IOWA FAMILY PHYSICIAN

Vol. XLVII No. 3 / WINTER 2020-2021

MEET NEW IAFP PRESIDENT
LONNY MILLER, M.D.

INSIDE:

- Telehealth Tips that Benefit the Provider and Patient
- Factors Contributing to Health Care Disparity
- Meet Jeffrey Quinlan, M.D., Chair of University of Iowa Department of Family Medicine

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

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

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

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

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

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

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

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

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

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

Let's Stop HIV Together.

July 2020

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

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In this issue

President's Message 2

Editor's Desk 3

Student's Corner

Advocacy in Medical Education: A Learner's Perspective 4

Resident's Corner

COVID-19 and the Opportunity to Humanize Obesity 6

CRMEF Closing Update 8

Guest

Get to Know Jeffrey Quinlan, M.D. 10

Telehealth Tips that Benefit the Provider and Patient 12

Factors Contributing to Health Care Disparity 13

Physician Leadership in 2020 16

Office News

2020 Recap 18

Member Advocacy

2021 Legislative Priorities 20

2020 PrimCare PAC Contributors 21

Education

Physician Business Leadership Certificate Program 22

Members in the News

New Board of Director Members Named 24

Lonny Miller, M.D. Named President of the IAFP 25

New Members 26

Foundation News

Rural Medicine Scholarships Available 27

2020 Foundation Donors 28

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Greetings From Your 2020-2021 IAFP President

By Lonny Miller, M.D.

Delivering extraordinary care for our patients under normal circumstances can be a challenge. Throw in a global pandemic, and things become interesting. 2020 showed that one of the most valuable tools in the toolbox of a family physician is that of 'resilience.' Over the past many months, you've been asked to change your schedules, your work flow, and even your skill sets to match the ever changing needs of our patients and the health care system. No other specialty possesses this innate ability to adapt quite like family medicine. In our daily lives, many of us are seeing COVID-19 patients in our clinics and emergency rooms, attending to them in our hospitals, educating our patients on preventive measures as an extension of our public health roles, and providing mental health care to the survivors of COVID-19 and the loved ones of those who lost family members and friends to the pandemic. While many subspecialists are enthusiastically staying within their own lanes, it is family physicians who have stepped up, and asked our communities and healthcare systems, "How can we help?" The value of the comprehensive care we provide is becoming more apparent than ever before.

Another thing that 2020 taught me is how appreciated we are by those who matter. At times we may feel like cogs in a machine. Indeed, a perceived lack of appreciation is a leading factor in physician burnout. But this year has reminded me of how trusted and appreciated we are by our patients. When patients are afraid and confused by differing directives and opinions on COVID-19, they turn to those who they trust – us.

You all are a compassionate, resilient, and appreciated bunch of docs. It is an honor to serve you this year.

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Advocating for Iowans Means Vaccinating Iowans Against COVID

By Jason Wilbur, M.D.

Happy New Year, family doctors and allies of family medicine! Raise a glass with me and let's toast good-bye to 2020 and hello to 2021. I'm sure you are thinking what I'm thinking: 2021, please bring us an end to this pandemic.

One year ago, many of us hoped that the pandemic – if it came to Iowa at all – would be contained. So…that didn't happen, and almost one year after COVID was declared a pandemic, it is still the biggest health challenge we face this year. As we approach 5,000 Iowa deaths due to COVID, we also know that the effects of COVID are not limited to the individuals with the disease. COVID has disrupted economies, education, family lives, and so much more. For example, the pandemic seems to be accelerating drug overdose deaths, with sharp increases in opioid- and cocaine-related deaths in 2020. A survey conducted in June 2020 by the CDC found markedly increased rates of anxiety and depression in the U.S. population (2 to 3 times higher than the same period in 2019). Additionally, there are preliminary reports of increased suicide rates and non-COVID related mortality rates (possibly due to delayed seeking of care and/or lack of access due to overwhelmed health care facilities). COVID is hitting us everywhere.

With the emergence of several effective vaccines, there is light at the end of the tunnel, but we have a long, long way to go. Iowa is close to the bottom of U.S. states in terms of percentage of citizens vaccinated (48th) and percentage of allocated vaccines administered (30th). Unfortunately, we are also currently ranked near the bottom of the allocation list (46th in the U.S. for vaccines allocated per capita). Why is Iowa lagging?

Well, dear reader, this issue is supposed to be focused on advocacy, and I choose to focus on COVID vaccine access and distribution. There is simply no other way that we are going to get out of this pandemic. As a nation, we missed the opportunities for containment long ago. Our health care system is profit-centered and operates highly efficient systems that are not equipped to handle a pandemic. Our public health system is chronically underfunded, decentralized and antiquated. These systems will not end the pandemic: the only way out is with a vaccine. That is where our attention must be directed.

What can we do? Well, our voices can be powerful, especially when we speak as one. We are fortunate that the IAFP Executive Vice President, Pam Williams, has attended many IDPH COVID vaccine planning meetings. That's one point of contact. We also have a solid lobbying team (Cornerstone) that can help us carry our message to the Iowa State House. Hopefully, we all know our local state reps and senators; if you don't, then now is a good time to make that connection. Beyond these contacts, we can reach out to our U.S. Congressional Representatives, and make sure that they know the dire need that Iowa has. I would hope that Governor Reynolds and our U.S. Senators and Representatives know that Iowa is dwelling in the basement as far as COVID vaccine goes. If they don't, we need to educate them. If they do know, then we need to get them to prioritize vaccine allocation and distribution in Iowa.

Since this is an issue on advocacy, I want to leave you with some great resources for learning about advocacy. One major barrier to engaging in advocacy is taking that first step. Where do you start? The Society for Teachers of Family Medicine has a concise but informative, free online course that introduces key concepts and tools for advocacy. It can be found here: https://stfm.org/advocacycourse. Of course, the AAFP and the IAFP have loads of information that will help you get started as well. You can get started with the AAFP website (https://www.aafp.org/advocacy.html) or the IAFP (http://iaafp.org/advocacy/).

Finally, as always, please reach out to me with your comments, corrections and suggestions for our magazine. You can find me at jason-wilbur@uiowa.edu.

Advocacy in Medical Education: A Learner's Perspective

By Emily Ruba, MS2, University of Iowa Carver College of Medicine

"Hi, I need some help." The girl approached me; her voice lowered nearly to a whisper. She told me that she had some questions she hoped I could answer. I pulled her aside, sensing that whatever the situation, it would require discretion.

That Saturday morning, I was volunteering as the coordinator of a student-run free medical clinic held by the University of Iowa Mobile Clinic. The girl who had approached me introduced herself as a volunteer with the partner organization hosting our clinic, called Shelter House. She told me that a woman staying at Shelter House had approached her and asked about being tested for HIV, one of a number of services our clinic offered. The woman was, most understandably, scared. She had disclosed to the volunteer that she had been sexually assaulted the previous night. Given the circumstances of the assault, the woman was concerned that she may have been exposed to HIV or another sexually transmitted infection. She was also experiencing homelessness and did not currently have health insurance. Not sure who to turn to, and fearful of entering the clinic, she selected this young volunteer to be her advocate.

This difficult situation was made even more challenging by a number of factors that day. The first was lack of access to trained staff who could provide the necessary resources in this situation. The social worker usually accessible to residents of Shelter House was not available on the weekend. The volunteer who I'd spoken with had not been trained on how to help in these situations. Additionally, due to the COVID-19 pandemic, our Mobile Clinic volunteer staff was limited, so we did not have a healthcare provider that day who could speak to the patient. As a result, her care fell to me, a relatively untrained and unequipped medical student who lacked the knowledge to fully address her needs in a way that I felt she deserved.

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The second issue presented itself in my own knowledge gaps about the HIV screening test utilized by our clinic. My limited knowledge of screening tests led me to question the validity and reliability of such a test, especially when the potential exposure had occurred only one day prior. I wondered how this rapid, affordable version of HIV testing might compare to the same test performed in the cutting-edge University of Iowa lab that I toured as part of my medical school curriculum. The patient's lack of insurance and reliable transportation might create issues accessing a better diagnostic test. However, I questioned how I might reliably communicate the need for follow up to a patient who was not comfortable speaking to me directly.

I soon realized that if the patient were to test positive for HIV, the responsibility of counseling her as to what this meant would fall to me. So far, the patient had only communicated with me through another person, too distraught to enter the clinic herself. I was concerned about her emotional state and worried that this might create communication difficulties that could compromise possible follow up care.

That day, there were many things which I did not know. The volunteer had approached me with a couple of basic questions about how the test worked, but I walked away with more questions than answers. That day, I didn't know that HIV cannot be detected the day after it is transmitted, during what is known as the "window period" when viral loads are too low for tests to detect. I didn't know that rapid HIV screening tests have excellent (>99%) sensitivity and specificity, but only for chronic infections. I didn't know that forensic testing, pregnancy testing, and STI screening following a sexual assault are covered by the state of Iowa, making the patient's uninsured status irrelevant if she only went to an emergency room for treatment. What I did know was this: the patient's status as a homeless, uninsured woman living through an unprecedented pandemic did not warrant her receiving potentially substandard care and inadequate counselling about her options.

Ultimately, I decided not to administer the HIV test to the patient that day. Given the information I had at the time, I felt that I could not justify administering it to the woman without the confidence that I would be able to appropriately communicate her options to her should it come back positive. Instead, I began calling around to a number of community organizations to see if I could identify another place where she might be able to get the support she needed. I spoke to the Rape Victim Advocacy Program and learned that I could request an advocate to be sent to her location to counsel her about her options. From a counselor at the National Sexual Assault Hotline, I learned that she could present to an emergency room and to have the costs covered by the Iowa Sexual Abuse Examination Program. Together the volunteer and I worked to identify a bus trip that the woman could use to visit an emergency room later in the day and be evaluated, and the volunteer communicated this information to her.

"This difficult situation was made even more challenging by a number of factors that day. The first was lack of access to trained staff who could provide the necessary resources in this situation."

This situation challenged me both intellectually and emotionally. It required me to be resourceful and sensitive, and though I did the best that I could with the resources I had, I did not walk away feeling that I had found the optimal solution for the situation. However, this experience had a profound impact on me as both a learner and as a person. Because of my own knowledge gaps, I had the experience of connecting with advocates from local organizations that work with victims of sexual assault, and I now feel comfortable doing the same in the future should a similar situation arise, either through Mobile Clinic or otherwise. In this situation, problem-solving, collaboration, and self-reliance in the face of uncertainty were necessary tools in advocating for my patient, just as they are in any situation where we advocate for the well-being of others.

Practical opportunities for students to develop advocacy skills are a valuable but often voluntary part of medical education. However, these opportunities are crucial to shaping future healthcare providers who are equipped to understand the needs of their communities and to provide appropriately patient-centered care. Students are best empowered to help their communities when they are equipped with a pragmatic understanding of barriers to care and an appreciation for the judicious utilization of healthcare resources. I have been fortunate to have been introduced to these opportunities early in my education, and these experiences have undoubtedly deepened my commitment to the practice of medicine in low-resource settings. It is of vital importance that the Iowa medical community continue to promote the engagement of learners in such opportunities.

COVID-19 and the Opportunity to Humanize Obesity

By Ramy Salib, M.D., R3 / University of Iowa Health Care Family Medicine Residency Program

The COVID-19 pandemic has impacted our daily lives in so many ways. People everywhere are struggling with maintaining a healthy lifestyle. Because of stay-at-home orders and sudden unemployment, many have lost their regular routines. When we talk about lifestyle, in particular, activity and wellness, we face new obstacles. Gyms are closed, and in cases where they are open, it may not be safe for people to be at the gym. We have also lost a lot of our daily low-level activity. The subtle loss of this activity comes with repercussion – in big cities and urban areas, such as New York City, it is known that people tend to weigh less because they are often walking more. Today's snapshots of NYC and other big cities, which used to be crowded with people walking, are now virtually deserted. It is evident that the pandemic has produced significant health effects, well beyond the virus itself. Overall increases in unstructured time and inactivity, combined with the stressors of the pandemic, have led to concerns within the public about weight gain, sedentary behavior and overeating.

One of my patients said, "It's the quarantine 15," when speaking of his recent weight gain. I later learned his comment is a reference to an explosion of social media posts regarding the vulnerability of the community to gaining weight. A search of "quarantine 15" yielded more than 30,000 Instagram posts displaying indulgent foods. These social media posts may be undermining efforts to engage in healthy habits. The validity of these posts is real. Many in the community are stocking up on foods with a longer shelf life such as frozen and processed foods. On the other hand, fresh fruits and vegetables, which do not last long, have become less valuable in the eyes of the consumer.

For children and adolescents, online courses have become the new educational norm. After class and homework, children are often unable to go outside and play due to COVID restrictions. Furthermore, the winter season brings darkness and

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cold early in the day in many areas of the U.S. Overall, these new eating habits and lack of exercise can be very harmful, especially in children. As time progresses, these habits build a lifestyle that children may continue even after the end of this pandemic.

Due to the numerous challenges that the pandemic poses to our community, we must now work to establish new healthy routines. Even during this time of added pressure, individuals dealing with obesity or weight gain should continue to seek support and medical treatment when needed. Now more than ever, it is important for people to take charge of their health, and healthcare providers need to advocate for patients in support of these efforts.

I feel that It is our job as physicians to "flood the region" with positive messages encouraging self-care. I have shifted a considerable amount of my patient counseling away from being solely weight-focused to stressing the importance of good health and general well-being. Even in the midst of the pandemic, patients have been more receptive to the value of optimizing their health to align with their personal goals. As family physicians, we can speak with our patients and community about how stigmatizing messages, such as social media posts, can affect them and their health, and how we can help support them and their goals. For the same reason, physicians must also realize that many individuals cannot focus on their weight right now due to increased work demands (including ourselves as essential workers), hardships, and concerns for safety and even survival. Furthermore, as people react differently to stress, many face increasing levels of fear, anxiety and depression. Our care of patients must employ individualized approaches to care. When patients report weight gain, we can offer support and communicate acceptance without judgment. We should validate the unprecedented stressors that everyone is facing, while still helping our patients achieve their goals.

All habits take time to establish. Everyone is acclimating to this new normal. I encourage people to establish new healthy habits now by being proactive and breaking out of their comfort zone. Instead of giving in to those comfort foods, we should plan ahead for meals rather than picking up a meal at the last minute. This time has created an opportunity to raise our culinary skills (myself included) and do more cooking at home. Eating nutritious foods and assuming healthy lifestyles should be an enjoyable and happy way to live. By doing this together, we can manage our health and weight during this pandemic and beyond.

"For children and adolescents, online courses have become the new educational norm. After class and homework, children are often unable to go outside and play due to COVID restrictions. Furthermore, the winter season brings darkness and cold early in the day in many areas of the U.S. Overall, these new eating habits and lack of exercise can be very harmful, especially in children."

"Knowing is not enough, we must apply. Willing is not enough, we must do." - Johann Von Goethe.

As a final thought, I want to express my gratitude to my fellow healthcare workers at University of Iowa Health Care and around the globe for constantly pouring themselves into their craft. My co-workers have shown great resilience day in and day out during this pandemic and they continue to do so. Despite daily exposure to the virus, worrying about getting a loved one at home sick, emotional stress, and long hours of duty, they have shown up strongly and answered the call. Their courage and selflessness has been inspirational and has reminded me of the reasons I picked up that first medical school application form. Thank you for your relentless dedication to humanity.

CRMEF Closing Update

Last January the news came out that the Cedar Rapids Medical Education Foundation would be closing at the end of the academic year. Through the generosity of our members, the Mercy and St. Luke's Medical Staff, St. Luke's Hospital, Mercy Medical Center in Cedar Rapids, and the IAFP Board of Directors we were able to contribute $5713.00 to each of the displaced residents. Many of our members have asked how these residents are doing. Here is a spotlight on a few of the residents that were impacted.

Callie Pittard, DO

I have been forever grateful for what IAFP did for the residents who were displaced. The contribution absolutely saved us because the program closing down was something we were obviously not expecting. I ended up at The University of Tennessee at Chattanooga and my partner and I had no idea how we were going to afford moving across the country in the middle of the pandemic. Also, my partner was not able to find a job right away so we were able to use the contribution to cover all our moving expenses and our new rent while he found a job.

As far as being in a new program, it was a tough adjustment, especially moving into 3rd and final year of residency but it has allowed me to become more resilient. I was also asked to be Chief Resident of the new program and have accepted a fellowship next year in Surgical Obstetrics. The fellowship is right here in Chattanooga, TN so it worked out perfectly.

Fellipe Lima, MD

During my orientation in my intern year, I was told that the symbol of the American Board of Family Medicine is a Phoenix to symbolize the ability of Family Physicians to re-invent themselves, the constant renewal of the specialty in face of changes and of its broad scope.

When I was told that my program was going to close, my mind was flooded with a series of questions: What will happen to my family, where are we going? Couples matching as medical students was a struggle in itself, but to now find a program willing to take 2 interns as second-years seemed like an even greater challenge.

Then, there were more "mundane" questions: What are we going to do with the apartment we had bought, with plans of staying in the corridor for at least three years? If we have to move to another state, how are we going to afford this on our intern salaries, that were funding a family of three...

All of that to say, thanks to the support (in placement and financial) of the Iowa Academy of Family Physicians I was able to not only withstand this change, but to thrive in it. I am enjoying the experience at the MercyOne Des Moines Family Medicine residency -- the relocation to a major urban center, the opportunity to engage with a different community and with a large population of Hispanic Immigrants, learning more about Point-of-Care Ultrasound.

I have nothing but gratitude to this amazing family of Family Physicians that have done so much for me and my own family - and helped me transform a setback in a force for change.

Thank you for all you have done!

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Get to Know Jeffrey Quinlan, M.D., Chair of University of Iowa Department of Family Medicine

Dr. Jeffrey Quinlan took over the role of the Chair of the University of Iowa Department of Family Medicine last year. Dr. Quinlan previously served as professor and chair of the Department of Family Medicine in the F. Edward Hébert School of Medicine at the Uniformed Services University of the Health Sciences in Bethesda, Maryland. We had the chance to ask him a few questions and are excited to introduce him to you. Welcome to Iowa Dr. Quinlan.

Tell us a little bit about your background.

I was born and raised in Pennsylvania with my three siblings (2 sisters and a brother). My father was a narcotics agent and my mother stayed home to raise the kids. I was the first in my family to go to college. I went to the University of Pittsburgh for both undergraduate and medical school. When it came time to look at medical schools, I didn't have a good way to pay for it and in exploring options discovered the military scholarship. I applied to and was blessed to have been offered a Navy scholarship which covered the cost of my education. I planned to pay back my 4 year commitment and then head back to Pennsylvania but 4 years turned into 28.

I've been stationed in Charleston, SC, Camp Pendleton, CA, Sigonella, Italy, Orlando, FL, Jacksonville, FL, and Uniformed Services University (USU) in Bethesda, MD. I was at USU serving as Chair of Family Medicine when I retired.

I am married to Sarah Jorgensen, who is also a Family Physician and I have 4 children – Joseph (26), Hannah (24), Lily (10), and Luke (7).

What brought you to the University of Iowa?

I have really enjoyed both undergraduate and graduate medical education during my career in the Navy, and I appreciate the challenges associated with be the Chair of Family Medicine. As I began to think about life after the Navy, I knew I wanted to incorporate all three into my next adventure. My wife is from Dubuque and we also knew we wanted to get closer to them. Last fall the opportunity to interview at the University of Iowa came up and I jumped on it. After my first interview, I knew I would accept the position if it were offered – it combined what I was looking for in my career, Iowa City seemed like a great place to live, and it had a lot to offer my family.

What do you think is the biggest hurdle facing family medicine as a discipline today?

This is a really difficult question because I think there are a few hurdles which are important. If pressed, I think I would have to say recruitment of the next generation of family physicians. The United States is already facing a primary care shortage and that is only going to worsen over the next decade or more. With the options available to today's medical students combined with the average medical school debt there are a lot of attractive options that don't include primary care, and family medicine specifically.

What have your years in the military taught you?

I've learned a lot of lessons from the military. Some of the most important are the value of team work and a sense of an aligned mission; the importance of frequent, transparent, and effective communication; the effectiveness of servant leadership; and the true sacrifice that our warfighters and their families often make for our country voluntarily – it continues to amaze me to this day what these men and women are willing to do to ensure our freedom.

We understand that this will be your first job as a civilian physician and leader. What unique challenges are you preparing for in that role?

Probably the biggest challenge for me in both roles will be to learn to navigate the financial environment associated with civilian medicine and an academic department of family medicine. In the military we have one payer (the American taxpayer) and a fixed budget to work from – that is obviously very different from life at the University of Iowa.

Many people think of Iowa as a mostly rural, mostly white state. However, Iowa has numerous minority communities that are underrepresented in medicine and at high risk for health disparities. What can family physicians do in Iowa to help bridge these gaps?

This is a great question and I'm glad you asked it. My answer focuses on charity. Even though we are one of the lower paid medical specialties, most of us still are incredibly secure and could give up a small amount of our income and time to help those less fortunate than ourselves.

I will be challenging my department to expand on the charity that we are currently providing through outreach

to these communities in our local area. This will include exploring ways that we can meet the underserved populations where they are and can better provide the medical care that they need and deserve. I would encourage family physicians throughout Iowa to do the same. At the same time, we will explore ways that we can work with private and public payers, as well as charities, for them to increase their charity in the same ways.

What do you think the lasting impact of COVID-19 will be on family medicine practices?

This is another tough question. I am hopeful that there is some good that comes out of it. One example would be more flexibility in what a "visit" means and how and where we can provide one. Increased flexibility to provide telehealth and asynchronous care (that is reimbursable) could decrease some of the burden family physicians face today while increasing revenue.

How can we best address the rural healthcare shortage in Iowa?

This starts with who we are recruiting into our medical schools. We need to seek more students who come from rural areas to start with as we know they are more likely to return to rural areas. Then we need to recruit more students into primary care, and family medicine in particular. I think this starts with providing clerkships and other opportunities for students to see the potential of a rural practice and ultimately ends with substantive changes to reimbursement and student loan repayment. I think we need to also continue to partner with advanced practice providers (nurse practitioners and physician's assistants) who may be interested in practicing in those areas. Finally, I've been involved in a project to train military enlisted medical providers (paramedic equivalents) to act as physician extenders utilizing a combination of an electronic decision support tool and immediate physician access through telemedicine. Ultimately, this could greatly expand an individual physician's reach well beyond their own community.

Carver College of Medicine graduates have been entering family medicine in lower numbers over the past few years. How can we get more students into family medicine?

I think some of my answer above addresses this question. It starts with who we recruit as students. We then need to continue to get family physicians in front of them through all stages of their training so that they can better appreciate what we bring to the table. It ends with lower medical school debt and improved reimbursement that makes a career in family medicine seem less daunting financially.

What are you looking forward to experiencing in Iowa?

In general, we are looking forward a little bit slower pace of life than we had in the DC area. I gave up commuting two hours a day to come here and I plan to take full advantage of that. It will allow me to spend more time at work when I need to without impacting my family and when work isn't calling it will allow me to spend more time with them. We are excited about all of the outdoor activities that Iowa has to offer. We're also looking forward to participating in our local community and finding ways to make a difference outside of work.

How do you plan to interact with the Medical Community in Iowa, especially family physicians around the state?

I'm looking forward to being an active member of the Iowa Medical Society and the Iowa Academy of Family Physicians. I know we will continue to offer our annual refresher through the department, and I look forward to exploring other opportunities for us to support our colleagues throughout the state. I'm open to phone calls, emails, or visits to discuss ways that we might do that in a meaningful way.

What is your vision for expanding and promoting family medicine training in Iowa, both in undergraduate and graduate medical education?

First, I'd like to get our department out to undergraduate pre-medical meetings throughout the state. I think it is important to introduce students at this level to the field of family medicine. In my experience, a lot of students considering medical school don't really understand our specialty.

Moving into undergraduate medical education, we have a strong Family Medicine Interest Group at the University of Iowa already, but I plan on exploring ways that we can make it even stronger. This will involve meeting with student leadership to understand what the important issues are for them and how we can better meet their needs. We will also continue to explore ways that we can get more of our students' exposure to the incredible family physicians throughout the state with the hopes that they get motivated for our specialty. Additionally, I plan on looking at ways that we can engage with Des Moines University to work collaboratively towards this goal.

As far as graduate medical education is concerned, it was disappointing to hear that the Cedar Rapids residency program closed. I do think that there is still a great opportunity for training in that city and I would like to explore a way to ultimately bring family medicine training back to Cedar Rapids. I'd also like to explore additional ways for all the programs in the state to increase their existing collaboration. Finally, we plan on exploring several new fellowships at the University of Iowa that may appeal to medical students and residents including operative maternity care and a hospitalist fellowship.

Telehealth Tips that Benefit the Provider and Patient

By Kelly Skelly, MD, Clinical Associate Professor, Department of Family Medicine, University of Iowa Hospitals and Clinics
Marcy E. Rosenbaum, PhD, Professor of Family Medicine, University of Iowa Carver College of Medicine

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With the onset of an unprecedented pandemic, health care providers are increasingly asked to provide high-quality health care through video and phone calls to treat a variety of medical conditions and illnesses in their pediatric patients, not just those with COVID-19 concerns. Available research confirms that patients are accepting of telehealth visits.[1] Telehealth visits can and do effectively include pediatric patients with their parents.

In this brief article, the focus is on how to make communication during a telehealth visit the most effective using several evidence-based communication strategies.

Pre-visit preparation

Regarding scheduling telehealth visits, evidence suggests that the best telehealth visits are with a provider known to the patient/family.[2] When possible, consider the age of the pediatric patient to schedule the most effective visit time, to avoid naps or other age specific behaviors. Before initiating the call, it is helpful to make certain the area is free from background noise, and the provider is relatively comfortable with minimal distractions (real or virtual). For video visits, making sure the provider's face is well lit with no back lighting allows the patient to clearly see the provider.

Beginning the visit

Smiling and using a pleasant tone of voice when beginning the call conveys to the patient a welcoming attitude from the provider.[3] Opening the visit with an introduction and explanation of the provider's role is helpful. It is important to confirm that the time is correct, the patient has privacy, and the interaction is confidential. During pediatric visits, communicating directly with the child as well as the parent is important. Acknowledging that technology can be an issue is helpful so that the parent or patient knows what to do if they are cut off or things do not work as planned. Encouraging the patient and parent to ask questions if they are unable to hear or see is also helpful. It may be appropriate to overtly state the purpose of the visit and review its expected duration. Similar to in-person patient encounters, taking a minute at the beginning to establish rapport with the patient about a nonmedical topic allows a personal connection to set a caring tone for the visit. Additionally, having an age-appropriate prop, such as a book or stuffed animal during a video visit, can set a kid-friendly atmosphere.

During the visit

Throughout the visit, it is important to use positive nonverbal communication through a warm tone of voice. Also, looking at the camera rather than the person's face on the screen during a video visit can help put the patient at ease. It is useful for the provider to acknowledge when looking at or typing in the Electronic Health Record (EHR), so patients do not feel the provider is distracted by working on other tasks. In addition, because it is difficult to notice nonverbal expressions of emotion and empathy over the phone or video, it is important that the provider is very explicit in recognizing and responding to emotional cues from the patient when they express concerns, hesitate, or sigh, indicating emotional distress. Responding to these cues with verbal empathy and statements like, "That sounds really difficult," can make the patient feel more heard and supported.[3,4,6,7] Summarization, and using animated nonverbal acknowledgments (nodding) during a video visit, also demonstrates to the patient the provider is listening.

During the sharing information and patient education part of the visit, there are real opportunities to improve patient outcomes with effective communication. Beginning information sharing by assessing the patient/ parent starting point, "What do you know about strep throat?" can identify concerns and knowledge base early, and help save time depending on the patient/parent level of understanding. To aid in patient comprehension, it is important to speak slowly and clearly and avoid jargon where possible. In telehealth visits in particular, it can be helpful to minimize information density by shortening the amount of information into small chunks that the patient can easily take in and understand, followed by pauses to check patient understanding and make room for patient or parent questions.[3,4,6,7]

Ending the visit

Closure of the visit is most successful if communication is clear with several simple steps. Orienting the patient to the end of the telehealth encounter is important by summarizing what has been discussed or planned. Utilizing teach back to assess the patient's understanding with a question like, "To make certain I made sense, what changes will you make to your medication?" is really effective in identifying misinformation

and increasing patient adherence.[3,6,7] At the end of each visit, clarifying next steps regarding follow-up and future communication is the final thing patients really value.

References

1. Gardner MR, Jenkins SM, O'Neil DA, Wood DL, Spurrier BR, Pruthi S. Perceptions of video-based appointments from the patient's home: a patient survey. Telemed J E Health. 2015;21(4):281-285.
2. McGrail KM, Ahuja MA, Leaver CA. Virtual Visits and PatientCentered Care: Results of a Patient Survey and Observational Study. J Med Internet Res. 2017;19(5):e177-e177.
3. Martinez E, Sattler A, Sherman M, Wootten M. Communication tips for physician phone visits during COVID-19. Family Practice Management. https://www.aafp.org/journals/fpm/blogs/inpractice/entry/telephone_visit_tips_2.html
4. Schrager S. Managing a telephone encounter: five tips for effective communication. Family Practice Management. https://www.aafp.org/journals/fpm/blogs/inpractice/entry/telephone_visit_tips.html
5. Powell RE, Henstenburg JM, Cooper G, Hollander JE, Rising KL. Patient Perceptions of Telehealth Primary Care Video Visits. Annals of Family Medicine. 2017;15(3):225-229.
6. Academy of Communication in Healthcare. COVID-19 Quick-Tips To Connect. Accessed April 25, 2020. https://www.achonline.org/Portals/36/COVID-19%20Resources/Covid-19%20telemedicine%20FINAL4_2_20.pdf
7. Saba GW, Chou CL, Satterfield J, et al. Teaching patient-centered communication skills: a telephone follow-up curriculum for medical students. Med Educ Online. 2014;19:22522-22522

Factors Contributing to Health Care Disparity

By Emad Abou-Arab, MD, Clinical Assistant Professor, Department of Family Medicine, University of Iowa Hospitals

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In Iowa, as in the rest of the country, COVID-19 continues to disproportionally affect minority communities. Hispanics and Blacks make up close to 10% of the population in Iowa, but 25% percent of COVID-19 cases.[1] Iowa has a small but growing community of immigrants. As of 2018, 6% of Iowa residents are foreign born and about 8% speak a language at home other than English.[2] Five percent of native-born Iowans have at least one immigrant parent. Although the nonwhite population in Iowa is close to 10%, 30% of Medicaid patients in Iowa are nonwhite.[3] Social determinants of health such as sociocultural factors, ethnicity, race, and limited English proficiency (LEP) have an essential role in patient care. Many other factors, including health systems, provider bias, and the patient, may contribute to racial and ethnic disparities in health care.[4] The ability to communicate effectively is increasingly important to provide quality health care to patients from diverse cultural backgrounds.

ASKED is a mnemonic useful for health care providers to consider prior to seeing patients of diverse cultures.[5] The following questions can help providers reflect on their ability to treat patients in the most objective way possible.

A	Awareness	Am I aware of my personal biases and prejudices toward cultural groups different than mine?
S	Skill	Do I have the skill to conduct a cultural assessment in a culturally sensitive manner?
K	Knowledge	Do I have knowledge of the client's worldview and the field of biocultural ecology?
E	Encounters	How many encounters have I had with patients from diverse cultural backgrounds?
D	Desire	Do I really "want to" be culturally competent?

Health care providers interact with their patients differently, but must be aware of certain principles that can affect their ability to interact with patients in a culturally liberated manner.[6]

1. **Explicit racism:** Overt and often intentional, practiced by individuals who openly embrace racial discrimination and hold prejudice toward racially defined groups.
2. **Implicit racism:** This is not the opposite of explicit racism. It refers to a provider's utilization of unconscious biases when making judgements about people from different racial and ethnic groups, e.g., microaggression.
3. **Cultural ignorance:** A health care provider who has little or no prior exposure to the specific cultural group and may experience fear or a lack of understanding due to their inability to relate to the patient.

(continued on page 14)

(continued from page 13)

4. **Colorblindness:** A health care provider who denies the reality of cultural differences that are important for effective interactions. They have made the decision that they are committed to equality for all and treat all people alike, regardless of cultural background.

5. **Culturally liberated:** A provider who does not fear cultural differences and is aware of his or her attitude toward specific groups. The provider encourages the patient to express feelings about ethnicity and then uses these feelings as a shared experience.

Providers should learn a set of key concepts and skills that enhance the ability to communicate with, diagnose, and treat patients with diverse, sociocultural backgrounds. There are six core, cross-cultural issues, which are discussed below. They are: (1) styles of communication; (2) mistrust and prejudice; (3) autonomy, authority, and family dynamics; (4) the role of the provider and biomedicine; (5) traditions, customs, and spirituality; and (6) sexual and gender issues.[6] In addition, the mnemonic ETHNIC is a framework for culturally competent clinical practice.[7,8] *(see page 15)*

1. **Styles of communication:** How patients communicate matters. Issues related to communication include eye contact, physical contact, and personal space. How patients prefer to hear "bad news." Is the patient stoic or displays symptoms freely?

2. **Mistrust and prejudice:** Many patients mistrust the health care system. Providers must recognize prejudice and its effects and attempt to build trust by reassuring the patient of their intentions. Show respect for the patient's concerns and keep in perspective the patient's best interests.

3. **Autonomy, authority, and family dynamics:** How does the patient make decisions and what is the role of the family? Who makes the decisions, the patient or the family? Often there is an authority figure within the family or community. What role do spiritual leaders play in making important decisions?

4. **The role of the provider and biomedicine:** What are the patient's expectations of the clinician and traditional medicine? Does the patient have differing views on alternative medicine versus biomedicine?

5. **Traditions, customs, and spirituality:** How do traditions and spirituality influence the patient? What are the patient's views and attitudes toward medical procedures, such as drawing blood? Are there culturally specific therapies that the patient prefers or practices, such as diet?

6. **Sexual and gender issues:** Regarding the physical exam, does the patient prefer a male or female provider? Office staff should check with the patient when scheduling the appointment. Clinicians should use preferred pronouns for patients who are transgender. They must also consider the issue of shame or embarrassment when discussing sexual issues. Understand the differences in sexual behavior, orientation, and identity.

Another important aspect of cross-cultural communication is the proper use of interpreters when seeing patients with LEP. When a patient has LEP and the provider doesn't speak the same language, the provider must use a competent health care interpreter. Interpreters need to be used when any part of the patient's care is funded by a federal program (e.g., Medicaid). Most importantly, interpreters must be used when the quality of care will be affected if there is any misunderstanding. Research has shown that untrained interpreters or family and friends result in about 50% of miscommunication and is a significant source of medical errors. The clinician is ultimately responsible for effective communication.

Tips for successful interpretations:[7]

- Do not depend on relatives, friends, or children to interpret.
- Ensure the interpreter is appropriate for the encounter.
- Always address the patient, not the interpreter.
- Focus on the patient during interpretation. Observe their body language and cues.
- Speak in a normal voice, clearly, and not too fast.
- Avoid medical jargon and technical terms.
- Keep statements short, one question at a time, allowing for interpretation.
- Be prepared to repeat statements or questions.
- Have the interpreter ask the patient to repeat important instructions or details.
- Instruct the interpreter not to add or omit information, especially not to offer advice.

Multiple factors contribute to racial/ethnic disparities in health care, including barriers to effective clinicianpatient interactions (e.g., language and different cultural beliefs), system barriers (lack of interpreter services or ethnically diverse clinicians), and clinician biases. Effective and patient-centered cross-cultural communication is a means of improving quality, achieving equity, and eliminating the significant racial/ ethnic disparities in health care that persist today.

NOTE: CultureVisionTM is a user-friendly database that gives health care professionals access to culturally competent patient care. Visit: https://www.crculturevision.com/

References

1. The COVID Racial Data Tracker. Retrieved from https://covidtracking.com/race
2. https://www.americanimmigrationcouncil.org/research/immigrants-in-iowa
3. Distribution of elderly and non-elderly with Medicaid by Race/Ethnicity. Retrieved here.
4. Green AR, Carney DR, Pallin DJ, et al. Implicit bias among physicians and its prediction of thrombolysis decisions for black and white patients. J Gen Intern Med 2007; 22:1231.
5. Campinha-Bacote J. The process of cultural competence in the delivery of health care services: A culturally competent model of care. Journal of Transcultural Nursing. 2003;13(3), 181-184.
6. Bell P, Evans J. (1981). Counseling the Black client: Alcohol use and abuse in Black America. Minneapolis, MN: Hazelsen Foundation.
7. U.S. Department of Health and Human Services, Health Resources and Services Administration. Transforming the Face of Health Professions Through Cultural and Linguistic Competence Education: The Role of the HRSA Centers of Excellence.
8. Levin SJ, Like RC, Gottlieb JE. ETHNIC: A Framework for Culturally Competent Clinical Practice. In Appendix: Useful Clinical Interviewing Mnemonics. Patient Care. 2000;34(9): 188-189.

ETHNIC: A mnemonic framework for culturally competent clinical practice

E	Explanation	• What do you think may be the reason you have these symptoms? • What do friends, family, others say about these symptoms? • Do you know anyone else who has had or who has this kind of problem? • Have you heard about/read/seen it on TV/radio/newspaper? (If the patient cannot offer explanation, ask what most concerns them about their problem.)
T	Treatment	• What kinds of medicines, home remedies, or other treatments have you tried for this illness? • Is there anything you eat, drink, or do (or avoid) on a regular basis to stay healthy? • What kind of treatment are you seeking from me?
H	Healers	• Have you sought any advice from alternative/folk healers, friends, or other people (nondoctors) for help with your problem? Tell me about it.
N	Negotiate	• Negotiate options that will be mutually acceptable to you and your patient and that do not contradict, but rather incorporate your patient's beliefs. • Ask what are the most important results your patient hopes to achieve from this intervention.
I	Intervention	• Determine an intervention with your patient. May include incorporation of alternative treatments, spirituality, and healers, as well as other cultural practices (e.g., foods eaten or avoided in general, and also when sick).
C	Collaboration	• Collaborate with the patient, family members, other health care team members, healers, and community resources.

Levin SJ, Like RC, Gottlieb JE. ETHNIC: A framework for culturally competent clinical practice. In Appendix: Useful clinical interviewing mnemonics. Patient Care. 2000;34(9):188-189.

EMBARC's COVID-19 Crisis Response Hotlines

Hours: Monday to Friday, 9 a.m. to 5 p.m. Please leave a message if the line is busy, or after 5 p.m.

Burmese: 515-207-9442
Chin dialects: 515-216-0974
French: 515-216-0654
Karen: 515-216-0143
Karenni: 515-216-0712
Kirundi: 515-207-9614
Kunama: 515-216-0745
Lingala: 515-216-4329
Spanish: 515-344-3936
Swahili: 515-216-0611
Tigrinya: 515-207-0127

Weekly News in the above languages at: https://sites.google.com/embarciowa.org/embarc-crisis-response/home

COVID-19 Language Resources

For links to the following web sites, view the EPSDT newsletter online at: iowaepsdt.org/other-resources/epsdt-newsletter

- American Sign Language Videos-CDC
- Centers for Disease Control and Prevention - Resources for Limited English Proficient Populations
- Congolese Health Partnership Videos
- COVID-19 in Iowa
- Crescent Community Health Center - Marshallese Language
- EMBARC (Ethnic Minorities of Burma and Advocacy and Resource Center)
- Hawaii Office of Language Access
- Iowa Department of Human Rights – Language Access
- Iowa Department of Public Health
- Iowa Spanish Helpline (515-344-3936)
- Refugee Alliance of Central Iowa and partners Multilingual Hotline (877-558-2609)
- Test Iowa – Free COVID-19 Testing (Spanish available)
- Switchboard – technical assistance site for refugee health and translated health materials.

Physician Leadership in 2020

By Sarah Ledger, DO

I was honored to accept a scholarship from the Iowa Academy of Family Physicians to attend the 2020 Physician Business Leadership Certification Program. In medical school, we are not given a playbook on leadership (let alone, leading during a pandemic). We study and study, then study some more, along with completing a grinding residency process to culminate in being a master of the healing arts. But our learning doesn't stop there; it is truly lifelong. *"For what is a master, but a master student?" - Neil Peart.*

I had the training to be a competent physician and the tools to continue learning medicine. I needed more education on leadership as well. During the 4 sessions of the program, we were able to gain tools to help us navigate as leaders through today's medical chaos (aka the year 2020). We also became more proficient on Zoom since most of our sessions were virtual.

To be a physician is to lead. Being a physician leader has been especially important over the past 10 months as we have battled this major pandemic. *"Crisis does not build character, it reveals it." -James Lane Allen*. We have been faced with many challenges – medically, emotionally, economically, and societally. It is difficult to convince one person to make a change in their lifestyle; it's a whole other ballgame to change the lifestyle of society.

"A leader is one who knows the way, goes the way, and shows the way." - John C Maxwell. A leader must step up, make that change, and hold themselves accountable. It can be difficult to lead by example. This is something that my family struggled with at first. My kids questioned why they didn't get to take part in a group activity, why they had to wear masks when no one else did at first, and why they couldn't have their friends over. My husband (also medical) and I had to help them understand the value of these changes for themselves and others using positive communication. This was something that we discussed in the "Coaching Colleagues" session of the program. They became leaders themselves, showing others the way. *"Leaders don't create followers; they create more leaders." - Tom Peters.*

When I became aware that Pfizer was conducting a study for a new COVID 19 vaccine in my area, I was immediately intrigued. Based on my research and medical knowledge, I felt that it was safe and honestly, our only option to get out of this pandemic. *"The saddest aspect of life right now is that science gathers knowledge faster than society gathers wisdom." -Isaac Asimov*. I enrolled and was selected. I certainly understood why most people wouldn't feel comfortable volunteering. I had no expectation for others to do the same. But doing this made me feel amazing. It made me feel part of the long-term solution. When people would ask me why I would take such a risk, I would reply that it's a way for me to help on a broader scale. I was just one person and I was already doing what I could to protect my local community. This was a way for me to go beyond that. This was a way for me to lead by serving mankind. *"Leadership and learning are indispensable to each other." -JFK*

Part of growing as a leader is realizing when you have to take a step back and work on managing yourself. My stress level was rising. I was putting in more time at work and spent more energy educating the public, but the virus continued to spread. Each day presented new hurdles. I struggled to understand the lack of trust and respect some people had towards our scientific and medical leaders. With this lack of trust comes increased resistance to change. It was sucking up my energy. Where did this lack of trust come from? Surely, this wasn't sparked by our political leaders. Or was it? Non-medical political leaders were making claims that the research did not support. *"And if the blind lead the blind, both shall fall into the ditch." -The Holy Bible.* Politicians were accusing healthcare workers of falsifying records to make more money! I felt devalued and defeated. It's against our medical ethics oath and frankly, what healthcare worker has time to deal with something like that amid fighting off a crisis? And then I remembered, *"Only the guy who isn't rowing has time to rock the boat" -Jean-Paul Sartre*. So, I stepped back and kept rowing. We must continue to educate our local community one person at a time. *"For I alone cannot change the world, but I can cast a stone across the waters to create many ripples." -Mother Theresa*. Physicians will continue to lead. Physicians will continue to educate and help others in our communities. Physicians will be good role models and stand up for what is right, even if it is hard. *"Be the change that you wish to see in the world." -Mahatma Gandhi*

Sanford Worthington invests $3M into local cancer care

Cancer patients can now get the most precise radiation treatment close to home thanks to the installation of a new, $3.4 million TrueBeam linear accelerator.

"At Sanford Health, we are committed to delivering the highest quality cancer care and health care to patients in Worthington and our surrounding communities," said Jennifer Weg, executive director of Sanford Worthington Medical Center. "With a new linear accelerator right here in Worthington, we are bringing new radiation treatment options close to home."

Linear accelerator in cancer treatment

So what is a linear accelerator? Well, it is a state-of-the-art device programmed to deliver high-energy X-rays that conform to the specific size, shape and location of a tumor. It will give providers the ability to target and destroy cancerous cells in a precise area of the body, with minimal exposure to surrounding healthy tissue.

"What this means for patients is accuracy, speed and comfort," said Sanford Health's Amber Frisch, supervisor of radiation therapy in Worthington. "What it means for the radiation oncology professionals is the ability to treat many different types of complex cancer cases."

The TrueBeam radiotherapy system can treat tumors in places that can be hard to reach or that are near critical organs, such as the heart and lungs. In addition, the accuracy of treatment permits higher radiation doses while reducing the risk of exposure to healthy tissue.

By having the capacity to deliver higher dosages of radiation, patients can heal in fewer sessions. A tumor that might need 20 to 40 sessions of conventional radiation therapy can be reduced to less than five, for instance. These shorter sessions also lower the risk of side effects in patients due to less sessions and less long-term exposure to radiation.

"It integrates advanced imaging and motion management technologies that makes it possible to deliver treatments more quickly, while monitoring and compensating for tumor motion," Frisch said. "Before and at any point during a treatment, the linear accelerator can generate the 3D images used to fine-tune tumor targeting – something that wasn't possible with earlier technologies."

Better tumor targeting technology

The TrueBeam system will improve on cancer treatment in many ways including:

- **Improved precision:** The accuracy of the TrueBeam system is measured in increments of less than a millimeter.
- **Shorter radiation sessions:** Some treatments that once took 10 to 30 minutes can now be completed in half the amount of time. Faster treatment delivery is not only more comfortable for patients, but reduces the chance of tumor motion during treatment, which helps protect nearby healthy tissue and critical organs.
- **Advanced imaging:** The new imaging technology quickly produces 3D images in real time for more precise tumor targeting.
- **Motion tracking:** For lung and other tumors subject to respiratory motion, the TrueBeam system offers gating, which makes it possible to monitor the patient's breathing and compensate for movement of the tumor while radiation is being delivered.

SANFORD
CANCER CENTER

2020 Recap

By Pam Williams, Executive Vice President

I was full of anticipation for 2020 and was looking forward to an exciting year. I had no idea just how strange and exciting it would be. We were hit with very disturbing news in late January with the announcement of the closing of the Cedar Rapids Family Medicine Residency Program. The Board kicked into high gear and reached out to the Cedar Rapids program director and faculty and realized the situation could not be altered. Board Chair Jim Bell wrote a letter to the editor of the Cedar Rapids paper that was published, and IAFP Foundation President Dawn Schissel reached out to the Foundation Board of Trustees who quickly put together a fundraiser that proved the generosity and philanthropic spirit of IAFP members. The IAFP committed $15,000 to support the displaced residents and 44 members contributed very generous individual donations and St. Lukes and Mercy each contributed $15,000 matching grants for a total of nearly $80,000. The displaced residents all found other program and appreciated the $5,713 checks they received from the Foundation.

The Board of Directors met in February followed by a very successful Legislative coffee, hosted by the Advocacy Committee at the Capitol. Members from around the state joined us to lobby for AAFP legislative priorities with their representatives. This gathering gave us the opportunity to share our views on workforce initiative, scope of practice, medical liability reform and telehealth.

IAFP President Sherry Bulten, MD, President-Elect Lonny Miller, MD and staff, Katie Cox and I were able to attend the Multi-State Conference in Dallas, Texas in late February. This conference provides the opportunity for leaders from 14 central states to get together to share state advocacy efforts, best practices and to hear from AAFP leaders. Who knew that this would be the last time any of us would be able to gather in person for the rest of 2020?

"For children and adolescents, online courses have become the new educational norm. After class and homework, children are often unable to go outside and play due to COVID restrictions. Furthermore, the winter season brings darkness and cold early in the day in many areas of the U.S. Overall, these new eating habits and lack of exercise can be very harmful, especially in children."

When COVID-19 hit, the AAFP was quick to respond by building a robust website, offering weekly town hall meetings and a weekly CME activity addressing the latest developments in dealing with the health crisis. The IAFP started distributing the monthly e-newsletter on a weekly basis to

share information in the rapidly changing environment, created a designated closed Facebook page for interested members and worked with other Iowa healthcare associations to assure consistent messaging. I am currently serving on a work group created by the Iowa Department of Public Health to address issues related to vaccine planning and distribution.

Life as we all knew it changed so rapidly. The AAFP found it necessary to cancel many of the scheduled conference but was quick to provide a virtual option for many of them as well. The National Conference of Special Constituencies was held through a virtual platform. The Annual Leadership Forum and Family Medicine Advocacy Summit were cancelled. The National Conference of Medical Students and Family Medicine Residents was held as a virtual event, including a virtual exhibit hall that gave students the opportunity to visit with representatives of hundreds of family medicine residency programs. The State Legislative Conference, AAFP Congress of Delegates and FMX were also held as virtual events.

In the middle of the summer AAFP long term EVP, Douglas Henley, MD retired and turned over the responsibilities to Shawn Martin who had been the AAFP Vice President for Government Relations.

The IAFP found it necessary to cancel the summer meetings to be held at Lake Okoboji and Galena, Illinois. These meetings are scheduled to be held in the summer of 2021. It was with considerable regret that the 2020 Annual Meeting was also cancelled. The Annual Business Meeting and installation of officers was held as a virtual event, and the CME topics planned for 2020 will all be moved to the 2021 conference. The IAFP has been offering virtual CME to help members keep up with their state mandated requirements and provided a KSA on Palliative Care to help members keep up with ABFM certification requirements. The IAFP is also offering a series of webinars on a variety of cancer topics that are available on-demand through the web site.

In addition to the meetings above, the IAFP collaborated with a program spearheaded by the Iowa Hospital Association, that also included the Iowa Medical Society and the Iowa Health Collaborative. The Physician Business Leadership Program is a certificate program that is in its second year and which was designed as four in-person full day training program with additional requirements in networking and involvement with other industry activities. The audience is emerging and aspiring physician leaders. These programs were moved to a virtual format. Sarah Ledger, DO, was selected as the IAFP scholar for this activity.

I would like to extend a special thank you to Dr. James Bell who will finish his term as Board Chair and therefore is leaving the Board after many years of service. His diligent, consistent, and inspired leadership has guided us through many challenges including the governance restructure, strategic planning, and several Bylaws revisions. He has risen to every challenge and been a strong spokesperson for the IAFP. We appreciate his accessibility and willingness to address issues and resolve problems.

Dr. Sherry Bulten has been a dedicated President of the IAFP and we know she will step into the role of Board Chair with a commitment to leading us through what appears to be challenging times ahead.

Congratulations to our incoming President, Dr. Lonny Miller. We look forward to a great year and know we will be in good hands under his leadership.

It is my pleasure and privilege to extend a special thank you to Dr. Jenny Butler who has chaired the Education Committee for many years. Under her leadership the IAFP Annual CME Conference has gone through incredible growth and has become a respected and anticipated source of CME for Iowa Family Physicians. As she steps down as chair we hope she will continue to be involved in IAFP activities.

I would also like to thank Brian Mehlhaus as he concludes his term as Delegate to the AAFP Congress of Delegates. He has led been a positive contributor to discussions at Board of Directors meetings and has led our delegates through the deliberations at the Congress of Delegates including helping us adapt to the virtual Congress this year.

I thank all of those members who serve on the Boards of the Academy, the Foundation and the PAC and all who serve as delegates, and on state and national committees. I also want to thank our very dedicated and hardworking Academy staff. We could not accomplish the work that is done throughout the year without them. I am so privileged to be able to work with Katie Cox and Kelly Scallon and every day starts as a new adventure with these two. Please share your gratitude with them when you have a chance.

It is so difficult to express the depth of my admiration and respect for Iowa Family Physicians. Thank you for your care of the people of Iowa through this most difficult time and for the spirit and leadership you demonstrate each and every day. I thank you for your continued membership and involvement in our organization. I encourage you to take advantage of the great CME offered by the Academy and challenge you to become involved in this great organization that represents you at the state and national level. Our continued success is dependent upon each of you. It remains an honor and a privilege to serve as your Executive Vice President and I hope 2021 gives us many opportunities to meet in person.

IAFP LEGISLATIVE ISSUES

The IAFP Legislative Priorities appear on page 20. Even though we will not be able to host the legislative coffee this year we will still provide weekly updates while in session so please check your email for important updates. We will also call on you from time to time to use the AAFP Speak Out feature to communicate concerns to your legislators on issues as they arise. If Advocacy is of interest to you, please consider joining the Advocacy Committee at http://iaafp.org/committee-volunteer-form/

2021 Legislative Priorities

1. Workforce Initiatives

- The Academy will continue to explore ways to increase quality physician access topatients 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 maintaina physician centered primary care workforce in Iowa. As such, IAFP supports:

  i. Increased funding for the Rural Primary Care Loan Repayment Program,

  ii. Increased state funding for the Medical Residency Programs

  iii. Continued funding for psychiatric training at Des Moines University.

  iv. Establishment of an Iowa National Guard Loan Repayment Program.

  v. Increased funding for medical residency programs that focus on mental health, OB/GYN and primary care.

2. Telehealth

- In 2015 the IAFP was instrumental in creating payment parity for Medicaid patients beingtreated in person or through telehealth technology. The IAFP will advocate for private pay parity. In 2018 legislation was passed requiring commercial payors to provide parity forcoverage, meaning the use of telehealth care is covered by healthcare insurance. IAFPwill look to expand telehealth further to increase access to physicians for rural orunderserved Iowans.

3. Medical Liability Reform

- In Iowa, noneconomic damage awards from juries has climbed sharply. More than $63Mhas been awarded in noneconomic damages in just five cases. Noneconomic damages aredefined as intangible harms like "severe pain, physician and emotional distress, loss ofenjoyment", etc. IAFP supports closing loopholes in the state's cap on noneconomicdamages.

- Capping noneconomic damages will reduce skyrocketing insurance premiums and benefitrecruitment of physicians.

4. Scope of Practice Protection

- IAFP is opposed to legislation that would erode physician's ability to practice within theirfull scope and put Iowa patients in harms way. To this end, IAFP is aware of the followingperennial legislative initiatives:

  i. Pharmacy Statewide protocols. IAFP will monitor the legislation put forth to ensurepatients care and the physician-patient relationship is not compromised.

  ii. Direct entry midwives. The IAFP opposes direct entry midwives due to their lack ofeducational and medical training, and the impact this gap in education has on caringfor their patients.

  iii. Naturopathic physicians. The IAFP opposes the licensure and recognition of naturopathic physicians because of the manner in which this group practices (i.e. do not follow evidence-based practices).

5. Medicaid Managed Care

- IAFP members continue to believe that value over volume is the answer to truly keeping patients well and bettering their health. With this in mind, IAFP supports Medicaid payment reform that pays physicians based on value rather than traditional fee-for-service payment methodology. IAFP will work to ensure there is proper oversight on the managed care companies overseeing the Medicaid program..

6. Access to Care and Public Health

- IAFP supports initiatives that promotes access to care in Iowa. As primary care physicians we understand the importance of access to care in both urban and rural settings. Additionally, IAFP supports public health initiatives like smoking cessation programs, obesity programs, etc.

7. COVID Priority Language

- The deadly COVID-19 pandemic has caused national economic disruption and generated significant uncertainty for many Iowans. The IAFP, along with other primary care organizations, is working with the Iowa Department of Public Health (IDPH) and the CDC monitoring guidance and findings as they become available. To promote public

health and economic recovery, government decisions must be based on evidence- not politics or individual interest.

- COVID Vaccination. The development of safe, effective vaccines and treatments are essential to protect the public's health and restore the nation's economy. The IAFP calls for a transparent review and approval process that adheres to scientifically rigorous standards to ensure safety and effectiveness of the vaccine(s). It is critical all Iowans receive the flu vaccine this season to stay as healthy as possible and not transmit influenza creating an even worse public health situation on the ground.

- Testing- Routine, rapid, accurate and easy to access COVID-19 testing- followed by timely and efficient contact tracing is needed to help prevent further spread.

- Family docs are on the front line fighting this pandemic and look to state and national policy makers to listen to science, ease the suffering of the economy and protect the health and well-being of Iowans.

Thank you to our 2020 PrimCare PAC Contributors!!!

Laura Abels, DO
Robin Barnett, DO
Jim Bell, MD
Laura Bowshier, MD
Jenny Butler, MD
Corrine Ganske, MD
Jeff Hoffmann, DO
Amr Kamhawy, MD
Doug Martin, MD
Brian Mehlhaus, MD
Lonny Miller, MD
Noreen O'Shea, DO
Doug Peters, MD
Steve Richards, DO
Thomas Richmann, MD
Dawn Schissel, MD
Jennifer Stone, MD

Physician Business LEADERSHIP Certificate Program

The Iowa Academy of Family Physicians is partnering with the Iowa Hospital Association, Iowa Medical Society and the Iowa Healthcare Collaborative on a program in its third year to provide Physician Business Leadership training to physicians in Iowa. Participants in this program will gain tools to become successful leaders in today's complex health care environment.

For more information and registration please visit www.ihaonline.org/education/physicial-business-ledership-certificate-program/

Session Overviews

SESSION ONE | FEB. 23

- 8:30 am - Introduction to IHA
- 9 am - The Art and Challenge of Coaching Colleagues to Enhanced Performance Jeff Morris, MD, MBA, Studer Coach, Pensacola, Florida
- 10:30 am - Managing the Difficult Physician Colleague Jeff Morris, MD, MBA, Studer Coach, Pensacola, Florida
- 1 pm - Advocacy 101 Kim Murphy, JD, Vice President and Assistant General Counsel, Iowa Hospital Association
- 2 pm - Adjourn

SESSION TWO | MARCH, 17

- 1 pm - DISC Assessment Training Session
- 3:30 pm - Adjourn

SESSION THREE | APRIL 14

- 8:30 am - Introduction to the Iowa Healthcare Collaborative
- 9 am - Health Care Finance 101 Susan Horras, VP, Finance, Iowa Hospital Association
- 10:30 am - Crisis and Grief Leadership During a Disaster Event Joshua Morganstein, MD, DFAPA, Assistant Director, Center for the Study of Traumatic Stress, Uniformed Services University, Bethesda, Maryland
- 1 pm - CEO CMO Moving in the Same Direction Linn Block, RN, BSN, MHA, CEO, Manning Regional Healthcare Center and Chuck Nordyke, RN, BSN, MSN, MBA, CEO, Clarinda Regional Healthcare Center
- 2 pm - Adjourn

SESSION FOUR | JUNE 9

- 8:30 am - Introduction to the Iowa Medical Society
- 9 am - Negotiations and Conflict Management Azeemuddin Ahmed, MD, MBA, Clinical Professor and Executive Vice Chair, Department of Emergency Medicine, University of Iowa
- 10:30 am - Data and Decision-Making John Richardson, Director, Iowa Hospital Association
- 1 pm - Time to Move Upstream and Invest in Our Health: Addressing Social Determinants of Health and Population Management Yogesh Shah, MD, Chief Medical Officer, Broadlawns Medical Center, Des Moines
- 2 pm - Adjourn

SESSION FIVE | AUGUST 10

- 8:30 am - Introduction to the Iowa Academy of Family Physicians
- 9 am - Health Care Futurist (Part 1): A Survival Guide for Health Care Organizations Steven Berkowitz, MD, Chief Physician Executive, Northern Light Health and President, Northern Light Medical Group
- 10:30 am - Creating Margin: How to Survive in a Fee for Service-based World While Transitioning to Value-based Health Care Don Klitgaard, MD, FAAFP, CEO, MedLink Advantage
- 1 pm - Health Care Futurist (Part 2): Patient as a Partner in Care Steven Berkowitz, MD, Chief Physician Executive, Northern Light Health and President, Northern Light Medical Group
- Post-event Opportunity - One-on-One CMO Coaching with Dr. Berkowitz

Would you like to get involved at the Academy? JOIN A COMMITTEE!

Committees meet once a year in a face-to-face meeting. This year, the meeting will be conducted October 28, 2021.

EDUCATION COMMITTEE: Responsible for all continuing education programs of the Academy that includes the Clinical Education Conference and the Winter/Summer meeting.

MEMBER ADVOCACY COMMITTEE: Duties include serving as an advocate for family physicians and their patients in matters relating to the delivery of health care, and promotes the image of family physicians in the state of Iowa. In addition, the committee seeks members to serve on committees and boards for government and other health care related organizations, and assists in the legislative activities of the Academy including grassroots lobbying (Key Contacts). The committee is also responsible for the annual legislative coffee at a TBD date.

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

To get involved: email Kelly at kscallon@iaafp.org or fill out form online at: https://www.surveymonkey.com/s/IAFPvolunteerform

New IAFP Board of Director Members Named

The new IAFP Board of Director were installed via zoom on November 11th. Congratulations to our newly elected Board Members! Thank you for serving IAFP.

- **President-Elect -** Laura Bowshier, M.D.
- **Vice President -** Corrine Ganske, MD
- **Board Chair -** Sherry Bulten, M.D.
- **District 2 Director -** Sarah Ledger, DO
- **District 2 Director -** Nicole Brokloff, MD
- **Director At Large A -** Spencer Carlstone, MD
- **Delegate to the AAFP -** Don Klitgaard, MD
- **Alternate Delegate to the AAFP -** Jeffrey Hoffmann, DO

We would like to give a special thank you to our board members whose term has ended. Jim Bell, IAFP Board Chair and Brian Mehlhaus, AAFP Delegate. Their dedication and service to the Board of Directors has been inspiring and appreciated. We thank you for all the time, commitment and passion you have brought to our board.

We would also like to thank Jenny Butler for her leadership, wisdom, guidance, and service as she steps down as chair of the education committee. Thank you for your service to the IAFP.

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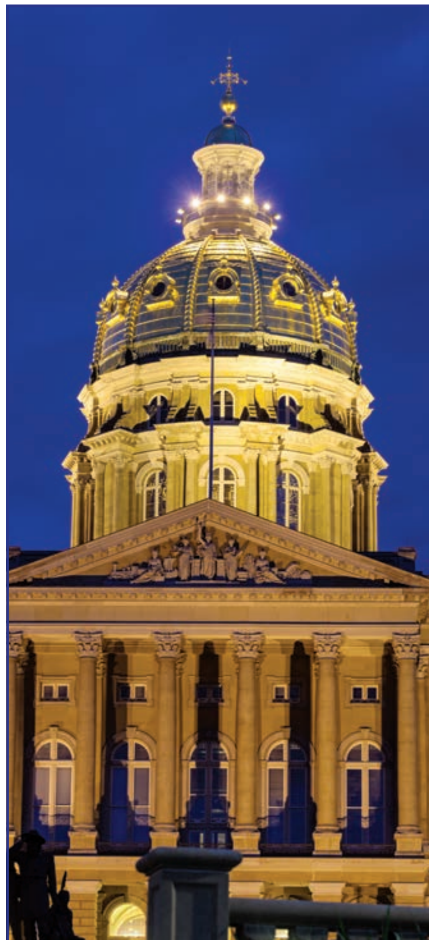
Lonny Miller, M.D. Named President of the Iowa Academy of Family Physicians

Lonny Miller, M.D. of Creston was installed as President of the Iowa Academy of Family Physicians at the virtual IAFP Business Meeting and Officer Installation held November 11, 2020.

Dr. Miller will serve a one year term as IAFP President and will represent the IAFP at state and national family medicine leadership and legislative events.

Dr. Miller completed his undergraduate degree at Simpson College. He attended medical school at the University of Iowa. Dr. Miller completed his family medicine residency at Fort Wayne Medical Education Program-Family Medicine.

Dr. Miller currently practices family medicine with Greater Regional Health in Creston and Corning.



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
- ❑ $750 GOLD MEMBERSHIP
- ❑ $500 SILVER MEMBERSHIP
- ❑ $250 BRONZE MEMBERSHIP
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Signature______________________Exp. Date ___________

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

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

New Members

Active

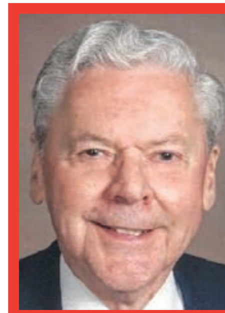
Gabriel Eljdid, DO Cedar Falls
Sheran Fernando, MD, Corning
Patrick Gordon, MD, Dubuque
Molly Olson, DO, MPH, Delhi
Ojash Raval, DO, West Des Moines
Seth Winterton, MD, Cherokee

Residents

Tanya Aggarwal, MD
Kyle Carver, MD
Mary DeFrance, DO
Katherine Evans, DO
Ellie Fishbein, MD
Robert Garekis, DO
Austin Granatowicz, MD
Jacob Groen, DO,
Katie Keefer, MD
Cassady Miller, MD
Samuel Orvis, MD
Kubat Rahatbeck, MD
Joseph Rattenni, DO
Ben Schwab, DO
Hannah Stein, MD
Harris Syed, MD
Aaron Weaver, MD
Ronald White, DO

Students

Tope Banwo, Des Moines University
Kaylie Barnett, University of Iowa
Brandon Bates, University of Iowa
Alex Benben, Des Moines University
Ajmain Chowdhury, University of Iowa
Amanda Dolley. Des Moines University
Peter Eckard, University of Iowa
Charles Gaccione, Des Moines University
Steven Halvorson, Des Moines University
Zoe Heis, Des Moines University
Grant Hurt, University of Iowa
Tanner Kempton, University of Iowa
Elyse Kerian, University of Iowa
William Kivlin, Des Moines University
Derek Koon, Des Moines University
Yuriy Kuzyk, Des Moines University
Rebecca Lank, University of Iowa
Torey Lasater, University of Iowa
Matthew Mahoney, Des Moines University
David Moore III, University of Iowa
Taryn Nishimura, University of Iowa
Thomas Pak, University of Iowa
Peter Sanchez, University of Iowa
Chandler Tinsman, University of Iowa
Emily Trudeau, University of Iowa
Pichit Thanupakorn, University of Iowa
Jiti Manoja Uppugunduri, Des Moines University
Nathan Walton, University of Iowa



In Memoriam

Germain L. Schmit, MD
Cedar Rapids

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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 2021
- 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 2021
- 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, 2021.

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

Thank you to our 2020 Foundation Donors!!!

Laura Abels, DO
Mabior Ayuen, MBA, PhD
Robin Barnett, DO
Larry Beaty, MD
Jim Bell, MD
George Bergus, MD
Laura Bowshier, MD
Jenny Butler, MD
David Carlson, MD
Craig Clark, MD
Myra Daniel, MD
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Stephen Pallone, MD
Jim Paulson, MD
Steven Perkins, DO

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Heidi Van Maanen, DO
Daniel Vanden Bosch, MD
Jamie Wallace Smith, MD
Christine Warner, MD
Jason Wilbur, MD
Pamela Williams
Claudia Zavala, MD

2020 was an amazing year for the IAFP Foundation. Thanks to your generous donations, the IAFP Foundation raised $90,837!!!

Don't see your name? Contribute to the Foundation in 2021 to see your name listed here.

The Giving Tree

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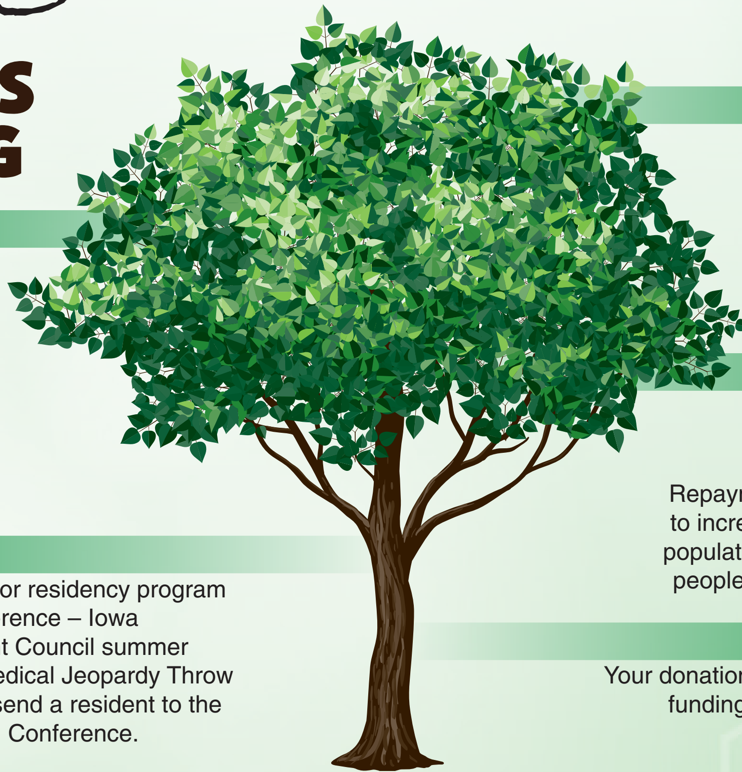
BRANCHES OF GIVING



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.

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Des Moines, IA 50309

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