IAFP

IOWA FAMILY PHYSICIAN

Vol. XXXXIII No. 3 / SUMMER 2016

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IAFP
IOWA FAMILY PHYSICIAN

Official Publication of the Iowa Academy of Family Physicians
Vol. XXXXIII No. 3 / SUMMER 2016

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(Re)-Member us

By Noreen O'Shea, D.O.

The Iowa Academy of Family Physicians (IAFP) is defined as a "membership" organization, as well as being a professional organization. I would like to touch on the how those designations inform the work of the IAFP Board and staff and what we want/expect from our members.

Service to the IAFP members takes place in a variety of ways. In the last issue of this magazine, I discussed the role of Advocacy. The IAFP Legislative Committee, and ultimately the Board, strategizes each fall with our lobbyist, Mr. David Adelman, on our approach to the upcoming legislative session. Depending on the make-up of the legislature and the agenda of the governor, we may suggest or even develop legislation. More commonly, however, we work with legislators who have drafted bills in response to the concerns of their constituents and express how these bills make affect practice environments, health of the public and patient safety concerns. This is an important role, as the majority of legislators are eager to hear all sides of an argument. This is how and where your voice is so important—your legislator needs to hear not only ow the bill affects you and your staff, but also your patients and community. "Re-member" us when we contact you about an important piece of legislation, especially in the scope of practice realm.

You may know us by our role in Education. The most obvious way we demonstrate that role is through our annual meeting in the fall ("Re-member" to sign up!). We also coordinate smaller meetings in the winter, often in a location warmer than Iowa. Those winter meetings often feature your fellow members as speakers; so if you have a practice passion, consider honing your presentation skills in front of a friendly audience. We also heard your desire for a summer educational opportunity and brought back the Summer CME Weekend Getaway, occurring at the Iowa Great Lakes in June. This "re-newed" offering has been popular with our member, especially those in the "west of I-35" practices. Stay tuned for other summer offerings. Finally, don't forget about the Cancer Screening Webinar Series and the Federal Motor Carrier Safety Administration Certification Training Course (which also offers an web-based platform).

"We also heard your desire for a summer educational opportunity and brought back the Summer CME Weekend Getaway, occurring at the Iowa Great Lakes in June."

Did you know IAFP has a committee that specializes in "membership"? The Member Services committee sees its role as both serving and recognizing the wonderful Family Physicians in the great state of Iowa. When you have concerns regarding privileging in your hospital or health system, come to us for a sounding board and a guide for dealing with these important issues. This IAFP committee also has the enviable job of recognizing the great teachers, mentors, leaders and family medicine "icons" among us (Educator of the Year, Family Physician of the Year, Young Physician of the Year and the Lifetime Achievement Award). I love to hear the stories of these wonderful clinicians and educators. "Re-member" to nominate your peers and to share with us how they touched you, their patients and their communities.

It is pretty obvious we cannot do our work without you, our members. We need to hear from you, whether that takes place in the form of a nominating letter, a suggestion for a topic for us to cover at the fall meeting (or an offer to speak at our winter meeting) or a piece of legislation you are passionate about. Respond to our surveys, which are quick and easy ways to tell us how you feel and think. Or, wax poetic about the doctor who delivered you, mentored you and is now your practice partner. "Re-member" the profession of Family Medicine!

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What Does It Mean To Be a Member?

By Jason Wilbur, M.D.

As I sat down to pen my editorial to you, members and friends of the Iowa Academy of Family Physicians, I was boxed into a conundrum. Our Membership Services Committee decided (myself included) to dedicate each issue this year to a particular theme. For this issue, the theme is "membership." My first thought was, "Great! I'll write about the IAFP's mission and what it does for members – you know, drum up excitement about being an IAFP member!" Then came the second thought, "Wait a minute. Almost all my readers will already be members." Back to the drawing board.

Next, I thought I would employ the old high school English class trick of using a dictionary definition as a starting point. You know, "Merriam-Webster defines membership as…" But then the voice of Ms. Baker, my high school English teacher, rang out in my head, "Don't take the easy way out!" Strike two.

Then I realized that I have a mission, and I just need to state it. My mission is two-fold: (1) to engage current members in the efforts of the IAFP and (2) to reach out to friends and non-members whose interest in primary care aligns with that of the IAFP.

To our current, active IAFP members: we are a relatively small group, slightly more than 1,200 active family physician members. For comparison, my local high school has more "members" and other health care organizations in the state boast more physician members (the IMS and UIHC, to name two). When you bring a group of people together with their differing backgrounds and views, what happens? You start to define yourself and your friends by those differences. High schools have cliques and the IMS and UIHC have their various specialties. The same thing can happen even in our small band of family physicians. We define ourselves within the IAFP by how we are different: full scope or focused practice, rural or urban, small practice or large multispecialty group, academic or community-based.

As is readily apparent to anyone who tunes in to any form of media during this presidential election cycle, when a group focuses on how its members differ, it ceases to be a cohesive unit and may fragment into its component parts. So, rather than taking a page from the Trump or Clinton playbooks, we members of the IAFP might instead draw from Pope Francis or the Dali Lama and concentrate on our common purpose.

> *"Then I realized that I have a mission, and I just need to state it. My mission is two-fold: (1) to engage current members in the efforts of the IAFP and (2) to reach out to friends and non-members whose interest in primary care aligns with that of the IAFP."*

What brings us together in the IAFP? Despite our various interests, backgrounds, geography, and any other of the dozens of things that differentiate us from one another, we are united in our common purpose of strengthening primary care as the medical foundation for a healthier Iowa. The mission of the IAFP states:

> *We advocate for, educate and support family physicians in their efforts to improve the health and well-being of patients, families and communities.*

Does this sound like a mission we can all get behind? I suspect it is. Our specialty is the only one of the medical specialties that is concerned with the healthcare of everyone – outpatient and inpatient, young and old, insured and uninsured, simple health concerns and complicated diseases, the individual patient and the whole community's health. This is what brings us together and defines us the physician organization that cares for the health of all Iowans.

What does it mean to you to be a member of the IAFP? Rather than paraphrase the first part of the often repeated quote from John F. Kennedy, "What can my academy do for me," I want to take a moment to consider what we can do for the IAFP – and why we might take that view.

Like links in a chain, the members of the IAFP are what give it strength. If you believe in the mission of this organization, then lend it your strength. Together we

can do more good for the health of Iowans than we can as individuals in our various settings. What might you do as members to further our mission?

- Maintain your AAFP membership, which automatically maintains your IAFP membership.
- Tell your IAFP board members what you need from the IAFP to improve the health of Iowans.
- Support IAFP efforts with your presence at the annual meeting, legislative breakfast, and other gatherings throughout the year.
- Support PrimCarePAC and the IAFP Foundation.
- Sponsor a student to attend the National Conference of Family Medicine Residents and Medical Students this summer.
- Run for a director position on the IAFP Board of Directors.
- Offer to teach at an IAFP CME course.
- Talk about the IAFP with students, residents and non-members.
- Encourage non-members to join.

Now, allow me to reach out to those readers who are not currently active members. Maybe you just let your membership lapse this year, maybe you are a student or resident who is graduating but staying in Iowa, maybe you are a friend of family medicine but are not yourself a family physician. There are many things that the IAFP and AAFP do for members, and you can learn all about that at www.iaafp.org or at www.aafp.org. But my question is simple. Do you believe in the mission of the IAFP and common purpose of family physicians? If you do, become a member. The IAFP could use your help!

As always, please send me your comments, thoughts and recommendations for what you want to see in this magazine. I can be reached at Jason-wilbur@uiowa.edu.

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- West Lakes Sleep Center
- Women's Center

So Much to Learn, So Little Time!

By Grant Zomermaand, M2

It's hard to believe it's already spring. It feels like yesterday that I was starting my first clinical rotation in January. I am a second year medical student at the University of Iowa and am a part of the first class of a new curriculum. Instead of the typical 2 years spent in lecture halls, we were done in 1 ½ years and will spend 2 ½ years in clinical rotations.

Before we started clinical rotations, one of our advisors told us that we would see dramatic improvement in our clinical skills after just one rotation. Looking back, I can see that this was true. I've learned how to write a competent clinical note, and I've made significant improvements in my physical examination, interviewing, and presentation skills. Though I have learned so much, I still feel incredibly incompetent at times. Sometimes it is difficult not to compare myself with those who are further along in training. I wish that I had their knowledge and skills right now, but I realize that it took them years to gain those skills. It is important to focus on the progress that I have made and to continue to put in the effort to improve.

I have finished two rotations, Pediatrics and Internal Medicine. These were great rotations to have first; they gave me a great clinical base to build on. I have seen patients from days old to patients in their 80s. It is humbling to be a part of people's lives when they are struggling through perhaps the hardest things they have every faced. I am grateful for the extra time that I can spend with patients as a medical student. It allows me to do what I can, however small, to help them through those times. This could be anything from grabbing an extra pillow for someone to getting my butt kicked playing video games with an 8-year-old.

I learned a lot in these last few months, but also have a long way to go. Each rotation I realize more and more just how much there is to know in medicine. I am currently on an ophthalmology rotation. There is an immense amount of information to know just about the eye. At an academic medical center like the University of Iowa, many of the ophthalmologists have completed fellowships and are experts in one part of the eye. If some of these world-renowned physicians can spend an entire career on just one part of the eye, how can I be expected to know everything about the entire body? It makes me appreciate just how much family physicians need to know. They may not have to be the foremost expert in a certain area, but they need to know a lot about a lot.

"Before we started clinical rotations, one of our advisors told us that we would see dramatic improvement in our clinical skills after just one rotation. Looking back, I can see that this was true. I've learned how to write a competent clinical note, and I've made significant improvements in my physical examination, interviewing, and presentation skills."

I have an interest in family medicine, and the very large scope of practice is both appealing and daunting. I love that they can address the problems of any patient that walks through the door. They can work in clinic, inpatient settings, the emergency department, and the operating room. If they have an interest in a certain area of medicine, they can tailor their practice to that area and still maintain the ability to see a variety of other things. They would not have any problems getting a job in a small town or a big city. All of these things are positives for me. However, looking at the amount of knowledge required can be daunting as a student. Sometimes it's hard to see how I will ever gain all of the necessary skills to address every problem a patient might have. Though these doubts sometimes creep in, I know that it can be done, as I have met many amazing family physicians.

The time has flown by up to this point, and I'm sure it will continue to do so. In two years I'll be where the fourth year students are now. It is an exciting time for them, as they are graduating and moving on to residency. This year, 24 students from the University of Iowa matched into Family Medicine. I am excited for them as they continue to expand their knowledge and skill sets, and I look forward to being in their shoes in two years.

Congrats to Our Award-Winning Students!

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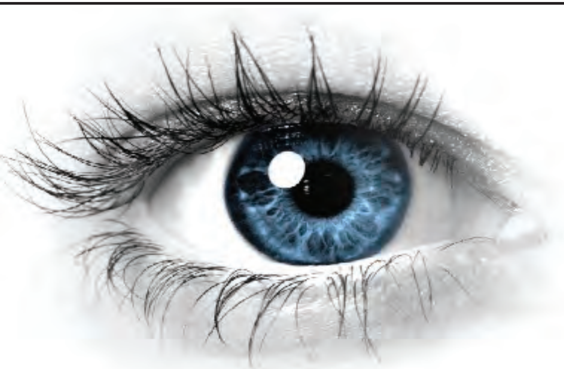

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Healthy Outside and Inside

By David Janssen, M.D., R1 / Genesis Quad Cities Family Medicine Residency Program / Davenport, Iowa

During one of my first months of residency, I saw an emergency room patient in his fifties who had been seen three times in the past week for vague complaints of dizziness, malaise, heart palpitations, and dyspnea. Prior visits showed normal vitals, physical exam, lab work, EKG, and imaging, and his symptoms did not seem to constellate into a classic diagnosis. As I interviewed the patient, attempting to form a differential, I noticed that his answers and body language seemed guarded. His wife and sister appeared concerned and supportive, but he did not look them in the eye. Something told me to ask about his mood. His eyes immediately filled with tears, and he confessed that he had felt severely depressed with thoughts of suicide for several months and that he was hiding this from his family because he did not want to bother them.

Depression in Primary Care

According to the National Institute of Mental Health, each year about 6.7% of adults and 11.4% of adolescents (age 12 to 17) in the United States suffer at least one major depressive episode.[1] People with co-morbidities like heart disease, cancer, or diabetes are up to four times more likely to experience depression. Depression is the leading cause of disability for people aged 15 to 44. Eighty percent of those treated for depression show improvement of symptoms within 4 to 6 weeks, but unfortunately less than two out of three patients receive treatment. Family doctors are often the first to recognize depression, and appropriate treatment is critical to the health of the patient. Despite knowing these statistics from medical school, I have still found myself surprised by the frequency and severity of the diagnosis in my daily continuity clinics.

Depression interacts with every other health problem. Despite higher suicide rates and substance abuse associated with depression, heart disease is still the number one killer of patients with depression. Compared to the general population, patient struggling with depression are more likely to neglect themselves. When you feel so low that you cannot even get out of bed, you are unlikely to eat a healthy meal, engage in exercise, take your pills on time, or make doctor appointments. Depressed patients may use cigarettes or alcohol as over-the-counter medicine to help with anxiety and sleep issues or cope with chronic pain. A holistic view of the patient in primary care should always consider the role that depression and the mind play on the treatment of illness.

A Research Opportunity Flags Potential for Depression

As part of collaboration with the University of Iowa, another resident and I asked our patients with a past diagnosis of depression to fill out a questionnaire about their ACE score. The Adverse Childhood Experience (ACE) study was first performed at Kaiser Permanente from 1995 to 1997. It asked patients about ten different adverse childhood experiences like loss of a parent, physical abuse in the home, or substance abuse in the home, and correlated these scores with co-morbidities like heart disease, depression, substance abuse, and cancer.[2] Interestingly, the study found a high correlation with a dose-response curve and found that on average, patients with an ACE score of 4 out of 10 or greater lived ten years less than patients with a lower score. When we polled our depressed patients, I was not surprised to see many of them had scores greater than 4. A few even scored 10/10. These patients are at high risk for severe medical illness and need optimal treatment including addressing their mental health concerns.

Patient Education Helps

Unfortunately, stigma and misinformation can still be barriers to depression treatment. I recently saw a young man named John who described his symptoms of major depressive disorder perfectly, but was then upset when I made the diagnosis. Despite the problems associated with his illness including homelessness and loss of employment, John was resistant to treatment and I asked him why.

> "If I have depression," he said, "that means that I'm abnormal and that my brain is messed up. I don't want to be on pills that will make me not who I really am."
>
> "Would you say that if you had diabetes?" I asked. He looked at me blankly. "Would you say that you were abnormal and that your body was messed up and that you didn't want to take pills to change you?"
>
> "Of course not."

We discussed that Type II diabetes is a disorder in which the body stopped listening to insulin as it should, so we treat it with medicine that makes the body listen better. In the same way, a depressed patient's brain does not function as it should with the neurotransmitters present, so we give medicine that modify them and make the brain work as it should. After a few more questions, John agreed to try an SSRI and see a therapist. He thanked me for taking the time to address his concerns. This interaction reinforced for me that taking the time to educate can help decrease stigma regarding depression

and increase rates of compliance with treatment.

Being a Family Physician Helps

About a month ago I saw a teen named Adam who presented in my clinic to follow up on his fatigue. He had been seen for this twice before with no answers despite modifying his sleep hygiene. As his family doctor, I knew that his brother was undergoing treatment for aggressive cancer, and I asked him how that was affecting him. He became quiet for a minute and then slowly shared that he could not sleep or eat or focus on his school work because of worry. He felt guilty about his brother and felt hopeless about the situation. Adam agreed to see our clinic's counselor in the next week or two to discuss his mood and work on developing coping skills. His mother thanked me for getting him to talk; she was worried about him but due to her other son's frequent medical appointments, she had not been able to talk to him much. This experience showed me the unique opportunity a family doctor has to view a patient through the context of family and recognize depression when it is less obvious.

As my residency progresses, I have no doubt that I will have more opportunities to counsel and educate patients that are potentially suffering from depression. As a family physician I hope to be mindful of each patient's mental state and how it affects their care. As actor Robert Urich once said, "A healthy outside starts with a healthy inside."

1. Center for Behavioral Health Statistics and Quality. 2015. Behavioral health trends in the United States: Results from the 2014 National Survey on Drug Use and Health. HHS Publication No. SMA 15-4927, NSDUH Series H-50. Retrieved from http://www.samhsa.gov/data/.

2. Centers for Disease Control and Prevention. 2015. ACE Study. Retrieved from http://www.cdc.gov/violenceprevention/acestudy/about.html.

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Findings From Iowa Eating Disorders Needs Assessment: Primary Care Providers Must be Prepared to Prevent, Recognize, and Treat Eating Disorders

By Kimberly A. S. Merchant, MA

Because specialized care for Iowans with eating disorders is scarce in the state, primary care providers must become more aware, learn about resources, and do more to promote and provide treatment for patients with eating disorders, according to a statewide needs assessment.

A needs assessment of eating disorder programs and services in Iowa was conducted by researchers in the University of Iowa College of Public Health in 2015. Participants from 36 locations across the state volunteered to respond to questions and provide information over a three-month time period. Interviews were conducted in person or over the telephone. Participants were asked to self-identify in one of the following categories: provider (those who treat eating disorders, such as physicians, therapists and dietitians); patient, still struggling; patient, recovered; family; other (such as dentist, school counselor); or combination. Of the 83 participants, 22 self-identified in a combination of two categories; thus, 105 perspectives were represented in the study.

Background

According to the National Eating Disorders Association, more than 20 million women and 10 million men in the U.S. suffer from an eating disorder at some time in their life. In addition, as many as 25 million struggle with disordered eating and sub-clinical eating disorders.[1] Eating disorders fall into the following brief diagnoses and descriptions, which are a summary of the American Psychiatric Association's Fifth Edition of the Diagnostic and Statistical Manual of Mental Disorders (DSM-5) published in 2013.[2]

Anorexia Nervosa – inadequate food intake leading to a weight that is clearly too low; intense fear of weight gain, obsession with weight, and persistent behavior to prevent weight gain; inability to appreciate the severity of the situation.

Binge-Eating Disorder (BED) – frequent episodes of consuming very large amounts of food but without behaviors to prevent weight gain, such as self-induced vomiting; a feeling of being out of control during the binge-eating episodes; feelings of strong shame or guilt.

Bulimia Nervosa – frequent episodes of consuming very large amounts of food followed by behaviors to prevent weight gain, such as self-induced vomiting.

Eating Disorder Not Otherwise Specified (EDNOS) – a feeding or eating disorder that causes significant distress or impairment, but does not meet the criteria for another feeding or eating disorder. It is also known as Other Specified Feeding or Eating Disorder (OSFED).

Eating disorders are misunderstood and stigmatized. Eating disorders are deadly, and the prevalence is growing.[3-5] The prevalence of BED among those who are obese is 8% to 28%.[6] To address the many misconceptions about eating disorders, The Academy for Eating Disorders along with other major eating disorder organizations recently agreed to disseminate the following Nine Truths about Eating Disorders.[7]

Nine Truths about Eating Disorders

1. Many people with eating disorders look healthy, yet may be extremely ill.
2. Families are not to blame, and can be the patients' and providers' best allies in treatment.
3. An eating disorder diagnosis is a health crisis that disrupts personal and family functioning.
4. Eating disorders are not choices, but serious biologically influenced illnesses.
5. Eating disorders affect people of all genders, ages, races, ethnicities, body shapes and weights, sexual orientations, and socioeconomic statuses.
6. Eating disorders carry an increased risk for both suicide and medical complications.
7. Genes and environment play important roles in the development of eating disorders.
8. Genes alone do not predict who will develop eating disorders.
9. Full recovery from an eating disorder is possible. Early detection and intervention are important.

In Iowa

Translating the prevalence of clinically diagnosed eating disorders in the U.S. to Iowa's population indicates 293,876

people in the state struggle with eating disorders.[8]

Currently, in Iowa, University of Iowa Hospitals and Clinics (UIHC) has the only inpatient (up to 13 beds) and partial (daytime) hospitalization eating disorders treatment programs. The entire UIHC program, which includes outpatient clinical care, comprises three specialized therapists, three part-time specialists for the adult program, and four staff who work primarily with eating disorders. Outside of UIHC, there are an estimated 15 outpatient specialized therapists and dietitians within the state.

Thus, many children, men, and women are not adequately treated or go undiagnosed. As a result, Iowans often turn to their primary care providers, including family care physicians.

Stories of Participants

Patients and families shared stories of interactions with primary care providers. Representative quotes are shown below. The perspective of the participant is shown within parentheses.

- The eating disorder started for me when I was 12. I weighed 140 pounds, not at all out of line with my growth curve and puberty. My pediatrician told me to lose weight. So, I lost 20 pounds in two months. When I went back to the pediatrician, he said lose 10 more. *(patient recovered)*

- A doctor triggered my relapse. When I was pregnant, I was clear with him about my history with eating disorders. I had gained a lot of weight, but I was okay with that. I was happy to have my baby. When I went in for the six weeks post-partum appointment, the doctor said it was inexcusable that I was still fat and had not yet lost weight. That was my worst year. *(patient recovered)*

- Over the past couple of years, my wife has started to have some problems – anemic, throat issues, and internal bleeding thought to be due to anemia. She had a colonoscopy; her doctor said there is a small nick in her esophagus. But, no one brought up bulimia. Now, that she has told me about having the eating disorder, it makes sense. *(family)*

- Even after explaining that I was 5’10” at 117 pounds, I was told that I was not thin enough to have an eating disorder. I hear that I am not thin enough all the time in my head, now the doctor is telling me. He reinforced the eating disorder. *(patient struggling)*

- I used to be a size 10. Now I am a size 2 and losing my hair. My doctor wanted blood work done to test for thyroid. Maybe when the results come in, she’ll know I have an eating disorder. *(patient struggling)*

Providers themselves offered the following suggestions.

- Doctors need to be more educated. They look away even though symptoms are present, such as low heart rate and dehydration.

- Providers need ongoing education. They need a phone-a-friend helpline. A lot of psychiatrists don’t want to do eating disorders.

- Website would help if kept up to date and was user-friendly. A person would be better. With practical information for doctors, such as letting them know what to have in a blood draw.

- Primary care providers have to do better at all this. We need to leave psychiatrists for the really tough cases; we can’t drop everything on them. We are all going to have to do the heavy lifting. We have to make doctors comfortable with codes and resources.

Conclusion

Primary care providers, including family care physicians, are critical to preventing, recognizing, and treating eating disorders in Iowa. They need more opportunities to learn and become prepared. They also need access to additional resources to appropriately assist patients and families.

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Spring/Summer Update

By Pam Williams, Executive Vice President

I'm so proud and honored to work for the Iowa AFP and to share experiences with our members that show how truly important Family Medicine is to Iowa and that reinforce what a bright future there is for Family Medicine in Iowa.

The end of the legislative session wrapped up on a positive not as the state will continue to match the funds to support the Rural Iowa Primary Care Loan Repayment Program to the same degree as previous years even though this is not the case for other line items. We are indebted to our lobbyist David Adelman for continuing to lobby for Family Medicine and loan repayment throughout the year.

I just returned from the AAFP's Family Medicine Congressional Conference in Washington, D.C. and was so proud of our delegation led by our Advocacy Committee Co-Chairs David Carlyle and Steve Richards, AAFP President Noreen O'Shea and members Laura Bowshier and Rob Lee. I wish all of you could have witnessed our Family Medicine resident Amber Meyer and medical student Emily Boevers as they spoke and shared personal stories with our senators and legislators encouraging continued and sustained funding for teaching health centers and in support of legislation to curb opioid addiction. The fall issue of Iowa Family Physician will include reflections from Amber and Emily.

In May we sent a full delegation to the National Conference of Constituency Leaders (NCCL) and Annual Chapter Leaders Forum (ACLF) in Kansas City. Representing the NCCL constituency groups were: Sarah Olsasky – Women Delegation; Joseph Freund – GLBT Delegation; Lisa Lavadie-Gomez – Minority Delegation; Anna Holzer – IMG Delegation; and Margaret Vittrioto-Kahn – New Physician Delegation. Attending the ACLF conference were IAFP President Noreen O'Shea, Board Chair Dawn Schissel, President-elect Jenny Butler and Vice President Scott Bohner. Staff Katie Cox and I also attended. Congratulations to Dr. Lavadie-Gomez who was elected as co-convener for the Minority Delegation for 2017 and as an Alternate Delegates to the AAFP Congress from the Special Constituency Group.

Since taking over this position in 2010 I have received repeated requests from IAFP members to bring back the Okoboji conference which we have done. We will be returning the first week in June and hope to make this an annual event.

I hope many of you will join us at the AAFP Congress of Delegates in September in Orlando as we support the candidacy of Rob Lee for AAFP President-elect. If you are planning on attending the Congress or FMX and will be in Orlando on Monday evening, September 19 please join us for the candidate hospitality event. If this is a possibility, please contact Katie Cox at kcox@iaafp.org.

I would also like to extend my congratulations to Marcia DeRoin, Executive Director of the Nebraska Academy as she retires from the NAFP in May. She has been a great friend to the IAFP and wonderful mentor to me. I am also very excited to welcome Liz Simon as the new Executive Director. Former IAFP EVP Janet Wee and I had the great pleasure to attend Marcia's retirement festivities last month and to get to spend time with Liz.

I hope many of you have or plan to participate in the series of cancer prevention webinars that we are sponsoring with the Iowa Cancer Consortium and the IDPH. This is a great opportunity to earn a free hour of Prescribed CME for each webinar.

Congratulations to Nebraska Chapter Executive Marcia Deroin on her retirement. IAFP EVP, Pam Williams, and former IAFP EVP, Janet Wee, are pictured with Marcia and Kansas EVP, Carolyn Gaughan.

This issue also provides detailed information on the Annual Clinical CME Conference, so please review the great program put together by our Education Committee and plan to join us in November. IAFP is working very hard to bring a variety of CME opportunities to you so I encourage you to get involved, participate and, as always, give us your feedback and suggestions.

Have a great summer!

The Giving Tree

BRANCHES OF GIVING

STUDENTS

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

RESIDENTS

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

TAR WARS

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

RURAL LOAN REPAYMENT

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

UNRESTRICTED

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

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TO SUSTAIN THE BRANCHES OF OUR
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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.

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Why Rob Lee, MD Will be the Next AAFP President-Elect

By Doug Martin, M.D., IAFP Alternate Delegate to AAFP Congress of Delegates

I recall that the first time that I met Rob Lee was at one of the IAFP Winter Get-a-Way meetings in Cancun in the mid-1990s. I had just started my practice in Sioux City and Rob was a partner with Tom Evans.

As we began to learn more about one another and share experiences on the various IAFP Committees there were some characteristics that I noted about the good Dr. Lee that stood out. We shared some commonalities; we had children that were roughly the same age, we had both been through a positive undergraduate fraternity experience, and we had both attended community-based residencies that prepared us well for the variety of practice challenges that were coming our way. We had some differences; allegiances to different college football programs, differing perspectives on the workers' compensation and disability systems, and a passion for running (I have none).

As I watched Rob grow and become IAFP President and then go on to become more involved at the national level within the AAFP and eventually being elected to the Board of Directors, it became clear to me that this man needed to eventually become an AAFP President.

Why was I so sure of this? And, why I am I writing this article? Is this just another one of those articles that a state academy "has to" put in its journal when they run a national candidate?

Those within the IAFP who know me well understand that I have a bit of a reputation for being able to figure out quickly what skills sets people have and which ones they don't. All prior IAFP Execs (and also the execs on some other organizations I belong to) claim that I can size up physicians after just talking and watching them for a short time and can tell what they will be good at. I suppose this "gut reaction" has been somewhat of a learned gift given my practice that is now almost completely devoted to workers' compensation injury care and medicolegal evaluations.

The thing about Rob Lee that I need to communicate is that my first impressions were spot on. Over the years, I have been amazed that he has followed a path nearly exactly as I would have expected. But, leaders and folks with vision have a tendency to do that. I know that those within the IAFP don't need convincing, but here are my four basic reasons why Rob will become AAFP President:

HE IS A CONSUMATE COMMUNICATOR

Leaders need to be great communicators. Think Ronald Reagan, perhaps the best example of a modern-era US President with exemplary communication skills. Communication is not just about being able to speak well in front of a crowd. It is a craft that extends into the ability to effectively explain and instill information amongst various different individuals and groups, in various different ways. Rob is an expert at not only expressing thoughts at a one-on-one level, but he is also able to do it in a large assembly gathering. He is one of those leaders who is able to "own the room" when there is a speech to be made, a trait that is quite rare amongst physician leaders.

HE UNDERSTANDS HIS LIMITS

Before you think this a strange thing to talk about when discussing leadership, no leader has ever been able to be good at everything. Especially in Family Medicine, where there is such a diversity concerning practices and levels of expertise, a leader understands that if there is an issue that comes up for which they do not have a good understanding, they need to lean on others for that level of expertise. This is where some physician leaders get themselves into trouble. The AAFP and its mission and vision are too important to have someone who tries to just "wing it". One obvious characteristic that I have noted about Dr. Lee is that he asks questions. Sometimes lots of questions. That should tell everyone that there is a desire to understand issues and empathize with physicians who sometimes have quite different experiences and challenges than he has. Yet, the leader must understand those perspectives in order to be representative of the thoughts and needs of the entire

IAFP is proud to present Rob Lee, M.D. as a candidate for AAFP President- Elect. The elections will take place at the Congress of Delegates in Orlando, Florida September 18-21, 2016. The IAFP will have a large delegation in Florida supporting Dr. Lee and would love to have you join us. If you plan on attending the Congress of Delegates or the Family Medicine Experience please let Katie know at kcox@iaafp.org so she can add you to the mailing list and keep you updated.

body of Family Medicine, not just those areas in his “comfort zone”.

HE IS A QUICK THINKER

Leaders have to be on their toes. Always. The ability to analyze a sticky situation quickly and react appropriately is not an easy thing. Whether you are being interviewed by a news reporter, or being grilled as an expert witness by a sharp attorney (been there, done that, got the t-shirt) a leader has to be able to show poise, calm, and professionalism at every turn. Rob Lee is quite possibly the best physician leader that I have ever seen in this area. I can’t recall him every being stymied by a difficult question, halted by a controversial issue, or distracted by others who exhibit off-track behavior. He seems to be able to handle all pressure situations quite well.

HE IS AN ADVOCATE

Leaders need to be adept at furthering a message. At the AAFP forefront, advocacy for the Family Physician is needed at multiple levels. Obviously there is a continued need for this in both the Federal and State governments. I have witnessed Rob’s interaction with state legislators, the Governor, and US Senators and Representatives. He “gets it” regarding how to weave in and amongst the politics of medicine and on issues of payment reform and over-burdensome regulation. He is also able to effectively argue for the virtues of Family Medicine within the greater house of medicine. Having been a President of the Iowa Medical Society no doubt has helped him in this area. As an AMA Delegate for Iowa who sits next to me as I serve similarly for a small specialty society (IAIME – formerly known as AADEP), I can attest that he is quick to understand how current and debated future AMA policy affects the family doctor and is able to articulate these things on the floor of the House and in Reference Committee testimony.

There are other traits that Rob Lee possesses that also make him well-suited to be the next AAFP President-Elect, but this is a magazine article and not a dissertation. Likeable, friendly, energetic, passionate, trustworthy, and ingrained are other descriptors that come to mind.

I have confidence that the next AAFP President-Elect will be from Iowa. It’s about time. Our state chapter is noteworthy for its accomplishments over the years, and many other state chapters and national staff have recognized this. It is time that we put forth one of our own to lead the national academy.

Family Medicine Congressional Conference: A Student and Resident Perspective

Every year, a handful of our members travel to Washington, DC for the Family Medicine Congressional Conference. By attending the conference, we are able to better understand the issues that affect family medicine at the federal level and learn about current priorities. This year, we took a student and resident member for the second time. Below are some trips highlights along with feedback from our student and resident attendees.

Emily Boevers

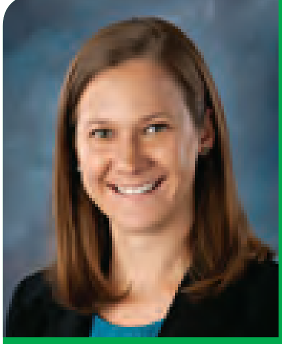
Recently, I was able to attend the Family Medicine Congressional Conference thanks to the generous sponsorship of the IAFP. I was pleased and proud to count myself among the IAFP delegation. Though there were only seven of us, some states had no representation and were left without a voice. Hearing from experts in fields ranging from state election policy to opioid control to mental health reform, we covered only a sliver of the issues that face patients and providers today. Collaborating with others who take an interest in health policy, I appreciated the wealth of knowledge, breadth of experience and passionate physicians that will catalyze healthcare improvement.

At the end of Day One, discussing our policy priorities, I could not help but be excited to head to the capital. For regardless of whether I like politics, I was part of the process of making policy, and I wanted to be great! In fact, I felt that I needed to be great: policy, whether great or rotten, impacts our patients young and old, our practices large and small. Policy impacts my life as a student and my future as a resident and my career as a physician. I was there not on behalf of myself, but on behalf of the patients I have seen and will see, my community, my classmates and my colleagues.

On Day Two, we headed to the capital. The scale of our national government was overwhelming. Buildings upon buildings housed representatives for each state, along with policymakers and public officials in other capacities. As the day went by, my understanding of the process of making good healthcare laws was increasingly complex. In each hallway and on every street corner, we passed other groups representing other interests; I realized how many voices are in the fray. Once or twice, my heart sank as I wondered if we were even making a difference. However, state representatives responding knowledgably about opioid concerns, Title VII funding or Teaching Health Centers restored my confidence in the process. As a student, I asked our representatives to commit funding for primary care training and investigation just as students commit to the long haul of a career in medicine. I asked them to empower physicians with the tools they need to manage patients' use of opioids so that we could see fewer patients, neighbors and families cope with addiction.

After returning home, I looked around at all the ways that healthcare policy plays out in medical education and clinical practice. In the way that we speak to patients about risks and benefits, in the codes we use and the bills we send, and in the relationship with our communities and patient populations, policy is at work. We may be individuals in a clinic, clinics in a system, systems spanning states and comprising the dynamic field of medicine, but our collective voice speaks with the heart and breath of each of us. Healthcare policy is all around us, and it is our right and clinical responsibility to interact with it. Thank you for allowing me the opportunity to do so.

Emily Boevers
M2 Carver College of Medicine



Amber Meyer

As a second year resident, I was honored to have the opportunity to attend the AAFP Congressional Conference in Washington, D.C. earlier this Spring. The AAFP Congressional Conference is made up of family physicians, residents, and medical students from across the country. The first day of the conference consisted of listening to multiple speakers to help prepare for the day on the hill. They shared with us some of the major concerns that the AAFP had and our strategy to influence legislation. I had not previously been overly interested in politics, but hearing the enthusiasm and passion of other family physicians was encouraging. It was inspiring to hear them speaking of topics that I also deal with on a daily basis.

By the end of the first day of the conference, we had our Iowa team of seven discussing which topics each of us would cover with our members of congress from Iowa. We were able to meet with Senator Grassley, Senator Ernst, Representative Loebsack, and Representative Young. We had some seasoned physicians with us, who have met with our congress members multiple times in the past, and other inexperienced people such as myself who had once met a Senator on a 5th grade trip to D.C. However, we were all important members of the team and all had different perspectives to bring up. The members of congress were all very interested to hear about what residency is like and what my plans were after residency. I got a few high-fives for planning to stay to practice in Iowa. We were able to talk with them about the issues we are facing nation wide with opioid abuse as well the importance of Graduate Medical Education funding.

Residency gets busy and I think sometimes it is easy to forget some of the bigger picture issues that are affecting our patients, as well as family physicians, residents, and medical students nationwide. I am now more attuned to what is going on as far as the AAFPs stance on legislation as well as what I can do to help make a difference. The IAFP gave me the opportunity to not only realize, but to voice to our Iowa members of congress what is important to Iowa family physicians.

Amber Meyer, MD
Genesis Quad Cities Family Medicine Residency Program

From left: David Carlyle, MD; Emily Boevers, M2; Rob Lee, MD; Steve Richards, DO; Senator Joni Ernst, Noreen O'Shea, DO; Amber Meyers, MD; Laura Bowshier, MD and Pam Williams.

Iowa Academy of Family Physicians End of Session

By David Adelman, IAFP Lobbyist

MEMORANDUM

To: IAFP
From: David Adelman Matt Hinch & Frank Chiodo - Cornerstone Government Affairs
Date: May 5, 2016
Re: End of Session update

Going past its scheduled time for adjournment (April 19th), the Iowa Legislature finally resolved several contentious issues and adjourned on April 29. Traditionally with election year session's legislators tend to be risk-averse, however the 2016 session of the Iowa General Assembly had a number of issues affecting Iowans and Iowa small businesses. Most notably discussed were education-funding, Medicaid managed care, tax coupling with federal code, and an effort to improve water quality.

Moreover, in March the Revenue Estimating Committee reported to the Legislature they had to cut $46 million out of their overall budget number that had been projected in December. This realization was bad news for any interest group wanting an increase in funds or a creation of a new state program needing dollars. The Governor was able to sign into law a bio-renewable chemical tax credit; a priority of his administration for the last 3 years. The Legislature did find common ground on K-12 education funding by increasing the "per-pupil" amount spent by 2.25%. Additionally, the Legislature was also able to come to an agreement coupling parts of the Iowa tax code with the federal tax code.

Water Quality

The Legislature was unable to agree on funding statewide water quality programs prior to adjournment. The focus on improving Iowa's water quality sharpened in 2015 when Des Moines Water Works filed a federal lawsuit against drainage districts in three northwest Iowa counties. The lawsuit contends that the districts' tile lines exacerbate pollution in drinking water by moving nutrients more quickly from farm fields to waterways, which cities like Des Moines must pay to remove. State officials have said the water supplies of about 260 Iowa cities and towns are highly susceptible to being contaminated by nitrates and other pollutants. The state's Nutrient Reduction Strategy, adopted in 2013, aims to reduce rural and urban nitrogen and phosphorous levels through a science- and technology-based framework.

The House, Senate and Governor had three different ideas dealing with the problem but in the end agreed that any tax hike or appropriation of dollars had virtually no chance of winning approval this year. The Iowa Senate approved a bill raising the state sales tax by three-eighths of 1 cent, which would generate about $180 million starting next year. About 60 percent of that revenue would be directed to cleaning up Iowa's polluted waters. A proposal by Gov. Terry Branstad to divert a portion of future sales tax revenue growth meant for school infrastructure toward programs to curb water pollution was rejected by the General Assembly. Conversely, the House passed their own plan to generate nearly half a billion dollars for water quality efforts over 13 years by shifting money from state infrastructure projects and using revenue Iowans already pay on their water bills.

Health and Human Services Budget

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Report

In a number of areas, the House and Senate versions were quite close. In addition to reconciling budget numbers, few policy provisions were agreed to in the final conference report.

1) Meningitis vaccination- requires a student going into 7th grade to have received a meningitis vaccination and a booster in 12th grade.

2) Naloxone- Earlier this session, the legislature passed and the governor signed SF 2218, expanding access to the opioid antagonist naloxone. The bill that was signed needed several corrections prior to implementation. The conference report makes those corrections, including clarifying that a person in a position to assist an overdosing individual may be prescribed naloxone, and striking the section that made implementation of the Act contingent on available funding. It also allows a pharmacist to dispense naloxone through a standing order or a collaborative practice agreement with a physician.

3) Medicaid Privatization Oversight.

   a. Legislative Health Policy Oversight Committee to meet twice during the interim; hear concerns, make recommendations, and ensure effective and efficient administration of the Medicaid managed care program
   b. Clarifies the authority and duties of the Long-Term Care Ombudsman to advocate for Medicaid members. $100,000 added for 1 more Managed Care Ombudsman
   c. Expands and clarifies duties and authority of the Medical Assistance Advisory Council (MAAC). Consumers will have a stronger voice on the MAAC. Consumer will co-chair MAAC and MAAC Executive Committee. Governor must appoint 10 consumer members by July 1, 2016. The Long Term Care Ombudsman and a member of the hawk-i Board are added to MAAC.
   d. MAAC statewide public meetings will continue through 2017. DHS will submit a compilation of recommendations and input to the Legislative Health Policy Oversight Committee.
   e. Accountability and Transparency: Requires reporting (quarterly and annually) and public posting of data on consumer protections, outcome achievement and program integrity
   f. External quality review reports and NCQA reports on the 3 MCOs shall be submitted directly to the legislature
   g. The DHS Council, MAAC, Hawk-i Board, MHDS Commission, and the Office of Long Term Care Ombudsman shall regularly review Medicaid managed care and report their findings to DHS, for inclusion in the annual report to the legislature. They will also submit relevant minutes of their meetings quarterly to the legislature.
   h. Program Policy Improvements
      i. At a recipients request an MCO will continue services during an appeal and provide adequate prior notice of potential recovery of costs
      ii. Providers shall be allowed to file appeals on a recipient's behalf
      iii. MCOs shall not impose more restrictive scope of practice requirements or standards of practice on a primary care provider than those in current state law
      iv. MCO shall attempt to set up single case arrangements with out of network providers
      v. Occupational therapy is added as a covered service in hawk-i

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4) Physician Medicare Rate Alignment with Medicaid- The governor's proposal eliminates the enhanced Medicaid rates for primary care physicians that were first enacted as part of the *Affordable Care Act*. The conference report does not "enroll" this reduction.

5) Dual Eligible Payments- The Governor proposed a measure which eliminates Medicaid coverage for Medicare crossover claims on dually eligible enrollees when the Medicare rate is higher than the Medicaid rate. The conference report does not "enroll" this reduction.

6) Medicaid Rate Floor- The conference report codifies a measure already found in the managed care organizations' contracts with the state, establishing Medicaid rate floors as those rates in existence on June 30, 2016.

7) PRIMECARRE- $74,000- The Governor's request was honored by the Senate and House.

8) Rural Primary Care Loan Repayment Program- $1.6 million in the Education Budget, $105,000 in the HHS Budget.

9) Medical Residency- $2million - Appropriated funds to the medical residency training state matching grants program through the Iowa Department of Public Health. Priority in awarding these grants shall be given to psychiatric and family practice residency.

10) Graduate Medical Education Payments- The governor's proposal denies requested state funds for this program, which offers funding for UIHC's medical students, citing concern that training more medical students will be ineffective until Iowa meets the need for more residency positions that graduates of Iowa medical schools can fill. The conference report did not include this request in their versions of the legislation.

11) DMU Health Care Professional Recruitment Program- $401,000- Provides student loan repayments for graduates of Des Moines University's DO, DPM, DPT, and PA programs. In exchange for four years of full-time service in an eligible rural community, the state awards up to $50,000 toward an awardee's student loans, which then must be matched by the awardee's employer, hospital or community. Status quo from FY16. The Governor's request was honored in both the final conference report.

12) University of Iowa Family Practice Program- $1.79 million- Provides financial, educational, and technical support to a statewide network of community-based family practice physician residencies. Status quo from FY16. The Governor's request was honored in both the final version.

13) University of Iowa Primary Care Initiative- $649,000- Funds four separate programs in support of rural physician recruitment, placement, and retention services. Status quo from FY16. The Governor's request was honored in both the conference report.

Children's Health

Although there were risks in cuts to early childhood funding we are happy to report through a coalition of advocates dollars for most programs stayed status quo and increased in a few areas. The Shared Visions Preschool Program remained funded. This program serves high risk children, ages three to five, in 51 Iowa counties. The programs are accredited by the National Association for the Education of Young Children. These programs are funded by the Child Development Coordinating Council (CDCC). The CDCC receives approximately 2/3 of the State's standing General Fund appropriation for early childhood at-risk

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programming. In addition to funding Shared Visions preschools, the CDCC uses approximately 10.0% of the allocation to fund parent support programs.

The most contentious of legislation was the Health and Human Services bill. Final action setting funding and policy for health and human services faced delays related to House-Senate differences over Medicaid oversight and funding for Planned Parenthood. A conference committee reached a compromise on those issues and others, and both chambers approved its report in the early evening on April 29. The conference report contains three appropriations specific to early childhood issues.

The legislation increases appropriations for Iowa's 1st Five Initiative to $3,275,059 -- $1,076,000 more than the initiative received in fiscal year 2016. With this additional funding, 1st Five will be operational in at least 65 Iowa counties in fiscal year 2017 and likely expand to additional sites.

The approved report also contains $300,000 for two sites to plan how to establish local children's mental health crisis services systems. The sites will be selected through a competitive selection process. The bill also directs DHS to (1) choose three to five programs to serve as children's well-being learning labs and (2) oversee an advisory committee to build upon the efforts of an earlier children's mental health and well-being work group.

The legislation further appropriates $50,000 to continue annual surveys on the effects of childhood trauma on the health of adult Iowans. A new report on the findings from 2012-14 surveys will soon be available. The Central Iowa ACEs 360 Steering Committee has published an Executive Summary of this research.

Finally, the legislation continues longstanding funding for the Iowa Child Abuse Prevention Program, including: $125,000 from the Temporary Assistance for Needy Families (TANF) program and $202,000 in a line-item specifically for child sexual abuse prevention instruction

Policy Legislation affecting Physicians

SF 2188 (psychologist prescribing) – Proponents were successful in passing SF 2188, which would grant prescriptive authority to psychologists. In the end, the bill passed with an amendment that restricted the use of narcotics and mandates the Iowa Board of Medicine promulgate joint rules with the Board of Psychologists relating to supervision and collaborative practice agreements.

HF 2384 (Medical Marijuana)- proponents of HF 2384, the medical marijuana legislation until the very end attempted to find a path forward for the bill after it was sent to the House Ways and Means Committee where there the chair has voiced his opposition to the legislation. The idea to attach the policy to a budget bill was abandoned after it was determined that doing so would cost House Republicans too many votes to secure final passage of the budget bill. Proponents are expected to enter the 2017 legislative more determined than ever.

SF 2144. The Iowa General Assembly passed legislation, Senate File 2144, to permit disclosure of otherwise confidential behavioral health information under Iowa law for care coordination purposes. SF 2144 was signed by Governor Branstad on April 6 and became effective on that day. SF 2144 first amends Iowa Code section 125.37, confidentiality of substance abuse treatment facility records, to permit disclosure of patient records for care coordination purposes "if not otherwise restricted by federal law or

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regulation." In the same way, SF 2144 amends Iowa Code chapter 228, disclosure of mental health and psychological information, to permit disclosure of confidential mental health information for care coordination purposes "if not otherwise restricted by federal law or regulation." Care coordination is defined by reference to Iowa Code section 135.154* as "the management of all aspects of a patient's care to improve health care quality." Behavioral health providers are encouraged to remain cautious before disclosing sensitive substance abuse and mental health patient information within SF 2144's broadly defined context of care coordination. To the extent that this new Iowa law conflicts with federal laws and regulations, federal law prevails. Too, permissible disclosures under SF 2144 must satisfy conditions, such as those set forth in section 228.2, governing permissible disclosures.

Thank you for the opportunity to represent the organization during the 2016 legislative session. We look forward to engaging in the November election and positioning ourselves for a successful 2017 session.

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IOWA & MARYLAND ACADEMY OF FAMILY PHYSICIANS

2017 WINTER CME CRUISE

ABOARD THE ROYAL CARIBBEAN ALLURE OF THE SEAS

JANUARY 29 - FEBRUARY 5, 2017

SHIP DEPARTS FROM FT. LAUDERDALE, FL / PORTS- BAHAMAS, ST THOMAS & ST MAARTEN

You must register for the CME portion of the cruise separately this can be done by going to www.iaafp.org

CRUISE REGISTRATION (ALL FEES ARE PER PERSON) CIRCLE YOUR CHOICES

• Deluxe Ocean Stateroom w/balcony, based on double occupancy	$1019.00
• Junior Suites	$1799.00
• Interior Staterooms	$749.00
• Taxes and Fees	$111.29
• Gratuities	$90.65

OPTIONAL FEES:

• Cruise Care Travel Insurance	$119.00 Suites / $89.00 Balcony / $59.00 Interior

ROUNDTRIP AIRPORT TRANSFER:

• Fort Lauderdale	$33.50
• Miami	$60.00

CRUISE DEPOSIT/ PAYMENT SCHEDULE

- Initial Deposit of $300.00 per person at the time of booking
- Final Payment: Balance due no later than November 15, 2016

CRUISE CANCELLATION/ATTRITION

- Between 57-89 days prior to sailing the cancellation penalty is $250.00 per guest.
- Between 29-56 days prior to sailing the cancellation penalty is 50% of the total price.
- Between 29-56 days prior to sailing the cancellation penalty is 50% of the total price.
- Between 15-28 days prior to sailing the cancellation penalty is 75% of the total price.
- Between 14-0 days before until sailing date there is no refund.

Please note that we expect the cruise to sell out so please register ASAP to assure your spot!
To register by phone: Call Katy at 312-404-4054. To register by email please attach the form and send to katy@leisurecorptravel.com.

_______________________ Legal Name of 1st Person in Cabin (If more than 2 people traveling fill out separate form)

_______________________ Legal Name of 2nd Person in Cabin

_______________________ Date of Birth/Citizenship

_______________________ Date of Birth/Citizenship

_______________________ Street Address   City   State   Zip

_______________________ Phone#   Emergency Phone #   Fax   E-mail Address

PAYMENT INFORMATION FOR CRUISE: Cruise payments will go the LeisureCorp Travel Agency

TOTAL FOR CRUISE TO LEISURECORP: $____________

_____ Credit Card Type - please circle AX Visa MasterCard Discover

_____ Check (make check out to LeisureCorp)

_______________________ Name (as it appears on the card)

_______________________ Credit Card Number

_______________________ Expiration Date

_______________________ CCV Code (three digit code on the back of the card)

2017 Annual Clinical Education Conference Faculty Proposal/Abstract

The 2017 IAFP Annual Clinical Education Conference will be held November 1-4 at the Downtown Marriott Hotel in Des Moines, Iowa. The conference starts on Thursday evening and continues all day on Friday and ends on Saturday. Most presentations are limited to 30 minutes followed by a 20 minute Q & A/Panel Discussion of all of the speakers who presented during the morning or afternoon block.

If you are interested in teaching at this conference, please complete the information below and return this form along with your topic suggestion and evaluations from previous presentations if available. The 2017 Curriculum will include topics in these areas: Cardiovascular, Female Reproductive, Hematology, Nephrology, Musculoskeletal, Population-Based Care, Psychiatry and Special Sensory.

Submit a separate form for each topic:

Title of Proposed Topic:

____

Statement of Identified Need:

____

Objectives (NOTE: The Education Committee may modify these changes to meet identified learner needs and/or gaps):

At the conclusion of this presentation the participant should be able to:

1) ____

2) ____

3) ____

Proposed Faculty:

Name: ______________________________ Specialty: ______________________________

Email: ______________________________ City: __________________ Phone: __________________

Please note proposed topics will be reviewed by the IAFP Education Committee who will make the final determination of which topics will be presented at the conference. Preference will be given to those topics that fall within the IAFP CME curricular framework outlined above and are received by January 15, 2017.

Return to:

Pamela Williams, IAFP
100 East Grand Avenue, Suite 170
Des Moines, Iowa 50309
Email: pwilliams@iaafp.org
Fax: 515-283-9372
Phone: 515-283-9370

POLICY:
Appointment to Serve on IAFP Committees

Each year a communication is published in the Iowa Family Physician Magazine calling for volunteers to serve on IAFP committees and appointments. Volunteers and appointments will be accepted throughout the year.

Committee appointments and terms will follow the process below.

All volunteers will be sent the Conflict of Interest Statement for completion and review by the Board or Executive Committee for approval. Volunteers completing this process will be considered candidates for the committee they have selected.

The Board of Directors or the Executive Committee will review and approve committee appointments throughout the year. The candidates will be evaluated based of the following criteria:

1. The candidate is a member in good standing with the IAFP

2. The candidate complies with the AMA Code of Ethics per AAFP membership criteria

3. The candidate has no conflicts of interest or the conflicts can be resolved to the committee's satisfaction.

IAFP Committee appointments will be effective upon approval of the Board or Executive Committee. Terms are currently one year in duration with the option to renew the appointment each year.

To volunteer, please visit www.iaafp.org/committees

68TH IAFP CLINICAL EDUCATION CONFERENCE

November 3-5, 2016

Downtown Marriott, Des Moines, Iowa

THURSDAY, NOVEMBER 3. 2016

IAFP BUSINESS MEETINGS

8:00 am	PAC Board Meeting
9:00 am	Foundation Board Meeting
10:30 am	Education and Membership Committee Meetings
12:30 pm	Advocacy Committee Meeting
2:30 pm	Board Meeting

ANNUAL CLINICAL EDUCATION CONFERENCE OPENS

4:00 pm	Registration
5:30 pm	Welcome/ Introductions & Overview
5:45 pm	END OF LIFE CARE: PALLIATIVE CARE CONSIDERATIONS IN END-STAGE SYSTOLIC HEART FAILURE AND COPD - W. David Clark, MD, Clinical Associate Professor of Family Medicine Palliative Care, University of Iowa, Iowa City
6:25 pm	END OF LIFE CARE: CARE OF THE DWINDLING DEMENTIA PATIENT Michelle Weckmann, MS, MD, University of Iowa Healthcare, Iowa City
7:10 pm	TO DO OR NOT TO DO: ETHICAL CHALLENGES AT END OF LIFE CARE - Norma J. Hirsch, MD, FAAHPM, FAAP, Assistant Professor, Department of Behavioral Medicine, Medical Humanities, Bioethics, Des Moines University, Des Moines
7:55 pm	Question and Answer/ Panel Discussion
8:15 pm	Recess
8:15-9:15 pm	2015 Donor Appreciation Reception (In recognition of 2016 Donors of the IAFP Foundation, Rural Loan Repayment Program and PrimCare PAC)

FRIDAY, NOVEMBER 4, 2016

6:30 am	Registration
7:00 - 8:30 am	Breakfast in Exhibit Hall
7:15 - 7:45 am	IAFP Business Meeting
7:55 am	Introductions and Announcements
8:00 am	HYPERTENSION: EVIDENCE-BASED GUIDELINES AFTER SPRING AND HOPE3 - Paul James, MD, Professor and Chair, Department of Family Medicine, University of Iowa, Iowa City
8:30 am	MYSTERY OF THE ADRENAL GLAND - Pearl Dy, MD, Iowa Diabetes and Endocrinology Center, Des Moines
9:00 am	HEPATITIS C - Jorge Zapatier, MD, Mercy Gastroenterology Clinic, Des Moines
9:30 am	Break – Exhibit Hall
9:50 am	PAP SMEAR - In cooperation with the Iowa Chapter of the American Cancer Society and supported by the Iowa Department of Public Health - Hannah Heckart, MD, Great River Women's Health, West Burlington
10:20 am	HIP IMPINGEMENT SYNDROMES - Shawn Spooner, MD, UnityPoint Clinic-Sports Medicine, Urbandale
10:50 am	Resident Case Presentation – TBD
11:00 am	Q & A/Panel Discussion from Morning Presentations
11:30 am	Lunch and Keynote Presentation: AAFP Update - TBD
12:15 pm	Visit Exhibits
12:30 pm	JOURNAL CLUB LIVE - Mark Graber, MD, Professor of Family and Emergency Medicine, University of Iowa Carver College of Medicine, Iowa City and Jason Wilbur, MD, Associate Professor, Department of Family Medicine, University of Iowa Carver College of Medicine, Iowa City
1:30 pm	EVIDENCED BASED GUIDELINES FOR RETURN TO WORK - Douglas W. Martin, MD, FAAFP, FACOEM, FAADEP, Medical Director, UnityPoint Clinic- Occupational Medicine, Sioux City
2:00 pm	RADON: LINKS TO LUNG CANCER In cooperation with the Iowa Chapter of the American Cancer Society and supported by the Iowa Department of Public Health - Cynthia Wolff, MD, Mercy Medical Center, Akron
2:45 pm	Break in Exhibit Hall with Dessert - Sponsored by Midwest Dairy
3:15 pm	USE OF ANTI-PSYCHOTICS - Ronald Berges, DO, Mahaska Health Partnership, Oskaloosa
3:45 pm	CARE OF THE RETURNING SOLDIER - LTC Jeffrey Lanier, MD
4:15 pm	Resident Case Presentation – TBD
4:25 pm	Q & A /Panel Discussion - From Afternoon Presentations
5:00 pm	Recess for the Day
5:00 pm	Reception/ Resident Medical Jeopardy - Join us at 5:00 pm for snacks and refreshments as you cheer on your favorite Jeopardy team at 5:30 in this fun and lively competition. - Doug Martin, MD, MC
6:00 pm	Reception & Wine Grab
7:00 pm	Installation & Awards Banquet
9:00 pm	Post-Banquet Reception

SATURDAY, NOVEMBER 5, 2016

7:15 am	Past President's Breakfast
7:30 am	Breakfast for Registrants
8:00 am	UPDATE ON ABFM PROCESS/ PROCEDURES – GET ANSWERS TO YOUR QUESTIONS - Joe Tollison, MD, Senior Advisor to the President, American Board of Family Medicine, Lexington, KY
10:00 am	Adjourn

OPTIONAL SESSION - ADDITIONAL FEE REQUIRED

8:00 am	ABFM Self-Assessment Module (SAM) - ASTHMA - Mark Graber, MD, Professor of Family and Emergency Medicine, and Jason Wilbur, MD, Clinical Associate Professor, Department of Family Medicine, University of Iowa Carver College of Medicine, Iowa City

Navigating the Future
2016 IAFP Clinical Education Conference Registration Form

Name____Spouse/Guest Name (s) (if attending) ___________________________

Address ____

City____State_________________________________ Zip __________________

Phone____Email ____

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

A. Thursday, Friday and Saturday November 3-5 CME Registration Fees:

Registration Type	Early Fee (Until 10/1/2016)	Regular Fee (Starting 10/2/2016)
Active Member	$295	$350
New Physician Member (< 7 yrs in practice)	$250	$275
Life/Inactive Member	$195	$195
Resident/Student Member	N/C	N/C
PA/NP who works with an AAFP member	$295	$350
Non-Member (includes PA/NP)	$395	$450
Faculty	N/C	N/C

Thursday ONLY-End of Life Care (This is included in the full conference registration. Select this if you ONLY want to attend this session)
Member $80 _______ Non-Member $100 _______

All attendees will receive a flash drive at the conference loaded with the syllabus as part of your registration fee. The syllabus will also be available online prior to the conference for you to download and print free of charge. NO PAPER COPIES WILL BE PROVIDED.

To help with meal and material counts please selcet which sessions you will attending.
☐ Thursday Evening ☐ Friday ☐ Saturday Morning ☐ None of the options listed above
Total Section A: __________

B. Optional Courses to be held on Saturday, November 5:

Asthma - SAM Course (4-6 hours) Member $175 _______ Non-Member $200 _______
Total Section B: __________

C. Installation/Awards Banquet:

Friday Evening, Installation/Awards Banquet: *($25.00 for registered attendee)* Yes _______ No_______
Spouse/Guest Banquet Fee @ $75 per person Number of guests for: Friday Banquet_______
Total Section C: __________

D. Donations:

Rural Primary Care Loan Repayment Program in the Amount of: $________
IAFP PrimCare PAC Donation in the Amount of $_______
Foundation Donation in the Amount of: $________

Total Section D: __________

E. Payment:

Section A: $_______ **Section B: $**_______ **Section C: $**_______ **Section D: $**_______ **Total Due:** $____________

2 EASY WAYS TO REGISTER:

1) Mail completed registration form with payment to: IAFP, 100 East Grand Ave, Ste 170, Des Moines, IA 50309

2) Register online at: www.iaafp.org

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

Okoboji: A stroll down memory lane...

Robin Barnett, DO & Sons

Steve Shook, MD

Gerry Stanley, Sr., MD

Francis Pisney, MD & Daughter

Joe Kennedy, DO & Family

Steven Mineart, MD & Family

Katie Cox, long before she worked at IAFP

Sue Langbehn, MD & Don Skinner, MD

Kelly Ross, MD

George Kappos, MD & Family

Doug Hoch, MD & Family

Join us to create new memorable moments!

Screening for colorectal cancer saves lives through prevention and early detection.

Make sure that ALL of your patients 50 and older regularly get screened.

Your recommendation to your patients to get a regular screening test is the most powerful influence there is.

The American Cancer Society offers free materials to make it easier for you to make sure that each and every one of your patients who should be screened gets screened for colorectal cancer:

- Web-based toolbox and guides to help you increase screening rates in your practice
- Free patient brochures, videos, and wall charts
- Sample patient screening reminder tools for you to adapt for your practice

Visit **cancer.org/colonMD** for details.

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Meet A Member

Get to Know….

Rob Lee, M.D. , IAFP Past President and Candidate for AAFP President-Elect

1. Why did you pick family medicine?

When I went into medicine, there were only two kinds of physicians that I knew about, family physicians and surgeons. When I got into Madison, every rotation was my favorite. I wanted to be an otolaryngologist, then a cardiologist, then the orthopedist, then the dermatologist, then a gynecologist. Finally I figured out the only way I could do all of those was family medicine.

2. Favorite part of being a family physician?

My favorite part of being a family physician is the gratitude my patients show for the care they get. What other job do you get to hear thank you, frequently followed by a hug or a hearty handshake 25 times a day?

3. Biggest challenge facing family medicine today?

Physician burnout is the most challenging issue facing family medicine today. Every year we lose the equivalent of one graduating medical school class to suicide. We need to go help our physicians identify the symptoms for now and equip them with skills to overpower it.

4. How do you balance your professional and personal life?

We know we cannot care for others unless we care for ourselves.. That is one of the first lessons I teach new moms. I take that advice to heart. I know I am a better position, husband, father, and leader when I make time to take care of myself through exercise, hobbies, and dialogue with my colleagues.

5. Favorite ice cream flavor?

Heath bar blizzard from Dairy Queen

6. Favorite song?

One Call Away by Charlie Puth. That seems to sum up my invitation to my patients, my family, and my family medicine colleagues.

7. Tell us something people would be surprised to know about you?

That I was a band geek, playing alto saxophone for the marching band.

8. Favorite Movie?

On Golden Pond

9. Favorite Book?

John Grisham novels

10. What was your first car?

Was a VW rabbit

New Members

Active

Robert Beck, MD, Cedar Rapids
Casey Clor, MD, West Des Moines
Anne Darby, DO, Des Moines
Case Everett, MD, Oskaloosa
Ojiaku Ikezuagu, MD, Corydon
Todd Isaacson, MD, Shenandoah
Benjamin Kumor, MD, Asbury
Sandhya Nallu, MD, Muscatine
Ekaterina Roman, MD, Ankeny
Anjali Sobti, MD, West Burlington
John Swisher, DO, Mason City

Resident

Kevin Hanigan, DO, Riverhead
Luei Wern Ong, MD, Iowa City
Kathleen Schroeder, MD, Coralville
Michelle Shafer, DO, Davenport
Victoria Tann, MD, Coralville
Robert Wood, DO, Iowa City

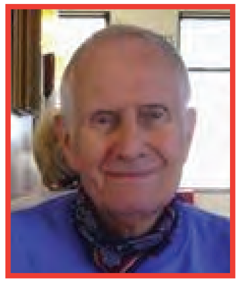
Student

Cole Cheney, University of Iowa
Ellen Gardner, University of Iowa
Mangala Gopal, Des Moines University
Kristin Hetz, University of Iowa
Shelby Hopp, University of Iowa
Hannah Trembath, University of Iowa
Lisa Weaver, University of Iowa

In Memoriam

Robert Dunlay, MD

Wayne E. Rouse, MD
IAFP President 1984-1985



Les Weber, MD
IAFP President 1978-1979

CORRECTION: *We offer our deepest apologies. Dr. Enfred Linder was listed under the "In Memorium" section in our last issue. Our office had been given inaccurate information and we apologize for the confusion.*

Congratulations to Dr. Lavadie-Gomez!

Congratulations to Lisa Lavadie-Gomez, M.D. on being named the Minority Co-Convener at NCCL and Alternate NCCL Delegate.

Thanks to Our 2016 Foundation Donors:

Melissa Austreim, MD
Larry Beaty, MD
Scott Bohner, DO
R. Ried Boom, MD
Jenny Butler, MD
Josephine Dunn Junius, MD
Garrett Feddersen, DO
Donal Gordon, MD
Stephen Holmes, MD
George Kappos, MD
Eleanor Lisa Lavadie-Gomez, MD
Rob Lee, MD
Michael Maharry, MD
Douglas Martin, MD
Lonny Miller, MD
Kenton Moss, MD
Steven Perkins, DO
Steve Richards, DO
Dawn Schissel, MD
Dustin Smith, MD
Kate Thoma, MD
Joel Wells, DO
Jason Wilbur, MD

Don't see your name and want to make a donation? Visit our web site to make a donation or turn to page 13.

New Residents

Broadlawns Medical Center Residency Program
Jeremy Cordes, DO (DMU)
Elizabeth Dupic, MD (Iowa)
Alexandrea Jacobs, DO (DMU)
Heather Leong Holstein, DO (DMU)
Andrew McMurray, DO (DMU)
Audra Poterucha, DO (DMU)
Kelsey Randel, DO (DMU)
Nathan Thomas, MD (Iowa)

Cedar Rapids Family Medical Education Foundation
Alexandre Efimov, MD (Ross- Dominica)
Christine Hawks, MD (American- St. Maarten)
Andrew Ingraham, MD (Antigua)
Brian Marovets, MD (Iowa)
Erika Toyoda, MD (South Dakota)
Bora You, MD (Saba- Caribbean)
Ivan Zadounaev, MD (Ross- Dominica)

Genesis Quad Cities Family Medicine Residency
Nicole Brokloff, MD (Iowa)
April Lanning, DO (DMU)
Jonghyun Lee, DO (DMU)
Monique Phillpotts, MD (Southern Illinois)
Rajak Randhawa, MD (St. Kitts and Nevis)
Christina Woodhouse, MD (Iowa)

Iowa Lutheran Family Medicine Residency Program - Des Moines
Daniel Hanson, MD (Ross- Dominica)
Sarah Jones Ketter, DO (Rocky Vista)
Samantha Keady, DO (DMU)
Kavita Powaria, MD (India)
Eryn McClutchey, DO (DMU)
Meredith Swenson, DO (DMU)

Mercy Medical Center Residency Program - Des Moines
AJ Abcejo, DO (Kansas City)
Saeed Afaneh, MD (Ross- Dominica)
Julia Black, DO (Kansas City)
Matt Ferguson, DO (DMU)
Jasmina Sabric, DO (DMU)
Dania Siddiqui, MD (St. James)
Nayab Syed, MD (St. James)
Marissa Pyle, DO (Kansas City)

North Iowa Mercy Residency Program - Mason City
Jonathan Demory, MD (Toledo)
Kelly Duggin, MD (Ross- Dominica)
Travis Johnson, MD (Poland)
Alec Pramhus, MD (St. Matthews- Grand Cayman)
Preyanshu Parekh, DO (DMU)
Katherine Renfer, DO (Michigan State)

Northeast Iowa Family Medicine Residency Program
Michelle DiCostanzo, MD (Wayne State)
D. Pierre Gingerich-Boberg, MD (Wisconsin)
Violet Kyakumanya Mwanje, MD (Uganda)
Danny Lewis Jr., MD (Minnesota)
Kurtis Lucas, MD (Oklahoma)
Kelly Tse, MD (UMHS- St. Kitts)

University of Iowa Family Medicine Residency - Iowa City
Jessica Alston, MD (Iowa)
Whitney Kaefring (Iowa)
Emily Nielsen, MD (Iowa)
Stephen Pape, MD, MPH (Florida)
Jessica Ryba, MD (Iowa)
Puja Toprani, MD (Florida)

Siouxland Medical Education Foundation Residency Program
Erin Kastl, DO (Kansas City)
Laramie Lunday, MD (North Dakota)
Katie Savio, DO (Lake Erie)
Ashley Tiahrt, MD (Nebraska)
Chris Wolf, DO (DMU)
Tou Lee Xiong, MD (Minnesota- Duluth)

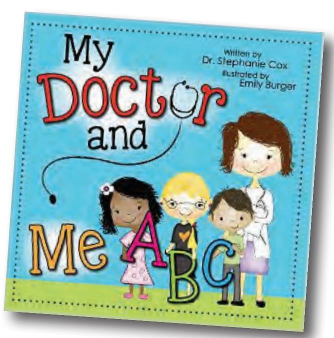
2016 Match Highlights

- 3,105 medical students and graduates matched to family medicine residency programs in 2016, the most in family medicine's history as a specialty.
- Family medicine offered 3,260 positions, 44 more than 2015.
- 24 students from University of Iowa went into Family Medicine
- 49 students from Des Moines University went into Family Medicine

Dr. Cox Writes New Book

IAFP Member Dr. Stephanie Stitt Cox recently wrote a book titled "My Doctor and Me ABC." The book introduces kids to the sights and sounds of the doctor's office through the ABCs. The goal of the book is to acquaint kids with keeping their bodies healthy and to help ease any worries about going to the doctor office.

The book is available on amazon.com, barnesandnoble.com and iTunes.



A reputation is like trust.

It takes years to grow, but can be ruined in seconds. Make sure your reputation is protected with malpractice insurance coverage from PSIC.

Malpractice insurance is underwritten by Professional Solutions Insurance Company.
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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 $2,500 Farm Bureau Scholarships that are given to two students and two residents annually. Eligibility requirements are:

Resident (R3)

- Completing an Iowa residency program in 2016
- Locating in a practice in a rural Iowa setting under 10,000 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 2016
- Holding membership in the IAFP/AAFP
- Demonstrated scholarship and achievement in medical school
- Completion of the application requirements

Application Requirements

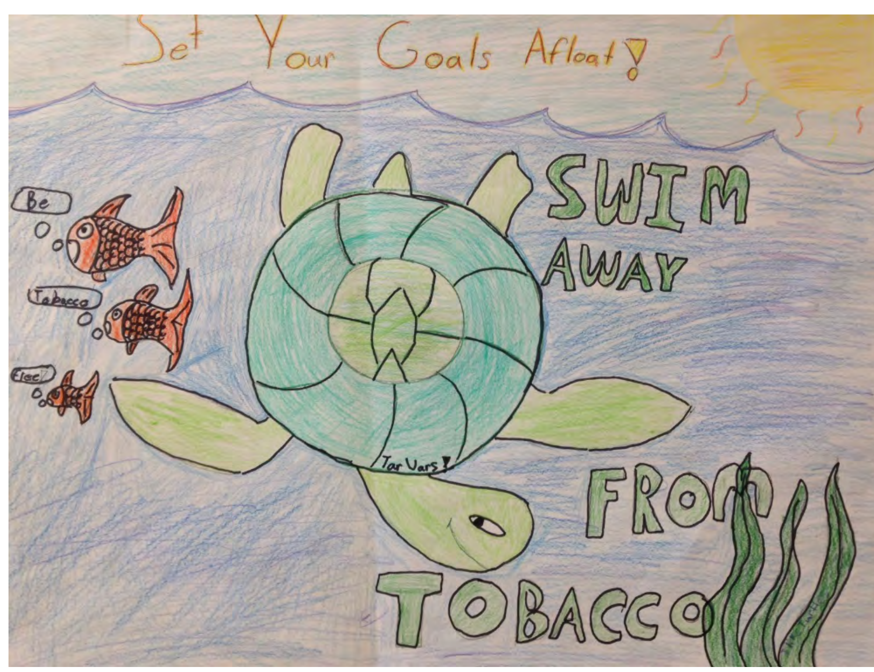
- Write a brief essay explaining your personal philosophy about medical care, in particular family medicine, and outline your intended career plans
- Enclose a curriculum vitae
- Enclose two letters of recommendation from faculty members at the residency program or medical school

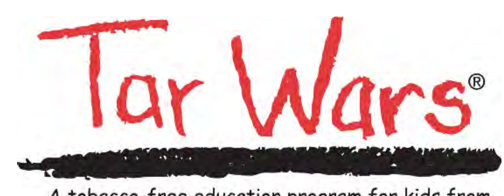
Criteria for Consideration

- 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 10,000 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, 2016.

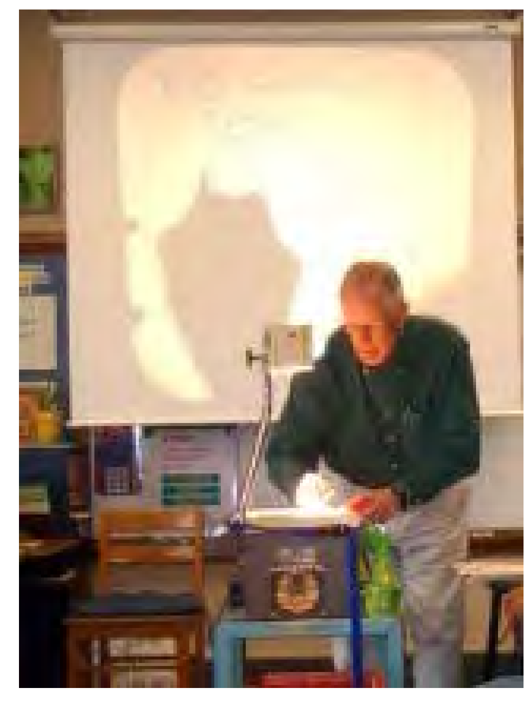
For further information contact Kelly Scallon at the IAFP Foundation office 800-283-9370 or via e-mail at kscallon@iaafp.org.





The competition was strong for the 2016 Tar Wars Poster Contest! Congratulations to our first place winner: Haley Rork from Clayton Ridge Elementary in Garnavillo! Thanks to the University of Iowa FMIG, members, teachers and schools that participated in Tar Wars this year!

The Weber Legacy



Tar Wars is a tobacco-free education program for fourth- and fifth-grade students, owned and operated by the American Academy of Family Physicians. Dr. Les Weber has been a crucial part of the Tar Wars program in Iowa. As the leading Tar Wars presenter in Iowa City and Cedar Rapids, Dr. Weber was responsible for teaching the Tar Wars program to thousands of children.

With unsurmountable drive and passion, Dr. Weber has left his mark on the Tar Wars program and inspired so many. He received countless awards and recognition for his efforts in shepherding the program in Iowa.
His leadership, devotion and dedication to Tar Wars is a model for all family physicians in working towards a tobacco-free world. Iowa and America are healthier today because of his efforts. Dr. Weber passed away on April 3, 2016. We would like to remember him not only for the impact he had on Tar Wars, but also the impact he had on so many IAFP members.

Adopt a Student

for National Conference

Your help is needed to assist in sending students to the 2016 National Conference for Residents and Students. We are asking members to provide scholarships to students to attend the 2016 National Conference for Residents and Students in Kansas City. Cost to attend for a student is $300.

Many of the great leaders of the state and national academies are students who were products of the AAFP National Student conference. Your help is needed to continue this wonderful tradition! With the focus on primary care it is all the more important to expose more students to family medicine.

Here is feedback from one of the students who attended in 2015!

I found the AAFP National conference to be an immensely rewarding experience. The expo hall alone is worth the cost of attendance, to meet with the variety of family medicine programs in attendance. Not only does the conference give students a rare opportunity to explore many different residency programs in a low-pressure setting, it also allows us to discover more about what we are looking for in a residency. Additionally, it was a great decision to bring my wife along. She was able to talk with residents, and in some cases their spouses, to get a feel for what life in the towns the residencies in would be like. I think it is not only a great idea, but also an important step in preparing for residency interviews for medical student to attend the national conference.

Benjamin Dilger, M4

TO MAKE A DONATION, visit the Students & Residents tab on our website to make a secure credit card payment online or please mail in your payment (payable to the IAFP Foundation) to: 100 East Grand Avenue, Suite 170 | Des Moines, IA 50309. Contributions are tax deductable.

2016 National Conference for Residents and Students

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