THE OFFICIAL PUBLICATION OF THE MONTANA ACADEMY OF FAMILY PHYSICIANS

MONTANA FAMILY PHYSICIAN

Fall 2019 – MONTANAAFP.ORG

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MONTANA ACADEMY OF FAMILY PHYSICIANS

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CONTENTS

EDITION 3

*The **Montana Family Physician** is printed, addressed, and mailed to every family physician, resident, and medical student in Montana as well as all 50 other state chapters.*

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Edition 3

MAFP President's Welcome

Amy Matheny, MD, MPH, FAAFP

Hello Montana family physicians, residents, and medical students!

Greetings Fellow Montana Family Physicians,

As the autumn season is upon us and the landscapes change, we are reminded of the transitions and transformations that are part of the cycles of our lives. Some are exciting with a sense of discovery and newness, while others force us into a new reality for which we were not ready. Thus are the seasons of our personal and professional lives. I can't help but think this quarter's magazine highlights such a theme.

I would be remiss to not first recognize a major jolt and change for us at the Montana Academy of Family Physicians Board of Directors. In our inaugural summer edition, we introduced you all to Dr. Dennis Salisbury from Butte, who was a long-time member of our board, serving as a past president and national AAFP delegate, among other national leadership roles. We were excited to announce his candidacy for the AAFP Board of Directors. Unfortunately Dennis had an unexpected change in his health in the interim, and we lost a dear friend and colleague just a few weeks ago in early October. You can learn more about Dennis in the *In Memoriam* article that follows. He has touched the lives of patients in Butte for over 25 years, as a "Grand-doctor" as he proudly called himself, as well as Family Physician colleagues across the nation. His presence will be deeply missed.

A collection of articles and essays submitted from Montana medical students and residents highlights the energy and advocacy that so defines this stage of training and discovery. From the efforts of the Montana WWAMI Family Medicine Interest Group in promoting our great specialty, to the formative rotational experiences that shaped a PNWU student's career path, our Montana medical students show the bright future of our workforce. Our resident board member from the Montana Family Medicine Residency shares an update on LGBTQ health in Montana, while the Family Medicine Residency of Western Montana is recognized nationally for its number of graduates practicing rurally. Both articles highlight the dedication of our state's residency programs to caring and advocating for our communities.

Along a continued theme of transformation, a reprint from the August 2019 supplement of the *Annals of Family Medicine* highlights findings from a number of recent studies focused on practice transformation. Access to this supplement was emailed to MAFP members in September, and the link to the supplement is reprinted in this edition. Also, a submission shared from the Ohio Academy of Family Physicians highlights one clinic's experience with a model of practice transformation to limit administrative burden that subsequently reduced burnout.

The Montana delegation at the AAFP Congress of Delegates. From left to right: Jeffrey Zavala, MD, Alternate Delegate, Billings; Heidi Duncan, MD, Delegate, Billings; Amy Matheny, MD, Alternate Delegate, Missoula; Janice Gomersall, MD, Delegate, Missoula; Michael Strekall, MD, Board Member, Helena; Linda Edquest, MAFP Chapter Executive, Helena.

Before you know it, the seasons will change again. Of course, the winter season in Montana brings snow, which will complement our 61st annual Big Mountain Medical Conference in Whitefish! This year's conference promises to bring another excellent collection of CME offerings. In addition to multiple clinical topics, the meeting will also include optional programs on Point of Care Ultrasound (POCUS) and a 4-hour Medication-Assisted Treatment training that provides half of the required hours to qualify for the DEA waiver to prescribe buprenorphine. Check out the meeting brochure at the end of this issue for more details.

As Thanksgiving approaches, I want to express my sincere gratitude for your membership in the Montana Academy of Family Physicians. Regardless of the season of your career, from the Grand-doctors to the students experiencing Family Medicine for the first time, you create the fabric of one of the most incredible Family Medicine communities in the country. The heart and soul of what Family Medicine is all about is alive and well in Montana, and that is because of YOU.

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Dennis Salisbury, MD, FAAFP

1962-2019

The Montana Academy of Family Physicians celebrates the life of Dr. Dennis Salisbury, a former chapter president and long-time member of the board of directors. An incredible Family Physician leader and advocate, Dr. Salisbury passionately represented Montana family physicians and their patients from the local level to many leadership roles with the American Academy of Family Physicians. His leadership, friendship, sense of humor, and kindness will be greatly missed.

Dennis was born in 1962 in Walnut Creek, California. He moved with his family to Idaho in 1972 where he lived until graduation from high school in Coeur d' Alene. He attended the University of Idaho, Whitworth University, and the University of Washington College of Medicine, where he met the love of his life Jessie. He completed residency at Phoenix Baptist in 1993 and high-risk OB fellowship in Spokane, Washington in 1994. He moved to Butte, Montana in 1994 and remained in practice there until the time of his death. Dennis was highly respected in the field of Family Medicine both locally and at the state level. He was a member of a group of physicians that is monikered "Grand-doctors:" this title means he served the citizens of Butte long enough to deliver babies to women that he had delivered. He was very dedicated to the care of patients. Nationally he worked tirelessly for patient advocacy through the AAFP and on Capitol Hill; his work impacted many individuals.

Dennis had a great sense of humor and a positive attitude. He was known for his ability to build consensus with wit and thoughtful perspective. He was an active member of St. John's Episcopal Church and then Christ Church Anglican. He was an avid percussionist for the Butte Symphony for many years. He enjoyed reading multiple books simultaneously, dabbling in coffee roasting and telling dad-jokes. He loved his family, traveling, skiing, camping, hiking in Montana, and collecting various watercraft. His wife and three children as well as his extended family, coworkers and colleagues will ardently miss his loquaciousness, his genuine love of the Lord and his intentionality.

To honor Dr. Salisbury's legacy, a memorial fund has been established through the AAFP Foundation. To make a donation in his honor, please visit https://www.aafpfoundation.org/foundation/get-involved/give/donation-form.html and select the "Dennis Salisbury Fund" from the designation drop down menu. Thank you for considering this token of remembrance and celebration of our dear friend and colleague.

Kalispell Regional Healthcare Opens First-of-it's Kind Pediatric Facility in Montana

Finding local, high-quality specialized medical care for a seriously or chronically ill child can be one of the most daunting challenges in an already gut-wrenching scenario. For many families in Montana, that used to mean traveling out of state, causing more stress and financial hardship in an already difficult situation. Not anymore. That's because Kalispell Regional Healthcare, one of the largest and fastest-growing health systems in Western Montana, has announced the opening of Montana Children's, the first children's pediatric facility of its kind in the state. Montana Children's began treating patients in its new $60-million, three-story, 190,000 square-foot facility on July 1, 2019.

Montana Children's brings together all the high-level pediatric specialists, some not found anywhere else in the state, to serve patients in an advanced facility designed especially for children and their families. More than 100 pediatric/family medicine primary care providers and more than 40 pediatric subspecialties, including cardiology, critical care, dentistry, endocrinology, gastroenterology, maternal-fetal medicine, neonatology, neurology,neurosurgery, oncology and hematology, psychiatry, radiology, sleep medicine, surgery, among others, are members of the pediatric medical staff.

The new facility's first floor opened on July 1 and the second and third floors will open in later phases in the coming years. The first phase includes a 12-bed pediatric unit, a 6-bed pediatric intensive care unit (PICU) and a 12-bed neonatal intensive care unit (NICU). All rooms are designed for maximum privacy with a home-like comfort and large enough to accommodate overnight family members who want to be with their children. The NICU has dedicated sleeping rooms for parents who want to be close to their babies but need rest away from the sounds of medical monitors. Both the PICU and NICU each have a dedicated family room equipped with a seating area, TV, full kitchen, washer, dryer and showers to provide families with the comforts of home.

Set on the campus of Kalispell Regional Medical Center in Kalispell, Montana, the new children's facility will eventually house many pediatric physicians, including the largest team of pediatric subspecialists in the state of Montana. "Before the pediatric program started at KRH in 2015, thousands of children were forced to leave the state annually to seek pediatric specialty medical care," says Federico G. Seifarth, MD, FAAP, FACS, pediatric surgeon and medical director of Montana Children's. "Our new hospital will serve families across Montana. By providing care to patients close to home we aim to make children and families more comfortable and allow access to pediatric specialized care to everybody."

For more information on Montana Children's, please visit **montanachildrens.org**

MONTANA CHILDREN'S
KALISPELL REGIONAL HEALTHCARE

ParentingMontana.org

a Source of Support for Montana Families

Wouldn't it be great if kids came with instructions? Being a family doctor, you're often asked about parenting, how to handle certain behaviors, and available resources. The Department of Public Health and Human Services collaborated with Montana State University to develop ParentingMontana.org; a website focused on parenting.

ParentingMontana.org provides evidence-based tools for family doctors, parents, foster parents and other adults raising children (such as grandparents) to support a child's success from birth through the teen years. You'll find easy-to-use tools and practical guidance for issues like establishing routines, getting homework completed, growing confidence, handling bullying, and even preventing the misuse of substances. The site is designed to work well on desktop computers, mobile devices, and tablets. You can search by age and issue to easily find guidance quickly.

"Our family medicine doctors receive training on developmental milestones but not on how to solve the wide range of behavior dilemmas parents bring to us regularly," explained Nanette Lacuesta, MD, a family medicine residency program director. Family doctors often face a host of issues for which they could use guidance.

Family doctors have available through ParentingMontana.org media such as posters and handouts that can be downloaded and printed to give to patients or provided in waiting rooms. The guidance can be viewed online or printed. Summary documents of the guidance can also be printed.

Check out the website at www.ParentingMontana.org. As you use the website, if you have suggestions or questions contact ParentingMontana@gmail.com; to connect with a Montana Prevention Specialist in your region see https://dphhs.mt.gov/Portals/85/amdd/documents/SubstanceAbuse/PSCountyRegionList.pdf.

Reference:
Board on Children, Youth, and Families. (2019). *Consensus Study Report, Fostering Healthy Mental, Emotional, and Behavioral Development in Children and Youth: A National Agenda,* Washington DC: The National Academies of Sciences, Engineering, and Medicine. Available online at: http://www.nas.edu/MEB-Health.

Montana WWAMI Update

Written by MaKenna Siebenaler, MS2
Outgoing Medical Student Representative to the MAFP Board of Directors

Montana WWAMI has recently welcomed the new E-2019 class here in Bozeman. Although many of them do not know yet what they want to specialize in, they are all very excited about participating in Family Medicine Interest Group (FMIG) events! Morgan Julian and Kristen White, the current FMIG leaders, have exciting events planned this fall. These include a casting and splinting workshop and a delivery workshop. Both of these workshops have been very successful in the past and they hope to provide valuable skills to future students. "We are looking forward to introducing the new incoming class to the wide variety of opportunities that Family Medicine offers," says Morgan. The Montana WWAMI FMIG was honored for their hard work in promoting Family Medicine with a 2018/2019 American Academy of Family Physicians Program of Excellence Award (see picture).

Other WWAMI developments include the creation of an inter-professional course dedicated to teaching students to work with other health professionals. The Health Equity course is at several medical schools throughout the Pacific Northwest, and we are excited that Bozeman is now participating. This is important training during the didactic curriculum, and current clerkship students comment on the importance of these skills in clinic. WWAMI students have also been busy advocating, most notably for the continuation of graduate medical education funding. Several WWAMI students going into Family Medicine want the opportunity to train at teaching health centers in our state, and we have been vocal about preserving these valuable resources as learners and for patients.

Morgan Julian and Kristen White, current Montana WWAMI Family Medicine Interest Group leaders, holding a 2018/2019 American Academy of Family Physicians Program of Excellence Award recognizing the group's strong work in promoting Family Medicine.

UM Family Medicine Program Top Rural Doctor Producer in Nation

Reprinted from UM News Service

The University of Montana's Family Medicine Residency of Western Montana recently was recognized for graduating more family physicians that go into rural practice than any other program surveyed in the country.

The 2019 graduating residency class with FMRWM faculty and staff. The University of Montana's Family Medicine Residency of Western Montana recently was recognized for graduating more family physicians that go into rural practice than any other program surveyed in the country.

The Rural Training Track Collaborative conducts an annual survey of residency programs to recognize those who consistently produce high numbers of rural doctors on a three-year rolling average. The 2019 survey found that FMRWM produced an average of seven new rural doctors each year.

"We have made great efforts to build a training program with deep connections to rural Montana communities," said Rob Stenger, the residency program director. "It is a privilege to recruit and train the next generation of rural Montana family physicians, and wonderful to be recognized nationally for our efforts."

Montana suffers from a shortage of primary care physicians, which is predicted to grow to almost 200 new doctors needed by 2030. Before the creation of FMRWM in 2013, Montana had the lowest number of postgraduate training positions for new doctors per capita of any state in the nation.

FMRWM, which is a program of the UM College of Health Professions and Biomedical Sciences, was created with a mission to develop family physicians who are compassionate, clinically competent and motivated to serve patients and communities in the rural and underserved areas of Montana.

The program accepts 10 new residents a year from about 800 medical student applicants. The three-year training program prepares them to practice rural family medicine, with a goal of having them stay in Montana. Of FMRWM's four graduating classes, 77% have gone on to practice in rural or underserved areas, with 72% remaining in the state in Montana communities, including **Browning**, **Helena, Lewistown**, **Libby**, **Polson**, **Red Lodge**, **Ronan** and **Whitefish**, as well as staying locally in **Missoula** and **Kalispell**.

> "It is a privilege to recruit and train the next generation of rural Montana family physicians, and wonderful to be recognized nationally for our efforts."
>
> Rob Stenger, Residency Program Director.

"We developed a program with a robust curriculum where residents spend time working in rural communities throughout the state," said Dr. Darin Bell, FMRWM assistant director of rural education. "We have a dedicated group of clinics and hospitals in rural areas that are invested in helping our residents become the best family doctors they can be. It's fantastic to see those efforts paying off, as our graduates often get hired by the same rural communities that help train them."

The residency program is sponsored by Missoula's Providence St. Patrick Hospital and Community Medical Center, as well as Kalispell Regional Medical Center. Resident and faculty physicians have outpatient clinics at Partnership Health Center in Missoula and Flathead Community Health Center in Kalispell. All residents spend a significant portion of their time working and training at a network of 15 rural hospitals and clinics throughout western Montana.

The newest class to join the program started in July, and recruiting for the next class begins this month.

RTTC is a network of medical schools and primary care residencies across the United States dedicated to increasing the training and development of doctors who practice primary care medicine in rural areas.

This release is online at: http://bit.ly/2km0xAw

LGBTQ Health and Why It Is Important for the Montana Family Physician

Written by Brook Murphy, MD
Montana Family Medicine Residency
Resident Representative to the
MAFP Board of Directors

The Realities of Homosexuality in Rural Areas

I am very proud to say that I grew up in rural Montana and many of the values I hold near to my heart were modeled beautifully to me from a young age. I am humbled by how well my community took care of one another growing up. After the death of my grandfather, neighbors were eager to offer their condolences and support. They provided food for my family so we could focus on spending time with one another and honoring my grandfather's life. While in many ways rural towns understand this community living best, one particular group is often unable to participate, or becomes a chameleon in order to participate. Our need for belonging is important, and depression fills its void. This explains why many LGBTQ youth hide their identity until they graduate and leave our rural towns for a larger, more inclusive community. This in turn fuels the notion in rural areas that homosexuality is a choice, as it does not seem to exist where it is not welcomed. Unfortunately, the damage done early on is often long-lasting, especially in those who were abandoned by family. Depression and suicide rates among LGBTQ, as a result, are much higher than the national average. As Montana family physicians, we are painfully aware that we lead the nation in suicide rates. The LGBTQ community is a group that needs our help and focus.

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The Numbers

- Depression in LGBTQ is 9 times higher than the general public.
- LGB youth are 3x more likely to die by suicide; Trans youth are 4x more likely to die by suicide.
- Montana ranks #1 in the country for the state with the highest suicide rate.
- 59.5% of US LGBTQ youth felt unsafe at school because of their sexual orientation.
- 70.1% of US LGBTQ youth were verbally harassed at school due to their orientation.
- 34% of LGBTQ youth stated they have been bullied on school grounds, 10% with a weapon.
- 5% of Americans are LGBTQ; what percentage of your patients are LGBTQ?

What We Can Do

Like other youth, we know that LGBTQ youth who grow up in a safe environment have better health outcomes. Look for other accepting individuals in your community who can provide a safe environment. Most Episcopal churches are doing a great job at this. Many communities in SW Montana have PFLAG chapters, and this can be easily expanded to your community. For moments of crisis, your patients should be aware of the Trevor Project Crisis Hotline which can be reached at 1-886-488-7386.

While we want to make an impact now in our clinics, the challenge at this time is getting LGBTQ patients into our clinic as they have not felt welcomed. Taking a walk through your clinic through the eyes from someone in this community can help see the barriers. Starting at the front, does your clinic have a rainbow flag, or "Everyone is Welcome" signage at the front? Signage can be obtained by joining the PrideFoundation.org network. A contentious but important change is to edit intake forms to include options for sexual orientation, pronouns, preferred name, sex at birth, gender identity and relationship status. I was recently in one of our rural, satellite clinics where a patient began our visit by showing his disgust of our intake forms which had such language. While it can be tempting to avoid change to keep the peace, it is important to remember that likely no one avoids care for this change, but many avoid care because we have not adapted. For the patient angry about the intake form, this can provide a moment to inform them of the realities they may not know exist.
When recently asking a friend what prevents his peers from seeking care, he said a large portion of judgement comes from the front desk, nursing, or MA who see them prior to our visit. While we often get limited training on LGBTQ health, our staff often receive none. Modeling this care to staff demonstrates that this community deserves our respect. During your interaction, allow yourself to apologize if you addressed your patient inappropriately. This tells your patient that you care about getting this right. Heterosexual and homosexual patients alike often lie about their sexual health if they feel judged, and it is important to be able to take a detailed sexual history. For example, testing for gonorrhea and chlamydia needs to be tested at the site of intercourse (vagina, anus, and even throat). Anal pap smears should be done on gay men starting at age 40, or at 25 if your patient is HIV positive. Pap smears with lesbian women should mirror that of straight women.

Care for Transgender patients can be most daunting. One in two Trans patients say they had to teach basic Trans health to their provider. To make this simple, ask: "Which organs does my patient have and are they on hormonal therapy?" Male to female patients should receive preventive care as you would provide for a male patient if they still have testicles and a prostate. Conversely, for female to male patients, continue with pap smears and mammograms as you would for your female patients as long as they still have a cervix and breast tissue. If they still have a uterus, uterine abnormalities such as endometrial cancer should still be taken into consideration for abnormal uterine bleeding.

Hormonal therapy can increase triglycerides and blood pressure, but evidence for increased cardiovascular risk is mixed at this time. The greatest risk for cardiovascular disease appears to be among male to female patients receiving estrogen,

but more data needs to be collected. DVT risk factors can be reduced by using transdermal estrogen as opposed to oral estradiol. Counsel your patient of the potential risks.

And lastly, prevent HPV and HIV. The 9-valent HPV vaccine series covers the viruses affecting 90% of cervical and >90% of anal cancers. Lesbian women have a higher rate of HPV and cervical cancer, but receive fewer pap smears. The HPV vaccine is recommended up to age 26, but older patients also benefit. All sexually active individuals should be screened for HIV. For those in a relationship with someone with HIV, discuss PrEP, which is up to 96% effective in preventing HIV transmission with consistent use. It is often provided at a discount from the drug company if not covered by the patient's insurance. If a patient had an encounter with someone with HIV, PEP can be provided in the first 72 hours which can prevent transmission. Finally, test for STDs yearly if your patient has a new partner. Most infections are asymptomatic. Remember that all those in your community deserve a safe place to live in and also deserve basic preventive care. Join the movement in making this a patient's right!

"LGBT Youth | Lesbian, Gay, Bisexual, and Transgender Health | CDC." Centers for Disease Control and Prevention, Centers for Disease Control and Prevention, https://www.cdc.gov/lgbthealth/youth.htm.

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Facilitating Practice Transformation in Frontline Health Care

"Reprinted with permission from the Annals of Family Medicine"

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This supplement to the *Annals of Family Medicine* brings together early learning from multiple examples of health extension and practice transformation support, with the goal of informing future efforts to improve our health care system. As this supplement is published, 2 major federal investments testing health extension, a model of practice facilitation, to achieve practice transformation will be ending. One is the $112 million, multiregion EvidenceNOW: Advancing Heart Health in Primary Care initiative of the Agency for Healthcare Research and Quality (AHRQ), a multistate research effort to test the health extension model.[1,2] The other is the nearly $700 million Transforming Clinical Practice Initiative (TCPI) of the Centers for Medicare & Medicaid Services (CMS), a practice facilitation demonstration project touching all 50 states that aimed to support 140,000 clinicians.[3] The response to the call for papers for this supplement garnered 50 submissions. Although we are not able to publish all of them, work not published here will also contribute to what has been learned from these large federal investments.

The history of how we got to EvidenceNOW and TCPI is important, and the special report by Kaufman et al[4] in this supplement reminds us of the history behind Section 5405 of the Patient Protection and Affordable Care Act (ACA) that authorized the Primary Care Extension Program.[5] This program was modeled after the Cooperative Extension Program (US Department of Agriculture), which revolutionized farming in the United States over the last 100 years by testing and speeding dissemination of innovation. Its application to health care was pilot-tested by the Regional Extension Centers under the Health Information Technology for Economic and Clinical Health Act of 2009. The ACA authorized but did not fund the Primary Care Extension Program; however, AHRQ used this authorization to launch a pilot project in 2011, Infrastructure for Maintaining Primary Care Transformation (IMPaCT), with 4 states, which Kaufman et al[4] describe. The success of this pilot project led to EvidenceNOW and further supported the decision by CMS to invest in the TCPI demonstration project. Although authorization of the Primary Care Extension Program remains law, it is unclear how these important demonstration projects will translate into new programs that can continue to speed development and dissemination of innovation in health care. Cooperative Extension has demonstrated considerable returns on investment, both in the United States and abroad.[5] Without sustained investment in a health care extension, however, it is difficult to achieve a similar return on investment.

Facilitation can sometime help practices figure out how to return to their roots by focusing on core functions of primary care. Continuity is a basic, highvalue function of primary care shown to be related to improved patient outcomes, reduced costs, and greater satisfaction of both patients and clinicians. Yet, it is not routinely measured or supported in clinical practice. Gukasyan and Wong6 describe their development and implementation of an empanelment toolkit in safetynet clinics that were part of the Los Angeles Practice Transformation Network. The authors' expressed goal was to support continuity, and the effort required considerable practice facilitation for implementation and routine use. Practice facilitation is necessary not only for the novel, but often for the fundamental functions.

Facilitation is sometimes necessary when introducing new tools that enable small practices to expand their capacities. Pariser and her team at the University of Toronto[7] extended a

decadeold model of interdisciplinary care into a virtual, telemedicine consultation environment to support practices that did not have interdisciplinary teams and were struggling to adequately care for very complex patients. Hourlong consultations produced a robust set of patient-informed recommendations that reflected the interplay between polypharmacy, functional disability, social determinants of health, and chronic physical and mental health conditions. These consultations reduced emergency department visits and hospitalizations, and were generally agreeable to both physicians and patients. Practices that cannot bring expanded patient services into their offices need help when introducing virtual tools that produce the same functionalities, but that might be too complex otherwise.

Wagner and colleagues at the University of Alberta[8] illuminate differences in primary care team mental models and implications for supporting transformation in practices that are not early adopters. They found a range of practice models from "the doctor takes care of patients and hires some people to help her/him" to "we take care of patients," with varying levels of care delegation in between. Early adopters tend to function in teambased models, spreading authority among team members to help in decision making, are more willing (and likely) to experiment with innovations, and can hold big-picture ideas about how innovations fit their practice vision. The authors suggest that moving beyond the early adopter phase will require even more coaching, skill building, and team development. Understanding these differences between early adopters and other practices not only is critical for facilitators to support practice transformation, but also identifies culture change as having a potentially important role.

Understanding which practice facilitation modalities improve care remains an open question. Parchman and his team[9] conducted a randomized controlled trial in smaller practices across 3 states, offering the practices various types of implementation support plus facilitation. They found that large proportions of practices did not engage in shared learning opportunities or educational outreach visits, both of which provided practices the opportunity for connecting with colleagues at other practices. This lack of engagement might be a sign of workload in busy practices. The study further found that all practices improved, regardless of the combination of implementation strategies offered. Their results suggest that effective facilitation may need to work at relationship and engagement in order to compete with existing practice priorities and stressors. This is not to say that remote practice facilitation will not work at all or for at least some changes, however. Adler and his TCPI team10 developed remote practice coaching for nearly 3,000 optometrists in all 50 states to promote provision of urgent eye care to reduce emergency department use. Practice facilitators (here called quality improvement advisors) remotely conducted practice assessments, established goals with each practice, and assisted with implementing iterative plan-do-study-act cycles. Electronic reporting demonstrated increases in urgent eye care visits with associated cost reductions of more than $150 million over 13 months.

It is important to remember that practice transformation can induce stress, too, as Grumbach and his team11 found. Their study further showed that team members may not experience this stress in the same direction. They assessed burnout among clinicians and staff engaged in primary care redesign over 7 years and found variation in burnout, particularly that staff may experience rising burnout when clinicians' is in decline, and they surmise that "primary care transformation requires continuing efforts to promote meaningful work and sustainable workloads among all members of the primary care team." This may be particularly true when work is simply being shifted. If, instead, practices' resources are increased while work is redistributed, all involved may benefit. This strategy was used in the Primary Care Redesign teambased model tested by Smith and colleagues.[12] This model increased the ratio of medical assistants to clinicians from about 1:2 to 2.5:1 while also expanding the role of medical assistants, and was facilitated by practice coaches. Clinician burnout was reduced by one-half with simultaneous improvements in quality, patient access, and clinician panel size—all while maintaining staffing costs. Most practice transformation efforts do not increase resources, and this study demonstrates that doing so can improve all aspects of the quadruple aim,[13] including at least holding pervisit costs constant. Although clinician burnout was reduced significantly, as in the study by Grumbach and colleagues,[11] staff stress scores increased initially before returning to baseline.

Sometimes, practice facilitation seems straightforward as in the case of Guck and his colleagues,14 who describe a single-practice innovation as an approach to high-risk patients. They implemented an interprofessional collaborative practice (IPCP) model within an academic practice that included staff and clinician training, patient care preparation, and care-planning conferences. Analysis of patient outcome data collected for a year before and a year after implementation of the IPCP model found meaningful improvements on multiple out-come measures. It is unlikely that this model would be easily spread without practice facilitation.

A qualitative study of small, independent practices by Rogers et al[15] is instructive about the complexity of support offered by practice facilitators. Specific supports that were highlighted included connecting practices to the external health care environment, often through teaching and information sharing, and providing electronic health record (EHR) and data expertise, commonly by teaching functionality and providing technical assistance. These small practices noted 3 key benefits of practice

continued on page 16>

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facilitation: (1) creating awareness of quality gaps, (2) connecting practices to information, resources, and strategies, and (3) optimizing the EHR for quality improvement goals. Consistent with these findings, Khanna and colleagues in the Garden Practice Transformation Network[16] focused on translating quality and cost data into a practice transforma-tion analytics dashboards for practices. Their study echoes both a qualitative study of family physicians participating in TCPI about their reasons for doing so,[17] and a study by the EvidenceNOW evaluation team, ESCALATES.[18] The dashboard became a tool for practice facilitators to help practices develop quality improvement plans and celebrate success, but fewer than one-half of practices still found the information to be actionable. Khanna et al[16] reiterate the lesson that "smaller practices are most likely to lack resources to review, interpret, and act on data." Gritzer and col-leagues in the Garden Practice Transformation Network[19] describe an innovation that entailed facilitating small practices' use of patient portals that offers several exemplars of the study by Rogers et al,[15] namely, practice facilitator interventions with EHR vendors to enable patient portal functionality, help practices understand related return on investment, teach them to use portal functions, and assist them in realizing the role of patients in informing and improving quality. These studies are important for showing that effective practice facilitation is not just technical assistance, but rather may need to also include help with using quality data and building confidence and skills, sharing learning, and even conducting advocacy.

Addressing social determinants of health is increasingly discussed as a necessary function of outpatient care. Community-oriented primary care is a well-tested and systematic way for practices to define practice community, then assess and address community needs, evaluate outcomes, and repeat.20 This approach has proven difficult to implement for several reasons, including problems with defining "community." Rock and colleagues21 tested the relationship between actual and clinician-predicted geographic service area and found vast discrepancy. They conclude that "practices need tools to better understand the communities they serve before they can be expected to undertake population-level interventions."

To read any of the articles referenced in this piece, please visit http://www.annfammed.org/content/17/Suppl_1

What comes after EvidenceNOW and TCPI is an open question. How the information learned will inform future efforts to support practice transformation is, too. Letourneau et al22 outline a multistate effort by the Network for Regional Health Improvement and its 30-member regional health improvement collaboratives to increase access to opioid use disorder treatment in several states. They discuss a general approach to practice facilitation able to adapt to variation in state resources and policies, and in local relationships. The authors describe regional health improvement collaboratives as independent, nonprofit organizations composed of multiple stakeholders who come together to improve health and health care, and note that they must include health care professionals, payers (health plans), health care purchasers (employers), and consumers. Collectively, these collaboratives cover 32 states and already serve as TCPI entities, quality improvement organizations, regional extension centers, and health information exchanges. Opioid use disorder is an important epidemic for which practice facilitation could increase the rate of best-practice adoption, but its collaborative management also presents an exemplar of the benefits of practice facilitation in addressing urgent health issues to come.

Several of the articles in this supplement are the early products of nearly $800 million invested by federal health agencies to test transformation facilitation in thousands of practices across the United States. Collectively, they tell a story of practices needing relationships and real support in achieving meaningful improvement, if not fundamental transformation. These articles describe strategies for helping practices use technology to strengthen relationships with patients and to offer complex patients expanded services. They capture the complexity and spectrum of practice culture and the need to meet them where they are in order to help the difficult process of change. Most speak to the need for meaningful relationships and work, without which in-person support does not work, and some show how remote support can work when it is available. Two articles[11,12] remind us that the hard work of change can produce stress and even burnout, sometimes differently across the team, but others suggest that engaging the whole team can enable meaningful improvements. Many are instructive bout the important functions of practice facilitators and how these functions may differ by practice type, offering guidance on preparing this workforce.

Most practices lack time, energy, and resources to make these changes on their own, and most lack means of learning about the policies pushing them to change or examples from which they can learn. Farming was in a similar situation a century ago, prompting federal and state governments set up the Cooperative Extension system that is still facilitating and speeding transformation of the process whereby that nation's nutritional needs are met. It is one of our most emulated programs around the world, and evidence of its investment returns make it one of the most supported federal pro-grams. Practice facilitation, health extension, and other forms of support for practice transformation and community health improvement are important systems-level interventions to improve health care and accomplish the quadruple aim.13 The benefits of such improvements generally accrue across multiple stakeholders, making funding of such "public good"

efforts a challenge. Further results from EvidenceNOW, TCPI, and other large-scale practice and community health improvement efforts will emerge over the next few years and should inform whether and how the United States will support practice transformation facilitation and community health improvement efforts in the future.

To read or post commentaries in response to this article, see it online at http://www.AnnFamMed.org/content/17/Suppl_1/S2.

Key words: practice transformation; organizational change; innovation; quality improvement; professional practice; health extension; outreach; practice facilitation; primary care; burnout; health information technology; practice-based research
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22. Letourneau LM, Ritzo J, Shonk R, Eichler M, Sy S. Supporting physicians and practice teams in efforts to address the opioid epidemic. Ann Fam Med. 2019; 17(Suppl 1): S77-S81. Wednesday, January 29, 2020

The Lodge at Whitefish Lake
Afternoon
4:30 – 5:00 Registration
5:00 – 6:00 Evidence Update: 10 Recent Practice-Changing Papers For Family Medicine—Timothy Caramore, M.D.
6:00 – 6:15 Break for Dinner (Buffet Provided)
6:15 – 9:15 Physician Health First — Nicole Eull, PsyD

Misconceptions in Addiction Medicine

Essay written by Jessica Lancaster, OMS IV
Pacific Northwest University College of Osteopathic Medicine

Hunched, with his hands on his knees, rubbing his sweaty hands together anxiously, he sat staring at the ground. He was pleasant and answering my questions appropriately, but I knew something was off. Proceeding with the conversation, I asked the typical questions of any MAT visit follow up: Are you using your medications as prescribed? Is your current dosage still effective? How are your behavior health visits going? How, in general, are you feeling?

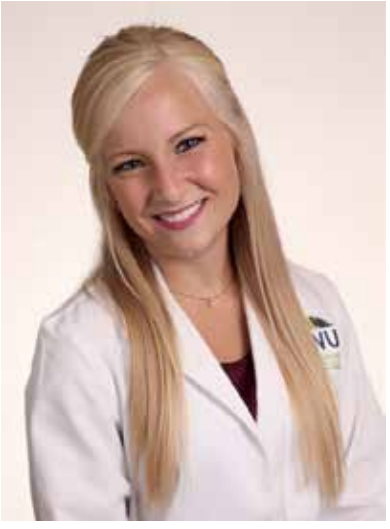
When I asked the last question, he looked up, locked eyes with me, and replied, "I've been extremely anxious this week and haven't been sleeping." After a brief pause, he continued, "I have been so stressed because at my last MAT visit, I forgot to report that I started taking my gabapentin again and I know I'm supposed to report all the medications I am taking. I am so sorry, please, please don't kick me out of the program. I have been so worried about it this whole week!"

John has been a patient of the community MAT (Medication-Assisted Treatment) program for almost two years. This was my first visit with him on my Family Medicine rotation and during my encounter I was shocked at how distraught and fearful he was of losing access to his Suboxone treatment. To us, as providers, gabapentin is more or less a medication we would rather see patients with chronic pain taking than any of the alternative options. Furthermore, we would never scrutinize a patient for taking this medication if they believed it helped. However, John didn't know this, he just saw his failure to report as a potential catastrophe to his finally, normal life.

As I learned more about John, I was saddened to discover he was another victim of medical negligence, suffering the consequences of the opioid crisis that has plagued our society. Several years ago, John suffered a traumatic amputation of the digits on his left hand after a snow blowing accident. Partial re-attachment of the second and third phalanges was successful, however he still suffered from terrible phantom pain. After the surgery he was prescribed Oxycontin. As he came to the end of his prescription, he was left high and dry; still suffering significant pain but without a means of relief, leaving him with no choice but to turn to the streets for pain management. He self-medicated with mostly heroin which was the cheapest at the time. His addiction cost him his job, his wife, and custody of his daughter. It is a tragic story of addiction, but John has grit. He knew he couldn't fight the cravings he had, but something had to be done. That's when he found the MAT clinic.

I'm embarrassed to admit, prior to this rotation I was biased. "Opioid addiction...they know it's wrong, it's ruining their life, why can't they stop? Suboxone treatment – aren't they just exchanging one addiction for another?" I was naïve. However, I think it's safe to assume that many medical students and even physicians are naïve in their knowledge surrounding this topic. It wasn't discussed in my medical school courses and if that's true across the board, then this is a fault that should be changed across the country.

About a month ago, I attended a talk on addiction medicine, specifically Suboxone treatment. During this talk, I had a moment of enlightenment and also a feeling of sheer guilt. The speaker



made a phenomenal reference that I feel is necessary to share.

First of all, we have to understand what constitutes addiction. The American Psychiatric Association describes addiction as "a complex condition, a brain disease that is manifested by compulsive substance use despite harmful consequence". The key here is "…brain disease". Initial introduction of an addictive substance and continued use cause changes in the brain's wiring leading to intense cravings and make it hard to stop despite negative consequences. Therefore, addiction is a *disease*. That's a hard, cold fact. Then why is it so difficult for us to treat it like one?

When attending this talk, the speaker compared Suboxone to albuterol - polar opposites you would think, but the further he broke down this comparison the clearer the world of addiction treatment became. Here's the scenario – you have two patients: one is a teenage female complaining of breathing issues, and the other is a teenage

male complaining of heroin use. Your female patient reports, "Doctor, I have difficulty breathing every time I try to run or exercise. I hate it. It's keeping me from being able to participate in sports with friends and I feel left out!" Easy – you prescribe her an albuterol inhaler and tell her to take a few puffs before she exerts herself. Your male patient reports, "Doctor, I tried heroin several months ago with some friends. I know I shouldn't have done it and it was supposed to be a one-time thing, but now I can't stop using or thinking about using. I've even started stealing money from my parents to buy more and the school is threatening to expel me!" Easy – you prescribe Suboxone and instruct him to take his prescribed dose daily. Both patients return a month later. You ask your female patient how she feels, "I'm great Doctor, I take a couple puffs before I exercise, and I feel *normal*." You ask your male patient how he feels, "I'm great Doctor, I haven't used in a month, yet I feel *normal*."

You succeeded as a physician, you helped both of the patients with their disease. But here's the mind-boggler, would you ever make your asthmatic patient stop taking their albuterol? Are they suddenly just going to cure themselves one day? Probably not. Then why is there implicit bias present when a patient is on chronic Suboxone therapy? Why is the culture to wean them off a substance, for a chronic disease, that makes them feel *normal*? Did they too just cure themselves overnight? You wouldn't take albuterol away from an asthmatic so why take Suboxone away from an addict? Seems simple when you spell it out this way, but like I said before, I wrongly thought Suboxone was indeed just exchanging one addiction for another.

Suboxone is a combination medication of buprenorphine and naloxone. Buprenorphine is a partial agonist at opioid receptors, which means it causes lower activation as well as binds tighter and longer than true opioids themselves. As the dose increases, its analgesic effects reach a plateau and it starts to act as an antagonist. Therefore, buprenorphine does not produce the same *high* and it is much harder to overdose on than your typical opioids. Additionally, due to its tight binding affinity, if a user was to take another form of an opioid medication on top of their Suboxone dose, no high would occur. The second ingredient, naloxone, is a full opioid antagonist, it binds to opioid receptors and blocks them from being activated. It, however, is inactivated in the gut and instead is an added ingredient to keep users from misusing Suboxone via snorting or injecting. For a provider to prescribe such medication, a Drug Addiction Treatment Act (DATA) wavier is required which is accomplished by completing an eight-hour continuing education class. Overall, this medication is a great option for long term treatment of opioid addiction. It provides minimal abuse as well as overdose potential coupled with enough activating action to prevent withdrawal and cravings.

"My views on addiction and chronic Suboxone treatment have been forever changed and I, without a doubt, plan to attain my DATA waiver to help patients like John."

Back to John. Seeing the pleading in his eyes when he begged me not to kick him out of the MAT clinic solidified for me the true impact this medication can have on a patient's life. In fact, John was now head mechanic at the local auto shop and had full custody of his thriving, five-year-old daughter. A simple guy with a medical disease, taking a daily treatment, that makes him function like his normal self is a medical success, wouldn't you say?

My views on addiction and chronic Suboxone treatment have been forever changed and I, without a doubt, plan to attain my DATA waiver to help patients like John. As family physicians, we are first line in this ongoing war against opioid abuse. We have an opportunity to make a tremendous difference in many lives; I urge everyone to put aside any bias they might have, educate themselves, and take time to obtain a prescribing waiver. Together, let's spread more *normalcy*.

Stopping Burnout at the Source:

Delegating the Administrative Burden

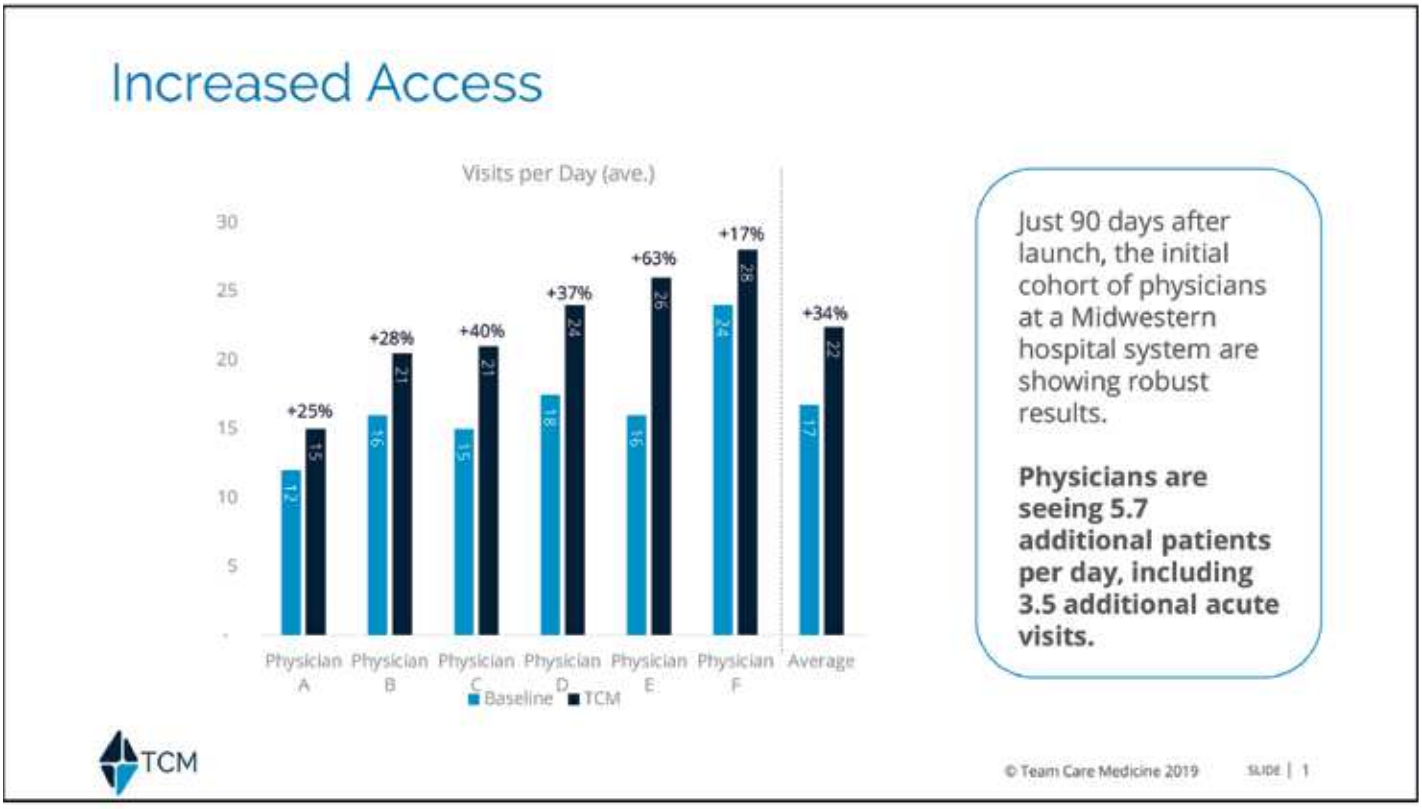
By: Peter Anderson, MD with James Anderson, MD. Reprinted with permission from the Ohio Academy of Family Physicians

I was drowning in a sea of administrative requirements. With the advent of the electronic health record (EHR) at my health system, I moved much more slowly through patient visits and spent much of my time staring at the screen rather than making eye contact with my patients. I poured more and more of my days (and my evenings) into tasks that did not require years of medical school and residency training. Like all too many other family physicians, I was burning out.

My long-time nurse felt similarly worn out and when she turned in her resignation, it was the last straw—I knew I needed to figure out a better way of practicing medicine.

What I wanted was an experience more like a surgeon, who walks into the operating room with the patient prepared, the equipment ready, and the nurses available. That vision inspired me to tinker, experiment, and innovate to create a comprehensive primary care workflow that would allow me to focus just on the tasks that required my MD designation. Equipping, empowering, and expanding my clinical support staff not only freed me up from administrative tasks that I should have delegated years earlier, it also allowed me to improve care and increase patient access. I was enjoying medicine again and was going home at night with my charts 100% current. My patients were delighted to find that they could now make same-day appointments for acute conditions rather than seeing a stranger at an urgent care center. System leadership at Riverside Health System in Newport News, VA, was delighted to see my financial profile flip from losing six figures per year to the most productive practice in the network.

In the ensuing years, the Team Care Medicine (TCM) Model has been



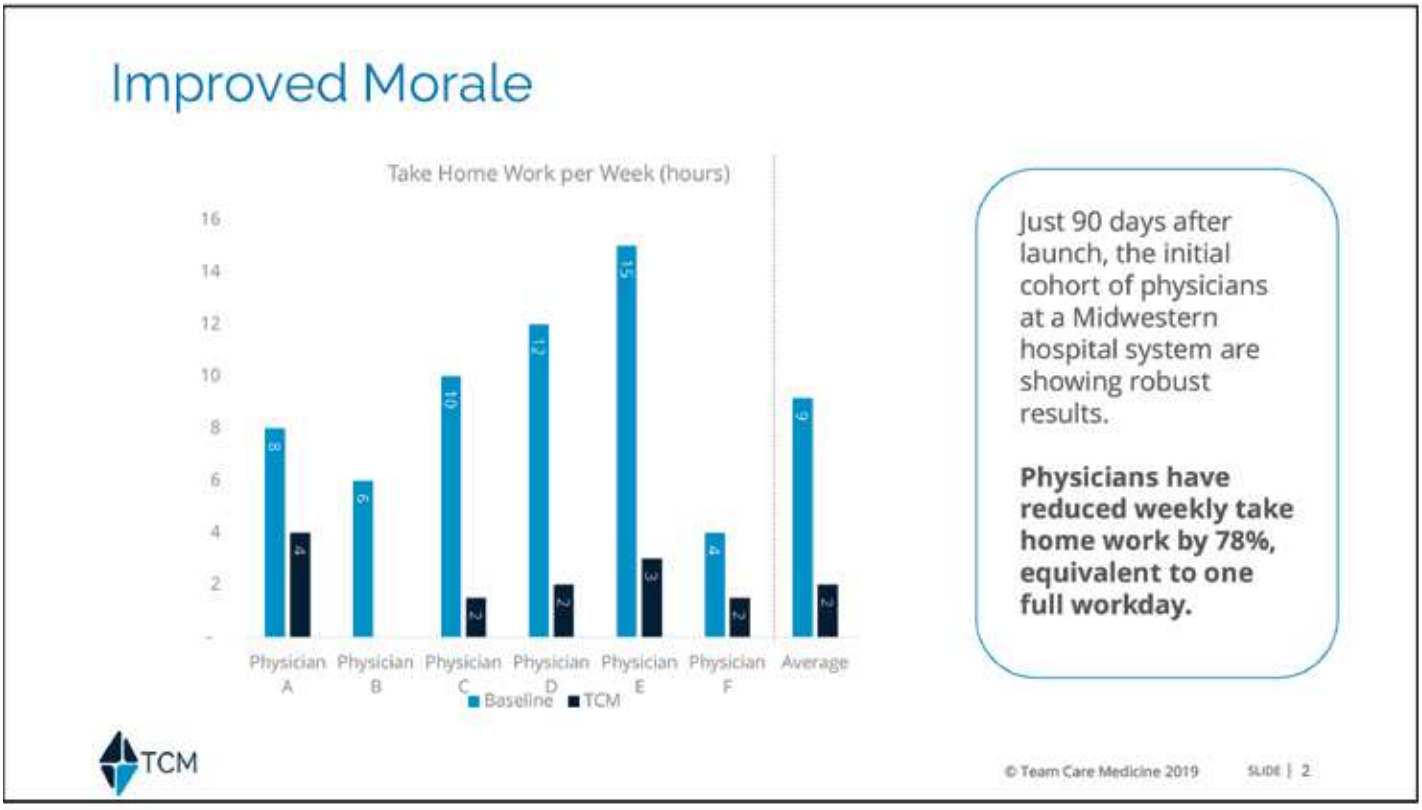
endorsed by the American Medical Association, the American Board of Internal Medicine, the American Academy of Family Physicians, and other healthcare leaders across the United States. The TCM Model reflects a handful of basic insights but, like individual steps in a dance, putting them all together in a cohesive, organic sequence takes good coaching and intentional practice. To be clear, it is not a set of tips and techniques to be selected a la carte based on personal preference.

The transformation starts with a major shift in mentality for the physician. Though medical schools rarely include the management training coursework included in an MBA program, providers must embrace the reality that they manage a team. Their role can and should be less like the star player that needs the ball in their hands all the time and more like the team captain that raises the performance of the entire team through coaching and leadership on and off the court.

In the TCM Model, the clinical staff (registered nurses, medical assistants, etc.) take on a role called the Team Care Assistant™ (TCA). They execute six discrete steps in the patient visit. Crucially, the physician is only present for two of them. Much of the administrative work is performed at the beginning and the end of the visit, and is performed by the TCA rather than the physician. When the physician is present, the TCA summarizes the preliminary medical information that has already been collected, in much of the same way that a medical student presents the patient's case to the attending physician. Then the TCA scribes the very concise examination by the physician, freeing up the physician to hone in on the diagnosis and prescription without even touching the keyboard.

Because they operate extensively without the physician in the room, each TCA offers dramatically more leverage to the physician's time than a scribe. Indeed, a high functioning TCM physician can be supported by up to four TCAs at the same time, while an individual physician never needs more than one scribe. A simple workflow with two TCAs is illustrated below.

In recent years, the Team Care Medicine Model has been adopted by a range of practices from coast to coast, including small federally qualified health centers and large integrated delivery networks. Physicians have learned to coach, to lead, and to delegate in the exam room. They're reporting restored joy in medicine as they engage the patient rather than the computer and go home on time with all their charts current. With improved clinic access, patients are delighted to get same day acute appointments with their own physician rather than an urgent care center. Executives are pleased by a strong ROI as the increase in visit volumes easily covers the conversion costs, not to mention the improved morale and retention of the physicians. This is just the beginning and I'm delighted that relief from administrative burden is beginning to restore primary care nationwide.



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Wednesday, January 29, 2020

The Lodge at Whitefish Lake
Afternoon

4:30 – 5:00 Registration
5:00 – 6:00 Evidence Update: 10 Recent Practice-Changing Papers For Family Medicine—Timothy Caramore, M.D.
6:00 – 6:15 Break for Dinner (Buffet Provided)
6:15 – 9:15 Physician Health First—Nicole Eull, PsyD

Thursday, January 30, 2020

The Lodge at Whitefish Lake
Morning

7:00 – 9:00 Finding Truth in the Failed Theories of Heart Disease—James Painter, Ph.D., R.D.
What's Your Carbohydrate & Fasting IQ? The Science Behind Both—James Painter Ph.D., R.D.
11:00 Ski Races

Afternoon

4:30 – 5:30 Vaccine Safety in the U.S.—Sophia Newcomer, Ph.D., MPH
5:30 – 6:30 Hepatitis C—Management in Primary Care—Amy Matheny, M.D.
6:30 Reception with food and drinks
Trophy Presentations for Ski/Snowboard Races

Friday, January 31, 2020

The Lodge at Whitefish Lake
Morning

7:00 – 8:00 Update in Alzheimer's Disease: Solutions For Early Identification & Management—James Galvin, M.D., MPH
8:00— 9:00 Cases in Diabetes Management: Incorporating The New Evidence—Elizabeth Paddock, MD
9:15—1:30 Optional Buprenorphine Course for Office Based Treatment of Opioid Use Disorder—This treatment meets American Society of Addiction Medicine requirements for applying for DEA Waiver

Afternoon

1:45 – 4:15 Point of Care Ultrasound. A Hands on Approach to Understanding the Applicability of Bed-side Ultrasound — Elizabeth Paddock, M.D. ($100 additional registration fee required and space is limited)
4:30—5:30 Hair & Scalp Disorders—Amanda Hartman, M.D.
5:30—6:30 Osteoarthritis: Before & After Joint Replacement Surgery—Timothy Joyce, M.D.

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- Deferred student loan payments of borrower (medical) may be excluded from the calculation of a borrower's monthly debt-to-income ratio.
- At least one borrower on loan must have one of the following designations: Medical Resident, MD, DDS, DMD, OD , DPM, DO.
- Future income can be used if effective within 60 days of closing.

Contact Jackie Helman to get started on your custom loan today. 406.259.2000

MONTANA HEALTH FCU