Letters to the Editor

In Response

Support for Commentary on AAFP Scientific Assembly

To the Editor:
As a fellow faculty member, I want to thank John Standridge, MD, for his commentary on the American Academy of Family Physicians (AAFP) Scientific Assembly. I could not agree with him more. After attending the AAFP Assembly when it was last in Chicago, and being disgusted by the advertising and opulence, I have not gone back. I attend other academic annual meetings, and I’ll be at the Society of Teachers of Family Medicine Annual Spring Conference in Chicago next April, but I won’t go to the AAFP Scientific Assembly for the very reasons Dr Standridge enumerates. I wonder how we might make this statement to the AAFP leadership or how to influence their decision making on the subject of drug company support for the Assembly.

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More on Scientific Assembly Drug Company Support

To the Editor:
The gentle diatribe by John Standridge, MD, on the relentless subversion of our discipline by the pharmaceutical industry lacks a sense of outrage. Let me assure him that he now knows at least one colleague who “wants to exclude drug companies from our events.”

In addition to the embarrassing opulence of the AAFP Annual Scientific Assembly—where jumbo shrimp outnumber clinical pearls—is the recent publication of the AAFP’s 2006 edition of Family Doctor: Your Essential Guide to Health and Well-being. Open the cover and the first thing to greet you is—the Target Pharmacy. Dive into the book, and you find 102 pages of advertisements. (I admit that I had troubling counting them accurately, because they are integrated so seamlessly into the text that it’s hard to know where the ads end and the advice begins. Could it be that they are the same?)

Is family medicine a wholly owned subsidiary of the medical-industrial complex? Are we so impoverished that we can’t pay for our lunches and CME? Are we willing to trade our integrity for small trinkets from Big Pharma while our patients pick up the bill?

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Reference

New Research

The Logic Model as a Framework for Community Program Evaluations: The Food Literacy Partners Program

To the Editor:
Many community-based health improvement initiatives are implemented without a formal evaluation plan. With increasing emphasis on evidence-based strategies, the value of health initiatives must be demonstrated. We found that the Logic Model is an effective method for designing an evaluation for programs already in place. We applied the Logic Model in the evaluation of the 5-year-old Food Literacy Partners Program (FLPP). Lay volunteers are trained to broadcast specific nutrition messages in a
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Linking activities to expected (short, intermediate, and long term) changes are expected to occur to impact health. It may be useful in community-oriented primary care programs.

To generate the FLLP logic model, we identified resources—both monetary and human expertise—and stakeholders whose contributions would enrich the process. Among the stakeholders were course instructors, graduates of the training program, funders, and health agencies. We reached consensus on the assumptions and expectations for the nutrition problems addressed: if people acquire food and nutrition information (short-term impact), they will adopt health-promoting behaviors and share their success with others (medium-term impact). The long-term impact would be a healthier community.

For programs already in place, outlining activities is straightforward. For each activity, short-term (knowledge and attitude change), intermediate-term (behavior change), and long-term (health status change) outcomes are stated. Linking activities to expected impacts helps determine if planned activities are sufficient to meet stated impacts. If not, the model needs examination to determine why expected outcomes are not occurring. For FLLP, we found the food and nutrition knowledge gain (short term) and behavior change (medium term) and the ability to transfer this knowledge (medium term) were not occurring as predicted.

When planning the evaluation scheme based on the Model, the evaluation methods need to be examined. For FLLP, we were collecting data about individuals’ pre-FLPP and post-FLPP nutrition and physical activity behaviors and course evaluations. These data were not able to give us the entire picture of program effectiveness. For our final evaluation plan, we integrated the results from a new survey of past participants, volunteer records, course evaluation forms, and available data on physical activity and nutrition behaviors.

Our experience with the Logic Model helps us see other ways it can be used in family medicine. In an era of shrinking resources and increasing demands for clinical productivity, teachers of family medicine can also use the Logic Model to assure that curriculum innovations or alterations have been considered from all aspects and highlight the value of change. Analysis of existing programs against the Model may show where value can be added or more efficient use of resources can be made. Likewise, in the community, clear statements of plans with outcomes achieved makes funding more likely for future projects. In addition, use of the Model makes evaluation substantive to the desired outcomes, versus student opinion surveys, the more typical data available to faculty for professional documentation toward promotion.

Developing the Model was a useful tool even with a 5-year-old program. It described FLPP to our funders and stakeholders and allowed adjustment of training content and methods to create the desired impacts. We were able to efficiently determine strengths and weaknesses of FLPP and define recommendations for change and improved sustainability. We recommend the Model to clearly delineate responsibilities, activities, and how impacts will be evaluated in community-based health improvement programs.

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REFERENCES

Family Medicine Residents and Home Visits

To the Editor:

Background

By 2030, one in five Americans will be older than age 65, many of them with some kind of disability. A significant number will utilize home care and community services to accommodate their needs.

The family medicine residency at Jefferson Medical College, Thomas Jefferson University, has had a home visit program since 1981. The residents are required to participate in home visits with attending physicians. The residents average approximately 44 home visits by the end of their training. To investigate the impact of the current home visit program, we surveyed the family medicine residents’ attitudes and knowledge on caring for elderly, homebound patients.

Methods

We surveyed first-, second-, and third-year residents (n=27) in the fall of 2003. The survey consisted of two parts. The first section was