IAFP

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INSIDE:

- Exploring Diversity of Practice Styles
- 2019 Annual Conference Program

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Is Marcus Welby Dead?

By Jim Bell, M.D.

If you don't know the reference to the iconic TV family physician, Google him. How do we sync the image of the doctor who does everything, for everyone, all the time, with the reality of practicing medicine now? This issue of our magazine is devoted to diversity in practice styles, so let's look at "E Pluribus Unum" backwards and forwards.

I have done Power Point presentations where I will flash a picture of Dr. Welby and claim that there never was such a doctor, or that there was but he/she is now extinct, or that the "new version" of that person now requires a team. Probably none of those are exactly correct.

When I came out of residency in Cedar Rapids, I joined a partnership with two other family doctors. We rotated the task of paying the light bills, dropping off the deposits at the bank every night, and figuring out the tax withholding for our employees. We knew every penny of our overhead and our "salary" was whatever was left. Our practice was full spectrum including OB and we all took our own call unless we were physically out of town. Anyone looking at our practice would have to admit it was a full service operation and that we were the definition of the family doctor.

Things change. Over the years we stopped doing OB, then stopped hospital rounds except for newborns, then stopped hospital work altogether. Meanwhile I became a part time hospice medical director and that service grew to include palliative care. After 21 years, things expanded to the point where I knew I could no longer serve both my primary care patients and the hospice/palliative care service and I had to choose one or the other. So for the last 12 years I have practiced full time hospice and palliative medicine.

I loved every minute of my old practice and I love every bit of what I do now. Funny thing is, I still see many of my previous patients-- not always good news for them but almost always good connectivity. Sometimes I tell them I'm the "stealth family doctor" in the hospital. My two original partners are now doing urgent care. Others from the group as it has grown have assumed leadership roles in various organizations. I think about

"Things change. Over the years we stopped doing OB, then stopped hospital rounds except for newborns, then stopped hospital work altogether. Meanwhile I became a part time hospice medical director and that service grew to include palliative care."

the different opportunities and paths taken by those in my residency class, our community, and those active in IAFP leadership. Some work for insurance companies or are part time/full time in administration. Some are hospitalists, others in occupational medicine. Some do C Sections, one took over hospice and oversees 7 long term care facilities. Some are in academics. One runs the Iowa Healthcare Collaborative, one just went to work for the VA, others are in FQHC's.

My own family physician is in my old practice, and in addition to full time family medicine he is on the IAFP board and is an informaticist for the health system. There are a myriad of other career paths that have Family Practice training as a springboard.

All of the people I think about as I look at the list above are family physicians, and none are "less" so because what they do is different than what I started out doing 33 years ago. We have family doctor DNA and it doesn't go away. No matter what we do, our generalist training becomes the filter for decision making and *that makes a difference for the better*. When a family doctor thinks about "what to do now," it breaks down silos and barriers, overcomes obstacles, keeps the patient first. That is true whether a patient is right in front of us or we are in a conversation about population health, or somewhere in between. I'm really proud to be a family physician and I am proud of family physicians in diverse practices everywhere.

There is Marcus Welby in all of us.

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Unity in Diversity

By Jason Wilbur, M.D.

In 2019, the *Iowa Family Physician* magazine themes have changed from the tradition of focusing on education, membership and advocacy, and this issue is devoted to diversity in practices. Diversity in practice styles is one of the most attractive aspects of a career in family medicine, and simultaneously, it is one of the most challenging barriers to advancing our specialty and advocating for ourselves and our patients. From the outside looking in on family medicine, it is sometimes difficult to discern just exactly what it is we do and who our patients are.

Imagine the Wilburs at a family reunion. Some distant cousins are chatting with us and ask what we do for a living. My wife is an oncologist. She can describe her job in 2 words: "cancer doctor." Her response might start a conversation or scare away the cousins, but they have an idea of what she does right away. My job description takes a paragraph and my audience's gaze starts drifting to the dessert table as I'm wrapping it up. I realize I need a better "elevator pitch." In fact, Family Medicine needs a better elevator pitch. How do we do that in our "big tent" specialty with so many different doctors doing different things?

Here's the problem: If I say, "I'm a family doctor," my cousins will immediately have a set of assumptions that will probably prove incorrect. Maybe their experience is of family doctors in urgent care centers. Or maybe they will think of a family doctor in their small town who practices obstetrics and covers the ER in addition to her office practice. Or maybe they will picture the family doctor who covers all the local high school teams and is known for skills with sports medicine issues. I would be none of these. I would be the family doctor that is also a geriatrician and spends half his time in education and half in patient care and also performs vasectomies, joint injections, etc., etc. You get the idea – because you are a family doctor. But it's a difficult idea to convey in two words for the cousins.

Among all the various types of careers we have, our postgraduate training is one unifying element. Our manner of thinking about medicine is another. We are trained as generalists. We view patient concerns through a biopsychosocial model from our first days of residency, and we continue to think about whole-person care even when we limit our scope of practice to a location (e.g., hospital, ER) or a segment of the population (e.g., geriatrics) or a particular skillset (e.g., procedural skills, sports medicine). There are advantages to this kind of training and thinking: we learn to be good problem solvers, we become good communicators, and we develop a degree of comfort with ambiguity. Perhaps these are the unifying elements we bring to our diverse practices.

> *"My job description takes a paragraph and my audience's gaze starts drifting to the dessert table as I'm wrapping it up. I realize I need a better 'elevator pitch.' In fact, Family Medicine needs a better elevator pitch."*

I will close with one final thought from my friends in Indonesia. We in the U.S. often think of ourselves as "the great melting pot" of many different people from many backgrounds, but Indonesia could easily give us a run for that title. The national motto of Indonesia, a country of many religions and cultures and over 700 languages, is "Unity in Diversity." It is a beautiful ideal to which we in family medicine should also aspire. In your practices – perhaps very different from mine – I hope that you and I can agree that we are generalists unified in the training we experienced and in our desire to do the very best for our patients.

As always, please email me with any comments you have and any ideas for the magazine. You can reach me at jason-wilbur@uiowa.edu. Have a wonderful fall!

The Many Faces of Family Medicine

By Jay Blomme

Family medicine truly is a wonderful specialty. There are many things that brought me to apply to family medicine, and a significant one is the wide variety of possibilities of practice that are afforded within the specialty. For this article, I would like to reflect on the experiences that enlightened me to much of what this specialty has to offer.

Like many medical students with families outside the healthcare industry, my initial view of medicine was primarily shaped by the experiences I had as a patient. I remember being a young child going to the doctor's office, and aside from the one episode where multiple nurses had to hold me still for my vaccination, I always enjoyed being seen. This same doctor cared for my mother, my father, my friends, and so many others throughout my small community.

Coming in to medical school, I had a vision of family medicine that was still based on what I had seen growing up: outpatient family medicine, seeing about 30 patients a day. The summer after my M1 year, I worked with a rural medicine practice in southern Iowa, through the MECO program at the University of Iowa. It was my first experience seeing family medicine as a provider over the span of months, not just hours of shadowing. During my time there, I also saw the occupational medicine and worker's comp clinics that were set up in the area. It was an aspect of medicine that I was unfamiliar with, and I enjoyed the different nature and perspective. It was also my first time seeing a physician's practice that had been tailored to their specific interests and skillset, in addition to their more traditional responsibilities.

The physicians there also brought me to their visits to the nursing homes, which was my introduction to the geriatric focused aspect of family medicine. I supplemented that experience with a dedicated geriatrics rotation in later years. We saw patients at various ranges of health and functionality, and many patients were on hospice. It was with these visits and experiences that I truly learned the importance of clear communication, defining the goals of care, and doing no harm.

Emergency medicine was also a cornerstone of my time in southern Iowa. This hospital ER was staffed entirely by family medicine trained physicians. It was here I first began to hone the process of working up a patient, generating both a differential and a treatment plan. My attending was excellent in teaching me to remember my do-not-miss diagnoses, and he presented multiple opportunities for learning procedures, interpreting radiographs, and communicating with patient families. It was a change from the typical, steady workflow of the office, and I relished the opportunity to be an increasingly independent member of the team.

Later in my education, I was introduced to the concept of rural inpatient family medicine. Before clinic, my attending and I would round on our hospitalized patients, making sure they were receiving the adequate care they needed and evaluating their readiness for discharge. I was impressed with the severity of patients we were managing, and it was a valuable insight into the necessity and function of the county hospital. At the same time, I was introduced to obstetric care just down the hall from our inpatient ward. As a person who immediately passed on holding the baby at family reunions, I was particularly terrified of beginning OB responsibilities. However, my preceptor showed me what obstetric care was like, from pregnancy, to delivery, and to post-natal care. It was eye-opening to see the importance of family practitioners providing obstetric care to rural communities that otherwise would have to travel much longer distances in order to deliver.

Finally, leading to my last year of school, I spent time on a month-long sports medicine rotation. Once again, this specialty showed a different aspect of family medicine that was relatively unfamiliar to me. Whereas I had become used to tackling multiple chronic medical conditions in the outpatient setting, here I was trained to do an efficient, yet thorough, evaluation of musculoskeletal complaints on a population of younger and active patients. My preceptors reinforced the importance of knowing the anatomy and function of each muscle and nerve, harkening back to my very first semester back in the lab. Through this rotation, I also worked with fellows who do sideline care for football games this fall.

Time and time again, I have been astounded at the wide ranging varieties of practice I have seen through my many rotations. In just a few short years of rotations, I have seen family medicine physicians in inpatient medicine, outpatient medicine, geriatrics, emergency medicine, sports medicine, occupational medicine, obstetrics, and procedures. I feel privileged to apply into this specialty, and while I do not know exactly what I want my practice will look like in the future, I do know that family medicine will provide me no shortage of options for a fulfilling career.

2019 National Conference for Students & Residents

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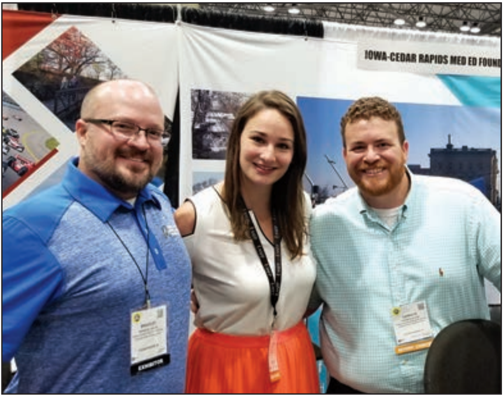

Cedar Rapids Family Medical Education Foundation

Bradley J. Willis, MD, MPH, Faculty;
Callie Pittard, DO, R2;
Derrick Alger, MD, R3

Iowa Lutheran Family Medicine Residency Program - Des Moines

Tyler Olson, MD, R3; Ericka Tank, MD, R2; Chris Champion, DO, Faculty; Jeri Paca, Faculty; Seth Streeter, DO, R2

North Iowa Mercy Residency Program- Mason City

Jerry White, MD, Faculty;
Jed Padre, MD, R3;
Amanda Tran, MD, R2

Siouxland Medical Education Foundation Residency Program

Mary Catherine Mohr, DO, R1;
Kristin Maylott, DO, R1;
Amy Rief-Elks, DO, Faculty

University of Iowa Family Medicine Residency - Iowa City

Kelsey True, MD, R3;
Stephanie Pickthorn, MD, R1;
Justis Stolz, R2;
Elise Barlow, Faculty;
Jason Wilbur, MD, Faculty;
James Jackson, MD; R3;
Kate Toma, MD, Faculty;

Northeast Iowa Family Medicine Residency Program - Waterloo

Stanley Nickarz, MD R2;
Inger Lied, MD, R2;
Linus Leivon, MD, R3

Quad Cities Genesis Family Medicine Residency Program

Steve Sorensen, MD, Faculty;
Peter Kim, MD, R1

Thanks to all our members that helped send a student to National Conference!

Jim Bell, MD	Mara Groom, DO	Donna Nelson, MD	Dawn Schissel, MD
Scott Bohner, MD	Jeff Hoffmann, DO	Dale Nystrom, MD	Donald Skinner, MD
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Angela Greif, MD	Kevin Locke, MD	Thomas Richmann, MD	Kate Thoma, MD

IAFP hosted a special Iowa event at National Conference where Iowa students, residents, program directors, program coordinators and faculty gathered to both socialize and answer students' questions.

The Most Diverse of Practice Styles

By Hannah Thompson, D.O., R2 / Broadlawns Family Medicine Residency Program / Des Moines, Iowa

Historically, family medicine physicians have been counted on to deliver babies, provide home visits, admit and follow patients in the hospital, and of course, tend to the day-to-day ailments of their communities. In today's world, where generations are moving into the cities and away from rural communities, is there still a role for full spectrum family medicine physicians?

I would argue, "Of course there is!" And, more importantly, of course there *should be*. With shrinking numbers of residency graduates entering rural practice, these populations are receiving less and less access to quality health care. This gap in access is sure to increase with the baby boomers' retirement stage quickly making itself evident. Less access leaves vulnerable populations – obstetrical patients, patients with less mobility unable to make the drive to a bigger town with medical services, patients unwilling to make the drive to nearby towns for a provider they don't even know personally – even more at risk.

A rural physician must be uniquely well-rounded and skilled. By electing to forego a mostly clinic-based practice in the urban environment and instead seeking out rural communities to practice diverse modes of care, a family physician accepts a formidable challenge. The decision to accept this opportunity to provide not just day-to-day clinic medicine, but also obstetrics, inpatient medicine, geriatrics, and emergency medicine, meanwhile expanding and strengthening a wide but necessary subset of skills can be daunting. However, the residency training of primary care physicians in the Midwest is such that graduates are prepared for this exact environment.

Young physicians are being called to invest in smaller communities. As physicians, we are constantly reminded in residency that this career holds responsibilities; we as doctors have the opportunity (and the duty) to impact and educate our communities. I would argue that in a rural setting, this impact is even more striking. Advocating for preventive health, living out a healthy lifestyle, and building relationships have a greater potential to influence townspeople who know you personally, who you visit with at a local sports game or parade, than in a city where you're just another face. The opportunity to be a driving force behind a community's health education can be both inspiring and invaluable.

"Practicing in a small town emphasizes the importance of cultivating relationships. Physicians are not just taking care of a panel of patients who they won't ever see upon stepping out of the office. By living in the rural community one practices in, chances are that a physician will run into their Tuesday afternoon appointment on Saturday morning at the grocery store."

Practicing in a small town emphasizes the importance of cultivating relationships. Physicians are not just taking care of a panel of patients who they won't ever see upon stepping out of the office. By living in the rural community one practices in, chances are that a physician will run into their Tuesday afternoon appointment on Saturday morning at the grocery store. Rural physicians may be given the privilege of full access into people's … their patients'… lives, health scares, and mental health crises, all intertwined with walking alongside them as they age.

I was asked to write an article on the diversity of practice styles for this magazine edition. As a family physician training in Iowa, the opportunities at my fingertips are limitless. My scope of practice can range from hospital-based practice, clinic-based practice, urgent care, ER only, nursing home, concierge medicine, insurance medicine and telemedicine. The choices vary from a strict 40-hour work week, to three twelve-hour shifts, to nights and weekends only, and more.

I can't think of a more diverse style of practicing medicine than being a rural family physician − doing something different each week, each day, or each hour. To be capable and confident in my skills to take care of anything from birth to the grave, and to do that in a close-knit town with people I know and care for − that sounds like a pretty diverse practice to me.

NCCL Experience

By Rosalie Cassidy, MBA, MD, R3

This year I was privileged to attend the National Conference of Constituency Leaders (NCCL) in Kansas City. The Iowa Academy of Family Physicians offered an opportunity to one resident to attend this conference with their chapter – they happened to choose me! I have to be honest; I was not quite sure what I was getting myself into but knew anything that mentioned the chance to increase my leadership skills would be worth it.

The day started with breakfast and an orientation for newcomers. This focused on the process of resolution writing and got everyone excited about possibly being able to implement changes. Next I moved with my group of new colleagues to listen to the NCCL Plenary. The speaker was beyond inspiring! The conference then breaks down into the different consistencies including, but not limited to, New Physicians, LGBT and Women. I followed the IAFP's Women's chapter delegate to meet and discuss any and all ideas we had related to medicine and policy change. What happened next surprised me most. We were given time to gather with others around similar ideas and write resolutions. We were not only learning and discussing but actually being called to ACTION. I was excited to be part of three different resolutions, each of which I was able to stand in front of all conference members to state my support. In between times of action, there were also several lectures or panel discussions to attend on numerous different topics.

On the last morning, a very official meeting occurs during which time we determine if our resolutions were passed or not – and then there is time for people to contest. I was very excited to see all three resolutions that I partook to have been accepted. This means they will get passed along to the American Academy of Family Physicians and hopefully result in some new policies. It was quite a process but wow, what an experience. I left thinking that I had actually made a difference – and gained new colleagues!

I would certainly recommend anyone who is interested in sharing ideas or wanting to impact policy change attends this inspiring event.

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Family Medicine – Which Path Do I Take?

By Pam Williams, Executive Vice President

It's so very exciting to visit with Iowa members and learn about how their practices have changed over time and to speak with those new to practice and hear about their hopes and aspirations for the practices they are joining.

One of the most exciting events we host each year is a Family medicine speed dating event for the Family Medicine Interest Group (FMIG) at University of Iowa. At our last event we introduced students to ten family physicians from across the state who spoke about their practices and the opportunities for diversity that family medicine affords them. We had representatives who practice in rural and urban communities, a solo practitioner, one whose practice includes obstetrics and many procedures, a physician whose practice has an emphasis on sports medicine, one whose practice is primarily geriatrics and one who practice palliative care. The students were so intrigued to learn the many practice styles available to them. If you have a practice that story you would like to share with medical students and are willing to travel to Iowa City on a week night in the spring, please volunteer by dropping a note to kscallon@iaafp.org so that you can join us next spring.

A group of nearly 60 family physicians and their guests/families joined us for our first Mediterranean CME cruise in June. The diversity of their practices and interests was shared through their CME presentations which covered topics such as disaster medicine and PTSD from those who have served as first responders and in the military. We learned about the value of community health workers from a physician in rural practice and a physician in solo practice shared some of the many interesting cases encountered throughout the year.

Some of the leadership opportunities we offer practicing physicians and residents and students during the year should help to enhance their practice in the future. The AAFP Family Medicine Congressional Congress provides exposure to AAFP advocacy efforts and teaches participants how to share stories with legislators to strengthen our conversations. The National Conference of Constituency

I was so honored to be able to attend retirement celebrations for two long term chapter executives this summer:

Carla Coleman with the Arkansas Chapter

Carolyn Gaughan with the Kansas Chapter

Leaders provides the opportunity for those representing constituency groups to find common ground with other physicians from throughout the United States to write resolutions to the AAFP. This year we funded 13 medical students to attend the AAFP National Conference of Family Medicine Residents and Student Members. This conference gives students the opportunity to visit with residency programs from around the country, so that if they are seeking more diverse training opportunities they are likely to find it during the conference. Of course, Iowa residency programs work very hard to encourage students to attend Iowa programs.

The range of career options within family medicine is broad and includes geriatrics, adolescent medicine, hospice and palliative care, pain medicine, sleep medicine, emergency medicine and urgent care, hospitalist medicine, sports medicine, public health, international medicine, and wilderness medicine.

Family Medicine residents who wish to combine requirements with electives in an area of concentration to gain in-depth experience in a particular area may do so by participating in a combined residency program, or they may choose to pursue fellowship training after graduation. Combined residency training programs are hybrids that combine elements of two different specialty programs. They do not constitute a separate specialty but are designed to lead to board certification in both specialties. There are currently four types of dual-certificte residency programs for family medicine: family medicine/psychiatry; family medicine/emergency medicine; family medicine/internal medicine; and family medicine/preventive medicine. These combined training programs are generally four to five years in duration.

It is reassuring to know that most family physicians find their careers satisfying and rewarding. Family physicians realize they make a difference in the health and well-being of others, and they value the long-term relationships they have made with their patients and those in the community in which they serve.

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ABFM to Expand the Longitudinal Assessment Pilot in 2020

By Ashley Webb, Director of Outreach and Elizabeth Baxley, Executive Vice President

ABFM certified family physicians who were in their 10th year and due to take their examination in 2019 were offered the option of participating in a pilot that provided an alternative approach to the one-day examination in a secure test center. Named Family Medicine Certification Longitudinal Assessment (FMCLA), this new approach provides a mechanism for Diplomates to accomplish their examination requirement through a more flexible process that includes selecting the time, location and pacing of answering questions as well as the ability to utilize references, much like they do in practice. Twenty-five questions are delivered quarterly, and participants must complete 12 quarters (300 questions) over four years to complete the FMCLA version of the examination. This allows for up to four quarters "off," or to finish the exam in less than four years. According to ABFM, feedback from this first year has demonstrated that the platform works well and is well-received, and participants have commented on the fact that they are learning along the way, while still testing. Because of the early success, the pilot is being expanded to allow those who are currently certified and who have their 10-year examination requirement due before the end of 2020 to participate in FMCLA beginning in January.

125 Iowa AFP members who were due to take the examination in 2019 chose to participate in the FMCLA pilot, and we have been able to speak with a few who were willing to share some of their thoughts about the process. In addition, we heard from members who are considering FMCLA as an option for their future summative assessment, but who have questions about the process.

Most who responded indicated they have found the questions and the process reasonable and feel confident that this approach will be appealing to most Diplomates. Members believe the longitudinal assessment provides a lower stress environment. They appreciate that the assessment, after the first year of participation, will allow them to compare their performance to date to the passing standard of the one-day exam, thus ascertaining the probability that they would pass the full exam.

Other Diplomates have questions about the process:

When testing identifies an area of deficiency, are there resources to improve that educational deficiency? If you are not improving in that area, what is the recourse.

ABFM is assessing how the current pilot group is preparing for FMCLA and will have that information as part of the pilot outcomes. Keeping up with current medical literature relevant to family medicine, using board review and other comprehensive review courses for general medical updates, and learning from the critiques provided with each FMCLA questions are some ways that participants are reporting they are preparing.

This is a 10 year plan of taking quizzes every quarter. Is there a point where you are for so far behind in your score, that you will not pass?

FMCLA is a 3-4 year process, depending on how participants pace themselves. After year one, and ongoing thereafter, participants will see how they are performing in relation to the passing standard. This provides an opportunity for focused study in areas of identified need. If someone is unsuccessful in passing FMCLA, their certification will be extended one additional year and an opportunity to retake using the one-day examination will be provided. No decisions about pass/fail will be made until after 300 questions are completed.

What remediation is available to those who are struggling?

The ABMS Vision Commission Report called for all ABMS Boards to begin working on plans for remediation opportunities. There is a committee of people at the national level looking at this, and it includes members of specialty societies. ABFM is in conversations with the AAFP about how they might partner on remediation opportunities.

Many questioned the expense involved in the maintenance of certification but appreciate changes that are being made.

ABFM has no intention of changing the $200 annual fee for all components of certification and the examination fee of $250 in the 10th year is also not increasing. There have been no increases in certification costs, and FMCLA development and implementation was funded by ABFM without any fee increases.

ADDITIONAL NOTE

As a side note I wanted to share that I have been so very fortunate to be among a group of chapter executives that have been meeting with the staff leadership of the ABFM. The purpose of the meetings is to determine how the ABFM can add value to chapters, learn about ways they can engage with chapters and our members to establish a process for regular and on -going feedback and continue to work to enhance communications and chapter/diplomate support. The chapter executives are very excited to be included in this process to have the opportunity to share your issues and concerns with them. I have been impressed with their interest and responsiveness and I hope IAFP members will be beneficiaries of these efforts.

Celebrate the Great American Smokeout® November 21, 2019

The Great American Smokeout® is an annual event that encourages people who smoke to make a plan and quit for the day. Sponsored by the American Cancer Society, this event will take place on November 21, 2019 and serves as an effort to promote cancer prevention, reduce second hand smoke exposure and improve the health of all Americans.

Around 17 percent of Iowans aged 18 and older reported as being current smokers in 2016 (BRFSS, 2016). Tobacco use increases the risk for coronary heart disease, stroke and lung cancer.

As a healthcare provider, you have a special role in educating your patients about tobacco's impact on health and tobacco cessation services offered here in Iowa. This November celebrate the Great American Smokeout® by encouraging your patients to call Quitline Iowa at 1-800-QUIT-NOW (784-8669) to access qualified tobacco cessation coaches and other necessary support for successful tobacco cessation. Quitline Iowa is a toll free number available to anyone living in Iowa ages 13 and older. Quitline Iowa is available 24 hours a day and seven days a week.

The Quitline Iowa website also offers providers a *Quitline Iowa 101* training, as well as a CME and CE certified training program on the *Ask, Advise and Refer (AAR)* tobacco-cessation intervention protocol. The AAR protocol training also includes a review of approved pharmacotherapy that may help tobacco use cessation.

The Iowa Department of Public Health (IDPH) now offers a program for teens who want to quit using tobacco, including e-cigarettes and vape. The new *My Life My Quit* program includes educational materials designed for teens and created through focus groups with teens, subject matter experts and community stakeholders. Teens can text or call a toll-free number (855-891-9989) dedicated for teens, or they can visit mylifemyquit.com for real-time coaching. Through the program, teens work with a coach who listens and understands their unique needs, provides personalized support, and helps them build a quit plan to become free from nicotine.

To learn more about Quitline Iowa, click here or *My Life My Quit*, click here. To access the Quitline Iowa 101 and the AAR tobacco-cessation intervention protocol trainings, click here. If you have any questions, you may contact Tabetha Gerdner, Tobacco Use Prevention and Control Division at the IDPH, at (515) 281-7132.

References:

Iowa Department of Public Health (IDPH), (2017). Health in Iowa BRFSS Annual Report from the Iowa 2016 Behavioral Risk Factor Survey. Des Moines: Iowa Dept. of Public Health, 2017. Retrieved September 2019 from http://www.idph.iowa.gov/brfss.

This article was prepared by the Iowa Comprehensive Cancer Control Program in collaboration with the Tobacco Use Prevention and Control Division at the Iowa Department of Public Health. For more information, please call 515-281-7689 or visit www.idph.iowa.gov.

The Giving Tree

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: ______________________________

____

❑ Make a donation online at www.iaafp.org

❑ Pay by check ❑ Pay by credit card

❑ Visa ❑ MC ❑ Other______________

CC#______________________CVC Code ______

Signature________________Exp. Date ______

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

Strong Physician Recommendation Increases HPV Vaccination Rates

HPV vaccination completion rates lag behind the completion rate for other recommended adolescent vaccines. In 2018, only 43% of Iowa's adolescents completed their HPV vaccination series.[1] Although the rate has increased in the past few years (in 2015, it was only 21%), there is room for improvement. The most evidence-based solution to increase vaccination uptake is for a trusted provider, like a family physician, to provide a strong recommendation.[2] Recommend HPV vaccinating in the same way and on the same day as all adolescent vaccines.

A strong recommendation for the HPV vaccine sounds like this: "Now that your son is 11 years old, he is due for vaccinations today that will help protect him from meningitis, HPV cancers and whooping cough. Do you have any questions?"

The HPV vaccine helps prevent six types of cancers. While there is screening available for cervical cancer, there is no screening for the other cancers caused by HPV infection. The HPV vaccine is very safe and effective for males and females. The CDC recommends 11- to 12-year-olds receive two doses of HPV vaccine 6 to 12 months apart. A three-dose schedule is recommended for teens and young adults who start the series at ages 15 through 26 years. In 2019, the FDA expanded the approved indications of the HPV vaccine to include adults age 27 through 45.

All team members at your office, including at the front office staff,

UNDETECTABLE MEANS UNTRANSMITTABLE

People living with HIV who take their medications as prescribed and have a low amount of virus in their blood are considered undetectable and have effectively no risk of transmitting HIV to their sexual partners.

Source: https://www.cdc.gov/hiv/risk/art/index.html

IDPH Iowa Department of Public Health

TALK TO YOUR PATIENTS ABOUT U=U.

should be aware of the HPV vaccine's importance. All team members should be educated on proper vaccination practices and recommendations, ready to answer parents' questions, and/or regularly remind and recall parents. Staff can regularly check immunization records, place calls to remind families about getting vaccines, and let you know if parents have additional questions. Knowing the HPV vaccination completion and refusal rates among your patients can be helpful for tracking progress.

There are many resources out there to help you increase the HPV vaccination rate in your office. The Iowa HPV Workgroup is a collaboration of public health professionals, cancer survivors, researchers and healthcare providers working together to increase HPV vaccination rates across the state. The workgroup has created a resource guide for health care professionals including family physicians. This guide includes tips and resources on how to give a strong recommendation for the HPV vaccine.

The workgroup is facilitated by the Iowa Cancer Consortium and meets regularly via webinar. Interested in collaborating with the Iowa HPV Workgroup? Contact Tessa Allred at the Iowa Cancer Consortium at allred@canceriowa.org or 319-467-4569.

[1] Iowa Public Health Tracking Portal. *Immunization in Iowa*. Retrieved from https://tracking.idph.iowa.gov/Health/Immunization. 24 June 2019.

[2] Hswen Y. et. al. (2017) Improving Physician Recommendations for HPV vaccination: The Role of Professional Organizations. *Sex Transmitted Diseases*, 44(1), 42-47.

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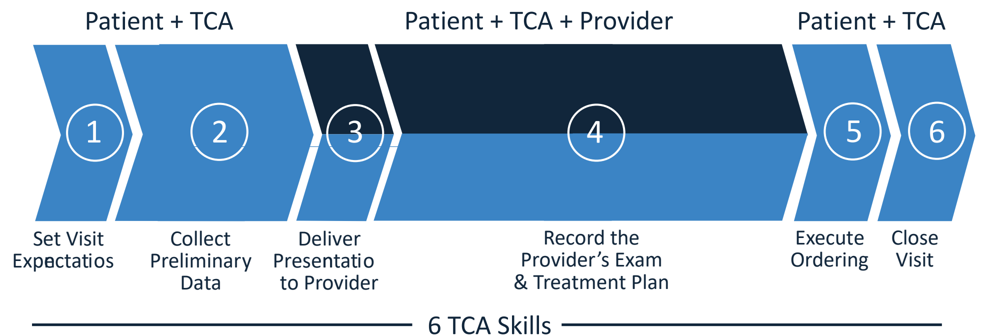
Stopping Burnout at the Source: Delegating the Administrative Burden

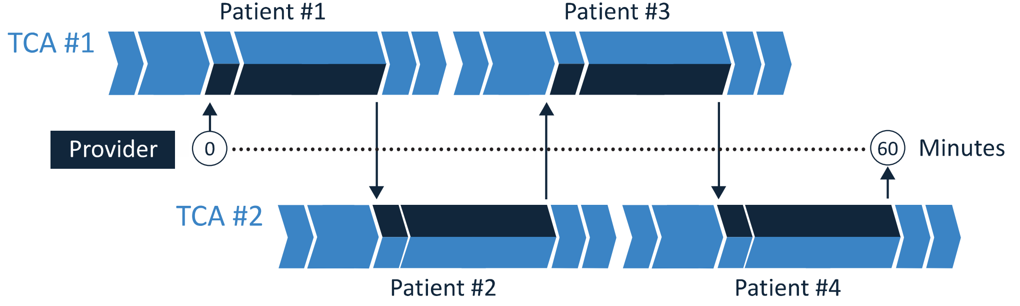
By Peter Anderson, MD with James Anderson, MD

I was drowning in a sea of administrative requirements. With the advent of the electronic health record (EHR) at my health system, I moved much more slowly through patient visits and spent much of my time staring at the screen rather than making eye contact with my patients. I poured more and more of my days (and my evenings) into tasks that did not require years of medical school and residency training. Like all too many other family physicians, I was burning out.

My long-time nurse felt similarly worn out and when she turned in her resignation, it was the last straw—I knew I needed to figure out a better way of practicing medicine.

What I wanted was an experience more like a surgeon, who walks into the operating room with the patient prepared, the equipment ready, and the nurses available. That vision inspired me to tinker, experiment, and innovate to create a comprehensive primary care workflow that would allow me to focus just on the tasks that required my MD designation. Equipping, empowering, and expanding my clinical support staff not only freed me up from administrative tasks that I should have delegated years earlier, it also allowed me to improve care and increase patient access. I was enjoying medicine again and was going home at night with my charts 100% current. My patients were delighted to find that they could now make same-day appointments for acute conditions rather than seeing a stranger at an urgent care center. System leadership at Riverside Health System in Newport News, VA, was delighted to see my financial profile flip from losing six figures per year to the most productive practice in the network.





In the ensuing years, the Team Care Medicine (TCM) Model has been endorsed by the American Medical Association, the American Board of Internal Medicine, the American Academy of Family Physicians, and other healthcare leaders across the United States. The TCM Model reflects a handful of basic insights but, like individual steps in a dance, putting them all together in a cohesive, organic sequence takes good coaching and intentional practice. To be clear, it is not a set of tips and techniques to be selected a la carte based on personal preference.

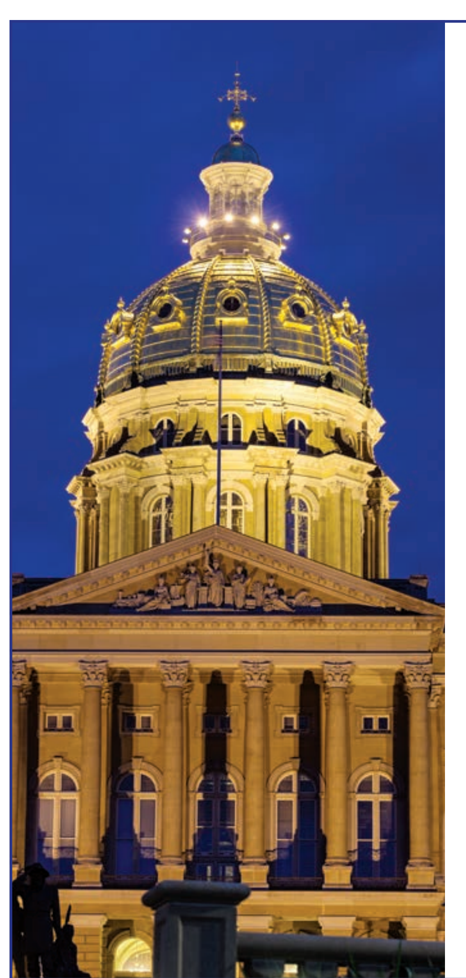
The transformation starts with a major shift in mentality for the physician. Though medical schools rarely include the management training coursework included in an MBA program, providers must embrace the reality that they manage a team. Their role can and should be less like the star player that needs the ball in their hands all the time and more like the

team captain that raises the performance of the entire team through coaching and leadership on and off the court.

In the TCM Model, the clinical staff (registered nurses, medical assistants, etc.) take on a role called the Team Care AssistantTM (TCA). They execute six discrete steps in the patient visit. Crucially, the physician is only present for two of them. Much of the administrative work is performed at the beginning and the end of the visit, and is performed by the TCA rather than the physician. When the physician is present, the TCA summarizes the preliminary medical information that has already been collected, in much of the same way that a medical student presents the patient's case to the attending physician. Then the TCA scribes the very concise examination by the physician, freeing up the physician to hone in on the diagnosis and prescription without even touching the keyboard.

Because they operate extensively without the physician in the room, each TCA offers dramatically more leverage to the physician's time than a scribe. Indeed, a high functioning TCM physician can be supported by up to four TCAs at the same time, while an individual physician never needs more than one scribe. A simple workflow with two TCAs is illustrated below.

In recent years, the Team Care Medicine Model has been adopted by a range of practices from coast to coast, including small federally qualified health centers and large integrated delivery networks. Physicians have learned to coach, to lead, and to delegate in the exam room. They're reporting restored joy in medicine as they engage the patient rather than the computer and go home on time with all their charts current. With improved clinic access, patients are delighted to get same day acute appointments with their own physician rather than an urgent care center. Executives are pleased by a strong ROI as the increase in visit volumes easily covers the conversion costs, not to mention the improved morale and retention of the physicians. This is just the beginning and I'm delighted that relief from administrative burden is beginning to restore primary care nationwide. Visit www.teamcaremedicine.com for more information.



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.

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
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- ❑ $500 SILVER MEMBERSHIP
- ❑ $250 BRONZE MEMBERSHIP
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❑ 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.

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THURSDAY, NOVEMBER 14

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 Ethics and End of Life Care - Jim Bell, MD

6:30 pm Physician Aid in Dying - Nicholas Kluesner, MD, FACEP

7:00 pm Pediatric End of Life Care - Abimbola Olayinka, MD

8:00 pm Question and Answer/ Panel Discussion

8:15 pm Recess

8:15-9:15 pm **2019 Donor Appreciation Reception** - In recognition of 2019 Donors of the IAFP Foundation, Rural Loan Repayment Program and PrimCare PAC

** Members must have donor ribbon to attend*

FRIDAY, NOVEMBER 15

7:00 am Registration

7:00-8:30 am Breakfast in Exhibit Hall

7:55 am Introductions and Announcements

8:00 am Time to Move Upstream and 'Invest' in our Health: Addressing Social Determinants of Health - Yogesh Shah, MPH, MD, FAAF

8:30 am Teen Suicide "They Talk about Dying Now What?" - Bruce Buchanan, ACSW, LISW, BCD

9:00 am Type 2 Diabetes Mellitus in Children and Adolescents - Jennifer Cook, MD

9:30 am Q & A/Panel Discussion

9:45 am Break – Exhibit Hall

10:05 am Concussion Management for Adolescent Athletes - Shawn Spooner, MD

10:35 am Inflammatory Bowel Disease - Archana Verma, MD

11:05 am Q & A/Panel Discussion

11:20 am Lunch and Keynote Presentation: AAFP UPDATE - Alan Schwartzstein, MD, FAAFP

12:20 pm Visit Exhibits

12:50 pm JOURNAL CLUB LIVE - Mark Graber, MD & Jason Wilbur, MD

2:05 pm Testosterone Therapy in Men with Hypogonadism - Vidya Aluri, MD

2:35 pm Q & A/Panel Discussion

3:05 pm Break in Exhibit Hall

3:35 pm Management of the Syncope Patient - Suzanne Feigofsky, MD, FACC, FHRS, FACP

4:05 pm Pneumonia Treatment Changes and Antibiotic Stewardship - Douglas Hornick, MD

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 16

7:15 am Past President's Breakfast

7:30 am Breakfast for Registrants

8:00 am Pain Management and Opioids: Balancing Risks and Benefits - Karen Muchowski, MD, FAAFP

10:00 am Break

10:15 am Building Pathways in Pain Management: Osteoarthritis and Chronic Low Back Pain - Douglas W. Martin, MD, FAAFP, FACOEM, FAADE

11:15 am Medical Cannabis-Pharmacology, Medical Science and Iowa Law - Kevin T. Schleich, PharmD, BCACP

12:15 am Q & A/Panel Discussion

12:45 am Adjourn

OPTIONAL SESSION - NEW TIME ADDITIONAL FEE REQUIRED

11:15 am Knowledge Self Assessment (KSA) – Hospital Medicine - Mark Graber, MD and Jason Wilbur, MD

AAFP Special Guest - Alan I. Schwartzstein, MD, FAAFP, a family physician in Oregon, Wisconsin, is speaker of the American Academy of Family Physicians Congress of Delegates and an officer on the AAFP Board of Directors. As an AAFP board member, Dr. Schwartzstein advocates on behalf of family physicians and patients to inspire positive change in the U.S. health care system. He is a family physician at SSM/Health Dean Medical Group in South Central Wisconsin, where he has practiced for the past 30 years. Dr. Schwartzstein has over 35 years of clinical experience and background in leadership, community service, public health, advocacy and education. He also serves as a clinical assistant professor at the University of Wisconsin School of Medicine and Public Health in Madison, where he teaches both students and residents.

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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 14-16 CME Registration Fees:

Registration Type	Early Fee (Until 10/7/2019)	Regular Fee (Starting 10/8/2019)
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 16

Knowledge Self-Assessment: Health Medicine (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

Canceling 14 or more days from course date will result in a full refund minus a $25.00 administrative fee. Canceling 13-0 days before course date will result in a full refund minus a $50.00 administrative fee.

REGISTER TODAY!

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www.iaafp.org/2019-Annual-Meeting

2020 SAINT LUCIA WINTER CME GETAWAY

(Pending receipt of final contract)

WHERE
Royalton, Saint Lucia, Caribbean

WHEN
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TOTAL COST FOR 2 PEOPLE FOR 7 NIGHTS
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Please visit *www.iaafp.org/2020-Saint-Lucia* for more details.

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- Nightly Entertainment
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The IAFP Has Had a Very Busy and FUN Summer!

On June 2-9 the IAFP & NAFP Mediterranean CME Cruise was held aboard the Norwegian Epic. The cruise provided breathtaking scenery, unique excursions, and a full and engaging CME program. A few of the ports that the attendees had the pleasure to explore were Barcelona, Naples, and Cannes.

The IAFP 2019 Okoboji Summer CME Getaway was held June 20-22 at Bridges Bay Resort. The attendees enjoyed half-day CME sessions and then were free to enjoy the rest of their day with family and friends. Unfortunately, the weather was not very corporative for boating and outdoor activities, but fun was had by many in the indoor waterpark!

We would love for you to experience our next CME getaway! We will be back in Okoboji at Bridges Bay Resort June 11-13, 2020. In addition, we are in the process of planning a meeting at Eagle Ridge Resort in Galena, Illinois to give you two great summer family options. Stay tuned for more details!

ITALIA

Save the Date

Summer CME Getaway Eagle Ridge Resort in Galena, Illinois June 25-27, 2020

Official Notice

As required by the IAFP Bylaws this is the official notice of Annual Business Meeting to be held on Thursday, November 14th at 5:00 pm at Prairie Meadows Event Center.

IAFP Secretary –Treasurer, Corrine Ganske, MD

New Members

Active

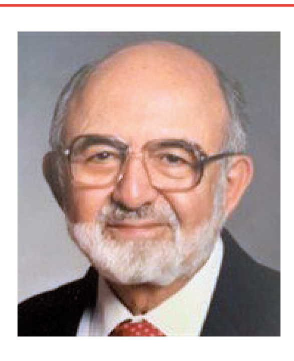
Geoffrey Dankle, MD, Norwalk
Meredith Dryden, MD, Carroll
Nhuhang Ho, MD, Bettendorf
Marie Oberst, DO, Iowa City

Residents

Jessica Briggs, MBBS, Des Moines
Patrick Luft, MD, Des Moines
Elizabeth Matthew, MD, Des Moines
Yusuf Mohamed, MD, Des Moines
Ujwal Patel, MD, Des Moines
Garrett Risley, MD, Des Moines
Jaspreet Singh, MD, Des Moines

Students

Erik Anderson, University of Iowa
Madison Bagnall, University of Iowa
Gabriel Bernbeim, Des Moines University
Jason Blake, Des Moines University
Kaity Bobadilla, Des Moines University
Hannah Bray, Des Moines University
Claire Carmichael, University of Iowa
Brian Casillas, University of Iowa
Katherine Champoux, University of Iowa
David Crompton, University of Iowa
Stephen Davick, University of Iowa
Harpinder Dhinsa, University of Iowa
Dorina Feher, Des Moines University
Kelsey Fischer, Des Moines University
Maggie Gannon, University of Iowa
Nelli Ghazaryan, Des Moines University
Joshua Godding, University of Iowa
William Guthmiller, Des Moines University
Weiren Liu, University of Iowa
Katherine Littlejohn, Des Moines University
Kathryn Marcus, University of Iowa
Savannah Marker, Des Moines University
Miles McNeir, Des Moines University
Katelyn Myers, Des Moines University
Sonia Nair, Des Moines University
Blaire Nasstrom, Des Moines University
Tristan Pennella, Des Moines University
Sumar Quint, Des Moines University
Danielle Thiessen, Des Moines University
Neelpreet Toor, Des Moines University
Joyce Wahba, University of Iowa



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Physician Business Leadership Certification Program

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IAFP members participating in the program are: Brian Anderson DO, Harlan (2nd from left), Bryon Schaeffer, MD, Clarinda (4th from left), Renee Diamond, MD, Clarion (5th from left), Erika Brown, MD, Decatur (6th from left) and Laura Bowshier, MD, Waukee (6th from right) Not pictured are Heather Babe, MD, Shenandoah and Craig Wittenberg, MD, Pella.

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- Epic EMR System
- Highly-educated patient base
- Large, established referral network
- Physician owned and governed
- Integrated medical center
- One of the least litigious states in the country

This community has a wonderful small-town feel yet boasts big-city amenities. With one of the highest-rated school systems in the nation, close proximity to several major metropolitan cities and numerous parks and recreation, this charming community is truly a perfect place to live and work.

EEO/AA Employer/Protected Vet/Disabled

Contact Doug Kenner
866.670.0334 or dkenner@mountainmed.net

Extraordinary Care, Every Day

IAFP Board Member Laura Bowshier, MD and Advocacy Committee member Bryon Schaeffer, MD after receiving their course completion certificates.

Achieve healthier outcomes—for everyone.

In its first major development for The EveryONE Project, the AAFP compiled an in-depth toolkit to help physicians recognize and respond to social factors that impact the health of patients.

The EveryONE Project toolkit is **validated, intuitive, action oriented,** and **free**. Utilize it to:

- Raise awareness about the effects of social determinants of health.
- Discover specific health risks in patients of all backgrounds.
- Understand and manage potential biases that may exist.
- Connect patients with essential resources in their area.

Reveal and address the unseen health hurdles your patients face every day. **Start using The EveryONE Project toolkit now.**

aafp.org/EveryONE/tools

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