Highlights of Tennessee AFP at the 2013 AAFP National Conference of Family Medicine Residents & Medical Students, held the first of August in Kansas City. See page #16.

Mary Massey places Honorable Mention #9 in the National Tar Wars Poster Contest – See page #8.

Join us in Gatlinburg on October 29-November 1 for the Tennessee Academy of Family Physicians’ 65th Annual Scientific Assembly!
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President’s Corner

Editorial: Lessons from a Patient

National TAR WARS Poster Contest

Patient-Centered Medical Home: To Be or Not To Be?

Slate of Nominees for 2014 TNAFP Officers and Board of Directors

Members of the 2013 TNAFP Congress of Delegates

TNAFP at the 2013 AAFP National Conference of Family Medicine Residents and Medical Students

Leaders on The Move

2013 Outstanding Student in Family Medicine Award Winners

Practice Opportunities
This is my final Presidents Corner. I want to say I have truly enjoyed serving the Tennessee Academy of Family Physicians and all of my colleagues across the state in such an honorable and noble specialty. I want to encourage you all to be the beacons of light and shining stars that illuminate our unequaled contribution to the rest of society.

Our strategic planning committee has set forth a vision that emphasizes our need for better communication and utilization of current technology. We also see the need for a public relations strategy. The government, business, and the American people are recognizing that effective primary care is the cornerstone of a successful healthcare system. There is a clear recognition that PCMH is a valuable concept that should be properly rewarded. We contend that it functions best when it is physician led. At the same time, our skill sets continue to be underappreciated at the academic and political levels. As we quietly and righteously care for our patients, we are being misrepresented and demeaned. A recent article by “The Daily News Service of the PEW Charitable Trusts” on July 19, 2013, titled “Nurse Practitioners Slowly Gain Autonomy,” states, “supporters also argue the practice of Family Medicine has changed in the past 20 years, making the training and skills of NP’s even more appropriate for the job. In the earlier days of Family Medicine, doctors treated a wide variety of illnesses, set bones and performed minor surgery. Today, most spend their days treating common colds, managing diabetes, hypertension and other chronic diseases, and diagnosing and referring patients to specialists.” We have to do a better job with public relations. In this era of spin control, the truth and facts take a back seat to perception and political views.

We still are the only specialty that cares for patients from cradle to grave and does obstetrics and surgical procedures and endoscopies and emergency medicine and hospital and ICU care. We serve rural parts of our state and nation in greater numbers than any other entity that wields a prescription pad. We have quietly gone about the business of caring for this nation without pomp or circumstance. We just “do the right thing!” It is time that each and every one of us carries our torch high above our heads and lets our light shine.

So, when you think about the difference you’ve made in this world and the lives you have touched, think about your personal statement you wrote when applying to medical school and residency. Ask yourself if you have become the family physician you wanted to be. Hopefully, you will be pleased. If not, then it’s never too late to get busy.

To bolster your faith, and at the same time illuminate Family Medicine’s challenges, I would like to share the recent Facebook posting of Jennifer Rahn from Vanderbilt Medical School. I know some
of her story and she is quite a remarkable and courageous future colleague……..

“I’ve been sitting here tonight trying to write my personal statement on why I want to practice family medicine, specifically in a rural and underserved area. After spending the last few months trying to convince myself that I actually wanted to do something different so that I didn’t let Vanderbilt down by choosing such a “lowly” specialty, I have finally come to the realization of what I’ve known subconsciously for a long time. Tonight, I found myself writing about things like my own background growing up in a rural town, about the experiences I had observing the sparsity of access to care with my dad before he passed away, and about my strong desire to serve as an advocate not only for healthcare but also for education so that children from backgrounds just like my own can realize they have potential beyond what society seems to have outlined for them. I found myself discussing how fortunate I was to have wonderful counselors and role models along the way and to be involved in an organization like Clemson First that served as an advocate for me and many other first generation college students, and how I wanted to be able to be that role model and advocate for others. By writing out these things, I began to feel a sense of excitement about my future career that I had never really experienced before. As I took a break from writing, I ironically enough came across this study that a friend posted on her Facebook wall. The study was looking at the distribution across the US of poor children who were (and also who were not) able to rise out of poverty. Seeing the blanket of red across South Carolina and the rest of the southeast, representing a high number of children who are not able to advance themselves out of poverty, further proved to me just how passionate I am to choose a career in rural family medicine despite the inferior viewpoints that many may have about the specialty. I can’t make a huge impact on that blanket of red, but I want to do my best to make at least a tiny dent in it. Tonight is seriously the first time that I have not felt at least a twinge of embarrassment to admit I want to be a family physician, and I am so glad that I have finally replaced that embarrassment with a feeling of excitement. I think that means I have finally figured out exactly what it is I want to be when I grow up….even though I’ve secretly known it all along! Http://www.equality-of-opportunity.org/”

I hope each of you are what you wanted to be. Let your light shine!

Your Servant,
Alan Wallstedt, M.D., Brentwood
Lessons from a Patient

Sometimes, in the course of a physician’s career, he/she comes upon a patient whose memory will linger long after the physician-patient relationship ends. For me, such was the case with Mrs. G. (the name and details have been changed, so as to protect the confidentiality of the patient).

I had returned to a faculty position after working as an outpatient doctor for several years. My first rotations on the hospital service were arduous, as I got back into the swing of inpatient care, and I faced each with more trepidation than I would have had for a root canal. It was during such a hospital stent that I first pulled down “Volume II” of Mrs. G.’s chart at the nursing station. Back in those days, a multi-volume paper chart was a sure sign of a “frequent flyer,” and either indicated major medical problems, serious non-compliance, or both. Either way, it meant hard work for an attending who was assuming her care.

I scanned through the data. Mrs. G. was a divorced female in her mid-fifties and a brittle diabetic. She had every “–opathy” that diabetes could bestow, and had already undergone a renal transplant over a decade previously, as well as bilateral above-the-knee amputations. She also had hypertension, hypothyroidism, and a lengthy list of other issues. I wondered if she were in for rejection of her transplanted kidney, but was relieved to find that was not the case. Apparently, she was admitted with a recalcitrant soft tissue infection of the hand, which had already cost her a few fingers, and now, was threatening even more devastation.

As I read through the tome that was her chart, I felt the stirrings of a mixture of compassion and dread within me. She was definitely a “train wreck,” and had certainly endured more than her fair share of illness and surgery. An image of her began to form in the recesses of my mind. Most likely, she was a shriveled, despondent woman with missing limbs, lying with gaunt features, peering timidly from a hospital bed, anxiously awaiting the verdict of whether her tissues would survive. I would have little hope to offer her, for the chart didn’t look encouraging.

I sighed and headed for the room.

To my surprise, it was a robust, “Come in!” that responded to my timid knock. I opened the door to find a well kempt, younger-than-the-stated-age-appearing lady sitting by the bed, looking up from her morning coffee and newspaper, inspecting me through reading glasses with bright eyes. Softly, CNN mumbled in the background from the TV. She was cheerful and polite and she offered a gentle chuckle to each of my attempts at humor. We both somberly regarded the wound, and she acknowledged the remoteness of full recovery. However, by the end of the visit, she had inspired me to hope for something more.

Thus went our first encounter. Over the years, there would be many, many more. She was hospitalized that time for several weeks, but did make it to discharge without further amputations. However, she soon was back in for the same problem. There were more infections and one episode of early rejection, as well as a DKA admission or two, and it often seemed that she spent the majority of her time in the hospital. Many an intern cut his/her teeth on those multiple chart volumes, as they learned how to help her cheat death and dismemberment, time and time again. Watching her bounce back from the edge so many times, we began to consider her immortal. Throughout the vast majority of those admissions, her smile would come shining through. Maybe it wouldn’t be the day of admission, but as she began to improve, she would ask for coffee and a newspaper, and she would, once again, make our team feel hopeful. Miracles were real. Mrs. G. was still going strong, and anything seemed possible.

One day on morning rounds, a resident who had seen her though a rough hospitalization was presenting her case in his usual brisk, no-nonsense manner, when he added something to the effect of, “I just don’t understand Mrs. G. If I had lost both my legs, and half of my hand, and was in and out of the hospital like her, I’d want to kill myself, but every day, she’s in there smiling, and taking it all in stride. How can she do that?” he marveled. I thought that was an excellent question. I mumbled something about people being able to adapt more than we might expect, but I challenged the team to talk with Mrs. G. about her coping mechanisms. I also broached the subject with her later that day, myself. I explained that the team had trouble understanding how she could be so upbeat when she had endured so much, and asked her to teach them how she had adapted. She told me that she still was able to do many things that she enjoyed. She could keep up with current events through the newspaper and the TV and could either read or watch...
other programs for entertainment. She could call her family on the phone and keep in touch with them, knowing that they cared about her. She believed that things would work out for the best. At the conclusion of her list, she added that she also had faith in her medical team.

Mrs. G. was definitely a “teaching case” on many levels. Eventually, she accepted nursing home placement where her most recent infection and her uncontrolled diabetes might have a better chance of coming into control, and I was the attending for her there. It was a difficult transition for her. She was frequently on the phone to the ombudsman and had multiple meetings with the administration and social worker there. I never knew all the details, but some issues related to money and others to her desire for more independence. Inevitably, they would reach a compromise and she’d still be there when our team appeared each month. At one point, a frustrated resident called to inform me that Mrs. G. and the nursing staff were having problems. The nurses had found a bottle of narcotics for Mrs. F. in her room, prescribed by another physician. Ultimately, it was revealed that she had gone out on a pass with her brother (her only relative who resided in town) and had apparently visited a local urgent care center during that time. We had a little chat with Mrs. G. She sheepishly apologized, promised that she would never do such a thing again, and denied that she had a need for ongoing pain management. After that the conflicts seemed to resolve and there was never another such incident, to my knowledge.

To everything there is a season, and as time marched onward, Mrs. G.’s season came to a close. She was admitted to the hospital, unresponsive, with what appeared to be sepsis. All of her organs seemed to be suffering from the strain, having used up all their reprieves, and there would be no cheery smiles or soft chuckles this time. I assumed her care on a Friday evening and by Saturday morning, she was gone. Rounds that day were somber. Something seemed askew. A world without Mrs. G.; now, that was hard to imagine.

Although her body proved to not be immortal, her spirit lingers with me. Her face is the one I see when I hear the term, “uncontrolled diabetes,” and I think of her example when someone needs encouragement. It is said that our patients are our best teachers. In addition to countless lessons to our team regarding diabetes management, drug-drug interactions, signs of organ rejection, wound management, etc., she also taught us that the power of the human spirit can overcome hurdle after hurdle, a well-reasoned prognosis does not account for a strong will to live, and even patients whom we think we know well can pull a “fast one” with controlled substances. We also learned to not judge a patient by the magnitude of the chart and that losing one’s body parts, piece by piece, does not have to result in a proportional loss of autonomy or optimism. I remember the stark contrast between the resident’s perception of what it would be like to live as Mrs. G. and her own perspective, and I know that we physicians have to be very careful as we advise our patients and their surrogate decision makers on determining quality of life in scenarios before they arise. We are also challenged by the faith she had in her medical team, inspiring us to bring all of the healing arts to the bedside in order to bolster not only our patient’s physical needs, but to also encourage them to reach toward the best possible outcome. As those of us who knew her try to promote her lessons, it just may be that Mrs. G. really does have immortality.
2013 NATIONAL TAR WARS Poster Contest

Tennessee’s Mary Massey of Lafayette places Honorable Mention #9

The Massey Family at National Tar Wars Poster Contest

Congressman Diane Black

Sarah Osborn, Sr. Legislative Aide to Congressman Chuck Fleischmann

Senator Lamar Alexander and Senator Bob Corker

Erin Bays, Legislative Aide to Congressman Stephen Fincher

Mary at Senator Alexander’s and Senator Corker’s Tennessee Tuesday Breakfast
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. The Tennessee Academy coordinates the Tar Wars program in Tennessee.

Your help in teaching Tar Wars in your local school classrooms would be appreciated! The 2013-2014 Teaching Guides will be available in September on the Tennessee AFP website at: www.tnafp.org. Or, if you have questions, please contact: Cathy Dyer, Tennessee Tar Wars Coordinator, at the Tennessee AFP office: Toll Free at 1-800-897-5949; Nashville/Brentwood calling area at 615-370-5144; Email at tnafp@bellsouth.net.

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My title refers to the famous opening phrase of a soliloquy in Shakespeare’s play Hamlet. In the soliloquy, Hamlet questions whether or not it is worthwhile to stay alive when life contains so many hardships. The practice of medicine can have its hardships as well. “Change management” seems to be the new mantra in the practice of medicine, and change can be difficult for us all.

The Patient-Centered Medical Home (PCMH), is likely one of the most significant new concepts in medical practice over the last few years. In this article, I want to define and review the history of the PCMH as well as discuss the recognition programs associated with PCMH accreditation. I would like to then discuss some reasons for becoming a PCMH, some pitfalls and challenges, and finally, the resources available to help. I realize some may well be familiar with this information, but many are not and are still trying to decide “to be, or not to be” a Patient-Centered Medical Home. I hope this information will help them to be able to make that decision.

The PCMH model is defined as an approach to providing comprehensive primary care for children, adolescents, and adults. This definition was laid out by the American Academy of Family Physicians (AAFP), American College of Physicians (ACP), American Osteopathic Association (AOA), and American Academy of Pediatrics (AAP) in the “Joint Principles for the PCMH.” Critical principles within the model include access to a personal physician who leads the care team, a whole-person orientation to providing patient care, and integrated, coordinated care with a focus on quality and safety. The term “medical home” was actually introduced by the AAP in 1967. The Institute of Medicine (IOM) mentioned the medical home in 1996 in its publication, Primary Care: America’s Health In A New Era. In 2002, The Future of Family Medicine (FFM) project reinforced the concept. In 2005, the Patient-Centered Primary Care Collaborative (PCPCC) was founded by large employers and the major primary care associations: AAFP, ACP, AOA and AAP. The organizations were charged with building a national movement promoting the widespread adoption of the PCMH. The Joint Principles mentioned above were established in 2007. In 2008, the National Committee for Quality Assurance (NCQA), Utilization Review Accreditation Commission (URAC), the Joint Commission (TJC), and the Accreditation Association for Ambulatory Health Care (AAAHC) launched medical home accreditations programs. The NCQA program is most certainly the leader, with over 5,700 recognized medical homes as of July, 2013. Practices are recognized for a 3-year period and 3 levels are recognized. The most recent 2011 NCQA requirements have 6 “standards,” which define broad goals. Each standard has a number of “elements” (some of which are a “must pass”). Points are earned for each element. Point totals indicate the level achieved (I, II, III). Other accrediting organizations, which require site visits, include the AAAHC, URAC, and TJC. There are also state or regional programs and even some payor-led PCMH programs. Each program has its own idiosyncrasies and some may be a better fit for certain types of practices (large, small, rural, etc).

The big question you may be asking is why you should pursue PCMH status. I will suggest several reasons. With the U.S. spending between $476 to $992 billion on
unnecessary health care services and waste, the consensus continues to build around the PCMH and its role in achieving the objectives of the Institute for Healthcare Improvement’s Triple Aim: better care, better health, and lower costs. Rhode Island BCBS saw a 17-33% reduction in healthcare costs for PCMH patients. Boeing calculated a 20% lower healthcare cost driven by participants in a PCMH program with Regence Blue Shield. Patients who have a PCMH were found to be more productive and more likely to stay on the job. It enhances the experience of patients and quality of care. The Michigan BCBS pilot (the largest initiative in America) saw significant decreases in adult hospital admissions and declines in ER visits. One PCMH demonstration site improved from experiencing 90-day waits for appointments to successfully offering same-day appointments (references are available for above data).

There may be greater career sustainability for physicians...a better quality of practice. The PCMH provides a mechanism to improve the quality of physician practice by providing them the resources and tools to get back to the core values of why physicians entered practice. In addition, there is improved compensation as most reimbursement going forward will likely be a blended payment model, consisting of a fee-for-service component, a per member-per month, and a performance-based (quality) component, which is likely best achieved in a PCMH model. It may be the best model to successfully compete in the emerging fee-for-value system. In order to thrive in a patient-, payor-, employee-driven world (which is where we are finding ourselves), the PCMH is practical, if not necessary.

I did not say it would be easy or simple. There are challenges and pitfalls. There can be significant ramp-up costs, as well. The American College of Physicians website provides some cost estimates. However, some payors may provide some financial assistance in the transition. An example would be BCBS in this state, who may provide assistance with case management, EHR transition, etc., based on a sound business plan, in order to help practices achieve PCMH status. The transition has a number of variables, including practice size and existing capabilities. Patient population characteristics can influence the transition, as well. Staff capabilities are an important variable, as well. All of this falls within the concept of “change management,” which can be the most challenging issue of all, but there is a lot of assistance available.

Resources are numerous and the cost is all over the map. Googling for PCMH consulting firms resulted in over 27,000 results (evidence that we do still live in a capitalist society). The ACP, AOA, AAP all have their own tools and “tool kits” available to assist in the transition on their websites. Given that I am a family doctor, I will focus on our own Academy’s resources, which are numerous and will be expanding soon.

If you go to the AAFP website, there is a section on the PCMH where you can find a checklist which can be applied to your practice, and an overview, as well as more specific information on practice organization, health information technology, quality care, and patient-centered care. This fall (introduced at the AAFP Scientific Assembly) a PCMH Planner will be introduced, which is a significant enhancement to help physicians transform their practices to the PCMH model of care. It will be available through an electronic platform and will provide clear step-by-step direction, tools, and resources for the transition. Certainly, don’t forget TransforMED, which is a subsidiary of the AAFP and provides ongoing consultation, support, tools, and resources for the PCMH transition process. Delta Exchange is TransforMED’s collaborative social network, which allows participants a means to interact, exchange ideas and has nearly 8,000 members.

So, there you go...what, why, challenges, how, and help (assistance). There is evidence that the PCMH model can improve quality and efficiency, while improving patient satisfaction and physicians’ quality of practice. Unfortunately, things just seem to get more complex, and change is just something to which we are all getting very accustomed, and of course, change is hard, even for the better. Everyone will have to decide “to be, or not to be” a Patient-Centered Medical Home. Its value continues to be debated, and I suggest it will be for some time. Hopefully, this information will be helpful to some degree, in focusing your thoughts and motivating you to move forward in this challenging environment.

Wes Dean, M.D.
Powell
SLATE OF NOMINEES FOR 2014 TENNESSEE AFP OFFICERS & BOARD OF DIRECTORS

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VICE SPEAKER OF THE CONGRESS:
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DELEGATE TO A.A.F.P.:
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ALTERNATE DELEGATE TO A.A.F.P.:
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ALTERNATE DIRECTOR:

DISTRICT 9 - DIRECTOR:
Kevin Wheatley, M.D., Paris

ALTERNATE DIRECTOR:
Susan Lowry, M.D., Martin

DISTRICT 8 - DIRECTOR:
Patrick Andre, M.D., Humboldt (to replace the unexpired term of Kevin Wheatley, M.D.)

DISTRICT 11 – RESIDENTS:
Ashley Fields, M.D., MPH, Nashville (Meharry)
Katherine Hall, M.D., Maryville (UT Knoxville)

The Resident receiving the largest number of votes at the Tennessee AFP Congress will serve as Director; and the Resident receiving the 2nd largest number of votes will serve as Alternate Director.

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Sydne Ford, Nashville (Meharry)

ALTERNATE REPRESENTATIVE:
Joshua Hollabaugh, Nashville (Vanderbilt)
TENNESSEE AFP’S
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October 29-November 1, 2013; Gatlinburg Convention Center

If you have not received your Tennessee AFP Program/Registration Brochure for this year’s annual meeting, please notify the Tennessee AFP office so one can be mailed to you, or you can access a copy on the TNAFP website at www.tnafp.org.

Included, again, in this year’s annual assembly program is one hour on “Physician Prescribing and Monitoring of Scheduled Drugs” on Friday, November 1, which will meet your required 1 hour, designed specifically to address prescribing practices of the required 40 hours to maintain your Tennessee medical license.

We hope to see you in Gatlinburg the last week of October!

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FOR FURTHER INFORMATION CONTACT
Roger Zoorob, MD, MPH, FAAFP
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PROPOSED AMENDMENTS TO THE CONSTITUTION & BYLAWS FOR CONSIDERATION BY THE 2013 TENNESSEE AFP CONGRESS OF DELEGATES

The 2012 American Academy of Family Physicians’ Congress of Delegates adopted a new version of the AAFP Bylaws which contained significant changes. As required of all state/component chapters of the American Academy of Family Physicians, the Tennessee AFP Congress will be voting on a new, revised version of the Tennessee AFP Bylaws to keep the TNAFP Bylaws in compliance with the AAFP Bylaws. If you wish to receive a full version of the proposed TNAFP revised Bylaws, please contact the Tennessee AFP office. Elected Chapter/District Delegates and Alternates will receive a copy in their Congress packets mailed approximately 2 weeks prior to the TNAFP Congress being held on Tuesday, October 29.

RESOLUTIONS RECEIVED FOR INTRODUCTION TO THE 2013 CONGRESS OF DELEGATES

At the time of publication of this Fall issue of the Tennessee AFP journal, no Resolutions for the 2013 Tennessee Academy of Family Physicians’ Congress of Delegates had been received.

TENNESSEE AFP AT THE 2013 AAFP NATIONAL CONFERENCE OF FAMILY MEDICINE RESIDENTS AND MEDICAL STUDENTS

Follow Me To Tennessee

UT St. Francis Family Medicine Residency
TENNESSEE AFP AT THE 2013 AAFP NATIONAL CONFERENCE OF FAMILY MEDICINE RESIDENTS AND MEDICAL STUDENTS

ETSU Family Medicine Residencies – Bristol, Johnson City, Kingsport

Meharry Medical College Family Medicine Residency

UT Knoxville Family Medicine Residency

UT Chattanooga Family Medicine Residency

UT Jackson Family Medicine Residency
Once a year, family medicine leaders and educators come from across the nation to share their knowledge with family medicine residents and medical students at the American Academy of Family Physicians’ National Conference of Family Medicine Residents & Medical Students (NCFMRMS) held in Kansas City.

Your Tennessee AFP and Tennessee AFP Foundation supported the attendance of a total of 25 medical student members from the four medical schools in Tennessee to attend this year’s NCFMRMS, and additionally the attendance of your Resident Voting Delegate, Adam Lett, M.D., UT Knoxville, and Student Voting Delegate, Sydne Ford, Meharry. The Tennessee Family Medicine Residency Programs, along with the Tennessee AFP, occupied booths in the “Follow Me To Tennessee” row in the exhibit hall at the conference.

(The Tennessee AFP thanks Heather Greenway, UT Jackson Family Medicine Residency; ETSU Department of Family Medicine; and, Paul Hannam, Meharry Medical Student, for their donations of pictures from the NCFMRMS.)

(Thank you to Doctor Sherry L. Robbins for the use of her mountain photograph on the “Follow Me To Tennessee” Signs.)
THE STRENGTH TO HEAL and get back to what I love about family medicine.

Do you remember why you became a family physician? When you practice in the Army or Army Reserve, you can focus on caring for our Soldiers and their Families. You’ll practice in an environment without concerns about your patients’ ability to pay or overhead expenses. Moreover, you’ll see your efforts making a difference.

To learn more, contact your local medical recruiter or visit healthcare.goarmy.com/u311

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The Alzheimer’s Association is the world’s leading voluntary health organization in Alzheimer’s care, support and research. The Association provides support, resources & education to those affected by Alzheimer’s and other types of dementia. Their 24/7 Helpline at 1-800-272-3900 is available to anyone anytime. Connect with your local chapter by calling the Helpline and share this great resource with the families you work with.

Find a local Walk to End Alzheimer’s to participate in at alz.org/walk.
Your patients no longer have to suffer from seasonal and perennial allergies. By offering this service line, physicians are able to provide a higher level of allergy care, safely and effectively.

About United Allergy Services:

- Under the direct supervision of the physician, UAS tests, analyzes, and performs dilutions.
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- Focus efforts on patient safety, patient compliance and patient outcomes.
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Interested in becoming a UAS Allergy Center? Visit www.UnitedAllergyServices.com or call 888.50.Allergy.

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I write to you very honored and thankful for being selected as the Outstanding Student in Family Medicine at ETSU. It felt great to be recognized at our graduation ceremony and even sweeter when my 7 year old niece proclaimed she wanted to “grow up, be smart like me, and get 2 awards at her graduation” as well! It has been a great privilege and honor to work with the TN Academy as the student member of the Board of Directors. I hope to be further involved over the next three years since I am staying in TN for residency! I look forward to seeing many of your friendly faces in Kansas City, San Diego, Gatlinburg and of course Nashville. :o)

Theo Hensley
(ETSU)

Hello,
I am honored that I was selected to be the TNAFP Outstanding Student in Family Medicine. Thank you Cathy for all your support over the past four years. Please send my thanks to the President and staff of TNAFP.

I will be training at the University of California San Francisco Family and Community Medicine Residency Program at San Francisco General Hospital.

Lamercie Saint Hilaire
(Meharry)

Thank you so much for arranging the wonderful dinner. I am really honored by the wonderful award and gift from the Tennessee AFP. I loved working with you for the past four years and I look forward to seeing you again at future conferences. I think you’ve got a fun bunch of potential Family Medicine candidates coming through Vanderbilt right now too!

Jessica Cornett Allen
(Vanderbilt)
MY WEAPON
IN THE FIGHT AGAINST ARTHRITIS

What’s your weapon? Visit FightArthritisPain.org
Lamercie was kind enough to share her personal statement with the TNAFP.

It was a hot day in Haiti, May 30, 2010, almost five months after the devastating earthquake rocked the country. It was the first day of my medical mission trip and I was on the bus with my fellow volunteers heading for our commune. As I passed homeless families, buildings in rubble, and polluted streets, I experienced waves of shock, sadness, anger, and finally despair. While stopping for bottled water, another volunteer asked me to interpret for a group of children gathering around the bus. As I was interpreting I realized I did not know the Creole word for hope, so his words of encouragement were lost in translation. Afterwards, I climbed back onto the bus feeling defeated and broken hearted. Fortunately, over the next 10 days I was inspired by the strength of all the survivors. I became less encumbered by the negativity surrounding me, and more amazed by the wonderful people I interacted with every day. I was determined to make any difference I could, working 14 hour days in the tropical heat with a smile on my face. I eventually learned that the Creole word for hope is “espwa.” Thanks to my experience in Haiti, I now have a strong sense of “espwa” that I carry into every obstacle I face and for the future as a whole.

I am a first generation Haitian-American. I come from a poor background, and healthcare was not always an option for my family. At an early age I knew I wanted to be a doctor, for the sake of my family and to serve others. From the very beginning of my medical school career, I knew I wanted to become a Family Physician. I have enjoyed every rotation I have been on, whether it involved performing a well child physical exam, scrubbing in on a hernia repair, delivering a baby, or managing a senior’s diabetes. I look forward to the challenge of managing a multitude of medical conditions, unrestricted by patient demographics. I truly want to care for the whole patient and their entire family. Through Family Medicine I can fulfill all of my passions: patient education, continuity of care, preventive and integrative medicine. That is precisely why Family Medicine is the perfect fit for me.

My medical experience so far at Meharry Medical College has allowed me to receive a great medical education, become an advocate for the elimination of health disparities, and serve the student body and the community. I have had great experiences tutoring medical and dental students, serving on the board of the Pre Alumni Society, and working as a columnist and editor of The Pulse, our student run newsletter. I take time to participate in various community service opportunities such as coordinating Project R.E.C.E.S.S., a health expo at a local elementary school. I am a future doctor, but a student for life. I enjoy learning from experienced attendings and residents while working in a team that shares my value of quality patient care. Most importantly, I feel that the true reward of being a physician comes from the patients. I feel a great sense of accomplishment whenever I am able to help a patient, no matter how small the task. Whether I was explaining the importance of proper foot care to an elderly diabetic or spending time listening to music with a young male with HIV, I enjoyed every relationship. This year I was nominated by my peers and inducted into the Gold Humanism Honor Society for my excellence in clinical care, leadership, compassion and dedication to service. I would like to earn a position in a residency program that shares these attributes and will continue to cultivate my passions.

In closing, I have strong aspirations. I want to serve the underserved in my local and global community. In my practice of medicine I plan to empower my patients to be advocates for their own health, prevent –even reverse–diseases, emphasize the importance of nutrition and healthy lifestyle, while practicing integrative medicine and comprehensive healthcare. I am also determined to be a leader in my community by participating in health policy, advocating for social justice, traveling abroad on medical mission trips and staying affiliated with an academic institution to educate future physicians. Ultimately, I am proud and excited to say that I am going to be a Family Physician.
Help Your Patients Enjoy Dairy Again

Many health authorities agree that low-fat and fat-free milk and milk products are an important and practical source of key nutrients for all people — including those who are lactose intolerant.1,2,3,4,5,6

In fact, the 2010 Dietary Guidelines for Americans (DGA) recognizes dairy foods as an important source of nutrients for those with lactose intolerance.7 Milk is the #1 food source of three of the four nutrients the DGA identified as lacking in the diets of Americans – vitamin D, calcium and potassium – and the DGA recommends increasing intakes of low-fat or fat-free milk and milk products to help fill these nutrient gaps.

A Solutions-Focused Approach

People who are lactose intolerant should know that when it comes to dairy foods, practical solutions can help them enjoy the recommended three servings of low-fat and fat-free dairy foods every day*, without experiencing discomfort or embarrassment:

• Gradually reintroduce milk back into the diet by drinking smaller amounts of milk at a time, trying small amounts of milk with food, or cooking with milk.
• Drink low-lactose or lactose-free milk products, which are real milk just with lower amounts or zero lactose, taste great and have all the nutrients you’d expect from milk.
• Eat natural cheeses, which are generally low in lactose, and yogurt with live and active cultures, which can help the body digest lactose.

Visit nationaldairycouncil.org for more information, management strategies and patient education materials.

* The 2010 Dietary Guidelines for Americans recommends 3-Every-Day™ of Dairy, a science-based education program encouraging Americans to consume the recommended three daily servings of nutrient-rich low-fat or fat-free milk and milk products, to help improve overall health.
If you are looking for a partner or practice location, send information preferably by email to: tnaf@bellsouth.net, or, by fax to: 615-370-5199. Information for practice opportunities will be accepted only from Tennessee AFP members and will be placed in the Tennessee Family Physician at no charge. You are required to include your name, address and/or telephone number and/or fax number and/or email address, as contact concerning opportunities will be made directly between interested parties and not through the Tennessee AFP. Information will be placed in four (4) editions, unless the TNAFP is notified otherwise. **Deadline for the next issue (Winter) is October 18, 2013.**

- A well-established 6 physician, 2 nurse practitioner family practice in Smithville, Tennessee is seeking a full-time Board Certified Family Practice physician to join their growing practice. The physicians currently have full privileges at DeKalb Community Hospital, a 71-bed full-service local hospital. One-in-six call. Full benefits and competitive salary. Located near beautiful Center Hill Lake. For more information, please contact Michiko Martin, Office Manager at (615) 597-4395, Ext. 236, by email mmartin@dtccom.net or by mail – 302 N. Congress Blvd, Smithville, TN 37166-2704; or, contact Hugh Don Cripps M.D., Doug Hooper M.D., Jack R. Rhody M.D., William H. Sherwood M.D., Steven Cooper M.D. or Kevin R. Rhody M.D at (615) 597-4395. For more information about the community, please visit www.smithvilletn.com and for more information about the local hospital, please visit www.dekalbcommunityhospital.com.

- Department of Family and Community Medicine – Faculty Position: The Department of Family and Community Medicine at Meharry Medical College is currently seeking a Board Certified Family physician to serve as a full-time faculty. The position includes faculty appointment at the level of Assistant or Associate Professor depending on experience and qualifications. Previous academic experience as a residency or clerkship faculty or fellowship training is preferred. Nashville is an excellent community and offers many amenities. The department has eighteen Family Medicine residents and also administers Preventive and Occupational Medicine Residency Programs and a Sports Medicine Fellowship.

  For further information contact: Roger Zoorob, MD, MPH, FAAFP, Endowed Professor and Chair, Department of Family and Community Medicine, 1005 Dr. D. B. Todd, Jr. Boulevard, Nashville, Tennessee 37208; rzoorob@mmc.edu; 615-327-6572; familymedicine.mmc.edu
  
  Meharry Medical College is an Equal Opportunity Employer.

- Busy primary care health department clinic seeks family practice physician to care for mostly adult patients with an occasional pediatric visit. Clinic hours are 8:00-4:30, M-F. Patient’s charges are based on income. After hours call is limited to telephone triage and is rotated among APN’s with physician back-up. Competitive salary and great benefits including paid holidays, 401-K, state pension plan, health and dental insurance, life insurance, and paid sick and annual leave. CME opportunities available. Student loan repayment program available. Please contact Fred Vossel MD if interested at: fred.vossel@tn.gov.

- An established Federally-Qualified Health Center located in the foothills of the Great Smoky Mountains is currently seeking a Board Certified/ Board Eligible Family Practice physician. We are looking for a motivated provider that is committed to providing comprehensive care to patients of all age groups. We offer competitive salary with full benefits, and paid malpractice insurance. We are also an approved site for the NHSC Loan Repayment program. For more information please contact Amy Keener, Human Resource Officer or Joel Burroughs, MD, Medical Director at (423) 442-2622. You may also submit your CV to akeener@chotahealth.org.
Meaningful Use is a journey.

We can help guide your path.

Several healthcare organizations across Tennessee have joined the Health eShare Direct Pilot to exchange information using a federally developed secure email messaging service known as Direct.

This technology allows participants in healthcare—medical, clinical and administrative staff—to send and receive encrypted patient health information, while complying with HIPAA regulations.

Qsource, a Tennessee-based nonprofit healthcare quality improvement and information technology company, is currently working with the Tennessee Office of eHealth Initiatives to support the Health eShare initiative.

Pilot communities include Memphis, Chattanooga and Hickman County. Each are testing and developing use cases for Direct secure messaging with the goal of improving workflow and increasing efficiency in healthcare organizations.

In Memphis, care coordinators are using Direct to share care plans and discharge information, as well as setting appointments and coordinating gaps in care. In Chattanooga, patient discharge notifications, as well as summaries and patient charts, reach care coordinators instantaneously in an effort to prevent costly hospital readmissions.

Beginning in June, Qsource will use lessons learned and effective use cases to transition from the pilot phase and expand the Health eShare initiative statewide with a goal of enrolling 4,000 participants by Jan. 31, 2014.

Visit HealtheShareTN.com to learn how Direct can benefit you and your patients.

Incentive funding up to $63,750 is available for Eligible Professionals (EPs) within the Medicaid program seeking to achieve Meaningful Use of an EHR. Through special funding, tnREC is offering free or low-cost health information technology services if an EP meets the Medicaid patient volume thresholds.

We help healthcare providers take the right steps to implement new technologies that enhance and improve the quality of care available.

We can do the same for you.

Apply online
www.tnrec.org
“Like me, you’ve probably noticed some professional liability insurance carriers recently offering physicians what seem to be lower rates. But when I took a closer look at what they had to offer, I realized they simply couldn’t match SVMIC in terms of value and service. And SVMIC gives me the peace of mind that comes when you’re covered by a company with a stellar record of over thirty-five years of service and the financial stability of an “A” rating or better since 1984. At SVMIC, I know it’s not just one person I rely on... there are more than 165 professionals who work for me. And, since SVMIC is owned by you, me, and over 14,000 other physicians across the Southeast, we know our best interests will always come first.”