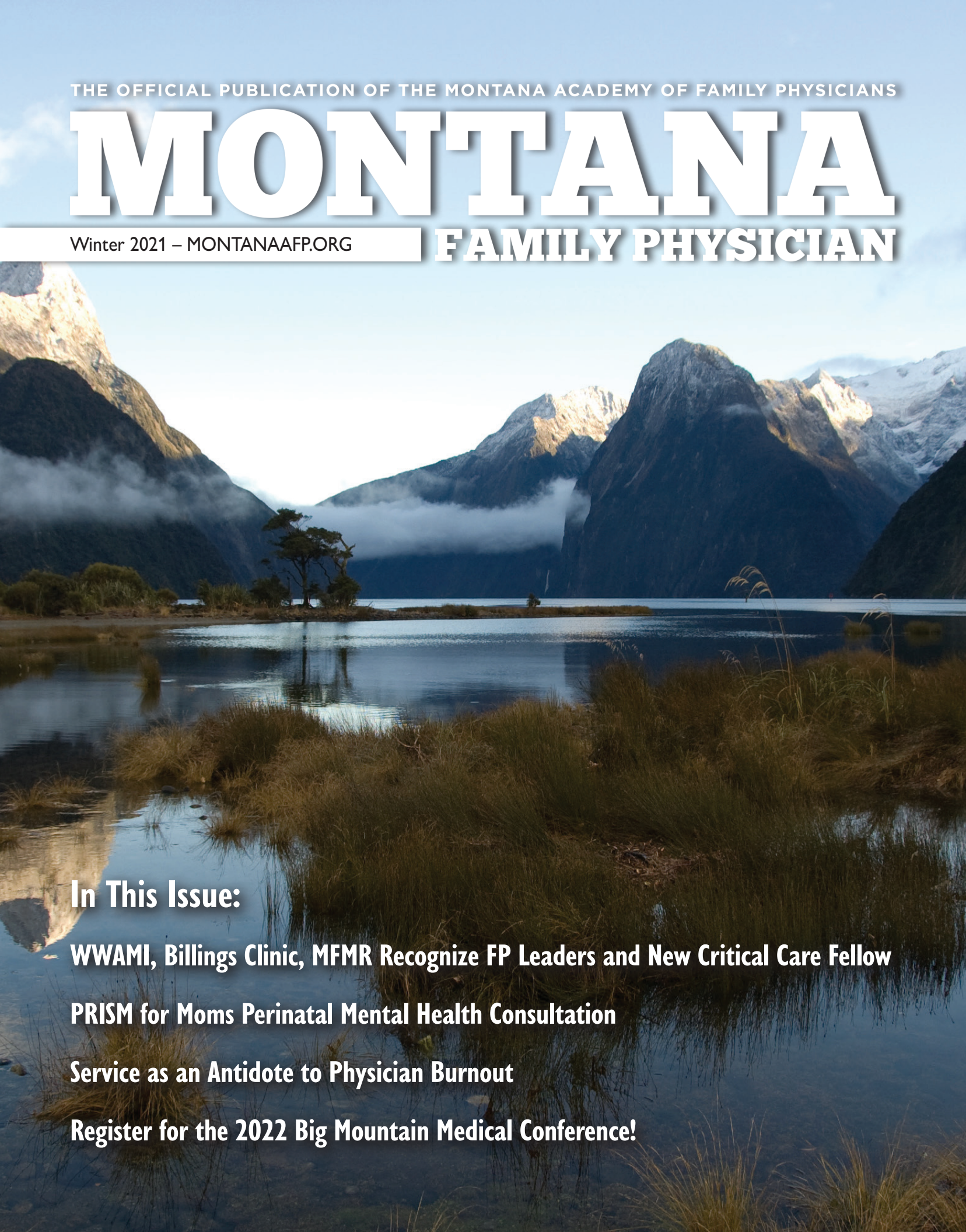
THE OFFICIAL PUBLICATION OF THE MONTANA ACADEMY OF FAMILY PHYSICIANS

MONTANA FAMILY PHYSICIAN

Winter 2021 – MONTANAAFP.ORG



In This Issue:

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EDITION 11

*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 11

MAFP President's Welcome

Michael Temporal, MD

Wishing all of our family of family medicine the best this holiday season. Since the last issue of Montana family physician, your board has been very busy working on your behalf.

In the annual meeting of the AAFP Congress of Delegates, new officers and Board of Directors were elected. Representing the breadth of our specialty, these people represent rural, urban, academic, private practice and community health centers with a broad geographic footprint. More importantly, during the interview and selection process, your Montana delegates and alternate delegates asked insightful questions on how they will represent all of us and our need for advocacy, equity and excellent physician-led family medical care.

If you haven't already made plans to attend our winter meeting in Whitefish and our summer meeting in Chico, I hope you can flex your schedule to mix family and professional time in great settings. The education committee has put together great topics and speakers.

Finally, remember that you are welcome to join your Board and leaders in representing Montana family medicine at the national and regional level. We are looking for future board members, attendees to the AAFP National Conference of Constituency Leaders and our legislative meetings. Also, the AAFP has national commissions that help form policy and services to meet the needs of all of our practices. If you would like more information let our chapter executive Linda Edquest or myself or any of your Board know, and we would love to get you more involved.

2022 will be a great year and hopefully the worst of the pandemic will have passed. Be a part of making family medicine the center of the healthcare system for our patients. Thanks for all you do.

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MAFP Board of Directors Profile

John Miller, MD, Missoula

I grew up in the small mining town of Wallace, Idaho where I graduated high school, and in Moab, Utah when it was a mining town before tourism changed it so dramatically. My mother was a social worker for mining families in both communities, and also worked on the Navajo Reservation in Southern Utah.

I attended the University of Washington School of Medicine as part of the (then) WAMI program from Idaho, completing my first year at the University of Idaho in Moscow. I met my future wife, Nerissa Koehn, during medical school. She was born and raised in Missoula. I then graduated in 2000 with my medical degree from UW and a Masters in Public Health from Harvard School of Public Health.

I completed residency training at Tacoma Family Medicine in Tacoma, Washington. After couples matching and hearing many stories from friends, I completed a research project about the ethics of the Match, published several articles, and won a national AAFP resident research award for this work.

From 2003-2011, I worked in family medicine including deliveries, ER, and inpatient care at an Indian Health Service Hospital in Zuni, New Mexico. I also directed the service unit Diabetes Program that included prevention outreach to the Zuni and Navajo tribes. I coordinated a robust student and resident teaching program, and worked with trainees from across the country.

We moved back to Montana in 2011 to help start the Family Medicine Residency of Western Montana. My wife was the program's Associate Director. I worked as Medical Director of Partnership Health Center in Missoula and clinical director for the residency program.

I began involvement with Montana Academy of Family Medicine by attending the winter CME (Big Mountain Medical Conference) in January 2012. I then agreed to serve as Program Chair and have coordinated the winter CME since January 2015. I also served as residency faculty representative to the Board of the MAFP before being named to the Board and serving as President of the Board in 2017-18. I currently serve as Secretary-Treasurer.

At the end of 2017, we resigned our positions at the residency program to travel and work overseas before our oldest started high school. We traveled extensively, including a six-month stint working as GPs in Rotorua on the North Island in New Zealand.

Just before the start of the COVID-19 pandemic, I completed three months working near South Luangwa National Park in eastern Zambia as the on-call doctor for a group of safari companies, and volunteering at a local rural clinic.

I started working as a nearly halftime contracted physician in the Blackfeet Community Hospital Emergency Room in Browning, Montana. I also share a family medicine practice with my wife at Western Montana Clinic, a multi-specialty group in Missoula.

Dr. John Miller with his wife, Dr. Nerissa Koehn, at the clinic in Rotorua, New Zealand.

I enjoy caring for patients of all ages and backgrounds. Highlights range from continuity with patients, working with kids, and teaching which included deliveries and other procedures. Helping to start the residency program in Missoula was a team effort. We were fortunate to be able to recruit strong residents from the beginning as well as outstanding faculty members who have made the program all that it has become.

The evolution of my career exemplifies some of the range of possibilities within family medicine. It progressed from full spectrum care in Zuni, to full time as an administrator and faculty member, to travel and international work, to now working in a continuity clinic and as a contracting physician in the ER.

My main priority is having time with my wife and our three children, 10th, 6th, and 2nd graders, all three girls who are active in sports. I also prioritize physical activity: running (shorter and slower than in the past); rafting and skiing (still searching for the perfect line), and other outdoor activities. I also enjoy reading and am an avid sports fan.

I feel so fortunate to live, work, and raise my kids in Montana. Montana has awesome physical beauty. In the medical field, we have a shared sense of responsibility and respect that enables us to do important and rewarding work.

Heidi Duncan, M.D., to Join AHA Board

Billings Clinic

Heidi Duncan, M.D. has been named Chair of the American Hospital Association's Region 8 Regional Policy Board (Region 8 RPB) also granting her a seat on the AHA Board. Dr. Duncan has been a member of the Billings Clinic staff since 1994 and added the role of Physician Director of Health Policy to her clinical work in 2014. She was named to AHA's Region 8 Regional Policy Board in 2019.

As a physician leader and policy leader, Dr. Duncan advocates for education and community health improvement, such as innovative ways of providing healthcare to historically marginalized communities that include American Indians, children and seniors. Her policy work has included innovations in telemedicine and virtual visits; reaching consensus on Medicaid expansion and developing new residencies.

Dr. Duncan received letters of support for her candidacy for AHA Region 8 RPB Chair from Montana Governor Gianforte; MHA President and CEO Rich Rasmussen; Beartooth Billings Clinic CEO, MHREF Board Chair and former AHA Trustee Kelley Evans; and Billings Clinic CEO Dr. Scott Ellner.

In his letter of support, Rich Rasmussen wrote:

"Dr. Duncan is a highly respected practicing physician serving patients at Billings Clinic (Billings, Mont.) and throughout Eastern Montana. She is a recognized voice for patients and the communities she serves. She brings valuable, real-time operational and patient care experiences to the Regional Policy Board and the AHA...

Outside of her role as a clinician, she is also a highly effective advocate for hospitals. As an active member of the Montana Hospital Association, Heidi participates in our educational programs, membership engagement efforts, AHA events and contributes to our PAC. Currently she serves on the Region 8 Policy Board and in that role has brought operational, clinical and strategy experiences to the board."

Mind the Gap:
Substance Use Health Treatment Gaps in Montana

Data from the National Survey on Drug Use and Health (NSDUH) reveals a widening gap between the number of people in need of substance use treatment and the number of those who receive treatment to address this need This is known as the treatment gap. The Substance Abuse and Mental Health Services Administration (SAMHSA) data spanning 2013 to 2019 shows that while this treatment gap has decreased in the United States overall, it has increased in Montana. This suggests there is a growing need for improved screening for substance use problems among Montana residents and better connection to available resources once that need is identified.

Prevalence of alcohol and illicit drug use

The prevalence of illicit drug and alcohol use in Montana is alarming. Table 1 shows the prevalence of alcohol and illicit drug use by age group according to the 2018-2019 NSDUH data (1). Illegal alcohol use in the past month for Montanans between the ages of 12 and 17 years was 12% as compared to a national prevalence of 9%. For comparison, the prevalence of alcohol use among people 18-25 years old and 26 years and older was greater than 60% for Montana and 55% for the nation.

Although illicit drug use is less common than alcohol use, Montana's higher than average prevalence remains consistent across age groups (Table 1). The prevalence of illicit drug use in the past month was 16% for Montanans aged 12 years and older, as compared to 12% nationwide.

Table 1: Prevalence of people who use alcohol or illicit drugs by age group, 2018-2019, NSDUH

Age group	Alcohol Use Prevalence, Montana	Alcohol Use Prevalence, US	Illicit Drug Use Prevalence, Montana	Illicit Drug Use Prevalence, US
Age 12-17 years	12%	9%	12%	8%
Age 18-25 years	63%	55%	31%	24%
Age 26 or more years	62%	55%	15%	11%
OVERALL (Ages 12+)	58%	51%	16%	12%

Alcohol and Illicit Drug Treatment Gap

Table 2 describes the prevalence of US and Montana residents in the treatment gap for alcohol and illicit drug use by age group. The national and Montana differences in drinking among age groups are similar to the treatment gap for alcohol use. Approximately 5% of US residents fell into the alcohol treatment gap, representing 2% of residents aged 12-17 years, 9% of residents aged 18-25 years, and 5% of residents above the age of 25 years. Montana continued to exceed national levels with 7% of our residents needing, but not receiving, specialty treatment for alcohol use. By age group, Montanans in need of, but not receiving, treatment for illicit drug use made up 4% of people aged 12-17 years, 7% of Montanans aged 18-25 years, and 2% of those aged 26 and years and older. The national treatment gap for illicit drug use has grown 15% from the time period spanning 2013-2014 to 2018-2019, reaching 3% of all people aged 12 and above. More rapid growth occurred in Montana for the same time period, with an increase of 54% to reach 3% in 2018-2019.

Table 2: Prevalence of people in the alcohol or illicit drug use treatment gaps by age group, 2018-2019, NSDUH

Age group	Alcohol TREATMENT GAP, Montana	Alcohol TREATMENT GAP, US	Illicit Drug TREATMENT GAP, Montana	Illicit Drug TREATMENT GAP, US
Age 12-17 years	3%	2%	4%	3%
Age 18-25 years	13%	9%	7%	7%
Age 26 or more years	7%	5%	2%	2%
OVERALL (Ages 12+)	5%	7%	3%	3%

Differences in groups sizes influence the outcomes reported in the data. To account for this, we also need to consider the treatment gaps in terms of per capita distribution. Table 3 describes the rates of demographic groups (per 10,000 people) falling into the treatment gap for alcohol use and illicit drug use (2). Montana and national data show that the alcohol use treatment gap most prominently affects men, American Indians/ Alaska Natives, and residents between the ages of 18-25 years. However, this treatment gap in Montana appears more substantial when compared to the national average. Montana and national data show that 97% of people meeting the criteria for alcohol use disorder as defined in the 4th edition of the Diagnostic and Statistical Manual of Mental Disorders (DSM-IV) and needing, but not receiving, alcohol treatment, reported feeling that they didn't need treatment. Montana's illicit drug use gap was also slightly larger

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than the national average, with excessive burden on indigenous populations and residents aged 18-25 years. Unlike the alcohol treatment gap, men and women shared the burden of the illicit drug gap equally. Nationally, 93% of people meeting DSM-IV criteria for needing, but not receiving, treatment for illicit drug use reported feeling that they didn't need treatment; due to limitations of the data, statewide estimates were not available.

Table 3: Rates of residents in need of specialty treatment but not receiving it for alcohol or illicit drug use in Montana and the US, 2015-2018, per 10,000 people, NSDUH

Category	MT, Alcohol	US, Alcohol	MT, Illicit Drugs	US, Illicit Drugs
Sex				
Female	*544*	*380*	*272*	*184*
Male	*888*	*691*	*273*	*329*
Race				
White only	*715*	*551*	*260*	*248*
American Indian/ Alaska Native only	*1,200*	*700*	*600*	*331*
Other racial profile	*606*	*446*	*303*	*273*
Age group				
Age 12-17 years	*400*	*191*	*400*	*293*
Age 18-25 years	*1,351*	*1,010*	*811*	*676*
Age 26 years or more	*648*	*493*	*173*	*181*
OVERALL	**717**	**531**	**273**	**254**

Potential solutions to address the treatment gap

Addressing the alcohol and illicit drug use treatment gaps requires a combination of screening and intervention. The U.S. Preventive Services Task Force recommends drug use screening among adults age 18 years and above, including pregnant women, although evidence regarding the balance of benefits and harms for screening adolescents for unhealthy drug use remains insufficient (3).The Screening and Brief Intervention and Referral to Treatment (SBIRT) is a framework through which physicians screen for potential substance use and mental health issues and deliver a brief intervention. Screening can occur in primary care centers, as well as hospital emergency rooms, trauma centers, or other settings (4; 5; 6; 7). Physicians can administer SBIRT via telehealth, removing potential barriers of lack of transportation, lack of childcare, schedule conflicts, or fees for services (8). The evidence base is growing for benefit of using SBIRT to in identify and treat patients for mental health and substance abuse problems (9; 4; 5).

A 2019 statewide survey of Montana adults found that 86% of respondents aged 18 years or above were screened for alcohol use during their last annual exam, but only 75% were asked how much they drank and 39% of the group were asked about binge drinking by their provider (10). Screening among American Indian and Alaska Native (AI/AN) patients was significantly higher (91%) compared to non-Hispanic white (NHW) patients (86%), showing a need for improved screening among NHW patients. Screening for alcohol use increased with the educational level of the patient, even though patients with less than a high school diploma or equivalent had the greatest proportion of heavy drinking (11%). People with disabilities (PWD) reported that their physicians asked about their alcohol use less (82%) than people without disabilities (88%). Along with reducing substance use, connecting patients with a trained provider additionally improves patient satisfaction with care (6).

Consistent and recurrent clinical screening is required to accurately identify patients who might benefit from treatment. Research has shown that recovery from alcohol or illicit drug use takes multiple attempts. Given data that successful cessation occurs after a mean of 5 attempts and a median of 2 attempts, physicians screening and educating patients remain critical even after a patient has completed a treatment program (11). Patient characteristics play a key role in recovery, including the nature of relapse activities (12; 13), history of trauma (14), and whether antisocial personality disorder is a factor (15). People in rural setting who use drugs have significantly earlier ages of onset abuse and differing profiles of drug selection compared to their peers in urban settings (16).

Once a need for referral is identified by screening, the CONNECT referral system allows service providers in Montana to send and receive referrals to a spectrum of services on a secure, web-based platform. The system is available to agencies at no cost and improves the referral process by establishing accountability and improving the process of securely exchanging patient information (17). This resource is available for use outside of the clinical setting as well, allowing more agencies to connect Montanans to the services they need. To get started with CONNECT, points of contact can be found on the CONNECT Referral system website at https://connectmontana.org/about-connect/counties/.

Recommendations for providers

By combining SBIRT with CONNECT, physicians play an integral role in supporting patient health and building resilience against substance use and recidivism. There are clear health equity disparities in terms of the burden of substance use and the absence of treatment. Physicians have a critical role in educating patients about the risks of alcohol and drug use, conducting screening and brief interventions for substance use and mental health issues, and making referrals for specialty care, when indicated. These activities have the potential to positively impact the health and well-being of your patients and connect them with the treatment they need.

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UNIVERSITY OF MONTANA
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MONTANA PRIMARY CARE PROVIDER SURVEY

We are conducting a survey about routine childhood vaccination practices and child and adolescent COVID-19 vaccines.

In December, a survey will be mailed to Montana physicians, physician associates/physician assistants, and advanced practice registered nurses specializing in family medicine or pediatrics. You may complete the survey on paper or online.

Your participation in this survey is important. Your input will inform strategies to increase vaccination rates across the state.

Contact Information:
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Emma Wright, MD
emma.wright@mso.umt.edu

Funded by a National Institutes of Health COBRE Award (1P20GM130418)

Updates from Montana WWAMI

UWSOM Department of Family Medicine Awards 2021

The UW Department of Family Medicine is pleased to announce the winners of the inaugural year of the Department of Family Medicine Awards, which coincides with the 50th anniversary of the department. Family Medicine attracts exceptional faculty and staff who have made remarkable contributions to the department, specialty, and communities over these past 50 years. The Department is thrilled to honor 50 recipients in the following award categories: Clinical Excellence – Educational Excellence – Leadership Excellence – Research Excellence – Staff Excellence – Justice, Equity, Diversity, and Inclusion (JEDI) Excellence – Chair Awards.

Dr. Neil Sun Rhodes

Dr. LeeAnna Muzquiz

UWSOM Montana WWAMI Faculty Dr. Neil Sun Rhodes of Browning and Dr. LeeAnna Muzquiz of Polson, were honored with this award; Dr. Sun Rhodes for Educational Excellence, Dr. Muzquiz for Leadership Excellence. The educational excellence award celebrates those who have made significant contributions to teaching, advancement/sponsorship, and mentorship of learners and colleagues. The leadership excellence award celebrates those who have made significant contributions to advancing the mission and vision of the Department of Family Medicine. Considerations included those with a demonstrated commitment to teamwork, sponsorship of others, and contributions to diversity, inclusion, and equity within the organization. Congratulations!

Montana WWAMI Pre-Med Summit

Every other year, Montana WWAMI organizes a pre-med summit for those interested in finding out more about applying to medical school. Held in Helena at the Carroll College campus on September 25th, 2021, the event welcomed 68 guests, most of them students in addition to undergraduate pre-med advisors from area colleges and universities.

Representatives from the University of Washington School of Medicine, Montana State University, the University of Montana, Carroll College, the Billings and Missoula Clinical Tracks, and Montana WWAMI Foundations and Patient Care Phase were on hand to present details about the application and financing process and med school interview preparation. Particularly popular were the mock interviews with audience volunteers. Montana WWAMI medical students were on site, participating in a panel discussion to provide a student perspective and answer questions. Breakout sessions included an overview of NHSC and MRPIP programs, pre-med research opportunities, application advice, guidance on writing a personal statement, discussion of the residency years and a dialogue about diversity in medicine. Also included was a Q & A session on financial aid and program specifics about the Montana TRUST program and the combined MD/PhD program. The military arms of the government (Army and Navy) also participated in break-out sessions and Q&A.

PreMed Summitt Attendees Carroll College 2021

The summit was sponsored by many healthcare organizations in the state: Montana AHEC, Bozeman Health, Cabinet Peaks Medical Center, Montana TRUST, U.S. Army, U.S. Navy, Barrett Hospital, MSU, Carroll College, University of Montana, and the UWSOM. Undergraduate students from across the state interested in becoming a physician congregated to learn about the application process to the WWAMI program.

Seeley Lake Clinic Joins UM Resident Physician Program

Partnership Health Center clinic in Seeley Lake.

The University of Montana-sponsored Family Medicine Residency of Western Montana has expanded its resident physician medical services to Partnership Health Center's **Seeley Lake** Clinic.

The expanded service was made possible by a federal grant through the Health Resources & Services Administration. The residency program is one of 20 organizations nationally to receive the HRSA grant, with the goal of increasing rural training and exposure for resident physicians specializing in family medicine and primary care.

Training in rural areas is paramount to the FMRWM mission to train clinically competent physicians to practice in rural and underserved areas of Montana. According to a 2016 analysis by the University of Washington, resident physicians training in rural and underserved areas are more likely to continue practicing in those areas. Fifty-two of 56 counties in Montana are currently designated as primary care shortage areas.

The first resident physician to train at Seeley Lake is third-year resident Dr. Zach Carlson. He is one of three residents who will share patient duties at the Seeley Lake Clinic this academic year. Dr. Nick Zakovich, a third-year resident and Dr. Jacqueline Ordemann, a second-year resident, also will provide services at the clinic.

"I was excited for the opportunity to rotate to Seeley Lake because of the potential for more acute visits, since unlike Missoula there are no urgent care clinics or emergency rooms nearby to handle these needs," Carlson said. "I'm happy to report my first clinic session exceeded this expectation. Taking care of patients with acute concerns in an area with limited resources is great practice for a potential future job in a rural area, and I look forward to more experiences going forward to better prepare me for my future practice."

Interested residents submitted an application for consideration for the Seeley Lake position. Three residents were chosen and will continue providing services through the 2021-22 academic year. FMRWM will take applications each year to replace graduating residents. Program managers also expect to extend the rural continuity clinic program to Kalispell track residents in the coming year.

FMRWM is a three-year family medicine residency program based in Missoula with a track in Kalispell. Each year the program recruits 10 first-year residents and graduates 10 third-year residents. At any given time, there are 24 residents located in Missoula and six located in Kalispell.

Missoula residents complete their continuity clinic at Partnership Health Center, and Kalispell residents complete their continuity clinic at Greater Valley Health Center. FMRWM is part of the University of Washington Family Medicine Residency Network and is sponsored by Providence St. Patrick Hospital and Community Medical Center in Missoula and Logan Health in Kalispell.

Q&A with Montana Rural Critical Care Fellow Alyssa Lautenschlager, MD

Dr. Lautenschlager is the 2021-22 fellow in the first year of the Montana Rural Critical Care Fellowship, a partnership between Billings Clinic and the Montana Family Medicine Residency. She is currently learning and working at Beartooth Billings Clinic in Red Lodge, Montana.

Why did you choose the Montana Rural Critical Care Fellowship?

My goal with this fellowship is to be able to provide the best care that I can for my patients. I heard about the Rural Critical Care Fellowship while I was working in the Emergency Department at a Critical Access Hospital in Browning, Montana. Due to the remoteness of the hospital's location it was imperative that I be able to care for a broad spectrum of medical conditions, from car accidents to rodeo injuries to GI bleeds and severe sepsis. I was inspired by the energy and dedication of all the physicians and staff at Billings Clinic and decided that this would be a great place to further my training to be able to better serve the community and my patients.

What do you like best about providing family medicine with emergency medicine in rural areas?

The people. Both patients and other employees. There is a camaraderie among everyone who works at rural hospitals - we get to know everyone well and work together on both big and small problems. I love the teamwork that you can have in these locations.

> "It has been a great experience so far and I am excited about the new skills that I have learned in such a short time. Everything will help my future patients."

What are the biggest challenges as a family physician providing emergency medicine at critical access hospitals?

As you might expect, one of the biggest challenges is the limitation of resources. For example, one hospital that I have worked in does not have a ventilator - so we have had to manually bag intubated patients until flight can arrive. Many are very limited on the amount of blood they carry. Getting certain labs or imaging studies can be very challenging. It requires you to problem solve and be a little more creative in your care.

What are three new things you've learned in the first three months of your fellowship?

I have had the opportunity to learn many things over these first three months. One of the most useful has been the management of critically ill COVID patients, which is particularly applicable working in medicine today. Another theme among my ICU rotation was post-cardiac arrest care. I have also had the opportunity to expand my procedural skills, including trauma-related skills such as chest tubes and central lines.

What would you say to other family physicians considering the Montana Rural Critical Care Fellowship?

It has been a great experience so far and I am excited about the new skills that I have learned in such a short time. Everything will help my future patients. It's definitely hard to step away from being an attending physician and leave my position at my previous hospital, but it will be worth it in the long run. I would recommend it for anyone looking for more experience, with the goal of taking care of critically ill patients in rural settings.

For more information or to apply for the 2022 Rural Critical Care Fellowship, contact Billings Clinic Physician Recruitment at physicianrecruiter@billingsclinic.org.

Montana PRISM for Moms:
Perinatal Mental Health Consultation and Support

Ariela Frieder MD
PRISM for Moms, Medical Director

As a Perinatal Psychiatrist in the field for the past 15 years, I have witnessed, first hand, the difficulties faced by women with mental illness during pregnancy or postpartum in accessing specialized psychiatric care. Often, these women suffer, and many with devastating consequences to themselves, their children, families and society as a result of stigma, the lack of social resources, financial constraints and lack of specialized psychiatric care available to them.

I am an OBGYN in my country of origin. Since the start of my career I was interested in understanding how maternal physical and mental health as well as how pregnancy complications affect the health and life of their offspring. I began my medical career in a city hospital in Buenos Aires, Argentina and saw, first hand, how the adversities women faced had an impact in the relationship with, and in the development of, their children. Since then and during my career in Psychiatry my mission has been to help women with psychiatric illnesses and/or in disadvantaged circumstances improve outcomes for their children.

Some of the things I will share below are likely well known to you as a Family Practice physician. I'm also sure you have witnessed first hand the debilitating effects of mental illness in women of reproductive age. I came to learn that mood disorders are highly prevalent among women of reproductive age. It was not too long ago when it was believed that pregnancy was protective against mental illness. However, new evidence suggests that the emergence of a new psychiatric disorder or the relapse of a preexisting one during pregnancy or postpartum is highly prevalent (10-20%). Perinatal Mood and Anxiety Disorders (PMADs) are the number one complication of pregnancy and childbirth. Nationally, PMADs affect **one in seven** pregnant and postpartum women, and during Covid pandemic the rate is **one in five** perinatal women. Depression is one of the leading causes of maternal deaths, often through suicide. Pregnant women with Mood and Anxiety Disorders frequently think about suicide. Perinatal Mood and Anxiety disorders can be severe and disabling requiring hospitalization. Suicide accounts for 20% of deaths in the postpartum period. It is the leading cause of maternal death in the first year postpartum usually by violent means. It is estimated that less than 50% of perinatal depression cases are identified in routine clinical practices. 50% of women with perinatal depression do not get the help they need!

Psychiatric illnesses during pregnancy and postpartum can cause considerable distress to mother, family and children. Postpartum depression tends to be long-lasting and can last certainly more than a year if untreated. Short and long-term developmental, cognitive and behavioral effects on the child have been seen when mothers suffer from PMADs. Moreover, psychiatric symptoms in the postpartum can lead to reduced interaction and irritability towards the child and therefore affect bonding. In addition, pregnancy is a major determinant in the cessation of psychiatric medications. For example, and as written in the literature, most women do not receive further antidepressant prescription beyond six weeks of gestation. Moreover, women who stop taking their psychiatric medication during pregnancy have a 68% chance of having a depressive episode while women who continue their medication have a 26% chance of relapsing. So, as you can see, it is important to keep these women under care and treat them with the best evidence based practices to improve outcomes.

Now, I am excited to introduce to you PRISM for Moms, a specialized consultation line for frontline providers. "PRISM" stands for Psychiatric Referrals, Intervention, and Support in Montana.

PRISM for Moms is a state funded, subspecialty psychiatric consultation service for Montana-based clinicians caring for women during the perinatal period. Frontline providers are welcome and encouraged to utilize this consultation line to access expert support, assistance and evidence-based recommendations on how to treat pregnant and postpartum women. The line is answered by a perinatal psychiatrist who has expertise in treating perinatal patients with mental health conditions. We provide information about psychiatric best practices in mental health and medication management for perinatal women. We also assist with referrals to appropriate mental health services for this population. The consultation line is answered 24/7 by a support specialist. The psychiatrist will call back the provider within 24 hours of their call. If needed, we can provide a one-time face-to-face consultation with the patient.

PRISM for Moms is supported by a 5-year grant from the Health Resources and Services Administration's (HRSA) Maternal and Child Health Bureau (MCHB) to enhance systems for screening, assessment, and treatment of depression, substance use, and other behavioral health disorders in pregnant and postpartum patients. In Montana, this program is managed as a partnership that includes DPHHS' Health Resources Division, Frontier Psychiatry, and Healthy Mothers, Healthy Babies.

We get calls from all regions of Montana about women with depression, anxiety, psychosis, bipolar disorder, substance abuse, among other diagnoses, that are managed by their primary care provider during pregnancy and postpartum. Some of these

cases are complex and understandably are difficult to treat by a provider who is not specialized in the medication management of perinatal women. One case that comes to mind as an example, is of a high functioning woman with apparent history of depression and anxiety, treated with an antidepressant in the pregnancy, who had a manic psychotic break in the postpartum. PRISM for Moms was contacted and we helped with the care of this patient by providing information about the best management of bipolar disorder and postpartum psychosis. Moreover, we had the opportunity to evaluate this woman in a virtual one-time consultation which helped the treatment team with her medication regimen and treatment plan. We avoided the tragic outcomes often associated to postpartum psychosis.

Our goal is to be a resource to, and support, healthcare professionals in Montana who are providing mental health care to women during pregnancy and the postpartum period. We do this by: 1) facilitating the early identification of perinatal risks and mental health symptoms; 2) implementing first-line management of mental health and substance use disorders; and 3) making meaningful referrals to additional community resources.

In addition to the PRISM for Moms Consultation Line, I also want to introduce you to the 3D ECHO Perinatal Mental Health Clinic. This 3D ECHO program is offered by a partnership between Mountain-Pacific Quality Health and Frontier Psychiatry. It's a four-state, tele-mentoring initiative that delivers medical education and health care management to clinicians in rural and frontier settings. This program, which focuses on Perinatal Mental Health, is a series of ten one-hour long sessions, that include interactive didactic and case discussions facilitated by experts in the field of perinatal psychiatry. This is a learning opportunity designed to help you and your staff become more comfortable in treating perinatal patients suffering from mental illness.

I am very excited to share the news about PRISM for Moms and I encourage you and your staff to take advantage of this program. You can call us at 1-833-83-PRISM, 1-833-837-7476 or submit an e-consult at https://prismconsult.org/.

We look forward to hearing from you!

Do you wish you had more support treating your patients mental health or substance use disorders?

Any Montana clinician who is caring for the mental health of pregnant women or women in the postpartum period is welcome to utilize the PRISM for Moms consultation line to receive additional resources and support.

PRISM for Moms is a subspecialty psychiatric consultation service for Montana-based clinicians caring for women in the perinatal period. Clinicians are welcome to use this free service to discuss psychiatric diagnosis and treatment options for patients who are pregnant or who are in the postpartum period.

Calls will be answered 24/7 by a support specialist. The clinical team at Frontier Psychiatry will review clinical information and provide you with additional resources or recommendations based on the case. Cases received by 4 pm will be returned the same day. Cases received after 5 pm will be returned the following business day.

Call 1-833-83-PRISM
(1-833-837-7476)
or visit
www.prismconsult.org

A Perspective on Physician Burnout as Seen Through the Eyes of a Medical Mission Director

Katherine Lynn Walker, MD

As a physician, who does not have at least some sense of burnout? We hear about this every day. And, the stressors surrounding the COVID-19 pandemic have only worsened the situation.

As the founder of MissionCMEcuador, the director of numerous medical mission brigades, and past presenter on the topic of burnout at a National AAFP conference, I would like to highlight a new perspective on how to combat physician burnout. Have you ever considered participation in a humanitarian medical mission?

As part of this discussion, I would like to provide some background regarding burnout. A generally accepted definition of burnout by a pioneer in the field, Christina Maslach, is that ongoing work related stress leads to emotional and physical exhaustion, detachment, and a reduced sense of personal accomplishment. In other words, a state of being chronically tired, cynical, and discouraged.

It is estimated that over 50% of physicians report symptoms of burnout. And, statistics show that family physicians suffer from significantly higher rates of burnout than physicians in most other specialties.

Common extrinsic causes of burnout include frustration with bureaucratic tasks and electronic health records (EHRs), long work hours, a lack of autonomy, reduced reimbursement, and a feeling of being a "cog in a wheel." Intrinsic contributing factors include a tendency for physicians to be self-critical, perfectionistic, and overly idealistic. Does this sound familiar?

Consequences of burnout affect the physician, the patient, and the healthcare system as a whole. Data indicate that physical conditions such as anxiety, depression, and even reduced cardiovascular health are exacerbated by burnout. For the patient, overall quality of care may be reduced due to an increased rate of medical errors, lower patient compliance with recommendations, increased malpractice rates, and overall lower patient satisfaction. At the organizational level, rising costs related to physician recruitment and retention, decreased productivity, and reduced morale are all negative consequences.

So, how can we move toward a state of physician well-being? There is no "right answer." In fact, the solution is multi-factorial. At an organizational level, the situation can be improved by increasing resources to primary care. Specifically, beneficial strategies include targeted training of ancillary personnel to help with physician administrative duties, and streamlined EHR processes. On a personal level, each physician must employ self-reflection to identify their biggest personal stressors. Then, it is possible to take a focused approach toward reducing burn-out.

Some obvious ways to increase personal well-being involve going back to the basics. Specifically, an emphasis on improving diet, exercise, and sleep habits has been shown to be beneficial. There is also evidence that mindfulness practices such as meditation, gratitude, and becoming aware of your inner critic can help with transition toward a more positive attitude.

It follows that studies support the act of volunteerism as a means to reduce burn-out. Commonly, volunteering can foster a feeling of 'making a difference.' It can serve as a distraction from personal stressors and help facilitate self-renewal. As an example, participation in medical brigades provides the opportunity to work with patients in high- need settings who are truly appreciative. Often in a low-resource area, there are reduced barriers to the doctor-patient relationship which allow for a more satisfying clinical interaction. Additionally, mission trips can reinforce a sense of gratitude and remind physicians of 'why they went into medicine in the first place.'

A meaningful quote from one of the studies used to prepare this article is: "People may volunteer for missions with the idea that they will provide necessary services to needy recipients. Yet, a common remark heard among those returning from such mission trips is 'I didn't realize how much I would benefit from doing this. I thought I was going to give to them, but actually they gave to me.'"

In conclusion, as the state of the COVID-19 pandemic improves and travel restrictions ease, consider participation in a medical mission brigade as a means to reduce burn-out. Speaking from personal experience, this type of trip can reinvigorate your love of medicine.

To explore one such opportunity, please visit missionCMEcuador.com for more information.

A warm hello to my fellow AAFP members!!

My name is Katherine Lynn Walker. I am a Board Certified Family Medicine Physician with over twenty years of clinical experience and over ten years of leadership experience on international medical brigades. I work in a private practice located in Boulder County, Colorado. And, I also serve as an Adjunct Faculty member at the St. Anthony North Family Medicine Residency in the greater Denver area.

I wanted to take this opportunity to introduce MissionCMEcuador, a program that I developed and presented at the AAFP Global Health Summit National Conference in 2020. In collaboration with the Ecuadorian Ministry of Health in Otavalo, this one-of-a-kind international opportunity allows US-based physicians to provide medical care in underserved areas of the Otavolo Canton, located in the Imbabura Province of Ecuador. In addition, it is possible to earn up to 30 CME credits as part of the program. Some of these credits may be obtained via participation in on-line courses prior to a trip, some will be earned in-country, and the remainder may be acquired through an optional teaching aspect of the program. In addition, the week-long program includes some tourist attractions, like visiting the "Mitad del Mundo" (or the "Middle of the World"), as Ecuador lies on the equator. Also, as a possible extension of the trip, the Galapagos Islands and Machu Picchu are nearby "bucket list" destinations.

Due to COVID, the trips have been suspended temporarily. However, there are plans to resume the program in 2022. If you are interested in learning more, please visit https://missioncmecuador.com for information on the program. I will respond personally

ABFM National Journal Club

NOW AVAILABLE

To help family physicians stay current with advances in medical literature, support shared decision making with patients and families, and advocate for their patients with subspecialists, health systems and payers, ABFM has launched the National Journal Club Pilot activity.

WHAT IS THE ABFM NATIONAL JOURNAL CLUB?

In addition to the Knowledge Self-Assessment (KSA) and Continuing Knowledge Self-Assessment (CKSA) activities, the ABFM National Journal Club Pilot activity is now available to all Diplomates and residents through your MyABFM Portfolio. This new service provides convenient access to the latest peer-reviewed articles and the ability to earn valuable certification points.

NATIONAL COMMITTEE OF FAMILY PHYSICIANS CURATED ARTICLE SELECTION

Reviewed and curated by a national committee of family medicine experts, the pilot will initially feature 40-45 articles that have been evaluated and ranked according to relevancy, methodological rigor, and impact on practice. Available at no additional charge, the articles will cover a variety of topics and feature relevant content from numerous prominent medical journals throughout the United States.

EARN KNOWLEDGE SELF-ASSESSMENT ACTIVITY POINTS

Select and read an article, reflect on what you read, and demonstrate mastery by correctly answering four assessment questions provided for each article. For each assessment completed, you will earn one (1) certification point toward your certification points requirement. Earn 10 certification points and fulfill your KSA requirement for each 3-year stage by completing 10 article assessments. There are unlimited opportunities to achieve a minimum passing score. If you have already completed your minimum certification activity requirement through other activities, you may still enjoy as many articles as you like through this free service.

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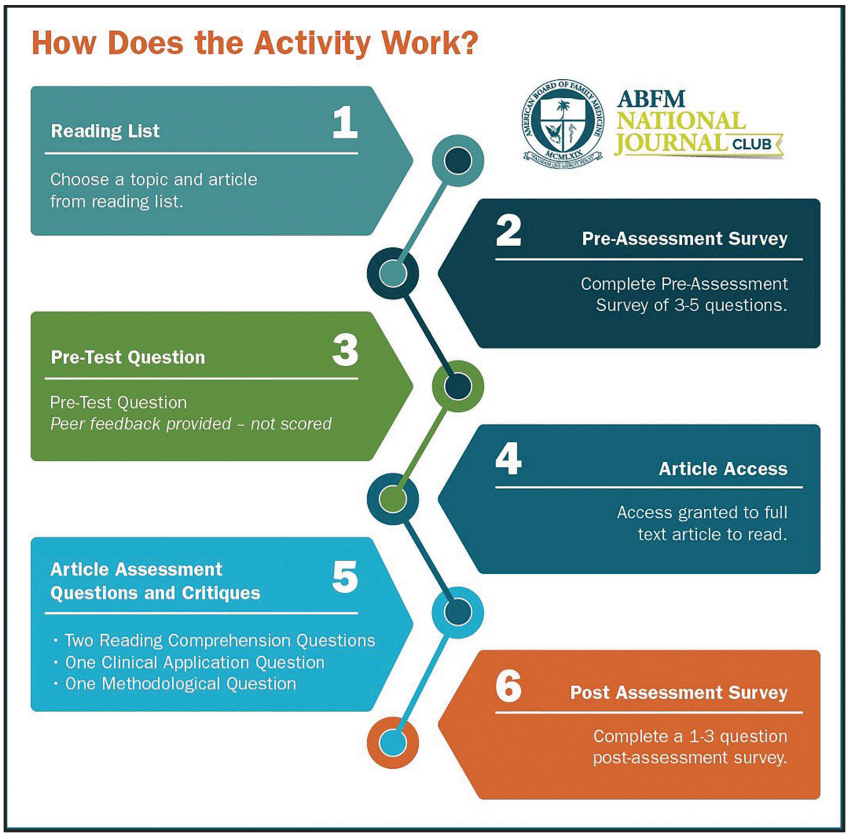

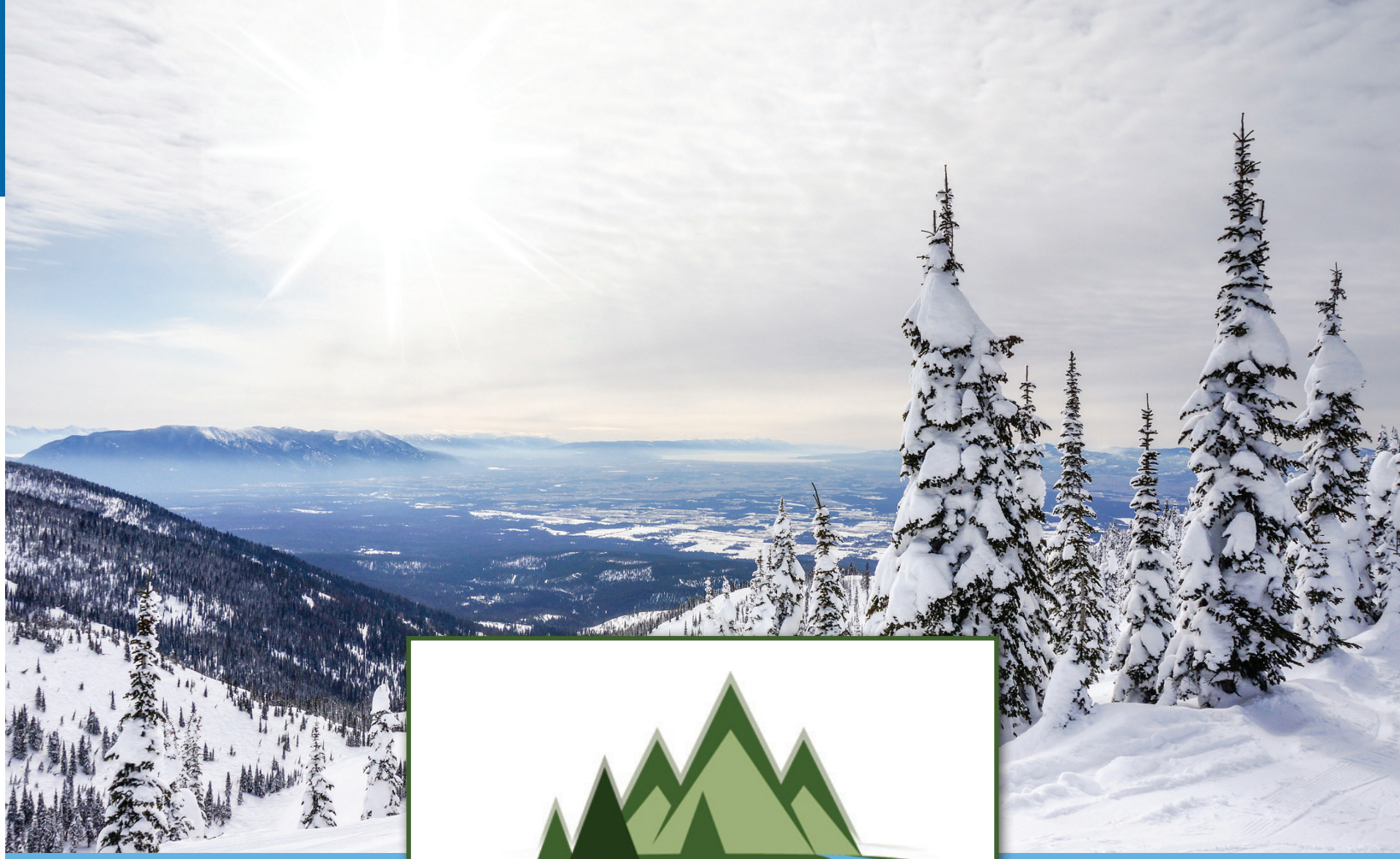

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