THE OFFICIAL PUBLICATION OF THE MONTANA ACADEMY OF FAMILY PHYSICIANS

# MONTANA FAMILY PHYSICIAN

Spring 2025 – MONTANAAFP.ORG

## In This Issue:

MAFP and MT AAP Join Forces for Advocacy Day

DPHHS: Pertussis on the Rise in Montana

Managing Neonatal HSV Exposure and Disease

AAFP: "Our Purpose Is Clear"

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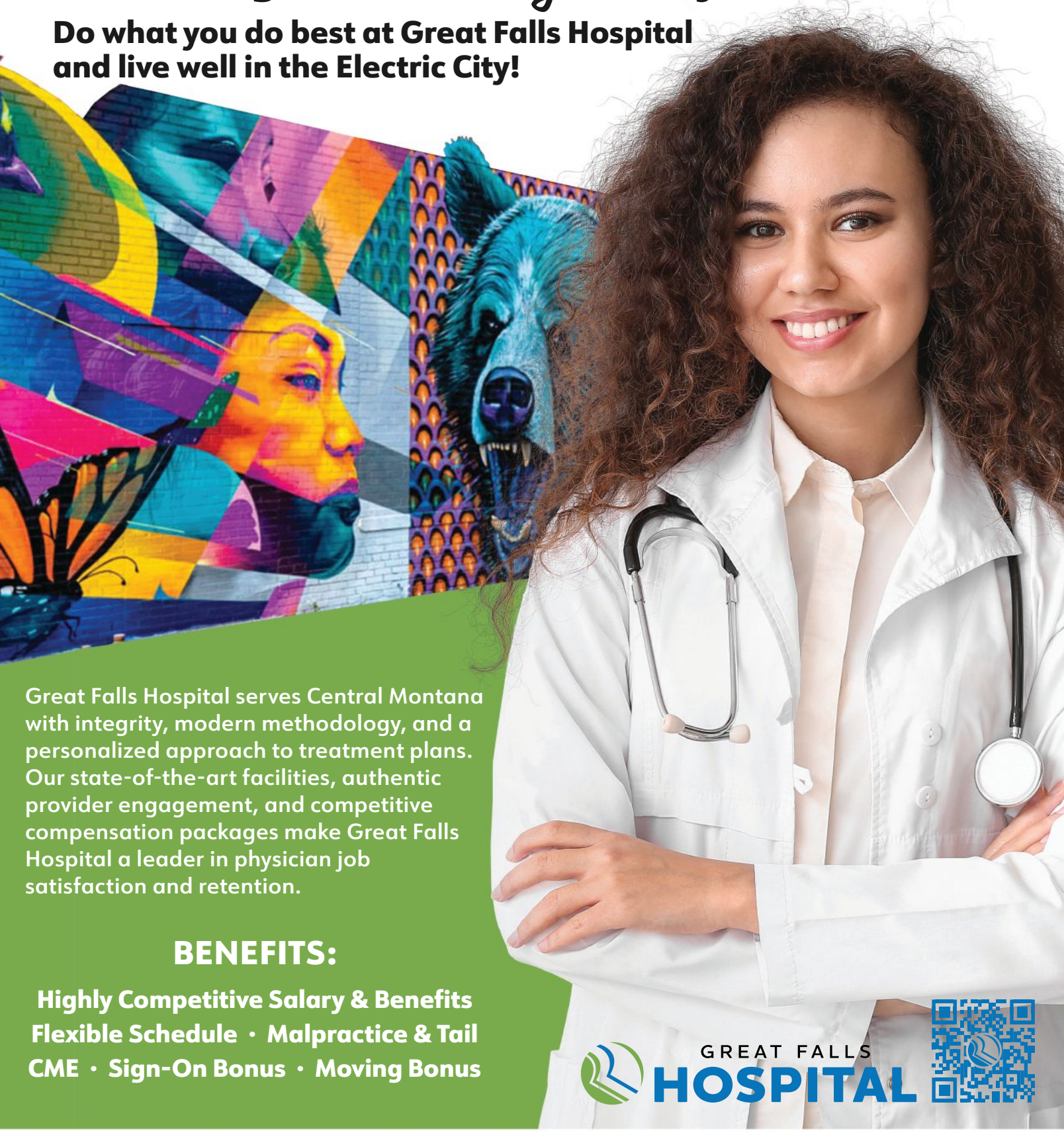

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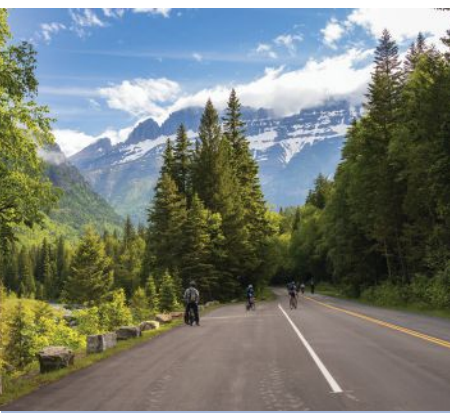
*The **Montana Family Physician** is printed, addressed, and mailed to every family physician, resident, and medical student in Montana as well as all 50 other state chapters.*



**On the Cover:**
*Cyclists on the Going-to-the-Sun Road with mountain background, Glacier National Park, Montana*

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**Edition 24**

## CONTENTS

EDITION 24

4 MAFP President's Welcome

6 2024/2025 MAFP Board of Directors and Officers

8 MT DPHHS Updates

9 WWAMI Update

10 MFMR: Wellness for Family Physicians

11 Community Children's Clinical Pathways

14 Updates from the American Academy of Family Physicians

15 74th Annual Meeting and Primary Care Conference of the Montana Academy of Family Physicians

16 Combatting Stigma with Knowledge

18 Helping Children and Adolescents Cope With Traumatic Events

20 Family Medicine Advocacy Rounds



# MAFP President's Message

*Saul Rivard, MD, 2024/2025 MAFP President*

Greetings MAFP members!

At the time of writing this message, there has already been a great deal of activity at the state capitol. Numerous bills affecting health care and its delivery have been presented. MAFP, in partnership with the Montana Chapter of the American Academy of Pediatrics (MTAAP), is working diligently to advocate for Montana's providers and patients.

On January 22nd, MAFP and MTAAP hosted an Advocacy Day at the state capitol, which gave providers an opportunity to meet legislators to discuss pertinent bills and policies. On behalf of MAFP, I provided testimony on two separate issues: increasing behavioral/mental health funding, and continuing Medicaid expansion. With approximately 75,000 Montanans able to access care through Medicaid expansion, this has been a top priority for MAFP's Advocacy Committee. We have continued to prioritize three areas of advocacy for family physicians: decreasing administrative burden, improving access to care, and opposing criminalization of medical care. Your membership contributions allow for this important work to be achieved.

There are many ways for you to become involved in the state legislative process. Simply reaching out to your district's legislators and informing them about the issues that affect you can be incredibly effective. If you would like to testify (this can be in-person, via Zoom, or by submitting a letter), please contact me or any one of our Board Members. If there is one thing I have learned this year, it's that legislators are eager to hear from primary care physicians.

Lastly, MAFP recently presented the 64th Annual Big Mountain Medical Conference January 29th-31st at The Lodge at Whitefish Lake. This conference provided an exciting combination of topics and engaging speakers. Right around the corner, the MAFP will be presenting the Annual Meeting at Chico Hot Springs June 19th & 20th. I encourage you to register and make your reservations early so you don't miss out!


Dr. Rivard testifying during Advocacy Day on a bill expanding behavioral/mental health funding.

MAFP and MT AAP Members attending a house floor session during Advocacy Day.

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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.

# Three Reasons Why You Were Given Top Priority to Be Vaccinated Against COVID-19

1. You are on the front lines and risk being exposed to people with COVID-19 each day on the job.

2. Protecting you also helps protect your patients and your family, especially those who may be at higher risk for severe illness from COVID-19.

3. You matter. And you play an essential role in keeping your community healthy.

## *Lead the way!*

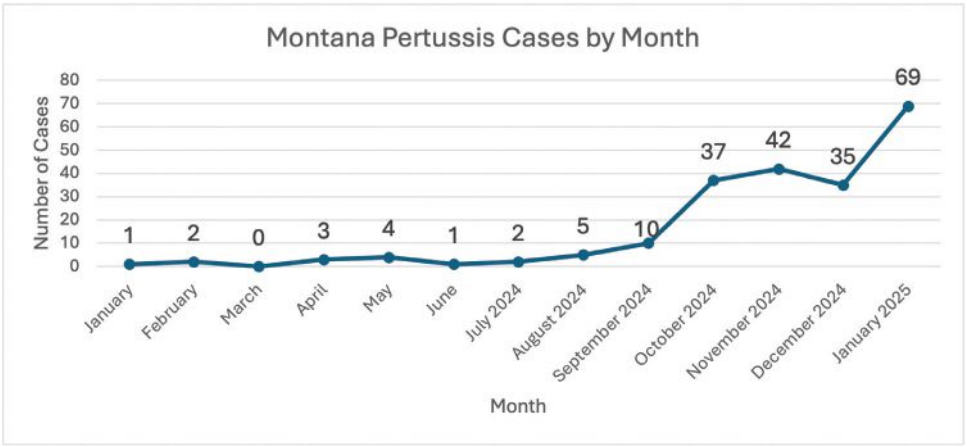
## Encourage your coworkers, patients, family and friends to get vaccinated.

www.cdc.gov/coronavirus/vaccines

12/09/20

# Pertussis Is on the Rise in Montana

Pertussis cases continue to rise in Montana. There have been more than sixty cases in 2025, impacting nine Montana counties. Healthcare providers play a critical role in preventing the spread of pertussis. Early clinical recognition, diagnosis, and treatment are core elements to preventing a pertussis outbreak. Prompt notification of your local public health department of suspect pertussis cases initiates contact tracing efforts to allow for timely post-exposure prophylaxis of exposed contacts, when necessary. This may involve household members, exposed individuals who are at risk for severe pertussis disease, and those who will have contact with individuals at high risk for severe pertussis disease.




Certain laboratories associated with Montana healthcare facilities may take a week or more to issue test results. If a clinician suspects pertussis based on a strongly suggestive clinical history, if the person is at risk for severe pertussis disease, or the person will have contact with someone at risk for severe disease (e.g., infants, pregnant women in their third trimester), the Centers for Disease Control and Prevention (CDC) recommends presumptively treating a suspect case with appropriate antibiotics without delay for pending test results.

Vaccination remains the best way to protect against infection. *Pertussis Vaccination Recommendations* for children through adults are available from the Centers for Disease Control and Prevention (CDC).

# Montana WWAMI Student Receives Prestigious Edwin E. Osgood Award

In January, four Montana WWAMI students had their research abstracts and posters selected for the 2025 Western Medical Research Conference in Carmel, California. The American Federation for Medical Research, which is geared toward medical student research, sponsors the annual Western Medical Research Conference. The AMFR is an international, multi-disciplinary association of scientists engaged in all areas of biomedical and patient-oriented research, from the laboratory, to translational to clinical. The organization works to foster the development of future generations of clinical scientists and investigators through its own initiatives, while encouraging public, private, and governmental investment in the development of these individuals. The mission of the AMFR is to "develop and mentor tomorrow's leaders in medical research".

Montana WWAMI medical student Isbah Khan (E-23) was awarded at the conference with the Edwin E. Osgood Award, considered one of the most prestigious honors for university student researchers. Isbah is a second year Montana WWAMI student. Billings is her hometown. Three other Montana WWAMI students presented at the conference. The students were joined by Montana WWAMI Foundations Dean, Brant Schumaker, DVM, MPVM, PhD, along with Patient Care Phase deans, Serena Brewer, DO, and Jay Erickson, MD.

**Isbah Khan,** Edwin E. Osgood Award winner**:** *Donor-recipient Telomere Dynamics in Long Term Survivors of Allogenic Hematopoietic Stem Cell Transplant;* Masumi Ueda-Oshima, MD; UW School of Medicine and Fred Hutchinson Cancer Center

**Chelsea Koessel**, *Fostering an Inclusive Future: Advocating for a United and Equitable Community via the Uptown Business Improvement District (BID) in Butte, MT;* Serena Brewer, DO; Butte, MT

**Gabby Spurzem**, *Financial Toxicity in Cutaneous Lymphoma: A Mixed Methods Study;* Chris Su, MD; UW Department of Hematology and Oncology

**Mackenzie Winters**, *Work Performance and Quality of Life Among Young Adult Cancer Survivors;* Neel S. Bhatt, MD, MPH, MBBS; Fred Hutchinson Cancer Center

# Managing Your Health and Wellbeing During a Long Montana Winter

*Jacalynn Kim, DO*

After the hustle and bustle of the holiday season, winter in Montana grinds on. The days remain short, the snow builds up and temperatures can be frigid.

As family practice physicians, we see more patients coming in with respiratory and other seasonal infections. We are also treating many patients struggling with their mental health. This can lead to higher workloads, increased stress and exposure to illness. All of this can take a toll on our work/life balance, health and mental wellbeing.

By taking simple steps to stay healthy and active, we can continue to be better physicians and learners for our patients, our colleagues, our families and ourselves.

- **Prevent illness**: Make sure you stay up to date on your immunizations, wear a mask with patients who are ill, and make sure you wash hands between patients.
- **Find winter activities:** You can try outdoor activities like skiing or ice fishing, or try a new indoor hobby like sewing, reading, crafting or painting.
- **Find ways to separate yourself from work:** Look for ways to relax away from your phone. Read or do a puzzle at home, find an enjoyable way to exercise, or find a social event to attend like a concert, play or community group.
- **Improve your nutrition:** Focus on foods that emphasize vitamin D and C and high fiber like fruits and vegetables. Try to stay away from processed foods.
- **Boost your immune system:** Consider a multi-vitamin high in vitamin C.
- **Get outside:** Not only can more time outside boost your vitamin D, but colder weather can mean more time indoors with people, increasing your exposure to illnesses. If you don't have a dog, volunteer to walk a shelter dog, or walk with a friend or family member.
- **Try light therapy:** Using bright light therapy to mimic natural sunlight can be an effective treatment for Seasonal Affective Disorder by regulating our circadian rhythm, boosting mood and energy levels.
- **Get warm:** Saunas or hot yoga classes can help you get warm during especially cold days.
- **Be more social:** Group activities like exercise classes check two boxes – they're social and they get you moving. Other ideas are book clubs, church groups or neighborhood organizations.
- **Stay hydrated:** Dry cold air in the winter means chapped lips and dry skin. Aim to drink at least 64 ounces of water each day and avoid flavoring with sugar or sweetener. Run a humidifier to add moisture to your indoor air (your plants will thank you, too!).

## Wellbeing and resiliency

During our days seeing patients, we are often exposed to people struggling with their mental health, which can affect our mental wellbeing. If you have a difficult visit, find a moment to check in with a colleague or supervisor.

As a wellness lead in the Montana Family Medicine Residency, I am part of a team that works with residents and faculty year-round to help manage stress and build community in our practice.

It's okay to reach out for help. There are resources available through your organization's employee assistance program, local counselors, mental health and wellness apps like Better Health, and other online resources.

*Dr. Jacalynn Kim, DO, will graduate in the Montana Family Medicine Residency class of 2026.*

# 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.communitymed.org/pathways

*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.

continued on page 12 >

continued from page 11>

# Neonatal HSV Intrapartum Exposure

**Asymptomatic neonate following vaginal or cesarean delivery to mother with visible genital lesions that are characteristic of herpes simplex virus (HSV)**

OB provider obtains swab of lesion for HSV NAAT LabCorp 188056 and culture‡ with typing of positive results

‡ If available locally

**Maternal history of genital HSV preceding pregnancy?**

**NO**

Send maternal type specific serology for HSV-1 & HSV-2‡

At ~HOL24*, obtain from neonate:
- HSV surface cultures‡ and NAAT LabCorp 188056
- HSV blood PCR LabCorp 138651
- CSF cell count, chemistries, HSV PCR LabCorp 139800
- Serum ALT

**START IV ACYCLOVIR 60 mg/kg/d Q8hr**

**Maternal HSV Infection Classification?¥**

First episode (primary or non primary)

Continue acyclovir; may treat for only 10 days if CSF testing negative & ALT normal IF neonate continues to appear well

Recurrent

**Neonatal testing all negative (cultures negative at 48-72h)?**

YES

May discharge before NAAT is resulted if return precautions and follow up arranged

NO

Continue acyclovir; may treat for only 10 days if CSF testing negative & ALT normal IF neonate continues to appear well

**Evaluation and treatment is indicated before HOL24 if neonate develops illness; consider if ROM >4-6 hrs or neonate is ≤37w GA*

**YES**

At ~HOL24*, obtain from neonate:
- HSV surface cxs‡ & NAAT LabCorp 188056
- HSV blood PCR LabCorp 138651

**If neonate remains asymptomatic, DO NOT START ACYCLOVIR**

**Neonatal testing all negative (cultures negative at 48-72h)?**

NO

Obtain from neonate:
- CSF for cell count, chemistries, HSV PCR LabCorp 139800
- Serum ALT

**START IV ACYCLOVIR 60 mg/kg/d Q8hr**

YES

May discharge before NAAT is resulted if return precautions and follow up arranged

*Normal ALT* ≤ 2x upper limit of normal

Continue acyclovir; may treat for only 10 days if CSF testing negative & ALT normal IF neonate continues to appear well

*HSV surface testing: from vesicle(s), mouth, conjunctiva, nasopharynx, rectum, and any site of skin disruption*

**¥MATERNAL HSV INFECTION CLASSIFICATION** *(Based on Table 3.24 HSV, Red Book)*

| Maternal classification | Genital NAAT/culture | HSV-1 & HSV-2 IgG |
|---|---|---|
| Documented first-episode / primary infection | Positive, either virus | Both negative |
| Documented first-episode / non primary infection | Positive for HSV-1 | Neg for HSV-1 AND pos for HSV-2 |
| | Positive for HSV-2 | Pos for HSV-1 AND neg for HSV-2 |
| Assumed first-episode (primary or non primary infection) | Positive for HSV-1 OR HSV-2 | Not available (N/A) |
| | Negative OR N/A | Neg for HSV-1 &/or HSV-2 or N/A |
| Recurrent infection | Positive for HSV-1 | Positive for HSV-1 |
| | Positive for HSV-2 | Positive for HSV-2 |

*Algorithm based on Figure 3.7 & 3.8. Herpes Simplex. Red Book: 2024-2027 Report of the Committee on Infectious Diseases.*

LAST UPDATED Jan 2025

# Neonatal HSV Disease

Herpes simplex virus (HSV) can cause a range of illness after the neonatal period, from asymptomatic infection to gingivostomatitis or herpes labialis ("cold sores" or "fever blisters") to disseminated infection in immunocompromised patients. For at risk newborns, maternal HSV genital infections can be asymptomatic especially if a primary, or first time, infection. After a primary infection, HSV may persist in a latent form until reactivated as a recurrent infection.

**When should I worry about neonatal transmission?**
The risk of transmission to neonate is significantly higher in primary maternal infections acquired closer to time of delivery (50-60%) than recurrent infections (<3%), most likely due to lack of transplacentally acquired antibodies in the neonate and exposure during delivery to larger quantities of virus.

Fortunately, since most maternal infections during pregnancy are recurrent, neonatal HSV remains uncommon, with incidence of 1 in 2000 births in the US. However, 75% of infants with HSV infection are born to mothers who are asymptomatic so it is important to maintain a high suspicion for HSV infection if there are suggestive signs or symptoms.

Neonates with HSV infection should remain on contact precautions and not have delayed bathing, similar to those born to mothers with active genital lesions. People with active lesions should maintain careful isolation of lesion and hand hygiene. Mothers and others with herpes labialis should wear a disposable mask when caring for their neonate and avoid kissing until lesions are crusted. Breastfeeding may continue unless there are lesions on the breast.

### INCREASED RISK FACTORS FOR DISEASE

- Type of maternal infection (first episode / primary infection > first episode / non primary infection > recurrent)
- Maternal HSV serostatus
- Mode of delivery (vaginal > cesarean)
- Duration of rupture of membranes
- Disruption of cutaneous barrier (use of fetal scalp electrodes, other instrumentation)
- HSV serotype (HSV-1 > HSV-2)

### CATEGORIES OF NEONATAL HSV DISEASE

- Localized skin, eyes, and/or mouth (SEM disease) (45%) – generally presents at DOL 7-14 with 80% having a vesicular rash.
- Localized CNS disease (30%), with or without skin, eye, or mouth involvement - often presents at DOL 14-21 but usually within first month of life, with seizures, lethargy, irritability, poor feeding, temperature instability, and bulging fontanelle. 60-70% also have a rash but not necessarily on presentation.
- Disseminated disease (25%) which affects multiple organs, most prominently liver, lungs, skin, eyes, mouth, and often CNS – commonly symptomatic around DOL 7-14, presenting with respiratory and hepatic failure / DIC, and not uncommonly encephalitis.

**How should I manage neonatal HSV disease?**
- All disease should be treated with intravenous acyclovir 60 mg/kg/day divided Q8hr. The length of therapy depends on the category of disease, with disseminated disease being treated for 21 days, CNS disease for 21 days, and SEM disease for 14 days (minimum durations).
- For disseminated disease with CNS disease, repeat CSF HSV PCR and routine testing before stopping treatment. If CSF continues to have detectable DNA by PCR at end of therapy, continue treatment until PCR is negative (retest 7 days later).
- All neonates should have neuroimaging, ideally brain MRI, before completion of treatment.
- All neonates should have ophthalmologic evaluation.
- After completing IV acyclovir, treat with oral acyclovir suppressive therapy for 6 months (300 mg/m2/dose TID) with monthly dose adjustments.
- Measure absolute neutrophil counts (ANC) twice weekly when on high dose acyclovir, then every 2 weeks for the first month then monthly when on suppressive therapy, adjusting treatment if ANC <500 for prolonged period.
- Consider neurodevelopmental evaluation at 1yo.

**Neonates whose mothers have history of genital HSV but no active lesion at time of delivery only require observation** unless a first-episode infection was during the third trimester, and then the neonate should be managed similar to the neonate born to a mother with an active genital lesion but a recurrent infection.

**Educate families of neonates to monitor for symptoms until approximately 6 weeks of age**

Sources – 1. Red Book: 2024-2027 Report of the Committee on Infectious Diseases (33rd edition), 2. Pinninti & Kimberlin, Neonatal HSV: Seminars in Perinatology (2018).

# In Times Like These, Our Purpose Is Clear

*By Jen Brull, M.D., FAAFP*
*AAFP President*

*The following article is reprinted with permission from the American Academy of Family Physicians.*

Today, as we recognize Women in Medicine Day and the start of Black History Month, I am reflecting on the roots of family medicine. Our specialty was born out of a social movement — one that recognized the failures of a fragmented, inequitable health care system and responded with a commitment to accessible, patient-centered care. Family medicine has always been about ensuring that every individual, regardless of who they are or where they live, has the opportunity to achieve health.

These values are not just guiding principles; they are the foundation of our work. They transcend politics and remain central to why we chose this profession — to serve patients and communities with compassion, evidence and advocacy.

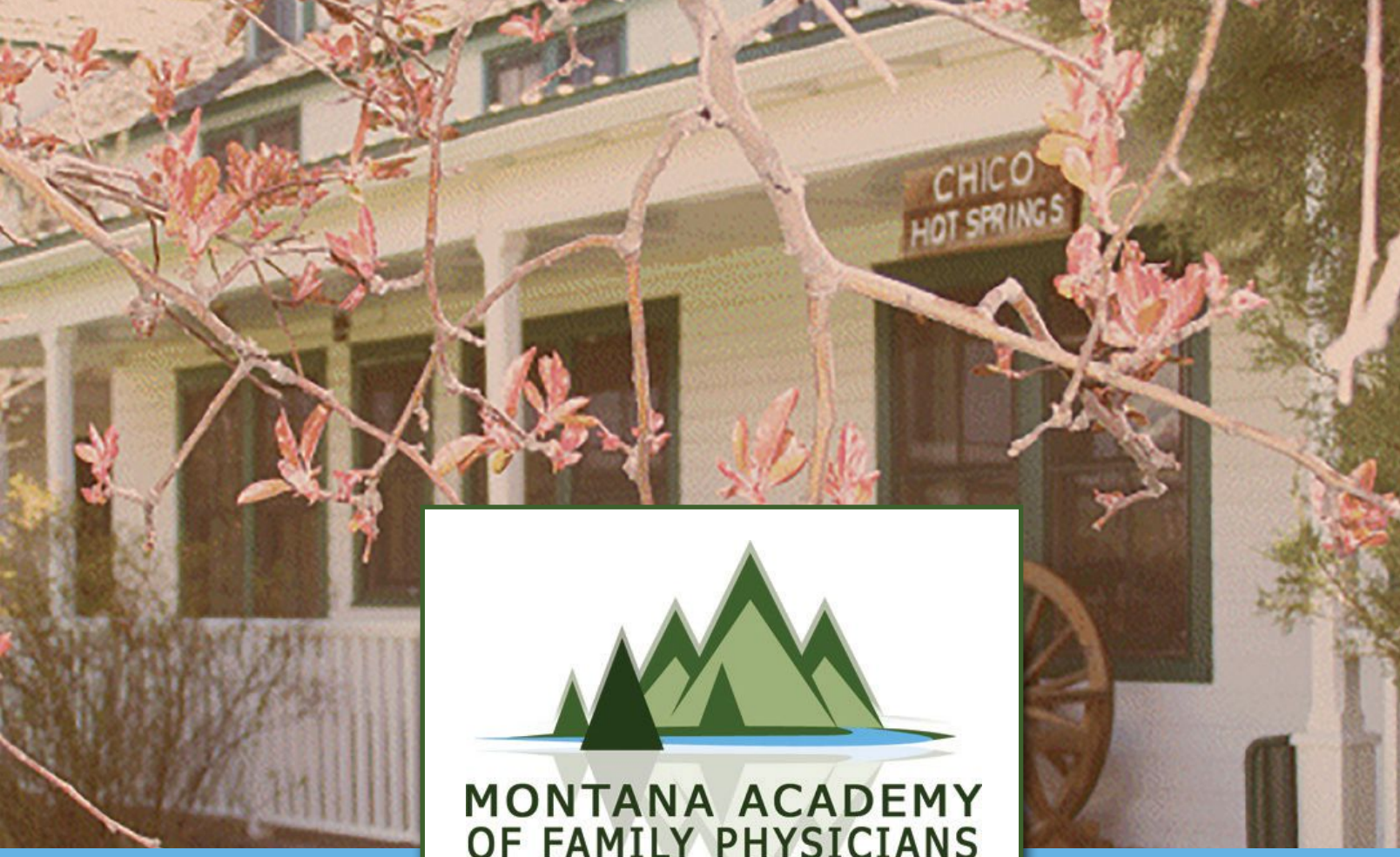
In the past two weeks, we have seen an unprecedented number of executive orders and actions that threaten the health of our patients, the practice of family medicine and the well-being of the communities we serve. The pace and scope of these changes are concerning, and I want to be clear: The AAFP shares your concerns, and we are taking action.

Our advocacy efforts are focused on protecting patient care, defending evidence-based medicine and science, and ensuring that family physicians can continue to provide the full spectrum of care our patients need. We are pressing members of Congress to intervene where necessary, advocating for key health care programs and funding, and engaging in public and media outreach to highlight the real-world impact of these policy changes. We are also working to give you the resources and support you need to navigate this uncertain landscape.

Advocacy takes many forms. While immediate, high-profile action can be powerful, lasting change often requires strategic engagement, persistence and coalition-building away from the spotlight. Direct confrontations may feel cathartic, but they don't always lead to meaningful solutions. Nonetheless, if a time comes when we need to take our cause to the streets — figuratively or literally — we will be ready. Family medicine has never shied away from standing up for what's right, and we won't start now.

This is a difficult time, and I know many of you are feeling troubled and uncertain about what lies ahead. In moments like these, our purpose remains clear. Family medicine has always stood up for our patients, for our communities and for the future of health care.

Thank you for all that you do. We are in this together, and the AAFP will continue to stand with you.




MONTANA ACADEMY
OF FAMILY PHYSICIANS

74th Annual

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

## June 19-20, 2025

## 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!*

# Combatting Stigma with Knowledge

*By: Madeline Beasley Peacock, Ph.D., Public Health Advisor*
*and Robert Baillieu, M.D., M.P.H., Physician and Senior Advisor, Center for Substance Abuse Treatment*

SAMHSA
Substance Abuse and Mental Health Services Administration

Substance Use Disorders (SUDs) are chronic disorders of the brain with a risk of recurrence but from which people can, and do, recover. Like other medical conditions, some people are more susceptible to developing a SUD than others. According to the Substance Abuse and Mental Health Services Administration's (SAMHSA) National Survey on Drug Use and Health, only about 25 percent of people who had used alcohol and illicit drugs within the past year met the criteria for a SUD diagnosis.[1] For this subgroup of people, the brain disease model underscores the brain changes that happen with SUDs and that drive a person to continue using substances despite all the negative consequences and harms that follow.

For countless generations, however, people with SUDs have been subjected to a false social belief, or stigma, that their use of substances and its consequences were a result of their moral failings or lack of willpower. This stigma impacts their lives – resulting, for some, in loss of child custody, loss of employment, and incarceration rather than treatment.

The impact of stigma extends far beyond these direct consequences. Research shows that stigma creates barriers to seeking treatment, with many individuals avoiding help due to fear of judgment or discrimination. Health care settings, which should be safe spaces for seeking help, can sometimes perpetuate these harmful attitudes. Studies have found that even experienced health care practitioners may hold unconscious biases that affect the quality of care they provide to individuals who have SUDs.

Moreover, internalized stigma – when individuals begin to believe these negative stereotypes about themselves – can lead to decreased self-esteem, increased isolation, and reduced hope for recovery. This creates a devastating cycle where stigma itself becomes a barrier to healing and recovery.

Fortunately, individuals who have histories of a SUD are now protected from job discrimination by the Americans with Disabilities Act of 1990. However, judgmental attitudes – even sometimes harbored by the practitioners who can otherwise provide effective SUD treatment – and other forms of discrimination still occur. This is despite the reality that their SUD is the result of long-term, neurobiological brain changes often complicated by genetic predispositions, impacts of early childhood adverse experiences, and other environmental factors.

## Breaking Down Stigma

One way to break down the stigma impacting people is to understand SUD as a brain disease. This can help reduce stigma in several crucial ways:

1. It shifts the narrative from personal blame to medical understanding, recognizing that SUDs involve biological changes and are not a matter of willpower.

2. It places SUDs in the same category as other chronic medical conditions that benefit from ongoing management and support.

3. It emphasizes the importance of evidence-based treatment approaches rather than punishment or moral judgment.

4. It supports the role of all health care practitioners in screening for and treating SUDs, rather than viewing people who have SUDs as having primarily legal or moral issues.

Recent research[2] has shown that when health care providers receive education about the neurobiology of addiction, their attitudes toward patients who have SUDs improve significantly. This scientific understanding helps replace stigmatizing beliefs with empathy and evidence-based approaches to treatment. However, addressing stigma requires a multi- faceted approach beyond just education about the brain disease model.

One of the most powerful tools in reducing stigma is direct interaction with people in recovery. Through peer support programs and recovery storytelling, health care providers, community members, and policymakers gain firsthand exposure to the human reality of SUDs. These personal connections challenge stereotypes and misconceptions, replacing them with understanding and empathy.

Health care organizations play an important role in dismantling stigma by instituting operational changes. By implementing comprehensive stigma awareness training for all staff members, organizations can create environments where individuals feel safe seeking treatment. This transformation goes beyond surface-level changes – it requires

a fundamental shift in culture that prioritizes equitable treatment and dignity for all patients. Many health care systems have found success by integrating addiction treatment into primary care settings, making it as routine as managing diabetes or hypertension.

The media wields significant influence in shaping public perceptions of SUDs, and thoughtful public education campaigns can help challenge longstanding misconceptions. Success stories of recovery, particularly those highlighting the diverse backgrounds of people affected by SUDs, help demonstrate that addiction touches all communities, and that recovery is possible for everyone.

Systemic change also requires robust policy support. When insurance coverage for SUD treatment expands, more people can access the care they need. Strong legal protections against discrimination in employment and housing provide essential stability for individuals in recovery. Harm reduction programs save lives and provide crucial points of contact for individuals who might otherwise avoid health care settings entirely. Sustained funding for research helps improve treatment approaches, while parity laws ensure that individuals seeking treatment for SUDs receive the same level of care as those with other medical conditions.

Health care professionals benefit from ongoing education that goes beyond understanding addiction's neurobiology. Training in cultural competency helps providers recognize and respect the diverse experiences of their patients. Trauma-informed care approaches acknowledge the complex relationships between trauma and substance use, while skills in motivational interviewing enable more effective patient interactions. Education about implicit bias helps providers recognize and address their own prejudices, and training in person-first, recovery-oriented language ensures that communication supports rather than undermines recovery. Community engagement initiatives also play a vital role in reducing stigma. When local organizations, religious institutions, and community leaders come together to support recovery efforts, the partnership creates a network of understanding and support. Educational programs in schools can help prevent stigma from taking root in younger generations by promoting understanding and empathy from an early age.

Finally, workplace programs that support employees in recovery and that provide education about SUDs help reduce stigma in professional settings. When organizations create policies that treat SUDs as health conditions rather than moral failings, it enables employees to seek help without fear of discrimination.

The media wields significant influence in shaping public perceptions of SUDs, and thoughtful public education campaigns can help challenge longstanding misconceptions. Success stories of recovery, particularly those highlighting the diverse backgrounds of people affected by SUDs, help demonstrate that addiction touches all communities, and that recovery is possible for everyone.

## A Chronic Condition – Not a Choice

No one chooses to develop an SUD, and they can happen to anyone. While people may struggle to manage them, help is available.

For more information and resources on SUD Treatment Month, visit the SUD Treatment Month Toolkit.

To learn how to get support for mental health, drug, or alcohol issues, visit FindSupport.gov. If you are ready to locate a treatment facility or provider, you can go directly to FindTreatment.gov or call 800-662-HELP (4357). If you or someone you know is struggling or in crisis, help is available. Call or text 988 or chat at 988lifeline.org .

Treatment works. Recovery is possible.

## References

1. Substance Abuse and Mental Health Services Administration. (2024). Key substance use and mental health indicators in the United States: Results from the 2023 National Survey on Drug Use and Health (HHS Publication No. PEP24-07-021, NSDUH Series H-59). Center for Behavioral Health Statistics and Quality, Substance Abuse and Mental Health Services Administration.

2. The Centers for Disease Control and Prevention. 2024. The Addiction Medicine Primer: An Overview of Treatment of Substance Use Disorders.

https://www.samhsa.gov/blog/combatting-stigma-knowledge

# Helping Children and Adolescents Cope With Traumatic Events

Every year, children and adolescents experience disasters and other traumatic events. Family, friends, and trusted adults play an essential role in helping youth cope with these experiences.

## How do children and adolescents respond to traumatic events?

It is typical for children and adolescents to have a range of reactions after experiencing or witnessing a traumatic event, such as a natural disaster, an act of violence, or a serious accident.

**Regardless of age, children and adolescents may:**

- Report having physical problems such as stomachaches or headaches.
- Have nightmares or other sleep problems, including refusing to go to bed.
- Have trouble concentrating.
- Lose interest in activities they normally enjoy.
- Have feelings of guilt for not preventing injuries or deaths.
- Have thoughts of revenge.

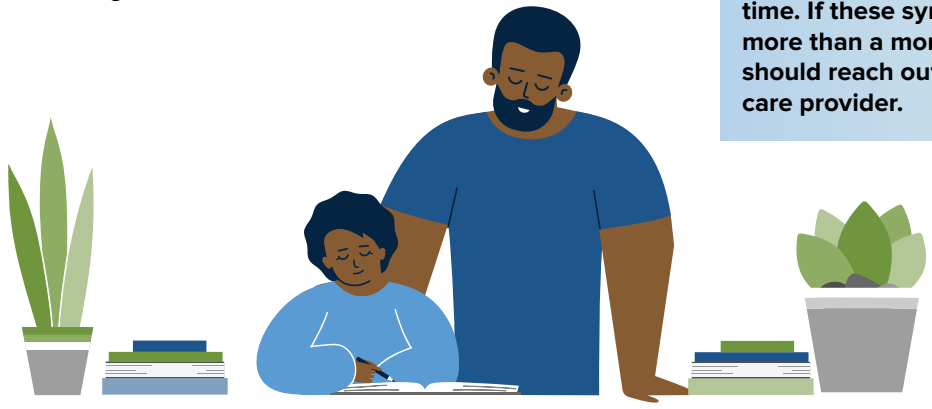
**Young children (age 5 and younger) may:**

- Cling to caregivers and/or cry and be tearful.
- Have tantrums, or be irritable or disruptive.
- Suddenly return to behaviors such as bed-wetting and thumb-sucking.
- Show increased fearfulness (for example, fear of the dark, monsters, or being alone).
- Incorporate aspects of the traumatic event into imaginary play.

**Older children (age 6 and older) and adolescents may:**

- Have problems in school.
- Withdraw or become isolated from family and friends.
- Avoid reminders of the event.
- Use drugs, alcohol, or tobacco.
- Be disruptive, disrespectful, or destructive.
- Be angry or resentful.

**Many of these reactions are normal and will lessen with time. If these symptoms last for more than a month, the family should reach out to a health care provider.**



## What can adults do to help?

How adults respond to trauma can strongly influence how children and adolescents react to trauma. When caregivers and family members take steps to support their own ability to cope, they can provide better care for others.

Caregivers and family members can help by creating a safe and supportive environment, remaining as calm as possible, and reducing stressors. Children and adolescents need to know that their family members love them and will do their best to take care of them.

**Do:**

- Ensure children and adolescents are safe and that their basic needs are addressed.
- Allow them to be sad or cry.
- Let them talk, write, or draw pictures about the event and their feelings.
- Limit their exposure to repetitive news reports about traumatic events.
- Let them sleep in your room (for a short time) or sleep with a light on if they are having trouble sleeping.
- Try to stick to routines, such as reading bedtime stories, eating dinner together, and playing games.
- Help them feel in control by letting them make some decisions for themselves, such as choosing their meals or picking out their clothes.
- Pay attention to sudden changes in behaviors, speech, language use, or strong emotions.
- Contact a health care provider if new problems develop, particularly if any of the following symptoms occur for more than a few weeks:
  - Having flashbacks (reliving the event)
  - Having a racing heart and sweating
  - Being easily startled
  - Being emotionally numb
  - Being very sad or depressed

**Don't:**

- Expect children and adolescents to be brave or tough.
- Make them discuss the event before they are ready.
- Get angry if they show strong emotions.
- Get upset if they begin bed-wetting, acting out, or thumb-sucking.
- Make promises you can't keep (such as "You will be OK tomorrow" or "You will go home soon.")

## Where can I find help?

The Substance Abuse and Mental Health Services Administration (SAMHSA) offers a Disaster Distress Helpline**,** which provides immediate crisis counseling for people who are experiencing emotional distress related to any natural or human-caused disaster. The helpline is free, multilingual, confidential, and available 24 hours a day, 7 days a week. You can call or text the helpline at 800-985-5990 or visit the helpline website at **https://disasterdistress.samhsa.gov**.

SAMHSA also provides the Behavioral Health Treatment Services Locator, an online tool for finding mental health services in your area. Find treatment programs in your state at **https://findtreatment.samhsa.gov**. For additional resources, visit **www.nimh.nih.gov/findhelp**.

If you, your child, or someone you know is in immediate distress or is thinking about hurting themselves, call 911 or call the **National Suicide Prevention Lifeline** toll-free at 1-800-273-TALK (8255). You also can text the **Crisis Text Line** (HELLO to 741741) or use the Lifeline Chat on the National Suicide Prevention Lifeline website at **https://suicidepreventionlifeline.org**.

## Where can I find more resources?

National Institute of Mental Health:
Coping With Traumatic Events
**www.nimh.nih.gov/copingwithtrauma**

National Institute of Mental Health:
Child and Adolescent Mental Health
**www.nimh.nih.gov/children**

Centers for Disease Control and Prevention:
Caring for Children in a Disaster
**www.cdc.gov/childrenindisasters**

National Child Traumatic Stress Network
**www.nctsn.org**

National Institute of Mental Health

NIH Publication No. 22-MH-8066

**www.nimh.nih.gov**

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# Family Medicine Advocacy Rounds

AAFP
AMERICAN ACADEMY OF FAMILY PHYSICIANS

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**Family Medicine Advocacy Rounds – Issue 31, January 2025**

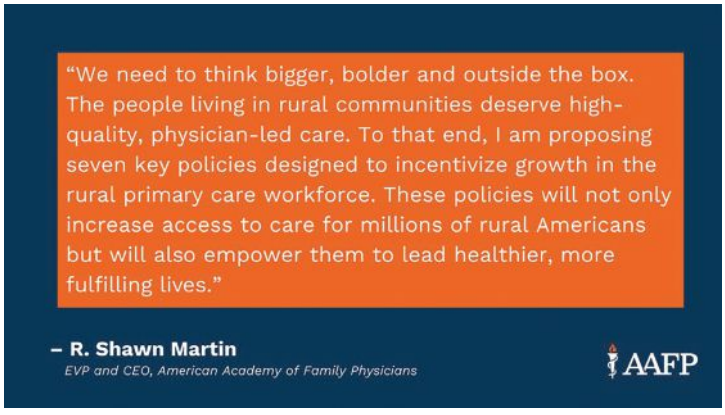
Welcome to Family Medicine Advocacy Rounds — the American Academy of Family Physicians' monthly tip sheet to educate, engage and update you on the latest policy issues affecting family physicians and their patients.

## AAFP Welcomes 119th Congress

As the 119th Congress convenes, the AAFP believes there are opportunities to work together to enact policies that will help ensure accessible, affordable health care for all Americans. In a letter to Congress, the AAFP outlined a continued focus on four key priorities.

- **Recognizing the value of primary care**, which is crucial for improving health outcomes, reducing health care costs and enhancing patient satisfaction. More resources and support are needed to ensure that our nation appropriately values primary care, including sweeping Medicare payment reform, support for alternative payment models to facilitate a more meaningful transition to value-based care and protecting physicians' clinical autonomy by addressing health care consolidation and misaligned incentives such as site-of-service payment differentials.
- **Reducing administrative burden**, such as excessive documentation, prior authorizations and billing requirements. Reducing this burden allows physicians to focus more on patient care, enhances job satisfaction and increases efficiency within the health care system, ultimately improving the quality of care and patient outcomes.
- **Increasing and sustaining the primary care workforce** to address growing workforce shortages due to an aging population and physician burnout. Increasing and sustaining the workforce requires policies that promote training, support and retention of family physicians. Efforts such as enhanced medical education, loan forgiveness programs and better compensation are essential to attracting and maintaining a strong family physician workforce.
- **Improving health care** to ensure that Americans have access to high-quality health care. This involves addressing disparities in health care access, affordability and quality. Policies should focus on expanding access to rural and underserved populations and improving care coordination. To achieve better health outcomes for all while reducing health care costs in the longer term, policies should also promote low-cost, high-value care such as immunizations and other preventive services.

## AAFP CEO: Seven Bold Policies to Reshape Rural Health Care




The U.S. faces a growing problem: diminishing access to physicians and health care services for 60 million people living in rural communities. Rural residents face longer travel times to receive care, and there is increased pressure on those physicians remaining in the community.

In a new piece in Healthcare Dive, AAFP CEO and Executive Vice President R. Shawn Martin outlined new policies to champion rural health care. He called for

- tax credits for physicians practicing in health professional shortage areas;
- professional liability insurance coverage via the Federal Tort Claims Act;
- tax deductions for teaching and mentoring medical students and residents in rural practices;
- rural Medicare payment enhancement;
- prompt pay in Medicare Advantage;
- strengthening "healthy Americans" incentives; and
- direct contracting with primary care physicians for Medicare and Medicaid patients.

All communities, including rural communities, deserve access to high-quality, accessible primary care. Martin challenged the new Congress and administration to seek bold policy changes that make this a reality for the millions of Americans who call rural communities home.

Additionally, the AAFP, along with the National Rural Health Association and the American Heart Association, is a co-sponsor of the Rural Health Disparities Summit in Washington, D.C. on Feb. 13. AAFP leadership and members will be participating in a panel on rural residency programs and training, which is essential in building the primary care workforce. You can register at the link above and the event is open to media.

## AAFP Responds to New FDA Proposed Nicotine Rules

The U.S. Food and Drug Administration (FDA) issued a proposed rule to limit nicotine levels in cigarettes and other combusted (smoked) tobacco products to minimally addictive or non- addictive levels.

The AAFP knows tobacco use is the leading cause of preventable, premature death in the U.S., killing nearly half a million American each year, costing the nation over $241 billion annually in health care expenses and causing nearly a third of all deaths from cancer and cardiovascular disease.

If finalized, the proposal that would accelerate declines in smoking and save millions of lives from cancer, cardiovascular disease and other tobacco-related diseases.

At the same time, the AAFP is discouraged that the FDA also authorized types of flavored Nicotine pouches, which can lead do youth nicotine addiction. We've repeatedly called on the FDA to ban all flavored tobacco and nicotine products due to their appeal to children. The AAFP will continue to engage with the FDA on all nicotine and tobacco policies.

## New Report Shows U.S. Overdose Rate Higher Than Other Countries'

***Why it Matters*:** A new Commonwealth Fund report shows that, in 2022, about 108,000 people in the U.S. died of an overdose — a jump of more than 50% since 2019. While 2022 was the first year that overdose deaths had declined since 2018, the United States continues to have the highest rate of such deaths in the world, by a substantial margin. Given the scope of specialty and geographic distribution, family physicians play a critical role in the prevention and treatment of opioid use disorder, especially in rural and under-resourced communities.

## What we're working on:

- Although removal of the X-waiver requirement to prescribe buprenorphine was a significant step by Congress, the AAFP sent a letter last year urging lawmakers to enact policies that remove additional barriers for accessing medications for opioid use disorder (MOUD). This remains an AAFP priority for the 119th Congress.
- The AAFP has been working to reduce stigma and increase access to appropriate treatment. This includes by acknowledging that OUD is a chronic condition that falls within the scope of practice for family physicians to treat. Family physicians work with patients to manage their diabetes, hypertension and arthritis — OUD should be no different.
- The AAFP continues to advocate for streamlining prior authorization requirements that create significant barriers for family physicians and can delay the start or continuation of MOUD. These delays lower adherence to recommended treatments, which can lead to adverse health consequences for patients.
- The AAFP continues to push for integrating behavioral health into primary care practices to increase patient access to MOUD. Unfortunately, while many family physicians want to integrate behavioral health services in their practices, they face burdensome startup costs and payment and reporting challenges that prevent integration.

## What We're Reading

- AAFP Board Chair Steve Furr, M.D., FAAFP, spoke to MedCentral about Medicare payment cuts. "We have not had an inflation update for 21 years. Can you imagine any business still surviving after 21 years if they were not able to raise their prices?" he said.
- Editors of MedPage Today selected some of the best quotes their reporters heard in 2024. "It's very, very clear that physician spending is not the problem in healthcare," said Jen Brull, M.D., FAAFP, president of the American Academy of Family Physicians, commenting on proposed payment cuts under the Medicare physician fee schedule.
- AAFP Board member Kisha Davis, M.D., FAAFP, spoke to the NBC Baltimore affiliate station about preventing respiratory illnesses such as RSV and COVID-19 during cold and flu season. Family physicians play a critical role in conversations about vaccines.

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

## About American Academy of Family Physicians

*Founded in 1947, the AAFP represents 130,000 physicians and medical students nationwide. It is the largest medical society devoted solely to primary care. Family physicians conduct approximately one in five office visits — that's 192 million visits annually or 48 percent more than the next most visited medical specialty. Today, family physicians provide more care for America's underserved and rural populations than any other medical specialty. Family medicine's cornerstone is an ongoing, personal patient-physician relationship focused on integrated care. To learn more about the specialty of family medicine and the AAFP's positions on issues and clinical care, visit www.aafp.org. For information about health care, health conditions and wellness, please visit the AAFP's consumer website, www.familydoctor.org*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