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USAFP 2024 ANNUAL MEETING & EXPOSITION

23 – 28 MARCH 2024

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

MISSION

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

Edition 65

your academy leaders
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In March 2023 I had the honor of representing the American Academy of Family Physicians at a Summit on Medical Education in Nutrition. This was a collaborative meeting in Chicago involving multiple organizations (ACGME, AAMC, AACOM) and specialties tasked by the White House Conference on Hunger, Health, and Nutrition to improve nutrition education in graduate and undergraduate medical education. Despite a variety of efforts at various institutions, dietary risk remains the number one cause of poor health in our country.[1]

A 2020 survey found that "less than half of all LCME accredited medical schools included nutrition content related to social determinants such as food insecurity in 2019".[2] At the summit, Dr. Craine Lenders from Boston University discussed surveys done by their research group. A striking statistic included the reported and perceived amount of nutrition education received in medical schools. Our medical schools report an average of 25 hours of nutrition training during undergraduate medical education. Trainees reported receiving less than 5 hours. What an interesting gap in reported and perceived training in nutrition! In this same survey, only 11% of students felt well prepared to advise patients on their nutrition. Most medical schools still do not provide the recommended amount of nutrition education.[2]

Despite all the education that we receive (or do not receive), we continue to fall short on adequately addressing lifestyle, nutrition, food insecurity, and food as a determinant of health with our patients and within the communities we serve.

Food insecurity is a determinant of health – it is one of the most important social determinants of health. Our ACGME RC in Family Medicine mentions nutrition once.[3] Yes, once! It mentions food when discussing resident access to food during residency, and never mentions lifestyle. It mentions diet only when discussing resident/faculty well-being. Not our patients. Not our communities. It does not address lifestyle.

In medical education, competency is an observable ability of a health professional, integrating multiple components such as knowledge, skills, values and attitudes. Family Medicine does not have a single competency on nutrition, lifestyle, or food.[4] Entrustable Professional Activities (EPAs) in Family Medicine do not mention nutrition, lifestyle, or food.[5] For those who are not familiar with EPAs, the American Board of Family Medicine states that EPAs are critical activities that constitute a specialty and the elements that experts and society consider belonging to that specialty. EPAs also define the knowledge, skills, and attitudes that resident physicians must have before they graduate. The ACGME supplemental guide does not discuss nutrition training.[6] It discusses food deserts, food insecurity and identifying food as a problem, but does not delve into how to solve that problem or how to equip our profession to address it. Even more troubling, surveys of medical students reported by the AAMC show that medical students (and likely residents) face food insecurity themselves.[7]

As a profession, what can we do about it? There is no single easy solution.

After returning from the summit, I wanted to build off the momentum gained to support our uniformed medical students and family physicians. Spoiler Alert: You may recognize lifestyle and nutrition programming at our upcoming USAFP Annual Meeting in New Orleans that addresses these knowledge gaps. I also hope to continue serving as a point of contact for the AAFP in furthering nutrition/lifestyle education throughout medical education, specifically in Family Medicine.

There is a lot of work to be done in medical education. The Lifestyle Medicine curriculum that is being embraced by the Air Force is one way to address competencies at all levels of medical education and I am happy to see their efforts at the level of the Defense Health Agency Clinical Communities.[8]

We all know that gaps between ideal vs real practice are wide and difficult to navigate due to:

- the lack of payment models for services that address preventive health, social needs, and community-based interventions
- the vast amount of misinformation and blurred lines between fads and facts
- the lack of training across the continuum as new evidence becomes available
- the lack of a shared mental model about the practice of competency-based medical education

How can we navigate these barriers as uniformed family physicians?

The statistics are striking. We must have an awareness of the food insecurity that exists within our own uniformed communities. Despite having a steady flow of income, many of our junior officers and junior enlisted servicemembers face food insecurity in their lives, which affects their health, their family's health, human performance, and readiness. Furthermore, food insecurity extends beyond nutrition and into many areas of life given how demanding our military lifestyle is. It is important for all of us to educate ourselves, each other, and our patients in nutrition

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and lifestyle medicine and I hope that our organization can help assist in furthering that capability.

By the time I write my next (and sadly last) President's message, we will be well into the New Year. Now is the time for all of us to think about healthy ways to address our own lifestyle. Now is the time to help the lifestyles of the people around us. **We are foundational.** We are looked upon as trusted resources for teaching the future of our profession, furthering our own learning, and educating others throughout our communities. **We are relevant.** We, as uniformed family physicians, are called upon to lead the way in keeping our community healthy. Our USAFP will always be a resource, and I am hopeful we will continue to help build the foundations that lead to a better life for all those around us. **We are family.**

Have a happy, safe, and blessed Fall! Please do not forget to reserve your hotel room for the 2024 USAFP Annual Meeting in New Orleans!

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

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Click on the QR code to the right to see the summary and our recommendations from the Summit on Medical Education in Nutrition

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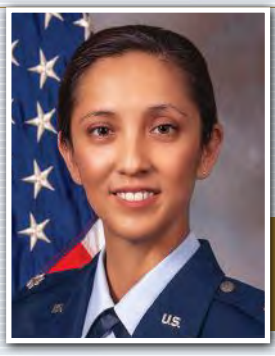

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editor's voice

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/**

Dear Friends and Colleagues,

E Komo Mai (welcome) to another edition of the Uniformed Family Physician! In many locations temperatures are cooling down, and nature is providing an amazing color show. I hope that you are all enjoying the beautiful Fall weather and spending time with loved ones with your favorite warm beverage in hand (pumpkin spice anyone?).

This edition of the UFP is packed with great articles and highlights the diverse experiences of our USAFP community. Dr. Marshall shares how to make "Quick Wins" in MHS GENESIS by explaining MPages workflow and Note Titles. Dr. Pflipsen delves deep into qualitative research and explores how paradigms and assumptions influence our understanding of the world. Dr. Manning and Ms. Regina Julian provide insight into the business side of medicine to help us understand practice management. Brace yourself for a Clinical Informatics/ Practice Management Mash-Up Masterpiece by Dr. Garcia and Dr. Campbell who share how to transfer an encounter between providers in MHS GENESIS. Dr. Shahbodaghi unpacks test-taking strategy and Dr. Powell explores professionalism in GME. We are fortunate to have two operational medicine articles in this newsletter including a job feature by USAF International Health Specialist (Briane Neese), and an informative article on Enlisted Medical Personnel. Dr. Carter and Dr. Arbuthonot reflect on how we can bridge the gap to address persistent disparities in the workforce through mentorship, sponsorship and coaching. I would like to give a special shout out to ENS Cain and Dr. Cowell who represented our chapter and served as delegates to the AAFP's National Congress of Family Medicine Residents and National Congress of Student Members in Kansas City. Check out their article "Empowering Family Medicine's Youngest Leaders", to learn more about how the AAFP prioritizes resident and student input. Dr. Riegleman unpacks burnout as an organizational phenomenon and Dr. Rogers shares a leadership book review on "Immunity to Change" which explores how we can identify and overcome our own barriers to growth. In this edition we also have an exciting update about the 2024 USAFP Annual Meeting in New Orleans!

Mahalo nui loa (thank you very much) to all of our 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 Fall edition of the UFP. It is an absolute honor and privilege to serve as your Vice President and Editor of this newsletter. I look forward to seeing many of you in New Orleans for the USAFP 2024 Annual Meeting! In the meantime, consider submitting an article for a future edition of this newsletter and nominating a peer for an award. Scan the QR code below to learn more about how our chapter recognizes outstanding contributions made by USAFP members. During this busy season, I encourage you to be deliberate about taking time to rest, restore, and reconnect with yourself and your loved ones. Wishing you a peaceful and joyous holiday season!

Me Ka Mahalo Nui (with gratitude),
Gigi

Hawaiian word of the Quarter:
Ola (meaning life, health, well-being, thrive, heal)

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

2024 Annual Meeting Update

We're busy crafting a conference that we hope will be energizing, educational and leave you feeling reinvigorated with NOLA spirit. As Uniformed Family Physicians, we have chosen a broad and challenging scope of clinical practice. We plan to stress the importance of maintaining a strong knowledge base while staying up-to-date on the latest evidence-based strategies as the foundation upon which we provide high-quality primary care. We have expanded the opportunities for folks to present at the USAFP Annual Meeting with the hope of maximizing opportunities for funding support. Our goal is to make this the best attended USAFP Annual Meeting EVER while we celebrate who we are: We are Foundational. We are Relevant. We are Family.

With over 25 years of medical student participation in our conference, we're excited to offer a Residency Fair to provide medical students a chance to get to know all the FM Residency Programs in one place. In addition, we are offering a medical student track at the conference to help our future FM physicians better prepare for the demands of residency life.

This year's conference will kick off on Saturday, March 23rd with a preconference ABFM KSA on Behavioral Health Care along with a few core primary care topics. Each day will kick off with AMAZING keynotes, and a post-lunch keynote will bring us back together for learning and camaraderie. In the evenings, the Big Easy offers numerous locations within walking distance to gather with new and old friends, and the all-attendee party at the House of Blues promises to bring us together for a taste of classic NOLA cuisine and culture as we kick back, relax, and celebrate Family.

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!

Laissez les bon temps rouler!
Andy McDermott and Kerry Sadler
2024 USAFP Annual Meeting Co-Chairs

LOOKING FOR VOLUNTEERS!

If you are interested in leading an early morning wellness/fitness class, please let us know! In addition to an informal run around the dazzling city of New Orleans, we'd love to offer morning wellness activities. Please reach out to Kristi at kreynolds@vafp.org to get involved.

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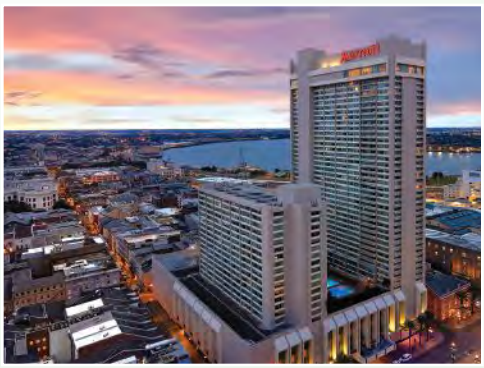

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The room rate is prevailing government per diem at $184.00 per night single/double occupancy.

The cut-off date for reservations is Friday, 1 March, 2024. The USAFP encourages you to make your reservations early. In the past, the rooms have sold out prior to the cut-off date.

The group rate will be honored 3 days prior and post conference based on guestroom and rate availability.

Please make your reservations online via the QR code below. If you would prefer to make your reservation over the phone, please call 1-888-236-2427 and make reference to the Uniformed Services Academy of Family Physicians.

Cancellations must be received at least 72 hours (3 days) prior to the arrival date in order to avoid a possible one night's room and tax penalty.

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Assessing and Teaching Professionalism in Graduate Medical Education

THE IMPACT OF PROFESSIONALISM IN MEDICAL TRAINING AND PRACTICE

What does professionalism mean to you? A typical answer is "adherence to standards of a given profession." In the medical profession, we often do not give professionalism serious thought until someone commits an egregious act – think Dr. Larry Nassar or "Dr. Death" Joseph Michael Swango, the list goes on, unfortunately. To have a significant impact, unprofessional behavior among physicians need not be so egregious. In a 2008 survey of 102 US healthcare facilities, 77% of healthcare professionals witnessed physicians' unprofessional behavior, and 65% witnessed this at least five to six times yearly. These behaviors lead to preventable adverse events and compromise patient safety.[1] Prior studies have demonstrated a strong association between medical board disciplinary action against physicians and prior unprofessional behavior in medical school.[2] The "you know it when you see it" approach to assessing professionalism is prone to bias and ineffective in instilling and maintaining professional behavior in physicians.

THE STERN MODEL – A FRAMEWORK FOR DEFINING, ASSESSING, AND TEACHING PROFESSIONALISM

Starting in medical school, assessing and teaching professionalism must be deliberate, and the lessons must be reinforced throughout graduate medical education. The importance of professionalism in graduate medical education is given by the fact that professionalism is one of the six ACGME Core Competencies and a focus area in the Clinical Learning Environment Review (CLER) Program. Professionalism, along with its multitude of associated skills and attributes, is very abstract. Fortunately, we have a framework from which we can assess and teach professionalism. David Stern developed this framework in 2006.[3] The foundation of the Stern Model includes clinical competence, communication skills, and an understanding of ethics. We expect medical students to transition to GME with a solid foundation in these three areas and to further solidify their professionalism throughout residency training. From this foundation stand four pillars –accountability, altruism, excellence, and humanism – these attributes elevate and support the highest level of professionalism and should be a focus in GME. Another attribute which is not part of the Stern Model must be included in this framework are the concepts of cultural competence and humility.[4]

How do we go about assessing and teaching skills to develop these attributes? First, let us define each attribute. Accountability in the medical profession means we, as physicians, take responsibility for our behaviors and actions in clinical practice. Altruism means that we place patients' interests above our own. Excellence means a commitment to life-long learning and advancement of knowledge. Humanism is characterized by maintaining respectful and compassionate relationships between physicians, as well as all other healthcare team members, and their patients. Cultural competence is a set of congruent behaviors, shared knowledge, attitudes, and policies that come together in a system, organization, or among professionals, enabling effective work in crossing cultural situations.[4] Cultural humility involves engaging different cultures through self-reflection with openness and authenticity.[5]

Fig. 1 Framework for defining professionalism (adapted from ref. 3)

There are several ways to assess the attributes of professionalism, including tests of knowledge, structured clinical exams, direct observation, patient assessments, simulations, incident reporting, and reviews of patient complaints and professionalism lapses.[6] Methods to teach professionalism in GME can and should meet cognitive (knowledge), affective

Table 1. Methods for Teaching Professionalism (adapted from Thomas and Kern)

Cognitive	Affective	Psychomotor (Behavioral/Performance)
Readings	Group discussion	Supervised clinical experience
Lectures	Reflection on experience	Reflection on experience
Online learning resources	Role models	Role models
Team-based learning	Role-plays	Simulation/Standardized patients
Peer teaching	Feedback	Audio or video review of the learner
		Behavioral interventions
		Feedback

(attitudinal), and psychomotor (behavioral or performance) objectives. The following table lists the recommended educational methods for each objective.[7]

Within the cognitive domain, teaching the components of emotional intelligence (self-awareness, self-regulation, motivation, empathy, and social skills) through readings, lectures, and team-based learning may provide a sound knowledge base for learning and practicing professional behaviors.

ROLE MODELING AND FEEDBACK ARE KEY TO ASSESSING AND TEACHING PROFESSIONAL BEHAVIOR

Role modeling and feedback are the best methods to teach professional behaviors within the affective and psychomotor domains. These two approaches require special attention because they may be the most difficult for us to apply. A deliberate approach to role modeling, SUPERmodeling, is an excellent way to teach behavioral performance skills.[8] Figure 2 highlights the critical components of this approach. The Self-Awareness component involves identifying teaching opportunities that can be role modeled. The Unconscious Becomes Conscious component may involve a pre-brief before the learning encounter so that the learner fully understands the clinical teacher's intent. The Plan Debrief component is an opportunity to reinforce this understanding and address any additional questions or concerns from the learner. Finally, the Encourage Reflection component helps both the teacher and the learner explore their performance during the encounter, process emotional responses to the encounter, and consider possible changes in their behavior or clinical reasoning process. Feedback, both formative and cumulative, is critical to assessing and teaching professional behavior, but can be challenging, especially when lapses are severe. Use the Feeling, Behavior, Impact (FBI)[9] approach in these situations. In this approach, first point out the specific behavior you observed, describe how the behavior made you feel, and the impact this behavior will have on others if the behavior continues.

Professionalism is a core competency of medical education. As we transition to competency-based medical education, it is important to consider that many of the social and cultural aspects of professionalism are delivered through a complex hidden curriculum. Standards of professionalism may not be applied or assessed equitably amongst learners. For example, those with minoritized identities (including but not limited to women, racial and ethnic minority groups, gender and sexual minority groups) may not be perceived as meeting the professionalism standard due to their hair, dress, or communication style.[10,11] As clinical leaders and medical educators, we must be aware of the tension that exists between assimilation and inclusion in medical education, and the additional burden placed on individuals from marginalized groups. By role-modeling, giving feedback and engaging in reflective practice, we can mitigate the negative impact of the hidden curriculum around professionalism. We can focus on the four pillars - accountability, altruism, excellence, and humanism - and grow the next generation of uniformed family physicians to be the medical professionals needed by our nation.

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Shifting Paradigms: An Intro into the Realm of Qualitative Research

In order to understand the difference between quantitative and qualitative research, one must first ask oneself "What's my paradigm?". A research paradigm is the philosophical framework that one's research is based on and defines the claims and assumptions that the researcher is using to approach how they interpret the nature of reality (ontology). Defining one's ontological approach then lends itself to asking how do we know things about this reality (epistemology) and what procedures we can use to acquire that knowledge (methodology).

How do paradigms and assumptions of reality influence our understanding of our world? Let us start by taking the concept of a coin. What makes a coin a coin? One may argue it is a coin because it is round and flat on both sides. We can measure the radius, diameter, thickness, and weight. It has distinctive markings defining its value. In essence, it exists in an external and fixed reality, and even if we were not in the room, the coin would still exist. On the other hand, one may argue the coin does not exist independently upon itself. The coin only exists because we have socially constructed the idea of a coin and that social construction has given it value and meaning. Without the context within which that coin exists, it would cease to exist as a coin. While neither of these lenses of reality are necessarily wrong, they do highlight how the lens through which we see the world shapes our assumptions about what we deem to be true. Indeed, the paradigm in which we situate ourselves influences our approach to medical research and how we understand and accept the outcomes from that research.

Evidenced based medicine (which often defines randomized controlled trials as the gold standard) assumes a post positive paradigm and lends itself to the qualitative methodologies we are most familiar with. Within a post positivist paradigm, one believes that there is a single external and fixed reality that can be observed, measured, and understood. Reality follows predictable regularities, and that reality exists independently from oneself. And yet there are limits to our ability to accurately capture the precise truth and the best we can do is approximate it. We cannot fully understand that reality because it is so complex, and as we learn more, our understanding of reality continuously changes and evolves.

What we know about this post positivist epistemology is centered on causal explanations based on observations. The knowledge we gain is tentative and true for the moment, as further research often reshapes that knowledge. Knowledge is not value free, as there is an acknowledgement that findings are developed from the interaction between the researcher and the object of study. However, it is possible, using empirical evidence, to distinguish between more and less plausible claims by testing hypotheses and distinguishing validity. To do so, post positivists rely on methodologies rooted in statistical analysis that reduce error and provide us certainty within a defined level of probability. For example, as clinicians, we are all too familiar with the concept that a p value of <0.05 indicates a certainty within 95% - and therefore accept that if our results meet this threshold, our findings are validated as being true. Surveys, meta-analyses, and randomized controlled trials are examples of quantitative methodologies that rely on statistics for validation of their findings.

Qualitative research, on the other hand, is often rooted in a constructivist paradigm. This paradigm assumes that multiple realities co-exist and rejects the notion that there is a singular objective reality that can be known. These realities are constructed in social ways and are products of mutual understanding within the context in which they are situated. Knowledge is consequently co-constructed from interactions between individuals and shaped by our values. In fact, we, as the researcher, are also a part of the knowledge creation, as there can be no total separation between the researcher and the object of study. The knowledge we gain is influenced and shaped by our values, the participant's values, and the values of the social context of study. Constructivist research is, therefore, grounded in qualitative methods that study social phenomena through interviews, observations, and documents. (Table 1)

Table 1: Methods commonly used in qualitative research

Interviews	Utilizes an interview template. Allows for open ended questions and clarification of participant responses. May yield new insights to probe and explore. Data consists of verbatim quotations and the value of data lies within the range of meanings and ideas.
Observations and Fieldwork	Observes a specific scenario in a natural setting. Data consists of a collection of field notes to describe what is observed and/or descriptions of social life and discourse. Includes reflections by the observer to add context.
Documents	Review of written materials and documents to elicit meaning and understanding. Documents often have been recorded without the researcher's intervention. Examples include organizational records, social media postings, correspondence, publications and reports. Data consists of excerpts that records and preserves context.

Situating ourselves within one or the other paradigm is a choice; and each paradigm helps us to answer different kinds of questions in different kinds of ways. For example, let us consider that we want to study vaping in the military. As a post positivist, one may have an idea or theory about this topic, and believing there is an external reality to uncover, we would undertake an objective and deductive approach to prove true or false different aspects of this idea or theory. In this case, the research may involve conducting a survey and analyzing the results numerically to validate that theory. The survey would include questions that are created based on the researcher's own understanding of vaping in the military (often derived from a literature review or personal experience) and of which they are out to prove agreeance or dis-agreeance within the study population. The responses are then analyzed with statistics. As such, surveys attempt to seek quantitative data that can be proven to be true through analysis and therefore can be reliably generalized across multiple populations. When performed well, surveys can provide insight into a phenomena, yet in general, lack the depth and richness that can emerge when one can explore and clarify responses through other methods, such as an interview process.

So let us shift and approach the study of vaping in the military to a constructivist paradigm using interviews as our data collection method. In this paradigm, instead of seeing theory as needing to be proven, we either utilize theory as a lens to inform the research being conducted or use our study to inductively develop new theories and ideas. The implication is that the research questions cannot always be definitively established before the study begins - but can emerge, evolve, and change as the study progresses and interpretation of the data develops. Information about the participants and the context in which they are studied is imperative to interpreting the conclusions of the research. Taking an inductive approach to understanding vaping in the military through interviews offers the space for interactions that provide deeper meaning. We further develop that meaning through the iterative process of coding and peer debriefing to identify themes and patterns in the data. The study constantly evolves as the data is interpreted. The researcher works to build descriptions from the interviews, to analyze and contrast themes, and to bring theory into the analysis. All this data intersects to inform our understanding and develop as sophisticated descriptions as possible.

The advantage of a post positive orientation utilizing survey data collection methods is that it provides a quantitative approach to measure the reactions of a many people to a set of questions — facilitating comparison through statistical analysis of the data

continued on page 14

continued from page 13

and delivering a generalizable set of findings. By contrast, the advantage of a constructivist orientation utilizing interview data collection methods provides a qualitative approach to produce meaning from a much smaller number of people and cases in order to increase the depth of understanding of the cases and situations studied. One is not necessarily better than the other, but they answer different questions – through different lenses - about the phenomenon studied.

For those less familiar with qualitative research, one may ask "If statistical analysis is the validation method of quantitative research, what approaches are taken to validate the quality of research in the constructivist paradigm?" In other words, what makes qualitative research trustworthy? The trustworthiness of qualitative methods hinges on the credibility, transferability, dependability, and confirmability of the research. Credibility is analogous to internal validity and ensures the research was conducted using accepted qualitative research practices and the interpretations are reinforced by the data collected. Transferability assesses if the research has provided enough detail to assess the extent to which the results are useful in other contexts where similar situations exist. Transferability is analogous to external validity and generalizability in quantitative research. Dependability is comparable to reliability in positivist research and assesses the extent to which the research can be audited and reviewed to validate the interpretations drawn from the analysis. And lastly, conformability recognizes that research conducted in the constructivist paradigm can never be construed as objective and is the extent to which the researcher demonstrates reflexivity within their research and findings. Reflexivity is when a researcher reflects on their own thought processes, assumptions, and beliefs and how that affects the research.

Rigorous high quality qualitative research ensures these principles are adhered to and thematic analysis is an often-utilized method that can instill trustworthiness. The advantages of thematic analysis include the relative ease in learning and applying the method, the flexibility to adapt to the type of research questions that can be addressed, and its ability to be used across qualitative data collection methods (document reviews, interviews, and observations). It is imperative, however, that the researchers explicitly state their paradigmatic orientation and role of theory in the analysis as to not confuse the reader and lose credibility, as thematic analysis is malleable to both post-positivist (deductive) and constructivist (inductive) orientations. Thematic analysis itself is a method of analyzing data to identify repeated patterns and to interpret and construct those patterns into themes. The themes should strive to provide important insights that address the research question. The themes themselves are derived through an iterative step wise process of generating initial codes, searching for themes within the codes, reviewing the themes among the research team, and ultimately defining and naming those themes. To ensure dependability, the research team should keep detailed notes regarding their thought processes and decisions when developing, discarding, and refining their themes. The final step is explaining within the research paper how these themes answer the research questions, why these themes are of importance, and how they add to the existing body of knowledge that is already published.

So, if you want to know how much soldiers vape in the military, a quantitative analysis will give you the answer. If you want to know what vaping means to soldiers, you have to talk to them, listen to them and hear their stories. These are the questions that will get at the in depth and contextualized understanding of the phenomenon: how it affects them, how they think about it, what they do about it. Ultimately, qualitative research provides context to social phenomenon through understanding how people interpret and attribute meaning to their experiences within the world.

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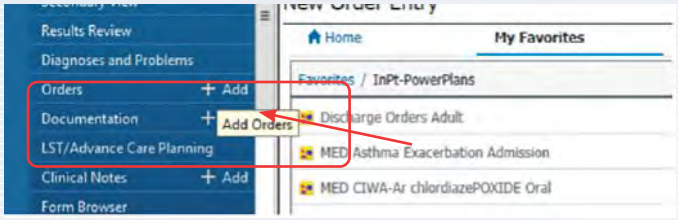
Quick Wins in MHS GENESIS

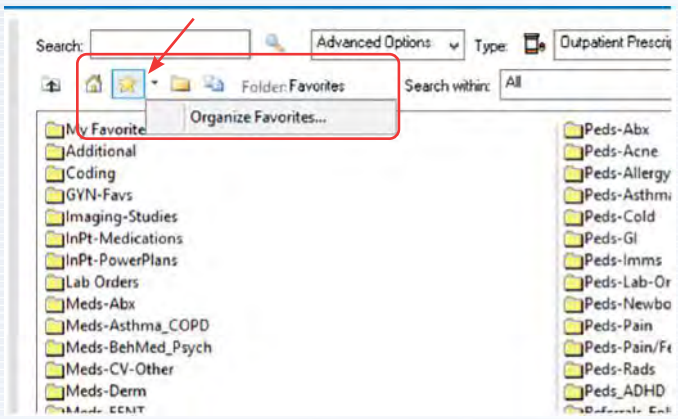
As you read this article, the entire MHS (at least the fixed facilities) will have transitioned to MHS GENESIS, with the Western Pacific completing the transition at the end of October/beginning of November 2023. MHS GENESIS, the Department of Defense's newest electronic health record system, brings a plethora of new features and capabilities to the table for both veterans and newcomers. Whether it's the MPages Workflow, Note Titles, or the overall organization of the platform, there are numerous ways to customize and streamline tasks to suit individual preferences and workflow needs. This USAFP article delves deep into some of the immediate enhancements you can incorporate, ensuring a more intuitive and productive user experience. Dive in to discover how to harness the power of MHS GENESIS effectively, reduce after-hours work, and optimize patient care.

1. MPAGES WORKFLOW (LIGHT MENU) NEW ORDER ENTRY VERSUS QUICK ORDERS TAB

This one depends on preference, and either can work. I prefer MPages Workflow/Light Menu because I do not like to leave my workflow. However, you can have it both ways. Here is how:

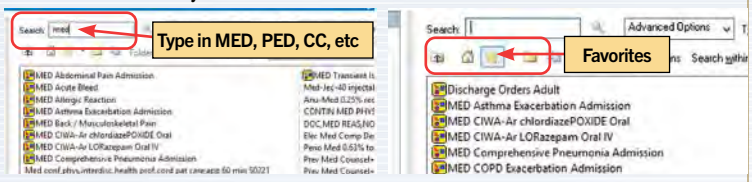
A. Go to the Dark Side (Dark Menu/TOC), young Padawan, and click +Add in the Orders bar. This opens the Order Entry menu → Organize Favorites next to the Favorites "star":





B. If not already done, create your Outpatient and Inpatient Folders (or just Outpatient if you do not do inpatient).

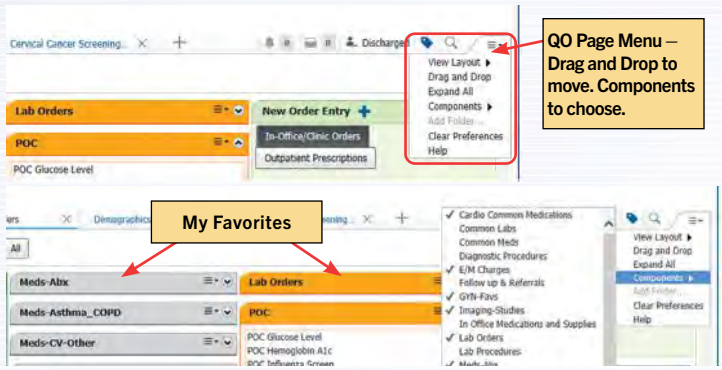
C. If you use Outpatient or Inpatient Power Plans (Order Sets), use the Order Entry menu (while there) to find and add Power Plans into your created Power Plans folders. Now, your Power Plans are in your workflow.



D. Add your Favorites (several ways to do that) or organize your current Favorites from the Organize Favorites menu. You can use Organize Favorites to move folders and/or individual orders as desired.

E. Once that is done, you can access all your Favorites/Folders from the New Order Entry MPage workflow.

F. If you desire to use Quick Orders, go to the Quick Orders tab and hit the Menu (three horizontal lines/Burger/Whatever you call it) to add and remove components, which includes your Favorites Folders.



G. Use the Drag and Drop feature to move groups around to enhance efficiency for you.

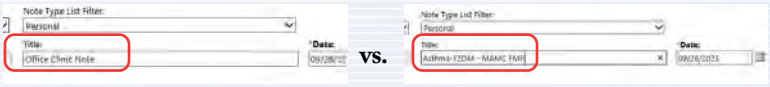
H. Add more Lab/Rad Favorites from someone at your Command. Add Pharmacy favorites from anyone, though Command is best to ensure you order what is on the formulary beyond the Basic Core Formulary.

I. You are now done and ready to be a lot more efficient and reduce "Pajama Time" (after-hours work).

2. NOTE TITLES

Do not use the standard Note Title for your notes. Title them based on the primary diagnosis/problem or primary and #2 diagnoses/problems. Adding your clinic/site name is optional, and if you choose this option, place the clinic/site name after the problem-based component.

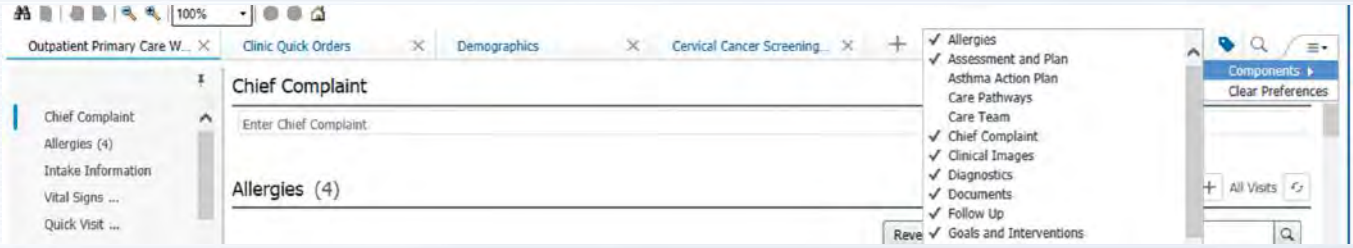
This use of diagnosis in the note title allows searching on the problems for ongoing care, F/U, Med Boards, VA disability, etc. It takes little time upfront and can save lots of time on the back end. It is an easy win for your patient and future providers (which may be you).



3. ORGANIZING YOUR MPAGES WORKFLOW/LIGHT MENU

Whether you do Inpatient, L&D, or Outpatient care, it is very important to organize your MPages Workflow (Light Menu) to have the items you need/use and put them in order of your workflow. In the Light Menu, you can always move things up and down or add and subtract things.

A. Most folks have developed a workflow, even if their Light Menu is not organized to support it.
B. To verify your workflow, ask someone to record a Light's On session that captures your mouse clicks and keystrokes.
C. Using that information, organize your MPages Workflow items to match your verified workflow, putting the unused items at the bottom.
D. Run through 1-3 clinics/inpatients to verify the workflow (this can be done for any of the MPages workflows, inpatient or outpatient).
E. Once done, uncheck the Components in the Page Menu (remember the 3 horizontal lines/"Burger") to remove them from that view. You can always add them back if needed later.
F. You are now organized to match your typical workflow and eliminate unwanted overhead/administrative burdens.
G. Unfortunately, you do have to do this for each workflow. Once set, it will remain set until you decide to change it.



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Adventures of a Super Genesis Family Doc!

Look! In the clinic, it's a bird, it's a plane, No! It's a super-using, patient-transferring Uniformed Family Physician!

It's 3 pm (1500 for you military types), and your family medicine colleague, Dr. Caresalot is running behind after taking care of a challenging patient. He's in with this third-to-last patient, but he's over an hour behind, and you know this particular patient well. There's no way he is going to be done soon. As a caring, resilient colleague, you know he has been looking forward to an upcoming family event all week. He must get home by 5 pm (1700) to attend a kindergarten dance recital, "Dance of frenzied fricasseed flowers" by the budding composing duo, Campbell and Garcia. Since you finished early, thanks to your use of smart phrases combined with two back-to-back 'No Shows', you offer to see his last two patients. You head to the front desk to accomplish this feat, but your admin clerk says, "No can do Doc". Since we switched to MHS GENESIS, we can't transfer patients between physicians because you are different "resources." You fume about your attempt to do a good deed but then realize, "Wait, I do know how to do that!"

Adventures of the GENESIS Voyager! Zoom! In the depths of the administrative galaxy, not everything is as it seems. And in this chaotic realm, understanding how things work can be... well, a superpower!

STAGE ONE: THE COSMIC CONUNDRUM OF CONCEPTS!

While roaming the corridors of MHS GENESIS, you stumble upon a peculiar realization: Appointments, Encounters, and Notes are NOT the same celestial bodies!

Imagine Appointments as a stellar reservation system - a cosmic dance where a resource, a patient, and a point in the time-space continuum merge. It's the plan of action, the blueprint of the galaxy. Now, rocketing in are the Encounters! They're the actual fusion of the patient, the resource, and the moment. It's where the rubber meets the asteroid, so to speak.

And, ah, in the MHS GENESIS nebula, you can't simply shuffle these appointments like space cards. Unlike the neighboring Cerner Millennium galaxy, where you can twist time and swap resources, MHS GENESIS marches to its own cosmic beat. Wondering why? It's by design, not destiny! But fear not, space traveler. If you believe there's room for intergalactic improvement, channel your concerns to the Primary Care Clinical Star Council (AKA the Primary Care Clinical Community of Interest- ask your Department Chair or Consultant) and make your voice echo through the void!

And remember, the power of observation is strong here. The ability to peer into any schedule from any quadrant is both a gift and a responsibility. Be sure to use this power wisely, for the cosmic audit is ever watchful.

DANCE OF FRENZIED FRICASSEED FLOWERS

Choreography by Bard

Music by Campbell and Garcia

Setting: A lush garden filled with exotic flowers.

Costumes: The dancers wear brightly colored tutus and flower crowns.

Synopsis: The dance is a celebration of the beauty and chaos of nature. The dancers embody the different flowers in the garden, each with its own unique personality. They move with frenzied energy, their movements mirroring the fluttering of petals and the swaying of stems.

Opening: The dancers enter the stage in a flurry of color and movement. They twirl and leap, their tutus billowing behind them. The music is fast and exciting, capturing the energy of the dancers.

Flower Waltz: The dancers pair up and begin to waltz. They move gracefully, their movements in sync with each other. The music is soft and romantic, creating a sense of harmony.

Flower Battle: The dancers break apart and begin to fight. They slap at each other with their petals and stomp on each other's stems. The music is chaotic and dissonant, reflecting the intensity of the battle.

Flower Transformation: The dancers begin to transform. Their petals fall off and their stems shrink. They become smaller and more delicate. The music becomes slower and more ethereal, reflecting the transformation of the flowers.

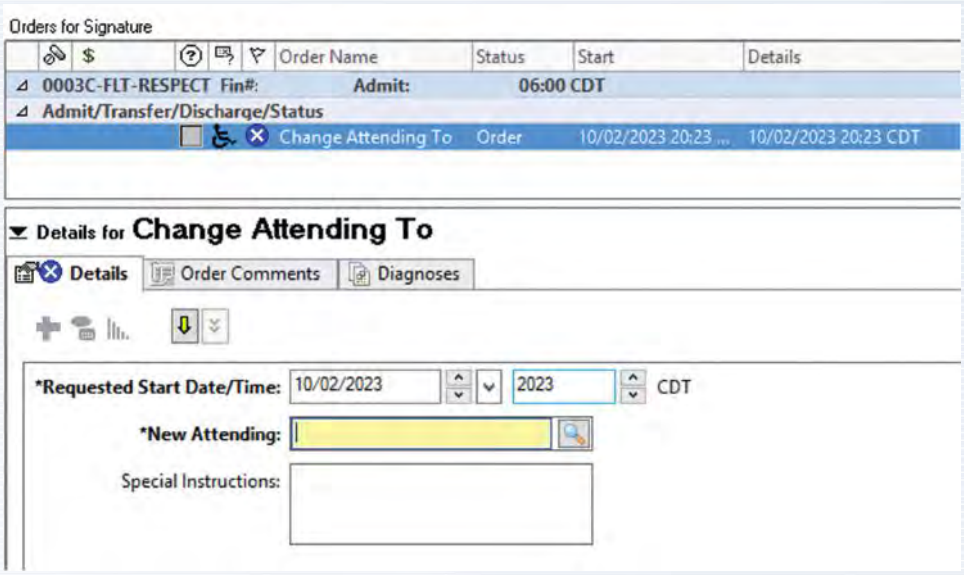
Closing: The dancers gather together in a circle and dance slowly. They move with grace and beauty, their movements mirroring the cycle of life and death. The music is soft and haunting, creating a sense of closure.

Ending: The dancers exit the stage, leaving behind a garden that is both beautiful and chaotic

STAGE TWO: ENCOUNTER EMPOWERMENT EXPEDITION!

Buckle up, as you now possess the tools to alter the fabric of encounters! Changing the encounter captain, or "attending," as Earthlings might call it, is pivotal. This isn't just about who's steering the ship; it impacts cosmic billing and the very structure of the space-time workflow. To maneuver this, simply initiate the 'Change Attending To' command sequence. Modify the order's cosmic coordinates and voilà! Your chosen one becomes the new encounter captain.

But a word of caution: here, the term 'attending' doesn't signify the overseer of the encounter but rather the resource engaged with the patient. The terminology might seem like a galactic goof, but remember, the universe is vast and ever-expanding. Just like our quest for better labels.



You save the day thanks to your compassion and understanding of clinical informatics. After sending your physician to 'enjoy' "Dance of the frenzied fricasseed flowers," you reflect on how your knowledge reduced burnout and enhanced patient experience. What a great day! Now, if you could just tame that unruly, overpopulated medication ordering listing...

To GENESIS and Beyond!

USAFP MENTORSHIP PROGRAM

Looking for a mentor? Interested in mentoring others?

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

HOW DOES IT WORK?

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

WHAT AM I SIGNING UP TO DO?

Participant responsibilities are as follows:

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

WHEN AND HOW WILL I GET MY MATCH?

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

IS THERE ANYTHING I CAN DO TO HELP?

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

MEMBERS IN THE NEWS

USAFP Members Corinne Landis, MD, Scott Paradise, MD, and David Klein MD, MPH, received the American Family Physician Article of the Year Award for their excellent scholarly contributions to family medicine. Their study, "Evidence-Based Contraception: Common Questions and Answers," received the highest rating from AFP editors and the most online views.

Pictured left to right: Scott Paradise, MD, David Klein, MD, MPH, and Corinne Landis, MD

Dr. Landis currently serves as the regimental surgeon for the Marine Raider Regiment at Camp Lejeune, North Carolina.

Dr. Paradise serves as the senior medical officer for the Marine Centered Medical Home Wallace Creek at Camp Lejeune.

Dr. Klein serves as an associate professor of family medicine and pediatrics at the Uniformed Services University School of Medicine and associate clinical professor of family medicine at the University of California, Davis School of Medicine.

Congratulations Drs. Landis, Paradise, and Klein!

MEMBERS IN THE NEWS

USAFP Past President Pamela M. Williams MD, FAAFP was awarded the 2023 Careers in Medicine (CiM) Excellence in Medical Student Career Advising Faculty Award by the Association of American Medical Colleges (AAMC). Dr. Williams, currently the associate dean for Student Affairs at the Uniformed Services University of the Health Sciences (USU), received the prestigious recognition for her unwavering commitment to supporting the success of medical students.

The award was presented at the AAMC's annual meeting in Seattle on Nov. 3, 2023. According to the AAMC's announcement, Williams was acknowledged for developing a robust program for USU, directly advising more than 9,000 students since taking on her role as associate dean.

Williams was also recognized for serving as a mentor and role model to USU's diverse national faculty, actively engaging in outreach and faculty development, and ensuring that the faculty play a vital role in supporting students' personal career development and overall success. Her advocacy for students with senior leaders and policy-makers, which resulted in more standardized application policies and procedures across the Army, Navy, and Air Force, was also a contributing factor in her receipt of the award.

Congratulations Dr. Williams!

ABFM KNOWLEDGE SELF-ASSESSMENT

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.

Register Here!

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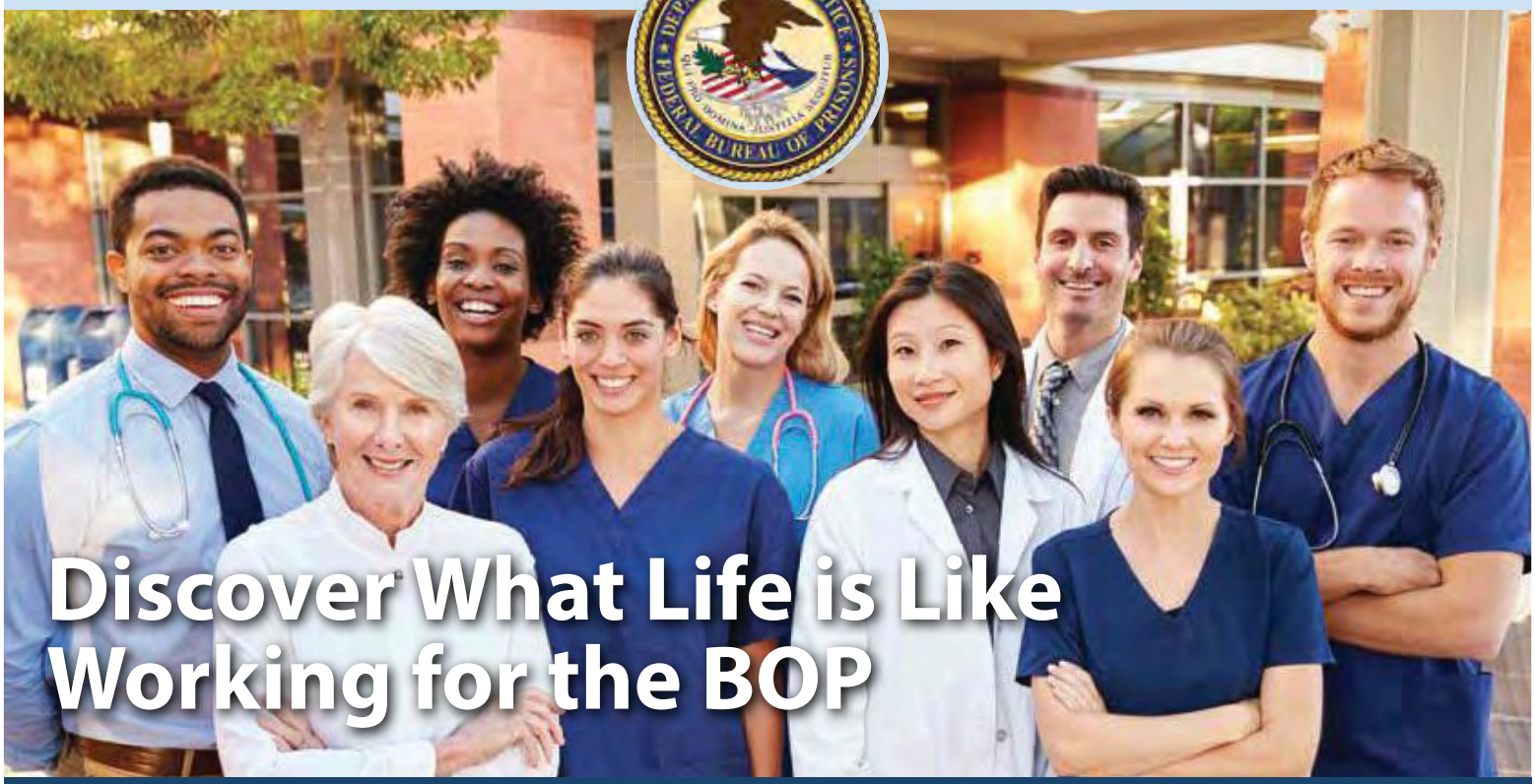

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committee report
EDUCATION

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Test Taking: Tips and Strategies for Success on the Big Day

The push for uniformity in medical education by the passionate medical education reformers of the last century brought standardized testing to the fore. Medical students, medical residents, fellows, and even staff physicians are presumed to have the skills necessary to master large amounts of information rapidly and to successfully demonstrate this mastery during standardized, computer-based testing.[1] Such mastery requires not only adequate study skills but also adequate test-taking acumen. Test-taking strategy, like any other skill, can be successfully taught and mastered by motivated learners.

Modern medical learners are tested frequently and must satisfactorily navigate individual medical knowledge exams at all levels of training. Such exams include the NBME (National Board of Medical Examiners) Subject Examinations, commonly referred to as Clerkship Shelf Exams, Steps Exams (1, 2, 3) of the USMLE (United States Medical Licensure Examination) or the COMLEX (Comprehensive Osteopathic Medical Licensing Exam), and lastly for Family Medicine Residency Graduates, the ABFM (American Board of Family Medicine) Exam for board certification.

The current Family Medicine Certification Examination (FMCE) offered by the ABFM consists of a timed, computer-based multiple-choice question examination. The exam is 300 questions in length and includes questions regarding the diagnosis, management, and prevention of illness, among other topics. The exam is designed to measure clinical decision-making ability and the requisite medical knowledge needed to make decisions as related to the specialty of Family Medicine. The content of the FMCE is the same for both candidates seeking initial certification and candidates seeking to continue their certification.

Many medical learners struggle on multiple-choice, clinical vignette-based knowledge exams, and assisting these learners poses a significant challenge to interested medical educators.[2,3] Common remediation strategies emphasize honing test-taking techniques and completing many practice questions. The above techniques work best when paired with comprehensive efforts to improve overall medical knowledge and clinical reasoning.[4]

All current standardized medical testing relies on one best-answer format, with multiple-choice questions to facilitate knowledge demonstration and mastery. As the testing format is known, the following are test-taking strategies that are designed to help learners master the subtle art of test-taking:

1. **The Stop & Glance Technique**: This technique emphasizes briefly reviewing or "glancing" at the answer choices prior to reading the entire question or clinical vignette. This approach facilitates users adopting the correct mental framework for answering the question. For example, is this a question regarding diagnosis, treatment, management, a medication side effect, or a guideline-based recommendation, etc. Overall, this tactic allows for more efficient sorting and processing of the material on the test taker's path to successfully selecting the correct answer.
2. **Avoiding Premature Closure:** Premature closure is otherwise known as jumping to conclusions. This is one of the most common errors made by test takers. Marking an answer correct immediately upon presentation can lead to premature closure; that is, the test taker is less likely to seriously consider alternative answers that appear later in the list of answer options. Only after reading all options should examinees select the correct response.
3. **Take a Second Look:** After reading the test question, if the correct answer does not leap off the page, do not panic! Carefully re-read the question to ensure that a piece of critical information was not inadvertently overlooked. If, after a single re-reading, no new information presents itself, do not waste time further re-reading the question, as this is unlikely to benefit the test taker in any meaningful way. Furthermore, this prevents the examinee from moving on to the next question and costs precious time.
4. **Always Look for "The Reveal" at The End:** Test writers have a limited space to include clinical information. Therefore, authors will frequently place unexpected revelations of facts near the end of the question stem. Astute test takers should capitalize on this beneficial final information.
5. **Use All of The Information Provided:** Test writers have a limited space in which to convey all the information necessary to answer the question. Careful, purposeful reading is essential, as internal clues often lead you to the correct answer.

6. **Go with Your Gut:** Upon reviewing responses, the examinee should consider that the first thoughtful answer marked is usually the best answer. Second-guessing is not likely to aid testing performance. However, should the test taker realize they misread or misunderstood a question, making an answer selection change may be reasonable.
7. **Don't Be Afraid to Skip:** Modern, computerized testing makes it easier than ever to quickly and efficiently mark questions that the test taker is unsure of and return in a timely manner. Note: If time limits are an issue, consider marking an answer as a precautionary measure. Skipping around allows for the possibility of using information from a different question to potentially answer a previous question.
8. **Don't Overthink the Test:** Do not try to out-guess the test writers! Doctors are great at this! Test takers should rely on standard medical knowledge to respond to answer options. Test questions on the FMCE are not written to be "tricky." Writers do not depend on subtle wording to identify the intended response, although the specific information in each question is important.
9. **Keep Moving Forward:** No matter how difficult the question, examinees should keep in mind that each question is worth only one point. Fretting over and mentally dwelling on a previous question will only impair performance on other test questions.
10. **The Final Look Through:** Test takers should review exam content if excess time remains. However, caution should be exercised; change answers only if new or overlooked information is discovered or a question was previously misread. Changing answers for any other reason carries with it a high probability of marking items incorrectly!

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THE USAFP TURNS 50 IN 2025!!

Your Board of Directors and 2025 Program Co-Chairs, Cat Delaney, MD, and Matt Noss, DO, are planning for a 50th Celebration during the 2025 USAFP Annual Meeting (location and dates TBD). Calling all members to create a "50th" logo design that will be used beginning at the 2024 USAFP Annual Meeting to start the USAFP's year long acknowledgement of the great history of the organization.

If you are interested in submitting a design for a logo, please send your drawing and/or photo file to Cheryl Modesto (cmodesto@vafp.org). Deadline for submission is 31 December 2023. Your USAFP Board of Directors will select the winning design and the winner will be awarded a complimentary registration to the 2024 USAFP Annual Meeting.

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AAFP National Conference: Empowering Family Medicine's Youngest Leaders

This summer, your Resident and Student Representatives for the USAFP Board of Directors had the privilege of attending the AAFP's widely attended National Conference of Family Medicine Residents and Medical Students in Kansas City. We were honored to represent the Uniformed Services chapter of the AAFP among residents and medical students from across the country. Recognizing that many of our readers may not be familiar with this event, we would like to provide some background information along with our reflections on the experience.

While much of National Conference is directed toward helping medical students apply to family medicine residency (including an expansive Expo Hall and various application- and interview-related presentations), the three-day conference also includes numerous educational sessions and workshops geared toward residents and students at all levels of training. Broadly, these workshops span topics such as clinical knowledge, procedural skills, lifestyle medicine, and diversity, equity, and inclusion. This year there was also a session dedicated to fellowships in family medicine.

While we took advantage of these academic sessions, our primary focus at the conference was to serve as delegates to the AAFP's National Congress of Family Medicine Residents and National Congress of Student Members, representing the Uniformed Services chapter alongside delegates from each U.S. state and territory.

We also had the unique opportunity to sit on Reference Committees. Throughout the conference, resident and student attendees work to write 'resolutions' that reflect where they believe the AAFP should focus their time and efforts (public health, improving medical education, etc.). From there, resolutions are taken to their respective Student or Resident Reference Committees. The committees hear the evidence for and against the proposed change in an open hearing, deliberate in a closed committee session, and ultimately

recommend whether each resolution be adopted. The recommendations of the committee are then brought to the Congress of Delegates, where a debate and voting are held. While the main priority is voting for board members, anyone who attends the Congress can speak for/against and vote on the resolutions that are brought forward (the only exception being that Reference Committee members may not vote on the resolutions on which they deliberated). Resolutions that are passed become action items for the AAFP Board of Directors so the process of resolution writing creates an invaluable communication channel within the organization for resident and student advocacy.

As we participated in these parliamentary procedures as delegates and Reference Committee members, we were struck by a few things. First, the overall experience was educational regarding the behind-the-scenes workings that influence family medicine in the U.S. Second, we were deeply impressed by the AAFP's prioritization of resident and student input. The Reference Committees, Congress sessions, and the conference at large put up-and-coming family physicians in the spotlight, enabling us to share our insights, values, and ideas to influence organizational policy. The overarching message was that if we show up and do the work, the AAFP will not only listen with genuine interest, but will do its best to implement proposed changes. Talk about empowerment! Lastly, we were inspired by the empathy and mutual respect displayed by these aspiring family physicians, even when debating over controversial issues. Many of the residents and students who spoke during these sessions held deep-seated beliefs which were in direct conflict with those of others, but they were able to demonstrate their passion and articulate their viewpoints while maintaining a level of professionalism and integrity that we found admirable. It was a distinct privilege to vote alongside these dedicated individuals while reaffirming the

Uniformed Services' place within the larger picture of family medicine.

National Conference reminded us that our chosen specialty is one which truly values the individual contributions and collective voice of its newest members. Many students we spoke with at the conference expressed gratitude for having the opportunity to attend, and several residents noted that they wished they had known about the conference during medical school. If you're reading this as a resident or medical student, we strongly encourage you to consider attending next year's National Conference (1-3 August 2024) and to get involved in committees, advocacy, leadership, or whatever inspires and empowers you.

The Resident and Student Directors attended AAFP FMX (26-29 October 2023) and will be attending the USAFP Annual Meeting and Exposition (23-28 March 2024). We look forward to connecting with you all in New Orleans! You can also contact us any time with questions about AAFP National Conference, the National Congress of Family Medicine Residents, and the National Congress of Student Members.

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Enlisted Medical Personnel: An Underutilized Deployment Force Multiplier

UPDATED FROM 2020 ARTICLE BY JEFFREY L. KINARD, DO, FAAFP

Our enlisted medics are often underutilized operational medicine force multipliers in the deployed environment as well as our resource constrained posture in-garrison. They do not have precisely comparable civilian counterparts and in our joint operating environments, it is essential to have a viable understanding of each services' enlisted medics' training to allow them to practice to their fullest capability and to not have them relegated to taking vitals or other more basic tasks. In this article, the USAFP Operational Medicine Committee profiles several enlisted medical specialties in the various services to provide a side-by-side view of capabilities.

AIR FORCE

Air Force Independent Duty Medical Technicians: 4N0XIC

Authors: Capt Shannon "PADDLES" McCown, MD and Maj Meghan "MOE" Tape – 406th Air Expeditionary Wing, Ramstein, AB, Germany

Independent Duty Medical Technicians (IDMT) are highly trained medical assets. They attend an intensive 13-week training course after selection which teaches them everything from full physical exams, pharmacology, diagnosis, and treatments in accordance with protocols outlined in their handbooks. After training they are able to further their education by attending courses such as jump school, paramedic school, and SERE (Survival, Evasion, Resistance, Escape).

After their initial course, these airmen must finish their mission qualification by training in the areas of immunizations, laboratory, dental, bioenvironmental engineering, public health, medical logistics, and TOPA (Tricare Operations and Patient Administration). After becoming fully upgraded and verified by their supervising physician, they are able to deploy as a medical powerhouse that is capable of performing all the necessary medical readiness and public health requirements for their base.

IDMTs who deploy are typically attached to individual units and travel with their unit outside-the-wire on missions. Their main role is to provide immediate triage and treatment in case of casualties, coordinate casualty evacuation, and facilitate defense of patients. When not actively joining the fight downrange, IDMTs will often be tapped to be advisors to commanders on deployments/TDYs, be

the lead POC for initiation of international and joint medical partnerships, and instructors for advanced medical courses. Bottom line, IDMTs serve as a Swiss army knife within the medical field. They have a wide scope of training and are able to support as a mobile physician extender in any environment throughout the world.

Further information and regulations for IDMTs can be found in AFI 44-103.

Pictures feature TSgt Kayle "Kronk" Southerland conducing basic field casualty care for BMT trainees, SSgt Justin Sharp providing in field care during an AFSOC assessment, and SSgt Ma Sekina Sanvictores and various medics from the 8th Medical Group at Kunsan AB, Korea conducting medevac training.

ARMY

Role: Combat Medic (MOS: 68W)

Author: LTC Matthew Noss - 7th Special Forces Group (Airborne), Eglin AFB, FL

Clinicians should be aware that there are several different types of medics in the U.S. Army. The 68W medic is the Army's typical medic series. 68W's can seek further training to become flight paramedics (68WF2) or SOCM medics (68WW1). SOCM medics are medics who have had additional special operations medical training but have not gone to the Special Forces Qualification Course. 18Ds are Special Forces Medics that are assigned to Army and Joint Special Forces units and have completed all Special Forces training. It is important to understand the medic's initial training and skills validation, the ways they can be utilized, the importance of sergeant's time training and the clinical training of medics to be able to fully maximize a medic in various clinical environments.

Clinicians within a military Medical Treatment Facility (MTF), as well as

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conventional operational units, will most commonly work with the 68W medic. The training, tasks, and scope of these positions can be found in Army publications TC 8-800 and MC 40-50. A new medic joining a unit from Advanced Initial Training (AIT) will be minimally proficient in tactical combat casualty care (TCCC) and has received some training in patient assessment. They will be Emergency Medical Technician (EMT) – Basic certified. AIT does not include garrison MTF type training; therefore, medics will need plenty of feedback when initially working in a clinical setting. To maintain 68W qualification, medics must complete biennial EMT recertification and Basic Life Support certification. Medics complete Table VIII training and assessment as part of their EMT continuing education hours and skills validation at a minimum of every other year. As part of this training, medics receive education and validation of trauma skills, airway management, intravenous access and medication administration, medical tasks, triage and evacuation, force health protection, and a block of education on assessment of the OB/GYN and pediatric patient, to include assisting in vaginal delivery.

Most clinicians are aware of a medic's understanding of TCCC. Many, however, have a poor understanding of a medic's education in

procedural tasks, medical skills, or force health protection.

Truncated List of Medic Training Tasks per TC 8-800:

Intravenous access and medication management	- Intravenous (IV) and Intraosseous (IO) infusion - Intramuscular (IM) and Subcutaneous (SC) injection - Insertion of a Nasopharyngeal Airway (NPA) - Insertion of a supraglottic airway (i.e. King LT, I-Gel) - Perform a Surgical Cricothyroidotomy
Medical Tasks	- Medical Documentation: SOAP Note - Vital signs measurement to include visual acuity - Limited patient assessment: MSK, HEENT, Pediatrics, and OB/GYN - Treatment of diabetic emergency, anaphylactic shock, and seizures - Use of Automated External Defibrillator
Force Health Protection	- Implementation of suicide prevention measures - Treatment of: altitude illness, heat/cold injury, insect bites/stings, snake bites

With additional training, medics can be utilized to initiate and manage IV infusions and administer IM and SC immunizations. Experienced medics and senior medics can be trained to apply the Army's Algorithm-Directed Troop Medical Care (ADTMC) system in a busy aide station or MTF. Medics should be encouraged to write SOAP notes, understand vital signs, assess a patient through physical examination, and appropriately report to a clinician. The U.S. Army Physician Assistant Handbook, Chapter 13, is a good resource for battalion operations such as sick call and triage.

Sergeant's time and clinical training of medics should be performed regularly and documented in the Soldier's competency file. Documentation of this training is important, as most medics will likely not be allowed to perform these tasks in the MTF setting without it. Formal training on a regular basis is important for medics to maintain their trauma and non-trauma medical skills. Medics often lose their TCCC skills when stationed in a clinic and lose their documentation and assessment skills when assigned to line units.

Far too often medics are utilized as medical support assistants in the clinical setting, tasked only to take vital signs and make appointments, or to mop the motor pool when assigned to the line. It is important that we, as uniformed physicians, take an active role in the training and development of our medics. This is the only way our medics can be proficient and competent when they are placed in a situation where they are alone and must be unafraid.

NAVY

Role: Corpsmen (HM) and Independent Duty Corpsmen

Author: LCDR John J. Koch, NMRTC, Great Lakes

Clinicians across services should be aware that many different specialties exist within the rate of Navy Hospitalman (HM) or Corpsmen. All Navy Corpsmen attend Corpsman A-School at the Medical Education and Training Campus at Fort Sam Houston which lasts 19 weeks. Following that Corpsmen are designated a "Quad Zero" (Naval Enlisted Classification [NEC] 0000). After successful completion, corpsmen have the opportunity to attend multiple other schools to gain further designation as one of dozens of other NECs including Radiation Technologist, Surgical Technologist, Pharmacy Technician, or Dental Assistant among others.

U.S. Navy Independent Duty

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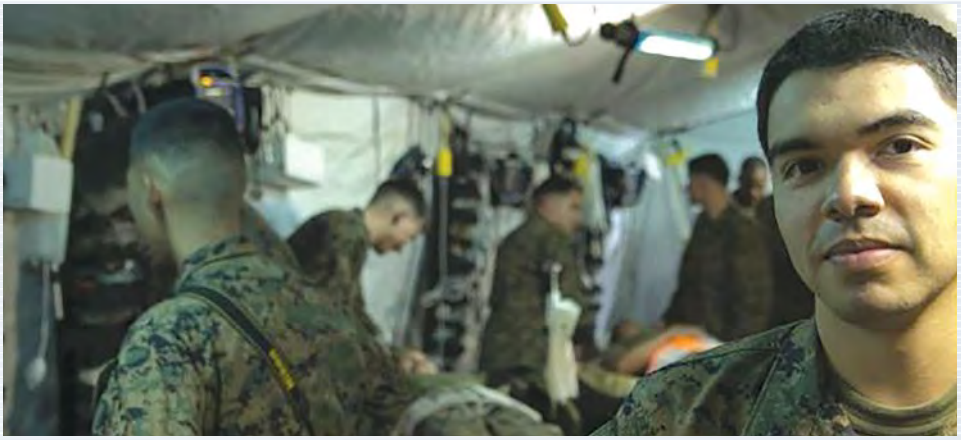

to become familiar with enlisted medic capabilities and regulations. Throughout my career, I have personally enjoyed mentoring and working with enlisted medics with many going on to become nurses, physician assistants, or even physicians themselves. From doing battlefield acupuncture to managing a busy sick call, if you take the time to train them as valued members of the team, you will have true medical capability extenders.

Corspsman (IDC) is defined in OPNAVINST 6400.1D as a senior corpsman who has successfully completed IDC "C" School and received additional education and training to function within the fleet as an independent physician extender. The Navy Medicine Education, Training, and Logistics Command offers the 12-month course in San Diego where IDCs received both classroom and practical education in the requirements to serve as the Senior Medical Department Representative aboard ships, submarines, with U.S. Marine Corps, and special operations units. Upon completion IDCs are eligible for registration for a National Provider Identification (NPI) number.

Upon assignment all IDCs practice under the supervision of an assigned clinical supervisor who provides clinical oversight, support, and advice. Clinical supervisors also ensure that all IDCs are able to train to the competencies listed in NAVMED 6400/2 which serves to outline their scope of care. IDCs may assess and treat all active-duty service members and foreign military members. All practicing IDCs must be part of a command managed IDC Supervision Program, outlined in OPNAVINST 6400.1D which provides specific instructions on the supervision, training, and practice scope for IDCs.

FINAL THOUGHTS

This article has provided a brief overview of enlisted medical specialties to promote their full-scope utilization across a range of clinical environments. I encourage you

committee report
PRACTICE MANAGEMENT

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Family Physician Leaders and Understanding Practice Management

What is Practice Management (PM) and why should you care? The role of a Family Medicine Physician is so much more than just seeing patients. Understanding the business side of medicine is crucial, regardless of whether you are just out of residency or a seasoned clinician. This article will address key tenets in PM including operations, human resources, financials, information technology, population management and compliance. Being able to negotiate on behalf of your clinic (and yourself) is one of the key leadership skills for Family Physician Leaders.

OPERATIONS

The first step in seeing patients is to give them a way to access you. A fundamental part of PM is understanding clinic templates, access standards and practicing active template management. The Defense Health Agency (DHA) published guidance on templates and appointing. This includes the well-known template requirement of 100 appointments per week, utilizing 85% of them for a panel of 1,100 patients. The 100-appointment target (per one full-time equivalent) is derived from 40 hours in a week and 20-minute appointments. This equates to 6 hours and 40 minutes of appointments with 1 hour and 20 minutes of administrative time each day for other tasks such as writing notes, responding to labs, and training. PM also includes planning the right mix of 24-hour and future (FTR) appointments on the days and times desired by patients. Data shows that many clinics are scheduling most appointments Tuesday-Thursday and are doing 3-4 hours of clinic in the morning, providing few appointments over lunch and scheduling appointments for only 1-2 hours in the afternoon, ending at 3 pm. Conversely, data demonstrates that morning appointments are the least utilized, patients go to Urgent Care and the Emergency Room the most on Mondays and Fridays and in the mid-to-late afternoons on weekdays. It is important to plan templates based on patient demand and remember that there are two peaks in each day for desired care, the morning and late afternoon. The requirements above are for one full-time equivalent; however, most Family Physicians do not have 5 full days of continuity clinic and DHA recognizes that there are half days for procedures, precepting, leadership and more. PM requires an understanding of the data to make decisions and an understanding of all the variables that pull providers away from clinic. It also includes aligning enrollment to the time in clinic, then aligning the right number of appointments for that enrollment.

HUMAN RESOURCES (HR)

PM includes having the right mix of staff to see patients. This includes front desk clerks, support staff, medics, nurses, and providers, who are empowered to work at the top of their expected skill set and who are military, government services (GS) and contractors. DHA increased authorities to hire GS at each

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Military Treatment Facility (MTF) and hiring is getting faster, with a DHA goal of 60 days or less. Remember, it is easier to keep a GS employee than to hire one, so make sure to use retention incentives. There are many classes available to help those leading and managing GS and contractor employees. Take advantage of them. Finally, so many people have been hired in the last few months, that DHA is now concerned about hitting the civilian pay cap and leaders must prioritize hiring. Please advocate for hiring the needed number of clinical support staff.

FINANCIALS

There are key items to understand in PM related to how money flows. Each MTF is paid for the number of enrollees, based on a sub-capitated model. Years ago, when Patient Centered Medical Home (PCMH) started, there was a huge effort to change the funding for primary care from Relative Value Units to a set dollar amount to care for your patients, so that you could focus on providing team-based practice without a focus on bean counting. That effort succeeded, and the portion of the MTF budget for primary care is based on this flat fee (~$430-460 depending on geographic area) multiplied by the number of enrollees. There are also incentives for performance-based metrics. This is money you can earn for just doing the right things for your patients. PM requirements are to enroll up to the expected number of provider FTEs and to not leak care to the network.

PM includes understanding how metrics are derived. All clinic work is in a B code such as BGAA or BGZA, inpatient work is in an A code and all other time is in E, F, and G codes. Why does this matter? The time spent in A and B codes identify the expected time for work done in clinic or on the ward. If a provider writes crazy 8s on the Defense Medical Human Resource System-Internet (DMHRSi) for all B code time, the provider will look inefficient in terms of workload produced because it will not include the 6 hours and 40 min of admin time each week. The MTF will appear inefficient with excess staff, as the system accounts for an expected percentage of non-B code work. If an attending puts 80 hours in the A code while doing the wards for a week, the total inpatient workload will look like there are two primary care providers available. While frustrating to have to complete, DMHRSi is crucial in telling your story and managing your MTF's budget. Currently, there are incentives to make sure that enlisted personnel are putting in their readiness time in DMHRSi for when they go to the range or cover a base event. Not correctly accounting for provider and team time is costing the MHS hundreds of millions of dollars annually so it is important to correctly document the time available to different tasks accurately.

Recently, it was discovered that many providers had not been updating their HIPAA taxonomy code related to their National Provider Identifier (NPI) number. For instance, a board-certified FP who never updated their taxonomy from when they were an intern, receives no workload credit for any patient they see. It is critical to update one's taxonomy with each change in job, from intern, to resident, to attending. If dual boarded, list the primary taxonomy you spend the most time in. See below for examples.

INFORMATION TECHNOLOGY

Family Medicine has seen the evolution of face-to-face visits to phone visits to asynchronous messaging to virtual visits. In the future, more and more care will be provided virtually, and DHA is piloting new tools at five facilities to expand opportunities to use technology in caring for our patients. In addition, efforts to standardize workflows in MHS Genesis continue, including adding all the VA DoD Clinical Practice Guidelines into the workflows. The PM committee works with the Clinical Informatics Committee to share best practices in using MHS Genesis and leveraging technology in caring for our patients.

POPULATION MANAGEMENT

Under the sub-capitation payment model, managing your patient population is key. This includes reviewing preventive medicine measures, tobacco usage, weight, depression screening and more. This can also include utilization management, which provides information on the highest utilizers in your patient population. This data can also help you to distribute patients more evenly across provider panels.

COMPLIANCE

There are many types of compliance involved in PM. For example, are you keeping up with chart reviews and are your provider files ready for Joint Commission? Are your access standards within the ones codified in federal regulation (24hr and FTR within 7 days)? Are you following DHA guidance? Which one? All of them? They are at https://www.health.mil/Reference-Center/DHA-Publications . There are seasoned leaders, websites, policies, and often staff at your MTF who can help with these and other PM compliance questions.

In closing, thank you for what you do every day as Uniformed Family Physician Leaders. Each of you lead every day with your patients, your staff, and your colleagues. Raise your hand and volunteer for the next job, even if you do not think you are qualified. Join the USAFP Practice Management Committee, or any USAFP Committees. Teach, learn, and share your experiences. The only constant is change, so lifelong learning is critical to your success, to your clinic's success and to all of our success. PM is just one piece of the puzzle but one that is critical to you, your clinic and your patients.

EXAMPLE TAXONOMIES

- "*Student in an Organized Health Care*"
  - Code: 390200000X; still in medical school
- "*Military Health Care Provider (subspecialty not indicated)*"
  - Code: 171000000X; an intern without a license
- "*PHY General Practice (no subspecialties)*"
  - Code: 208D00000X; resident with license or General Medical Officer
- "*Family Medicine*"
  - Code: 207Q00000X; graduated residency (includes those in fellowship)

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LTC Jesse P. DeLuca
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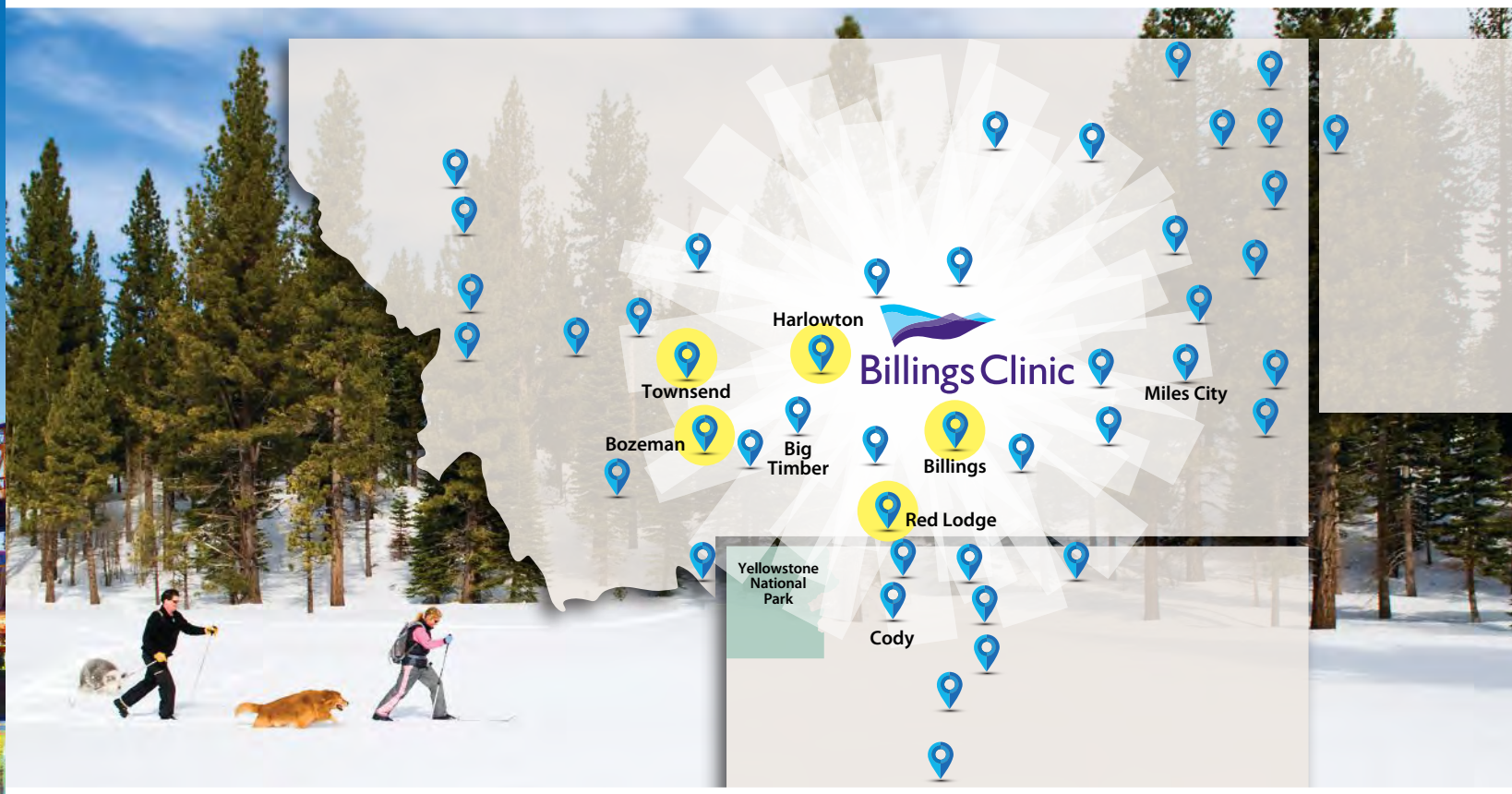

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David L. Riegleman, MD
Wellness & Resiliency Committee Chair
Brooke Army Medical Center
driegleman@gmail.com

How Can We Decrease Burnout? Lessons Learned and a Possible Way Forward

REDEFINE THE PROBLEM

John Dewey once said, "A problem well stated is a problem half solved." Too often, we find ourselves working so hard to find a solution when we have altogether forgotten the original problem. We find that our task-driven mentality can often become a self-licking ice cream cone. It is for these reasons that we must redefine the problem of burnout.

In the ICD-11, burnout is now included as an organization phenomenon rather than a disease suffered by an individual (1). Refocusing our understanding on how our organizational climate contributes to burnout is necessary if we are to fix it. We must shift our attention, and of course the conversation, to how burnout results from an impaired relationship between us and our *workplace environment*. Just like dirty scrubs, we can bring our feelings of burnout home with us, but the dangers of each stem from our clinic. This is a revolving door, as well. We take those feelings right back to work where a negative cycle of attrition and job loss leads to high turnover and diminishing job satisfaction (2).

Furthermore, even though most burnout seems to fall into the category of "Overload Burnout," we must recognize the impacts of "Under-Challenged Burnout" and "Neglect Burnout" (3). Instead of simply being drained from always attempting to do more with less, underappreciation at work and the inability to impart solutions – even when ones are available – can sometimes hurt us even more. Recognizing these subtypes of burnout when they arise is essential for leaders and organizations. Finally, we must remember that burnout is not simply an inevitable final stage with no hope of recovery. It can be reversed, and we should continue to educate, encourage, and advocate for others who are experiencing burnout.

FOCUS ON ORGANIZATIONAL CHANGE, NOT INDIVIDUAL INTERVENTIONS

Many of us have listened to or given presentations on the importance of individual well-being. Engaging in activities such as yoga, mindfulness, and maintaining a healthy, balanced diet are all practices to improve our individual health and well-being. However, none of these individual interventions solve

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USAFP Career Center

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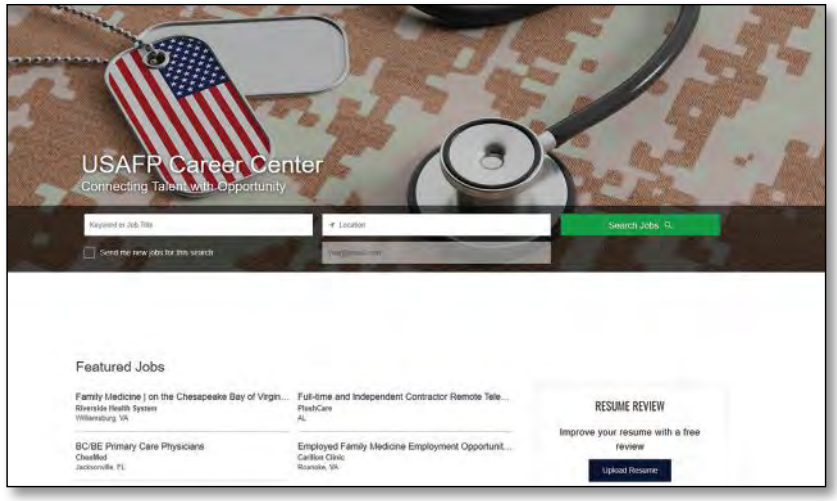

The career center is a resource that provides members a complimentary opportunity to search for family medicine positions available across the country. Explore employment opportunities or recruit for open positions within your MTF. In addition to the complimentary job search resource, the USAFP has discounted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

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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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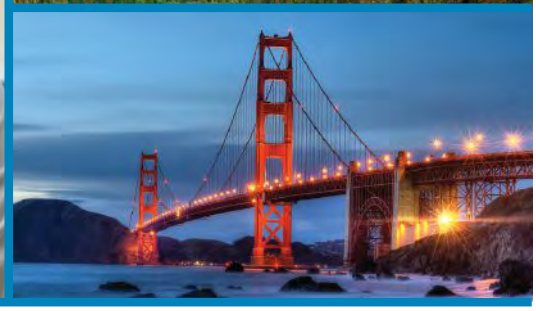

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NEWSLETTER SUBMISSION DEADLINE

REMINDER: The deadline for submissions to the Winter magazine is 5 January 2024.

RESEARCH GRANTS

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

RESEARCH JUDGES

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

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

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the organizational issue of burnout. The Healthy Workplace Study sought to identify what improvements could be made within the workplace to improve clinician's lives in a primary care setting (4). This study was a multi-site, primary care physician-focused research project that took place at 34 clinics across the nation and examined multiple interventions. The results of the Healthy Workplace Study can be used as a framework to help us tackle the complex organizational problem of burnout.

The first intervention in the study was aimed at improving interpersonal communication and teamwork. This included arranging meetings where physicians could contribute their ideas by identifying problems and proposing possible solutions. This study showed that interventions in communication led to greater improvements in clinician satisfaction.

The second intervention involved optimizing workflow. In my opinion, this may be the most challenging intervention to make, however, it may also be the most important. This study showed that workflow interventions reduced burnout when compared to the control group. By utilizing our team members (enlisted medics, clinical assistants, nurses, etc.) to their fullest potential, we can redistribute workload and reduce clinical burden on the physician. This also decreases the likelihood of neglect burnout for those working alongside us.

The third intervention looked at targeted quality improvement (QI) projects and found that this was also associated with reduced burnout when compared to the control group. We can transform our work environments and reduce burnout by streamlining MHS GENESIS workflow and other workflows in the clinical arena. This takes time and effort, but the rewards of targeted QI projects can improve our own lives as well as the lives of our patients and teammates.

WORK TO GET KEY STAKEHOLDERS INVOLVED AND MOTIVATE ORGANIZATIONAL IMPROVEMENT

The previous article written by the Wellness and Resiliency Committee focused on the importance of social interconnectedness. Social connection is key to improving our relationship with our work environment and addressing burnout. Joe Sweeney aptly named his book *Networking is a Contact Sport*. I believe that organizational improvement is also a contact sport. Even though we may not always have the positional authority to make a desired change, there are many around us, above us, and next to us who do. Don't forget that regardless of your positional authority, we all have influence as uniformed family physicians. Let's keep motivating each other and striving to create a healthy workplace environment that provides key elements such as autonomy, an opportunity to demonstrate competency and a sense of belonging (5). Keep your fire burning!

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Bridging the Gap

ERSS 31

The "85% Solution" rule suggests that optimum effort trumps maximum effort. It assumes that you are responsible for approximately 85% of your success, and the remaining 15% is up to chance. When it comes to the workplace, having 15% left to chance seems like a substantial amount. How do we bridge that 15% gap to address persistent disparities and inequity in the workforce?

According to the 2023 Current Population Survey and Current Employment Statistics from the Bureau of Labor Statistics, three-quarters of women aged 25-54 have a job, and 84% work full time. Men continue to out earn women in every age group, and this not only persists, but worsens with increasing age. Women's earnings plateau mid-career, while men's continue to rise, and these earning gaps are even more pronounced for women of color.[1] Further, women's representation in senior leadership positions ("C-suite"), only represents 32%, which is 10% less than the overall representation of women in the workforce (42%).[2] There is certainly room for improvement, which begs the following questions: Are we maximizing our 85% effort and how can we better address that remaining 15% to eliminate the ongoing disparities instead of leaving it to chance?

When my mother completed the British equivalent of high school in England in the late 1950's, she had five career choices: Secretary, schoolteacher, salesgirl, nun, or housewife. Given this myriad of options, she chose to be a secretary. The way she described her former work environments to me strikingly resembled scenes out of "Mad Men", the television series that ran from 2007-2015, complete with sexism, chauvinism, and prejudice. Thankfully, when I entered the workforce, there were far fewer restrictions in place compared to what my mother experienced, but overall progress was slow.

CDR Arbuthnot and Carter

Christine Spong and Rachel Carter

I joined the United States Marine Corps (USMC) in 1997, which was exactly one year after the restriction against women pilots was lifted. Thanks to that "lucky" timing, I was a Cobra

helicopter pilot the first half of my military career, an opportunity not afforded to the women in the USMC who preceded me. I was often the only female in many aviation units. I am now a Family and Emergency Medicine physician. As I write this article, I am preparing to deploy as an Individual Augmentee, and I am currently undergoing weapons training at an Army base. The Officers-In-Charge (OICs) and Assistant OIC's of both deploying Navy medical units are women. In fact, all the O-5's and above are women. This is wonderful to see, however, it is in stark contrast to the under-representation of women in senior leadership seen across industries.

In recent decades, there has been more opportunity and fewer legal or regulatory barriers to military career advancement for underrepresented groups. Despite progress, there are still glass ceilings in place for women and minority groups. While we can illustrate individual examples of constituency members achieving the highest-level leadership positions, such as the new Chief of Naval Operations, representation remains very low at these levels. In 2021, according to the Department of Defense, women accounted for 17.3% of the active-duty military force[3], and 41% of the military identified as a member of a minority

Trauma Training (SIM Patient)

Al Taqqadum 2004

group.[4] Only 7.1% of admirals and general officers are women[5], and the percentage of general or flag-officers who identify as a member of a minority group is 10.4% (Army), 9.2% (USMC), 6.5% (Navy) and 5.5% (Air Force).[6] So, how do we recruit and retain individuals from underrepresented groups so that they are considered for promotion into leadership positions?

Dan Nielsen, an author who focuses his work on leadership excellence, has written that 85% of our success can be augmented by responsibility, self-empowerment, and personal accountability.[7] What about that other 15%? It can feel like there are no easy solutions, but mentorship, coaching and sponsorship are action items for those seeking to bridge that 15% gap.

Most of us are familiar with mentorship. Mentorship is a long-term relationship with a more senior person that provides guidance to the mentee about career, work/life integration, research, or anything else that might benefit the mentee. The key to mentorship is that it is a relationship. It requires time and commitment. It is bidirectional, and to be most effective it requires a personal connection or "chemistry". Mentorship often occurs as part of a formal mentorship program; however, many find informal mentors throughout their careers and benefit from having multiple mentors. There is no one correct way to find a mentor or a mentee. More recently, group mentoring has come to the forefront through opportunities like mentoring circles. In these peer-to-peer groups, members of an organization develop and grow together. This group dynamic helps to create networks and build a community-like atmosphere while, at the same time, elevating accountability and creating a safe-space to discuss uncomfortable issues. Group mentoring requires structure and training to ensure that the group meets its goals and objectives. If you would like more mentorship or better mentorship, check out "Making the Most of Mentors: A Guide for Mentees" by Judy Zerzan et al. This book offers some excellent advice, and a checklist which is available free online.[8]

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Even with excellent mentorship, a servicemember may never reach their full potential without opportunity, luck, or that last 15%. This scenario is where sponsorship has proven to be more valuable than mentorship. Sponsorship is pushing people towards opportunities that exist or might exist. This can be done by suggesting a colleague's name in a meeting when an opportunity arises or reaching out to someone who may be a "good fit" for a position and encouraging them to apply. Letters of recommendation or offering authorship on a paper are other ways to sponsor individuals. By cracking open that door, the service member can step through and demonstrate their abilities. The key to sponsorship is that it should be utilized to bolster individuals with demonstrated ability and high potential who either have not been offered opportunities or who don't know how to access them. Often, we ignore emails that list upcoming opportunities because they don't apply to us directly anymore. If we all took a moment to think about others who might benefit from these prospects and opportunities, we could elevate our level of sponsorship. Sponsorship can help us to narrow that remaining 15% gap.

Professional coaching and leadership training has also become quite popular, especially in the realm of burnout prevention and leadership development. Coaching is about active listening and reflective dialogue to help the individual generate actionable solutions and plans on their own. Many training programs are now integrating longitudinal coaching programs into their curriculum, with benefits to include reduction in stress, decreased errors, and improved clinical decision making.[9,10] The GROW coaching model, first developed in the 1980s by business coaches Sir John Whitmore and Alexander Graham, includes 4 steps that can be utilized to cultivate success and growth: Goal, Realities, Options (or Obstacles), and Will (or Way Forward).[11] It is a coaching framework designed to encourage coachees to set goals, navigate obstacles and discover solutions on their own. This is just one of many coaching-centric models that can be employed. If you are interested in finding a professional coach, the military counselors found in Fleet and Family Centers (Navy), Airman and Family Readiness Centers (Air Force), and Army Community Service Centers (Army) are a valuable resource and often have training in coaching. The American Medical Association also has a good introductory webpage on coaching as well with information for both coaches and coachees.[12] Other coaching opportunities may be provided through online courses, workshops, through professional societies or through employee assistance programs.

Much of what is discussed in this article is further explored in the faculty development courses offered by the USUHS Faculty Development team. If you are not familiar with their offerings, be sure to check out the Faculty Development page of the USUHS website.[13] Many of the courses are offered virtually and are applicable to both your personal and professional life (uniformed and civilian). I encourage you to explore this more! We should not allow 15% to be left to chance or luck. By choosing to mentor, sponsor, or coach just one person, you can have a tremendous impact. Let's work together to bridge the gap, reduce disparities in our workforce, and find ways to support others in achieving their career goals.

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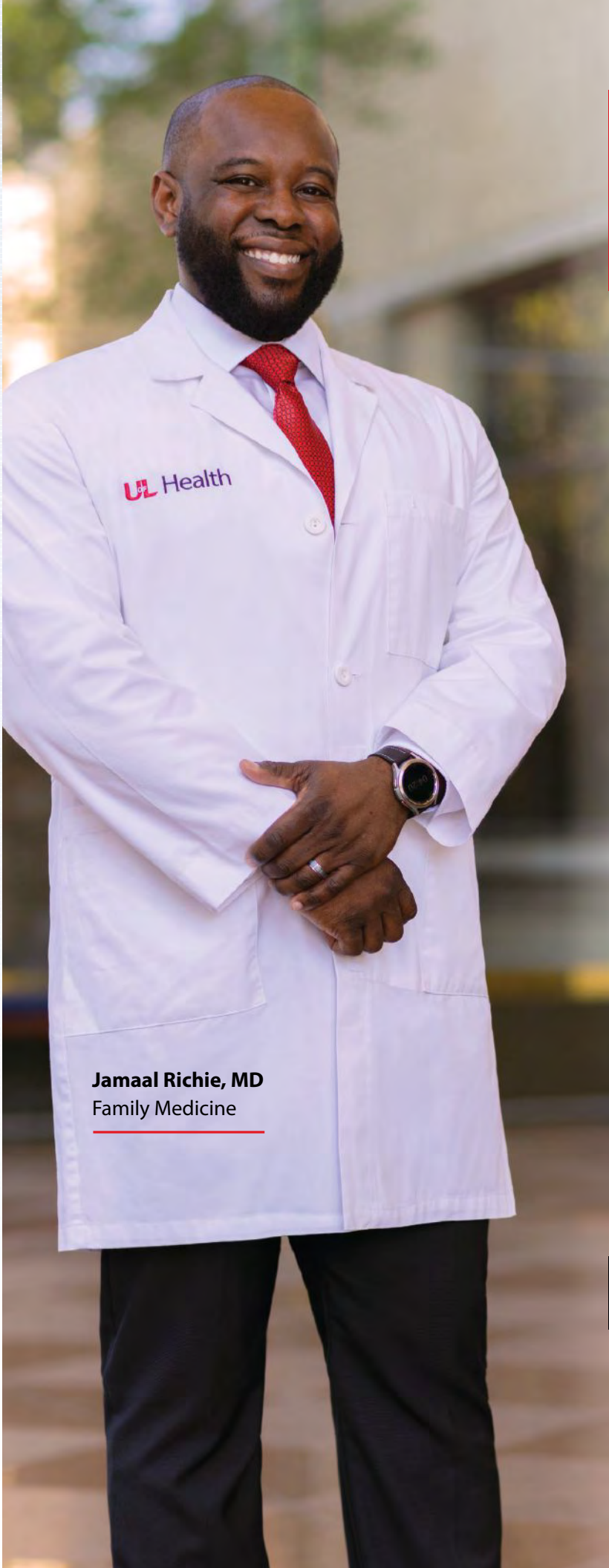

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Family Medicine

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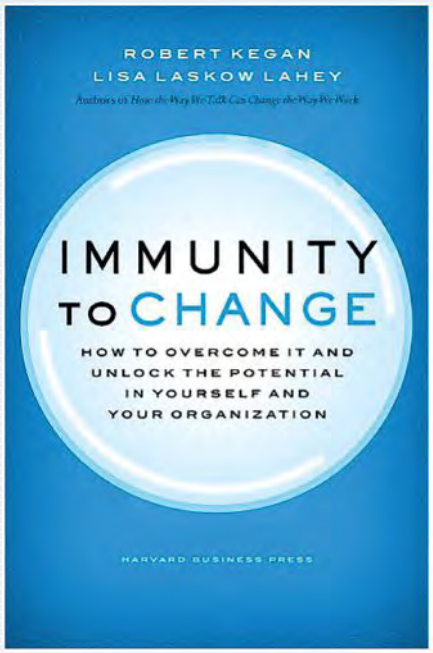
Immunity to Change: Overcoming Personal Barriers to Growth

BY ROBERT KEGAN AND LISA LASKOW LAHEY



When I think back to my time in medical school, one of the most challenging topics to learn was immunology. I was amazed by the complexity of the different pathways and the intricate ways that the body fights disease, remembers disease, and fights it again. In short, what I learned is that the body teaches itself to prevent experiencing difficult things. Harvard Researchers Robert Kegan, Lisa Laskow Lahey, and their team have spent decades studying how our bodies build similar defense mechanisms to change. They even expand their findings to describe how organizations do these same things. The book's main point is that people and organizations are not stifled by fear of change, but more by steadfast mindsets that they have not overcome. The book begins by sharing the results of a research study that showed that when given the ultimatum of death or lifestyle change, many patients still do not change. The authors argue that if life and death can't change people, then motivation and desire to change clearly cannot be the only factors. They define immunity to change as the inability to change because of deep-rooted assumptions and conflicting commitments.

This book investigates the complicated psychology of personal growth and self-improvement. Drawing on their extensive research, experiences in real life, and their time teaching these principles, the authors present a compelling framework to help readers understand and overcome the deeply ingrained barriers that hinder growth. In addition to offering valuable insights into the complexities of human behavior, the team also offers practical strategies that we, as uniformed family physicians, can utilize to help bring transformative change. At the core of this book is the idea that individuals often resist change due to unconscious beliefs and fears. These hidden barriers create a form of immunity to change, preventing individuals and organizations from reaching their potential. The authors introduce the Immunity Map, a powerful tool that they have developed to help readers uncover these hidden barriers by identifying their competing commitments, big assumptions, and internalized core values. By going through this structured process with multiple real-life examples, the book demonstrates how individuals can confront their hidden barriers.

Goal	Behaviors that keep me from my goal	Competing commitments	Big assumptions
Be more direct in expressing both expectations and constructive feedback with my team	I soften the message when sharing my expectations or feedback I agree with or support an initial proposal, only to feel the need to ask for more details later I often don't advise them when they could have handled interpersonal interactions more effectively I don't share constructive feedback for the discomfort this caused me	To be liked To be supportive, and for my team to feel that their boss believes in them To avoid conflict To avoid disagreement To not be "bossy" (though I recognized the irony, given I was actually their boss)	If I share negative feedback, my team will feel that I don't care about them Conflict is bad Being a boss is being bossy, and that is the same as being b****y Being bossy is immodest, and that's one of the worst qualities in the world

Example Immunity Map

This book is divided into three parts. Part one provides new ways to understand change. It outlines the need of transforming your mindset from a socialized mind to a self-authoring mind, and finally self-transforming mind. This is important because our brains can understand, process, and assign meaning in different ways depending on mindset. The socialized mind is heavily influenced by societal norms and values, or in your organization maybe "the way we have

always done things." The self-authoring mindset takes a step back and decides if the underlying principles, beliefs, hidden curriculums, agendas, and other social drivers are representative of the individual or organizational goals. The self-transforming mindset can finally address the limits of existing barriers and make actionable commitments based on new or more clear principles. Part two of the book introduces the research and tools that Kegan and Lahey have developed to help address people and organizations' immunity to change, including the Immunity Map. This section includes multiple personal and organizational examples that many of us can relate too. Part three of the book is very active and helps the reader walk through the process. The experience is very personal and rewarding.

For those of you who are more seasoned and find yourself mentoring, coaching, and sponsoring young officers, this tool is a great way to systematically work through change. Ask your mentee to choose one goal they would like to accomplish. Next have them think through and write down the actions they are doing now to prevent that goal from happening. Then have them reflect and spend some time considering the conscious and subconscious commitments that these behaviors reflect. Finally, ask them to explore the assumptions they make about themselves, the organization, or society that result in them making these competing commitments. This exercise can be truly eye opening for both you and your mentee. For strategic leaders who cannot understand why your organization struggles to make the necessary changes to move forward, practicing this same activity with your leadership team can help as well.

To me, this book stands out for its profound insights into the human psyche and its practical approach to personal transformation. The authors' approach makes the principles applicable to a wide range of readers. The strength of this book lies in its emphasis on reflection in the beginning and then actually guiding the reader through the activity in part three. As we learn more about professional identity formation, it is imperative for us to reflect on how our commitments and assumptions reflect our personal values, the values of the profession of medicine, and the values of the profession of arms, and how these values impact our ability to grow as individuals, as a military, and as a health system.

Promoting Research in the Military Environment

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

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

Photo Courtesy of U.S. Army

Visit us online at
www.usafp.org/research
for resources or to find a mentor.

BRIAN H. NEESE, Col, USAF, MC, FS
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In this series, the Operational Medicine Committee will highlight Uniformed Family Physicians who have served in operational assignments.

International Health Specialist

1. TELL ME ABOUT YOUR CURRENT ASSIGNMENT, UNIT, AND PREVIOUS OPERATIONAL JOBS.

My current job is Air Forces Southern (AFSOUTH) Command Surgeon. Our mission is to engage with Partner Nation military medical personnel to advance Security Cooperation interests, goals, and objectives in Latin America. We plan and execute a number of readiness training exercises for Air Force (and joint) medics where they deliver healthcare in austere environments throughout Central and South America, as well as the Caribbean. We also work with Partner Nation military medical organizations and personnel to increase capacity in various aeromedical related areas (Flight Medicine, Operational Medicine, Aeromedical Evacuation, CCATT, etc.). Finally, we provide medical support for Detainee Movement Operations out of Guantanamo Bay (GTMO), Cuba.

Previously, I was on staff here as an International Health Specialist (IHS) from 2011-2015. Other jobs I've held have not been operational (Staff Family Physician, Medical Operations Squadron CC, IHS Liaison Officer at SAF/IA – Pentagon), Command Surgeon at National Defense University/Student at Eisenhower School, and Dep Director at 81 MDG (Keesler). I have had many short "deployments" into Latin America leading the types of missions referenced above, including serving as Expeditionary Medical Operations Squadron CC during the New Horizons 2018 training exercise in Panama. I also served 1-year deployed as the 380th Medical Group Commander at Al Dhafra AB, in the United Arab Emirates.

2. WHAT KIND OF TRAINING AND PREPARATION DID YOU HAVE TO DO?

Training and preparation for IHS missions includes lots of CBTs (IHS Program office manages a lot of them) that cover topics such as SOUTHCOM AOR Familiarization, Cross Cultural Competency, and Air Advisor training. There are also in resident courses such as the UN Humanitarian Civil-Military Course (UN-CMCoord), the Humanitarian Assistance Response Training Course (HART), the

Expeditionary Medical Support-Health Response Team (EMEDS-HRT), Battlefield Airmen Training-Bridge Course, Combat Casualty Care Course, and Emergency War Surgery. While on Component/Numbered Air Force HQ staffs, I have done Air Force Forces (AFFOR) Intermediate Staff Course, various Security Cooperation courses (through the Defense Security Cooperation Agency) such as the Security Cooperation Management Action Officer Course and the International Programs Security Requirements Course. As a leader in the Air Force Medical Service, I have done courses such as the AF Executive Skills Course. In support of Healthcare Recruiters, I completed the AF Recruiting Service Health Professions Physician Liaison Workshop.

As an IHS member, I have had to focus on my language training over the years as well. This has included participating in the Language Enabled Airmen Program (LEAP). Through the LEAP, I have participated in lots of online courses for Spanish, Portuguese, and Hebrew. I have also completed Language Immersion Training Events (LITE) in Brazil and Israel. LITEs are 3-4 week immersion experiences in foreign countries. During a LITE, participants study in formal language classes usually for a half day each day. Then, participants will spend the afternoons and evenings immersing and engaging in the local language and culture. If you are reading that line and thinking that sounds crazy, there is no way the Air Force does something like that, just google "LEAP LITE" and see it for yourself! (NOTE, the LEAP program enhances foreign language capability, it does not develop it from scratch. If you have a Defense Language Proficiency Test score of at least 1/1 or higher, you are probably competitive to join the program.)

3. WHAT ARE SOME OF THE REWARDING AND CHALLENGING ASPECTS OF YOUR JOB?

I am living squarely in the world of Plans and the Planning Enterprise (i.e., how to deploy personnel and equipment in support of a war effort). That is tough because none of my background is in planning. But it's fun to learn new things! The other world I live in here, and have for much of my career, is Security Cooperation. This involves building relationships with a wide variety of stakeholders, to leverage creativity, imagination, and vision to create effects. We also use cultural and foreign language skills to engage with our partners. All of this is done to advance the Combatant Commander's Security Cooperation goals and objectives. This all requires effort and learning, but in the end is extremely rewarding.

4. TELL ME ABOUT A UNIQUE EXPERIENCE(S) YOU HAD IN YOUR POSITION

I think leading the medical team during New Horizons 2018 in Panama was the highlight of my career. It was the most operationally challenging environment I have ever been in. Each day I was working with our military medics, logisticians, Joint Task Force leadership, reachback headquarters staff, other stakeholder military organizations, local civilian healthcare authorities (National and Regional Ministry of Health, hospital directors), and even local politicians and police forces. Much of that was done in Spanish, on foreign soil surrounded by a foreign culture. It was awesome!

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5. HOW DID YOU FEEL YOUR FAMILY MEDICINE TRAINING PREPARED YOU FOR OPERATIONAL MEDICINE?

My Family Medicine training was in the civilian world (med school and residency). In the Air Force, I was given an opportunity while a Staff Physician to deploy on a New Horizons mission to the Dominican Republic. This mission opened my eyes to the world of Security Cooperation, altering forever the course of my career. I was fortunate to be trained in a field (Family Medicine) that touches on every aspect of individual, and even population health. It is that sweeping exposure and perspective that made me, as it does all Family Medicine physicians, able to operate in dynamic, unique, and austere environments.

This is why I push to get Family Medicine doctors, especially our young residents, down on our AFSOUTH missions. In fact, we have spent the past year building plans to send Family Medicine faculty and residents down regularly into Central and South America. I want to see them go and integrate into hospitals in Jamaica, Colombia, and Peru. There they will be forced to operate in technology austere or otherwise resource constrained environments, while working through challenging cross-cultural divides. Embracing and overcoming these challenges in a relatively safe environment will prepare our doctors to execute the Air Force's new Agile Combat Employment concept of operation – a concept key to the future war fight.

6. WHAT ADVICE DO YOU HAVE FOR THOSE WANTING TO GO INTO AN OPERATIONAL POSITION?

Find your interest or niche and go for it. Consider getting your Flight Surgeon wings. This will open up a world of mission opportunities and experiences which are complementary to Family Medicine skills, interests, and practices. One assignment doing operational medicine will illuminate for you what the Air Force organization seeks to accomplish, how it prepares and presents forces to accomplish those objectives, and how it builds plans to apply capabilities to Fly, Fight, and Win. All of this will enrich your service experience, make you a better officer, and deepen your appreciation for an Air Force career.

consultant's report
COAST GUARD/PUBLIC HEALTH SERVICE

Philip A. Wixom, MD
USCG Air Station Sacramento Clinic
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Hello, PHS and Coast Guard family medicine colleagues. As 2023 comes to a close, we may find ourselves reflecting on the past year and all that was accomplished. The end of the year also serves as an invitation to turn our thoughts to the upcoming year to consider our continuing and/or new plans and goals.

For the Commissioned Corps, the end of the year also brings with it the annual COER and promotion package season. Here are a couple of relevant updates:

- COER: Link to process changes for 2023 - https://dcp.psc.gov/ccmis/COER/COER_Changes_m.aspx A couple of highlights:
  - For all users, the Officer Concurrence stage now occurs after the Rater and Reviewing Official stages rather than in-between those stages as in years past.
  - For Raters, each Rater comment box that accompanies a numerical score will now have a minimum character count of 100 characters.
- Promotion: Promotion year 24 introduces significant changes and I encourage all to become familiar with the updates at this link: https://dcp.psc.gov/ccmis/promotions/Promotions_Updates.aspx Of note:
  - Members will have their temporary grade converted to the equivalent permanent grade as temporary grade promotion is discontinued (except for flag grades).
  - Promotion eligibility is slightly altered to reflect the conversion to permanent grades.
  - Promotion zones are being introduced.

One the operational side, USCG and PHS continue to support Operation Vigilant Shield (OVS) off of the coast of south Florida with continuous deployments of medical providers and staff as well as remote personnel in support of the Coast Guard's mission to respond to illegal maritime migration in the region. Medical personnel are providing medical care, including mental health care – to migrants as well as operators. This is an ongoing mission and is in addition to many other provider deployments and movements.

In closing, I hope that 2023 has been a rewarding and productive year. I also invite you to look forward to 2024, including the USAFP annual meeting taking place March 23-28 in New Orleans; increased PHS representation at that meeting would be fantastic. Best wishes for a wonderful festive season and may the end of the year and new year bring peace.

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.

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 these outstanding awards, please send a letter of support to Matt Schulte (mschulte@vafp.org) no later than 1 February 2024.

For more information, please scan the code.

2023 AAFP Congress of Delegates

LEADERS ELECTED, RESOLUTIONS DEBATED AND A NEW NOMINATING COMMITTEE CREATED

The AAFP Congress of Delegates was held 24-27 October in Chicago, Illinois. The USAFP was well represented by Past Presidents Drs. Aaron Saguil and Marcus Alexander who served as Delegates and USAFP President Kevin Bernstein, MD and USAFP Past President Deb Manning, MD who served as Alternate Delegates. The USAFP was also represented on a national level by USAFP Membership and Member Services Committee Co-Chair Eileen Tatum, MD and USAFP member Sterling Brodniak, DO who served the Congress as Member Constituency Alternate Delegates.

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

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

Jen Brull, MD Fort Collins, CO - President-Elect
Russell Kohl, MD Stilwell, KS - Speaker of the Congress
Daron Gersch, MD Avon, MN - Vice Speaker
Sarah Sams, MD Columbus, OH - Director
Brent Smith, MD Cleveland, MS - Director
Jeffrey Zavala, MD Billings, MT - Director
Matthew Adkins, DO Columbus, OH - New Physician Board Member
Janet Mwaukoni, DO Lake Forest, IL - Resident Board Member
Taree Chadwick Reno, NV - Student Board Member

2022-23 AAFP President Tochi Iroku-Malize, MD Long Island, NY, assumed the role of AAFP Board Chair and Steven Furr, MD Jackson, AL, was installed as Academy President.

USAFP Delegation – AAFP Member Constituencies Alternate Delegate Sterling L. Brodniak, DO, MBA, FAAFP; AAFP Member Constituencies Alternate Delegate Eileen D. Tatum, MD; USAFP Executive Director Mary Lindsay White, MHA; USAFP Past President and Delegate Aaron Saguil, MD, MPH, FAAFP; USAFP Past President and Delegate Marcus Alexander, MD; USAFP Past President and Alternate Delegate Debra A. Manning, MD, FAAFP; and USAFP President and Alternate Delegate Kevin M. Bernstein, MD, MMS, FAAFP

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

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

During the meeting (held prior to AAFP FMX), the Congress of Delegates agenda included addresses from AAFP officers, resolutions from chapters, and reports from the Board of Directors. The Delegates and Alternates representing the AAFP constituent chapters, and the member constituencies reviewed 45 resolutions in reference committees. The wide array of topics included administrative burden/prior authorization, primary care investment, health system reform, insurance plan participation, scope of practice, reproductive health related issues, and billing and coding policies just to name a few.

The most debated topic of the Congress was around the recommendation to create a Nominating Committee to identify future AAFP leaders. Having passed the congress, this new committee will focus on building a slate of candidates for AAFP president-elect, speaker, vice speaker and at-large Board members each year with the skills and background to meet the changing needs of family medicine. Previously, candidates for these positions were nominated by their chapters under rules that varied between chapters.

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

https://www.aafp.org/about/congress-delegates/2023.html

VETERANS
HEALTH AND WELLNESS FOUNDATION

PROSTATE CANCER
CME ACTIVITY

Addressing Health Care Disparities and Improving Patient Outcomes in Prostate Cancer: Expert Perspectives on Optimizing ADT

Prostate cancer is the leading cause of cancer and the second leading cause of cancer death in men in the United States. Among prostate cancer patients, Veterans and black men are two populations at a substantially greater risk to experience worse outcomes due to inequities in care.

Medical androgen deprivation therapy (ADT) is the standard of care for advanced prostate cancer management but may be associated with a broad range of adverse effects. Of these, increased risk of cardiovascular (CV) events is among the most serious, as CV disease is the most common non-cancer cause of death in patients with prostate cancer.

Developed for urologists, oncologists, and radiation oncologists, this educational activity will use patient scenarios to address disparities in the management of US Veterans and Black men with advanced prostate cancer and implement recommendations when assessing CV risk factors and selecting ADT.

Faculty

Alicia K. Morgans, MD, MPH
Genitourinary Medical Oncologist
Dana-Farber Cancer Institute
Boston, Massachusetts

Neal Shore, MD, FACS
Chief Medical Officer
Urology/Surgical Oncology, GenesisCare
Myrtle Beach, South Carolina

For information about continuing education credit that will be available, please contact RedMedEd at 610.251.6841 or education@redmeded.com.

Support for this activity has been provided through an educational grant from Pfizer Inc. and Myovant Sciences Ltd.

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USAFP Committees

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

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Valley Medical Center is an acute care hospital and clinic network committed to providing safe, quality, compassionate care since 1947, and is a component entity of UW Medicine.

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- Oldest and largest public district hospital in Washington state
- Serves 600,000+ residents in one of the nation's most culturally diverse communities
- Thriving medical center and the largest nonprofit healthcare provider between Seattle and Tacoma
- Dedicated to our mission of "Caring for our community like family," including our "work family"
- Safety is our core value, with respect, compassion, collaboration, equity, diversity, inclusion, innovation, wellness and excellence as some of our most important priorities

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- Primary care clinics in Covington, Kent, Maple Valley, Newcastle and Renton serve as a medical home for care management
- Urgent care clinics provide a safety net of after-hours care, including telehealth and walk-in consult
- 50+ specialty clinics provide access throughout the district

Qualifications

- BE/BC in family medicine/internal medicine
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  - Medical professional license in Washington state
  - DEA with full prescriptive authority

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- Competitive salary, generous vacation and sick leave, relocation assistance, public student loan forgiveness program participation, and valuable healthy living benefits—learn more at **valleymed.org/careers/benefits**
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- **American Medical Association's 2022 Joy in Medicine Health System Recognition Program** for our efforts to improve physician well-being and combat burnout
- **The Joint Commission's** award of full accreditation triennially for meeting and exceeding national and safety performance standards

"I truly think that every single person on the care team and administration bring value to the team and really are working together to make sure that we deliver care the best that we can to our patients in our community."

Dr. Shannon Markegard, DO

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Provider Recruiter

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