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THE UNIFORMED FAMILY PHYSICIAN

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VISION

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

MISSION

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

This newsletter is published by the Uniformed Services Academy of Family Physicians. The opinions expressed are those of the individual contributors and do not reflect the views of the Department of Defense or Public Health Service.

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Edition 33

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president's message

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#USAFP2016 Health, Readiness, Family Medicine and You

Get ready for #USAFP2016 in Denver, Colorado March 18-22! Drs. Kwon and Larson have developed an amazing CME conference for you. Go to www.usafp.org/annual-meeting and register! Wait, are you waiting for conference approval and local funding before committing to attending? Here's why you shouldn't wait. Register Now!

First, all of the consultants from the services are actively working on conference approval. And while the process is long, I am hopeful that there will be no concerns and #USAFP2016 will be approved. However, in this era of fiscal uncertainty, budget battles and threats of sequestration, we MUST look for continued sustainability of our Annual Meeting without the reliance on TDY funding.

Second, the value of our world-class conference cannot be compared and, I argue, is second to none. Just check other similar conferences to compare the value that #USAFP2016 offers. There is no other meeting like this in the world with Family Physicians from all services and across the world represented. It isn't just high-quality CME, but leader and talent management, mentorship and camaraderie that cannot be experienced anywhere else. If you haven't been to one, I urge you to consider attending—you'll never forget the experience. Our theme, "Health is Primary" is our Academy's major campaign for Family Medicine. I remain passionate for the need to promote health and change the conversation from a disease-focused model of care to one that strategically places health in the forefront; not only for our patients, but also for our specialty and for us. #USAFP2016 will key into the concepts of health and wellness. This is not just an issue for long-term health. This is a military readiness issue. Musculoskeletal injuries are the #1 cause of non-deployablity for the military. And guess what…obesity and elevated waist circumference are key risk factors for musculoskeletal injury. By focusing on health, we will absolutely increase the readiness of the force. We will also focus on currency of our Family Medicine skills, with a great program of board review topics, workshops and SAMs. A new feature is a fabulous workshop on point of care ultrasound. This is a technology that Family Medicine can capitalize on to improve the patient care experience. So, learn about military readiness, maintain your clinical currency and expand your skillset!

Our theme, "Health is Primary" is our Academy's major campaign for Family Medicine. I remain passionate for the need to promote health and change the conversation from a disease-focused model of care to one that strategically places health in the forefront; not only for our patients, but also for our specialty and for us. #USAFP2016 will key into the concepts of health and wellness. This is not just an issue for long-term health. This is a military readiness issue.

Finally, Denver, Colorado is a great city to visit and explore. Colorado is one of the healthiest states in our union. With their culture of health and outdoor activity, come see what the state has to offer. Enjoy the mountains, renew old relationships and start new friendships and let's make health primary! Register NOW and start planning your trip to Denver!

editor's voice

JAMES ELLZY, MD

Hopefully you are getting psyched about the upcoming winter holidays (time with your biological family or family of choice) and USAFP Annual Meeting (other family of choice *smile*). I am happy to share many good articles with you again in this issue, while making plans to see you all in Denver!

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consultant report

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Optimism for Conference Approval Process Changes!

Great step forward in the conference approval philosophy and process! Make note, there are no immediate policy adjustments yet, but it looks like our voices have been heard and change is on the horizon!

From the first two paragraphs of the Deputy Secretary of Defense's Memo:

> DoD participation in conferences and similar events is critical to our ability to share information and break down barriers that block innovation. Given continued constraints on our resources, the Department must remain a responsible steward of the taxpayers' dollar with regard to conference expenditures. In recent years however, excessive restrictions on conference participation and attendance by DoD personnel have become counterproductive, undermining the professional development for communities such as our science and technology, MEDICAL, and education personnel, and making it more difficult for them to come together with others to promote the free exchange of ideas that drive creativity and innovation.
>
> For these reasons the attached DoD Conference Policy update guideline for conference approval so as to make conference participation and attendance by DoD employees easier, not harder.

Certainly, more to come once SECNAV gives us guidance on how we should proceed. Until then, continue to heed the guidance from the BUMED Conference Approval site: *http://www.med.navy.mil/Pages/Conference-Info-2.aspx*

NAVY FAMILY PHYSICIANS LEAD AND SUCCEED—WE ALWAYS HAVE!

Did you know that currently we have *two* Family Physician Admirals with the Deputy Chief of Staff for Medical Operations (M3), Rear Admiral Ken Iverson and the Medical Officer of the Marine Corps, Rear Admiral David Lane? Additionally, at one point this summer we had *five* Family Physician Commanding Officers across our enterprise! CAPTs Maureen Padden and Chris Quarles turned over their positions at Pensacola and Bremerton, respectively, while CAPTs Fred McDonald and Barth Merrill continue on at Oak Harbor and Naples while CAPT Melanie Merrick is the CO of the USNS Mercy. The Deputy Chief of the Medical Corps? …Our own CAPT Mae Pouget.

And our leadership footprint doesn't end there. This year we have had XOs

(CAPTs Kris Belland, Steve Blivin, Jim Young) and OICs (CAPTs Terri Allen and Jack Wyland). With the Marines we have MEF Surgeons (CAPTs Tara Zieber and George Semple), MLG Surgeons (CAPT Hyunmin Cho and CDR Adolfo Granados), Division Surgeons (CAPT Brian Smoley and CDR Erica Wiedl), Airwing Surgeons (CDRs Dave Webster and Charlie Wilson) and Marine Forces Pacific Surgeon, CAPT Dave Krulak. Other specific Force Surgeons include CAPTs Scott Cota, Pete Johnson, Chris Lucas, Bryan Schumacher, and Brett Sortor.

We've had an unprecedented 8 SMOs on carriers including CAPTs Tim Halenkamp and Kim Toone (who also serves as the Specialty Leader for Aerospace Medicine), and CDRs Todd Gardner, Carlos Gomez-Sanchez, Rod Hagerman, John Moore, Chris Orsello, and Dave Picken. Four Commander Amphibious Task Force (CATF) Surgeons (CAPTs John Crabill and Robert Jackson, and CDRs Mark Nguyen and Alan Vanderweele) are also FPs.

We have the Director of the National Intrepid Center of Excellence in CAPT Walt Greenhalgh. CAPT Mark Stephens Chairs the tri-service Department of Family Medicine at the USUHS and residency program directors include CAPT Greg Jones, CDR Jim Keck, CDR Kelly Latimer, CAPT Erik Schweitzer and CDR Rick Temple (Family Medicine Residencies) and CAPT Tim Lavan (Aerospace Medicine Residency). Our Primary Care Sports Medicine Specialty Leader is CDR John Biery and CAPT Todd May runs the Sports Medicine Fellowship.

Now make no mistake, this list can go on and on. There are numerous SMOs, Directors, Department Heads, BUMED staff, other special project physician leaders who are Family Physicians.

In preparing this update I am reminded how far and wide Navy FPs lead across Military Medicine. And again, make no mistake- those listed above scratch the surface of Navy Family Physician Leaders. I will go even further—through visits, teleconferences, meetings and other communications (both public and private) I am deeply heartened by one thing—Navy FPs innate capability and desire to lead at every level! Through tough times as well as smooth times, via respectful criticism and leading by example-- Navy FPs step up!

Please don't blur over my assertions as empty bromides! I personally see FPs leading across the globe every day!

Also, I realize that many folks are increasingly concerned about diminished promotion opportunities, and the statistics clearly state that being selected for CDR and CAPT are getting more challenging. Yet, FPs are on the right side of the bell-curve in most statistics regarding promotion and opportunity.

So I am asking our "junior" Navy FPs—look at the opportunities explored and achievements secured by your predecessors. I guarantee you that each of those names I've mentioned above would NOT reflect back on their career as "times were always easy," or "change was never dynamic" or "opportunities were always handed to me."

We as FPs are the ultimate utilitarian physician for modern military medicine. The demand for our services has never been greater. The prospects for leading will continue to grow. Reach out for mentorship. Contact those leaders noted above and pick their brains! Contact CDR Adam Saperstein for more information about how to be a formal mentor or mentee!

And lastly, continue to lead from whichever level you currently stand. Grow where you are planted. You are so well-equipped for success!

Be well!

The University of Texas Rio Grande Valley

• Founding Program Director, Family Medicine
• Teaching Faculty

University of Texas Rio Grande Valley, School of Medicine
Rio Grande Valley, Texas

The University of Texas Rio Grande Valley seeks full time faculty in the Department of Family and Preventive Medicine under the direction of Dr. Eron Manusov with a passion for teaching, building/creating new programs and supporting a population that is underserved. Opportunities include a new medical school, teaching, research, clinical care, program development, interprofessional and integrated care, and community outreach that will fill a vital need and have significant impact on the quality of care delivery and health outcomes for the region.

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consultant report
CG/PHS

GREETINGS USPHS/COAST GUARD PHYSICIANS!

Sending out a call for my USPHS fellow physicians to consider running for position of director to serve on USAFP Board of Directors, a position will become vacant every two years!

This is a great opportunity to serve, work with and learn from phenomenal staff.

Please consider running for this position if you enjoy teamwork, camaraderie, participating in diplomatic processes and lastly if you wish to expand your understanding of the USAFP as a living breathing body of doctors improving healthcare for our troops.

This past week, I had the honor of traveling to Denver, CO as an Alternate Delegate and saw the AAFP Congress in action. It was a fast paced meeting of delegates from around the country, all of them family medicine doctors with goals of improving this nation's health. The group met to elect new board members, as well as to complete business for the year. I attended as an Alternate Delegate representing the NCCL as a member of special constituencies; this group is comprised of women and men of minority descent, as well as underrepresented groups such as women and people who identify as GLBT.

Over the weekend, the hard work we put in paid off, several important resolutions dealing with issues of access and social determinants of health were approved.

Read more: *http://www.aafp.org/news/2015-congress-fmx/20151005educationrefcomm.html*

I believe my co-workers are providing **great** health care for their patients, participating in peer review and maintaining open lines of communication among health care teams and patients, which ultimately leads to patient satisfaction and improved health for our patients and our selves.

WORKING WITH PAPER HEALTH RECORDS IN USCG MEDICAL CLINICS:

In the month of September 2014, I wrote with great joy about the eagerly anticipated launch of EPIC/IHIS the USCG EHR which was to be the answer to our documenting woes. Sadly, this program will not be released as expected. Today, I literally wrote notes with pen and paper while seeing my patients; the billing sheets were also completed at the end of the day. The information from the billing sheets as well as the patient appointments for the day were logged into a DOS based program called CHCS (the Composite Health Care System which allows us to track appointments, enter consults, labs, meds, radiology requests; however, it does not allow us to document patient care).

Although this may seem odd, as I am living in the US working for a DHS agency, serving active duty USCG members, paper HMR is our current process! Some may think working with this very antiquated system to be cumbersome. I must tell the truth…this sudden thrust into a disconnected system has provided a very timely moment of reflection as well as an opportunity to dream of what comprises a useful health record, electronic or otherwise.

The ideal health record chronicles a patient's life, their illnesses, symptoms, therapies, resolutions, as well as their return to health. The record serves as a communication device to speak to future providers and allow them to see the cumulative care a patient receives over the course of a career, or in the case of children their lifetimes. Every encounter does not require a multipage note, filled with extraneous information, as we have rapidly discovered in our attempt to complete records using preprinted templates.

What comprises good medical care will never be completely agreed on. My personal opinion is that fundamental to all patient doctor interactions is a relationship, which can be enhanced by appropriate interpersonal skills, or interrupted by the intrusion of record keeping.

Imagine the caricature of a record keeping doctor with his back turned to the patient as he is more interested in filling out his forms for billing rather than evaluating the patient's medical ailments.

continued on page 10

University of Colorado
Anschutz Medical Campus
School of Medicine
Department of Family Medicine
University of Colorado
Family Medicine Clinic at Park Meadows

Senior Instructor – Physician,
University Family Physicians at Park Meadows
Position #7840 – Job Posting #F02246

The Department of Family Medicine at the University of Colorado Denver Anschutz Medical Campus is seeking a full-time family physician for our South Metro-Area clinic site at Lone Tree/Park Meadows. The Department's clinical faculty members are recognized for providing innovative, integrated, patient-centered care. The Park Meadows clinic is a busy, ambulatory clinic serving a mix of patients from the surrounding community and is part of the University Hospital system. The Park Meadows clinic is certified as Patient Centered Medical Home and is undergoing practice re-design towards exemplary patient-centeredness and a superior patient experience. Applicants must demonstrate experience and competence patient care and an interest in teaching. This position is full-time and applicants for full-time positions will have priority. Women and minorities encouraged to apply. Detailed job descriptions and qualifications required can be found on jobsatcu.com and the Department's website, *http://fammed.ucdenver.edu/home/careers.aspx*.

REQUIRED QUALIFICATIONS: MD/ DO degree, Colorado Medical License, DEA Certificate, Board Certified/Board eligible in Family Medicine. Practices full spectrum of ambulatory Family Medicine. Must obtain Medical Staff privileges at University of Colorado Hospital.

JOB RESPONSIBILITIES: Applicant will be a member of the practice clinical faculty: Sees patients and manages patients within context of a Patient Centered Medical Home practice, serving as a continuity provider for a panel of patients. Teaches students in the provision of patient care, participates in scholarly activity, serves as a leader and role model for fellow physicians and learners.

ESSENTIAL JOB FUNCTIONS: 100% - Provides high quality patient care at University Family Medicine Clinic at Park Meadows

- Provides ambulatory care at University Family Medicine Clinic at Park Meadows a minimum of 32 hours of appointments per week.
- Exemplifies the highest standards in patient care as a faculty member
- Participates in home call approximately five weeks per year.
- Participates in quality improvement efforts
- Participates in education of interdisciplinary students assigned to the clinic.

PREFERRED QUALIFICATIONS: Two years of practice experience in ambulatory and Patient Centered Medical Home/Integrated Practice settings preferred. Individuals with other clinical or practice experience will be considered.

Salary is commensurate with skills and experience. The University of Colorado offers a full benefits package. Information on University benefits programs, including eligibility, is located at *http://www.cu.edu/pbs/* Applications are accepted electronically at *www.jobsatcu.com*. Review of applications will begin immediately and continue until position is filled.

When applying at *www.jobsatcu.com*, applicants must include:

1) A letter of application which specifically addresses the job requirements and outlines qualifications
2) A current Curriculum Vitae

Questions should be directed to ***regina.garrison@ucdenver.edu***.

"The University of Colorado Denver and Health Sciences Center requires background investigations for employment."
"The University of Colorado is committed to diversity and equality in education and employment."

This does not conjure up a warm feeling for the doctor as a healer rather a cool calculating business man is what comes to mind; however, maybe this is a good thing, more money should equal better care or superior care.

No, in fact: "In 2014, the Commonwealth Fund analyzed healthcare systems of 11 developed countries, the US came in at number 11 on this list — dead last. It had the most expensive health care costs per capita, at over $8,500, and the most expensive health care expenditures overall, at 17.7 % of GDP. It scored worse than every other country in the report."

Read more: *http://www.cheatsheet.com/business/3-of-the-best-and-worst-countries-for-medical-care.html/?a=viewall#ixzz3nodFesrn*

So wherever you are right now, know that Medical Officers working for the USCG do not currently have one unifying EMR system where all medical records are available for review. However, in spite of this, I believe my co-workers are providing **great** health care for their patients, participating in peer review and maintaining open lines of communication among health care teams and patients, which ultimately leads to patient satisfaction and improved health for our patients and our selves.

These are my thoughts, and they may differ broadly from my superiors and my co-workers, please feel free to email me with questions and comments **regardless** of your agency affiliation.

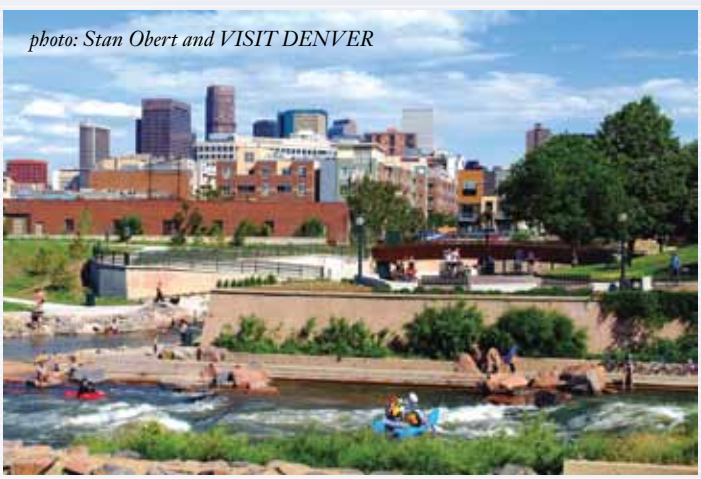
Thank you for your service, dedication and please do send any and all critiques, corrections, updates to me: Maria De Arman at *maria.d.dearman@uscg.mil*.

USAFP 2016 Annual Meeting & Exposition
Health is Primary

Register today for the USAFP 2016 Annual Meeting & Exposition scheduled 18-22 March at the Sheraton Denver Downtown Hotel in Denver, Colorado. The program offers a steady flow of presentations that highlight health and wellness, sleep, nutrition, and fitness. In addition, practice management, the patient-centered medical home and physician leadership. Don't miss out on this amazing program and the opportunity to enjoy the diversity of CME, re-connect with old colleagues and friends, and come out with a refreshed realization of the central role family physicians play in our nation's healthcare and the readiness of our armed forces.

Registration and hotel information can be found online – *www.usafp.org.*


photo: Steve Crecelius and VISIT DENVER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When the Student Becomes the Teacher: RATs

As an attending, I've just survived a week on the inpatient team (carrying around my umbrella for my black cloud) and am thinking about the feedback to give the second and third year residents. They did great (of course); the patients were well cared for, clinical questions were appropriately posed to consultants, the "system" was successfully navigated. What is there to improve? I often find myself encouraging these individuals that they are ready and need to fully embrace the role of educator on the team; they should look for opportunities to do more teaching. Recently I reflected, "I would like them to do more teaching, but have I given them the tools?"

There are several reasons to invest resources in arming residents with tools to improve their teaching skills. They are already teaching, and doing a significant amount. It is estimated residents spend 20% of their time teaching junior learners and report it as one of their primary responsibilities.[1] Medical students report up to a third of their education on clinical rotations comes from residents.[2] In addition to junior learners, residents are engaged with teaching other health care professionals. Residents report a better grasp of content after teaching. Improved teaching skills would also benefit their patient education abilities and are encompassed under several of the patient care and communication milestones.

The importance of fostering the resident-as-teacher (RAT) has been increasingly recognized. In a 2014 survey of Family Medicine program directors (to include 8 military programs!) 85% of programs offered formal resident-as-teacher instruction, up from 52% of Family Medicine residency programs in 2001. Despite a large majority of programs having formal educational instruction, 72% of program directors felt residents would benefit from even more training.[3]

What content should a RAT curriculum include? How much time should be set aside for a successful RAT curriculum? Should the curriculum be executed at the institution, program, or individual level? Should participation in a RAT curriculum be optional or mandatory? What medium should the information be distributed through? Unfortunately, there are no easy answers to these questions; curricula available online and discussed in the literature span the extremes when addressing these facets. The good news is this means a RAT curriculum can be highly adaptable to the needs of your learners and resources available at your institution.

Common items to include in a RAT curriculum include: the RIME model (Reporter, Interviewer, Manager, and Educator), the one minute preceptor and five micro skills, bedside teaching, teaching rounds and morning report, teaching procedures, and feedback and evaluation. These topics can be presented in a variety of modalities to include online self-directed modules, small group lectures, or large group lectures.

A 2014 article in Academic Medicine took a slightly different approach. In this study, focus groups queried medical students as to what they learned from residents and effective teaching strategies implemented by excellent resident teachers. The comments from these focus groups were then categorized into 20 themes and further organized into seven domains: role modeling, focusing on teaching, creating a safe learning environment, providing experiential learning opportunities, giving feedback, setting expectations, and stimulating learning. The authors note that traditionally, resident as teacher curricula are modeled after behaviors of teaching faculty. Using these seven domains as a curriculum outline would target behaviors specifically identified by students (often the "end user") as being effective teaching strategies.[4]

How do you evaluate the success of a resident as a teacher and your curriculum? A frequently used tool in the literature is a self-assessment, often in the form of a pre-intervention and post-intervention questionnaire. While this may allow the resident to reflect on potential self-identified strengths and weakness it focuses more on the curriculum; this format does not allow for specific details from an observer (or the intended learner) on what was effective and areas to improve on. Other assessment options include: objective structured teaching exercises

(OSTEs), objective structured clinical examinations (OSCEs), direct observation, and videotaped evaluation. Learner evaluation is also a great opportunity to see from the "end user" what was effective. Learner evaluation can be viewed in the context of the learner the resident taught and the resident themselves as the learner of your curriculum.

Looking for resources to improve or develop your RAT curriculum? A quick literature search will return several examples of successfully implemented and published curricula. That being said, a 2013 review article in the Journal of Graduate Medical Education looked a little closer at available articles. The authors looked for curricula literature that met three criteria: reproducible in your own program, discussed assessment tools, and discussed educational outcomes. Thirty-nine articles were determined to be appropriate for review based on the above initial screening criteria. Of the 39 articles, only one was deemed to have enough detail on both curricula and assessments that could be fully reproduced.[5] In addition to peer reviewed journal articles, there are several online resources available. The American Academy of Family Physicians has recommended curriculum guidelines for family medicine residents entitled "Residents as Teachers and Precepting in Postgraduate Practice."[6] The Society of Teachers of Family Medicine has submissions in the online resource library.[7] In addition, MedEdPORTAL has several resources to include presentations, evaluation tools, and multimedia components.[8] Many academic institutions have their curricula with materials publically available. Finally, the USAFP Education Committee has several products to include a faculty development resident elective rotation outline.[9]

I challenge you to be open to opportunities to provide residents instruction on how to be effective teachers and to implement an evaluative tool to identify strengths and areas for improvement. The entire team benefits when we give residents more tools in their teacher tool-kits.

REFERENCES:

[1]Schwenk T, Whitman N. *Residents as teachers: a guide to educational practice.* Pacific Grave, CA. Whitman Associates; 2005.

[2]BarrowMV. Medical student opinions of the house officer as a medical educator. *J Med Educ.* 1966;41:807-810.

[3]Achkar AM, Davies MK, Busha ME, Oh RC. Resident-as-teacher in family medicine: A CERA survey. *Fam Med.* 2015 Jun;47(6):452-8.

[4]Karani R, Fromme HB, Cayea D, Muller D, Schwartz A, Harris IB. How medical students learn from residents in the workplace: a qualitative study. *Acad Med.* 2014 Mar;89(3):490-6.

[5]Bree KK, Whicker SA, Fromme HB, Paik S, Greenberg L. Residents-as-teachers publications: What can programs learn from the literature when starting a new or refining an established curriculum? *J Grad Med Educ.* 2014 Jun;6(2):237-48.

[6]AAFP Reprint No. 290B. Recommended Curriculum Guidelines for Family Medicine Residents: Residents as Teachers and Precepting in Postgraduate Practice. AAFP Website. *http://www.aafp.org/medical-school-residency/program-directors/curriculum.html.* Accessed September 24, 2015.

[7]STFM Resource Library. Society of Teachers of Family Medicine Website. *http://www.stfm.org/Resources/STFMResourceLibrary.* Accessed September 24, 2015.

[8]MedEdPortal. *https://www.mededportal.org.* Accessed September 24, 2015.

[9]Madigan Faculty Development. USAFP Education Committee Website. *http://www.usafp.org/committees/education/madigan-faculty-development.* Accessed September 24, 2015.

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!

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

ad space pending

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Part I in a Multi-Service Series on Perspectives of Operational Medicine
So you want to be an Army Operational Doc?

When I initially took the position of Brigade Surgeon, I had no idea what that meant. I had reviewed the roles and responsibilities of the Brigade Surgeon in the AMEDD Staff Officer's handbook, spoken to several mentors and performed a "left seat, right seat" with the outgoing physician; yet I still did not have a clear picture of how to get my Unit medically ready. During my time in this position, I found that there was a significant gap and lack of communication between Command Teams and the medical staff. All the Commanders knew about their Soldiers was what they read in the poorly written templated profile and did not have any awareness of what I did as a physician. So, I put together a quick study guide to help improve not only medical readiness but also communication between Commanders and the Medical Staff section. This article highlights several key issues that can often be challenging for physicians in a new operational environment.

HIPPA – DOES THE MILITARY REALLY HAVE HIPPA RULES WHEN IT COMES TO ACTIVE DUTY?

As physicians, we are well–versed on the Health Insurance Portability and Accountability Act. Yet, in regards to HIPPA disclosures in the military, we have a different responsibility of the Command Teams and certain information is essential to the mission. Therefore, while HIPPA continues to apply and is very important in the Operational Doc's practice; certain information can be shared with the Commanders. This information includes duty restrictions, changes in deployment status, medications that limit duty performance, suicidal or homicidal ideation, conditions impairing the Soldier's performance of duty, risk of heat/cold injury, hospitalization, serious illness, date/time of medical appointments and command directed BH evaluations. Above all else we can disclose certain information, if military mission outweighs the interests served by notification which is determined on a case by case basis. A quick way to remember what we can disclose to the Commander is the 5 Ds: Danger, Drugs, Duty, Directed and Deployment Limiting. Other information that is not pertinent to the mission and must remain restricted includes information that does not impact readiness/deployability, such as specific diagnosis (outside of a profile), specific procedures, description of treatment plan, specific appointments with clinics, specific medications (including dosages, frequencies, etc.), information about dependents and patients who self-refer to the Army Substance Abuse Program.

All the Commanders knew about their Soldiers was what they read in the poorly written templated profile and did not have any awareness of what I did as a physician.

SICK CALL SLIPS AND PROFILES – THE MILITARY DOCS PRESCRIPTION PAD

Now that we know what we can and cannot discuss with Commanders; how do we communicate a Soldier's injury/illness with Commanders? We use the DD Form 689 (Sick Call Slip) and the DA Form 3340 (Profile). The DD Form 689 allows open communication between medical provider and Commanders for short term medical conditions less than 14 days. Whereas, the DA Form 3340 is used for long term medical conditions which could last longer than 14 days. Only profiles located in the E-profile system are valid. We, as medical providers, must remember that these are only recommendations. Commanders can choose whether or not to accept our medical recommendations, and would assume responsibility/liability for their Soldiers. If

continued on page 16

the sick call slip or profile is written by a Military Medical Provider, it is considered a direct order and can be used in UCMJ procedures if the Soldier is non-compliant with care. A temporary profile can be written up to 90 days with the exception of Pregnancy profiles. A permanent profile is indefinite and must be reviewed every year and then renewed by medical provider every 5 years.

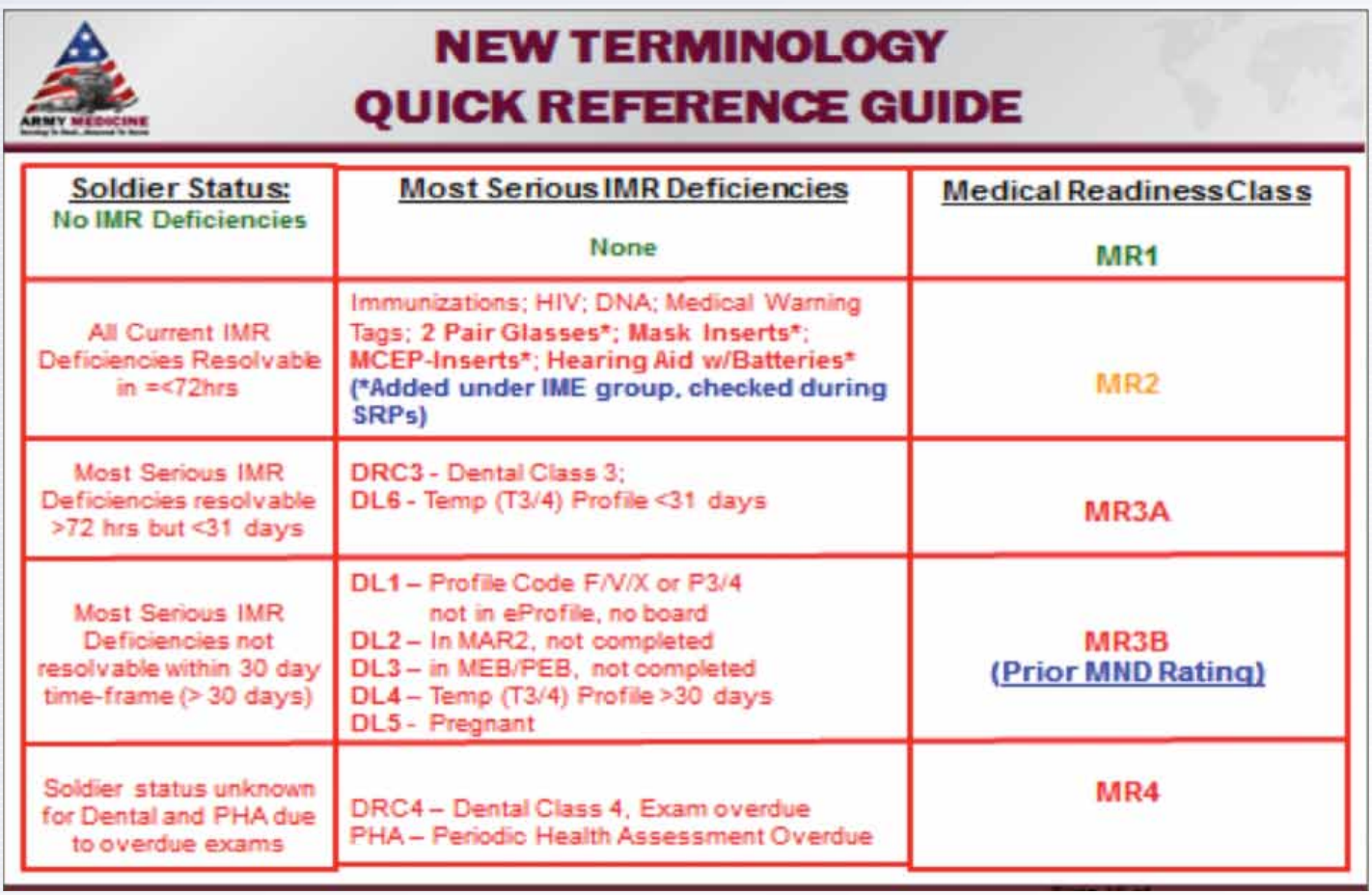
MEDPROS – GREEN IS GOOD

MEDPROS, The Medical Protection System, is the system of record which allows Commanders to track their unit's Medical Readiness. It allows Commanders to review those Soldiers who have a DL (Deployment Limiting) status or have a LDP (Limited Duty Profile). **All Soldiers with a Medical Readiness Class (MRC) 1 or 2 will be considered as Available and all Soldiers with an MRC 3A, 3B, or 4 will be considered as Non-available.** This concept becomes very important in the pre-deployment planning when looking at medical non-availables vs medical non-deployables. Below, the chart and key describes the MRC status that can be assigned to a Soldier.

MEB/IDES – WHAT DOES IT ALL MEAN?

Integrated Disability Evaluation System (IDES) or more commonly known as the "MEB" (short for Medical Evaluation Board) is the process by which an injured Soldier is evaluated to determine whether they meet retention criteria as outlined in AR 40-501 or not. The determination to start the MEB process or place a Soldier in the IDES program occurs at the Medical Retention Decision Point (MRDP), which can happen any time from initial injury to 365 days post injury/illness. The MRDP is met once the determination is made that the Soldier is unlikely to recover within one year of injury. The MDRP is the point when it has been determined that further treatment will NOT cause the Soldier to meet retention standards per AR 40-501. Typically, this decision is made within 1 year of being diagnosed with a medical condition that does not appear to meet medical retention standards; but can occur sooner depending on the injury and the Soldier's job roles and responsibilities. The entire IDES process can take anywhere from 100-300 days depending on the number of Soldiers enrolled. Operational physicians and Commanders can track their Soldier's progress in the IDES System using the Command Management System (CMS) located on the Medical Operational Data System (MODS) website.

While, the quick guide does not possibly sum up all of the roles and responsibilities of being an operational physician, it is a great start on understanding how Commanders think and where their priorities are in regards to Medical Readiness.



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The Essential Medical Apps for Taking Care of Children

Disclaimer: The views expressed are those of the author(s) and do not reflect the official policy of the Department of the Army, the Department of Defense or the U.S. Government.

The following is a list of essential medical apps family physicians should have on their smartphones when taking care of children. Links to iPhone and Android platforms are provided for each app on the USAFP website *(www.usafp.org/about-usafp/uniformed-family-physician-newsletter)*. The apps are listed based on my experiences working as a full scope Family Medicine physician including obstetrics and pediatrics.

1) UPTODATE OR DYNAMED/ DYNAMED PLUS

For many of us, UpToDate is the medical application of choice for answering clinical questions. This app is ideal at the point care in clinic, on the ward, in the NICU/PICU, during rounds, morning report, anywhere really. It is the most comprehensive app available for primary care specialties such as pediatrics and is available as a mobile app for individual and institutional subscribers to UpToDate.

That said, UpToDate isn't the only choice out there for quick medical reference tools. Alternative reference apps that hold their own against UpToDate include Dynamed. Although not as comprehensive as UpToDate, Dynamed/ Dynamed Plus is one of the most evidence based apps available. The interface takes some getting used to, but is efficient once you are used to it. Other alternatives would include Essential Evidence Plus and Medscape.

UpToDate: Price: $495/year UpToDate
Dynamed: Price: $395/year for Dynamed

2) DRUG WARS: EPOCRATES OR MICROMEDEX OR LEXI-COMP

Epocrates has been my go to drug guide since I was a medical student. It has changed a lot over the years, but the most important feature has remained the same. It simply has the friendliest, fastest user interface of any of the comprehensive drug guides. If you purchase the premium, Epocrates Essentials you also receive a fairly useful medical calculator, point of care tables, alternative medicines, and a disease content section developed in conjunction with the British Medical Journal.

However, for the most detailed and complete drug information available you simply cannot go wrong with Lexi-Comp. I find that I use Epocrates more in clinic when I need its speed and Lexi-Comp when I am on the wards and need more detail about a particular medication. Further, while Epocrates might have a free version, they do have a closer relationship with pharma and your personal information is shared with outside organizations.

An outstanding and significantly cheaper alternative to Epocrates Essentials or Lexi-Comp is Micromedex. This app may be available to readers via institutional subscription, but can be obtained on its own for a small annual fee. Micromedex provides a similar level of detail as Lexi-Comp on issues such as pharmacokinetics that are missing from Epocrates.

Price: Basic: Free; Epocrates Essentials: $159.99/year
Price: $175/year Lexi-Comp Clinical Suite to $595/year Lexi-Comp Complete + Online
Price: $2.99/year Micromedex Drug Reference Essentials

3) RED BOOK OR NELSON'S PLUS PNEUMONIA AND IGUIDELINE

The Johns Hopkins ABX guide is my go-to "bug" guide, but it doesn't include pediatric infectious disease recommendations. The "gold standards" for pediatric infectious disease topics are the AAP Red Book and Nelson's Pediatric Antimicrobial Therapy. Both contain valuable information, but each has significant drawbacks. The Red Book is quite expensive for a standalone app if you are not an AAP member, especially since much of its information could be found in UpToDate and/or Dynamed. If you subscribe to Pediatrics Care Online, you can access the Red Book. The key with many of the AAP publications is to ensure you are a dues paying member as this permits

access to many of their publications for free. I found the Red Book to be a useful "replacement" for the otherwise hefty AAP text. The cheaper Nelson's lacks the textbook like feel of the Red Book, but is hindered by an extremely clunky user interface. I do not recommend it. Two related infectious disease apps are Pneumonia and iGuideline. Pneumonia is a free app from Joshua Steinberg that includes both adult and pediatric pneumonia guidelines. iGuideline is a free collection of guidelines including pneumonia and fever without source among others developed by a children's hospital in Kansas City.

Red Book: Price: $149.99 (free for AAP members)

Nelson's Pediatric Antimicrobial Therapy: Price: $39.99

Pneumonia: Price: Free

iGuidelines: Price: Free

4) SHOTS AND CDC VACCINE SCHEDULES APPS

There is no right answer when it comes to finding a good vaccination app, as I find it to be a personal decision based on your needs and comfort with the app's user interface. Of the many vaccine apps on my iPhone, I find Shots and the CDC Vaccine Schedules apps each very useful. I tend to use Shots more from experience than anything else, but the CDC Vaccine interface is pretty nice. The key with vaccine apps is updates. With the ACIP recently updating flu vaccine guidelines in children, Shots contains the updates whereas the CDC app refers you to their website to view the current update. For a fantastic app on vaccines for parents, make sure to "prescribe" CHOP Vaccines on the Go. This app is truly a one stop shop to educate parents and assist you in debunking the many myths surrounding vaccines.

Shots: Price: Free

CDC Vaccine Schedules

CHOP Vaccines on the Go

5) KIDOMETER AND PEDI QUIKCALC

When it comes to outstanding pediatrics apps for family physicians there are many options, but one of the best is Kidometer. Kidometer combines a developmental milestones, vaccines, lab values, nutritional information, and critical care app all in one. The problem is that Kidometer hasn't been updated in two years and doesn't do peds medication dosing.

To fill the gaps of the orphaned Kidometer, I recommend Pedi QuikCalc. Although many "adult" drug guides such as Epocrates and Lexi-Comp perform peds medication dosing, none are easier to use at the point of care than Pedi QuikCalc—the best peds dosing app since PediDoser was taken off the app store. Another alternative is BluCard described below.

Kidometer: Price: $4.99

Pedi QuikCalc: Price: $1.99

6) PEDI STAT, BLUCARD, EMRA PEDS MEDS, INRP

When it comes to rapidly finding the proper medication doses and resuscitation gear needed for peds emergencies, the gold standard is Pedi STAT. It is simply outstanding for ease of use and functionality when you don't have a Broselow tape in your hands. But Pedi STAT isn't the only show in town. Excellent alternatives include BluCard (which also is an outstanding pediatric medication dosing app) and EMRA Peds Meds. If you are looking strictly for a nice summary of the NRP algorithm, then consider iNRP. It is from the makers of the NRP guidelines, but is only a web-app.

Pedi STAT: Price: $7.87

BluCard: Price: Free

EMRA Peds Meds: Price: $2.99

iNRP: Price: Free

7) PEDIATRIC CARE ONLINE AND AAP APPS

Is there a comprehensive, all-encompassing pediatrics app? I stated at the beginning of this list, that either UpToDate or Dynamed/Dynamed Plus fit that bill. One alternative, especially for AAP members, is the excellent Pediatrics Care Online. This app includes a pediatric quick reference text book, Bright Futures well child resources, a pediatric drug dosing guide, the Red Book and an online textbook, all of the AAP guidelines, etc. The AAP offers a wide variety of apps from the official AAP app to Healthy Children Magazine. Most are free to AAP members and many are free, though some are seemingly overpriced and clunky to use.

Pediatric Care Online: Price: Free to AAP members

8) APPS FOR PARENTS

What apps do we recommend you consider "prescribing" to parents? Those apps could be an entire review unto itself. Some of the apps, that I have prescribed to parents include Healthy Children, KidsDoc, WebMD Baby, CHOP Vaccines on the Go, and Sprout Baby. For answers to questions about overall children's health, especially development in the first years of life, I frequently recommend Healthy Children (the website is much more user friendly than the app), WebMD Baby, and Sprout (not sure I entirely trust the information, but the interface is very slick). For vaccine myth busting, I recommend CHOP Vaccines on the Go for the well written articles, videos and reliable information. Finally, for pediatric urgencies and emergencies, I recommend KidsDoc. This app is like having a doc in the home with information on a wide variety of medical conditions and common drug dosing tables for parents.

Healthy Children: Price: Free

WebMD Baby: Price: Free

Sprout: Price: Free

CHOP Vaccines on the Go

KidsDoc: Price: $1.99

9) VISUALDX

Not a day of clinic goes by in Family Medicine where a parent brings in a

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child who has a rash or skin lesion they want evaluated. Although many of us are comfortable with common skin rashes such as eczema, rashes that defy easy pattern recognition are frequent and complicated by systemic signs and symptoms or chronic medical conditions. Prior to my smart device days, I would break out a dermatology text such as Habif's Clinical Dermatology. Now with derm apps such as VisualDx, textbooks are out. VisualDx allows you to search by topic—such as eczema to see a wide variety of pictures, diagnostic signs/symptoms, differential diagnosis, and treatment options. But what really stands out is its ability to allow you to build a differential diagnosis by combining history and physical exam findings. You plug into the menu what you are seeing using common dermatology terms, add other physical exam findings, vitals, history and it generates a handy differential diagnosis. I really haven't found an alternative dermatology app that I prefer, but an alternative would be EM Rashes.

VisualDX: Price: $199.99 Essentials; $299.99 Complete

EM Rashes: Price: Free

10) BILI APPS

For making clinical decisions regarding phototherapy, you can't go wrong with either Bilicalc or Bilitool; although, Bilicalc is not free ($1.99) and Bilitool is only a web app currently. You are likely better off paying a dollar more for PediQuikCalc which contains Bilicalc and much more.

Bilicalc

iMedicalApps Review - Price: $1.99

11) MISC APPS

Some apps just don't "fit" nicely into any one category. Need an app for promoting children's' oral health? Make sure you download the excellent and free app, SmilesForLife, from the Society of Teachers of Family Medicine. It contains a handy fluoride dosing table among other useful tools. Trying to help parents pick and fit a car seat for their newborn or upgrading seats for their toddler? Consider downloading either Car Seat Helper or Car Seat Check for recommendations. Another great free app from Joshua Steinberg is Lead Screen, especially useful in states that mandate lead screening. Finally, a few free apps from the AAP include ADHD tracker and Change Talk, an app that assists providers in tackling tough conversations about weight and pediatric obesity.

SmilesForLife: Price: Free

Car Seat Helper: Price: Free

Car Seat Check: Price: $1.99

Lead Screen: Price: Free

Chicago's Northern Suburbs

Family Medicine Physician

The Department of Family Medicine at NorthShore University HealthSystem, (NorthShore) the principal academic affiliate of the University of Chicago Pritzker School of Medicine, is currently seeking exceptional Family Medicine physicians for practice opportunities in several locations. Responsibilities include managing the care of patients of all ages in the office and using a strong hospitalist program for inpatient care. The Department has many distinguished faculty and attending physicians and continues to grow every year. This is an excellent opportunity to provide quality patient care in a lucrative practice within a highly successful organization. We offer a competitive salary and comprehensive benefits package.

The successful candidate for this position will have completed a family medicine residency and be board certified or board eligible by the American Board of Family Medicine. Academic appointment to the University of Chicago Pritzker School of Medicine is available to qualified candidates.

NorthShore is a member of the Mayo Clinic Care Network; Mayo's only collaboration of its kind in the Chicago region. Located in Chicago's Northern suburbs, NorthShore is a physician-led, multi-specialty group with 900 plus physicians and growing. You'll benefit from being part of a fully integrated healthcare organization spanning 4 hospitals, along with more than 100 Medical Group offices. NorthShore has been named one of the "Most Wired" healthcare organizations in the country by *Hospitals & Health Networks Magazine*, and our EMR system, EPIC, is the "gold standard" in the industry.

Qualified candidates should submit their CV to:

Kathleen Gliva, Physician Recruiter
Email: kgliva@northshore.org
Phone: (847) 663-8250

NorthShore
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EOE: Race/Color/Religion/Sex/National Origin/Protected Veteran/Disability, VEVRRA Federal Contractor

committee reports
RESIDENT AND STUDENT

Jason Butler – Army
Womack Army Family Medicine Residency

Breanna Gawrys - Air Force
Fort Belvoir Community Hospital Family Medicine Residency

Jed Siebel - Navy
Jacksonville Naval Hospital Family Medicine Residency

Fall is here!

As pumpkin spice lattes fill the air we hope our new medical students, interns and residents have successfully transitioned into their new roles; for the third year residents, a rewarding transition into practice.

Since our 2015 Annual Meeting this past spring, your resident directors have had the opportunity to represent USAFP at the AAFP National Conference for Family Medicine Residents and Students (NCFMR) in Kansas City and attend the mid-year USAFP Board of Directors meeting in Denver.

At NCFMR, USAFP gained exposure with a prime location in the exposition hall, where we presented USAFP's role and mission to residents and students from HPSP, USUHS and non-military individuals. For some this was their first exposure to USAFP. NCFMR also provides an avenue to present change. This occurs at the national congress of residents and delegates where USAFP was able to send one delegate.

At NCFMR, USAFP gained exposure with a prime location in the exposition hall, where we presented USAFP's role and mission to residents and students from HPSP, USUHS and non-military individuals.

During the conference, it was refreshing to see the involvement and roles that uniformed students and residents achieved. One resident was selected for the Family Medicine Emerging Leaders Institute. Another supported the Army recruiters at their local booth; and students from USUHS were also actively involved at the convention. Your academy provided a scholarship that paid the registration fee for a medical student to attend the conference. We appreciate the interest from those who applied.

Hopefully, you have received letters through the HPSP and USUHS office or from your chief residents, discussing resources that USAFP offers to all of its members to include POEMs, Audio Digest and avenues to contact your USAFP resident directors with any concerns that you feel need to be presented to the board.

We recently attended the mid-year board meeting in Denver and wait in anticipation for this year's upcoming conference. The venue should serve as a great place to improve clinical skills, hear great speakers and collaborate with other family physicians. We encourage everyone whether student, resident, or staff to come experience your USAFP annual conference where HEALTH IS PRIMARY.

We look forward to seeing you in Denver!

EVERY DOC CAN DO RESEARCH

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

If interested, please send a request to *dreamy@vafp.org*.
Tools Available:

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

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

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Scholarly Activity for Dummies and Quality Improvement: Not Just for Nurses Anymore!

Scholarly Activity (SA) for many family physicians is like regular exercise for many of our patients. We know it's good for us, but we can't find the time or motivation to make it happen. No other professional accomplishment can instill a feeling of pride like seeing your name in print and receiving emails from people calling you "expert." SA has other benefits besides the admiration of your colleagues. (table 1)

TABLE 1: PERSONAL BENEFITS OF SCHOLARLY ACTIVITY (SA)

- Opportunity to present at conferences (important in this era of TAD constraints!)
- Fitness report/Officer Evaluation Report Bullet
- Curriculum vitae expansion – SA directly affects civilian salary negotiations
- It's fun and you're curious
- Develop critical thinking, leadership, and time management skills
- Improve your writing and presentation technique
- Establish valuable connections and friendships
- Increased competitiveness for residency or fellowship application

DEFINITION OF SCHOLARLY ACTIVITY

For your work to be considered SA by the Accreditation Council for Graduate Medical Education (ACGME), it must satisfy three criteria: 1) The work must contribute to the body of knowledge of the specialty; 2) It must be subject to peer review; and 3) It must be shared with peers. This "sharing" must occur at the regional or national level for faculty and fellows. Residents need only share at the local or state level, though they are encouraged to share at higher levels.

TABLE 2

TYPE OF SCHOLARSHIP	DEFINITION	EXAMPLES
Discovery	Build new knowledge through hypothesis-driven original basic, clinical, epidemiological research on health or disease	**Resident** – present original research at a local competition **Faculty** – publish original research in a national medical journal
Integration	Synthesize current knowledge to make it useful to others	**Resident** – write a patient centered article in the local paper **Faculty** – publish a clinical review article in a national journal
Application	Use knowledge to improve healthcare, medical practice, health systems operation, public health, or policy	**Resident** – present a QI project on improving FMC clinical operations at the hospital PI Fair **Faculty** – Present a QI project improving processes for a group of practices at a Regional meeting
Teaching	Design, implement, and evaluate educational curricula, rotations, courses, materials, or on-line resources to educate students, healthcare professionals, patients, or the public	**Resident** – develop a self-care program for patients and present at a residency conference **Faculty** – publish an evaluation method in a state or national medical journal

The ACGME defines four broad categories of SA. (table 2) The forums for presentation are multiple. ACGME is not picky: original grant-funded published research, review articles, textbook chapters, presentation at meetings, development of educational material, or participation in national organizations can all satisfy the ACGME. Use your strengths to decide on a venue.

REQUIREMENT FOR SCHOLARLY ACTIVITY AND QUALITY IMPROVEMENT IN FELLOWSHIP AND RESIDENCY

SA is not optional for faculty, fellows, or residents. Luckily the ACGME says Quality Improvement (QI) is SA. The two naturally overlap. Research discovers new knowledge and QI uses avail-

FIGURE 1: PBLI–3 IMPROVES SYSTEMS IN WHICH THE PHYSICIAN PROVIDES CARE

HAS NOT ACHIEVED LEVEL 1	LEVEL 1	LEVEL 2	LEVEL 3	LEVEL 4	LEVEL 5
	Recognizes inefficiencies, inequitites, variation, and quality gaps in health care delivery	Compares care provided by self and practice to external standards and identifies areas for improvement	Uses a systematic improvement method (e.g., Plan-Do-Study-Act [PDSA] cycle) to address an identified area of improvement Uses an organized method, such as a registry to assess and manage population health	Establishes protocols for continuous review and comparison of practice procedures and outcomes and implementing changes to address areas needing improvement	Role models continuous quality improvement of personal practice, as well as larger health systems or complex projects, using advanced methodologies and skill sets

able knowledge to systematically analyze current practice and implement changes to immediately improve processes or outcomes. The ACGME expects residents to finish two SA's during residency, and one should be a QI project. Faculty should complete two SA's over five years to a wider audience with a grander influence to satisfy ACGME requirements.

The residency curriculum must include basic principles of research. Residents must learn how research is conducted, evaluated, explained to patients, and applied to patient care. Programs must provide resources so residents can complete their SA. While not explicitly stated, this likely means carved out time. Some programs have a formal Research Rotation while others have a more longitudinal approach.

SA falls under the ACGME Core Competency of Practice-Based Learning and Improvement (PBLI). In 2013 the ACGME further honed each of the Core Competencies into several "Milestones." Residents progress from level 1 (medical student) to level 3 or 4 by the time they graduate. Level 5 defines where we should all strive to be. Figure 1 shows the PBLI milestone that incorporates QI.

Even if you aren't in a residency, PBLI (along with the 5 other Core Competencies) is part of the Performance Appraisal Report (PAR) that gets signed by your Credentials Committee when your privileges are renewed. Someone has to check that you "cooperate in continuous improvement process (self & others)." Clearly, QI cannot be just the purview of our nursing colleagues! So what is a military family physician to do?

SCHOLARLY ACTIVITY RESOURCES FOR FACULTY AND RESIDENTS

The most difficult step in conducting SA is getting started. Fortunately, a multitude of options are available that we will outline to facilitate the first step. Some options require more time and commitment while others may be completed within a few weeks. SA can span the gamut from scholarly writing to clinical research to curriculum development to quality improvement.

There are several readily available scholarly writing opportunities that lend themselves to shorter time to completion and may be a nice starting point for SA. The Family Physicians Inquiries Network (FPIN) offers a variety of peer-reviewed scholarly writing formats with increasing increments of involvement. The format most commonly utilized by residents is the Help Desk Answer (HDA) which consists of a critical appraisal of the literature on a clinical question to develop an evidence-based answer. HDA's are published in the monthly Evidence-Based Practice journal. Select HDA's are featured in American Family Physician or the Journal of Family Practice. Another option is writing or revising a chapter or algorithm for the 5-Minute Clinical Consult (5MCC) textbook. Editing subjects for 5MCC is a great way to learn a topic on a more in-depth level. There are a multitude of additional venues for scholarly writing spanning from AFP Photo-Quiz case reports, editorial pieces, review articles, and book chapters.

Clinical research is a great way to contribute to the larger body of medical literature. Such endeavors do require a greater amount of effort and time, including the development and implementation of an IRB protocol. Research that does not involve greater than 'minimal risk' and fits certain categories, usually data that is collected for non-research purposes, may be considered for expedited review. Contact your local Department of Clinical Investigation or one of the USAFP research judges for answers and ideas of how to get started.

If research is not your forte, consider curriculum development as a potential form of SA. Curriculum development could involve topics like simulation training/cases, educational curriculum, evaluation tools, or population health education programs. This curriculum development must be shareable and reproducible for other locations.

QI may be the most accessible form of SA for those in clinical or leadership roles. At the most basic level, the ABFM requires maintenance of certification

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consisting of Part IV Performance in Practice. The ABFM module system or AAFP METRIC system will lead you through this requirement. Taking your QI project to the next level may include collecting associated survey or clinical data. An effective QI project with supporting efficacy data is ripe for publication or presentation. Since faculty must share their QI findings outside of the facility to count as SA for ACGME purposes, you will have to go through your IRB and complete a simple non-research determination process. Depending on your facility policies, the Human Protection Agent (HPA) on your IRB should be able to make this determination and provide an approval letter for you to proceed with data collection for publication or presentation.

Sharing what you have found or developed is very rewarding and can help further develop your topic. Depending on your topic, there are many different presentation venues via podium or poster presentation that are available, starting with your very own USAFP. We welcome all case reports, educational research, and clinical research (including PI/QI projects!) for submission into the USAFP research competition.

Don't be a "SA Couch Potato!" Get up and get going by choosing a topic and venue based on your strengths and what you enjoy. There is a wealth of options. Jump into one. It will be easier than you think and will be a rewarding addition to your practice.

REFERENCES:

[1]ACGME *http://www.acgme.org/acgmeweb/portals/0/pfassets/programresources/120_family_medicine_scholarship_guidelines.pdf*

[2]ACGME Family Medicine Milestones, 2013

[3]AFP METRIC *http://www.aafp.org/cme/cme-topic/all/metric.html*

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Making Health Primary through Osteopathic Manipulative Therapy, Integrative Medicine, and Physical Fitness

One of the components of the Health is Primary Campaign is promoting health and wellness through partnerships with our patients. I am fortunate to have trained in Osteopathic Manipulative Medicine (OMT) as well as battlefield acupuncture (BFA), and offer these modalities to patients whenever possible. Recently, I had a clinic encounter that both challenged and inspired me. The patient, accompanied by her husband, was wearing a back brace, and made slow, cautious movements when walking and getting up to the exam table. She explained that she had surgery several months ago for bulging discs in her lumbar spine and had a hard time getting an appointment with Physical Therapy. Her surgeon had prescribed her a combination of long and short-acting narcotics as well as Lyrica, which she had been taking reluctantly. Through tears, this patient explained to me that she was afraid of becoming dependent on these medications and felt as though she was "in a fog" while taking them, but did not know of any other options. After a lengthy discussion, I switched her to Cymbalta, made a plan to slowly taper the opioids, and set her up with OMT and BFA sessions with me every 2-3 weeks. She came to me two weeks later for a follow-up and looked like a revived version of herself. She was ecstatic to tell me that she had quit taking her opioids and felt significant improvement in pain with the medication switch and after just one treatment with OMT and BFA. I have been seeing her regularly for maintenance adjustments for the past two months; and each time she has more range of motion and improved mood. She has been faithfully seeing PT in between our appointments and has started a regular exercise regimen. This patient remains one of the most positive encounters I have had so far throughout my short time as a Family Medicine Physician.

Recently, I have teamed up with several of my colleagues trained in Integrative Medicine, Osteopathic Medicine, and pain management to create a mini-curriculum of OMT, yoga/meditation, acupressure, and nutrition. Over the past few months, we have brought this course to Fort Belvoir Community Hospital providers and addiction medicine patients as well as providers at the National Intrepid Center of Excellence at a recent Pain Management Symposium. Through this program our vision is to empower patients to optimal health of their mind, body and spirit through self-care modalities. Integrative medicine is a developing field and can truly improve the way we approach medicine with our patients. These modalities have been shown to help patients struggling with addiction, PTSD, depression, anxiety, chronic pain, and a host of other ailments. We will be bringing our CAM workshop to the USAFP Conference in March and hope to see many of you there.

Another important aspect of partnering with patients to promote health and wellness is through physical fitness. Personally, endurance running, triathlons, and yoga have provided avenues for personal development in areas outside of academia, social venues with like-minded individuals, and team camaraderie. One group in particular that I found upon moving to DC is Team Red, White, and Blue (RWB): a national organization with the mission statement to "enrich the lives of America's veterans by connecting them to their community through physical and social activity." They provide weekly social events, running meetups, yoga classes, and an enormous amount of support at local races. Team RWB is free for active duty military, veterans, and civilians to join. Over the past two years, I have introduced many colleagues as well as patients to this organization, which has helped them connect to the local community and promote their health through fitness and social events. Health and fitness are important aspects of the Health is Primary campaign, and hopefully this mindset can help improve the way we approach medicine with our patients.

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Harnessing the Power of Wearable Technology for Healthy Behavior Change

Sometimes our patients can teach us a thing or two. Recently one of my patients (let's call him Bob) returned to the Family Medicine clinic having lost 20lbs over the past two months. When I asked him how he did it, he extended his arm and revealed a black wrist bracelet. "FitBit!," he exclaimed. Bob went on to show me with incredible enthusiasm how he tracked his daily steps, calories burned, stairs climbed, heart rate, and also sleep duration. Even more intriguing for the data junkies amongst us (like me), Bob demonstrated how his bracelet instantly transmitted all his metrics wirelessly to a fitness application on his iPhone, where he could see weeks and weeks of results. Nearing the end of our twenty minute appointment, Bob continued to show me even his graphical trends and an award won against his brother for most stairs climbed in the past week.

I knew that so called "wearable technology" had been around for years, but this was my first encounter where I had seen real results…and utilizing a competitive angle. This competition could be personal or with many others through mobile sharing, social media, and cloud technology. There is some research out there that examines wearable technology's utility in healthy behavior change and reduction in BMI. A meta-analysis in 2012 showed at least in the short term, mobile or wearable digital devices appear to help people exercise more and lose weight.[1] The research concluded that more research is needed to find out if people stick to their goals in the long term. The advances in wearable technology over the past three years have been profound. Now with improved smartphone apps, mobile sharing, sleep polysomnography, and wrist heartrate technology, the amount of feedback we can get from our daily behavior is astounding. Just this month in the American Journal of Preventive Medicine, a randomized trial comparing FitBit to the standard pedometer showed a statistically significant increase in physical activity duration in the FitBit group.[2]

It finally donned on me with my encounter with Bob that we have reached an affordable price point for a fun ever present "coach" that can assist many of our chronic disease patients in achieving healthy weight loss, reducing their medication load, and most importantly improving mortality rates and quality of life. I was so intrigued that right after work that day I sped to my nearest electronics store and picked up a FITBIT for myself. Even as an avid marathoner and Ironman triathlete, I admit that after several weeks using it I am hooked. The greatest benefits I get from my FitBit are tracking how much sleep I am getting throughout the week, my resting heart rate as an indicator of increased stress, and total active minutes throughout the day. Now several of my colleagues (and patients) are competing virtually each day on how many steps we take.

This advance in technology; allowing competition and personal involvement in health behavior needs to be recognized by primary providers for its utility. There are numerous wearable technologies out there, and I in no way am advocating for one over the other. I am just highlighting my patient encounter of enlightenment and bringing it to the attention of other uniformed Family Physicians. The constant lecture we give our patients about "diet and exercise" often leads to eyes glazing over. Well fear not! Affordable wearable technology has given physicians a way to make the subject of 'healthy lifestyle behavior change' more interesting, exciting, and most importantly personal. Just as video games can lead to a tenacious focus of mind and will – wearable and sharable technology is helping our patients take increasing ownership of their behaviors based on continuous feedback, competition, goals, and motivating notifications. So next time you see a patient who needs to up their activity level and lose some weight, flash your sporty bracelet and encourage them to make a bit of a fitness purchase. It works! It's fun!

REFERENCES:
[1]Bacigalupo R, Cudd P, Littlewood C, et al. Interventions employing mobile technology for overweight and obesity: An early systematic review of randomized controlled trials. Obesity Reviews. 2012; 14: 279-291
[2]Cadmus-Bertram L, Marcus B, Patterson R, et al. Randomized Trial of a Fitbit-Based Physical Activity Intervention Am J Prev Med. 2015 Sep;49(3):414-8

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CONTACT: **Dr Patrick Lynch**
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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 winter magazine is 20 December 2015.

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...
James Ellzy, MD
ellzyj@gmail.com

Timothy L. Switaj, M.D., FAAFP
AMEDD Center and School
timothy.l.switaj.mil@mail.mil

If Disney Ran Your Hospital: 9½ Things You Would Do Differently

by Fred Lee

No doubt you or someone in your family has had the pleasure of partaking of the Disney experience. It might have been at a theme park, on a Disney cruise ship, or peripherally through Disney's television networks and stores. Disney has built its reputation as a premier customer service organization through the visitor experience. Routinely, their cast members go beyond mere satisfaction to provide an unbeatable and memorable vacation inspiring the loyalty of their guests. Disney's premier customer satisfaction and experience reputation has led to the creation of the Disney Institute which trains people, teams, groups, and companies in the Disney way. In 2004, Fred Lee, a former Disney Executive, published the book *If Disney Ran Your Hospital: 9½ Things You Would Do Differently* to provide healthcare managers with insights to improve the patient experience, the Disney way. He sought to take some of the key concepts that Disney managers use to create their culture and apply them to the healthcare setting. With Disney it is all about the culture…creating a management led culture to provide a premier guest experience. Despite being more than a decade old, many of the principles are still very valid and integrate well with our move towards High Reliability and drive to provide the premier patient experience.

CHAPTER	CONCEPT
1	Redefine Your Competition and Focus on What Can't be Measured (the ½ concept)
2	Make Courtesy More Important Than Efficiency
3	Regard Patient Satisfaction as Fool's Gold
4	Measure to Improve, Not to Impress
5	Decentralize the Authority to Say Yes
6	Change the Concept of Work from Service to Theater
7	Harness the Motivating Power of Imagination
8	Create a Climate of Dissatisfaction
9	Cease Using Competitive Monetary Rewards to Motivate People
10	Close the Gap Between Knowing and Doing

Within the book there are 10 concepts, prevalent in the Disney mindset, which Fred Lee exports to the healthcare setting.

In my career I have seen the use of several of these concepts for the betterment of our beneficiaries. While all of these concepts have things to teach us, I will focus on a select few which are applicable to our current landscape in the Military Health System (MHS) initiatives.

REDEFINE YOUR COMPETITION AND FOCUS ON WHAT CAN'T BE MEASURED

In order to truly understand satisfaction you need to understand the drivers of satisfaction. Studies have repeatedly shown that key facets such as teamwork, keeping the patient informed, friendliness, responding to patients in a reasonable time, talking to patients in terms they understand, and care and compassion are the most critical drivers of satisfaction. Many of these are based on a patient's perception. Perceptions can be difficult to manage, even more so than outcomes, yet both are important in building satisfaction and require very different skill sets. Perceptions are based primarily on one-to-one interactions with staff members. A culture needs to be instilled within healthcare that allows for the interactions necessary to create the perceptions we desire from our patients. Not infrequently, management will be told of poor perceptions through complaints. But when we focus on complaints, we are merely responding to issues that have already happened. We may be able to mitigate the situation but we cannot go back and correct the perception. Managers should look beyond the complaints, to the perceptions being created by their staff within those one-to-one interactions with patients. They would benefit from ensuring the culture necessary to create desired perceptions for our patients regardless of whether or not there are complaints.

MAKE COURTESY MORE IMPORTANT THAN EFFICIENCY

In order to truly be efficient, we need to break down the barriers between Departments, promote inter-departmental communication and cooperation, and build a culture of teamwork

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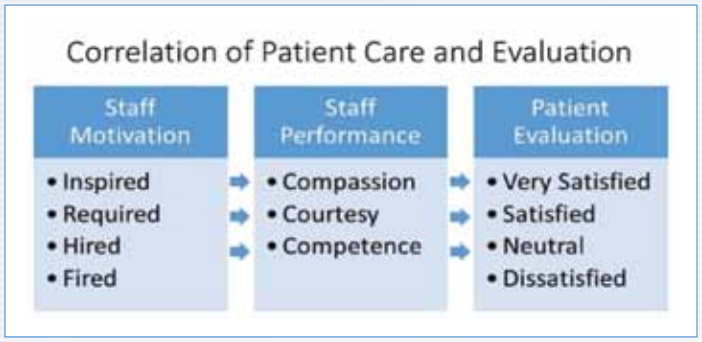
focused on courtesy and service. When management creates a culture of courtesy above all else, barriers between departments fall, teamwork emerges, and efficiency results. Fred Lee says, "Accountabilities drive structure and structure drives culture." He encourages healthcare managers to ensure that the culture of courtesy is the root upon which their organization is built and to see through the phony efficiency created when silos and interdepartmental barriers exist.

REGARD PATIENT SATISFACTION AS FOOL'S GOLD

Satisfaction is important but is it more important for our patients to be satisfied or to be loyal? Fred Lee argues that the true measure of your success in the patient experience is through patient loyalty. It only takes one memorable experience to create a story. A patient who had everything go as expected with no memorable event has no story to share. Those of us who have been to a Disney park likely remember a specific event or instance that created a memorable event…the story. These events and stories are the basis for loyalty. Healthcare managers need to create a culture which allows their staff the freedom and power to create these memorable experiences…the patient's story. Many cite three factors to create a memorable experience and loyalty: competence, courtesy, and compassion. It is the latter two that drive true satisfaction with compassion being the key driver more than the others.



DECENTRALIZE THE AUTHORITY TO SAY YES

This concept is the one that I have personally seen have the most impact in improving patient perceptions, the patient experience, and building patient loyalty. It can however be a difficult concept for many mangers to grasp since it takes away some of their own decision-making authority. Studies have shown that in healthcare, the barriers to allowing staff members at all levels to say "Yes" comes from middle management, not first-line supervisors or senior managers. Fred Lee says, "It is not possible to create a world-class service culture as long as we keep structures that are defined by layers of bureaucracy and departmental barriers to speed and responsiveness." The sooner we resolve a situation, the better for the patient and the organization. In order to achieve this effect, our staff, at all levels, needs to be empowered to fix patient situations in the moment they occur. This level of empowerment can only be achieved through an organizational cultural shift, one that is necessary with today's empowered patients.

CREATE A CLIMATE OF DISSATISFACTION

True change and improvement is driven by dissatisfaction. We are all bombarded with metrics on a regular basis. These metrics create dissatisfaction in the level of current performance and motivate us to improve through initiative and change. Dissatisfaction is not that dissimilar from the high reliability concept of preoccupation with failure. Preoccupation with failure tells us to expect that things will go wrong and try to identify the *what* and *how* of those failures in order to target your improvement strategies and effect change. With dissatisfaction, we are doing the same thing but more qualitatively, and in this context, more in line with the patient experience. By identifying areas of dissatisfaction amongst patients and/or staff, we can identify where we need to improve and target improvement strategies to effect change. As we do with our quantitative quality measures, we should use our qualitative dissatisfaction to target areas for improvement in the overall patient experience.

CONCLUSION

Many of the concepts within this book lend themselves to current initiatives within the MHS. The theme throughout the book is the need to create a culture of respect, trust, compassion, and empathy for our patients and staff. This is not dissimilar from what is necessary to be a High Reliability Organization. The APLSS survey already has questions about courtesy, trust, and loyalty, but we tend to pay more attention to the individual satisfaction questions. At least within our Military Treatment Facilities, we need to pay more attention to these questions. It can only help us on our journey to High Reliability and creating a premier patient experience.

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USAFP Resident Board Member Jason Butler, DO Appointed Delegate to the AMA

USAFP Member and Army Resident Board Representative Jason Butler, DO has been appointed to represent the American Academy of Family Physicians (AAFP) as a delegate to the American Medical Association Resident Fellow Section. He was nominated by the USAFP and his appointment was recommended by the AAFP Commission on Education. Dr. Butler will represent the AAFP at the AMA beginning with the Interim Meeting in November and his terms ends fall of 2016. Congratulations Dr. Butler!

Don't Miss Out on Complimentary USAFP Membership Benefits

DAILY INFOPOEMS

The USAFP is pleased to continue providing as a membership benefit a free subscription to Daily POEMs from Essential Evidence Plus. Daily POEMs (Patient Oriented Evidence that Matters) alerts and 3,000+ archived POEMs help you stay abreast of the latest and most relevant medical literature. Delivered directly to you by e-mail every Monday through Friday, Daily POEMs identify the most valid, relevant research that may change the way you practice. Monthly, the complete set is compiled and sent for additional summary review. Ongoing since 1996, their editors now review more than 1,200 studies monthly from more than 100 medical journals, presenting only the best and most relevant as POEMs. The acclaimed POEMs process applies specific criteria for validity and relevance to clinical practice. If you want to subscribe, please e-mail the USAFP at *cmodesto@vafp.org* so your e-mail address can be added to the distribution list.

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The USAFP is pleased to provide as a membership benefit continued access to Audio Digest MP3 files in the area of Family Medicine, Pediatrics and OB/Gyn.

For those not familiar with Audio-Digest, they produce over 300 audio CME/CE programs each year. These programs are derived from lectures recorded at more than 285 CME/CE meetings across the country, always with permission of the sponsoring organizations and the lecturers involved. The objective of Audio-Digest CME/CE activities is to update healthcare professionals on advances in the diagnosis and management of medical disorders. The primary goal of each activity is to provide practical information that will improve professional competence in caring for patients.

The USAFP has an institutional subscription which allows our members to access the MP3 files in Family Medicine, Pediatrics and OB free of charge. If you are interested in obtaining CME for the modules, please call Audio-Digest at (800) 423-2308 and they can assist you with the paid subscription of your choice.

To access please email *cmodesto@vafp.org*.

STFM TEACHING RESOURCES

The USAFP provides a complimentary subscription for USAFP members to the Society of Teachers of Family Medicine "Teaching Physician" online resource! The site offers videos, tips, answers to frequently asked questions, and links to in-depth information on teaching topics, such as:

- Preparing your practice team for a learner
- Integrating a learner into office routines
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This will help ALL USAFP members teach medics, PA's, NP's, medical students, residents and each other and provides you with quick answers to questions that arise during your daily interaction with learners. You can also earn up to 40.5 CME credits by reviewing the information on the site! If you are interested in receiving a log-in and password to access these resources, please e-mail *cmodesto@vafp.org* or call the USAFP Headquarters Office at 1-804-968-4436.

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STAFFING UPDATE

The USAFP Headquarters Office welcomes Kristi W. Reynolds as Director, Medical Education and Events.

USAFP Academy Awards

Please take the time to nominate one of your fellow family physicians for one of the prestigious awards noted below.

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 physician and the contributions made by family physicians to the continuing health of the people in the Uniformed Services.

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.

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.

To nominate your peers for either of these outstanding awards, please send a letter of support to Matt Schulte (mschulte@vafp.org). **The deadline is 25 January 2016.**

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- Established hospitalist program to assist with admissions and inpatient management
- Salary guarantee and comprehensive benefits package
- Productivity incentive opportunities
- Annual CME allowance
- Relocation assistance.

For immediate consideration please contact:

Tamie Bradbury, Physician Recruitment
509-221-5980
tamie.bradbury@trioshealth.org

About Trios Health

Trios Health is the Kennewick Public Hospital District's system of care serving the greater Tri-Cities. The District operates two hospitals to accommodate the area's fast-growing population: Trios Women's and Children's Hospital and Trios Southridge Hospital—a new, state-of-the-art facility that opened in July 2014.

Trios Medical Group, comprised of over 100 employed physicians and providers, serves as the core of a growing medical staff network of 300+ providers throughout the Tri-Cities and includes practices and services at nine Care Centers and four Urgent Care Centers.

For more information about Trios Health, visit our website: trioshealth.org.

Lifestyle in the Tri-Cities

The Tri-Cities region is situated at the confluence of the Columbia, Snake, and Yakima Rivers in southeastern Washington. With over 300 sunny days a year, we are home to endless recreational opportunities including water sports, hunting, fishing, golfing, and 3 professional sports teams. We are a thriving suburban community with easy access to major metropolitan areas of the Pacific Northwest, including Seattle, Spokane, and Portland.

Excellent education systems, affordable housing, cultural arts and entertainment, and a variety of outdoor activities all combine to make the Tri-Cities a rich, vibrant community.

The Uniformed Services Academy of Family Physicians
1503 Santa Rosa Road, Suite 207
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www.usafp.org

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