THE UNIFORMED FAMILY PHYSICIAN

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2024 ANNUAL MEETING & EXPOSITION
MARRIOTT NEW ORLEANS

NEW ORLEANS, LA

23 – 28 MARCH 2024

Journal of The Uniformed Services Academy of Family Physicians

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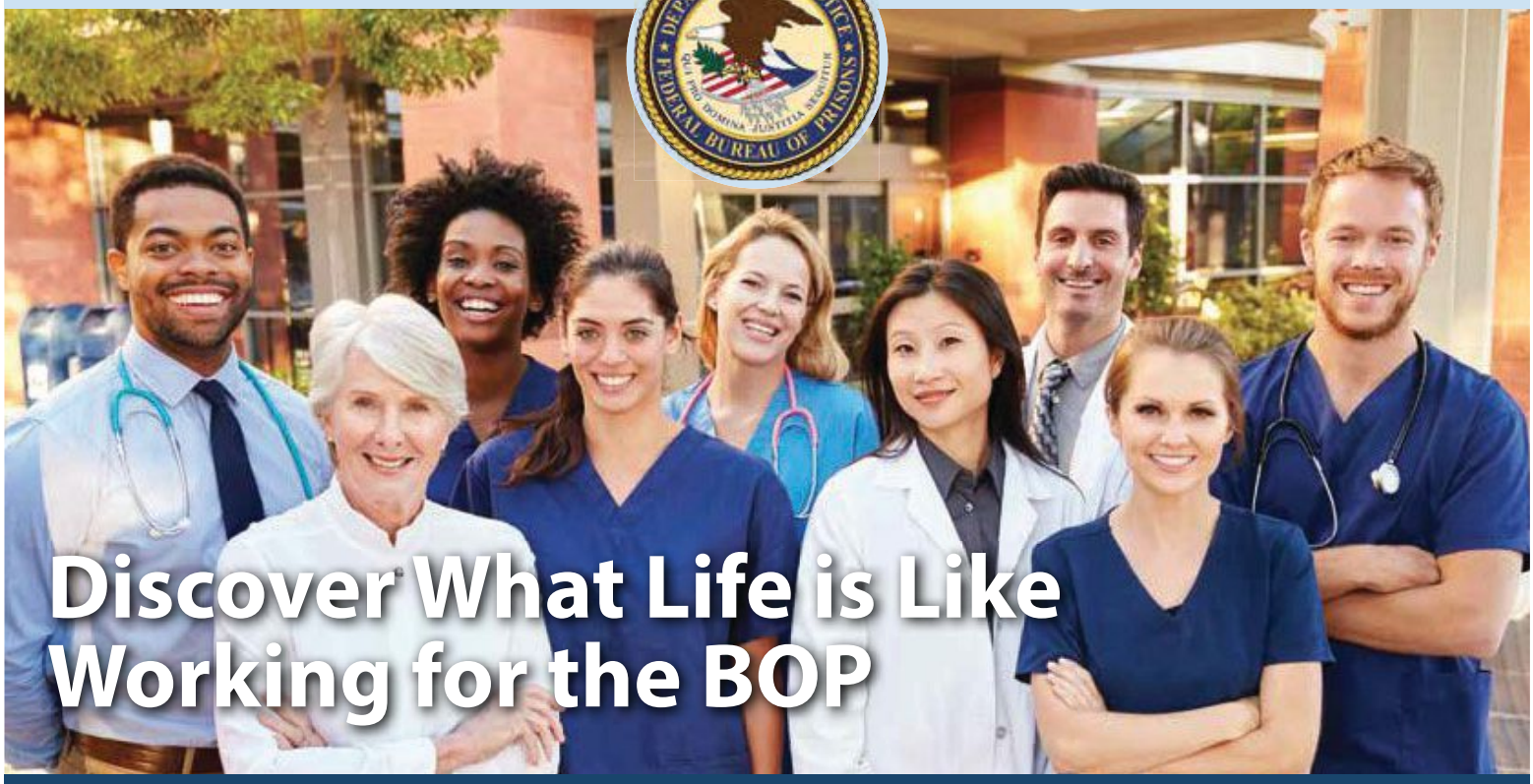

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VISION

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

MISSION

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

Edition 64

your academy leaders
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Greetings! I hope everyone is enjoying the summer months as this is personally my favorite time of the year. It's graduation time for our classes of Family Medicine residents and interns! As I peruse a variety of social media posts sharing photos of our graduates, it brings excitement to see so many new Family Medicine physicians headed out to do amazing things as they embark on their first assignments.

I remember my own graduation day fondly with many emotions: the relief of completing training mixed with a bittersweet feeling of moving away from the communities that raised us to become fully trained and certified. The friendships that we created amongst our peers in our intern and residency classes are ones that last a lifetime. Despite almost a decade going by, I thoroughly enjoy receiving messages from residency classmates that pop up via text, as well as following the adventures of friends on social media.

This year's graduation was personally a very momentous one and one that I will remember for a lifetime. I had the distinct honor of serving as the keynote speaker at the Naval Hospital Jacksonville Family Medicine Residency Program's graduation ceremony. The graduates that invited me were part of the last class of residents that I was blessed to have the opportunity to teach during my time there and I cannot thank them enough for the opportunity.

Here, I would like to paraphrase the take home messages from the graduation speech in order to share it with all graduates in our USAFP community. I hope you find these messages helpful as they helped shape my continuous development in a far from perfect career in medicine.

Foot Stomp #1 – Know the difference between true resiliency and being asked to be okay with moral injury.

You may have heard the following statements at some point during your training: When the going gets tough, persevere. Mission accomplishment. Keep the goal in site.

Practice mindfulness during tough times. Here's a pizza party to make everything better. Sound familiar? When is resiliency amidst burnout more consistent with moral injury?

To me, moral injury occurs when you notice things getting done the wrong way while others disguise mindfulness tactics to make you feel better about your bad situation. You clearly notice that you are not optimizing patient care due to systemic issues. You feel helpless. Compare this to getting things done the right way, safely, for your patients. Working effectively with the folks you work for as well as the people you are leading during tough times; feeling satisfied, going to sleep at night knowing the decisions you made were the ones you would make according to your own vision and mission statement. Notice the difference. Seek help when you are experiencing moral injury.

Foot Stomp #2 – Write your personal mission or vision statement

A great mentor of mine (one of my program directors during residency), CAPT Retired Tim Mott, assigned me this exercise when times grew really tough prior to my residency graduation. I was totally out of balance. It was one of the best things I ever did. CAPT Mott challenged me. Now I challenge you to do this before arriving to your next assignment. What is your purpose? What do you want your legacy to be? When all is said and done and your time spent in your career and eventually in life is complete, what do you want to be remembered for? What will you be remembered for?

My mission is to inspire all people to lead a life that's healthy and balanced while leading a balanced, healthy life of my own.

My vision is to work as a servant leader while keeping my wife, son, family, friends, colleagues and patients at the center of all decisions including the ability to say "no" to better the lives of people around me while advocating for a better, more equitable health care system for all.

My vision and mission statement have not changed much in the last 10 years. The only thing I have added is my wife and son. This is my North Star when making all decisions – whether to take on a new leadership position, take vacation, answer an email or advocate for others (especially regarding an issue I disagree with).

Use your personal mission and vision to promote and maintain balance. Refer to your mission and vision for key decisions going forward. If you are not balanced and need help, reach out. Make wellness a priority.

When you get to your upcoming assignment – take some time to observe. Gain an understanding of your commander's mission, vision, and strategic objectives. Appreciate the skillsets of everyone around

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you, especially your fellow officers, skilled corpsmen/medics and techs. Have a phone-a-friend list. Look at the things around you that you want to improve that will create a lasting impact well after you leave. Are you okay with making decisions that do not bring you personal reward or recognition, but are decisions that are better for everyone else around you? These are questions to chomp on as you decide how to use your personal mission and vision statements in all facets of your life. These can be ways that you combat burnout and moral injury, and shift towards being truly resilient. You and your people are your biggest assets. Advocate for them.

Foot Stomp #3 - Everything that has happened to this point happened for a reason. Everything that happens next you are prepared for.

Are you ready? Is anybody nervous about their next assignment? It's okay, I know I was.

Remember that it's okay to say that you don't know or that you need to ask for help.

For those going to serve with the line, it is their expectation that you know the answer to everything having to do with medical. You don't need to know everything, you just need to know what you don't know, acknowledge your limitations and bring solutions.

Be willing to lead change. We need you to help shape the future of military and family medicine. It is far from perfect. Take on leadership roles.

As Ted Lasso says, "Taking on a challenge is a lot like riding a horse, isn't it? If you're comfortable while doing it, you're probably doing it wrong."

Along with taking on these roles – pick and choose your roles carefully to prevent being overcommitted and the cause of your own burnout. Be okay with saying "no".

Graduates – this is the day that you celebrate. You have accomplished all the training you need to be successful Physicians, Family Medicine Physicians. Over 9,000 hours dedicated towards training (just in residency alone). You are not Providers; You are not Resources. You are Physicians.

Residency graduates - you are Family Medicine Physicians. Irreplaceable, never interchangeable.

You have a skillset like nobody else in all of medicine. You take care of all ages and stages from womb to tomb. You are prepared.

You are the physicians for your patients, your squadrons, your units, your ships, your senior leaders, as well as your fellow physicians and peers. You are called upon to fill gaps in remote places, overseas, as well as within hospitals because only you have the knowledge and capabilities to take on all of these roles.

Graduates: Be balanced. Be Bold. Be Champions of Family Medicine.

We are Foundational. We are Relevant. We are Family.

Enjoy the next stage of your career. Your friends and family at USAFP are here for you.

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UW Medicine
PRIMARY CARE

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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/**

Aloha Mai Kākou (warm greetings)!

It's Summertime! I hope that you are all enjoying the warm weather and spending time relaxing with friends and family. Summer is a time of transition, with our newest graduates heading out to their first duty assignments and PCS season bringing many uniformed family physicians to new locations both near and far. Whatever this season brings, I wish you the very best!

This Summer edition of the UFP highlights multiple areas of our USAFP community. Dr. Carter shares the incredible advocacy work that was done by our contingent of representatives to the National Conference of Constituency Leaders (NCCL) in Kansas City, Missouri. Advocacy gets a win! A team from Travis FM Residency (Dr. Gonzalez, Dr. Locke and Dr. Klein) discuss the potential of using Big Data for research within the Military Health System and Dr. Maurer shares helpful information on Top Medical Apps for smart devices. Dr. Garcia provides practice management tips to optimize efficiency with MHS Genesis in order to reduce "Pajama Time" (charting after duty hours). We are fortunate to have several articles focused on operational medicine topics. Dr. Hu shares his operational experience as an Army Flight Surgeon and discusses how uniformed family physicians must balance patient confidentiality with a commander's "need to know". Dr. Shook also shares his operational experience as an Airborne Brigade Surgeon doing arctic medicine. On the clinical side, Dr. Balogun and Dr. Valerio unpack what it means to be a multifunctional physician and provide advice to family physicians working in urgent or emergent care settings. Dr. Ogren reflects on the importance of social connectedness to promote health and well-being. We also have an exciting update about the upcoming 2024 Annual Meeting in New Orleans!

Mahalo nui loa (thank you very much) to all of these authors as well as the other UFP contributors for sharing their time and insights in the development of this newsletter. Please sit back and enjoy this edition of the UFP. You are all doing tremendous work on the front lines of family medicine. Please consider submitting an article for a future edition so that this newsletter captures the diverse voices and unique experiences of our USAFP community. Reach out to me directly if you have ideas for UFP articles. During this time of transition, I encourage you to be deliberate about taking time to rest, restore and reconnect with yourself and your loved ones. Congratulations again to all of our graduates! Remember to stay connected to our USAFP community as you transition into your new roles and responsibilities. YOU ARE prepared for the road ahead. Stay hydrated out there and show 'em what Family Medicine can do!

Me Ka Mahalo Nui (with gratitude),
Gigi

Hawaiian word of the Quarter: Ho'omaha (meaning *to rest, to take a vacation, to take a break)*

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2024 Annual Meeting Update

We are Foundational. We are Relevant. We are Family. We are the first line of defense and the healthcare quarterbacks for the most diverse patient population. Our empathy, adaptability and wide breadth of knowledge from cradle to grave make us indispensable and essential to all realms of healthcare.

Our annual conference is CRITICAL to Uniformed Family Physicians. We reconnect, share best practices, maintain skill sets, and ensure that we continue to provide the best care for our patients. The USAFP 2024 Annual Meeting promises to bring you up-to-date, evidenced-based topics while cultivating the valuable and versatile skills that distinguish us from our non-uniformed counterparts.

In hopes of maximizing attendance, we are busy reviewing the robust response to our call for speakers and developing an annual meeting that provides a wide range of presentations, hands-on sessions, and research topics. The historic city of New Orleans is known for its vibrancy, entertainment, and energy. A variety of culinary delights, recreational activities and historical sites are within walking distance from our hotel. We are crafting the 2024 Annual Meeting in a way that encourages family attendance and we encourage family members to explore this amazing city and the annual conference with you.

So, brush up on your French Cajun, Google "second line" to avoid any cultural faux pas, and get ready for a personally and professionally fulfilling time with us in New Orleans!

À Bientôt!
Andy McDermott and Kerry Sadler
2024 USAFP Annual Meeting Co-Chairs

More detailed information about the program will be available in the upcoming months. You don't want to miss this much anticipated scholarship and mentorship, and fellowship event! If you have any questions or want to contact the programs Co-Chairs, please email USAFP2024@gmail.com.

consultant's report
NAVY

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Greetings Navy Family Medicine colleagues! We are in interesting times, as we shift to a larger operational footprint.

THE DETAILING LISTS - HOW NAVY MEDICINE MANAGES BILLETS

As I write this, CAPT Shari Gentry is receiving Family Medicine billet priorities and we expect the Non-Specialty Specific lists due in a few days. Since most of us will be changing jobs within a few years, I'd like to discuss the options and how they have changed recently.

1. Senior Executive Medicine (SEM) – This is a list of jobs that the Surgeon General signs off on. Most are designated for those with command experience, but not all. Two years ago, these decisions were responsible for much of the unprecedented delay in orders. This year was better.

2. Command – This is actually XO screening, since completion of a successful XO tour puts one in line for a CO job. Command screenings are banked, so selected individuals do not have to apply again if they do not find their name on a list.
   - Hospital XO's have to be an O-6, but smaller commands including research centers can be O-5.
   - Because the screening is for a job, there is no certainty about location. They do try very hard to fit into people's top 3 choices, and they do respect EFMP restrictions.
   - Screening involves an interview with 4 service hospital CO's and then a board. Those who do not have hospital director/CMO/ECOMs experience will often be declined for XO and offered a CMO position to gain this experience.

3. Milestone – While the primary milestone billet for the medical corps is the Chief Medical Officer (CMO) position, similar to CNO for nurses and DFA for MSC's, we can also apply for Officer in Charge (OIC) positions at branch clinics and some research and training commands.
   - This year, they added senior operational billets that were previously on the NSS list or detailed separately. I expect to see more senior operational jobs on this list next year.
   - I encourage anyone with at least 1 year as a Commander to consider applying for Milestone billets.
   - Same location uncertainty as Command, but they do try to match the top several on your list.

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 some 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 with amazing locations not normally available to Family Medicine are often on this list.

4. Operational Medical Officer (OMO) – BUMED continues to be committed to a conversion of the General Medical Officer (GMO) over the next 4 years.
   - This summer, FM added 12 former GMO billets due to the staffing issues that has impacted the entire medical corps, especially FM.
   - There will always be a GMO option for folks who want to switch residencies
   - There will always be Flight and UMO pathways for graduating interns.

5. General Medical Education (GME) – We will always have fellowship opportunities, mainly Sports Medicine.
   - We opened a second Sports fellowship in Camp Lejeune this summer, led by our colleagues Emily Crossman and Jon Gruber.
   - We also have a position in the National Capital Consortium, where our fellows can support USNA athletics.
   - After at least four years, the option for FM-OB at Camp Lejeune is back.
   - 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.

6. Advertised Positions – These are the billets that I advertise through weekly emails from the Corps Chiefs.
   - 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 priority in negotiation for the following orders.

7. Family Medicine Slates – Don't forget our bread and butter.
   - These are the billets that require Family Medicine, both in our NMRTC's and operational locations, and this is our baseline commitment to BUMED and the line.
   - In 2023, our staffing issues led us to have to gap more than one third of our CONUS MTF billets.

PROMOTION – FM HOLDS ITS OWN

We recently saw the O-6 promotion list and are still awaiting O-4 and O-5 at the publication deadline. Congratulations to the following officers in our FM community who were selected for promotion!

CAPTAIN

Arriel Atienza
April Breeden
Helen Cann
James Chung
Garfield Cross
Ken Fechner
Lisa Gibson
Sean McGrath
Ray Portier
Nelly Rice
Robert Uniszkiewicz

The statistics for FM show that we are promoted at just over the average for MC officers in the Navy.. They would be higher, but some of our folks are included in the flight surgery or UMO communities.

	In Zone			Above Zone			Below Zone			Total Select Rate	
Rank	#	% in FM	% in MC	#	% in FM	% in MC	#	% in FM	% in MC	FM	All
CAPT	6/9	67%	65%	0/4	0%	20%	2/26	8%	3%	46%	43%

The Career Pathway for Family Medicine includes at least one operational tour prior to Commander (0-5) and a senior operational tour prior to Captain (0-6). Joint Professional Military Education (JPME-1), a collection of Naval War College courses that can be taken remotely, is included on both promotion board instructions and the career pathway.

Have a wonderful end of summer and fall.

Mike

DETAILER UPDATE:

Greetings Navy Family Medicine Team!

I have recently sent out the 2024 PCS opportunities and will be compiling everyone's inputs before finalizing assignments and writing orders for you. Please keep in mind that I try to look at the whole picture for everyone including family needs, professional growth and needs of the Navy. Detailing priorities remain the same with a focus on filling Operational and OCONUS billets and then looking at CONUS MTF billets. Of note, I will look ahead to your next tour after this if I'm not able to get you something within reason on your ranking list this time, but it takes flexibility and a willingness to do something different like exploring the pacific seas or making brunch plans while working in Bahrain – they are amazing! For anyone applying for the opportunities CAPT Arnold described, I will hold on your placement and orders until results are out for your respective application(s) and I wish you the best of luck! As always, please feel free to reach out to me to discuss career planning or a record review.

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Data Mining for Gold: Use of Military Big Data to Answer Important Questions

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"I noticed that some Family Medicine physicians are using data from military health records to answer important research questions. Is that something I can do at my duty station?" The answer is YES!

WHAT IS BIG DATA?

The digitization of medical records has opened new doors for researchers. Never before have inquisitive minds had access to such massive quantities of high-quality medical data at their fingertips. The healthcare industry is one of many to have started tapping into Big Data, a term often used to capture the complexity, variety, and immensity of these vast modern data sets. Data mining, or the analysis of Big Data, has already been used for many exciting purposes in the health field. For example, electronic health record (EHR) data has been used to develop clinical prediction models such as the Framingham risk score, which is used extensively in the primary care setting to predict the risk of heart disease.[1] In addition to clinical data, medical databases often store descriptive data such as patient demographics, which can identify sociodemographic trends of health conditions, and improve the quality of care for those most vulnerable. The great news is that this form of investigation is accessible to any Family Physician who wishes to start diving in and seeking answers to their questions.

THE MILITARY HEALTH SYSTEM DATABASES – ENDLESS POTENTIAL

Military medicine is especially poised to benefit from Big Data analysis owing to the sheer size of the Military Health System (MHS), one of the largest healthcare systems in the world. There are two commonly used computational environments from which to pull MHS data: the MHS Data Repository (MDR) and the MHS Management Analysis and Reporting Tool (MHS MART, commonly called M2).

The MHS Data Repository (MDR) is the Defense Health Agency's (DHA) centralized data repository that has gathered decades of healthcare information from MHS and non-MHS facilities (i.e., healthcare purchased by the MHS for TRICARE beneficiaries) worldwide.[2] The repository contains health information for approximately 9.6 million beneficiaries, across all military branches for care received in over 50 hospitals, 500 medical clinics, and 300 dental clinics.[3] MHS beneficiaries include active duty, national guard, reserve, and retired service members, as well as their dependents and survivors.[3]

A variety of information from military treatment facilities can be accessed. Examples include referral data, subjective/objective notes, appointments, vital signs, radiology and laboratory orders and results, medication orders, surgeries, immunizations, ER visits, inpatient admissions, billing, costs of care, operational injuries and exposures, deployment data, death files, and more.[4,5] The MDR also stores administrative data (e.g., billing codes) from care received at non-MHS facilities for beneficiaries and monthly enrollment and demographic data, allowing researchers to get a more complete picture of healthcare utilization for beneficiaries across healthcare settings. Data elements available for use for your specific research project can be found in the relevant data dictionary.[4,5] Although there are a limited number of people that have MDR access, clinicians may be able to team up with these individuals if they have similar research interests to extract the data, or submit for formal dataset request from the J-5 Analytics and Evaluation Division team at DHA.

Luckily, another system exists which contains a similar wealth of information and is simpler to navigate. M2, an MDR-derived portal to MHS data with a drag and drop interface, allows users without significant coding expertise to perform ad-hoc data queries.[6] M2 contains the last five fiscal years of DHA health care data and is frequently utilized at Military Treatment Facilities (MTFs) where analysts perform searches and retrieve results within minutes. It enables MTF leaders to make more informed health care decisions as data from this database generate reports

on enrolled populations using many of the same data elements found in the MDR. This can be a valuable tool for performing research involving smaller cohorts (e.g., 5,000 people or records). Say you wish to identify patients with a rare disease, data can be identified and quickly pulled from M2 using a number of ICD billing codes. Motivated clinicians who plan to carry out multiple studies over time can certainly obtain M2 access after completing the required application and training modules.

Additional avenues are available to access data specifically for military members such as the Defense Medical Surveillance System (https://www.health.mil/Military-Health-Topics/Health-Readiness/AFHSD/Epidemiology-and-Analysis). Resources such as this provide opportunities to collaborate with research groups and increases the chances of finding partners with similar research ideas. These databases are large in size and constitute information from the diverse population of service members and their families. They are truly powerful resources for those who wish to mine them for the gold within.

HARNESSING POWER: THE PROCESS OF ACCESSING MHS BIG DATA

Learning mastery of navigating M2 or the MDR can take patience, however diligence can yield great value. For a first-time miner of MHS databases, the timeline from conception of a research question to the acquisition of a dataset for analysis may be approximately nine to twelve months (figure 1). Those who already have established access to the desired data system may be able to retrieve their results about 3 months sooner. The following are suggested steps to enable your research vision to become a reality as smoothly as possible:

Step 1: Create a research question! Your question should be specific, measurable, and relevant. Most importantly, it should be something that you are genuinely curious and passionate about, as this makes the journey to answer it more enjoyable. The following are a just a few examples of the types of questions which could be answered with EHR data: What is the incidence of a rare genetic disorder among children of service members? What is the time from diagnosis of a specific type of cancer to first hospital admission for an associated complication? How does a patient's rank contribute to their healthcare utilization (number of healthcare visits, prescriptions for medications, treatments)? Is there an association between filled prescriptions for a specific medication and body mass index?

Step 2: Perform a literature search of what has already been published on your topic of interest. A review of the relevant literature can help you to refine your research question into one that is more meaningful, adding to the current knowledge base. It can also provide useful ideas on how to design your

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research methodology including exclusion and inclusion criteria, identification of variables and outcomes, and approaches to statistical analysis. You can learn from the experiences of those who have gone before you, allowing you to anticipate and address limitations making conclusions gleaned from the analysis stronger. A well-designed investigation using data from the MDR or M2 to answer a question asked previously using smaller cohort can generate results from a large and diverse study population and lead to conclusions that may be relevant to the general U.S population, not just the military.

Step 3: Build a research team! If possible, find a mentor with experience dealing in Big Data. Because this type of research may require some data management skills, and MHS data has safeguards requiring levels of review for access. A mentor can provide guidance to help get you started and reduce your chances of having to re-accomplish steps down the road that may delay progression of the study. A mentor can also help you anticipate issues with research design, establish timelines, connect you with an experienced biostatistician, help with applying for Institutional Review Board (IRB) approval, and provide guidance on analyzing your data and submitting your final product for publication. If you need help identifying a mentor, consider contacting your local Clinical Investigations Program (CIP), reaching out to local or national scholars within your area of research interest, or networking at a relevant conference.

You may have a fantastic research question, but working with a biostatistician or epidemiologist can be very helpful to identify the data elements needed to answer your question and to choose the appropriate statistical tests for evaluating the dataset. Our practice is to offer authorship to any data manager, biostatistician, or mentor on the team to recognize their considerable contribution in managing and analyzing data or guiding the project. Check with the institution where you work to see if they employ a biostatistician; many military medical centers do! If you or a team member have a faculty appointment or are in a student status at the Uniformed Services University (USU), a statistician may be available for consultation at the Biostatistics Consulting Center (BCC).

It is also encouraged to recruit a junior mentee such as a junior learner who can learn from the project, get motivated to conduct future research, and provide valuable assistance with jobs that are appropriate for their level of experience. Tasks can include conducting a literature review, creating figures or tables, or writing sections of the manuscript.

Step 4: Apply for research approval from your local IRB. The IRB is responsible for evaluating any proposal, certifying its scientific validity, and safeguarding the protection of rights and welfare of those participating in the research or contributing to the dataset. The IRB ensures that studies comply with the current policies of the Department of Health and Human Services and DHA, that investigators have completed all required training (e.g. CITI training), and that all appropriate permissions and protections have been obtained.[7] Your local IRB and/or CIP can guide you in completing the necessary forms. For planning purposes, the approval process from time of submission may take two to three months but can be longer based on the complexity of the proposal. Research using de-identified data may be exempt from full IRB review making the timeline shorter than in some other study types.

Step 5: Apply for a Data Sharing Agreement (DSA) with DHA. The DSA ensures that DHA datasets are managed in compliance with federal laws and DHA policies. DSAs are reviewed and approved by the DHA Privacy and Civil Liberties Office.[8] Your local IRB will likely have the necessary forms for this application process. Datasets that are not de-identified require higher levels of approval with a strong, convincing explanation as to why the data must be analyzed in this way. The research team will need to specify which data elements are needed to complete the research project such as the population (e.g., active duty, dependents), demographics (e.g., sponsor rank, age), time period of TRICARE enrollment, conditions of interest, and associated terms to identify data (e.g., ICD codes). Once completed, DSA forms should be emailed with the IRB application and approval letter to the following email address for submission: dha.ncr.pcl.mbx.data-sharing@health.mil. Post-submission, the review may take two to three months.

Step 6: Pull requested data once the DSA is approved. If you are unable to find a local analyst with access to the system that is best suited for your research question, the J-5 Analytics and Evaluation Division team at DHA can perform the data extraction for you. The request, which requires IRB and DSA approvals to be uploaded, can be submitted via the following website: https://carepoint.health.mil/sites/AERP/SitePages/Landing.aspx. This process can take approximately two to three months, but depends on the complexity of the data pull. If the dataset is particularly large, the research team should have a member with experience in data management.

Step 7: Perform your data analysis! While your biostatistician does their magic, your team can be working on sections of the manuscript such as the introduction, methods, proposed table layouts, reference formatting, etc. Or you can start dreaming up your next study!

Using the framework outlined above, the MDR and M2 can be accessible to almost any military clinician who has a question to answer. There are naturally some limitations inherent to this kind of research, however,

which should be taken into consideration. For example, the accuracy of the information stored in these databases can be affected by inaccurate or incomplete coding or documentation practices. Additionally, the same limitations which apply to any other analysis of pre-existing data apply to Big Data analytics as well. This includes an inability to determine causation, missing data, and a need to be vigilant for the effects of confounding variables and biases. Overall, it is a relatively inexpensive way to generate meaningful answers to important questions. We encourage uniformed family physicians who want to take their research to the next level, or who want to engage in research for the first time, to consider diving into Big Data.

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FIGURE 1. *Timeline depicting period from conception of research question to retrieval of Big Data. Events with dotted baseline indicate variable time period for completion. Events with solid baseline are typically completed within time period listed above.*

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 Fall magazine is 2 October 2023.

RESEARCH GRANTS

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

RESEARCH JUDGES

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

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

Please write to me...
Jeanmarie B. Rey, MD, FAAFP,
jeanmarie.rey@usuhs.edu

PROMOTING RESEARCH IN THE MILITARY ENVIRONMENT

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

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

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Greetings USAFP Community! Our Education Committee would like to encourage your participation in our next virtual group KSA: Care of Children on Tuesday, December 5th from 1800–2100 EST. These virtual KSAs have been a great way for us to interact with each other outside of the annual meeting. It also provides us with CME, improved medical knowledge, and most certainly some fun and laughter. For this current issue, we are very grateful to COL Maurer for providing us with an update on the top medical apps for your smart devices. Apps have become essential for providing up to date, evidence-based, cost-conscious care. COL Maurer breaks these down nicely for us so you know which apps are worth downloading and using in your day-to-day patient care.

Top Medical Apps for Your Smart Device

Greetings, everyone! Here is my curated selection of the best medical apps to install right now on your smart device! Happy downloading!

1. DYNAMEDEX: ALL THE GOODNESS OF DYNAMED PLUS NOW WITH MICROMEDEX

DynaMedex from EBSCO was founded by a family physician, Dr Brian Alper. Dynamed covers over 4000 topics and monitors over 500 journals. Although not quite as comprehensive as UpToDate, DynamedMedex is one of the most evidence-based apps available. DynamedMedex continuously updates and pushes out weekly additions to all their topics. Military providers can access this via DHA and/or local MTF library resources by creating their own DynaMedex account then downloading and logging into the app on their smartphone.

Evidence-based medicine

Arguably more up to date than UpToDate, DynaMedex is the essential EBM app for primary care. The app is highly referenced, "in-line", and expert content reviewers. Now with IBM Micromedex baked in and free to all in DHA, this is a must have medical reference.

Price

- Free (for military providers) via your MTF.

Likes

- Easier to use and improved user interface with predictive search (when compared to original Dynamed Plus app)
- Micromedex Clinical Knowledge Suite integration.
- Thousands of photos and graphics.

Dislikes

- Still less comprehensive than UpToDate (fewer topics and specialties covered).
- Layout of search results in some sections needs work.
- Difficult to scroll through long treatment sections of the topics in the app. Needs shortcuts for those sections of the app.

Overall

The new and improved DynaMedex along with UpToDate is the app for primary care physicians, residents and students who want an outstanding, easy to use, comprehensive evidence-based medicine app for use at the point of care.

Available for download for iOS and Android.

- https://apps.apple.com/ca/app/dynamedex/id1519312217
- https://play.google.com/store/apps/details?id=com.ebsco.dmx&hl=en_US&gl=US

2. PRESCRIBER'S LETTER: KEEP UP WITH ALL THINGS BIG PHARMA THROUGH A PRIMARY CARE LENS

The Prescriber's Letter, like the Natural Medicine's Database (also free to military providers), includes both an extensive website of content and a companion medical app included together as part of the subscription. The Prescriber's Letter consists of a monthly newsletter on developments in drug therapy, disease specific content, numerous charts and tables on therapeutics, CME offerings, and at different subscription/optional levels, live webinars, journal club, etc. Most importantly, the Prescriber's Letter takes NO money from advertisers or the pharmaceutical industry so their recommendations if not based solely on the evidence are expert opinion without any drug company bias.

Evidence-based medicine

The Prescriber's Letter app contains the latest information on drug therapy with evidence-based recommendations whenever possible. The medical app is well referenced with online and offline Detail Documents that review the current

literature. The Prescriber's Letter app offers CME that the AAFP recognizes as "evidence-based" for credit. The medical app and companion website contain innumerable charts, tables, and documents to help primary care and specialists with simple as well as complicated medical decisions.

Price
- Free via DHA/MTF libraries

Likes
- Unbiased, evidence-based content that is delivered frequently (at least) monthly.
- Free CME that populates into your AAFP account.
- Medical App works offline with most content.

Dislikes
- Not all content is available "offline" on the app.
- Interface could be more modern.
- App crashes occasionally.

Overall

The Prescriber's Letter is an indispensable guide to the latest and greatest information in the world of medical therapeutics and Big Pharma with abundant information on safety and evidence-based medicine. The medical app truly is unbiased and includes "gotta read" monthly newsletters and practical medical information spanning almost any and every topic in primary care. The drug reference app can be used both for hunting and foraging in the evidence-based medicine world which makes it invaluable.

Available for iOS and Android
- https://apps.apple.com/us/app/prescribers-letter/id1441182446
- https://play.google.com/store/apps/details?id=com.trc.PRL&hl=en_US&gl=US

3. SANFORD GUIDE: THE "BUG GUIDE" TO GO WITH YOUR DRUG GUIDE!

For years I have been recommending either the outstanding Johns Hopkins ABX Guide or the equally outstanding Sanford Guide. Due mostly to interface preference, I previously gave a slight thumbs up to Hopkins over Sanford, but not anymore. Over the intervening years, the Sanford Guide app has improved its "load time" and undergone numerous interface changes. The app is better in nearly every way. The outstanding content certainly hasn't changed but is just even quicker and easier to access.

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Evidence-based medicine

The Sanford Guide to Antimicrobial Therapy (2023) has been the authority in infectious disease prescribing for decades. The app contains the expert guidelines from the Infectious Diseases Society of America (IDSA). The app version of Sanford is outstanding and highly preferable to the paper version of the Guide.

Price

- Free to military providers (or $34.99).

Likes

- Interface is faster than ever and easier to use.
- Detailed coverage of pathogen topics and drug numerous calculators, sections on prevention, prophylaxis, and vaccines.
- Cloud support across all your devices.

Dislikes

- "Content" subsections not as detailed as previous "Quick Jumps" for some topics.
- Topic content may not be detailed enough for those used to UpToDate and DynaMedex.
- Some tables and graphics are not optimized for mobile.

Overall

The Sanford Guide to Antimicrobial Therapy remains an outstanding infectious diseases app that has continued to improve over the years. The latest 2023 version is a minor facelift that keeps it on a level footing with the Hopkin's Guide. You cannot go wrong with either of these guides. Every provider who prescribes antimicrobials should have one (or both) of these guides.

Available for iOS and Android.

- https://apps.apple.com/au/app/sanford-guide/id863196620
- https://play.google.com/store/apps/details?id=com.sanfordguide.amt&hl=en_US&gl=US

4. HEALTH MAINTENANCE VISITS: ANOTHER WINNING APP FROM DR JOSHUA STEINBERG, MD

Dr Joshua Steinberg comes to the rescue again! This time he teamed up with Dr Paula Dygert, MD at Providence Family Medicine Residency in Spokane, WA, to create a quick reference medical app for students, residents, and faculty in primary care. The Health Maintenance Visits app combines the content of the CDC and Bright Futures pediatrics recommendations for children along with the USPSTF recommendations for adults—all in one free app. Over the years, I have reviewed numerous medical apps from Dr Steinberg so check out all his free apps made by a family physician for family physicians.

Evidence-based medicine

Health Maintenance Visits includes checklists of screening, counseling and chemoprophylaxis for patients presenting for prenatal care visits, well-child and well-adult visits. The information contained in the app grids is derived from evidence-based and expert-based guidelines from the CDC, Bright Futures, and the USPSTF. The medical app provides the information in an easy-to-use interface that can be used at the point-of-care.

Price

- Free.

Likes

- Includes nearly everything for prenatal care, pediatric and adult visits in one place.
- Well-referenced with hyperlinks.
- Layout is basic but easy to follow/choose between visit checklists.

Dislikes

- Checklist are modified PDFs which can be difficult to read on smaller devices.
- No evidence ratings for any of the recommendations listed.
- Needs update for latest USPSTF recs.

Overall

The Health Maintenance Visits medical app is another winner for students, residents, and faculty in primary care. The free medical app includes easy to use checklists for health visits from the "cradle to the grave" of family medicine.

Available for iOS and Android.

- https://apps.apple.com/us/app/health-maintenance-visit-lists/id1153278996
- https://play.google.com/store/apps/details?id=healthmainvisits.drstein.com.healthmaintenancevisits&hl=en_US&gl=US

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

COL Maurer's Mobile Medical Apps to Download

Downloading these apps will help for following along and trying them out during my medical app session. These apps are free either in the app store or through the AMEDD Virtual Library or possibly through your MTF Library/university-affiliated library/Uniformed Services University (check it out). A few have some cost associated with them; wait until I demo those to decide whether you want to purchase them. Most apps are available for Android and most work "offline" meaning no Wi-Fi/cellular connectivity required.

1. **UpToDate**: you can get the mobile version for free via DHA/AMEDD Virtual Library.
2. **DynaMedex**: you can get the mobile version for free via DHA/AMEDD Virtual Library.
3. **Essential Evidence Plus (EE+)**: free access via DHA/AMEDD Virtual Library by going to STATRef.
4. **Medscape**: Free in app store
5. **QxMD Calculate or MDCalc or EBMCalc**: Free in app store (also recommend **QxMD Read**--free in app store and can put medical library info into app to have access to content on your phone!)
6. **Dr Steinberg** --all of Dr Joshua Steinberg's apps are free--just type in his name and pick.
7. **Epocrates** or **Lexicomp** or **MicroMedex**: free access to Lexicomp and MicroMedex via DHA/AMEDD Virtual Library and/or as part of UpToDate and DynaMedex respectively...there are free versions of Epocrates available; you just need 1 of the 3.
8. **Hopkins or Sanford Guide**: you can wait on this one since either one is $29.99 each.
9. **Prescriber's Letter/Medical Letter**: you can wait on this one since either one is $143/$159 each.
10. **Pedi QuikCalc**: app is $4.99—worth the $$! But can wait till I demo it.
11. **AHRQ/ePSS**: free in app store
12. **ADA Guidelines app**: free in app store.
13. **ASCVD Risk Calculator or CV Risk**: free in app store. Get the one by the American College of Cardiology or Dr Steinberg.
14. **SHOTS or CDC Vaccine**: free in app store.
15. **VA/DHA/T2 Medical/BH Apps:** free apps made by the VA/military for providers/patients. https://health.mil/News/Mobile-Apps
16. **Best of the rest:** See primary presentation handout for a by specialty/category list of apps to consider/recommended.

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USAFP Represents at ACLF/NCCL and Advocacy gets a win!

USAFP Delegation – President Kevin M. Bernstein, MD, FAAFP, Secretary/Treasurer James D. Warner, MD, Alexis Aust, MD (New Physician – Air Force), President-Elect Mimi F. Raleigh, MD, FAAFP, Rachel E. Carter, MD, FAAFP (IMG – Air Force), Mariama A. Massaquoi, MD (Minority – Army), and Eileen D. Tatum, MD (Woman – Navy) Not pictured; Sterling L. Brodniak, DO, MBA, FAAFP (LGBTQ - Army)

USAFP sent a full contingent of representatives to the National Conference of Constituency Leaders (NCCL) from May 8-11 in Kansas City, Missouri. The conference provides an opportunity for the constituencies to advocate for change in medicine by proposing resolutions for the AAFP to act on through legislative agenda, funding, policy statements and other formats. The member constituencies can submit up to 50 resolutions at NCCL regarding opportunities to support their constituency, their practice, their patients or the specialty of family medicine in general. The resolutions are then sent to one of the following reference committees; Advocacy, Organization & Finance, Health of the Public and Science, Education, and Practice Improvement where debate is heard and then a recommendation is made whether to send the resolution forward to the AAFP Board of Directors or not.

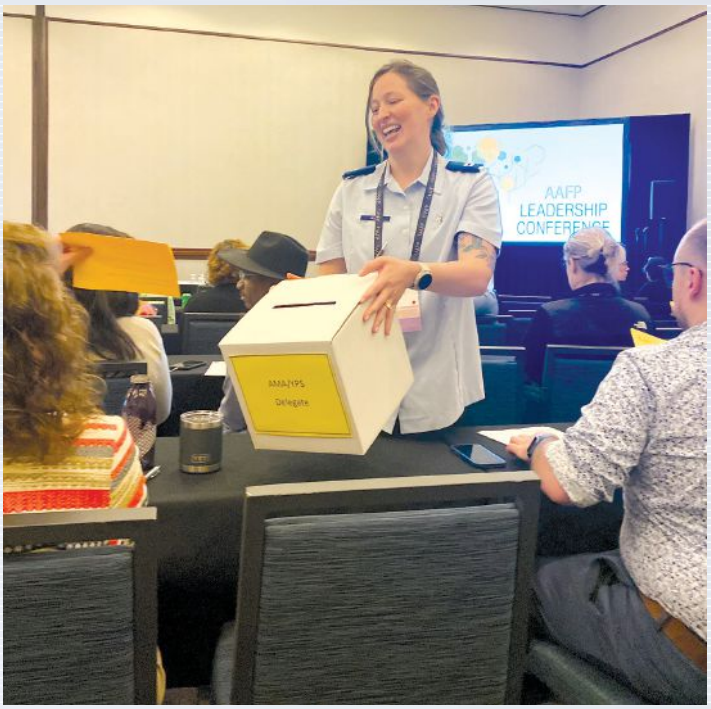
NCCL produced 48 resolutions this year and USAFP members co-authored four of those resolutions. The resolutions are entitled: "Ensure access to Medical Care Across State Lines" coauthored by LT Eileen Tatum, MD, USN; "Pulling the Trigger on Gun Violence" co-authored by Nicole Yedlinsky, MD; "Strengthening Ties to Support Access to Restricted and Banned Healthcare" and "Improving Access and Reaffirming Universal Coverage for Pre-Exposure Prophylaxis (PrEP) in HIV" both co-authored by Sterling Brodniak, MD were all adopted in full or modified format for consideration by the AAFP Board of Directors.

The USAFP contingency also had a stellar year in leadership. Rachel Carter, MD was co-convener for the International Medical Graduate (IMG) constituency and chaired the Health of the Public and Science Reference Committee. Sterling Brodniak, MD and Eileen Tatum, MD, both in their first year representing USAFP were elected Co-conveners for the LBGTQ+ and Women's constituencies respectively for the 2024 NCCL and then were also elected as alternate delegates to the AAFP Congress of Delegates. Alexis Aust, MD was selected as a teller and was essential in helping to manage the many close votes that occurred during debate of the resolutions.

Serendipitously NCCL got to celebrate some of its prior

Elieen D. Tatum, MD and Sterling L. Brodniak, DO, MBA, FAAFP

Alexis Aust, MD, Sterling L. Brodniak, DO, MBA, FAAFP, and Eileen D. Tatum, MD



Alexis Aust, MD acting as teller during the debate of the resolutions

advocacy work when on May 11th (the last day of the conference), the Food and Drug Administration (FDA) issued its final guidance eliminating time deferments for blood donations for gay and bisexual men.[1] The new policy is to be implemented in August 2023 and now, instead of restricting gay and bisexual men as a group, each blood donor (regardless of sexual orientation or gender identity) will have an evidence-based individual risk assessment.

It has been a long journey to get to this point. In 1983 at the start of the AIDS epidemic, the FDA instituted a lifetime deferral for blood and organ donation for men identifying as gay or bisexual. In 2006 the American Association of Blood Banks, America's Blood Centers, and the American Red Cross issued a joint statement stating the blood-ban was "medically and scientifically unwarranted" and the FDA "treats individuals who are not MSM according to their risk levels and should make its policy fair and consistent by treating all potential donors according to risk levels." In addition, NCCL through resolution in 2010, 2011, and 2014* (which the AAFP accepted and supported) helped continue the pressure on the FDA. Despite the fact that all blood donations in the United States have been screened for HIV since 2013 it wasn't until 2015 that the FDA changed the lifetime deferral to a one-year celibate deferral. Through continued advocacy, the FDA was pushed to change policy again in 2020 and the one-year celibacy requirement was reduced to 3 months. Unfortunately, this still left gay and bisexual men stigmatized for being a member of a group rather than applying an evidence based individualized risk stratification.

In 2022, NCCL again submitted a resolution to end the practice, but by this time Representative Valerie Demings had introduced House Resolution 8168, the Science in Blood Donation Act of 2020 during the 116th Congress, which was endorsed by the AAFP. Following this, the FDA indicated via letter to Congress in September 2021 that it was looking into ending the restriction for blood donations solely related to sexual orientation or gender identity. In September 2022, data collection was completed in the Assessing Donor Variability And New Concepts in Eligibility (ADVANCE) Trial, a study funded by the FDA and carried out by three of the largest blood centers in the United States (Viralant, OneBlood, American Red Cross).[2] This study looked at whether different donor criteria could be used while maintaining blood supply safety and the results informed the policy change.

After 40 years it was a wonderful moment to celebrate a positive change towards more inclusive, evidence-based medicine. Advocacy often takes time, but eventually it moves forward! If you want to represent USAFP at NCCL in the future please reach out. As always, if you have an idea or identify something that the Member Constituencies Committee should take for action, please let us know.

* NCCL began in 1990 but records of resolutions are only available from 2009 and forward

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Balancing Patient Confidentiality with a Commander's "Need to Know"

While deployed, a helicopter pilot arrives in your austere aid station after hurting his shoulder while playing ultimate frisbee. He is the lead planner for an upcoming mission and is mission essential. As a uniformed physician, you understand HIPAA and its Military Command Exception. You inform the Commander of his Soldier's injury and inability to fly. However, you also provide a potential solution as a good staff officer. You recommend he fly as a passenger during the mission, thereby allowing the injured SM command and control of the tactical picture and maximizing mission success.

Family medicine physicians train to take a holistic view of a patient's medical care. If assigned as an operational physician, this skill set is critical in understanding the patient's medical needs related to the current operational environment and the Commander's responsibility to complete the mission while balancing risk. A time may come when a Service Member's medical condition directly impacts the unit's ability to complete a mission. It will be the responsibility of the operational medical officer to protect the service member's medical information while also communicating pertinent information to the Commander to make the best decision possible to meet the Commander's overall intent.

The Health Information Portability and Accountability Act (HIPAA) Privacy Rule established the standards for protecting protected health information while conducting health care interactions electronically by covered entities. (https://www.hhs.gov/hipaa/for-professionals/index.html) The Department of Health and Human Services published the initial HIPAA Privacy Rule in December 2000, modified in August 2002, with final compliance required on April 14, 2003. (https://www.hhs.gov/hipaa/for-professionals/index.html)

The law provides for a series of exceptions to the general privacy rule. The Military Command Exception permits the use and disclosure of protected health information (PHI) under specific circumstances. Medical providers are required to protect a Service Member's confidentiality. However, under certain circumstances, they may divulge specific PHI to Commanders to execute missions and mitigate risk to the greatest extent. This article will address the Military Command Exception and the circumstances in which military medical providers may share PHI with their commanders.

PHI is "individually identifiable health information that is transmitted or maintained by electronic or any other form or medium." (DoDI 6025.18) A covered entity is "a health plan or health care provider that transmits any health information in electronic form in connection with a HIPAA standard transaction." (DoDI 6025.18) Through the "Military Command Exception," covered entities may disclose PHI for "authorized activities" to a Service Member's Commander or another person designated by the Commander. (45 CFR 164.512(k)(1)) These authorized activities include determining the member's fitness for duty, fitness to perform a particular assignment, or carrying out any other activity essential for the military mission. (45 CFR 164.512(k)(1)) The Military Command Exception only allows permission to disclose PHI; it does not require the covered entity to disclose PHI. Any disclosure of PHI should be the minimal amount of information required. (45 CFR 164.512 (k)) Additionally, commanders are not authorized to directly access a Service Member's medical records unless authorized by the HIPAA Privacy Rule or the Service Member themselves. (45 CFR 164.512 (k))

Department of Defense Instruction (DoDI) 6490.08 protects a Service Member's confidentiality related to mental health care or voluntary substance misuse education. It explicitly balances the need for confidentiality among Service Members while also allowing commanders the information required to mitigate operational requirements and risk. Generally, if a Service Member seeks mental health care, substance misuse education services, or both, a covered entity will not inform the Service Member's commander. However, if any of the below situations arise, DoDI 6490.08

not only permits the release of PHI to the commander or designated individual but requires the release of it: (DoDI 6490.08)

- There is a serious risk of self-harm by the Service Member.
- There is a serious risk of harming others, including any disclosures concerning child abuse or domestic violence.
- There is a serious risk of harm to a specific military mission.
- The Service Member is in the Personnel Reliability Program or has mission responsibilities of such potential sensitivity or urgency than normal notification standards would significantly risk mission accomplishment.
- The Service Member is admitted or discharged from any inpatient mental health or substance misuse treatment facility.
- The Service Member is experiencing an acute mental health condition or is engaged in an acute medical treatment regimen that impairs the member's ability to perform assigned duties.
- The Service Member has entered into or is being discharged from a formal outpatient or inpatient treatment program to treat substance misuse.
- The Service Member is obtaining a command-directed mental health evaluation.
- The notification and release of PHI due to other special circumstances in which proper execution of the military mission outweighs the interests served by avoiding notification, as determined on a case-by-case basis by a covered entity.

Additionally, all PHI obtained by Commanders, or their authorized representatives, will be protected by the Privacy Act of 1974. Therefore, once PHI is received, a Commander will protect the PHI and provide it only to personnel with an official need to know. A Commander within the United States military bears significant authority and trust. The Military Command Exception further expands upon these authorities related to Service Members' PHI.

The law and DoD policy guide military medical providers seeking to appropriately balance a Service Member's confidentiality with a Commander's requirement to plan successful operations and mitigate risk. Work with the unit's Judge Advocate General (JAG) officer for any questions or concerns regarding HIPAA and the Military Command Exception. The JAG officer is an invaluable resource, and the relationship set between medical and legal only enhances an operational medical officer's ability to advise the Commander and ensure mission success. Find additional resources on the Defense Health Agency's "Military Command Exception" webpage at: http://www.health.mil/Military-Health-Topics/Privacy-and¬Civil-Liberties/HIPAA-Compliance-within-the-MHS/Military-Command-Exception

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Decreasing "Pajama time" through Electronic Health Record Optimization

How often do you need to log into the electronic health record (EHR) after hours to complete clinic notes? If it's often, you are probably in good company. A 2017 study exploring the Epic EHR demonstrated that the average family physician spent about 90 minutes outside of regular clinic hours working.[1] So, working outside of duty hours is, unfortunately, exceedingly common. As our health system continues its transition to MHS Genesis from our legacy systems, this working after hours won't go away, but we can make it better. In this article, we'll discuss accessing Genesis at home with a Common Access Card enabled computer, look at the research, and discuss strategies to reduce your time spent charting outside of clinic hours, sometimes known as "pajama time".

With the EHR transition, we no longer need to go through the old Application Virtual Hosting Environment (AVHE) infrastructure and instead can access MHS Genesis directly through its own online access portal. Our anecdotal tests suggest this is 90% faster, cutting your log in time considerably. All you need is a CAC enabled computer with the appropriate certificates installed. You don't need to be on a Virtual Proxy Network (VPN). Navigate to https://access.mhsgenesis.health.mil and log in with your CAC. Incidentally, this is also the 'back up site' you can use if your local military genesis network doesn't work. This new access point is significantly faster than AVHE and will save all of us precious time.

Before we explore decreasing "pajama time", understanding some of the research literature on physician EHR use will help us utilize tools more thoughtfully in the clinic and at home. Just how much time do family physicians spend in the EHR versus in direct patient care? In one study looking at an average 11.4 hour work day, about 5.9 hours are spent working in the EHR.[1] So, a little over half of total work time is spent in the EHR. On one hand, this provides many opportunities for improved efficiency. On the other hand, simply having more efficiency tools is not necessarily better. An enterprising 2022 study explored primary care physicians' EHR proficiency behaviors and their association with time spent in the EHR.[2] This study was done at an institution using Epic. Among other findings, the more Auto Text a physician created, the more time the physician spent in the EHR! Yikes, so this suggests that more is not necessarily better. In fact, the authors found that almost none of their studied proficiency behaviors decreased total time spent in the EHR. This should give us pause as we consider our own system.

MHS Genesis comes with a lot of buttons and new capabilities such as Auto Text, stored orders, and Quick Visits. This bewildering assortment of ways to accomplish tasks can often leave a physician challenged about what is best. This perhaps may be why military clinicians have not found a considerable usability difference between MHS Genesis and the legacy systems.[3] The challenge for us, then, is to consider which optimization efforts are highest yield. While creating an encyclopedic Smart Phrase well visit covering all preventative medicine services may be enticing, this goal comes at a cost of much greater time spent in the EHR. We know from other work that to comprehensively deliver all United States Preventative Services Taskforce (USPSTF) grade 'A' and 'B' recommendations would require 131% of all available direct face to face time.[4] Keep in mind, this analysis does not consider the time spent documenting this care![4]

Now that we know this information, is investing in improving MHS Genesis even worth it? The answer is a resounding YES! In the face of these informative studies, consider this: If you can shave 15 minutes each day off the workday by decreasing clicks, over the course of the work week you will get over an hour of your life back. This adds up to over 60 hours per year back in your pocket. Creating encyclopedic plans for common problems will not likely achieve this because this strategy only lengthens

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your documentation without decreasing the amount of EHR time. Moreover, any time there is a slight change in the evidence or your clinical practice, you will, undoubtedly spend much time adjusting your Auto Text. Unlike this approach, smart optimization of MHS Genesis of common tasks will decrease your EHR time. With each Auto Text, stored order or quick visit you add, consider whether this will enable you to work better and not simply increase busy, non-value work (like citing every USPSTF recommendation, every time, in every note).

For example, every day when using MHS Genesis in an ambulatory clinic, you will use the primary care outpatient workflow. In this workflow, you can customize what the order is for each one of the 'modules'. Thus, you can organize it to work best for you. You can also anchor the Subjective Objective Assessment and Plan components of the note to 'float' as you scroll through information. Reflect on how you access a patient's information and then order the modules correspondingly. This alone should save you minutes per day as you reduce the amount of time spent scrolling to acquire the information you need.

Next, do you know what your personal top 10 diagnoses are? Do you know where to find this information? You can request access to the Financial Management Information System (https://fmis.health.mil) or ask your group practice manager or medical director to provide this to you. Or simply keep a running tally for a week. Once you know these diagnostic codes, you can then ensure you have the right Auto Text, saved orders and even Quick Visits saved to maximize your effectiveness and speed in documentation. If you have the documentation for these top ten diagnoses properly created, you should be faster and experience less "pajama time". Even more practically, most of us will have annual preventative maintenance visits in our top ten and will respond to patient prescription refill portal messages daily. To that end, the USAFP practice management committee has created three Auto Texts (under user 'david.garcia.0005') to help you decrease your EHR time. We have a male annual preventative maintenance visit (.usafpmwell) and a female annual preventative maintenance visit (.usafpfwell). Finally, you will find a refill Auto Text which will enable you to quickly respond to refill requests (.usafprefill). Let's all work smarter, not harder (or longer!) in the EHR.

Here's to working better together and going home on time!

- Your USAFP Practice Management Committee

Disclaimer statement: The opinions and assertions contained herein are the private views of the author and are not to be construed as official or as reflecting the views of the Uniformed Services University of the Health Science, the U.S. Air Force, or the U.S. government. Auto Texts and other USAFP practice management material do not constitute a standard of care nor should be used as a peer review standard. Users employ these tools at their own discretion and with an assumption of all medical practice risks.

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The Multifunctional Physician - Advice to Family Physicians Working in Emergency Rooms or Urgent Care Settings

Victorinox, original makers of the Swiss Army Knife, describe it as an icon that is the embodiment of multifunctionality, inventiveness, and precision.[1] In the military's toolbox filled with medical professionals, we, family physicians, are the Swiss Army Knife. The American Academy of Family Physicians (AAFP) describes us as "[specialists]...qualified to treat most ailments and provide comprehensive health care for people of all ages — from newborns to seniors."[2] Family physicians work in a wide variety of settings including both outpatient and inpatient environments as well as urgent or emergent care settings in urban, suburban, rural and truly remote communities. The military takes full advantage of the family physician's multifunctional capabilities.

The AAFP estimates that 31% of family physicians deliver emergent care in some capacity.[2] In the uniformed services, family physicians often work in urgent or emergent care environments. This is especially true while practicing in rural or remote locations such as deployment or assignments overseas. Here are a few tips if you find yourself with an assignment that involves urgent or emergent care.

1. **Identify your weaknesses:** If you already know that you will be working in an urgent or emergent care setting, do a self-assessment and determine your knowledge gaps. If you are still in residency, you have the opportunity to do electives in the areas you feel deficient in. For those of you who have completed residency training, you may find it more beneficial to shadow another clinician or moonlight in the urgent/emergent care setting. Additionally, you will benefit from having reference texts available. One highly recommended reference is Tintinalli's Emergency Medicine Manual. Other forms of media such as smart phone apps, podcasts, video reviews, or conferences, may also help in your efforts to boost your knowledge. Other recommended resources include EMRA ABx app, Pedi STAT, WikEM, palmEM, and resources on EM:RAP.

2. **Lean on your training:** After you've arrived at your new location, rely on your family medicine training. Many patients who present to the emergency room or urgent care at MTFs are similar to those you may see as an acute appointment in the family medicine clinic. You are well prepared for these situations, however, you should always reason through the life threatening diagnoses that could also be the cause of a patient's symptoms. To do this, you can use different mnemonics that assist clinicians in creating broad differentials.

3. **Learn about your surroundings**: Another key to success when practicing in the urgent or emergent care setting is knowing what resources you have available. As soon as you arrive, look at the supply closet and patient rooms to see exactly what resources you have available to you. If you think something important is missing, request it early! Knowing where everything is located can save you precious time when dealing with a critically ill patient. Be sure your technicians are also familiar with how patient rooms are set up and what medical supplies are in stock. Part of knowing your surroundings is knowing about other people within your facility or other hospitals with specialty services that are nearby. You should also be familiar with modes of transferring patients to other facilities (i.e. BLS ambulance, ALS ambulance, helicopter, etc.) and be aware of transports times and procedures for patient packaging and handoff.

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Jamaal Richie, MD
Family Medicine

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4. **Know your capabilities:** Be acquainted with your own limitations and the limitations of the facility. There are many conditions you may feel very comfortable with treating, but it is just as critical to know when you will need to ask for help or transfer a patient to a higher level of care. Consider asking for assistance with complex cases early. If you anticipate that you may need to transfer a patient for continued care or a higher level of care, begin the process early. Transfers typically take more time than expected due to additional administrative items that need to occur prior to the patient's departure. Ask for help from your hospital administrative staff that work alongside you.

5. **Keep an open mind:** As uniformed family physicians, each of us will likely have the opportunity to practice medicine in the urgent/emergent care setting. You may find yourself in remote and austere environments with limited resources. Family physicians thrive in these challenging environments because of our training, our adaptive mindset and our multifunctional capabilities

I've always been a sucker for any "Choose Your Own Adventure" story. I would have never guessed that the military would grant me the opportunity to choose my own adventure and work in two different emergency departments after graduating from family medicine residency. One day, you may find yourself in a similar situation. When that time comes, lean on your training and be the multifunctional icon that you were trained to be.

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Incorporating Social Connectedness in Wellness and Resiliency

Wellness and Resiliency are often described as having various pillars essential in supporting each other towards the overall goal of forming a healthy and resilient individual. If we can strengthen these pillars in day-to-day life, then resiliency is increased. If one or more pillars begin to fail, then wellness and resiliency deteriorates. Most of us have witnessed patients whose quality of life begins to spiral downwards after suffering a blow to one of these pillars. A warfighter may be pulled from their team while they attempt to recover from an injury. However, decreased social interaction and their lack of purpose, combined with new onset pain, begin to take a toll on their mental health and overall wellbeing.

In family medicine, we have a unique view on how to accomplish the task of improving the health of our patient. We understand that medicine is a team sport. We will refer patients to counseling to optimize mental health. We encourage sleep and physical activity. We encourage patients to deliberately consider their spiritual needs, often recommending mindfulness, yoga, meeting with chaplains, or discussions with spiritual leaders in their community. The resources available to improve physical, mental, and spiritual wellbeing are easily identifiable. We simply click a button, provide a phone number, a name, or building number, and the patient in front of us will be provided with information to assist them in moving forward. Addressing social needs is trickier, and, if left unmet, can have a large impact on the wellness and resiliency of our patients, and ourselves.

Social connection as a public health issue has recently gained interest and visibility with the *Annual Review of Public Health* recently publishing an article on the topic.[1] Additionally, the US Surgeon General recently released an advisory on "Our Epidemic of Loneliness and Isolation".[2] In the advisory, Dr Vivek Murthy comments on how recently 1 in 2 adults report experiencing loneliness.[2] In an environment where virtual meetings and telework have become common, isolation can grow and social connection can decrease.

Social connection is a broad term used to describe the structure, function, and quality of social relationships of an individual.[1] These two recent publications list study after study showing how increased levels of social connection is tied to better physical health, mental health, and lower morbidity and mortality, even after adjusting for other social determinants of health. Social isolation increases risk for premature death. In fact, a low level of social connection has the same negative impact on premature mortality risk as smoking 15 cigarettes a day.[2] Social isolation also increases risk of heart disease, stroke, infectious disease, dementia, anxiety, and depression.[1,2,3] Adults who experience higher levels of loneliness (the subjective level of disconnect between desired level of social connections and actual levels), have greater than two times the risk of depression than those who never feel lonely.[3] The evidence even suggests that these relationships may be causal in nature.[1] But here's the rub: despite the growing evidence on social connectedness and its ability to bolster health, the medical community does not do a particularly good job accounting for our patient's level of social connectedness.[1]

When was the last time you were at a medical appointment and someone asked you about your level of social connectedness? When was the last time you asked a patient about their level of social connectedness, and if they were satisfied with it? Recognizing the impact social connectedness has on health presents a great opportunity to optimize wellness and resiliency for both our patients and ourselves.

The CDC lists 5 ways to improve social connection.[4]

1. Establish and maintain social connections.
2. Consider the support you give, receive, and have available to you.
3. Strengthen the quality of social connection.
4. Address barriers to social connection.
5. Talk with a health care provider about concerns like stress, loneliness, and social isolation.

While this is an excellent list, it is important to remember that a patient may not feel comfortable discussing a lack of social connection in a medical setting unless we specifically give them and opportunity. Screening for social connection is as simple as asking open ended questions to patients on the social connections in their lives before delving deeper into quality and satisfaction. While military installations (often populated by individuals living geographically separated from family and close friends) may seem like a recipe for social isolation, they are also filled with opportunities to meet new people in the workplace, gym, sports/interest groups, and local community events. As front line physicians tasked with providing care to entire families from cradle to grave, we must seek to understand where are patients are on the spectrum of social connectedness. We owe it to them, and to ourselves, to screen for and recommend meaningful social connection to ensure that patients remain as happy and healthy as long possible.

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Wellness and Resiliency Committee Resources

SOCIAL:

Understand the key takeaways from the U.S. Surgeon General's Advisory on The Healing Effects of Social Connection and learn how to take action to help you, your loved ones, and your patients:

EMOTIONAL:

Read an article by the Center for Healthy Minds at the University of Wisconsin which discusses how to mentally train your brain to reduce emotional distress:

ENVIRONMENTAL:

Use a tool provided by The Nature Conservancy to calculate your carbon footprint and find ways to decrease it in the future:

INTELLECTUAL:

Follow the European Space Agency's quest to discover more about dark energy and its effects universal expansion:

SPIRITUAL:

Take a short quiz to find a volunteer position within the American Red Cross that suits you best to increase the sense of purpose and meaning in your life:

PHYSICAL:

Sign up for a DEKA experience to improve you cardiovascular and functional fitness:

FINANCIAL:

Check out this website on financial fitness by military one source

Congratulations USAFP!

During the AAFP Annual Chapter Leadership Forum (ACLF) the USAFP was recognized for the following accomplishments

Highest Percent Retention of New Physicians for 2022 (as of December 31, 2022)
2nd place Extra Large Chapter

Highest Percent Increase in Student Membership for 2022 (as of December 31, 2022)
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100% Resident Membership Recognition (as of February 28, 2023)

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Care of Children
Tuesday, 5 December
6:00 p.m. – 9:00 p.m. EST Via Zoom
USAFP Member Cost: $50.00

Don't miss out on the USAFP Education Committee's offering of a virtual KSA on Tuesday, 5 December. This is a great way to both satisfy the ABFM requirements for Family Medicine Certification and to learn practical applications of the material. The KSA faculty team will present each of the 60 questions and discuss the important teaching points.

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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?

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In this series, the Operational Medicine Committee will be highlighting Uniformed Family Physicians who have served in operational assignments.

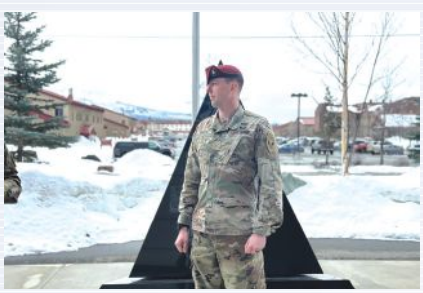
Airborne Brigade Surgeon with MAJ Jacob Shook

Tell me about your current and previous operational jobs you have held and a general weekly schedule.

I am currently transitioning from 2/11th Airborne (ABN) Brigade Surgeon position into the Alaska National Guard. I practice in Palmer Alaska at CAPSTONE FAMILY Medicine. Prior to this, I was the 4-25th ABN Brigade Surgeon and 1/40th CAV Battalion Surgeon in 4-25th ABN in Fort Richardson, Alaska.

What kind of training and preparation did you have to do?

I trained to the highest physical standards that I could during residency prior to joining an Airborne unit. I made sure that I showed up on the first day able to cruise through Airborne School without any fitness issues. I found attending Air Assault school at the end of PGY3 year useful in understanding helicopter operations.



What are some of the rewarding and challenging aspects of your job?

The most rewarding part of Army Medicine is taking care of Soldiers. I believe that there is a certain amount of "drinking the Kool-Aid" that makes the job more fun. Joining the runs, Spur rides, and other events will bring you into the fold and help you to earn trust within the unit.

Arctic Medicine is a difficult operational environment to say the least. Jumping out of aircraft in -35°F increases the risk of cold weather injury. An unexpected challenge in the cold was protecting myself. I got frostbite taking my gloves off to evaluate a patient with suspected spinal fracture during an airborne operation in a remote part of Alaska. I found out ketamine freezes and that most medical equipment fails in the arctic environment. This has led to many opportunities at USAFP and within the Special Operations community to share my knowledge gained from first-hand experience and to assist with updating arctic medicine doctrine and tactics, techniques and procedures (TTPs).

Tell me about unique experiences in your position.

When I arrived at our unit, they had just redeployed from Afghanistan. We lost our Arctic prowess during our time on deployment cycles in CENTCOM AOR. During my time as a Battalion Surgeon we stepped up our efforts in the Arctic. As a result, I have field tested, developed, and refined Arctic Medical doctrine. Most of the current information on arctic medicine stems from testimonials of people put in extraordinary situations.

How well do you feel your family medicine training prepared you for operational medicine?

I have a strong belief that Family Medicine is the BEST specialty for operational medicine. Military family physicians can manage emergent injuries, are trained in trauma through ATLS and have the widest breath of primary care knowledge that is applicable to day-to-day medicine at the unit. Just as important as trauma, Family Physicians care for Soldiers and their families while at home. I believe the importance of high-quality, day-to-day care is often overlooked, but it is important for the mind, body and spiritual care of our Soldiers.

What advice do you have for those wanting to enter an operational position?

The best advice I could give someone wanting to go into operational medicine is throw out any preconceived notions of what it will be like. Be humble, kind and understanding. Remember, *like a parachute, your mind only works if it is open.*

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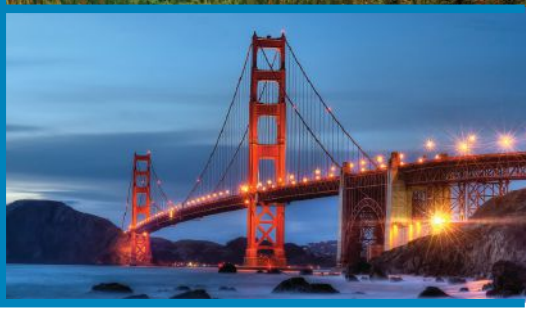

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Featuring
Collin G. Hu DO, FAAFP
U.S. Army Medical Corps
NCC Sports Medicine Fellow
Collin.g.hu.mil@army.mil

In this series, the Operational Medicine Committee will highlight Uniformed Family Physicians who have served in operational assignments.

Army Flight Surgeon with MAJ Collin Hu

Tell me about your current and previous operational jobs you have held and a general weekly schedule.

I recently moved to A.T. Augusta Military Medical Center in Northern Virginia to begin the NCC Sports Medicine Fellowship. Before my fellowship, I was a Flight Surgeon for three different Army aviation elements. As an Army Flight Surgeon, I had a lot of autonomy. In a typical week in the clinic, I dedicated four half days to clinical work, including sick call and flight physicals. I dedicated the other half of those days to specific patient appointments, meetings, and administrative requirements. I did my best to keep one day open weekly to fly on aircraft, train my medics, or maintain my operational skills and medical readiness.

What kind of training and preparation did you have to do?

I completed the Flight Surgeon course before going to my operational assignment. Historically, folks have been able to complete this 6-week course at Fort Novosel (formerly known as Fort Rucker), Alabama as a medical student at USU or during elective rotations during residency. Most of my Flight Surgeon training for the assignment occurred on the job. I had the opportunity to attend Army Airborne School, SERE-C (High Risk), and a 10-week medical indoctrination course specific to my aviation unit. This course familiarized me with various types of aircraft and the nuances of providing in-flight critical care. Additionally, it qualified me to conduct aircraft hoisting and Fast Rope Insertion. If assigned to an aviation unit, I recommend flying on top of your 4 hours a month requirement. How often can you say you get paid to get on an aircraft and fly around 50 feet off the ground?

What are some of the rewarding and challenging aspects of your job?

In this role, you have an opportunity to interact with individuals outside of a traditional clinic environment. These interactions can be in a field exercise, deployment, flying in an aircraft, or just by taking a stroll down the road to the motor pool or hangar. You learn what various Soldier's job entails, build rapport, and foster trust. Ultimately, this allows us to provide better care to those individuals and their families, which is rewarding to me as a Family Physician. You genuinely become that small-town physician with the unit being your community.

There are two challenges all operational physicians need to be aware of and adapt accordingly. First, although you report directly to your Commander, you are each patient's advocate as their primary care physician. Concerns regarding the health and safety of a patient or the medical risk of a potential operation will arise. At those times, we have a duty to voice our concerns and provide an alternative solution. It takes courage to speak in a room full of type-A individuals who may significantly outrank you and are very operationally (not clinically) minded.

Second, we are ultimately advisors to the Commander. A Commander may deem the medical risk necessary depending on the mission. It becomes our responsibility to provide recommendations to the Commander and mitigate the medical risk to the best of our ability using our knowledge as Family Physicians. Blending our medical expertise with the operational environment means recognizing and

filling potential medical gaps before they occur. Anticipating medical risks is one of the most challenging aspects of being an operational physician. However, it is also one of the most fulfilling.

Tell me about unique experiences in your position.

Every deployment, training event, or TDY is a unique experience. For me, however, the answer to this question centers around our medics. In addition to knowing your patients, you have the unique opportunity to lead, train and mentor the medics under your charge. These medics are generally very eager to learn and will keep you on your toes regarding up-and-coming trauma care. They want us to use our knowledge as Family Physicians to fill in their clinical knowledge gaps and innovate trauma care at the point of injury. Seeing your medics thrive, whether conducting a real-world CASEVAC or coaching them to successfully apply to medical school, are experiences unique to an operational physician.

How well did you feel your family medicine training prepared you for operational medicine?

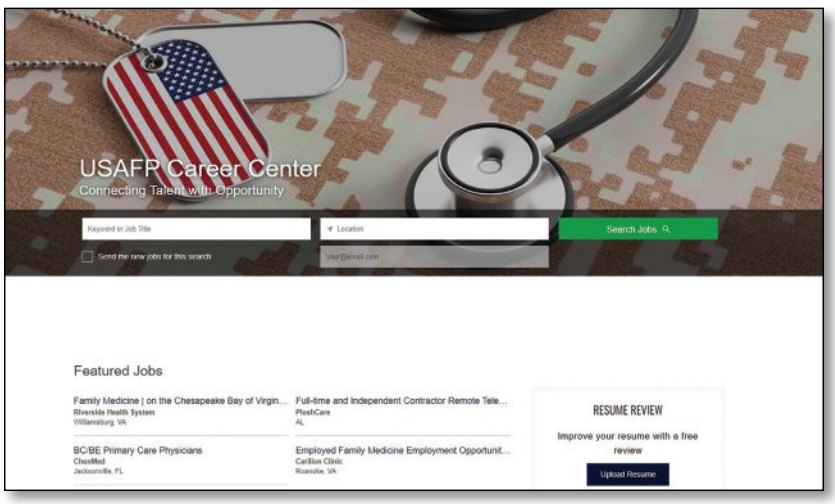
My opinion is biased, but a Family Physician is the ideal operational physician. The training received in residency will help you cover over 90% of the medical concerns you may encounter.

What advice do you have for those wanting to enter an operational position?

For those interested in operational medicine, talk to senior line medics and corpsmen, find a line officer as a mentor, and contact the operational physician or PA for a unit you may be interested in. They will generally provide an objective view of life in their unit, their expectations for an operational physician, and, more importantly, what they have seen from physicians that have thrived. Much of the trepidation stems from not knowing what we do not know. Talking to these individuals and asking questions may quell many fears and set you on a path to a unique, challenging, and fulfilling position. If interested, I am happy to discuss Operational Medicine within the Army in more detail. Feel free to contact me at: collin.g.hu.mil@army.mil.

USAFP Career Center

Your Hub for Physician Employment Opportunities Across the Country



The career center is a resource that provides members a complimentary opportunity to search for family medicine positions available across the country. Explore employment opportunities or recruit for open positions within your MTF. In addition to the complimentary job search resource, the USAFP has discounted rates for members that want to advertise open positions. Posting your resume is anonymous and complimentary.

Manage Your Career - search and apply to multiple family medicine positions, upload your anonymous resume, and allow employers to contact you through the Career Center's messaging system, set up job alerts specifying your skills, interests, and preferred location(s) to receive email notifications when a job is posted that matches your criteria.

Recruit for Open Positions - promote your jobs directly to USAFP members via the exclusive Career Center email system, search the anonymous resume database to find qualified candidates, manage your posted jobs and applicant activity easily on this user-friendly site.

To access the Career Center visit www.usafp.org and utilize the Career Center link on the home page or visit www.usafp.careerwebsite.com. Please utilize the USAFP Career Center to find or fill a job in the future. If you have any questions, please do not hesitate to contact the USAFP at 804-968-4436 e-mail Matt Schulte at mschulte@vafp.org.

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- Stress testing
- Blood work
- Allergy injections
- Protime (coumadin) monitoring
- Minor orthopedics services
- Weight Management

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Greenwood is a picturesque town situated in the foothills of South Carolina and on the shores of Lake Greenwood. It is a three-hour drive to Charleston's beautiful beaches, two hours to the Appalachian Mountains, and equivalent distances to both Atlanta and Charlotte. It is called both "the Emerald City" and "the Lakelands" due to its desirable climate and the numerous lakes in close proximity. It offers year-round golf, seasonal watersports and excellent hunting and fishing opportunities.

Self Regional Healthcare is a non-profit hospital, is the region's largest employer and enjoys the benefit of a large, private endowment ensuring its financial solvency. It provides care to the residents of Greenwood, Abbeville, Laurens, Saluda, McCormick, Edgefield and Newberry Counties. Self Medical Group is the large medical practice division of Self Regional Healthcare that employs 60 primary care physicians and 53 specialists in addition to 44 hospital-based physicians.

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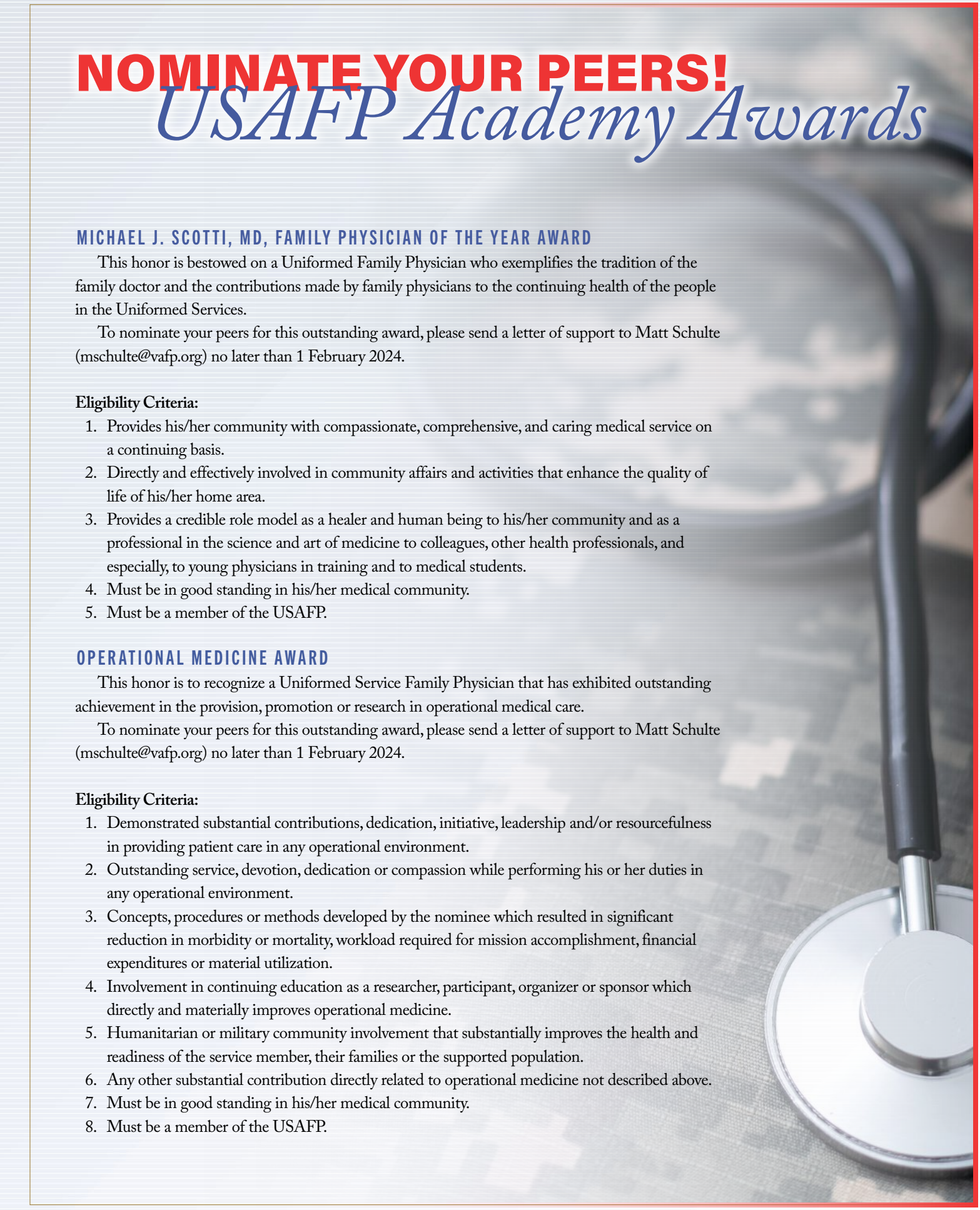
Travis FM Graduates

Carl R. Darnall Army Medical Center Family Medicine Residency Program, Fort Cavazos, TX FM Graduates

NOMINATE YOUR PEERS!
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 1 February 2024.

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 1 February 2024.

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.

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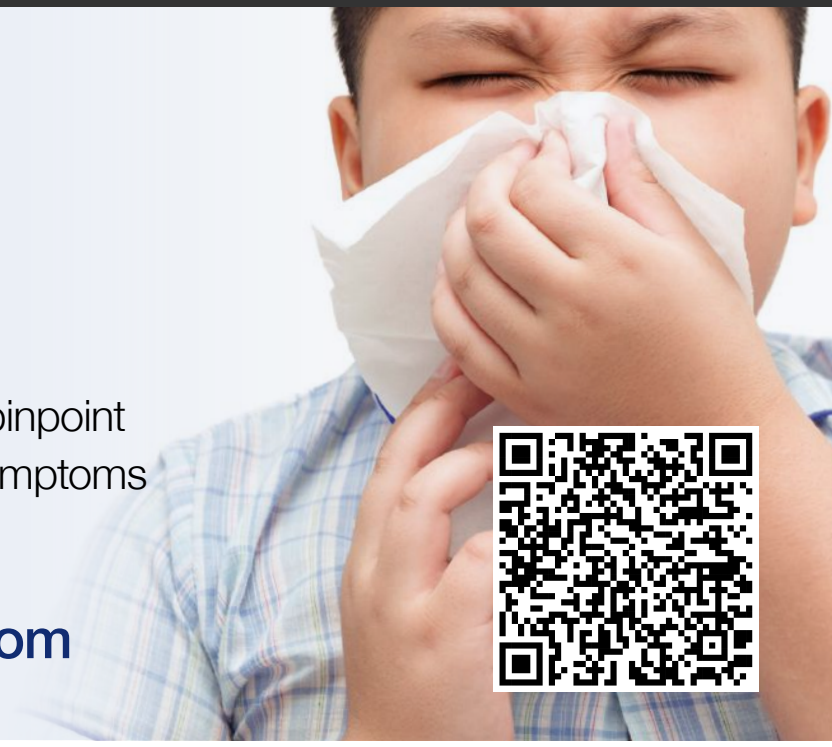

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