THE UNIFORMED FAMILY PHYSICIAN

Spring 2021 ▪ Vol. 14 ▪ Num. 1 ▪ Ed. 55

AARON SAGUIL MD, MPH, FAAFP INSTALLED AS 2021-2022 USAFP PRESIDENT

– SEE PAGE 11

Journal of The Uniformed Services Academy of Family Physicians

Join the Leader in Correctional Health Care

The Federal Bureau of Prisons is seeking Medical Officers (Physicians) in the following specialties: General Practice, Family Practice, Internal Medicine and Psychiatry and Nursing - (Mid Levels, RN's, LPN's & Nursing Assistance)

Apply online to our open continuous job announcement: www.USAJOBS.gov

What does the BOP offer?

- ✔ A supportive, safe and secure environment with opportunity for growth and advancement, geographic flexibility
- ✔ Competitive Federal Government salary and benefits, including health care and retirement, malpractice coverage
- ✔ Mid-level provider support
- ✔ No insurance hassles
- ✔ Modern facilities, electronic records
- ✔ Potential for Loan Repayment and/or Recruitment Bonus

Contact our National Recruitment Team
Phone: 1-800-800-2676 ext 5 or 919-575-8000 ext. 7123
E-mail: BOP-HSD/Recruitment@bop.gov
Website: www.bop.gov
The Federal Bureau of Prisons is an Equal Opportunity Employer

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
Mary Lindsay White: mlwhite@vafp.org
Cheryl Modesto: cmodesto@vafp.org

Newsletter Editor
Leo A. Carney, DO, FAAFP

VISION

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

MISSION

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

Edition 55

your academy leaders
OFFICERS AND COMMITTEES

OFFICERS

PRESIDENT
Aaron Saguil, MD, MPH, FAAFP
USUHS, San Antonio, TX
aaron.saguil@usuhs.edu

PRESIDENT-ELECT
A. Marcus Alexander, MD
AFPC, TX
marcusindc10@gmail.com

VICE-PRESIDENT
Leo A. Carney, DO, FAAFP
HQMC - Health Services
Arlington, VA
leocarney@icloud.com

SECRETARY-TREASURER
James D. Warner, MD
Air Station Clearwater, FL
jwarnere@yahoo.com

PAST PRESIDENT
Debra A. Manning, MD, FAAFP
Bureau of Medicine & Surgery
Falls Church, VA
dr.deb.manning@gmail.com

EXECUTIVE DIRECTOR
Mary Lindsay White, MHA
Richmond, VA
mlwhite@vafp.org

DIRECTORS

AIR FORCE
Jeanmarie Rey, MD, FAAFP
USUHS, Bethesda, MD
alohagigi@gmail.com

Kattie Hoy, MD, FAAFP
Nellis AFB, NV
kattie.hoy@gmail.com

Alexander C. Knobloch, MD, FAAFP
Travis AFB, CA
acknobloch@gmail.com

ARMY
Drew C. Baird, MD, FAAFP
Fort Hood, TX
drewbaird002@yahoo.com

Meghan (Mimi) Raleigh, MD, FAAFP
Fort Bragg, NC
mraleigh32@yahoo.com

Caitlyn M. Rerucha, MD, FAAFP
Fort Bragg, NC
caitlyn.m.rerucha@gmail.com

NAVY
Kevin M. Bernstein, MD, MMS, FAAFP
Naval Hospital Jacksonville, FL
kevin.bernstein@gmail.com

Francesca M. Cimino, MD, FAAFP
Fort Belvoir, VA
francescacimino@gmail.com

Jules Seales, MD
USUHS, Bethesda, MD
phedre.e@gmail.com

PUBLIC HEALTH SERVICE
Khalid A. Jaboori, MD, MPH, FAAFP
USCG Seattle, WA
kjaboori@hotmail.com

Preciosa P. Pacia-Rantayo, MD, FAAFP
USCG Base Cape Cod, MA
Preciosa.p.pacia-rantayo@uscg.mil

RESIDENTS
Ashley S. Yano, MD
Fort Hood, TX
ashley.s.yano.mil@mail.mil

Eileen D. Tatum, MD
Naval Hospital Jacksonville, FL
Eileen.d.tatum@gmail.com

Raquelle "Rocky" Newman, MD
Nellis AFB, NV
raquelle.s.newman.mil@mail.mil

STUDENTS
Abigail Hawkins
USUHS, Bethesda, MD
Abigail.hawkins@usuhs.edu

Varun Gopinath
Northeast Ohio Medical University
vgopinath@neomed.edu

AAFP DELEGATES
Debra A. Manning, MD, FAAFP
Bureau of Medicine & Surgery
Falls Church, VA
dr.deb.manning@gmail.com

Aaron Saguil, MD, MPH, FAAFP
USUHS, San Antonio, TX
aaron.saguil@usuhs.edu

ALTERNATES
A. Marcus Alexander, MD
AFPC, TX
marcusindc10@gmail.com

Kevin M. Bernstein, MD, MMS, FAAFP
Naval Hospital Jacksonville, FL
kevin.bernstein@gmail.com

CONSULTANTS

AIR FORCE
Christopher E. Jonas, DO, FAAFP, CAQSM
Falls Church, VA
jonaschris@hotmail.com

ARMY
Kevin M. Kelly, MD, FAAFP
Fort Bragg, NC
kmkellymd2003@yahoo.com

NAVY
James W. Keck, MD, FAAFP
Naval Hospital Jacksonville, FL
jkeck@usna94.com

COMMITTEE CHAIRS

CLINICAL INFORMATICS
Barrett H. Campbell MD, MBA, CPE, FAAFP
Madigan Army Medical Center
barrett.h.campbell@gmail.com

CLINICAL INVESTIGATIONS
Robert C. Oh, MD, MPH, FAAFP (Chair)
Madigan AMC, WA
Roboh98@gmail.com

Heidi L. Gaddey, MD, FAAFP (Vice Chair)
Travis AFB, CA
heidigaddey@yahoo.com

CONSTITUTION & BYLAWS
Adriane E. Bell, MD, FAAFP
Fort Bragg, NC
adriane.e.bell@gmail.com

EDUCATION
Tyler S. Rogers, MD, FAAFP
Madigan Army Medical Center
trogers09@gmail.com

Tyler J. Raymond, DO, MPH, FAAFP
Madigan Army Medical Center
drtylerraymond@gmail.com

Erica Meisenheimer, MD, FAAFP
Madigan Army Medical Center
erica.sturtevant@gmail.com

MEMBER CONSTITUENCIES
Janelle M. Marra, DO, FAAFP
Naval Hospital Camp Pendleton, CA
jmarra08@gmail.com

MEMBERSHIP & MEMBER SERVICES
Anja Dabelic, MD, FAAFP
Personnel Cmd. Millington, TN
anja.dabelic@gmail.com

NEWSLETTER EDITOR
Leo A. Carney, DO, FAAFP
HQMC - Health Services
Arlington, VA
leocarney@icloud.com

NOMINATING
Debra A. Manning, MD, FAAFP
BUREAU OF MEDICINE & SURGERY
Falls Church, VA
dr.deb.manning@gmail.com

Aaron Saguil, MD, MPH, FAAFP
USUHS, San Antonio, TX
aaron.saguil@usuhs.edu

A. Marcus Alexander, MD
AFPC, TX
marcusindc10@gmail.com

OPERATIONAL MEDICINE
Haroon Samar, MD, MPH
Madigan Army Medical Center
haroon.samar@gmail.com

Adolfo Granados, DO, MHA, FAAFP
Naval Medical Center, San Diego, CA
amem6842@sbcglobal.net

John W. Lax, MD, FAAFP
Aviano Air Base, Italy
johnwlax@gmail.com

PRACTICE MANAGEMENT
Timothy L. Switaj, MD, MBA, MHA, FAAFP
Fort Sam Houston, TX
tim.switaj@gmail.com

RESIDENT AND STUDENT AFFAIRS
J. David Honeycutt, MD, FAAFP
Nellis AFB, NV
davehoneycutt@hotmail.com

Alexander C. Knobloch, MD
Travis AFB, CA
acknobloch@gmail.com

WELLNESS & RESILIENCY
David Riegleman, MD
Brooke Army Medical Center, TX
driegleman@gmail.com

2021 PROGRAM CO-CHAIRS
Kevin Bernstein, MD, MMS, FAAFP
Naval Hospital Jacksonville, FL
kevin.bernstein@gmail.com

Jules Seales, MD, MPH
USUHS, Bethesda, MD
phedre.e@gmail.com

2022 PROGRAM CO-CHAIRS
Stephen M. Young, MD
Baumholder Army Garrison, Germany
smyoung87@yahoo.com

Mariama A. Massaquoi, MD
Fort Benning, GA
mariama.massaquoi@me.com

president's message

AARON SAGUIL, MD, MPH, FAAFP

Aaron Saguil, MD, MPH, FAAFP
Associate Dean, Regional Education
San Antonio
F. Edward Hébert School of Medicine
Uniformed Services University

Greetings, Friends!

I am writing this after an incredibly successful virtual conference organized by our USAFP staff; our Past President, Deb Manning; and our outgoing meeting co-chairs, Kevin Bernstein and Jules Seales. For those able to attend, it was great to share the same virtual space as you. For those whose responsibilities required you elsewhere, our staff are working to make some of the programming enduring for your later consumption.

I have two things that I would like to share in this newsletter—our "Better Together" campaign and an update on our 2022 Annual Meeting.

1. BETTER TOGETHER

At the annual meeting, we announced the continuing theme for this current year and the 2022 Annual Meeting: "Better Together." Better Together acknowledges that our collective wisdom and ability exceed that of any individual. We are smarter together and stronger together.

Those who spoke at our meeting and our Service Specific breakouts laid out a list of the many challenges we face: medical billet reallocations, special pay disparities, continuing overseas and domestic deployments, transitions between virtual health and in person clinic visits, the subsuming of care delivery responsibilities by the Defense Health Agency, a new electronic record, the Defense Wide Review, and more—like the coronavirus 19 pandemic. These challenges have direct and indirect effects on our everyday lives. They can make us feel isolated. In my address, I stated that while some might think this sets us up for burn out, I think it is more appropriate to say that we are at risk for a moral injury. "Burn out" indicates that the fault is within us—that we are not resilient enough to face these changes. "Moral injury" acknowledges what is really happening: that we want to do right, but the system precludes us from doing so.

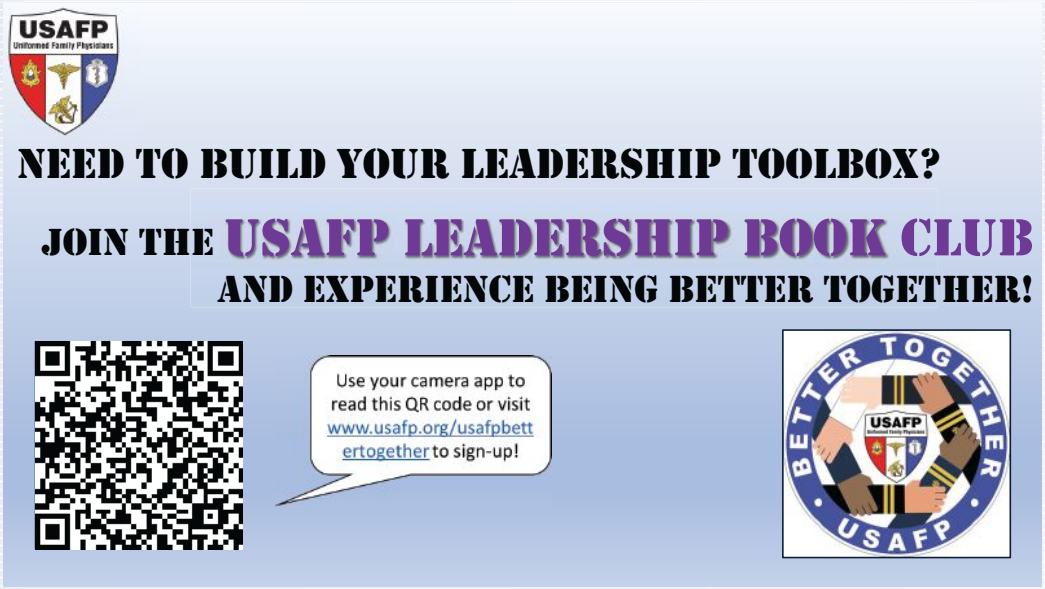
With this is mind, we created the Better Together campaign. Our hope is that bringing members together will allow us to enjoy the benefits of community with one another. Being together is the antidote for isolation. Being together allows us to enjoy one another. Being together gives us a more robust network with hard-earned wisdom upon which to draw. Somewhere, within our membership are people who know how to make MHS Genesis work and are willing to share that information. Within our corporate body we have people who have discovered how to have a fulfilling deployment with lessons learned to pass down. In the USAFP, we have folks who literally are sitting at the table in the Pentagon and at Congress, advocating for your special pays and your billets with the senior leadership of the Services. We have people who have likely faced the issues that you face and can help you feel and be better…together.

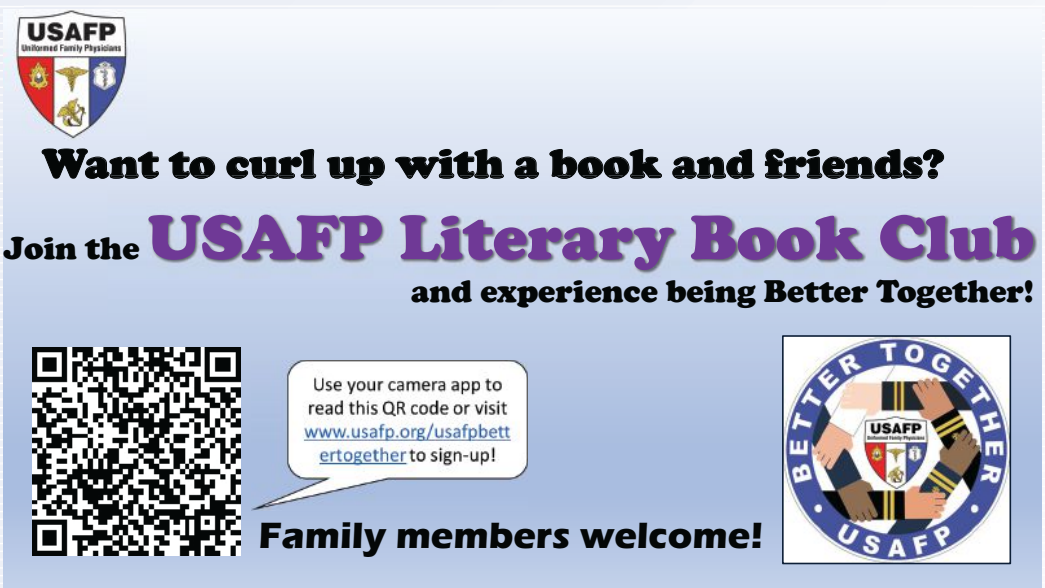
In this spirit, we have created groups to help you connect. The first four are a leadership book club, a journal club, a fitness club, and a literary book club. The first two are intended for members, while the latter two are intended for members and family who wish to participate. Is being a part of a literary book club going to help you prepare for your next deployment? Perhaps not directly. But you might meet someone who can help you prepare. And, by joining the club with your significant other, you might be introducing that someone you love to people who can offer support during your physical absence.

As part of this article, we are including the initial advertisements for each of the clubs. If you wish to join any (or all!) of them, just use the QR code to be taken to a short survey that will collect your name and email to add you to the group.

continued on page 6

continued from page 5





2. 2022 ANNUAL MEETING

I wish that I could give you the location for our 2022 Annual Meeting. Although we haven't locked down a location yet, we have been looking at places with these three criteria in mind: family-friendly and welcoming, a per diem that allows for limited funds to be divided among the greatest number of people, and be in relative proximity to simulation resources that will allow us train our members in the Individual Critical Task Lists and Knowledge/Skills/Abilities needed to remain mission ready. As soon as we have a location and time, we will share them with all of you.

What I am excited to share with you is that we have two outstanding officers who will help make this happen. MAJ Mariama Massaquoi is faculty at the Martin Army Community Hospital Family Medicine Residency, Fort Benning, Georgia, and has completed the family medicine obstetrics fellowship. MAJ Steve Young is the chief medical officer of the Baumholder Health Clinic in Germany. Both have tremendous experience with the breadth of uniformed family medicine and are working to make our 2022 Annual Meeting one in which we can gather, in person, to experience life together.

Thank you for all that you do for our Service Members, our families, and for each other. We are, and continue to be, Better Together!

ATTENTION MILITARY HEROES

WE INVITE YOU TO BECOME A CENTURION HEALTHCARE HERO!

When you joined the military, you dedicated your life to serving our county.

At Centurion, we dedicate our lives to servicing the underserved.

Join our team!

Continue your mission of public service with an easy transition into correctional healthcare.

- Structured environment with a team approach
- Desirable, set schedule with no night, weekend or holiday shifts required
- No RVU's, no billing, and no managed care
- Competitive, guaranteed salaries and comprehensive benefits
- Company paid malpractice insurance
- Veteran friendly company and corrections clients

Correctional Medicine, similar to Military Medicine, provides evidenced based medicine to a unique population within a policy focused framework. My experience as a military physician provided for a smooth transition into a challenging and rewarding second career as a correctional health care physician.

John Lay, MD
LTC(R), US Army
Regional Medical Director
Centurion with the Florida Department of Corrections

For more information, please contact Teffany Dowdy:
teffany@teamcenturion.com or 770.594.1444

www.centurionjobs.com | Equal Opportunity Employer

centurion™

Leo Carney, DO, FAAFP
HQMC – Health Services, Arlington, VA
leocarney@icloud.com

HAVE AN ARTICLE YOU WOULD LIKE TO SUBMIT IN THE UNIFORMED FAMILY PHYSICIAN? PLEASE SEE THE INSTRUCTIONS FOR ARTICLES AT **WWW.USAFP.ORG/USAFP-NEWLSETTER/**

HELLO USAFP!!! What an incredible and exhausting year! Our lives have changed drastically and are continuing to change as I type. The Military Health System has encountered both internal and external threats; our world has fought against a global pandemic; our country has dealt with protests and riots; and all this only scratches the surface of the challenges we face. Through all of this, Uniformed Family Physicians have continued to show their worth to our aligned Services and our nation as a whole. THANK YOU ALL for the sacrifices you and your families make every day!

Better Together! Could there be a more appropriate and timely motto? We must remember that our focus has to be on our similarities and not our differences. Directing our efforts to meet predetermined outcomes will assist in staying *Better Together*. Proverbs 29:18 states, "Where there is no vision, the people perish." This could not be truer than when an organization loses sight of its goals and mission. As you review the Mission and Vison of the USAFP below, ask yourself the following questions: As a member of the USAFP, what can I do to help meet the Mission and Vision? Would I like to get more involved? Do I know other Uniformed Family Physicians who need to be members, but currently are not?

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

VISION - *The USAFP will be the premier professional home to enhance the practice and experience of current and future Uniformed Family Physicians.*

Final thoughts. The greatest thing about the USAFP (in my opinion) are the friendships and contacts you will make. Please take care of yourselves and your peers. We often fail to recognize when our friends and coworkers are struggling. In this crazy time in which we live, some of us are struggling more than normal. Reach out if you are struggling and reach out to people who are struggling. If you have questions about the USAFP or how to get more involved, please reach out to the staff or a board member. Until the next letter, stay *Better Together!*

SMARTER TOGETHER - STRONGER TOGETHER - BETTER TOGETHER

CALL FOR SPEAKERS

We invite you to submit your ideas for CME presentations to help serve your fellow family physicians in expanding their knowledge and skill sets during the USAFP 2022 Annual Meeting.

If you are interested in presenting a CME session at the USAFP 2022 Annual Meeting, please complete the Call for Speakers via the link below.

https://www.surveymonkey.com/r/2022CALL

For those of you interested in submitting more than one topic for consideration, please complete the survey for each topic.

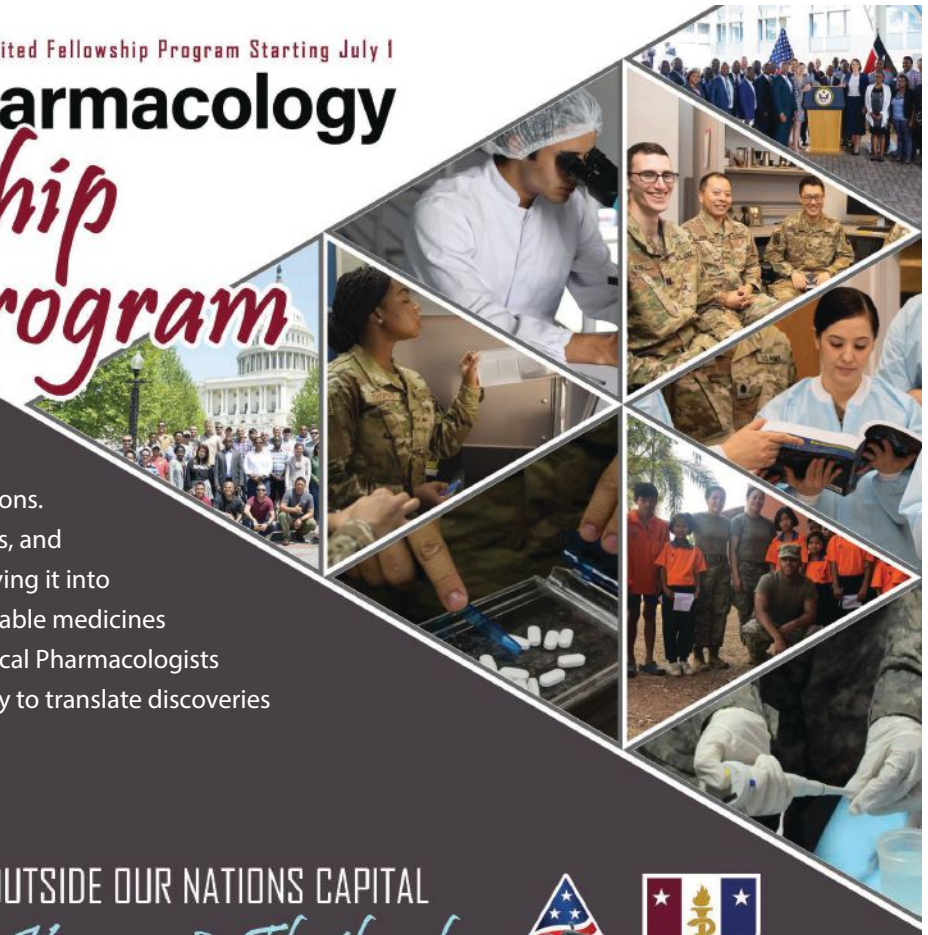
The deadline for submission is 15 June 2021. The promotional brochure and hotel reservation link will be available in October 2021.

2022 Program Co-Chairs
Stephen M. Young, MD
Baumholder Army Garrison
smyoung87@yahoo.com

Mariama A. Massaquoi, MD
Fort Benning, GA
mariama.massaquoi@me.com

Two-Year Accredited Fellowship Program Starting July 1

Clinical Pharmacology Fellowship Program



What is Clinical Pharmacology?

Clinical Pharmacology is the specialty of developing answers for modern medical limitations. Clinical Pharmacologists develop drugs, vaccines, and biologics by evaluating bench research and moving it into clinical trials. They also repurpose currently available medicines and monitor the safety of medicines in use. Clinical Pharmacologists work with government, universities, and industry to translate discoveries in the research lab to the beside.

OFFERED IN 2 LOCATIONS RIGHT OUTSIDE OUR NATIONS CAPITAL

with rotations overseas in Kenya & Thailand

ARMY MEDICINE
Bringing Value...Inspiring Trust

Fellowship Highlights:

- Conduct laboratory, animal, or clinical research under the supervision of a mentor.
- Participate in the teaching of Clinical Pharmacology to medical students, house staff, and practicing of physicans.
- Three month rotation with a review division at the FDA.
- Participate in continuing medical education, research seminars, and journal clubs.

Current Research Interests:

- Changes to antibiotic drug levels in soldiers exposed to exercise, heat exertion, traumatic brain injury.
- Exploring the use of pharmacogenomics in the military to optimize patient care and soldier readiness
- Defining risk factors for adverse drug reactions in deployment relevant medications.

Fellowship Eligibility Requirements:

- Active Duty Army PhDs /PharmDs (71A or 71B)
- Active Duty Army Physicians board eligible/ certified in primary specialty

For more information contact:
LTC Jeffrey Livezey, MD: jeffrey.livezey@usuhs.edu
or LTC Jesse Deluca, DO: jesse.p.deluca.mil@mail.com

http://www.ushus.edu
http://wrair-www.army.mil

new members

THE USAFP WELCOMES THE FOLLOWING NEW MEMBERS...

ACTIVE

Dean Cardi, DO

Katie Coble, MD

Bradley Harr, DO

Alexander Sparkman-Royo, MD

RESIDENT

Andrew Caudill, MD, MPH

Bridget Colgan, MD

Nathan Meier, DO

Roy Wagner, DO

STUDENT

Jeffrey Backofen

Nicole Barnes

Luke Bechler

James Bishop

Anna Bridges

Matthew Brown

Lance Charlton, II

Ida Dhanuka

Matthew Duff

Joshua Engel

Jacob Farr

Elisa Giammo

Charles Goodman

Morgan Halliburton

Canaan Hancock

Erin Hedglen

Kolton Kaspar

Rachel Kester

Lindsay Kingston

Alexander Kofskey

Somin Kwon

Daniel Le

Emily Montgomery

Aubrey Mount

Uyen Nguyen

Hector Nieves Santiago

Benjamin Phelps

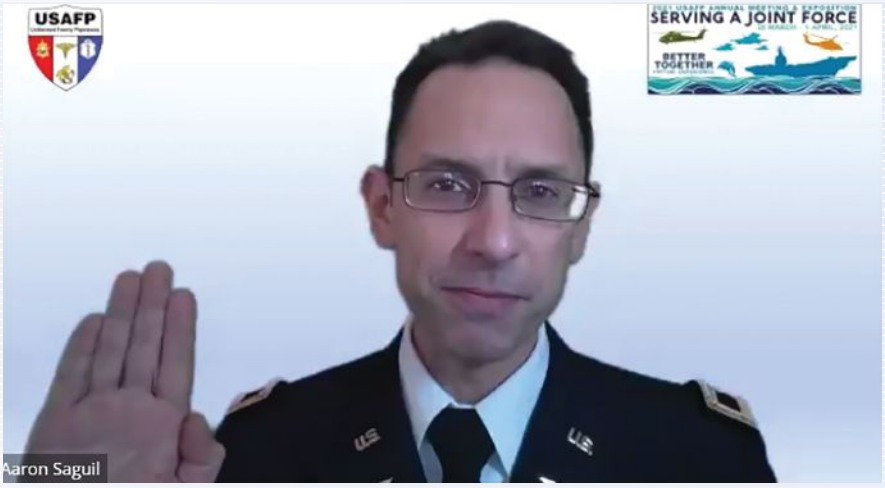
Tristan Ruiz

Jon Solomon

Thomas Tippit

Paul Wurtz

Aaron Saguil MD, MPH, FAAFP Installed as 2021-2022 USAFP President



Aaron Saguil MD, MPH, FAAFP was installed as 2021-2022 USAFP President by AAFP President Ada D. Stewart, MD, FAAFP. The installation took place on Wednesday, 31 March during the USAFP 2021 Annual Meeting.

CONGRATULATIONS TO THE 2021-2022 USAFP BOARD OF DIRECTORS

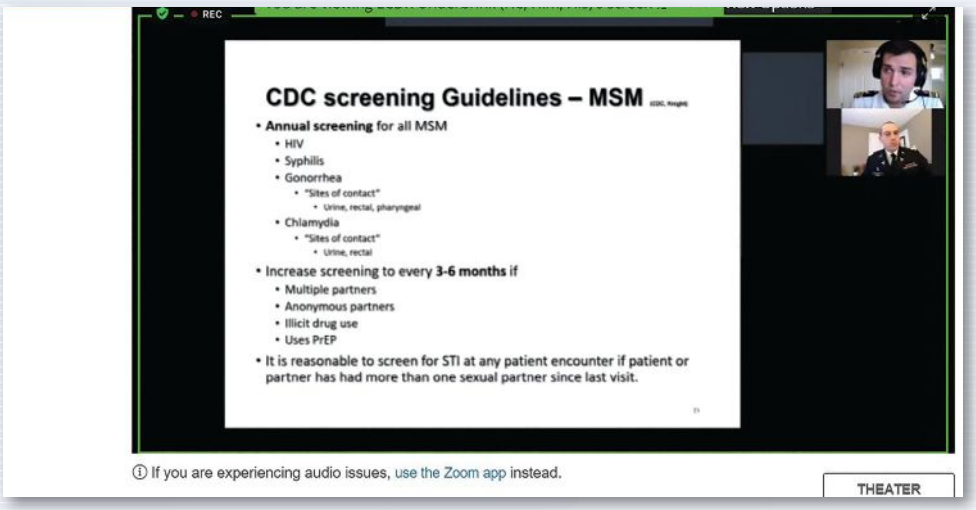
THE NEWLY ELECTED OFFICERS AND DIRECTORS ARE:

USAFP 2021 Annual Meeting was a Huge Success!

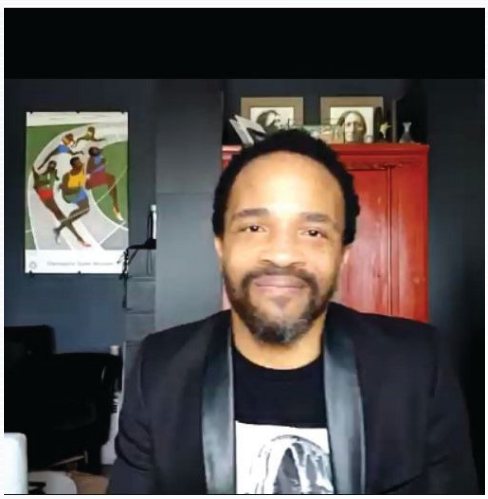
The USAFP Annual Meeting was held 26 March - 1 April and had over 500 attendees. The virtual conference included 7 days of continuous CME, excellent Keynote Speakers on core medical topics including wellness, leadership, and family medicine certification.

AAFP President Ada D. Stewart, MD, FAAFP installed the USAFP 2021 Officers and Directors during the event. Social events were held in conjunction with the annual meeting including a welcome reception where attendees had the opportunity to connect with old and new friends! Even though we couldn't meet in person, Doc You Don't Know Jack went on as scheduled with Navy taking the win!

Meeting comments highlighted the outstanding conference!



- Loved the polls
- Thanks for all you do!
- In general, all excellent speakers. Wonderful education and experiences. Awesome research. Thank you.
- Excellent job with this conference in challenging times. Great format.
- I really like being able to chat and make comments during the lectures. Overall a good experience!
- You all did such a wonderful job bringing this together. You work has far reaching impact. Thank you for being so easy to talk to, with which to connect and quick to problem solve and trouble shoot.
- Thank you! This was great given COVID
- Great work guys!!



MURRAY-CALLOWAY
COUNTY HOSPITAL

MURRAY STATE
UNIVERSITY

Join Our Team

We are looking for the following specialties:

OB/GYN

With over 60 physicians representing 29 medical specialties, we are looking for additional physicians to join our team.

Our Advantages

- Competitive Salary & Incentive Plans
- Student Loan Payment Assistance
- Coverage of Medical Licenses & Dues
- Coverage of Malpractice Insurance
- $15K Relocation
- $6K Continuing Medical Education Allowance
- Professional Fulfillment
- Flexible Work/Life Balance

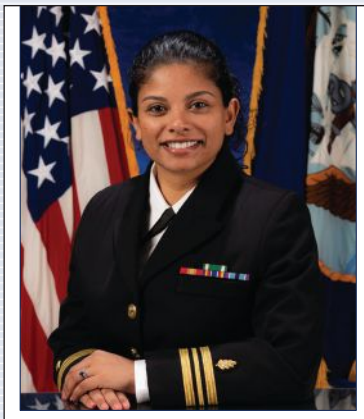
Our Community

- Home to MSU Racers - NCAA Division 1 Basketball
- Convenient to Land Between the Lakes Outdoor Recreation - hike, camp, hunt, golf, boat, and enjoy.
- Top Ranked Schools in Kentucky
- Friendliest Small Town in America by Rand McNally
- #1 Best Place to Live in Kentucky
- 100 Best Communities for Young People
- Playful City, USA Designee

To find out more about joining our team - Call Stephanie Nutter-Osborne, Provider Liaison, 270.762.1583 or email sdosborne@murrayhospital.org

MURRAYHOSPITAL.ORG

2021 Academy Awards



2021 PRESIDENT'S AWARDS
JULES SEALES, MD
&
KEVIN BERNSTEIN, MD

In recognition of your creativity, dedication, passion, and outstanding service to the Uniformed Services Academy of Family Physicians as Program Co-Chair for the 2021 USAFP Virtual Annual Meeting & Exposition.

You embraced the challenge to conceptualize, design, and execute a comprehensive and dynamic virtual program that "Serves Joint Forces" and meets the needs of our diverse membership.

Through your tireless effort, you have helped your friends and colleagues in all Services to grow professionally as clinicians and leaders.

2021 Operational Medicine Award
Myro Lu, DO

In deepest appreciation and admiration for instituting best practices and innovative solutions within operational medicine to both U.S. and Afghan medical providers.

Your establishment of a U.S. military modeled flight medicine program to the Special Mission Wing (SMW) of Afghanistan is to be greatly commended.

A constant educator of combat care at local and national levels through the Tactical Combat Casualty Care sessions, the Tripler Capstone Project, at the Afghan SMW flight clinic and the Tripler Family Medicine Residency Program.

You are paramount to the success of the next generation of operational medicine family physicians.

2021 MICHAEL J. SCOTTI, MD
FAMILY PHYSICIAN OF THE YEAR

Uniformed Family Physicians

With utmost gratitude and sincerest applause to all uniformed family physicians for your incredibly selfless work in the fight against the COVID-19 pandemic.

The public health efforts you displayed not only in the military community but in your deployments to aid the civilian communities is truly above and beyond.

This award is a small token to recognize the heroic efforts of all USAFP members and the lasting impact your comprehensive and compassionate care will have on the health of the public.

You adapted, sacrificed, and delivered care on the front lines in unprecedented conditions to protect the health and well-being of all and for this you embody what it means to be a truly outstanding Family Physician.

consultant's report
CG/PHS

Preciosa P. Pacia-Rantayo, MD, FAAFP
USCG Base Cape Cod, MA
vawhag@hotmail.com

Happy Spring! In this issue, an easy read on updates from both PHS and Coast Guard follows.

FROM THE CORPS

In December, RADM Susan Ortega, Director Commissioned Corps Headquarters reminded officers to always be ready for the possibility of deployment. PHS officers have seven days to inform Medical Affairs Branch if they have any medical issues that may affect their readiness status. More importantly, it is the officer's responsibility to upload their medical waiver via e-DocU.

Chief Professional Officer, CAPT Brian Lewis recently sent a message to inform officers that the Unaccompanied Children(UC) mission takes "precedence over all agency deployment" and he advised that officers should be ready for deployment within 48 hours of notice.

FROM THE COAST GUARD:

COVID 19 vaccine started rolling out of Coast Guard clinics in December 2020. All districts have been busy ensuring that this evolution is successful. Both Moderna and Pfizer vaccines are the mainstay for both CG members and any other eligible employees. Accordingly, Strike Teams have been on the road to vaccinate our service members. Other commands, such as Air Station Cape Cod assist other clinics, such as Kaehler Medical in picking up vaccines and distributing them to remote locations for administration.

Med Team 2 on deployment in support of Southwest Border Mission (March - April 2021). From the left HS1 Kathryn Montgomery, HSCS Justin Stephen, CDR Preciosa P. Pacia-Rantayo and HS2 Samantha Hughes.

HS3 Colby Storm administering a COVID-19 vaccine (picture taken with patient's permission)

Covid 19 vaccine evolution at Base Cape Cod

TRAINING

The Coast Guard has instituted a service-wide mandatory training to deter extremism in the military. The training had a mandatory completion date of March 31, 2021.

DEPLOYMENT

In support of the Southwest Border Mission, the first round of medical teams (Physicians, Physician Assistants, IDHS, and HS) have deployed. Locations spread across the southern region of Texas; deployment length is longer and mission is expected to last for several weeks.

EVERY DOC CAN DO RESEARCH

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

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

Tools Available:

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

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

consultant's report
NAVY

James Keck, MD, MBA, FAAFP
Naval Hospital, Jacksonville, FL
jkeck@usna94.com

Greetings, Navy FM! In preparation for this article, I looked back at the newsletter from a year ago and found myself marveling at all that has happened since those early days of the COVID-19 pandemic. I had commented that the coming months would provide opportunities for us to grow as clinicians, educators, and leaders. The interval year has proven my statement to be true as you were called to respond to various challenges in providing care, not just to our traditional beneficiaries, but also in support of our communities in the civilian sector. I appreciate all you have done, especially in the face of all the other changes we are facing. During the recent USAFP Navy Breakout session, I was glad to share with many of you updates on the major issues. In this report, I'll recap the key items that were discussed.

USAFP ANNUAL MEETING

I would like to start with a word of gratitude towards our academy for their work in hosting a highly successful virtual "live" annual meeting. While we all look forward to the day when we can once again gather in-person, I could not have imagined a better engineered substitute. Bravo Zulu! I think the innovations and successes that were seen in this year's meeting will only make future conferences that much better. I'm already looking forward to next year's event (location TBD at article deadline.) If you are already considering attending, your best bet to get approved is to be accepted as a speaker or research presenter. The deadline to submit is 30 May 2021.

MANNING STATUS

As of 31 March 2021, we had an inventory of 366 uniformed Family Medicine physicians for 411 billets, which includes 37 "Fair Share" billets (positions which are not specifically tagged for a FM doc.) Our community includes 32 Sports Medicine, 8 FM-OB, 7 Faculty Development, 1 Geriatrics, and 1 Adolescent Medicine trained physicians. Our inventory translates to an 89.1% overall fill rate and a gap of 45 billets. These stats are relatively unchanged from this time last year. Our manning will see a downward trend in the coming months as individuals retire or release from active duty at the end of their commitments, no doubt exacerbating the stress of gaps at your commands. We traditionally see a boost in our manning (and thus can eventually backfill a number of

continued on page 18

continued from page 17

the gaps) thanks to our residency graduates who join our ranks each summer. If you are approaching your PRD (or the end of your obligated service) and are wondering about what to do next, please reach out to our detailer to explore options. The goal is to align your professional goals with available opportunities and priorities. I am also available to be of help, so don't hesitate to reach out to me.

BSO-18 (NAVY) TO BSO-27 (USMC)

Many are starting to hear about another initiative that has been in the works for a couple of years, but is now finally hitting implementation phase. Separate from any other manning actions (e.g. MEDMACRE, GMO conversions, POM-20), the USMC has bought a number of medical corps billets (not just FM) to augment their operational medical support. These billets will be attached to USMC operational units (e.g. Med BN's), with phased detailing beginning as early as later this year (2021). FM has 17 of these new billets, which are located at: Camp Lejeune (4), Camp Pendleton (6), Okinawa (1), Pearl Harbor (3), and NMC Portsmouth (3).

DETAILING

Our detailer, CDR Tara O'Connell, continues to work hard to match every member of our community with a position that aligns their professional goals with available billets and in a way that also meets the needs of the Navy. We are both very grateful for all the patience shown by officers who are in line to execute orders this coming summer. Timelines were pushed to the right for detailing more senior positions throughout Navy Medicine (e.g. CO/XO, CMO, OIC, non-specialty specific billets), which had a downstream impact for detailing our community. Additionally, billets targeted by POM (divestitures/cuts) in FY21-24 were pulled from the list of billets to be detailed, changing the options available.

Looking forward, if you are slated to PCS in the summer of 2022, please put on your "to-do" list contacting CDR O'Connell 12 months out from your PRD. As with every detailing cycle, do know that the "must-fills" are operational and OCONUS positions. The most recent promotion guidance is emphasizing more than ever the importance of doing an operational medicine officer (OMO) tour as well as highlighting the diversity of geographic assignments. I encourage you to discuss with the detailer when best to rotate to one of these billets relative to your promotion timeline. CDR O'Connell can be contacted at PERS via her email tara.oconnell@navy.mil or by phone: (901) 874-4037.

POM/DIVESTITURES

Since I mentioned the divestitures, let me jump into an update. The possibility of divestitures (cuts) in billets across all services medical departments continues to loom over the military health system. While these billet reductions were put on hold by Congress until a review of the medical manpower requirements under all national defense strategy scenarios has been completed, various actions have been taken to move us in the direction of a reduced end-strength. Reduced retention bonuses (see below) and detailing changes (previously mentioned) are two of the more visible impacts. What is clear is that uncertainty will remain until Congress makes a final determination. To share with you a snapshot of the projected manning impacts, FM is slated to lose 90 billets by FY24, which is a reduction in our community of 24% (not including Fair Share billets.) If our personnel inventory stays at current levels, our manning will jump to 114% (historical note: FM has not been 100% manned since 2002.) These cuts are almost all coming from CONUS clinical billets. As a result, we'll see the proportion of our operational + OCONUS footprint increase from 42% to 55% of our billets. (This does not include any operational billets FM will receive as a result of future GMO conversions.) While FM is forecasted to lose the most billets, other specialties will see a greater percentage of their communities reduced (for example: Derm -62%, Ophth -50%, ENT -49%, OBGYN -48%, Neurology -48%, Peds -42%, Uro -35%, IM -32%.)

USAFP MENTORSHIP PROGRAM

Looking for a mentor? Interested in mentoring others?

If so, check out: *www.usafp.org/mentorship*

HOW DOES IT WORK?

The program uses a brief intake survey to complete/to identify a mentee's needs and then matches that person with a mentor well suited to meet those needs.

WHAT AM I SIGNING UP TO DO?

Participant responsibilities are as follows:

- Communicate with your mentor/mentee at least once per quarter
- Before signing off, select a topic for discussion for the next session
- Continue the program for (at least) the next year
- Complete a brief feedback survey at the end of one year to help improve the program

WHEN AND HOW WILL I GET MY MATCH?

Matches are made on a rolling basis. Mentees should expect to receive an email identifying their mentor within 3 weeks of signing up.

IS THERE ANYTHING I CAN DO TO HELP?

Definitely! The success of the program is directly tied to member participation. Please consider signing up and sharing this information widely with your military Family Medicine colleagues, including retirees.

SPECIAL PAYS

We had hoped that FY21 would see a rebound in our Special Pays Plan. Unfortunately, the uncertainty created by the divestitures has resulted in FM retention bonuses (RB) going unchanged from FY20. As a review: compared to FY19, only 2 and 3 years contracts are available (no 4 year and 6 year contracts), and there is a restriction in renegotiating new contracts. The RB for the remaining contracts are $2k less than FY19 ($15k vs $17k for the 2 year term; $23K vs $25k for the 3 year term.) Since special pays are a retention tool, it is not surprising that reduced RB's have impacted not just Family Medicine, but a number of other communities. And while we remain undermanned, this is not the case in a post-divestiture end-strength scenario. It is my perspective (OPINION) that as long as the possibility of divestiture implementation remains, it will play a part in subsequent RB decisions. Leadership does recognize the value FM brings to the operational mission, as was stated by the SG in our breakout session. Your response on the frontlines of the COVID-19 response serves as an example of your versatility and mission impact, and I will continue to share this perspective at every opportunity. I am glad to talk with anyone who has questions, or facing a difficult career decision as a result.

KSA'S UPDATE

Implementation of KSA's continues to move forward. As a review, on 14 July 2020, the SG signed a package of 41 Naval Medical Readiness Criteria (NMRC), with a plan that will eventually see 139 checklists developed. These NMRC's are more commonly known as KSA's, which are the "Knowledge, Skills, and Abilities" that Naval personnel are supposed to possess in order to do their jobs well. Navy Medicine has been working to define and standardize the KSA's for medical personnel, with an operational-readiness focus. They are broken into 3 categories:

1) Core Practice / Clinical Currency
2) Expeditionary Skills for readiness / Readiness Currency
3) Platform Training for Readiness.

These were developed in collaboration with senior FM leaders, as well as those of our sister services (reflecting a joint effort.)

To help with the implementation effort, the Naval Medical Force Development Center (NMFDC), a part of BUMED, is developing dashboards ("Navy Proficiency Dashboard") to easily allow commands and individuals to see where they stand on their KSA's. The dashboard is a work in progress, but is emerging as a primary tool for tracking these metrics. Going forward, it will be the Navy Medicine Readiness and Training Commands/Units (NMRTC/U's) that will be responsible for getting their personnel ready and meeting their KSA's. At this point, commands should be taking a look at their KSA's and performing a gap analysis. It should be the goal to get as many KSA's as possible within your 4 walls, and then explore partnerships to resource the remaining needs. This may include connecting with a local MTF, partnering with a local VA or civilian facility, or arranging for TAD.

It should be noted that KSA's are a work in progress and will continued to be reviewed, validated, and amended as needed. Thus, I invite your feedback as we move into the implementation process. For another summary, go to: https://mccareer.org/2020/08/24/what-are-ksas/

GMO CONVERSION

A *proposa*l has been drafted for the conversion of GMO, Flight Surgery, and Undersea Medicine Officer billets, in which these positions will be filled by residency trained physicians. This would align the Navy with the model used by our sister services. Additionally, an increasing number of states are requiring 2 years of GME for medical licensing, which will eventually make this transition necessary. Finally, medical students desire straight-thru training. This initiative would impact approximately 415 GMO, FS, and UMO billets. It would involve a gradual transition over 5 years to residency trained Operational Medical Officers (OMO's), timed

continued on page 20

MEMBERS IN THE NEWS

The USAFP Board of Directors encourages each of you to submit information on USAFP "Members in the News" for publication in the newsletter. Please submit "Members in the News" to Cheryl Modesto at *cmodesto@vafp.org*.

NEWSLETTER SUBMISSION DEADLINE

REMINDER: The deadline for submissions to the Summer magazine deadline is 28 June 2021.

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...
Leo A. Carney, DO, FAAFP,
HQMC – Health Services
Arlington, VA
leocarney@icloud.com

PROMOTING RESEARCH IN THE MILITARY ENVIRONMENT

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

Whether you are deployed or in garrison, the USAFP research judges can help! Visit us online at http://www.usafp.org/committees/clinical-investigations/ for resources or to find a mentor.

continued from page 19

with a gradual increase in straight-thru GME training opportunities. The OMO's would be mainly primary care, but no decision have been made on which specialties will get which OMO billets. However, it is anticipated that FM will get proportionally less than the other primary care specialties given our comparatively larger operational footprint.

MILESTONE (CMO, OIC), CO/XO OPPORTUNITIES & APPLICATION PROCEDURES

As I was typing this column, the notice for milestone (CMO, OIC) opportunities was released, and it is anticipated that CO/XO Opportunities and Application Procedures will be available by the time your eyes read this page. Check out the Office of the Corps Chief website for more info.

DHA TRANSITION UPDATE

Amid the COVID-19 pandemic response, the DHA transition has been paused. Since my last update…its back on. Guidance was provided by both the Secretary of Defense and the Assistant Secretary of Defense for Health Affairs on 09 November 2020 to resume the transition of MTF administration and management from the Military Departments (MILDEPs) to the DHA in support of the implementation plan. The secretary charged DHA with 3 priorities:

1) ensuring the delivery of high-quality healthcare,
2) utilize the MTF's as much as possible for readiness workload, and
3) ensuring the medical readiness of the force.

More details can be found in the memorandum from the SECDEF at: https://www.milsuite.mil/book/docs/DOC-901303.

[As a review, the Military Health System (MHS) consists of 51 military hospitals, 424 clinics, and 248 dental clinics, serving 9.5 million services members, military retirees, and their families. In 2013, the SECDEF directed the establishment of the DHA as part of the DoD's effort to reform the DHS. Section 702 of NDAA 2017 directed the DHA to assume authority, direction, and control of all MTFs by 01 Oct 2018. This date was amended to NLT 30 September 2021 by NDAA 2019. The transition began on 01 Oct 2018 with 31 CONUS MTF's being redesignated under DHA administration and management. The following year in Oct 2019, DHA assumed responsibility of all MTFs within CONUS, Hawaii, and Puerto Rico, with a plan to transition the remaining MTFs using a phased, conditions-based approach. DHA is in the process of establishing 21 Market Offices. Because of the COVID-19 pandemic, the Deputy SECDEF approved a pause in transition activities to focus on COVID-19 response efforts. On 05 August 2020, the Secretaries of the Army, Navy, and Air Force, along with the the Chief of Staff of the Army, CNO, Chief of Staff of the Air Force, Commandant of the Marine Corps, and the Chief of Space Operations, called for the return of all military hospitals and clinics already transferred to the DHA and suspension of any planned moves of personnel or resources. On 03 September 2020, the Deputy SECDEF noted that the MHS reform was directed in law, and planned to better understand the concerns of the services. The 09 November 2020 memo referenced above resumed the transition.]

NEW PROGRAM DIRECTOR AT NAVAL HOSPITAL JACKSONVILLE, FL

I am pleased to share with you that CDR Dustin Smith has been appointed as the newest Family Medicine Program Director of the FM residency program at NH Jacksonville. He follows in the shoes of CAPT Kris Sanchack, who completed 5 years at the helm providing outstanding leadership during a time of extraordinary change and challenges. CAPT Sanchack leaves behind an award winning program that recently hit the 50 year milestone since opening its door. His leadership of a team that provided outstanding training and mentorship will continue to positively impact all those we serve. We are grateful for his commitment and service and wish him fair winds and following seas! And congratulations and best of success to CDR Smith!

NEXT FAMILY MEDICINE SPECIALTY LEADER

Later this year, I will be turning over as your Specialty Leader. On April 1, I sent out an email with the official announcement for interested candidates to submit applications, and it was also posted on the Medical Corps Chief website. The goal is for the next individual to be identified in time to participate in the next GME cycle with turnover at the GME Selection Board in November 2021.

COMMUNICATION:

As has been my habit, I am going to continue to list the below venues as a means for us to stay connected as a community, corps, and service:

- Office of the Corps Chief Website: https://esportal.med.navy.mil/bumed/m00/m00c/M00C1/
- Milsuite.mil (https://www.milsuite.mil): Search: "Navy Family Medicine".
- Email: I send out periodic announcements to the community. If you haven't heard from you, then I probably do not have you in my email group. Send me an email at james.w.keck.mil@mail.mil, and I will get you added. Family Medicine leaders at local commands, I ask you to please check with your FP's to see if they are getting my emails to ensure they are in the loop.

This article is one of my lengthier contributions, and speaks to the reality of all the issues with which you wrestle every day. I am grateful to be serving with you and consider it a privilege to be a voice for our community. Please don't hesitate to reach out to me with any questions or concerns. Stay well!

George R. Mount, MD, FACR FACP
Director, Leader & Faculty Development Fellowship
Madigan Army Medical Center
geo.mount@gmail.com

The Importance of Trust in a Time of Extraordinary Change

Cliché as it may be, the statement, "The only constant is change," rings especially true given the extraordinary events of the past year. We are so accustomed to change that we employ terms such as "Semper Gumby" or "Flexecution" without a second thought. Given this ubiquity, how do we, as leaders, not only manage times of extraordinary change but instead excel and thrive in such times? Though numerous leadership principles and philosophies focus on leading through change, nearly all such tenets are anchored in the critical element of trust. Trust is the often difficult to measure feeling or belief that one has in the reliability, ability, strength, or truth of someone or something.[1] Trust is the foundation for all types of interactions in our society: trust is why we feel comfortable driving through an intersection if the traffic light is green or why we will accept a small, 6" x 3" piece of paper (check) as a form of payment. In an eloquent essay, written on his 100th birthday, former Secretary of State George Shultz succinctly notes, "Trust is the coin of the realm."[2]

Recognizing the vital importance of trust, Steven R. Covey celebrates and explores this essential element of effective leadership in his book, *The speed of trust: The one thing that changes everything*. Covey argues that trust impacts two outcomes: speed and cost.[3] When trust is low, speed decreases while cost increases. Increase trust, and you increase speed and decrease cost. Covey cites the example of airline travel post-9/11 as an example of how lower trust led to a decrease in speed (longer waits through airport screening, requirements to arrive at the airport earlier, etc.) and increased costs (fees, time, screening, etc.). Applying this simple relationship to times of extraordinary change, one quickly recognizes the impact that trust, or the lack thereof, has on our ability to lead through change. With an established and firm foundation of trust, leaders and organizations adapt to change more quickly and do so with fewer costs. As Covey notes, "Trust truly is the one thing that changes everything."

If we agree that trust changes everything, how do we increase trust within our organization? Covey posits trust as a function of two elements: character and competence. He explains, "Character includes your integrity, your motive, your intent with people. Competence includes your capabilities, your skills, your results, your track record. And both are vital." Though Covey's dissection of trust provides a reasonable and digestible approach to how one might effectively build trust, Harvard professor and leadership consultant Frances Frei expands our understanding of the essential elements of trust.[4] Frei focuses more acutely on the related qualities of authenticity ("I experience the real you") and logic ("Your reasoning and judgment are sound"). Frei expands further by adding a third essential element of trust: empathy. That is, the ability to understand or to be aware of the feelings, thoughts, or experiences of another person (or, as Frei puts it, "I believe you care about me and my success"). These three elements, authenticity, logic, and empathy build her Trust Triangle (figure below). Frei argues that when trust is lost in a relationship or an organization, it almost always reflects a breakdown in one, or more, of these three core factors.

Frei labels a breakdown in one of the three core factors as a "trust wobble". Frei further explains, "…when trust is broken, or fails to get any real traction, it's usually the same driver that has gone wobbly on us — authenticity, empathy, or logic." Additionally, she argues that we can identify our typical trust wobble, and even more importantly, we can focus our efforts to shore it up. In doing so, we enhance trust. To accomplish this task, Frei suggests that leaders start with a simple exercise in which one examines a recent incident where trust was undermined. Once such an episode is identified, one must take responsibility for the lack of trust and then carefully review which of the three core factors was the primary driver. Taking this exercise to the next level, Frei recommends examining a series of such episodes to see if one can identify a recurrent theme. With your trust wobble in hand, the work of correcting one's deficit can begin. Frei provides several strategies one might employ to address each of the three core elements. For example, if you note a recurrent wobble in empathy, you might pay attention to your behavior in a group setting. Are you more concerned about what you're getting from the group interaction rather than ensuring that others' needs are being met?

With an enhanced understanding of trust's criticality, let's return to the constant challenge of change. As you may have already noted, a change in program leadership occurred in the Leader & Faculty Development fellowship this past year. Following in the footsteps of an exceptional leader, I recognize the impact of my selection for the fellowship and the Family Medicine community. I understand and celebrate the fellowship's tradition of excellence, wherein multiple graduates of

continued on page 24

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

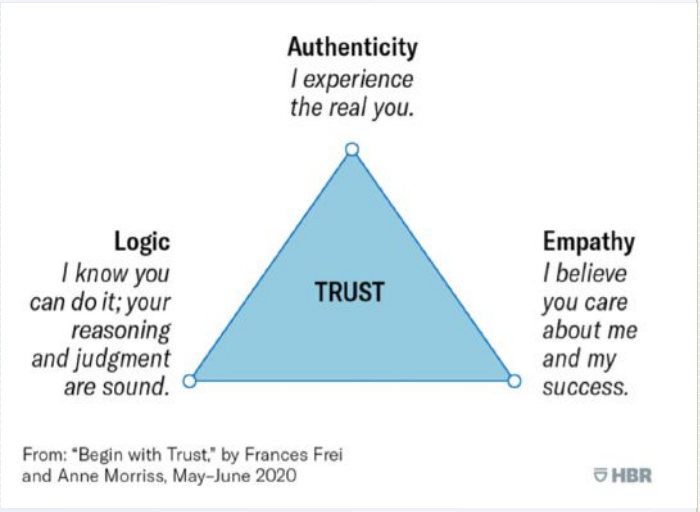
501.223.3322 • 800.880.3322 • www.PinnaclePointeHospital.com

TRICARE® Certified

continued from page 22

the program subsequently advanced to high levels of academic, clinical, and military leadership. Similarly, I recognize the fellowship's foundation is one built on trust. This foundation quickly became evident as I began to work with an exceptionally talented and diverse group of fellows. From day one, the fellows exhibited all three of Frei's core elements of trust. As the fellows seamlessly shared their authentic selves while demonstrating a competence grounded in logic, it was quickly apparent the talented group I was fortunate to be joining. We joked about a "special sauce" that made our fellowship tick. During one of our engaged fellowship sessions, I recognized what ingredient was key to that sauce: empathy. When I looked around the room, I saw fellows that worked under the guiding principle of ensuring that their colleagues' needs were being met. We operated in the space of trust, and in doing so, we adapted to a significant change in leadership with speed and limited costs.

Recognizing that change will be inevitable whatever your path forward as a leader may be, what is your plan to build trust in your interactions with others and within your organization? Are you interested in genuinely examining leadership principles? Do you wish to enhance your toolkit as an educator and serve as a developer of other educators? Does an environment built on trust, adaptable and flexible in times of change, sound like a space in which you would thrive? If you answered yes to these queries, please consider our fellowship and talk with your service consultant to explore your application options. We welcome all those committed to our mission of developing military physicians, able to lead and equip physicians at all levels, and to advance military medicine through innovation and research. Please also reach out to me, or any member of our team, through the fellowship list serve (usarmy.jblm.medcom-mamc.list.faculty-development-fellowship@mail.mil).



REFERENCE LIST

1. Dictionary Merriam-Webster. Merriam-Webster.com. https://www.merriam-webster.com/dictionary/trust. Published 2002. Accessed February 20, 2021.
2. Shultz, GH. The 10 Most Important Things I've Learned About Trust Over My 100 Years. WashingtonPost.com. http://www.washingtonpost.com. Published December 11, 2020. Accessed February 20, 2021.
3. Covey, SR, Merrill, RR. The Speed of Trust: The One Thing that Changes Everything. New York, NY: Simon and Schuster; 2006.
4. Frei, F, Morriss, A. Begin with trust. Harvard Business Review. 2020;98(3):112-121.

Don't Miss Out on Complimentary USAFP Membership Benefits

DAILY INFOPOEMS

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

Our patients have voted us best.

Our team has voted us best.

Patient First is looking for the best.

TOP WORK PLACES 2020 — CELEBRATING 10 YEARS — BALTIMORE SUN MEDIA

TOP WORK PLACES 2020 — The Washington Post

TOP WORK PLACES 2020 — Richmond Times-Dispatch

Physician opportunities available now.

Patient First has received "Top Workplace" awards from the *Washington Post, Baltimore Sun,* and *Richmond Times-Dispatch*, and our patients continue to recognize us as the "best urgent care" provider in their areas. Come join an award-winning team at one of our 70-plus medical centers across the region, and thrive in a supportive, team-oriented environment that enables you to work the way you want.

- Comprehensive compensation package
- Outstanding benefits
- Flexible schedules
- Highly trained staff
- Comprehensive EMR system
- Full-service on-site lab
- On-site dispensary
- Desirable work/life balance

To learn more, please contact us at 804-822-4478
or physiciancareers@patientfirst.com.
Or visit www.patientfirst.com/careers

Patient First®

committee report
CLINICAL INFORMATICS

Barrett Campbell, MD, MBA, CPE, PMP, FAAFP
Chair, Clinical Informatics Committee
JBLM, WA
barrett.h.campbell@gmail.com

This committee update contains the MHS GENESIS Wave Schedule, a request for your participation in a learning needs assessment, and a brief overview of clinical informatics. Presented in reverse order, these topics are an attempt to meet your needs as an Academy member and Uniformed Family Physician. As a committee, we need your help in defining requirements and assessing performance in meeting those requirements.

Defining requirements is a difficult practice, as evidenced by the degree of success in matching Electronic Health Records with clinical requirements. These difficulties exist across all domains of practice, not just within the military.[1,2] To improve the likelihood of success, sharing a common understanding of capabilities and objectives set a foundation upon which to build. Towards this object, I offer the following brief description of the discipline of clinical informatics.

Clinical informatics is the intersection of clinical practice, technology, and health systems.[3] To some degree, each of us is directly affected by clinical informatics. More than just the 'techie' doc, clinical informaticists work to improve the environment of care through reasoned application of technology, informed by data analytics and application. With the increase over the years of evidence-based guidelines, sound data entry, processing, and application increase in importance to clinical practice. A large focus of clinical informatics is also change management, recognizing the human element in system development.

With this brief sketch in mind, the Clinical Informatics Committee needs your help to focus our efforts. Please use this QR code and complete the linked needs-assessment survey. Your answers inform our efforts to meet your needs. Without your

Figure 1. Needs assessment (https://www.surveymonkey.com/r/BC_Needs-Assessment)

continued on page 28

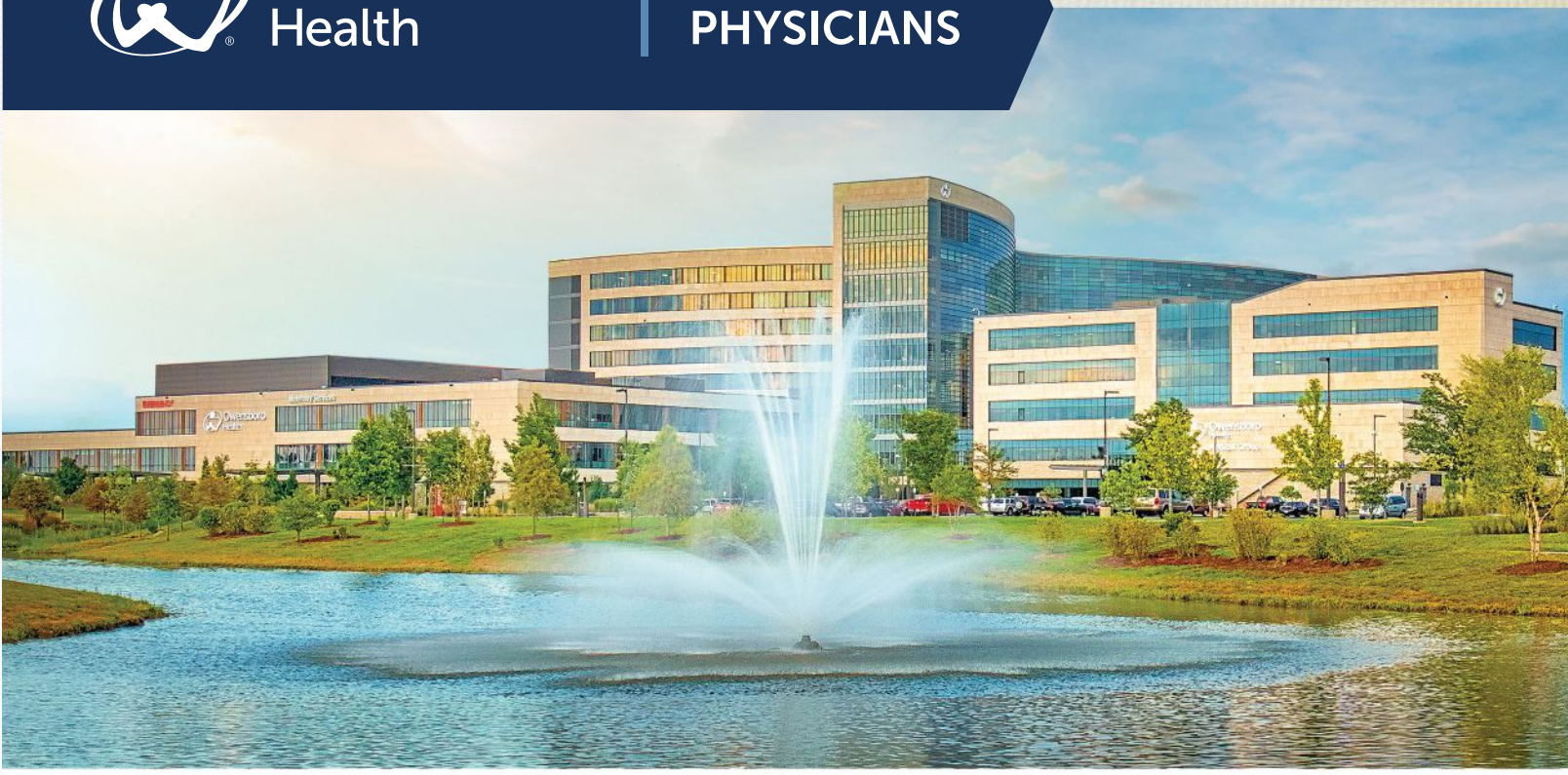
RISE ABOVE.

Come care with us.

HERE, WE'VE RISEN ABOVE. We've pioneered advanced care for our friends and neighbors in this region that we are proud to call home. We've risen above and built a team of dedicated caregivers; together, for and around one thing – our patients. We've risen above and built a state-of-the-art hospital with leading-edge design and technology rivaling any in the nation. We enjoy a low cost of living but an exceptional quality of life, all in a community that feels large, yet is comfortable enough to call home.

Owensboro Health

RECRUITING PHYSICIANS



(502) 593-6114 / CALL / TEXT

Kathryn Coble, Physician Recruiter
kathryn.coble@owensborohealth.org

CENTRALLY-LOCATED IN THE MIDWEST

MULTIPLE PRIMARY CARE OPPORTUNITIES

- Competitive base compensation, guaranteed for two years with RVU bonus potential / Up-front bonuses / Full benefit package
- Health system-employed position with integrated Epic electronic medical records system

Family Medicine Residency Faculty

- Affiliated with the University of Louisville, a new program with seven residents in the first class of 2020
- University-sponsored program hosting six resident slots per year (19 total by 2022)
- Brand-new clinic space with eighteen exam rooms and four classrooms

UNIVERSITY OF LOUISVILLE
Family Medicine Residency

Family Medicine Outpatient

- Robust referral base / 14-county coverage area / population draw of over 400,000
- Outpatient only or traditional model of inpatient rounding with group shared call.

Urgent Care

- Urgent care hours: Monday – Friday, 8 a.m. – 8 p.m.
- Work/Life balance with 182 shifts annually and opportunity for additional shifts

continued from page 26

input, we can guess at your individual needs and may not serve you in the most effective way.

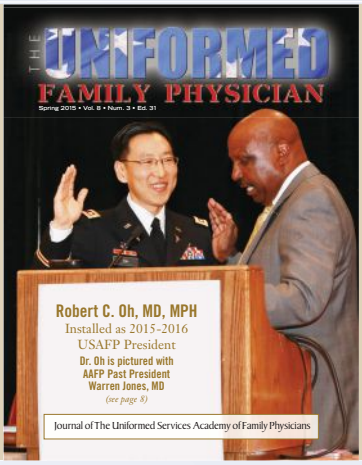
Clinical informatics as a discipline and committee overlaps significantly with the other USAFP committees and with the practice of medicine within our enterprise. Beyond simple information retrieval, incorporation of clinical informatics competencies benefits information organization, delivery, and assessment.[4] Efforts to assess and address social determinants of health rely on data access and aggregation efforts. Further, understanding system limitations regarding access and communication aids efforts to promote health equity and eliminate bias. Operationally, risk communication with commanders relies on accurate and timely assessments, aided by leveraging the many disparate technology systems as well as working across lines of command to positively influence outcomes. Successful talent management relies on systems understanding to analyze inventories and implementation of integrated skill/readiness metric capture. Without informatics, these efforts can all be successful albeit with a considerable risk of failure due to integration failures. With sufficient application of clinical informaticians, these efforts are more likely to achieve success in a shorter time.

I add the caveat to the above statement recognizing the proverbial elephant in the room. The MHS GENESIS implementation is a topic in which members frequently engage the informatics committee.

MHS GENESIS, the Cerner Millennium-based Electronic Health Record continues to roll out, planned to complete in just under three years. The road to GENESIS is filled with complexity.[5] As an integrated record, there are many benefits over the legacy system of separate applications. Please realize that GENESIS is not one application. It is a suite of applications, designed to function together. These applications provide documentation, opportunities for collaboration, and clinical-decision support across inpatient, outpatient, and dental care settings. Operationally focused workflows, such as mass vaccination, provide functionality not typically seen in civilian settings. We supply this rollout schedule to provide an idea of the go-live dates. The largest MTF in the cohort determines the name for each Wave. As an example, Wave Carson, with go-live at the end of April, contained about 21 distinct installations across 11 states.

As a massive project, the GENESIS rollout is not without its setbacks. As an application, GENESIS is not without its limitations. As a data source, GENESIS is not without its peers. Service readiness systems, such as ASIMS, MERS, and MODS, along with personnel systems, DEERS, logistics systems, such as M3PT, the legacy applications, AHLTA, CHCS, Essentris, AHLTA-T, and occupational health systems, such as DOEHRS, all provide

continued on page 30



continued from page 28

the data defining the care we provide and driving the policy which enables this care. Much like an iceberg, many of our systems do not enjoy a general awareness. Figure 2 provides the current Wave schedule. Light blue blocks represent the time taken to setup and validate configuration, with go-live approximated by the red lines. Darker blue indicates post-go-live support. This schedule is subject to change.

There are multiple efforts at many levels designed to ensure individual and site success with GENESIS. This committee supports these efforts, and will work to support and advocate further needs, as identified. Again, please take the time to complete the needs survey. Thank you for your time, attention, and shared commitment to patient care!

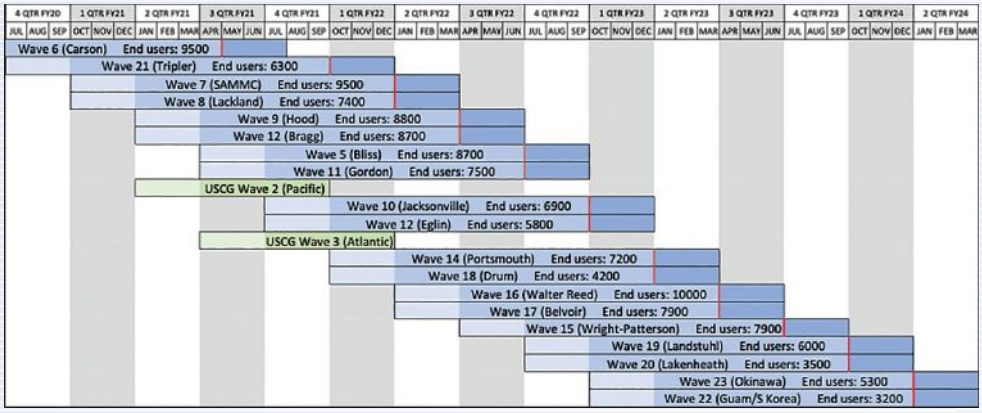


Figure 2. Wave Schedule

REFERENCES

1. Fairbanks T, Savage E, Adams K, Wittie M, Boone E, Hayden A, et al. Mind the Gap. Applied Clinical Informatics. 2016;07(04):1069-87.
2. Sullivan T. Coast Guard seeks new EHR vendor after failed Epic implementation. Healthcare IT News [Internet]. 2017 April 25 [cited 2021 April 6]. Available from: https://www.healthcareitnews.com/news/coast-guard-seeks-new-ehr-vendor-after-failed-epic-implementation.
3. Gardner RM, Overhage JM, Steen EB, Munger BS, Holmes JH, Williamson JJ, et al. Core content for the subspecialty of clinical informatics. J Am Med Inform Assoc. 2009 Mar-Apr;16(2):153-7.
4. Hersh WR, Gorman PN, Biagioli FE, Mohan V, Gold JA, Mejicano GC. Beyond information retrieval and electronic health record use: competencies in clinical informatics for medical education. Adv Med Educ Pract. 2014;5:205-12.
5. Mendez BH. MHS Genesis: Background and Issues for Congress. Congressional Research Service (CRS) Report. 2019 (R45987).

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
https://usafp.org/clinical-investigations/
for resources or to find a mentor.

Interested in Joining a USAFP Committee?

Visit usafp.org/committees to get involved with one of the many great USAFP committees. Full descriptions and responsibilities are noted on the website along with an electronic interest form. Once you join, participate in the committee discussion forums to connect with your peers on initiatives of interest to you!

CLINICAL INFORMATICS COMMITTEE

Definition - This committee is charged to assist in the training and advising of USAFP members in the use of Health Information Technology (HIT) tools available to them, and to encourage involvement in development of emerging products in the DoD.

CLINICAL INVESTIGATIONS COMMITTEE

Definition – 1) Promote scholarly activities, in general, and in particular original research among Academy members; 2) Help educate USAFP membership in areas of research and scholarly activity.

CONSTITUTION/BYLAWS AND STRATEGIC CHARTER COMMITTEE

Definition - Standing committee to assure that Bylaws remain current and reflect the objectives of the organization.

EDUCATION COMMITTEE

Definition - The Education Committee focuses on continuing medical education (CME) and graduate medical education (GME) issues from residency through the remainder of a member's career. The committee promotes quality CME programs provided by and through the USAFP and serves as the conduit to the AAFP for CME approval of education programs sponsored by USAFP members. The committee promotes the development of curricula and fosters communication among the military training programs. It is not intended to duplicate the Resident committee, but rather to address educational issues and faculty development.

MEMBER CONSTITUENCIES COMMITTEE

Definition - This committee was established to ensure cultural competence in regard to serving and educating patients and members; to promote enfranchisement of patients and physicians in specific member populations; to foster leadership and mentoring opportunities among specific member populations; to promote inclusivity within the USAFP by increasing representation of specific member population views and interests; and to address issues of current and emerging specific member populations.

MEMBERSHIP AND MEMBER SERVICES COMMITTEE

Definition - The purpose of the USAFP is to serve the membership. The MMSC will monitor this service and establish projects to serve the membership as needed.

OPERATIONAL MEDICINE COMMITTEE

Definition - The Operational Medicine Committee exists to support and enable USAFP members to successfully respond to ever-changing wartime, peacetime and contingency operational/ readiness requirements through scholarly activities, information sharing and leadership.

PRACTICE MANAGEMENT COMMITTEE

Definition - This committee is charged to monitor and evaluate the provision of health care services to military beneficiaries by members, to include Family Medicine representation on hospital staffs, and monitor changes in health care delivery as it impacts on the specialty and our patients.

RESIDENT AND STUDENT AFFAIRS COMMITTEE

Definition - Established to study and address special problems, needs and concerns of students and residents in relationship to military family medicine.

WELLNESS AND RESILIENCY COMMITTEE

Definition - The Wellness and Resiliency Committee is charged with actively increasing interest in preventive health and encouraging increased quantity and quality of scientific activities that emphasize this important area of family medicine.

Rob Oh, MD, CIC Chair
VA Puget Sound Health Care System
robohmd@gmail.com

The 2021 Virtual Research Competition

COVID. Virtual. Pivot. Resilient. Impressive. These are some of the words that describe the 2021 Research competition. Together, though, we are #BetterTogether. Despite the challenges, the members of the USAFP forged through a successful virtual research competition. Without fail, your inquisitiveness and thirst for scholarly activity led to, simply, an amazing competition once again. Some stats. What is a CIC newsletter without some descriptive statistics?

ANNUAL RESEARCH COMPETITION STATS

- Total Research Submitted: 131 abstracts (50- Army, 44 Navy, 37 Air Force)
- All 15 residencies submitted research projects
- 67% presented research for the first time

For those of you who couldn't watch the virtual competition, here are the winners with the abstracts. In addition, 2021 saw a new category of winners. At the suggestion of our esteemed research judges, a COVID19 category was created for these unique times.

Finally, for the 2022 competition, look for the email about the abstracts for submission opening in July!

OVERALL WINNER OUTSTANDING ACHIEVEMENT IN SCHOLARLY ACTIVITY

Madigan Family Medicine Residency, Madigan Army Medical Center

MAJ Jeffrey Burket – Program Director

OUTSTANDING ACHIEVEMENT IN SCHOLARLY ACTIVITY / NAVY

Camp Lejeune Family Medicine Residency, Naval Medical Center Camp Lejeune

CAPT(s) Elizabeth Leonard – Program Director

OUTSTANDING ACHIEVEMENT IN SCHOLARLY ACTIVITY / ARMY

Fort Benning Family Medicine Residency, Martin Army Community Hospital

MAJ David Bury – Program Director

OUTSTANDING ACHIEVEMENT IN SCHOLARLY ACTIVITY / AIR FORCE

Nellis AFB Family Medicine Residency, Mike O'Callaghan Military Medical Center

Lt Col Kattie Hoy – Program Director

FIRST PLACE COVID-19 CASE REPORT

COVID-19 Associated Pancreatitis

2LT Paige Macky, Uniformed Services University

SECOND PLACE COVID-19 CASE REPORT

NOVID to See Here: EVALI during a Viral Pandemic

CPT Marc Cook, DO, Womack Army Medical Center, Fort Bragg

THIRD PLACE COVID-19 CASE REPORT

Giving COVID-19 Induced VTE the Slip: A Case of PE in an Ambulatory Patient with Mild Disease

Capt James P. Killoran, Jr., MD, Eglin AFB

FIRST PLACE CLINICAL INVESTIGATION

Use of Ambulatory Blood Pressure Monitor in the Diagnosis of Hypertension by Family Physicians

Capt Andrew Gaillardetz, MD, Scott AFB/Saint Louis University

SECOND PLACE CLINICAL INVESTIGATION

Sweep it Under the MAT: Medication-Assisted Treatment for Opioid Use Disorder

CPT Kathryn Gouthro, MD, Madigan Army Medical Center, JBLM

THIRD PLACE CLINICAL INVESTIGATION

Predictors for PAP Adherence Among Active-Duty Military Personnel Newly Diagnosed with Obstructive Sleep Apnea

CPT Lea Choi, DO, Womack Army Medical Center, Fort Bragg

FIRST PLACE EDUCATIONAL RESEARCH

Professional Identity Formation in Faculty Developers

2Lt Caleb W. Kiesow, Uniformed Services University

SECOND PLACE EDUCATIONAL RESEARCH

Gain, No Pain: Boosting Family Medicine Residents' Knowledge, Skills, and Confidence in Treating Patients with Chronic Pain

CPT Stephen Nellis, DO, Womack Army Medical Center, Fort Bragg

FIRST PLACE CASE REPORT

ROLO: Whole Blood Transfusion Option for Forward Deployed Units

CPT Kaoru H. Song, MD, Tripler Army Medical Center

SECOND PLACE CASE REPORT

Put it in the Water: Atorvastatin as a Preventative for Ovarian Cancer Related Mortality

CPT W. Schaefer Leber, MD, Madigan Army Medical Center

THIRD PLACE CASE REPORT

Rash Response? A Rare Case of Stimulant-Induced Cutaneous Small Vessel Vasculitis

MAJ Peter P. Studebaker, DO, Darnell Army Medical Center, Fort Hood

FIRST PLACE POSTER DISPLAY / CLINICAL INVESTIGATION

No Rest for the Weary: Improving PAP Therapy Adherence through One-Time Behavioral Intervention

CPT Charles W. Mounts, DO, Womack Army Medical Center, Fort Bragg

SECOND PLACE POSTER DISPLAY / CLINICAL INVESTIGATION

Attitudes Toward Obstetric Practice in Uniform

CPT Jessica Coulter, MD, Madigan Army Medical Center, JBLM

THIRD PLACE POSTER DISPLAY / CLINICAL INVESTIGATION

Operation Blood Rain: The Effect of Airdrop on Fresh Whole Blood

Maj Robert L. Tong, MD & Maj Roselyn W. Fuentes, MD, Eglin AFB

FIRST PLACE POSTER DISPLAY / EDUCATIONAL RESEARCH

Operation Bushmaster: A Threshold Experience

Lt Charisse Villareal, MD, Fort Belvoir Community Hospital

FIRST PLACE POSTER DISPLAY / CASE REPORT STAFF CATEGORY

CIDP: A Rare Risk of Immunizations in an Active-Duty Trainee

CPT(P) Daniel Jason Frasca, DO, Eisenhower Army Medical Center

FIRST PLACE POSTER DISPLAY / CASE REPORT RESIDENT CATEGORY

A Case of Penile/Scrotal Shingles: Broadening your Differential for Common Things in Uncommon Places

Capt Jared Wesley Baird, DO, Nellis AFB

SECOND PLACE POSTER DISPLAY / CASE REPORT RESIDENT CATEGORY

Congrats! It's a…Foot Pain? Sacral Plexopathy after Spontaneous Vaginal Delivery

CPT Ryan Coffey, MD, Fort Benning, Martin Army Community Hospital

THIRD PLACE POSTER DISPLAY / CASE REPORT RESIDENT CATEGORY

Hiding Behind a Normal X-ray: HPV Positive Anal Cancer Disguised as Hip Pain

Capt Anna Milliren, DO, Travis AFB

THIRD PLACE POSTER DISPLAY / CASE REPORT RESIDENT CATEGORY

"After Chewing on that, I had a Change of Heart"

LT Cody S. Holmes, DO, Naval Hospital Pendleton

2021 Juried Podium Abstracts

FIRST PLACE COVID-19 CASE REPORT

COVID-19 ASSOCIATED PANCREATITIS

Primary Author: Paige Macky, 2nd LT

Introduction/Objective: The SARS-CoV-2 virus and its sequelae continues to be evolving and challenging. Presented is a patient with acute pancreatitis 10 days after COVID-19 pneumonia, suspicious for COVID-19 pancreatitis.

Case Presentation: A 43-year-old female presented with five days of progressing epigastric abdominal pain. Medical history was significant only for an admission 10 days prior secondary to COVID-19 pneumonia. Evaluation revealed severe tenderness in the epigastrium, leukocytosis, mild lipase elevation, and positive SARS-CoV-2 swab. Abdominal CT showed enlargement of the pancreatic head with fat stranding and thickening of the proximal duodenal wall, consistent with acute pancreatitis. Right Upper Quadrant Ultrasound was unremarkable. Patient was admitted for fluid resuscitation and pain control. On hospital day 3, she became febrile with new oxygen requirement and an elevated CRP. Diagnosis of COVID-19 pancreatitis was made, she was started on remdesivir, dexamethasone, and tocilizumab, and within 24 hours had significant improvement. She ultimately completed five days of remdesivir and ten days of corticosteroids with complete resolution of symptoms.

Discussion: Though mechanism, incidence, and prevalence of COVID-19 pancreatitis remains unclear, viruses are a common cause of acinar cell injury. Literature review supports pancreatitis secondary to the SARS-CoV outbreak in 2003 with similar lab and imaging findings, and recent literature supports pancreatic involvement of the SARS-CoV-2 virus.

Scholarly Questions: Should patients with acute pancreatitis, with no clear etiology, be treated for presumed COVID-19 pancreatitis during this pandemic?

Conclusion: The patient presented had history and exam most consistent with COVID-19 pancreatitis, although literature on the SARS-CoV-2 virus and its sequelae are limited. Further studies are warranted to clarify SARS-CoV-2 associated pancreatitis, its mechanism, and typical presentation. In light of the current pandemic, physicians should consider the patient's entire history and presentation, and consider treating for COVID-19 as indicated.

SECOND PLACE COVID-19 CASE REPORT

NOVID TO SEE HERE: EVALI DURING A VIRAL PANDEMIC

Primary Author: Marc Cook, CPT, DO

Introduction/Objective: E-cigarette, or vaping, product use associated lung injury (EVALI) presents with a constellation of progressive respiratory symptoms, requiring exclusion of other diffuse airspace diseases to properly diagnose. Presented is a patient with dyspnea occurring in the setting of a COVID-19 respiratory pandemic and a history of e-cigarette cannabinoid use.

Case Presentation: A 22-year-old female with a close-contact exposure to COVID-19 presented to the emergency room with fevers, cough, diarrhea, and dyspnea. Evaluation revealed elevated inflammatory markers and diffuse bilateral opacities on chest imaging. She required supplemental oxygen and was admitted for treatment of presumed atypical or viral pneumonia. Infectious etiologies were eventually ruled out, including with negative COVID-19 PCR testing on four separate nasopharyngeal and a bronchoscopic alveolar lavage sample. EVALI was diagnosed based on e-cigarette cannabinoid use in the previous 90 days with appropriate CT findings and absence of a plausible alternative diagnosis. The patient returned to baseline with a systemic steroid taper.

Discussion: Formal diagnostic criteria for EVALI have not been agreed upon, however case definitions involve use of an e-cigarette in the previous 90 days, lung opacities on chest imaging, exclusion of lung infections, and absence of a plausible alternative diagnosis. The presenting clinical manifestations overlap significantly with COVID-19. With a paucity of information surrounding both disease courses, and a notably high false negative rate in current COVID-19 testing, these conditions can be difficult to differentiate.

Scholarly Questions: Can EVALI be reliably distinguished from COVID-19?

Conclusion: In the setting of our current global pandemic, the possibility of COVID-19 should be considered in all patients with new onset respiratory symptoms. However, EVALI should be included in the differential diagnosis as a mimicker of COVID-19 in patients presenting with respiratory symptoms, lung opacities on chest imaging, and a history of vaping or e-cigarette use.

THIRD PLACE COVID-19 CASE REPORT

GIVING COVID-19 INDUCED VENOUS THROMBOEMBOLISM THE SLIP: A CASE OF PULMONARY EMBOLISM IN AN AMBULATORY PATIENT WITH MILD DISEASE

Primary Author: Captain James P Killoran Jr, MD

Introduction/Objective: Increased risk of thromboembolism in the setting of COVID-19 infection is a well-documented phenomenon, particularly in the ICU setting. Lesser is known about the risk of venous thromboembolism (VTE) in mild cases and whether thromboprophylaxis is warranted.

Case Presentation: A 60-year-old male presented for evaluation of fever, sore throat, cough, and mild shortness of breath. He was normotensive with a heart rate of 70bpm and SpO2 97%. COVID-19 testing proved to be positive. Three days later, he reported worsening shortness of breath and right-sided chest pain with deep inspiration. He was advised to report to the Emergency Department for evaluation, where he was found to have a pulmonary embolism.

Discussion: COVID-19 gains entry to pneumocytes via the ACE-2 receptor. Researchers postulate this backs-up the RAAS system, leading to a pro-thrombotic environment. In ICU settings, the incidence of VTE's in severe COVID-19 infections approaches 33% despite prophylactic-dosed anticoagulants. Although seemingly rarer, case reports detailing VTE›s in mild cases of COVID-19 infections continue to be reported, but studies centering on whether DVT prophylaxis is warranted in these instances is lacking. The American Society of Hematology recommends low-dose aspirin, post-hospitalization, in patients that have elevated VTE risk . Additionally, orthopedic studies surrounding aspirin DVT prophylaxis and the INSPIRE trial have both shown efficacy toward preventing VTE's. It seems reasonable that aspirin could be efficacious to patients with mild COVID-19 infection.

Scholarly Questions: In the outpatient management of mild COVID-19 infections, should providers prescribe low-dose Aspirin for prophylactic VTE treatment?

Conclusion: Hypercoagulability resulting from COVID-19 leads to an increased risk of VTE's. Low-dose aspirin has shown efficacy toward preventing VTE's in other settings. It would stand to reason, that patients with mild COVID-19 infections, without contraindications to anti-platelet therapy, may benefit from prophylactic low-dose aspirin. Further, studies are needed to determine if this is a reasonable approach.

FIRST PLACE CLINICAL INVESTIGATION

USE OF AMBULATORY BLOOD PRESSURE MONITOR IN THE DIAGNOSIS OF HYPERTENSION BY FAMILY PHYSICIANS

Primary Author: Andrew Gaillardetz, Capt, MD

Introduction: According to the United States Preventive Services Task Force (USPSTF), the diagnosis of hypertension is best confirmed by 24-hour ambulatory blood pressure monitoring (ABPM). Many family physicians remain unaware of this recommendation or lack easy access to an ABPM. We surveyed members of the Uniformed Services Academy of Family Physicians (USAFP) to identify hypertension diagnosis knowledge and resource gaps.

Methods: Design: Cross-sectional survey as a part of the IRB approved Omnibus Survey. Questions were evaluated by a clinical investigations committee for validity and reliability Setting: USAFP's 2020 Annual Meeting (Virtual) Study Populations: Registered attendees of 2020 Annual Meeting Main Outcome Measure(s): Knowledge of hypertension diagnosis recommendations, diagnosis practices, access to 24-hour ABPM, perceived barriers, and interest in using 24-hour ABPM Statistical Test(s) used: Descriptive statistics and chi-square to determine bivariate associations by respondent characteristics

Results: 285 out of 2559 eligible members responded to the survey for an 11.1% response rate. Only 37.3% of respondents correctly identified 24-hour ABPM and home blood pressures (HBP) as the recommended methods for confirming hypertension. 34.4% of respondents have relied on office-based blood pressures (OBP) alone to confirm the diagnosis of hypertension in the last year. 8.8% have never used home logs and only 5.1% used 24-hour ABPM a majority of the time to make the diagnosis of hypertension. 36.4% say they have ABPM currently available for patients, and 75.9% would use 24-hour ABPM if available. The greatest perceived barriers for ABPM use were access and logistical support for the implementation of ABPM in practice.

Conclusion: A significant portion of the surveyed family physicians did not identify the gold standard for confirming a diagnosis of hypertension. Clinical practice appears to align with this knowledge gap. Future research could investigate educational projects as well as quality improvement initiatives.

SECOND PLACE CLINICAL INVESTIGATION

SWEEP IT UNDER THE MAT: MEDICATION-ASSISTED TREATMENT FOR OPIOID USE DISORDER

Primary Author: CPT Kathryn Gouthro, MD

Introduction: The opioid epidemic is a national health crisis and affects beneficiaries of the Defense Health Agency (DHA). VA/DoD practice guidelines recommend the use of Medication-Assisted Treatment (MAT) for Opioid Use Disorder (OUD) and chronic pain. However, there is a lack of training and prescribing of MAT, especially among family physicians. The objectives of this study were to assess provider opinions regarding MAT, evaluate interest and identify barriers for MAT training and prescribing.

Methods: A cross-sectional survey was emailed to USAFP members in May 2020. There was an 11.1% response rate (n=285). The survey included demographic information and nine questions addressing MAT for OUD in multiple choice, 5-point Likert scale, and best answer format. Analysis included descriptive statistics, bivariate analysis, and multiple logistic regression.

Results: 79% of responders agreed that MAT is effective for OUD, 74% felt

continued on page 36

continued from page 35

it should be offered in the DHA, and 77% agreed that family physicians should offer MAT. 65% have been informed of MAT training, though only 34% have had the opportunity for training. 15% have completed training, and 9% have a DEA waiver for buprenorphine. Interestingly, 40% of respondents do not want MAT training. In bivariate, and multivariable analysis controlling for multiple demographic characteristics simultaneously, the only significant differences were that more women than men assessed MAT as effective (88% vs. 72% , $p < 0.05$), and fellowship trained versus non-fellowship trained responders were more likely to have had the opportunity for training (43% vs. 28%, $p < 0.05$).

Conclusion: The majority of USAFP members agree that MAT is effective and should be offered for OUD. Few have received the training to prescribe MAT, and fewer still currently hold a buprenorphine DEA waiver. Further investigation should focus on overcoming MAT prescribing barriers to elevate training interest among family physicians in providing this resource to patients within the DHA.

THIRD PLACE CLINICAL INVESTIGATION

PREDICTORS FOR PAP ADHERENCE AMONG ACTIVE DUTY MILITARY PERSONNEL NEWLY DIAGNOSED WITH OBSTRUCTIVE SLEEP APNEA

Primary Author: Lea Choi, DO, CPT

Introduction: Obstructive sleep apnea (OSA) is prevalent among the US military and a source of significant morbidity. Efforts to improve therapy adherence are critical to improving treatment of the disease. The purpose of this project was to identify factors related to adherence to continuous positive airway pressure (PAP) therapy.

Methods: Seventy-six active duty patients (92% men, mean age 39.48, SD 7.72, range 24-61 years), newly diagnosed with OSA, participated in a 90-minute behavioral intervention forum which included a self-assessment. The interactive forum included a didactic portion and facilitated discussions about OSA, PAP therapy, methods to develop habitual PAP use, and understanding of barriers to and readiness for PAP use. Patients' responses on the self-assessment were correlated with PAP adherence data to better understand factors associated with treatment adherence. Data were analyzed using descriptive statistics and linear regression analysis.

Results: Mean nightly usage of at least 4 hours was 23.56 days and 21.71 days at the 30-day and 60-day mark, respectively. On the days used, mean usage was 6.08 hours and 5.90 hours at the 30-day and 60-day mark, respectively. Regression analysis showed that age, self-efficacy (i.e., confidence in therapy adherence despite challenges), and therapy readiness were significant predictors of at least 4 hours nightly usage at the 30-day mark ($R2 = 53\%$, $P < .001$); no significant predictors emerged for the 60-day mark ($R2 = 25\%$, $P > .05$). On days used, sleep distress, self-efficacy, and therapy readiness were significant predictors of average usage hours at the 30-day mark ($R2 = 44\%$, $P < .002$); no significant predictors emerged for the 60-day mark ($R2 = 36\%$, $P < .02$).

Conclusion: Sleep distress, self-efficacy and therapy readiness are associated with increased PAP device use. Further research could focus on methods targeting these factors to enhance PAP therapy success.

FIRST PLACE EDUCATIONAL RESEARCH

PROFESSIONAL IDENTITY FORMATION IN FACULTY DEVELOPERS

Primary Author: 2d Lt Caleb W Kiesow, B.S.

Introduction: Professional identity formation is a complex construct continually evolving related to an individual's experiences. (Steinert 2019) Sparse literature on the identities of faculty developers demonstrates how it affects other identities, impacts careers, and connects aspects of their teaching. (O'sullivan 2014) Faculty developers continue their role in order to grow professionally, develop mastery, and connect with others (O'Sullivan 2015). Increasing ACGME faculty development requirements, and rapid turnover of junior faculty in our 15 military Family Medicine Residencies, highlight the need for faculty developers. In 2017, the Uniformed Services University of the Health Sciences trained faculty to serve the MHS as local faculty developers. We aimed to understand how the identities of these faculty developers developed. This study received approval as an exempt protocol (DBS.2020.129) at USUHS.

Methods: We employed a constructivist thematic analysis methodology using an inductive approach to understand the experiences of faculty developers. Semi-structured recorded interviews were conducted by a member of the team uninvolved in analysis of the data. Interviews were transcribed, checked for accuracy, and de-identified. Four coders analyzed data beginning with overall familiarization of the data, codebook creation, and codebook application to all transcripts. Coding and thematic analysis was completed iteratively. Memos were used to document understanding of data and created an audit trail (Kiger 2020).

Results: Multiple themes emerged. Including: the impact of being a faculty developer, the barriers and motivators for continuing that role, and how new identities emerged. Impacts include how being a faculty developer bolstered faculty member's careers and enhanced individual purposeful teaching. Motivating factors include personal development, collegial relationships, and influence on educators. Identity formation developed differently with regard to timing and relationship to other identities.

Conclusion: Faculty Developers in the Uniformed Services shape their identities, add to the educational culture, and strengthen residency training, from a multitude of factors and experiences.

SECOND PLACE EDUCATIONAL RESEARCH

GAIN, NO PAIN: BOOSTING FAMILY MEDICINE RESIDENTS' KNOWLEDGE, SKILLS, AND CONFIDENCE IN TREATING PATIENTS WITH CHRONIC PAIN

Primary Author: Stephen Nellis, CPT, DO

Introduction: Given the opioid epidemic in America, primary care physicians must know the breadth of treatment strategies for chronic pain. This project's aim was to evaluate the efficacy of a pain curriculum in a military family medicine residency.

Methods: Family Medicine residents completed a two- or four-week rotation at the Interdisciplinary Pain Management Center (IPMC) at Womack Army Medical Center (WAMC). The learning activities include assigned readings, treating chronic pain patients, and presenting a case at the weekly virtual tele-education conference. Assessment instruments included a pre and post survey of residents' self-rated confidence about their skills in 12 pain management topics, a 10-item pre-post measure of basic pain knowledge, and a 25-item post-rotation quiz related specifically to rotation learning activities. These measures were developed specifically for this pain curriculum. Data were analyzed using descriptive statistics including paired sample t-tests and Pearson correlations.

Results: Using a 6-point Likert scale (0-5, no confidence to full confidence), residents' (N=22) self-rated confidence about their pain management skills ranged from mean scores of 1.89 to 3.93 in the pre-rotation survey and from 4.00 to 4.83 in the post-rotation survey. Pre to post confidence improved significantly, mean rating = 2.89 and 4.33 respectively (mean difference 1.44, 95% CI 1.16, 1.73; $P < .001$). Scores on the 10-item pain quiz increased significantly; mean pre and post rotation scores were 8.16 and 9.37 respectively (mean difference 1.21, 95% CI 0.60, 1.82; $P < .001$). Scores on the 25-item post-rotation test was high (Mean = 20.26, SD = 1.98). The 25-item quiz scores correlated significantly with the pre and the post basic pain knowledge scores ($r = .45$, $p < .05$ and $r = .59$, $p < .01$, respectively).

Conclusion: The pain management curriculum has boosted residents' confidence about their skills and knowledge on treating patients with chronic pain.

FIRST PLACE CASE REPORT

ROLO: WHOLE BLOOD TRANSFUSION OPTION FOR FORWARD DEPLOYED UNITS

Primary Author: Kaoru H. Song, MD, CPT

Introduction/Objective: Whole blood resuscitation can save a patient's life and limit the complications of severe blood loss. This case demonstrates the first-time use of Ranger O Low Titer (ROLO), a forward walking blood bank using predetermined donors, and how it can increase survivability from a massive non-compressible hemorrhage in a resource scarce environment such as in a combat zone at Point-Of-Injury (POI) care.

Case Presentation: 33-year-old active-duty male conducting combat operations sustained a right sided complex blast injury in an enclosed space. The blast injury pattern included significant bone and soft tissue damage, as well as damage to the major arteries and veins. POI care was initiated, and 4 units of cold stored whole blood were given. Despite initial resuscitative measures, the patient continued to clinically deteriorate. Unable to evacuate the area, the senior medic called for ROLO donors to the casualty collection point. After giving his 1 unit of fresh whole blood, the donor returned to the fight. A total of 2 units of ROLO whole blood were given to the patient before he was evacuated from the helicopter landing zone.

Discussion: In both military combat injuries and civilian trauma experiences, whole blood resuscitation has proven mortality benefits in several studies. The ROLO walking blood bank takes the next step in aiding resuscitation by providing fresh whole blood at POI.

Scholarly Questions: Should ROLO, a forward walking blood bank using predetermined donors, become standard operating procedure for trauma resuscitation?

Conclusion: Resuscitation with whole blood can mean life or death in the battlefield. ROLO provides smaller, more forward-deployed units with resupply without the administrative burden of storage. In conjunction with the Golden hour, ROLO can be incorporated as the standard Damage Control Resuscitation (DCR) to reduce the risks of non-compressible hemorrhage. By taking precautionary steps in the pre-deployment setting, ROLO offers an invaluable alternative to conventional resuscitation.

SECOND PLACE CASE REPORT

PUT IT IN THE WATER: ATORVASTATIN AS A PREVENTATIVE FOR OVARIAN CANCER RELATED MORTALITY

Primary Author: CPT W. Schaefer Leber, MD

Introduction/Objective: Ovarian cancer (OC) is the most lethal gynecologic cancer in the United States with a 5-year survival rate less than 50%. Early diagnosis plays an important prognostic role. However, routine screening in average-risk women fails to reduce mortality and increases harm. Recent literature supports the use of statins to reduce all cause and cancer-specific mortality in OC.

Case Presentation: A 76-year-old female physician presented with severe

continued on page 38

continued from page 37

abdominal pain after months of bloating, early satiety, and firmness in her left lower quadrant. Imaging revealed bilateral pelvic masses which were surgically resected. Pathology confirmed high-grade serous OC and carcinosarcoma on the right and left ovaries, respectively. One year after completing adjuvant chemotherapy, repeat CT imaging revealed an enlarged lymph node. She subsequently developed debilitating back pain, rectal pressure, and changes in stool caliber. Her symptoms coincided with increased tumor size and up-trending CA125 levels from 15U/mL to 69U/mL. After follow-up was delayed, the patient self-prescribed atorvastatin 20mg daily. Within 4 weeks, her CA125 level decreased to 15U/mL and her symptoms resolved.

Discussion: There are limited pharmacologic options for OC prevention, particularly for women at average risk. Invasive surgical management, with or without chemotherapy, remains the mainstay of management. Women with OC often face the reality of living with cancer instead of living after cancer. This patient elected to trial statin therapy to temporize her worsening chronic OC. The literature shows a 40% reduction in mortality for OC patients who start statin therapy. Moreover, in vitro studies suggest statins may delay or prevent OC through mechanisms related to induction of apoptosis in OC cells.

Scholarly Questions: Should women at average or high risk for OC and those diagnosed with OC be placed on a statin?

Conclusion: Statin therapy for prevention and/or management of OC is an exciting prospect for all who include women in their practice.

THIRD PLACE CASE REPORT

RASH RESPONSE? A RARE CASE OF STIMULANT INDUCED CUTANEOUS SMALL VESSEL VASCULITIS

Primary Author: Peter Studebaker, DO, Major

Introduction/Objective: Peripheral vasculopathy, including soft tissue breakdown, is a rare documented adverse effect to stimulant therapy. Presented is a novel case of cutaneous small vessel vasculitis (CSVV) with features of IgA vasculitis (IgAV; Henoch-Schoenlein purpura [HSP]) developed after starting Adderall.

Case Presentation: A 28 year-old male with Crohn's disease on Remicaide presented with palpable petechial purpura and severe arthralgia to all extremities. He started Adderall 20mg sixteen days prior. He also had an untreated throat culture from four days prior positive for non-group A beta hemolytic streptococcus species. Based on his rash, positive culture, and urinalysis showing hematuria and erythrocyte casts, he was admitted for presumptive IgAV. Adderall was held and symptoms improved with corticosteroids and amoxicillin. He restarted Adderall within days of discharge, and symptoms recurred within one day of medication resumption. Skin biopsy from initial presentation confirmed acute leukocytoclastic vasculitis, the hallmark of CSSV.

Discussion: Medical literature describes rare reports of stimulant induced peripheral vasculopathy, a general term for extremity blood vessel disorders. In patients with susceptible vasculature, stimulant therapy may cause vasoconstriction and ischemia through increases in noradrenaline and dopamine concentration. Effects described include vasospam (e.g Raynaud's phenomenon), acral cyanosis, and livedo reticularis. Case reports are lacking however specifically for stimulant caused CCSV/IgAV. Common causes of CSSV/IgAV would include recent upper respiratory tract infection (especially streptococcus), immunosuppressive therapy, such as Remicade, or recent immunizations. The recurrence of symptoms within one day of reintroducing Adderall in this patient despite continued use of corticosteroids and appropriate streptococcus treatment make other causes less likely.

Scholarly Questions: Is CSSV or its subset IgAV directly caused by stimulants?

Conclusion: Family physicians frequently prescribe stimulants to patients with attention deficit hyperactivity disorder. Although generally considered safe, stimulants should be recognized as having the potential to cause or worsen vascular symptoms in susceptible patients.

2021 Juried Poster Abstracts

FIRST PLACE POSTER DISPLAY / CLINICAL INVESTIGATIONS

TITLE: NO REST FOR THE WEARY: IMPROVING PAP THERAPY ADHERENCE THROUGH ONE-TIME BEHAVIORAL INTERVENTION

Primary Author: CPT Charles W. Mounts, DO

Introduction: Obstructive sleep apnea (OSA) is a treatable cause of daytime sleepiness and associated medical problems. Positive airway pressure (PAP) therapy adherence is generally sub-optimal. This project examined PAP therapy adherence in patients with OSA using a KSA (Knowledge, Skills, Attitudes) behavioral intervention.

Methods: The analytic sample comprised 174 active duty patients (93% men; mean age 40.83, SD 8.62, range 24-67) in 3 groups: KSA forum participants (N=76), those who chose not to attend (N=56), and those who attended a mandatory education class (N = 42; randomly selected cases from a patient cohort in 2018). The KSA forum was an interactive 90-minute session that addressed Knowledge about OSA and PAP, Skills to develop a habitual loop for nightly PAP use, and Attitudes about readiness, barriers, and solutions for sustaining PAP use. Frequency of PAP use was assessed for all groups at 30 days and 60 days from the class date. Adherence was defined using Medicare criteria (PAP use > 4 hours per night for at least 70% of nights during a 30-day period). Data were analyzed using descriptive statistics and chi-square test.

Results: Baseline scores on the apnea hypopnea index, insomnia severity, sleepiness, and age were non-significant between the 2019 Show and No Show groups. At the 30-day mark, 97% (n = 74/76) of patients in the Show group, 20% (N = 11/56) in the No Show group, and 100% (N = 42/42) in the mandatory education group were adherent (P < .001). At the 60-day mark, adherence rates for the Show, No Show, and mandatory education group were 68%, 36%, and 50%, respectively (P < .001).

Conclusion: Patients who participated in the KSA forum or mandatory education session were more likely to be adherent with PAP therapy when compared to patients who did not participate.

SECOND PLACE POSTER DISPLAY / CLINICAL INVESTIGATION

ATTITUDES TOWARD OBSTETRIC PRACTICE IN UNIFORM

Primary Author: CPT Jessica S Coulter, MD

Introduction: Obstetrics practice in family medicine has declined nationwide from 50% in the 1980s to 9.7% in 2012. Uniformed family medicine is unique in that it has higher training standards and more opportunities for practice than the community, however, surveys show increasing discomfort in deliveries after deployments. This survey assesses operational and non-operational family medicine physicians' preferences, comfort and support for obstetrics while examining the role of obstetrics in the identity of the uniformed family physician.

Methods: Design: Cross Sectional Survey Setting: Online survey emailed to 2559 eligible USAFP members Population: 285 respondents (11.1% response), 159 analyzed with 126 excluded for incompletion or unstudied population (residents or students). Main Outcome Measures: 10 questions plus demographics with discrete best answer and Likert scale. Statistical Tests Used: Descriptive and inferential statistics for comparison of groups.

Results: For practicing staff physicians with no differences in operational physicians or non-operational physicians except where noted: 79.2% positive experience delivering babies, 79.8% comfortable delivering babies, 49.6% deliver babies in their current role , 42.8% believe delivering babies is important to identity of a military family physician, 33.3% endorse command support delivering babies, 23.3% endorse support for additional training in delivering babies, significant difference between operational and non-operational, p <0.05 (0.048)

Conclusion: The majority of respondents surveyed shared a positive experience and comfort delivering babies, however less than half currently practice or agree that delivering babies is important to the identity of a military family physician. Finally, less than one third reported command support for practicing or furthering their training in delivering babies. Our data does not reveal causes for these beliefs, but shows an incongruity among identity, practice, and the ability to develop. Further clarifying the overlap and identifying areas for change for those who practice obstetrics and who feel unsupported may reduce moral distress and improve retention and satisfaction.

continued on page 40

continued from page 39

THIRD PLACE POSTER DISPLAY / CLINICAL INVESTIGATION

OPERATION BLOOD RAIN: THE EFFECT OF AIRDROP ON FRESH WHOLE BLOOD

Primary Author: Major Robert L. Tong, MD, FAAFP

Introduction: Administration of fresh whole blood (FWB) is a life-saving treatment that prolongs life until definitive surgical intervention can be performed; however, collecting FWB is a time consuming and resource-intensive process. Furthermore, it may be difficult to collect sufficient FWB to treat critically wounded patients or multiple hemorrhaging casualties. This study describes the effect of airdrop on FWB and explores the possibility of using airdrop to deliver FWB to combat medics treating casualties in the pre-hospital setting when FDA approved cold stored blood products are not readily available.

Methods: Four units of FWB were collected from volunteer donors and then loaded into a blood cooler which was dropped from a fixed-wing aircraft under a Standard Airdrop Training Bundle (SATB) parachute. A control group of 4 units of FWB was stored in a blood cooler which was not dropped. Baseline and post-intervention labs were measured in both airdropped and control units, including full blood counts, PT/PTT/INR, pH, lactate, potassium, indirect bilirubin, glucose, fibrinogen, lactate dehydrogenase, and peripheral blood smears.

Results: The blood cooler, cooling bags, and all 4 FWB units did not sustain any damage from the airdrop. There was no evidence of hemolysis. All air dropped blood met parameters for transfusion per the JTS Whole Blood Clinical Practice Guidelines

Conclusion: Airdrop of FWB in a blood cooler with a SATB parachute may be a viable way of delivering blood products to combat medics treating hemorrhaging patients in the pre-hospital setting, though further research is needed to fully validate the safety of this method.

FIRST PLACE POSTER DISPLAY / EDUCATIONAL RESEARCH

OPERATION BUSHMASTER: A THRESHOLD EXPERIENCE

Primary Author: LT Charisse Villareal, MD

Introduction: The threshold concept is an educational tool that works on the spatial metaphor of walking through a portal. This concept can be used to characterize the process of professional identity formation. In our qualitative study, we evaluated students' reflective practice essays through the lens of threshold concepts to further characterize the process of professional identity formation. For USU students, Operation Bushmaster represents one of the first times that they concurrently inhabit the dual roles of military officer and (soon-to-be) physician.

Methods: In this qualitative study, we analyzed a data set of 49 de-identified reflective practice essays written by fourth year medical students following the completion of Operation Bushmaster to elucidate what students gained from the experience. Additionally, we evaluated students' responses through the lens of the threshold concept to determine whether ontological shifts occurred during students' Bushmaster experiences.

Results: The theme of "the military physician," met our criteria for a threshold concept, in that it was transformative, integrative, and troublesome. Prior to Operation Bushmaster, many of the students saw themselves simply as medical students rather than as almost doctors. Following the exercise, some identified more strongly with the role of military physician, while others continued to overestimate the amount of time remaining to complete the transformation from student to doctor, or to integrate the roles of physician and military officer.

Conclusion: Operation Bushmaster is a threshold experience whereby many students attain their new identity as a military physician. This work serves to further elucidate the liminal space in which medical students reside on their journey to physician, as well as the moment of realization by many that becoming a military physician encompasses more than simply the sum of the roles of physician and military officer.

FIRST PLACE POSTER DISPLAY / CASE REPORT STAFF CATEGORY

CIDP: A RARE RISK OF IMMUNIZATIONS IN AN ACTIVE-DUTY TRAINEE

Primary Author: CPT(P) Daniel Jason Frasca, DO

Introduction/Objective: Chronic inflammatory demyelinating polyneuritis (CIPD) is an acquired, immune-mediated sensorimotor peripheral neuropathy, which may lead to chronic neurological deficits. The case presented is an Active Duty trainee who developed this rare disorder.

Case Presentation: 20 year old male Active Duty trainee presents with two months of numbness and tingling of extremities with progressive weakness, and physical training limitations. Past medical history only significant for multiple immunizations given one month prior. Initial evaluation showed mild elevations in muscle enzymes and inflammatory markers. Other labs, MRI of brain were negative, and EMG/NCS were unremarkable. Symptoms progressed until patient could not walk unassisted with significant sensation changes. Three months after onset, a repeat EMG/NCS noted diffuse demyelination consistent with CIPD. Patient was admitted for IVIG therapy, discharged on a steroid taper. Intensive physical therapy showed

improvement, and regained his ability to perform his duties. He graduated and ultimately PCSed to Japan.

Discussion: CIPD is typically progresses slowly and responds well to early therapy. Options include IVIG, plasmapheresis or steroids. Relapses are common, especially in the first year, and can lead to chronic deficits. Immunizations are noted as possible triggers, hypothesized secondary to molecular mimicry from auto-antibodies attacking the peripheral nervous system. Limited literature suggests immunizations have a risk to induce a relapse.

Scholarly Questions: Can Active Duty Service members with history of CIPD receive future immunizations?

Conclusion: Immunizations have been reported as probable inciting incidents and causes of relapses. This risk should be part of the medical decision-making process when deciding to immunize a soldier and when reviewing medical readiness. Further studies are warranted to better elicit this possible correlation and causation.

FIRST PLACE POSTER DISPLAY / CASE REPORT RESIDENT CATEGORY

A CASE OF PENILE/SCROTAL SHINGLES: BROADENING YOUR DIFFERENTIAL FOR COMMON THINGS IN UNCOMMON PLACES

Primary Author: Capt Jared Wesley Baird, DO

Introduction/Objective: Shingles is commonly considered in older adults and occurs primarily in the thoracic or facial dermatomes1. Presented is a case of S2-3 dermatome varicella zoster in a young, healthy male.

Case Presentation: A 26-year-old male presented with a complaint of rash on his scrotum and penis. Symptoms began 1 week prior to presentation and included pain and itching on his scrotum, with a cluster of clear fluid vesicles over a 4-5cm2 area involving the left side of his scrotum. This was followed by a new 1cm area on the left underside of his penis the day before presentation. He denied bleeding, discharge, crusting, or recent sexual contact. Patient's PCR herpes swab was positive for varicella zoster, with negative testing for HSV and other sexually transmitted infections. Results finalized 1 week after presentation, outside the therapeutic window for antivirals. The pain and rash persisted for another week.

Discussion: Cases of sacral nerve root shingles are rare, about 4-8%1 of total shingles cases, and usually occur in immunocompromised or elderly patients. Shingles in this distribution is often associated with urinary complications and constipation2. While this patient's case was uncomplicated, he may have benefited from empiric treatment. While the Tzank smear is an inexpensive and fast test to diagnose herpes virus infections3, in this case it would not have readily distinguished between HSV and HZV.

Scholarly Questions: How effective is antiviral treatment in preventing complications of sacral shingles?

Conclusion: With greater consideration for a herpes zoster diagnosis, this patient's clinical course could have been shortened and the potential for complications averted. In patients with unilateral rash, clinicians should forego Tzanck testing in favor of PCR and consider empiric treatment while awaiting testing results.

SECOND PLACE POSTER DISPLAY / CASE REPORT RESIDENT CATEGORY

CONGRATS! IT'S A…FOOT PAIN? SACRAL PLEXOPATHY AFTER SPONTANEOUS VAGINAL DELIVERY

Primary Author: Ryan M. Coffey, MD, CPT

Introduction/Objective: The lumbosacral nerve roots that innervate the pelvis and lower extremities are vulnerable to injury during childbirth because of their location at the pelvic outlet. Injuries of these nerve roots during childbirth are rare, affecting less than 1/20,000 women. This case demonstrates a rare case of lumbosacral plexopathy following a vaginal delivery.

Case Presentation: A 23-year-old primigravida with prenatal course complicated by BMI of 40 and fetal macrosomia presented for elective induction of labor at 39 weeks gestation. During the second stage of labor, she remained in the high fowler›s position to relieve recurrent variable decelerations. She developed persistent decreased sensation to her left lower leg and foot after the epidural was discontinued. She subsequently developed pain in the L4-S1 distribution. Electromyography demonstrated a mild left sacral plexopathy with absent signal in the left medial plantar sensory nerve and diminished signal in the left sural sensory nerve. Her symptoms responded to low-dose pregabalin and improved over time.

Discussion: Many factors increase the risk of developing postpartum lumbosacral nerve injuries. Non-anesthetic factors are more commonly implicated in these injuries and include obesity, nulliparity, macrosomia, unnatural maternal positioning, prolonged second stage of labor and instrumented vaginal delivery. Anesthetic causes of postpartum lumbosacral plexopathy are rare, occurring in only 4% of anesthetized women. Most patients can expect a full recovery within six months with minimal intervention including physical therapy and pain management.

Scholarly Questions: Is there certain number of risk factors in combination with regional obstetric anesthesia that significantly increase the risk of developing lumbosacral plexopathy?

Conclusion: The patient presented had multiple risk factors for sacral plexopathy. Regional anesthesia may potentiate these risk factors as patients may be less responsive to pain or discomfort when placed in unnatural labor positions. Providers should be aware of these risks and attempt to minimize them during labor.

continued on page 42

continued from page 41

THIRD PLACE POSTER DISPLAY / CASE REPORT RESIDENT CATEGORY

HIDING BEHIND A NORMAL X-RAY: HPV POSITIVE ANAL CANCER DISGUISED AS HIP PAIN

Primary Author: Anna Milliren, Capt, DO

Introduction/Objective: Hip pain is a common presenting complaint in the primary care clinic. We present a patient with months of posterior hip pain, ultimately diagnosed as squamous carcinoma of the pelvis.

Case Presentation: 57-year-old male presented to clinic in January 2020 with 4 months of left hip and gluteal pain from suspected piriformis syndrome. Initial management included physical therapy and pain management. In May, he phoned complaining of persistent pain. An X-ray was unremarkable. In August, we discovered a new exam finding of positive log roll test, prompting advanced imaging. MRI and CT scan showed an 18cm complex cystic and solid mass within the left pelvis and incidental DVT in the left femoral vein. Lesion biopsy and aspirate cytology showed carcinoma with squamous differentiation. PET-CT found no evidence of metastatic disease.

Discussion: Chronic hip pain is commonly seen in primary care. Our patient represents a rarely described example of squamous carcinoma of unknown primary in the pelvis. In this case, avascular necrosis was considered given the new finding of a positive leg roll test, but the resultant MRI identified a malignant mass as the etiology of symptoms. Existing guidelines from the American College of Radiology state chronic hip pain with non-diagnostic X-ray should be followed with MRI if needed. Based on current evidence, there is no clear timeline for when providers should consider advanced imaging in this patient population. Additionally, there are no published guidelines to outline in which scenarios this is most helpful.

Scholarly Questions: Are there exam findings that should be considered high risk and always prompt advanced imagining?

Conclusion: Family physicians encounter posterior hip pain frequently in practice. Advanced imaging should be considered in patients who have persistent pain despite standard treatment.

THIRD PLACE POSTER DISPLAY / CASE REPORT RESIDENT CATEGORY

"AFTER CHEWING ON THAT, I HAD A CHANGE OF HEART"

Primary Author: LT Cody S Holmes, DO

Introduction/Objective: Atrial fibrillation (AF) is a common arrhythmia affecting more than 30 million people worldwide and increases the risk for death, heart failure, and other comorbidities. Presented is a case of AF highlighting a rare precipitating cause of a common arrhythmia.

Case Presentation: A 65-year-old male with history of hypertension presented with chest pain after being discharged from a hospitalization 1 week prior with a new diagnosis of AF. He re-presented in AF with rapid ventricular response (RVR). He had an indeterminate rise in troponins and was admitted for continued monitoring and treatment. He was observed to have predictable episodes of AF with RVR during mealtimes with chewing and swallowing. These symptomatic bouts could be self- managed with slower eating. Cardiology recommended starting diltiazem and discharge with close follow-up. He had a normal echocardiogram and no additional exacerbations of his AF after initiating diltiazem and lifestyle adjustments.

Discussion: This case of AF is suspected to have a component of induction by swallowing. AF is most commonly caused by abnormalities or damage to the heart's structure, but as in this case can have rare precipitants. This trigger of AF has only been described in a few other rare case reports. While management of AF in primary care is often focused on either rate or rhythm control, in some instances, treatment can go beyond pharmacologic methods. A lifestyle modification of slower eating decreased this patient's frequency of AF exacerbations and symptoms.

Scholarly Questions: With deglutition-induced atrial fibrillation, would other lifestyle modifications and referrals to speech or occupational therapy reduce symptomatic episodes when compared to pharmacologic intervention alone?

Conclusion: Atrial Fibrillation is a common arrhythmia that can often have rare precipitating factors. Our case demonstrates one of these unusual cases which may lead to other treatments beyond typical pharmaceutical therapies.

committee report
CONSTITUTION, BYLAWS, AND STRATEGIC CHARTER

Adriane E. Bell MD, FAAFP
Fort Bragg, NC
adriane.e.bell@gmail.com

USAFP UPDATE:

The Constitution, Bylaws, and Strategic Charter Committee welcomed the new Chair, Dr. Adriane Bell and new Board Liaison, Dr. Khalid Jaboori. Over the course of the next year, the committee plans to review the chapter Bylaws for consistency with Board policy and compliance with the AAFP Bylaws. In addition, we plan to work with our Chapter President, Board Liaisons, and Committee Chairs over the next year to create the strategic planning report for 2022.

Erica Meisenheimer, MD, FAAFP
Madigan Army Medical Center
erica.sturtevant@gmail.com

Tyler Raymond, DO, MPH, FAAFP
JBLM, WA
drtylerraymond@gmail.com

Tyler Rogers, MD, FAAFP
Madigan Army Medical Center
trogers09@gmail.com

Better Together Through Education!

Hello USAFP members! We would like to start by introducing the new team of co-chairs to lead the Education Committee. MAJ Erica Meisenheimer is a current fellow with the Leader and Faculty Development Fellowship and will be transitioning to faculty at Fort Belvoir Community Hospital this summer. Dr. Tyler Raymond is a core civilian faculty member at Madigan Army Medical Center, and MAJ Tyler Rogers is also a fellow who will be transitioning to faculty at Martin Army Community Hospital. Lastly, LTC Drew Baird will be the incoming board liaison to the committee. Please reach out to us if you have ideas or requests for the committee!

We would like to extend our gratitude to the former committee chair, LTC Garrett Meyers and board liaison COL Joshua Will for their dedicated time and effort leading this committee over the past few years.

As we work as an academy this year to grow "better together," the Education Committee has identified three lines of effort on which we hope to focus: (1) providing synchronous educational opportunities, (2) improving awareness of and access to asynchronous educational resources, and (3) supporting the USAFP Annual Meeting. Below, we have outlined some of our ideas and initiatives for each of these lines, but we also want to hear from you. Please take 2-3 minutes to fill out a learning needs assessment (LNA) to give us more information to better serve you! You may use the link here (https://www.surveymonkey.com/r/N3H7MHT) or the QR code below to access the form.

SYNCHRONOUS EDUCATIONAL OPPORTUNITIES

The Education Committee is excited to officially sponsor the new USAFP Better Together Journal Club, which is open to all academy members. The journal club will be led by MAJ Roselyn Fuentes, 96 MDG Director of Clinical Research at Eglin AFB. Anyone interested in participating may sign up at https://www.surveymonkey.com/r/USJournalClub or by using QR Code below.

Additionally, the committee is looking into other live education opportunities that can be offered outside of the Annual Meeting. Our goal is to leverage the virtual learning environment by offering opportunities for education and camaraderie aside from the Annual Meeting.

QR code for the Education Committee's Learning Needs Assessment:

QR code to sign-up for the Better Together Journal Club:

ASYNCHRONOUS CLINICAL AND EDUCATIONAL RESOURCES

The committee would also like to broaden its current repository of asynchronous clinical and faculty development resources. We hope to provide new ways for our academy members to utilize available resources and to continue to develop professionally. We have some great opportunities to provide these resources, so please fill out the LNA, and let us know what would be the greatest benefit to you!

SUPPORT FOR USAFP

We are grateful to LCDR Kevin Bernstein and LCDR Jules Seales for their hard work planning a successful virtual Annual Meeting. The Education Committee is looking forward to partnering with past, current, and future Annual Meeting co-chairs to assist with the educational offerings at future meetings. Our aim is to foster continuity between the meetings and to better support the Annual Meeting co-chairs in their planning and execution efforts.

Our goal is that through these lines of effort we can foster education and collaboration for all USAFP members, whether you are in an operational, clinical, academic, or administrative assignment. We also know that USAFP is a foundation that brings together educational leaders from our medical schools, residencies, and fellowships; and with the arrival of new virtual learning environments, we hope to better align educational efforts in the post-pandemic era. Let's become better together through education!

Janelle Marra, DO, FAAFP, CAQSM
Camp Pendleton, CA
jmarra08@gmail.com

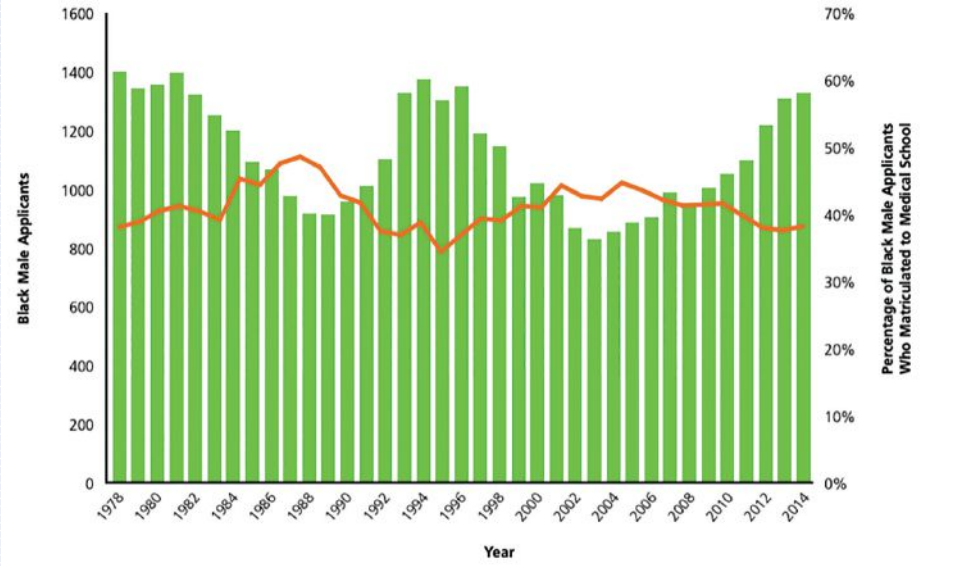
Black Men in White Coats

Black Men in White Coats is a documentary, released in February 2021, discussing the lack of black male physicians, in the United States. The documentary examines the experiences of a group of underrepresented physicians, and examines some of the factors that lead to the "leaky pipieline" of black men seeking to become physicians. The producer of the documentary, Dr. Dale Okorodudu, M.D. , an internal medicine and pulmonary and critical care specialist, first began DiverseMedicine in 2011, to use community programs and social networking to expose underrepresented students to the field of medicine, and provide them with mentorship. He established Black Men in White Coats in 2013, in a response to the Association of American Medical Colleges (AAMC) report highlighting black male applications were lower in 2013 than in 1978. In February 2019, he started the Black Men in White Coats Youth Summit in Dallas, Texas. The first summit hosted more than 1,500 students of varying ages. Since then, the summit has continued annually, while expanding to multiple sites.

The documentary, Black Men in White Coats, has reached a wide audience through the IndieScreening website, (https://indiescreening.com/) since release in February. Screenings often include a virtual panel discussion with black male physicians. Uniformed Services medicine played a key role in the documentary, with the Navy and Army as corporate sponsors for the documentary, and the former Surgeon General, Vice Admiral Jerome Adams, as one of the key guest speakers.

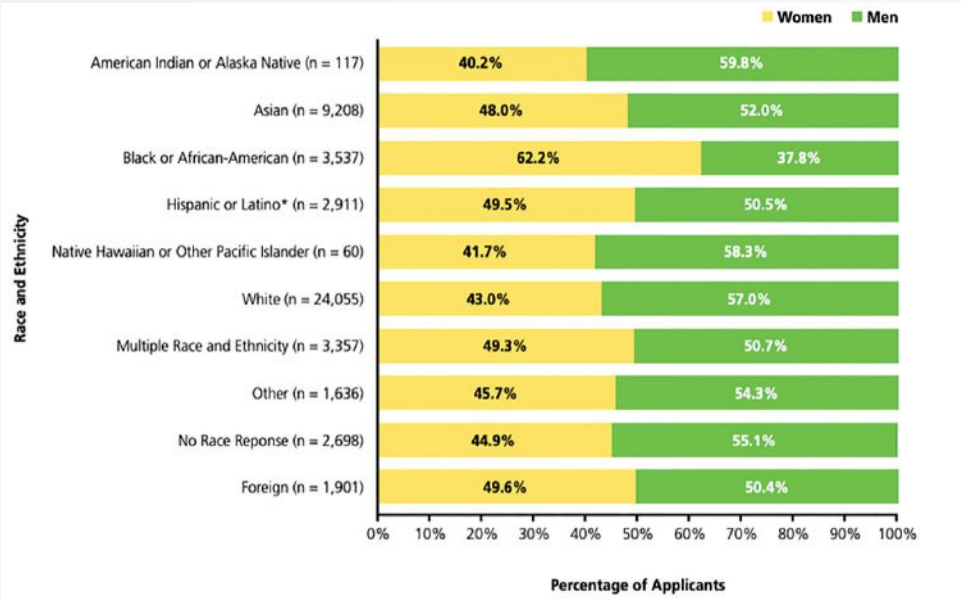
Prior to USAFP's annual conference, the Navy offered a multiday virtual screening, and a virtual panel discussion with black

Figure 1. Number of black or African-American male medical school applicants (bars) versus percentage of black or African-American applicants who matriculated (line), 1978–2014.



Source: AAMC Data Warehouse: Applicant and Matriculant File, as of 5/11/2015.

Figure 3. Percentage of U.S. medical school applicants by gender and race and ethnicity, 2014.



Note: Six students did not report their gender, so they were excluded here.
Source: AAMC Data Warehouse: Applicant and Matriculant File, as of 3/26/2015.

Navy physicians from medical students up to seasoned staff physicians.

The USAFP Member Constituency committee was able to offer a screening of Black Men in White Coats during the recent USAFP conference, and allow commentary on the discussion board.

Some shocking statistics shared regarding black physicians :

- 4.4% of all US medical residents are black 2.9% female and 1.5% male
- Only 2% of America's physicians are black men
- In 1978, there were 1,410 black male applicants to medical school, compared to only 1,337 in 2014.
- 18% of black high school sophomores in 2002 aspired to become physicians.
- Black men represent 2% of full-time faculty at M.D. granting institutions.
- The life expectancy of black men is 4.5 years lower than that of non-Hispanic white men

If you have an interest in continuing the discussion of how to foster diversity in medicine, please consider watching the documentary, and using the resources below.

Black Men in White Coats Website
https://www.blackmeninwhitecoats.org/

DiverseMedicine Website
http://diversemedicine.org/

Podcast : Black Men in White Coats (2018- current) https://podcasts.apple.com/us/podcast/black-men-in-white-coats/id1434968172

Podcast: Black Men in Medicine, Meeting the Challenge https://www.aamc.org/news-insights/podcast-black-men-medicine-meeting-challenge

Facebook page:
https://www.facebook.com/BlackMenInWhiteCoats/

AAMC Altering the Course:
Black Males in Medicine (2015) https://store.aamc.org/downloadable/download/sample/sample_id/84/

Addressing and Eliminating Racism at the AAMC and Beyond:
https://www.aamc.org/addressing-and-eliminating-racism-aamc-and-beyond

An American Crisis:
The Growing Absence of Black Men in Medicine and Science https://www.nap.edu/read/25130/chapter/1

Tour For Diversity in Medicine
http://tour4diversity.org/

Mentoring in Medicine
http://medicalmentor.org/

Does Doctor Race Affect the Health of Black Men?
https://www.nber.org/bah/2018no4/does-doctor-race-affect-health-black-men

Young Doctors DC
https://www.youngdoctorsdc.org/

The greatest injustice of all is the Inequality of health
– Martin Luther King Jr.

You can't be what you can't see
– Dr. Dale Okorodudu

As a Black man, who is also a physician and Surgeon General, I've been thought of as the help, a janitor, anyone but the doctor
– Vice Admiral Jerome Adams MD

Your zip code is more important than your genetic code in terms of your health.
– Vice Admiral Jerome Adams MD

A Special Thank You to the 2021 USAFP Annual Meeting Exhibiting Organizations

The following organizations exhibited their products and services during the USAFP 2021 Annual Meeting. The Academy is fortunate to have such great support from these organizations.

3RNet
Allergan, an AbbVie Company
American Board of Family Medicine
Bayer Healthcare
Brymill Cryogenic Systems
Centura Health
Coast Guard Healthcare
GSK
Gundersen Health System
HSHS Medical Group
Kaiser Permanente
Mayo Clinic
Mission Resiliency at Laurel Ridge
Optum
Patient First
Penn State Health
Sutter Health - Bay Area
ThermoFisher Scientific
United States Medical Center for Federal Prisoners
US WorldMeds / HEMA Biologics
VALNEVA
Veterans Health Administration

A Special Thank You to the 2021 Annual Meeting Sponsors

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

SILVER SPONSOR
Patient First
US WorldMeds / HEMA Biologics

BRONZE SPONSOR
3RNet
Bayer Healthcare
Coast Guard Healthcare
ThermoFisher Scientific
United States Medical Center for Federal Prisoners
VALNEVA

Erin M Connor MD
7SFG TMC Eglin AFB
econn2007@gmail.com

Heather M. O'Mara DO
Tripler Family Medicine Residency
hschlesinger@gmail.com

2021 CMS Coding Guidance - A Win for Primary Care

COVID, COVID, COVID, extremism stand down, COVID, ponytails, and earrings, MHS Genesis, COVID, coding changes, COVID, COVID. Wait, coding changes? Hopefully this isn't the first time you are hearing about the 2021 Center for Medicare & Medicaid Services (CMS) coding changes that went into effect January 1, 2021. These changes are a big win for primary care, as outlined below, and will likely change your documentation patterns and possibly practice workflow.

BACKGROUND

For a quick background reference point, let's review coding 101 prior to 2021. International Classification of Diseases (ICD) -10 includes over 200,000 codes published by the World Health Organization to identify diagnoses and describe medical conditions. The American Medical Association (AMA) publishes the Current Procedural Terminology (CPT) book with over 7,800 procedural codes. Evaluation and Management (E/M) CPT codes are reported to request reimbursement for billing in the outpatient setting. Using the 1995 or 1997 CMS Documentation Guidelines, common outpatient E/M CPT codes such as 99201-99215 were generated by a combination of items such as: circumstances of the visit (new or established patient), elements obtained in the history and physical, diagnoses (ICD-10 codes), complexity as evidenced by prescriptions or laboratory/radiologic studies ordered, and time spent during the visit to include counseling time.[1,2] As an example, to code and be reimbursed for an encounter as a 99213 in 2020, the visit would be with an established patient and require at least two of three of the following: an expanded problem focused history, an expanded problem focused physical examination, or medical decision making of low complexity. To justify the problem focused vs expanded problem focused vs detailed vs comprehensive visit there was a complex widget counting of history and physical exam elements in addition to medical decision making[2,,3] To paint this picture to coders and succeed in reimbursement, a large documentation burden fell on physicians. Often medically unnecessary elements were included in frustrated attempts to tally enough points to get paid for work being done.

In 2019 the Medicare Physician Fee Schedule (MPFS) introduced new rules representing some of the most significant changes to coding in over 20 years. The reported goals were to reduce administrative burden, improve payment accuracy, and update the code set to reflect current day medical practice. No longer was there going to be a complicated bingo card to determine the reimbursement for your efforts. Rather, outpatient coding would be based on time OR medical decision making! (For those of you who are wondering what happened to blended rates, where the same reimbursement was going to be applied to 99202-99204 and 99212-99214 that was also part of the 2019 MPFS but was abandoned before implementation.)[2]

NEW RULES

The 2021 rules allow for either time based coding or coding based on medical decision making. Time based coding includes both face to face and non-face to face activities performed by a qualified health care professional on the day of the encounter. Qualified health care professionals are defined as licensed professionals who are practicing independently. The AMA includes a helpful list of definitions where there are any terminology questions.[3] What are some examples of activities that count towards time based coding? Preparation before seeing the patient (reviewing prior encounters, lab results, radiologic studies), obtaining and reviewing separately obtained history, time spent with the patient, ordering medications, labs, radiology studies, referring and communicating with other health care professionals, documenting in the electronic medical record, counseling of the patient and/or family members, and care coordination. Remember, to code based on time the above activities have to be done on the day of the encounter by the qualified medical provider. Time spent by clinical staff doing routine duties does not count.[2,3,5]

Coding based on level of medical decision making (MDM) is a little more

2021 Time Intervals for CPT Codes 99202-99215			
New Patient	Time	Established Patient	Time
		99211	N/A
99202	15-29 min.	99212	10-19 min.
99203	30-44 min.	99213	20-29 min.
99204	45-59 min.	99214	30-49 min.
99205	60-74 min.	99215	40-54 min.

Table 1: Time Based Coding Requirements[2,4]

Level of MDM (Based on 2 of 3 Elements)					
New	Est	Final MDM	Number of Problems	Amount of Data	Risk of Complications
99202	99212	Straightforward	Minimal	Minimal	Minimal
99203	99213	Low	Low	Limited	Low
99204	99214	Moderate	Moderate	Moderate	Moderate
99205	99215	HIgh	High	Extensive	High

Table 2: Coding based on MDM[6]

Code	2020 RVU	2021 RVU	Percent Increase	Code	2020 RVU	2021 RVU	Percent Increase
99202	0.93	0.93	-	99212	0.48	0.7	46%
99203	1.42	1.6	13%	99213	0.97	1.3	34%
99204	2.43	2.6	7%	99214	1.5	1.92	28%
99205	3.17	3.5	10%	99215	2.11	2.8	33%

Table 3: 2021 RVU Changes

nuanced. There are three components to MDM in the 2021 guidelines. The number of problems and complexity the provider addresses during the encounter. The amount and/or complexity of data to be reviewed and analyzed. Types of data includes: tests, documents, orders, discussion with external sources. The third category is the risk of complication from the decision at the encounter. The MDM categories are categorized as straightforward, low, moderate, and high.[3,4,5] The AMA MDM chart approved by CMS outlines the different requirements to code based on MDM and can be accessed at: https://www.ama-assn.org/system/files/2019-06/cpt-revised-mdm-grid.pdf.[5]. A summarized version can be seen in Table 2. Two of three elements (problem, data, risk) must be met or exceeded to determine the overall level of service. For example, if an established patient visit is "low" on number of problems, "moderate" for amount of data, and "low" on risk of complications the final level based on MDM is "low" and would be coded as a 99213.[6]

You may choose which type of coding you are going to use for a given encounter based on which one results in a higher E/M. If using time based coding, it is recommended you document in the encounter the total time spent and what it was spent on (ie: reviewing recent consult with cardiology, face to face with patient, entering orders, and discussing with case management). For every encounter you should include a medically relevant and appropriate history and physical to support your diagnoses and medical decision making. In addition, you must still include all elements mandated by your organization to support requirements such as The Joint Commission.

The AMA has adjusted the Relative Value Unit (RVU) assigned to the outpatient CPT codes 99202-99215 with higher values assigned starting in 2021. Higher RVUs and less needless documentation - sign me up! Unfortunately, there are concerns that these adjustments might be too good to be true, and RVU reimbursement may be reduced by CMS and/or MGMA requirements may increase (can't have too much of a good thing, after all).[6]

POTENTIAL WORKFLOW CHANGES

Other than avoiding checking AHLTA boxes like "normal external ear" how might this change what I do? All of that time spent doing "pre-scrubbing" and getting a jump start on documentation? You might still want to keep this part. This work identifies issues before the visit that may lead to rescheduling patients, gathering additional information that may be difficult the day of the encounter, and help your clinic run more smoothly (those spinning AHLTA wheels in the exam room are a bummer). While you can't count this work in your time based coding, it is probably still a worthwhile investment. Should you keep track of face to face time and non-face to face time over the course of the day? This one likely doesn't require much investment on your part and might be worth it if you are consistently underestimating how much time you spend dropping by the clinical pharmacist to run something by them, digging through old records, or finishing documentation. Calling that patient back at the end of the day when the labs are back, versus waiting until tomorrow? Also probably worth it as you can wrap

continued on page 48

continued from page 47

it into the time you spent for that day and potentially bump into the next higher E/M code. Alternatively, a t-con the next day would be no workload credit as it would be follow-up from a visit in the prior seven days. Looking for the check boxes in AHLTA for Review Of Systems elements or physical exam elements not needed for your medical decision making? Stop doing this one!

Time will tell what will happen with RVU reimbursement and MGMA requirements. However, the 2021 CMS coding changes represent a step in the right direction towards easing administrative burdens.

Do you have any great workflow pearls or coding considerations for MHS Genesis? Share your gems on the USAFP Practice Management Forum Facebook page!

REFERENCES:

1. Emelda M. "Difference Between CPT and ICD Codes." DifferenceBetween.net. April 13, 2011. Accessed April 6, 2021 at http://www.differencebetween.net/science/health/difference-between-cpt-and-icd-codes/.

2. "99202-99215: Office/Outpatient E/M Coding in 2021". Accessed April 6, 2021 at https://www.aapc.com/evaluation-management/em-codes-changes-2021.aspx.

3. CPT evaluation and management (E/M) office or other outpatient (99202-99215) and prolonged services (99354, 99355, 99356, 99XXX) code and guideline changes. American Medical Association. 2019. Accessed April 7, 2021 https://www.ama-assn.org/system/files/2019-06/cpt-office-prolonged-svs-code-changes.pdf.

4. Milette, K. Countdown to the E/M Coding Changes. *Fam Pract Manag.* 2020 Sep-Oct;27(5):29-36.

5. "Coding for Evaluation and Management Services". Accessed April 7, 2021 at https://www.aafp.org/family-physician/practice-and-career/getting-paid/coding/evaluation-management.html.

6. New and Established Office Visits Evaluation and Management 2021 presented by the Tripler Army Medical Center Coding Department February 2021.

committee report
RESIDENT AND STUDENT AFFAIRS

James Honeycutt, MD, FAAFP
Nellis AFB, Nevada
davehoneycutt@hotmail.com

Welcome back to all who attended the 2021 Annual Meeting and Exposition in the virtual space! This conference was a unique opportunity for students, residents, and family physicians to learn together how best to serve our Joint Force! We would like to thank all who were involved with the planning, preparation, and execution of the annual meeting and extend a special thank you to our outgoing Resident Directors, Chris Cruz (USN), Ryan Coffey (USA), and Alexis Aust (USAF), for a truly outstanding year of service on the board! Also, congratulations to our new Resident Directors Ashley Yano (USA), Eileen Tatum (USN), and Raquelle "Rocky" Newman (USAF)!

In this issue, we are pleased to report the following updates on our committee's efforts to further the strategic aims of the Uniformed Services Academy of Family Physicians.

MEMBERSHIP

The committee was able to engage with some of our full-time out of service (FTOS) residents and invite them to attend the annual meeting. It was a great experience connecting to these residents and gaining a better understanding of the challenges they face while training outside of the Military Health System. Our goal for this year is to continue to expand this outreach in order to increase their involvement in the USAFP, increase their attendance at and contributions to the annual conference, and share information on military specific curriculum with them to best prepare them for active-duty service after graduation.

With regards to student membership, we did see a significant decline from 461 to 248 student members. The greater drop in membership was from HPSP members. We would encourage all of our student members to reach out to HPSP students at their schools who may be interested in family medicine and invite them to consider joining the USAFP as either a full or adjunct member. Our resident membership did increase to 446 members, and we were excited to have over 150 of you in attendance at this year's conference!

Finally, we hope to encourage membership through our presence at the AAFP Resident and Student Virtual Conference in July. In 2018 and 2019 we were able to resume hosting a student interest dinner at the AAFP Resident and Student Conference. The resident

directors reported attendance of 18-20 members each year (triple the attendance from the last held dinner in 2015). Our new resident directors will be refocusing outreach efforts given that the conference will be held virtually this year, but we hope to be able to reinstate the student interest dinners again at the 2022 AAFP Resident and Student Conference.

OPERATIONAL

This year's annual conference did an exceptional job of teaching leadership and readiness in military medicine. As a committee, we strive to continue to provide students and residents the chance to learn about operational medicine experiences. The operational medicine committee held a forum with several family physicians from disparate operational areas within the uniformed services that provided an engaging and incredibly informative learning environment for those students and residents interested in operational medicine opportunities. As a committee, we will continue our repository of operational rotations for current medical students and residents by reaching out to members of the USAFP who are currently working in operational settings. Please reach out to us if you have an interest in these rotations.

EDUCATIONAL

At this year's annual conference, we had 30 students and 151 residents in attendance. That is more students than we have had attend for several years. While a virtual conference presents new challenges, it also provided a unique opportunity for students and residents to attend without having to overcome the logistical obstacles of funding, travel, and time away from rotations. We hope in the future to find ways to include some options for remote participation for residents and students given the great responses from this year's conference.

We will be rolling out the invitation next year again to allow USAFP members to sponsor a medical student to attend the conference should they feel so inclined. Again, it is a great way to provide students the opportunity to learn, network, and explore the amazing scope of family medicine! For our residents and faculty, please encourage medical students rotating at your programs to apply for a scholarship to attend the 2022 meeting. Students, keep an eye out for information on the scholarship. We would love to have you next year!

Finally, congratulations to team Navy for taking home the win this year at the Doc, You Don't Know Jack quiz bowl! I'll admit that I was worried about how the event would unfold given the technical challenges and not having the audience "in the room where it happened." But Dr. Campbell did an amazing job with the technology, and all of you who attended kept the chat line full of cheers, jeers, and more energy than a power converter from Tosche Station.

SCHOLARSHIP

The quality of the research and presentations this year was outstanding. We actually had submissions from all 15 programs! Again, the Army, Navy, and Air Force resident directors will be working with their services' chief residents to push out timelines and dates for submitting scholarly activity so that we can continue to have increased involvement. Stay alert for potential case reports, possible quality improvement projects within your institution, or faculty who are engaged in and passionate about scholarly work and can serve as a mentor to help get you started!

LEADERSHIP

While we were unable to hold the full-day annual Leadership Seminar at the USAFP Annual Meeting, we did conduct one workshop and one roundtable event during the conference. Both were well attended and well received by the participants. Attendees will have 1.5hr credits added to their transcript which the committee will continue to maintain. When residents or students complete 6 credit hours, they will be awarded by the academy a Certification in Resident and Student Leadership. This certification should help identify those students and residents who have additional training that would prepare them to assume roles of leadership in their institutions. We hope to see even more residents and students next year at our highly productive and engaging seminar!

ADVOCACY

The Uniformed Services University of the Health Sciences' (USUHS) Family Medicine Interest Group (FMIG) is increasing advocacy through involvement in community service, attendance at conferences, and enrollment in the USAFP. For the third consecutive year, the USAFP Executive Committee has appointed two student representatives to the USAFP Board of Directors to continue advocacy efforts. Applications were received and evaluated by the USU Family Medicine Department for USU applicants, and by our committee for the HPSP applicants. We are excited to begin working with Abigail Hawkins as the USUHS Student Board member and Varun Gopinath as the HPSP Student Board member. We'd also like to thank last year's student representatives, Austin Frye and Anna Priddy, for their selfless service on the Board of Directors.

We are looking forward to a great year! It's never too early to start thinking about the 2022 USAFP Annual Meeting. Please keep an eye out for the "Call for Speakers" and the deadline for research abstract submissions!

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

John J. O'Brien, MD, FAAFP
University Place, WA
scubadoc99@mac.com

Limitless

BY JIM KWIK

When Aladdin finds the magic lamp with a genie inside, he is offered 3 wishes, for anything in the world. His story is entertaining due to his total mismanagement of this amazing opportunity. But if he had been only given one wish, what should he have asked for? Of course, an unlimited supply of wishes!

In a similar vein, if YOU were offered the chance to learn only one thing which could substantially change your future, what one learning endeavor should you invest your precious/limited time in? How to manage your finances? How to speak Chinese? How to Meditate? While all are excellent choices, the correct answer is to Learn how to LEARN, which surprisingly few of us have actually been taught how to do.

Celebrity Brain Coach Jim Kwik has motivated and educated thousands of people to shed their own learning limitations by showing them the incredible superpowers residing within their own brains. He suffered a significant head injury at a young age; he was told that he had a "broken brain" and would never amount to much. However, through his struggles to learn, he discovered an amazing model for helping anyone to truly become limitless in their ability to learn new things efficiently and with superb retention.

Why are so many of us "limited" in the first place? Kwik describes the 4 D's which we may have all experienced:

- **Digital Deluge**: we now consume as much data in a single day as an average person in the 1400s would have absorbed in an entire lifetime; but this "data"/information is not knowledge
- **Digital Distraction:** nonstop digital connectedness makes focus nearly impossible
- **Digital Dementia**: Short term memory pathways will start to degenerate if we overuse technology, outsourcing our brain, not treating our brain like the muscle it is
- **Digital Deduction**: the reliance on technology to solve every question confuses people's perception of their own knowledge and intelligence, leading to overconfidence and poor decision-making

Kwik proposes an engaging model to overcome the 4 D's and optimize your brain's capabilities; the elements that you need are:

1. **Mindset**: Do you have a Growth vs. Fixed Mindset? How can you overcome the 7 Lies of Learning?
2. **Motivation**:
   a. What is your Purpose?
   b. Techniques to maintain maximal brain energy through the entire day
   c. Proven techniques to help foster the change we need in our habits
   d. Guidance on achieving a state of FLOW on a regular basis
3. **Methods**: Specific skills to improve your ability to learn

MINDSET: Carol Dweck's highly praised book Mindset highlighted the vital difference for an individual's ability to overcome learning obstacles when they have a Growth versus a Fixed Mindset! The Fixed Mindset leads you to embrace the "7 Lies of Learning", restricting you from properly using your brain.

	7 Lies of Learning	7 Truths of Learning
1	Intelligence is fixed	Intelligence is fluid
2	We only use 10% of our brains	We can better use the brain
3	Mistakes are failures	Embrace failure and learning
4	Knowledge is power	Knowledge X Action is power
5	Learning new things is difficult	Learning is a process
6	The criticism of other people matters	Be your own hero
7	Genius is born, not made	Genius is created from Deep Work

The Growth Mindset is so crucial to our ability to learn that everyone should know the difference between the Fixed and Growth Mindset, recognizing that we may actually hold a fixed mindset toward certain areas (I can't draw; I could never learn a language; I suck at Math/Research/etc.).

	Fixed Mindset	Growth Mindset
View of Intelligence:	Fixed	Can be Developed
Leads to a desire to:	Look Smart	Learn

These desires cause you to react in markedly different manners:

Challenges	Avoid	Embrace
Obstacles	Get defensive/give up easily	Persist in Face of Setbacks
Effort	See Effort as Fruitless or worse	See Effort as Path to Mastery
Criticism	Ignore Useful Negative Feedback	Learn from Criticism
Success of Others	Feel Threatened	Find Lessons and Inspiration
Result	Achieve Less Than Full Potential	Reach Ever-Higher Levels Achievement

The Growth Mindset allows for an intriguing possibility: **There isn't an ability that we have or don't have, only an ability that we have or haven't CULTIVATED!**

MOTIVATION: This section pulls from other authors recent work, to provide the backdrop to improve your learning capability and optimize your brain power

-Purpose: Start with Why (Simon Sinek)

-Manage your ENERGY, not your TIME: The Power of Full Engagement (Jim Loehr and Tony Scwartz) which focuses on how to optimize your brain's function through appropriate Sleep, Activity, Nutrition, Rest/Recovery, which harkens to the Army's Performance Triad

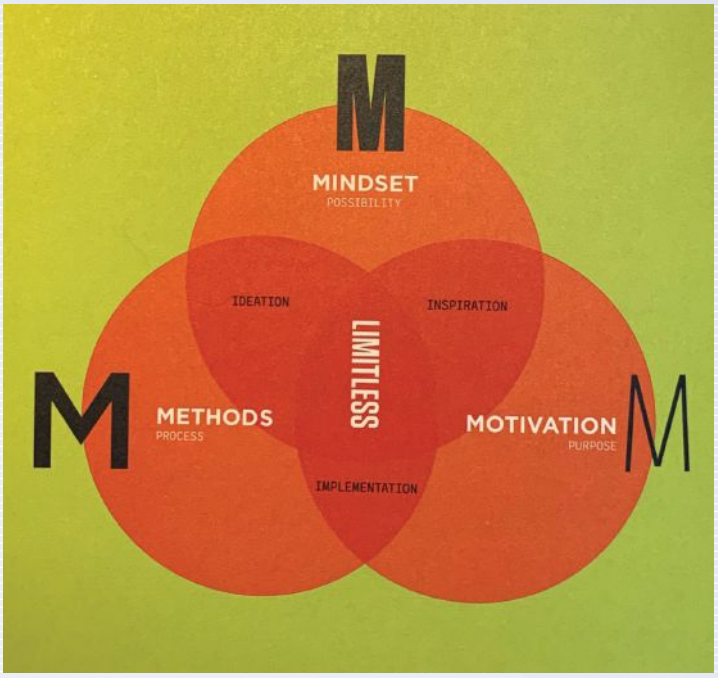
-Even after becoming motivated to make change, changing your habits can still be hard; start with "Small Simple Steps" as described in the following recent books:

Tiny Habits, TJ Fogg
Atomic Habits, James Clear
The Power of Habit, Charles Duhigg

-Motivation comes easily when you can learn how to achieve "Optimal experiences" on a regular basis as described in Flow, Mihaly Csikszentmihalyi

METHODS: The final section provides easy to use upgraded learning techniques that you will lament about why you didn't know this prior to medical school!

-**Focus**: It is not just a challenge for people with ADHD; we all need to learn how to calm our busy minds, cut out distractions and avoid the tendency to try to multitask



-**Study**: our brains are not wired for long blocks of studying and definitely not for all-nighters.
-**Memory**: Excellent tips on memorizing the key points to a lecture/speech, as well as great tool how to remember names of people you meet in social settings
-**Speed Reading**: This is a skill I have always avoided because I assumed I wouldn't remember anything, but I just didn't know how to do it. Amazingly, my speed improved from 350 to 525 words per minute, with no loss of comprehension; Kwik provides other exercises to increase your effective reading speed even more!
-**Thinking**: Several methods to improve the quality of your thinking process, to include trying on the "6 types of thinking hats"

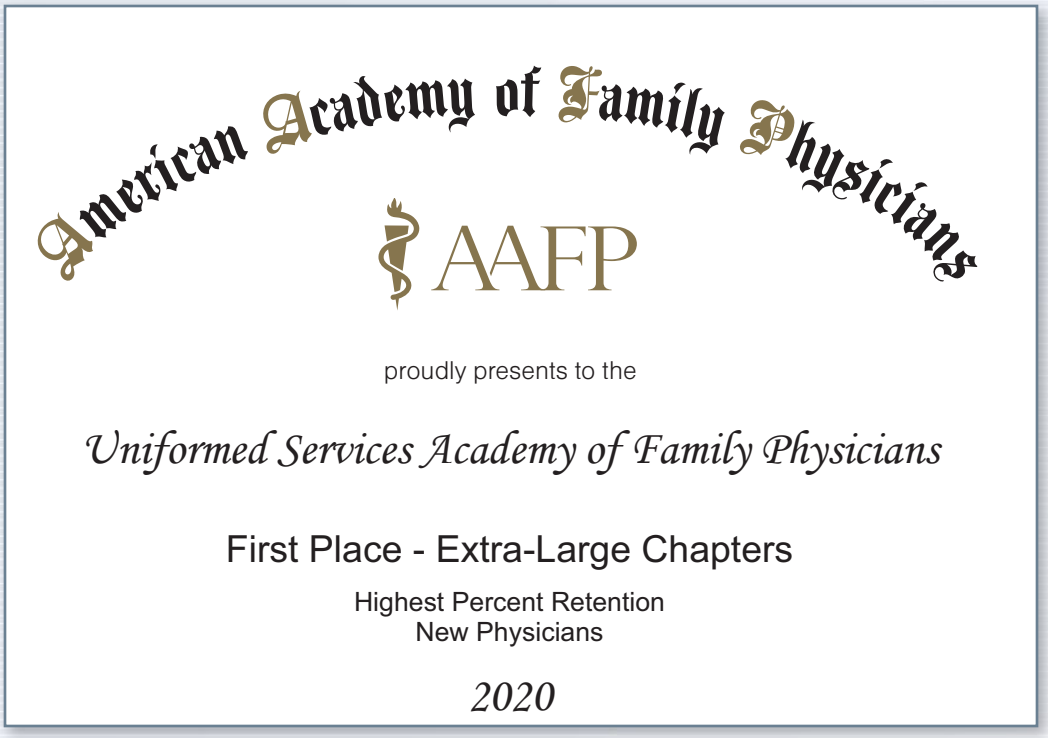
Jim Kwik's Limitless is the ultimate guide to combining the current science behind brain fitness, learning enhancement and mental acuity, and it can help you to better tap the unused potential in your brain!

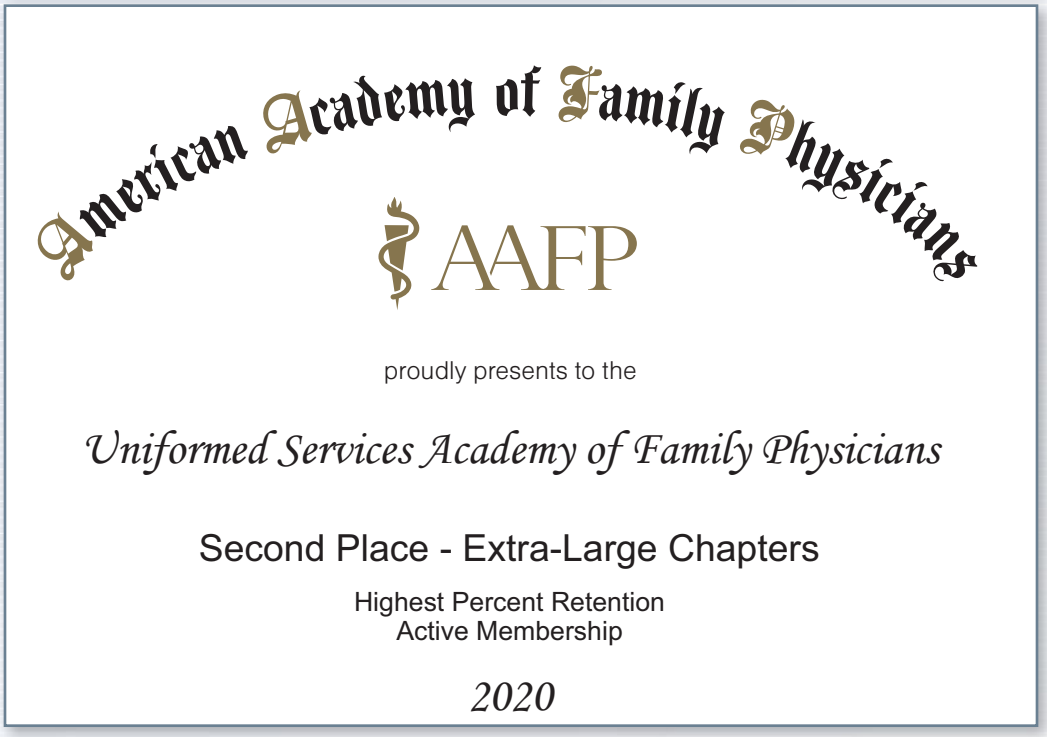
The American Academy of Family Physicians is proud to recognize the USAFP for its' membership achievements:

First Place: Highest Percent Retention of New Physicians – Extra-Large Chapter

Second Place: Highest Percent Retention of Active Members – Extra-Large Chapter

Thank you to all members for your continued interest and participation in the USAFP!





USAFP Members Participate in AAFP's Annual Chapter Leadership Forum and National Conference of Constituency Leaders

Twelve family physicians represented the USAFP at the Annual Chapter Leadership Forum (ACLF) and the National Conference of Constituency Leaders (NCCL) held virtually on 29 April – 1 May. USAFP was represented at ACLF by President-Elect Marcus Alexander, MD, Vice President Leo Carney, DO, Directors Drew Baird, MD and Kevin Bernstein, MD and USAFP Past President and AAFP Director James Ellzy, MD. USAFP representatives for NCCL included Jules Seales, MD, Spencer Fray, MD, Alex Knobloch, MD, Rachel Carter, MD, Sterling Brodniak, DO and Janelle Marra, DO.

Megan Mahowald, MD led the Women's Constituency as one of its Co-Conveners and will continue to serve as Member Constituency Delegate to this year's Congress of Delegates. Dr. Bernstein, an AAFP Delegate to the AMA Young Physician's Section, led the NCCL orientation session as well as the election for the new AAFP Delegate to the AMA Young Physician Section. Drs. Mahowald and Bernstein also served on the NCCL Advisory Group, planning the NCCL over the past year.

ACLF is the AAFP's leadership development program for chapter-elected leaders, aspiring chapter leaders, and chapter staff. Among other roles, ACLF functions as an orientation for emerging leaders who serve on chapter boards, as well as professional development for new and seasoned chapter staff. Drawing more than 300 attendees this year, ACLF also features targeted breakout sessions on chapter governance, advocacy, and communication.

Dr. Spencer Fray

Dr. Janelle Marra

NCCL is the AAFP's leadership and policy development event for underrepresented constituencies. NCCL serves as a platform for different perspectives and concerns of AAFP members to help bring about change. The five constituencies with representation include: Women, Minorities, New Physicians, International Medical Graduates and gay, lesbian, bisexual, and transgender physicians, or physician allies. At NCCL, physicians develop skills to advocate for issues that are relevant to specific constituencies, practices, the specialty, and patients.

During NCCL, USAFP authored or co-authored 9 of the 41 resolutions that were discussed. In addition to the incredible participation in the resolution writing process, USAFP members Janelle Marra, DO and Spencer Fay, MD were elected by their respective constituency groups to serve as 2022 NCCL Member Constituency Co-Conveners and elected by the entire NCCL delegation to serve as Member Constituency Alternate Delegates to the AAFP Congress of Delegates in September. Congratulations to Drs. Marra and Fray!!

You Asked, We Answered!

ADDITIONAL INFORMATION ON THE COMPLIMENTARY ABFM FAMILY MEDICINE CERTIFICATION

Your question: Can we use the Post-9/11 GI Bill benefits to get our ABFM Maintenance of Certification (MOC) fees reimbursed?

Answer: It depends on whether you are using your Post-9/11 GI Bill Benefits (up to 36 months of education benefits) yourself or whether you have already transferred or plan to transfer your Post-9/11 GI Bill Benefits to one or more of your dependents.

1. If you are planning to use yourself or are already using at least one month of your own Education Benefits: YES, you can seek and receive reimbursement for MOC fees.
2. If you are planning to transfer 100% of the benefits or have already transferred 100% of the benefits to one or more of your dependents: NO, you cannot seek or receive reimbursement for MOC fees.

For more info about the Post-9/11 GI Bill and its benefits, please visit: https://www.va.gov/education/about-gi-bill-benefits/post-9-11/

If you want to learn more about transferring some or all of your Post-9/11 GI Bill Benefits: https://www.va.gov/education/transfer-post-9-11-gi-bill-benefits/

Please verify with the VA if you have any questions.

MEMBERS IN THE NEWS

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

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

Congratulations to the following USAFP members!

Teresa Allen DO, FAAFP
Andrew Baldwin MD, MPH, FAAFP
Bo Barber MD, FAAFP
Hyrum Bronson DO, FAAFP
Jennifer Brown MD, FAAFP
Benjamin Buchanan MD, FAAFP
Moses Cheng DO, FAAFP
Edwin Choi MD, MS, FAAFP
Eric Chumbley MD, FAAFP
Carlton Covey MD, FAAFP
John Crabill MD, FAAFP
Mohenish Daughtry DO, FAAFP
Miriam Dinatale DO, FAAFP
Angela Dunn DO, MPH, FAAFP
John Earwood MD, FAAFP
Jeffrey Feinberg MD, FAAFP
Breanna Gawrys DO, FAAFP
Thomas Hair MD, FAAFP
Collin Hu DO, FAAFP
Jeremy Kenison DO, FAAFP
Jeehun Kim MD, FAAFP
Michael Kim MD, FAAFP
Alexander Knobloch MD, FAAFP
Debra Koenigsberger MD, FAAFP
Michael Leader MD, FAAFP
Elise Leisinger DO, FAAFP
Dana Lilli MD, FAAFP
Myro Lu DO, FAAFP
Blake Marvin MD, FAAFP
Gary Means MD, FAAFP
Erica Meisenheimer MD, FAAFP
Patricia Millner MD, FAAFP
Michael Moore DO, FAAFP
Jason Musser DO, CPE, FAAFP
Brian Neese MD, MS, MPH, FAAFP
Nicole Nelson DO, FAAFP
Preciosa Pacia-Rantayo MD, FAAFP
Elyse Pierre MD, FAAFP
Arwyn Raina MD, FAAFP
Tyler Rogers MD, FAAFP
Tristan Sevdy MD, FAAFP
Brian Shahan MD, FAAFP
Jennifer Slowik DO, FAAFP
Savannah Smith MD, FAAFP
James Smith MD, FAAFP
John Steely MD, FAAFP
Jillian Sylvester MD, FAAFP
Kathleen Tilman MD, FAAFP
Robert Tong MD, FAAFP
Evelyn Vento MD, FAAFP
MariaRegina Wicks MD, FAAFP

Find your future at Banner Health®

Your commitment to service.
Our commitment to you.

- Financially sound with Fitch rating of AA-
- Access to academics and network of specialists
- Dedicated resources to mitigate burnout and encourage well-being
- Development opportunities
- Excellent compensation
- Public Service Loan Forgiveness
- **Our Diversity & Inclusion efforts includes resources for military veterans**

Primary Care positions now available for BE/BC physicians in Family Medicine, Internal Medicine, Geriatrics or IM/Peds.

Banner Health: A highly-ranked health system operating in six states and a physician-led organization that strives to make healthcare easier so that life can be better...for patients, and physicians too!

Arizona: With dozens of clinics and health centers in Arizona, and plans for expansion, Banner Health is hiring for several locations, including: Glendale, Goodyear, Peoria, Sun City West and San Tan Valley.

Also hiring in CA, CO, NE, NV, WY.

Apply today - PracticeWithUs.BannerHealth.com
For more information: Pam Disney (602) 747-4397 or doctors@bannerhealth.com

www.bannerhealth.com

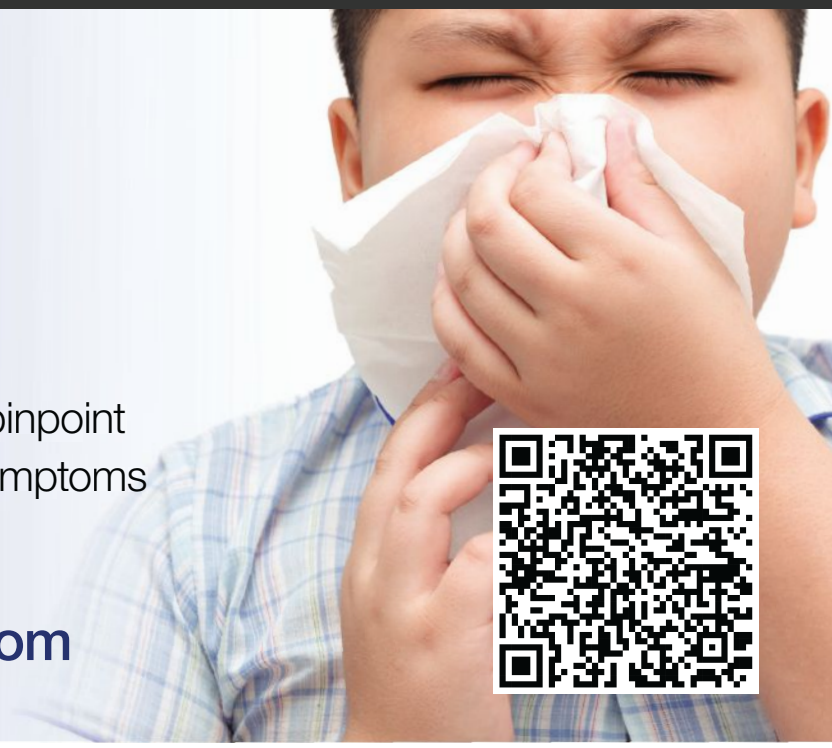
The Uniformed Services Academy of Family Physicians
1503 Santa Rosa Road, Suite 207
Richmond, Virginia 23229
www.usafp.org

ImmunoCAP™ Specific IgE

The difference between **knowing it** and blowing it.

Choose **sIgE blood testing** to help pinpoint the causes of your patients' allergic symptoms and provide faster relief.

Find out more at allergyai.com



Review these helpful resources:

Allergen Reference Encyclopedia >

Provider Resource Library >

On Demand Education >

On-site or virtual education is available
in support of all Federal contracts.
Contact Adrion Waters for more information.

adrion.waters@thermofisher.com
(240) 610-8917

DoD Reference Laboratories:

- Wilford Hall ASC
- Eisenhower AMC
- William Beaumont AMC
- Womack AMC
- Tripler AMC
- Landstuhl Regional MC

ThermoFisher SCIENTIFIC