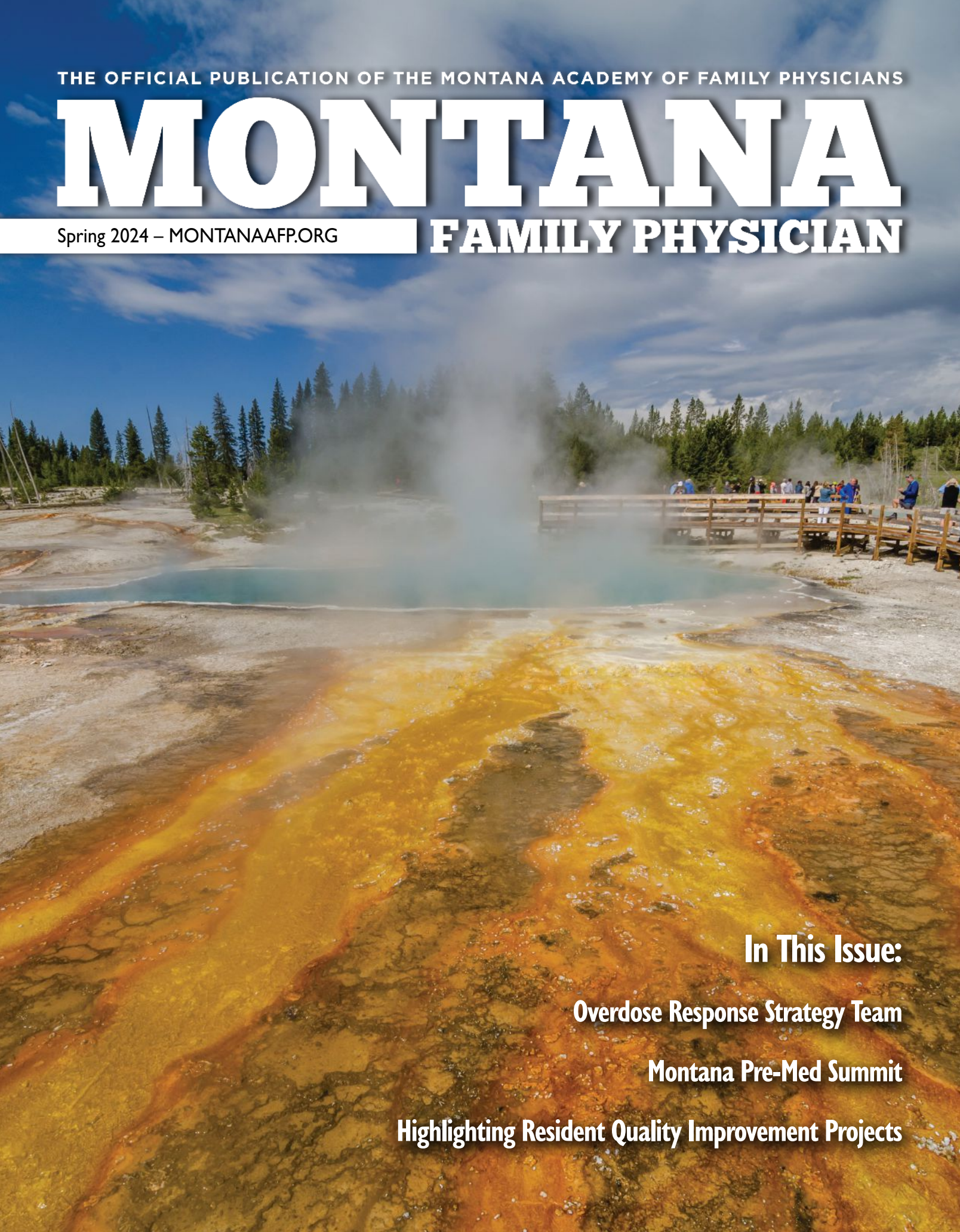
THE OFFICIAL PUBLICATION OF THE MONTANA ACADEMY OF FAMILY PHYSICIANS

MONTANA FAMILY PHYSICIAN

Spring 2024 – MONTANAAFP.ORG



In This Issue:

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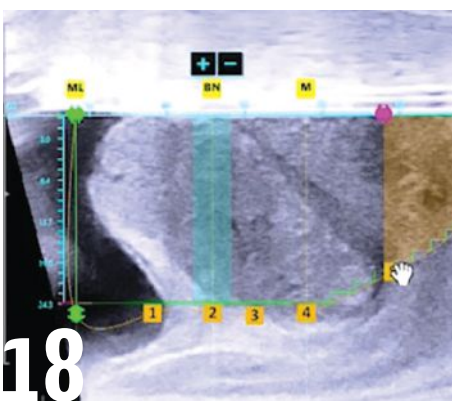

*The **Montana Family Physician** is printed, addressed, and mailed to every family physician, resident, and medical student in Montana as well as all 50 other state chapters.*

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MAFP President's Message

Michael Strekall, MD, 2023/2024 MAFP President

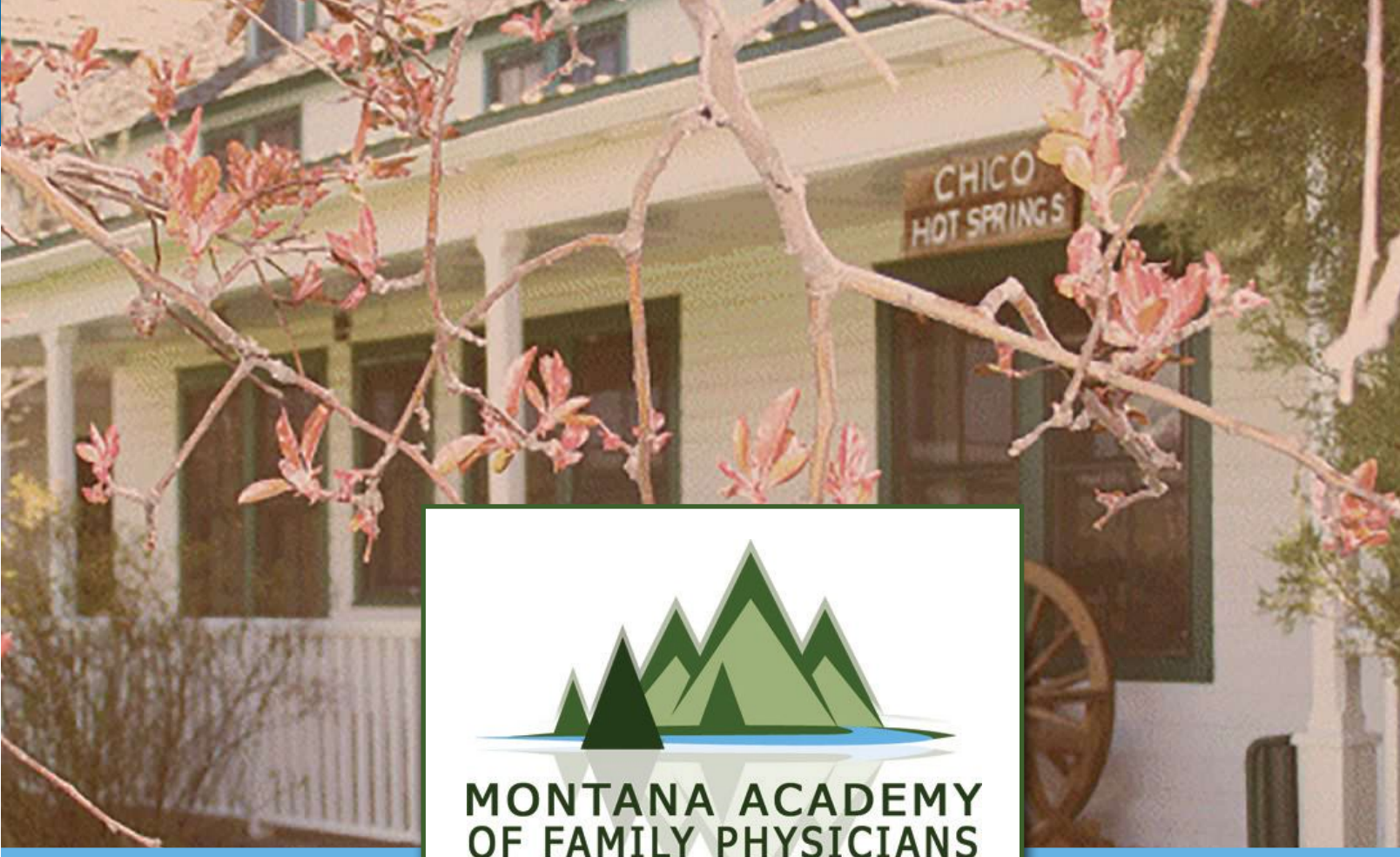
Greetings from your academy and your current president. Many of you know that I am a "recycled" board member and am currently serving my second term as MAFP president. I thoroughly enjoy our leadership work and want to suggest that any of our current members consider joining this group if you have any interest in the business and future of family medicine. I attended the Congress of Delegates, COD, meeting in Chicago last October and was again enthused to meet our national leaders. They share our values and goals for the future of health care. This is a committed group of FPs, who still practice family medicine, and are involved in the AAFP national goals. At the conclusion of the COD, Dr. Jeff Zavala from Billings was elected and installed as a new national AAFP board member; this creates an opportunity for Montana FPs to have input into the future of Family Medicine as led by the AAFP. So, if you have strong feelings about where the future of your profession is headed, please contact Dr. Zavala or any of your current Montana board members.

Another area of interest for me is to reestablish a more direct relationship with the University of Washington dean and offer an opportunity for the leadership of the WWAMI states to meet with Dr. Tim Dellit, who is the newly appointed dean of the University of Washington School of Medicine. The first time I was president of the MAFP, meetings were held annually with the former dean, Dr. Paul Ramsey, to explore how the university was meeting goals in establishing primary care in the WWAMI states. This was fruitful for all involved and encouraged sharing of ideas for supporting medical students in choosing a primary care future. We need more family doctors to continue leading medicine toward a healthier future, both in our country and in Montana. I am hopeful that I can rekindle interest in a regular meeting involving all the WWAMI leaders and Dr. Dellit.

Now is the time to become involved with health care issues that Montana will be focusing on with the legislative session starting in January of 2025. I am aware that many committees meet about 6 months before the session begins, so we need to be proactive in our support of our senators and representatives. Most of them need our professional experiences and our family medicine training before their bills enter the next session. We are uniquely gifted at explaining and educating them as to how changes will affect the health care of our patients. Trying to earnestly help them can result in better language in proposed bills, and hopefully, we will have better decisions made for Montana citizens. Your MAFP leadership has been exploring options to share a lobbyist to assist the legislative committee. This daunting task of being at the legislature daily can be performed by a lobbyist, and this will help our committee and academy leadership be more aware of issues that are pending. The knowledge of upcoming proposed bills will allow us to be ready to respond to those future challenges as they arise. If any member of the MAFP has interest in participating during the session, or has connections with our legislators, please feel free to contact your leadership with your input.

Now is the time to become involved with health care issues that Montana will be focusing on with the legislative session starting in January of 2025.

Finally, please don't forget to take time away for yourselves and your families from the rigors of medical practice. We all must work at PREVENTING BURN OUT in our profession, as many people are counting on us to continue helping treat and prevent disease. My hope is that you continue to enjoy being a family physician, balancing your professional and personal life, and remembering why you went into medicine.



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Highlight on some recent COD Resolutions

Submitted by Janice Gomersall, MD, FAFFP, delegate MAFP

As many of you know, the American Academy of Family physicians holds its annual Congress of Delegates meeting (COD) in late August to early October. Each state, recognized territory, or special interest group sends delegates and alternate delegates to vote on the resolutions brought forth by chapters. These submitted resolutions are researched by the AAFP as to prior amendments, financial impact if passed, relation to the goals and mission of AAFP, and then are presented at the reference committees. Ever since COVID affected in-person meetings, we have held the reference committees two weeks prior to the COD via virtual platform. Chapter representatives can submit written or verbal testimony regarding these resolutions. Then at the COD, the reference committees present their recommendations as to adoption, and then there can be debate on the Congress floor. Voting is done by the delegates during the COD.

Any member of AAFP can attend the COD, although only delegates and alternate delegates can speak on the floor of COD, and only delegates can vote (or alternates sitting in for the delegates). If you are interested in the process, you may consider attending. COD usually occurs just prior to the FMX Scientific Assembly CME. Check out the AAFP website for more information on COD. This year it will be held in Phoenix AZ Sept 22-25th.

The following are the resolutions that were adopted at the latest COD held in Chicago in October 2023.

Resolutions adopted Regarding Family Medicine advocacy - AAFP will :

Establish Family Medicine Week on national level and coordinate between states similar to what both California and Michigan already have been doing (Resolution 201).

Promote and Increase Native American representation in Family Medicine (207).

Advocate that hospitals grant Obstetrical privileges for trained family physicians and continue to reaffirm importance of obstetrical training in residency by working with ACGME (303).

Support congruent licensing fees for both allopathic and osteopathic physicians (304).

Another applicable resolution for Montana and rural communities was in reference to the scoring system used for NHSC repayment – resolution was that the AAFP would explore a comprehensive reevaluation and assessment of the effectiveness and equity of the Health Professional Shortage Areas scoring criteria employed by the National Health Service Corps program with appropriate revisions to meet the physician workforce needs for the most needy rural communities and underserved areas (506).

Resolutions adopted Regarding Patient Advocacy:

Supporting legislation to alleviate the burden of diaper need for needy families with young children (412).

Support policies that provide comprehensive continuous health care coverage and access for people who are currently incarcerated, including advocating for Medicaid coverage (413).

Resolution regarding privacy in sports preparticipation forms – to support efforts to only release the medical eligibility portion of the forms to the schools, and only medically relevant information identified during the preparticipation eval (401).

After long discussion, adopted the resolution that the AAFP support eliminating mandatory reporting to law enforcement for adult intimate partner violence victims, and also that the AAFP support requirements for referrals to local and/or national domestic and sexual violence advocacy services for adult intimate partner violence victims (503).

Amend the current AAFP policy and add support for both over-the-counter oral contraceptives and oral emergency contraceptives (502).

An amendment addressing cost to insured patients compared to non-insured patients: Resolved that the AAFP advocate for policies that limit the cost of a medication to an insured patient with medication coverage to the lower range of prices that a non-covered patient can achieve at cash price either before or after application on a non-manufacturers free discount care, and that AAFP communicate to law-makes and other pertinent stakeholders describing the ethical dilemma of the medication pricing process and how it adversely affects insured patients (512).

AAFP support the Modernizing Opioid Treatment Access act to expand access to methadone for treatment of opioid use disorder (OUD) and that the AAFP work with government agencies and other relevant stakeholders to implement a viable plan for the US to expand access to methadone for OUD (514).

Adopted resolution regarding regulation for persons convicted of violent offenses that the AAFP share model legislation with chapters in order to enhance advocacy efforts aimed at reducing gun violence. (505).

Resolutions adopted Regarding financial reimbursement:

Update current policy on long term care to address all the administrative and cost barriers to access long term facilities

and at-home care, address need for compensation to family physicians directing such care, and support a more comprehensive national policy on compensation for family physicians directing long term care for individuals (307).

And the bane of most physicians in practice – prior authorizations – this resolution was that the AAFP explore viable processes by which a physician may be compensated for participation in the peer-to-peer and prior authorization processes (508).

Vaccine coverage: Resolved that the AAFP advocate with the CMS and the US Congress to allow physicians to seek reimbursement under MCR Part B for the cost of furnishing and administering all vaccines recommended by the ACIP, including payment for vaccine products and administration (515).

Resolutions adopted Regarding Education and Training:

Support and advocate for evidence-based, standardized universal training on suicide training (205).

Develop physician education materials about self-managed abortions, available on the AAFPs "Reproductive Health: Clinical Guidelines and Practice Resources" care resource webpage (408).

Resolutions adopted Regarding Recognition of special groups/ determinants of health:

Advocacy for removing Race as a factor in clinical decision support tools used in multiple organizations (405).

Recognizing that inequities in access to civil legal aid services for health-harming legal needs is a social determinant of health (406).

Encourage multistate and national EHR vendors to include tools to document both Adverse Childhood Experiences as well as Positive Childhood experiences so that individual and population assessment can be used to inform intervention strategies, and also to encourage payment through CPT codes for administering the screening (305).

Study and advocate for further study of the prevalence and impacts of anti-fat bias in healthcare (409).

More on determinants of health: Resolved that the AAFP explicitly recognize the existence of political determinants of health that influence the social determinants of health and consider making an addendum to all policies to recognize these political determinants where appropriate (510).

Rosewood amendment that the AAFP believes that reparations are appropriate and necessary when direct connection of specific acts of violent or discrimination can be established and individuals who have been impacted by such violence or discrimination can be identified (411).

Any member of AAFP can attend the COD, although only delegates and alternate delegates can speak on the floor of COD, and only delegates can vote (or alternates sitting in for the delegates). If you are interested in the process, you may consider attending. COD usually occurs just prior to the FMX Scientific Assembly CME. Check out the AAFP website for more information on COD. This year it will be held in Phoenix AZ Sept 22-25th.

And some of the following resolutions may have had a bit of politics and required some lengthy discussions:

Late resolution adopted regarding political risk – That the AAFP explore including in its background information a risk assessment grading for each resolution to help assess and explain the potential reputational risks and benefits to the organization and its advocacy efforts (late resolution 2).

On gun violence, adopted resolution that the AAFP encourage the Family Medicine Political Action Committee to screen and consider support for candidates who support bans on high-capacity assault-style firearms and the AAFPs core advocacy policies. Also adopted that the AAFP include addressing gun violence among its key priorities for 2024, transparently present steps taken to address this priority to the general AAFP membership, and report back to the COD in 2024 (504).

Montana Overdose Response Strategy Team wins national award for work to combat drug crisis

The Montana Overdose Response Strategy (ORS) Team received a national award for Outstanding Public Health/Public Safety Collaboration for their work with public health and public safety agencies across the state to save lives and improve overdose responses in Montana communities. The Office of National Drug Control Policy (ONDCP) recognized the team on September 12, 2023.

The ORS Team is comprised of CDC Foundation Public Health Analyst Jordan Friend and William Janisch a Drug Intelligence Officer who works for Montana's Division of Criminal Investigation. The ORS Team works closely with the Montana Injury Prevention Program at the Montana Department of Public Health and Human Services on the Overdose Data to Action grant funded by the CDC.

Friend and Janisch work with public health and public safety agencies across the state to save lives and improve overdose responses in Montana communities by utilizing the Overdose Detection Mapping Application Program (ODMAP). ODMAP provides suspected overdose data across jurisdictions to help officials respond immediately to increases or spikes in overdose events. In 2022, Friend and Janisch brought together more than 100 different public health and public safety agencies across the state to coordinate overdose responses and implement intelligence gathering using the ODMAP, increasing the use of ODMAP in Montana by more than 328 percent.

The team also enhanced coordination and communication when issuing overdose alerts between local, state, tribal, and federal agencies and continues to work with tribal entities to set up ODMAP accounts. Additionally, Friend and Janisch developed a community overdose spike response toolkit for communities across the state to use in their overdose response plans to prevent more drug overdose deaths.

The Overdose Response Strategy Team began their work in late 2021 to assist communities in addressing the rising number of drug overdoses. Last year, the State Crime Lab reported 77 overdose deaths involving fentanyl – an increase of 1,750 percent from 2017 when there were just four.

Montana Pre-Med Summit

Montana WWAMI organizes a pre-med summit every year for those interested in finding out more about the medical school application process. This year, the event was held in Bozeman at the Norm Asbjornson Hall on October 7th, 2023. We welcomed 82 guests, most of them students and undergraduate pre-med advisors from area colleges and universities.

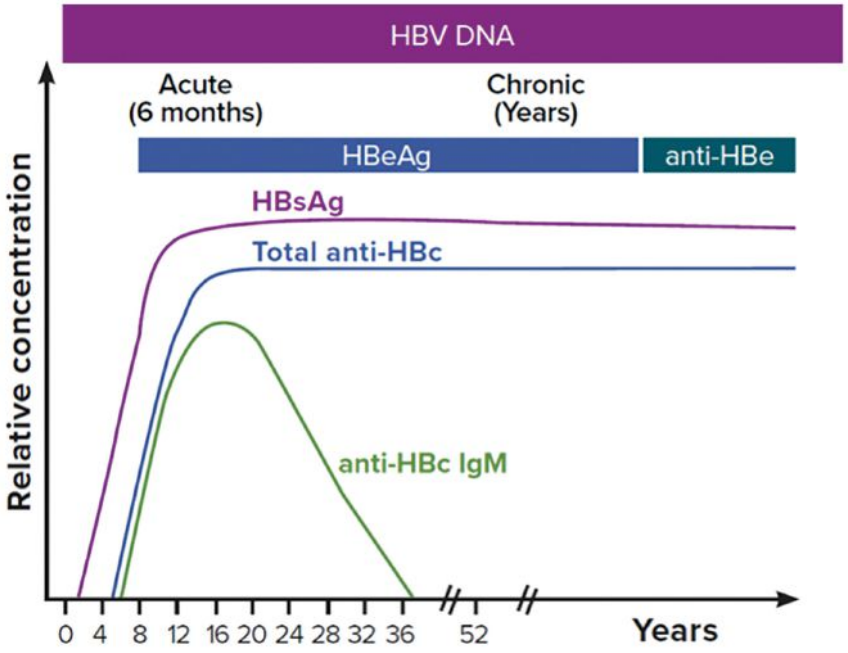
Representatives from the University of Washington School of Medicine, Montana State University, the University of Montana, Carroll College, the Office of the Commissioner of Higher Education, the Billings, Bozeman and Missoula Clinical Tracks, and the Montana WWAMI Foundations and Clinical offices were on hand to present details about the application and financing process and med school interview preparation. Montana WWAMI medical students were on site to provide a student perspective and answer questions. Breakout sessions included loan repayment programs, preparing for the MCAT, pre-med research opportunities, application advice, and a dialogue about equity in medicine. The session on Crafting a Personal Statement is a perennial favorite, presented by MT WWAMI faculty Mike Geurin, MD. Also included was a Q&A session on the program specifics about the Montana TRUST program and the combined MD/PhD program. One military arm of the government, the US Army, also hosted a table and answered students' questions.

The summit was sponsored by many healthcare organizations in the state: Montana AHEC, Big Horn Hospital Association, Livingston HealthCare, Montana TRUST, MSU, Carroll College, University of Montana, and the UWSOM.

Hepatitis B Screening Guidance

The Centers for Disease Control and Prevention (CDC) recommends hepatitis B virus (HBV) screening for all adults aged 18 years and older and pregnant women during each pregnancy regardless of vaccination status and history of testing. In Montana, hepatitis B is one of three required serological tests (syphilis, hepatitis b surface antigen, and rubella) for women seeking prenatal care, as found in Montana Code Annotated Title 50, Chapter 19. Acute, chronic, and perinatal hepatitis B infections must be reported to your local health department, as per ARM 37.114.203.

Hepatitis B serological test results distinguish whether an individual has acute or chronic hepatitis B infection. The available laboratory tests include hepatitis B surface antigen (HBsAg), surface antibody (anti-HBs), total antibody to hepatitis B core antigen (anti-HBc), and IgM antibody to hepatitis core antigen (IgM anti-HBc). Occasionally, envelope or "E" antigen will



Lab concentrations for acute Hepatitis B and chronic Hepatitis B time frames and results.

also be used (HBeAg). Antigen positivity denotes infection, while antibody positivity denotes immunity from previous infection or vaccination against hepatitis B.

The CDC recommends a screening approach for adults using a triple panel test strategy, including hepatitis B surface antigen (HBsAg), antibody to hepatitis B surface antigen (anti-HBs), and total antibody to hepatitis B core antigen (total anti-HBc). The recommended screening for pregnant women is hepatitis B surface antigen during each pregnancy, preferably during the first trimester, regardless of vaccination status and history of testing.[1]

Hepatitis B infection is based on clinical, laboratory, and epidemiologic findings. Laboratory evidence of an acute infection includes a positive anti-HBc test, and a positive HBsAg, prior to disease resolution. The presence of HBsAg indicates that a person is infectious. Chronic infection is confirmed with two separate positive serological HBsAg test results, obtained at least 6 months apart. In chronic hepatitis B infection, HBsAg and anti-HBc will remain positive. An isolated positive anti-HBc result needs further interpretation. In a person susceptible to hepatitis B, all tests will be negative. Immunity from vaccination will result in only an anti-HBs positive test, and immunity due to natural infection will show anti-HBc and anti-HBs results. Any detectable HBV DNA level is considered positive for surveillance purposes.

Testing Guidance for Hepatitis A

Hepatitis A is a vaccine-preventable disease caused by the hepatitis A virus (HAV), which is found in the stool and blood of people who are infected. Symptoms of the infection include fever, malaise, anorexia, nausea, abdominal discomfort, dark urine, and jaundice. HAV infection occurs after direct contact with an infected person, or ingestion of contaminated food or water. Hepatitis A infections must be reported to your local health department, as per ARM 37.114.203. Montana has a low incidence of HAV infection – 1 case was reported in 2023.

Screening asymptomatic people for hepatitis A is generally not recommended and can lead to false positive results. HAV infection is confirmed during the acute or early convalescent phase of infection by the presence of IgM anti-HAV in serum. IgM generally becomes detectable 5 to 10 days before the onset of symptoms and can persist for up to 6 months. The total antibody test for HAV measures both IgG anti-HAV and IgM anti-HAV and is not necessarily an indicator of current infection. A positive total antibody test for HAV could be evidence of current infection, past infection, or history of HAV vaccination. Only a positive IgM anti-HAV should be used for diagnosis of active HAV infection.

Additional resources on HAV infection can be found at the links below:

- https://www.cdc.gov/vaccines/pubs/pinkbook/hepa.html
- https://www.cdc.gov/mmwr/preview/mmwrhtml/mm5418a1.htm

References

1. Centers for Disease Control and Prevention (CDC) Screening and Testing Recommendations for Chronic Hepatitis B Virus Infection (HBV): https//www.cdc.gov/hepatitis/hbv/testingchronic.htm
2. CDC Interpretation of Hepatitis B Serologic Test Results: https://www.cdc.gov/hepatitis/hbv/interpretationOfHepBSerologicResults.htm
3. CDC Hepatitis B Surveillance Guidance: https://www.cdc.gov/hepatitis/statistics/surveillanceguidance/HepatitisB.htm

Trans-Affirming and Gender Diverse Medical Care

Jennifer Selland, MD, Family Medicine
Residency of Western Montana, Missoula

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:

Access to trans-affirming medical care, including trans-affirming surgery, remains limited in rural areas due to structural and institutional barriers. Multiple recent studies have shown that access to trans-affirming care is associated with a decrease in mental health disparities among trans and non-binary people and positive psychological effects[1,2]. As the need for trans-affirming care in the Missoula community has been increasing, so has the need from providers to provide hormone replacement therapy (HRT) for trans-affirming care.

AIM:

Having a patient on hormone therapy comes with challenges – more frequent follow-ups, need for medication adjustments, and frequent hormone monitoring. Additionally, the decision to start hormone therapy is not without risk, and providers who provide this type of trans-affirming care to patients need to fully understand the risks and benefits and be able to explain these to patients. I aim to compile a resource that will aid providers in providing hormone therapy and hopefully ease some of the seemingly extra workload that comes along with it.

KEY MEASURES FOR IMPROVEMENT:

Provider confidence with prescribing FtM and MtF hormone therapy, provider confidence of risks and benefits of hormone therapy, increased conversation between providers and patients about the risks of hormone therapy, and ease of utility of accessing trans-affirming hormone therapy guidelines.

PROCESS OF GATHERING INFORMATION:

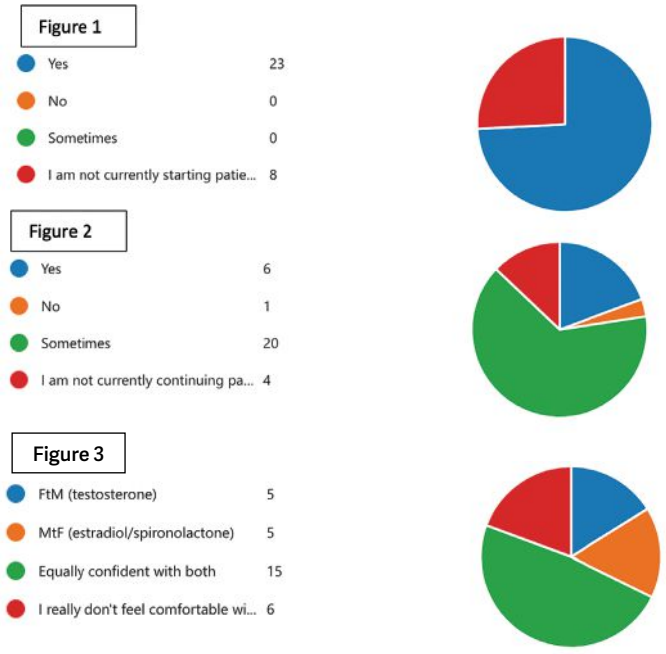
Assessing the need – A survey was sent out to FMRWM faculty and residents, as well as providers, asking for input on what sorts of resources would empower providers to feel comfortable and confident in providing full-spectrum trans-affirming and gender diverse care. There were 31 total respondents to this survey and responses were anonymous. It was an 8-question survey and took approximately 4 minutes for respondents to complete.

ANALYSIS AND INTERPRETATION:

Survey Response - Risk/benefit discussions around HRT – are they happening?

- When a patient is HRT naïve [figure 1]

- When a patient is new to the provider but already on HRT (either at or transferring from an outside clinic) [figure 2]



Survey Response - Provider confidence overall:

- Assessed a scale from 1-10 (with 1 being no confidence at all, and 10 being full confidence/no questions or concerns at all), providers were asked how confident do you feel about counseling patients about the risks and benefits of trans-affirming HRT?
  - Average answer was a 5 out of 10 (31 respondents)

- Assessed on a scale from 1-10 (with 1 being no confidence at all, and 10 being full confidence/no questions or concerns at all), how confident do you feel about prescribing and monitoring trans-affirming HRT?
  - Average answer was a 6.83 out of 10 (31 respondents)

Survey Response - What type of hormone therapy are providers most confident with, or none?:

Survey Response - When asked about areas relating to trans-affirming and gender diverse medical care that you feel you would benefit from having in a concise resource that is easily available in your daily practice – the top answers were, in order:

1. Spironolactone dosing and when to start
2. Testosterone dosing and monitoring
3. Estradiol dosing and monitoring
4. Risks of testosterone therapy
5. Puberty blockers for transgender and gender diverse youth
6. Risks of estradiol therapy
7. Fertility options for transgender people

Trans-affirming and gender diverse medical care is a growing area of medicine, and primary care providers are frequently asked to support patients in either gender transitioning or non-binary affirmation by prescribing HRT. It is challenging to find a concise, user-friendly guideline in a quick search to support providers in this practice.

Based on these results, providers who are choosing to provide hormone therapy for trans and non-binary people are routinely having risk/benefit discussions with patients if they are the ones initiating their hormone therapy for the first time. These discussions dramatically decrease when a patient is being continued on hormone therapy, despite not knowing what the initial risk-benefit discussion may have been. I did not include a question that asked whether or not providers who responded "sometimes" to this question were asking patients about their understanding of the risk of hormone therapy first. Additionally, providers feel more confident on average about prescribing and monitoring hormone therapy (6.83 out of 10 average confidence) than they do about counseling patients about the risks and benefits of hormone therapy (5 out of 10 average confidence). There is an equal split between providers comfort with FtM and MtF hormone therapy. Additionally, in the response section for what providers would benefit from, there were a few responses that stated concerns with HRT as treatment for gender dysphoria, citing a lack of evidence behind hormone therapy and long-term data on harm. Given the above responses, I am working on creating a guide for providers to help them make an individualized, informed decision on hormone therapy with their patients and easily dose/monitor these hormones. I also hope to further explore new evidence behind hormone therapy and outcomes of it on the transgender and non-binary communities, so I can make sure that all providers have this information in an accessible way.

EFFECTS OF CHANGE:

I hope that the guide I have created for providers can be a quick reference for prescribing and monitoring hormone therapy. I also hope that the patient hand-outs regarding the risks of hormone therapy I have created will serve as a guide for providers during these conversations, as well as something for patients to take home so that they can make an informed decision about what is best for their health. I plan to continue this QI project next year, as it was such a large undertaking and came with a significant amount of scholarly research, so I hope to be able to share my guide and hand-outs with providers this summer 2023 once they are finalized, and then get feedback on them and assess their impact on clinical practice.

LESSONS LEARNED:

Trans-affirming and gender diverse medical care is a growing area of medicine, and primary care providers are frequently asked to support patients in either gender transitioning or non-binary affirmation by prescribing HRT. It is challenging to find a concise, user-friendly guideline in a quick search to support providers in this practice. Throughout my work, I looked at multiple resources, and found some variation in recommendations for practice or guides with abbreviated information. It took much longer than I had anticipated to pull it all together. This is an evolving area of medicine, making it all that much more important that patients are making informed decisions about their care. Please see below for the references and resources that I utilized in my research.

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Mongolia rotation teaches value of public health

By Dr. Adam Putnam

Mountainous Mongolia is a beautiful, sparsely populated place with a harsh climate and a rural population mostly engaged in raising livestock. The similarities with Montana struck me when I arrived in that east Asian nation for a four-week rotation in June.

My flights to the capital city of Ulaanbaatar took about 30 hours altogether. Half of the country's 3 million citizens live in the capital, which has large teaching hospitals and comprehensive medical services. Many of their patients have traveled days to reach definitive healthcare. There is no air service outside the capital for a vast area four times as large at Montana. Two-lane paved roads lead to provincial capitals. Beyond them, roads may simply be bumpy tracks that require vehicles to navigate rocks and rivers.

Each year, one Montana Family Medicine Residency second- or third-year resident has the opportunity for a rotation in Mongolia. The COVID-19 pandemic interrupted the program, so mine was the first Mongolia trip since 2019. MFMR partners with BioRegions and Montana State University in Bozeman on these rotations to improve the health of people in Mongolia. The collaboration also enhances Montanans' understanding of healthcare in situations with limited resources.

I was part of a 14-person team that included four University of Washington medical students and two Mongolian medical students. BioRegions organizers on our team knew everybody we met and served as our drivers, translators and cook.

Our Mongolian hosts asked our team to focus on stroke care. Stroke is the second leading cause of death for men and women in Mongolia, behind ischemic heart disease.

Considering the remoteness of the population, I decided to focus on stroke prevention. I planned education about the importance of controlling high blood pressure and managing diabetes. BioRegions brought me ideas for stroke education, based on their surveys of what the Mongolian bagh (rural) doctors wanted to learn about.

Our final destination was the Darkhad Valley in northwestern Mongolia between the Ulaan Taiga and Khoridol Saridag mountain ranges. People live in wooden houses with wood stoves. Diets are based on meat from their herds of sheep, goats, yaks or cows. The meal is usually slaughtered and cooked the same day. Potatoes and carrots grow there, but other vegetables must be trucked in from distant cities. Rural residents prepare milk and yogurt. Vodka is a popular beverage as well as fermented mare's milk that tastes like beer.

We were welcomed warmly on our trip by provincial governors, physicians and other citizens wherever we went. I accompanied rural doctors on home visits to stroke survivors who were being cared for by family. I offered recommendations for preventing further disability, like talking to patients about the importance of moving around. I saw myself as a consultant to the local healthcare providers, not as some white knight riding into intervene with clinical care.

One provincial clinic had just received its first ultrasound machine. We pulled the machine out of the plastic wrap, set it up and demonstrated how to use it. I use point-of-care ultrasound in my Montana practice for a variety of cases, so I know how valuable this imaging modality can be. I suggested that next year's Mongolia team include an ultrasound technician to provide more training.

I tried to teach self-care because one clinic visit without follow up won't help stroke patients very much. I learned that even in the remote valley, people had referrals to appropriate care. They have appointments with specialists in the cities. The distance to that care is a challenge.

BioRegions has been working in this area of Mongolia for 30 years and provides the collaboration that makes our MFMR rotation possible. Our BioRegions hosts announced where we would be and people traveled to meet us. In one place, I suddenly learned that my audience expected a four-hour presentation. I improvised and spent a day talking about self-care and answering questions – all with a translator.

In Mongolia, everything for me was a learning experience. I was amazed by how hard healthcare professionals and patients work just to maintain medical care.

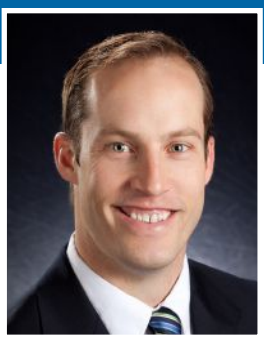
I was humbled to be welcomed into patients' homes. I learned that when you have almost no medical resources and you're in the middle of nowhere, you have think simply, keep it easy and try to meet people where they are.

As family physicians in the Montana, how often do we get to walk into a patient's home? If I knew how all my patients lived, I would change a lot about how I practice.

Dr. Adam Putnam, a third-year resident of the Montana Family Medicine Residency, plans on rural Montana practice after graduation in summer 2024.

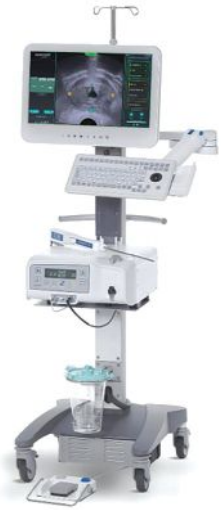
Western Montana Health System Pioneers Advancements in Urological Surgical Care

Robotic Aquablation Therapy shows better patient outcomes



Chris Wicher
Jeff Redshaw

Community Medical Center is pleased to begin offering Aquablation® therapy. Aquablation therapy, an exciting, new, minimally invasive procedure for men suffering from Benign Prostatic Hyperplasia (BPH).



What is Aquablation?

Aquablation is a minimally invasive surgical technology for benign prostate enlargement, which uses a heat-free high-pressure water jet to remove obstructing prostate tissue. A recent 5 year randomized controlled trial comparing Aquablation with TURP (long considered the gold standard), found equivalent improvement in flow rate and symptom score with a lower complication rate and a strong safety profile.[1] Its high-speed resection time and potential for preservation of sexual function are major strengths.[2] The procedure can be used to treat prostates of almost any size. In clinical studies, men who had Aquablation therapy had significant symptom relief and very low rate of irreversible complications – incontinence, ejaculatory and erectile dysfunction.

What are the advantages of Aquablation?

- Reduced resection time
- Reduced overall procedure time
- Strong safety profile
- Preservation of key anatomical structures
- Preservation of sexual function
- Good learning curve
- No ionizing radiation
- Avoids thermal damage
- Histology specimens available

Who qualifies for Aquablation?

Inclusion criteria:

- Moderate to severe lower urinary tract symptoms refractory to pharmacotherapy
- Age > 50 years
- International Prostate Symptom Score > 12
- Maximal flow rate Qmax < 12 ml/s

Exclusion criteria:

- Active infection
- Neurogenic bladder/sphincter abnormalities
- Some prior prostate surgeries
- High anesthetic risk

Success of Aquablation

Aquablation therapy is the only procedure that removes prostate tissue with a robotically controlled heat-free waterjet technology, which minimizes human error in removing prostate tissue and ensures that prostate tissue is removed precisely, consistently and predictably.

- 10/10 men preserved erections
- 9/10 men preserve ejaculation
- 10/10 men preserve continence
- 2x improvement in the flow of urine
- 16-point IPSS improvement (BPH symptom score)

To refer a patient for Aquablation or for a consultation with an Aquablation specialist, visit CommunityMed.org/Refer-Aquablation

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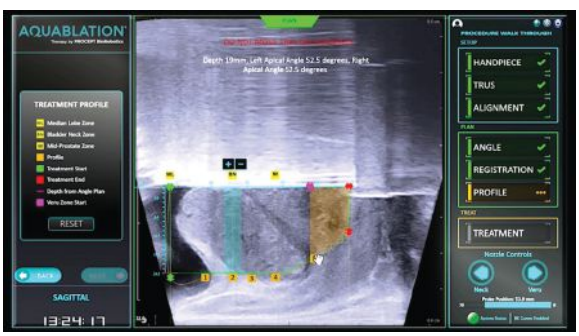

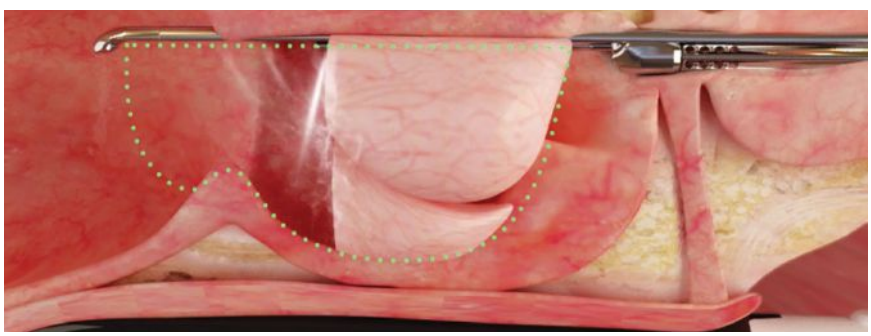

Family Medicine Advocacy Rounds

AAFP
AMERICAN ACADEMY OF FAMILY PHYSICIANS

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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 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.

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