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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 58

your academy leaders
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Greetings, Friends!

This is my last newsletter as your President, and I'd like to thank you for the opportunity to lead our chapter through what have continued to be interesting times. Although I'm writing this in the midst of the Omicron wave, my hope is that you are reading this with the pandemic finally receding and a new and hopefully better normal approaching.

Below, I'll touch on a few items that have been on my mind and will hopefully be meaningful to you as well.

1. READING AS A PROFESSIONAL

Like you, I make an effort to keep up with a small corner of the medical literature. I read the American Family Physician cover to cover, I listen to the occasional podcast, I subscribe to InfoPoems (free with your USAFP membership), and I read on my patient's conditions (UpToDate, PubMed, clinical practice guidelines).

I also try to keep up with readings to enhance my leadership ability. Recent entries include Inside the Five Sided Box and Leadership BS (both featured in the USAFP Leadership Book Club), The First 90 Days (a repeat read, recommended by my soon to be boss) and its sequel Your Next Move, and Team of Teams and No Time for Spectators (both read with my Infantry second lieutenant son). I'm hoping that I'm retaining some of the lessons these books contained. At the very least, I'm hoping the volume of reading is having an impact on my subconscious.

In addition to this, I try to spend time with the Bible daily. As I write this, my streak on YouVersion is 132 consecutive days. I'm hoping to keep that going throughout 2022! I'm also working through a whole Bible in a year plan.

One area of my reading that is admittedly anemic is my attention to non-medical, non-leadership reading. Sadly, I haven't read as much in this sphere (unless you count my growing comic book/graphic novel collection), but I recently finished Klara and the Sun and read most of People of the Book (both featured in the USAFP Literary Book Club), and completed the somewhat long but thoroughly enjoyable process of reading Charles Dickens' David Copperfield.

I sometimes forget how much fiction has to teach us about people, life, leadership, and even medicine. David Copperfield was an amazing reminder of this. Dickens' characters are a wonder to behold. There are mean villains in whom redemption will not be found and without any good qualities to break up the baseness of their characters. There are others who seem fair but prove foul, brought to the place they are through the ill guidance of others, the impact of their lived society, and the poor choices they make. There are others who seem inconsequential, almost like they are destined to be only foils off of which David plays, but who come through when the chips are down and earn their just acclaim. There are those who hate, and who are hated in turn. There are those who love, and whose love is both requited and not. And there is David, who learns the hard lessons of life as a youth, takes steps both good and erring as an adolescent, experiences the vicissitudes that life can visit on a young man, and who grows wiser and more settled as the author expends ink upon his recollections as an older man.

The people we meet, the lives we live, the folks we lead, and the patients we serve are so much more than the characters whose exploits we read about on the page. But that reading takes us to different worlds, allows us to see that which the author highlights and to guess at what the author hides, and allows us to draw lessons that impact the way we perceive the world around us. Fiction gives us insight into what it is like to be someone with cause to grieve, examples of laudable and desultory ways of sharing time with others, warnings about pitfalls to avoid and encouragements to accomplishments worthy of praise. Fiction allows us to put on the masks of others and to narrow the distance between the thoughts and judgments that race within our heads and the aspirations and narratives that others tell themselves.

All of this is a long way of saying that I encourage your habits of reading from (and listening to) a wide variety of materials—your medical journals and textbooks, your leadership development resources, sacred writings (if you are so inclined), and the wider world of literature. For me, the lessons I've learned and the worlds I've encountered continue to pay dividends for me as I grow and

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mature in my practice, profession, and personal relationships. I think I'm a better officer and physician for it!

2. THE BLESSING OF COMMUNITY

I retire on July 31st. August 1st will be my first day as a retiree—the status I'll hold for the rest of my life. About one and a half years ago, this looming transition kicked off a process of extended soul searching: What do I want to do when I grow up? Where is God calling me to be? How do I take the next step?

Fortunately, those are questions that I don't have to answer alone. Thirty-one years of being associated with the military have taught me some great life lessons (some of which are in my prior columns) and have given me some fantastic mentors and friends. As I started looking at second acts on websites like USA JOBS, AAMC Career Connect, and AAFP Career Link, I found that I was still drawn to the mission of academic medicine. After a couple swings and misses with a non-profit and a local institution, I became serious about looking at family medicine chair positions in the Southeast.

With an idea of where I wanted to go, I reached out to a number of current and former chairs, all of which are still, or formerly were, members of the USAFP. Dean Seehusen, Janette South-Paul, Jeff Quinlan, Jay Fogarty, Brian Reamy, and Dana Nguyen, among others. They provided me with fantastic advice, spoke on my behalf, wrote me letters of recommendation (which were likely more eloquent than I deserve), and solicited positions on my behalf. With their help, and the help of others, I'll be joining the University of Florida College of Medicine Department of Community Health and Family Medicine as chair in June 2022.

It is not a stretch to say I wouldn't be looking forward to this position without the community that comes with military service and membership in the USAFP. Encouraging friendships, supportive networks, challenging advice, and opportune sponsorships have made my next steps possible.

I wish the same for each of you. When the time comes to consider a next step in or out of uniform, I'd encourage you to leverage our USAFP network. Never once has a ranking officer turned down my request for advice, and all have given generously of their time. We have a phenomenal chapter—let it work for you!

And if you want to reach out to me, my email is militaryfamilydoctor@gmail.com.

3. THE THINGS I CHERISH MOST

Approaching terminal leave has made me more reflective. Looking back, I have been watching the career highlights film and thinking about those things that brough savor to the ROTC, HPSP, and Active Duty years. Here's a few of them.

a. Realizing that the Army might be the place for me based on the diversity and mission focus of the cool people I met in ROTC, including Craig Taylor, my buddy from the Class of 1995.
b. Meeting my wife, Beth, while trying a new church in Tallahassee during my first week of medical school as an HPSP recipient (and being married one year to the day later).
c. Having our first son, Caleb, while finishing my fourth year in Gainesville. He's now done ROTC himself and is at Infantry Basic Officers Leadership Course, and it would be hard for Beth and I to be prouder.
d. Doing residency at Fort Belvoir (DeWitt), being surrounded by Army family docs for the first time and making lifelong friends, like our very own Rob Oh, who continues to serve the USAFP. We had our son, Philip, at the old DeWitt hospital, and he's now a junior at the University of Southern California. Thankfully, my GI Bill took the hit for that one. He's grateful, and we're grateful that he stays a big part of our lives.
e. Being the doc for a small community of Americans and German friends in Grafenwoehr and receiving some of the best career advice I have ever heard from Dave Sproat and Jeff Clark: "Do your job to the best of your ability, and doors will continue to open for you."
f. Being accepted to the Madigan Faculty Development Fellowship and being actively sponsored by Dean Seehusen—who still continues to sponsor me. The whole faculty development family continues to open doors and allow opportunities for professional growth. It was here that I started paying closer attention to what academic leadership looked like and made the definitive decision to stay in the Army for a career.
g. Joining the faculty at the Eisenhower residency, working with fantastic house staff (who are now academic leaders in their own right, like Drew Baird) and being mentored by Karen Phelps, who epitomized servant leadership. When she was department chief, she was still pulling OB call, inpatient weeks, and clinic like the rest of us.
h. Taking a turn in Afghanistan. So many of you have deployed much more than I have, and I thank you for doing the hard work. For me, Afghanistan was where I saw military medicine in its purest form. We cared for Soldiers,

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Sailors, Marines, and Airmen. We pulled out all the stops. We mobilized an international medical team to do what we do best—make sure that someone's loved one makes it back from freedom's frontier to home as whole and expeditiously as possible. We didn't document on an electronic medical record, we didn't host JCAHO, or the ACGME, or anyone else. We put on our uniforms, did our job, prayed that God would be merciful to our troops, and rejoiced when we heard they made it home safely.

i. Making a career reset at USU. The circumstances of my joining the faculty relied on people like Mark Reeves and Mark Stephens who had both an interest in military family medicine and my career. That bit of sponsoring opened up a world to me and gave me the opportunity to work with my proudest legacy—the many students whose lives have left me richer for their touching upon my own life. Alex Knobloch and Becca Lauters were my first FMIG leaders and rekindled my passion for the specialty. The many after them have continued to reaffirm my faith that our specialty is in incredible hands.

j. Sharing military medicine with pre-meds as the admissions dean. Traveling the country, seeing the pipeline into military medicine, hearing the excitement, and seeing the future on college campuses and at pre-health fairs—our next few decades are so, so bright. To help so many people choose military medicine and to see them grow into residents and now attending physicians in their own right is a blessing.

k. Closing the chapter in San Antonio. It brings me such joy to see the students that I met on interview day step out onto clinical clerkships and audition rotations. It reminds me that great oaks from tiny acorns grow. And we are making some tall, sturdy, well rooted oaks.

I think I will end here. Thank you all for your part in an incredible three decades with the Army. May God cause His face to shine upon you and to bless you as you continue to be a blessing to each other, your respective Services, and the United States of America.

Cheers,

Aaron
militaryfamilydoctor@gmail.com

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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/**

This will be my last letter to you as the Vice President of the USAFP. It has been and honor and a privilege to serve the membership in this capacity. This past year has been anything but normal. As I reflect on this time, I have fond memories of annual meetings past. 2022's Annual Meeting will be a great reunion for seasoned members and an incredible welcoming to those on the younger side of their career. Regardless of your future ambitions, please make every effort to join us in Anaheim as we celebrate the contributions of military Family Medicine. See you there!

Semper Fi,

Leo Carney

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Revolution in the USAFP Poster Competition?

There are many great things that will happen in Anaheim this year – seeing far-flung colleagues, gaining inspiration, and absorbing education and research from many different venues. As research judges, we may be a bit more biased towards the research. We encourage you all to peruse the posters this time. You will notice that the posters look very different, and we hope that you will see why.

In early 2019, Dr. Mike Morrison developed a revolutionary poster design in lieu of how researchers traditionally communicate using the scientific poster. We are requesting that all research teams use this new format, often called "Poster 2.0".

The "Poster 2.0" format places the main research finding at its center written in plain language in large font size. It's like a punch line. Imagine a billboard or a bus stop ad. It quickly gives attendees the main finding that not only communicates easily but acts as the hook to start the stop-and-discuss feature of a poster session. A Quick Response (QR) code placed underneath the summary statement allows attendees to use their smartphone to link to a document with details of the study. A column on the left briefly provides highlights from the abstract: Introduction, Methods, Results, and Discussion. In the traditional poster, this information is the poster, but now it serves as a reference for attendees to skim. The column on the right presents data in the form of images, graphs, tables or diagrams to further explain or answer questions. The goals are to make the poster clear and efficient, to facilitate discussions with researchers and to enable attendees to survey many posters while focusing on those most interesting to them.

As the new poster format has been used, presenters have already made changes to the original design. Some call these "Poster 1.5" as they integrate elements of the traditional poster to find the best format.

Little research exists comparing poster session attendees' preference on poster design. Last year, we included the Poster 2.0 format in our Omnibus Survey. We showed a previous award winning poster in the traditional format and the Poster 2.0 format, seen on page 13. When asked about clarity, efficiency, and enticement, about half of the respondents preferred the new format. Slightly more than half if you include those with no preference.

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.

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

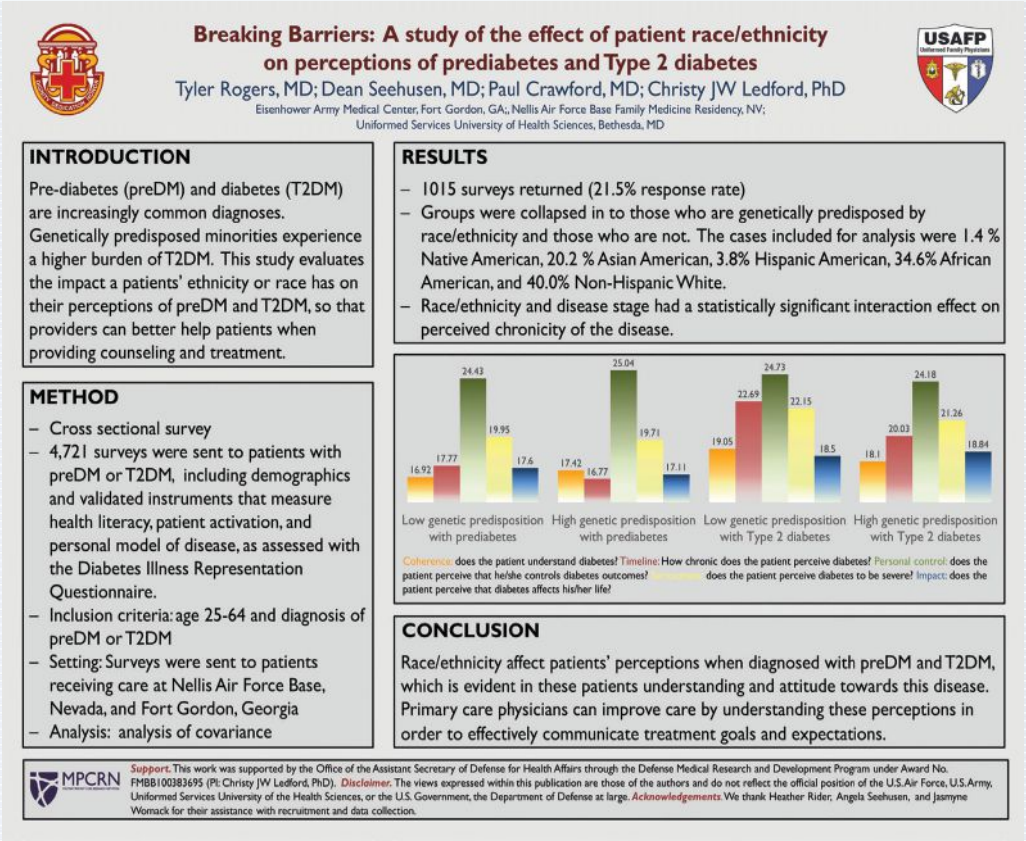
That was enough for us. We are hoping for a poster space where we can all get the main ideas of our colleagues' research on a leisurely stroll. Instead of deciphering through dispirited rows of posters with cute titles and crowded text, we will read the key point in large letters. Then we will each choose the ones we want to look into more, and we will stop to discuss with our colleagues and review the charts and illustrations.

We supplied templates to the research teams, with suggested ways to adapt both studies and case reports to the new format. We're looking forward to what our members create from these beginnings.

If you want to see more details from Dr. Morrison's original idea, scan the QR code.

#betterposter
#Poster2.0

Figures:



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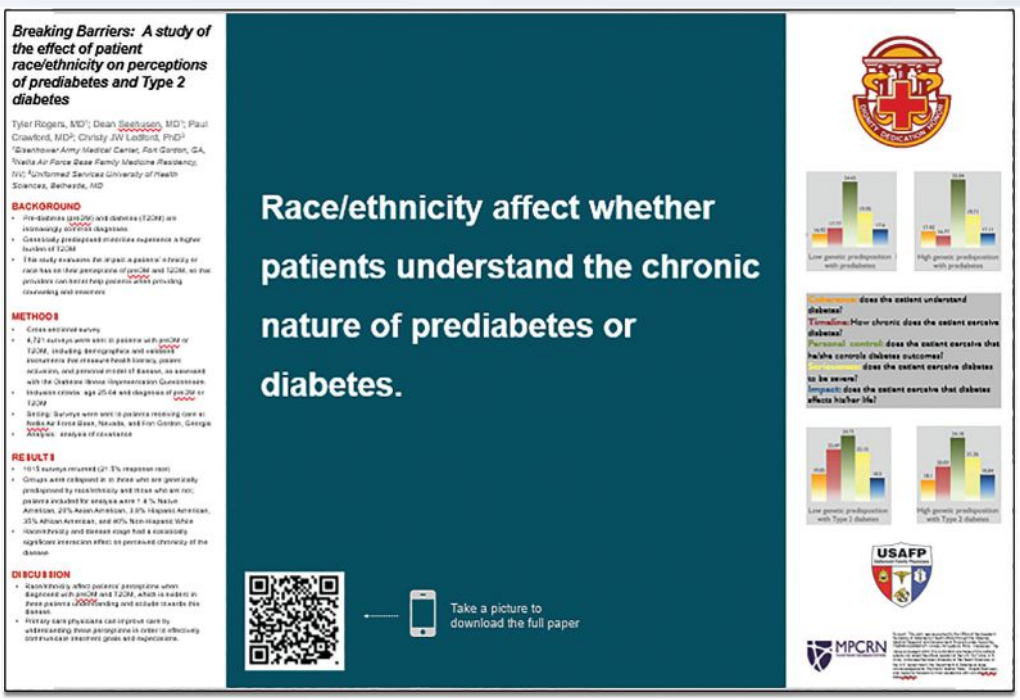

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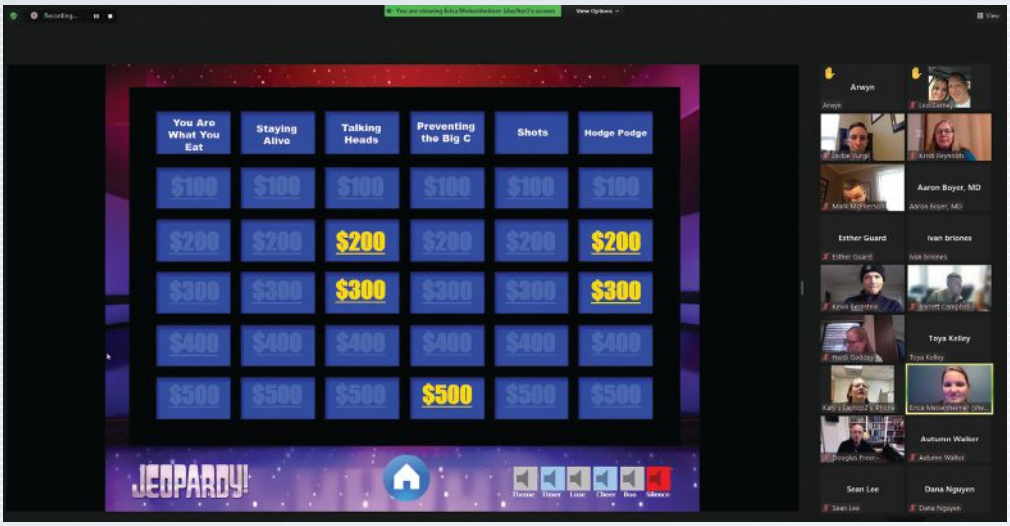


USAFP Members participate in the virtual KSA.

Committee Updates

Virtual KSA

Congratulations to USAFP members Arwyn Raina, Mark McPherson, and Barrett Campbell for winning the Education Committee's first Winter KSA event!

In December, the Education Committee hosted an interactive virtual KSA designed to help our members maintain certification while also maintaining connection with one another. The Annual Meeting provides us a wonderful opportunity each spring for CME, networking, and fellowship, but we wanted to spread this throughout the year. We had approximately 20 attendees join us over Zoom for a Jeopardy-style game, and these three Army doctors now have bragging rights until the next one comes along. Those participating suggested we continue to do these throughout the year, so look for updates on more of these opportunities after the Annual Meeting!

POCUS Subcommittee

A new subcommittee was founded at the USAFP Board Meeting in September. The POCUS subcommittee, chaired by Scott Grogan and John Sullivan, will fall under Education Committee. More information to come, so stay tuned!

Education Committee Website

Our next task is to update the Education Committee corner on the USAFP website to include a repository of resources for CME, deployment medicine, faculty development, and more. If you have any suggestions for resources you think should be included, we invite you to contact the Committee co-chairs.

AVOIDING DEATH BY POWERPOINT

By the time you all read this, the USAFP Annual Meeting will be just around the corner, so we wanted to take this opportunity to share some thoughts and suggestions for creating impactful presentations.

Too frequently, we are asked to present on a topic, and the first thing we do is open up PowerPoint to start making slides on all of the things we want to talk about. My challenge for you is to do some pre-work before that step to be more purposeful in your approach.

Our learners need to be able to take our lessons with them, to think critically about them, and to apply them to future situations; for that to happen effectively, presenters need to think beyond the standard "sage on the stage" lecture format and allow learners to interact and engage with the content at hand.

So how do we do this? The first, and most important step, is to pause and make intentional decisions about the goals and content of our teaching sessions by considering three big questions:

1) Why?
2) What?
3) How?

WHY?

As Simon Sinek says, start with "why." Before you do anything else, it is essential to understand and refine your goals in presenting this topic. Ask yourself:

- Why do I want this specific group of people to learn this topic?

- What do I want them to do differently or think differently as a result of this talk?
- Why should this audience care about this topic?

WHAT?

Once you know your why, you can use that to decide the focus of your content. This seems like it should be obvious, but if we are not deliberate in this step, we set ourselves, and our learners, up for failure. Whether you are talking about rashes, hypertension, or asthma, it isn't feasible to talk about everything you probably want to, so be purposeful in narrowing it down. Your learners will get more mileage out of a few well-chosen and deliberate lessons than they will grasp from an extensive review of the entire topic. This time, ask yourself:

- If they remember nothing else I say, what do I truly want them to understand?
- What 2-4 key points do I want my audience to take away with them? Allow yourself to filter everything else out. You can always provide a handout or additional resources for those elements you've omitted. QR codes can be really helpful for this.

HOW?

Finally, once you've clarified your why and narrowed down your what, move on to the "how."

- How can I deliver this content to my audience to best facilitate my "what" and "why"?
- What other logistical factors affect this? Timing, location, resources, and number of participants are just some of the things to keep in mind.

Jane Vella, an expert on adult education theory, breaks down the "how" into four essential components, which she calls the 4 A's:

- **Anchor**: Start by helping your audience relate to your content. This can be a pre-quiz to tap into prior knowledge, a case to relate to, an icebreaker exercise, an anecdote, quote, or video; the possibilities are endless. Allow your anchor to give the audience a sense of your why; why should they care about your topic?
- **Add**: Present new content. This might be done through lecture, but videos, demonstrations, role play, article excerpts, case discussions, etc. are all other options. When we are not deliberate in our planning, the "add" tends to become the entirety of our presentations, but it is really only one part.
- **Apply**: We want to make sure our audience understands and can use what we are teaching them. Give them the opportunity to practice and apply your lessons while they are still in the room with you. This is the step that is most often omitted, but it is also the most essential in guaranteeing the transfer of knowledge into future practice. The QR code below will bring you to a compilation of interactive techniques that can be used for either the "add" or "apply" steps.
- **Away:** This step can take on a number of forms, but essentially it is a challenge to your learners to identify how they will use these lessons in their future practices. This can be done as a final discussion (learners can talk in small groups about a change they will make moving forward), a commitment to act (learners create an action plan of sorts and identify the first step they will take when they leave), or even just an inspiring question or thought that will allow them to think about the impact your talk may have on them.

Pausing to make intentional decisions about your "why," "what," and "how," including identifying your 4 A's, does take time up front, but it pays dividends in the long run. Once complete, these steps provide an outline for the actual creation of your talk and help to ensure that your presentation remains focused, interactive, and impactful.

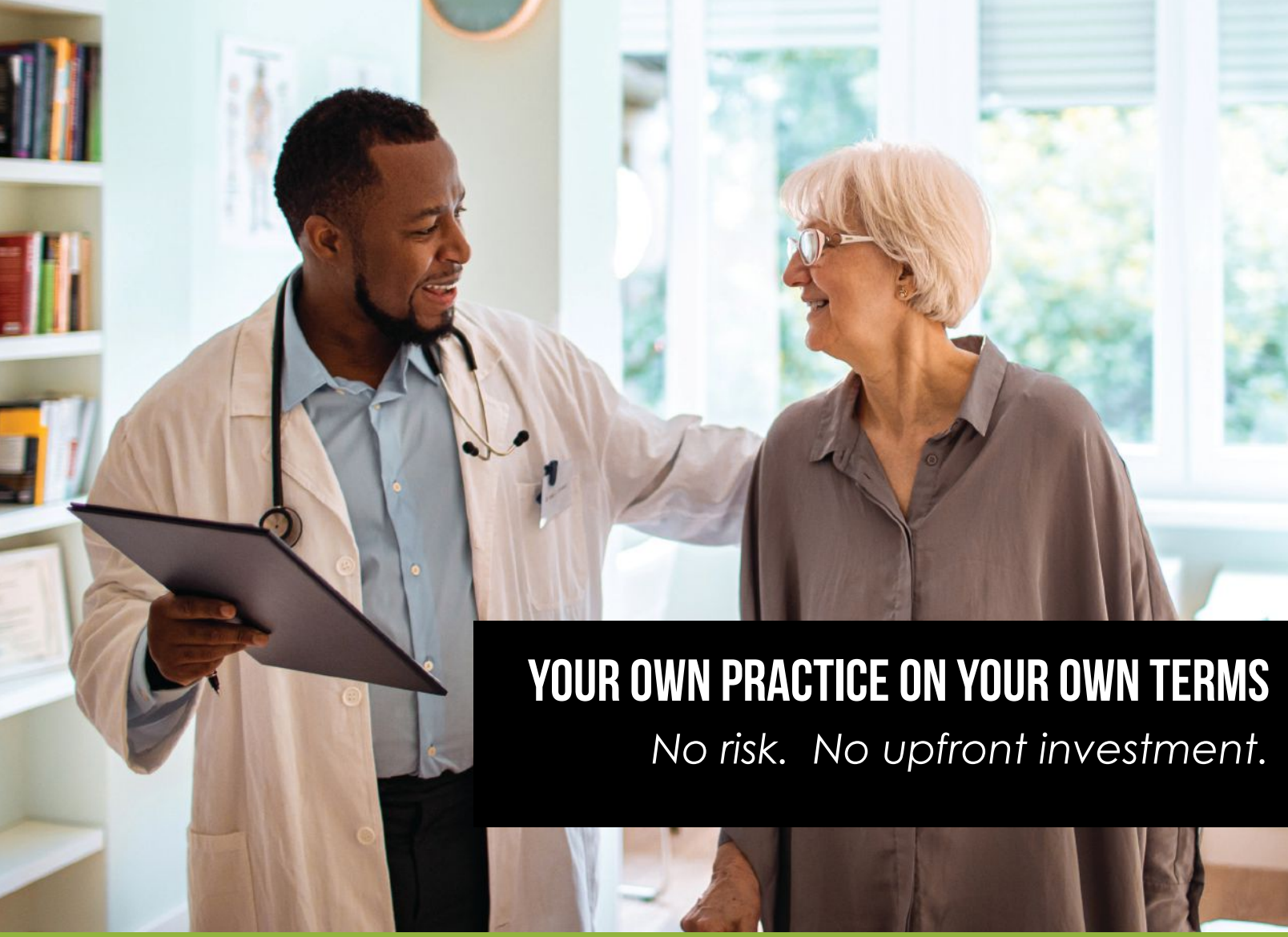
REFERENCES

The content of this article is Education Committee co-chair Erica Meisenheimer's adaptation of Jane Vella's "8 Steps of Design." More information about Jane Vella, the full eight steps, and dialogue education can be found through Vella's own organization, Global Learning Partners, at https://www.globallearningpartners.com/ (QR code below).

QR CODES:

Ideas for Interactive Teaching Techniques:

Global Learning Partners:



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Isn't it time to be captain of your own ship?

Wayne Lipton, Managing Partner, Concierge Choice Physicians

Lately, there has been a lot of talk about depression and burnout among physicians. The pressure on today's doctors to see more and more patients and meet "productivity goals" is taking the joy out of medicine, and even pushing some of the best, most qualified physicians to retire early.

What if there was a way to practice a kind of personal, relaxed and satisfying style of medicine, while still earning a strong income?

Fortunately, there is. Concierge medicine has been around for more than 20 years now. It began as a patient-driven response to the depersonalization of medicine that was then only just beginning. Patients longed for a return to the old-style of medicine, when they had a physician who knew them and their family, and could serve as a trusted health advisor and advocate. Physicians needed to preserve their way of practicing as well. With ever-increasing overhead and declining reimbursements, it became a challenge to maintain a thriving private, independent practice.

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Today, concierge medicine continues to flourish and grow, with many different types of practice models available to physicians of all sizes and specialties. More patients are signing on as members than ever before, proving that this model still answers a distinct need for this type of high-touch care in the market.

And, physicians who practice concierge medicine report the highest levels of professional satisfaction.

After all, there is pride in being your own boss, making your own staffing decisions, and taking all the time you need with your patients and private life, free from worry and financial constraints. Concierge physicians report less stress and greater happiness with their work/life balance, and with the relationships they have with their patients.

Physicians in our concierge programs say:

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"I joke, but my concierge program is saving my life as a physician."

"I still spend the same amount of hours in the office, but the work is less compressed and more enjoyable."

"I truly believe I know my patients and their needs better than ever before."

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Then you should learn more about the private practice opportunities in our network. The first generation of concierge clients are retiring, and they are looking for qualified, compassionate physicians to take over their private concierge practices and care for their patients. To learn more about opportunities near you, particularly in California, Virginia, New York, New Jersey and Texas, **contact Michele McCambridge, CCP's Senior Vice President at mmccambridge@choice.md.** All inquiries will be kept confidential.

CONCIERGE CHOICE PHYSICIANS

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Transition from Residency: Reflections on the First Year of Independent Clinical Practice

PROLOGUE: As the Chair of the Practice Management Committee, I am very excited to be offering this paper for publication in our USAFP journal. Too often, when we talk about practice management we focus on leading clinics or above. However the concept of practice management also applies to our own individual practices, how we work with our team and patients, how we become efficient in delivering primary care. Thus, what follows is an exceptional account from a new Staff Family Physician on how she struggled to manage her own practice and what she did to fix it. – Timothy Switaj, COL, MC, Chair, Practice Management Committee

This month I reach the one-year mark from graduating residency, and I have been reflecting on my first year of independent clinical practice. My mentors in residency told me that the first year would involve tremendous growth, and this has absolutely been true. Here are some of the challenges I faced and how I tackled them, and some lessons I learned along the way.

One of the biggest transitions over the past year for me was moving from a large military treatment facility (MTF) to a smaller outpatient-only clinic. Waiting on specialists to fax over results, requesting records over and over, having to ask patients to come back in to sign records release forms, getting 20+ t-cons a day of scanned results from various providers - all things I didn't need to worry about when at a large MTF with in-house specialists. This part of the job is still burdensome, but now I know some tricks. I always counsel patients explicitly on how to schedule the off-base appointment ("Don't wait for a letter to come in the mail!") I instruct them to call the clinic if they haven't heard back a week after their imaging, because chances are we haven't received it. When my records requests fail, I ask them to obtain their records themselves. Also, if I have a medically complex patient for whom I am placing multiple specialist referrals, I have them schedule another appointment with me generally about a month later to touch base and bring me up to speed. I have also heard of innovative policies at other clinics, such as having the paper copy of the fax signed and acted on by the primary care manager (PCM) prior to it being scanned into AHLTA, to expedite processing. If you have somehow expedited outside record review at your clinic, let me know!

Learning the operational side of medicine, such as knowing which conditions require a Medical Evaluation Board (MEB), completing Periodic Health Assessments (PHAs), and writing Narrative Summaries (NARSUMs) was also a big battle. I highly recommend the "Med Standards" app for a quick reference for appropriate Air Force Instructions (AFIs), Army Regulations (ARs), and Navy documents; it is updated monthly. One of the first mistakes I made was working on evenings and weekends to try to catch up on a backlog of a dozen NARSUMs that I was assigned when I arrived. Now, a year later, my process is to have the patient schedule a 40-minute appointment for a NARSUM. For annual Review-in-Lieu-of (RILOs), I request that the patient schedule a 20-minute appointment, but only after they have seen any required specialists. Prior to their appointment I review specialist notes, and I then use the scheduled appointment time to write the NARSUM or a RILO with the patient present, and review it with them. This is helpful in several ways – the patient understands exactly what is in their paperwork, the work that was previously consuming all of my free time is now integrated into my daily schedule, and I submit the NARSUM immediately following their appointment, so there is less delay and subsequent backlog. This is also important for when conditions requiring MEB are caught during Separation History and Physical Examinations (SHPEs) – identifying that a modified RILO/NARSUM needs to be submitted, writing it with the patient, and submitting immediately after the appointment expedites processing so hopefully they can still separate/retire on time.

I didn't expect how variable clinic policy can be. One of the biggest mistakes I made at the beginning of this year was not clearly communicating with my techs. I expected all notes to be documented in AHLTA, and past medical history, surgical history, medications, and allergies updated at every visit, which was standard at my residency program. However, our clinic policy when I first arrived was that only future encounters were

documented in AHLTA and 24 hour and sick call visits were documented on paper which was then scanned into AHLTA at the end of the clinic. During this policy, our medication reconciliation rate was a dismal 62%. I attempted to start a process improvement to copy forward notes ahead of time for all encounters. This was temporarily successful when we had a summer hire that could spend the time copy-forwarding notes, and was also greatly helped when sick call was discontinued at our MTF. But what really had the biggest impact for me personally was just talking with my techs and asking them to fix the note before I saw the patient. I couldn't expect a problem to be fixed when I wasn't saying it was a problem.

Another lesson learned was working too much at home and in the evenings. In residency, I set strict rules for when I would leave work based on daycare pickup time, but now I couldn't seem to stop spending all day Saturday catching up. Part of this was due to unrealistic expectations I set on myself, like thinking that I could catch up on a huge backlog of NARSUMs in a month. Part of this was due to poor communication with my team – at one point I was spending hours copy-forwarding notes. Part of this also was just due to having an entirely new empanelment! Now I have seen many of my patients at least once, and am just updating my previous good note – so at least that effort wasn't wasted. Lastly, one of the major things I've started doing in clinic is finishing my note before I move onto my next patient. I am always more efficient at the time of the encounter then when trying to recall it later, and spending five minutes to write it before seeing the next patient saves me fifteen minutes in the evening. Now even if I haven't managed to answer a single t-con, review a result, or check my email, at least my notes are done by 4:30. One of the other things that has been incredibly helpful in achieving this without getting too behind in clinic is that we have an hour of admin time here and there in our clinic day; while we do not have any big chunks of time for admin work, I actually prefer having it interspersed throughout the day because it gives time to catch up if I am running behind.

One of the biggest helps to me during this transition from resident to attending life was reaching out to other Air Force Family Medicine Captains to walk me through the process. The Air Force Medical Corps Captains and Majors Leadership Council (CMLC) has recently compiled a slew of resources on military medicine for new grads, and I encourage all new Air Force Captains and Majors to reach out to Jessica.c.bright.mil@mail.mil and join the AF MC CMLC. Another huge help was talking with my clinic leadership and Surgeon General of the Hospital (SGH), particularly when I had a problem. I encourage everyone to use these resources, especially new residency grads.

committee report
RESIDENT AND STUDENT AFFAIRS

Eileen Tatum, MD, PGY3
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Resident wellness is a topic near and dear to the hearts of many, particularly in the winter season. We have built curricula, scheduled dedicated didactic and social time, and discussed burn-out much more openly than in years past. As we navigate the holidays, colder weather, the end of daylight savings, and the residual impact of COVID-19 on our residencies, wellness remains ever-more important.

Dr. Laura Vater is a narrative writer, advocate for medical trainees, and oncology fellow at Indiana University who is soon to begin a career as a GI oncologist. During her training she created a tool called the SMILE Scale to assess and promote her own health. It is now being used to promote the health of other clinicians as well as patients. I chose to interview her as the focus of this issue's article to gain insight into medical trainee wellness and advocacy.

TELL ME ABOUT THE SMILE SCALE AND HOW YOUR INTEREST IN ADVOCACY BEGAN.

"The SMILE Scale is a daily self-assessment of 5 basic areas of health:

S - Sleep enough. Did I sleep 7-9 hours today? Was my sleep restorative?

M - Move my body. Was I physically active for 30 minutes or more today?

I - Inhale. Exhale. Did I find at least 10 minutes to reduce stress in a healthy way?

L - Love and connect. Did I meaningfully connect with someone today?

E - Eat to nourish. Did I choose foods that nourish my body, including at least 5 servings of fruits and/or vegetables?"

"My interest in advocacy for medical trainees began when I took a deep dive into the literature on sleep, physical activity and stress. I believe our health is interconnected: when we are well, we are better able to care for patients. Advocating for our health as clinicians supports not only our health now and for the years to come, but also the health of our patients."

DO YOU VIEW SOCIAL MEDIA AS A POTENTIAL SOURCE OF WELLNESS IN THE RESIDENT EXPERIENCE?

"Medical training can be isolating. Many residents are going through the same experiences, yet can feel alone through it all. Social media can be a tool that connects trainees going through similar experiences, reminding them they are not alone. If you choose to have a social media platform, remember that it is a tool for connection and information, but don't feel like you have to spend all your time there or become a slave to content creation."

TELL ME ABOUT SOME RECENT POLICY IMPROVEMENTS YOU ARE AWARE OF IN YOUR INSTITUTION.

"My internal medicine residency program did away with 28 hour calls on ward months and ICU rotations, and instead adopted a night float system. This decision was based on emerging data on sleep, resident health, and patient safety. We were also the second program in the nation to implement a pregnancy policy, protecting sleep in the 2nd and 3rd trimesters of pregnancy. Sleep deprivation in pregnancy is known to increase the risk for preeclampsia and preterm labor, and we want to protect the sleep of pregnant residents to protect their health. Additionally, since I graduated my residency now has an opt-out counselling option for all residents, with trainees automatically enrolled in monthly therapy."

WHAT WOULD YOU TELL YOURSELF AS A THIRD YEAR RESIDENT, IF YOU COULD GO BACK?

"I would remind myself that we experience unique challenges in training, yet rarely talk about these challenges. Regularly witnessing illness, trauma and death is not normal, and can take a toll on our mental health. Sleep deprivation and chronic stress can also take a toll on our physical and mental health. Sleep deprivation is an independent risk factor for anxiety, depression, and suicidal ideation. I would tell any resident that if you find yourself experiencing a decline in your mental health, know that it's not your fault, you don't lack resilience, and you are not weak. This is a result of sleep loss, chronic stress, and witnessing illness and death. Your health is more important than any career, and

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Physician Opportunities

Rural Primary Care

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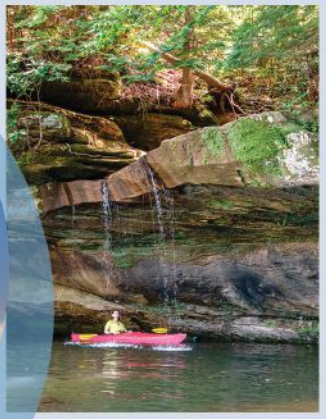

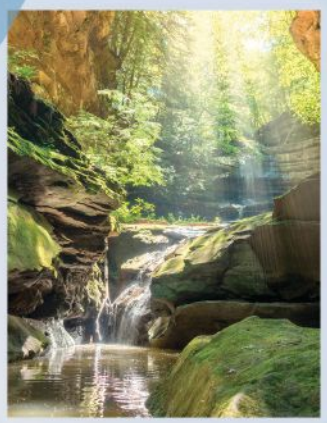

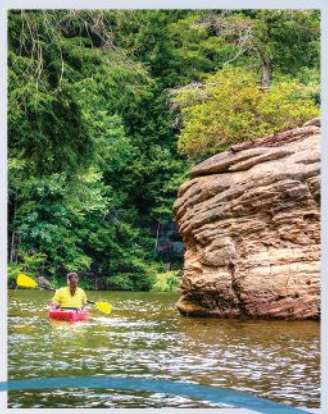

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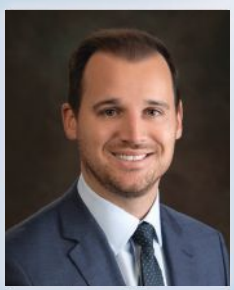

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continued from page 20

seeking support is a sign of strength,"

WHAT DO YOU THINK NEEDS TO CHANGE NEXT TO PROTECT RESIDENT HEALTH AND WELLNESS?

"We need to continue to advocate for the health of trainees at all levels, including the national level. Legislation is being put forward to expand the number of residency slots. Having more residents would allow for night float systems with increased flexibility and more reasonable hours, since staffing limitations are the main reason programs keep 28 hour calls in place.

From the perspective of a fellow, I would hope to see a change in home call systems. Home call does not have the same work hour restrictions as in-house call. This is a huge cause for persistent, continued exhaustion.

Lastly, I am a proponent of reducing all shifts to 16 hours or less, and improving patient sign outs. This reduces fatigue-related medical error and helps protect the mental and physical health of trainees. It also helps reduce the risk for needle sticks and car accidents among residents."

In our conversations, Dr. Vater recommended the book *Why We Sleep* by Matthew Walker, PhD. His writings outline the history of sleep deprivation in the residency training model, which was formed on the basis of the esteemed physician William Stewart Halstead, who founded the surgical training program at Johns Hopkins in 1889. His beliefs that physicians should commit themselves to learning the practice of medicine were influential, setting an example of cocaine-induced wakefulness over many consecutive days. Current ACGME work hour restrictions have limited trainees to 24+4 hours of continuous work. However, this schedule demands more than is acceptable for optimal brain function.

After 22 hours without sleep, human performance is impaired to the same level of someone legally drunk. As it stands, throughout residency, one in five medical residents will make a sleepless-related medical error that will cause significant, liable harm to a patient. The Institute of Medicine (part of the US National Academy of Sciences) has issued a report suggesting that working for more than 16 hours is hazardous for both the patient and the physician. Note that several pilot studies in the US have shown that when resident shifts are limited to no more than 16 hours, with at least 8 hour rest opportunity before shifts, the number of serious medical errors drop by over 20 percent. Looking beyond medical error, a 2014 randomized study demonstrated significantly lower scores of emotional empathy in a sleep deprived group of study participants. A 2018 case control study of over 6000 drivers demonstrated that driving after sleeping less than 7 hours within a 24 hour period is associated with elevated risk of culpable vehicle crash involvement. Those who slept less than 4 hours had 15.1 times the odds of having been culpable for a car crash. Sleep is essential to the safety of our doctors as well as our patients.

As stated by Dr. Vater, we can hope that for future generations of medical trainees, work hours will be restricted to 16 hours per shift at most. Residents would ideally have a rest window to allow for commute, physical activity, adequate nutrition, and family connection in addition to at least 7 hours of restful sleep between shifts. This will help protect the health of residents, as well as patients. In the meantime, we will cope and reach our highest potential within the working conditions outlined for us. We will care for one another, connect amidst the struggle that is medical training, and pause to carefully consider our level of fatigue before driving home after that 24 hour call. We will ask for help, extend a hand when needed, and strive for program level improvement while we wait for systemic change.

The author assumes full responsibility for the ideas and opinions expressed in this article, which should not be considered the opinions of the U.S. Navy or the Department of Defense.

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- 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?

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99 LESSONS LEARNED FROM DISNEY TO IMPROVE THE PATIENT EXPERIENCE

BY JAKE POORE

Anyone who knows my family and me knows that we are Disney fanatics. I do not know how that came to be, but it did. Whether you are or not, I think we can all agree there are many things the Disney Corporation does very well, especially delivering an unforgettable customer experience. During the last two years under the umbrella of the COVID pandemic, we have seen the reluctance of patients to come seek timely medical care. We would like to believe that patients come to see us solely for the quality of care we provide; however, in reality it is a combination of the care and the experience. Research has told us that patients value their experience as a factor in deciding whether or not to seek care and it has also shown us that patients who perceive a better experience are more compliant leading to improved health outcomes. Our goal should not to become Disney or the Ritz-Carlton, but to offer the best experience possible for our patients. As leaders, it is imperative for us to set the conditions within which this can happen, hence my interest in this book.

I wrote my first leadership book series article on Fred Lee's book, If Disney Ran Your Hospital: 9½ Things You Would Do Different. In it, he applied his experiences from Disney to healthcare. It was a fascinating read and I have personally brought several items from that book into places I have led through my career. This past March I had the opportunity to listen in to a virtual talk given by Jake Poore, another former Disney executive now making his career in healthcare helping facilities improve their patient experience. What I found truly fascinating about his talk was how small, simple changes can drastically improve the experience of patients. His new book walks readers through many of these small changes. Most of the concepts are not new, and my rocket scientist brother would probably agree are not rocket science, but warrant revisiting periodically especially as our Military Health System (MHS) is changing in the post-COVID world. For this article, I am going to do something a little different, since this column is about leadership, and focus this article solely on the leadership tips he presents in that section of the book.

One theme that echoes throughout this book, especially in the leadership section, is employee empowerment. Interestingly this was also one of the major themes in Fred Lee's book based on his time at Disney. As leaders, we need to empower our staff to be the one that makes a difference in the patient's experience. This starts with setting Operational Priorities, a prioritized list of what matters to the organization. Does being on time to a meeting matter more than helping a patient find their way through the building or stopping a potential safety issue? After setting Operational Priorities we need to provide our staff a "common set of tools and common language." In military vernacular I see this as Mission Command, giving intent, guidance, and setting right and left limits.

A simple technique that I have used in my career to help empower staff is telling them the why. Mr. Poore comments on this as well in his book. When staff understand the why, they feel more empowered to act. Additionally, letting staff know how their role affects the bigger picture of the organization is important. Studies show that staff satisfaction is higher when they understand their role in the organization. There is the famous story about JFK asking the janitor at NASA what his job was. His response was related to putting people on the moon. In this book, a similar interaction is noted between Dr. Michael DeBakey in Houston and a janitor there. After that interaction, when asked, the janitor's response was "Dr. DeBakey and I save lives." I have personally seen in recent months the value of staff understanding the why and how they fit into the bigger picture.

Studies show that employees can solve 67% of all business problems. The tradition of ringing a bell at the conclusion of cancer treatments, or naming parking lots and numbering the spaces, all came from employees trying to make the patient experience better. Engaging with employees allows us to capitalize on the diversity of thought and ideas present amongst our incredibly diverse staff. Staff have great ideas but frequently do not feel like they can share them. Encourage the sharing of ideas from the end-user level up and ensure that you use your staff for their expertise in their specific role.

Another theme that Mr. Poore explores having to do with employees is recognition. Studies have shown repeatedly that people leave jobs because of their management and the lack of feeling appreciated. Part of that is informing them of their role in the bigger picture of the organization as discussed above. The other piece is recognizing when good things happen. Mr. Poore recommends before visiting an area, call first and find out about good things people

have been doing recently, so that you can recognize them in real time. We typically spend most of our time on visits focusing on what is not working but we need to flip the script to focusing on what is working. Even if something did not go quite right but the intention was sincere, it can be recognized. Mr. Poore calls it "Celebrate the Intent, Coach the Behavior." Publicly celebrate the intent and the motivation of the employee but privately coach them on the result.

Expectation setting is an area in which we can definitely take a lesson from Disney. Disney posts the wait times at every line so you know how long you will be waiting. How long should our patients wait after checking in? Did you know that in Section 32 of the Code of Federal Regulations there is a legal standard that our patients wait no longer than 30 minutes after checking in? I do not believe our patients know; however, it is a question on the JOES survey. Much has been written about expectation management especially in the restaurant sector. Restaurants typically tell you a time beyond when they expect to seat you so that, upon seating you sooner they exceed your expectations. They also fill the walls of the waiting area with paraphernalia to try to distract you so time seems to move faster. While we cannot do exactly this in healthcare, we can set expectations with our patients. A simple and cheap way is to put up a board on the wall listing all providers and whether they are on-time or delayed. Even without a board this is easy by having someone periodically go through the waiting area and letting waiting patients know of the delays and the why if appropriate. Research has shown that patients generally do not mind the wait, what they mind is no one telling them or keeping them updated. Simple interventions to improve the patient experience.

Lastly, ensure that not only you but all of your leaders are personally setting the example. I consider integrity to be one of the most important leadership characteristics. I define integrity as doing the right thing even if no one is watching. Mr. Poore refers to it as ownership. He says, "If you see it, hear it, or smell it – you own it." This behavior needs to be modeled by leaders first and foremost and staff will adopt it.

In conclusion, I hope you appreciate the revisiting of these simple concepts for leading to improve the patient experience. As I stated above, they are not rocket science but still not something we tend to do well in many of our clinics. This article has focused on leading to improve the patient experience but I want to ask you to consider it more customer experience than simply patient. Changing the mindset to customer experience brings in the satisfaction of our staff who are also our customer. Many of the ideas discussed above will improve the customer experience, not just the patient. Finally, I would like to challenge you, as leaders in our MHS, to change one thing that improve the experience of patients and/or staff within the next 3 months. It does take some time but in my opinion, it is well worth it. Thanks for reading.

Lead, Equip, Advance
LEADER AND FACULTY DEVELOPMENT FELLOWSHIP

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Whether serving as a clinic OIC, command surgeon, or as residency faculty, military medical officers need skills to be effective team leaders. Medicine is a team sport and overwhelming evidence supports that highly functional teams achieve the best clinical results. Team-based care in a patient-centered medical home reduces cardiovascular mortality for diabetic patients. An interdisciplinary team in a hospital works together to resuscitate the patient in cardiac arrest. Teamwork is ubiquitous in healthcare, and doctors often lead a multidisciplinary team of highly skilled health professionals. Too often leadership in medicine is learned through observation as part of the hidden curriculum. To be effective team leaders, physicians must deliberately develop these skills and teach them to learners.

THE LEADER'S ROLE

The role of the leader of the healthcare team is crucial to providing high quality and safe patient care. The Agency for Healthcare Research and Quality (AHRQ) recognizes the need for effective teams in medicine and the development of leadership skills. Through TeamSTEPPS, a course developed collaboratively with the Department of Defense, AHRQ is improving patient safety by building leadership capacity and explicitly defining the role of the leader in the healthcare setting. Leaders have two essential responsibilities to the team. First, leaders provide clarity of purpose that allows the team to be focused and accountable. Second, they are responsible for cultivating an environment that allows the team to work most effectively.

CLARITY OF PURPOSE

Purpose and shared understanding motivate teams to innovate and work collaboratively. To be effective, perform optimally, and achieve success team members need to know why they exist as a team and as an organization. It is the team leader's responsibility to clearly communicate the organization's purpose. Consider a clinic team preparing for a Joint Commission visit. How the leader communicates purpose will determine the level of success and the longevity of the results. If the team sees its purpose as simply to pass an inspection, people avoid failure by limiting their actions to finding irregularities and checking the box. However, if the team believes they exist to ensure safe and high-quality care, each person will take the initiative to achieve this by developing long-term solutions to systems-based problems. In his book, Start with Why, Simon Sinek says, "people don't buy WHAT you do, but WHY you do it." It

is this understanding of the "why" that inspires teams to take small steps towards a larger goal. By clearly defining the team's purpose, the leader keeps the group focused on the core mission. An understanding of the shared purpose allows team members, without explicit direction, to take individual initiative in their scope of practice and area of responsibility. Leaders paint the big picture or describe the broader context to create a shared purpose which ensures individual actions move teams towards the organizational vision.

To develop trust, leaders must show consistency in their words and actions with the organization's purpose. According to Sinek, this consistency of what leaders do with the "why" of the organization is what lends to the leader's authenticity. A battalion surgeon is responsible for mentoring and coaching a team of medics, who pay close attention to consistency between words and actions of the leader. What medics hear and see the doc doing daily translates into how they take care of patients. This credibility and authenticity allow the leader and the team to have influence beyond its footprint. Commanders and senior enlisted leaders trust and seek out the medical officer's advice if they see consistency in the medical team's actions with mission of the unit. When a team understands why it exists, believes in its mission, and the leader's actions are consistent with his or her words, they will achieve the best medical readiness and clinical results. But all this starts with the leader first believing in the organization's "why" and conveying a clear purpose to the team.

A CULTURE THAT SUPPORTS TEAMWORK

Leaders have a responsibility to ensure that the team's culture values individual efforts and team success. They must model behavior that shows appreciation of their teammates' effort and achievement. Creating a sense of belonging and a shared purpose gives people a sense of worth that motivates more than monetary incentives. A sense of relevance and belonging enables teams to thrive in times of high stress. Despite many hardships while deployed, service members often consider their time away from loved ones and comforts of home worthwhile. Undoubtedly, it is the shared purpose and the sense of belonging that makes these sacrifices rewarding.

In *Team of Teams*, General McChrystal points out that "trust affirms purpose, and purpose affirms trust, and together they forge the individual into working teams." This is at the heart of how a leader ensures an environment that develops others and produces results. McChrystal compares leaders in complex environments to a gardener that cultivates the soil, weeds, and waters the plants. Conversely in the command-and-control model, the leader is seen confidently providing direction based on his or her experience and knowledge. The team largely feeds information to the leader and implements the plan under his guidance. Although successful in some situations, this approach is less likely to bear fruit in more complex and dynamic environments. McChrystal points out that it is the plant that produces fruit, not the gardener. The leader's focus is on the team's overall well-being, and ensures that each individual member is respected, develops and grows, and bears fruit.

In the traditional leadership model, a faculty physician on an inpatient team is seen as the purveyor of knowledge and direction. Under this direction, a team of residents and students will implement the plan. But an attending physician's most important job is to create the climate that optimizes learning and patient care. He or she is ultimately responsible for the psychological safety of the team. For example, by establishing ground rules for rounding, the attending can ensure that each member feels safe to share their concerns and points of view. When differing opinions are respected and acknowledged, the entire team, especially students and junior residents feel open to share their ideas and talk about doubts without fear of a negative reaction. This is essential for learning to occur, creativity to thrive, and crucial for patient safety. The leader fosters the environment, so each team member feels that their work is valued. Residents and students are less likely to burn out if they have a sense of belonging to a team that values their work. The moral injury that so many in health care regularly face is because they feel isolated, undervalued, and their efforts are not consistent with the purpose that brought them to medicine as a career. The attending physician who tends to the team's environment, will safeguard people from burnout and ensures individual growth and team success. More than issuing orders, the leader's responsibility is to care for the team, which in turn cares for the patient.

NEVER MORE CRUCIAL

The clear purpose in military medicine can be hazy when our teams are supporting COVID-19 missions across the nation, caring for refugees, providing disaster relief worldwide, and all the while maintaining medically ready forces for a more lethal near-peer adversary. The role of "leader" on a clinical team has never been more crucial. We owe our teams clarity of purpose and a climate in which they are valued, and our actions must be in line with our mission. Trust and a shared purpose go hand in hand for healthcare teams to achieve the best clinical outcomes and highest readiness of the force.

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Dismantling Anti-Black Racism in Medicine

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The murders of George Floyd and countless other members of the Black community by police prompted family medicine journals and professional societies to publish antiracism statements that provide actions, plans, and accountability structures to eliminate systemic anti-Black racism in medicine.[1,2] Health disparities in cancer outcomes, diabetes mellitus management, and pain treatment are evidence of the results of systemic anti-Black racism in medicine.[3] Other examples include exclusionary practices such as fewer patients who are Black receiving organ transplants[4] and disrespect toward women who are Black[5] (e.g., mistreatment during childbirth,[6,7] the death of family physician Dr. Susan Moore[8]).

Anti-Black racism is perpetuated by the limited compositional diversity of health systems, and racism happens in the absence of overtly racist people.[9-11] Policies regarding promotion, hiring, access to resources, and assigning value to work that advantages White people and disadvantages Black people (and other people of color) are the hallmark of systemic anti-Black racism.[12] Such policies similarly affect the medical community, with fewer opportunities available to physicians, residents, and students who are Black. The resulting diminished supply of Black physicians negatively impacts the care family physicians provide to Black patients,[13] and increasing the number of physicians who are Black has been identified as a means to eliminate health disparities.[3] *Table 1* outlines specific actions that physicians can take to eliminate systemic anti-Black racism.[10,13-18]

TABLE 1

Individual Actions That Physicians Can Take to Eliminate Systemic Anti-Black Racism

Problem	Individual action
Anti-Black racism contributes to the disproportionate prevalence of Black patients who are uninsured and enrolled in Medicaid.[14]	Choose to work in practices that serve patients enrolled in Medicaid and patients who are uninsured, and make changes to private practices to ensure that Black patients in these categories are served well. Advocate for higher reimbursement for physicians, more generous Medicaid income cutoffs, and Affordable Care Act Medicaid expansion.
Anti-Black racism and White privilege silence the voices of Black members of our society.	Apply an antiracist equity lens and advocate for systematic changes in our society to address systemic anti-Black racism, which is a significant cause of inequities in social determinants of health and health disparities.[15] Recognize that White privilege advantages some and disadvantages others, and speak out to include Black colleagues in decision-making.[15]
Medical students who are Black experience a lack of opportunities and more mistreatment.[16]	Use physician offices as pathways to opportunity and to level the playing field for students who are Black. Many of these students are our patients, and family physicians should encourage them in their professional growth.
The lack of physicians who are Black and in leadership is evidence of systemic anti-Black racism in medicine and its profound impact on decision-making.[10]	Influence local hospital medical staff and professional societies to actively recruit Black physicians, and encourage Black physicians to become active members and move into leadership positions. Seek opportunities to collaborate with student organizations such as the Student National Medical Association and add Black voices to efforts to serve the Black community.
Systemic anti-Black racism and White privilege get their power from the denial of their existence.[13]	Seek education on the roots of systemic and institutionalized racism in the United States, learn from others who have experienced the effects of racism, and then actively share this knowledge with others. The medical literature has multiple articles on what practicing physicians can do[13,15] and where they can learn about systemic anti-Black racism.[17,18] Professional organizations can provide CME on eliminating the systemic anti-Black racism that is pervasive in the recruitment and hiring of physicians and its foundational role in health inequities.

Information from references 10 and 13-18.

Systemic anti-Black racism is pervasive; therefore, antiracism needs to be pervasive to combat it. Antiracism is more than abandoning racist attitudes and practices; it is identifying anti-Black racism and undoing it. Family physicians can adopt antiracist attitudes such as identifying policies, not people, as the problem, celebrating racial differences, confessing when we are racist, and believing we can overcome racism.[19] Family physicians can move initiatives from web pages to actions by participating in these initiatives, and we can use our influence as physicians to seek out and dismantle systemic anti-Black racism. Small, individual actions collectively have a large impact on creating a more equitable society for everyone.

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AFP Editorial:

DISMANTLING ANTI-BLACK RACISM IN MEDICINE

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In the reprint on pages 30-31 of the editorial in the December 2021 edition of American Family Physician, written by Dr. José Rodriguez, Dr. Kendall Campbell and Dr. Judy Washington, a summary of 5 key problems and individual actions that can be used to help eliminate systemic anti-black racism was given.

I wish to highlight some ways that the 5 key problems and individual actions can be applied to our practices in military medicine.

"Small individual actions collectively have a large impact on creating a more equitable society for everyone"
- Dr. Rodriguez, Dr. Campbell, Dr. Washington

Problem #1, which addresses disproportionate prevalence of Black patients who are uninsured or on Medicaid, may be a challenge to frame in military medicine, as we are a single payer, universal healthcare, but I would encourage the military specific individual action to look at barriers to seeking healthcare, which may be rooted in Anti-Black Racism.

Problem #2, which addresses White privilege, charges individuals to apply an antiracist lens and advocate for systemic changes. I would encourage our membership to look at social determinants of health with our patients, and try to address these factors. This individual action also calls those of us who are White to recognize our White privilege advantages, and recognize those who are Black may not have had disadvantages we did not experience. Getting the first-person narrative from someone with a lived experience is key in any systemic changes.

Problem #3, which addresses the problem of lack of opportunities and more mistreatment in medical students who are Black, calls for the individual action to recruit students who are Black and to mentor them into the field of medicine. The lack of diversity of Black physicians has been seen across the services, and as practicing physicians, we need to strive to achieve a physician pool that more closely mirrors the diversity of our patients.

Problem #4, which addresses the lack of physicians who are Black in leadership positions, calls for the individual action to actively recruit, mentor and sponsor physicians who are Black into leadership positions. It also calls for collaboration with the student organizations, such as Student National Medical Association, to increase the representation of Black voices.

Problem #5, which addresses how the denial of systemic anti-Black racism and White privilege given them power, and charges us with the individual action to education ourselves and those under our education to the roots of systemic racism in the U.S. and learn from the first-person accounts of those who have experienced the effects. The military branches and the graduate medical education programs have begun addressing some of these roots with professional military education and continuing medical education. I implore us to continue to find ways to discuss the past medical disparities to try to aim towards a more equitable future.

In summary, the authors point out that due to the pervasiveness of anti-Black racism in medicine, the anti-racism needs to be equally pervasive.

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  Rapid improvement in glucose control has been associated with a temporary worsening of diabetic retinopathy. Patients with a history of diabetic retinopathy should be monitored for progression of diabetic retinopathy

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Patients are waking up to a type 2 diabetes treatment that may help them meet their A1C goals

From baseline to Week 26,
Compared to Januvia®, RYBELSUS® delivered

Superior A1C reductions[1,2]

Mean change in A1C **Primary endpoint**

-1.3% RYBELSUS® 14 mg (n=465; Baseline: 8.3%; $p<0.001$)

-1.0% RYBELSUS® 7 mg (n=465; Baseline: 8.4%; $p<0.001$)

-0.8% Januvia® 100 mg (n=467; Baseline: 8.3%)

Superior weight reductions[1,2]

Mean change in body weight **Confirmatory secondary endpoint**

-6.8 lb on RYBELSUS® 14 mg (n=465; Baseline: 201 lb; ETD -5.5 lb; [95% CI; -6.6, -4.4])

-4.8 lb on RYBELSUS® 7 mg (n=465; Baseline: 201 lb; ETD -3.5 lb; [95% CI; -4.4, -2.4])

-1.3 lb on Januvia® 100 mg (n=467; Baseline: 200 lb)

RYBELSUS® is not indicated for weight loss.

ETD=estimated treatment difference.

See Study Design below.

No dosage adjustment for[1]:

- **Patients aged ≥65 years:** No overall differences in safety or efficacy were detected between these patients and younger patients, but greater sensitivity of some older individuals cannot be ruled out
- **Hepatic impairment:** In a study in subjects with different degrees of hepatic impairment, no clinically relevant change in semaglutide pharmacokinetics (PK) was observed
- **Renal impairment:** In patients with renal impairment, including end-stage renal disease (ESRD), no clinically relevant change in semaglutide PK was observed

Please see Important Safety Information below regarding Acute Kidney Injury.

To learn more, visit RYBELSUSpro.com

- **Hypoglycemia:** Patients receiving RYBELSUS® in combination with an insulin secretagogue (e.g., sulfonylurea) or insulin may have an increased risk of hypoglycemia, including severe hypoglycemia. The risk of hypoglycemia may be lowered by a reduction in the dose of sulfonylurea (or other concomitantly administered insulin secretagogue) or insulin. Inform patients using these concomitant medications of the risk of hypoglycemia and educate them on the signs and symptoms of hypoglycemia
- **Acute Kidney Injury:** There have been postmarketing reports of acute kidney injury and worsening of chronic renal failure, which may sometimes require hemodialysis, in patients treated with GLP-1 receptor agonists, including semaglutide. Some of these events have been reported in patients without known underlying renal disease. A majority of the reported events occurred in patients who had experienced nausea, vomiting, diarrhea, or dehydration. Monitor renal function when initiating or escalating doses of RYBELSUS® in patients reporting severe adverse gastrointestinal reactions
- **Hypersensitivity:** Serious hypersensitivity reactions (e.g., anaphylaxis, angioedema) have been reported in patients treated with RYBELSUS®. If hypersensitivity reactions occur, discontinue use of RYBELSUS®, treat promptly per standard of care, and monitor until signs and symptoms resolve. Use caution in a patient with a history of angioedema or anaphylaxis with another GLP-1 receptor agonist

Adverse Reactions

- The most common adverse reactions, reported in ≥5% of patients treated with RYBELSUS® are nausea, abdominal pain, diarrhea, decreased appetite, vomiting and constipation

Drug Interactions

- When initiating RYBELSUS®, consider reducing the dose of concomitantly administered insulin secretagogue (such as sulfonylureas) or insulin to reduce the risk of hypoglycemia
- RYBELSUS® delays gastric emptying and has the potential to impact the absorption of other oral medications. Closely follow RYBELSUS® administration instructions when coadministering with other oral medications and consider increased monitoring for medications with a narrow therapeutic index, such as levothyroxine

Study Design

PIONEER 3: Head-to-head vs Januvia®

In a double-blind, double-dummy trial with a primary endpoint of mean change in A1C from baseline to 26 weeks, 1864 adult patients with type 2 diabetes on metformin alone or metformin with a sulfonylurea were randomized to RYBELSUS® 3 mg (n=466), RYBELSUS® 7 mg (n=465), RYBELSUS® 14 mg (n=465), or Januvia® 100 mg (n=467), all once daily.[1,2]

To learn more, visit **RYBELSUSpro.com**

References: 1. RYBELSUS® [package insert]. Plainsboro, NJ: Novo Nordisk Inc; April 2021. **2.** Rosenstock J, Allison D, Birkenfeld AL, et al. Effect of additional oral semaglutide vs sitagliptin on glycated hemoglobin in adults with type 2 diabetes uncontrolled with metformin alone or with sulfonylurea: the PIONEER 3 randomized clinical trial. *JAMA*. 2019;321(15):1466-1480.

Please see additional Important Safety Information in the Brief Summary of the Prescribing Information, including Boxed Warning, on the following pages.

RYBELSUS® semaglutide tablets 7mg | 14mg

RYBELSUS® (semaglutide) tablets

Rx Only

BRIEF SUMMARY: Please consult package insert for full prescribing information.

WARNING: RISK OF THYROID C-CELL TUMORS: In rodents, semaglutide causes dose-dependent and treatment-duration-dependent thyroid C-cell tumors at clinically relevant exposures. It is unknown whether RYBELSUS® causes thyroid C-cell tumors, including medullary thyroid carcinoma (MTC), in humans as human relevance of semaglutide-induced rodent thyroid C-cell tumors has not been determined *[see Warnings and Precautions]*. RYBELSUS® is contraindicated in patients with a personal or family history of MTC or in patients with Multiple Endocrine Neoplasia syndrome type 2 (MEN 2) *[see Contraindications]*. Counsel patients regarding the potential risk for MTC with the use of RYBELSUS® and inform them of symptoms of thyroid tumors (e.g. a mass in the neck, dysphagia, dyspnea, persistent hoarseness). Routine monitoring of serum calcitonin or using thyroid ultrasound is of uncertain value for early detection of MTC in patients treated with RYBELSUS® *[see Contraindications and Warnings and Precautions]*.

INDICATIONS AND USAGE: RYBELSUS® is indicated as an adjunct to diet and exercise to improve glycemic control in adults with type 2 diabetes mellitus. Limitations of Use: RYBELSUS® is not recommended as a first-line therapy for patients who have inadequate glycemic control on diet and exercise because of the uncertain relevance of rodent C-cell tumor findings to humans *[see Warnings and Precautions]*. RYBELSUS® has not been studied in patients with a history of pancreatitis. Consider other antidiabetic therapies in patients with a history of pancreatitis *[see Warnings and Precautions]*. RYBELSUS® is not indicated for use in patients with type 1 diabetes mellitus.

CONTRAINDICATIONS: RYBELSUS® is contraindicated in patients with: A personal or family history of medullary thyroid carcinoma (MTC) or in patients with Multiple Endocrine Neoplasia syndrome type 2 (MEN 2) *[see Warnings and Precautions]*. A prior serious hypersensitivity reaction to semaglutide or to any of the excipients in RYBELSUS®. Serious hypersensitivity reactions including anaphylaxis and angioedema have been reported with RYBELSUS® *[see Warnings and Precautions]*.

WARNINGS AND PRECAUTIONS: Risk of Thyroid C-Cell Tumors: In mice and rats, semaglutide caused a dose-dependent and treatment-duration-dependent increase in the incidence of thyroid C-cell tumors (adenomas and carcinomas) after lifetime exposure at clinically relevant plasma exposures. It is unknown whether RYBELSUS® causes thyroid C-cell tumors, including medullary thyroid carcinoma (MTC), in humans as human relevance of semaglutide-induced rodent thyroid C-cell tumors has not been determined. Cases of MTC in patients treated with liraglutide, another GLP-1 receptor agonist, have been reported in the postmarketing period; the data in these reports are insufficient to establish or exclude a causal relationship between MTC and GLP-1 receptor agonist use in humans. RYBELSUS® is contraindicated in patients with a personal or family history of MTC or in patients with MEN 2. Counsel patients regarding the potential risk for MTC with the use of RYBELSUS® and inform them of symptoms of thyroid tumors (e.g., a mass in the neck, dysphagia, dyspnea, persistent hoarseness). Routine monitoring of serum calcitonin or using thyroid ultrasound is of uncertain value for early detection of MTC in patients treated with RYBELSUS®. Such monitoring may increase the risk of unnecessary procedures, due to the low test specificity for serum calcitonin and a high background incidence of thyroid disease. Significantly elevated serum calcitonin value may indicate MTC and patients with MTC usually have calcitonin values >50 ng/L. If serum calcitonin is measured and found to be elevated, the patient should be further evaluated. Patients with thyroid nodules noted on physical examination or neck imaging should also be further evaluated. **Pancreatitis:** In glycemic control trials, pancreatitis was reported as a serious adverse event in 6 RYBELSUS®-treated patients (0.1 events per 100 patient years) versus 1 in comparator-treated patients (<0.1 events per 100 patient years). After initiation of RYBELSUS®, observe patients carefully for signs and symptoms of pancreatitis (including persistent severe abdominal pain, sometimes radiating to the back and which may or may not be accompanied by vomiting). If pancreatitis is suspected, RYBELSUS® should be discontinued and appropriate management initiated; if confirmed, RYBELSUS® should not be restarted. **Diabetic Retinopathy Complications:** In a pooled analysis of glycemic control trials with RYBELSUS®, patients reported diabetic retinopathy related adverse reactions during the trial (4.2% with RYBELSUS® and 3.8% with comparator). In a 2-year cardiovascular outcomes trial with semaglutide injection involving patients with type 2 diabetes and high cardiovascular risk, diabetic retinopathy complications (which was a 4 component adjudicated endpoint) occurred in patients treated with semaglutide injection (3.0%) compared to placebo (1.8%). The absolute risk increase for diabetic retinopathy complications was larger among patients with a history of diabetic retinopathy at baseline (semaglutide injection 8.2%, placebo 5.2%) than among patients without a known history of diabetic retinopathy (semaglutide injection 0.7%, placebo 0.4%). Rapid improvement in glucose control has been associated with a temporary worsening of diabetic retinopathy. The effect of long-term glycemic control with semaglutide on diabetic retinopathy complications has not been studied. Patients with a history of diabetic retinopathy should be monitored for progression of diabetic retinopathy. **Hypoglycemia with Concomitant Use of Insulin Secretagogues or Insulin:** Patients receiving RYBELSUS® in combination with an insulin secretagogue (e.g., sulfonylurea) or insulin may have an increased risk of hypoglycemia, including severe hypoglycemia *[see Adverse Reactions, Drug Interactions]*. The risk of hypoglycemia may be lowered by a reduction in the dose of sulfonylurea (or other concomitantly administered insulin secretagogue) or insulin. Inform patients using these concomitant medications of the risk of hypoglycemia and educate them on the signs and symptoms of hypoglycemia. **Acute Kidney Injury:** There have been postmarketing reports of acute kidney injury and worsening of chronic renal failure, which may sometimes require hemodialysis, in patients treated with GLP-1 receptor agonists, including semaglutide. Some of these events have been reported in patients without known underlying renal disease. A majority of the reported events occurred in patients who had experienced nausea, vomiting, diarrhea, or dehydration. Monitor renal function when initiating or escalating doses of RYBELSUS® in patients reporting severe adverse gastrointestinal reactions. **Hypersensitivity:** Serious hypersensitivity reactions (e.g., anaphylaxis, angioedema) have been reported in patients treated with RYBELSUS®. If hypersensitivity reactions occur, discontinue use of RYBELSUS®; treat promptly per standard of care, and monitor until signs and symptoms resolve. Do not use in patients with a previous hypersensitivity to RYBELSUS® *[see Contraindications and Adverse Reactions]*. Anaphylaxis and angioedema have been reported with GLP-1 receptor agonists. Use caution in a patient with a history of angioedema or anaphylaxis with another GLP-1 receptor agonist because it is unknown whether such patients will be predisposed to anaphylaxis with RYBELSUS®.

ADVERSE REACTIONS: The following serious adverse reactions are described below or elsewhere in the prescribing information: Risk of Thyroid C-cell Tumors *[see Warnings and Precautions];* Pancreatitis *[see Warnings and Precautions];* Diabetic Retinopathy Complications *[see Warnings and Precautions];* Hypoglycemia with Concomitant Use of Insulin Secretagogues or Insulin *[see Warnings and Precautions];* Acute Kidney Injury *[see Warnings and Precautions];* Hypersensitivity *[see Warnings and Precautions]*. **Clinical Trials Experience:** Because clinical trials are conducted under widely varying conditions, adverse reaction rates observed in the clinical trials of a drug cannot be directly compared to rates in the clinical trials of another drug and may not reflect the rates observed in practice. Pool of Placebo-Controlled Trials: The data in Table 1 are derived from 2 placebo-controlled trials in patients with type 2 diabetes. These data reflect exposure of 1071 patients to RYBELSUS® with a mean duration of exposure of 41.8 weeks. The mean age of patients was 58 years, 3.9% were 75 years or older and 52% were male. In these trials, 63% were White, 6% were Black or African American, and 27% were Asian; 19% identified as Hispanic or Latino ethnicity. At baseline, patients had type 2 diabetes for an average of 9.4 years and had a mean HbA_{1c} of 8.1%. At baseline, 20.1% of the population reported retinopathy. Baseline estimated renal function was normal (eGFR ≥90 mL/min/1.73m^2) in 66.2%, mildly impaired (eGFR 60 to 90 mL/min/1.73m^2) in 32.4% and moderately impaired (eGFR 30 to 60 mL/min/1.73m^2) in 1.4% of patients. Pool of Placebo- and Active-Controlled Trials: The occurrence of adverse reactions was also evaluated in a larger pool of patients with type 2 diabetes participating in 9 placebo- and active-controlled trials. In this pool, 4116 patients with type 2 diabetes were treated with RYBELSUS® for a mean duration of 59.8 weeks. The mean age of patients was 58 years, 5% were 75 years or older and 55% were male. In these trials, 65% were White, 6% were Black or African American, and 24% were Asian; 15% identified as Hispanic or Latino ethnicity. At baseline, patients had type 2 diabetes for an average of 8.8 years and had a mean HbA_{1c} of 8.2%. At baseline, 16.6% of the population reported retinopathy. Baseline estimated renal function was normal (eGFR ≥90 mL/min/1.73m^2) in 65.9%, mildly impaired (eGFR 60 to 90 mL/min/1.73m^2) in 28.5%, and moderately impaired (eGFR 30 to 60 mL/min/1.73m^2) in 5.4% of the patients. Common Adverse Reactions: Table 1 shows common adverse reactions, excluding hypoglycemia, associated with the use of RYBELSUS® in the pool of placebo-controlled trials. These adverse reactions occurred more commonly on RYBELSUS® than on placebo and occurred in at least 5% of patients treated with RYBELSUS®.

Table 1. Adverse Reactions in Placebo-Controlled Trials Reported in ≥5% of RYBELSUS®-Treated Patients with Type 2 Diabetes Mellitus

Adverse Reaction	Placebo (N=362) %	RYBELSUS® 7 mg (N=356) %	RYBELSUS® 14 mg (N=356) %
Nausea	6	11	20
Abdominal Pain	4	10	11
Diarrhea	4	9	10
Decreased appetite	1	6	9
Vomiting	3	6	8
Constipation	2	6	5

In the pool of placebo- and active-controlled trials, the types and frequency of common adverse reactions, excluding hypoglycemia, were similar to those listed in Table 1.

Gastrointestinal Adverse Reactions: In the pool of placebo-controlled trials, gastrointestinal adverse reactions occurred more frequently among patients receiving RYBELSUS® than placebo (placebo 21%, RYBELSUS® 7 mg 32%, RYBELSUS® 14 mg 41%). The majority of reports of nausea, vomiting, and/or diarrhea occurred during dose escalation. More patients receiving RYBELSUS® 7 mg (4%) and RYBELSUS® 14 mg (8%) discontinued treatment due to gastrointestinal adverse reactions than patients receiving placebo (1%). In addition to the reactions in Table 1, the following gastrointestinal adverse reactions with a frequency of <5% were associated with RYBELSUS® (frequencies listed, respectively, as placebo; 7 mg; 14 mg): abdominal distension (1%, 2%, 3%), dyspepsia (0.6%, 3%, 0.6%), eructation (0%, 0.6%, 2%), flatulence (0%, 2%, 1%), gastroesophageal reflux disease (0.3%, 2%, 2%), and gastritis (0.8%, 2%, 2%). Other Adverse Reactions: *Hypoglycemia:* Table 2 summarizes the incidence of hypoglycemia by various definitions in the placebo-controlled trials.

Table 2. Hypoglycemia Adverse Reactions in Placebo-Controlled Trials In Patients with Type 2 Diabetes Mellitus

	Placebo	RYBELSUS® 7 mg	RYBELSUS® 14 mg
Monotherapy			
(26 weeks)	**N=178**	**N=175**	**N=175**
Severe*	0%	1%	0%
Plasma glucose <54 mg/dL	1%	0%	0%

Add-on to metformin and/or sulfonylurea, basal insulin alone or metformin in combination with basal insulin in patients with moderate renal impairment			
(26 weeks)	**N=161**	**–**	**N=163**
Severe*	0%	–	0%
Plasma glucose <54 mg/dL	3%	–	6%
Add-on to insulin with or without metformin			
(52 weeks)	**N=184**	**N=181**	**N=181**
Severe*	1%	0%	1%
Plasma glucose <54 mg/dL	32%	26%	30%

*"Severe" hypoglycemia adverse reactions are episodes requiring the assistance of another person.

Hypoglycemia was more frequent when RYBELSUS® was used in combination with insulin secretagogues (e.g., sulfonylureas) or insulin. Increases in Amylase and Lipase: In placebo-controlled trials, patients exposed to RYBELSUS® 7 mg and 14 mg had a mean increase from baseline in amylase of 10% and 13%, respectively, and lipase of 30% and 34%, respectively. These changes were not observed in placebo-treated patients. Cholelithiasis: In placebo-controlled trials, cholelithiasis was reported in 1% of patients treated with RYBELSUS® 7 mg. Cholelithiasis was not reported in RYBELSUS® 14 mg or placebo-treated patients. Increases in Heart Rate: In placebo-controlled trials, RYBELSUS® 7 mg and 14 mg resulted in a mean increase in heart rate of 1 to 3 beats per minute. There was no change in heart rate in placebo-treated patients. **Immunogenicity:** Consistent with the potentially immunogenic properties of protein and peptide pharmaceuticals, patients treated with RYBELSUS® may develop anti-semaglutide antibodies. The detection of antibody formation is highly dependent on the sensitivity and specificity of the assay. Additionally, the observed incidence of antibody (including neutralizing antibody) positivity in an assay may be influenced by several factors including assay methodology, sample handling, timing of sample collection, concomitant medications, and underlying disease. For these reasons, the incidence of antibodies to semaglutide in the studies described below cannot be directly compared with the incidence of antibodies in other studies or to other products. Across the placebo- and active-controlled glycemic control trials with antibody measurements, 14 (0.5%) RYBELSUS®-treated patients developed anti-drug antibodies (ADAs) to the active ingredient in RYBELSUS® (i.e., semaglutide). Of the 14 semaglutide-treated patients that developed semaglutide ADAs, 7 patients (0.2% of the overall population) developed antibodies cross-reacting with native GLP-1. The neutralizing activity of the antibodies is uncertain at this time. **Postmarketing Experience:** The following adverse reactions have been reported during post-approval use of semaglutide, the active ingredient of RYBELSUS®. Because these reactions are reported voluntarily from a population of uncertain size, it is not always possible to reliably estimate their frequency or establish a causal relationship to drug exposure. *Hypersensitivity:* anaphylaxis, angioedema, rash, urticaria

DRUG INTERACTIONS: Concomitant Use with an Insulin Secretagogue (e.g., Sulfonylurea) or with Insulin: When initiating RYBELSUS®, consider reducing the dose of concomitantly administered insulin secretagogue (such as sulfonylureas) or insulin to reduce the risk of hypoglycemia *[see Warnings and Precautions and Adverse Reactions]*. **Oral Medications:** RYBELSUS® causes a delay of gastric emptying, and thereby has the potential to impact the absorption of other oral medications. Levothyroxine exposure was increased 33% (90% CI: 125-142) when administered with RYBELSUS® in a drug interaction study. When coadministering oral medications instruct patients to closely follow RYBELSUS® administration instructions. Consider increased clinical or laboratory monitoring for medications that have a narrow therapeutic index or that require clinical monitoring.

USE IN SPECIFIC POPULATIONS: Pregnancy: Risk Summary: Available data with RYBELSUS® use in pregnant women are insufficient to evaluate for a drug-associated risk of major birth defects, miscarriage or other adverse maternal or fetal outcomes. There are clinical considerations regarding the risks of poorly controlled diabetes in pregnancy *(see Clinical Considerations)*. Based on animal reproduction studies, there may be potential risks to the fetus from exposure to RYBELSUS® during pregnancy. RYBELSUS® should be used during pregnancy only if the potential benefit justifies the potential risk to the fetus. In pregnant rats administered semaglutide during organogenesis, embryofetal mortality, structural abnormalities and alterations to growth occurred at maternal exposures below the maximum recommended human dose (MRHD) based on AUC. In rabbits and cynomolgus monkeys administered semaglutide during organogenesis, early pregnancy losses and structural abnormalities were observed at exposure below the MRHD (rabbit) and ≥10-fold the MRHD (monkey). These findings coincided with a marked maternal body weight loss in both animal species *(see Data)*. The estimated background risk of major birth defects is 6–10% in women with pre-gestational diabetes with an HbA_{1c} >7 and has been reported to be as high as 20–25% in women with a HbA_{1c} >10. In the U.S. general population, the estimated background risk of major birth defects and miscarriage in clinically recognized pregnancies is 2-4% and 15-20%, respectively. Clinical Considerations: *Disease associated maternal and fetal risk:* Poorly controlled diabetes during pregnancy increases the maternal risk for diabetic ketoacidosis, pre-eclampsia, spontaneous abortions, preterm delivery, and delivery complications. Poorly controlled diabetes increases the fetal risk for major birth defects, stillbirth, and macrosomia related morbidity. Data: *Animal Data:* In a combined fertility and embryofetal development study in rats, subcutaneous doses of 0.01, 0.03 and 0.09 mg/kg/day (0.2-, 0.7-, and 2.1-fold the MRHD) were administered to males for 4 weeks prior to and throughout mating and to females for 2 weeks prior to mating, and throughout organogenesis to Gestation Day 17. In parental animals, pharmacologically mediated reductions in body weight gain and food consumption were observed at all dose levels. In the offspring, reduced growth and fetuses with visceral (heart blood vessels) and skeletal (cranial bones, vertebra, ribs) abnormalities were observed at the human exposure. In an embryofetal development study in pregnant rabbits, subcutaneous doses of 0.0010, 0.0025 or 0.0075 mg/kg/day (0.06-, 0.6-, and 4.4-fold the MRHD) were administered throughout organogenesis from Gestation Day 6 to 19. Pharmacologically mediated reductions in maternal body weight gain and food consumption were observed at all dose levels. Early pregnancy losses and increased incidences of minor visceral (kidney, liver) and skeletal (sternebra) fetal abnormalities were observed at ≥0.0025 mg/kg/day, at clinically relevant exposures. In an embryofetal development study in pregnant cynomolgus monkeys, subcutaneous doses of 0.015, 0.075, and 0.15 mg/kg twice weekly (1.9-, 9.9-, and 29-fold the MRHD) were administered throughout organogenesis, from Gestation Day 16 to 50. Pharmacologically mediated, marked initial maternal body weight loss and reductions in body weight gain and food consumption coincided with the occurrence of sporadic abnormalities (vertebra, sternebra, ribs) at ≥0.075 mg/kg twice weekly (≥9X human exposure). In a pre- and postnatal development study in pregnant cynomolgus monkeys, subcutaneous doses of 0.015, 0.075, and 0.15 mg/kg twice weekly (1.3-, 6.4-, and 14-fold the MRHD) were administered from Gestation Day 16 to 140. Pharmacologically mediated marked initial maternal body weight loss and reductions in body weight gain and food consumption coincided with an increase in early pregnancy losses and led to delivery of slightly smaller offspring at ≥0.075 mg/kg twice weekly (≥6X human exposure). Salcaprozate sodium (SNAC), an absorption enhancer in RYBELSUS®, crosses the placenta and reaches fetal tissues in rats. In a pre- and postnatal development study in pregnant Sprague Dawley rats, SNAC was administered orally at 1,000 mg/kg/day (exposure levels were not measured) on Gestation Day 7 through lactation day 20. An increase in gestation length, an increase in the number of stillbirths and a decrease in pup viability were observed. **Lactation:** Risk Summary: There are no data on the presence of semaglutide in human milk, the effects on the breastfed infant, or the effects on milk production. Semaglutide was present in the milk of lactating rats. SNAC and/or its metabolites concentrated in the milk of lactating rats. When a substance is present in animal milk, it is likely that the substance will be present in human milk *(see Data)*. There are no data on the presence of SNAC in human milk. Since the activity of UGT2B7, an enzyme involved in SNAC clearance, is lower in infants compared to adults, higher SNAC plasma levels may occur in neonates and infants. Because of the unknown potential for serious adverse reactions in the breastfed infant due to the possible accumulation of SNAC from breastfeeding and because there are alternative formulations of semaglutide that can be used during lactation, advise patients that breastfeeding is not recommended during treatment with RYBELSUS®. Data: In lactating rats, semaglutide was detected in milk at levels 3-12 fold lower than in maternal plasma. SNAC and/or its metabolites were detected in milk of lactating rats following a single maternal administration on lactation day 10. Mean levels of SNAC and/or its metabolites in milk were approximately 2-12 fold higher than in maternal plasma. **Females and Males of Reproductive Potential:** Discontinue RYBELSUS® in women at least 2 months before a planned pregnancy due to the long washout period for semaglutide *[see Use in Specific Populations]*. **Pediatric Use:** Safety and efficacy of RYBELSUS® have not been established in pediatric patients (younger than 18 years). **Geriatric Use:** In the pool of glycemic control trials, 1229 (29.9%) RYBELSUS®-treated patients were 65 years of age and over and 199 (4.8%) RYBELSUS®-treated patients were 75 years of age and over. In PIONEER 6, the cardiovascular outcomes trial, 891 (56.0%) RYBELSUS®-treated patients were 65 years of age and over and 200 (12.6%) RYBELSUS®-treated patients were 75 years of age and over. No overall differences in safety or efficacy were detected between these patients and younger patients, but greater sensitivity of some older individuals cannot be ruled out. **Renal Impairment:** The safety and efficacy of RYBELSUS® was evaluated in a 26-week clinical study that included 324 patients with moderate renal impairment (eGFR 30 to 59 mL/min/1.73m^2). In patients with renal impairment including end-stage renal disease (ESRD), no clinically relevant change in semaglutide pharmacokinetics (PK) was observed. No dose adjustment of RYBELSUS® is recommended for patients with renal impairment. **Hepatic Impairment:** In a study in subjects with different degrees of hepatic impairment, no clinically relevant change in semaglutide pharmacokinetics (PK) was observed. No dose adjustment of RYBELSUS® is recommended for patients with hepatic impairment.

OVERDOSAGE: In the event of overdose, appropriate supportive treatment should be initiated according to the patient's clinical signs and symptoms. A prolonged period of observation and treatment for these symptoms may be necessary, taking into account the long half-life of RYBELSUS® of approximately 1 week.

More detailed information is available upon request.

For information about RYBELSUS® contact: Novo Nordisk Inc., 800 Scudders Mill Road, Plainsboro, NJ 08536, 1-833-457-7455

Date of Issue: April 2021
Version: 3

Manufactured by: Novo Nordisk A/S, DK-2880 Bagsvaerd, Denmark

PATENT INFORMATION:

http://www.novonordisk-us.com/products/product-patents.html

novo nordisk®

RYBELSUS®
semaglutide tablets 7mg | 14mg

USAFP Better Together Clubs

LEADERSHIP BOOK CLUB

The Leadership Book Club met on 14 December and had a great discussion on the book titled, *Inside the Five-Sided Box: Lessons from a Lifetime of Leadership in the Pentagon* by Ash Carter. The book is a great insight to how the DoD works at the top levels while also providing great leadership lessons. Thanks to Dr. Clay Rabens for facilitating the discussion.

The next meeting of the Leadership Book Club will be held in person and virtually at the 2022 USAFP Annual Meeting. Specific date and time TBD.

LITERARY BOOK CLUB

The Literary Book Club met on 28 October and had a fun discussion on *People of the Book* by Geraldine Brooks. The next meeting of the Literary Club will be held on 17 February and the book for discussion is *The Last Garden in England* by Julia Kelly. Thanks for Dr. Sandy Kimmer and Beth Saguil for leading the discussions!

JOURNAL CLUB

The Journal Club met on 21 October with Drs. Janelle Marra and Aaron Saguil's facilitation of discussion on an article that answers a clinical question and demonstrates how you can conduct impactful, operationally minded research, even while deployed! The title of the article was *Accuracy of the Tuning Fork Test for Determination of Presence and Location of Tibial Stress Fractures in a Military Training Population*. Dr. Marra was a co-author on the article.

The club also met on 7 February and discussed the article titled, *Signs and symptoms that rule out community-acquired pneumonia in outpatient adults: a systematic review and meta-analysis*. Thanks to Dr. Roselyn Fuentes for leading the discussion.

The Journal Club discussion is approved for 1.5 prescribed CME credits from the American Academy of Family Physicians. USAFP will report credits for those that attend.

FITNESS CLUB

A personal and family fitness group with the vision of connecting USAFP members and their families across the globe. Connect and follow each other's fitness adventures with some added "friendly competition" events sprinkled in for fun. How? Get a free Strava account through the app store and search for "USAFP Fitness Group" to join the fun!

To sign up for future Better Together sessions, visit www.usafp.org/usafpbettertogether.

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new members

THE USAFP WELCOMES THE FOLLOWING NEW MEMBERS…

ACTIVE

Scott Blanchet, DO
Joshua Boucher, DO
Susan Colla, DO
David Nguyen, MD
Aaron Patzwahl, MD
Jacob Thomas, DO
Matthew Wright, DO

RESIDENT

Francis Janton, MD
Aundrea Kastl, DO
Brendan Lushbough, DO
Lena Nowacki, DO
Boone Parkinson, DO
Hannah Pyle, MD

STUDENT

Renee Anderson
Natalia Barzanji
Joshua Bates
Corbit Bayliff
Michael Bolton, MBA
Miles Brooks
Patrick Castro
Kieran Chung
Andrew Collyer
Alexandra Corns
Brian Davis, MBA
Sebastian De la torre
Christina DeInnocentiis
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Corey McKenzie
Diana McKinnon
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Carolyn Turner
Bryan Urbina
Justin Weeks
Melina Williman, BSN
Michael Willis

AUGUSTA UNIVERSITY

Family Medicine Faculty Positions
Department of Family Medicine
Medical College of Georgia

The Department of Family Medicine in the Medical College of Georgia (MCG) at Augusta University is hiring the following faculty positions:

- **Clinical Family Physician** to support the Family Medicine and Augusta University Health primary care clinical services. The Family Medicine Clinic provides nearly 30,000 patient visits per year. This physician will provide care for a panel of individual private patients and, when needed, will also provide patient care coverage for faculty members who serve as teaching faculty.

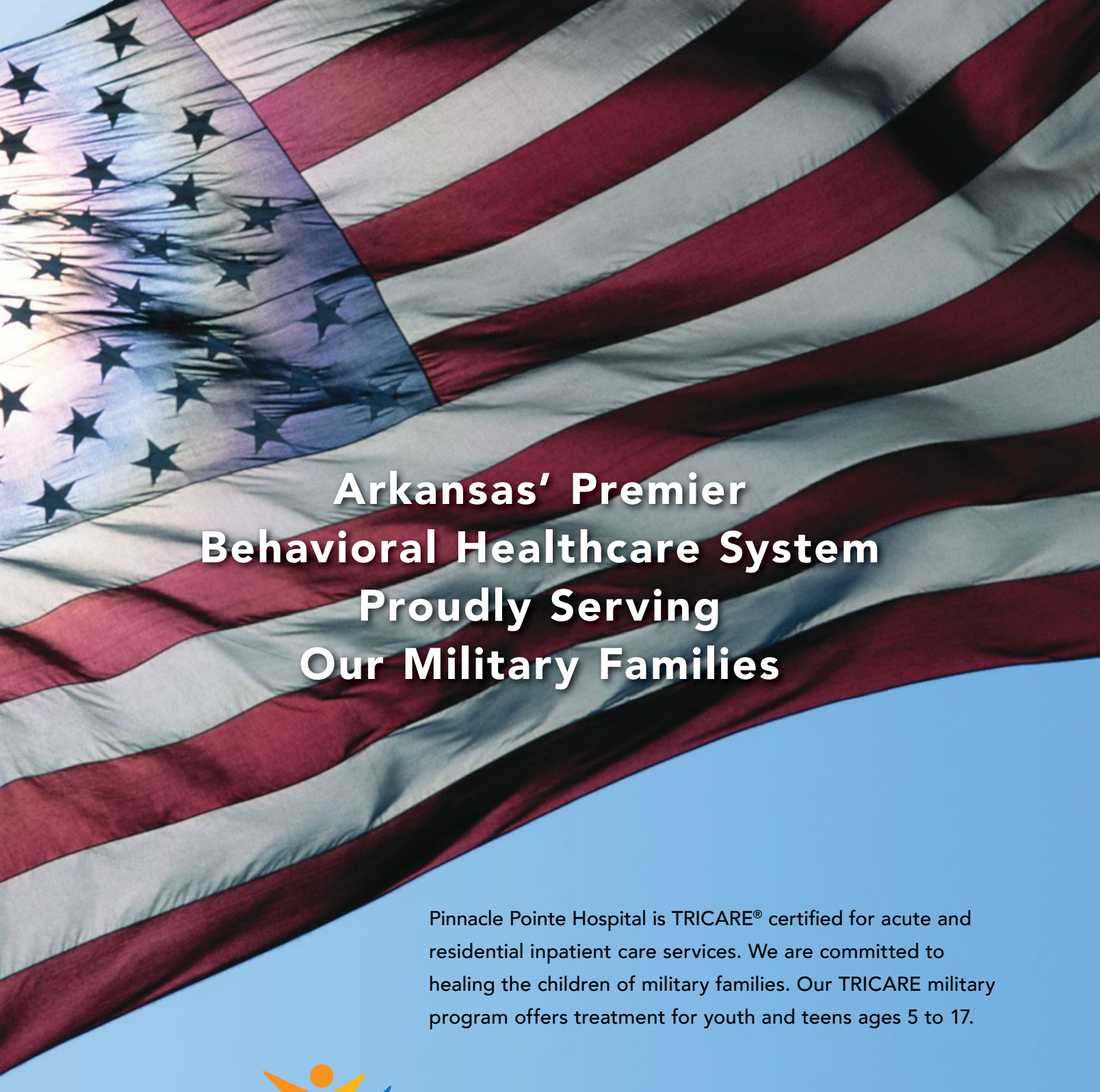
- **Clinician Educator** to support teaching, scholarship, and service programs in response to anticipated growth in undergraduate medical education class size, the Family Medicine Residency Program, and Augusta University Health primary care clinical services. Clinician Educators provide academic support in all years of MCG's undergraduate medical curriculum, including preclinical electives and interdisciplinary required courses and a six-week Family Medicine distributed clerkship. MCG has just begun a 3-year medical school option for those students entering primary care careers, to include Family Medicine.

Qualified candidates will have completed an ACGME or AOA accredited Family Medicine Residency Program and be board-certified (or board-eligible) by the American Board of Family Medicine.

The Department of Family Medicine is a military friendly work environment with former Active Duty providers from all three services among its faculty, including the Department Chair. The department has an ACGME accredited Allopathic Family Medicine Residency Program, an ACGME accredited 1+2 rural track residency program, and a concurrent AOA accredited Osteopathic Family Medicine residency component. DFM is opening a Primary Care Sports Medicine Fellowship in 2022 with plans for a Geriatric Fellowship and an Addiction Medicine Fellowship to follow.

Clinical teaching and services occur concurrently in the Family Medicine Clinic and at Augusta University Medical Center within the AU Health System as well as other affiliated local and regional clinical sites. The Family Medicine Clinic is recognized by the National Committee for Quality Assurance as a Patient-Centered Medical Home. Patient-and Family-Centered Care concepts are the guiding principles for new clinical program development in the university's academic health center as exemplified by its Children's Hospital of Georgia.

If interested in learning more about these positions, please email a letter of interest and current CV to:
Arman Razavipour, MBA, Physician Recruiter
Air Force, Retired
Email: arazavipour@augusta.edu
Medical College of Georgia at Augusta University, 1120 15th Street, AA 1010, Augusta, GA 30912



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MEMBERS IN THE NEWS

Congratulations to USAFP Members Appointed to AAFP Commissions



USAFP members Jeanmarie "Gigi" Rey, MD, Tim Switaj, MD, and Janelle Marra, DO were appointed in December 2021 to serve on AAFP Commissions. Board-appointed commission members bring strategic and innovative ideas to light on one of seven commissions. Their insight informs policy recommendations, develops new programs and projects, and streamlines action.

Dr. Rey was appointed to a four-year term on the Commission on Education. The focus of this commission is to develop recommended policy and disseminate expertise and new information related to the education and professional development of family physicians until the residency training period is completed.

Dr. Switaj was appointed to a four-year term on the Commission of Quality and Practice. The focus of this commission is to work to improve the practice environment of family physicians.

Dr. Marra was appointed to a four-year term on the Commission on Membership and Member Services. This commission guides the AAFP's membership efforts and assists the constituent chapters in their efforts.

Congratulations to Drs. Rey, Switaj and Marra - outstanding family physician leaders!!

USAFP Member Janet West, MD Appointed to Continue Her Service as AAFP Delegate to the AMA

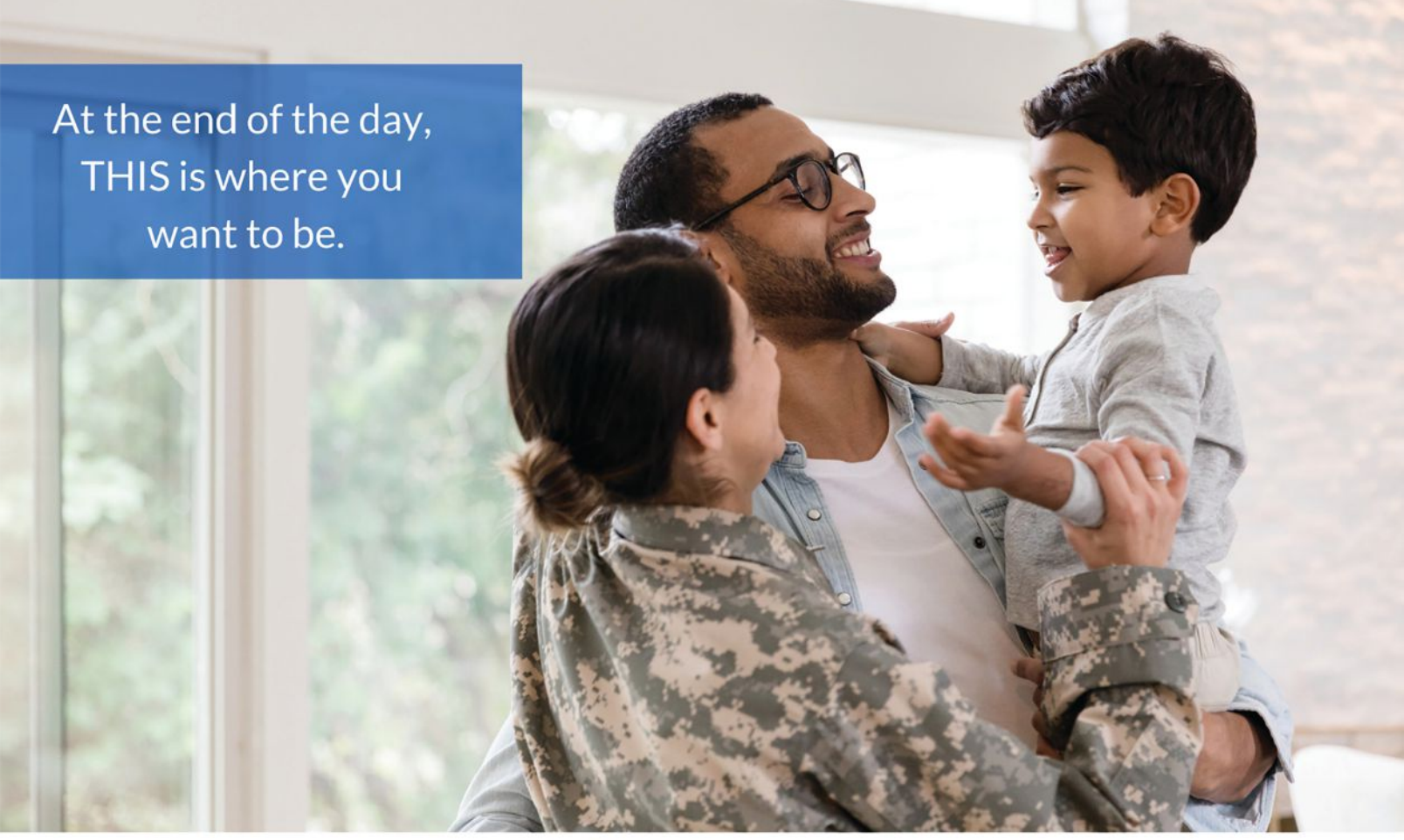
Janet West, MD has been appointed to serve as an American Academy of Family Physicians delegate to the American Medical Association for a two-year term that began December 15, 2021. Janet has served the AAFP in this capacity since 2014.

As an AAFP delegate to the AMA, Dr. West will serve as an important communication, policy, and membership link between the AMA and grassroots physicians. Delegates are a key source of information for AAFP members on activities, programs, and policies of the AMA and are also a direct contact for the individual AAFP member to communicate with and contribute to the formulation of AMA policy positions, the identification of situations that might be addressed through policy implementation efforts and the execution of AMA policies. Congratulations Dr. West!

Don't Miss Out on Complimentary USAFP Membership Benefits

DAILY INFOPOEMS

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



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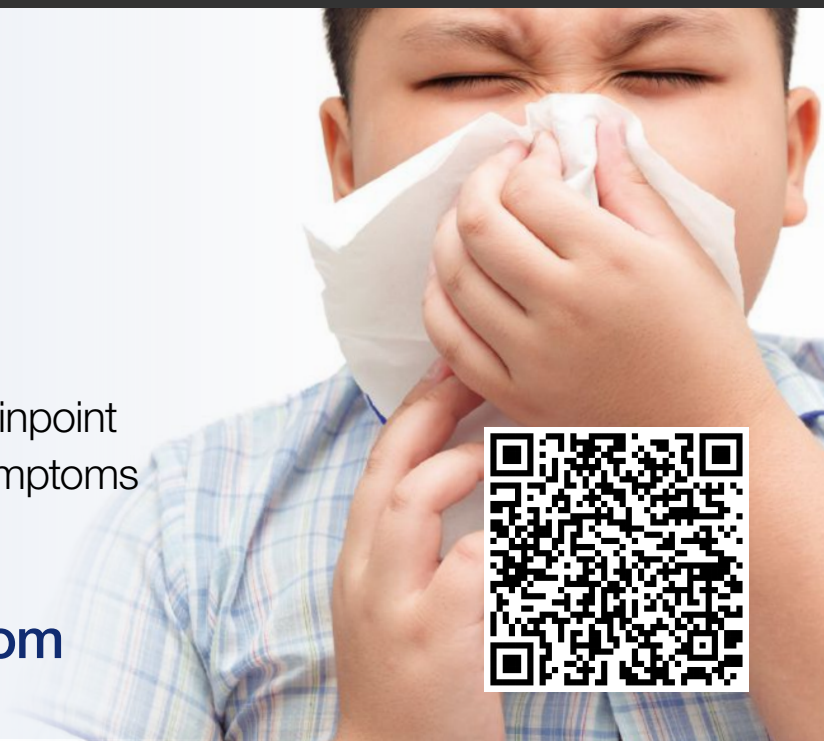

Review these helpful resources:

Allergen Reference Encyclopedia >

Provider Resource Library >

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