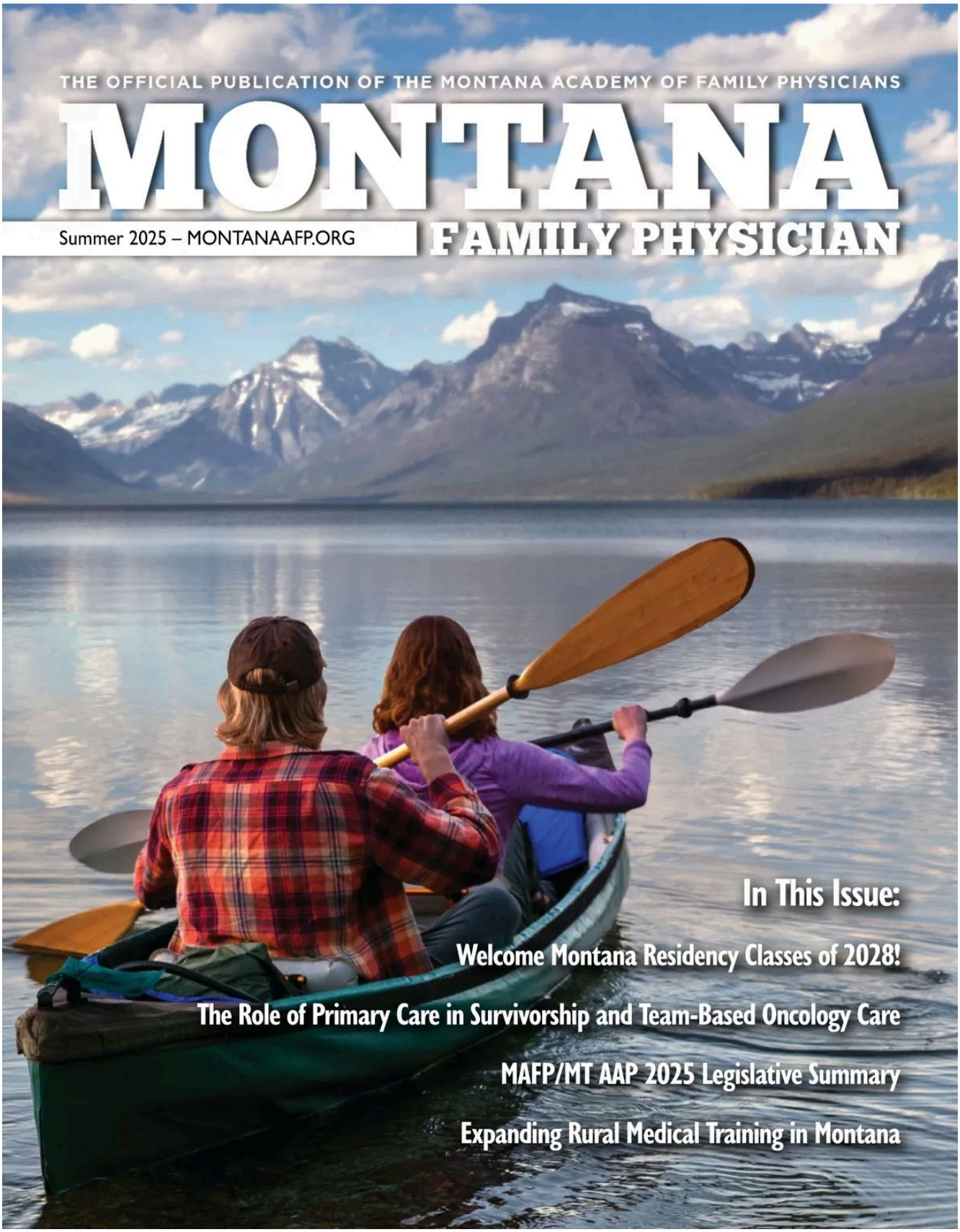
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MONTANA
FAMILY PHYSICIAN
Summer 2025 – MONTANAAFP.ORG
In This Issue:
Welcome Montana Residency Classes of 2028!
The Role of Primary Care in Survivorship and Team-Based Oncology Care
MAFP/MT AAP 2025 Legislative Summary
Expanding Rural Medical Training in Montana

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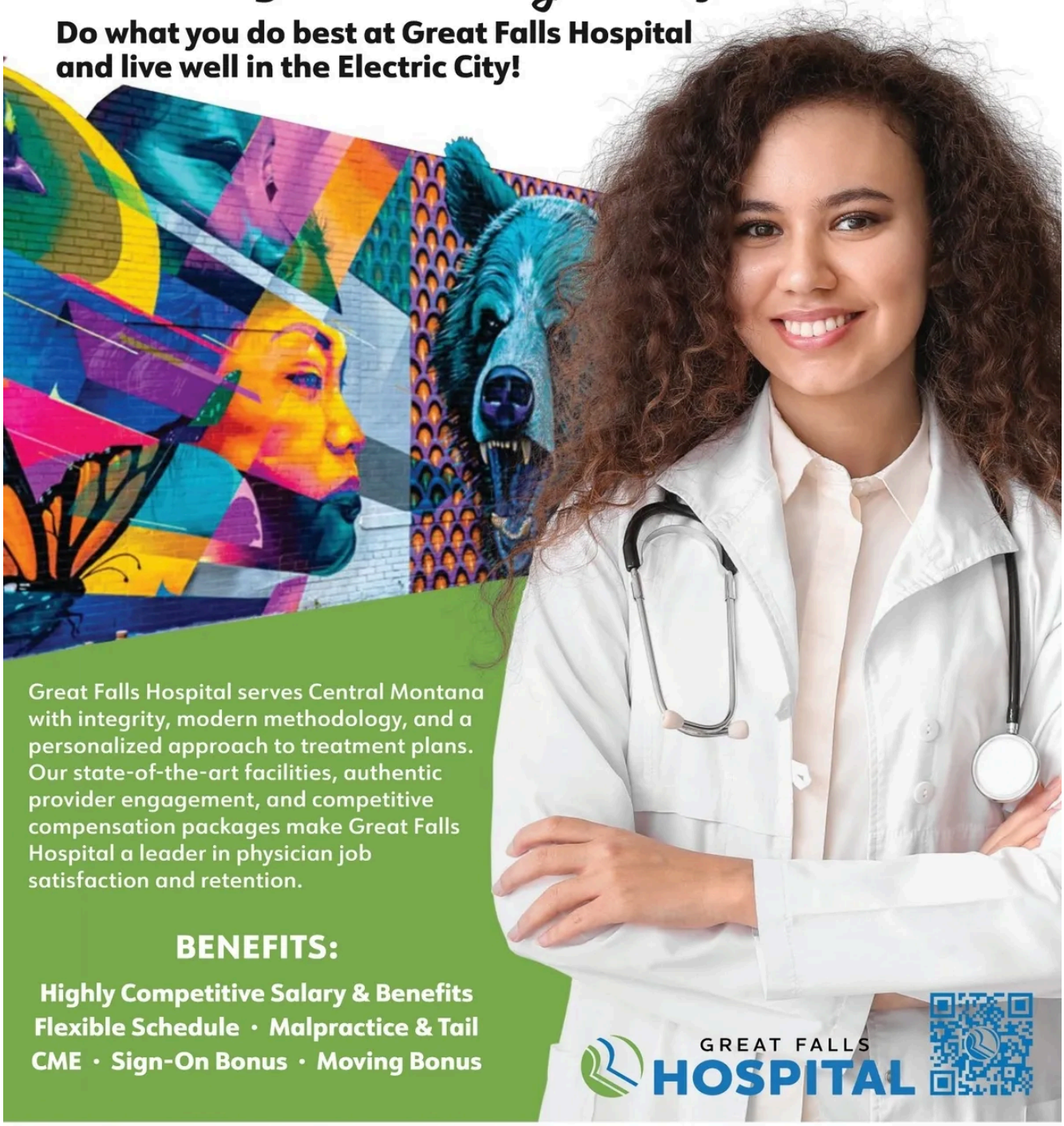

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MONTANA ACADEMY OF FAMILY PHYSICIANS

THE OFFICIAL PUBLICATION OF THE MONTANA ACADEMY OF FAMILY PHYSICIANS

MONTANA FAMILY PHYSICIAN

*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:
Adventurous traveling couple rowing a boat on a perfect scenic lake in a beautiful national park

PCI Publishing Concepts, Inc.

Created by
Publishing Concepts, Inc.

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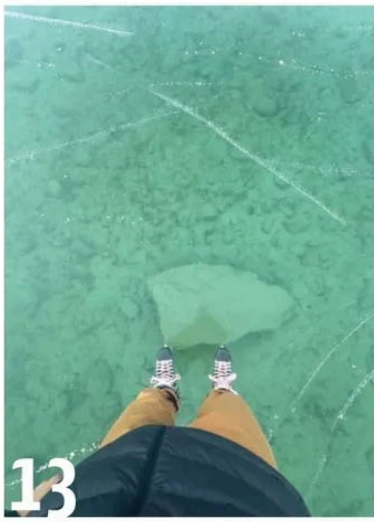

MAFP President's Message

Saul Rivard, MD, 2024/2025 MAFP President

Greetings, MAFP members!

It is with a profound sense of gratitude that I write this message. The 2025 Montana legislative session has recently concluded. I feel that it was an exciting and productive session overall and I am grateful that the MAFP's voice was heard throughout numerous bills.

As many of you know, the MAFP joined with the Montana Chapter of the American Academy of Pediatrics (MTAAP) to form a legislative advocacy consortium for this year's session. Through this, our two organizations were able to join efforts in either supporting or opposing key legislation. I would like to thank our colleagues at MTAAP for their shared support for Montana's families and healthcare providers. Our lobbyist, Stacey Anderson, helped us navigate the legislative system and provided invaluable guidance. I also appreciated each of our MAFP members who testified, either in person or remotely, or reached out to their local legislators.

MAFP tracked over 80 bills this session and provided comment on 69 bills in total this session. We supported important bills, including those that will simplify prior authorization and decrease administrative burden. Additionally, MAFP helped to support the passage of House Bill 245 that lifted the sunset on Medicaid expansion and will provide coverage for 75,000 Montanans. This was truly a collective effort.

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Lastly, on behalf of the Montana Academy of Family Physicians, I would like to thank Dr. Amy Matheny for her years of service on our board and her instrumental contributions to the MAFP magazine. She will be greatly missed by all of us at MAFP and we wish her all the best in her next adventure.

In gratitude,

Saul Rivard, MD
MAFP President, 2024-2025

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Board Member Profile

Janice Fordham, MD

Laurel, MT

Growing up in Georgia, I never imagined that my career in medicine would lead me to Montana. My journey began at the University of Georgia, followed by medical school at an AUC School of medicine, and then residency at AnMed Family Medicine Residency in Anderson, South Carolina. After completing my training, I moved to Montana in 2013 and began practicing at Laurel Family Medicine, where I have been ever since. Now part of Intermountain Health, my practice has become a place where I not only care for patients but also build lifelong relationships within the community.

Practicing in a smaller town just outside of Billings has given me the opportunity to care for multiple generations of families. In fact, one of my greatest joys is treating a family with five generations under my care. Family medicine is about continuity, trust, and being there for patients through all stages of life, and I feel privileged to provide that level of care here in Laurel.

In addition to my clinical practice, I currently serve as the Medical Director for Primary Care. While leadership brings new challenges, I remain committed to seeing patients and staying connected to the heart of family medicine.

Outside of work, my husband and I love spending time with our three daughters, ages 10, 10, and 11. Whether we're hiking, exploring national parks, camping, or boating at Yellowtail, we take every chance we can to explore the beauty of Montana together. If we aren't exploring, we are usually toting our kiddos to sporting events, which has also afforded us the opportunity to see more of Montana.

My decision to join the board of the Montana Academy of Family Physicians was driven by my passion for this field and my desire to help grow our membership. Family medicine is the backbone of healthcare in our state, and I want to ensure that we continue to support and advocate for our physicians and the communities we serve. By strengthening our network, we can promote the value of primary care, encourage the next generation of family physicians, and advance healthcare in Montana.

Engaging Family Physicians in Hepatitis C Treatment

I want to take a moment to reflect on a truly remarkable milestone in the field of medicine - the development of a safe, well-tolerated, and effective treatment for hepatitis C. Hepatitis C was once considered a chronic and debilitating disease but can now be cured in more than 95% of cases. However, despite the availability of accurate diagnostic tests and an effective cure, many people continue living with hepatitis C infection. Left untreated, hepatitis C can cause advanced liver disease, liver cancer, and death.

It is estimated that more than 2 million U.S. adults have hepatitis C virus (HCV) infection, with rising incidence among younger adults and in association with injection drug use.[1] Up to forty percent of U.S. adults are unaware of their hepatitis C infection.[2] In Montana, recent estimates suggest that more than 14,000 individuals are living with hepatis C infection.[3] Your patients may be unaware of hepatitis C infection risk factors and screening recommendations. CDC offers fact sheets and posters that can be placed in clinic waiting or exam rooms to support patient education and screening.

Testing is the first step towards accessing curative treatment. The CDC, the United States Preventive Services Task Force (USPSTF), and the American Association for the Study of Liver Diseases with the Infectious Diseases Society of America (AASLD-IDSA) recommend universal hepatitis C screening, which includes:

- adults at least once in their lifetime, and
- pregnant women during each pregnancy.[4,5,6]

Recommendations support initial screening with HCV antibody and, if positive, reflex HCV RNA testing to establish the presence of active infection. People who test positive for hepatitis C should be treated with direct-acting antiviral (DAA) medications to prevent liver damage and further spread. Treatment is recommended for all individuals with hepatitis C infection, including persons living with HIV and those with active substance use. Currently available DAA treatments can cure most people in 8-12 weeks.

It is essential that we increase the number of Montana primary care providers who treat hepatitis C. Most insurers, including Montana Medicaid, do not require a specialist prescriber for antiviral treatment, which aligns with a key Centers for Disease Control and Prevention (CDC) strategy to increase access to and uptake of hepatis C treatment. It is important to offer hepatitis C treatment where people with hepatitis C receive other services, such as primary care offices, community clinics, substance use treatment centers, and correctional facilities.

Hepatitis C is a reportable disease in Montana. Consider leveraging local public health resources in your community to ensure follow up of a positive hepatitis C screening results and to support a warm handoff to clinical providers who offer treatment, if necessary.

Excellent clinical resources are available for clinician education, training, and consultation on the use of DAA agents to support more widespread access to treatment, as below.

- AASLD-IDSA HCV Guidance: Recommendations for Testing, Managing, and Treating Hepatitis C is a web-based HCV guidance platform to enable rapid, accessible dissemination of new and/or updated information and recommendations regarding hepatitis C infection.
- ECHO – Offers didactic trainings, clinical support, and case consultation for hepatitis C infection.
  - Montana Hepatitis C and HIV Prevention
  - Indian Country Hepatitis C ECHO
  - University of New Mexico ECHO Programs

By integrating non-stigmatizing universal hepatitis C screening for adults and pregnant women, as well as testing people with known risk factors for hepatitis C, into our standard clinical practice and initiating treatment promptly, we can make a substantial impact on individual and public health, prevent hepatitis C progression to severe liver disease, and reduce transmission rates.

Together, we can work towards eliminating hepatitis C infections and optimize the health of our fellow Montanans.

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WWAMI Updates

Montana WWAMI Faculty Development Conference

The Montana WWAMI Faculty Development Conference was held April 2-4 at Fairmont Hot Springs in Anaconda. This annual event gathers WWAMI teaching faculty from around the state and provides an engaging platform in which to share ideas on how to be effective clinical educators. With close to 600 Montana WWAMI teaching faculty, ongoing efforts to create and support the culture of teaching at WWAMI sites are important.

CMO of Codman Square Health Center in Boston and Vice-chair at Boston University Medical School Dept. of FM, Renee Crichlow, MD, FAAFP, opened the conference with two impassioned talks, *All of Us and the Necessity of Action* and *Putting Mission into Motion, Skill-building for Long-term frameworks for Sustainable Change.* The rest of the weekend focused on engaging and supporting student learning, including sessions on creating a positive learning climate, the use of artificial intelligence in health care and medical education, and how to be a skilled and effective author when writing a narrative evaluation. Faculty were also provided with a walk-through of the many benefits of being a UWSOM faculty member, which includes access to the UW's Health Sciences Library. UWSOM curriculum updates were also presented and discussed. Montana WWAMI students attended the conference as well. Their input provided exceptional opportunities for discourse and feedback to the faculty.

We extend our thanks and appreciation to the following sponsors of the conference. This annual event would not be possible without the support of our community partners:

- Blue Cross Blue Shield of Montana
- Bozeman Health
- Silver Bow Medical Society
- Montana Academy of Family Physicians
- Montana Hospital Association
- Montana Medical Association
- Montana Primary Care Association
- Montana WWAMI TRUST
- MSU Office or Rural Health/AHEC
- One Health
- Partnership Health Center
- UWSOM Office of Rural Programs

Mark your calendars ~ April 10-12, 2026 MT WWAMI Faculty Development Conference at Fairmont Hot Springs.

The Benefits of Providing Primary Care in School-Based Health Centers

Dr. Megan Littlefield

Primary care providers working in Federally-Qualified Health Centers are often identifying patient needs and finding creative solutions to address those needs.

School-Based Health Centers (SBHCs) offer a creative and effective solution to many of the issues faced by primary care providers, while improving health outcomes and academic results for students.

SBHCs complement existing school health services by facilitating access to primary care, behavioral health and other wrap-around services. The result is improved student, school staff and community health literacy and outcomes. This in turn contributes to positive educational results, including reduced absenteeism, decreased disciplinary actions and improved graduation rates.

In 2015, RiverStone Health worked with healthcare and school partners to open the second SBHC in Montana at an underserved elementary school. Based on gaps identified through the Community Health Needs Assessment the previous year, the focus at the Orchard Elementary clinic was increasing access to care for students and their families for medical and behavioral health.

Over the past decade, we have seen the success of the Orchard School clinic and our clinic at Medicine Crow Middle School not only in patient outcomes but also in provider satisfaction.

Provider benefits

As a provider seeing patients at our SBHC clinic, I appreciate the time and focus that the environment allows during appointments. Students and their families are already comfortable in the school, and not having to travel to appointments means that there is a better no-show rate and lower stress level.

For students with chronic medical conditions like diabetes and asthma, it is easier to monitor and check in with these patients when necessary.

Mental health concerns are becoming more common in children and adolescents, yet many youth do not have access to treatment. The accessibility of our behavioral health providers in the school building means that students can see their counselor more regularly, including before and after school and without missing class.

In consultation with parents, SBHCs allow teenagers to easily engage with their providers, allowing them to increase their health literacy and confidence.

RiverStone Health's SBHCs have been a valuable learning environment for our residents from the Montana Family Medicine Residency, allowing them to immerse themselves in pediatric care during their time at those sites.

Partnerships are key

The success of SBHCs requires strong partnerships with schools, parents and guardians and other stakeholders.

The clinic works with existing school counseling and nursing programs to complement, rather than replace services. The newest RiverStone Health SBHC at Billings Senior High School was the result of working with the school district to identify needs and space where the clinic could be most effective.

Every member of the SBHC staff is key to building and maintaining the ongoing relationships with the schools we serve. The team works closely with counselors, educators and staff to make sure that communication is ongoing and that HIPAA and FERPA privacy is maintained as they outreach to students and families.

As regular access to primary care and behavioral health care remains a challenge, especially for children and adolescents, I have found my work in SBHCs innovative and meaningful.

Dr. Megan Littlefield is a pediatrician and internal medicine physician and the chief medical officer at RiverStone Health. To schedule an appointment at the RiverStone Health Clinic, call 406-247-3350.

My Final National Conference

Robell Bassett, WWAMI MS4

Robell Bassett, MS4 (center right) with fellow medical student attendees at National Conference.

It's the 50th anniversary of the AAFP National Conference in Kansas City, Missouri and the current president Sterling Ransone, MD delivers a warm welcome to thousands of family physicians and family physicians to be. Within his introduction he states a fact that left me astonished: "55 years ago there was 20 family medicine residencies, today there are more than 780." I sat there in disbelief, marveling at the dramatic change that can occur in one lifetime. We often are reminded of the primary care shortage in the United States, a persistent challenge in medicine, but 780 family medicine residencies is evidence that as a whole we are trying. There is always room for growth but this conference and the amount of family physicians is a symbol that there is immense value in the front line physician for a community.

The first feeling was astonishment and the second was overwhelm. I applied to medical school to become a family physician, I've attended this incredible event every summer of medical school, and now I'm a 4th year. I'm no longer in the stands, I'm on the field and these conversations matter, these conversations are my future. For those unfamiliar, the AAFP National Conference is not small. It's an enormous gathering that serves many functions from dozens of workshops to research poster., I was there for two main purposes, I was selected as the Montana Delegate for the AAFP Student Congress and my residency list is nerve-wrackingly - to be determined.

The first role was illuminating. I was unaware what Student Congress was going into the conference. I didn't know that AAFP had such an incredible leadership opportunity with a direct tangible impact. Being a delegate gives medical students and residents from each state the opportunity to voice the family medicine needs of their own state. Congress consists of impactful chapters and the chance to learn how to propose change by writing resolutions that get presented to the AAFP. It was incredible seeing fellow students and residents step up to the microphone and advocate for the change they believe in.

Regarding residency, the AAFP National Conference is an incredible way to get an in-person connection with the programs of your dreams, or to stumble on a dream you never knew about. The greatest challenge for most applicants is the sheer size of the experience. Hundreds of booths are in a 70,000 square foot expo hall, all with extravagant signs and accoutrements to go along with the discussions about each program's unique mission.

The paradox of choice is pervasive in this setting, with so much opportunity it can quickly become stressful. Because at the end of the day, we will only open up a letter and match at one. It's natural to feel the cortisol; medical school is a long arduous journey that crescendos to this very moment. I gained strength by chatting with medical students from across the country and world. We all want to find a place that feels like home.

Every story has it's obstacles but I'll never forget connecting and sharing a conversation with a mother from Namibia. I thought she was attending, well technically she was, but she spent the last 2 years taking the same board exams I just took, not to mention in her third language. She's been a practicing physician for over a decade. My heart sank hearing that for international students, no matter how many degrees or years practicing medicine, if they want to see patients, they have to go through a United States residency. As a mother of two she had a lot on the line – we were from two different worlds and here we are both trying to match. I felt her story and the hero's journey of being an international student. Discussions with her and many others reminded me that I'm not alone, and reminded me yet again of the privilege of all this.

The conference always ends with an electric concert at the Midland Theater where we all sing and celebrate this truly exciting time. The last song this year was very moving for my biggest tip when approaching the abundance of programs. "What's up" by 4 Non Blondes, where the chorus eloquently sings "heyyyy, what's going on." The song is a reminder for me to just say hey and when in doubt walk up and introduce yourself. It moves me to not let the stress of "what if" get in the way of a human conversation. You never know until you try.

I flew out early Saturday morning, and in the air I marveled at Mount Rainier – the sun glistening along it's glaciers – and my heart was whole meeting so many new medical students and family physicians from across the world. The stress was gone, I got to have incredible conversations with programs I thought about for years, and I met a few new ones too. If you asked me to pick at that time, and I don't think I could. I called up my classmate Randy. He's on his own endeavor towards cardiothoracic surgery, I told him about the conference, and he confidently said "there's no wrong answers." There really isn't, it's going to be ok. I'm about to be a family physician.

Continuous Learning and Lake Skating

Robell Bassett, WWAMI MS4

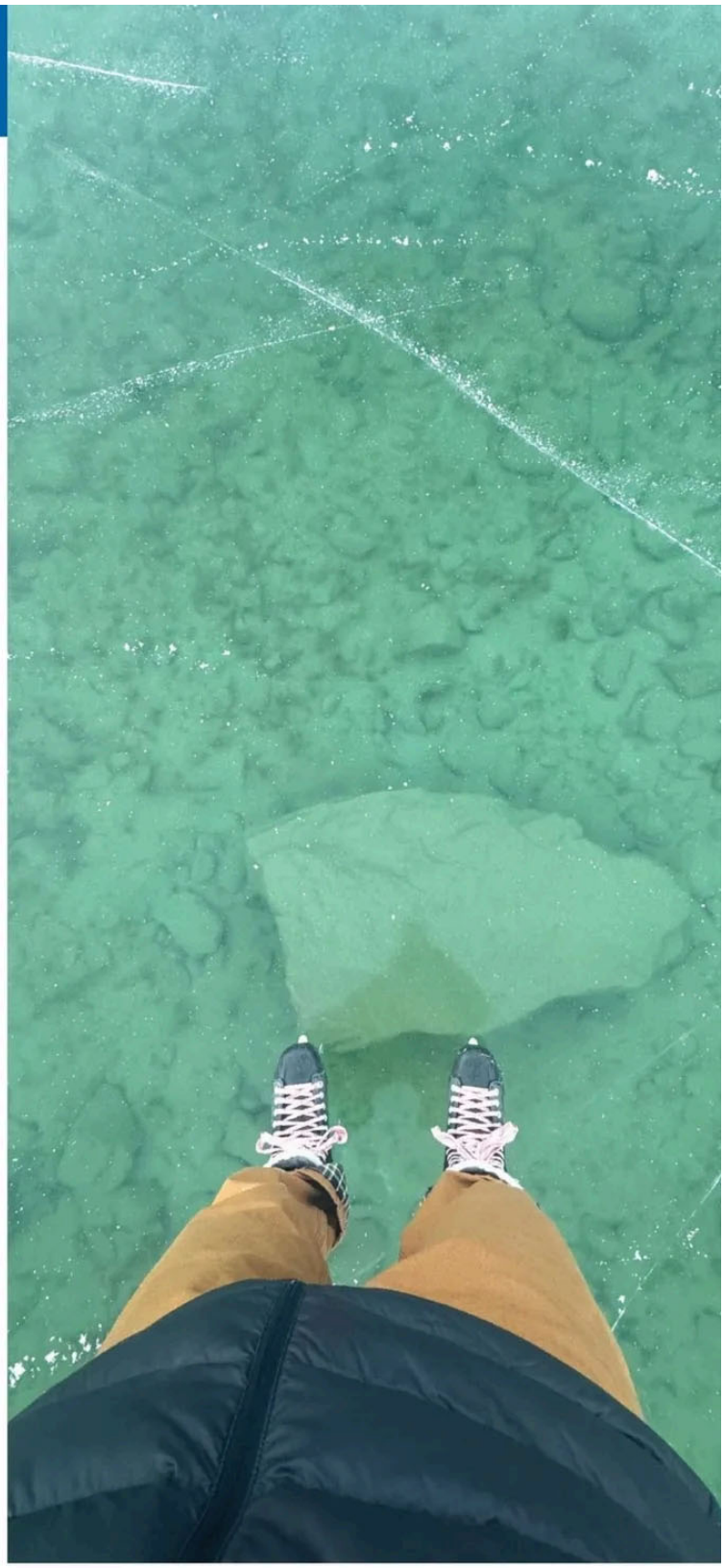
As a medical student, I've always been first in line for good food, great conversations, and incredible skiing. This year marked my second time attending the Montana Academy of Family Physicians (MAFP) Conference in Whitefish, and once again, it did not disappoint.

The scientific process never stops, but for many physicians juggling demanding clinics, staying "up to date" can feel like an afterthought—often limited to the tail end of a specialist call or buried in an Epic chat thread. Conferences like MAFP offer a rare opportunity to step back, engage, and learn from local specialists who deeply impact patient care. Hands were in the air and conversations were abundant as we discussed the Top 10 articles of the year, the nuances of hormone replacement therapy, evolving ADHD management, and expanding oncology care in rural communities. For many family physicians, it's a chance to be a student again—asking questions, critically thinking, and re-energizing their approach to patient care.

As a fourth-year medical student, I found myself in an interesting limbo—teetering between euphoric anticipation for my first job and paycheck in over four years and self-imposed terror over my rank list, hoping I land in the right place. MAFP's generosity allows students to attend for free, offering an invaluable chance to connect with physicians, hear their training experiences, and gain insights over coffee and bacon that will help guide my own path.

This year's conference also provided an unexpected gift. The lack of fresh snow meant ski conditions were mediocre—but it opened the door to something even more magical: gliding across a perfect sheet of translucent ice on Whitefish Lake. I laced up my old hockey skates, and as I moved across the glassy surface, stress about Match Day melted away. It felt like scuba diving—clear rocks below, the occasional trout darting away, Big Mountain glistening in the background. Skating with no bounds I was reminded again of the privilege of this path I'm embarking on.

Fourth year can feel existential—after years of organic chemistry, the MCAT, and USMLE, we're suddenly told to take a breath and "chill." A skill that, by now, has been nearly depleted from a medical students body. MAFP offers the perfect balance—a space to stimulate my prefrontal cortex while also embracing the stillness I'm supposed to be learning. I look forward to coming back, and next time, I wonder—will I be skiing, or ice skating?



MAFP Welcomes Montana's Incoming Family Medicine Intern Classes!

Expanding Rural Medical Training in Montana

Darin Bell, MD, Associate Director of Rural Education
Family Medicine Residency of Western Montana

This summer marks the completion of the Enhanced Rural Access and Training (ERAT) Program, a five-year initiative led by the Family Medicine Residency of Western Montana (FMRWM) at the University of Montana. Funded through HRSA's Primary Care Training and Enhancement (PCTE) grant program, to strengthen healthcare in rural and underserved communities, ERAT has expanded training opportunities for family medicine residents in order to improve care across Montana.

Since 2020, the ERAT Program has worked to better prepare residents for the unique challenges of rural healthcare. Efforts have included hands-on training in addiction medicine, telehealth services, interprofessional teamwork, point-of-care ultrasound, and culturally responsive care for American Indian populations. The program also developed two specialized rural training pathways: a Rural Intensive Track and a Longitudinal Rural Ambulatory Experience, allowing residents to spend extended time in rural clinics and hospitals.

Dr. Darin Bell, FMRWM Associate Director of Rural Education

Jessica Tripp, FMRWM Grants Manager

By the numbers, here are some of the results from the 5-year project:

- More than 270 rural and underserved rotations were completed by residents.
- Over 70 residents received telehealth training
- 17 residents have registered for the Rural Intensive Track, with two graduates 2 completing the track so far
- 19 residents have taken part in the Longitudinal Rural Experience
- 349 healthcare providers and staff across Montana's rural areas received residency-led training, to improve care delivery.

Since the ERAT program began, graduates of FMRWM have overwhelmingly chosen to stay and practice in Montana, drawn by strong community connections, diverse clinical opportunities, supportive work environments, and a shared commitment to caring for rural populations.

Beyond the grant completion, most of ERAT's innovations are set to continue, including expanded rural training and efforts to address key challenges such as the opioid crisis, expanded access to telehealth services, and preparation for working with marginalized populations. Through these processes FMRWM hopes to help ensure that Montana's rural communities will benefit from a stronger, more prepared healthcare workforce for years to come.

The Health Resources and Services Administration (HRSA), Department of Health and Human Services (HHS) provided financial support for this project. The award provided 100% of total costs and totaled $2,485,329. The contents are those of the author. They may not reflect the policies of HRSA, HHS, or the U.S. Government.

The Role of Primary Care in Survivorship and Team-Based Care of Cancer Patients

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. This disparity is driven by several factors. Socioeconomic determinants of health, including increased rates of poverty and lack of insurance increase the financial toxicity associated with cancer treatments and, in combination with decreased health literacy, can influence treatment decisions. Limited access to specialized care and fewer healthcare resources necessitates longer travel times to treatment centers, which also increases financial toxicity. Travel distance is also associated with reduction in the receipt of standard of care treatment as well as any treatment whatsoever following a cancer diagnosis. The distance to travel for cancer care is particularly marked in rural areas of the plains states and the intermountain west.

Cancer care is complex and requires a coordinated "team" of individuals to ensure the best outcomes, including managing both the acute and long-term effects of cancer treatments. 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. The inclusion of PCPs in the care of their patients with cancer is particularly important in rural areas where cancer treatments may be administered at great distance from the patient's home. Most disease and treatment-related complications will manifest when patients are at home. However, there has been little effort to formally include PCPs in the care of their patients with cancer and their inclusion in care teams remains largely ad hoc.

The IOM report emphasized the importance of a well-trained care team. Cancer-specific training exists for nearly all members of the cancer team, except for PCPs. This has created the need for education regarding their function in the care of cancer patients. A review of survey data, including nearly 11,000 PCPs, regarding their perspective highlights this need. While 95% of PCPs preferred a "more active role" in the care of their patients with cancer, only 50% felt prepared to manage the late effects of cancer treatment. It may be speculated that a much smaller proportion are comfortable managing the effects of ongoing treatments. Finally, PCPs "rarely and inconsistently" received sufficient information from their oncologist. This information highlights the need for more effective education, as well as communication with the centralized oncology team.

There is a clear need for education regarding the role of PCPs as members of a care delivery team for their patients with cancer. The IOM's 2006 report established a role for primary care physicians in post-cancer treatment survivorship care. Educational materials are available regarding survivorship care. However, information regarding the role of PCPs during active treatment for cancer is limited. The intent of this article and future articles in this journal, is to address this gap.

The role of a PCP in the care of a patient with a cancer diagnosis is the provision of primary care and not the provision of the care for which an oncologist is uniquely trained. In a general sense this can be viewed as 3 distinct roles: 1) Management of non-oncologic comorbidities during and after cancer treatment. For many early-stage cancers, the risk of dying from cancer is less than the risk of death from other causes and therefore, ongoing management of co-existing health risks is appropriate. 2) Identification of complications related to cancer and its treatment. Coordination with the oncology team is appropriate in this case. 3) Management of the long-term physical and emotional effects of a cancer diagnosis and treatment and monitoring for disease recurrence. This is the essence of survivorship care. Survivorship care plans provided by the oncology team should provide patient-specific information to guide and coordinate this care. These issues will all be addressed in more detail in forthcoming articles in this journal.

Care coordination is imperative for a well-functioning team. There are no standardized approaches to optimizing care coordination, but role definition and standardized workflows facilitate this process. In addition, well-established lines of communication are critical to care coordination, and this is particularly true when care crosses institutional lines and is geographically disparate. While a shared electronic health record facilitates information transfer this does not exist in

many situations of shared care. To avoid gaps in care delivery attention to construction of a team-based approach that allows for rapid and reliable communication among team members is important. Therefore, when choosing an oncology service with which to share care it is important that a plan is in place for care coordination to optimize patient-centered care.

High-quality cancer care is patient-centered and requires construction of a well-functioning care team that includes the patient's PCP. In rural areas that lack oncology resources, this is particularly true, since the PCP is the patient's primary point of contact with the care system. Construction of a well-functioning care team 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. It is also important that team members understand their roles and are educated to function well in those roles. It is the purpose of this article as well as subsequent articles in this series to provide that education.

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MAFP / MTAAP Advocacy Committee 2025 Session Summary

That's a wrap! The 2025 legislative session has ended, although there are still bills in the process of being signed by legislative leaders and sent to the Governor's desk for his signature or veto.

Montana AAP partnered with the Montana Academy of Family Physicians on our legislative advocacy this year, and our joint Advocacy Committee tracked 138 bills related to health. Committee members testified both in person and in Zoom on a total of 57 bills, with 19 unique health care professionals providing testimony. This presence was hugely impactful! We shaped a lot of the specifics of health-related legislation and had some important wins.

Our priority bills this legislative session related to **access to care** (Medicaid coverage and accessibility, and also prior authorization barriers we face with private insurers) as well as maintaining **strong immunization policies**.

See a summary of a few highlighted bills below! And on the federal level, MTAAP has been actively reaching out to the federal delegation to advocate against the proposed $880 billion in federal Medicaid cuts. More will come on this topic in the next few days and weeks, and we encourage you to reach out to your congressional representatives to urge them to protect Medicaid.

Access to care

- **House Bill 245** – Lifts the sunset on the Medicaid expansion program indefinitely, preventing a potential loss of coverage for 75,000 adults (SUPPORTED, BILL PASSED)
- **House Bill 185** – Expands continuous eligibility (no needing to re-enroll with income changes) for children under 6 years old on Medicaid (SUPPORTED, BILL FAILED)
- **House Bill 881** – Allows children with disabilities to "buy in" to Medicaid by paying premiums capped at 5% or 7.5% of income, depending on income (SUPPORTED, BILL PASSED)
- **House Bills 544, 398, 399 and Senate Bills 446, 447, 449** – Reforms the prior authorization (PA) process for Montana-regulated private insurers. [Note that Montana law can't affect insurers based out-of-state, and ERISA and state plans were also not included.] (SUPPORTED, ALL BILLS PASSED)
    - prohibiting PA on oral or inhaled generics medications
    - prohibiting PA any inhaler for asthma, COPD, or chronic lung disease; or any insulin for diabetes
    - extending the minimum duration of a PA to 6 months (formerly 3), or to 12 months if for a chronic disease
    - ensuring previous PA is honored for at least 3 months on changing insurers
    - requiring that peer-to-peer review be done by a true peer with experience treating the particular condition
    - ensure that no PA is required for hospital discharge prescriptions for at least 72 hours
    - prohibiting PA for medications used to treat substance use disorder

Strong vaccine policy

- **House Bill 747** – Allows child care centers to set their own policies regarding whether they accept religious exemptions to vaccines and notify parents of that policy (because new DPHHS rules would otherwise require acceptance of non-medical exemptions) (SUPPORTED, BILL FAILED)
- **House Bill 364** – Requires schools to report aggregate, de-identified immunization exemption numbers to the state health department yearly. Data reporting stopped in 2021, and Montana is the only state not currently reporting this information (SUPPORTED, BILL FAILED)
- **Senate Bill 474** - Adds a new category of non-medical "informed consent" exemptions for child cares and schools; adds schools and child cares to the area of the law that prohibits discrimination based on immunity status (OPPOSED, BILL FAILED)
- **Senate Bill 475** – Bans any vaccine containing aluminum (OPPOSED, BILL FAILED)
- **House Bill 371** – Bans mRNA vaccines and create a penalty for anyone who administers one (OPPOSED, BILL FAILED)
- **Senate Bill 382** – Adds a new category of non-medical "informed consent" exemptions to required immunizations for child care (OPPOSED, BILL FAILED)
- **Senate Bills 467 & 269** – Change child care rules to limit vaccination requirements and other safety regulations (OPPOSED, BILL FAILED)

Other important bills:

A few bills we supported:

- **House Bill 2** - This bill contains the entire budget for the state; pediatricians and family doctors specifically advocated to add an amendment restoring funding for autism evaluation and diagnosis clinics, which was recommended by the Behavioral Health Systems for Future Generations task force (SUPPORTED, AMENDMENT ADDED)
- **Senate Bill 497** - Creates a Safe Harbor program to allow physicians to address burnout symptoms without fear of unnecessary reporting to licensing boards (SUPPORTED, BILL PASSED)
- **House Bill 195** - Modernizes the medical malpractice noneconomic damage cap to gradually increase it and bring it in line with other states (from $250,000 to $500,000), and help prevent a constitutionality challenge from succeeding (SUPPORTED, BILL PASSED)
- **Senate Bill 390** - Adds vapor products (e-cigarettes) to the Clean Indoor Air Act to prohibit indoor vaping in public buildings (SUPPORTED, BILL PASSED)
- **Senate Bill 211** - Allows intranasal epinephrine to be administered in an anaphylaxis emergency by school personnel (IM epinephrine already allowed by law), with a prescription written to the school for supply (SUPPORTED, BILL PASSED)
- **House Bill 600** - Allows schools to develop a plan to administer albuterol in respiratory distress emergencies, with a prescription written to the school for supply (SUPPORTED, BILL PASSED)
- **House Bill 620** - Protects physicians across all specialties by prohibiting non-compete agreements in Montana (SUPPORTED, BILL PASSED)
- **House Bill 792** - Revises marijuana labeling rules to emphasize health risks and driving while intoxicated (SUPPORTED, BILL PASSED)
- **Senate Bill 147** - Revises the Montana Indian Child Welfare Act and lift its sunset indefinitely (SUPPORTED, BILL PASSED)
- **House Bill 869** - Provides funding for AEDs to be available at school sporting events and venues, and provides for training of coaches in recognition and treatment of sudden cardiac events (SUPPORTED, BILL PASSED)

A few bills we opposed:

- **Senate Bill 164** - Creates a felony child endangerment charge for parents or health professionals who enable access to gender affirming care for youth (OPPOSED, BILL FAILED)
- **House Bill 754** - Makes it cause for CPS to remove a transgender child from their home if their parents affirm their child's gender (OPPOSED, BILL FAILED)
- **Senate Bill 218** - Adds unusual provisions to medical malpractice laws to create more liability for providers treating adults or children with gender dysphoria, including penalties that apply even if the standard of care is followed; amendment removed the unusual provisions and left only a slightly longer statute of limitations for this care (OPPOSED, BILL PASSED BUT WITH SIGNIFICANT AMENDMENT)
- **House Bill 291** - Limits local and state ability to regulate air pollution (OPPOSED, BILL PASSED)
- **House Bill 498** - Prohibits community water fluoridation (OPPOSED, BILL FAILED)
- **Senate Bills 221 and 282, House Bills 270 and 285** - All bills to weaken Montana Environmental Policy Act to weaken environmental assessments, pollution oversight, and prevent any consideration of climate impact, among other things (OPPOSED, BILLS PASSED)

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!

The 74th Annual Meeting of the *Montana Academy of Family Physicians*

June 19-20, 2025
Chico Hot Springs, Pray, Montana

PRIMARY CARE CONFERENCE

All presentations will be held in the Convention Center

THURSDAY, JUNE 19

7:00 a.m.	***Registration & Continental Breakfast***
7:20 a.m.	***Conference Welcome***
7:30 a.m.	Shedding Light on Type 2 Diabetes: Weight Management, Co-morbidities A& Future Breakthroughs ***Speaker TBD***
8:30 a.m.	Understanding Patient-Provider relationships in rural HIV Care: Insights from a Montana Needs Assessment ***Kaitlin Fertaly, Ph.D.***
9:30 a.m.	***Break***
10:00 a.m.	Travel Medicine ***Catherine Ebelke, PA-C***
11:00 a.m.	Sports Medicine ***Logan Wilz, M.D.***
Noon	***Business Luncheon Meeting*** (All registrants are invited to attend)
1:00 p.m.	What's Hot, What's Not in the World of STIs ***Shannon Dowler, M.D.***
2:00 p.m.	The Now and Future of ABFM Board Certification ***Ashley Webb***
3:00 p.m.	***Adjourn***
6:00 p.m.	***MAFP Barbecue*** ***Officer Installation & Montana Family Physician of the Year Presentation***

FRIDAY, JUNE 20

7:00 a.m.	***Continental Breakfast***
7:20 a.m.	***Conference Welcome***
7:30 a.m.	Prevention & Treatment of Chronic Ailments With Nutrition ***Greg Rice, M.D.***
10:00 a.m.	***Break***
10:15 a.m.	Bridging the Gap: Evidence-Based Pharmacotherapy for Alcohol Use Disorder in Primary Care ***Eric Arzubi, M.D.***
11:15 a.m.	Physician Burnout ***Annie Morrison, M.D.***
12:15	***Lunch (Update on Prior Authorization Passed in the Legislature)*** ***Kim Longcake, ANP***
1 :00 p.m..	Pathology Presentation ***Annie Morrison, M.D.***
2:00 p.m.	General Surgery Presentation ***Robert Maher, M.D.***
3:00 p.m.	***Adjourn***

MAFP OFFICERS

President:	Saul Rivard, M.D., Missoula	***Delegates:***	Janice Gomersall, M.D., Missoula
President-Elect:	Katrina Maher, M.D., Helena		LeeAnna Muzquiz, M.D., Polson
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			Jason Sarisky, M.D., Bozeman

Brought to you by Western Montana Area Health Education Center

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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.

Family Physicians Weigh in on Appropriations

***Why it matters*:** There are several primary care priorities in the fiscal-year 2026 Labor, Health and Human Services, Education and Related Agencies appropriations bill as Congress finalizes federal spending.

The Labor-HHS appropriations bill provides critical funding for agencies and programs family physicians and their patients rely on for access to care, research to improve the efficacy and safety of health care and medical treatments, essential primary care workforce programs, and disease prevention and health promotion efforts.

***What we're working on*:** The AAFP supports funding for several health care priorities, including the following.

- Robust funding for the Centers for Disease Control and Prevention, which is critical to supporting activities and programs that protect the health of our communities. The AAFP joined the CDC Coalition, a nonpartisan coalition of over 150+ organizations committed to strengthening public health infrastructure and prevention programs, in a letter to Congress urging funding.
- The AAFP joined the Campaign for Tobacco Free Kids in signing letters to appropriations leaders requesting $310 million for the CDC's Office on Smoking and Health in FY 2026 to invest in tobacco prevention and cessation programs. These will protect kids, save lives and reduce the cost of treating tobacco-caused disease.

AAFP Shares Recommendations for AI in Health Care

Why it matters: The family medicine experience is based on a deeply personal patient-physician interaction that often requires support from technology, including artificial intelligence, to optimize care. The AAFP is identifying ways technology solutions, including artificial intelligence (AI), can reduce the administrative burdens that take family physicians away from what they care most about: taking care of patients.

What we're working on: The AAFP is a member of the Health IT End Users Alliance, which recently finalized policy recommendations for the use of AI in health care.

- The AI consensus statement outlines the key issues related to the use of AI in health care, including opportunities and challenges, followed by a set of recommended policy principles for the federal government and private industry to undertake.
- These principles focus on the health care industry's responsibilities when using AI, particularly regarding safety and transparency; liability; privacy; security; administrative burden and workflow incorporation; end-user education, participation and leadership; accessibility and usability; mitigating bias; and AI use in payment and coverage activities.
- This consensus statement supports the AAFP's ongoing advocacy regarding the importance of responsible and secure AI development, training, implementation and monitoring.
- Mandi Neff, the AAFP's regulatory and policy strategist, moderated a panel titled "Artificial Intelligence From the End-User's Perspective" on April 8 as part of the American Health Information Management Association's ongoing Washington Update series.
- The panel provided an opportunity for the AAFP to connect with health information experts across the country and highlight our perspective on the ever-expanding adoption and use of AI in health care. Properly designed AI tools offer family physicians the opportunity to reduce administrative burden and to spend more time with their patients, though there are still many transparency, liability and education-related questions that need to be addressed to guarantee these tools' safety and prevent adverse patient outcomes.

CMS Releases 2026 IPPS Proposed Rule

On April 11, CMS released the fiscal-year 2026 Hospital Inpatient Prospective Payment Systems proposed rule. As the largest funder of graduate medical education, Medicare plays a significant role in addressing physician maldistribution and disparate access to care across the nation.

While technical changes have been proposed to a few of the calculations involved in direct GME and to the new Transforming Episode Accountability Model, the core tenets of both GME and TEAM are proposed to remain the same.

We appreciate CMS' ongoing recognition of the importance of primary care continuity through the TEAM Mandatory Model. The AAFP supports the role of family physicians in providing continuity of care to their patients in all settings, both directly and by coordinating care with other health care professionals.

What We're Reading

- Medicaid isn't a handout — it's a lifeline. This is the message that family physician leaders in Alaska, Maine and Missouri shared with senators ahead of the budget reconciliation. Read more in the Anchorage Daily News, the Bangor Daily News and the Kansas City Star.
- Cynthia Chen-Joea, D.O., M.P.H., C.P.H., FAAFP, an AAFP board member, talked with Chief Healthcare Executive in a recent interview about ways to improve maternal health. Four in five maternal deaths are preventable, federal officials say.
- AAFP board member Sarah Sams, M.D., FAAFP, spoke to Healio about the importance of bolstering vaccine confidence amid a resurgence of measles.

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

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