IAFP

IOWA FAMILY PHYSICIAN

Vol. XLVII No. 3 / SUMMER 2020

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"Family Medicine will be the foundation for a healthier Iowa."

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IAFP IOWA FAMILY PHYSICIAN

Official Publication of the Iowa Academy of Family Physicians
Vol. XLVII No. 3 / SUMMER 2020

In this issue

Taking Care of You During the Pandemic

By Sherry Bulten, M.D. - IAFP President 2020

I would like to give a big SHOUT OUT to all Iowa Family Physicians. During this Covid-19 pandemic family physicians are serving in so many different roles and are doing so bravely and capably.

I am sure that I am not alone in my concerns for the mental and emotional stress this horrible virus has placed on our front line physicians. Much has been noted of those working in the exhausting, high volume, and high mortality settings.

Not as much is made of the stressors of office-based physicians. Stressors may include loss of sense of self and purpose as well as financial stresses for physicians who have been furloughed, even partially. As family physicians we are used to being the wise ones, solving health matters both physical and emotional with calm knowledgeable ease. We coach that a person has to take care of themselves first, fill up their basket before they can give to others. We have "learned" thru medical school, residency and years of practice that we can just push on. What happens when it all becomes too much?

Hopefully most are doing well with simple wellness measures. Think of something you like to do. Clean up your diet or cook and bake more. Get out for walks, bike rides or enjoying the sun as you dig and plant. We have the greenest grass this year as my husband does all the weeding, feeding and dethatching that we normally find a chore but is really rewarding when you can take your time. What indoor activities do you want to catch up on with extra time? Jigsaw puzzles, sewing, wood crafts are a favorite of many. My daughter-in-law has instituted what she calls "personal time" right after lunch for an hour and a half. The kids, 4 and 7, are not allowed to talk to her or invade her space. No have-to-do's are allowed, only want-to-do's such as reading, meditating or even Facebook without small ones over her shoulder. This may not be unique but is so wise and healthy.

For some the down or anxious feelings may be just too much for simple wellness measures. If this is you, I urge you to utilize some additional help. Please, PLEASE, give yourself PERMISSION to do so. Your partner can hug you, your banker can reassure you that the coffers will fill again, but only you can give yourself permission to seek help. Even with all the toughness and knowledge we physicians have developed there are times when we need to ask for help. You may not want to label these difficulties as anxiety, depression or PTSD. Melancholia, blues or insomnia work just fine. As we tell others, think of it as a consultation – used just as a consultation for a physical ailment. I do know what I speak of. I fell way down and hard 10 years ago when I had to leave the office for a physical problem. Any

of us may hit a hard spot where we may benefit from some form of help. None of us is unworthy of this assistance. In the throes of depression, the self-esteem may sincerely believe that one is unworthy. Believing you are worthy just because you're a child of God, while true, may not be enough. I encourage you to ask for and seek out help if needed. You are valued, loved and appreciated. We need you as a community leader, a volunteer, a partner and parent. I believe in you.

Many resources are available thru both the IAFP and the AAFP. Please visit the IAFP COVID-19 website (http://iaafp.org/COVID-19/) for a link to physician wellness resources.

Thank you all for your hard work, commitment and bravery. We will come through this stronger and more resilient. Wishing you and your families safety and health.

THANK YOU HEROES

Scattered throughout this issue you will find boxes like this with quotes from family physicians gathered from the AAFP COVID-19 Rapid Response Member Exchange Chat Forum.

"Every tragedy has a silver lining."

Primary care providers (PCPs) are on the front line for detecting and reducing the spread of HIV.

Approximately **1 in 7** people living with HIV is **unaware** of his or her status. About **40%** of new HIV infections are **transmitted** by people **undiagnosed** and unaware they have HIV.

The CDC recommends that everyone between the ages of 13 and 64 get tested for HIV at least once in their lifetime as part of routine health care.

For those with specific risk factors, CDC recommends getting tested at least once a year. Patients who may be at high risk for HIV include:

- Heterosexuals who themselves or whose sex partners have had ≥ 1 new sex partner since their most recent HIV test
- Sexually active men who have sex with men
- People who exchange sex for money or drugs
- People who inject drugs and their sex partners
- Sex partners of people with HIV
- People receiving treatment for hepatitis, tuberculosis or a sexually transmitted disease

Routine, opt-out screening removes the stigma associated with HIV testing, is cost effective, fosters earlier diagnosis and treatment, and reduces risk of transmission.

Despite seeing a PCP in the last year, more than **75%** of patients at **high risk** for HIV weren't offered an HIV test during their visit

The Centers for Disease Control and Prevention (CDC) and the Iowa Department of Public Health (IDPH) are asking PCPs to take the following steps:

1) Conduct routine HIV screening at least once for all their patients regardless of risk factors
2) Conduct more frequent screenings for patients at greater risk for HIV
3) Link all patients who test positive for HIV to medical treatment, care, and prevention services

Learn more at https://idph.iowa.gov/hivstdhep/reporting/HIV

Let's Stop HIV Together.

STOP HIV IOWA

IDPH Iowa Department of Public Health

From the ashes: What Will Arise After the Pandemic?

By Jason Wilbur, M.D. - IAFP Editor

Fellow family physicians of Iowa, I sincerely hope that as I write these words you are recovering from the exhaustion, financial strains, losses and anxieties that the coronavirus pandemic has brought to our state. Although we planned this issue of *Iowa Family Physician* to focus on rural medicine, we could not possibly avoid COVID, even as I grow tired of hearing about it.

There are so many different approaches I could take with this column, and I could go on ad nauseum in many different directions, but as Shakespeare said, "Brevity is the soul of wit," and I will not bore you with all of my thoughts on the pandemic. Rather than hand-wring about what terrors may befall us or engage in a discourse on the politics of mask-wearing, I will turn my attention to the silver linings on this thundercloud.

As with any crisis, there will be changes for the good that arise from this one. I don't mean to diminish the suffering that is happening now and will undoubtedly be magnified over time, but plenty has already been written from that perspective. Instead, I hope to illuminate the opportunities that this crisis brings and how family medicine can play a role in the direction our state goes from here.

One notable change is our shift to focus on patient safety rather than patient satisfaction. Now, patients are screened for infection, required to wear masks, and not allowed companions for their visits or procedures – all in the name of delivering safer care. If Press-Ganey scores disappeared because of COVID, none of us would mourn their death. Perhaps no one will care to answer the question, "What if Disney ran your hospital?" anymore. It seems silly and almost quaint to emphasize getting that 5-star rating when daily we are reminded of the reality that delivering healthcare is about meeting people where they are when they are hurting or terrified or dying. As vital providers in healthcare systems, family physicians should use this time to champion a "back to basics" focus on safe and high-quality care, which will definitely require patient feedback but should not be driven entirely by the hospital's marketing department. We need to insist on "safety first" for our staff as well as our patients and to re-focus the attention of administrators on quality and safety, not satisfaction and ratings.

In the name of patient safety, telemedicine suddenly launched to the forefront of healthcare delivery. That genie will not go back into its bottle easily. Until March, telemedicine was only slowly gaining acceptance and then only in certain areas of medicine, notably mental health. Payment for telemedicine lagged behind traditional modes of healthcare delivery and was restricted in such a way as to be difficult for family physicians to utilize. COVID has forced rapid changes in telemedicine use and reimbursement. At UIHC, my head was almost spinning from our quick transition to telemedicine – and I have welcomed that change. Many times in the past I have thought that a 3-month ADHD follow-up could have been accomplished by telemedicine, but we couldn't do it. Now we can. In fact, we have suddenly realized how many in-person visits could be accomplished by other means. Conversely, I previously did not have any ability to charge a "visit" for a prolonged phone call with a patient that included all the elements of a "SOAP" note. Now much of that previously unreimbursed care is billable. Family physicians need to fight to keep these gains in telemedicine for multiple reasons: efficiency, safety, and patient satisfaction (well…we can use the argument when it suits us, right?).

The pandemic has laid bare weaknesses in our system that physicians have understood but that citizens at large

did not know: lack of a robust public health system, lack of surge capacity at our hospitals, healthcare insurance tied to employment that is vulnerable in a down economy, and insufficient access to primary care services for many. The pandemic gives us an opportunity to discuss these and other issues and to propose solutions to our state and national leaders. These will be tough discussions and hard choices, and family physicians should be at the table as they are occurring. I urge you to engage local and state government officials, hospital administrators and your communities at large to address these issues. This is an opportunity to engage more with IAFP and AAFP, who can help carry your message, too. Family physicians bring a perspective to healthcare that bridges many gaps, and we are skilled at looking at complex problems and offering pragmatic solutions – just what is needed right now.

Since the pandemic came to Iowa, what has changed in your practice? What do you see as opportunities for family medicine to contribute to a better and stronger Iowa? Please send me your thoughts, or better yet, consider writing a "life after COVID" column for *Iowa Family Physician*. As ever, you can reach me with thoughts and comments at jason-wilbur@uiowa.edu.

Understanding Rural Medicine

By Samantha Fitzgerald, MS2, Carver College of Medicine

Rural medicine programs are offered by medical schools across the country, but few students entering medical school understand what these programs involve. Many students and physicians believe that rural medicine is the equivalent of family medicine, and students interested in practicing rurally are not interested in the academia of medicine. As a student who started her training with community-based rural practice in mind, I have heard many positive and negative statements surrounding rural medicine and wanted to share these and some important takeaways for physicians training the next generation of primary care physicians, whether they decide to practice rurally or not.

Rural medicine is often thought to be a low-paying, 1-2 provider family medicine clinic with limited resources located far from tertiary care centers. In reality, I have experienced rural family medicine clinic networks that utilized teams of physicians, advanced practice providers (APPs), nurses, and schedulers to satellite out from one central hospital to six nearby towns and care for thousands of individuals living in rural communities in Northeast Iowa. Without these integrated healthcare teams, the rate of burnout in these clinics would be significantly higher due to individual provider's patient loads and the quality of patient care would decrease. Additionally, most universities that offer rural medicine programs have repayment plans, with states like Iowa that also offer student loan repayment programs for practicing rural health physicians. Many facilities offer monetary signing incentives as well when working within a rural healthcare network. Most rural health education programs include graduates from all primary care specialties, including family medicine, pediatrics, internal medicine, psychiatry, general surgery, and obstetrics/gynecology. As a medical student who has fallen in love with the OR but also thoroughly enjoys her experiences in family medicine, something I like to share with my preceptors when assumptions are made about my future career is that "everyone has an appendix that may need removing, and babies are being born everywhere." It is possible to pursue a career in family medicine and undergo additional OB/Caesarian-section training to create a blended practice that best suits my interests.

Lastly, rural medicine is an extremely versatile field. As a primary care provider, you may find yourself staffing an emergency department, providing OB or nursing home cares, serving as the county coroner, working closely with physical therapy to fill the needs of a PM&R physician, covering the inpatient units as a hospitalist, and much more. The limits to what you can do are dependent on your training and what you feel comfortable with. Many rural health providers are brilliant physicians with expertise in many fields best suiting them to help as many patients as possible. They are also experts at amassing resources, practicing evidence-based medicine, identifying complex cases that require referral to a tertiary care center, and distinguishing which centers will best benefit the health of their patients.

What are the takeaways of this article for current and future primary care providers? First, don't write off students who are interested in rural medicine as disinterested, future family medicine providers. These students may have an interest in your specialty and are thinking of ways to integrate that into their future community practice. Well-rounded training is the key to creating competent providers, regardless of specialty. One of my favorite moments in my training came from an Orthopedic Surgeon during my first day on the clerkship, stating that "everyone needs joint replacements!" and providing me with a list of hospitals in the state that were hiring general Orthopedists. Next, educate yourself on the current legislation in Iowa about Critical Access Hospitals and the shortage in primary care across the state. Other than the 7-8 cities in Iowa with population >25,000, the majority of the state is rural that still needs quality healthcare. Physicians that work in rural areas also have a higher density of Medicare/Medicaid patients, so education on the government health systems, coding, and billing will be extremely useful in our training. If you are a student interested in rural medicine but fall in love with a specialty, worry not! Many hospitals will satellite in specialty providers a few times per week so you can still have a mixed practice between larger tertiary care centers and Critical Access Hospitals. These are a few simple guidelines to shed some light on common questions asked of students interested in rural medicine and to hopefully better the training of primary care physicians as a whole.

THANK YOU HEROES

"This disease is like wildfire and persists like a fire in a coal mine."

2020 IAFP/ Don Tesdall Memorial Outstanding Student Award - Jay Blomme, University of Iowa

Jay Blomme is an Iowa native who grew up in Audubon, IA. He spent his first summer of medical school in Osceola, IA at Clarke County Hospital as a part of the MECO program. Jay worked with Dr. Kyle Glienke in Storm Lake, IA for his core clerkship in Family Medicine and has completed numerous other electives in Family Medicine. His preceptors rate him very highly, as he demonstrates outstanding clinical knowledge and excellent patient communication skills. In addition to his academic achievement, Jay has been an active leader in the Carver College of Medicine Family Medicine Interest Group, serving as Co-President in the 2019-2020 and inspiring other students in Family Medicine.

Jay enjoyed his time in medical training with FM physicians across the state. "I worked with incredible physicians and PA's at UIHC, Clarke County Hospital, MercyOne North, and Iowa Lutheran Hospital. I want to specifically emphasize my time working with Dr. Kyle Glienke at BVRMC in Storm Lake, Iowa. I feel that my weeks up there were instrumental in my professional development through medical school. He has been a role model for me, and I wish I could have worked with him even longer."

Jay plans to complete his Family Medicine residency at John Peter Smith Hospital in Fort Worth,TX and hopes to return to practice in rural Iowa after completion of his training there. We are certain he will be a wonderful asset to his residency program and to the patients that he will serve in the future. Congratulations, Jay!

PROVIDE FINANCIAL AND MENTORSHIP SUPPORT TO STUDENTS

IAFP MEDICAL STUDENT SUPPORT PROGRAMS

The IAFP provides several opportunities for Iowa family physicians to provide financial and mentorship support to students who express an interest in family medicine as a career. Research shows that student interest is dependent on many factors, including early exposure and mentorship/ role modeling by practicing family physicians. Both mentors and mentees benefit from these professional relationships. We have many options for you to help support this process and we hope you will consider donating financially and/ or educationally.

1. Adopt-a-Student option ($400) allows practicing family physicians to be matched with one (or more) interested students, providing both financial and mentorship support to the specific student during medical school. Matches will take into consideration mentor/mentee preferences, geography, and mentor practice factors.

- Financial support is used to:
  - Offset expenses for travel and accommodations for attendance at the AAFP National Conference in Kansas City, where students gain energy and information about family medicine residency programs and may attend educational sessions of interest to future family physicians.
  - Support students during early curriculum with resources, study break treats, as well as offsetting travel/accommodation expenses for shadowing opportunities and mentorship connections.
- Mentorship support includes quarterly contact with students as arranged. These connections may take various forms and will be supported by the UI Department of Family Medicine Medical Student Education Program:
  - Electronic conversations
  - Face-to-face or Skype meetings
  - FMIG event co- attendance
  - Shadowing connections during summer or school breaks
  - Precepting students for required and/or elective family medicine clerkships

2. AAFP National Conference Sponsorship Only ($300 each) will provide funding to offset travel expenses for student(s) to attend the conference and gain energy and information about family medicine residency programs as well as to attend educational sessions of interest to future family physicians.

3. Mentorship Only (no financial contribution) allows physicians to connect with students as described in option 1, without associated financial support.

To learn more and sign up for this program, visit www.iaafp.org/adopt-a-student

IOWA ACADEMY OF FAMILY PHYSICIANS FOUNDATION

Thank You for Supporting the Cedar Rapids Family Medicine Residents

FIRST YEAR RESIDENTS: Chelsea Lima, MD; Bailey Englund, DO; Fellipe Lima, MD; Zahn Raubenheimer, MD; Brock Mills, DO; Bledar Haxhui, MD and Ryan Cook, DO.

SECOND YEAR RESIDENTS: Danielle Howsare, DO; Sayeed Ahmed, MD; Rachel Atherton, MD; Oleksandra Bem, MD; Callie Pittard, DO; and Tiernan Murphy, MD.
Not Pictured: Kyle Cassidy-Wescott, MD.

In January the news came out that the Cedar Rapids Medical Education Foundation would be closing at the end of the academic year. The IAFP Board of Directors and the IAFP-Foundation were concerned about the residency program closing and wanted to show their support by contributing a $1,000 grant to each of the displaced residents. The IAFP issued a call-to-action to members, receiving an outpouring of support and additional funding. We are humbled and overwhelmed by the generosity of our members for their individual contributions and by the matching contributions of $14,000 each made by the IAFP, the Mercy and St. Luke's Medical Staff, St. Luke's Hospital and Mercy Medical Center in Cedar Rapids, which raised the amount of each individual contribution to $5713.

It is our hope that these funds will help offset any costs associated with their transitions. We wish them the best of luck with their transition and in the future!!!

Resident	New Program
Sayeed Ahmed, MD	MercyOne Des Moines
Rachel Atherton, MD	Genesis (Davenport)
Oleksandra Bem, MD	UMass Fitchburg
Kyle Cassidy-Wescott, MD	University of Iowa
Ryan Cook, DO	University of Pittsburgh
Bailey Englund, DO	University of Missouri, Kansas City
Bledar Haxhiu, MD	Larkin Hospital (Palm Springs, FL)
Danielle Howsare, DO	Genesis (Davenport)
Chelsea Lima, MD	MercyOne Des Moines
Fellipe Lima, MD	MercyOne Des Moines
Brock Mills, DO	University of Tennessee, Chattanooga
Tiernan Murphy, MD	University of Iowa
Callie Pittard, DO	University of Tennessee, Chattanooga
Zahn Raubenheimer, MD	University of Missouri, Kansas City

THANK YOU HEROES

"One great benefit of telehealth is the opportunity to see a new/different side of our patient's lives. I think there can be large value in that. Yes there certainly are those TMI moments, but more often positive ah-ha moments where barriers to improving their health become immediately obvious."

Thank you to our Cedar Rapids Residents Donors!!!

We would like to sincerely thank everyone that supported the Cedar Rapids residents as they transition to new residency programs. We are humbled and overwhelmed by the generosity of our members for their individual a and by the matching contributions of $14,000 each made by the IAFP, the Mercy and St. Luke's Medical Staff and the $14,000 made by Mercy Medical Center and St. Luke's Hospital. Together, we raised $79,991.

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Claudia Zavala, MD

THANK YOU HEROES

"I am concerned about our patients' isolation as well along with their increased risk for depression. I am encouraging the kids who are out of school to make cards and little videos for our patients :)"

Home

An Essay by Danielle Howsare, D.O., R2 / Cedar Rapids Family Medicine Residency Program / Cedar Rapids Medical Education Foundation / Cedar Rapids, Iowa

I won't lie. When I was told that the theme of this edition of the Iowa Family Physician was going to be rural medicine in Iowa, my first thought was, "What in the world do I have to contribute to that discussion?" I am a proud Iowan, but I grew up in Iowa City (not considered a rural community by Iowans), and am currently practicing in an even more urban area. Though I whole-heartedly support continuing to improve access to high quality medical care in rural Iowa, I have virtually no experience or advice to offer on the best ways to make it happen. However, when I began my medical career, there was no question in my mind that Iowa would be where I would pursue my future practice. Furthermore, in my experiences during my education, and now through two years of residency, I have become more and more passionate about family medicine in Iowa. In so doing, I now believe one thing for sure – rural or not, we need to recruit, train, and keep good family doctors here.

Despite the state of Iowa having two highly rated medical schools, and consistently being ranked one of the best states to practice medicine, we are not immune to the shortage of family doctors. As I'm sure many of you know, multiple organizations including American Academy of Family Physicians, American Board of Family Medicine and the Association of Family Medicine Residency Directors, have joined to establish the America Needs More Family Doctors: 25 x 2030 Collaborative1. The goal is right there in the title – increase the percentage of medical graduates choosing family medicine as their specialty to 25% over the next 10 years.

I recognize that Iowa needs all specialties and not everyone belongs in family medicine, but we can do better. As a resident, I have worked with many medical students over the past two years. I've tried my best to be a good representative of our specialty, to teach them all that family medicine can offer, and to hopefully help them consider it not just as a legitimate career choice, but maybe as even the right choice for them. Looking ahead to my future practice, I hope to be able to consistently offer shadowing or rotation opportunities for students. I know that I am young in this field and that this is not a new topic for family physicians. However, I would encourage everyone to continue to consider ways we can reach future family doctors in order to motivate them to stay right here at home in Iowa. The people of this great state deserve the best in primary care, and continuing to increase the numbers of quality family medicine physicians will give them just that.

It would be impossible to discuss the training of family physicians in Iowa without addressing the unanticipated closure of my family medicine residency program at the Cedar Rapids Medical Education Foundation in Cedar Rapids, Iowa. I'm sure that there were many factors that contributed to this decision, and I admit that the dynamics of postgraduate training logistics and finances are far above my current scope of knowledge. Nevertheless, I think we can all agree that reducing the numbers of training opportunities for Iowa family medicine residents can do nothing to help serve our future patients and Iowa communities. This disruption, not just to our education, but to our lives, has not been an easy one to swallow. I am definitely not the only one affected whose expectations, ambitions, and plans for the remainder of my residency were turned upside down. I am, however, one of the very fortunate to be joining another superb community-based Iowa family medicine residency program, the members of which have welcomed me with open arms.

Though I continue to grieve what I lost, I know that I will receive excellent education from exceptional people, and will continue training in the state that I love. Through one of the most difficult times of our lives, I have been astounded by and so grateful for the immediate and unwavering support from members of the entire medical community, locally, throughout the state, and even around the country. This experience has shown me yet again what a special community we have as family physicians, and as Iowans. To each and every one of you, I think I speak for every member of my program when I say you have our sincere gratitude. This is my home, our home. Let's continue to support one another, and support family medicine in our state.

1) JACOB PRUNUSKE, MD, MSPH, Medical College of Wisconsin, Wausau, Wisconsin - *Am Fam Physician*. 2020 Jan 15; 101(2):82-83.

THANK YOU HEROES

Like Jerry Garcia said: "Somebody has to do something and it is incredibly pathetic it has to be us."

Change is Difficult: Resident Responses to COVID19 Direct Patient Care

By: Elise Duwe, MD, PhD, PGY2 and Rosalie Cassidy, MD, MBA, PGY3

To say that the world changes by the day, perhaps even the hour, because of COVID-19 understates the actual colossal situation. The following are two resident responses to COVID-19. Elise, a PGY2, recorded her reflection initially as an audio diary while commuting on Highway 20 across half of Iowa. Rosalie, a PGY3, wrote her response after being the COVID provider in the clinic for a week, as well as the chief on the inpatient service when the first COVID positive patient arrived. The reflections retain their original grit in order to motivate your own reflections. We are all challenged, frustrated, motivated, invigorated, and questioning together in this difficult time.

Elise: It's April 8th, and I am yet again driving across Iowa. I must be somewhere where the pigs are because it really smells like pigs today. It's gotten warmer and so then the pig poop aerosolizes. Aerosolization is something important right now. Is this patient aerosolizing and this one not? What kind of precautions do we need? Is Sars-CoV2 aerosolized transmission or just droplet? It seems really able to get people infected regardless of how much exposure they have. I just listened to a podcast that ended with a violinist playing the theme from Dvorak's New World Symphony which both my paternal grandparents had at their funerals. My grandmother's funeral was right around a year ago, and in residency there isn't enough time to process. Although I haven't processed through stuff for awhile now. And that's not good, because it just keeps building and building.

I'm still on inpatient service, so that just makes me grumpy in general. I was really snarky about virtual visits with a faculty member. We are supposed to pre- and post-staff all virtual visits. Extra extra micromanaging. Regardless of license. Regardless of if you are usually able to see your patients in clinic with a staffer on standby for questions but not directly present within your clinical interaction. I ask questions. I use faculty expertise. I ask questions to a fault sometimes. It feels like faculty don't trust us as residents. I know that they just don't trust the system. But it has to be this way. It has to be so that our patients are safe. Other residencies are doing basically only virtual visits. Another residency has residents do check check-in calls from first year without mandatory staffing obligations. Intimidating, freeing, great learning. It's an empowering and scary thing. It's how we learn to manage our patients in a way consistent with great primary care. I know my patients, and the staffers don't know my patients. I really value that relationship with my patients. And I value continuity so much. It's what I grew up with. It's the way I think medicine needs to be.

So I made sure to follow the rules when I had virtual visits yesterday. And I pre-staffed all of them, and I post-staffed all of them and still, the faculty said they needed to see the patient. Why? I don't understand why. I don't understand what faculty will glean from seeing my patients' faces on a screen without knowing who they are. They are my patients so I know who they are.

My COVID patient got intubated last night because he was requiring a lot more FiO2, and his chest x-rays were getting

(continued on page 12)

THANK YOU HEROES

"I am going to ask a difficult question that some of you might be asking yourself as well but difficult to ask. What is the recommendation for physicians who are in high risk groups (older than 60, diabetic, chronic diseases and immunocompromised), besides usual precautions for this virus? Should we continue to expose ourselves? I fit in those categories (well almost 60) and I took other peoples "walk in" shifts since nobody else was stepping up. But should I? There is impact on my family if I die from this as well as obviously my impact . . . does the desire to help supersede the desire to take care of and be responsible to our families? What are your takes on this? Others out there in the same predicament?"

(continued from page 11)

worse. So he did indeed go into ARDS (acute respiratory distress syndrome). The pulmonologist said he was going to. It was pretty much guaranteed. It was day 10, so he's kind of reading the textbook on when things are supposed to happen. I don't know if he'll read the textbook that there's an 86% mortality rate off the ventilator. Our other patient on ventilator has been on it for 12 days, I believe, at this point in time. That's a really long time on a ventilator.

I want to know what exactly is happening with the deaths of the ones who do die. So many dying! Are families deciding to withdraw care? Are the patients actually dying despite the ventilators? Have they all been mandatory DNRs? Are they coding before they are declared dead? I want more specifics so that I can be a bit more informed when I talk to family. With this guy, I should probably have talked about code status already, but I didn't because he was so nervous. He was so nervous I put him on scheduled anxiety medicine so that he would sleep and breath deeper and all of that. He had these coughing fits that got him really worked up. Then he would watch his oxygen saturation plummet and get more nervous and choke on his own spit. Very uncomfortable, I'm sure, especially for someone who hasn't been sick before. Which is how I would be if I got it. Potentially not very tolerant of how it was going--of being short of breath. I hate coughing, especially since there's nothing good to do about it besides treat the underlying disease process. So I hadn't talked to him about the fact that a code on a COVID positive patient is really hard. I got his code status at the beginning, but I didn't broach this difficulty then because he was on room air. I knew he was going to crump at some point in time. I just didn't know when. And I should have been one step ahead instead of one step behind. But now I need to talk with his wife and figure out what she wants to do because something should be figured out. He'll probably be full code. He's healthy. He's not that old. I'll see how she responds to our challenges in doing a code given COVID and PPE. A lot of young people are dying from this. Not really in Iowa yet. Mostly old people in Iowa. I wish I new how the COVID patients could die. And I just need a break again.

"By the second day, he was intubated. By the second week I didn't think he was going to survive. I saw the havoc that COVID-19 can have on the body. I felt helpless. Everyone had a difference in opinion on how to proceed with treatment. I was the middle man between the Intensivist, the ID (infectious disease) specialist, and the family. Weeks later, the patient was discharged from the hospital; however, I was still left questioning: how did this man survive when others have not? Old, young, sick, healthy - it affects us all."

Rosalie: It is May 7th when I write this. It had a death rate similar to the flu… and it wasn't even in our area… what were people freaking out about? This was mid March. I do not have a TV, and I do not watch or google the news, so most of my initial information about COVID-19 came from people sending me memes on instagram. Slowly but surely, the disease inched towards us, here in Iowa. I was on the inpatient service when we admitted our first COVID-19 positive patient. He was an older but healthy gentleman who definitely seemed worn out but kept a positive outlook. By the second day, he was intubated. By the second week I didn't think he was going to survive. I saw the havoc that COVID-19 can have on the body. I felt helpless. Everyone had a difference in opinion on how to proceed with treatment. I was the middle man between the Intensivist, the ID (infectious disease) specialist, and the family. Weeks later, the patient was discharged from the hospital; however, I was still left questioning: how did this man survive when others have not? Old, young, sick, healthy - it affects us all.

THANK YOU HEROES

"It's time to get "ugly" with health plans!"

Our family practice clinic created a dedicated COVID-19 clinic (run by PGY3s). One resident would be in charge of this clinic each week. I thought I would hate it, but I actually loved the experience. We kept it fun by giving it a different name each week, it started as the "COVID Cantina," and my week, I was "Queen of the COVID Cobana." I liked feeling that the clinic was mine. I was in charge. I decided who to swab and when to follow up. I spent hours perfecting my dot phrases and templates to make the visits all flow the same. I was lucky to have landed during a time when tests were readily available, and I had the opportunity to basically screen everyone, rather than have to decide like my former colleagues in the COVID Cobana. My day started with a daily telephone meeting for updates and then consisted of numerous telephone, virtual, and parking lot visits. It was different with a specific amount of continuity of care. I overall really enjoyed it. I can admit, though, that it was a busy week, and I was exhausted that weekend. I have to do this again in two weeks. It will be interesting to see how things have changed at that point. Everything changes so quickly…

I remember when it really started to hit here, someone told me that everyone will be affected by this, whether it is personally or knowing someone else whose life was changed. I felt like that was likely a true statement. Do I feel like I have been affected? Yes and No. I am a physician, so I am used to seeing sick people. I don't say that to mean that I've become cold or lost my humanity, but I don't think it affects me like it might others. I've yet to be overwhelmed by COVID patients, and I've yet to know someone close to me with COVID. Yes, I am getting sick of staying at home and am missing some human connection, and yes, this has been just an overall interesting point in time to be a part of, but I am not sure I feel personally affected by COVID. I think I need to be thankful for that. Because I know it has negatively affected many, many others.

***

May we all move forward through these changes with grace and gratitude and intentionality.

Adapting a Family Medicine Residency Clinic in Iowa Hotspot for COVID19

By: Shamim Khan, MD, PGY3; Adam Roise, MD, MPH, faculty; Elise Duwe, MD, PhD, PGY2

March Madness at our family medicine residency program usually involves completion of basketball tournament brackets and a spin in the SOAP process once in a while. When you throw in spring break and an occasional snowstorm, the month seems to fly by.

This year, when Governor Reynolds signed her COVID-19 Proclamation of Disaster Emergency on March 9, a new version of March Madness was upon us. Like at every clinic and residency program in the state, normal routines were quickly upended. Patients started calling to cancel long-standing appointments. Staff became nervous about seeing potentially sick patients, as well as interacting with residents going back and forth between hospital and clinic. Numerous education rotations were put on hold. Over a period of weeks, we worked quickly as a team of front office staff, nursing staff, faculty, and residents to develop new workflows that allowed us to continue to carry out patient care and our educational mission. This involved minimizing exposure to/from staff, adjusting our patient care processes, and addressing changing educational experiences during this time.

When the Governor's order came down, our county was yet to have a positive COVID case. In line with the order, we quickly worked to minimize risk of transmission amongst clinic staff. Staff that could work from home were set up to do so. Administrative staff, managers, human resources, pharmacy, health coaching, and behavioral specialists stopped coming into the clinic. While pulling staff out of the clinic, we also divided our clinic, marking off a designated area specifically for COVID-19 suspected cases. We moved a staff break area, spread tables apart in the staff lunch area, and stopped mail delivery around the office. Tape appeared on the floor to draw attention to six-foot spacing, internal doors were propped open, and facemasks were donned by both medical professionals and patients. Chairs were moved from waiting areas to provide appropriate sparse spacing. We worked on picking up the phone to talk with someone down the hall instead of walking to their office. Meetings and weekly educational conferences for resident physicians occurred on a digital platform. Residents seeing patients in the hospital were not brought into the clinic to see patients in the afternoon. We put up plexiglass barriers to protect front office staff at check in. All staff began monitoring temperatures two to three times a day. One nurse and one resident physician (usually PGY3) were designated each week to work only in the "COVID corner," protecting our supply of PPE and quickly becoming our clinic experts in outpatient COVID care.

To keep patients safe, we quickly explored telehealth options, designing consent forms and adjusting documentation workflows. Access services staff screened patients for possible COVID symptoms while making appointments and during reminder calls. Positive responses were sent to the COVID provider to address virtually, if at all possible. Depending on patient symptoms, current CDC guidelines, and testing options available to us, patients were directed to self-quarantine or present for a parking-lot swab. If a patient required assessment in the clinic, they were met in the parking lot, given a mask, and escorted up the back staircase to the designated rooms.

While developing our COVID-19 corner, we started working on what more could be done for non-COVID-19 patient concerns. Visit numbers for annual wellness and chronic disease care dropped dramatically. While we were getting virtual visit platforms up and running, we expanded our Chronic Care Management program. Nurses and

THANK YOU HEROES

"Yesterday during a telehealth visit with a patient he lit up a cigarette! I didn't say something right away, but at the end of the visit I asked him about his smoking - he had quit before the pandemic. He was a bit embarrassed because he said he didn't even realize he was smoking."

resident physicians were charged with calling Medicare and Medicaid patients with two or more chronic conditions - the folks that are at highest risk for complications from COVID-19, as well as those most likely to be lonely or have social determinants of health making it difficult for them to maintain basic needs. We focused on preserving these patients' health during this time to keep them out of the hospital; we also counseled them on how to stay safe and assure they had the essentials they needed, such as toilet paper, food, and an adequate supply of chronic medications. In short order, we had virtual and phone visit platforms and novel workflows that allowed us to interact with patients in new ways. This helped us provide important care and reassurance to our patients. Nursing home visits at our four main facilities became overlapping chains of video conferencing calls as patients and physicians rotated on and off the screen.

Finally, as an educational organization, we had to consider how we continue to teach during this time. With PPE limitations and specialty clinics with minimal patient care, most resident rotations were cancelled. Back-up residents were identified to cover clinic and hospital services. Self-study selectives were developed with identification of self-study curricula, board-prep resources, scholarly activity project time, and other rotational learning resources. Regular didactic time was adapted to a video conferencing platform, and we quickly learned how to share screens and use the chat feature. As we started to see COVID positive patients in the clinic and hospital, didactics emphasized care of COVID in these settings. We also discussed how to deal with fear and uncertainty for patients and colleagues as we started to have patients poorly progress and die.

Looking back, it was a fire-hose of change thrust upon us: questions to answer, lots of concerns to consider, and lots of uncertainty to address. Adaptations that would have taken months to years to take effect were implemented in a span of weeks--our March Madness. Through the grace, adaptability, and hard work of our team members, we are continuing to shape our work to keep each other safe, to keep our patients cared for, and to keep constantly learning.

Welcome New First-Year Residents

Broadlawns Medical Center Residency Program
Spencer Aldridge, DO (Des Moines University)
Thomas Biederman, DO (Des Moines University)
Katherine Dvorak, DO (Des Moines University)
Tyler Folkerts, DO (Des Moines University)
Taylor (Johnson) Glab, DO (Lake Erie College– Greenburg)
Timothy Jay, DO (Des Moines University)
Geoffrey Jung, DO (Des Moines University)
Michael Winters, DO (Des Moines University)

Genesis Quad Cities Family Medicine Residency
Kyle Carver, MD Southern Illinois University, Carbondale, IL)
Mary DeFrance, MD (University of Illinois – Rockford)
Emily Gudenkauf, DO (AT Still University – Kirksville, MO)
Kubat Rahatbeck, MD (University of Iowa)
Jenna Sarantakos, DO (Des Moines University)
Ronald White, DO
(Lake Erie College Of Osteopathic Medicine – Greenburg)

University of Iowa Family Medicine Residency
Tanya Aggarwal, MD (Indira Gandhi Medical College – India)
Ellie Fishbein, MD (Rush Medical College, Chicago, IL)
Samuel Orvis, MD (University of Iowa)
Hannah Stein, MD (University of Illinois – Peoria)
Harris Syed, MD (University of Vermont)
Aaron Weaver, MD
(Medical College of Wisconsin – Milwaukee)

Family Med/Psych Residents
Jacob Groen, DO (Pacific Northwest University)
Joseph Rattenni, DO (Lincoln Memorial University)

Iowa Lutheran Family Medicine Residency Program
Demi Eble, MD (University of Iowa)
April Forsyth, MD (University of Iowa)
Sarah Freeland, DO (A.T. Still University – Kirksville)
Hannah Hartman, DO (Des Moines University)
Lindsey Hohulin, DO (Des Moines University)
Austin Pillon, DO (Des Moines University)

North Iowa Mercy Residency Program
Stephanie Baldwin, MD (University of Iowa)
Grant Landon, DO (Edward Via College of Osteopathic Medicine, Blacksburg, VA)
Elizabeth Orr, MD (University of Minnesota – Duluth)
Abigail Pira, MD (University of the East – Ramon Magsaysay – Phillipines)
Alexis Smirlis, MD (St. George's University of London)
Bryan Taylor, DO (Liberty University of Osteopathic Medicine. Lynchburg, VA)

Mercy Medical Center Family Medicine Residency - Des Moines
Bethany Citerella, MD (Ross University)
Elliot DeBlieck, DO (Touro University Nevada COM)
David Huber, DO (Kansas City University COM)
Kiara Jennings, DO (Nova Southeastern University COM)
Obidike Nwadike, MD (Windsor University)
"PJ" Patrick James Panzu, MD
(American University of the Caribbean)
"Beth" Elizabeth Petelin, DO (Kansas City University COM)
Max Reiche, MD (Indiana University School of Medicine)

Siouxland Medical Education Foundation Residency Program
Katherine Evans, DO (A.T. Still University – Kirksville, MO)
Robert Garekis, DO (Des Moines University)
Austin Granatowicz, MD (University of Nebraska)
Cassady Miller, MD (University of Nebraska)
Shannon Salerno, MD (University of Kansas, Kansas City, MO)
Ben Schwab, DO (Des Moines University)

Northeast Iowa Family Medicine Residency Program
Diangle Acosta Bonilla, MD
(University of Medicine and Health Sciences – St. Kitts)
Kinza Ali, MD
(Windsor University School of Medicine – St. Kitts)
Myriam Benoit, MD
(St. James School of Medicine –Anguilla)
Ashley Dohlman, MD (Ross University – Barbados)
Lesley Green, MD (Universidad de Guayaquil Faultad de Ciencias Medicas – Ecuador)
Felix Kurilov, MD
(University of Medicine and Health Sciences – St. Kitts)

2020 NRMP Match Highlights

Match Day celebrations were canceled at medical schools across the country in the wake of the COVID-19 pandemic, but family medicine still had reason to celebrate results of the National Resident Matching Program Main Residency Match that were released March 20.

- 4,335 medical students and graduates matched to family medicine residency programs (categorical and combined) in 2020, the most in family medicine's history as a specialty, and 487 more than 2019. The results marked 11 years of growth in overall positions offered and filled for family medicine in the NRMP Match, with a steep increase in recent years.
- Of those matches:
    - 1,557 were U.S. allopathic medical school (MD) seniors
    - 1,399 were osteopathic medical school (DO) seniors
    - 788 were U.S. international graduates (IMGs)
    - 405 were foreign IMGs
    - 120 were previous graduates of U.S. MD-granting schools
    - 65 were previous graduates of DO-granting schools
    - 1 was from another pathway (e.g., Canadian, fifth-pathway)
- Most notably in 2020, the final shift to a Single Accreditation System and consolidation to the NRMP Match as well as the growing number of osteopathic graduates is responsible for much, but not all, of the year-over-year growth.
    - Family medicine offered 4,685 positions, 557 more than 2019 and 13.7% of positions offered overall.
- Iowa highlights:
    - 73 Iowa students matched into family medicine (15 from University of Iowa, 58 from DMU)
        * 18 of those students stayed in Iowa

THANK YOU HEROES

"Another one that many have probably experienced in doing a telehealth visit with a patient while a spouse is walking around not fully clothed. I finally understand the expression TMI!"

COVID-19 RESOURCES

With the global spread of COVID-19, IAFP wishes to provide members with the most accurate information as the Coronavirus situation evolves and wishes to direct members to these trusted resouarces:

The State of Iowa:

The state of Iowa has released an updated dashboard that will be updated daily to include comprehensive tracking of COVID-19 in Iowa.

coronavirus.iowa.gov

CDC's Coronavirus Center for Healthcare Professionals:

Updated daily. Direct access to interim guidance on key issues, extensive health resources, etc.

www.cdc.gov/coronavirus/2019-ncov/hcp/index.html

AAFP's Coronavirus Center:

As more is being learned about the coronavirus infection, the AAFP has a team that is monitoring the situation on a daily basis and posting all relevant updates on its dedicated COVID-19 resource. There is a lot of evolving, and sometimes inaccurate, information about the situation, so members can be confident that this page contains the most recent information they need that is aligned with the CDC and focused squarely on family medicine.

www.aafp.org/patient-care/emergency/2019-coronavirus.html

Iowa Department of Public Health:

Provides a variety of resources for physicians, patients and the public.

https://idph.iowa.gov/Emerging-Health-Issues/Novel-Coronavirus

Iowa Academy of Family Physicians:

We are also continually adding links to resources and other relevant information that we think will benefit our members along with updates from IAFP Lobbyist, David Adelman.
Please visit ***www.iaafp.org/covid-19*** to view these resources.

THANK YOU HEROES

A physician from Boulder to another Family Physician fearful of losing their practice

"(((((Dr. Anonymous)))))

(the younguns tell me those parentheses are how we're supposed to type a hug)

I'm in a similar boat, but too broke, not old enough, and too full of proverbial piss and vinegar to retire yet.

I passed thru scared.

It really sucked.

Now I am angry - but it's the kind of anger that fuels me.

Remember (and this is for all of us!):

No matter what "the system" does to you, to us, to our patients, to this country... NEVER FORGET that the work that we've done, the work that we give our lives to, is a lifeline to many, and a vital thread that holds the fabric of community together.

I don't know you personally, but I know without a doubt that there are human beings who are alive today - both physically, and because you inspired them to not give up - because you chose to serve your community as a Family Physician.

No-one, NO-ONE, can take that away.

No-one can erase the years and the moments that you have made possible for the patients whose lives you've touched.

Sometimes, when I sit with a patient at the end of their lifespan or during a brutally painful transition, we look together at how their life has mattered, how the world is a better place for them having been here.

Maybe it's time to do the same with ourselves and our practices.

*This weekend, my partner in life, who is my business support for the practice, worried whether bankruptcy would mean that we had "failed" - that they had "failed me." I thought about the amazing human being I have chosen to share my life with, and all of the countless ways my world is enriched by everything they do, everything they are. NO. No, being financially choked to death by an inhuman system is not a "failure." Had my partner never ventured out to try the unknown, create beautiful art and relationships and show others that it's okay to be ourselves, that it is healthy and necessary and needed in the world for us all to pursue our dreams -- had they never risked and never done any of these things, THAT would have been a failure. Had they stayed in the family business that did not feed their soul, stayed in a place that did not cherish their unique sparkle, allowed the dreariness of mundane expectations to crush the spirit out of them -- THAT *would* have been a failure. Instead, they - and we - chose the risks and adventures of not waiting for permission to serve in love, to celebrate and nurture and protect life, to give others a chance to pursue their dreams. That IS what success looks like.*

A hundred years from now, nobody is going to care what our credit scores were during the Great Pandemic Collapse of 2020, or whatever historians will someday call this mess.

Think of the stories that are passed down in your family or community, from generation to generation, remembering who was important, and why. I guarantee you won't find much in there about accounting or the drudgery that never got caught up. But you will find stories of love, of resilience, of standing by one another through hardship and change, and of the simple beauty of being fully human with one another.

If it is time to say: you've done enough; you've served enough; you've given enough; you've more than earned your rest -- then let it be said. Let others cherish and celebrate you, and let go of the burden of always trying to make it right for everyone else. Sit back, and let them remind you of how much you have given, and how much it has mattered.

We are trained how to rush into battle. We are taught how to endure and serve for the long haul. But too often, we are never told that it's okay to be done. If the next step on your path is to retire to the simple pleasures of your own loved ones and personal pursuits, that too is good, and you have earned it. If the next step on someone else's path is to shift away from clinical care, or to walk away from any situation that abuses and undervalues them, then that, too, is good. It is an act of strength to walk away from systematic abuse. Do not apologize for protecting your soul and preserving yourself. Discover for yourself -- and teach others through your process -- how to end one chapter with grace and gratitude, and how to step into the next chapter with serenity and an open heart.

I wish you a long, rich, colorful and healthy next chapter, bolstered by joyful reminders of the magic you made possible through your years of service."

EHDI JCIH Recommended Best Practice Updates 2019

Dr. Jeff Hoffmann represent the IAFP on the EHDI Board and shares why the recommendation below are important:
I find that EHDI recommendations play an integral part in helping the family physician evaluate their newborn patients. Through this current pandemic our focus has been on preventing and treating the Coronavirus. Though this is very important, we as physicians need to continue to remember to treat and evaluate the wide range of other illnesses and conditions of all of our patients. Hopefully this position statement presented by the EHDI will help clarify the importance of evaluating hearing loss in early infancy.

Updates on Early Hearing Detection and Intervention Best Practices

The JCIH *Year 2019 Position Statement: Principles* and Guidelines for Early Hearing Detection and Intervention Programs became available in October 2019. It is available for free downloading in its entirety of 44 pages through the following link. http://jehdi.usu.edu/

The scope of the Position Statement is broad, including recommendations for audiologists, early intervention programs, EHDI programs, pediatricians/primary care providers, otolaryngologists, geneticists/genetics counselors, and researchers. In this paper, I share the information most pertinent to you as pediatricians.

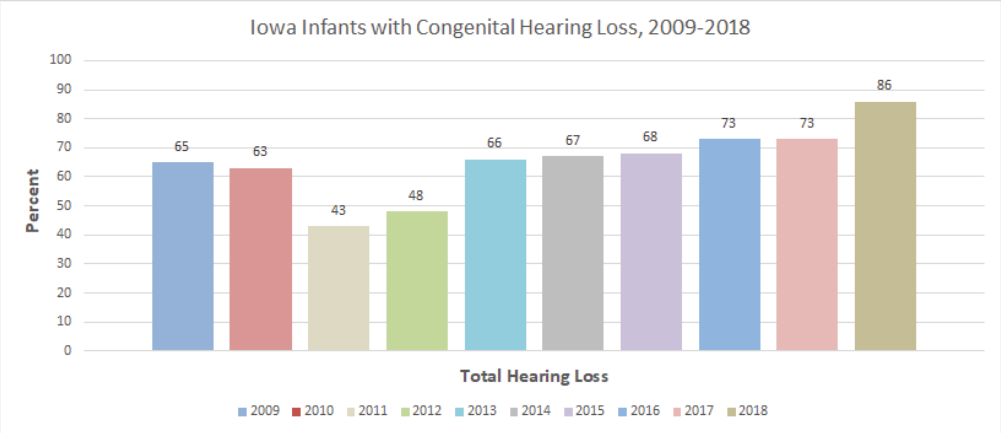
"Fail" is the new "refer." Previously "refer" was the preferred way of stating a "did not pass." However, the term "refer" is confusing, and has been replaced with "fail." A fail is given if a child does not pass in one or both ears.

"Hearing loss" is differentiated from "hearing thresholds outside the typical (normal) range." A newborn who has deafness or is hard of hearing, has not "lost" hearing. However, a child identified with a progressive or late onset condition of deafness or hearing impairment has lost hearing.

How are we doing with the 1-3-6 EHDI Goals?

The nation is doing well with meeting the first EHDI goal of newborn hearing screening by 1 month of age. However, we still struggle with getting diagnosed by 3 months those infants who failed their screen. Factors include babies born at home, rural areas lacking in services or equipment, and more importantly providers not moving infants along in a timely manner. Some doctors are not aware that a screen performed in the medical home needs to be reported in the EHDI database, as required by law.

FIGURE 1



For purposes of clarification, the actual diagnosis of hearing impairment is made by the audiologist, who then immediately refers to Otolaryngology so a cause can be determined, and medical and/or surgical treatment can be rendered. The audiologist can fit the child for hearing aids if appropriate. Early developmental intervention should be started as soon as possible after diagnosis, so language acquisition is not delayed. The timeliness of intervention is so important that the goals are changing to 1-2-3-month timeline (screening completed by one month, audiologic diagnosis by 2 months, enrollment in early intervention by 3 months) for those states who currently meet the 1-3-6 benchmark.

How many Iowa children with hearing loss are identified during infancy?

We are identifying more and more infants with hearing loss as you can see from *FIGURE 1* above. In 2018, we identified 86 children with congenital hearing loss or 2.3/1000. Another 2-3% will be identified with late onset or progressive hearing loss. This magnifies the importance of moving children along from screening to re-screen to a diagnostic assessment in a timely manner.

We need to do better with getting the children diagnosed and referred to early intervention in a timely manner.

Iowa EHDI 's last set (2018) of 1-3-6 outcomes data shows nearly complete success with screening newborns by one month, but only about 3/4 of those newborns with a failed screen are diagnosed by 3 months, and only about 2/3 of those diagnosed with hearing impairment are enrolled in early intervention by 6 months. *(See FIGURE 2)*

The 2017 IA data when compared to the National averages shows similar outcomes for the 1-3-6-month goals. IA is doing better than the nation, however, when it comes to those with failed screens who are lost to follow-up. *(See FIGURE 3)*

FIGURE 2

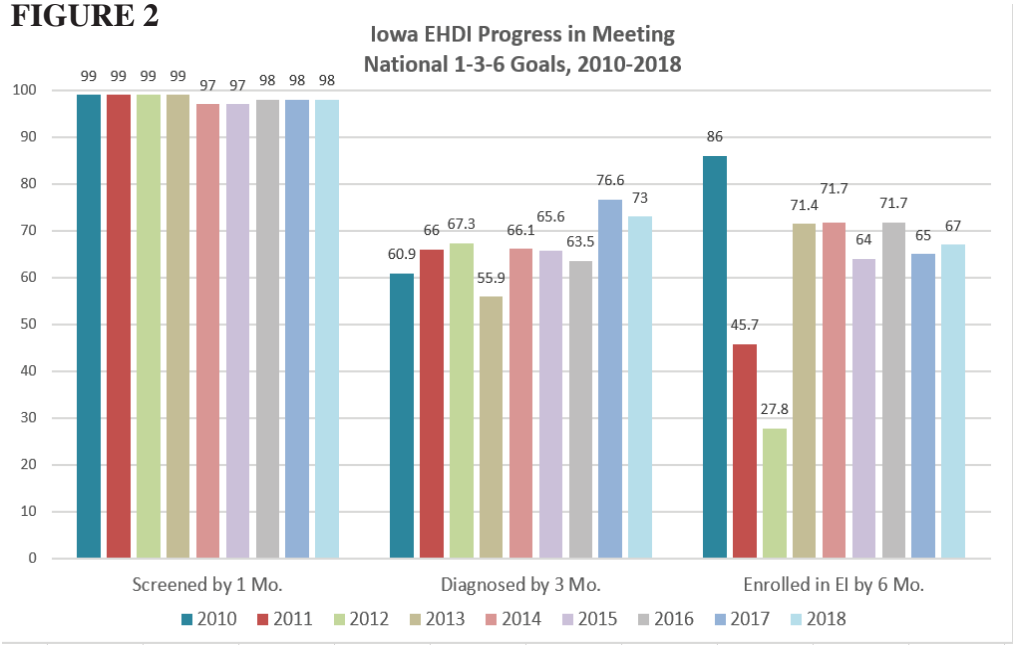
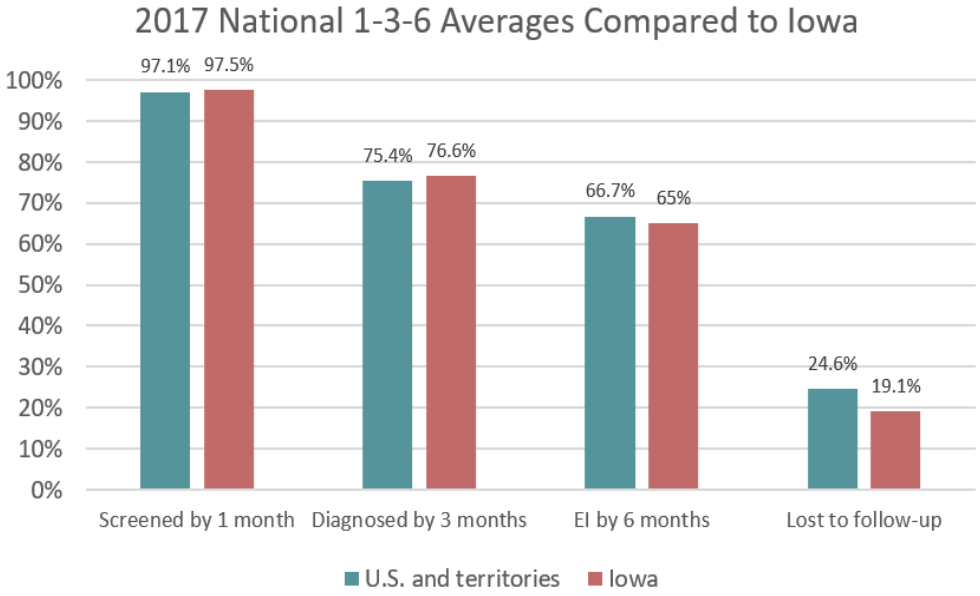


FIGURE 3



What has changed with newborn screening recommendations?

It is now acceptable to use otoacoustic emissions to rescreen an infant who fails an AABR screen, but only in the newborn nursery. This is due to the very low incidence of auditory neuropathy in newborns discharged from the nursery as compared to the NICU. A child with auditory neuropathy will often fail the AABR, then pass the OAE. This pattern of screening would not be acceptable in NICU infants given the higher incidence of hearing loss and auditory neuropathy. The screening recommendation for NICU infants is the sole use of AABR. In well-born infants, a pass on either OAEs or AABR is acceptable, if both ears passed in the same screening session. NICU infants who fail the AABR should be referred immediately to an audiologist for rescreening or diagnostic testing. When possible, infants should be diagnosed by an audiologist prior to hospital discharge from the NICU. Babies with severe ear malformations or stenosis of ear canals should skip the hearing screen and be referred immediately to an audiologist for a diagnostic hearing evaluation.

All hearing screen results need to be reported to the state EHDI program.

If standard screening equipment (OAEs or AABR) is not available at the birthing hospital, or if the baby is birthed at home, the screen may occur at the PCP's office. It is important that we understand behavioral responses to a whispered sound or noisemaker do not qualify as adequate screening. Otoacoustic and AABR equipment in the office setting requires calibration by trained professionals, and the hearing screen program requires audiology oversight. If OAE screening is not available in the PCP office, a referral should be made immediately to ensure the infant is screened before one month of age. If an infant is screened in the office, the PCP is responsible for reporting the results to the EHDI program.

What can we do about infants lost to follow-up and undocumented results?

Certain situations place a baby at risk of getting lost to follow-up or lost to documentation in the Universal Newborn Hearing Screening system. These are 1) when babies born at home or in other locations out of hospital where there is no screening equipment, 2) when babies are born across state borders where there are separate EHDI databases, 3) when infants are discharged from the hospital before a screen is done, and 4) when a baby is transferred to another hospital either in-state or out-of-state. In all these situations, systems need to be put into place to assure that screening is done as recommended within the EHDI 1-3-6 goals, and that the results are shared between providers and databases. These systems may include

(continued on page 22

(continued from page 21)

phone notifications to families, written agreements between providers and hospitals, and reminders in transfer notes.

PCP should monitor middle ear status

As a newborn, retained amniotic fluid or persistent middle ear effusion (MEE) can delay or confuse the diagnosis of hearing loss. Management of MEE and associated conductive hearing loss should be coordinated by the PCP with referral to Otolaryngology following diagnosis or input from the infant's audiologist. Tympanostomy tubes may be indicated. Conductive hearing loss has causes other than just MEE, which may require more extensive evaluation with bone and air conduction tests and radiographs.

What follow-up is needed for newborns who pass the hearing screen?

Every newborn should be assessed for risk factors associated with early childhood hearing loss. If no risk factors are identified, the infant should receive ongoing surveillance of communication development starting at 2 months of age and continuing into childhood as recommended in the AAP Periodicity Schedule. Prevalence of confirmed deafness/hard of hearing is 1.79/1000 in the neonatal period and 3.65/1000 by school age. This increase represents not only children with delayed onset or progressive hearing loss, but also likely includes some children who had minimal or mild hearing impairment at birth. This is because otoacoustic emissions used in infants may not identify those with mildly elevated hearing thresholds of 25 to 40 db.

The risk factors for delayed onset hearing loss are now organized differently. Previously there were several factors that required follow up evaluation of hearing by 6 months, and another several that required follow up by 24-30 months. Now, there are 12 risk factors, separated into 2 groups (predominantly perinatal factors versus factors that could be perinatal or postnatal). Also, the follow up period has been changed (lowered for most) to by 9 months of age. Others are to be no later than 3 months after occurrence; this includes ECMO, congenital CMV, culture-positive infections associated with SNHL, and events (head trauma/ skull fracture, chemotherapy) associated with hearing loss. Zika requires follow up at 1 month if there was lab evidence of Zika in the infant. Caregiver concern about speech/language development, developmental regression, or hearing requires immediate referral for hearing evaluation.

Congenital CMV deserves special mention as a leading cause of progressive, delayed onset hearing loss. It occurs in 0.2 to 2% of live births internationally. Antiviral treatment with ganciclovir is still being studied, however several studies show protection against hearing deterioration caused by CMV, not without concerns about toxicity.

Infants with Zika syndrome or possible prenatal Zika exposure should have a standard screening at birth and an AABR by age 1 month if the newborn screen was passed using OAE.

With more than 400 syndromes and genetic disorders associated with hearing impairment (or atypical hearing thresholds), their presence is a risk factor. A family history of childhood onset hearing loss is a risk factor given the possible genetic nature. At least fifty percent of the causes related to being deaf or hard of hearing are hereditary. Therefore, a genetics evaluation is important when looking for a cause of hearing impairment, with genetic testing and genetic counseling being offered to the family.

Please review *TABLE 1* from the Position Statement paper for the risk factors and diagnostic follow up recommendations.

THANK YOU HEROES

"Over the past two days, I've noticed a sharp uptick in expressed, and unexpressed, anxieties mounting as this is unfolding both with healthcare staff and the general public."

"I think we need to do some damage control to start managing anxieties at this time. Our patients, staff, friends and family are counting on us to be the leaders and guide them through the pandemic."

"While being vigilant with mitigation, containment measures, we might consider shifting some focus to the positives."

"The opportunities for what to do with time are endless and we can encourage people to capitalize on self-isolation."

TABLE 1

Risk Factors for Early Childhood Hearing Loss: Guidelines for Infants who Pass the Newborn Hearing Screen

	Risk Factor Classification	Recommended Diagnostic Follow-up	Monitoring Frequency
	Perinatal		
1	Family history* of early, progressive, or delayed onset permanent childhood hearing loss	by 9 months	Based on etiology of family hearing loss and caregiver concern
2	Neonatal intensive care of more than 5 days	by 9 months	As per concerns of on-going surveillance of hearing skills and speech milestones
3	Hyperbilirubinemia with exchange transfusion regardless of length of stay	by 9 months	
4	Aminoglycoside administration for more than 5 days**	by 9 months	
5	Asphyxia or Hypoxic Ischemic Encephalopathy	by 9 months	
6	Extracorporeal membrane oxygenation (ECMO)*	No later than 3 months after occurrence	Every 12 months to school age or at shorter intervals based on concerns of parent or provider
7	In utero infections, such as herpes, rubella, syphilis, and toxoplasmosis	by 9 months	As per concerns of on-going surveillance
	In utero infection with cytomegalovirus (CMV)*	No later than 3 months after occurrence	Every 12 months to age 3 or at shorter intervals based on parent/provider concerns
	Mother + Zika and infant with no laboratory evidence & no clinical findings	standard	As per AAP (2017) Periodicity schedule
	Mother + Zika and infant with laboratory evidence of Zika + clinical findings Mother + Zika and infant with laboratory evidence of Zika - clinical findings	AABR by 1 month AABR by 1 month	ABR by 4-6 months or VRA by 9 months ABR by 4-6 months Monitor as per AAP (2017) Periodicity schedule (Adebanjo et al., 2017)
8	Certain birth conditions or findings: • Craniofacial malformations including microtia/atresia, ear dysplasia, oral facial clefting, white forelock, and microphthalmia • Congenital microcephaly, congenital or acquired hydrocephalus • Temporal bone abnormalities	by 9 months	As per concerns of on-going surveillance of hearing skills and speech milestones
9	Over 400 syndromes have been identified with atypical hearing thresholds***. For more information, visit the Hereditary Hearing Loss website (Van Camp & Smith, 2016)	by 9 months	According to natural history of syndrome or concerns
	Perinatal or Postnatal		
10	Culture-positive infections associated with sensorineural hearing loss***, including confirmed bacterial and viral (especially herpes viruses and varicella) meningitis or encephalitis	No later than 3 months after occurrence	Every 12 months to school age or at shorter intervals based on concerns of parent or provider
11	Events associated with hearing loss: • Significant head trauma especially basal skull/temporal bone fractures • Chemotherapy	No later than 3 months after occurrence	According to findings and or continued concerns
12	Caregiver concern**** regarding hearing, speech, language, developmental delay and or developmental regression	Immediate referral	According to findings and or continued concerns

Note. AAP = American Academy of Pediatrics; ABR = auditory brainstem response; AABR = automated auditory brainstem response.
* Infants at increased risk of delayed onset or progressive hearing loss
**Infants with toxic levels or with a known genetic susceptibility remain at risk
***Syndromes (Van Camp & Smith, 2016)
****Parental/caregiver concern should always prompt further evaluation.

Hearing amplification

Hearing can be amplified using hearing aids, cochlear implants, bone conduction hearing devices, and assistive hearing technologies. A child over 1 year of age with bilateral severe to profound SNHL who does not make expected progress with hearing aids should be considered for cochlear implants. Regular assessment of hearing status and amplification devices by a skilled audiologist in coordination with otolaryngology for ear health optimizes auditory development which is critical for spoken language development.

Support Systems

The impact of social determinants of health is ever increasing. The importance of building connections with family support groups, deaf communities or individuals, early intervention services, spoken language and/or sign language instructors, family service coordinators, and counseling services cannot be understated. To make a referral for early intervention services, following parental consent, please contact the Iowa Family Support Network by calling 1-888-425-4371 or through their website. To make a referral for family-to-family support, please call ASK Resource Center at 1-800-450-8667.

Important IAFP Updates

By Pam Williams, Executive Vice President

I have never been prouder to work for an organization of family physicians. During these unprecedented times, your commitment and spirit are inspiring. I have been an observer of the AAFP COVID 19 Rapid Response Member Exchange chat forum as you share your concerns, fears and compassion for your patients and your resolve to see this thing through. From your sharing I have learned so much as you learn and share more about the progression of this disease. I have shed tears as you express your helplessness in dealing with the unknown. I have laughed as you have shared humorous anecdotes. Scattered throughout this issue are quotes from family physicians who have posted on the site in the Thank You Heroes boxes. I hope you will be inspired as I have been.

Below, you will find some important updates.

CME/CONFERENCES

We are so sorry to disappoint members who had registered for the summer conferences at Lake Okoboji and Galena, Illinois. It was a very difficult decision but it seemed to be the best call at the time. Both conferences are rescheduled for 2021 and I hope that times will be better then and that many of you will be able to join us. The conference at Bridges Bay in Lake Okoboji will be held on June 10-12, 2021 and the conference at the Eagle Ridge Resort in Galena, Illinois will be held on July 8-10, 2021. Please mark your calendars.

Plans are still progressing for the Annual CME Conference and Business Meeting November 12-14, 2020 at Prairie Meadows Conference Center in Altoona. The Education Committee has planned a great CME Conference. Louis Kuritzky, MD is coming back to Iowa by popular demand to present a series of presentations during the week. Caitlin Pedati, MD, the Iowa State Medical Director and Epidemiologist will present an update on infectious disease in Iowa that should be very informative. Also back by popular demand is Journal Club Live with Jason Wilbur, MD and Mark Graber, MD who will also lead an optional KSA on Saturday afternoon on Palliative Care. We are looking into options to present the conference virtually if we find it is not practical to hold the conference in person. Registration fees will be refunded or modified and applied to a virtual event as necessary due to COVID 19.

For those who have enjoyed the destination CME conferences in the past, we are holding off on scheduling anything for 2021 for now. Once we have some clarity on COVID 19 and its progression and the status of a vaccine we hope to schedule something special. For now, the uncertainties of travel, contracts, penalties, etc. make it very difficult to make a commitment.

AAFP CME EVENTS

The AAFP has gone virtual or canceled the live CME events through the end of July. They have not yet made a determination about the Congress of Delegates or FMX but have indicated they will do so at the late July Board meeting. I encourage you to participate in the virtual weekly Town Hall Meeting and the Friday night CME session hosted by the AAFP.

AAFP CME/DUES RELIEF

– *www.aafp.org*

AAFP members whose CME re-election cycle ends on Dec. 31, 2020, who have not met the requirement, will have an additional year to fulfill their CME requirement.

Members whose CME re-election cycle ended on Dec. 31, 2019 will now have until Dec. 31, 2020 to report their CME, which they earned prior to Dec. 31, 2019, to remain eligible for membership (original deadline was May 5, 2020).

Any members who have not yet paid their 2020 dues will now have until July 14, 2020 to do so.

ABFM RECERTIFICATION EXTENSIONS - *www.theabfm.org/covid-19*

ABFM has postponed the April 2020 administration of the Family Medicine Certification examination to July. All physicians who were approved to sit for the April exam schedule an appointments for dates in July and August.

Changes to Certification Deadlines

At this time, ABFM has made the following accommodations to the deadlines for continuous certification participation:

All Diplomates with a three-year stage ending in 2020 will have a one-year extension on completing all stage requirements.

For Diplomates participating in FMCLA, the Quarter 1 deadline has

already been extended through June 15, 2020; we anticipate extending completion guidelines further for subsequent quarters. For first year participants, we will adjust the meaningful participation guidelines.

Any Diplomate in Year 10 of their certification cycle who opted for the one-day examination will have an additional year to meet their examination requirement.

For those facing financial hardship as the result of the pandemic, we will establish a method for delaying 2020 payments. This will take a short time to be implemented online, but once available, Diplomates will find information about this in their **Physician Portfolio**.

These extensions do not prevent anyone with a 2020 deadline from staying on the current timeline. Certification activities will be accessible for anyone who wants to use them.

IOWA BOARD OF MEDICINE

– CME and Licensure Requirements
- https://medicalboard.iowa.gov/

CME

All requirements for in-person continuing medical education and all deadlines and other requirements for continuing medical education that are unable to be satisfied due to the health emergency, are temporarily suspended during the period of this health emergency. If a licensee is unable to complete the required continuing medical education required for renewal of their Iowa medical license due to the health emergency, they should note that on their next renewal application.

License Renewal Requirements

All license renewal requirements and deadlines continue to be temporarily suspended during the period of this health emergency. If a licensee had an active Iowa medical license on March 22, 2020, the expiration date will be automatically extended for the duration of this health emergency.

MEMBER COMMUNICATIONS

It is very difficult to strike a balance in the amount of communication to members during this difficult time. We know your inboxes are over-flowing so we think long and hard before we send something out to the full membership. You may have noticed that we are sending our monthly e-newsletter out each week now and will continue to do so since information is changing and coming in so rapidly. I encourage all of you to sign up for the AAFP COVID 19 Rapid Member Exchange chat forum. The IAFP has also established a private Facebook page for our members to share COVID 19 communications specific to Iowa. Both of this provide an opportunity for exchange of information, ideas and emotional support.

For the time being we will try to keep you up-to-date through the weekly e-newsletter and special communications if necessary.

THANK YOU HEROES

Thank you IAFP members for your hard work, your resilience and caring for the people of Iowa. No matter what your role has been you are all heroes to us. Stay well.

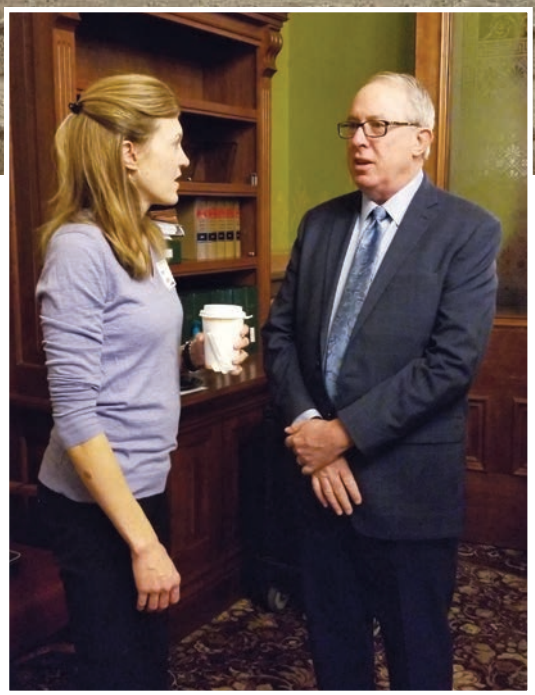
"I have loved the stars too fondly to be fearful of the night." ~ Galileo Galilei

THANK YOU HEROES

"I think this whole pandemic thing has brought a lot of important messed up medical system issues into very clear focus for family doctors - particularly for the older physicians amongst us who have been "tolerating" the status quo for some time and "treading water" to our retirement. I guess we as the old bulls (and cows) on the hill tops here have the easy way out here - we just hang up the stethoscopes, close the doors and finally enjoy our families and the sunsets we missed over the years because we thought we did important things and were appreciated for it. I only hope the younger docs who don't have that sunset option are paying attention to the very serious issues mentioned that made that belief of importance and appreciation that we predicated our sacrifice on was such a fallacy. We as Family Docs work hard. We are not stupid and most of us could have done or been anything we wanted - we just chose medicine. We are not health policeman - we are the compassionate learned guides of our patients. We are not government pawns but rather are the latest spawns of a tradition of compassionate sacrifice and caring. We are not the oarsman of the insurers but are rather the stewards at the helm of this health care vessel we captain. We deserve respect for our offered and given sacrifice, we deserve appreciation for our altruistic focus based on years and years of medical education and professional molding and yes we deserve to be paid for what we do."

2020 Legislative Coffee Recap

We held our Legislative Coffee on February 12, 2020 at the Iowa Capitol Building. There were about 50 physicians and legislators in attendance. Our physicians were able to discuss our legislative priorities face-to-face with representatives from their district. Thank you to all who attended and made this another successful event!

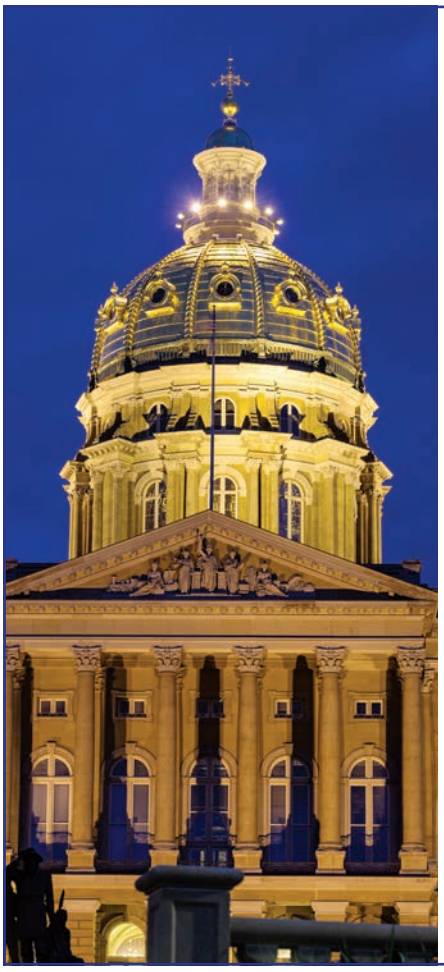


Thank you to our 2020 PrimCare PAC Contributors!!!

Jim Bell, MD
Laura Bowshier, MD
Lonny Miller, MD

Doug Peters, MD
Thomas Richmann, MD
Noreen O'Shea, DO

Thanks to your generous contributions!
Donate now to see your name in a future magazine.



WHAT IS THE IAFP PRIMCARE PAC?

IAFP PrimCare PAC is the state political action committee of the Iowa Academy of Family Physicians. The PAC is a special organization set up to collect contributions from a large number of people, pool those funds and make contributions to state election campaigns.

WHERE DOES MY DONATION GO?

IAFP PrimCare PAC will make direct contributions to candidates for the Iowa General Assembly (either State House of Representatives or State Senate), and statewide offices. Contribution decisions are made in a nonpartisan way based on candidates' positions, policies and voting records as they relate to family physicians and our patients. Direct contribution decisions are made by the PAC Committee.

IAFP PrimCare PAC

I ALREADY PAY MY DUES—ISN'T THAT ENOUGH?

Election laws prohibit the use of membership dues for donations to political candidates. Funds to be used for donations to candidates must be raised separately from membership dues. Voluntary PrimCare PAC donations are what will enhance IAFP's clout in the elections and with elected members of the Legislature.

IAFP PRIMCARE PAC DONATION:

- ❑ $1000 PLATINUM MEMBERSHIP
- ❑ $750 GOLD MEMBERSHIP
- ❑ $500 SILVER MEMBERSHIP
- ❑ $250 BRONZE MEMBERSHIP
- ❑ OTHER _____

Name _____

Address _____

❑ Pay by check ❑ Pay by credit card

❑ Visa ❑ MC ❑ Other _____

CC# _____ CVC Code _____

Signature _____ Exp. Date _____

Contributions to PrimCare PAC are not deductible for federal income tax purposes. Voluntary political contributions by individuals or an LLC to PrimCare PAC should be written on a PERSONAL CHECK OR PERSONAL CREDIT CARD. Funds from corporation cannot be accepted by the PAC. Contributions are not limited to suggested amounts. The Iowa Academy of Family Physicians will not favor nor disfavor anyone based upon the amount of or failure to make a PAC contribution. Voluntary political contributions are subject to limitations of FEC regulations.

MAIL FORM & PAYMENT TO: IAFP, 100 E GRAND AVENUE, SUITE 240 | DES MOINES, IA 50309 | FAX (515) 283-9372

Iowa Academy of Family Physicians
WE WANT YOU!!
2020 Volunteer Form

We continually strive to identify new and emerging leaders and to offer opportunities for members to get involved in the work of the IAFP. Please consider volunteering for a committee or consider running for the Board of Directors when a position opens up in your district. We have other opportunities for involvement which are briefly outlined below.

IAFP COMMITTEES

Committees meet once a year in a face-to-face meeting. Other meetings are conducted via conference call. **In 2020 the committees will meet on November 12, 2020 at the Prairie Meadows Conference Center in Altoona, Iowa just prior to the Clinical Education Conference**.

EDUCATION COMMITTEE:
Responsible for all continuing education programs of the Academy that includes the Clinical Education Conference and the winter and summer meetings.

MEMBER ADVOCACY COMMITTEE:
Duties include serving as an advocate for family physicians and their patients in matters relating to the delivery of health care, and promotes the image of family physicians in the state of Iowa. In addition, the committee seeks members to serve on committees and boards for government and other health care related organizations, and assists in the legislative activities of the Academy including grassroots lobbying (Key Contacts). The committee is also responsible for the annual legislative coffee at the Capitol in February each year. Biweekly update calls are held when the legislature is in session and participation in these is optional.

MEMBER SERVICES COMMITTEE:
Oversees the production of the *Iowa Family Physician* magazine and the Membership Directory. In addition, the committee recommends public relations projects to the board of directors. Current projects include FP of the Year, Educator of the Year, Lifetime Achievement Award, and numerous public relations efforts. The committee reviews all membership applications, relocations, delinquent CME records and members delinquent in dues payments. The committee also conducts membership surveys.

Committee Reimbursement
The IAFP will reimburse expenses for committee member's travel and lodging if necessary to attend meetings of the above committees.

OTHER VOLUNTEER OPPORTUNITIES

The IAFP is unable to provide reimbursement for expenses for the volunteer opportunities listed in this section with the exception of the AAFP Special Constituencies Delegates.

LEGISLATIVE KEY CONTACT:
Willingness to respond quickly to key contact alerts regarding state and federal legislation by contacting a member of the Iowa Congressional delegation or a state legislator through the AAFP Speak Out web site.

AAFP SPECIAL CONSTITUENCIES DELEGATE:
The IAFP seeks individuals to represent the IAFP at the AAFP National Conference of Constituency Leaders. Categories to serve are Women Physicians, New Physicians, International Medical Graduates, Minority Physicians and GLBT. The IAFP reimburses participants for the registration fee and hotel expenses. **Please indicate below if you would be interested in representing the IAFP at this conference. It is held in the spring each year.**

UI FAMILY MEDICINE PRECEPTOR:
The key to the success of the UI Family Medicine Preceptorship is based upon the unique value of having students work one-on-one with an Iowa private-practice community family physician that loves to teach and allows the student to participate ACTIVELY in the care of patients. To teach in the Family Medicine Preceptorship of the UI Department of Family Medicine we ask that you:

- Attend a workshop prior to teaching the first student.
- Be engaged full-time (minimum of 80% time) in an Iowa community private practice office setting.
- Are currently board-certified in family medicine.
- Have completed residency training in Family Medicine.
- Be willing to teach at least 1 third-year medical student each year.

For more information, contact Jill Endres at 319-353-7175 or jill-endres@uiowa.edu

IOWA DEPARTMENT OF PUBLIC HEALTH COMMITTEES:
Periodically the IAFP provides names of family physicians to serve on state committees such as Rural Health Advisory Committee, Medicaid Advisory Committee, EMS Advisory Council, Trauma Services Advisory Council, Child and Adolescent Obesity Task Force, Diabetes Control Program, Cancer Control, Developmental Disabilities, Statewide Perinatal Committee, etc.

CLINICAL CONTENT EXPERT/CONTENT RESOURCE:
Occasionally we look for content experts or resource people to advise us in a clinical topic area, to present at a conference, to review content or to represent us to outside groups. For instance, we are currently looking for a member to serve as a as a liaison to the Iowa Chapter of the American Academy of Pediatrics on childhood obesity. If there are clinical topic areas in which you are willing to serve as a resource to the IAFP, please list the content area(s) in the space below.

SERVICE ON IAFP COMMITTEES:
Committee recruitment occurs through calls for volunteers published in the *Iowa Family Physician* magazine and through volunteers identified during meetings/communication throughout the year. Committee members may be appointed any time during the year and terms will follow the process below.

All volunteers will complete a Conflict of Interest/Disclosure form for review and approval by the Board or Executive Committee. Volunteers completing this process will be considered candidates for the committee they have selected. The IAFP Executive Committee will review and approve committee appointments prior to the Annual Meeting. The candidates will be evaluated based of the following criteria...

1. The candidate is a member in good standing with the IAFP
2. The candidate complies with the AMA Code of Ethics per AAFP membership criteria
3. The candidate has no conflicts of interest or the conflicts can be resolved to the committee's satisfaction.

IAFP Committee appointments will be effective after board approval. Terms are currently one year in duration with the option to renew the appointment each year. Candidates will be notified of their acceptance upon completion of this process.

COMMITTEE VOLUNTEER RESPONSE FORM

Instructions: *Please select all of the committees and opportunities for which you wish to apply. You may place "#1" by the committee you most wish to be appointed to if you wish.*

I wish to serve on an IAFP Committee/Board of Directors

- ☐ Education Committee
- ☐ Member Advocacy
- ☐ Member Services
- ☐ I would be interested in serving as an alternate director of my district when a vacancy occurs

I wish to serve in these other areas

- ☐ Legislative Key Contact
- ☐ IDPH/DHS Committees
  Areas of interest for IDPH/DHS Committees

  _____

- ☐ Clinical Content Resource
  Areas of clinical interest_____

  _____

- ☐ **I wish to serve as an IAFP Representative to the AAFP at the National Conference of Constituency Leaders in April of 2021**

Please select the constituency in which you wish to serve:

- ☐ New Physician
- ☐ Women
- ☐ Minority
- ☐ International Med Grad
- ☐ GLBT

** Greatest Need for Minority and International Med Grad*

Fax to 515-283-9372 or email to kscallon@iaafp.org
or fill out form online at:
http://iaafp.org/conflict-of-interest/

Name_____ Practice Name _____

Address _____ City_____ Zip _____

Phone_____ Fax _____

Email_____

IOWA ACADEMY OF FAMILY PHYSICIANS
STRONG MEDICINE FOR IOWA

72ND ANNUAL CONFERENCE
STRONGER THAN EVER

NOVEMBER 12-14, 2020
PRAIRIE MEADOWS CONFERENCE CENTER

2020 ANNUAL CONFERENCE REGISTRATION FORM

Name_____ Spouse/Guest Name (s) (if attending) _____

Address_____ City_____ State_____ Zip _____

Phone_____ Email_____

Additional Accommodations (Vegetarian Diet, Food Allergies, Other)_____

A. Thursday, Friday & Saturday November 12-14 CME Registration Fees:

Registration Type	Early Fee (Until 10/7/2020)	Regular Fee (Starting 10/8/2020)
Active Member	$299	$350
New Physician Member (< 7 yrs in practice)	$250	$275
Life/Inactive Member	$195	$195
Resident/Student Member	N/C	N/C
PA/NP who works with an AAFP member	$295	$350
Non-Member (includes PA/NP)	$399	$450
Conference Faculty	N/C	N/C

IMPORTANT NEW CHANGES: The syllabus will be available online prior to the conference for you to download and/or print free of charge. A USB syllabus can be purchased for $10.00 by emailing kcox@iaafp.org. NO PAPER COPIES WILL BE PROVIDED.

To help with meal and material counts please select which sessions you will attending.

❑ Thursday Evening ❑ Friday ❑ Saturday Morning ❑ None of the options listed above

Total Section A: _____

B. OPTIONAL COURSES TO BE HELD ON SATURDAY, NOVEMBER 14

Knowledge Self-Assessment: Palliative Care (4-6 hours) Member $175 ____ Non-Member $200 ____

Total Section B: _____

C. FRIDAY INSTALLATION/AWARDS BANQUET:

Friday Evening, Installation/Awards Banquet: ($35 for registered attendee) Yes ____ No____

Spouse/Guest Banquet Fee @ $75 per person Number of guests for Friday Banquet____

Total Section C: _____

D. DONATIONS:

❑ Rural Primary Care Loan Repayment Program in the Amount of: $_____

❑ IAFP PrimCare PAC Donation in the Amount of: $_____

❑ Foundation Donation in the Amount of: $_____

Total Section D: _____

E. PAYMENT:

Section A: $_____
Section B: $_____
Section C: $_____
Section D: $_____
Total Due: $_____

CANCELLATION POLICY

You may cancel without penalty if cancellation request is received up to and including 15 days prior to the start of the conference. Due to financial obligations incurred by the Iowa Academy of Family Physicians no refunds or credits will be issued on cancellation requests received less than 15 days prior to the start of the event.

SCHEDULE OF EVENTS

NOVEMBER 12-14, 2020

THURSDAY, NOVEMBER 12

IAFP BUSINESS MEETINGS

9:00 am	Foundation Board Meeting
10:30 am	Education and Membership Committee Meetings
12:30 pm	Advocacy Committee Meeting
2:30 pm	Board Meeting

ANNUAL CLINICAL EDUCATION CONFERENCE OPENS

4:00 pm	Registration
5:00 pm	Annual Business Meeting
5:45 pm	Welcome/Introductions & Overview
6:00 pm	Social Determinants of Health
6:30 pm	Update on Infectious Disease in Iowa
7:00 pm	Acute Coronary Syndromes
8:00 pm	Question and Answer/ Panel Discussion
8:15 pm	Recess
8:15-9:15 pm	2020 Donor Appreciation Reception In recognition of 2020 Donors of the IAFP Foundation, Rural Loan Repayment Program and PrimCare PAC * Members must have donor ribbon to attend

** Members must have donor ribbon to attend*

FRIDAY, NOVEMBER 13

7:55 am	Introductions and Announcements
8:00 am	Autism
8:30 am	B12 Deficiency
9:00 am	Q&A/ Panel Discussion
9:15 am	Break – Exhibit Hall
9:35 am	Diabetic Kidney Disease
10:35 am	Geriatric Psych Issues
11:05 am	Q & A/Panel Discussion
11:20 am	Lunch and Keynote Presentation: AAFP UPDATE
12:20 pm	Visit Exhibits
12:50 pm	JOURNAL CLUB LIVE
2:05 pm	Renal Case Studies
2:35 pm	Q & A /Panel Discussion
3:05 pm	Break in Exhibit Hall
3:35 pm	ABFM Update
4:35 pm	Q & A /Panel Discussion
4:50 pm	Recess for the Day
5:30 pm	Reception/ Resident Medical Jeopardy
6:00 pm	Banquet Reception
7:00 pm	Installation & Awards Banquet
9:00 pm	Post-Banquet Reception

SATURDAY, NOVEMBER 14

7:15 am	Past President's Breakfast
7:30 am	Breakfast for Registrants
8:00 am	Breast Cancer Screening
8:30 am	Comprehensive Management of Osteoporosis
9:00 am	Transgender Care
9:30 am	Q & A /Panel Discussion
9:45 am	Break
10:00 am	Female Sexual Dysfunction
10:30 am	Sex Trafficking
12:00 pm	Q & A /Panel Discussion
12:15 pm	Adjourn

OPTIONAL SESSION ADDITIONAL FEE REQUIRED

12:15 am	Knowledge Self-Assessment (KSA) – Palliative Care

REGISTER TODAY!

www.iaafp.org/ 2020-Annual-Meeting

SPECIAL GUEST SPEAKER **LOUIS KURITZKY, MD**

Dr. Kuritzky is a nationally recognized speaker, having given over 1,300 presentations over his career on topics including Allergy, Psychiatry, Dermatology, Immunizations, Doctor-Patient Relationship, Inter-Professional Relations, Orthopedics, Public Health, Radiology, and Urology. In addition, he has authored over 150 publications. Dr. Kuritzky is currently a Clinical Assistant Professor of Family Medicine at the Main Street Clinic in Gainesville, Florida.

Telligen QI Connect™

Partnering to improve health outcomes through relationships and data

You're on the Front Lines, We've Got Your Back!

We created Telligen QI Connect™ to support your practice's needs through collaborative partnerships and learning events, at **no-cost** to you.

As the Quality Improvement Organization (QIO) for Colorado, Illinois, Iowa and Oklahoma, our immediate mission is to help you know and understand how local and national regulations that impact you are evolving amongst the COVID-19 pandemic and other challenging healthcare issues.

Telligen QI Connect™ provides the latest tools, resources, and best practices, so you can focus on providing the best quality of care to your patients. Join any or all of the following Affinity Groups:

Telligen QI Connect™ is here to provide COVID-19 support with:

- Telehealth information and resources
- Infection prevention and control
- Peer-to-peer collaboration
- Best practices for billing
- Researching answers to your questions
- Adapting workflows during the pandemic
- And more!

Patient Safety and Care Transitions

- Adverse drug event prevention
- Care transitions
- Social determinants of health
- ED visit and readmission reduction

Nursing Home Quality

- Five star improvement
- Adverse drug event prevention
- Infection prevention
- ED visit and readmission reduction

Chronic Disease Prevention and Self-Care

- Cardiovascular event prevention
- Smoking cessation
- Diabetes prevention & self management
- Slowing progression of chronic kidney disease

Opioids & Behavioral Health

- Opioid prescribing best practices
- Pain management best practices
- Behavioral health integration in primary care
- Behavioral health screening

Collaborate with over 60 healthcare communities and over 1,400 (and growing) participants across our four state region who have already joined Telligen QI Connect™.

Email us at TelligenQIConnect@telligen.com to share your practice's needs, or visit www.telligenqinqio.com to find out what Telligen QI Connect™ can do for you. Together we can navigate the current COVID-19 state of affairs while also holding hope for the pandemic-free future.

Quality Improvement Organizations
Sharing Knowledge. Improving Health Care.
CENTERS FOR MEDICARE & MEDICAID SERVICES

Telligen

This material was prepared by Telligen, the Medicare Quality Innovation Network Quality Improvement Organization, under contract with the Centers for Medicare & Medicaid Services (CMS), an agency of the U.S. Department of Health and Human Services. The contents presented do not necessarily reflect CMS policy. This material is for informational purposes only and does not constitute medical advice; it is not intended to be a substitute for professional medical advice, diagnosis or treatment. 12SOW-IA-QIN-04/23/20-3665

Telligen QI Connect™

Partnering to improve health outcomes through relationships and data

Telligen, Iowa's Quality Improvement Organization, is Here for You!

Telligen is a population health and quality improvement company based in West Des Moines, Iowa. In our role as the Quality Innovation Network-Quality Improvement Organization (QIN-QIO) in Iowa, we have worked with physicians on their quality improvement initiatives for over 45 years. The Centers for Medicare & Medicaid Services (CMS) appoints QIN-QIO organizations, one for each state and the U.S. territories, to advance the national healthcare quality strategy. This means that we can help you achieve your quality improvement goals for the Merit-based Incentive Payment System (MIPS), Alternative Payment Models (APMs), and other goals for providing better care and better health at lower cost. The QIN-QIO program is funded by the Medicare Trust Fund, so there is no cost to you.

CMS awarded the current QIN-QIO 5-year contract to Telligen in November 2019, for Iowa, Illinois, Colorado, and Oklahoma! Over 1,400 physicians and other healthcare providers have joined us so far. Our program, called Telligen QI Connect™, will provide regional learning collaboratives and resources to address opioid prescribing and pain management, behavioral health integration and screening, chronic disease prevention and self-management, patient safety, care transitions, and nursing home quality.

Since the COVID-19 pandemic reached the United States, we are now focused on supporting healthcare providers through this crisis by providing resources and weekly video conferences with subject matter experts to share the latest updates and answer your questions. A list of events can be found at www.telligenqinqio.com. You can also access the slides and recordings from past events. These resources are available to everyone – you do not need to join Telligen QI Connect™, to access these COVID-19 resources, although we hope you do! Be sure to check out our telehealth series and other topics relevant to your practice.

We want to thank you for all you are doing at this critical time in our nation's history. You are caring for our families, communities, and loved ones. We admire and appreciate you! Let us know how we can help. Join us at Telligen QI Connect™. For more information or to learn more about our program offerings, email us at TelligenQIConnect@telligen.com or visit www.telligenqinqio.com.

With Warm Regards from Telligen's QIN QIO Leadership Team:

Bruce Grothuis, Vice President Federal Health Solutions
Christine LaRocca, MD, Medical Director
Sue Stefan, DNP, Executive Director
Tracey Durns, MBA, Program Director
Michael Boyson, MHA, Director
Katy Brown, PharmD, Senior Clinical Pharmacy Program Manager

Quality Improvement Organizations
Sharing Knowledge. Improving Health Care.
CENTERS FOR MEDICARE & MEDICAID SERVICES

Telligen

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Annual Business Meeting Notice

As required by the IAFP Bylaws this is the official notice of Annual Business Meeting to be held on Thursday, November 12th at 5:00 pm at Prairie Meadows Event Center.

IAFP Secretary –Treasurer, Jason Wilbur, M.D.

IAFP Call for Resolutions

Resolutions are the official means by which you as a member have input into the governance and political process of the American Academy of Family Physicians. If you have a topic you are interested in addressing then we encourage you to submit a resolution for consideration by the IAFP Board of Directors. IAFP can help guide you through the process of writing your resolution. You can find more information and resources at *http://iaafp.org/aafpresolutions/* Resolutions are due June 30th.

THANK YOU HEROES

"So medical students, while you may in some ways be kept on the sideline, get out and find a way to help during this crisis. Get your classmates together and go to your dean or the Family Medicine chair and ask what you all can do. Go to your churches, your food banks, your shelters. Do it together. You'll be glad you did - now and in 20 years. And be sure to call your mother tomorrow."

Members Up for Re-Election in 2020

Nesrin Abu Ata, MD
Mukti Aich, MD
Nandita Alla, MBBS
Alecia Allen, MD
Rhea Allen, MD
Amy Andersen, MD
Qadnana Anwar, MD
Jamie Armbruster, MD
Heather Babe, MD
Amy Badberg, MD
Shivendra Bahadur, MD
Eileen Barto, MD
Nancy Barton, MD
Steven Bascom, MD
Paul Baumert, MD, FAAFP
Todd Bean, MD
Nicholas Bechtold, DO
Robert Bender, MD
Ricardo Bendezu, MD
Gena Benoit, MD
Pierre Bernard, DO
Mitchel Bernstrom, MD
Michael Bird, MD
Scott Bohner, DO, FAAFP
Anne Boileau, DO
Misty Bowen, DO
Charles Brindle, MD
Josiah Brinkley, MD
Laura Brunsen, MD
Orville Bunker, MD
Dean Bunting, MD
Dennis Bussey, DO
Jerald Bybee, MD
Byron Carlson, MD, FAAFP
David Carlyle, MD, FAAFP
Rodney Cassens, MD
Rebecca Chackalackal, MD
Illa Chandani, MD

AAFP Changes to CME Requirements

- AAFP members whose CME re-election cycle ends on Dec. 31, 2020, who have not met the requirement, will have an additional year to fulfill their CME requirement.
- Members whose CME re-election cycle ended on Dec. 31, 2019 will now have until Dec. 31, 2020 to report their CME, which they earned aprior to Dec. 31, 2019, to remain eligible for membership (original deadline was May 5, 2020).

Arthur Check, DO, FAAFP
Meredith Christ, DO
Lindsey Christianson, DO
Kyle Christiason, MD, FAAFP
Danielle Clark, DO
Patrick Cogley, MD
Teresa Coon, MD
Clinton Cummings, DO
Ryan Dahlby Albright, MD, FAAFP
Myra Daniel, MD
Amanda Dannenbring, DO
Aisha David, MD
Christine Davis, DO
Lisa Davis, MD
Brianne Day, DO
Ashley Dean, MD
Renee Diamond, MD
Gyobanna Driver, MD, FAAFP
John Ebensberger, MD, FAAFP
Jill Endres, MD, FAAFP
Gary Erbes, MD
Lee Fagre, MD, FAAFP
Daniel Feddersen, MD
Daniel Fick, MD
Clayton Francis, MD
David Fraser, MD
Robert Friedman, MD
Amy Fulton, MD
Amanda Gerber, MD
Debbie Gibbs, MD
Kyle Glienke, MD
William Goble, DO
Denise Greene, MD
Michael Greiner, MD, FAAFP

(continued on page 36)

THANK YOU HEROES

"This virus is truly going to just flow thru our world uninhibited and our goal has to be to slow it down as best we can to allow time for our unprepared critical care levels of care to expand to acceptable levels to care for the sickest of the sick and along the way console our patients as best we can when they (and we) have to deal with the realities this virus will create. I know in my heart that we in primary care are made for this but the rapid focus change and relative clinical impotence this thing has created in us is difficult for me to accept and adapt to - but I/we will. And so we go."

(continued from page 35)

Adelaide Gurwell, MD
Bernadette Gyano, MD
Mary Haas, DO
Jennifer Haden, DO
Wendy Hansen-Penman, DO
Jody Harmsen, MD
Jane Hartnett, MD
Jeffrey Hartung, DO
Savita Hegde, MD
Michelle Heim, DO
Brad Heithoff, MD
John Hembry, DO
Abigail Hemken, MD
John Hilsabeck, MD
Robert Hinnen, MD
Glenn Hockett, MD
Scott Honsey, MD, FAAFP
Cynthia Hoque, DO
Jimmie Horton, MD
Lawrence Hutchison, MD
Mark Irland, MD
Anshul Jain, MD
Elizabeth Jauron, MD
Eric Johnson, DO
Jay Johnson, DO
Leah Johnson, MD
Mark A Johnson, MD
Connie Joylani, MD
Amr Kamhawy, MD, FAAFP
Colleen Keating, MD, FAAFP
Pamela Keller, MD
Jessica Kennedy, DO
Susan Kennedy, DO
Suzanne Kersbergen, DO
Matthew Kettman, MD
Allison Kovar, MD
Natalie Lanternier, MD
Toni Lauffer, DO
James Law, DO
Sangil Lee, MD
Jerry Lehr, DO
Barcey Levy, MD
Sarah Ling, DO
Theodore Lockard, MD
Marnie Loftus, DO
Rodney Logan, MD, FAAFP
Ronald Lotoc, MD
Timothy Lowry, MD, FAAFP
Andrew Luke, MD
Xin Luo, MD
Thomas Lyons, MD
Michael Maharry, MD
Mark Mahoney, MD
Elizabeth Mangrich Hickman, MD
Paul Manternach, MD
Leszek Marczewski, MD
Ashley Mathes, DO
Yulia Matveeva, MD
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John Pymm, DO
Brian Ray, DO
Brigit Ray, MD
M Yvonne Rayborn, MD
Sarah Renze, MD
Larry Richard, MD
Kelly Ross, MD
Daniel Rowley, MD
Lisa Ruckman, MD
Kelly Ryder, MD
Christian Sanchez, MD
Julie Sandell, DO
Brian Sankey, DO
Sonia Sather, MD
Cosette Scalloan, MD
Amy Schantzen, DO
John Schantzen, DO
Catherine Schierbrock, MD
Thomas Schreiber, MD
Thomas Schryver, MD
William Schulte, MD, FAAFP
Robert Schultes, MD

THANK YOU HEROES

"My straw house is falling down. The notices of my 22 year independent practice closure went out 2 weeks ago. We will see our last patient July 30, and I will join the brick house security of the largest emergency room provider in the nation. I hope to sit back and watch the transformation of family medicine from the safety of that sideline. We shall see how this plays out."

Lynne Senty, DO
Yogesh Shah, MD, FAAFP
Shalina Shaik, MD
Wendy Shen, MD
Brian Shian, MD
Susan Sieh, MD
Andrea Silvers, MD
Prachi Singh, MD
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Joseph Yankey, DO
Dennis Zachary, MD
Arleen Zahn-Houser, MD, FAAFP

This article ran in the Winter 2019/2020 issue with the wrong award recipients name printed. We apologize for the mistake and any confusion it may have caused. Below is the corrected article.

Paul Volker, M.D. Named IAFP Medical Educator of the Year

Dr. Volker after receiving the IAFP Educator of the Year Award

Paul Volker, M.D. of Des Moines was named the 2019 Iowa Medical Educator of the Year. The presentation was made during the 2019 Iowa Academy of Family Physicians (IAFP) Annual Awards and Installation Banquet on Friday, November 15 at Prairie Meadows Event Center. The Medical Educator of the Year Award is presented annually to recognize a physician who is providing outstanding quality in family medicine education. Nominees are submitted by students, practicing physicians and educators.

A colleague had this to say about Dr. Volker "Dr. Volker brought a wealth of experience to his work in the Family and Internal Medicine Department when he joined DMU in 2015. He had practiced in a rural area for almost 30 years and was immediately tapped to head the Rural Medicine elective. This elective has grown into an Inter-Professional experience for our osteopathic medical students, physical therapy students and other interested health care professional students from around the Des Moines area. I highly recommend Dr. Paul Volker, MD for the Iowa Academy of Family Physicians' Educator of the Year."

Congratulations to Dr. Volker!

New Members

Active

John Pymm, DO, Storm Lake
Kelli Roenfanz, DO, Des Moines
Thomas Schreiber, MD, Dubuque
Julie Schroeder, MD, Davenport
Claire Stefl, MD, Ames
Alexandra Witherspoon, MD, Estherville

Students

Brady Bollinger, University of Iowa
Jennifer Brenner, Des Moines University
Dallin Brownell, Des Moines University
Alexandra Cooke, Des Moines University
Anthony De Leon, University of Iowa
Haley Egan, University of Iowa
Kathryn Estes, Des Moines University
Emily Facile, Des Moines University
Bryan Gordon, Des Moines University
Alison Hefel, University of Iowa
Grant Henning, University of Iowa
Dhruv Kothari, University of Iowa
Cory Lin, University of Iowa
Madison Meyer, Des Moines University
Irene Morcuende-Gonzalez, University of Iowa
Gabriella Morgan, University of Iowa
Catalina Mulauax, University of Iowa
Brittany Pederson, Des Moines University
Anthony Schneider, University of Iowa
Pombie Silverman, University of Iowa
Ben Wagner, Des Moines University
Kenneth Wee, Des Moines University
Anna White, University of Iowa

In Memoriam

Dr. Roy W. Overton Jr.
West Des Moines

THANK YOU HEROES

"I have loved getting to do home visits via telehealth. I have gotten to meet a treasured dog, cat, plant, craft project. I have learned so much about the environment in which my patients live. I did pastoral work before I became a doc so I love this part of the journey."

RURAL MEDICINE SCHOLARSHIPS AVAILABLE!

M4 Students & R3 Residents!

The Iowa Farm Bureau Foundation and the Iowa Academy of Family Physicians' Foundation would like to encourage you to apply for the $5,000 Farm Bureau Scholarships that are given to one student and one resident annually. Eligibility requirements are:

Resident (R3)

- Completing an Iowa residency program in 2020
- Locating in a practice in a rural Iowa setting under 26,000 population
- Holding membership in the IAFP/AAFP
- Demonstrated scholarship and achievement in medical school
- Completion of the application requirements

Student (M4)

- A medical student graduating from the University of Iowa Carver College of Medicine or Des Moines University
- Entering an Iowa Family Medicine Residency program in 2020
- Holding membership in the IAFP/AAFP
- Demonstrated scholarship and achievement in medical school
- Completion of the application requirements

Application Requirements

- Write a brief essay explaining your personal philosophy about medical care, in particular family medicine, and outline your intended career plans
- Enclose a curriculum vitae
- Enclose two letters of recommendation from faculty members at the residency program or medical school

Criteria for Consideration

- Quality of the submitted brief essay. (40%)
- A demonstrated interest in rural practice as shown by completing a preceptorship or elective experience in a rural Iowa community under 26,000 population, and/or in the judgment of the committee, are likely to pursue a career as a family physician in rural Iowa, i.e. being from a rural background. (30%)
- Demonstrated scholarship and achievement in medical school. (15%)
- Quality of letters of recommendation. (15%)

The deadline to receive letters is June 15, 2020.

For further information contact Kelly Scallon at the IAFP Foundation office 800-283-9370 or via e-mail at kscallon@iaafp.org.

Thank you to our 2020 Foundation Donors!!!

The Ahrendsen Family Donor Advised Fund
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Christine Warner, MD
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Claudia Zavala, MD

Thanks to your generous contributions!
Donate now to see your name in a future magazine.

THANK YOU HEROES

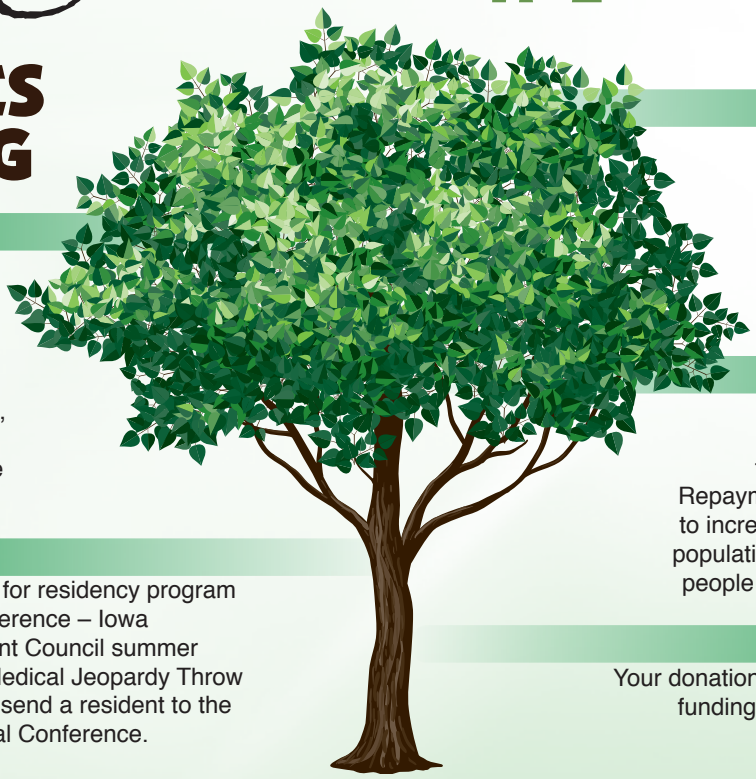
"I personally will hang around at one level or another for a while and I hope I can offer my support for the next generation of healers who I hope are presently having their eyes opened wide by this new reality (which isn't really new at all) and who will unite as a group to correct the unfairness and failure of the medical system see as they must lead going forward. This pandemic will pass and I hope the lessons brought to light by its coming will be seriously and fully evaluated by Family Medicine in general and the AAFP in particular as the tip of our sword and I hope that evaluation and that sword lead to reform and change.

And So We Go"

The Giving Tree

IOWA ACADEMY OF FAMILY PHYSICIANS FOUNDATION

BRANCHES OF GIVING



STUDENTS

Your support provides funding for the Annual FMIG dinner, $300 scholarships for students attending the AAFP National Conference, the outstanding student award, and travel expenses to send a student to the Family Medicine Congressional Conference.

RESIDENTS

Your support provides funding for residency program visits, the AAFP National Conference – Iowa Residency exhibit hall, Resident Council summer meeting luncheon, Resident Medical Jeopardy Throw Down, and travel expenses to send a resident to the Family Medicine Congressional Conference.

TAR WARS

Your support helps fund Tar Wars, a preventative smoking program which educates students in the 4th/5th grade about the benefits of remaining tobacco-free. Money raised helps to fund the Iowa Tar Wars Poster Contest.

RURAL LOAN REPAYMENT

Your support helps to provide funding for students entered into the Rural Iowa Primary Care Loan Repayment Program. This program helps to increase Iowa's primary care physician population and improve access to care for people living in Iowa's rural communities.

UNRESTRICTED

Your donation helps to support programs where funding is needed in the areas of resident and student programming.

WE NEED YOUR HELP
TO SUSTAIN THE BRANCHES OF OUR GIVING TREE

To build strong roots for family medicine in Iowa, we are asking **all Iowa family physicians** to donate to the IAFP Foundation. ANY amount is appreciated! We are aiming for **100% participation**! We need **everyone's** help to sustain the branches of our giving tree. Below are the different levels of donation.

IAFP Foundation:

- ❑ **$1000 Grand Patron**
- ❑ **$750 Patron**
- ❑ **$500 Benefactor**
- ❑ **$250 Sponsor**
- ❑ **$100 Friend**
- ❑ **Other** _____

Please use my donation for: (Check all that apply)

❑ Unrestricted ❑ Tar Wars
❑ Residents ❑ Rural Loan Repayment
❑ Students / Family Medicine Interest Groups

Your gift is tax deductible as the IAFP Foundation is a 501 (c) 3 chartable organization.

Name: _____

Address: _____

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❑ Make a donation online at www.iaafp.org

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MAIL THIS FORM AND PAYMENT TO: IAFP, 100 E GRAND AVENUE, SUITE 240 • DES MOINES, IA 50309 • FAX (515) 283-9372

Iowa Academy of Family Physicians
100 East Grand Ave • Ste 240
Des Moines, IA 50309

pwilliams@iaafp.org
kcox@iaafp.org
kscallon@iaafp.org
www.iaafp.org

Phone 515-283-9370
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