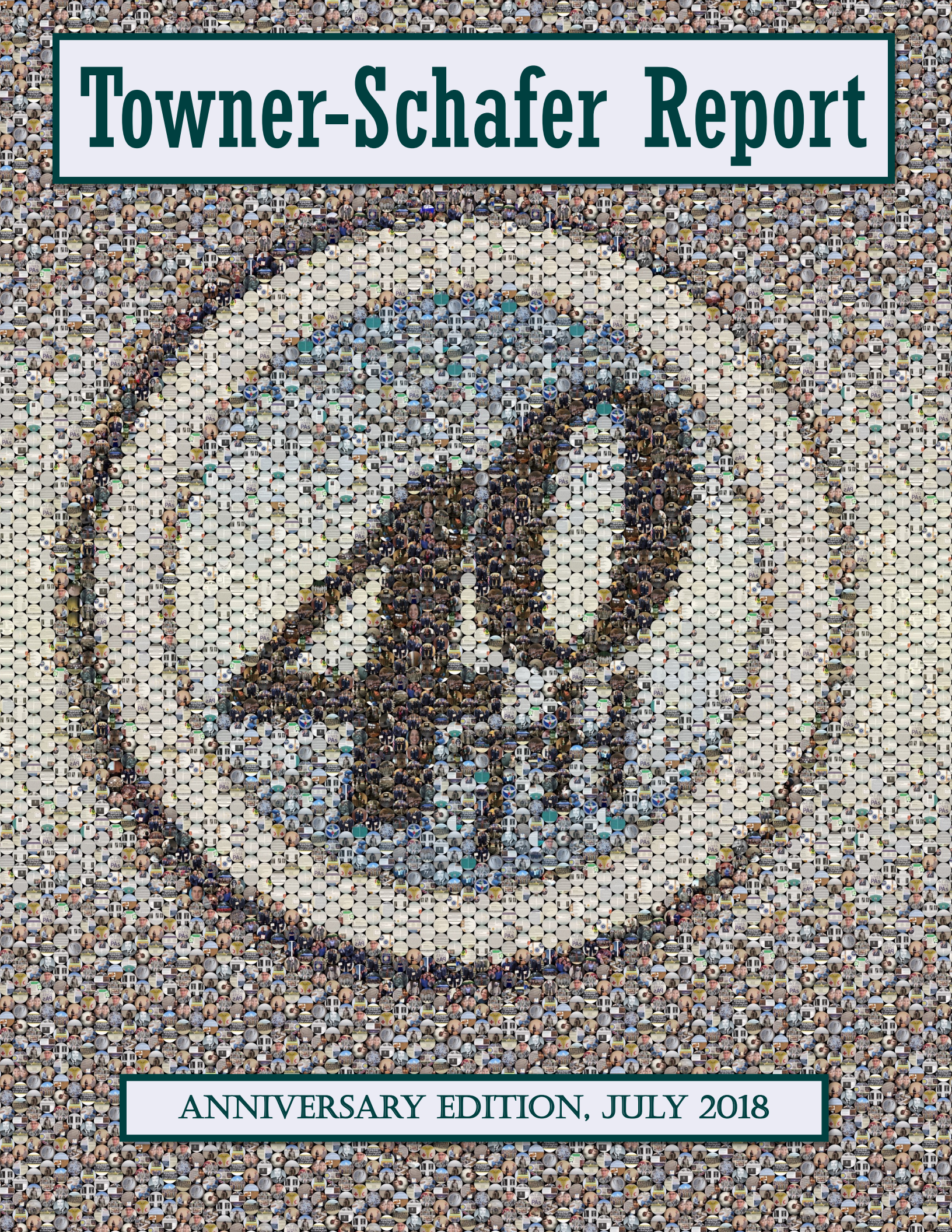
Towner-Schafer Report



ANNIVERSARY EDITION, JULY 2018

The Towner-Schafer Report

1978 → 2018

Towner-Schafer Report

THE OFFICIAL NEWSLETTER OF THE SOCIETY OF AIR FORCE PHYSICIAN ASSISTANTS

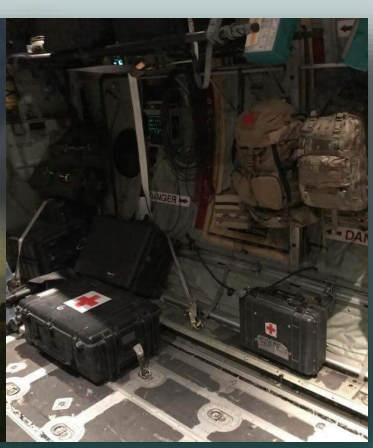
SUMMER EDITION 2018

Inside this issue:

Not already a SAFPA member?!

PAs "Out of the Box" — Capt Whitney Patrick

This time two years ago I was where most of you find yourself today - working in family health seeing 90+ patients a week buried in notes and t-cons. To be honest, I was bored and frustrated. I joined the AF through HPSP with the hope that I would be on the front line of the mission, deploying and practicing medicine in austere environments. Fast forward two years and I am exactly where I hoped to be as I prepare for my second deployment in the past year. Don't get me wrong, Family Health is important and the mission downrange would not be possible without our PAs in the clinic back home. For those of you looking to explore other options as an AF PA, I am here to shed some light on working as a Special Operations Forces Medical Element (SOFME). *...Continued*



Register online at safpa.org NOW!!

Operational Medicine: AFSOC PA-C

Capt Whitney Patrick

The Operational Support Medicine (OSM) team at Hurlburt Field is comprised of eight Flight Surgeons, four PAs, 12 IDMTs, two Aerospace Physiologists, one Operational Psychologist, one MSC, one Public Health tech, one Bio-environmental tech, and one 4A (aka TacAdmin). The OSM flight is embedded in the one Special Operations Support Squadron. Additionally, all providers are attached to various flying squadrons where we are able to manage aircrew needs in Ambulatory Care Units (ACUs). This allows us to get to know the aircrew and their unique mission, improving our ability to care for our patients. The OSM core mission is to maximize warfighter performance through world-class health care and prevent human factors from negatively impacting Air Commando performance. While at home we manage patients (in the ACU or at Flight Medicine), write aircrew waivers, provide med coverage for field trainings, fly with our squadrons, participate in joint exercises, and train to maintain our field medicine skills for deployment. While deployed we continue to provide medical care for our aircrew and function as an asset for casualty evacuation and prolonged field care. We deploy to multiple locations around the world, each one provides a unique opportunity for us to contribute our skills and knowledge.

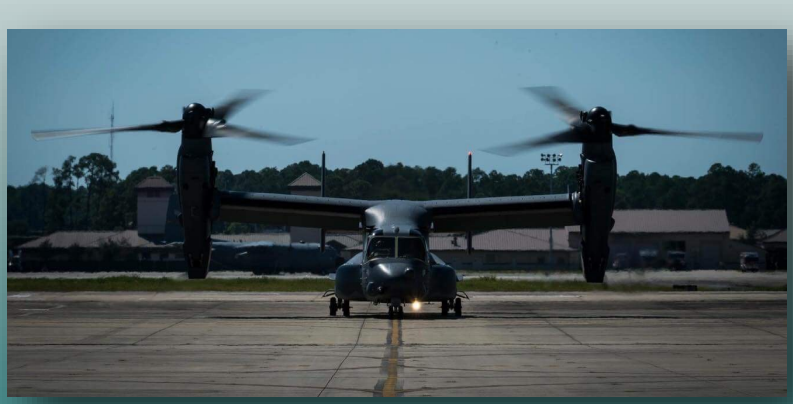
The training pipeline for a PA takes about nine months to complete and includes the following courses:

- Aerospace Medicine Primary 101/201
- Survival, Evasion, Resistance, and Escape Level C
- Water Survival and Dunker
- Introduction to Special Operations Course/ Introduction to Special Operations Medicine
- Field Skills Training or Air Commando Field Course
- Center for Sustainment of Trauma and Readiness Skills
- Advanced Trauma Life Support
- Tactical Combat Casualty Care and Casualty Evacuation Course

These courses challenged me, expanded my medical knowledge, helped me grow us a PA and as an Officer, and were honestly some of the most fun I have ever had! How often do you get the opportunity to speed through an obstacle course in a beater vehicle with no windows while two vehicles of highly trained former military personnel chase you down with sim rounds! I am very thankful for the opportunity to work with great people, doing an exciting and rewarding mission.

MEDICINA BONA LOCIS MALIS!

If any of you are interested in joining the SOFME team or would like some additional information about being a PA in operational medicine, please feel free to contact me at: whitney.patrick.1@us.af.mil.



How To: Write an IPAP Recommendation

Maj(s) Sarah Sims

Greetings colleagues! I want you to imagine you're on a board reviewing **128 packages** ranging from **42-91 pages each** and your timeline is roughly **three days**. How much time will you be able to devote to each package? What stands out amongst the applicants? I was honored to sit on the IPAP selection board this year, and man am I glad I didn't have to compete against these candidates! Many were valedictorian Olympians (well maybe that's an exaggeration) which left us digging for clues to rack and stack them. To standardize the scoring process, we categorized the data into grades, letter of Intent (LOI), fitness scores, video, letter of recommendation (LOR), and overall score. With so many qualified applicants and without the ability to meet them in person, we rely on YOU as the PA to be honest and forthcoming with your recommendation letters. Four quick points on the LOR and I'll get out of your hair:

Authenticity & Credibility: Tell us about your background. What makes you a credible recommender? Are you an AF Family Medicine PA, are you IPAP trained, do you know the candidate well in the clinical setting? Perhaps you have experience precepting PA students or as an instructor or teacher. Give specific examples, otherwise your letter may look more like a stock template than a genuine letter. Examples include: "I have been precepting applicants for 12 years and he is my absolute #1 of 30+" or "I have been an educator for 30 years and she is by far the most driven and bright pupil I've ever had." Additionally, some of the best feedback we received was negative, such as: "he does not have a good bedside manner." The board especially needs to know if you have reservations about a candidate. The best way you can help is by making an authentic statement.

Awareness: Is the applicant and their family aware of the rigors of IPAP and are they accepting of this? Does their transcript reflect their ability to learn multiple subjects simultaneously and at a fast pace? Perhaps they were deployed and still managed to take classes at the same time? Are there family issues that would detract from their education this coming year? Ensuring the candidate is not only a good fit for the fast-paced program but also ensuring their family is ready for this as well is the right thing to do for the Airman AND the program.

Above & Beyond: With the multitude of qualified applicants this year, the tipping point became the perceived desire to be a PA. That "perceived desire" was determined by the LOI and those who didn't just meet but exceeded the required shadowing hours. Some members were geographically separated from a PA and had to drive an hour each way but still obtained greater than 40 hours. Conversely, some applicants received exactly 40 hours and/or all hours by specialty PAs. While we completely understand that specialty PAs have awesome jobs and they love them, the overwhelming majority of PAs will begin their careers in Family Med, and thus need to be aware of the demanding job of a PCM. It is preferable (not mandatory) to have 40 hours with a Family Med AF PA. If none are located at the member's home station, they may have to venture out further or reach out to other bases or services to satisfy this requirement. If this was the case, please say so in your letter as it demonstrates a commitment and willingness to go the "extra mile" to prepare him/herself for the board.

Write it Anyway: So you don't think this candidate is a good fit? Write the letter! ESPECIALLY if you have reservations about them! You can choose to make the letter viewable to the candidate or just the board. Listen, we live in a world where people are afraid of not giving a "firewall five" because it could hurt someone's career. If you don't write the letter, someone else will. The next person may not know the candidate as well and write them a glowing letter. The board will make their decision based on what is given to them. Those who are chosen for next year's board will appreciate your candor.

I hope this article was useful! I'm available at sarah.e.sims2.mil@mail.mil if you have any questions hit me up, cheers!

Speak Another Language? Apply To LEAP!

What is LEAP?

LEAP stands for Language Enabled Airman Program. It is administered by the Air Force Culture and Language Center at Maxwell AFB and was initiated in October 2009. "LEAP is a training program designed to sustain and enhance the existing language skills of general purpose forces (GPF) USAF Airmen. The objective of LEAP is to develop cross-culturally competent leaders across all Air Force specialties with working level foreign language proficiency". **AFI 36-4001, Air Force Language, Regional Expertise and Culture Program**."

How do I apply?

The next LEAP application deadline will be posted here: **http://culture.af.mil/leap/**. The required application documents are: DLPT/OPI score 2/2 minimum, OPRs, Academic transcripts, SURF, nominee comments, and Commander Endorsement. First things first, sign up for the DLPT (defense language proficiency test) at your local education office. If you score 2/2 reading/listening you will need to re-test annually, if you score 3/3 re-testing is every two years. If needed one can re-test every six months. The OPI (oral proficiency interview) is produced by the defense language institute (DLI) but is not part of DLPT. It is easier to apply to it once you are in the LEAP program as it assesses oral proficiency after training and will provide that extra proficiency level for example 2/2/2.

What are the advantages of LEAP?

1) Foreign language proficiency bonus (FLPB) – maximum $500 per language! Does LEAP pay if I speak Spanish? **YES**! Most common languages are classified as "prevalent in the force" such as Spanish and a majority of European languages (e.g. French, German, Italian) and thus are not eligible for language bonus UNLESS you are part of the LEAP program or other specialized billets. Great monetary incentive, right? Once you meet the requirements and obtain the LEAP Special experience identifier (SEI) you are authorized for FLPB.

2) **eMentor** computer-based online classes and special project: Every two years LEAP requires one to attend an e-mentor online class session. The class is specific to the language level and is an excellent way to practice and learn cultural elements of that language. I was a 3/3/3 before taking these classes but after the classes I was a more confident 3/3/3 in terms of speaking, writing and listening. The special project is optional. At the end of the four-month self-directed independent study one presents a special topic in one's foreign language to the eMentor Online Virtual School panel.

3) **LITE** (language intensive training project): This is a rewarding and practical immersion program. Every two years one is eligible to go on a fully paid four to six week in-country TDY. In June 2016, I was fortunate to participate in the *Africa Partnership Flight's* first medical outreach courtesy of the LITE program. I was honored to work alongside our very own Maj Butler who led the International health specialist team. I was able to utilize language skills enhanced after the eMentor and special projects, to immerse in the culture/translate as well as use my AFSC as a PA to see patients. This is by far the best example of why the LEAP program is so important.

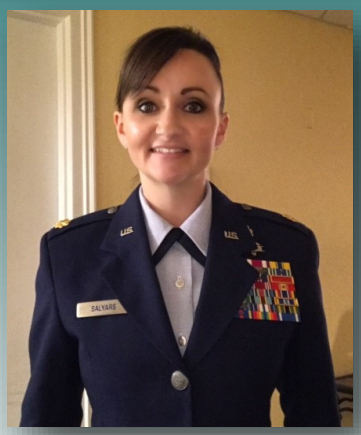
I have been a member of the LEAP program since 2014 and hope this article dispels some myths about the program and language pay and encourages you to apply. If you have any questions refer to the resources below or email me at **mumbi.m.ngugi.mail@mail.mil**.

Resources:

AF LEAP: **http://culture.af.mil/leap/**
AF LEAP Facebook: **https://www.facebook.com/groups/AFLEAP/**
LEADeR: **https://cmsweb.maxwell.af.mil/Leap/jsp/ParticipantHome.jsp**
AFI 36-4001, Air Force Language, Regional Expertise and Culture Program
AFI 36-4002, Air Force Foreign Language Proficiency Bonus
DoDD 5160.41E AF Strategic Language List (SLL) (contact local education office for updated copy)

Maj(s) Ngugi PA-C treating a patient while TDY in Kenya

Outgoing SAFPA President — Major Karen Salyars



July 2018 means "**Happy 40th Birthday**" to the TSR (and to me, ha-ha)!!! This month also marks the last time I'll write to this amazing group of PAs as your SAFPA President, and I'm honored and humbled to have had this opportunity to serve you. We've had an eventful few months since our last edition of the TSR! First, I want to thank the entire team of hard working people who worked tirelessly to put together the February Air Force PA Refresher Course (AFPARC)! It was a phenomenal event, providing CMRP hours, CME, hands-on workshops, invaluable mentoring opportunities and more! If you didn't get a chance to make it this year, please apply through unit or central funding for our February 2019 AFPARC…which will be BACK at the DRURY again! While it was nice to explore other options in downtown San Antonio, I know a lot of people who are as excited as I am to have it back at the Drury Plaza on the Riverwalk.

Another big event recently was the AAPA Conference in New Orleans, last May! Our House of Delegates representatives attended 3 days of intense discussion, including Optimal Team Practice, consideration of changing our "Physician Assistant" title and much more! I cannot stress enough how important it is that you support *BOTH* our Society of Air Force PAs (SAFPA) *AND* the American Academy of PAs (AAPA). When you pay your *discounted* AAPA dues, it's critical that you choose SAFPA as your affiliated constituent organization! This makes you a "Fellow" member and the more Fellows we have with AAPA, the more House of Delegate representatives we're allowed. Unfortunately, we recently went from three seats to two at the HOD, which means SAFPA's voice got a little smaller. (For comparison, the Army has three seats, the Navy and Veteran's Caucus also have two seats).

I had the great pleasure of lecturing on melanoma and an Endo PANRE crash course this year at AAPA, and I encourage everyone to consider submitting a lecture on the topic of their choice too! Applications can be submitted through the end of July. It's a great way to get a complimentary AAPA registration, hotel room for one night and more! I'd like to thank all of my awesome friends and former students who came to my lectures—it was great to see those friendly faces mixed in the audience! We also had an informal General Membership meeting and dinner with a fantastic turnout—thanks to all who made it!

SAFPA President cont'd... Major Karen Salyars

One of the more "fun" things I've had the opportunity to be a little (literally) part of this year was mercilessly squeaking in the ear of our departing AF Surgeon General, Lieutenant General Ediger regarding the considerable limitations of Air Force Flight Medicine PAs. I've had the great fortune to jump into the (non-AFSOC) Flight Med world since 2017, and I was shocked at the restrictions we face as PAs (only Flight Surgeons can make the aeromedical disposition; numerous bases require Flight Surgeon co-signature for all PA clinical notes; we cannot wear wings; most cannot wear flight suits; and the list goes on). As a former Army PA, it's a vast difference from what I was used to (none of those restrictions for Aviation PAs in the Army!). I couldn't help but try to advocate on our behalf, especially considering AF Flight Surgeons are between 40-50% manned—we were MADE for this! So, in December 2017 I got brave and asked the question of our Surgeon General, and was a bit disappointed in the answer…but I got another shot in March 2018 to have lunch with him and he said "…we've had a lot of discussion on this over the past few months and I do think that PAs will have an expanded role in Flight Med in the near future." I was grinning from ear to ear. To top it all off, my Sq/CC heard Lt Gen Ediger brief an entire conference of flight docs on this *very* topic –that WE will play a critical role in Flight and Operational Medicine very soon, in a greater capacity than what we are currently serving!!! Our senior PAs paved the way for PAs to get our foot in this door, so why don't we just try knocking the entire thing down?!? I hope to hear more great news about this soon!

Finally, it's bittersweet to write this last letter as your SAFPA President. While I didn't accomplish as much as I'd personally hoped during this past year, I had the most amazing SAFPA BOD team who absolutely killed it! We have a new (and beautiful) website, a new SAPFA shop, a phenomenal new coin and of course, an entirely new Board of Directors elected by YOU! As I step aside, Maj Rodney Ho steps in as your new President, and Maj Chris Scharfenstine (President-Elect) behind him in 2020—you are left in very capable and motivated hands. I can't wait to see where this Board of Directors team takes SAFPA next! Air Force PAs are truly the best and the brightest in our profession. It's been an honor and a privilege to serve you—**thank you** for this opportunity to serve you!

Incoming SAFPA President — Major Rodney Ho

Hello fellow SAFPA members! It is an honor and privilege to serve as your new president. First off I would like to introduce our newly elected board members:

President-Elect: Maj Chris Scharfenstine
HOD: Capt Gael Gauthier
DAL Activities: Maj(s) Sarah Sim
DAL Communications: Maj Julie Glover
DAL Membership: Maj Emily Shanes

Here are my **three priorities** as your new president:

1. Reaffirm commitment to our members
2. Enhance collaboration with other civilian, sister service PA organizations and across AFMS
3. Provide a unified voice for the support of Air Force PAs across the Military Health System (MHS)

This past March, I had the distinct privilege to attend the AAPA Leadership Advocacy Submit (LAS). I was able to see first-hand, how AAPA provides a unified voice for PAs from across the country at the capitol. I was assigned with other Texas state constituents such as the Texas Academy of Physician Assistants (TAPA). The second day we marched (took the metro) to the state capitol and met with several lead legislative aids of senators and congressmen to advocate for sponsorship on two proposed bills. These two bills were also supported by the American Academy of NPs. The first bill, entitled H.R. 1617, the Promoting Access to Diabetes Shoes Act. This bill if approved, would allow PAs and NPs to certify a patient's need for therapeutic shoes. Currently PAs and NPs must send their Medicare patients to a physician to certify the need for diabetic shoes (AAPA, 2018, Feb 18). This causes a distribution and delay in a patient's care. The second bill entitled, H.R. 1825, the Home Health Care Planning Improvement Act which allows PAs and other advance care providers the ability to certify and manage home health care Medicare beneficiaries (AAPA, 2018, Feb 26). You may be thinking these two pieces of legislation do not directly affect me in a military healthcare setting. I would say to you, "yes". However, one day you will leave the Air Force and might be employed in the civilian sector. For this very reason, it is important to stay familiar with policies that affect PA practice.

For the first time ever, we had 20 NPs and 10 IDMTS attended our recent AF PA Refresher Course (AFPARC) 2018. They were blown away by the quality of training we provided and would like to return for AFPARC 2019. We had the privilege of having the incumbent AF SG, Lt Gen Hogg as our guest speaker at AFPARC 2018. It was such a positive experience to observe multiple medical professionals in one room. As seen at the AAPA LAS and our last AFPARC, we must evolve and embrace collaboration to succeed for a common goal: providing safe and outstanding health care!

In closing, I am honored to serve you, the members. You are the foundation of SAFPA and the organization would not exist without your support. I hope to establish an education scholarship for members who want to advance their education in a healthcare related degree. This scholarship still needs to be voted on and approved by the SAFPA Board of Directors, so more to follow. We hope to secure a vendor to create SAFPA memorabilia, such as t-shirts, sweaters and coffee cups. Lastly, I would love to hear ideas and recommendations from the members. So if you have a question or an idea to improve the organization, please send me an email to **rodney.a.ho.mil@mail.mil**.

Here to serve you,

Rodney Ho
President, SAFPA
"Leadership is a privilege, not a right"

Upcoming events:

Air Force Physician Assistant Refresher Course: 18-22 Feb 2019

Call for Submission for SAFPA awards: Oct/Nov 18

The Consultant's Corner — Col Terry R. Mathews

Off the desk by the clock next to my half full coffee mug…

I cannot believe it has been two years in the seat already, and still with the coffee rings! First, I want to thank our SAFPA team for such a great edition commemorating this 40th year of the TSR. The SAFPA board in 1978 officially changed the name of the SAFPA Newsletter to the Towner-Schafer Report with First Edition, Vol. 1, No. 1 assigned to the July/August 1978 printing. Lt. Ernest Riggs out of Grand Forks AFB was the first editor, punching out the edition on a word processor mailing copies to all members. This was a big step in modernization with it printed in color, both black AND white (ok, and a red official SAFPA logo by Ken Cyr also).

In 1978, the AF announced it had sufficient manning and no new classes would start after entry of class 780607. In fact, it was stated the program would only restart under a Tri-Service model (spring forward nearly 20 years to IPAP). This was also the first time AF Recruiting Service was provided a quota for civilian accessions, with request to bring in five civilian trained PAs for FY78. With projections of a stable workforce due to recent authorization for commissioning, AF manpower office was confident it could reach and maintain its goal of 450 PAs by June 1980. Apparently not, though, as high attrition and limited accessions then just like now drove a manning shortage forcing the AF to reopen the USAF PA Training Program at Sheppard AFB in 1980 and not wait for the Tri-Service program to take shape.

We had to regain a lot of lost ground over the last 18 years due to draconian force cuts in 2000-2001 when we lost 49% of our authorization. Although we once again now have nearly 450 authorizations across four major product lines, we need more PAs as we are becoming more and more integral to the AF in Operational roles. We have PAs leading the AF Nuclear mission from tech school screening to Base-level, to MAJCOM and inspections. We have PAs in direct patient care as PCMs and in specialty tracks. We now have "Boots" on the ground leading research and acquisitions with ability to at start entry-level and progress up the food chain. Finally, with our numbers increasing on the AF Line side, we all need to become more Readiness focused and hone our trauma skills to feed the Operational beast. With continued involvement in the Middle East, the slow build across the remoteness of Africa, boots on the ground in South America, and our continued preparedness for the Pacific theater, our HMO skills are just not enough anymore. We are taking on many more deployment missions, and some will have us as a sole provider. Hence, you will note new Continuous Medical Readiness Program requirements now on the books. Yes, we are ALL in the red, and we all must ensure we are operationally ready to go out the door. There will be more Emergency Medicine and Trauma training opportunities, and you will have the chance to hone you inpatient skills as well.

Finally, promotions were bittersweet the last few releases. We gained a few, but lost a few also. We had -0- picked up for Colonel. It is hard to compete for Colonel if we do not have enough Lt Cols to compete for leadership jobs. For Lt Col, we hit 23% with 3 out of 13 records meeting the board. Our real winner was the Major board with 83% selection and 40 people picked up.

The Consultant's Corner cont'd... Col Terry R. Mathews

Off the desk by the clock next to my half full coffee mug...

When we look at the numbers and dig into the records of those not selected, the biggest factor for non-selection is lack of PME for rank. If you do not do your PME, you have not only burned the bridge, but you have burned the farm. Once you are passed over twice (in the zone and above the zone), if you are retirement eligible, you will be forced to retire seven months later. Most obligations will not count to retain you. Because of extensive enlisted time for most of our PAs, by the time you reach the Lt Col board, most are retirement eligible. There is no exceptions except by SecAF waiver as authorized in Federal Statute. This is not a policy we can change. Other significant losses are separations for those not retirement eligible and have not reached "sanctuary". Personnel with derogatory information in their record, a referral OPR, multiple fitness failures, etc, are not being retained. Those records meet a personnel board and the members are not recommended for retention. We have no input to this process.

Bottom line: Get your stuff done, keep a clean record, and start honing your trauma skills. We are on our way, but the Master plan hinges on you!

- Tweeks!

PA Operations Update Lt Col Robert Brown

It's a great time to be a PA in the USAF. Wow! What a busy and eye opening 6 months in Ops it has been. It has been my pleasure to serve as your "interim" Ops officer. First off, I would like to thank retired Lt Col Paul Bott for all he did with Ops. He truly made a difference in his time in the USAF. It is amazing to continue see all the challenges our PAs are taking on across the USAF.

AFPARC 2019 is now in the planning stages and we will be back at the Drury Inn, San Antonio Riverwalk. It is scheduled for 18-22 February 2019. We have decided to put a larger emphasis on mentoring. In fact, we plan on spending the first day focusing on mentoring triggering more discussions during the week. We will once again be focusing on CMRP items but will also add topics for all scopes of PA practice. The recently updated CMRP and the AF focus on readiness will continue to drive requirements with an emphasis on currency. If you are involved in "Off Duty Employment (ODE)" and getting the currency skills you need for CMRP, your CMRP representative can sign you off. I will also be reaching out to specialty consultants to help develop links to training sites that can be utilized for CMRP. If interested in being a guest lecturer at the AFPARC, please contact myself or Maj(s) Sarah Sims.

IPAP is growing. We had the largest student application pool since early 1990's for this year's IPAP selection board. This is largely due to increased recruiting efforts from our awesome AF team at IPAP. They increased the applicant pool 200% and have also increased the number of seats the AF has at IPAP, now at full capacity. I would like to give kudos to the IPAP staff to include Lt Col Richard Weber retired, Lt Col/Dr. Julie Freilino, Major William Schultz, and Major Chad Roasa. Lastly, please welcome to Lt Col Mary Webb who will be the new IPAP Senior Service Rep.

...Continued

Important Dates:

- BOMO: 30 Jul —10 Aug 2018
- Health Care Management Course 13-18 Aug 2018
- BLAST Dates TBD
- 2019 HPERB PA Fellowship application window is OPEN now!

PA Operations Update cont'd... Lt Col Robert Brown

Finally, I want to put emphasis again on mentoring and information flow. We have been working on a mentoring page on the KX in order for everyone to know who their senior mentors are and how to contact them. We are also looking at all the tabs on the PA KX site to see how we can provide you with relevant information that will help all of our PAs. If you have an area of interest, let me know and we may tag you to help improve our site to include starting Milsuite. **- Lt Col Brown**

Be sure to congratulate all to our recent promotees...

Lt Col

Barbara Acevedo

Kenneth Beadle

Deborah Karrer

Major

Ameduri, Craig R

Annies, Natalie Marie

Aylward, Timothy J

Cary, Scott W

Farmer, Justin S

Garcia, Juan J Jr.

Geldor, Shunrie Taburada

Griesser, William T

Healy, Brooke Marie

Hemsworth, Jesse L

Henderson, Cory Ryan

Howell, Curtis J

Jarvis, Jeffery C

Jobe, Michael T

Jones, Jonathan S

Kesterson, Stephan C

Lancaster, Drew Edward

Martin, Daniel Allen

McBean, Melvin K

McCampbell, Andrew S

McCue, Patrick A

McKenna, Justin E

Meyer, Jamie L

Mommaerts, Jason L

Mondfrans, Brandon L

Ngugi, Mumbi M

Nguyen, Anh Phoa Thi

Ostrom, Sarah J

Post, Jodi L

Rannow, William Daevid

Richmond, Laramie J

Salinas, Eric

Sayre, Gary L

Schmelzer, Lindsey P

Sims, Sarah E

Smith, Nathan Glenn

Tague, Emmalyn V

Trotter, David J

Volturo, Christopher P

Yeun, Clayton KC

Well deserved congrats to all!!

IPAP Update

Maj William C. Roasa

The Interservice PA Program has been working tirelessly to provide world-class education to our students and ensuring great future providers are joining the ranks of the PA profession and AFMS! Our class size has been steadily increasing - we had our largest interservice class start in August 2017 with 80 new students! Additionally, we started our largest AF class on 3 Jan 2018 with 20 students!

Following the retirement of Lt Col Richard Weber earlier this year, we recently welcomed Lt Col Mary Webb as the AF Senior Service Rep during the first week of July!

The following individuals have graduated from IPAP over the past year:

Class 15-1

1Lt Doran, Kelly
1Lt Hawkins, Kristopher
Capt Hatcher, Lindsey
Capt Hewett, Emily
1Lt Hough, Cristina
1Lt Jenkins, Jesse
1Lt Land, Matthew
1Lt Lee, Gerard
1Lt Paschen, Lee
1Lt Wallace, Cleveland
1Lt West, Noah

Class 15-2

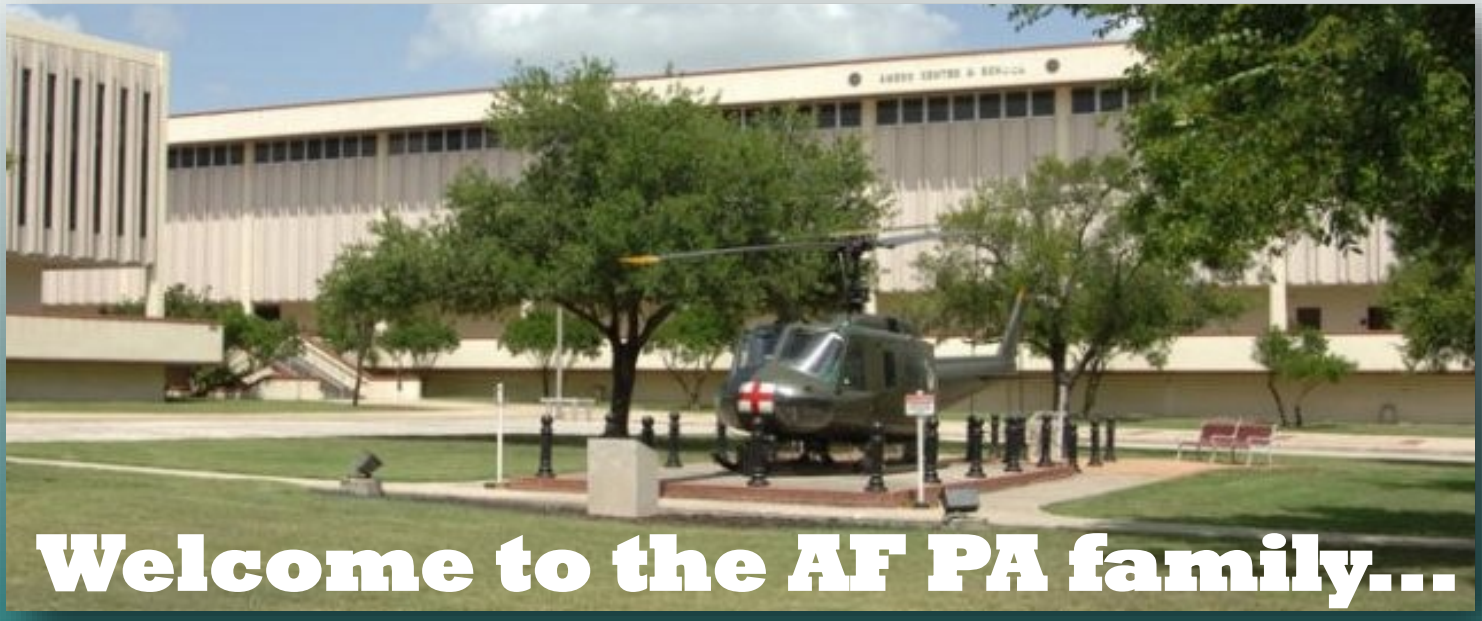
1Lt Anderson, Kasumi
1Lt Hunter, Dana
1Lt Johnson, Latoya
1Lt Ingersoll Jr., Thomas
1Lt Lincoln, Kwanza
1Lt Price, Caren
1Lt Reed, Jeffery
1Lt Roberts, Sheri
1Lt Russell, Luke
1Lt Williams, Brandy

Class 15-3

1Lt Bergmann, Adriane
Capt Brendel, Lauren
1Lt Darrow, Kristofer
1Lt Denittis, Alyse
1Lt Depaula, Paulo
1Lt Granger, Teryn
Capt Hamrick, Matthew
1Lt Janda, Keith
Capt Katrein, Keeley
1Lt Klukkert, Mellissa
1Lt Lawrence, Matthew
Capt Miltenberg, Danielle
1Lt O'Brien, Erin
1Lt Porras, Javier
1Lt Russell, Noah
1Lt Salbato, Rockford

Class 15-4

1Lt Ayala, Benda
1Lt Billig, Charles
1Lt Bufford, Gregory
1Lt Davey, Peter
1Lt Enos, Courtney
1Lt Garcia, Pablo
1Lt Glidewell, Anthony
1Lt Huff, Eric
1Lt Johns, Dennis
1Lt Jones, Patrick
1Lt Lewis, Jennifer
1Lt Morrison, Jamie
1Lt Moore, Erin
1Lt Parker, Wesley
1Lt Smiley, Shelby
1Lt Trudo, Nicholas



Don't forget to sign up for SAFPA... we need your fresh faces and talent!

IPAP Update cont'd... Maj William C. Roasa

Class 17-1

Congrats to our newest AF Phase-I Graduates!

OT Banghart
OT Broome
OT Caiano
OT Duffy
OT Ganz
OT Johnson
OT Lawson
OT McIlvaine
OT Owens
OT Taylor
OT Trinidad

Interservice Physician Assistant Student Society Update

IPASS receives JBSA Large Group Volunteer of the Year Award for 2017

Congratulations to all members of IPASS for being selected for the 2017 Volunteer of the Year Award. IPASS volunteers contributed 1,133 man-hours over the course of 2017! Your hard work, dedication and selfless service have not gone unnoticed.

Historian's Minute

Lt Col Brandi A. Ritter

Many of you know the history of how our profession began, but I have discovered some interesting facts to share with you, and also provide the history on why our newsletter is called the Towner – Schafer report.

During WWII and in Vietnam, physicians were no longer being drafted and there was a growing shortage of physicians in the military as well as in the community. The physicians that had been drafted were leaving the Services in droves. Dr. Eugene Stead worked with Emory University and developed a fast-track 3-year curriculum to educate physicians for military service. Then, in 1965, Dr. Stead established the first PA class at Duke University – there were four ex-Navy Corpsmen in the class and three graduated in 1967.

With the Approval of the Assistant Secretary of Defense, Health and Environment. Lt Gen Alonzo Towner, AF Surgeon General, was able to stand up an Ad Hoc Committee on Physician Assistants effective 29 Sep 1970. In a letter dated 12 Oct 1970, General Towner the "Father" of Air Force PAs, directed the formation of a training program for PAs to begin in 1971. The Air Force was the first uniformed service to initiate an "in house" program. The program that started at Sheppard AFB did not award a degree at that time. Later, in an effort to get PAs commissioned, Lt. General George E. Schafer, AF Surgeon General, started a program at Homestead AFB with students attending Miami Dade Community College in order to receive a 2 year degree in Nursing.

On 7 July 1971, General Towner flew to Sheppard AFB to open the PA course on its first day. In his welcoming address to the first class of 25 PA students, the General emphasizes his feelings: "In a way, I feel like a father with a newborn son and that's really not so much an exaggeration as you might think. You are "Towner's Boys" and you are as important to me as my own son might be because your success as physician assistants will be the highlight of my professional career and the high water mark of my term as Surgeon General."

In December 1971, a revised training plan was submitted, changing the course length for Phase II from 15 months to 12 months. In reviewing this document, I found the following statement and felt it important enough to share: "Intelligence, the ability to relate to people, a capacity for calm and reasoned judgement in meeting emergencies, and an orientation toward service are qualities essential for the assistant to the primary care physician." That pretty much describes our profession.

In 1972, the University of Nebraska evaluated the Air Force program, and in 1973 the program became affiliated with the University of Nebraska, awarding a baccalaureate degree.

One of the most challenging hurdles Air Force PAs have had to overcome is the issue of rank. When the first 23 PAs graduated in June of 1973, they were promoted to senior enlisted ranks of E-6 or E-7, with the ability to gain the rank of E-8 and E-9. This was occurring at a time when the Army and Navy were awarding the rank of warrant officers to their PAs. In 1975, the Air Force initiated a program to determine the feasibility of commissioning Air Force PAs. In December 1977, the Assistant Secretary of Defense, Manpower, Reserve Affairs and Logistics, gave permission to start commissioning on 1 April 1978. In 1978, CMSgt George McCullough was serving as a PA at the White House and became the first military PA to be commissioned.

Unfortunately, in 1979, the House Committee on DOD Appropriations review of the fiscal budget stated that "… the Air Force reluctance to maintain warrant officers in their force structure has no bearing upon the decision to commission physician assistants." So, the physician assistants that had already been commissioned were to be given assignments, responsibilities, and training in line with other BSC officers, and not necessarily allowed to work as PAs.

Historian's Minute cont'd... Lt Col Brandi A. Ritter

Finally, the Defense Authorization Bill of fiscal year 1982 directed that the appropriate rank for physician assistants in the Air Force is commissioned officer. Without the vision of the Air Force surgeon generals, especially General Schafer and Lt General Paul W. Myers (AF Surgeon General), the commissioning of PAs in the Air Force probably would not have occurred in this timeframe.
Keep in mind that there was a "rank cap" of O-4/ Major at that time with the rationale of preventing a bureaucracy of PAs that could outrank their physician counterpart. Chuck Edgerton was the first PA to receive the rank of Major. Then, in 1982, the rank cap was lifted and William Keller was the first PA to assume the rank of Lieutenant Colonel.

As AF PAs continued to excel, the "Dial-A-Doc" program was the first house call program in the AF and was manned by a PA. A Rand study in 1980 compared physician assistants to physicians concerning quality of care. The report showed that for 25 of 28 criteria, the physician assistant's performance equaled or exceeded the physician's performance.
As you can see, without the efforts of General Towner and General Schafer (and General Myers) PAs would not be where we are today. We owe them our thanks and by naming the Society of Air Force PAs newsletter the Towner-Schafer report, we remember them.

General Schafer

General Towner

Reminder! Nominate a colleague for one of the many annual SAFPA awards.

Categories:

- **Paul W. Myers Award** *(Outstanding MD/PA/NP Preceptor; may be AD, reservist, guard, or DoD employee)*
- **Douglas Webb Excellence Award** *(Outstanding SAFPA fellow w/<4yrs as a PA)*
- **Jerrold L. Wheaton Award** *(Outstanding SAFPA fellow mbr, Capt or above w/>4yrs as a PA)*
- **Tony DiTommaso Clinical Publishing Award** *(PA author who has published an exceptional clinical/research article within the last calendar year i.e. Feb 2017– Feb 2018, TSR CME article submissions count ...just sayin')*

All nominees (except the Paul W. Myers Award), **MUST** be current SAFPA "fellow" (AAPA) members, in good standing.

Nominations shall be submitted on a Word document, in a paragraph format similar to an Air Force Commendation Medal or Meritorious Service Medal, with a maximum of 14 lines. The final sentence of the nomination should summarize why the nominee should be selected for the award. A template will be uploaded to SAFPA website soon!

Nomination submissions must be received by the SAFPA President-Elect, Maj Chris Scharfenstine **no later than February 1, 2019**. Please email to: **Lloyd.c.scharfenstine.mil@mail.mil**

Award winners will announced during the SAFPA General Membership Dinner at the next AFPARC.

Interested in HPERB fellowship?!

You should be...

This could be You ;)

This year's training quotas were recently published and it is time to consider clinical fellowship training! For interested applicants, contact both Maj Michael Rabener (GME) and the respective program director **ASAP**:

- **Gen Surgery** – Maj(s) Stephen A. Smith
- **Emergency Med** – Maj Lance Camacho
- **Ortho Surgery** – Maj Jeremy Barnett
- **ENT** – Lt Col Mickey Rutter

If clinical fellowships are not your thing, there are additional HPERB opportunities in PRP, Force Development Programming, Readiness, and Strategic Deterrence & Nuclear integration. See link to BSC education page below.

Please review your SURF for accuracy, ensure your **rank appropriate PME is completed prior to the start of the program** (June). Additionally, your interest should be included in your **ADP comments** and supported by your local leadership (Flt and Sq/CC) even though this is not an absolute requirement for application.

Major Requirements include:

(<— Warning = not an all-inclusive list!)

- Agree to incur a program-specific **active duty service commitment**.
- **Physically qualified for worldwide duty**. May request waiver for C1 from Corps Ch; C2-C3 are non-waiverable.
- Have **at minimum two years time on station** (TOS) prior to program start, not time of application.
- For DSc programs, **a non-waiverable GRE** verbal and quantitative score minimum **297** (within the past 5 years of prgm start date).
- Additional details and application requirements can be found on the BSC Education website **here**.

Below are the **PROJECTED** date milestones for your appropriate planning—> Application window is OPEN NOW.

Applications due to PDs & Corps Chief NLT **13Aug** —> packages are due to AFPC: **30Aug 2018!**
AFIT Board: **Oct 2018** (projected)
Fellowship Start: **Jun 2019**

Clinical Training Sites:

General Surgery (18 month DSc) – BAMC, TX (Future? Travis AFB, CA and/or Nellis AFB, NV)
Emergency Medicine training (18 month DSc) – BAMC, TX and Nellis AFB, NV
Orthopedics (18 month DSc) - BAMC, TX and Travis AFB, CA), and Wright-Patterson AFB, OH (12mo cert prgm)
ENT (12 month certificate program) - BAMC, TX

Questions...? See BSC education website (above) or reach out to your nearest PA mentor!

Doctor of Science (DSc) PA Specialty Fellowship Expansion

Left to Right: Col Terry Mathews, Lt Col TJ Bonjour, Baylor Dean Peter Grandjean, and Maj Michael Rabener

As part of Col Mathew's master plan to take over the BSC world, we are expanding training sites for the Armed Services-Baylor DSc fellowships in Emergency Medicine and Orthopaedics to Nellis and Travis AFB respectively. These are primarily Air Force training sites but will likely grow into integrated training with the Army and possibly Navy in the next several years. As these programs grow and the demand for more specialty trained PAs increases, we needed additional training pipelines to fuel our expansion. San Antonio Military Medical Center will remain the hub for DSc training and continue to host the annual research course and doctoral defense, but these two new sites will provide outstanding clinical and didactic opportunities for PA fellowship trainees.

We arrived at Nellis AFB to meet Maj Danny Villalobos, ER Flight Commander and Program Director for the new EM training platform, and were escorted through the facilities top notch simulation training center, state of the art ICUs and lastly to the controlled chaos of the emergency room. Capt Lisa Mannina, MD greeted us there and will be the acting medical director for the EM site. Coordination and strong, collegial bonds between Col Virginia Garner, 99th Medical Group Commander, Col Paul Crawford, Director of Medical Education and Family Medicine Research Director, and local hospital leadership helped solidify off site rotations at the brand-new VA emergency department and with University Medical Center in downtown Las Vegas. Baylor Dean Peter Grandjean, Associate Dean of the Robbins College of Health and Human Sciences, stated "The faculty and staff at Michael O'Callahan Hospital on Nellis AFB, at the VA Hospital and at University Medical Center (UMC) in downtown Las Vegas demonstrated an eagerness to help initiate, grow and prosper the DScPA-EM program."

The Air Force provides numerous cadre (physicians, nurses and technicians) as part of the Sustained Medical and Readiness Training (SMART) platform that partners with UMC downtown. Several of those highly skilled physicians are attendings in Emergency/Trauma department, Trauma ICU and various medical/cardiac ICUs. Col Brian DelMonico, Emergency Medicine and Pulmonary Critical Care, and Lt Col Jeremy Kilburn, Internal Medicine and Pulmonary Critical Care, are two leaders in the community and advocates for the expansion of training at Nellis. They will provide oversight and instruction in the high volume (100,000+ annual visits per year) UMC Emergency Department and guide EMPA fellows on their intensive care unit months. The number of procedures available in this environment may even surpass the excellent training at SAMMC.

VA Medical Center, Las Vegas, NV

Nellis's Col Paul Crawford has a strong research and existing research agenda. His team has won top honors in the Air Force for many quality research projects and medical publications over the last several years. He currently has over 25 active IRB-approved protocols, excellent funding and funding capabilities. Lt Col Kilburn, Pulmonary Critical Care Fellowship Director at UMC, hosted tours through four 16 bed ICU pods where the EMPA fellows will have training and patient care opportunities that, in many aspects, will be more involved than other existing clinical sites due to the acuity and patient population in the heart of downtown Las Vegas. We are looking forward to launching our first two trainees, Capt Nathan Fritts and Capt Travis Callahan, at this inaugural site in June 2018.

...Continued

DSc PA Fellowship Expansion cont'd... Maj Michael Rabener

The site visit to Travis AFB and David Grant Medical Center (DGMC) was every bit as successful as our experience at Nellis AFB. Maj Jeremy Barnett has secured the support of 60th Medical Group and DGMC Commander, Col Michael Higgins to establish DSc Orthopaedic training at David Grant Medical Center, Shriners Pediatric Hospital and UC Davis Medical Center. DGMC is a joint site, accepting active duty and VA patients as part of their health care services. The hospital boasts an average of over 2000 outpatient visits, 2200 prescriptions, 2200 labs, 63 emergency room, 170 dental visits, and 27 surgeries daily. Rotations and clinical experiences (pre-op, operating room and post-op) at DGMC will be overseen by a willing group of orthopaedic surgeons, among those are Dr. Dan Choi, Dr. Dana Hess, Dr. Spencer George, and Dr. Nick Skordus. Maj Barnett will have programming support of Capt Diego Melgar-Gray, a 2017 graduate of the DSc EMPA program.

Another impressive component of the site visit was the research opportunities at DGMC. DGMC GME Coordinator, Bradley Williams, Clinical Investigation Coordinator, Lt Col Leonardo Tato are more than eager to involve DSc candidates in the outstanding research being conducted at DGMC Clinical Investigation Facility (CIF). The research potential for DSc learners is unparalleled. Lt Col Tato directs over 70 active protocols and 20 animal model protocols per year. The CIF team includes ER physicians (USAF and UC Davis), surgeons, PhDs with health care/engineering backgrounds and a veterinarian to coordinate the vivarium and research. Cutting-edge research in anti-coagulation and non-compression tourniquet technology are among the projects that have garnered over $12 million in research funding last year and resulted in over 22 patents in the past 5 years. Additionally, DSc residents will be eligible for competitive USAF Resident Research Award of up to $100k/yr ($10k awarded/yr).

Left to Right: Maj Michael Rabener, Maj Jeremy Barnett, Col Terry Mathews, Dean Peter Grandjean, and Lt Col TJ Bonjour at UC Davis and Shriners Pediatric Hospital

Maj Barnett has developed strong ties with physicians at UC-Davis MC and Shriners and secured the PLAs, TAAs and MOUs so that the learners will have rotation experiences, capitalizing on the strengths of each site. Drs. Deb Templeton (Site Director) and Michelle James are point of contacts for the Pediatric rotations at Shriners, which is right across the street from UCDMC in Sacramento. Both hospitals have beautiful facilities and plenty of opportunity for hands-on experiences throughout their rotations at these sites. DGMC will be a top site for DSc PA training in clinical orthopaedics. "I believe that all requirements for maintaining high quality clinical experience and research that are hallmarks of Army-Baylor DScPA programs will be met in all respects" said Dean Grandjean.

Maj Michael Rabener, DSc, EMPA-C
USAF Graduate Education Manager
EMPA Consultant & Program Director

Don't wait, apply NOW!

Application window for fellowships is **OPEN** now. Contact your desired program directors and/or specialty consultants ASAP with your intent to apply.

See page 12 for details and Prgm Dir contact info.

Left to Right: Maj Michael Rabener, Maj Jeremy Barnett, Col Terry Mathews, Dean Peter Grandjean, Lt Col TJ Bonjour, and MAJ Ben Kocher

Expanding Boundaries for OSA

Maj Stephen E. Vela

(Left to Right) TSgt Padgett, Col Elsayed von Bayreuth, BG Murphy, Maj Vela, & LTG (ret) Roudebush

How many of you have had to tell a patient, "I'm sorry TSgt Smith, but the reporting instructions for your deployment specifically state there is no reliable power source. You're ineligible to take this deployment because you require CPAP with access to a reliable power source." Unfortunately this is becoming more common as more and more people are diagnosed with OSA including many of our active duty, Guard, and Reserve military members. 22 million Americans and 1 in 15 adults are estimated to have moderate/severe OSA.[1] Most of us are aware the number of military members being diagnosed has been consistently increasing over the past several years. Most often members are reporting to their providers when they are reaching the end of their careers with the hope that a late diagnosis of OSA will increase their VA disability rating. However, given the frequent visits for insomnia or daytime somnolence in the primary care setting, this late diagnosis has started to trend toward earlier diagnosis and even young lean men are being diagnosed with OSA.[2] This may be related to our patients becoming more intelligent about the many co-morbidities related to OSA including daytime fatigue and sleepiness, potential cardiovascular problems, possible modulating influence on certain other medications (e.g. sedatives), and eye related problems (e.g. glaucoma) to name a few.[2,3,4,5,6,7]

As the statement above indicates, the current verbiage of the regulating USAF document is: "with access to reliable electric power supply." My fellow researchers and I all agree this wording is not sufficiently objective to enable precise determination if a particular deployed location is suitable for members with known controlled OSA. Is availability of an electric power supply 50% of the time considered reliable? Would a predictable 20 minutes of power supply per hour be considered reliable? Is the power supply derived from solar photovoltaic panels during daytime hours of sunshine be considered reliable? These questions remained without definitive answers and this usually results in a conservative decision to keep the location "Unsuitable" to members who require CPAP to control OSA; it's easier to say no to an otherwise acceptable member.

During the past 15 years, the missions of the men and women in the United States Armed Services have changed. It is rather common for small teams to operate in austere locations for extended periods of time without any access to many support functions to include medical services and, most important to our research, a hard wired, reliable electrical power supply. Also changed are the demographics of our military members in some of the most critically manned careers including aviation and Special Forces. From our daily interactions with crews who are deploying around the globe we have repeatedly witnessed a critical mission where the most qualified member could not be deployed to the austere location because of the Duty/Mobility Limiting Condition of: OSA, controlled by CPAP. What we set out to do is define how much "reliable power" would be required if we issued CPAP batteries to our deploying members. It seemed this was an easy fix if we could issue deploying members everything they would need to secure the reliable power supply needed. Therefore, they would in essence be bringing their own reliable power supply.

...Continued

Expanding Boundaries for OSA cont'd... Maj Stephen Vela

We developed the "TRAVIS KIT" which has two CPAP machines and four batteries with four separate chargers. This would permit a member to be independent of a power supply for more than eight days given that each battery can support more than two sleep cycles. Even the occasional, interrupted, or unreliable resumption of power supply would assure sufficient battery recharge. We proposed considering a change or addition of, "a minimum of 2 hours power in any 3 day period of time", to the governing terminology. Even if the terminology is not changed, we would like the Travis Kit to become common knowledge so when a deployment waiver is submitted for a member, reading they have a Travis Kit will potentially make that member acceptable.

WHAT WE AIMED TO ACHIEVE

1. Counter the perceived adverse consequences of an OSA diagnosis and possible jeopardy to a valued career. Provide an environment more conducive for a military member to come forward and disclose his/her potential OSA issue to get the needed CPAP while easing the psychological negative impact of an OSA diagnosis on the member. Many of our members have had "perfect health" for many years of their career. OSA may be their first diagnosis of a "chronic disease". Self-denial or concern for career impact can come into play and delay their presentation to medical personnel. We often see this in aircrew who will purposefully avoid reporting symptoms due to concern for DNIF and this has crossed over to other service members who are concerned about being labeled "non-deployable". Especially with the recent update to policy indicating non-deployable members would be subject to separation.
2. Increase the availability of service members to deploy to almost all forward mission sites; rather than the current "locations with reliable power supply."
3. Project a "specialized gear" rather than a "medical device" image, thus protecting patient privacy issues. Calling it a CPAP or OSA Kit is equivalent to instantaneous disclosure of the patient diagnosis. We elected to "borrow" a familiar specialized gear look such as night vision gear (NVG). Placing the Travis Kit into a helmet bag incites reference to NVGs and other "generic specialized gear" rather than "specialized medical devices." We replaced the bulky and oversized packaging the CPAP and equipment came in with a small discrete double helmet bagged package. One of the helmet bags is flight suit green while the second helmet bag is desert tan colored, so the appropriate color can be on the outside as the mission dictates, while the doubled bags provide padding as a substitute for the discarded oversized packaging.

OUR LIMITED FIELD TRIAL

This report is based on a limited field trial of two Aircrew Members, both with OSA corrected by CPAP. They were provisioned with two batteries and two chargers each, to evaluate their "Ability To Survive and Operate" (ATSO) for two operational goals:

1. Perpetually utilize the CPAP machine nightly on exclusive battery power for an extended period (over one month) while complying with accepted guidelines of minimum use of five hours per sleep cycle for at least 90% of the cycles. Both batteries were to be charged for no more than 2-4 hours daily.

   a. For the first goal, both crew members were able to run exclusively on batteries only for over one month, by alternating use of the two batteries. For this part of the study, the members charged both batteries for at least 2 hours every day. Approximately three hours achieved a full charge on a battery.

2. Starting with fully charged batteries (and without additional recharging) determine endurance (i.e. the number of nights a CPAP machine could be utilized on battery power only before the charges were exhausted) while complying with accepted guidelines of minimum use of five hours per sleep cycle for at least 90% of the cycles.

   b. For the second goal, one crew member was able to use two fully-charged batteries for six consecutive sleep cycles before the charges were exhausted. The second crew member was able to use two fully-charged batteries for four consecutive sleep cycles before the charges were exhausted. The difference was attributed to how long over five hours the CPAP was used (e.g. five versus eight hours use) and use of attachments such as the humidifier.

We set the number of batteries contained in the Travis Kit to four, rather than two batteries (two sets of two batteries, with two sets of two chargers) to assure ATSO for at least four days. While the calculated endurance with four fully charged batteries is more likely eight to 12 days based on our results, we elected to consider this study validated for only four days (one sleep cycle=one fully charged battery) to account for possible deterioration of battery performance and any other differences in usage time or attachment use. Therefore, continual operation of a CPAP machine with battery power, while relying on the occasional availability of a power supply for at least two hours in a 72 hour period of time to recharge the four batteries is expected to be sufficiently "reliable" in any environment.

TRAVIS KIT

We developed a 10 kg kit, (20 named items each with a functional-duplicate spare), which fits in a helmet bag (doubled for cushioning). The discrete name guards patients' privacy. Four chargers to charge the four batteries for two hours of continuous or interrupted power via any available source (e.g. generators or solar photovoltaic panels). There is a minimal footprint & EMF emission (716 gm). Two Data Cards for each CPAP device; one to be mailed to the medical waiver authority at the member's home base for compliance verification while the spare is in use (see next page).

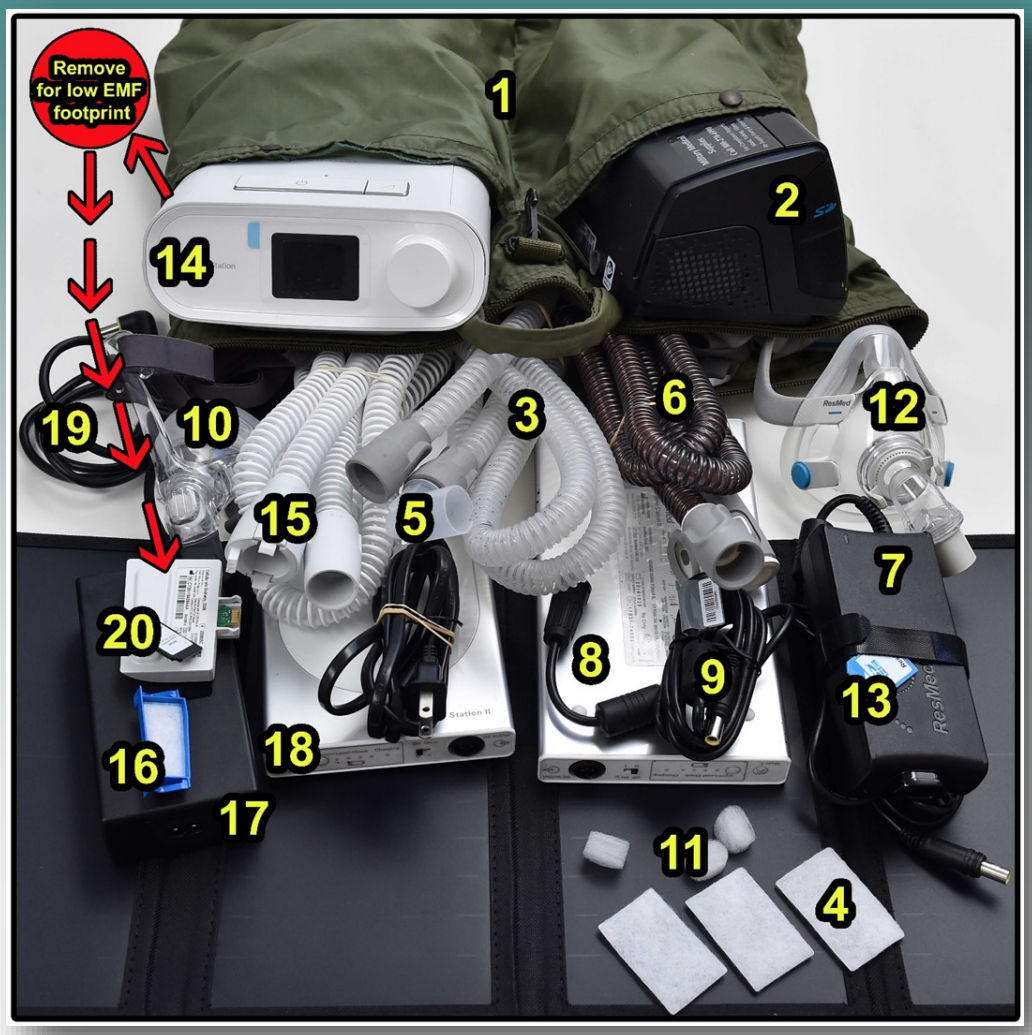
Not issued but considered is the unnumbered item at the bottom of the table. A foldable photovoltaic solar panel module that can be fitted with boost switchable power supply that would enable limited recharging.

The provisioned supplies are designed to permit resilience in operation. Each item has, at least one duplicate (and sometimes 4 duplicates). This enables assured ATSO despite possible harsh field conditions where some critical items can get lost, damaged, or otherwise rendered inoperable from heat or other environmental conditions. Therefore, each component can take, at least, one hit of becoming "InOp" without loss of functionality. The four batteries and four chargers are the key to withstanding unpredictability and unreliability of a power supply. Even the most occasional restoration of power would accumulate sufficient stored power over four batteries to restore functionality for at least one sleep cycle. The items in the Travis Kit (MOD-0) are discussed on the following page.

Interested in writing your own feature article?

Contact one of the SAFPA DAL for Comm or any other BOD member!!

Expanding Boundaries for OSA cont'd... Maj Stephen Vela



1. Two helmet bags, one olive green and one desert tan: Provide a compact package with adequate padding suitable for deployment to desert or European theaters. Enables issue and reissue of the gear to identified personnel.

2. One AirSense10 CPAP machine: Primary "in garrison" CPAP. Has cellular and blue tooth connectivity. Device will seek cell tower access to upload use statistics to "the cloud." Compliance data is also stored on a memory card and the data from/to the card and "the cloud" are synchronized daily. Non-detachable humidifier chamber. One very important possible issue is that the cellular and blue tooth modules are "built into" this device and cannot be physically removed. This is undesirable when the member is deployed to a sensitive operational location where a telematics module seeking cell tower connectivity may be an EMF "giveaway" of location.

3. Two unheated tubing: To be used in environments where no condensation of humidified breathing air is anticipated.

4. Ten filters for AirSense10 above: >1 year supply.

5. Two connecting tubing adapters.

6. Two heated tubing for AirSense10: To be used in environments where condensation or freezing of humidified breathing air is anticipated.

7. Two batteries for AirSense10: To be used to assure full operation despite possible lack of power supply.

8. Two chargers for AirSense10: For charging batteries simultaneously to take full advantage of power when available.

9. Two Battery-to-AirSense10 cables: Used to connect batteries to AirSense10 CPAP machine.

10. Two nasal masks and harnesses: To be used if member is primarily a nose breather.

11. Ten filters for nasal masks above: Would be sufficient for over one year supply without resupply.

12. Two full-face masks and harnesses: Used if mbr is primarily a mouth breather, or has URI/allergies which interferes with nasal breathing.

13. Two data cards for AirSense10: To store "use data," the second card is sent back to home station for verification of compliance monitoring.

Expanding Boundaries for OSA cont'd... Maj Stephen Vela

14. One DreamStation CPAP machine: Primary "in field" CPAP. With physically removable cellular and bluetooth module. Device will not seek or emit EMF signals, a desired condition for field use. With the module inserted, it will establish "cloud" connectivity, and upload use data as noted above for the AirSense10. Detachable humidifier chamber, reduces the device size by 50% and reduces the battery usage. Device without humidifier chamber will fit into the Operational Camouflage Pattern (OCP) pants cargo pocket.

15. Two heated tubing for DreamStation: To be used in environments where condensation or freezing of humidified breathing air is anticipated.

16. Ten filters for DreamStation: Would be sufficient for over one year supply without resupply.

17. Two chargers for DreamStation: For charging batteries simultaneously to take advantage of power when available.

18. Two batteries for DreamStation: To be used to assure full operation despite possible lack of power supply.

19. Two Battery-to-DreamStation cables: Used to connect batteries to DreamStation CPAP machine.

20. Two data cards for DreamStation: To store "use data," the second card is sent back to home station for verification of compliance monitoring.

The numbered (1-20) list serves as a "brevity code" way of referencing particular items for issue, re-issue or resupply from the parent unit to the deployed personnel. A pocket card and a 5"x7" card with this list is included with the Travis kit.

Our ultimate goal is to get the word out to everyone that there is a possible option to canceling a deployment or completing a reclama. The Travis Kit can provide a reliable power source in remote areas as long as there is minimal power available to recharge the batteries. There are many members worried about being separated from the Air Force because they are unable to deploy to all areas due the need for a CPAP. If enough people start asking for a waiver to use the Travis Kit to supply power in austere environments, then maybe the Air Force will change the verbiage requiring a 'reliable power source'. We do have interests and support from high levels including LTG (sel) Murphy and LTG (ret) Roudebush along with some MAJCOM SGHs.

If you have any questions regarding this article or you would like further details, please feel free to reach out to Maj Vela at stephen.e.vela.mil@mail.mil or Col (Dr.) Elsayed von Bayreuth at alaaeldeen.m.elsayedvonbayreuth.mil@mail.mil.

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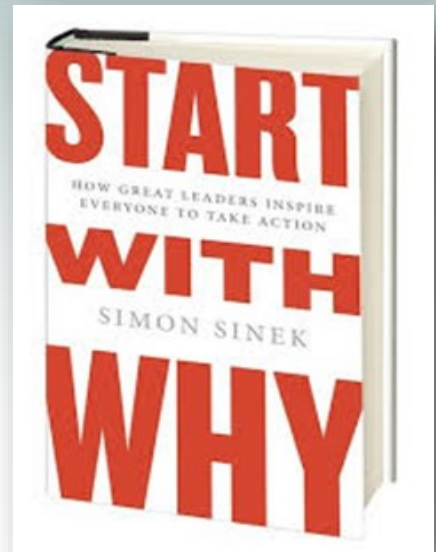
A PAs Bookshelf... Col MJ Ellis & "Friends"

"The more you read, the more things you know. The more that you learn, the more places you'll go." —Dr. Seuss

I've recruited a couple of colleagues to offer you some great reads. **Major Chris Scharfenstine**, Surgical Services Flight Commander, at Joint Base Elmendorf-Richardson reviews *The 5 Choices; The Path to Extraordinary Productivity*. **Major Ryan Kastern**, BSC Utilization Officer, AFPC, Joint Base San Antonio reviews *The Checklist Manifesto: How to Get Things Right*. I'm throwing in my two cents with *Start with Why: How Great Leaders Inspire Everyone to Take Action.*



Start with Why: How Great Leaders Inspire Everyone to Take Action
By Simon Sinek
Genre: Nonfiction, Business, Leadership, Personal Development

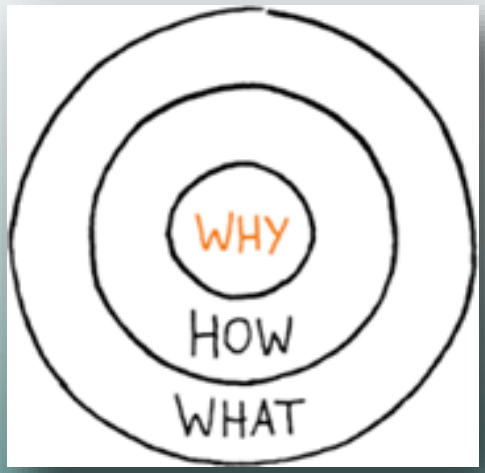
Imagine a world where we wake up inspired to go to work.

Samuel Langley embarked on a mission to develop and fly the first powered airplane. He was intelligent and well educated. He had backers that gave him $50,000, which was a lot of money at the turn on the 20th century. With help from his numerous connections, he assembled and paid a 'dream team' to help him. Samuel Langley was motivated by fame and money. He wanted the prestige of being first.

The Wright Brothers had no funding. They put every dime they earned from their bicycle shop into this project. They had no college education. They had no connections, just some very motivated friends. The Wright Brother had a dream. They wanted to change the world. They believed flight would benefit others. Despite failure after failure, they kept trying because they had a vision and were passionate about WHY.

And in December 1903, the Wright Brother soared for 59 seconds over the dunes of North Carolina and made history.

Other reviewers have found "*Start with Why*" too long and redundant. I've read it twice! What can I say, I'm a Simon Sinek fan. I like his storytelling style. Sinek has studied the leaders-who've had the greatest influence in the world. He talks about his Golden Circle idea, which provides a framework upon which organizations can be built, movements can be lead, and people can be inspired. And it all starts with WHY.



If you need the reader's digest version there is a famous (5 million+ views) TED Talk too. https://ted.com/talks/simon_sinek_how_great_leaders_inspire_action?utm_source=tedcomshare&utm_medium=email&utm_campaign=tedspread

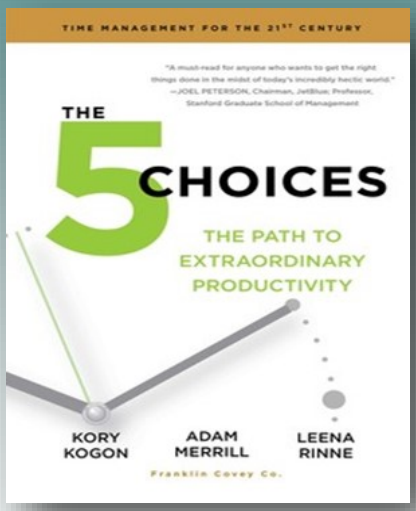
I also **highly recommend** Sinek's **"**Millennials in the Workplace". Touted as the "Interview that broke the Internet". https://youtu.be/hER0Qp6QJNU

What on your bookshelf?

Send me your reading list and tell me what you loved/hated about the books; melanie.ellis@us.af.mil

A PAs Bookshelf... Col MJ Ellis & "Friends"

"The more you read, the more things you know. The more that you learn, the more places you'll go." —Dr. Seuss

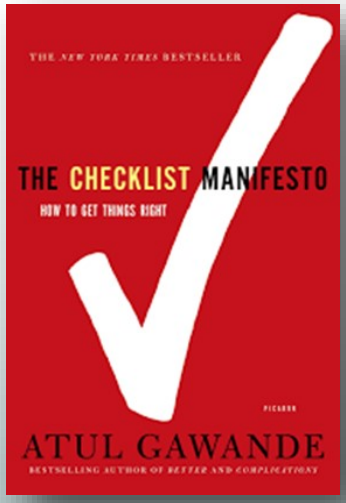


The 5 Choices: The Path to Extraordinary Productivity
By Kory Kogon, Adam Merrill, and Leena Rinne
Genre: Nonfiction, Business, Leadership, Productivity

I was attending a squadron commanders meeting hosted by the Wing Commander where the topic of discussion was being an organized leader. One of the issues brought up was the relentless emails that flood our inboxes. The discussion ensued until one of the squadron commanders introduced this book and expressed how much they related to the examples and how much it helped them to stay on task despite the day to day distractions. I was the "fly on the wall" during this discussion but, it peaked my interest as my inbox is endless and I always feel disorganized.

Are you one of those people who feel as if they are busy all day but, at the end of it, feel as if you've accomplished nothing? When you leave work are your charts complete, emails answered, tasked delegated, and projects on schedule? Are you decompressing on the way home or still thinking of the things you need to accomplish the next day? If so, *The 5 Choices* is for you!

The book discusses five steps to a more productive day and provides examples that the reader easily relates to. It helps you identify what is important to YOU and enables you to function in a Q2 world (read and you will understand) thereby changing your day from being busy to productive. BIG difference! Who knows, after reading this, maybe you will be someone who lives in the utopia where you maintain an inbox of ZERO!



The Checklist Manifesto: How To Get Things Right
By: Atul Gawande
Genres: Non-fiction, Medicine, Business, Self-Help

Gawande penned a very smooth and engaging piece. This general surgeon, public health researcher and MacArthur Fellow quickly sells his "back-to-basics" credo and the value of utilizing checklists. He states that, "medicine has become the art of managing extreme complexity and a test of whether such complexity can be humanly mastered". The author challenges his readers "to be humble enough to admit their own humanity and take simple steps to prevent simple errors". His recount of both triumphs and catastrophes in not only medicine, but the construction and aviation industries, are memorably germane. Gawande's words seems foundational to the tenets of the Air Force Medical Service's vision for, "Trusted Care, Anywhere".

Two enthusiastic thumbs up! This compilation of wisdom is expertly delivered and a must-read for all leaders and professionals. As our world continues to become engulfed in complexity, Gawande's message shines light on the power of the checklist. However, in order to unlock this insight, you must accept that "man if fallible but maybe men are less so."



CME Article

Appendiceal Mucocele: *An important incidental finding, case study, and review of workup*

By Capt Jesse Gronsky DSc, PA-C
Misawa AB, Japan

Maj(s) Stephen A. Smith DSc, PA-C
Ft Sam Houston, TX

Learning Objectives:

Readers should be able to:

- Formulate an appropriate DDx for RLQ pain including appendiceal mucocele
- Initiate basic work up for an appendiceal mucocele including appropriate imagining studies
- Understand the different surgical treatment options of an appendiceal mucocele

Case Presentation:

History of present illness: 39 year old female presents to family practice with three days of dysuria, hematuria, and severe right flank pain. The patient has a prior history of nephrolithiasis and states this feels similar. She denies fever but does endorse chills and sharp "stabbing" flak pain unrelieved by Ultram which she had at home from a previous episode.

Allergies: Penicillin, Sulfa drugs, Hydrocodone
PMHx: Ovarian Cysts, Migraines, ADHD
Surgical Hx: Tonsillectomy 2013, Hysterectomy 2012
Social Hx: Denies ETOH, tobacco, or illicit drug use
Family Hx: Denies any known personal or history of malignancy
Medications: Concerta 18mg PO daily, OTC Tylenol and Motrin PRN

Physical Exam: Vital signs: BP=104/64, HR=74, RR=20, SpO2=98% on RA, Temp=98.9 degrees F, Pain=8/10. General: Well-Developed, well-nourished female. Head: Normocephalic, atraumatic. Lungs: Clear to auscultation bilaterally. Heart: Regular rate and rhythm—no murmurs, rubs, or gallops. Abdomen: Non-distended abdomen with normoactive bowel sounds in all four quadrants. Abdomen is soft but tender to palpation in RUQ and below the liver edge without guarding, rebound, or peritoneal signs. + CVA tenderness. Extremities: Warm and well-perfused, no clubbing, cyanosis, or edema. Psych: Alert and oriented x 3, answers questions appropriately. Euthymic with congruent affect.

Initial Workup:

PCM ordered a non-contrasted computed tomography (CT) "stone protocol" along with basic lab work.

Labs: Microscopic UA: +3 Bacteria. UA: Positive Leukocyte Esterase, Positive Nitrate. CMP and CBC: Unremarkable.

Non-contrasted CT Abdomen: IMPRESSION: 1. Minimal right hydronephrosis. Ureters are normal in course and caliber. No dilation of either ureter. There is a new 4 mm calculi in the right hemipelvis. This 4 mm calculi appears to be adjacent to the distal right ureter but not within the distal right ureter. No definite ureterolithiasis. 2. Right nephrolith measuring 3 mm. 3. Possible appendiceal mucocele. Appendix mildly dilated measuring 1 cm in transverse dimension and contains mucinous type material.

...Continued

--> A possible appendiceal mucocele was found incidentally on the initial non-contrast abdominal CT, therefore a subsequent CT abdomen with contrast was ordered to better view the appendix and surrounding anatomy.

Additional Workup:
CT Abdomen with contrast: IMPRESSION: 1. Right renal hypoattenuating lesion with possible pseudo-enhancement or true enhancement. Consider MRI for further evaluation. 2. Enlarged appendix with no evidence of adjacent inflammation and low attenuation of the wall suggestive of mucosal hyperplasia. Recommend continued surgical evaluation.

Lab work was unremarkable aside from cystitis. Following the contrasted abdominal CT, an appropriate referral for surgical consultation was placed for further evaluation and management of the appendiceal mucocele.

———-

Background:
The diagnosis of appendiceal mucocele is rare (identified in less than 1% of all appendix specimens post-appendectomy) and refers to any lesion that is characterized by a distended, mucous-filled appendix—see Figure 1 (1-3). However, making the correct diagnosis and completing a full workup is paramount in preparation for definitive surgical management as they can be associated with malignancy. Mucocele of the appendix is the result of obstruction of the appendiceal orifice with intraluminal accumulation of mucoid material often with associated distension (4). There is a spectrum of histologic changes that can be found in the mucosa of appendiceal mucoceles ranging from benign epithelium to the invasive changes of mucinous adenocarcinoma (5). Intact mucoceles smaller than 2 cm are almost always benign. Histopathology of mucoceles can be broken down into the four main histologic subtypes based on the characteristics of their epithelium.

- **Mucinous Cystadenomas** are the most common which make up 63-85% of all cases. These are on the benign end of the spectrum and are associated with marked luminal distension (up to 6cm).
- **Simple or Retention cysts** are benign lesions that result from non-tumoral obstruction of the appendiceal orifice usually from fecolith or inflammatory stricture and are characterized by normal epithelium and mild luminal dilation (~1cm).
- **Hyperplastic Mucoceles** demonstrate local or diffuse villous hyperplastic epithelium resulting in mild luminal dilation and comprising ~5-25% of all mucoceles identified.
- **Mucinous Cystadenocarcinomas** are malignant lesions that represent 11-20% of cases and demonstrate stromal invasion, desmoplastic reaction, and/or presence of epithelial cells in the peritoneal implants. Luminal distension is usually severe (6).

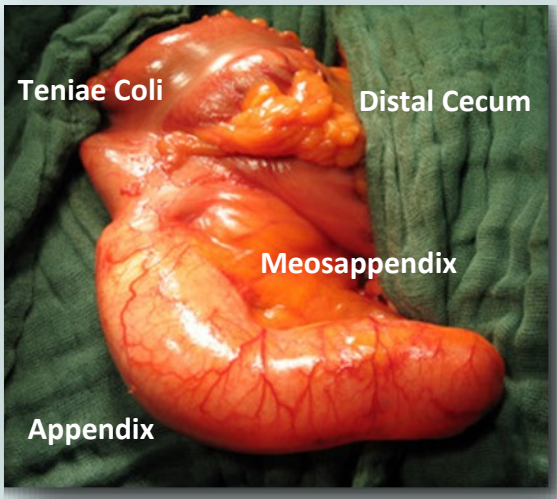


Figure 1 - Gross specimen of appendiceal mucocele

Malignant mucinous cystadenocarcinomas are the primary reason that a full workup must be completed prior to surgical intervention as histologic subtype, lesion size, invasion of local and/or distant structures effect definitive operative approach and management. Ideally, work up should be initiated simultaneously with surgical consultation in order to expedite definitive management.

Workup and Diagnosis:
Many patients are asymptomatic and the diagnosis of appendiceal mucocele is discovered incidentally. However, some patients will have nonspecific abdominal pain while others may present with symptoms consistent with acute appendicitis. The most common symptom associated with an appendiceal mucocele is right lower abdominal pain,

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whether it be acute or chronic. Secondary manifestations such as bowel obstruction, intussusception, and/or urinary symptoms are also possible depending on the size and anatomical location of the lesion. Peritonitis, sepsis, and spread of potentially malignant cells can also occur if there is an appendiceal mucocele rupture either spontaneously or iatrogenically. So-called *pseudomyxoma peritonei* occurs when the mucin-secreting cancer cells produced by the cystadenocarcinoma from of an appendiceal mucocele spread throughout the peritoneum due to the mucinous spillage. This can lead to accumulation of thick gelatinous solution in the abdomen which can present similar to ascites and spread potentially malignant cells throughout the peritoneal cavity. Thus, every effort is made to keep the mucocele intact during extraction (7-11).

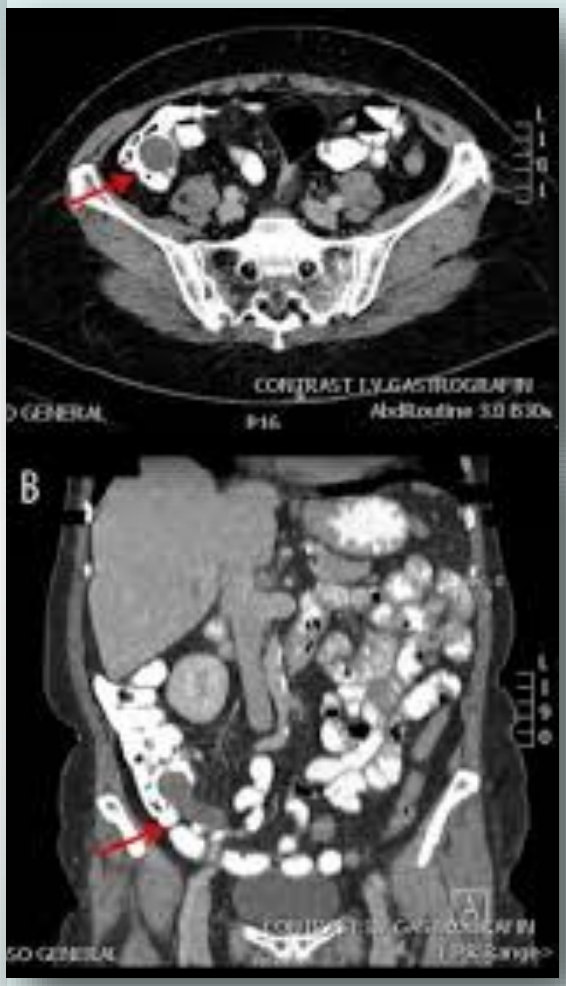


Figure 2 - CT Abd with contrast showing appendiceal mucocele

Understandably, physical exam can vary greatly between patients with some having completely benign exam and others with tenderness to palpation periumbilically or in the right lower quadrant. A palpable mass may be present in the right lower quadrant. Peritoneal signs (e.g. fever, pain out of proportion, guarding, abdominal rigidity, Rovsing's/Psoas/Jar/or Obturator signs) on exam can be present in the acute or sub-acute setting of appendiceal rupture similar to acute appendicitis.

Mucocele of the appendix can be identified on multiple imaging modalities. Plain radiographs play little role in the diagnosis of appendiceal mucocele. Most plain films, such as KUB if ordered, appear normal although it is possible a mass could be seen in the right lower quadrant or mass-effect on the bowel and/or bladder with very large lesions. Ultrasound is helpful in the diagnosis of appendiceal mucocele which may reveal a heterogeneous cystic mass that is well encapsulated unless the mucocele has ruptured. Mucoceles often do not have a thickened appendiceal wall which can help differentiate the diagnosis from acute appendicitis (12). CT scan has also proven to be helpful in the diagnosis of an appendiceal mucocele which typically show a cystic round, tubular, or encapsulated appendiceal mass—see Figure 2. Wall calcification seen on a CT scan of the appendix is highly suggestive of an appendiceal mucocele despite being seen in less than half of all cases. CT alone cannot determine if an appendiceal mucocele is malignant but wall abnormalities and soft tissue thickening can be associated with malignancy (13).

Basic lab (e.g. CBC, CMP, UA, etc) are typically nonspecific in the diagnosis of appendiceal mucocele but should be ordered upon initial presentation as part of a thorough work up. With an isolated appendiceal mucocele, a CBC can be normal but also might reveal an elevated WBC or anemia. Metabolic and electrolyte abnormalities are also possible. Case reports document that erythrocyte sedimentation rates (ESR) and tumor makers such as carcinoembryonic antigen (CEA), and CA 19-9 could also be elevated, particularly if the mucoceles is malignant, however these should not be ordered in the primary care setting (14,15).

Endoscopy is also important in the diagnosis and or the workup of appendiceal mucoceles. An appendiceal mucocele can be found incidentally on screening colonoscopy or diagnostic endoscopy as part of a workup for other symptoms.

...Continued

If an appendiceal mucocele is present obstruction of the appendiceal orifice can occasionally be visualized and the distended/mucous-filled appendix can cause displacement into the cecum. The submucosa surrounding the appendiceal orifice often appears as a mass bulging into the cecum with an appearance typically described as "rounded" with normal "starched glossy mucosa." It is important to note that this mass/bulging will not normalize or flatten with insufflation. Central ulceration may also be present which can potentially drain a mucoid fluid which is sometimes referred to as the "volcano sign"—see Figure 3 (16). Biopsies should be taken of any endoscopically visualized abnormalities despite the fact that they can occasionally miss deeper underlying malignancies. Few studies have formally evaluated the use of endoscopic ultrasound, but when used can assist in the diagnosis of appendiceal mucoceles. On endoscopic ultrasound the appendiceal mucocele will typically appear anechoic to hypoechoic and will appear heterogeneous (17).

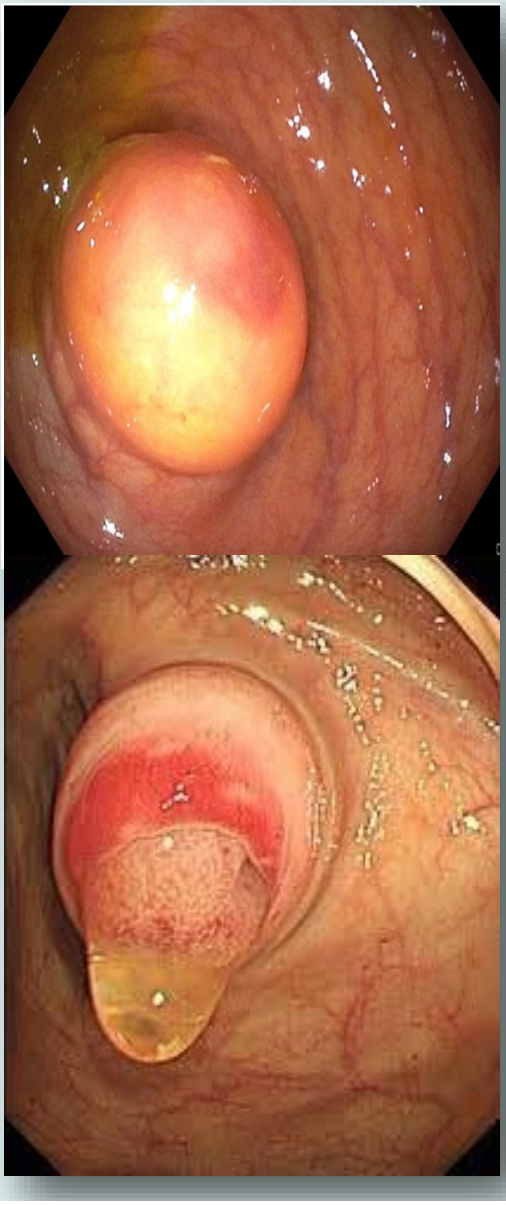


Figure 3 & 4 - Appendiceal mucocele on endoscopy without and with "Volcano Sign."

In all cases, when an appendiceal mucocele is identified either incidentally, or as part of a formal workup, surgical consultation should be obtained. The only definitive way to rule out malignancy is through pathologic analysis completed after surgical removal (18).

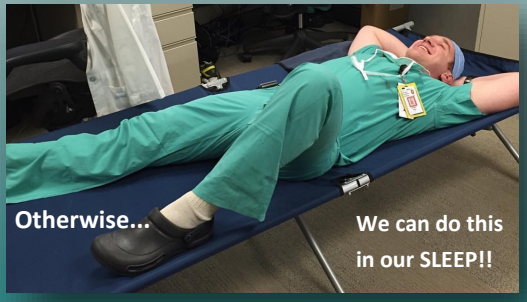
Surgical Management:
Even if there is low clinical suspicion or the mucocele appears benign on imaging, surgical excision is indicated due to the potential risk of malignancy, particularly if the lesion is ≥2 cm. Depending on the severity of the disease, the literature describes multiple surgeries that are acceptable when removing an appendiceal mucocele including laparoscopic vs. open appendectomy with or without partial/full cecetomy, right hemicolectomy, or even more extensive excisions in the case of suspected or confirmed metastases (19). Laparoscopic approach can be utilized in the majority of cases, however the surgeon must take extra care when removing the mucocele from the abdomen and when placing the mucocele in the catch bag to prevent intraoperative spillage of mucin which can lead to mucin seeding and pseudomyxoma peritonei (20).

Case Outcome:
In this case, our patient first underwent a colonoscopy which was normal, then went on to have an uncomplicated laparoscopic appendectomy and partial cecectomy. She was discharged from the hospital the same day as surgery and had an unremarkable postoperative recovery. Subsequent pathology was negative for malignancy, thus no further specialty care was required.

See next page for **CME Test!**

Are you tired of General Surgery DOMINATING your TSR?!

Submit your own CME and/or feature article to your friendly DAL Comm or any other BOD member!!



CME Questions:

1. What is the incidence of appendiceal mucoceles seen on pathology following appendectomies?

   A. 1%
   B. 5%
   C. 15%
   D. 25%

2. What is the most common histopathologic sub-type of appendiceal mucocele?

   A. Simple or Retention Cyst
   B. Mucinous Cystadenoma
   C. Mucinous Cystadenocarcinoma
   D. Hyperplastic Mucocele

3. Which test is LEAST helpful in the diagnosis of appendiceal mucocele?

   A. Computed Tomography (CT)
   B. Colonoscopy
   C. Ultrasound
   D. Plain radiographs

4. Which finding on colonoscopy is consistent with an appendiceal mucocele?

   A. Meatball sign
   B. Volcano sign
   C. Double bubble sign
   D. Coffee bean sign

5. Which disease can be secondary to mucinous spillage from an appendiceal mucocele?

   A. Small bowel obstruction
   B. Ovarian cysts
   C. Pseudomyxoma peritonei
   D. Colitis

6. Which would be an acceptable treatment strategy for an appendiceal mucocele?

   A. Seral exams and monitoring
   B. Percutaneous drainage
   C. Biopsy
   D. Appendectomy

***** For Cat 1 CME credit[$], email your answers to DAL Activities Capt Stuessy at kevin.stuessy@us.af.mil *****

[$] *Final AAPA approval still pending*

2018 AAPA House of Delegates

Maj Ryan Kastern

On 19-21 May 2018, Maj Steve Vela and I had the honor of representing SAFPA at the AAPA HOD in New Orleans, Louisiana. According to the AAPA, "The House of Delegates (HOD) is responsible for enacting policies establishing the collective values, philosophies and principals of the PA profession". During that time, 290 delegates heard testimony, deliberated and voted on 59 resolutions. A complete summary of the 2018 HOD Actions are available on the AAPA website however I have highlighted a few of these resolutions below.

One of the most extensively and passionately deliberated resolutions was **2018-8-14:** Changing the Professional Title of Physician Assistants. The HOD passed a resolution that, "requests that the Board of Directors contract with the appropriate independent consulting/research firms to investigate state/federal, financial, political, branding aspects, and alternatives to the creation of a new professional title for physician assistants that accurately reflects AAPA professional practice policies, reporting the results to the 2019 HOD." I feel that the word, "assistant", will always cause some level of confusion amongst the general public and state/federal legislators. During the HOD, multiple delegates provided testimony on how our current duty title was hindering their efforts to convince their state legislators to adopt Optimal Team Practice.

Next, **2018-B-06:** Federally Employed PAs, was a resolution authored by AAPA's Commission on Government Relations and Practice Advancement (GRPA). The resolution aimed to redefine AAPA's stance on the federal requirements set by the Office of Personnel Management (OPM) to include removing the requirement for federal PAs to maintain their national certification. After it was discovered that the GRPA wrote the resolution with virtually no input from the federal service PA leaders, the delegates from the federal chapters intervened. Ultimately, the HOD voted to refer the resolution back to the GRPA and they were directed to report at the 2019 HOD meeting.

Maj Stephen Vela, AAPA President Gail Curtis, Maj Ryan Kastern

2018-C-01: Recognizing New PA Certifying Agencies was a resolution that was tabled from the 2017 HOD. During that timeframe, the AAPA and NCCPA were involved in a public dispute over "high stakes" recertification exams and the AAPA threatened to start another national certifying agency. The amended resolution that was adopted stated, "AAPA endorses the National Commission on Certification of Physician Assistants (NCCPA) Certification Exam as the only entrance standard for PAs." As the NCCPA prepares to start a trial for an alternate recertification process, I view this final resolution as a temporary cease-fire between the AAPA and NCCPA.

In closing, on behalf of your HOD Delegates, I want to thank you for entrusting us to represent you at the AAPA HOD. My two-year term in the HOD ends in July and Maj Bre Kormendy will be assuming chief delegate duties. Recently elected delegate, Capt Gael Gauthier, will join Maj Kormendy at the 2019 AAPA HOD. If you have any questions, please feel free to contact me at ryankastern@yahoo.com.

* SAFPA BOD SPOTLIGHT *

MAJ JULIE M. GLOVER
Title: DAL Comm (Jr.)

Displayed PA appears even shorter in real-life!

Maj Glover joined the Air Force in 2008 as a direct accession and is currently stationed at Wright Patterson AFB (WPAFB) serving as an Emergency Medicine Physician Assistant. She is also Clinical Adjunct faculty and the WPAFB site coordinator for students from Kettering College's PA Program. At this time, she is also serving in Afghanistan on her third deployment dodging IDF and breathing in the "special air" 1 mile above sea level. In her spare time, she enjoys spending time with her family especially her two dogs and cat, petting all other animals, traveling, randomly yelling out "cow" or "horse" if seen while driving, binging Netflix with no chill, working on tact, silently judging grammar mistakes due to OCD grammar nazi tendencies, and scrolling social media when she should be sleeping, and also making people laugh with ridiculous "dad" humor.

Education
2016 – Doctorate of Science, Emergency Medicine, Baylor University, JBSA-Ft Sam Houston, TX
2006 – Masters of Science, PA Studies, DeSales University, Center Valley, Pennsylvania
2005 – Bachelor of Science, Medical Studies, DeSales University, Center Valley, Pennsylvania

Assignments
Jan 2017 – Present, Emergency Medicine PA Wright-Patterson AFB, OH
May 2015 – Dec 2016, Fellow, Emergency Medicine PA Resident, Ft Sam Houston, TX
July 2012 – May 2015, Family Practice PA, Aviano AFB, Italy
Sept 2013 – August 2014, Executive Officer, Aviano AFB, Italy
July 2008 – July 2012, Family Practice PA, Seymour Johnson AFB, NC

Awards/Decorations
Meritorious Service Medal
Joint Service Commendation Medal
Air Force Commendation Medal
National Defense Service Medal
Iraq Campaign Medal with Bronze Star
Global War on Terrorism Medal
Air Force Nuclear Deterrence Operations Service Medal

MAJ(s) SARAH SIMS
Title: DAL of Activities (Jr.)

Capt Sims is currently the Program Director for the Independent Duty Medical Technician program at Fort Sam Houston, Texas. She loves outdoor adventures with her husband Cliff and three children ages 5, 3, and 1. She has a passion for teaching and enjoys lifting, reading, tex-mex, and coffee.

Education
2011 Bachelor of Science, UNMC
2012 Master of PA Studies, UNMC

Assignments
2012-2014 Cannon AFB, NM, AFSOC
2014-2017 JB Elmendorf-Richardson, AK, PACAF
2017-present JB San Antonio, TX, AETC

Awards/Decorations
59th TRG Lance P. Sijan Leadership Award 2018, Junior Officer
Air Force Commendation Medal with two oak leaf clusters
Meritorious Unit Award with one oak leaf cluster

We love hearing from our members!

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- Activities: **Maj(s) Sarah Sims; sarah.e.sims2.mil@mail.mil** (2018-2020)

SAFPA Representation to AAPA's House of Delegates:

- **Chief Delegate: Maj Bre Kormendy: breanne.m.kormendy.mil@mail.mil** (2017-2019)
- **Delegate: Capt Gael Gauthier; gael.h.gauthier.mil@mail.mil** (2018-2020)

SAFPA BOD email address: **SAFPABOD@gmail.com**

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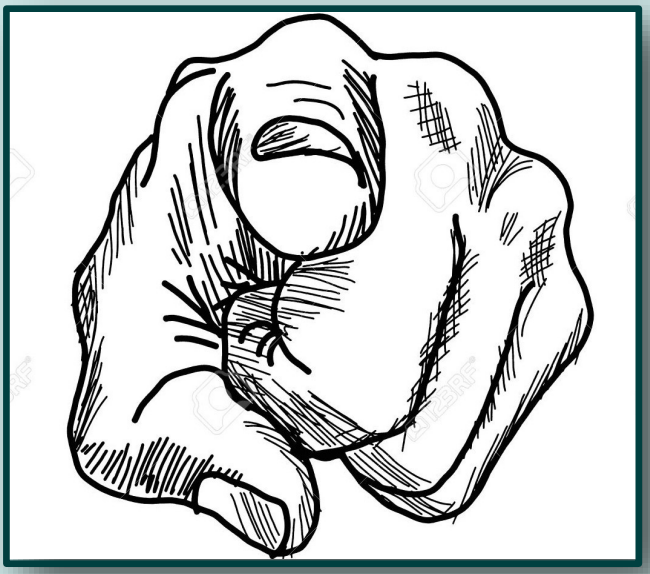
Reach out to us with questions or ideas

The TSR is YOUR newsletter!



I would again like to take a minute and personally thank all of those who contributed to this publication. It takes the concentrated effort of **MANY** to make this happen and this 40th anniversary issue was no exception! I especially would like to thank Maj(s) Kesterson for his spearheading the effort which produced our AMAZING cover mosaic that I feel truly represents the growth that we have had over these many years. I also thank the rest of those who wrote feature articles for this issue which made it one of our very best ever (in my humble opinion). We still need **YOUR** feedback. If you see something you like…. Tell us! Similarly, if you see something you don't, or know of something we should have included and may have missed… Please make it known, then consider writing something of your own.

You'll never find an easier bullet—> this is an **AF-wide PA journal** that reaches **450+ PAs** across the AFMS!!

We are looking for the following articles:

- 1-2 CME articles**… case studies, clinical updates (new BP guidelines/treatment perhaps?), get creative!! MUST include "learning objectives" and 5-6 questions related to the material (you know the drill)
- "Out of the Box" PA Job Highlight = ex. Leadership, Command, Operations, AFMOA, Staff…
- "How To..?" Update SURF, writing tips (OPRs, PRFs), PME tips and tricks, etc...
- IPAP Update & Articles (we are hoping for at least TWO student articles this go around)
- "Mentorship Matters" = "Silverbacks," lets put your experience to WORK
- "Efficiency / Team practice tips" — Do you make your 19-20 patients/day look easy? Share your expertise.
- Non-clinical articles / Interest pieces / etc… get creative!!

Projected deadline for article submission for the Winter TSR is 1 Dec 2018!!

Please reach out to **Maj(s) Smith** and/or **Maj Glover** with questions.

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