THE UNIFORMED FAMILY PHYSICIAN

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Journal of The Uniformed Services Academy of Family Physicians

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VISION

The USAFP will be the premier professional home to enhance the practice and experience of current and future Uniformed Family Physicians.

MISSION

The mission of the USAFP is to support and develop Uniformed Family Physicians as we advance health, readiness, and wellness through education, scholarship, advocacy, and leadership.

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Edition 46

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president's message

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Greetings!

I hope all of you enjoyed a joyous holiday season and a fantastic start to the new year of 2019! I am writing to you all after a nice break from work where I enjoyed some down time to recharge my batteries as the final months of my year as USAFP President and my position here as DCCS at Fort Sill draw to a close.

1. Get ready! I hope by this point you have taken a good look at the schedule for our upcoming Annual Meeting in St Louis. This is looking like one of the most ambitious schedules USAFP has put together in many years. First, a big thanks to our Program Chairs, Laurel Neff and Heather O'Mara, for all of their tireless work to finalize the schedule from the record breaking number of submissions from our membership. This year's meeting takes the Annual Meeting back to its "original length" prior to the government shut-down in 2012. This additional day has allowed us to add a lot of educational content, workshops, and "new ideas" that we haven't had the room to squeeze in recently. So lock in those hotel rooms now and work on those TDY/TAD orders to St Louis! I can't wait to see all of you there!

2. Lead! As many of you know, I have been emphasizing our need as Family Medicine physicians to lead at all levels! We had a number of our USAFP members selected for command

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Congratulations to the Newly Elected 2019-2020 USAFP Officers and Directors

President-Elect – Navy
Debra A. Manning, MBA, MD, FAAFP
HQMC Health Services

Vice President – Army
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PHS/CG Director
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Navy Director
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Naval Hospital Jacksonville, FL

Air Force Resident Director
Betsy Curry, MD
Eglin AFB

Army Resident Director
Brian Merrigan, MD
Ft. Belvoir Community Hospital, VA

Navy Resident Director
Michelle Dentinger, MD
Naval Hospital Camp Pendleton

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on recent command boards—congrats! I want to personally congratulate all of the following Family Physicians selected:

Army Command:
COL Marty Doperak- Tripler AMC
COL Chris Jarvis- Womack AMC
COL Christian Meko- 44th Medical Brigade
COL Jason Wieman- 30th Medical Brigade
COL Chris Warner (dual boarded psychiatrist and family physician)- Madigan AMC

Army LTC Command
LTC Jason Ferguson

Army LTC Command Alternate List
LTC Dave Bode, LTC Daniel Cash, LTC John Gartside, and LTC Julie Hundertmark

Navy Commanding Officer
CAPT Steven Kewish and CAPT David Krulak

Navy Executive Officer
CAPT David Webster and CAPT Manny Alsina

This is a tremendous "show of force" for Family Medicine leadership across the DOD. Congrats again to Dr. James Ellzy for his election as Director on the Board of the AAFP at this Fall's AAFP Congress of Delegates! Finally, a very special congrats to our newest USAFP Board Members:

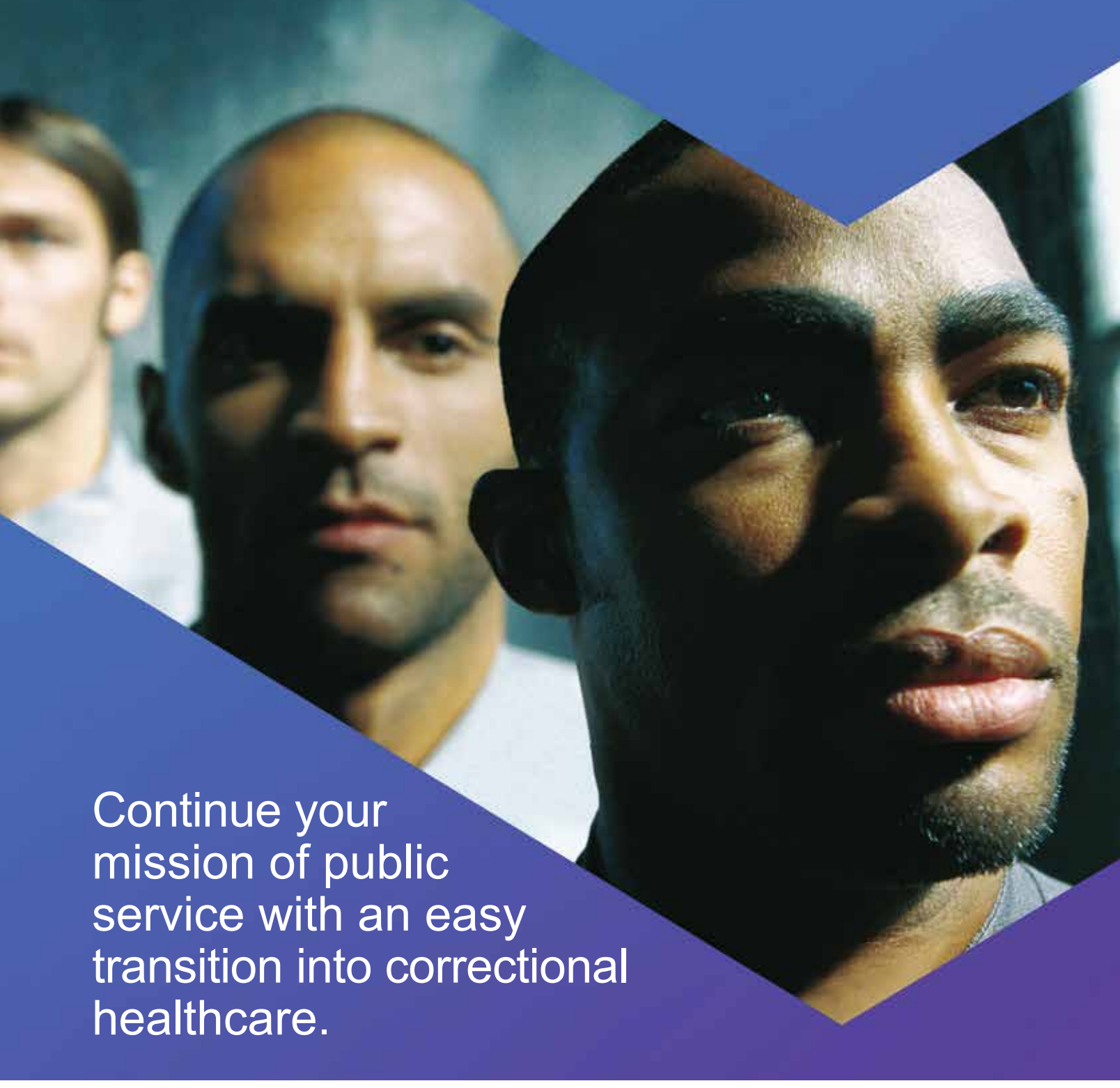
President Elect - Debra A. Manning, MD, MBA, FAAFP
Vice President - Aaron Saguil, MD, MPH, FAAFP
Air Force Director - Jeanmarie (Gigi) Rey, MD, FAAFP
Army Director - Drew C. Baird, MD, FAAFP
Navy Director - Kevin M. Bernstein, MD, MMS, FAAFP
Public Health Service/Coast Guard Director - Khalid A. Jaboori, MD, MPH, FAAFP
Air Force Resident Director - Betsy Curry, MD
Army Resident Director - Brian Merrigan, MD
Navy Resident Director - Michelle Dentinger, MD

All of you have answered the call to lead at the highest levels and I am very proud of you and thankful for the sacrifices you all are making.

3. Take Care of Each Other! One of my focus areas this year is physician wellness. As someone who has struggled personally with this at times during my career, it is a topic near and dear to my heart. I encourage all of you in leadership positions to ensure you are getting enough sleep, exercise, and proper nutrition AND that you are ensuring the same of your subordinates. I am lucky in my current position to enjoy mandatory five day/week physical fitness training. Granted, some days I don't feel "lucky" at all, but overall I have reaped the benefits of daily exercise to help as much with my mental fitness as with my physical fitness. It may not be feasible to institute something like this at your duty station, but make sure you are getting daily exercise in some fashion. A little goes a long way and recent studies don't really seem to see a ceiling effect to how much or how hard. At our annual meeting we will help "encourage" you to get some exercise by bringing back the USAFP Richard Emerine, MD Memorial 5K Run which will go right through the newly renovated St Louis Arch National Monument Park. Bring your running shoes and join us! Additionally, the meeting will address other key elements of physician wellness including sleep, nutrition, and a keynote from Dr. Mark Greenawald, a nationally recognized expert on physician wellness who has spoken at both STFM and FMX. Dr. Greenawald will also be hosting a workshop following his keynote which will be capped off by a wellness panel hosted by LTC McKay. Finally, MG Clark is working with the Army Medical Corps to develop an approach to wellness termed "Physician Prosperity". This new program will address four domains: personal, professional, relationship/family, and spiritual. We plan to include some additional content on this exciting new approach at the St Louis meeting.

4. Learn! Don't forget to log all of your CME from this past year! I always take a day over the holidays to ensure my AAFP account reflects all of the CME I have received at conferences such as USAFP, Board Review, STFM, FMX, etc., and take the quizzes of all of the AFP journals that I can get through in one year! And if you missed it, you have up to 3 years to claim certain AAFP CME credits! If you still are short, not to worry as our Annual Meeting in St Louis will offer over 40 hours of CME—the most we have offered in years and even more than FMX offers. Finally, I think you all know that the quality of the CME that YOU all give at USAFP is the best in country so please come and hear your colleague give the best CME for the dollar that you can find anywhere.

Take Care and see you in St Louis!
Doug



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editor's voice

DEBRA A. MANNING, MD, MBA, FAAFP

Happy New Year my fellow Family Physician Leaders! I am writing to you from Hawaii this time- I know, hard life. I am here TAD, but found some time to catch this beautiful sunset. I had a great visit and met with many young providers (I am getting old). I had one conversation with a provider who was describing an interaction with a patient who was struggling with feelings about their newborn and the fatigue they were feeling. He relayed that since his wife experienced postpartum depression, he was able to connect with the patient and he watched a sense of relief wash over her. These are some of the most rewarding moments in our field when we can connect and make a difference in our patient's lives (and he did address her postpartum depression). Our conversation then turned to making those same connections with colleagues who are sometimes struggling. We both named things we have done that have helped us with work life balance, such as using a lawn service, and having a maid service in order to spend more time with our families. We talked about meal planning on weekends, and the new industry of planned meals delivered to your home, so you don't have to do the food prep. We each could name friends who simply had not thought to do these things until it was mentioned- so mention it. Share your life hacks with others. As Dr. Maurer charged, take care of each other, and take care of yourself. For additional ideas, take a look at Dr. McKay's article on growing resilience.

I want to highlight another article in this newsletter. You may not be in the Air Force, but their consultant report this quarter is a fantastic summary of why we are uniformed family physicians. We are a critical war time specialty. We are critical. Take a minute to read Dr. Anton's Consultant's Report.

I have to take a moment to talk about the proposed manpower cuts that are being discussed, especially with the transition to the DHA. These are two separate change management events going on at the same time. Rumors are flying, folks are scrambling with questions, and that increases stress for everyone. I was asked several times this week how they can plan cuts, yet our retention bonus just added a six year option? I recognize all these pressures, and I don't have the answers but I know there are many people across all the Services working the issues. Watch for change fatigue in yourself and others.

Thank you one last time for the opportunity to serve as your Vice President and editor of the Uniformed Family Physician. And thank you for all that you do each day! If you have recommendations or articles you would like to submit, please email me at dr.deb.manning@gmail.com or the USAFP staff. I hope you enjoy the Winter 2019 Newsletter!

Hawaiian Sunset

HAVE AN ARTICLE YOU WOULD LIKE TO SUBMIT IN THE UNIFORMED FAMILY PHYSICIAN?
PLEASE SEE THE INSTRUCTIONS FOR ARTICLES AT
WWW.USAFP.ORG/ABOUT-USAFP/UNIFORMED-FAMILY-PHYSICIAN-NEWSLETTER/

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The Value Of Uniformed Family Medicine Physicians

Have you ever been at a social gathering or on a plane, making small talk with new friends who have no familiarity with the military, and the question comes your way, "so, what do you do for a living?"
How do you answer? Usually, my conversation goes something like this:
"I am a physician in the Air Force," I reply.
"Oh, do you, like, have to wear a uniform and everything?" the person asks.
"Yes, I wear a camouflage uniform to work every day."
A response which usually triggers wide eyes and an open mouth on the inquirer.
"It's nice, I don't have to decide what to wear," I joke, to lighten the conversation.
Then the inevitable question ensues:
"Why?"

Think back to when you joined the Air Force. We all had our reasons for joining: family tradition, pride and service to our country, money for medical school tuition, medical benefits and retirement, travel and adventure, to name a few! These examples might explain why we personally have chosen to wear the uniform, but *why does the Air Force need us in uniform?*

As the Military Health System (MHS) undergoes historical change, there is an imperative to define a comprehensive, evidence-based role for the ***Uniformed*** Family Physician. Robust Air Force Family Medicine Physicians (44F3s) are the backbone of medical support for the Air Force Medical Service (AFMS) goals of achieving full spectrum readiness, strengthening the joint warrior team and driving transformation.[12] We do this by directly contributing to worldwide primary care, providing battlefield care, enabling cost-effective military primary care, and maintaining a medically ready force. In the following article, I will share with you some of the reasons why we proudly wear the uniform and how we provide value to the Air Force.

WE ARE OPERATIONAL

The 2017 National Defense Authorization Act (NDAA) Section 725 specifies capabilities for the provision of services in operational health care. [3] Military Family Physicians deliver these requirements to the battlefield. In fact, we possess the knowledge and skills to manage over 1600 symptoms and diagnoses. [9] Our diverse skill set is requested for approximately 50 annual deployments (18% of our clinical authorizations), far exceeding the numbers of other physician specialties [4] in the Air Force medical corps. Our training enables us to stabilize and treat patients in the emergency department setting, assist in the operating room, manage inpatient wards and evaluate all conditions that present to the deployed ambulatory clinic. For example, in the deployed setting we manage non-combat musculoskeletal injuries--up to 34% percent of troops suffer this while deployed and this accounts for 24% of all medical air evacuations.[11] In addition to supporting overseas deployment operations, our Air Force Family Physicians are permanently stationed at air bases worldwide! These clinicians are considered forward deployed and are the sole source of primary care for many active duty and their dependents. Also, Family Physicians actively participate in international healthcare activities to include education and training, traveling to partner nations and sharing knowledge and skills through the promotion of Global Health.

WE ARE FUNDAMENTAL TO HOMESTATION CARE AND MEDICAL READINESS

Family Medicine is the bedrock of cost-effective health and readiness in military primary care. According to the 20th report of the Council on Graduate Medical Education on Advancing Primary Care, better health care outcomes and lower costs relate directly with increased availability of primary care physicians.[5] An increase of one primary care doctor per 10,000 people reduces Emergency Department visits by 10.9%, decrease outpatient visits by 5%, and decrease inpatient admissions by 5.5%. [6] When able to practice full scope care, Family Physicians can perform women's health procedures, musculoskeletal injections, laceration repairs, spirometry, ultrasound imaging, and a diverse array of skin procedures. Each of these skills proves highly useful in the deployed environment and can reduce costly specialty referrals and expedite care in garrison.

The daily operations at home stations across the world require keeping our Airmen medically ready for duty. This imperative to the Air Force Medical Service Strategy primarily falls on our 76 Military Treatment Facility Family Health Clinics

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where we serve as Medical Directors and Primary Care Managers (PCMs) for the approximately 262,591 non-flyer Air Force active duty population.[10] Subsequently, most medical profiles are written by Family Health clinicians. Improving focus on the Deployment Availability Working Group (DAWG) and streamlining expedient care is essential for our active duty to either return to full readiness or medically separate from active service. To best meet the Secretary of Defense's "deploy or get out" directive, we will be *actively* facilitating the care of the Airmen on profiles just as flight medicine manages their pilots who are DNIF. Family Medicine teams will shape the future of the Operational Medical Readiness Squadrons (OMRS) and be key to the continuous readiness of the human weapon system.

WE TRAIN MILITARY FOCUSED PHYSICIANS

The MHS has a vested interest in training and growing our Military Family Physicians. Continuing high quality military Family Medicine Graduate Medical Education (GME) is essential for our pipeline and ensures our physicians have the knowledge, skills and abilities (KSA) to support our combatant commanders and specialized active duty line units. By managing our own training programs, the Air Force can ensure key operational KSAs are obtained during residency while still maintaining the broad clinical exposure required for medical excellence and national accreditation. Our six Air Force Family Medicine Residency programs have Sports Medicine Fellowship trained physicians on faculty to ensure that Family Medicine graduates achieve proficiency in musculoskeletal care: one of the most common etiologies of fitness, duty, and deployment limitations. Additionally, military trained Family Physicians can hit the ground running at their first duty station with minimal ramp up time. Studies corroborate the quality and sound investment of military GME: our graduates have first time board certification pass rates of 95% vs 87% national average [7] and longer overall retention rates than civilian-trained counterparts.[8]

WE SUPPORT AEROSPACE MEDICINE

Over the years, many Family Medicine physicians have transitioned to flight medicine; we make ideal flight surgeons due to the similarities in patient demographics and a solid foundation of military primary care fundamentals. In the future, we will move towards incorporating more Aerospace Medicine exposure during Air Force Family Medicine Residency; this will allow for residents to get experience in the fundamentals of flight medicine early on. Continuing to grow our joint pipeline with Aerospace Medicine in Family Medicine GME programs would benefit the Air Force by integrating operational exposure into training and benefit our aviation community by providing highly trained physicians for our approximately 50K active duty personnel on flying status.

WE ARE MILITARY LEADERS

Family physicians also contribute greatly to the ranks of AFMS leadership. Roughly one hundred (25%) of us across the AFMS are serving as Medical Directors, Chief of the Medical Staff, Group and Squadron Commanders, Graduate Medical Education Faculty, and in other positions at Air Staff and Headquarters

levels. Every year, we see many 44F3s move on to these duties as part of military career progression. Every one of us is a leader in some way, even without an official title, right down to the new Captain PCM on the Air Force Medical Home team, where we lead our technicians and nurses in the care of our patients. Physician leadership is valuable and we need to step up and be an advocate for patient safety and full-scope quality care, especially during this time of transition for the MHS. Family Medicine physicians have, and will continue to have, a strong voice in the discussion--we are driving innovation and transformation.

CONCLUSION

In conclusion, strengthening Family Medicine is more important than ever as we reshape the Military Health System. While we all chose to join the Air Force for a variety of reasons, we are united by our uniform in the service to our country. Family Physicians are leaders who possess the knowledge, skills and abilities that are essential to achieving our AFMS goals--we are more relevant than ever to the future of military medicine. Just as the theme for our 2019 USAFP Annual Meeting states, we are: Ready! Teaching, Healing, Leading into the Future! My fellow Family Physicians, thank you for your dedication to our patients, contributions to the Air Force and your service to our country. Next time you are asked, "why do you wear the uniform," how will you answer?

For source documents, information about deployments, and hot topics in Family Medicine, check out our updated knowledge exchange page: https://kx2.afms.mil/kj/kx1/FamilyMedicine/Pages/home.aspx

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consultant's report

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Greetings and Happy New Year, Public Health Service and Coast Guard Family Physicians! I hope you all enjoyed the holidays and some time with family and friends. Best of luck to everyone eligible for the 2019 promotion cycle. As you know, several new policies have been made regarding Readiness Compliance, Health Profession Special Pay, and Involuntary Separation. Please make sure you review these new policies and check to make sure your readiness information is up to date.

Our Chief Professional Officer, CAPT Brian Lewis (Brian.Lewis@fda.hhs.gov) and the Physician Professional Advisory Group (PPAC) have been working together to help us understand all of these new policies. As of this writing, there are no updates on clinical requirements for physicians in non-clinical billets, except that we all have a clinical requirement of 80 hours per year in order to receive special pay, with few exceptions.

Be sure to check out the website for the 54th Annual Scientific and Training Symposium at the Minneapolis Convention Center, May 6-9th, registration opens March 1.

By the time you receive this issue of *Uniformed Family Physician*, we will have a new PHS/CG member for the USAFP Board of Directors. It has been my pleasure serving and representing you to the Board, and wish our incumbent Board member all the best.

That's all I have for now.

Sarah.Arnold@fda.hhs.gov

consultant's report

NAVY

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Greetings, fellow FP'ers! Welcome to the winter edition of my periodic news. This is an exciting time for Navy Medicine with MEDMACRE, DHA transitions, and talk of divestitures. Like you, I hear rumors of varying degrees of reliability. And no doubt some of the uncertainly can be anxiety provoking. I see it as one of my roles to be a source of timely and accurate information. This article is one avenue for sharing information with you. So with that introduction, let's get to some updates.

SPECIAL PAYS

Hopefully by now you've received the FY-19 Special Pays announcement with guidance. One of the new items is the addition of a 6 year retention bonus for Critical Wartime Specialties…which includes Family Medicine. I recommend you use this annual update as a reminder to check your LES's to make sure you are getting paid appropriately. If you have a question about your pays that cannot be answered by your local PSD, send an email to the BUMED Navy Medical Special Pays Program at usn.ncr.bumedfchva.mbx.specialpays-bumed@mail.mil. Another resource is the Corps Chief's Office Career Planner, CAPT William Beckman (William.a.beckman.mil@mail.mil.)

CONFERENCE APPROVAL:

Our Annual Meeting is nearly upon us. For those planning to attend, the date (5-10 Mar 2019) and location (St. Louis, MO) are no secret. Our community's request to attend was submitted on time (91 days in advance!) and I am keeping my fingers crossed that we will have received a positive response by the time this article is released (Approved!). If not, you can track it (and any other conferences that are being reviewed) right along with me by surfing over to the BUMED's Conference Information and Policy page at: https://es.med.navy.mil/bumed/m00/m00c/Pages/conferenceinfo.aspx.

POST-USAFP ACTION ITEMS:

Once you return home from attending USAFP, I will need you to add one more item to your "to do" list. I am required to account for EACH sailor that attended, and provide the final dollar cost to the Navy…within 2 weeks of the conference end. Thus, as soon as you know the cost of your TAD from your DTS voucher, please send that $$$ figure to me. ** Please be sure to include the cost of the conference FEE, which may not be included in your DTS voucher. *** Finally, if you were originally approved to go, but for some reason could not make it, than please let me know as well.

PERFORMANCE EVALUATION TRANSFORMATION:

On 10 Nov 2018, NAVADMIN 279/18 provided an update on the efforts to transform our performance evaluation process to one that places an emphasis on merit over seniority or tenure. It will eliminate forced distribution and rate performance on a paygrade-based objective standards. The effort is in phase III of 5 proof-of-concept testing, with a test population of 10,000 sailors from 140 active and reserve commands. For more details, check out the entire NAVADMIN.

PROMOTION PREPARATION

On 17 Dec 2018, the FY20 Promotion Boards and Medical Corps Lineal List Promotion Plan were released, along with the schedule for promotion boards for this year (for promotion in FY-20). It serves as our annual reminder that time marches on, and preparation for your next promotion is an essential task. While CAPT and CDR boards will be happening close to the publication of this newsletter (05 Feb and 26 Mar respectively), I highly recommend preparing NOW for FY-21 promotion boards. Look at FY-20 promotion zones to estimate where you are in the promotion cycle, and prepare your records for your next board. *Remember, it is your record that gets promoted…make sure it accurately reflects your service.* If you have not yet had a Career Development Board (CDB) at your local command, ask for one. Your detailer and I are also here to provide guidance. If you plan to communicate with the selection board, know that only eligible officers may send in correspondence, and it must arrive no later than 10 calendar days before the convening date of the board.

DIVESTITURES (POM20)

Some of you may have started to hear talk of plans for divestitures in Navy Medicine. In other words, billets across the medical department are on the table for reductions. The title for this initiative is *Project Objective Memorandum 2020*. There is still a lot that is not known, and details are still being ironed out. So I do not have reliable detailed information to share with you. But I do know this issue touches our sister

Services as well and that these cuts are separate from MEDMACRE. What any reductions will finally look like is still to be determined, and our leadership is actively engaged in the right mix to support our mission and YOU. To keep you in the loop, I send out emails to the community when available. Another reliable (although not official) option is to periodically check MCCareer.org (*see below*.) I also invite you to reach out to me directly with any questions or concerns.

COMMUNICATION:

I've mention the below list of communication venues for us to stay connected as a community, corps, and Service, and they bear repeating for your ready reference:

- Office of the Corps Chief Website: A Medical Corps Homepage has been created via the BUMED SharePoint in an effort to improve timely communication and serve as a repository of useful info: https://esportal.med.navy.mil/bumed/m00/m00c/M00C1/ (NOTE: page is CAC enabled.) Such items as billet announcements/detailing opportunities, and career management resources can be found there.

- Milsuite.mil (https://www.milsuite.mil): Another CAC-enable website, this DoD sponsored site was started as a knowledge management endeavor. A Navy Family Medicine group has been created, where you can find a cornucopia of information (search: "Navy Family Medicine"). I'll be posting information here, which I will link in emails sent out to the community.

- MCCareer.org: The *Navy Medical Corps Career Blog* is a great repository for career management. This site is highly recommended as you prepare for your next career milestone and promotion.

- Email: If you have not received any community announcement emails from me, then I probably do not have you in my email group. Send me an email at james.w.keck.mil@mail.mil, and I will get you added. Family Medicine leaders at local commands, I ask you to please check with your FPs to see if they are getting my emails to ensure they are in the loop.

That's all for this edition. Thanks for all you do and don't hesitate to reach out to me with any questions or concerns. Stay well!

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Combating Poor Test Taking SkillsLeader and Faculty Development

Even though many of us are already well versed in standardized tests, the significance of the results can give anyone pause. For those few who experience failure, it can be devastating. Failure has a tremendous impact to the individual as well as the organization and those who fail once are much more likely to fail again. For the individual, the most obvious ramification is the potential impact on their career, but there can also be significant psychologic ramifications. For the organization, it requires a significant amount of time and resources to remediate the deficiency. Between 7-28% of residents required formal remediation at some point during training. The impact of a single struggling learner on a residency program required a median of 18 hours of faculty time for remediation. The scope of the problem is vast as well with 94% of internal medicine programs surveyed in 2000 having at least one struggling learner. A recent study, published in Academic Medicine, isolates poor test taking skills into six distinct subtypes as well as providing guidance on strategies for remedying these issues. Given the impact and pervasiveness of this issue, it is imperative to address test taking deficiencies as soon as possible.

These deficiencies can easily and quickly be teased out by having the test taker read clinical-vignette-style test questions with an uninterrupted think-aloud exercise with a preceptor using the question review form. They should read the question aloud as well as their thought processes and decision making. The preceptor covers the answers as well as the last sentence of the stem question; e.g., the actual question being asked. The learner then reads the paragraph aloud and answers the questions from the question review form in succession. Here are some strategies for recognition and solutions for six distinct subtypes:

1. *Lack of script recognition*. After reading the question stem, the test taker fails to identify the diagnosis, the clinical scenario and/or disease severity, supporting factors, or inconsistent factors (if any). For example, they might not recognize that a 70 year old male tobacco user presenting with a cough might have COPD. In order to remedy this deficit, have the test taker engage the test question in terms of disease script (classic signs and symptoms of a disease process) from the start. Have them sort clinical information based on the script and change scripts if needed to accommodate new information. Have the test taker study disease in context of clinical presentation and ensure clinic exposure to enrich disease scripts.

2. *Lack of script specificity*. The test taker can recognize the diagnosis but gives incomplete or inaccurate information about the clinical scenario and/or disease severity, supporting factors, or any inconsistent factors. The test taker can often narrow down their answer to two choices since they recognize the diagnosis, but cannot delineate any clinical subtypes, severity, or differences in diagnostic strategy, therapy, or prognosis related to the disease subtype. In the case of the 70 year old patient with COPD, they might recognize the diagnosis but not be familiar with all the treatment options presented. In order to resolve this deficiency, by again, having the test taker engage the test question in terms of disease script and specific clinical scenario from the start, then refining the disease script using the clinical information to deduce the severity and/or subtype of disease. They should study the different diagnostic, therapeutic, and prognostic implications of disease subtypes and increase clinical exposure for richer scripts.

3. *Premature closure ("jumping to a conclusion")*. Test takers who display this deficiency will make an early decision on the diagnosis, ignore or fail to recognize inconsistent information, and may list facts that are inconsistent with their chosen diagnosis. Let's return to our 70 year old patient with COPD. If the question states that he just completed a long flight, the test taker with premature closure might decide that it is a pulmonary embolism and then ignore the smoking history or other inconsistent information. To combat this issue, the test taker should stop after reading the question stem and note the features supportive of the diagnosis as well as features which are inconsistent with the diagnosis. They should address all markedly abnormal findings and essentially *prove* that their diagnosis is the correct one.

4. *Underconfidence*. Test takers who display underconfidence will often have a history of several examination failures or suboptimal performances and have subsequently learned to

distrust their clinical reasoning. The test taker knows the answer but will talk themselves out of the correct answer while reading aloud. In order to combat this, they should rate their confidence after answering and compare mean confidence scores on questions answered correctly vs. incorrectly. Over time, the test taker will re-calibrate their own confidence and learn to trust their clinical decision making.

5. *Inappropriate causal attribution*. This deficiency is evident with superficial or incorrect explanations of why the right answer is correct and the wrong answers are incorrect. The test taker is unable to articulate why they got the answer that they did because they are relying on key words/associations. They have a limited understanding or knowledge of the underlying disease process. They might prescribe an antibiotic because they know that that it is commonly prescribed, but might not know the mechanism of action and situations where this might not be appropriate. In order to solve this issue, the test taker should examine each answer and explain why it is right or wrong during practice questions. They should predict the annotated answer and think about situations in which the wrong answers would be correct. Ideally, they should also cut back on the number of questions per practice session to allow for an in-depth review of their answers and speed back up when the deficit is corrected.
6. *Inappropriate adaptive inferences*. The test taker will be able to identify their knowledge gap after answering a practice question, but be unable to articulate an effective learning plan. For example, the test taker might correctly identify the disease script as acute hepatitis B infection, but picks the wrong serologic test might have a remediation plan to 'read more about hepatitis B'. The solution for this deficiency is to provide the test taker with an appropriate learning plan. In the case of the hepatitis B question, a more appropriate plan might be to make a graph of the different serologic markers of hepatitis B and the timing of each while explaining the markers which correspond to acute infection. Have them identify how they have mastered concepts in the past and mirror their learning plan to accommodate their personal strategy.

If the test taker understands the disease script in detail, they can explain why an answer is correct or incorrect, knows how to develop a study plan, but hasn't spent the time to learn the material, the reason behind the deficit should be explored. Specifically, secondary causes, such as learning disability, physical and/or mental health issues, personality disorder, substance abuse, or outside stressors (ill family member, etc.) should be carefully discussed and addressed if needed.

In conclusion, having a standardized method to remediate test takers with poor testing skills can not only help them reach their goals but it also allows the preceptor the opportunity to provide useful feedback. For further resources (such as the questionnaire), questions, or comments on this topic, please feel free to contact the Leader and Faculty Development Fellowship via email at: usarmy.jblm.medcom-mamc.cal.ldr-faculty-fellowship@mail.mil. I look forward to hearing from you.

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1. Guerrasio J, Aagaard EM. Methods and outcomes for the remediation of clinical reasoning.
2. J Gen Intern Med. 2014 Dec;29(12):1607-14.
3. Yao DC, Wright SM. National survey of internal medicine residency program directors regarding problem residents. JAMA. 2000 Sep 6;284(9):1099-104.
4. Andrews MA, Kelly WF, DeZee KJ. Why Does This Learner Perform Poorly on Tests? Using Self-Regulated Learning Theory to Diagnose the Problem and Implement Solutions. Academic Medicine. 2018 Apr 93(4): 612-615.

Looking for a mentor? Interested in mentoring others?

If so, check out: *www.usafp.org/mentorship*

HOW DOES IT WORK?

The program uses a brief intake survey to complete/to identify a mentee's needs and then matches that person with a mentor well suited to meet those needs.

WHAT AM I SIGNING UP TO DO?

Participant responsibilities are as follows:

- Communicate with your mentor/mentee at least once per quarter
- Before signing off, select a topic for discussion for the next session
- Continue the program for (at least) the next year
- Complete a brief feedback survey at the end of one year to help improve the program

WHEN AND HOW WILL I GET MY MATCH?

Matches are made on a rolling basis. Mentees should expect to receive an email identifying their mentor within 3 weeks of signing up.

IS THERE ANYTHING I CAN DO TO HELP?

Definitely! The success of the program is directly tied to member participation. Please consider signing up and sharing this information widely with your military Family Medicine colleagues, including retirees.

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Breastfeeding in Boots

In Family Medicine, we have the potential to interact with multiple members of the family during the many changes which occur during a pregnancy and the postpartum period. For those currently serving in the military, or working in military work spaces, some unique variables may also exist. While 75% of people initiate breastfeeding, by 6 months of age, the rate drops to 43%. In people of color, the initiation rates are estimated to be 58% and drop to 28% by 6 months of age. These rates fall short of the Healthy People 2020 goals of 82% initiation and 61% at 6 months of age. Below are some resources for discussions on lactation in military members.

1. **Maintain a healthy diet and adequate fluid intake**

   While a very basic recommendation, remembering to eat a balanced meal, and knowing what that means, can be challenging in the postpartum period.

   My Plate has an excellent resource for dietary needs when partially or exclusively breastfeeding, which you or your patients can utilize to determine ideal diet and fluid intake during this time. https://www.choosemyplate.gov/moms-breastfeeding-nutritional-needs

Military Breastfeeding Policies

Branch	Deployment	Supervisors	Private Area	Time	Breast Pump Equipment	Education	Other
Air Force	-12 month deferment from deployment after birth of child. -Remain eligible for field training and mobility exercises. BF encouraged.	Supervisors should work with AF members on a plan to continue breastfeeding	Provide private, clean area for milk expression; restrooms are not appropriate	-Attempt to arrange schedules to allow 15-30 minutes every 3-4 hours to express milk. - BF is not a reason for granting "excessive" time away from work	AF members supply their own equipment and handle storage of milk. Airmen in the field may need to discard milk collected.		Contact MTF or community hospital to ask for a lactation consultant. Airmen may be exposed to environmental contaminants and should discuss with HCP or Occupational Health.
Army	-6 month deferment from deployment after birth of the child. -Remain eligible for field training and mobility exercises. BF encouraged.	Discuss needs with supervisor or commander *sample letter available*	Soldiers will need access to a private space.	-Mothers will need 2-3 20-minute breaks during 8-hour workday. -BF is not a reason for granting "excessive" time away from work.	Army members supply their own equipment and handle storage of milk Soldier in the field may need to discard milk collected	Information provided on collecting and storing human milk, using a breast pump, frequency	Contact MTF or community hospital to ask for a lactation consultant. Soldiers may be exposed to environmental contaminants and should discuss with HCP or Occupational Health.
Coast Guard	Direct access to baby handled on a case-by-case basis.	Communicate with commanding officer to address concerns or issues	Commanding officer will ensure availability of a private, clean room for expressing milk	BF is not a reason for granting "excessive" time away from work	Coast Guard members supply their own equipment and handle storage of milk. Guardsman onboard ship may need to discard milk collected.		
Marine Corps	-6 month deferment from deployment after birth of child. -Remain eligible for field training and mobility exercises. BF encouraged.	Report to chain of command as soon as possible to allow for evaluation of the workplace	Servicewomen must be provided, at a minimum, a clean, secluded space (not a toilet space) with ready access to water source	-Mothers will need 2-3 20-minute breaks during 8-hour workday. -BF is not a reason for granting "excessive" time away from work.	Marine members supply their own equipment and handle storage of milk. Marines in the field or onboard ship may need to discard milk collected.		Contact MTF or community hospital to ask for a lactation consultant. Marines may be exposed to environmental contaminants and should discuss with HCP or Occupational Health.
Navy	-12 month deferment from deployment after birth of child. -Remain eligible for field training and mobility exercises. BF encouraged.	MTF and clinic personnel encouraged to develop plans to educate supervisors, COs, and OICs, including child development centers	Must provide private accommodations for breast milk expression with door that can be secured, running water accessible	-Mothers will need 2-3 20-minute breaks during 8-hour workday. -BF is not a reason for granting "excessive" time away from work.	Navy members supply their own equipment and handle storage of milk. Sailors onboard ship may need to discard milk collected.	Breastfeeding education should begin at first prenatal visit. Health care staff should be trained in breastfeeding management and counseling.	Navy strongly endorses BF for the first year of the infant's life. Free formula discouraged, and if given, must be accounted for, controlled, and issued with standard medical supply procedures. Sailors may be exposed to environmental contaminants and should discuss with HCP or Occupational Health.

*Note: MTF = "Medical Treatment Facility"

This is NOT an official DOD document and is neither endorsed nor approved by the DOD.

2. **Continue prenatal supplemental vitamin**

The recommendation to continue use of a supplemental prenatal vitamin during breastfeeding is based on maternal health and the metabolic demands of lactation. Obtaining nutrients and vitamins from food is preferable, but in many patients is not sufficient. Depending on dietary intake, dietary restrictions and if the person is attempting to lose significant weight postpartum, differing recommendations of supplemental vitamins may be recommended. https://kellymom.com/nutrition/vitamins/reference-intake-table/

3. **Adequate support system**

Support from family members, spouse, and peers can be very important in initiation and continuation of breastfeeding. Support can be evaluated during peripartum visits and postpartum visits. Online support groups can be useful, as well as in person options. https://www.mom2momglobal.org

4. **Workplace accommodations**

If you are in a supervisory position, discussing plans for flexible scheduling to accommodate ongoing breastfeeding or breastmilk expression may help reduce some maternal stress in returning to work. With all Service specific policies, supervisors are required to facilitate finding a comfortable private location, with running water and refrigeration, that is not a restroom. Different locations may have some unique challenges, and meeting with people returning to the workplace to discuss this early, is vital to remove a barrier for lactation continuation. https://emeraldcoastbreastfeeding.com/includes/MilBstfdngPolicies.pdf

5. **Lactation Friendly Uniform Components**

Over the past couple years, lactation friendly clothing has been increasingly visible. Recent uniform policies in the Army and Air Force have allowed for use of specific alternate components of the uniform to assist in ease of breastfeeding and milk expression. Discussing alternate uniform components helps open the discussion about breastfeeding in uniform, and helps normalize breastfeeding in boots. https://www.missmilitarymom.com/collections/uniform-breastfeeding-t-shirts

These are some things to consider as we move forward towards the Healthy Person 2020 goals, especially in our unique military population.

REFERENCES:

1. Ten Steps to Successful Breast Feeding
2. https://www.who.int/nutrition/bfhi/bfhi-poster-A2.pdf?ua=1
3. Baby Friendly Support for Parents https://www.babyfriendlyusa.org/for-parents/resources-for-parents/
4. Surgeon General Call to Action to Support Breastfeeding: https://www.surgeongeneral.gov/library/calls/breastfeeding/factsheet.html
5. Breastfeeding Resources:
6. https://phc.amedd.army.mil/topics/healthyliving/wh/Pages/BreastfeedingandBreastHealth.aspx
7. Mom2Mom: https://www.mom2momglobal.org
8. Breastfeeding Report Card: https://www.cdc.gov/breastfeeding/pdf/2018breastfeedingreportcard.pdf
9. Military Breastfeeding Policies: https://emeraldcoastbreastfeeding.com/includes/MilBstfdngPolicies.pdf

MEMBERS IN THE NEWS

The USAFP Board of Directors encourages each of you to submit information on USAFP "Members in the News" for publication in the newsletter. Please submit "Members in the News" to Cheryl Modesto at *cmodesto@vafp.org*.

NEWSLETTER SUBMISSION DEADLINE

REMINDER: The deadline for submissions to the Spring magazine is 30 March 2019.

RESEARCH GRANTS

The Clinical Investigations Committee accepts grant applications on a rolling basis. Visit the USAFP Web site at *www.usafp.org* for a Letter of Intent (LOI) or Grant Application. Contact Dianne Reamy if you have questions. *direamy@vafp.org*.

RESEARCH JUDGES

Applications for research judges are accepted on a rolling basis. Please contact Dianne Reamy (*direamy@vafp.org*) to request an application.

DO YOU FEEL STRONGLY ABOUT SOMETHING YOU READ IN THE UNIFORMED FAMILY PHYSICIAN? ABOUT ANY ISSUE IN MILITARY FAMILY MEDICINE?

Please write to me...
Debra A. Manning, MD, FAAFP
dr.deb.manning@gmail.com

PROMOTING RESEARCH IN THE MILITARY ENVIRONMENT

Have a great idea for operational research but are unsure where to start or how to get approval?
Whether you are deployed or in garrison, the USAFP research judges can help!
Visit us online at http://www.usafp.org/committees/clinical-investigations/ for resources or to find a mentor.

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Goals for the New Year – Growing Resilience!

Happy New Year! The older I get, the more amazed I am with how much faster years fly by. The year 2020 used to be some futuristic sci-fi stretch of the imagination. Now, it is less than a year away! It seems like yesterday we were dealing with Y2K!

Needless to say, the New Year is a natural cycle to reflect upon accomplishments and shortcomings from the past and re-evaluate goals for the future. The holiday period is often very refreshing and can inspire us to set ambitious goals. I am completely convinced that type-A well-disciplined military physicians have no difficulty setting and following through with resolutions! Okay, perhaps upon returning to work and demanding routines, well-intentioned change falls a bit flat.

So, this brings about a series of rhetorical questions. What was your reaction to your assessment of the previous year? What inspired you in future goal setting or motivated you to target change? Are your goals outcome oriented or process oriented? Where do you currently stand with regards to your new goals, and how does that make you feel?

Keeping in mind your answers to the questions above, let's see if we can use our reflection on the past and goals for the future to further build our resiliency. We will briefly review types of goals and then explore factors associated with resiliency. Resiliency and goal setting often work together.

To begin, establish a goal – there are many types to choose from. Outcome oriented goals focus on the end result and often compare you to others (score in the top 5% on certification exam/finish in the top 3 at a race). Performance goals identify a specific standard to be achieved (answer 80% of all questions correctly/run 2 miles in under 13 minutes). Process goals deal with a technique or strategy necessary to perform well (time management with answering questions/running with cadence of at least 180 steps per minute). Individuals have far more control over process goals than outcome goals. Process goals typically drive performance goals. I am a huge proponent for process goals as I see the reward in controlling the activity more so than being fixated by the result.

Now that we have a goal, let's take a closer look at resiliency. Resiliency is the process of adapting well in the face of adversity or significant sources of stress. Several factors associated with resiliency include having a positive outlook, being able to manage emotions effectively, being able to set and adhere to realistic plans, having an internal locus of control, and being able to view oneself as a fighter (opposed to being a victim). Resiliency is not an inherent trait, but rather a skill that can be developed over time. Emotional awareness, understanding what you are feeling and why, is pivotal in improving resilience. Understanding emotions can provide key information about what needs to change

in your life. Ideally, your emotions helped influence your goals above, helping provide a motivating reason for change. If not, no sweat! Change is difficult and often creates stress making challenging goals a tool to help build resiliency!

Personally, I have developed some very demanding fitness goals in my efforts to establish a work-life equilibrium – challenging fitness goals help me sleep better and eat more healthily while not being over-consumed by work. Not too long ago, I would feel exhausted and overwhelmed after an endless day of work not feeling like I had much control over anything. However, I recalled training for a marathon during residency and how it gave me some focus outside of work and how much better I felt when training for something than just going through the everyday motions of work. My "why" behind my goals is largely to drive balance, have fun, and to discover what the body is capable of doing.

Nonetheless, I feel very frustrated when I need to miss training sessions as work and life compete for my time. While I prefer afternoon training sessions in the warmth of daylight, these are most often lost in the struggle for time by everything else. If I do find time late in the day, my physical and mental energy are often lacking. This is NOT to say I wake up all excited, full of energy, and ready to train; however, I do tend to have more control over my morning than my afternoon. Accordingly, my daily goal is to get up and get through the first nine minutes of my training session before I make the decision to carry on or stop. More times than not, I feel better after nine minutes than I did when I started. However, if after nine minutes I'm not feeling any better, I stop and move on without regrets celebrating the win that I tried and understanding my body had different requirements for the day. Either way, I owned the part of the day I could control the most! (…there is no rhyme or reason for "9" – but single digits are always less daunting and getting started is over half the battle!)

The New Year is a great time for reflection and re-evaluation of goals. Regardless of your individual goals and desires, use the opportunity to focus on the process to drive change and build resiliency by understanding your emotions and controlling how you respond to adversity. If still scrounging around thinking about an actionable process goal, consider adding ten (well, maybe nine) minutes of reading to your daily routine. A few of my book recommendations include *Getting Things Done- the art of stress free productivity*, by David Allen; *Mindless Eating*, by Brian Wansink; and *Mindset*, by Carol Dweck. Happy New Year to all – and I look forward to seeing you at USAFP!

REGISTER NOW!

Register today for the USAFP 2019 Annual Meeting & Exposition scheduled 5-10 March at the Hyatt Regency St. Louis at the Arch Hotel in St. Louis, Missouri. The room rate is government per diem at $133.00 per night for single/double occupancy. Please register and make your room reservations today!

Visit **www.usafp.org/annual-meeting/2019-2/** for more information and to register.

USAFP 2019 Annual Meeting & Exposition: Ready! Teaching, Leading, Healing Into the Future

Programming Spotlight: Pain Symposium – *5 March 2019*

Pain Specialists treat complex and chronic pain patients. In Primary Care, we treat all patients with pain. Join us as we delve into the world of pain management, including:

1. Role of the Primary Care Pain Champion
2. The MHS Stepped Care Model
3. Setting Pain Treatment Goals
4. Opioid Safety in the MHS
5. Non-pharmacological treatment options

Visit www.usafp.org to learn more! Registration is included in the 2019 Annual Meeting materials.

USAFP 2019 Annual Meeting & Exposition
5-10 March • St Louis, MO

Clinical Pharmacology Fellowship Program

Clinical Pharmacology Fellowship

What is Clinical Pharmacology?

Clinical Pharmacology is concerned with better the understanding and use of existing drugs, and development of more effective and safer drugs for the future. Clinical Pharmacology allows one to stand between the research lab and the bedside, in a unique position to translate laboratory research Into new drug therapies. Clinical pharmacologists are a bridge between the science and practice of medicine.

Who can apply for the Fellowship?

The Clinical Pharmacology training program is available to active duty Army physicians who are board eligible/certified in a primary specialty and active duty Army PhDs/ PharmDs (71A, 71B, or 67E) who have a doctoral degree in one of the life or medical sciences from an accredited academic institution in the United States, Canada, or non-U.S. degree equivalent. A research background, mathematical inclination, and pharmacology/medical experience is preferred. Civilians could be considered if they joined the Army and successfully compete for a position in the program.

Additional activities include:

- Conduct laboratory, animal, or clinical research under the supervision of a mentor
- Participate in the teaching of Clinical Pharmacology to medical students, house staff, and practicing physicians
- Three month rotation with a review division at the FDA
- Participate in continuing medical education, research seminars, and journal clubs

Potential Job Assignments

- WRAIR (Silver Spring, MD)
- USU (Bethesda, MD)
- Overseas labs (Thailand, Kenya)
- USAMMDA (Ft. Detrick, MD)
- USAMRIID (Ft. Detrick, MD)
- USAMRICD (Aberdeen Proving Ground, MD)

Walter Reed Army Institute of Research
http://wrair-www.army.mil

Contact: MAJ(P) Jeffrey Livezey, MD,
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Uniformed Services University
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Scholarship in Military Family Medicine – the USAFP Clinical Investigations Committee and the USU Military Primary Care Research Network

Many of us graduate from medical school with big plans to do research or pursue scholarly activities, however, we quickly learn that the knowledge and skills to fulfill those plans weren't taught in medical school or residency. If you are anything like me, when I became a junior faculty member at Naval Hospital Jacksonville, I really didn't have a clue on how to begin to put together a research protocol that would come close to being approved by an Institutional Review Board (IRB). Reaching out to my colleagues, I quickly learned that they all had similar experiences and that any success they had came largely through trial and error. There were few resources available to provide support and guidance. Fortunately, times have changed. USAFP members have two resources available to them to assist in their scholarly pursuits.

The Clinical Investigations Committee, chaired by COL Robert Oh, is charged with promoting scholarly activities, in general, and in particular original research among Academy members, and helping to educate USAFP membership in areas of research and scholarly activity. As you are likely aware, each year, the Committee organizes and judges the Research Competition at the Annual Meeting. Information on the competition can be found at: https://www.usafp.org/research/abstract-submission-competitions-categories/.

The Clinical Investigations Committee also provides on-line resources for Family Physicians looking for guidance on how to get started in research. These resources can be accessed through the USAFP website at: https://www.usafp.org/research/. The committee is currently in the process of reviewing and updating the materials found on those pages to include more multimedia presentations. Check back often for updates.

Finally, the Clinical Investigations Committee, oversees the USAFP Grants Program. The Committee reviews Letters of Intent/Applications on a rolling basis. Applications are available for both Small (up to $1500 for up to 2 years) and Large (from $1500 to $ 5000 for up to 3 years) grants. Small grants require only a letter of intent in order to be considered for funding. Large grants additionally require a full application which can be found at: https://www.usafp.org/research/usafp-research-grants-program-large-grant/. A USAFP Research Grant is a great way to obtain funding to carry out smaller research projects at your local command.

In addition to the USAFP Clinical Investigation Committee, USAFP members at one of the 15 DoD Family Medicine Residency programs can also access the Military Primary Care Research Network (MPCRN). The brain child of Col (Ret) Brian Reamy when he was the Chair of Family Medicine at USU, the MPCRN has steadily grown over the past decade or so. The MPCRN promotes physician inquiry, discovery and improvement to enhance patient care. Our Leadership Team is based at Uniformed

Services University and we connect medical professionals at the 15 military family medicine residency training sites to promote collaborative scientific inquiry and physician improvement. MPCRN now supports more than $6 million in intramural and extramural grant funding toward its goal of promoting physician inquiry, discovery, and improvement to enhance patient care. The core team includes Christy Ledford, PhD (Research Director), Stephanie Bunt, PhD (Director of Program Development), Chris Bunt, MD (Medical Director), Lauren Cafferty, MA (Clinical Research Coordinator), and Jeremy Jackson, BA (Publications Coordinator).

The two primary ways to get involved in the MPCRN are through investigator initiated original research and network opportunities. For investigators who have their own ideas for a research project, the MPCRN can assist with guidance in study design, statistical analysis and editorial/publishing assistance. Additionally, for those looking for network opportunities, the MPCRN can facilitate connections with other residents and faculty who are planning upcoming projects or are involved in ongoing projects that are seeking local Physician Champions. For additional information please see: https://www.usuhs.edu/mpcrn.

The MPCRN also has direct outreach to the residencies. Members of the core MPCRN team conduct site visits to residency programs. During these visits, team members provide education to residents and faculty and are available for on-site consultation on scholarly project ideas. For a schedule of upcoming visits, please see the website above. MPCRN is currently working to develop online resources to augment those currently available on the USAFP website. Please stay tuned for additional information on this effort.

At the USAFP Annual Meeting in March the Clinical Investigations Committee and the Military Primary Care Research Network will join forces to present the Research Mentors Workshop. This workshop will be held on Friday 08 March from 1330 to 1800. During this session, the core MPCRN team will present on current efforts and will seek ideas for future projects. MAJ Adrienne Bell will present on how to develop a poster presentation. Following Dr. Bell's presentation, members of the Clinical Investigation Committee will facilitate a small group session during which participants will "score" posters in order to identify what makes a poster "good". While this session is primarily for Research Mentors at the residency programs, we welcome anyone who is interested in the topics to be presented.

We look forward to seeing you at one of the many Clinical Investigations Committee or MPCRN activities at USAFP!

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Top Medical Apps for Winter 2019

Greetings! Here are four recent apps for your smart device to ensure you are practicing the best evidence based medicine at the point of care!

1. PE AND DVT DX: DR STEINBERG UPDATES HIS GREAT APP TO INCLUDE PREGNANCY

One of the most common diagnosis in inpatient medicine is venous thromboembolism (VTE). According to the Centers for Disease Control and Prevention (CDC) as many as 900,000 people per year are affected by VTE. Tragically, upwards of 100,000 people die of VTE; 30% die within 1 month of the diagnosis. Due to these sobering statistics, the proper and timely diagnosis of VTE is critical. There are several accepted clinical decision rules for VTE most commonly used being the Well's Criteria and the Geneva Score. The original Well's score for DVT was published in 1997 and Well's PE score in 2000. Since then countless validation studies have been published including those that incorporated the scores with the d-dimer lab test and radiographic modalities including ultrasound, CT and VQ scans. When these scores are combined with the above labs/rads, the positive and negative predictive value of the tools increases significantly. This permits providers to "rule-in" and "rule-out" VTE quickly using a point-of-care calculator. The scores can be found on many calculator apps such as MDCalc, QXCalculate, but few combine all of the calculators including Geneva in one app with all of the supporting literature. For more than 10 years, I have been using Dr Joshua Steinberg's original DVT/PE app for palm, then Window, and most recently iOS. He has just updated this app to now include VTE diagnosis in pregnancy using the Geneva score in addition to the classic Well's scores for DVT/PE.

Evidence based medicine

The app contains information from the most widely accepted publications on the work-up of VTE including the original Well's studies, the Christopher Investigator studies, review articles on the topic, and a recently published study on the work-up of VTE in pregnancy. The app cleverly assembles this data into easy to follow algorithms using the Well's criteria for DVT and PE, Geneva score for VTE in pregnancy, and various modalities including d-dimer, lower extremity ultrasounds, CT, and even VQ scanning. The app is a one stop shop for VTE diagnosis.

Price

o Free

Likes

Evidence-based algorithms now updated with the latest studies.

Question based format for navigating many sections of the app with auto-screen switching.

Covers multiple scenarios and multiple diagnostic testing modalities.

Dislikes

App doesn't perform any "math"/ calculations for the user.

Pictures of algorithms do not pinch/ zoom/landscape.

Not available for Android.

Overall

An outstanding update to one of Dr Steinberg's original apps. PE/DVT Dx now includes the ability to work-up DVT/ PE in pregnancy using data from a recently published study. He also has made some more minor changes to the interface, added more references, and some under the hood improvements. The app is still basic in that you have to do "your own math" on the Well's and Geneva scores, but otherwise is very user friendly. It is indispensable for providers who work-up VTE patients.

Available for Download for iPhone and iPad. Not available for Android at this time.

o https://itunes.apple.com/us/app/pe-dvt-dx-tool/id415226337?mt=8

2. DIZZYFIX: TEACHES THE EPLEY MANEUVER FOR VERTIGO ON YOUR SMART DEVICE

"I'm dizzy, doctor!" Those were the words of a patient I saw in clinic recently. Upon further questioning, it was clear this patient had vertigo. The question was what type? Luckily, a good patient history and physical exam can both make a solid diagnosis and in some cases, treat the patient. Primary care providers must know how to properly perform the Dix-Hallpike maneuver to help make a diagnosis of vertigo especially the most common form, Benign Paroxysmal Positional Vertigo (BPPV). Luckily, the vast majority of vertigo cases seen in primary care are due to BPPV and this very disturbing condition (for the patient) can be effectively treated in nearly 90% of the cases by proper performance of the Epley Maneuver. An enterprising ENT physician and inventor in Canada, Dr Matthew Bromwich, created a unique solution to BPPV. He created an app called DizzyFix for providers to teach proper diagnosis and treatment of BPPV using the Dix-Hallpike and Epley Maneuvers, and the DizzyFix device that patients can place on any "ball cap" to guide them through the Epley Maneuver at home.

Evidence based medicine

DizzyFix comes from the DizzyFix company who markets a DizzyFix device for home use by patients with BPPV. The app and device are designed by an ENT provider, Dr Matthew Bromwich from Canada. The device sells for $150 CDN and is available on Amazon.com. There is some evidence for the device published in the medical literature and some for the app as well. Both help providers and patients perform the Epley Maneuver which does have solid evidence. The app unlike the device is for providers to help ensure a proper diagnosis and initial treatment of BPPV. The app is based on solid literature for the proper diagnosis and treatment of BPPV with the Dix-Hallpike and Epley Maneuvers. The detailed educational section of the app contains more than 60 medical references.

Price

Free to download; $8.99 for full version via in-app purchase.

Likes

High quality videos demonstrating proper performance of the Epley Maneuver.

Numerous educational sections on other vertigo diagnoses, evaluation, and treatment.

Education section well-referenced.

Dislikes

App is expensive and videos about Epley available on YouTube.

Use of app can be cumbersome per the included instructions.

Not available for Android.

Overall

DizzyFix is nearly the perfect solution for the evaluation and treatment of BPPV in the office setting. The app walks providers through the diagnosis and treatment of BPPV via the Dix-Hallpike maneuver for diagnosis and the Epley Maneuver for treatment. The app is fairly easy to use and takes advantage of the iPhones sensors. The primary downside is the price for the in-app purchase. Basic videos of the maneuvers are available on the internet.

Available for Download for iPhone, and iPad. Not available for Android currently.

- o https://itunes.apple.com/us/app/dizzyfix/id368171014?mt=8

3. CDC PNEUMORECS: ENSURES YOUR PATIENTS RECEIVE THE CORRECT PNEUMOCOCCAL VACCINES AT THE RIGHT TIME IN THE RIGHT SEQUENCE

One of the most common tasks during clinic is to ensure my patients are up to date on their vaccinations. In 2015, the CDC/FDA/ACIP introduced the new pneumococcal conjugate 13 valent vaccine (PCV13) for use in adults in addition to the pneumococcal polysaccharide 23 valent vaccine (PPSV23). For many of our clinic's nursing staff, residents and faculty, the transition caused some confusion. The guidelines have been revised slightly since then with the most current pneumovaccine guidelines published in November 2018. Despite updates to existing "shots" apps such as Shots by STFM, CDV Vaccines and ACP Immunization Advisor, the process can still be challenging to explain to patients and ensure immunizations are given at the right time and in the proper sequence. Recently, the CDC entered the pneumovaccines fray with their own app to help providers called, CDC PneumoRecs. This app covers both infant/child as well as adult pneumovaccines. The app uses a patient's date of birth (DOB) to calculate which vaccine(s) the patient requires, when, and in what sequence based on age and risk factors.

Evidence Based Medicine

CDC PneumoRecs utilizes the 2018 vaccine guidelines published by the ACIP and the CDC in Morbidity and Mortality Weekly to create an app that provides the recommended pneumovaccine based on age, risk factors, and dosing interval. The app does not contain any reference tables or PDFs, but does link to the CDC website.

Price:

- o Free

Likes:

Utilizes the 2018 ACIP and CDC vaccine recs.

UI uses patient date of birth to calculate the correct vaccine based on indication and proper dosing interval.

Available for Android.

Dislikes:

Does not include any tables or PDFs of the actual recs.

Hyperlinks for references included in app.

UI forces use of DOB/can't just enter patient's age.

Overall

The CDC helped to create the existing crazy pneumonia vaccination recommendations so appreciate the effort to simplify the guidelines at the point-of-care. The app is almost too simple, lacking any of the supporting documentation. For a more detailed pneumovaccines app (though more focused on adults) check out Dr Steinberg's PVax app. Overall, the new CDC PneumoRecs app may help increase vaccinations and ensure the proper sequence of vaccines is provided just by using a simple app.

Available for Download for iPhone, iPad, and Android.

- o https://itunes.apple.com/us/app/pneumorecs-vaxadvisor/id1440647099?mt=8
- o https://play.google.com/store/apps/details?id=gov.cdc.ncird.pneumorecs&hl=en_ US

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Five Ways to "Think Operational"

Following the 2018 USAFP Annual Meeting, the Board of Directors rebranded the Operational Medicine Committee's focus to include readiness and remind members that, whether or not you consider yourself operational, you really are. After all, Family Medicine physicians are the front lines of military health care.

Here are five ways to "think operational" next time you lace up your boots and throw on a stethoscope to see clinic:

1. ASK YOUR PATIENTS ABOUT THEIR JOBS.

I ask this question every day in my Flight Medicine clinic, but there is no reason why it should be overlooked in Family Medicine. The ankle sprain duty restrictions I provide to a Security Forces defender will probably look different from those given an administrator who rarely leaves their desk. Even within one career field, you may have someone who flies the proverbial "mahogany bomber" (Air Force speak for a desk) versus their colleague that works in the summer sun to build a new road or fix aircraft. Duty and mobility restrictions are the primary mechanism for the medical team to communicate with a member's commander or supervisor, and need to give leaders appropriate expectations on how to utilize their troops.

Asking patients about their specific work duties not only provides clinicians with a more accurate picture of occupational risks and appropriate duty restrictions but also establishes rapport. One of the best books I have read is the timeless *How to Win Friends and Influence People* by Dale Carnegie. In the book, one of Carnegie's first tips on conversation is that people enjoy talking about themselves and have a desire to feel important.[1] Asking a patient about work not only provides them a listening ear, but also gives you an opportunity to better understand their duties and how they fit into the military mission. While not explicitly stated, asking about a patient's career also offers a chance to practice active listening and understanding a patient's lifestyle, two suggestions from the AAFP on building doctor-patient relationships.[2]

Finally, checking a member's occupation is the last line of defense in ensuring they have an appropriate occupational/operational disposition. Air Force colleagues will be familiar with Arming Use of Force (AUoF) regulations, that is, the specific protocols that must be followed to report concerns about a Security Forces member's ability to carry a weapon. At most Air Force bases, AUoF personnel are empaneled in Family Medicine. Similarly, I have seen instances where aircrew, or other career fields that should be assigned to Flight Medicine, are not appropriately identified when registering with TRICARE and end up under Family Medicine. While these service members are still receiving expert care, not getting appropriate aeromedical dispositions on their note jeopardizes their flying status. Despite having several mechanisms in place to prevent these scenarios (e.g., the infamous Swiss cheese model), it still occurs.[3] Often the attentive front desk personnel or the operationally minded Family Medicine physician discovers these clerical errors by simply asking about the patient's job.

2. CHECK INDIVIDUAL MEDICAL READINESS (IMR) OF EACH PATIENT AT EVERY VISIT.

Review a member's IMR during clinic visits. The extra few seconds it takes to inform the patient of needed immunizations or deployment health exams is much easier than weeks of phone tag to get a patient back to the treatment facility. An easy way to do this is to ask the technician to incorporate IMR in the chart scrub before clinic, which will help identify multiple missing IMR items over the course of a typical day.

With the Defense Health Administration now handling much of the care we deliver, readiness remains a service-specific function. While accessing sister service IMR systems may feel cumbersome, each branch of service is diligently working to make them more interoperable. Every physician visit is an opportunity to ensure that members are operationally ready to deploy. Through ASIMS, the Air Force medical readiness portal, I can now update a PHA or check most IMR data on sister service members across all branches despite lacking direct access to MEDPROS (Army)

or MRRS (Navy/Marines/Coast Guard). Sister service personnel should also have a liaison, or someone with access to their respective system, to help input new data. Bear in mind, this could even be someone at another installation. For example, at Scott Air Force Base, we send vision screening and profile updates for Army personnel to an office at Ft. Leonard Wood for input into either MEDPROS or E-Profile.

3. ASK TO VISIT A WORK CENTER.

This concept may not be helpful for everyone, but chances are there are a fair number of readers who have entire specific units or duty sections empaneled to them. Using the AUoF example, many installations have a particular Family Medicine team that is responsible for all Security Forces members. These situations create opportunities to get to know a unit, their leadership, and their mission, not to mention what they actually do (see the first recommendation). At my last base, the Family Medicine physician with Security Forces even had the chance to wear a protective suit and be "attacked" by military working dogs. Opportunities like this not only better connect you to your patients and the missions you support, but they may even provide some fun memories.

4. INTERVENE EARLY TO KEEP MEMBERS MISSION READY.

There are good reasons the special operations community has embedded clinicians and other specialized providers (e.g., physical therapists, mental health professionals). It is imperative that these highly-trained assets are available at a moment's notice. Operators also have physically and mentally demanding occupations. I'm not saying Sergeant Snuffy should get an immediate MRI like the franchise quarterback (thanks Choosing Wisely Campaign!),[4] but always think about the next steps to get someone back in the fight as soon as possible. For instance, if someone comes into clinic with patellofemoral syndrome, offer a few exercises to jump-start their rehab in addition to providing any physical therapy referrals.

5. KEEP YOURSELF MISSION READY.

Whether reviewing your own IMR and deployability or getting adequate sleep the night before clinic, ensuring that you are operationally ready for duty is critical. Maintaining a healthy lifestyle and exercising regularly are all topics we preach to patients, but we need to ensure we practice these habits ourselves.

Clinic can be monotonous and overwhelming at times. A thorough discussion of burnout would be beyond the scope of this article. However, it is important to diversify your career to remain engaged and mission ready. For many of us, attending a USAFP Annual Meeting workshop is a great way to sharpen clinical skills and learn something new. Take advantage of unique opportunities in military medicine throughout your career as well. Do you want to learn acupuncture, or spend an assignment as part of a flying squadron? Or, would you enjoy dipping your toes into academic medicine? The military offers you this broad range of opportunities while still allowing you to advance your career.

Operational readiness is critical to military Family Medicine. Asking patients about occupational duties, checking a patient's IMR in clinic, visiting work centers, and intervening early to ensure readiness are all ways to incorporate an operational mindset into a Family Medicine clinic. We must also continue to revisit our own personal readiness by remaining physically fit, engaged in our work, and up to date in clinical medicine. Secretary of Defense deployability directives in early 2018 were a wakeup call to our forces and a reaffirmation that military medicine's readiness posture doesn't stop at the walls of the treatment facility.

After all, Family Medicine physicians are the front lines of military health care.

1. Carnegie D. *How to Win Friends and Influence People*. New York: Simon & Schuster; 1936. P. 20.

2. American Academy of Family Physicians Division of Medical Education. "Tips on Building Doctor/Patient Relationship." https://www.aafp.org/dam/AAFP/documents/medical_education_residency/fmig/tips_relationships.pdf. Accessed November 4, 2018.

3. Reason J. *Managing the risks of organizational accidents*. Aldershot: Ashgate; 1997.

4. American Board of Internal Medicine Foundation. Choosing Wisely Campaign. http://www.choosingwisely.org/. Accessed December 22, 2018.

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The Power of Full Engagement

Managing Energy, Not Time, Is the Key to High Performance and Personal Renewal

BY JIM LOEHR AND TONY SCHWARTZ

Feeling as though you're not performing at your maximal potential? Feeling as though something is lacking or not like "it used to be"? Or feeling tired, anxious, disinterested, or irritable? Then this is the book for you and one that has been on my reading list for much too long. Jim Loehr and Tony Schwartz's *New York Times* Bestseller focuses on the four areas of our lives that must be actively engaged to maximize energy and performance: Physical, emotional, mental, and spiritual. When any of these are ignored, it's much like the resultant decreased performance of an engine when any of the fluid levels drop too low. And in contrast to many management and leadership books focusing on time management, Loehr and Shwartz make the compelling argument that it's our management of energy (and the time invested into these four areas) that make leaders organizationally and personally successful.

"Performance, health and happiness are grounded in the skillful management of energy"

The book is divided into three sections: the first details the four sources of energy, the second on the "training system" one can use to improve in these areas, and the third is a variety of assessment tools and development plans to make you successful in this pursuit. One of the most beneficial aspects of the book are the multiple real world examples (either clients of theirs or famous persons) and how lack of energy in the different components affected their home lives, work lives, and their outlook on the future. I promise you will see yourself in many of these examples.

The energy sources build on each other and it starts with your physical health (exercise, diet, sleep, etc.). Without maintaining your physical strength and stamina, how can you expect to perform at work and home at the highest level. Second is the focus on your emotional energy stores. Feeling underappreciated, anxious, irritable, or distant in relationships all have negative impacts on our ability to perform. The authors then concentrate on the mental realm and the need to stimulate your brain to stay sharp. Specifically, we must determine how to say "no" in order to give us time to think. As Leonardo da Vinci said, "The greatest geniuses sometimes accomplish more when they work less". Busier doesn't equal better; all too often we multitask and waste time and energy on things better delegated to someone else or not done at all. In the final section, and what the authors believe to be the most important, is the spiritual component. Although religion can be part of this, it is much more about your attention to what inspires and drives you and what matters most to you. Or as Simon Sinek says, "Start with Why". The authors also probe into the values we rate greatest and what actions we take to live consistently within those values (which they term virtues). For a very detailed breakdown of the specific components of the book, please refer to the detailed book summary COL (Ret) John O'Brien wrote on this book in 2004 which is posted to the USAFP Leader's Book Club webpage (as are all our book summaries).

"To maintain a powerful pulse in our lives, we must learn how to rhythmically spend and renew energy"

continued on page 30

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usafp

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To be successful, not only must we be intentional, but we must be realistic and honest with ourselves. We've all heard the analogy that life is not a sprint, but a marathon; however, how many of us still sprint everyday all day long? I know I'm guilty of this. As the authors emphasize throughout the book, we must take time to refresh and renew. The way by which we do this can be unique to us, but the value of doing so is universal. This allows us to focus and maximize the quality, not just the quantity, of our energy.

As I mentioned in the opening of this article, this book has been on my list for a long time and I wish I had read it earlier. I assumed it would be more of an overview of the four different areas and advice for improvement, but the book became much more of a philosophical analysis of myself and my life, reminding me of many of the things that I have let slip. This past year has been one of the most professionally successful in my career and one of the most challenging for me on a personal level. Despite being selected early for Colonel, completing Senior Service College, and being selected for O-6 command, my personal well-being and relationships with my family and friends have suffered. I stopped taking care of portions of all four energy areas and also (ashamedly) fell back on unhealthy and self-destructive coping mechanisms. With the help of family, friends (many who are amazing members of USAFP), my church, and counseling, I am becoming me again. However, as the authors so well describe in this book, if I fail to address all four of these aspects in my life, I cannot and will not perform at my highest level. My goal this year is to refocus my energy to be the best Christian, Husband, Father, Friend, Leader, Officer, and Physician I can be.

To those who have helped me (specifically in the last year), I give you a very heartfelt thank you. For any of you who are currently struggling, please don't be stubborn and resistant to getting help. And I am absolutely willing to talk with any of you any time if I can be of help (C: 931-436-5146; mnfandre@gmail.com). And finally, please take the time to read this book and invest in yourself; you're worth it and it will help you! All God's Blessings to you and best wishes for an amazing 2019!

AAFP CME CALENDAR

For Members in the National Capital Area. For other AAFP sponsored CME, please visit www.aafp.org/cme/browse/all-locations.html

April 24-26, 2019
PerformanceNavigator Cardiometabolic Conditions
Hyatt Regency Reston
Reston, VA
https://www.aafp.org/cme/browse/location.tag-virginia.html

July 24-27, 2019
Family-Centered Maternity Care
Hyatt Regency Reston
Reston, VA
https://www.aafp.org/cme/browse/location.tag-virginia.html

September 11-14, 2019
Musculoskeletal and Sports Care
Hyatt Regency Reston
Reston, VA
https://www.aafp.org/cme/browse/location.tag-virginia.html

committee reports

RESIDENT AND STUDENT AFFAIRS

Alex Knobloch, MD, CAQSM
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Happy New Year! As we all take time to reflect on the year that has concluded and make resolutions for the year to come, the Resident and Student Affairs Committee wanted to update you with some of our 2018 accomplishments and our excitement for what 2019 holds for our resident and student members.

1) Since 2017, the AAFP membership application was modified (thanks to USAFP members!) to include an option for medical students to identify themselves as active duty military or as having a military service obligation due to the Health Professions Scholarship. The intent for this change was to help our chapter better identify and connect with the HPSP student members of AAFP. Since the application change, AAFP has been working with USAFP to determine the membership status for these students that best serves their need to utilize their medical school's family medicine resources, as well as to network with military family physicians. After AAFP received feedback from student members, as of October 2018, all students identifying as HPSP will be placed in their local state chapter. Their names will be provided to USAFP to make contact and offer full membership in our chapter or the option of receiving USAFP communications in an adjunct status. Please help support our continued efforts to share our USAFP resources with our HPSP students, particularly when they are rotating at our GME programs!

2) We received several applications from USU and HPSP students for the student director position on the USAFP Board of Directors. This is the first time we've been able to fill that position since 2013!

3) The USAFP presence at the AAFP National Conference of Family Medicine Residents and Medical Students continues to grow! Our resident directors organized a USAFP member dinner during the 2018 conference this past summer, with attendance up to 18 members (almost triple the attendance from a few years ago). If you're attending the 2019 conference this summer, reach out to the 2019 USAFP resident directors for more info to take advantage of this awesome networking opportunity!

4) Don't miss the Resident and Student Clinical Leadership seminar at this year's annual meeting. This year's topic: Ready to Lead and Able to Follow! The seminar will include two workshops over the course of the half day session, designed to help attendees build their skill set to ensure readiness as both a clinical leader and follower in residency and beyond. All students and residents are invited to attend both workshops, while current and future chief residents are highly encouraged to attend. And be sure to join in the fun on Wednesday night for both this year's edition of "Doc, You Don't Know Jack!" and the Resident and Student Reception that will follow after. Make sure to check out the meeting program for more information.

5) We'd love to see as many residents and students as possible in St. Louis, but if you're unable to attend this year's annual meeting, it's never too early to start thinking about next year! If you've never attended before, this is THE conference to attend, whether you get the opportunity to present a lecture or research or are attending for an amazing opportunity to learn and network. Find a faculty mentor that can assist you in generating ideas for lectures, workshops, or research.

EVERY DOC CAN DO RESEARCH

Have you wanted to do a research project but were not sure how? Would you like a user friendly workbook to help you over the inertia of starting a project? The Clinical Investigation Committee is pleased to offer user friendly tools for organizing, planning, and starting a research project.

If interested, please send a request to *direamy@vafp.org.*

Tools Available:

- Every Doc Can Do Research Workbook
- Every Doc Can Do A Poster
- Every Doc Can Do A Scholarly Case Report Workbook

Clinical Investigation Research Tools also available on-line at *www.usafp.org.*

new members

THE USAFP WELCOMES THE FOLLOWING NEW MEMBERS...

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Caitlin Brauer
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About the location: On main street, parking at front door, handicap accessible. Rear parking for staff and rear entrance. Landlord local and responsive. 3 LARGE exam rooms, waiting room, business/ private office, nurse and provider work zone, break room, and 2 restrooms.

About the practice: 90+% insurance, most medicare is Health Spring. AR lower than average, computerized appts and billing (capable of more-Doctor's Access software-272.03/mo), COMCAST. Call group quite reasonable, 1:5, no inpt or ER coverage.

About the patients: I like to say most of my elderly patients are playing golf, not chronically ill on mega meds and oxygen. Many have become friends of my family.

About the staff: Nurse for 20+ years, office manager 18 years, office help 3 mornings a week. All will need replaced.

Obviously, type of practice, kind of patients, EMR, and staffing all flexible as desired by provider(s) — DRs, NPs, OR PAs. Practice is on the edge of town where there has been and will continue to be large scale housing built. Several full and/or part time providers could easily thrive. Office comes FULLY furnished. Terms would be quite negotiable. Please call anytime.

Stephen Bollig, MD • 625 E Main St., Ste 4 • (c) 615-308-3381 • sbollig@aol.com

REMEMBER: *Tennessee has no state income tax, Hall investment tax fully repealed by Jan 2021 (2% in 2019 and 1% in 2020), and hardly EVER snows appreciably in central Tennessee!*

Promoting Research in the Military Environment

Have a great idea for operational research but are unsure where to start or how to get approval?

Whether you are deployed or in garrison, the USAFP research judges can help!

Photo Courtesy of U.S. Army

Visit us online at http://www.usafp.org/committees/clinical-investigations/ for resources or to find a mentor.

Open Door is currently looking for a Clinic Medical Director.

To learn more about this opportunity, at a clinic in the largest community health center on California's north coast, our competitive salary, and bonus package, please contact Angela Mendes at (707) 496-5465, amendes@opendoorhealth.com, or visit opendoorhealth.com.

Come and Visit Our Booth to Learn More

RELOATION ASSISTANCE AND SIGNIFICANT SIGN-ON BONUS

Seeking Family Medicine Physicians –
St. Louis County, Missouri

Mercy | *Your life is our life's work.*

Mercy Clinic is seeking BE/BC **Family Medicine Physicians** to join established and growing, outpatient practices in **St. Louis County, Missouri, and surrounding communities.**

Mercy, a three-time IBM Watson health top five large U.S. Health system in 2018, 2017, 2016, is a faith-based organization and serves millions annually. Mercy Clinic is a strong, physician-led and professionally-managed, multi-specialty group. Located in seven states, Mercy is comprised of 40 hospitals and more than 2,500 Mercy Clinic physicians.

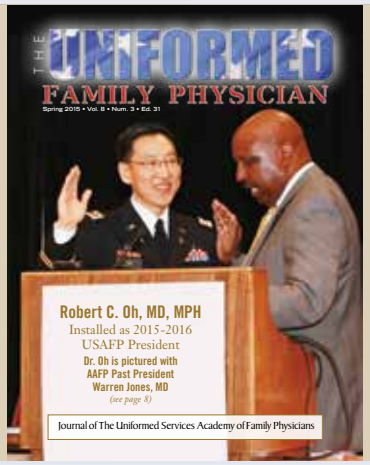
Mercy offers...

- Competitive compensation model and comprehensive benefits package.
- Professional liability coverage
- Monday through Friday scheduling, no weekends
- A team of Physicians, Nurse Practitioners, and full support staff including Nurse On Call for after hour support
- Outpatient care only
- A large, established multi-specialty referral network
- Partnership in a physician led, multi-specialty organization

Become a part of our legacy and help us build a healthier future.

For more information, please contact:
Lisa Hauck, MBA | Senior Physician Recruiter
314-364-2949 | fax: 314-364-2597
Lisa.Hauck@mercy.net | Mercy.net
EEO/AA/Minorities/Females/Disabled/Veterans

Watson Health
15 TOP HEALTH SYSTEMS
2018



Mercy

Visit us at Booth 15

Become a part of our legacy and help us build a healthier future!

Now Seeking
BC/BE Family Medicine Physician

Mercy Clinic, named one of the top five largest U.S. health systems in 2018, 2017 and 2016 by **IBM Watson Health**, is seeking **BC/BE Family Medicine Physician** to join our established groups throughout our healthcare ministry *(see map)*.

Our Positions Offer:

- Integrated health system with a competitive compensation model and professional liablity coverage
- $50,000 Recruitment Incentives
- Residency Stipend for early commitment, CME allowance and relocation assistance
- Comprehensive benefits including health, dental, vision and life insurance
- Retirement options with employer matching
- System-wide EPIC EMR

Mercy is comprised of more than 40 acute care and specialty hospitals, 800 physician practices and outpatient facilities, employing 44,000 co-workers and more than 2,100 Mercy Clinic Physicians. Mercy is named a top American employer by **Forbes** magazine, ranking 108 among 500 employers in the U.S. and spanning 25 industries.

For available openings visit ***mercy.net/careers***

Locations Include:

Missouri:
- Bolivar
- Branson
- Buffalo
- Joplin
- Lebanon
- Mountain Grove
- MountainView
- Ozark
- Republic
- Rolla
- Springfield
- St. Louis
- St. Robert

Arkansas:
- Barling
- Bentonville
- Berryville
- Clarksville
- Eureka Springs
- Fort Smith
- Green Forest
- Lowell
- Paris
- Rogers
- Springdale
- Waldron

Oklahoma:
- Ada
- Ardmore
- Edmond
- Moore
- Norman
- Oklahoma City
- Piedmont
- Poteau
- Sallisaw
- South Oklahoma City

Kansas:
- Fort Scott
- Pittsburg

Truven Health Analytics | IBM Watson Health
15 TOP HEALTH SYSTEMS
2017

For more information, please contact:

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EEO/AA/Minorities/Females/Disabled/Veterans

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