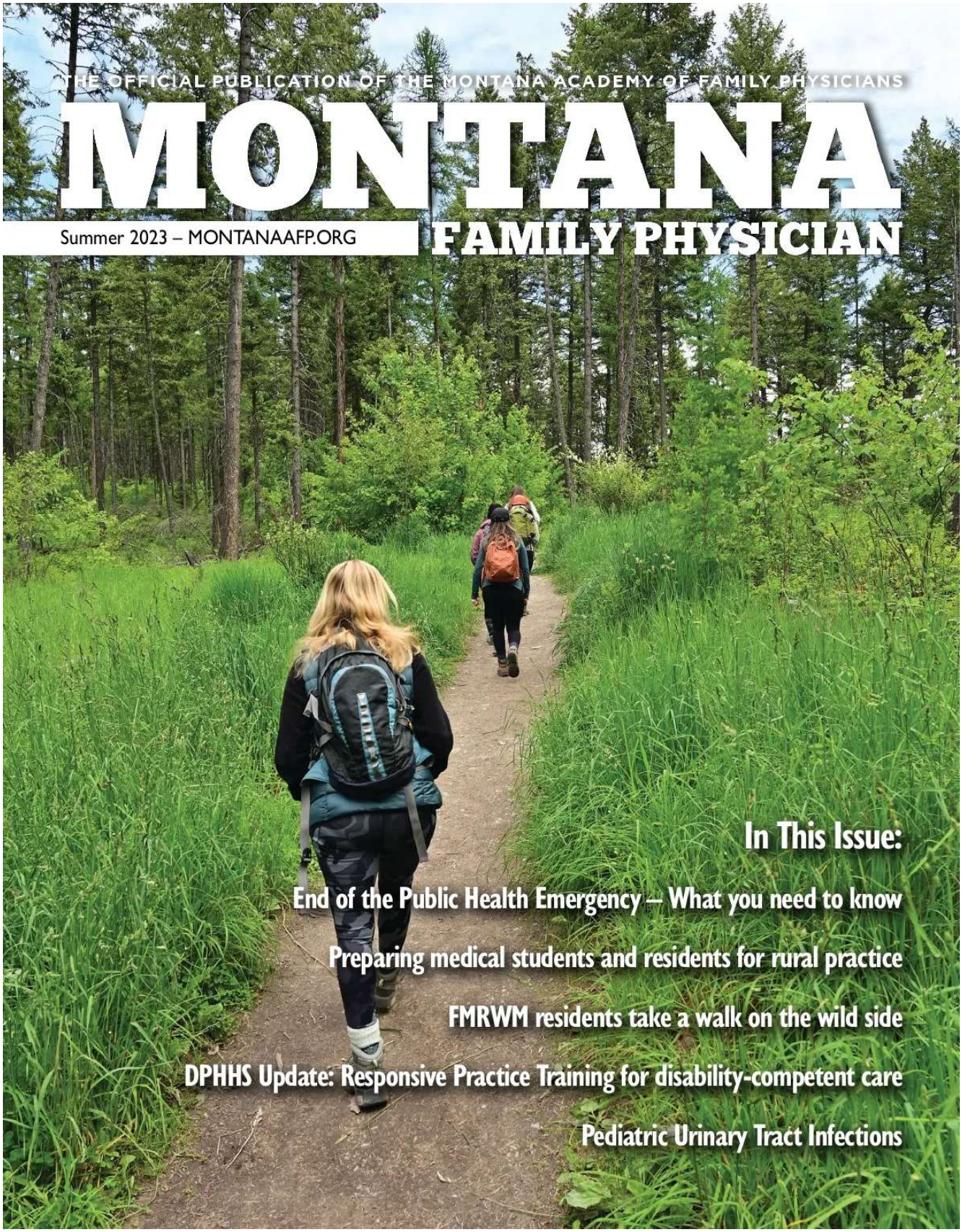
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In This Issue:
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MONTANA FAMILY PHYSICIAN

*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 17

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EDITION 17

MAFP President's Welcome

Heidi Duncan, MD, FAAFP

Greetings MAFP Friends,

I started to contemplate what to write for this message on a gray, gloomy spring day and realized that my initial reflections mirrored the weather. I was thinking about our state legislative session which has been challenging for healthcare on many fronts. I reflected on the significant financial stressors that healthcare is facing around the country and right here at home. I thought about four of my long-time patients that passed away in the last month. Three of those patients were at the end of long lives and had developed significant health challenges including dementia that made their passages sad but also brought an end to their suffering and their caregivers' stress. One patient passed away too early from metastatic colon cancer found on first screening colonoscopy.

After the initial grayness of my mood, I shifted to reflect on the bright spots in my week and decided to focus my message on those bright spots with thankfulness and appreciation. We all have moments when we get discouraged by aspects of the work we do each day, and it is easy for me to grumble about paperwork, a full inbox of messages, and grumpy people. However, I also think it is true for most of us in Family Medicine that the relationships with our patients are bright spots in our lives. My clinic is my "happy place". I love the relationships I have developed over 28 years. I love the opportunity to sit with my patients and listen to their stories, and to partner with them on their healthcare journeys. I have made a commitment to myself to be intentional in appreciation of my patients and my relationships with them. It keeps me engaged in my work despite the rocky moments and gray days.

I am also grateful for the incredible coworkers with whom I have the privilege to work every day in clinic and with my health policy work. Medicine is certainly a team sport and my teams bring joy to my day.

I am looking forward to spring and summer and sun and appreciating bright spots! I hope to see you in Chico for our summer meeting. Thank you for all the work that each of you do. I appreciate you.

Heidi

MAFP News

Pediatric Mental Health Care Access (PMHCA) Program Utilization Chapter Funding Awarded!

MAFP is excited to announce the chapter has been awarded funding to support PMHCA program utilization. Linda Edquest, Executive Vice President, will be partnering with MAPP-Net (Montana Access to Pediatric Psychiatry Network) over the next six months. The funding will support the following goals:

- Increase awareness of your PMHCA program, including additional REACH programming.
- Provide education and training to your state PCPs to effectively partner with your PMHCA program for teleconsultation and support.
- Support efforts to advance the sustainability of your PMHCA program.
- Build capacity among your state PCPs to support the mental and relational health needs of children, adolescents, and families.

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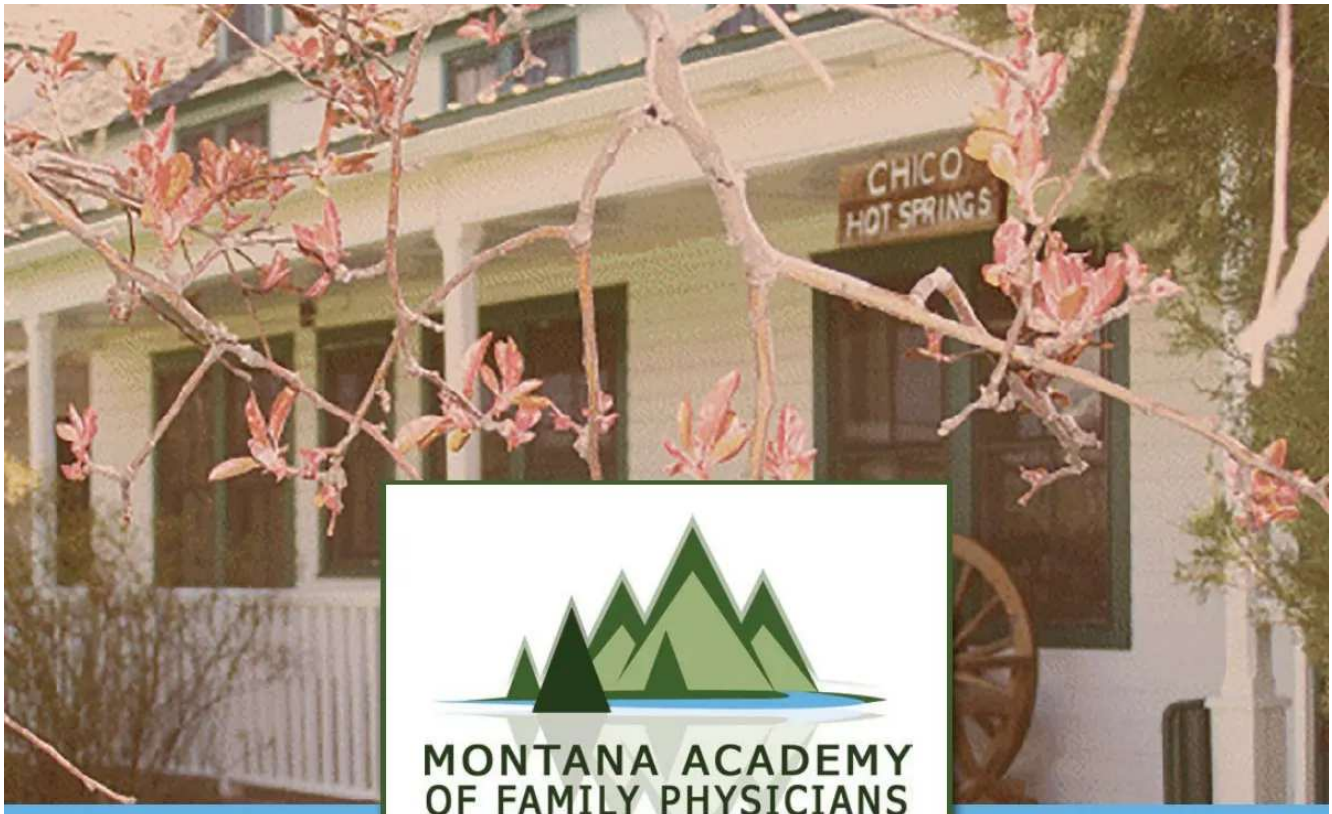
Are you interested in getting involved with the Montana Academy of Family Physicians Board of Directors or committees? Please reach out to our chapter executive, Linda Edquest, at linda@montanaafp.org, for more information.



MONTANA ACADEMY
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72nd Annual

Meeting and Primary Care Conference of the Montana Academy of Family Physicians

June 22-23, 2023

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Application for CME credit has been filed with the AAFP.
Determination of credit is pending

Board Member Profile

Jason Sarisky, DO
Miles City

I was born and raised in Livingston, Montana, and spent most of my childhood running around town long before A River Runs Through It and Yellowstone ever came along. You could say I was "Montana" before Montana was cool. I did all of the typical Montana things growing up – camping, hunting, fishing, and Chico Hot Springs!

After graduating from Park High, I fought fires for the Forest Service before heading off to Montana State University, where I studied Criminology. Shortly thereafter, I attended the Police Academy and then served as a law enforcement officer in different communities around Montana. I am proud to have helped start Livingston's Bike Patrol – a program that is still going strong to this day. At the same time, I owned and operated several businesses.

After over a decade in law enforcement, I decided to go back to school and become a physician. I wanted to serve my community in a different way – by helping to prevent bad things from happening instead of always "responding" after the fact. I had been an EMT and volunteer firefighter, and as part of my law enforcement duties I frequently responded to medical calls where I was often the first on scene and had to render life-saving first aid or CPR. This part of my job always made me feel valued and appreciated. Helping folks during medical emergencies was the impetus for me eventually becoming a physician.

I never grew up wanting to be a physician. In fact, heck, none of my family had ever even finished college! But I was determined. I gave up business and law enforcement and went back to school. I did this with two young children and an aging grandmother and worked full time as a tech at the hospital. It surely was not a walk in the park, but I was never deterred once I started down the path to pursue medicine. My grandmother always told me that I could do whatever I put my mind to, and I did!

I graduated from Montana State University and then from Pacific Northwest University of Health Sciences (PNWU) in Yakima, Washington. I chose to become a DO because I figured the more tools I had in my toolbox the better the overall care I could offer to my patients. I completed my Family Medicine training at the Montana Family Medicine Residency (MFMR) in Billings and started my first job as an attending physician with One Health in Miles City, which is where I practice today. I was recently appointed Clinical Instructor with the University of Washington's Department of Family Medicine. I also currently precept residents and medical students at MFMR on my "day off."

One could say that my journey to becoming a physician was not straight, but I cannot imagine being the physician that I am today without having had all of the life experiences that I had before medicine. These experiences have allowed me to bring a totally different perspective to medicine, which I feel benefits my patients not only in their physical health but also their social and spiritual health as well – truly in keeping with the osteopathic philosophy.

I have always supported the AAFP, even as a medical student, and when I was asked if I would be interested in serving on the MAFP Board of Directors, I was excited about the opportunity. I am passionate about protecting the patient-physician relationship. I also support and practice evidence-based medicine and will do whatever I can to do what's right for the patient.

Although I have a lot in my life to be proud of, I am most proud of my children. The oldest is incredibly intelligent and works in healthcare IT. The youngest just graduated from Navy Boot Camp. There is nothing I enjoy more than spending time with them. And I could never have become a physician without my amazing husband, who has been my best friend and strongest supporter for the last almost 20 years. My family is the foundation of my life, and my family doc journey would not have been possible without them.

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MT DPHHS Updates

MT Disability and Health Program

Responsive Practice: Inclusive Health Care Delivery Training

When it comes to delivering equitable healthcare to people with disabilities, most providers are not confident in their ability to do so.[1] Almost 14% of all non-institutionalized Montanans have a disability and increasing evidence shows they experience health care disparities.[2,3] It is vital for health providers to know how to respectfully support patients with disabilities. That is why the Montana Disability and Health Program (MTDH) at the Department of Public Health and Human Services (DPHHS) is promoting the Responsive Practice Training across Montana.

What is the Responsive Practice Training?

The Responsive Practice Training enhances health care providers' ability to deliver disability-competent care that is accessible to people with intellectual, mobility, and other disabilities. This is a 1.5-hour virtual self-paced training. It builds on knowledge you already have and identifies opportunities to maximize wellness for this population. Through the two modules you will learn strategies and approaches to identify, address, and help remove barriers to care. After you complete the training, technical assistance and resources will be available through MTDH.

What are people saying about this training?

The DPHHS Public Health and Safety Division School Nurse Consultant, Sara Howser-Burke, encourages other health professionals to take the training. Mrs. Howser-Burke understands how "the demands in healthcare can require us to be heavily task-oriented, to the extent that we start to think of people as tasks. This can help provide structure for clinical practice, but you may lose some of that genuine interaction and human respect. This training was a good refresher and reminder for bringing back individualized care and respect."

DPHHS Acting State Medical Officer, Dr. Maggie Cook-Shimanek completed and recommends this training, saying it was, "very well done. The best part is the training reflects realistic clinical scenarios and involves people using their own adaptive equipment. The training highlights that even simple modifications in the office and in practice can better accommodate people with different abilities."

How do I sign up for the Responsive Practice Training?

The Responsive Practice Training includes two modules that run about 1.5 hours in total. These modules include videos with interactive elements. Once you start a module, you should complete it within 24 hours, or the system will require you to start over. There is a separate link for each module. You may start them at any time.

1. Responsive Practice: Providing Health Care and Screening to Individuals with Disabilities.
   - Use the link: bit.ly/ResponsivePracticeMod1
   - Contact Hours: North Country Health Consortium/ NNH AHEC approved this activity for 1.0 AMA PRA Category 1.0 Credits™ and 1.0 Nursing Contact Hours (Activity #521).

2. Responsive Practice: Accessible and Adaptive Communication.
   - Use the link: bit.ly/ResponsivePracticeMod2
   - Contact Hours: North Country Health Consortium/ NNH AHEC approved this activity for 0.5 AMA PRA Category 1.0 Credits™ and 0.5 Nursing Contact Hours (Activity #522).

What will I take away from these trainings?

By the end of the training, you will be able to:

- Recognize health inequity and that people with disabilities may experience health disparities.
- Reduce barriers faced by people with disabilities and improve access to health care & preventive services.
- Presume competence to address the patient directly; respect privacy, autonomy, and individuality; and allow time for mutual understanding.
- Identify and use alternate methods of communication and set clear reasonable expectations.

After you complete the training, you can opt in to receive information from the Montana Disability and Health Program about options for technical assistance to improve the

accessibility and quality of care for patients with disabilities in your health care setting.

The Responsive Practice training was developed by the New Hampshire Disability and Health Program and updated in 2022 by a 10-state collaborative funded by the Center for Disease Control and Prevention (CDC). For questions, contact Mackenzie Jones with MTDH at Mackenzie.Jones@mt.gov.

References

1. Iezzoni LI, Rao SR, Ressalam J, Bolcic-Jankovic D, Agaronnik ND, Donelan K, Lagu T, Campbell EG. Physicians' Perceptions Of People With Disability And Their Health Care. Health Aff (Millwood). 2021 Feb;40(2):297-306. doi: 10.1377/hlthaff.2020.01452. PMID: 33523739; PMCID: PMC8722582.

2. Disability characteristics, Montana, 2016-2020 American Community Survey 5-year estimates. U.S. Census Bureau; 2020. Accessed December 29, 2022. https://data.census.gov/table?q=disability&g=0400000US30&tid=ACSST5Y2020.S1810.

3. Montana Behavioral Risk Factor Surveillance System. Behavioral Risk Factor Surveillance System Office, Montana Department of Public Health and Human Services; 2020. Accessed December 1, 2022

Brucellosis in Montana – What you need to know

Canine brucellosis is an infectious disease caused by a bacterium called *Brucella canis* (*B. canis*). Over the past year, canine disease prevalence has increased and there is a broader geographic distribution of dogs testing positive for *B. canis* throughout Montana.

Laboratory personnel, veterinarians, and animal caretakers are the groups with the greatest *Brucella canis* exposure risk due to the nature of their occupations. The most significant route of human *B. canis* exposure is through direct contact with canine birthing fluids, canine abortion products, or vaginal discharge from an infected dog, since higher concentrations of *B. canis* bacteria are found in these substances. Human exposures may occur when an individual is assisting with birthing or whelping and has direct contact with the bodily fluids from the infected dog or newborn puppies.

The risk of *B. canis* exposure in a household setting from simply touching a dog bowl or toy is low, especially if animal owners practice good hand hygiene following contact with a potentially infected canine. Parents should encourage good hand hygiene practices after interacting with household pets and ensure that items like food bowls and toys are kept out of reach of children who may mouth these objects.

Before breeding dogs, both the male and female dog should be examined by a veterinarian and tested for the disease. If there is a potential for exposure to birthing fluids, breeders should employ protective measures such as using gloves, eye protection, and covering abraded skin before contact with canine bodily fluids and implement appropriate handwashing and environmental cleaning measures after birthing is complete. Individuals should not administer mouth to mouth resuscitation to stillborn puppies. Children should be kept away from birthing animals to prevent potential exposures to contaminated materials.

Establishing the true prevalence of human *B. canis* infection is complicated by nonspecific clinical signs and symptoms, a low index of clinical suspicion by providers, and challenges related to diagnostic testing. The signs and symptoms of human *Brucella* infection may include persistent, intermittent, or recurrent fever, sweats, malaise, anorexia, headache, arthralgia, weight loss, arthritis, weakness, generalized achiness and lymph node enlargement. Signs of illness can occur within one week to several months after an exposure but occur an average of 2-4 weeks following infection. Individuals with a compromised immune system, including pregnant women, or persons with artificial heart valves, are at greater risk of developing severe symptoms if infected. Infants and children have a slightly higher exposure risk, given an immature immune system, mouthing behaviors, and inconsistent hygiene practices, such as good hand washing.

MTDPHHS cannot test for canine brucellosis in asymptomatic humans. Notify public health officials in your county immediately if you suspect a patient was exposed to or contracted brucellosis from a dog. State public health can coordinate with the Department of Livestock for animal testing purposes, which may help inform whether there is a need for human testing.

Additional resources can be found at Montana Department of Public Health and Human Services (https://dphhs.mt.gov/publichealth/cdepi/diseases/Zoonotic), Montana Department of Livestock (https://liv.mt.gov/Animal-Health/Reportable-Animal-Diseases/Brucella-canis), and the CDC (https://www.cdc.gov/brucellosis/pdf/brucellosi-reference-guide.pdf).

WWAMI Update

Med Students Given a Taste of Rural Medicine More Likely to Return

UW medical school alumni who had trained as medical students in rural areas were almost twice as likely to set up their practices in a rural location, a new UW Medicine led study has found. The study was published this month in the Journal of the Association of American Medical Colleges.

A survey of 1,172 UW School of Medicine alumni who graduated between 2009 and 2014 looked at the number who participated in the Rural Underserved Opportunities Program, or RUOP. The survey found that a significant number who participated in RUOP eventually established their practices in rural communities. Of the 1,172 graduates, the study tracked 994 UW medical school alumni in the analysis because their current physician work addresses could be traced after graduation.

Of those students, 570 participated in RUOP training, and 111 were currently working in rural communities after their training, the study found.

The researchers concluded that "educational programs are crucial public health interventions that can promote health equity through proper distribution of health care workers across rural regions of the U.S."

"This study provides a promising connection between the RUOP program and the medical graduates' decision to work in rural areas, said lead author Arati Dahal, a researcher with Center for Health Workforce Studies and the Department of Family Medicine at the UW School of Medicine. "If more funds are directed toward supporting such programs, and as well as steps such as robust scholarship opportunities directed toward attracting more medical students to enroll in programs like RUOP, it is possible to ameliorate the rural physician workforce shortage that has been a major concern for those involved in health care delivery in the U.S."

The study noted that "there is a broadly recognized and persistent rural physician shortage in the U.S. As of 2021, 61% of the designated primary care shortage areas were in rural areas. This rural physician workforce shortage shows no sign of ameliorating, the report stated, "especially considering the physician burnout with COVID-19 and the aging rural physician population."

"Compared to urban areas, the rural communities experience higher rates of chronic illness, more maternal and infant mortality, and lower life expectancies," the authors wrote.

Established in 1989, RUOP offers medical students a four-week rotation in rural areas of Washington, Wyoming, Alaska, Idaho and Montana. The students participate between the first- and second-year of medical school to get an early introduction to rural health care. While in the program, students work alongside a primary-care physician. They also learn about the local community, as well as complete a public health care project within the community.

The mean age of the medical students was 29 years, with 53.9% being female. About 70% were white. The students who grew up in rural areas were more likely to have been interested in participating in RUOP and to later choose to practice in a rural area, the review found.

Dahal stressed that one of the important limitations of this study is that the students were not randomized to RUOP and non-RUOP arms and therefore, the research could not definitively claim a truly causal relationship between RUOP and a decision to practice in rural areas. Nonetheless, she added, by using a robust statistical approach and controlling for demographic, initial interest and future career intent variables, the researchers were able to build a strong empirical connection between the medical students' participation in RUOP and their decision to work in rural areas of the country.

While most medical schools do not offer long-term rural programs in their curriculum, RUOP could be a model "and an example of how it is also possible for medical schools to create high-impact and influential rural training programs for a large number of students with a relatively small investment," the researchers said.

"The findings of this study emphasize that educational programs and policies are crucial public health interventions that can promote health equity through proper distribution of health care workers across rural regions of the country," the report concluded.

Rural Rotations Prepare Physicians For Rural Practice

By Dr. Garth Brand

The Montana Family Medicine Residency was established to train family physicians for Montana. Our mission really is around rural practice.

We have always incorporated opportunities for rural rotations into our residents' training. In the past two years alone, residents have done Montana rotations in Roundup, Columbus, Red Lodge, Miles City, Hardin, Polson, Livingston, Browning, Deer Lodge, Whitehall, Big Timber and Mammoth Hot Springs, which is just across the Wyoming border. Residents do rotations at family practice clinics in Billings in addition to RiverStone Health Clinics to gain understanding of how various practices work in different settings.

Now we are stepping up that small town experience with the addition of continuity rotations. Two years ago, Dr. Ashley Quanbeck, MFMR Class of 2010, became the preceptor for our new rural rotation at One Health in Hardin. Dr. Quanbeck also serves as CMO for One Health's network of Montana and Wyoming clinics. Last summer, two third-year residents, Dr. Yuri Brito and Dr. Christian Kilpatrick, completed one-month rotations in Hardin. They have since returned to One Health multiple days a month for continuity rotations.

We sent Drs. Kilpatrick and Brito out early in the year to experience the area and get to know some of the patients. My hope is that we can use this model for elective rotations plus continuity clinics for second- and third-year residents.

This is a pilot program that we hope to extend to other nearby clinics. Our continuity clinics are subject to the Accreditation Council on Graduate Medical Education requirement that continuing rotations involve no more than 60 minutes of travel one way. The Billings-Hardin commute is 45 minutes.

Dr. Quanbeck and I meet periodically to discuss the rotation. While in the Hardin rotation, our residents may see hospital patients with Dr. Quanbeck and they may have opportunity to see patients via telehealth. Dr. Orin Hansen also assists in precepting at OneHealth.

It's been really fun to see that growth in rural training. One Health is different than RiverStone Health Clinics, but has goals similar to our organization so it is nice to connect. Dr. Quanbeck has great insight. Residents naturally enjoy learning from her.

Dr. Kilpatrick has been staffing same-day clinics in Hardin where he sees patients with conditions such as COPD, diabetes, atrial fibrillation, heart failure and coronary artery disease that he has helped them manage over time. He has worked with Dr. Quanbeck in the Federally Qualified Health Center and in Big Horn County Memorial Hospital, which are several blocks apart.

"One of the biggest benefits on the full elective was to do both hospital and clinic," Dr. Kilpatrick said. "You have to prioritize clinic patients and hospital patients, inpatients and outpatients for continuity throughout the day. Your really have to prioritize what workups are needed today and what can wait."

"It gives you a good sense of what it's like to work in a rural community with limited resources. They also do more in-house procedures that we refer out, such as podiatry and wound care. The clinic's 30 minute-appointment schedule can be extended, providing more time with each patient and allowing me to do procedures."

Dr. Kilpatrick cared for a full range of patients, from pregnant women and newborns to elderly adults at One Health and Big Horn County Memorial Hospital.

"It is a fantastic opportunity," he said. "Anybody interested in doing rural clinic should check it out."

Dr. Brito's Hardin experience began with a three-week rotation at the end of summer 2022. He lived in a student house just three minutes from the clinic. Staying in the small community gave him the opportunity to jog around town and attend a high school football game.

For Dr. Brito, seeing more pediatric patients, especially school-age children, has been the most valuable aspect of his Hardin continuity clinic rotation.

"From a resident's point of view, the continuity rotation is a good way to expand my experience with different people," Dr. Brito said. "The pace of life and lifestyle adds to the breadth of experience."

The more time residents spend in rural areas, the more likely they are to choose to practice in rural communities. According a study reported in the *Journal of Graduate Medical Education*: "Rural exposure during family medicine residency training is associated with a five- to six-fold increase in subsequent rural practice with a positive dose effect for greater degrees of exposure, yet less than 10% of graduates experience any rural training during their residencies." (Russell 2022)

It is important to actually train residents in rural places, not only inside medical centers. The United States has been training more and more physicians, but we are not seeing more of those physicians choosing rural practice. We need to train physicians in rural areas, so they are more likely to stay.

Dr. Garth Brand, M.D., is executive director of the Montana Family Medicine Residency.

Reference: Family Medicine Residencies: How Rural Training Exposure in GME is Associated with Subsequent Rural Practice. Deborah J. Russell, MBBS, MClinEpid, PhD; Elizabeth Wilkinson, BA; Stephen Petterson, PhD; Candice Chen, MD, MPH; Andrew Bazemore, MD, MPH. *J Grad Med Edu* (2022) 14 (4):441-450. https://doi.org/10.4300/JGME-D-21-01143.1

FMRWM Update

Taking a Walk on the Wild Side:

Wilderness Medicine Training at the Family Medicine Residency of Western Montana

By Rob Cruikshank, MD and Jeff Walden, MD, FMRWM Faculty

Picture this – you lie in your sleeping bag on the shore of Lake Josephine after a hard day of hiking in Glacier National Park. Soft waves lap the shoreline near your tent, lulling you to sleep. But just as you drift off, screams rip through the night. You sit up and realize the sounds are coming from a campsite about a hundred yards away that you hiked past earlier.

You grab your headlamp and rush through the darkness, adrenaline coursing through your body. Flashlight beams bob through the trees ahead. You run towards the screams and burst into the campsite, only to be greeted by chaos. Directly across from you, about twenty-five yards away, the remains of a tent flap in the wind. Several shredded candy wrappers lie scattered about, but what holds your attention are the two people on the ground before you.

One, a young female, has been eviscerated and lies moaning as she attempts to hold in her intestines with her hands. Off to her side lies a young male. In the light from your headlamp you see bright arterial blood staining his pajama pants, rhythmically pumping from a gaping wound in his thigh. Even as you watch, the pumping begins to slow as his life ebbs away.

Two other college-aged campers turn when they hear your approach. Eyes wide with shock and fear, together they shout one word: "Bear!" And then: "Please, help us!"

How prepared would you be for this situation?

Well, if you had graduated from the Family Medicine Residency of Western Montana (FMRWM)'s Wilderness Life Support course, a simulated bear attack would have been just one of several scenarios you would have experienced during your training.

The course forms just one of the tenets of FMRWM's wilderness medicine curriculum, designed to push family medicine doctors beyond their comfort zones. What exactly is wilderness medicine? Although not well defined, the term "wilderness medicine" has historically meant the prevention and treatment of injury and illness in a wilderness setting [1]. Seemingly straightforward, such a definition belies the range of wilderness medicine. A quick glance at any wilderness medicine textbooks reveals just how broad this discipline is, encompassing everything from water purification to wild animal attacks, lightning strikes, high altitude medicine, dive medicine, survival scenarios, travel medicine, and much more.

Such a thorough base of medical knowledge means that wilderness medicine aligns well with primary care [2]. Much like the improvisation encountered during a typical day (or even single patient visit) in clinic, adaptability and spontaneity are key aspects of wilderness medicine [3]. Moreover, as interest in travel to

remote areas grows—whether in the United States or elsewhere—family physicians are increasingly asked to screen and provide health recommendations for those traveling into the field [4]. Having a working knowledge of the concepts of wilderness medicine can help physicians provide the best care for their patients regardless of setting.

Because of this, here at FMRWM we have developed a unique wilderness medicine curriculum that exposes interested residents to a spectrum of wilderness skills. What began with the vision of Dr. Darin Bell and the support of founding program director Dr. Ned Vasquez has morphed into an entire, year-long curriculum for residents that includes three separate "wilderness weekends," time set aside for wilderness medicine topics during our weekly didactic sessions, and the ability to gain certification in an advanced life support wilderness course.

The wilderness weekends form the core of our curriculum. Three times a year a group of adventurous residents, faculty, and staff head out for a long weekend at a nearby state park. Each season provides its own focus—orienteering, heat illness, and submersion injuries in the summer followed by a focus on hypothermia, reading snow packs, and avalanche search and rescue in the winter—but the structure of the weekends remains the same. Thursday evening consists of telling stories and sipping beverages, combined with vocal and guitar performances or fun board games by the light of gas lanterns. Fridays and Saturdays are spent learning outdoor medical and survival skills through a mix of hands-on activities and discussions. Most wilderness weekends culminate on Sunday morning with a MedWAR-style race where teams use their newly acquired skills and compete to rescue a familiar faculty member with a penchant for poor decisions in the outdoors. Femur fractures, gushing wounds, and C-spine injuries abound. Is the scene safe? Don't forget your MARCH assessment! Stabilize those injuries and carry the patient to the nearest helicopter pickup site a few hundred yards away. A tarp, rope, and daisy chain will help.

We've found that wilderness weekends aren't complete without a few unplanned challenges. Whether it's paddle boarding for hours back to camp against a stiff headwind, a "simple" three-hour hike that became a seven-hour saga, or rock climbers who get over their heads, even leisure time can turn exciting. Impromptu feats of strength involving throwing heavy things have become campfire legend (shout out to Dr. Dan McCarthy).

Besides the fun of our wilderness weekends, we augment the curriculum with designated times for wilderness medicine during our didactic curriculum. During both didactic sessions and our weekends, we practice survival skills like building emergency shelters, tying knots, or discussing water purification. On the medical side we focus on patient assessment, wound management, splinting fractures, and transporting patients in the backcountry. Ever wondered what to bring in your medical kit? We've got an answer—or several—for you!

Rounding out our curriculum, every 18 months we offer certification through the Wilderness Life Support (WLS) course, previously known as Advanced Wilderness Life Support. During our most recent weekend this past February, fourteen residents and faculty completed the hybrid WLS course. Six hours of online pre-course learning preceded twenty hours of hands-on training, during which learners experienced the simulated aftermath of the bear attack mentioned above (with ketchup aplenty) as well as mass casualty lightning strikes, fallen rock climbers, avalanche burials, and hypoglycemic runners.

Wilderness medicine training pairs well with overall family medicine training. Whether it's time during didactics learning about lightning strikes or a weekend of learning, fun, and connection, our wilderness medicine curriculum is the perfect prescription to combat the stresses of residency training, while also preparing for a lifetime of safer adventuring outdoors.

References:

1. Alexander W, Bright S, Burns P, et al. Wilderness Medicine, *Medical Clinics of North America*. 2016;100(2):345-56.
2. James Buchanan https://www.statpearls.com/ArticleLibrary/viewarticle/31765. Access March 20, 2023.
3. Freer, L. Wilderness medicine. *The Lancet*;Volume 362:s6 - s7
4. Freedman, DO, Chen LH, Kozarsky PE. *N Engl J Med*. 2016; 375:247-260

Updates from the American Academy of Family Physicians

Public Health Emergency Ending: 6 Things to Know

With the COVID-19 public health emergency set to expire on May 11, the AAFP is preparing members for coming changes and working to preserve innovations that have helped family physicians protect their patients and their practices through the pandemic.

New policies that arose under the PHE touch nearly every part of family physicians' practices, from patients' ability to access care to the payment physicians receive. That's why the AAFP is navigating this transition using a two-pronged approach: ramping up advocacy that has already brought wins, and helping members adjust as they maintain thriving practices.

Here are six key points family physicians should know at this stage of the PHE wind-down:

1. Federal Vaccine Purchase and Distribution Will Continue for a While

Although COVID-19 vaccines will eventually move to the commercial market, the timing will not be tied to the end of the PHE. The administration has said that after May 11, the federal government will continue purchasing and distributing COVID-19 vaccines, meaning physicians can continue to order them for free and patients can still expect to receive the vaccines without out-of-pocket payment through private and public health plans.

As patients' trusted partners in care, family physicians are in the best position to administer these vaccines. The AAFP is emphasizing this point in advocacy to ensure family medicine practices will be able to buy vaccines at reasonable prices and will be paid fairly for administering them once they move to the commercial market — likely in late summer or early fall.

2. Medicaid Beneficiaries Are Losing an Important Safeguard

The Families First Coronavirus Response Act had required Medicaid programs to keep beneficiaries continuously enrolled. That protection ends on April 1, when states will be able start disenrolling those who no longer meet eligibility requirements.

Congress and CMS created some guardrails that will protect beneficiaries and help those who lose Medicaid benefits enroll in other coverage. The AAFP is also pressing for more changes that would help preserve patients' access to care, including better physician payment and fewer administrative burdens.

3. Telehealth Flexibilities Will Continue

The pandemic ushered in telehealth flexibilities that helped family physicians keep their communities safe when many people were uncomfortable with face-to-face visits.

Because the move carried other benefits, such as making it easier for patients with transportation challenges to see their family physician, the Academy made a strong case that these flexibilities should outlast the PHE.

The advocacy paid off with legislation that keeps Medicare telehealth flexibilities, including coverage and payment of audio-only encounters, in place through 2024, as well as a proposal from the Drug Enforcement Administration to continue allowing some prescribing via telehealth. The Academy is preparing detailed comments on that proposed rule.

4. A Boost to the FP Pipeline Is at Risk

The PHE also brought a change that helped family medicine build a stronger workforce: an expanded "primary care exception" that allowed all levels of Medicare outpatient evaluation and management visits, as well as several other services, to be furnished independently by residents and billed by their teaching physicians as long as they reviewed the care provided.

The AAFP is fighting hard to keep this rule in place even after the PHE expires as a way to maintain the robust residency training and deep patient-physician relationships that are essential to a strong primary care-centered health care system.

5. Family Medicine Is at the Table to Address Long COVID

The AAFP has made it clear that primary care must be at the center of any effective plan to address long COVID, even after the PHE winds down, and the administration responded with proposed funding for research and treatment that lines up with this advocacy.

Now the Academy is making sure family medicine has a key role in the country's response to long COVID, and that patients can get the care they need.

6. Family Physicians Can Count on Help Navigating Changes

Watch aafp.org for tools, tips and advocacy to help members succeed as the full scope of the post-PHE landscape takes shape.

In addition, an HHS fact sheet explains how the transition will affect many changes that were rolled out during the pandemic. The *Federal Register* has also published guidance on the end of the PHE, and the Association of American Medical Colleges offers related information about residency supervision and payment issues.

Updates from the American Academy of Family Physicians

AAFP Family Medicine Advocacy Rounds

AAFP Applauds Proposed Prior Authorization Rules from CMS

Why it matters:

The AAFP supports two recent proposed rules from the Centers for Medicare and Medicaid Services (CMS) that mark a significant step toward addressing the harms caused by prior authorizations. If finalized, these rules would bring much needed administrative simplification for physicians while reducing care delays for patients.

What we're working on:

- The AAFP has repeatedly called for streamlined prior authorization to alleviate physician burden and lessen care delays. To that end, we provided comprehensive comments on a related proposal to automate prior authorization processes across payers by 2026.
- The AAFP is also encouraged by CMS's proposal to address inappropriate denials of prior authorization in Medicare Advantage and to require Medicare Advantage organizations to adopt evidence-based, publicly accessible coverage policies.
- The AAFP is hopeful these policies will advance timely, equitable access to care for beneficiaries and urged CMS to apply the same principles to prescription drug coverage across payers. AAFP leaders went to Capitol Hill this month to urge Congress to reintroduce and pass the Improving Seniors' Timely Access to Care Act, which would codify some of these policies into law and protect Medicare Advantage patients from unnecessary delays in care for years to come.

AAFP Recommends Action to Prevent SUD Care Disruption

Why it matters:

Among the many AAFP wins in the Consolidated Appropriations Act of 2023 was the removal of the X-waiver—an administrative burden that hindered access

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AAFP Updates

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to life-saving medications for treatment of opioid use disorder (MOUD). The same legislation requires SAMHSA and the DEA to implement a new training requirement for all licensed prescribers of controlled substances.

What we're working on:

- The AAFP recently sent recommendations to SAMHSA and the DEA, urging them to:
  - Accept qualifying educational offerings that are certified under the AAFP credit system, the primary source of continuing education for nearly 130,000 family physicians
  - Clarify that clinicians who have already completed safe prescribing and SUD treatment training will not have to complete duplicative trainings to satisfy new training requirements.
  - Ensure training and reporting requirements do not cause care disruptions or significant administrative burden.

Match Day 2023: AAFP Welcomes Largest Family Medicine Class in History

Why it matters:

Primary care is the only health care component for which an increased supply is associated with better population health and more equitable outcomes. Despite the significant role that primary care plays in our health system, primary care accounts for a mere 5% to 7% of total health care spending. Last week marked history for family medicine, with more than 4,530 positions filled in family medicine—the largest ever. While we celebrate this milestone, we will still need up to 48,000 additional primary care physicians by 2034. The AAFP has long advocated for policies that invest in the primary care workforce to meet the diverse needs of our growing and aging population.

What we're working on:

- The AAFP has collected interviews with AAFP SVP of Education, Inclusiveness, and Physician Well-Being, Dr. Margot Savoy, MD, MPH, AAFP VP of Education, Karen Mitchell, MD, FAAFP, and Richard Easterling, Student Representative to the AAFP Board of Directors and visit our media resource center. **Media outlets are free to use these interviews for broadcast or publication with credit to the AAFP.**
- AAFP leaders visited Capitol Hill this month to encourage policymakers to invest in programs that bolster the primary care workforce. We're pleased Congress has reintroduced the Conrad 30 & Physician Access Act, which allows foreign doctors studying in the U.S. to remain following their residency in exchange for practicing in medically underserved areas and ensures timely access to care.
- The AAFP submitted testimony for last month's Senate HELP Committee workforce hearing and responded to the Committee's request for information to identify policy solutions to address the growing health workforce shortages. The AAFP's testimony and RFI response outlined several recommendations to invest in the primary care workforce, including:
  - Strengthening and investing in federal graduate medical education programs
  - Diversifying the physician workforce
  - Addressing the burden of medical student debt
  - Supporting physician-led, team-based care and the integration of behavioral health and primary care
  - Enacting telehealth policies that extend the capacity of our health care workforce
  - Stopping anti-competitive contracting practices that harm clinicians and patients

AAFP Applauds MedPAC Action on Medicare Physician Payment

Why it matters:

MedPAC released one of its two annual reports on March 15 that included recommendations to improve Medicare Physician payment. The AAFP is particularly pleased MedPAC recommended a 2024 payment update to address rising practice costs and that they recommended Congress enact add-on payments for physicians caring for low-income beneficiaries.

What we're working on:

- The AAFP joined the American Medical Association and other physicians across specialties urging Congress to enact a Medicare physician payment update that fully accounts for inflation and rising practice costs. That means a payment update at least equal to 100% of the Medicare Economic Index.
- This month, AAFP leaders engaged with lawmakers on Capitol Hill to advocate for a sustainable Medicare payment system and conveyed how Medicare cuts place significant strain on family physicians and undermine progress toward value-based care. Sustainable annual updates to the Medicare physician fee schedule are a critical precursor to advance health equity and improve access to care.
- The AAFP continues to advocate that the annual threat of Medicare cuts underscore the urgent need for Congress to prioritize reforms to the Medicare physician fee schedule – which is the only Medicare payment system lacking an annual inflationary update.

Proposals in POTUS's Budget Reflect AAFP Advocacy Priorities

Why it matters:

The president's FY 2024 budget includes important investments in primary care, including no-cost coverage of primary care and behavioral health visits, investments in the primary care workforce, and ensuring affordable health coverage for all. The AAFP has long advocated for many of these priorities and looks forward to working with Congress as it finalizes the FY 2024 federal budget.

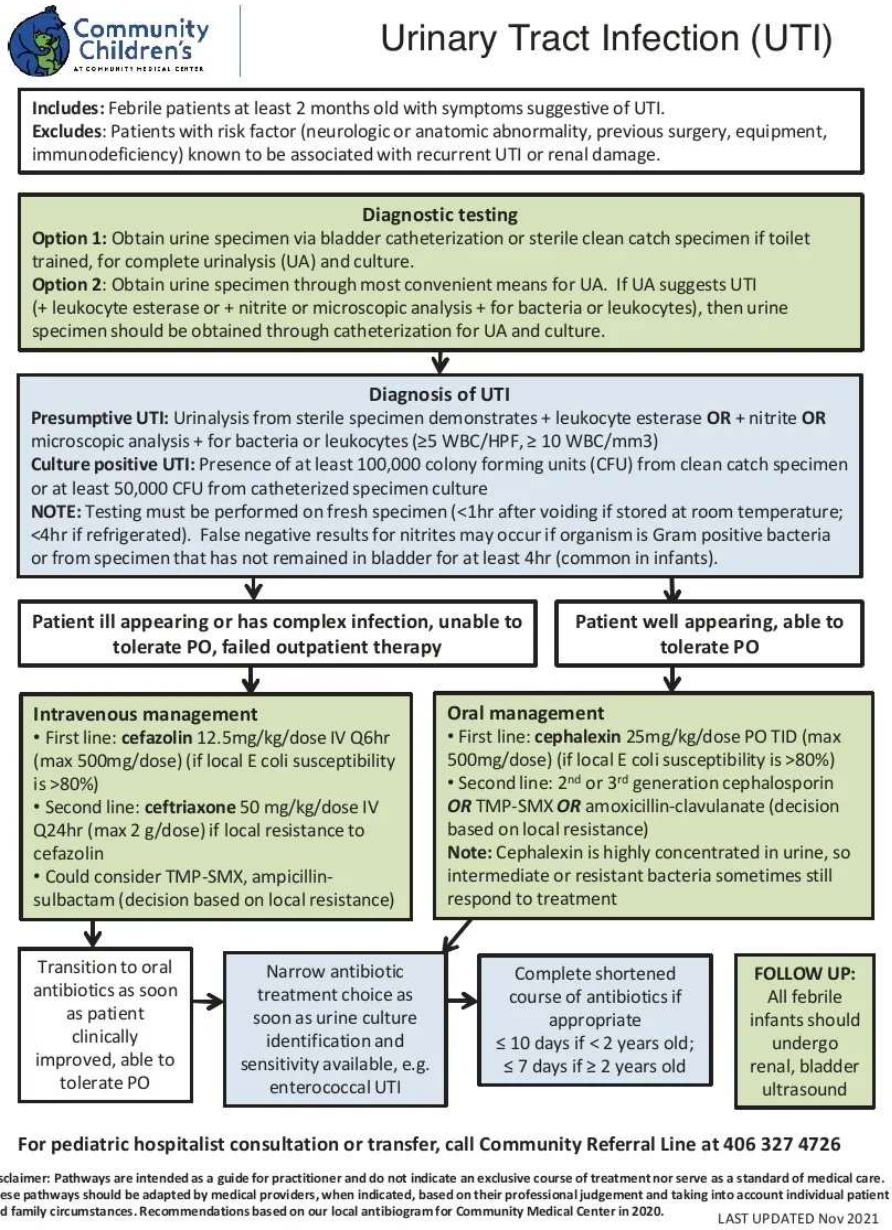
For the latest policy updates impacting family medicine, follow us at @aafp_advocacy.

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.



Learn more about Hep C testing/treatment and HIV prevention

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ABOUT THE PROJECT ECHO SESSIONS

ECHO participants engage in a virtual community with their peers where they share support, guidance and feedback.

During an ECHO session, participants present real (anonymized) cases to the specialists — and each other — for discussion and recommendations. Participants learn from one another, as knowledge is tested and refined through a local lens.

ECHO sessions help close gaps in care, ensuring that high quality treatment can be delivered to the underserved in geographically remote areas, such as rural and tribal Montana.

SESSION INFORMATION

Sessions are held the 1st and 3rd Tuesdays of each month at noon **via Zoom**.

FOR INFORMATION OR TO REGISTER

SCAN ME

umt.edu/ccfwd/training/projectecho/

Questions?
Contact Stacie Pannell, RN, BSN
stacie.pannell@umontana.edu

Project ECHO

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In support of improving patient care, this activity has been planned and implemented by University of Montana Center for Children, Families and Workforce Development and Project ECHO. Project ECHO® is jointly accredited by the Accreditation Council for Continuing Medical Education (ACCME), the Accreditation Council for Pharmacy Education (ACPE), and the American Nurses Credentialing Center (ANCC), to provide continuing education for the healthcare team.

AMA Designation Statement
Project ECHO® designates this live activity for a maximum of 1.0 *AMA PRA Category 1 Credit™*. Physicians should claim only the credit commensurate with the extent of their participation in the activity.

ANCC Designation Statement
Project ECHO® designates this live activity for a maximum of 1.0 ANCC contact hour. Nursing contact hours will be awarded for successful completion of program components based upon documented attendance and completion of evaluation.

PA AAPA CATEGORY 1 CME

AAPA Credit Designation Statement – Live
Project ECHO has been authorized by the American Academy of PAs (AAPA) to award AAPA Category 1 CME credit for activities planned in accordance with AAPA CME Criteria. This activity is designated for 1.0 AAPA Category 1 CME credit. PAs should only claim credit commensurate with the extent of their participation.


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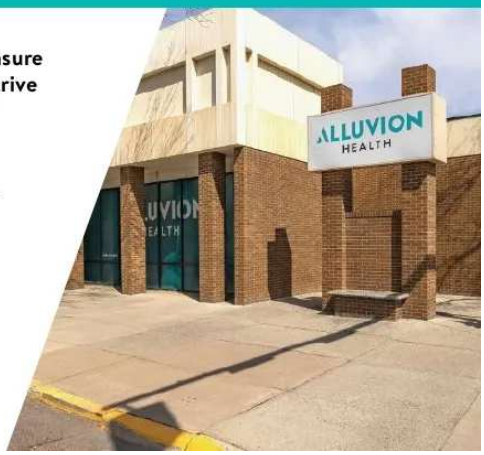

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