Campbell University Puts Primary Care in Focus
### 2012-2013 NCAFP Board of Directors

**Executive Officers**

<table>
<thead>
<tr>
<th>Position</th>
<th>Name</th>
</tr>
</thead>
<tbody>
<tr>
<td>President</td>
<td>Shannon B. Dowler, MD</td>
</tr>
<tr>
<td>President-Elect</td>
<td>William A. Dennis, MD</td>
</tr>
<tr>
<td>Vice President</td>
<td>Thomas R. White, MD</td>
</tr>
<tr>
<td>Secretary/Treasurer</td>
<td>Rhett L. Brown, MD</td>
</tr>
<tr>
<td>Board Chair</td>
<td>Brian R. Forrest, MD</td>
</tr>
<tr>
<td>Past President (ex officio)</td>
<td>Richard Lord, Jr., MD</td>
</tr>
<tr>
<td>Executive Vice President</td>
<td>Gregory K. Griggs, MPA, CAE</td>
</tr>
</tbody>
</table>

**District Directors**

<table>
<thead>
<tr>
<th>District</th>
<th>Name</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Jessica Triche, MD</td>
</tr>
<tr>
<td>2</td>
<td>Matthew M. Williams, MD</td>
</tr>
<tr>
<td>3</td>
<td>Scott E. Konopka, MD</td>
</tr>
<tr>
<td>4</td>
<td>Tamieka Howell, MD</td>
</tr>
<tr>
<td>5</td>
<td>Janice E. Huff, MD</td>
</tr>
<tr>
<td>6</td>
<td>Alisa C. Nance, MD</td>
</tr>
<tr>
<td>7</td>
<td>David A. Rinehart, MD</td>
</tr>
</tbody>
</table>

**At-Large**

- Holly Biola, MD
- Charles W. Rhodes, MD

**IMG Physicians**

- Joseph P. Pye, MD

**Minority Physicians**

- Benjamin F. Simmons, MD

**New Physicians**

- Jennifer L. Mullendore, MD

**NC Family Medicine Departments**

- Michael L. Coates, MD

**Family Medicine Residency Directors**

- William A. Hensel, MD

**Resident Director**

- Mo Shahsahebi, MD (Duke)

**Resident Director-Elect**

- Aaron George, DO (Duke)

**Student Director**

- Katy Kirk (ECU)

**Student Director-Elect**

- Julie Barrett (ECU)

**FM Department Chairs & Alternates**

<table>
<thead>
<tr>
<th>Chair (WFU)</th>
<th>Michael L. Coates, MD</th>
</tr>
</thead>
<tbody>
<tr>
<td>Alternate (Duke)</td>
<td>J. Lloyd Michener, MD</td>
</tr>
<tr>
<td>Alternate (ECU)</td>
<td>Kenneth K. Steinweg, MD</td>
</tr>
<tr>
<td>Alternate (UNC)</td>
<td>Warren P. Newton, MD, MPH</td>
</tr>
</tbody>
</table>

**AAFP Delegates & Alternates**

<table>
<thead>
<tr>
<th>AAFP Delegate</th>
<th>Mott P. Blair, IV, MD</th>
</tr>
</thead>
<tbody>
<tr>
<td>AAFP Delegate</td>
<td>Karen L. Smith, MD, FAAFP</td>
</tr>
<tr>
<td>AAFP Alternate</td>
<td>L. Allen Dobson, Jr., MD</td>
</tr>
<tr>
<td>AAFP Alternate</td>
<td>Michelle F. Jones, MD</td>
</tr>
</tbody>
</table>

**The NCAFP Family Medicine Councils**

- Advocacy Council: Robert L. Rich, Jr., MD, Chair (co-sponsor: William A. Dennis, MD, Vice Chair)
- CME Council: Thomas R. White, MD, Chair
- Health of the Public Council: Charles W. Rhodes, MD, Chair
- Practice Enhancement Council: Rhett L. Brown, MD, Chair

Details on p. 13
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, organizational integrity and viability.
- Creativity and flexibility.
- Member-driven involvement in leadership and decision making.

Additional details on the NCAFP strategic plan are located at www.ncafp.com/academy/mission
Member Needs Assessment is Your Opportunity to Provide Much-Needed Feedback to the NCAFP

“When you are given your voice, shout out!”

Perhaps while it has not always been the case, in the current milieu of this hallowed practice of medicine we are frequently on the receiving end of tremendous amounts of “feedback” from others. In the PCMH model, patients are empowered to call or email any time of day or night for appointments or labs or just to ask a question. If we are not timely in our responses, or if our systems suffer downtime due to maintenance, we are likely to receive fairly vocal negative feedback. If our systems and tracking methods are not adequate for current measures set by others, we get feedback by way of withheld meaningful use dollars or lower level of NCQA recognition.

Despite family doctors historically having a strong drive to address preventive health, if our pap numbers or colonoscopy counts don’t cut the mustard, insurers will send volumes of often erroneous feedback in reports to our offices. God forbid your Medicare patients buy a drug for $3 generic price without using their Part D, because your mail will be inundated with feedback about how standard regimens are not being prescribed. In complex patients we might prescribe too many, or too few, too soon, too late...there is no shortage of feedback.

Perhaps if you have hospital privileges you get reports on the number of charts that are overdue or if your attendance at staff meetings is below par. If you want to order an MRI or an ultrasound on a patient, you might receive feedback from a nameless radiologist manning a phone somewhere about another study that is required first. It seems, almost daily, we are receiving volumes of feedback. Well, friends, now is your chance to be the one giving feedback.

Every five years or so your Academy revisits the strategic plan to make sure we are driving in the direction the membership wants us to go. Our specialty society is run by an elite, though small, staff and the volunteer leadership of your peers. Whether in the role of committee chair or as a board member or on the executive committee, it is your colleagues who are often called upon to help advise the staff in the direction to steer this stealth ship.

It is critical -- in order to maintain the power and effectiveness to represent our members -- that periodically we reach out to our entire membership to get opinions and input to drive us into the next strategic plan. In the next few weeks each of you will be contacted by email with a member needs assessment. We want and need your feedback! The political environment has been in a state of unprecedented drama. Where do you want the Academy to stand on issues like Medicaid expansion and reform, insurance exchanges, public health policy, and scope of practice issues? How can we serve member needs more consistently with CME, communication, and technology advances?

Please take the five or 10 minutes to be the one in the seat giving the feedback this time—the good, the bad, and the ugly!
WHAT IF YOU COULD RESTORE CONTROL OF YOUR PRACTICE, SPEND MORE TIME WITH YOUR PATIENTS, AND INCREASE YOUR PROFITABILITY?

YOU CAN

Our Simplicity™ software platform allows you to add a robust direct pay business to your existing practice and offer your services directly to patients and local employers.

To find out more or schedule a demo of our Simplicity™ software:

PhysicianCareDirect.com or call 855-PCD-2300
Moving Policy Forward to Go Back to The Heart of Family Medicine

Since the dawn of the new year, three policy implications have arisen at the federal level that are likely to have great influence on the next steps in primary care. These include modeling for more robust transitions of care, as well as proposed reimbursement incentives for chronic care management. A third, likely more subtle undercurrent, is the possibility for a paradigm shift from payment metrics built around quality to those focused on efficiency.

Reflecting on how these political circumstances would affect incentives for primary care, I began to consider their direct and long term impact on training for our future Family Medicine leaders. After all, medicine has a tendency towards cyclic trends, with major themes seemingly reappearing throughout American history. One need look no further than the recurring push for universal coverage or efforts to manage costs in the United States health care system. This presents the challenge of keeping pace with the forefront of advancement and change, while continuing to keep an eye on the lessons of the past.

I am encouraged as I see some of the threads of these policy discussions as hinting at the roots of our profession— at the very heart of personalized care, population health, community, and those virtues exemplified in the foundations of Family Medicine.

1) Transitional Care Codes

Following a century dominated by increased hospital utilization, policymakers from both sides of the aisle recognize that strong primary care provides an essential foundation to a restructured health care system. The five new Medicare CPT codes developed by CMS have been reimbursement incentives for chronic care management. Among serious discussion over the past six months has been the evaluation of models for phasing out reimbursement under the traditional fee-for-service structure. I have noticed an increased emphasis on the “efficient use of resources” in determining payment.

This efficiency has been proposed as the next step beyond providing quality care. It is centered not around meeting whole population percentages for say, colonoscopy screening; but rather making the right decisions both for the individualized needs of the patient as well as for the cost-impact on the system. I think this could represent a boon for primary care, and a more personalized approach to management and treatment.

To add to all of this, support continues for the Patient-Centered Medical Home (PCMH) as just the sort of model that combines the value that political leaders desire and the consistency and compassion that our patients deserve.

Family physicians stand much to gain in aligning practice mechanisms to take advantage of policy innovations. Further, we must equip our residents and trainees to not only learn from those lessons of the past, but to prepare as passionate advocates for the future.

While certainly not an exclusive path, policy represents one of many and a powerful means to reinvigorate the roots of Family Medicine.

Along the way, I am eager for our future Family Medicine leaders to witness passion driving policy, and policy reinvigorating passion in a continuum. Now, that is just the sort of cyclic trend in family medicine we can all rally behind.

4. Proposed 2014 Medicare physician fee schedule; Complex Chronic Care Management Services. 78 Federal Register 139 (19 July 2013), pp. 43337 - 43342
My Experience at the 2013 Family Medicine Congressional Conference

By Rebekah Hughey Collymore, MD

The 2013 Family Medicine Congressional Congress changed my life. As a child and young adult, I had little to no interest in politics. I was focused on the sciences and math—concrete things that I could be sure about. Government and politics were abstract entities that I heard about on the evening news, but had no direct effect on my life. As I got older, I began to realize the importance of voting, electing people to represent my personal interests and those who shared my values, as they could have tremendous influence on the quality of my life. However, it was not until FMCC that I saw policy on a much grander scale. As I walked through the halls on Capitol Hill, talked to congressman, legislative aides, and members of my own local chapter of AAFP, I truly got a sense of how important active political involvement is.

When I first got into town, I didn’t know what to expect. I got in town just in time for dinner, and met the fellow scholarship winners in the lobby. My first impression was good. Everybody was friendly, welcoming, and there was an air of excitement and anticipation. Walking to the restaurant, everyone seemed energized. We were all curious to know who are these fellow residents who share my interests? What do they think about these next two days? What can I learn from this short time I will have with him or her before I go on to meet with my state delegation? What in the world have I gotten myself into?

Dinner at Ella’s Pizza was relaxing and reassuring. I sat with Dr. Mitchell, program director of Providence Family Medicine residency in Southfield, Michigan, as well as 4 other scholarship recipients. We sat back, laughed, told familiar stories about residency life, and posed for pictures. We enjoyed laughs, pizza, salad, dessert. I also got an opportunity to discuss my career goals with Dr. Mitchell, who is very passionate about her role as a teacher. She believes that this is indeed her calling, and gave me specific examples of the gratification she receives from being able to shape the careers of her residents—especially those who are struggling academically. I shared with her that I am also considering an academic career, with the ultimate goal of possibly becoming a program director. She seemed genuinely interested in me as an individual and excited for me about my decision to accept a position at my program as a faculty development fellow.

Tuesday was an early morning. We arrived to the conference to the smell of a wonderful hot breakfast accompanied by a variety of pastries, teas, and, of course, an unlimited supply of coffee. Then we all found our way to our respective state table, where we met and mingled with the other members of our state delegation. I was fortunate enough to be able to sit with the North Carolina AFP president and executive vice president, and discuss legislative issues unique to our state. This was eye-opening as well. One important issue they highlighted was Teaching Health Centers, which are ambulatory care centers with residency programs. This is a pilot program receiving federal funding through the Affordable Care Act (ACA), and so residency programs are only guaranteed funding for a total of 5 years. Because we are approaching year number 3, programs are being put in an undesirable position of either accepting a new class of residents without being able to guarantee their funding for the whole 3 years, finding alternative funding sources, or choosing not to accept residents for at least another 2 years, at which time funding may be renewed. We were asking legislators to do 2 things. One was to reauthorize the funding. The second question or “ask” was to re-appropriate the money through Medicare, similar to the manner in which other GME is funded. This would ensure a more stable source of funding. We were told that the second “ask” could be accomplished in a budget-neutral way, which was an important point to make with our republican leadership. We were also briefed on other issues as well in preparation for our visit and, by the end of the day, I returned to my room armed with everything I needed to become a first-time lobbyist on Capitol Hill.

One of my most gratifying and exciting experiences was in the office of a representative. We arrived at the office, were greeted by their healthcare legislative assistant and immediately ushered into his office. Because I was designated to lead the session, I sat next to him at a small round table with two others. The rest of our delegation sat a bit further away on the couch. I introduced the group, told him the reason for our visit, and then began to speak about the Teaching Health wCenters (THC). When I began to discuss Medicare funding for the THC, he interrupted abruptly and said, “what about 340b?” I had no idea what he was asking me. However, another member of
BUIES CREEK -- Just over a sweeping knoll off Highway 421 east of Lillington, North Carolina's newest medical school opened earlier this month. Students in the inaugural class of the School of Osteopathic Medicine at Campbell University have begun their medical journeys at a school with a mission to train community-based physicians for rural and underserved care. This is North Carolina's first new medical school since the creation of the Brody School of Medicine at East Carolina 35-years ago, bringing the state's total to five medical schools including Brody, UNC, Wake Forest and Duke.

Campbell University's vision of improving rural and underserved care is rolling out at a critical time. Similar to many states, North Carolina is struggling to train enough primary care physicians to meet its growing demands. According to workforce data published by AAFP's Robert Graham Center, the state currently ranks 33rd nationally in the number of primary care providers per capita. Several factors are combining to make this need even more critical, including a steadily growing population, ensuing changes in care delivery models, and an aging population. Campbell leaders began to recognize the scope of this issue in 2010 while conducting due diligence in creating its Physician Assistant program. As university leaders digested reports like the 2007 NC Institute of Medicine's primary care workforce study, one of its central recommendations struck an important chord: addressing NC's primary care provider problem would require either larger medical school enrollment or a new medical school.

At the outset, Campbell leaders thought the idea of establishing a new medical school might be prohibitively expensive. Alongside the major funding obstacles were huge unknowns, the most important of which was how to deliver the required clinical experiences. The school didn't own a hospital and probably lacked the necessary clinical relationships. But after a visit to small Mississippi-based William Carey University who itself created a new osteopathic college in 2010, Campbell president Dr. Jerry Wallace was convinced the university could meet the challenge.

"The model of osteopathic education is in many ways similar to pharmacy education in that the clinical experiences can be provided using a non-centralized, distributed approach," commented Dr. Wallace. "Given our experience with our pharmacy school, we knew we could be successful."

That Mississippi trip was in early, 2010. Today, just over three years later, students are already enrolled and learning in Buies Creek. Campbell's speed of development and startup has been remarkable.

Campbell has a long history of establishing new schools related to the health sciences. Beginning in 1985 when it founded its School of Pharmacy -- itself the nation's first new pharmacy school in four decades -- the university has successfully started a number of allied health degree programs. Most recently, its new Physician Assistant program will graduate its first class next year. Campbell also offers a Physical Therapy doctoral program and a number of unique dual-degree tracks that combine their business, law, and health sciences disciplines. With each program, the university was reacting to a need. For its new medical school, the concern about North Carolina's primary care workforce is driving everything - including the types of physicians the school ultimately wants to produce.

"Our goal will be to have 50% of our graduates go into primary care," noted Dr. John Kauffman, founding Dean of the school. "We want to provide primary care and general specialists to all of North Carolina, but especially to its rural and underserved areas." Dr. Kauffman went on to describe the widening access disparities between the state's urban and rural areas, and characterized it as an issue impacting everyone.

Campbell's mission to produce community-based primary care physicians has played the lead role in the school's launch. Student recruiting, faculty development, curriculum design, and even the construction of its teaching facilities have all been developed around this vision. According to Kauffman, the end goal has been to create a holistic and integrated environment that will foster its mission and primary purpose: to educate and prepare community-based physicians for the rural and underserved populations in North Carolina, the Southeastern United States and the nation.

"But even with these goals, Campbell couldn't succeed without recruiting the right medical students. Dr. Kauffman explained that a range of factors were considered for each prospect in its inaugural class. He described how identifying students most likely to pursue primary care careers was ever present, with natives from small or rural communities being particularly attractive.

"The greatest predictor of rural practice is rural
birth. We’ve looked at this and a number of factors as we selected our first class, all in the hopes of identifying those students who are most likely to practice in a rural or underserved community,” he explained. All told, 43 North Carolina natives are enrolled in the inaugural class.

Supporting student selection, Campbell has recruited a medical faculty and built an administrative structure to match. With many of today’s medical schools plagued with cultures that run counter to promoting primary care, Campbell has made every effort to promote unity of purpose. Kauffman noted that the university has been equally deliberate in hiring founding faculty and administrative staff who share the school’s commitment and are excited about primary and community-based care. Everybody is pulling in the same direction.

Campbell is not alone in seeing the great need for primary care for the underserved or for the belief that osteopathy can play a major role in helping to address it. The school is representative of a nationwide trend that has seen osteopathic medical education steadily grow. Since 2000, the number of osteopathic medical schools in the US has risen from 19 to 34 and now offers more than 1,900 new physician training slots. According to a report published last year by the American Association of Colleges of Osteopathic Medicine, osteopathic medical schools now include 26 colleges, four branch campuses and four remote teaching sites spanning 25 states.

Osteopaths, by and large, also have begun to make up an increasingly larger portion of the national primary care workforce. Approximately 60% of practicing osteopathic physicians practice in the primary care specialties of family medicine, general internal medicine, pediatrics, and obstetrics and gynecology.

Campbell features a medical student body of 162, making it the state’s second largest school behind UNC. Large class sizes like these are not uncommon in the nation’s osteopathic schools. In fact, osteopathic schools are currently expanding their class sizes much more quickly than are their allopathic counterparts. By 2019 it is expected that upwards of 25% of all US medical students will be Doctors of Osteopathy. This increase in osteopathic education is the result of steadily changing perceptions of DOs that began in the very early 1960s. Over the last five decades, a steady series of developments have brought DOs out of their separate hospitals and clinics and into practice directly alongside their allopathic peers. While Campbell recognizes that North Carolinians will need to be educated on what osteopathy is, it’s a worthwhile fight that will pay big dividends.

“At Campbell, we are inspired to do this because we see the need and it’s compatible with our purpose,” explained Dr. Wallace.

If you visit Buies Creek today, the most visible symbol of Campbell’s commitment can be seen in its new state-of-the-art teaching facility on Hwy. 421, the Leon Levine Health Sciences Center. At 96,000 square-feet, the building was designed from the ground up to offer the latest in teaching technology within a space geared to encourage interaction and collaboration.

To fund the capital investment required for Leon Levine and the entire school, Campbell reached out and found several partners across the state. The university was able to secure $4M in funding from partners like the Kate B. Reynolds Charitable Trust and the Golden Leaf Foundation. In doing so, Campbell received the largest foundation gifts in the university’s 125-year history. With additional financial commitments of $24M to date, the university has invested over...
The value of membership with Medical Mutual has never been greater!

- Additional discounts
- Member savings accounts
- Cash dividends
- Enhanced coverages
- Improved practice resources
- Timely risk management services & tools

Professional Liability | Employee Benefits | Business Insurance

A.M. Best has awarded Medical Mutual’s professional liability coverage the highest rating of “A” (Excellent) for nine consecutive years.

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

Medical Mutual is proud to be a Corporate Sponsor of the North Carolina Academy of Family Physicians
In this new series, the NCAFP is highlighting Chapter leaders and members who are working in important public health roles.

**Dr. Tom Koinis Keeps Busy Working to Improve Public Health**

Oxford, NC - Dr. Tom Koinis is continuing to work to improve public health by taking an active role in a number of key public health initiatives, both in Granville County and nationally. Koinis is a Past President of the NCAFP (1997), as well as a Past President of the NCAFP Foundation (2000-2004). He most recently served the AAFP as Chair of the Commission on Health of the Public & Science in 2010.

Dr. Koinis currently serves as Clinical Director of the ‘northern tier’ of the Northern Piedmont Community Care network. He has been involved with his local CCNC network since 2006. In addition to his CCNC efforts, Dr. Koinis also continues to be involved in a several immunization-related initiatives, including serving on the NC Immunization Advisory Council for the past 16-years. He also served on the NCIOM’s Dental Task Force that advised NC’s Medicaid program. Additionally, Dr. Koinis has been the AAFP representative to a number of ACIP groups, including Rotavirus, Hepatitis, and Zoster. Locally he remains active on the Board of Trustees of the Granville Medical Center where he is a member of its Finance Committee. So what drives and motivates him to continue such important work? “Volunteering is like the ‘icing on the cake’ for me. It keeps me motivated to serve my patients, my practice and my community as best as I can,” Koinis explained. “But it also offers a different perspective that helps me understand the needs of my community more. And I get to utilize my skills and experience in a different way. It’s great!”

**Dr. Shannon Dowler Receives Association Contribution Award by State Community Health Centers**

The North Carolina Community Health Center Association (NC-CHCA) awarded its 2013 Association Contribution Award to NCAFP President Dr. Shannon Dowler of Hendersonville. Dr. Dowler was presented with the award during NCCHCA’s 35th Anniversary Primary Care Conference in Charlotte in mid-June. NCCHCA is an association of 31 health center grantees and other partners and bestows its Association Contribution Award to an individual or organization that has contributed significant to its enhancement. Enhancement may come in the areas of program development, improving financial status, improving relations with organizations, or in assistance to Association members. Dr. Dowler currently serves and Chief Medical Officer at Blue Ridge Community Health Center.

**Fighting for the Health of Your Patients:**

**A Look Back at the 2013 Legislative Session**

The 2013 legislative session has been one of the busiest ever, with the Academy fighting for you and your patients every step of the way. While much of our effort focused on preserving a physician-driven Medicaid program and in opposition to outsourcing the program to managed care companies, we addressed numerous issues in the session that just ended. Let me outline a few of these:

**MEDICAID**

In April, Governor McCrory announced a significant effort to reform Medicaid. While we know our state’s Medicaid program isn’t perfect, our state, through Community Care of NC, has made great strides to improve quality and lower cost. During the reform debate, we have sought to convey three key principles: any reform should be built on a robust system of primary care; we should not outsource scarce healthcare dollars to profit-driven, out-of state managed care companies; and healthcare stakeholders need to be at the table for any reform discussions. These key messages were highlighted on a new micro-website developed by the NCACP, www.ourNCHCHealthCare.com. Fortunately, the NC General Assembly slowed the process and required the Department of Health and Human Services to provide significant information prior to moving forward with any reform efforts. In addition, the Legislature established a small Medicaid Reform Advisory Group to help provide guidance to the process (members of that group had not been appointed as of press time). The state budget also had several significant provisions around Medicaid, including:

- An initial plan to move all pregnant women from 133 to 185% of the federal poverty level from Medicaid onto subsidized policies on the Health Benefits Exchange. This proposal was successfully defeated.
- A reduction in annual physician visits for Medicaid recipients before requiring prior authorizations from 22 to 10. Fortunately, patients with chronic conditions are exempt from the 10-visit limit.
- Development of a shared savings program for Medicaid providers. The plan includes a 3 percent hold back for all providers (with the exception of primary care at least until 2015). A plan to redistribute these funds in a shared savings model is scheduled to be developed by June 30, 2014, with distribution of the funds beginning in January, 2015. Much about this particular effort is unclear, including whether the federal government will ultimately allow the state to implement such a hold back.
- A requirement to better integrate mental health data with CCNC in order to improve care coordination.

~ Continues on next page ~
Fighting for the Health of Your Patients:

These Medicaid changes and reform efforts are certainly a mixed bag, and the NCAFP will continue to fight for you and your patients as the process continues.

PARENTAL CONSENT

House Bill 693 would have required adolescents to have notarized parental consent before a physician could talk with them about STDs, alcohol or drug abuse, mental illness or pregnancy. The NCAFP, along with others, fought this bill emphatically. Not only would the bill have served as a significant infringement on the physician-patient relationship, it would have also caused significant harm to adolescent healthcare in NC. Fortunately, the bill was withdrawn from a House floor vote after having been approved by the House Health Committee.

IMMUNIZING PHARMACISTS

During the last two legislative sessions, pharmacists have sought to expand their authority to provide immunizations, initially asking to provide all immunizations down to age seven without any physician involvement. The NCAFP had two key guiding principles: that the coordination with the medical home be preserved (no further fragmentation of care) and that enhanced access only be provided in a manner that was absolutely safe for the patients. In the end, a compromise bill will allow pharmacists to provide five immunizations for adults under a physician-driven protocol: Pneumococcal, Zoster, Tdap, Hep B and Meningococcal. Pharmacists can still give influenza vaccine down to age 14. Previously, other than influenza, a pharmacist could only give Pneumococcal and Zoster under specific physician order. The new rules require that the protocol be supervised by a licensed physician practicing in North Carolina, that a pharmacists check the NC Immunization Registry prior to giving the vaccine, that the vaccine be recorded in the registry and reported to the individuals primary care physician (if the individual has one), that information be provided about the importance of a medical home if the person does not have one, and that standardized screening questions be utilized which will ultimately be agreed upon by all parties involved in the legislation including the NCAFP. In addition, Tdap cannot be given if an individual is requesting it due to an injury. The NCAFP leadership ultimately believed that this bill provided expanded access for public health reasons without putting patients at risk or undermining the medical home.

MIDWIVES

Several legislative proposals looked at expanding the authority of midwives (both nurse midwives and lay midwives). The most troubling bill involved decriminalizing the practice of lay midwifery. Lay midwives do NOT have nursing training and only take very short certification courses. Had this bill passed, anyone with a designation of a certified professional (again non-nurse) midwife could have delivered babies in the state without any liability. The NCAFP vehemently opposed this legislation. The question of expanded authority for certified nurse midwives will be studied by the General Assembly. The NCAFP will monitor that process.

OTHER PUBLIC HEALTH ISSUES

Several other public health issues arose during the legislative session. The NCAFP supported the Youth Skin Cancer Prevention Act that would have prohibited anyone under the age of 18 from using indoor tanning facilities. The bill passed the House and will likely be considered by the Senate next year. In addition, the NCAFP supported funding for tobacco prevention efforts. While funding was not budgeted at levels seen in previous years, the General Assembly did preserve limited funding for operation of the QuitLine.

This is just a sampling of the issues NCAFP addressed before the General Assembly this year while always considering our core mission: to advance the specialty of Family Medicine, in order to improve the health of patients, families, and communities in North Carolina.
Can you believe it’s that time of the year again? Time to start looking towards fall, when the air chills, the leaves fall and North Carolina’s largest family medicine and primary care conference takes place.

The NCAFP’s annual Winter Family Physicians Weekend is scheduled for Dec. 5th through Dec. 8th, 2013, at The Omni Grove Park Inn, in Asheville. Program Chair, Dr. Richard Lord, Jr., and Vice-Chair, Dr. J. Carson Rounds are planning a program filled with a variety of evidence-based CME lectures, and a great line-up of optional workshops, seminars and satellite learning opportunities. The meeting will provide high quality education along with a fun array of social activities and events. Early December is a wonderful time to be in the mountains and a great way to kick off the 2013 holiday season.

Make plans now to arrive a day early (Wednesday, Dec. 4th) to take advantage of pre-conference CME workshops. At press time, specific details are still being worked out, but to learn more, visit www.ncafp.com/wfpw to read more about the SAMS Working Group from 3pm to 9pm and the Mastering Hands on Procedures Workshop (Joint Injections & Skin Biopsies) from 3pm to 9pm. Pre-registration is required for each of these workshops.

For the second straight year, the Winter Meeting will be almost entirely ‘Green,’ meaning that a traditional paper syllabus will NOT be provided. All program information and conference learning materials will be available online or possibly via a mobile app for registered attendees. Registered participants will receive an email with a web link approximately one week prior to the conference. The email will include a username and a password that will enable you to download, save and/or print your preferred program materials and course handouts. These online materials will be available for 90 days after the program. If you prefer to have a printed paper copy of the general session lectures and conference materials, you must purchase a paper syllabus in advance for $35. NOTE: The Optional Workshops & SAMS Study Working Group will provide printed handouts.

The NCAFP has blocked 80% of The Omni Grove Park Inn’s sleeping rooms for this event. Please book your rooms early as the hotel will sell out. The sleeping room block offers a variety of room types. Guests may choose from Run of the House Rooms at $209 per night, Resort View Rooms at $219 per night and Mountain View Rooms at $229 per night. Please call the hotel directly at 800-438-5800 or 828-252-2711 to make your reservations.

Additional rooms are also available at a discounted conference rate at the Renaissance Asheville Hotel (phone 800-468-3571) at $159.00 per night and at the Crowne Plaza (phone 800-733-3211) at $125.00 per night. Be sure to mention the NCAFP room block to receive the discount. Book early; rooms will fill up quickly. Both the Renaissance Asheville and the Crowne Plaza Hotel will offer a free shuttle service to Winter meeting attendees staying at these locations. The shuttles will provide transportation to and from the hotels to The Omni Grove Park Inn during the NCAFP's scheduled events and activities.

All NCAFP members will be receiving the official meeting brochure in the coming weeks. The brochure will include up-to-date conference information; members can also find this online as well at www.ncafp.com/wfpw. To register, simply mail or fax your registration form with your credit card number or check made payable to the North Carolina Academy of Family Physicians. Registrations can also be completed online at www.ncafp.com/wfpw. Members of the NCAFP or the AAFP may receive our Early Bird Registration Rate by completing the registration process by Monday, November 4, 2013. Please contact the NCAFP Meetings Department for more information or to request a brochure and registration form by calling (919) 833-2110 or (800) 872-9482 (Toll-free in NC only) or via email at meetings@ncafp.com.
Physician-driven accountable care organizations ("ACOs") are working. The even better news is that this trend is predictable and inevitable.

ACOs are working – as other materials from the Toward Accountable Care Consortium detail, there are eight fairly straightforward elements required to create a successful and sustainable ACO: (1) a change in financial incentives from those which reward volume, such as fee-for-service, to ones which reward value, like shared savings, if quality benchmarks are met; (2) a primary care core; (3) physician cultural change; (4) patient engagement; (5) robust data collection; (6) clinical best practices; (7) administrative infrastructure; and (8) enough scale.

A number of ACOs that do not have these elements will fail, but fortunately, more and more are being set up properly. Recently, the consulting firm, The Boston Consulting Group, reported that ACO-like Medicare Advantage plans are reporting positive results. They are all distinguished by having “a selective network of providers, financial incentives that are aligned with clinical best practices, and active care management that emphasizes prevention in an effort to minimize expensive acute care.” Not only are emergency department and ambulatory surgery procedures down 20-30%, but their analysis of data on 3-million Medicare patients showed that quality went up. These patients had lower single-year mortality rates, shorter average hospital stays, fewer readmissions, and better sustainability of health over time.

Physician-Led ACOs Are Better – If ACOs are good, physician-sponsored ones are better. At a recent national meeting of health insurance companies, Paul Ginsburg, Ph.D., President of the Center for Studying Health System Change, told the insurers that, “I think physician-led ACOs inherently make markets more competitive because they have an opportunity to shift patients toward high-value hospitals.” Similarly, Charlie Baker, former Secretary of Health and Human Services for Massachusetts, told the group that nearly all of the Medicare Advantage risk contracts are with physician groups and not hospitals. Medicare Advantage participants are chosen by insurers, and he indicated that they know that contracting with physician ACOs is the best way to save money. This truth is becoming more evident, and there are now more physician-led ACOs than any other.

Changing Compensation – Primary care is the only discipline mandated to be in ACOs participating in the Medicare Shared Savings Program. This is because ACO success stems from keeping people out of the hospital, avoiding expensive procedures and reducing unnecessary tests and imaging. The “rich target fields” for ACOs to accomplish this are primarily prevention and wellness, coordination of high-cost complex patients, reduced hospitalizations, and transition management across our fragmented system. These are all in primary care’s wheelhouse. This is reflected in early ACO shared savings models. Specialist compensation will evolve as more sophisticated value-add innovations involving them drive quality and savings.

This author firmly believes that the successful and sustainable ACOs will tie shared savings distributions to relative contribution. A merit system will thus likely be primary care weighted. For example, one ACO posted this distribution: 12% to infrastructure; of the remainder, 60% to primary care, 40% to specialists, and 0% to hospitals. The small sample survey at left shows widely varying models, but in all cases where distribution is broken out, primary care receives as much or more than specialists.
A fully evolved ACO should incentivize all providers and facilities along the entire continuum of care, but always in proportion to their value-adding contribution. Whilst this economic reward is gratifying and validating, physicians are sometimes surprised that the biggest reward has been empowerment to do health care right and regain control of the physician/patient relationship. They say that seeing happier, healthier patients, and being able to spend more time with them, has returned the fun to the practice of medicine.

1) Kaplan, J., et al., Alternative Payer Models


We invest our financial strength in you

Defending southeast physicians for more than 30 years

• Consistent dividends*
• The best North Carolina attorneys
• North Carolina peer physician claims review
• Industry leading Patient Safety
• Owners Circle® rewards program
• Doctor2Doctor® peer support

Medical malpractice insurance for North Carolina physicians

Call 1-866-798-5281 or visit MagMutual.com

* Dividend payments are declared at the discretion of the MAG Mutual Insurance Company Board of Directors. Since inception, MAG Mutual Insurance Company has distributed more than $108 million in dividends to our policyholders.

Insurance products and services are issued and underwritten by MAG Mutual Insurance Company and its affiliates.
NC Division of Public Health Seeks Reports of Acute Pesticide Injuries

All providers encouraged to report

Your help is needed. The North Carolina Division of Public Health, Occupational and Environmental Epidemiology Branch, wants to learn more about how pesticide use may affect those who live and work in our state. Public Health is tracking acute pesticide-related illness and injury because pesticides are designed to be toxic agents, use is widespread, and over-exposures can result in both acute and long-term effects if products are not handled as directed. Who is at risk? EPA reports that large quantities of conventional pesticides are used in agriculture and in homes; almost three-fourths of United States households use pesticide1. Populations at highest risk include the elderly, children, and those engaged in agricultural activities such as farmworkers, pesticide handlers (often farmworkers who work under an applicator's license) and pesticide applicators on and off the farm. North Carolina has a large migrant farmworker population compared to most states and is second in the nation for the number of pesticide applicators certified to do commercial spraying on farms and at residences2,3.

We are asking health providers to report all suspected or confirmed cases of acute pesticide illness or injury to the North Carolina Pesticide Incident Surveillance Program. North Carolina public health law (10A NCAC 41F .0101 – .0103) requires physicians to report. Nurses and other support staff, under direction of the treating provider, can also report. Reporting is easy. Call Carolinas Poison Center (CPC) 24/7, at 1-800-222-1222. Poison control specialists have been trained to ask questions that will fulfill reporting requirements. Advice regarding recognition and treatment of pesticide illness is also available from CPC. The other option is to fax or call in a report to Public Health, see http://epi.publichealth.nc.gov/oew/pest/reporting.html for instructions. Please call the Occupational and Environmental Epidemiology Branch with questions at 919-707-5900.

New Program Helps Physicians and Practices Connect to The NC Health Information Exchange

Community Care of North Carolina (CCNC) and the Division of Medical Assistance (DMA) are partnering to assist Eligible Professionals (EP) in meeting the requirements of Stage 2 Meaningful Use. CCNC is offering a program to EPs that provides a subsidy to connect to the North Carolina Health Information Exchange (NC HIE). The connection will have the capability to assist EPs in meeting the following Meaningful Use objectives: Electronically submit Clinical Quality Measures (CQMs) to the NC Medicaid Incentive Payment System (NC-MIPS); electronically access and submit electronic data to the North Carolina Immunization Registry and other public services as available; electronically access and submit electronic data to specialized clinical disease registries; and exchange key clinical information among providers of care and patient-authorized entities electronically. Along with these key objectives, EPs will become participants on the NC HIE and thus will have full access to the core services of the NC HIE. To be eligible for this program, an EP must have received an incentive payment under the Medicaid rule or be a member of the Community Care of North Carolina program. For additional information, please contact Chris Scarboro (919) 745-2379 cscarboro@n3cn.org or Jayson Caracciolo (919) 926-3901 jcaracciolo@n3cn.org.

(2) Census of Agriculture, 2007
(3) NASDA Research Foundation; Cooperative Agreement with Washington State University and EPA # http://www.cpard.wsu.edu/reports/totalApplicators.aspx
MEDICAID WILL CHANGE
But FPs Can Help Make The Changes as Positive as Possible

Beginning with the Governor’s proposal to change the Medicaid program through a program called a “Partnership for a Healthy North Carolina” and taking into account the final budget as passed by the House-Senate conference committee, it is apparent that the Medicaid program is changing. Those changes will affect all of our members who care for the Medicaid patient. We applaud the efforts of those legislators who have listened to our concerns about the proposed changes to the Medicaid program and who have fought for those positions favorable to our interests. To those legislators, we say “Thank you”.

During the discussions surrounding the Governor’s proposal and legislative alternatives, one theme has been consistently heard: a desire that all Medicaid providers have “more skin in the game.” Whether in reference to legislated withholds or changes to the providers per-member-per-month (PMPM) payments or the Governor’s proposed managed care entities who would also shift more of the financial burden to providers, it is apparent that providers will be more at risk and will be called upon to produce more savings for the Medicaid program. As providers, what can we do to produce those savings and protect our own reimbursement now? In other words, what can you do to help lower costs now.

Reduce ER Utilization
One of the first and most cost effective mechanisms will be to reduce Emergency Room (ER) utilization. While we cannot mandate that our patients not use the ER, we must look at all mechanisms that promote our offices as the preferred alternative to costly ER visits that are time consuming for the treatment of minor illnesses. Certification of our offices as Patient Centered Medical Homes (PCMH) requires exploration of concepts such as extended hours, more open-access scheduling, and improved after hour communications, all of which can help lower ER utilization. Studies of the ER utilization patterns of our Medicaid patients has confirmed that many patients fail to realize that our offices are open during the times when they are being seen for minor illnesses, with many patients revealing in surveys that they were unaware of our office hours, particularly our afterhours clinics.

Utilization of the Medicaid Preferred Drug List
Another mechanism to promote savings for the Medicaid program involves greater use of medications from the Medicaid Preferred Drug List (PDL). In general, generic drugs are preferred over brand name drugs (except for a few exceptions) and greater use of the medications from the PDL would substantially lower medication costs. This would be most obvious for behavioral health medications where there is currently a high usage of brand name medications which may cost the program several hundreds of dollars per month.

Behavioral Health Integration
In addition to the prescribing practices surrounding behavioral health, as primary care providers, we need to advocate for a greater integration of behavioral health and physical health. That may involve mechanisms such as behavioral health workers becoming part of our primary care practices, promoting the increased sharing of data between our practices and behavioral health practices, to taking over the care of stable behavioral health patients in those areas where psychiatrists are in short supply.

The Academy has consistently advocated for a greater integration of behavioral health with physical health and now is the time to see that this happens.

Personal Care Services and Durable Medical Equipment
Another area where we can impact Medicaid costs surrounds the
authorization for personal care services and durable medical equipment. While none of us wish to deny needed services, by using the authority we exercise as providers and denying unneeded services, we can produce additional savings for Medicaid.

Sharing of Imaging and Lab Data

Finally, help promote the sharing of radiologic and lab data between our offices and the specialists, hospitals, and ERs where our patients are receiving additional care. We all have examples where we perform a CT scan or other study to evaluate our patients one week only to have the scan repeated the following week if they are seen in the ER, and then repeated again the next week when seen by the specialist when there has been no change in the clinical status. Certainly, linkage of our offices with the various statewide HIE efforts will help to improve data sharing but we must speak up as patient advocates, question the performance of redundant/inappropriate diagnostic testing, and make sure that our offices are properly sharing data when needed for the extended care of our patients.

Your Academy asks you to consider these and other possible steps which can help promote Medicaid savings and demonstrate to our elected officials that family physicians are serious about our commitment to the program. If you have ever thought of possible ways to produce Medicaid savings, NOW is the time to share those ideas with this Academy and your local Community Care network.

More Than 25 Medical Students Participate in Summer Family Medicine Interest Programs

It’s been a busy summer for NCAFP student interest programs! One of these programs -- the Rural Health Experience -- provided in partnership with the MAHEC Hendersonville FM Residency Program, provided 10 students with an exciting opportunity filled with a combination of clinical time with a rural family physician and group didactics and activities. During Week 1, students engaged in a variety of activities ranging from visiting Blue Ridge Health Services (FQHC) and other rural clinics, to participating in patient house calls, engaging in physician and patient panels, and hearing about funding and assistance with job placement and loan payoff from the Office of Rural Health and Community Care. Other opportunities that took place were whitewater rafting on the Nantahala followed by white water rescue training and an afternoon at Camp Pinnacle to help train camp counselors in first aid. This proved to be educational for the younger counselors and a lot of fun for med students to play the role of victim. During their clinical experience some of the locations students were placed include Linville, Bat Cave, Cherokee, Bakersville and Hayesville; all of which provided great exposure to family medicine in rural areas.

Through the three programs offered by the NCAFP: Externship, Family Medicine Scholars and the Rural Health, 26 medical students participated in nearly 3500 hours of clinical experiences and learning opportunities in community-based practices.

Sparta Fifth-Grader Visits Washington, DC, as 2013 Tar Wars Poster Winner

Rylie LaRue, a fifth-grader from Sparta and North Carolina’s 2013 Tar Wars poster contest winner, traveled to Washington, D.C., in early July for the national poster contest and conference. This year’s Tar Wars awards ceremony took place at the Hyatt Regency Washington on Capitol Hill in Washington, D.C., where LaRue’s original poster design was among the 36 on display. LaRue’s poster message: Through Song, Rhythm and Harmony… We Can Spread the Word……Live Tobacco Free was created based on her interest in music and playing the fiddle. Rylie and her family also saw the sights in the Washington, D.C. area and had the opportunity to visit with their legislators. LaRue met with Senator Burr’s staff, receiving a personalized tour of the Capitol. She also spent time with Congresswoman Virginia Foxx where she visited the House Floor and other areas only accessible to Senate and House members.
Primary Care in Focus, continued from p. 9.

$80M dollars in creating the school. The NC AFP made a $25,000 contribution over five years to help fund establishment of activities designed to encourage students to enter Family Medicine, including their own Family Medicine Interest Group, much like the Academy already contributes to our four existing medical schools. The N.C. Medical Society also provided a $25,000 contribution to the new school.

For a medical teaching facility, the Levine Center offers all of the latest conveniences. Wired classrooms, high-tech patient simulation labs and modern clinical examination areas are just a few of its features. But its true strength may be its ability to bring students from different disciplines together. Campbell envisions Levine acting as the main interaction and learning hub for all of its health sciences programs. There’s been a conscious effort to create an environment where students can interact, learn, work as teams, and collaborate.

"Inter-professionalism is critical across all of the professions. You see that today in healthcare," commented Dr. Wallace. "Our goal is to foster collaboration within our health professions in every way possible." Dr. Wallace went on to explain that the university’s ultimate goal in to encourage students to learn together as a means for them to learn about the team-oriented nature of care delivery.

A big part of why starting a medical school is so daunting relates to what’s needed outside the confines of the sponsoring institution. Student clinical rotation sites are just as integral as teachers and classrooms. Creating the relationships to establish and deliver these takes a lot of effort. For Campbell and its large class size, clearing this hurdle continues to be a major effort.

From a high level, Campbell is pursuing a de-centralized approach designed to locate medical students into the types of communities they might eventually serve. The university is aggressively working to establish partnerships with hospitals and clinics in rural and underserved areas, as well as with some larger regional facilities. The goal is to create a network of rotation sites that mirror the characteristics of rural or underserved community practice, with regional tertiary care playing a role too. Dr. Kauffman envisions Campbell students living, learning and possibly even completing their residency experiences at these satellite locations.

"We believe that a student who moves to a community during their 3rd year of medical school, hopefully goes on to residency train there, will put down significant roots and be a permanent part of the community," he shared as he described the underlying strategy.

Campbell has already made solid progress in achieving this vision. Last February, it announced a new partnership with Lumberton-based Southeastern Health that represents exactly the type of approach the school wants to replicate. Southeastern will provide training capacity for approximately fifty third- and fourth-year medical students, with additional residency opportunities provided post-graduation. Campbell students (and residents) will train alongside primary care physicians at Southeastern Regional Medical Center and throughout the network’s of 40 clinics. Dr. Kauffman noted that the university is busy working to establish similar types of agreements with other major health care institutions in the region.

Beyond its clinical rotation network, building residency training capacity continues to be Campbell’s most significant challenge. At least some help, however, may be on the way. As the allopathic-osteopathic accreditation merger moves forward in 2015, osteopathic students will be given more flexibility in choosing their residency training. Right now, DO students who successfully match with an AOA-accredited program cannot participate in the ACGME allopathic MATCH. This forces many DO students to select one avenue or the other. This merger is expected to help alleviate at least some of this pressure, but much more development is needed.

But Dr. Kauffman and the entire university remain confident. They’ve come very far already and more progress is certainly ahead. With a clear mission, a growing need, and a committed team, it’s only a matter of time.

Congressional Conference, from p. 7.

my group addressed this question. It turns out that he was asking about the alleged abuse by 2 NC hospital systems of a piece of legislation designed to provide affordable medications to the poor. He wanted to know why we couldn’t use that money instead of asking for more government funds. It was then that I learned about distracters. The 340b did not have anything to do with our conversation but it was something he knew a lot about. He knew very little about the purpose of THC’s or GME funding, and did not understand that I was not asking for any additional money. I was able to politely tell him that this was not relevant and to redirect him to the issues at hand. That was a very satisfying experience for me.

In short, I left Washington D.C. a different person. Firstly, I gained a tremendous amount of confidence in myself and my ability to communicate complex issues effectively within a very short amount of time. Our meetings were, for the most part, brief, and we had several issues we needed to discuss. We also had to have enough knowledge to field follow-up questions. Secondly, I learned that there was an entire world about which I knew very little, but was eager to learn more. I am now committed to delving deeper into the world of policy and how pieces of legislation are written, defended, and adopted on Capitol Hill. Finally, I was grateful for the opportunity to be given this experience, and hope that it will be as exhilarating for other residents as it was for me.

1) http://www.graham-center.org/online/graham/home/tools-resources/npi.html
3) Our Purpose/Mission, School of Osteopathic Medicine, Campbell University, http://www.campbell.edu/cusom/about-us/our-purposemission/
5) What is Osteopathic Medicine, www.campbell.edu/cusom/osteopathic-medicine/what-is-osteopathic-medicine/
6) The Transformation of Osteopathic Medical Education, N. Gevitz, PhD., Academic Medicine, V.84, N06, ; June , 2009, p. 705.
7) The Transformation of Osteopathic Medical Education, N. Gevitz, PhD., Academic Medicine, V.84, N06, ; June , 2009, p. 701.