THE OFFICIAL PUBLICATION OF THE MONTANA ACADEMY OF FAMILY PHYSICIANS

MONTANA FAMILY PHYSICIAN

Summer 2024 – MONTANAAFP.ORG

In This Issue:

TRADITIONAL VALUES – CONTEMPORARY METHODS

Established in 1917, commitment to personalized patient care has been a non-negotiable cornerstone of Great Falls Hospital. Our robust complement of primary care, oncologic services, and surgical specialties offers the region access to world-class medical expertise and quality outcomes right here in Central Montana. Patients choose Great Falls Hospital.

We continue to meet the healthcare needs of 250,000 rural Montana patients by prioritizing provider well-being and job satisfaction, enhancing clinic resources, and expanding our service lines. Great Falls Hospital demonstrates its dedication to our patients and providers through meaningful conversations and thoughtful strategic planning. Our 36-bed hospital expansion and addition of two new ORs and two Cath Lab suites are prime examples of our leadership in healthcare.

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MONTANA ACADEMY OF FAMILY PHYSICIANS

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MONTANA FAMILY PHYSICIAN

CONTENTS

EDITION 21

*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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David Brown, *President*
dbrown@pcipublishing.com
1-800-561-4686 ext. 103

For advertising info contact
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Edition 21

MAFP President's Message

Michael Strekall, MD, 2023/2024 MAFP President

My term as president will be ending soon so I wanted to share some observations regarding our academy.

With about 450 members, we are defined as a medium sized state academy by AAFP. However, we are a small group in the 4th largest state! I am very proud that we provide competent health care to all individuals regardless of their social, economic, religious, gender, ethnic, or political affiliations. I applaud you all as we continue to care for all ages that we serve.

The election of Jeff Zavala, MD, to the AAFP board of directors, presents Montana family doctors with an opportunity to have a more direct voice in national medical issues that impact our state. Such issues include Medicare reimbursement, physician workload, administrative burden, and physician burn out, all of which remain at the top of our list of concerns. If you have questions or suggestions, please share them with your Montana board members or Dr. Zavala

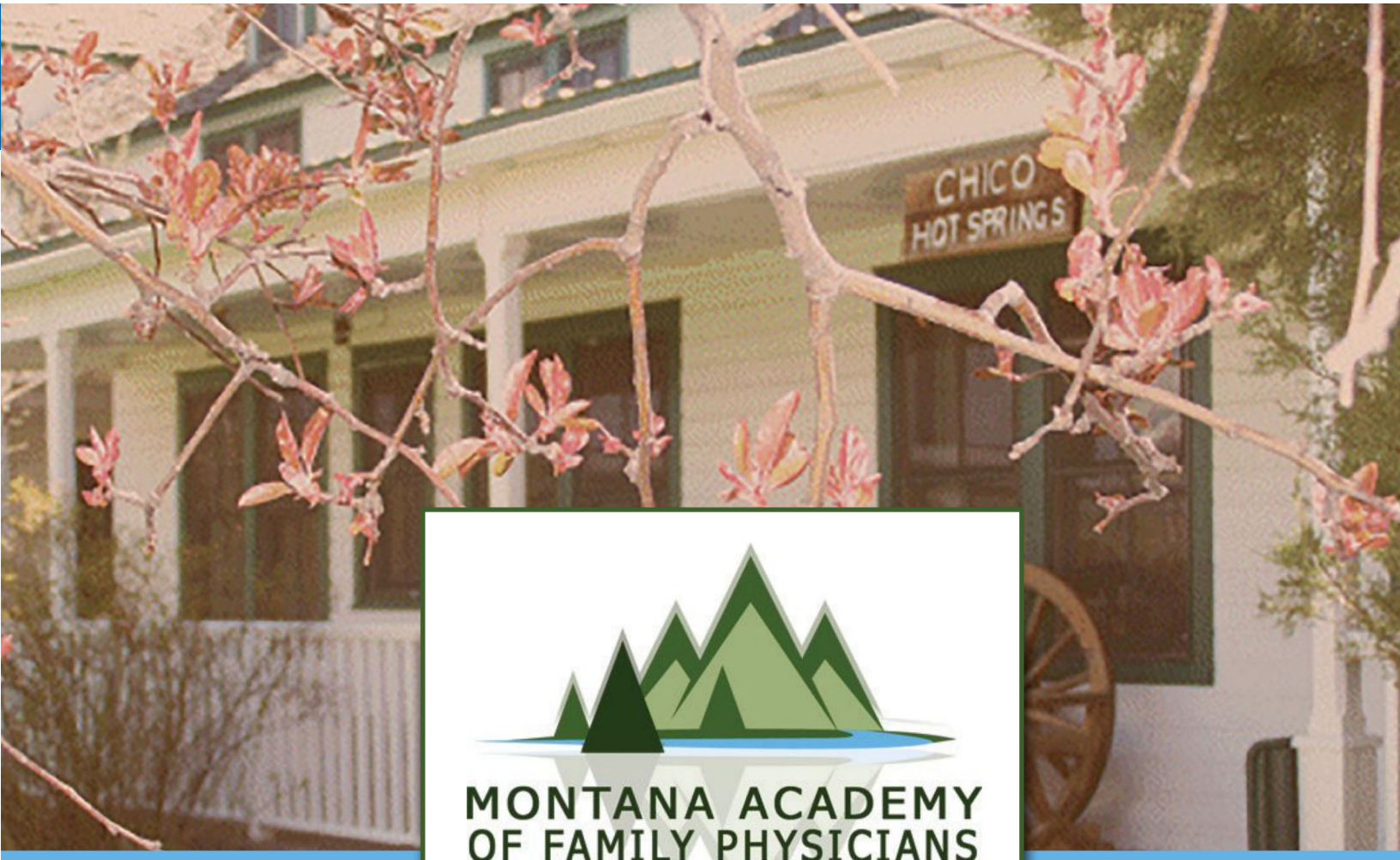
One area of ongoing concern is pediatric mental health. Our executive vice president, Linda Edquest, and I have worked with the Montana pediatric leadership to introduce the Referral and Evaluation service for Abused Children, REACH, program, which focuses on pediatric mental health issues and training. This virtual REACH training is currently free to the registrants and will again be available this fall. CME is also free because of the grants our pediatric colleagues have garnered. Don't miss this valuable opportunity! If you have questions, please contact Linda or me, and we will guide you to available resources.

With about 450 members, we are defined as a medium sized state academy by AAFP. However, we are a small group in the 4th largest state! I am very proud that we provide competent health care to all individuals regardless of their social, economic, religious, gender, ethnic, or political affiliations. I applaud you all as we continue to care for all ages that we serve.

Now is the time to plan to attend our annual summer meeting. It will be held at Chico Hot Springs in Pray, Montana, June 20 through 21st. I suggest that you register online for the educational sessions and then call Chico Hot Springs 406-333-4933 to secure your room, using the MAFP's group discount. The CME offers will include many topics such as ADHD, dermatology, OB, obesity, Pap guidelines and wellness discussions. Chico and the surrounding area have lots of family friendly activities, including nearby Livingston and Yellowstone Park. Please look for the brochure in your mailbox or go to the website, www.montanaafp.org to review the event and sign up.

At Chico you'll have an opportunity to meet Dr. Sarah Sams, MD, FAAFP, who is the AAFP board member attending our meeting. She is an associate director and full-time faculty member of Grant Family Medicine Residency in Columbus, Ohio. She will offer insight into the AAFP board of directors and be able to discuss national concerns.

Thank you for allowing me to represent you while I have served as your state president. I will be passing the baton of leadership to Dr. Saul Rivard, MD. As attendees at the conference, you and your families are all invited to join your board of directors for an indoor reception, picnic, and election of new officers at Chico Hot Springs on June 20th. I look forward to seeing you at the summer meeting.



MONTANA ACADEMY
OF FAMILY PHYSICIANS

73nd Annual

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

June 20-21, 2024

Chico Hot Springs, Pray, MT

Register on line at: www.montanaafp.org

Application for CME credit has 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.

PrEP IS A GAME CHANGER

HIV NEXUS

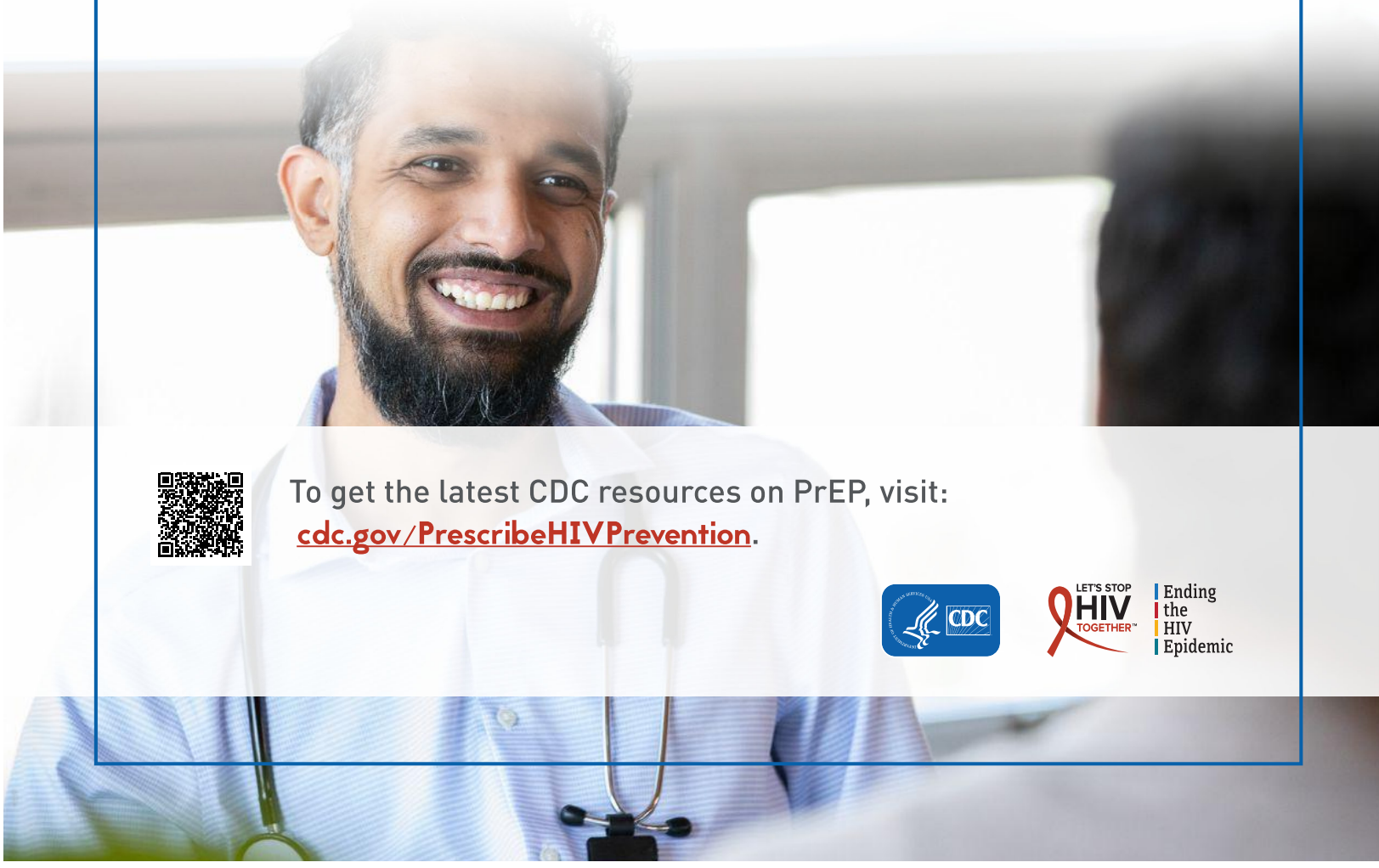
CDC RESOURCES FOR CLINICIANS

Prescribe PrEP to Your Patients.

Pre-exposure prophylaxis (PrEP) is 99% effective at preventing HIV from sex when taken as prescribed, making it a game changer for ending the HIV epidemic. Yet, not enough people who could benefit from PrEP are prescribed it. You can help increase PrEP coverage by talking to all your sexually active patients about the benefits of PrEP.

CDC's updated **PrEP Toolkit** contains resources for you and your patients, including:

- The latest CDC guidance on prescribing PrEP to prevent HIV.
- Posters about PrEP, available in both English and Spanish, to display in your practice.
- Strategies for starting conversations with your patients about PrEP.
- Information for patients about how PrEP works, its side effects, and how to pay for it.



To get the latest CDC resources on PrEP, visit:
cdc.gov/PrescribeHIVPrevention.

CDC

LET'S STOP HIV TOGETHER™ | Ending the HIV Epidemic

Board Member Profile

Courtney Honken, MD

I consider myself lucky to be born, raised, and now training in Montana as a resident physician at the Montana Family Medicine Program in Billings. I grew up in Frenchtown, MT where I loved the small town spirit. The camaraderie and support I had there has had a strong influence on my goals in life (namely, to not sit in traffic or live anywhere with more people than deer). My undergraduate years were spent at Montana State University where I was converted to a lifelong Cats fan. My parents are unfortunately a House Divided as my brother became a Griz. I studied Bioengineering with an interest in prosthetics. To balance the science and math, I also minored in Hispanic Studies and had the opportunity to study abroad in Valencia, Spain for a semester. Upon graduating, I interned with a Prosthetics and Orthotics group where I learned that I enjoyed patient interactions and direct care more than fabricating equipment. This started my path into medicine. While I got my ducks in a row to apply to medical school, I worked for LifeCenter Northwest on their Tissue Recovery team. I gained some invaluable exposure to the world of organ and tissue donation. It's also where I met my now-husband so win-win all around!

I was accepted into the UW Montana WWAMI medical school as well as the TRUST (Targeted Rural and Underserved Track) program. My TRUST site was Libby, MT where I was fortunate enough to spend time with the fantastic providers there and get to know their beautiful corner of the world. My husband was also a TRUST student in Libby. We both loved it so much that we got married at a campground near Lake Koocanusa! When looking for residency programs, MFMR drew me in with their emphasis on rural Montana medicine and care provided to underserved populations. I am currently in my first year with the program and have loved getting to stay in Montana for my training. Eventually, my husband and I would like to settle down in rural Montana once we have finished training.

When I'm not at the clinic and the weather cooperates, I love being on the river and camping with friends and family. There's something about sleeping on a hard ground and smelling like campfire smoke that really rejuvenates me (while also making my back hurt and appreciate my bed that much more). During the winters, I make my way to the hot springs whenever I can. I have however retired from rolling in the snow before getting back into the warm water. No matter the time of year, I enjoy visiting all local breweries. You just can't beat a good Montana beer with friends. Currently, I am attempting to develop a green thumb though I haven't made it past hard-to-kill houseplants yet. Turns out I am better at caring for humans!

We Need You!

Join our integrated care team in rural Colorado! We are looking for MDs and DOs to join our integrated (medical/dental/behavioral health), patient centered, federally qualified health clinic in Lamar, CO.

- We provide a full slate of medical support professionals to complement your role at our clinic, easing the burden wherever possible.
- Lamar is the county seat in rural Prowers County in southeastern Colorado. There are two elementary schools, middle school and a high school, alternative school, and charter school for secondary education, as well as a community college.
- We are conveniently located 3.5 hours from Denver and just over 2.5 hours from Colorado Springs.

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Contact: **people@highplainschc.net** or visit: **http://www.highplainschc.net/**

Montana Osteopathic Medical Association

Billings Clinic

MOMA Primary Care Roundup

August 9-11, 2024 + 60 days enduring content

- Choose to attend in-person or online!
- Earn up to 26.0 credits across a variety of disciplines
- Receive 60 additional days to view most content in enduring format

Register by August 7th for 60 days of access to the enduring material.

Scan the QR code or visit billingsclinic.cloud-cme.com for more information and to register!

This activity is sponsored by the Montana Osteopathic Medical Association in partnership with Billings Clinic.

AOA
The Montana Osteopathic Medical Association is accredited by the American Osteopathic Association to provide osteopathic continuing medical education for physicians.

The Montana Osteopathic Medical Association designates this program for a maximum of 26.0 AOA Category 1-A credits and will report CME and specialty credits commensurate with the extent of the physician's participation in this activity.

AAFP
Application for CME credit has been filed with the American Academy of Family Physicians. Determination of credit is pending.

How Can Health Care Providers Address the Health Disparities Experienced by American Indian Communities in Montana?

American Indian (AI) Montanans die at younger ages than White Montanans. The median age at death among AI men was 60 years and among AI women was 64 years between 2017 and 2021.[1] That is 15 years younger than white men and 17 years younger than white women in MT. Examining the leading causes of death by age group prior to age 65 can suggest the most effective interventions to prevent pre-mature deaths among AI Montanans.

The most common causes of death among AI children and adolescents are unintentional injuries and suicides.[1] These two causes of death account for more than half of all deaths among AI Montanans aged 0 to 24 years old. Across all age group about 40% of unintentional injury deaths are due to motor vehicle crashes and 30% are due to poisoning from drugs or alcohol.[1] The most common substances associated with drug poisoning deaths were methamphetamines, opioids, and the combination of alcohol with other drugs.[1]

Perinatal conditions (mainly related to birth trauma and consequences of preterm birth) and birth defects were the third and fourth leading causes of death among youth.[1] These causes accounted for nearly all infant deaths. Birth certificate data from this same period show that only 48% of AI women reported starting prenatal care in the first trimester and nearly 7% reporting not receiving any prenatal care.[2]

The leading causes of death among young adults were very similar to youth with unintentional injury still being the most common cause and suicide being the third. However young adults are also dying of chronic conditions at an unusual level for this age group. Chronic liver disease was the second leading cause of death.[1] Nearly all chronic liver disease deaths in this age group were due to alcoholic liver disease.[1] Heart disease was the fourth leading cause of death among AI young adults. Ischemic heart disease accounted for about 1/3 of heart disease deaths.[1]

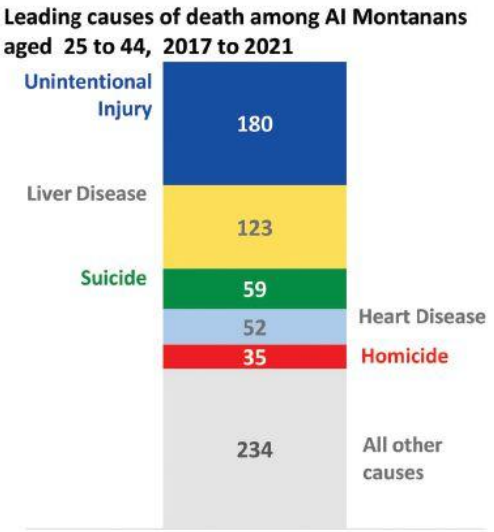
Nearly half of death among middle aged AI Montanans were caused by chronic conditions: heart disease, cancer, and chronic liver disease. Ischemic heart disease was still the major type of heart disease in this age group accounting for nearly 70% of heart disease deaths.[1] The leading causes of cancer deaths were lung and bronchus (18%), colon and rectal (12%), liver and bile duct (10%), pancreas (9%), and breast (5%) cancers. Liver disease was still almost entirely due to alcoholic liver disease.

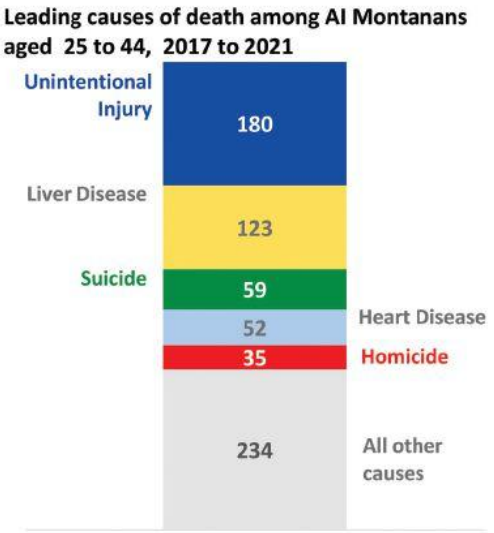
COVID-19 was the fourth leading cause of death among AI aged 45 to 64.[1] Of course, these deaths occurred entirely in 2020 and 2021. Among deaths in those two years alone COVID-19 was the most common cause of death in this age group.

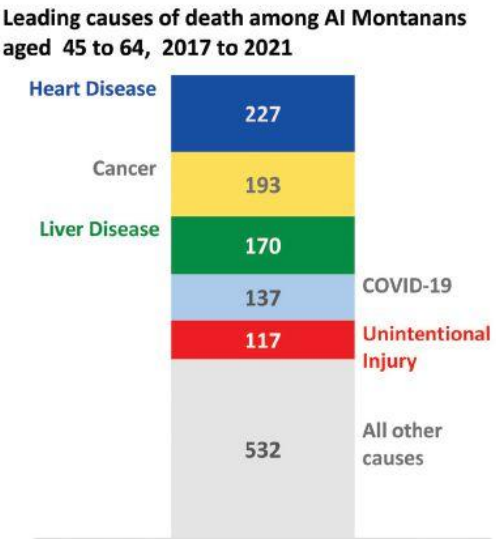
The most common causes of premature death are largely related to modifiable risk factors including: commercial tobacco use, alcohol use, substance use disorder, poor diet, little or no physical activity, and lack of preventive healthcare such as: vaccines, cancer screening, or high blood pressure management. Changing these risky behaviors requires correcting the current social environment and acknowledging the historical trauma that led to it.[3]

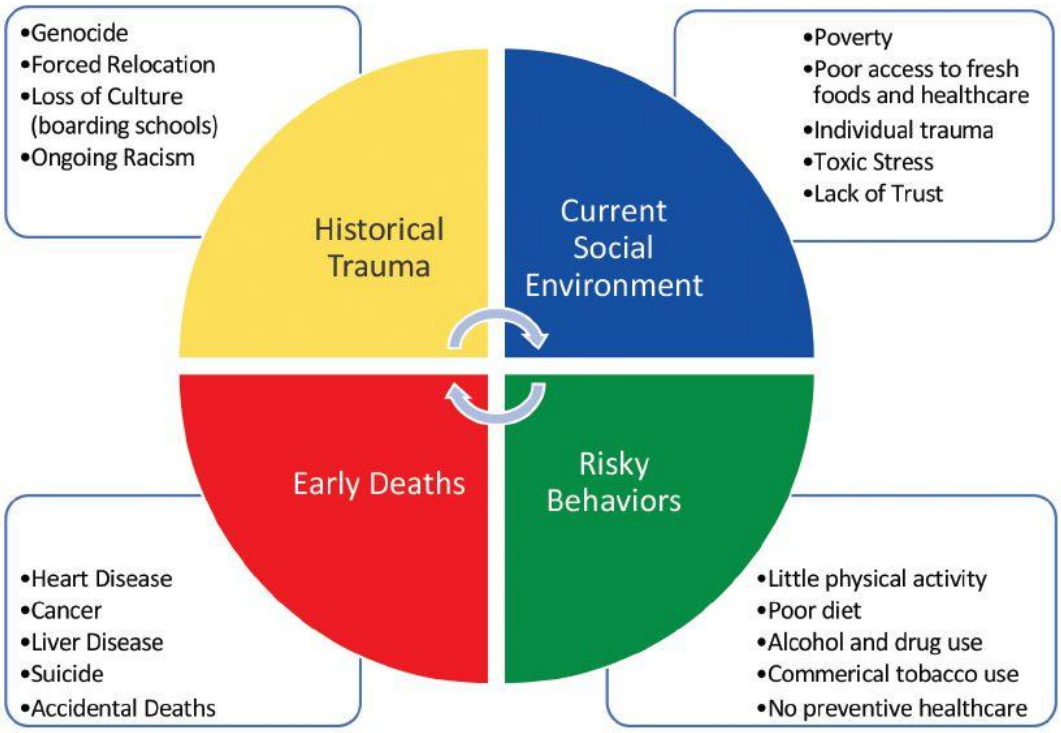
Health care providers can address the social determinants of health through partnerships between local and tribal governments, community organizations, public health, and other health care organizations.

- Learn about the cultural practices of the tribes you work with and the importance of including traditional healing practices with modern medical treatments when that is the patient's preference.









References

1) Montana Department of Health and Human Services, Montana Office of Vital Statistics, death data 2017 to 2021.

2) Montana Department of Health and Human Services, Montana Office of Vital Statistics, birth data 2017 to 2021.

3) Warne, D., & Lajimodiere, D. (2015). American Indian health disparities: Psychosocial influences. *Social and Personality Psychology Compass*, *9*(10), 567-579.

- Talk to patients about their barriers to adopting healthy lifestyles and work with them to identify ways to reduce those barriers.
- Ensure access to medical and behavioral health preventive care services, including relevant patient-reported and biometric screenings (e.g., cancer, mental health, substance use).
- Provide in-office health and safety education with the goal of reducing risk factors for injury (e.g., seat belt use, gun safety) and disease.
- Reach out to community and social services organizations in your area to identify local resources and refer patients who could benefit from their services.

Montana medical providers are well-poised to enhance the health and well-being of their patient population. Acknowledging and incorporating your patients' social needs into clinical practice is essential for delivering high quality, culturally informed care and improving the health of all Montanans.

WWAMI Updates

Montana WWAMI Clinical Dean, Jay Erickson, MD, joined four Montana WWAMI TRUST Scholars, Erin Calkins (E-2020) and three first year students, Chelsea Koessel, Olivia Reid, and Allie Stevens, at the National Rural Health Association Policy Institute in Washington D.C. last February. A key focus of TRUST is to educate, encourage and support students to deepen their understanding and abilities as healthcare advocates, particularly around rural health. The NRHA provides the opportunity for students to explore and engage in healthcare advocacy.

Erin Calkins (E-20 Anaconda TRUST Scholar) reflected on her experience at the NRHA.

- I learned about the collaborative nature of participating in national associations, what that looks like on a national level, and how organizations can leverage member voices and expertise to make impacts to policy.
- I learned about legislation and how to approach representatives of congress and their staff about important topics that significantly impact the populations we serve as rural healthcare providers.
- I learned that about 18 million women of reproductive age live in rural communities, and that over 50% of rural counties have no hospital-based obstetrical system. Rural residents have a 9% greater probability of severe morbidity and mortality. Currently, there are three specific pieces of legislation directed at improving rural maternal health outcomes.
- Health Resources and Service Administration (HRSA) sponsors a National Maternal Mental Health hotline, which I will share with my colleagues and my patients.
- I now know that 80% of rural America is medically underserved with only 10% of US physicians practicing in rural areas. There are programs through HRSA designed to increase residency programs in rural areas, with the goal of improving workforce development. Students who train in a rural area are more likely to stay and practice in a rural area. I am a TRUST scholar and I have applied to two residency programs with rural tracks. The unfortunate truth is there are limited positions in rural tracks, especially in OB/GYN.
- Medicaid expansion has been a lifeline to rural Critical Access Hospitals, and if Medicaid expansion were to be discontinued, many rural communities would be at risk of CAH closure, creating further distances to reach care.
- I was grateful to attend with Dr. Erickson, as his passion for rural medical education was inspiring and our conversations regarding approaches to improving healthcare in Montana helped to frame my approach to residency training and post residency planning. I appreciated the opportunity to mentor first year UW medical students at the conference. I was able to answer many questions about later medical education phases and provide a sounding board for RUOP and WRITE project ideas related to rural underserved community projects. I am excited to see where they end up practicing and hope it is also in rural Montana.

MONTANA WWAMI

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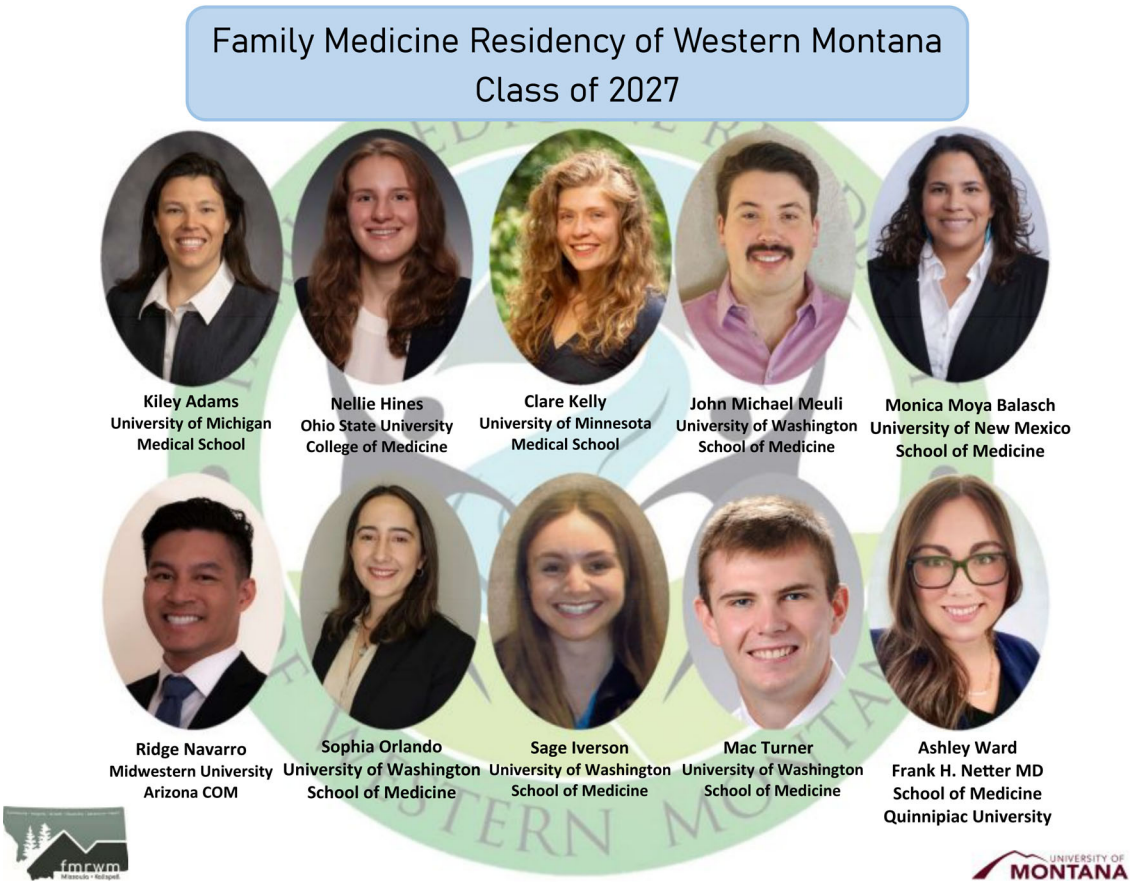
WWAMI
UW SCHOOL OF MEDICINE
Regional Campuses

MAFP Welcomes Montana's Incoming Family Medicine Intern Class!



Part-Time Precepting:
Rewarding Work With Residents

By Roxanne Fahrenwald, MD

Community preceptors – physicians working as part-time or "PRN" faculty, supervising and teaching residents – provide important perspective to primary care residents. The work is rewarding for the preceptors, too.

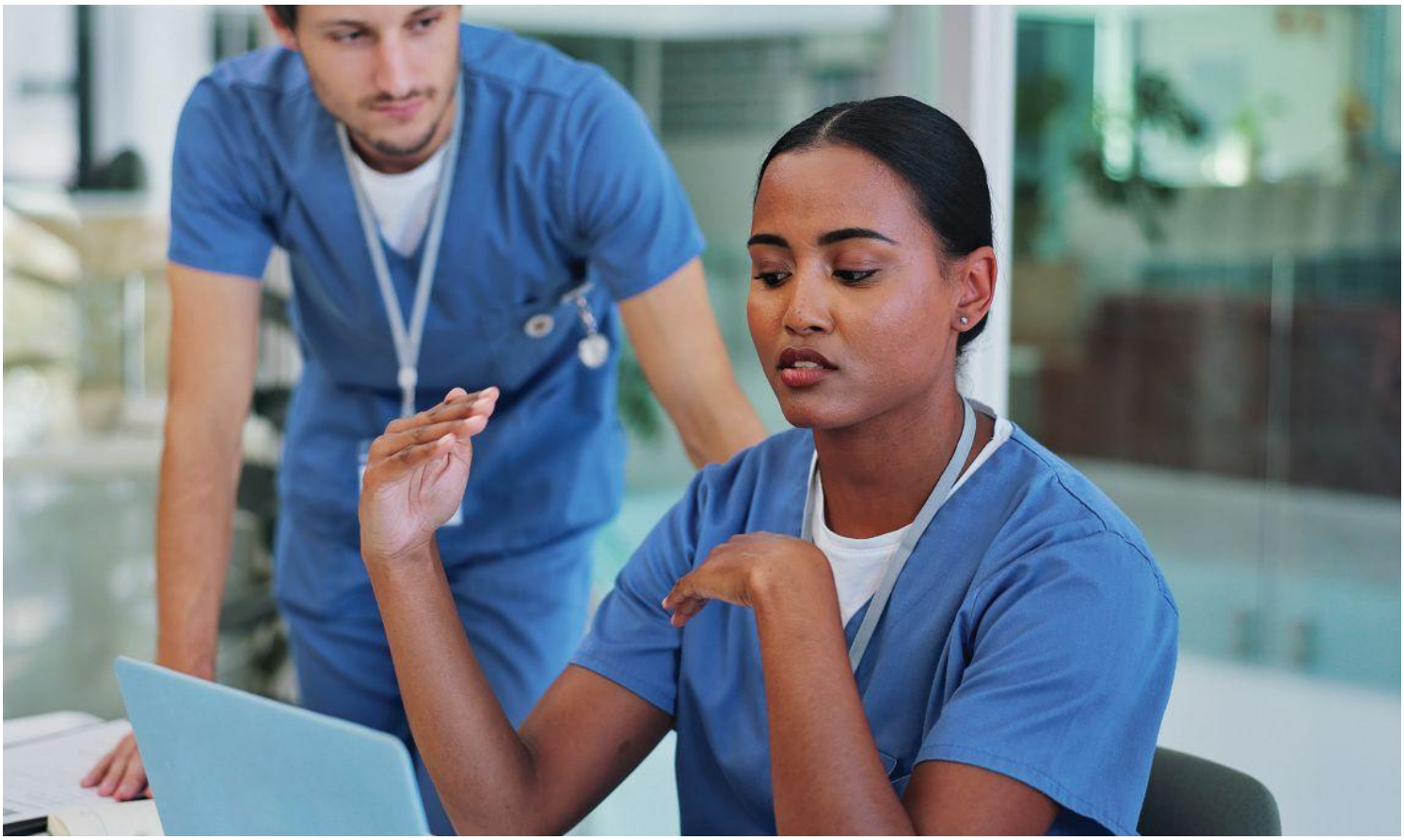
When I was director of the Montana Family Medicine Residency based at RiverStone Health Clinic in Billings, we recruited community family physicians to work with residents in local hospitals and our teaching clinic. Physicians in private practice can add valuable perspectives born from experience to the residents' training, complementing the full-time faculty who may have a more academic outlook.

There are benefits to community physicians who precept. As a preceptor, you will learn about the latest treatments and research in patient care and hear residents' questions. It will keep you on your toes. Precepting can also provide opportunities to recruit new partners. You get to know residents and learn who may be a good fit to join your practice. There are now 40 MFMR graduates practicing in Billings or within an hour's drive of the city.

Community preceptors look at practice as employed physicians, which is what most residents will be when they graduate. When they sit down with residents to discuss patients, they share practical points of view, knowing the resources that are available and what patients will do and can't do. It's a different context for assessing patient needs as an individual.

Community preceptors can also model how to integrate medical practice into real life. They share tips on what residents must do to become efficient in clinical practice. They know how you need to organize your day so you can have a life – so you're not up at midnight finishing your clinical notes; you're asleep.

My career has been in academics – first in New York and then in Billings -- except for two years after residency in Alaska. Some of this was also engaging with national academic and community health center organizations and with advocacy. I retired from full-time faculty and clinical work for family reasons. Then I asked to return and only teach.



I always learn new things from residents. I help them explore and develop their style, practice and patient panel. They are determining what they are going to do after they graduate. Some will be great in academics, others in hospitals, clinics or a combo of those settings.

As a part-time preceptor, I have complete control over my schedule. If I want to take a vacation or visit family, I do. I give the MFMR scheduler a calendar of my availability months in advance. As a "PRN" employee, I am doing what I love to do in a place with a mission that I agree with completely. At RiverStone Health, we care for everyone.

A majority of our patients are economically disadvantaged and often uninsured. RiverStone Health Clinic serves many patients who are homeless. We have a high number of patients with multiple chronic illnesses, and others who struggle with substance use disorders and other mental health conditions. This requires thinking about the patient's life and context as you recommend treatment. If your patient needs specialty care, can you find a specialist who will take the case? Does the patient have transportation to follow up therapy? Our patients give private practice physicians a broader understanding of their community and services.

I work with all the residents at RiverStone Health Clinic, Billings Clinic and St. Vincent Regional Hospital. I precept maternity care, and care of children and adults. Residents are responsible for the electronic "paperwork" and I am responsible for seeing that they do it correctly. It's way less documentation for me than in my own practice!

MFMR and most residencies nationwide commonly have faculty vacancies. Even if all regular positions were filled, residencies would have room for more part-time faculty.

When MFMR started, it was the first and only medical residency in Montana. Now there are three primary care residencies and residents train at multiple sites, including Billings, Missoula and Kalispell. If you live a reasonable distance from one of these communities, you might give the residency a call about precepting. My guess is they'll say: "When can you start?"

You'll get a lot out of it, maybe even a new physician partner. You'll learn some new things and share your wisdom and experience with residents. You'll exchange perspectives in new and wonderful ways. You have a lot to share and a lot to give. Try it!

Dr. Roxanne Fahrenwald, MD, moved from New York to Billings in 1998 to become a faculty physician at the Montana Family Medicine Residency, just three years after the residency was accredited.. After serving as director for 16 years, she continues teaching and mentoring.

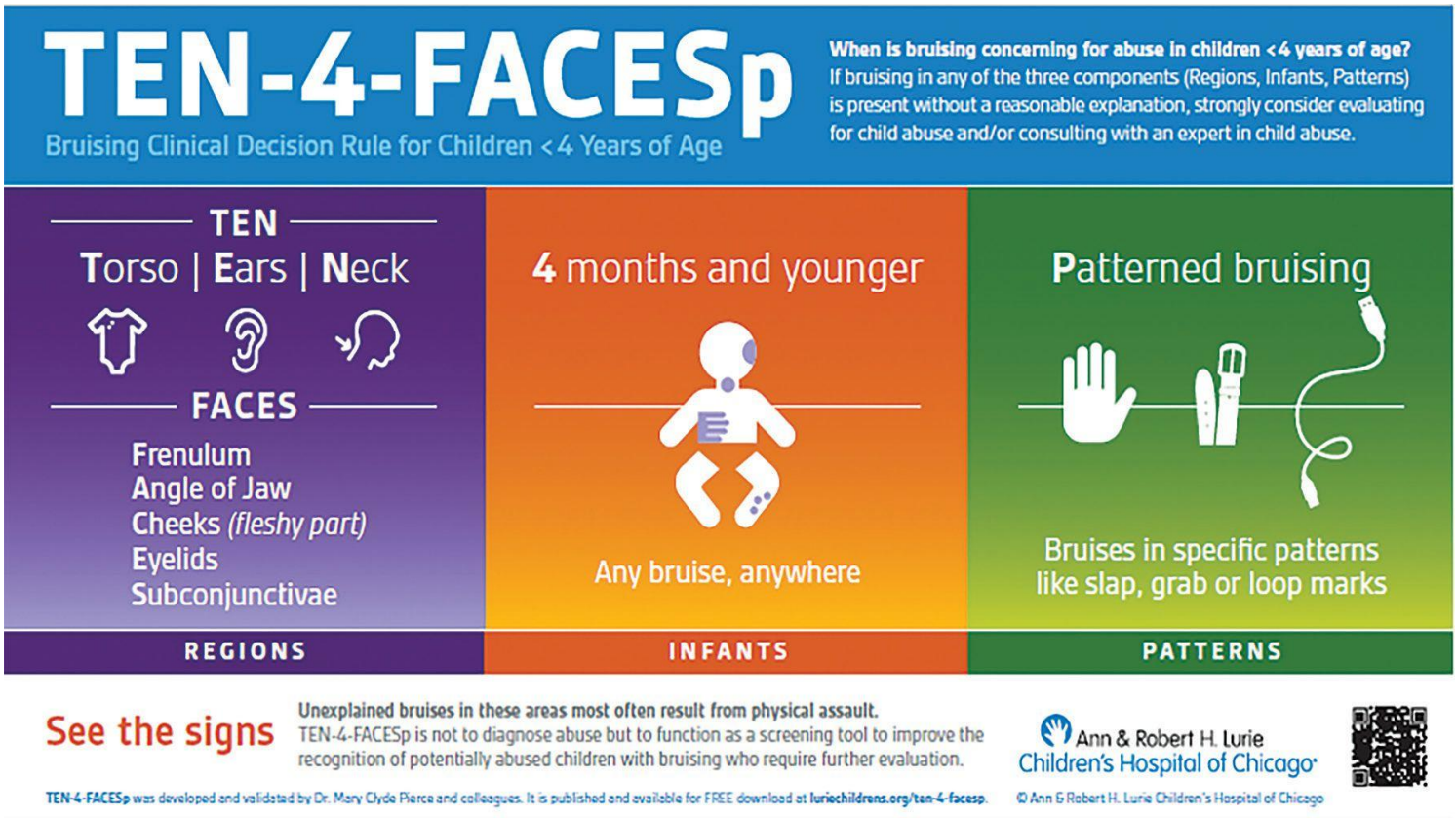
Bruising in Certain Locations Can be Highly Suggestive of Abuse in Children

It is imperative that everyone, especially those who provide medical care for children, are educated on the common warning signs of child abuse. One way to remember some of these warning signs is the "TEN-4 FACESp" Bruising Clinical Decision Rule (Pierce et al, JAMA Network Open 2021).

The "TEN-4 FACESp" Bruising Clinical Decision Rule states that any bruising on the Torso, Ears and Neck (TEN) as well as the Frenulum, Angle of jaw, Cheeks, Eyelids, Subconjunctivae (FACES) and Patterned (p) bruising for children under the age of 4, and AND bruising on a child who is not yet pulling up or walking, especially 4 months of younger, is a big red flag for child abuse. Having one of these bruises has been found to greatly predict the risk of more serious injury, including abusive head trauma (Sheets et al, Pediatrics 2013).

The American Academy of Pediatrics' policy statement, Abusive Head Trauma in Infants and Children (Narang et al, Pediatrics 2020), affirms that particular attention should be given to "TEN-4" bruising. Learn more at https://youtu.be/evFiNHfFJ4o from Lurie Children's Hospital and https://www.youtube.com/watch?v=UNeIk6yeac8 from Norton Children's Hospital.

Montana promotes the education of medical providers, nurses, social workers, first responders, and other professionals who work with children and families on this rule, including through pediatric abusive head trauma (formerly known as Shaken Baby Syndrome) training. One such resource for education is the Children's Alliance of Montana (https://childrensalliancemt.org/).



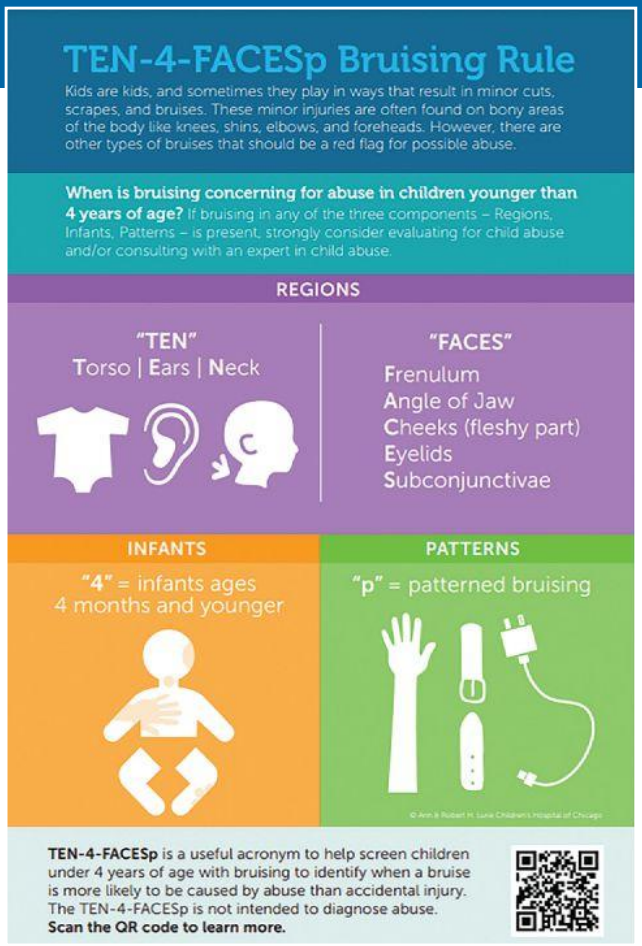
https://research.luriechildrens.org/en/community-population-health-and-outcomes/smith-child-health-outcomes-research-and-evaluation-center/tricam/ten-4-facesp/

We are looking to medical providers who care for children to help spread the word. We hope to create discussion and interest around the "TEN-4 FACESp" Bruising Clinical Decision Rule so the general public understands these signs of abuse, along with the importance of preventing child maltreatment and supporting families. One way we are hoping to spread the word is to have Montana join many other states in having October 4th proclaimed TEN-4 Day.

Will you join us in recognizing the TEN-4 FACESp Bruising Rule by adding your signature to the request for Proclamation by the Governor's Office for October 4, 2024 to be the first TEN-4 Day in the State of Montana?

Laurie Carter, MD, FAAP
Montana Chapter of the American Academy of Pediatrics
Child Abuse Champion

MTAAP



https://faceitabuse.org/wp-content/uploads/2023/03/TEN-4-FACESp-brochure.pdf

App from Lurie Children's to assess the plausibility of injury being due to physical abusebrochure.pdf

Interprofessional Team-Based Oncology Care:

Engaging Primary Care Providers in collaborative oncology care delivery from diagnosis through survivorship

Jack O. Hensold MD
Bozeman Health Cancer Center
Quality of Life Committee, Montana Cancer Coalition

Marg Hammersla PhD, ANP-BC
Montana State University, Mark & Robyn Jones College of Nursing
Quality of Life Committee, Montana Cancer Coalition

Becky Franks, MA
Cancer Support Community, Montana
Quality of Life Committee, Montana Cancer Coalition

Providing high quality oncology care from diagnosis through survivorship in rural and frontier communities presents unique challenges and opportunities. The use of an interprofessional team-based approach to oncology care with oncologist and primary care providers (PCP) collaboratively managing patients has the potential to improve health outcomes and patient experience.[1] Rural and Frontier residents with cancer have worse outcomes than their urban counterparts. This is due to geographic barriers, lower rates of health insurance, and socioeconomic disparities. Further, those living in the most remote areas appear to be forgoing any treatment at rates higher than those living closer to regional cancer centers. In Montana, as in much of the intermountain west, the geographic barrier to care is heightened by the scarcity of oncologists, as well as their clustering in larger regional centers: Nearly 90% of oncologists in Montana are based in just 6 of the 56 counties in the state.

Approximately 90% of direct cancer care in Montana is provided in regional cancer centers. Individuals undergoing treatment are returning to their home community between treatments, often greater than 60 miles from the regional center. This results in the need for the side effects of treatment, follow-up, and survivorship care to be managed, at least in part, by their primary care provider near the patient's home. Advantages of a team-based approach to care (Figure 1) for patients undergoing oncological treatment include reduced adverse events, decreased care fragmentation, and improved experience measures for patients.

During ongoing treatment most side effects become evident in the days following administration of anti-cancer medications. For patients living in rural areas, this occurs after they have returned to their home community. This often results in patients with side effects of treatment presenting to their primary care provider for acute management. In addition, patients often have pre-existing medical conditions, some of which may be exacerbated by cancer treatments that the primary care provider will need to take into consideration. However, there are few reported care models regarding the integration of PCPs into the ongoing care of cancer patients actively receiving therapy, although some large academic centers are developing such programs. Not surprisingly, surveys of PCPs indicate the need for education regarding the physical and psychosocial side effects of cancer treatments.

Figure 1: Interprofessional Team-Based Oncology Care

Follow-up and survivorship care is a time where the need for a team-based approach to care is vital as patients transition from active treatment to surveillance and any ongoing care needs. Survivorship is viewed to begin at diagnosis and extend through the lifetime of the patient, however, there are very specific survivorship care needs that begin upon completion of anti-cancer therapy. The goal of survivorship care is to address the physical, psychological, and social impacts of cancer treatment. Models for providing survivorship care have been developed since the Institute of Medicine's initial report on survivorship in 2006. In large, urban, resource-rich health care settings specific cancer survivorship clinics have been created to address the needs of patients upon completion of therapy. However, these models are not transferrable to small rural health care settings that lack the resources to develop and staff such a clinic. Thus, delivery of survivorship care falls to rural health care providers, as well as critical access hospitals, who may not be prepared to identify and address late and long-term effects of treatment. A survey of PCPs in Montana demonstrated only 1/3 felt fully comfortable with provision of survivorship care, a result that is consistent with national survey data. Thus, there is a need for education of PCPs regarding survivorship.

The development of a team-based oncology care model that includes PCPs in rural areas in both supportive care and survivorship care for cancer patients requires a well-thought-out strategy to improve integration of PCPs into the care of their patients with cancer. Further underlying this need, surveys indicate that as many as 95% of PCPs would prefer a more active role in the care of their patients during all phases a cancer journey. Current models of cancer care are inadequate as oncology clinics focus on navigating the increasing complexity of treating cancer, and the patient's primary care provider is not consistently incorporated as part of the care team resulting in potential care gaps and poor patient experience. As noted above, some academic centers are beginning work on incorporation of PCPs into the care of their patients with cancer and publications have championed the need for team-based oncology

care. Team-based oncology care incorporates oncologists, PCPs, social workers, nurse navigation, and community support services into the overall care for a patient diagnosed with cancer. However, implementation of team-based practices into the care for rural cancer patients is particularly challenging.

In addition to PCPs, a team-based oncology model needs to include community resources. Bringing these supportive organizations into the care team facilitates uptake of the vital services that they provide. The Montana Cancer Coalition (MTCC), a division of the state Department of Public Health and Human Services, strives to ensure better quality of life and enhance the odds of survivorship through prevention, early detection, and state-of-the-art cancer care. The MTCC has focused on improving survivorship care in Montana for several years. Most recently the MTCC launched a pilot project utilizing Project ECHO for survivorship education. Lessons learned from this pilot project have informed a new initiative beginning in 2024. There are 3 goals for this initiative, 1) ENGAGEMENT of the care teams, including both oncology providers and PCPs to emphasize the importance of team-based care for cancer patients, 2) Delivery of an EDUCATIONAL component and 3) Development of a RESOURCE, to provide easily accessible supplemental educational information to providers regarding cancer survivorship. An overriding goal of this effort is to facilitate communication among care providers regarding the benefits of team-based oncology care and to encourage development of team-based care. Current strategies to meet these goals include a presentation scheduled at the annual meeting of the Montana chapter of the American College of Physicians in September 2024 as well as plans to provide this presentation at CME activities in healthcare facilities throughout the state.

While the rationale and the models for team-based care are being developed in academic centers, the greatest need for their application is in smaller communities that receive care from multiple health systems, where efficient utilization of the more limited resources is essential. The need for effective and efficient care delivery will only increase as cancer case numbers increase with the anticipated aging of the population and with the continued improvement in cancer therapies resulting in an increase in the number of cancer survivors. In addition, the national focus on increasing access to cancer care will increase the role of primary care providers as more cancer care is administered in rural areas in collaboration with the local health care system. New models for increasing access to oncology care, including throughout survivorship, in rural areas are already in place in Montana on a small scale including the utilization of telemedicine and the delivery of online psychosocial supportive programs to improve quality of life. With the continued emphasis on the role of access to high quality oncology care in improving outcomes in rural areas utilizing a team-based care model in rural areas has the potential to reduce the urban-rural outcome gaps.

1) For an in-depth review of this subject, see https://doi.org/10.1200/EDBK_349391

Family Medicine Advocacy Rounds

AAFP
AMERICAN ACADEMY OF FAMILY PHYSICIANS

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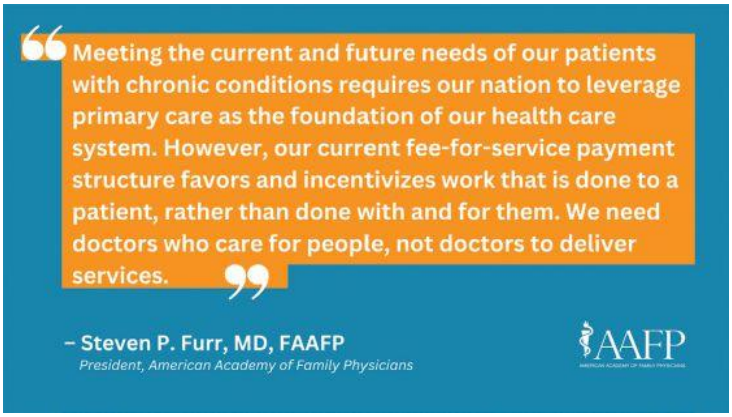
Welcome to Family Medicine Advocacy Rounds—the American Academy of Family Physicians' monthly tip sheet to educate, engage, and update you on the latest policy issues affecting family physicians and their patients.

AAFP President Highlights Need for Medicare Payment Reform



Why it matters: AAFP President Steven P. Furr, M.D., FAAFP, testified before the Senate Finance Committee on April 11 for a hearing titled "Bolstering Chronic Care Through Medicare Physician Payment."

Furr told senators how failure to invest in and uplift the true value of primary care is impacting patients every day. In his testimony, he outlined how improving traditional fee-for-service payments for primary care will further accelerate the transition to value-based payment models and ultimately better invest in primary care, lower costs, and improve health outcomes.

What we're working on:

- We've seen that advancing comprehensive, long-term Medicare payment reform will improve access to care for millions of beneficiaries.
- The AAFP is urging Congress to
  - more appropriately value the work of primary care within the Medicare physician fee schedule, which is the framework for many value-based payment arrangements;
  - reform budget neutrality requirements that unnecessarily pit physician specialties against one another while undermining CMS' ability to invest in all the services a patient may need;
  - address existing financial barriers that dissuade patients' utilization of chronic care management and other primary care services by waiving cost sharing responsibilities; and
  - provide primary care physicians and practices with more prospective, sustainable revenue streams that allow them to tailor the care they deliver to their patients' needs.

AAFP Applauds White House for Taking Action to Increase Student Loan Repayment

Last week, the Health Resources and Services Administration (HRSA) announced actions to support the primary care workforce. The AAFP applauds HRSA for moving to increase loan repayments by 50% for primary care physicians who practice in high-need and rural areas. This will improve access to care and strengthen the primary care physician workforce.

Family Physicians Appreciate New Value-based Payment Model

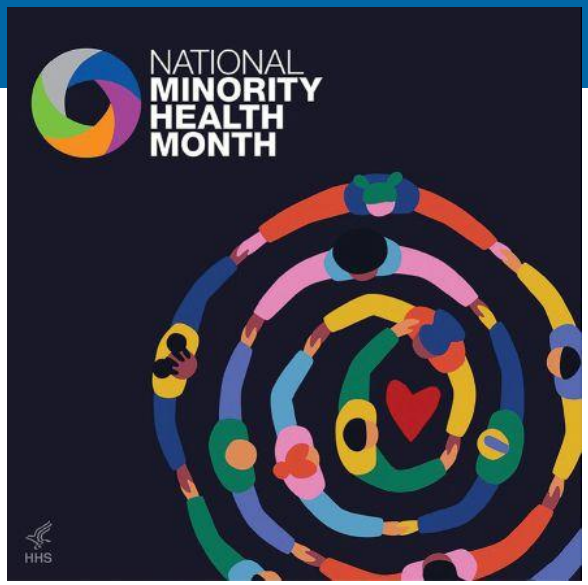
Why it matters: Family physicians know how value-based payment models support primary care and provide practices with predictable, stable revenue streams and flexibility to deliver high-quality, patient-centered care.

The Centers for Medicare and Medicaid Services recently announced the ACO Primary Care Flex Model. The new model will provide additional support to sustain practices participating in the Medicare Shared Savings Program, and it reflects several recommendations that the AAFP has shared with the Center for Medicare and Medicaid Innovation.

On March 6, AAFP member and Nebraska family physician Bob Rauner, M.D., M.P.H., FAAFP, testified before the U.S. Senate Committee on Budget during a hearing titled "How Primary Care Improves Health Care Efficiency." In his testimony, Rauner outlined how, in Nebraska, his physician-led accountable care organization has produced cost savings and improved patient outcomes.

Family Physicians Recognize National Minority Health Month

Why it matters: Family physicians are uniquely connected to their communities and witness firsthand the social and structural inequities in health and health care that disproportionately affect minority communities, making them well-positioned to intervene to reduce health disparities.



Part of health equity is addressing our maternal health crisis. AAFP Board Chair Tochi Iroku-Malize, M.D., M.P.H., FAAFP, wrote in *Medical Economics*: "While maternal mortality is a devastating reality, it is largely preventable. Family physicians play a key role in ensuring pregnant patients and babies have the best chance at a long and healthy life. By prioritizing postpartum care, and by recognizing the unique role of family physicians, we can make significant strides towards addressing this crisis."

What we're working on:

- The AAFP is urging Congress to tackle the steep medical student loan debt that makes a career in medicine unviable for many. Medical student debt can significantly affect underrepresented and low-income students and restrict their representation in the physician workforce.
- We're advocating for passage of the Resident Education Deferred Interest Act, which allows medical residents to defer their federal student loan interest during residency. This legislation would save them a significant amount of money in interest they would otherwise accrue and pay back during a time in their careers when their pay is quite low.
- The AAFP is calling on Congress to support the Stabilize Medicaid and CHIP Coverage Act, which would streamline coverage and improve equitable access to care. As the largest single payer of maternity care in the U.S., covering 43% of births nationwide, Medicaid and CHIP programs play a critical role in addressing our nation's maternal mortality crisis.
  - The AAFP also endorsed the Healthy MOM Act, which establishes a special health care enrollment period for pregnant people, guarantees one year of continuous Medicaid eligibility for postpartum individuals, and helps address maternal mortality.
  - We continue to support the Momnibus to address the Black maternal health crisis and stand as a resource to the Black Maternal Health caucus to meet moms where they are, get moms the care they need, and reduce these alarming rates.

Nominations are open for the 2025 Montana Family Physician of the Year!

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

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How Does the Activity Work?

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1 Reading List
Choose a topic and article from reading list.

2 Pre-Assessment Survey
Complete Pre-Assessment Survey of 3-5 questions.

3 Pre-Test Question
Pre-Test Question
Peer feedback provided – not scored

4 Article Access
Access granted to full text article to read.

5 Article Assessment Questions and Critiques
- Two Reading Comprehension Questions
- One Clinical Application Question
- One Methodological Question

6 Post Assessment Survey
Complete a 1-3 question post-assessment survey.

New articles now available

Human Trafficking Warning Signs

Warning Signs

- Signs of physical abuse (burn marks, bruises, cuts)
- Pelvic or abdominal pain; appears malnourished
- Tattoos or branding
- Possession of large amounts of cash, multiple cell phones and/or hotel keys ; offers to pay in cash
- Caught lying about age/possession of false ID; lacks official identification documents
- Avoids social interaction and authority figures/law enforcement
- Seems to adhere to scripted or rehearsed responses in social interaction; someone always speaks for them
- Unable or unwilling to give an address or information pertaining to parents/guardian
- Maintains sexually explicit profiles on social networking sites; over-familiar with sexual terms and practices
- Suicide attempt
- Bizarre relational dynamics/unsettling behavior
- Disorientated about date, time, and place
- Appears fearful, anxious, depressed, submissive, hyper-vigilant, paranoid, or excessively hostile
- Seemingly excessive number of sexual "partners"
- Multiple or frequent pregnancies and/or abortions
- Fearful attachment to a cell phone (often used for monitoring or tracking)

How Hospitals Can Help

What is Human Trafficking?

- Modern day slavery
- Exploiting a person through force, fraud or coercion
- Sex trafficking, forced labor or domestic servitude
- Human trafficking is happening everywhere around the globe to people of any age, gender, race, socioeconomic status or nationality
- Any person under the age of 18 involved in a commercial sex act

Identifiers of a Trafficker

- Significantly older than their female companions
- Encourages illegal activities and/or inappropriate sexual behavior
- Vague about his/her profession
- Demanding or pushy about sex
- Someone that exerts an unusual amount of control over the patient

How to Help a Victim of Trafficking

- Separate any companions from the patient and provide a quiet, safe place for the patient
- Attend to any physical needs of the patient; don't rush the patient
- Adopt open, non-threatening body positioning (sit at eye level, avoid touching patient unless given permission, be aware of body language, avoid crossing arms)
- Engage the patient with active listening skills, respectful and empathetic language; avoid judgment
- Educate hospital staff on the red flags and the protocol of actions to be taken
- Document suspected and confirmed trafficking using the new ICD-10 codes
- Invest community benefit dollars towards anti-trafficking initiatives
- Become acquainted with community groups/resources that help victims

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