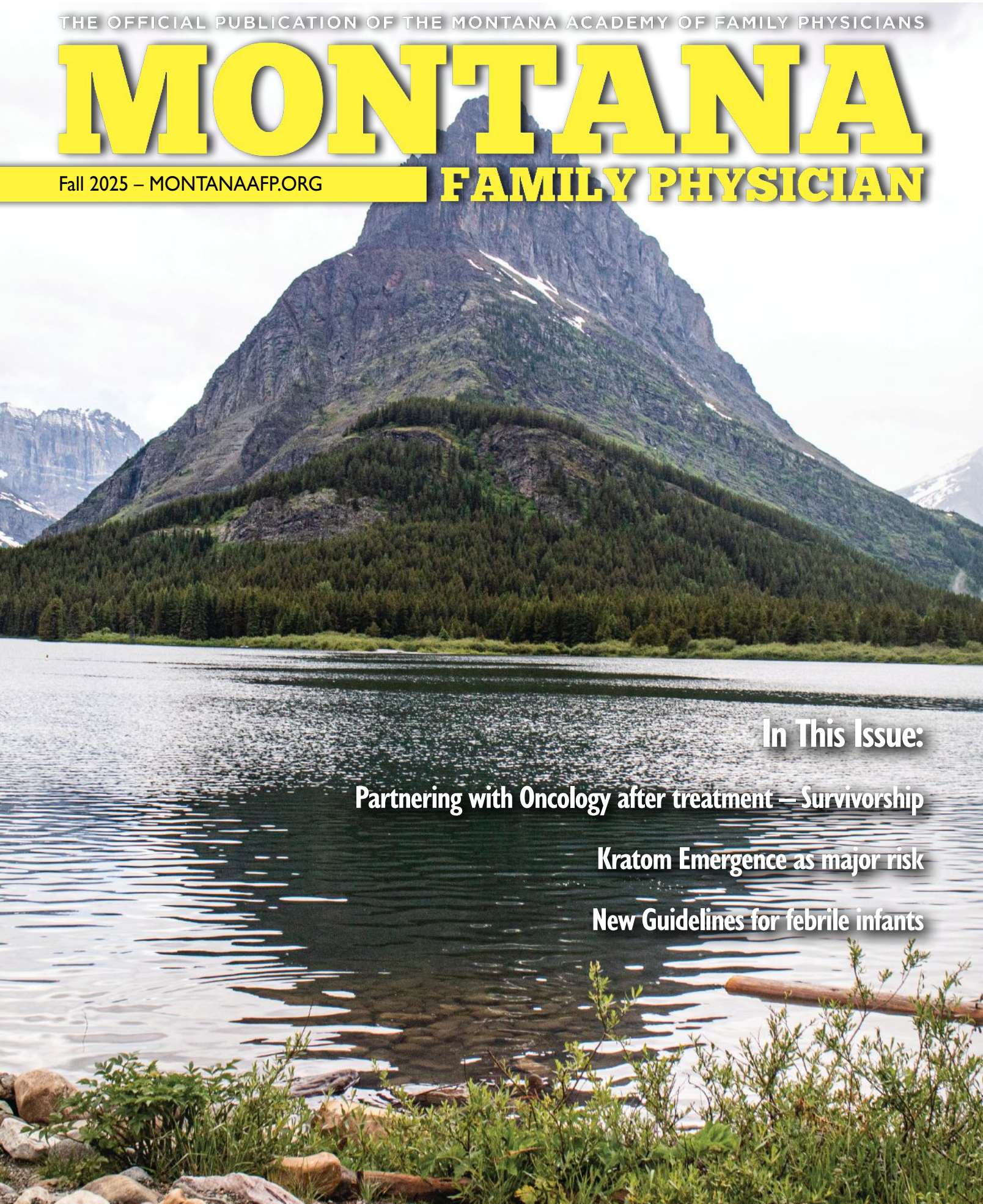
THE OFFICIAL PUBLICATION OF THE MONTANA ACADEMY OF FAMILY PHYSICIANS

MONTANA FAMILY PHYSICIAN

Fall 2025 – MONTANAAFP.ORG



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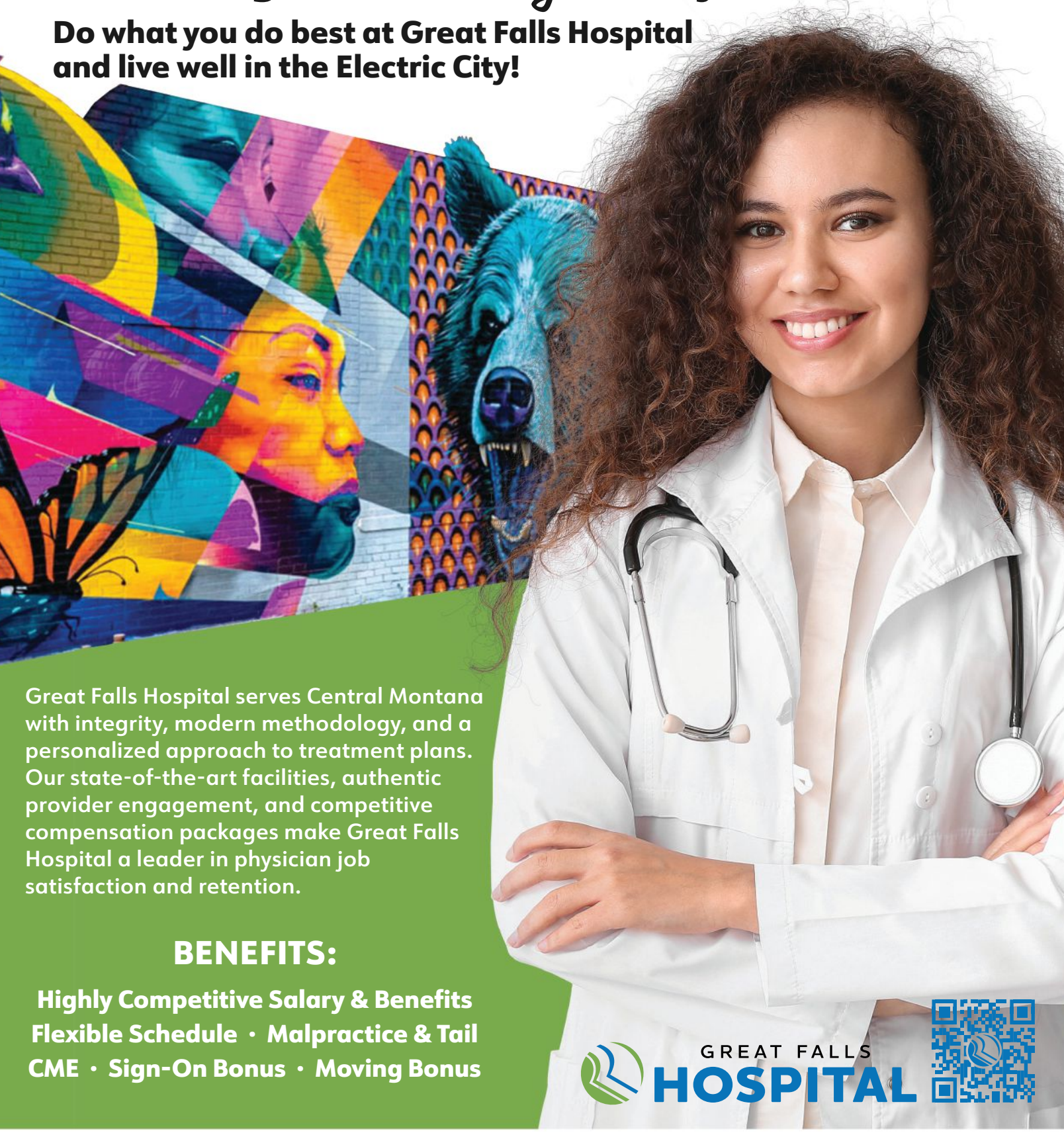

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*The **Montana Family Physician** is printed, addressed, and mailed to every family physician, resident, and medical student in Montana as well as all 50 other state chapters.*

On the Cover:
Many Glacier hotel and Swiftcurrent lake, Glacier national park, Montana, USA

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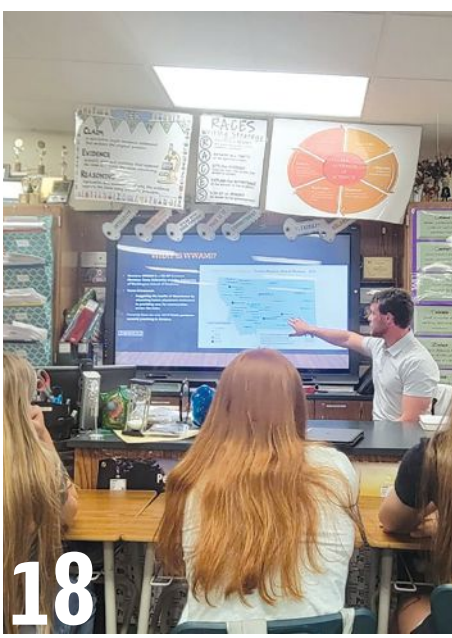

MAFP President's Message

Katrina Maher, M.D.
2025/2026 MAFP President

Greetings MAFP,

I am honored and humbled to be your newly installed president of the Montana Academy of Family Physicians. My journey with the MAFP began as a resident member, and I was immediately drawn to a passionate group of physicians dedicated to serving our members and our communities.

As a family physician practicing here in Montana, I am a firm believer in the power of our organization and our collective commitment to the MAFP mission: "to promote Family Medicine, support our members in providing optimal health care for all Montanans." This mission is the bedrock of our work, and it has never been more vital. This mission is the foundation of our work, and it's more vital now than ever. In our vast and diverse state, family physicians are the cornerstone of healthcare, serving as a trusted source of information in a world full of misinformation.

The past year has brought significant progress at the state level. We saw the power of our collective voice during the last legislative session, where our advocacy efforts—in collaboration with the Montana Chapter of the American Academy of Pediatrics—led to the passage of three bills designed to streamline the prior authorization process. This is a testament to what we can achieve when we work together to protect our patients and our profession.

Looking ahead, we face significant challenges, including dismantling the ACIP committee, changes to the reimbursement of Medicare and Medicaid, and increasing barriers for physicians interested in family medicine. We have an amazing group of people committed to ensuring that the concerns of Montanans are heard at the national level. In October, our delegates will be in Anaheim, CA, to help shape the policy of the AAFP at the Congress of Delegates. We will continue to advocate for policies that support family physicians and ensure access to quality healthcare for all Montanans.

Thank you for all that you do every day for your patients and your communities. I encourage you to get involved, share your ideas, and join us in our mission. We are looking forward to connecting at the upcoming MAFP Big Mountain Medical Conference from January 28-30, 2026 at The Lodge at Whitefish Lake Resort.

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Lifestyle Medicine and the Primary Care Provider

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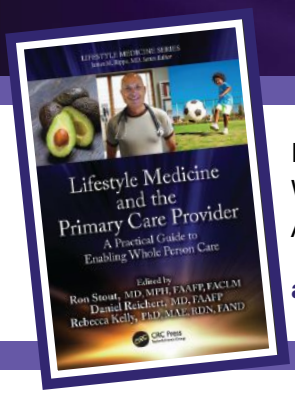

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Janice Gomersall, MD, FAAFP

Missoula, MT

Periodically we ask one of our board members to write a little about themselves for the magazine, so now it is my turn. I have been on the MAFP board for the past 13 years, have been President of the chapter at one point and continued to serve as an alternate delegate, and currently serving my last term as one of two delegates to the AAFP Congress. I also just was elected as Secretary-Treasurer. It has been an incredible experience being on the board and getting the " total picture" of the MAFP and AAFP. I have also been appointed to the Fam Med PAC of the AAFP for a two year position. I have been in Montana for almost 30 years and the last 13 years have been able to "pay back" by serving in positions on the MAFP board.

My starting point was undergrad and medical school both at Univ of Calif Davis - which turned out to be the longest time I ever lived in one place up to then (yes, my dad worked for the government and I love to tell stories!). Went on to work towards the MPH in the Univ of Washington School of Public Health, then residency at a new (at the time) program in Renton at Valley Medical Fam Med residency. We had an incredible OB experience there being the only residents in the busy hospital, which led me to include OB in my practice, even joining others with the distinction of "grand doctor" — meaning I delivered the baby of a patient of mine who I also delivered. I practiced full spectrum including hospital care until 7 yrs ago when I joined the Veterans Admin community clinic where I am today. In between I had a busy private practice in Renton, south of Seattle (had to limit my deliveries to 110 a year, partner had 150….) then moved to Montana in 1996 when my youngest of three was 2 years old. I worked with Western Montana Clinic, then moved over to Community Medical Center. I always seemed to tack on another consulting job however, with the most exciting being the Primary Care Medical Home medical director for MT DPHHS. Also kept up with volunteering in a couple residencies and with the WWAMI medical students and RUOP. We love Montana and feel fortunate that my children grew up being able to hike, raft, camp, hunt, and experience "anything outdoors".

Not sure of my next gig as I am finally acquiescing to my husband's plea for retirement (not sure retirement is for me but will try…).

I must admit that "being in the know" is a draw for me. I always seemed to get myself assigned to boards, or in positions at my organizations so I knew what was going on. In the current climate of practice, we rarely if ever get to call the shots- I feel I am participating however and that means I am contributing. One important way to make your voice heard is to attend our legislative days in Helena, testify on a bill (we partnered with the MT Acad of Peds this year for a stronger voice), send emails to your representatives, and on a national level attend FMAS (Family Medicine Advocacy Summit) in Washington DC. You could also contribute to the FamMedPAC, our AAFP political action committee. The FamMedPAC boosts our Academy leaders to not only have the strength of Family Medicine but also finances for a "seat at the table" (which is unfortunately how it works). Talk to me more about how a small donation goes a long way.

If you feel like joining us on the board please let us know - mention it to a board member or contact Linda Edquest at Linda@ MAFP.org for more information.

Janice Gomersall, MD, FAAFP

Dr. Gomersall with MTAFP at the Congress of Delegates.

Dr. Gomersall and Linda Edquest in Washington DC at FMAS.

Dr. Gomersall and husband, Kevin O'Meagher.

Goodbye Dr. Amy Matheny!

We are saying goodbye to our founding editor of the MAFP Magazine this summer as Dr. Amy Matheny and her family have embarked on a new journey practicing family medicine in a small town with our neighbors to the north. After training residents to practice in a rural setting she now will be doing it herself. I had the good fortune of spending a few hours with Amy on our way to the MAFP summer CME conference in Chico Hot Springs this year and experienced her ongoing love for family medicine.

Amy's and my paths have crossed a few times over the years through shared patients, the MAFP Board of Directors, the WMFMR, presentations at our CME conferences, and attending national conferences, and I have witnessed her passion for anything "family". At one of the National Constituency conferences in Kansas City she visited the booth on state chapter magazines, brought a proposal to the MAFP board, and started the Montana AFP magazine all inside of a year's time. This successful endeavor occurred while also being a MAFP board member and Secretary-Treasurer, faculty at the Western Montana Family Medicine Residency, and delivering and raising her beautiful and handsome twins (yes, twins), and a host of other responsibilities. We wish her well in her new practice and do hope to see her at our conferences once in a while as it is only a "short" drive across the border to our winter conference. Perhaps she can share her new knowledge of the Canadian health system with us when she comes!

Miles City Family Physician Honored for Lifelong Commitment to Rural Montana Health

Dr. Susan Gallo, a beloved and steadfast figure in Montana's healthcare landscape, has been nominated for the prestigious 2025 Dennis Salisbury Family Physician of the Year Award by the Montana Academy of Family Physicians (MAFP).

With over 25 years of practice and a reputation for delivering compassionate, multigenerational care, Dr. Gallo's impact spans from the delivery room to the far reaches of Eastern Montana's rural clinics. She is credited with delivering over 1,000 babies throughout her career and has cared for families across five generations—an achievement that speaks not only to her endurance, but her enduring connection to the lives of her patients.

"She's the kind of doctor who gets stopped at the farmer's market every five feet for a warm hello from patients," wrote Dr. Marjorie Albers, who submitted the nomination on behalf of Gallo. "Her presence in the community is a living testament to the values of family medicine."

Dr. Gallo's influence extends beyond patient care. She has served as a clinical instructor for the University of Washington's TRUST and WRITE programs for over a decade, mentoring medical students and encouraging a new wave of physicians to serve in underserved and rural communities. Her leadership, steady guidance, and late-night support for younger colleagues have made her a go-to mentor in Miles City and beyond.

Her contributions to medical education, leadership within the Montana medical community, and advocacy for family medicine have earned her numerous honors, including serving as MAFP President in 2004 and being named a Fellow of the American Academy of Family Physicians in 2007.

Whether speaking at the Montana WWAMI Foundations campus or chairing critical hospital committees, Dr. Gallo continues to lead with poise, passion, and a profound sense of purpose.

"She is more than deserving of recognition," Albers emphasized. "Her work enriches our profession and the lives of everyone around her."

The Role of Primary Care in Survivorship Care of Cancer Patients

Margaret Hamersla PhD, ANP-BC, Mark and Robyn Jones College of Nursing Montana State University & Jack Hensold MD, FASCO, on behalf of the Montana State Oncology Society and the Montana Cancer Coalition

Patients with cancer living in rural areas have worse outcomes than those in urban areas. A recent article in this journal summarized the factors contributing to this disparity: Limited access to care, either due to financial or geographic barriers is a common cause. These barriers are amplified in Montana where the resources to deliver cancer care are limited compared to national averages. While addressing these barriers is difficult, improvements in care coordination can enhance care delivery independent of these barriers.

Care of patients with cancer requires a coordinated "team" of individuals to ensure the best outcomes. In 2013 the Institute of Medicine (IOM) acknowledged the importance of primary care providers (PCPs) as part of a well-coordinated, patient-centered cancer care team. Eight years prior to that, in a report addressing the challenges of patients previously diagnosed with and treated for cancer, the IOM acknowledged the importance of "coordination between specialists and primary care providers to ensure that all of the survivor's health needs are met." Inclusion of PCPs in the care of their patients with cancer is particularly important in rural areas where cancer care may be administered at great distance from the patient's home.

Cancer survivorship refers to the experience of individuals with a history of cancer, including those living with cancer and those free of cancer, from the time of diagnosis onward. However, a more limited definition of survivorship is the period after diagnosis and treatment. By that latter definition, cancer survivors constitute an estimated 5% of the U.S. population. An estimated 2.8 million of those reside in rural areas, including those in the Mountain West. The transition to cancer survivorship care begins after anti- cancer treatment concludes.

Cancer survivors have complex needs, including surveillance for recurrence of the primary cancer and development of secondary cancers, management of long-term and late physical and psychosocial effects, promotion of wellness (e.g., diet, exercise), and management of comorbidities. Both surveillance schedules and management of delayed treatment effects are dependent upon the specific cancer diagnosis and the treatment(s) administered. Post-traumatic stress disorder is also common, adding to the overall burden. Roughly 30–40% of survivors report unmet needs such as lack of emotional support, unmanaged side effects, fear of recurrence, or financial strain. While oncology teams should provide the relevant information regarding surveillance and later effects of treatment, PCPs are often responsible for care delivery during survivorship.

To facilitate quality care during cancer survivorship care transition, clear communication and collaboration among the healthcare team, including oncology and primary care providers, are necessary. Per the National Cancer Institute, the five domains of quality cancer survivorship care include: 1) prevention and surveillance for recurrences and new cancers; 2) surveillance and management of physical effects; 3) surveillance and management of psychosocial effects; 4) surveillance and management of chronic medical conditions; and 5) health promotion and disease prevention.

To provide actionable strategies for oncologic practice, the American College of Surgeons' Commission on Cancer (CoC) recommends that cancer survivors receive a written summary of their treatment and a plan for addressing ongoing care coordination beyond initial treatment. This concept has been operationalized in recommendations and practice as a survivorship care plan (SCP), a document developed by oncology providers that contains a treatment summary and follow-up care plan, used as a tool to enhance communication between cancer survivors, oncology providers, and primary care providers.[10] Barriers to use of a specific SCP include time to prepare the document, confusion about who is responsible to complete and maintain the plan (e.g., surgeons, medical oncology,

radiation oncology, nursing), and lack of reimbursement for the completion of the plan. Some larger cancers centers have created a comprehensive survivorship program that includes an oncology healthcare team that specializes in survivorship care, but this is not practical in smaller cancer centers with insufficient staffing. Despite well-documented national standards, recommendations, and frameworks, a significant care gap persists when transitioning to survivorship care.

The survivorship transition requires clear communication and teamwork among the cancer survivor, oncology provider, and primary care provider. While the primary care provider mainly handles long-term follow-up after survivorship transition, consultation and cooperation from the oncology provider is necessary. Of the approximately 81,000 cancer survivors in Montana, 58% report that they did not receive a treatment summary or a follow-up care plan at the conclusion of their treatment. Identifying strategies to address gaps in cancer care transitions is crucial for improving survivor outcomes, enhancing quality of life, and reducing the financial burden on survivors and caregivers. Thus, two decades removed from the 2005 IOM report cancer survivors are still "Lost in Transition." Improving survivorship care does not require additional resources but rather a focus on establishing roles and workflows with team members connected via reliable lines of communication. This is work that can begin now with attention to improved communication and care coordination between PCPs and oncology teams.

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Febrile Young Infants:
Data-Based Change

The management of febrile young infants has always required a balance: the risk of invasive procedures, antibiotics and hospitalization against the danger of missed urinary tract infections, bacteremia, or bacterial meningitis. That balance has long been challenging, and with the publication of 2021 AAP guideline, has shifted again.

Improved screening for Group B streptococcus, the introduction of conjugate pneumococcal and Haemophilus immunization, and advances in food safety have changed the epidemiology of infections in febrile young infants over the years. Studies of large numbers of infants also showed that commonly used laboratory criteria (ANC, total WBC count, I:T ratios for the Boston and Philadelphia criteria) missed a substantial number of children with invasive bacterial infections, including meningitis.

The 2021 guideline respond to these realizations. Among other things, they incorporate inflammatory markers into decision-making, using statistically derived thresholds for laboratory cutoffs. This allows more nuanced guidance about obtaining lumbar punctures in infants 22 days old or greater.

The guideline applies to infants 8-60 days of life with temperature ≥100.4°F or ≥38°C and no evident source of infection, and breaks guidance into three age ranges: 8-21 days, 22-28 days, and 29-60 days. It's important to note that guidance applies only to well-appearing young infants. Clinical judgment is still critical. In any toxic appearing neonate or infant, the answer is ALWAYS to do everything: throw the proverbial "kitchen sink" of investigations at them.

Key takeaways about the 2021 guidelines:

- We now focus on IBIs (invasive bacterial infections) rather than SBIs (serious bacterial infections), to allow for models to specifically predict bloodstream and CSF infections without including UTI. UTIs are common, and UTI testing should be done in all febrile young infants.
- Inflammatory markers are helpful to improve sensitivity and specificity for IBIs, but we often use them in combination:
    - If procalcitonin is available quickly, that's preferred -- use that along with ANC
    - If procalcitonin is unavailable, use abnormal ANC or CRP, or a temperature > 38.5°C as a substitute inflammatory marker
- Be wary of HSV infection, especially in the first 3 weeks of life
- Although LPs in infants 22 days or older *may* be deferred in patients with negative inflammatory markers, they remain necessary in the first 21 days of life
- In the era of readily available respiratory viral PCRs, a positive PCR can be helpful – but it can also be a red herring. Documented respiratory viral infections do reduce the risk of IBI, but data are not robust. It remains unclear whether a positive PCR should change evaluation, especially for infants <29 days.
- For hospitalized infants, monitoring cultures for only 24-36 hours is sufficient

Community Children's

Febrile Infant Pathways (8-60 days)

Inclusion criteria
- Well appearing
- Documented temperature ≥ 100.4°F or ≥ 38°C by history or rectal measure in clinical setting of office or emergency department
- Gestational age at birth ≥37 and <42 weeks
- Age 8-60 days old

Exclusion criteria (If any are true, manage without this pathway!)
- Newborns 0-7 days old post hospital discharge (in this age group, perform full sepsis evaluation and start empiric treatment)
- Born preterm at less than 37 weeks gestation?
- < 2 weeks old with perinatal course complicated by maternal fever, infection or antimicrobial use?
- Febrile infant with high suspicion of HSV infection or vesicles?
- Focal bacterial infection (like cellulitis, omphalitis, septic arthritis, or osteomyelitis)?
- Clinical diagnosis of bronchiolitis, with or without positive RSV result?
- Documented or suspected immune compromise?
- Neonatal course complicated by surgery or infection?
- Congenital or chromosomal abnormalities?
- Medically fragile infant requiring technology or ongoing therapeutic intervention to sustain life?
- Received immunizations within the last 48h?

Infants who *MAY* be included:
- Upper respiratory tract infection symptoms (that are not diagnostic of viral bronchiolitis)
- Diarrhea → stool specimen testing; if negative result, then may use the clinical pathway
- Acute otitis media
- Recent antimicrobial use if current age greater than 2wo
- Positive respiratory viral testing

HSV checklist:
If any are true, proceed to full evaluation and empiric HSV treatment
- ☐ Mother with active HSV lesions
- ☐ Maternal fever 48h before or 48h after delivery
- ☐ Seizures in infant
- ☐ Vesicles on skin, scalp, or mucus membrane exam
- ☐ Hypothermia
- ☐ CSF with pleocytosis for age in absence of positive Gram stain
- ☐ Leukopenia
- ☐ Thrombocytopenia
- ☐ Elevated ALT

Abnormal inflammatory markers:
- ☐ Procalcitonin (PCT) >0.5ng/mL
- ☐ CRP >20mg/L
- ☐ ANC >4000/mm³

For **CSF** send: cell count, Gram stain, glucose, protein, culture, and if able meningitis/encephalitis PCR panel

HSV studies: CSF PCR; HSV surface swab of conjunctiva, nasopharynx, mouth, and anus for cultures or HSV PCR; HSV blood PCR; and serum alanine aminotransferase (ALT)

Urine testing: *May* collect a clean catch urine for initial testing, but if the UA results are abnormal then a sterile urine specimen via bladder catheterization must be obtained

Abnormal UA would be:
- ☐ +Leukocyte esterase
- ☐ ≥ 5 WBCs/HPF
- ☐ ≥ 10 WBCs/mm³

Algorithms based on the REVISE collaborative work and updated with 2021 AAP Febrile Neonate Clinical Guideline

For pediatric hospitalist consultation or transfer, call Community Referral Line at 406-327-4726

Community Children's

Febrile Infant Pathways

Antimicrobial Treatment

	No focus identified	Bacterial meningitis	Urinary tract infection	If need HSV coverage also
8-21 days old	Ampicillin 50mg/kg Q8h AND Ceftazidime 50mg/kg Q8h OR Gentamicin 4mg/kg Q24h	Ampicillin 75mg/kg Q6h AND Ceftazidime 50mg/kg Q8h	Ampicillin 50mg/kg Q8h AND Ceftazidime 50mg/kg Q8h OR Gentamicin 4mg/kg Q24h	ADD Acyclovir 20mg/kg Q8h
22-28 days old	Ceftriaxone 50mg/kg Q24h	Ampicillin 75mg/kg Q6h AND Ceftazidime 50mg/kg Q8h	Ceftriaxone 50mg/kg Q24h	ADD Acyclovir 20mg/kg Q8h
29-60 days old	Ceftriaxone 50mg/kg Q24h	Ceftriaxone 50/kg Q**12h** OR Ceftazidime 50mg/kg Q8h AND Vancomycin 20mg/kg Q8h	Ceftriaxone 50mg/kg Q24h OR Cephalexin 25mg/kg Q6h OR Cefixime 8mg/kg Q24h	ADD Acyclovir 20mg/kg Q8h

Infants can be observed/monitored at home when ALL of the following are met:
- ☐ Urinalysis is normal
- ☐ None of the inflammatory markers obtained are abnormal
- ☐ CSF analysis is normal or (+) enterovirus
- ☐ Verbal teaching and written instructions are provided for home monitoring:
    - Change in general appearance, i.e. dusky color, respiratory distress, or other distress
    - Behavior change, including: lethargy, irritability, inconsolable crying, difficulty consoling/comforting, other distress
    - Difficulty feeding
    - Vomiting
    - Decreased urine output
- ☐ Follow up plans for reevaluation in 24h are developed
- ☐ Plans are also outlined in case of change in clinical status, including means of communication between the family and providers and access to emergency medical care

Algorithms based on the REVISE collaborative work and updated with 2021 AAP Febrile Neonate Clinical Guideline

For pediatric hospitalist consultation or transfer, call Community Referral Line at 406-327-4726

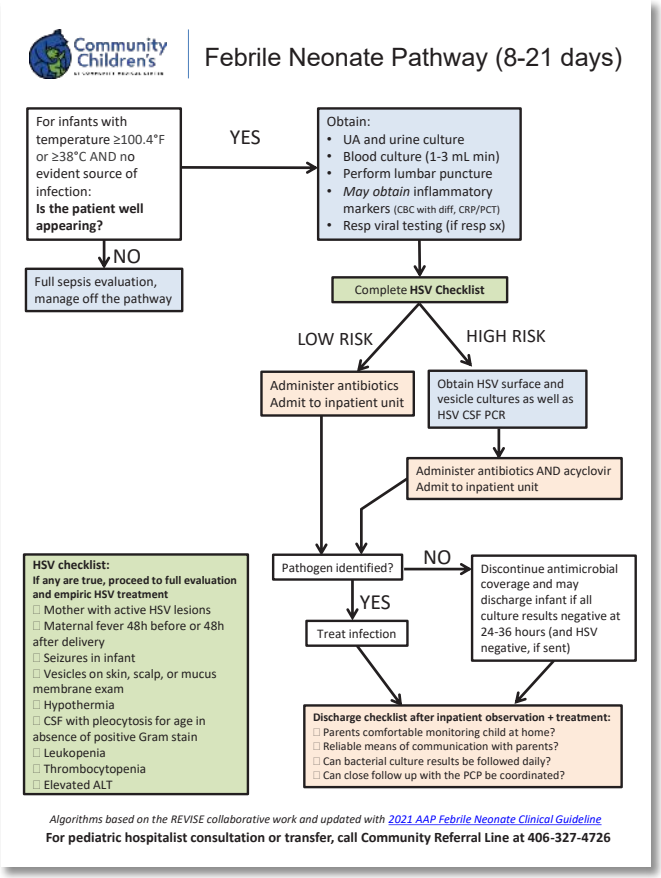
- Remember: Any ill-appearing infants deserve full investigation and empiric treatment

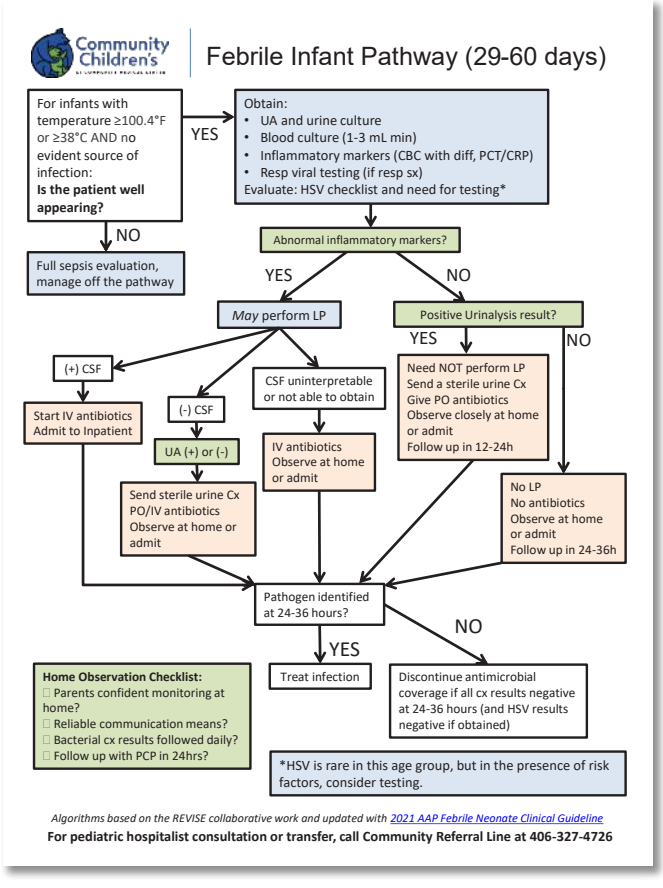
The new guidelines perform well at identifying low-risk infants and reducing the need for invasive procedures and hospitalization for infants more than 21 days old.

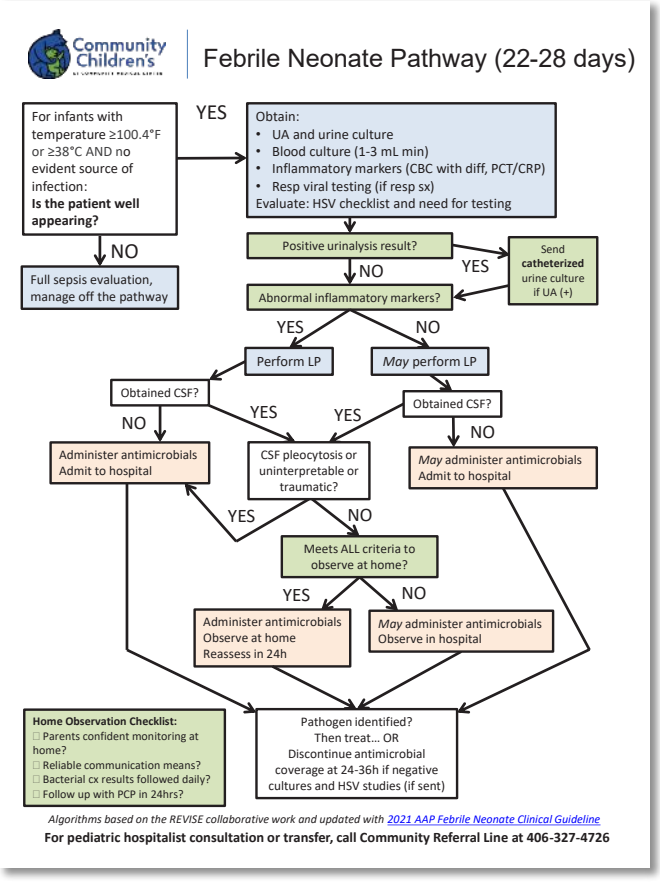
Nevertheless, the greatest challenge in improving care is usually not in writing good guidelines – it's in ensuring that new best practices are disseminated and used. At Community Children's, where I practice in Missoula, pediatric hospitalists have created febrile infant flow charts that we post online to guide clinical decision making and antimicrobial selection for ourselves and for other Montana providers. We also recommend bookmarking the excellent Children's Hospital of Philadelphia (CHOP) pathway. CHOP has decision support tools to help practitioners approach a variety of inpatient and outpatient pediatric conditions.

The care of febrile infants is improved when we can accurately define the risks and benefits of our management, and apply the latest data our specific situation. Utilizing flow charts and pathways don't hem us in – they should empower us to seek the balance that's right for the patient and family we're treating. Keep them close, and remember to look at the patient before the labs!

Inflammatory Marker (IM)	Definition of Abnormal
Procalcitonin	> 0.5 ng/mL
Absolute neutrophil count	> 4000 neutrophils/µL







Family Medicine Advocacy Rounds

Issue 37, July 2025

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 Reacts to 2026 Medicare Physician Fee Schedule Proposed Rule

The American Academy of Family Physicians (AAFP) is encouraged by proposed changes in the 2026 Medicare physician fee schedule that would help build a stronger, more sustainable health care system.

Notable updates proposed by CMS include:

- modernizing how medical services are valued,
- reducing barriers to patient-centered care and
- expanding support for behavioral health and at-home services through updated billing codes.

The AAFP also welcomes proposed increases to the Medicare conversion factor—3.8% for participants in qualifying alternative payment models and 3.6% for others—but notes that these are largely due to a one-year statutory increase. Without a long-term fix, practices continue to face renewed financial strain in 2027.

To ensure stability and continued access to care, the AAFP urges Congress to enact a permanent annual inflationary adjustment to Medicare payments. Read our full statement.

CMS Final Rule Brings Changes to ACA Marketplace Enrollment and Coverage

Starting Aug. 25, a new CMS rule makes several changes to ACA Marketplace coverage. While intended to improve oversight, the rule has sparked concern among health advocates, including the AAFP, for its potential to limit access to care, especially for vulnerable patients.

Key changes include

- ending monthly enrollment for low-income individuals,
- shortening open enrollment to end Dec. 31,
- allowing insurers to deny coverage for unpaid premiums,
- removing automatic re-enrollment for some,
- defining certain gender-affirming procedures as not essential benefits and
- excluding DACA recipients from ACA eligibility.

The AAFP pushed back on these provisions - warning they may harm patients and conflict with medical standards. We emphasized that care decisions should be guided by physicians, not regulations.

Some parts of the rule align with AAFP goals, including stronger broker oversight and keeping federal open enrollment open through year's end. However, new flexibility for state and non- Marketplace insurers to set their own timelines starting in 2027 remains a concern.

AAFP and 100+ Health Organizations Urge Protection of USPSTF

Why it matters: The United States Preventive Services Task Force's (USPSTF) transparent, rigorous and scientifically independent process ensures that patients can benefit from trusted, evidence-based preventive care, and that physicians can make up-to-date recommendations. Recent actions by the Department of Health and Human Services have put that at risk.

What we're working on: The AAFP joined more than 100 health organizations in a joint letter to Congress urging lawmakers to protect the integrity of the USPSTF. The Task Force makes recommendations for primary care and disease prevention through a rigorous, multistep process in collaboration with the public and medical experts. These include cancer screenings, mental health counseling, vision exams and much more.

300+ Family Physicians Call on Lawmakers to Support Family Medicine

Last month, more than 300 family physicians from across the country convened in Washington, D.C., for the Family Medicine Advocacy Summit. Physicians from 44 states met with lawmakers and congressional staff to share stories and champion legislative policies that bolster family medicine, including:

- Preserving the Medicaid program. Medicaid is a critical safety net for millions of Americans—from routine checkups and maternal care to mental health and life-saving preventive services. Any funding cuts or restrictive reforms would put vulnerable patients at risk and increase costs across the system.
- Reforming Medicare physician payment. Our outdated Medicare payment system undervalues and underpays for primary care, threatening the stability of physician practices and their capacity to provide essential care. Sustainable, long-term payment reforms are urgently needed to support the viability of primary care.
- Protecting the Public Service Loan Forgiveness (PSLF) program, as well as other loan- repayment and scholarship programs. Family physicians often carry significant student debt, and many choose to serve in high-need areas where salaries may not reflect the critical work they do. PSLF is a lifeline—helping keep physicians in the communities that depend on them most. We urged lawmakers to protect and expand upon these programs, so that more physicians can afford to answer the call to service without being buried in debt.
- Urging Congress to protect public trust in vaccines and evidence-based care. Getting vaccinated helps protect vulnerable people, including newborns and people with weakened immune systems. It creates a community of immunity.
- AAFP president Jen Brull, MD, FAAFP, wrote about these critical topics in an op-ed in Medscape.

AAFP Disappointed Over Passage of H.R. 1

As highlighted during the Family Medicine Advocacy Summit, family physicians repeatedly expressed deep concerns with several provisions in H.R. 1 , which was signed by President Trump on July 4. Sweeping and draconian cuts across the health care system will leave as many as 16 million individuals without health care coverage over the next 10 years.

The AAFP will continue to advocate for policies that protect Medicaid and put patients first.

AAFP Submits Feedback on NIH's Proposed AI Strategy

The AAFP has weighed in on the National Institutes of Health's (NIH) forthcoming artificial intelligence (AI) strategy. The letter emphasizes the unique role of family medicine in delivering comprehensive, person-centered care, as well as the need for AI tools to support, not disrupt, that experience.

The AAFP urges NIH to adopt a principles-first approach, anchored by transparency, equity, trustworthiness and accountability. We also call on NIH to embed practicing physicians throughout the AI lifecycle—from design to evaluation—to ensure that tools are practical, effective and aligned with real-world care delivery.

The AAFP's recommendations highlight the importance of rigorous evaluation, workforce readiness and cross-agency alignment, while advocating for AI solutions that reduce administrative burdens and advance health equity.

What We're Reading

- Amid rising measles cases, AAFP President Jen Brull, MD, FAAFP, spoke to CNN about the urgent need for Americans to get vaccinated.
- AAFP President-elect Sarah Nosal, MD, FAAFP, conveyed to Bloomberg the risk of disappearing federal data.
- Dr. Nosal also spoke to Medscape about how doctors can help patients who lose insurance under federal budget cuts.
- AAFP Board Director Shannon Dowler, MD, FAAFP, appeared on the *New York Times*'

The Daily podcast to talk about how cuts to Medicaid will harm rural communities.

Talking to your Patients about the Dangers of Kratom

By Amy Solomon

Like gambling addiction, kratom is a serious problem in Montana and across the U.S., and one that is often overlooked by patients and their providers in the exam room.

Kratom is derived from the *Mitragyna speciosa* tree native to Southeast Asia. Products made from the tree's leaves contain intoxicating chemicals that bind to the brain's opioid receptors. In small doses, kratom produces stimulant-like effects. In large doses, it produces opiate or sedative effects. Traditionally chewed in leaf form, commercial kratom is now manufactured and widely sold in highly concentrated powders, capsules, energy drinks and gummies that pose serious health risks.

The U.S. Food and Drug Administration (FDA) has not approved kratom as a prescription drug, food additive or dietary supplement. It is illegal in 6 states and some municipalities, but is unregulated in Montana. The U.S. Drug Enforcement Administration (DEA) has listed kratom a "drug of concern". Because of the lack of regulation, products consumers are buying are not standardized or tested for concentration or potential contamination by other substances like heavy metals.

Although kratom is marketed as an alternative to narcotics or for "safe" or "natural" pain management, it is an addictive substance, and there have been known overdoses due to kratom in Montana. Neonatal Abstinence Syndrome has been observed in babies born where kratom was used during pregnancy. Side effects of kratom use include psychosis, nausea, confusion, constipation and sweating.

Users experience mild to serious withdrawal symptoms when stopping kratom use that are similar to opiate withdrawal, like nausea, vomiting, sweating, diarrhea, tremors, restlessness or loss of appetite.

Talking to your patients

Knowing the side effects, common uses and dangers of kratom can help you talk openly with your patients of all ages.

Because kratom is currently unregulated in Montana, it is commonly sold in gas stations, kava bars, vape shops, health food stores, online and erroneously marketed as a supplement. Many sellers do not restrict customers based on age, so many young people are using kratom without understanding the dangers.

Talking to teen patients during conversations about tobacco, marijuana and alcohol use can help educate them about the lack of regulation, serious side effects and addictive nature of kratom.

Many patients may not consider kratom a substance of concern, so it is helpful to ask them specifically if they are using it. Ask about kratom use as part of your regular history taking with patients and consider adding kratom and other substances to the intake form.

You could also ask patients if they are taking anything they experience withdrawal from. If you have a patient who is experiencing withdrawal symptoms, but denies opiate use, think about kratom.

Testing for Mitragynine, kratom's active ingredient, is possible during a comprehensive urine drug screening but may need to be specifically requested.

Treating kratom addiction is similar to treating addiction to opiates. Medication Assisted Treatment (MAT) with buprenorphine or methadone can be one option. Counseling on abstinence and withdrawal management is another option. For many users, Narcotics Anonymous meetings are helpful.

Being aware that kratom use is becoming increasingly common and knowing how to talk to your patients about the dangers of this unregulated and uncontrolled substance can help prevent unnecessary addiction, overdoses and adverse health outcomes.

Amy Solomon, MD, is a faculty physician at Montana Family Medicine Residency. She is a family medicine doctor specializing in addiction and integrative medicine. She has been an addiction medicine specialist since 2012.

Encouraging Rural High Schoolers to Dream Big

Alex Wickens Encouraging Rural High Schoolers

Third-year Montana WWAMI TRUST student Alex Wickens knows firsthand how uncertain the path to medicine can feel, especially for students growing up in rural towns. That's why he's committed to giving back by visiting high schools across Montana, encouraging students to consider futures in medicine and educating them about the WWAMI program.

Alex Wickens

Wickens, who grew up in Lewistown and is currently completing his clinical training in Miles City, shares his own story to help students see what's possible — no matter where they come from.

"As a high school student, I had a lot of uncertainty about going to college and all that it entailed," said Wickens. "I wish someone would have come to talk to me about what to expect. So, I figured I could be that person for someone else."

During his presentations, Wickens breaks down the path to becoming a doctor, introduces the WWAMI program, and speaks openly about the challenges and rewards of pursuing a career in rural healthcare.

"One of the biggest issues in rural medicine is the shortage of providers. WWAMI is designed to help solve that problem," he explained. "I didn't even know Montana had a medical school when I was in high school."

Now Wickens is focused on rural primary care and hopes to return to Lewistown as a family or internal medicine physician after completing his education.

A first-generation college student, Wickens earned his undergraduate degree from the University of Texas Permian Basin, where he was named the outstanding biology graduate of 2022. Before starting medical school, he worked in construction to pay for tuition and later worked as a phlebotomist in Lewistown's hospital and at a local plasma donation center.

"I wanted to do something that was worthwhile and would make a difference in my community," he said. "The greatest need I saw was for rural doctors."

Save the Date!

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Presents The 66th Annual

Big Mountain Medical Conference

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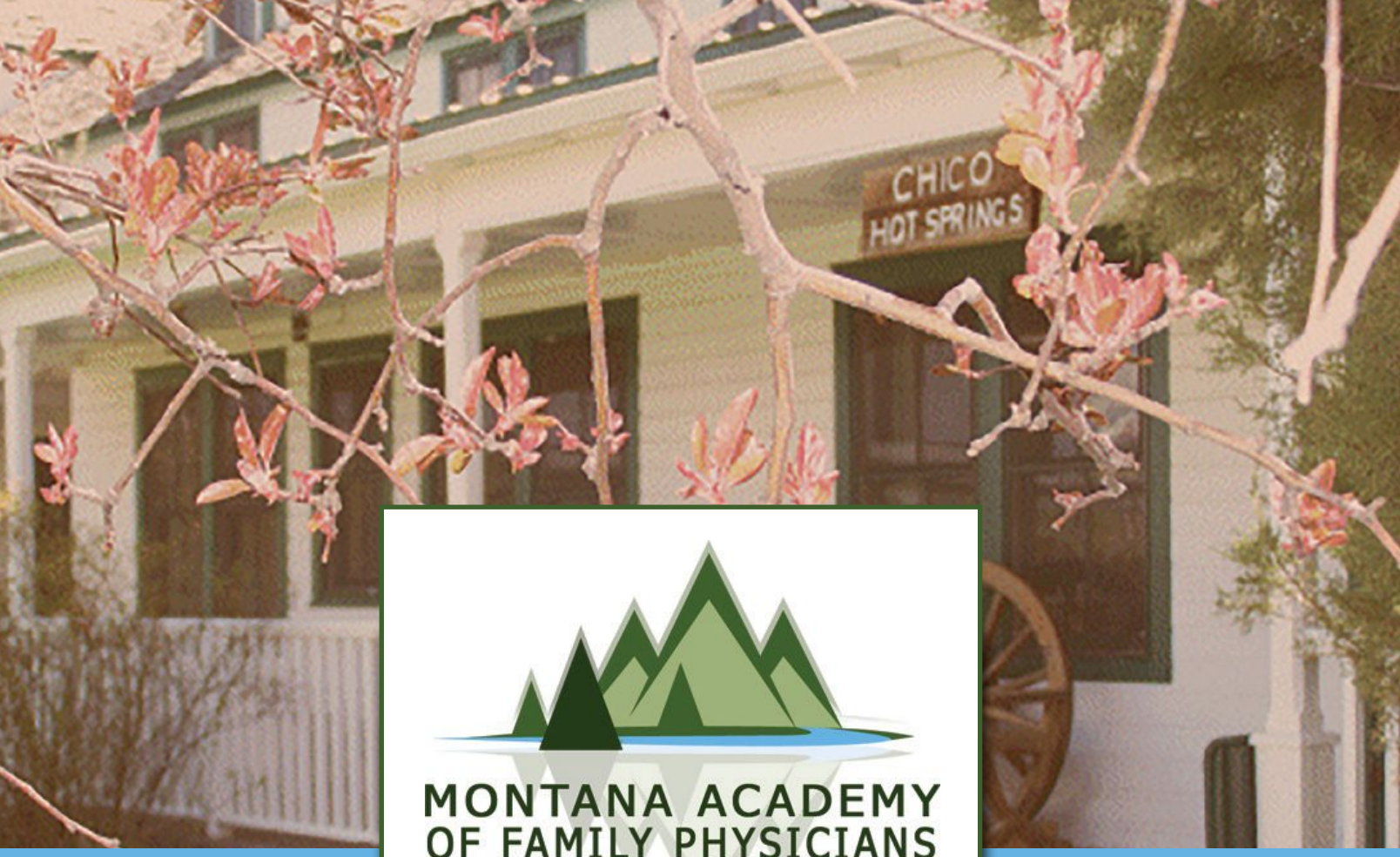
The Lodge at Whitefish Lake Whitefish, Montana

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

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



MONTANA ACADEMY
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74th Annual

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

June 18-19, 2026

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

To celebrate 25 years of the Montana Family Medicine Residency, the CME program will include many MFMR alumni as well as former and current faculty. There will be excellent educational sessions and opportunities to connect with colleagues and friends!

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1

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*Online e-consult requests are also available for providers serving pregnant and post-partum patients.

2

Step 2

A care coordinator will screen and triage calls to ensure they are appropriate for the line and ask for patient demographics, contact information, and a summary of the consultation request. Please have patient information on-hand.

3

Step 3

A Psychiatrist will return your call within approximately 30 minutes, during business hours.

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