THE UNIFORMED FAMILY PHYSICIAN

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INSTALLED AS 2019-2020 USAFP PRESIDENT – SEE PAGE 9

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 joint readiness, health and wellness through education, scholarship, advocacy, and leadership.

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your academy leaders

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president's message

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"Be Human"

I humbly suggest that deep and meaningful connection with another family physician is one of the most potent options for maintaining our wellness.

Greetings friends! Please accept my warmest personal appreciation and hope for good health and wellbeing for you, your families and loved ones. It is a tremendous and humbling honor to serve you. At the same time, I am seeking your help. Over the next three journals, I plan to expand on topics of which I spoke at our incredible annual meeting in St Louis. These include: "Be Human," "Focus Forward," and "Be Grateful." As I do so, I invite you to join me in considering, and most importantly acting upon, applicable principles in your personal spheres of life. I ask you to come together and work to improve our personal lives at individual levels. There is no question, we face monumental challenges: leadership reorganization, the roll out of a new electronic health record, and staffing changes. Now, more than ever, I feel it is critical for us to lean on one another for strength and support. I believe there are few better friends or problem solvers than uniformed family physicians. Let us begin our efforts together by "Being Human."

When did the toxic, hidden narrative emerge that suggested physicians cannot get sick, tired, have any weakness, or ever ask for help? Why is humility often considered weakness in our profession? These outdated notions have led to significant pathology. Particularly troubling is an ongoing study by *Medscape* on family physician burnout and associated challenges.[1] Authors indicate that 51% or more of family physicians suffer burnout, depression, or both and merely 22% consider themselves happy at work. To combat this, family physicians pursue exercise and a multitude of other individually performed remedies with minimal success. Notably missing, however, is seeking the counsel and comfort of another family physician. I humbly suggest that deep and meaningful connection with another family physician is one of the most potent options for maintaining our wellness. For those of you who were able to make it, consider the way you felt during the USAFP Annual Meeting when surrounded by fellow family physicians. Ponder conversations, experiences and reunions you had. Most have indicated the highlight of participation in USAFP is the camaraderie, support, courage, and strength we draw from other family physicians who face common challenges and share common bonds. I will state unequivocally that this is the case for me. The strength and courage I draw from each of you is the principle therapeutic effect of membership in this academy. Unfortunately, the meeting is only one week, and 51 weeks remain until the next meeting. Could our daily lives improve by deliberately transporting the strength of our USAFP membership closer to home for daily consumption? I believe it could.

A potential first step is by being transparent and seeking support from one another at the local level. We cannot wade through disease and death daily without being affected, so let's drop the old notions of physicians being bulletproof. We face unprecedented challenges but acknowledging our humanness with one another and working together to find solutions to our problems can uniquely equip us to face challenges. Might we schedule regular meetings with a fellow uniformed family physician locally to talk things out, repair our armor, and sharpen our swords? These meetings could occur at the end of a clinic day or week and could be done in person, by phone, videoconference, text, or email. They need not be lengthy, but always must be genuine. If we can meet briefly and regularly, we might be able to prevent some of the prolonged and elaborate therapies needed for enormous

continued on page 6

continued from page 5

personal crises. Could we serve as remedies or even as burnout vaccines for one another until the next infusion from the Annual Meeting can occur? I believe we can fix our problems one by one at close range and I ask you to do join me in working to do so. This begins by being genuine, acknowledging our challenges together, and working for solutions at the lowest possible levels. Let's pull together so that not one of us ever stands alone and so that we can live the principles we teach our patients to live. Let us start by acknowledging our humanness with one another.

Most have indicated the highlight of participation in USAFP is the camaraderie, support, courage, and strength we draw from other family physicians who face common challenges and share common bonds.

REFERENCES

1. Medscape Family Physician Lifestyle Report 2018: Personal Happiness vs Work Burnout. (2018) https://www.medscape.com/slideshow/2018-lifestyle-family-physician-6009224. Accessed 30 March 2019.

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Treasure Trove

Greetings, Friends!

You are holding a treasure trove in your hands.

I've always enjoyed contributing to this newsletter, skimming its contents, and selecting a few articles for a deep dive each month. Now, as editor, I've read each article in this issue at least three times and better see how all of our colleagues' contributions come together to paint a broad picture of uniformed family medicine as it exists today.

There are things in this issue that you don't want to miss!

First, I would encourage you to read the consultant and specialty leader columns from each of the Services, including your sister ones. As we become increasingly joint, experience the Defense Health Agency's assumption of responsibility, and live through the transitions outlined in the National Defense Authorization Acts of 2017 and 2019, that which is happening in your sister Services will soon be your personal reality. So why not get up to speed now? And while you are at it, check out Deb Manning's piece on the Operational Medical Home. You'll be better prepared to provide excellent Soldier, Sailor, Airmen, Marine, and Coast Guardsman care and will be two steps ahead of everyone else in understanding the increasingly complex uniformed medical landscape.

Next, sharpen your medical toolkit with Doug Maurer's ever popular medical apps column. And, while you are hanging around that section of the newsletter, refresh your leadership bookshelf with John O'Brien's pick of the quarter: Radical Inclusion. You'll come away with time saving applications for your clinic visits and some practical leadership advice from our 18th Chairman of the Joint Chiefs of Staff, GEN (ret) Martin Dempsey.

After that, there's even more for you to explore. Getting ready to deploy or looking for good advice to give to one of your colleagues about to go downrange? Myro Lu's operational medicine committee report has practical and timely advice. So does Breanna Gawrys's column for the wellness and resilience committee. Interested in becoming a champion for health literacy among your vulnerable populations? Check out Janelle Marra's piece for membership constituencies. Would you like to celebrate our chapter's achievements? Please wander over to Rob Oh's clinical investigation committee report or to Christina Valerio's resident and student affairs committee brief—our members submitted 136 research abstracts this year and our chapter has grown to just under 1,000 student and resident members!

And please don't miss Chris Jonas's Presidential column. We are all facing pressures, and some more than others—productivity, advancement, deployment, schooling, uncertainty, and life changes, among others—and yet, we still have to wake up and live life every day. Some days are wins, but others leave us wondering what we've accomplished and why we now have to chase "Y" when we've been focusing on "X." Chris reminds us that where two family physicians are together, one is not alone. We can find support, encouragement, comfort, and solace by connecting with one another.

So, to say that this issue is a treasure trove is no hyperbole. Please enjoy this newsletter, reflect on its contents, and know that you are not alone. We are uniformed family physicians, and we stand together by design. If you like something you read and wish to respond, please email me at aaron.saguil@usuhs.edu and let me know if it is okay to print your comments.

Christopher E. Jonas, DO, FAAFP Installed as 2019-2020 USAFP President

Over 525 attendees took part in the 2019 Installation of USAFP Officers and Directors Luncheon on Saturday, 9 March 2019 at the Hyatt Regency at The Arch in St. Louis, MO. AAFP President John S. Cullen, MD, FAAFP installed 2019-2020 USAFP President Christopher E. Jonas, DO, FAAFP and the other Officers and Directors of the USAFP Board of Directors during the luncheon.

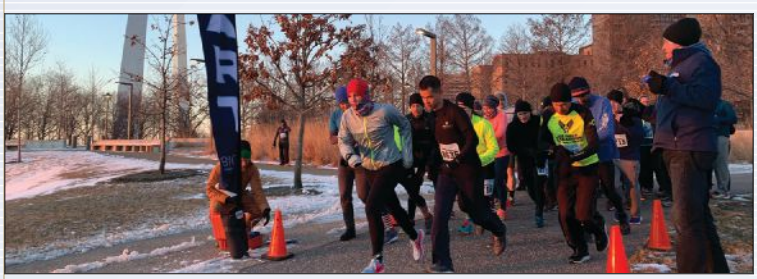
Dr. Cullen installs Christopher E. Jonas, DO, FAAFP as 2019-2020 USAFP President.

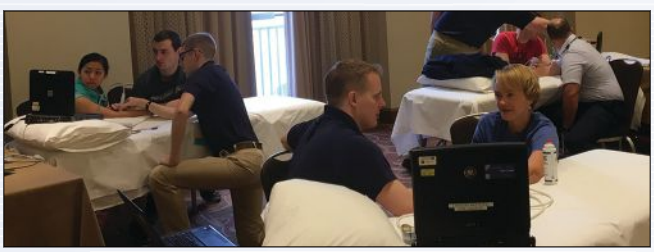
Dr. Cullen installs the 2019-2020 USAFP Board of Directors Pictured left to right are Kevin M. Bernstein, MD, MS, FAAFP, Navy Director; Alexander Lam, Student Director; Michelle Dertinger, MD, Navy Resident Director; Brian Merrigan, MD, Army Resident Director; Khalid A. Jaboori, MD, MPH, FAAFP, Public Health Service Director; Drew C. Baird, MD, FAAFP, Army Director; Debra A. Manning, MD, FAAFP, President-Elect; Aaron Saguil, MD, MPH, FAAFP, Vice President; Jeanmarie Rey, MD, FAAFP, Air Force Director; Elizabeth Curry, MD, Air Force Resident Director; Paige White, Student Director

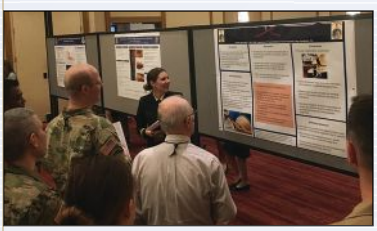
2019 Annual Meeting & Exposition

Over 545 family physicians and other health care professionals attended the 2019 USAFP Annual Meeting & Exposition at the Hyatt Regency at the Arch in St. Louis, Missiouri. The photos and comments show the success of the conference!

- Outstanding, one of the best USAFP meetings for CME quality, location, hotel and program I've attended.
- Excellent as usual! Thanks!
- Really a great conference and location. Thanks for putting it together! All attendee dinner at Cardinal Nation was awesome.
- Best meeting in the past 5 years in terms of content, length, variety.
- Coffee and tea on breaks were much appreciated. The CME quality and length of conference was on point. Thank you!
- I have the privilege to go to a lot of various conferences in my current job....USAFP remains the best meeting for content and camaraderie!!
- Good meeting for my first-time attendance! I will definitely attend another USAFP meetings in the future!
- Another awesome conference! Thanks again!
- Awesome content and program.
- Great USAFP event!
- Great job once again!
- Thank you for such a well-organized and meaningful conference. There was a very large array of topics and I thought it went very well.







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2019 Academy Awards

CONGRATULATIONS TO THE 2019 FAMILY PHYSICIAN OF THE YEAR AWARD RECIPIENT JOHN C. LAIRD, MD, FAAFP!

Michael J. Scotti, MD Family Physician of the Year
John E. Laird, MD, FAAFP, CDR, MC, USN

Dr. Laird's award reads as follows: "In recognition of your seamless energy to improve the quality of medical care and the practice atmosphere in family medicine clinics. Your efforts as it relates to the delivery of acupuncture education, pain management education and the implementation of the "Joy" project are unparalleled. Your drive complemented these innovative focuses and speaks volumes as to your ability to educate and motivate your fellow staff. You truly have the personal and professional attributes of an outstanding Family Physician and exemplify the specialty of Family Medicine."

Dr. Laird receives his award from 2018-2019 President Douglas M. Maurer, DO, MPH, FAAFP

Dr. Clark is pictured with 2018-2019 President Douglas M. Maurer, DO, MPH, FAAFP.

Dr. Beutler is pictured with 2018-2019 President Douglas M. Maurer, DO, MPH, FAAFP

2019 PRESIDENT'S AWARDS

Jeffrey B. Clark, MD, FAAFP, BG, MC, USA

Dr. Clark's award reads as follows: "In deep appreciation for your many years of service to the USAFP and to military Family Medicine. Your positive style of always "Leading by Example" even during times of transition and uncertainty in the DoD/DHA ensured all family physicians they could count on you to represent all that military medicine can be. Your efforts to create and institute pain management education will be long lasting within the DHA. It is for these qualities and efforts that you are sincerely thanked and commended. "

Anthony I. Beutler, MD, FAAFP, Col, MC, USAF

Dr. Beutler's award reads as follows: "In sincere appreciation for over 10 years of service to the USAFP in the capacities of Committee Chair and Director on the Board. All that you have accomplished in the research arena is invaluable. USAFP is forever in your debt for creating the premiere research event of any chapter meeting in the country. Your efforts to ensure annual meeting attendees via acceptance to the research competition and rise with research is unparalleled. Those efforts have made many a good researcher better and more importantly, created the "gateway drug" into academia for many USAFP members. For this, you are truly special and to be commended."

Heather M. O'Mara, DO, FAAFP, LTC, MC, USA & Laurel A. Neff, DO, MBA, FAAFP, LTC(P), MC, USA

The awards for Drs. O'Mara and Neff read as follows: "In recognition and deep appreciation for your outstanding leadership associated with creating and executing the 2019 USAFP Annual Meeting & Exposition. Your innovative, comprehensive and dynamic program focused on the theme "Ready, Teaching, Healing – Leading into the Future" exceeded the educational needs of our diverse membership. Through your tireless efforts, you have helped your friends and colleagues in all services to grow professionally as clinicians and leaders."

Drs. O'Mara and Neff receive their award from 2018-2019 President Douglas M. Maurer, DO, MPH, FAAFP

Debra A. Manning, MD, MBA, FAAFP, CAPT, MC, USN

Dr. Manning's award reads as follows: "In recognition for your outstanding service in many capacities and roles within the Uniformed Services Academy of Family Physicians. Your leadership for many years at the committee level, including Program Co-Chair in 2009, at the Board level as Director and at the Executive Committee level have an outlasting impact on the successes of our Academy. I honor you for your commitment to bettering academic medicine and military readiness during your decorated Naval Career and your personal friendship to me for much of my career."

Dr. Manning is pictured with 2018-2019 President Douglas M. Maurer, DO, MPH, FAAFP

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USAFP Annual Meeting Air Force Service Specific Breakout Summary

Check out the Family Medicine Knowledge Exchange (Kx) site (https://kx2.afms.mil/kj/kx1/FamilyMedicine/Pages/home.aspx) for the AF/SG slides and notes from the break out session.

For those of you who were not able to join us at the 2019 USAFP Annual Meeting, following tradition, we had a *lively* service specific breakout session! During this time, our Air Force Surgeon General (AF/SG), Lt Gen Dorothy Hogg, spoke to us. She delivered an update on the Air Force Medical Service (AFMS) Transformation and fielded *tough* questions from the crowd. She specifically said "**WE NEED YOU,**" in reference to uniformed family physicians. In addition to our home station care impact on Airman readiness and deployability, she highlighted that the majority of those injured down range suffer Disease Non-Battle Injuries (DNBI) and that WE are the ones taking care of these patients. She challenged us to define our down-range mission; this will drive the knowledge, skills and abilities that we will write into our Comprehensive Medical Readiness Program (CMRP) requirements.

Lt Gen Hogg recognizes that for most of us, our scope of care is currently limited within the four walls of our Military Treatment Facility (MTFs); re-organizing to support Active Duty-only care poses a continued risk to currency/readiness related clinical skills. She supports our full depth and breadth of practice. Additionally, she affirmed that the AFMS will need clinicians, like family physicians who are skilled in the care of children and maternal health, to respond to natural disasters and humanitarian crises. To that end, she encouraged us to think about how we can obtain clinical currency in readiness skills outside our MTFs, perhaps as embedded providers within a civilian medical center. The Readiness Analysis Comprehensive Evaluation (R.A.C.E.) Team here at the Air Force Medical Operations Agency (AFMOA) is ramping up and those on the team are dedicated to creating solutions for providers across the AFMS to remain current in CMRP requirements. By the way, I need to hear from those of you who have deployed! Send me an e-mail with everything you "wish you would have known" or you are "glad that you did know." Our CMRP checklist is a dynamic document and your input is valuable as we revise its scope with an eye to readiness.

Finally, Lt Gen Hogg talked about ***Disruptive Innovation*** and discussed RESET as a success story! She shared nine tips to inspire transformation within your organization and encouraged us to think **"without a box."** Specifically, "if it is not illegal, immoral, or unethical, then go for it!" As we work on new processes and solutions, she reminded us to consider a joint service approach and think ***"unified."*** It was an honor to host our AF/SG—we are very appreciative for her support! Check out the Family Medicine Knowledge Exchange (Kx) site (https://kx2.afms.mil/kj/kx1/FamilyMedicine/Pages/home.aspx) for the AF/SG slides and notes from the break out session. I have also uploaded my slides with manning updates, scope of care updates, assignments, deployment information, and career pyramids for your review.

Later in the session, after Lt Gen Hogg departed to catch her plane, we had a frank and open discussion about our issues and concerns. We need to hear all voices when it comes to advocacy for our career field. As a group, we can make a difference. Many of you brought up frustrations and challenges regarding scope of care and practice management, concerns about the future of Air Force graduate medical education, and quality of life. Your suggestions, complaints, and inputs were valuable to the discussion. As your consultant, I want to hear it all so that I can

accurately reflect what is happening in the field and speak up for us with every chance I get. So let's keep the dialogue and network going! Please consider using the Family Medicine Kx discussions page as a place to problem solve and share solutions.

Speaking of concerns, the term "moral injury" has become the new buzz word to better describe "burnout." The term was first used to describe soldiers who went to war and witnessed atrocities or felt deep internal conflict about participating in violence. In healthcare, "moral injury" is a result of our internal conflict with what we are doing every day and what we dreamt we would be doing in the ideal system when we all penned our medical school application personal statements so many years ago: "I want to help people, I want to make a difference in the world..." Now, many of us find ourselves in the daily grind, behind a computer screen instead of spending that time with our patients. We are missing the continuity and relationship with our patients that is so deeply ingrained in our Family Medicine training but is challenging to achieve in the current system. Burnout implies that we are not resilient enough to handle the pressures of the system. This is not true; we are resilient! "Physicians are smart, tough, durable, resourceful people. If there was a way to **MacGyver** themselves out of this situation by working harder, smarter, or differently, they would have done it already."(1) So what can we do when we feel powerless at times like these?

"You gain more control over your life by paying closer attention to the little things," said Emily Dickinson. That is great advice now more than ever. Lt Gen Hogg talked about the big issues that are being decided at levels like Congress and the Defense Health Agency. Try not to let the uncertainty of these decisions create stress in your life. Instead, I encourage you to pick a small "crazy maker" in your day and work towards a process that fixes it. Over the years, I have implemented a few "MacGyver" techniques myself to achieve small successes and improve my daily clinic life. Share your MacGyver "wins" on the Kx discussion board. We can gain strength and resilience by coming together as a community and helping each other. I just posted about my telephone consult "crazy maker" fix and welcome any questions about it. If you don't have access to the Kx but have suggestions and solutions that you would like to share, please send me an email and I will post it for you.

Thank you for taking care of our patients, each and every day. I welcome feedback, suggestions for the Kx website and future articles, and discussion about all things related to family medicine.

REFERENCES

1. Talbot, Simon G and Dean, Wendy. "Physicians aren't burning out. They're suffering from moral injury." https://www.statnews.com/2018/07/26/physicians-not-burning-out-they-are-suffering-moral-injury/

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 July 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. *dreamy@vafp.org*.

RESEARCH JUDGES

Applications for research judges are accepted on a rolling basis. Please contact Dianne Reamy (*dreamy@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...
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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.

consultant report
ARMY

Army Consultant Report
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The Annual Meeting was another homerun! Thank you to our Army leaders for hosting a fantastic event and to our teams back home for covering patient care so that others could attend. Congratulations to all on your success in the research competitions, effective workshops, and high yield seminars and discussions. I always leave the meeting energized and re-committed to military medicine. After having the opportunity to hear from so many of you, I left with an additional sense of reassurance that we have the right people serving as our Army evolves.

I highly encourage that you read the latest Medical Corps Newsletters. They can be found on the Medical Corps Sharepoint at https://mitc.amedd.army.mil/sites/AMP/AMC/Pages/MedicalCorps.aspx

There is a specific link for newsletters. They are packed full of good information and contain the latest updates on many topics of interest.

READINESS

"Although our intellect always longs for clarity and certainty, our nature often finds uncertainty fascinating." Carl von Clausewitz

The initial conversion of MTOE Assigned Personnel (MAP) is complete. As you may recall, this conversion moves individuals previously assigned to Military Treatment Facilities (MTF) to MTOE units, with day-to-day duties back at the MTF. I have heard or seen many officers ask, "Why didn't the Army Medical Department (AMEDD) figure the details out before initiating the change?" The simple answer is that the Army directive required the change to occur immediately. Leaders in the AMEDD and in United States Army Forces Command (FORSCOM) saluted and moved out. That's what we do sometimes. It's been disruptive and challenging. Much good is coming out of the change. From MG Clark's Chief's Corner in the March Newsletter:

"In my view the most important thing is that MTOE and MTF Army Medicine Leaders are communicating and collaborating even more than before. It is even more obvious that we are ONE TEAM/ONE PURPOSE and we must understand and trust each other. No one is perfect; we'll muddle through some aspects. But, good relationships within our ONE TEAM will best serve our ONE PURPOSE and each individual Soldier and Family. That's what Leaders do."

In my current duties, I have the opportunity to be part of the MAP conversation from the perspective of both an MC Officer and MTOE commander. I have seen the collaboration and communication and I am convinced we will be better for it.

MAP conversion: the rater and senior rater should be at the organization in which the officer spends the majority of time.

You can find the updated FORSCOM guidelines for MAP within the documents section of the MC Corps Sharepoint. You will see that Fragmentary Order 1 to the FORSCOM MAP Operations Order contains changes in response to feedback from the force. For example, the order now reads that the rater and senior rater should be at the organization in which the officer spends the majority of time. There is also a great set of updated FAQ's in the document folder.

ASSIGNMENTS

Our 61H assignments officer at Human Resources Command (HRC), MAJ Elko, continues to work hard to get the right people assigned to the right organizations and to align the Army requirements with officer development and officer preferences. She is reaching out to individual officers on a daily basis, and we are communicating frequently. This is my first time going through the full cycle of assignments as your consultant, and I am seeing first-hand how challenging the task is for HRC. Many variables impact the

process, to include the Graduate Medical Education selection board (fellowships), command selection, strategic billet selection, 60A assignments, Assignment Interactive Module Version 2 (AIM 2.0) input from officers and organizations, operational assignments, and this year, MTOE Assigned Personnel allocations. The Surgeon General's manning guidance requires HRC to fill organizations according to priority. Operational units, Security Force Assistance Brigade, and OCONUS locations are examples of assignments having top priority while our CONUS MTFs are lower priority. As a reminder, this is all occurring in the assignment cycle in which we changed the AMEDD Distribution Plan (ADP) significantly. This led to an approximately 15% reduction in ADP positions at most MTFs. Thank you to everyone for your help and patience.

TAKE LEAVE

We need you at your best. So, take time off; spend it with those most important to you, do things that you want to do, and clear your mind of the daily stresses and challenges. Leaders, make sure the people on your team are taking leave. In the Army and in medicine, we must always have a mission first mindset. To complete the mission, we need people who are ready: we must take care of ourselves and others.

Thank you for all you are doing. It's a great day to be an Army family doc! One Team, One Purpose… Conserving the fighting strength since 1775!

I highly encourage that you read the latest Medical Corps Newsletters. They can be found on the Medical Corps Sharepoint at https://mitc.amedd.army.mil/sites/AMP/AMC/Pages/MedicalCorps.aspx

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.

consultant report
CG/PHS

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Public Health Service (PHS) officers, Coast Guard (CG) medical officers, and family medicine friends, greetings from the snowy city of St. Louis! This year's USAFP meeting, like so many before, was another excellent event in the city of beer, baseball, and the Arch! This year is a transition year for the PHS Director position. As we say farewell to Captain Sarah Arnold and thank her for her years of service and commitment to the USAFP, we welcome LCDR K. Jaboori, MD, MPH to his new position. LCDR Jaboori is the current Senior Medical Executive, Base Seattle, USCG, and will be a great asset to the Board of Directors.

Captain John Hariadi, MD, FAAFP and me at the USAFP 2019 Annual Meeting.

PHS MEETING PERSPECTIVE

This year's meeting proved to be another exceptional one. What was great about this year was the involvement of more PHS officers as presenters and attendees. This year's meeting was kicked off by one of our own, Captain John Hariadi, MD, FAAFP, with his talk on the "FDA's role in Confronting the Opioid Epidemic." Captain Hariadi's talk was a great starter for the conference and a reminder of the still present fact of opioid abuse in our country. According to the Center for Disease Control, National Center for Health Statistics, the number of deaths from opioid related deaths has doubled from 21,089 in 2010 to 42,249 in 2016. You can find more information at the Surgeon Generals advisory page, www.surgeongeneral.gov, which catalogues the initiatives of our current US Surgeon General, Vice Admiral (VADM) Jerome M. Adams, MD, MPH, and includes a link to the CDC guidelines for prescribing opioids for chronic pain.

The USAFP conference is always a great place to meet your fellow uniformed family physicians from our sister services and meet new PHS officers from different agencies. It was great to see officers from the Bureau of Prisons (BOP), Food and Drug Administration (FDA), Indian Health Service (IHS), and US Coast Guard. The new CG Surgeon General, RADM Dana Thomas, Director of Health, Safety, and Work-Life, was present to share her vision of the new CG medical initiatives that will pave the way to a stronger CG medical service. RADM Thomas relieved RADM Schwartz on March 1, 2019, to assume her current role after transferring from the New Jersey Department of Health where she was serving as the medical director for emergency preparedness. RADM Thomas previously served in the CG as the Chief of Occupational Medicine and the Senior Aeromedical Consultant at the Personnel Service Center prior to her agency transfer. We in the CG are excited for her return and look forward to the direction in which she will take us over the next few years. I would like to thank RADM Schwartz for her service to the CG and good sailing in her career as she moves into her new role as Deputy Surgeon General of the Public Health Service.

Also attending this year was RADM Michael Toedt, MD, FAAFP, Assistant Surgeon General, USPHS and Chief Medical Officer, IHS. RADM Toedt joined the practice management and medical informatics interest group informational sessions and seems eager to continue his work with these interest groups. Keen to improve IHS recruitment, he spent some

Surgeon General RADM Dana Thomas, MD

time at the IHS recruitment booth alongside Dr. Joe Gray and Susan Swanz. It is awesome to see our senior leadership so involved with USAFP and I am eager to see the PHS presence increase over the coming years.Thank you RADM Toedt for attending and we hope to see you as a presenter at next year's conference (no pressure)! For any future PHS attendees from other agencies, please feel free to reach out to me at next year's conference so we can cover all the PHS officers supporting the USAFP and generate more PHS related presentations and activities.

RADM Michael Toedt, MD, FAAFP pictured with Dr. Joe Gray and Susan Swanz at the HIS recruitment booth during the USAFP 2019 Annual Meeting.

This year's meeting featured a great variety of continuing medical education (CME) presentations. In addition to great CME, the meeting also offered the ALSO Instructor Course, the Hypertension KSA/CSA, and Childhood Illness KSA/CSA, and multiple hands-on workshops. Favorite presenters returned and were reinforced by new talent. It was amazing to see the many Uniformed Services University of Health Sciences (USUHS) speakers and research presentations. As a former graduate, I love seeing my alma mater represented by outstanding physicians and officers such as Commanders Michael Arnold and Francesca Cimino. Although not an official CME presentation, the first speaker was Dr. W. Robert Kiser, MD, FAAFP (USN Ret), who presented an emotionally moving view into his life as a physician and his outlook on the professional life in medicine. If you haven't heard the "broccoli talk," you missed a great one and I would encourage everyone to attend his talks in the future.

PHS DEPLOYMENTS

The PHS is still assisting the Department of Homeland Security US Customs and Border Protection (CBP) with medical screenings of family unit aliens (FMUA) and unaccompanied children (UAC) at border patrol stations along the Southwest border. The CG responded to this action in January, and it has since been taken over by the PHS. They are still in need of volunteers to provide additional support for urgent and emergent evaluation and treatment of FMUAs and UACs referred by CBP (planning factor: up to 300 apprehensions per day in each location, of which approximately 10% might require HHS medical evaluation and/or treatment). Common issues of concern are infectious disease screening, trauma, exertional injuries, environmental exposure, and acute exacerbation of chronic conditions. Locations for deployments include El Paso, TX; Wellton, AZ; and Tucson, AZ. If you are willing to volunteer for deployment please reach out to the Readiness and Deployment Operations Group at RedDOG-Response@hhs.gov and CDR Beth DeGrange at Elizabeth.DeGrange@hhs.gov.

RedDOG has notified some agency liaisons that they are reviewing the qualified deployed officer rosters for Hurricane Harvey/Irma/Maria for the Crisis Response Service Award (CRSA) and an Outstanding Unit Commendation Award (OUC). I am hopeful that we should start seeing some movement on these awards soon. So, if you deployed during the season for Hurricanes Harvey/Irma/Maria be expecting something to show up in your official personnel folder. As a first responder during Hurricane Harvey while I was stationed in Houston, I would also like to personally thank all the officers who responded or supported these deployment missions.

PHS UPDATES

Where to begin? So many changes in the PHS over the last several months it makes my head spin just trying to compile all the new updates! Let's try to address our specialty pay in the PHS. The PHS put out "2019 Changes to Health Professions Special Pays (HPSP)," available at https://dcp.psc.gov/ccmis/bulletin/HPSP_changes.aspx, on 20NOV18. The Policy outlines the clinical requirements for incentive pay (IP) and retention bonus (RB), respectively. The new 2019 IP agreement is required for all eligible officers, with the exception of officers with 28 or more years of service toward retirement who cannot enter into a two-year service commitment for a new RB. In addition, the policy adds that an IP and Board Certification Incentive Pay (BCIP) may be terminated by a HPSP review board, involuntary termination board (ITB), board of inquiry (BOI) or an involuntary retirement board (IRB). Basically it means that officers are at risk of losing IP and BCIP if they fail to meet any conditions of service for any period of time!

Next, the "2019 HPSP Agreements and Pay Schedule," available at https://dcp.psc.gov/ccmis/bulletin/HPSP_agreement.aspx, was released on December 3, 2018. IP will be paid monthly on a pro-rated daily basis at the end of the month (i.e. payment for April on May 1). In addition, our first 2019 HPSP payment for newly received and processed agreements was March 1, 2019 and will contain payment for 33 days. This means our pay won't be received until after April 1! If you don't get your IP in your April pay, please contact your pay officer.

continued on page 22

continued from page 21

The third of these notifications, "HPSP POM 821.70: HPSP Submission, Effective Dates, and Subspecialty Rates," https://dcp.psc.gov/ccmis/bulletin/HPSP_submission.aspx, was released on January 29, 2019. The update reported that your HPSP pay should start within 90 days after receipt of your completed agreement in the Division of Commissioned Corps Personnel and Readiness (DCCPR) or within 90 days after DCCPR receives all necessary supporting documentation. They restate that your first possible payment won't be until April 1, 2019. They also describe the shift in your 2019 IP payments to the end of the month and that it may appear like we won't get paid for one month. PHS says that the payment is only shifting to the end of the month instead of the beginning of the month and we should be settled in April. My recommendation is to check your earning statements carefully for December through April. Make sure your pay is correct and, if not, contact you pay technician and liaison to make sure all the correct paperwork was filed appropriately! Check out the information regarding compensation at https://dcp.psc.gov/ccmis/HPSP/HPSP.aspx .

The latest issue with HPSP involves those officers who are retirement eligible in the next couple years. The change in our pay contracts offset those few officers nearing retirement with legacy four-year contracts timed to end at retirement and before 2022. These officers would have experienced unexpected and unintended pay cuts just before retirement were it not for the new transitional HPSP (T-HPSP), policy. Most of us will not be affected by this policy, but, if you are retiring before 2022, please reach out to the Physician Professional Advisory Committee (PPAC) Compensation Chairs, LCDR Lee Astle (lastle@anthc.org) and LCDR Mary Boyd (moq6@cdc.gov), and your agency liaison, to ensure you are signed up for T-HPSP.

On a more positive note, the PPAC recently developed a "Medical Category Resource Guide" intended to provide detailed introductory information on many topics, including calls to active duty, applicable to all Corps physicians. If you haven't heard about it, please check it out on the "max.gov" website at https://community.max.gov/download/attachments/1286474606/Medical%20Category%20Resource%20Guide_2019.0222.pdf?api=v2. I would like to give a shout out to LCDR Khalid Jaboori and LCDR Emily Petersen, CDC Division of Reproductive Health, for getting this together for everyone! If you haven't been receiving the PPAC list-serve emails or emails from the Chief Medical Officer, go to https://list.nih.gov/cgi-bin/wa.exe?A0=COMMCORPS_MEDOFFCRS and click subscribe on the right.

Speaking of PPAC, I want to make sure everyone is aware of the annual PPAC awards for physicians. Unfortunately, this year's deadline just passed but please be aware of them for next year. I am a member of the PPAC Awards Subcommittee, led by CAPT Edgardo Alicea, and we review the annual awards presented at the USPHS Scientific and Training Symposium. This year, the award winners will be honored at the Minneapolis Convention Center. There are four awards PPAC gives out annually: Clinical Physician of the Year, RADM Boris D. Lushniak Physician Leader of the Year, Junior Physician of the Year, and Research Physician of the Year. Each award has its own set of criteria. The award information, including submission requirements, can be found on the PPAC website. In addition, we send out the award information on the PPAC list-serve, so make sure you are signed up and prepared for next year's submissions! In case you have never attended the USPHS Annual Scientific and Training Symposium, I would encourage all PHS officers to attend as often as possible. It is a great conference for all Commissioned Corps officers to assemble, earn CME, and build professional relationships. If you are interested in attending this year, please visit https://www.phscof.org and attend not only the CME events, but also attend other PHS specific events such as the Caduceus Dinner, the Minority Officers Liaison Council (MOLC) 2019 Awards Breakfast, the PPAC Awards, and deployment readiness and clinical skills training!

As part of the PPAC Outreach Subcommittee Family Medicine Team, along with Captain Sarah Arnold and CDR Ryan Sheffield, our goal is to unify all the PHS family physicians (FP) in coordinating information that pertains to us across all PHS agencies. Our first initiative was a ten-question survey that was sent out to everyone who had their emails listed on the PPAC list-serve and identified as FP's. According to the PPAC medical officer roster, there are 124 FP's serving in the PHS and we received roughly a two-thirds response to the survey. The full data will be sent to PPAC, but I wanted to share these highlights from the questions:

1) 25% of FP's have already served 16-20 years, with less than 10% having served less than 5 years.
2) 54% of FP's are at the temporary rank of O-6, and 25% are at O-5.

3) 35% of FP's are attached to the Indian Health Service and 27% are attached to the Coast Guard.
4) 49% of FP's are providing direct health care, while 16% are in supervisory roles.
5) 41% of FP's are considered satisfied with their service, while 21% are only partially satisfied or not satisfied at all.
6) 29% of FP's are satisfied with their roles, responsibilities, and degree of support available as a PHS CC officer; 61% of FP's are either not satisfied or only partially satisfied.
7) 43% of FP's indicated their most important priority was retirement benefits and salary, followed by 60% who, combined, said allegiance to one's coworkers, patients, and/or mission within one's agency was their top priority.
8) 46% of FP's plan to serve beyond 20 years but retire before mandated, with 20% of FP's planning to retire at 20 years.
9) 40% of FP's indicated that increased advocacy to PHS CC leadership by the PPAC Outreach Subcommittee was its most important function.
10) 52% of FP's indicated that they are USAFP members, with 20% of FP's indicating they are not interested in additional information or becoming a member of USAFP.

We will be setting up an FP meeting soon. Make sure your email is on the list-serve and that you are identified as an FP in order to receive the invite. We hope to review all the results of the survey and identify what PHS FP's are interested in cultivating over the next few years. If you are interested in serving in the PPAC or have ideas for the PPAC Outreach Subcommittee Family Medicine Team, please reach out to Captain Arnold, CDR Sheffield, or myself!

The last PHS update regards the Commissioned Corps modernization that will affect how the PHS is organized, our mission, and what will be expected of all PHS officers. Recently we had a large Commissioned Corps town hall where Assistant Secretary for Health (ASH) Admiral Brett Giroir proposed changes to strengthen the PHS. Based on a recent assessment, Admiral Giroir is proposing to downsize the overall size of the PHS while recommending an increase in physicians to reshape the Service. ADM Giroir has commented that the Corps must be competent in its ability to serve our underserved populations and be able to contribute to the tempo of PHS deployments. If we cannot meet these two missions, then the concern is that we can be replaced by civilians and the Corps will no longer be necessary. If you missed this town hall meeting, you can access the information located on the Commissioned Corps Management Information System website. Log onto the secure area officer sign in and find the link labeled "Commissioned Corps Modernization" on the left side. From that link, you can find another link to "Presentations and Resources." It has been asked to not redistribute these slides or share with the public.

LASTLY

I would like to thank all of my fellow PHS physicians who showed up at and/or spoke at this year's USAFP meeting! I will miss Captain Sarah Arnold as she is leaving the PHS/CG Director position. Thank you, Sarah, for your mentoring over the last few years and your presence on the board. You will be missed. It is always great to return to the USAFP Annual Conference to catch up with friends, to see what one's fellow FP's are doing across the services, and meet new friends. With approximately 52% of PHS FP's being USAFP members, I would challenge all PHS FP's to attend next year! I look forward to seeing everyone in Anaheim, California, for the 2020 USAFP meeting.

USAFP MENTORSHIP PROGRAM

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.

consultant report
NAVY

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Remember, it is your record that gets promoted…make sure it accurately reflects your service.

Greetings, fellow FP'ers! I'm feeling energized on the heels of another great USAFP Annual Meeting. Many thanks to all that volunteered to teach, organize, and contribute in so many other ways to make this the premier continuing medical education conference. I enjoyed the opportunity to chat with many of you. If you could not attend this time, do know that you were missed and very much appreciated for standing the watch. THANK YOU!

During our community's break-out session, we were able to provide updates on a number of hot button topics impacting not just the FM community, but also the DoD, including Program Objective Memorandum (POM) 2020/2021 and the Defense Health Agency transition. I will take this opportunity to summarize these updates for those who could not attend.

MANNING STATUS & DETAILING

As of 28 Feb 2019, we had 360 uniformed family physicians for 408 billets, which includes 29 "Fair Share" billets. This translates to an 88.2% overall fill rate and a gap of 48 billets. Thus, if you are feeling the pinch of gapped billets, do understand it is known and getting visibility. Our community is projected to see this gap close going forward (and POM can certainly be a game-changer in a positive way if fully implemented). If you are approaching your projected rotation date (PRD) or your end of obligated service (EOS) and are wondering what to do next, please reach out to our detailer, CDR Anja Dabelić, to explore options. The goal is to align your professional goals with available opportunities and priorities. I am also available to be of help, so don't hesitate to reach out to me.

DIVESTITURES (POM20)

During our break-out session, we had a discussion about the proposed plans for divestitures (i.e. billet cuts) in Navy Medicine. The title for this initiative is *Project Objective Memorandum 2020*, with projected changes in the billet profile being implemented in FY2020 and FY2021. Since specifics are still being worked out, there is still a lot that is not known. Here is what I do know as I sit and type this (which, for some items, is more than I knew at the time of the annual meeting):

- The changes are forward looking and meet changing wartime requirements in support of the National Defense Strategy (think: reallocation of resources).
- This is not a Bureau of Medicine decision.
- This impacts the Army and Air Force medical departments as well.
- Numbers aren't certain, but are estimated to impact about 5,000 billets for Navy Medicine, impacting all corps (MC, NC, MSC, corpsmen).
- Under the current phasing plan, 60% of billets will be reduced in FY20 and remainder in FY21
- There is NO plan for forced reductions or forced attrition.
- Billets initially identified for reduction were tied to the effort to reduce, move, or eliminate some existing Expeditionary Medical Facilities (EMF's).
- Training programs (e.g. graduate medical education) are planning to be maintained, although they may look different in the future.
- There are NO changes to promotion at this time.
- There's NO discussion of reductions to civilian or contract positions.

Your leadership remains actively engaged in this effort, with the goal to ensure that any reductions will ensure continued support of our mission and YOU. I will be diligent in communicating with you as we learn more details. I also invite you to reach out to me directly with any questions or concerns.

UPDATE: DEFENSE HEALTH AGENCY (DHA) TRANSITION

The first phase of the transition of DoD Military Treatment Facilities (MTF) to DHA is just over six months old. At the break-out session, I shared some perspectives from the Navy's first MTF to fall under DHA: Naval Hospital Jacksonville, FL (NHJax).

- There have been no seismic changes at the deckplate level. Patient care continues without much notice. Looking forward, there is the possibility of a change in the mix of patients, to include a greater proportion of active duty.
- NHJax has a new name (or, more accurately, a second name): Navy Medicine Readiness & Training Command (NMR&TC). The people are the same, but it highlights the hospital's dual missions: readiness and providing the health care benefit. This differentiation has heralded a renewed focus on the true cost of readiness--cue knowledge, skills, and abilities (KSA).
- The dual mission of the organization parallels a shift in the organizational structure, which now has two reporting chains. Currently, most of the hospital leadership is dual-hatted, with all active duty personnel still having one boss (CO NMR&TC…who is also the CO of NHJax), who reports to both DHA (NHJax) and Navy Medicine (NMR&TC).
- The transition has been, and will continue to be, a learning process, with MTF's sharing lessons learned.

I will continue to report updates as the transition marches on. The next phase begins October 1st, 2019, when most of the Eastern US facilities will fall under DHA, representing 52% of all military facilities, 54% of personnel, and 57% of enrollees.

"SPRING CLEANING" TIME: PROMOTION PREPARATION

The spring marks that time of year when boards meet to select the next round of officers for promotion to the next rank. Each year, around December, the lineal list and promotion plan are released along with the promotion board schedule. You should use this time of year as a prompt to look at your record and do a "spring cleaning." This will save you from scrambling at the last minute to provide updates and fill in gaps. *Remember, it is your record that gets promoted…make sure it accurately reflects your service.* Additionally, 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.

COMMUNICATION:

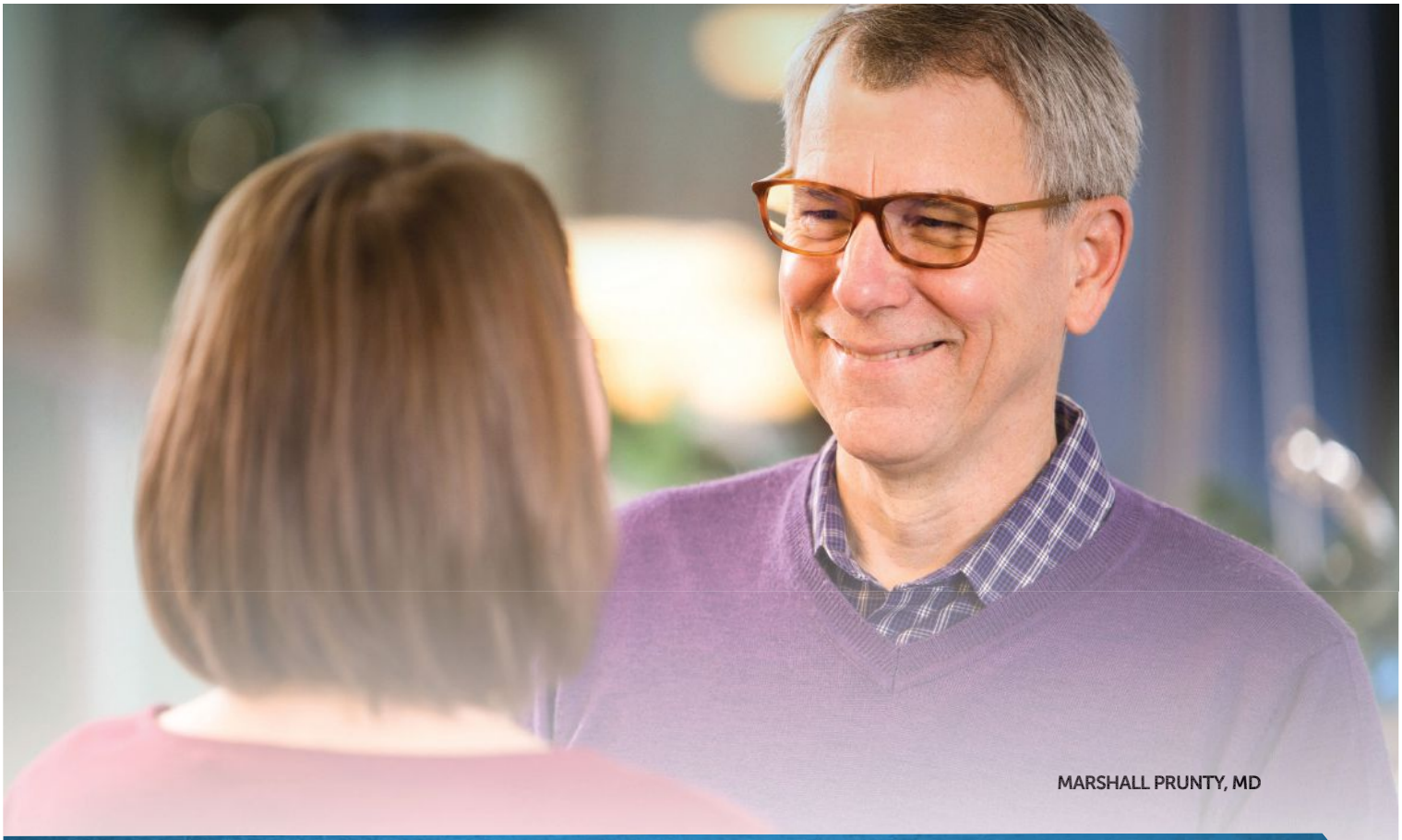
With each column, I'm going to continue to provide the below list of communication venues for us to stay connected as a community, corps, and service:

- 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 FP's to see if they are getting my emails to ensure they are in the loop.
- MCCareer.org: The *Navy Medical Corps Career Blog* has been renamed "*Joel Schofer's Career Planning Blog*," but continues to be a treasure trove of career management gouge, and is highly recommended as you prepare for your next career milestone and promotion.
- 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 information: 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-enabled 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, and will send links to it in emails sent out to the community.

NEW CHIEF OF THE MEDICAL CORPS:

In August, RDML Paul Pearigen will be finishing his tenure as your Chief of the Medical Corps and turning over the reins to RDML (sel) Jim Hancock. RDML Hancock has training in both family and emergency medicine, and recent tours include US Fleet Forces Surgeon, CO at NMC Camp Lejeune, and BUMED Medical Plans (M3.) Our community (and Navy Medicine) is grateful to RDML Pearigen for his leadership and support during a time of significant change and we look forward to welcoming RDML (sel) Hancock to the helm.

As I close, I wanted to leave you with a quote that I recently read: "Change is the law of life and those who look only to the past or present are certain to miss the future" – President John F. Kennedy. I am encouraged by the leadership that is in place as we navigate the latest waves of change to ensure Navy Medicine remains strong and ready to meet our mission. I look forward to working with you as we move forward. Thank you for your committed service every day and stay well!



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Director, Leader and Faculty Development Fellowship
Madigan AMC, WA
robohmd@gmail.com

Leading Change

"If you don't like change, you're going to like irrelevance even less."
- General Eric Shinseki, 34th Chief of Staff of the Army

Change is constant in the military, but today's changes seem seismic, revolutionary, and painfully disruptive. Whether it's MHS Genesis, reorganization of all military treatment facilities under the Defense Health Agency, the National Defense Authorization Act (NDAA) of 2017, or NDAA 19, change seems to be all around us. How do we respond as Uniformed Family Physicians? I believe this talented group of physicians can lead through the changes.

A little over 15 months ago, I had the immense privilege of becoming the fellowship director for faculty development. This fellowship, in existence since 1985, has graduated over 90 leaders and physicians – many of them today's program directors, department leaders, strategic level officers, specialty consultants, and flag officers. Despite the pedigree of graduates, the program was recently under the threat of closure as the Army combed through its inventory in an effort to diminish or even eliminate less operationally relevant fellowships. Faculty development was under the microscope. Through Doug Maurer's leadership, the fellowship survived the culling. A new strategic direction was formulated to forge the fellowship's next evolution.

Recognizing the changing role of the medical corps officer and the needs of the Army, we decided to leverage two big concepts from Good to Great, a classic on the fellowship reading list. At last year's strategic planning meeting, we confronted the brutal facts. We considered what we could contribute to military medicine, what motivated our passion, and what the fellowship could do best. Despite the fellowship's roots in graduate medical education (GME), we realized we needed to think more broadly about our strengths. We collectively determined that the fellowship's true core competency is development of leaders, not just within GME but within military medicine as a whole. With this in mind, we developed a bold new mission and vision statement with three strategic goals:

FELLOWSHIP VISION:

The Madigan Leader and Faculty Development fellowship will be the premier leader development pathway for military physicians.

FELLOWSHIP MISSION:

To develop military physicians able to lead and equip physicians at all levels and to advance military medicine through innovation and research.

STRATEGIC GOALS:

To ensure readiness to fulfill leadership roles in military medicine, fellows will train in the following areas:

1. **Lead and Manage:** To enhance fellows' leadership and management skills to develop skills necessary to assume all leadership roles in the MHS.

2. **Train and Equip:** To develop fellows' ability to skillfully communicate and effectively train complex subjects.

3. **Innovate and Advance Military Medicine:** To create visionary leaders able to advance and innovate the military healthcare system.

The two-year fellowship allows a unique blend of being clinically active (30% clinical/teaching) while concurrently pursuing a Master's degree (Master of Public Health, Master of Business Administration) and actively participating in military medicine. For example, our projects this year include developing innovative platforms for teaching, expanding our role in leader development to encompass not only Madigan but the entire Puget Sound Enhanced Multi-Service Market, and developing a military readiness curriculum that nests within the ACGME Milestone framework. In addition, we are investigating how we can incorporate point of care ultrasound as the next game changing technology to advance military medicine both in residency and for all family physicians.

While the future of the fellowship and military medicine looks unclear, distant, and frankly scary, I find comfort in the adaptability and resilience of the uniformed family physicians of the past and present. We are family physicians, called to lead, equip and advance. As we turn to the future, who better than the uniformed family physician to lead through this time of immense change. Let's do it together.

If you are interested in becoming a fellow and exploring ways to lead, equip and advance military medicine, please don't hesitate to contact us.

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Beyond the Standard Deployment Checklist

Thank you to all who have sent, and continue to send, articles to the Operational Medicine Committee. Just as the spring and summertime is considered by many as permanent change of station (PCS) time, there are some of you receiving deployment orders. Whether it is a six- to nine-month deployment to the Middle East or an equally tough assignment in the Pacific region, it can be a stressful time. Like in-processing and out-processing an installation, there is likely a soldier readiness process (SRP) or deployment checklist your unit or hospital will provide you. This checklist will ensure that you have completed your required online training, received applicable vaccinations, updated medical and dental records, finished next of kin paperwork, and confirmed your next evaluation is ready to go by the day you leave. In addition to these standard checklists, you must prepare yourself both physically and mentally for the upcoming deployment. In this article, we will focus on deployment considerations that are not on a standard checklist.

The first item on our list is to refresh your knowledge of Tactical Combat Casualty Care (TCCC). The best way to do this is on the deployedmedicine.com website or app

The first item on our list is to refresh your knowledge of Tactical Combat Casualty Care (TCCC). The best way to do this is on the deployedmedicine.com website or app (available for iOS and android). This is the platform used by the Defense Health Agency (DHA) to push the information needed to improve the readiness and performance of deployed military medical personnel. The platform allows you to download the TCCC guidelines, watch videos, listen to podcasts, and more. Want to know about in-the-field resuscitative endovascular balloon occlusion of the aorta (REBOA)? Well, you are in luck because the website has a video on that!

After you identify the area of the world to which you are deploying, you will need to do your own medical research. Often, as soon as you set foot into the deployed environment, you will be assumed to be the medical subject matter expert and will be expected to advise your command. You can start your research at the Centers for Disease Control and Prevention (CDC) website: https://wwwnc.cdc.gov/travel/destinations/list. Once you get a good handle on immunizations, malaria prophylaxis, non-vaccine-preventable diseases, and a healthy travel packing list, it's time to focus on the specific region of the country to which you are going . This is where you can utilize your medical operations officer. That person has access to resources, classified and unclassified, to help build a medical threat query. Additionally, you can review recent after-action reports for medical casualties and evacuation cases, which can be accessed through the DoD trauma registry: https://jts.amedd.army.mil/

Your next source of information, and maybe the most important, is contacting the person you are replacing on the ground. There is likely someone downrange already doing your job, and a quick email may be enough to put you in touch. That

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.*

person will have the most current information about what you should bring downrange, what the current operational tempo is, and any current medical issues. They can provide guidance on pre-deployment items not to miss. If you can talk to the person on the ground, you will quickly learn about the hospital with which you will work, what type of equipment you will have downrange, and how many medical personnel you'll have. Don't forget to get your interfacility credential transfer brief (ICTB) signed from your local credentialing office. Your person downrange can take that ICTB and help get your credentials approved before you arrive in country.

Another good habit is preparing your gear as soon as you know when you are going. If you don't have the luxury of knowing months in advance, then start packing at least one to two months out. While you may pick up another set of gear from a CONUS replacement center (CRC), you should pack your aid bag, additional critical care ruck sack, and any other things that are nice to have. Once everything is packed, do your preventive maintenance checks and services (PMCS). There is nothing like having an awesome first aid kit and then not being able to see it in the dark because you forgot to change your headlamp batteries. In addition to the PMCS you do now, make sure you do it again one month and one week out from deployment. And remember, don't forget to bring extra batteries.

Once you are downrange, it's time to get to work. Ensure you are properly in-processed to the unit or the hospital. Addtionally, look to update the medical common operating picture (MEDCOP). Make sure other medical providers in theater know you have arrived and are replacing whoever that might be. Make sure your contact information is correct and ensure the MEDCOP is up to date on contact information, hospitals in the area, surgical capabilities, and MEDEVAC assets. Again, your medical operations officer who helped you while you were still in CONUS will be a good resource in obtaining the current MEDCOP.

Lastly, find out which medical assets are housed on base with you. There are not only physicians, but PAs, medics, independent duty corpsmen (IDCs) and independent duty medical technicians (IDMTs) running around your area. See if you can get together on a regular basis—maybe for weekly medical didactics or other team building events. If there are mass casualty rehearsals, work together to ensure you have a good plan in place. Know where your mass casualty medical supplies are located, ensure the equipment is not expired, and confirm that all personnel know how to use the equipment. Overall, while on deployment, continue to improve yourself and those around you.

BEYOND THE STANDARD CHECKLIST

1. Refresh TCCC knowledge with the deployedmedicine.com website or app
2. Research the geographic area
3. Contact your medical operations officer
4. Contact the person you will be replacing (person on the ground), get moving on your ICTB
5. Prepare your gear
6. In-process on the ground and update the MEDCOP
7. Work with other local medical assets, prepare for mass casualty events

CLINICAL INVESTIGATIONS COMMITTEE

Robert C. Oh, MD, MPH, FAAFP
Madigan Army Medical Center, WA
robohmd@gmail.com

WOW! The Clinical Investigations Committee (CIC) had a banner year from 2018-2019. We celebrated Dr. Anthony Beutler's ten years of leadership as we bid him farewell upon his coming retirement. He has taken the CIC to a new level and I hope to sustain his efforts as your CIC Chair. Please also welcome Dr. Heidi Gaddey as Vice-Chair. She will be heading up the charge of improving collaboration and communication with local research mentors. Some highlights from this year:

ANNUAL RESEARCH COMPETITION STATS

- Total research submitted:136 abstracts (51 Army, 43 Navy, 42 Air Force)
- All 15 residencies submitted research projects
- 49% of those participating presented research for the first time

OMNIBUS SURVEY

Thank you! Your voice is critical in studying the hot topics germane to uniformed family physicians. Topics that have been published recently in the literature are highlighted here:

1. Acupuncture and Pain

Crawford P, Jackson J, Ledford CJW. The association between acupuncture training and opioid prescribing practices, *Pain Medicine*, https://doi.org/10.1093/pm/pny243

2. Gender Dysphoria

Schvey NA, Blubaugh I, Morettini A, **Klein, DA**. Military family physicians' readiness for treating patients with gender dysphoria. *JAMA Internal Med.* 2017;177(5):727-729.

These are the fruits of the 2016 omnibus survey and we will highlight the survey in a future newsletter. We also saw some great research questions on breastfeeding, running gait training, pharmacogenomics, diabetes and pre-diabetes this year and we look forward to more great survey topics in the future. Look for the call for questions to come in the October time frame.

RESEARCH MENTOR WORKSHOP

We had an awesome time learning about the "deadly sins" of poster presentation and learning how to actually "judge" posters. We presented different single site research projects and, with the help of the Military Primary Care Research Network, was able to select an outstanding project to expand into a multisite collaboration. Stay tuned for more information as this project germinates.

RESOURCES

We will start working on upgrading the resource section on the USAFP research website. Stay tuned as we move closer to opening the research competition in July.

Thank you for the great energy and ideas. Please continue to send me more! Interested in research? Please join us on the committee or consider applying to be a research judge. For more information, please visit the website: http://www.usafp.org/committees/clinical-investigations/.

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2019 USAFP Research Winners

Poster Case Report Winners

1ST PLACE CASE REPORT POSTER DISPLAY RESIDENT CATEGORY

Beware of this Infection

LT Micah Pastula MD, Naval Hospital Jacksonville, FL; Kayla McManus DO, University of Florida Pediatric Residency, Jacksonville, FL; Matthew Bankowski Ph.D, Baptist Medical Center Jacksonville, Jacksonville, FL

Introduction/Objective: Since 1927, fewer than 175 cases of human infection with Chromobacterium violaceum have been reported worldwide, but there is an associated case-fatality rate of up to 65%. This case calls attention to a distinct exposure that is consistently associated with this deadly infection. **Case Presentation:** A 16-year-old male presented to the ED with a laceration to the plantar aspect of his left foot sustained after jumping barefoot into a pond on a hot summer day in rural Florida. The 3cm laceration was irrigated and sutured. He returned ten days later with significant cellulitis, wound dehiscence with purulent drainage, and dorsal forefoot fluctuance. CT showed multiple abscesses of the foot. He was started on clindamycin and Zosyn, and surgical debridement was performed the next morning. After the wound culture grew out Serratia and Chromobacterium violaceum, he was transitioned to a prolonged course of ciprofloxacin, which was curative. **Discussion:** C. violaceum is a gram-negative, facultative anaerobic bacillus that thrives in aquatic environments. Human infection is rare, but associated with rapid progression to sepsis, metastatic abscess formation, multi-drug resistance, relapsing infection, and a remarkably high case-fatality rate. Infected patients tend to be young men and commonly present during the summer with sepsis or localized skin infection after exposure to freshwater of a tropical environment. Although widely resistant to antibiotics, C. violaceum is generally susceptible to fluoroquinolones, tetracyclines, and trimethoprim-sulfamethoxazole. A 2-3 month course of antibiotics is generally recommended to prevent relapse. Our case highlights key risk factors for C. violaceum infection and a favorable response to appropriate antimicrobial therapy. **Scholarly Questions:** Should we culture all abscesses associated with tropical freshwater exposure? **Conclusion:** Military personnel are frequently exposed to stagnant freshwater of tropical environments. Maintaining a high suspicion for C. violaceum infection in at-risk cases allows for early identification and proper treatment of this frequently lethal infection.

1ST PLACE CASE REPORT POSTER DISPLAY MEDICAL STUDENT CATEGORY

A Medical Plot Twist: Gastric Volvulus in a Soldier Remote from Laparoscopic Sleeve Gastrectomy

2LT Ashley Yano, MS4; CPT Jennifer Veldhuyzen, MD; LTC Garrett Meyers, MD Uniformed Services University, Bethesda, MD; Carl R. Darnall Army Medical Center, Fort Hood, TX

Introduction/Objective: Intermittent gastric volvulus (IGV) is an uncommon cause of nausea and vomiting. We present a Soldier with intractable nausea, vomiting, and abdominal pain caused by IGV years after a gastric sleeve procedure. **Case Presentation:** A 47-year-old active duty female E-8 with past medical history including stroke, peptic ulcer disease, and gastroesophageal reflux presented with five days of nausea, vomiting, and intolerance of oral intake. Physical exam was notable for hypertension and abdominal tenderness without peritoneal signs. Abdominal CT revealed post-operative status from an unreported sleeve gastrectomy. The patient later admitted this procedure was performed five years prior. Symptoms persisted despite medical therapy. Upper endoscopy revealed gastric torsion, which was reduced during the procedure. Subsequent barium swallow showed persistent partial volvulus. She was transferred for bariatric surgeon assessment, and symptoms improved gradually without surgical intervention. **Discussion:** Our literature review showed this to be the first reported case of IGV presenting several years after sleeve gastrectomy, and the first described in an active duty Soldier. Prior case reports describe IGV after sleeve gastrectomy only in the immediate post-operative period. They also report IGV incidence mainly in the elderly or those with congenital abnormalities. IGV is a challenging diagnosis because of nonspecific presenting symptoms that can vary from nausea and vomiting to mimicking acute coronary syndrome. Radiology may have low sensitivity due to the condition›s intermittent nature, and in various cases IGV has eluded detection on CT and even barium swallow. The health impact associated with this case of IGV illustrates the importance of appropriately advising Soldiers considering unauthorized weight loss treatments. **Scholarly Questions:** What is the incidence of gastric volvulus remote from laparoscopic sleeve gastrectomy? **Conclusion:** Family physicians will increasingly manage the care of patients after bariatric procedures. Nonspecific symptoms including nausea and emesis, when intractable, may require diagnostic persistence and consideration of uncommon complications including volvulus.

2ND PLACE CASE REPORT POSTER DISPLAY RESIDENT CATEGORY

DRESS to Impress: An Atypical Presentation of Drug Reaction with Eosinophilia and Systemic Symptoms

Cordell Hachinsky, MD, CPT, MC; Sean Morris, MD, CPT, MC; Mary A. Noel, MD, MAJ, MC Martin Army Community Hospital, Fort Benning, Georgia

Introduction/Objective: Drug-induced hypersensitivity syndrome (DIHS), also known as drug reaction with eosinophilia and systemic symptoms (DRESS), rates amongst the most severe adverse cutaneous drug eruptions. This case highlights an unusual dermatologic presentation in a Soldier who developed DRESS after receiving trimethroprim/sulfamethoxazole. **Case Presentation:** An 18-year-old male Soldier presented to the Emergency Department following a syncopal episode. On examination the patient had facial edema, a diffuse morbilliform rash, bilateral conjunctivitis, and was febrile to 103.2 degrees. Notable hospital labs include a significant transaminitis (as high as AST/ALT: 690/1114), Eosinophilia of 12.2% (WBC of 3.4), and an acute kidney injury (Creatinine 1.6). The patient was on day 10 of Bactrim DS for a culture-confirmed MRSA abscess. He met criteria for a "definite" case of DRESS/DIHS using the RegiSCAR scoring system. His laboratory abnormalities persisted for 27 days. Work-up for other potential causes was negative. He missed approximately two months of Basic Training. No long-term sequelae have been seen after 6 months.

Discussion: DIHS/DRESS is relatively rare but with a significant short term mortality rate (~10%) and serious long-term sequelae (risk of thyroiditis, myocarditis, pancreatitis, and systemic lupus erythematosus). Per IDSA guidelines, trimethoprim/sulfamethoxazole is a first-line treatment for suspected MRSA abscesses and is commonly prescribed to Servicemembers. DRESS/DIHS is also commonly misidentified, potentially leading to severe sequelae, especially in training or austere environments. **Scholarly Questions:** Should laboratory investigation be performed for all suspected cutaneous drug-reactions or is discontinuing the medication enough? **Conclusion:** Servicemembers presenting with cutaneous findings after starting trimethoprim/sulfamethoxazole should be evaluated with a CMP and CBC (with differential and peripheral smear). Use of a scoring system such as the RegiSCAR criteria can also help in potential cases. The literature does not appear to support any limitations for continued military service, though in the short-term it seems likely to make Soldiers more susceptible to exertional injuries.

3RD PLACE CASE REPORT POSTER DISPLAY
RESIDENT CATEGORY

Puzzling Pediatric Primary Pyomyositis

CPT Kathryn E. Oppenlander, MD Family Medicine Residency, Carl R. Darnall Army Medical Center, Fort Hood, Texas

Introduction/Objective: Primary pyomyositis (PPM) is a rare infection of skeletal muscle that can cause permanent disability and is often initially misdiagnosed due to lack of disease familiarity. Presented is a pediatric case of PPM misdiagnosed as transient tenosynovitis. **Case Presentation:** A 2-year-old female presented with 24 hours of right leg pain, limp, and external rotation of the hip. Labs showed an increased CRP (16.7-mg/L) and leukocytosis (14.9-103/mcL). Radiographs were normal and ultrasound showed a small effusion. She was admitted for transient tenosynovitis and discharged after pain and CRP improved. She returned four days later with fever of 101.5°F and tachycardia. She had an erythematous swelling of the right thigh, refusal to stand, and worsening CRP (51.8) and leukocytosis (23.3). Intravenous vancomycin was started. MRI revealed a right rectus femoris intramuscular abscess. After two surgical washouts, intraoperative cultures grew methicillin-resistant Staphylococcus aureus. She was transitioned to oral clindamycin and improved over a seven-day hospital course. **Discussion:** PPM is classically a tropical disease, with a reported hospital incidence of 1-4%. PPM is rare in temperate climates, with 246 reported cases in the United States from 1981-2004. Temperate cases are more common in adults and immunocompromised individuals. Reported pediatric cases of PPM are increasing; a recent retrospective Australian study showed an increased incidence from 2.04 to 8.73 cases per 10,000 ER admissions during the first and last quarters over ten years. Infections, exercise, and trauma with subsequent hematological seeding have been cited as possible causes of PPM. **Scholarly Questions:** Why are pediatric PPM cases increasing? **Conclusion:** Non-specific symptoms including fever and myalgia often result in misdiagnosis of PPM. Due to disease progression, abscess formation has often already developed by the time PPM is diagnosed. Given the rise in temperate cases of pediatric PPM, advanced imaging should be sought sooner in limping children without an obvious cause.

continued on page 36

continued page 28

Case Report Winners
Not pictured Lt Shea Wickland, MD 1st place Case Report Resident Category

1ST PLACE CASE REPORT PODIUM PRESENTATION RESIDENT CATEGORY

The Use of Tranexamic Acid (TXA) for the Treatment of Acute GI Bleeding

Shea Wickland, LT, MD, Naval Hospital Camp Pendleton, Oceanside, CA; Julian Nicholas, MD, PhD

Introduction: Tranexamic acid (TXA) is an antifibrinolytic agent that is FDA approved for the treatment of cyclic heavy menstrual bleeding. It has been shown to reduce death due to bleeding in trauma patients and women with postpartum hemorrhage. Presented is a case of a patient with acute transfusion-dependent gastrointestinal bleeding who was successfully treated with TXA. **Case Presentation:** An 87-year-old man presented to the emergency room with sudden onset painless hematochezia. He underwent emergent colonoscopy, which demonstrated extensive diverticulosis but no evidence of active bleed. He continued to have intermittent hematochezia over the next three days requiring a total of four units of PRBC's. Additional imaging with tagged red blood cells and CT angiogram failed to identify the source of bleeding. He received a TXA infusion with subsequent resolution of his hematochezia. **Discussion:** Acute lower gastrointestinal bleeding is a medical emergency resulting in a mortality rate of approximately 3%. The bleeding site is not always identified on colonoscopy and further treatment may be warranted in patients with ongoing or recurrent bleeding. TXA has been shown to reduce the need for blood transfusion in surgical patients, and has been studied in a variety of conditions including postpartum hemorrhage, intracranial hemorrhage, and trauma. Currently there is an international randomized controlled trial underway investigating the use of TXA in patients with acute gastrointestinal bleeding. **Scholarly Question:** What is the role for empiric therapy with TXA for the treatment of acute gastrointestinal bleed? **Conclusion:** As illustrated by this case, treatment with TXA could be considered in patients with acute gastrointestinal bleeding, particularly when endoscopy is not readily available. However, currently there is insufficient evidence to support the empiric use of TXA and larger studies are needed to assess its effect on overall morbidity and mortality.

2ND PLACE CASE REPORT PODIUM PRESENTATION RESIDENT CATEGORY

Prevention of Zolpidem Withdrawal in the Primary Care Setting *Bradley McCullough Capt, DO, Alex Kim Capt MD (Travis AFB, David Grant Medical Center-Family Medicine Residency Program)*

Intro: Zolpidem is common in the primary care setting, yet there are few reports of withdrawal symptoms in patients taking standard dosages. Primary care literature discusses the dangers of zolpidem without establishing clear guidelines on how to taper chronic users. **Case presentation:** 65-year-old woman presented to clinic requesting refill of 10mg zolpidem which she had been using for twelve years. She developed dependence resulting in severe withdrawal symptoms requiring hospitalization for nausea, vomiting and headaches. Zolpidem was tapered by 2.5mg per month. Low dose clonazepam (0.5mg) was used for withdrawal symptoms as needed. Initially she used clonazepam 4-5 times weekly, but after one month she only required it 1-2 times per month. At 3 months her zolpidem dose was down-titrated to 5 mg, and at 5 months she had discontinued the medication without further withdrawal symptoms. **Discussion:** In 2013, zolpidem was the most widely prescribed hypnotic medication. The prevalence of withdrawal from zolpidem is not clear. Several case studies have discussed using benzodiazepines to manage withdrawal symptoms in the hospital setting for patients previously taking high doses of zolpidem. Zolpidem is not approved for long term use or in doses exceeding 5mgs in female or geriatric patients. This case exemplifies a patient on incorrect dosing for her gender and age. The benzodiazepine taper used is certainly a reasonable option, albeit not without risks. To avoid hospitalization, a benzodiazepine was selected based on the available case reports and a lack of further guidance from the literature. **Scholarly Question:** How should a patient with withdrawal symptoms be tapered off zolpidem in the out-patient setting? **Conclusion:** We describe an effective, out-patient method to taper a patient previously hospitalized for withdrawal symptoms from zolpidem. There is little guidance in literature for clinicians tapering zolpidem in the primary care setting; this represents an area ripe for future inquiry.

3RD PLACE CASE REPORT PODIUM PRESENTATION RESIDENT CATEGORY

What A Drag: A Case of Electronic Cigarette Associated Acute Eosinophilic Pneumonia.

Molly Booy, M.D., MAJ Karla Vega-Colon, M.D., and MAJ Samuel Tiglao, D.O. Tripler Army Medical Center, Honolulu, HI

Introduction: Electronic-cigarettes (E-cigarettes) are commonly marketed for smoking cessation. However, the rate of recreational use, particularly amongst teenagers and young adults, has increased by 900% from 2011 to 2015. This case highlights potential detrimental health effects of E-cigarettes on otherwise young healthy adults.

Case: A previously healthy 18-year-old Active Duty Navy female presented for one day of non-productive cough, dyspnea, and pleuritic chest pain following a 2-month history of E-cigarette use. Exam and initial assessment were notable for tachycardia, tachypnea, hypoxemia, fever, diffuse rhonchi, and leukocytosis. CTPA showed diffuse ground-glass opacities and interlobular septal thickening in a "crazy paving pattern." Antibiotic and antifungal therapies were initiated. Due to increasing oxygen requirements and interval worsening of radiographic airspace disease, a bronchoalveolar lavage was performed, revealing 26% eosinophils and sterile cultures, meeting diagnostic criteria for acute eosinophilic pneumonia (AEP). High-dose steroids were initiated with rapid and complete resolution of symptoms and hypoxemia.

Discussion: E-cigarettes were introduced in the US in 2006, and use has increased astronomically despite a paucity of evidence to support their safety. AEP is a rare affliction characterized by acute respiratory failure with lung eosinophilia without evidence of infection. Several hundred cases have been described in the literature, about 25% of which have been attributed to traditional cigarette use. We present only the second case of E-cigarette associated AEP. While the impacts of E-cigarettes remain unclear, this adds to the mounting evidence that there are serious, potentially fatal, effects.

Scholarly Question: What are the potential

continued on page 35

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Department of Family
and Community Medicine

Health Sciences Assistant/Associate Clinical Professor

The University of California, Davis School of Medicine is recruiting for a full-time Assistant or Associate Professor in the Health Sciences Clinical Professor series in the Department of Family and Community Medicine.

The position will be expected to contribute with distinction in the areas of clinical care, teaching, mentoring of trainees, and University and public service. Responsibilities include direct inpatient and outpatient clinical care in all aspects of family medicine, including obstetrical care. Teaching is required and will include supervision of medical students, residents, and fellows in both inpatient and outpatients settings. The percent time devoted to clinical care, teaching, and mentoring of trainees will be negotiated with the Department Head.

As the region's only academic health center, UC Davis Health is focused on discovering, applying, and sharing knowledge and providing the highest quality of care. UC Davis Health is a hub of innovation that encompasses UC Davis Medical Center, UC Davis School of Medicine, The Betty Irene Moore School of Nursing at UC Davis and UC Davis Medical Group. UC Davis and UC Davis Health also commit to inclusion excellence by advancing equity, diversity and inclusion in all that we do. We particularly encourage applications from members of historically underrepresented racial/ethnic groups, women, and individuals with disabilities, veterans, LGBTQ community members, and others who share in our vision to achieve a diverse and inclusive community. The UC Davis Medical Center has been recognized by the Human Rights Campaign Foundation, the nation's largest lesbian, gay, bisexual and transgender (LGBT) organization, as a "Leader in LGBT Healthcare Equality" in its annual Healthcare Equality Index report for the seventh year in a row.

We serve an incredibly diverse population of urban and rural patients, with a focus on care of the under-served, and fully engage in the educational, research and service missions of the University of California.

Specific core duties, functions and responsibilities:

- Direct inpatient and outpatient clinical care in all aspects of family medicine, including obstetrical care
- Teaching is required and will include supervision of medical students, residents, and fellows in both inpatient and outpatients settings

The candidates must have the following qualifications:

- MD or DO degree
- Successful completion of an approved family medicine residency training program
- Demonstrated experience in the teaching of students and house staff
- Ability to obtain a Medical License in the State of California
- Be Board certified or board eligible in Family Medicine
- Recent outpatient clinical practice, including outpatient clinic, inpatient ward service and obstetrics
- Demonstrated community service
- Ability to work cooperatively and collegially within a diverse environment, with demonstrated experience mentoring women, people from ethnic/racial minority groups, students with disabilities, and other under-represented groups
- Ability to adhere to policies and procedures of the University

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Qualified applicants should upload a curriculum vitae and statement of teaching to **https://recruit.ucdavis.edu/apply/JPF02646**. Statement of teaching should discuss experience teaching medical school students, mentoring residents, and providing inpatient and outpatient clinical care, including obstetrical care, and the names of three to five references with accurate contact information.
For full consideration, applications must be received by March 13, 2019. However, this position will remain open until filled through June 30, 2019.

This recruitment is conducted at the assistant or associate rank. The resulting hire will be at the assistant or associate rank, regardless of the proposed appointee's qualifications.

The University of California, Davis is an affirmative action/equal opportunity employer with a strong institutional commitment to the achievement of diversity among its faculty and staff.

Under Federal law, the University of California may employ only individuals who are legally able to work in the United States as established by providing documents as specified in the Immigration Reform and Control Act of 1986. Certain positions funded by federal contracts or sub-contracts require the selected candidate to pass an E-Verify check. More information is available **http://www.uscis.gov/e-verify.**

UC Davis is a smoke- and tobacco-free campus effective January 1, 2014. Smoking, the use of smokeless tobacco products, and the use of unregulated nicotine products (e-cigarettes) will be strictly prohibited on any property owned or leased by UC Davis-- indoors and outdoors, including parking lots and residential space.

continued from page 36

adverse effects of E-cigarette use?
Conclusion: More research is needed to determine the effects of E-cigarette use. Patients should be counseled on the unknown safety profile and potential risks, and physicians should consider AEP in the differential diagnosis of acute respiratory distress, particularly in otherwise young, healthy E-cigarette users.

2ND PLACE EDUCATIONAL RESEARCH PODIUM PRESENTATION RESIDENT CATEGORY

Change in Injections After Initiating Primary Care Musculoskeletal Injections Clinic

Paul Seales, MD MS LCDR MC USN[1], Kevin Bernstein MD MMS FAAFP LCDR MC USN[2], Kerry Sadler, MD LT MC USN[2], Joseph Sapoval, MD LT MC USN[2], [1]Fleet Surgical Team Four, Norfolk, Virginia, [2]Family Medicine Residency, Naval Hospital Jacksonville, FL

Introduction: Despite the prevalence of musculoskeletal (MSK) complaints in primary care, residents receive limited teaching in MSK conditions. Research supports that creating dedicated MSK experiences significantly increases resident ability to manage MSK conditions while reducing specialist referrals. This study assesses whether introduction of a MSK Injection Clinic at a Family Medicine (FM) residency changes resident and staff MSK injection practices. **Design**: Single group, pretest-posttest **Setting**: Naval Hospital Jacksonville FM Residency **Study Populations**: All FM residents (n = 19) and Internal Medicine (n=4), Orthopedic (n=8) , and FM (n=10) staff who performed injections between 22DEC2017-21MAR2018 (pretest) to 22MAR2018-22JUN2018 (posttest). **Educational Intervention**: On 22MAR2018, the first ever resident-staffed MSK Injection Clinic was embedded into the Naval Hospital Jacksonville FM clinic. Patients needing injections were referred to this clinic. A fellowship-trained Primary Care Sports Medicine physician provided oversight and guidance. **Main Outcome Measure**: Number of injections performed in Family Medicine, Internal Medicine, and Orthopedic clinics. **Statistical Test(s) Used**: Descriptive statistics and two-tailed, paired t-test **Results**: In the pre-test group, 78.7% of injections were performed in Orthopedics vs. 13.5% in FM and 7.7% in Internal Medicine clinic. In the post-test group, 43.7% of injections were performed in the FM clinic. There was a significant difference in mean number of injections performed by FM residents in the three months before (0.8) and following (7.2) (p=.009) the start of the injection clinic. There was no statistically significant difference in injections performed by any staff. **Conclusion**: This resident-run MSK Injections Clinic significantly increased mean number of injections performed by FM residents. This pilot study provides a model for increasing musculoskeletal injections and improving the Sports Medicine curriculum for FM residents. Future research will evaluate sustainment of this effect as well as decreased Orthopedic injections secondary to fewer FM and Internal Medicine referrals.

Educational Research Winners

1ST PLACE EDUCATIONAL RESEARCH PODIUM PRESENTATION RESIDENT CATEGORY

Effects of Advanced Airway Techniques for Family Medicine Physician Trainees

LT Paige Bowman, MD[1]; LT Kastley Marvin, MD[2]; CDR James Chung, DO, MPH[1]; LCDR Matthew Keller, MD[3]; LCDR Art Ambrosio, MD, MBA[2], [1]Department of Family Medicine, Naval Hospital Camp Pendleton, Oceanside, CA, [2]Department of Otolaryngology- Head and Neck Surgery, Naval Medical Center San Diego, San Diego, CA, [3]Department of Otolaryngology- Head and Neck Surgery, Naval Hospital Camp Pendleton, Oceanside, CA

Introduction: Endotracheal intubation is an advanced airway technique requiring substantial training and clinical experience to maintain competence. Within the military, family medicine physicians are in the unique position of working in operational billets requiring expertise with ATLS algorithms and the procedures necessary for stabilization of complex trauma patients, including securing an advanced airway. We created a training course that pairs didactic education for airway assessment and advanced intubation techniques with a hands-on skills session. **Methods:** This course was designed to establish a needed curriculum for training family medicine physicians in advanced airway techniques. **Design:** Single group pretest-posttest **Setting:** Naval Hospital Camp Pendleton Family Medicine Residency Program **Study population:** Twenty-eight residents of all post-graduate training levels participated in the single session training course **Intervention:** Didactic teaching session on airway management and hands-on skill session using direct laryngoscopy (DL) and video-assisted laryngoscopy (VAL) on a normal and difficult airway simulator **Outcome measures:** Participants were scored using the Intubation Difficulty Scale (IDS) to assess proficiency and completed surveys to assess comfort with DL and VAL intubation before and after the training. **Statistical tests:** Student's t-test for parametric data and Wilcoxon signed rank test for non-parametric data. **Results:** The average time to successful intubation was significantly decreased after training from 51.96 to 23.71 seconds for DL (p=0.006) and from 27.89 to 17.07 seconds for VAL (p=0.003). Participant scores using the IDS were also significantly improved for DL and VAL (p=0.015 and 0.001, respectively). All participants rated their comfort level with both techniques as high following training. **Conclusions:** Advanced airway management is a critical skill for any physician involved in caring for critically ill patients, though few trainees receive formal training. Addition of an airway training course with simulation and hands-on experience can improve trainee proficiency and comfort with advanced airway techniques.

2ND PLACE CLINICAL INVESTIGATION PODIUM PRESENTATION RESIDENT CATEGORY

Use of Single Question Metrics Vs Realm-SF as a Measure of Health Literacy

Thomas Schelby, MD, 375th MDOS, Scott Air Force Base, Illinois
Michael Kim, 375th MDG, Scott Air Force Base, Illinois

Introduction: The Rapid Estimate of Adult Literacy in Medicine – Short Form (REALM-SF) is a widely-used, statistically validated method to determine patient health literacy. It has disadvantages in time of testing and variations in provider interpretation. We studied the use of multiple, single-question alternatives for rapid assessment of patient health literacy. This study is the first comparison of these single validated questions versus the REALM-SF.
Methods:

a Design - Cross-sectional Study
b. Setting - Southwest Illinois Family Medicine Residency, affiliated with Scott AFB
c. Study Populations - Active Duty, Retired, and Tricare Dependents ages eighteen and older
d. Intervention - Subjects were administered a questionnaire with standard seven REALM-SF words, along with three separate validated single question metrics
e. Main outcome measures - REALM-SF score compared to three, single-question health literacy scores. Secondary outcomes were demographic predictors for health literacy.
f. Statistical Testing - Logistical regression analysis, Pearson's correlation coefficient.

Results: With regression modeling, when controlling for demographic factors, a patient's education level was a statistically significant predictor of REALM-SF scoring (p=0.05). Demographic factors were not statistically significant. Single questions did weakly correlate with REALM-SF scores with Pearson's correlation coefficients of 0.228, 0.32, and 0.133 respectively ($p < 0.05$). However, responses to any single question were not predictors in this population when controlling for other variables. **Conclusion**: While statistically significant weak correlation was demonstrated between each single question and REALM-SF scores, these correlations were not demonstrated in regression after controlling for confounders. A single demographic factor (level of education) was identified as a strong predictor of health literacy. Single question evaluations may offer an expedited method of determining patient health literacy in a family medicine population, but we were unable to be validated in this study. Further research could establish a new single question for health literacy that incorporates the level of education.

1ST PLACE CLINICAL INVESTIGATION PODIUM PRESENTATION / RESIDENT CATEGORY

The Smart Way to Quit? A Randomized Control Trial of Behavioral Therapy Via the 2morrow Smartphone Application (APP) Plus Nicotine Replacement Therapy (NRT) Versus NRT Alone for Tobacco Cessation

CPT Stephanie Skelly, MD, Madigan Army Medical Center, Joint Base Lewis-McChord, WA; MAJ Benjamin Arthur, MD, FS, FAAFP; Bob Marshall, MD, MPH, MISM, FAAFP; Maribeth Duffy, MD, FAAFP; COL Douglas Maurer, DO, MPH, FAAFP

Clinical Investigation Winners

Original Research Winners

Introduction: Almost 70% of smokers attempt to quit annually but only 4-6% are successful. Research demonstrates nicotine replacement therapy (NRT) plus behavioral therapy improves smokers' quit rates over medication alone. We sought to determine if a phone APP with validated behavioral therapy techniques, Acceptance and Commitment Therapy (ACT) via the SmartQuit APP by 2Morrow plus NRT would improve smoking quit rates over NRT alone. **Methods:** Design – 12-month randomized control trial. Setting – Primary Care Clinics, Joint Base Lewis-McChord, Washington. Study population –154 non-pregnant Soldiers and eligible military beneficiaries, age > 18 with tobacco use disorder who own Android or iOS devices. Intervention – APP with real-time coaching and self-paced exercises/ modules plus NRT versus NRT alone. **Main outcome measures**: Self-reported quit rates, self-reported number of cigarettes smoked daily, stress level on the Perceived Stress Scale (PSS). Secondary outcome measures – Percentage APP module completion Statistical tests used – Odds ratio with 95% CI, paired samples t-test. **Results**: Patient follow up declined at 3, 6 and 12 months for both APP plus NRT and NRT only groups (92%, 83% and 13% versus 95%, 82% and 11%). There was no significant difference in quit rate at 3 months as 30 day Point Prevalence Abstinence for APP plus NRT vs NRT alone (27% vs 14%; OR 2.3; 95% CI, 0.94-5.4). There was no significant difference in quit rate at 6 months for APP plus NRT versus NRT alone (26% vs 22%; OR 1.31; 95% CI, 0.56-3.06). **Conclusion:** The addition of the SmartQuit APP by 2Morrow incorporating ACT to NRT did not increase quit-rates at 3 or 6 months follow up. Further studies with improved power and APP adherence may improve cessation.

1ST PLACE ORIGINAL RESEARCH STAFF CATEGORY

Battlefield Acupuncture for Post-Partum Pain Control

Michael Kim, Capt, MD, 375th MDG, Scott Air Force Base, Illinois; Paul Crawford, Col, MD, 99th MDG, Nellis Air Force Base, Nevada; David Moss, Maj, MD, 99th MDG, Nellis Air Force Base, Nevada

Introduction: Post-partum pain can have significant ramifications for quality of life. Acupuncture is increasingly used for management of pain. However, evidenced based strategies that incorporate acupuncture for post-partum pain are lacking. We compared Battlefield Auricular Acupuncture (BFA) plus standard analgesia versus standard analgesia alone for the reduction of pain in the immediate post-partum period.

Methods:

a. Design - Randomized controlled trial (RCT)
b. Setting - Mike O'Callaghan Federal Medical Center
c. Study Populations – Post-partum vaginal deliveries with initial pain score of 4 or greater on a 0-10 scale.
d. Intervention - Sedatelec® ASP Gold needles were placed bilaterally using the BFA technique.
e. Main outcome measures - Time to sustained 50% reduction from initial pain.
f. Statistical Test Used - Two sample T-Test, Kaplan Meier Time-to-Event Analysis

Results: The mean time to 50% sustained reduction of initial pain in the standard analgesia group (n=33) was 6 days compared to 5 days in the standard analgesia plus BFA (n=37) therapy group (p=0.35). By 11 days post-partum, 87.1% in the standard group and 83.5% in the study group had achieved the primary outcome (p=0.65). The mean total morphine equivalent units (MEUs) in the standard group compared to standard plus BFA group were

continued on page 40

continued from page 39

88mg and 82mg respectively (p=0.45). Conclusion: There was no statistical difference between standard analgesia and standard analgesia plus BFA therapy in achieving sustained 50% pain reduction from the initial post-partum pain score. MEUs, a surrogate pain marker, also did not achieve statistical significance. This single site RCT suggests that BFA does not provide additional benefit to standard analgesia therapy for immediate post-partum pain. To reflect real world scenarios, we recommend further study with any technique that the available acupuncturist finds the most appropriate for each patient.

2ND PLACE ORIGINAL RESEARCH STAFF CATEGORY

Building Best Practices of Peer Coaching for Medical Educators Using Nominal Group Technique

Adriane E. Bell, MAJ, MC, USA, Uniformed Services University of the Health Sciences, Bethesda, MD; Holly S. Meyer, PhD, Uniformed Services University of the Health Sciences in Bethesda, MD; Lauren A. Maggio, PhD, Uniformed Services University of the Health Sciences, Bethesda, MD

Introduction: Peer coaching is a faculty development approach that improves teaching practice. Elements include peer observation of teaching, feedback, and collegial exchange. It supports reflection on teaching, cultivates workplace learning, and fosters learning cultures. Yet, there is a paucity of literature to assist faculty developers in program development and implementation. There is no published consensus on the characteristics of peer coaching programs that foster teaching effectiveness. This gap limits understanding of design features that can be implemented to improve medical educators' teaching skills and instructional outcomes. **Methods:** The authors convened a focus group of seven experts to arrive at consensus on best practices of peer coaching for medical educators. The focus group convened via video-teleconference and utilized the consensus building methodology, Nominal Group Technique. Process steps included an introduction, silent idea generation, idea sharing, group discussion, and voting. Consensus was reached with over fifty percent agreement. Data was qualitatively analyzed using inductive content analysis. Themes were identified, and quotes extracted to explain individual and group thinking. **Results:** Nominal group technique resulted in 17 best practices which were connected by a theme of trust. All experts recommended a framework for the observation process with a pre-observation meeting and post-observation debrief. All stressed the importance of confidentiality and fact-based feedback. To promote collegial exchange, most agreed peer coaching should be a formative process. The environment should be safe and nonthreatening. Finally, peer coaching should be supported at multiple levels within an organization. **Conclusion:** Expert consensus generated a list of 17 best practices of peer coaching for medical educators that optimize teaching effectiveness. The authors acknowledge that this is a preliminary step that will be refined through future qualitative and quantitative research. The results provide a needed resource for faculty developers to utilize in creating effective peer coaching programs.

3RD PLACE ORIGINAL RESEARCH STAFF CATEGORY

The Impact of Facility Condition on Perception of Training Quality

Michael Kim, Capt, MD, 375th MDG, Scott Air Force Base, Illinois

Introduction: Our residency had the unique opportunity of transitioning from a separate office building and hospital built in 1954 into a modern, new hospital construction with attached clinic, purposefully built for the residency. The goal of this study is to determine if the perception of the quality of a family medicine residency is significantly affected by the condition of its facilities.

Methods

1. Design - prospective cohort study
2. Setting - Southwest Illinois Family Medicine Residency, affiliated with Scott AFB
3. Study Population - 42 residents, 13 faculty
4. Educational Intervention - transition from old facility to new facility
5. Main Outcome Measure - Primary outcome was the perception of overall program quality. On a scale of 0 to 10 (0 being lowest quality, 10 being highest quality), pre-transition and 6 months post-transition. Secondary outcomes assessed specific curriculum such as outpatient, inpatient, procedures, and obstetrics.
6. Statistical test used – Paired T Test, pre and post transition anonymous survey responses were matched using participant generated code.

Results: The mean for the primary outcome of overall program quality pre and post transition was 7.00 and 7.32 respectively (95% CI [-1.097, 0.460], p=0.41). This represents a mean difference of +0.32 on a 0 to 10 scale. **Conclusion:** Although there was an overall small increase in the perception of the quality of our program based on an anonymous survey 6 months post transition to our new facility, it did not reach statistical significance. The evidence suggests that amongst residents and faculty, the overall condition of its facilities has little impact on the perceived quality of a residency. Although participants were blinded to the purpose of the survey, significant bias is still possible. We suggest further areas of research should include prospective medical students. Practical use of this data include appropriate allocation of resources and time in quality improvement projects.

Scholarly Activity Winners

Single Site Showcase Winner

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Importance of Health Literacy

According to the U.S Department of Health and Human Services, health literacy is defined as "the degree to which individuals have the capacity to obtain, process, and understand basic health information needed to make appropriate health decisions." Health literacy is identified as a key issue in the Healthy People 2020 section on social determinants of health. Lower levels of health literacy appear to be closely tied to poorer healthcare for less literate individuals and the dependents for whom they care. This lack of literacy contributes to the $1.24 trillion estimated annual cost of healthcare disparities in the US.

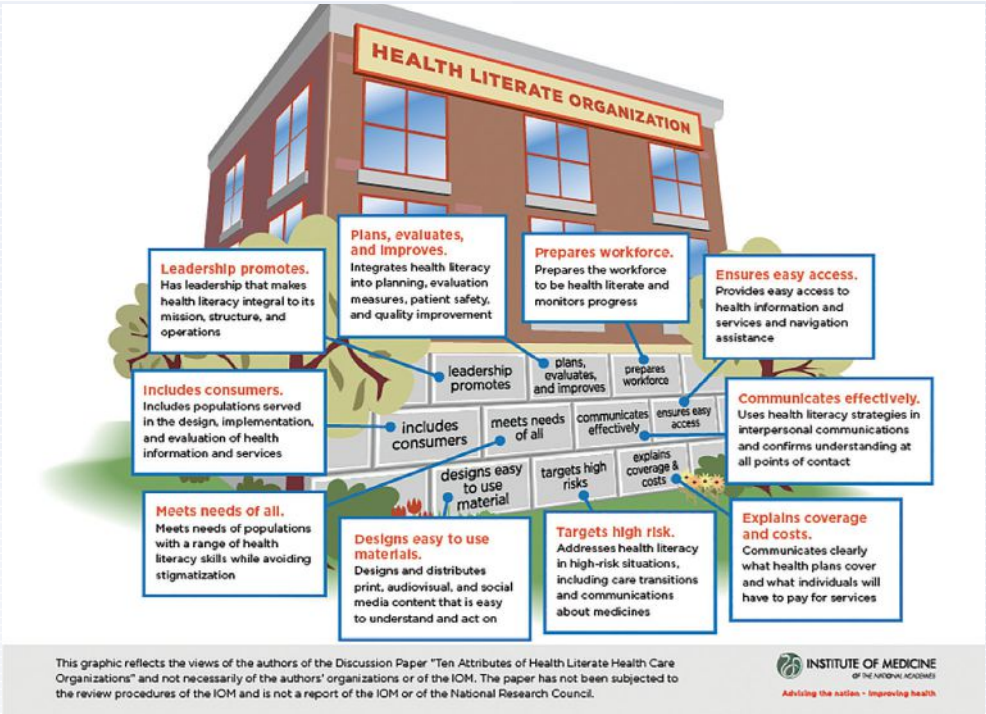
Those at increased risk for below basic health literacy include people with less than a high school degree, people at or below the poverty level, racial and ethnic minorities, immigrants and refugees, and older adults. Those who do not speak English as a primary language have some of the greatest disparities. The National Assessment of Adult Literacy (NAAL), showed that people of color have comparatively worse scores in document literacy. One study found 74% of Spanish speaking patients have inadequate health literacy, compared to just 7% of English-speaking patients.

The national culturally and linguistically appropriate services (CLAS) standards in health and health care were created to help decrease healthcare disparities and improve health literacy. Utilizing appropriate tools and integrating the use of technological devices may help bridge the gaps in health literacy in some of the patient populations we routinely encounter in the military, where only 12% of the population is felt to be health literate. For those interested in researching more on this topic, the Agency for Healthcare Research and Quality provides access to health literacy measurement tools, to include the Short Assessment of Health Literacy (Spanish and English), the Rapid Estimate of Adult Literacy in Medicine (short form), and the Short Assessment of Heath Literacy for Spanish Adults. For additional tools, which can be sorted by topic area, language, validation size, age demographic, and other filters, the Health Literacy Tool Shed is also available.

Attributes of Health Literate Health Care Organizations

1. Has leadership that makes health literacy integral to its mission, structure, and operations.
2. Integrates health literacy into planning, evaluation measures, patient safety, and quality improvement.
3. Prepares the workforce to be health literate and monitors progress.
4. Includes populations served in the design, implementation, and evaluation of health information and services.
5. Meets the needs of populations with a range of health literacy skills while avoiding stigmatization.
6. Uses health literacy strategies in interpersonal communications and confirms understanding at all points of contact.
7. Provides easy access to health information and services and navigation assistance.
8. Designs and distributes print, audiovisual, and social media content that is easy to understand and act on.
9. Addresses health literacy in high-risk situations, including care transitions and communications about medicines.
10. Communicates clearly what health plans cover and what individuals will have to pay for services.

https://nam.edu/wp-content/uploads/2015/06/BPH_Ten_HLit_Attributes.pdf



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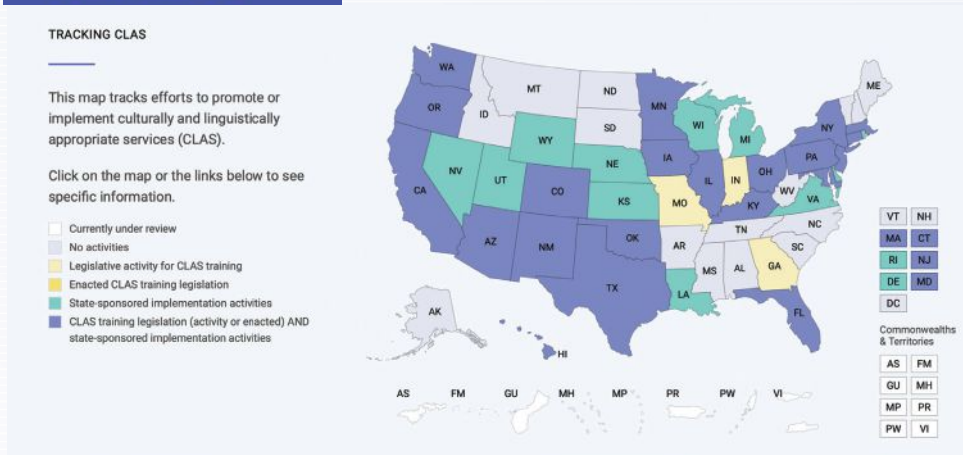
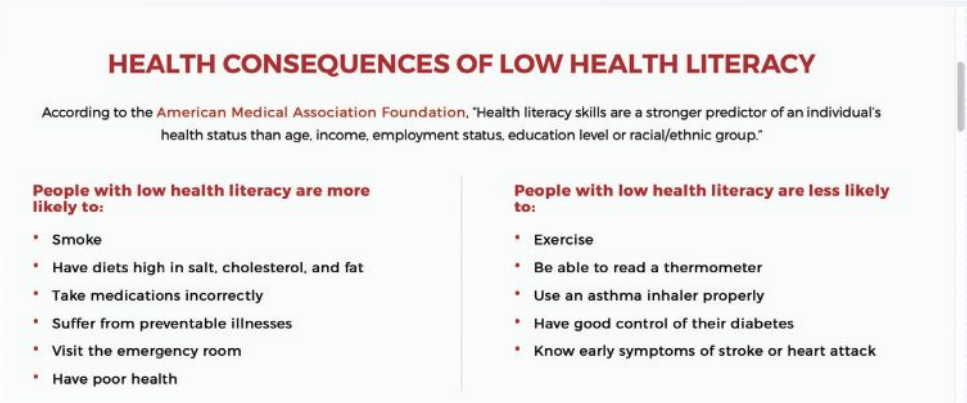


https://www.thinkculturalhealth.hhs.gov/clas/clas-tracking-map



http://www.nhcoa.org/our-work/nhcoa-programs/health-literacy/

REFERENCES/RESOURCES:

Healthy People.gov
http://www.nhcoa.org/our-work/nhcoa-programs/health-literacy/

CDC
https://www.cdc.gov/healthliteracy/learn/resources.html
Navy and Marine Corps Public Health Center (Health Literacy Resources)
https://www.med.navy.mil/sites/nmcphc/health-promotion/Pages/health-literacy.aspx

HHS National CLAS Standards
https://www.thinkculturalhealth.hhs.gov/assets/pdfs/EnhancedNationalCLASStandards.pdf

Ten Attributes of Health Literate Health Care Organizations
https://nam.edu/wp-content/uploads/2015/06/BPH_Ten_HLit_Attributes.pdf

National Institute of Health on Minority Health and Health Disparities (health information in multiple languages)
https://nimhd.nih.gov/programs/edu-training/language-access/health-information/index.html

National Hispanic Council of Aging
http://www.nhcoa.org/our-work/nhcoa-programs/health-literacy/

AHRQ Health Literacy tools
https://www.ahrq.gov/professionals/quality-patient-safety/quality-resources/tools/literacy/index.html

Health Literacy Tool Shed
http://healthliteracy.bu.edu/all

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Radical Inclusion: What the Post-9/11 World Should Have Taught Us About Leadership

GEN (R) MARTIN DEMPSEY AND ORI BRAFMAN.

Personalization: "Inclusion is about concentrating the what (i.e., the directive, the goal) and distributing the how." Give subordinates reasonable freedom to personalize how to execute the tasks you have designated. Let them amaze you with their creativity.

Prior to becoming Chair of the Joint Chiefs of Staff, GEN Martin Dempsey, Commander, U.S. Army Training and Doctrine Command, flew to the remote mountains of Afghanistan to evaluate how junior leaders were adapting to fighting the Global War on Terror (GWOT). He wanted to improve Soldier training for this evolving environment. His visit to a frontline infantry captain was eye-opening, and he marveled at the wisdom of this young officer who introduced him to Ori Brafman's classic book on leaderless organizations, The Starfish and the Spider (which would become a model for understanding terrorists arranged in networks). Upon his return to the United States, GEN Dempsey invited Mr. Brafman to advise him on possible strategies that Army leaders could use as the GWOT continued.

Ori Brafman is an University of California, Berkeley (UC Berkeley) professor who gladly engaged with GEN Dempsey. They formed a strong bond, bringing a unique, combined perspective to the topic of leadership in the post-9/11 era. Based on their nearly decade-long conversations, they decided to produce leadership guidelines for the rapidly changing world in which we now find ourselves.

Two of the most important evolutions that they describe in the operating environment are the "digital echo" and the increasing "power of narratives."

The **digital echo** represents the lightning fast speed with which "information" is passed through the internet and social media, often at the cost of accuracy and honesty. This creates challenges for leaders, often putting them in a reactive, as opposed to proactive, leadership stance. We have all seen how "information" surrounding political issues can spiral out of control, only later to be proven inaccurate or just plain wrong. Regardless, leaders often spend an inordinate amount of time dealing with these types of situations.

The **power of narratives** is also rising at a rapid rate. In the past, we would often find that most people had a shared understanding of the facts of a situation. More recently, it appears that those on different sides of an argument are in a rush to create a narrative that favors their side, with both sides spinning the latest news, making it difficult to discern fact from opinion. Mr. Brafman dissects the narratives surrounding the 2017 UC Berkeley visit by conservative activist Milo Yiannopoulos as a classic example of how EVERYONE got the story wrong.

Why is this so important? Facts depend on expert validation to persist, while narratives simply need to be retold. "Narrative battles" are not won by simply proving that the opposing narrative is in some way inaccurate; they are won by drowning out the counter-message!

While the world and operating environment has been rapidly changing, leadership techniques have not adjusted at the same pace. For the remainder of the book, the authors share their concept of radical inclusion and recommend techniques that can be used to foster success in these evolving times. They include anecdotes from GEN Dempsey's impressive 41-year military career and Mr. Brafman's unique experiences at Berkeley.

Real inclusion is NOT about letting just anyone in; it's about understanding the pillars of inclusion:

- **Participation**: allow everyone in the organization (like a captain in remote

Afghanistan) the opportunity to impact the entire organization

- **Personalization**: "Inclusion is about concentrating the *what* (i.e., the directive, the goal) and distributing the *how*." Give subordinates reasonable freedom to personalize how to execute the tasks you have designated. Let them amaze you with their creativity.

- **Purpose**: create sense of belonging/ commitment to your organization for ALL members

Inclusive Leader recommendations in this new environment:

1. Give them memories
   a. Most important responsibility leaders have, make people feel they belong
   b. Types of Memories to give:
      i. Successes
      ii. Failures
      iii. Being cared for
      iv. What right looks like
      v. What wrong looks like
2. Make it matter (connect effort with meaning)
   a. GEN Dempsey has kept a box with a card for each of the Soldiers that have died under his command on his desk as a continual reminder why what he does matters so much
   b. We all want to believe that our efforts make a difference. It is the leader's responsibility to make sense of things for their followers, so they understand how their actions fit into the big picture.
3. Learn to imagine
   a. Wayne Gretzky, arguably the greatest Hockey player of all time, attributed his amazing success to "skating where the puck is going, not to where it has been."
   b. Definition of imagination: "a learned attribute; some combination of training, experience and eventually instinct that produces creativity in complex environments at the speed of TEAMWORK"
4. Develop a bias for action (prevent decision paralysis)
   a. Recognize that "in our complex world, learning is active and iterative; we need to act, assess, and act again" for optimal results.
5. Co-create context
   a. Recognize that the best ideas do not always (or even often) come from the top of the organization. Figure out a way to collaborate at EVERY level of the organization, especially from those on the front lines.
   b. How do you ensure that everyone has an opportunity for input in a timely manner?
6. Relinquish control to build and sustain power
   a. Leadership by concrete dominance is increasingly unsustainable in today's operating environment. The most effective leaders will allow control to flow out of their hands and into the capable, trained hands of the members of our organizations.
   b. "Real power is measured not in degree of control but rather in the ability to find optimum, affordable, enduring solutions to complex problems."

Radical Inclusion is a superb addition to the leadership library of the 21st century leader who recognizes the changing environment and wants to maximize the **engagement** of all members of his or her organization.

committee reports

RESIDENT AND STUDENT AFFAIRS

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Welcome back! At the time of this writing, we have recently returned from the 2019 Annual Meeting and Exposition in St. Louis. The conference was a wonderful opportunity for students, residents, and practicing family physicians to learn, be well, and lead! We would like to thank all who were involved with the planning, preparation, and execution of the annual meeting and extend a special thank you to our outgoing resident directors, Paige Bowman (USN), Stephanie Rosen (USA), and David Riegleman (USAF), for a truly outstanding year of service on the board. Also, congratulations to our new resident directors Brian Merrigan (USA), Michelle Dentinger (USN), and Betsy Curry (USAF).

In this issue, we are pleased to report the following updates on our committee's efforts to further the strategic aims of the USAFP.

MEMBERSHIP

Last year, the committee received the list of full-time out of service (FTOS) residents from the USAF Family Medicine Consultant. Our goal for this year is to continue to expand this list in order to increase their involvement in the USAFP; increase their attendance at, and contributions to, the annual conference; and share information on military specific curricula with them to best prepare them for active duty service after graduation.

In addition to FTOS membership, we continued to increase overall membership and activity within the academy. We've grown to an astounding 529 student members, an increase from 362 last year, and 437 resident members. We now comprise over 30% of the USAFP membership!

Finally, we hope to encourage membership through our presence at the AAFP Resident and Student Conference in August. Last year we were able to host a student interest dinner at the conference for the first time in three years. The resident directors reported attendance of 18 members (almost triple the attendance from 2015). Our new resident directors will be continuing this outreach effort at the 2019 conference. If you are attending the 2019 AAFP National Resident and Student Conference, please take advantage of the opportunity to connect and network with HPSP students and military family medicine residents and faculty!

At this year's annual conference, twenty-one students applied for scholarships, and there was enough funding to support all 21 students!

OPERATIONAL

This year's annual conference did an exceptional job of teaching leadership and readiness in military medicine. As a committee, we strive to provide students and residents the chance to learn about operational medicine experiences. This year, we will be reaching out to program directors to identify current residents with operational experience who are willing to share with others. Additionally, we intend to build a repository of operational rotations for current medical students and residents by reaching out to members of the USAFP who are currently working in operational settings. Stay tuned!

EDUCATIONAL

At this year's annual conference, twenty-one students applied for scholarships, and there was enough funding to support all 21 students! As a result of an earlier request for applications and increased advertising, we had a 50% increase in the number of applicants for the scholarship. Thank you to all USAFP members who chose to sponsor a medical student to attend the conference so that the students had the opportunity to learn, network, and explore the amazing scope of family medicine! For our residents and faculty, please encourage medical students rotating at your programs to apply for a scholarship to attend the 2020 meeting. Students, keep an eye out for information on the scholarship. We would love to have you here next year!

Finally, congratulations to team Air Force for taking home the win this year at the "Doc, You Don't Know Jack" quiz bowl! The event continues to be a popular and much-anticipated annual event at the conference.

SCHOLARSHIP

The quality of the research and presentations this year was outstanding! Again, the Army, Navy, and Air Force resident directors will be working with their Services' chief residents to push out timelines and dates for submitting scholarly activity

so that we can continue to have increased involvement. Stay alert for potential case reports, possible quality improvement projects within your institution, or faculty who are engaged in scholarly work and can serve as a mentor to help you get started!

LEADERSHIP

The annual leadership seminar at the USAFP annual meeting was a huge success, and we received outstanding reviews from over 30 students and residents who participated. Moving forward, we hope to be able to offer a certification in resident and student leadership for those who attend all sessions in order to help identify those students and residents who have additional training that would prepare them to assume roles of leadership in their institutions. We hope to see even more residents and students next year at our highly productive and engaging seminar!

ADVOCACY

The Uniformed Services University of the Health Sciences' (USUHS) Family Medicine Interest Group (FMIG) is increasing advocacy through involvement in community service, attendance at conferences, and enrollment in the USAFP. For the first time since 2013, we appointed two student representatives to the USAFP Board of Directors to continue advocacy efforts. We are excited to begin working with Paige White as the USUHS student board member and Alexander Lam as the HPSP student board member!

We are looking forward to a great year! It's never too early to start thinking about the 2020 USAFP Annual Meeting in Anaheim!

Disclaimer: The views expressed in this material are those of the authors, and do not reflect the official policy or position of the U.S. Government, the Department of Defense, or the Department of the Air Force.

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committee reports
EDUCATION COMMITTEE

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Top Medical Apps for Spring 2019

Greetings! Here are four recent apps that will help ensure you are practicing the best evidence-based medicine (EBM) at the point of care!

1. "AHRQ QUESTION BUILDER"

Some providers describe a feeling of dread when a patient pulls a list of questions out of their pocket. I am not one of them. In fact, I love it. It allows me to quickly assess what we need to cover and what can wait. Answering patient questions allows me to better ensure the patient is satisfied and engaged with the encounter and helps me improve the patient's understanding of their medical condition and required treatments. For many years, the Agency for Healthcare Research and Quality (AHRQ) has provided an outstanding website for patients called "Questions Are the Answer" to which patients can go to plan for provider visits. Now the AHRQ has released a mobile app for iOS and Android that brings this tool to smart devices everywhere.

Evidence based medicine

The app contains valuable information for patients, including videos of how to better prepare for healthcare visits. It aims to utilize patient questions and answers to improve understanding and engagement. The app links to numerous AHRQ resources, which in turn link to high quality EBM resources like ClinicalTrials.gov, Medline, and Cochrane to ensure patients can find quality information about their medical conditions and treatments.

Price

o Free

Likes

- o Unique question builder for patients to prepare questions and answers.
- o High quality video examples and links to trusted AHRQ resources.
- o Available for iOS and Android.

continued on page 48

continued from page 47

Dislikes

- Interface to enter questions and answers a bit clumsy.
- Menu of reasons for visit and potential questions slightly limited.
- Videos and AHRQ resources require internet connection.

Overall

"AHRQ Question Builder" is an outstanding app that helps patients prepare for their medical visits. The app's easy to use interface will help ensure patients maximize their appointments and improve their engagement. The app allows patients to store/share their questions and contains numerous video examples and links to online resources for use after their encounters.

Available for Download for iPhone, iPad, and Android.

- https://itunes.apple.com/us/app/ahrquestionbuilder/id1455119729
- https://play.google.com/store/apps/details?id=gov.ahrq.qata&hl=en

2. DHA "DECIDE + BE READY" CONTRACEPTION APP

Discussions about contraception options are some of the most important conversations that occur during well woman visits. Unfortunately, visits are often rushed, and patients and providers are not always prepared to discuss all available contraception methods at the level of detail required for an informed decision. Luckily, the Defense Health Agency (DHA) has released an app designed to help. Their new app, "Decide + Be Ready," contains easy to follow information about each form of birth control. The app is a joint project between providers at DHA and the Uniformed Services University (USU) with the University of California San Francisco (UCSF).

Evidence based medicine

The DHA "Decide + Be Ready" app contains evidence based information on the most common forms of contraception available. The app uses a unique interface designed to aid patients in making the best contraception decision. The app incorporates patient preferences and their unique health conditions to aid in the decision making process.

Price

- Free

Likes

- Easy to follow, answers the most common questions about all forms of contraception.
- Ability for patients to create a unique birth control profile.
- Unique deployment related content, yet still applicable to all women.

Dislikes

- Some screens in the app are seemingly hidden.
- Some patients may not find the information detailed enough.
- Not available for Android currently (but coming soon).

Overall

The new "Decide + Be Ready" app from DHA and UCSF brings evidence-based information to patients to help guide them to the best contraception decision. App allows for an educated and interactive discussion between patients and providers. For providers, I would still recommend either the CDC "US MEC" app or Dr Steinberg's "Contraception Point-of-Care" app for their use.

Available for Download for iPhone, and iPad. Available soon for Android.

- https://itunes.apple.com/us/app/decide-be-ready/id1451879300?mt=8

3. DHA "PAIN AND OPIOID SAFETY" APP

Prescription and non-prescription opioid abuse has risen to epidemic proportions. Statistics from the CDC are staggering. Deaths from opioid overdoses have increased over six-fold since 1999 with over 165,000 fatalities. Every day in the US, 44 people die of prescription opioid overdose and over 7,000 are treated in emergency rooms across the country. In early 2016, the CDC released their opioid prescribing guideline and immediately generated a great deal of controversy. In 2017, the Department of Defense (DOD) and the Veterans Administration (VA) also released an opioid prescribing guideline with similar recommendations. DHA and their mHealth Clinical Integration Division's (formerly T2 or National Center for Telehealth and Technology) newest app, "Pain and Opioid Safety," brings together the most current CPG's on chronic pain from both the DOD/VA and CDC.[1]

Evidence based medicine

The information in the app comes from the 2017 DOD/VA opioid guideline, 2015 DOD/VA substance use disorder guideline, the 2016 CDC opioid guideline, and several others. All of the guidelines are developed from a systematic review of the evidence and expert opinion. The app contains an evidence-based pain assessment tool and numerous links to online resources for patients and providers: help line numbers, videos on naloxone use, etc. The app includes brief summaries of key sections from the CDC opioid guideline, but full versions of the guidelines require an internet connection.

Price

o Free.

Likes

o Simple to use interface for accessing PDF's/sections of pain/opioid guidelines.

o Helpful information for both patients and providers with numerous links/numbers and a pain assessment tool.

o Available for iOS and Android.

Dislikes

o No morphine equivalency calculator included.

o PDFs of most CPG's and resource handouts require internet connection.

o Videos require internet connection/YouTube.

Overall

The DHA "Pain and Opioid Safety" app is an outstanding addition to both the iOS and Android app stores. The app provides key DOD/VA clinical practice guidelines on opioid prescribing, substance use disorder, low back pain and the CDC opioid prescribing guideline. That alone would be enough, but the app has dedicated sections for patient and provider resources and a helpful pain assessment tool. The only drawback is the amount of information that only can be accessed via an internet connection. Since this is a government app, I would have thought the guidelines would be fully downloaded with the app.

Available for Download for iPhone, iPad and Android.

o https://itunes.apple.com/us/app/pain-opioid-safety/id1263249959

o https://play.google.com/store/apps/details?id=org.t2.opioidsafety

4. MEDICARE.GOV "WHAT'S COVERED" APP

In January, the Centers for Medicare and Medicaid Services (CMS) launched a new app called "What's Covered." The app takes some of the most popular information from the Medicare.gov website and puts it in the palms of patients and providers. Medicare coverage is booming, especially as our population ages and states expand coverage. For example, in 2015, over 54 million people had Medicare coverage. This is expected to explode by over 30% to more than 80 million people by 2030.2 The primary focus for the app is on the common "what's covered" preventive services questions. For example, the app will give patients rapid answers as to whether mammograms are covered at their age and how frequently they can get them.[2]

Evidence based medicine

The app contains valuable information for patients and providers regarding what's covered in Medicare Part A/Part B plans. The app has an intuitive search function with bottom-line up-front answers about specific services that are or are not covered. This is followed by more detailed information such as age/gender restrictions, frequency of coverage, price, etc. All data is available on the Medicare.gov website, but the app is much more user friendly.

Price

o Free

Likes

o Comprehensive answers to all of our Medicare questions for Part A/B.

o Intuitive interface with multiple modalities to find information.

o Available for iOS and Android.

Dislikes

o Requires our Medicare patients to own a smart device.

o Some additional clicking and scrolling required to get to information.

o Not many links or comprehensive references available in the app.

Overall

Medicare's "What's Covered" is an app I wish I had many years ago. The app is like having your own social services worker/nurse case manager/referral management person wrapped up into one app. Medicare patients with a smartphone (not necessarily a given) MUST download this app. If you care for Medicare patients and don't know all the in's/out's of Medicare coverage (like me), then you too should download the app so you can provide accurate information to your patients.

Available for Download for iPhone, iPad, and Android.

o https://itunes.apple.com/dk/app/whats-covered/id1444143600

o https://play.google.com/store/apps/details?id=gov.medicare.coverage&hl=en_us

1. Center for Disease Control and Prevention. https://www.cdc.gov/drugoverdose/epidemic/index.html. Accessed April 15, 2019

2. Center for Medicare Services. https://www.cms.gov/newsroom/press-releases/new-app-displays-what-original-medicare-covers Accessed April 15, 2019

Operational Medical Home: Active duty care in PCMHs

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Greetings to my fellow family physicians! I am writing this article with the Chief of Clinical Business Operations at the Defense Health Agency (DHA), who is proud to support you. While at the Annual Meeting, I had several conversations about the active duty Patient Centered Medical Home (PCMH). I wanted to summarize some key points related to the readiness of our Soldiers, Sailors, Airmen, and Marines (and Coast Guardsmen, too!) We use the term, "operational medical home," to encompass Soldier Centered Medical Home, Fleet Centered Medical Home, Marine Centered Medical Home, and any clinic that cares for an active duty population. We recognize some active duty patients are seen in medical homes that also care for family members and retirees; however, this article addresses rumors we have heard about the care of service members in active duty medical homes and on how we can prepare ourselves to support these patients and our own ready medical capabilities.

First, active duty patients are our NUMBER ONE priority by federal statue. They are followed by active duty family members, then retirees, and then family members of retirees.[1] We are uniformed family physicians who care for uniformed patients first and foremost.

Second, active duty patients DESERVE PCMH! We keep hearing this rumor that those on active duty are healthy and don't need PCMH. We would write an expletive here, but we would get in trouble. EVERYONE deserves patient-centered, comprehensive, coordinated care with enhanced access that is holistic and focused on preventing and treating current or future causes of disease. These are the tenets of the medical home, and, in order to support the readiness of our warfighters, those on active duty need them. There is no readiness-focused or ethical rationale to support the assertion that active duty patients only need reactive, fragmented, episodic care until they develop preventable, chronic illness. Moreover, we cannot ensure active duty personnel are ready to deploy at a moment's notice without effective PCMH operations. PCMH supports all parts of the Quadruple Aim and PCMH is the ideal model to support readiness. To demonstrate our commitment to the PCMH model of care, the PCMH Service Leads and the DHA are codifying the first procedural instruction (PI) on PCMH standards, operating principles, team roles, and staffing ratios, which are currently in final development.

Third, active duty only clinics need to be STAFFED as a PCMH. We cannot short these critical readiness platforms of needed support staff. We have recently visited some active duty only clinics that had neither nurses nor an adequate number of providers to meet the demand of their patients. If you work in one of these clinics, read your Service medical home policies in the interim until we finalize the DHA-PI on PCMH. Currently, each Service has staffing standards; while there are slight differences among Services, they are very similar. These standards include nurses, clerks, and support staff ratios. We should not be robbing the active duty clinics to staff other clinics. One of the first steps in a medical home is to look at the total number of patients and match the number of providers to the number of patients. These numbers vary from a minimum of 500:1 patient to provider ratio (line funded, unit based enrollment), to a minimum of 1100:1 for military treatment facility (MTF) providers (Defense Health Fund-funded). Information on empanelment standards is available in DHA-PI 6025.11. You should know the category into which your billet falls; if your do not, ask your specialty leader or consultant . Support staff should be allocated proportionally to the number of providers. Enrollment numbers are based on unit size and an average utilization rate of 4.1 visits per person per year. Sometimes active duty service members use more healthcare than the elderly, especially when considering administrative visits unrelated to illness, so check your utilization rates. Arm yourself with data so that you are prepared for a conversation with your leadership about meeting medical home standards for your active duty population.

Fourth, taking care of active duty does not represent the FULL SCOPE of family medicine, but it can come close. Active duty care is a wide mix of adolescent medicine, early geriatric medicine (don't tell any senior officers we said that), procedures (skin, vasectomies, long term contraception), musculoskeletal care, mental health care and yes, zebras, which can appear in the active duty population. Keep in mind that you should not concentrate your career solely in the operational medical home. You must be proactive and plan your career in such a way as to give yourself opportunities to do other facets of family medicine, such as the care of expectant mothers and younger children.

Fifth, we all will need experience in INPATIENT medicine in the future. Under the draft Joint Staff knowledge, skills and abilities (KSA) for family medicine, each of us will do, at a minimum, two weeks of inpatient medicine annually. It has been seven years since I was teaching faculty and on the wards. I attended the hospitalist sessions at the annual meeting and found them to be fantastic; I hope they provide the lectures

again next year. I have zero details of how this set of KSAs will roll out, or when they will be implemented. Don't shoot the messenger. Family medicine is a flexible specialty, and several of our deployed positions include managing the wards. As we receive more information, we will ensure you are updated on what KSA training is required, and when and how to obtain it.

To establish bi-directional communication on DHA PCMH policies, get your feedback, answer questions, and assist you in dealing with challenging issues in primary care practice management, we hold twice-weekly DHA question and answer webinars at times designed to be convenient for all our team members world-wide. Wednesday webinars are at 1700 Eastern time and Friday webinars are at 0900 Eastern time. Contact the DHA Clinical Business Operations Sharepoint site to get telephone call-in numbers.[2] You also may join the DHA Clinical Business Operations Facebook page to be added to the Outlook invitation so you can join the Adobe Connect meeting to ask questions.[3]

In summary, with all the change going on, we have the opportunity to take really great care of our most important patients, our active duty service members, which also includes ourselves and our own ready medical capabilities. Empower yourself to make changes to your operational medical homes to assure the same standards of care for all on active duty in PCMH. We are honored to care for them and to serve with them.

> There is no readiness-focused or ethical rationale to support the assertion that active duty patients only need reactive, fragmented, episodic care until they develop preventable, chronic illness.

1 32CFR199.17
2 https://info.health.mil/hco/clinicsup/hsd/pcpcmh/sitepages/home.aspx
3 https://www.facebook.com/groups/DHAHealthcareOpsQA/

MEMBERS IN THE NEWS

Congratulations to the USAFP Members that Received the AAFP Degree of Fellow

The Degree of Fellow recognizes AAFP members who have distinguished themselves among their colleagues, as well as in their communities, by their service to Family Medicine, by their advancement of health care to the American people and by their professional development through medical education and research. Fellows of the AAFP are recognized as Champions of Family Medicine. They are the physicians who make family medicine the premier specialty in service to their community and profession. From a personal perspective, being a Fellow signifies not only 'tenure' but one's additional work in your community, within organized medicine, within teaching, and a greater commitment to continuing professional development and/or research.

Congratulations to the following USAFP members!

Benjamin T. Arthur, MD, FAAFP
Nick Bennett, DO, FAAFP
David Christopher Bury, DO, FAAFP
Helen L. Cann, MD, FAAFP
Connie Chung, MD, FAAFP
Maria Dolores de Arman, MD, FAAFP
Michael M. Dickman, DO, FAAFP
Brian Scott Ford, MD, FAAFP
David Stephen Garcia, MD, FAAFP
CDR Jason Andrew Gordon, MD, FAAFP
Richard E. Gray, DO, FAAFP
Matthew Kendall Hawks, MD, FAAFP
Khalid A. Jaboori, MD, MPH, FAAFP
Andrew John McDermott, MD, FAAFP
Anastasia M. McKay, MD, FAAFP
Joel Meyer, MD, FAAFP
Garrett John Meyers, MD, FAAFP
Michael Ryan Odom, MD, FAAFP
Erika Alyse Overbeek-Wager, DO, FAAFP
Natasha Jai Pyzocha, DO, FAAFP
Jeanmarie Barnhart Rey, MD, FAAFP
Jennifer Ellen Salguero, DO, FAAFP
Eric Robert Vaught, DO, MPH, MBA, FAAFP

Pictured are those who were in attendance at the 2019 Annual Meeting receiving their AAFP Degree of Fellow.

Finding Professional Satisfaction During Deployment

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Hello, readers! Capt Breanna Gawrys, currently deployed to the Middle East, expressed interested in being part of the Wellness and Resiliency Committee but was unable to attend USAFP due to deployment. We chatted about her experiences, and Breanna noted she was having a really great time. With the palpable concern within the community about the ongoing transformation of the medical services, Breanna is seizing opportunities. So, I asked her to share her story. Breanna writes:

"The idea of deployment brings up a lot of different emotions for everyone -- excitement, fear, anticipation, and uncertainty to name a few. For some, deployment is a break from the routine monotony of clinic and seemingly endless online trainings, but for others, deployment is a jarring and unwelcome change. I am two months into my current rotation and feel extremely fortunate for several reasons:

1) I had numerous mentors who mentally prepared me for deployment.
2) I had frequent contact with the physician I was replacing and had a very good idea of what to expect.
3) I have incredible colleagues with which to work.
4) I am at an established base and in a "safe" zone, which mitigates some of the typical stresses in a deployed setting. We have opportunities to train with those who forward deploy and do frequent emergency drills to remain ready for action.

"Perhaps most importantly, I deployed with an open mindset and had ideas of how to leave a lasting impact. These last few months could easily have been miserable - missing family, unable to practice my true "full scope" (family medicine obstetrics trained and previously doing a lot of obstetrics, inpatient care, vasectomies, and other procedures at home station), enduring hot weather and surrounded by sand and dirt, etc. **Instead these months have been easily some of the most fun and rewarding I've had in a while**! We recently had the opportunity to host a children's health fair at the embassy - which was a unique and fun experience! I have been using my training in osteopathic manipulative treatment and acupuncture to broaden my colleagues' scope of practice, hosting weekly evidence-based medicine and procedural lunch-and-learns, and taking advantage of the small close-knit community on base to truly feel like a family doctor. A lot of the patients I see in clinic I also see in the dining facility, at the gym, and numerous other places on base. I have the ability here to closely follow patients to see if they truly are improving from their musculoskeletal injury, influenza, pneumonia, laceration, etc. I have been surprised by how open the community here is to osteopathic treatment and acupuncture to treat both acute and chronic conditions. Our leadership fully supports outreach and camaraderie with our Air Force colleagues at nearby Army installations.

I have been using my training in osteopathic manipulative treatment and acupuncture to broaden my colleagues' scope of practice, hosting weekly evidence-based medicine and procedural lunch-and-learns, and taking advantage of the small close-knit community on base to truly feel like a family doctor.

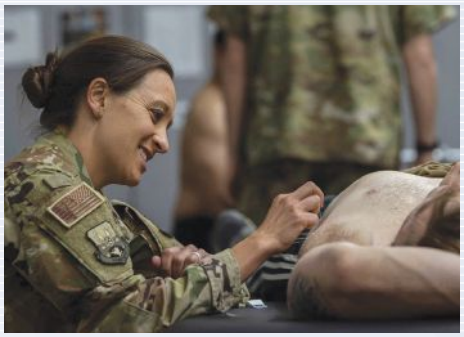
"We have seen a variety of medical conditions and function like an urgent care center or emergency room with limited treatment options and capabilities compared to our home station. This allows us to think

"outside the box" a bit differently than we would otherwise – solving problems creatively is incredibly rewarding. At the same time, we still have plenty of support from specialists for complex cases. In fact, the specialists are very receptive and accommodating in answering clinical questions and seeing difficult cases.

"Our medical group has truly come together over the last two months through various emergency drills. We have seen dramatic improvement in teamwork and communication, which has paid dividends in real-world scenarios. We have the unique opportunity to partner with, and learn from, our coalition and flight medicine trained physicians. I have also been able to reciprocate and share my skill sets. With the increased focus on operational medicine in recent years, I would encourage all military family physicians to embrace these opportunities and look for ways to improve not only your current practice but also to train your deployed technicians, independent duty medical technicians, physician assistants, nurses, and fellow physicians."

I am sure many family physicians have shared experiences similar to Breanna – truly blooming where planted, looking past obstacles, and finding opportunities. I would

just like to underscore a couple of the key factors Breanna highlighted as contributing to her fortune: mentorship and incredible colleagues. We are truly blessed in military medicine to be surrounded by outstanding people with shared values. Military medicine is changing, but we all have the opportunity to influence these changes in a positive way. We are never alone, and I cannot think of a better group of people with which to help redefine history. If you are interested in sharing your story, please consider the Wellness and Resiliency Committee as a platform.



new members

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Bethany Davis, MD
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