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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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Edition 49

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On Gratitude

Uniformed family medicine is seriously challenging, yet one second in this sacred and noble profession, even on dire days, is such an honor to me. I believe legions of people would give anything to be a physician or an officer for just one moment. And yet, we get to serve as both! For this issue's presidential message, I want each of you to know the incalculable appreciation and respect I have for you. I really don't know what statistical universe makes a guy like me president of anything unless it is because of my family and associations with you. I feel like the luckiest person alive and marvel often at the tremendous talent, effort, courage, diligence and trust throughout this academy. It is astonishing to consider the breadth and depth of what each of our 3000+ members do collectively and individually.

Thank you for working so very hard every day, making the world a safer place through honoring your military and medical oaths with unmatched diligence. Our specialty and academy are incredible because you sacrifice daily, serving the finest patients of all ages, genders, and races in all the world. Thank you for being willing to make the ultimate house calls, treating patients and their families at home and abroad, in war or peace. For what's worth, I want you to know you inspire me to be a better physician and human and that I try daily to measure up. I hope you can feel something of the gratitude I have for the lives we have, including my associations with you. Words are wholly inadequate to articulate how much it means to me to serve with you.

When the going gets tough, may the toughest always seek Uniformed Family Physicians. And when they do, may our answer always be that we will gratefully go and fight disease and death on land, fight disease and death in the air, and fight disease and death at sea, with courage matching theirs. I humbly offer this brief note of thanks along with my very best wishes and hope for excellent health, safety and success for you and your families in all you do. I look forward to seeing you at our next meeting in Anaheim or sooner!

The opinions expressed here are those of the author alone and do not reflect those of the US Air Force, Department of Defense, Air Force Medical Corps or Uniformed Services University of the Health Sciences.

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Advice I've Loved Enough to Pass on

I'm writing this while doing a recruiting tour through the state of Arkansas and soon to be temperatures in the high teens. Even though I intentionally said "yes" to helping out the Medical Recruiting Battalion based on presumed seasonable weather, the arctic bomb had other plans.

Since I don't have many editorials left, I'd like to use this one to share leadership lessons through a slightly different lens—that of good advice I've received. You'll see some of my successes and failures, but more than anything else I hope you'll take away some useful advice as you progress in your career. I'll break this down by threads: silver bullets and swords to fall on, the five conversations you need to have with your boss, and getting the right people on the bus.

DO YOU REALLY NEED TO FALL ON EVERY SWORD? HOW MANY SILVER BULLETS DO YOU HAVE?

As an ROTC Cadet I became frustrated and angry frequently. Honestly, it was less about being a Cadet and more about being in my late teens and early twenties. I had a laser sharp focus on myself and not enough concern for the needs of others. I'd like to think I've improved (mellowed?) with age, but I still have a long way to go; I have to actively work at being generous. Anyway, after watching me in action for two years, my professor of military science (PMS) pulled me aside. He gave me some of the first career defining advice I ever received.

"Aaron, you're throwing some pretty sharp elbows there."

"Yes, Sir."

"Why do you think you're angry?

"I'm frustrated (about what, I cannot remember); I know I'm right, but I'm being told that I'm wrong."

"Take some advice?

"Yes, Sir."

"You can't die on every hill. You need to choose your battles and decide which are worth fighting. Even if you are right, not every argument is one you need to win."

I'd like to say that my PMS permanently changed my life then and there, but I'd be lying. This lesson would pop up again in the DeWitt intermediate care unit during my residency. After another day in which my attending gave less than helpful patient care advice, I told her that if she wasn't up to taking care of sick patients she ought to step aside and let me and my senior do so. I almost assuredly used more impolitic language, but I don't recall the words.

Watching for his moment, my senior recognized the moment as a teachable one.

"Aaron, you might catch more flies with honey."

"Hrumph."

"Okay if I tell you a story?"

"Okay."

"When I was a young lieutenant in the cavalry, my commander called me and my fellow butterbars into the office. He told us that we each had two silver bullets. Two opportunities to stop all work, gain his full attention, bring an issue to his notice, and get an immediate resolution. He told us to marshal the bullets well, because once they were gone, we wouldn't get anymore.

"Well, one of the other lieutenants shot both of his bullets right-away, and, true to his word, the commander took care of the issues for the lieutenant on the spot. When the lieutenant brought a third issue, the commander looked at him and said, 'Son, I think your chamber's empty.'

"I held onto my bullets. It made me learn to do things by working with my peers and subordinates, finding creative ways of getting things done. I always knew I had a bullet in case I really needed it, but that lesson has stuck with me. Do you get what I'm saying? Isn't there another way we can make sure our patients get cared for that doesn't belittle our attending or call her out?"

Well, I think I got what he was saying. My senior's words struck a chord for me and brought back my PMS's lessons from long ago. Silver bullets, hills and swords—not everything is worth an angry tirade; a lot of things that seem dire and necessary to me are only so when seen through my point of view. Better to practice calm and patience and shoot that bullet or take that hill when no other way will do.

I did that in Afghanistan. At least I thought I did at the time. I deployed with an area support medical company out of Fort Bragg that was subsumed into Task Force

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Dr. John Lay, MD
LTC(R), US Army
Regional Medical Director
Centurion of Florida

Correctional Medicine allows me to continue the mission of serving an underserved population. It has given me the opportunity to use the leadership skills that were developed during my military career while continuing to uphold the core values that were engrained in me. I also found that it was a great transition as I was moving from military to civilian life.

Dr. Clayton Ramsue, MD
Retired Lt. Col. US Air Force
Statewide Medical Director
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Med upon arrival. Shortly thereafter, our evacuation element was detached and sent down to augment a Canadian-led hospital in Kandahar. Our predecessors had decided that enhancing the role three multinational medical unit made a lot more sense than running an independent aid station. The hospital gained more manpower and evacuation capabilities, American service members gained quicker access to diagnostic and treatment services, and our unit learned how to be interoperable with other nations' medical personnel and equipment. Truly, the definition of win-win.

All was great until an Army colonel reservist tried to pull the American element from the hospital. To this day I don't know his reasoning, but as the senior member of the detachment, I asked him why. At this point, our medics had bonded and shared missions with their Canadian and British counterparts; my physician assistant and I had taken care of multiple trauma patients alongside our multinational colleagues; and our small role 3 had been responsible for saving multiple American sons and daughters. The answer that I received was that we needed to set up a level one battalion aid station, focus on the Americans, and let the rest of the coalition forces take care of themselves. That's it.

In retrospect, I should have reached out to that Army colonel's boss (who was also my rater). He had asked me to come to him with issues, and while I found him a straight shooter, I also found him intimidating. I also wasn't sure if the Army colonel was acting under his direction. So, instead, I wrote a 12 page white paper about how extracting the Americans from the role three would degrade the hospital's capability and ours, how pulling the Americans would negatively impact diplomatic relations (the Canadian public was about to vote in a referendum about their continued presence in Afghanistan, and this small hospital was a tremendous source of pride to the Canadian people), and how pulling the American presence would significantly imperil the access of American medical staff to diagnostic imaging and ancillary services (capabilities we didn't possess).

When I hit "send," with a galaxy of American and Canadian luminaries cc'ed, I figuratively shot my silver bullet and fell on my sword on a hill I thought was worth taking. It felt pretty literal though. I ended up in my rater's office and was appropriately dressed down. He let me know that a blast email wasn't the way we did business in the military and that he meant it when he told me that I should call him with stuff like this. He told me he'd take care of the situation, that he wasn't going to allow us to be moved out, and that I better damn sure (stronger language removed) come straight to him in the future. He was right, I should have given him a chance to sort things first. We ultimately continued operations, relationships with our Canadian allies were preserved through a national referendum that affirmed the need for a continued Canadian presence in Afghanistan, and we continued to save lives.

FIVE CONVERSATIONS

Back when I attended the Madigan faculty development fellowship, our director started a leadership book club. We read some great works together, and one of our lessons learned came from Michael Watkins' The First Ninety Days. In the book Watkins talks about having five conversations with your boss, each centering on a different aspect of your relationship with her. These talks include the following:

The situational diagnosis conversation: how does your boss see the current work environment? Are we looking at a start-up, a turn-around, or possibly a sustaining success operation?

The expectations conversation: what does your boss expect of you? What does your boss' boss expect of her?

The style conversation: how does your boss like to be contacted? What information does she expect to hear, how frequently, and how detailed?

The resources conversation: what personnel, finances, space, logistics, and administrative support will you need to fulfill your mission?

The personal development conversation: what opportunities are there for your personal growth in this job? How can your boss network you, give you the right assignments, and mentor you to grow?

The other major theme that I remember from this book is that it is important to achieve early wins to build social capital for longer term gains. I've found this tidbit and the five conversations to be helpful in framing every position I have had in the military since, and I think it will help me when I eventually make the transition to full time civilian life.

GET THE RIGHT PEOPLE ON THE BUS

In Jim Collins book, Good to Great, there are a lot of memorable concepts that have been widely adopted; maybe you have heard of the hedgehog principle? One of my takeaways from that book was the idea that, in hiring, if you get the right people on the bus, the bus will drive itself exactly where it needs to go. Stated another way, hire for attitude and potential—you can always teach specific skills, but remediating attitudes is a far more difficult proposition.

My leaders at USU have really exemplified this. In our department of family medicine, my first boss actively brought in several junior faculty (as well as a couple senior ones) over his tenure. We had a mix of skills, we were all educators, and we were passionate about teaching. The positions he had for us, though, were in areas that were new to most of us—taking on this course, teaching in that area, being responsible for those student efforts. And he didn't assign us our responsibilities unilaterally. He spoke with us, assayed our interests, and gave us an opportunity to build our plates, taking on responsibilities for areas that appealed to our temperaments. This is not to say that he didn't make sure that every position was

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covered—he did. He just let us go about the work of divvying it up in collaboration with him and each other.

I think this was a pretty successful tack. In doing things this way, our boss had a group of pretty high morale teachers role modeling family medicine to students (we had some bumper crops choose FM those years), the work got done, and we were developing new skill sets. That taught me a lot—if you get the right people on the bus (we were hired for attitude and potential over specific skill sets), the bus will drive itself where it needs to go.

ALL THINGS COME TO AN END

As a bonus, the last bit of advice that I'll share was given me by a future neurologist doing his internal medicine preliminary year while I was at the University of Florida for medical school. As a medical student himself, this future neurologist had a resident he admired greatly, who really helped him acculturate to the world of medicine. This role model resident shared that some of the lessons we learn are white pearls and some are black. The former we strive to do, the latter we avoid. He even had two notecards, one with a white pearl and one with a black pearl, that he would flash periodically as he and the my future neurologist were went about their day with different teaching staff.

One day, the future neurologist was getting his hind quarters handed to him during rounds by a particularly caustic attending. Crestfallen, he could only stand there and take the abuse. Out of the corner of his eye he noticed his role model resident, standing behind the attending. The resident's face was impassive, but slowly, almost imperceptibly, he raised the card with the black pearl on it. That changed everything for the resident—it was the bit of mental armor he needed to endure the abuse. Unfortunately, it was also about the funniest thing he could have imagined at the moment—a red-faced attending and a sheepish resident raising the BS card. The future neurologist fell on the floor laughing, which caused the attending to lose his lunch and storm off in a fury.

What I take this anecdote to mean is that we learn from every person we encounter in a leadership position. All will offer us white and black pearls. Some will offer us more white pearls than black, and others vice versa. Our job is to collect the white pearls, do our best not to pass along the black ones, and lift the folks around us.

So, if you've gained any white pearls from this retrospective, you humble me. And the black ones? Just feel free to pitch them out.

Cheers!
Aaron

In Memoria – Terrence J. Schulte (September 13, 2019)

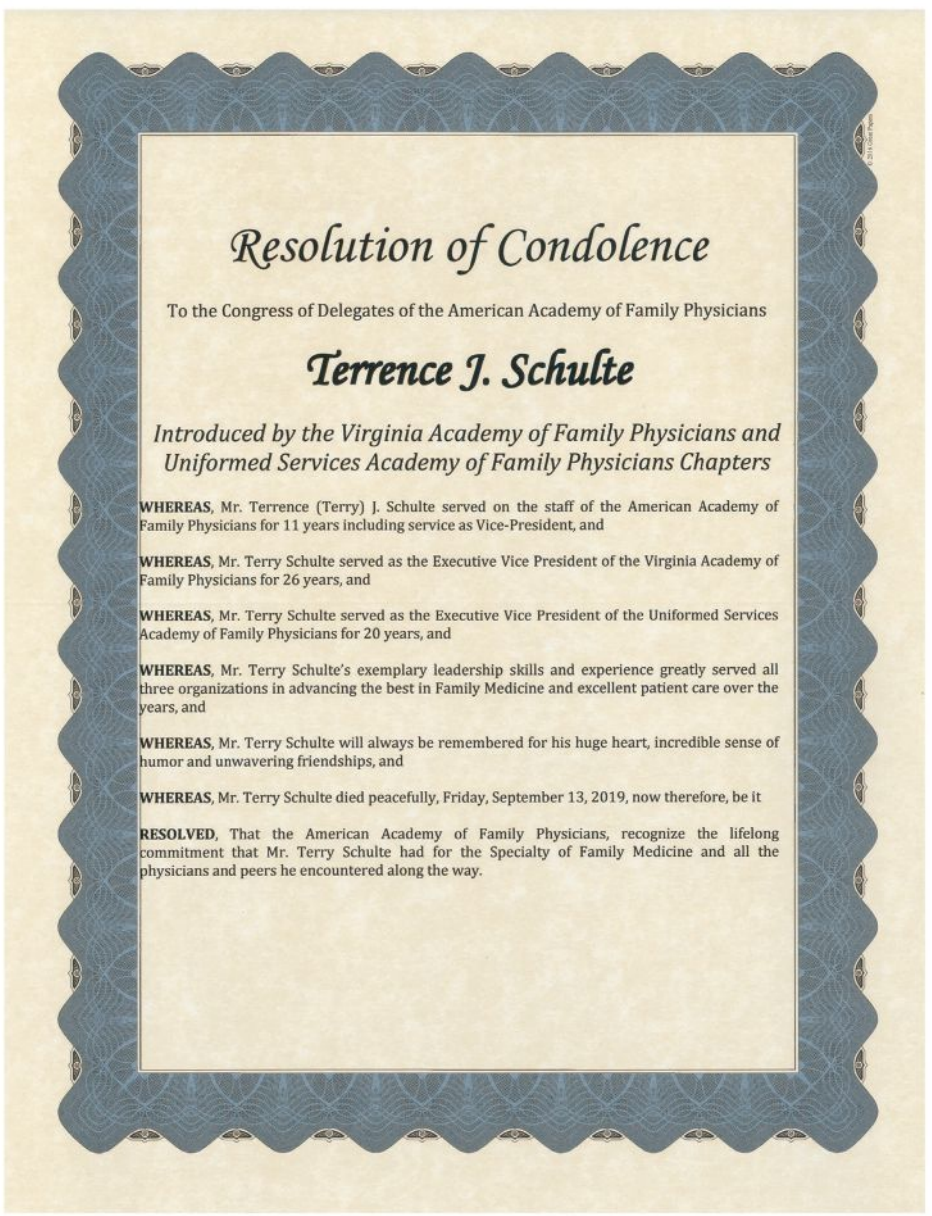
The USAFP is greatly saddened by the loss of longtime Executive Terrence J. (Terry) Schulte. Terry passed away peacefully on Friday, 13 September, after a courageous battle with cancer. Terry will be remembered for his unique sense of humor and wit and for his kindness and generosity that impacted all of those that knew and loved him. He was truly one of a kind and will be forever missed in the hearts of his family and friends.

Terry began serving as the Academy's Executive Director in 1996 after the USAFP broke ties with The Phoenix Corporation, an association management company in Richmond, Virginia. He was then the Executive Vice President of the Virginia Academy of Family Physicians and being local to Richmond, stepped in to help the USAFP in any way needed. That was history, Terry lead the USAFP for another 20 years until his retirement in 2015. Terry worked tirelessly on behalf of the Family Physicians in the USAFP and is to be given full credit for leading the USAFP out of financial hardship and into its current position as a financially solvent, thriving membership organization. He left his unparalleled mark on many many military physicians and the Academy. He never let anyone forget that before all of this he was loyal to the USAF!!

Terry was born on June 6, 1946, in Joplin, Missouri, to Dr. Gregory and Margaret Schulte. He loved his native state of Missouri and his beloved Missouri Tigers, but also had a love for the Commonwealth of Virginia where he dedicated over 20 years of service to the Uniformed Services Academy of Family Physicians. Terry was also a Vietnam veteran and avid patriot serving in the United States Air Force from 1966 to 1970.

Terry was a hero to his two sons Matthew Schulte of Richmond, Virginia, and Michael Schulte of Overland Park, Kansas, and beloved grandfather to his four grandchildren Madelyn, Gavin, Samuel and Matthew Schulte of Overland Park, Kansas, and loving brother to Thomas Schulte and Marcia Autry both of Joplin, Missouri.

The Academy will be forever grateful to Terry for his incredible leadership, huge heart and unwavering friendship. He loved everything USAFP and for this, he will never be forgotten.



Resolution of Condolence

To the Congress of Delegates of the American Academy of Family Physicians

Terrence J. Schulte

Introduced by the Virginia Academy of Family Physicians and Uniformed Services Academy of Family Physicians Chapters

WHEREAS, Mr. Terrence (Terry) J. Schulte served on the staff of the American Academy of Family Physicians for 11 years including service as Vice-President, and

WHEREAS, Mr. Terry Schulte served as the Executive Vice President of the Virginia Academy of Family Physicians for 26 years, and

WHEREAS, Mr. Terry Schulte served as the Executive Vice President of the Uniformed Services Academy of Family Physicians for 20 years, and

WHEREAS, Mr. Terry Schulte's exemplary leadership skills and experience greatly served all three organizations in advancing the best in Family Medicine and excellent patient care over the years, and

WHEREAS, Mr. Terry Schulte will always be remembered for his huge heart, incredible sense of humor and unwavering friendships, and

WHEREAS, Mr. Terry Schulte died peacefully, Friday, September 13, 2019, now therefore, be it

RESOLVED, That the American Academy of Family Physicians, recognize the lifelong commitment that Mr. Terry Schulte had for the Specialty of Family Medicine and all the physicians and peers he encountered along the way.

consultant's report
PHS/COAST GUARD

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Public Health Service (PHS) officers, Coast Guard (CG) medical officers, and family medicine friends, greetings from Coast Guard Air Station Clearwater, Florida! The Coast Guard has responded to many deployments and opportunities for PHS officers to support the health of our nation in 2019. Earlier this year, I deployed to the Southwest border to support immigration operations and I have just returned from the Hurricane Dorian response in September. I would like to share my experience during the hurricane operation and then transition to updates from the PHS and Physician Professional Advisory Committee (PPAC).

HURRICANE DORIAN RESPONSE

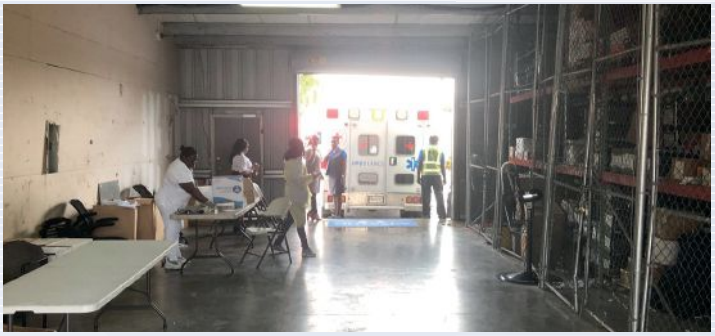
It was the week of September 1st, Sunday night about 20:00, when my Executive Officer called me at home to let me know that I needed to prepare a medical team for deployment the next morning. I remember it like it was yesterday. "Hey Doc, its XO. The skipper is going to need you to deploy with a team tomorrow for the Dorian response. Not sure what to expect but be prepared for the worst," was his opening line. He wasn't sure what we would find or what other medical support we would have, only that we would be stationed at Atlantic Undersea Test and Evaluation Center (AUTEC), U.S. Navy, Andros Town, Bahamas. I immediately called my clinic supervisor, Chief Gonzalez, and prepped my deployment team of four health service technicians (HS). I then prepared my clinic for my departure and told my wife our leave would be cancelled for the Labor Day holiday in favor of my all-expense paid vacation to the Bahamas, courtesy of the U.S. Coast Guard.

Captain Warner on H60 helicopter refueling on Coast Guard Cutter James.

I arrived at work first thing in the morning on September 2nd in order to prepare for the deployment. I prepped both of my flight surgeon "go bags," treatment bags that contain ACLS protocol medications, AEDs, and miscellaneous medications for trauma, infections, and pain management. I also had my HSs get our trauma bag prepped for flight; it included trauma and casualty dressings, intra-venous fluids, and miscellaneous medical supplies. I updated my deployment team and completed a pre-hurricane briefing with my medical staff about potential injuries, treatment protocols, and command and control for the mission.

We boarded the C-130 and arrived at AUTEC in the late morning. We were following the tail of Dorian–it was still positioned over the Grand Bahamas and Abaco Island. Once we landed, we stored our gear at the AUTEC bachelor officers' quarters and made our way to the AUTEC Naval Clinic to discuss medical capabilities and MEDEVAC procedures. I established a working relationship with Dr. Jere Fitts, AUTEC clinic medical officer and staff, identifying surge medical care resources if needed. Afterwards I spoke with the AUTEC emergency management services (EMS)/fire chief, identifying local EMS protocols and capabilities. I returned to the operations center to identify the medical support mission afterwards, and as soon I walked in the door the Air Boss, LCDR Lumpkin, looked up at me and said, "Doc! Suit up and get on the next H60 heading to Abaco. The storm's wind wall just moved North and we are flying in following the tail." I looked at him and smiled, grabbed my helmet, my go bag, gathered two of my HSs,

Captain Warner with Dr Hanna Alvarez Ambulance EMS Medical Officer and her staff Nassau Bahamas.



Triage bay at Odyssey Airport for medevac drop off.

and boarded H60-6044 for the initial wave of MEDEVAC flights to Marsh Harbor Health Center, Abaco, Bahamas, riding the tail of Hurricane Dorian.

I took HS1 Bennington and HS2 Zaborowski for my HS support, in conjunction with the regular air crew of the H60, which included one aviation survival technician (AST), or rescue swimmer. We had a one-hour rough ride north to the island of Abaco and it was already early twilight, hurricane winds pushing the helicopter to its maximum safety limits. We landed right outside the Marsh Harbor Medical Clinic, one of only two buildings still standing in the area. When flying overhead, the area looked like a massive bomb had exploded and scattered debris everywhere. Everywhere there were collapsed houses with missing roofs and cars piled onto one another. The clinic was the only building still standing with electricity. After landing in two to three feet of water, we navigated through the parking lot and made our way to the building entry. There were local folks huddled everywhere and anywhere to get protection from the elements. The parking lot was filled with destroyed vehicles, the medical clinic entryway sheltered shaking people, and the clinic hallways were filled with masses seeking protection and medical attention. As we entered the clinic, it was packed from wall to wall and we had to push our way through to find the medical bays and staff.

At the Marsh Harbor Clinic, I met with Dr. Carter; at the time, he was in the middle of repairing huge leg lacerations and dressing limb amputations. I wasn't sure if he was the calmest person I had ever met, or if he was simply sleep deprived and shocked by his situation, but he spoke with a slow, steady voice as he explained his patient's prognosis. We triaged his first wave of MEDEVAC patients and creating a method and schedule for further USCG MEDEVAC. I was able to assess their local capabilities and reviewed their resources. Unfortunately, the facility was without proper security to leave a USCG medical team for on-site support; not a viable option in this mass-casualty situation. We initiated the first MEDEVAC of five patients to Nassau's Princess Margaret Hospital, with illnesses and injuries varying from arm amputation, chronic renal failure requiring dialysis, abdominal blunt force trauma, and severe lacerations with closed head injuries.

We landed at the Odyssey Airport, well after dark with hard rain still pelting us as we hand carried several of the patients to EMS crews already prepared to meet us on the tarmac. After landing, we returned to AUTEC to coordinate the next day's MEDEVAC missions with the air boss. We prepped and I ensured we had one HS on each flight to support the AST's with any needed medical assistance.

On September 3rd, Dorian decided to hover over Grand Bahamas Island and we were unable to enter the island for additional medical evacuation. I boarded H60-6044 to Nassau, Odyssey Airport, in order to liaison with local Bahamian EMS services and determine local hospital capabilities. There I established MEDEVAC protocols with Dr. Jones, medical officer in charge of the triage site at Odyssey, for incoming MEDEVAC patients transported on USCG platforms. We also developed a drop off site for bio-hazard waste from our USCG AST/HS MEDEVAC flights. I was also able to meet and work with Dr. Hanna Alvarez, ambulance EMS medical officer, in order to develop the triage site at Odyssey Airport for incoming USCG MEDEVAC. Dr. Hanna worked with local government officials to procure five ground ambulances to support MEDEVAC missions, ensuring they would be prepared to

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take patients to Doctor's Hospital, Princess Margaret Hospital, local medical clinics, or to shelters for displaced citizens.

I assisted in transporting a patient with head and neck trauma to Princess Margaret Hospital from Odyssey Airport. This allowed me to identify key personnel at Princess Margaret Hospital and to tour their emergency room while learning their protocols for crisis response. Most importantly, I was able to establish communications with emergency room staff to include Dr. Davis, the chief of the emergency department, Dr. Wells, and Dr. Burnett. It was important to assess hospital capabilities and develop a working understanding of the local support system of local medical clinics and shelters. On my return to AUTEC that night, we prepped for the next day as Dorian finally moved north.

On the morning of September 4th, I boarded H60-6027 to Grand Bahamas, Freeport, to locate Rand Memorial Hospital and liaison with the medical staff. We did not have internet capability and were only able to locate Rand by means of a cartoon tourist map. Unlike Abaco Island, Grand Bahamas had weathered the storm with much better success. By the time we landed there, people were outside drying clothes on clothes lines, others were driving around, and kids were outside playing. Many of the homes seemed unaffected, and the flooding downtown was minimal with most roads open. I ran with the AST to Rand Hospital and made contact with the Rand medical team: Dr. Sharon Williams, hospital administrator; Dr. Forbes, medicine chief, and Dr. Lee, ICU attending. Rand Memorial Hospital was using back-up generator power and had suffered some flooding damage, but the water was already quickly receding. We identified their current capabilities and limitations following Dorian. Their medical staff was awesome and capable, and we only identified a single case that required MEDEVAC: a young child

Medevac at Marsh Harbour Clinic Abaco Island Bahamas first night trailing Hurricane Dorian.

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with head trauma, ventilated and sedated. We asked the medical team to prepare him for transport with their mobile ventilator while we refueled prior to evacuating the child to Princess Margaret hospital.

On our way to Coast Guard Cutter James to refuel, we transferred five nurses and a single doctor to the otherwise inaccessible Eight Mile Rock Clinic on the other side of the island; the one main road connecting it to Rand Hospital was still blocked by debris and flooding. Following the transfer of the medical staff to Eight Mile Rock, we boarded the CGC James to refuel then returned to Rand Hospital for the medevac of the intubated child.

We were able to land at the Grand Bahamas International Airport to receive the patient for MEDEVAC. Rand had only one working ambulance and was without a working helicopter pad. The patient was a pediatric case with head trauma, new onset seizures, and history of cardiac surgery, and was currently intubated and ventilated. Upon arrival, the patient was unable to be ventilated by machine, was in respiratory distress, had falling blood pressures and heart rate, and was being ventilated via bag-mask valve by the transport nurse. My decision was to immediately return the patient via EMS back to Dr. Lee in the Rand ICU for re-stabilization. I felt the risk of transfer in the H60 was greater than sending the patient back to Rand. As a USCG flight surgeon, I am required to be a subject matter expert in assessing MEDEVAC risk against possible medical gain. Unfortunately, the risk of moving the patient exceeded the medical gain. Eventually the U.S. Navy was able to send a surgical team on a larger helicopter platform with their own equipment to evacuate the patient to Miami, Florida.

By the end of the day, the USCG sent additional medical assets to support our mission for the remainder of hurricane operations. We continued to augment

Marsh Harbour Clinic Coast Guard HS leading ambulance to medevac landing zone.

the ASTs on their MEDEVAC missions and we continued to transport medical evacuees to the Odyssey Airport and eventual definitive care at Princess Margaret Hospital.

On September 5th, I was provided additional medical assets and started tasking them, including our newly arrived physician assistant, LT Gardner. We continued operations in support of the islands and provided vaccine and medication transport, medical asset transport, identification and communication between different clinics that had been separated (like the Fox Town Clinic on Abaco Island), and we continued augmenting all flights with our HS teams. By this time, the helicopters were constantly flying and being tasked throughout the islands. We heard that the U.S. Department of Defense was being activated and was already staged in the vicinity to further assist on a much grander scale. Our tempo and missions de-escalated as the Navy started stepping in with more assets to help stabilize the Bahamas.

By September 6th, the USCG medical MEDEVAC missions started to dwindle and we began to draw down. I figured it was time to head home and I prepared for my departure and return to Clearwater, FL. We maintained a medical footprint for nine days in AUTEC, supporting operations and providing MEDEVAC mission support. It was a great experience to fly with the pilots and crewmembers that I take care of on a daily basis. To be able to see first-hand what our fellow service members do, sacrificing for the needs of others, was absolutely amazing to witness. At the end of our mission, following a hurricane with catastrophic winds topping 185 miles per hour that devastated multiple islands throughout the Bahamas, more than 900 Coast Guardsmen, nine cutters and 32 aircraft mobilized to deliver desperately needed aid and assistance. This resulted in 198 sorties to

Dropoff zone for medevac cases at Odyssey Airport Nassau Bahamas.

Coast Guard Team at AUTEC.

answer 1388 search and rescue calls, ultimately saving or assisting the lives of 457 people. I am truly honored to be part of such a great organization, and it is my privilege to serve the U.S. Coast Guard.

PHS UPDATES

Let's start the update with the new PHS motto! ADM Giroir unveiled the results of our survey-voting tool that went out a few months back: "In Officio Salutis" (In the Service of Health). Thank you all for participating in its selection. PHS believes the service motto will help us reflect and reinforce our values. ADM Giroir will publicly address the new motto during the Association of Military Surgeons of the United States conference in December.

Commissioned Corps Headquarters (CCHQ) continues to release policy updates related to deployments and readiness. You can find these updated policies at https://dcp.psc.gov/ccmis/. For a recap, Commissioned Corps Instruction (CCI) 241.02, "Deployment of Corps Officers," dated 2 October 2019, assigns the responsibilities and requirements to which Corps officers must adhere while on active duty and prescribes procedures to ensure efficient deployment of officers in response to urgent or emergency public health needs. Personnel Operations Memorandum (POM) 821.76, "Deployment Procedures," dated 3 October 2019, specifies deployment procedures for Corps officers responding to urgent or emergent public health care needs. These policies went into effect on October 25, 2019. Per the bulletin releases you received, the key points are as follows. First, CCHQ will conduct a thorough review of the current tiered response structure. Until further notice, officers will remain with their currently assigned teams, maintain basic readiness, and remain ready to deploy during their on-call months. Second, CCHQ will work with Health and Human Services (HHS) agency liaisons to notify supervisors of the procedure changes. Specifically, CCHQ will inform liaisons that the Assistant Secretary for Health (ASH) can deploy officers assigned to an HHS operational division /staff division without supervisory approval. For those officers assigned to non-HHS Agencies, they will continue to be deployed in accordance with the Memorandum of Agreement/ Understanding between the Corps and the non-HHS Agency.

In addition, the ASH and the Surgeon General (SG) recently signed several new and revised Commissioned Corps Directives (CCD), CCIs, and POMs. CCHQ has posted these new and revised policies to the Commissioned Corps Management Information System (CCMIS). Key changes were made in multiple polices. First of all, regarding medical policies, CCD 128.01, "Medical Fitness for Duty" (formerly "Medical Review Board"), affirms that an officer must meet the standards for deployment in order to be considered medically fit-for-duty; delegates to the ASH the authority to establish medical accession and retention standards, as well as the authority to determine the circumstances in which these standards can be waived; modifies the authorized composition of the medical review and medical appeals boards; and clarifies the administrative process for an officer being separated on the basis of unsuitability.

Secondly, CCI 393.01, "Medical Review Board" (formerly, "Disability Retirement") specifies who may refer an officer for a fitness-for-duty (FFD) evaluation if the officer is unable to engage in the physical activities associated with deployment or if the officer cannot meet medical readiness standards; establishes the circumstances under which the Director, CCHQ, can remove an officer from the list of officers pending a medical review board (MRB); clarifies the responsibilities of the MRB and the information they must include in their report to the SG; and clarifies an officer's appeal rights.

CCI 393.02, "Medical Appeals Board" clarifies the process of appealing an MRB recommendation; specifies the timeframe for submitting new documents to the appeals board; and establishes the circumstances under which an officer can withdraw his/her appeals request.

CCI 221.01, "Medical Accession

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Standards" establishes the medical accession standards required to serve in the Commissioned Corps and the circumstances and processes under which the Commissioned Corps can waive a medical accession standard for an individual candidate.

CCI 633.01, "Special Pays" clarifies eligibility and limitations for certain specific health professions special pays (e.g., officers assigned to fellowship and training programs are not eligible for accession bonuses [AB], critical wartime skills accession bonuses [CWSAB], and retention bonuses [RB]).

CCI 671.07, "Post 911 Education Benefits" clarifies the process for officers to use in exercising this benefit.

CCD 157.01, "Transfer of Education Benefits" delegates authority from the Secretary to the ASH to administer the Post 911 Transfer of Education Benefits to eligible dependents.

POM 821.72, "Waiver of Disqualifying Medical or Dental Conditions" details the procedures for the medical accession standard waiver process as established in CCI 221.01.

Check out the Frequently Asked Questions (FAQ) at the Commissioned Corps Management Information System FAQ webpage, or please contact the Readiness and Deployment Branch at RedDOG@hhs.gov.

PHS READINESS & COER

It is flu season, so don't forget to receive your annual flu shot and upload it into electronic document upload (eDOC-U). Remember that medical affairs (MA) will only accept immunization submissions via eDOC-U located in the officer secure area (OSA). Any immunizations or medical documents sent via email will be deleted and cannot be processed.

Please don't forget to complete your PHS-7044 (annual physical fitness test [APFT])! In addition, if your height and weight reflect a body mass index out of Corps retention weight standards, you must also complete a 7044-1 for estimated percent body fat. Please view the Corps retention weight standards webpage for more information and policies. Go to the CCMIS website and look under the "Readiness" tab to find the APFT information and PDF's of the PHS-7044 and PHS-7044-1. You must submit verified APFTs through the eDOC-U application in the OSA of this website. APFTs must be uploaded to meet basic readiness requirements. Detailed instructions on uploading the APFT are available in the eDOC-U user guide in the application. Officers who are unable to do a category of exercises (cardiorespiratory endurance, flexibility, etc.) due to a medical limitation can request a medical waiver for that component and complete the rest of the APFT.

As you are aware, the 2019 commissioned officers' effectiveness report (COER) system is now open. Refer to POM 821.73 for processing details and guidance. As a reminder, transfer COERs with end dates after July 1 become annual COERs. Make sure you pay attention to the submission deadlines for the 2019 COERs:

1. Online annual COER is available to officers on 18 October 2019.
2. Online annual COER is due to the rater by 01 November 2019.

Flying over Abaco Island looking for landing zone for medevac missions at Marsh Harbour Clinic.

3. Online annual COER is due to the reviewing official (RO) by 15 November 2019.
4. The annual COER is due to the agency liaison by 13 December 2019. **DHS Liaison requests COERs by December 6th, if possible
5. The annual COER is due to Commissioned Corps Headquarters (CCHQ) by 31 December 2019.
6. The online COER will be disabled on 4 January 2020.

Check out https://dcp.psc.gov/ccmis/COER/COER_Index_m.aspx for your 2019 annual COER POM.

Don't forget that if you are an officer eligible for promotion, it is your responsibility to inform your reviewing official (RO). The reviewing official statement (ROS) is mandatory for all promotion eligible officers. The ROS is optional, but strongly recommended for officers not eligible for promotion.

Officers with a transfer COER must ensure their RO submits a 2020 ROS to their agency Commissioned Corps liaison.

PHS PPAC UPDATES

The PPAC specialty interest groups have sprung up within the PPAC Outreach Subcommittee, currently chaired by CDR Keren Hilger, with groups covering all the PHS specialties. Recently there is a new outreach group: Uniformed Services University of Health Science (USUHS) graduates. If you are a graduate like me, and wish to get connected, please reach out to us. The interest groups have really developed into incredible networking and support opportunities for medical officers with common threads beyond medical specialties. Unbeknownst by many, USU graduates still in their first 7 years of their payback are facing some interesting challenges that are jeopardizing their specialty pays. If you're a USUHS graduate, please look us up on the PPAC website or reach out to CDR Hilger or me to get connected.

In addition, if you haven't heard, USUHS President Dr. Richard Thomas, MD, DDS, FACS, just sent out an email that indicated USUHS is being targeted for budgetary reductions as part of the "Defense-Wide Review" (DWR). As Dr. Thomas stated in his email, "These cuts will, in effect, close the University.

University leadership has not been included in the earlier discussions and we have not had any meaningful representation during these DWR sessions. Our review of the DWR materials reveals significant flaws in the analysis. On October 31, the DWR committee will meet with Defense Secretary Mark Esper during which we anticipate they will recommend that he close the University." Spread the message and let's gather support for our alma mater in any way we can.

Lastly, if you aren't a member of PPAC or the family medicine interest group please feel free to reach out to Captain Sarah Arnold, CDR Ryan Sheffield, or myself! We are here to support you and represent family medicine physicians to PPAC. If you have ideas, questions, or comments, please contact us at your convenience. Our next meeting is November 6, 2019, 1500 EST. We are establishing mentoring, promotion assistance, and guidance in all things PHS related to family medicine physicians. And if you are not a voting member of PPAC, know that there are several voting positions opening next year if you are interested in serving!

LASTLY

I would like to thank all of my fellow PHS physicians who continue to serve in the support of the health of our nation. In addition, this will be my last USAFP PHS Consultant article as I end my tour on the USAFP Board of Directors next spring. It has been my honor to hold this title and represent my fellow family medicine PHS medical officers. If you are a USAFP member, please consider serving in the near future as a PHS Director! It will be great to see everyone next year and catch up with friends in Anaheim, California for the 2020 USAFP meeting. Until then, "In Officio Salutis" (in the service of health)!

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.

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Family Medicine at the Tip: Integrated Operational Support

He was a 39-year-old E7 pararescueman, sitting in front of me in my family medicine clinic three years ago. He had just finished telling me about his knee pain, how it had been present for a couple of years, how it was really starting to limit his work, and how it ultimately meant he was no longer able to operate at the level needed to continue to lead in the field. His disappointment was palpable, and my overwhelming feelings of inadequacy raced through my mind. I had maximized my management options and used the skills I had at the time, yet he was not better. If only this issue had been addressed two years ago before the biopsychosocial effects of chronic pain had set in. There had to be a better way to take care of this community who gives so much.

Imagine a practice without scheduled appointment times in which you can spend an hour with a patient or do their follow-up visit in the gym between exercises. The principle metric that counts is providing highly capable and deployable Airmen to the line squadron commander. Such is my practice now as the primary care sports medicine (PCSM) doctor at the 57th Rescue Squadron. I currently serve as the 'team-doctor' for a group of pararescuemen (PJs) and combat rescue officers (CROs) assigned to a guardian angel (GA) squadron.

PJs are a unique blend of highly trained paramedic, rescue specialist, and unconventional ground force within the Air Force. They undergo a rigorous training pipeline which takes over two years to complete and includes a daunting indoctrination course, static line and freefall jump training, dive training, paramedic certification, weapons training, high angle rescue ropes training and much more. They are an elite community, highly trained, and highly valuable to the special operations mission-set, often working with Army operational detachment alpha (ODA) teams, augmenting Navy SEAL teams, and serving in both the GA and special tactics teams within the Air Force.

After investing millions in training these operators, they traditionally would be assigned to a squadron with medical care provided by their flight surgeon, many of whom have a background working in emergency medicine, family medicine, or as general medical officers (GMOs). There has, traditionally, been a gap between their operational importance and the care the Air Force Medical Service has been able to provide, with assigned medical officers sometimes lacking the subject matter expertise or the sensitivity to operations crucial to caring for this community. Starting a few years ago, as part of a program called Preservation of the Force and Family (POTFF), PCSM physicians started to be assigned to GA squadrons along with a certified athletic trainer (ATC), physical therapist (PT), strength and conditioning coach, and a psychologist and/or clinical social worker. This team became an embedded part of the squadron to provide integrated operational support (IOS) with the mandate of working towards performance optimization, injury prevention, and rapid diagnosis/treatment with prompt return to duty. It was an idea modeled after the similar, but different, squadron medical element (SME) flight surgeon whom the Air Force has utilized to provide an in-house trusted agent for pilots. Along with the personnel came an influx of equipment, resources and energy.

Fundamental to the success of the IOS model is the perception of a trusted physician, who not only knows the patient and their family, but also understands the mission requirement, understands the tempo and can flex based on those needs. Today, I am the lead of the human performance team, which means incredible variability in my day-to-day work. Each day begins with squadron PT, an event which is pivotal for my practice. It is there, while I exercise, that I have a chance to see our operators in their natural environment. The questions of 'can this patient physically do his job' are answered there in front of my eyes. Additionally, this is where many of our conversations about injuries start, with operators frequently asking me about an ache or a pain that happens when they perform certain lifts or endurance training. The entire squadron has mandatory PT, and at that point, the human performance team's work really begins. We operate in a manner similar to a collegiate training room, with an open bay and open access for anyone who needs evaluations or treatments. We offer a full capability of diagnostics, treatments and rehab in the squadron, so our members are seen, diagnosed, treated, and dispositioned in a matter of minutes, no call to an appointment line required.

While the majority of my work focuses on musculoskeletal injury and my training in sports medicine, there is a large portion of my traditional family medicine role needed as I also provide care for all the squadron's spouses and children. This is a treasured role for me and is clearly a family-centered care experience, the family medicine I envisioned when I chose the specialty. When I see a spouse, I know the stressors that may be ongoing – an upcoming deployment, a long TDY, or dependents struggling with their health. This allows me to integrate what I know is happening in the squadron with what is happening in the family – a huge piece of the POTFF initiative.

While these opportunities are currently only available to PCSM physicians, similar and equally important roles are likely to become available in the future for family physicians without a certificate of added qualifications in sports medicine. As the Air Force moves to an operationally minded medical force, line commanders are likely to demand similar capabilities for all airmen.

In the midst of a significant amount of change in the AFMS I encourage each of us to identify ways to stay intimately familiar and 'in-touch' with our fundamental mission. In particular, challenge yourself to seek not only functional endpoints for your patients (physically capable of deploying) but seek to propel your patients to higher levels of performance (deploying and improving the mission capability of their unit). Consider ways to take good medicine to the point of injury by challenging the comfort and status quo of delivering care exclusively in the medical clinic. As a physician, make yourself part of your unit's team by engaging in team events and workouts. Challenge yourself in these new ways and you, as I have been, are likely to be surprised by how much joy it can return to your practice.

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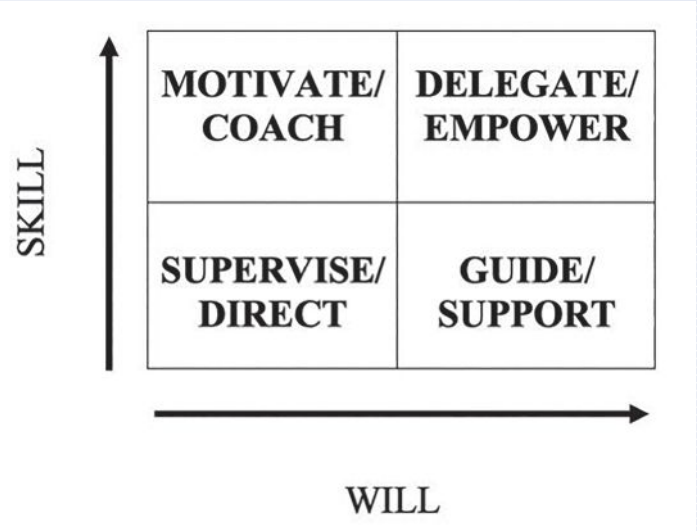
A Framework for Navigating Difficult Learners: Skill vs Will Matrix

It was the fall of 2015. I was in the second year of my program, about to start my first family medicine inpatient rotation as an upper-level resident. I was excited – excited to not be an intern anymore and excited to finally teach the intern and medical students. Then entered my intern for the rotation, S.D.; he was one of our best and brightest. The scores for the annual in-training exam had just come back, and S.D. had been recognized by the program for earning the highest score in the history of the program. Immediately, I started to think about how I could push and teach him and was instantly overwhelmed. I hoped silently that maybe he would be awkward with patients so I could at least teach him about communication skills. But, of course, the patients loved him. Our first week working together, I was determined to find a way to challenge him, but my desire to teach him medical concepts in our inpatient rounds quickly turned in to him teaching me, and he did it as humbly as possible. So now he is bright, good with patients, humble, and genuinely just a great guy. The worst! After swallowing my ego and spending some time reflecting, I realized I was approaching this the wrong way. S.D. was not the worst; he was a great asset to our team. He was highly skilled and extremely motivated. The more that I delegated to him, the happier he was, and he excelled. I also realized that with autonomy and a little room to work on his own, he did provide opportunities for me to give him suggestions to improve his work. This experience taught me about leading highly skilled and highly motivated learners and led me to a tool to help leaders approach different learners and meet them where they are. It is not groundbreaking, but it is an excellent framework to apply when leading different types of people.

During the 1970s and early 1980s, Paul Hersey and Ken Blanchard developed situational leadership theory in the business literature. Their theory suggests that leadership depends upon individual situations and that no single leadership style can be considered the best. They suggest that a good leader will adapt their leadership styles to address individual situations. The theory suggests that leadership techniques come from the leader and that leaders must pair their styles to the maturity level of the group led[1,2].

While developing their Situational Leadership Theory, Blanchard and Hersey looked at multiple factors that affect leadership styles. They discovered that employee maturity was best described as a combination of two factors: competence and commitment. Blanchard designated four types of employee: high competence and high commitment, low competence and high commitment, high competence and low commitment, and low competence and low commitment. Together he and Hersey described the leadership styles that are best suited to address each of the four types of employee. They developed the original skill versus will matrix below. In education we can adopt this business principle easily and use it as a framework to interact with our learners.[1]



LOW WILL-LOW SKILL: SUPERVISE/DIRECT

These learners are typically new to the system and often do not want to be there; however, this category may also include new learners who simply lack confidence[2]. When dealing with these types of learners, faculty often must be prescriptive in tasks and assignments, directing and supervising them closely through completion. Supervising these learners often requires solid guidelines, control, and decision-making from the leader. This type of leadership is often time consuming and should ideally be temporary as learners grow into other quadrants[3]. It is easy to identify these learners as lazy or unmotivated (and that may very well be the case), but there are plenty of learners in this category who may be reacting to life stressors of which the leader may be unaware. It is important to be direct with these learners and clear with expectations, but make sure to find ways to inspire them and to identify potential underlying issues. It is also important to identify and recognize success when they do something well.

LOW WILL-HIGH SKILL: MOTIVATE/COACH

These are the learners who are very competent but lack the motivation to perform their tasks. They are often some of the most difficult to teach and lead. In order to get these learners to participate, their leaders must tap into what motivates them. Leaders must identify and encourage those with low confidence. At first, the leader will be coaching and handling most of the decision-making, but, given time and communication, the idea is to eventually empower the learner to make decisions[3]. Coaches must spend time communicating and finding their learner's internal motivators, but they should be careful to remain a coach and not a therapist.[2] Competent learners often will fall in to this category if they lose their drive. Generally, this is a result of the learner being bored, feeling like they are not recognized for their work, or some other frustration. It is very important to recognize the reason for their change in motivation in order to address it. Once you identify these learners' motivators, use positive and negative reinforcement to coach them.

HIGH WILL- LOW SKILL: GUIDE/SUPPORT

This group encompasses the majority of the learners in medical schools and residency programs. The average resident comes to residency very motivated to become an excellent physician but lacking the training, skills, and knowledge to practice independently. This is what residency is for, and faculty should be guiding and supporting learners to encourage their growth. These learners do well if given the right tools to succeed: clear expectations, feedback, and, like the other three learner types, recognition of success. By offering the learner training and other opportunities to improve, her or his skills will gradually increase[2]. While guiding these learners and being supportive, leaders must be very careful not to appear condescending or patronizing to the learner as this can undermine the relationship between them.

HIGH WILL-HIGH SKILL: SUPERVISE/DIRECT

These individuals, like S.D. whom I discussed earlier, are those highly motivated and highly competent learners that generally grasp concepts and move at a quicker pace than other learners. It is important to involve these learners in the decision-making process. These learners do best when given freedom and autonomy. The teacher should set clear and challenging goals and then follow closely to identify opportunities to challenge them further[3]. It is very easy to delegate to these learners, but leaders must be careful not to delegate too much.[2] Delegating too much can make learners feel like the teacher is taking advantage of them. Additionally, leaders must consider the halo effect, a tendency to favor higher performers, and make sure that they are evaluating the learner fairly and not giving special treatment.

When challenged with leading difficult learners, take a minute to place them in one of these four categories and try to utilize the leadership tools specific for each group. Hopefully, you find new ways to interact with, and teach, your learners!

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Beyond The Bench-Top: Research in the Field

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GOALS:

1. *Data you gather from your daily work can support and improve operational medicine.*
2. *GME platforms can engage in scholarship with the line communities.*

A common perspective of scholarly activity is that it takes too much time and effort without enough return for the physician.[1] However, with the paradigm shifts occurring in military medicine, from Defense Health Agency restructuring to refocusing on readiness and electronic medical record changes, clinician scholarship is needed now more than ever to ensure that the restructuring is aligned with the best outcomes for our patients.

Rather than feeling uncomfortable with these changes, military physicians may view this period as an ideal time to shape the future of military medicine through intentional, readiness-driven projects – many of which we are already doing as part of internal process improvement. Further, our graduate medical education system has the unique ability to contribute not only to the traditional fields of clinical knowledge, but to the operational literature as well. In the following newsletter, we hope to emphasize the essential role of clinician- and resident-driven scholarly activity in improving clinical and operational readiness and discuss practical tips for getting started.

UNLOCKING CLINICIAN POWER

Whether you work in a clinic or are attached to a unit, you are uniquely positioned to perform clinically- and operationally-pertinent scholarly activity. Scholarly activity is not limited to prospective clinical trials; it includes any quantitative effort to improve patient care, from quality improvement (QI) to process improvement (PI) interventions. Joining together with our clinical team, QI/PI projects like these are an easy step into scholarly activity with tangible benefits for physicians and patients.

Many of us see readiness-impacting clinical issues that we are uniquely equipped to tackle. On the other hand, we may feel unsure about how to formally evaluate a problem or how to develop and test a solution. A simple first step is to redefine the clinical problem as a readiness problem. If you have access to them, start by asking line side leaders how they perceive this problem, or if they are aware that this issue may be degrading readiness. Working with our line counterparts, we can define the problem in readiness terms and develop a solution that can be shared with other units.

Do not be afraid to work directly with operators or other clinician

researchers to combine resources and brain power to solve problems. Medicine, research, and the military are all team sports. Armed with data, we are empowered to bring about positive transformation. This becomes an opportunity to make change from the grass roots level to better inform senior leader decisions. Senior leaders often have a strategic mindset but may lack the tactical data to make the best-informed decisions – unless we in the clinical trenches provide them with it.

DON'T LIMIT YOUR INTERVENTION TO A BULLET ON YOUR EVALUATION

A common frustration for physicians is creating a good outcome at one military treatment facility (MTF), then transitioning to a new location and having to recreate the wheel. We can limit this by ensuring that we present and publish our methods and outcomes. In an upcoming letter in Military Medicine, CAPT Matthew Case describes how Naval Hospital Jacksonville was able to integrate graduate medical education into readiness training using the concept of an "operational-scholar," a key component of which is preservation of operational innovation through peer reviewed publication.[2] Sharing their success through publication not only enables a seat at the table in their MTF, but may enable improvements to be implemented service-wide.

Further, readiness interventions uniquely help the line side realize the alignment of goals between medical research and the operational mission. Consider sharing your findings via commander's call, Prostaff, or the base newsletter. Anecdotally, we have found this has continued to grow support and buy-in for ongoing scholarly interventions; when the base commander tells your hospital commander how much they appreciate your scholarship, you tend to enjoy a great deal of support!

Too often, patient-oriented improvements become officer professional record, officer evaluation report, or fitness report bullets, never shared with the greater medical community. Make an effort to share readiness-related projects from which we may all learn.

GME IMPACT ON READINESS RESEARCH

Beyond growing expert clinicians, there is a unique role for military graduate medical education (GME) platforms to directly impact our war fighters through scholarly activity. The 2017 National Defense Authorization Act reiterates the importance of military medical GME to "fully support the operational... medical readiness of the Armed Forces."[3] In some cases, this is already happening. For example, in the 2017-2018 period, 63% of the San Antonio Uniformed Services Health Education Consortium (SAUSHEC) research publications had application to military-relevant topics.[4] The GME setting is uniquely fit for this mission due to increased support for scholarly activity, academic focus, and some flexibility in schedules that does not exist for non-GME associated clinical colleagues. Under this rubric, there are increased opportunities to work directly with our operational groups to innovate.

This sort of medical-line collaboration is already occurring with great results. At one of our author's residency program, a former flight medicine resident without prior scholarly activity training was contacted by a Naval Explosive Ordnance Disposal (EOD) program due to a concern for high injury rates causing training drop-outs. Through

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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 1 January 2020.

RESEARCH GRANTS

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

RESEARCH JUDGES

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

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

Please write to me...
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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.

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his efforts, a multidisciplinary medical team (emergency medical technicians, physical therapists, nutritionists, strength trainers, and mental health providers) was integrated into their training program with decreased injuries resulting in a 12% increase in graduation rate and $1.6 million in cost savings.[5] These impressive results were shared at our base, drawing the attention of the occupational and physical therapy department, who are now formulating a similar program to be instituted locally. The project was then shared at last year's USAFP conference and is gathering attention from other EOD training sites with similar interest. With the support of the Military Primary Care Research Network (MPCRN), this study is being prepared for publication to share on a national stage. This is just one example of how a family medicine resident served a vital role to facilitate improved operational outcomes.

As demonstrated in this example, residents can directly impact operator health. Additionally, with these exposures, residents benefit from collaboration with the line side. Exposure increases knowledge of the operational requirements of our warfighters, allowing residents to provide more informed future care. Finally, residents and faculty are required to perform scholarly activity by the Accreditation Council for Graduate Medical Education. This is an important extrinsic motivator that can be directed toward readiness/operational efforts. Once residents have this scholarly activity exposure and training, they are more likely to continue to integrate the principles of research within their clinical practice, thus furthering the growth of literature around operational interventions.

OPPORTUNITIES FOR SCHOLARLY MENTORSHIP AND A CALL TO ACTION

USAFP has research tools available to help clinicians, residents, and faculty overcome time, support and mentorship barriers. The Clinical Investigation Committee (CIC) maintains these research tools on-line at www.usafp.org. Step by step instruction on topics such as how to do a case report, start an institutional review board approved study, or write a grant are available through the research handbook called "The Recipe."[6] Additionally, the CIC is developing a more comprehensive online curriculum that will be accessible everywhere family medicine physicians serve. The first modules of these will be presented by some of the top military medicine research leaders and filmed during a research workshop at USAFP's 2020 Spring Conference (You should come!). Further, opportunities for collaboration and mentorship exist with MPCRN, which connects medical professionals with research resources at 15 military family medicine residency training sites.

Evidence-based care is the foundation of our patients' health. We at the USAFP CIC believe that just as military family medicine physicians are the tip of the spear in providing that care, we are ideally situated to lead clinically relevant scholarship to improve it.

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Top Medical Apps for Winter 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. Simply Sayin' App

Pediatric visits can be the most enjoyable part of the day in a busy primary care practice. However, our pediatric patients are often anxious and suspicious of these visits--fearful of poking, prodding, and the dreaded "shots." All of this anxiety is amplified when children are admitted to the hospital or must undergo medical procedures. Additionally, despite their intelligence, our medical jargon is simply too challenging for them to comprehend. Phoenix Children's Hospital has produced an app for parents to help explain complex medical terms in soft language using the teach back method. The goal is to help enhance comprehension prior to visits, admissions, and procedures via easy to understand terms, illustrations, and sounds. Parents can use the app as a teaching tool for their children. The app uses a soft language glossary, quality illustrations, and sound clips to enhance comprehension between medical providers, parents, and kids. The app also is easily toggled between English and Spanish.

Evidence based medicine

The Simply Sayin' app is based on the teach back method of patient education. This helps to ensure understanding and retention of medical information. Additionally, the app uses age appropriate language to avoid medical jargon and enhance comprehension.

Price

- o Free.

Likes

- o Comprehensive glossary of medical terms and procedures; quality illustrations/sound clips.
- o Detailed directions for providers and parents.
- o Available in English/Spanish with a touch of a button.

Dislikes

- o Font can be a bit small in some parts of the app.
- o No links to teach back resources.

Overall

Another highly useful app from Phoenix Children's Hospital, the same folks who produce the excellent Car Seat Helper app. Simply Sayin' uses the teach back method for both providers and parents to explain medical terms and procedures to children. The app's ease of use, comprehensive glossary, and illustrations make it a winner.

Available for iPhone, iPad, and Android.

- o https://apps.apple.com/us/app/simply-sayin-medical-jargon-for-families/id645810680
- o https://play.google.com/store/apps/details?id=com.mediakube.pch.simplysayin

2. AAFP Neighborhood Navigator Website

In a busy primary care practice, providers frequently encounter patients with issues involving social determinants of health. Too often we are pressed for time and may not be able or feel comfortable enough to dive into these issues with our patients. Whether this is simply due to a lack of time and/or a lack of knowledge of how to screen for social determinants of health, we frequently miss opportunities with these patients. Resources are available and it is our duty in primary care to attempt to help match patients with these resources. Therefore, providers need a systematic method to screen patients for social determinants of health at each and every visit. In 2016, the American Academy of Family Physicians (AAFP) created the EveryONE Project to address these concerns. The EveryONE Project created training resources for providers and their healthcare teams to learn to screen and evaluate patients for social determinants of health. The group collected validated screening forms in multiple languages. In addition, with just a zip code, the EveryONE Project helps providers find resources to address virtually any social determinant of health.

Evidence based medicine

The EveryONE Project has developed the Neighborhood Navigator website (and other materials/sites) to address the problem of social determinants of health. The website is a project of the AAFP's Center for Health Diversity and Equity. Their website cites a number of references and studies regarding the issues surrounding social determinants of health. How exactly the working group and website is able to gather so much outstanding information on resources with just a zip code isn't fully explained, but clearly it is a very impressive search engine. The website also advocates for screening and includes validated screening tools in multiple languages for use at the point of care.

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Price
- o Free* (to AAFP members only).

Likes
- o Comprehensive resources for nearly any social determinant of health.
- o Easy to use with just a zip code.
- o Quality training videos, training presentations, screening forms, etc.

Dislikes
- o No app available, but website is mobile friendly.
- o Reportedly limited to AAFP members only.
- o Needs its own dedicated website.

Overall

The Neighborhood Navigator website from the EveryONE Project and the AAFP is one of the most helpful websites I have encountered in my career. Dedicated to improving the evaluation and management of social determinants of health, the website almost magically presents an almost overwhelming number of resources to help your patients with just a zip code. The website is mobile friendly as no app is available. Every AAFP member should use this website and train their healthcare team on screening for social determinants of health (website includes screening forms in multiple languages, training videos, etc.) and use the Neighborhood Navigator to connect patients with resources.

Available on any web browser, no app versions available at this time.
- o https://www.aafp.org/patient-care/social-determinants-of-health/everyone-project/neighborhood-navigator.html

3. DHA Positive Activity Jackpot App

Since 9/11, the country has been at war. This longest conflict in US history has resulted in an enormous number of active duty soldiers and veterans with mental health concerns. Part of the response to these issues was the creation of numerous apps by the Department of Defense National Center for Telehealth and Technology (aka "T2"), now rebranded as the Defense Health Agency's Web & Mobile Technology Programs Group at Joint Base Lewis-McChord. Their apps are targeted to both patients and providers and cover topics ranging from depression, insomnia, post-traumatic stress disorder, traumatic brain injury, and resiliency.

The Positive Activity Jackpot app provides a type of behavioral therapy for depression called pleasant event scheduling (PES). The app is NOT meant to be a substitute for the "gold standard" depression treatments of cognitive behavioral therapy (CBT) and/or medications. Instead, the app is intended to be prescribed along with those proven treatments to help patients build resilience and resist the negative thoughts that can cause anhedonia and other depression symptoms. The app provides a "jackpot" of activities via an augmented reality game that resembles a slot machine and utilizes the user's GPS/location services for suggestions.

Evidence based medicine

The DHA Positive Activity Jackpot app contains highly useful activities for patients to "practice" while receiving proper mental health treatments for depression and similar mental health conditions. The app is evidence-based utilizing a therapy technique called pleasant event scheduling (PES). The app includes references and utilizes a slot machine game format for patients.

Price
- o Free

Likes
- o Fills a gap for an app for depressed patients via an augmented reality game.
- o Great number of activities to choose from and the ability to create/customize own activities.
- o Available for Android.

Dislikes
- o User interface still seems a bit basic yet cluttered.
- o GPS integration/locality suggestions inconsistent/not deeply integrated.
- o Occasional "bugs" when using leading to unintended "pulls" on the slot machine.

Overall

The updated Positive Activity Jackpot app from the Defense Health Agency (DHA) provides a fantastic opportunity for primary care and behavioral health providers to prescribe a highly useful, fun, and easy to use app for their patients. The app can provide hours of fun for patients to build resilience and keep their mind off negative depressive symptoms via PES. The app could be improved by deeper integration of the app with the user's mobile device. A must have app for any provider who treats depression or similar mental health issues.

Available for Download for iPhone, iPad, and Android.
- o https://apps.apple.com/us/app/positive-activity-jackpot/id1464064861
- o https://play.google.com/store/apps/details?id=t2.paj&hl=en_US

4. Women's Preventive Services Initiative Website

The beauty and challenge of a specialty such as Family Medicine is trying to keep straight what care must be provided to patients of various ages. My previous go-to apps for this include the excellent AHRQ ePSS, Bright Futures, Pregnancy A to Z, and Dr Joshua Steinberg's Health Maintenance Visit apps.

But are the above "enough" for women's health? The American College of Obstetricians and Gynecologists (ACOG) teamed up with the US Department of Health and Human Services (HHS) and the Health Resources and Services Administration (HRSA) to create the new Women's Preventive Services Initiative (WPSI). This group brought together the women-specific health maintenance recommendations from numerous key groups into one (relatively) easy to

navigate website/web app. The website includes a searchable well-woman chart and provides recommendations by category such as age, pregnancy, HIV, cancer, etc. To aid in implementation, the website includes an entire social media toolkit, handouts, and downloadable charts. The website is mobile friendly, but there is no dedicated app, unfortunately. Using the WPSI web app, we can quickly determine which preventive services a particular woman needs based on the best available evidence.

Evidence based medicine

The ACOG WPSI website and web app is a joint venture between ACOG and HRSA. The app incorporates evidence-based health recommendations from ACOG, USPSTF, ACIP, IOM, and Bright Futures, among others. The app is relatively easy to access and use. Some recommendations are more evidence based than others depending on the source. Not all recommendations include a level of evidence rating or a clear reference. Some recommendations such as screening for breast cancer appear to give both the recommendation from ACOG and USPSTF without clearly delineating between the two. Some of the footnotes within the app help to clarify some of these differences, but the data is not as easy to find as it could be.

Price

- o Free.

Likes

- o Comprehensive lists of women's preventive health recommendations.
- o Ability to view by subject, age, condition (i.e.: pregnancy, HIV, etc.).
- o Quality social media toolkit, handouts for providers and patients.

Dislikes

- o No app available, but website is mobile friendly.
- o Some recommendations more evidence based than others. Not every recommendation comes with a level of evidence rating or clear reference.
- o Scrolling in the app can be cumbersome for some sections with multiple clicks/links.

Overall

The Women's Preventive Services Initiative (WPSI) web app from ACOG and HRSA brings an AHRQ/ePSS like interface to women's health maintenance issues. The app takes the most current recommendations from reputable organizations (some recommendations more evidence based than others) including ACOG, USPSTF, and Bright Futures and combines them into one web app. The information can be accessed multiple ways including downloading PDF's or using the online interactive health maintenance chart.

Available on any web browser, no app versions available at this time.

- o https://www.womenspreventivehealth.org

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Report from 2019 National Conference of Constituency Leaders

I am pleased to submit this report on behalf of the USAFP Delegation to the 2019 American Academy of Family Physicians National Conference of Constituency Leaders (NCCL)! NCCL convenes each spring in Kansas City alongside its Annual Chapter Leadership Forum (ACLF).

The ACLF provides sessions and networking opportunities for chapter executive leadership and staff to collaborate each year. The NCCL provides a voice and leadership opportunities to traditionally underrepresented constituencies: women; minorities; new physicians (within the first seven years of practice); international medical graduates (IMG); and lesbian, gay, bisexual, and transgender (LGBT) family physicians. At the meeting, we debate a variety of topics brought forward by attendees, network with other AAFP members, and pass resolutions that are then forwarded to the various AAFP Commissions, the Congress of Delegates, or the Board of Directors to help shape the future of our academy.

As usual, the USAFP assembled a complete delegation representing all constituencies! This delegation included Preciosa Pacia-Rantayo, MD (IMG), Courtney Halista, MD (New Physician), Megan Mahowald, MD (Women), Marilou Gonzalez, MD (Minority), and Patrick Simpson, MD (LGBT). The USAFP was represented at ACLF by President Christopher Jonas, DO, President-Elect Debra Manning, MD, and Army Director Joshua Will, DO. Also in attendance for NCCL and ACLF was USAFP Past-President James Ellzy, MD, currently serving on the AAFP Board of Directors and me, serving as AAFP New Physician Delegate and Co-Convener for NCCL.

The USAFP was acknowledged during a chapter luncheon brief by the Chair of the AAFP Commission on Membership and Member Services as 1 of 25 chapters with a full delegation, #1 amongst large chapters for this past year's increase in student membership, and #2 amongst large chapters for its retention of new physician members!

The NCCL business sessions made up a majority of the conference and included leadership training, resolution writing, national elections, and a large dose of parliamentary procedure where resolutions were debated, possibly amended, and eventually brought to a vote.

Resolutions were grouped into separate reference committees that were organized based on the structure of the AAFP commissions. Among the numerous resolutions brought forth by attendees, ten were co-authored by the USAFP delegation, five of which were adopted or reaffirmed as AAFP Policy. One resolution brought forward by your USAFP delegates, inspired by the Lifestyle Medicine Interest Group (make sure to sign up for MIGs!), was one that I co-authored. It requested the AAFP to develop a policy statement that mirrors the American Academy of Pediatrics 2019 policy statement on "public policies to reduce sugary drink consumption in children and adolescents." This was adopted for action by the Academy. The resolution also asked the AAFP to join the American Academy of Pediatrics and the American Heart Association in support of the policy statement. This resolution was adopted by the NCCL Congress to be implemented by the AAFP.

The Reference Committee on Education considered a resolution co-authored by Dr. Mahowald that asked the AAFP to collaborate with the American Board of Internal Medicine (ABIM) to allow family physicians to sit for the ABIM critical care board exam. This would, in turn, make family physicians eligible to attend critical care fellowships. This resolution was reaffirmed as current policy as this action is currently with the ABIM for consideration with support from the American Board of Family Medicine. Another adopted resolution that I co-authored asked the AAFP to support legislation that incentivizes and/or provides funding for the inclusion of lifestyle medicine education in medical school education, graduate medical education, and continuing medical education.

The Reference Committee on Practice Enhancement considered a resolution co-authored by Dr. Gonzalez that asked the AAFP to collect and distribute best practices in state legislation to assist with financial incentives in the expansion of clinical preceptor opportunities. The reference committee recommended this resolution be adopted. This committee also offered a substitute resolution from a resolution that I co-authored that requested the AAFP to support legislation and regulatory policies that incentivize active patient participation in evidence-based lifestyle changes as well as reimbursement for family physicians providing lifestyle medicine initiatives. This substitute resolution was adopted.

The Reference Committee on Organization and Finance was tasked with resolutions dealing with academy-specific operations. A substitute resolution from a resolution co-authored by Dr. Simpson that was adopted requests the AAFP to use its existing rapid media response system to heighten AAFP presence in the media in response to legislation and social injustices that are in conflict with existing AAFP policies.

In addition to resolutions, we had the opportunity to elect new AAFP leaders for each constituency. As usual, the USAFP continues to grow its leadership involvement with the AAFP at every opportunity! This past NCCL, Dr. Mahowald had the honor of being nominated and elected by our fellow state chapter women constituency delegates to serve on the Member Constituencies delegation to the AAFP Congress of Delegates at the 2019 Congress in Philadelphia. Dr. Mahowald served as an alternate delegate, representing the voice of our special constituency physician members worldwide. The following year, she will serve as a Member Constituencies Delegate for the 2020 Congress of Delegates in Chicago. In addition to these responsibilities, she will lead the Women's delegation as co-convener for the upcoming 2020 AAFP NCCL meeting. In this position, she will assist the meeting's convener with planning and programming next year's leadership conference and will lead the Women Constituency caucuses, business sessions, and elections.

Lastly, this NCCL was bittersweet for me as I completed my term as the New Physician Delegation Co-Convener. I was involved in the business session, helped plan and execute the leadership meeting, and helped with related events—to include a community service project with the Boys and Girls Clubs of Greater Kansas City. In addition to planning, I had the opportunity to serve as Chair for the Reference Committee on Education, where we heard testimony on resolutions assigned to our committee and made recommendations to adopt, or not adopt, proposals for new AAFP policy. After the conclusion of the leadership meeting, I also finished my term as the AAFP New Physician Delegate to the 2019 Congress of Delegates in Philadelphia. The ability to serve in a national role with the AAFP is incredibly rewarding.

Overall, the AAFP NCCL is a high impact, high speed meeting that is full of networking and mentorship opportunities. I definitely encourage anybody interested in representing one or more of these constituencies at NCCL to let the USAFP leadership know that you would like to be considered as a delegate for one of the upcoming conferences! It is truly a great experience!

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Military Medicine Transformation: Ensuring Medical Readiness in the Clinical Setting

INTRODUCTION

Our Military Health System (MHS) is in the midst of profound changes. These changes, based on Congressional mandates, are occurring in part to maximize military medical resources and ensure the United States has the most lethal, medically ready, operational force in the world. As military family physicians, we are extremely well positioned to serve at the "tip of the spear" in this transformation and to ensure that our MHS fully supports this objective. From a practice management perspective, I believe family medicine physicians must master three basic functions in order to leverage the changes associated with military medical transformation. First, family physicians must understand medical transformation at the strategic level so that that they can more fully understand the effect on clinical operations. Second, they must maintain a comprehensive understanding of the metrics of medical readiness and the factors that most influence readiness. Third, they must continually develop and strengthen ties between the medical and operational communities.

STRATEGIC UNDERSTANDING OF MEDICAL TRANSFORMATION

Family physicians must understand the strategic changes taking place to fully understand the impact of these changes on clinical operations. The transfer of military treatment facilities (MTF) to the Defense Health Agency (DHA) has been associated with numerous challenges, one of which is trying to ensure seamless oversight and resourcing of garrison medical resources such as public health, warrior care, and medical simulation. From an Army perspective, the ongoing Army Medical Command (MEDCOM) transformation, which involves changes to the structure of the Army's Office of the Surgeon General (OTSG), while developing a Medical Readiness Command (Provision) and Medical Readiness Directorates, challenges how we assign medical personnel between brick and mortar MTFs and operational units. As family physicians, and as leaders in military medicine, we need to understand these changes so that we can ensure the continued resourcing of vital medial capabilities and mitigate the effects of distributing medical personnel away from our brick and mortar facilities to the operational forces.

COMPREHENSIVE KNOWLEDGE OF MEDICAL READINESS STANDARDS

Family medicine physicians must also have a comprehensive understanding, and must perform regular comprehensive analyses of, the metrics of medical readiness in order to influence positive change. Whether it is tracking required immunizations, labs, audiology and vision screens, or the tracking of more complex metrics such as the status of temporary and permanent profiles, family physicians must maintain constant visibility in order to maximize readiness. For example, a significant increase in troop lab and immunization deficiencies might lead a physician to the discovery that the supporting MTF is not open at times during which local operational units have time to address their needs. This analysis could then lead to an agreement by the MTF Commander to change or increase available clinical hours. As another example, a large, rapid increase in temporary musculoskeletal injuries might lead to the discovery that a unit has recently implemented an overly aggressive physical training regimen. This knowledge could be used to influence leaders to modify their physical training to ensure fitness while minimizing injury.

Probably the most challenging metric to influence are long-term temporary profiles that extend beyond 60 to 90 days. While significantly decreasing the number of these profiles is extremely challenging, it is vital that the family medicine physician develop and implement tools which allow for routine, comprehensive analysis of these profiles. As a medical leader, you will want to have a knowledge of treatment plans, determine whether the appropriate specialty providers have been engaged in care, determine whether a Service Member is missing scheduled rehabilitation and or specialty care appointments, and determine

whether the service member meets criteria for a medical evaluation board. The routine, comprehensive review of these temporary profiles can lead to a substantial decrease in the overall number of long-term profiles and can increase the rate of return of those service members to normal duty.

STRENGTHEN RELATIONSHIPS BETWEEN THE MEDICAL AND OPERATIONAL COMMUNITIES

Whether a family medicine physician is serving as the Officer-in-Charge of a Solder Centered Medical Home, or is the Brigade Surgeon for a maneuver brigade, the medical readiness of their service members is dependent upon close cooperation between the medial and operational communities. The cornerstone of this relationship is the establishment of formal agreements between the MTF and operational units, such as the development of Installation Health Service Plans or IHSPs. The purpose of these agreements is to provide formal guidance and designate responsibility for staffing support between operational unit providers and those providers assigned to an MTF. In addition, these agreements specify the medical resources (such as labs, immunizations, pharmacy, and specialty resources such as physical therapy and behavioral health) that an MTF must provide to their associated operational units. On a more informal level, it is also vital that family physicians participate and help lead more informal relationships between MTFs and operational units, such as a routine meeting between operational providers and MTF Commanders and staff, to ensure that there is a common understanding of the resources, challenges, and potential gaps in medical care. In addition, it should be the responsibility of MTF leadership to ensure maximum availability and utilization of MTF resources to optimize availability of Soldier centered clinic and ancillary services.

In conclusion, military family medicine physicians, with their clinical and leadership skills, are ideally suited to work and succeed within the realm of military medical transformation. Understanding the implications of strategic medical transformation, performing comprehensive tracking and analysis of medical readiness metrics, and ensuring robust relationships between the operational unit and MTF leadership will ensure that military family medicine physicians remain at the forefront of this revolution in military medicine.

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Performance Management

Healthcare in the Military Health System is an extremely busy endeavor. As family physicians, we're not only expected to maintain clinical proficiency, but also to be teachers to residents and medical students, advisors to commanders, and leaders of our clinics and medical departments. We all have patients to see, notes to write, meetings to attend, and lectures to prepare. Additionally, most of us who have completed graduate medical education have military and/or civilian staff members whom we rate, senior rate, or for whom we serve as higher level reviewers. Since we can't be late to see our patients or miss meetings, since lectures have deadlines, and since we're all role model clinicians who complete all of our notes in 72 hours, where does that leave performance management? If we're not careful, performance management can be relegated to end-of-cycle counseling sessions, or "sorry-I've-been-busy-please-review-what-I've-written-about-you-and-let-me-know-what-you-think" sessions—sometimes even conducted over e-mail. Have you ever been in this position, either as a subordinate or rater? Here I'll share some tips for successful performance management. Most of these are written using the Department of Defense Performance Management Appraisal System (DPMAP) as a paradigm and are therefore more applicable to civilian employees. That said, I hope you can extract some useful tips for evaluating your officers and non-commissioned officers as well.

ORGANIZE YOURSELF—DEVELOP PERFORMANCE MANAGEMENT FOLDERS

Successful performance management for your employees starts with getting organized. To do this, know who you rate or senior rate, both military and civilian. Ensure you develop a performance management folder for each staff member where you'll keep pertinent information. Your organization may have a standard operating procedure (SOP) that outlines what should be kept in an individual's folder. If not, consider keeping similar information in everyone's folder. Information such as record briefs, position descriptions, career maps, last two to three evaluations, written counseling statements, handwritten notes from individual performance management meetings, and support forms not only help you get to know your staff, but will be useful should you or your staff members transition. Your performance management folder on an employee can be transferred to a new supervisor to help with continuity during such a transition. You should follow your organization's performance management SOP or consult with your civilian personnel advisory center regarding the contents of a performance management folder that should transfer with a civilian employee to a new supervisor.

ORGANIZE YOURSELF—DEVELOP A RATING STRATEGY

For military members that you rate or senior rate, it is exceedingly important that you understand limitations on rating profiles—what percentage of individuals can you "top block"? You need to be aware of your historic ratings and your current rating pool so you know how many "top blocks" you can give for each grade during a rating period. I personally keep an excel spreadsheet for everyone that I have rated or senior rated, separated by rank, and how I rated them. This helps me keep track of my profile for a particular rank and allows a historical basis of comparison, when necessary, to help provide stronger enumeration for exceptional performers. Knowing your profile, plus knowing who you currently rate, allows you to determine how you can allocate ratings during your current rating period. I personally try to manage my profile for a rank so that I always have room to give a "top block" for an exceptional performer who winds up with an off-cycle rating for any reason.

Part of developing a rating strategy is knowing more than just how many civilians and how many servicemembers of different ranks you must rate. During the rating period you should ensure you take time to get to know those you rate. Get to know what their future plans are so you can tailor written comments on your evaluation, and recommendations for future assignments, to their desires. I have found the use of career maps (you can find them for civilians by job series; for Soldiers you can find them by military occupation specialty and area of concentration at Army Career Tracker) to be invaluable aids in guiding those conversations.

DEVELOP PERFORMANCE STANDARDS

In order to manage performance, employees must know what is expected of them. Employees should be held accountable to standards of conduct

and standards of performance. What differentiates between standards of conduct and standards of performance? Standards of conduct are those professional standards that you expect of all employees, regardless of specific position, such as timely attendance and dress code. For civilian employees, the key is to have these standards in writing with acknowledgment that employees are aware of the need to uphold these standards. Standards of performance are those standards, with elements of performance, with which you will rate a civilian employee during the rating period. I have found an effective way to differentiate between what is a standard of performance and what is a standard of conduct is this: things that are must-dos 100% of the time and non-negotiable, where you can't exceed a standard (i.e. show up to work on time, submit DMHRSi and ATAAPS on time, etc.), are standards of conduct.

Standards of performance are measurable standards that you expect a fully successful employee to achieve by the end of a rating period. One of the goals of effective performance management is to help distinguish employees who perform to standard from those who are not meeting the standard, while also identifying those who are exceeding the standard. Most civilian employees should meet the standard, while a small minority of truly exceptional employees will exceed the standard. **Performance management standards are written at the fully successful level.** DPMAP does not require you to further clarify standards other than define fully successful.[1] I have, however, found it effective to make it clear to civilian employees not only what defines fully successful, but also to define what exceeds the standard (DPMAP 5) and what does not meet the standard (DPMAP 1). Effective performance standards are written using the SMART criteria—specific, measurable, achievable, relevant, and time-bound. If you find the majority of your employees are scoring a 1 or a 5 for a particular standard, then you may want to re-look at whether you have made your standards too difficult or too easy to achieve. In order to manage through points of transition that may occur during a rating period, I recommend including the source of the metric that you are using in the evaluation, and who in the organization is the point of contact for obtaining the metric. Annotate as well if the source of the metric is employee self-report—make the employee tell you how they have met or exceeded the standard.

Developing the right performance standards that drive your employees to excellence is time-consuming, but when done effectively it is time well-spent. Not only should performance standards be written using the SMART criteria—the standards you choose need to be ones that drive improvement in your organization. For example, "by the end of your rating period, you will attend 95% of inpatient multidisciplinary rounds" may be a SMART performance objective. And at the end of the rating period your employee may have gone to 100% of multi-disciplinary meetings, likely exceeding the standard. But is attending a meeting really what you're looking to get out of that employee (might this be an example of a standard of conduct as opposed to a standard of performance)? "By the end of the rating period, you will have led 50% of multi-disciplinary meetings and developed a minimum of one performance improvement project based on concerns addressed during the meetings" might be a better way to ensure that attendance at that meeting drives organizational improvement. Effective performance standards are also nested with those of your leaders—the performance standards you write for your employees should drive improvement in your performance standards, which should be nested with those of your boss. When done effectively, you will find that, as a manager, meeting your performance standards comes from effectively managing the performance of your staff.

COUNSEL YOUR EMPLOYEES

Whether you rate military or civilian employees, or both, hopefully by now you know that effective performance management is more than just a beginning of the rating period and end of the rating period discussion. DPMAP requires three touchpoints during the rating period at a minimum—initial counseling, midpoint counseling, and close-out counseling. The Army officer evaluation system, as an example, requires initial counseling and then three subsequent counseling sessions during the rating period. When it comes to meeting with your employees to discuss their performance, quite frankly, more is better. Try to set a goal of meeting with your employees at least every 90 days. Remember earlier when I mentioned the standards that are too rigid, or too easy to achieve? If you find that a standard is no longer applicable, you are able to change it during the rating period. For civilians, DPMAP requires that employees are on approved standards for a minimum of 90 days before they can be rated against that standard.[1] If you wait, therefore, toward the end of a rating period to catch-up on counseling your employees, you may miss an opportunity to modify those standards. Plus, more frequent meetings with your employees means more opportunities to get to know their strengths and areas for improvement and therefore inform their professional development.

CONCLUSION

At the end of the day, if you are deliberate with your performance management system, you will find it much easier to rate your employees at the end of a rating period. By having regular touchpoints with your staff, and measuring

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their performance against clearly defined standards, you will find that an employee's evaluation will pretty much write itself. You will also find that, whether the evaluation is stellar or not that impressive, the results of the evaluation will not come as a surprise to the employee. Effective performance management may be time-consuming, but it is worthwhile when you see the outcomes of effective performance management on organizational performance and individual development.

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KEY TAKE-AWAYS

1. Be deliberate in
   a. Managing your rating profile
   b. Writing effective performance standards
   c. Taking the time to counsel your staff
2. Have an organized performance management documentation system—think transitions!!
3. Use the SMART criteria to write performance objectives
4. Assess whether you have your objectives too difficult, too easy, or just right
5. Nest your employees' objectives within your own objectives, and nest your objectives with those of your boss

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Committee Report
WELLNESS & RESILIENCY

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Conflicted... A Desire to Seek Care and a Duty to Report

While recently applying for a new state medical licensure, I was reminded of the "fitness" for practice questions that accompany most licensure applications. Some states use a very broad question to elicit if there are any medical and/or mental health conditions which could impair your ability to practice medicine. Other states have specific questions regarding mental health diagnoses and treatments. There have been a few legal challenges alleging these questions violate the Americans with Disabilities Act, but this has not compelled state medical boards to refrain from asking these questions. The American Medical Association (AMA) and the Federation of State Medical Boards of the United States (FSMB) have both issued guidelines opposing expansive mental health questions, yet the practice of individual boards remains unchanged.

Throughout their careers, doctors are taught that they are physically and emotionally unbreakable. They cannot be wrong, cannot make mistakes, and cannot get sick. A 2017 study found that one-third of doctors reported meeting criteria for a mental disorder but were reluctant to seek professional help because of fears of repercussion (Dyrbye, 2017). Although the last two decades have seen increasing use of the term "burnout," mental health experts are troubled by the thought that overusing the word may be covering up underlying mental health or substance abuse diagnoses (Bianchi, 2015; Wurm, 2016).

A 2018 systematic review stated that the suicide rate among physicians was 28-40 per 100,000, two to three times that of the general population. The evidence found that an overwhelming number of physicians who die by suicide have untreated or undertreated depression or other mental illnesses (Patel, 2018). The United States is not unique; studies from Finland, Norway, Australia, Singapore, China, and elsewhere have shown an increase in anxiety, depression, and suicidal thoughts among medical students and health care professionals.

Liselotte Dyrbye, co-director of the Mayo Clinic's Physician Well-Being Program in Rochester, Minnesota found 32 of 48 medical license boards' applications ask about mental health conditions. Her research group found that 40% of 5,800 physicians surveyed were reluctant to seek formal medical care to treat a mental health problem out of "concerns about repercussions to their medical licensure (Dyrbye, 2017)." State medical boards are charged with

protecting the public, however, their efforts may be further stigmatizing mental health disease and resulting in fewer physicians getting the help they need.

For their part, multiple state medical boards argue that physicians can seek mental health treatment without having to report it. Providers are expected to voluntarily self-report when they believe their condition affects their ability to competently practice. The medical board then reviews these reports on a case-by-case basis. This self-reporting option, medical boards claim, allows physicians a process by which they can get the help they need while supporting recovery. At least 39 states have "sick doctor statutes" that permit licensure suspension for physicians who cannot practice medicine safely because of illness or substance use disorders. These physicians are encouraged to seek treatment voluntarily and are provided a clear path to licensure re-instatement upon completion of their treatment. State medical societies have also established physicians' health committees and treatment programs to assist physicians in maintaining or reinstating licenses.

Physician impairment, defined by the AMA and reaffirmed by the American College of Physicians, is a public health issue which involves a physical, mental, or substance-related disorder that interferes with a physician's ability to undertake professional activities competently and safely (AMA, 1973; Candilis, 2019). Signs of physician impairment include deteriorating personal hygiene, increased absence from professional functions or duties, emotional lability, poor sleep, and increased professional errors. So, who should voluntarily report themselves to the state medical board? While this varies by state, the self-reporting option on the application seems to be viewed more positively by state medical boards when compared to physician impairment being reported by colleagues or patients. Seeking help early on before signs of impairment should be the goal. Ultimately, physicians are responsible for being familiar with their state reporting requirements and complying accordingly.

Medical professionals should be highly encouraged to identify and seek treatment early in the course of an impairing disease to prevent worsening of their condition. By avoiding the potential for impairment and workplace errors, physicians will be able to best serve their patient's healthcare needs. Physicians have many resources available to them through their state medical societies and the American Academy of Family Physicians to get the help they need. In addition, these entities can provide individual recommendations regarding the duty to report to the state medical board and how to proceed with initial state license applications or renewals.

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Who Am I?

If you read the title of this newsletter and thought, "I'm Jean Valjean!" you're my kind of people! But in all seriousness, I mention Victor Hugo's protagonist for two very specific, and soon to be apparent, reasons. First, I'd like to tell you about my intern year . . .

I started my family medicine residency in June 2015. I remember how excited I was to finally practice medicine and call myself "doctor". My brother had bought me an embroidered white coat for my birthday and, along with my monogrammed stethoscope, I was ready to go! I started the academic year on two weeks of outpatient family medicine. Pretty nice, right? Predictable schedule, no call, and tons of support from the clinic preceptors. I finished those two weeks thinking, "Residency is going to be easy." Then came the stretch from Hell. I subsequently did two weeks of night float, followed by a month of inpatient adult medicine, a month of adult emergency medicine, a month of combined cardiology/intensive care, a month of surgery, and, finally, a second month of inpatient adult medicine. By the time New Year's arrived, I had not celebrated a single holiday with my family, had missed two of my medical school friends' weddings, and had broken up with my long-term boyfriend because I simply didn't have the time or energy to devote to a relationship. I was exhausted, angry, and considering quitting medicine all together.

I remember driving home from the hospital after a particularly stressful day and asking myself, "Why am I so miserable?" Academically, I was doing well. I was meeting the expected milestones for a first-year resident and was beginning to feel more comfortable with my medical decision making. However, I was still unhappy. I remember calling my Dad, hoping that he would provide some perspective and pull me out of my funk. When he answered, he was breathless and said quickly, "Hey, I'm playing tennis right now. Can I call you back in a bit?" "Sure," I said despondently. "No problem." I kept driving and thought to myself, "When was the last time that I played tennis? I used to love to play tennis! And now that I think about it, when was the last time that I played the piano? I used to be good at that too. What else had I stopped doing since I started residency?"

That night, I made a list:

1.) Play more tennis.
2.) Play piano at least once weekly.
3.) Always be reading a book for pleasure.
4.) Volunteer.
5.) Tell the people who you love that you love them.

The list was taped to my fridge for the next year. It is the reason why I'm still a doctor.

Over the next twelve months, I slowly remembered who I used to be. I enrolled in weekly tennis lessons and, suddenly, signing out on time became paramount. By scheduling an activity after work, I learned how to prioritize and was motivated to work efficiently. I also became comfortable with the notion of leaving work behind for the following day. If it wasn't integral to patient care, it could wait. Additionally, "my tennis friends" became just "my friends" and I developed a wonderful group of non-medical people to keep me grounded. I don't think that my Dad realized it at the time, but by prioritizing tennis, he handed me two proverbial candlesticks.

The other expectation that I struggled with as a resident was the notion that doctors are invincible. I was in a car accident in the Spring of my second year. The accident happened late morning on a Sunday and I was expected to work the overnight shift that night. However, my car was totaled and was not drivable. I had never been in a car accident before and was emotionally distraught. I called the chief resident at the program where I was rotating and explained what had happened. I asked if I could have the night off so that I could arrange for my car to be towed, find a rental vehicle, and coordinate a ride home. Rather than express her concern and ask if I was physically okay, her immediate response was, "Is that really necessary?" At that moment, I realized that I had lost my humanity and was simply a body. A number. Thankfully, I had the wherewithal to insist that I needed coverage, but the remainder of my rotation was tainted.

Why is it unacceptable for a doctor to show weakness? Why are we made to feel less if we can't function on five hours of sleep? Why are we expected to work when we're febrile and nauseous? Essentially, why are we embarrassed to be human?

Having survived residency, I can reflect on my experience with the advantage of time. I can identify mistakes and acknowledge missed opportunities. Now, when rotating medical students and incoming residents ask me how to succeed in residency, I tell them the following:

1. Remember who you were before you started residency. Pick at least three hobbies or passions that are integral to your sense of self and don't give them up. If you must, put a sticky note on your fridge as a daily reminder.
2.) Prioritize. Work to live. Don't live to work.
3.) Make friends outside of work. It'll give you perspective.
4.) Learn how to say, "I need a break."

Thanks to my intern year list, I made time to re-read *Les Mis* and learned how to play the soundtrack on the piano. Four years later, I am still taking tennis lessons, I volunteer at a homeless shelter regularly, and I tell my parents every day that I love them. I'm still a doctor and I can confidently say that I love my job. So ask yourself, "Who am I?" and if you don't like the answer today, do something about it.

RISE ABOVE.

Come care with us.

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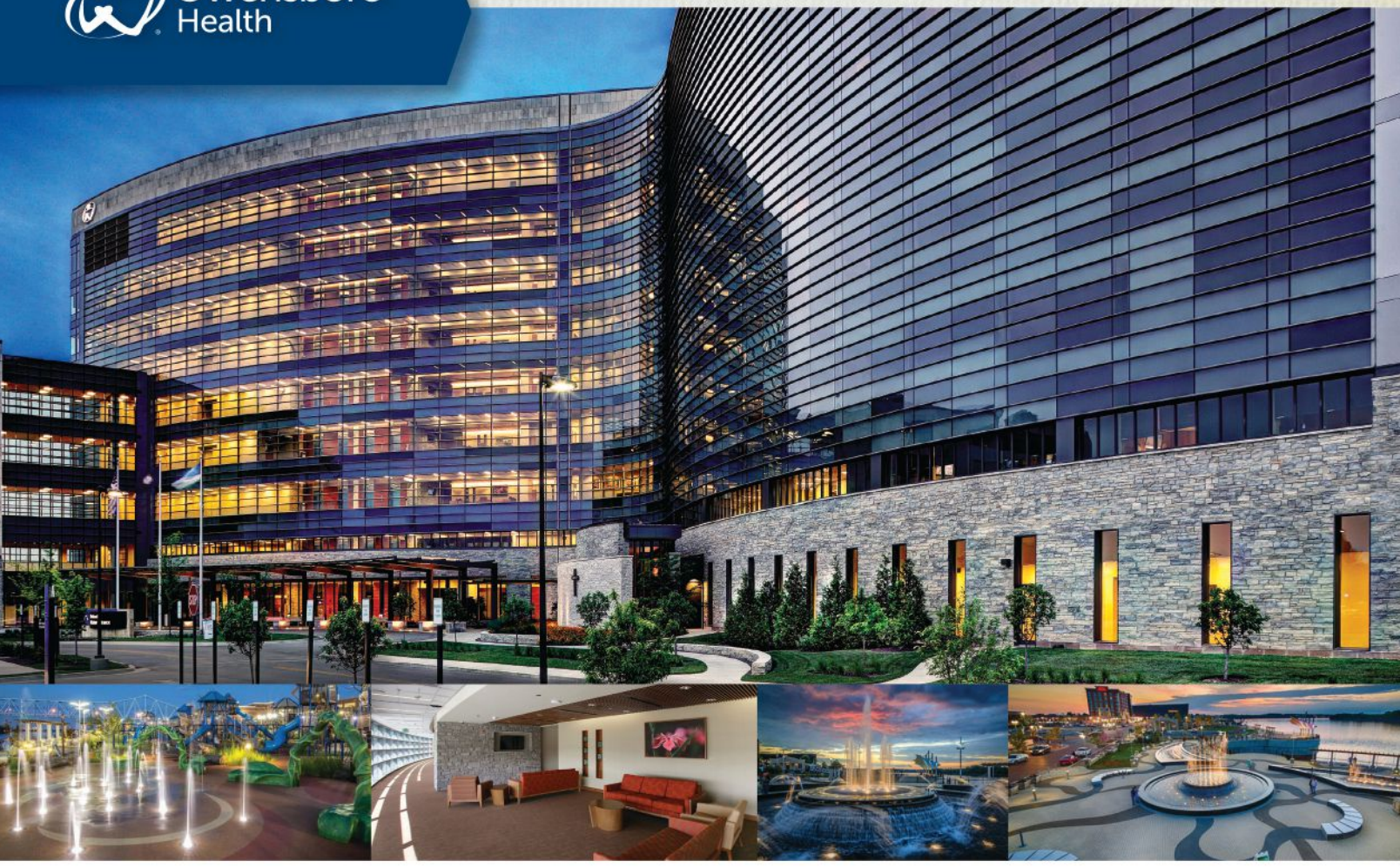

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Managing the Unexpected: Sustained Performance in a Complex World

BY KARL E. WEICK AND KATHLEEN M. SUTCLIFFE

"Change is the only constant in life." Heraclitus, a Greek philosopher, uttered this line almost 2500 years ago. Many of us have heard it and lived it. In the military, we are amid great change. Our future is uncertain and the path to get there is changing hourly. We also face uncertainty as physicians. Dr. William Osler once said, "Medicine is a science of uncertainty and an art of probability." In these times of change in both the military and medicine, we need physicians to lead us through the uncertainty. In the book Managing the Unexpected, Karl Weick and Kathleen Sutcliffe use the framework of high reliability to offer practical techniques and strategies on how to lead through unexpected events to achieve sustainable success.

Change can be planned or forced upon us by unexpected events. The former has well defined models on how to lead change. Two of the most recognized models are those of John Kotter (Professor of Leadership, Emeritus, Harvard Business School) and Jack Welsh (former Chairman and Chief Executive Officer, General Electric). However, what do you do when something unexpected happens? Kotter and the GE model provide a set number of prescriptive steps to plan the implementation of change. Weick and Sutcliffe surmise that when the unexpected occurs, it is already too late to plan for change. The underlying premise of their book is that we need to prepare our organizations in advance in order to be able to handle the unexpected. They have chosen the principles of high reliability, depicted in table 1, as the guiding principles for creating nimble organizations. They encourage leaders to mindfully coordinate around these five principles in what is termed high reliability organizing (HRO). HRO will prepare leaders to manage the unexpected.

The authors offer numerous examples of companies that failed to manage the unexpected. They also offer background information on the five principles of HRO. I will not delve into those here but instead will focus more on pieces of practical advice for allowing a leader to better manage the unexpected.

Before we start, there are two terms that are crucial to define. **Sensemaking** and **circumstances**. "Sensemaking is about sizing up a situation while you simultaneously act and partially determine the nature of what you discover... [it] is seldom an occasion for passive diagnosis. Instead, it is an attempt to grasp a developing situation in which the observer affects the trajectory of that development." They define circumstances simply as "flux."

HRO, in part, is based upon sensemaking, specifically, collective sensemaking. The authors focus on three things we need to do in order to be successful:

1. We must trust the reports of others and be willing to base our beliefs and actions on them.
2. We must report honestly so that others can use our observations to help them come to valid beliefs.
3. We must maintain self-respect, which means we have to respect our own perceptions and beliefs and seek to integrate them with the reports of others without belittling either them or ourselves.

These three principles are critical to collective sensemaking and thus our ability to adapt to the

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unexpected. From this comes adaptive managing, the fundamental task of attending to, sorting out, and prioritizing circumstances. In large part this is based upon our ability to communicate with our employees. Communication is something that we all learn about and hear about regularly, and yet, it is something upon which all of us can improve.

The book offers two protocols to assist in ensuring the best communication of unexpected events to maximize the organization's ability to manage through them. Psychologist Gary Klein proposed a protocol called **STICC: situation, task intent, concerns, and calibrate**. Each of these terms bears with it a question that we need to ask ourselves when we are relaying critical information to ensure the information is actionable. An example from the book on how this would sound follows:

1. The **Situation** = Here's what I think we face.
2. The **Task** = Here's what I think we should do.
3. The **Intent** = Here's why I think that is what we should do.
4. The **Concerns** = Here's what we should keep our eye on because if that changes, we're in a whole new ball game.
5. **Calibrate** = Now talk to me. (Tell me if you don't understand, can't do it, or see something I don't.)

Another way, offered by the authors, to approach this is to ask yourself the following:

1. To what is my attention directed (object)?
2. With what is my attention directed (resources)?
3. For what is my attention being directed (goal)?

These frameworks help convey the critical aspects of a situation, make it more meaningful, allow us to focus our efforts in real time, place our attention where it needs to be, and guide the organization during times of the unexpected.

Communication about an event when it occurs aside, the focus of the book is setting the conditions for a mindful organization that can best sustain operations through unexpected circumstances. The book offers examples of companies that have either succeeded or failed (or both) in managing the unexpected. However, the gist of the principles in this book are based on the Federal Aviation Administration, National Aeronautics and Space Administration, and Navy carrier operations. Thus, we need to ask ourselves, based on their experiences, how do we set the conditions for mindful organizing? The authors provide practical strategies organized around the five principles of high reliability. I doubt that these are new concepts to most of you, but they bear refreshing from time to time. To that end, I will elaborate on a few of the more salient strategies.

The overarching themes on mindful organizing lie in how we engage with, train, and empower our employees. I know for many of us, getting out and doing walk rounds can be tough as we are frequently glued to our e-mail inbox and computer screens full of spreadsheets. However, I have personally seen, in my career, how many of the strategies in this book can help strengthen an organization and help it sustain success through tough times. In order for that to occur though, we must engage not just with subordinate leaders, but also with front line employees on a regular basis. Ultimately it rests with us as leaders to set the conditions and establish the culture of mindful organizing. We need to stay connected to the front lines as much as possible and cannot establish a mindful organization from an office, conference room, or chair.

Regular engagement with our front-line employees helps us stay relevant and keeps us on top of the pulse of the organization. For physician leaders, I would also recommend staying relevant through clinical practice. The benefits to us of being in the clinic side-by-side with our front-line employees is invaluable. While engaging with staff at all levels, we need to seek out bad news. Employees are far more likely to voluntarily report good news and hold the bad news to themselves. It is incumbent upon us to ask questions in order to elicit the bad or potentially bad news so that we can manage it before it snowballs out of control. The goal is to be in front of the issue and prevent it from being an unexpected event. Remember as well to cultivate healthy skepticism and ask questions publicly when appropriate prior to making decisions. None of us want people that blindly follow because that is what they are told to do. It is crucial for our employees to know that we want them to speak up and bring us the good and the bad. The book encourages us as well to treat our past

continued on page 44

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experience with ambivalence. Experience is a good guide and can help with the initial response to the unexpected, however, almost every situation has uniqueness; as such we should not just rest on our laurels and treat things as we always have. Lastly, don't forget that there is expertise all around us. We need to defer to the experts whenever possible and encourage the imagination and decision-making skills of those around us to successfully manage the unexpected.

When looking to see if your team is mindfully organized and ready for the unexpected, you can self-assess using the mindfulness organizing scale shown in Table 2. This can help direct your efforts in toward creating a mindful organization. There are other practical tips and tools throughout the book on which I have not elaborated. They serve as reminders on how to practice HRO to set an organization up for success in managing the unexpected. It is impossible for us to remember and execute every one of these strategies, protocols, tips, or tools. However, I encourage everyone to refresh on these topics periodically as we continue our march through the current cycle of change through the unexpected.

Table 1 – Descriptions of HRO principles

Principle	Description
Preoccupation with failure	The need for continuous attention to anomalies that could be symptoms of larger problems. Concentration centers on anomalies, cues, normalizing, wariness, and doubt.
Reluctance to simplify	Simplification obscures unwanted, unanticipated, unexplainable details and in doing so, increases the likelihood of unreliable performance
Sensitivity to operations	Close attention to what is going on right now, in the present. Definitions of the situation matter, and it is one's sensitivity to these definitions that also matters.
Commitment to resilience	A combination of keeping errors small, of improvising workarounds that keep the system functioning, and of absorbing change while persisting. Resilience requires elasticity and recovery.
Deference to expertise	A pattern of respectful yielding, domain-specific knowledge, compressed and generalizable experience, and relative expertise.

Table 2 – The Mindfulness Organizing Scale

How well does each of the following statements describe your work unit, department, or organization? Enter next to each item below the number that corresponds with your conclusion:

1 = not at all, 2 = to some extent, 3 = a great deal.

We have a good "map" of each other's talents and skills.
We talk about mistakes and ways to learn from them.
We discuss our unique skills with each other, so we know who has relevant specialized skills and knowledge.
We discuss alternatives as to how to go about our normal work activities.
When discussing emerging problems with coworkers, we usually discuss what to look out for.
When attempting to resolve a problem, we take advantage of the unique skills of our colleagues.
We spend time identifying activities we do not want to go wrong.
When errors happen, we discuss how we could have prevented them.
When a crisis occurs, we rapidly pool our collective expertise to attempt to resolve it.

Scoring: Add the numbers. If you score higher than 22, your firm's mindful organizing practices are strong. If you score between 14 and 21, your firm's mindful organizing practices are moderate. Scores lower than 14 suggest that you should actively be thinking of ways to improve your firm's mindful organizing practices.

Why Is Our Internet So %&@#(-ing Slow?

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While the electronic health record (EHR) has become a ubiquitous part of medical care, consistent and fast electronic connectivity remains elusive. In the military, fast connectivity is complicated by operating across platforms and theaters: ships, planes, deserts, and in the future, space. As we said during residency, "we can put a missile through a window across the world, but we can't send an e-mail." With daily military operations looking far into the future, why does it feel like our internet is stuck in the past?

And, as you might expect, the answer is complicated. Otherwise, we would have fixed it already!

Most computers in the military are designed to have a decent 8 GB of RAM to help run necessary basic programs. Many of the machines I have worked with in my residency worked quite well as stand-alone laptops; it was connecting to the military system, staying on it, and working on it that brought my laptop to a crashing halt. Why the traffic jam?

When you sign on to the computer at your local military treatment facility (MTF), you are signing onto your service's intranet, whether it be Army, Navy, or Air Force. As one might expect from the name, this isn't a medical system – this is a line system we piggy-back on. It was originally started to help warfighters communicate at the speed of the future (back when the future was just *using* the internet), and, as such, security has been, and remains, paramount. The security software placed on our machines can amount to up to 70% of the latency on the system. Everything on your hard drive must be de-coded and re-coded in every interaction. Everything on the internet must be de-coded and re-coded. Virtualization, or the running of multiple computer systems on only one physical computer network, has been helpful in reducing some of this effect, but this continues to be a significant cause of slower browsing speeds.

But software is only part of the latency. The physical connections we use in the military are often less than ideal. The fiberoptic cables themselves are either old or are just too small in number to properly handle all the in and out-going traffic. As you can imagine, there's a tremendous amount of demand on base: everything from Facebook to AHLTA to live-streamed drone footage. And to complicate it, these cables are owned by the communications command, not by medical. So, when the bandwidth is prioritized, medical has to compete, and it will universally be secondary to operational missions.

So why can't we just upgrade everything all at once? While it is tempting to think of upgrading computer systems real-time, doing so is constrained by government spending. Budgets are often made two to five years in advance. By the time the newest tech is purchased, those systems may very well be out of date.

There is hope that the Defense Health Agency (DHA) may bring us access to centralized and optimized software and websites. But it will not change the increasing physical or security requirements that plague us. Indeed, as software progresses and we require more from our computers, like the ability to conduct telemedicine, our speeds may continue to slow if significant upgrades are not performed. As family physicians, arguably high-volume users of the system, we must advocate for ourselves by reporting outages, brownouts, and problems – even as reporting causes more administrative burden.

But therein lies opportunity. DHA has full control of health information technology departments, so DHA will have the ability and responsibility to collate all outages from all systems as they arise. If we run into situation in which our deployment system, our periodic health assessment systems, or our AHLTA system become unusable, we need to report that EACH AND EVERY time. If we do so, someone will have the opportunity to see the aggregate data to advocate to DHA for the places or systems hurting the most.

So, with these issues in place, how do we move forward?

1) Collaboration: Share macros, mentor your colleagues. Efficiency can help make up for slow systems. Teach, teach, and teach. Recover. And then teach.
2) Advocacy: Tell leadership what you need! Tell them (and show them) why! Pull and use data, and don't be afraid of giving something up (i.e. Facebook) for something that you want.

Of note, while we have many a Department of Defense instruction and Defense Health Agency policy governing us, there is no policy mandating the minimum connectivity required at each MTF, percentage of time that each system is required by contract to be active and usable, nor how often this system has to be re-evaluated for consideration of further upgrades. Creating these would be a great first step for advocacy.

For those of us interested, pursuing informatics is one way of joining the fight. Everyone is welcome to place helpdesk tickets, and current and previous chief medical information officers have taken the time to track these. But as is often the case in medicine, we need more of us skilled in informatics to raise our concerns together or we will find ourselves falling further and further behind.

2019 AAFP Congress of Delegates

SEPTEMBER 23-25, 2019

PHILADELPHIA, PA

USAFP Members serving as AAFP Delegates were President Christopher E. Jonas, DO, FAAFP and Past President Douglas A. Maurer, DO, MPH, FAAFP. USAFP Members serving as AAFP Alternate Delegate were President-Elect Debra A. Manning, MD, FAAFP and Vice-President Aaron Saguil, MD, MPH, FAAFP. Kevin M. Bernstein, MD, MMS, FAAFP served as AAFP New Physician Delegate and Megan B. Mahowald, MD as AAFP Member Constituency Alternate Delegate.

The Congress of Delegates (COD) is the American Academy of Family Physicians' (AAFP) policy-making body. Its membership consists of two delegates and two alternates from each constituent chapter and from the member constituencies including new physicians, residents, students, and other constituency groups represented at the AAFP Leadership Conference. The Congress of Delegates meets annually to address resolutions brought forward by constituents on topics that are of interest to physician members and the patients they serve.

The Congress elects new officers and members to serve on the Board of Directors during the meeting. The Officers and Board Members elected are noted below.

Ada Stewart, MD, South Carolina, President-Elect
Alan Schwartzstein, MD, Wisconsin, Speaker
Russell Kohl, MD, Kansas, Vice Speaker
Andrew Carroll, MD, Arizona, Director
Steven Furr, MD, Alabama, Director
Margot Savoy, MD, MPH, Deleware, Director
Brent Sugimoto, MD, MPH, California, New Physician Director
Kelly Thibert, D., MPH, Ohio, Resident Director
Ms. Margaret Miller, Tennessee, Student Director

AAFP members are welcome to participate in hearings of the five reference committees: Advocacy, Education, Health of the Public and Science, Organization and Finance, and Practice Enhancement. Reference committees are committees of the COD that consider business (resolutions) items referred to them for recommendation to the COD for debate and action.

During the meeting (held prior to AAFP FMX), the Congress of Delegates agenda includes addresses from AAFP officers, resolutions from chapters, and reports from the Board of Directors. The Delegates and Alternates representing the AAFP constituent chapters and the member constituencies reviewed over 80 resolutions in reference committees. The wide array of topics included administrative burden, primary care investment, health system reform, pharmacy formularies, insurance plan participation and hospital privileges, reproductive health related issues, insurance coverage for alternative treatments, all-payer claims databases, CME and family medicine certification just to name a few.

If you are interested in learning more about the AAFP Congress of Delegates check out the link at https://www.aafp.org/about/governance/congress-delegates.html.

Front Row: USAFP Executive Director Mary Lindsay White; AAFP Member Constituency Alternate Delegate Meghan B. Mahowald, MD; AAFP Alternate Delegate and USAFP President Elect Debra A. Manning, MD, FAAFP
Back Row: AAFP New Physician Delegate and USAFP Director Kevin M. Bernstein, MD, MMS, FAAFP; AAFP Delegate and USAFP Past President Douglas A. Maurer, DO, MPH, FAAFP; AAFP Delegate and USAFP President Christopher E. Jonas, DO, FAAFP; AAFP Alternate Delegate and USAFP Vice President Aaron Saguil, MD, MPH, FAAFP and AAFP Director and Past President James A. Ellzy, MD, FAAFP

USAFP Members Enjoy the All Member Reception During FMX

USAFP members attending the 2019 AAFP FMX were invited to attend a reception sponsored by the USAFP. The reception was held at the Field House in Philadelphia and provided fun, food and camaraderie for all!

American Board of Family Medicine

Self-Directed Clinical Performance Improvement Activity

The Self-Directed Clinical Performance Improvement (PI) Project pathway allows you to report customized improvement projects, regardless of the scope of care you deliver. This pathway can be used to satisfy the Performance Improvement requirement for continuing certification. Some key things to know about this pathway:

- You may report a project you conducted alone or participated in within a single practice group, an ACO, or other larger group practices
- You can use this pathway whether you see patients in a continuity setting, or if you are providing non-continuity episodic care (e.g., hospitalist, telemedicine, locums, urgent care, emergency department, etc.)

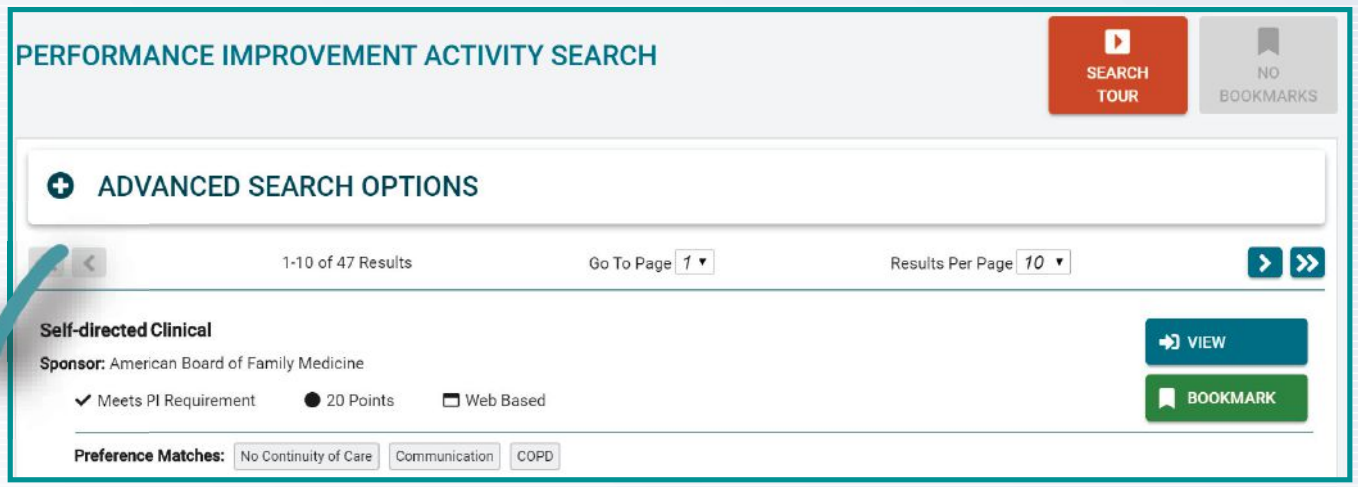
What information will you need to provide?

- **The start and end date of the improvement project.** Your credit is applied as of the end date of the project, once it is confirmed to have meet the ABFM PI Requirements.
- **If externally funded, how the project was funded.** The project must meet the ABFM Industry
- Support policy that prohibits pharmaceutical and device manufacturer influence on activities for certification credit.
- **The relevant topic areas for the project.** Select one or more topic areas to categorize the project.
- **What problem or gap in quality was the project intended to address?** An example of a gap might be influenza vaccination rates in your practice that were consistently lower than the national standard, resulting in an increased frequency of flu among your patients.
- **As a result of identifying the gap in quality, what did the project aim to accomplish?** An aim statement is a clear, quantifiable goal set within a specific time-frame. It states what you tried to change, by how much, and by when. An aim statement is broken into three parts:
  - ⇒ **What did you try to change?** (e.g., we aimed to improve our practice's influenza vaccination rate)
  - ⇒ **What was your improvement goal?** (e.g., improving our rate to 85% compliance)
  - ⇒ **What was the timeframe for this to be accomplished?** (e.g., within 9 months)
- **What measures were used in the project to evaluate progress?** Measures are directly related to the aim statement, showing whether a project's changes are resulting in improvement. An example measure might be:
  - ⇒ **Measure Name:** Influenza vaccination compliance
  - ⇒ **Goal:** 85%
  - ⇒ **Data Source:** Electronic Medical Record
  - ⇒ **Collection Frequency:** Monthly
  - ⇒ **Number of Patient Records:** 25 or more

- **The results of the improvement project.** Provide the baseline and follow-up percentage or number meeting the stated measure(s).
- **The interventions or changes that were made during the project.** An example intervention might be education for your clinical staff on the importance of this vaccine, added compliance check in the patient's Electronic Medical Record, and utilizing pamphlets on this vaccine in well-patient visits.
- **How were you involved in the project?** Were you the project leader? Did you review the data periodically to assess improvement? Were you part of the team that designed the project and reviewed the results? Were you an active participant in deciding on the intervention(s)? Demonstration of active involvement in the improvement process is necessary for approval of a self-directed activity.

Ready to get started?

Login to your ABFM Physician Portfolio at **www.theabfm.org**, select Access Performance Improvement Activities from the main screen, on the PI screen you can click on view all activities and choose the Self-Directed Performance Improvement Project: Clinical from the list.



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ABFM is here to help you with this important step to becoming a board-certified Family Physician. We have staff who serve in our Support Center that can answer questions you may have or direct you to the right person who can meet your needs.

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Special Article

Amidst the changes in military medicine, find your M's

From the time I did my first temporarily assigned duty as a health professions scholar, I was told about changes coming my way. The green-screen terminals of CHCS would launch into an era of CHCS-2, aka AHLTA. From there we heard talk of "purple" uniforms and "joint" everything. General medical officer rotations would sunset and nobody would promote without Joint Professional Military Education levels one and two. The verses have changed, but the refrain of "change is coming" has remained the same.

The past three years have witnessed a staggering and accelerating series of changes in how we practice and how we provide healthcare to beneficiaries and the line community. The acceleration of change and continual course corrections can leave us exhausted, nauseated, and uncertain of much at all.

At no point in my career have I felt that I had a certain plan which would withstand first contact with reality, but whether my time in uniform lasts three or thirteen more years, I have found solid ground in "my M's." When asked whether I will take on a particular role, rather than considering what the impact will be on my chances for promotion, I have found comfort in considering how it will affect my passions for medicine, the mission, the members, and the opportunity to give and receive mentorship within our community. If a job or collateral duty will markedly detract from my ability to contribute to one of my passions, without increasing my contributions to another "M," then I am comfortable with graciously declining the opportunity.

Certainly, there are benefits to time in service and rank, but don't wait to figure out where your passions lie. My list need not be yours, but consider it, consider the years before you, and the changes that await us all. If the world turns upside down, where and how will you find satisfaction as you wear the cloth of our nation? Consider this, if only to clarify what fires you up and ensures that your emotional and professional buckets are never dry.

CDR Cormac O'Connor

new members

THE USAFP WELCOMES THE FOLLOWING NEW MEMBERS...

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Vi Nghiem
Rachel Parker
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Meghan Plunkett
Matthew Ponder
Oana Povian
Steven Prueitt
Niels Ryden
Kyle Sexton
Carlie Skellington
Ryan Stevens
Lauren Williams

USAFP Academy Awards – Nominate Your Peers!!

MICHAEL J. SCOTTI, MD, FAMILY PHYSICIAN OF THE YEAR AWARD

This honor is bestowed on a Uniformed Family Physician who exemplifies the tradition of the family doctor and the contributions made by family physicians to the continuing health of the people in the Uniformed Services.

To nominate your peers for this outstanding award, please send a letter of support to Matt Schulte (mschulte@vafp.org) no later than 12 January 2020.

Eligibility Criteria:

1. Provides his/her community with compassionate, comprehensive, and caring medical service on a continuing basis.

2. Directly and effectively involved in community affairs and activities that enhance the quality of life of his/her home area.

3. Provides a credible role model as a healer and human being to his/her community and as a professional in the science and art of medicine to colleagues, other health professionals, and especially, to young physicians in training and to medical students.

4. Must be in good standing in his/her medical community.

5. Must be a member of the USAFP.

OPERATIONAL MEDICINE AWARD

This honor is to recognize a Uniformed Service Family Physician that has exhibited outstanding achievement in the provision, promotion or research in operational medical care.

To nominate your peers for this outstanding award, please send a letter of support to Matt Schulte (mschulte@vafp.org) no later than 12 January 2020.

Eligibility Criteria:

1. Demonstrated substantial contributions, dedication, initiative, leadership and/or resourcefulness in providing patient care in any operational environment.

2. Outstanding service, devotion, dedication or compassion while performing his or her duties in any operational environment.

3. Concepts, procedures or methods developed by the nominee which resulted in significant reduction in morbidity or mortality, workload required for mission accomplishment, financial expenditures or material utilization.

4. Involvement in continuing education as a researcher, participant, organizer or sponsor which directly and materially improves operational medicine.

5. Humanitarian or military community involvement that substantially improves the health and readiness of the service member, their families or the supported population.

6. Any other substantial contribution directly related to operational medicine not described above.

7. Must be in good standing in his/her medical community.

8. Must be a member of the USAFP.

MEMBERS IN THE NEWS

CONGRATULATIONS TO USAFP RESIDENT MEMBERS JULIE CREECH, DO AND STUART BATTEN, MD FOR BEING CHOSEN TO RECEIVE THE 2019 AAFP AWARD FOR EXCELLENCE IN GRADUATE MEDICAL EDUCATION.

Of the 3,500 eligible family medicine residents, only 12 are selected for the AAFP Award for Excellence in Graduate Medical Education.

This esteemed distinction has recognized outstanding family medicine residents for leadership, civic involvement, exemplary patient care, and aptitude for and interest in family medicine since 1952.

Drs. Creech and Batten were recognized during a breakfast held during the AAFP Family Medicine Experience (FMX) in Philadelphia, Pennsylvania in September.

Congratulations!!

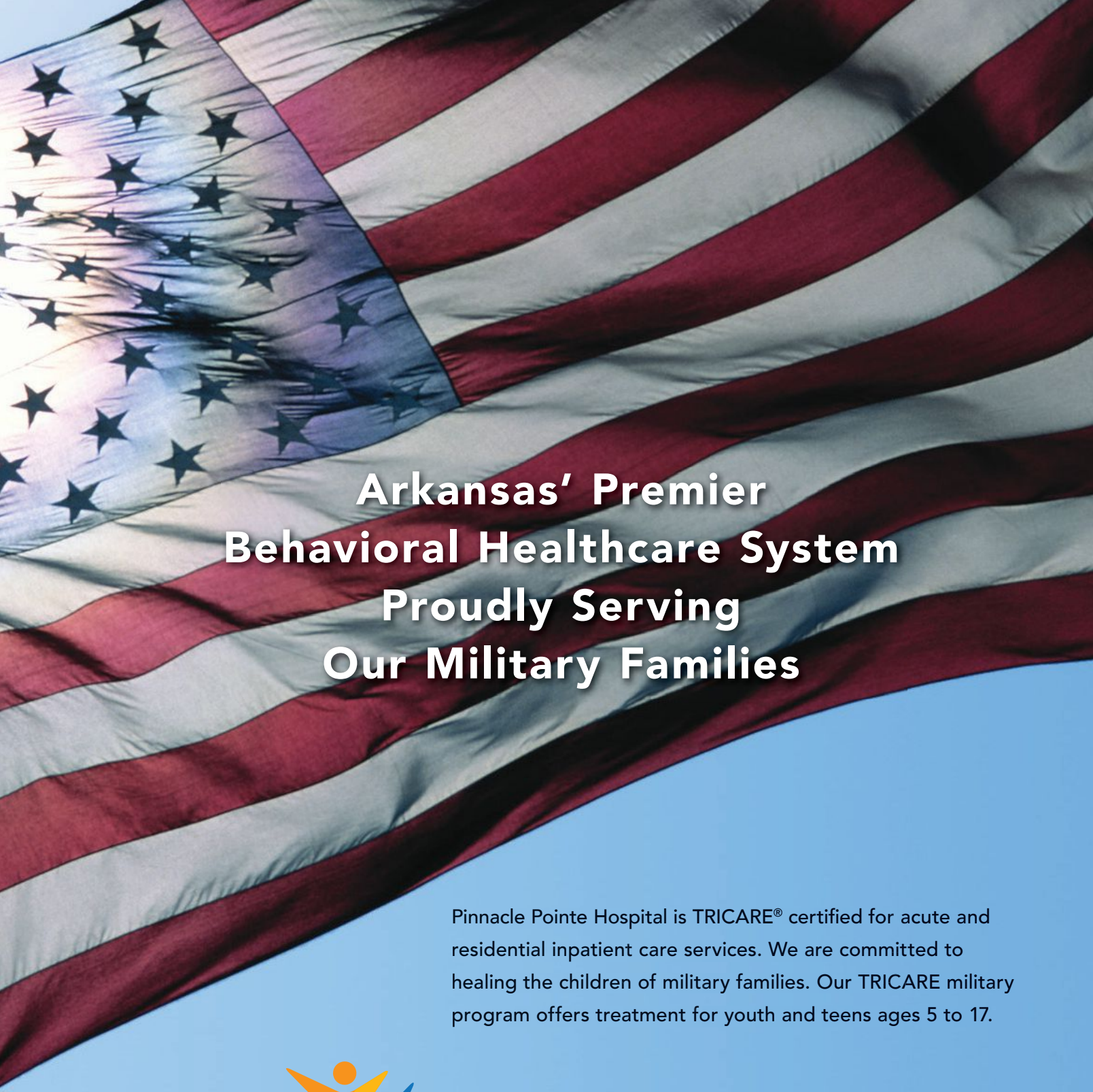
Promoting Research in the Military Environment

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.



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