Department of Family Medicine and Community Health
UNIVERSITY OF WISCONSIN
SCHOOL OF MEDICINE AND PUBLIC HEALTH

Madison and Baraboo Family Medicine
Residency Programs

Scholarly Projects and Community Health Learning Experiences

From the Class of 2026

Julia Beccue, MD

Projects Completed During Residency:

Community Health Learning Experience:

Why Does Your Doctor Care So Much About Your Blood Pressure?

Scholarly Project:

Clinic Quality Improvement Poster Presentation: Including All Learners

During this quality improvement project, Belleville clinic aimed to lower blood pressures in our patients by incorporating all clinic members into the process of measuring a second blood pressure reading if patients had an elevated initial blood pressure reading. The goal was to increase the capture of accurately abnormal blood pressure readings and raise awareness amongst the team when abnormal readings were measured. Clinicians and medical assistants received data on how frequently they were obtaining a second blood pressure reading following an abnormal initial reading, and this data was compared across peers. Involving all members of the clinical team led to increased buy-in and higher levels of accountability in capturing second blood pressure readings. By increasing our awareness of abnormal readings, blood pressure control was improved due to increased intervention.

I'd like to thank my residency class for being the best support group a girl could ask for. Thank you to my family for always being there for me and providing a respite from hard days at work. Thank you to my partner, Ramses, for always pushing me to be the best version of myself. Finally, thank you to the faculty for being such fantastic role models!

Julia Beccue, MD (she/her) grew up in rural Illinois, attending the University of Illinois at Urbana-Champaign for her undergraduate degree, and the University of Illinois College of Medicine – Rockford for her medical degree. Growing up in a rural area instilled a desire to strengthen her community by helping individuals in it to thrive and influenced her journey through medicine. Julia is particularly interested in behavioral health, preventative medicine, and health education. It is important to her to provide better access to care and help patients take charge of their health. Julia has enjoyed designing and implementing health education events that focus on physical and mental health topics. Caring for communities by participating in Wrap Around Rockford, a mobile healthcare initiative, and working in the Pilsen Food Pantry have been formative experiences for her. Julia stays active by playing basketball and volleyball. She enjoys traveling, trying new cuisine, and spending time with family and friends.

Why Does Your Doctor Care So Much About Your Blood Pressure?
By Julia Beccue, MD

Why does your doctor care so much about your blood pressure? As a primary care physician, high blood pressure is a condition I talk about with my patients all day long. A common phrase I hear from patients is, “Well, I feel fine. I don’t really want to take medicine.” It’s understandable why patients think this way - there’s a reason we say “out of sight, out of mind”. When you can’t feel when something is wrong, as is usually the case when your blood pressure is a little high, it doesn’t always feel like something that needs to be dealt with, unlike something that causes noticeable discomfort, like a cut that needs stitches or an infection that needs antibiotics. So what’s the deal with high blood pressure, and why does your doctor care so much about it?

It’s important to define what “blood pressure” is to know why it matters. Blood pressure is the amount of force that pushes against the walls of your arteries when your heart pumps blood. There are two parts to the number you see when you check your blood pressure - the top (systolic) number, or the amount of pressure against the walls of arteries when your heart squeezes, and the bottom (diastolic) number, or the amount of pressure against the walls of arteries when your heart relaxes between heartbeats. A normal blood pressure reading is typically around 120/80 or less. When blood pressure is higher than normal over long periods of time, even just a little higher, it can lead to issues throughout the body, particularly the heart, kidneys, brain, and even the blood vessels themselves. Many things can contribute to higher blood pressure, including high-salt diet, alcohol consumption, sedentary lifestyle, poor sleep, high stress, and genetic factors.

Thinking about the impacts of high blood pressure on the body can be compared to water running through a plumbing system. Just like how high water pressure can cause cracks in pipes, when your blood pressure is higher than normal over long periods of time, the blood vessels experiencing that pressure can become damaged and stiff, which in turn can lead to higher blood pressure. Pipes with high water pressure can develop leaks, and blood vessels can too. These leaks can come in the form of strokes or aneurysms, and those can be deadly. High water pressure can also damage appliances by increasing strain on the different components and causing them to wear out early; similarly, high blood pressure makes the heart and kidneys work harder and make them wear out early, too.

Let’s focus on the heart itself. When it tries to pump against a high pressure system, the heart muscle can get thick. The increased thickness of the heart muscle makes it harder for it to pump effectively. The thick muscle has a harder time relaxing, which leads to less room inside of the heart, which leads to less blood being pumped out of the heart with each heartbeat. The heart and blood vessels are a fairly closed system, so when the pump isn’t working well, the blood behind the pump can start backing up into the vessels. This can lead to extra fluid in the legs, which looks like swelling, and extra fluid in the lungs, which looks like trouble breathing. Once things get to this point, it’s called heart failure. Heart failure is a leading cause of hospitalization in the US, and it’s the number one cause of hospitalizations in Medicare patients.

But do not despair - there is hope. Just as there are many factors that can contribute to high blood pressure, there are many ways we can treat it, many of which focus on lifestyle changes. The DASH (Dietary Approaches to Stop Hypertension) diet focuses on lowering the

amount of salt, red meat, and saturated fats in the diet while increasing things like fruits, vegetables, lean proteins, and whole grains. Reducing alcohol intake is another key lifestyle change that can lower blood pressure - no amount of alcohol is considered “healthy”, but limiting alcohol to no more than 2 drinks per day for men and no more than 1 drink per day for women can help. Physical activity level is important for blood pressure control - the American Heart Association recommends aiming for 75-150 minutes per week of aerobic exercise and/or resistance training. Improving sleep, including addressing sleep apnea if present, can lower blood pressure, as can reducing overall stress levels. Reducing total body weight by at least 5% can have a great impact on blood pressure. It’s important to note, however, that some people can make all of the recommended lifestyle changes and still have high blood pressure. Genetic reasons for high blood pressure can make it difficult to control blood pressure without the use of medications. Aside from lifestyle changes, medications are a staple in how we treat high blood pressure. Taking medications to treat high blood pressure isn’t a failure; it’s using one of the multiple tools in the toolkit to prevent worse health outcomes down the road.

With an understanding of what blood pressure is, why high blood pressure matters, and what you can do to lower your own blood pressure, I hope you feel empowered to discuss it with your doctor to keep yourself healthy for years to come.

Sophie Chatas, MD

Sophie Chatas, MD (she/her) is interested in full-spectrum family medicine, with particular interests in community engagement and women's health. She looks forward to continually expanding her knowledge of health issues, building enduring relationships with patients, and serving as an advocate in a complex healthcare system. While a medical student at the University of Michigan, Sophie was committed to improving the medical education experience for all students as chair and member of a learning environment task force. She further developed her advocacy skills through mentoring, projects for at-risk populations, and support groups aimed at mental wellness. Growing up in Columbus, Ohio, Sophie fell in love with Williamstown, Massachusetts, where she attended Williams College. Sophie loves running and spending time outside. She enjoys baking and ice cream making, and unwinds by reading on the couch with her two cats.

Projects Completed During Residency:

Scholarly Project:

Less Pain, More Gain: Transforming Gyn Procedures with Better Pain Management

Community Health Learning Experience:

EnRICH (Enhancing Representation to Improve our Community's Health)

The EnRICH (Enhancing Representation to Improve our Community's Health) program supports medical students who have demonstrated a commitment to health equity or who have overcome substantial personal or structural barriers to higher education—groups historically underrepresented in medicine. As resident participants, we helped with general planning and support for the group, and we completed a needs-based assessment to understand how students felt they could best be supported by residents. Based on this feedback, we created resident office hours, providing an informal space for students to connect with residents, ask questions, and seek guidance on a range of topics.

I want to thank my husband Chris, who has been there for me every step of the way during this residency journey. I couldn't have done this without you and your endless encouragement and patience. Thank you to my parents and brother, who have been my biggest supports from the start. Finally, thank you to the entire R3 class, who I love very much, and to my patients and my whole Wingra family, who have shaped me into the physician I am today.

Paracervical block training for Gynecologic Procedures

Winter Refresher Course for Family Medicine

Jess Dalby, MD; Kim Krawzak, MD; Sophie Chatas, MD

March 2026

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Disclosures

- We do not have any relationships with commercial interests to disclose.
- We do not intend to reference unlabeled or unapproved uses of drugs or products in this presentation.

2

Learning Objective

- Learn multiple pain management options for gynecologic procedures
- Demonstrate paracervical and intracervical blocks

3

Patient Case: the fear of pain

- 18 yo G0P0 interested in an IUD
- Friend had painful IUD placement
- Anxiety around pain of procedure

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Expert Reviews ajog.org

Best practices for reducing pain associated with intrauterine device placement

Check for updates

Lisa L. Bayer, MD, MPH, FACOG; Samir Ahuja, MD, FACOG; Rebecca H. Allen, MD, MPH, FACOG; Melanie A. Gold, DO, DMQ, DABMA, FAAP; Jeffrey P. Levine, MD, MPH; Lynn L. Ngo, MD, MPH, FACOG; Sheila Mody, MD, MPH, FACOG

From 1/28/2025

ACOG The American College of Obstetricians and Gynecologists

ACOG CLINICAL CONSENSUS

NUMBER 9

JULY 2025

Pain Management for In-Office Uterine and Cervical Procedures

Committee on Clinical Consensus–Gynecology. This Committee Opinion was developed by the American College of Obstetricians and Gynecologists' Committee on Clinical Consensus–Gynecology in collaboration with Genevieve Hofmann, DNP, WHNP-BC, Kimberly Hoover, MD, and Kristin Riley, MD.

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Article review

We will split into 3 groups to focus on the recommendations for the following procedures:

- IUD insertion
- Endometrial biopsy
- Colposcopy-directed cervical biopsy

Take about 10 minutes to read the article and 10 minutes to discuss within your group. We will then return to discuss as a larger group.

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Article discussion questions

- Do the recommendations focus on **improving patient-oriented outcomes**, explicitly comparing benefits versus harms to support clinical decision-making?
- Are the recommendations based on graded **evidence**, and do they include a description of the **quality (e.g. strong, weak) of the evidence**? Which recommendations in the article are supported by the strongest evidence, and which rely more on expert consensus or values?
- ACOG explicitly names **clinician bias** and **historical minimization of gynecologic pain**. How effectively does the article integrate this acknowledgment into its clinical recommendations?
- What has been **your experience** with pain management for gyn procedures in your practice? How have you **already applied** these principles and/or how would you like to **apply them going forward**?

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TABLE 2
Factors associated with the likelihood of increased pain during IUD placement[a]

Social, demographic, and psychological factors	Physical and medical factors
Age (adolescence)	Nulliparity
History of trauma	Multiple cesarean deliveries
Anxiety or mood disorder	Not currently breastfeeding
Baseline anxiety (fear)	Dysmenorrhea
Anticipation or expectation of pain	Anatomical: extreme retroverted uterus, anteflexed/retroflexed uterus, narrow cervical os, tortuous cervical canal, uterine fibroids
Previous painful IUD placement	Prior cone biopsy of cervix
Previous negative reaction to pelvic exam	Prior failed IUD placement
Race[b]	Size of IUD inserter[c]
Lack of mental preparation	Difficulty or pain with uterine sound
Higher level of education (≥7 y)	Time between last delivery and IUD placement (>13 mo)
Higher emotional reactivity	Menstruation (nulligravidas)

IUD, intrauterine device; *LNG*, levonorgestrel.

[a] Currently, it is not possible to predict with certainty whether a patient will experience severe pain or discomfort during the procedure; [b] Race as a risk factor is likely due to complex social and institutional realities and inadequately treated pain; [c] Increased pain has been reported with 52 mg LNG-IUD compared to 13.5 mg, 19.5 mg, or copper 380 mm² IUD [Table adapted from Gemzell-Danielsson et al[38] with additional sources[7,16,31,33,34,124–127]].

Best practices for reducing pain associated with intrauterine device placement. Bayer, Lisa L. et al.American Journal of Obstetrics & Gynecology, Volume 232, Issue 5, 409 - 421

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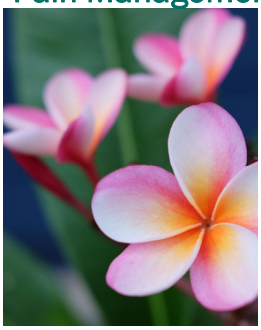
Non-Pharmacologic Pain Management Options



- Pre-insertion counseling
- "Verbal analgesia"
- Lavender/peppermint aromatherapy
- Distraction with music or TV
- Valsalva instead of tenaculum use
- Heating pad for abdomen/cold towel for forehead

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Verbal Analgesia

- Distraction
- Word Choice
- Patient centered

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Pharmacologic Pain Management Options

- Naproxen
- Ketorolac
- Tramadol
- 10% lidocaine spray
- Topicals – prilocaine cream or EMLA cream
- Lidocaine injection

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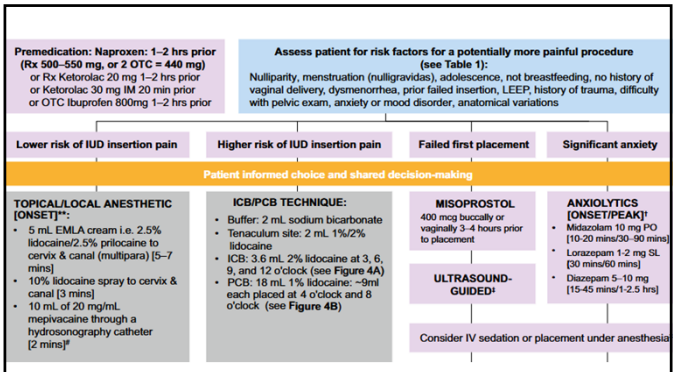

Best practices for reducing pain associated with intrauterine device placement. Bayer, Lisa L. et al. American Journal of Obstetrics & Gynecology, Volume 232, Issue 5, 409 - 421

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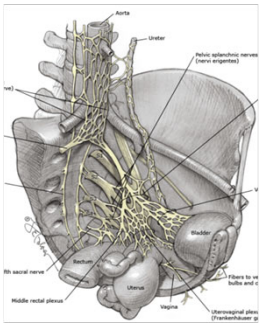
Paracervical block anatomy

Injected lidocaine is used to block pain transmission through the **uterovaginal plexus**

- Innervates the upper vagina, cervix, and lower uterus
- Fibers derived from the inferior hypogastric (pelvic) plexus (T10-L1) and sacral nerve roots (S1-S4)



Pelvic autonomic nerves *from UptoDate*

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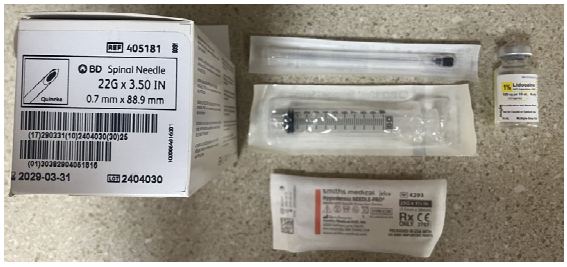
Block Equipment

- 1% lidocaine
- 10ml syringe

Paracervical block: Spinal needle 22G x 3.5in

Tenaculum site block: 22-25G x 1.5in



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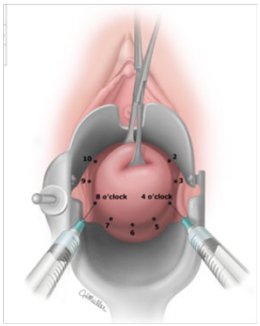
Paracervical Block Procedure



- Injection of 20ml buffered 1% lidocaine
  - Inject 2 mL superficially at 12 o'clock external cervix => place tenaculum (slowly)
  - Then inject 9mL each at 4 and 8 o'clock vaginal fornices at depth of 3cm

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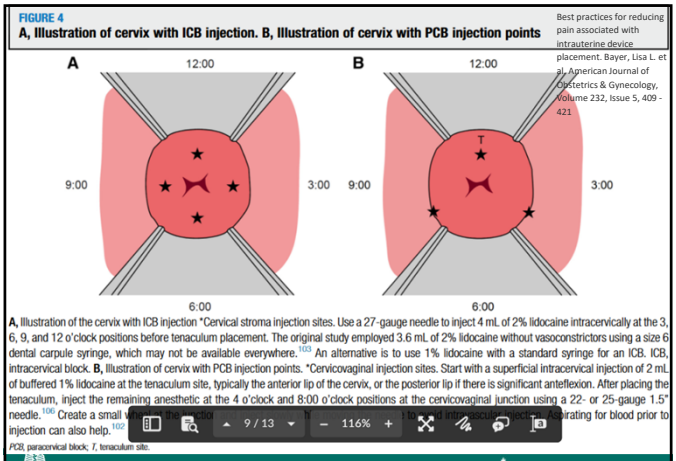

Best practices for reducing pain associated with intrauterine device placement. Bayer, Lisa L. et al. American Journal of Obstetrics & Gynecology, Volume 232, Issue 5, 409 - 421

A, Illustration of the cervix with ICB injection. *Cervical stroma injection sites. Use a 27-gauge needle to inject 4 mL of 2% lidocaine intracervically at the 3, 6, 9, and 12 o'clock positions before tenaculum placement. The original study employed 3.6 mL of 2% lidocaine without vasoconstrictors using a size 6 dental carpule syringe, which may not be available everywhere.[103] An alternative is to use 1% lidocaine with a standard syringe for an ICB. ICB, intracervical block. **B,** Illustration of cervix with PCB injection points. *Cervicovaginal injection sites. Start with a superficial intracervical injection of 2 mL of buffered 1% lidocaine at the tenaculum site, typically the anterior lip of the cervix, or the posterior lip if there is significant anteflexion. After placing the tenaculum, inject the remaining anesthetic at the 4 o'clock and 8:00 o'clock positions at the cervicovaginal junction using a 22- or 25-gauge 1.5" needle.[106] Create a small w… the cervi… h… to avoid intravascular injection. Aspirating for blood prior to injection can also help.[105]

PCB, paracervical block; *T,* tenaculum site.

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Paracervical Block Complications

- Common complications: pain, bleeding from the puncture site
- Uncommon complications: hematoma formation, infection
- Serious complication: **local anesthetic systemic toxicity (LAST)**
  - Early prodrome: tinnitus, metallic taste, perioral paresthesias
  - Late: seizure, bradycardia, hypotension

Avoid intravascular injection and remember the maximum lidocaine dose!

- 4.5mg/kg
  - about 200mg (20ml of 1%) in a 100lb patient

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Coding & Billing Tips

- The 22 modifier can be used:
  - If the work to insert IUD is substantially greater than usual
  - In the case of an unsuccessful insertion followed by a successful insertion during the same session

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PRACTICE TIME!

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Sheza Dalloul, MD

Projects Completed During Residency:

Scholarly Project:

FPIN: In patients using an intrauterine device (IUD), does menstrual cup use increase the risk of IUD expulsion compared with other menstrual products or no cup use?

Community Health Learning Experience:

Verona News Opinion Section

My community health project was writing health education articles for the Verona Press, a local newspaper for Verona, Wisconsin. This was to improve community health literacy and make evidence-based medical information accessible to the public. I aimed to address common health questions and topics, translate medical knowledge into clear, practical information, and promote preventive health behaviors. I carefully selected topics that I believed were relevant and topical to community readers, often building from questions I received while in clinic. Examples of articles that I wrote are articles on acid reflux, calcium supplementation, statins, and eating for better blood pressure.

A sincere thank you to my family for carrying me through not only residency, but all of my medical training. It is an understatement to say I would not be here without you or even be the person I am today without you. You are all angels and are my biggest blessing and strength. Thank you dad, mom, Tamer (my Madison buddy), Remy, and Rama. I love you all so much.

Sheza Dalloul, MD (she/her) calls Vernon Hills, Illinois home, and attended DePaul University and Chicago Medical School at Rosalind Franklin University. As a medical student, she enjoyed volunteering in a free clinic while on her family medicine rotation. Sheza finds connections with diverse communities by practicing medicine. To Sheza, humanity and empathy are the foundation of medicine. Hearing her patients' stories is a highlight in building a relationship between Sheza and her patients. She is passionate about being a physician for a diverse range of people, of all ages, to uplift and support those persevering through medical difficulties. Outside of medicine, Sheza loves hiking, cooking, and working out.

Topic
In patients using an intrauterine device (IUD), does menstrual cup use increase the risk of IUD expulsion compared with other menstrual products or no cup use?

Authors
Sheza Dalloul MD, Lee Dresang MD

Affiliation
University of Wisconsin Department of Family Medicine & Community Health

Bottom line
Menstrual cup use may be associated with an increased risk of IUD expulsion, although the evidence is limited and inconsistent. Clinicians should counsel patients on careful menstrual cup removal and use shared decision-making. Strength of Recommendation: B

Evidence Summary
.A 2023 systematic review concluded that evidence suggests a possible association, though study quality was low and heterogeneous.[1] There are no Cochrane Reviews on the topic. One RCT was identified. All of the other studies discussed below were included in the 2023 systematic review which concluded there is a possible association between menstrual cup use and IUD expulsion, but better-quality evidence is needed.

A 2020 RCT comparing 250 people with an IUD used a menstrual cup with 796 with no menstrual cup use found a higher percentage of IUD expulsions among those using a menstrual cup than those who did not at 12 months (32/203 [15.8%] vs. 42/843 [5.0%]) and 36 months (58/250 [23.2%] vs. 75/796 [9.4%]).[2]

A 2019 case series described seven unintentional IUD expulsions temporally associated with menstrual cup use, suggesting a potential mechanism involving traction on IUD strings or suction during cup removal.[3]

A 2019 questionnaire found that among 56 IUD users who experienced an IUD expulsion, 17 (30.9%) used an menstrual cup. There was a positive association between concurrent menstrual cup use and IUD expulsion (OR: 2.75; 95% CI 1.40–5.42, p= .002), but no association with concurrent tampon or pad use.[4]

a 2012 retrospective chart review found that among 743 IUD users, 27 (2.5%) experienced an IUD expulsion in the first 6 weeks. There was no statistical difference between patients who used cups, tampons or pads.[5]

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Mario Giacobassi, MD

Projects Completed During Residency:

Scholarly Project:

Firearm injury prevention

Community Health Learning Experience:

Re-entry Health Needs Assessment

This project aims to improve health outcomes for people returning from incarceration by strengthening community partnerships, clinician education, and care transitions. In collaboration with Nehemiah, it focuses on developing curriculum to increase resident and physician competence, reducing stigma, and establishing timely linkage to primary care. Barriers include institutional mistrust, policy restrictions, and competing re-entry priorities. The curriculum and interventions are co-designed with community input to ensure equity and relevance. Though early in development, the project emphasizes relationship-building, highlighting family medicine's unique role in bridging clinical care and community engagement to reduce disparities for formerly incarcerated individuals.

I have a lot of gratitude as I near the end of residency as this has not been a solo journey. Thank you to my wife, Amanda, for always being a source of encouragement and keeping life going at home. I want to thank my family, my parents and Amanda's parents in particular for all of the support. My kids, Louis and Eva, for helping me leave work at work, and laugh and have fun with the limited time at home. I want to thank all of our incredible faculty, the clinic staff, residency staff. I was fortunate to train here and wouldn't have reached this point without the wisdom, love and guidance from many along the way.

Mario J Giacobassi, MD (he/him) has had an adventurous journey to becoming a family medicine physician. Growing up near Milwaukee, he moved to Utah and got a degree in Emergency Services Administration. He spent six years as a wildland firefighter, then worked in neuroscience research studying the mechanisms of pain and sensation. While in medical school he became a father to two children, which shaped his medical school experience. Mario enjoys the broad scope of practice within family medicine and appreciates the opportunity to build longitudinal relationships with patients. He enjoys taking his kids to the woods, backpacking, camping, or even just short walks after school. Mario plays the violin and piano, which has become part of his children's bedtime routine. He loves cycling- from mountain biking to commuting year around and enjoys weightlifting.

Curbside Consultation

Firearm Injury Prevention: Practical Office Tips

Commentary by James Bigham, MD, MPH, FAAFP; Melissa Stiles, MD, FAAFP; and Mario Giacobassi, MD, Department of Family Medicine and Community Health, University of Wisconsin School of Medicine and Public Health, Madison, Wisconsin

Case Scenario

O.C., my 14-year-old patient, presents for a preparticipation sports examination before his high school volleyball season starts in several weeks. I care for his entire family, including his 8-year-old sibling, mother, and father. O.C.'s older brother is also my patient but no longer lives at home. O.C. shares that he has no physical or mental health concerns. My screening includes the American Academy of Pediatrics Bright Futures Questionnaire, and his mother lists that the family has firearms in the home. When I ask O.C. and his mother about her response, they share that the patient and his older brother own several hunting rifles. They state the rifles are stored without trigger or cable locks in an unlocked gun cabinet.

Commentary

Family physicians are well suited to engage in patient-centered discussions that promote firearm injury prevention. In 2018, the American Academy of Family Physicians published a position paper on the prevention of gun violence, recommending that family physicians ask patients about firearms in their homes; with patients who do own firearms, physicians are encouraged to discuss the safe storage of firearms and ammunition.[1] A 2020 survey of more than 1,000 primary care physicians in North America showed that most who were surveyed were comfortable asking their patients about firearms; however, less than 8% were comfortable counseling them on firearm safety.[2] This commentary is intended to serve as a framework for how physicians can translate the American Academy of Family Physicians call to action into clinical practice.

CLINICAL CONSIDERATIONS

Legality, medical ethics. Some clinicians may have concerns about the legality and medical ethics of screening for firearm possession and storage practices.[3] In the United States, no federal or state laws explicitly prohibit physicians from asking patients about gun ownership or discussing firearm safety. From 2011 to 2015, several states enacted laws restricting or regulating such inquiries to protect patients' privacy (e.g., Missouri) and to prevent data collection on gun ownership (e.g., Minnesota, Montana).[3,4] In 2011, the most restrictive of these physician gag laws passed in Florida, but it was overturned in 2017 after a court found it violated physicians' First Amendment rights.[5]

Patient reactions. Viewing firearm injury prevention as a clinical intervention through the lens of clinical ethics shows that this subject is within the scope of practice of a family physician. Counseling prevents harm by modifying conditions that have the potential to cause harm. It should be provided in a manner that is acceptable and does not harm the patient, promotes autonomy through respectful informational exchange, and aligns with the principle of distributive justice. Nevertheless, clinicians may be uncertain about how to initiate such conversations, worry that patients may be offended, or fear reprisal. Some patients may be hesitant to disclose firearm ownership. Research shows that when the rationale supporting screening for the risk of firearm-related injury is shared, many patients willingly engage in a dialogue around safe storage.[6,7]

SAFETY

In the United States, approximately 42% of households possess firearms.[8] A national survey suggests that more than one-half of firearm owners do not safely store every firearm they own.[9] Thus, as of September 2023, an estimated 4.6 million U.S. children reside in a home with a loaded, unsecured firearm.[10,11]

Firearm-related injury is the leading cause of death among those 1 to 17 years and younger, and 90% of child

Additional content is available with the online version of this article.

Case scenarios are written to express typical situations that family physicians may encounter; authors remain anonymous. Send scenarios to afpjournal@aafp.org. Materials are edited to retain confidentiality.

This series is coordinated by Caroline Wellbery, MD, associate deputy editor.

A collection of Curbside Consultation published in *AFP* is available at https://www.aafp.org/afp/curbside.

Author disclosure: No relevant financial relationships.

and adolescent firearm-related suicides were completed with a firearm owned by a family member. Considering this, family physicians have a significant role in screening and counseling patients and families on firearm injury prevention and safe storage.[11,12]

AT-RISK POPULATIONS

Screening for the risk of firearm injury should be performed for those living in homes with children, older adults, individuals with mental health conditions that increase the risk for suicide or homicide, those at risk for intimate partner violence, and military veterans. Given the prevalence of firearms in U.S. homes, clinicians may want to employ universal screening during preventive health visits.[13] Statistical modeling forecasts that if just 20% of homes that do not currently have safe storage of all firearms implemented safe storage strategies within the home, 323 youth firearm shootings would be avoided, and 135 youth deaths from firearms would be prevented annually.[14] This demonstrates that even with limited behavioral change, safely storing firearms can have an influential effect.

DISCUSSION

Set a respectful tone. Key elements of successful screening include maintaining a conversational and nonjudgmental tone while respecting the patient's knowledge of firearms.[6] Because of the potentially politicized nature of discussing firearms, physicians may want to reflect on their personal beliefs around firearms before inquiring about the presence of firearms in a patient's home. Most firearm owners take injury prevention seriously. Leveraging this common point of concern may prove helpful for clinicians during firearm injury screening.

Language matters. Physicians should consider using more neutral terms (e.g., firearm rather than gun) because some words may carry unintended connotations.[15] When discussing storage, the focus should be on firearm responsibility and prevention of unauthorized access rather than the use of language that may come across as limiting an individual's right to own firearms. Learning why a patient owns firearms (e.g., hunting, sport, personal protection) may provide a natural starting point for discussion while also guiding specific recommendations for safe storage or staging of firearms.

Examples of how to initiate this conversation could include asking about firearm access as a standard part of the patient's social history *(Table 1)*. Risk screening should include questions about the presence of firearms in any places visited by children, including the homes of friends and family members. Offering parents scripted questions and statements (e.g., "our family doc wants us to ask") for various situations (e.g., before a playdate) may prove helpful.

Be prepared to counsel patients on risk reduction and safe storage of firearms. The National Shooting Sports Foundation outlines the core principles of safe firearm storage in their Firearms Responsibility in the Home resource.[16]

- Firearms brought into a residence should be unloaded
- Firearms should be stored and secured with a locking device (e.g., trigger lock, cable lock, locking gun case, firearm safe; *eTable A*)
- Ammunition should be stored separately and locked up

Children should be instructed to never touch firearms unsupervised and to immediately find a trusted adult should they encounter an unsecured firearm.[17] Clinicians should also underscore that simply storing firearms out of sight or telling children not to touch a firearm is insufficient for injury prevention.

The most common reason patients say they own a firearm is for self-protection (88%); thus, the goal for many of these patients may be safe staging of the firearm with ammunition available.[10] One staging option is placing the firearm in a lock box easily accessed with a biometric scan, fob, or confidential punch code. To reduce the risk for personal injury, the firearm chamber should be clear with the loaded magazine removed and placed next to the firearm within the safe-storage device.

When patients believe that in-home storage is inappropriate because of concerns about access by or injury to a child, another family member, or even themselves during a time of mental health crisis, offsite storage of firearms is a viable option. This includes voluntary temporary transfer of firearms to a loved one or to a local gun shop that offers firearm storage.

TABLE 1

Sample Screening Questions for Patients About Firearm Accessibility

Preliminary questions
"As we talk about injury prevention, I want to check in about any firearms you may have in your home. Are there firearms in your home?"
"Because of the risk of injury from firearms, I ask all my patients about access to firearms. Do you have access to firearms?"
If patient shares affirmative access to firearms, follow up with clarifying questions
"What is your plan to prevent unintended access to your firearms?"
"What is your plan to keep high-risk individuals (e.g., children, people with mental health disorders) from gaining access to your firearm(s)?"
"Do you have any concerns about your mental health that make you feel uncomfortable about your current access to firearms?"

For patients who disclose access to unsecured firearms, physicians may elect to provide the patient with a safe-storage device. Many health systems have trigger or cable locks available for distribution to patients. Receiving locking devices in real time and free of charge has proved to be the most effective intervention to influence safe storage by patients.[18] Based on a patient's needs and preferences, the clinician may refer the patient to a local expert, such as a gun shop, for purchase of a lock box or gun safe. In addition, collaboration with gun shops allows clinicians to refer patients for training, such as safety or certification classes to reinforce the principles of safe firearm operation and storage to further reduce the risk for firearm injury.

Case Resolution

Unprompted, O.C. and his mother share that they should better secure the family's rifles. Discussion points for this visit should focus on storage options, including trigger and cable locks and gun safes. If your clinic stocks trigger and cable locks, you can show these in the examination room, giving the patient the option to select a locking device for each rifle. If O.C.'s mother expresses a preference for a gun safe, one option is to provide her with the contact information for a local gun shop that sells safes and to encourage her to discuss purchasing a gun safe with her partner so that the entire family is on the same page. Consider checking in with the parent during their own future visits about their progress in safe firearm storage. If they share that storage solutions have been enacted, make a note for O.C.'s next visit to tell him you are proud of him for being a responsible sportsman and then check in on how storage options are working for him and his family.

The authors thank Steve D'Orazio, owner of Max Creek Outdoors, Oregon, Wis., and President of the Oregon Sportsman's Club, Oregon, Wis., for his partnership and passion for firearm injury prevention education. We also thank our friends Jean Papalia, Leah Rolando, and Tom DuVal at Safe Communities Madison-Dane County, Madison, Wis., for their ongoing work to reduce firearm injuries in our community.

Address correspondence to James Bigham, MD, MPH, at james.bigham@fammed.wisc.edu. Reprints are not available from the authors.

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eTABLE A

Firearm Storage Options

Type	Description	Price ($)	Beneficial features
Cable lock	Can be used on most firearms Allows for quick access in an emergency Cable runs through the barrel or action of the firearm to prevent it from being accidentally fired; requires a key or combination to unlock	10 to 30	Accessible Affordable Theft deterrent
Gun case	Option for concealing, protecting, or legally transporting a registered firearm Available in a variety of materials (e.g., plastic, fabric, metal) Must be locked with an external device	10 to 150	Affordable Portable Protects from damage
Lock box	Reliable protection with integrated locks Option for legally transporting outside of the home	20 to 150	Accessible Portable Protects from damage
Electronic lock box	Effective way to store or legally transport firearms Some are specially designed for quick access to stored firearms	50 to 200	Portable Protects from damage Theft deterrent
Full-size and biometric gun safes	Protect from the elements Allow storage of multiple firearms in one place Available in many sizes Many have biometric options	200 to 2,500+	Protects from damage Theft deterrent

Information from National Shooting Sports Foundation. Gun storage for your lifestyle. June 5, 2013. Accessed April 2, 2024. https://www.nssf.org/articles/infographic-a-range-of-gun-storage-options-for-your-lifestyle/

Rita Henien Bybee, DO

Projects Completed During Residency:

Scholarly Project:

The Impact of Practicing Osteopathic Manipulative Treatment on Physician Well-Being and Professional Fulfillment: A Pilot Study

Community Health Learning Experience:

Building Bonds, Breaking Stigma: Prenatal and Postpartum Health Education at ARC Maternal and Infant Program

The ARC Maternal and Infant Program (ARC-MIP) delivers trauma-informed prenatal and postpartum health education to pregnant and newly postpartum women residing at ARC House, a residential program serving individuals involved with the criminal legal system. The six-session rotating curriculum covers nutrition, mental health, lactation, pelvic floor health, and delivery expectations, facilitated through interactive, discussion-based sessions. In 2026, ARC-MIP was awarded a $2,000 DFMCH grant to support educational materials. Looking ahead, the team is working to expand resident involvement, establish formal data collection with the Department of Corrections, and grow the program into a sustainable part of the family medicine residency.

Thank you to the residency faculty and my Northport mentors for your guidance, support, and for demonstrating such a beautiful spectrum of providing thorough, patient-centered, and evidence-based family medicine care. To our awesome admin team for your tireless coordination. To the whole Northport clinical and admin team – you are such an important part of our residency journey! Thank you for your patience and encouragement. Thank you to Julia Yates, for being such a calming and insightful presence when I needed it most. Thank you to my partner Jayer, for keeping me nourished and supporting my physical and mental health through residency's many stresses. To my sister Tarnim – thank you for your unwavering support throughout this whole ordeal… your insight, advice, and encouragement has made me a better doctor, but more importantly a better human. To my fellow third-years: we've had so much fun! Thank you for the wonderful memories and for being such incredible colleagues—let's leave in love, and arrive on purpose.

Rita Henien Bybee, DO (she/her) was born in Thun, Switzerland and has made her home in St. Joseph, Michigan, Lake Havasu City, Arizona, and now Madison. Her experiences developing meaningful relationships with patients led Rita to understand how health encompasses significantly personal and holistic priorities, physical wellbeing, and elimination of disease. She appreciates full spectrum family medicine, the opportunity to pursue her medical interests in prenatal care and obstetrics, geriatric and palliative medicine, and LGBTQ+ and gender-affirming care. With experience as a liaison and a service project event coordinator of a community health center in Flagstaff, AZ, Rita learned firsthand the importance of addressing social determinants of health. She rotated in many community health center sites, from critical access clinics to rural hospitals, which provided her with exposure to diverse patient populations from varying cultural and socioeconomic backgrounds. This enriched her mission to uplift the individualized health aspirations of her patients, recommend practical and accessible treatments for their lifestyle and continually adapt her approach to serving her community's health needs. Rita stays well-rounded in her activities outside of medicine- trail running, hiking, cross-country skiing, reading, and live musical theater. She also enjoys traveling and trying new outdoor activities with her family and friends.

Title: The Impact of Practicing Osteopathic Manipulative Treatment on Physician Well-Being and Professional Fulfillment: A Pilot Study

Authors: Rita Henien Bybee, DO and Sarah James, DO FACOFP

Background: Physician burnout represents a significant and growing challenge within healthcare. More than half of family medicine physicians report experiencing burnout, with some estimates as high as 63%. Burnout—also described as moral injury, compassion fatigue, or chronic workplace stress—can negatively affect physician wellbeing, resilience, professional efficiency, career satisfaction, and patient care. While substantial literature describes the benefits of receiving osteopathic manipulative treatment (OMT) in patients, little research has examined how providing OMT may affect the practicing physician.

Objective: To investigate how providing OMT may influence physicians' sense of wellbeing, professional fulfillment, and job satisfaction.

Methods: A 10-minute mixed-methods survey including quantitative and qualitative questions was developed to characterize respondents' clinical practice and frequency of OMT provision, assess burnout symptoms using the Stanford Professional Fulfillment Index, and evaluate perceived effects of providing OMT during the workday. Attendees at the Wisconsin Statewide Osteopathic Collaborative Conference were invited to voluntarily complete the survey.

Results: Twenty-seven out of 30 osteopathic family physicians completed the survey. Most respondents reported incorporating OMT into clinical practice regularly: 50% reported using OMT 1–2 times per week, 32% ≥3 times per week, 14% occasionally, and 4% rarely. Approximately 75% agreed or strongly agreed that providing OMT increases connection with patients. More than half indicated that providing OMT increases job satisfaction (57%) and may help mitigate burnout (57%). Analysis of qualitative responses identified three primary themes: enhanced physician-patient interaction through hands-on care and patient engagement; perceived clinical usefulness, including contribution to symptom improvement and provision of a non-pharmacologic treatment option; and practice-related constraints, most commonly time limitations and structural barriers related to workflow and reimbursement.

Conclusions: Physicians who incorporate OMT into clinical practice reported an increase in patient connection and job satisfaction as well as perceived mitigation of burnout. These findings provide preliminary insight into the relationship between proving OMT and the physician

professional experience and highlight the need for further investigation among larger and more diverse physician populations.

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Emily Horn, DO

Projects Completed During Residency:

Quality Improvement Project:

Improving Hypertension control in Primary Care: Does aiming for lower blood pressure goals result in improved compliance measures?

Scholarly Project:

An Osteopathic Approach to Chronic Ankle Instability

For my scholarly project I led a presentation and demonstration at the Fall 2025 WAOPS conference in Pewaukee, WI. As part of this presentation, I discussed the prevalence and pathophysiology of chronic ankle instability and reviewed the model of chronic ankle instability put forward by Hertel and Corbett in the Jun 2019 edition of the Journal of Athletic training. We then discussed the diagnostic approach to ankle instability and reviewed the anatomy of the ankle. Time was then spent demonstrating several osteopathic treatment modalities for the ankle, which included individual table time. This was followed by a brief review of best practices for preventing acute ankle injuries from developing into chronic ankle instability.

Thank you to all of the wonderful faculty and staff at our little clinic in Baraboo, and a special thanks to Dr. Hannah, our fearless program director for his leadership. I also want to thank Kellie Churchill, our amazing residency coordinator for helping me retrieve the data for my QI project, Dr. Kling for his amazing osteopathic mentorship, and Dr. James for her continued guidance and for landing us an osteopathic intern so my patients can continue to receive excellent osteopathic care next year. I would be remiss if I didn't recognize my amazing co-senior Sadie, you are amazing always, and my clinic mentor Dr. Howen, for helping me through a difficult but rewarding final year in Baraboo. Finally, I will thank my lovely parents for putting me through school, and my two cats who are my constant companions at home.

Emily Horn, DO, fell in love with family medicine while scribing for a family physician in rural Minnesota. Emily hails from Rockford, a small town in central Minnesota. She has a passion for rural healthcare and the unique challenges and opportunities it brings, having worked in rural hospitals and clinics in Minnesota, Idaho, and South Dakota. She was drawn to the Baraboo program for its commitment to teaching full-scope rural medicine, as she loves doing a little bit of everything. Her interests include obstetrics and women's health, LGBTQ+ health, diabetes management, minor procedures, and osteopathic manipulative treatment. Emily earned her undergraduate degree in Biochemistry at Grove City College in Grove City, Pennsylvania. She is a member of the AAFP, AOA, ACOFP, and CMDA, and an affiliate member of ACOG. She was the President of the ICOM Chapter of CMDA, a founding member of the ICOM LGBTQ + Allies group, and was inducted to her college's Tau Alpha Pi Theatre Honorary 2016. She enjoys sewing clothing and making costumes, watching the MN Wild with her cats, writing Pysanky, and playing Dungeons and Dragons.

Improving Hypertension control in Primary Care: Does aiming for lower blood pressure goals result in improved compliance measures?

Emily Horn, DO

Identified Issue: Suboptimal compliance with ECQM measures for controlling high blood pressure within the residency clinic.

Objective: To improve the percentage of hypertension control amongst patients diagnosed with hypertension to <140/90 within the Baraboo residency clinic (6 providers).

Plan: Residents within the clinic were instructed to adjust medications in their patients who were already diagnosed with hypertension toward a treatment goal of <130/80. This was accomplished by a brief educational session amongst the residents reviewing the new guidelines and enforcing the end goal of improving our quality measures. The goal was reviewed and reinforced monthly with the residents.

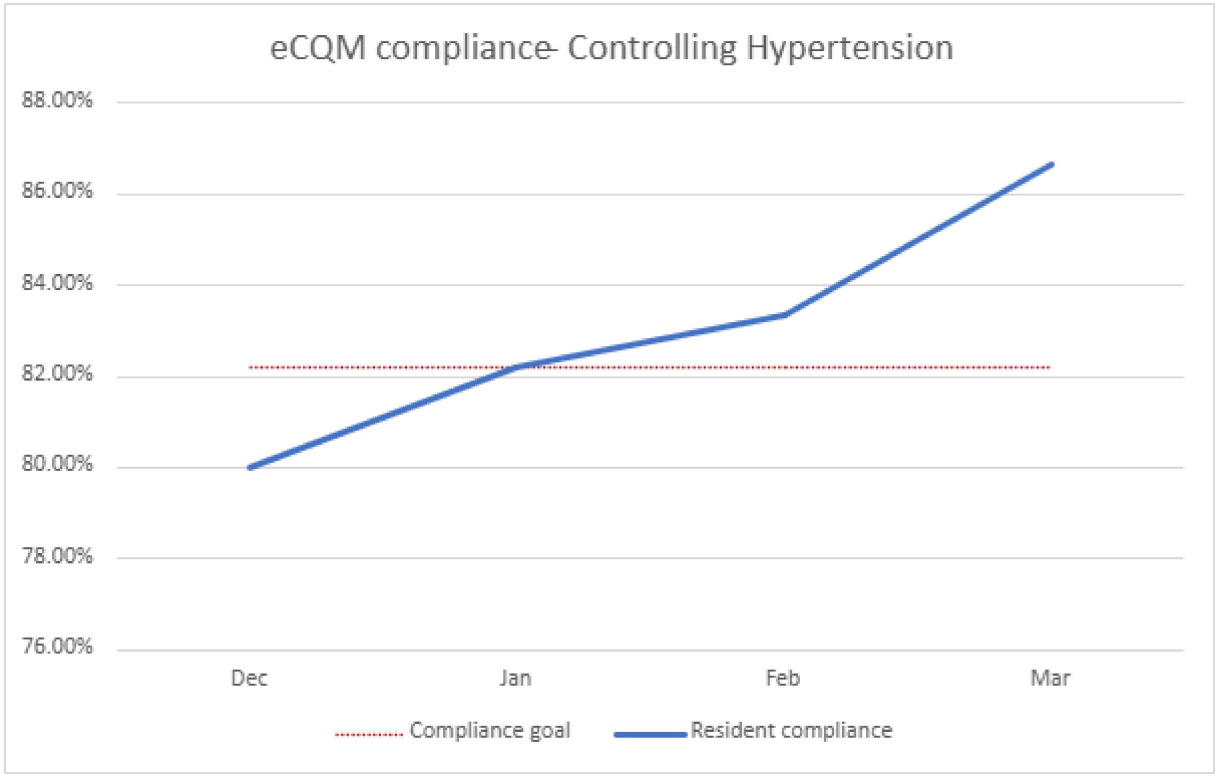
The following guideline from the AHA/ACC/Multisociety High Blood Pressure Guidelines released in August 2025 was used:

"HBP is the most prevalent and modifiable risk factor for the development of CVDs, including coronary artery disease, heart failure, atrial fibrillation, stroke, dementia, chronic kidney disease, and all-cause mortality. The over-arching blood pressure treatment goal is <130/80 mm Hg for all adults, with additional considerations for those who require institutional care, have a limited predicted lifespan, or are pregnant."

Results: The quality measure being assessed was eCQM measure CMS-165, which is defined as adult patients <85 years of age with a last recorded blood pressure of <140/90. Prior to the beginning of the QI period in December 2025, compliance for this ECQM within the residency clinic was 80.00%, reflecting 56 out of 70 patients with hypertension having a BP <140/90. The quality improvement project was initiated in January 2026, and the results for each individual resident and clinic totals are reported in the table below. Data was collected from the ECQM database by our residency program coordinator and reported per month, per resident with numerators and denominators.

The result of the quality improvement project was favorable, with overall compliance rising to 83.3% by the end of February, and preliminary data from March showing compliance at 86.7%, though the preliminary sample size was significantly smaller than the previous months as this data is not finalized until April. Overall, the brief intervention and aim towards the lower blood pressure target was successful in improving ECQM compliance within the residency clinic. Additional and more detailed analysis of patient data was not done at the time of this QI project.

	Dec-25			January 2026			February 2026			March 2026		
	# Pts <140/90	# HTN Pts	%	# Pts <140/90	# HTN Pts	%	# Pts <140/90	# HTN Pts	%	# Pts <140/90	# HTN Pts	%
Wolf	12	15	80.0%	16	17	94.1%	9	11	81.8%	4	6	66.7%
Jackson	9	13	69.2%	13	17	76.5%	17	20	85.0%	1	1	100.0%
Horn	13	15	86.7%	18	20	90.0%	22	22	100.0%	4	4	100.0%
Park	2	2	100.0%	4	6	66.7%	11	14	78.6%	1	1	100.0%
Anderson	14	16	87.5%	5	8	62.5%	15	22	68.2%	2	2	100.0%
Wecker	6	9	66.7%	4	5	80.0%	1	1	100.0%	1	1	100.0%
Total	56	70	80.0%	60	73	82.2%	75	90	83.3%	13	15	86.7%



Sadie Jackson, MD

Sadie Jackson, MD, is drawn to family medicine for the strong doctor-patient relationships that are built through continuity of care. She was born and raised Stoughton, Wisconsin and completed her undergraduate degree at Kalamazoo College, major in Biology and minoring in Studio Art. She attended medical school in Wausau, WI at Medical College of Wisconsin - Central Wisconsin Campus. She is a member of the Gold Humanism Honor Society, Phi Beta Kappa, and Alpha Lambda Delta.

Sadie has a love for art and crafts, and kept up her hobbies of knitting and crocheting during her residency. She has completed 3 handmade sweaters and is nearly finished with her fourth.

Sadie looks forward to providing compassionate primary care in the Madison area with Group Health Cooperative next year.

Project Completed During Residency:

Scholarly Project:

Improving Depression Follow-up Documentation in a Primary Care Setting

My performance improvement project evaluated strategies to enhance documentation of treatment and follow-up plans for adult primary care patients screening positive for depression (PHQ-9). Pre-intervention EMR review showed 81.6% of at-risk patients had documented plans. A simple intervention, modifying note templates to include PHQ-9 and GAD-7 scores, improved this to 87.5% post-intervention. Screening rates remained suboptimal (74.8%), with an estimated number of at-risk patients potentially missed. Overall, embedding screening data into documentation workflows improved clinical follow-up, demonstrating that small, system-level changes can enhance care quality while highlighting the need to increase depression screening rates.

I cannot thank my family, my partner, and my friends enough for their unconditional support. I would not be where I am today without them. I would also like to thank my beloved emotional support kitty, Ciara, who has been at my side since I was 15 years old.

Improving Depression Follow-up Documentation in a Primary Care Setting

Sadie S Jackson, MD

Introduction

All patients 18 years of age and older should have yearly depression screenings (PHQ-2/9) for detection and management of major depressive disorder. The objective of this performance improvement project was to increase the percentage of documented treatment and follow plans for those identified as at risk (positive PHQ-9).

Methods

I analyzed data from the electronic medical record (EMR) over the 4.5 months preceding this project. In this review, I excluded patients younger than 18 years, procedural visits (e.g., skin biopsies, joint injections), and prenatal visits, which utilize the Edinburgh Depression Scale. I modified my standard note templates to include PHQ-9 and GAD-7 scores, thereby reducing barriers to reviewing these values within the EMR. The goal of this project was to improve documentation of treatment and follow-up plans to ≥90% for patients identified as at risk.

Results

During the pre-intervention period, 225 patients were seen for office visits (after exclusions). Of these, 175 patients were screened (77.78%), and 38 of those screened were identified as at risk (21.71%). Among at-risk patients, 31 had documented treatment and follow-up plans (81.58%).

During the post-intervention period, 274 patients were seen for office visits. Of these, 197 patients were screened (71.90%), and 48 were identified as at risk (24.36%). Among these patients, 42 had documented treatment and follow-up plans (87.50%).

During this project, I identified an additional area for improvement: overall depression screening rates within the clinic. Over the 9-month study period, only 74.84% of eligible patients were screened. Of those screened, approximately 23% were identified as at risk. Based on this rate, an estimated 29 of 127 unscreened patients may have been at risk for depression, representing missed opportunities for diagnosis.

Conclusion

A simple modification to note templates improved documentation and clinical action for at-risk patients from 81.6% to 87.5%. This project demonstrates that small changes in provider documentation can enhance recognition of at-risk patients and improve quality of care. It also highlights the importance of increasing screening rates, as several potential cases of depression may have been missed during the course of this project.

Kelly Kramer, MD

Projects Completed During Residency:

Scholarly Project:

Is Dilapan-S effective for induction of labor?

Community Health Learning Experience:

Capital High Parenting Program

The Capital High Parenting Program is a collaboration between the family medicine program and Capital high school, a non-traditional school that provides a personalized learning experience for at-risk youth. We volunteer in the health classroom, which includes working with a class for pregnant teens and young parents. In listening to their experiences and answering their questions, I have learned a lot about the students' perception of health and healthcare providers. In particular, this experience has emphasized to me the importance of personal relationships in bridging the gap between the community and healthcare providers and improving trust in the healthcare system.

Kelly Kramer, MD (she/her) is a Wisconsinite through and through- growing up in Sherwood and attending St. Norbert College in De Pere for her undergraduate degree, and UW-Madison for her medical degree. Her passion for providing quality healthcare for people with developmental disabilities led her to found a local chapter of the American Academy of Developmental Medicine and Dentistry. She studied the transition from pediatric to adult healthcare for patients with Down Syndrome at the Waisman Center. She has also participated in a leadership training program that works to improve services and support for children with neurodevelopmental disabilities, where she developed a deep understanding of their unique healthcare needs. Kelly is also interested in women's health and obstetrics, addiction medicine, and community health. She is an avid reader and unwinds listening to podcasts. She stays active by hiking and playing tennis. Quality time with her family and friends is spent playing card games and board games.

Thank you to my husband, Dylan, for your unwavering support through medical school and residency, especially after the birth of our daughter, Rose. I could not have done this without you. To my parents and sisters, thank you for your constant, unwavering belief in me throughout my entire life. Thank you to all my friends, co-workers, and mentors who have been with me at every step in my education, I hope to make you all proud.

Title: Is Dilapan-S effective for induction of labor?
Word Count: 823

HDA Question: Is Dilapan-S as effective as cervical ballon catheter for cervical ripening for induction in patients at term?

Evidence based answer

Dilapan-S is as effective as a single balloon foley catheter for preinduction of labor with no significant difference in adverse outcomes (SOR A, individual RCTs with similar results). Patient satisfaction may be greater with Dilapan-S compared to foley balloon (SOR B, individual RCTs with inconsistent results).

Methods

This clinical question was developed as an HDA through a standardized, systematic methodology (HDA Methods, Supplemental Digital Content)

Evidence Summary

A 2019 single center RCT (N= 419) examined the non-inferiority of Dilapan-S to a single foley balloon catheter for inpatient cervical ripening.[2] Patients were term with an unfavorable cervix and a singleton fetus in cephalic presentation; patients with a history of cesarean section were excluded. The intervention group had as many Dilapan rods placed as possible (average of five) and the control had a single foley balloon catheter with 60 cc placed. The primary outcome was the rate of vaginal delivery. The secondary outcomes included change in Bishop score, rate of cesarean delivery, time to active labor and delivery, and patient satisfaction. Vaginal delivery was more common in the Dilapan-S group compared to the foley balloon group (81.3% vs 76.1%, absolute difference 5.2%; *P*= 0.197), indicating noninferiority per the prespecified margin of 10%. There was no difference in secondary outcomes, with the exception of a longer time with Dilapan-S in place vs balloon catheter (666 min vs 774.1 min; *P*<.0005). Patients with Dilapan-S were also more satisfied than patients with the Foley balloon as far as sleep (*P*=.01), relaxing time (*P*=.001), and performance of desired daily activities (*P*=.001). The rate of adverse events was low and similar for both groups.

A 2024 single center RCT (N= 174) examined the effectiveness of Dilapan-S to single-balloon catheters for outpatient cervical ripening.[3] Patients were at term, nulliparous or multiparous. Patients who were GBS positive or with a history of prior C section were excluded. The intervention group received up to 3 Dilapan-S rods while the control group received a 30 cc foley balloon catheter. The primary outcome was time from admission to delivery, and the secondary outcomes included change in dilation, rate of cesarean delivery, rate of a composite of adverse outcomes, and patient satisfaction. Time from admission to delivery was similar for both Dilapan-S and the foley balloon (18.01hrs vs 17.55 hours; absolute difference 0.46hr, *P*=0.04). There was no difference in secondary outcomes, including patient satisfaction for the Dilapan-S vs balloon catheter (92.77% vs 96.20%; *P*=0.5). There was no significant difference in harms between the two groups. This RCT was limited by lack of patient blinding. Notably, this RCT was underpowered based on participation enrollment.

A 2025 single center RCT (N=80) examined the effectiveness of Dilapan-S vs balloon catheter for outpatient cervical ripening.[1] Patients were term, nulliparous or multiparous, with a singleton cephalic fetus and no previous cesarean delivery. The intervention group had 3–5 Dilapan-S rods placed while the control had a single balloon Cook catheter placed. Both groups were discharged and instructed to return for admission in 12 hours. The primary outcome in this non-inferiority study was change in Bishop score. Secondary outcomes included patient satisfaction, mode of delivery, time to delivery, maternal and neonatal outcomes, and cervical

ripening failure. There was no difference in change in Bishop score between the Dilapan-S and balloon catheter groups (3.0 [2.0−5.0] vs 3.0 [2.0−4.5], *P*=.91). Compared to the balloon catheter group, the Dilapan-S group had increased patient satisfaction (1 point on a 10-point scale,]; *P*<.01) and less cervical ripening failure (17.5% vs 45.0%; *P*<.01). There was no difference in mode of delivery, time to delivery, or maternal and neonatal outcomes. Patients reported no difference in pain with cervical ripening experience. This RCT was limited by lack of patient blinding and was underpowered to detect differences in several secondary outcomes.

A 2024 single center RCT (N=296) examined the effectiveness of Dilapan-S compared to foley balloon catheter for pre-induction cervical ripening in India.[4] Patients were nulliparous or multiparous, 37-41 weeks gestation with cephalic, singleton pregnancies, unfavorable cervix and no history of cesarean section. The intervention group had 1-3 Dilapan-S rods placed for up to 12 hours. The control group had a foley balloon catheter placed for up to 12 hours. The primary outcome was the rate of vaginal delivery. Secondary outcomes included change in Bishop score, delivery mode, time to delivery, and rate of augmentation, and adverse maternal and neonatal outcomes. The rate of vaginal delivery was not significantly different between Dilapan-S and Foley balloon based on a non-inferiority margin of 10% (68.6% vs 70.4%; absolute difference of -1.8%, 95% CI 0-4). For secondary outcomes, significant differences between Dilapan-S and Foley balloon included higher need for augmentation with prostaglandins (68.3% vs 20.2%; *P*<.001). There was no difference in the rates of cesarean section or adverse outcomes. Limitations of this study included a lack of blinding.

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Briana Krewson, DO, MPH

Projects Completed During Residency:

Scholarly Project:

Osteopathic Minutes

Community Health Learning Experience:

Community Partner Engagement in Group Medical Visits at Verona Family Medicine Clinic

UW Health Verona Clinic's Fitness & Lifestyle Challenge group medical visits (GMV) have provided a novel approach to chronic condition management for the last 11 years (2014-2025). Annual groups consist of approximately 20 adult patients, recruited from clinic PCP panels. GMVs operate as a series of 90-minute sessions, meeting every 2-4 weeks for a 3-5 month period, and are led by a team of family medicine faculty and resident physicians. During GMVs, clinicians and community partners deliver a teaching topic, healthy food offerings, time for movement, and small group discussion to review patient-specific clinical data and chronic disease management, set self-management goals and discuss barriers to health behavior change. Engagement of community, health system, and academic partners to support lifestyle medicine interventions has been a critical component of GMV delivery and impact. This was presented at the annual American College of Lifestyle Medicine conference in Nov 2025.

Briana would like to thank her husband, David Miller, who has been an immense source of support during her time in residency. She would also like to thank her parents Lynne and Doug, grandparents, sister Rachel, brother-in-law Ben, parent-in-laws Rill and Steve, sister-in-law Rella, and extended family for their support through residency as well. She would also like to thank her co-residents, who have become her WI family, her attending physician mentors, and her friends all over the country for being so understanding of her residency schedule and being her crutch on the hardest of days. Finally, a shoutout to Jake her pup who provides daily unconditional love!

Briana Krewson, DO, MPH (she/her) developed her passion for family medicine when she started vegetable gardening, rooting her interests in the connection between the earth and human health. Prior to medical school, she had experiences across the globe that shaped her, including completing her Fulbright Fellowship in Poland, and medical research in subarctic Canada and Alaska. Today, she has multiple areas of interest, including humanism in medicine, lifestyle medicine, osteopathic manipulative treatment, narrative-based medicine, and academic medicine. She looks forward to strengthening the health of her community and supporting long-term relationships with patients at both their healthiest and most vulnerable moments. In her time outside of medicine, she is an enthusiastic vegetable gardener, loves baking desserts, and stays active doing yoga and hiking trips with her husband David and dog Jake.

Osteopathic Minutes

Briana Krewson, DO, MPH
Zoe Roth, DO

- OMT lecture series during resident didactics
- Resident-lead and resident designed
- For DO and MD residents to learn together
- Mini lecture (osteopathic tenants, data, technique), followed by hands-on practice
- Occur once per month (roughly) for about 30-50 mins per session
- *presented at the ACOFP faculty development conference virtually, on Feb 8th 2025*

	R1 (Starts January yearly)	R2/3 (#1)	R2/3 (#2)
July		OMT Refresher - Screening and basic modalities / the osteopathic exam	OMT Refresher - screening and basic modalities / the osteopathic exam
August		Low back pain #1	C-spine
September		Knee	C-spine #2
October		Shoulder	T-spine
November		Headache	UE - Wrist/Elbow
December		Open Lab (review)	Open Lab (review)
January	Low back pain #1	Low back pain #2	Sacrum
February	PNA/Asthma	Breastfeeding/Latching - newborn OMT	T-spine #2
March	Shoulder	URI - ENT	Inominates
April	Knee	Pregnancy OMT	Physician Choice
May	Headache	ST/Fascia	Open Lab (review)
June	URI - ENT	Open Lab (review)	

Samantha Lease, DO

Samantha Lease, DO fell in love with family medicine for the breadth of care she can give her patients and the depth of the relationships she can build with them. Originally from Minnesota, she obtained her Bachelor's in Biochemistry from College of St. Benedict, her Master's in Biomedical Sciences from Iowa State University, and her Osteopathic Medicine degree from Des Moines University where she also served as chief OMM fellow. She and her husband spend their time chasing big dreams and keeping themselves grounded with amateur homesteading. Samantha is launching a private practice this summer offering full-service outpatient family medicine.

Projects Completed During Residency:

Community Health Learning Experience:

OMT at Madison Street Medicine

Scholarly Project:

Navigating Legal & Negotiating Risk

Navigating Legal & Negotiating Risk was presented to the ACOFP Faculty Development & Program Directors' Conference in February 2025. The presentation described the process through which the new CHLE program, "OMT at Madison Street Medicine", gained residency program approval and liability coverage. The process involved email chains and meetings with 11 different departments in both UW Health and the University of Wisconsin as well as communications with Madison Street Medicine. Through this process, high-yield principles emerged for future outreach projects to use. The audience for this presentation included faculty and program directors from family medicine residency programs around the country.

My greatest gratitude goes to God, who gave me my purpose and the strength to achieve it. Thank you to my amazing husband who has multiplied my joy while we're chasing wild dreams together. Thank you to my parents for raising me to value integrity and to never give up. Thank you to my siblings and nephews whose humor and encouragement have helped me get here. Thank you to my in-laws who actively support all of our family's endeavors.

CHLE SBAR SUMMARY

Sam Lease

Situation:

Madison's unhoused population has low access to conventional care and a plurality of conditions effectively treated with Osteopathic Manipulative Treatment (OMT).

Background:

Stakeholders include Madison's unhoused population, Madison Street Medicine, local ERs and urgent cares, and the UW Family Medicine Program. The Madison Street Medicine "Community Needs Assessment" from 2023 was used to inform on this project. This project aims to treat the unhoused population with OMT which requires no overhead (zero cost) to return these patients quickly back to function and avoid unnecessary ER and urgent care visits. Because of the often immediate improvement appreciated after OMT, our primary measure of success is improvement in patient condition including subjective symptom improvement and increase in observed function. Barriers in the implementation of this project were largely in the legal and risk management space, but these barriers were overcome in partnership with appropriate affiliated groups.

Assessment:

Results were immediately evident for 100% of cases. Subjective symptom decrease examples include decrease in pain and improvement in breathing. Objective function improvement examples include improved gait, increased range of motion, and more efficient coughing expectoration. We learned that the unhoused population, most of whom are uninsured/underinsured benefit greatly with one treatment, something that is effective for the transient portion of the population and also needed for the more stable portion of the population that need ongoing care outside the traditional setting. Family medicine physicians add value to this experience due to the breadth of medical knowledge we bring to patients that often have multiple comorbidities affecting their chief complaint.

Recommendation:

The next appropriate step in this CHLE would be to offer additional evenings at the men's shelter to provide OMT. Currently this experience is offered once per month. Additional nights, perhaps twice per month, would expand access for this population that demonstrably needs and observably benefits from it.

Noah Maerz, MD

Noah Maerz, MD (he/him) is a Wisconsin native with a passion for rural medicine and community health. He is drawn to family medicine because of the potential for long-term relationships with patients, as well as being able to focus on a patient as a whole and getting to know them on a deeper level. Noah received his undergraduate degree from UW-Madison in Biochemistry and also obtained a Certificate in Global Health, before completing his medical degree at the University of Wisconsin School of Medicine and Public Health. Participating in the Wisconsin Academy for Rural Medicine (WARM) program gave him the opportunity to see a wide range of medical cases. Noah also has experience in mobile medicine, providing care for disadvantaged populations, and strives to improve access to care. He enjoys volunteering for hometown events and teaching high school students about careers in the medical field and the importance of rural medicine. In his free time, he enjoys hiking, golfing, playing cards, and snowmobiling.

Projects Completed During Residency:

Scholarly Project:

Effect of berberine on type 2 diabetes mellitus

Community Health Learning Experience:

Wisconsin Area Health Education Centers (AHEC)

For my Community Health Learning Experience, I partnered with Wisconsin Area Health Education Centers to engage with high school students and increase their interest in the medical field. As part of this, we are working with the Belleville and surrounding area high schools to set up a HOSA chapter and create job shadowing opportunities. I also attended the HOSA regional and state leadership conferences and served as a judge for various competitions.

A huge thank you to my parents and family for all of their support through these many many years of schooling. Thank you to my lovely wife Julia for putting up with all of the long hours during residency and making sure that I am supported at home. Thank you to my co-residents and faculty for being such a joy to work with or I would not have made it through these 3 years.

Title: Effect of berberine on type 2 diabetes mellitus

Word Count: Evidence-Based Answer: 74 Evidence Summary: 694 Total: 768

HDA Question: Are berberine-containing supplements effective for lowering blood sugar in type 2 diabetes?

Evidence-Based Answer

Berberine-containing supplements modestly improve fasting plasma glucose (reduction between 10-18 mg/dL), 2 hours post-prandial glucose (reduction by 20 mg/dL), and HbA1c (reduction between 0.25-0.70%) in adults with type 2 diabetes mellitus when used alone or as adjunctive therapy to standard treatments. Strength of evidence is limited by heterogeneity, lack of trials in the United States, and limited reporting on blinding. (SOR: B, Two systematic reviews and meta-analyses and one umbrella meta-analysis of medium quality)

Methods

This clinical question was developed as an HDA through a standardized, systematic methodology (HDA Methods, Supplemental Digital Content).

Evidence Summary

A 2024 umbrella design meta-analysis containing data from 11 meta-analyses (N=15,297) compared the efficacy of berberine on fasting plasma glucose (FPG), HbA1c, homeostasis model assessment for insulin resistance (HOMA-IR), and several inflammatory markers in adult subjects.[1] While the overall population included in the study were not specific to type 2 diabetes mellitus (T2-DM), subjects were adults treated with berberine between 9-19 weeks. A broad inclusion criteria included only meta-analysis studies that reported effect sizes and confidence intervals and investigated berberine on at least one glycemic control metric (11 studies) or evaluated inflammatory biomarkers (4 studies). Multiple subgroup analyses were conducted, including effects specific to T2-DM subjects, treatment duration (>12 wks vs <12 wks) and treatment dose subgroups (>1200 g/day vs <1200 g/day). Berberine reduced FPG by -0.77 mmol/L [13.9 mg/dL] (95% CI -0.90 to -0.63), and HbA1c by -0.57% (95% CI -0.68 to -0.46). HbA1c effect size was similar when accounting for only T2-DM subjects (-0.59%, 95% CI -0.71 to -0.48). Reported effect size was substantially improved by shorter treatment duration (<12 wks) and higher treatment dose (>1200 g/day), although head-to-head subgroup statistics were not definitively presented. HOMA-IR (4 studies) and associated inflammatory markers were

similarly improved with berberine supplementation. This study did not report on adverse events. Limitations of the study include heterogeneity among meta-analyses and inclusion of studies predominantly conducted in a single country (China) which weakens the ability to extrapolate to other countries/populations like the USA.

A 2024 systematic review and meta-analysis of randomized controlled trials (RCTs) evaluated the effectiveness of berberine for glycemic control in adults with T2-DM.[2] This review separated the trials into two groups: berberine alone and berberine as supplemental therapy to a diabetes medication. The review included 50 RCTs (N=4,150) that enrolled adults with T2-DM of varying duration and baseline glycemic control. Patients with severe hepatic, renal, or cardiovascular disease were commonly excluded. Berberine was administered orally, most often as berberine hydrochloride 900–1,500 mg two to three times per day. Primary outcomes included HbA1c and FPG. Pooled analysis of studies using berberine alone showed a significant reduction for FPG (17 studies; mean difference –0.59 mmol/L [10.6 mg/dL]; 95% CI, –1.18 to –0.01) but not HbA1c (11 studies; mean difference –0.24 %; 95% CI, –0.60 to 0.11). Pooled analysis of studies using berberine to supplement diabetes medications showed a significant reduction for both FPG (30 studies; mean difference 0.99 mmol/L [17.8 mg/dL]; 95% CI, -1.28 to -0.70) and HbA1c (25 studies; mean difference -0.69%; 95% CI, -0.99 to -0.39). Berberine was associated with mild adverse events such as gastrointestinal discomfort. The review was limited due to the quality of the trials as most (46 out of 50) had unclear explanations of the randomization and blinding processes.

A 2022 systematic review and meta-analysis of 37 RCTs (N=3,048) evaluated berberine for its effect on glycemic control in adults of all ages and genders with T2-DM.[3] The review included trials with durations ranging from 2 weeks to 6 months. Trials compared berberine treatment to placebo or no drug and/or berberine plus oral hypoglycemic agents to a control group of the same Oral hypoglycemic agents. All 37 trials compared FPG, 31 (N=2,683) also compared HbA1c, and 34 (N=2,884) compared 2-hour postprandial blood glucose (2hPBG). Berberine treatment was associated with statistically significant reductions in FPG and HbA1c with a decrease in the weighted mean difference of FPG by −0.82 mmol/L [14.8 mg/dL] (95% CI, −0.95 to −0.70), HbA1c by −0.63% (95% CI, −0.72 to −0.53), and 2hPBG by −1.16 mmol/L [20.9 mg/dL] (95% CI, −1.36 to −0.96). Subgroup analyses suggested that the magnitude of the glucose-lowering effect was related to baseline FPG and HbA1c levels and that controlling for baseline levels improved heterogeneity seen in other studies. Safety analyses did not show a significant increase in total adverse events (14 RCTs, N=1,321; relative risk [RR] = 0.73; 95% CI, 0.55–0.97) or hypoglycemia risk (9 RCTs, N=820; RR = 0.48; 95% CI, 0.21–1.08) with berberine versus control. This study was limited by most of the RCTs being conducted in China and by risk of bias with many included trials having poor reporting of allocation concealment and blinding of participants and personnel.

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Spenser Marting, MD

Spenser Marting, MD (he/him), grew up in Wausau, Wisconsin and chose family medicine because of its emphasis on caring for people within the context of their families and communities. He attended the Medical College of Wisconsin in Milwaukee, where he served as board chair of a student-run free clinic during the first year of the COVID-19 pandemic and helped expand care through a new telehealth program.

At the University of Wisconsin Madison Family Medicine Residency, Spenser served as chief resident for the 2025–2026 academic year and cared for patients at UW Health Northport Drive Clinic. He especially enjoys building long-term relationships with patients and working together to support what matters most to them in their health.

Spenser will stay at UW for an Addiction Medicine fellowship next year and hopes to practice family and addiction medicine while contributing to medical education. Outside of work, he enjoys swimming, public radio, backpacking, and walking his rescue dog with his wife.

Projects Completed During Residency:

Community Health Learning Experience:

"Let's Cook Together" with Goodman Community Center and UW School of Medicine and Public Health

Scholarly Project:

FPIN Help Desk Answer: In patients with hypertension, does nitrate-containing oral beetroot supplementation lower blood pressure?

Hypertension is a common condition and a major contributor to cardiovascular disease. This scholarly project reviewed evidence from two recent meta-analyses of randomized controlled trials on whether nitrate-rich beetroot juice can help lower blood pressure in adults with hypertension. The meta-analyses found that daily beetroot juice supplementation may reduce clinic-measured systolic blood pressure by about 5 mmHg. However, studies have not consistently shown improvements in diastolic or 24-hour ambulatory blood pressure. Beetroot juice is generally well tolerated, with minor side effects such as red discoloration of urine or stool, and may offer a small adjunctive benefit for blood pressure management.

I'm deeply grateful to the people who supported me through residency and medical training. To my wife, Anna—my companion and constant source of wisdom, comfort, and strength. To my parents, Miriam and Charles, who have supported me on the long journey to becoming a physician from the very beginning. To my co-residents and faculty, who have shaped the doctor I am today. I could not have done this without you. And to my dog Norbert, who reminds me that sometimes the best medicine is joy.

CHLE Name: Goodman Community Center CHEP – Let's Cook Together!
Primary Community Member(s): Madison area senior adults, Goodman Community Center, Gayle Laszewski (Asst. Director of Older Adult Programs), UW medical students
Resident Name: Spenser Marting, MD and David Miller, MD
CHLE Manager/Faculty Mentors: James Bigham, MD

Situation
Older adults are a vital population whose wellbeing is strongly influenced by nutrition and social connection. With aging, nutrition becomes more complex due to chronic disease, medication effects, mobility changes, and fixed incomes. Opportunities for social engagement may also narrow, increasing risk for loneliness and poorer health outcomes. Programs that combine nutrition education, practical skills, and social interaction can support healthy aging.

Background
The Goodman Community Center provides programming for adults age 50 and older, offering activities and resources that support healthy living across the Madison community. "Let's Cook Together" is an existing course, developed in collaboration with the UW medical school, that is designed to introduce new foods, teach cooking skills, and foster social connection. Medical students rotate through the course, leading five to six weekly sessions. Most sessions are virtual to reduce transportation barriers, and the final session is in-person. Each session includes a student led cooking demonstration and a presentation on a health topic. After six weeks, a new cohort continues the program. The family medicine residents serve as continuity leaders across cohorts with faculty mentorship to maintain curriculum consistency and community relationships.

Assessment
This project has not been formally evaluated, but rather evaluation has relied on participant engagement, informal feedback, and sustained attendance. Participants actively engage in discussions, ask questions, and share personal experiences related to food, culture, and chronic disease management.

Applying an equity lens highlights important barriers. Virtual sessions improve access for participants with mobility or transportation challenges but require digital literacy that not all participants possess. Economic constraints also shape recipe planning, as ingredient affordability and grocery access vary. These insights reinforce the importance of culturally familiar foods, low-cost ingredients, and practical recommendations that align with participant's lived realities.

Reflections/Recommendations

Next steps could involve developing simple pre- and post-surveys to better assess participant learning and student engagement. Offering optional technology support or a virtual site option (e.g., connecting to the Zoom meeting at Goodman) could reduce digital access barriers. Continued collaboration with community partners should guide culturally relevant recipes and topics.

Strengths of this project include strong community partnership, continuity across student cohorts, and an engaging format that combines education with practical application. The hybrid structure balances accessibility with meaningful in-person connection. Limitations include reliance on informal evaluation methods as well as technology, financial, and transportation barriers.

With respect to community engagement, we reflected on our role as family doctors, the experience of our partner (Goodman Community Center), and optimizing the relationship. As family doctors, we bring value with our whole person approach to health and health promotion as well as medical knowledge; this experience consistently reframes our perspective towards health promotion and reminds us of the strengths present in the many older adults with whom we interact. The Goodman Center has its own interests, particularly promoting and extending the reach of this event; we have adjusted to meet these needs through our iterative development.

This experience reinforced the value of community-based health promotion. As a family physician, we will be more intentional about connecting patients with community resources and tailoring recommendations to social and economic contexts. Family medicine physicians can bridge clinical care and community wellbeing by partnering with local organizations to make health education more accessible, relational, and responsive to lived experience.

David Miller, MD

David Miller, MD (he/him) grew up in eastern Pennsylvania, journeyed down to New Orleans for his undergraduate degree, received his medical degree at Thomas Jefferson University, and found his way to Madison for residency. He is drawn to family medicine because of the connections he makes with the people he works with, both colleagues and patients. With core tenets of open-mindedness, compassion, and lifelong learning, he is interested in integrative medicine, mental health, gender-affirming care, inpatient medicine, and Point-of-Care Ultrasound. David is certified to teach yoga and is passionate about promoting wellbeing through community and accessibility. He loves to spend time with family and friends, cook creatively with his wife's garden produce, and explore Madison's extensive outdoors.

Projects Completed During Residency:

Scholarly Project:

Balancing Blood Pressure and Wellbeing: a Group Medical Visit at Northport Clinic

Community Health Learning Experience:

Let's Cook Together: Community-Based Nutrition Education for Older Adults

Through a partnership with the Goodman Community Center, UW medical students lead weekly cooking demonstrations and health topic discussions for Madison-area adults 50+. As residents, we provide continuity across cohorts and help maintain the community relationship and curriculum. Sessions are mostly virtual to keep things accessible, with one in-person gathering to close each cohort. Participants share personal experiences around food, culture, and chronic disease management, making each session a connective exchange. For us, it reinforces how family medicine can extend beyond the clinic by linking patients to community resources that meet them where they live.

I am tremendously grateful for my wife, Bri Krewson, who has been my co-adventurer through residency and a constant source of support, inspiration, and love. My mom, dad, and sister have been a present and positive force, from raising me to be a loving human to encouraging me to experience the wonder and challenges of this world. I couldn't have asked for better co-residents and attendings, people who quickly became close friends and an extended family. The camaraderie and connection I've found here is something I will forever cherish deeply.

Balancing Blood Pressure and Wellbeing

A group medical visit model at UW Northport Clinic

David Miller, MD

1

Background

Group medical visit curriculum co-led by resident physicians and behavioral health providers to support patients with co-existing hypertension and mood disorders

Target demographics

- Hypertension: patient who started anti-hypertensive agent within the last 2 years
- Depression/anxiety/stress: patient who has perceived issue with these conditions

Logistics

- 90-minute group medical visit from 3:30 pm to 5:00 pm.
- 6 total GMVs spaced ~ every 2 weeks.
- 6-8 patients scheduled between two residents' schedules, which count toward the patients being seen in a resident's half-day.
- Staffer during that half-day responsible for staffing those GMVs.

2

Purpose

Hypertension and mood disorders commonly co-occur in primary care and can be challenging to manage, especially in patients with social isolation and limited behavioral health access.

- Patient goals
  - Improve blood pressure and mental health
  - Foster community support
- Resident goals
  - Learn about and facilitate GMV
  - Model meaningful collaboration between resident physicians and the behavioral health team

3

Structure

- Grounding: brief mindfulness led by BHC
- Discussion: barriers, wins, and peer feedback
- Didactic topic: focused education segment

SESSION 1 **Intentions & Community** Connection · goal setting · self-assessment	SESSION 2 **Self-Compassion & Stress** Mindfulness · coping tools	SESSION 3 **Nutrition & Nourishment** DASH diet · mindful eating
SESSION 4 **Movement & Energy** Physical activity · motivation · overcoming inertia	SESSION 5 **Sleep, Recovery, & Boundaries** Sleep hygiene · insomnia tools · setting limits	SESSION 6 **Sustaining Change** Action plans · next steps · community

4

Metrics and hopes

- Statistically and clinically significant reduction in systolic blood pressure
- Stable or reduced antihypertensive medication use
- Improvement in PHQ-9 and GAD-7 scores
- Improved patient understanding of lifestyle and stress factors related to blood pressure
- Increased sense of community and reduced social isolation

Samantha Prince, MD

Projects Completed During Residency:

Community Health Learning Experience:

Antenatal Care Research and Global Health Training Experience at the NICE Foundation, Hyderabad

Scholarly Project:

Creation of a OneHealth Simulation to Prepare Trainees for Global Health Experiences

Purpose: To evaluate a One Health simulation for teaching interconnected drivers of disease and clinical decision-making in resource-limited settings.
Methods: We developed and piloted a brucellosis-focused simulation within SUGARPREP for residents across specialties and assessed it in a post-session survey.
Results: Seven residents (78% response) rated the session highly (mean 4.43/5). Qualitative feedback highlighted improved systems-level thinking, resource awareness, and interprofessional collaboration.
Conclusions: A One Health simulation is an effective, engaging approach to teaching complex global health concepts. Future work will include pre/post assessments and interdisciplinary case development.

I am incredibly grateful to the Wingra faculty for their support, guidance, and dedication throughout my residency. A special thank you to Ann Evensen for being my global health guru, academic mentor, and all-around superstar—your mentorship has shaped my path in so many meaningful ways. I'm excited to stay on next year and continue this important work together.

And to my partner, Riccardo—thank you for your unwavering support through the many busy and challenging weeks of residency. And to our dogs, Selva and Skye, and glorious baby cat Nora.

Samantha Prince, MD (she/her) has always called Wisconsin home, having lived in Oconomowoc, Milwaukee, and Madison. She obtained her bachelor's degree from UW-Milwaukee in Cell and Molecular Biology and Women's and Gender Studies, and attended medical school at the University of Wisconsin School of Medicine and Public Health. While in medical school, she participated in TRIUMPH (Training in Urban Medicine and Public Health) in Milwaukee, where she worked on a community project assessing traumatic brain injury in survivors of domestic violence. During residency, Samantha has been actively involved in global health, including a trip to Hyderabad, India, to the NICE foundation, which deepened her commitment to health equity and cross-cultural care, and she developed a strong interest in academic family medicine. Her clinical and academic experiences have further strengthened her interests in women's health, gender-affirming care, and public health disparities. After graduation, Samantha will be pursuing an LGBTQ+ primary care fellowship to continue advancing inclusive, affirming care for diverse patient populations. Outside of medicine, she enjoys spending time with her partner, traveling, skiing, reading, rowing, language learning, and snuggling her dogs and cat.

nice
Saving Lives

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NICE Foundation Collaboration

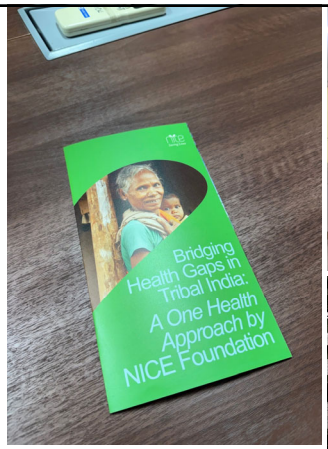
1

2

3

NICE hospital, Hyderabad

- Pediatric unit
- NICU
- Labor and delivery floor
- Pharmacy
- Ultrasound, X-ray
- Lab
- Cafeteria (Canteen)
- Faculty rooms for visitors!



4


"One Health"
• Interdisciplinary trip (vet, med students, undergrad, MPH, health admin student)
• Visited veterinary clinic, poultry farm
• School visits
• Visited primary health center, community health center

5


Paderu
• Tribal village outreach
• Fixed-day services
• Traditional birth attendant education (helping babies breathe)
• NICE hub – prenatal/postnatal care center
• Macaques

6

Ranastalam

- Fixed-day services
- Community education
- Education in school
- Group prenatal visits/education
- Individual house visits for antenatal care
- Community-wide campaigns



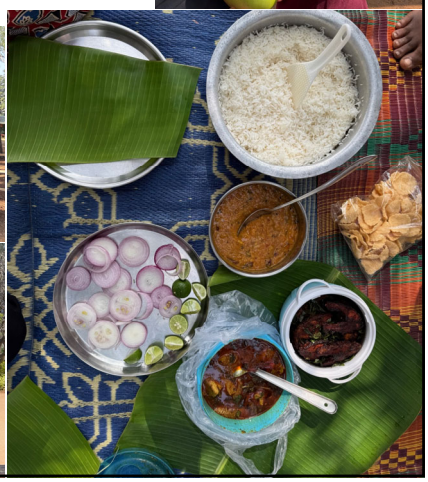

7





Thank you!



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Justine Resnik, MD

Justine Resnik, MD (she/her) is a family medicine physician dedicated to caring for patients across all stages of life. Her professional interests include community health, women's health, LGBTQ+ care, rural medicine, and medical education, with a focus on improving access to inclusive, high-quality care in underserved communities.

Dr. Resnik completed her undergraduate and medical education at the University of Nevada, Reno. During residency, she pursued a rural training pathway and volunteered at Community Connections Free Clinic in Dodgeville. She also partnered with local stakeholders to help establish a free clinic in Darlington, Wisconsin, expanding access to care for underserved populations.

She is passionate about teaching and has contributed to medical education through clinical and simulation-based initiatives, including helping implement a rapid response simulation curriculum during her R2/R3 years. She will serve as academic faculty with the University of Nevada, Reno Department of Family Medicine.

Outside of medicine, she enjoys spending time with her family and daughter, as well as snowboarding, hiking, camping, ceramics, and drawing.

Projects Completed During Residency:

Scholarly Project:

Establishing a Rural Free Clinic & Rural Free Clinic Elective For Resident Learners: Family Medicine Resident Experiences

Community Health Learning Experience:

United Neighbor's Free Clinic

My Community Health Learning Experience involved collaboration with a grassroots movement working to establish a free clinic to address local healthcare gaps in Lafayette County, WI. As a resident physician, I contributed a clinical perspective during monthly planning meetings. Additionally, I participated in a community forum to engage and recruit interested participants. I also assisted in developing a PowerPoint presentation, which was presented and well received at a county board meeting. As of right now, we are still working on obtaining 501(c)(3) status, with plans to open the United Neighbor Free Clinic in summer 2026.

I want to thank my wonderful family for supporting me since the very beginning. I especially want to thank my amazing husband, Robert, for keeping me grounded and for always believing in me, even when I didn't believe in myself. I also want to thank my beautiful daughter, Eloise, who brings so much light and joy into my world.

Establishing a Rural Free Clinic & Rural Free Clinic Elective for Resident Learners: Family Medicine Resident Experiences

Department of Family Medicine and Community Health
UNIVERSITY OF WISCONSIN
SCHOOL OF MEDICINE AND PUBLIC HEALTH

Justine Resnik, Hazel Behling and Jillian Landeck

Department of Family Medicine and Community Health, University of Wisconsin–Madison

Introduction

In 2024, Dr. Aaron Dunn the current medical director at Dodgeville Community Connections Free Clinic (CCFC), reached out to UW DFMCH to discuss supporting ongoing efforts to set up a free clinic in Lafayette County. In early discussion with community partners involved in this initiative, it was identified that finding willing providers to staff the free clinic was a possible barrier. As part of our contribution to our community partners, the US DFMCH worked to see how we could help provide a consistent source of resident volunteers. Currently we are working to giving interested residents dedicated time in their schedule to participate in volunteerism for elective credit with hopes this could provide a unique learning experience for residents with the added benefit of filling a need in a neighboring community.

Methods

- Worked with community partners to identify an ongoing need that the UW DFMCH could help address.
- It was established that the developing rural free clinic had potential staffing limitations that residents could potentially help address.
- Evaluated ongoing volunteer efforts within the already established Community Connections Free Clinic in Dodgeville to see if residents could reliably be available to volunteer in addition to traditional residency work.
- Also worked on finding avenues within already established curriculum to allow residents to count their volunteerism towards graduation requirements via our Community Health Learning Experience (CHLE) Elective.
- Will begin to collect survey data regarding CHLE residents' experiences with Free Clinic Volunteerism
- If resident experience is positive, plan to start elective rotation available to all residents.

Key Statistic for Layfette County

1 primary care physician for every 4200 people

2550 preventable hospital stays per 100,000. This means approximately 565 preventable hospitalization stays in a course of a year in Lafayette County

In 2023, 43% of CCFC patients were traveling from Lafayette County to receive care at CCFC in Iowa County.

Preliminary Data

When discussing logistical concerns with the United Neighbor's Free Clinic Steering Committee, conversations arose regarding having residents help staff the clinic. We worked to identify if it would be feasible to have consistent resident representation at the free clinic in the future. There were already ongoing volunteer initiatives occurring at Belleville Clinic encouraging residents to volunteer at Community Connection Free Clinic in Dodgeville. In between August 2023 – August 2025, 9 residents were identified as having special interests in rural medicine as demonstrated by there involvement in the Rural Health Equity Track or Rural Pathway. Of these residents 5 out of 9 chose to volunteer. On average residents who chose to volunteer would volunteer 1.3 times per year. During conversations with residents, many barriers were identified that preventing them from volunteering.

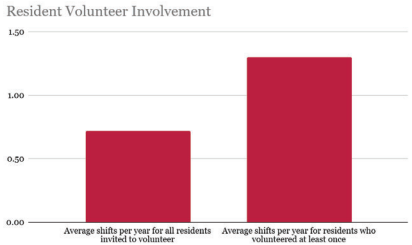


Figure 2 – Average shifts worked at Community Connections Free Clinic by Belleville residents. Residents were self identified as having a rural interest. Data collected from August 2023 – August 2025.

Resident Experience at Free Clinic

Typical Evening:

- Residents present to Community Connections Free Clinic or United Neighbor's Free Clinic (once open) on a weekday evening of their choosing.
- They evaluate patients, order labs, complete procedures and prescribe medications through onsite pharmacy.
- They typically see 3-7 patients in an evening
- They work with staff to help facilitate patient follow-up with community organizations and resources.
- An attending physician is present in the clinic for residents to staff patients with.
- Follow-up regarding labs is completed by medical director, so residents do not have additional tasks to follow-up on after the clinic session is over.

Resident Feedback Regarding Free Clinic Work:

"It has been very rewarding arriving to clinic and seeing the sigh of relief in clinic staff when you are able to help a patient with a specific procedure or see a patient in a specific demographic. Feel this is what makes family medicine physicians perfect for this type of work"

"As I progressed through residency. I've grown to appreciate the free clinic experience more and more. You get the honor of caring for these incredible patients who are so grateful to be receiving care. I come away from these visits with such a sense of community and connection. Knowing you made a true difference is powerful and why we all got into medicine in the first place."

Limitations

Barriers to volunteering at free clinic

Resident continuity clinic running late and unable to get to free clinic on time

Variable schedules making it hard to plan out far in advance when residents may be available

Burn out in PGY-1 year especially

Overview of Free Clinic Timeline

Early 2024: Dr. Aaron Dunn reaches out to Mary Knellwolf, Carly Winslow and Belleville Clinic to discuss possibility of starting a free clinic in Lafayette County

October 2024: Community meeting open to the public was held to gauge community interest in establishing a free clinic

October 2024: Community members were selected to become part of the Steering Committee Board.

Fall 2024: Met with local hospitals, healthcare organizations, pharmacist and other community organizations. Began to establish partnerships.

Fall 2024: Began to break down logistical hurdles including staffing, location, funding, EMR, pharmacy and partnerships

April 2024: United Neighbor's Free Clinic was officially chosen as the clinic's name

May 2025: Presented at the County Board Meeting and obtained county approval.

August 2025: 501c3 articles of incorporation were filed and approved. Clinic bylaws are being drafted.

Future Directions

United Neighbors Free Clinic has a tentative start date for November 2025. Three residents have been identified who will attend the clinic as part of their Community Health Learning Experience. Once the elective is fully established, resident survey data will be collected to evaluate the quality of the learning experience. Another future area of research would be to see how rural free community work impacts resident employment location preferences after residency.

Zoe Roth, DO

Zoe Roth, DO (she/her) hails from the Rocky Mountains where she attended the University of Colorado-Boulder and the Rocky Vista University College of Osteopathic Medicine. She is interested in osteopathic manipulative medicine (OMM), sports medicine, healthcare advocacy, LGBTQIA+ healthcare, gender affirming care, and Latinx healthcare. As a sports medicine intern for the University of Colorado Athletic Department, Zoe worked with the women's basketball, volleyball, and lacrosse teams. She was a founder and president of the Osteopathic Medical Student Coalition of the Colorado Society of Osteopathic Medicine. An avid photographer, Zoe shared her love of subject, composition, and light by teaching photography to children and teens battling cancer through the PabLove Foundation. She is fluent in Spanish and is passionate about bridging communication barriers and providing inclusive, unbiased, and equitable care. Zoe stays active with powerlifting, CrossFit, mountain biking, and snowboarding.

Projects Completed During Residency:

Scholarly Project:

Perceptions and barriers to treatment for urinary incontinence in female collegiate athletes

Community Health Learning Experience:

EnRICH Mentorship Program

The EnRICH (Enhancing Representation to Improve out Community's Health) program supports medical students who have demonstrated a commitment to health equity or who have overcome substantial personal or structural barriers to higher education --groups historically underrepresented in medicine. As resident participants, we helped with general planning and support for the group, and we completed a needs-based assessment to understand how students felt they could best be supported by residents. Based on this feedback, we created resident office hours, providing an informal space for students to connect with residents, ask questions, and seek guidance on a range of topics.

To my supports, both those near and far, I would not have been able to succeed, persist or thrive as I did during residency without you all.
First, I want to thank my lovely and steadfast co-residents; this journey would not have been the same without your love, compassion, joy, smiles, and laughter along the way.
I'd also like to thank the entire staff (MA's, RN's, BHC, Mary, Stacey and more) and faculty of the Wingra Clinic; you all kept me on task, time, and pushed me to be the best doctor I could be for our amazing patients, while allowing me to human along the way!
Huge thank you to my personal mentors, Drs Ildi Martonffy, Thomas Hahn, Erin Hammer, Kathleen Carr, Sarah James, Brenna Gibbons, and Patricia Tellez-Giron -- your love, dedication, attention, passion and patience allowed me a space to grow without bounds.
Thank you for my parents and my brother who've been present each and every step of the way.
And, of course, thank you to my fiancé, Lauren. You've held me up at my worst and celebrated me at my best. Next stop Iowa City!

Perceptions and barriers to treatment for urinary incontinence in female collegiate athletes

Zoe Roth, DO[1]; Megan Agnew PhD, MPH[2]; Jennifer A Sanfilippo, LAT, PhD[3]; M. Alison Brooks, MD[2]; Erin Hammer, MD, MPH[2]

1. Department of Family Medicine and Community Health, University of Wisconsin School of Medicine and Public Health
2. Department of Orthopedics and Rehabilitation, University of Wisconsin School of Medicine and Public Health
3. Badger Athletic Performance, University of Wisconsin, Madison

DEPARTMENT OF Family Medicine and Community Health
UNIVERSITY OF WISCONSIN
SCHOOL OF MEDICINE AND PUBLIC HEALTH

BACKGROUND

Stress urinary incontinence (SUI) is underrecognized in the young athlete population. Hypothesized mechanisms for SUI are increased abdominal pressure, hypertonicity of pelvic floor musculature, and low estrogen states such as those found in low energy availability. Within the literature, a large degree of heterogeneity exists, which limits our understanding of the impact of SUI specifically within nulliparous female collegiate athletes.

This is a mixed methods study performed to investigate the epidemiology of stress urinary incontinence (SUI) symptoms in nulliparous NCAA D1 female athletes– and to explore athletes' perceptions of SUI and barriers to treatment.

METHODS

Female D1 collegiate athletes completed a survey regarding their experience with SUI as a part of the standard annual intake forms. Baseline demographic and clinical characteristics of athletes who reported SUI were compared using t-tests or Chi squared tests.

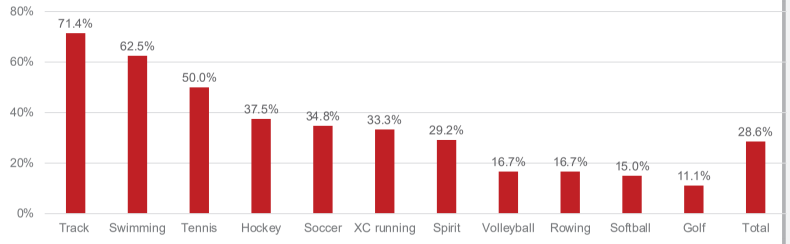
Athletes who screened positive for SUI were recruited for qualitative semi-structured interviews. These interviews were conducted on an elective basis. Zoom transcriptions were then analyzed for common themes.

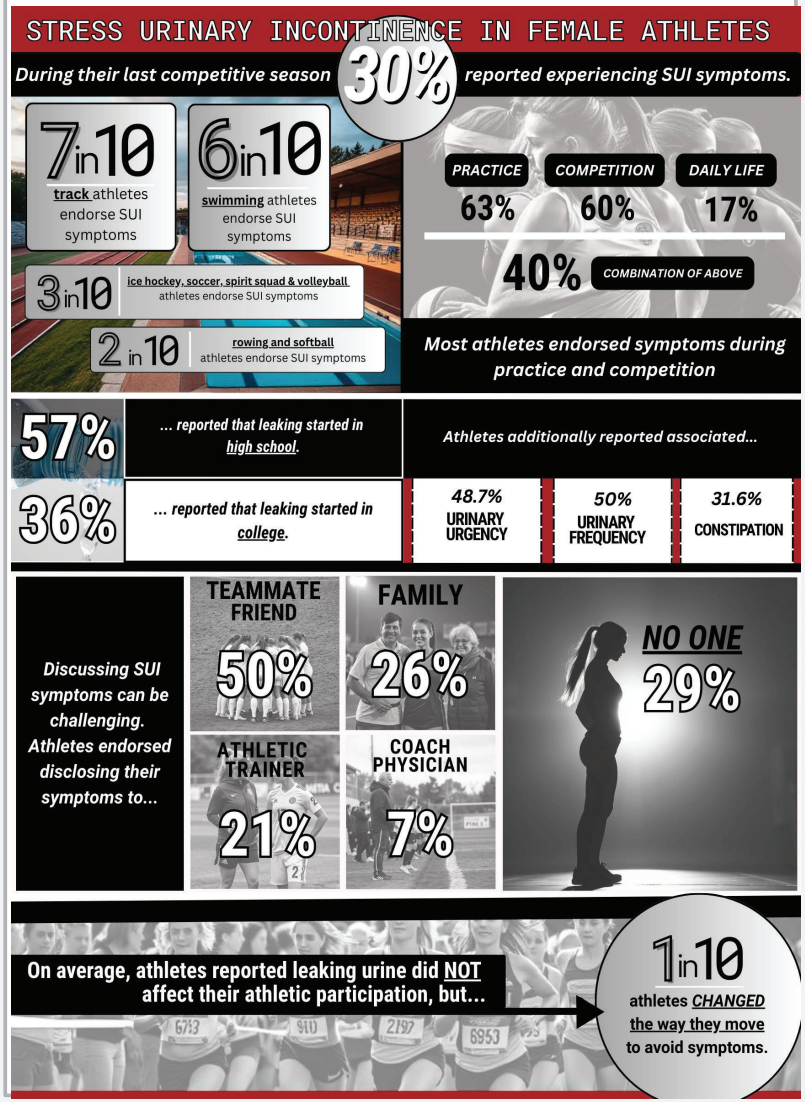
ACKNOWLEDGMENTS

Much gratitude and appreciation to the AMSSM Research Abstract Review Committee for consideration and selection. Thank you to Drs. Hammer and Brooks for their long-standing support and guidance. Thank you to study facilitators Dr. Megan Agnew and Dr. Jen Sanfilippo.

RESULTS

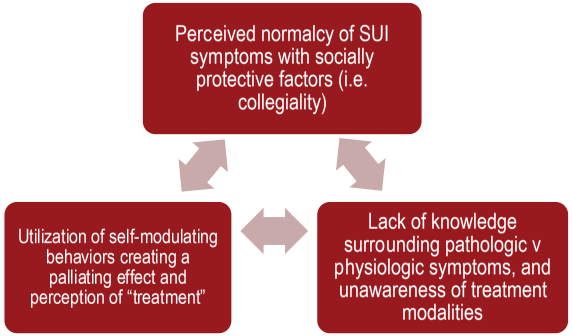
Percent of athletes reporting stress urinary incontinence





DISCUSSION

Our results highlight the high prevalence of SUI in collegiate athletes, including non-impact athletes like swimmers. This further underscores the necessity for screening all nulliparous female athletes to understand the impact, identify affected athletes, and effectively treat once athletes seek care. Those reporting more urinary urgency (OR=2.04; 95% CI: 0.6, 7.1; p=0.26), frequency (OR=2.66; 95% CI: 0.74, 9.58; p=0.14), and constipation (OR=2.72; 95% CI: 0.67, 11.1; p=0.16) had higher odds of reporting a score greater than 1 (median score) for whether urine leaking affected their athletic participation. Associated symptomatology may increase screening accuracy and facilitate earlier initiation of treatment for athletes. Initial qualitative evidence demonstrates a multifactorial nature to barriers in seeking care for SUI symptoms, as below:



CONCLUSION

Nearly a third of D1 female athletes experience SUI and over half started having symptoms before college. Unexpectedly, 16/26 swimmers (61.5%) reported SUI which opposes popular belief that impact sport athletes are at highest risk for SUI. Athletes are reluctant to seek treatment and demonstrate a profound degree of normalization surrounding an abnormal, treatable physical ailment.

Julie Vaughan, MD

Projects Completed During Residency:

Community Health Learning Experience:

Building Bonds, Breaking Stigma: Prenatal and Postpartum Health Education at ARC Maternal and Infant Program

Scholarly Project:

Hospital Overdose Prevention Effort (HOPE) Kits

Naloxone is a life-saving medication that can reverse overdose from opioids and take-home naloxone kits are associated with decreased mortality for those who use opioids in both prescription and illicit forms. Patients tend to have a positive or neutral perception of being offered naloxone and perceive improved relationships with their clinician. The labor and delivery unit at a Midwest academic hospital does not currently prescribe naloxone for antepartum and postpartum patients and is implementing a take-home naloxone program with educational materials upon hospital discharge for at-risk pregnant and postpartum patients. Hospital staff will receive training on opioid use disorders, naloxone use, and ways to discuss naloxone with patients. We plan to evaluate the impact of training on staff experiences and perceptions related to opioid use, naloxone, and comfort providing care for patients with substance use disorders before and after their training. We hypothesize that training will improve staff experience and confidence providing care to patients with substance use and discussing naloxone, which may ultimately positively impact patients' experiences with their healthcare team and reduce risks relate.

I'm incredibly grateful to my family for their constant love, support, and encouragement throughout this journey. Thank you to my attendings for their guidance, wisdom, and dedication to teaching. Thank you to the staff at Belleville Clinic for your support and for the care you provide to our patients every day. And to my co-residents—thanks for the camaraderie, the humor, and for proving that a little teamwork (and a lot of coffee) can get us through anything.

Julie Vaughan, MD (she/her) has a passion for healthcare access, which is her driving force for education and activism. Advocating for patients, caring for those with complex needs, and caring for underserved populations is important to her. She has worked on teaching patients self-advocacy and sustainable lifestyle changes, receiving a grant for her continued work with the ARC Maternal and Infant Program. She has also volunteered at outreach clinics in Madison and Dodgeville, addressing both urban and rural needs. Julie has served in a number of leadership roles in medical school and residency focusing on her key interests of preventative/lifestyle medicine, chronic disease management, women's health, and reproductive justice. Julie loves traveling to experience new cultures, hiking in beautiful places, and spending time with her newborn son. At home with her two cats, she loves to bake for family and friends and design charcuterie boards.

CHLE Final Report

SBAR Report: Family Medicine Resident–Led Education at ARC Maternal and Infant Program

S – Situation

Pregnant and postpartum women residing at the ARC Maternal and Infant Program (MIP), a Department of Corrections–affiliated residential program, face significant barriers to health literacy, self-advocacy, and trust in medical systems. Family Medicine resident physicians provide monthly, 90-minute educational sessions aimed at improving maternal health knowledge while fostering positive, bias-aware relationships between residents and this underserved population.

B – Background

Literature supports community-based, trauma-informed prenatal and postpartum education as an effective way to improve health literacy, self-efficacy, and engagement in care, particularly among marginalized and justice-involved populations. Relationship-based, longitudinal exposure also reduces implicit bias and improves trainee comfort with underserved communities.
Key stakeholders include ARC MIP residents, ARC staff, Family Medicine resident physicians, and Family Medicine faculty mentors.

The aims of the project are to: (1) increase health literacy and confidence in self-care and self-advocacy among women at ARC MIP, and (2) foster trusting, equitable relationships between women and Family Medicine residents while reducing resident bias.
Due to Department of Corrections restrictions, evaluation focuses on pre- and post-participation surveys of residents, qualitative feedback from ARC staff, and observation of engagement and attendance trends.

A – Assessment

Resident surveys demonstrated increased confidence in providing pregnancy and postpartum education, greater comfort working with justice-involved populations, and increased awareness of structural barriers to care. ARC staff reported consistently high engagement, positive participant response, and perceived value of ongoing Family Medicine involvement.
Applying an equity lens highlighted how power, trauma, and carceral systems shape patient–provider interactions. Residents learned to shift from didactic teaching toward shared dialogue, to center lived experience, and to rely on ARC staff expertise. The team gained a deeper appreciation for humility, partnership, and flexibility as core components of equitable work.

R – Recommendation / Reflections

Appropriate next steps include sustaining monthly sessions, expanding resident participation with structured equity-focused orientation, and strengthening continuity through smaller, consistent resident teams.

This experience will inform my future practice of family medicine by reinforcing the central role of community engagement, trauma-informed care, and equity-focused reflection in improving maternal health outcomes and building trust with marginalized populations.

Project overview

1. Literature/Data Review
This project is informed by literature demonstrating that community-based, trauma-informed prenatal and postpartum education improves health literacy, self-efficacy, and engagement in care, particularly among marginalized populations. Evidence also shows that longitudinal, relationship-based interactions reduce mistrust and implicit bias while enhancing resident education in health equity and social determinants of health. Internal program feedback from ARC staff indicates strong participant engagement and positive experiences with Family Medicine involvement.

2. Need Addressed
Pregnant and postpartum women involved with the criminal legal system face barriers to health education, self-advocacy, and trusting relationships with clinicians, contributing to health inequities.

3. Aims
To increase participant health literacy and confidence in self-care and advocacy, and to foster positive, bias-aware relationships between women at ARC MIP and Family Medicine residents.

4. Community Partner Engagement
ARC MIP staff serve as equal partners in topic selection, scheduling, implementation, and ongoing feedback. Other community partners engaged include content area aexperts in lactation and behavioral health.

5. Evaluation
Evaluation focuses on qualitative resident and staff feedback and attendance trends inform program refinement. Data collection is limited by Department of Corrections restrictions.

6. Equity Lens
An equity lens is applied through trauma-informed education, shared decision-making, community partnership, and resident training in cultural humility and structural awareness.

Evaluation

Formal evaluation of this project was limited by Department of Corrections restrictions that prevent direct data collection from women residing at ARC MIP. As a result, outcomes were

assessed through qualitative feedback from residents and ARC staff, and observations of engagement and continuity. Resident qualitative data demonstrated increased confidence in providing pregnancy and postpartum education, improved comfort working with justice-involved and underserved populations, and greater awareness of social and structural barriers affecting maternal health. Residents also reported reduced apprehension and increased sense of connection when engaging with ARC MIP participants over time.

Qualitative feedback from ARC staff has been overwhelmingly positive. Staff consistently reported high attendance, strong engagement, and participant enthusiasm for Family Medicine–led sessions. Women frequently asked questions, requested follow-up topics, and demonstrated growing comfort interacting with physicians in a nonclinical setting. Continuation and expansion of the program, including involvement of additional residents, further suggests perceived value and sustainability.

Applying an equity lens deepened our understanding of how power, trauma, and prior health care experiences shape patient engagement. Residents reflected on how traditional medical hierarchies and carceral systems can reinforce mistrust and silence patient voices. By shifting sessions from didactic teaching to shared dialogue, residents learned to center participant expertise, validate lived experience, and adapt language and pacing to community needs.

The equity lens also highlighted the importance of humility and partnership. ARC staff expertise proved essential in shaping content, timing, and approach, reinforcing that equitable work requires shared ownership rather than academic control. Overall, the project strengthened resident capacity to practice trauma-informed, equitable care while fostering trust and empowerment within a historically marginalized community.

Next Steps

The next steps for this project focus on sustainability, refinement, and deeper integration of equity-informed practices. Programmatically, we plan to continue monthly 90-minute sessions and expand participation to include additional Family Medicine residents with interests in maternal health and public health. Session content will be increasingly shaped by ARC staff feedback and participant-driven themes, ensuring relevance and responsiveness. Residents will receive more structured orientation on trauma-informed care, power dynamics, and the criminal legal system to better prepare them for equitable engagement. Future efforts will also explore opportunities to involve interprofessional learners, such as social work or lactation consultants, as guided by ARC priorities. All next steps will continue to center community partnership, shared decision-making, and respect for lived experience, consistent with the equity lens applied throughout the project.

This project has several strengths. It is grounded in a strong, trusted partnership with ARC MIP and embedded within an existing residency program, supporting feasibility and sustainability. The longitudinal, relationship-based model fosters trust, continuity, and meaningful engagement, benefiting both participants and resident physicians. The project also offers a low-cost, scalable

approach to addressing maternal health inequities while enhancing resident education in health equity and cultural humility.

There are also important limitations. Department of Corrections restrictions prevent direct collection of participant-level outcome data, limiting the ability to formally measure health or behavioral changes among women at ARC MIP. Outcomes therefore rely on resident self-report and qualitative staff feedback, which may introduce bias. Additionally, resident turnover and competing clinical demands can challenge continuity and consistency. Despite these limitations, the project demonstrates meaningful educational and relational impact and provides a strong foundation for continued, equity-centered growth.

Community Engagement

As a Family Medicine physician, my role added value through clinical breadth, continuity-oriented thinking, and an equity-centered approach to care. Family Medicine training emphasizes whole-person care across the reproductive life course, which informed topic selection and delivery of practical, relevant education for pregnant and postpartum women. My clinical background allowed me to translate evidence-based guidance into accessible, nonjudgmental language and to model trauma-informed, patient-centered communication for resident physicians. Additionally, my role helped bridge the academic medical center and ARC MIP by aligning educational goals with community priorities, advocating for flexibility in scheduling and content, and reinforcing the importance of relationship-building over one-time interventions. My presence as a physician also helped normalize respectful, collaborative interactions with medical providers in a nonclinical setting, contributing to trust and reducing hesitancy to engage with health care.

Community partners faced several burdens during implementation. ARC MIP staff navigated competing priorities, including security requirements, staffing limitations, and the complex needs of residents, while also coordinating space, schedules, and communication with the residency program. The presence of external partners can add emotional and logistical labor, particularly when staff must orient new residents, manage group dynamics, and ensure that programming aligns with facility rules and participant readiness. Because participant feedback could not be formally collected, staff also carried the responsibility of informally relaying participant experiences and needs.

Community–clinical engagement relationships could be optimized in several ways to improve the cost-benefit ratio for both physicians and partners. Clearer upfront role definitions, standardized session templates, and resident orientation materials can reduce repetitive staff effort. Longer-term scheduling commitments and smaller, consistent resident teams would enhance continuity and reduce coordination burden. Compensation or protected time for community partner participation, when feasible, would acknowledge the value of staff expertise. Finally, ongoing bidirectional feedback and shared decision-making ensure that programming remains responsive, efficient, and mutually beneficial, strengthening trust while maximizing impact for both the community and the clinical training environment.

Your Future

This experience will meaningfully inform my future practice of family medicine by reinforcing the importance of relationship-based, community-centered care. Working with pregnant and postpartum women at ARC MIP highlighted how trust, continuity, and respectful communication can shape patients' willingness to engage in care. I will carry forward a greater emphasis on meeting patients where they are, prioritizing listening over agenda-setting, and recognizing the impact of trauma, systems involvement, and social context on health behaviors and outcomes. This experience also strengthened my commitment to education as a clinical tool, particularly in empowering patients with knowledge and confidence to advocate for themselves.

Applying an equity lens in my future practice will involve actively acknowledging and addressing power imbalances between clinicians and patients. I will strive to use trauma-informed approaches, clear and accessible language, and shared decision-making, especially with patients who have experienced marginalization or mistrust of health systems. An equity lens also means reflecting on my own biases, understanding structural barriers to care, and advocating for flexible care models that accommodate patients' lived realities.

Family medicine physicians are uniquely positioned to engage communities due to the specialty's broad scope, continuity across the life course, and emphasis on social determinants of health. Meaningful community engagement allows physicians to better understand patient needs outside the clinic walls and to co-create solutions that are culturally responsive and sustainable. Such partnerships can improve health outcomes by increasing access to care, strengthening trust in medical systems, and addressing upstream factors that influence health. This project affirmed that community engagement is not ancillary to clinical care but an essential component of equitable, effective family medicine practice.