care to more prevention and wellness care and SAVES money. CCNC has saved the State of North Carolina 100s of millions of dollars. This is exactly the type of model the State of Massachusetts should be looking at. There they expanded coverage for everyone, but did not address primary care workforce issues, quality of care or long-term costs.

Lastly, we must enact Tort Reform. That is a tall order with the current administration in Washington, or the last for that matter, but without it, without some protection, doctors will continue to practice defensive medicine and the cost of care will continue to skyrocket.

So there are lots of mountains to climb, lots of rivers to cross, and lots of problems to solve.

Where do I stand on health care reform? I do support what Dr. Heim and the AAFP are continuing to try to bring to the forefront of the health care reform debate. It’s really quite simple. I believe that the key to designing a new health care system is to reemphasize the centrality of primary care by:

- Ensuring health care coverage for all and aligning financial incentives to support this system (http://www.aafp.org/online/en/home/policy/policies/h/healthcare.html)
- Redesigning the manner of primary care delivery modeled on a ‘patient-centered medical home’ (http://pcpcc.net/content/joint-principles-patient-centered-medical-home)

See, these are precisely the things that WILL address access, quality of care, and cost. This has been proven time and time again.

What will we be doing as an Academy on our state level?

- Well, for one, we must continue to engage Blue Cross and Blue Shield of North Carolina (BCBSNC). Last year, we were fortunate to pass Senate Bill 877 which gave physicians in this state some much needed relief from unilateral contract decision-making by the insurance industry. We must continue to monitor how BCBSNC and other insurers implement the provisions of this legislation, and this has included expressing our concerns to the state Department of Insurance.
- In addition, we continue to work WITH BCBSNC as we help them understand the importance of primary care and to ensure primary care physicians receive adequate pay for their services. And our voice is being heard. BCBSNC has implemented a bonus program based primarily on the tenets of the Patient-Centered Medical Home, and their leadership is helping carry the message to the UNC system that producing more primary care physicians should be a priority for our state medical schools. Have we gone far enough? Absolutely not. But we believe they are steps in the right direction.
- We will need to continue to keep our eye on the ball in terms of the state budget crisis and protect Medicaid funding and the wonderful work CCNC has done for our state.
- I want to work with Greg to improve communication and increase outreach between our Academy and our residency programs in the state. We will be traveling to our state’s residency programs to encourage more faculty involvement in our CME programs, as well as

See INAUGURAL ADDRESS on back cover
In A Year with So Many Legislative Issues, We Have To Stay Focused

By Dr. Brian Forrest, Chair, NCAFPAcademy Advocacy Council

The following is a brief summary of the Academy's top priorities for this year in the NC General Assembly. While not exhaustive, it will give an idea of our major concerns.

Support Community Care - Community Care of NC, a crown jewel in terms of Medicaid savings and care management in our state, is in competition with private insurers that would like to see Medicaid driven by a private HMO model. While private HMOs may try to show a leaner bottom line to state officials, they simply cannot achieve the quality of care, physician driven outcomes, and cost savings that CCNC promises and delivers for patients. Your Advocacy Council considers the preservation and expansion of this program to be essential to many of our objectives, including helping with the modernization of practices into patient-centered medical homes (PCMHs). There is no other physician led infrastructure in place that can function as efficiently to help practices transform into the modern practice described in the Future of Family Medicine Project.

Fight Any Medicaid Cuts - The state budget continues to lag behind projections and currently is expected to have between a $600M - $1B shortfall in 2010. Due to the lack of revenue there are two major budget items that will likely continue to see cuts, Medicaid and Education. Given the current environment, it is likely that Medicaid will be sought out to make up for the bulk of the difference. A Preferred Drug List has already been implemented and additional prior authorizations on medications are expected later this summer. Prior authorizations have become a real burden to practices and now extend to ultrasound and other non-plain film imaging. These frustrating barriers to care are likely to further decrease patient access to physicians who accept new Medicaid patients. Your Academy is vigorously trying to limit any more cuts or regulation of patient care that diverts physicians’ time away from patients and towards more bureaucracy. We will certainly oppose any additional cuts to Medicaid payment for family physicians and will look for innovative ways to increase payment, such as a proposal to increase the per-member/per-month payments to family physicians.

Promote Continuity Over Convenience - Retail Health Clinics have recently announced expanded scope of services including cholesterol, blood pressure, and hypertension management. They have also expressed interest in becoming Medicaid providers in NC. We have had several meetings with officials from Minute Clinic and Medicaid, and without significant restrictions and limitations, we are opposed to these expansions. We believe this undermines the continuity relationship of the family physician with their patient. This fragmentation can also lead to children not receiving well visits or screenings because they receive their immunizations as a “pop in” visit at a retail health clinic to meet school requirements and therefore never come in for scheduled screenings. Similarly, patients normally followed for several complex medical conditions may have medicines refilled without proper monitoring or follow up with their physician. Recently, due to the NCAFPA communicating these issues nationally, the AAFP has withdrawn its general support of retail health clinics, and the formal relationship with these clinics at the national level has ended.

Additionally, while the Academy has supported increased access to vaccinations, we also oppose increased unrestricted vaccine administration at pharmacies. Pharmacists have requested to be able to provide a broad range of vaccines without authorization by a physician. This will also fragment the continuity relationship of the patient and their primary care physician. As a separate issue, the Academy has generally supported the idea of a per member fee on insurance plans to help fund the universal vaccine program, though the details of such a proposal are important and will be given some scrutiny.

Strengthen Workforce Development - Primary care workforce development continues to be a concern and we are working on several ways to improve medical student interest, increase funding, and emphasize the importance to our medical schools of matching a higher percentage of students into family medicine. The new Family Medicine Scholars program (see article on p. 10) will select the most talented students at each medical school in the state and through mentoring programs, leadership development, and scholarship funding will help make their decision to choose our specialty a preferred option.

As National Health Reform proceeds and the current aspects of the recently passed bill unfold, we will continue to advocate for family physicians and their patients during the implementation phase.

Participate & Advocate

We would appreciate your attendance at “Advocacy 101” on June 8th and 9th. We will be teaching physicians how to advocate for policies and, following the event, we will be going en masse to the legislature that Wednesday with a white coat show-of-force to make sure the voices of family physicians in our state are heard. It is going to be a fast paced year for advocacy, and as a concerned member, we hope you will come along for the ride! For questions about future meeting times and dates please contact Greg Griggs at the Academy office.
Family Medicine On The Rise, but Still Has Barriers To Overcome

By Gregory K. Griggs, MPA, CAE, Executive Vice President

“Family Medicine will be a highly valued cornerstone of the healthcare system for the state of North Carolina.” It’s a simple statement. It’s also the key to all of our Advocacy efforts, and one of the four key goals of the NCAFP’s strategic plan.

Over the past few issues of the NC Family Physician, my column has focused on key elements of our strategic plan, previously addressing CME and Health of the Public. It seems appropriate that I now move to Advocacy at what I believe is one of the key moments in the history of your profession, both nationally and in North Carolina. It’s a pivotal time and we need your help.

Whether you believe healthcare reform at the national level is good or bad, the fact is that it is now a reality. And with a bill that long, it is very likely that there is something in there for everyone to love and something in there for everyone to hate. But as an optimist, I want to focus on what I believe is good about the current state of healthcare in our country (not necessarily the bill but the direction I believe we are moving.)

First, I believe family medicine and primary care are beginning to be valued more – not enough, but more. The Center for Medicare and Medicaid Services increased primary care rates slightly for 2010. Our own General Assembly protected primary care E&M codes during our last legislative session. And Congress has mandated that all Medicaid programs pay primary care at 100% of Medicare for at least the years 2013 and 2014. Again, it’s not enough, but these are all moves in the right direction.

Second, the insurance industry -- both at the state and national level -- is investing in quality programs that increase compensation for primary care physicians. Patient-Centered Medical Home pilots, based on what Community Care of North Carolina has done in our own state, are taking place all over the country. Some of these include enhanced Per Member Per Month payments, while others pay significant quality incentives for practices moving toward PCMH recognition by the National Committee for Quality Assurance.

Third, this year showed a slight uptick in medical student interest in family medicine. National match results improved with more slots filled in the MATCH, and more U.S. medical students choosing family medicine. While I won’t yet call this a trend, I am encouraged.

Yet, there is much, much more to be done. With our state continuing to face an economic crisis, funding cuts are likely once again, including cuts to the Medicaid program. And even though Community Care of North Carolina has received national accolades and has documented long-term savings, the wolves from traditional Medicaid HMOs are at the door promising short-term savings to elected officials looking for anywhere to cut.

And there’s certainly still more to be done at the national level, particularly to find a permanent fix for the SGR (sustainable growth rate). Shortly after you read this article, we will be in Washington once again pushing for increased compensation for family medicine and a better environment for primary care. Each year in May, representatives from Chapters all over the country descend on Washington for the Family Medicine Congressional Conference. Last year when we made the trek, both Republicans and Democrats agreed that something has to be done about the pay disparity between primary care and sub-specialists. But now it’s time for them to act. It may take a while, but both your chapter and national representatives will not rest until we’ve taken greater steps in that direction.

I believe the focus is turning, at least to some degree. There’s more talk around prevention and how to keep patients out of the hospital in the first place, and to make sure they don’t return once they have been there. Once again, CCNC is at the forefront, particularly with their work with dualy eligible Medicaid/Medicare recipients through the new 646 waiver.

Yet workforce issues remain. If compensation doesn’t increase dramatically, there will continue to be a shortage of family physicians. In addition, there are NPs and PAs at the door shouting that they are the answer. But they are not. The math is simple. Two years of post-graduate training simply does not equal four years of medical school and three years of residency. Two does not equal seven; it’s a simple equation. You are better trained, better prepared, have greater ongoing educational requirements and greater ability to meet the needs of our country’s population.

I believe family medicine is the answer to improved outcomes, better cost controls and a healthier overall population. But we need your help. To make our goal a reality, it takes your involvement. Give to your Political Action Committee, FAMPAC. Come with us to the state legislature. Call your congressman. And this year you can’t use, “I Don’t Know How” as an excuse. On June 8-9, we are going to teach you how to build relationships with your elected officials and ultimately influence public policy in North Carolina. I hope you will join us for this important Advocacy event (please see page 9 for more details). We want to be a show of force in the General Assembly with dozens of family physicians in white coats descending on the Legislature with well-armed arguments.

“Family Medicine will be a highly valued cornerstone of the healthcare system for the state of North Carolina.” It can happen, but we need your help! Get involved today!
ECU Selected By AAFP as a Top Ten US Medical School for Producing Family Physicians

New Family Medicine Center to Open Late This Year

The Brody School of Medicine at East Carolina University has earned an Achievement Award from the American Academy of Family Physicians (AAFP) that recognized the school’s efforts to foster student interest in family medicine and produce graduates who enter the specialty. Based on a three-year average, for the period ending October 2009, 19.2% of ECU’s graduates have entered an ACGME-accredited family medicine residency program! This statistic classifies the Brody School of Medicine as one of the Top 10 medical schools in the nation for producing Family Physicians.

In other news, ECU Chancellor Steve Ballard and Family Medicine Department Chair Dr. Ken Steinweg hosted a “Topping Out Ceremony” for the new ECU Family Medicine Center and Frances J. and Robert T. Monk, Sr., Geriatric Center in early March. The new facility is expected to open late this year and is located on the ECU Health Sciences Campus at the intersection of Arlington and Heart Boulevards near Pitt County Memorial Hospital. NCAFP Vice President Brian Forrest, MD, and Executive Vice President Greg Griggs, MPA, CAE, represented the Academy at the event. Former NCAFP Presidents Dr. Jim Jones (1972, who was the first chair of the Department of Family Medicine at ECU) and Dr. Christopher Bremer (1990) also attended the event, along with State AHEC Director Tom Bacon, DrPH, Vice Chancellor of Health Affairs Phyllis Horns, DSN, MPH, members of the NC General Assembly (Rep. Marian McLawhorn, Rep. Edith Warren, and Sen. Don Davis), and members of the faculty and staff of the Department. Pictures of the event are available on the Academy's website at www.ncafp.com/inpictures.

Past President Dr. Mott Blair, IV, of Wallace Running for NC House of Representatives

NCAFP Past President Dr. Mott Blair (2003) filed for the NC House of Representatives District 4 in February. The filing places Dr. Blair on the ballot for the seat currently held by Rep. Russell Tucker, who has chosen not to seek re-election. Blair does not face a primary opponent, but has opposition in the general election in November. In addition to his Academy service, Dr. Blair brings a wide array of experience to his campaign. He is past Wallace Chamber of Commerce President, a former Director of the Duplin County Agribusiness Council, and a former member of the Duplin County Board of Education. House District 4 is comprised of Duplin and a small part of Onslow County.

Important AAFP Membership Changes to be Aware Of

The AAFP recently has implemented some key changes to its membership and dues policies. All members are advised to pay close attention to AAFP mailings, as important membership information is often included. Recent changes include:

• Installments for 2010 dues has been extended to August 10th, but the deadline to set up an installment plan or pay 2010 dues was May 3rd;

• Dues payment is now required upon applying for Active, International & Supporting membership categories.
At Medical Mutual, we are dedicated to serving you with a comprehensive array of insurance products.

Professional Liability  |  Employee Benefits  |  Commercial

A.M. Best has awarded Medical Mutual's professional liability coverage the highest rating of "A" (Excellent) for four consecutive years.

Find out more by calling 800.662.7917 or visiting www.medicalmutualgroup.com

Diamond Level Sponsor of the North Carolina Medical Group Managers
‘Advocacy 101’ Conference will Engage Physicians with Elected Officials

The Academy will be holding a very important advocacy training event for family physicians, residents and students on June 8th and 9th in Raleigh at the Marriott City Center Hotel. This 2-day training and outreach event conference entitled, ‘Advocacy 101 - How YOU Can Help Make an Impact on Public Policy in North Carolina’ will begin on Tuesday, June 8th, 2010, with a 4-hour training session delivered by NCAFP Governmental Affairs Consultant Peyton Maynard that will cover the fundamentals of advocacy and the state budget process. Former Gubernatorial Budget Advisor Dan Gerlach will also speak, as will Senator William Purcell, Chair of the Senate Health Committee.

The conference will begin with a review of a number of important ‘dos-and-don’ts’ regarding lobbying and advocacy, and will present a brief review of the key items before the legislature and their potential impact on the specialty. Following this segment, former Budget Advisor Dan Gerlach will give an explanation on how the state budget is constructed, with follow-up insight on this process to be shared by Senator Purcell and possibly Rep. Bob England.

This information and lessons learned will be put to the test on Wednesday, June 9th, as members visit the N.C. General Assembly to meet with their elected officials. All members who plan to attend are encouraged to register as quickly as possible due to limited time in scheduling representative appointments. A complete agenda of the event, as well as online registration, is available on the NCAFP website at www.ncafp.com/advocacy101. If you have questions about the event or require additional information, please contact Kathryn Atkinson, NCAFP Meetings Coordinator, via email at katkinson@ncafp.com or dial (919) 833-2110.

NCAFP’s Mid-Summer Meeting is Always Educational and Fun-Filled!

There is no better time to soak up the sun with family, friends and colleagues than the Academy’s annual Mid-Summer Family Medicine Digest in Myrtle Beach, SC. The Academy will be presenting a great line-up of continuing medical education, workshops and fun from July 4th-10th, 2010, at the Kingston Plantation. Program Chair Timothy J. McGrath, MD, has planned an outstanding program that offers a convenient learning schedule and a packed agenda full of variety for family physicians and primary care professionals. And while evidence based credits for portions of the program are still pending as of press time, the meeting is expected to offer almost 50 AAFP Prescribed credits, not including additional ones available to attendees who participate in the conference’s Self-Assessment Module (SAM) Study Hall.

Learning & Educational Topics

The Mid-Summer meeting will offer physician attendees the chance to complete an important primer on electronic health records (EHR) selection, become knowledgeable about adding profitable in-office procedures, and even complete an important step in their re-certification through a SAM Study Hall on diabetes. Each of these learning components has been scheduled to offer plenty of relaxation time for family and fun in between. The complete lineup of general session topics is still being finalized, but a majority are already published online at www.ncafp.com/msfd. Some topics include Hypertension, Adult Pneumococcal Disease, Rational Weight Loss, and Combination Therapy for Lipids. Complementing the meeting’s general sessions track will be three key workshops. A practice management workshop on how to successfully implement an EHR will review the American Recovery and Reinvestment Act’s CMS EHR Incentive Program, several critical EHR implementation steps, and strategies for attaining ‘meaningful use.’ Next, a hands-on workshop outlining how to add profitable in-office procedures to a family medicine/primary care practice will also be offered. This workshop will be comprised of two segments: A) Mastering Joint Injections describing the indications and contraindications for joint and soft-tissue injections; and B) Mastering Cosmetic Procedures that will address various laser techniques, including minor laser surgery, techniques for laser hair removal, vascular and pigmented lesions, and other related services. Finally, rounding out the educational offerings, a SAMs Study Hall on Diabetes will be held that will work through the knowledge assessment section for the MC-FP SAM requirement (Part II). Attendees to this study hall will need to complete this module's...
More Good News for Family Medicine!

By R.W. Watkins, MD, MPH, FAAFP
NCAFP President

Whether or not you believe that health care reform is good news for family medicine and primary care physicians, we can ALL believe that our new Family Medicine Scholars Program is GREAT news for family medicine in North Carolina!

The six-year program is the result of the work of many people with the N.C. Academy of Family Physicians and the NCAFP Foundation, including Academy EVP Greg Griggs, MPA, CAE; Allen Dobson, MD; Chuck Rich, MD; Brian Forrest, MD, and others. It is also important to recognize the Blue Cross and Blue Shield of North Carolina Foundation, which will provide funding for the effort, alongside the Academy.

The project is a two-tiered effort to increase interest in family medicine among North Carolina medical students. The Family Medicine Scholar’s Program will consist of a small group of first-year medical students who will be selected from the state’s four medical schools through a competitive application process each year. Each of the recipients would be paired with a “Master Preceptor” during the course of the three-year program. Master Preceptors would be selected on their ability to teach students as well as their participation in various quality programs such as CCNC, NCQA, etc. They would be forging a strong relationship with their students through clinical skills building, exposure to the Patient-Centered Medical Home, as well as community leadership activities, and the like. The second piece of this effort will work toward increasing interest in family medicine in general by involving more practicing family physicians with the Family Medicine Interest Groups at the four medical schools and increased student involvement at the NCAFP Annual Meeting.

The overall goal will be to increase the number of N.C. medical students who choose family medicine as their career. This is particularly important as the UNC system implements medical school expansion. In order to meet the state’s healthcare needs both now and in the future, more students must be encouraged to enter family medicine and other primary care specialties. This program is a tremendous step in that direction. Look for complete details of this program after a formal public announcement likely sometime in June. In the meantime, questions about the program should be directed to Tracie Hazelett, Manager of Family Medicine Interest Initiatives, at the Academy at 919-833-2110 or thazelett@ncafp.com.

In order to meet the state’s healthcare needs both now and in the future, more students must be encouraged to enter family medicine and other primary care specialties.
Health disparities exist because of gaps in the health status of certain population groups. In order to reduce these gaps, it is essential to first identify the populations most at risk. The Institute of Medicine (IOM) recommends that race, ethnicity and language data be included in electronic health records to help identify these populations and their needs. The IOM believes that this data collection is important for quality improvement and the elimination of health disparities.

The Culturally and Linguistically Appropriate Service (CLAS) Standards, developed by the Office of Minority Health, agree that healthcare organizations should collect data on patients’ race, ethnicity, and written and spoken language. This information should also be periodically updated. Providers can use this data to understand their patient population, the disparities that exist in those populations and monitor improvements. The data can also be utilized for designing interventions and informing policy related to health inequities.

Through the Health Disparities Initiative (HDI), the NCAFP Foundation provides support to practices in implementing the CLAS standards, including updating patient demographic information for health records. Other grant activities include increasing physician collaboration and outreach with disparate population groups in their local communities and developing a comprehensive educational curriculum for NCAFP meetings.

The NCAFP Foundation would like to thank the following practices for participating in the Health Disparities Initiative (HDI) in Buncombe County: Mission Children’s Clinic, Asheville Cardiology Associates and MAHEC Family Medicine in Asheville. Each of these groups has made great strides in adoption and implementation with the CLAS standards. In the second year of the HDI Phase II, three practices will be recruited in Mecklenburg County to participate in an intensive practice-based initiative which will include an assessment of their level of compliance with CLAS, staff trainings and guidance in implementation with CLAS and other quality improvement strategies. The practices will be recruited through a partnership with the Mecklenburg County Medical Society.

As an outcome from the Health Disparities Initiative Phase I, the NCAFPF created an online CME curriculum available for 3 credit hours titled “Understanding and Addressing Healthcare Disparities.” Dr. John Smith examines the definition and the history of health disparities and evidence of successful strategies to eliminate health disparities. The online CME can be accessed at www.ncafp.com/healthcaredisparities.

Complete information on the Health Disparities Initiative is available at www.ncafp.com/disparities

Past President Dr. Tommy Newton Honored by Clinton Sampson Chamber

School Fitness Program Lauded

The Clinton-Sampson Chamber of Commerce bestowed its highest honor -- Outstanding Chamber Member of the Year -- on NCAFP Past President Dr. Tommy Newton (1995) in late March. Dr. Newton was recognized for his extensive community involvement, including his most recent work in creating the Fitness Renaissance Program, a school-based program that combats childhood obesity. This successful program is currently expanding in Sampson County and recently received grant funding from the Kate B. Reynolds Foundation. The award recognized Dr. Newton for playing a key role in numerous community affairs, including service to the Clinton High School Athletic Boosters Club, the Clinton Recreation Center Advisory Board, as well as his leadership of Clinton’s successful 2007 All-American City award.

Hudspeth Testifies on Integrated Care Before Legislative Committee

Dr. Richard Hudspeth, Medical Director for the Access II Care CCNC Network, discussed efforts to integrate medical and mental health care before the NC Joint Legislative Oversight Committee on Mental Health. Dr. Hudspeth was part of a team that outlined the work that his local CCNC network had undertaken with their local mental health program, Western Highlands Network. Dr. Hudspeth noted that over 50% of the Aged, Blind and Disabled population (ABD) served by his network has at least one mental health diagnosis. Other speakers included Western Highland’s CEO Arthur Carder and Jennifer Wehe, Executive Director for Access II Care.
Resources Abound to Transform Your Practice and Increase Your Revenue

By Brent Hazelett, MPA, NCAFP Chief Operating Officer

With all of the talk about the Patient-Centered Medical Home (PCMH) Model and the need for primary care doctors to transform their practices, it’s easy for physicians to get overwhelmed and discouraged, often before a complete understanding of PCMH is even present. The NCAFP and AAFP have both resolved to help members take on this challenge and the NCAFP Practice Enhancement Council has made PCMH a top priority for 2010 and beyond.

And now that at least one North Carolina insurer has placed real monetary incentives behind PCMH principles, it is the hope of NCAFP leadership that more and more members across this state will take the next steps towards NCQA recognition. Blue Cross and Blue Shield of North Carolina’s Blue Quality Physician Program uses NCQA recognition as the centerpiece of earning significant increases on Evaluation and Management (E&M) codes for practices on their base primary care contract (please contact your BCBSNC representative to see if you may qualify).

For those not familiar with NCQA (National Committee for Quality Assurance), their Physician Recognition Programs identify physicians who deliver superior care using standards firmly rooted in medical evidence. To date, over 13,000 physicians nationwide have been recognized by NCQA in the areas of diabetes care, cardiovascular care, back pain care and practices that use information and systems to provide preventive and chronic pain management. With regard to PCMH recognition, practices may achieve one of three levels of recognition, based on their ability to perform the functions required in each of the nine standards measured by NCQA.

The best way to gauge your practice’s initial performance is to take a quick, free assessment at www.transformed.com. AAFP also has a great PCMH checklist, which can be accessed directly from their homepage at www.aafp.org. While TransforMED is a for-profit arm of AAFP that may charge fees to assist with practice transformation, they also have a wealth of free information and resources on their website. Another valuable resource offered by TransforMED is Delta Exchange. Delta Exchange is an exclusive online practice transformation learning network dedicated to physicians, clinical staff, office staff and primary care-focused residency programs. For a relatively small fee physicians and their staff can join an exclusive forum of peers that are also involved in the PCMH practice transformation process. Imagine a place where you can immediately access PCMH resources, ask questions of leaders and leaders who have already gone through the process, share documents, collaborate on solutions and connect with other practices who are endeavoring to make PCMH changes. For more details about Delta Exchange, visit www.transformed.com/delta-exchange.

For those that attended the NCAFP Annual Meeting in December, you saw firsthand how private industry is helping advance the PCMH model through the coalition known as the Patient-Centered Primary Care Collaborative (PCPCC). The PCPCC is a diverse group of large employers, primary care societies, national health plans, patients’ groups and others who support the PCMH concept. For more information on how the PCPCC is helping motivate change, visit their website at www.pcpc.net.

As the NCAFP continues to compile resources to educate and assist family physicians in the PCMH process, please frequently visit the “PCMH Portal” on the website at www.ncafp.com/pcmh. The Academy is working to add and update the resources helpful to practices and publish them online. If you have resources you have used and found helpful on PCMH and would like to share them through this tool, please let us know by emailing us at bhazelett@ncafp.com.
Accountable Care Organizations

ACOs: Friend or Foe?

By Ken Bertka, M.D., F.A.A.F.P.

Throughout the health care reform debate in Congress, all of the proposed bills contained provisions for promoting development of Accountable Care Organizations (ACOs). So, what is an ACO? Will ACOs be good for patients? Are ACOs a positive step in the right direction for family physicians and other primary care physicians?

At the core, this proposed care model is a means by which physicians and other health care providers are part of a network responsible for quality and certain components of the cost of care for a defined patient population. An ACO is dependent upon a strong foundation of primary care. Ideally, this foundation is based upon the patient-centered medical home (PCMH) model of care. From this perspective, the ACO can be thought of as the “medical home neighborhood” aligning the goals and incentives of non-primary care physicians and other providers with those of a network of PCMH practices.

Federal health care reform efforts in the U.S. are focused on increasing health insurance coverage, improving quality and controlling cost. From a health care reform perspective, the ACO model of care is aimed at cost and quality. The main goal of the ACO model is to reduce health care cost, or at least “bend the cost curve” down while at the same time improving clinical quality and patient satisfaction. An ACO is NOT a health maintenance organization (HMO) as it does not accept insurance risk – the risk of whether a patient who is part of the defined ACO population is sick or well.

Accountable care organizations can have various structures to fit the environment in which they function. These include:

- A collection of primary care practices working together through an Independent Practice Association (IPA) or some other organizational structure
  - A collection of primary care practices and non-primary care specialists working together through an Independent Practice Association (IPA) or some other organizational structure
  - A clinically integrated system of primary care practices, non-primary care specialists, and hospitals working together through an integrated delivery system (all physicians employed) or through a physician-hospital organization (PHO) of independent providers who are clinically integrated
  - Physician and non-physician health care providers, public health agencies, social service organizations and other community organizations working jointly to improve health care for a broad patient population.

Elliott Fischer, a proponent of ACOs, supports the concept of virtual ACOs as long as three key ACO elements are supported:

- Local accountability for quality and per capita cost for the local patient population
- Standardized performance measurement
- Payment reform that transitions payments from encouraging volume and procedures to increasing quality outcomes and value (quality/cost).

The concept of a virtual ACO is particularly important for small- and medium-sized independent practices especially those located in more rural areas. Formation of virtual networks of practices with infrastructures that can support data sharing and the collection of quality measures across practices will be a requirement for ACO formation.

ACOs will not happen overnight. Just like PCMH practice transformation, the medical home neighborhood transformation to an ACO model will require well-organized planning, decision making and implementation under strong physician leadership. Most importantly, the foundation of the ACO care model is effective family medicine (primary care) emphasizing access to care, continuity of care, comprehensiveness, and coordination. Harold Miller in his white paper How to Create Accountable Care Organizations identifies eight prerequisites for primary care practices to participate in ACOs:

- Complete and timely information about patients including the services they are receiving
- Technology and skills to support population management and coordination of care
- Adequate resources for patient education and self-management support
- A culture of teamwork in the practices
- Coordinated relationships across all practices, specialties and providers
- The ability to measure and report on quality of care
- Infrastructure and skills for management of financial risk
- A commitment by senior leadership to improving value as a top priority backed by a system to drive improved performance. (continued)

This article appeared in the spring 2010 edition of The Ohio Family Physician and is reproduced with permission from the Ohio Academy of Family Physicians. Its conclusion will appear in the next issue of the NC Family Physician.
Get to know MAG Mutual!
Comprehensive Medical Professional Liability Insurance

Premium rates reduced by an average of 8%

$15 million dividend declared in 2008

0% premium installment financing plan now available

Local claims defense, risk management and account team

North Carolina Physicians Claims Committee

Call MAG Mutual’s Andy York toll-free at 1-888-892-5218 or Mike Tekely toll-free at 1-888-834-5940 today.

www.magmutual.com

Dividend payments are declared at the discretion of the MAG Mutual Insurance Company Board of Directors.
Free Program Improves Prescription Access for Eligible Uninsured North Carolinians

In today's economy, millions of Americans, including many living in North Carolina, have lost their jobs unexpectedly, taken salary cuts, or have lost their health benefits. In fact, in North Carolina, 16 percent of the state's population does not have healthcare coverage. As a result, family physicians are seeing an ever-increasing number of uninsured patients. Many of the uninsured, as well as the insured, are forgoing doctor's visits, preventive tests and the filling of prescription medicines to save money. Fortunately, prescription assistance resources are available that can help uninsured people gain access to the medicines they need to stay healthy and to manage chronic conditions.

Rx Help for Uninsured Individuals

One free program, Together Rx Access, which is sponsored by many of the nation's leading pharmaceutical companies, provides eligible individuals and families with immediate and meaningful savings on prescription products right at their neighborhood pharmacies. To date, 67,000 North Carolinians are already Together Rx Access cardholders.

Individuals may be eligible for the Together Rx Access Card if they do not qualify for Medicare, do not have public or private prescription drug coverage, and have a household income of up to $45,000 for a single person to $90,000 for a family of four (income eligibility is adjusted for family size). Cardholders can save between 25 to 40 percent1 on more than 300 brand-name prescription products and range of generics used to treat high cholesterol, diabetes, depression, asthma, and many other common conditions. The Together Rx Access Card is free to get and free to use.

Nearly 2,000 pharmacies accept the Together Rx Access Card in North Carolina. Cardholders simply bring the Card to their neighborhood pharmacist along with their prescription, and the savings are calculated right at the pharmacy counter. There are no enrollment costs, monthly dues or hidden fees.

Free, Quick and Easy Enrollment

Together Rx Access offers potential cardholders easy ways to enroll, and no documentation is required. Visit TogetherRxAccess.com to instantly enroll online, or dial the toll-free phone number 1-800-250-2839. All enrollment materials and the Together Rx Access website are available in English and Spanish. A Together Rx Access quick start savings card is also available. Potential enrollees simply detach the Card from a brochure, and call the toll-free number to find out if they are eligible, enroll and instantly activate their Card. Family physicians interested in receiving a supply of brochures or quick start savings cards for distribution to eligible patients, can visit www.togetherrxaccessonline.com/order/.

NCAFP's Push Leads MAG Mutual Insurance to Reclassify Circumcisions as Part of Class 1A Coverage

Advocacy efforts by both the North Carolina and Georgia Chapters resulted in MAG Mutual Insurance Company announcing in mid-March that circumcisions performed by family physicians will now fall under Class 1A Coverage. Previously, family physicians performing this procedure were put into Class 2 Coverage, which included minor surgery. This led to an average increase in the cost of malpractice coverage by almost $3,000! This issue was one of many discussed during the NCAFP Health of the Public Council meeting in Asheville last December. Pediatricians performing circumcisions had always been considered Class 1A. Unfortunately, many family physicians who possess the same level of circumcision training were being classified as Class 2. Some family physicians, especially those operating rural practices, noted that this forced them to re-consider the procedure altogether. The NCAFP inquired with MAG Mutual about the discrepancy, as did our colleagues from the Georgia Chapter. Tedda Voe, Medical Relations Manager for MAG Mutual, announced the positive change through an e-mail to the Chapter in March.

New Medicaid Personal Care Services Process Took Effect April 1st

NC DMA began conducting a new referral assessments process for personal care services (PCS) on April 1st, 2010. Independent assessments are being conducted by The Carolinas Center for Medical Excellence (CCME) and will determine recipient eligibility and authorized service levels. Prior approval for PCS claims are now required, and claims for services that exceed authorized levels will be denied. Individuals applying for PCS must now obtain a referral from their primary care or attending physician and must schedule an office visit if they have not been seen in the previous 90-days. PSC now also requires physician attestation of medical necessity for the service. This program is being implemented in response to Session Law 2009-451. A memorandum outlining this new procedure is available on the NCAFP website at www.ncafp.com/resources/tracks (See New Personal Care Services Process story).

NC Agromedicine Institute to Expand On-Farm Safety Audits

The NC Agromedicine Institute is an inter-institutional partnership of East Carolina University, NC State University, and NC Agricultural & Technical State University. The Institute promotes the health and safety of the state's farming, fishing, and forestry communities through research, prevention/intervention, and education/outreach. The Institute recently received funding from the Kate B. Reynolds Charitable Trust and the NC Health & Wellness Trust Fund Commission to adapt and implement AgriSafe and Certified Safe Farm programs in NC. The programs which were originated at the University of Iowa blend preventive and primary care with education/outreach and an on-farm safety audits to improve health outcomes for individuals living and working in the farm environment. Services are provided by healthcare professionals and Cooperative Extension agents who have received specialized training in agricultural health and safety. To learn more the Institute, the AgriSafe Network of North Carolina, and how your family practice can partner with them to address agricultural health needs, contact Robin Tutor, tutorr@ecu.edu; 252.744.1045.
meeting with the residents to help build up our stable of future leaders for Family Medicine in our area.

- We want and need to develop more innovative and strategic partnerships with people like the TCL Institute (a local CME House) who are working with us on over a million dollar grant to develop innovative CME programming through an unrestricted grant from Takeda. In addition, our ongoing CME programs related to procedural skills - funded through an unrestricted grant from Gebauer is another example of bringing innovative programming through both hands-on and online training. These types of programs can be significant sources of non-dues revenue for the Academy, and partnerships such as these will allow for a broader range of CME programs that would be difficult for us to deliver alone.

- We want to expand the types of sponsors we have at our meetings. There is a world of products and services that can be helpful to family docs in their daily practices and we want those businesses to exhibit at our meetings as we watch pharmaceutical monies dwindle away.

- We want to work with groups like NC Prevention Partners and Eat Smart Move More NC in order to improve the health of our children and adults in the state through prevention programs.

- We want to institute prevention-oriented projects through partnerships with others such as our residency programs to develop more leaders in health promotion and disease prevention.

As I move into the final segment of what I wanted to share with you, I want you to think about something that maybe we don’t talk about much – at least as a group. We are people who care for the whole person – body, mind, and spirit - right? Let’s not forget that in our own lives and in this organization, that we walk, and live, and breathe as whole people. There is a spiritual component to our lives, and thus, there is a spiritual component to our practices. There is even a spiritual component to this organization and, I submit, a spiritual component to health care reform. I do not want to sound preachy or overly religious – not that I would ever be mistaken for an overly religious man. But I do want us all to recognize that perhaps in this fight – and make no mistake – it is a fight, to call upon Providence in our struggle. Pray for your leadership. Pray for your Academy. Pray for your elected leaders. And I would ask you to pray for favor for our specialty, in midst of all these changes, as we endeavor to influence healthcare reform.

Finally, our PAC needs your support. Politicians only understand two things – votes and campaign donations – not necessarily in that order – oh, and photo ops. In 2008, your Academy made some key contributions to our now-elected leaders. Those contributions made a difference and they allow us to “remain at the table” and that, my friends, keeps us “off the menu”. That is the sad truth.

We must continue to educate our legislators about the value - and the plight of our state’s family physicians. Remember, Family Medicine is the only specialty represented in all 100 counties in North Carolina. We are 2,700 strong. If we speak with one voice, along with our friends in primary care, we will be heard.

It is the greased palms from which we get our most hardy handshakes. There are a lot of hands out there to shake! Others are doing this much better than we are. The top 36 PACs in NC gave a total of over 7 million dollars last year! and now many of those groups continue to scramble to make sure their interests, including tax breaks worth at least $1 billion a year, are not harmed. The top of the heap? The N.C. Association of Trial Lawyers at $607,000. Who else is on the list in the top 36? The N.C. Hospital Association at $301K, and there are two anesthesiology PACs in the top 36 with about $200K. There are 14 anesthesiology PACs in our state, by the way. Our FAMPAC - with 2,700 family physicians - about $8,000. Compare that to the trial lawyers at $607,000. Who do you think speaks with a louder voice to our legislators?

Remember if each of us contributed just $100 a year to FAMPAC, we could be one of the leaders in this auspicious group with over $270,000! Imagine what could be done with that. Imagine how loud our voice would be in Raleigh. I am going to ask each of you to contribute that amount - today. If you can afford more, please do it. How many of you will stand with me to give AT LEAST $100 today to FAMPAC?

Let me say in closing that I have been humbled by the fact that this organization would entrust me with the responsibility to help lead it. I need your support, your wisdom and understanding, and I need temperance in order to keep my mouth shut when I should and open it when I need to - and I ask for your prayers. I will be praying for you and for our Academy – both our state and national leadership. I will be praying for our specialty – and for us to be valued for the work that we do.

Thank you for your attention.