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Greetings! Hopefully your summer is going well. I wanted to share some info on how our USAFP chapter is “all in” with the AAFP. You may not realize that the USAFP is the only non-geographical chapter of the larger AAFP; the other chapters being the fifty states, three of five US territories and the District of Columbia. Every fall the AAFP convenes the Congress of Delegates (AAFP’s policy-making body). Two delegates and two alternates from each constituent chapter and from the member constituencies including new physicians, residents, students and other constituency groups represented at the AAFP Leadership Conference (more about that in a moment) comprise the Congress. At the Congress of Delegates (COD), delegates elect new officers and three members to serve on the AAFP Board of Directors for the following 12 months. Also, business items (resolutions) are debated and voted on. Historically the USAFP selects delegates and alternates to the COD from past presidents and current officers. Rob Oh and I will be delegates this year; Christopher Jonas and Kim Roman, alternates.

As for the annual April AAFP Leadership Conference, there are two sections: National Conference for Constituency Leaders (NCCL) and Annual Chapter Leader Forum (ACLF). USAFP is proud to send representatives for each constituency (international medical graduates, LGBT, minorities, new physicians, and women) to NCCL. And two of the last three years our chapter has put forward a resolution that has been adopted by that body (and subsequently been sent to the AAFP Board of Directors for consideration). We usually send our four chapter leaders to ACLF to learn more about governing a major non-profit organization as well as exchange ideas with leaders from fellow chapters.

Lastly I would like to share that the USAFP Executive Director and Officers have embarked on cleaning up our chapter bylaws. Recommended administrative changes have been sent to the bylaws committee for review and presentation at the September Board meeting in San Antonio.

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Northwest Washington Family Medicine Residency located in Bremerton, Washington seeks a full-time, full scope Family Medicine physician for a faculty position. We are a newly-accredited, community-based, 8/8/8 residency program. We are the only residency program affiliated with CHI Franciscan Health Harrison Medical Center, a full service regional medical center. Offering a very competitive compensation and comprehensive benefit package.

We provide full spectrum training including: obstetrics, sports medicine and inpatient medicine with an emphasis on equipping our residents to practice in any rural or underserved community setting. Applicants must be ABFM board certified family physicians (MD/DO) who provide full spectrum care and share a passion for underserved medicine. Responsibilities of all faculty include teaching residents and students in clinic and hospital settings, developing an outpatient practice at the Bremerton site and sharing OB and inpatient call.

We are dedicated to providing a superior training experience with unique opportunities including: a full basket of outpatient procedural skills (colposcopy, treadmill testing and front-line ultrasound), an embedded HIV specialty clinic, a longitudinal interest-guided community medicine rotation, training in Medication-Assisted Therapy (MAT) for opiate dependence, enhanced longitudinal mental health training, and global health rotation opportunities. Our residents will work directly with a broad range of local specialists for maximal hands-on training.

Located on the Kitsap Peninsula, we are surrounded by breathtaking water and mountain views, yet we are a short ferry ride from downtown Seattle. Housing is very affordable (with a median price half that of Seattle). Our schools are excellent and there is a plethora of parks and outdoor recreation opportunities. Exceptional quality of life is what makes this region’s residents and guests smile.
Courage to be Conscientious

Although it was 13 years ago, I remember my first call night as a new Resident in Family Medicine as if it were yesterday. My attending began the night uttering startling words I will never forget, “Practice as if everyone is trying to kill your patient. You cannot miss a single detail. Always be conscientious of your patient, their family, all specialists and others participating in their care. Never forget that your patient’s greatest risk factor is your knowledge and your conscientiousness.” He taught these principles further by quietly commanding daily diligence in checking and rechecking lab, imaging and procedural results. He even asked that we read and ponder them ourselves independent of specialist opinions. He studied every detail and communicated deliberately with every member of the medical team in a professional manner. He trained us to look for subtleties in speech, posture and facial expressions that bespoke unsaid concerns in our patients and colleagues. He was quietly and consistently 5 minutes early for lectures, meetings and even seemingly small events and was mindful of his dress and grooming always and expected the same of us. We learned when to laugh, when to cry and when to rejoice with patients….most importantly when to know the difference. He taught us to be the calming voice of reason in every room we find ourselves in (no matter our role) and to never draw attention to ourselves but rather quietly build others. Because of the way he conducted himself, this incredible Uniformed Family Physician was trusted and praised by all who knew him and he wanted us to have the same. On one occasion a junior resident challenged his conscientiousness doctrine and his reply was profound, “It doesn’t matter what others do, I promise you that if you conduct yourself in this way, you will be the kind of Uniformed Family Physician patients and colleagues need.” No matter what stage of our career we find ourselves in, the courage to be conscientious is a premier characteristic that defines true success as Uniformed Family Physicians.

In 2009, researchers at the University of Minnesota studied 627 medical students in an effort to discover what traits most predicted success in medical training. Characteristics studied included: neuroticism, extraversion, openness, agreeableness and conscientiousness. Conscientiousness was found to be twice as predictive of success in training across 7 years than any other trait and was further defined as: competence, order, dutifulness, achievement, striving, self-discipline, and deliberation. Conscientiousness lent itself to good study habits, but was more important during clinical years and the most conscientious students also had the least disciplinary actions. (1) Certainly there is added importance for conscientiousness for a Soldier, Sailor, Airman/Woman, Marine, Coastguardsman/Woman or Pubic Health Servant. Although my attending never used these words, he lived by them and thankfully taught us to do the same….but what about success beyond training?

The value patients place on conscientiousness above all traits a physician can exhibit is profoundly compelling. There is great data describing the importance of attention to medical, laboratory, and technical details, but conscientiousness appears to be infinitely more about physician-patient communication. The old adage, “they don’t care what you
know until they know you care” has application. Wen and colleagues found that people most value physicians who exhibit “excellent listening, caring, compassionate and transparent care. Patients want doctors who are accessible, practice in interdisciplinary teams and verbalize that they have the patient’s best interests at heart.” (2) Conversely, the perils of poor conscientiousness persist beyond medical training as well. In 1997, a landmark study was conducted at the University of Toronto on patient-physician communication and found physician conscientiousness to be the supreme trait once again. Authors found that physicians who demonstrated the highest levels of patient conscientiousness (half of the doctors studied) had NEVER been sued. The less conscientious half had been sued at least twice. (3) They found further and very specifically, the physicians who had never been sued (3):

1. **Spent more than 3 minutes longer with each patient.**
2. **Made orienting comments such as, “First I will examine you, and then we will talk the problem over.”**
3. **Actively listened, including statement such as, “go on, tell me more about that.”**
4. **Were more likely to laugh and be funny during the visit.**

There is no doubt that Uniformed Family Physicians face the broadest and deepest challenges in medicine in terms of breadth of age and situations we could find ourselves in and the need for conscientiousness is paramount. Data supports what my attending demonstrated at the beginning of residency, that conscientiousness can be replicated when peers and teachers demonstrate it and demand it of one another.(4) May our deliberate attention to our external dress, grooming, awareness, communication and timeliness always reflect our internal honor for conscientiousness? Will we always help each other to have the courage to be conscientious in action and communication as well? It is my hope that the concepts presented in this edition of the USAFP newsletter will help us to do so.

**REFERENCES**


Value-based care: A physician’s perspective

“Fine FPs, this quarter I am turning over the Specialty Leader section to LCDR McDermott to discuss the ongoing implementation of Value Based Care.”

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“Raise your hand if you’re happy with the way we do medicine?” The room, previously filled with talk, was awkwardly silent and the air void of hands.

“Why do we do the same thing, get the same results, and have the same frustrations?” This was my introduction to value-based care, by a guest lecturer and pioneer in the field.

The following three months witnessed an orchestrated chaos, proving to be a beautiful marriage of business analytics, care pathways, and outcome metrics that matter to both providers and patients. I was lucky enough to be a member of the development team for diabetic care and was surprised to find the disease was more involved than monitoring hemoglobin A1c. Speaking with several patients who were members of the team, it became apparent the struggle was not from poor understanding of the disease, but was about the “why” we are struggling. The “why” ultimately dictates the value-based care infrastructure.

While each Integrated Practice Unit, or IPU, is different, the Diabetes IPU developed a core team of five providers: physician, pharmacist, dietitian, behavioral health specialist, and nurse educator. A care navigator (a hospital corpsman in the Navy Medicine model) serves as a liaison and coordinator of care. Our core team intimately develops the care pathways and meets regularly for treatment boards to discuss complicated patients and form more integrated treatment approaches. In addition, each patient meets with every member of the core team, generally in a round-robin setting.

How is value-based care different? The heart lies in the focus: prioritizing what’s important to patients, in their words. Patient-reported outcomes anchor this approach, and measures of success rely heavily on patients’ responses. For the Diabetes IPU, we periodically ask patients to rate the statement: “I find it hard to do all of the things I have to do for my diabetes” on a 0 to 10 scale. Our hope is that with time, patients’ ratings improve, showing that they feel more in control of their diabetes. This same approach is true for each IPU, and asking questions best represents the patients’ perceptions of their care.

By relying on patient-reported outcomes, I connect with patients in a much different manner. Each story resonates and I’m permitted to peek into individuals’ lives and see how their disease impacts them. Most of my time is spent listening, and this provides insight into forming individualized care plans that patients feel intimately involved in constructing. It’s an empowering process both for patients and providers.

Value-based care represents a renaissance in how we provide care, and it’s rooted in simplicity. Patients have said that providers don’t listen enough. Providers claim we don’t have enough time to listen. The architecture of value-based care provides a framework for enabling an authentic, patient-focused experience that respects the individuality of each patient and helps providers understand each patient’s story. Patients are not algorithmic, and their care shouldn’t be either.

As our pilot at Naval Hospital Jacksonville expands, we’ve incorporated a Family Medicine Residency Program. Following an initial patient visit, LT John Koch (a third year resident), stared at the ground perplexed. I asked him why.

“This is not at all what I thought it would be. All we did was ask questions about why she was having a tough time with her diabetes. This is not what I went to medical school for,” LT Koch replied.

I smiled.

“Now we know why she’s struggling. Her story clued us in as to why she hasn’t

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Clinical Pharmacology Fellowship

What is Clinical Pharmacology?
Clinical Pharmacology is concerned with better understanding and use of existing drugs, and development of more effective and safer drugs for the future. Clinical Pharmacology allows one to stand between the research lab and the bedside, in a unique position to translate laboratory research into new drug therapies. Clinical pharmacologists are a bridge between the science and practice of medicine.

Who can apply for the Fellowship?
The Clinical Pharmacology training program is available to active duty Army physicians who are board eligible/certified in a primary specialty and active duty Army PhDs/PharmDs (71A, 71B, or 67E) who have a doctoral degree in one of the life or medical sciences from an accredited academic institution in the United States, Canada, or non-U.S. degree equivalent. A research background, mathematical inclination, and pharmacology/medical experience is preferred. Civilians could be considered if they joined the Army and successfully compete for a position in the program.

Additional activities include:
- Conduct laboratory, animal, or clinical research under the supervision of a mentor
- Participate in the teaching of Clinical Pharmacology to medical students, house staff, and practicing physicians
- Three month rotation with a review division at the FDA
- Participate in continuing medical education, research seminars, and journal clubs

Potential Job Assignments
- WRAIR (Silver Spring, MD)
- USU (Bethesda, MD)
- Overseas labs (Thailand, Kenya)
- USAMMDA (Ft. Detrick, MD)
- USAMRIID (Ft. Detrick, MD)
- USAMRICD (Aberdeen Proving Ground, MD)
been taking her medicine. We were able to offer a different care plan to her, one that she was part of making. We found out the why, and now we can use our tools to better mesh with her individual story. I would argue this is exactly what you went to medical school for.”

He laughed, “Well, when you put it that way…”

I don’t claim value-based care provides all of the answers our community so desperately seeks for a more sustainable system. I’m certain the value-based care methodology has transformed my approach to the patient. It has taught me (again) to prioritize patients and their stories, since those stories form the foundation of the physician-patient connection. Maybe (just maybe), patients’ individual stories will better guide us to choose the right tools from our toolbox, as LT Koch learned. Maybe downstream, traditionally-defined patient outcomes will also improve. We’re already starting to see this with A1c scores. At the heart of this reformation needs to be a realization of our commitment: to help patients and value them as individuals.

DISCLAIMER

The views expressed in this article are those of the author and do not necessarily reflect the official policy or position of the Department of the Navy, Department of Defense, nor the U.S. Government.

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Wherever you see yourself and your new practice, chances are a CHS-affiliated hospital is nearby. And if you choose to practice with one, chances are you’ll be glad you did. Approximately 27,000 physicians – employed and independent – serve on the medical staffs of 137 CHS-affiliated hospitals in 21 states. The hospitals deliver a wide range of health services and function as vitally important members of their local communities. Last year, physician satisfaction was high at 89 percent, and 91 percent of physicians said they would recommend the hospitals with which they are affiliated to family and friends.*

In 2013, The Joint Commission named 93 CHS-affiliated hospitals as Top Performers on Key Quality Measures. An array of national quality recognitions and honors includes accredited chest pain centers, accredited stroke centers, and Centers of Excellence for bariatric services.

While we’re literally “all over the map,” we’re focused on helping you find a place to build a successful practice. Affiliated hospitals have the flexibility to meet individual needs and the ability to offer competitive recruitment packages and start-up incentives, which may include medical education debt assistance and even residency stipends. Hundreds of physicians choose CHS-affiliated hospitals each year – for quality of care and quality of life. One may be right for you!

For more information, visit: www.chsmedcareers.com. Email: docjobs@chs.net  Call: 800-367-6813

*CHS-affiliated facilities included 135 hospitals in 2013.
Temporary Grade promotions for this year are posted on the CCMIS website. Congratulations to all who promoted this year! As you know, promotion to O5 and O6 are competitive in all categories. For medical category this year, the promotion rate was 25% for O5 and 31% for O6. For anyone who did not promote, I highly recommend seeking mentoring advice. The mentoring subcommittee of the Physician Professional Advisory Committee (PPAC) provides mentors for career and promotion advice. Additional resources can be found in the “Promotions” tab of the CCMIS website, http://ccmis.usphs.gov/ccmis/.

As you may be aware, VADM Vivek Murthy has stepped down from the position as Surgeon General, and our acting Surgeon General is now RADM Sylvia Trent-Adams. The webpage for the Commissioned Officers Association of the USPHS has an interesting editorial from Dr. Richard Carmona, 17th US Surgeon General, originally published in *Military Medicine*, regarding political appointment for this Office. The editorial can be found here: http://www.coausphs.org/media/1603/instantadmirals_militarymedicine_2017.pdf

Prior to VADM Murthy’s departure, he announced that a Memorandum of Agreement was signed to provide the Veterans Administration (VA) with Commissioned Corps officers who will deliver clinical care to veterans in VA hospitals and clinics in underserved communities. The initial agreement is a 5 year commitment with the potential to be extended. A limited number of officers will be selected initially, with preference given to new recruits.

The 52nd Annual USPHS Scientific and Training Symposium was in Chattanooga, TN, on June 6-9th, and as always, was hosted by the Commissioned Officers Foundation for the Advancement of Public Health. Over 1000 people attended the annual gathering of PHS officers and state and local health professionals. Several informative workshops and lectures on a variety of topics were available. Keynotes were delivered by Dr. James Marks, President, Robert Wood Johnson Foundation; RADM Sylvia Trent-Adams, Acting Surgeon General; Dr. Erika Lee, Director of Immigration History Center at the University of Minnesota; RADM Ali Kahn (ret), Dean, University of Nebraska Medical Center College of Public Health; RADM Anne Schuchat, Acting Director, Centers for Disease Control and Prevention, and RADM Boris Lushniak (ret), Dean, University of Maryland School of Public Health. The Training Symposium is a wonderful annual event and a great opportunity to meet, network, and socialize with your fellow PHS officers, receive some worthwhile training, and get up to speed with what’s happening in Public Health.

That’s all I have for now. Please feel free to contact me with any questions or issues: Sarah.Arnold@fda.hhs.gov.

HOW DOES IT WORK?

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.
Family Medicine Opportunities
Positions in Missouri
Excellent Student Loan Repayment Program

Mercy Clinic, a regional and national recognized leader in healthcare, is seeking BE/BC Family Medicine Physicians to join established group practices in Missouri throughout St. Louis, Jefferson and Franklin Counties.

The Position Offers:
- Integrated health system with a competitive income guarantee.
- Comprehensive benefits including health, dental, vision and CME.
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- Mercy Clinic Maryland Heights.
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- Mercy Clinic Gerald.
- Mercy South County

About Mercy Clinic:
A strong, physician-led and professionally-managed multi-specialty group with more than 700 physicians and 45 medical specialties. Mercy Clinic is a part of Mercy Health, the fifth largest Catholic Health Care System in the nation. Located in seven states, Mercy is comprised of 43 hospitals employing 40,000 co-workers and more than 3,500 Mercy Clinic physicians.

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Newport Hospital and Health Services is located in Newport, WA in the Northeast corner of the state along the Idaho border and serves approximately 17,000 patients. Some of Washington’s best recreational amenities are in our own backyard! To learn more about us and view all current job listings, visit NewportHospitalAndHealth.org.

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Hello Everyone,

I hope that everyone is finding time to enjoy the summer with families and friends. Our folks work hard, and it is important to take the time to recharge. The summer brings with it the last quarter of FY17. I think much of the tone for FY17 was set by the National Defense Authorization Act for FY17. If you have not had a chance to glance over it, I would recommend a quick look at the summary by googling “NDAA 2017 summary.”

This gives a good idea of the perceptions of the Senate Armed Services Committee, and specifically the perceptions and goals of the Military Compensation and Retirement Modernization Commission for the Military Health System. These perceptions and goals are important to keep in mind as we think of the positive changes the AFMS has made in 2017 and the challenges we still have to figure out.

What are key statements in the 2017 NDAA for us all to be aware of?

While it is important to understand the MHS specific statements, there are some noteworthy generalities. The national defense budget is $602 billion, with nearly $23 billion in unfunded requirements of which $7 billion were considered readiness-related. Thus, even things that we think make perfect sense and are valid requirements that drive funding or resourcing are competing with $23 billion worth of similar requirements that won’t have funding. There are money and manpower limitations that are real and that we have to keep in mind as members of the system that we are trying to improve.

The NDAA specifically targeted comprehensive reform of the military health system as a means for sustaining the quality of life of the men and women of the total force and their families. This proposed reform targeted improving operational medical force readiness, improve access to care, and expand beneficiaries’ choices of health plans while providing higher quality care and a better experience of care. The NDAA stated that there is a lack of additional capacity to enroll patients in bottle-necked primary care clinics, but beneficiaries continue to be required to receive care at military hospitals. The NDAA also states that data shows that military healthcare providers have much lower productivity than their comparable civilian counterparts (productivity goal of 40% Medical Group Management Association median), which severely limits beneficiaries’ access to care. This statement about MGMA targets is clearly not applicable to primary care given that AFMH targets are enrollment based; however, the general implication is that DoD physicians don’t produce enough clinical care. Additionally, the NDAA states that the total cost to provide healthcare in military treatment facilities is greater than the cost in the private sector. This did not state if the requirement costs of ready medics and a medically ready force was included in the comparison.

The statement about MGMA targets limits beneficiaries’ access to care. This NDAA summary states that data shows that military healthcare providers have much lower productivity than their comparable civilian counterparts (productivity goal of 40% Medical Group Management Association median), which severely limits beneficiaries’ access to care. This statement about MGMA targets is clearly not applicable to primary care given that AFMH targets are enrollment based; however, the general implication is that DoD physicians don’t produce enough clinical care. Additionally, the NDAA states that the total cost to provide healthcare in military treatment facilities is greater than the cost in the private sector. This did not state if the requirement costs of ready medics and a medically ready force was included in the comparison.

The NDAA specifically recommended several provisions: eliminate the requirement for pre-authorization for specialty care referrals, improve pediatric care and related services, incentivize participation in disease management programs, require a standardized appointment process, require contracts for turn-key primary care/urgent care clinics at MTFs, establish performance accountability for military healthcare leaders, right-size the footprint of the MHS to meet operational medical force requirements, and authorize conversion of military healthcare provider positions to civilian or contract positions. Our AFMS leadership has prepared to offer objective cost verses benefit data and feasibility regarding the application of these provisions and reform targets.

What things has the AFMS done thus far?

Many things have been done to improve the quality and safety of care delivered by the AFMS. Some measures directly impact outcomes, and others are positive steps towards desired outcomes. Some examples follow below.

The AFMH branch completed time motion studies at three MTFs to objectively quantify provider workload by three categories: time spent caring for scheduled patients, time spent caring for patients without an appointment, and time spent doing no clinical work. In total the providers averaged 57 hours per week. This data will be key in shaping current and future workload and manpower models. AFMOA is currently working with A1 manpower as they conduct site visits to relook at family health clinic workload and staffing models.

A pilot was started by placing 20 non enrolled AFMH contract providers at 11 MTFs to mitigate short term (less than 6 month) vacancies. This was then included to establish 23 non enrolled civilian provider positions in the FY 18 POM that started to fill in January 2017. Additionally, 19 non enrolled positions were requested in the FY 19 POM. Thus a commitment has been made to...
Their full capacity as we do down garrison and utilizing their skills to greater use of enlisted providers in proposing solutions such as making care. Dr. Kellerman also goes on to missions in addition to beneficiary per beneficiary and support combat. By this data, we are actually cheaper billion provided care for 11.3 million. Permanente FY16 budget of $64.6 million beneficiaries, verses Kaiser $48.8 billion provides care for 9.8 million. FY17 budget for military health of $10.4 trillion. Workload for PHAs was calculated and included in considerations for FY18 and FY19 manpower programming in the POM as well as mitigation strategies until potential POM authorizations would be available.

Physician representatives joined recruiters on visits to civilian medical schools, residencies, and the AAFP National Conference of Family Medicine Residents and Students generating hundreds of interested candidates and potentially significantly bolstering Family Medicine recruitment. Additionally the medical corps office has vigorously engaged with HPSP students and held several primary care dial-ins facilitated by program directors and consultants in order to bolster primary care recruitment.

While there may be disagreement with some of the NDAA assertions or solutions, there is complete agreement that reform of the military health system is required to improve not only the quality of care delivered, but also to improve patient satisfaction and staff satisfaction. There have been many strides taken in the right direction. In addition to continued systematic improvement, we as family physicians must continue to embrace ownership of our empaneled patients, function as efficiently as possible, and utilize all the members of our team to their full scope.

As always I thank you for your hard work and the amazing care you provide.

WE ARE … FAMILY MEDICINE

Antoin “Marcus” Alexander
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OPERATIONAL MEDICINE

How Do I Get My Patient Home From Overseas/Deployment?

WHERE DOES MY PATIENT GO?

Have you been deployed, been stationed overseas or been in a training scenario where you needed a patient that you were caring for transferred or airlifted to a higher level of care? Have you ever wondered where your patient went or how they got back to their home station? Have you heard of an Air Force Form 3899 or patient movement request form? Have you heard of the Theater Patient Movement Requirement Center (TPMRC)? If you haven’t and you aren’t familiar with this process, then this is vital information you want to know and be familiar with if you are deployed or stationed overseas.

WHAT IS TPMRC?

TPMRCs are joint units that work directly for the United States Transportation Command Surgeon General (USTRANSCOM SG). There are three TPMRCs stationed throughout the world and are responsible for different Geographic Combat Commands (GCC) or AORs. Each TPMRC functions as the focal point to validate, coordinate and communicate information for safe patient movements in the AORs. TPMRC-East is located at Ramstein Air Base Germany and is responsible for patient movements in AFRICOM, CENTCOM and EUCOM. TPMRC-West is located at Hickam Air Force Base, Hawaii and is responsible for patient movements in PACAF. Lastly, there is TPMRC-Americas stationed at USTRANSOM headquarters at Scott AFB, Illinois and they are responsible for patient movements in SOCOM and the continental United States (CONUS).

There are four standard job positions at each TPMRC. Two of these positions are the patient movement controllers (PMC) and the patient movement operations officers (PMOO). They coordinate all the required administrative information. The other two positions are the patient movement clinical coordinators (PMCC) and the validating flight surgeons (VFS). They coordinate all of the clinical aspects of the patient movement. The responsibility of a TPMRC is to clinically and administratively validate regulated patient movement requests (PMRs) for DOD associated individual that need to move more than 100 miles for medical care.

UNREGULATED VS REGULATED

An unregulated move is either CASEVAC or MEDEVAC. CASEVAC is a movement of casualties via any method of transport in an expeditious manner. MEDEVAC traditionally refers to Army, Navy, Marine Corps, and Coast Guard patient movement using pre-designated tactical or logistic aircraft, boats, ships, and other watercraft temporarily equipped and staffed with medical attendants for en route care.

A regulated move is one that is done through the Aeromedical Evacuation (AE) system. AE specifically refers to USAF provided fixed-wing movement of validated patients with official patient movement request (3899). This type of move uses organic and/or contracted mobility airframes with USAF or CIV equivalent AE aircrew trained explicitly for this mission.

WHAT IS A PMR OR AIR FORCE FORM 3899?

A PMR is simply a transfer summary. It’s standard practice that when a patient needs to transfer to a higher level of care you prepare a transfer summary. The summary has the individual’s personal and clinical information including history of present illness, medication, labs, allergies, required equipment and what was needed next in the patients care. This is the standardized patient movement process established by the Department of Defense (DOD). When a patient needs to move to a higher level of care, a PMR/3899 is generated by the sending Military Treatment Facility (MTF) and submitted to the corresponding TPMRC. This 3899 is a legal, electronic record that becomes part of the permanent medical record so it needs to be filled out and submitted correctly. This submission is accomplished through a computer program called TRANSCOM Regulating Aeromedical Command and Control Evacuation System or “TRAC2ES” for short. If the sending MTF/SHIP/Facility does not have access to TRAC2ES then...
an electronic form can be filled out and submitted directly to the TPMRC and they can enter it.

**WHAT HAPPENS WHEN THE TPMRC GETS THE 3899?**

When the TPMRC receives the PMR from a sending MTF, it is reviewed both administratively and clinically (see Figure 1). The PMC and the PMOO administratively make sure there are the proper orders, ID cards, Tricare authorizations, billing and any attendant information and much more. Clinically, the PMCC and the VFS review the medical situation. They make sure that the location that the patient is going to is appropriate, they determine its precedence (urgent vs priority vs routine), appropriate mode of travel, and make any adjustments or interventions needed for safe transportation. Communication is paramount during this process. Once all the information is received, then the PMR is validated.

Validation is a logistician term, meaning that a requirement has been submitted to the Tanker Airlift Control Center (TACC) or the Aeromedical Evacuation Control Team (AECT) because they control the planes. Once they get the requirement, they make plans for finding a plane to move the patient. Once a plane is assigned, TACC/AECT lets TPMRC know and then TPMRC calls the MTF and other involved about the mission timeline.

TPMRC builds a mission plan in TRAC2ES for in-transit visibility. The MTF with the Contingency Aeromedical Staging Facility (CASF) or En-Route Patient Staging System (ERPSS) are then responsible to make sure the patient gets to the flight line to be handed over to the aeromedical evacuation (AE) crew to take care of the patient during the flight to their next destination. The AE crew usually consists of a flight nurse and technicians. If the patient needs more intensive care, a critical care team (CCATT) can be added on to the flight to take care of the patient.

**WHAT ARE SOME UNIQUE ISSUES AT TPMRC?**

Some of the medical factors faced at TPMRCs are battle injuries, communicable diseases, ground transportations, working dogs, extracorporeal membranous oxygenation (ECMO), burn injuries, Neonatal Intensive Care Unit (NICU) moves and CCATT moves with critically ill patients. We also move coalition and allied forces when they need help. Additionally, with the deployment tempo in some locations, it’s important for us to be aware of the capabilities of each location because of potential poor turnover between rotations and the new providers not being aware of local resources. If we can’t move our DOD patients, we coordinate with International SOS to arrange civilian air ambulance movements. One of the biggest challenges we face is making all of these arrangements and decisions without ever laying eyes on the patient. We must question extensively and thoroughly to make sure we understand the patient’s situation.

There are a lot of non-medical factors for each TPMRC to consider. Some of these are weather, working with foreign governments and hospitals, aircraft maintenance problems, availability of aircraft, crew duty day limitations, en-route stops, diplomatic clearances, local exercises, tail to tail transfers, foreign national issues, and in-flight emergencies.

**WHAT IS IT LIKE WORKING AT TPMRC?**

Working at TPMRC is dynamic and no two days are the same. At TPMRC, we cover 24/7/365 and we never know what is going to happen during our shifts at work. Some days and nights are very long but we know that our troop’s lives are in our hands and we want to help our colleagues safely and efficiently get the patients the proper care they need. If you ever have questions feel free to call. A few resources for patient movements are Air
Stop Wasting Time: How to Run Meetings Effectively

Think about the last meeting you attended. Was it worthwhile or a waste of time? Now think about the last meeting that you ran. Was it worthwhile for your participants...or did it waste their time?

Why do we hold meetings? Peter Drucker, a notable U.S. business executive, states, “We meet because the knowledge and experience needed in a specific situation are not available in one head, but have to be pieced together out of the knowledge and experience of several people.”

In an ideal world, meetings allow organizations to make decisions, explore new ideas and brainstorm, teach, review progress, build teams, and solve problems. Unfortunately, many of us have attended meetings that were held for the wrong reasons: passing on information that could have been shared in an email, because it is the “weekly” meeting, to vent, or to listen to one person talk without any collaboration from the group.

Recent collaborative research shows that business executives in the United States consider over two-thirds of meetings to be failures. It also states that senior managers spend up to 50% of their time in meetings. Despite the general assumption that experience makes one more proficient, that paradigm does not apply to running meetings. Running more meetings does not make you better at running meetings. Running more meetings does not make you better at running meetings (unless, of course, you have had specific training or sought feedback about how you run your meetings).

Many of us end up in positions where we are expected to lead meetings—whether it is a hospital committee meeting, a planning meeting at an operational unit, or one of the several meetings that occur in residency programs. Have you ever considered how you run your meetings? Thankfully, running meetings is like many of the other aspects of medicine: a skill that can be acquired instead of a natural talent. The following method for running effective meetings is obtained from John Cleese’s “Meetings, Bloody Meetings”—a comical training video that shows how meetings should be run akin to court rooms, with specific goals, objectives, structure, and outcomes (see a preview at www.youtube.com/watch?v=vE7jfQt2ic4).

1. **Plan** – Ensure you define your objectives for this meeting. How do you measure success at the end of the meeting? Determine the consequences of not holding your meeting. Would your objectives still be achieved by disseminating information through an email? Planning requires thought and attention; consider blocking time in your schedule to plan the meetings you are running in the upcoming weeks.

2. **Inform** – After defining your objectives, decide who should attend. Nothing is more frustrating than showing up at a meeting where you weren’t needed, or attending a meeting where the key people are not in attendance. Next, inform those attending what is to be discussed and why. Consider asking for their input ahead of time about what should be on the agenda. Finally, decide and obtain the information needed for the meeting. The agenda should include the following: the issue and background for each item, what you hope to achieve (outline objectives), request(s for) supporting information needed, and list the people who should be at the meeting.

3. **Prepare** – The agenda can provide crucial structure to your meeting. It should be arranged in a logical order. Allot times for each item on the agenda. Attendees will have more brainpower and focus at the beginning of the meetings, so consider ordering the “important” items that will require collaboration or discussion early on. Oftentimes, the “urgent” items that may not be as important end up being discussed first if there is not a clear agenda, and those “urgent” discussions can overtake the time devoted to discussing the “important” items. Send out your agenda ahead of time so meeting participants know what to expect and can give you feedback about the agenda.

4. **Structure and Control** – Now, it’s time for the meeting! It is very helpful to have “Ground Rules” for your meetings. Ground rules typically include rules like beginning and ending on time, keeping focused on the topic at hand, one person speaking at a time, showing respect for others, monitoring how much you as an individual are speaking, and avoiding multitasking on devices during meetings (which over
90% of meeting attendees admit to doing!). As you move through the agenda, it will be helpful to keep the structure of the discussion like you would a case in a courtroom: evidence, interpretation, argument, and action. This can keep attendees from jumping back to information already covered, and it also ensures that all the information (evidence) is presented initially without people unveiling new information later on during the “argument.”

5. **Summarize and Record** – If nothing is recorded from your meeting, how do you know what was discussed and decided? A recorder should be assigned for a meeting, and you should give that person clear expectation for how and what is recorded. By annotating who is present and absent in the minutes, it may persuade those who routinely miss or are late to meetings to ensure they are in attendance on time. Also, minutes should include the due-outs assigned in the meeting. Disseminating the minutes to the participants and other stakeholders should occur in a timely fashion.

One aspect that you cannot necessarily control is the types of participants and the amount that they contribute. Some participants can be described as the chatterbox (people who talk often and long and like to share), the clam (people who don’t say a word and are very difficult to draw out), and the tortoise (people who are slow to get going but who will contribute eventually). As you facilitate the meeting, here are some responses to help you get the appropriate contribution from each type of participant:

- “Great. Next, let’s hear from someone who we haven’t heard from yet” (chatterbox close, clam and tortoise have permission to speak)
- “Thank you. Is there an alternative perspective that we haven’t heard yet?” (pulling out information from clam and tortoise)
- “I see. Can you elaborate on why that may be?” (getting past the first response from a clam or tortoise to achieve meaning on their initial statement)
- “You have some interesting ideas. How about we meet after the session for a few minutes so I can learn more?” (chatterbox close).

Some Uniformed Family Physicians are stationed in remote locations or are required to conduct meetings over the phone or via video-teleconference. These recommendations for running effective meetings apply to those meetings too! The following tips can help you run virtual meetings more effectively:

1. Double-check your technology platform before the meeting is supposed to begin
2. Utilize the “hand-raise” function or a chat box in video-teleconferencing that allows participants to contribute without interrupting the speaker
3. Ask speakers to introduce themselves every time they speak if you are unable to see them or if the audience is not familiar with everyone
4. Clearly define when you want discussion and input to avoid those awkward silences where people aren’t sure if you are finished talking.

Research on virtual meetings shows that 4% of participants admit to multitasking on video calls whereas 57% of participants admit to multitasking on phone conferences. Consider using video teleconference when you can to engage your participants more. 2

In conclusion, planning time to implement the first three steps listed above is crucial to the success of your meeting. That extra time can save “wasting time” during the meeting. Your meeting’s success is dependent on you as the leader of the meeting. Remember to actively listen, help manage conflict, and hold the meeting to the agenda. Also, be aware of how much you are speaking during the meeting versus listening to the members of your team. If you are in a situation where you are not leading the meeting, you can share this article with the leader or help build the agenda for the next meeting. You can also solicit feedback from the meetings you run. Now, consider what you can change for the next meeting you run, share it with a colleague who will hold you accountable, and run a more effective meeting!

**REFERENCES**


Here are three new apps to help you and your smartphone leap into Summer and better manage cardiovascular disease!

1. **LDL-C Manager (FREE)**
   - In 2013, the American College of Cardiology (ACC) released new cholesterol guidelines that moved away from LDL-C treatment targets and launched their controversial Pooled Equations calculator.
   - Nearly four years later, those guidelines and their excellent ASCVD app are well entrenched in primary care. However, many cardiologists and lipidologists cried foul over the seeming removal of LDL targets.
   - The publication of the IMPROVE-IT trial demonstrated some additional benefit of aggressive lipid lowering in patients with acute coronary syndrome by the addition of ezetimibe to moderate intensity simvastatin. This study has its flaws and critics, and it brought back the “lower is better” debate.
   - In 2016, the ACC supplemented their 2013 guidelines by focusing on LDL management and appeared to bring us “Back to the Future” of ATP III with additional recommendations on treating to LDL targets. The ACC’s latest app, LDL-C Manager, combines all three of their cholesterol apps in one: ASCVD, Statin Intolerance, and LDL-Lowering Therapy.

2. **ACC DAPT Risk Calculator (FREE)**
   - Since the development of the first bare metal (BMS) and drug eluting stents (DES), the literature and guidelines have been debating about how long to continue anti-platelet therapy. Currently, the recommendation is for at least 30 days of DAPT after a BMS and at least 6 months after a DES. The guidelines were less clear about DAPT beyond 12 months. The benefits of longer term DAPT include a lower risk of stent thrombosis/myocardial infarction (MI) and major adverse cardiovascular and cerebrovascular event. But there is a greater risk of moderate to severe bleeding.
   - In 2016, the DAPT Study was published in JAMA and included a DAPT calculator to assist providers in making decisions about prolonged DAPT. If a DAPT score is less than 2, patients should probably just receive aspirin, but if the DAPT score is 2 or greater, continuing DAPT out to an additional 18 months (30 months total) should be considered. The DAPT study yielded a NNT of 30 for prevention of one additional CV event over aspirin alone without a significant increase in bleeding.
   - ACC has published their version of the DAPT calculator including links to the current ACC guidelines on the topic.

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**Disclaimer:** The views expressed are those of the author(s) and do not reflect the official policy of the Department of the Army, the Department of Defense or the U.S. Government.
patients on DAPT. It provides an evidence based DAPT calculator for evaluating longer antiplatelet therapy at the point of care.

LIKES

- Easy to use, intuitive interface for data input.
- Evidence based outcome data with graphic representation.
- Extensive additional resources linked within app.

DISLIKES

- Outcome data generated by app doesn’t include NNT/NNH.
- Additional resources all internet based; nothing local in app.
- Minimal instructions on use of the app or explanation of results of calculations.

OVERALL

ACC DAPT Risk Calculator is a “must have” app to assist in the management of patients who may require DAPT after stent placement.

EVIDENCE BASED MEDICINE

ACC BridgeAnticoag app takes current ACC guidelines and combines them with clinical trial data to assist providers in managing patients with nonvalvular atrial fibrillation on anticoagulation who require procedures/surgery.

LIKES

- Easy to use, intuitive interface for data input.
- Evidence based outcome data with clear recommendations on stop/start times.
- Extensive additional resources linked within app.

DISLIKES

- App doesn’t include NNT/NNH or recent bridging studies just ACC CPG recs.
- Additional resources all internet based; nothing local in app.
- Minimal instructions on use of app.

OVERALL

ACC BridgeAnticoag is a “must have” app to assist in the management of patients with nonvalvular atrial fibrillation on anticoagulation who may need their anticoagulation interrupted or bridged prior to procedures/surgery.

3. BridgeAnticoag App (FREE)

As the population ages, we continue to see more patients diagnosed with atrial fibrillation. Frequently, these patients require chronic oral anticoagulation. For decades, we have used Vitamin K antagonists such as warfarin. Due to complex monitoring and dosage adjustments, drug interactions and potential side effects such as hemorrhagic stroke and gastrointestinal bleeding, patients and providers have hoped for an alternative to warfarin. Over the last few years, a multitude of target specific oral anticoagulants (TSOAC’s) for treatment of nonvalvular atrial fibrillation have been approved. How should providers handle patients with nonvalvular atrial fibrillation on anticoagulation who require procedures or surgery? BridgeAnticoag takes the latest ACC guidelines on the topic combined with recent literature to create a point of care app to help providers.

MEMBERS IN THE NEWS

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

NEWSLETTER SUBMISSION DEADLINE

REMINDER: The deadline for submissions to the Fall magazine is 15 October, 2017.

RESEARCH GRANTS

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

RESEARCH JUDGES

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

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

Please write to me...
Christopher E. Jonas, DO, FAAFP
jonaschris@hotmail.com
Hello Family Medicine Colleagues!  
Here at the 92nd Medical Group, Fairchild AFB, the new $11 billion Electronic Health Record (EHR), named MHS GENESIS®, launched over 4 months ago. On that same day, we removed AHL TA and CHCS from our workstations and started using the JLV (Joint Legacy Viewer) to review all past encounters. It has been quite a ride for our clinics since then. I have been fortunate to serve as a pediatrician and super-user for the DOD’s newest electronic health record system and want to give you some insight on what to expect from a physician’s perspective.

So, first off, why Fairchild?  
Fairchild was considered the best clinic to start off with because it’s small – but not too small! Fairchild AFB does not have any inpatient services, but we do have a pharmacy, limited radiology and lab services, a stand-alone dental clinic, and 8 outpatient clinics – family medicine, pediatrics, women’s health, flight medicine, behavioral health, physical therapy, optometry, and occupational medicine. Each section deployed MHS GENESIS® and is back up to full operations. I’m seeing my normal patient load (up to 90 patients a week), and I’m learning new ways to write and refine my notes using MHS GENESIS® every day.

If you’ve never used anything but AHLTA, you’ll be pleasantly surprised by what you can accomplish with MHS GENESIS®. For some of us, it was a steep learning curve, but definitely worth the effort to adapt.

It’s hard to complain about being able to open multiple patient charts at once! Ordering medications, labs, and radiology is intuitive, and complemented by quick orders and favorites. Medication reconciliation removes all redundant medications and ensures they are spelled correctly if entered by your techs. Our integrated message center ensures telephoned medications and referrals are placed in a single record, without bogging down workflow or the patient’s total documentation. The workflow (how you accomplish tasks, like screening, etc…) is completely customizable and initially tailored to each clinic. The system has been very reliable and outages are rare, but if they occur, services are restored quickly. My favorite part: an entire note can fit on a single printed page!

However, as to be expected, there have been some growing pains. We are working on bringing TSWF-style standardization to the ad hoc forms that our techs rely on to start patient encounters both for training and consistency. Much of the efficiency gained for physicians relies on setting up individual ‘autotext’ (or macros) to fill routine histories, review of systems, exams and plans. Autotext cannot be shared between physicians or among clinics yet, but we will have this capability in the future. We are still working through integrating ASIMS with the robust immunizations tab embedded in MHS GENESIS®. But even with some growing pains, we have adapted our workflows and in many ways improved patient care overall.

Many of our lessons learned and fixes here at Fairchild will be incorporated into subsequent ‘go-lives’ or implemented behind the scenes. We have an outstanding team here working long hours to make MHS GENESIS® successful, not only at our clinic, but for the rest of the Northwest and beyond. Please remain positive that those AHLTA, Essentris and CHCS icons will one day disappear from your desktop! That said, change is always
difficult and I can guarantee there will be some frustrating moments. Likely, your experience will differ from mine – a new EHR will not be a bucket of sunshine for everyone. But overall, it’s a great EHR and after only a short period, many of us here cringe at the thought of ever having to revert back to AHLTA. If you’d like to learn more, please visit www.health.mil/mhsgenesis for the latest news and planned roll out of MHS GENESIS.

ADDENDUM:
So, sitting here at HQ I have been pretty happy at how things have gone! There is definitely work that needs to be done, but Dr. Migliuri’s satisfaction isn’t an exception. Primary care providers like this more than AHLTA – and I’m glad to have improvement where we can!
So, what to do now? GET INVOLVED. Join the Clinical Informatics Committee. Join the TSWAGs. Join the site steering committees. Join TSWF/OSIPT. You don’t have to be a “computer person”; you just have to acknowledge, and care about how our Electronic Health Records (EHRs) affect you. Questions? Feel free to e-mail me at Matgbarnes@gmail.com.
Disclaimer: These are views of individuals, as opposed to views of the DoD and Air Force.

EVERY DOC CAN DO RESEARCH
Have you wanted to do a research project but were not sure how? Would you like a user friendly workbook to help you over the inertia of starting a project? The Clinical Investigation Committee is pleased to offer user friendly tools for organizing, planning, and starting a research project. If interested, please send a request to direamy@vaafp.org.
Tools Available:
• Every Doc Can Do Research Workbook
• Every Doc Can Do A Poster
• Every Doc Can Do A Scholarly Case Report Workbook
Clinical Investigation Research Tools also available on-line at www.usafp.org.

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Beebe Healthcare is a progressive, growing, not-for-profit community health system with a 210-bed hospital and numerous outpatient facilities throughout southern Delaware.
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• Repeatedly recognized with national awards
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• 300+ providers on staff; 48,000+ Emergency visits
• Margaret H. Rollins School of Nursing

Southern Delaware location:
• Recreational opportunities include water sports, outdoor life, golf and cycling
• Cultural offerings range from beach life and festivals to theater, fine art and superb dining
• Praised for the quality of our beaches and boardwalks (National Geographic, Parent’s Magazine, Travel & Leisure)
• Low state taxes and no sales tax
• A short drive from Philadelphia, DC, and Baltimore

Email cover letter and CV to Marilyn Hill, Director of Physician Services, mhill@beebehealthcare.org • www.beebehealthcare.org
Beebe Medical Group Administration • 1515 Savannah Road, Suite 102 Lewes, DE 19958
Not a visa opportunity • Beebe Healthcare is a non-smoking and fragrance free system.
When I think about our 2018 Annual Meeting and Exposition theme of “Bridging the Gaps,” I can’t help but feel an overwhelming excitement for the work our committee will continue to do in building and maintaining those very first bridges across which tread our new and future members. I’m excited to focus on better utilizing the five tools of investment, instruction, inspiration, involvement and inclusion. As an educator, there is no greater investment I can hope to make toward the future of military family medicine than the world-class instruction that is provided in our residencies and clerkship sites across the uniformed services. While I hope that my involvement in their professional development will be an inspiration, most often I am the one inspired by their hard work and passion for our profession. Finally, I fully expect our committee to not only align itself with the following six goals and strategic directions of our academy, but to also continue broadening our area of inclusion in regards to both the diversity of our meshwork and the breadth of the team’s impact.

MEMBERSHIP

The adjunct membership for our HPSP students now allows these future family physicians to participate in both their local AAFP chapters, as well as our academy. It is our aim that this will result in greater outreach, networking and mentoring for these students by our committee and the USAFP. We are currently collecting data to ensure that we are indeed reaching these potential members, and that our efforts translate into increased membership and activity within the academy.

OPERATIONAL

Webinars are becoming an increasingly popular and effective way for program directors and others to reach out to students to answer relevant questions and provide career guidance in preparation for graduate medical education. The committee is working to serve as a clearinghouse by collecting topics, dates and times of future webinars for distribution to students and residents. We’re not making any new bridges here, just pointing to the highly successful ones that several of you have already constructed. If you know of an upcoming webinar, please feel free to relay that information to our committee so we can get the word out through our channels to all those that are interested.

EDUCATIONAL

As Dr. Knobloch stated in our last report, we were able to sponsor 11 students at our 2017 Annual Meeting. Those students had additional costs covered by the generous donations of several conference attendees. I know we thanked you in our last report, but I want to take a moment to thank you yet again. Or better yet, I’ll let the students thank you. One student wrote, “the USAFP meeting was an incredible experience…as far as I’m concerned there is no better conference for a 3rd year HPSP student interested in Family Medicine to attend. The scholarship for hotels and travel assistance really made the difference with my ability as a student to attend…there is no way we’d be able to handle those expenses…[it] was a life-saver.” Lest we think that our investment only reached 11 students, we also know from replies that students “have been relaying the value of my experience to HPSP underclassmen who are also interested in Family Medicine in the hope that they will be able to also benefit from this experience next year.” And while 11 is a fantastic number of student scholarships, we hope to further broaden our inclusion of even more students through the continued generosity of our members in 2018 as well.

SCHOLARSHIP

I am always amazed at the quality of research and presentations by our residents every year. I was also surprised to see one of our medical student scholarship recipients presenting this year. While the quality of this scholarly work is outstanding, the number of residents and students participating in these works can be improved. The committee is deliberately thinking of new ways to involve more residents and students in research and presentations at the annual meeting. The Army, Navy and Air Force resident directors will continue to reach out to chief residents in all programs to find and share best practices. We would ask that faculty presenting at the annual...
meeting take a moment and ask, “how can I include a resident in this work?” For those members that are working outside of an academic center, please feel free to reach out to our committee so we can help you find a nearby HPSP student for you to involve. I personally know the increased workload that comes from the coordination and mentorship required to involve students and residents in presentations. I also know that it can make the experience infinitely more rewarding.

LEADERSHIP

We received great feedback on our resident and student leadership seminar from the 2017 Annual Meeting. For the last few years we have been rotating in new topics each meeting to provide variety for attendees from year-to-year. However, we have noted that we have very few members attending consecutive annual seminars. Also, given the quality of positive feedback we received this year, we have chosen to standardize the seminar for the next few years. We strongly encourage the attendance of all chiefs-elect, and would also encourage graduating residents to consider attending as their clinical leadership skills will soon be in high demand. All other residents and medical students are also invited to attend as we continue to receive feedback from these participants that the session was highly productive for them as well.

ADVOCACY

The Tri-Service Residency Facebook page continues to draw steady traffic. Our resident directors will continue to reach out to chief residents to ensure that information is updated regularly. This may also be a great location for the committee to post information regarding future webinars as well. Look for this site features to continue to become more robust throughout the year.

Disclaimer: The opinions and assertions contained herein are the private views of the author and not to be construed as official, or as reflecting the views of the U.S. Air Force Medical Service or the U.S. Air Force at large.

DAILY INFOPOEMS

The USAFP is pleased to continue providing as a membership benefit a free subscription to Daily POEMS from Essential Evidence Plus. Daily POEMS (Patient Oriented Evidence that Matters) alerts and 3,000+ archived POEMS help you stay abreast of the latest and most relevant medical literature. Delivered directly to you by e-mail every Monday through Friday, Daily POEMS identify the most valid, relevant research that may change the way you practice. Monthly, the complete set is compiled and sent for additional summary review. Ongoing since 1996, their editors now review more than 1,200 studies monthly from more than 100 medical journals, presenting only the best and most relevant as POEMS. The acclaimed POEMS process applies specific criteria for validity and relevance to clinical practice. If you want to subscribe, please e-mail the USAFP at cmodesto@vafp.org so your e-mail address can be added to the distribution list.

AUDIO DIGEST

The USAFP is pleased to provide as a membership benefit continued access to Audio Digest MP3 files in the area of Family Medicine, Pediatrics and OB/Gyn. For those not familiar with Audio-Digest, they produce over 300 audio CME/CE programs each year. These programs are derived from lectures recorded at more than 285 CME/CE meetings across the country, always with permission of the sponsoring organizations and the lecturers involved. The objective of Audio-Digest CME/CE activities is to update healthcare professionals on advances in the diagnosis and management of medical disorders. The primary goal of each activity is to provide practical information that will improve professional competence in caring for patients.

The USAFP has an institutional subscription which allows our members to access the MP3 files in Family Medicine, Pediatrics and OB free of charge. If you are interested in obtaining CME for the modules, please call Audio-Digest at (800) 423-2308 and they can assist you with the paid subscription of your choice. To access please email cmodesto@vafp.org.

PRIMARY CARE R.A.P.

The USAFP Education Committee has arranged for a member discount on the outstanding Primary Care R.A.P. (Reviews and Perspectives) Podcast. This podcast combines outstanding speakers from all over the world and outstanding production values making it one of the best podcasts available for primary care physicians. Primary Care RAP offers 3 hours (42 hours/year) of audio CME each month including up to 3.5 hours of AMA PRA Category 1 CME Credit(s), and up to 3.5 credit(s) by the American Academy of Family Physicians. USAFP Members receive 25% off the annual subscription price of $395 when using the code “USAFP” at checkout or this direct link: http://www.hippoed.com/pc/rap/promotion/usafp

Don’t Miss Out on Complimentary USAFP Membership Benefits
The following is part one of a two-part series to be published in the Summer and Fall USAFP Newsletters.

Scholarly activity often proves difficult, even for the small percentage of military family physicians serving in the academic setting. For the rest of us in operational, clinical, administrative, or leadership roles, it may seem nearly impossible to achieve. This article is written for the latter group with the purpose of encouraging, inspiring, and equipping you with the information needed to participate in scholarly activity despite the known challenges and time constraints of non-academic medicine assignments. We hope that sharing key experiences with how we have continued to produce scholarly works as junior military family physicians will empower you so that you may employ this knowledge and have an opportunity to contribute to the medical literature and scholarly community.

Tips from CPT Kyle Hoedebecke, currently serving as Clinic OIC in Yongsan, South Korea:

Upon completion of residency, I entered into an operational job with the 82D Airborne. I loved my new role, yet soon discovered how this position only offered a limited ability to continue primary care research. This is not a challenge unique to physicians in operational roles, rather for anyone working outside of the academic setting.

One of the best ways to continue your scholarly activity is through continued involvement in professional family medicine organizations. The Uniformed Services Academy of Family Physicians (USAFP) and American Academy of Family Physicians (AAFP) are great starting points, offering multiple member interest groups (MIGs) for different focal points within our profession. For those wishing to remain involved in or return to the teaching realm, the Society of Teachers of Family Medicine (STFM) is a great resource. I have taken advantage of their well-developed research groups and databases previously. Furthermore, they have several fellowships that you can perform from anywhere around the world to prepare you for your future leadership or faculty positions.

In the global health realm, you can connect with the rest of the world’s family medicine community via the World Organization of Family Doctors (WONCA) and its New and Future Family Physician Movement - Polaris - where many of their collaborations are performed virtually due to the vast distances between members. For example, through Polaris I formed the first multi-centered digital Balint group with family physicians in 12 countries around the world. At the same time, I have been afforded other unique opportunities like performing a Medical Education Cooperation with Cuba (MEDICC) Mini Fellowship to Havana, an exchange in Greece, and giving a keynote address in Kazakhstan. The last three years have resulted in collaborations with over 200 individuals in 110 countries producing over 20 publications in eight languages.

But how does one know where to engage? This depends on you! Questions such as “What are your interests?” or “Do you have a better method to provide care?” can be good starting points. At the same time, make sure that your research engagement is of personal motivation.

Beyond personal interests, you must surround yourself with hardworking individuals who desire to publish. These can be motivated young medical professionals with less experience looking for their first publication or more senior physicians who better understand how to navigate the intricacies of the peer-review process. My experience has been that these individuals are few and far between in the non-academic setting; therefore, the aforementioned organizations like USAFP, AAFP, WONCA, and STFM are great places to network and identify mentors.

Finally, I highly recommend continued engagement with academic teaching institutions such as the Uniformed Services University or your local medical school where you can continue official engagement as an assistant professor. In addition, this will open more doors both during and after your time in the military. Finally, other ideas include creating your own local journal club as well as serving on journal staff as an editor or reviewer.
The following is a compilation of ideas and basic “how-to” information that we have found attainable even in the settings of limited resources for conducting research or limited experience as junior military family medicine physicians while we were serving in non-academic assignments.

Case Reports: Case reports are one of the most attainable scholarly activities for those with heavy clinic loads or that are serving in operational assignments. Military family physicians in these positions are frequently exposed to unique clinical cases. A good case report is one that generally identifies one of the following: a rare or unusual clinical condition, a previously unreported or unrecognized disease, a unique or different use of imaging or diagnostic tests to assist in diagnosis of a disease, unusual side effects to a therapy, or an unexpected or undocumented response to a treatment. The creativity of military physicians in resource-limited environments (such as deployment) often makes a case interesting to the general medical audience. Case reports are generally one of the least time-consuming scholarly projects to undertake; they are brief and focused. They do require a literature review of what has already been published on the topic, patient consent, and high-resolution pictures or images (when applicable). It is very important to ensure that the case is a novel presentation or an interesting educational topic.

The main components of a case report are an abstract (usually 200-300 words), introduction, clinical case presentation, discussion and conclusion. Most case reports are less than 2000 total words. The discussion should clearly communicate what makes the presented case different from others reported in the literature. The conclusion provides take-away teaching points for the reader.

Several journals accept interesting case reports. Acceptance rates can be fairly high for some journals, and nearly all case reports are peer-reviewed. The Journal of Family Practice (JFP), American Family Physician (AFP), Military Medicine (Mil Med), and Journal of Special Operations Medicine (JSOM) are recommended because they accept case reports or photo quizzes, have clear author guidelines on their websites (see page 28), are peer-reviewed, frequently publish cases written by military physicians, and do not charge an open-access fee to the author for publishing. The British Medical Journal (BMJ) Case Report journal is another option. BMJ offers a fellowship that you can purchase for an annual fee that authorizes an unlimited number of case report submissions for the year with an acceptance rate of around 70 percent. The Journal of the American Board of Family Medicine (JABFM) accepts case series.

Before submitting a case for publication, you should first submit the abstract to a conference for presentation. Creating a poster or short podium presentation about your case to present at a regional, national, or international conference also counts as scholarly activity. A case report typically cannot be presented after it has been submitted for publication. The USAFP Annual Meeting and AAFP FMX both solicit abstracts for case reports from family continued page 28
medicine staff (not just students, residents, and fellows). For USAFP, abstracts are due in September for the March meeting. For AAFP FMX, the call for abstracts is in the Spring for the Fall annual meeting.

A key point for those who want to author a case report is to obtain written patient consent. When you see a patient that you think may be interesting or different, have them sign a consent form for publication. USAFP has example consent forms on their website. Virtually all journals require patient consent for publication and also provide consent forms on their websites. Most conferences also require patient consent in order to present the case as poster or podium.

Author Guidelines:
- www.aafp.org/journals/afp/authors/guide/departments.html (for AFP Photo Quiz)
- www.mdedge.com/jfponline/page/author-guidelines (for JFP Case Reports and Photo Rounds)
- militarymedicine.amsus.org/page/milmed/author-guidelines (for Mil Med Case Reports)
- https://jsomonline.org/Author%20Requirements.pdf (for JSOM Case Reports)
- casereports.bmj.com/site/about/guidelines.xhtml (for BMJ Case Reports or Imagine In…)
- www.jabfm.org/site/misc/ifora.xhtml (for JABFM Case Series)

Develop a Quality Improvement Project: The Institute for Healthcare Improvement (IHI) Open Access has online training modules in quality improvement and safety. It details how to plan, study, implement, and evaluate quality improvement projects. This training is available for free for military members, paid for by Defense Health Agency. The website is www.IHI.org/Login and group code is DCAB4CF2. Well-designed quality improvement projects can be submitted as scholarly presentations. STFM holds a Conference for Practice Improvement in November/December that accepts abstracts for works-in-progress. At this conference, you have the opportunity to obtain suggestions from colleagues for possible future interventions to strengthen your study design. You can then present your final data or next iterations of your project data at the STFM Annual Conference or Practice Improvement meeting. USAFP also accepts staff abstracts for Quality Improvement projects.

Become a Peer Reviewer: You can obtain CME credits and complete scholarly activities by peer-revewing. To get started, follow the directions below. AAFP has collected information from all of the major primary care journals on best-practices for peer reviewing, which makes it easy to get started. We recommend applying to 1-2 journals at a time. Note that when you first get accepted as a peer reviewer, you should anticipate to be sent an article in one your areas of interest within the first 1-3 months, so make sure that you have the time available. Peer reviews take 2-8 hours on average to complete, depending on the article type. After your first review, you will then be sent abstracts to review with the option to serve as a peer reviewer for the full article or defer. It is important to be timely in submitting your comments back to the editor and use the format that the journal suggests.

General peer reviewer information available from AAFP: http://www.aafp.org/dam/AAFP/documents/afp/reviewer-resources.pdf

Peer Reviewing by Journal:
- AFP: http://www.aafp.org/journals/afp/reviewers/guide.html. Email the editorial office afpjournal@aafp.org expressing interest in becoming a peer reviewer.
- JABFM: Complete the peer reviewer volunteer form available at www.jabfm.org and fax to (313) 577-9828 or email to jabfm@med.wayne.edu.
- JFP: Email the Editor-in-Chief, Dr. John Hickner at hickner@uic.edu or editorial office at jfp.eic@gmail.com, expressing your interest in becoming a peer reviewer. Expect a response email with application to become a peer reviewer.
- BMJ: http://www.bmj.com/about-bmj/resources-reviewers/become-bmj-reviewer. Reviewers should submit their applications through the online editorial office. There are also many additional resources available for peer reviewers available at http://www.bmj.com/about-bmj/resources-reviewers/guidance-peer-reviewers.
- Mil Med: http://militarymedicine.amsus.org/page/milmed/reviewer-application. Download the peer reviewer application and email the application with a copy of your CV to milmed@amsus.org.
- Academic Medicine: Email the editorial office at acadmed_online@aamc.org expressing your interest in becoming a peer reviewer and visit the following website for additional peer reviewing resources and instructions: http://journals.lww.com/academicmedicine/Pages/ForReviewers.aspx
- JSOM: It is recommended that you are a member of the Special Operations Medical Association. If an active member, contact the editorial management office editor@jsomonline.org or administrative assistant Sophia.rodriguez@jsomonline.org

To be continued in the Fall USAFP Newsletter.
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"Essentialism: The Disciplined Pursuit of Less"

BY GREG MCKEOWN

In our hectic 21st Century lives with so many choices on how to spend our time, we find ourselves and our families stretched too thin, running from one event to the next. We are busy but not productive, and often feel that our time is constantly being hijacked by other people’s agendas. For those of us in the military, we are “on duty” 24/7, tethered to our cellphones, pagers or blackberries. Is this really what our profession demands from us? I recommend a better way to balance our lives: “Essentialism” is an idea whose time has come.

Essentialism is more than a time-management strategy or a productivity technique. It is a systematic discipline for discerning what is absolutely essential, then eliminating everything that is not, so we can make the highest possible contribution toward the things that really matter. By forcing us to apply more selective criteria to determine what is Essential, the disciplined pursuit of less empowers us to reclaim control of our own choices about where we spend our precious time and energy—instead of giving others the implicit permission to choose for us.

Essentialism is not one more thing; it’s a whole new way of doing everything. It’s about doing less, but better, in every area of our lives. I wish I had found this book at the beginning of my career; I would have not been as stressed out about trying to do everything and never saying no to requests from others.

ESSENCE: What is the Core mind-set of an Essentialist?

1. Individual Choice:
   a. A choice is not a thing, a choice is an ACTION. If we surrender our ability to choose, something or someone else will step in to choose for us. While we may not have control over our options, we always have control over how we choose among them.
   b. If you could only do one thing with your life right now, what would you do?

2. The Prevalence of Noise
   a. We live in a world where almost everything is worthless (noise), and a very few things are exceptionally valuable. John Maxwell: “You cannot overestimate the unimportance of practically everything.”

3. The Reality of Trade-offs:
   a. We can’t have it all or do it all.
   b. Essentialists see trade-offs as an inherent part of life, NOT as an inherently negative part of life.
   c. Instead of asking, “What do I have to give up?” they ask “What do I want to go BIG on?”

EXPLORE: How can we discern the trivial many from the vital few?

To determine what is truly essential, we need:

• Space to Think: Especially when life seems to get busy, we need to build thinking time into our schedule

• Time to Look and Listen: Essentialists need to be powerful observers and listeners. Keep a journal and review it monthly

• Permission to Play: “play” is not just a break from work, but is very often the source of creative, imaginative breakthroughs

• Wisdom to Sleep: Essentialists see adequate restful sleep as necessary for operating at high levels of contribution

• Discipline to Apply Highly Selective Criteria to the Choices we Make: If the answer to whether or not something is essential is not a DEFINITE YES, then it is a NO
ELIMINATE: How can we cut out the trivial many?

In this section of the book, the “Essential Intent” of work or personal goals is clarified. Unlike the vague mission statements of many companies, an Essential Intent is both inspirational and concrete, meaningful and memorable, and allows everyone in an organization to clearly understand our shared priority mission. Developing an Essential Intent is hard work, but once you have done this, you can now start the elimination process (Uncommit, Edit, Set Boundaries). If you read nothing else in this book, see the Chapter on “Dare,” which discusses the power of a graceful NO (people will actually respect you MORE), and the 8 techniques we all need to have in our “NO Repertoire.”

EXECUTE: How can we make doing the vital few things almost effortless?

In this section, we learn how to invest the time we saved by eliminating nonessentials into designing a system to make execution almost effortless.

Techniques include:
• Buffer: Plan ahead and create a buffer to prepare for the unforeseen.
• Subtract: Don’t default to bandage solutions; Find and remove the obstacles that are keeping us from being successful.
• Progress: Celebrate small wins.
• Flow: the genius of routine. Proactively change to better habits, and once the habit is established, the activity won’t require as much brain focus.
• Focus on the present.

Summary: ESSENTIALISM is a discipline you apply each and every time you are faced with a decision about whether to say YES or whether to politely decline. It’s a method for making the tough trade-off between lots of good things and a few really great things. It’s about learning how to do less but better so that you can achieve the highest possible return on every precious moment of life.
I encourage everyone to strongly consider this life-changing approach to all aspects of your life!
I am pleased to submit this report on behalf of the USAFP Delegation to the 2017 American Academy of Family Physicians National Conference of Constituency Leaders (NCCL). NCCL convenes each year in conjunction with its Annual Chapter Leadership Forum (ACLF) to provide a voice and leadership opportunities to traditionally underrepresented constituencies: women, minorities, new physicians (within the first seven years of practice), international medical graduates (IMG), and lesbian, gay, bisexual, transgender (LGBT) family physicians.

As usual, the USAFP assembled a complete delegation representing all constituencies! This delegation included LCDR Ana Solis (IMG), LCDR Kevin Bernstein (New Physician), Capt Sarah Avila (Women), CPT Haroon Samar (Minority), and LT Patrick Simpson (LGBT). The USAFP was represented at ACLF by USAFP President CAPT James Ellzy, President-Elect COL Douglas Maurer, Vice President LtCol Christopher Jonas, and Past-President Col Christopher Paulson.

The NCCL provides our recent residency graduates and underrepresented constituencies the opportunity to gain leadership experience, debate a variety of topics brought forward by attendees, network with other AAFP members, as well as pass resolutions that are then forwarded to the various AAFP Commissions, the Congress of Delegates, or the Board of Directors to help shape the future of our Academy.

Headlining the conference’s main stage presentations and town hall meetings included the Medicare Access and CHIP Reauthorization Act (MACRA), the latest proposed version of the American Health Care Act (AHCA), and the newly launched AAFP Center for Diversity and Health Equity – an initiative focused on addressing the social aspects of health care. Details of each continue to be discussed by AAFP leadership and staff at the Academy as well as in D.C.

The NCCL business sessions made up the rest of the conference and included leadership training, resolution writing, national elections, and a large dose of parliamentary procedure where resolutions were debated, possibly amended, and eventually brought to a vote.

Resolutions were grouped into separate Reference Committees that were organized based on the structure of the AAFP Commissions. Our delegation had a few members that served on Reference Committees including Capt Sarah Avila (Reference Committee on Practice Enhancement), CPT Haroon Samar (Reference Committee on Health of the Public and Science), and LCDR Kevin Bernstein (Reference Committee on Education).

Among the numerous resolutions brought forth by attendees, there were several from each Reference Committee that caught our delegation’s attention.

The Reference Committee on Education considered and adopted a wide variety of resolutions related to continuing medical education as well as graduate and medical student education. One resolution that was adopted called on the AAFP to support the removal of the American Board of Family Medicine recertification board examination as a mandated requirement for maintenance of certification (MOC). This would be in line with the American Board of Internal Medicine as they recently removed this as a mandated requirement for MOC. Other resolutions that were adopted tasked the AAFP with advancing the knowledge of trainees and current family physicians in regards to social determinants of health; community needs assessments, health care disparities, transgender medicine, undesired and nonviable pregnancy, fertility awareness-based methods of family planning, and opioid use disorder. In support of physician well being, delegates also adopted a resolution for the AAFP to investigate the feasibility of having AAFP members self-report approved physician wellness activities for AAFP elective CME credit.

The Reference Committee on Health of the Public and Science debated several resolutions about social determinants of health and elimination of barriers to adequate health care. This also included adequate payment for care coordination and data collection. Many members viewed the AAFP’s new Center for Diversity and Health Equity as a valuable resource to help advance the AAFP’s priorities and policies towards eliminating barriers to health. Other resolutions that were adopted asked the AAFP to provide free and easily accessible gender and sexual health education on the AAFP website, update its breastfeeding toolkit to share best practices for workplace accommodations for breastfeeding.
physicians, and to more strongly support clean air and clean water protections.

The Reference Committee on Advocacy heard testimony and adopted several resolutions to safeguard the health of immigrants as well as eliminate barriers for immigrant physicians with appropriate work visas who practice in the United States. Another resolution was adopted to oppose legislation that allows insurers to opt out of providing maternity and reproductive health care coverage.

The Reference Committee on Practice Enhancement had a variety of resolutions that were considered. One resolution that was adopted asked the AAFP to protect the ability for family physicians to train and practice in emergency departments. This resolution is important, as there are many instances where trainees, surgical teams, and other operational family physicians obtain training in local emergency departments and trauma centers in preparation to deploy. Another resolution also dealt with scope-of-practice for the provision of operative obstetrics by family physicians. It asked the AAFP to help family physicians navigate the credentialing process by creating a toolkit with specific resources outlining general credentialing processes within hospital systems. Next, a resolution was passed asking the AAFP to actively work to remove barriers for family physicians that want to provide full-scope maternity care services, including high-risk and surgical obstetrics. There were also quite a few resolutions dealing with payment and coverage for a variety of services that family physicians provide including radiologic services, reproductive technologies, and other procedures.

The Reference Committee on Organization and Finance was tasked with resolutions that could change the way the AAFP is structured and how it does business in the future. One resolution that was adopted asked the AAFP to further diversify its Board of Directors by adding an additional member elected by one of the NCCL member constituencies (other than the New Physician constituency, which already holds a Board seat). Another resolution attempted to increase retention of new resident graduate AAFP membership by asking the AAFP to develop language to help graduating residents negotiate with their employers for support in paying state and national specialty society dues as part of their compensation and CME packages. A couple of resolutions that were also adopted asked the AAFP to identify locations for its events that are consistent with its nondiscrimination policies as well as to ensure the availability of gender-neutral restrooms at AAFP events.

It was an honor and a pleasure to serve on behalf of our USAFP New Physicians as its delegate at NCCL! We had a powerful delegation with strong voices that brought the USAFP’s ideas and concerns forward at this national meeting. I definitely encourage anybody interested in representing one or more of these constituencies at NCCL to let the USAFP leadership know that you would like to be considered as a delegate for one of the upcoming conferences! It is truly a great experience!
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In December 2016, the 2017 NDAA was signed into law. No previous NDAA has been as prescriptive to the Military Health System (MHS). This article outlines the changes that will impact all MHS family physicians, the reasons behind the NDAA requirements, how the MHS will meet congressional intent and how these changes also will apply to specialty care.

Section 704 of the NDAA directs the MHS to make urgent care (UC) available until 2300 hours and to expand Patient Centered Medical Home (PCMH) hours at locations where there is sufficient demand to justify the expense. Further expanding on Dr. Joshua Will’s article in the Spring 2017 Uniformed Family Physician, we are outlining the reasons behind congressional requirements. First, patient expectations across the United States are changing, with patients demanding more convenient hours. Second, competition from the private sector is increasing with
the growth of UC clinics. Finally, to support a medically ready and ready medical force, the MHS must maximize capture of patient care to the direct care system. While the direct care system delivers most enrollee primary and urgent care in Military Treatment Facilities (MTFs), PCMH appointments are not always available at times and days convenient to our patients. For example, less than one percent of MTF PCMH appointments are available after 1500 hours although demand data demonstrate that each MTF experiences a late afternoon demand surge. In contrast, the Medical Group Management Association (MGMA) Annual Practice Operations Report demonstrates the proliferation of patient-centered hours in primary care across the United States with over 44 percent of practices offering appointments on Saturday and 17 percent offering appointments on Sunday. (1) The MHS 704 plan will offer extended PCMH hours in at least one clinic at over 70 percent of MTFs. The MHS is codifying the criteria for making operating hours decisions in a new Department of Defense (DoD) policy.

Section 709 of the NDAA directs the MHS to implement standard processes, procedures, appointment types and expected number of encounters per day for each full-time provider. The goal of Section 709 is to optimize the direct care system. Since the 2014 Secretary of Defense-directed MHS Review of Quality, Safety and Access, primary care has improved 40 percent in access to appointments within 24 hours and 22 percent in access to future appointments, through the use of standard processes in PCMH. Conversely, a recent study by Merritt Hawkins demonstrated that access to care in major metropolitan areas and mid-size cities deteriorated 30 and 38 percent, respectively over this same timeframe. (2) While dramatic progress has been made in our PCMHs, there is less uniformity in specialty care across the MHS.

The MHS developed standard processes and procedures for appointments based on leading practices in industry including from the Institute of Medicine and Kaiser Permanente, high-performing MTFs and patient feedback. These standards were codified in the 2017 Section 709 Report to Congress (RTC) and briefed to representatives from the Senate Armed Services Committee (SASC) in July 2017 by members of the Tri-Service PCMH Advisory Board. These standards apply to primary, specialty and behavioral health care in both the legacy appointing system and MHS GENESIS and include: the use of team-based care and pre-visit planning to maximize the value of each appointment, first call resolution procedures, simplified appointing, the use of clinical support staff protocols, the integration of virtual health options and the requirement to balance appointments throughout the workday, especially late in the afternoon.

While most of these processes are in place in our PCMHs, these changes will be a major cultural change for specialty care. Specialty care appointment templates will be managed and booked centrally in response to Section 709 requirements. In addition, specialty care consults will be available to book before the patient departs the MTF or within 24 hours. Specialty care will be measured against access goals, the expected number of appointments per day and leakage to the purchased care sector. The standards outlined in the 709 RTC will be documented in a DoD policy and will apply across the direct care system.

Standard processes support the MHS’ journey to becoming a High Reliability Organization (HRO). Inherent in HRO principles is continuous process improvement based on leading practices. An important component in the development of leading practices is patient feedback. To formalize the process of obtaining patient feedback, the MHS is implementing bi-directional communication with patient and family partnership councils at every MTF as directed in Section 731 of the 2017 NDAA. These councils will help us develop and identify leading practices within the MTFs that will be used to develop future standard processes for implementation across the MHS.

The PCMH Advisory Board is honored to serve as your voice in MHS governance. We are confident that implementation of these standards will support readiness, optimize care in the MTFs and make the direct care system the system of choice. Thank you for all that you do in caring for our patients.

REFERENCES


Get ready for a wide range of topics focusing on operational medicine, leadership, faculty development, research, and evidence-based family medicine core topics. Additionally, we will offer plenty of talks that Bridge The Gap for military education including conversations on financial planning and transitioning out of the military.

We have tried and true workshops and some new offerings, including Botox® for PCMs, to enjoy! As always, USAFP will hold its annual research competition and offer a unique opportunity to network with colleagues all across the globe. An ALSO Instructor course and a DHA-sponsored Pain Management course will also be offered on the first day of the conference.

The Sawgrass Resort will feel like a respite from your busy military life! Located less than a mile from Ponte Vedra Beach, a shuttle will take you to the resort’s club house to enjoy two outdoor pools, beach activities like volleyball, ocean kayaking and paddleboarding, and their beachside restaurant and grill. At the main hotel, there is a spa, a 24-hour fitness center, three additional pools including a surfing lagoon, mini-golf, three restaurants, Starbucks and access to the TPC golf course. In close driving distance are other parts of Jacksonville Beach, St. Augustine, and downtown Jacksonville. We are thrilled to be offering USAFP 2018 in this corner of the Southeast.

More detailed information about the program will be available in the upcoming months. While we are not going to coordinate our own 5K, we are planning to connect with Jacksonville’s racing community and provide information on self-participation in the St. Patrick’s Day 5K.

You don’t want to miss this premier education and rejuvenation event! If you have any questions or want to contact the programs Co-Chairs, please email USAFP2018@gmail.com.

Maria DeArman, MD & Francesca Cimino, MD
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Capt Chloe Shea USAF, CPT Carolina Stark USA and LT Elizabeth Rettie USN were recognized as the Outstanding Graduates entering Family Medicine. LT Rettie was also the recipient of the Class Esprits de Corps Award and the US Navy Surgeon General’s Award as the Outstanding Navy Graduate.
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