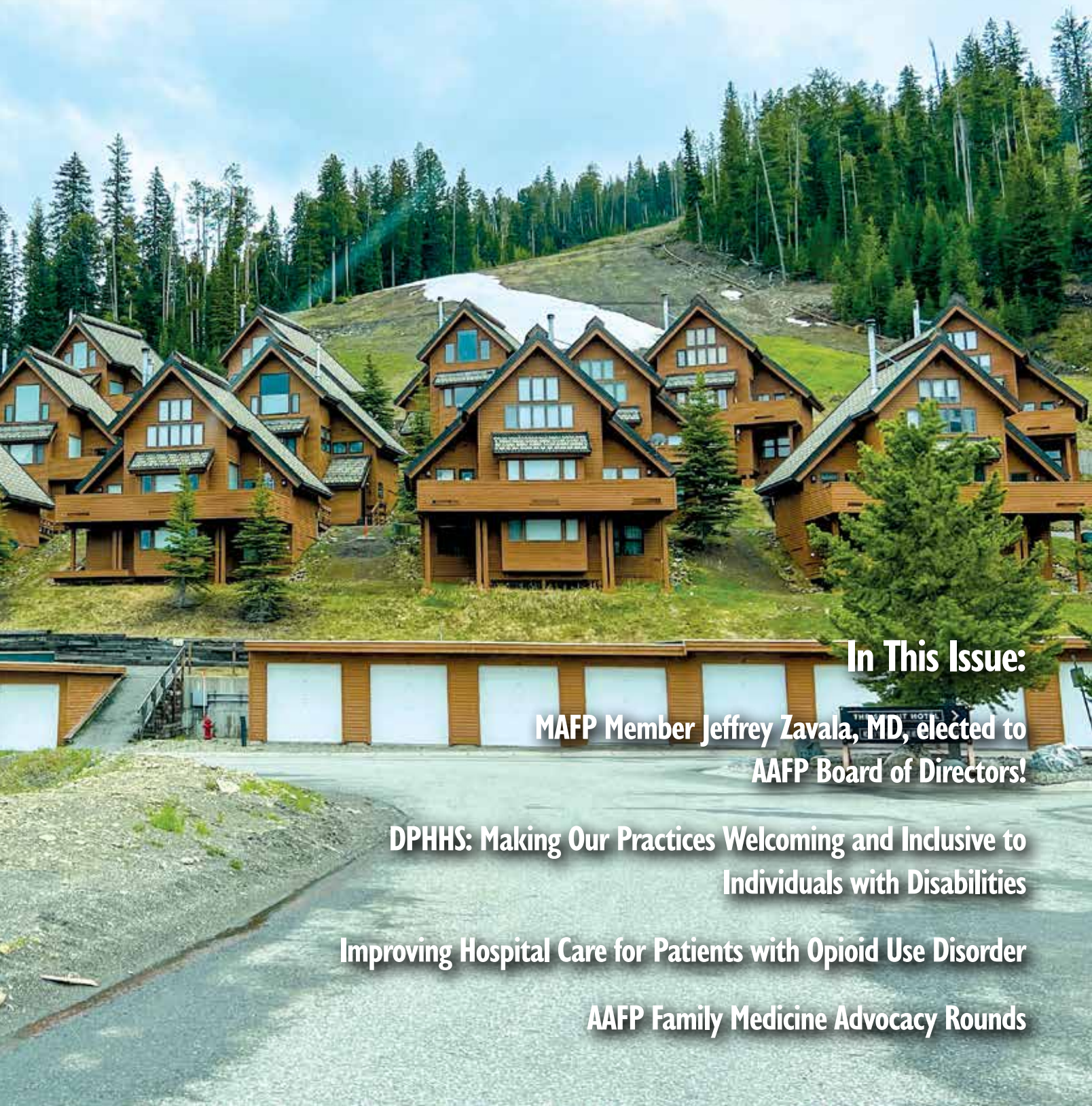
THE OFFICIAL PUBLICATION OF THE MONTANA ACADEMY OF FAMILY PHYSICIANS

MONTANA FAMILY PHYSICIAN

Winter 2023 – MONTANAAFP.ORG



In This Issue:

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MONTANA ACADEMY OF FAMILY PHYSICIANS

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*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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dbrown@pcipublishing.com
1-800-561-4686 ext. 103

For advertising info contact
Victor Horne
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Edition 19

MAFP President's Welcome

Family Gatherings Upcoming

Michael Strekall, MD, 2023/2024 MAFP President

By the time you read this edition of the Montana Family Physician, our national family of leaders will have met in Chicago at the national convention and Congress of Delegates. We will have a new president of the AAFP, Dr. Steven P. Furr, MD, and three new board members will be elected, including Dr. Jeff Zavala, one of our own from Montana. Jeff has been a leader for many years both nationally and in the Montana Academy of Family Physicians. Our family doctor members and the interests of our patients will be well served with him participating at the national board level. Please contact him or any of your Montana board members with questions, suggestions, and opinions that you may have.

In the last edition of this publication, I suggested taking time away from the rigors of busy practices and taking time to get rejuvenated in our personal lives. Has that been a priority for you? We give this type of advice out freely to our patients and even to our colleagues, but are we actively engaging in this healthy lifestyle for personal balance? Prevention of burnout is imperative for each of us to survive the current and future changes in medicine. As a group, doctors have much higher suicide rate when compared to other professionals. Please don't wait to get into a desperate situation before noticing that you have dug yourself into a hole. It takes a genuine and caring person to seek professional assistance for oneself; making time for yourself is a vital step in the right direction. We, family physicians, need to be healthy in body, mind and spirit to enjoy our practices and the family that surrounds us.

Looking to the future, it is time to book your reservations at the Lodge at Whitefish Lake for the annual MAFP winter meeting, January 24-26, 2024. Dr. John Miller has organized another great CME meeting, which is coupled with world class skiing at Big Mountain. We will have morning and evening lectures, with several opportunities to reconnect with other Family Doctors and the speakers who are doing the CME presentations. This is a location to bring the family, enjoy outdoor activities either on the mountain or in Whitefish, relax away from the office, and learn new information for your practice of medicine. PLEASE JOIN US IN JANUARY!!

Save the Date!

MONTANA ACADEMY OF FAMILY PHYSICIANS

Presents The 64th Annual

Big Mountain Medical Conference

Jan 24-26, 2024

The Lodge at Whitefish Lake Whitefish, Montana

Register on line at:http://www.montanaafp.org

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

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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.

ADOPT A PATIENT-CENTERED APPROACH

Create an Inclusive Environment for Your Transgender Patients.

Many transgender people face stigma and discrimination in their daily lives that put them at increased risk of HIV and prevent them from accessing HIV services they may need.

By adopting a patient-centered approach, you can help reduce your transgender patients' barriers to HIV prevention and care. The Centers for Disease Control and Prevention recommends the following steps to create a welcoming environment in your practice:

- Politely and privately ask all patients for their correct name and pronouns.
- Use inclusive language on your intake forms, such as transgender and nonbinary gender options.
- Include images of transgender people of various races and ethnicities in your marketing and educational materials.
- Implement a policy that allows people to use the bathroom that matches their gender identity.

For resources on delivering patient-centered HIV care to your transgender patients, visit: cdc.gov/TransformingHealth.

CDC

LET'S STOP HIV TOGETHER

Ending the HIV Epidemic

Board Member Profile

Alec Kerins, MD, PGY3

- I grew up in Helena, MT – spent most of my childhood on the soccer field and raising livestock for 4-H
- Attended Lewis & Clark College in Portland, OR. After graduating, joined Teach for America and taught high school Biology in the San Francisco Bay Area
- Spent the next 9 years in education – Director of Education at ExplorationWorks (Helena, MT), Biology teacher and department chair at KIPP Denver Collegiate (Denver, CO), Assessment Specialist for Denver Public School District (Denver, CO)
- Attended the University of Colorado for Medical School. Was part of the Rural Track, spending most of my clinical rotations in rural communities around Colorado
- Served as co-president of the Student Chapter of the Colorado Medical Society – focused on providing opportunities for medical students to engage in advocacy and policy. Also held several leadership roles within the CU Family Medicine Interest Group throughout the 4 years of medical school
- Returned to Montana for Residency. Currently a 3rd year family medicine resident at the Family Medicine Residency of Western Montana in Missoula.
- Currently serving my second year as a Resident on the MAFP Board of Directors
- I am passionate about ensuring all individuals, regardless of zip code or socioeconomic status, have access to high quality medical care. Special areas of interest within Family Medicine include HIV/HepC care, Policy, Emergency Medicine, Inpatient Medicine, Integrative Medicine
- Will be working at Ruby Valley Medical Center starting in August, 2024 – scope of the role includes outpatient, inpatient and emergency room coverage
- Married to Tashia who is a School Counselor in Twin Bridges, MT. I have two sons, Summit (5) and Lark (3) who are ecstatic to be living in the Ruby Valley. Personal interests include trail running, fly fishing, downhill and cross country skiing, camping. As a family we enjoy traveling and spending as much time as possible outside.

Fishing with Lark on the West Fork of the Bitterroot River

With Summit and Lark in the Ruby Valley

Trail running with Tashia up St. Mary's Peak

Trail running up St. Mary's Peak

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2023-2024

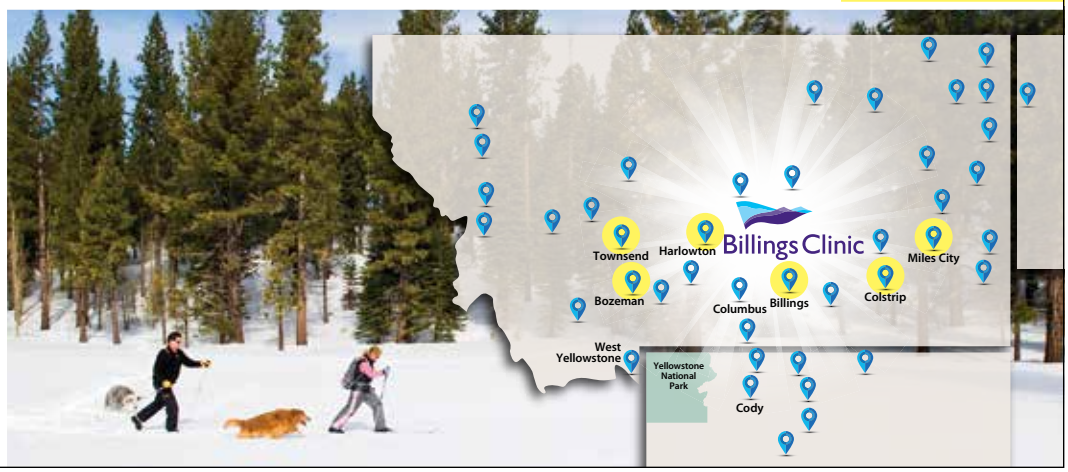
Family Medicine Opportunities

Our physician-led, independent, non-profit health system provides a collegial network of regional physicians and APPs, with 80+ specialties to support you.

- Stipend, starting bonus, loan repayment available depending on location
- Teaching opportunities with medical students and residents
- The only ACS-verified Level I Trauma Center in Montana (Billings)
- Regional aeromedical transport, specialty outreach and telehealth support
- FM with OB care at Miles City site currently
- Our many locations offer a variety of practice styles in friendly communities with amazing outdoor recreation in your backyard. ***You can make a difference here.***

Frontier Critical Access Hospital Fellowship

Apply now to begin August 2024! Trailblazing 1-year **fellowship with MT Family Med Residency** prepares recent grads for rural & frontier medicine.



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MAFP Congratulates Jeff Zavala, MD on AAFP Board Election!

MAFP delegation at the Candidate Hospitality Event

Every year the Congress of Delegates (COD), the policy making body of the American Academy of Family Physicians (AAFP), elects the leadership of the Academy. Our AAFP Board of Directors is led by the Board Chair who is also the immediate past president, the President, and the President-Elect. Joining these leaders are the Directors who are elected by their peers for three-year terms. Each year, three directors are elected by the Congress. They are joined by the Speaker, Vice Speaker and three other directors (Student, Resident and New Physician directors) who serve one-year terms and are elected by their peers at the Resident and Student Conference, and the National Conference of Constituency Leaders (NCCL). The Board of Directors meets four times a year to discuss and act on the business of the Academy as well as the resolutions passed by the Congress of Delegates, and they serve as the face and voice of the AAFP along with our Executive Vice President/CEO. We have had the opportunity to meet many of our stellar Family Medicine leaders over the years at our Montana annual meeting.

The AAFP Congress met in Chicago on October 25-27, 2023 and the Montana Academy (MAFP) had the privilege to run a candidate for the Board of Directors. Dr. Jeff Zavala of Billings has been involved in work of the AAFP since medical school, and we were pleased and proud to support his successful candidacy. The process of running for the Board and the commitment of time and energy to the role is significant and we appreciate Dr. Zavala's service and commitment.

MAFP delegates and officers at the Congress of Delegates

Jeff brings important perspectives to the Board as he has practiced full-scope rural Family Medicine in Red Lodge, obtained certification in Sports Medicine, completed a fellowship in endoscopy and operative obstetrics and practiced in a multispecialty group practice in Utah for five years before returning to Montana to become the Chief Medical Officer for the medical group at St. Vincent Hospital. He is currently the CMO for Montana and Northern Wyoming for SCL Health – now Intermountain Health Medical Group. His platform for his campaign is simplifying the practice of medicine by reducing the daily burdens of things such as preauthorization, charting for reimbursement, and time-consuming payer credentialling, and in bringing the joy back to practicing family medicine. Visit https://www.aafp.org/about/meet-our-leadership/candidates/get-to-know/board-candidates/cand4.mem.html to read more about Dr. Zavala, including his personal statement for his candidacy, biography, and CV. His fellow director candidates were Dr. Brent Smith of Mississippi and Dr. Sarah Sams of Ohio.

The MAFP delegation supported Dr. Zavala's successful candidacy at the COD with present and past MAFP board members, and by our awesome Chapter Executive, Linda Edquest. Our delegation included Dr. Janice Gomersall (delegate), Dr. LeeAnna Muzquiz (delegate), Dr. Michael Temporal (alternate delegate), Dr. Mike Strekall (president), Dr. Rob Stenger, Dr. Larry Severa, Dr. Heidi Duncan and Lynn Zavala.

Thank you for your service to our Academy, members and patients, Jeff!

Responsive Practice: Inclusive Health Care Delivery Training

The Montana Disability and Health Program (MTDH) at the Department of Public Health and Human Services (DPHHS) is promoting the Responsive Practice Training to enhance health care providers' ability to deliver disability-competent care that is accessible to people with intellectual, mobility, and other disabilities. Through the two modules you will learn strategies to identify, address, and help remove barriers to care.

Virtual self-paced training.

1.5-hours (2 modules).
FREE with CE Credits included.
Post Training Technical Assistance

Visit bit.ly/ResponsivePracticeMoreInfo for training objectives and details about CE credits.

MODULE 1 - Responsive Practice: Providing Health Care and Screening to Individuals with Disabilities.

- Use the link: bit.ly/ResponsivePracticeMod1 to register.
- CE credits available for Physicians, Nurses, and Pharmacists in Montana.

MODULE 2 - Responsive Practice: Accessible and Adaptive Communication.

- Use the link: bit.ly/ResponsivePracticeMod2 to register.
- CE credits available for Physicians, Nurses, and Pharmacists in Montana.

The Responsive Practice training was developed by the New Hampshire Disability and Health Program. For questions, contact Mackenzie Jones or Erin Bley.

Montana Arthritis Program

In the United States (U.S), arthritis is a prominent cause of chronic disease. It is estimated that one-quarter of U.S. adults have arthritis (25%, BRFSS, 2015-2021).[1] In Montana, the burden of disease is higher than the national average, with an estimated 237,000 (28%) of Montana adults living with a diagnosis of arthritis or an associated condition.[2] Arthritis symptoms vary by disease etiology, but commonly include pain, stiffness, and swelling in and around affected joints. Some inflammatory types of arthritis, like rheumatoid arthritis, can also affect other body systems.

Arthritis affects people of all ages, races, and sexes. In Montana, certain groups experience a higher prevalence of arthritis, including adults aged 45 years or older, adults with lower household income, adults with disabilities, adults that live in rural areas, adults that do not participate in physical activity, obese adults, current smokers, and veterans.

There is no known cure for arthritis. Early diagnosis and conservative management can improve disease outcomes. While risk factors such as genetics, increasing age, and sex cannot be modified, some risk factors are modifiable. The goal of arthritis treatment is to minimize joint damage, reduce pain, and improve or maintain daily function and mobility.

CDC recommends five self-management steps that can reduce arthritis pain, improve daily function and quality of life, and prevent or delay disability, as below.

(1) Participate in a self-management education workshop;
(2) Stay physically active;
(3) Maintain a healthy weight;
(4) Protect joints from excess stress; and
(5) Talk with a health care provider.

The Montana Department of Health and Human Services (DPHHS) *Montana Arthritis Program* is working to improve the quality of life for Montanans affected by arthritis and other rheumatic conditions by increasing awareness about appropriate arthritis exercise and self-management activities. The *Montana Arthritis Program* works with local organizations to implement arthritis approved evidence-based classes:

Stay Active & Independent for Life (SAIL)

SAIL is a 12-week arthritis management and falls prevention exercise program for older adults (aged 65 years and older) that focuses on strength, balance, and mobility. The exercises are joint safe movements to help reduce joint pain and stiffness, while increasing strength and balance. Exercises can be done sitting or standing.

Walk with Ease

The Walk with Ease program is a 6-week walking program for anyone to start or a maintain a low-impact exercise program to help manage or prevent arthritis. The Walk with Ease is offered in a group or self-directed format.

To learn more about the *Montana Arthritis Program*, please visit the DPHHS *Montana Arthritis Program* website. To find and share resources like community based exercise programs with patients living with arthritis, please visit the DPHHS *Community Based Programs* website.

References

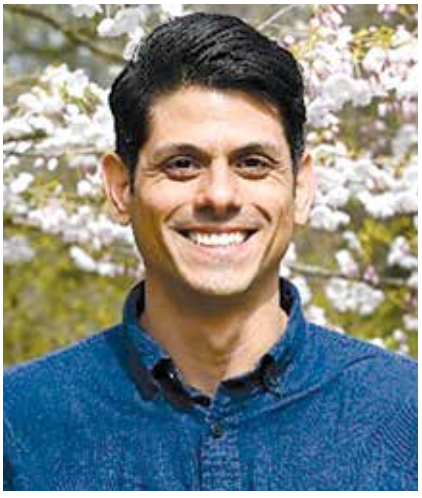
1. United States 2015-2021 Behavioral Risk Factor Surveillance System Report
2. Montana 2021 Behavioral Risk Factor Surveillance System Report

MONTANA WWAMI ALL-FACULTY RETREAT Bi-Annual

Part of Montana WWAMI's ongoing commitment to quality undergraduate medical education in our state is to make sure that Montana WWAMI teaching faculty have access to robust faculty development. With that, Montana WWAMI offers two in-person, in-state "All-Faculty Retreats" each year as well as more tailored sessions at our Track locations in Billings, Bozeman, and Missoula, and via our Stern Faculty Educator series with Dr. Laura Goodell. As well, the specific departments at the UWSOM host annual curriculum events for faculty, and there is a UWSOM Center for Learner and Innovation in Medical Education (CLIME) that is offers year-round Clinical Teaching Programs.

The most recent All-Faculty Retreat took place in Bozeman on October 6, 2023. Its focus was a preview of the competency-based evaluation system that is being developed at the UWSOM. Speakers were Joshua Jauregui, MD, UWSOM Assistant Dean for Clinical Curriculum, who presented the primer on Using EPA's and Competencies in Clinical Evaluations; Amanda Kost, MD, WRITE Co-director, UWSOM Office of Rural Programs shared about the WRITE Experience with EPA Based Assessment Model, Panel of Preceptors/Students; and the "EPA Expert," Bob Englander, MD, Adjunct Professor of Medical Education, University of Illinois, Chicago shared about Implementing EPAs to Advance Competency-Based Learning and Assessment. Attendees earned 4.5 CME credits for their attendance.

The next Montana WWAMI All-Faculty Retreat is scheduled for April 12, 2024, at Chico Hot Springs Resort. It is immediately followed by the annual Montana WWAMI Faculty Development weekend conference. If you have any questions about future sessions or ideas/topics that you would like to explore as a faculty educator, please contact Montana WWAMI Clinical Dean, Jay Erickson, MD, jerick@uw.edu or Stern Regional Faculty Educator for Montana, Laura Goodell, MD, lmgood@uw.edu.



Joshua Jauregui, MD, UWSOM Assistant Dean for Clinical Curriculum

Amanda Kost, MD, WRITE Co-director, UWSOM Office of Rural Programs

Bob Englander, MD, Adjunct Professor of Medical Education, University of Illinois, Chicago

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Key Concepts to Quality Care for Patients with Intellectual and Developmental Disabilities (IDD)

Sarah Davis, DO, Family Medicine Residency of Western Montana, Kalispell

This article series will highlight projects that Montana family medicine residents have worked on during their training years. We have selected projects that we hope will be helpful and relevant to family physicians. Not all of the projects necessarily met their aspirational goals, but the concepts and processes offer ideas for other clinics to consider.

PROBLEM: There is limited dedicated education/training provided across many medical specialties on caring for individuals with IDD. This can often lead to lack of confidence amongst staff and providers in their own abilities to care for these individuals and in turn can lead to decreased quality of care.

AIM: To improve quality of care provided to patients with intellectual and developmental disabilities at Greater Valley Health Center in Kalispell.

KEY MEASURES FOR IMPROVEMENT: Overall improved staff/provider confidence level in caring for patients with IDD in order to improve the care we provide and introduction of attainable changes that can be made in clinic.

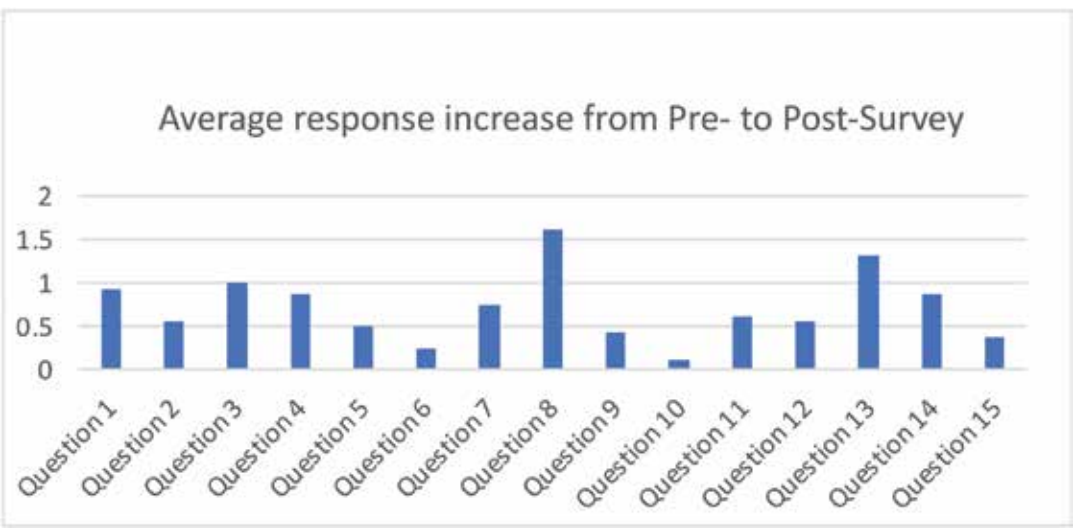
METHODS/PROCESS OF GATHERING INFORMATION: A power point presentation was given at GVHC All Staff Meeting on March 21st, 2023 on the "Keys to Quality Care" for patients with intellectual and developmental disabilities. A pre- and post- survey (using a Likert scale) was distributed to attendees to measure staff and provider's level of comfort and perceived competency when interacting with and caring for patients with intellectual disabilities both before the presentation and after.

There were sixteen participants at the GVHC all staff meeting who attended the lecture AND filled out both the Pre- and Post- lecture surveys. Of the 16 individuals who participated, 4 were medical or dental providers (2 MD/DOs, 1 NP, 1 DDS), 5 were RN/LPN, 5 were behavioral health specialists and/or integrated care managers and 2 were Patient Health Info/Patient Access specialists, and the data was organized by splitting participant surveys into these four staff/provider categories. The surveys both had the exact same core 15 questions that were asked before and after. The pre-survey contained a few additional questions regarding more demographic information including: the participant's role/position at GVHC, training or credentials, and their previous personal experience with interacting with individuals with IDD (including having a family member, friend or acquaintance with IDD, prior volunteer or work experience, or little to no prior experience). The post-survey included few short answer questions at the end inquiring about most valuable thing learned from the presentation, what they would like to learn more about in the future, and barriers to potential improvements to care at our clinic in their opinion.

ANALYSIS AND EVALUATION: (Please see attached surveys to reference for questions)

There were many ways the data could be interpreted, and provided excellent insight for future projects, however I chose to focus the evaluation to a few key aspects of the findings for the purposes of this project.

The graph below depicts the average change in responses prior to the presentation to after. A value of 1 represents an increase to the next response towards Entirely Agree on the Likert scale (for instance an increase of 1 may be from and overall average response from participants as "Somewhat agree" for a particular question" to an average of one response above, "Mostly agree" after the presentation). The response to several questions improved nearly 1 or more measures on the Likert scale after attending the presentation. The questions that appear to have had the most improvement after the presentation were question 8, 13 and 3, indicating that participants felt more comfortable about the physical accommodations some patients with IDD may require and how best to provide these, they felt more confident in their ability to avoid making assumptions about the abilities of patient with IDD, and they felt more confident in their overall ability to help/care for people with IDD when they come into clinic. The question with the least amount of change from Pre- to Post-survey response was question 10, which discusses the importance and need to pay attention to details such as affect, body language and behavior when assessing patients with IDD, but this was however because most everyone strongly agreed with this statement before and after the presentation.



The graph above demonstrates the results for question 1, which asks if the participants' prior training/education has prepared them to care for patients with IDD, that most participants somewhat/mostly disagree. This supports the original proposed problem and need for additional education and training in this domain. Those that mostly disagreed were among patient access specialists and behavioral health/ICM participants, amongst those who reported having more training were providers and nurses, though still few agreed.

The graph above demonstrates participants responses to question 15 prior to the presentation (in blue) and after the presentation (in orange). Overall post-survey responses were slightly improved indicating that participants may have learned things they can implement into their daily practices to help improve the clinic experience and care for these patients.

LESSONS LEARNED: There were many conclusions that were able to be drawn from the data, and will be helpful to guide future efforts, not all were able to be addressed here in this brief summary. Overall, the results support the original hypothesis that healthcare professionals often feel they have not received enough formal training in regards to caring for individuals with IDD. Many domains did show slight improvements after receiving the presentation, however this is just a limited exposure to topics that were able to be presented in a slideshow during a short verbal presentation, continued efforts must be made to make significant impact in improving the quality of care for these individuals. The short answer questions also demonstrated common themes in the most valuable things learned from the presentation including ways staff/providers can better prepare ahead of time for visits, more about assist and communication devices, and generalized awareness for the unique needs they might face. Common responses to what participants would like to learn more about included more resources that are available to these patients and practice guidelines such as screenings. The largest barriers they face are time and lack of exposure/experience working with this population.

STRATEGIES FOR CHANGE AND IDEAS FOR THE FUTURE: The following proposed strategies are ways I will focus efforts in the coming year:

- If there is staff interest, I will consider providing lunch time presentations on high yield topics regarding care for those with IDD.
- Can also consider preparing virtual/written resources to provide and send to staff, that way they are able to look through these when time permits rather than having to attend additional in person lectures
- Will help make staff aware of volunteer opportunities/community events to help gain familiarity with working with this population if interested.
- Continue discussions with administration and management about small attainable changes we can make in clinic to best serve this population
- Can consider an interactive event allowing self-advocates and families to teach and interact with us

Teaching medicine in Montana's wild outdoors

By Dr. Paolo Gerbasi

Daylight was fading on a freezing January day when we got the call about a woman with a leg injury outside of Red Lodge. Our team of Montana Family Medicine Residency and community physicians hiked through the forest to reach the patient's location. Her injury was assessed and the leg was stabilized. We constructed a rope litter and carried her in darkness down a hillside and through the snow until we reached a parking lot.

That was our Advanced Wilderness Life Support practice scenario, so there was no actual injury. But the challenges of receiving and responding to emergency calls in the backcountry are real in every season. In the summer, our training includes how to procure water, disinfecting water, how to procure food, identifying wild plants and animal that may be hazardous to you. We have a ropes and knots workshop and lessons on building emergency shelters.

The Montana Family Medicine Residency Wilderness Medicine Track will be doing another rescue practice this winter. We will learn how to rescue people from avalanches and how to prevent powder snow suffocation. We will teach how to read terrain to assess avalanche risk and safely approach a patient's location to prevent getting caught in an avalanche or triggering one. We will evaluate and process ski injuries and injuries from cold exposure. We will learn how to prevent injury from cold and high elevations. We will learn to build snow caves as emergency shelters.

In March, the MFMR Wilderness Medicine Track will hold a retreat in Paradise Valley. Participants will learn skills that they can use when they are trekking in the great outdoors. MFMR Wilderness Medicine faculty and residents have presented annually at Montana Academy of Family Physicians summer conferences at Chico Hot Springs.

In the clinic or hospital, the physician has a wide range of resources to care for patients. In the great outdoors, it's a whole different world. Excellent medical skills aren't sufficient to care for patients if you have no equipment, medication, communication or transportation.

That's why our Wilderness Medicine Track emphasizes preparation and prevention. We have nine residents in the track. They participate in quarterly didactics on outdoor medicine as well as hands-on outdoor training and two retreats annually. During their three years of residency, all track participants have opportunities to learn at national Wilderness Medical Society conferences.

We open our wilderness medicine training to local nurses, physicians, physician assistants and nurse practitioners. Our chief wilderness medicine residents, Dr. Adam Putnam and Dr. Alexander Hetrick, organize and present quarterly didactics. Recent speakers have included Dr. Jim Guyer, MFMR faculty member and military helicopter pilot, discussing medical flight topics. John Felton, Yellowstone County health officer, explained public health disaster and emergency management.

The Wilderness Medicine Track helps with recruitment. Often, MFMR residents are avid outdoors people.

A hunter and hiker myself, I am starting my third year as director of the Wilderness Medicine Track. Each year, graduating MFMR residents have fulfilled the requirement to be certified as Fellows of the Academy of Wilderness Medicine.

MFMR is highly supportive of faculty learning opportunities that enhance teaching of our residents. That support includes funding for fellowships, conferences and other professional education. The residency gave me the time and resources to attain my FAWM in a year and a half. It broadened my horizons, I never thought I would be teaching wilderness medicine. You have to become more skilled and more resourceful. I enjoy the challenge of being prepared to provide care with what I carry in my backpack.

The biggest skill is preparation. You can't prepare for all eventualities. You assume risk by entering the wilderness. Living in Montana and enjoying the outdoors, I have become aware of the need for trying to anticipate the problems that could occur in the wild.

Dr. Paolo Gerbasi is the director of the Montana Family Medicine Residency Wilderness Medicine Track and practices family medicine at RiverStone Health Clinic in Billings.

Care of the Hospitalized Patient with Opioid Use Disorder

Dr. Brett Bell, Clinical Assistant Professor of Medicine
Family Medicine Residency of Western Montana/University of Montana

Patients with opioid use disorder are hospitalized and present to the emergency department at a higher rate than patients who do not have opioid use disorder. These hospitalizations can be challenging and difficult for both patients and physicians, but with a shift in our approach to shared decision making with the patient, allowing autonomy when possible and reviewing some important principles for management of opioid use disorder, we can turn the hospitalization into an opportunity to connect someone with treatment and restore some trust in the health care system.

It starts with communication – some communication tips that can help with patients who struggle to trust the health care system:

- Sit down, get at the patient's eye level or below if possible
- Slow down – spending extra time to explain and discuss the patient's medical situation will save time in the long run
- Use the phrase "not a whiff of judgement" as your guiding principle
- Notice opportunities for affirmations "you are so tenacious, you've tried to quit so many times" and validation "you must be so miserable right now"
- Avoid getting defensive

A common fear among physicians taking care of patients with opioid use disorder in the hospital setting is that by giving the patient opioids in the hospital, we are somehow going to make the person's addiction worse, or that by giving them opioids in the hospital we are somehow "giving in to drug seeking."

It is important to remember that patients with opioid use disorder by definition have very high opioid tolerances. This has two important implications for their medical care:

1. Opioid withdrawal must be treated before any opioids given for pain relief will be effective. Think of this as "filling the opioid deficit"
2. Due to their high opioid tolerance, patients with opioid use disorder will need higher doses of opioids compared to what would be needed for a typical opioid naïve patient.

When patients ask for opioids to treat their withdrawal symptoms or ask for higher doses of opioids to treat their acute pain, they are not "drug seeking" or looking to "get high" from hospital-ordered opioids; they are asking for effective pain relief. Opioids have some serious risks, but as long as the patient's respiratory rate remains above 12 or they do not appear sedated, giving high doses in a monitored inpatient hospital setting is generally safe. This treatment approach does not make their addiction worse. In fact, in one study of patients with invasive bacterial infections due to injection drug use, patients with opioid use disorder who had their withdrawal symptoms treated in the hospital stayed in the hospital to complete more days of antibiotics, compared to patients who did not receive any opioids. Furthermore, if a patient is admitted with infective endocarditis from their injection drug use, can things really get much worse from there?

Treating pain and withdrawal in the hospital helps get patients onto evidence-based treatment for their opioid use disorder. Patients who start treatment for their opioid use disorder in the hospital have reduced 30-day and 90-day hospital readmissions, are more likely to attend outpatient follow up appointments, are less likely to discharge against medical advice, and are less likely to have opioid overdoses after hospital discharge.

So, what options do we have for treating opioid withdrawal in the hospital? There are three basic strategies, each with their own advantages and disadvantages:

1. Methadone
   - Advantages: no risk of precipitated withdrawal when starting, can be used to treat opioid use disorder on discharge
   - Disadvantages: higher risk of respiratory depression, complicated pharmacokinetics, dose can't be increased faster than every 3-5 days, complicates discharge planning if patient lives far from a methadone program (only four in Montana)
2. Buprenorphine
   - Advantages: lower risk of respiratory depression compared to methadone, can be used to treat opioid use disorder in the outpatient setting, much easier access to treatment throughout the state
   - Disadvantages: risk of precipitated withdrawal
3. Acute pain relief opioids at high doses
   - Advantages: familiarity, simpler medication regimen, no risk of precipitated withdrawal
   - Disadvantages: very frequent dosing and very high doses may be required, cannot be used to treat opioid use disorder at hospital discharge.

So which approach is the correct one? Well, talking to the patient about what they would like to do and offering the various options is one way to give them some autonomy as well as gauge how ready they are to enter treatment. Starting buprenorphine when the patient is acutely in pain may be challenging, even if it is the best option for treatment for them after discharge. The initial priority should be on relieving the patient's withdrawal symptoms and treating their pain aggressively.

If the patient decides they want to start buprenorphine later on in the hospital stay, there is a way to do this that reduces the risk of precipitated withdrawal from the buprenorphine. This involves starting at a very low dose of buprenorphine while continuing the other opioids and slowly increasing the dose of buprenorphine over the course of several days.

Some physicians might worry that using methadone, buprenorphine or high-dose opioids to treat opioid withdrawal in the hospital might get them into legal trouble. Fortunately, the Code of Federal Regulations allows a lot of leeway for physicians to treat opioid use disorder and opioid withdrawal in the hospital as they see fit. This is in contrast to the outpatient setting, where methadone can only be dispensed from a methadone program and where pain relief opioids cannot be prescribed to treat opioid use disorder.

What if a patient who is already on methadone or buprenorphine is admitted to the hospital? The recommendation from both the Society of

Hospital Medicine and the American Society of Addiction Medicine is to continue their methadone or buprenorphine. Stopping the methadone or buprenorphine and then transitioning the patient back to their medication later runs the risk of interrupting treatment, which can lead to relapse with illicit opioids and possible overdose and death. The only scenario where it is clinically appropriate to discontinue either methadone or buprenorphine would be if there is concern for over-medication or sedation and respiratory depression on admission. For patients on methadone maintenance therapy, a phone call to the patient's methadone program is extremely helpful for verifying the person's daily dose and ensuring follow up care. Keep in mind that typical doses of methadone to treat opioid use disorder are higher than doses used to treat chronic pain. A typical effective dose of methadone for opioid use disorder is 80-150mg, and doses of up to 200mg are not unheard of.

In terms of treating acute pain, there are some important principles:

- Treat moderate pain with scheduled opioids, but write hold parameters for safety (don't give if RR < 12 or patient is sedated, for example)
- Treat severe pain with a PCA, which provides an element of safety and patient autonomy
- Schedule medications like Tylenol and NSAIDs, and don't forget multi-modal pain control
- Every patient should be on a bowel regimen
- Offer nicotine replacement therapy

When it comes time for discharge planning, consider the following:

- If the patient is discharging to a methadone treatment program, call the methadone program 3-5 days before discharge and ensure they can get a dose the day after discharge – avoid holiday or weekend discharges for this reason

- If a patient is discharging on buprenorphine, ensure that they have a follow up appointment with someone who can prescribe buprenorphine and ensure they are discharged with a prescription for the time between hospital discharge and their follow up appointment
- Occasionally, patients need to be discharged on pain management opioids in addition to medications to treat their opioid use disorder. This is fine from a legal perspective if the opioids are prescribed for an acute pain condition such as post-surgery. In this situation, it is best to call the patient's PCP and ensure that you, the patient and the PCP are all on the same page about a taper plan
- For all patients, prescribe Narcan, screen for Hepatitis C, HIV and syphilis, discuss smoking cessation and discuss pregnancy prevention with patients at risk of pregnancy

Resources to learn more:

- The Curbsiders Addiction Medicine Podcast has several episodes that touch on treating addiction in the hospital
- MAT Chat – a monthly forum for providers treating opioid use disorder around Montana – reach out to the Montana Primary Care Association for more information
- The ASAM Online Fundamentals of Addiction Medicine course is an excellent overview for primary care

Family Medicine Advocacy Rounds

AAFP
AMERICAN ACADEMY OF FAMILY PHYSICIANS

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Welcome to Family Medicine Advocacy Rounds—the American Academy of Family Physicians' monthly tip sheet to educate, engage, and update you on the latest policy issues affecting family physicians and their patients.

Family Physicians Continue to Support G2211 Add-on Code

Why it matters: Primary care visits are thoughtful, complex, and all about ensuring patients' health care needs are met. Here's the catch, though: All that work physicians do isn't appropriately paid for.

One Medicare physician billing code — set to go into full effect in 2024 — is specifically designed to pay more accurately for the complex, high-value visits that primary care physicians provide as part of a continuous relationship with a patient. The equation is simple. Better payment equals better patient access and better outcomes. G2211 can make this a reality.

Unfortunately, this important policy advance, poised to improve health care nationwide, has attracted opposition. But the misperceptions driving criticism of G2211 do not stand up to scrutiny.

What we're working on:

- The AAFP and 36 other health organizations, representing millions of clinicians, patients, and key members of the health care community, have joined together to urge Congress to support comprehensive primary care and the implementation of the G2211 code in 2024 to bolster the health care workforce and safeguard Medicare beneficiaries' access to high-quality, patient-centered care.
- The letter follows the AAFP's comments on the 2024 Medicare physician fee schedule proposed rule, which applauds the Centers for Medicare and Medicaid Services for advancing several proposals to support primary care. In addition to promptly implementing G2211, this includes new coding and payment for screening and addressing unmet social needs, and more accurate payment for behavioral health integration.
- The AAFP and the American College of Physicians also sent a joint letter to Congress on the need to support full implementation of G2211 in 2024. The letter stressed that G2211 will:
  - sustain primary care and other physician practices that Medicare beneficiaries rely on;
  - bolster the physician workforce;
  - appropriately value primary care and other longitudinal, continuous care under the MPFS; and
  - ensure that the Medicare program provides patients with timely access to comprehensive, longitudinal care.
- The AAFP continues to call on Congress to end unsustainable physician payment cuts by enacting an annual inflationary update, reform arbitrary Medicare budget neutrality requirements, and invest in community-based primary care. Learn more facts about G2211 here: https://www.aafp.org/advocacy/advocacy-topics/physician-payment/medicare/advocacy-focus-g2211.html

House of Medicine United in Reaffirming Workforce Priorities

Why it matters: The physician shortage is a complex issue affected by growing demand, a history of underinvestment in primary care, an aging physician workforce, and economic pressures on the rural health system.

The U.S. faces a projected physician shortage of up to 124,000 physicians by 2034, with demand for physicians outpacing supply (AAMC). Further, the Health Resources and Services Administration (HRSA) estimates that, by 2025, there will be a shortage of more than 250,000 mental health professionals, including psychiatrists.

For physicians—in communities both urban and rural, in hospitals, clinics, and independent practices—a workforce shortage contributes to burnout, inability to take on new patients, shortened visit times, financial challenges, and increased administrative burden.

The AAFP has consistently advocated in support of federal policies to address the shortage and maldistribution of adult and pediatric primary care, psychiatric, and other high-need specialties.

What we're working on:

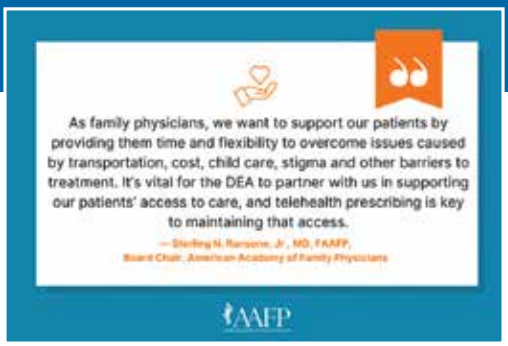
- The AAFP supports the bipartisan Lower Costs, More Transparency Act, which includes reauthorization for seven years of the Teaching Health Center Graduate Medical Education program and will

ensure that Medicare and its beneficiaries are paying the same rates for physician-administered drugs in off-campus hospital outpatient departments as they do in physician offices.

- The AAFP and the American Academy of Pediatrics, the American College of Obstetricians and Gynecologists, the American College of Physicians, the American Osteopathic Association, and the American Psychiatric Association sent a joint letter to Congress urging investment in a strong primary care workforce and enactment of policies including:
  - **the Conrad State 30 and Physician Access Reauthorization Act**, which allows physicians who complete their residency in the U.S. to waive the requirement to return home for two years if they agree to practice in an underserved area for three years;
  - **long-term reauthorization of the THCGME program or the Doctors of Community (DOC) Act;** the THCGME program helps to attract and retain physicians in rural and medically underserved communities while addressing the issue of physician maldistribution;
  - **the Mental Health Professionals Workforce Shortage Loan Repayment Act of 2023**, which would make mental health practitioners eligible for the loan repayment program passed in the SUPPORT Act five years ago;
  - **the Resident Education Deferred Interest (REDI) Act**, which would allow borrowers to qualify for interest-free deferment on their student loans while in a medical or dental internship or residency program; and
  - **the Rural Physician Workforce Production Act**, which would lift the current cap on Medicare reimbursement payments to rural hospitals that cover the cost of taking on residents, to alleviate the disadvantage that rural hospitals face when recruiting new medical professionals.

AAFP Weighs in on Telehealth Prescribing of Controlled Substances

Why it matters: Millions of patients live in health shortage areas and face months-long waits for an in-person appointment, leaving them reliant on telehealth appointments to access care. That's why the AAFP recommends permanent telehealth prescribing regulations that prioritize established patient-physician relationships while facilitating equitable access to care for our patients.



AAFP Board Chair Sterling Ransone, M.D., participated in a public listening session with the Drug Enforcement Agency to discuss telehealth prescribing of controlled substances. In the session, Ransone reiterated the AAFP's recommendations that the DEA should not impose additional telehealth prescribing restrictions for controlled substances on physicians who have already established a patient relationship through an in-person visit.

What we're working on:

- The AAFP recently provided comprehensive comments, sharing support for guardrails that protect the patient-physician relationship and patient safety but also raising concerns about how the rules could result in significant burden and strain for both patients and physician practices.
- The AAFP recommends that the DEA permanently allow telehealth-only prescribing of buprenorphine for the treatment of opioid use disorder.
- The AAFP urges the DEA to focus on addressing diversion and improving oversight of telehealth companies instead of imposing complex, burdensome regulations on physicians.

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

# # #

About American Academy of Family Physicians

Founded in 1947, the AAFP represents 129,600 physicians and medical students nationwide. It is the largest medical society devoted solely to primary care. Family physicians conduct approximately one in five office visits — that's 192 million visits annually or 48 percent more than the next most visited medical specialty. Today, family physicians provide more care for America's underserved and rural populations than any other medical specialty. Family medicine's cornerstone is an ongoing, personal patient-physician relationship focused on integrated care. To learn more about the specialty of family medicine and the AAFP's positions on issues and clinical care, visit www.aafp.org. For information about health care, health conditions, and wellness, please visit the AAFP's consumer website, www.familydoctor.org.

Nominations are open for the 2024 Montana Family Physician of the Year!

Visit
https://montanaafp.org/awards/
to submit nominations

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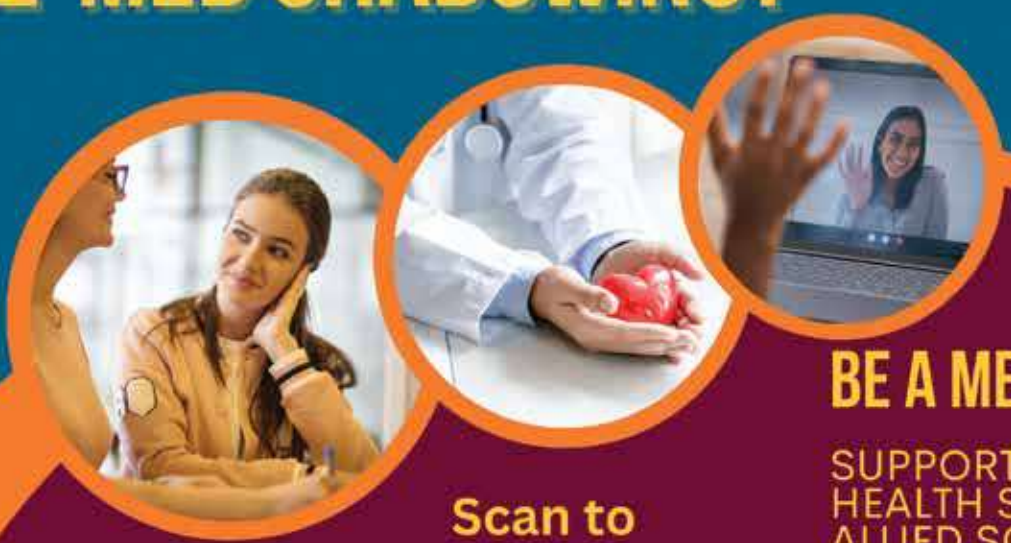

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