THE OFFICIAL PUBLICATION OF THE MONTANA ACADEMY OF FAMILY PHYSICIANS

MONTANA FAMILY PHYSICIAN

Spring 2021 – MONTANAAFP.ORG

In This Issue:

National Rural Health Day: Celebrating Rural Family Physician Leaders

DPHHS Corner: Preventing Lead Poisoning, CKD, COVID-19 and Mental Health

Seven National Organizations Call for a New Primary Care Paradigm

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MONTANA FAMILY PHYSICIAN

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EDITION 8

*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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Created by
Publishing Concepts, Inc.

David Brown, *President*
dbrown@pcipublishing.com
1-800-561-4686 ext. 103

For advertising info contact
Jesseca Youngblood
jyoungblood@pcipublishing.com
1-800-561-4686, ext. 115

Edition 8

MAFP President's Welcome

Jeremy Mitchell, DO

Dear Colleagues

I hope you are doing well in 2021. Thank you for the work you are doing in healthcare and for your communities. I am optimistic that this is going to be a good year. I have received my COVID-19 vaccines and I expect that by the time you read this, the entire state will be administering vaccines to our most at risk in the general population. We have moved past the elections and I am hopeful that no matter which side of the ballot you voted, that we can work together for the bettering of our communities and state.

I have 3 kids in the public school system and they have either been in a virtual or hybrid model since March 2020. However, my kids are now in the process of returning to 100% school, albeit with many new protocols to prevent the spread of disease. I am hoping that we can get our teachers vaccinated soon and that we can keep our kids in school in a safe environment.

I suspect you are in the same situation as me in that hospital and clinic work are still stressful, but I am starting to see a light at the end of the tunnel of this pandemic, and I am holding on to hope. This is my 10th year of clinical medicine and I have always been in rural settings, in critical-access hospitals. It seems that in reading the news that rural hospitals were a little slower to get the COVID vaccine, but I feel honored to be working in rural America, and wouldn't have it any other way. Please read the article in this magazine that is celebrating profiles of the Montana National Rural Health Day Awards. We have great rural physicians in Montana. I'd like to thank you again for your work as a Montana Family Physician. It is hard work but you are making a difference in your community and state.

Jeremy Mitchell, DO

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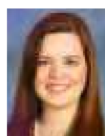

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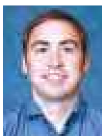

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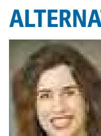

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Mike Strekall, MD

Dr. Mike Strekall is a Board member of the Montana Academy of Family Physicians. A native Montanan, he graduated from Carroll College and attended the University of Washington School of Medicine as the entering WWAMI class of E-77. During medical school, he married his college sweetheart, Brenda, also a graduate of Carroll College. His family medicine residency was in Yakima where they were blessed with two sons, Ken and Joe.

In 1985 the family returned to Helena, MT, where Dr. Strekall joined both the Hawkins-Lindstom family practice group and the MAFP. He became involved with the leadership of the MAFP in 2002, and he was elected as the 2nd VP for the academy and became the MAFP president in 2006. He and Brenda enjoyed attending the Congress of Delegates, where he sat as an alternate delegate in 2001, then as a delegate from 2002 to 2006. He also enjoyed being the editor of the MAFP newsletter from 2004 to 2010.

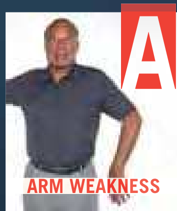
In 2009, Dr. Mike moved from the private sector to the Montana VA Medical Center at Fort Harrison. He practiced full time, learned much about Montana's rich military history, and provided comprehensive health care to his panel of veterans. He became of one of two physicians who coordinated care for the Montana Foreign Prisoners of War. It was a humbling experience to meet and talk to this special group of war veterans. For over 4 years, he was the South Central section chief and managed the physicians and the advanced practice providers at Fort Harrison and in the outreach clinics in Anaconda and Bozeman.

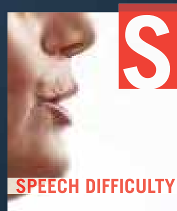
After 9 years at the VA, Dr. Mike returned to the private sector and is currently employed by St. Peter's Health as a full time Family Physician. At the 2019 summer MAFP annual meeting, he reconnected with the leadership and accepted a director position on the board, then moved into the 2nd VP position in 2020. He feels that today's family physicians have a unique opportunity to mold the future of health care, both in Montana and nationally. He believes that family physicians are the backbone of this country's health care system and says, "we need to represent the needs of all patients regardless of their diversity."

In his free time, Mike enjoys outdoor sports, including fishing, upland bird hunting, cross country skiing, snowshoeing, hiking, and camping. The summers often find him in the flower and vegetable gardens at home in the Helena valley. Prior to COVID, he and his wife loved attending the Special Olympics events to watch with their son Kenny compete in bowling, field and track events, and basketball.

In his own words, Dr. Mike says "'Living in the state of Montana is a gift. Membership in the MAFP connects us despite the large distances between our practices. As a board member, I will strive to support the ideals and concerns of all Montana's Family Physicians."

SPOT A STROKE





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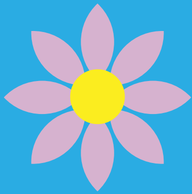
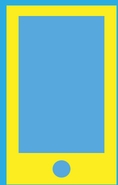


Stay Calm.



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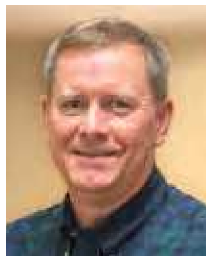
National Rural Health Day: Montana WWAMI and MAFP Celebrate Rural Family Physician Leaders

Information on awardees provided by:
Montana WWAMI Clinical Education Office
MSU Office of Rural Health and Area Health Education Center website
(http://healthinfo.montana.edu/nrhd/newman/winners.html)

NOSORH Community Star Recognition



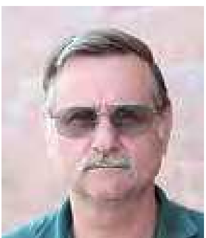
Jay S. Erickson M.D., Assistant Clinical Dean for Montana WWAMI, is a 2020 National Organization of State Offices of Rural Health (NOSORH) Community Star Award recipient. NOSORH's annual Community Star recognition program is one of the features of National Rural Health Day. Each Community Star recipient represents the faces and initiatives that are working to address the social determinants of health and improve the lives of those in rural communities.

2020 Dr. Frank Newman Rural Health Award Winners

In honor of National Rural Health Day, the Montana Office of Rural Health/AHEC and Montana Rural Health Association provides the opportunity to honor physicians in the state who represent the spirit of the late Dr. Frank Newman and his nearly 50 years of service to rural communities and healthcare in the state. The following awardees include UWSOM faculty who teach for Montana WWAMI TRUST as well as other Family Physicians demonstrating leadership in their communities.

Rural Clinician Leadership

Dr. Anne Millard – Frances Mahon Deaconess, Glasgow, MT
Dr. Anne Millard is lead clinical faculty in Glasgow, teaching TRUST students who have a passion for rural or underserved medicine. As such, Dr. Millard works with students longitudinally off and on during the first three of their four years of their medical education. Not only does this create a strong teacher-student bond, it provides students with the knowledge of what it means to be a rural clinician. Her commitment to her patients, her students and to her colleagues has created a solid teaching site. As a dedicated physician in rural Montana, she is keenly aware of the workforce needs in the state and how important the WWAMI program is in serving that need.



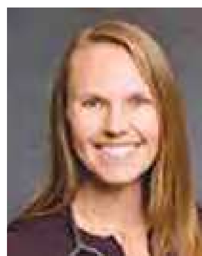
Dr. James Upchurch – Crow/Northern Cheyenne Hospital, Bighorn Valley Health Center, Hardin, MT
Dr. James Upchurch embodies Dr. Newman's commitment to rural health and support for health professions in rural/frontier Montana. Dr. Upchurch's practice and leadership has reached many aspects of healthcare in rural communities throughout Montana. Dr. Upchurch is board certified in Family Medicine with an added qualification in Geriatrics and has a master's degree in education and human development. He is a licensed paramedic and has served in the U.S. Army Special Forces. Dr. Upchurch has promoted the health and well-being of rural/underserved communities in his family medicine practice by providing a full range of care for Indian Health Service at Crow Agency and Bighorn Valley Health Center in Hardin, Montana.

Dr. Mike Sura – Central Montana Medical Center, Lewistown, MT
To exemplify the spirt of Dr. Frank Newman, a physician must have a unique set of characteristics. They should be honorable, ethical, optimistic, dedicated, influential, humble…to name just a few. Lewistown, Montana's Dr. Mike Sura, epitomizes all of these characteristics. He effortlessly leads Central Montana Medical Center to greater aspirations in rural healthcare and never seems rattled by obstacles that comes his way.

Rural Health Leadership

Dr. Gordon Bell – Frances Mahon Deaconess, Glasgow, MT
Dr. Gordon Bell arrived in Glasgow, MT after completion of an internship to serve his National Health Service Corps commitment in 1978. He went on to spend his entire 39 year career serving the people of Glasgow and Valley County. His leadership of the medical community in Glasgow helped produce an amazing positive culture that resulted in improved healthcare outcomes. He worked hard to stay up to date with the most modern medical knowledge and helped to elevate the quality of care delivered by all of the providers.

Future of Rural Health Award



Dr. Kelly Smith – Barrett Hospital & Healthcare, Dillon, MT
Dr. Kelly Smith precepts RUOP, TRUST and WRITE students in Dillon, Montana. For the Clerkship, she
teaches TRUST/WRITE students in the clinic and hospital setting, providing one-on-one oversight in the clinic and for obstetrics care. She is committed to Longitudinal Integrated Clerkship-style teaching, which works particularly well in a rural setting. As a young female physician in such a rural outpost as Dillon, Dr. Smith serves as a role model for her students.

Please visit http://healthinfo.montana.edu/nrhd/newman/winners.html to read more about the 2020 winners' incredible contributions to their communities and rural healthcare in Montana.

Healthcare Providers are Key to Preventing Childhood Lead Poisoning

Lead exposure can cause considerable damage to children's developing brains.[1] Childhood lead poisoning remains one of the most serious threats to the health and well-being of Montana's younger children. And yet, *childhood lead poisoning is 100% preventable*. Consider this, more than 50% of Montana homes may contain lead-based paint and many residents live near Superfund sites where soil is contaminated with lead. Aging water supply systems built with lead plumbing or fixtures represent another possible source of youth lead exposure. High priority settings such as schools are beginning to test their water supplies for lead, both voluntarily and in response to DPHHS requirements. Despite this, a 2012 DPHHS pilot study on lead prevention surveillance showed that only a tiny percent of Montana's children with elevated blood lead levels (i.e., greater than 5 µg/dL) are being identified and managed.

Lead poisoning frequently goes unrecognized because it often presents with no clear symptoms. *The only way to diagnose lead poisoning is by testing a child's blood for lead.* The American Academy of Pediatrics (AAP) currently recommends a risk assessment at ages 6, 9, 12, 18, and 24 months, and again at ages 3, 4, 5, and 6 years.[2] If the risk assessment is positive, then test for lead in a child's blood.[3] Blood lead testing is covered by Medicaid and Healthy Montana Kids (HMK) *Plus*.[4] HMK *Plus* requires children to be tested for lead poisoning at 12 and 24 months.[4] The AAP and the Centers for Disease Control and Prevention no longer recommend universal blood lead screening except for children living in high prevalence areas with increased risk factors such as older housing.[5] AAP provides recommendations on medical management of childhood lead exposure and poisoning at this link: https://www.pehsu.net/_Childhood_Lead_Exposure.html.

1 American Academy of Pediatrics "Lead Exposure in Children" available at https://www.aap.org/en-us/advocacy-and-policy/aap-health-initiatives/lead-exposure/Pages/Lead-Exposure-in-Children.aspx
2 https://www.aap.org/en-us/documents/periodicity_schedule.pdf
3 https://www.aap.org/en-us/advocacy-and-policy/aap-health-initiatives/lead-exposure/Pages/Detection-of-Lead-Poisoning.aspx
4 Healthy Montana Kids Plus https://dphhs.mt.gov/Portals/85/hrd/documents/MedicaidMemberGuide2020.pdf
5 https://www.cdc.gov/nceh/lead/acclpp/final_document_030712.pdf

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Chronic Kidney Disease:
Quietly Developing, Vastly Overlooked

Silent, devastating, and unknown to most who have the condition, Chronic Kidney Disease (CKD) should be a household name, familiar to all Americans. However, most people remain unaware of this condition. Currently, 15% of American adults, or 37 million people are estimated to have CKD. [1] Many patients under your care may be at elevated risk for developing the disease.

The most recent estimates from the Centers for Disease Control and Prevention (CDC) predict 1 in 2 adults between the ages of 30 and 64 will develop CKD in their lifetime. [2] Among the estimated thirty million American adults with CKD, over 80% are unaware of the condition.[3] Those who do receive a diagnosis are often in more advanced stages of the disease when it is discovered. These statistics indicate that unrecognized chronic kidney disease is a major public health issue, which will grow if left unchecked. Fortunately, screening and education offer providers the opportunity to identify and effectively treat risk factors for this condition.

Hypertension and diabetes are the two leading risk factors for developing CKD. At minimum, patients with either condition should be screened annually for albuminuria. However, fewer than 10% of those with hypertension and less than 40% of those with diabetes receive testing for CKD. [3] While annual screening is not recommended for the average person without risk factors, those who have a family history of kidney disease and those over 60 years old should also be considered for screening.

Estimated glomerular filtration rate (eGFR) and urine-albumin creatinine ratio (ACR) are two tests which can allow providers to recognize decreased renal function at early stages. Persistent proteinuria for three or more months and/or a decreased eGFR (minimal loss of function indicated at 60-89 ml/min/1.73m^2) are warning signs that steps should be taken to slow the progression of the kidney disease.[3]

Patient education through team-based care is crucial to ensure a multifaceted approach and to improve patient outcomes. A consult with a dietitian is important not only in educating the patient about reducing sodium intake but also appropriate protein consumption in attempt to reduce albuminuria. Dietary therapy can also guide patients in limiting phosphorus and potassium intake, when appropriate. [4] Lifestyle changes can be encouraged though referral to tobacco cessation programs, as smoking cigarettes can be associated with progressing CKD. Self-management education around increasing physical activity and overall lifestyle changes can result in improvements such as reduced blood pressure.

Medication therapy initiation and management are also important components of comprehensive CKD care. Angiotensin-converting enzyme (ACE) inhibitors and angiotensin II receptor blockers (ARBs) are key treatments in patients with albuminuria and are effective for slowing CKD progression. [4] Pharmacists can also assist in patient education about the nuances of living with CKD, such as avoiding non-steroidal anti-inflammatory drugs, exercising caution with use of herbal supplements, as well as how to optimally and accurately monitor their blood pressure. These professionals are another reliable, educated source of information for patients to turn to with questions and for guidance.

The Montana Diabetes Program (MDP) at MT DPHHS offers a quality improvement project for medical providers and grant funding related to screening for CKD. The goal of this project is to assess and improve protocols and practices around screening for CKD in your facility, including using tools already available in the electronic health record. The MDP also provides a dedicated website, known as a Hub, on CKD. To view the CKD Hub, learn more about opportunities to improve CKD screening, and see other projects available through the MDP visit https://dphhs.mt.gov/publichealth/Diabetes.

References

1) Centers for Disease Control and Prevention. (2019, March 11). Chronic kidney disease in the United States, 2019. Retrieved from: https://www.cdc.gov/kidneydisease/publications-resources/2019-national-facts.html

2) Centers for Disease Control and Prevention. (2019, June 4). Info cards on kidney disease. Retrieved from: https://www.cdc.gov/kidneydisease/publications-resources/infocards.html

3) National Kidney Foundation. (n.d). Chronic kidney disease change package: Population health strategies for cardiovascular and kidney disease risk reduction. Retrieved from: https://www.kidney.org/sites/default/files/02-11-8036_jbl_ckd_change-pack-v17.pdf

4) National Institute of Diabetes and Digestive and Kidney Diseases. (n.d.) Manage patients with chronic kidney disease: Slow progression & reduce complications. Retrieved from: https://www.niddk.nih.gov/health-information/professionals/clinical-tools-patient-management/kidney-disease/identify-manage-patients/manage-ckd/slow-progression-reduce-complications

COVID-19 and Mental Health:
Editorial Comments from a Montana Psychiatrist

As I was preparing to sit down and begin writing this article, I received the latest issue of Clinical Psychiatry News, a monthly newsletter that is sent to members of the American Psychiatric Association. "Despair 'Hiding in Plain Sight'" read the headline, followed by a feature story documenting the acceleration of our country's mental health crisis caused by the COVID-19 pandemic.

You don't have to look very far for evidence that COVID-19 has sparked two pandemics; the second marked by rapidly spreading emotional distress. For now, many resources being deployed by government agencies and by private healthcare organizations are being appropriately directed to speeding up the distribution and provision of newly developed vaccines. The prospect of population-wide vaccination is a welcome light at the end of a horrible COVID-19 tunnel - and this time it may not be an oncoming train!

I fear, unfortunately, that, when the COVID-19 wave starts to recede, it will reveal that our collective mental health has taken a greater hit than we had feared. There are already some concrete signs that this is likely. Recent data shows that the overall number of ED visits for children is down for 2020 compared to previous years; however, the number of mental health-related ED visits has already bounced back to pre-pandemic levels.

Several forces are contributing to the downward trend in the mental health of our youth. First, the general uncertainty and unpredictability of the pandemic's course generate anxiety and distress. A lack of developmentally critical peer social interactions on the playground and in the classroom compounds the problem; TikTok and Instagram definitely don't do the trick. Second, the profound economic pain inflicted on the majority of families is putting strain on the family system and on the ability of parents and guardians to support their children and each other. Third, we are likely to see a scary surge in cases of domestic violence and of child abuse and neglect precipitated by the growing struggle experienced by parents and caregivers. Ongoing social isolation is making it more difficult for mandated reporters to identify the telltale signs among survivors of ongoing family-inflicted toxic stress.

Unsurprisingly, the impact on mental health is felt among adults as well. In December 2020, the US Census Bureau reported nearly a four-fold increase in the proportion of individuals reporting symptoms of anxiety or depression, a jump to 42% from 11% in December 2019. Furthermore, adults who struggle with serious mental illness (SMI), including severe psychotic and mood disorders, are especially vulnerable during this time. The life expectancy of individuals with SMI is already up to 25 years shorter than their non-SMI neighbors due to worse pre-morbid general health, polypharmacy, limited access to healthcare, and adverse socioeconomic factors. These conditions make individuals with SMI especially susceptible to the dangers of COVID-19 infection.

There is a lot more data out there to support the argument that our mental health is at greater risk today than before the pandemic. Unfortunately, it's much harder to access information to guide our response to this growing crisis.

Strangely, I am optimistic about our ability to tackle this problem IF we can get out of our own way. Sadly, it took the COVID-19 pandemic to feel a sense of urgency to identify and remove certain administrative and cultural barriers to care. Payers became more open to reimbursing video- and phone-based patient encounters, regulators made it easier to provide clinical care across state lines, and a growing number of providers and healthcare leaders decided that telehealth might be a viable option after all.

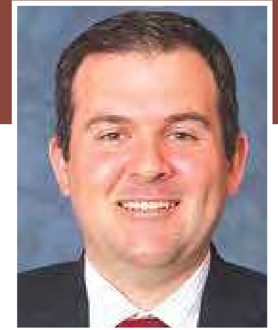
We owe it to our patients to maintain this sense of urgency, asking ourselves everyday what we as leaders and clinicians can do to make mental health care in Montana more user-friendly. One day, COVID-19 will no longer dominate healthcare-related conversations, but financial and geographic barriers to care will remain. The last 12 months represented a "pilot phase" of what healthcare delivery can look like with a more open-minded and flexible approach. I admit, we psychiatrists aren't always known for embracing change; however, a growing number of us have been pushed to offer telepsychiatry services, teaching us that it works and that patients often like it.

In addition to making direct patient care more accessible, the growing virtual workforce has made it easier than ever for primary care clinics to implement the Collaborative Care Model (CCM), the gold standard in the delivery of integrated behavioral health. The psychiatrist-consultant, a critical component of CCM, is now readily available via Zoom. Fortunately, in recent years, a growing number of payers have committed to reimbursing this model of care.

If anything, COVID-19 has validated my long-standing belief that, in healthcare, we have to continuously play offense. In 2020, our health systems of care were caught flat-footed and we were forced to play defense. I hope we can commit to combining an ongoing sense of urgency with an openness to creative solutions as we come together to tackle Montana's mental health crisis. Our patients deserve nothing less.

Eric Arzubi, MD
CEO, Frontier Psychiatry
2020 Recipient of the MMA's Dr. Jack McMahon Service to Montana Physicians Award

Updates from the Montana Family Medicine Residency



Garth Brand, MD,
Program Director MFMR

Greetings from Montana Family Medicine Residency,

In writing this update to the MAFP, I am reflecting back on the wild and turbulent year we have all had. We just wrapped our interview season which was conducted 100% virtually this year. Discussing the rank list was one of the last in person events we had in 2020, and Match Day 2020 was one of our first virtual events. I am immensely hopeful coming out of interview season where I had the opportunity to talk with around 100 future family doctors. Despite the technological barriers they faced, their passion for family medicine shone through. I believe the future of family medicine here in Montana - and across the country - is very bright with intelligent, kind, and dedicated applicants going into our specialty.

Despite COVID limitations, we have had a very successful year recruiting faculty to the program. Three new faculty members joined our team early in 2021, and we have three additional faculty members that will be starting over the next 12 months.

- Dr. Paolo Gerbasi was in MFMR's second graduating class and has been practicing outpatient/ inpatient with OB in the Billings area since 1998.
- Dr. Tom O'Brien is a recent MFMR graduate who was practicing outpatient medicine in rural Maine and wanted to get back into education.
- Dr. Staci Lee is a local infectious disease doctor who has taken over as our Ryan White director and is half-time faculty.
- Dr. James Denisar-Green will be starting in May 2021 and is currently running a rural track in Washington. He wants to stay in education and be closer to family here in Montana.
- Dr. Isaac Fonken will be starting in August 2021. He is currently a 3rd year resident in Colorado and has interest in both underserved and OB care.
- Dr. Angel Eads will be starting in January 2022. She has been working at a FQHC in Rhode Island. She is currently on a 1 year sabbatical in New Zealand and will be joining us afterwards.

We are excited to announce that we are starting an unaccredited fellowship in Rural Critical Care (RCC) in partnership with Billings Clinic. Over the past decade, it has become increasingly challenging for residents to practice high-acuity procedures and other skills needed within critical care contexts. This creates barriers for newly trained physicians to move directly into rural practice. There is an urgent need to expand advanced emergent and critical care training for newly-qualified family medicine physicians interested in rural practice. The RCC Fellowship will create a clinical experience to give family physicians procedural and skill-based training with critically ill patients to prepare them for rural practice. The 1 year experience will be split between 6 two month units alternating between hospital-based rotations at Billings Clinic and onsite training at critical access hospitals around the region. In addition to this clinical experience, fellows will engage in weekly leadership, scholarly, and teaching activities to further develop the necessary skills to perform as a leader in the rural healthcare setting.

The MFMR board has placed a significant investment in POCUS. We will be purchasing Butterfly IQ ultrasound probes for all residents to expand our access to POCUS in clinical spaces. We believe that training in POCUS is another important focus area to help residents prepare for rural medicine and procedural training. Our sports medicine fellowship received a very generous donation from Mike & Diane Boyett of a new GE ultrasound machine which has been a big upgrade for our fellow and will help provide excellent care to our patients.

Finally and most importantly, we were able to get all of our residents and faculty vaccinated with the first round of vaccines that were made available in Billings. This showed the high level support MFMR receives from our sponsoring institutions that prioritized residents for vaccination. MFMR is incredibly thankful for the ongoing support from all of our sponsoring institutions.

I am incredibly hopeful that as we advance vaccinations across the state, we will soon see a return to medical education as it has looked in the past, though there are some silver linings that I believe are here to stay as well. Take care.

Community Children's Becomes the First Hospital in Montana to Provide 24/7 In-House Level III NICU Providers

(on right): Bonnie Stephens, MD Neonatologist, Developmental-Behavioral Pediatrician and NICU Medical Director

January 21, 2021, Missoula, Mont. — Community Children's at Community Medical Center in Missoula is the first Level III NICU in Montana to provide in-hospital neonatal providers 24/7. For babies that require immediate attention, a provider is now available in the hospital at all times; they no longer need to wait for them to drive in to the hospital afterhours.

"As a Level IIIB NICU, caring for critically ill babies born as small as twelve ounces from across Montana, all of our neonatal providers felt it was important that we provide in-house immediate care around the clock," said Dr. Bonnie Stephens, Neonatologist, Developmental-Behavioral Pediatrician and NICU Medical Director.

In addition, Community Children's neonatologists are providing neonatology support to newborns born at Providence St Patrick Hospital who need Level II care, with those requiring Level III care being transferred to the NICU at Community Children's. The hospital also provides a dedicated NICU Flight Team, that travels to outlying hospitals to stabilize babies born too early or with complications and transports them to the NICU in Missoula.

(from left to right) Cindy Gwozdz, NNP-BC & Kathleen Gorman, NP

About Community Children's at Community Medical Center

Community Children's is a pediatric healthcare system that is part of the Community Medical Center in Missoula, Montana. Community Children's is dedicated to enhancing the health of Montana children with specialties and certifications that often can only be found in major cities. Features a 16-bed pediatric inpatient unit and pediatric intensive care unit, 34-bed Level IIIB neonatal intensive care unit, 24/7/365 pediatric prepared emergency department and offers medical, surgical, fetal therapies, pediatric inpatient and outpatient rehabilitation, pediatric surgery, pediatric sedition and pediatric infusions. Additional services include maternal fetal medicine, NICU follow-up clinic and our pediatric specialty clinic hosts specialists from Seattle Children's & Colorado Children's among others. CMC is a joint venture with LifePoint Health and Billings Clinic. Communitychildrens.org

Community Children's NAS Clinical Pathway:

Eat Sleep Console

Community Children's at Community Medical Center in Missoula has developed simple, evidence-based clinical pathways to guide care for common pediatric conditions. Clinical pathways can be a base upon which to improve the use of evidence-based therapies and help standardize care throughout Montana. These are free for distribution and can be used by anyone, with attribution.

Pathways are intended only as a guide for providers and staff. No pathway can cover every clinical scenario, so they should be adapted to specific patients and situations based on clinicians' professional judgment.

The clinical pathways can be found at https://www.communitychildrens.org/. *Montana Family Physician* will highlight additional pathways in future editions, but please go to the website for the most current versions as these will be updated regularly.

YOU ARE THE CHAMPIONS

To our heroes on the frontlines of healthcare for what you are doing each and every day.

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Community Children's AT COMMUNITY MEDICAL CENTER

Eat Sleep Console Pathway

Includes: Newborns at risk for NAS due to substance exposure in utero, whether prescribed opioids (methadone, buprenorphine, or pain meds), benzodiazepines, illicit opioids, or other illicit substances (but not THC alone)

Excludes: Neonates exposed to ONLY nicotine, THC, or non-opioid prescription medications

RN initiates E/S/C protocol if newborn meets inclusion criteria, automatic addiction counselor (LAC) consult

Mom in established substance use treatment program (MAT)

Mom with suspected illicit substance use in pregnancy →

- Review maternal history / speak with OB
- Send CordSTAT
- If mom visibly intoxicated or history of illicit substance use in the past week, recommend NO breastfeeding (physician must order this)

Non-pharmacologic care (skin-to-skin, swaddling, holding, rocking, pacifier, low stim environment), parent or support person encouraged to stay with infant

Assessment:

- Infant able to sustain feeding for 10 minutes OR take 10 mL via bottle
- Infant sleeps > 1 hour after feeds
- Able to console within 10 minutes

Breastfeeding guidance

- Verify HIV negative (can breastfeed if Hep C+ regardless of viral load)
- Encourage breastfeeding for patients on prescription opioids or in established MAT program with no illicit substance use in past week
- If mom THC +, advise we recommend abstaining from THC while breastfeeding
- Use Lactmed https://www.toxnet.nlm.nih.gov/pda/lactmed.htm for guidance on other maternal medications

ANY parameter not met due to NAS

- **Team huddle**
- If known opioid exposure: **Give morphine 0.05 mg/kg**, continue to assess and give morphine Q3 PRN if not meeting all criteria
- If no known opioid exposure: Reassess for possible opioid use, consider alternate causes of irritability (sepsis, etc), continue aggressive non-pharmacologic care

All 3 parameters met

- LAC, neonatal therapists (PT), SW continue work with family
- CPS report for illicit drug use (not if THC alone or if adherent to MAT program) **OR** if abuse or neglect is known or suspected
- Home visiting & CDC referral prior to discharge (by SW or RN CM)

NICU consultation recommended if:

- Morphine being administered every 3 hours and withdrawal symptoms not controlled
- Oversedation
- Temperature instability, respiratory distress, or other signs/symptoms of alternate disease process

Discharge criteria:

- If opioid exposed but no severe NAS symptoms: After **5 days** for non-methadone opioids, after **7 days** for methadone
- If requires morphine, >48 hours after last dose
- Recommend monitoring & counseling for 5 days for meth, cocaine, other illicit substances
- Safe discharge plan in place

For neonatologist phone consultation or transfer, call Community Referral Line: 406-327-4726

In an Unprecedented Move, Seven National Primary Care Organizations Launch Joint Vision to Rewire Primary Care Financing

With COVID-19 as a catalyst, the organizations developed recommendations to fundamentally change the way primary care is financed, improve health equity and boost clinicians' ability to offer seamlessly integrated care

Richmond, Va., (December 22, 2020) – Seven of the nation's largest primary care physician organizations today released recommendations on the urgent need to change the way primary care is delivered and financed. The American Academy of Family Physicians, the American Academy of Pediatrics, the American Board of Family Medicine, the American Board of Internal Medicine, the American Board of Pediatrics, the American College of Physicians, and the Society of General Internal Medicine represent more than 400,000 physicians and have created a unified vision to change the conversation and modernize primary care as we know it.

This collaborative work comes at a critical time when the health of the population has weakened, and the primary care setting has been severely strained by COVID-19. Handling nearly 40 percent of all health care visits, primary care clinicians have made incredible adaptations to continue to provide care during the pandemic, yet they have been largely left out of national pandemic relief legislation. A series of clinician surveys conducted during the pandemic has shown widespread closures and layoffs among primary care practices despite the critical role these practices and clinicians play in pandemic recovery efforts.

"Primary care physicians cannot adequately meet the needs of their communities if they remain shackled to payment schemes which reimburse for volume instead of value," said John Brady, MD, Chair of the American Board of Family Medicine. "Many current regulatory demands unnecessarily distract clinicians from patient care. Coming out of the pandemic, a return to the status quo is not sufficient. The American public deserves better."

These seven national organizations developed specific recommendations to advance primary care as a public good, shift the model of financing primary care and dismantle the regulatory and financing structures that interfere with optimal individual and population health. The unified vision includes a shift from

cost-based attributes of the current model (sick care, organized around episodic, transactional, and fragmented care delivery) to a model grounded in health equity and investment – with attributes based in health and organized around longitudinal, relational and integrated care delivery.

"Primary care provides patients of all ages with the care they need to be healthy. In pediatrics, it means ensuring children can receive critical services, like immunizations, that promote their lifelong health and development," said Sally Goza, MD, FAAP, President of the American Academy of Pediatrics. "We must ensure that our primary care infrastructure is strong and well supported if we are to assure the health of Americans across their lifespan."

In an open letter to policy makers, payers, purchasers and the public, the seven organizations call on:

- **The federal government** to increase investment in safety net programs, public health agencies and community-based services and support so that they may partner with the medical care sector in addressing structural racism and social drivers of health.
- **Health care organizations** to invest in existing community-based social services and ensure that the flow of dollars supports services such as food banks and other safety net programs that address social drivers of health.
- **Fellow physician and clinician societies** to create a roadmap for dismantling the policies and regulatory structures that enshrine the current paradigm, and to build multi- stakeholder support for a roadmap.

The collaboration was convened by the Larry A. Green Center and facilitated by X4 Health as part of their continuing effort to change the conversations around primary care in support of improved health for all Americans and the strengthening of primary care.

"Never have these seven physician societies and their boards worked together in this way," said Rebecca Etz, PhD, co-director of The Larry A. Green Center and associate professor, Department of Family Medicine & Population Health at VCU. "Before COVID-19, our healthcare system was already failing us. We have a new opportunity today to protect primary care and ensure it is there for us both now and long after COVID-19. Our team at the Larry Green Center is extremely proud to work with X4 Health in enabling this work."

More information about any of these organizations and the new vision for primary care finance can be found at www.newprimarycareparadigm.org.

The seven national primary care physician organizations:

- American Academy of Family Physicians, for inquires contact Megan Moriarty at mmoriarty@aafp.org
- American Academy of Pediatrics, for inquires contact Devin Miller at dmiller@aap.org
- American Board of Family Medicine, for inquires contact Shannon White at swhite@theabfm.org
- American Board of Internal Medicine, for inquires contact John Held at jheld@abim.org
- American Board of Pediatrics, for inquires contact Chris Perry at cperry@abpeds.org
- American College of Physicians, for inquires contact Jacquelyn Blaser@acponline.org
- Society for General Internal Medicine, for inquires contact Francine Jetton at jettonf@sgim.org

Staffed by:

The Larry A. Green Center (convener)**:**

The Larry A. Green Center works to reclaim and reconstitute the intellectual foundations of primary care, to advance the science of primary care, and to deliver on a decades old promise: better health, improved health care, and a synergistic focus on both humanism and healing.

X4 Health (facilitator)**:**

X4 Health is a purpose-driven organization specializing in social impact design, solving problems that matter in health care with passion and precision. Learn more at www.X4Health.com.

CDC Updates Immunization Schedules for 2021

Family Physician Offers Tips in Light of Pandemic

The following articles are reprinted with permission from the American Academy of Family Physicians.

Both schedules underwent a number of changes and contain updates on several vaccines for each population, including recommendations on vaccination against COVID-19. Schedules are available on AAFP.org and the CDC website.

Highlights and General Updates

- For both the child/adolescent and adult immunization schedules, updates to tetanus, diphtheria and toxoid containing vaccines (Td and Tdap) in the management of wound infections were made with added guidance for use of Tdap for all pregnant women.

- For both schedules, the "Special Situations" section of notes on the influenza vaccination were revised for all patients who have egg allergy with symptoms other than hives, and for situations in which quadrivalent live attenuated influenza vaccine should not be used. These situations include receiving the antiviral medications oseltamivir or zanamivir within the previous 48 hours, receiving peramivir within the previous five days or receiving baloxavir within the previous 17 days.

- Recommendations were added to the general information on childhood immunizations schedules to address the decline in outpatient pediatric visits resulting in declining immunization rates during the COVID-19 pandemic. These recommendations include strategies to separate well visits from sick visits, highlight the importance of in-person newborn visits, continued developmental surveillance and early childhood screenings, and the recommendation to identify children who have missed well-child visits and/or recommended vaccinations to contact them and schedule vaccine appointments.

- Interim guidance to prevent mother-to-child transmission of hepatitis B virus during COVID-19-related disruptions in routine care and preventive services before, during and after labor and delivery was added.

- MenQuadfi (MenACWY-TT) was added to the list of meningococcal vaccines that provide protections against serogroups A, C, W and Y.

- Vaccine catchup guidance job aids were developed for several vaccines, including pneumococcal conjugate vaccine; *Haemophilus influenzae* type b-containing vaccines; diphtheria, tetanus and pertussis-containing vaccines for children ages 4 months through 6 years; Tdap vaccines for children ages 7 years through 9 years and children ages 10 years through 18 years; and inactivated polio vaccine.

- Changes to the general information on adult immunizations schedules include the addition of links to frequently asked questions for ACIP recommendations on shared clinical decision-making, the removal of any reference to Zostavax, a live zoster vaccine that is no longer available in the United States; the addition of MenACWY-TT to the list of meningococcal ACWY vaccines available for those 2 years and older; and the addition of the American Academy of Physician Assistants as an approving partner of the vaccine schedule.

- The note for hepatitis B vaccination was revised to include shared clinical decision-making for HepB vaccines in patients with diabetes who are 60 years or older.

- The note for HPV vaccines was revised to clarify that vaccination is recommended for everyone through age 26 years and that no additional doses of are recommended after completing a series at the recommended dosing intervals using any HPV vaccine. Under the "Shared Clinical Decision-Making" section, the text was modified to clarify that a 2- or 3-dose series is recommended for some adults ages 27-45, and under the "Special Situations" section, clarifying language on age ranges recommended highlighting the need for a 3-dose series for those with immunocompromising conditions, including HIV infection, regardless of the age at which initial HPV vaccination was added.

- For influenza vaccination, text was added to the "Special Situations" section regarding egg allergies more severe than hives. "If using an influenza vaccine other than RIV4 (quadrivalent recombinant influenza vaccine/Flublok) or ccIIV4 (cell culture-based quadrivalent recombinant influenza vaccine/Flucelvax)," the schedule says, "administer in medical setting under supervision of health care provider who can recognize and manage severe allergic reactions." Two additional bullets were added: "Severe allergic reactions to vaccines can occur even in the absence of a history of previous allergic reaction. Therefore, all vaccine providers should be familiar with the office emergency plan and certified in CPR" and "A previous severe allergic reaction to influenza vaccine is a contraindication to future receipt of the vaccine."

- For meningococcal vaccination, MenQuadfi was added to the "Special Situations for MenACWY" section in all relevant subsections. Booster dose recommendations for groups listed under "Special Situations" and in an outbreak setting (e.g., among men who have sex with men and in community or organizational settings) were added for both MenACWY and MenB booster doses.

- The pneumococcal vaccination note links were updated and reordered for clarity for routine vaccination in patients 65 years or older.

Additional child/adolescent immunization schedule updates that family physicians should be aware of included the following:

- The *Haemoplius influenzae* type b vaccination note was revised to clarify that for catchup vaccination, no further doses are recommended if a previous dose was administered at age 15 months or older.

- The "Birth Dose" section of the hepatitis B vaccination note added text clarifying the recommendation for infants with

continued on page 22>

Kids will spend 11 minutes dressing Spike up like a princess.

How about two minutes to brush their teeth?

Brushing for two minutes now can save your child from severe tooth pain later. Two minutes, twice a day. They have the time. For fun, 2-minute videos to watch while brushing, go to 2min2x.org.

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continued from page 20>

birth weight of less than 2,000 grams whose mothers are HBsAg-negative. In these infants, administer one dose at chronological age 1 month or hospital discharge (whichever is earlier and even if weight is still less than 2,000 grams).

- The HPV vaccination note was revised to include recommendations for interrupted schedules. If the vaccination schedule is interrupted, the series does not need to be restarted.

- The note for meningococcal serogroup A, C, W and Y vaccination added information about the use of MenQuadfi in the "Special Situations" section, with additional dosing guidance on use of Menveo in infants who received their first dose at age 3-6 months.

COVID-19 Vaccines: What Family Physicians Should Know

COVID-19 vaccination recommendations for children, adolescents and adults are highlighted under the Table 1 recommendations for each schedule.

The ACIP recommends the use of COVID-19 vaccines within the scope of the Emergency Use Authorization or Biologics License Application for the particular vaccine. Interim ACIP recommendations for the use of COVID-19 vaccines are available on the ACIP Vaccine Recommendations and Guidelines web page.

The AAFP, which reviews all ACIP recommendations for approval through the Commission on Health of the Public and Science, approved the ACIP's recommendations in December 2020.

Any authorized COVID-19 vaccine in accordance with the recommended age and conditions of use is recommended for those ages 16 and older with a phased allocation of vaccine distribution. The recommendations provide guidance for federal, state and local jurisdictions while vaccine supply is limited, considering scientific evidence regarding COVID-19 epidemiology, ethical principles and vaccination program implementation considerations. ACIP COVID-19 vaccine allocation recommendations are interim and may be updated based on changes in conditions of EUA, FDA authorization for new COVID-19 vaccines, changes in vaccine supply or changes in COVID-19 epidemiology.

Phase 1 of COVID-19 vaccination is divided into three stages. Phase 1a includes all health care personnel and residents of long-term care facilities; phase 1b includes*frontline* essential workers (non-healthcare workers) and people 75 years and older; and phase 1c includes everyone 65-74 years of age, those 16-64 years of age with medical conditions that increase the risk for severe COVID-19 disease and all essential workers not previously vaccinated.

Phase 2 includes everyone 16 years and older not already recommended for vaccination.

ACIP defines essential workers using guidelines developed by the Department of Homeland Security's Cybersecurity and Infrastructure Security Agency. Frontline essential workers are a subset of essential workers likely at highest risk for work-related exposure to SARS-CoV-2 infection because their work-related duties must be performed on-site in close proximity to the public or to coworkers. The list of frontline essential workers includes first responders (e.g., firefighters and police officers), corrections officers, U.S. Postal Service workers, grocery store workers, public transit workers and those who work in the education sector.

States and jurisdictions may differ in the phases of distribution, so it is important to refer to the plan being used in a specific area. AAFP members are invited to view a list of state-by-state distributions plans on the Academy's COVID-19 Vaccine Distribution web page.

COVID-19 and Immunization Rates

Pamela Rockwell, D.O., the AAFP's liaison to the ACIP and an associate professor in the Department of Family Medicine at the University of Michigan Medical School in Ann Arbor, explained the effect of the pandemic on immunization rates throughout the population to *AAFP News*.

"As always, improving childhood and adult vaccination rates must be a priority for all family physicians, now more importantly than ever," said Rockwell. "Childhood vaccination coverage has declined in all milestone age cohorts (except for birth-dose hepatitis B coverage typically administered in the hospital setting) due to fewer outpatient visits to primary care offices during the pandemic. This creates alarming conditions with high probability for a vaccine-preventable disease outbreak, especially due to measles, which requires vaccination coverage of 90% to 95% to maintain herd immunity to prevent outbreaks."

Rockwell suggested a number of ways family physicians could modify the processes by which vaccines are traditionally administered to children to help them get caught up.

"Successful strategies to improve immunization rates for all ages include regularly assessing patients' vaccine needs at every visit, whether the visit is for preventive, acute or chronic care, and whether the visit is in person or through telemedicine," Rockwell said. "Followup immunization recommendations made during telemedicine visits can be completed during established followup visits, or additional 'immunization only' visits with medical assistants or nurses can be offered."

Rockwell also suggested clinicians could reach out to patients by reviewing EHRs and state immunization registries, creating lists of patients who are behind on vaccinations, and offering drive-through immunization clinics.

Rockwell also emphasized the importance of educating patients about vaccines and dispelling myths about immunizations.

"Ongoing vaccine education to combat the growing spread of disinformation and misinformation online is especially important through direct physician/patient contact, use of mailers, office posters and handouts, and through social media platforms like Twitter, Facebook and YouTube," she said.

AAFP Resources

The AAFP is continually monitoring the COVID-19 vaccine development, authorization and distribution process to update members on how to prepare themselves, their practices and patients. Updated information can be found on the Academy's COVID-19 Vaccine web page.

The AAFP also recently launched a consumer PR campaign encouraging people to be vaccinated for influenza and to receive other routine immunizations. The campaign aims to reduce vaccine hesitancy and emphasize that vaccination is a selfless act of prevention that helps protect those who are more vulnerable and builds a community of immunity. Members are invited to visit the campaign site, which contains a brief video, patient-friendly materials, and other resources for encouraging people to get their immunizations.

Finally, the AAFP's Immunizations & Vaccines web page has robust information about immunizations and increasing routine immunization rates during the COVID-19 pandemic.

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1/1.2 billion

Odds of having a child diagnosed with autism

1/88

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