THE OFFICIAL PUBLICATION OF THE MONTANA ACADEMY OF FAMILY PHYSICIANS

MONTANA FAMILY PHYSICIAN

Winter 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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Edition 23

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EDITION 23

MAFP President's Message

Saul Rivard, MD, 2024/2025 MAFP President

Greetings, MAFP members!

This past September, the Congress of Delegates (COD) held its annual meeting in Phoenix, AZ. The COD is the AAFP policy-making body whose membership consists of two delegates and two alternates from each constituent chapter. This year, Montana was well-represented by delegates LeeAnna Muzquiz, MD (Polson), and Janice Gomersall, MD (Missoula); and alternate delegates Janice Fordham, MD (Laurel), and Jason Sarisky, DO (Bozeman). More than 40 resolutions addressed a broad range of issues that impact family physicians' practices daily. After thoughtful review and discussion, delegates then voted on each resolution. For more information about the 2024 COD and its resolutions, you can visit this website: https://www.aafp.org/news/2024-congress-fmx/cod-action.html. During this meeting, Jen Brull, MD, FAAFP, of Fort Collins, CO, was installed as the new president of the American Academy of Family Physicians. I look forward to the good work she and the AAFP Board of Directors will accomplish on behalf of family physicians and our patients.

In Montana, we are fast approaching the beginning of our state's legislative session, convening January 6, 2025, and continuing for 90 days. The Montana Academy of Family Physicians is dedicated to ensuring that the important issues affecting the health of Montanans, and the physicians who care for them, are represented and heard this legislative session. Important issues the MAFP plans to address include access to care, criminalization of medicine, Medicaid expansion, and decreasing administrative burden.

If you are interested in testifying before a committee, please contact me or any one of our Board Members. Do not worry if you have never testified. I feel the most effective testimony is one that provides real-life stories and examples. Narratives can be incredibly powerful, especially as they pertain to legislation.

Finally, if you have not done so already, I encourage you to register for MAFP's annual Big Mountain Medical Conference, held in Whitefish, MT, January 29-31, 2025. In addition to earning highly relevant CME, participants can experience boundless opportunities to play in Montana's winter wonderland, or simply relax and enjoy the amenities offered by The Lodge at Whitefish Lake.

As I often tell my patients this time of year, stay warm, healthy, and upright!

Members of the Montana Delegation at the 2024 AAFP Congress of Delegates. From left: Jason Sarisky, DO (Bozeman), Linda Edquest (Chapter Executive, Helena), Janice Fordham, MD (Laurel), Janice Gomersall, MD (Missoula), LeeAnna Muzquiz, MD (Polson), Saul Rivard, MD (Missoula)

Save the Date!

MONTANA ACADEMY OF FAMILY PHYSICIANS

Presents The 64th Annual

Big Mountain Medical Conference

January 29-31, 2025

The Lodge at Whitefish Lake Whitefish, Montana

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

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

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Syphilis Treatment

Montana continues to experience a syphilis and congenital syphilis outbreak. Penicillin G benzathine (Bicillin L-A®) is the first line recommended treatment for syphilis and is the only recommended treatment for pregnant women infected with or exposed to syphilis.

In April 2023, the Centers for Disease Control and Prevention (CDC) reported some providers were unable to procure enough penicillin G benzathine (Bicillin L-A®) from Pfizer, the sole manufacturer. On June 10, 2024, Pfizer shared an update that their 2.4 million Units/4 milliliter Bicillin L-A® supply is now available, but the available supply of their 1.2 million Units/2 milliliter Bicillin L-A® product has limited inventory which may not cover market demand.

Montana DPHHS recommendations:

- Continue to monitor local supply of Bicillin L-A®.
- Order sufficient Bicillin L-A® to treat **all** patients diagnosed with syphilis and their contacts, as it is the recommended treatment for syphilis. The 2.4 million Units/4 milliliter Bicillin L-A® formulation is currently available. There is limited inventory of 1.2 million Units/2 milliliter Bicillin L-A®.
- Notify DPHHS if you are unable to order sufficient Bicillin L-A® by emailing HHSSTDprogram@mt.gov. If you do not have sufficient supply, have contacted DPHHS, and are awaiting assistance in ordering sufficient supply, prioritize using Bicillin L-A® to treat pregnant women with syphilis and babies with congenital syphilis. Penicillin is the only recommended treatment for these populations.
- Appropriately stage syphilis cases to ensure appropriate use of antimicrobials. Early syphilis (primary, secondary, and early latent) only requires 2.4 million units of Bicillin L-A®.
- A few reminders:
    - A thorough physical exam is necessary to accurately stage syphilis. Primary lesions are often hidden inside the mouth, anus or vagina; signs of secondary syphilis may be found on the skin, mouth or anogenital area (i.e. mucous patches, condyloma lata). The rash of secondary syphilis can be subtle.
    - Historical syphilis serologic test results can assist with staging a patient with latent syphilis as early latent if there is evidence of new infection within the last year (e.g., new seroconversion or a sustained four-fold increase in RPR titer in an individual who has had syphilis in the past).
    - Reviewing signs and symptoms and sexual partner history from the past 12 months can assist with determining the likelihood of syphilis acquisition within the last 12 months, which only requires 2.4 million units of Bicillin L-A® instead of 7.2 million units.

Pfizer Bicillin Availability Report: https://www.pfizerhospitalus.com/injectables_availability_report

CDC STI Treatment Guidelines: https://www.cdc.gov/std/treatment-guidelines/syphilis.htm?ACSTrackingID=USCDCNPIN_122-DM109263&ACSTrackingLabel=Clinical%20Reminders%20during%20Bicillin%20L-A%C2% AE%20Shortage&deliveryName=USCDCNPIN_122-DM109263

Please contact Kristi Aklestad at kristi.aklestad@mt.gov for more information.

Guidance for the Respiratory Virus Season

Fall is an exciting time of the year- school is back in session, pumpkin spice and apple flavored treats are here, and the green leaves are beginning to turn into vibrant shades of red, yellow, and orange. Fall is also the time of year that viral respiratory illnesses, such as COVID-19, influenza, and respiratory syncytial virus (RSV), begin to circulate in Montana.

Information below summarizes updated guidance for the 2024-2025 respiratory virus season. The CDC has provider-specific guidance for respiratory illnesses located at https://bit.ly/3YA8W3G. For more information on general recommendations or to view current data for respiratory conditions in Montana, visit http://bit.ly/40ibOne.

General Recommendations

The CDC recommends the following precautions be taken by anyone who has tested positive for or who is experiencing symptoms of a viral respiratory illness:

- **Stay home and away from others (isolate)**. Individuals may return to their normal daily tasks when, **for at least 24 hours**, both of the following are true:
    - They have an improvement in symptoms overall **-AND-**
    - They have been fever-free without the use of a fever-reducing medication.
- **Seek testing and/or treatment**. Individuals who are at risk of developing severe illness should consider seeking health care promptly for testing and/or treatment to reduce the severity of their illness.

After returning to their normal daily activities, individuals should consider taking additional precautions, such as practicing good hand and respiratory hygiene, for 5 days to keep those around them safe.

Immunization Recommendations

Vaccines are available to protect against severe outcomes of COVID-19, influenza, and RSV infections.

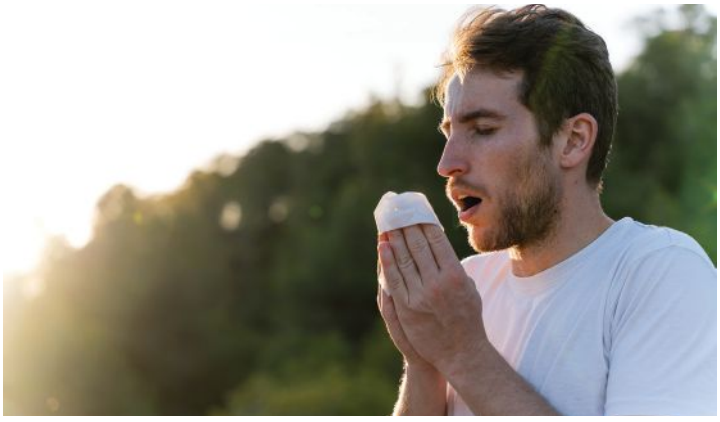
- Updated 2024-25 COVID-19 and influenza vaccines are recommended for everyone six months and older.
- Adults 75 years and older and adults aged 60-74 years at increased risk of severe RSV are recommended to receive RSV vaccination. Pregnant women between 32-36 weeks of pregnancy entering RSV season may receive one RSV vaccine, which will also protect their infant. Children under eight months entering their first RSV season or who are between eight and 19 months with certain health conditions entering their second RSV season may receive an RSV antibody product.

Infection Control Recommendations for Healthcare Settings

Healthcare facilities can also prepare for and mitigate potential infection control gaps related to the transmission of viral respiratory pathogens.

The following infection control measures should be implemented in **all** healthcare settings at the first point of contact (i.e., building or department entrance) with a potentially infected person and should be incorporated into infection control practices as one component of Standard Precautions to prevent the transmission **all** respiratory viruses (https://bit.ly/4dX4eBw):

1. Display visual alerts such as" Cover Your Cough" and hand hygiene posters.
2. Encourage respiratory hygiene and cough etiquette and access to respiratory hygiene stations in waiting areas for patients and visitors.
3. Mask and separate people experiencing symptoms of a respiratory virus infection, such as offer masks to those that are coughing or sneezing during periods of increased respiratory infection activity in the community.
4. Advise healthcare providers to empirically apply appropriate Transmission-Based Precautions, including placement in a single-person room, when examining a patient with known or suspected respiratory infection. Precautions should be based on the clinical syndrome and the likely etiologic agents (e.g., which respiratory viruses are circulating in the community, contact with someone known to have influenza) and modified once the pathogen is identified or a transmissible infectious etiology is ruled out.
5. Monitor and manage ill healthcare personnel.



Laboratory Testing

The Montana Public Health Laboratory (MTPHL) offers a multiplex PCR panel that tests for influenza A, influenza B, COVID-19, and RSV for a cost of $65 per test. Testing at MTPHL allows for further sequencing or subtyping of the virus to characterize what pathogens are circulating in Montana (*e.g.*, COVID-19 sequencing, influenza A subtyping, influenza B genotyping). For more information on ordering testing at MTPHL, including what types of specimens to collect and media to use for transportation, visit https://bit.ly/4fgsQX6.

Resource

CDC Nursing Home Toolkit for Viral Respiratory Illnesses: https://bit.ly/40gaa5d

Welcoming Helena and Plains to Montana WWAMI TRUST

Montana WWAMI's commitment to redress the maldistribution of physicians by placing more physicians in the rural areas of the state (one of MT WWAMI's five founding goals when it was established more than 50 years ago) continues to be a focal point of how and where we train our medical students. Our innovative TRUST program admits 12 students each year and provides a rural/underserved focus during students' medical school training. Established as a pilot in 2008, TRUST is now a flourishing and sought after focus of students applying for admission. Admitting students who are interested in training with a rural focus is proving effective.

Seventy percent of Montana TRUST scholars match into either a primary care specialty (FM, IM-primary, Peds) or needed specialty in Montana (Surg and Psych). The initial TRUST data shows that of the returnees to the state, the trends are promising, with over 60% of Montana TRUST students returning to the state and one out of three returning to a rural location in Montana.

As Montana WWAMI seeks to provide rich training experiences for students across the state, we welcome our two newest TRUST sites, PureView Health in Helena and Clark Fork Valley Hospital in Plains, which join our other 10 rural/underserved training sites in Montana: Anaconda, Butte, Dillon, Glasgow, Hamilton, Hardin, Lewistown, Libby, Livingston, and Miles City. Madeline Turner, M.D. (MT WWAMI alum E-07), serves as the lead faculty in Helena, and Jessica Valentine, M.D. (UWSOM alum), is the lead in Plains. Welcome!

PureView Health Center

Madeline Turner, M.D., UWSOM Clinical Instructor, FM

Clark Fork Valley Hospital & Family Medicine Network

Jessica Valentine, M.D., UWSOM Clinical Assistant Professor, FM

By Shae Saunders, MD

How Physicians Can Help Lower Montana's Suicide Rate

As a family practice physician in my third year of residency, I find immense satisfaction in caring for multiple generations of families, seeing their children grow and thrive. I was born and raised in Montana, and caring for people here is personal.

It troubles me that Montana has consistently ranked among the top 5 states in the U.S. for rates of suicide, and that firearms account for 60% of the suicides in Montana.

My track in public health and advocacy has been focused on building on RiverStone Health's efforts to prevent accidental injury or death to children by securing firearms in the home and lower the rates of suicide in Montana.

RiverStone Health plays a unique role in the community as the city-county public health department and community health center. Public health funding allows us to provide free gun locks to anyone in the community wishing to safely store firearms in their home.

During well-child checks at RiverStone Health clinics, parents are asked about any unsecured firearms in the home and offered free gun locks.

The goal of talking to parents about safe storage of the guns in their home is not to regulate or chastise, but to help prevent unintentional injury or death to children.

Gun ownership is deeply ingrained as part of the culture in Montana. For generations, firearms have provided food, sport and protection in some of the most rural and remote places in the country. Unfortunately, firearms injuries are the leading cause of death for Americans age 18 and younger, with children under age 14 at greatest risk of accidental injury.

Nationally, firearms now cause more deaths of children than motor vehicle accidents, according to the CDC. Seatbelts are required safety equipment in vehicles because they are proven to save lives. Safe storage of firearms has also been proven to save lives, and it is a public health imperative to provide them to as many people as possible.

It starts with one simple question – "Are there firearms in the home?" – with the intent to start a conversation and increase awareness of potential safety risks for children in the home.

Ultimately, I would like to see our gun safety initiative expanded, especially to older adults through Medicare wellness visits and annual exams. In a state that is rural, aging, has high alcohol use and gun ownership, older men in Montana have the highest suicide rate of any demographic in the state.

Gun locks can delay access to a firearm when someone is experiencing an impulse to harm themselves. Studies show that this delay can save lives.

I grew up around guns. My father and brother are hunters and firearms collectors. My husband is a veteran. Firearms have been woven into my life, like many Montanans. But many providers come to RiverStone Health from different backgrounds.

It starts with one simple question – "Are there firearms in the home?" – with the intent to start a conversation and increase awareness of potential safety risks for children in the home.

By surveying my fellow physicians about their current comfort level and knowledge about gun locks and firearms safety, we can identify training opportunities to make sure all our providers are comfortable having these important conversations with our patients.

Physicians, as community leaders and a source of trusted information for their patients, are in a unique position to talk with their patients about difficult topics. We make it a practice to screen each patient for substance use, depression and anxiety, and conversations about gun safety in the home are a natural extension of that.

RiverStone Health is committed to a trauma-informed approach to care through all our interactions with patients. Paired with an informed conversation about safe storage of firearms, I believe that we can save lives.

Ten-4 Day: Raising Awareness of Signs of Child Abuse

Laurie Carter, MD, FAAP, MTAAP Child Abuse Champion
Kylee Bodley, MTAAP Executive Director

Bruises are among the most common injuries that children sustain. But how can we know which bruises were caused by accident, versus bruises that were caused by non accidental trauma or physical abuse?

It is very important that adults can recognize which bruises are concerning for physical abuse because about one third of children who sustain life threatening abusive injuries had preceding minor injuries, often bruises, noticed by an adult. Additionally, child maltreatment is a public health problem with lifelong medical and emotional consequences. Adults who reported physical abuse when they were children were more likely as adults to report chronic physical and mental health conditions.

The clinical decision tool, TEN-4-FACESp was developed by physicians at the Children's Hospital of Chicago to help identify non accidental injuries. "TEN" refers to bruises on the Torso (T), Ears (E) and Neck (N). The number "4" represents infants 4 months and younger with any bruise, anywhere, as well as children younger than 4 years old with bruising in any of these parts of the body.

Additionally, "FACES" refers to injury of the Frenulum (the tissue that runs in a thin line between the lips and gums), Angle of the jaw, Cheeks, Eyelids and Subconjunctivae (the white part of the eyes), all of which are on the face. Finally, "P" represents any unexplained patterned bruising.

This tool is to help highlight areas of a child's body that are more prone to physical abuse, if there is not a good history or mechanism to explain the injury, and should alert anyone, even if not a medical professional, to worrisome bruising. Adults with regular access to or communication with children who have reason to believe a child has been abused are required to report it to the authorities. Mandatory reporters in Montana include teachers, police officers, and child care providers, but anyone with a reasonable suspicion of abuse may also make a voluntary report. They should follow the below steps if concerning bruising is found on a child:

Documentation: Take photos of the injuries. Bruises can change and fade quickly, so taking photos early and in different lighting and angles can be helpful to health care providers.

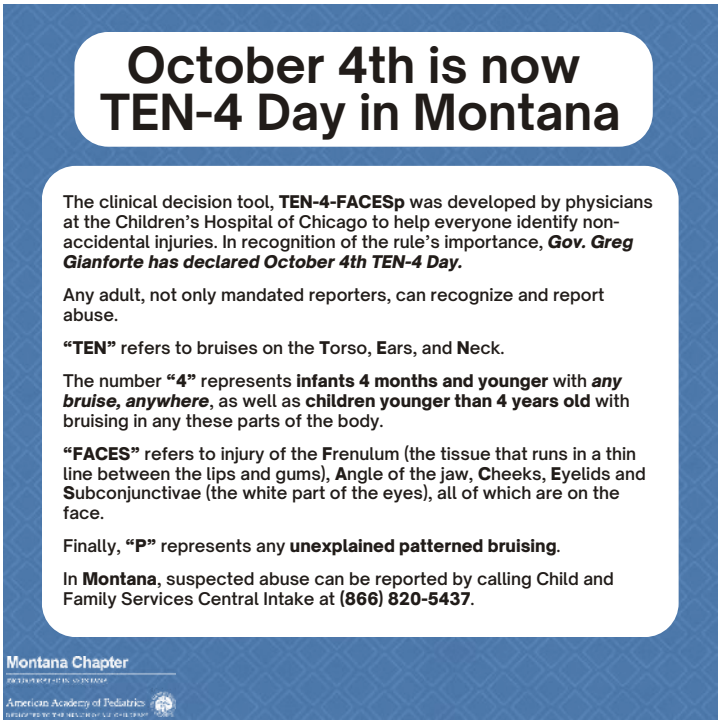
Medical evaluation: Bring the child to their primary care provider or the local emergency room.

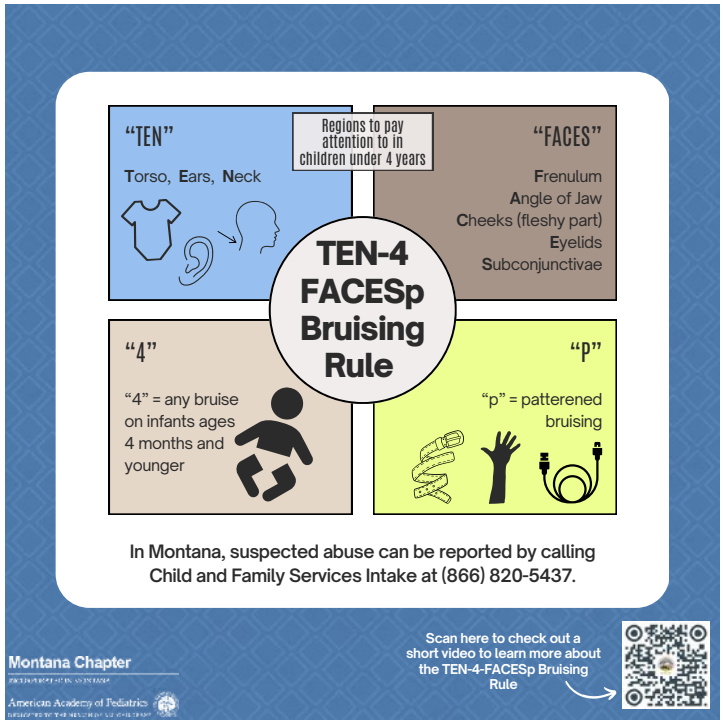
Report: Suspected cases should be reported to Montana DPHHS Centralized Intake at 1-866-820-5437.

Governor Greg Gianforte has proclaimed October 4th, 2024, in the State of Montana as TEN-4 Day to honor the importance of recognizing concerning bruises and injuries on young children and to emphasize the importance of training adults to recognize, report, and prevent child abuse.

How can you participate for TEN-4 Day? Every day, every adult, everywhere should learn how to identify an injury that is concerning for abuse and then have the injury documented, evaluated and reported. But even more importantly, we need to support our children and their families to prevent these non accidental injuries from occurring at all.

For more information on TEN-4-FACESp, go to faceitabuse.org/ten4rule.





Community Children's
AT COMMUNITY MEDICAL CENTER

Non-Accidental Trauma (NAT) Pathway

Presence of Concerning HISTORY for NAT

- Injury explanation is inconsistent with likely injury mechanism or developmental capabilities
- Explanation of injury is unknown or denied, changes with time or among witnesses
- Delay in seeking care, domestic violence history, premature or medically complex child
- Previous CFS involvement or previous unexplained minor (sentinel) injury
- <6 months old without explanation for irritability, respiratory distress, vomiting, altered mental status, seizures, bruises or other injury – possible abusive head trauma (AHT)

Presence of Concerning INJURY for NAT

BRUISES
"TEN-4 FACESp"

- Bruises on **T**orso (chest, abdomen, buttocks, genitalia), **E**ars, **N**eck
- Above bruise in a child ≤**4** years and ANY bruise in infant ≤**4** months
- Bruises on **F**renulum, **A**ngle of jaw, **C**heek, **E**yelids, **S**clera, **P**atterned bruises

BURNS/BITES

- Patterned burns
- Burns without splash marks, with sharp lines of demarcation
- Burns with suspicious areas of sparing
- Bite size not consistent with history

FRACTURES

- Ribs, especially posterior
- Classic metaphyseal lesion
- Unusual locations: scapular, sternal, vertebral fractures
- Midshaft humeral or femoral fracture in infant/toddler
- Multiple or healing fractures
- Any fracture in non-ambulatory infant without adequate history

RECOMMENDED INITIAL EVALUATION:

Laboratory testing

- CBC/platelets, PT/INR/PTT, CMP, lipase, urinalysis
- If bruises: vWF antigen/activity, factors VIII & IX levels
- If fractures: Phos, 25-OH vitamin D, PTH
- If altered mental status: urine toxicology screen

Radiologic testing

- Skeletal survey if <2 yo, also obtain skeletal survey of any household contact <2 yo; consider in 2-3 yo, especially if developmental delays
- Abdominal CT (IV contrast) if AST or ALT >80, lipase >100, abdominal bruising, distension or pain
- Head CT (non contrast) if <6 mo; consider <12 mo especially if face/head bruising, neurologic symptoms/signs, skull fracture
- Must make plan to repeat skeletal survey in 2 weeks

Consultations

- Montana Child & Family Services Centralized Intake (866-820-5437)
- Ophthalmology examination if radiologic evidence of AHT

For Pediatric Hospitalist consultation or transfer, call Community Referral Line: 406-327-4726

Community Children's Clinical Pathways

Community Children's at Community Medical Center in Missoula has developed simple, evidence-based clinical pathways to guide care for common pediatric conditions. Clinical pathways can be a base upon which to improve the use of evidence-based therapies and help standardize care throughout Montana. These are free for distribution and can be used by anyone, with attribution.

Pathways are intended only as a guide for providers and staff. No pathway can cover every clinical scenario, so they should be adapted to specific patients and situations based on clinicians' professional judgment.

The clinical pathways can be found at https://www.communitychildrens.org/. *Montana Family Physician* will highlight additional pathways in future editions, but please go to the website for the most current versions as these will be updated regularly.

The Promise and Pitfalls of AI in Primary Care

Steven E. Waldren, MD, MS
Reprinted from FPM/March/April 2024

Near the end of 2022, a group called OpenAI launched ChatGPT, a large language model (LLM) artificial intelligence (AI) chatbot. It may have seemed like a novelty at first (e.g., "Write a poem about Medicare in the style of *Hamilton*"), but it soon became apparent that ChatGPT and AI models like it could have huge implications for education, business, and even medicine.

By January 2023, ChatGPT had become the fastest-growing consumer software application in history, reaching 100 million users in just two months (TikTok held the previous record at nine months).[1] Before the end of the year, other companies launched similar products, such as Google's Bard and Microsoft's Bing Chat (now Copilot).

AI is here to stay and will likely become more embedded in our daily lives in the coming years. If used properly, it could be a tremendous boon to primary care physicians, potentially ridding us of administrative tasks that are a leading source of burnout.[2] But, as with any new technology, there are downsides. This article seeks to illuminate some of the ways AI can help primary care practices now and in the near future — and some of the ways AI could be downright dangerous.

WHAT IS AI?

At its most basic, AI is when computers try to mimic how the human brain works, learning from the information (data) they take in and becoming progressively more capable.

AI has existed in various forms for decades, but what's different about ChatGPT and other LLMs is the sheer amount of data they are able to process and their ability to be "generative." Generative AI can take a prompt from a user (an input as text, image, etc.) and can output almost instantly a novel response based on what it has learned from a massive corpus of existing data. Using Google or another traditional search engine is like looking through books in a library yourself and copying down what one author wrote. But using a generative AI program is like having an assistant who can look through all the books in the library and synthesize all of that information into a brand new answer.

LLMs are generative AI models trained on enormous volumes of text. The training process allows the model to learn statistical relationships between words and phrases. It then uses these relationships to predict the most likely next word given the user's prompt (and the prior words it just generated). In its most simplistic sense, it is a fancy autocomplete model like you see in smartphone texting applications, where the phone predicts what you may want to type next based on phrases you've used in the past.

One of the reasons AI researchers are so interested in LLMs is the potential for "emergence," which is when an AI model can accomplish tasks that it was not explicitly trained to perform. There is some debate among academics about whether the current models have achieved true emergence, but there is no denying that LLMs can generate responses far beyond what people assumed they could accomplish.

What does that mean for health care? It's not entirely clear yet, but the technology is moving fast. Early LLMs could barely pass the U.S. Medical Licensing Examination, but more recent models, such as Google's medically focused Med-PaLM 2, have achieved relatively high scores.[3,4] Some of the leading EHR companies are also testing ways to integrate generative AI within their programs.[5]

USER BEWARE

Before we get to how the new generative AI models can help, we should understand how they could harm. First, it is important to remember that these models were trained to generate the best next word (probabilistically speaking) — not to understand logic, the scientific method, or medical questions. Second, their learning is only as good as the data used to train the model (a common maxim in computer science is "garbage in, garbage out," which means that any shortcomings in the data used to create a program will manifest themselves in the program's execution). This leads to two of the biggest problems with current generative AI products: bias and hallucinations.

Any significant biases in the data can be learned by the model. Then the model's responses will be informed by these same biases, which is why you may have read reports of chatbots producing conversations that are racist, sexist, homophobic, or otherwise awful.[6] Bias in medicine is well- documented, even in clinical guidelines.[7] Therefore it would not be surprising for generative AI models trained on existing scientific literature to perpetuate these biases. AI developers are designing and implementing tactics to confront this challenge, but AI users should be conscious of the potential for bias in the responses.

The second shortcoming is when LLMs make up something that is not true. AI literature calls this a "hallucination," which conveys the concept that the AI does not seem to "know" it is being untruthful (i.e., lying). If confronted by the user (with a subsequent prompt), the model is likely to continue to respond as if the hallucination were true, or respond like a toddler and deny it did anything wrong. This type of behavior makes sense. The model was trained to predict the next best word and learned from the vast amount of human text, not all of which adds up. But hallucinations are a very serious obstacle for being able to use LLMs in medicine. For example, in one high-profile instance, ChatGPT created an entire fake data set to support a hypothesis about ophthalmologic care.[8]

Generative AI models are always learning, and each iteration is generally more capable than the last, but it's not advisable to use the current models to guide clinical decision making. You must be able to carefully double-check the AI's answers, and after doing that you've likely wasted more time than you saved. Plus, surveys show most patients are uncomfortable with the idea of doctors using AI to inform treatment decisions.[9] Fortunately, surveys also show most doctors are similarly wary of it.[10]

COMMON USES IN PRIMARY CARE

Now that we've provided the necessary caveats about AI in medicine, it's time to get to the fun part: how generative AI can help family physicians with some of the tasks they most despise. (If you

want to experiment with generative AI as you read this article, you can create a free account at https://chat.openai.com or https://bard.google.com, but make sure to follow the safeguards described in the box below.)

With a quick browse through the web, we can find news stories, journal articles, blog posts, and forums that discuss the possible uses of LLMs in health care.[11-15] These range from performing administrative tasks to generating communications for patients to translating medical jargon. Here are some of the use cases.

- **Rewriting medical or legal forms** in patient-friendly language. For example, you might ask the AI program to "Rewrite this informed consent form for those who read at an eighth-grade level: [insert text]" or "Create a new informed consent form for those with low health literacy."
- **Summarizing information** such as a patient's medical record, a report, insurer policies and regulations, and journal articles.

THREE SAFEGUARDS FOR USING AI IN MEDICAL PRACTICE

1. Use artificial intelligence (AI) large language models (LLMs) when the physician or other user is able to easily verify the accuracy of the AI output. For example, it is easy for a physician to look at an AIgenerated office visit note and quickly verify whether it is accurate and complete. But when using LLMs to generate initial drafts of messages to patients about lab results or post-diagnosis/post-procedure instructions, first ask, "Can I independently verify the accuracy of the AI response?" and "Does verifying it take less effort and time than generating the output myself?"
2. Do not enter any protected health information or private organizational information into open online LLMs, such as ChatGPT and Google's Bard. For those cases, instead use an LLM embedded in a company focused on health care solutions, such as an EHR vendor, that will operate under a HIPAA business associate agreement. Do your due diligence on the company by asking them questions about the safety of their solution, including their processes to ensure accuracy. You should also plan to verify the output because you are still liable for the safety of your patients. It is essential to protect patient privacy and organizational security. The information entered into an AI model is not safeguarded from public view unless specifically noted, as in a proprietary model.
3. Use the LLM only in low-risk situations. Clinical uses are not recommended in primary care at this point. But independent physicians or physicians in leadership positions could consider leveraging LLMs for administrative functions, for example, creating employee policy documents or generating newsletters for teams. Verification of the information is still needed in these cases. Consider the LLM response a first draft that you must edit, which is still usually much faster than creating a document from scratch.

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An example would be asking an AI embedded in your EHR to "Give me all the information on [patient X] pertaining to diabetes" or asking ChatGPT to "Summarize this journal article: [insert text]."

- **Generating initial drafts of patient communications** such as responding to portal questions, explaining test results, providing general education on chronic disease care, or explaining new diagnoses. Researchers have found that ChatGPT often responds to patient questions with more empathy than physicians (the machines don't have the same time constraints as us).[16] Still, when it comes to test results, you might want to explain abnormal results yourself and reserve AI for explaining normal results ("Explain normal results for an electrocardiogram").

- **Searching for information within a trusted source** such as the medical record ("Has the patient had a colonoscopy in the last 10 years?") or an evidence-based guideline ("Using the following guideline, what is best course of treatment for a patient with [condition]? The guideline is [text of the guideline]"). While this might seem like using AI to aid clinical decision making, it's actually using AI to search and curate the trusted guideline that is aiding your decision making.

- Populating clinical registries. AI programs within EHRs can increasingly take on this data entry task, using medical records to find and place the appropriate patients on the registry ("Find all patients who have billed for services involving [insert ICD-10 codes] in the past two years and put them in a spreadsheet").

- Generating initial drafts of referral letters, prior authorization requests, **insurance appeals, etc.** For example, "Write a letter to [insurance company] requesting authorization for a patient to get an MRI of the left knee." To strengthen your prior authorization request, ask the AI program to reference scientific literature that supports it (but remember to double-check for AI hallucinations), or paste in the insurance company's template or copies of similar requests that were successful in the past and tell the program to use them as models.

- **Generating documentation from an audio recording of an office visit**. There are already AI products on the market that act as virtual scribes, recording the appointment, transcribing it in its entirety, creating a summary, and placing it in the patient's record.[17]

Even the uses described above require safeguards (see previous page), such as considering the AI-generated text to be a draft that you must review for accuracy. I would not recommend just firing up ChatGPT, for instance, and using it immediately in practice. Although its makers have added options to keep your chat history private, conversations with ChatGPT are still recorded temporarily and the program has suffered privacy breaches in the past.[18] So, while it might be fine for rewriting generic informed consent forms, any information that is proprietary to your organization or HIPAA-protected should go through an AI platform covered under a HIPAA business associate agreement. And, as noted, current AI models can produce "hallucinations." The consequences may not be as dire for administrative tasks versus clinical ones, but it's still something to be alert to.

LOOKING FORWARD

In my mind, there is no question LLMs will have a prominent position in medicine over the next several years. We are already at a place where there is too much information for humans to manage in health care.

Having AI that can summarize and review every piece of information and never forget a single data point can significantly improve health outcomes and decrease the cognitive burden on physicians. Having AI that can handle administrative tasks will free physicians from the EHR and paperwork and allow them to focus on the patient and care delivery. At least one university is already offering a combined doctor of medicine/master of science in artificial intelligence degree to help prepare physicians for this future.[19]

Yet, I also think AI presents significant peril. As long as the financial incentives of medicine are misaligned, there are market pressures to leverage innovations such as LLMs to do things that are not in the best interest of patients and primary care (such as insurers allegedly denying claims based on AI algorithms).[20] Because of AI's promise and peril, I believe primary care physicians must become educated about it and its application in medicine. Family physicians should weigh in on the design, development, and deployment of AI in medicine to ensure it is more helpful than harmful to patients, primary care physicians, and practices.

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Partnering to Close Montana's Mental Health Gap: How Frontier Psychiatry Supports Primary Care Providers

By Eric Arzubi, MD, CEO and Co-Founder of Frontier Psychiatry

Every family physician in Montana has likely felt the strain: you know your patient needs mental health or addiction treatment, but the resources just aren't available close by, or the wait times stretch on indefinitely. Across the state, patients with mental health or addiction issues often have nowhere to turn when they need timely care. This is where Frontier Psychiatry can help.

Since we launched in 2020, our mission has been simple: we're here to support you, the family physicians who are committed to the well-being of your patients in Montana. Through nearly 100,000 telehealth visits for 20,000 patients statewide, we've made it possible for patients to access high-quality psychiatric and addiction treatment without having to travel hundreds of miles or wait weeks to see a specialist.

Our partnership approach ensures that every patient in need of psychiatric care can receive it, and that we're closing the loop on each referral by keeping you informed and involved in their journey to recovery.

A Statewide Partner for Mental Health Care

Frontier Psychiatry's team of 30 providers includes board-certified psychiatrists and specially trained advanced practice providers (APPs). We offer expertise in addiction psychiatry, child and adolescent psychiatry, geriatric psychiatry, and perinatal psychiatry. This depth of specialization allows us to provide comprehensive support for patients of all ages and stages, addressing diverse mental health and addiction issues with evidence-based care.

Our partnership with the State of Montana has enabled us to operate psychiatric consultation services in child and adolescent psychiatry, as well as perinatal psychiatry. As we work closely with the Department of Public Health and Human Services (DPHHS) to rebrand the consultation line as MT PAL (Montana Psychiatric Access Line), we're aiming to make access to expert psychiatric guidance seamless and accessible for primary care providers statewide.

FRONTIER PSYCHIATRY

Delivering Timely, Quality Care for the Patients You Serve

We understand that family physicians are often on the front lines of identifying and managing mental health needs. It's a challenging responsibility, especially in rural and remote areas where resources are stretched thin. At Frontier Psychiatry, our goal is to make it easier for you to connect patients with the right mental health support, no matter where they live in Montana.

By accepting Medicare, Medicaid, and commercial insurance plans, we're committed to ensuring that our services are accessible and financially feasible for patients across the state. Whether you're seeking a one-time consultation to develop a treatment plan or you're referring a patient for ongoing care, we're here to provide expert guidance that complements your practice.

The Data: Reducing Hospitalization and Improving Patient Outcomes

The difference that access to mental health specialists can make is clear in our data. We recently completed an actuarial analysis of our 2022 Montana Medicaid data, comparing patients with mental illness and substance use disorders treated by Frontier Psychiatry to similar patients who had not received our services. The results were striking: our patients were hospitalized at a rate 30% lower than their peers.

This outcome speaks directly to the power of improving access to quality mental health care and timely intervention. We're committed to building on these outcomes by continuing to work with family physicians to expand access to mental health care statewide.

Closing the Referral Loop: Keeping You Informed

One of the biggest concerns we hear from primary care providers is the difficulty in following up on referrals. You send a patient for specialized care, but then you're left wondering: Did they receive the treatment they needed? Are they responding well?

At Frontier Psychiatry, we take this responsibility seriously. Every time you refer a patient to us, we make it a priority to close the loop. We ensure that you receive our notes and any relevant documentation promptly, so you know the status of your patient's care and can stay informed about their treatment progress. This communication loop means you can maintain continuity of care and better support your patients' mental health journey.

Our Shared Goal: High-Quality Care for Every Montanan

Your commitment to your patients' physical and mental health drives our work every day. We know the challenges you face in balancing the roles of generalist and mental health provider, especially with limited mental health resources across Montana.

Our telehealth model was designed with your needs in mind, ensuring that even the most remote patients can access high-quality mental health care without unnecessary delays or travel.

Together, we can bridge the gaps in Montana's mental health landscape. With Frontier Psychiatry as your partner, we're here to provide expert support so that you can focus on what you do best—caring for the whole patient.

If there's one thing we've learned from working alongside Montana's primary care community, it's that the best outcomes come from partnerships that prioritize the patient above all else.

Thank you for the work you do. We look forward to continuing our collaboration and helping your patients lead healthier, more hopeful lives.

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 Calls for Regulatory Reform This Fall

Why it matters: The Medicare program is essential in helping millions of people access comprehensive, continuous primary care. However, Medicare physician payment declined 29% between 2001 and 2024, when adjusted for inflation.

While the 2025 Medicare physician fee schedule proposed rule includes some proposals to strengthen primary care, its 2.8% reduction in the Medicare conversion factor once again highlights the urgent need for congressional action to ensure that physician payments keep up with the costs of running a practice. Read the AAFP's response to the 2025 MPFS proposed rule.

What we're working on:

- The AAFP is working with lawmakers to secure positive, inflation-based annual updates for Medicare physician payment. One proposal to do this is the Strengthening Medicare for Patients and Providers Act (H.R. 2474), which would provide physicians with an annual inflation-based payment update tied to the Medicare Economic Index.
- We are also advocating for a payment system that enables family physicians to invest in practice transformation and adopt alternative payment models — something that is out of reach for most practices given the long history of undervalued payment for primary care
- Without reform, the current Medicare payment system will further destabilize primary care practices, accelerate consolidation, and erode the primary care physician workforce.
- The AAFP also urged CMS to use caution when implementing new conditions of participation (CoPs), especially regarding the proposed CoPs on obstetrical services and the financial challenges that small and/or rural hospitals will face with implementation.
- The AAFP supports efforts to improve maternal health outcomes and address significant shortcomings in holistic, comprehensive care through pregnancy, birth, and postpartum services. However, we are concerned that without further tailoring of the requirements, small and rural hospitals may experience undue burdens while they continue to struggle to meet the need for maternity care services in underserved communities.

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

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