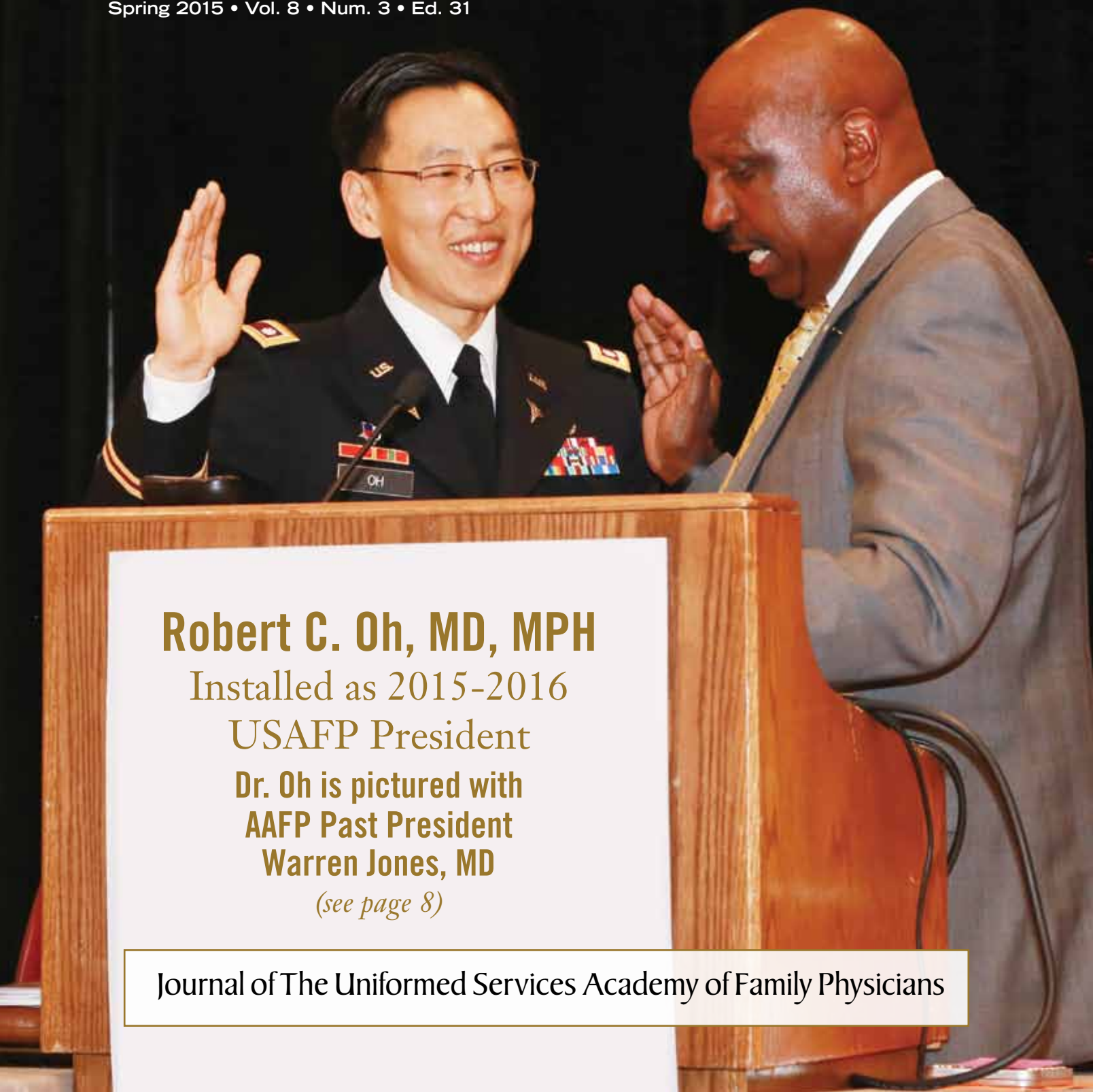
THE UNIFORMED FAMILY PHYSICIAN
Spring 2015 • Vol. 8 • Num. 3 • Ed. 31



Robert C. Oh, MD, MPH

Installed as 2015-2016 USAFP President

Dr. Oh is pictured with AAFP Past President Warren Jones, MD

(see page 8)

Journal of The Uniformed Services Academy of Family Physicians

Doctor Recommended.

In 29 states and more than 200 hospitals.

Wherever you see yourself and your new practice, chances are a CHS-affiliated hospital is nearby. And if you choose to practice with one, chances are you'll be glad you did. Approximately 22,000 physicians – employed and independent – serve on the medical staffs of more than 200 CHS-affiliated hospitals in 29 states. The hospitals deliver a wide range of health services and function as vitally important members of their local communities. Last year, physician satisfaction was high at 89 percent, and 91 percent of physicians said they would recommend the hospitals with which they are affiliated to family and friends.*

In 2013, The Joint Commission named 93 CHS-affiliated hospitals as Top Performers on Key Quality Measures. An array of national quality recognitions and honors includes accredited chest pain centers, accredited stroke centers, and Centers of Excellence for bariatric services.

While we're literally "all over the map," we're focused on helping you find a place to build a successful practice. Affiliated hospitals have the flexibility to meet individual needs and the ability to offer **competitive recruitment packages and start-up incentives**, which may include medical education debt assistance and even residency stipends. Hundreds of physicians choose CHS-affiliated hospitals each year – for quality of care and quality of life. One may be right for you!

CHS Community Health Systems

For more information, visit: ***www.chsmedcareers.com.***

Email: docjobs@chs.net **Call:** 800-367-6813

**CHS-affiliated facilities included 135 hospitals in 2013.*

THE UNIFORMED FAMILY PHYSICIAN

The Uniformed Services
Academy of Family Physicians
1503 Santa Rosa Road
Suite 207
Richmond, Virginia 23229
804-968-4436
FAX 804-968-4418
www.usafp.org

USAFP e-mail
Terry Schulte: tschulte@vafp.org
Mary Lindsay White: mlwhite@vafp.org

Newsletter Editor
James Ellzy, MD: ellzyj@gmail.com

VISION

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

MISSION

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

pcipublishing.com

Created by Publishing Concepts, Inc.
David Brown, President • dbrown@pcipublishing.com
For Advertising info contact
Michele Forinash • 1-800-561-4686
mforinash@pcipublishing.com

Edition 31

your academy leaders

OFFICERS AND COMMITTEES

OFFICERS

PRESIDENT
Robert C. Oh, MD, MPH
Ft. Belvoir, VA
Robert.c.oh.mil@health.mil

PRESIDENT-ELECT
Christopher Paulson, MD
Eglin AFB, FL
Paulson_nd@yahoo.com

VICE PRESIDENT
James Ellzy, MD
BUMED, Washington, DC
ellzyj@gmail.com

SECRETARY/TREASURER
Kimberly Roman, MD
US Coast Guard
Washington, DC
Kimberly.W.Roman@uscg.mil

PAST PRESIDENT
Mark J. Flynn, MD, FAAFP
Camp Pendleton, CA
Mark.flynn@med.navy.mil

EXECUTIVE DIRECTOR
Terrence J. Schulte
Richmond, VA
tschulte@vafp.org

DIRECTORS

AIR FORCE
Christopher Jonas, DO
The White House, Washington, DC
Christopher.jonas@whmo.mil

Jessica Servey, MD
USUHS
Jessica.servey@usuhs.edu

Kirsten Vitrikas, MD
Travis AFB, CA
Kirsten.vitrikas@us.af.mil

ARMY
Kevin Kelly, MD, MBA
Ft. Hood, TX
kevin.m.kelly2.mil@mail.mil

Laurel Neff, DO
Fort Wainwright, AK
Laurel.a.neff.mil@mail.mil

Mark E. Stackle, MD, MBA
Ft. Bragg, NC
markstackle@gmail.com

NAVY
John Laird, MD
Camp Lejeune, NC
john.e.laird8.mil@mail.mil

Michelle Lynch, MD
Camp Lejeune, NC
michelle.m.lynch8.mil@mail.mil

Brian Smoley, MD, MPH
Camp Pendleton, CA
Brian.amoley@med.navy.mil

PUBLIC HEALTH SERVICE
Edgardo Alicea, MD
USCG Savannah, GA
Edgardo.alicea@uscg.mil

Maria DeArman, MD
USCG Corpus Christi, TX
Maria.d.dearman@uscg.mil

RESIDENTS
Jason Butler, DO
Ft. Bragg, NC
jason.n.butler.mil@mail.mil

Jed Siebel, DO
Naval Hospital Jacksonville, FL
edmund.j.siebel.mil@mail.mil

Breanna Gawrys, DO
Ft. Belvoir, VA
briegawrys@gmail.com

AAFP

DELEGATES
Pamela M. Williams, MD
Nellis AFB, NV
Pamela.williams@us.af.mil

Robert C. Oh, MD, MPH
Ft. Belvoir, VA
Robert.c.oh.mil@health.mil

ALTERNATES
Christopher Paulson, MD
Eglin AFB, FL
Paulson_nd@yahoo.com

James Ellzy, MD
BUMED, Washington, DC
ellzyj@gmail.com

CONSULTANTS

AIR FORCE
Marcus Alexander, MD
AFMOA, San Antonio, TX
Antoine.Alexander@us.af.mil

ARMY
Shawn Kane, MD
Ft. Bragg, NC
shawnfkane@yahoo.com

NAVY
Timothy Mott, MD
Naval Hospital Pensacola, FL
timothy.mott@med.navy.mil

COMMITTEE CHAIRS

CLINICAL INFORMATICS
Matt Barnes, MD
Ft. Belvoir, VA
matbarnes@gmail.com

CLINICAL INVESTIGATIONS
Anthony Beutler, MD
USUHS, Bethesda, MD
thesportsmd@yahoo.com

CONSTITUTION AND BYLAWS
James W. Keck, MD
Naval Hospital Jacksonville, FL
jkeck@usna94.com

EDUCATION
Douglas Maurer, DO
Madigan AMC, WA
Douglas.m.maurer.mil@mail.mil

HEALTH PROMOTION AND DISEASE PREVENTION
Debra Manning, MD, MPH
Naval Hospital Pensacola, FL
Dr.deb.manning@gmail.com

MEMBER CONSTITUENCIES
Luis Otero, MD
Charleston AFB, SC
Luis_oterojr@yahoo.com

Yolanda Backus, MD
JBER, AK
yolandafig@hotmail.com

MEMBERSHIP AND MEMBER SERVICES
Adam Saperstein, MD
USUHS
Adam.saperstein@usuhs.edu

NEWSLETTER EDITOR
James Ellzy, MD
BUMED, Washington, DC
ellzyj@gmail.com

NOMINATING
Mark J. Flynn, MD, FAAFP
Camp Pendleton, CA
Mark.flynn@med.navy.mil

Robert C. Oh, MD, MPH
Ft. Belvoir, VA
Robert.c.oh.mil@health.mil

Christopher Paulson, MD
Eglin AFB, FL
Paulson_nd@yahoo.com

OPERATIONAL MEDICINE
Jason Ferguson, DO
Tripler AMC, HI
Jason.l.ferguson.mil@mail.mil

Barrett Campbell, MD
Fort Irwin, CA
Barrett.h.campbell.mil@mail.mil

PRACTICE MANAGEMENT
Elizabeth Duque, MD
Ft. Hood, TX
Elizabeth.h.duque.mil@mail.mil

2015 PROGRAM CO-CHAIRS
Michael Mercado, MD
Camp Pendleton, CA
Michael.mercado@med.navy.mil

Janet West, MD
Naval Hospital Jacksonville, FL
janet.m.west14.mil@mail.mil

2016 PROGRAM CO-CHAIRS
Edward Y. Kwon, MD
FT. Belvoir, VA
eddiekwon6@yahoo.com

Shane Larson, MD
Fort Carson, CO
shane.l.larson.mil@mail.mil

RESIDENT AND STUDENT AFFAIRS
Aaron Saguil, MD, MPH
USUHS, MD
Aaron.saguil@usuhs.edu

Robert C. Oh, MD, MPH
USAFP President
Ft. Belvoir, VA

president's message

ROBERT C. OH, MD, MPH

Our Journey to Health – Start Small but Start Now

Energized and in awe. That's the feeling I felt after 5 days of great CME, catching up with old friends and meeting new people. I thank those that came up to me and encouraged me after the installation luncheon. For those not able to make it, I'd like to use this column to recap my vision for the next year and also to challenge our members to begin the journey to health, and making health primary. But first, let's go over those numbers that I mentioned in Crystal City. This is the reason why we need to make the shift from disease care to a focus on health and wellness.

BIG BUCKS, LITTLE BANG

We spend nearly 18% of our GDP, 2.7 trillion dollars, yet we fall short in many measures of "health" according to the World Health Organization.[1]

OBESITY AND DIABETES

35% of US adults are obese, and 17% of our children are considered obese. And the trajectory continues to rise. If we don't do anything about it, by 2030 it is projected that 50% of our nation will be obese.[2] Nearly 47% of all the US population either have diabetes or are prediabetes. 29 million (9.3%) people have diabetes and 86 million (37%) adults have Prediabetes. Most (9 out of 10) do not even know they have prediabetes. And, if there's nothing done, up to 15-30% of those with prediabetes will convert to diabetes in 5 years.[3]

Over the next year, let's journey together. I will use this space to explore topics on health and wellness. If you have a topic on health, please consider writing an article in the Uniformed Family Physician.

TOO MUCH SUGAR

150 lbs of sugar is what the average American consumes. Less than 100 years ago, it was only 4 lbs of sugar per person per year.[4] The rates of obesity and Diabetes has skyrocketed over the last 20 years, and I believe we have a public health crisis on our hands. While there are many debates of why this is occurring, I am more and more convinced that the low fat diet we've been preaching has caused this epidemic by inadvertently displaced nutrient dense foods for fast, available sugar and refined carbohydrates.

THE COST OF PREVENTABLE DISEASES

160 million (nearly one/half of Americans) have a chronic preventable disease of obesity, diabetes, hypertension, or CV disease. And one estimate is that it accounts for 78% of our healthcare costs. This is the Elephant in the Room. Especially since we know that lifestyle changes can protect you from these chronic diseases. The EPIC Norfolk study followed 23,000 people and found that if you have these 4 behaviors, it reduced the risk of diabetes by 93%, MI by 83%, strokes by 50% and even cancer by 36%. What are they? 1. Not smoking. 2. Exercise 210 minutes/week, 3. A Healthy diet, and 4. Maintain BMI < 30. So, can these chronic diseases be prevented? I truly believe so.

TURNING OFF THE TAP

Mark Hyman has written, "Disregarding the underlying causes and treating only risk factors is somewhat like mopping up the floor around an over-flowing sink instead of turning off the faucet, which is why medications usually have to be taken for a lifetime."[5] Doctors are excellent at learning the different methods of floor mopping, and mopping the floors more efficiently. We are even good at documenting how we were able to mop the floors. We are good at looking at different mops, towels, brushes to do our job better. Meanwhile the clinics and hospitals are overrun with water, and not many of us are looking at turning off the faucet. Are you tired of mopping the floors? I sure am.

TWO SIDES TO THE SUPPLY/DEMAND EQUATION

So, what can we do about it? Well, if we don't do anything now to slow down the tap, this epidemic of obesity and dia-

continued on page 6

betes, we will constantly be overwhelmed and eat up our healthcare resources. I recognize we have a clear need for more physicians as our population ages and gets sicker. But again, we all know that there's always two sides to the supply and demand equation. The demand for access seems never ending. The more we tackle and improve the HEDIS metric for diabetes one person at a time, there's 10 more to track. Instead of just focusing on increasing supply of physicians to handle the demand, why don't we also turn down the demand? Wouldn't that be better?

OUR CHALLENGE

We need to really shift the way we think about medicine, and family medicine. The AAFP is undergoing a remarkable campaign called "Health is Primary." There are many nuances to this, but clearly, one of the goals is the need to shift our focus from disease care (which we are really good at) to one of health-promotion and preventing disease. So, where do we begin? We are a bunch of super smart and innovative individuals who can figure this out. Collectively we are stronger, and I want to challenge the members of our Academy to look into their respective foxholes on how we can "Make Health Primary." Together we can start the small shift into taking ownership in health promotion and prevention. Pastor Wayne Cordeiro from New Hope Oahu once said, when tackling something daunting, "Start small, but Start Now." If nothing else, sign up for the *Health Is Primary* campaign at *www.healthisprimary.org* and get educated on the campaign. More importantly though, do it for yourself. Where can you look at improving your health and wellbeing? How can we take care of our family or our patients if we don't take care of ourselves?

Over the next year, let's journey together. I will use this space to explore topics on health and wellness. If you have a topic on health, please consider writing an article in the Uniformed Family Physician. Although this is a seemingly daunting culture shift together we can make health primary. Let's start small, but let's start now!

REFERENCES:

[1]Centers for Disease Control-Health Expenditures. *http://www.cdc.gov/nchs/fastats/health-expenditures.htm*

[2]Centers for Disease Control-Obesity Facts. *http://www.cdc.gov/obesity/data/facts.html*

[3]Centers for Disease Control and Prevention. *National Diabetes Statistics Report: Estimates of Diabetes and Its Burden in the United States*, 2014. Atlanta, GA: US Department of Health and Human Services; 2014.

[4]USDA –Chapter 2. Profiling Food Consumption in America. *http://www.usda.gov/factbook/chapter2.pdf*

[5]Hyman M a., Ornish D, Roizen M. Lifestyle medicine: treating the causes of disease. Altern Ther Health Med. 2009;15(6):12-14.

editor's voice

JAMES ELLZY, MD

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

How fortunate that my first newsletter as the new editor is just after the annual meeting. Our chapter is buzzing with energy, undoubtedly for many from the camaraderie of spending time with old friends and colleagues. The energy is evidenced by the plethora of submissions for this edition as well! It's full of useful information for everyone from students and residents to senior physicians nearing the end of their career (and all in between too). It also covers all aspects of uniformed physicians: clinical, executive/administrative, operational, research, and teachers.

The current newsletter format seems to work well for us, so I'm not planning on making any changes. But if you have any ideas on items you would like to see or things you don't want to see anymore… feel free to email me and let me know. In the meantime, sit back and enjoy!

CORRECTION: Please note a correction from the Winter 2015 edition due to the mislabeling of the Operational Medicine Article "What Every Deploying Doc Needs to Know About: Chemical Weapons and Warfare" — incorrect authors listed. The author of the article is Barrett Campbell, MD, FS Chief, Primary Care, Weed Army Community Hospital, Fort Irwin, CA *barrett.h.campbell.mil@mail.mil.*

Robert C. Oh, MD, MPH Installed as 2015-2016 USAFP President

Over 380 attended the 2015 Installation of USAFP Officers and Directors on Saturday, 21 March 2015 at the Hyatt Regency Hotel in Arlington, VA. AAFP Past President Warren Jones, MD installed 2015-2016 USAFP President Robert C. Oh, MD, MPH and the other Officers and Directors of the USAFP Board of Directors during the luncheon.

Dr. Oh is pictured presenting his Incoming President's Message.

Pictured left to right are the 2015-2016 Officers and Directors that were installed at the Installation Luncheon – Jason Butler, DO, Army Resident Director, James Ellzy, MD, Vice President, Christopher Paulson, MD, President-Elect, Kimberly Roman, MD, Secretary/Treasurer, Kirsten Vitrikas, MD, Air Force Director, Kevin Kelly, MD, Army Director, Michelle Lynch, MD, Navy Director, John Laird, MD, Navy Director, Breanna Gawrys, DO, Air Force Resident Director and Jed Siebel, DO, Navy Resident Director.

The **University of Tennessee Department of Family Medicine** invites applications from highly qualified and experienced family physicians to fill two key leadership roles at our UT-Saint Francis Residency Program. We are seeking two eager, enthusiastic individuals to serve as the PreDoctoral Director for medical students at the University of Tennessee College of Medicine and a Medical Director for the newly established Physician Assistant program in the College of Allied Health Professions.

The PreDoc director will be responsible for all four years of medical student training in family medicine. The Director role involves developing goals and objectives, curriculum, evaluation systems, faculty development, scholarly engagement in the critical appraisal of the literature, directing the medical student lecture series and working closely with the Family Medicine Interest Group. The individual will work closely with our residency programs in Jackson, Knoxville and Chattanooga to ensure standardized training and evaluation for each student.

The Medical Director of the Physician Assistant program will work closely with the PA leadership team and faculty to provide oversight of the PA program. Curriculum development, evaluation and feedback, faculty development and providing lectures are the major responsibilities.

In addition to the specific leadership responsibility, the successful candidates will have the wonderful opportunity to work with a dynamic faculty, practice the full-spectrum of family medicine that includes obstetrics in a very supportive academic and practice environment; and help train a great group of medical students, residents and fellows. Qualified applicants should hold the MD/DO degree, be board certified, and have proven experience as a physician, leader and clinician educator. Obstetrics and research are negotiable. Academic rank and salary are commensurate with qualifications and experience.

Interested applicants should submit a cover letter and CV to

Dr. David L. Maness, Professor and Chair UT Department of Family Medicine 1301 Primacy Parkway, Memphis, TN 38119

The University of Tennessee is an EEO/AA/Title VI/Title IX/ Section 504/ ADA/ ADEA institution in the provision of its education and employment programs and service.

Patient First®

You Take Care of Patients. We'll Take Care of You.

Get the work and lifestyle advantages you want at Patient First

Patient First is one of the leading primary and urgent care providers in the mid-Atlantic with over 50 locations throughout greater Washington DC, Maryland, Virginia, Pennsylvania, and New Jersey. Because Patient First was founded by a physician, we thoroughly understand both the flexibility and freedom you want in your career and personal life. If you're ready for a career where you are as important as one of our patients, contact Patient First. We're looking for full and part-time primary care physicians to join our staff. At Patient First, you will receive a wide range of benefits:

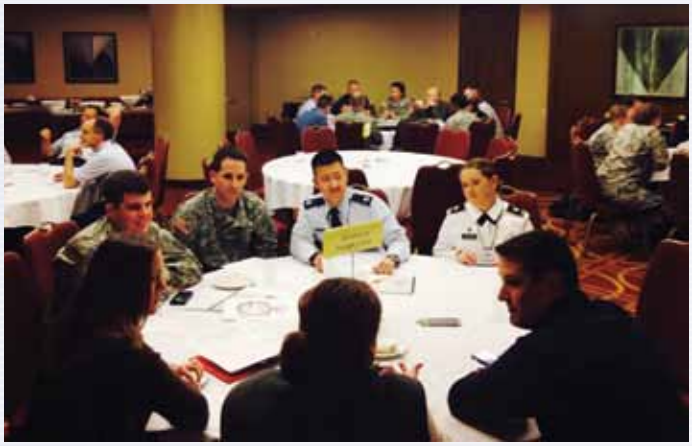
- Competitive salary
- Team-oriented environment
- Flexible schedule
- Career advancement opportunities
- Excellent malpractice insurance
- Health, dental, vision, life, and disability insurance

To learn more about career opportunities at Patient First, contact Recruitment Coordinator Eleanor Dowdy at 804-822-4478 or eleanor.dowdy@patientfirst.com or visit prcareers.patientfirst.com/

2015 USAFP Annual Meeting
Another Successful Year!

Over 460 family physicians and other healthcare professionals attended the 2015 USAFP Annual Meeting & Exposition at the Hyatt Regency Hotel in Arlington, Virginia. Meeting attendees raved about the outstanding CME program and the activities available in the Washington, DC area. The photos and comments below summarize the success!!

- It was a superb conference. It's been several years' since I've been able to attend and how wonderful and refreshing to get this opportunity again. Thank you!
- This conference was very well organized and met my CME goals as well as achieving a better understanding of the future of MHS family medicine.
- Everything was awesome!
- Best conference for FM docs bar none!
- Congrats on a great meeting!
- Very well chosen topics and speakers. Great to see residents getting highly involved in lecturing.



A Special Thank You to the 2015 USAFP Annual Meeting Exhibiting Organizations

The following organizations exhibited their products and services at the 2015 USAFP Annual Meeting. The Academy is fortunate to have such great support from these organizations.

3RNet
Abbott Point of Care
Actavis
Allina Health
AMSUS - Society of Federal Health Professionals
Anne Arundal Medical Center
Bayer HealthCare
Brymill Cryogenic Systems
Carilion Clinic
Centra Medical Group
Colorado Family Medicine Residencies
Confluence Health
Corizon Health
Darnall Family Medicine OB Fellowship
Defense and Veterans Brain Injury Center
EmCare
Essentia Health
Evoke Neuroscience
Geisinger Health System
GlaxoSmithKline
Gundersen Health System
Human Performance Resource Center
Humana
Indian Health Service
Inova Health System
JenCare Neighborhood Medical Centers
Kaiser Permanente - MAPMG
Kaiser Permanente - TPMG and SCPMG
Madigan Faculty Development Fellowship
Magnolia Medical Clinic - Ft. Walton Beach, FL
Mary Washington Healthcare
Mayo Clinic
MedExpress
Medimix Specialty Pharmacy
Merck Federal Healthcare Affairs
Millennium Health
Ministry Health Care
National Center for Telehealth & Technology
NeilMed Pharmaceuticals
Nuance Communications
Otto Trading, Inc.
Patient First
Pfizer
Pioneer Health Services
Shoreland, Inc.
Tennessee Rural Partnership
Texas Association of Community Health Centers
The Inline Group
The Medication - Induced Suicide Foundation (MISSD)
The National Campaign to Prevent Teen & Unplanned Pregnancy
Thermo Fisher Scientific
Total Pain Solutions
TPMG
Tri-Service Workflow
UNC Faculty Development Fellowship
United States Coast Guard
University of Texas Medical Branch
Walgreens
Wolters Kluwer (Lippincott)
Yakima Valley Farm Workers Clinic

A Special Thank You to the 2015 USAFP Annual Meeting Sponsors and Partners

The significant support of these organizations is greatly appreciated by the Uniformed Services Academy of Family Physicians.

SILVER PARTNERS

Abbott Point of Care
Geisinger Health System
Patient First

BRONZE PARTNERS

3RNet
Actavis
Allina Health
Carilion Clinic
Colorado Family Medicine Residencies
Humana
Mary Washington Healthcare
Medimix Specialty Pharmacy
Merck Federal Healthcare Affairs
Millennium Health
Ministry Health Care
The Inline Group
TPMG
UNC Faculty Development Fellowship

2015 Academy Awards

Congratulations to the 2015 Family Physician of the Year Award Recipient

2015 USAFP Michael J. Scotti, MD Family Physician of the Year

Kevin O'Connor, DO, FAAFP; COL, MC, USA

Dr. O'Connor's award reads as follows, "In recognition and deep appreciation for your unparalleled commitment to family medicine, the Uniformed Services, and our nation's leaders. You are a tremendous example of providing compassionate and comprehensive medical care on a 24/7 basis while serving as the Physician to the Vice President of the United States and as White House Physician. Specifically, your provision of routine and emergency medical services for an astonishing 625 missions (over 2,000 flight hours) in support of the Vice President, his family and their staff is remarkable. Spending 945 days away from home, traveling to 66 countries in support of the mission is indicative of your enormous dedication. In addition, providing direct medical care for the President's Cabinet, The US Secret Service and visitors to the White House complex on a daily basis is praiseworthy. You exemplify the tradition of a truly outstanding military family physician and your efforts reflect great credit on you, the Uniformed Services Academy of Family Physicians and the Specialty of Family Medicine." **Special Note: Vice President Joe Biden and his wife Dr. Jill Biden submitted a very moving video congratulating Dr. O'Connor that was viewed by the attendees of the 2015 USAFP Installation and Awards Luncheon.**

Dr. O'Connor is pictured with 2014-2015 USAFP President Mark J. Flynn, MD.

Congratulations to the 2014 Operational Medicine of the Year Award Recipient

2014 USAFP Operational Medicine of the Year Award

Russ S. Kotwal, MD, MPH, FAAFP; COL, MC, USA (Ret)

Dr. Kotwal's award reads as follows, "In recognition and deep appreciation of your substantial contributions, dedication, initiative, and leadership to and within operational medicine. While serving with the 7th Ranger Regiment, you established the first and by far the most successful unit-based pre-hospital trauma registry to be used in the conflicts. This registry drove continuous process improvements (PI) of pre-hospital emergency care (PHEC) not only for the Rangers but indeed across all of DOD. You are quite probably the most published family physician in the area of operational medicine that includes more than 20 Pub Med citations. Your analysis in your publication "Eliminating preventable death on the battlefield" demonstrated the lowest incidence of preventable deaths among combat fatalities ever reported in a major conflict. As the first Director of the Trauma Care Delivery for the U.S. Army Institute of Surgical Research Joint Trauma System, you organized and led a comprehensive review of pre-hospital trauma care in Afghanistan in 2012. Your outstanding accomplishments, expertise and education reflect great credit on you, the Uniformed Services Academy of Family Physicians and the Specialty of Family Medicine." *(Note: Dr. Kotwal would have received this award last year at the 2014 Annual Meeting but he was unable to attend.)*

Dr. Kotwal is pictured with 2014-2015 USAFP President Mark J. Flynn, MD.

Congratulations to the 2015 Operational Medicine of the Year Award Recipient

2015 USAFP Operational Medicine of the Year Award

Riley J. Burke, DO, Captain, USAF, MC

Dr. Burke's award reads as follows, "In recognition and deep appreciation for your service as one of the 24th Special Operations Wing's exceptional physicians. You have excelled in the implementation of the resiliency team approach caring for more than 110 Air Force Special Tactics commandos while serving as the talented leader of a high-performing resiliency team that includes Physical Therapy, Human Performance (strength training), Operational Psychology, and spiritual support. Whether returning wounded battle-tested warriors to the battlefield or pushing those warriors to fitness levels expected of elite athletes you surpass all expectations. Your care through daily clinical and non-clinical interactions led to a 400% increase in clinical encounters as the warrior-athletics quickly saw marked improvement in their health and physical performance. Your outstanding dedication and accomplishments reflect great credit on you, the Uniformed Services Academy of Family Physicians and the Specialty of Family Medicine."

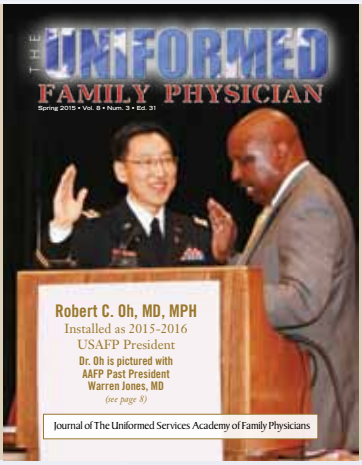
Dr. Burke is pictured with 2014-2015 USAFP President Mark J. Flynn, MD.

Congratulations to Those Physicians that Received President's Awards from 2014-2015 USAFP President Mark J. Flynn, MD

Michael Mercado, MD & Janet West, MD

Drs. Mercado and West's awards read as follows: "In recognition of your dedication, passion, and outstanding service to the Uniformed Services Academy of Family Physicians as Program Co-Chair for the 2015 Annual Meeting in Crystal City, Virginia. You took on the challenge to conceptualize, design, and create a meeting program to meet the needs of our diverse membership, against a backdrop of fiscal uncertainty. Through your tireless effort, you have helped your friends and colleagues in all services to grow professionally as clinicians and leaders.

Pictured left to right are 2015 Program Co-Chair Janet West, MD,
2014-2015 USAFP President Mark J. Flynn, MD, and 2015 Program Co-Chair Michael Mercado, MD.



consultant report
CG/PHS

Maria D. De Arman M.D.
SECTOR/AIRSTA Corpus Christi
Maria.D.DeArman@uscg.mil

Greetings from South Texas!

Fellow USPHS Officers the call to attend THE Leadership Pre-Conference which will be held in conjunction with the Scientific and Training Symposium has gone out, mark your calendars and plan on attending! This year marks the 50th Anniversary of the Annual Conference, which will be held in Atlanta, GA. If you have not yet decided and are on the fence, please peruse the site at the following web address: *http://symposium.phscof.org*. The opportunities for training, networking and education are phenomenal and are guaranteed to fuel your imagination, creativity as well as to challenge development of your leadership style. Hope to see you there!

USCG Medical Officers, let me preface the following information with a disclaimer. I transferred to the USCG in 2012, during the past 3 years I have had the pleasure of making new friends, learning a whole new phraseology, and enjoying the mental stimulation which comes from learning new things, going new places, and meeting new people. I have been collecting useful information, in hopes of eventually creating a tangible product that others planning to join PHS may use in their process.

In the spirit of sharing: please note, below, extremely, super, useful website that I discovered is: *http://www.uscg.mil/announcements/*. This is THE repository for announcements, which affect our CG life. Here are some of my favorites this year: you might have heard that the CG does NOT have a PT test for all members, which is true. What you might not be aware of is that in the interest of addressing the civilian workforce, the USCG actually created policy to allow civilians to participate in workout time while at work, see **ALCOAST 079/15** for details. If you read **ALCOAST 013/15**, you will find information regarding **free tax assistance** available from CGSPRT!! Vaccination policy changes for wastewater workers see **ALCOAST 027/15**, polio and HEP A no longer required for this subset of the population, decision based on CDC guidance. Also, please note, **ALCGPSC 039/15** has been released and covers, **new** guidance for the processing of **Aviation Physicals and waiver requests**. Please note the appropriate emails for submission of waivers are:

EPM – ARL-PF-CGPSC-EPM-1-Career-Retentions@uscg.mil
OPM – ARL-PF-CGPSC-OPM-2-aviationmedicalwaiver@uscg.mil

Peruse this site and keep up to date on information as it is released. Again, I beg your indulgence for my enthusiasm and joy at such simplicity; my USPHS/USCG career is only 3 years old.

You may also hear some grumbling from your patients, this month because of COMDTINST M1000.4 release date of March 2015, new guidelines regarding retention. Also, please note, the Coast Guard Personnel Manual is being eliminated and reissued as a set of manuals, which will allow for more expedited review of updates and promulgation of policy changes (Yay Progress!).

Lastly, wanted to share a quick patient case that came up recently, no names, just the facts:

20 year old male reports symptoms of abdominal pain to his IDHS (Independent Duty Hospital Services Technician: AKA Corpsman). Care ensues and within 24 hours of symptom onset, the Corpsman is requesting medevac off of the cutter for this particular patient. In an interesting twist of fate, I happen to be flying in the 144 this particular afternoon when the call for the medevac is vetted and get to observe the medevac from the air. As we circled the cutter and watched the patient amble on deck and climb into the waiting HELO, I made the comment to the pilots I was flying with, "that patient does not have appendicitis." It was his swagger that convinced me his was not an acute abdomen.

I luckily was asked to co-ordinate patient's reevaluation, as the ER had released him and the cutter required patient to be cleared by a military physician prior to return to underway conditions. So, I was able to review all records. ER note reflected findings of CT scan consistent with constipation. Patient's prior history documenting 2 years of service and 2 years of medical care, at this point in career, this patient has already had a chest CT scan for chest pain during training, which turned out to be anxiety; a Head CT after an accidental blow to the head during sports training; and multiple referrals for concerns which were unfounded.

> I ask that you join me in interviewing our IDHS', gauging their current levels of diagnostic skill and assist in improving the medical care rendered in our super sick bays, our clinics, and especially aboard our cutters underway.

During the interview process, I asked patient about his childhood, and his parents' view of medical care, discovered extensive history of likely childhood neglect. Patient was very open and honest in discussing his high anxiety in regards to illness and his very real concern that every ache, every pain, heralds genuine life ending disease.

My thoughts in regards to this patient and others like him are that we must interview more, examine more carefully, and probe mental health history with the tenacity of a first year med student. The cumulative effects of ionizing radiation are well documented, the investment of 30 minutes of my time during a 20 minute slot, may actually guide patient's thinking, assist in self discovery, personal growth; not to mention money saved in avoiding unnecessary procedures, thereby significantly decreasing iatrogenic harm.

I think back to that bouncing eager walk to get on the helicopter, even from my birds' eye view, I recognized a 'healthy' walk inconsistent with an acute abdomen; should this not have been apparent to the HS who evaluated him? This patient's chronic access to care, which has been carefully documented for the past 2 years, should that not have raised a red flag and encouraged more conversation between provider and patient?

My fellow Medical Officers, if you have read this far, I appreciate your time, and I ask that you join me in interviewing our IDHS', gauging their current levels of diagnostic skill and assist in improving the medical care rendered in our super sick bays, our clinics, and especially aboard our cutters underway. Education is the key! – SEMPER PARATUS!

consultant report
NAVY

Tim Mott, MD
Naval Hospital Pensacola, FL
Timothy.mott@med.navy.mil

"BULLETS… AND THEN SOME…"

BULLETS

ENHANCING COMMUNICATION — MILSUITE

Congratulations to CDR Jim Keck for being the 100th Family Physician to sign up for MilSuite and join the Navy Family Medicine mailgroup! He has won a "Don't Tread On Me" performance top. Now I'm looking to award the 200th sign-up. Therefore, if you haven't done so yet, on your CAC-enabled computer go sign up at *https://login.milsuite.mil/* and join this progressive forum for communication. Shout out to CAPT Greg Thier for all the hard work pushing forward this venue for FPs!

CONFERENCE APPROVAL

More evolution… The approval process will be moving to an online application process in the near future. Please still allow no less than four months (smaller conferences) to six months (larger conferences) for submissions. The link for all updated information is: *http://www.med.navy.mil/Pages/Conference-Info-2.aspx*.

Some conference FAQs:

Q: *Do board review courses need approval?*
A: No. By instruction, strict "classroom style" board review courses where information is passed essentially by fire hose and there is no associated conference are exempt. There is no need to submit for approval. Caveat- "Board review" courses in Tahiti where information is passed through a Mai-Tai straw with two hours of exhausting CME daily… *don't count*.

Q: *How do I get BUMED lines of accounting for approved conferences?*
A: You Don't. The BUMED conference approval process is simply that, an approval process. It is not tied to funding. Your individual command still needs to approve and fund your TAD to an approved conference.

Q: *Can I attend conferences on permissive TAD without going through the conference approval process?*
A: Yes. Again, per the conference approval instruction, if your command blesses your no-cost TAD, you are free to attend any conference you wish on your own dime.

Q: *OK, I don't want to waste my time completing all the submission paperwork if I am going to be denied. What are the keys to getting approved?*
A: The following are the justifications that will best support your submission:

1. Being a board member or committee chair for the organization holding the conference.
2. Receiving an award at the conference.
3. Being an individual invited to present a lecture or scholarly work.
4. Being in a situation where a conference is the only and/or most cost-effective venue for you to get specific, just-in-time training or CME for ongoing certification or licensure.

Q: *Going to conferences like the USAFP are powerfully important in developing, shaping, mentoring and inspiring young FPs thereby creating the best quality Navy Medical Officers possible. Isn't all this justification process over-reactionary and actually detrimental to career development, retention and ultimately overarching mission achievement?*
A: I am highly sympathetic to this concern. In fact, I would not have been approved 17 years ago to attend my first USAFP conference if the current justifications were in place. Yet, that conference sticks out in my memory as a singular moment where my passions for Navy Family Medicine went to the next level! However we are dealing with a new reality born out of a violation of trust (which was *not* our blunder, by the way). For now, our role is to maximize conference attendance while strictly adhering to the current rules, and constructively developing quantitative and qualitative justifications for enhanced conference attendance.

FULL SCOPE AND CAREER IMPLICATIONS

For career progression it is helpful to maintain your full-scope FP skillset as best as possible. In December I heard Admiral Bono discuss promotion. She stressed diversity in jobs and geography, and "sustained superior performance" as the keys to promotion. One of the keys to diversity and "superiority" is getting back to an MTF where you are likely to have a larger peer group from which you can break out. And one of the ways to increase your

One of the keys to diversity and "superiority" is getting back to an MTF where you are likely to have a larger peer group from which you can break out.

chances to get to an MTF is to maintain your full-scope skillset. With the most recent O-6 Board having a 50% selection rate, we must be more proactive than ever with our career planning and management. I could write this whole article on this topic, but I won't at this moment—suffice it to say, please contact me if you have questions about your career and your personal proactive planning for promotion.

SPECIAL PAYS

BCP — I'm hearing regularly that folks are "losing" their Board Certified Pay (BCP). This is not completely the case, but may seem so at first. What is happening now is related to Maintenance of Certification (MOC) changes. What? Upon completion of your triennial MOC, the ABFM will issue your ongoing certification anywhere between the New Year and February 15th. This means that you won't have proof of ongoing certification and are likely to have an abrupt end to your BCP until you can provide this documentation from the ABFM. The Special Pays office is simply following their instruction in allowing this to stop. Take heart, however, you will receive all BCP for any period that is gapped due to this delay in certification notification from ABFM. I fully understand that this issue can be frustrating, but the point should be moot in a couple years with the anticipated changes in BCP.

MSP/ISP — reason to renegotiate annually (a tip). If you are receiving a four year MSP/ISP bonus, it may be smart to renegotiate annually for a new four year bonus. Why? There is no guarantee that the bonus money will remain at its current rate (although I have no information otherwise). Therefore, if you were in year three of a four-year contract and the MSP/ISP bonus were to drop, then you'd only have one more year at the current rate. However, if you had "locked in" a four-year MSP/ISP annually, you are always in "year one" of that amount, therefore you'd receive the "old"/ higher bonus for three more years. And… if, by chance the bonuses go up, you can renegotiate for the increased bonus… and subsequent commitment.

VOICES FROM THE FLEET

I asked four junior FPs to share some information about their current billets. I love what they shared!

LCDR Vi Song Tring, MC, USN

Greetings from 6th Marine Regiment in Camp Lejeune, NC! I'm starting my 6th month as the Fightin' Sixth's Regimental Surgeon and am thankful for this billet after recently completing my Family Medicine residency. This has been a dream come true. I get to wear 3 major hats. First and foremost, I am the PCM for about 270 Sailors and Marines, but also provide osteopathic treatment for the entire 2nd Division. My residency training has made me confident in managing sports injuries, chronic conditions, and emphasizing preventive medicine. My outstanding Independent Duty Corpsman (IDC) and I constantly train our junior Corpsmen for future careers since many aspire to become physicians or PA's. Managing the LIMDU program has been a full time job and is the most difficult aspect of my job. My second job as the RAS Surgeon allows me to work with the Regimental Senior Enlisted Leader and the four Battalion Aid Station (BAS) Surgeons assigned to a Battalion within the 6th Regiment. Together, we man, train, and equip our Battalions in preparation for various exercises and deployments with MEUs and SPMAGTFs. Finally, I represent Navy Medicine as a Department Head amongst the staff within the 6th Marine Regiment Headquarters. It has been both a rewarding and challenging experience advocating for my patients while ensuring the Marine Corps mission is accomplished. It has been an honor and a privilege to work with the finest fighting force and I look forward to seeing you in the fleet.

LCDR Daniel Elliott, MC, USN

(A Friday morning before a long weekend) I make sure that my son is packed for his trip to Rome with the basketball team then get on the road. It is a crisp, clear morning and the roads are empty. The local station is playing Nirvana, the Stones and AC/DC as the sun rises behind the snow-capped Apennine mountains. My clinic schedule is full for the morning. Parents booking appointments to make sure that little Johnny will be able to fly to Dublin, Paris, Barcelona for the weekend. I am not on call and don't have any continuity patients due, so the weekend is free. If the weather holds, there is hiking, a local chocolate festival, picking lemons from my trees for a first batch of limoncello and, maybe, the Greek ruins at Paestum or the Roman amphitheater at Capua where Spartacus started his revolt. Rain means a trip to the bufala mozzarella factory with cheese, salami and prosciutto and the Naples catacombs tour. All of this plus COLA?

LT Suzanne Clayton, MC, USN

It was my first day onboard the USS George H. W. Bush, an aircraft carrier on its maiden deployment in the middle of the Arabian Sea. After flying onboard via COD and being shown through the maze of p-ways to my stateroom, I wandered down ladder wells and past the mess decks into medical for the first time. I was standing there, brand new and feeling out of place, when a 50-something year old male officer walked in somewhat slouched over stating he woke up not being able to move the left side of his body. He was having a stroke. Welcome to Operational Medicine. On a ship you are the ER provider, the Internist, and the OB/GYN – you are an FP! There are IUDs to be placed and vas deferens to be snipped,

continued on page 18

while taking unexpected breaks to evaluate walk-in patients with chest pain or run down the p-way to syncopal patients. You oversee a patient admitted with pneumonia. You confirm an IUP, then see a Sailor with a broken ankle. You manage HTN, DM, and various other chronic diseases in between doing I&Ds. The benefits of the FP skillset in operational platforms became apparent each day onboard! I was thankful on a regular basis for my Family Medicine residency training.

LT Jessica Bluhm, MC, USN

I am the Medical Officer for Fleet Surgical Team Four (FST-4), based in Norfolk, VA. The FST is a group of about 16 individuals including a surgeon and OR staff, as well as ICU staff, and administrative support. Our main function is to augment the large-deck amphibious ships while they are underway. We are also ready to be called in support of other missions needing medical/surgical providers for a short-term basis. When our ships are in port, my role is to manage preventative medicine for the Team and our assigned Squadrons, and I have the opportunity to work in various branch clinics. The in-port schedule is flexible, allowing time for additional training and conferences. This billet is a great mix of both operational and clinical experience. Getting my Surface Warfare pin is a bonus!

As always, thank you for what you do. Be well!

"The views expressed in this article are those of the author and do not necessarily reflect the official policy or position of the Department of Navy, Department of Defense, nor the U.S. Government."

Thomas Mahoney, MD
Peterson AFB, CO
thomas.mahoney@me.com

Clinical Workflow:
What is it and why does it matter to me?

"Workflow refers to how a practice organizes its staff and resources to conduct defined tasks to produce outcomes." (Lee and Schartzer)

With this broad definition, workflow encompasses all that we do, good or bad. The goal of standardizing clinical workflow is to accomplish these tasks as efficiently as possible and realize mutually desired outcomes.

Those efficiencies can be time-based efficiencies (such as completing tasks in logical order without need for repetition or backing up). They can also be utilizing resources appropriately, or matching appropriate tasks with those with appropriate level of training and maximizing your resources and personnel by utilizing them for their intended roles.

The Tri-Service Workflow (TSWF) was developed in order to leverage AHLTA as a way to manipulate workflow in the best way possible. Essentially, the TSWF suite of forms provide a framework for conducting and documenting clinical encounters for common problems; but they're more than just forms. The training associated with these workflows tries to match roles with abilities and conduct our care and documentation as efficiently as possible. Unfortunately, AHLTA is a very limited system, and the clinical decision support it provides is just as limited; we're stuck with mitigating (instead of solving) redundancies in documentation and passive (or "blues-clues") decision support. So, training these forms and the workflow behind them is essential to making them work right!

Essentially, the TSWF suite of forms provide a framework for conducting and documenting clinical encounters for common problems; but they're more than just forms.

Another benefit of standardized workflow is transportability. In an ideal world, if we have standardized workflows and nomenclature, we would not require as much time or effort to "learn the system" at each MTF we were assigned as we moved from base to base.

Why is a metabolic panel called a BMP at one location, a BPLUS at another, a CHEM7, and a METABOLIC PANEL at still another? The MHS is currently looking to standardize many of these processes and nomenclatures as part of the EHR modernization.

Most have by now heard of DHMSM, the defense health management system modernization program that will replace AHLTA with a next generation electronic health record. Check out this fact sheet if you haven't heard about the program; *http://www.med.navy.mil/navydays/2014%20DHITS%20Presentations/EHR/fact_sheet_DHMSM.pdf*

Work is underway identifying common workflows that will be implemented in whatever EHR gets selected. I had the opportunity to spend the last week of March at a workshop helping to validate a subset of the hundreds of workflows/processes that have been identified throughout the MHS. I saw many members of

continued on page 20

EVERY DOC CAN DO RESEARCH

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

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

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

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

our academy and chapter represented at all levels of this workshop. Rest assured that we have a voice. But your voice is wanted and needed as well. These workflows will be available for "public" comment on milsuite at *https://www.milsuite.mil/book/groups/dod-ehr*. I encourage you to register on milsuite and set up alerts to follow the discussions and provide input. Get involved!

Lee, J., & Shartzer, A. (2005). Health IT and Workflow in Small Physicians' Practices. *National Institute for Health Care Management Foundation, http://www.nihcm.org/~nihcmor/pdf/AHRQ-QandA.pdf April.*

Commentary by Matthew Barnes:

This is an excellent article about the MOST critical part of having a good day in clinic. Our workflow literally defines our day. Workflow is the difference between a turbulent and a smooth clinic. Many of our workflows aren't set up to streamline care that should be – well – streamlined; and as a result, our 15 minute visits take 30 minutes, and our 45 minute visits take 90 minutes.

The biggest barrier to workflow is training and implementation. We've all done ER rotations, and we know how to efficiently take care of chest pain – but why does it take twice as long to handle chest pain in clinic? We know the answer – because your team likely doesn't know how to efficiently handle a chest pain patient. I'm sure that we all agree that there's a 100% chance that we'll have a chest pain patient head to our clinic in the future – so why don't we train to it?

I've heard multiple sound reasons: everything from dysfunctional clinics to staff turnover. But the fact remains: until the workflow changes, these common problems will keep recurring and will keep grinding your clinic to a halt.

As you become leaders, I recommend that you find those turbulent workflows (patients with multiple complaints, codes, curbsides, etc…) and you find/enact ways to mitigate them. In even the most dysfunctional places, you'll likely find that everyone is invested in having a smooth clinic – because everybody wins! If you invest the training time in your team, you'll be able to mitigate workflow problems, and you'll be heading home a little earlier. And yes – the importance of workflow is evidence based.

With that, I'd recommend getting to know what's already out there. Tri-Service Workflow has training specific to workflow (both operational and clinical) on their website: *www.tswf-mhs.com*. There are a number of forms and processes out there to help you manage your clinic -- everything from our challenging cardiovascular patients to our chronic opioid therapy patients.

Have an idea? Hate something? Want to change something? Want us to come out and train you? Let us know! We actively seek out feedback (literally receiving 2000+ change requests per year).

You can also ping us on milsuite: *https://www.milsuite.mil/book/groups/tswf-form-development*

Also, feel free to e-mail me at *matgbarnes@gmail.com* with any questions.

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 www.usafp.org/research.htm for resources or to find a mentor.

Transitioning Military and Federal Healthcare Providers

CONTACT: **Dr Patrick Lynch**
Patrick.Lynch2@ihs.gov
(928) 205-2301

- Relocate to the beautiful mountain resort community of Pinetop, Arizona, located within the largest contiguous ponderosa pine forest in the world with over 180 miles of developed hiking, mountain biking, and cross-country skiing trails throughout the community
- Opportunity to practice full-spectrum medicine if desired, to include ER, urgent care, low-risk OB, inpatient and outpatient medicine
- Alpine skiing and snowboarding only 36 miles away; three 18-hole courses in Pinetop and an additional four courses within 20 miles in nearby Show Low, AZ
- Wonderful four season climate with sunshine more that 70% of the time year-round
- Openings include both federal civil servant positions as well as positions for uniformed officers of the Public Health Service Corps
- Military physicians, FNPs and PA's have the opportunity to transfer services and retain active duty benefits, to include 20 year retirement, TSP, loan repayment, Tricare, access to military base lodging, recreational facilities and space-A flights; for compensation questions: *http://www.usphs.gov/profession/physician/compensation.aspx*

committee reports
CLINICAL INVESTIGATIONS

Drew C. Baird, MD, FAAFP
Darnall Army Medical Center
drew.c.baird.mil@mail.mil

At this year's USAFP Annual Meeting, the Clinical Investigations Committee conducted a successful podium and poster Research Competition, continued the Rise with Research sessions, and held a workshop for research mentors on turning process improvement projects into research. Many thanks to all of the resident and staff physicians who presented their posters or podium presentations, and to all of the research mentors who assisted them!

There were 88 total submissions to the Research Competition this year (74 residents, 13 staff, 1 medical student) and 35 acceptances for presentation (25 residents, 9 staff, 1 medical student). Eighty percent of DoD Family Medicine residencies had presenters at USAFP; the residencies at Darnall Army Medical Center (AMC), Ft. Hood, TX, and Madigan AMC, Joint Base Lewis-McChord, WA, had the most submissions with 15 and 11, respectively; while the residencies at Camp Pendleton, CA, and Offutt Air Force Base (AFB), NE, doubled their submissions from last year. Of note, the total number of clinical investigations submitted to the competition nearly doubled from last year and two thirds of all presenters were presenting for the first time.

Winners of this year's Research Competition were as follows:

Poster Competition – Case Report

- 1st place: Mitchell M. Selco, DO, Camp Pendleton Naval Hospital; *Schwannoma in a Patient with Postpartum Preeclampsia*
- 2nd place: Daniel Kim, DO, Camp Pendleton Naval Hospital; *Chlamydial Pharyngitis: Mimicking Streptococcal Pharyngitis*
- 3rd place: Edmund J. Siebel, DO, Jacksonville Naval Hospital; *Topiramate Associated Acute Angle Glaucoma in a Pediatric Patient*

Poster Competition – Clinical Investigation, Resident category

- 1st place: Jacqueline Lis Yurgil, DO, Robins AFB, GA; *Copy Forward Process Efficiency: A Pilot Study*

Poster Competition – Clinical Investigation, Staff category

- 1st place: Douglas M. Maurer, DO, MPH, Madigan – Fort Lewis AMC/ Madigan Army Medical Center; *Project Fit4Duty: A Patient-Centered Approach to Preventing Overweight/ Obesity in Military Communities*

Podium Competition – Case Report, Resident category

- 1st place: Mary Alice Noel, MD, Fort Benning AMC/Martin Army Community Hospital; *I Triple Dog Dare You: Competitive Risk-Taking Behaviors in Young Male Soldiers*
- 2nd place: John Vogel, DO, Travis AFB/David Grant Medical Center; *Face Presentation, Risk Factors, Recurrence, and Role for Cesarean Section*
- 3rd place: John DiGiovanni, DO, Tripler AMC/Tripler Army Medical Center; *Sickle Cell Trait, Hematuria and Vasopressin: A Surprising Solution*

Podium Competition – Case Report, Staff category

- 1st place: Lawrence M. Gibbs, MD, St. Louis University Belleville/Scott AFB; *Beware of the Beetle: A Case Report of Severe Vesicating Dermatitis*
- 2nd place: Timothy J. Coker, MD, Offutt AFB/University of Nebraska; *Harlequin Syndrome: An Unforgettable Face*

Podium Competition – Educational Research

- 1st place: ENS Chase Hughes, Uniformed Services University; *A Pilot Study of Medical Student Perceptions of Standardized Patient Feedback*

Podium Competition – Clinical Investigation, Resident category

- 1st place: Caitlyn Rerucha, MD, Fort Bragg AMC / Womack Army Medical Center; *Military Healthcare Providers Knowledge and Comfort Regarding the Medical Care of Active Duty Lesbian, Gay, and Bisexual Patients*
- 2nd place: Zachary Prather, MD, Fort Hood AMC / Darnall Army Community Hospital; *Process Improvement Project – Improved Recognition and Diagnosis of Pediatric Hypertension in a Family Medicine Clinic*

Podium Competition – Clinical Investigation, Staff category

- 1st place: Erik J. Schweitzer, MD, Bremerton Naval Hospital; *Cancer Screening: Any Homeport in a Storm*
- 2nd place: Sara M. Pope, MD, MPH, Bremerton Naval Hospital; *The Effect of the Patient-Centered Medical Home on Cervical Cancer Screening Rate in a Navy Family Medicine Clinic*

Outstanding Achievement in Scholarly Activity among Residency Programs

- Air Force: Nellis AFB Family Medicine Residency
- Navy: Jacksonville Family Medicine Residency

- Army: Darnall AMC Family Medicine Residency
- Tri-service: Fort Belvoir Family Medicine Residency
- Military Health System (MHS): Womack AMC Family Medicine Residency

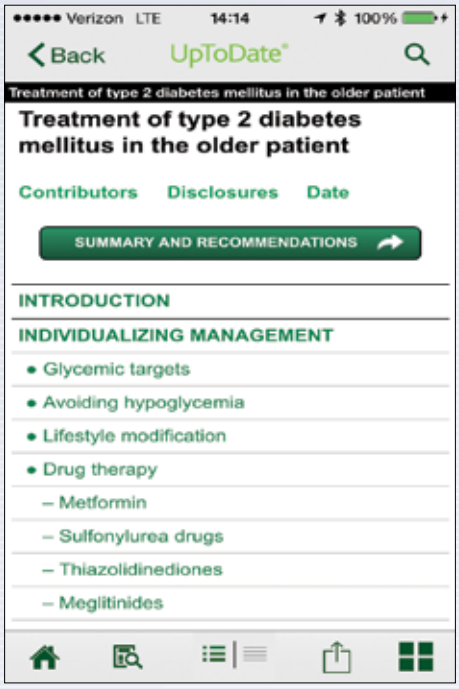
For the second year, the Clinical Investigations Committee held Rise with Research sessions on Saturday morning of the USAFP Annual Meeting. The USAFP receives many more submissions than can be presented in the Research Competition, and Rise with Research was created to promote scholarly activity across the USAFP. Those selected for Rise with Research presented their posters during four thematically-grouped presentations on Saturday morning of the conference. In total, 29 posters were presented (27 residents, 2 staff), representing 13 different Family Medicine residencies.

On Thursday afternoon of the USAFP meeting, the Clinical Investigations Committee held its annual research mentor workshop for residency research mentors and any other meeting attendees interested. The workshop was entitled, "Beyond the MTF: Elevating Your PI to Practice Changing Research," and it provided participants with the background, tools, and techniques necessary to transform process improvement projects – which are increasingly required by ACGME, ABFM, Joint Commission, etc. – into well-designed, data-driven scholarly protocols that can result in evidence-based improvements in the quality and safety of care. We hope to highlight the details of this workshop in a future Clinical Investigations Committee column.

Douglas M. Maurer, DO, MPH, FAAFP
Madigan Army Medical Center, WA
Douglas.m.maurer.mil@mail.mil

Three Cheaper UpToDate Alternatives for Physicians

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



For many of us, especially my residents and fellows, UpToDate is the medical application of choice for answering clinical questions. It is not surprising why. UpToDate is now one of the oldest and most respected sources of medical information. Founded in 1992 by Dr Burton Rose, UpToDate has grown into a juggernaut. Nearly every academic medical center in the United States uses UpToDate. I have been using it since I first was exposed to it during my Family Medicine residency. It became my go to app on my Palm Pilot and every Smart Device I have owned since.

Until recently, it was difficult (and expensive) to use the mobile version of UpToDate on your device. Unless you were an individual subscriber like me, you couldn't enjoy UpToDate on your mobile device. In 2013 that changed with the introduction of UpToDate Anywhere. If your medical center has an institutional subscription, you can get access to UpToDate Anywhere on your iPhone, Android or Windows Phone devices for FREE. However, those apps require a cellular or wireless connection to work. Only individual subscribers (for an additional fee) can get UpToDate Mobile Complete which permits true offline access. This is what I use in my hospital, and it works fantastically well.

So what if you want offline access, but don't want, or can't afford, an individual subscription? What if you want something that is just as or even arguably more evidence based and up to date than UpToDate? What are the viable alternatives to UpToDate? I have found three good alternatives to UpToDate. All three have their own strengths and weaknesses. Only one is free, but all are cheaper than an individual subscription to UpToDate. For the purposes of this article, all three of these alternatives were evaluated on a new iPhone 6 running iOS 8.1.

Essential Evidence

Price: $85 for Individual Subscription plus Institutional Subscriptions

When I first became an evidence based medicine convert, I went looking for medical apps that truly presented the "evidence" not just "expert opinion." The app that initially met my needs was InfoPOEMS (*http://www.essentialevidenceplus.com/*). Founded by Dr Mark Ebell, a family physician and current Deputy Editor for Evidence-Based Medicine of the American Family Physician journal, InfoPOEMS was my go to app on my old Treo smartphone.

InfoPOEMS would simultaneously search multiple databases including the entire Cochrane Library, the 5 Minute Clinical Consult, all the guidelines in the National Guideline Clearinghouse, numerous medical calculators and rarely seen clinical prediction tools, and most notably a collection of handpicked summaries of the evidence from over 100 top journals. It would make any evidence based medicine junkie salivate. In the mid-2000's, InfoPOEMS was sold to Wiley and rebranded as Essential Evidence Plus. Frankly, it hasn't changed much since-and from a mobile perspective it is worse. The Palm and Windows Mobile apps were discontinued after those operating systems lost ground to iOS and Android. The Essential Evidence app was redesigned as a universal mobile web app. This is a tremendous drawback. The days of offline use of InfoPOEMS are gone! The mobile app is clumsy and requires significant use of the "refine" option to get the best answers. If you use it solely from a desktop/laptop perspective, the interface is definitely usable. I still use this reference daily and ensure all of my residents and fellows receive the Daily POEM. This resource could really be top notch if it had a true offline app. At $85 for an individual subscription, Essen-

tial Evidence is really a bargain compared to $499 for an individual subscription to UpToDate.

Links: Mobile app: *http://www.essentialevidenceplus.com/m/.*

Dynamed

Price: Variable: $99.99 Student, $149.95 Resident, $199.95 Licensed Medical Practitioner, $395 Physician plus Institutional Subscriptions

Dynamed from EBSCO -- this resource was also founded by a family physician, Dr Brian Alper. Dynamed is in many ways a hybrid of UpToDate and Essential Evidence with a sprinkling of Medscape. Dynamed covers over 3,200 topics and monitors over 500 journals. Unlike UpToDate which reviews topics quarterly, Dynamed continuously updates and pushes out weekly additions to all of their topics. In fact in several articles including a 2011 BMJ article; Dynamed was more up to date than UpToDate (http://www.bmj.com/content/343/bmj.d5856.full).

Dynamed also is free of most "editorializing" that sometimes is seen in UpToDate. Dynamed gives you the evidence and extensive sources for that evidence. That also is one of its greatest drawbacks. Unlike the "Encyclopedia Britannica" approach that UpToDate takes to its topics—extensive, multiple pages, mini-novels—Dynamed has a much more "bulleted" format. It's a "just the evidence" approach. I like it, but many of my residents find it too narrowly focused. When they are looking for a comprehensive explanation, they still turn to UpToDate. Frankly, I like the "quick, to the point" approach and many times can find the answer faster with Dynamed -- IF it is one of the topics that they cover.

Again, UpToDate has over 10,000 topics. Frankly, the biggest drawback I have with Dynamed is its new interface. Previously, Dynamed on a mobile device was accessed via the Skyscape app. You would open the Skyscape and see the Dynamed icon, tap it and you were off to the races. In 2013, Skyscape re-launched with the Omnio app. The point was to combine the Skyscape apps with news, drug guides, etc…sort of like Medscape. However, now when you open Omnio you see a variety of options, not your Skyscape apps. You have to tap on "My Pages" to see your apps such as Dynamed. This may seem like a minor inconvenience, but I find it an unnecessary barrier to the Dynamed app.

Better than or just as good as UpToDate:

1. More up to date than UpToDate.
2. Fully downloadable onto device (no cellular connection required).
3. Cheaper than UpToDate ($395 vs. $495/year) for non-residents. Subscriptions for residents ($149.95 vs. $199.00/year).

Where UpToDate is still better:

1. More comprehensive (over 10,000 vs. 3,200 topics).
2. Ease of use, more intuitive mobile platform.

Links: iOS: *https://itunes.apple.com/us/app/omnio/id293170168?mt=8*

Android: *https://play.google.com/store/apps/details?id=com.skyscape.android.ui*

Medscape

Price: Free

First, let's take a look at the Medscape App with eMedicine. The free Medscape app is available for iPhone, iPad, Android, and Amazon's Kindle Fire. Medscape is an interesting mix of an app! It is part clinical reference, part drug guide, part news aggregator, part CME app. The Medscape app includes an excellent clinical reference section that includes a drug guide and interaction checker as easy to use as Epocrates (and more popular in the iOS App Store) along with a medical disease and condition reference, the popular and up to date Medscape medical news, and continuing medical education offerings.

The app itself is free, but remember that many apps including Medscape share user information with the pharmaceutical industry. The best part is that the entire app can be used offline. However, when you compare UpToDate to Medscape, the differences are readily apparent. The Achilles heel of the Medscape app is its medical disease and condition reference. Medscape states that it contains over 4,400 conditions. For a free app, this isn't bad, but compared to UpToDate' s nearly 10,000 it leaves a lot to be desired.

The Medscape app is a great alternative to UpToDate for basic drug dosing, drug interaction checking, etc. as the UpToDate equivalent isn't easy to use or at all intuitive. The app's medical news and CME sections rival its competitors, but the medical reference still falls short of finding the most up to date, evidence-based answers to questions at the point of care. It should be noted that you can also accumulate CME just by searching using UpToDate, Dynamed, and/or Essential Evidence Plus.

Links: iOS: *https://itunes.apple.com/app/medscape/id321367289*

Android: *https://play.google.com/store/apps/details?id=com.medscape.android*

Kindle: *http://www.amazon.com/WebMD-LLC-Medscape/dp/B007JOA03M/ref=sr_1_4?s=mobile-apps&ie=UTF8&qid=1331834681&sr=1-4*

Conclusion

There are alternatives to UpToDate. Depending on your institution, budget and personal preferences, Essential Evidence, Dynamed, and Medscape are all worthy alternatives. Medscape is the easiest of the three to use while Essential Evidence and Dynamed are the most evidence based.

My go-to app remains UpToDate, but of the three, I find Dynamed the best alternative to UpToDate with regards to the quality of the content, reliability and ease of use. If they could improve the app's platform and delivery, Dynamed could supplant UpToDate as the go-to medical reference. If you aren't sure if your institution has access to Essential Evidence or Dynamed, make sure to talk to your medical librarian.

Michael Mercado, MD
Camp Pendleton, CA
Michael.Mercado@med.navy.mil

Population Health: A Prescription for Healthier Patients

As a family physician, I deal with a common dilemma: patients with chronic conditions sometimes leave my clinic without the underlying causes being properly addressed. My time with patients is primarily spent discussing and managing diseases rather than addressing the lifestyle habits that perpetuate them. Participating in population health initiatives at my command at Naval Hospital Camp Pendleton (NHCP) has given me hope that medicine doesn't have to be this way. I share my experience with you all, my family physician colleagues, with the vision that we will remain steadfast in focusing on "health" rather than "health care."

In 2012, we at NHCP joined Naval Medical Center San Diego (NMCSD) to begin implementing population health strategies to optimize the health and well-being of our patients and reduce overall health care costs. Patients were segmented into primary, secondary, and tertiary prevention populations and we implemented measures to improve the health outcomes of our sickest patients – those in the tertiary category with complicated, chronic disease states such as advanced cardiovascular disease or poorly controlled diabetes.

Our team from NHCP and NMCSD proactively identified and managed the health of almost 400 patients targeted for their chronic conditions and high utilization of the health system. Results included a 20 percent reduction in emergency department (ED) use, 28 percent reduction in inpatient admissions, and over 5 million dollars in cost savings! So, how did we achieve this success?

First of all, we developed a way to identify and target our sickest patients for interventions by harnessing the technology and data analytical capabilities currently available at military treatment facilities (MTFs) throughout the MHS. Our team developed a patient "scorecard" to pull information from three different databases (CHCS, M2, AHLTA) into a single, easy-to-read document. The scorecard provides a snapshot of individual patients' chronic conditions, emergency room use, hospital admissions, appointments with primary and specialty providers, and their overall health care costs.

Once we identified patients needing interventions, our PCMH teams used the scorecard information to customize and guide targeted intervention measures, and optimize the patients' health. Leveraging the PCMH team-based approach, our physicians worked with the embedded specialists – our clinical pharmacists, behavioral health consultants, and case managers – to ensure the targeted patients were getting in to see their providers, medication regimens were safe and efficacious, and barriers to improving their health were addressed.

In addition, a web portal was developed to connect NHCP and NMCSD providers and beneficiaries to a directory of free or low-cost health, wellness, and social services throughout the San Diego region, both on base and within the local community. Resources accessible through the site include nutrition management courses, fitness centers, and mental health services. One of the many benefits of being part of the military community is that our patients have access to state-of-the-art fitness centers, tobacco cessation courses, and more, most of which are offered by MWR organizations on bases worldwide. Many of these resources and services not only support the improved health and wellness of our tertiary patient population but, as we begin implementing our next phase of population health management, these resources will fully support our primary and secondary prevention strategies.

A shining example of using population health strategies to improve the health of our patients at NHCP is through our shared medical appointments. Currently, we offer group appointments to our diabetic patients once a month in Family Medicine. These appointments are held collaboratively with our embedded clinical pharmacist who can meet with patients during the appointment to discuss their medications and labs, and make any changes if needed. We then spend some time reviewing and reflecting on individual "SMART" goals, my favorite segment of the visit. Additionally, patients engage in a focused learning session with a dietitian, podiatrist, IBHC, or family physician to discuss topics ranging from foot care to Blue Zone living, that enable our patients to learn more and be proactive in managing their own health. At the conclusion of each appointment, to "practice what we preach," we end with a group walk around the hospital. It is a joy to observe patients connect with each other and form their own community, learning from and supporting each other.

In support of our Academy's focus on health and wellness, I hope that this good news story will inspire all of us uniformed family physicians to more fully engage our primary care teams, integrate community health and wellness resources into patient care, and empower our patients to make health and wellness part of their everyday life.

committee reports

MEMBER CONSTITUENCIES

Luis Otero, MD
Charleston AFB, SC
luis.otero.1@us.af.mil

Before moving into the meat of the article I planned, I wanted to bring up that the USAFP Board has changed the name of what used to be the Special Constituencies Committee to the Member Constituencies Committee. This aligns us with the language that AAFP is using. It also helps reorient our members to the purpose of the committee, which is to highlight opportunities and topics of interest for member constituencies which have been perceived to be underrepresented or whose issues or concerns are not adequately heard. The new language broadens the scope of member constituencies and includes new pathways for member constituencies to form. Part of this is the formation of member interest groups such as rural medicine or OB in family medicine. If you are interested in learning more, check out the member constituencies resources page on the AAFP's website.

Moving on to my main topic… recently, we've seen individuals, from the Presidential administration to the Secretary of Defense and various service secretaries, mention that they are open to reviewing policies which bar transgender individuals from serving in the military. The Army has elevated the authority which can authorize the discharge of transgender troops. It is estimated that there are over 100,000 retired or separated transgender military veterans and an estimated 15,000 transgender individuals currently serving. This means it is more and more likely that we as uniformed family physicians will find ourselves providing care for a transgender individual.

Now, some of us may have already had this experience, whether it was with a service member, dependent, retiree, or other recipients of care from the Public Health Service. This was not a topic I learned about directly in residency, but gained exposure to through a community clinic whose clientele was principally LGBT. The American Association of Medical Colleges put together suggested curriculum to help physicians gain exposure in their training. I also wanted to highlight a resource I found particularly useful, which was the primary care protocol for transgendered patient care developed at UCSF. It walks you through the evaluation of individuals who may be transgendered or gender variant. The World Professional Association for Transgender Health also sets out standards of care and diagnostic criteria. Links to both of these resources can be found on the USAFP Member Constituencies webpage.

The topic of transgendered health always reminds me of the importance of family physicians and our approach to the health of a patient. Our approach is not to look at a patient as a medical problem to fix. We examine the environment a person resides in and tailor our medical recommendations using the best evidence and applying them to the particular system of influences. In the case of a transgender person, asking to understand their experience, as well as asking the ever important question of what they are seeking for wellness and health are paramount. Just like asking a patient with a terminal illness what they are seeking as a goal of care, many times we will be surprised (and awed) by what our patients' aspirations truly are.

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 Mary Lindsay White at *mlwhite@vafp.org*.

NEWSLETTER SUBMISSION DEADLINE

REMINDER: The deadline for submissions to the summer magazine is 20 July 2015.

RESEARCH GRANTS

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

RESEARCH JUDGES

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

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

Please write to me...
James Ellzy, MD
ellzyj@gmail.com

Laurel Neff, DO
Ft. Wainwright, AK
laurel.a.neff.mil@mail.mil

MENTORSHIP

This year, the motto for the USAFP Annual Conference was "Equip, Adapt, Mentor." Mentorship came in many forms. From informal networking sessions and evening get-togethers, to lectures on topics such as the "Mentoring Model for Effective Feedback" and "Prezi-fied Mentoring: Be Inspired to Mentor and be Mentored," to the Speed Mentoring session. There were many opportunities to learn about and benefit from mentorship.

The Webster definition of a mentor is "someone who teaches or gives help and advice to a less experienced and often younger person." But more importantly, as Dr. Amanda Cuda looks back over her career in the military it is the "360 degree mentoring interactions" that she loves about USAFP and that "it's a big pot of friendships, mentoring partnerships, and future/current mentors." Dr. Mary Alice Noel and Dr. Jason Gordon both appreciated the opportunity for speed mentoring at the conference. Dr. Noel commented, "My experience speaking to at least 10 senior Family Medicine officers and two general officers provided an invaluable opportunity for me as a future Family Medicine residency graduate." Dr. Gordon added, "The speed- mentoring provided me with an opportunity for active learning during the conference, which I found important."

Given that the uniformed services of which we are a part is a hierarchical organization, it is important to remember that either a mentor or a mentee (and sometimes both) can initiate the relationship. While not all mentorship relationships start with establishing expectations, this is often a critical first step. Areas to discuss may include:

- Setting goals.
- Determining how (and how often) you will communicate.
- Finding creative ways to communicate in order to expand on the relationship.
- Expecting to learn and achieve milestones with the mentors giving specific feedback.
- How to be accountable to each other and encourage active listening on both sides (especially the mentor), and
- Realizing the process is designed to be protégé-centered.

As Dr. Jeffrey Clark pointed out in his keynote address on the opening night of the conference, mentorship is important to the development of our specialty. There are significant rewards, as Dr. Scott Grogan agrees, when previous colleagues and former residents seek out your advice as a mentor. Often times there is a deep sense of pride in seeing someone you mentor succeed and grow, which keeps mentors motivated to continue. Mentorship helps both the mentor and the mentee to develop as leaders in the uniformed services.

As your chapter's Members and Membership Services Committee, we look forward to being able to expand the ability of our members to seek out mentors. Be on the lookout for our new tool this coming summer through the USAFP website. Thank you for being a member of this academy; it is an honor to serve with each and every one of you.

West County Health Centers

Caring for our Communities

a californiahealth center

Wine County Opportunity

West County Health Centers seeks a mission driven, clinically excellent licensed Family Practice Physician, passionate about working with a diverse underserved population in scenic, rural western Sonoma County. Our organization is recognized nationally as an exemplary leader in:

- Comprehensive relational care in a team-based environment
- Integrated behavioral health and primary care
- Innovative use of technology
- Wellness focused, integrative medicine

Board certified MD or DO

Contact:
Phyllis Early 707 824-3379
pearly@wchealth.org

For more information please visit our employment page at www.wchealth.org

PHYSICIANS NEEDED FAR NORTHERN CALIFORNIA (HUMBOLDT-DEL NORTE)

Severe need for Primary Care (Family Medicine/Internal Medicine) in beautiful Humboldt-Del Norte counties. Medical Student Loan Repayment options due to our federal designations as health manpower shortage areas (for primary care and mental health). Please visit the Humboldt-Del Norte County Medical Society's website under "Physician Recruitment"

www.hdncms.org

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

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

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

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

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

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

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

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

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

When applying at *www.jobsatcu.com*, applicants must include:
1) A letter of application which specifically addresses the job requirements and outlines qualifications
2) A current Curriculum Vitae

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

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

Elizabeth Duque, MD
Fort Bliss, TX
Elizabeth.h.duque.mil@mail.mil

Managing Patient Demands

Patients are constantly inundated with advertisements and endorsements for a variety of medical products, from medications to genetic testing. Patients then translate these into requests to their doctors. Patient demands change the way we treat patients. For example, when Angelina Jolie came out that she tested positive for the BRCA gene and had a double mastectomy, the referrals for BRCA testing doubled. In one study, 19.8% of patients received a narcotic from their primary care provider when requested, versus 1% when it wasn't requested.[1] In 2007, when Oprah Winfrey told women they needed ovarian cancer screening with CA125, I personally had many women requesting this test from me. I was initially overwhelmed with what to say to patients and how to say it, and several women did not want to believe me or were not satisfied with my answer. At least I had organizational guidelines to back me up on my decision. Unfortunately, many times physicians are faced with requests where guidelines conflict or don't exist and the answers are not clear cut. How do we handle these demands from our patients?

Patient demands often create a dilemma within us as providers. There are competing tensions in these encounters. We must find the right balance to get to the right answer in the right way for the patient. The emotional response that physicians may have to patient demands is one such tension. Requests can be viewed as a threat to our identity. Here we are physicians with many years of schooling and training behind us, and someone read something on the internet and now knows more than we do (or thinks they do). Even the most humble and self-aware person can have this emotional response. This can create difficulties in how we respond to patients if not aware of it and manage it.

Patient demands often create a dilemma within us as providers. There are competing tensions in these encounters. We must find the right balance to get to the right answer in the right way for the patient. The emotional response that physicians may have to patient demands is one such tension. Requests can be viewed as a threat to our identity. Here we are physicians with many years of schooling and training behind us, and someone read something on the internet and now knows more than we do (or thinks they do). Even the most humble and self-aware person can have this emotional response. This can create difficulties in how we respond to patients if not aware of it and manage it.

Another competing tension is the doctor-patient relationship. This relationship is essential to treating patients and most providers don't want to erode that relationship by just saying "no" to a request. Similarly is the customer service focus of our profession. Although debatable in how important this should be stressed in our industry, most of us still have customer service performance our providers' objectives. Many providers feel that they have to say "yes" to patient demands because it could hurt their customer service rating and thus hurt evaluations and retention bonuses.

Time management is another competing tension when handling demands. We are limited in the amount of time we have with patients. Their requests are often on top of multiple other issues that they had wanted to address that day. It is often easier and more efficient to just say "yes" rather than go through the explanation of why you need to say "no," or what needs to happen to get to "yes." Finally, there are ethically competing demands, the most prominent of which is patient autonomy versus professional integrity. In medicine, patient autonomy is one of the foremost ethical considerations we have. This can conflict with our professional integrity, which requires us to recommend and do what is best for the patient and society. We must consider risks and benefits. We took an oath to "do no harm." Physicians must also be good stewards of the resources of medicine. Patient autonomy

does not mean that they get whatever they want, but it is a truly informed decision on what the options are. We as physicians are a part of educating them to make the patient informed. In the end, no patient can force us to give them something that is against our clinical judgment.

There are not many studies out there looking at this topic but those that exist show that patients' requests are seen frequently in physician offices. One study quoted that in 10% of visits a specific medication is requested by a patient.[2] So, how do you respond when you get a patient request? The answer is usually "it depends." It depends on what guidelines are out there to support your decision, how much risk would the request entail and how far are you willing to go to hold on to your answer. But before you answer, consider a few things.

1. Self Awareness – we need to be aware of our biases and emotions before responding. We need to understand that our self-image may be challenged and that both we and the patient bring biases to the encounter. We also need to challenge those initial assumptions that we bring. For example, I know that when I hear "Dr. Oz says…" I start to tune out. I need to understand my biases so that I can meet the patient on the same level to start to address their concerns. By challenging those initial assumptions I can hear the patient and look for the need in their request.
2. Understand the patient request – We need to dig a little deeper into understanding the root of a patient's request. Are they requesting a specific medication or referral because they are feeling that they aren't being helped by the system? Is there an underlying concern and need that they are looking to have addressed, and making the demand is their attempt to fulfill that need? Finally, what are the assumptions and biases that they are bringing to the table? We may never know all of these, but we can try to get the patient to open up so that we can meet the patient somewhere we can both agree on.
3. Know your bottom line – There may be lines that you are not willing to cross. Where are those boundaries? It is good to know these prior to entering the room if possible (this is one of the tenets for negotiators before they start negotiating). By knowing your boundaries it allows you to know where you can compromise and where you can't.
4. Consider alternatives – If there is time for prep work, this is where it is important to set up "the plan" on how you would like the interview to go. What compromises are out there that you can offer to the patient? Are there other things that can be done to meet their needs? If there is nothing available in your system that you aren't willing to budge on, are there trials that they might be able to enroll in? This can be useful if they are requesting specialized tests or things that haven't been fully studied yet and guidelines don't exist.

Finally you need to answer the patient's demand. Your answer could be "Yes." This is often the answer when the medication or test is relatively low risk, even if it may not be clinically indicated or recommended. It is also often the answer when guidelines are vague, conflicting or don't exist. You wouldn't be alone in this answer. 85% of ER doctors ordered chest x-rays for patient when requested, even though 0% thought it was clinically indicated.[3] Your answer might be "no." I would recommend that you follow up with why it is "no." Usually, this is easiest if there are guidelines or regulations that you can fall back on. An example would be, "my hospital doesn't allow us to prescribe drug x until drug a, b and c are tried first." But, most of the time, your answer is going to be "maybe." This is the compromise area. This is where you can say, I could do this for you but here is the normal approach to this condition, and attempt to get the patients buy in to this. I have seen this example frequently with consult requests like "I can send you to dermatology if you insist but I am capable of doing the skin exam myself and it would save you time and an appointment since we can do it right now, rather than waiting a couple of months to get to see the specialist."

Handling patient demands is not easy. In fact, it can be extremely challenging because of the competing tensions that occur when demands are made. That being said, by being self-aware and being empathic with the patient, it doesn't have to lead to a negative encounter for you or the patient.

ENDNOTES:

[1]Asscher, E., Bolt, I., & Schermer, M. (2012, June). Wish-fulfilling Medicine in Practice: a Qualitative Study of Physician Arguments. *Journal of Medical Ethics*, *38*(6), 327-331.

[2]McKinlay, J. B., Trachtenberg, F., Marceau, L. D., Katz, J. N., & Fischer, M. A. (2014, April). Effects of patient Medication Requests on Physicians Prescribing Behavior: Results of a Factorial Experiment. *Medical Care*, *52*(4), 294-299.

[3]Ballard, D., Reed, M., Wang, H., Arroyo, L., Benedetti, N., & Hsu, J. (2008, December). Influence of Patient Costs and Requests on Emergency Physician Decisionmaking. *Annals of Emergency Medicine*, *52*(6), 643-650.

REFERENCES:

[1]Asscher, E., Bolt, I., & Schermer, M. (2012, June). Wish-fulfilling Medicine in Practice: a Qualitative Study of Physician Arguments. *Journal of Medical Ethics*, *38*(6), 327-331.

[2]Ballard, D., Reed, M., Wang, H., Arroyo, L., Benedetti, N., & Hsu, J. (2008, December). Influence of Patient Costs and Requests on Emergency Physician Decisionmaking. *Annals of Emergency Medicine*, *52*(6), 643-650.

[3]Brett, A. S., & McCullough, L. B. (2012, January 11). Addressing Requests by Patients for Nonbeneficial interventions. Journal of American Medical Association (JAMA), 307(2), 149-150.

[4]Burger, I. M., & Kass, N. E. (2009, April). Screening in the Dark: Ethical Considerations of Providing Screening Tests to Individuals When Evidence is Insufficient to Support Screening Populations. The American Journal of Bioethics, 9(4), 3-14

[5]McKinlay, J. B., Trachtenberg, F., Marceau, L. D., Katz, J. N., & Fischer, M. A. (2014, April). Effects of patient Medication Requests on Physicians Prescribing Behavior: Results of a Factorial Experiment. *Medical Care*, *52*(4), 294-299.

[6]Paterniti, D. A., Fancher, T. L., Cipri, C. S., Timmermans, S., Heritage, J., & Kravitz, R. (2010, Feb 22). Getting to "No". *Archives of Internal Medicine*, *170*(4), 381-388

committee reports

RESIDENT AND STUDENT AFFAIRS

Breanna Gawrys, DO
USAFP Resident Board Member

Jason Butler, DO
USAFP Resident Board Member

Jed Siebel, DO
USAFP Resident Board Member

As newly appointed Resident Directors, this year's USAFP conference was energizing and inspiring. There was a vast array of academic lectures and workshops, and many opportunities for networking. We had an impressive turnout of both residents and students, and enjoyed being able to meet with them and increase involvement in USAFP!

Throughout the week we began to understand our role and responsibilities on the Board of Directors. It was clear that our primary aim (outside of representing our fellow residents) was to increase participation in USAFP. Current residents and medical students are the future of the Academy and it is our goal to help educate them of the scholarship, mentorship, leadership, and networking opportunities it offers.

Over the past two weeks we have found that a large number of HPSP students did not know USAFP existed, and many residents are unaware of its benefits. In the era of physician fatigue and challenges with Active Duty retention, awareness and participation in a group of similarly interested students and physicians can help diffuse stressors and positively influence the environment in which we all work.

Our plans to achieve these goals include staying in regular contact with all Family Medicine Residents through email communication and social media, reaching out to HPSP and USUHS medical students to increase awareness of and participation in USAFP, and representing the Academy at the AAFP National Conference for residents and students in Kansas City in July. We firmly believe that if we can help increase awareness of USAFP and its benefits for the future physicians, residents, and junior faculty among us, we can help shape the future of military Family Medicine.

Aaron Saguil, MD, MPH
Bethesda, MD
aaron.saguil@usuhs.edu

Building the Military Medicine Pipeline – Let the First Face They See Be Our Face

We've all seen the dire numbers: a 20,000 primary care physician shortage by 2020[1] and a declining percentage of family medicine residency spots filled with U.S. senior medical students (44.2%).[2] The picture can look bleak—there is a national need for more family physicians, yet not enough graduating students choose primary care. These realities are reflected in the military, where we all wish we had many more family physicians to take on clinical, operational, academic, and executive roles.

So where do we go to find more future family physicians? Our various recruiting commands are out combing civilian residencies and practices, trying to find willing family doctors, but the number they bring onto active duty each year is low. Our residencies do better—they actively educate and shape HPSP and USUHS students during the critical clerkship year with success. As a result, scores of students choose family medicine annually.

All of this is great, but as the serial bank robber Willie Sutton once said, you "go where the money is." As our recruiters work with practicing physicians, they reach family physicians by ones and twos. As residencies work with students, they reach them by the dozens.

As our recruiters work with practicing physicians, they reach family physicians by ones and twos. As residencies work with students, they reach them by the dozens.

But that may not be where the most money is. There is a potentially untapped source of over 48,000 people each year that might go on to become military family physicians…pre-medical students.

Pre-medical students are hungry for two things: information and role models. There is a tremendous amount of misinformation in the cyber-ether, and students are hungry for someone who has survived the rough and tumble of the admissions and medical education process to provide them with wisdom and guidance. Likewise, pre-medical students are beginning the process of medical professional identity formation, and they are looking for role models to demonstrate what it looks like to be a member of our noble guild.

We in military family medicine have a tremendous opportunity here—by visiting with pre-medical students, we can provide them information and encouragement, while leaving them with an indelible model to follow as they aspire to their own medical career. We have the opportunity to be the face of medicine to them—a military family medicine face.

Visiting, conversations, shaping, sharing, role-modeling—these are the essence of recruiting. As you might imagine, this can be a tremendous amount of fun—especially if you are equipped and helped with logistics!

At USU, we are actively looking for those who would like to recruit for both USU and the HPSP program. With respect to USU specifically, our Office of Recruitment and Admissions is happy to connect you with a local pre-health program and to provide you with brochures, business cards, contact capture cards, and a pre-fabricated slide deck suitable for presentation or for reference during your visit. We will also send you a "cheat sheet" on the current educational program at the University so that you feel comfortable handling common questions. If you would also like to recruit for the HPSP program, we can help connect you with a local area recruiter for information and promotional items—they may even be willing to travel with you to your event!

The next step is really easy—you may either contact me or my team (*aaron.saguil@usuhs.edu*, *althea-green.dixon@usuhs.edu*, *rebekah.wright.ctr@usuhs.edu*) directly about recruiting opportunities, or you can fill out a two minute survey indicating your interest at *http://tinyurl.com/MilMedRecruit* We would love to talk with you and help you be a Face for all those future Military Physicians out there!

REFERENCES:
[1]Health Resources and Services Administration *http://bhpr.hrsa.gov/healthworkforce/supplydemand/usworkforce/primarycare/ accessed 01APR15*
[2]American Academy of Family Physicians *http://www.aafp.org/dam/AAFP/documents/media_center/charts-graphs/Family-Medicine-Positions.jpg accessed 01APR15*

Jason Ferguson, DO, MBA
Tripler Army Medical Center, Honolulu, HI
jason.L.ferguson.mil@mail.mil

Military Family Physicians are Operational Physicians

As its founding members intended, the Operational Medicine Committee represents and supports the uniqueness of military Family Physicians. It is the single committee that distinguishes USAFP from any other chapter of the American Academy of Family Physicians.

Greetings friends and fellow Family Physicians. For those individuals who were able to attend this year's USAFP conference, I think they would agree that it should be added to the "wins" column for our Family Medicine team. The energy was high, the quality CME topics were relevant and timely, and the conversations with friends and mentors were as inspiring and meaningful as ever. Although the conference has become increasingly complex to plan and host in the past few years, its importance to our specialty remains evident. Many thanks to Drs. Mercado and West, as well as the USAFP board members, for their selfless leadership. For those who were unable to attend, please know that you were missed and we hope to see you at next year's gathering.

From the perspective of the Operational Medicine Committee, we seized the opportunity at this year's annual conference to reflect, mentor, and expand our vision and reach within the chapter. Today's operating environment is quite dynamic, regardless if you currently work in an operational, clinical, academic, research, or leadership billet. Although the two main theaters of combat that we have known for over a decade have headed towards a close, they remain a continuing threat. We now shift our focus more towards the healing of our experienced warfighters and the readiness of our force, as we work towards becoming more of an expeditionary force with new missions in Africa and the Pacific. At home, the culture-changing concepts of the PCMH and the Quadruple Aim have been established and continue to be integrated. Graduate Medical Education continues to skillfully produce quality physicians to our ranks, albeit under increasing constraints and challenges. All of these changes are occurring during significant budget decreases and the downsizing of forces.

Due to our numerous transitions, the theme for this year's Operational Medicine CME was titled "Using Experience Gained to Guide Us Now and In the Future." Eighteen different and well-researched Operational Medicine topics were presented by some of our own subject matter experts over the course of the conference. The focus of the presentations was diverse and included updates on Ebola in Africa, the growing knowledge of sleep and its operational significance, the focus of injury prevention, the IDES and medical board process, and the evidence and lessons learned of TCCC (Tactical Combat Casualty Care) as we continue to advocate for its standardization and expansion throughout and across all of the uniformed services. The quality of the presentations was excellent and the time spent by the speakers is certainly appreciated.

As these dynamic times are sure to continue, the Operational Medicine committee is adapting its near term mission focus this year to ensure that we do all we can to meet the needs of each military Family Physician. This includes shifting the emphasis from deployment specific topics and resources to our home station and expeditionary needs and challenges, to include medical readiness and medical training. Looking into the future, the committee has created distinct working groups to address five key areas:

1. Refinement of the mission of the Op Med Committee and definition its core competencies
2. Mentorship, career guidance, and retention of junior ranking physicians and students
3. Establishment of a core, cross-service Military Unique Curriculum for USAFP meetings and CME
4. Further integration of the PHS and USCG service specific resources and presentation opportunities
5. Military topics specific to female Family Physicians

Each of these groups is still looking for additional members. We need your ideas and help to refine our targeted products. These working groups will be meeting

quarterly by teleconference this year. This means that it is NOT TOO LATE to join in the discussion and leadership.

As we heard from our Flag Officers' addresses this past meeting, military Family Physicians are unique. We have a duty to both the medical and military professions. The common thread of members of the USAFP is that there is an operational medicine physician in all of us, regardless if we are currently working in a designated operational assignment or not. PCMHs that take care of our warfighters directly shape their health and readiness. This includes our bright and passionate resident physicians who are eager to make a difference in our service members' lives and within our organization. Our academic faculty are responsible for teaching our future ranks what is exclusive and special about military medicine. Our researchers and developers are endlessly trying to prevent future injuries of our service members by studying operational environments. Each military Family Physician influences and shapes the operational world.

As its founding members intended, the Operational Medicine Committee represents and supports the uniqueness of military Family Physicians. It is the single committee that distinguishes USAFP from any other chapter of the American Academy of Family Physicians. Please contact me or MAJ Barrett Campbell for additional information about joining the committee or one of our working groups listed above. The only thing that you need is a passion for taking care of service members and your peers. Thank you for everything you do to keep our service members strong!

Sebastian R. Schnellbacher, D.O.
Faculty Development Fellow, Madigan
Sebastian.R.Schnellbacher.mil@mail.mil

CHANGE: The Sole Constant

"You've got to be very careful if you don't know where you're going, because you might end up someplace else." –Yogi Berra

Military medicine exists in a world of uncertainty. Change bombards us from every direction. Military budgets are shrinking, and there is a risk of another sequester before the year's end. The Army has downsized to 450,000 troops with rumors of further cuts to 420,000 (interestingly, the United States Military has not been this small since before World War II). Later this month, the administration is planning to respond to recommendations made by the Military Compensation and Retirement Modernization Commission. These recommendations include possibly replacing Tricare with an insurance system similar to the Federal Employees Health Benefits Program. Later this year the DOD will start to roll a new electronic medical record system which has not yet been selected. Meanwhile, the world itself is mired in uncertainty. Potential conflicts exist in the Middle East, Eastern Europe, the Pacific theater, and Africa. As a result, it is difficult to predict when and where the military will be called into action. Even ignoring the world around us, our profession itself remains in perpetual flux. The majority of the medical knowledge I was taught in medical school is now out of date twice over. To further complicate matters, there are so many peer reviewed articles that it is physically impossible to stay absolutely up to date on all of the medical advances. Change seems to be accelerating, and uncertainty will be our bedfellow for years to come.

People react to change in different ways. Some people prefer to put on blinders and remain ignorant to the changes around them. Others become so incensed at the change going on around them that they become angry and refuse to adapt. I have also seen individuals so afraid of change that they freeze in terror or even run the other way. This raises the question: How should one react to change?

In his short parable, "Who Moved my Cheese?," Dr. Spencer Johnson focuses on the interplay between change and individuals. Dr. Johnson uses cheese as a metaphor for a thing we want or value in life, and examines the ways four different characters respond to the constant of change. Throughout the book, these characters discover universal truths about life and change (see Table 1).[1] Some characters avoid complacency and monitor the environment so they have the best warning of impending and inevitable change. Others become so comfortable with the known that they do not notice that their "cheese" is changing until it is gone. Some of these will eventually be able to adapt and search for something new. Other individuals will steadfastly refuse to adapt in the hopes that the world will return to the previous status quo. At best, these individuals lose relevancy. At worse, these individuals truly learn the lesson that "if you don't change, you can become extinct."[1] This concept takes new relevance when one considers some of the possible recommendations that the Military Compensation and Retirement Modernization Commission made for the military healthcare system.

TABLE 1

- If you do not change, you can become extinct.
- Having "cheese" makes you happy.
- The more important your "cheese" is to you the more you want to hold on to it.
- Smell the "cheese" often so you know when it's getting old.
- Noticing small changes early helps you adapt to bigger changes that are to come.
- When you see that you can find and enjoy new "cheese" you change course.
- It is safer to search in the maze than to remain in a "cheeseless" situation.
- Old beliefs do not lead you to new "cheese."
- The quicker you let go of old "cheese," the sooner you will find new "cheese."
- Movement in a new direction helps you find new "cheese."
- Imagining myself enjoying new "cheese" even before I find it leads me to it.
- What would you do if you weren't afraid?
- When you move beyond your fear you feel free.

As leaders, it is not sufficient to approach change from an individual perspective. John Kotter, in his book "Leading Change" outlines eight steps that must be accomplished to allow significant organizational change (see Table 2).[2]

The first phase in Kotter's model is to establish a sense of urgency. Kotter believes that complacency is a commonality shared by many stagnant and decaying organizations. This complacency is often worsened by the lack of an obvious crisis, history of overabundant resources, organizational stove piping, low performance standards, and inappropriate metrics or markers of success. To fight the inertia of complacency, leaders can increase target benchmarks,

TABLE 2

Eight Steps of Organizational Change

1. Establish a sense of urgency
2. Create the guiding coalition
3. Develop a vision and strategy
4. Communicate the change vision
5. Empower broad-based action
6. Generate short-term wins
7. Consolidate gains and produce more change
8. Anchor new approaches in the culture

measure broader markers of performance, or even allow a crisis to develop more fully.[2] An example of this could be attempts to increase compliance with time tracking in the military medical system. Compliance tends to improve once an organization understands that future funding is linked to DHMRSi, and realizes that decreased reporting will lead to a decrease in funding and a potential loss of jobs.

After a sense of urgency has been established, Kotter's next step is to create a guiding coalition. A coalition is important because the pace and complexity of our current environment makes it impossible for one individual to successfully champion significant organizational change. To be most effective, a coalition needs to include people in positional power to make a change, individuals with expertise in the area, individuals with credibility throughout the organization, and people with strong leadership. In the primary care context, the OIC, head nurse, and an experienced physician form a robust core of a change coalition.

The next step is for the coalition to develop a shared vision and strategy. This step is one of the most critical steps in organizational change. In order to be effective, Kotter believes that a vision should be imaginable, desirable, feasible, focused, flexible, and communicable.[2] Even more importantly the vision should challenge the organization to step out of its comfort zone. Ideally, the vision will also incorporate benchmarks that are easy to measure. A potential vision could be "In the next 2 years, our clinic will be considered the model of a Soldier Centered Medical Home in the Army. In order to obtain this objective, we need to increase our access by 40% and increase continuity by 30%. This will be achieved by implementing team outcome measures, a patient focused mindset, and removing barriers to provider productivity. Our goal will not only allow us to provide better holistic care, but will also improve the working environment for the entire team."

The communication of a vision change is the 4th step in Kotter's model. Successful change is depends on the entire organization understanding the vision. To enhance communication to the organization as a whole, the message should be simple, use metaphors or analogies when possible, utilize multiple channels, repeat itself over time, transparently explain challenges, and be bidirectional in nature.[2] The efforts the AAFP is utilizing to communicate their "Health is Primary" campaign is both a good example of well-designed communication and how difficult it can be to spread a message throughout an entire organization or profession.

After communicating the vision through the organization, the members must be empowered to effect change. This can best be done by modifying organizational structure to be more compatible with the vision, provide personnel with needed training, align personnel and information systems with the vision, and confront individuals who undercut the needed change.[2] For example, if your organization wants to implement the latest cholesterol guidelines, you might first need to address conflicting HEDIS metrics. Other changes could include changing the job descriptions of civilian employees to better match the desired end state.

These changes lead to the establishment of short term wins, achievements that both build momentum and bridge efforts towards long term goals. Ideally, most of these short term wins were not by happenstance, but were a planned part of the transformational strategy. This stage is also the ideal opportunity to publically reward early adopters and encourage other individuals to adapt.

With the success of the short term goals, larger challenges can be addressed, and the wave of change can spread throughout an organization. Finally, over time, an organization's culture is modified, and the new approaches are consolidated into the organization. Once this accomplished, the organizational change is complete.

I would encourage everyone as individuals and as leaders to assess their surroundings. What is the "cheese" that you need to strive for now and in the future? What are the changes on the horizon, both in the military and national healthcare systems? Instead of resisting change, change must be embraced as an absolute force of nature. What do we need to do in our own lives to adapt to change? What do we need to do as leaders in our respective organizations? How should family medicine physicians and the USAFP change in order to remain relevant? Personally, I believe that the "Health is Primary" campaign is a good start for our profession. I also feel that as a caucus of leaders in family medicine, our organization has the potential to lead our profession through this time of great change.

BIBLIOGRAPHY:
[1]Johnson, Spencer. Who Moved My Cheese? New York: Penguin Putnam, 2002.
[2]Kotter, John P. Leading Change. Boston: Harvard Business Review Press, 2012

Nicole Powell-Dunford, MD, Schofield Barracks, HI, nikkipd@gmail.com
Tom Rogers, MD, Pacific Region Medical Command, Thomas.j.rogers26.mil@mail.mil

Everything You Need to Learn to be DCCS (Deputy Commander for Clinic Services*) You Learned in Kindergarten

For the first 30 days as DCCS, every day is like the first day of kindergarten – brand new rules, systems and relationships. Every week a new nuance of the quality assurance regulations to discern, a new work place dilemma to contemplate, a new leadership challenge to overcome. But before you know it you will hit your groove and realize this is one of the best assignments a Family Medicine physician could ever have. As DCCS you have the opportunity to coordinate a tremendous amount of talent, to serve as a trusted advisor to the Commander and to foster the high reliability organization. Although days are long and often challenging - most of the keys to your success will be the very things you learned in kindergarten.

Play well with others: As senior medical officer you set the example. Listen without interruption. Lavish praise in public, but admonish in private. Treat everyone from housecleaning and janitorial staff with the same dignity and respect that you accord the VIPs. Hold providers accountable for that same dignity and respect towards patients and one another. Respect SMEs and build bridges. Keep your inner voice to yourself if what you are about to say is not True, Helpful, Insightful, Necessary or Kind (THINK). Synchronize DCCS lanes with the other deputy commanders. Teamwork is the key to the entire Command Team's success. Trust your department chiefs and senior clinical leaders by providing guidance but allowing innovation and growth.

If you stumble, get back up: Reflect on how to do better when difficult times arise. You will fail and make errors daily. Try to not make the same errors twice and count your failings as a blessing – for they are often our best teachers.

Organize and compartmentalize: A place for everything and everything in its place: Log and track all your administrative responsibilities. Keep special track of providers who need special mentoring or attention. Set internal due outs on a large calendar and review daily so you will never fall behind a tasking.

Don't run with scissors: Safety is a priority for the high reliability organization. One of your biggest charges is to ensure top quality peer review programs, M&M (morbidity/mortality) and near adverse event reporting. Safety reporting must be incentivized, with no questions of retaliation within your organization.

Eat alphabet soup: Prepare for eMSM (enhanced multi-service market), CAFBHS (child and family behavioral health services) and PCMH (patient centered medical home) initiatives by learning as much as possible about them. Read the OPORDs/operations orders and SOPs as many times as you need to understand - burying your head in the sand is not an option.

Stay ready: Never forget that the primary purpose of Army Medicine is to ensure readiness. If your productivity looks great on paper but the line units your clinic support have low medical readiness – you have failed. Likewise you should ensure your own professional readiness. Roll up your sleeves and see patients. Set the example with self-directed CME readings.

Always learn something new, each day and each week: There is no more valuable way to build trust and confidence than to walk through the clinics daily and to ensure you see patients, even if only 5 encounters a month. In doing so you will learn first-hand the challenges that the providers and OICs in your organizations face. One of the greatest gifts you can give your organization is a world class CME program. Build or delegate a once a week category 1 AMA CME program through your CME coordinator. CME keeps your providers engaged in lifelong learning and a local program will save thousands in travel and conference registration for those unable to secure funding for conferences.

Take care of yourself: Spend time with your family. Only with rare exception should you not sit at the table and eat a meal with your Family. Our Commander sends his deputies out to rotate physical training with different clinics, and hosts a once weekly ultimate Frisbee game for OICs/NCIOCs – these are super ways to keep fit while staying engaged in the organization. Make sure you find a physical activity that is fun to you – a healthy mind needs a healthy body.

Listen to your teachers: Never be too ashamed to reach back to your Family Medicine colleagues and mentors for assistance and support. In Family Medicine, we support one another!

**DCCS is similar to Air Force SGH or Navy ECOMS Chair/DMS/DPC*

Arkansas' Premier Behavioral Healthcare System Proudly Serving Our Military Families

Pinnacle Pointe Hospital is TRICARE® certified for acute and residential inpatient care services. We are committed to healing the children of military families. Our TRICARE military program offers treatment for youth and teens ages 5 to 17.

Pinnacle Pointe
BEHAVIORAL HEALTHCARE

Pinnacle Pointe Behavioral Healthcare System • 11501 Financial Centre Parkway • Little Rock, Arkansas 72211

501.223.3322 • 800.880.3322 • www.PinnaclePointeHospital.com

TRICARE® Certified

The Uniformed Services Academy of Family Physicians
1503 Santa Rosa Road, Suite 207
Richmond, Virginia 23229
www.usafp.org