THE UNIFORMED FAMILY PHYSICIAN

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VISION

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

MISSION

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

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Edition 61

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Hello Uniformed Family Physicians and Happy Fall!

Fall has always been my favorite season, filled with majestic moments and views of nature's boldest transformations. This Fall started off with a bang at the AAFP Congress of Delegates (COD) and the USAFP Annual Board of Directors and Strategic Planning meetings. At the AAFP COD, two delegates and alternate delegates from each state chapter in addition to delegates from the National Conference of Constituency Leaders (NCCL) participated in hearings of the five reference committees, reviewed resolutions presented to the COD, elected new AAFP officers, and forged through difficult topics as the AAFP's policy making body. Two of our past USAFP presidents, Dr. Debra Manning and Dr. Aaron Saguil represented our membership as delegates. Dr. Kevin Bernstein and I served as the USAFP alternate delegates. Of the five NCCL Member Constituency delegates to the COD, two were USAFP members, Dr. Janelle Marra and Dr. Spencer Fray. Another USAFP member, Dr. Rachel Carter, was selected as one of the five NCCL Member Constituency Alternate Delegates.

For the resolutions that require additional information for the COD to consider, they are sent to AAFP commissions to review, deliberate, and make recommendations for strategic ideas to the AAFP BOD. There are currently eight AAFP commissions, which include four USAFP members: Dr. Laurel Neff, Dr. Jeanmarie Rey, Dr. Janelle Marra, and Dr. Timothy Switaj. It was inspiring to watch the collaborative efforts of family physicians from across the country, working together to drive healthcare in positive directions. It was invigorating to be reminded that Uniformed Family Physicians have been and will continue to be strong contributors to the AAFP vision of transforming heath care.

It was also energizing to get to spend time with one of the most diverse groups I have had the opportunity to be a part of -- the USAFP Board of Directors (BOD). Uniformed Family Physicians from different services, career paths, races, ethnicities, and genders came together to work through our Academy's plans for the next year. Our discussions highlighted how much knowledge, experience, leadership, and diversity lies within the USAFP membership, and how much we need to remind and encourage everyone's active participation through all of the available USAFP opportunities.

The 2023 USAFP Annual Meeting Co-Chairs, Dr. Rebecca Lauters and Dr. David Garcia, provided an update regarding the amazing conference planned for 30 March – 4 April in Orlando, Florida. The annual meeting is our foundational event for our members to engage via research presentations, lectures, and small group didactics. The annual meeting is also a time for members of the ten USAFP committees to come together in person and to meet with the USAFP BOD to share their ideas and contributions. Serving on committees is an excellent method for USAFP members to assume greater roles in shaping our chapter, as well as providing exposure to additional fantastic leadership opportunities within the AAFP. USAFP members can join a committee by submitting a committee interest form online at https://usafp.org/committees/ or by attending the annual Committee Interest meeting at our annual meeting. The committee page on the USAFP website outlines the role of each committee and the contact information for each committee chair can be found near the beginning of this newsletter (Officers and Committee page 4). Each year, the USAFP President identifies any committee chair vacancies and seeks to fill those committee leadership positions with active members from within the committee. Please keep an eye out for these projected chair vacancies and for projected vacancies for USAFP National Conference of Constituency Leaders (NCCL) delegates to be announced as we approach the annual meeting in March.

Additionally, this is the time each year where the USAFP Nominating Committee identifies potential nominees for upcoming vacancies on the Executive Committee as well as on the USAFP Board of Directors. These nominees are identified either through self-nomination or by nomination from other members. The Nominating Committee will build the slate of candidates from these nominations to present to the USAFP membership for voting/selection. This year we will be looking for nominations for the following positions: President Elect (Army), Vice President (Air Force), Army Director, Navy Director, CG/PHS Director and Air Force Director. Please submit your nominations to https://usafp.org/contact-us/. Typically, Executive Officer nominees have served on the Board of Directors and nominees for the Board of Directors have served as committee chairs and/or been active in USAFP via lectures/ research at the annual meeting, writing articles for the quarterly newsletter, participation in committees, and/or participation as an NCCL USAFP delegate. If you would like to offer to contribute to the quarterly newsletter, please send a message to https://usafp.org/contact-us/.

I would implore all of our members to engage in contributing to our academy in any of the above opportunities. We are a stronger and more impactful organization when we utilize the collective capability of our diverse membership.

Here's to a great Fall season,
We Are…Family Medicine!
Marcus Alexander

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editor's voice

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 fellow family physicians! Welcome to another edition of the ***Uniformed Family Physician***. It was great to gather with the USAFP Executive Committee, Board of Directors, and Committee Chairs in Washington, DC in September. It remains inspiring to see the incredible innovation coming out of our committees. Despite a period of tremendous change and transition within the military health system, USAFP leaders continue to be on the cutting edge of supporting our members and our patients through mentorship; the development of operational and administrative medicine reference tools; support for Wellness, Resilience, Diversity and Inclusion initiatives; and through the committed support of research and scholarly activities. It was particularly rewarding to see our resident and medical student directors in attendance. Each of them demonstrated such a passion for our specialty that I left the meeting realizing that the future of military family medicine is incredibly bright!

This edition of the ***Uniformed Family Physi*cian** is packed with a collection of articles I know you will enjoy. The Operational Medicine Committee provides the second installment of their series focused on highlighting USAFP members in Operational Medicine. In this segment, Adolfo Granados offers an excellent overview of the career and wisdom of CAPT Torrin Velazquez whose service in a variety of key Navy and Marine operational assignments illustrates many valuable lessons for all physicians serving with the line. On a related topic, Philip Flatau explores the importance of effectively communicating the nature of risk when talking with senior line commanders.

David Riegleman, the Chair of the Wellness and Resiliency Committee, outlines several simple, yet important, steps toward achieving financial wellness – an often underappreciated aspect of overall well-being. In the arena of leadership, Tyler Rogers continues the ongoing Leadership Book Series by compiling an excellent summary of the 4 Disciplines of Execution by McChesney, Covey, and Huling. The book offers a thoughtful approach for helping organizational leaders at all levels focus their teams to accomplish their WIGs (Wildly Important Goals). Haroon Samar outlines a three pillar approach (Training & Education, Developmental Experiences, and Reflection) to develop junior leaders so they are well prepared to assume roles of growing responsibly throughout their careers.

Building upon one of the most successful research competitions in USAFP history, the Clinical Investigations Committee continues to strive to ensure that many of the excellent research presentations and posters from the Annual Meeting are submitted for publication. Sajeewane Seales and Tyler Rogers provide a comprehensive overview outlining the crucial steps necessary to get an article published.

The Education Committee Co-Chairs (Tyler Raymond, Erica Meisenheimer, and Tyler Rogers) delve into the importance of teaching residents and medical students how to be successful incorporating the tools of telehealth medicine into their clinical tool bag since the COVID pandemic has generated significant interest from patients in receiving care virtually.

This edition also contains a number of reflective articles based on AAFP engagement experiences. Janelle Marra provides an excellent overview of the recent AAFP National Conference of Constituency Leaders and the Annual Chapter Leader Forum which took place in person after two years of COVID restrictions. Her article outlines just how active USAFP members are at the national level advocating for many of our special constituencies. Charisse Villareal, one of the USAFP Resident Directors, reflects on the power of advocacy after attending the AAFP National Conference for Medical Students and Residents. Her piece illustrates the importance of physicians as advocates whether that is at the national level or within the local MTF. Finally, I'd particularly like to highlight Erin Lucero and Tema Fodje, our USAFP Medical Student Directors, for providing an inspirational summary of their attendance at the AAFP National Conference where they heard from our specialty's senior leaders speaking about the state of Family Medicine in the United States, and how to incorporate new technologies into our scope of practice.

In closing, I strongly encourage each of you to consider nominating someone for the USAFP Physician of the Year and/or the USAFP Operational Medicine Physician of the Year Awards. We have a tremendous number of talented family physicians in our population, and these awards allow us an opportunity to recognize some of these great leaders at our annual meeting next spring. Thank you for what you do each and every day for our patients and each other!

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MEMBERS IN THE NEWS

Timothy Switaj, MD, MBA, MHA, FAAFP, received the AAFP's Robert Graham Physician Executive Award for his leadership efforts at the U.S. Department of Defense to improve access to high-quality health care for members of the U.S. Military and their families. Switaj is currently the chief medical officer of the Defense Health Agency's San Antonio Market, where he develops and implements clinical policies for the largest teaching health system in the Department of Defense. Switaj also leads the Defense Health Agency's Patient-Centered Home Advisory Board, where he oversees policy development for the entire Military Health System.

This award is named in honor of Dr. Robert Graham, AAFP Executive Vice President from 1985 to 2000. Dr. Graham dedicated his career to improving health care access and fostering the tenets of family medicine. His long-term dedication and commitment to the specialty of family medicine and health care as a whole are the principal foundations for the creation of this award. This award recognizes an outstanding family physician for their role as a physician executive and is reserved for Academy members whose executive skills in health care organizations have contributed to excellence in the provision of high-quality health care, and demonstrated that family physicians can have an impact on improving the overall health of the nation.

Nominees for the Robert Graham Physician Executive Award must meet the following requirements:

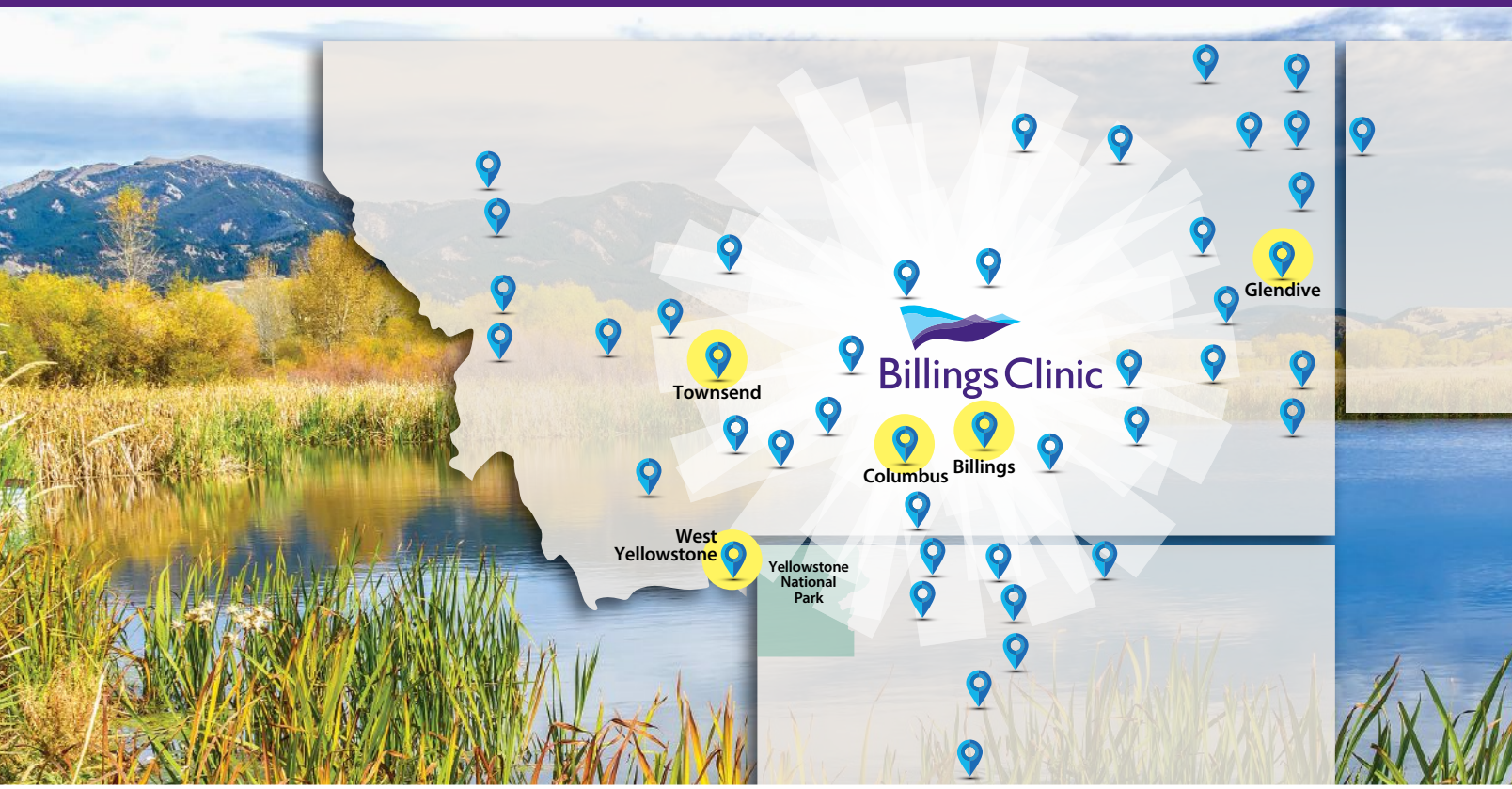
- *Documented executive leadership skills in health care organizations through:*
  - *Encouraging innovation in health care financing, organization and/or delivery.*
  - *Contributing to excellence in the provision of high-quality health care.*
  - *Improving patient safety and well-being.*
  - *Fostering the tenets of family medicine.*
- *Have a minimum of five years experience in an executive leadership position.*
- *Be a current member of the AAFP.*

Congratulations Dr. Switaj!

2021-22 AAFP President Sterling Ransone, MD, presents the award to Dr. Switaj during the 2022 AAFP Congress of Delegates held in Washington, DC. AAFP Speaker Russell Kohl, MD looks on.

USAFP Delegates and Alternates, Drs. Kevin Bernstein, Aaron Saguil, Marcus Alexander, and Deb Manning pictured with Dr. Switaj.

Physician-Led Medicine in the Rocky Mountains



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Our Next Job – One Third of Us This Year, Another Third Next Year

Greetings, Navy Family Medicine colleagues! Having been your Specialty Leader for one year, I'm reaching that stage where I may be able to answer more questions from colleagues than I defer.

As I write this, Shari Gentry has received Family Medicine billet priorities and our colleagues are sending in the Non-Specialty Specific lists due in a few days. Since all of us will be changing jobs in the near future, I'd like to discuss the options and how they are being handled by BUMED and BUPERS.

1. Senior Executive Medicine (SEM) – This is a list of jobs that the Surgeon General approves. Most are designated for those with command experience, but not all. The process for filling these jobs was responsible for the worst delays of the detailing for Summer 2022.
2. Milestone/Command – These jobs are also controlled by the SG and require an application. Milestone and Command screenings are banked, so selected individuals do not have to apply again. The rough thing about both is that location is a bit of a lottery

   Milestone – I encourage anyone with at least one year as a Commander to consider applying for Milestone billets. For the Medical Corps, our primary milestone billet is the Chief Medical Officer (CMO) position, similar to Chief Nursing Officer (CNO) for nurses and Director for Administration (DFA) for Medical Service Corps officers. We can also apply for Officer in Charge (OIC) positions at branch clinics and some research and training commands.

   Command Screening – Most Executive Officer (XO) billets require being an O-6, so command screening is primarily for our Captains. Screening involves an interview with four service hospital COs and then a board. Those who do not have hospital director/CMO/ECOMs experience will often be declined for XO and offered a CMO potions to gain this experience.
3. Non-Specialty Specific (NSS) – This is a list of all the billets that can be filled by any specialty, including OIC of Fleet Surgical Teams and most leadership positions with the Marines. While most positions are for O-5 and above, there are a few O-4 positions listed. I recommend everyone review this list closely, because gems like the two NATO positions from this list are often hidden there. A colleague in a different service let me know that we should be proud of our openness with these since some services are more restrictive with how these jobs are advertised.
4. Operational Medical Officer (OMO) – BUMED continues to be committed to a conversion of the General Medical Officer (GMO) over the next four years. Similar to our sister services, there will still be a GMO option for folks who want to switch residencies, and I expect a Flight and GMO pipeline will remain for interns. Last year, 20% of interns last year were offered straight-through residency contracts, which will rise to 40% this fall and 60% in 2023. The OMO job list represents those GMO positions that have been lost.
5. General Medical Education (GME) – We will always have fellowship opportunities, particularly in Sports Medicine. In 2023, we will open a second Sports fellowship at Camp Lejeune with our colleagues Emily Crossman and Jon Gruber serving as the plank owners of this new fellowship. We may also obtain a semi-permanent position in the National Capital Consortium, where our fellows can support USNA athletics.

   Outside of Sports Medicine, it becomes more challenging. We may have a few more Geriatrics opportunities in the next few years since we are still short. For OB, BUMED only tracks requirements for two FM-OBs in the Navy and we have that many serving as NMRTC COs. Twice a year, we put in a wish list that includes FM-OB slots and I'm steadily working on the BUMED decision makers. I would love to add a hospitalist position with the Army program, but FM-OB is higher priority.

   We haven't had a Faculty Development slot for the Army Madigan program in nearly a decade, and I don't see that coming back. I encourage anyone with interest to look at the USU Health Professions Education program, which has two Master's programs and even a PhD. It's free but part time and it takes enough time that commands should provide some FTE offset.

   Second residencies are possible but challenging for BUMED to approve. To make it work, applicants would have to be applying to a specialty with lower manning – General Surgery, Anesthesia, Psychiatry and Occ Med fill that requirement. It's still a tough sell to the SG – would you want to lose a fully trained FP to fill a slot that a resident would otherwise take?

6. Advertised Positions – These are the billets that I advertise through my weekly emails, which may be just a shameless plug to get the folks who aren't on my list to reach out to me. Most often these are at BUMED, DHA or Joint Commands, and can include interesting jobs like the White House Medical Unit and the aide to the DHA Director. This also includes GSA deployments, which include a "front of the line" discussion with Shari and myself for the billet after deployment.
7. Family Medicine Slates – Don't forget our bread and butter. These are the billets that require Family Medicine, both in our NMRTCs and operational slots, and this is our baseline commitment to BUMED and the line. We create two separate slates – Junior (O-3 and mostly O-4) and Senior (O-5 and O-6) and expect everyone to submit preferences for them. Shari then performs a complicated optimization task – allowing as many folks as possible to pursue other dreams, meet our FM commitments and try to get as many first choice billets as possible.

DETAILER UPDATES

Greetings Navy Family Medicine!

We have been in full swing detailing for the 2023 PCS Cycle. It has been a true pleasure working with the Family Medicine community and I truly appreciate everyone's flexibility and patience. As many of you have probably already noticed while working together, detailing priorities remain focused on covering Operational and OCONUS billets. While I have appreciated the wide interest in the new Operational Medicine Officer billets, please remember the Family Medicine community is full of operational billets as well that we must fill – we are a lucky community in that regard. PERS is also continuing to detail the Non-specialty specific billets for which many talented Family Medicine physicians applied! Regarding the Senior Executive Medicine positions, these positions can be viewed on the Office of the Corps Chief's Executive Medicine website. If you are post command and would like to be considered for a position please reach out but these positions will be handled primarily through the Corps Chief's office.

Please reach out to me any time to discuss assignment opportunities or the detailing process. I'm also always available for record reviews and to discuss best steps for promotion. It's your career and I'm here to support it!

Lastly, as we wrap up the detailing for 2023, please provide feedback to Mike or myself on what you felt went well or could improve or if you have any suggestions. I am here to serve you and want it to be the best experience possible.

Enjoy the holidays and reach out any time!

Shari Gentry, shari.l.gentry.mil@us.navy.mil

NO DIVESTITURES IN SIGHT

Hopefully you have noticed that the word "divestiture" has not been spoken in a while. Now that GMO conversions are in progress and the needs are increasing, the focus is more on the fact that we need more of many specialties, especially FM. I'm hopeful that we will see this reflected in bonuses, but I'm very much on the outside of those discussions.

PROMOTION

We celebrated the selections to O-6 in the last issue, but now we have two more ranks whose promotion results were released. Congratulations to the following officers in our FM community who were selected for promotion!

COMANDER

Derek Austin
Angelo Baquir
Timothy Brooks
Aaron Conway
Larry Cowles
Derek Deboer
Justin Deskin
Jon Gruber
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LIEUTENANT COMMANDER

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Anastasia Mercer
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Holly Perkins
Elizabeth Rettie
Fernando Rios
Josh Sohn
Giacomo Tomasello
Thong Tran
Samuel Ward
Adam Will
Katherine Zeigler

continued on page 12

continued from page 11

Promotion Lessons Learned

Our promotion rates are as essential to our community as they are to the individuals. While our colleagues have individual decisions to make as far as retention, we have a corporate responsibility to ensure our colleagues have the best chance at advancing while they serve. We must improve this. Our promotion stats for this year need to improve for both O-4 and O-5:

	In Zone			Above Zone			Below Zone			Select Rate	
Rank	#	% in FM	% in MC	#	% in FM	% in MC	#	% in FM	% in MC	FM	MC
LCDR	29	85%	87%	3	38%	58%	1	2%	0.4%	76%	85%
CDR	10	48%	57%	6	35%	45%	0	0	0.3%	42%	52%
CAPT	4	80%	67%	3	33%	22%	1	5%	2%	57%	43%

While I was previously crowing about our O-6 rates, the O-4 and O-5 rates are not at all where they should be. I argue that in our current military medicine environment, FM promotions should be higher than average. This is my priority – and the focus of Shari, myself and our Assistant Specialty Leaders.

From looking at records, we know some of the issues behind great doctors not being selected. Most of the folks who were not selected for O-4 had missing items on their Officer Summary Record (OSR). I sent out instructions on fixing the OSR and PSR. If you did not receive that, please contact me to send it to you again.

For the O-5 selections, it seems to be more complicated, and involves optimizing Fitreps as well as the record. In some places, FM physicians at branch clinics don't have the opportunities to get graded on par with physicians at the main hospital. This can be fought with enterprise-supporting collaterals, but may take some strategic focus on picking billets based on promotion timing.

While many folks who did not select have reached out to myself and Shari, I encourage everyone to do so. We'll work with you to optimize your records and get you the best letters to the board.

ASSISTANT SPECIALTY LEADERS

The selection of our Assistant Specialty Leaders is still pending as I write this, but they will be assigned as you are reading it. I'm counting on this assistance to move the needle on supporting our promotions and our support of operational medicine and our colleagues serving in operational roles.

USAFP – ANOTHER WAY TO SERVE

Like service to BUMED and DHA, please don't forget that USAFP is another way to serve your colleagues. USAFP encourages its members to participate on one of the many committees, write articles like this one for the quarterly newsletter, and by attending and presenting at the Annual Meeting each Spring. We have also started to see growing representation by FMs serving in operational roles. I'll continue to advertise opportunities, but consider joining a committee as the initial step.

USAFP also wants to have more great articles in quarterly publication like you see here. If you have something to share, I can help connect you with the right people. These articles are peer reviewed prior to publication - by committee chairs and the Vice President.

USAFP 2023: NEED ALL NAMES BY 5 DECEMBER 2022

As this issue highlights, the next USAFP Annual Meeting is 30 March – 4 April 2023 in Orlando, Florida. **Each** individual Family Physician attendee under a Navy Medicine command or funded by BUMED must be approved **by name** to attend, based on an individual justification. I will need your information by **MONDAY, 5 DEC 2022 ** to produce the combined package for submission.

Want to review a primary source? Go to https://esportal.med.navy.mil/bumed/m00/m00c/Pages/conferenceinfo.aspx for more information.

GRATITUDE

Thank you for all your daily actions in service to our nation. I continue to be honored by this opportunity to advocate for our community. Please reach out to me whenever I can be of help with questions or advice or connect you with other colleagues who can. Stay well, friends, and I wish you a safe and happy holiday season.

Thanks, Mike

The views expressed are those of the authors and do not necessarily reflect the official policy or position of the Department of the Navy, Uniformed Services University of the Health Sciences, Department of Defense, or the U.S. government.

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FOR MORE INFORMATION CONTACT:

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ARMY MEDICINE
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Greetings from Florida!

USAFP 2023 Annual Meeting & Exposition

30 March – 4 April
Orlando, Florida

Greetings from sunny Florida! We're excited about the upcoming USAFP Orlando 2023 and hope you are too! We are in the final stages of selecting our presenters and let us tell you, it is going to be phenomenal. As is typical for our strong, diverse, flexible chapter, the groundswell of interesting, pertinent topics for this next year's conference promises to dazzle beyond belief.

We have workshops planned to promote your clinical skills as well as wellness and professional development both in and out of uniform. Look for an announcement at the next newsletter for an exciting surprise to improve your care of critical inpatients. Popular offerings will return next year to improve your camaraderie. We are delighted that Dr Jeannette South-Paul (COL ret) will be inspiring us to consider strength through diversity during one of our keynotes. There is simply so much to look forward to at this conference.

So, mark your calendars today for March 30th through April 4th, 2023 (Pre-Conference March 29). There will be dolphins, dwarves and magical creatures galore, and not just at the conference! Don't forget to stop by MWR for special discount tickets to the surrounding attractions.

Until next time,

Cum Delphini scientiae,

Becca Lauters and Dave Garcia
Your USAFP 2023 Co-chairs

Make your Hotel Reservations!

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The room rate is government per diem at $159.00 for the March dates and $129.00 for the April dates per night single/double occupancy.
The cut off date for reservations is Wednesday, 8 March, 2023.
The USAFP encourages you to make your reservations early. In the past, the rooms have sold out prior to the cut off date.
Cancellations must be received at least 72 hours (3 days) prior to the arrival date in order to avoid a possible one night's room and tax penalty.

Please make your reservations online via the QR Code below. If you would prefer to make your reservation over the phone, please call 1-407-351-5555 or 1-800-380-7917 and make reference to the USAFP Annual Conference.
Please include any special bedding requests (i.e. one bed, 2 beds, etc.) in the request box when making your reservation.

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Prime the Pipeline:
DEVELOPING PHYSICIAN LEADERS

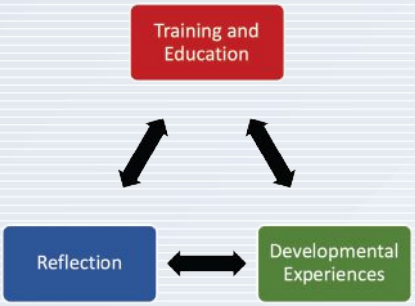


Figure 1 – Leadership Development Framework

Within our health care system, junior physicians are often put in charge of others, sometimes before learning the leadership skills needed for success. As interns and residents progress in training, they are expected to assume greater responsibility for patient care while leading small teams. This responsibility accelerates as junior staff officers become unit surgeons, medical directors, and residency faculty. Some physicians fail to rise to this challenge and cannot adjust to their new roles. Often, this occurs because the skillset that made them successful early in their clinical training is different than the skills needed to succeed as a leader.

Preparing junior officers for new leadership roles is an essential task for midgrade and senior leaders in our healthcare system. The framework outlined above can serve as a helpful guide for leader development. Those responsible for developing others should focus their effort on three key areas:

1) Developing new skills through education and training.
2) Ensuring deliberate practice in key developmental roles.
3) Guiding reflection to improve Awareness and Self-Assessment.[1]

DEVELOPING NEW SKILLS THROUGH EDUCATION AND TRAINING

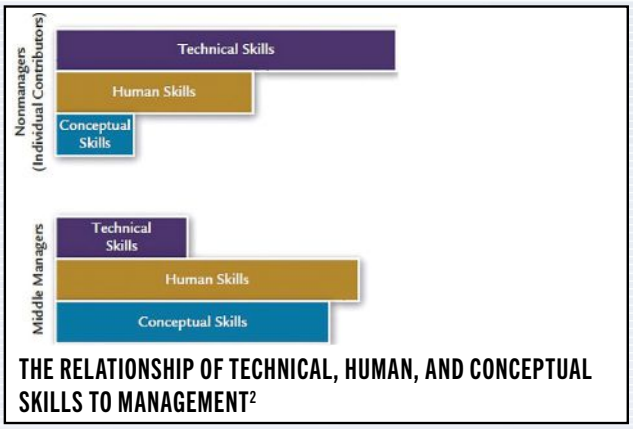
First and foremost, physicians must be clinically competent before assuming leadership roles. Medical expertise and the ability to effectively interact with patients and collaborate with other clinicians allow physicians in leadership to speak credibly about healthcare delivery and its impact on patients. After completing graduate medical education and achieving board certification, physician leaders will benefit from further training focused on leader development. It is imperative for department chiefs, residency program directors, and supervising command surgeons to make attendance at leadership courses, such as those required for professional military education, a priority for junior physicians.

As physicians take on responsibility for clinical operations, they need to develop management expertise, generally not previously learned in medical school or residency training. In 1955, American psychologist Robert L. Katz identified three managerial skills for effective leaders—technical skills, interpersonal (human) skills, and conceptual skills.[2] Most medical training focuses on developing technical skills, but for physicians to be successful in leadership roles, they will need to hone interpersonal skills like effective communication and conflict resolution. In addition, they must develop conceptual skills like resource allocation and decision-making. The diagram below demonstrates this transition in skill development as one moves from an individual contributor to a manager. Often, leaders perceive direct patient care as too essential to spare physicians for further leadership training. However, without these opportunities, more senior leaders hamstring junior leaders and limit their ability to be successful.

ENSURING DELIBERATE PRACTICE IN KEY DEVELOPMENTAL ROLES

The renowned leadership author and speaker John Maxwell describes the difference between equipping and developing others. He says, "When you equip people, you teach them how to do a job. When you develop them, you are helping them to improve as individuals."[3] Learning interpersonal and conceptual skills are key to equipping new leaders for success in early developmental assignments. However, to improve as individual leaders, physicians must deliberately practice the new skills acquired in key developmental roles in order to grow. Swedish psychologist Dr. Anders Ericsson describes deliberate practice as a focused task with the intent to improve from the current level to a higher level of performance with the assistance of a coach who helps individual leaders learn a skill they were not able to do before.[4]

To maintain the strength of an organization over time, senior leaders must not only identify future leaders but must also develop them for important assignments. To identify officers with the potential, motivation, and capacity for growth in these new roles, leaders need to get to know their direct reports. At the heart of mentorship is knowing the men and women you oversee, and showing them that you personally care about them and their aspirations. When first meeting the officers in your charge, ask them about their professional and personal goals.



THE RELATIONSHIP OF TECHNICAL, HUMAN, AND CONCEPTUAL SKILLS TO MANAGEMENT[2]

Figure 2 – Non-Manager and Middle Manager Skills

Where do they see themselves in five to ten years? What skills do they want to develop? What and who is important to them in their personal and professional life? Once a leader has the answers to these questions, the next step is to match the officer with the appropriate available opportunities.

GUIDING REFLECTION TO IMPROVE AWARENESS AND SELF-ASSESSMENT

The third leg of the leader development framework is reflection. The importance of reflection during and at the culmination of a developmental experience cannot be over-emphasized. Junior leaders must reflect on their past experiences to grow from their successes and failures. If a junior leader attends a leadership course, the senior leader should ask them what they learned from the training and how they plan to use it. After appointing someone as a new leader on a team, intermittently ask them to reflect on their experiences and what adjustments they think they should make. The act of reflection forces an individual to connect the dots between theory and practice while fostering deeper learning from the experience. Educator and philosopher John Dewey said, "We do not learn from experience. We learn from reflecting on experience."[5] It is the responsibility of the senior leaders to guide junior officers in this reflective exercise. By setting aside time to evaluate their experience, junior leaders will better appreciate their successes and failures. Through this reflective process, they can see themselves in a new light and consider what additional skills to pursue for future opportunities.

In conclusion, when developing future physician leaders, it is critical to break down the myth that leadership qualities are immutable. Instead, senior leaders must emphasize the fact that leadership skills improve and develop over time. To succeed as new leaders, physicians must understand the importance of developing not only their clinical ability, but also their leadership acumen. Leaders should set conditions within their organizations that ensure junior physicians receive the training that will grow their interpersonal and conceptual skills. Next, junior officers must be matched to developmental assignments where the deliberate practice of new skills allows them to blossom as leaders. And lastly, for lifelong learning and self-development, new physician leaders must practice reflecting on their past experience to assess their strengths and deficiencies more effectively.

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Writing for Publication

I remember being overwhelmed during intern orientation when reviewing all the requirements needed to graduate. The most daunting requirements to me were those dealing with scholarly activity and research. I hated "research" and wanted nothing to do with "scholarly activity." However, with a few helpful tips and mentorship from people who sought and excelled at scholarship, I slowly realized that participating in scholarship was less daunting than I expected, and in many instances, it was fun.

In an effort to alleviate any similar anxiety in others, we wanted to share these scholarship tips with you. These eight steps to writing for publication will help you systematically prepare for your next publishing opportunity. We hope you will use what you learn to publish all those amazing case reports, educational and clinical research projects you presented in Anaheim at the last USAFP meeting.

1. **Prepare to write**. The best way to prepare for publication is to read. Read different types of publications from randomized control trials, to review articles, to editorials. Reading helps you identify what journals and editors are looking for when you write for them. Pay attention to the differences in style. How did the articles' depth and breadth change? In which journals were particular articles published?
2. **Consider Experience.** As you get ready to write, let the experience you are trying share determine the type of writing you will do. For example, a cool clinical experience may result in a case report that poses a clinical question. A personal experience may result in a narrative essay. It is also critical to review what other authors write about your topic. This is why a literature review is so important.
3. **Determine Authorship.** Deciding who gets to be an author on the paper should be straight forward. The International Committee of Medical Journal Ethics lays it out for us. See this website for details on authorship (www.icmje.org). In essence, authors should:
   a. Make a substantial contribution to the concept or design of the project or analysis of the data, depending on when the author joined the team in the research process.
   b. Contribute to drafting the article.
   c. Approve the final product.
   d. Be accountable for the work.
4. **Write.** This step should be based on a system that works for you.
   a. Confer with the other authors, frame your thoughts, and make a timeline and plan for each section. Read the paper requirements for each journal very closely to make sure your submission passes the journal editor's first benchmark.
   b. Then, write! The first goal is just get the words on paper. Try to write a little every day to keep your momentum going on the project. It's okay to write out of order as well. Go ahead and knock out the easy sections first.

      These are the typical sections in a scientific publication:

      i. *Introduction.* The introduction should include a concise review of the literature, explain why the topic is important and relevant, and include a hypothesis and objectives.

      ii. *Methods.* This section should include how the study was designed, how the data was collected, and the quantitative and/or qualitative analysis that was completed.

      iii. *Results.* The results section is one of the main portions of the paper. It should include the demographic data, primary and secondary outcomes, and their statistical significance. This information should be presented as concisely as possible. Tables and figures are typically also included in the Results section.

      iv. *Discussion.* In this section, authors should summarize the key findings and compare it with current literature. Authors should also discuss strengths and limitations and suggest future opportunities. Some articles will also include a Conclusion which can concisely identify the implications of your research.

5. **Choose a Journal.** Choosing the appropriate journal is tough. The first step is to consider your desired audience and the journals that serve that audience. Think back to the experience you are trying to convey. After determining the audience and a list of potential journals, choose the most prestigious or impactful first. Shoot for the stars! A journal's impact is measured by its impact factor, which is the number of times the journal is cited divided by the number of articles published in the previous two years. For example, the *New England Journal of Medicine* has an impact factor in the 50s, whereas the *Annals of Surgery,* a more topic specific journal has an impact factor of seven. You can also use the Journal Author Name Estimator (JANE) website (https://jane.biosemantics.org) by entering your title or abstract into the search function. The site then compares your work with millions of others and recommends journals that may be interested in your work. Check out a list of journals that take case reports and educational research with the QR codes below.

WHERE TO PUBLISH CASE REPORTS

6. **Submit Your Paper.** This sounds so simple, and in some ways, it is. First make sure to get local approval as needed from your local Public Affairs Officer (PAO) or legal office. Double check that you followed the journal's submission requirements before you submit…then get ready to wait. The review process takes time. The journal administrators review for basic compliance with the journal's submission rules. The editor determines if it should go to peer review or not. If peer review is required, the editor will send your article to several reviewers who will offer feedback. Once the peer reviewers have completed their work, the editor renders a final decision which can be one of the following:
   a. Rejected: this means you are done. Move on to the next journal on your list. Only 1 of 3 submissions are accepted for publication, so don't take this personally.
   b. Revise & Resubmit: this means you have not been accepted for publication and you need to make significant revisions to be accepted. Use the reviewer comments to make changes.
   c. Accepted with Revision: This is great. With some revisions, you are going to be published in this journal.
   d. Accept As Is: This is very rare, but it can happen
7. **Revise.** Revising the paper is pretty straight forward. Take time to grieve but start the revision process early so that you don't miss any deadlines. Reach out to your co-authors. While the lead author typically takes the lead, plan to divide and conquer. Address the comments from the reviewers. Be grateful for their feedback and if you are rejected, make the suggested changes before submitting to a different journal. Control your emotions and make it easy for them to say yes. It is okay to disagree, just respectfully explain why in a comment. Get clarification if needed. Address all comments thoughtfully with page/line numbers and use tracked changes to stay organized.
8. **Celebrate.** You did it! Celebrate by updating your CV and don't forget to claim the CME credit for writing.

Writing for publication can seem overwhelming, but hopefully, the steps outlined above will help make you successful. The USAFP has other resources on our website to include *The Recipe,* which gives more detailed tips on how to move forward with research. If you have submitted an abstract, presented it at the conference, you really have done most of the work. Follow these steps and get published!

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:

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

committee report
EDUCATION

Clinical Education:
BEST PRACTICES FOR TRAINING MEDICAL STUDENTS AND RESIDENTS IN TELEHEALTH

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INTRODUCTION

COVID19 has reshaped the healthcare system in many ways, especially the advent of virtual technology and telemedicine. Outside our military health system, patients have grown accustomed to online office visits with their physicians. Within the Defense Health Agency (DHA), we have started rolling out new *video connect* software to support telehealth services. Telehealth undoubtedly improves access, lowers costs, and increases effectiveness of chronic disease management. Just as our delivery of healthcare has transformed in recent years, so must our approach to educating medical students and residents regarding these new innovations. Our curriculum needs to adapt to better teach learners at all levels how to use this software and to effectively integrate telehealth into their scope of practice.

BACKGROUND

There is currently a mismatch between most patients and physicians when it comes to telehealth. Many studies have shown that patients have a strong desire to use telehealth and a high satisfaction with its use. At the same time, there is a lack of training to prepare physicians for this modality and medical students are graduating feeling unprepared to use it effectively. A study at the start of the pandemic showed that over 50% of students going into Family Medicine are interested in using telehealth and over a quarter are undecided, leaving only a few uninterested.[1] However, only 17.4% of students had prior patient exposure using telehealth while 82.6% did not.[1]

Telehealth technology can also serve as an effective teaching modality. Telephone consultations, video consultations, and face-to-face consultations have been found to have similar rates of satisfaction as clinical learning environments for students.[2] It is also suggested that the combination of different clinical learning environments may offer more positive outcomes than one alone.[2] So how do we do this effectively?

RECOMMENDATION I: MASTER YOUR TELEHEALTH PLATFORM

As the teacher, it is essential that you are prepared and comfortable using the technology. Mastery of your telehealth platform will allow you to effectively troubleshoot challenges, and therefore maximize time focused on teaching, observation, and learner assessment.[3] Familiarity and confidence with the system will also allow you to teach students the competencies in key areas of the telehealth curriculum. These competencies include the technical skills needed to operate the equipment and software, the communication skills necessary to respect patient privacy while obtaining informed consent, virtual physical exam skills, and the limitations inherent in telehealth visits including its potential to increase disparities in care.[3] Ideally, consider providing students with desk-side time with your institutional trainers during orientation, and pair students with technologically proficient residents and faculty for telehealth visits.

RECOMMENDATION II: USE THE TELEMEDS FRAMEWORK AS A MODEL

Patient-centered communication skills are essential to providing care that is respectful and responsive to patient preferences, especially in the virtual environment. These skills ensure that patient values guide clinical decisions. The virtual platform presents challenges, but also offers opportunities for us as educators to evaluate and teach these skills. Dr. Maria Alkureishi and her colleagues developed the TELEMEDS mnemonic which presents a framework for teaching patient-centered virtual practices to trainees (Figure 1).[4]

TELEMEDS: Tips to Optimizing Virtual Visits		
T	Test it out first	Prior to the visit, practice using your virtual visit platform. Check audio and video. Test mute and screen share. Practice splitting the screen to see patient and the EHR at the same time.
E	Evaluate your schedule	Identify patients that should not have virtual visits. Proactively anticipate needs for the visit.
L	Layout an agenda	Contextualize the visit agenda by reviewing your patient's interval health history. Note any outstanding orders or preventive health needs that should be addressed.
E	Establish visit rules	Introduce yourself and team members. Verify patient. Determine a technical back-up plan. Identify your patient's goals for the visit and balance those with your agenda items.
M	Modify your speech	Vary tone and inflection. Speak slowly to allow for buffering and lag. Pause for questions often. Check for understanding.
E	Encourage patient engagement	Look for opportunities to educate patients using screen share. Demonstrate websites and review EHR information. Engage patients in note writing when appropriate and jointly create an after visit summary to reinforce the plan.
D	Demonstrate positive nonverbal communication	Maintain good eye contact. Smile or express concern when appropriate. Signal active listening by nodding or shaking your head.
S	Summarize next steps	Be specific about when and how to follow up. Encourage patient portal use to review their after visit summary and chart updates for reference. Elicit direct patient feedback.

Figure 1: *Alkureishi ML, Lenti G, Weyer GI, Castaneda J, Choo Z, Oyler J, Lee W. April 2020*

Many of these steps occur before the visit begins, and require preparation between the preceptor and trainee. Begin by giving them *time to test it out*. This could be with a simulated patient, family member, fellow medical student or the preceptor. Let them practice using the features of the system. Next, *evaluate your schedule* with the trainee to determine where to properly embed them within encounters based on their level of training and competency. *Layout an agenda* by reviewing prior documentation, diagnostic results, and preventive health needs.

During the visit, begin by *establishing visit rules*. This is done through introductions, confirming the proper patient is present, and establishing the patient's location in case of an emergency. It is important to *modify your speech* during a virtual visit. There is often a lag in the transmission of audiovisual elements so it is important to pause and speak slowly. *Encourage patient engagement* through screen sharing, physical exam elements, and documentation. *Demonstrate positive nonverbal communication* through various techniques to show active listening (e.g. good eye contact and head nodding). Before ending the visit, *summarize next steps*. This is best done by encouraging use of the patient portal, being specific with follow up plan, and asking the patient for direct feedback so you and the trainee can improve your skills.

RECOMMENDATION III: ENSURE TIME AFTER THE VISIT FOR DEBRIEFING AND FEEDBACK

Just as you do in regular face to face clinic visits, it is essential to have a huddle after telehealth visits to provide an opportunity for the student to ask questions and to provide them with feedback from the virtual encounters. Providing feedback in the moment engages the student and helps them grow their telehealth skills over time.[3] It is important to base this feedback on your direct observations since this also helps assess their competency level with telehealth skills. One model for a post session huddle is the "ask-tell-ask framework" which promotes reflection and self-assessment.[3] This begins by asking the student to reflect on their performance and telehealth skills, followed by the preceptor telling them what they observed. Lastly, ask the student to reflect on your feedback and develop goals for the next telehealth session.

ADDITIONAL RESOURCES

If you are feeling underprepared to teach telehealth to students and residents, the Society of Teachers of Family Medicine (STFM) has a free telemedicine curriculum for members available at https://www.stfm.org/telemedicinecurriculum. The learning objectives are mapped to the Association of American medical Colleges (AAMC) telehealth competencies which are available at https://www.aamc.org/data-reports/report/telehealth-competencies. There are five models and each take 15-30 minutes to complete. The AAMC competencies for telehealth include six domains: (1) Patient Safety and Appropriate Use of Telehealth, (2) Access and Equity in Telehealth, (3) Communication via Telehealth, (4) Data Collection and Assessment via Telehealth, (5) Technology for Telehealth, and (6) Ethical Practices and Legal Requirements for Telehealth.

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National Conference of Constituency Leaders and Annual Chapter Leader Forum:

BACK IN PERSON

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, both NCCL and ACLF were able to resume in person in Kansas City, MO. NCCL is an opportunity for underrepresented medical leadership groups to gain leadership skills, meet other colleagues who share similar interests, and participate in creating resolutions to bring to the AAFP Congress of Delegates (COD).

The NCCL Constituencies mirror the groups included in our member constituencies committee, including women, underrepresented minorities, new physicians, international medical graduates (IMG), and LGBTQ+ physicians. USAFP's delegates this year included Taylor James, MD (Women), Dan Molina, MD (Minority), Alex Knobloch, MD (New Physician), Rachel Carter, MD (IMG), Sterling Brodniak, DO (LGBT), and Kevin Bernstein, MD (Young Physician Section – American Medical Association (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 delegates to the ACLF included James Warner, MD, Marcus Alexander, MD, and Kevin Bernstein, MD.

On April 27, the attendees of NCCL and ACLF were welcomed back to Kansas City at the reception event. On April 28, the constituencies separated into working groups and created ten resolutions to forward to the reference committees including advocacy, education, health of the public and science, organization and finance, and practice enhancement.

Attendees from USAFP helped author three of the 43 resolutions voted on, including:

Promoting Research in the Military Environment

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

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

Photo Courtesy of U.S. Army

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

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: 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 -- Young Physicians Section (AMA-YPS). One USAFP member was elected, Rachel Carter MD (IMG co-convener and alternate delegate).

I am looking forward to being involved in next year's NCCL 2023, scheduled for May 9-11, 2023 in Kansas City, MO. If you have an interest in attending, please let us know, so we can put your name up for nomination as a USAFP delegate. For more information on AAFP NCCL, please visit the website https://www.aafp.org/events/aclf-nccl/nccl.html.

CHALLENGE ACCEPTED

Are you facing a problem at your current duty station and not quite sure how to solve it? Is there a new task you've been asked to take on? Are you in a position with no prior experience? Is there a cultural environment that you're unfamiliar with and not sure how to adapt?

Well, you don't have to tackle it alone. The Member Constituencies Committee has developed an opportunity to present your challenge to USAFP leaders, so that we can address your problem together – Challenge Accepted!

Just scan the QR code and fill out the anonymous survey, so that we can gather the appropriate resources and leaders to discuss a new challenge every month via zoom. There's no issue too big or too small, and we can help find a solution together.

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The views expressed in this article [lecture, etc.] are those of the author and do not necessarily reflect the official policy or position of Fort Belvoir Community Hospital, the Defense Health Agency, Department of Defense, or U.S. Government.

"Engagement can combat feelings of powerlessness."

And so began one of the first sessions of the AAFP National Conference for Medical Students and Residents (AAFP NC) in Kansas City, Missouri. As a new PGY3 resident, I suddenly felt completely seen. How many times have I felt like an uninvolved bystander rather than an active participant in my career and education?

As sweeping changes occur in all of our clinics – new reforms from DHA, the transition to MHS Genesis, and the usual struggles that occur at the height of PCS season (too many patients, not enough staff) – the title of the session reminded me that the best approach is usually to lean into reform and engagement rather than run from it.

Sometimes the word 'advocacy' can feel as nebulous as 'wellness' 'burnout' 'mindfulness' and 'efficiency' – but here in the Kansas City convention center, the word didn't feel so abstract. There were medical students and professionals from all 50 states who were inspired and motivated to learn how to better hone their voice and craft. Advocacy, I learned, meant using your voice, platform, skills and expertise in your unique way to meet the needs of our patients, profession, and shared community.

AAFP NC was a great reminder that we are not only surrounded by an amazing community, but are also part of it. Our community is filled to the brim with passionate people who all know 'why' they serve – most of us just need a small reminder to access the power of that passion. Some are motivated by their drive to help those experiencing homelessness. Others are driven by trying to drive down healthcare inequities. One of the medical students, ENS Colin Smith, talked to me about his work with Court Appointed Special advocates (CASA) and guardian ad litem (GAL). When he is not on an interview rotation, he is going to the Missouri court system to advocate for children in the foster system.

There was no better time to remind myself that we are indeed better together than during the Resident Congress. If you are like me, prior to the conference, I had no idea there was a Resident Congress in AAFP or what role they play. Essentially, every year the entire Resident Congress holds elections for student and resident leaders as well as conducting hearings to pass resolutions. Each chapter has a delegate (shout out to Capt Taylor O'Neil, MD PGY3 at Scott Air Force Base) who is responsible for hearing the resolutions and nominating representatives. However, when it comes time to authoring and passing resolutions, any member of the AAFP can participate.

The proceedings sounded funny – 'I motion that item number 2 be extracted for debate.' 'I second the motion.' 'I propose to withdraw my amendment' etc... However, as foreign as the parliamentary talk and procedure seemed to be, it was awe inspiring to witness the topics the Resident Congress chose to discuss. For example, some resolutions up for debate included advocating for medicine assisted training for opioid withdrawal to become required curriculum from the ACGME. Another proposed to start a new international medical graduates' chapter of the AAFP, and to increase the AAFP's global health strategy. I was surprised to discover that the AAFP is the #1 trusted and recognized national association that lobbies Congress. I felt empowered as a resident member of the academy to vote on resolutions – a power not just

granted to the delegates. At the end of the Congressional session, we had voted on 12 resolutions that could become AAFP policies.

During the student storytellers' session, Dr. Rose Marie Leslie reminded us that all have expertise in something. It's up to us to use our voice and share that expertise. As a medical student, she started a Tiktok aimed at increasing health awareness and has since amassed a significant online following.

The person who said it best was Dr. Maria Johnson who talked about an unfortunate counseling session she had had with a trusted faculty member. She was told that 'there is a time to be leader and there's a place to be a resident' when she brought up concerns regarding system issues. She then talked about how for some, leadership is a choice, but for her it couldn't be. The same is true for family medicine physicians in the military. As military officers, we have the privilege and responsibility to care for our patients and health of the unit. Without providing constructive criticism to the systems we work in, we are doing ourselves and our patients a huge disservice. By diminishing the role that advocacy plays in our day to day life, we diminish our own voice, space, and decision making power.

Ultimately, advocacy does not have to include running for a national position or writing long policies regarding whatever cause you believe in. Advocacy can be much less complicated -- one of the most important ways we can contribute is by simply showing up and participating. Most hospitals and clinics have committees that are responsible for various decisions. At my home institution, there are Patient Safety Committees and Town Halls where leadership listen to concerns that staff care to voice. It can also look like signing up for an organization that is already doing the work to advance whatever cause or policy change you believe in – such as USAFP or AAFP.

As change continues, it will be important to continue to provide input, whether you're a top executive or a motivated medical student just starting out. I felt empowered by using my voice and vote at the conference. I look forward to seeing all the great work that USAFP continues to do. I hope to continue to hear the voices of my fellow residents and students while serving in military medicine.

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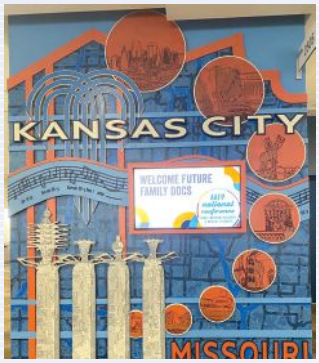
Student Director Report on the 2022 AAFP National Conference (AAFPNC)

The 2022 AAFP National Conference (AAFPNC) marked the return of the AAFP's in-person activities after a two-year hiatus; the energy that surrounded the conference was palpable. For the majority of fellow students, this was their first AAFPNC, due to the effects of the COVID-19 pandemic. For many resident physicians, this conference served as a return home after many years and a chance for fellowship with friends and colleagues from across the country. We were able to connect with those within both the civilian and military medicine communities, affording us the opportunity to learn about the nuances of practicing within both communities.

The workshops and keynote sessions that we attended gave us insight not only into our future careers, but also into who we are as people and what we bring to family medicine.



THE IMPORTANCE OF THE FAMILY PHYSICIAN

During the AAFP National Conference opening, Dr. Sterling Ransone, the current AAFP President, spoke regarding the importance of the family doctor, which we saw grow throughout the COVID-19 pandemic. The family physician, the person many rely on for not just their health, but also guidance, played a pivotal role. Family doctors were speaking to their patients, in their communities, and beyond. Their contributions helped spread information regarding the virus, vaccines, and personal safety measures. Many of us, from students to practicing physicians, can recall how we saw family physicians make a difference during the initial and subsequent waves of the pandemic. For us, even more so now, we know how vital the family doctor is, has, and will always be.

For numerous students, ourselves included, who are pursuing family medicine, there is always the question regarding our choice of specialty - often with negative tones or subsequently hearing people speak disparagingly about it. Dr. Ransone spoke regarding how recent studies show that family doctors are among the most trusted specialties, which speaks volumes. The thing that connects all of us going into family medicine is our love of people and our communities. That common thread is what continues to fuel all of us.

POCUS

As military medical students, it can sometimes be confusing determining which skills we are learning will be employed primarily in a military setting versus those which will be used in both civilian and military medicine environments. Point of Care Ultrasound (POCUS) is a great example of this. While it is easy to imagine the value of this skill in a deployed setting or while working at a smaller, more remote MTF, it was gratifying to see POCUS highlighted at the AAFPNC highlighting its universal value in civilian medicine as well. During a rotation earlier this year at Fort Belvoir Community Hospital, I (Erin Lucero) was lucky enough to witness a POCUS Cardiac session, showing that with even a simple scan you can identify concerning pathology quickly allowing treatment to start while awaiting a final report. POCUS is transforming family medicine's ability to do more with less. These skills are expanding across the nation, in urban and rural communities, military and civilian domains, to better inform us, to provide better access to care, and to better help our patients.

DOING MORE WITH LESS

Other sessions at AAFPNC also emphasized doing more with limited access; including how to make simple models for less than $20 to practice, maintain and even refine skills. Practicing joint injections, skin biopsies, frenectomies or even amniotomies, can be done in any setting regardless of whether a patient is physically present. Alongside refining hands-on skills, the AAFPNC also highlighted refining our knowledge to have the best and most recent Patient-Oriented Evidence to guide our practice, ensuring that we stay current on cancer screening recommendations and data as well as best practices for issues ranging from low back pain to depression. Medicine remains an art focused on life-long learning and improvement. We must continue to reinforce and recommit these ideals to practice the best medicine we can, not simply the medicine we've previously known.

SHARING OUR STORIES

The Keynote of the AAFP National Conference was "Student Storytelling: A Collection of Powerful Voices." This session had a panel of four physicians, including USAFP's very own LCDR Brian Ford, who each shared an important story from their residency and staff assignments. The stories ranged from defying what a doctor is "supposed" to look like to bringing your true, most authentic self to your practice. One theme that was common throughout all of the stories told was the feeling of imposter syndrome many of us feel. When the audience - made up of medical students, residents, and attendings - were asked to stand if they had ever felt imposter syndrome, every single person in the exposition hall stood. Imposter syndrome is something that all of us experience at some points in our lives. For us student directors, our imposter syndrome was prominent when we were applying to medical school, starting clerkships, and even now in our final year applying to residency. There is always the worry of "Am I qualified enough to match?", "Will somebody figure out they made a mistake and I shouldn't be a doctor?" These sentiments are not unique to us. A beautiful concept brought up during this talk is that part of our fear of not belonging, or being enough, is what brings us all together. All of us, and the nuances that make us who we are, belong within this wonderful specialty we call family medicine.

The AAFP National Conference was an amazing experience and left us with a renewed sense of excitement for the future of family medicine. We cannot wait to go back year after year and not only see the continued progress family medicine makes, but also to be surrounded by our colleagues, military and civilian alike, where we connect over the amazing field that brought us together.

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The Art of Communicating Risk:
A PRIMER FOR MEDICAL LEADERS

INTRODUCTION

When was the last time you had to brief operational or senior non-medical military leaders regarding a particular medical component or risk? Perhaps it was a specific patient they were concerned about, a complicated medical plan for an upcoming operation, or how best to support their unit and mission. How did it go? How did you feel? Do you recall that portion of your medical boards? You know, the section outlining the algorithmic steps of strategic communication and advising senior military leaders? Many in the medical field struggle with how to communicate effectively and appropriately with our line colleagues. However, there are many practical steps we can proactively take as medical leaders and military officers to prepare for these conversations. Despite the temptation to frame a detailed algorithmic approach to communication, I would encourage you to think more broadly and critically in your approach to communicating operational risk. I have found that three components of strategic communication has made it possible for me to succeed as a medical officer with many commanders: 1) Build trust with all colleagues and commanders, 2) develop relationships with units and commanders, and 3) listen and learn about the operational environment from a commander's perspective.

STRATEGIC COMMUNICATION

Strategic communication is an art that allows connection and learning across diverse career fields. In his book *Leading at the Strategic Level in an Uncertain World*, James Browning describes two critical elements of strategic communication:

> The *cognitive element* relates to the ability to think about what one wishes to communicate (the content and desired outcome), and with whom to communicate of many potential audiences/publics. It is the ability to identify the strategic audiences and to appreciate their values, objectives, and willingness to listen…The *social element* of interpersonal communication relates to the ability to understand the recipient of the communication—how best for the listener to not only receive the information but also understand the message."

It should come as no surprise that as medical leaders, we should first seek to understand the essential aspects of strategic communication and operational language utilized by our senior leaders. How does this drive their understanding of mission

command and operational risk? What are their values and priorities? Which traits and characteristics are most valuable to them? As medics, we too often fail to understand our operational commander's mission and core priorities. Only when we seek to learn and listen can we develop meaningful strategies that sharpen our ability to communicate recommendations and risks effectively. Browning suggests that, "The important point here is that effective communication becomes a two-way dialogue. In fact, unless there is a meaningful, two-way exchange of meaning, it is not communication, but rather information dissemination." As medical leaders, we must avoid the tendency to solely disseminate medical information, lest we restrict our ability to communicate effectively with our senior leaders.

Two components matter most for communication between medical and line leaders: trust and relationship development. Built on a foundation of character, competency, and authentic service, author James E. Lukaswzewski notes that trust "is what permits, sanctions, and protects interpersonal openness, candor, truthfulness, and face-to-face engagement…an advisor is trustworthy because he or she is helping and advising for the obvious benefit of the other person.". The first critical component of commander relationships is that trust truly matters. As medical leaders, the importance of building trust and rapport with our operational leaders cannot be overstated, and yet is not automatically conferred. The second component, developing relationships, can only come through ongoing, dedicated investment spent with operational units and commanders. For many medical leaders, this is incredibly challenging. However, it is a crucial component of effective strategic communication. Opportunities to integrate and embed medical assets with operational units should be encouraged and promoted to build trust and relationships over time.

MISSION COMMAND AND OPERATIONAL RISK

Besides building trust and developing relationships for effective strategic communication, medical leaders should also endeavor to learn the essential component of mission command and operational risk as understood by the commander. The joint staff provides a fundamental look into the critical aspects of mission command as valued by the operational commander. Common themes include building trust and relationships and the need for continuous dialogue to share and gain understanding. Furthermore, the joint publication outlines the significance of clear guidance, empowerment, and the commander's intent. Not surprisingly, the components of trust and empowerment are continuously highlighted and set the framework for the commander's willingness to accept operational risk.

As defined by the joint staff, risk is "the probability and consequence of an event causing harm to something valued… accurately appraising risk allows leaders and staffs to manage and communicate risk effectively to inform decisions across disparate processes." Risk assessment includes four key steps to include: 1) Problem Framing, 2) Problem Assessment, 3) Risk Judgement, and 4) Risk Management. This understanding is crucial for the medical leader to connect with operational leadership. Commanders are often comfortable assuming risk and will probe and question medical recommendations to ensure they have a complete picture of the environment. Despite our medical tendency to be risk-averse, commanders tend to welcome risk if it can be mitigated and if they have a validated recommendation from medical leaders; recommendations should be built on trust, relationships, and an understanding of the operational mission and risk.

COMMUNICATING MEDICAL RISK

A medical leader has to provide vital medical recommendations to operational commanders. The conversation is often low threat and cordial when accomplished appropriately, based on the above principles. However, when missing key components, the medical leader is often left unprepared and will undoubtedly field more questions than necessary. Our role as medical professionals remains to advocate and understand our patients while practicing excellent medicine. If we do nothing else, we must do this. But when keeping that in mind, and merged with the principles outlined, I've found this combination to be highly effective for medical leaders within the operational community. When strategic communication happens the right way, a trusted environment is often created, relationships can be developed, and we can foster creative multidisciplinary support solutions between the medical leader and the operational team.

As medical leaders, we must always remember that we are advisors to operational commanders. We must be prepared for the commander not to accept our recommendation (despite having done everything correctly). When this occurs, it is essential to realize that it is not personal but rather based on operational mission requirements, perhaps outside our purview. We must separate our best medical recommendation from our core identity and be prepared to carry on with the operational mission. But this is not always easy or comfortable. Some time ago, I was within an austere Sub-Saharan African country 3,000 miles from western-level medical care, and the commander did not accept my advice. Although I had accomplished what I felt to be strategic communication built on trust, relationships, and understanding of the operational mission, my medical recommendation was adjusted based on the commander's intent.

continued on page 30

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As military leaders and officers, we must be prepared to accept this reality and flex accordingly. Despite my frustration in the ultimate result, I realized that my operational leadership had a better grasp on the working environment.

TAKE HOME POINTS

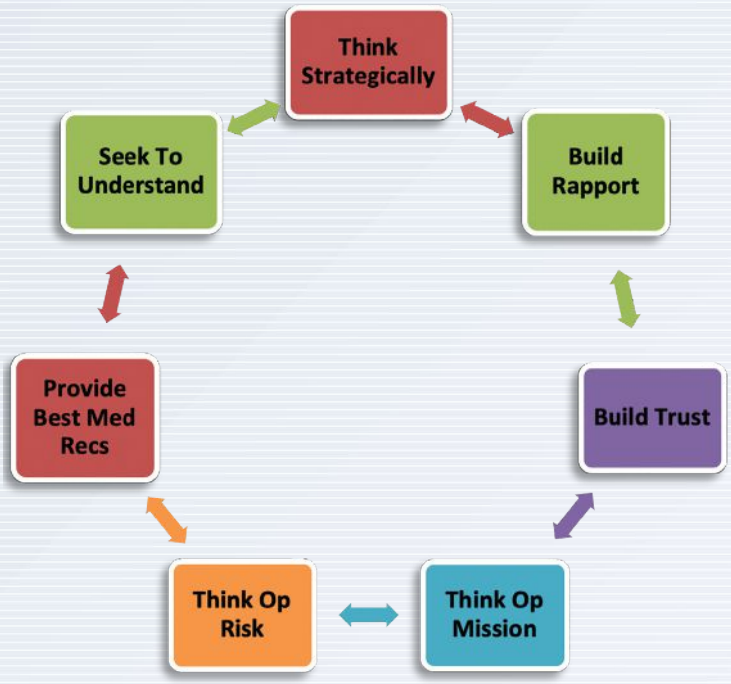
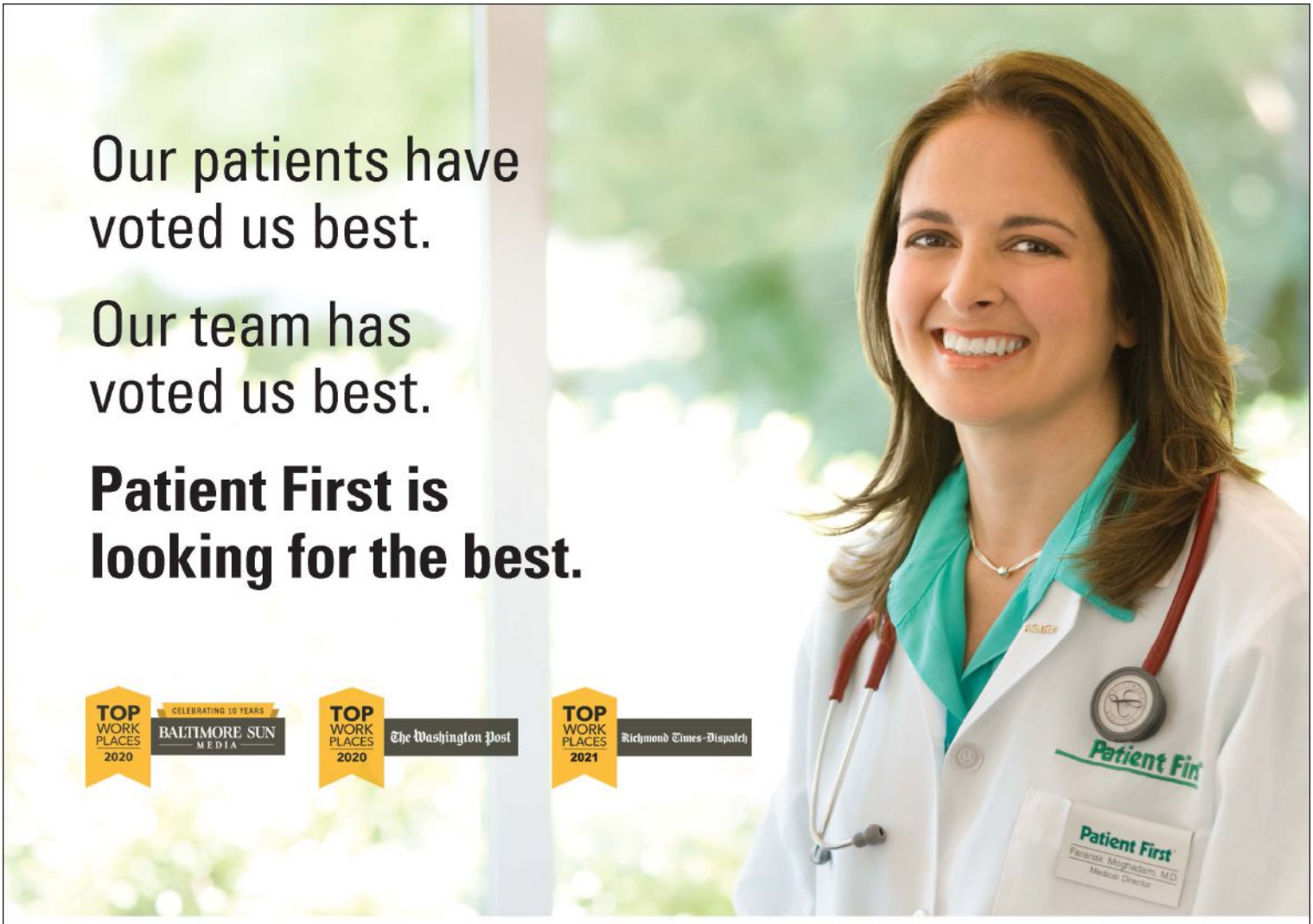


Figure 1: Key Traits of Operational Risk Communication for the Medical Leader

Note: Each component builds on and supports the other. A complete operational risk assessment involves a holistic engagement and recommendation to include the components of trust, understanding of the operational mission and risks. best medical recommendation, strategic communication/ understanding, and rapport.

SUMMARY

After serving eleven years with special operations and having recently graduated from squadron command, I have found that three components of strategic communication has made it possible for me to succeed as a medical officer with many commanders: 1) build trust with all colleagues and commanders, 2) develop relationships with units and commanders, and 3) listen and learn about the operational environment from a commander's perspective. By incorporating these three ideas into your communication plans, you will develop a foundation for building rapport and understanding with your operational commanders. As medical leaders, there is much to learn from our line colleagues. Maybe we can assume more risk while leveraging trust and empowerment in our teams. Perhaps we can advocate for further integrated medical operations. Regardless, we must innovate and accelerate our approach to operational medical support moving forward—and communicate always. Our future depends on it.



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Committee Updates

The Wellness & Resiliency Committee would like to update our readers on the AAFP's 2023 Leading Physician Well-being Program which is now accepting applications. This program is a tuition free, 10-month course where participants learn about physician well-being, develop leadership skills to guide others, and implement change within your organization to promote well-being. Please visit aafp.org for more information if you are interested in learning to how lead physicians to champion well-being.

OBTAINING FINANCIAL WELLNESS

I would like to start this article the same way any other financial discussion begins – with a disclaimer. I am a physician, not a financial advisor. The content in this article is for educational purposes only and are my own personal opinions. You must conduct your own research to be successful in making, saving, investing, and spending money.

Even though the main purpose of this disclaimer is to inform you of my background, and to protect you from following any ensuing advice blindly, it is also meant to highlight the individuality of the journey to financial wellness. While some are opening up their first credit card account at the beginning of medical school, others may be preparing for retirement at the end of their military or medical careers. Some may be attempting to pay off loans to get them out of debt, while others are determining whether they should purchase another short-term investment property in order to retire early on passive income alone. This journey truly is different for everyone.

This disclaimer statement also introduces four cardinal actions one must take along their personal journey to financial wellness. *Making* money generally refers to our wage. In the classic sense, it is the valuation of our time while we are employed. As we receive regular paychecks, it is important to understand what we make annually, monthly, and hourly to understand how others value our time. *Saving*, simply stated, refers to the money we set aside for future use and is part of our monetary worth. *Investing* is using the money we earn to work for us. We employ our wages to increase our monetary worth outside of the time during which we are actively employed. *Spending* is how we use money as a tool to transfer our time back to obtaining our goals. Developing balance between these four activities is essential in obtaining financial wellness, both now and in the future.

The fact that we follow unique paths makes it difficult to distill all-encompassing financial wellness advice into one article. After reviewing many books, blogs, and podcasts, however, there seem to be ten practical pieces of advice that are often repeated and fit into each of the four categories listed earlier. I offer these only to help those who suffer, like me, from "analysis paralysis." If you are not incapacitated due to the amount of available financial literature, please skip ahead to the resources section where the favorites of mine and my colleagues are listed. Alternatively, if financial wellness for you equals employing a financial advisor to manage your finances, please simply use this article as a starter for discussion should you so desire.

MAKING

1. Ensure that you are receiving all of your entitled pay. Compare your monthly Leave and Earnings Statement on myPay with the Military Pay Tables & Information on the Defense Finance and Accounting Service website at dfas.mil.
2. Ensure that you are receiving all of your entitled benefits. Research your GI Bill eligibility and, if desired, transfer it to your spouse or dependent children at va.gov/education. Understand in what state you are resident and consider switching your primary legal residence to a tax-free state, if applicable.
3. Consider moonlighting if you are legally allowed to work outside of the military. This off-duty employment does not have to be medical-related. Instead, it could involve monetizing a hobby which you otherwise enjoy doing. Explore further at passiveincomemd.com.

SAVING

4. Live below your means. Saving 15% of your total paycheck is roughly the minimum you should be saving to adequately prepare for retirement. Increasing your savings rate above 15% could allow you to retire early and have fewer concerns

about market fluctuations when it comes time to hang up your white coat. Learn more about how much you need for retirement at mrmoneymustache.com.

5. Use military incentives to save more. The military provides the Savings Deposit Plan (SDP) for deployed service members which guarantees returns of 10% for the duration of the deployment. Deployed personal may also increase their TSP retirement contributions to $61,000. Themilitarywallet.com offers articles on the SDP and retirement contribution limits.

INVESTING

6. Utilize the Thrift Savings Plan (TSP) to automatically withdraw money from your paycheck and invest it in a federal retirement investment plan. If you are enrolled in the Blended Retirement System and have over two years of service, ensure that you are contributing at least 5% of your base pay to the TSP since the government will match up to 5% of your contributions. Switch your contributions at myPay.dfas.mil and find more information at tsp.gov.
7. Contribute to a Roth individual retirement account (IRA). In addition to your TSP contributions, you can open a Roth IRA with an institution of your choice and contribute up to $6,000 annually (increases to $6,500 in 2023) if you are younger than 50 and make less than $125,000 annually as a single tax filer. If your income is higher, you can contribute to a traditional IRA with the option to convert it to a Roth IRA (also known as a backdoor Roth IRA). Current IRA income and contribution limits can be viewed at irs.gov and the backdoor Roth IRA process is detailed at whitecoatinvestor.com/backdoor-roth-ira-tutorial.
8. Invest additional income in a taxable account with an institution of your choice. Just because you have maximized your tax advantaged accounts like the TSP and IRAs, it doesn't mean that you have to stop investing. You can still make your money work for you by investing in a diversified portfolio on your own. Read Dr. Dahle's article about how to create a portfolio at whitecoatinvestor.com/how-to-build-investment-portfolio.

SPENDING

9. Pay off your loans. Getting out of debt can be an amazing weight off your shoulders and help you realize financial wellness in an instant. There are many paths to becoming debt free which include student loan repayment and forgiveness programs, refinancing, and even the simple Dave Ramsey Debt Snowball Method which leverages human emotions with debt payments.
10. Make a budget. Developing and adhering to a budget can do wonders for your spending plan. It allows you to focus spending your hard-earned money on things, people, charities, and activities which align with your goals and passions in life. Without a vision and a goal towards which to work, the true balance of financial wellness cannot be attained.

FURTHER RESOURCES:

AAFP: "Physician Health First" and "Personal Finance Basics for Medical Students"

AAMC: "FIRST (Financial Information, Resources, Services, and Tools)"

Almanack of Naval Ravikant: A Guide to Wealth and Happiness by Eric Jorgenson

Military One Source

"Money is a Tool, so Stop Treating it as the Goal" by Eric Roberge, *Forbes*

Rich Dad Poor Dad by Robert Kiyosaki and Sharon Lechter

The Total Money Makeover by Dave Ramsey

The White Coat Investor: A Doctor's Guide to Personal Finance by James Dahle, MD

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.

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4 DISCIPLINES OF EXECUTION

BY CHRIS MCCHESNEY, SEAN COVEY, AND JIM HULING

In the 1960s, the United States was in a "race to space" with the Soviet Union, and the Soviets were winning. The Russians were the first to space when Sputnik launched into orbit. The United States had invested large sums into the National Aeronautics and Space Administration (NASA), but the U.S. was lagging behind its prime international competitor. President Kennedy knew something had to change. He set a new goal for the organization by clearly stating:

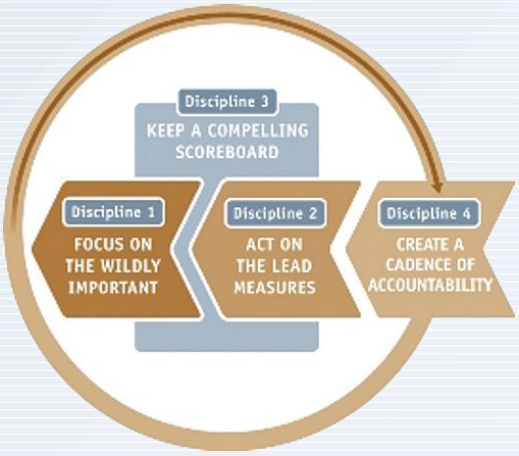

Figure 1 *– The 4 Disciplines*

> "I believe that this nation should commit itself to achieving the goal, before this decade is out, of landing a man on the moon and returning him safely to the earth." - JFK

President Kennedy revitalized NASA with this one challenge. NASA abandoned multiple other large and expensive projects and focused on this one. On July 21, 1969, Neil Armstrong's moon landing accomplished President Kennedy's audacious goal and the rest is history!

Many of us find ourselves in similar predicaments on a personal level. Our list of things to do is so long and overwhelming that we often get stuck and fail to accomplish anything. The things we do achieve often feel haphazard, and we grow frustrated that we could not complete the rest of the items on our list. Organizations can fall victim to this behavior as well. Many of us find our organizations strategically planning to address a myriad of issues. We commit to accomplishing multiple goals without a deliberate approach on how to prioritize and resource these initiatives adequately. Often, the daily minutia of what we do prevents us from executing larger goals. In their book, **The 4 Disciplines of Execution: Achieving Your Wildly Important Goals**, Chris McChesney, Sean Covey, and Jim Huling describe this phenomenon as the "Whirlwind." The whirlwind includes all the daily tasks required to do our jobs that prevent us from focusing on our larger goals. The authors describe four disciplines that can help us overcome the whirlwind and more successfully achieve our larger objectives.

DISCIPLINE #1: FOCUS ON THE WILDLY IMPORTANT GOAL

The book calls this the "WIG." This is one critical goal. Most leaders struggle with narrowing their priorities to a single objective, but in order to successfully achieve big goals, everything can't be the priority. Focusing on one goal (or two at the most) will help the team focus their energy most effectively. The process of choosing the WIG is often beneficial since it allows a team to deliberate together before deciding on the chosen goal. By including as many team members as possible, the team can ensure that a diverse set of ideas are considered. It is imperative that the WIG is both challenging, but also achievable. The authors describe several rules to follow when choosing the WIG.

1. No team focuses on more than two WIGs at a time.
2. The battles chosen must win the war. WIGs lower in the organization must serve to achieve the WIGs at the top of the organization.
3. Senior leadership can't set the lower-level WIGs but they can veto them. People need to be involved in setting the goals to be engaged in achieving them.
4. All WIGs should be in the form of going from X to Y by a certain date.

DISCIPLINE #2: ACT ON LEAD MEASURES

It is important for teams to measure activities that drive results. The authors highlight two types of measures, lag measures and lead measures. Lag measures describe results such as what you are trying to achieve. Lead measures define the supporting activities or sub-goals which can help get to your final results. Consider companies

that sell their products in a grocery store. The lag measures will be their sales and profits. A lead measure could delineate the percent of the company's product that is shelved at eye level to catch the attention of customers compared to the number of items shelved on less desirable shelves. The book further outlines two types of lead measures: small outcomes and leveraged behaviors.

Small outcomes examine results which the team can assess at quick intervals. For example, one such metric could be the weekly patient access metrics for your clinic. This information provides leadership with real time information that can drive decisions to adjust changes to the strategic approach to improve patient access to care.

Leveraged behaviors, on the other hand, track specific activities. For example, scrubbing your list of patients for the next day and identifying patients that can be cared for with a message or virtual visit, thereby opening access for others to come in person. Just as it is important to limit your WIG to one, it is also important to limit the number of lead measures you choose to track. If the initial lead measures identified aren't effective, you can switch to other lead measure metrics as you iteratively work through the process with your team.

DISCIPLINE #3: KEEP A COMPELLING SCOREBOARD

Your team needs to know where they stand. Annual or even quarterly reviews are not good enough. Human nature propels people to compete and engage more seriously when they know the team is keeping score. As in sports, the scoreboard should be visible, should show lead and lag measures, and immediately illustrate whether the team is "winning" or not. The goal is to create a winnable game that plays out in real time. Winning helps morale. The whirlwind does not provide this type of positive affirmation, so a scoreboard for your WIG can help.

As a medical student, I travelled to the hospital at Fort Campbell for an obstetrics rotation. During a visit to the local Family Medicine Clinic, I saw a bulletin board which listed the specific metrics being tracked within that clinic delineated down to the specific providers. At first, I was concerned that the providers would be upset having their names listed alongside their individual metrics in such a public place. But, after talking with a few of the staff in that clinic, I realized that the entire team recognized their role in achieving their clinic's strategic goals and that the information on the bulletin board helped them recognize their progress in real time. The hospital commander at that time had accurately recognized that physicians are motivated and hard working by nature. The scoreboard within the clinic provided a compelling visual aid to help keep motivation levels high among the team.

DISCIPLINE #4: CREATE A CADENCE OF ACCOUNTABILITY

Discipline four outlines how to execute initiatives to accomplish the WIG. The authors suggest that each team responsible for a WIG meets weekly at a minimum. These weekly meetings are designed to hold members personally accountable, make tweaks to the team's short-term goals, address problems, adjust strategy, and commit to actions for the next week. The authors highlight two hard and fast rules. First, the meeting is at the same time and place each week and is the priority for that organization. Second, all activities related to the routine "whirlwind" must stay out of the meeting at all cost. The authors go on to describe some useful approaches to running this weekly accountability meeting. The meetings should be short (no more than 30 minutes) and have the same items on the agenda each time. These agenda items include:

1. Account: Individuals report on their commitments from the previous week.
2. Review the Scoreboard: Doing so allows you to learn and problem solve.
3. Plan: Make new commitments for the next week.

The key to success is that each commitment must be specific and deliverable. Commitments to "try to get to" or "to work on" goals are not satisfactory. Each commitment much actively move a lead measure. Attendance and consistency in these weekly meetings are the foundation to successfully accomplishing your most important goals.

WHY SHOULD WE TRUST THIS PROCESS?

In the book, the authors point out that this approach is not simply an academic exercise. They relate that the framework was developed over many years and is based on the direct knowledge gleaned from over 1500 consulting engagements. The four disciplines are deceptively simply, but can drive successful organizational advancement with hard work and commitment.

COMMON PITFALLS:

The authors describe some common obstacles that teams encounter during this process and lay out ways to avoid them:

1. Don't mistake the whirlwind tasks for WIG commitments.
2. Make sure each session has a clear commitment that changes each week.
3. When someone fails to meet their commitment, treat them with dignity and respect, reinforce accountability, don't accept unfulfilled commitments, and encourage performance.

This book gives some very basic ideas on how to accomplish important goals within an organization more efficiently. The rules are hard and, at some point, your team will want to bend them, even just a little. But, by remaining consistently focused on identifying a single important goal, garnering team input and buy-in, and by faithfully committing to regular meetings to review progress and adjust approaches, your organization can also achieve success in its most critical areas.

In each issue of The Uniformed Family Physician, the Operational Medicine Committee will be highlighting an operational assignment and a Uniformed Family Physician who has been in the job.

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Operational Medicine Job Profile: Navy Surface Warfare and Fleet Marine Force Officer

Presenting CAPT Torrin Velazquez

Uniformed family medicine physicians are poised to succeed in operational assignments because of the breadth of knowledge, versatility of skills, and clinical diversity innate to the specialty. Therefore, family medicine training facilitates adaptation to any environment. The personal and professional experience and growth gained during operational tours strengthen self-confidence and improves the standing of family medicine as positively impactful to the warfighters. The Operational Medicine Committee takes great pleasure in showcasing some amazing colleagues who have done a variety of operational assignments. The goal is to spark interest in operational medicine, improve provider knowledge of the operational environment, and facilitate mentorship and positive role modeling.

For this article, the committee presents Navy Captain Torrin Velazquez, currently serving as Executive Officer for the Navy Medicine Readiness and Training Command -- Camp Pendleton in Southern California. His previous operational tours include Regimental Surgeon for a Marine Logistics Regiment, Group Surgeon for a Marine Aircraft Group, Battalion Surgeon and Medical Director for Camp Leatherneck-Bastion-Shorbak Complex Afghanistan, Squadron Surgeon for Naval Surface Group Middle Pacific and Afloat Training Group Middle Pacific, and Staff Physician in support of deployed Naval Special Warfare Team and Coast Guard ships in Bahrain.

HOW DID FAMILY MEDICINE TRAINING PREPARE YOU FOR OPERATIONAL MEDICINE?

When asked how his family medicine training prepared him for operational medicine, CAPT Velazquez stated, "It is the best preparation anyone can have for operational medicine." He said that Sailors and Marines around the fleet expected him to know all aspects of medicine while fielding many questions not only about the service members themselves, but about their parents, spouses, children, and even their pets. He opined that, "With a background in family medicine, you have a strong foundation to figure out the issues that come with normal human (and pet) physiology in abnormal environments."

WHAT ADDITIONAL TRAINING WAS HELPFUL IN PREPARATION FOR OPERATIONAL TOURS?

Regarding any specific training or preparation for operational assignments, he stated that early on in his career, he completed on-line courses such as the Basic Readiness Officer Course, the Chemical, Biological, Radiological, and Nuclear Course, the Mild Acute Concussive Evaluation Course, and other pertinent courses that would be beneficial. For assignments with the Fleet

Marine Force, he offered that Field Medical Training Battalion West at Camp Pendleton and Field Medical Training Battalion East at Camp Lejeune provide the Field Medical Service Officer Course as an orientation to Marine Corps expectations for Navy officers. Once assigned to a unit, those officers are eligible to earn the designation of Fleet Marine Force Warfare Officer, a comprehensive program which includes Marine Corps history, weapons qualification, and successful completion of the Marine Corps Physical Fitness Test.

Similarly, for assignments with the fleet, CAPT Velazquez shared that the Surface Warfare Medical Institute in San Diego hosts the Surface Warfare Medical Department Officer Indoctrination Course as an introduction on how to run a ship's medical department. Once assigned to a ship, those officers are eligible to earn the designation of Surface Warfare Medical Department Officer, a rigorous program which includes naval history, propulsion systems, weapons systems, and navigation.

WHAT WAS CHALLENGING AND REWARDING ABOUT YOUR ASSIGNMENTS?

As for challenging aspects of operational assignments, CAPT Velazquez advised to always provide appropriate medical care particularly when, "…the right thing medically is not always the popular choice especially when recommending duty limitations to operational leaders." However, with challenges also come rewards and for CAPT Velazquez the most memorable was the special bond that quickly develops between operational units and their organic medical personnel. According him, such a bond is forged through shared struggles with Operational Tempo, work-up cycles, the ubiquitous hurry up and wait, and the "Semper Gumby" attitude needed to adjust to constant change.

Reminiscing about unique experiences, the two that stood out the most for him were the field training with Brazilian Marines at their base in Brazil and his work with the Bahraini Ministries of Interior and Defense. Through such assignments, he gained a better appreciation for, "…the barriers, limitations, and threats other countries face on the world stage and the importance of integration of capabilities amongst allies to build a better team."

WHAT ARE YOUR RECOMMENDATIONS FOR JUNIOR OFFICERS PREPARING FOR FUTURE OPERATIONAL TOURS?

Captain Velazquez had a few recommendations for anyone interested in an operational position. He stated that medical students and residents should seek out operational rotations as most family medicine residencies offer an operational GME program. He offered that military medicine is operational medicine; thus, every service member patient encounter can impact deployability. He also mentioned the USAFP's Operational Medicine Committee as a resource for various operational areas for all services. He had two last points to make, "First, remember that when you go operational, you are privileged to be given a glimpse into the world of operators who go directly into harms' way. Your job is to ensure they know that regardless of what happens to them, they will be taken care of medically. That is the force multiplier that operational medical personnel bring. Second, remember that you will return to medical clinics or hospitals, but those operators will PCS to other operational units. For many units, you represent military medicine regardless of your rank. At no other time in your career will you be able to impact the hearts and minds of service members as you do when you are operational. Embrace it."

2022 AAFP Congress of Delegates

The AAFP Congress of Delegates was held September 18-21 in Washington, DC. The USAFP was well represented by Past Presidents Drs. Deb Manning and Aaron Saguil who served as Delegates and USAFP President Marcus Alexander, MD and USAFP President-Elect Kevin Bernstein, MD who served as Alternate Delegates. The USAFP was also represented on a national level by USAFP Director Janelle Marra, DO, AAFP Delegate to Member Constituencies and USAFP members Spencer Fray, MD, AAFP Delegate to Member Constituencies and Rachel Carter, MD, Alternate Delegate to Member Constituencies.

This was the first time the Congress met in person since the 2019 Congress in Philadelphia. The Delegates and Alternates from the state chapters and member constituency groups not only had to convene the business of the 2022 Congress but also had to address those resolutions that had been extracted for discussion from the 2021 virtual Congress that was held back in February 2022 after being cancelled in the fall of 2021 due to COVID.

The Congress of Delegates (COD) is the American Academy of Family Physicians' (AAFP) policy-making body. Its membership consists of two delegates and two alternates from each constituent chapter and from the member constituencies including new physicians, residents, students, and other constituency groups represented at the AAFP Leadership Conference. The Congress of Delegates meets annually to address resolutions brought forward by constituents on topics that are of interest to Physician members and the patients they serve.

The Congress elects new officers and members to serve on the Board of Directors during the meeting. The Officers and Board Members elected are noted below.

Steven Furr, MD Jackson, AL - President-Elect
Russell Kohl, MD Stilwell, KS - Speaker of the Congress
Daron Gersch, MD Avon, MN - Vice Speaker
Kisha Davis, MD, MPH Bethesda, MD - Director
Jay Lee, MD, MPH Costa Mesa, CA – Director
Teresa Lovins, MD Columbus, IN - Director
Rupal Bhingradia, MD Jersey City, NJ - New Physician Board Member
Chase Mussard, MD Portland, OR - Resident Board Member
Richard Easterling Jackson, MS - Student Board Member

USAFP Delegation with AAFP Board Chair Ada D. Stewart, MD, FAAFP

Janelle Marra, DO, FAAFP, CAQSM testifying at the AAFP Congress of Delegates

The USAFP hosted a reception for members attending AAFP's FMX. Below are photos of members enjoying the reception

2021-22 AAFP President Sterling Ransone, MD, FAAFP assumes the role of AAFP Board Chair upon the conclusion of this year as AAFP President and Tochi Iroku-Malize, MD, MPH, MBA takes on the role of Academy President.

AAFP members are welcome to participate in hearings of the reference committees: Advocacy, Cross-Topical, Health of the Public and Science and Practice Enhancement. Reference committees are committees of the COD that consider business (resolutions) items referred to them for recommendation to the COD for debate and action.

During the meeting (held prior to AAFP FMX), the Congress of Delegates agenda includes addresses from AAFP officers, resolutions from chapters, and reports from the Board of Directors. The Delegates and Alternates representing the AAFP constituent chapters, and the member constituencies reviewed over 30 resolutions in reference committees and discussed over 39 extracted items of business from the 2021 virtual Congress. The wide array of topics included administrative burden/prior authorization, primary care investment, health system reform, insurance plan participation and scope of practice, reproductive health related issues, billing and coding policies, CME and family medicine certification just to name a few.

If you are interested in learning more about the AAFP Congress of Delegates check it out here.

new members

THE USAFP WELCOMES THE FOLLOWING NEW MEMBERS...

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Kristen Barta MD
Angadpal Batra MD
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Jeffrey Bevan MD
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Emily Buck MD
Patrick Campbell MD
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Kayla Carman DO
Ryan Carnegie DO
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Nicholas Carter MD
Laura Chachula DO
Kurt Christen MD
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Zari Cofield MD
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Elizabeth Conlon MD
Marc Cook DO
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Hillary Darrow MD
Samantha Daum DO
Sarah Davis MD
Spencer Dean DO
Harrison Dilworth MD
Kyle Doerr DO
James Dreher MD
Isaac Edwards MD
Danielle Ellzey DO
Andrew Engle MD
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Krystyna Golden MD
Kathryn Gouthro MD, MS
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Victoria Hall MD
Erika Hallak DO
Andrew Hamilton DO
Daniel Harren MD
Colin Hart MD
Eric Hasenkamp MD
Joshua Herring DO
Renaldo Hidalgo DO
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Terrell Washington MD
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Zachary Wiser DO
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Oussama Alserwy
Ahmad Al-Zughoul
Leo Andrada
Jordan Armes
Zackary Bailey
Laura Belovs
Seth Biehn
Emma Bowman
Kate Boyle
Meaghan Brophy
Paige Cackovic
Thomas Chameli
Brenda Chang
Som Chaturvedi
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Christian Hernandez-Zegada
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Scott Roberts
Chance Rummler
Natalie Saddic
Ajay Saraf
Cody Scott
Max Shap
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Jacob Steins
Nathan Swift
Simon Turkington
Mckenna Wade
Matthew Ward
Joseph Wright

Nominate Your Peers!

Winners will receive round trip airfare, 2 days per diem, 2 nights hotel, and waiver of the registration fee to the Annual Meeting. They will be recognized and receive a plaque at the Annual Meeting and also be recognized in the USAFP newsletter edition following the Annual Meeting.

USAFP Academy Awards

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

This honor is bestowed on a Uniformed Family Physician who exemplifies the tradition of the family doctor and the contributions made by family physicians to the continuing health of the people in the Uniformed Services.

To nominate your peers for this outstanding award, please send a letter of support to Matt Schulte (mschulte@vafp.org) no later than 12 January 2023.

Eligibility Criteria:

1. Provides his/her community with compassionate, comprehensive, and caring medical service on a continuing basis.
2. Directly and effectively involved in community affairs and activities that enhance the quality of life of his/her home area.
3. Provides a credible role model as a healer and human being to his/her community and as a professional in the science and art of medicine to colleagues, other health professionals, and especially, to young physicians in training and to medical students.
4. Must be in good standing in his/her medical community.
5. Must be a member of the USAFP.

OPERATIONAL MEDICINE AWARD

This honor is to recognize a Uniformed Service Family Physician that has exhibited outstanding achievement in the provision, promotion or research in operational medical care.

To nominate your peers for this outstanding award, please send a letter of support to Matt Schulte (mschulte@vafp.org) no later than 12 January 2023.

Eligibility Criteria:

1. Demonstrated substantial contributions, dedication, initiative, leadership and/or resourcefulness in providing patient care in any operational environment.
2. Outstanding service, devotion, dedication or compassion while performing his or her duties in any operational environment.
3. Concepts, procedures or methods developed by the nominee which resulted in significant reduction in morbidity or mortality, workload required for mission accomplishment, financial expenditures or material utilization.
4. Involvement in continuing education as a researcher, participant, organizer or sponsor which directly and materially improves operational medicine.
5. Humanitarian or military community involvement that substantially improves the health and readiness of the service member, their families or the supported population.
6. Any other substantial contribution directly related to operational medicine not described above.
7. Must be in good standing in his/her medical community.
8. Must be a member of the USAFP.

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 20 December 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. *dreamy@vafp.org*.

RESEARCH JUDGES

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

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

Please write to me...
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?

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

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USCG Base Cape Cod Kaehler Memorial Clinic

Fall is in the air! For most of us it is such a welcome relief from the heat.

As of this writing, the USAFP Board of Directors and Committee Chairs are meeting in Washington, DC to finalize planning for the Annual Meeting next March in Orlando, Florida. It is another event that is expected to be a great success.

Without further delay, here are some updates from across the organization.

First will be from the Commissioned Corps followed by narratives from the Coast Guard.

1. **Line of Duty Determination (LOD)** - POM 821.82 defines the process involved in the determination of an officer's medical condition and whether it "occurred or was aggravated" while on active duty. The policy affects both regular and reserve Commissioned Corps officers. The process to determine LOD status is included in the POM, including an outline of the appeals process. LOD assessments cannot be used for disciplinary action, or to recoup reimbursement for any medical expenses.
2. **Public Health Reports (PHR),** the official journal of the Office of the U.S. Surgeon General and the U.S. Public Health Service recently posted its newest issue online. The link to the website is Public Health Reports | HHS.gov.
3. **Training Opportunity** – Commissioned Corps Training Branch has partnered with Emory University to develop a refresher training geared towards clinicians with emphasis on emergency and disaster response. Registration is available through the CCLMS website.
4. **Deployment Preparation Plan Form** – During the August Department of Homeland Security meeting with the Commissioned Corps, the Deployment Preparation Plan form was discussed. The form is to be completed prior to deployments or duty-related absences and should contain the officer's plan for the care of their family and other personal and professional affairs. The form is expected to be available by October 1, 2022 and will go into effect on January 1, 2023.

Updates from the US Coast Guard:

1. **TRAMU** Tailored Readiness Availability Mobile Unit (TRAMU) - District One's first TRAMU event was completed during the last week of August. The purpose of this mission was to reach our remote units located in Maine. The team conducted medical readiness activities and addressed the medical concerns raised by local service members. The team evaluated approximately 200 Coast Guard members and received positive feedback from the supported units.

HS2 Unpingco and HS3 Kane shown here preparing the laboratory section of the TRAMU event.

The tent set up in Southwest Harbor Maine as part of the first TRAMU evolution in District 1.

Kaehler Medical clinic staff enjoying the day playing paintball

View taken by author while hiking with other Coast Members in Bar Harbor Maine

2. **Transgender Policy** - Update to Transgender Service Policy – The new policy change requires a separate page for command endorsement for gender transition requests (GTR). This endorsement elucidates the requested change to gender marker in DEERS. The support should come from the first Captain (0-6) or CG –15 in the member's chain of command. Additionally, a separate endorsement is needed to show the unit's ability to support the member during their entire transition. For further information on the new guidance here is the link https://www.mycg.uscg.mil/News/Article/3151333/coast-guard-updates-transgender-service-policy/

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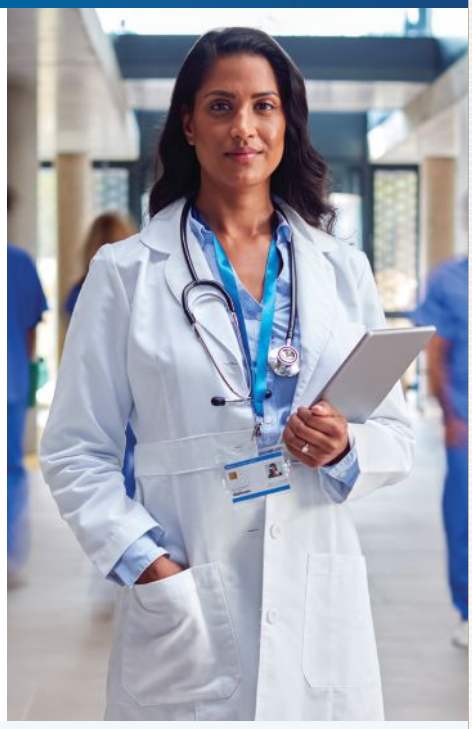

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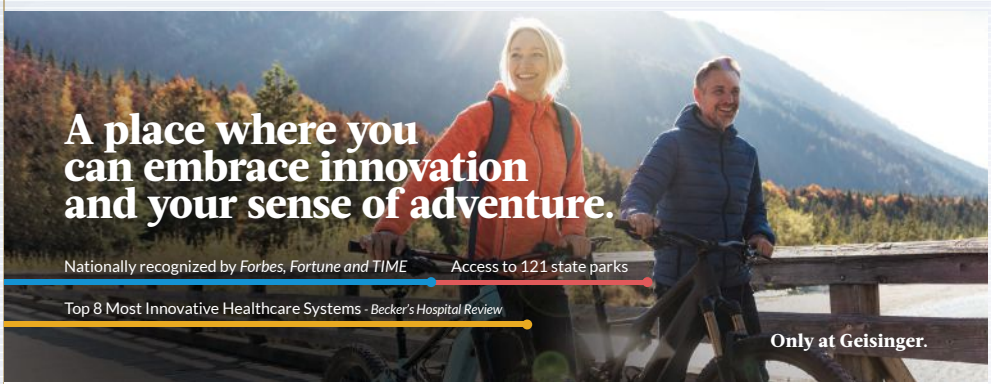

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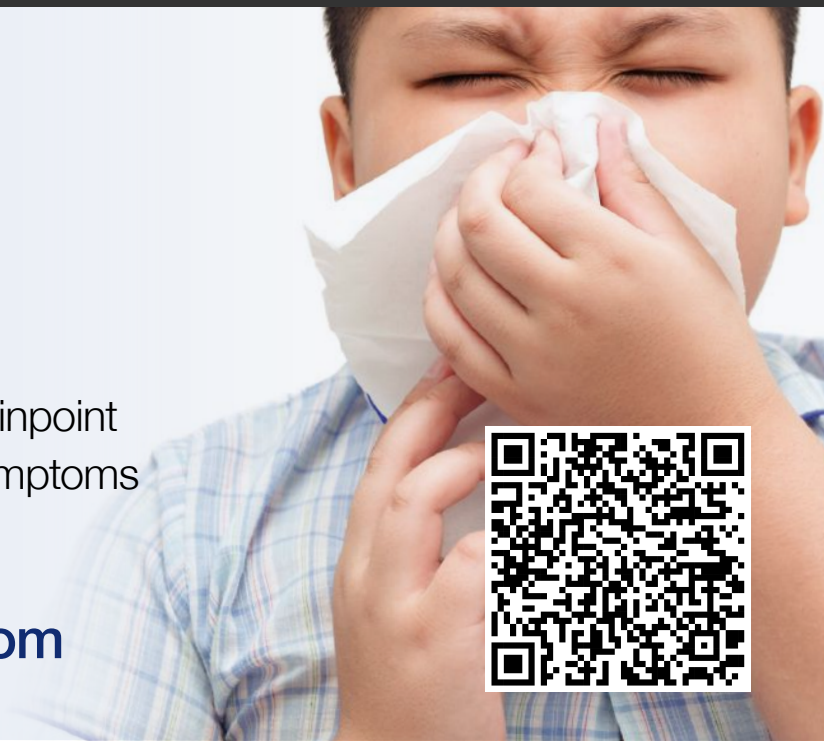

Review these helpful resources:

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
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