IAFP
IOWA FAMILY PHYSICIAN

VOL. LII NO. 3 / WINTER 2024-2025

MEET NEW IAFP PRESIDENT
SARAH C LEDGER, DO, FAAFP

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- Reducing Radon Exposure Prevents Lung Cancer in Iowa

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6500 University Avenue, Ste 100, PMB 123
Windsor Heights, IA 50324
Phone: (515) 244-4182
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IAFP IOWA FAMILY PHYSICIAN

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In this issue

The Dual Role of Family Physicians

By Sarah C Ledger, DO, FAAFP

It has been my honor to serve on your IAFP board for the past eight years as a director, then Vice President, President-Elect, and now your Academy President. Over the years, we've navigated many transitions, and I am proud of all we have accomplished together. Your board and staff work tirelessly to provide you with the highest quality educational opportunities, the best advocacy for family medicine, and the support you need to thrive in your careers. Becoming an active member of the Academy has enabled me to engage more deeply with the broader dimensions of family medicine—through advocacy, education, and member engagement.

Sonia, our executive vice president, has been with us for over a year now. Her hard work and innovative ideas have been transformative for our organization. Our staff members, Kelly and Katie have dedicated years to this organization. I'd like to express my gratitude to these three women who truly are the backbone of the Iowa Academy.

I grew up outside Fairfield, Iowa, a small town in the southeast corner of the state. I stayed in Iowa for college at Loras in Dubuque, then attended Des Moines University for medical school. Although I spent some time on the East Coast for rotations, I ultimately returned to Iowa for my residency at the Iowa Lutheran program in Des Moines. I have been a physician owner at Family Medicine of Mt Pleasant for over 14 years. I have three beautiful children- Isabella, Emersen, and Brecken. At my independent practice, I have 4 physician partners, and we employ 5 physician assistants. We provide physician-led team-based care. My initial attraction to this clinic was its independence. Yes, we are still out there!

Family medicine is the cornerstone of comprehensive healthcare, dedicated to providing continuous and holistic care for individuals and families across all ages, genders, diseases, and parts of the body. Family physicians are uniquely positioned to understand patients within the context of their community and family life, advocating for personalized and patient-centered care that promotes overall well-being.

We must ask ourselves: when did healthcare become just a business? When did family physicians become replaceable cogs in a wheel, pushed by administrators? In my opinion, this shift towards corporatization has been one of the greatest failures of our healthcare system. Large systems have taken over, making decisions based on profit rather than patient care. Did you know that in the U.S., there are approximately 10 healthcare administrators for every physician? Healthcare administration has grown exponentially, while the number of physicians has remained stagnant and, in many areas, declined.

Who better to lead healthcare than physicians themselves? None of us went to medical school solely for financial gain and corporate greed. We endured long hours, the weight of student loans, and the stresses of this profession because we care deeply about healthcare, our patients, and our communities. I am excited to finally witness a growing trend of physicians stepping away from larger systems and embracing independent practice. Physicians in independent practice tend to be more satisfied with their jobs, more connected with their communities, and driven by patient-centered values.

Of course, independent practices face significant challenges today—insurance credentialing, payment hurdles, and competition from larger health systems, to name a few. The COVID-19 pandemic only deepened many of these challenges. I am fortunate to have practice partners with whom I have trusting relationships. My group has a guiding principle that we live by: "Base your decisions on what is best for the patient, and your business will follow."

This simple approach has sustained our independent practice, even during the pandemic.

Throughout the next year, I would like to foster growth, collaboration, and education around independent practice styles in medicine. I want to educate residents and students early on about this practice style. I plan to create a network or platform of communication for independent practices to share innovative ideas, challenges, and solutions. If we work together, we can learn from and support each other's success. I want to advocate for the smaller independent practices, who don't always have a strong voice in the legislature. If you want to join us in advocacy, please reach out to me or your Academy. Family physicians should be encouraged to take back the practice of medicine. Let's ensure that healthcare is for our patients, not for corporations.

In closing, I'll leave you with some words of wisdom from Shawn Martin- our wise AAFP Executive Vice President:

"While the world around us may be uncertain, trust in you, our country's family physicians, is not. People in communities across the country will be counting on you. Because the relationships between you and your patients transcend current events, and they most certainly transcend politics. What you do matters. Family medicine matters."

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The Federal Motor Carrier Safety Administration has established a National Registry of Certified Medical Examiners with requirements that all medical examiners who conduct physical examinations for interstate commercial motor vehicle drivers must complete a training course and pass a certification examination. Please contact the IAAFP at 515-244-4182 with questions.

If you are a certified medical examiner through the FMCSA/NRCME, your certification is valid for 10 years, are required to recertify every 10 years. For those of you certified in 2013, you are eligible to recertify any time before your certificate expires. In order to maintain your ability to continue to perform DOT exams, you are required to complete an accredited training course and pass the NRCME certification exam before your certification expires. You can complete the recertification starting at 9 years following your initial certification. Examiners who were certified in 2013 can now pursue recertification through the IAAFP.

This session is 5 hours long and offers AAFP CME credit.
For more information about the program go to

www.iaafp.org

A Call to Action

By Jason Wilbur, M.D.

Welcome to our winter 2025 issue and happy new year! Yep, it's the advocacy issue. While many of my past columns have a "rah-rah-family-medicine-rocks" flavor, I will try to avoid excessive cheerleading in this issue. We have much to be grateful for, but we have plenty of work to do, too.

Advocacy needs to be active. We need to DO something in order to advocate for our patients, our profession, and ourselves. While vision statements and endorsements are necessary to know who we are and where we are going, they are not sufficient to accomplish our goals without action. So, consider this column a call to action.

Family medicine is a "big tent" specialty, covering a vast array of physician practice styles, health care systems, patient populations, and careers. It's easy to divide us: urban versus rural; academic versus private practice; full spectrum versus focused practice; and system versus system. So, we should forgive one another for putting our personal professional and potentially niche issues ahead of broader issues facing family medicine. But I believe there are many issues on which we can find broad agreement, and that is where we as an academy should focus our energies. There are a couple currently active issues in Iowa and one that I think we would all like to see resurrected, and these are where our energies as an academy should be focused.

Increase Medicaid payments

There is a bill in an Iowa House committee to set minimum annual provider payment increases for Medicaid based on the percentage increase in the consumer price

index or 2.5%, whichever is less. You may argue about whether you agree with that number, but the key factor is that this would occur automatically, rather than be subject to an annual legislative vote. Given how low Medicaid reimbursements are, we need to advocate for reform.

Reform prior authorization (PA) processes

The bureaucratic death-of-a-thousand-cuts that we endure – in large part due to frivolous PAs and other minutiae – increase burnout which can lead to physicians reducing their work hours or leaving medicine altogether. As of the writing of this column, there is a bill in the Iowa House that would require insurers to abide by minimum processing times for PAs, review PA utilization annually to determine necessity and value of the PA, and establish pilot programs for PA exemptions for physicians. We should support any movement toward making the PA process more stream-lined.

Ban non-complete clauses in physician contracts

To the best of my knowledge, there is no activity on this item in the current legislative session. However, bills have been advanced in the past. In our current environment where most physicians are employed by health systems, non-compete clauses serve only the system, not patients or physicians. While most of us truly love our work and our employers, being indentured to them breeds resentment among physicians and limits patients' access to their doctors.

Perennial issues of broad interest to family medicine include enhancing pathways to enter family medicine practice, reducing bureaucratic burdens on physicians, and increasing access to family physicians.

If you agree that these are priorities for you, then it is time to act! You can give money to the IAFP PrimCare PAC or the AAFP FamMed PAC. You can join the IAFP Advocacy Committee, respond to AAFP and IAFP calls to action, and reach out personally to your legislators. Your voice matters, and all our voices together will make Iowa a better place for family doctors and 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*.

The Many Definitions of Advocacy

By Srinath Nandakumar, M2 at the Carver College of Medicine

The new year marked a transition to a new phase of my medical education – the start of clinical clerkships. Leaving behind the large lecture halls of Iowa City, I would be thrust into the clinics and hospital wards of Des Moines. I would be learning not just from reading dense textbooks and absorbing endless lecture slides, but from talking with and treating real patients – each with their own unique life story. During my first week, I found myself in an adolescent medicine clinic. Here, I would see patients between the ages of 14 and 22, who were often being managed for conditions such as ADHD, depression, anxiety, and suicidal ideation.

In order to build rapport and connect with this population, one must be creative. The clinician I was working with certainly had a few tricks up his sleeve. In clinic, we were about to see one particular patient who had a history of being bullied in school and currently suffered from a constellation of conditions, including depression and ADHD. As we were about to go in, my preceptor said to me, "I think I'll need to bring out my hat for this one." He gestured to a box above his shelf, in which lay an excessively flamboyant hat, something you might see people wearing at Mardi Gras. It was in stark contrast to his otherwise standard, business-casual outpatient-clinician outfit. We walk in to greet the patient, who I observed to be an adolescent sporting an "emo" outfit – featuring a black hoodie and long black hair covering his eyes. In fact, throughout the entire patient encounter, I never saw the upper half of his face.

My preceptor, wearing his flashy hat, energetically began speaking to the patient. He started with casual, non-medical conversation such as, "What presents did you get for Christmas?" and following up on details from the patient's life that they had both discussed during the last visit. Initially, my clinician's animated personality was met with nonverbal hand gestures, which then slowly progressed to single word responses like "sure" after a few minutes of talking. Ten minutes of this rather one-sided conversation had gone by when my preceptor finally addressed the elephant in the room. "Are you ever going to look at me? I wore this hat for you and was wondering when you were going to acknowledge it." It was at this point that the patient looked up through his hair and smiled; the last 10-15 minutes of conversation had culminated in an immense payoff. This effectively broke the ice and warmed the patient to further conversation as we dove into the relevant medical discussion.

As I began to write this article on this issue's theme of "advocacy," I was unsure where to begin. After all, I had little experience dealing with legislation or government. However, as I remembered this patient and the thoughtful way that my preceptor structured the encounter, I realized that "advocacy" is a term that transcends our classical definition.[1] Advocacy is not just about trying to negotiate with the politicians that are sitting inside ornate buildings or influencing the creation of complicated policy written in legalese. To me, advocacy is entrenched in the exam room. In the clinical setting, it means not only effective medical management but also understanding and tackling the social determinants of our patients' health. It means creatively finding ways to build trust and rapport with those you serve. It means showing compassion for our patients, even for those who may not be reciprocating that compassion. Advocacy in the clinical setting means holistically, creatively, and unequivocally doing everything in your power to champion the best interests of the patient.

What are some ways that you, the Iowa Family Physician, can engage in advocacy? You could stop by the state capitol on February 20th for the IAFP Legislative Coffee – an event where you can meet state lawmakers and explain the experiences you have had with your patients and why it matters that they shape policy that works toward their best interests.[2] You could write to the local and federal representatives, reiterating the legislative priorities that IAFP and AAFP have set and beyond.[3,4] You could initiate and continue dialogue with hospital/clinic leadership to change existing or enact new procedures. However, advocacy foundationally lies within every patient interaction that we have: as we seek to empower individuals to live the best life that they can.

[1] https://www.dictionary.com/browse/advocacy
[2] https://iaafp.org/events/event-5
[3] https://iaafp.org/Priorities/
[4] https://www.aafp.org/advocacy.html

IOWA ACADEMY of FAMILY PHYSICIANS

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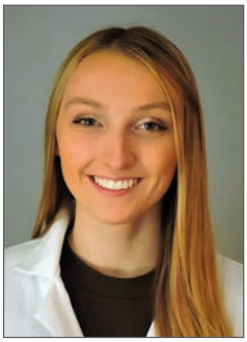
FARM BUREAU AWARDS RURAL PHYSICIAN SCHOLARSHIPS

Two ($5,000) Iowa Farm Bureau Rural Family Medicine Scholarships were awarded in 2024.

"America is facing a physician shortage, but rural areas are especially vulnerable," said Ronnette Vondrak, Community Resources Manager for the Iowa Farm Bureau Federation (IFBF), "That's why IFBF is proud to sponsor the Rural Family Medicine Scholarship to encourage highly-valued graduates to stay in Iowa and practice medicine in a rural community." The scholarships encourage residents upon graduation to pursue a medical career in Iowa communities with populations under 26,000.

Award winners with Foundation President - Robin Barnett, DO, MBA, FAAFP



2024 Student Recipient

JAYDEN AMSLER, MD - Growing up in Wiota, Iowa, a town with a population of under one hundred people, going to the doctor was something you only did when you were on the verge of death. Jayden has always found this mindset concerning and hopes to change it for future generations. After receiving her undergraduate degree at University of Iowa, she decided to stay for medical school. During medical school, she made her mark serving as the FMIG VP of procedure clinics and eventually Co-President. She also did the summer research fellowship program at the University of Iowa Free Radical & Radiation Biology Lab. This year, she began her residency at the University of Iowa where she hopes to learn how to best help rural Iowans. She also hopes to serve as a mentor to medical students in Iowa so that she can encourage future generations to pursue careers in primary care and to remain in Iowa and our rural communities.

2024 Resident Recipient

SAVANNAH MARKER, DO - Savannah grew up in rural Madison County, and eleven years ago, moved to college to start her journey to medicine. She attended medical school at Des Moines University and has called Broadlawns her home for the last three years. She has received numerous honors and scholarships, participated in countless scholarly activities and as climbed the leadership chain- finally serving as Chief Resident in 2023. Since leaving home, she has missed living in a small town and finally accomplished her dream of moving back to Winterset. Her goal of becoming a rural physician may already be accomplished but her career is just starting. Savannah's future goals include improving access to healthcare through a full spectrum practice, building upon family medicine through advocacy and teaching, and ultimately becoming a trusted physician by developing a strong relationship within her community.

The Primary Care Physician Advocate

By Luke Hallman, MD, R2 / MercyOne Northeast Iowa Family Medicine Program – Waterloo / Waterloo, IA

When I sit down to think about advocacy in the medical field, it often is something that I do not have the time to do. Advocacy is no doubt an important endeavor for a plethora of varying and diverse reasons; however, to me, it just ends up adding onto an already full schedule of practicing medicine. It then becomes something that, while important at the end of the day, it can be brushed aside for more pressing issues. When I was looking more into advocacy to write an interesting take or some clever point to make, I started to realize that as a primary care physician, I am doing much more advocacy than I realize.

Traditionally, advocacy in medicine is often thought of as lobbying our lawmakers to take such actions as improving reimbursement from Medicare, Medicaid, and private payors, and addressing physician burnout, the cause of which is multifactorial. Such advocacy is usually something that is done by large organizations like the American Medical Association or the Iowa Medical Society, and the average physician's involvement is often truly little. However, I believe that advocacy extends beyond just lobbying or talking to lawmakers – rather, I propose that most of what we do as primary care physicians is advocacy, maybe not for ourselves as physicians, but rather for our patients.

As family medicine doctors we are advocating for our patients almost constantly, whether or not we think of what we are doing is advocacy. We advocate in a number of ways daily; however, I think that the most effective and often missed way that we do advocate is through our charting and documentation.

Charting and documentation are also things paramount to our practice of medicine for the purposes of billing and insurance coverage as well as telling the patient's story to other providers who do not see them as often as we primary care physicians do. While charting is something that many of us find burdensome and does not relate to patient care, I would posit that, in fact, it does affect patient care in many ways. I think that these thoughts stem from a saying I have heard so many times, that at this point, I have developed a neural pathway for just repeating it: "If it is not documented, then it did not happen."

Physicians understand that charting is not just documenting the work that we are doing as physicians for billing and insurance purpose. I realize that this may not be all that insightful or even surprising to some, but charting is a part of advocating for our patients and is something that I feel is not talked about enough. As primary care providers, our charting and note-writing affects our patients' access to care in three major areas: access to medications and treatments, access to specialty care, and how other healthcare providers view our patients.

Access to medications and/or treatments is perhaps the easiest portion to understand as it is something that we are frequently doing, especially when dealing with insurance companies. When I prescribe a medication that insurance decided requires a prior authorization, one of the first things I must do is provide the chart notes. If my charting does not justify the patient's need for the medication, regardless of the actual existence of the patient's need, then the prior authorization gets rejected. I believe that writing notes that allow my patient to access medication, even those deemed necessary for a prior authorization, is advocating for them. It is more than justifying my medical decision making, but also ensuring that my patient can access and have insurance coverage for the medications that will make them healthier.

Enabling a patient's access to specialty care is also a form of advocacy that we as primary care physicians provide similarly to charting for our patients to get their medications. Charting plays a vital role in making sure our patients

"Enabling a patient's access to specialty care is also a form of advocacy that we as primary care physicians provide similarly to charting for our patients to get their medications."

are successfully referred to specialists when it is necessary for them to see those specialists. The other way we as primary care physicians advocate regarding specialty care comes from when and how we talk to our specialist colleagues about our patients. The difference between a referral that seems like the patient just wanted the referral verses that referral being necessary care that a physician recommends and supports can be crucial—it may affect the speed, efficiency, and effectiveness of a specialist's care. We must provide the support and relay that the patient will benefit from their needed care and that care is beyond our training to provide.

This foregoing point, ensuring that our patients are well-treated when they see other providers, is vital. For example, upon review of the notes and referral information, does the charting distinguish between the patient having "drug-seeking" behaviors verses that they have legitimate acute or chronic pain that was being treated. How we relay our perception of any patient encounter to other physicians can create negative or positive opinions of our patient before the specialist even walk into the exam room. It is not just what we say when we chart, but how we say it that is important.

Ultimately, I feel that how and what we say when completing notes about our patients affects so many more aspects of their care than even what I have outlined here. I know that traditional advocacy is often intimidating, and at least to me somewhat overwhelming. Yet, there is so much to be done in terms of advocacy. For me, advocacy will not be something I do in a politician's office; rather it will be done in how I document my patient care. Sometimes the strongest advocacy we can do for our patients and ourselves happens in places we would not ordinarily expect. Simply put, at the end of the day, I believe that we participate in a form of advocacy everyday just by being good family medicine physicians.

Medical Resident Jeopardy Throwdown

On November 7th, 2024, 9 Iowa Residency programs participated in the 12th Annual Medical Resident Jeopardy Throw-Down. The teams each consisted of 2-3 resident participants and was hosted by Dr. Doug Martin! Fun was had by all as they enjoyed drinks and appetizers while they cheered on their favorite residency program. In the end, Broadlawns pulled off their fourth victory. A very special thank you to Douglas Martin, MD for developing the questions and running the contest. Thanks to all the teams that participated!

Broadlawns Medical Center Family Medicine - Narrow Yards

Genesis Quad Cities Family Medicine - Trish's Troops

Iowa Lutheran Family Medicine - Suture Self

Mercy Des Moines Family Medicine - No Mercy

MercyOne North Iowa Medical Center Waterloo - Waterloo Warriors

MercyOne North Iowa Family Medicine Mason City - North Iowa Mental Mavericks

Central Iowa Family Medicine - Waterloo- Family Quizicians

University of Iowa - Team Herky

University of Iowa - Sioux City - Team SUX

The 2024 Champions – Broadlawns Medical Winners:
Jessica Aguilera, DO | Megan Slattery, MD | Raquel Relph, DO

Reducing Radon Exposure Prevents Lung Cancer in Iowa

Authors: Jill Heins-Nesvold, MS, Nationwide Senior Director of Health Systems Improvement and Indoor Air Quality and Mimi Guiracocha, DNP, RN, Nationwide Director of Health Systems Improvement for the American Lung Association

Americans spend 90% of their time indoors, making indoor air quality critical to the health of families. In indoor environments, the levels of some pollutants are often two to five times higher than outdoor concentrations.

The air we breathe is filled with lots of things including gases and particles – most are too small to see with the naked eye. Everything we breathe affects our health. Just as with outdoor air quality, young children, older adults and people with existing lung disease are most at risk of negative health effects from poor indoor air quality, but pollutants can affect anyone.

Health effects from poor indoor air pollutants include short-term symptoms like headaches, eye, nose and throat inflammation, coughing and painful breathing, bronchitis and skin irritation. Extreme side effects of indoor air pollutants can impact the central nervous system, cause exacerbations in respiratory diseases such as asthma and COPD and even cause cancer after long term exposures. Poor indoor air can also impact the blood, spleen, liver and reproductive system.

As healthcare professionals, we should all be familiar with indoor air pollutants, no matter the field you practice in.

- Healthcare professionals are trusted messengers of health-related matters and can communicate the risks of indoor air pollutants and offer mitigation strategies.
- Early identification and intervention are key to minimizing exposure and health impacts.
- Vulnerable populations, including children, older adults, pregnant individuals and individuals with existing lung disease are disproportionately affected by indoor air pollutants. Healthcare professionals can advocate for policies and interventions to reduce exposure and promote health equity. Join the American Lung Association's Lung Action Network today to learn more about how you can advocate for the community you serve.

Healthcare professionals play a vital role in protecting their patients from the health impacts of indoor air quality by:

- Educating patients and caregivers
- Screening and identifying at-risk patients
- Recommending mitigation strategies
- Advocating for policy changes

The American Lung Association conducted a nationwide survey of over 900 healthcare professionals about their practices and understanding of indoor air pollution and its health impacts. Survey respondents agreed that healthcare professionals should assess and actively support patients' understanding of indoor air pollution. However, only 1 in 4 (26.4%) of respondents are satisfied with their current knowledge of the health effects of indoor air pollution and only 2 in 5 (39.8%) are familiar with the health effects of indoor air pollution. Healthcare professionals reported that they were least familiar with radon (65% of respondents were not at all, slightly, or somewhat familiar).

Radon is a naturally occurring invisible, odorless gas that comes from the radioactive breakdown of uranium in soil, rock and water. Radon enters the home through cracks in foundations, basements, floors, walls and other openings, and into the air we breathe. Radon decays into radioactive particles that you can breathe in. The particles remain attached to lung tissue after you exhale. These particles emit alpha radiation which strikes lung cells (primarily the epithelial cells) and damages DNA. DNA damage can cause mutations and cancer development.

Elevated levels of radon are found in homes in every state, and in some states, radon levels are elevated in as many as 1 in 3 homes. The U.S. Environmental Protection Agency (EPA) provides a map of radon zones to help organizations understand potential radon levels in their area. The only way to detect radon in a home is to test the air. Do-it-yourself, short-term (3-7 day) test kits are simple to use and available for less than $20. Test kits can also be purchased at local hardware stores or from certified radon measurement professionals.

Radon levels are measured in pCi/L (picocuries per liter). 4.0 pCi/L is the level established by the EPA for mitigation action and buildings that test at 2.0 – 4.0 pCi/L are advised to consider mitigation. The only way to reduce elevated radon levels is to have a professional mitigation

system installed that draws radon from the soil and releases it into the outdoor air. These systems can cost up to $2,500. Patients can call their state radon contact to see if financial assistance is available. Patients should re-test their home within 30 days of mitigation and then every 2 years.

Since radon exposure is not currently standard for screening in patient questionnaires and does not present symptoms in patients, it is critical that healthcare providers take a few minutes to discuss radon with every patient. Some populations of specific focus include:

- Individuals with recent address changes
- First-time homebuyers
- Those who currently smoke
- People who are pregnant or are new parents

Healthcare professionals can use the same framework to assess and treat radon exposure as risk factors for serious illness.

1. Ask if your patient is aware of the risks of radon and has had their home tested
2. Provide education and resources on the health risks of radon
3. Recommend that they test their home for radon and install a professional mitigation system if levels are above 4.0 pCi/L
4. Follow-up on testing and mitigation progress at future appointments.

The American Lung Association has developed tools to aid healthcare professionals to identify, screen and treat patients at-risk for the health impacts of radon. Healthcare providers can access "Resources for Healthcare Professionals", including videos, factsheets, decision support tools and patient education materials at *Lung.org/radon*.

New Zealand Experience

Jeff Hoffmann, DO

I've had a rewarding career as a family physician, serving for 4 years in Rock Rapids, then moving to Guttenberg, spending the next 32 years practicing the full range of our specialty. From full range obstetrics to covering the emergency room, then following inpatients in our local hospital, to seeing my daily patients in the clinic, it was as they say, 'living the dream'. However, one dream ends, and another begins.

I wasn't quite ready to retire, so Carolyn and I made the decision to follow another dream…practicing in New Zealand. It wasn't easy leaving the surroundings that we had become accustomed to. But to not pursue the dream would have left a hole in our lives.

So here we are, living in Ahipara, New Zealand on the North Island. I practice with the Te Hiku Hauora Clinic in Kaitaia, the gateway to the northern most tip in New Zealand. There are no stoplights, the Tasmin Sea is on our west and the Pacific Ocean on our east. Since we are but one of a handful of clinics in the far north, we see over 50,000 patients a year. The majority are Māori,

Though New Zealand is known as one of the world's 'wealthy countries', the Far North is not in that category. Our patients are poor, often marginalized, and do not have access to some of the basic needs that many of the citizens of New Zealand are offered. Though I see the full range of conditions in the clinic, the severity of the illness is often quite amazing.

Hypertension, diabetes, obesity, and gout are the major chronic conditions. However, substance abuse, depression, and physical and mental abuse is quite common. Though this may seem overwhelming, our clinic does an amazing job getting people in and offering not only general practice (New Zealand's term for family practice), but we have counseling services, health coaches, and visiting nurses for patients or families in need.

We have a hospital staffed by 4 general practice physicians who run the emergency room, as well as the inpatient wards. All deliveries are done by midwifes and all emergency surgeries

or critical patients are flown out either to Auckland or Whangarei. We have only basic labs and x-ray. Though ultrasound will come weekly, all CT and MRI are a minimum of 1-½ hours away.

New Zealand has a government run healthcare system, although many patients in the country have private insurance. Unfortunately, that usually isn't the case for our population. However, the horrors that I heard about the governmental run system aren't as bad as one might believe. Yes, you will wait months for a hip or knee replacement. However, if you are having a MI, stroke, acute cholelithiasis, etc., you will be taken care of immediately. All accidents are covered by the government, even simple sprains and strains. All parents get a total of 26 weeks of parental leave, and their employment is protected for a year after delivery. All patients under 18 get free health care. Plus, most of the basic medications are funded and offered to patients at no cost or a minimal co-pay of $5.00.

Hopefully this gives a glimpse of what it is like working with the indigenous population in New Zealand. I could have gone to Auckland or Wellington and practiced in an urban environment. However, I do not think I would have gained the perspective that I have living in the far north. Learning Māori culture and embedding ourselves into the local community has been an experience that will never be forgotten.

Yes, we have been able to travel on weekends. From Hobbiton to the Waipua Forest, to Camp Reinga, where the Tasmin Sea and the Pacific Ocean meet, New Zealand is truly a country of beauty. So, If any of you have a dream, please follow it. If you are on Facebook, you can follow our adventure.

New Year. New Website. New Logo.

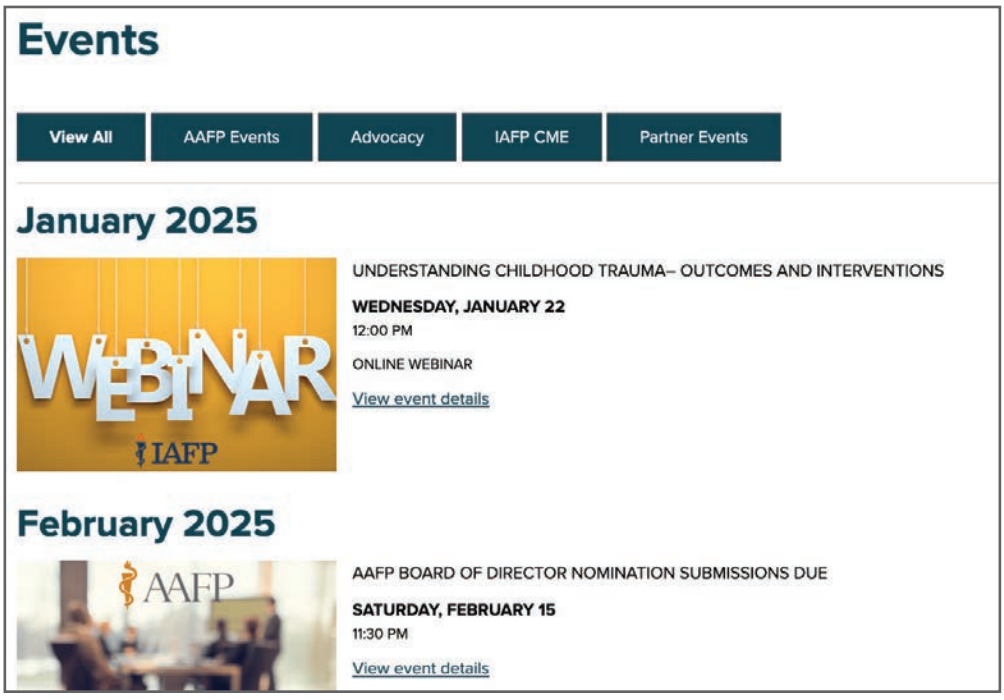
By Sonia Bell, MBA, Executive Vice President

I know you are used to a wordier article in the Office News portion of the IAFP Magazine. But since this is my (well, I think of it as Katie, Kelly, and mine) space to update you with what I/we believe are the most important things happening in the IAFP Office, I am taking that liberty with this issue and running with it. After all, who doesn't prefer more graphics in articles?!

Early last Fall, we started our work on a much-needed refresh for iaafp.org. With the financial and programmatic support of the Board of Directors, we forged our path forward; comparing the designs of other AAFP chapters and healthcare nonprofits, researching new trends, and meeting with our website development team at Visionary to align our ideas with website development best practices. After some

tweaks to improve the user experience and better organize our content, we soft-launched the new site in mid-January. If you haven't had the chance to peruse the site yet, here's your "*iaafp.org* Website 101" tutorial!

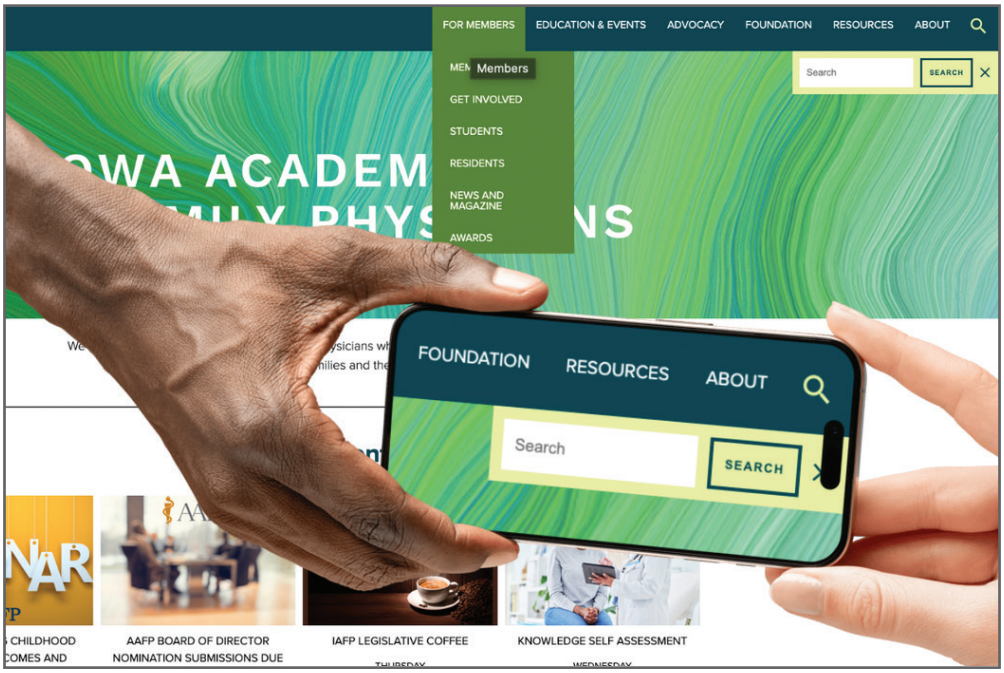
The new site features a more streamlined design with topical navigation organized by IAFP's core mission areas: Education, Advocacy, and Support. Upcoming events are highlighted on the homepage with a link to navigate to the expanded list of all upcoming events easily *(see top left image)*.



On the Events page *(see bottom left image)*, all upcoming events are listed in chronological order with the option to filter them by category:

- AAFP Events like FMX and Congress of Delegates
- Advocacy Events like our upcoming Legislative Coffee
- IAFP CME, including live webinars and the Annual CME Conference
- Partner Events hosted live by partners such as the Iowa Cancer Consortium, the Iowa Pediatric Mental Health Collaborative, and others

Across the website header, the navigation menus drop down with helpful site page titles. And if you still can't find what you are looking for, our new search function allows visitors to search the entire site for content *(see right image)*.



And, as hinted in the title of my article, we also have a new logo! This Fall, the AAFP advised all chapters of their new marketing and branding strategy, which included logo refreshes for all chapters. Since we were preparing to publish our new site, they expedited our logo update and got that to us just in time. We will gradually replace the previous logo and branding colors with the new format throughout the coming weeks, infusing our traditional green color where possible to differentiate the Iowa chapter from our national and other chapter partners.

Lastly, in an attempt to both update you on some upcoming events and tempt you to explore IAFP's new website, I chose to end my article with another crossword puzzle! All answers to this puzzle can be found somewhere on our new website and answers are submitted via an easy online form. One winner will be randomly chosen to win a $100 Mastercard gift card, more details on page 19!

As always, thank you all for your continued dedication to your patients, colleagues, communities, and our chapter. Katie, Kelly, and I consider ourselves lucky to work for such a great organization and hope that our efforts make your experience with IAFP easy and enjoyable. Please send any feedback you have on the new website to any of us, our emails are listed on… wait for it….*iaafp.org*. (Specifically, *iaafp.org/staff*) ;)

2025 Legislative Priorities

1. Health of the Public

IAFP is opposed to legislation that would erode physicians' ability to practice within their full scope and that puts Iowa patients in harm's way. Specifically, the IAFP is committed to monitoring the scope of practice protection, supporting vaccination as a tool for healthy communities, and promote policies that protect and preserve patient-physician relationships.

2. Workforce Initiatives

The Academy will continue to explore ways to increase quality physician access to patients in Iowa through workforce programs like the Primary Care Rural Loan Repayment Program drafted by the IAFP in 2014. Fully funding these programs is critical to maintain a physician centered primary care workforce in Iowa. As such, IAFP supports:

- Increased funding for the Rural Primary Care Loan Repayment Program,
- Increased state funding for the Medical Residency Programs

3. Maternal Care and Insurance Coverage

- In the current ACA marketplace, qualifying life events triggering a special enrollment period include the birth of a child but do not include pregnancy. Health and Human Services has declined previous requests to establish pregnancy as a qualifying life event triggering a Special Enrollment Period.
- This causes a gap in insurance coverage for pregnant women because they earn too much to qualify for Medicaid, are not enrolled or eligible for employer-sponsored plans, and become pregnant outside of the ACA Marketplace Insurance enrollment period.
- Women who do not receive prenatal care are three to four times more likely to die from pregnancy-related complications, and their infants are three times more likely to have a low birth rate and five times more likely to die in infancy.
- IAFP endorses and publicly advocates the U.S. Department of Health and Human Services and Congress for establishing pregnancy as a triggering life event for a Special Enrollment Period in the Affordable Care Act Marketplace.

4. Reform Prior Authorization

- Prior authorization continues to be a leading cause of physician burden. Time-consuming administrative processes encumber family physicians, divert valuable resources from direct patient care, and delay the start or continuation of necessary treatment. This leads to lower rates of patient adherence to treatment and negative clinical outcomes.
- IAFP supports the improvement of coverage criteria, increasing transparency of prior authorization and medical necessity determinations, and preventing inappropriate coverage denials by organizations.
- The IAFP will support prior authorization reform, enabling physicians and patients to have access to clear guidelines for prior authorization requirements and timely responses from insurance plans.

5. Increased Medicaid Reimbursement Rates

- IAFP supports increased Medicaid reimbursement rates for primary care services and for physicians in rural communities. Increased reimbursement allows for better patient access, improved outcomes, and healthier communities.
- IAFP also supports increased Medicaid reimbursement rates and coverage for dental care services. Inadequate dental coverage and reimbursement reduces the ability of patients to access routine dental care. This leads to chronic medical conditions such as diabetes and cardiovascular disease and delayed diagnosis of serious dental issues, which can compound and create larger medical issues.

Thank you so much to our 2024 PrimCare PAC Donors:

Robin Barnett, DO
Jim Bell, MD
Laura Bowshier, MD
Dave Carlyle, MD
Patrick Courtney, MD
Jennifer Donovan, MD
John Ebensberger, MD
Corrine Ganske, MD
Madeline Godar, MD
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Sarah Ledger, DO
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Elizabeth Stoebe, DO
Donell Timpe, MD
Jason Wilbur, MD
Mack Worthington, DO

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 contributions directly support legislators who are informed and committed to family medicine's business and practice management issues. Family medicine interests are much more likely to receive greater attention among the many competing interests and constant stream of proposals put forward consideration.

IAFP members at the Iowa State Capitol for the Governor's bill signing for postpartum Medicaid coverage (SF2251) and nonmedical switching (HF626), May 2024.

IAFP meeting with Senator Chuck Grassley in Washington, D.C.

TO DONATE

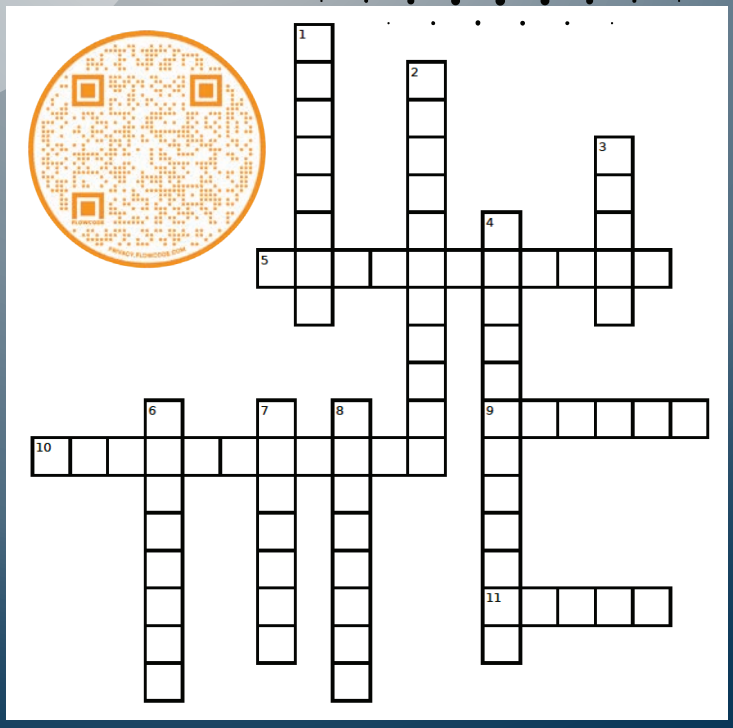
VISIT IAAFP.ORG/PRIMCARE-PAC
OR
MAIL YOUR PERSONAL CHECK TO:
IAFP PRIMCARE PAC
6500 UNIVERSITY AVE
SUITE 100, PMB 123
WINDSOR HEIGHTS, IA 50324

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.

IOWA ACADEMY of FAMILY PHYSICIANS

NEW YEAR, NEW WEBSITE, NEW LOGO, NEW CROSSWORD

One lucky winner will receive a $100 PrePaid Mastercard!



To play, submit your answers and contact information online by scanning the QR code or navigating to this site:

https://www.surveymonkey.com/r/IAFPWinterPuzzle

DOWN

1. Former IAFP President Dr.____ is the IAFP PAC Board Chair.
2. The AAFP and ABFM CME credit reporting systems do not ____ with one another.
3. Active members must report at least 150 credits of approved CME every ____ calendar years.
4. The Family Medicine Certification ____ Assessment is the alternative to the one-day examination requirement for family medicine certification.
6. The ___ Achievement Award is awarded to one or more family physicians who accomplished amazing things in their careers.
7. Former IAFP President Dr. ____ is the IAFP Foundation Board President.
8. You can visit iaafp.org/____-Family-Medicine to learn more about the IAFP's work to increase student interest in careers in family medicine.

ACROSS

5. Members can visit iaafp.org/____ to review volunteer opportunities and easily complete and submit a Committee Volunteer Form.
9. The Rural Iowa Primary Loan Repayment Program selects ____ students every year.
10. Thursday, February 20 at 7:30 a.m. is IAFP's ____ Coffee at the Iowa State Capitol.
11. IAFP's next KSA, "Care of Women", is live via Zoom on Wednesday, ___ 30, 2025. Register today to earn 8 CME credits from the comfort of your own home or office!

HINT

Visit iaafp.org/events to find some answers to the above AND register for one of our upcoming events!

Online submissions are due by Friday, February 28.

A prize winner will be drawn from the successful competition entries and contacted by email. The winner and puzzle key will be published online and on our social media channels!

Thank you to 2024 Annual Meeting Exhibitors and Supporters

We want to extend a big thank you to our 2024 IAFP Annual Conference exhibitors and supporters. We appreciate your support of family medicine in Iowa!

2024 IAFP Exhibitors

- Abbott Rapid Diagnostics
- Abbvie
- Aledade Inc.
- Amgen
- Avera Medical Group
- Bayer Healthcare
- Boehringer Ingelheim
- Buena Vista Regional Medical Center
- Bureau of HIV STI and Hepatitis NuCara Capacity Extension Program
- Capital Orthopaedics and Sports Medicine PC
- CARR,Inc
- Copic
- Diabetic Equipment & Supplies
- Docs Who Care
- Dynavax
- Iowa Cancer Consortium
- Iowa Family Support Network/EveryStep
- Iowa Newborn Screening Program/ University of Iowa Children's Hospital
- Iowa Primary Care Association
- Iowa Research Network
- Oasis Health Partners
- Organon
- Pfizer,Inc
- Sanford Health Equipment
- Sanofi
- The Iowa Clinic
- UCS Healthcare
- UnityPoint Clinic
- University of Iowa Family and Community Medicine Clerkship

2024 IAFP Supporters

- Buena Vista Regional Medical Center
- Iowa Beef Industry Council
- McFarland Clinic
- Wellmark

Sarah Ledger, DO, FAAFP Installed As President of the Iowa Academy of Family Physicians

AAFP Vice Speaker, Dr. Daron Gersch installing Dr. Ledger as IAFP President

Dr. Sarah Ledger, DO, FAAFP, of Mount Pleasant, was officially installed as President of the Iowa Academy of Family Physicians during the installation and awards ceremony on November 7, 2024.

Dr. Ledger, a Fairfield, Iowa native, earned her undergraduate degree from Loras College before attending medical school at Des Moines University. She completed her residency at the Iowa Lutheran Family Medicine Residency Program in Des Moines and currently practices at Family Medicine of Mount Pleasant, PC, in Mount Pleasant, Iowa.

Dr. Ledger and her fellow family physicians undergo extensive training beyond medical school to deliver the highest quality patient care. This includes completing a three-year residency and comprehensive training that spans the entire human lifespan, from birth to end-of-life care. They are well-versed in numerous medical disciplines, including pediatrics, geriatrics, internal medicine, psychiatry, surgery, obstetrics, gynecology, and community medicine.

Dr. Ledger and her family following her installation

IAFP Past Presidents

Ernest Shaw, MD 1948-1949
C.D. Gibson, MD 1949-1950
C.V. Hamilton, MD 1950-1952
Joseph G. Fellows, MD 1952-1953
Paul F. Chesnut, MD 1953-1954
Frank D. McCarthy, MD 1954-1955
William D. Sproul, MD 1955-1956
Charles A. Nicoll, MD 1956-1957
Donald H. Kast, MD 1957-1958
Robert L. Knipfer, MD 1958-1959
Lewis J. Jacques, MD 1959-1960
Henning W. Mathiason, MD 1960-1961
Verne L. Schlaser, MD 1961-1962
Eugene L. Smith, MD 1962-1963
William A. Castles, MD 1963-1964
C.H. Stark, MD 1964-1965
Arnold T. Nielsen, MD 1965-1966
Raymond F. Frech, MD 1966-1967
Lee E. Rosebrook, MD 1967-1968
Howard E. Rudersdorf, MD 1968-1969
William A. Seidler, Jr., MD 1969-1970
Harold Moessner, MD 1970-1971
Charles W. Beckman, MD 1971-1972
Dennis J. Walter, MD 1972-1973
Charles R. Hawkins, MD 1973-1974
Frederic M. Ashler, MD 1974-1975
James H. Coddington, MD 1975-1976
Keith A. Garber, MD 1976-1977
Roger W. Boulden, MD 1977-1978
Leslie E. Weber, Jr., MD 1978-1979
Gene E. Michel, MD 1979-1980
Marvin R. Moles, MD 1980-1981
Robert A. Weyhrauch, MD 1981-1982
Mary Ann Arends, MD 1982-1983
Merlin U. Broers, MD 1983-1984
Wayne E. Rouse, MD 1984-1985
Milton J. VanGundy, MD 1985-1986
Charles E. Driscoll, MD 1986-1987
Robert Q. Christensen, MD 1987-1988
Larry H. Boeke, MD 1988-1989
James D. Kimball, MD 1989-1990
Donald A. Soll, MD 1990-1991
M. Gene Parks, MD 1991-1992
Harold E. Eklund, MD 1992-1993
Laine D. Dvorak, MD 1993-1994
A. Clinton MacKinney, MD 1994-1995
David A. Carlyle, MD 1995-1996
Thomas C. Evans, MD 1996-1997
John R. Carroll, MD 1997-1998
George T. Kappos, MD 1998-1999
Steven L. Wolfe, MD 1990-2000
Robert A. Lee, MD 2000-2001
Stephen D. Richards, DO 2001-2002
Gerard J. Stanley, MD 2002-2003
Larry D. Beaty, MD 2003-2004
David K. Larson, MD 2004-2005
Susan E. Langbehn, MD 2005-2006
Brian C. Mehlhaus, MD 2006-2007
Douglas W. Martin, MD 2007-2008
Don Klitgaard, MD 2008-2009
Amr S. Kamhawy, MD 2009-2010
Donald L. Skinner, MD 2010-2011
Jeffrey J. Hoffmann, DO 2011-2012
Robin Barnett, DO 2012-2013
Thomas B. Hoehns, MD 2013-2014
Dawn Schissel, MD 2014-2015
Noreen O'Shea,DO 2015-2016
Jenny Butler, MD 2016-2017
Scott Bohner, DO 2017-2018
James Bell, MD 2018-2019
Sherry Bulten, MD 2019-2020
Lonny Miller, MD 2020-2021
Laura Bowshier, MD 2021-2022
Corrine Ganske, MD 2022-2023
Kate Hanrahan, MD 2023-2024

Thomas Baer, MD Receives Iowa Family Physician of the Year Award

Dr. Thomas Baer with IAFP Board Chair, Dr. Corrine Ganske

Dr. Thomas Baer

Dr. Thomas Baer, a dedicated family physician from Malvern, has been honored as the 2024-2025 Iowa Family Physician of the Year by the Iowa Academy of Family Physicians. The award was presented during the installation and awards ceremony held on November 7 at Prairie Meadows Event Center.

The Iowa Family Physician of the Year award is presented to one outstanding physician in Iowa who best exemplifies the tradition of the family doctor and epitomizes the finest standards of family medicine.

Dr. Baer graduated from the University of Iowa College of Medicine in 1989 and completed his residency at the Lincoln Medical Education Foundation in Lincoln, Nebraska, in 1992. He currently serves the Malvern community.

One nomination letter praised Dr. Baer's deep commitment to his patients and his innovative approach to overcoming healthcare barriers: "Dr. Baer understands the challenges of accessing healthcare and will do whatever is necessary to address it. He noticed that some patients struggled to come in during the week, so he opened his clinic for two additional days each month to accommodate those who could not visit during regular hours. Dr. Baer's dedication extends beyond the clinic; he is an advocate for community involvement, recognizing that a strong community contributes significantly to the well-being of its members. Dr. Thomas Baer is not just a physician; he is an integral part of the Malvern community."

Congratulations Dr. Baer!

Congratulations to Our New Board Members

AAFP Vice Speaker, Dr. Daron Gersch installed the new IAFP Officers and Board of Directors at our Annual Awards and Installation Ceremony.

(Pictured from left to right)
At- Large Director, Tim Mcoy, DO, District 3 Director, Madeline Godar, MD, District 3 Director, Jenna Kemp, MD, Board Chair, Kate Hanrahan, MD, Vice President, Mara Groom, DO & President Elect, Jason Wilbur, MD.

Thank you for serving and congratulations on your new positions.

Norwalk Family Physician Receives Lifetime Achievement Award

Dr. Christopher White

Des Moines, IA – Dr. Christopher White was honored with the 2024 Lifetime Achievement Award by IAFP at their Annual Awards and Installation Ceremony on November 7.

Dr. White's journey in medicine began with his undergraduate studies at Drake University, followed by medical school at Loyola-Stritch School of Medicine in Maywood, IL. He completed his family medicine residency at Iowa Lutheran Hospital in Des Moines, graduating in 1987. He currently practices at Primary Health Care at Mercy in Des Moines.

The Lifetime Achievement Award is particularly distinguished as recipients are nominated by fellow members of the IAFP, with a committee of physician members selecting the honorees. The IAFP extends its gratitude to Dr. White for his outstanding service to his patients, his community, and the field of family medicine.

The IAFP would like to thank Dr. White for his significant contributions to his community, patients, and family medicine.

In Memory Of

THIS PAGE IS DEDICATED TO THE CHERISHED MEMORY OF OUR MEMBERS WHO HAVE RECENTLY PASSED. MAY THIS PAGE BE A REMINDER OF THE LOVE AND JOY THEY BROUGHT INTO THE WORLD, AND MAY IT OFFER COMFORT AS WE CARRY THEIR MEMORY WITH US ALWAYS.

PAUL BROWN, MD

DALE CHRISTENSEN, MD

DANIEL COLE, MD

WILLIS DANKLE, MD

JIM KIMBALL, MD

BILLY NORDYKE, MD

ALAN PATTERSON, MD

MARK TYLER, MD

JOHN ZIMMER, MD

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 2025
- 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 2025
- 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, 2025.

For further information contact Kelly Scallon at the IAFP Foundation office 515-244-4182 or via e-mail at kscallon@iaafp.org.

THE HEART OF THE FOUNDATION

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.

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.

THANK YOU TO ALL OF OUR 2024 DONORS!

WANT TO SEE YOUR NAME HERE? PLEASE DONATE BELOW!

Candyce Ackland, MD
Robin Barnett, DO
Larry Beaty, MD
Jennifer Bell, MD
Jim Bell, MD
Samantha Bissen, DO
Nicole Brokloff, MD
Jenny Butler, MD
Melanie Cleveland, MD
Patrick Courtney, MD
Shawn Dawson, MD
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Daron Gersch, MD
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Sarah Ledger, DO
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Robert Nathanson, MD
Donna Nelson, MD
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Francis Pisney, MD
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Larry Severidt, MD
Kelly Skelly, MD
Elizabeth Stoebe, DO
Sally Studer, DO
Jason Wilbur, MD
Heidi Van Maanen, DO
Mack Worthington, DO

To keep family medicine in Iowa strong, we are asking **all Iowa family physicians** to donate to the IAFP Foundation. ANY amount is appreciated! We are aiming for **100% participation**! Below are the different levels of donation.

IAFP Foundation Donation:

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

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

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

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

Make a donation online at *www.iaafp.org* or

- ❑ Pay by check _____

Name: _____

Address: _____

_____

MAIL THIS FORM AND PAYMENT TO: IAFP | 6500 UNIVERSITY AVE, SUITE 100, PMB 123 | WINDSOR HEIGHTS, IA 50324 | FAX (515) 244-4131

Concerned about an infant or toddler's development?

Do you know a family that needs support services?

Families, physicians and anyone who works with children, birth through age 5, can make referrals to the **Iowa Family Support Network**.

We can connect families to:

- **Early ACCESS for developmental concerns.**
- **Family support** *including in-home consultations and nurse visits.*
- **Parenting groups in their area.**
- **Community resources** *such as food, clothing, housing and more.*
- **Children at Home Program** – *Assistance for families who have a child under 22 in the home with a disability.*

IFSN is your ONE SOURCE for free screenings and referrals.

Iowa Family Support Network

Contact us today.
1(888) 425-4371

IAFamilySupportNetwork.org

Email: IAFamilySupportNetwork@everystep.org

Iowa Family Support Network (IFSN) is a collaboration between Maternal, Infant, and Early Childhood Home Visitation Program and Early ACCESS. *IFSN is operated by EveryStep.*