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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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Focus Forward

Uniformed family medicine is seriously challenging, yet one second in this noble profession, even on dire days, is a profound honor. I believe legions would give anything to be a physician *or* an officer for just one moment. And yet, we get to serve as both every day! I don't know what universe makes a guy like me president of anything unless it is because of my absolutely amazing family and associations with you. It is astonishing to consider the breadth and depth of what our 3000+ members do. And yet, a number have indicated they feel distressed in some ways and wonder about their past, present and futures in military medicine and life. Despite facing daunting challenges, I feel optimistic about our collective ability to flourish. You might ask, "How can we flourish with all we face as uniformed family physicians?" I believe we can do so by focusing forward by attending to daily patterns, noting sources of happiness, and studying successful role models.

WEAVING FOCUS FOUNDATIONS INTO DAILY PATTERNS

Consider for a moment what brought you to this point in your life. Did your daily patterns get you where you are or are you here as a result of something entirely external? I suspect you had a few foundational ways of thought and action that allowed you to endure difficult times and successes. Is your present state one of happiness or do you feel miserable? Are you following foundational patterns that aided you through past difficulties? Might this be a time to self-reflect on your patterns and adjust?

It is my opinion that happily maneuvering through college, medical school, residency, staff, faculty, uniformed family medicine, and life requires daily, disciplined pursuit of deliberate patterns of excellence. I believe successfully doing small and simple things well can yield lasting happiness and fulfillment—rather than having to rely on big moments that sometimes crowd our attention. When big moments fade, our recurring patterns of life determine our happiness. Examples of deliberate daily patterns for small, sustained successes could include rising early, devoting time for professional growth or for self-improvement study, examining one's relationships, ensuring regular exercise and rest, conducting spiritual devotions, and practicing goal setting. I think of these recurring practices as "focus foundations." I propose happiness and resilience are built from regularly returning to focus foundations and realizing these are more important to our happiness than external forces or situations. I know of no oath, certificate, command, degree, position or title that assures happiness. Some of the happiest people have no certificates and many unhappy souls have reams of them. Success and happiness seem to be proportional to daily foundational patterns.

WHAT MAKES YOU HAPPY?

Sometimes we backslide from our focus foundations and lose our ability to focus forward. This can cause unhappiness or cause our happiness to be dependent upon some external entity when, really, our happiness could come from within. In reality, we control our patterns, our happiness, and our forward focus. Think of the happiest people you know. Are they happy because of external items, situations, or forces or do they choose to live happily through maintaining focused foundational patterns? Could we be happier by renewing our best personal focus foundations and cultivating or returning to them?

Sometimes, I wonder if success is an addiction, one that we mistakenly believe will bring us happiness. Does external validation through certificates, rank, status, paychecks, followers, or titles bring happiness, or does happiness lie with regular completion of small and simple things in life? I

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believe it is the latter. Candidly, the unhappy moments in my life have come when I was lax in keeping my own focus foundations. Conversely, no matter the challenges, focused foundational patterns sustained me when other things failed. Might we focus forward through returning to these foundations? Might we find happiness by making much needed adjustments in our patterns of being? I invite you to consider this alongside me.

FOLLOW ROLE MODELS

But what if we don't know where to start? Perhaps a study of role models can aid us? I have always loved studying what truly great humans have done when facing their most difficult times. What I have taken from my study is that every single noble and great human I have ever read about maintained focus foundations despite profound external challenges. It occurs to me that those who maintained focus foundations enjoyed lasting happiness before and after external successes came and went. Patterns sustained those remarkably resilient ones when money was low, debts were high, tragedy struck, or monumental changes happened. Some have written personal foundational habits of conduct,[1, 2] while others have suggested focusing on doing small, simple and satisfying things that lead to happiness.[3] Some of the most effective lessons come from studying how great people actually live. Might we more closely study daily habits kept by those possessing great peace and happiness?

Thank you for working so very hard every day, making the world a safer place through honoring your 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. My friends, thank you for being willing to make the ultimate house calls by treating our patients and their families at home and abroad, in war or peace. I want you to know that you inspire me to be a better physician and human and that I try daily to measure up. You help me to keep my own personal focus foundations and hopefully I have helped you to do so. May we always keep personal focus foundations and help others to do the same. I humbly offer these thoughts with my very best wishes and hope for excellent health, safety and forward focus for you and your families.

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Beyond

GREETINGS, FRIENDS!

Welcome to this summer edition of the Uniformed Family Physician. As with the last issue, you have a wealth of knowledge to peruse between the front and back cover.

Since this issue is a little slimmer, I'll leave you to discover those contents yourself. What I'd like to do is share some of the opportunities that I and my colleagues have utilized to develop ourselves as academic, research, and executive leaders outside the strict boundaries of the USAFP and the military professional development pipeline (that is, the job-related positions you take, schooling you pursue, and collateral obligations you execute; I'll only touch on those a little bit).

Consider this a road map (incomplete as it is) for finding additional successes beyond the responsibilities that you faithfully execute every day in service to our Nation. You may be operating on full band width already—in which case feel free to skim this article and file it for future reference. You may be pre-contemplative, thinking, "Can I take on more?" You'll receive no urging here—you know where you are on your life's journey and how best to parcel out your time. And some of you might be looking for new venues to showcase your talents for the benefits of others. If you have read this far, then I encourage you—read on!

ACADEMIC LEADERSHIP

For many, our first foray into academic leadership begins with the one-on-one teaching we provide to peers as students and residents. From there, we go on to lead study groups, give talks to our fellow learners at morning report or grand rounds, and then are foisted upon an unsuspecting public as attendings. We go on to continue to teach our peers, our medics/corpsmen/medical technicians, our fellow clinicians and, as always, our patients.

So, by definition, you have been, and will continue to be, an academic leader. Congratulations!

If you are looking to do more, you might consider seeking an assignment to one of our residency training programs, or perhaps a fellowship—like sports medicine, or women's health, or even a faculty development one like the one offered by Madigan, or the University of North Carolina, or Stanford—to learn new skills to impart to medical learners. I won't speak more of this—you likely already know your options.

An additional way to grow as an academic leader is to help others accumulate medical knowledge as a presenter at local, regional, national, and international conferences. There are a host of places (reputable ones—do not answer those emails asking you to be the main stage presenter for the International Society of Gynaecology meeting in Riga) that will allow you to build out your portfolio and serve others by teaching. Certainly, give back to the USAFP. If you are a student or resident, consider presenting at the AAFP National Conference in Kansas City. Likewise, consider presenting at the AAFP Family Medicine Experience. Other venues that welcome students include the Society of Teachers of Family Medicine and the World Organization of National Colleges, Academies and Academic Associations of General Practitioners/Family Physicians (WONCA, for short). Many of these venues accept poster proposals (a nice gateway into teaching), and some have opportunities for stage presentations. And if you are a resident or student, you might find it a bit easier to break into the circuit if you pair up with a faculty mentor. Many of us who currently speak at these societies likewise had a sponsor when we started.

As you make your way to attending-hood, you'll find that the opportunities for teaching grow rapidly. You'll be growing junior military medical learners by leading rounds, lecturing, and giving formal presentations; it will be easiest to do this if you are in a residency program, but you'll also have many opportunities to teach if you are serving in an operational billet, in a non-training clinic or hospital, or in an administrative capacity. As an attending, you'll have increased success in having proposals accepted for speaking engagements at the aforementioned venues. You will also have more success in submitting articles for publication. If you are interested in becoming a published author, you'll be happy to know that almost every issue of the American Family Physician has at least one article or department written by a military family physician—the AFP is a great place to start. Within our chapter, or previously associated with our chapter, you have Mike Arnold, Chris Bunt, Dean Seehusen, and me as members of the AFP editorial board; all of us are happy to help you jumpstart your AFP writing career. You might also consider some of the other journals that family physicians use to keep abreast of the specialty. If you have a good practice tip you might consider Family Practice Management, or you might consider writing a review article for the Canadian Family Physician or the Journal of

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Family Practice. Of course, you are always welcome to submit to the Uniformed Family Physician!

Another way to take a deep dive into the world of educational leadership is to get an academic appointment with the institutions that send learners your way. Do you have students from a local (or remote) medical or osteopathic school shadow you in practice? Then you really deserve to have an academic appointment as one of their faculty. Do you teach physician assistant students or nurse practitioner students? Their sponsoring institution should likewise appoint you. Do you teach USUHS learners? Then you really should have a USUHS faculty appointment—you may find out how at this page: https://www.usuhs.edu/fam/faculty-promotions. A nice guideline for what is expected of an appointed faculty and what allows one to promote to associate or even full professor is the USU Instruction "SOM Policies for the Academic Administration of the Faculty," also known as Instruction 1100. It is hosted behind the USU firewall, but if you would like a copy (i.e. if you have made it this far in the article), send me an email.

And if you want to grow your portfolio by learning at the feet of others, consider making your way to a healthcare educator's course. Multiple medical institutions host these, and sometimes your Service will pay for your training. On the other hand, if you are looking for a no-cost option (yet a high quality one), you might consider USU's Graduate Programs in Health Professions Education at https://www.usuhs.edu/hpe.

RESEARCH LEADERSHIP

My personal opinion is that leadership in research goes to the person willing to stick it out the longest. If it was easy, they would call it "search." Instead, when trying to discover something new, you must look for that thing over and over and over again. That is why it's called "re-search." As with academics, though, there are many opportunities to become a leader in this field.

As a student and resident, you likely had a research requirement. And some of you may not have hated it—that's good. I'd like to submit, however, that research is for everyone. Not necessarily the hunched over the counter basic science type of research (although that is good for some!), but the research that takes uncertainty and makes it known—like when you answer a clinical question. That is research. Anytime you fill in the gaps for yourself and others, that is research. From Family Physicians Inquiries Network Help Desk Answers, case reports, case series, and poster presentations on the one hand to participation in a major randomized, blinded, clinical trial or network study, research takes many forms.

So where to start? No matter your level, please consider submitting your research to the USAFP. Your chapter has a vested interest in developing your talent. The Clinical Investigations Committee even offers mentorship. Also consider your institution's research day if they have one—this is a low barrier-to-entry way to get your scholarly activity in front of other people and to make some connections for yourself. Also consider the Military Health System Research Symposium—they offer opportunities for both poster and oral presentations.

When you are ready to disseminate beyond the military community, consider again the AAFP's Family Medicine Experience and National Conference, the STFM, and the North American Primary Care Research Group (also in the business of mentoring junior learners). You might also branch beyond family medicine, depending on the nature of your studies; you might aim to present at sports medicine conferences, global health conferences, women's health conferences, academic medicine conferences, or more.

Of course, presenting a poster or oral discussion is for those with completed research. You may be wondering how to dip your toe in, or back into, the research world. Like I mentioned before, the USAFP may be a good start; you could initiate your own project with the mentorship of a research judge, or you might jump onto a project in progress—like those generated by the omnibus survey. You might also check out the Military Primary Care Research Network (https://www.usuhs.edu/mpcrn), hosted by the USU Department of Family Medicine. The MPCRN offers opportunities to lead studies or to participate in ongoing studies as a local champion. You don't need to be a USU graduate to utilize the MPCRN—it is definitely worth checking out!

Another way to get into the world of scholarly activity is to volunteer for your facility's Institutional Review Board—talk about drinking from the fire hose! You'll learn a lot about research in a little time (do make sure you have the bandwidth to take this on—it is usually time intensive).

And as for publishing, we have an embarrassment of high-quality journals dedicated to publishing family medicine and primary care original research, like Family Medicine, the Annals of Family Medicine, and the Journal of the American Board of Family Medicine. There are also places where you can publish the curricula and educational interventions you create: https://www.mededportal.org/ and https://resourcelibrary.stfm.org/home. Both are repositories for your educational accomplishments.

Honestly, I don't think anyone just wakes up one day and decides to take on a major research project without any mentorship or previous experience. Everyone starts somewhere, so my best piece of advice is that if you want to do research, find someone who is already doing research and ask them to show you the ropes. We are family physicians—when was the last time any of us said "no" to mentoring someone?

EXECUTIVE LEADERSHIP

I have to be honest with you—I am not the best person to tell you the secrets of making flag officer rank in the military. If that is your desire, we have some fantastic

chapter members who could do a far better job. I won't name them here (because I would inadvertently omit someone), but I think you know who they are.

That said, I do have some ideas that you might consider if you wish to grow your executive leadership talents outside the normal military medical progression. Even as students and residents, you are taking on additional responsibilities for the welfare of others; as the scope of that responsibility grows to encompass ever larger numbers of people, you step into the realm of executive leadership.

Like a broken record, I'll circle back to the USAFP—if you are looking to expand the scope of your impact beyond your institution's walls, you don't need to look further. Serve as a committee chair, allow yourself to be nominated as a director (student, resident, Service), take on responsibilities for programming—these are all ways to grow your portfolio.

Likewise, I'll circle back to the AAFP. As a student, you have an opportunity to lead at a local level FMIG, but you also have an opportunity to take on a national level position, like regional coordinator, or even national coordinator. Residents also have opportunities to lead with the AAFP through National Conference and, along with students and practicing physicians, on the AAFP's Commissions—the bodies that help the AAFP direct national policy, review literature for the benefit of the health of the public, and advocate for family medicine with other national and international organizations. As a student, resident, or practicing physician, your USAFP nominating committee is the organization that can help you plug into these national opportunities.

In addition, you can look to the other family medicine organizations like STFM and the American Board of Family Medicine for opportunities to serve. And, of course, there are opportunities to lead beyond family medicine, like with the American Medical Association, the Association of American Medical Colleges, the National Hispanic Medical Association, the American Medical Women's Association, and the National Medical Association. Most of the times, the opportunity to lead goes to the person who shows interest, shows up, and shows a willingness to work.

CONCLUSION

Friends, this is approaching 2,000 words, and I'm not sure how many of you have read this far. For the erstwhile ones who have, feel free to use me as a resource to help you find opportunities to grow as an academician, researcher, and executive. And if you made it to this very last sentence, look me up next time you are in San Antonio and we'll grab a frosty beverage together.

Cheers,
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consultant's report
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My family's new hobby is sailing. When you are sailing, you cannot control the wind, but you can adjust your sails. This past year, we most definitely have been adjusting our sails as new guidance comes out in the form of memoranda for record (MFR), Defense Health Agency procedural instructions (DHA-PI), and concept of operations plans (CONPLANS). Last fall, I introduced my four focus areas as your consultant: innovation and information technology, physician leadership, retention, and readiness. As I enter into my second year, I would like to sail through what has happened on these four fronts over the past 12 months.

INNOVATION AND INFORMATION TECHNOLOGY

As you may have heard, the Veterans Health Administration will be transitioning from Vista to the Cerner electronic health record with plans to go live in three Pacific Northwest facilities next year. Once the Veterans Administration (VA) and DoD are on the same platform, medical recordkeeping will be streamlined and interoperable throughout the continuum of a service member's life. In July, I returned from a combined Cerner workshop with VA physicians. I was able to refresh my memory on the functionality of the Cerner platform and how to use the workflows. While it has been two years since I used the system at Fairchild, I remembered how much I preferred documenting in MHS GENESIS and appreciated the improved medication reconciliation and integrated secure messaging features! I look forward to hearing from those of you at Travis, McClellan, and Mountain Home who will be going live with MHS GENESIS later this year.

My aspiration to have my own Alexa in the exam room with me, scribing and ordering the latest evidence-based medications, laboratory or radiological studies is likely still years away. However, new ways to query and visualize medical data here at Air Force Medical Readiness Agency (AFMRA) Analytics has gone prime-time with the Comprehensive Medical Readiness Program (CMRP) task analysis dashboard. This dashboard takes information out of the Medical Readiness Decision Support System (MRDSS) and displays it in an interactive platform which can provide information about CMRP completion at a variety of levels (Air Force Medical Service, Major Command, Military Treatment Facility, or single Air Force Specialty Code or person). If you are the functional manager for 44F3 CMRP at your Medical Group, please call me! Let's talk about the upcoming changes and walk through this dashboard. Please also visit the RACE website on the knowledge exchange, https://kx.health.mil/kj/kx4/SGConsultants/Pages/RACE.aspx, and click on the CMRP task analysis tool for more information.

The newest dashboard, called the Manpower Common Operating Picture (MCOP), is still under development. It pulls data from our timecard system (Defense Medical Human Resource System internet, or DMHRSi), the squadron unit manning document, and encounter volume based on the Medical Expense Performance Reporting System (MEPRS), and coding data into an interactive platform where you can see how your lack of having two medical technicians for two months really impacted your productivity. It will capture and quantify the activities that take us out of face to face clinical time like readiness training, Airman Medical Readiness Optimization (AMRO), and deployments. The analytics team is working with the Air Force Medical Home Branch here at AFMRA to roll this out for testing and validation. Like I briefed at USAFP, while our family medicine, 44F3, manning is 94%, this is not really a true picture of *availability*. This will be a powerful tool to help tell our story to senior leaders as to what is really happening in the clinics.

PHYSICIAN LEADERSHIP

"Leaders are called to stand in that lonely place between the *no longer* and the *not yet* and intentionally make decisions that will... create history."[1] You are a physician leader at this very moment. While there is guidance in the form of MFRs, CONPLANs, and DHA-PIs, you are part of the "in-between" and how you lead your Air Force Medical Home (AFMH) team will set the tone and tempo for the future! We know the WHY (readiness) and the WHAT (Operational Medical Readiness Squadron, Healthcare Operations Squadron, Airman Medical Readiness Optimization [AMRO]), but you must influence the HOW by speaking up and providing input to your Chief of Medical Staff (SGH), Aerospace Medicine Chief (SGP), and Flight and Squadron Commanders. As the physician on the team, you are the medical authority, so make sure your practices are evidence-based and, if you have concerns, speak up!

During his first AFMRA Commander's Call, Brigadier General Koeniger said that our senior leaders are relying on us to "put things in front of them." That is, we need to provide feedback on what is working and what is not working because we are all treading in "uncharted territory" right now. If you are uncertain, please call us here at AFMRA, as we are your consultants! Call me directly as your consultant or call my new team, the Air Force Medical Home Branch--they are an amazing multidisciplinary group of knowledgeable people who are here for you. If you are a

Medical Director, you need to be dialing into the AFMH Monthly teleconference with your SGH for the latest information! If you need dial information, please visit the AFMH kx site: https://kx.health.mil/kj/kx4/PCMH/Pages/home.aspx.

RETENTION

Leading through change can be difficult and some of you have called me ready to jump ship. Does the reorganization mean "I will be limited to only seeing a certain type of patient and lose my skills?" I would like to point out that, over the past ten years, we have already undergone a reduction in our scope of care due to the overwhelming amount of work we are being asked to do every day. By dividing our work type and focusing our workflows, we should see improved efficiency with the goal of returning to a more fulfilling daily practice. Like I mentioned in my previous article, burnout is a misnomer, what we are facing is moral injury. No amount of Wingman Down days, resilience training, or free popcorn will change our feelings about the amount of work we are expected to do every day.

"Moral Injury locates the source of the distress external to the physician and within the business framework of healthcare itself."[2] To overcome this, we must overhaul the structure of our healthcare system and the way we work—the reorganization is doing just that. In fact, this month I spoke with one physician whose MTF had already divided their panels between Active Duty and beneficiary care. She was assigned a beneficiary care panel and has enjoyed more time to do procedures and overall greater satisfaction with her job—so much so, she has gone from counting down the days until separation to reaching out to me to discuss another assignment! I know this is not the case for all of you who have transitioned; there will be growing pains, but the end will be worth it. Please call me and let me know how things are going!

Another concern is to which squadron our family physicians will be assigned. At the time of writing this article, the Medical Squadron Reform Model CONPLAN is not yet published, however, the draft I have seen does not "force" any particular physician into HCOS or OMRS. I encourage you to have a discussion with your Flight Commander, Squadron Commander and SGH and let them know your passion and interests. There are benefits and challenges to being assigned to either squadron/population of patients, and my hope is that the MTF leaders will continue to consider physician professional interests and goals as they assign panels. Additionally, the patient centered medical home continuity requirement is to stay in the position for two years. We were able to include in the draft, for the purposes of maintaining currency for the Ready Medic, that rotating after two years should be a goal. Also of note, there is no change in the deployments process at this time; regardless of which squadron you are assigned to, if you wear the uniform, you will be expected to be ready for deployment in your band.

You have probably read about the military medical cuts in the newspapers. Remember this is referring to authorizations and overall requirements, not individuals. From a family medicine point of view, I can reassure you that if you want to stay in the Air Force, you should have no problem doing so. If you are coming up on four-years' time on station in Summer 2020 or your Active Duty Service Commitment is up in 2020, please call/email me and our assignments officer, Major Brian Scott. We want to hear your plans and let you know what assignments are likely to be available next summer. For those below the rank of O-6, it is also important to log on to MyVector (https://myvector.us.af.mil) and Talent Marketplace (https://www.milsuite.mil/book/groups/afpc-assignments-talent-marketplace) to convey your assignment preferences. I continue to send the message to senior leaders that family medicine is the cornerstone of Air Force Medicine. Instead of cutting our numbers, our authorizations should increase! If you remember the USAFP Winter Newsletter 2019 article about why we wear the uniform, you can see objective evidence that validates our versatility and enduring support to the defense of our country.

READINESS

Speaking of the **Ready Medic**, our updated CMRP is ready to be published soon! It will include and encourage obtaining currency cases as part of **everyday work.** Readiness is not achieved by a simple checklist. For example, you will be expected to have seen (based on ICD-10 codes or CPT codes) a minimum number of acute musculoskeletal cases as part of your daily practice. The same will be expected for women's health diagnoses. The intent is to incentivize the recapture

continued on page 14

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of currency cases at the MTF. Thank you for everyone who has shared downrange case volume by type and coding data with me to help validate these updated requirements! This is a living document so please continue to quantify skills you use in deployed locations to add to our supporting databank. If you think Battlefield Acupuncture should be a CMRP requirement, reach out to me and let me know how you used it in the deployed setting.

The Ready Airman/AMRO guidance was sent out at the end of July. This guidance provides instructions to optimally manage Airmen on mobility restricting profiles with the intent to return them to full duty or enter them into the Disability Evaluation System (DES). AMRO will be implemented to help reach the goal of 95% deployability in the USAF. AMRO applies to all MTFs, even if they have not transitioned to OMRS/HCOS units. The Air Force Medical Service CONPLAN, which will be coming out soon, further explains how this will be executed. Furthermore, DHA has approved an appointment decrement to enable PCMs with active duty patients to fully utilize the AMRO guidance with associated appointment decrements. Starting this process will take a lot of work but we were already doing this work without protected time, so this is a step in the right direction. After a few months of developing battle rhythm, it should be smoother sailing for you.

Thank you again for everything you do every day. As Family Physicians, we have a relationship with our patients that can never be fully understood and appreciated by the healthcare system. What happens in the exam room when our patients open themselves up in conversation, sharing things that they have never told anyone else and seeking our guidance cannot be quantified, predicted, or measured. We have weathered many storms this past year and it has not been easy; please continue to support each other. Our strength comes from our sense of community. Our profession is noble, honorable and special and I am very proud to serve alongside each and every one of you. I wish you Fair Winds and Smooth Seas over the coming months.

1. Mary Lou Anderson, Former Deputy Director, Bureau of Primary Health Care, April 1970.
2. Wendy Dean, Austin Charles Dean, Simon G. Talbot. *Why 'Burnout' is the Wrong Term for Physician Suffering.* Medscape July 23, 2019

OUTPATIENT FAMILY MEDICINE OPPORTUNITIES

SOUTHEASTERN PA COUNTIES

Berks • Chester • Montgomery • Philadelphia

Tower Health is a regional, integrated healthcare system that offers leading-edge compassionate healthcare and wellness services to a population of 2.5 million people across southeastern Pennsylvania. Tower Health has partnered with Drexel University College of Medicine to establish an additional site location for its College of Medicine in West Reading, PA, near Reading Hospital.

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Our network of employed physicians, Tower Health Medical Group, boasts more than 800 primary care and specialty providers in more than 100 locations. We are currently looking for skilled, compassionate **Family Medicine Physicians** to join the Tower Health team.

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Cynthia Fiorito, *Medical Staff Recruitment*
484-628-6737
cynthia.fiorito@towerhealth.org

EOE

TOWER HEALTH
Advancing Health. Transforming Lives.

consultant's report
ARMY

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Greetings fellow Army family physicians and friends. As we finish up another summer permanent change of station cycle, I hope this note finds you, your family, and those important to you doing well. Again, thank you to all those who protected the home front over the summer while a third or so of our team moved. Summer underlap is always challenging, and I know this summer was especially so for many of our organizations as operational requirements increased.

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

READINESS

We have a new Army Chief of Staff, GEN James McConville. In his initial message, he highlights that "winning matters" and "we win by doing the right things, the right way." His priorities are people, readiness, modernization, and reform. I encourage you to read his initial one page message emailed out to the force. A recap of that email's themes may be found here: https://www.army.mil/article/225377/new_chief_of_staff_taking_care_of_people_key_to_winning_the_fight

As you likely have heard, we have an approved plan to accelerate the Defense Health Agency (DHA) transition. All CONUS Military Treatment Facilities (MTFs) will transition to DHA on 1 October 2019. As MG Crosland, our new MC Chief and Army family physician, notes in the July MC Newsletter- "at the MTF levels, the mission remains unchanged; quality care to the most deserving while training the next generation of military physicians." Our senior leaders are asking us to continue providing outstanding patient care (I know you are already doing so in your clinics and hospitals) while building the family medicine officer bench. It's our charge as the leaders on the ground to make sure that our clinicians and teachers have everything they need to accomplish their mission. The DHA transition brings with it a set of challenges; fortunately, we are the right people to meet them head on.

ASSIGNMENTS

We have had an important change for us at Human Resources Command (HRC): CPT Edward Bentz is the new 61H assignment officer. Thank you to MAJ (P) Gloria Elko for her hard work and dedication to get the right people to the right places. She will be staying on at HRC.

HRC has shifted much of the branch specific information to the Assignment Interactive Module (AIM) 2 portal at aim.hrc.army.mil. Check out the 101 video, update your resume, and ask questions. Our individual organizational HR and S1 shops should be engaging the system as well. AIM was an important tool in the most recent assignment process and will continue to be so. The assignment officer and I will continue to engage with people, answer questions, and ensure that we get the right balance of assignments to all stakeholders. The bottom line is that the assignments process is evolving, and I encourage you to engage with the portal and with us so that we can help you manage your Army career.

MTOE assigned personnel (MAP) have made a transition from MEDCOM to HRC. We continue to assess how it is impacting individual Soldiers and organizations. Undoubtedly, it created unanticipated challenges, and we appreciate the comments we have received. Please continue to provide honest feedback and ask questions. While the nuts and bolts of the process have been complicated, confusing, and challenging, I am already personally seeing the benefits of the envisioned end state. Our MAP personnel were integrated into our medical brigade this summer. I

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.

am fortunate to have some really awesome officers, including our great 61H's, assigned to my battalion. They are asking to bring our medics over to the MTF for additional training and really contributing their expertise to our training. Our MAP gained a better understanding of what they need to do in order to be ready should we get the call to deploy. Stewardship is the key moving forward: MTF leaders, department chiefs, MTOE leaders, and command surgeons must engage each other to ensure this.

ARMY MEDICAL DEPARTMENT (AMEDD) AUTHORIZATIONS

AMEDD Leaders have been incredibly transparent as they worked a plan to decrease authorizations of medical personnel across the Service. They were directed to create these courses of action. However, final decisions aren't yet made. As you have likely heard, the potential changes to military medicine gained the interest of Congress. We are essentially in a holding pattern, at least as I write this. As we learn facts, we will share them. Please avoid speculation. You may have heard or seen spreadsheets without context that the authorizations for 61H would decrease. I currently expect the end strength of Army 61H's to steadily increase. We are well below our authorizations, and we are filling many of the AOC non-specific positions: 62B, 61N, 60A, and 05A. So any changes to our authorizations would be to unfilled spaces. The demand for Army family physicians is much higher than we can currently meet. Commanders on the line and in the hospitals consistently request us. There are opportunities to use our skillset everywhere. Keep doing what you do.

CLOSING NOTES:

Congratulations to the too numerous to list Army family physicians selected for promotion, awards, and strategic jobs this summer. Some important dates for upcoming opportunities:

Army GME: 31 Aug is the deadline for submitting PGY-2 and fellowship applications in MODS

AMEDD Senior Service College selection board: 9-13 SEP 19

AMEDD Intermediate Level Education selection board: 11-20 Sep 19

I'll end with another message from MG Crosland in regards to Army Medicine during this period of change:

"You matter. What you do matters. People are alive today because of what you do. Army Medicine will be better tomorrow because of you. Do not lose sight of what matters most-*Why you serve; What you are for; Why you exist; and How you can make it better.*"

Thank you for all you are doing–truly. What you do allows me to brag to our senior medical and Army leadership about how crucial family medicine is to our Warriors and dependents. It's a great day to be an Army family doc! One Team, One Purpose... Conserving the fighting strength since 1775!

Promoting Research in the Military Environment

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

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

Photo Courtesy of U.S. Army

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

consultant's report
CG/PHS

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Greetings from sunny(ish) Seattle! It has been a busy summer thus far. First off, congratulations to all the newly promoted officers in the USPHS! This year, temporary promotion rates to O-4, O-5 and O-6 were 61.5%, 27.5%, and 35.5% respectively. For the medical category specifically, this translated to 23 officers to O-5 and 21 officers to O-6. Historically this year's promotion rates were slightly lower compared to last year's 30% for 0-5 and 40% for 0-6 in 2018. To all those who were promoted, enjoy the moment and celebrate your accomplishment! For those who were not, please reach out to members of the Physician Professional Advisory Committee (PPAC) and mentoring subcommittee for lower quartile counseling and mentorship (co-chairs CDR Fran Abanyie-Bumbo (why6@cdc.gov) and Elissa Meites (dri9@cdc.gov). Additional information can be found at MAX.gov: https://community.max.gov/display/HHS/USPHS+Physician+PAC

SWITCHING GEARS…

A crying, tearless two-month-old with fever of 104.6 that had not eaten in days, was not making wet diapers or stooling, and was not acting normally per his mother. A one year old with severe cerebral palsy supposedly on daily seizure prophylaxis that had not taken his medication in weeks that had multiple seizures while detained. A 23-year-old diaphoretic female in excruciating abdominal pain with fever, nausea, and vomiting with a traumatic retroperitoneal hematoma. A 56-year-old severe diabetic with kidney failure on daily insulin and several other medications with diabetic ketoacidosis and recurrent episodes of syncope. This was a typical day providing care at a detention facility near the Southwest border.

I recently returned from a deployment to El Paso, TX, providing acute, urgent, and emergent care to thousands of migrants, mostly children, ranging from newly born infants to adolescents. We were joined by several other Coasties from around the nation and our PHS brethren. Having been on humanitarian missions to Guatemala and Hurricane Katrina, as well as on a deployment to Afghanistan, I can sadly say the conditions were truly dire.

As many of you have seen in the news, the situation at our southern border continues to deteriorate. In May of this year, border apprehensions reached an unprecedented all-time high of over 140,000 individuals, including 84,000 families and 11,000 minors. This adds to the running total of nearly 700,000 individuals apprehended since January along with a one million asylum case hearing backlog in the immigration courts. These figures on apprehensions are up nearly 400% from the same time in 2018. Most migrants are categorized as OTM or "other than Mexican" coming from the "Northern Triangle" of Central America (Guatemala, Honduras and El Salvador).

A typical day on the border mission would range anywhere from 9-12 hours, seeing over 50-150 people a shift. Ailments included dehydration, common cold, flu, ear infections, skin diseases, sepsis, diabeteic ketoacidosis, and cellulitis. Other unique encounters included care of transgender patients, multiple mental health issues, and chronic conditions associated with geriatric care. To say that the facility and supporting officers were overwhelmed is an understatement. I was very grateful for the opportunity to serve but was truly humbled by the plight of these individuals and families. If you have an opportunity to volunteer your time to this humanitarian mission, I would highly recommend assisting in any way you can by reaching out to your supervisors and liaisons for deployment opportunities.

HAPPENINGS AROUND THE CORPS…

1-USPHS SCIENTIFIC & TRAINING SYMPOSIUM 2019

On May 6, the 54th annual USPHS Scientific and Training Symposium took place in Minneapolis, Minnesota with the theme of "Better Health Through Better Partnerships." Attended by both ADM Brett Giroir and VADM Jerome Adams, the conference focused on leadership in public health through advocacy, education, research, and partnerships. Topics discussed included cultural awareness, deployment readiness, developing and implementing an outward mindset, leadership, and mentoring. Be sure to join your colleagues at the next conference June 15-18, 2020, in Phoenix, AZ!

2-USNS COMFORT

The US Navy Hospital Ship Comfort left Naval Station Norfolk on June 14 to begin its deployment to the Caribbean and South and Central America. In total, they will have 197 credentialed medical professionals on board comprised of PHS, Army, and Navy personnel. During their five-month deployment, they will provide medical support and assistance to Colombia, Costa Rica, Dominican Republic, Ecuador, Grenada, Haiti, Jamaica, Panama, Saint Lucia and St. Kitts and Nevis. Medical teams will work directly alongside host nation medical professionals that are absorbing thousands of Venezuelan migrants and refugees.

The USNS Comfort has a wide array of medical capabilities to include general surgery, ophthalmologic surgery, dental care, optometry and eyewear distribution,

general medicine, preventative medicine, and public health training. Thousands of individuals are expected to have their lives greatly impacted by this humanitarian mission. Thank you to all that are currently underway and have served in the past.

3-PPAC MENTORING SUBCOMMITTEE MEDICAL CATEGORY RESOURCE GUIDE

This is a shameless plug for all PHS physicians to utilize the Medical Category Resource guide that can be found through MAX.gov at: https://community.max.gov/display/HHS/USPHS+Physician+PAC+Mentoring+and+Career+Development+Subcommittee

The guide, created by LCDR Emily Petersen and me, is an up to date >30-page document that serves as an excellent reference tool assisting medical officers to identify resources, explain terms, and provide guidance to other fellow officers. The guide covers topics affecting all aspects of a medical officer's career in the USPHS and includes information on Corps leadership, Corps computer and communications systems, achieving basic readiness, promotions, benefits, participating in PHS committees, conferences, and workgroups.

Lastly, a very big thank you and a happy birthday to the USPHS Dental category, celebrating their 100th birthday on 24Jun 2019!

US Customs and Border Protection Station 1 -El Paso, TX

HS3 Homero Pandula, CDR Khalid Jaboori, HS3 Michael Travers

HS3 Homero Pandula, CDR Khalid Jaboori, HS3 Michael Travers , Sick Bay, Border Station 1, El Paso, TX

consultant's report
NAVY

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PUBLIC SERVICE ANNOUNCEMENT: IF YOU ARE NOT RECEIVING PERIODIC "COMMUNITY ANNOUNCEMENTS" FROM ME, PLEASE SEND ME YOUR EMAIL AND I WILL ADD YOU TO OUR LISTSERV.

Greetings, colleagues! As with all summers in the military, this is a time of moves – for us and our patients. Summers are also when we pause to celebrate the graduates from our residencies and fellowships. Congratulations to our newest family medicine staff (and those soon to graduate)! Well done and best of success in your first tour as a family medicine physician! *Public Service Announcement*: If you are not receiving periodic "Community Announcements" from me, please send me your email and I will add you to our listserv.

GRADUATE MEDICAL EDUCATION (GME) UPDATE

The 2019 BUMEDNOTE 1524 has been published and can be viewed online at: https://www.med.navy.mil/sites/nmpdc/professional-development/SitePages/Graduate%20Medical%20Education%20Overview.aspx (or just Google: "Navy Medicine Graduate Medical Education"). This year, our fellowship opportunities are in sports medicine. Regrettably, there are no slots being offered for faculty development, geriatrics, or FM/OB. Sports medicine is greatly undermanned while our community is relatively healthy with docs having received the latter training.

Navy GME Important dates:

09 July 2019	GME Application website (MODS) opens
30 Aug 2019	Deadline to create/submit new applications
15 Oct 2019	Deadline for submitting required supporting documents & modifying existing applications
28 Oct 2019	Joint Service Graduate Medical Education Selection Board (JSGMESB) scoring and placement begins.
11 Dec 2019	Navy GMESB results released (1200 EST) via MODS
10 Jan 2020	Training acceptance deadline for residents and fellow selectees

***IMPORTANT NOTES:

1) MODS can only be accessed from a ".MIL" computer. If you do not have access to MODS from a ".MIL" computer, you must complete a paper application. Email usn.bethesda.navmedprodevctrmd.list.nmpdc-gme-sb@mail.mil to request an application and submit it to the Navy Medicine Professional Development Center (NMPDC), which will create your account and input your application.

2) Flight surgery and undersea medicine are now separated from the GMESB, but will conduct work parallel to GMESB proceedings. Guidance should be available by the time this article goes to print.

PROMOTION

April and June saw the announcement of our community's newest Captains and Commanders. Congratulations to the following officers who were selected for promotion!

CAPTAIN

Ahlgrim, Joel
Bayard, Margaret
Becker, Brent
Dabelić, Anja
Green, Justin
O'Connor, Cormac
Staten, Robert
Wallace, William
Waterman, Bruce

COMMANDER

Ackerman, Vincent
Bidlack, Matthew
Bloir, Michael
Cabrera, Orlando
Carter, Rachel
Davis, Christopher
Donahue, Kathleen
Elenbaum, Stephanie
Ewing, John
Henderson, Patrick
Klimaski, David
Kuersteiner, Karl
Lennon, Robert
Lagoski, Danielle
Marra, Janelle
McDermott, Andrew
Monlux, Daniel
O'Connell, Tara
Portier, Ray
Ramsey, Jeremy
Ries, James
Smith, Dustin
Wonglopez, Jamie
Worley, Christopher

Promotion Stats

The family medicine in-zone (IZ) promotion rate for captain this year was 38.9%, which was below the overall Medical Corps IZ average of 51.0%. This does come on the heels of our 77.8% promotion rate in FY19. For FY20, FM saw an Above-Zone (AZ) selection rate of 16.7% (versus 17.9% overall). We saw a rebound in CDR promotions this year, with an IZ rate of 55.0% (compared to 27.8% for FY19) and just above the MC overall average of 52%. The AZ rate was 33.3%, also just above the average of 27.7%.

The statistics continue to show that your best chance to promote is when you are "in-zone." However, AZ selection opportunities remain much better than they have been in the past. The take home point is that career planning is essential. To highlight advice I've regularly passed on, records that help officers make promotion tend to follow these rules:

- Demonstrate sustained superior performance, diversity in leadership roles and duty stations, and break out fitness reports among one's peer group.
- One-of-one billets, which are common among operational positions, are better occupied in the early years of a new rank.
- In the two to three years heading into one's IZ look, one should seek out billets with larger peer groups in order to have an opportunity for break-out promotion recommendations (promote-->must promote-->early promote). Alternatively, ensure one has a tour where one is ranked in a peer group for at least one tour during the current rank.

I continued to be encouraged by the observation that there is no one pathway to success, and that one can deviate from the traditional blueprint and still be promoted. For more mentorship and guidance in regard to promotion, please contact our detailer, CDR Anja Dabelić, and/or me. We can review your record and help you plan your future. Additionally, the Medical Corps (MC) Career Development Board (CDB) policy was recently signed and the roll out for the program has begun. CDR Joel Schofer has been selected as the MC CDB Program Manager, and CAPT Marlene Sanchez has been selected as the Assistant PM. You can learn more about the program on the (CAC-enabled) MC Home Page: https://esportal.med.navy.mil/bumed/m00/m00c/M00C1/

MANNING STATUS & DETAILING

As of June 30, 2019, we had 380 uniformed Family Medicine physicians for 410 billets, which includes 27 "Fair Share" billets. This translates to a 92.7% overall fill rate and a gap of 30 billets. In the spring, we achieved an 87.1% fill rate thanks to new residency graduates joining our ranks. Our manning will trend down in the coming months as individuals retire or are released from active duty at the end of their commitments. If you are approaching your projected rotation date (PRD) or your end of obligated service and are wondering about what to do next, please reach out to our detailer, CDR Anja Dabelić, to explore options. The goal is to align your professional goals with available opportunities and priorities. I am also available to help, so don't hesitate to reach out to me.

DIVESTITURES (POM20/21)

The outcome of the proposed plans for divestitures (i.e. billet cuts) in Navy Medicine remains uncertain. The initiative, titled "Program Objective Memorandum 2020/21," has projected changes in the billet profile for FY20 and FY21. As with my last update, no final decision has been made, but we are currently in a pause. Congress may be weighing in, as there is language in the House Armed Services Committee's version of the FY20 NDAA that pauses the reductions until more analysis is done. Next, the House and Senate will conference to come up with a compromise, after which we should know more.

POST-GI BILL TRANSFERABILITY CHANGES: UPDATED

In a previous column, I passed along news that the Pentagon announced significant changes in the transferability of the Post 9/11 GI Bill (which CDR Joe Schofer nicely summarized on his MC Career blog, dated 22 Jul 2018.) These changes include:

- Effective July 12, 2019 (now, January 12, 2020—see update below), service members desiring to transfer their Post 9/11 GI Bill benefit to a spouse or children will need to do so no later than their 16th year of service. The requirement for the service member to have at least 6 years of service to apply for transfer remains in effect.
- Effective immediately, any sailors who can't serve four additional years are ineligible to transfer the benefit. This affects Navy personnel ineligible to serve four additional years due to their time in grade or an impending medical retirement.
- Regardless of where you are in your career, if you are considering transferring the benefit to one or more of your dependents, it's best to do so now, before the new rule takes effect.

Update: The DoD extended the start of the 16-year limit on transferability until 12 January 2020. However, the DoD memo does NOT extend the exception announced in NAVADMIN 020/19 for sailors over 10 years who are unable to serve 4 more years due to law or policy.

As a reminder: According to the DoD, the service member can make later adjustments, such as percentage amounts among dependents, or between spouse and children, but only after they have transferred the benefit.

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USAFP 2020

The next USAFP Annual Meeting is April 1-6, 2020, in Anaheim, California. Please start thinking about if you are going to attend and standby for the deadline to submit your info to me. I am anticipating needing your information by early-December. We should know by then who will be accepted to speak, and who will be invited to present research.

DHA UPDATE

The transfer of the administration and management of Military Treatment Facilities (MTF) from the Services to the Defense Health Agency (DHA) continues. Naval Hospital Jacksonville was the first Navy MTF to make the transition, and the first wave of transitions will conclude on September 30, 2019. It was recently announced that the phased transition has been accelerated. Beginning October, 2019, all CONUS MTF's will fall under DHA. As a review, DHA will be responsible for such elements as the following:

- Budgetary matters
- Information technology
- Health care administration & management
- Administrative policies & procedures
- Military medical construction

The next phase will also see a new leader at the helm of the DHA. In September, VADM Bono will be retiring. MG Ronald Place, who was recently confirmed for promotion to lieutenant general, was named as the next director of the DHA.

NEW RESOURCE: MYPCS

A new mobile application has been rolled out for Sailors who are undergoing a permanent change of station (PCS). This online application (no app to download) has CAC-less access. Current functions include checklists and links to external sites, resources, location and childcare information, and forms for housing. Future phases will include the ability to view full orders, upload receipts, and upload travel vouchers. You can find more information at the Navy App Locker: https//www.applocker.navy.mil/#!/apps

Stay well, Navy Family Medicine, and thanks for all you do!

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The Imposter Phenomenon: Mentorship, Culture, and Breaking the Cycle

Mentoring through the imposter phenomenon can be challenging. First, we must normalize imposter feelings. Second, challenge negative self-talk. Third, affirmation is key. Lastly, give credit where credit is due.

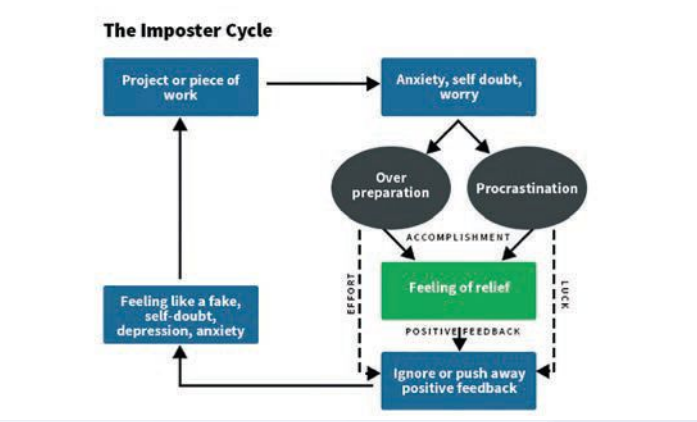

Figure 1: The Imposter Cycle – How assignment of a project or task can cycle through self-doubt, ignoring positive feedback, and feeling like a fake. Source: https://womenaccelerators.org/wp-content/uploads/2018/11/imposter01.jpg

It could happen any day now. Someone will eventually realize that I am a fraud and expose me to the world. "Fake it 'til you make it" can only carry me so far, and my luck is surely running out. I feel unworthy of the opportunity to serve as an Army officer and family physician; I feel underqualified to be entrusted with the great responsibility of providing medical care to our nation's bravest warfighters.

Can you relate? If so, you would be joining a growing contingent of those of us who label ourselves as imposters. With a shift in perspective and a few more tools in our belt, however, we can overcome the imposter phenomenon to find confidence and better live up to our full potential.

The imposter phenomenon is a personal struggle with inadequacy, self-doubt, and a sense of fraudulence despite demonstrable success.[1-4] Individuals may feel underqualified or incompetent, often having trouble internalizing their accomplishments.[5] The imposter phenomenon does not just affect those new to a job or endeavor; it also affects high performing individuals, those with ambitious careers, terminal degrees, and frequent promotions.[6]

In 1978, Drs. Pauline Clance and Suzanne Imes interviewed 150 successful, high-achieving women.[1] Despite their successes, these women chalked their accomplishments up to luck; Clance and Imes found they lacked internal validation and a sense of personal accomplishment. Clance and Imes went on to describe this pattern of self-doubt, poor self-worth, and fear of being exposed as fraudulent in their article, "The Impostor Phenomenon in High Achieving Women: Dynamics and Therapeutic Intervention."[1] Later research revealed that imposter phenomenon is equally prevalent in men and perhaps even more so in people of color. Imposter phenomenon has also been described across multiple fields, including academics, business, healthcare, and education.

Clance and Imes speculated that various factors contribute to the development of imposter phenomenon, with gender, family, and social culture playing key roles.[2] It has further been studied and thought to be rooted in labels attached by parents in childhood – for example, you may have grown up as "the smart one" or "the shy one."[6] If you are a millennial like me who grew up in the "every child gets a trophy" era, always being made to feel like a star performer may have imparted a sense of superiority to you. This may bleed into adulthood and manifest as perfectionism, or the reliance on others for praise and esteem when your own self-worth just doesn't measure up.

What does an imposter look like? Well, that can be hard to describe and often the imposter is hard to find. If you are like me, you may even find ways to compensate to better blend

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in to your surroundings when you experience the feeling of an imposter. As the imposter phenomenon is an experience and not a disorder, some authors and writers prefer the term "imposter phenomenon" over the frequently cited "imposter syndrome." While the imposter phenomenon doesn't have strict diagnostic criteria, Clance introduces the concept of the imposter cycle (figure 1), which can be helpful for identifying when you or others may struggle with imposter feelings.[2] This cycle begins when an achievement-related task is assigned to an imposter. Then, anxiety and self-doubt set in, resulting in either over-preparation or procrastination. Upon completion of the task, the feeling of relief and positive feedback are discounted, which in turn leads to feelings of fraudulence, worsening self-doubt, and mood changes, which then affect future tasks.[2]

As military physicians are constantly bombarded by achievement-based tasks, what would happen to an imposter in this position? Physicians and military officers are "special" by nature; we have excelled in education, our incomes provide secure lifestyles, and we are in positions of authority. Failure in our field can sometimes mean life or death. Can we break this cycle? Is there a way to overcome the imposter phenomenon? Absolutely. We must examine our perspective and realize that we are not alone.[7]

In 2015, actress Natalie Portman gave the commencement address at Harvard. Recalling her arrival to Harvard as a student in 1999, she said, "I felt like there had been some mistake, that I wasn't smart enough to be in this company, and that every time I opened my mouth I would have to prove that I wasn't just a dumb actress."[7] Poor self-worth is at the heart of the imposter syndrome. She goes on to encourage the graduates to "recognize the benefits of being a novice." If you find yourself in a new situation – a new workplace, a new rank, a new fellowship – embrace it. While conventional wisdom is of value, fresh minds bring creativity and new approaches to longstanding challenges. Whether we are new or seasoned, we are certain to find others who can relate to the imposter phenomenon. Ask around the office and I suspect you will find some high achievers who feel like imposters. If that's not enough to make you feel better, keep in mind what Tina Fey once said, "Seriously, I've just realized that almost everyone is a fraud, so I try not to feel too bad about it."[7]

In medical education, we must be vigilant for signs of imposter syndrome in learners. Self-doubt, self-criticism, and disengagement can be fatal to a learner.[8] Imagine the resident who is so afraid of failing at delivering a baby that he avoids labor and delivery at all costs; what happens

when he graduates and is the lone obstetric provider at a small community hospital? Think of the resident who says that she passed Advanced Trauma Life Support (ATLS) because of dumb luck alone... what effect does that have on her confidence when later she is at the head of a trauma table downrange? Do we want to create a culture of shame where perfectionism is expected and failure is abhorred, or do we want to foster an environment that encourages growth, self-discovery, and accountability?

Mentoring through the imposter phenomenon can be challenging. W. Brad Johnson and David G. Smith provide several tips.[9] First, we must normalize imposter feelings. Share with residents and colleagues that these feelings are more prevalent that it may seem. Share your own stories. Second, challenge negative self-talk. As Johnson and Smith recommend, be vigilant for comments like "I am so stupid!" "I totally botched that presentation!" or "I have no business being in this job!"[9] When you hear these, challenge them with concrete data and try to interrupt the imposter cycle with targeted questions. Third, affirmation is key. Counter imposter worries with "copious doses of affirmation and encouragement."[9] Highlight past accomplishments and review achievements to show your mentees that, yes, they do belong. Lastly, give credit where credit is due. Imposters will readily give away credit for an accomplishment. Be wary of those who consistently give credit to mentors or teammates while downplaying their own contributions.[9]

Robert Glazer writes, "It's a mistake to assume the people around you know more or deserve their position or success more; they often just have more confidence."[4] As military family physicians, we are constantly surrounded by high performers, and the success of others should motivate and embolden our thoughts and actions. If we let feelings of self-doubt and cynicism take hold, we begin to label ourselves as imposters and frauds. However, if we instead recognize that the imposter phenomenon is real and widespread, we can find strength in not allowing false ideas to cloud our image of self-worth. Our responsibility is to actively build cultures of inquiry, safety, and affirmation. We do this by modeling confident humility to those around us. When we look in the mirror, we know to look beyond the imposter and see a person worthy and brave enough to change the world.

Source:: https://medium.com/@AlyintheATL/a-few-words-on-impostor-syndrome-women-in-stem-5b50e465a671

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Top Medical Apps for Your Smart Device: Summer 2019 Edition*

Greetings, everyone! Here is my curated selection of the best apps for the Summer of 2019 for your smart device! Happy downloading!

1. Evidence Alerts: Customized "Best Evidence" Latest Studies to Your Smart Device

The evidence-based medicine (EBM) experts at McMasters University have teamed up with Dynamed Plus to provide Evidence Alerts--abstracts and commentary on the latest clinical studies in a new "foraging" tool. With expert commentary and EBM weblinks as well as integration with institutional PubMed and Dynamed Plus subscriptions, users can view, save, and curate their own collection of best evidence for future retrieval on their smart device.

Evidence based medicine

The app's developers pull content from over 120 journals and provide commentary on each article. The app allows one to customize content and frequency of alerts and is able to be used with or without the web-based Evidence Alerts site. Users can save content/view full text using their institutional PubMed subscription and/or view related Dynamed Plus content with the applicable subscription.

Price

- Free* (full article access/Dynamed content requires subscription)

Likes

- Daily EBM "best/latest" studies compiled by Dynamed and McMasters to your device.
- Customizable for content, institutional access for PubMed and Dynamed Plus accounts.
- Available for Android.

Dislikes

- Interface not as robust as QxRead regarding "look" and retrieval of saved content.
- Some features from McMasters are "hidden" in submenus; Dynamed Plus integration bug.
- Expert commentary should be "upfront".

Overall

A match made in heaven! The new Evidence Alerts brings you the latest and best EBM content customized by you. The app allows users to input their Dynamed Plus and/or institutional PubMed account information for full content/article access.

Available for Download for iPhone, iPad, and Android.

- https://itunes.apple.com/us/app/evidencealerts/id1453347992?mt=8
- https://play.google.com/store/apps/details?id=com.mcmasterhkr.evidencealerts&hl=en_US

2. Antidepressant Proposer: Helping Mental Health Providers Select the "Best" Antidepressant

An enterprising fourth year psychiatry resident at the University of Southern California, Theodore Huzyk, MD, has taken data on antidepressant prescribing from the Agency for Healthcare Research and Quality (AHRQ) and recent meta-analyses along with tables from UpToDate to create an antidepressant selector calculator. The app combines patient factors and drug side effects with overall results from the medical literature to create a unique list of drug options based on user input. The app ranks the "best options" down to the "worst options" and can be easily modified using toggles in the calculator. Although not meant to replace clinical judgement and current guidelines, the app can help guide patient-centered decision making.

Evidence based medicine

The app utilizes data from two network meta-analyses and AHRQ comparison articles to create an antidepressant calculator. The provider inputs patient data and/or side effects of medications to avoid (or side effects for which to select) and the app creates a customized list of antidepressant options. Whether or not this is better than "standard clinical practice" is of course highly debatable. Some of the best options truly would not be first line (TCA's/MAOI's) or are not available in the US--agomelatine for example.

Price

- Free

Likes

- Takes meta-analyses and AHRQ data to create handy calculator.
- Numerous modifiable variables included to create custom results.

- Designed by a resident in psychiatry.

Dislikes

- Interface nothing fancy and answers a bit clumsy (pregnancy data is not correct/consistent with safety guidelines for example).
- Some of the evidence about the articles on which the app is based is difficult to find.
- Not available for Android.

Overall

The Antidepressant Proposer takes several existing network meta-analyses on choosing the "best" antidepressant for a given patient and creates a simple to use calculator. The app was designed by a 4th year psychiatry resident to help other mental health providers, but the app could easily be used in primary care. Although the app doesn't have a slick interface, it is simple to use and provides evidence-based information on antidepressant selection. I am concerned about some of the answers provided for certain groups such as pregnancy.

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

- https://itunes.apple.com/us/app/antidepressant-proposer/id1434241446?mt=8
- https://play.google.com/store/apps/details?id=gov.ahrq.qata&hl=en

3. HEEADSSS Up: The Popular Screening Tool Comes to Mobile Devices

A team of providers in the UK, with a grant from Health Education England, has brought HEEADSSS screening to mobile devices via an interactive app. The app can be used anywhere in the world, but the developers have customized it to England. When you first log into the app (which requires your name and email address for unknown reasons), it prompts you to select which region in England you practice medicine. Once you begin the screening, the app asks you if you discovered any issues for a particular HEEADSSS domain. If you select "yes", the app provides links to national and regional resources specific to that domain. It works flawlessly! Furthermore, you can text or email these resources to your patient. If only we had something like this for the United States by zip code!

Evidence based medicine

The HEEADSSS screening tool has been used since the 1990s to evaluate for psychosocial issues primarily in adolescents and young adults (ages 10-24). The acronym is used worldwide and advocated for use in the United States by the American Academy of Pediatrics and others as the gold standard for psychosocial screening as part of routine care. Although not validated in the same sense as, say, a diagnostic test, HEEADSSS has been used extensively in research with numerous publications on PubMed utilizing it as a screening tool.

Price

- Free.

Likes

- HEEADSSS screener now in easy to use app format.
- Regional/national resources for each section; can text/email resources to patients.
- Available for Android.

Dislikes

- Resources limited to England.
- Not much information listed for each resource.
- Email address necessary for app registration.

Overall

The HEEADSSS app is a perfect tool for adolescent medicine in England. The app is an outstanding example of taking a basic screener like HEEADSSS and improving upon it via the regional and

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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 15 October 2019.

RESEARCH GRANTS

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

RESEARCH JUDGES

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

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

Please write to me...
Aaron Saguil, MD, MPH, FAAFP
aaron.saguil@usuhs.edu

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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national resources for each domain of the acronym. Even though the app may seem only applicable to providers in England, the HEEADSSS acronym is used around the world so this app is a fantastic tool for all primary care providers.

Available for Download for iPhone, iPad, and Android.

- o https://itunes.apple.com/us/app/heeadsss/id1418543003?mt=8
- o https://play.google.com/store/apps/details?id=com.heeadsss.heeadsssApp&hl=en_US

4. The GOLD COPD 2019 Pocket Guide: Going for the GOLD for the Best COPD Treatment

The new Global Initiative for Chronic Obstructive Lung Disease (GOLD) 2019 guidelines have been released with a companion app. Despite its Big Pharma backing, the app is the only one available that includes a number of COPD symptom questionnaires such as the COPD Assessment Test (CAT). The prior "official" GOLD app was last updated in 2017.

Evidence based medicine

The app includes the current "gold standard" GOLD COPD guidelines released in 2019 in app form. The app includes a toolkit that walks providers through the revised ABCD patient assessment, symptom assessment with calculators for the two most recommended COPD patient assessment questionnaires--COPD Assessment Test (CAT) and the Modified Medical Research Council dyspnea scale (mMRC)--and a treatment selector based on these assessments. Although the GOLD guidelines are evidence-based, many of their recommendations are expert opinion. The app includes links to the full PDFs with evidence ratings and references.

Price

- o Free.

Likes

- o Only app containing the current 2019 GOLD COPD guideline.
- o Includes revised ABCD assessment, CAT, mMRC, and treatment selector calculators.
- o Available for Android.

Dislikes

- o Doesn't include evidence rating for recommendations.
- o Lots of wasted space and some viewing issues (at least on my devices).
- o App not as intuitively designed as it could be.

Overall

The GOLD 2019 COPD Pocket Guide app brings the GOLD guideline PDF to life on mobile devices. It is the only COPD app you likely will need. The revised ABCD patient assessment tool allows providers to properly classify and treat patients at the point of care without paging through a long PDF. The caveat is that the evidence of efficacy for many COPD medications is weak when it comes to true patient-oriented outcomes and the GOLD guidelines contain a significant amount of expert opinion and pharmaceutical company ties.

Available for Download for iPhone, iPad, and Android.

- o https://apps.apple.com/us/app/gold-2019-pocket-guide/id1449840740
- o https://play.google.com/store/apps/details?id=org.goldcopd2019.pocket_guide&hl=en_US

*Portions of this article have appeared elsewhere before publication in Uniformed Family Physician

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Committee Report
CLINICAL INVESTIGATIONS

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Greetings from the Clinical Investigation Committee!!! As you know, we love research...in fact, we believe research is truly the "gateway" to a long and satisfying career in medicine. Whether your goal is academia, clinical or operational medicine, or healthcare leadership, participation in research will help you get there. We are excited to guide you on that journey.

Research is absolutely not just randomized, double-blinded, multi-center trials. Research is an investigative mind-set and attitude of inquiry. There are numerous areas of research ripe for family physicians. We, as uniformed family physicians, provide the bulk of healthcare to our Service Members, their families, and our retiree population and thus are well positioned to be the research leaders within the Military Health System.

With this thought in mind, the CIC in 2016 developed the USAFP Omnibus Survey. The Omnibus Survey is a data repository research protocol approved by the Uniformed Services University Institutional Review Board and is reviewed/approved annually. The survey involves an anonymous electronic questionnaire about knowledge, attitudes, and beliefs of practicing military family medicine physicians. The data is collected from attendees at the USAFP Annual Meeting. This information is used not only by each individual researcher who contributes to the survey, but by others who may access the de-identified, multiservice cohort data to answer scientific and policy related queries now and in the future.

Projects completed since 2016 using the Omnibus Survey have involved the following topics: bedside ultrasound, medical care for patients with gender dysphoria, women and military leadership, physician burnout, grit, satisfaction with work-life balance, pharmacogenomics at the primary care level, and family physician education on breastfeeding management...just to name a few.

From these study teams, Omnibus Survey projects have led to at least 11 national presentations, five publications (with two more in review), and more on the horizon! What's more, almost all of these projects involved students, residents, or fellows in training. As you can see, the Omnibus Survey is a SUCCESS!!!

So how can you get involved? Apply now to have your project included for the 2020 USAFP Omnibus Survey. Here are the application details:

1. Who: Any USAFP member can submit a research protocol for the Omnibus Survey. The survey team is led by Dr. Michael Arnold and is a subcommittee of the CIC.

2. What: A research proposal for a health-related topic of interest where querying the USAFP Annual Meeting participants would answer your important question.

3. When: The announcement for proposals will be sent from our USAFP research staff in late August or September with a suspense date of late October.

4. Where: Submit proposals online through the link provided on the USAFP website. If selected, your query will be administered during the 2020 USAFP Annual Meeting.

All applicants, if selected, are assigned an experienced research mentor to help refine their projects.

The CIC continues to be amazed by the quality of the research submitted by our members. Thank you for your service and we look forward to seeing your projects next year in Anaheim!!

EVERY DOC CAN DO RESEARCH

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

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

Tools Available:

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

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

Janelle Marra DO
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The Diversity Discussion

Recently, I participated in a half a day of diversity training as a part of the Advanced Medical Department Officer Course (AMDOC). During this training, my classmates and I were asked to look at the definition of diversity, how diversity impacts our lives, and the importance of diversity in our military. During this discussion, our moderator asked us to do the following: talk about race, discuss personal experiences with peoples of differing races than ourselves, ask hard questions, and get comfortable being uncomfortable. I would like to share some of the pearls I took away from this session and leave you with some tools to discuss diversity with your team.

Share your Experience

If you identify as a minority, share your story. While this may be intimidating, sharing your story is important so that others hear about your unique life experiences. Sharing your story with both individuals and groups is equally important. Some organizations have developed electronic forums and podcasts to share diversity stories. For an example see the website, http://diversestory.org.

Hear their Experience

Getting to know people's unique experiences is an important part of being an effective leader. Acknowledging people's experiences is an important way to value diversity. An example of this is the podcast, "The Will to Change: Uncovering True Stories of Diversity and Inclusion," by Jennifer Brown.

Know your bias

All people have biases, many of which are based on their previous life experiences. It is important to acknowledge your biases, as this can help mitigate their sometimes-harmful effects. Please see https://secure.understandingprejudice.org/.

Hold People Accountable

Hold people accountable when you see biases or microaggressions. According to the Merriam Webster dictionary, microaggressions are defined as "a comment or action that subtly and unconsciously or unintentionally expresses a prejudiced attitude toward a member of a marginalized group." Along with biases, it is important to recognize microaggressions and make others aware of their impacts. You may find examples of microaggressions at https://sph.umn.edu/site/docs/hewg/microaggressions.pdf.

Be an Ally

Merriam Webster defines an ally as "a person who aids and supports in an ongoing effort, activity, or struggle, often used specifically of a person who is not a member of a marginalized group but who expresses or gives support to that group." It is vital to sponsor and support those who differ from yourselves to continue to improve representation of minority groups in leadership roles. To be an effective ally, you need to recognize your privilege and how those who are in the minority do not share your privilege. A resource to consider is Melinda Epler's TED Talk, "Three ways to be a better ally in the workplace."

Practice Inclusion

Diversity does not exist in a vacuum; it is in partnership with inclusion. Inclusion requires us to create a welcoming environment for all members, whether part of the minority or majority. Diversity without inclusion will fall short of our goal of equity. To read more on the topic, please see the open access article, "Working toward gender diversity and inclusion in medicine:," available at https://www.thelancet.com/journals/lancet/article/PIIS0140-6736(18)33138-6/fulltext.

http://web.jhu.edu/dlc/resources/diversity_wheel/index.html

http://web.jhu.edu/dlc/resources/external_diversity_resources/

https://msw.usc.edu/mswusc-blog/diversity-workshop-guide-to-discussing-identity-power-and-privilege/

https://www.labschool.org/about/diversity-equity-and-inclusion

https://www2.deloitte.com/insights/us/en/deloitte-review/issue-22/diversity-and-inclusion-at-work-eight-powerful-truths.html

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Pacific Partnership 2019

HISTORY

On December 26, 2004, a magnitude 9.1-9.3 undersea earthquake occurred off the coast of Sumatra. The subsequent 100-foot tsunami killed over 200,000 people in 14 countries, with Indonesia suffering the most casualties. Sri Lanka, India, Malaysia, and Thailand also experienced significant damage and loss of life. The United States responded immediately via Operation United Assistance and was joined by various similar operations from the international community. This joint endeavor fostered goodwill and created an opportunity for future cooperation with Indo-Pacific nations. In 2006, the United States started Pacific Partnership as an annual deployment to the Indo-Pacific region with the goals of improving interoperability during disaster crisis response and building partnerships when engaged in humanitarian assistance. Over the years, the deployment morphed to direct patient care provided by American medical personnel. However, most recent iterations have re-focused on the mission's original intent and the 2019 iteration proved successful in that regard.

PACIFIC PARTNERSHIP 2019

Pacific Partnership has become the largest annual multinational humanitarian assistance/disaster relief (HA/DR) training operation in the region. The 2019 mission aimed to accomplish the enduring objectives of working closely with host and partner nations, improving interoperability, enhancing disaster response capabilities, advancing stability and security in the region, and developing new friendships while enriching persisting ones. Partner nations for this mission included Australia, Canada, Japan, South Korea, Peru, and the United Kingdom. Deployed US personnel were divided into two teams. One team embarked onboard the expeditionary fast transport ship USNS Brunswick (T-EPF 6), conducting operations in the host nations of the Federated States of Micronesia, Republic of the Marshall Islands, and Vietnam. The other team embarked onboard USNS Fall River (T-EPF 4) and was hosted by the Philippines, Malaysia, Timor Leste, and Thailand. Some US personnel flew to each country.

I was part of Team Fall River and our mission started in Tacloban, Philippines. Our team was responsible for multiple lines of effort and included subject matter experts in en-route care, HA/DR, engineering (Navy Seabees), and medical care (physicians, dentists, nurse practitioners, midwives, nurses, dieticians, pharmacists, optometrists, veterinarians, and more). Each line of effort conducted its training with host and partner nation personnel via subject matter expert exchanges. The medical line of effort engaged in side-by-side patient care with Filipino physicians at community clinics, primary care clinics at local hospitals, and through community health engagements as well as community health outreach team events. This provided a great opportunity to learn about the Filipino primary care system, particularly its challenges. It was enlightening to see how Filipino physicians relied on their medical acumen and experience to diagnose and treat patients as tests and imaging studies sometimes were not accessible. Our physicians also presented various topics at the clinics, the hospitals, and primary care conferences, which led to fantastic professional discussions and interactions.

Our next stop was Kuching, Malaysia where we did many of the same things we did in the Philippines. However, medical personnel with operational experience were part of a team conducting combat care training to Malaysian military and civilian personnel. The team presented an ATLS-like course while Navy Corpsmen provided courses based on Tactical Combat Casualty Care and First Responder training. Our time culminated with a very successful and intense field exercise incorporating all three courses. It included mass casualty scenarios, set up of a field trauma tent, and ground as well as air medical evacuations using Malaysian Army vehicles and a helicopter.

Next was Dili, Timor Leste, where the side-by-side patient care was conducted not only in the capital city, but in distant rural communities as well. Timor Leste is a relatively new independent country proud of its place in the international community. It was a phenomenal experience to see Timorese medical professionals truly committed to universal coverage and placing emphasis on developing great rapport with their patients. It was equally impressive to see

the appreciation patients expressed at being seen and how thankful they were for the services they received despite the limited medical resources. The mission ended in Sattahip, Thailand where we did not conduct any side-by-side medical care. Instead, we participated in a medical symposium presenting various topics pertinent to both military and civilian medical communities. The professional exchange and discussion with host and partner nation providers was extremely rewarding.

TAKE AWAYS

My expectation was that I would offer my expertise and experience to the medical professionals in each of the countries we were scheduled to visit. I think I learned more from them than they learned from me. The professional camaraderie, discourse, and exchange of ideas were superb and quite enjoyable. I was extremely impressed about how creative fellow medical professionals become when taking care of their patients in environments with limited resources. I was re-invigorated to see the dedication to their profession and their patients. This was a very fruitful, humbling, energizing, and enjoyable experience that I hope some of you will get the chance to fit into your busy lives.

PERSONNEL SELECTION

Although Pacific Partnership is an annual mission with enduring goals, the objectives differ every year based on host nation requests/requirements. Thus, Navy Medicine West (NMW) sends taskers to commands within its area of responsibility, requesting people with specific skill sets/expertise to accommodate such requests/requirements. The Plans, Operations, and Medical Intelligence Department (POMI) at each subordinate command is responsible for coordinating the selection of such personnel. Anyone with experience in events such as global health engagements, community health engagements, health service support engagements, community health outreach teams, theater support cooperation exercises, or prior Pacific Partnership participation is a good candidate for this mission. If you want to volunteer, you can contact your POMI. For people outside NMW, the Director of Medical Operations and her/his team selected for the mission can name request personnel. Since the Navy does not have veterinarians, the Army supports that requirement.

ASK AN OP MED DOC A QUESTION - USAFP.ASKADOC@GMAIL.COM

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Telemedicine: What's the current state of the Military Health System(MHS)?

We're trying something different for this quarter's issue – instead of a single article, we have one from each service, each with a different perspective and showcasing different capabilities. You'll see that, as a team, all three services are doing a lot of work on telehealth. For instance, all three services use Advanced Virtual Support for Operational Forces (ADVISOR), a 24-hour hotline for deployed docs to get specialty care. Likewise, Virtual Medical Centers are being used by the Army and Navy to bring specialty care to austere environments. There's even a Tri-Service Telehealth Group. But, you'll also see that each service is bringing individual innovations and individual projects to the fight.

The military is well-positioned to innovate in telemedicine. We don't necessarily have the same financial incentive structure as civilian institutions, which allows us more leeway to develop telemedicine technology. The military also has a readiness need and a strategic requirement for telehealth to care for warfighters. In addition to service members, our beneficiaries also provide a demand signal; many would love to save the commute to the medical center to be seen. Likewise, if you work in a remote MTF, think of how much money could be saved by preventing needless travel for specialty care. That said, when it comes to tele-health, there are still several challenges across all three services. The tele-health unfriendly relative value unit (RVU) is still used to measure productivity, there are MHS-wide connectivity/bandwidth issues, and there are significant issues with credentialing.

But there's one thing that is clear above all else: as the world is becoming more connected, the military health system is breaking down barriers of distance to provide excellent care everywhere. Expect to see telemedicine in your clinic soon.

The State of Air Force Telehealth

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The Air Force Telehealth program is robust and diverse and continues to expand. The following projects are operational.

1) *Project ECHO or synchronous eConsult:* ECHO builds specialty care capacity into the primary care clinic. It is a series of one hour monthly live webinars, (i.e. virtual grand rounds) consisting of CME accredited didactics followed by case presentations. Some 48 ECHO sessions were conducted last year in the specialties of diabetes, chronic pain, addiction, and acupuncture.

2) *Virtual visits via video teleconferencing:* We conduct telehealth encounters between providers and patients across MTFs with high quality video links in lieu of a traditional face to face encounter. CONUS offerings include tele-mental health, tele-dietary, and tele-genetics consultations. US Air Force Europe – Air Forces Africa offerings include most specialties. Some 3769 virtual video visits were conducted last year.

3) *Virtual telephone visits to the home*: We have conducted 273,000 of these encounters in the past year between primary care providers in the MTF and their empaneled patients at home for low acuity encounters not requiring a physical exam. Future plans are in development to transition these "telephone" visits to a "video" platform to further enhance the encounter. Policy guidance can be found in the manual and user guide in the Virtual Video Visits document folder at https://kx.afms.mil/kj/kx2/Telehealth/Pages/home.asp

4) *Tele-radiology:* We have created a virtual radiology group that can dynamically shift workload from remote sites with no radiologist to facilities where clinical expertise is available. In theory, all AF radiologists across all 75 MTFs can read "any image anywhere at any time." In practice some 15% of the total AF imaging volume is "tele" with 140,000 studies per year being read mostly at four major reading hubs.

5) *AF central electrocardiographic library archive project:* This provides the capability to electronically submit all cardiac studies from any of the 238 AF flight medicine clinics, in original raw digital data format, to a central archive at the School of Aerospace Medicine's Aeromedical Consult Service at Wright-Patterson Air Force Base. This reduces turnaround time on consultations to near real time. The library has expanded to 1.23 million studies representing 288,764 aviators and has enabled 13 research publications to be finalized.

6) *Tele-pathology:* Nine MEDCEN MTFs have pathology scanners that transfer the traditional fixed microscopic tissue on glass slide to a whole slide digital image. This enables improved access to quality pathology services 24/7/365 regardless of location and allows for the transmission

of digital images for tumor board reviews, consultation, remote reading, and retrieval of digitally archived samples for continuity of care and research and teaching.

7) *Tele-dermatology*: This joint MHS Program provides enterprise-wide access to Tele-dermatology services 24/7/365 in a timely manner regardless of geographic location or local availability of needed medical services. It has served 4,411 teleconsultations since inception.

Primary Care providers can request a tele-derm consult at https://carepoint.health.mil/SitePages/LandingPage.aspx

8) *HELP (Health Experts onLine Portal) & PATH (Pacific Area TeleHealth):* These web based platforms, serving the Atlantic and Pacific OCONUS locations respectively, enable routine asynchronous email teleconsultation between primary care providers and specialty providers. Some 919 patient cases have been served in the past year.

9) *ADVISOR (Advanced Virtual Support for Operational Forces):* This 24hr hot line, 1-833-ADVSRLN (238-7756), or DSN 312 429-9089, enables down range providers to get urgent specialty consultation over the phone with any of 64 sub-specialists on call.

10) *Remote Home Monitoring:* This project consists of daily nurse case management of complicated patients with diabetes armed with wireless web enabled devices that sync data from in-home glucometers, BP cuffs, weight scales, and pedometers. Some 1,534 encounters were done in the past year at Nellis AFB. Planning is under way to expand the service to the NCR and San Antonio markets.

The State of Naval Telehealth

CAPT Valerie J. Riege
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Readiness is the Navy's #1 priority. Operational Virtual Health (OVH) takes medicine to the warfighter, keeping them on mission and in the fight. Navy OVH programs enhance readiness by breaking down geographical barriers and extending access to health care providers. This allows Navy Medicine to use its clinical capacity more effectively, cross-leveraging clinical expertise when and where it is needed.

Operational Virtual Mental Health (OVMH):

OVMH provides behavioral health care around the globe. VMH providers use telecommunication and information technologies to reach Sailors and Marines in operational environments and in garrison. The Navy's OVMH capabilities are expanding to Naval Health Clinic Patuxent River and Branch Health Clinic Norfolk in a phased plan to extend mental health support to active duty service members (ADSM) in remote areas.

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Connected Corpsmen in the Community (CCC):

Using algorithms designed by subject matter experts, CCC diagnose and treat ADSMs with acute conditions at their location, which keeps Sailors and Marines on their mission or at training. Transportable Exam Stations allow a virtual reach-back to licensed independent providers. Corpsmen gain critical hands-on experience to increase their knowledge and ability, while increasing access to healthcare received outside of the military treatment facility.

Tele-Critical Care (TCC):

Tele-Critical Care enhances readiness by increasing volume and acuity of admissions. TCC connects critical care teams with remote ICU patients via audiovisual communications and computer systems. A single tele-intensivist can safely care for multiple patients at numerous facilities in real time with TCC through the use of advanced technology to assess the patient's condition, HIPAA-secure VTC, and remote EHR access. TCC nurses monitor spoke-site patients remotely 24-hours-a day, which increases patient safety and augments bedside nursing staff.

Virtual Medical Center (VMC):

The 1,960-square foot VMC at Naval Medical Center San Diego will deliver specialized medical care to patients underway on a warship or forward-deployed in a remote location—where specialty services may be limited or non-existent. The VMC provides synchronous VH by leveraging TCC staff to support high-acuity OVH, utilizing technology to support military medical facilities and patients globally.

Advanced Virtual Support for Operational Forces (ADVISOR):

ADVISOR provides a special operations forces medic immediate access to a critical-care intensivist or trauma surgeon in CONUS. The medic receives recommendations on dressings, wound care, and antibiotics to support prolonged field care. This early treatment results in improved outcomes for ADSMs.

Global Teleconsultation Portal (GTP):

There are currently two global teleconsultation portals. Health Experts OnLine Portal (HELP) serves ADSMs in the Atlantic, and Pacific Asynchronous TeleHealth (PATH) is dedicated to ADSMs in the Pacific. HELP and PATH programs provide asynchronous consultations from providers anywhere (e.g., ships, deployed, and OCONUS) to more than 65 specialties. HELP and PATH enable clinical consultations, facilitate patient movement coordination, and provide Operational Forces with secure information exchange to and from the military treatment facility.

Tele-Radiology (TRAD):

Tele-radiology is a service-wide capability used in locations where radiographic interpretation occurs from a distant site. Future TRAD plans include standardizing the Picture Archiving and Communication System to securely store and transmit electronic images and clinically relevant reports digitally.

Augmented Reality to Enable Remote Integrative Surgery (ARTEMIS):

This grant-funded work performed at the VMC develops and validates wearable augmented reality goggles (Microsoft HoloLens) for holographic procedural tele-mentorship. Pilot projects involve Hospital Corpsmen evaluating patients with the aid of a holographic surgical expert inserted into their field view.

The State of Army Telehealth

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The Military's first Virtual Medical Center (V-MEDCEN) was established on January 4th, 2018 at Brooke Army Medical Center in San Antonio, Texas. The V-MEDCEN is intended to support the administrative and clinical needs for the coordination and delivery of military virtual health (VH) across the globe. This is an expansive mission, but processes have been established to accommodate the needs of the operational force and the virtual experts. Broad gaps that the V-MEDCEN fills include coordination between the tactical experts' program implementation with the Military Health System (MHS) VH Committee strategic vision, care coordination between regions and MTFs, centralized privileging for MHS VH, support for regions/MTFs that lack certain medical specialties or need back-up support due to staffing shortfalls, and program management for operational and readiness programs. Programs created in coordination with the V-MEDCEN nest within the MHS VH strategic goals to 1) develop VH support for the warfighter, 2) support the MHS clinical communities, 3) use VH to improve access to quality care for MHS beneficiaries, and 4) manage costs through and within VH. The four priorities for the V-MEDCEN in its first year have been: care coordination across the enterprise, VH credentialing and privileging, establishing a VH education program, and synchronizing VH support for the operational environment (called operational virtual health or OVH).

Care coordination for VH is an information technology (IT) and personnel heavy endeavor. Military treatment facilities (MTFs) have regionally aligned referral patterns: scheduling systems have no mandate to coordinate care across time zones or outside their region of influence. However, in order to optimize return on investment, the VH system must utilize capacity where it exists across the MHS, regardless of geographic location. To this end, V-MEDCEN

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has adopted a software solution and referral management system utilizing coordinators to centrally schedule available clinicians and connect patients to providers to ensure both are in the right "location" at the right time for a successful time zone appropriate virtual encounter. This initial referral management system is imperfect but will improve once the new DoD electronic medical record is implemented across the enterprise.

Credentialing and privileging remain a challenge to implementing a successful VH system across the MHS. Currently, VH providers must be privileged at each facility where they provide services and all providers must be privileged at a physical MTF even if not geographically local to one. This process leads to tremendous complexity and duplication of efforts. Furthermore, there is no standard by which MTFs monitor care provided by VH. Instead, credentialing activities, including ongoing professional practice evaluation (OPPE) and focused professional practice evaluation (FPPE) processes, examine only the in-person, physical bedside care that clinicians provide without attending to care provided in the virtual space. While there are ongoing efforts by the V-MEDCEN, the Defense Health Agency (DHA) leadership, and MHS quality management to address these issues, progress has been made in creating a structure to support centralized VH privileging.

Providing education about VH is a key mission. V-MEDCEN staff perform in-person and virtual training to educate clinicians and administrators about the VH encounter workflow; etiquette to improve "screen side" presence; techniques to enhance clinical success in diagnosis, treatment, and care management (including emergency plans); and VH ethics. Additionally, the V-MEDCEN coordinates with MHS education workgroups to streamline the training programs across the enterprise in order to create a VH culture that is functional throughout the DoD. These efforts are also being synchronized with the Veterans Administration education programs.

Before the creation of the V-MEDCEN, numerous solutions existed to support the operational VH mission, and additional VH solutions existed to support Special Operations Forces (SOF). Integrating these siloed efforts and filling gaps between these pilots became the primary mission of the V-MEDCEN. The unifying concept emerged as the ADvanced VIrtual Support to OpeRational Forces (ADVISOR) system. To minimize network resource requirements, this system is predicated on a consult process that begins with routine needs being managed by the asynchronous Health Experts onLine Portal (HELP) & Pacific Area TeleHealth (PATH) portals. More urgent needs, defined by patient condition or operational context in which advice is needed in less than 24 hours, are managed through a telephone based automatic call distribution (ACD) system that connects local caregivers in the operational environment to on-call clinicians in garrison. Emergent calls for critically ill or injured casualties are also routed through the same ACD system to clinicians staffing workstations in the Joint Tele Critical Care Network. At any time, the local caregiver or the remote expert participating in the consultation may "escalate" technology solutions to support the clinical need, moving from asynchronous to synchronous phone or VTC technologies. The system also supports direct patient care encounters using the VTC solutions developed in Regional Health Command Europe (RHC-E). There are current research efforts and pilot projects to develop continuous remote monitoring solutions for operational needs (i.e. to track casualties through the echelons of evacuation) and for health optimization purposes (i.e. to maintain situational awareness of unit health and readiness to inform commanders about optimal performance to achieve mission success). The Mobile Medic and Connected Corpsman pilot programs further extend the capabilities of trained individuals through algorithmic care plans supported by reach-back telemedicine solutions to remote experts. Finally, there are ongoing research efforts underway to develop augmented reality supported remote procedural telementoring that will, in time, enhance surgical capabilities in austere care settings. Incorporating OVH programs into daily garrison clinical workflows prepares service members to use the tools in theater following the "train as you fight" model, but full deployment across the enterprise remains constrained until centralized credentialing and privileging become a reality. Until then, the ADVISOR system is available to active duty, DoD, and other U.S. Government departments in all deployed settings and in some use cases – video visits and asynchronous consultations – to garrison clinicians and beneficiaries. Of note, both transfer and evacuation plans remain responsibilities of caregivers and chains of command.

The establishment of the V-MEDCEN was just the first step in the arduous process of synchronizing VH throughout the military. Through the joint efforts of the DHA workgroups, expansion of VH hubs, and transparent communication, the hope is that VH will expand uniformly across the MHS enterprise.

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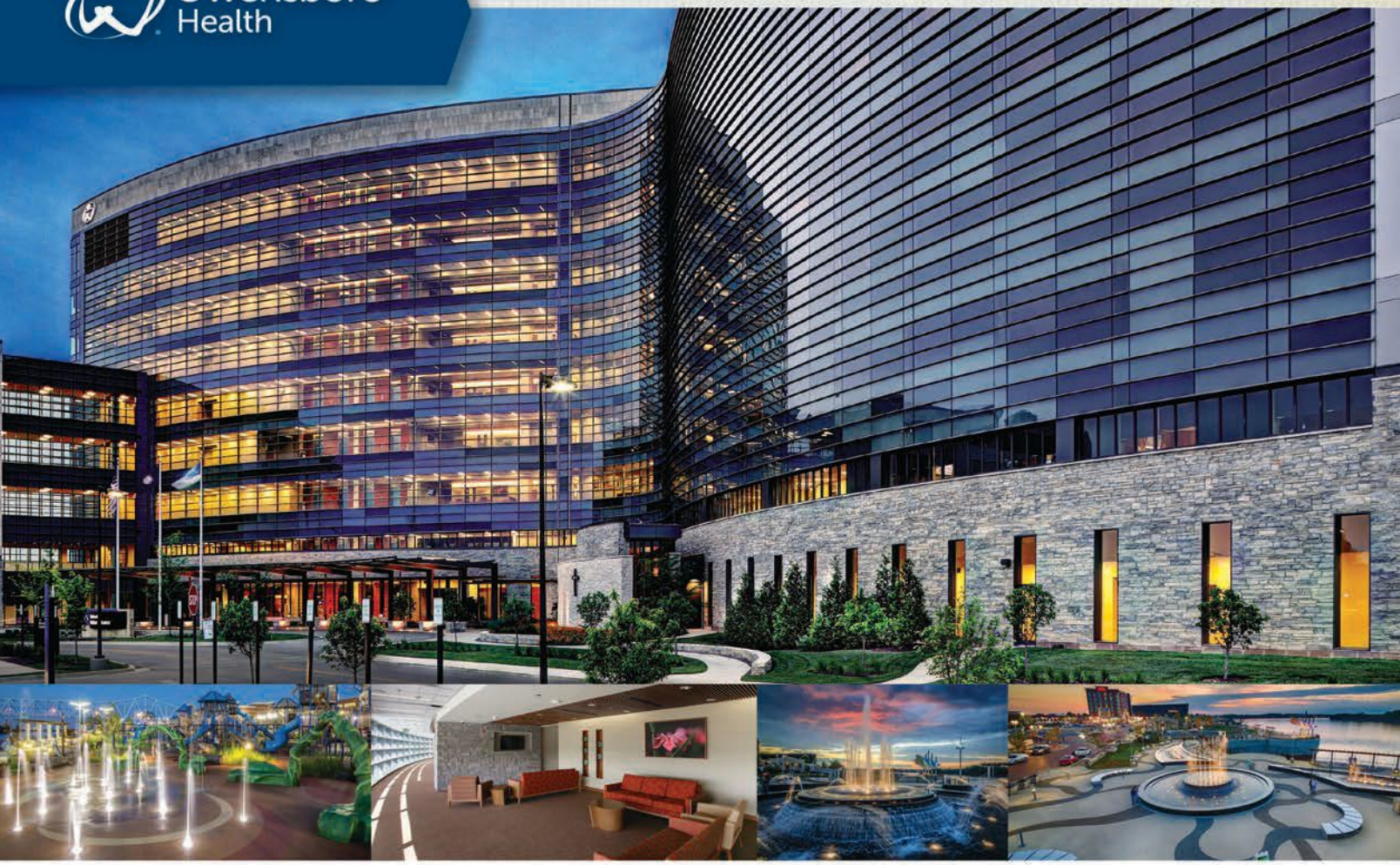

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Committee Report
RESIDENT & STUDENT AFFAIRS

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Greetings fellow medical students!

Hopefully you all are enjoying this summer and are not getting too stressed about application season. We really enjoyed meeting some of you at the AAFP National Conference of Family Medicine Residents and Students last month in Kansas City! Between devouring a 26-inch pizza at The Milwaukee Delicatessen Company and practicing suturing and ultrasound skills at the conference, a lot of connections were made, phone numbers swapped, and friendships begun. The community of providers distributed through all branches of the military is one of the things we love the most about military medicine!

The entire conference was a lot of fun. We especially enjoyed the theme of "Exploring More" of the niches and specialties in family medicine. Rural medicine, wilderness medicine, dermatology, and providing for marginalized populations were prevalent topics this year. There were also great sessions geared towards enhancing our life and wellness as providers that focused on exercise, financial management, nutrition, and more. The whole time, we couldn't help but think how we have even MORE opportunities available to us in the world of military medicine than our civilian colleagues. Operational medicine, flight and dive medicine, performance enhancement medicine, and deployed medicine are a few of the unique fields that comprise a significant part of what you and I will likely handle in our future careers.

I love telling people the story of when I learned how unique military medicine can be. While seeing an active duty member with spondylolisthesis, I asked about the most common inciting events associated with the condition, such as, "Did you recently lift something very heavy without bending your knees?" I later found out I would have had more success by asking "How many jumps have you logged?" This healthy, airborne qualified soldier in his mid-30's had a common injury from a cause not commonly seen by most civilian providers; yet it is the first thing a flight surgeon considers. These unique experiences are available to us in the military, and we hope that you are excited to take advantage of what our careers have to offer!

One way to introduce yourself to these opportunities and meet the physicians who can guide you is to join us at the USAFP Annual Meeting. Next year, the meeting will be held from April 1 – 6 in Anaheim, California. Make sure you sign up for the USAFP newsletter and email updates to stay informed of how to stay involved. There are even a select number of student scholarships for which you can apply! As always, we are available by email and social media if you have any questions. If you haven't already, go ahead and join the "Military HPSP Students and Physicians" Facebook page!

Best of luck with interview and application season. We are looking forward to seeing you in the clinics and on the wards soon!

Paige and Alex

Between devouring a 26-inch pizza at The Milwaukee Delicatessen Company and practicing suturing and ultrasound skills at the conference, a lot of connections were made, phone numbers swapped, and friendships begun.

**Editor's Note: the USAFP does not endorse the devouring of 26-inch pizzas."*

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Nine Lies About Work: A Freethinking Leader's Guide to the Real World

BY MARCUS BUCKINGHAM AND ASHLEY GOODALL

"It ain't what you don't know that gets you into trouble. It's what you know for sure, that just ain't so." Mark Twain

Ironically, although this quotation is often attributed to Twain, no one is sure that he ever said it, which reinforces the "danger of misplaced certainty."

The authors of this book had written an article several years ago for the Harvard Business Review about the uniformly unpopular ritual known as "performance appraisals," questioning the value of the process and the procedures used by most leaders to complete it. Based on the favorable response to that article, the authors were asked to write a book looking not just at performance appraisals, but the entire world of work.

Marcus Buckingham began his career working with the Gallup organization and has since gone on to become a huge proponent of strength's-based leadership theory. Ashley Goodall has been the lead researcher for understanding engagement and productivity at Cisco. Based on the leadership and organizational research they have done, Buckingham and Goodall have proposed some interesting perspectives and recommendations regarding many of today's current leadership practices.

The book begins with a significant paradox: why do so many of the ideas and practices that are held as "settled truths" at work end up being so frustrating and unpopular with the people they are supposed to serve? For instance, why is it "settled truth" that all the best leaders possess a defined list of attributes that you should aspire to acquire, when none of us have ever met a leader with every attribute on the list?

This paradox brings us to the authors' core idea for the book: the world of work today is overflowing with systems, processes, tools, and assumptions that are deeply flawed and push directly against our ability to express what is unique about each of us in the work we do every day. These processes were developed to help improve productivity and ensure objectivity at work, but with only 20% of global employees reporting that they are "fully engaged at work," it is obvious that something is not working right. And these processes together form the backdrop and justification for almost everything that happens to us at work (how we are selected for jobs, and then how we are evaluated, trained, paid, promoted and fired).

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Nine Lies About Work

	"Lie"	"Truth"	Reasoning
1	People care which COMPANY they work for	People care which TEAM they are on	TEAM is where work actually happens
2	The best PLAN wins	The best INTELLIGENCE wins	The world moves too fast for PLANS
3	The best companies cascade GOALS	The best companies cascade MEANING	People want to know what they all share
4	The best people are WELL-ROUNDED	The best people are SPIKY	Uniqueness is a feature, NOT a bug
5	People need FEEDBACK	People need ATTENTION	We all want to be seen for who we are at our best
6	People can reliably RATE OTHER PEOPLE	People can reliably RATE THEIR OWN EXPERIENCE	Because that's all we have
7	People have POTENTIAL	People have MOMENTUM	We all move through the world differently
8	WORK-LIFE BALANCE matters Most	LOVE-IN-WORK matters most	That's what work is really for
9	LEADERSHIP is a thing	We follow SPIKES	Spikes bring us certainty

The authors call these accepted ideas "lies," which is an overstatement, but they force us to critically review nine common workplace practices with an eye for at least tweaking/adjusting their focus and making them work better for everyone.

Each of the 9 "lies" presents a compelling argument; I would like to highlight two specific lies:

1. Lie #8: "Work/life balance matters most"

    a. The chapter uses the life of a physician as an example: why does a profession with the highest purpose at work suffer from a 50% burnout rate?

    b. If you look at how many traditionally view this "balance," many people assume "work is BAD, life is GOOD," so the key is to focus on decreasing work hours or making "life" a little bit better

    c. The authors recommend a different perspective: we need to find more "love-in-work," true joy from doing the things that utilize our greatest strengths as often as possible. Only 16% of workers say they play to their strengths daily, but 72% of workers say they have the ability to modify work to better play to their strengths (but few people actually do this)

    d. The Mayo Clinic found that physicians who reported spending at least 20% of their time doing things they loved at work had a dramatically lower risk of burnout!

2. Lie #4: "The best people are WELL ROUNDED"

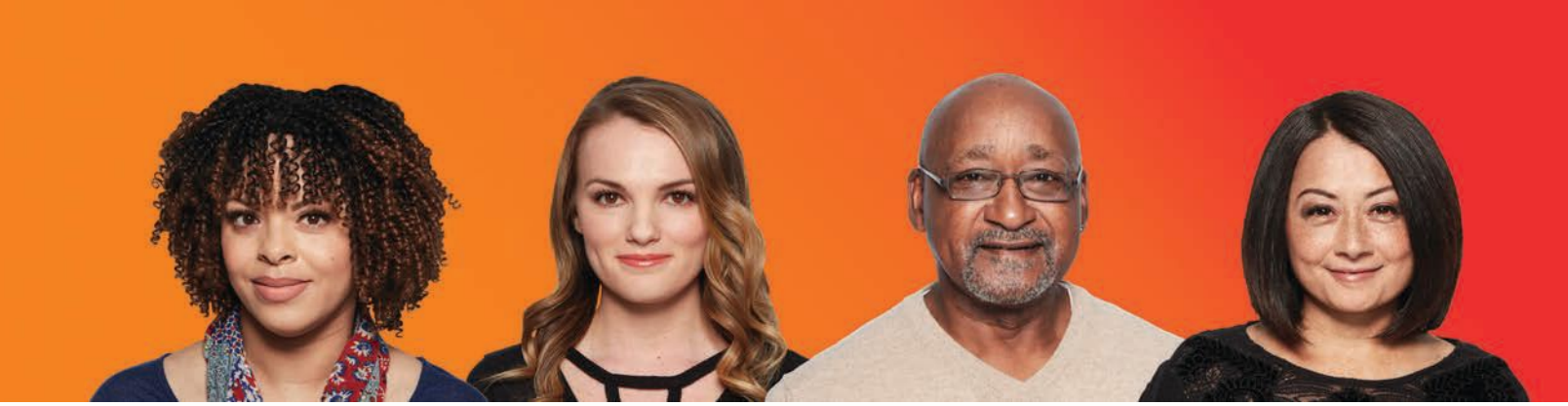
    a. We have all seen some form of the leadership competency model that begins, "every leader should have the following skills."

    b. The competency approach causes us to focus primarily on fixing our weaknesses.

    c. Many of the world's best leaders are "spiky," with their own unique set of high-level skills providing their competitive advantage.

    d. Consider focusing your efforts on continuing to improve your best skills, while also working on glaring weaknesses, or finding others to complement your skill set

This "Free Thinker's Guide" will challenge how you utilize some of the world of work's "settled truths" to help you find more "love-in-work!" Our people and our organization's performance will benefit greatly from this effort.



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