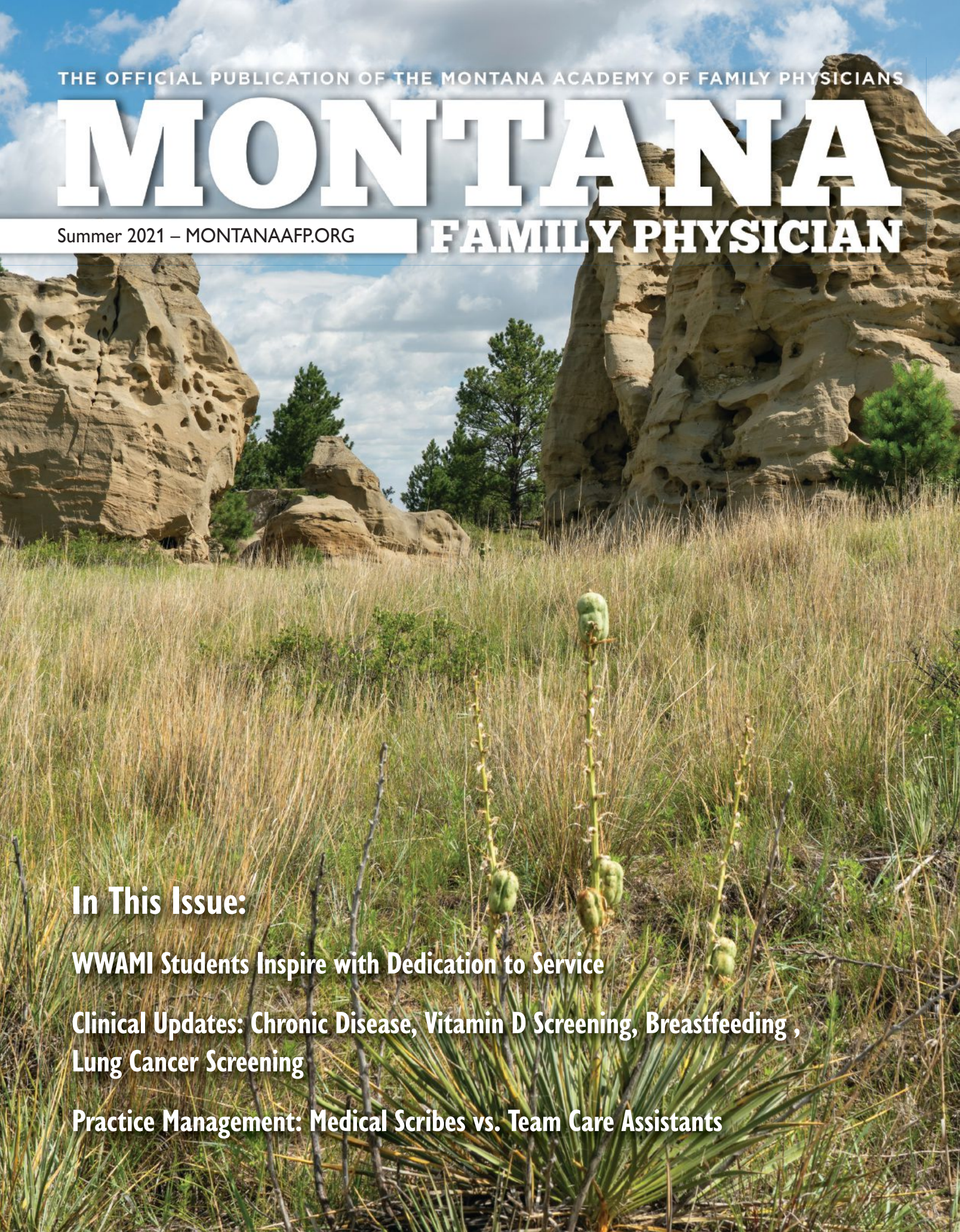
THE OFFICIAL PUBLICATION OF THE MONTANA ACADEMY OF FAMILY PHYSICIANS

MONTANA FAMILY PHYSICIAN

Summer 2021 – MONTANAAFP.ORG



In This Issue:

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EDITION 9

*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 9

Board of Director's Welcome

Dear MAFP Members,

Here's to warmer weather and all the fantastic things the summer season brings across Montana. While we have not yet fully emerged from the challenges of the COVID-19 pandemic, the increasing vaccination rates and decreasing case numbers are leading to hope and emergence of a new normal. The MAFP continues to commend the hard work and dedication you all have shown across Montana in helping to navigate your patients, colleagues, and communities through these challenging times.

The MAFP looks forward to returning to some normalcy as well, including revival of in-person CME meetings. We are excited for the Annual Meeting of the MAFP at Chico Hot Springs from June 10-11 and hope to see many of you there. Dr. Michael Geurin of Billings, our summer CME conference director, has worked hard to put together an excellent line-up of speakers. Stay tuned as well in the coming months for the announcement of our annual Big Mountain Medical Conference, which is scheduled for January 26-28, 2022, in Whitefish. Dr. John Miller of Missoula is the winter CME conference director and is planning another excellent CME program as well.

Outgoing MAFP President Jeremy Mitchell, DO

Incoming MAFP President Michael Temporal, MD

The MAFP worked with colleagues at the Montana Medical Association and the Montana Chapter of the American Academy of Pediatrics to advocate on a number of issues during this year's very busy legislative session. Areas of MAFP advocacy included vaccine status requirements for health care facilities, potential expansion of pharmacist scope of practice, local community enforcement of flavored tobacco product bans, masking requirements in schools, and care of transgender youth.

At the Annual Meeting in June we anticipate our annual leadership transitions. The MAFP wishes to thank outgoing President Jeremy Mitchell, DO, of Big Sky for his contributions through this challenging year. We look forward to welcoming our incoming President Michael Temporal, MD, of Billings! Dr. Temporal has also been serving as our chapter's Montana Medical Association Trustee and appreciate his advocacy and regular updates from our colleague organization.

MAFP wishes you an enjoyable summer, hopefully with some rest and rejuvenation, in addition to your ongoing hard work and dedication to your communities.

We are excited for the Annual Meeting of the MAFP at Chico Hot Springs from June 10-11 and hope to see many of you there.

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NEW FROM CDC

HIV NEXUS

CDC RESOURCES FOR CLINICIANS

HIV Nexus is a new comprehensive website

from the Centers for Disease Control and Prevention that provides the latest scientific evidence, guidelines, and resources on:

- Screening for HIV.
- Preventing new HIV infections by prescribing PrEP and PEP.
- Providing treatment to people with HIV to help improve health outcomes and stop HIV transmission.

To access CDC tools for your practice and patients, visit:

www.cdc.gov/HIVNexus

LET'S STOP HIV TOGETHER

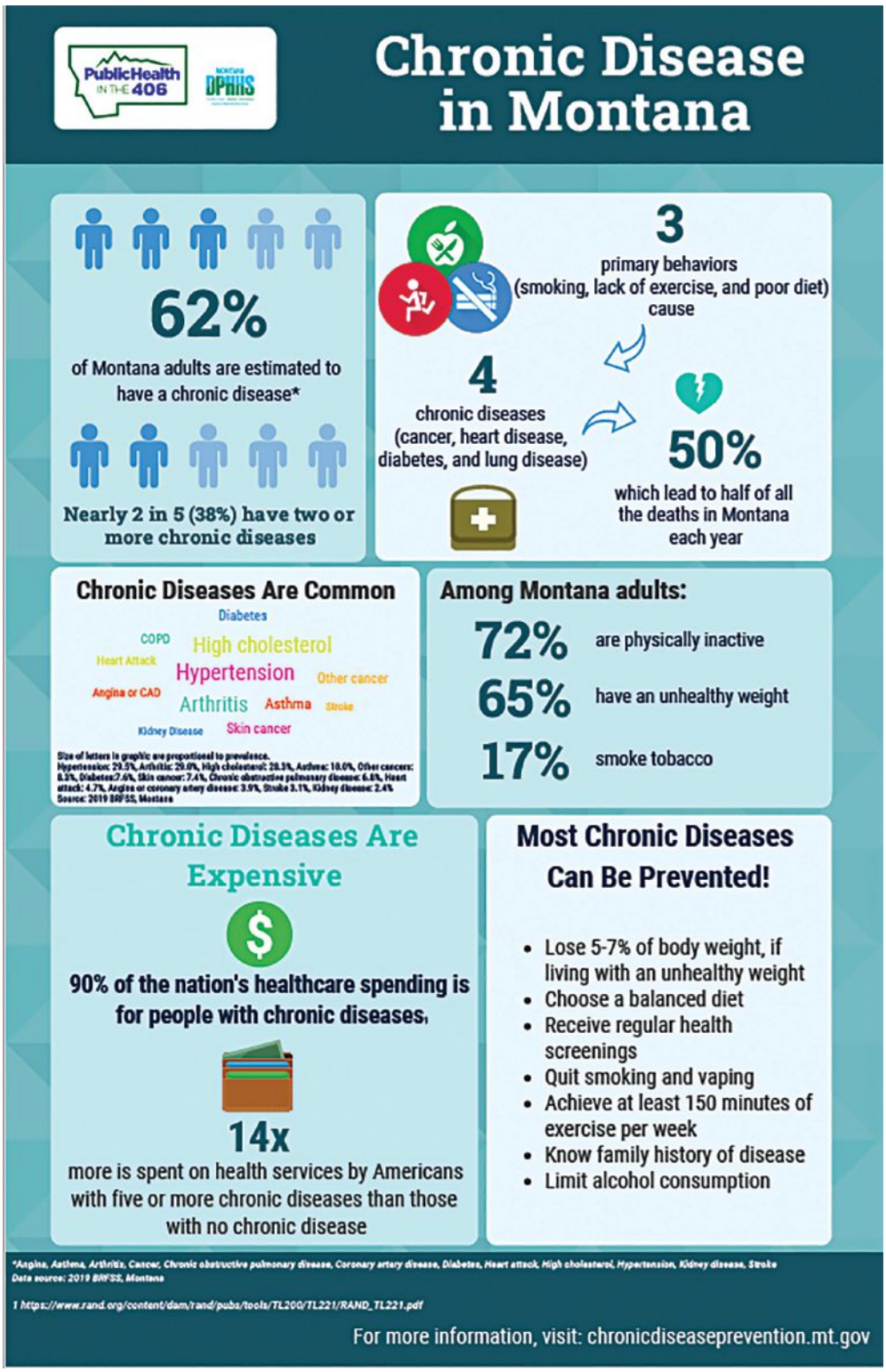
Ending the HIV Epidemic

Chronic Disease Management Resources from the Montana Department of Public Health and Human Services

Chronic diseases are incredibly common; almost two thirds of Montana adults have at least one chronic disease and almost 40% have two or more. Smoking, inadequate physical activity, and poor nutrition are the three primary behaviors that significantly contribute to four prevalent chronic diseases: cancer, heart disease, diabetes, and lung disease. These four diseases are responsible for 50% of all Montana deaths each year. Routinely reviewing lifestyle factors with patients can help to identify and address these issues early on. Making healthy choices can reduce a person's likelihood of getting chronic diseases and can improve their quality of life.

The DPHHS Community Programs Map is an excellent referral site for patients to find local health programs that can help prevent disease and injury as well as improve health and enhance quality of life (https://mtdphhs.maps.arcgis.com/apps/MapSeries/index.html?appid=1760de739c5342d2987add889df36525).

Chronic diseases are also complex and can be greatly influenced by social determinants of health such as socioeconomic status, education, employment, and environment. As such, it is important to address and treat chronic conditions through a continuum of health promotion, education, and empowerment. The Montana Chronic Disease Prevention & Health Promotion Bureau has multiple programs and resources that support healthy living and focus on disease prevention. This information can be found at https://dphhs.mt.gov/publichealth/chronicdisease.



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Updates from the Family Medicine Residency of Western Montana

Greetings from the team at the Family Medicine Residency of Western Montana in Missoula and Kalispell! It is an exciting time of year as we get ready to congratulate another class of excellent Family Physician graduates, while preparing to welcome our next incoming class of interns. Needless to say it has been a challenging academic year in the midst of a pandemic, working to keep our patients and team safe while also navigating a brave new world of virtual recruiting. Like many programs across the country, we had trepidations about how a season of Zoom residency interviews would go. We are ecstatic at the outcome of the Match and are excited to welcome our next groups of mission-driven future family physicians. In the process, we are excited to send off our 2021 graduates to many locations in Montana, including Miles City, Columbia Falls, Ronan, Butte, and Missoula.

Some exciting initiatives at FMRWM highlight our ongoing work to support our mission to serve the rural and underserved communities of Montana. Just before the start of the 2020 academic year, we learned of our acceptance as grantees of the HRSA PCTE-RTPC program – Primary Care Training Enhancement – Resident Training in Primary Care. This five-year, 2.5 million dollar grant will fund a variety of initiatives to enhance and expand training that supports rural as well as American Indian and Alaska Native populations. Our grant project, called the Enhanced Rural Access and Training Program (ERAT), includes focus on the following:

- Formalizing resident training tracks, with a focus on Rural Health and American Indian/Alaska Native Health
- Creation of rural continuity clinic sites, including a collaboration with the Seeley Swan Health Center in Seeley Lake
- Enrichment of resident training in key areas, including telemedicine, simulation, interprofessional activites, and medication-assisted treatment for opiate use disorder
- Expanded recruitment activities to promote interviewing and matching of students from rural and underrepresented backgrounds in medicine
- Enhancement of faculty development activities and support for our rural network
- Collection of data to understand what aspects of the curriculum promote matriculation into rural and underserved practice and what could lead to further improvements

FMRWM has a track record of graduating Family Physicians who serve rural and underserved communities in Montana and across the region. In 2019, FMRWM was recognized by the Rural Training Track Collaborative for graduating more family physicians that go into rural practice than any other program surveyed in the country. We hope that the ERAT project through the PCTE-RTPC grant will help us to further solidify this work in service of Montana.

If your clinical site is interested in exploring opportunities to train and/or recruit FMRWM residents, please contact Dr. Darin Bell, Associate Director of Rural Education, at darin.bell@mso.umt.edu.

The FMRWM Rural Network of sites across central and western Montana. Residents rotate throughout the network each academic year. The program works in collaboration with Family Physician educators and other representatives from the sites to provide support and curriculum development through individual site visits, the annual Rural Retreat, and the Rural Advisory Committee.

Interprofessional Student Vaccine Initiative

On Saturday, Feb. 6, WWAMI students and faculty collaborated with MSU University Health Partners staff, College of Nursing students and faculty, and Gallatin College medical assistant students and faculty, to administer over 800 COVID vaccine doses to MSU students, faculty, and staff in the state and county's 1B priority group. Three weeks later, the 2nd shots of the vaccine were delivered with more volunteers.

The "team of teams" approach demonstrated the value of shared leadership. We had a common vision, and the mission was accomplished very efficiently. These events were the largest interprofessional education events ever at MSU. The definition of interprofessional education is "occasions when two or more professions learn with, from and about each other to improve collaboration and the quality of care." At these events, medical students and nursing students learned from each other and their faculty how to give vaccine injections, how to provide patient education about a vaccine, and how to observe patients for adverse reactions after the injection. We taught nearly 100 health professional students how to work collaboratively to deliver high-quality care in a mass vaccination clinic. Kudos to the many faculty who participated.

(Adapted from comments by MSU Dean of the College of Nursing, Sarah Shannon, quoted in MSU President Cruzado's email to the university community.)

WWAMI Medical Student Update

Mac Turner
Montana WWAMI Medical Student
Representative to MAFP Board of Directors

Here to Help Where We Can

One of the things that medical students find to be most rewarding is service work. Many of us have volunteered and been involved wherever we have lived. However when the world shut down over the past year, so did the opportunities to be involved in interest groups, clubs, and service groups. As we began our journey as Montana WWAMI medical students, my classmates and I were given almost a blank slate. The Montana WWAMI program offers unlimited opportunity to give back to our home state and local communities, yet most of it either had to be restarted or reimagined. Here are some highlights of our accomplishments the past few months and what we hope to accomplish in the upcoming months.

With the start of 2021, came the start of the Montana state legislative session. Members of the MS1 class have attended meetings and worked with organizations including the Montana AAP, Montana Medical Association, Montana Academy of Family Physicians, and American College of Physicians. The WWAMI MS1 class has five core members of AMSA (American Medical Student Association) who have made emailing, calling, and connecting with legislators the club's main priority. Many other members of the class have taken it upon themselves to email or sign against/for bills as well. We believe part of our responsibility as future physicians is to be involved and care about public policy in our home state.

We cannot start talking about service work without mentioning the WWAMI Neighborhood Health Initiative. Formerly known as the "Foot Care Clinic," the WWAMI Neighborhood Health Initiative partners with the Bozeman HRDC Warming Center to provide foot care services, basic vitals, and free vaccinations. The Neighborhood Health Initiative hopes to expand its services by adding glucometry, A1C, HIV, syphilis and hepatitis C testing, and potentially mental health services. Additionally, they are actively fundraising for iPads for the clinic in order to track patients, input basic labs, document findings, and get patients referrals to the care they need. The Neighborhood Health Initiative also teamed up with our classmate, Courtney Liston, who spearheaded an initiative known as "Mardi Bras" that collected over 300 bras, over 300 pairs of new underwear, and over 2,000 each of pads and tampons for the Bozeman HRDC Warming Center. The team set up collection sites with drop boxes at Bozeman Health, Bridgercare, SHE Health and Wellness, Heebs Grocery, and Town and Country Grocery from March 1st to March 15th. The impactful idea was so well received in the Bozeman area that Courtney looks to expand into other interested Montana communities this upcoming Fall!

Working in collaboration with an existing local organization, AIDS Outreach, WWAMI students trained to provide free and confidential HIV and syphilis testing. WWAMI students staff the clinic every Saturday in Bozeman and provide POC testing, send referrals to Bridgercare for further care (including referrals for PrEP), provide condoms, and discuss risky behaviors and risk-reduction strategies with clients. This service project teaches WWAMI students valuable information about HIV epidemiology in Montana and provides extra training in motivational counseling.

> AMSA is a WWAMI club that, following the legislative session, will turn its focus to various "community change" projects. One of which is teaming up with Bridgercare to expand their LGBTQ+ Healthcare Ally Trainings beyond the greater Bozeman area and across the state.

Health Equity Circle is another service group within the Montana WWAMI program. Health Equity Circle is an inter-professional student led organization working to build skills to help address health inequities with chapters all across the mountain west. Our Montana WWAMI chapter's mission is to focus on learning, creating connections, and fostering relationships with local organizations working to create the Bozeman area and state of Montana a more equitable place. The group organized a speaker series with speakers from the Moyce Immigrant Health Lab at MSU, Transvisible MT, and Disability Rights MT. Health Equity Circle has many projects in the works. One of the most exciting is teaming up with Moyce Immigrant Health Lab and MSU Engineering to help improve the structure of translation services at Bozeman Health. The issue is that translation phones are difficult for hospital staff to access and that it takes extra steps to use translation services, making it inefficient to use for shorter patient

interactions. We hope to assess the structure of translation services at the hospital, and then MSU engineering will propose recommendations or implementation strategies for improved services. If this is something that could be helpful in another Montana community, please let Montana WWAMI Health Equity Circle know. Health Equity Circle will also help out with a health fair in June aiming to provide medical, dental, and social services for the Gallatin Valley Latinx population. Health Equity Circle is also attempting to restart its partnership with the Healthcare Connection Mobile Health Bus that was shut down due to COVID. The health bus's services included A1C, blood pressure, BMI, colorectal, lung, and breast cancer screening and free immunizations that WWAMI students could help administer alongside a provider.

AMSA is a WWAMI club that, following the legislative session, will turn its focus to various "community change" projects. One of which is teaming up with Bridgercare to expand their LGBTQ+ Healthcare Ally Trainings beyond the greater Bozeman area and across the state. In Montana there is a decent percentage of providers who may not have ever received education about LGBTQ+ health issues, do not feel confident in their ability seeing trans patients, and want to learn more about trans care. Bridgercare includes an experienced healthcare provider and a healthcare consumer-patient from the LGBTQ+ community as facilitators in each training when possible. Members of the Montana WWAMI MS1 class were lucky enough to attend a training this past April. It was powerful. Please let Montana WWAMI Health Equity Circle or Bridgercare know if you are interested in bringing this training to your clinic or taking it as an individual.

Overall, this is only a portion of the recent service projects that my class has worked on. And indeed, we are just first-year medical students with limitations. We are learners who are in the beginnings of their medical education. Montana WWAMI students are passionate and motivated to help where we can. As Montana continues to change and to face new challenges, the medical students here at Montana WWAMI are ready to help, to learn, and to be a part of future solutions.

Community Children's Clinical Pathways

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.

Quick Breastfeeding Reference for Moms with Substance Use

Drug / Medication	Breastfeeding Effects	Effects on Infant	Consider
Alcohol	• Passes into breast milk at same levels as in mom's bloodstream • Decreases milk supply (Beer does not stimulte milk production) • Changes the taste of breast milk	• Can cause your baby to be too sleepy • When used in excess, can cause your baby to have brain damage • Can cause you to be too sleepy to care for your infant safely	• Do not breastfeed (pump and dump) for 2 hours after drinking ≤ 2 drinks (2 beers, 8 oz glass of wine, or 2 oz of liquor) • If you drink more than 2 drinks avoid breast-feeding • Pump and dump for 12 hours after binge drinking
Amphetamines (Stimulants for ADHD)	• Passes into breast milk in small amounts at prescribed doses • At high doses, high levels pass into breast milk • May decrease milk production	• Can cause your baby to be agitated, hyperactive, have difficulty sleeping, have a poor appetite, poor weight gain, or tremors • Long term effects are not known	• Breastfeeding is ok at prescribed doses • If you take this without a prescription, pump and dump for 24 hours before breastfeeding • Consider asking your doctor to switch you to methylphenidate or bupropion
Benzodiazepine Sedatives ex: lorazepam (Ativan), alprazolam (Xanax), diazepam (valium), clonazepam (Klonopin)	• Passes into breast milk in varying amounts depending on the half-life of the individual medicine	• Can cause your baby to be too sleepy, not eat well, not gain weight • Can cause you to be too sleepy to care for your infant safely • If combined with opioids and/or alcohol, can cause your baby to stop breathing • Can cause withdrawl after stopping (irritability, crying, poor sleep, poor feeding)	• If you take thes occasionally, pump and dump for 8 hours before breastfeeding • If you take these daily, consult your doctor to consider tapering off / stopping use before breastfeeding
Buprenorphine (Suboxone)	• Levels in breast milk are low	• At high doses, can cause your baby to be too sleepy, pale, constipated, not sleep, not eat	• Breastfeeding is recommended while receiving buprenorphine for opiate dependency • Do not stop breastfeeding abruptly. Consult your doctor; taper off slowly to avoid withdrawal
Cocaine	• Passes easily into breast milk	• Babies are very sensitive to cocaine and cannot break it down, causing your baby to have seizures, high blood pressure, turn blue, choke, vomit, have diarrhea, tremors, high heart rate and irritability	• **Do not breastfeed for at least 90-days after taking** (pump and dump)
Gabapentin	• Doses prescribed by a doctor usually don't produce high levels in babies	• Effects on baby can include drowsiness, poor weight gain, and developmental milestones, especially when used with seizure or psychiatric medications	• OK to breastfeed at prescribed doses • Recommend caution, consult your doctor and consider stopping use if you are using more than prescribed (or > 2100 mg/day)
Heroin	• Passes into breast milk	• Can cause your baby to be too sleepy, not breathe, have low blood pressure, poor feeding, vomiting, tremors, restlessness • Can cause you to be too sleepy to care for your infant safely • Can cause withdrawal symptoms if you stop breastfeeding abruptly	• Do not breastfeed, pump and dump for at least 24 hours after using • Do not breastfeed if you use heroin daily • Consider enrolling in a treatment program with methadone or buprenorphine so you can breastfeed safely

Quick Breastfeeding Reference for Moms with Substance Use

Drug / Medication	Breastfeeding Effects	Effects on Infant	Consider
Ketamine	• Limited / no data available regarding breastfeeding	• Little data on effects on baby	• Recommend caution • Consult with your doctor and consider stopping/changing medications if able
Kratom	• Limited / no data in pregnancy or breastfeeding	• Effects on your baby are similar to the effects of heroin or morphine	• Do not breastfeed, pump and dump for 4 hours after using, if you use rarely • Pump and dump for 24 hours after using if you
Marijuana/ Cannabis	• THC is concentrated in breast milk, the brain and body fat for weeks to months after use • Can decrease milk supply	• Can cause your baby to be too sleepy, not wake up to eat or eat poorly • May increase the risk of SIDS • May cause developmental delays and behavior problems	• Use is strongly discouraged while breastfeeding. • Consider stopping use so you can breastfeed safely • Consult your doctor if you are unable to stop using
Methadone	• Passes into breast milk in small amounts • Breastfeeding may decrease withdrawal symptoms in infants who were exposed in utero	• Inconsistent use can cause your baby to be too sleepy, stop breathing, become pale, constipated, not wake up to eat or eat poorly • Can cause withdrawal symptoms if you stop breastfeeding abruptly	• Breastfeeding is recommended while receiving methadone for opiate dependency • If you use inconsistently, pump and dump for at least 12 hours after using • Do not stop breastfeeding abruptly. Consult your doctor. Taper off slowly to avoid withdrawal
Methamphetamine	• Passes easily into breastmilk in small amounts	• Can cause yoru baby to be agitated, irritable, have poor sleep, poor weight gain, and tremors • There are case reports of infant death due to exposure in breast milk • Long-term behavioral effects are reported	• **Breastfeeding is strongly discouraged** • Consider stopping use so you can breastfeed safely • Pump and dump for 48 hours after using
Opioids oxycodone, hydrocodone (Vicodin), codeine, morphine	• Passes into breast milk in small amounts • Breastfeeding may decrease withdrawal symptoms in infants who were exposed in utero	• Inconsistent use can cause your baby to be too sleepy, stop breathing, become pale, constipated, not wake up to eat or eat poorly •Can cause withdrawal symptoms if you stop breastfeeding abruptly •Can cause you to be too sleepy to care for your infant safely	• Breastfeeding is encouraged if you are under medical supervision with consistent use (i.e. chronic pain management or addiction treatment programs) • If you use inconsistently, do not breastfeed, pump and dump for 4 hours after using • Breastfeed at least 2 hours after, or mmediately before use • Do not stop breastfeeding abruptly. Taper off to avoid withdrawal • Consider enrolling in a treatment program to help you stop using or transition to medically supervised opioid therapy
SSRIs for depression or anxiety Fluoxetine (Prozac), Sertraline (Zoloft), Citalopram (Celexa), Escitalopram (Lexapro)	• Passes into breast milk in small amounts • Breastfeeding may decrease withdrawal symptoms in infants who were exposed in utero	• Can cause withdrawal symptoms if you stop breastfeeding abruptly	• Breastfeed as desired • Do not discontinue without consulting your doctor
Synthetic Cannabinoids (Spice, K2, others), CBD oil, THC products	• Little specific information on synthetic cannabinoids • THC is concentrated in breast milk, the brain and body fat for weeks to months after use • Can decrease milk supply	• Can cause your baby to be too sleepy, not wake up to eat or eat poorly • May increase the risk of SIDS • May cause developmental delays and behavior problems	• Use is not recommended • Consult your doctor and consider stopping use so you can breastfeed safely

Questions about breastfeeding with medications you are taking? Consult with your doctor.
Unable to stop taking any of the medications or drugs listed below? Speak with your doctor about treatment.

References:
1. Drugs and Lactation Database (LactMed). Bethesda (MD): National Library of Medicine (US); 2006-. Accessed Feb-April 2020. https://www.ncbi.nlm.nih.gov/books/n/lactmed
2. Briggs Drugs in Pregnancy and Lactation. Wolters Kluwer: LexiComp; Accessed Feb-April 2020. https://online.lexi.com
3. Hale, T. W., & Rowe, H. E. (2014). Medications & mothers milk: 2014. Plano, TX: Hale Publishing, L.P.

CommunityChildrens.org

USPSTF Final Recommendation

Evidence Lacking on Screening for Vitamin D Deficiency

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

On April 13, the U.S. Preventive Services Task Force posted a final recommendation statement, final evidence review and evidence summary on screening for vitamin D deficiency in adults.

Based on its review, the task force concluded that the current evidence is insufficient to assess the balance of benefits and harms of screening for vitamin D deficiency in asymptomatic adults. This is an "I" recommendation.

The recommendation applies to community-dwelling, non-pregnant adults who do not have signs or symptoms of vitamin D deficiency or conditions for which vitamin D treatment is recommended. It does not apply to people who are hospitalized or living in institutions such as nursing homes. People who are concerned about their vitamin D level are encouraged to consult with a clinician about their individual health needs.

"We know that vitamin D is an important nutrient for keeping bones healthy and may also have a role in other aspects of good health," said task force member Michael Silverstein, M.D., M.P.H., in a press release. «However, we need more research on what level of vitamin D people need to stay healthy before we can make a recommendation for or against screening."

While vitamin D is produced naturally in the body through exposure to sunlight, it can also be obtained through dietary supplements and some foods such as milk, salmon and egg yolks. Vitamin D plays an important role in bone health by promoting calcium absorption; consequently, a lack of vitamin D may contribute to bone diseases such as osteoporosis, osteomalacia or rickets.

Update of Previous Recommendation

The final recommendation statement updates and is consistent with the task force's November 2014 statement on the topic, which concluded at that time that there was insufficient evidence to assess the balance of benefits and harms of screening for vitamin D deficiency in asymptomatic adults. The AAFP supported the 2014 recommendation.

To update the recommendation, the task force commissioned a systematic review of the evidence on screening for vitamin D deficiency, including the benefits and harms of screening and early treatment. The review consisted of published studies, trial registries and other sources through March 12, 2020, with additional bibliographies from retrieved articles, outside experts and literature surveillance through Nov. 30, 2020. A total of 46 studies were included in the review, 13 of which were assessed as good quality.

While no studies directly evaluated the benefits of screening for vitamin D deficiency, 27 studies reported on the effectiveness of treatment of vitamin D deficiency for a variety of health outcomes. Among community-dwelling populations, treatment with vitamin D (either with or without calcium) was shown to have no effect on mortality or on the incidence of fractures, falls, cardiovascular disease, diabetes, cancer, depression or adverse events. Evidence for the impact of treatment with vitamin D on physical functioning was mixed, and evidence for the impact of treatment with vitamin D on infection was limited.

The task force also noted several research gaps. Specifically, it stated that more studies are needed to

- determine the cutoff level that defines vitamin D deficiency and whether it varies by clinical outcome or by patient subgroups as defined by race, ethnicity or sex;
- determine the benefits and harms of screening for vitamin D deficiency;
- clarify the impact of vitamin D on some health outcomes for which the current evidence is insufficient or where additional clarity is needed to determine optimal doses and regimens for benefits;
- clarify potential harms from intermittent high-dose regimens; and
- better differentiate the effects of treatment among patient subgroups.

Response to Public Comment

A draft recommendation statement was posted for public comment on the USPSTF website from Sept. 22, 2020 to Oct. 19, 2020.

In response to requests from some commenters that the task force evaluate the evidence on or make a recommendation regarding vitamin D supplementation, the USPSTF clarified that this recommendation focuses on screening for vitamin D deficiency.

The task force also noted that it has issued several recommendation statements that address supplementation with vitamin D for other conditions, including prevention of fractures in community-dwelling adults, prevention of cancer and cardiovascular disease and prevention of falls in older adults.

In response to other comments, the USPSTF clarified that this recommendation applies to asymptomatic, community-dwelling adults. It does not apply to those in institutional or hospital settings who may have underlying or intercurrent conditions that warrant vitamin D testing or treatment.

Finally, the USPSTF clarified that it did not review any of the emerging evidence regarding vitamin D and COVID-19.

Up Next

The AAFP's Commission on Health of the Public and Science plans to review the task force's final recommendation statement, final evidence review and evidence summary, and will then determine the Academy's stance on the recommendation.

Clinical Updates from the American Academy of Family Physicians

AAFP Updates Recommendation on Lung Cancer Screening

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

Less than a month after the U.S. Preventive Services Task Force issued a final recommendation statement on screening for lung cancer with low-dose CT, the Academy has published an updated recommendation on the topic.

The updated recommendation, posted on March 31, states that the Academy supports the task force's recommendation for annual screening for lung cancer with low-dose CT in adults aged 50 to 80 years who have a 20 pack-year smoking history and currently smoke or have quit within the past 15 years.

The Academy further states that it reviewed the evidence published in the USPSTF's final evidence review and determined that there was enough evidence to support a "B"-level recommendation for screening for lung cancer in adults at increased risk.

However, the AAFP acknowledges that the harms associated with annual screening with low-dose CT are not fully known at this time, and that there are numerous barriers to lung cancer screening in the community setting.

The updated recommendation also states that screening should be discontinued once a person has not smoked for 15 years or develops a health problem that substantially limits life expectancy or the ability or willingness to have curative lung surgery.

Finally, the Academy is calling for more research to determine the harms associated with screening with low-dose CT and to address barriers to care among communities of color.

Background

The Academy's updated recommendation varies considerably from its previous recommendation on the topic, which was published in 2013.

In 2013, the AAFP did not support the USPSTF recommendation for annual screening for lung cancer with low-dose CT in adults ages 55 to 80 who have a 30 pack-year smoking history and currently smoke or have quit within the past 15 years (also a "B"-level recommendation). Instead, the Academy expressed concern that the USPSTF's recommendation was based primarily on the results of one study, the National Lung Screening Trial, and concluded that there was insufficient evidence to recommend for or against screening.

After the USPSTF posted the updated final statement and evidence review, the data were reviewed by the Commission on Health of the Public and Science, which recommended support. Commission chair Sarah Coles, M.D., noted that results from the Nederlands-Leuvens Longkanker Screenings Onderzoek (NELSON) trial and other studies indicate that lung cancer screening does reduce mortality related to lung cancer, even if it doesn't impact all-cause mortality. This is similar to recommendations for other screenings, like breast cancer screening. However, data are still needed for those populations not included in high numbers in the trials, namely women and individuals of color.

Additionally, Coles said there were concerns over the lack of evidence for screening intervals and potential issues extrapolating the trial data from university settings to the community setting, which may disproportionately impact rural and urban underserved settings and communities of color.

More Resources Available Online

The AAFP maintains a collection of preventive services recommendations on its website. Members are invited to visit the Patient Care section of AAFP.org to review the recommendations and learn more about the Academy's guideline development process.

NASEM Report Heralds Primary Care Evolution, Urges Action

Findings Chart Necessary Future for Family Medicine

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

A comprehensive report published this month by the National Academies of Sciences, Engineering and Medicine strengthens the case for primary care as the foundation of the U.S. health care system. It also makes policy recommendations that reinforce several of the AAFP's long-standing advocacy positions.

"Primary care is the only health care component where an increased supply is associated with better population health and more equitable outcomes," concludes the 448-page "Implementing High-Quality Primary Care: Rebuilding the Foundation of Health Care," which reflects some 18 months of research.

The Academy was among the 17 co-sponsors of the study and plans to participate in stakeholder and lawmaker briefings accompanying its publication.

A snapshot of how the authors define "better" and "more equitable" in the context of primary care: Americans, per capita, spend more than twice what citizens in Australia, France, Canada, New Zealand and the United Kingdom pay for health care but experience worse health outcomes than people in those countries, the report notes. These nations, like the United States, are part of the Organization for Economic Cooperation and Development, whose members devote an average of 14% of all health care spending to primary care. In this country, primary care visits account for 35% of health care visits yet make up only about 5% of health care expenditures.

The report echoes and extends a 1996 Institute of Medicine report, starting with an updated definition of high-quality primary care as the "provision of whole-person, integrated, accessible and equitable health care by interprofessional teams who are accountable for addressing the majority of an individual's health and wellness needs across settings and through sustained relationships with patients, families and communities."

That earlier document, "Primary Care: America's Health in a New Era," (which the Academy also co-sponsored), made a similar call to prioritize primary care. But it was less definite in establishing accountability methods for its proposals, which went largely unheeded by legislators and policymakers. In the generation since, several of the issues it identified — including the limitations of fee-for-service medicine and the need to buttress the primary care workforce — have grown more acute.

NASEM's study acknowledges that urgency with a five-pronged implementation plan to make high-quality primary care available and accessible nationwide. Specifically, it calls for policies that:

- pay for primary care teams to care for people, not doctors to deliver services;
- ensure that high-quality primary care is available to every individual and family in every community;
- train primary care teams where people live and work;
- design information technology that serves the patient, the family and the interprofessional care team; and
- ensure that high-quality primary care is implemented in the United States.

The report's findings and recommendations support the Academy's position that the country's fee-for-service health care design promotes misaligned incentives and prizes "sick care" at the expense of population wellness. This dangerous gap was exposed and exacerbated by the COVID-19 pandemic.

AAFP EVP and CEO Shawn Martin said in a May 4 statement, "We look forward to working with policymakers, payers and our other partners in primary care to make the study recommendations a reality — the health of our nation depends on it."

Academy President Ada Stewart, M.D., of Columbia, S.C., added: "The NASEM report clearly spells out the case for increased investment in our primary care system and ensuring everyone in our country has access to high-quality primary care, something the AAFP has long advocated for. The COVID-19 pandemic further exposed flaws in our current health care system, including those related to many years of underinvestment in primary care."

Are Medical Scribes the Best Option to Combat Physician Burnout?

Steve Moberg,
Chief Operating Officer at Team Care Medicine, LLC

In the on-going battle to cure physician burnout, many hospital administrators and / or physician group leaders desiring to help, face the dilemma of adding yet more costs to an operation likely already struggling to turn a profit. In other cases, when administration is not providing the help, many exasperated doctors are paying for a scribe out of their own pocket. The burnout issue is real and hiring a scribe to help with the heavy EHR documentation burden is becoming a common approach to solving it. A few years ago, the College of Medical Scribe Specialists predicted 100,000 scribes would be employed by 2020. With the Covid Pandemic, it is hard to tell exactly where the number stands today but the bottom line is it is a fast-growing solution. At about $15 per hour (a rough national average) the annual expense with benefits can reach $25,000 to $35,000. So desperate is the situation, administrators add this expense with no guarantees of financial returns sufficient to pay for it. Yes, a scribe will bring some relief from EHR documentation, but the resulting productivity gains are mixed. Some doctors see a 6%-8% (the high end of the range) productivity lift, however, a 2019 $480,000 scribe model pilot at St. Charles Medical Group in Bend, Oregon was scrapped because the "modest" productivity gains (only ½ a patient visit added per day) were insufficient to pay for the scribes. For about the same cost, administrators could upgrade to a more powerful solution that has been proven to boost physician productivity by 20%-40% or higher. That kind of productivity gain will easily pay for an additional MA being added to the team in lieu of a scribe. In this article, we will compare a Team Care Assistant (usually an MA trained in the use of the Team Care Medicine Model) to the use of a typical medical scribe. We will evaluate what they do and the benefits each provides.

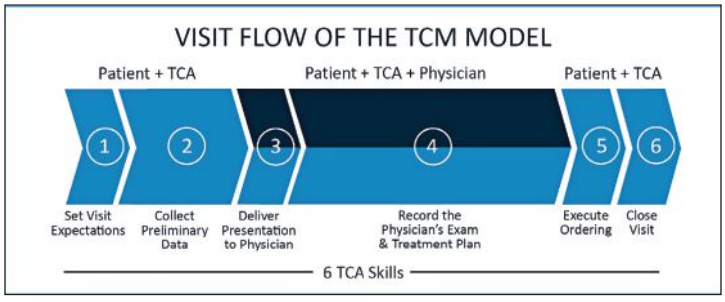
What is a Medical Scribe?

A medical scribe is quite simply a person that interfaces with the Electronic Health Record (EHR) during a patient visit freeing the doctor to focus on the patient. In most situations they require no specific certification or formal training to perform these duties. Candidates that possess soft skills like good listening, good communications, computer (typing) skills as well as some knowledge of human anatomy and medical terminology have an advantage. A high school diploma is a requirement and some background or courses in medicine is a benefit. Typically, a pre-med student is a good candidate however eventually they will move on so turnover may be an issue. A certification program is also available from the American Healthcare Documentation Professionals Group. In most cases, the medical scribe is not in the exam room independent of the physician other than to perhaps room the patient and collect a few vital measurements (temperature, blood pressure, etc.). Lastly, they are not nurses or even MAs, so there are functions they can't do which limits their versatility in the practice.

What is a Team Care Medicine TCA?

A Team Care Assistant (TCA) is usually a Medical Assistant (MA) or less often a Nurse (LPN or RN) trained by Team Care Medicine to execute a patient visit using the Team Care Medicine Model. The TCA is with the patient throughout the patient visit. They greet the patient and begin their 15-step process (fewer steps for an urgent visit) of interviewing the patient to capture all the patient's medical information including the use of template driven questions about the chief complaint. Once all the patient's medical information has been collected and updated in the EHR, the TCA notifies the physician, and the physician enters the exam room. The 5-15 minutes of data collection is then presented in a 2-minute crisp, data packed presentation to the physician in front of the patient. After presentation, the TCA *then* performs the role of a scribe, documenting any additional questions of the provider and answers of the patient. They also document any physical exam findings as well as the diagnosis and treatment plan of the physician in the EHR. Once the doctor has completed explaining the treatment plan to the patient, the doctor is free to exit the exam room and leave the TCA to again go over the treatment plan, perform any patient education and close the visit. See the following diagram of the Team Care Medicine visit flow.

Diagram-1



The Making of a TCA and a Team Care Medicine Team

The best Team Care Assistants are patient friendly, competent, good communicators, enjoy learning and possess good typing and computer skills. Team Care Medicine builds a customized / turn-key training program based on the customer's specific EHR and workflows. The TCM Model is melded into their existing processes to minimize the amount of change. A TCA's training begins with on-line training modules, activities to boost their medical terminology and the observation of

full traditional patient visits (the doctor does it all). Their training peaks during an intensive 2 ½ day on-site training and coaching event. Three classroom sessions are packed with instructor led course work and exercises as they and their provider learn to work together in this new team approach. Each team is assigned a TCM Coach to facilitate teamwork and the classroom exercises. The coach also follows their team back to the practice during two afternoon coaching sessions as the TCM Model is launched on live patient visits. The Coach is at the side of the TCA throughout the initial patient visits to ensure the model is launched smoothly and in a way that boosts the TCA's confidence. After the initial launch, the on-going training and skill development of the TCA continues during 30-minute weekly team meetings led by the physician using the TCM provided curriculum. A TCM Coach returns after just 2-3 weeks for more coaching and then quarterly after that for as long as the team desires.

How is the TCA Superior to a Medical Scribe?

There are meaningful differences between a scribe and a TCA in the work they perform, the satisfaction they bring to patients and in the superior financial benefit they produce making the TCA a much more valuable addition to the team than a scribe.

Work they perform:

The scribe is generally in the exam room only when the physician is in the exam room. The TCA, as outlined above works independent of the physician during portions of the visit. This is where the significant time savings occurs. A scribe does not collect the patient's information beyond vitals, nor do they present this data to the physician. A Scribe cannot perform medical procedures or screenings (such as for depression) because they have no medical training. A TCA on the other hand can perform these tasks. A Scribe does not do patient education or review the plan of the provider or close the visit allowing the doctor to slip out sooner, however, a TCA does all these things. A scribe does not take calls from patients with questions about their visit while the TCA fields many of the after-visit patient calls, protecting the physician from work that could easily be done by someone else. A TCA also helps set patient expectations such as helping to keep an urgent visit to just one issue or to let the patient with a list of 10 items know that the doctor will be made aware of them all but may only be able to evaluate 2 today and that an additional appointment(s) may be needed to cover the rest. A scribe does not engage in anything like this. Finally, the TCA working with the physician as a team just gets more done and it is done more efficiently, just like an OR Nurse helps the surgeon inside the operating room. All these differences add up to be significant benefits to the doctors and to the patients throughout the year. The benefits of a scribe are limited because the scope of work they perform is narrower than a TCA's. See Table-1 For a summary comparison of the differences between a TCA and a Scribe.

Table-1

Comparison of Job Functions / Duties of a Medical Scribe vs. TCA

#	Job Function / Duties	Scribe	TCA
1	Rooms Patient - Collects Vitals	Occassionally	Usually
2	Helps set visit expectations / boundaries	⊘	✓
3	Works independantly with the patient, ahead of physician	⊘	✓
4	Performs 15 Step TCM Model Interview of patient	⊘	✓
5	Performs full Med reconcilliation	⊘	✓
6	Performs any screenings / tests (depression, etc.)	⊘	✓
7	Asks template driven questions about the chief complaint	⊘	✓
8	Presents patient to the physician in front of the patient	⊘	✓
9	Acts as a scribe to record PE findings, diagnosis & plan	✓	✓
10	Works independantly behind the physician Re: Patient Education	⊘	✓
11	Pends all orders of the physician	⊘	✓
12	Closes the patient visit	⊘	✓
13	Handles many patient call-backs with questions about the visit	⊘	✓

The Patient Satisfaction They Deliver

With all the tasks on the plate of a primary care doctor working alone during a patient visit, it is easy for a patient to walk out the door at the end of the visit wondering if the doctor was really listening to them. When they hear the TCA crisply deliver their story to the physician and realize all the data points associated with their care, they know they have been heard. When the doctor explains the treatment plan and then the TCA repeats it and reviews the entire visit, they leave with a better understanding of the plan and what the doctor is asking them to do. Additionally, a 2019 ASHP Survey showed patients are less likely to ask questions about the care plan when they feel the providers are stressed and need to move on. They would more likely ask their questions to the TCA as they feel the TCA is more on their level. When they feel like they truly have a care team looking after them, it is very patient satisfying, and they view it all as better care.

The Financial Benefit They Deliver

The TCA is there to significantly increase the efficiency of the physician by doing ***ALL*** non-physician work. It takes 2.5 TCAs for a physician to use the Team Care Medicine Model on 100% of the day's patient visits. Most offices already have 1 to 1.5 clinical assistants per provider. Therefore, usually just 1 additional MA needs to be hired to round out the team. While the doctor and TCA #1 are in Exam Room #1 with Patient #1, TCA #2 is in Exam Room #2 with Patient #2 collecting all their relevant medical information and setting the table for the doctor to enter. When the doctor goes into Exam Room #2 with TCA #2 and Patient #2, TCA #1 wraps up the visit with Patient #1 and then begins the visit for Patient #3. See Diagram-2 depicting the provider hourly workflow.

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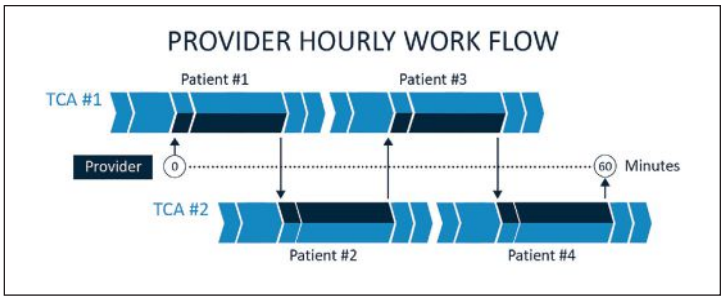
continued from page 21>

Diagram-2



This "dance" is repeated all day with the doctor going from exam room to exam room doing just the work that only they can do. The TCM Model flow also creates natural gaps throughout the day providing doctors a few minutes to knock out an item or two on their task list resulting in less work at the end of the day before heading home. The ability of a TCA to work independent of the doctor produces the big productivity boost over the scribe option. Otherwise, the patient visits are accomplished serially with the doctor and the Scribe doing each together. The TCA typically delivers a 20-40% productivity gain in visit volumes with similar gains in the amount of work they accomplish as a team during the visit (Work RVUs). They help the doctor see more patients and get more done during the patient visit. With similar costs (See Table-2) you get much more bang for your buck with a TCA as opposed to a Scribe (See Table-3).

Table-2

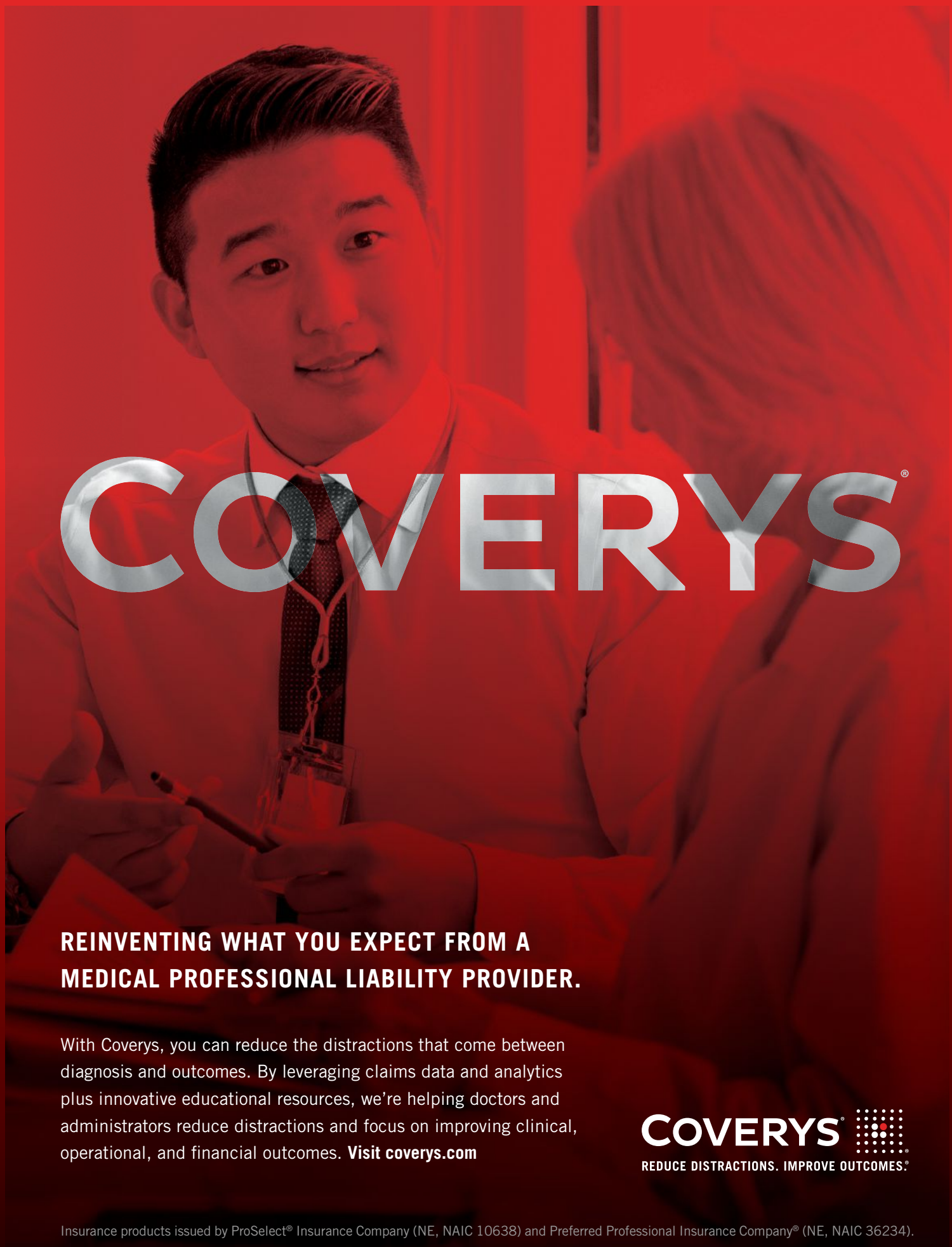
Team Care Assistant vs. Scribe: Financial Comparison				
Item	Hourly Rate	Benefits	Annual Cost	Productivity Gain
Scribe	$14.50	20%	$ 36,192.00	~8%
Team Care Assistant	$17.00	25%	$ 44,200.00	~25%

Table-3

Team Care Assistant vs. Scribe: Financial Comparison				
Item	Hourly Rate	Benefits	Annual Cost	Productivity Gain
Scribe	$14.50	20%	$ 36,192.00	~8%
Team Care Assistant	$17.00	25%	$ 44,200.00	~25%

Conclusion

A Team Care Medicine TCA paired with a motivated doctor looking for a solution to burnout while desiring to maintain the highest level of care for their patients is an overall more powerful and efficient solution than a medical scribe model. Administrators hesitating to add more expense to their primary care offices should have great confidence that they can now add the needed help and that doctors can generate enough additional revenue to more than cover the added expense.



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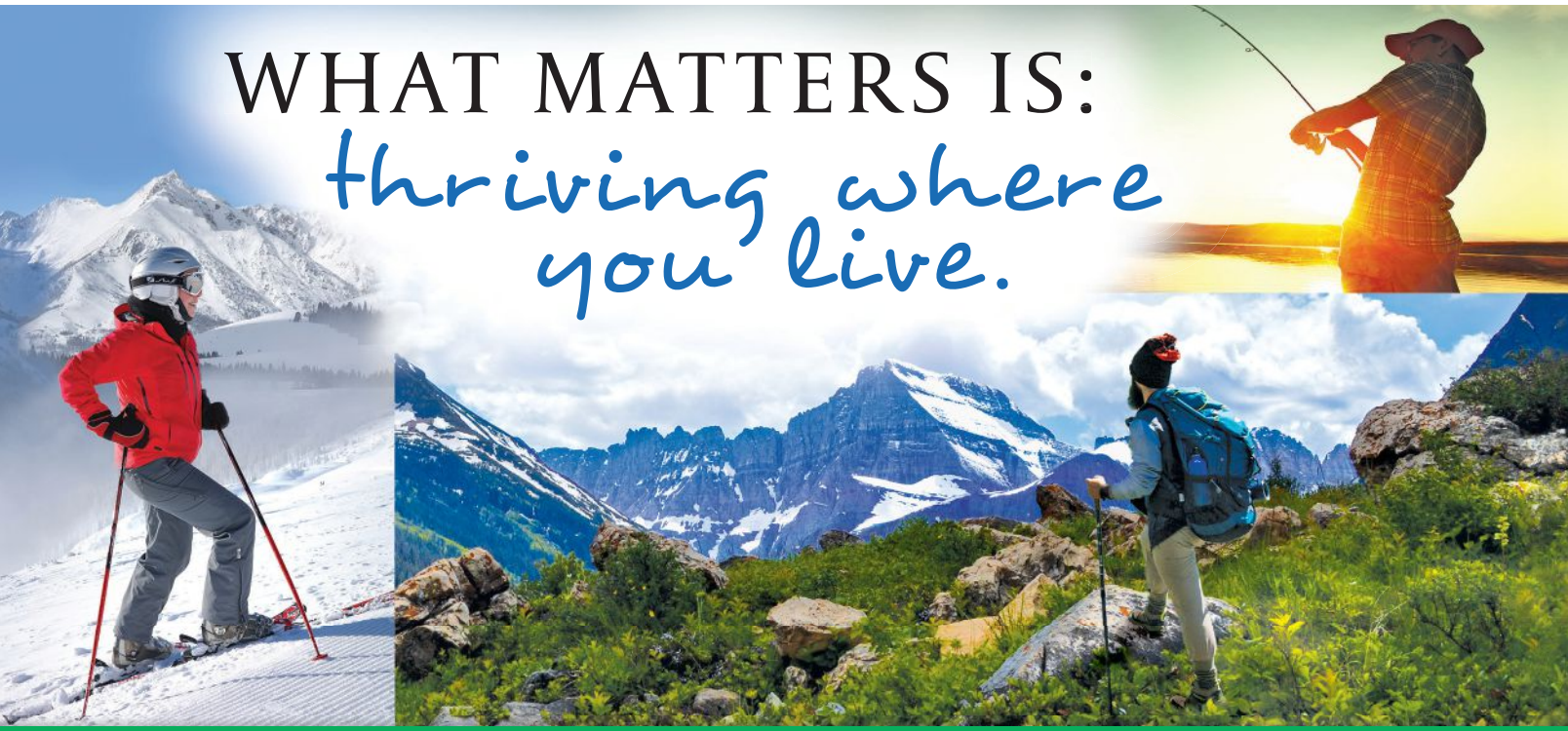

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