TENNESSEE FALL 2004

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An Official Publication of the Tennessee Academy of Family Physicians

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New Developments From the ABFP - *see page 6*

Everyone knows that professional football is a dangerous sport. Especially the people who are closest to it: the players and the league. That's why, in its constant search for ways to keep the athletes safe, the NFL decided to

ask

Vanderbilt's Dr. Kurt Spindler and the NFL Safety Council how players could be better protected from head injuries. They discovered that most injuries were occurring to the side of the head, where the helmet provided the least amount of protection. As a result, helmets were redesigned and the benefits are now being reaped by players of all ages—allowing them to keep their heads in the game.

Vanderbilt Sports Medicine

Hearts and Minds

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President's Corner

As I write this, my last, President's Corner, we are smack dab in the middle of summer with warm nights, the occasional thunderstorm, and the pervasive sounds of tree frogs. Last week the mid-state had a strange storm where the high winds arrived about thirty minutes before the rain, taking out a lot of trees which caused power outages that lasted for hours.

Power outages are common in our area: in the winter from ice and snow, in the spring from tornadoes and high wind, and in the summer from thunderstorms and lightning strikes. We were lucky here and avoided the electric power grid problems that affected the northeast last August, but without some quick reactions from TVA, it would have happened here as well. Think of the problems that California had a couple of years ago with power. Remember Hurricane Andrew that struck southern Florida in the early 1990's? Our power shouldn't be taken for granted.

I spent two and a half years in the West Indies with plenty of experience with no power. Sometimes our power problems were related to hurricanes. Sometimes they were secondary to generator failures or sometimes to "time-sharing" as I like to call the roving power outages to allow different parts of the island to have a few hours of electricity. It was not unusual to lose power at any time and I guess we adjusted to it.

When my office lost power for about an hour one afternoon last week, we had no phones, no computers, and no lights except the pen light that I used to write in my charts. It was so dark that we could barely see what we were doing. The power loss put us at a standstill.

My local hospital has made efforts to jump into the twenty first century and has a computer system to order tests and medication. We have learned to retrieve data from previous admissions to help us care for patients. The hospital has a generator for use if there is a power failure, but I'm sure it has its limits if the power is off for very long.

Power is needed for electronic medical records. Batteries and generators can help for short periods, but if a power outage lasts for any length of time, the back-up power is depleted and that EHR is worthless.

The Future of Family Medicine project recommendation: "Electronic health records that meet standards which support the New Model of Family Medicine will be implemented. The electronic health record will enhance and integrate communication, diagnosis and treatment, measurement

– continued on page 2

of processes and results, analysis of the effects of comorbidity, recording and coding elements of whole-person care, and promoting ongoing healing relationships between family physicians and their patients."

I embrace the changes suggested by The Future of Family Medicine Project. Even though I have worries about consistent power, I plan to invest in a system for electronic medical records in the near future. I feel that these concerns about power outages are something to be taken seriously and that should be addressed before EMR is used widely by Family Physicians.

I do have other concerns about EHR. Some of our members will be hard-pressed to find the funds to invest in a good system. Some, who haven't quite mastered email, may not want to jump into computers at all. Our leadership has recommended that electronic health records be in every family physician's office by 2006. Our Governor supports EHR to improve our current TennCare system.

Such radical change is always tough, but I hope to move my practice into the future with EMR and the other recommendations from The Future of Family Medicine Project. Just be patient with those of us that move a little slower into the future or those of us who decide to remain with the status quo. We can still be effective Family Physicians.

I'll still worry about the power.

Thank you for allowing me to serve as your President this year. It has been a rewarding experience.

J. Lynn Williams, M.D., Decherd
President

Slate of Nominees for 2005 Officers & Board of Directors

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TAFP Tuesday Doctor of the Day at Tennessee Legislature

A very big 'thank you' to the following TAFP members who took the time out of their practice to serve as the TAFP 'Tuesday Doctor of the Day' at the Tennessee Legislature during the 2003 legislative session. If you are interested in participating as a TAFP Doctor of the Day on a Tuesday in 2005, please contact Cathy Dyer at the TAFP office.

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LEE CARTER, M.D., Huntingdon

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DONALD ZEIGLER, M.D., Hixson

Proposed Amendment to the TAFP Constitution & Bylaws for Consideration by the 2004 TAFP Congress of Delegates

BYLAWS, CHAPTER VI, SECTION 3

TO AMEND THE BYLAWS of the Tennessee Academy of Family Physicians in Chapter VI, Section 3 by deleting the current wording entirely and replacing it with new wording.

Reads At Present

Section 3. The Board of Directors shall meet at least four (4) times each year, the dates being set by the existing Board of Directors. Additional meetings may be called by the President at his discretion.

As Proposed

Section 3. The Board of Directors shall meet at least three (3) times each year in the fall, winter and summer with all meeting dates and locations being set by the President for that year working in conjunction with the Executive Director. At the discretion of the President, a fourth meeting may be called in the spring.

As stated in Article VII, Section 5 of the Constitution, "The Executive Committee by majority vote of its members, shall have full authority to act for and in behalf of the Board of Directors, or when it is impractical or impossible to convene the Board. Meetings of the Executive Committee shall be held at the call of the Chairman. A report of its actions shall be given by the Executive Committee to the Board of Directors at the first meeting of the Board following the meeting of the Committee."

2004 Tennessee AFP Outstanding Student in Family Practice Awards

The Tennessee Academy each year presents an 'Outstanding Student in Family Practice' award to one recipient at each of the four medical schools in Tennessee. These medical students are nominated by their respective schools based on criteria developed by the TAFP Awards Committee. Students are evaluated on their demonstrated abilities and leadership, participation in school and community activities, academic standing, participation in TAFP and family practice activities. Each recipient must be a TAFP member in good standing and must be enrolled in a Family Practice Residency upon completion of medical school.

The 2004 recipients were:

DANNY LEWIS - Graduate of East Tennessee State University James H. Quillen College of Medicine, Johnson City (Self Regional Healthcare Family Practice Residency, Greenwood, South Carolina)

PAM HARRIS - Graduate of Meharry Medical College, Nashville (Shady Side Hospital Family Practice Residency, Pittsburgh, Pennsylvania)

BENJAMIN HARDY CRENSHAW - Graduate of University of Tennessee College of Medicine, Memphis (Good Samaritan Regional Medical Center Family Practice Residency, Arizona)

(There were no eligible graduating students at Vanderbilt, so no award was presented in 2004.)

The TAFP extends since congratulations and best wishes to each of the following 2004 recipients!

Practice Opportunities

If you are looking for a partner or a practice location, send information by mail to: TAFP, 4721 Trousdale Drive, Suite 202, Nashville, TN 37220; or by fax to: (615) 833-2677; or by email: tnafp@bellsouth.net. Information for practice opportunities will be accepted only from TAFP members and will be placed in the Tennessee Family Physician at no charge. Please include your name, address and/or telephone number and/or fax number since contact concerning opportunities will be made directly between interested parties and not through the TAFP. Information will be placed in four (4) editions unless the TAFP is notified otherwise. Deadline for the next issue (Winter 2004) is October 20, 2004.

• **Board-Certified Family Physician.** Available for office practice coverage during vacations, illness or leaves of absence. No OB. Willing to do hospital rounds if necessary. Respond to (615) 831-1810; or, cell phone (615) 972-7601. References available upon request.

• **Seymour –** Moving back to Louisiana and am looking for someone to take over my very busy solo practice. Less than 10% TennCare. X-ray on premises (whoever takes the practice gets ownership). Exam room equipment available. Staff willing to stay as well. Computer network and billing software available. No problems with the practice. I just have an excellent opportunity to move back to the small town where I grew up and my father was one of four physicians and practiced for 50 years. Opportunity for someone to step into a busy, profitable, established practice for a fraction of what it's worth. Contact: (877) 522-5557; email: jamesbellmd@earthlink.net

• **Knoxville –** Well established outpatient occupational and primary care practice is seeking BC/BE FP or IM associate physician. Desirable call schedule with no weekend or extended office hours. Well-organized office with productive staff, accepting selective insurance. Excellent benefit package. Please respond by fax to (865) 673-4971 Attn: Recruitment; or by e-mail to blsharp@knoxvillemedicalcenter.com.

• **Winchester –** Well-established call group of four have full practices in growing area and are looking for another physician to join their call group. The applicant must be willing to have a solo practice including inpatient coverage, weekend and ICU call. Perfer an AAFP/TAFP member with ABFP certification. No OB. Beautiful vacation and retirement area with excellent payer mix. Please contact: tsmithmd@bellsouth.net or (931) 967-9680.

Letter Received

Dear Ms. Dyer:

Sorry that it has taken me a while to write. We've been very busy with the move to Arizona and starting residency out here. But I want you to know how extremely grateful and honored I am to have been selected as the 2004 Outstanding Student in Family Practice Award at UT Memphis. Though I've chosen to move away for this phase of my career, I am confident that you and the rest of the TN AFP will continue to represent Family Medicine well, at all levels. I look forward to following events back in Tennessee.

All the best,

Benjamin Crenshaw

New Developments from the American Board of Family Practice

The American Board of Family Practice (ABFP) is the organization that is responsible for the certification of newly trained family physicians and the periodic re-certification of those who have previously been certified as Diplomates. The ABFP is one of the twenty-four specialty boards comprising the American Board of Medical Specialties (ABMS). Over the past few years the ABFP has undergone a number of changes that are beneficial to all family physicians–with additional changes planned in the near future. This article will outline a few of the significant changes.

Computerized Testing

The ABFP is engaged in the gradual conversion of our certification and re-certification testing programs from paper tests to computerized tests. By the year 2005, all of our tests will be computerized. This will mean that we will be able to offer the tests at many more sites than in the past, increasing the likelihood of getting a test site close to home, and making it much more convenient (as well as cheaper) for family physicians to take these examinations. Unfortunately, due to the need to verify the identity of those participating in the tests, we will not be able to offer home testing for the certification and re-certification tests.

Multiple Testing Opportunities Each Year

For the first time ever, in 2003 the ABFP certification and re-certification exams were offered on more than just one date in July. In addition to the July date, those who did not pass in July, or who were "off cycle" and unable to take the exams in July, were able to take the examinations in December 2003. Over 1700 candidates took advantage of this opportunity. In 2004, the exams will be offered on 4 dates in July, including 2 Saturdays, and also on one date in December. In 2005, the exams will be offered on 3 consecutive Fridays and Saturdays in July/August, and also in December. Just as an increase in the options for test sites has improved convenience for family physicians, an increased choice of dates will have the same effect. If a physician is able to take the test on a Saturday, it may decrease the need to be away from practice on a busy weekday.

Maintenance of Certification (MOC)

Over the next seven years, the traditional pattern of certification and re-certification examinations will be replaced by the new Maintenance of Certification for Family Physicians (MC-FP) program. This new process will provide a mechanism for continuous assessment of practicing family physicians. Until now, re-certification of family physicians has required completing 300 hours of continuing medical education, an office record review (in most cases), and a cognitive examination every seven years. The ABMS has been working with the ABFP and other specialty boards to develop the new process. For family doctors, the new approach will retain all of the current components, but will also require ongoing participation in some new activities

Tom E. Norris, M.D.

in the intervals between cognitive examinations. The goal of MC-FP is to allow continuing professional development through its four parts:

1. Evidence of Professional Standing–Until now, diplomates of the ABFP have had to possess a full and unrestricted medical license. In this new component, we anticipate that the licensure requirement will be retained, and a new process of peer review and/or patient review will be added. This component is currently being piloted by the ABFP in partnership with the ABMS. The mechanisms will probably be phone or web based, and it is anticipated that this component will need to be completed only once during each seven year cycle.

2. Lifelong Learning and Self-Assessment–This area has three parts. The first part will involve an opportunity for the physician to assess his knowledge of specific common medical problems (the first two problems will be diabetes and hypertension), through the completion of six web-based Self-Assessment Modules (SAM's). The second part will consist of patient simulations using the new Computer-Based Assessment System (CBAS) to demonstrate the physician's ability to manage a medical problem prospectively over a period of time. The third part will be to maintain the previous requirement of 300 hours of continuing medical education per certification cycle. It is important to note that the time spent participating in parts II and IV can be counted as part of the 300 hours or required CME.

3. Cognitive Expertise–The requirements of this component will be met by passing the re-certification examination.

4. Evaluation and Enhancement of Practice Performance–This new component will be introduced in 2005. It is anticipated that it will initially be a modified version of the traditional ABFP Computerized Office Record Review. Recognizing the importance of both patient safety and quality improvement, the record review will be transformed into a continuous quality improvement process designed to improve patient care. For those FP's who do not have a continuity practice, an alternative approach will be developed.

Many have asked why MC-FP is being implemented at this time. All of the Boards in ABMS have a responsibility to the public to improve their medical care by certifying physicians. ABMS has determined that a model of continuous learning and evaluation will accomplish this goal more effectively than a process based simply on periodic assessment. All of the specialty boards in ABMS will be gradually changing to this new model. It is anticipated that the continuous learning and self-assessment in MC-FP will benefit family physicians by enhancing their clinical knowledge, expertise, and skill. If this is accomplished, the care of our patients should be improved.

Each individual family physician will begin participating in MC-FP after their next re-certification exam. The process began in January of 2004 for those who took their certification and re-certification examinations in 2003. Over the next seven years all diplomates of ABFP will "roll into" the process. Much of the work will be accomplished on the web, and each participating physician will be able to track his progress using an "online portfolio".

Many family physicians have expressed concern that this new process will be more costly than the traditional system. In reality, the ABFP anticipates that total costs will be about the same. Part of this is made possible by the savings in travel costs and lost practice expenses that will be realized by offering the exam in far more locations on many more dates. Because the MC-FP process is continuous in nature, and not linked to a single "exam event", the ABFP

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has developed three alternative methods of paying for the process. For those entering MC-FP in 2004 these options are as follows:

- Single one-time payment–The entire cost of the seven-year process, including the re-certification exam at the end, can be paid a lump sum of $1150 prior to June 30, 2004.
- Annual payments for seven years–Physicians can choose to pay $200 per year for each year in the seven-year cycle, for a total of $1400. The first payment would be due by December 31,2004.
- Pay as you go–Physicians can also choose to pay $50 per year to cover the cost of their participation in MC-FP, with a larger payment in year seven to cover the exam costs. At this time we anticipate that the exam cost would be $1150, making the total $1500.

Since most family physicians who are ABFP Diplomates are also members of the American Academy of Family Physicians (AAFP), the AAFP and the ABFP have been working together to inform family doctors about this new program. It is anticipated that the AAFP will be developing CME programs to assist family physicians with parts I and II and possibly part IV of the MOC process.

The ABFP has developed a set of "Frequently Asked Questions", and these are available on their website at https://www.abfp.org/MOC/faq.aspx. One can also obtain a complete copy of the Maintenance of Certification Handbook through the website.

A New Blueprint for the ABFP Examinations

The ABFP has, for over 20 years, used a "content blueprint" that describes the substance of the discipline of Family Practice and that has been used to define both the subject areas and the proportions of questions in the ABFP certification and re-certification examinations. The current basic content blueprint includes Internal Medicine 36%, Surgery 6%, Obstetrics 7%, Community Medicine 9%, Pediatrics 13%, Psychiatry 7%, Geriatrics 12%, and Gynecology 10%.

In 2003, the ABFP decided to update the content blueprint. This decision was based on the changing landscape of family practice and was driven by the needs generated by upcoming changes in the examinations. No longer does it seem appropriate to describe family medicine in terms of derivatives of other specialties.

Based on this decision, the ABFP Examination Committee was asked to lead a taskforce to create a new blueprint. A group was assembled, including representatives of all of the organizations in the family of family medicine (AAFP, STFM, AFPRD, ADFM, etc.) and several working meetings were held to accomplish this job.

The outcome of the project has been the development of a new design for a content blueprint. This design will result in a test that is based on the actual content of family practice. It will be updated continuously as the content evolves. It will utilize the tools of the most advanced databases to allow the ABFP to create multiple examinations each year, while retaining excellent psychometric validity and reliability. Over time, this new system will allow our patients and their healthcare needs to define our discipline, rather than simply using derivations from other specialty areas.

Summary

As you can tell, the ABFP is changing in many ways–all aimed at helping family physicians improve their care of their patients. If you have specific questions about the ABFP, you can e-mail me at tnorris@u.washington.edu.

Tom E. Norris, M.D., Seattle, Washington
Member Board of Directors & Treasurer, ABFP

This article was written in mid-March and published in the April 2004 edition of the Washington Family Physician Journal. Dr. Tom Norris is the incoming President of the American Board of Family Practice Board of Directors.

Leaders on the Move & Information For Members

• ***Congratulations to the Family Medicine Interest Group (FMIG)*** at ETSU James H. Quillen College of Medicine for earning a 2004 Program of Excellence Award from the AAFP.

• ***Current Immunization Schedules are available*** on the AAFP website at: www.aafp.org/x10631.xml; or through the AAFP Order Department at (800) 944-0000. Additionally, there is a link on the TAFP website – www.tnafp.org.

• ***Tim Linder, M.D., Selmer, TAFP Legislative Chair,*** attended the AAFP's Spring Legislative Visit in Washington D.C. in May as your representative. The ultimate goal is for the Academy to remain a player in the national healthcare debates, with hopes for the Academy to reach a point where no health care decision is made without consulting family physicians.

• ***The Tennessee Healthy Weight Network*** recently released a state plan to promote healthy weight for Tennessee's children and youth. The TAFP is a member of the Network and was recognized in press releases.

• ***Charles Ball, M.D., Columbia, TAFP Speaker,*** has been appointed as the TAFP representation to the Task Force on School Vending Regulations formed from Tennessee legislation passed during the 2004 legislative session.

• ***Lynn Williams, M.D., President, and Cathy Dyer, Executive Director,*** represented the TAFP at a Practice Management Workshop for Saint Francis Family Practice Residents in Memphis in May, and at the July Meharry Family Medicine Interest Group Meeting for incoming freshmen medical students. Additionally, Doctor Williams and Cathy represented the TAFP at the AAFP's National Conference of Family Medicine Residents and Medical Students the end of July at a TAFP exhibit booth and hosted a Reception for all residents, students, faculty and staff from Tennessee.

• ***Cathy attended the National Tar Wars Poster Contest and State Coordinators' Workshop*** in Washington D.C. in July. The TAFP sponsored the attendance of the first place winning student in the Tennessee Tar Wars Poster Contest, Meagan Mickiewicz of Enville.

• ***Lynn Williams, M.D., President, Reid Blackwelder, M.D., President-elect, Don Polk, D.O., AAFP Delegate, Tim Linder, M.D., Legislative Chair and Cathy*** represented the TAFP at the 2004 Southeast Family Practice Forum in New Orleans in August. The Forum is composed of eleven AAFP southeast state chapters and meets yearly as a forum for information exchange between the state chapters.

• ***Cathy represented the TAFP*** at the State of Tennessee's Tobacco Use Strategic Planning Session in June. The purpose of the session was to develop a new comprehensive tobacco prevention, control and treatment strategic plan for all private and public stakeholders to adopt and implement.

• ***You can access your Academy CME records*** by going to www.aafp.org/myacademy, log in and go to 'My CME Record'.

• ***Reminders:*** The TAFP website is located at: www.tnafp.org. The TAFP email address is: tnafp@bellsouth.net.

Tennessee Academy of Family Physicians 56th Annual Scientific Assembly

OCTOBER 26-29, 2004;
Convention Center,
Gatlinburg, Tennessee

We hope to see you in Gatlinburg the end of October! If you have not received your assembly registration/program brochure, please contact the TAFP office or you can access the brochure at the TAFP website at: www.tnafp.org.

Rural Health Association of Tennessee (RHAT) Tenth Annual Conference

RHAT is offering a medical pre-conference for any interested person - professional or layperson. The conference will apply for CME and Nursing Credit for this cluster. For more information on this cluster or the remainder of the conference, please contact (615) 907-9707 or email rhatmail@bellsouth.net.

Wednesday, December 1, 2004

Location: Chattanooga Marriott Hotel
Cost: $75.00

"The Back Bone's Connected to the Hip Bone: Osteoporosis Prevention, Diagnosis and Treatment- Strategies for Success in Rural Areas" – Amy J. Keenum, D.O., Pharm.D.

"Pain Management in a Rural Setting – Strategies to Improve Patient Care" – Nancy M. Rockstroh, MD

"Depression" – Clay Jackson, MD

"Cholesterol" – Frank McGrew, MD

"Diabetes: National Guidelines and More" – Chris Graves, MD

"JNC 7 Guidelines and Therapy for Primary Care Providers" – Gregg Mitchell, MD

Recap of May 15, 2004 TAFP Board of Directors' Meeting

❖ Received report from the Executive Director on a meeting with the Meharry Family Medicine Interest Group student officers along with Doctor Roger Zoorob, new Meharry Department of Family Medicine Chair, and Diane McDermott, M.D., Meharry Family Practice Residency Director.

❖ Approved no change in 2004-2005 Tennessee AFP Resident dues ($12.50) and Student dues (-0-).

❖ Discussed at length Tennessee's 2004 'Match Rate' in family medicine, and the extremely low match of UT Memphis students in family medicine residencies. Referred to the TAFP Education Committee to present a plan to the Board for improving family medicine recruitment in Tennessee.

❖ Reviewed request from staff with UT Memphis Department of Family Medicine for TAFP support of a social event and residency fair in the fall, with the request being referred to the TAFP Executive/ Finance Committee.

❖ Received letter from Leon Harris, former TAFP Student Board Member from Meharry, thanking the TAFP for their support and allowing his participation in the TAFP as he and his wife, Pam, enter their family medicine residencies in Pennsylvania, with plans to return to Tennessee upon completion of their residencies.

❖ Received and reviewed draft of 2004 TAFP Annual Assembly program.

If you would like additional information on any of the above items, please contact the TAFP office in Nashville.

Are your patients watching their weight? Share the good news about dairy.

Milk, cheese and yogurt are not the first foods that come to mind when thinking of what to eat when dieting. But that's all about to change. Recent publications in leading journals suggest a link between dairy consumption and reduced body weight. In another study, overweight adults on a reduced-calorie diet that included at least 3 servings a day of dairy products like milk, cheese and yogurt lost more weight than those on similar reduced-calorie diets with minimal dairy.

Dairy naturally provides calcium as well as protein and other essential nutrients that dieters need and might miss when cutting out certain foods in their diet. Plus dairy is also an easy natural way to get calcium. Preliminary data indicates that calcium may play a role in the body's natural system for burning fat. More research is needed to better understand the link between weight loss and dairy.

So losing weight is really about 3 things: limiting the amount of calories and fat in the diet, getting exercise and eating the right things. One approach is to encourage your patients to include at least 3 servings of milk, cheese or yogurt as a part of a reduced-calorie diet. Simply put, if they change how they look at dairy, they may change how their bodies look. For more information on these and other studies, and to download a free Healthy Weight Education kit, visit www.nationaldairycouncil.org.

NATIONAL DAIRY COUNCIL

©2003 American Journal of Clinical Nutrition; Zemel MB et al., AJCN 75 (2): 342S, 2002, "Dietary Calcium and Dairy Products Accelerate Weight and Fat Loss During Energy Restriction in Obese Adults"; Lacroix, Zemel MB, Vol. 38 no. 2, 159–66, 1997, "Role of Dietary Calcium and Dairy Products in Modulating Adiposity" (review article); Journal of the American Medical Association, Pereira MA, Jacobs DR, Van Horn L et al., JAMA 287 (16):2081-89, 2002, "Dairy Consumption, Obesity and the Insulin Resistance Syndrome in Young Adults" The CARDIA Study.

Letter Received

TWIS

Tennessee Web based Immunization System

July 2004

Dear Doctor:

The Immunization Program is pleased to announce that access to the Department's Immunization registry is now available through the Internet to any practice, clinic or hospital that routinely gives childhood vaccines. The Tennessee Web Immunization System, TWIS, links to the state's immunization registry which contains immunization information on most of the young children in the state since January 1, 1994. TWIS has been vigorously tested over the last year and has proven to be a great benefit to the practices that enrolled in the test phase and has been universally praised by users.

TWIS will do the following:

- Eliminate the need to call health departments and other physicians to obtain immunization data;
- Print completed School and Pre-school Immunization Certificates, which need only a provider's signature or office stamp;
- Maintain patient immunization records from a variety of providers at one easily to use site;
- Allow better tracking and recall of patients in need of immunizations.

TWIS is a secured web site that is FREE, easy to use, and offers additional features such as links to other web-sites, Vaccine Information Statements in over 20 different languages, and updates on items of interest to you and your staff.

If your practice doesn't yet have access to TWIS and you would like this valuable tool there is a fast and simple registration process. Just send an e-mail to Health.IMM@state.tn.us expressing your interest in gaining access to TWIS. You will be sent two forms to complete and return to the Immunization Program. Complete instructions will be provided to you. After completing the forms, fax them to Joe Beaver at (615) 253-3279. The authorization process will take a few days. After it is completed, each of the employees in your practice deemed in need of access will receive individual user ID's and passwords and instructions on how to get to the web site. If you have questions about TWIS, please contact Joe Beaver at: Joe.Beaver@state.tn.us or (615) 532-8509.

Join in and be a Tennessee Tar Wars Volunteer

It only takes one hour of your time to teach one Tar Wars class in your local classrooms. Tar Wars is the AAFP's National pro-health tobacco-free education program and poster contest for 4th and 5th graders to discourage tobacco use among youth. The program uses a community-based approach and provides an opportunity for health care professionals, school personnel and community members to work toward a common goal of discouraging youth tobacco usage.

Your help in teaching Tar Wars in your local classrooms would be appreciated! If you are interested in being a Tennessee Tar Wars Volunteer, please contact Cathy Dyer, Tennessee Tar Wars Coordinator, at the TAFP office: Toll Free at (800) 897-5949; Nashville calling area at (615) 833-5522; Email at tnafp@bellsouth.net. Or, you can access information on Tar Wars via the Tennessee AFP website at: www.tnafp.org.

Lessons from Afar ...

As we continue to struggle with state budget issues and increasing expenditures for TennCare, perhaps we should look to the south for ideas. While Cuba is a communist country, there may still be lessons to be learned. The Gross Domestic Product (GDP) of the United States of America is $10.4 trillion compared to Cuba's GDP of $25.9 billion, and per capita GDP is $37,600 and $2,300 respectively in 2002 figures. Despite a much smaller economy, Cuba's infant mortality and life expectancy approach that of the United States of America.

Cuba is the largest of the Greater Antilles Islands. It is approximately 42,867 square miles with a population of roughly 11,263,429. This is slightly smaller than the state of Pennsylvania.

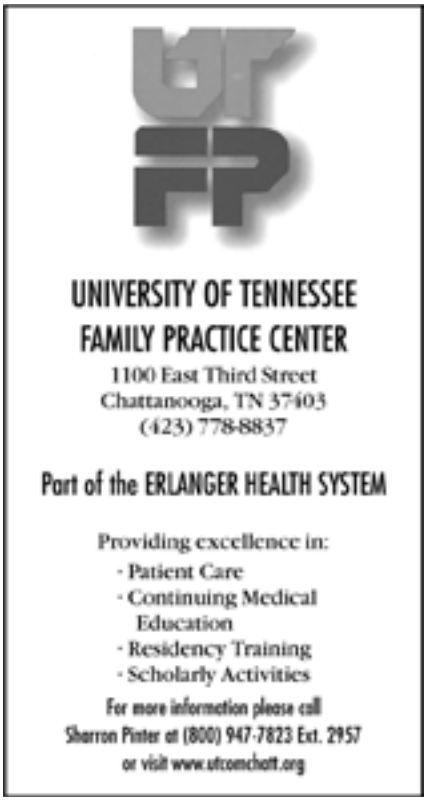
After the revolution in 1959 Cuba was largely aided and supported by the Soviet Union. Following the collapse of the Soviet Union in the late 1980's conditions in Cuba changed very much for the worse. Foods, medicines, and oil products became ever more scarce or non-existent for the average Cuban. This had a significant impact on the health care system.

In 1984 the Cuban government recognized they had a severe health care problem and implemented a pilot program. Before this date there was not an adequate medical system in Cuba. This pilot program trained Family Doctors to work along with nurses in the local community. What they created was a complete bio-psycho-social approach to health care with the Family Doctor and a nurse a part of and intimately connected to the people they serve. The Cuban system involves a very large bureaucracy with carefully defined chain of care guidelines and strict allocation of resources. This system has resulted in amazing results.

In 1959 Cuba had 6,000 doctors, mostly private doctors working in urban areas. Many left the country following the revolution. Infant mortality was 60/1000, and life expectancy was <60 years of age. Communicable diseases were not being addressed. Vaccines and immunization were uncommon. This remained relatively unchanged until 1984.

By 2002 66,325 doctors had been trained; 30,726 of these were Family Doctors providing

Classifieds



100% coverage to both rural and urban areas. Infant mortality had dropped to 6.5/1000, and life expectancy had risen to 76 years of age. These numbers are much closer to those of the United States of America.

There is now a comprehensive immunization program covering more than 13 diseases with 100% of children immunized. The most prevalent diseases are no longer communicable diseases. These now include hypertension, asthma, and diabetes. The leading cause of death overall is cardiovascular disease. Lung cancer is the most common cancer in men. Breast cancer is the most common cancer in women.

While multiple factors, including the United States' embargo, have led to major shortages and a lack of advanced care and high tech equipment, the basic primary care of the general population appears to rival or perhaps even exceed that of the United States. They have been forced to import technology from Europe or develop it on their own. They have a large program for development and manufacturing of vaccines as well as a strong public health system.

Each Family Doctor has a defined neighborhood of practice consisting of approximately 750 patients. The Family Doctor lives and practices in the same community. The Family Doctor is mandated by the state to see each healthy patient in his assigned practice at least twice per year. Those with health risks are seen more frequently based on their conditions. Mandatory home visits are made to fully understand the home and family environment and functionality. Genograms are created and kept on all families.

In 1984 the Cuban government recognized they had a severe health care problem and implemented a pilot program.

While the end results are amazing considering the available resources, there are serious trade-offs. Those who attend medical school are chosen by the state. Those deemed to have the skills necessary are taken back to train in sub-specialties as needed. These decisions are made by the state. The Family Doctor has no choice or voice in possible advanced studies or when to move up.

Patients also have no choices. The Family Doctor in their assigned area is the one they must use. The polyclinic and hospital assigned to their area are where they must go for treatment. More advanced care may require a trip to Havana. There are no exceptions to immunization requirements. Immunization rates of children reach 100% due to government pressures and sanctions imposed upon the citizenry.

Hospitalization is greatly frowned upon. Care and recovery are designed to be provided in the home. The family is responsible for providing this home care after discharge.

Low infant mortality partly goes with maternity homes - places for women who are not properly caring for themselves or not following the doctor's instructions can be sent. These allow for closer monitoring of the pregnancy to insure they follow the prescribed prenatal instructions and protocols. However, these homes also house high-risk (i.e. twins or gestational diabetic) pregnancies to insure better outcomes.

While not ignoring the many minuses of the system, the Cuban economy compared with the United States economy raises many questions regarding the efficiency and cost/value of service between the two systems. It appears the Cuban system is able to provide care at a lower cost compared to the United States of America.

Ray Walker, M.D., &
Mary Ellen Walker, Memphis

Editorial

My thoughts are divided between my experiences in starting a new practice and with excitement with the Future of Family Medicine project. This is an incredible time as an individual Family physician and as an Academy. Both experiences have provided a significant education.

Family physicians have the expertise and motivation to shape the future of American healthcare. As strong patient advocates, we are determined to improve patient safety and quality of care. This need for change was glaringly evident during a recent insurance company site visit. The company wanted to know how I evaluate my employees but not how I educate my newly diagnosed diabetics. They wanted to know if I regularly checked my fire extinguishers, but not if I performed routine well child exams for my younger patients. As individual physicians and as an Academy, we recognize that the focus needs to be redirected.

The insurance companies are collecting astronomical premiums but are not paying for an equally high level of care.

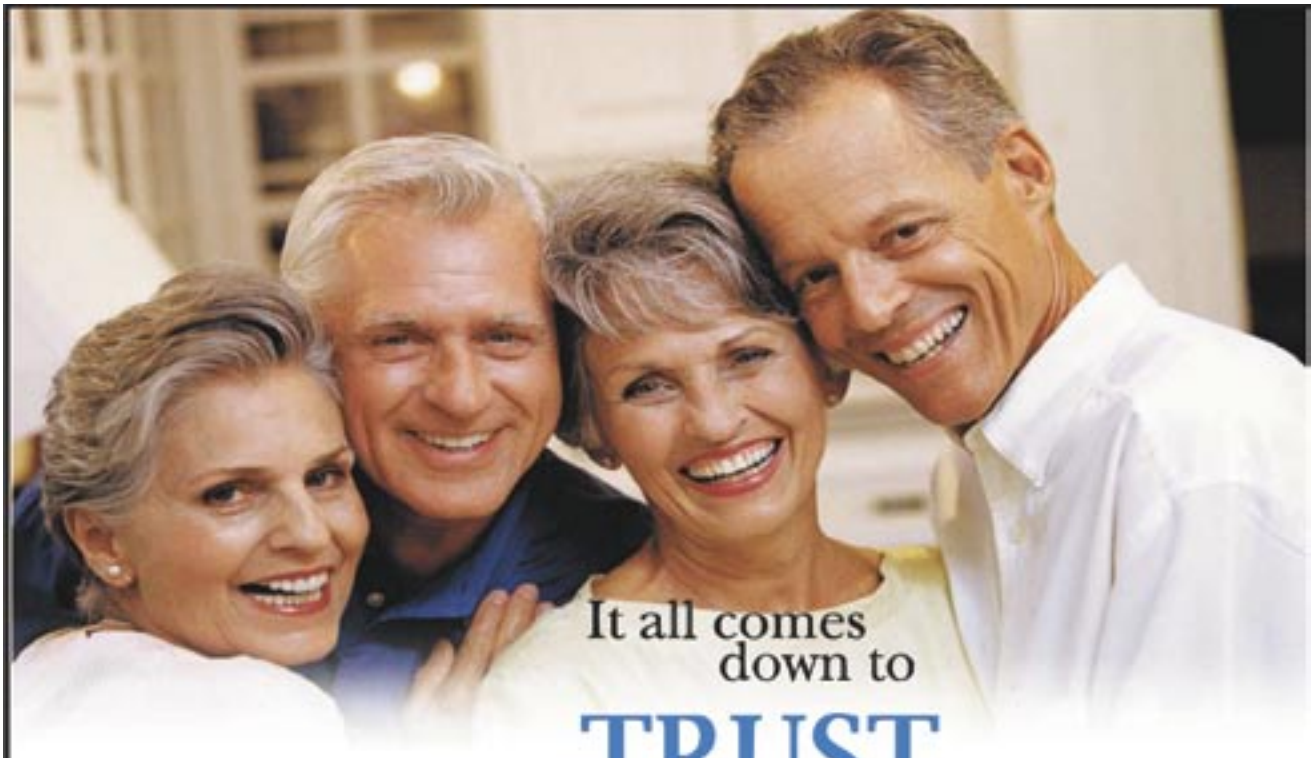
We also understand that patients frequently are unable to afford or access health insurance. Cost was a major concern for my employees when we chose our coverage. Because one nurse's children had been hospitalized two years ago for bronchiolitis, our premiums for family coverage jumped from $760 to $1100 per month. This is insane! Only perfectly healthy people can obtain affordable health insurance. All of us are healthcare consumers and we need to demand more reasonable premiums and more for our money.

The Future of Family Medicine project also acknowledged that we need reimbursement reform. Quality care involves more that 10 minutes in an exam room. It involves convenient access to the physician, education, and many other things for which physicians are not reimbursed. The insurance companies are collecting astronomical premiums but are not paying for an equally high level of care.

The AAFP has demonstrated great insight and leadership with this project. As a specialty, we needed to refocus and to become energized. As a physician starting a new practice, I needed the hope for something "new and improved." Also during this endeavor, I discovered that the AAFP offers an incredible number of resources and guidance. During every step of the process my partner and I relied on publications and advise from the Academy. We started with *Starting Your Practice from the Ground Up* and continue to use information from *Family Practice Management* on a daily basis.

This is an exciting time for us as an Academy and for me as an owner of a new practice. We have always been strong patient advocates. Now we have the wonderful opportunity to shape American healthcare. Let's share this excitement with our patients, colleagues, and medical students!

Kim Howerton, M.D., Savannah
Co-Editor



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