THE UNIFORMED FAMILY PHYSICIAN

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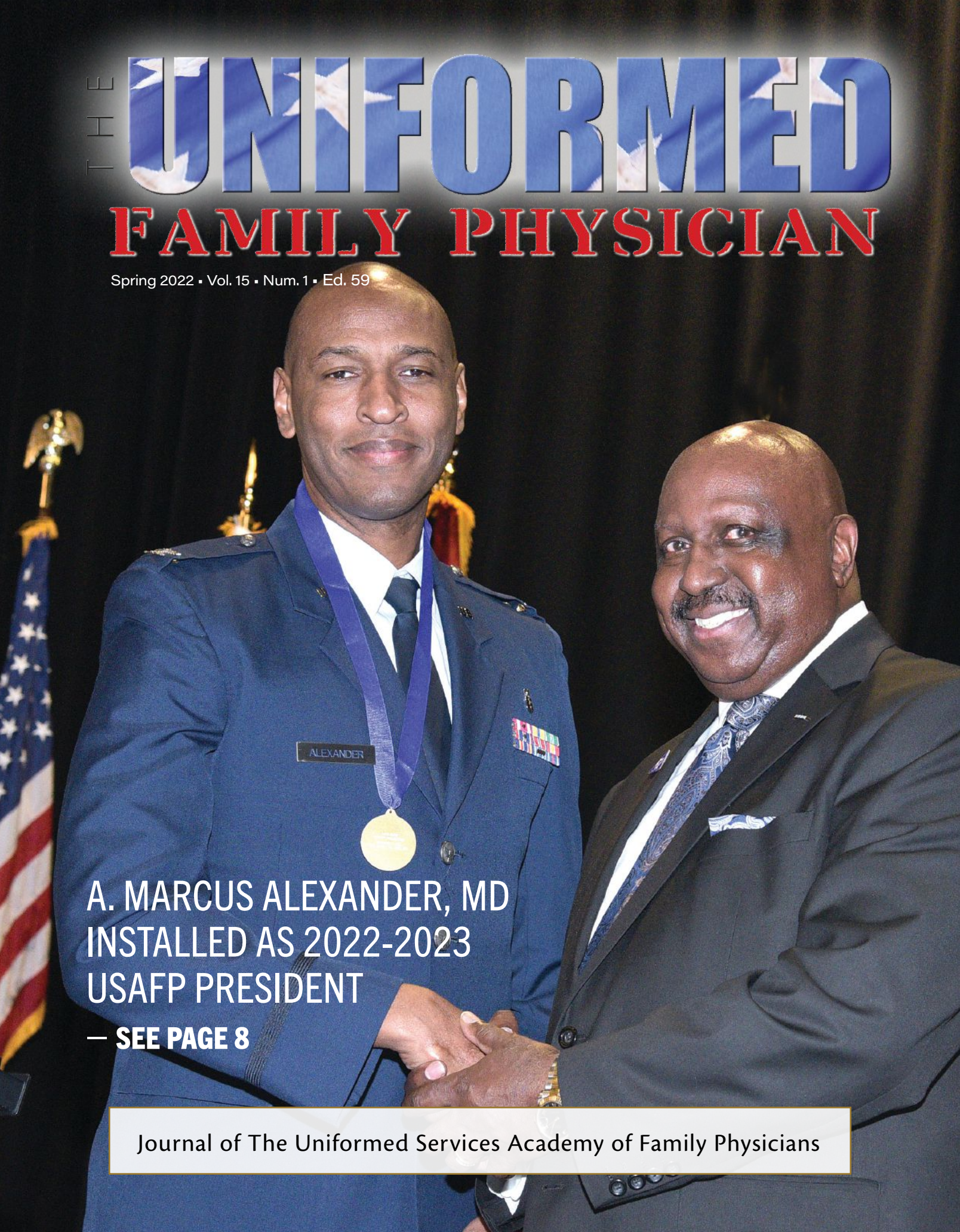

A. MARCUS ALEXANDER, MD INSTALLED AS 2022-2023 USAFP PRESIDENT

— SEE PAGE 8

Journal of The Uniformed Services Academy of Family Physicians

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VISION

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

MISSION

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

Edition 59

your academy leaders
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president's message

A. MARCUS ALEXANDER, MD

A. Marcus Alexander, MD
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Greetings to my Family Medicine family!

My cup is definitely full after our amazing time at USAFP in Anaheim. It is always a pure joy to have the opportunity to see everyone in person. The comradery, the fellowship, the mentorship, the sharing of ideas, the top shelf lectures, and the unrivalled research never fail to be just what the doctor ordered. I would like to thank you again for the opportunity to serve our USAFP chapter, and for your tireless efforts that provide superior operational readiness and heath care across the MHS.

At the annual meeting I shared a bit of my background, introduced my rally cry for the year ("We Are… Family Medicine"), and asked for your consideration and efforts on a few topics throughout the next year. I hope that we are able to utilize our USAFP committees, quarterly newsletters, and annual meeting as tools for our academy to grow together.

First, can each of us in our daily lives strive to utilize a "WE" mindset and approach versus an "I", "me", "they", or "them" approach? Can we lead by consistently considering our roles in MHS Family Medicine, our service specific issues, our interactions amongst all corps, and our relationships with all races, genders, and ethnicities from a we perspective? Can we consider both our service specific leadership and DHA leadership from a "we" perspective? By recognizing that WE have a presence and representative at every level, WE can influence the MHS, readiness, and heath care from all aspects as family physicians.

Second, can each of us take ownership that we ARE Family Medicine to those that interact with us each day? We each carry the torch of our specialty. The expectations and perceptions that patients, commanders, and colleagues have about Family Medicine will be based on the experiences they have with each of us based, not only on our demonstrated clinical ability, but also on our attitude and character.

First, can each of us in our daily lives strive to utilize a "WE" mindset and approach versus an "I", "me", "they", or "them" approach? Can we lead by consistently considering our roles in MHS Family Medicine, our service specific issues, our interactions amongst all corps, and our relationships with all races, genders, and ethnicities from a we perspective?

Third, remain humble but take pride in that we are Family *Freaking* Medicine! We provide compassionate and comprehensive care to all ages and all genders, while covering all diseases and all organ systems, building trust and respect in relationships, and growing ourselves through reflective mindfulness and lifelong professional and personal learning. You are each absolutely *freaking* amazing!

Lastly, can we reflect on the words of Kobe Bryant who advised others to "Be Great" or Teilhard de Chardin who said "do the ordinary with conviction of its immense importance"? In other words, can we aspire to vigorously prepare and commit towards a goal to be great at day-to-day tasks and the small things?

I look forward to another incredible year together: "We Are… Family Medicine!"

Mark E. Stackle, MD, MBA, FAAFP
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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/**

Greetings to all of you! It is my tremendous privilege to write my first column as your new USAFP Vice President and Editor for the *Uniformed Family Physician* (UFP). Like many of you who were fortunate enough to attend this year's Annual Meeting in Anaheim, I continue to feel a renewed sense of energy, connection, and purpose after spending time among my fellow uniformed Family Medicine colleagues in California. The opportunity to connect with old friends, make new ones, and witness the passion and enthusiasm within our resident and student communities was nothing short of inspiring. After missing out on attending the annual meeting for the past three years due to an Afghanistan deployment and the COVID pandemic, I didn't realize how much I had missed the intellectual stimulation and camaraderie that our academy offers each year.

The Annual Meeting also provided a chance to say farewell to a tremendous group of leaders whose engaged and innovative leadership helped maintain the strength of our academy during the tumultuousness of the past two years. I would particularly like to thank my predecessor as USAFP Vice President, Leo Carney, for doing such an exceptional job with the UFP during his tenure. Leo, thank you for your incredible work and for the smooth hand off of this exceptional publication.

This edition of the UFP highlights the remarkable diversity of interests present within our academy. George Mount's timely article on mentorship as an educational strategy offers concrete ways to facilitate more productive mentor/mentee relationships. Rob Oh's recap of the tremendously successful 2022 Research Competition concludes with a call to share more of this great work through publication. Adolfo Granados and Haroon Samar outline the Operational Medicine Committee's focus on delivering care in extreme environments and provide useful tips to family physicians new to operational medicine roles. Caitlin Granadillos, Sarah Kinkenon, and Heather O'Mara offer thoughtful advice for those leaders preparing their organizations for a successful transition to MHS GENESIS. Scott Grogan describes the tremendous utility of Point of Care Ultrasound and outlines some important considerations for those interested in adding this skill to their kit bag. One of our recent Program Chairs, Mariama Massaquoi, shares the Members Constituencies Committee's plan to build up a Diversity, Equity, Inclusion Toolkit within USAFP. Colby Neville and Brie Gawrys poignantly capture the diversity of deployed missions where family physicians have recently been called to serve and remind us of the importance of maintaining our full scope of clinical skills to thrive in these disparate environments. John O'Brien's review of 'The Burnout Epidemic' explores a crucial topic impacting the medical workforce and describes concrete ways we can address the growing challenges of physician burnout. I want to personally thank each of these authors along with the other UFP contributors for their thoughtful insights.

I hope you enjoy this edition of the UFP as much as I did. I will conclude by asking that each of you consider submitting an article for a future edition of the UFP. There is a wealth of knowledge within our academy and this publication serves as a valuable venue to share that information across our broad spectrum of readers. I wish all of you the very best this summer and look forward to a great year celebrating the noble profession of uniformed Family Medicine!

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A. Marcus Alexander, MD Installed as 2022-2023 USAFP President

Over 500 attendees took part in the 2022 Installation of USAFP Officers and Directors on Sunday, 3 April 2022 at the Anaheim Marriott in Anaheim, CA. AAFP Past President Warren A. Jones, MD, FAAFP installed 2022-2023 USAFP President A. Marcus Alexander, MD and the other Officers and Directors of the USAFP Board of Directors during the luncheon.

Dr. A. Marcus Alexander, MD being installed as 2022-2023 USAFP President.

Dr. Jones installs the 2022-2023 USAFP Board of Directors
Pictured left to right are Tema Fodje, HPSP Student Director; Charisse Villareal, MD, Navy Resident Director; Erin Lucero, USU Student Director; Molly Chandler, MD, Army Resident Director; Daniel Molina, MD, FAAFP, Public Health Service Director; Janelle Marra, DO, DO, FAAFP, CAQSM, Navy Director; Jedda Rupert, MD, FAAFP, Air Force Director, Mark Stackle, MD, FAAFP, Vice President; Kevin Bernstein, MD, MS, FAAFP, President-Elect

Not pictured: Mary Alice Noel, MD, Army Director; Taylor O'Neil, MD, Air Force Resident Director

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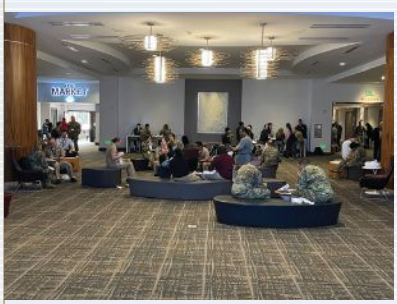
2022 Annual Meeting & Exposition

Over 500 family physicians and other health care professionals attended the 2022 USAFP Annual Meeting & Exposition at the Anaheim Marriot in Anaheim, CA. The photos and comments show the success of the conference!

- It was a great meeting.
- Thank you to the chairs for all their hard work!
- So wonderful to see everyone!
- This was my favorite USAFP conference so far...loved the location and loved the activities that my family could potentially do when I was at the conference.
- I loved this was in person this year.
- Bowling was best All attendee party to date. Fabulous food.
- The artic discussion was FABULOUS- must repeat, add time
- Excellent meeting. Great to be back in person.
- Overall Great Meeting
- Amazing conference as always. This is my favorite event of the year. Was great to get everyone back together.















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Friday, April 1
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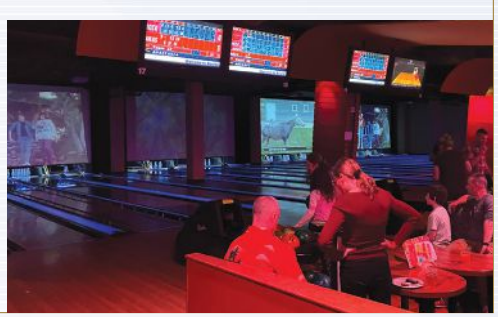

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The following organizations exhibited their products and services at the 2022 USAFP Annual Meeting. The Academy is fortunate to have such great support from these organizations.

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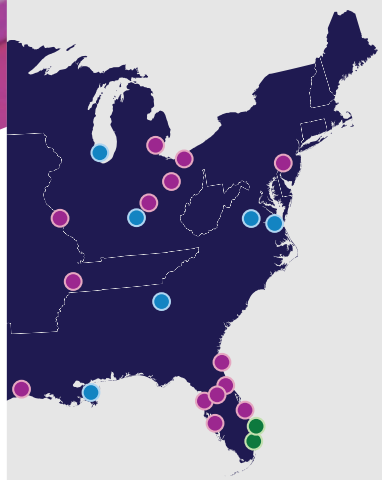

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2022 Academy Awards

Uniformed Services Academy of Family Physicians Lifetime Achievement Award
Jeffrey B. Clark, MD, MPH, FAAFP
MG(ret), USA, MC

Dr. Clark's award reads as follows "In recognition of your many years of sacrificial service to the nation and the United States military as a US Army Medical Corps Officer and a Family Physician. Your leadership and mentorship within the Military Health System and the USAFP is to be highly commended. Your dedication to role modeling the synergy of two professions - the profession of arms and profession of medicine - as an exceptional officer physician leaves a lasting legacy that continues to shape future generations of uniformed family physicians."

Congratulations Dr. Clark!

Dr. Nguyen is pictured with USAFP 2021-2022 President Aaron Saguil, MD, MPH, FAAFP.

Michael J. Scotti, MD Family Physician of the Year
Dana R. Nguyen, MD, FAAFP
COL, USA, MC

Dr. Nguyen's award reads as follows: "In recognition of the wide ranging and lasting impact that you have had on military medicine, uniformed family medicine, and national family medicine. As director of the family medicine clerkship, you guided over 1,000 students in the precepts of continuous, comprehensive, contextual care, and oversaw match rates to family medicine that were higher than almost any other allopathic school in the country. As military medicine's Chair, Department of Family Medicine, you remain a humble servant leader, lead by example, provide mentorship and sponsorship, advocate for the marginalized, and constantly give back to your chosen communities. The specialty of family medicine has reaped tremendous dividends from your efforts and has been strengthened for years to come. You truly are an outstanding family physician."

Congratulations Dr. Nguyen!

Dr. Noss is pictured with USAFP 2021-2022 President Aaron Saguil, MD, MPH, FAAFP.

Operational Medicine Award
Matthew R. Noss, DO, MSEd, FAAFP
MAJ, USA, MC

Dr. Noss' award reads as follows: "In recognition of your dedication and leadership that far extend beyond your assigned medical duties and contribute significantly to US military operations in a multitude of ways. Your actions ensured the readiness of Soldiers throughout USAEUR in the early days of the pandemic and prepared Special Forces units to safely train and deploy in the current high-risk environment. You acted quickly and efficiently to procure PPE and testing materials, while educating Senior Commanders on appropriate COVID-19 procedures, finding ways to re-engage operations in a safe manner. Your knowledge and understanding of operational medicine principles, combined with your demonstrated commitment to supporting the strategic global mission set of the US military, make you an ideal recipient of this award."

Congratulations Dr Noss!

Drs. Massaquoi and Young are pictured with USAFP 2021-2022 President Aaron Saguil, MD, MPH, FAAFP.

2022 PRESIDENT'S AWARDS

Mariama A. Massaquoi, MD
MAJ, USA, MC

Stephen M. Young, MD
MAJ, USA, MC

The awards read as follows: "In recognition of your outstanding leadership and selfless service to the Uniformed Services Academy of Family Physicians as Program Co-Chair for the 2022 USAFP Annual Meeting & Exposition. After your family medicine family spent over two years apart fighting a global pandemic while also caring for troops, veterans, and families across the world, you brought us back together. You created and executed an annual meeting that helped us be smarter together, stronger together, and better together--for a long time to come."

Congratulations Drs. Massaquoi and Young!

Drs. Rabens and Farnell are pictured with USAFP 2021–2022 President Aaron Saguil, MD, MPH, FAAFP. Dr. Clemente-Fuentes and Dr. Kimmer were not in attendance.

Clayton J. Rabens, MD, MPH
Lt Col, USAF, MC, SFS

Edwin A. Farnell, MD, FAAFP
LTC, USA, MC

Roselyn Clemente-Fuentes, MD, FAAFP
Major, USAF, MC, FS

Sandra L. Kimmer, MD
CDR (ret), USN, MC

The awards read as follows: "In recognition of your willingness to answer the call of your Academy to create ways to help us be smarter together, stronger together, and better together while fighting on the front lines of a global pandemic. The group you conceived, planned, and executed provided opportunities for member physicians over the world to connect, learn, and grow together despite the strain of domestic and international missions keeping them apart. Your efforts have created an enduring legacy for the Uniformed Services Academy of Family Physicians."

Congratulations to Drs. Farnell, Rabens, Clemente-Fuentes, and Kimmer!

Concierge Choice Physicians has a number of concierge partnership opportunities available in California, Virginia, New York, New Jersey and Texas

Each opportunity presents a path to managing your own concierge practice, with the support of Concierge Choice Physicians. The right candidate will be a team player who possesses a passion for the highest level of patient care, service and support, along with an entrepreneurial spirit.

If you are interested or have questions, please contact Michele McCambridge, CCP's Senior Vice President, at mmccambridge@choice.md. All inquiries will be kept confidential.

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Concierge Choice Physicians has been a leading provider of concierge medicine services for nearly 20 years. We have helped hundreds of primary care physicians and specialists across the country enhance their practices with the right membership medicine model. Our clients include private solo physicians, members of large groups and employees of hospital systems.

Should you take over a concierge medical practice?

A Q/A that will help you decide if you're right for concierge care

Wayne Lipton, Managing Partner, Concierge Choice Physicians

What is concierge medicine?
Concierge medicine is a style of practice where patients pay a monthly or annual fee in exchange for more time with their physician, greater support, convenience and connectivity. In short, it's a highly personalized form of medicine built on a strong doctor/patient relationship.

Why choose concierge medicine?
Concierge medicine is considered a highly satisfying style of medicine for physicians because it allows them to practice an old-school style of medicine, where they can spend as much time as necessary with patients, without the pressure of volume care or big box medicine. The annual fee they receive allows them to maintain a lucrative, but smaller patient panel with greater independence and control, without sacrificing revenue.

Patients report high levels of satisfaction with their concierge doctors. They appreciate being able to easily connect, get support managing their treatment regimens from all of their healthcare providers, and the greater emphasis on preventive wellness.

What kind of doctor can practice concierge medicine?
The best physicians for concierge medicine are those who see patients on an ongoing basis. Obviously, primary care physicians, but also specialists like cardiologists, rheumatologists, endocrinologists, and even pain medicine physicians. The most important feature is that the physician can serve as a patient's go-to or main physician.

Where is concierge medicine flourishing?
Concierge medicine is growing across the country. Not just in large cities, but even in rural areas where easy access to medical care isn't always possible. Some of the biggest concierge hot spots are: California, Virginia, New York, New Jersey and Texas. In fact, we have several physicians in these areas with thriving medical practices who are looking to retire and transition their concierge practice to a new physician who shares their philosophy of care.

What makes a good concierge physician?

- ✔ Physicians who value the time they spend with patients and who enjoy practicing a highly personalized form of medicine make excellent concierge physicians.
- ✔ Doctors who have worked for large healthcare organizations or institutions who may now be looking for less pressure and a better pace would appreciate the independence that comes with a concierge practice.
- ✔ Older, experienced physicians who want to extend their careers by 10 years or more, may find satisfaction in transitioning to a style of medicine that puts the emphasis on patient care, not productivity.

Does this satisfying practice style interest you?
If so, 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

consultant's report
CG/PHS

Preciosa P. Pacia-Rantayo, MD, USPHS
USCG Base Cape Cod Kaehler Memorial Clinic

Spring is finally here and we recently concluded a fantastic in-person Annual USAFP meeting in beautiful Anaheim, California! It was good to reconnect once again with friends and colleagues. During the Installation Luncheon, the winners of the Research Competition were announced and the new USAFP executive officers and board members were sworn in to their new positions. The newest fellows of the American Academy of Family Physicians were confirmed as well. We also had the opportunity to hear the outgoing USAFP President, Dr. Aaron Saguil, deliver his final remarks, and to hear the inspiring story and call to service from the new USAFP President, Dr. Marcus Alexander.

In our usual fashion, an update about Commissioned Corps and Coast Guard follows.

Picture taken during Air Station Cape Cod Mishap drill on February 17, 2022. Permanent Mishap Board (PMB) members prepare to proceed to the "mishap site."

UPDATES FROM COMMISSIONED CORPS:

In the last few weeks, the Commissioned Corps Headquarters (CCHQ) have sent several messages that involve updates to policies. A short list of these items will be mentioned here. All PHS officers should have received the full details in their email from CCHQ.

1. **Ethnicity and Race Information (ERI)** - All Public Health Service officers are encouraged to go into the Readiness and Deployment Branch (RDB) Self-Serve and fill out their ERI information.

2. **Fitness for Duty (FFD)** is an evaluation procedure where the Medical Affairs Board (MAB) can look at an officer's capability to perform their duties. Several examples were provided (email from CCHQ on March 23, 2022) regarding when the process can be initiated. The number one reason for starting the FFD process was related to circumstances involving officers with "excessive sick leave."

3. **Mental Health** - Officers are encouraged to seek Mental Health care if it is warranted. Additionally, seeking mental health care does not automatically mean that the FFD process will be initiated. However, there are certain conditions that must be met to avoid initiating the FFD process.

4. **New Directives** related to the modernization process were signed by Secretary Xavier Becerra. These directives pertain to Force Distribution and Management 122.02. Promotions 122.01, Retirement 124.01, and Fellowships, Scholarships, and Grants 125.04, and Protected Communications 121.06.

5. **Dental Insurance –** Starting July 3 this year, the dental provider for Public Health Service Officers will switch to United Concordia. A separate email was sent to officers that work with the Coast Guard that states that dental care will continue at the Dental Training Facility if space is available.

EVERY DOC CAN DO RESEARCH

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

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

Tools Available:

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

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

UPDATES AND NEWS FROM US COAST GUARD:

From this week's Weekly ALL-Hands Briefer (April 4, 2022)

1. **Body Composition** – On March 31, the new Body Composition Standard Instructions was distributed. A permanent addition is the Abdominal Circumference (AC) and Physical Fitness Test (PFT) as another method for compliance. More information about this updated policy can be found on the United States Coast Guard website (https://www.dcms.uscg.mil/military/Body-Composition-Program).

2. **Financial System Modernization Solution (FSMS)** – The Coast Guard has been catching up to complete Temporary Duty (TDY) backlogged claims. As of this writing, the agency has settled more than 25% of claims from last week.

3. **Recent Operations** – Here we highlight important recent contributions made by the men and women of the Coast Guard. First, a Ukrainian mariner suffering from abdominal pain was successfully evacuated to Hawaii. Personnel from Air Station Barbers Point utilized a H-130 Hercules to evacuate the patient to Oahu for further evaluation and care. Second, the Coast Guard Cutter Tahoma successfully repatriated 188 people to Haiti on March 22, 2022.

PMB members "meet" at the mishap site.

4. **COVID 19** – Updated Coast Guard COVID 19 guidance: In geographic regions where COVID transmission rates are low or medium, both vaccinated and unvaccinated members are not required to wear masks indoors. In regions where COVID transmission rates are high, it is recommended that all personnel regardless of vaccination status, wear a mask.

(Reference available upon request).

Wishing everyone a Happy Spring and Summer. Enjoy the weather!

George R. Mount, MD, FACR FACP
JBLM, WA
geo.mount@gmail.com

On a Role: Utilizing Role Modeling as an Educational Strategy

Who are your military medicine role models? I suspect several people quickly come to your mind. We often identify role models who provide a clear and powerful example of a consummate military physician and officer. Our role models demonstrate specific characteristics and ideals that resonate with us, representing the physician we hope one day to become. Role modeling is a critically important and often underappreciated educational strategy. Through role modeling, educators lead learners toward clinical competency and shape their professional identity as physicians and military officers. The process of grooming our colleagues and future successors remains a sacred privilege and duty. Role modeling the behaviors we hope to see is a powerful tool that we use to fulfill this duty.

Role modeling in medical education has been defined as "the process with which a learner observes a clinical teacher to develop and refine his or her practice."[1] Role modeling has traditionally been considered a passive process, arising primarily in the learner through observation. However, effective role modeling as an educational strategy requires a deliberate approach in which the educator actively and explicitly models desired behaviors. Shifting one's mindset to intentional role modeling provides a remarkably impactful education strategy.

ROLE MODELING: PERSPECTIVES AND OUTCOMES

When queried, our learners recognize role modeling as a critical influence on the core competency of professionalism and choices concerning their careers.[2] Learners understand that professionalism is best learned by example rather than through more traditional learning activities such as didactics. Effective role modeling gives our learners a tangible representation of the physician and military officer they hope to become. The

impact of role modeling on career choices cannot be overstated. When we consider the influences on our career decisions, we quickly recognize the vital individuals who played this critical role.

Faculty appreciate the extraordinary impact of role modeling on learners.[2] Faculty understand that teaching professional values of integrity, humanism, and selfless service cannot be accomplished effectively through lecture-based learning activities. Role modeling these attributes in the clinical environment demonstrates their importance and highlights the less tangible aspects of being a physician. When we reflect on formative moments in our career development, we likely remember witnessing powerful moments of humanism in equal number to those moments of interesting or unique patient clinical presentations.

Consider the impact of how and what we role model.[3-5] In a healthcare system with an ever-expanding number of challenges, we often struggle to suppress our pessimism and find the courage to role model optimism for our learners and peers. Instead, we might role model and recognize the true privilege we have to care for our Nation's finest. Additionally, consider the benefit of role modeling at the bedside when we direct our learners' focus to the compassion demonstrated to a patient and their family during particularly daunting circumstances, such as those near the end of life.

Accreditation bodies regularly ask us to consider trainee and learner well-being. How often are we pausing to emphasize or role-model our resiliency-seeking behavior? Might we make a more significant impact by explicitly role modeling the methods we employ to find work-life balance rather than assigning additional resiliency modules? Role modeling remains an underutilized teaching strategy with the potential to impact a wide-ranging variety of educational goals, many of which continue to be elusive despite our best efforts.

ROLE MODELING: CHALLENGES AND BARRIERS

Why do we struggle to implement such a powerful and readily available teaching strategy effectively? One of the primary challenges is the belief that role modeling occurs passively. After recognizing the requirement for explicit role-modeling, faculty still struggle with the required skills to implement it.[6] These skills include fostering reflection both in oneself and one's learners, fear of the required vulnerability, and the lack of a practical framework from which to begin. Finding the time to allow for the preparation, execution, and debriefing required for effective, active role modeling remains an ever-present challenge in today's complex and time-challenged environment. Despite significant headwinds on our path to implementing role modeling as a teaching strategy, we must heed this call to action.

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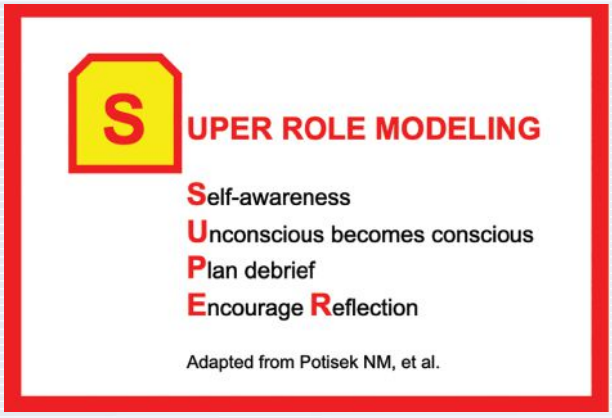
ROLE MODELING: A FRAMEWORK FOR SUCCESS

Let's consider a practical framework to assist us in implementing role modeling as an effective teaching strategy. Potisek et al. outline a role modeling framework in a memorable fashion, encouraging us to transform role modeling into SUPERmodeling.[1] Their mnemonic **SUPER** (increasing **S**elf-awareness, helping the **U**nconscious become conscious, **P**lan debriefing, and **E**ncourage **Reflection**) provides a straightforward guide to the task at hand.



Increasing self-awareness is the critical first step in which we must recognize that role modeling is happening both in our actions and in acts of omission. Our learners are observing our behaviors, both active and passive. Recognizing the power of our learners' observations unlocks the remainder of the framework. We then move our behaviors from the unconscious to the conscious in our learners by explicitly highlighting our behaviors. Tips to accomplish this task include:

- Giving our learners a specific behavior to look for in advance.
- Highlighting the beauty and the challenges of healthcare.
- Paying attention to our non-verbal behaviors (our learners certainly are).

To fully realize the benefit of this aspect of role modeling, we must open the door to vulnerability and ensure that we demonstrate the authenticity that our learners often crave.

Planning for and allowing time for post-activity debriefing will pay dividends. First, exploring the action and issues therein reinforces the intended teaching objective. To battle the challenges of time and efficiency in the clinical environment, faculty should set time limits for debriefing. Additionally, debriefing provides space for ever-critical feedback, ideally offered in a bidirectional fashion, with both the learner and the faculty exchanging feedback and developing an action plan for improvement.

The final, vital element in the framework is the encouragement of self-reflection. Self-reflection reinforces the power of role modeling as a teaching strategy and serves as the basis for the lifelong learning we strive to instill in our learners. Faculty can prime self-reflection by encouraging learners to pay attention to feelings or reactions they experience during a clinical event. Following the event, faculty should also detail what they had hoped to accomplish and where they might have failed to achieve their objective.

CONCLUSION

Explicit role modeling provides an effective teaching strategy. Both learners and faculty recognize the impacts of this teaching strategy, ranging from enhancing the inherent values of professionalism, influencing career choices, and impacting learner well-being. Despite implementation challenges, utilizing a framework offers a practical approach to effective role modeling. As we think back to those role models who influenced our careers, let us appreciate the impact of their influence while recognizing the impact we make when we employ role modeling as a teaching strategy for our learners.

Recognizing the power of role modeling, how are you working to implement this educator tool effectively? Are you interested in genuinely examining leadership principles? Do you wish to serve as a developer for other educators? Does an environment built on trust, adaptable, and flexible in times of change sound like a space in which you would thrive? If you answered yes to these queries, please consider the Leader & Faculty Development Fellowship, and talk with your service consultant to explore your application options. We welcome all those committed to our mission of developing military physicians to lead and equip physicians at all levels and advance military medicine through innovation and research. Please reach out to me or any member of our team through the fellowship list serve (usarmy.jblm.medcom-mamc.list.faculty-development-fellowship@mail.mil).

Acknowledgments: The concepts discussed above were adapted from a USUHS Faculty Development workshop initially developed by Dr. Jessica Servey, with subsequent updates made by Drs. Chris McMains and Joshua Will.

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

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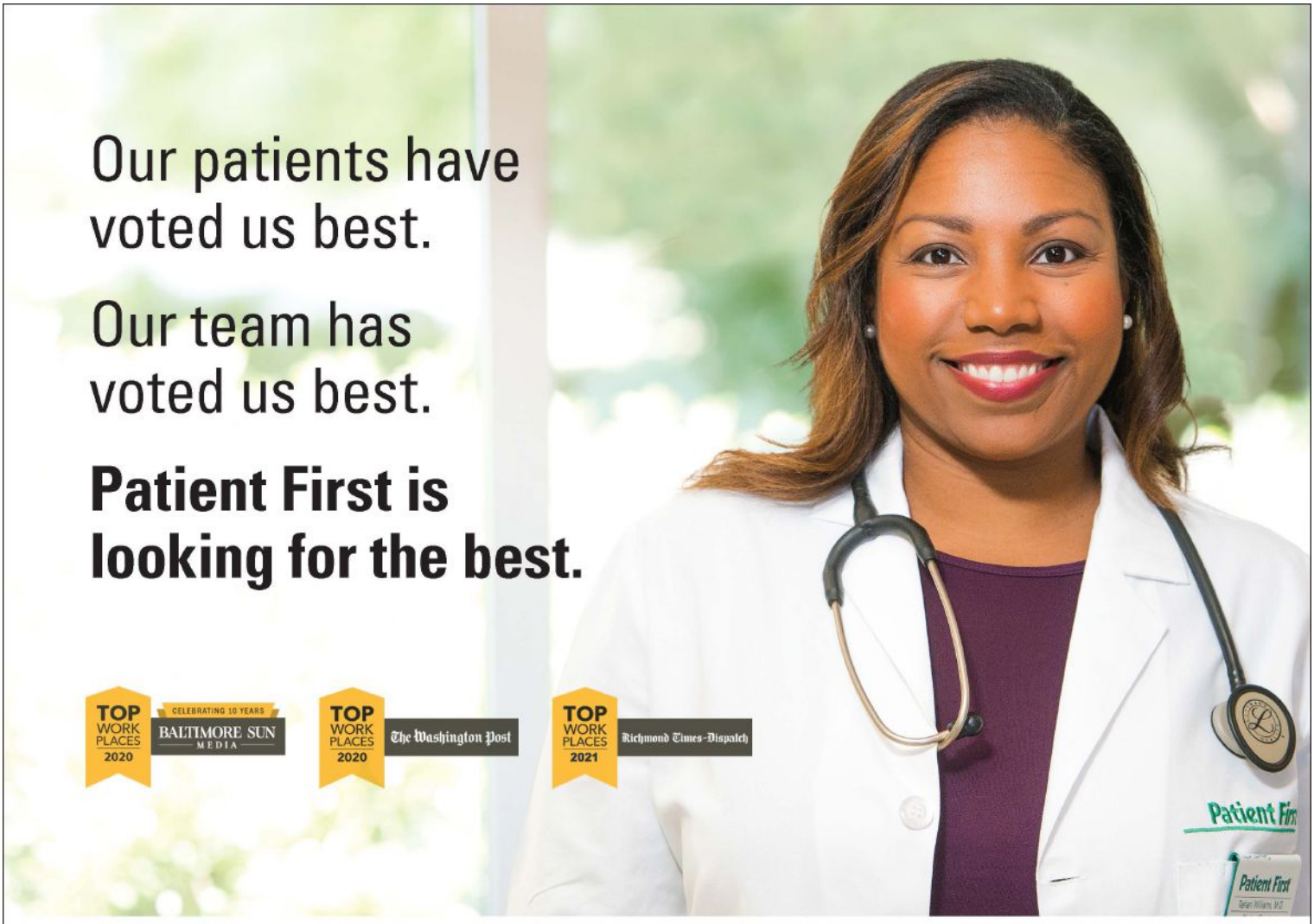

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2022 USAFP Research Competition Recap!

This year's Annual Conference theme, 'Better Together,' was certainly apropos for the 2022 USAFP Research Competition. Each of the terrific presentations, posters, and scholarly talks stretched my mind after spending the last two years focused all too intently on the coronavirus and COVID vaccine hesitancy. I truly enjoyed seeing you all in person and away from the virtual environment where fumbling with the "mute" button, typing instead of talking, and only wearing professional attire from the waist up were becoming all too common!

Also, let's congratulate Dr. Carl Covey for his selection as the new Vice-Chair for the USAFP Clinical Investigations Committee! In the near future, Carl will be reaching out to the local research mentors in order to connect with all the great work happening within each of our programs. Additionally, he will be working with me and the research judges to develop another fantastic research competition and workshop for the 2023 Annual Conference in Orlando.

2023 – ORLANDO

Bring back those Mickey Ears for 2023! The Clinical Investigations Committee leadership will be sending out information shortly regarding the abstract submission process which will open in July. For the 2023 competition, we are looking at enhancing our publication rates and decreasing the number of orphaned projects that never get shared with a broader audience. It is a sad fact that many excellent projects that represent numerous hours of hard work by residents, faculty, and students are never submitted for publication, and are left in the proverbial research orphanage or downright deleted. I am sympathetic to this trend since I have orphaned many research projects myself!

To that effect, we will be looking at ways to enhance publication. Remember – the whole goal of research is not just to connect in Orlando, but to disseminate newly discovered information that could help the medical community learn and advance knowledge in medicine. Stay tuned!

For those of you who were not able to witness this year's research competition, the winning abstracts are provided here for review.

Congratulations again! If anyone is interested in research and does not know where to start, please reach out to me – The Clinical Investigations team can point you in the right direction.

USAFP MENTORSHIP PROGRAM

Looking for a mentor? Interested in mentoring others?

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

HOW DOES IT WORK?

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

WHAT AM I SIGNING UP TO DO?

Participant responsibilities are as follows:

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

WHEN AND HOW WILL I GET MY MATCH?

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

IS THERE ANYTHING I CAN DO TO HELP?

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

2022 Juried Podium Abstract Winners

Clinical Investigation / Educational Research 1st Place Staff

Title: The Mediating Role of Family Acceptance and Conflict on Suicidality among Sexual and Gender Minority Youth

Primary Author: Lt Col David A. Klein, MD, MPH

Introduction: Prior research suggests sexual and gender minority (SGM) youth are profoundly impacted by levels of parental support. This study assessed mediating effects of generalized family acceptance and conflict on lifetime suicidal behaviors among a large diverse sample comprising both SGM and non-SGM youth in early adolescence, when intervention to optimize family dynamics may be critical.

Methods: Design: Cohort study comprised of first-year follow-up data from the Adolescent Brain Cognitive Development Study. Setting: Participants were recruited from twenty-one research sites across the United States. Study Populations: This population-based study recruits from select school systems across the United States optimized to mitigate selection biases. Participants are assessed regularly at preset intervals. Interventions: None Main Outcome Measures: SGM status was included as the independent variable, generalized (non-SGM specific) perceived family acceptance or family conflict sum score as the mediator, and the presence of lifetime suicidal behaviors as the dependent variable. Statistical Tests Used: Mediation was tested using a binary logistic regression model fitted with a generalized structural equation. Models adjusted for age, birth-assigned sex (as reported by the parent/guardian), and race/ethnicity.

Results: Of 11,235 youths with a mean age of 10.93 ± .64 years (4% indicating SGM identification), lifetime suicidal behaviors were reported by 1.5% (n = 164). Youths with SGM identities reported 40% less parental acceptance and 47% greater family conflict, compared to non-SGM peers. Both parental acceptance and family conflict partially mediated associations between SGM identification and odds of lifetime suicidal behavior (ps=.001).

Conclusion: Identification of modifiable risk factors for suicidality in this vulnerable population, including parental acceptance and family conflict, is critical to improving health outcomes. Clinicians should work with SGM youth and their families starting in childhood to optimize family dynamics and bolster acceptance to potentially reduce adverse health outcomes.

Clinical Investigation / Educational Research 2nd Place Staff

Title: Military Family Physicians Suffering from Imposter Syndrome

Primary Author: CPT Ariel Hoffman, MD & CPT Ashley Yano, MD

Introduction: Imposter syndrome (IS) was first defined in 1978 and is an important topic in medical education. Although characterized in medical training, IS has not been studied in military medicine. We hypothesize that the frequent position changes within the military physician's career aggravate imposter feelings. We present a cross-sectional study of military family physicians.

Methods: Design and Setting: Cross-sectional study using voluntary, anonymous data from 2021 Uniformed Services Academy of Family Physicians (USAFP) Annual Meeting Omnibus Survey. Study Population: USAFP Members, registered attendees. Intervention: None Main outcome measures: Incidence of imposter syndrome among military family physicians and impact of proposed risk factors. Statistical analysis: Descriptive statistics, chi-square, linear and logistic regression analyses.

Results: There was a 61% response rate of conference attendees (297/487). An optional Clance Questionnaire for IS was completed by 176 of the 297, which demonstrated at least mild IS in 91% and at least moderate IS in 58%. While all respondents who reported current IS also had IS by Clance Score, 82% of those who denied IS had at least mild IS by Clance score. IS is more likely in physicians who are of lower military rank and within 10 years of graduation from residency. Both the number of reported difficulties in training and the percentage of military positions in which IS was reported are linearly correlated with the Clance Score. Reported gender or ethnicity does not affect the likelihood of IS.

Conclusion: Imposter syndrome is common in military Family Physicians, especially when measured by a verified instrument. While IS is more common in early career physicians, rates are not affected by demographic variables. Given the high incidence identified in this study, further research is recommended to address how to help military family physicians understand and cope with Imposter Syndrome.

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Accepting on behalf of Dr. Harris are Drs. Pierre and Cimino

Clinical Investigation / Educational Research 3rd Place Staff

Title: Addressing Underrepresented Physicians in Military Medicine (URM) Through Cross Cultural

Mentorship: Defining The Problem

Primary Author: Lisa M. Harris, DO

Introduction: Mentorship and sponsorship are critical to physician recruitment, career development, and retention. According to the Association of American Medical Colleges (AAMC), underrepresented in medicine (URM) physicians represent 11% of American physicians from minority groups that represent 31% of Americans. Although URM physicians are not a homogenous group, many experience "Minority Taxes" that can undermine their professional objectives. Specific mentoring skills are necessary to foster cross-cultural mentorships and navigate differences between non-URM and URM physicians.

Methods: Design and Setting: Cross-sectional study using voluntary, anonymous data from the 2021 Uniformed Services Academy of Family Physicians (USAFP) Annual Meeting Omnibus Survey. Study Population: USAFP Members attending the 2021 Virtual Annual Meeting Intervention: None Main outcome measures: Military Family Physician demographics and URM mentorship practices Statistical analysis: Descriptive statistics, multivariate linear regression and chi-square analyses.

Results: The survey response rate was 61% (297 of 487 conference attendees). 10% of respondents identified as URM physicians. Over half of respondents do not have a URM mentee and have not collaborated with a URM colleague on a scholarly activity within the last 3 years. Most respondents feel they understand the historical context of racism (75.2%), have the skills to discuss racism (62.8%) and confidence to discuss racism (60.5%). However, only 54.7% feel they can recognize and address "Minority Taxes". URM physicians are more likely to have a URM mentee (p=0.042), more confident discussing racism (p=0.015), more likely to recognize and address "Minority Taxes"(p=0.001) and feel more skilled to discuss racism (p=0.026).

Conclusion: Based on this survey, military family physician demographics are consistent with civilian physician demographic data. Faculty development and leadership curriculums can improve URM physician recruitment, career development, and retention by addressing skills to support cross-cultural mentorship relationships. Additional studies are needed to further evaluate and identify implementation strategies.

Clinical Investigation 1st Place Resident

Title: Comparable Quality Between Telemedicine and In-Office Primary Care: An Analysis of 16 HEDIS Performance Measures in a Large Integrated Health System

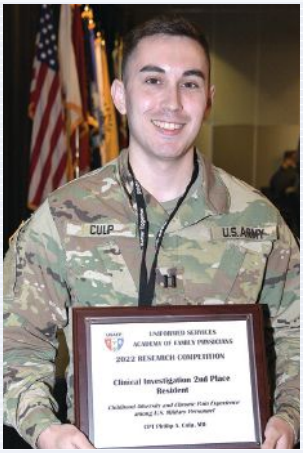
Primary Author: CPT Derek Baughman, MD

Introduction: Despite limited literature evaluating its quality, COVID-19 accelerated the widespread adoption of telemedicine. Federal legislation has temporarily supported telemedicine financing, but without evidence of its quality, there is little justification of telemedicine's value to substantiate its reimbursement and continued use.

Methods: In this retrospective cohort study, we compared sixteen HEDIS quality performance measures between in-office and telemedicine outpatient primary care encounters from 03/2020 - 04/2021. Eligibility criteria were measure specific according to the National Quality Forum. We used Slicer Dicer to mine patient encounter data in an integrated healthcare system (8 hospitals, 20,000 employees and 2,600 clinicians) across 200+ outpatient care sites in South-Central Pennsylvania. Main outcomes were quality performance based on HEDIS specified numerators and denominators. Chi-squared tests determined statistically significant ($p < 0.05$) differences between the 16-quality measures calculated for office and telemedicine encounters and multivariable logistic regression models adjusted for the odds of receiving preventive services based on sociodemographic factors (including social determinants and comorbidities).

Results: There were 491,522 eligible patients (426,291 in-office; 65,231 telemedicine) with the following highest demographic majorities: 55% female, ages 40-65, 82% white, 86% non-Hispanic, low overall health risk, and mostly commercial payers. Adjusted performance values favored telemedicine cohorts in 10 of 16 quality performance measures, notably in diabetes care (2 of 3), prevention (6 of 6), and behavioral health (depression screening). Quality performance favored in-office over telemedicine for cardiovascular care (4 of 5), but there was no difference for pulmonary care.

Conclusion: This study provides early, favorable evidence of telemedicine's quality in primary care. Given its potential to mitigate cost and improve access, telemedicine can provide high-value care and ought to continue qualifying for federal reimbursement post-pandemic.



Clinical Investigation 2nd Place Resident

Title: Childhood Adversity and Chronic Pain Experience among U.S. Military Personnel

Primary Author: CPT Phillip A. Culp, MD

Introduction: Chronic pain is a major burden on Soldier readiness as it can limit daily activities of life and work. The experience of childhood adversities (CA) has been associated with health outcomes, including chronic pain. The aim of this study was to examine the association between CA and chronic pain among Soldiers; a better understanding can inform treatment options.

Methods: From a review of 203 intake questionnaires completed by Soldiers seen at Womack Interdisciplinary Pain Management Center (IPMC), we identified a group (CA) of 20 consecutively seen Soldiers who checked "abusive" childhood home or history of pre-adolescent sexual abuse on the questionnaire. They were compared to a control group (non-CA) of 20 randomly selected Soldiers seen at IPMC, matched for age, gender, pain history duration, and pain problem. Pain intensity and impact were measured using the Defense and Veterans Pain Rating Scale (DVPRS). Mood was measured using the depression (PHQ-9) and the anxiety (GAD-7) scales from the Patient Health Questionnaire. Pain-related catastrophic thinking was measured using the Pain Catastrophizing Scale (PCS). The analytic sample comprised 32 men and 8 women. Data were analyzed using descriptive statistics and t-test analyses.

Results: Differences between CA and non-CA groups for age and pain history duration were non-significant (both Ps > .05). On the DVPRS, pain ratings for current, worse, and average were non-significant between groups (all Ps > .05). The CA group reported significantly greater effect of pain on mood (P < .03). Compared to the non-CA group, the CA group showed significantly higher depression and anxiety (both Ps < .000), and they had significantly higher pain catastrophizing scores (P < .03). **Conclusion:** There is a positive, significant relationship between depression, anxiety, and pain-related catastrophic thinking and history of childhood adversity; however, the influence of childhood adversity on pain intensity and impact was non-significant.

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Clinical Investigation 3rd Place Resident

Title: How Military Family Physicians Place IUD's and Perform Endometrial Biopsies

Primary Author: Capt Christina Valerio, MD, MPH & Capt Chloe Forlini, MD

Introduction: The common procedures of intrauterine device (IUD) insertions and endometrial biopsies can be technically challenging, painful and anxiety provoking for the patient. Limited research suggests that NSAID pretreatment and topical lidocaine reduce pain, while misoprostol does not. Evidence suggests that bimanual exams and tenaculums may not be necessary. We sought to characterize military Family Medicine physician practice patterns.

Methods: Design and Setting: Cross-sectional study using voluntary, anonymous data from the 2020 Uniformed Services Academy of Family Physicians (USAFP) Annual Meeting Omnibus Survey. Study Population: USAFP Members Intervention: None Main outcome measures: Military Family Physician practices and variation with gender and time in practice. Statistical analysis: Descriptive statistics and chi-square analyses.

Results: After conference cancelation, the survey was sent to all USAFP members. The response rate was 11.1% (287 of 2559 members). 175 respondents reported performing either procedure, with 65% performing both procedures and 24% performing only IUD insertions. For pre-procedural pain control, 69% give NSAIDs prior to the procedure while 5% use topical lidocaine. 48% reported never using anxiolytics and 55% reported never using misoprostol. When further stratified, female physicians were more likely to give NSAIDs pre-procedurally. During the procedure, 71% sometimes forgo a bimanual exam and 76% sometimes forgo use of a tenaculum. Physicians with less than 5 years in practice perform fewer bimanual exams. Nearly all respondents learned their techniques during residency.

Conclusion: Military Family Medicine physicians reported varied practice patterns for endocervical procedures. Residency programs are where these patterns are learned, and patient experiences can be improved by promoting pain reduction strategies suggested in the literature. Many respondents omit the bimanual exam and tenaculum placement, which is suggested to reduce discomfort. Further clinical investigations on procedural techniques and training strategies may optimize both physician and patient experience.

Clinical Investigation 1st Place Medical Student

Title: Family Medicine Physician Satisfaction Report: Military 2021 vs Civilian 2020

Primary Author: Capt Samuel J. Burton, MD

Introduction: Of 29 medical specialties in the Medscape Family Medicine Physician Compensation Report 2020, family physicians ranked 18th for feeling fairly compensated, and third from last (27th) for both choosing their specialty again and choosing medicine again. However, the Medscape data may not represent military family physicians' unique career experiences and subsequent satisfaction. Therefore, this study was conducted to identify if military and civilian family physicians are equally satisfied in their professions.

Methods: A collection of short surveys were combined and emailed to 2562 military family physicians via a professional organization list-serve from February-April 2021. The inquiry included six statements pertaining to professional satisfaction graded on a 5-point Likert scale. The main outcome measures were proportions of responses. The proportions were then compared, with permission, to the Medscape report revealing new relative rankings when compared to the other 29 specialties of the report. Statistical analysis was completed with a two-tailed Z-score for two populations.

Results: 198 attending military family physicians responded to this survey in 2021 and were compared to 2270 civilian family physicians that responded to Medscape in 2020. 62% of military family physicians feel fairly compensated compared to 54% of civilian family physicians, changing relative rank from 18th to 8th. 81% of military family physicians would reselect medicine compared to 70% of civilians ($p<0.001$), changing relative rank from 27th to 18th. 83% of military family physicians would reselect their specialty compared to 74% of civilians ($p=0.005$), changing relative rank from 27th to 4th. Lastly, 85% of military family physicians were satisfied with military-sponsored training.

Conclusion: Military family physicians were significantly more satisfied than civilian family physicians regarding compensation and willingness to choose medicine and medical specialty again. This focused study offers an important benchmark for leaders responsible for the Department of Defense healthcare mission and professional leaders aiming to strengthen family medicine.

Educational Research 1st Place Resident

Title: Creating a Diversity, Equity, and Inclusion Curriculum for Military Family Medicine Residents

Primary Author: Capt Afsoon Anvari, MD & LT Anna Rayne, MD

Introduction: Health disparities systematically and negatively impact disadvantaged groups, resulting in national calls to mitigate inequity. As clinicians caring for diverse communities of patients, family medicine physicians are uniquely poised to address health inequities, and targeting postgraduate education is frequently cited as a key solution. There are few reports of successful diversity, equity, and inclusion curricula described in the literature and none within the military health system. We prospectively studied the efficacy of an experiential and didactic teaching program on healthcare disparities knowledge in military family medicine residents.

Methods: A longitudinal curriculum in diversity, equity and inclusion was revised and implemented. Learners were assessed with a standardized exam in November 2019 and May 2021. 1. Design – Single group, pretest-posttest 2. Setting – Tri-service military family medicine residency program 3. Study Populations – 20/26 residents in graduating classes of 2021 and 2022 4. Educational Intervention(s) – Curriculum consists of annual team-based learning, quarterly morning didactics, an objective structured clinical examination (OSCE) on culturally-informed communication, caring for the underserved in a free clinic, and voluntary medical humanities meetings. 5. Main Outcome Measure(s) – A 19-question exam of standardized board questions pertaining to health disparities selected from prior American Board of Family Physician and American Board of Preventive Medicine in-service training exams 6. Statistical Test(s) Used – Paired t-test

Results: Across an 18-month time interval, 20 residents improved by 2.45 questions, a 12.9% improvement on the 19-question exam (p-value 0.002; 95% CI 1.08 to 3.82).

Conclusion: Resident physicians who participate in a longitudinal healthcare disparities curriculum improve in Family Medicine and Preventive Medicine Board questions addressing health inequities and social determinants of health. Applying this curriculum in other military family medicine programs may enhance diversity, equity and inclusion education of family medicine residents.

Case Report 1st Place Resident

Title: It All Started with a Pimple, How Did It End Up Like This? A Case of Steroid Resistant Pyoderma Gangrenosum

Primary Author: CPT Hillary Darrow, MD

Introduction/Objective: Pyoderma gangrenosum (PG) is a non-infectious, auto inflammatory dermatosis that occurs in only 3-10/1,000,000 patients but is associated with significant morbidity. Discussed here is a service member in whom early recognition of PG at the primary care level likely allowed for his successful management and continuation in military service.

Case Presentation: A 23-year-old healthy Active Duty male presented following three weeks of pustules on his left arm, and was diagnosed with cellulitis. Following two weeks of antibiotics, the patient's lesions were found to have progressed. In the setting of negative wound cultures, multiple antibiotic failure, and progression of the lesions to frank ulcers with granulomatous bases; the patient was diagnosed with PG and initiated on prednisone. The patient was referred to dermatology and received therapy with canakinumab, achieving resolution of his lesions at 18 months. Returning to unrestricted duty.

Discussion: PG is often misidentified as an infectious process on presentation, leading to detrimental debridement, broad spectrum antibiotics, and progression in the size and severity of the lesions. This condition has significant operational considerations, and prompt recognition can dictate the patient's chronic disability. In this case appropriate referral to dermatology allowed for relative containment of the patient's lesion, evaluation for syndromic PG (ie. Inflammatory bowel disease, malignancy), and initiation of anti-IL-1β monoclonal antibody therapy. Literature review demonstrates that our patient is younger and healthier than the typical PG population, and his resolution of symptoms with canakinumab is consistent with emerging case studies.

Scholarly Questions: Should transient immunosuppressive therapy prevent soldiers' participation in field training? Should canakinumab be considered as first line management of non-syndromic PG?

Conclusion: Continuity of care allowed a worsening clinical course to be recognized quickly, expanding the differential appropriately. Family Medicine's management of profile status and prompt escalation to dermatology and occupational therapy likely preserved this soldier's ability to continue in his military service.

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Case Report 2nd Place Resident

Title: Shot to the Heart

Primary Author: CPT Angadpal Batra, MD

Introduction/Objective: Adverse reactions and events to novel COVID vaccinations continue to be elucidated as a greater proportion of the population receives vaccination. To date, few studies have demonstrated myocarditis/pericarditis as an adverse reaction to vaccination. This case demonstrates development of myopericarditis two days following second dose of COVID vaccination in a previously healthy male.

Case Presentation: A 25-year-old Active Duty male with no prior illness or medical issues presents to the emergency department with acute onset chest pain, two days following the second dose of COVID-19 vaccination. On the day of his second vaccination, he reports developing tactile fever, body aches, and mild nausea. Two days later, the patient developed headache and sharp, substernal, pleuritic chest discomfort. Two subsequent EKG's revealed diffuse ST segment elevations. Furthermore, troponin, ESR, CRP, and AST were elevated. The patient's echocardiogram and cardiac MRI revealed normal structure and function without abnormalities.

Discussion: Emerging evidence suggests a temporal link between COVID vaccination and development of myocarditis but, to date, no such relationship has been shown with pericarditis. Myopericarditis may develop because of the robust inflammatory response elicited by vaccination and may not necessarily be characterized by imaging abnormalities. Inflammatory conditions involving the myocardium or pericardium following COVID vaccine related events are still poorly understood.

Scholarly Questions: Which findings are common characteristics of patient presentations of myocarditis following COVID vaccination?

Conclusion: To date, a small number of case reports indicate that common patient presentations of myocarditis following vaccination include younger age, male sex, substernal chest pain, preceding constitutional symptoms, and presentation most often 24-96 hours following second vaccination dose. While post-vaccination myocarditis cases continue to be reported, this case study demonstrates that myopericarditis may also be considered as a potential adverse reaction.

Case Report 3rd Place Resident

Title: "Altered Mental Status" in a 45-Year-Old Male: Guideline Ambiguity Results in Delayed Stroke Treatment

Primary Author: LT Charisse Villareal, MD

Introduction/Objective: The American Heart Association's (AHA) recommendation for thrombolytic therapy use for acute ischemic stroke (AIS) is contingent on clinical assessment of disabling symptoms. Presented is a case of a delayed treatment of AIS due to provider variability in clinical assessment and guideline ambiguity.

Case Presentation: A healthy 45-year-old male presented to the emergency department 2 hours after an acute change in mental status. The emergency physician evaluated the symptoms to be mild (National Institutes of Health Stroke Scale [NIHSS] score 3) and non-disabling. The admitting team evaluated the symptoms as mild and disabling, and subsequently ordered urgent MRIs which were positive for AIS without a large thrombus. Patient was started on maximum non-thrombolytic medical management as he was outside the thrombolytic window. Symptoms improved prior to discharge with the patient eventually making a complete recovery.

Discussion: The AHA currently recommends the use of thrombolytic therapy in patients with mild disabling symptoms, but not for mild non-disabling symptoms. Without a clear definition of disabling, this critical determination is left to the assessing provider's discretion at the time of the initial assessment. As a result, many eligible patients do not receive thrombolytic therapy. The use of urgent MRI in the presented case clarified the clinical variability in assessment and changed the treatment plan with thrombolytic therapy no longer an option due to the delay. The delay did not impact the long-term disability of the presented patient which is unfortunately not always the case.

Scholarly Questions: Would consistent use of urgent MRI in patients with an unclear AIS clinical presentation change the use of thrombolytic therapy? How would this effect long-term patient outcomes?

Conclusion: Clinicians should consider an urgent MRI in patients with suspected AIS with mild symptoms and an unclear disabling versus non-disabling determination.

2022 Juried Poster Abstract Winners

Poster Clinical Investigation Staff 1st Place

Title: Assessing Integration of Point of Care Ultrasound (POCUS) into Clinical Practice of Military Family Physicians

Primary Author: LTC Heather O'Mara, DO

Introduction: The objectives of this study were to identify the perceived importance of Point of Care Ultrasound (POCUS) by Military Family Physicians in the garrison and operational environment, current POCUS clinical practice, interest level for expanding knowledge and proficiency, and challenges to practice integration.

Methods: Design: cross-sectional survey. Setting: anonymous on-line survey. Study Population: Family Medicine physicians, medical students, and other healthcare professionals participating in the 2021 Uniformed Services Academy of Family Physicians annual meeting. Interventions: no interventions were made. Main Outcome Measures: 1) perceived importance of POCUS, 2) current POCUS credentialing status, 3) interest in expanding knowledge and proficiency, 4) challenges to practice integration. Statistical Test Used: Descriptive analysis.

Results: 297 conference participants responded for a 61% response rate. 72.9% (n=200) of respondents reported they felt POCUS was extremely important or important to clinical practice in the clinic or hospital setting. 83.9% (n=230) of respondents reported that POCUS was extremely important or important to deployed operational effectiveness. Of those who had completed residency, 3% (n=7) of respondents responded they were fully credentialed in nearly all POCUS modalities with an additional 46.3% (n=107) responding they were credentialed in at least 1 modality, the majority being obstetrical ultrasound. 79.2% of respondents (n=183) were interested in expanding their current credentials or obtaining initial POCUS credentials. Training funding and training time was the biggest challenge to implementing POCUS in clinical practice, with 40.5% ranking it the number one challenge (n=111) and 69.7% ranking it in the top two biggest challenges (n=191).

Conclusion: This study demonstrates most Military Family Medicine Physicians view POCUS as an important tool for both the deployed and hospital setting. There are a large number of Family Medicine physicians interested in expanding their POCUS knowledge and proficiency, with training funding and training time representing the biggest challenge to achieving this goal.

Poster Clinical Investigation Resident 1st Place

Title: A Randomized, Controlled, Multi-Site Trial of a Specific Acupuncture Protocol for the Treatment of Plantar Fasciosis

Primary Author: Capt Brett Rasmussen, MD

Introduction: Plantar fasciosis is a common cause of foot pain that has both a significant impact on a patient's quality of life as well as mission readiness in the military population. The aim of this study was to determine if the addition of a specific acupuncture protocol with electrostimulation to a standard exercise program is more effective at improving pain and function in adult patients with plantar fasciosis than a standard exercise program alone.

Methods: This was a randomized, non-blinded, multi-site controlled study of active duty and Department of Defense beneficiaries who were 18 years or older with a diagnosis of plantar fasciosis. 67 patients were randomized to either receive a deep ankle local acupuncture protocol along with home exercise program versus home exercise program alone. The primary outcome was change in the patient reported Defense and Veterans Pain Rating Scale (DVPRS) scores and the secondary outcome was change in the Revised Foot Function Index (FFI-R)-short questionnaire.

Results: The treatment group had a total of 32 patients (50 foot data points) and the control group had 35 patient (58 foot data points). Results of the intention to treat analysis indicate that acupuncture with electrostimulation demonstrates an immediate post-treatment reduction of DVPRS pain scores with a mean pain reduction difference of 0.9 points (95% CI, -0.7 to 1.1, $p<0.0001$), which reflects an average pain reduction of 26%. Furthermore, over a period of 12 weeks, acupuncture reduced pain by 36% in the acupuncture group verses 22% in control group ($p=0.013$, ANOVA)). It also improved FFI-R scores by 21% compared to 14% in the control group ($p=0.021$, ANOVA).

Conclusion: These results demonstrate that a specific acupuncture protocol with electrostimulation plus prescribed exercise is more effective than exercise alone at decreasing pain and improving function in both the short and long-term in adult patients with plantar fasciosis.

Poster Clinical Investigation Resident 2nd Place

Title: Association among Chronic Pain, Alcohol Consumption, and Tobacco Use in U.S. Soldiers

Primary Author: CPT Addison Bray, MD

Introduction: Chronic pain, hazardous alcohol consumption, and tobacco use have an impact on Soldier readiness. This study examined the relationship among these lifestyle habits and pain experience of Soldiers seen at the Womack Interdisciplinary Pain Management Center (IPMC).

Methods: Soldiers (N=203, 85% men, mean age 30.19, SD 7.10, range 19-55 years), treated at the IPMC, completed an intake questionnaire that included the Defense and Veterans Pain Rating Scale (DVPRS), a measure of pain intensity and functional impact. Alcohol use was measured using the Alcohol Use Disorders Identification Test-Concise (AUDIT-C). Patients were asked if they use tobacco, and how much/how often. Data were analyzed using descriptive statistics, Pearson correlation and t-test analyses.

Results: Mean duration of pain was 34.73 months (SD 38.66, median 24.00, range 3-240 months). The cut-off score in the hazardous drinking (HD) group was 4 for men and 3 for women. Compared to the non-HD group (N = 167), those in the HD group (N = 36) reported significantly higher interference on sleep and greater negative effect on mood (both Ps < .05). No significant difference was found between the non-tobacco (N = 144) and tobacco users (N = 59) on pain intensity, and pain effect on activity, sleep, mood and stress (all Ps > .05). Number of cigarettes smoked per day showed significant negative correlation with sleep interference and mood effect (both Ps < .03). Years of tobacco use showed significant negative correlations with pain intensity, worst pain, and average pain (all Ps < .05).

Conclusion: Soldiers with co-morbid pain and hazardous drinking reported greater effect of pain on sleep and mood. Higher amount nicotine users reported a significantly lower effect of pain on sleep and on mood; nicotine could likely be a coping mechanism. Additionally, long-term tobacco users were significantly likely to report lower pain intensity.

Poster Clinical Investigation Resident 3rd Place

Title: Pain it Forward: Mood Disorders and Chronic Pain

Primary Author: CPT Marc A. Cook, DO

Introduction: Up to 44 percent of soldiers are affected by chronic pain, creating costly impacts on disability and readiness. Chronic pain contributes to the risk of psychiatric disorders; however, the impact of the comorbid conditions needs elucidation. This study examined the association of co-existing clinical depression and anxiety with pain experience of soldiers seen at Womack's Interdisciplinary Pain Management Center (IPMC).

Methods: Soldiers seen at IPMC completed an intake questionnaire which contained the Defense and Veterans Pain Rating Scale (DVPRS), the depression (PHQ-9) and anxiety (GAD-7) scales of the Patient Health Questionnaire, Pain Catastrophizing Scale (PCS), and the Rolland-Morris Disability Questionnaire (RMDQ). We made comparisons between patients who met criteria for both a diagnosis of major depressive disorder and generalized anxiety disorder (D/A) and those without (non-D/A), using a threshold score of 10 or higher on the PHQ-9 and GAD-7. Of the 203 questionnaires retrospectively reviewed, we identified 115 and 52 for the non-D/A and D/A groups, respectively (mean age 30.92 versus 31.90). Data were analyzed using descriptive statistics and t-test analyses.

Results: Significant differences were found between the non-D/A and D/A groups on ratings of pain intensity, impact, and interference in functioning, pain catastrophizing tendency, and physical disability related to pain (all Ps < .001). Compared to the non-D/A group, soldiers who met criteria for simultaneous depression and anxiety diagnoses reported higher intensity of average pain, greater impact on sleep and stress, and stronger interference in functioning (all Ps < .001). D/A Soldiers also reported significantly greater pain catastrophizing tendency and greater physical disability (both Ps < .001).

Conclusion: Soldiers with chronic pain and comorbid clinical depression and anxiety suffer wide-ranging negative impact. The findings suggest that co-existing mood disorders must be identified and addressed to reduce negative impact of pain.

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Poster Educational Research 1st Place

Title: Where Do All the Kids Go? A Pilot Program to Increase Pediatric Enrollment in a Family Medicine Residency

Primary Author: Maj Rebecca Lauters, MD

Introduction: The Family Medicine Residency requirements state that residents must see 165 patients <10 years old in their primary clinic as a portion of the continuity visits to graduate. Family Medicine Residencies in the US have difficulty maintaining an adequate pediatric empanelment to meet the requirement. The military family medicine residencies face unique challenges with a limited patient population to draw from. The objective of this study is to evaluate the impact of embedding a pediatrician and their empanelment within a family medicine residency clinic (FMRC) and study the effect on pediatric encounter numbers.

Methods: Beginning March 2021, Kara Garcia MD, a staff pediatrician, was embedded into the Eglin Family Medicine Residency clinic, residents were assigned to work with her and see her clinic. Historical retrospective cohort study Eglin AFB FMRC 34 Family Medicine Residents 1) Staff pediatrician embedded into the Eglin FMRC in March2021 2) Number of pediatrics visits were calculated between May-Aug 2019 and May-Aug 2021 3) <10yo pediatric encounters were calculated for the 2019 and 2020 graduating classes for comparison at the end of the academic year. Main Outcome: Total number of <10yo visits in Eglin FMRC May-Aug 2021. Total number of pediatrics visits in Eglin FMRC between May-Aug 2021. Statistical Tests: Paired T-test

Results: In 2019 prior to COVID decrements and our intervention the total pediatric appointments in May-Aug 2019 was 993; the total number of <10yo appointments was 750. In May-Aug 2021 the total number of pediatrics visits was 1,785 and the total number of <10yo appointments was 1,382. This represents a 79.7% increase in total pediatric appointments and 84.2% increase in <10yo appointments.

Conclusion: Our ongoing study reveals a positive impact on total and <10yo pediatrics encounters between 2019 and 2021. This model could be implemented in other residency programs to support pediatrics encounter numbers.

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Poster Educational Research 2nd Place

Title: Project ROCKET: Residents Oriented Computer Knowledge EMR Training

Primary Author: Capt Cheng Zeng, DO & Capt Sue Chung, DO

Introduction: MHS GENESIS is the electronic medical record (EMR) system introduced to the Department of Defense in 2017. Despite end-user training, difficulties may still arise for family physicians transitioning to this new EMR. In inpatient setting, unfamiliarity can lead to incorrect orders or incomplete medication reconciliation, resulting in delayed patient care. We hypothesized that a standardized checklist may positively affect the efficiency and competence of physicians' inpatient EMR workflow.

Methods: Design: Randomized study with tested patients. Setting: David Grant USAF Medical Center Family Medicine Residency. Study Populations: Year one family medicine residents (n=12). Interventions: Residents in the intervention group received admission and discharge inpatient workflow guides as 'how to' documents . Both controlled and intervention groups received standard EMR end-users training and admission/discharge instruction sheets. Main Outcome Measures: Average time spent on task, task accuracy, and number of questions asked for assistance or clarification by residents for admission/discharge. Statistical Tests Used: Means with standard deviations. Unfortunately, none of the mean comparisons are statistically significant due to sample size.

Results: Average time of 65.1+/- 7.4 minutes for admission in the control group, compared to 58.3 +/- 9.5 minutes for the intervention group. Control group average time to complete a discharge was 17.5 +/-4.1 minutes compares to 18.7 +/-6.1 minutes for the intervention group. Mean admission accuracy scores for the control and intervention groups were 53.8 +/-7.7 and 60.5+/-7.2, respectively. Mean discharge accuracy scores for the control and intervention groups were 20.5+/-4.9 and 19.8+/-7.6. A total of 50 questions were asked by control group for clarification versus 21 questions from the intervention group.

Conclusion: A standardized workflow guide may help with time efficiency and accuracy for inpatient admissions in MHS GENESIS. Our results do not suggest significant improvement for inpatient discharges. However, this is likely due to similarity between the discharge instruction sheet and workflow guide.

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Poster Case Report 1st Place Resident

Title: A Rare Presentation of Non-Uremic Calciphylaxis

Primary Author: CPT Austin Tannenbaum, MD

Introduction/ Objective: Calciphylaxis is a small blood vessel vasculitis that presents with skin necrosis typically found in patients with end-stage renal disease (ESRD) on dialysis. This is a case report of patient with non-uremic calciphylaxis (NUC).

Case Presentation: An 87-year-old female with past medical history of chronic kidney disease (CKD) stage 3A2, hyperparathyroidism, and hypercalcemia presented to the clinic complaining of left lower extremity redness, pain, and blistering. The patient had presented to the Emergency Department twice for similar complaints the week prior, and was treated with clindamycin for suspected cellulitis without improvement. A stellate atrophic, indurated plaque with surrounding erythema and a large central eschar with ulceration was noted on the left lower leg. The patient was admitted and started on broad spectrum antibiotics. Dermatology was consulted and biopsies of the lesion were obtained for further evaluation and found to be diagnostic for calciphylaxis. Nephrology was consulted for recommendations regarding infusion of sodium thiosulfate (STS), but recommended surgical management due to risk of toxicity and adverse side effects. The patient was referred to wound care for surgical debridement and ongoing follow-up. The patient was discharged home with antibiotics and a plan for outpatient management.

Discussion: Risk factors for NUC include hyperparathyroidism, alcoholic liver disease, warfarin, and connective tissue diseases. Calciphylaxis carries a one year mortality rate of up to 50%. The most common cause of mortality is sepsis due to secondary infection. Our patient was discharged with antibiotics as a preventative measure prior to surgical intervention.

Scholarly Questions: What is the standard of care for NUC?

Conclusion: There is little evidence outside of case report supporting best practices for NUC. The management is multidisciplinary, involving Primary Care, Dermatology, Nephrology, and Wound Care. STS for calciphylaxis is an off-label use. Early diagnosis and debridement with a low threshold for antibiotics is critical in improving outcomes.

Introduction/Objective: Calciphylaxis is a small blood vessel vasculitis that presents with skin necrosis typically found in patients with end-stage renal disease (ESRD) on dialysis. This is a case report of patient with non-uremic calciphylaxis (NUC).

Dr. Kayla Watson accepting the award on behalf of Dr. Adamson

Poster Case Report 2nd Place Resident

Title: WHEN EPISTAXIS ATTACKS: Obstetric Care Turns Pulmonary/Critical Care

Primary Author: Capt Joseph R. Adamson, MD

Introduction/ Objective: Pulmonary arterial hypertension (PAH) is a rare cause of hypoxia in the post-partum period. Presented is a patient with undiagnosed Hereditary Hemorrhagic Telangiectasia (HHT) whose history of nosebleeds preceded post-partum PAH and life-threatening high-output heart failure.

Case Presentation: 22-year-old G1P1 s/p primary cesarean section complicated by severe preeclampsia presented to a 2-week postpartum visit with dyspnea, chest pressure, and cough. Found to have hypoxia, CXR with diffuse alveolar opacities, admitted for hypoxic respiratory failure to the OB service. CTA chest ruled out PE. Treated for pneumonia. Lack of improvement prompted concern for heart failure; echocardiography showed PAH. Transferred for right-heart catheterization which was unremarkable. PAH improved with diuresis. Readmitted for recurrent symptoms, liver CT done for incidental finding on CTA Chest showing hepatic arteriovenous shunt. Further history revealed recurrent worsening epistaxis. Diagnosis of HHT ultimately confirmed using genetic testing.

Discussion: Pulmonary hypertension is a rare post-partum condition with 12-38% mortality. Underlying etiologies are numerous, autosomal-dominant HHT is a rare cause, defined by vascular malformations in numerous locations throughout the body. Epistaxis with age-related progression is the most common presenting symptom of HHT and only two other documented cases of post-partum PAH were caused by undiagnosed HHT. Neither case followed pre-eclampsia, making this case atypical.

Scholarly Questions: Should women who complain of recurrent epistaxis during pregnancy be screened for HHT?

Conclusion: Shortness of breath and exertional dyspnea are common in life-threatening post-partum conditions like pneumonia, pulmonary embolism, and heart-failure. Due to its rarity, PAH is often initially overlooked. A high suspicion, broad differential, and careful history are needed to prompt appropriate testing to establish rare diagnoses – especially with unique presentations. Family physicians are well-suited to care for complicated obstetrics patients given our training in inpatient/emergency medicine. One should consider HHT in pregnant/post-partum patients without cardiac history who present with PAH or heart-failure, especially in light of recurrent epistaxis.

Poster Case Report 3rd Place Resident (Tie)

Title: Soldier Rattled by Second Snake Bite

Primary Author: CPT Brendan Lushbough, DO

Introduction/Objective: Rattlesnakes, copperheads, and water moccasins are members of the Crotalinae subfamily, account for the majority of snakebites in the United States, and are considered an occupational hazard for military members. This case demonstrates anaphylaxis after envenomation from two different species of the Crotalinae family in an active duty Servicemember.

Case Presentation: A 31-year-old with history of a copperhead snake bite as a child presented after receiving a rattlesnake bite. Initial presentation was significant facial and tongue swelling, difficulty breathing, and vomiting, and EMS treated him with an epi-pen. Primary survey in the emergency department additionally noted respiratory distress, mental status change, hypotension, tachycardia, and tachypnea. He was treated with five doses of 0.3mg intramuscular epinephrine, and ultimately required a continuous epinephrine drip for refractory symptoms until CroFab therapy was initiated. CroFab was continued in the ICU for 24 hours until symptom resolution, and patient was discharged three days later.

Discussion: Literature review reveals only two reported cases of systemic anaphylaxis after envenomation of two different Crotalinae species. In the United States, bites by Crotalinae snakes are most common in the summer months in the southern states, home to multiple United States military bases. Servicemembers deploy to austere environments inhabited by Crotaline snakes. While venom immunotherapy has been successfully implemented in the combat environment, it is both costly and complex for deployed units.7 Epi-pens provide a cheap, effective life-saving measure for envenomed Servicemembers that will require a higher level of care in both training and deployed environments.

Scholarly Questions: Does initial epi-pen administration reduce the use of Crofab after envenomation?

Conclusion: Anaphylaxis in a deployed environment requires preparation, well-trained personnel, and close interval access to medical facilities. Given documented reports of anaphylaxis to cross-species envenomation, epi-pens are a cost effective, potentially life-prolonging treatment that could provide soldiers time to evacuate to a higher level of care.

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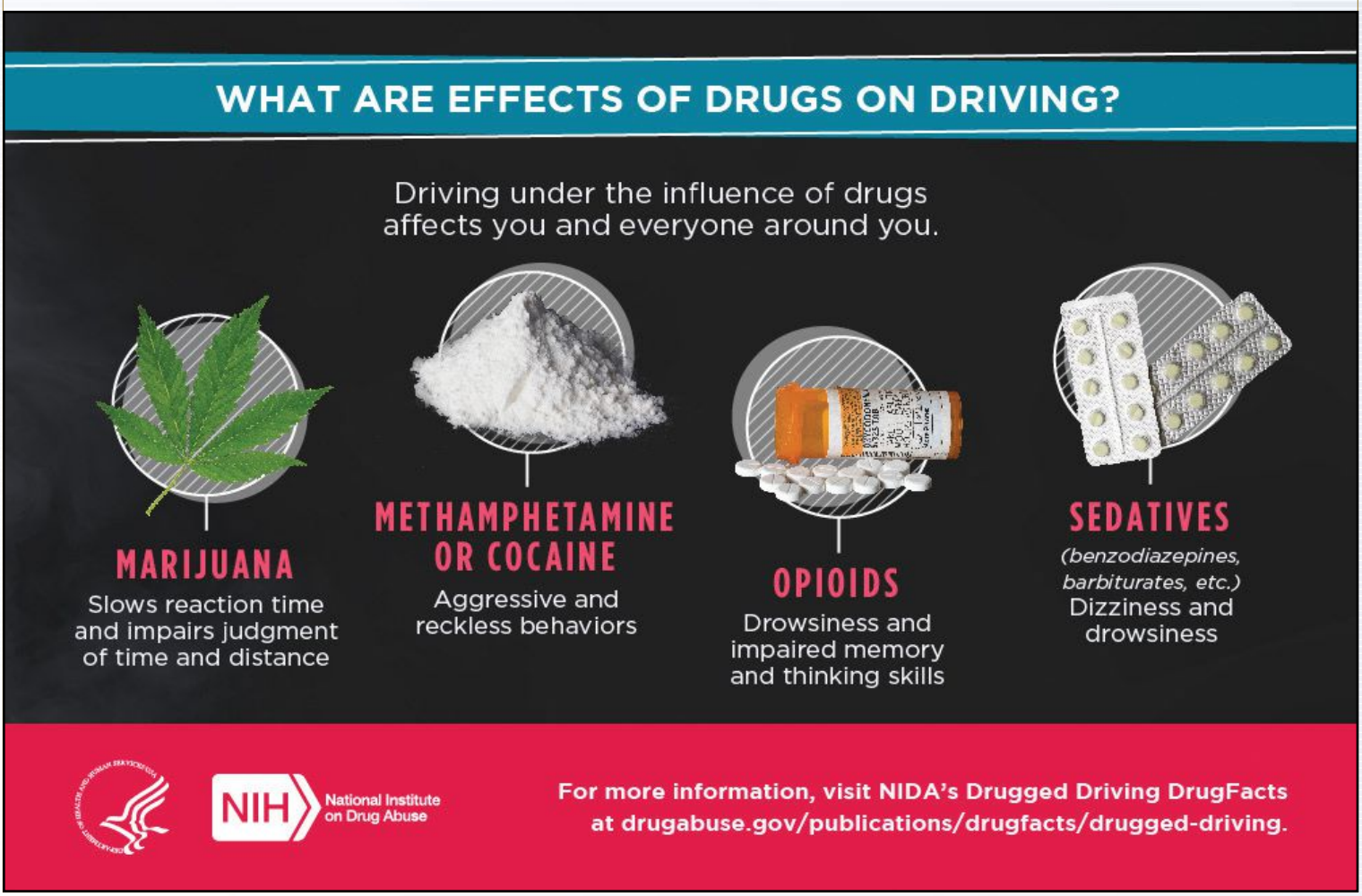

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Poster Case Report 3rd Place Resident (Tie)

Title: Low Risk is not No Risk: A Case of Unsuspected Necrotizing Fasciitis

Primary Author: Capt Taran W. Silva, DO

Introduction/Objective: Soft tissue infections are commonly seen on inpatient wards and many patients are risk stratified for potential necrotizing soft tissue infections (NSTIs) using the LRINEC Score. Presented is a patient risk stratified as "low but not no risk" using the LRINEC score, who had an NSTI.

Case Presentation: A 55-year-old female with a history of diabetes presented with upper back pain with skin drainage. Physical exam revealed erythema with tenderness that was out of proportion to exam, visible punctum without purulence, and induration without fluctuance. She was tachycardic and had a leukocytosis. CT scan showed no findings in the affected area. Ultrasound showed no abscess. She was admitted for sepsis secondary to soft tissue infection with LRINEC score of 5, indicating low but not no risk of NSTI and antibiotics were started. General surgery suspected a simple cellulitis without abscess. A few days later, the patient was brought to the OR after failing to improve, where she was found to have an NSTI.

Discussion: NSTIs typically present with erythema, edema, skin bullae, skin necrosis, fever, and crepitus. This patient was atypical because she had no bullae, necrosis of the skin, fever, or crepitus, and had an LRINEC score indicating a low risk of NSTI. The LRINEC score was created to screen for NSTIs, though it is based off data from one retrospective observational study with fewer than 500 patients and has performed poorly in external validation.

Scholarly Questions: Are there other clinical findings not included in the LRINEC score that may confer increased risk of NSTIs?

Conclusion: NSTIs are rare but lead to significant morbidity and mortality if not treated early. Clinical suspicion and pain incongruent with physical exam should prompt operative evaluation for NSTIs rather than relying on LRINEC scoring.

Poster Case Report 1st Place Medical Student

Title: Rare Skin Manifestations in an Elderly Patient with Waldenstrom Macroglobulinemia

Primary Author: CPT Kaleigh Mullen, DO

Introduction/Objective: Chronic medical conditions like venous insufficiency, diabetes, and chronic kidney disease may result in non-healing lower extremity ulcerations. However, in absence of these comorbidities, a non-healing lower extremity ulcer warrants further investigation, despite the age of the patient. The patient presented is an elderly female with a history of Waldenstrom Macroglobulinemia (WM) with a non-healing ulceration.

Case Presentation: An 86-year-old female with a history of WM and well-controlled HTN presented to clinic with a pustule that had expanded into a 5x6 cm ulceration despite topical and oral antibiotics over the course of six weeks. She was eventually admitted for cellulitis 8 weeks after presentation. While she had some improvement with intravenous antibiotics, the plastic surgeon who was consulted while inpatient was concerned for vasculitis etiology. Wound biopsy demonstrated stasis dermatitis with ulceration and underlying leukocytoclastic vasculitis. The patient ultimately was restarted on chemotherapy for WM and followed by wound care and hematology with improvement of symptoms after eight months of treatment.

Discussion: Only 5% of patients with WM develop cutaneous manifestations. Literature review demonstrates that prognosis of WM does not appear to be impacted by presence of cutaneous manifestations; however, cutaneous manifestations may reflect serum IgM levels and therefore primary presentation of WM or disease relapse. Immunosuppressive therapy should not be delayed in these patients, as wound care alone or treating possible secondary infections will not result in complete healing.

Scholarly Questions: What percentage of non-healing ulcerations in patients with history of WM are associated with relapse of disease?

Conclusion: Non-healing lower extremity ulcerations in patients with history of lymphoproliferative disorders may indicate recurrence of underlying disease. Research in the association of cutaneous manifestations and disease severity may demonstrate prognostic utility. Clinicians utilizing the knowledge of such association may prevent delays in care of lymphoproliferative disorders.

USAFP 2022 Outstanding Achievement in Scholarly Activity Awards

Overall Winner - Madigan Family Medicine Residency, Madigan Army Medical Center, JBLM, WA, Program Director MAJ Jeffrey Burket

Family Medicine Residency, Tripler Army Medical Center, Honolulu, HI, Program Director LTC Heather O'Mara

Family Medicine Residency, 96th Medical Group, Eglin Air Force Base, FL, Program Director Lt Col Jennifer Chang and Associate Program Director Dr. Rebecca Lauters.

Camp Lejeune Family Medicine Residency, Naval Medical Center Camp Lejeune, NC, Program Director CAPT Elizabeth Leonard. Dr. Joanne Gbenjo, staff physician and faculty research coordinator for the residency program accepted the award.

committee report
EDUCATION

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The Education has a new subcommittee – POCUS. Please visit www.usafp.org/committtees to join.

POCUS Corner: Ultrasound Is Great? Great. Now What?

Point-of-care Ultrasound (POCUS) is one of the hottest topics in primary care. It is easy to see why since POCUS is a powerful clinical tool that can be used for both diagnostic and therapeutic interventions. It facilitates education for our learners and patients about anatomy, physiology, and pathophysiology. It helps narrow differential diagnoses and improves time for proper treatment and disposition. Yet, for many, obtaining the necessary equipment and skill feels like the unattainable pot of gold at the end of the rainbow. Over the past few years, military physicians from multiple specialties, most notably primary care, have been clamoring over one another to bring POCUS to their clinical practices. Before you dive in head first and secure contracts for the fanciest or smallest machines available, it is crucial to consider what is needed to set yourself and your department up for long-term success.

Based on the 2021 USAFP Omnibus survey data, the vast majority of uniformed Family Medicine physicians perceive that the biggest barriers to POCUS implementation are training and equipment. While those are indeed barriers, the infrastructure to support image capture, labeling, storage, supervision, quality assurance, and portfolio development is usually an overlooked aspect of POCUS implementation. POCUS infrastructure is, in reality, probably the most important element to the successful employment of ultrasound within a practice. Without infrastructure to support the efficient development of privileging pathways, no amount of training or equipment will result in privileging of large numbers of family physicians.

Infrastructure considerations for any department should include asking the following questions:

1) Who will be allowed to perform scans and who will oversee them?
2) How will providers get access to ultrasound when they need it during clinical encounters?
3) How will transducers be appropriately cleaned if they become contaminated?
4) How will patient data be incorporated into the device and how will studies be ordered?
5) How will information and image transfer occur to long-term storage, such as Picture Archiving and Communication Systems (PACS)?
6) How will the images captured be integrated into patients' records?
7) How will documentation and billing occur, both of which require recallable images?
8) How will quality assurance review of images be conducted?

Solutions for many of these infrastructure problems are coming to military treatment facilities soon. In September 2022, the encounter-based imaging solution for MHS GENESIS will be piloted at Madigan Army Medical Center and will integrate patient demographics, ordering, labeling, documentation, billing, quality assurance, and portfolio development. To facilitate a successful rollout, any new ultrasound equipment must have an authority to operate on Defense Health Agency (DHA) networks. Ask your local information management experts to see if the equipment you wish to buy is already approved for use. If your desired device does not have an existing or pending DHA network approval to operate, you may end up facing significant delays while waiting to receive approval. If you are wondering where to look for equipment, try the electronic catalog, or E-CAT for short. Your administrative officers, Non-Commissioned Officers (NCOs), and/or simulation centers can help you search for equipment that is already pre-negotiated with vendors. Using the E-CAT will make your purchases easier and faster.

What else can you do now to help POCUS uptake in your clinics? The answers depend on your position.

Students:

- Ask questions during anatomy courses about sonographic appearances of normal and pathologic organs.
- Ask your rotation preceptors during clinical encounters about how POCUS could be used to help narrow differential diagnoses and guide therapy.

Residents:

- Look for opportunities in clinic where POCUS might be useful. Pre-position a machine before the exam or bring it in the room with you for the initial interview.
- Bring an ultrasound on inpatient rounds and use the opportunity to perform training examinations while teaching your patients about their anatomy and any pathology seen.
- Request an elective ultrasound rotation.

Staff/Faculty:

- Add POCUS cases to morning report schedules once a month.
- Familiarize yourself with privileging standards for POCUS. To this point, POCUS privileging is largely based on the American College of Emergency Physicians standards last published in 2016.
- Look for opportunities to use ultrasound in clinic; try using ultrasound to guide injections that you have previously performed blindly throughout your whole career.

Designated Clinical Champions:

- Ideally champions will be fully privileged for POCUS but it is okay if they are not. Negotiate with hospital or clinic leadership for support with training, equipment, and time. Champions should be able to execute the following: 1) Develop and oversee the longitudinal and rotational experiences for residents; 2) Collaborate with the other specialties who use ultrasound to facilitate supervised POCUS experiences; 3) Assist with equipment modernization; 4) Engage with MTF information management personnel to facilitate EMR integration of clinical images; 5) Ensure that quality assurance reviews are being conducted for scans performed by residents and staff.

Everyone:

- Join the AAFP POCUS Member Interest Group and plug in to the national community of Family Medicine POCUS enthusiasts.
- Join the USAFP POCUS Subcommittee which will help provide you with expert advice and resources specific to military primary care use of ultrasound.

As you move towards advancing your local POCUS efforts for clinical practice, continue the excitement, but be mindful of our responsibility to implement this technology with proper care and control. Recognize that all of us are in the effort together. If we pool our expertise and experience, we will have a greater impact on our patients and our community of family physicians. Happy scanning!

committee report
MEMBER CONSTITUENCIES

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Greetings Friends, Mentors and Colleagues. First, allow me to express my appreciation and excitement on being selected as the new Co-Chair for the Member Constituencies Committee. Second, here is a brief description of our purpose:

The Member Constituencies Committee was established to ensure cultural competence in regard to serving and educating patients and members… to foster leadership and mentoring opportunities among specific member populations; to promote inclusivity within the USAFP … and to address issues of current and emerging specific member populations...

To this end, if you are a member of one of the following constituencies and/or you are interested in learning more on how to improve the cultural competencies, opportunities and inclusivity of the USAFP, we invite you to join our committee! The specific member constituencies that we focus on include:

- New Physicians (less than 7 years out of residency)
- Female Physicians
- Lesbian, Gay, Bisexual, Transgender, Questioning or Queer Physicians
- Minority Physicians
- International Medical Graduates.

This year, one of our primary efforts will be developing a Diversity, Equity, Inclusion Toolkit within USAFP as an additional resource to decrease barriers to implementation within Graduate Medical Education programs. We will be collaborating with the Education Committee on this project as well. We will be drawing on resources already provided by the American Academy of Family Physicians (AAFP), the Accreditation Council for Graduate Medical Education (ACGME), the Society of Teachers of Family Medicine (STFM), and the Association of Family Medicine Residency Directors (AFMRD). If you are interested in contributing, please email me at mariama.massaquoi@gmail.com

We will also be working on providing safe and respectful opportunities for members to share their experiences and challenges in the military, where we seek to understand each other's history and lived experience and work together to move forward.

Finally, I would like to personally thank Janelle Marra for her tremendous leadership of this committee, her willingness to be a mentor for me during this process and her continued active participation as a member of the committee.

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committee report
OPERATIONAL MEDICINE

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In our desire to invigorate the work of the Operational Medicine Committee, we invite USAFP members to participate and contribute to the committee's effort and USAFP's overall mission to serve our members. As outlined in the bylaws of our organization, the mission of the Operational Medicine Committee is to support and enable USAFP members to successfully respond to ever-changing wartime, peacetime, and contingency operational/readiness requirements through scholarly activities, information sharing, and leadership. The committee works to strengthen the operational medicine roles of the Uniformed Family Physician by enhancing the operational knowledge, capabilities, and leadership abilities of all USAFP members.

HOW YOU CAN PARTICIPATE:

Sign up to be part of the USAFP Operational Medicine Committee by filling out the interest form at www.usafp.org/operational-medicine

UNIFORMED FAMILY PHYSICIAN NEWSLETTER

If you have a passion and/or an area of expertise, consider submitting an article to the Uniformed Family Physician quarterly newsletter. Topics to consider writing about are communicating risk to commanders, blood transfusion in the operational environment, walking blood bank implementation, arctic medicine and cold weather injuries, and other relevant topics in the field of flight and undersea medicine. We always welcome lessons learned from recent training exercises and

deployments that may help other military family physicians as they prepare for similar missions. For guidelines and instructions for authors visit www.usafp.org/usafp-newsletter.

2023 ANNUAL USAFP CONFERENCE TOPICS

Additionally, consider submitting a topic for the 2023 Annual USAFP Conference. The Call for Speakers submission portal is open now and will close on May 30, 2022. Visit www.usafp.org to access the submission link. Lastly, if you see an area of need and want to engage other family physicians in operational assignments, please reach out to the current committee co-chairs through our emails listed above.

REPORT FROM THE 2022 USAFP ANNUAL CONFERENCE:

There were over 15 operational medicine lectures, workshops, and panel discussions that occurred over the six days of the 2022 USAFP Annual Conference in Anaheim. Speakers presented a diverse series of topics including Afghanistan Evacuation lessons learned, the Air Force Readiness Forum, CBRNE considerations, and COVID response in the operational environment. Lectures on Arctic medicine and cold weather injuries had robust participation as well. In addition, attendees had the opportunity to participate in the Advanced Trauma Life Support Course and the Battlefield Acupuncture Workshop. We had engaging and robust participation by USAFP members during the Operational Medicine Committee interest meeting. The members recommended that the future work of the Operational Medicine committee focus on the following topics:

1. Communicating risk to commanders
2. Walking blood bank and low titer O whole blood transfusion
3. Artic Medicine and cold weather injuries
4. Care of the female warrior
5. Perspective of female physician leaders in the operational roles

TIPS FOR YOUR FIRST OPERATIONAL ASSIGNMENT

Lastly, we want to leave you with a few tips to consider as many of you will embark on your first job out of residency or report to your first assignment as an operational doc.

1. Research your gaining organization and get to know the history and motto of your new unit. Members of the unit generally take great pride in the organization's historical and current achievements. Your enthusiasm to be part of the team will set you up for success in your new assignment.
2. Schedule a meeting with the executive officer or direct supervisor in the first week after signing into your new unit. The earlier you can meet your boss, the sooner you will know what to expect from your new role.
3. Be curious about the unit's operational and training plan so you can best prepare the medical team to support the unit's mission.
4. Optimize your physical fitness in preparation for meeting your new unit. When the opportunity is there, demonstrate enthusiasm to participate in physical training, sports, and other activities which are commonly used to build camaraderie and esprit de corps within operational units.
5. In preparation for your initial counseling with your new Commander, consider the unique skills and abilities you bring to the fight as a military Family Physician, namely the ability to provide comprehensive and holistic care for service members and their families. Most commanders expect that you are clinically competent, but it is your composure, professionalism, and enthusiasm to be part of the team that will build trust with your new boss. Prepare a 30 second to one minute pitch that you can give to your new boss when asked about the capabilities that you (and those that you lead) can provide to the unit.
6. Connect with the medical leaders above, below, and around you in other sister units. These colleagues, often Family Physicians themselves, can serve as mentors while offering valuable counsel in your new role.
7. Get to know the hospital leadership on your base, and, at the minimum, meet with the Chief of Family Medicine. The Family Medicine Department at your hospital may allow you to maintain those clinical skills that are underutilized in your operational medicine assignment. More importantly, as you develop relationships with leaders at the hospital, you can use these connections to optimize the care of your unit by closing the gap between the operational community and the medical assets located on your new base.
8. Lastly, as you receive your orders and prepare to PCS, consider your leadership style, and how you want to mentor junior officers and other medical personnel under your supervision. Talk to your current mentor and supervisor or program director and residency faculty as you lean into your new role as a leader in the operational community.

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Don't Get Pulled Under, Tips to Help Your Clinic Ride the Genesis Wave

Change is always difficult, but with the right preparation, you too can ride the MHS GENESIS (MHSG) wave without being pulled under! Transitioning away from an almost 30-year-old electronic health record is no small feat. While the transition to MHSG can be stressful, the opportunity to consolidate inpatient, outpatient, and emergency care records into a single system greatly simplifies patient care. To help you and your team with this transition, we have identified seven key lessons to set your clinic up for success.

1. Identify your Key Team: Identify multiple SuperUsers since deployments or other taskers may pull one of them away. Consider having both clinic leadership personnel and motivated staff as SuperUsers. When choosing SuperUsers, think of individuals who are innovators or early adopters of technology, good communicators, and, most importantly, possess optimism in the setting of change. A positive attitude will carry your team far during times of stress! Ensure that your SuperUsers collaborate frequently and provide them a forum to share valuable tips with the rest of the staff.

2. Examine and Rethink your Workflows: Roles are more rigorously defined in MHSG. Each member of the team has a specific part to play in patient care and there is less ability to cross cover between jobs.
   - APPOINTMENT TYPES: Since there no detail codes for appointments to annotate if there are age or other practice restrictions (e.g. no OB) or to communicate the type of appointment (e.g. well-child or well-woman visit), it is important to work with the appointment booking personnel to establish a shared understanding of what kinds of appointments are appropriate for each provider's clinic template. See the Defense Health Agency MHS GENESIS Access Maintenance Manager SOP 1.1 for the list of appointment types and additional details on the MHS template language.
   - PATIENT TRACKING: How will you move a patient through the clinic physically and virtually? Currently, clinics may use a paper form to help track a patient throughout their clinic appointment and to facilitate communication among the health care staff. Within MHSG, this tracking is managed within the system. Patients will need to be electronically checked in, screened by the nurse, examined, and checked out. In MHSG, the check-in and check-out features are vital as they impact background functions. Failure to use these features appropriately can result in lost documentation and inhibit the ability for the patient to be seen in other sections of the hospital.
   - INTERNAL REFERRALS: How will you handle internal referrals such as scheduling patients for primary care procedures, immunizations, Sports Medicine or integrated Behavioral Health appointments? One option is to use a Referral 2.0 order, which would be managed the same way as external consults. These orders must be closed out through a specific workflow process (See the Defense Health Agency MHS Genesis RM 2.0 Referral Management Guide). While this takes additional manpower, it does offer the benefit of closing the loop by sending the completed encounter to the referring provider. Alternatively, you could use a "clinic follow up" order or send a message to a clinic inbox.

- STAFF AUTHORIZED TASKS: Ensure you establish protocols regarding what your staff can order and evaluate independently (e.g. continuity of care referrals, certain lab or medication orders, routine immunizations). Ensure your protocols align with the MHSG role capabilities.

3. Roles: MHSG is very strict with establishing roles and you must ensure your staff have training for the correct role.
   - NURSING ROLES: Develop an understanding of the differences among RN, LPN, and MSA role functions to adjust your standard operating procedures and clinic workflows within MHSG.
   - MASS READINESS TRAINING: Recommended for all providers who will do large volume pre-deployment and post-deployment screening.
   - ADVANCED SCHEDULING: Your Practice Manager and at LEAST one other person need this role for day-to-day schedule adjustments. Your organization may try to centralize this for the entire hospital, but that will severely limit your ability to adjust to things such as last-minute schedule changes.

4. Training events: Cerner trainers are focused on teaching you the very basics of MHSG such as its interface, appropriate terminology, and system capabilities. Pay-it-Forward personnel teach you more advanced practical tips for setting your preferences and workflows to complete your encounters.
   - SUPERUSER TRAINING: Your SuperUsers will have monthly one-hour webinars approximately nine months prior to go-live. SuperUsers will have additional JKO computer-based training modules they will need time to complete and 3-5 days of in-person training.
   - ROLE TRAINING: Identify which type of training you would like individuals to complete. Each individual will need approximately four hours for the computer-based JKO training modules. The instructor-led training will last approximately six hours and start two to three months prior to go-live. Remember, Pay It Forward staff will help you with everything you need to take care of the patient when the time comes.
   - LEARNING LAB: This will be offered during the month prior to Go-Live. This is optional, but provides another opportunity to interface with the system. You can use the pre-built scenarios provided by the trainers or ask questions that may have come up while trying to anticipate workflow changes. Consider attending as a multi-disciplinary team so everyone has a shared understanding of the workflow of all team members and how the pieces 'fit together.'
   - SIGN-ON FAIR: This will occur a few weeks prior to Go-Live and is required to ensure all users have access to the system.
   - FAVORITES FAIR: This is available the month of Go-Live, but must be scheduled AFTER the Sign-On Fair session to ensure you have access. Dr. Robert Marshall (USAFP Clinical Informatics Committee) has put together a wonderful guide which outlines several recommended settings. This is the only time you are approved to interface with the live environment before Go-Live, so leverage it to the best of your ability. You must manually configure your own account preferences. Your staff will need to know your Defense Medical Information System (DMIS) identifier to help with clinic mapping.
   - JUST IN TIME TRAINING: This will occur just before Go-Live. This is optional, and may not be well advertised at your organization. Consider bringing your clinic leadership and SuperUsers to test how all the components of your workflow come together during a patient encounter.

5. Don't get caught flat: Here are key things to prepare in advance:
   - ANCILLARY DEVICES: Document Scanners, ID Card scanners, and label printers all come as MHSG equipment. Use your workflows to decide where you want them placed (e.g. ID card scanner in immunizations or a label printer in the Procedures Clinic). Make sure to confirm these devices work prior to Go-Live.
   - CLINIC STOCK: Anticipate that each vaccine vial or clinic medication will need to be entered into your clinic's dispensing system in order to administer it in MHSG. Your pharmacy staff should be able to assist you with this.
   - DEA AND NPI NUMBERS: DEA numbers need to be accurately entered into MHSG or else you will not be able to prescribe controlled substances. This is especially critical for unlicensed residents and Physician Assistants who are using an institutional DEA number. It is also crucial that each provider's

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NPI number is entered into MHSG or else that provider will not be able to prescribe any medications.

- SURESCRIPTS: Ensure prescribers have activated their Surescripts accounts in advance.
- FETALINK: This system provides the ability to view fetal strips and will not work via a Wi-Fi network connection. It is mandatory to use this program on a wired LAN line. This is an important consideration when determining where to locate computers requiring access to FetaLink.

6. Final Considerations:
   - Consider adjusting your clinic templates to allow for more acute visits the month prior to Go-Live since some MHSG training events are scheduled with short notice.
   - Decrease scheduled appointments two days prior to Go-Live to allow time to close out all TRICARE secure messaging and AHLTA encounters.
   - Minimize new orders that may not be completed prior to Go-Live. For the last few days prior to Go-Live, maintain a HIPAA secure list for patient requests that can wait to be entered when MHSG comes online. This will ensure referrals and other ancillary orders are not lost during the cut-over to MHSG.
   - Plan events like pre-deployment screening prior to Go-Live. Encourage your patients to pick up their refills prior to Go-Live since the Pharmacy will also experience significant delays during the roll-out.
   - Find out who your Pay-It-Forward staff are early and coordinate with them regarding the best way to support you during the roll-out.
   - Consider establishing a naming convention for your clinic notes (e.g. Clinic-Diabetes). If you do not, every note will be entitled "outpatient encounter" and they will be difficult to sort through later when you need information about a specific diagnosis.
   - Clear the schedule for your leadership team as much as possible the week before and after Go-Live to respond to short suspense issues.

7. After Roll Out: Adapt, adapt, adapt. Be patient with yourself and each other.
   - Create a Command Station. Consider using your conference room as a central location for the leadership team, SuperUsers, and Pay-it-Forward personnel. This will facilitate easier access to the right people when questions arise.
   - Use the outpatient workflow. Resist the urge to work directly within a patient note. Avoid reliance on AHLTA since access to that system will soon disappear.
   - Configure Joint Legacy Viewer (JLV) to maximize efficiency. Create separate tabs for different sections of the EMR (e.g. encounters, radiology, labs, medications, immunizations). On each tab, use the widget tray to drag and drop multiple widgets of the same type onto a single tab. This will allow you to set different time period parameters so a large volume of data pulls simultaneously. Note, if you do this in advance through AHLTA, it DOES NOT carry forward to your JLV link in MHSG.
   - Request your lab and radiology departments to publish lists of the new names of common orders (e.g. at most institutions, a Quad Screen is now "AFP Tetra")
   - Verify that schedules are accurate. There will be a lot of mistakes and schedule corrections. Protect your Practice Manager's time so they can stay on top of it.
   - Continue to check AHLTA/CHCS for new results periodically while you can – what you ordered before the roll-over may not result in MHSG. Anticipate you may have AHLTA access for only 1-3 months after Go-Live.

     Develop a concise way to share information. A lot of information will be flowing in from multiple sources as your institution refines workflows and becomes familiar with MHSG. To prevent email fatigue or missed opportunities from verbal announcements, batch the learning points into one end-of-day email or create a shared document where each user can share critical items they have learned.

Don't forget to reward your team and yourself for all of the hard work invested into this process. Whether you submit awards for your staff or simply bring in coffee and donuts, every gesture of recognition will make the challenges that much easier to bear. While the transition to MHSG will inevitably bring challenges, careful planning will ensure your organization will be successful!

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Fight Tonight, a Shift in the Way We Prepare for Deployments

"When the time to perform arrives, the time to prepare has passed." Unknown

My first deployment came about the way I always expected. I received a call from my program director saying I was tasked to deploy to Al Dhafra Air Base in the United Arab Emirates (UAE) in about six months. Several checklists later, along with a TDY assignment for additional training, and I was ready to go. Prior to my departure, I connected with the person I was replacing, and began reading up on some of the medical conditions I was likely to see. When the time to deploy arrived, I felt about as prepared as I could be.

Upon my arrival at Al Dhafra, I operated the equivalent of an urgent care clinic. I treated patients with musculoskeletal injuries and fractures, depression and anxiety, coughs and colds, STDs and pregnancies, and even a few major trauma injuries. I helped prepare the base for possible mass casualty events and implemented a walking blood blank protocol with my colleagues. It was the type of deployment I had anticipated and considered "typical" in nearly every way.

In contrast, my second deployment involved receiving a phone call late on a Friday night informing me that I would be leaving within the next 72 hours to support a COVID operation in an unknown civilian location. By the following week, I was credentialed and working in a converted ICU with prison guards outside the rooms. This was not the type of deployment I would have ever envisioned. I scrambled to remember the appropriate ventilator settings and to establish relationships with the exhausted physicians I was tasked to assist. I remember wishing I had more time to prepare and review critical care management before being thrust into this setting.

The latter experience of deploying with short-notice and practicing in an unexpected environment is becoming the norm. Our Family Medicine colleagues have deployed to a wide variety of areas and found themselves in roles they never expected. Some have run inpatient services or had to intubate critically ill patients en-route for transport. Still others have converted clinics into emergency rooms or inpatient units in order to treat hundreds of refugees. We have gone from having six months to prepare for a deployment to receiving word less than 72 hours prior to providing assistance for overwhelmed hospitals, burgeoning refugee camps, or critical care transport missions from Europe. The concept of a "standard deployment" is disappearing. If we hope to develop a medical corps that is ready to "Fight Tonight," we must strive to maintain the breadth of skills attained during our residency training. For those approaching residency graduation, it is critical to maintain a growth mindset and avoid the lure of complacency after residency. We must maintain the diverse skills that so uniquely position Family Medicine physicians to provide care in a variety of settings throughout the world. As Family Medicine physicians, we are trained to provide a broad scope of clinical care to our patients. During our training, we may find ourselves going from a precipitous delivery to a neonatal resuscitation, then to handling acute emergencies on the inpatient ward or in the emergency department – often in the same day! Sometimes, however, there can be a tendency to avoid situations where we do not feel comfortable, whether that is leading a code or performing an intubation. Yet, as highlighted in the scenarios above, these are the very same tasks we may be asked to perform during a short notice deployment. In order

to be prepared, we should challenge ourselves to seek out opportunities and learn how to be comfortable with the uncomfortable. Maintaining our broad spectrum of clinical skills is not easy. There are often competing demands such as the need to maintain outpatient access to care or to complete computer based annual training. While the most senior leaders in military medicine are beginning to focus on the necessity of maintaining deployed medical skills, it is imperative that all of us do our part as well. For those serving in leadership roles in the clinic and hospital, work to create the conditions where family physicians have opportunities to practice in the emergency department or on the inpatient ward. Strive to develop policies that identify the importance of each physician maintaining the skills needed to practice at the top of their clinical privileges. For those who are not in leadership positions, seek out opportunities to maintain your skills by asking to work on the labor deck, in the emergency department or on the ward. If those opportunities are not available within your military treatment facility, consider exploring off-duty employment opportunities or asking to attend training events that offer additional procedural skill training. The luxury of having months to prepare for an upcoming assignment and to brush up on lost skills has passed. Recent world events have demonstrated that military family physicians will be asked to fill a variety of deployed roles. In order to be prepared for these varied future tasks, it is imperative that we maintain the broad set of clinical skills that we learned in residency training. Family Medicine is valued by the military for its versatility in a wide range of environments. However, if most of our newly graduated physicians are assigned to locations where they predominantly see routine outpatient clinic patients, it will be challenging to rapidly pivot to regain their inpatient medicine, trauma, or obstetrical skills. The agility of Family Medicine has never been more vital to the mission of the Uniformed Services. We need to be innovative and deliberate in the way in which we maintain that adaptability and resilience.

Disclaimer:

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

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Committee Updates

It felt like the day would never come when we would finally be given the opportunity to see one another at the USAFP Annual Meeting! With great fortune, however, that incredible week of fellowship and education reunited many of us again in Anaheim. During challenging times like these, one can certainly understand why convening with friends, mentors, and like-minded people rejuvenates our spirit. The annual meeting revitalized the Wellness & Resiliency Committee as well, and we wanted to update our readers on how we hope to grow together throughout the upcoming year.

DEFINING WELLNESS & RESILIENCY

Each one of us has faced seemingly insurmountable tasks in the past. Whether that was harvesting two bushels of strawberries in one day, passing your Gastrointestinal Module in medical school, or getting hold of that last spaghetti noodle with your fork, we often struggle to see a victorious outcome. The Wellness & Resiliency Committee faced a similarly challenging task as we attempted to assign definitions to the words "wellness" and "resiliency." Even the great philosopher physicians from our committee that gathered at the Anaheim Marriott posed a myriad of different definitions for these terms. I share this to illustrate the point that what makes a person both well and resilient is specific to each individual human being.

At the conclusion of our meeting, the members of Wellness & Resiliency Committee concluded that there are numerous strategies available that can address our unique wellness and resiliency needs. Examples of beneficial activities highlighted within our group included nutrition classes, sleep education, and financial enhancement among many others. Our committee has provided links to many valuable resources on the USAFP Website (https://usafp.org/wellness-and-resiliency/). Our committee plans to share additional resources that our academy members can use to remain both emotionally and physically healthy.

THE SEVEN FACETS OF WELLBEING

As one of my mentors once told me, becoming a physician requires becoming a lifelong learner. There are constantly new pursuits with which we fall in love simply by keeping an open mind. Also, we can always better ourselves at interests in which we already engage. The University of Chicago Student Wellness Center utilizes seven facets to help ensure that its students are promoting a healthy balance within their lives. Our committee believes that USAFP members, being lifelong learners, can use this paradigm to foster wellness and resiliency throughout the academy in the ways previously mentioned. You can visit the University of Chicago website to learn more (https://wellness.uchicago.edu/healthy-living/outreach)

Our goal for the upcoming editions of the Uniformed Family Physician is to explore each of the seven principles in more detail. Each quarterly newsletter will feature an installment of one portion of this continuum. Our first topic next quarter will be a review of the characteristics of financial wellbeing.

FUTURE GOALS

In addition to the upcoming articles exploring the seven facets of wellness, the Wellness & Resiliency Committee established additional goals. First, the committee wants to provide additional avenues for mentorship that span across installations and branches in recognition that military medicine will require more jointness moving forward. Second, the committee plans to incorporate USAFP family members into our initiatives since they are so critical to the overall wellbeing of our members. Finally, the committee plans to sponsor workshops and other activities that will promote wellbeing, including the establishment of "Wellness Warriors" at many of our military treatment facilities.

Our committee would love to have you part of our team! If you have an interest in joining the Wellness & Resiliency Committee or would like to write an article for an upcoming edition, please reach out to me. We are all in this together, and we are certainly better because of it.

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Bianca.Canales@kp.org or 510-421-2183

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Contact Harjit Singh at:
Harjit.X.Singh@kp.org or 510-295-7857

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

Harvard Business Review: The Burnout Epidemic: The Rise of Chronic Stress and How We Can Fix It

by Jennifer Moss

KEY POINTS TO THIS BOOK REVIEW:

1. Recent survey of Family Physicians (Larry Green Center) found that 71% report all-time high levels of burnout or mental exhaustion
2. Burnout is really an **organizational problem** resulting from **poor Corporate Hygiene** which requires improved leadership and an organizational solution
3. Leaders need to understand and counteract the Six Causes of Burnout, lead with empathy, and be good role models themselves for Healthy Behaviors

For the past decade, we have seen (and many of us have personally experienced) a significant rise in the rate of burnout at work, with many underlying factors. In the Military Healthcare System, we have faced the challenges of the wars in Iraq and Afghanistan, increasing documentation requirements in our Electronic Health Records, and rapidly increasing progress in medical research and knowledge. Healthcare has been one of the hardest hit professions in terms of burnout, with many of the traits that make excellent physicians also predisposing us to burnout and high rates of suicide.

The World Health Organization has defined Burnout as a syndrome conceptualized as resulting from chronic workplace stress that has not been successfully managed, with three dimensions:

- Feelings of energy depletion or exhaustion
- Increased mental distance from one's job, or feelings of negativism or cynicism related to one's job
- Reduced professional efficacy

In response, many companies have resorted to providing employees with programs aimed at empowering **individuals** to improve their own "self-care," but as the author points out, these measures are a "tactic, not a strategy," and they ignore several important truths about the six causes of burnout. Critically, Ms. Moss argues that burnout is not "just" an employee problem, but an **organizational** problem that demands organizational solutions. As leaders, we need to create the conditions in our workplaces that lead to a healthy, happy and high-performing workforce—one that is flourishing, not just surviving.

Ms. Moss describes the Six Causes of Burnout:

1. Workload
2. Perceived Lack of Control
3. Lack of Reward and Recognition
4. Poor Relationships
5. Lack of Fairness
6. Values Mismatch Between the Employee and Organization

The major force behind these six causes is "Poor Corporate Hygiene," which does not really lie with the individual employee. These causes can be averted, if only Leadership starts its prevention strategies further upstream.

The author describes in detail how the six causes contribute to Burnout, and I would like to highlight just a few:

1. Workload: Physicians have inherently long work hours, between their medical education/residency training as well as the burden of frequent on-call duties. Even when physicians have a "40-hour work week" of outpatient clinical care, the additional challenge of following up test results, trying to provide robust primary care in 20-minute time slots, completing EHR documentation and responding to patient phone/email messages often requires over 50 hours per week. Other factors impacting a physician's overall workload include:
   a. An increasing number of female physicians and dual working couples has increased the amount of family responsibilities that many physicians face
   b. As military medical officers, we also need time to maintain our own physical fitness, provide leadership for our clinical teams, and model healthy behaviors
   c. Physicians should stop being "always on":
      i. We need real mid-day breaks, avoid "lunch meetings"
      ii. Vacation: completely "off the grid"/no work email monitoring

iii. Limited on-call/24-7 availability
iv. No work on most weekends?

2. Perceived Lack of Control:
   d. No worker benefits from constant micromanagement
   e. Physicians would feel more engaged if they have more control of what they work on and who they work with; previous studies have shown that when employees can do the work that they value most for at least 20% of their work, they have much lower rates of burnout
3. Reward and Recognition:
   f. Employees perform their best with consistent recognition, which should come from both their clinical supervisors as well as gratitude from their fellow healthcare team members, for superb patient care or peer support
   g. One of the best ways that leaders can recognize their team members is by empathetic listening and then IMPLEMENTING their good ideas; Leaders need to do a better job of discovering and sharing Best Practices
4. Poor relationships:
   h. We spend 50% of our waking hours at work, so healthy relations are vital to our mental health. Do we have time to foster strong relationships or are we all too busy and stressed out to form healthy work bonds?
   i. Having a "best friend at work" and having supportive co-workers are the factors most closely linked to good health
   j. Does the workplace foster collaborative efforts within/between various departments, or is there a competitive drive for scarce resources?
5. Lack of Fairness: A variety of conditions can foster a lack of organizational justice: bias, favoritism, mistreatment by coworker or supervisor, unfair/unequal compensation or corporate policies. These become more significant in workplaces that lack the safety for employees to give honest feedback to the leaders.
6. Values Mismatch between organization and employee: should be established PRIOR to hiring process or during initial interview

All of these factors can be improved or worsened depending on the first line leadership that we experience in our clinical areas. Poor/infrequent communication is a common factor in the six causes.

Ms. Moss offers several insights into strategies that can help and how to measure burnout, to see if we are making any progress. Most importantly, she discusses those leadership skills most needed to help improve our Corporate Hygiene/Culture and thus decrease employee burnout.

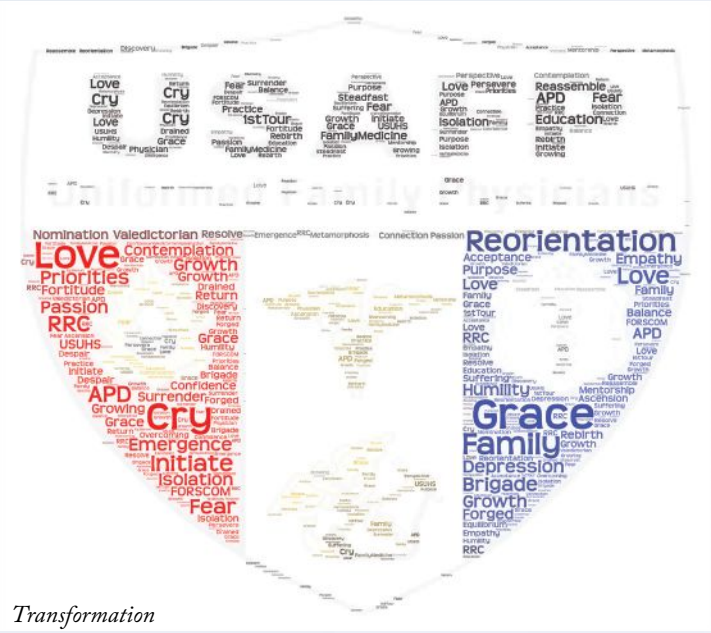
The remainder of the book focuses on what we can do as Leaders to decrease burnout in our workplaces. In addition to recognizing and addressing the Six Causes of Burnout, Leaders need to develop empathetic listening skills, learn to "Lead with Curiosity", and model individual habits that help to decrease the risk of burnout: regular exercise, quality sleep, good personal relationships and the avoidance of excessive work.

Shared Vulnerability—Shared Strength

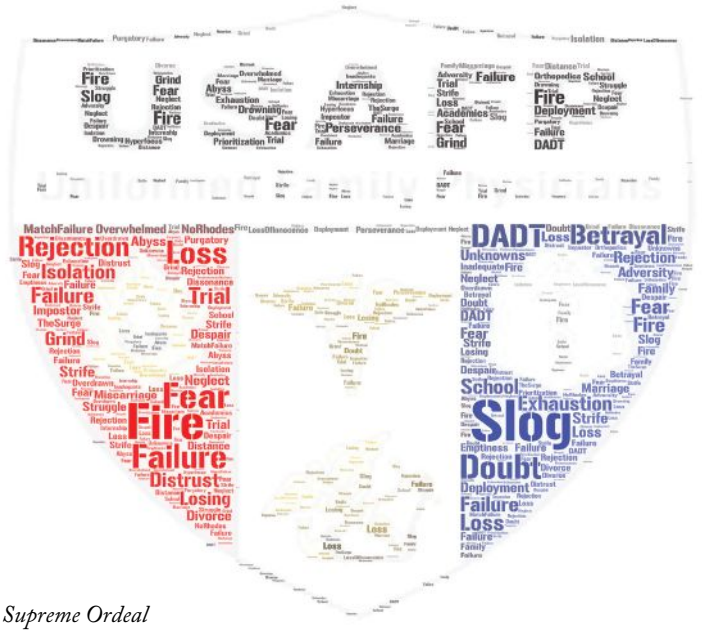
USAFP Family—thank you for the wonderful opportunity to linger in community and camaraderie while in Anaheim for the 2022 Annual Meeting. The ability to gather in person, exchange hugs and handshakes while luxuriating in the warmth of shared presence was nourishing (and, for me, quite needed!). Thank you also for engaging in shared dialogue with colleagues to share bits of your own Hero's Journey. As promised, the word clouds offer a glimpse into the Call to Adventure, Supreme Ordeal, Transformation and Hero's Return.

#WeAre …. Family Medicine!

**NOTE: USAFP Past President Mark B. Stephens, MD MS FAAFP, CAPT (ret) MC USN presented a Keynote Address during the 2022 USAFP Annual Meeting in Anaheim. Mark currently serves as Interim Associate Dean for Medical Education, Professor of Family and Community Medicine, Professor of Humanities at Penn State College of Medicine in University Park, PA.*

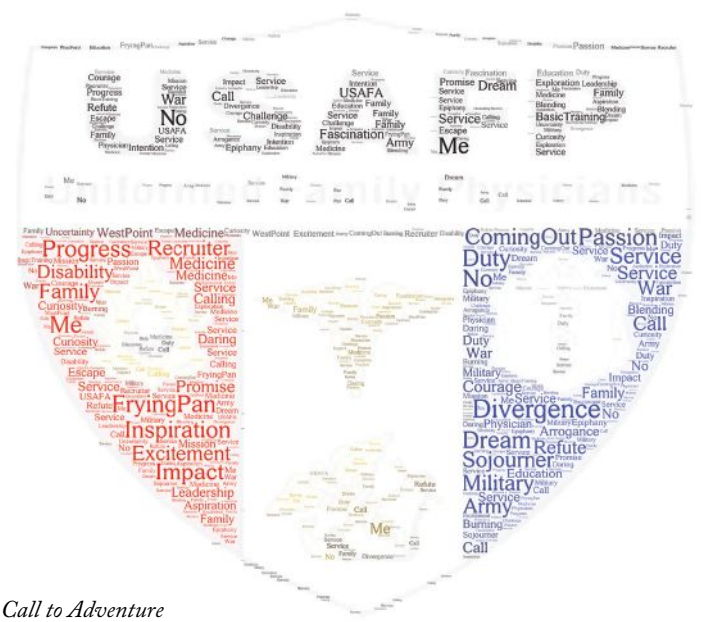


Transformation



Supreme Ordeal

Hero's Return



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National Conference of Constituency Leaders and Annual Chapter Leadership Forum: Back in Person in Kansas City!!

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

Due to COVID-19, the past two American Academy of Family Physicians (AAFP) National Conference of Constituency Leaders (NCCL) and Annual Chapter Leader Forum (ACLF) meetings were cancelled or held virtually. This April, NCCL and ACLF were able to resume in person in Kansas City, MO.

ACLF is the AAFP's leadership development program for chapter-elected leaders, aspiring chapter leaders, and chapter staff. NCCL is the AAFP's leadership and policy development event for underrepresented constituencies and serves as a platform for different perspectives and concerns of AAFP members to help bring about change. NCCL is also an opportunity for underrepresented groups in leadership in medicine to gain leadership skills, meet other colleagues who share similar interests and participate in creating resolutions to bring to the Congress of Delegates (COD). The NCCL Constituencies mirror the groups included in the USAFP member constituencies committee, including women, underrepresented minorities, new physicians, international medical graduates, and LGBTQ+ physicians.

USAFP's delegation to NCCL this year included Taylor James, MD (Women), Dan Molina, MD (Minority), Alex Knobloch, MD (New Physician), Rachel Carter, MD (IMG), Sterling Brodniak, DO (LGBTQ+), and Kevin Bernstein, MD (YPS- AMA Delegate). Janelle Marra, DO was the co-convener of the LGBTQ+ constituency and Spencer Fray MD was elected as the Minority co-convener. USAFP's delegation to the ACLF included USAFP President Marcus Alexander, MD and USAFP President-Elect Kevin Bernstein, MD. Thank you to Dr. Bernstein for serving in two capacities during the events.

On April 27th, the attendees of NCCL and ACLF were welcomed back to Kansas City at the Meet and Greet reception event. On April 28th, an opening session and plenary with AAFP's senior leadership provided updates on the Academy and addressed current issues of critical importance. Following the plenary, the NCCL constituency

USAFP Leaders pictured in the ballroom after the plenary lunch are: Alex Knobloch, MD, Kevin Bernstein, MD, Janelle Marra, DO, Taylor James, MD and A. Marcus Alexander, MD. (not pictured are Rachel Carter, MD and Dan Molina, MD)

Pictured are delegates to NCCL discussing resolutions submitted for consideration.

delegates divided out into working groups and created ten resolutions per group to forward to the reference committees including advocacy, education, health of the public and science, organization and finance, and practice enhancement. The evening of April 28th attendees from the USAFP joined leaders from the Virginia, North Carolina and Georgia chapters for dinner for a combined group of nearly 60 physicians and staff.

Attendees from USAFP helped to author three of the thirty-nine resolutions voted on, including:

HEALTH OF THE PUBLIC AND SCIENCE

3003: Support Transgender Child and Adolescent Athletes
3004: Social Determinants of Health: Expanding Screening and Service Reimbursement
3006: Equity for Non-Binary Service Members

To view current and past NCCL resolutions visit https://www.aafp.org/events/aclf-nccl/nccl/resolutions.html#past-years

Prior to the closing of the NCCL, voting commenced for the 2023 co-conveners, alternate delegates and delegates to the American Medical Association-Yong Physicians Section (AMA-YPS). USAFP member Rachel Carter MD was elected IMG co-convener and alternate delegate.

I am looking forward to being involved in the NCCL 2023, scheduled for May 9th -11th in Kansas City, MO. If you have an interest in attending, please let us know, so we can put your name up for nomination for a USAFP delegate.

For more information on AAFP NCCL, please visit https://www.aafp.org/events/aclf-nccl/nccl.html

For more information on the upcoming AAFP COD (scheduled September 19th -21st in Washington, DC) visit https://www.aafp.org/about/congress-delegates.html.

MEMBERS IN THE NEWS

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

NEWSLETTER SUBMISSION DEADLINE

REMINDER: The deadline for submissions to the Summer magazine is 28 June 2022.

RESEARCH GRANTS

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

RESEARCH JUDGES

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

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

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Mark E. Stackle MD, MBA, FAAFP
markstackle@gmail.com

PROMOTING RESEARCH IN THE MILITARY ENVIRONMENT

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

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

new members

THE USAFP WELCOMES THE FOLLOWING NEW MEMBERS...

ACTIVE
Ari Levine, MD
Benjamin Rud, DO

RESIDENT
Sonia Haider, MD
Aric Williamson, MD, MPH

STUDENT
Sarah Ames
Devyn Bahnmiller
Michele Bahtiarian
Alexandria Ballinger
Joseph Bell
Alex Belongy
Daniel Bender
Gerald Bowers, MHA
John Bravo
Nicole Butler
Nathaniel Camaret
Anthony Caskey
Ka Chan
Max Chou
Reese Cooper
Hunter Crawley
Hugh Dang
Devin DeFeo
Samantha Dumas
Lauren Edmonson
Al-Nasser Elsqaa, Sr
Gabriel Figueiredo
Laurynn Garcia
Reid Garner
Zachary Gilbert
Elsabet Haile
Ashley Halverson
Kellie Holovac
John Horspool, Jr
David Horton
Almaz Jamankulov
Cortes Jongjaroenlarp
Ryan Jung
Dawid Karapuda
Kiana Keller
Duane Kim
Clare Kinsella
Michael Kreiser
Julia Larson
Emma Lawrence
Gabrielle Le
Jennelle LeBeau
Ariella Lee
Yun Beom Lee
Jonah Liwag
Lourdes Lopez
Erin Lucero
Sean Lynch
Meg Lyons
Gordon Macy
Taylor Mallory
Lauren Manwaring
Katherine Marapese
Evangelia Mavrogiorgos
Matthew McDonough
Mary McMullen
Mohit Mehra
Nataleigh Messimore
Channah Mills
Nicholas Molinelli
Lindi Moore
Makenzie Myers
Cameron Myers
Alexander Nardone
Kalsuum Nasser Deen
Trey Nettles
Sophia Nguyen
Taylor Nolff
Obarikanemi Nwogu
Maia Ogembo
Brett Palmer
Shelby Patti
Nicholas Pepen
Trista Phelps
Nathan Pierron
Kaitlin Porter
Rhett Rainey
Anthony Reddick
Thomas Renner
Hunter Roberts
Mary Robey
Christina Roldan
Gary Rupp
Tessa Sawyer
Abhishek Singh
Jonathan Spirnak
Piragash Swargaloganathan
Elana Taute, BSN
Patricia Theard
Luna Tsang
Margaret Walker
Megan Walsh
Zack Wary
Michael Wells
Lahaina White
Andrew Wilson
Perry Wiseman, BSN
Haley Witt-Vering, MPH
Daniel Woo
Felix Yang
Jae You
Rona Yu
Austin Zohner

Congratulations to Military Residency Programs that Achieved 100% Resident Membership in the AAFP and USAFP

Darnall Army Medical Center Program - Fort Hood, TX

David Grant Medical Center Program - Travis AFB, CA

Dwight David Eisenhower Army Medical Center Program - Fort Gordon, GA

Madigan Army Medical Center Program – Tacoma, WA

Martin Army Community Hospital Family Medicine Residency - Fort Benning, GA

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

National Capital Consortium (Fort Belvoir Community Hospital) Program - Fort Belvoir, VA

Naval Hospital Camp Pendleton Program - Camp Pendleton, CA

Naval Hospital Jacksonville - Jacksonville, FL

Naval Medical Center Camp Lejeune Program - Camp Lejeune, NC

Tripler Army Medical Center Program – Honolulu, HI

US Air Force Regional Hospital Program - Eglin AFB, FL

Womack Army Medical Center, Department of Family Medicine - Fort Bragg, NC

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MEMBERS IN THE NEWS

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

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

Congratulations to the following USAFP members!

Frank J Arnold DO, FAAFP

Nadine Smith Barksdale MD, FAAFP

Elise Cooper Brandon MD, MPH, FAAFP

Dawn Pauline Callahan MD, FAAFP

Jennifer G Chang MD, FAAFP

James Chung DO, MPH, FAAFP

Bart M Diaz DO, FAAFP

Samuel Velez Galima DO, FAAFP

John J Koch MD, FAAFP

Daniel Paul Kuckel MD, FAAFP

Rebecca Ann Lauters MD, FAAFP

Nicholas Alan Rathjen DO, FAAFP

Kerry Philbin Sadler MD, FAAFP

Sajeewane Manjula Seales MD, FAAFP

Siavash David Shahbodaghi MD, MPH, FAAFP

Bryan Alexander Stepanenko MD, FAAFP

Karla Michelle Vega-Colon MD, FAAFP

Pictured are those who were in attendance at the 2022 Annual Meeting receiving their AAFP Degree of Fellow.

2023 USAFP Annual Meeting & Exposition

Call for Speakers

We Are.....
Uniformed Family Medicine

Together, we are strong, diverse & flexible

Thank you for your support and dedication to Uniformed Services Academy of Family Physicians through your interest in presenting at the 2023 USAFP Annual Meeting & Exposition in Orlando, FL. The meeting is scheduled 30 March - 4 April 2023 at the Renaissance Orlando at SeaWorld. We are excited to come together to showcase our passion and diversity in medicine, teaching and research as we continue to drive the specialty of Family Medicine forward.

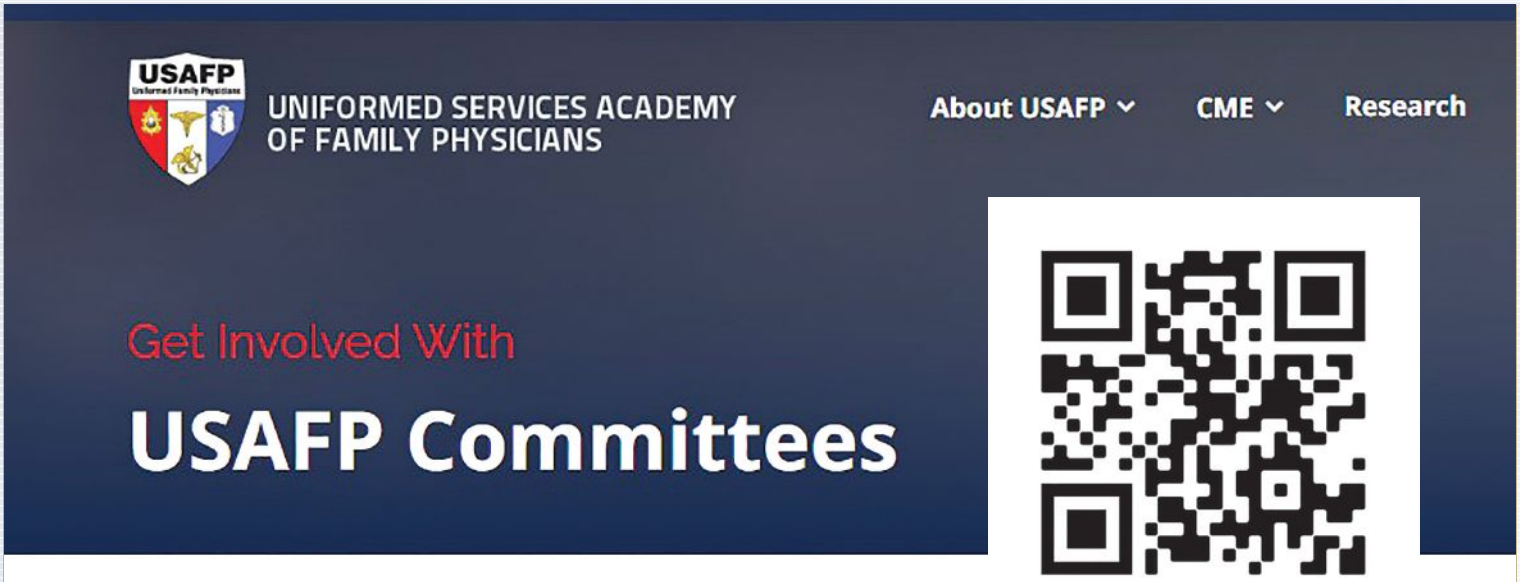
With this year's theme, " Together we are strong, diverse and flexible", we hope to showcase the breadth of Family Medicine and our integral role as the back-bone of the Medical Corps.

Please visit www.usafp.org and click Call for Speakers under 2023 Annual Meeting to complete the survey.

If you have questions, please contact us at Usafp2023@gmail.com.

Submission Deadline is: 30 May 2022

Dave Garcia, MD & Rebecca Lauters MD
Co-Chairs, 2023 USAFP Annual Meeting

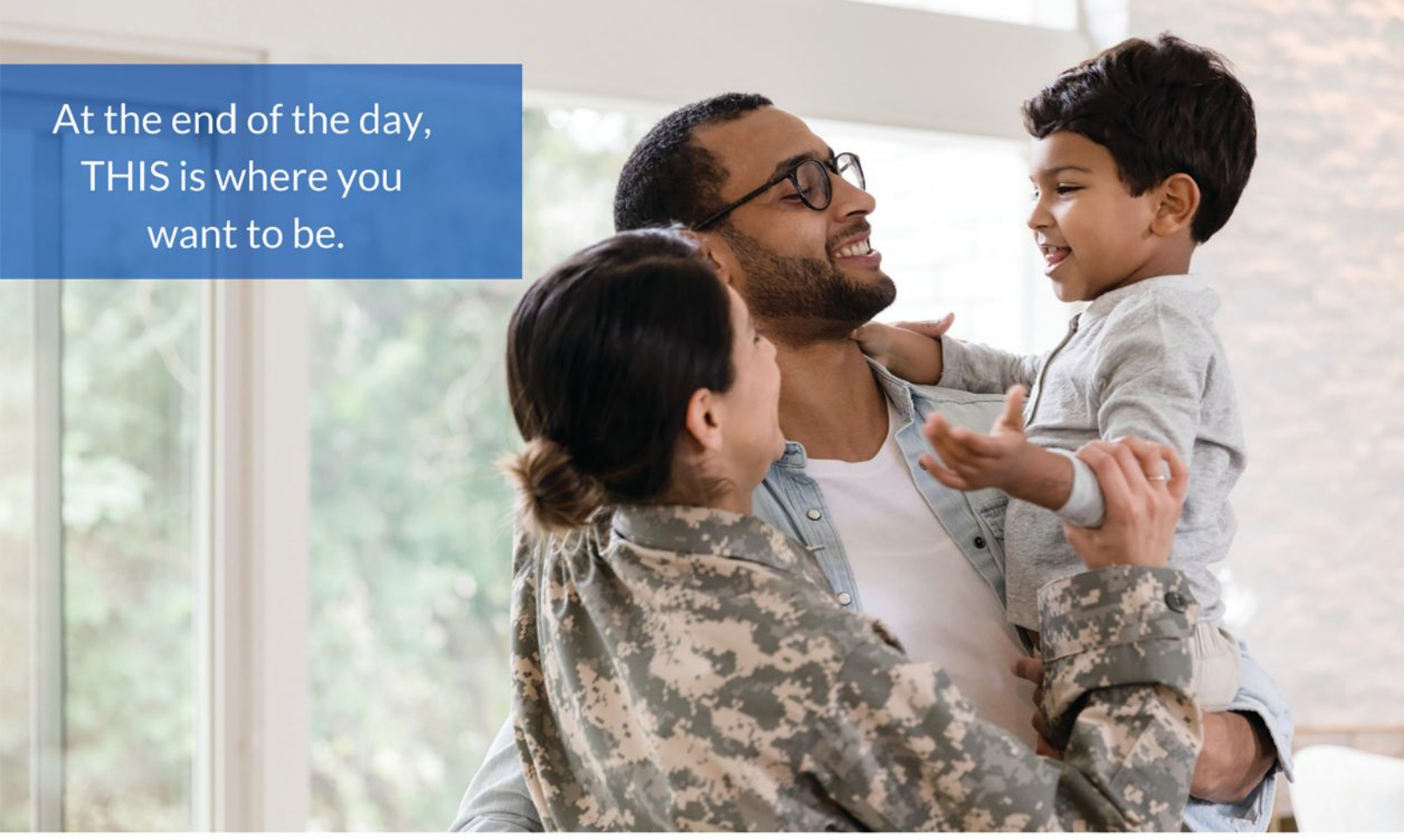


USAFP committees are charged with contributing to the overall mission of the USAFP by focusing on the strategic goals of the organization, communicating information to the Board of Directors, and assisting leadership in the decision-making process for current and future initiatives. The primary function of a USAFP committee is to involve members in their areas of interest and expertise. USAFP members are encouraged to participate on a committee(s). Participation on a committee(s) is a great way to enter the leadership pipeline of the USAFP. Each committee page has "Committee Interest Form" to inquire about joining.

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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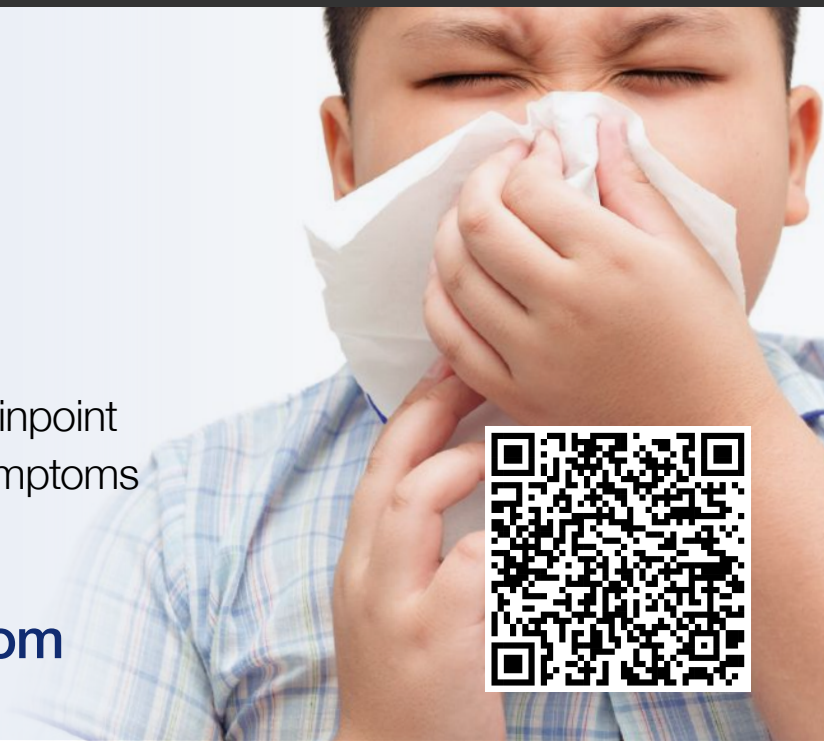

Review these helpful resources:

Allergen Reference Encyclopedia >

Provider Resource Library >

On Demand Education >

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

DoD Reference Laboratories:

- Wilford Hall ASC
- Eisenhower AMC
- William Beaumont AMC
- Tripler AMC

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