THE UNIFORMED FAMILY PHYSICIAN

Spring 2024 ▪ Vol. 15 ▪ Num. 1 ▪ Ed. 67

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INSTALLED AS
2024-2025 USAFP PRESIDENT

SEE PAGE 10

Journal of The Uniformed Services Academy of Family Physicians

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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 67

your academy leaders
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president's message

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Greetings Family Medicine Colleagues!

I'm writing this after an incredible meeting in New Orleans. I am full of gratitude to the USAFP Staff, Drs. Sadler and McDermott, and Dr. Bernstein for putting on an outstanding meeting and for their last-minute preparation to flex in the event of a government shutdown. It was wonderful to connect in person, learn from each other, and hear from the leaders in military family medicine (that's all of us)! I am humbled to serve as your President this year. I'd like to share some of my speech from the installation lunch with you.

It is so special to be together as we embark on the 50th year of USAFP. There is no better time for reflection as an organization and individuals. Looking back, we will document our history with the help of the newly minted USAFP foundation. Looking ahead, our current and future members will be the ones writing the next chapter in USAFP's history and I can't wait to see the incredible things you will do.

As Uniformed Family Physicians, we carry the tremendous responsibility of caring for those who serve or have served our country as well as their loved ones. Your dedication and commitment to providing quality healthcare is truly commendable and I'm proud to be in your midst. The leadership exhibited by each of you at all levels is inspiring. During our demanding and often challenging work, it's essential to remember the importance of finding joy in what we do. Our dual profession as family physicians and officers is more than treating illness, injuries, and turning a readiness slide green, it's about making a positive difference in people's lives, providing comfort, and fostering hope. USAFP's mission is ***to support and develop Uniformed Family Physicians as we advance joint readiness, health and wellness through education, scholarship, advocacy, and leadership.*** Our Academy does this through 7 goals, and today I'd like to focus on the 7th goal of our chapter which is Wellness and Resiliency: **to assist members in achieving well-being to enjoy meaningful work-life integration.**

My message today falls within this 7th goal, and I will consolidate it into 3 words: FIND YOUR JOY.

Brené Brown defines joy in *Atlas of the Heart* as an intense feeling of deep spiritual connection, pleasure, and appreciation.[1] It's often sudden, unexpected, short-lasting and high-intensity. It's characterized by a connection with others, or with God, nature, or the universe. Joy expands our thinking and attention, and it fills us with a sense of freedom and abandon. Brené's research describes the relationship between joy and gratitude as an "intriguing upward spiral." The upward spiral goes like this:

- Trait gratitude predicts future experiences of in-the-moment joy
- Trait joy predicts greater future experiences of in-the-moment gratitude
- And dispositional or situational joy predicts greater future subjective well-being.
- **It all just spirals up**

I am not a coach or a spiritual leader, but I believe that if we can cultivate this in our personal and professional lives, we will be in a better position to achieve the other 6 goals of our academy, because as Brene says, ***it all just spirals up.***

I do not want to minimize adversity or challenges. My message is not one of toxic positivity or looking at hardship through rose-colored glasses. In the Book of Joy: Lasting Happiness in a Changing World, the author writes of the Dalai Lama and Archbishop Desmond Tutu's week together. It notes, "Their courage, resilience, and hope in humanity inspire millions as they refuse to give in to the fashionable cynicism that risks engulfing us. Their joy is clearly not easy or superficial but one burnished by the fire of adversity,

continued on page 6

continued from page 5

oppression, and struggle. The Dalai Lama and the Archbishop remind us that joy is in fact our birthright and even more fundamental than happiness."[2]

I have the great privilege of interviewing medical students for residency training. I love hearing why they chose Family Medicine in the military. The stories of connection with patients and the profound impact they have on the student often spark a deep sense of purpose. For many, I am inspired and feel joy myself as I hear them recount their experiences.

So, how do we find joy in our work, especially when we leave here, amid busy schedules and high-stress, high-stakes environments where we uniformed family physicians find ourselves?

- Celebrate the small victories. We are all here at a meeting with record attendance & a record # of family members & medical students despite a very real threat of a government shut down. Medicine is often characterized by its challenges and complexities, but every day brings moments of success and progress. Whether it's helping a patient overcome a health obstacle, witnessing a family's gratitude, or simply making someone smile, take the time to acknowledge and appreciate these moments of joy. Before I left to come here, I called a 90-year-old patient who I knew would be on the phone with me for a long time. At the end of the call, she told me she loved me. It was pure, it was unexpected, it was joy, it made the phone call worth it.
- Savor individual moments. A sunrise from the hospital parking lot. A really good workout. Perhaps you're a retiree who's able to go to the commissary during a time that used to be work hours! Listening to music. Connecting with a friend or sharing a meal. A snuggle from a pet or a child. A warm cup of coffee.
- Consider a gratitude practice – individually and with your teams.
- Take care of yourself! As physicians, it's easy to prioritize the needs of others above our own. However, taking care of ourselves is essential for maintaining our passion for medicine. Make time for activities that bring you joy outside of work, prioritize your physical and mental well-being, and seek support when needed.
- Lastly, do what we do best as Uniformed Family Physicians: focus on human connection. In our increasingly digital and fast-paced world, the personal side is more important than ever. **Mentor someone and find a mentor yourself.** Take the time to listen (not just to patients, but to one another), understand concerns, and empathize with their experiences.

As we plan our 50th Annual Meeting, I ask each of you to consider what brings you JOY in your work. I ask you to share that with someone. Mentor someone. Lead someone. Find your joy. Be a part of making the next 50 years of USAFP the best it has ever seen. It all just spirals up.

1. Brown, B. *Atlas of the Heart: Mapping Meaningful Connection and the Language of Human Experience* Random House Publishing Group, 2021.
2. Bstan-'dzin-rgya-mtsho., Tutu, D., & Abrams, D. C. *The Book of Joy: Lasting Happiness in a Changing World.* New York, Random House, 2016.

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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/**

Hello USAFP Family,

I hope that you, like me, feel reinvigorated after this year's record-breaking, fun, and learning-filled USAFP Annual Meeting. I would like to recognize the incredible showing of Family Medicine physicians, residents, medical students, and spouses who helped make this conference so special. I applaud our Past President, Dr. Bernstein, the 2024 Co-Chairs, Drs. Sadler and McDermott, and the USAFP staff for bringing New Orleans to life and continuing a long tradition of excellent learning, connection, and inspiration. Thank you to our visionary President, Dr. Mimi Raleigh, for her poignant message to us all in her installation speech.

This year, I am honored to write to you as your Vice President and Editor for the USAFP Newsletter. It is a privilege to represent my found family and to give back to an organization that has inspired many military medical officers, leaders, and budding researchers. I am profoundly grateful to the preceding editors who strove to make this newsletter an inspirational trove of military family medicine articles. As I reflect on my journey, I am especially grateful to Seales Team 1, Dr. Paul Seales, for his love, friendship, and confidence through medical school, residency, deployments, and billets.

I find that this year, I am at a crossroads. This conclusion was spurred, quite possibly, by my sons' development from calling me "Mommy" to "Bro!" (exclamation point included)[1] and marveling at their unique generation. Like many folks, I have entered a phase surpassing nervous resident or "*apprentice*" standing on stage for research, but not yet the wise and experienced leader like those I look up to. Even as a military officer, I am in the middle, and there is a runway behind me and ahead of me. Like any apprentice following a path toward mastery, all of us reach this *journeywoman* status with much hand-holding and leaps of faith. However, this stage also bridges the gap between the apprentice's fresh take on issues and the master leader's steadying wisdom.

We know that the institution of military medicine is evolving. With humility, engagement, and acknowledgment of the gaps in our armor,[2] we have the chance to be part of solutions in a way that bridges our historic past and our future potential. As we map out new frontiers in medicine and society, I encourage us all to be good listeners who seek to understand, as well as brave, visionary navigators who chart the course and channel the joy that drew us to military family medicine.

With gratitude,

Jules

1. To this I respond with "Sis!" (exclamation point included)
2. Rosenbaum L. On Calling — From Privileged Professionals to Cogs of Capitalism? The New England Journal of Medicine. 2024;390(5):471-475. doi:10.1056/NEJMms2308226

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3. ENGAGE, IF NEEDED, WITH AUTHORS DURING THE REVIEW AND REVISION PROCESS.

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NEWSLETTER SUBMISSION DEADLINE

REMINDER: The deadline for submissions to the Summer magazine is 8 July 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*.

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Meghan "Mimi" Raleigh, MD, FAAFP Installed as 2024-2025 USAFP President

Over 500 attendees took part in the 2024 Installation of USAFP Officers and Directors on March 2024 at the New Orleans Marriott in New Orleans, Louisiana. USAFP Past President Jeannette South-Paul MD, FAAFP installed 2024-2025 USAFP President Meghan "Mimi" Raleigh, MD, FAAFP and the other Officers and Directors of the USAFP Board of Directors during the luncheon.

Meghan "Mimi" Raleigh, MD, FAAFP being installed as 2024-2025 USAFP President.

Dr. South-Paul installed the 2024-2025 USAFP Board of Directors

Pictured left to right are Meghan Raab, HPSP Student Director; Clare Kinsela, USU Student Director; Joshua P. Law, MD, Army Resident Director; Ross C. Stanton, MD, JD, MPH, Air Force Resident Director; Roselyn W. Clemente-Fuentes, MD, Air Force Director; Jeanmarie "Gigi" Rey, MD, FAAFP, President-Elect; S. "Jules" Seales, MD, FAAFP, Vice President; Elyse F. Pierre, MD, FAAFP, Army Director; Kerry P. Sadler, MD, FAAFP, Navy Director; Tegan N. Koski, MD, Navy Resident Director

2024-2025 USAFP President Meghan "Mimi" Raleigh, MD, FAAFP presents USAFP 2023-2024 President Kevin M. Berstein, MD, MMS, FAAFP with the outgoing President's plaque.

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2024 Annual Meeting & Exposition

Over 650 were in attendance at the USAFP 2024 Annual Meeting held in New Orleans, Louisiana in March! The photos and comments show the success of the conference!

- I look forward to USAFP each year as a time to learn, socialize, and recharge my wellness battery.
- Excellent meeting! Congrats to the co-chairs and USAFP staff for another job very well done!
- The All Attendee second line march to dinner was incredible!!
- Wonderful conference as always! This is consistently one of the best CME events I attend, and I always look forward to updating my practice based on pearls learned at the meeting.
- This was the best USAFP that I've attended in my 14 years in family medicine.
- Always my favorite! Can't beat the lectures, research, and CME topics.
- Thank you for a phenomenal meeting. We have the best staff in the AAFP!
- Outstanding CME week, but also great chance to catch up with colleagues.
- I've gone to a lot of conferences over the years, and by far this was my favorite one. Not only was there a great showing in terms of number of registrants, but the inclusivity of families and retirees made for a great event. I also love New Orleans as the destination - a great combination of fun events for young families, young people, and mid and senior officers. Well done!
- Thank you for a wonderful meeting! I was feeling down/burned out in my job and isolated away from a GME program…then this week reminded me of the joy of learning, the presence of my community that loves/supports me, and why I became a Family Physician!
- This is one of the best conferences I have attended. It was well planned and executed. The hotel was amazing. The food was excellent, and the availability of food, coffee and water was abundant. The personal service by the hotel staff was the best!
- Great meeting as usual. Well organized and smoothly run. Good food and comradeship


What's New in Cardiovascular Disease Prevention in 2024?


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A Special Thank You To Those Who Donated to Support Medical Student Attendance at this Year's Annual Meeting

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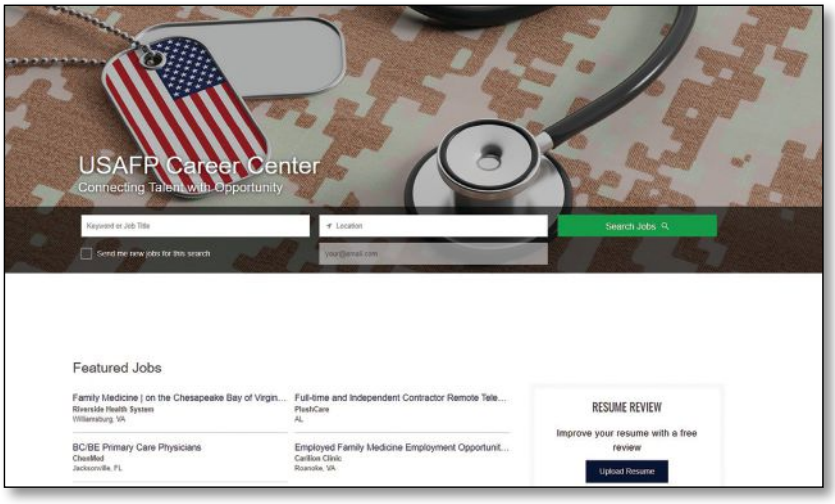
USAFP Career Center

Your Hub for Physician Employment Opportunities Across the Country



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

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

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

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

USAFP 2024 Academy Awards

Michael J. Scotti, MD, Family Physician of the Year Award
Michael L. Place, MD
MG (ret), USA, MC

Dr. Place's award reads: "In sincere recognition and deep appreciation for your invaluable contributions to Military Family Medicine, leadership, professional development, patient care, operational medicine, and the Uniformed Services Academy of Family Physicians. As Chief of Staff and Deputy Commanding General (Support) of US Army Medical Command & Office of the Surgeon General during a time of MHS transformation, you remained a humble servant leader continually striving to shape a positive and professional work environment. You remained grounded while in leadership positions by spending hundreds of hours to develop Soldiers into leaders through mentoring, coaching, and sage career advice in both formal and informal settings. Your advocacy for graduate medical education and specialty training, to protect and grow the pipeline for Military Family Medicine while role modeling through your positions as Regimental Surgeon, AMEDD Career Course director, Division Surgeon, Command Surgeon, and multiple levels of Command, while providing compassionate, comprehensive medical care is what it truly means to be a military family physician."

Congratulations Dr. Place!

Operational Medicine Award
Scott A. Stafford, MD
Lt Col, USAF, MC, FS

Dr. Stafford's award reads: "In recognition of your outstanding leadership and selfless dedication to Air Force Special Tactics while serving as Group Surgeon for the 720th Special Tactics Group at Hurlburt Field, FL. Your commitment to the operational medicine community epitomizes the best of our family medicine physicians that directly support the Air Force Special Operations Command and the Air Force Special Warfare community. Sustaining superior performance and achieving outstanding accomplishments over the course of your distinguished career in both clinical and operational medicine is unparalleled. You reflect great credit on what it means to be an exceptional operational military officer, the specialty of family medicine and the Uniformed Family Physician."

Congratulations Dr. Stafford!

President's Award
Robert C. Oh, MD, MPH, FAAFP
COL(ret), MC, USA

Dr. Oh's award reads: "In sincere appreciation for your dedication and service as Chair of the USAFP Clinical Investigations Committee. During your tenure, research submissions increased 39%; research venues expanded including the new Emerging Scholars Program; the 2.0 Poster Design for the juried competition was implemented; Rise with Research accommodates 60 additional research presentations annually; and the Omnibus Survey continually serves our membership's assessment need. Your commitment to advancing research is to be commended and congratulated as an enduring legacy for the Uniformed Services Academy of Family Physicians."

Congratulations Dr. Oh!

President's Awards
Kerry P. Sadler MD, FAAFP, LCDR, MC, USN and Andrew J. McDermott, MD, FAAFP, CDR, MC, USN

Their award reads: "In recognition and deep appreciation for your outstanding leadership associated with conceptualizing and executing the 2024 USAFP Annual Meeting & Exposition. Your innovative, comprehensive, and dynamic program focused on the theme "Foundational. Relevant. Family" exceeded the educational needs of the USAFP's diverse membership. Through your tireless efforts, you have helped your friends and colleagues in all services to grow professionally as clinicians and leaders."

Congratulations Drs. Sadler & McDermott!

President's Award
Jason M. Valadao MD, MA
CDR, MC, USN

Dr. Valadao's award reads: "In recognition and deep appreciation for your support, leadership, and peer mentoring throughout the years. You frequently "held down the fort" at the United States Naval Academy making it possible for me to serve the AAFP, AMA, and the USAFP to advocate for our patients, our communities, our colleagues, and to advance Family Medicine. I am forever grateful and offer my sincerest gratitude for your continuing friendship, most valued partnership, and sincere understanding."

Congratulations Dr. Valadao!

USAFP 2024 Annual Meeting Report

Kerry P. Sadler, MD, FAAFP
Naval Hospital Jacksonville, FL
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Andrew J. McDermott, MD, FAAFP
Naval Hospital GITMO
andrew.j.mcdermott@gmail.com

Hello USAFP Family!

Wow. We're still catching our breath from an incredible Annual Meeting. We came in with the goal of making the meeting "Foundational. Relevant. Family." We did that…and then some.

Thank you to all the attendees, the leaders who pushed to make sure we had as many people attend as possible, and the folks who held down the fort back home so we could make this happen.

In total:
683 Attendees (a record)
153 Residents
61 Spouses/Guests
52 Students

With top-notch Keynote speakers, a gigantic research presence, great lectures… great food, great company, great networking, and great mentoring. We celebrated family, celebrated togetherness, and celebrated a commitment to maintaining Family Medicine as the best specialty. Oh yeah, throw in an awesome Second Line March to the best All-Attendee Party ever (we're biased).

The new 2025 logo is already up on the website. As your new Co-Chairs, Kat and Matt, rally us as USAFP "Goes All In," our parting words to you are: continue to lead from the front. Continue to advocate. Continue to make this Annual Meeting a requirement. So much of what we do is the foundation of military medicine, with our relevance more important than ever., Our community must go all in, moving forward. It was an honor to serve as your Co-chairs and NOLA will always hold a special place in our hearts. À tout de suite!

Kerry and Andy

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consultant's report
NAVY

Michael J. Arnold, MD, FAAFP
Naval Undersea Medicine Institute
michael.j.arnold4.mil@health.mil

Greetings, Navy Family Medicine colleagues! It was so great to see so many of you at the USAFP Meeting! By the time you read this, I expect that the promotion boards will all be over and we'll be awaiting results.

DHA IS WORKING TO MAKE THINGS BETTER IN MTFS

LTG Crosland came back to USAFP for the second year in a row as the DHA Director. She remains committed to her vision of using technology to reduce the administrative burdens on provider teams. These changes are being introduced in incubator programs in Jacksonville and San Diego. Interestingly, models that focus on our ability to take care of patients without looking at availability or appointments are coming back. She took many hard questions and freely acknowledged that her message does not always match some of the messages we are getting from senior leaders who work for her. She let us know that she sees our staffing issues and she is on it.

USAFP NAVY MEDICINE BREAKOUT – RDML (SEL) BROWN

Our USAFP Navy breakout featured the first Navy Family Medicine physician promoted to flag rank in a decade, RDML (sel) Kevin Brown, who currently serves as commander of Naval Medical Center Camp Lejeune.

Dr. Brown talked about how FM is a critical wartime specialty and the "Swiss Army Knife" that Navy Medicine relies on. During our preparation for the next war, the Navy is going to need Family Medicine physicians who are ready to provide prolonged care in environments with limited resources. He then responded to many questions, a summary of which was sent to the Navy FM distribution email group. If you did not receive this summary, just reach out to me and I'll resend it.

CONUS MTF STAFFING

As you all know, staffing our MTFs is just getting more challenging. We are officially staffed to 83% of what we are supposed to be at according to how BUMED tracks it. In summary, we are 403 Navy FM physicians, with 84 of us in FM operational billets and 125 of us serving in non-FM tagged billets – Flight, UMO, Exec Med and billets labeled with other specialties. While 194 of us serve in MTF billets, 78 of us are OCONUS and 33 are in residency programs, so there are only 83 of us left to cover all the CONUS MTF billets outside a residency program.

While this pattern is seen throughout the Navy Medical Corps, the size and ubiquity of Family Medicine make the problem more acute. Navy Medicine has long struggled with General Surgeons and Anesthesiologists, but this year the gaps in Family Medicine will eclipse both.

This is the major point I am making to the Corps Chief office, and they recognize the issue. We saw a change in bonuses, and we are working to improve the culture in the MTFs. The Navy does some things great – annual leave, parental leave, and co-location policies. We need to ensure the working environment in our MTFs matches these policies.

NOTE FROM RDML (SEL) BROWN

Greetings Family Medicine colleagues!

It was great to see so many of my shipmates at USAFP, where it really was like coming home. I appreciated the chance to share the Surgeon General's North Star for Navy Medicine and his four Lines of Effort as we continue to develop and deliver a Maritime Medical Force to support global competition, crisis, and combat. Thank you for your active engagement during the breakout session—keep the questions coming and lean in to be part of the solution for hard problems.

I am honored by the opportunity to continue to serve with you as I transition to my next role. We have many challenges in the next few years, and I am thrilled to be on your team as we face them together.

Kevin Brown, MD

DETAILER UPDATES

Greetings Navy Family Medicine Community!

I regret that I was not able to make the Annual Meeting in New Orleans. As I write this, I'm still waiting to PCS to Millington to take over as your detailer. I know that CAPTs Frame and Arnold talked to many of you. We will publish my new email address after I check-in.

The 2025 detailing process will begin soon so be on the lookout for key opportunities included in Dr. Arnold's emails. The BUMED Milestone and Command screening opportunities are published with applications due on 15 June. I encourage senior FM physicians to apply – we need your leadership!

Most of my work will be with Family Medicine and Non-Specialty Specific opportunities. This summer, I will send ranking lists and the non-specialty specific billet opportunities for anyone with a PCS in 2025. In the fall, I will start putting orders in once I have seen everyone's input for their next duty station although I will wait until late fall for anyone applying to a BUMED Milestone, Command screen or non-specialty specific opportunity.

As we start the 2025 detailing cycle, please remember that operational billets will continue to be the top priority followed by OCONUS and then CONUS duty stations. If you have not been in an operational billet (Fleet or Fleet Marine Forces), I strongly encourage you to look at these opportunities to learn about the Navy you serve in and get a refresh from the Military Treatment Facility. It is extremely important for your leadership and promotion to be able to successfully navigate in both environments.

John Ewing, DO

PROMOTIONS – NEVER LOOKING BETTER

There are several reasons that promotions will continue to be better this year:

1. Staffing – When there are fewer physicians, promotion rates go up and zones come faster. We lost a lot of above-zone folks, so it's a great time to be in-zone. There are also fewer above-zone people compared to previous years. Watch the zones over the next few years – promotion opportunities could come sooner than you think.
2. Rule Changes – First, any officer getting out of the Navy in the next several months is taken out of the pool for in-zone promotions. We have also been granted the ability to take the LCDR in-zone promotion rate up to 99%.
3. Promotion Rates – Promotion Rates are as high as they have ever been – 90% for O-5 and 95% for O-6 – although this is the in-zone percentage.
4. One-of-One Fitreps Valued – One of the traditional issues with operational tours is that the 1-of-1 Fitness Reports common in operational jobs were difficult to compare to the MTF physician with the clear breakouts among peers. The Board Precept letters have been saying that they value operational tours despite 1-of-1 Fitreps, and I've seen more and more promotions of primarily operational colleagues. Soft breakouts are essential and line COs tend to be outstanding at this.

In the next issue, I hope to share real promotion data that confirm my optimistic assessment.

BONUSES

You know that I have neither input nor insight into the future bonuses. For the last few years, I have been unapologetic in reminding my bosses of how poorly the FM bonuses have been handled.

We now have the 6-year bonus back and it won't be going away. RDML Valdes told us that he proposed allowing annual renegotiation of bonuses. This proposal would both allow anyone to renegotiate if bonuses increase and allow anyone to add a year to the longest bonus they feel comfortable taking.

APPRECIATION

Thank you for all your daily actions in service to our patients, our Navy, and our nation. I continue to be honored by the opportunity to provide a voice for our community and advocate for my colleagues. Please reach out to me whenever I can be of help with questions or advice or to connect you with other colleagues who can. Enjoy your summer.

Thanks, Mike

George R. Mount, MD, MHPE, FACR, FACP
Madigan Army Medical Center
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Congrats on Your New Job!

STRATEGIES FOR A SUCCESSFUL TRANSITION

In the opening sentence of his oft-cited book, *The First 90 Days*, author Michael D. Watkins half-jokingly informs the reader that although the President is afforded 100 days to make good on campaign promises, the reader will get 90 days when taking on a new position.[1] The first 90 days form a critical, liminal period in any transition, given the many unknowns, the inevitable challenges, and the perceived need to prove oneself. Let's review Watkins' framework for success in the first 90 days, focusing on the ten elements Watkins reviews in his text, which I have organized into the following 4 areas:

1. **Personal Preparation** (*prepare yourself, accelerate your learning*).
2. **Early Effective Execution** (*match strategy to situation, secure early wins, negotiate success, achieve alignment*).
3. **Who's on Your Team** (*build your team, create coalitions, accelerate everyone*).
4. **Personal Check-In** (*keep your balance*).

PERSONAL PREPARATION

"What got you here won't get you there…"[2]

Personal preparation first involves mentally breaking from your old position and embracing the transition to a new one. This break should involve an explicit acknowledgment that the skills that have made you successful in the past may not be enough to achieve success in your new position. Critically, this break should include a focused reflection on your current strengths and areas for improvement. Additionally, a new position often requires an acceleration of learning to meet the accelerated slope of the learning curve that comes with a new role. Acceleration of learning does not mean haphazardly jumping into the process of understanding vital elements such as systems, technologies, organizational structure(s), politics, and culture, but instead taking a systematic and focused approach to deciding what you need to learn and how you might accomplish this task most efficiently. Personal preparation, therefore, includes both self-reflection and a systematic plan for learning about the organization you are entering.

EARLY EFFECTIVE EXECUTION

"Culture eats strategy for breakfast." (attributed to Peter Drucker)

Once you've prepared yourself for your new role through self-reflection, your systematic plan for learning will provide a basis for developing a strategy for early effective execution. Indeed, your learning plan should include identifying the situation in which the organization you are joining finds itself. Watkins proposes the acronym (STARS) to help with this task: S – Sustain Success; T – Turnaround; A – Accelerate Growth; R – Realign; S – Start-up. Each of these situations requires a different strategy and plan for success. For example, sustaining success requires a starkly different action plan than that needed to turn an organization around. Regardless of the situation identified, securing early wins will build credibility while also building momentum for you and your team. Therefore, strive to identify opportunities for these wins early in the first 90 days.

Negotiating what success looks like with your supervisor will be a key component of early execution in your new role and you must build an effective relationship with this individual. You can create this relationship through planned dialogue and clearly communicated goals and expectations. Understanding your supervisor's communication preferences and working style is likewise paramount. These early discussions with your supervisor should also include reviewing available resources to carry out the

strategy you've carefully crafted based on the situation you've identified (and clarified with your supervisor). Finally, in your discussions with your supervisor, inquire about a personal and professional development plan early.

As you develop and execute your strategy, you must align it with the direction and strategic vision of the organization. Developing a strategy misaligned with that of the organization you are joining is akin to pulling your oar out of sync with your teammates when attempting to win a rowing regatta – the boat will either sputter or fall out of line. In addition to the organization's mission and vision, other critical elements to consider in developing an aligned strategy include structure, systems, processes, and people. Underpinning all these elements are the culture and values you must stridently cultivate and maintain. As the above quote from Drucker reminds us, culture will eat your strategy for breakfast if neglected.

WHO'S ON YOUR TEAM

"First Who, Then What—get the right people on the bus."[3]

When you move to a new position, you take on new roles and responsibilities and, importantly, become a new member of a likely well-established team. If you are positioned as the leader of this team, evaluating your team will undoubtedly be one of your earliest tasks. As the above quote from Collins reminds us, this task can make or break both your short-term (i.e., first 90 days) and long-term success. Identifying and filling holes in your team should be balanced with aligning current team members with the roles that best fit their talents. Equally crucial to getting the right people on the bus is identifying the wrong people and either getting them off your bus or finding a different proverbial seat for them.[3] While building your team, look internally and externally to develop supportive alliances necessary to achieve your goals. These individuals or groups may lie out of your control, but their support is essential. Finally, remember that you are not the only individual experiencing a transition. Your addition to the team comes with a transition for team members. Look for opportunities to accelerate an effective transition for all involved: peers, supervisors, and subordinates.

PERSONAL CHECK-IN

"Secure your own oxygen mask first…"

Times of transition are, by nature, stressful. Military transitions, frequent as they may be, often entail geographic relocations and the challenges therein. When starting a new position, pause regularly for a personal check-in. Doing so will give you a better sense of balance, allowing for improved judgment when difficult decisions abound. This balance extends to managing your new transition regarding your family, friends, and outside interests. Staying engaged with those close to you will improve your perspective while providing a valuable resource for counsel and advice. Pause to secure your oxygen mask during a stressful transition, then turn to those nearby for mutual support and guidance.

As we approach PCS season and the transition to new positions, it remains imperative to approach the first 90 days systematically and deliberately. Prepping for success allows for early, effective execution as you join and build a new team. Maintaining personal and professional balance through frequent personal check-ins bolsters these efforts. Keeping these tenets in mind allows for a successful and rapid transition to a new position.

Are you interested in genuinely examining leadership principles such as those discussed above? Do you wish to serve as a developer for other educators? Does an environment built on trust, adaptability, and flexibility in times of change sound like a space where you would thrive? If you answered yes to these queries, please consider the Leader & Faculty Development Fellowship and talk with your service consultant to explore your application options. We welcome all those committed to our mission of developing military physicians to lead and equip physicians at all levels and advance military medicine through innovation and research. Please reach out to LTC Ashley Smith, incoming program director, or any member of our team through the fellowship list serve (usarmy.jblm.medcom-mamc.list.faculty-development-fellowship@health.mil).

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

REFERENCES

1. Watkins, M. D. (2013). *The first 90 days, updated and expanded: proven strategies for getting up to speed faster and smarter*. Harvard Business Review Press.
2. Goldsmith, M. (2010). *What got you here won't get you there: How successful people become even more successful.* Profile books.
3. Collins, J. (2016). *Good to great: Why some companies make the leap and others don›t.* Instaread.

USAFP FOUNDATION

INTRODUCING THE USAFP FOUNDATION!

Thanks to the vision of USAFP Immediate Past President Kevin Bernstein, MD and USAFP Past President Phil Volpe, DO, the USAFP now has a Foundation. The USAFP Foundation was incorporated as a non-profit 501(c)3 corporation in September 2023 and formally rolled out during the USAFP Annual Meeting & Exposition in March 2024.

The purposes of the Foundation are exclusively charitable, educational, and scientific, including, but not limited to, educating and inspiring future family physicians, and supporting Military and Uniformed Services Medicine now and into the future. This will be accomplished by orchestrating four key functions of the Foundation:

1. Raising funds to advance uniformed family medicine programs within USAFP in Education/Academics, Research, Communication, Continuing Education, Operational Medicine, Sponsorship, Mentorship and Leader Development.
2. Fostering a culture that attracts, prepares, motivates, and retains the next generation of Military/Uniformed Family Physicians by supporting programs which assist Students, Residents, and young Medical Corps Officers on their journey.
3. Supporting USAFP and its members to ensure their success and the success of future Military/Uniformed Family Physicians in serving our nation.
4. Capturing the history of Family Medicine in the Military and in the Uniformed Services; sharing our legacy; honoring our past; and inspiring our future.

The inaugural officers and trustees were appointed by the USAFP Executive Committee and will each serve either a two or four year term that began in January 2024 and are representative of all military services.

OFFICERS

Philip Volpe, DO, FAAFP
Chair
Debra A. Manning, MD, FAAFP
Secretary/Treasurer

The USAFP Foundation would like to memorialize those current and prior USAFP members that pass during the year at the annual meeting. If you are aware of a peer's passing, please send a note to Cheryl Modesto in the USAFP Headquarters office (cmodesto@vafp.org).

TRUSTEES

Kevin M. Bernstein, MD, FAAFP (USAFP Immediate Past President)
Jeffrey B. Clark, MD, FAAFP (Army 4-year term)
Evelyn L. Lewis&Clark, MD, FAAFP (Navy 4-year term)
Brian V. Reamy, MD, FAAFP (Air Force – 2-year term)
James D. Warner, MD (CG/PHS – 2-year term)

EXECUTIVE TRUSTEE

Mary Lindsay White, MHA

The USAFP Foundation is seeking financial donations to provide strong and vibrant support for the specialty of Family Medicine. If you are interested in making a tax-deductible donation to the USAFP Foundation, please click the QR code below. Contributions are tax deductible as charitable contributions for federal income tax purposes.

Thank you to those USAFP members that have donated to the Foundation. We are pleased to report that to date the Foundation donations have totaled $12,765.00 and helped support the attendance of 19 Health Professions Scholarship Students at the 2024 USAFP Annual Meeting. As noted in the key functions above, this use of donations directly supports the "Fostering of a culture that attracts, prepares, motivates, and retains the next generation of Military/Uniformed Family Physicians by supporting programs which assist Students, Residents, and young Medical Corps Officers on their journey."

To learn more about the Foundation and its Board of Trustees, please visit usafpf.org.

DONATE HERE!

Two-Year Accredited Fellowship Program Starting July 1

Clinical Pharmacology Fellowship Program

What is Clinical Pharmacology?

Clinical Pharmacology is the specialty of developing answers for modern medical limitations. Clinical Pharmacologists develop drugs, vaccines, and biologics by evaluating bench research and moving it into clinical trials. They also repurpose currently available medicines and monitor the safety of medicines in use. Clinical Pharmacologists work with government, universities, and industry to translate discoveries in the research lab to the beside.

Uniformed Services University and Walter Reed Army Institute of Research joint Program *with optional rotations overseas*

Fellowship Highlights:

- Conduct cutting edge drug development research across multiple specialties including COVID-19, Pain Control, Antibiotic Resistance, Warfighter Performance.
- Three month rotation with the FDA reviewing drugs in development and/or already approval.
- Robust Didactics and Immersive training to expand your future career potential.

Current Research Interests:

- Applying pharmacogenomics to evaluate risk to warfighter rediness and optimize patient care.
- Using state of the art pharmacometric analysis to determine drug dosing optimization under military relevant conditions such as blast, burn and exercise.
- Rapidly evaluating drugs to repurpose for military medical gap solutions.

Fellowship Eligibility Requirements:

- Active Duty Army PhDs (71A or 71B)
- Active Duty Army PharmDs
- Active Duty Army Physicians Board Eligible/Board Certified in Any Specialty

FOR MORE INFORMATION CONTACT:

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ARMY MEDICINE
Bringing Value...Inspiring Trust

committee report
PRACTICE MANAGEMENT CLINICAL INFORMATICS

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"Adventures of the Super-Genesis-Family-Doc: Creative Booking Solutions"

Fully recovered from the epic finale in the ballet triumphant, "Dance of the Fricassed Flowers" a.k.a. the interpretive dance version of 'Personalizing Genesis to Work Smarter, Not Harder' (available in USAFP Winter 2024), our fabled physician, the Super-Genesis-Family-Doc, gallantly returns to clinic. Ever since attending LTG Crosland's USAFP keynote address about "accelerating healthcare innovation," you ponder ways to add some flexibility in your day to take care of patients better. How do you switch from a reactive to a proactive mode of practice?

Donning your thinking cap, you look ahead at next week's schedule. A dawning sense of dread contorts your face as you see an appointment to "Discuss lab results" with Patient Sam Sloth Frequentflier. Patient SSF is known for his lengthy visits and sidebars about his hobby of succulent plant racing. You decide to strategically call him and discuss his labs via a *virtual appointment*. But how do you create an on-demand encounter? Ever since the switch from AHLTA (*requiescat in pace*) to MHS Genesis, this ability has been lost.

Thankfully, you get an assist from your colleagues at USAFP! The following QR code links to a tip sheet on the long-awaited "PROVIDER ENCOUNTER CREATION process!!! *Awaiting Applause*

It is important to note that Encounters are NOT the same as Appointments (See the last practice management article.) The "provider add encounter" creation does NOT create an appointment; it only creates an encounter. This allows you to create a billable encounter upon which you can place documentation, charges, and orders, but you will not have the full functionality that is permitted with an appointment, such as MHS Video Connect.

Add Encounter Tip Sheet

After triumphantly creating an on-demand encounter using the above instructions, you can tackle your schedule with newfound confidence. You are a beacon of innovation, a testament to the fact that even the most complicated systems can't hold a candle to a doctor with an awesome thinking cap, a phone, and an insatiable thirst for streamlining healthcare.

Two final notes:

1) This article is the result of collaboration between two committees, Practice Management and Informatics. "Better Together" in action! Contact us for more collaboration.
2) This references a DHA publication called a tip sheet. There are a ton more out there. Go to the DHA Milsuite to see the entire catalog. It's worth taking the time to do so. Go here: https://www.milsuite.mil/book/community/spaces/mhs-genesis-mtf

Contact the authors, Matthew Barnes (matgbarnes@gmail.com) and Dave Garcia (david.s.garcia36.mil@health.mil) with any questions!

USAFP MENTORSHIP PROGRAM

Looking for a mentor? Interested in mentoring others?

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

HOW DOES IT WORK?

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

WHAT AM I SIGNING UP TO DO?

Participant responsibilities are as follows:

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

WHEN AND HOW WILL I GET MY MATCH?

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

IS THERE ANYTHING I CAN DO TO HELP?

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

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2024 USAFP Research Competition Recap!

Mike Arnold, MD, CIC Chair
Naval Undersea Medical Institute
michael.arnold@usuhs.edu

Foundational and Relevant. Our New Orleans conference theme surely reflected the truly amazing research done by USAFP members. I am always impressed at how many outstanding projects are shared at our annual research competition. This contest was special in that a medical student was our overall winner in the case report poster competition and an Independent Duty Medical Technician won the staff category. Residents cleaned up in the podium presentations.

Of the record 191 abstracts submitted, only 40 competed in the research competition: 19 presentations at the podium for a conference of more than 600 uniformed family medicine physicians and another 21 presenting juried poster presentations. This best of the best competition truly highlighted the strength of the research and the diversity of presentations. We present the abstracts of all the winning presentations below. We hope that these members will inspire another leap forward in Las Vegas in 2025.

I also want to mention the Clinical Investigations Committee workshop at the conference. Our workshop on Survey Design prepared researchers for harnessing the Omnibus Survey, the all-attendee survey at the annual conference. This year, four research teams presented their Omnibus Survey projects in the research competition. At the workshop, many attendees got started on their own submissions. We also changed the Omnibus Survey submissions to be always open so that you can submit a proposal for a study throughout the year. On 15 November, we will judge the submissions to date for Las Vegas, but later submissions will just be carried to the next survey.

Our other goal is the publication of as many of these posters and podium presentations as possible. We know the research teams poured intense energy and time into their projects and the CIC is committed to help get those projects published and disseminated into the world. Working with our team, researchers submitted one-third of the projects from last year for publication in a Medline journal. We will be doing that again – helping our teams through the publication process so they can get the full reward for their work.

Continue the great research, discover that great case report, and work towards presenting your work in Las Vegas! Our submissions for the research competition for Las Vegas 2025 open in July 2024.

2024 Juried Podium Award Winners

Case Report 1st Place Medical Student

VLCADD: THE GENETIC CULPRIT BEHIND A RHABDOMYOLYSIS MYSTERY

Richard Rogers, 2LT, MS4, FIU Herbert Wertheim College of Medicine, Miami, FL Cora Blodgett, CPT, DO, Martin Army Community Hospital, Fort Moore, GA Mary Alice Noel, LTC, MD, MBA, FAAFP, Martin Army Community Hospital, Fort Moore, GA

INTRODUCTION: Exertional rhabdomyolysis (ERM), a common condition among military trainees, can stem from underlying genetic conditions. Here, we describe a case of ERM in a basic trainee with very long-chain acyl-CoA dehydrogenase deficiency (VLCADD), calling attention to under-appreciated ERM etiologies.

CASE PRESENTATION: A 19-year-old male basic trainee presented to the emergency department with recurrent diffuse myalgias after exercise that worsened overnight. Initial labs were consistent with rhabdomyolysis and transaminitis: CK 78,100, AST 1864, and ALT 266. His description of recurrent episodes prompted further questioning, where he revealed a prior diagnosis of VLCADD. Subsequently, an acylcarnitine profile showed elevated long chain acylcarnitine species. IV fluid resuscitation was initiated to goal urine output of 200 cc/hr. Dietary recommendations included fasting avoidance, fatmodified meals, and medium chain triglyceride supplementation. The patient was discharged on oral fluids with close interval follow-up after proven maintenance of urine output and downtrending liver enzymes and CK.

DISCUSSION: While many risk factors of ERM have been explored, the contribution of underlying genetic conditions in the military population remains unknown. Inborn errors of metabolism, mitochondrial disorders, and muscular dystrophies are associated with ERM and may present as late as early adulthood. These late-onset variants may have less severe symptoms, hindering diagnosis prior to military accession. With prevalence 2 of VLCADD estimated as high as 1:30,000 and increasing affordability of genetic testing, expedited workup may be indicated in recurrent ERM, ERM at low activity levels, or ERM with atypical organ dysfunction.

SCHOLARLY QUESTION: What is the prevalence of VLCADD, and other genetic conditions, in atypical ERM cases among military personnel?

CONCLUSION: In cases of recurrent ERM, like this patient, or cases of ERM from minimal activity or with atypical organ dysfunction, consideration of predisposing genetic conditions is imperative. Servicemembers may benefit from further testing and management strategies.

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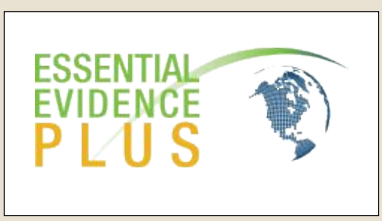

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Case Report 1st Place Resident

THE ROLE OF WHOLE BLOOD HAS REEMERGED IN THE DEPLOYED SETTING. IS IT TIME TO PUT IT TO USE IN MTFs?

Meghan E. Jastrzembski, CPT, DO, Fort Moore, Georgia 31905, Cora A. Blodgett, CPT, DO, Fort Moore, Georgia 31905, Kevin P. Hudson, CPT, MD, Fort Moore, Georgia 31905

INTRODUCTION: Exertional heat injuries, marked by elevated core temperatures and organ dysfunction, are common among military trainees, with incidence of 32/100,000 patient years in 2022. Organ failure and disseminated intravascular coagulation (DIC) are heat injury complications. Presented is a Soldier with heat stroke and DIC in a resource-limited facility.

CASE PRESENTATION: 23-year-old-male Ranger candidate found unresponsive during land navigation with core temperature of 44.3°C was brought to the ED. On arrival, Glasgow coma scale was 3. Patient was intubated, ice sheeted, intravascularly cooled, and transferred to the ICU. Initial platelet count 133. Patient began oozing blood and bruising spontaneously. Repeat platelet count 9, PT >20 seconds, and fibrinogen 129 mg/dL. Concern for DIC prompted transfer to tertiary center for blood products. Weather delayed transfer, and available blood products at MTF were limited to 6 units of fresh frozen plasma(FFP). Screened whole blood at on-post blood donor center was available but not authorized for MTF use. Patient received 4 units FFP awaiting transfer. After transfer, patient noted to have multi-organ failure, overt DIC, and labs below transfusion threshold for multiple blood components.

DISCUSSION: DIC treatment is complex and generally supported by expert opinions. Consensus is transfusion of platelet concentrate, cryoprecipitate and FFP guided by patient symptoms with few supporting RCTs. This case suggests utility of alternative DIC treatments when blood components are not feasible. Whole blood is a potentially safe alternative with evidence of successful use in DIC. Whole blood poses several benefits, including improved platelet function and volume resuscitation.

SCHOLARLY QUESTIONS: Should whole blood be authorized for use in resource-limited hospitals?

CONCLUSION: Exertional heat injury is documented in the military and DIC is a potential life-threatening sequelae. Low titer whole blood is used in deployed environments, but whole blood is not approved for use in MTFs. Ready availability and authorization for whole blood use in hospitals could improve patient outcomes.

Case Report 2nd Place Resident

SPOILED MILK – A CASE OF TREATMENT REFRACTORY LACTATIONAL MASTITIS

Hailey Murray, MD; John Bowling, MD, Dept of Family Medicine, Naval Hospital Jacksonville, Jacksonville, FL 32214

INTRODUCTION: Lactational mastitis affects 2.5-20% of breastfeeding patients and is often caused by Staphylococcus aureus or Group B streptococci. Here, a postpartum patient repeatedly presented with mastitis. She was found to have a multi-drug resistant pathogen identified from breast milk cultures, showing the utility of breast milk cultures in mastitis.

CASE PRESENTATION: 21-year-old G1P1001 presented with fever, breast erythema and tenderness. She was diagnosed with mastitis and prescribed amoxicillin-clavulanate. Symptoms persisted and she re-presented. Breast ultrasound was negative for abscess, and she was switched to dicloxacillin. Again, symptoms persisted, and she re-presented. Based off hospital antibiogram, trimethoprim-sulfamethoxazole was prescribed. Breast milk cultures were obtained. Prior to culture results, symptoms worsened and she was admitted for IV vancomycin. Cultures resulted with Staphylococcus epidermidis sensitive to fluoroquinolones, and resistant to penicillins and trimethoprim-sulfamethoxazole. She was transitioned to levofloxacin and discharged, leading to symptom resolution.

DISCUSSION: Postpartum patients commonly see family medicine physicians for lactational mastitis. While cases often respond quickly to typical antibiotic course, rarely physicians find themselves facing treatment refractory mastitis. While the WHO does recommend culturing the affected breast when possible, there is conflicting data on the utility of breast milk cultures due to high rates of contamination and noninfectious inflammation of the breast. The AAFP issued a C recommendation that breast milk cultures are rarely needed but can be considered in refractory or hospital-acquired cases. In this case, the culture identified a pathogen allowing for antibiotic adjustment and symptoms resolution.

SCHOLARLY QUESTION: What is the utility of breast milk cultures in treatment refractory lactational mastitis?

CONCLUSION: While guidelines are limited, breast milk cultures have a role in guiding further antibiotic management. However, cultures should be interpreted in the full clinical context to ensure clinicians are not responding to contaminants or noninfectious inflammation of the breast.

Case Report 3rd Place Resident

THE OTHER END: DIAGNOSING CROHN'S DISEASE FROM ORAL LESIONS

Cora Blodgett, DO, CPT, Martin Army Community Hospital, Fort Moore, GA, Karen Zhu, MD, CPT, Martin Army Community Hospital, Fort Moore, GA

INTRODUCTION: Crohn's disease (CD) is an inflammatory bowel disease marked by transmural mucosal lesions in the gastrointestinal tract. Family physicians often unveil initial symptoms including weight loss, hematochezia, and abdominal pain. Rarely, extraintestinal manifestations are the presenting complaint. **CASE PRESENTATION:** A 21-year-old male soldier presented with poor wound healing at wisdom teeth extraction sites three months post-

surgery. He denied previous medical history or family history. Exam showed verrucous lesions on gingivobuccal sulci and buccal mucosa and ulcerated lesions with erythematous bases on the hard palate mucosa. He was referred to otolaryngology with suspicion of aphthous ulcers. Two months later, he reported the lesions were enlarging, and a biopsy was taken by otolaryngology. Pathology review confirmed epithelioid granulomas consistent with oral Crohn's disease, orofacial granulomatosis, or sarcoidosis. Following GI referral, the patient reported regular diarrhea, hematochezia, and weight loss since onset of oral lesions. Endoscopy and colonoscopy were suggestive of Crohn's disease. Eight months after lesion onset, Humira was initiated.

DISCUSSION: Oral CD is a rare presentation, with estimated prevalence of 0.5%, and is mainly found in pediatric patients. Oral lesions may occur prior to onset of intestinal symptoms. Painful lip swelling, buccal cobble-stoning, and polyp formation are pathognomonic for oral CD, but patients may experience nonspecific lesions like glossitis, angular cheilitis or aphthous ulcers. Studies have shown that evidence of noncaseating epithelioid granulomas on oral tissue biopsy is highly associated with accurate diagnosis of CD.

SCHOLARLY QUESTIONS: Should otherwise healthy patients with persisting oral lesions have tissue biopsy sooner?

CONCLUSION: While a rare initial presentation, isolated oral lesions can be a herald sign of CD, especially in young patients. Family physicians should be suspicious for CD in characteristic oral cobble-stoning or polyps; but for persistent, nonspecific oral lesions, obtaining early tissue biopsy, careful history taking, and close follow-up may ensure timely, accurate diagnosis.

Educational Research 1st Place

ORGANIZATIONAL IMPACT OF A FACULTY DEVELOPMENT PROGRAM ON INTERPROFESSIONAL EDUCATORS

John Nowell, BS, ENS, USN, Uniformed Services University, Bethesda, MD 20814; Ryan Sanborn, BA, 2d Lt, USAF, Uniformed Services University, Bethesda, MD 20814

Co-Authors: Gayle Haischer-Rollo, MD, Diane F. Hale, MD, J. David Honeycutt, MD, Thomas McFate, PhD, Rhiana Saunders, MD, William Bowers, BS, Reece Tuckerman, BS, Jessica T. Survey, MD, MHPE, FAAFP

INTRODUCTION: Research has quantified the impact of faculty development on individual faculty members including increased knowledge of academic roles, improved skills to advance careers, enhanced promotion, and publication rates, and amplified social networks. There is sparse literature looking at the effects on organizational culture. We performed an exploratory qualitative study of the impact of a faculty development program on organizational educational culture with multiple teaching hospitals.

METHODS: Design – We performed a qualitative study from a constructivist paradigm and a phenomenological approach to

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understand lived experiences of faculty members. Setting/study population – We invited faculty who attended faculty development over a minimum of five years to participate in virtual focus groups. Data collection - Focus groups of 2-8 were conducted with a semi-structured interview, recorded, and transcribed. To maximize anonymity, focus groups were conducted by separate team members than the coders and participants used aliases.

Data analysis (statistical test) - Data was analyzed using thematic analysis by five physicians from three teaching hospitals within one organization. The IRB concluded this was not human subjects research.

RESULTS: Ten focus groups were conducted with 43 faculty participants representing 24 professions and 17 locations. From the thematic analysis the four themes were professionalization of the role of an educator, legitimization of the faculty role, value of community, and leadership perception and support. Numerous sub-themes are within the four themes including the transferability of skills, shared language, commonality amongst faculty, change in personal confidence and reflection, and the importance of outreach.

CONCLUSION: Our study demonstrated change within the culture over more than five years related to a faculty development program. The impacts were on the individual, inter and intradepartmental or program, and across a large organization. Further research could define in more detail the effects on faculty retention, continued personal growth, fostering resilience, and organizational strength.

Educational Research 2nd Place

IS 'BETTER' SMARTER: A RANDOMIZED CONTROLLED TRIAL OF KNOWLEDGE TRANSFER THROUGH POSTER DESIGN

Nolan Feola, Capt, MD, 96th MDG, Eglin Air Force Base, Florida 32542; Kayla Watson, Capt, MD, 96th MDG, Eglin Air Force Base, Florida 32542; Meghan N Lewis, Capt, MD, 316th MDG, Joint Base Andrews, Maryland 20762; Wade Kvatum, MD, Indiana University, Indianapolis, Indiana 47405; Sabrina Silver, DO CAQSM, Indiana University, Indianapolis, IN 47405

INTRODUCTION: Poster displays are a popular way in which to present scholarly activity. Much of the research of posters looks at visual appeal. Studies of knowledge transfer have evaluated standalone posters. None have looked at the format used to deliver information. The objective of this study was to evaluate the difference in knowledge transfer between two poster formats.

METHODS: - Design: Educational Research/Evaluation: observation/measurement (quasi-experimental); IRB-exempt through the Indiana University HRPP - Setting: 2023 USAFP Annual Meeting in the Expo Hall and near the registration desk - Study Population: Attending physicians, residents, and medical students in attendance at the meeting (94 total participants) - Educational Interventions: Participants each took a pretest and were randomized to one of two groups: the traditional poster or the #betterposter format. After viewing the poster, a ten-question posttest was completed. - Main Outcome Measures: Two of the post-test questions tested knowledge of the case's specific learning points. The other eight tested general knowledge of the medical topic presented. - Statistical Test Used: A one-factor ANCOVA

RESULTS: Statistical analysis of the full ten-item posttest summed score using ANCOVA and controlling for pretest score was not statistically significant. A one-factor ANCOVA, again controlling for pretest score, run on a two-item posttest score did show statistical significance ($F(1, 91) = 8.00$, $P = .006$); the average correct for the standard poster design was 1.45 (SD 0.57) compared to the #betterposter design average correct of 1.75 (SD 0.35).

CONCLUSION: Poster design did not impact general knowledge transfer of the case topic. However, posters designed in the #betterposter format did improve the viewer's knowledge related to the specific scholarly question and conclusion of the poster, supporting the use of a poster layout highlighting the conclusion in a clear, concise, and centrally presented manner.

Clinical Investigation 1st Place

ENSURING HEPATITIS B IMMUNITY IN MILITARY HEALTHCARE WORKERS: HEPLISAV-B VERSUS STANDARD HEPATITIS B VACCINE

Raquelle Newman, Capt, MD, Staff Physician, Spangdahlem Air Base, AE 09126, Alan Williams, MD, MPH, Associate Professor, Uniformed Services University, Bethesda, MD 20895

INTRODUCTION: To ensure immunity, healthcare workers (HCWs) should have documentation of a complete hepatitis B immunization series followed by a quantitative hepatitis B surface antibody (anti-HBs) titer. It is unclear which vaccine formulations or schedules are optimal for individuals who have been vaccinated but never had a titer above 10 IU/ml. The objective of this study is to compare standard hepatitis B vaccination to the newer adjuvanted vaccine (Heplisav-B) as a booster dose in previously vaccinated healthcare workers.

METHODS: Design - Observational cohort study, Setting - Ambulatory occupational health clinic, Study Population - De-identified hepatitis B vaccination and titer testing history where retroactively collected for 693 medical students who matriculated to the Uniformed Services University between the years of 2019 to 2022. Subjects were included if they had documentation of a single completed standard hepatitis B vaccination series followed by an anti-HBs titer below the accepted immune threshold (<10 IU/ml). Exclusion criteria included a prior positive anti-HBs titer or lack of appropriately timed follow up titer testing. Comparison groups - Booster dose of standard hepatitis B vaccine versus Heplisav-B. Main Outcome Measure - Confirmed hepatitis B immunity as evidenced by an anti-HBs level

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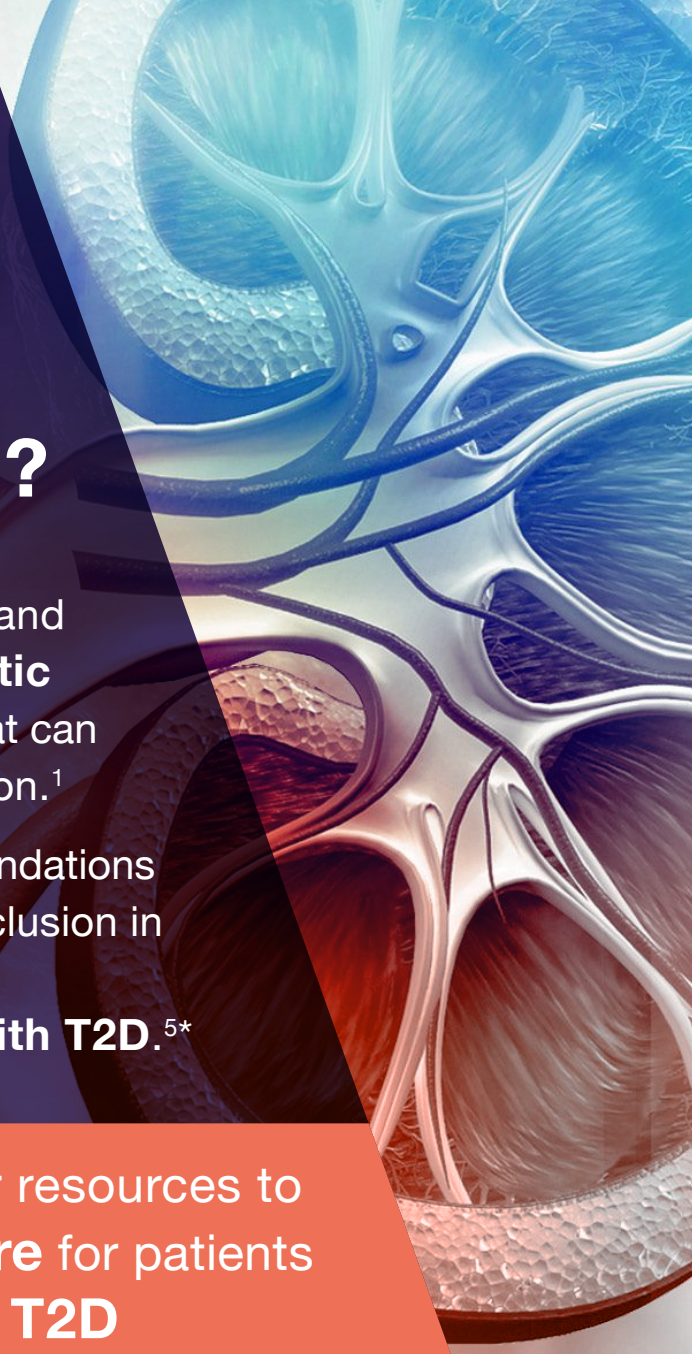
DO YOU KNOW HOW MANY OF YOUR PATIENTS WITH T2D HAVE UNDIAGNOSED CKD?



Kidney health tests (eg, UACR and eGFR) are **important diagnostic and prognostic indicators** that can be predictive of CKD progression.[1]

However, despite clinical practice recommendations from the ADA, AACE, and KDIGO,[1-3] and inclusion in HEDIS quality measures,[4] **both tests are performed in only ~52% of patients with T2D.**[5*]

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AACE, American Association of Clinical Endocrinologists; ADA, American Diabetes Association; CKD, chronic kidney disease; eGFR, estimated glomerular filtration rate; HEDIS, Healthcare Effectiveness Data and Information Set; KDIGO, Kidney Disease: Improving Global Outcomes; T2D, type 2 diabetes; UACR, urinary albumin-to-creatinine ratio.

*As evidenced by a retrospective electronic health record analysis of 513,165 adult primary care patients with type 2 diabetes from 1164 clinical practice sites in 24 member organizations of the American Medical Group Association. Investigators evaluated patterns of CKD testing, including eGFR and UACR tests alone and in combination between October 2016 and September 2019. Proportion of patients (~52%) with T2D who received UACR and eGFR tests derived from statistics captured in the last year of analysis (ie, October 2018 to September 2019).[5]

References: 1. Kidney Disease Improving Global Outcomes. KDIGO 2022 clinical practice guideline for diabetes management in chronic kidney disease. *Kidney Int*. 2022;102(suppl 5S):S1-S127. **2.** American Diabetes Association. Standards of care in diabetes–2023. *Diabetes Care*. 2023;46(suppl 1):S1-S291. **3.** Blonde L, Umpierrez GE, Reddy SS, et al. American Association of Clinical Endocrinology clinical practice guideline: developing a diabetes mellitus comprehensive care plan-2022 update. *Endocr Pract*. 2022;28(10):923-1049. **4.** National Committee for Quality Assurance. HEDIS MY 2023 measures and descriptions. Accessed March 27, 2023. https://www.ncqa.org/wp-content/uploads/2022/07/HEDIS-MY-2023-Measure-Description.pdf **5.** Stempniewicz N, Vassalotti JA, Cuddeback JK, et al. Chronic kidney disease testing among primary care patients with type 2 diabetes across 24 US health care organizations. *Diabetes Care*. 2021;44(9):2000-2009.

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>10 IU/ml, Statistical Test Used - Chi-squared test for comparison of proportions

RESULTS: After review of the data, 242 subjects met inclusion criteria for analysis, specifically: a single complete series and a hepatitis B surface antibody titer below 10 IU/ml. In this cohort of previous vaccinated individuals, a single booster resulted in 92.7% (Standard Hep B vaccine n=82) and 99.4% (Heplisav-B n = 160) confirmed immunity. The percent difference (6.7%) is statistically significant. (95% CI 1.9%-14.5%, p=0.0032)

CONCLUSION: For military healthcare workers who have a complete series and a titer below 10 IU/ml, a single dose of either hepatitis B vaccine is highly likely to result in confirmed immunity. Heplisav-B is somewhat more likely to result in confirmed immunity with a single dose. (99.4% vs 92.7%)

Clinical Investigation 2nd Place

ENHANCING INSOMNIA SEVERITY ASSESSMENT IN PRIMARY CARE: EVALUATING THE VALIDITY OF A FREQUENCY-BASED MEASURE OF INSOMNIA SYMPTOMS AMONG ACTIVE-DUTY SOLDIERS

CPT Lena Nowacki, DO1; Juliana S. Ee, PhD1; MAJ Holly B. Crellin, MD1; MAJ Joshua A. Davis, MD1; Jeffrey L. Goodie, PhD2; Godwin Y. Dogbey, PhD3; MAJ Rachel A. Egbert, DO1

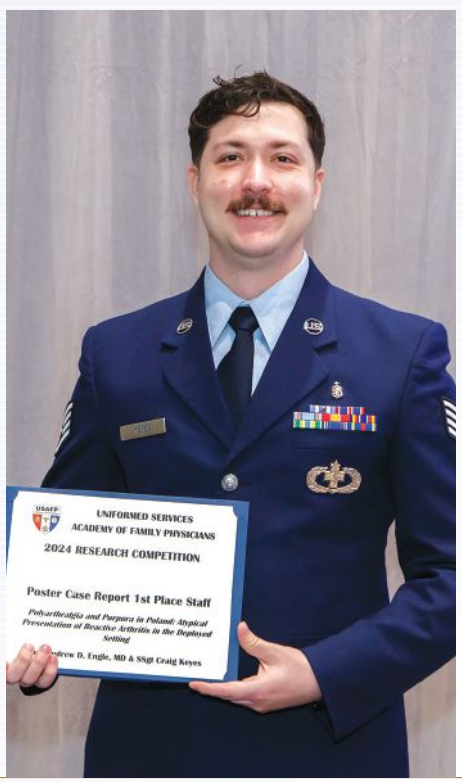
1Womack Army Medical Center, Fort Liberty, NC; 2Uniformed Services University, Department of Family Medicine, Bethesda, MD: 3Campbell University, Jerry M. Wallace School of Osteopathic Medicine, Lillington, NC

INTRODUCTION: Insomnia is often assessed with the Insomnia Severity Index (ISI), a Likert scale that requires respondents to rate the severity of their symptoms from "none" to "very severe." Given patients' subjective interpretation of severity labels could vary widely, this study examined the reliability and validity of frequency-based responses using a newly developed Sleep Health Questionnaire (SHQ) to assess insomnia.

MATERIALS AND METHODS: The study design was a cross-sectional, retrospective review of the SHQ completed by active-duty patients attending a sleep class at a family medicine residency clinic. The SHQ comprises 7 items that mirror the ISI items but is constructed to assess frequency of symptoms using a four-point scale (i.e., "not at all, several days, more than half the days, nearly every day").

RESULTS: Participants were 202 soldiers (33.4 ± 9.1 years). Concurrent validity of the SHQ was demonstrated by the statistically significant correlations between each of the corresponding 7 items of the ISI and SHQ, with r's ranging from 0.51 to 0.76 (all p's<.001). Particularly, the correlations between the following items: difficulty in sleep initiation, sleep maintenance, and early morning awakening, on the ISI and SHQ were moderately high at 0.76, 0.68, and 0.60, respectively (all p's<.001). Internal consistency reliability for the SHQ and ISI were comparable at 0.78 and 0.74, respectively. Convergent validity was shown by the significant correlations between SHQ total score and scores on the depression and anxiety screening tools at r = 0.48 and 0.42, respectively (both p's<.001).

CONCLUSIONS: These findings suggest that using frequency-based items of the SHQ could be a valid and reliable method for assessing insomnia that may enhance patient and physician understanding of symptom complaints. The effect of observer drift due to unclear operational definition of subjective descriptors could be eliminated. Further studies are needed to establish other psychometric indicators of the SHQ.



2024 Juried Poster Award Winners

Gender Influences in Family Medicine Military Residency Selection Process

Stephen Cagle MD[1,2], Christopher Nicholas MD[1,2], Pamela R. Hughes, MD[3,4]
Offutt AFB, University of Nebraska Medical Center, Scott AFB, St. Louis University

University of Nebraska Medical Center

Introduction

- Applying to and selecting a training program for residency is one of the most important decisions a medical student faces. Historically location, work/life balance, and program structure (curriculum, schedule) were rated the most important factors for residency selection.
- Limited data available on factors that influence a military match applicant's choice in residency and how those factors vary between male vs. female applicants.
- We aimed to determine if there were differences in experiences between male and female applicants to the military match and how they might impact match outcomes.

Methods

- Survey of 406 physicians at the annual Uniformed Services Academy of Family Physicians meeting.
- Survey asked questions regarding factors influencing residency choice. These include curriculum, faculty qualities, location, program reputation, resident qualities, and sense of fit.
- Secondary questions included number of interviews, number of audition rotations, presence of mentor, rank of selected program, and changes in selection after interview.
- Analysis by Pearson chi square in 2x2 analysis to determine difference based on gender.

Results

- 350 total responses were recorded with 159 self-identified females and 191 self-identified males responding.

Gender Experiences During the Military Match:

- Females were more likely to interview at 3 or more locations compared to male counterparts (p=0.013). Figure 1
- Males reported a higher rate of formal mentorship during the match process compared to female counterparts (32.4% vs 19.7%, p=0.009). Figure 2
- Females matched at a higher rate into their first-choice residency location (86.6% vs 78.9%), although statistical significance was not achieved (p=0.061). Figure 3

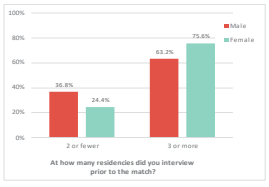


Figure 1

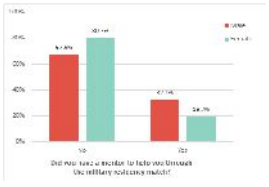


Figure 2

- Across all professional settings, females report lower rates of formal mentorship.

Scan QR code for abstract and more data tables and graphs.

Results Cont.

- There was no statistically significant difference between males and females in the following aspects of the choosing a residency program:
  - Most important factor in choosing residency (p= 0.190)
  - Changing program choice after interviewing (p= 0.931)
  - Reputation of program in decision (p= 0.583)
  - Number of audition rotations (p=0.681).

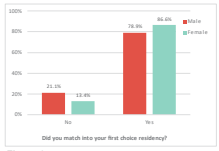


Figure 3

Discussions

- The military match is a closed system with a limited number of applicants and residency positions to meet the projected end strength needs of the military services.
- The experience of students entering the civilian match process is likely very different and outcomes are unlikely to mimic those entering the military match.

Scholarly Question

How do female and male applicants to the military match perceive their experience during the match process?

Conclusion

Gender identity did not seem to influence the outcomes of the match, but likely had an impact on the perception of experience during the match process.

University of Nebraska Medical Center

Perceived Barriers of Implementing Battlefield Acupuncture in Civilian Family Medicine Clinics

Steven Prueitt, DO, Stephen Cagle, MD
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University of Nebraska Medical Center

Background/Introduction

- Battlefield Acupuncture (BFA) is a quick, low risk procedure for treating acute and chronic pain
- BFA is most often utilized in military or VA environments
- Studies have been performed in civilian settings
- Incorporating non-opioid pain management strategies into patient care could improve outcomes and decrease harms to patients, and lower system-wide cost in treating pain
- BFA is routinely used at the Erhling Bergquist Clinic at Offutt Air Force Base, but not in the University of Nebraska Medical Center (UNMC) civilian system

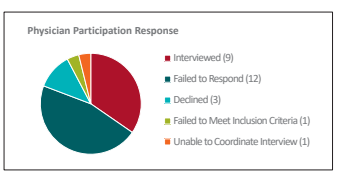
Objective/Purpose

- Identify perceived barriers of implementing BFA in UNMC Family Medicine clinics
- Gauge interest of physicians in learning and using BFA

Methods

- Qualitative study design
- Sample from faculty physicians in the UNMC Family Medicine Residency (FMR) program
- Demographic data obtained
- Semi-structured, 12-question interview
- Interest of subjects into learning BFA determined by self-reporting on 0-10 scale at conclusion of interview
- Interviews recorded and transcribed into text format
- Transcriptions reviewed independently and jointly by investigators for barriers and common themes

Results

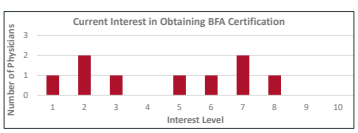


Perceived Barriers:

- 89% - out-of-pocket cost to patients
- 56% - unaware of the opportunity for training
- 44% - barriers of credentialing/privileging, training time, and supply acquisition
- 33% - patient and physician education
- 22% - time limitations in clinic, reimbursement, system-wide training, physician interest, and maintaining competence
- 11% - clinic affordability, leadership support, and need for recertification

Not Barriers:

- 56% - procedure duration
- 44% - equipment cost
- 33% - training time
- 22% - reimbursement
- 11% - training of clinic staff



Subject Demographics (n=9)

- Age: 34 years–63 years, with median of 45yo
- Gender: 5 males and 4 females
- Race: 8 Caucasian and 1 African America
- Time in Practice: <1 year–35 years (median 17 years)
- Clinic Location:
  - DOC – 6
  - Bellevue – 2
  - OneWorld – 1

Discussion

- All physicians interviewed perform other in-office procedures
- The majority felt that this technique could benefit their patients
- Physicians with lower levels of interest in learning BFA reported having too many time restraints at this time or needing assurance to be able to utilize in clinic before pursuing training
- Attending physician training and privileging is required in order to allow for resident physicians to use BFA

Conclusion / Future Directions

- There are many barriers to implementing BFA in civilian clinics
  - Reducing out-of-pocket cost to patients is paramount to ensuring patient access
  - Credentialing and privileging may have additional barriers to identify and overcome
  - Administrative and leadership support is critical for implementation after training
- Physicians are interested in learning this procedure
- Future research may be needed to implement BFA into the inpatient setting at UNMC
- Analysis into opioid-use and healthcare cost reductions with implementation of BFA would be beneficial but are challenging

Should We Walk on the Wild Side?
Wilderness Medicine Training and Deployment Preparedness

Anna T. Wiley, MD, FAAFP, Jill D. London, DO, FAWM, Ashley D. Brown, MD, MPH, FAAFP, FAWM, DipABLM

Offutt Air Force Base Family Medicine Residency, Nebraska Medicine

BACKGROUND

Operational medicine and wilderness medicine both offer unique challenges of practicing within a dynamic and austere environment.

STUDY QUESTION

Does wilderness medicine training increase military family medicine physicians' confidence in providing care in the deployed setting?

METHODS

Surveyed 404 military family physicians at the 2023 USAFP Annual Meeting.

Statistical analysis included descriptive statistics, Pearson chi-square, and logistic regression.

RESULTS

Among respondents who reported deploying "once" or more, those with formal wilderness medicine training (n=53) were more likely to be "very" or "extremely" confident in providing care in a deployed setting compared to those who had no wilderness medicine training (77% vs. 54%, p=0.004) (Fig. 1).

Among respondents who reported no deployment experience (n=149), those with wilderness medicine training were more likely to report feeling "very" or "extremely" confident in providing care in a deployed setting compared to those who had no wilderness medicine training (27% vs. 6%, p<0.001) (Fig. 2).

RESULTS

Wilderness medicine training increases confidence to provide patient care in a deployed setting regardless of deployment experience

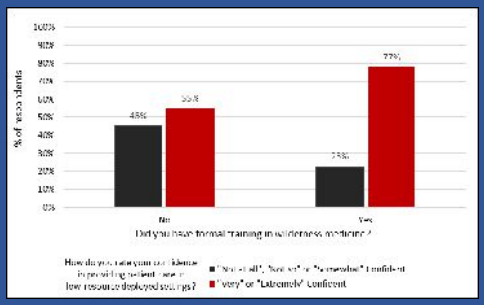


Fig. 1: Respondents who have previously deployed

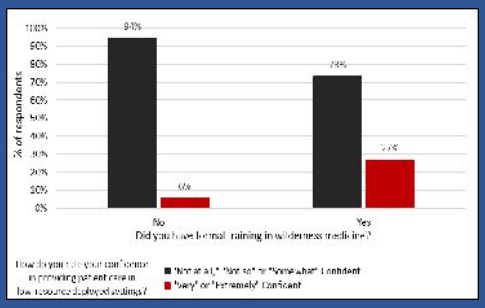


Fig. 2: Respondents who have not yet deployed

SCHOLARLY QUESTIONS

Can we incorporate standardized wilderness medicine training to improve family physicians' confidence in providing care in the deployed setting?

Does wilderness medicine training improve quality of patient care in the deployed setting?

CONCLUSION

Formal wilderness medicine training is associated with increased confidence in providing care in the deployed setting among military family physicians, in both those who have and have not deployed.

Implementing pre-deployment wilderness medicine training is likely to increase confidence for practicing medicine in the deployed setting for all family physicians, regardless of prior deployment experience.

Residents participating in a wilderness medicine elective

Take a picture to download the abstract

Special thanks to Col (Ret) John Barrett, MD and Jenenne Geske PhD

"Mirena Made Me Crazy"

ENS Madison Milbert[1], ENS Daniel Person[1], LCDR Steven Cornelius, MD

Uniformed Services University of the Health Sciences

BACKGROUND

- Well-documented levonorgestrel intrauterine device (IUD) adverse effects include bleeding irregularities, device expulsion, ectopic pregnancy, and uterine perforation[1]
- Side-effects focus on post-insertion period and not post-removal
- Adverse mental health effects after removal **not listed** in Mirena's "important safety information"
- Patients and the lay press have dubbed symptoms of IUD removal as the "Mirena Crash"

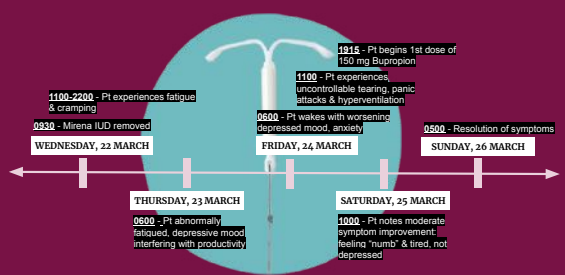
CASE PRESENTATION

- 2 days after Mirena IUD removal, a 23-year-old female presented with 36-hours of worsening panic attacks and crying outbursts
- Pt suffered episodes of panic and unexplained tears accompanied by an acutely depressed mood that she had never experienced
- Pt's PCP began Bupropion due to safety concerns. Episodes completely resolved after 36-hours on Bupropion.

DISCUSSION

- Levonorgestrel IUDs are generally well tolerated
- Patients are counseled on uterine perforation & ectopic pregnancy as potential adverse effects, though <1% of patients experience this[2]
- Up to 10% of users will develop adverse mental health effects when the device is first placed[2]
- Current case reports have not documented these effects **after** the IUD has been removed.
- Evidence of these effects after removal has only been documented empirically.

Removal of a levonorgestrel IUD can carry ***significant*** adverse mental health effects.



SCHOLARLY QUESTIONS

- How common are significant emotional symptoms after levonorgestrel removal?
- Should clinicians recommend a post-removal follow up for levonorgestrel IUD users?

CONCLUSION

- Globally, 23% of women using long-acting contraception chose intrauterine devices[3]
- Family physicians manage and reassess their patients' contraceptive methods.
- While physicians commonly warn patients of mental health symptoms due to hormonal treatments, risks of IUD removal are thought to be minor.
- This case and other anecdotal evidence suggest that hormonal IUD removal can have a transient yet important mental health impact.

REFERENCES

1. Mirena® (Levonorgestrel-releasing intrauterine system)52 mg. Mirena US. Accessed February 12, 2024. https://www.mirena-us.com/pi#isi.
2. Levonorgestrel intrauterine device: Drug information. UpToDate. Accessed February 12, 2024. https://www-uptodate-com.usu01.idm.oclc.org/contents/levonorgestrel-intrauterine-device-drug-information?search=mirena+iud&source=search_result&selectedTitle=2~150&usage_type=default&display_rank=2#F44941951.
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SCAN THIS CODE for abstract download & relevant literature

Polyarthralgia and Purpura in Poland: Atypical Presentation of Reactive Arthritis in the Deployed Setting

Andrew D Engle, Capt, MD, 495th FS
Craig Keyes, SSgt, IDMT, 492nd FS
Talon Miner, Maj, DO, 492nd FS

INTRODUCTION / OBJECTIVE

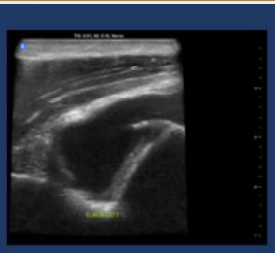
- 24 y/o male presents on deployment in Poland with asymmetric polyarthralgia, petechiae, and purpura
- Demonstrates benefits of partnering with foreign specialists in the deployed environment in addition to US telemedicine support

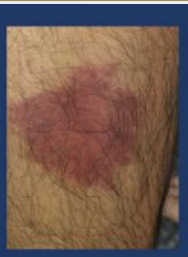
CASE PRESENTATION

- Right elbow and foot pain, elbow and 2nd and 3rd MTP effusion on POCUS
- Right leg purpura and bilateral extremity petechiae
- Presentation preceded two weeks prior by diarrheal illness
- Positive HLA-B27 and elevated CRP but otherwise unremarkable labs
- Some improvement with Etoricoxib, significant improvement with sulfasalazine

DISCUSSION

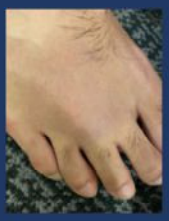
- Petechiae and purpura are atypical findings of seronegative spondyloarthropathies, more typically seen in vasculitis and platelet disorders
- Lab testing only available via host nation assets

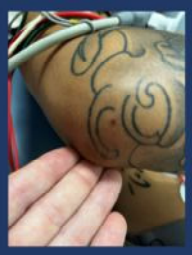




Reactive arthritis with petechia & purpura

- **Diagnosed in deployed setting**
- **No coagulopathy or renal disease**
- **HLA-B27 positive**





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DISCUSSION

- IgA Vasculilits, IBD, ITP, and other small vessel vasculitis are important DDX to consider

SCHOLARLY QUESTION

- What is the prevalence of petechia and purpura in HLA-B27 positive spondyloarthropathies?

CONCLUSION

- Seronegative spondyloarthropathies can present very atypically with small joint and upper extremity effusions and skin findings more typical of vasculitis
- Integration with host-nation healthcare systems in resource-poor, deployed setting can provide critical capabilities to diagnose and manage conditions in theater that would otherwise require evacuation

The authors thank Dr. Joanna Makowska and Dr. Filip Styrzyński at the Uniwersytet Medyczny w Łodzi, Poland

Physician Comfort and Other Barriers Related to Sexual Dysfunction Screening

CPT Hillary Darrow, MD[1]; CPT Ashley Yano, MD[1]; John Barrett, MD[2]

Introduction:

Sexual dysfunction affects over a third of American adults yet is documented in only 2% of primary care notes.

- Provider discomfort has historically been thought to drive under screening.
- Patients are 3-5 times more likely to report sexual dysfunction after direct inquiry
- Purpose: Evaluate family medicine physicians' viewpoints and other perceived barriers to routine screening.

Methods:

- *Design:* Electronic, quantitative, cross-sectional survey
- *Setting:* USAFP 2023 Annual conference
- *Study Population:* 378 Family Medicine Physicians belonging to USAFP
- *Interventions (if any):* None
- *Main Outcome Measures:* Frequency of routine screening, Physician comfort in discussing sexual dysfunction, and Physician perceived barriers to screening
- *Statistical Test(s) Use:* Descriptive statistics, bivariable analysis

Physician comfort does not affect routine screening for sexual dysfunction.

Clinical time and perceived patient discomfort may be to blame.

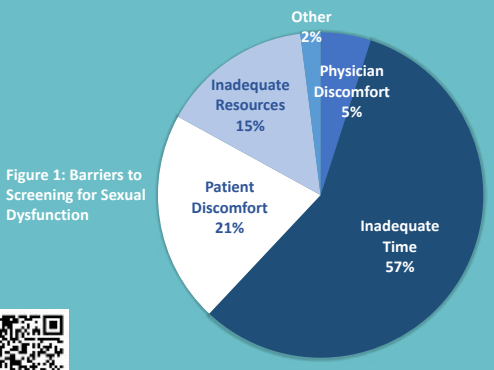
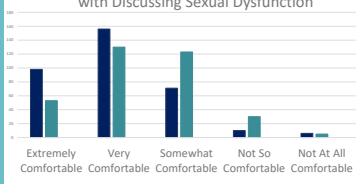


Figure 1: Barriers to Screening for Sexual Dysfunction

Take a picture to read the complete abstract, references, and related resources

Results:

Figure 2: How Comfortable Are Physicians with Discussing Sexual Dysfunction



- 242 (64%) of the respondents endorsed that they screen for sexual dysfunction during a routine well visit at least sometimes.
  - Physician demographics were not found to significantly affect screening frequency.
- 75 Physicians (19%) believed that patients would at least sometimes self-report sexual dysfunction without cuing.
- Physicians with discomfort perceived limited training (37%) and lack of resources (16%) as the largest contributors.

Conclusions:

- The majority of physicians deny discomfort with discussion of sexual dysfunction.
- The most frequently perceived barriers to screening were time and patient discomfort.
- These findings differ from those in historical literature and may provide guidance in reducing the discordance in sexual dysfunction incidence and treatment.

Affiliations:
[1] Family Medicine Obstetric Fellowship, Carl R. Darnall Army Medical Center, Ft. Cavazos, TX
[2]Department of Veterans Affairs

INTENTIAL OVERDOSE RESULTING IN AN ISOLATED SPINAL CORD INFARCT

Melissa Engel, MD
Tanner Pulsipher, DO
Adriana Carpenter, DO
Nellis AFB
Family Medicine Residency

INTRODUCTION

- Isolated spinal cord infarcts are rare and are most often caused by atherosclerotic disease or surgical procedures.
- This is a case of an isolated spinal cord infarct resulting from hypoperfusion in the setting of multi-drug overdose.

CASE PRESENTATION

- A 20-year-old male was brought to the Emergency Department by ambulance, found down for an unknown time after intentional ingestion of an indeterminate quantity of cyclobenzaprine, quetiapine, mirtazapine, and prazosin.
- Upon presentation, he was normotensive and his neurologic exam was limited by altered mental status, demonstrating only gross upper extremity movement and single beat clonus of the R ankle.
- Laboratory analysis was significant for an elevated lactic acid and creatinine kinase.
- He was treated conservative initially for overdose. By hospital day 4, his mentation improved, but his exam demonstrated complete paralysis of the lower extremities and motor deficits in the upper extremities.
- MRI brain and CTA neck were unremarkable.
- MRI spine demonstrated a large spinal cord infarct from C1-C7 involving the entire cross-sectional area of the spinal cord.

INTENTIONAL OVERDOSE RESULTING IN AN ISOLATED SPINAL CORD INFARCT

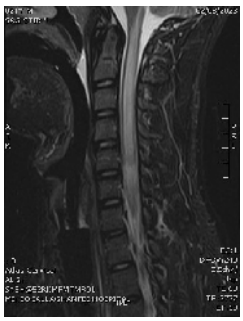
- **Hypotension is anticipated from intentional ingestion of multiple medications**
- **Consider hypotension as a cause of isolated spinal cord infarcts**

Scan QR Code to download the abstract and resources

DISCUSSION

- Hypotension is a rare cause of isolated spinal cord infarcts
- Hypotension is an anticipated outcome of ingestion of multiple vasoactive medications, but spinal cord infarct resulting from any of the stated medications has not been reported.
- In the absence of trauma, thrombosis or other known cause of hypoperfusion, hypotension is the most likely cause.
- Fewer than ten cases exist documenting infarcts resulting from hypoperfusion of any etiology.
- Subsequently, little data exists regarding prognosis or optimal management of hypoperfusion induced spinal cord infarcts.

IMAGING



CONCLUSIONS

- Though rare, spinal cord infarcts from hypotension should be considered in patients presenting with gross neurologic deficits.

We would like to acknowledge the invaluable work of the neurology team, clinical investigation team and family medicine residency at Nellis Air Force Base

Needling Away Tinnitus

Capt. Xenia Brianna Gonzalez, MD, Capt. Nana Amma Sekyere, MD, Capt. Melinda W. Ng, MD, Lt Col. Brent Feldt, MD
David Grant USAF Medical Center Family Medicine Residency, Travis AFB, CA

INTRODUCTION / OBJECTIVE

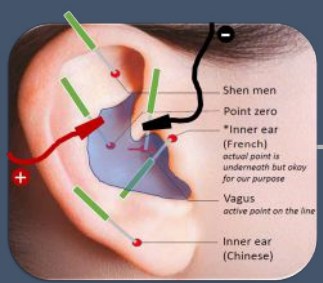
- Tinnitus is a chronic debilitating condition with limited treatments
  - Affects 10% of Americans, 8% of veterans
  - Most common service-connected disability; increasing incidence
- Presented: 36-year-old active-duty male with tinnitus, who improved after a unique acupuncture protocol

CASE PRESENTATION

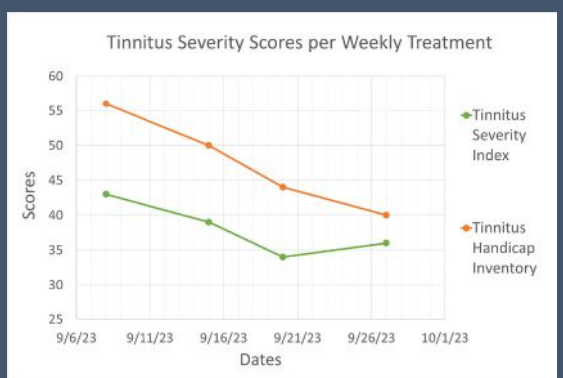
- Symptoms: bilateral, non-pulsatile
- Failed Therapies: brown noise
- Intervention:4x weekly auricular acupuncture sessions
- Results:
  - Tinnitus handicap inventory (THI): 56 → 40
  - Tinnitus severity index (TSI): 43 → 34
- No reported adverse effects

Acupuncture protocol and THI/TSI surveys here!

A *novel* tinnitus treatment that *worked!*



- ✓ 30-minute visit
- ✓ Once a week treatment
- ✓ Low-cost intervention
- ✓ Minimal side effects
- ✓ Symptom improvement sustained over 4 weeks



DISCUSSION

- First known case of saline with electroacupuncture protocol that improved tinnitus
- Compared to current literature, this case's THI and TSI scores decreased:
  - A) After 1x weekly vs 2x weekly
  - B) Within 4 weeks vs ≥ 8 weeks
- Can be a 30-minute appointment
- Minimal side effects and low cost

SCHOLARLY QUESTIONS

- How replicable are these results in other patients?
- How effective would this protocol be in managing tinnitus long term?
- Should an acupuncture trial be a part of standard tinnitus management?

CONCLUSION

- This electroacupuncture protocol with saline may effectively treat tinnitus, but further research is needed

Data Table and Abstract here!

EXTREMELY ELEVATED ALP (ALKALINE PHOSPHATASE LEVELS) DURING THE THIRD TRIMESTER

Author: Mary Kerby, DO, CPT

INTRODUCTION / OBJECTIVE

- ALP may increase by 3 times the upper limit of normal during pregnancy
- High ALP levels may be a marker for placental insufficiency, low birth weight, and preterm delivery

CASE PRESENTATION:

- 26 year old G2P1 at 38+5 weeks gestation
- Pre-eclampsia work-up
- Elevated ALP at 3863 U/L
- Liver ultrasound concerns for intrahepatic cholestasis of pregnancy and non-placental causes of ALP elevation
- Bile acids were normal
- ALP isoenzyme differentiation with markedly elevated placental levels with low liver, bone, and intestinal levels
- Close monitoring of ALP during the perinatal period
- Infant was born at term with a normal birth weight

SCHOLARLY QUESTION:

Are extremely elevated alkaline phosphatase levels in isolation an indication for induction of pregnancy?

An unusually high ALP level may be a marker for placental insufficiency, low birth weight, and preterm delivery

- **Gaps in management for extreme elevations in alkaline phosphatase during pregnancy exist**
- **We cannot reliably use an isolated marker of ALP to dictate management**

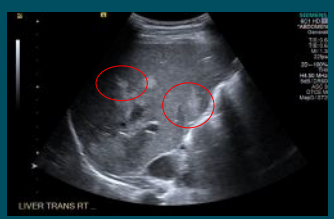


Figure 1: Patient's Liver ultrasound notable for abnormal nonspecific patchy echogenicities in red circles

Take a picture to download the full abstract

DISCUSSION:

- Limited case studies
- No universal guidelines for management of elevated ALP during pregnancy

CONCLUSION:

- No accepted correlation between a high level of ALP and fetal or maternal pathology.
- Clinical cases during pregnancy that result in abnormally elevated alkaline phosphatase may require more frequent monitoring

References / Disclosures:

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American Board of Family Medicine Certification Updates

NEW KSA PLATFORM

In 2019, ABFM leadership created the ABFM five-year strategic plan that outlined several initiatives, which included a new KSA platform, which made available to family medicine physicians and residents on March 15, 2023. This new KSA platform introduced an enhanced modern KSA user interface, a more intuitive experience, and offers enhanced features inside the KSA. Among these changes includes instant feedback on each question, the ability to review item critiques immediately after answering a KSA question, the option to submit comments on each question as the physician progresses through the KSA activity and the ability to customize a reference list for additional personal learning.

NATIONAL JOURNAL CLUB ARTICLE RELEASE

ABFM is excited to announce that the ABFM National Journal Club added a new set of articles in March 2024. All article assessments completed will earn 1 certification point and 1 CME credit, complete 10 article assessments to fulfill your minimum KSA requirement for your stage. Each article assessment activity will require you to demonstrate mastery by correctly answering all four questions for each article. The aim of the ABFM National Journal Club is to help family physicians to keep up to date, support shared decision making with patients and families and empower family physicians to advocate for their patients with subspecialists, health systems and payers. ABFM's approach builds on that of other Certification Boards and seeks to advance the methodology of journal article activities with structured literature searches, emphasis on methodologic rigor and a requirement of mastery.

IMPORTANT ABFM CERTIFICATION CHANGES

Recently the American Board of Family Medicine (ABFM) announced that beginning January 1, 2025, ABFM will transition to Certification 2025, the new Continuous Certification 5-Year Cycle.

It's important to note that ABFM will honor the current 10-Year Exam requirement. This means Diplomates will not be required to transition to the new 5-Year Cycle any earlier than 10 years from the last time they met their exam requirement.

The new 5-Year Cycle is being implemented to meet the American Board of Medical Specialties (ABMS) Standards for Continuing Certification. This change will help Diplomates maintain awareness of increasingly rapid medical advancements and changes in practice guidelines.

The new ABMS Standards for Continuing Certification state that "member boards must determine an interval no longer than five years of whether a Diplomate is meeting continuing certification requirements to retain each certificate."

All USAFP Members should visit their MyABFM Portfolio for specific timing of when they will transition to the new 5-year Cycle. Please refer to the Certification 2025 ABFM web page and 5-Year Cycle Chart.

For additional information or questions, contact Ashley Webb, ABFM's Director of Outreach at awebb@theabfm.org.

MYABFM PORTFOLIO

CERTIFICATION 2025 ABFM

5-YEAR CYCLE CHART

USAFP Virtual KSA Sessions

Join the USAFP Education Committee and complete your KSAs

USAFP Members - $50
Non-Member - $100

Heart Disease KSA
24 September, 2024
1700-2000 EST

Musculoskeletal KSA
10 December, 2024
1700-2000 EST

Updates on the Annual Meeting

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The USAFP Education Committee and Annual Meeting Sub-Committee would like to take this opportunity to highlight our recent 2024 annual meeting and showcase our upcoming meeting in 2025. Drs. Kerry Sadler and Andy McDermott were the co-chairs for this past meeting, which was a tremendous success despite a looming potential government shutdown. Their hard work and determination brought big numbers to The Big Easy. In addition to a record number of scholarly activity submissions, the conference drew 683 attendees, including a record number of spouses/guests (n=61), residents (n=153), and students (n=52). Thank you, Drs. Sadler and McDermott, for your selfless sacrifice of time and energy to our great organization!

You may have noticed that we developed Annual Meeting "Objectives" this past year to better align our programming. but Most importantly, these key objectives should help members in their efforts to secure funding for the meeting. It is not just a medical conference; it is an opportunity to enhance our skills and capabilities and share experiences that will improve our readiness and mission outcomes. For those who attended, we hope that it met these objectives and welcome your feedback as we prepare for the next annual meeting.

- The USAFP Annual Meeting provides high-quality continuing medical education covering the full scope of Uniformed Family Medicine.
- The Annual Meeting provides critical operational training to enhance joint readiness and skill sustainment.
- The Annual Meeting provides an open forum for the advancement of uniformed family medicine, resiliency, leadership development and learning collaboratives.
- The Annual Meeting is the premier setting for presenting scholarly work within the academy.
- The Annual Meeting provides a platform and opportunity to develop junior members, residents, and students through mentoring and engagement in the organization.

Lastly, our 2025 annual meeting co-chairs, Drs. Catherine Delaney and Matthew Noss, would like to take this opportunity to introduce you to their plans for our next meeting. In case you didn't know, USAFP is turning 50!

DRS. DELANEY AND NOSS ARE THRILLED TO ANNOUNCE THAT THE 2025 USAFP ANNUAL MEETING & EXPOSITION WILL BE IN LAS VEGAS!

We hope you'll join us for another fun-filled and CME-packed session March 19th – 24th, 2025, where we will celebrate our 50th Anniversary under the bright lights of Las Vegas, Nevada. The Annual Meeting will be hosted at the beautiful, family-friendly Westgate Las Vegas Resort & Casino. In addition to the spacious conference area and smoke-free accommodations with breathtaking views, there is a beautiful swimming pool, a large gym, and access to an 18-hole pro golf course at the neighboring Las Vegas Country Club. There are also several incredible restaurants and entertainment options right on site, including musical performances, casino games, and the world's largest Race & Sports Book. Even with all those wonderful amenities, you may still be tempted to spend some free time visiting the world-famous Las Vegas strip. A short, convenient tram ride from Westgate, you'll find an amazing assortment of food, entertainment, shopping, and exciting activities. Outside the strip, there are some great attractions as well, like the Red Rock Canyon National Conservation Area.

Our theme for this 50th annual celebration is, "Military Family Medicine Goes All In." Because we do! We go all in for the mission, all in for our patients, and all in for each other. Family Medicine is the heart and soul of military medicine. We pride ourselves on providing high-quality medical care that keeps our Service Members in the fight and ensures their families are safe and healthy at home. Our programming selections will highlight the hard work and dedication shown by the incredible members of our community. We encourage everyone to "roll the dice" and consider proposing a lecture topic, panel presentation, workshop, or research submission. The Call for Speakers deadline is May 31st, 2024, and the Call for Research Competition Abstracts will be announced soon. We look forward to participation from medical students, residents, new staff physicians, spouses and family members in addition to our seasoned CME contributors! Our goal is to provide a well-rounded selection of high-quality CME that reflects all facets of Family Medicine and the unique applications to our military mission set.

Come for the CME, and stay for the networking, mentoring, friendships, and good times! Thank you for all that you continue to do to serve your country, your patients, and each other. We can't wait to go all in with you next year in Las Vegas.

— Drs. Delaney and Noss

JOIN THE VALLEY FAMILY!

Now hiring PRIMARY CARE PHYSICIANS for clinics throughout South King County

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.

About Valley

- 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

Valley Medical Center Clinic Network

- 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

Benefits of working at Valley

- Competitive salary, generous vacation and sick leave, relocation assistance, and valuable healthy living benefits*
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- Endless opportunities to learn and grow, including leadership positions
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- Full support staff and manageable patient panels with ancillary support, including RN Care Management
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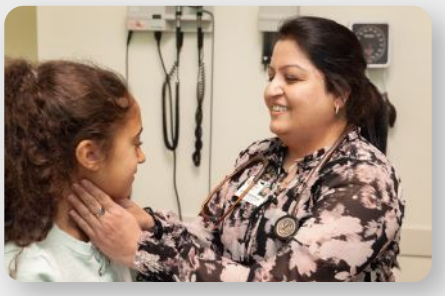
- **American Medical Association's 2022 Joy in Medicine Health System Recognition Program** for our efforts to improve physician well-being and combat burnout
- **The Joint Commission's** award of full accreditation triennially for meeting and exceeding national and safety performance standards

*Learn more at **valleymed.org/provider-benefits**



"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."

Shannon Markegard, DO

Scan the QR code for more details.

CONTACT: Mindy Schneider
Provider Recruiter
PhysicianRecruiting@valleymed.org

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UW Medicine
VALLEY MEDICAL CENTER

To learn more about provider careers at Valley, visit valleymed.org/job-openings.

Jeff Burket, MD
Madigan Army Medical Center
jeffrey.h.burket.mil@health.mil

You Will Be Ready when your chance to deploy comes!

Family Medicine physicians are *immensely* helpful in the operational and deployed setting. I had the opportunity to deploy last summer while stationed at a large Medical Treatment Facility and wanted to share some thoughts and encouragement regarding the experience - especially for those who are uncertain if they are ready to deploy because they are currently in a clinic or hospital setting. Here is the bottom line: *You are already far better prepared for your next deployment than you may think, and no one provides more benefit than a uniformed family physician.*

My experience, briefly: Madigan received a tasker for a 61H to augment the primary care capability of an Army's 528th Hospital Center, which assumed responsibility for running the U.S. Military Hospital – Kuwait (USMH-K). I traveled through the Conus Replacement Center (CRC) at Ft Bliss and joined the main body of the 528th at Camp Arfijan, Kuwait. USMH-K also provides medical providers and medics to a few other sites across CENTCOM, including to a post called Joint Training Center (JTC) outside of Amman, Jordan. After a few weeks in Kuwait, I rotated out to Jordan and remained there for the rest of the deployment.

To briefly describe the JTC clinical staff structure, normally the garrison command at JTC, Area Support Group – Jordan (ASG-J) has a command surgeon who functions as both the main advisor to the Commander as well as the OIC of the JTC clinic. The clinic provider team should also consist of the ASG-J surgeon, a provider from USMH-K, and two providers from tenant units at JTC (usually Physician Assistants), though they frequently supported their units on missions off-site. For most of the time I was in-country, there was no command surgeon in place. Two of the other locations in Jordan under ASG-J's purview had only medics stationed there. Finally, the clinic's providers served as a hub for coordinating with the local host-nation hospital where service members could get emergent and specialty care.

I summarize below how I, as a family physician, felt well-equipped to meet the needs of this operational mission and to take on some of the roles of a command surgeon.

- **Provide great primary care for personnel.** This function is already at the core of what we do. This includes bringing physician-level clinical reasoning to patient care and prescribing ability for women's health and behavioral health, which other specialties may not have.

- **Provide on-call coverage for urgent/emergent issues.** We are all trained in these areas in residency, sometimes do them during our usual clinic or hospital jobs, and all are topics we can train up on before and during deployment. For me, this category included musculoskeletal injuries like sprains or possible fractures, mild traumatic brain injury, waves of gastrointestinal illnesses, and most notably, a patient with pulseless arrest who responded well to ACLS intervention.

- **Figure out how to deliver the best care you can, with limited resources in an austere environment.** As well-trained family physicians, we seek to optimize patient care and keep care "in-house." We utilize our training and resources like the phenomenal Rx3 physical therapy app, mindfulness-based wellness, and the online Human Performance Resources by CHAMP, which covers topics such as physical, mental, sleep, and nutritional fitness. More and more, family medicine physicians are also able to utilize ultrasonography at the bedside.

- **Function as a liaison between multiple other providers/organizations/units.** This role is another core competency of the family medicine physician. It can take many forms including emails, electronic

messaging, physical profile forms, phone calls, or face-to-face conversations. This coordination includes getting to know key stakeholders: your own unit's leadership and staff section leads, other tenant or local unit commanders, medical providers and unit surgeons in your area, your higher medical support in theater, local host nation medical contacts, translators, and others. One example is helping determine whether a Soldier could stay in-country for care or needs MEDEVAC home.

- **Teach and provide oversight to medics and other junior providers at your location.** This function is inherent in how we train during residency and at both smaller and larger medical treatment facilities. We can run simulation, teaching, and training sessions so that we are ready for when badness happens. We are also already comfortable making determinations about what we can be comfortable letting medics handle with more indirect supervision utilizing the Algorithm-Directed Troop Medical Care (ADTMC) and when appropriate, providing some care "virtually" (be it via Signal App, MS Teams, or other methods).

- **Optimize workflow in a clinic.** Family physicians are connoisseurs of what good (or poor) clinic workflow and logistics look like. We frequently function as an OIC to help improve patient intake processes, coordinate provider schedules, update auto-texts in the medical record system, and consider what the pharmacy needs to stock. We also have experience communicating with our clinical leadership on what resources are needed to improve patient care.

- **Care about your teammates, including their readiness to perform clinical care as well as their overall well-being.** Nothing is more intuitive to our culture as uniformed family medicine physicians than caring for our people.

Much of what we draw upon to have success in these roles is inherent to being a family physician: we think in terms of systems, we care for patients holistically, we balance risks and benefits, we think of the populations and public health, and we provide counseling (to individuals and groups). We model professionalism, maintain humility and a learning mindset, and have a high work ethic. We understand that everything is a team sport, and that good relationships and open communication pave the way for smooth cooperation between organizations to enable successful patient care and mission completion.

There are, however, some specific training resources and guidance that can be highly beneficial:

1) **Reach out to the POC and any providers currently there to learn what you can**. What is the main mission and what conditions are being seen? What did those providers do well in their preparation and what are their lessons learned?
2) **Consider your gaps in these needed competencies between now and when you get there.** Think about both what the mission is and reflect critically upon yourself. Where are you strong/weak clinically? Do you need to gain some additional training or experience with, for example, MSK care, trauma, or inpatient, and how can you seek that at your home station before deploying?
3) **Are there courses you should attend before you go?** Ensure ATLS and ACLS are current via your local institution. Several courses via service schoolhouses of excellence are high-yield. For the Army: Tactical Combat Medical Care (TCMC; for Role 1 providers) or Theater Hospitalization (if working in a field hospital). Think about these early, as courses are only offered periodically.
4) **Gather resources:** compared to the past, we are awash in excellent resources available! **Subscribe or obtain digital access to resources available via your home institution's subscription or the DHA Virtual Medical Library**. At a minimum:
   - Up-To-Date or DynaMed
   - 5-minute clinical consul
   - Sanford or the Johns Hopkins Antibiotic Guidance for infectious disease care
   - **Deployed Medicine app**: It is simply a phenomenal resource. You can access TCCC guidelines, the Joint Trauma System Clinical Practice Guidelines, TCCC procedure videos, and so much more.

I encourage every family medicine physician to be eager to stand up and say yes to deployment opportunities. They are usually (for us) quite rewarding personally and professionally, as both officers and physicians. There is no better time than now and there is no provider better equipped to serve the soldiers, unit, and team than **you**, the uniformed family physician.

LINKS TO RESOURCES:

Rx3 physical therapy site: https://rx3.usuhs.edu/
Human Performance Resources by CHAMP: https://www.hprc-online.org/
DHA Virtual Medical Library: https://www.health.mil/Military-Health-Topics/MHS-Medical-Library
Deployed Medicine website/app: https://deployedmedicine.com/
Joint Trauma System resources: https://jts.health.mil/index.cfm/PI_CPGs/cpgs
Army Publishing Directorate: https://armypubs.army.mil/

Alex Knobloch, MD, CAQSM, FAAFP
Travis AFB, CA
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2024 Resident and Student Affairs Updates

What an amazing time to be a student member of USAFP! We had the highest number of students attend the annual meeting in New Orleans in years (52!) along with our highest student membership (693!), and the first Residency Fair at the annual meeting successfully showcased our military family medicine residency programs. The resident experience also remains strong, with 165 of our 430 total resident members joining us in New Orleans, another excellent showing from Navy residents to win Doc, You Don't Know Jack, and 34 incoming and outgoing chief residents of our military residencies making the 3rd annual Chief Resident Forum the most fruitful yet. Our committee would once again like to thank all who were involved with the planning, preparation, and execution of the Annual Meeting and extend a special thank you to our outgoing Resident and Student Directors, Kayla Watson (USAF), Courtney Cowell (USA), Kelly Le (USN), Danielle Cain (USU) and Michaela McFadden (HPSP) for their year of service on the Board of Directors!

In this issue, our committee would like to highlight our ongoing efforts to further the strategic aims of the Uniformed Services Academy of Family Physicians following the Annual Meeting.

MEMBERSHIP

As alluded to above, our resident and student membership numbers are setting records! Our committee hopes to continue to improve our outreach to HPSP students, utilizing new ways to share information with them, either through AAFP channels like the FMIG Network or through other organizations that have military medical ties. Additionally, we are beginning to investigate ways to recruit future uniformed family physicians even before medical school, strategizing what USAFP outreach to undergraduate students might look like. For those USAFP members with an interest in this area, please reach out to me as one of the Resident and Student Affairs Committee Co-Chairs with your ideas.

OPERATIONAL

Our committee has worked on creating a repository of operational medicine student rotation opportunities in the last few years. Please reach out to us if you have an interest in these experiences!

EDUCATIONAL

It's going to be hard for the 2025 Annual Meeting to top the resident and student attendance numbers achieved this year (though if I were a betting man, I think Las Vegas can give them a run for their money…). It won't hurt that the new USAFP Foundation is committed to programs that assist students and residents on their family medicine journey, including assisting with Annual Meeting travel scholarship funding. Our committee continues to collaborate with the Annual Meeting Co-Chairs to highlight "must attend" items for students and residents at each year's meeting, and we'll continue to ensure Annual Meeting staples like Doc, You Don't Know Jack bring joy and plenty of learning to all those in attendance (unless you're the unfortunate faculty member who just can't find their way off the stage…).

SCHOLARSHIP

A big thank you to the Clinical Investigations Committee for creating the Emerging Scholars program this year that gave our students a new forum to share their research with our chapter and help support their attendance at the Annual Meeting! Our committee will continue to look for ways over the next year to help promote and support resident and student scholarly activity – it's a gateway to participation in our chapter through which many of us have started our USAFP journey.

LEADERSHIP

The annual Resident and Student Leadership Seminar was a hit once again this year. We had 55 residents and students who attended at least one of the sessions including topics such as lessons learned from recent residency graduates, understanding personality types, developing negotiating skills and leading wellness changes in learning environments,. In its third year, we had another 14 members achieve enough credits to be awarded the USAFP Resident and Student

Leadership Certificate, highlighting those who have dedicated time at one or more annual meetings to hone their skills in preparation to assume leadership roles in their future duty assignments.

ADVOCACY

Congratulations to our incoming Student and Resident Directors: Ross Stanton (USAF), Joshua Law (USA), Tegan Koski (USN), Clare Kinsella (USU) and Meaghan Raab (HPSP)! In addition to the exciting initiatives these directors will be championing, the USAFP is looking to have a larger footprint at this year's AAFP National Conference of Family Medicine Residents and Medical Students. Along with resurrecting a USAFP-funded dinner for HPSP and USU students and uniformed family medicine residents and staff physicians in attendance, the Board of Directors approved funding to establish a booth where uniformed family physicians can share the immeasurable value of choosing to wear the uniform and practice in our specialty. We'll also be continuing our efforts to give our resident and student members a voice in this newsletter by providing a platform for them to address issues affecting their peers.

WELLNESS AND RESILIENCY

In addition to promoting wellness through our Resident and Student Leadership seminar and a recurring Uniformed Family Physician article, our committee would love to hear from our resident and student members on additional ways we can foster wellness and strengthen resiliency for this special population within our chapter. Please reach out to us with ideas!

As you can tell, we are looking forward to a great year! If you're a student, a resident, a resident or student at heart, or someone interested in continuing to elevate the resident and student USAFP experience, please join us in the Resident and Student Affairs Committee by completing the Committee Interest Form at https://usafp.org/resident-and-student-affairs-committee/.

Disclaimer: The views expressed in this material are those of the author and do not reflect the official policy or position of the U.S. Government, the Department of Defense, the Department of the Air Force or the Uniformed Services University.

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committee report
WELLNESS AND RESILIENCY

Janet West, MD, FAAFP
Naval Hospital Jacksonville
bruno186@umn.edu

Finding your Joy in Medicine

As we all get back to day-to-day life after our annual meeting, we wanted to highlight what a great variety of lectures, workshops, and events everyone brought this year. Here is just some of the great wellness content from our meeting:

- Financial lectures from Matthew and Rebecca Noss, Nick Bennett, and Christopher Bunt
- Wellness workshops from Amanda Cuda, Tyler Rogers, Mary Alice Noel, Jeanmarie Rey, Mimi Raleigh, Ariel Hoffman, Aundrea Kasti, Francesca Cimino as well as Ashley Yano and Mary Alice Noel
- Specific physician well-being lectures from Joshua Davis and Janet West
- Wellness exercise put on by Brooke Organ and Emily Buck
- All Attendee Celebration at House of Blues including the USAFP Second Line through the French Quarter

Additional wellness education and training opportunities include:

- AAFP Physician Wellbeing Conference: 24-26 March, Hilton Head Island, SC
  - Three days of interactive learning, growth, and connection at the only national event solely focused on the wellbeing needs of physicians.
  - https://www.aafp.org/events/physician-health-and-well-being-conference.html
- AAFP Leading Physician Wellbeing Certificate Program: last day for application submission 10 June 2024
  - A unique certificate program designed to help develop leadership skills to spearhead change among physicians and other clinicians in your practice or organization.
  - https://www.aafp.org/family-physician/practice-and-career/managing-your-career/leading-physician-well-being.html
- Champions of Wellness Healthcare Summit: 17-18 September 2024, Rochester, MN
  - An event to educate leaders on the systemic causes of distress and spread insights and solutions among champions striving to ensure staff wellbeing.
  - https://www.championsofwellness.com/events/

We are honored to serve as your Wellness and Resiliency Committee Co-Chairs and extremely eager to bring some amazing programming over the next year, including a virtual Wellness Symposium in the fall and other exciting changes, as we focus on helping everyone find their joy in medicine and go "All In" for wellness in Las Vegas, NV next spring!

Please join our committee and reach out to us via https://usafp.org/wellness-and-resiliency/.

David Shahbodaghi, MD
U.S. Army Reserve
Bliss, TX
dshahbodaghi@sheridanmemorial.net

A Reservist's Perspective

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

My name is MAJ David Shahbodaghi, MD and I am a Family Medicine Physician in the U.S. Army Reserve stationed at Fort Bliss, Texas. I currently serve as the OIC of the 7413 TMC (Troop Medical Clinic); part of the 7248th MSU (Medical Support Unit). I am part of a unique Army Reserve Program designed for Physicians and Dentists who are geographically remote from their units, known as the AMEDD Army Professional Medical Command (APMC). APMC provides centralized management of medical professionals to improve readiness, retention, and recruitment of Army Reserve critical medical personnel. It is a brigade equivalent command that was established with the strategic intent of providing healthcare providers with a flexible method of performing military duty that assists with retaining healthcare providers in the Army Reserve.[1]

I previously served in the CENTCOM Area of Operations with the U.S. Army Reserve's 3rd MCDS (Medical Command Deployment Support) as a Field Surgeon (62B) for Operation Spartan Shield and Operation Inherent Resolve. I also supported the 42nd Infantry Division: Tactical Command Saudi and CENTCOM Forward Command.

WHEN DID YOU TRANSITION TO THE U.S. ARMY RESERVE? TELL US WHAT YOU DO AS A CIVILIAN?

I commissioned as an Active-Duty Army Officer through the U.S. Army's F. Edward Hébert Health Professions Scholarship Program (HPSP) in 2010 and I transitioned to the U.S. Army Reserve from Active Duty in 2022.

In my current civilian role, I serve as the Chief Medical Officer (CMO) for Sheridan Memorial Hospital in Plentywood, Montana. I also serve as the Medical Director for the hospitals in Scobey, Montana and Culbertson, Montana. Together, these three facilities comprise the healthcare system that serves all of Northeastern Montana.

WHAT KIND OF TRAINING DID YOU UNDERGO IN PREPARATION FOR YOUR OPERATIONAL ROLES?

In preparation for my deployments, I received education at the Army's Combat Casualty Care Course (C4) and the Tactical Combat Casualty Care Course (TCMC) at Joint Base San Antonio. These courses are designed to enhance the operational medical readiness and pre-deployment trauma training skills of medical officers.[2] These courses provided me with the knowledge needed to conduct Role I and Role II operations in an austere, combat setting.

WHAT ARE SOME OF THE MOST REWARDING AND CHALLENGING ASPECTS OF BEING A RESERVIST?

Transitioning to the U.S. Army Reserve has been extremely rewarding and beneficial for both me and my family. The beauty of the Reserve Service Model is that it allows physicians to pursue full-time private-sector employment while still maintaining a meaningful role in the Army. As a Reserve Component Physician, I have had the opportunity to attend Active Training (AT) each summer and help support the training missions of all three Army service components by providing real-world medical services to soldiers. This role has been extremely fulfilling and professionally satisfying. The greatest challenge for physicians in the Reserve Component, as elsewhere, is the element of time. The profession of Medicine is more than a mere occupation, it is truly a vocation, which does not cease at the end of the clinic day. Therefore, being intentional about setting aside the time necessary to properly serve in the USAR has been my greatest professional challenge.

HOW DID YOUR FAMILY MEDICINE TRAINING PREPARE YOU FOR OPERATIONAL MEDICINE?

The specialty of Family Medicine affords residency-trained physicians a broad range of medical skills spanning the gamut of age and health status and this is even more true for military-trained family physicians. Military physicians are not only taught to be expert clinicians, but are also trained as capable officers, adept at the arts of leadership, adaptability, and managing risk. It is well known that military officers receive enhanced training in leadership tactics, techniques, and procedures.[3] This leadership training is further enriched via the military system in both Graduate Medical Education and initial postgraduate assignments, where residents and young attending physicians are placed in leadership roles well in advance of timelines typically seen in the civilian sector. Military physician leaders are trained by experienced military faculty to successfully lead at all levels. My family medicine education was truly ideal training for my subsequent operational assignments.

WHAT ADVICE DO YOU HAVE FOR THOSE WANTING TO PURSUE AN OPERATIONAL ASSIGNMENT?

There is quite a bit of overlap between the duties and responsibilities of physicians serving in operational roles and those serving in garrison assignments. Physicians must maximize learning in their current assignments before actively seeking out an operational role. The military-specific trainings mentioned above are also ideal primers for those who have never deployed or been in an operational role as a military physician.

REFERENCES:

1. Army Reserve Medical Command "About Us." Accessed April 1, 2024. https://www.usar.army.mil/Commands/Functional/ARMEDCOM/About-Us/.
2. Military Health System. "Combat Casualty Care Course." Accessed April 1, 2024. https://www.health.mil/Military-Health-Topics/Education-and-Training/DMRTI/Course-Information/Combat-Casualty-Care-Course.
3. Shahbodaghi, David, and Edwin Farnell. "COVID-19 Crisis: The Pandemic Highlights the Unique Training and Skills of Military Physicians Afforded by Military-Specific Graduate Medical Education." Military Medicine 186, no. 11–12 (November 2, 2021): 292–93. https://doi.org/10.1093/milmed/usab288.

MEMBERS IN THE NEWS

Kevin M. Bernstein, MD, MMS, CAQ-SM, FAAFP was appointed to the AAFP AMA Delegation. Members of the AMA House of Delegates serve as an important communication, policy, and membership link between the AMA and grassroots physicians. The AMA delegate/alternate delegate is a key source of information on activities, programs, and policies of the AMA. The delegate/alternate delegate is also a direct contact for the individual member to communicate with and contribute to the formulation of AMA policy positions, the identification of situations that might be addressed through policy implementation efforts and the execution of AMA policies. Delegates and alternate delegates to the AMA are expected to foster a positive and useful two-way relationship between grassroots physicians and the AMA leadership.

Dr. Berstein's term of service began on December 15, 2023, and ends on December 14, 2025.

Congratulations Dr. Bernstein!

CONGRATULATIONS TO THE USAFP MEMBERS THAT RECEIVED THE AAFP DEGREE OF FELLOW

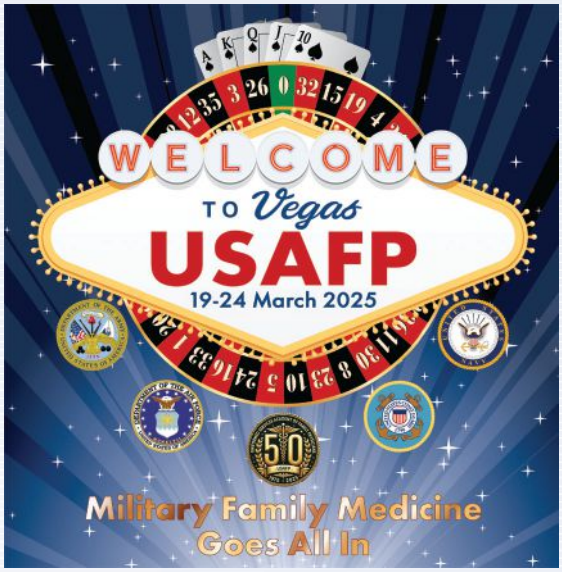
The Degree of Fellow recognizes AAFP members who have distinguished themselves among their colleagues, as well as in their communities, by their service to Family Medicine, by their advancement of health care to the American people and by their professional development through medical education and research.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

Congratulations to the following USAFP members!

Zachary Bevis MD, FAAFP
Justin Chaltry DO, FAAFP
Anna Christensen MD, FAAFP
Julie Creech-Organ DO, FAAFP
Stephanie Fulleborn MD, FAAFP
Kathryn Garner MD, FAAFP
Emily Goodwin MD, FAAFP
Noa Hammer MD, FAAFP
Sarah Kinkennon MD, FAAFP
Glynnis Knobloch MD, FAAFP
Briana Lindberg MD, FAAFP
Megan Mahowald MD, FAAFP
Brendan McCluney DO, FAAFP
Georgia McCrary DO, FAAFP
Brian Merrigan MD, FAAFP
Gordon Mok DO, FAAFP
Kathryn Oppenlander MD, FAAFP
Demian Packett MD, FAAFP
Kimberly Roman MD, FAAFP
Matthew Thompson MD, FAAFP
Elizabeth Williams MD, FAAFP
Tyler Wright MD, MS, FAAFP

Pictured are those who were in attendance at the 2024 Annual Meeting receiving their AAFP Degree of Fellow.

Call for Speakers



2025 USAFP Annual Meeting & Exposition

Military Family Medicine Goes All In
Las Vegas, NV (19-24 March 2025)

Thank you for your interest in presenting at the 2025 USAFP Annual Meeting and Exposition in Las Vegas, Nevada!

It is our goal to create an exciting and full scope program that highlights the passion and uniqueness of Uniformed Family Physicians. When we say, "Military Family Medicine Goes All In", we celebrate the dedication you show each and every day: commitment to the mission, compassion for our patients, and unconditional support for each other.

We welcome and encourage submissions from medical students, residents, faculty/staff, veterans, retirees, and spouses/family members. Some topic ideas are listed below and we're open to all of your great ideas as well.

Thank you for going "All In" with us to make next year's program a success!

If you have any questions or suggestions, please contact us at usafp2025@gmail.com.

SUBMISSION DEADLINE: 15 JUNE 2024

Catherine Delaney, MD & Matthew Noss, DO
Co-Chairs, 2025 USAFP Annual Meeting

"ALL IN" FOR THE MISSION

Operational Medicine
Large Scale Combat Operations
CBRNE
Austere medicine (cold/hot weather, wilderness topics)
Humanitarian Operations
Deployment Experiences/Lessons Learned

"ALL IN" FOR OUR PATIENTS

Preventative Medicine
Chronic Disease Management
Acute and Emergency Care
Procedures in Primary Care
Family and Community-based Care

"ALL IN" FOR EACH OTHER

Wellness for busy Physicians
Leadership/Mentorship/Career Development
Diversity, Equity, and Inclusion
Caring for our families
Graduate Medical Education

Calling all Spouses!!

The USAFP is looking for authors to write an article for the "Spouses Spotlight" in future Uniformed Family Physician editions. If you are interested or would like to nominate a spouse to author an article, please email Cheryl Modesto (cmodesto@vafp.org) and Jules Seales, MD (phedre.e@gmail.com).

USAFP Leaders Attend the AAFP's Annual Chapter Leadership Forum and National Conference of Constituency Leaders

Over 400 family physicians met in Kansas City 17-20 April for the AAFP's Annual Chapter Leadership Forum (ACLF) and the National Conference of Constituency Leaders (NCCL). Members from across services represented the USAFP at ACLF and NCCL.

USAFP President Mimi Raleigh, MD, USAFP President-Elect Gigi Rey, MD, USAFP Vice President Jules Seales, MD and USAFP Air Force Director Jedda Rupert, MD attended ACLF.

ACLF is the AAFP's leadership development program for chapter-elected leaders, aspiring chapter leaders, and chapter staff. Among other roles, ACLF functions as an orientation for emerging leaders who serve on chapter boards, as well as professional development for new and seasoned chapter staff. Drawing hundreds of chapter leaders each year, ACLF features targeted breakout sessions on chapter governance, advocacy, communication and much more.

USAFP members Mary Alice Noel, MD (Woman), Audrey Livesey, DO (LGBTQ+), Mariama Massaquoi, MD (Minority), Precious Pacia-Rantayo, MD (IMG), and Kathryn Gouthro, MD (New Physician) attended NCCL to represent the USAFP. USAFP Members Sterling Brodniak, DO and Eileen Tatum, MD, having been elected as Co-conveners at the 2023 NCCL for the LBGTQ+ and Women's constituencies respectively, served in this role in 2024 and will also serve as member constituents to the AAFP Congress of Delegates in Phoenix in September.

NCCL is the AAFP's leadership and policy development event for underrepresented constituencies. NCCL serves as a platform for different perspectives and concerns of AAFP members to help bring about change. The five constituencies with representation include: Women, Minorities, New Physicians (in the first seven years of practice following residency), International Medical Graduates (IMG), from schools outside the U.S., Canada, and Puerto Rico and Lesbian, Gay, Bisexual, Transgender, Questioning (LGBTQ+) physicians or physician allies.

At NCCL, physicians develop skills to advocate for issues that are relevant to specific constituencies, practices, the specialty, and patients. It also provides an opportunity for the constituencies to advocate for change in medicine by proposing resolutions for the AAFP to act on through legislative agenda, funding, policy statements and other formats. The member constituencies can submit up to 50 resolutions at NCCL regarding opportunities to support their constituency, their practice, their patients, or the specialty of family medicine.

On April 17th, the attendees of NCCL and ACLF were invited to attend a pre-conference DEI afternoon focusing on the topics of Advancing Health Equity, Understanding SDOH, Implicit Bias Training and Applying Anti-Racism to name a few.

Following the pre-conference offering, the ACLF delegation attended sessions focused on Board Leadership, Member Engagement, Advocacy, Communications, Education and much more. The NCCL constituency delegates attended their opening plenary titled, "A Path to Equitable Transformation of Healthcare Through Family Medicine" and then divided out into working groups and drafted resolutions to forward to the reference committees including advocacy, education, health of the public and science, organization and finance, and practice enhancement.

The 2025 ACLF/NCCL Conference is scheduled for April 23-26 in Kansas City, MO. If you have an interest in attending, please e-mail mlwhite@vafp.org so the USAFP can include your name for consideration. For more information on AAFP ACLF/NCCL, please visit https://www.aafp.org/events/aclf-nccl.html.



Incorporating Lifestyle Medicine Into Everyday Practice

Free Lifestyle Medicine Resources for Physicians

AAFP
AMERICAN ACADEMY OF FAMILY PHYSICIANS

Use the American Academy of Family Physicians' **Lifestyle Medicine Toolkit**.

THE JOURNAL OF FAMILY PRACTICE

Read *The Journal of Family Practice's* **A Family Physician's Introduction to Lifestyle Medicine** supplement.

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Home of Full Plate Living

new members

THE USAFP WELCOMES THE FOLLOWING NEW MEMBERS...

ACTIVE

Robin Camp, MD, MPH
Sarah Plyler, MD
Nicholas Ruppel, DO
Mason Tyler, DO

STUDENT

Keeley Adams
Julia Asada
Savannah Bahls
Kalli Barrett
Rebecca Beard
Nicholas Beraho
Patrick Brandenburg
Mark Brooks
Josie Browning
Jessica Burckhard
Stephen Burraston
Christopher Calderon
Adriel Carrillo
Taryn Cates-Beier
Michael Chavez-Galvez
Krithika Chetty
Stephen Christensen
Elizabeth Costello
Thomas Croft
Joshua Cruz
Jackson Dehn
Santita Ebangwese
Gentry Ensign
Brianna Fiegl
Reileigh Fleeher
Victoria Fonzi, MPH
Joseph George
Laura Goldsmith
Emerald Goranson
Charli Gruen
Eric Hennemann
Benjamin Honey
Breanna Ito
Marley Jacobs
David Johnson
Amanda Jones, NP
Elisabeth Kaza
Alex Kimble
Naden Kreitz
Woo Kwon
Anne Laird
Molly Lamb
William Lawson
Alissa Leyman
Evan Mak
Yuliya Mazo
Cedric Miller PA
Paige Mitchell
Megan Monroe
Michael Morell
Katherine Nagel
Maria Ochiai
Emamoke Odafe
Lourdes Palacios
Eleanor Park
Joseph Paturzo
Jordan Peoples
James Pike
David Pitts Jr
Juliana Pitzer
Joshua Pound
Gopal Pudasaini
Nicholas Pulciano
Camille Rich
Elise Rodrigues
Caitlin Ross
Anna Scheuring
Quinn Schroeder
Joseph Spirnak
Benjamin Stevens
Amanda Strong
Tyler Sturgill
Lauretta Suneborn
Ivanna Tang
Benjamin Tebbe
Tommy Thompson
John-Paulo Torre
Hector Trejo
Sean Twardy
Robert Upton, III
Javier Vélez Toro
Jesse Walter
Conley Walters
John Zablotney

Get Involved With

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.

ATTENTION USAFP MEMBERS:

The USAFP Board of Directors and Committee Chairs are shaping the direction of the Academy and would appreciate your feedback via a member survey. Please just take a few minutes to complete the survey and help the USAFP accomplish its mission and goals for member service. It is a very short survey, and you should be able to complete it in less than 5 minutes.

Your input is highly valued, and I thank you in advance for completing the survey.

We hope you are planning to attend the 2025 USAFP Annual Meeting & Exposition in Las Vegas, Nevada 19-24 March. It is a great way to be "All In for Military Family Medicine" reconnecting with friends and obtaining incredible CME.

Sincerely,

Meghan "Mimi" Raleigh, MD, FAAFP
President

The USAFP Foundation would like to memorialize those current and prior USAFP members that pass during the year at the annual meeting. If you are aware of a peer's passing, please send a note to Cheryl Modesto in the USAFP Headquarters office (cmodesto@vafp.org).

Family Medicine Opportunities

Want to join an exceptional organization? If you value quality, go above and beyond in making patients a priority and want to help cultivate a positive, healthy, work environment, we want to talk to you. We are focused on assembling an outstanding team who will work together to maintain our stellar reputation and build a strong brand for **Northern Arizona Healthcare** as we expand our services.

Our team of more than 200 of the highest quality providers who had their choice of healthcare organizations, chose **Northern Arizona Healthcare Medical Group**.

Here's Why:

- Patient-centered, physician led, team-based and collaborative work environment.
- Work-life balance is a priority with generous PTO.
- Financially stable, growing organization.
- 2 Hospitals, Cardiovascular and Orthopedic Spine Institutes, Rehab and Cancer Centers.
- AI Scribe Support.
- Clinics located in Flagstaff, Sedona, Cottonwood, and Camp Verde.
- Highly competitive compensation and benefits.
- Sign on bonuses up to $100k.
- Relocation bonuses
- CME
- Malpractice Coverage plus tail.
- Base salary $265,000, plus Incentives.
- Loan Repayment Programs.
- Low physician turnover and High patient satisfaction.

Live the Good Life:

In our Northern Arizona communities, you'll discover abundant opportunities to enjoy a lifestyle that's comparable to few other places. It is all here, four beautiful seasons, clean air, great neighborhoods and no traffic jams. No matter what you do for fun, recreational opportunities are everywhere -- downhill and cross-country skiing, gorgeous hiking trails, wine tasting, and fine dining. You will also find it ready-made for families with excellent public and private schools, thriving secondary educational facilities, and cultural breadth and diversity. In addition, wherever you live and work you are well-positioned for weekend getaways in the vibrant cities of Phoenix and Las Vegas.

If you want to join an organization at a time of growth, transformation, and innovation, centered on providing high quality, cost-effective, and convenient care for our patients, we want to talk to you!

Contact Physician Recruiter, Lori Stephenson at **Lori.Stephenson@nahealth.com** or call-**509-388-5124**.

You'll come for the View and stay for the Vision!

Northern Arizona Healthcare

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