THE OFFICIAL PUBLICATION OF THE MONTANA ACADEMY OF FAMILY PHYSICIANS

MONTANA FAMILY PHYSICIAN

Fall 2022 – MONTANAAFP.ORG

In This Issue:

Celebrations: 50 Years of Montana WWAMI and Residency Graduates!

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The Montana Health Equity Taskforce

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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.

CONTENTS

EDITION 14

4 MAFP President's Welcome

6 2022/2023 MAFP Board of Directors and Officers

8 Board Member Profile

9 Montana Asthma Home Visiting Program Updates

10 Celebrating 50 Years - Montana WWAMI - a Brief History

12 Family Medicine Inspiration at AAFP National Conference

13 Montana Family Medicine Residencies Congratulate 2022 Graduates!

14 Resident Quality Improvement and Scholarly Activity

16 Why Family Physicians Need to Know Their Legislators

18 Bridging the Gap: Montana Health Equity Task Force

20 Simulation in Motion Montana

12

20

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Edition 14

MAFP President's Welcome

Heidi Duncan, MD, FAAFP

Greetings MAFP friends,

It is my honor to write to you as your recently installed president. I am proud to be a member of the Montana Academy of Family Physicians since I moved home to Montana in 1994 and began work at Billings Clinic where I continue to practice and do health policy work. I love the work of MAFP and the amazing group of people who have served on the Board of Directors over the years, so much so that this is my second time as president! The mission of the MAFP is "to promote Family Medicine and support our members in providing optimal health care for all Montanans", and I assure you that our Board focuses on serving our patients, our communities and members.

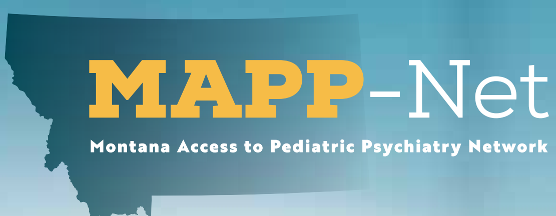
I was reading the messages from the last several presidents and reflecting on the presence of COVID-19 in our lives over the last 2+ years. Many of us initially hoped that we would "have it behind us" by this point, but we are realizing that we will continue to find ways to live with the ongoing presence of COVID-19. My heartfelt thanks go to all of you for work in continuing to be a trusted source of information in helping our patients and communities navigate all the stages of the pandemic, or endemic, or wherever we are.

Despite these challenges, we were able to have our summer CME meeting in Chico this year, and look forward to our winter CME meeting in Whitefish on January 25-27, 2023. The Congress of Delegates is planning to meet in person in September in Washington, D.C. I am impressed with how well the AAFP has been able to pivot to virtual reference committee work over the last two years but I think we all look forward to meeting in person again to continue to shape the policy of the Academy.

We are also preparing for our upcoming Montana state legislative session January-April 2023 where we will continue to work closely with our partners at the Montana Medical Association, Montana Chapter of the American Academy of Pediatrics and others to advocate for our patients and the health of our communities. As a membership organization, we have members with strong feelings on a variety of issues, and different sides of more controversial issues, and carefully choose our advocacy messages to focus on our ability to care for our patients. We welcome your input to the process.

In the face of uncertain times that sometimes seem a bit chaotic, I value the commitment of the MAFP to enhance the health and wellness of all people and communities in Montana, and I so appreciate the work that each of you do. Sometimes the work at hand seems a little daunting, and I like to remind myself of a quote from Abraham Lincoln that I recently heard: "The best things about the future is that it comes one day at a time." Let's make each day great!

MAFP board members gather at the summer CME meeting in Chico along with Dr. Steven Furr from the AAFP Board of Directors."



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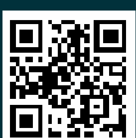

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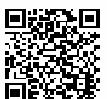

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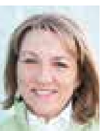
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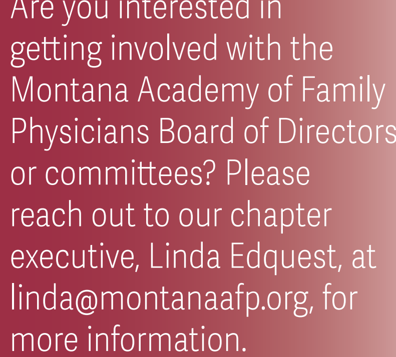
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Board Member Profile

Heidi Duncan, MD, FAAFP

I grew up in Potomac, Montana, a small ranching community 20 miles out of Missoula "up the Blackfoot" and did all the things you do when you grow up in a small town like 4-H, floating the river in the summer and doing all the school sports whether or not you are good at any of it! I went to grade school in Potomac and high school in Missoula where I graduated from Hellgate. After high school, I went to college at Stanford University, and then directly to medical school at UW with the WWAMI program. I stayed in Seattle for my Family Medicine residency at University of Washington including an extra year as chief resident and was very fortunate to return to Montana to practice.

I joined Billings Clinic in the summer of 1994, and my clinical practice has been at our West End clinic since then. My practice included inpatient care for 17 years and I delivered babies for 21 years. I love my four generation families, and that some of the kids that I delivered are now bringing their babies to me. I enjoy having medical students and residents rotate in our clinic. My first love is patient care, but I also realized during residency that I like to participate in other aspects of healthcare and policy that tackle broader issues that impact the health of our patients and communities and can either help or hinder our ability to do that care. Over the course of my career, I have done other jobs in addition to practice ranging from medical directorship of a Medicaid pilot HMO and a regional health plan to my most recent work in health policy. I have worked in a dyad as the Physician Director of Health Policy at Billings Clinic for the last 8 years, and greatly enjoy that work.

From the time I arrived in Montana, I found "my people" at the MAFP and have been involved on the Board since then in various capacities. I started as treasurer, have been an alternate delegate and then a delegate for a number of years, served one cycle through the presidential chain, and now I'm back! My interest in health policy was discovered through my work with AAFP and MAFP and involvement with our state legislature over the years, and then with my work on the AAFP Commission on Governmental Advocacy and Reference Committees at the Congress of Delegates. I love the Academy's dedication to being a voice for our patients, for the physician-patient relationship, and for making sure that family physicians remain a central part of our health care system.

My family includes my husband Jim who is the President of Billings Clinic Foundation, our daughter Mara age 19 who will be starting her second year at Montana State, and our needy but adored Springer Spaniels, Dillon and Dotty. We love traveling, but also love our home state and finding new back roads to explore and places to visit.

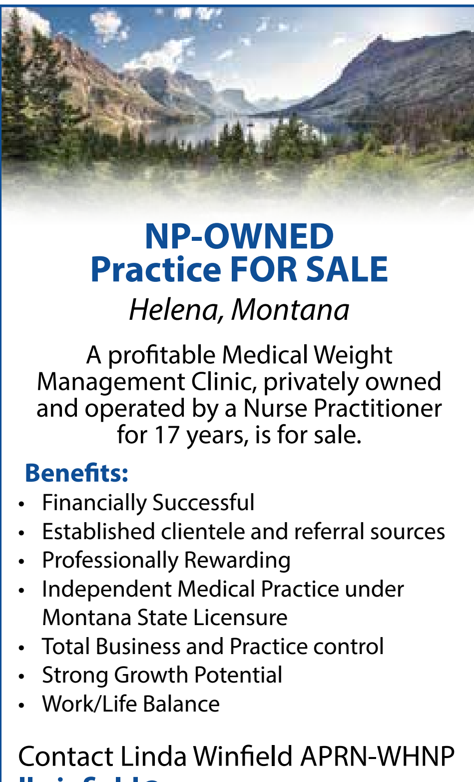
Montana Asthma Home Visiting Program Updates

There's great news for Montanans living with uncontrolled asthma. The Montana Asthma Home Visiting Program (MAP) is now available in all 56 counties! Nine MAP sites will continue to provide in-home asthma education and care coordination in 24 counties, while as of May 2022, the program is also accepting referrals for virtual home visiting in the counties outside of direct MAP service areas.

The MAP includes six contacts over a 12-month period with a nurse or respiratory therapist specifically trained in asthma education, care coordination, and home environment assessments for trigger identification. Home visitors coordinate with healthcare providers to ensure consistent messaging and to contribute to team based care. Participants who complete the program report fewer ED visits and hospitalizations, a reduction in missed school and work days, and significant improvements in asthma control, self-management skills, and self-efficacy related to asthma management.

In response to COVID-19, MAP sites began using a combination of telephone and HIPPA compliant video communication in lieu of face-to-face home visits. In-home visits and virtual visits follow the same structure. Participant data collected over the course of the pandemic showed virtual visits to be equally as effective as in-person visits at improving health outcomes for MAP participants. In addition to personalized asthma education, all participants receive trigger reduction materials including allergen proof mattress and pillow covers and HEPA air purifiers to create a clean space in the home.

Providers can refer asthma patients to the program in multiple ways. Those using the CONNECT bi-directional referral system can make direct referrals to the local MAP sites through the system. The MAP has also established a HIPPA secure online referral portal, which can be used to submit patient referrals directly to the program. This portal has been used to refer and enroll dozens of active MAP clients from areas all around the state. If your patients live in a community with no MAP site, the referral will be directed to one of the nine sites for virtual home visiting. The home visitor will follow-up with the referring provider to inform them that their patient has enrolled. The online referral page can be accessed through the asthma.mt.gov website and through local program websites. And finally, providers may simply contact the local home visitor in their area. Contact information for MAP sites can be found at dphhs.mt.gov/asthma/asthmahomevisiting.



Celebrating 50 Years - Montana WWAMI - a Brief History

The concept of regionalized medical education for the Pacific Northwest was developed in the late 1960s at the University of Washington School of Medicine. The need for more generalist physicians was recognized at the time as well as the need to obtain greater access to publicly funded medical education. The initial four states of the WAMI program (Washington, Alaska, Montana, Idaho) covered 25% of the land mass of the US but had less than 3% of the population. The UWSOM was the only medical school in the four-state region. The initial five goals of WAMI included (1) admitting more students to medical school from all four states, (2) training more primary care physicians, (3) bringing the resources of the UWSOM to the citizens and communities of each state, (4) redress the maldistribution of physicians by placing more physicians in the rural areas of each state, (5) avoid capital costs of building a new medical school. The WAMI program became "WWAMI" with the addition of Wyoming in 1996.

In 1971, in response to an invitation from the UWSOM, a proposal was submitted by the faculty and administration of Montana State University for placing the Montana component of the regionalized medical school at MSU. The proposal stressed the MSU educational goals as a land grant institution, as one of service to the people of the state in education, research and outreach programs. The strengths included the sciences, social sciences and the health-related fields of nursing, dietetics, medical technology, environmental health, veterinary science as well as the pre-health professional programs. Montana State University was selected as the Montana site in late 1971 after a comprehensive review by the UWSOM. Montana entered its first class of 10 students in 1973. Starting in 2013, the Montana WWAMI class size increased to 30 entering students, joining a total entering class size of 235 medical students at the UWSOM.

The initial funding for the WAMI program came from a $1 million grant from the Commonwealth Fund of New York City. Later federal funding continued to support the initial startup costs of the program. The state of Montana started token funding in FY 1975 with an appropriation of $15,000. In July 1 of 1975, the program entered 20 students and the state of Montana began fully funding the program.

Until 2014, Montana WWAMI students completed their first year of medical education at MSU-Bozeman and then joined their other WWAMI classmates in Seattle for their 2nd year of schooling. WWAMI students now complete 4 semesters of foundations phase training at their home state campus. The clinical patient care phase starts in the Spring of the 2nd year and allows students to complete required and elective clinical clerkships both in Montana and throughout the WWAMI region.

In alignment with the founding goals of WWAMI, the state has provided public medical education to its residents at a reasonable cost, has benefited greatly from WWAMI physician returns to the state to practice (both Montana and non-Montana WWAMI), and in particular more recently has seen an increased number of primary care physicians providing care to the rural outposts of the state. This is due to the implementation of TRUST, the Targeted Rural Underserved Training Track (pilot, 2008-2010, official start 2011), which now enrolls 12 students in each class. Recent Match and Practice outcomes data from Montana TRUST show that of the 68 TRUST students who have matched, 50% chose primary care. TRUST practice outcomes data is still lean, but promising, with 53% of TRUST alumni setting up "shop" in a rural community.

Please join us in recognizing and celebrating Montana WWAMI's 50th Anniversary celebration. A variety of celebratory events are being planned for the 2022-23 academic year, starting in the fall with a dinner on Sunday, Oct 9th featuring some of the pioneers of WAMI, and the 2nd year Student Project Poster Presentations on Oct. 10th.

The Montana WWAMI Foundations Phase and Clinical Education teams are proud of our work and hold dear our many partners who help make this program possible. We appreciate the ongoing support by our Governor, the Montana Legislature, the teaching commitment by our over 600 Montana WWAMI faculty and the hosting clinics and hospitals, and our partners in the field, including the Office of Rural Health/AHEC, the medical organizations of the MMA, MHA, and the MTPCA among others, and the WWAMI students and WWAMI alum, who make Montana WWAMI an ongoing success in our many communities across the state.

Jay Erickson, MD, Assistant Clinical Dean for Regional Affairs and WWAMI Montana, UWSOM, Whitefish

Martin Teintze, PhD, Assistant Dean, Foundations Phase UWSOM & WWAMI Director, MSU Bozeman

Lisa Benzel, Montana WWAMI TRUST Director, Dillon

Bernadette Duperron, Montana WWAMI Administrator, Program Operations, Whitefish

Kayla Ouert, Montana WWAMI Program Manager at MSU, Bozeman

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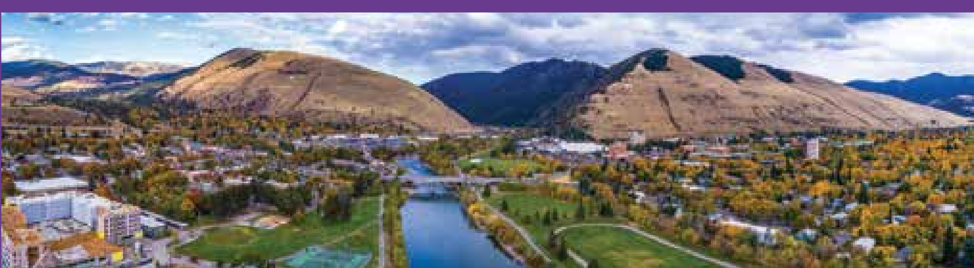

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dgottman@wmclinic.com or
(406) 721-5600

Brenna Cockburn, WWAMI MS4

Family Medicine Inspiration at AAFP National Conference

Attending the AAFP National Conference of Family Medicine Residents and Medical Students in Kansas City gave me the opportunity to learn new skills, to increase my knowledge base on important family medicine related topics, and to connect with residency programs of interest. Perhaps the most interesting workshop was focused on point of care ultrasound (POCUS). We had the opportunity to use the “Butterfly” portable ultrasound probe to practice ultrasound techniques on various parts of the body (lungs, heart, abdomen) on a live model. I also participated in various workshops, one of which provided education on management of medications for gender-affirming hormone therapy. During this session, I learned how to engage in patient-centered conversations, and I gained new knowledge about formulations of masculinizing and feminizing hormones. Additionally, I had the opportunity to network with nearly a dozen residency programs. I enjoyed meeting and talking with the residents and faculty of the programs to which I hope to apply. It was a great opportunity to get a feel for the people of the residency program, especially given that many of the interviews will be virtual. I also enjoyed connecting with other students from in and outside of WWAMI-land who shared similar interests. I feel very fortunate that I had chance to spend time with my Montana WWAMI classmates, explore a new city, and engage and learn with people who love family medicine as much as I do.

Montana Family Medicine Residencies Congratulate 2022 Graduates!

Montana Family Medicine Residency, Billings

Residents:

Bjorn Anderson, DO, is joining the U.S. Air Force and serving at Minot, ND.

Ian Coe, MD, will be practicing at Dunes Family Health Care in Reedsport, OR and also plans to do public health work for Coastal Douglas County.

Kellee Glaus, MD, will be practicing St. James Healthcare in Butte, MT.

Chris Hiett, MD, will be practicing as a hospitalist at Lutheran Hospital in Fort Wayne, IN.

Annie Morrison, MD, will be practicing at Community Hospital of Anaconda in Anaconda, MT.

Tom North, DO, will be practicing at West Grand Family Medicine, a clinic of SCL Health, in Billings MT.

Paul Weeden, DO, will be practicing as a hospitalist at St. Vincent Healthcare in Billings, MT.

Fellows:

Luke Sugden, DO, completed a one year MFMR Sports Medicine Fellowship. He will be practicing nonsurgical orthopedics and sports medicine at St. Luke's Sports Medicine in Twin Falls, ID.

Alyssa Lautenschlager, MD, completed the Rural Critical Care Fellowship sponsored jointly by Billings Clinic and MFMR. She will be practicing at the Indian Health Service's Crow/Northern Cheyenne Hospital in Crow Agency, MT.

Family Medicine Residency of Western Montana, Missoula and Kalispell

Missoula:

Zachary Carlson, MD is pursuing a Sports Medicine Fellowship at the Spokane Teaching Health Center in Spokane, WA

Grayson Cobb, MD, will be practicing at Western Montana Clinic in Missoula, MT

Mallory Koula, MD, will be practicing at Providence Grant Creek Family Medicine in Missoula, MT

Michelle Metcalf, MD, will be practicing at Bitterroot Health in Stevensville, MT

Katie Walicki, DO, will be practicing at Bitterroot Health in Stevensville, MT

Nick Zakovich, DO, will be practicing at Bitterroot Health in Hamilton, MT

Kalispell:

Genevieve Birang, DO, will be practicing at Oregon Medical Group in Eugene, OR

Shannon Rossio, MD is still exploring job opportunities and next steps are to be determined!

Kayla Whitmore, DO, will be practicing at Mountainview Medical Center in White Sulphur Springs, MT

Resident Quality Improvement and Scholarly Activity

Mallory Koula MD, Katie Walicki DO, Michelle Metcalf MD,
Family Medicine Residency of Western Montana, Missoula

This article series will highlight projects that Montana family medicine residents have worked on during their training years. We have selected projects that we hope will be helpful and relevant to family physicians. Not all of the projects necessarily met their aspirational goals, but the concepts and processes offer ideas for other clinics to consider.

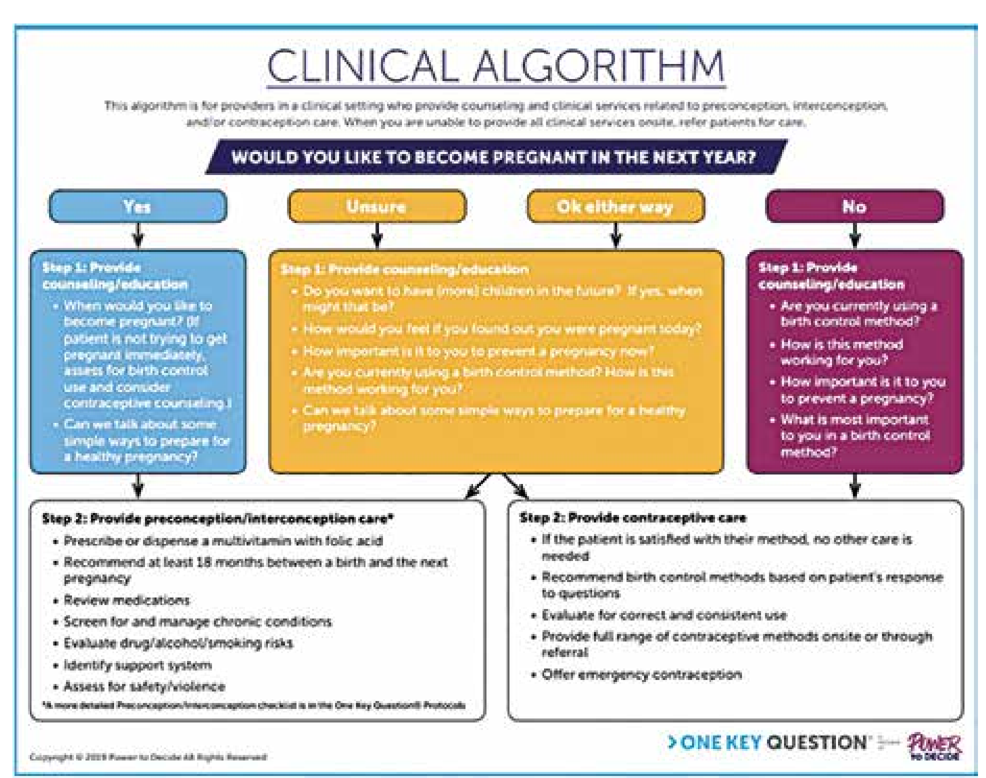
Incorporation of Contraception and Preconception Counselling

Problem: According to a 2016 study, 45% of the 6.1 million US pregnancies that occurred in 2011 were unintended, 27% were "wanted later" and 18% were "unwanted" (1). One Key Question(OKQ)) is an initiative that consists of one simple question designed to support patients in their goals for reproduction: "Would you like to become pregnant in the next year?,". This is more than a "yes" or "no" question. It can help start conversations about preventative reproductive health. Not only does this approach work to decrease unintended pregnancy rates by ensuring access to appropriate contraception, but also identifies patients who will benefit from health optimization prior to a desired pregnancy.

Project Aim: Improve evidence-based preconception and contraception counseling by creating and sharing a stream-lined workflow to use for patients of reproductive age (15-45 years old) who can become pregnant. The workflow will include an EMR template, patient education in the form of EMR smart phrases and physical in-clinic resources.

Improvement Measure: Templates were created to ease the incorporation of these conversations into clinic and EMR documentation.

The first template was the *OKQ template* to initiate reproductive health counseling. Depending on the patient's answer to OKQ, we then created a contraceptive counseling template as well as a preconception counseling template.



Algorithm taken from powertodecide.org [4]

The *contraceptive counseling template* pulled appropriate screening questions for birth control options into the HPI section:

- Personal history of migraine with aura, malignancy (breast, endometrial, cervical), uncontrolled hypertension, liver disease, ischemic heart disease, tobacco use, age >35, breastfeeding?
- Contraceptives tried in the past?
- Contraceptive most interested in?

It also automatically inserted resources that would be printed for patients so they could pursue self-education on contraceptive options.

- https://www.bedsider.org/birthcontrol
- https://www.reproductiveaccess.org/contraception
- https://www.reproductiveaccess.org/resource/medical-eligibility-initiating-contraception/

We created laminated resources with various contraceptive options that were distributed throughout the clinic.

The *preconception counseling template* pulled in appropriate history components:

- Meds taken: prenatal vitamins, any teratogenic medications?

- Chronic medical problems

- Reproductive history

- Social and mental health concerns

- Social history: ETOH, tobacco, other recreational drugs?

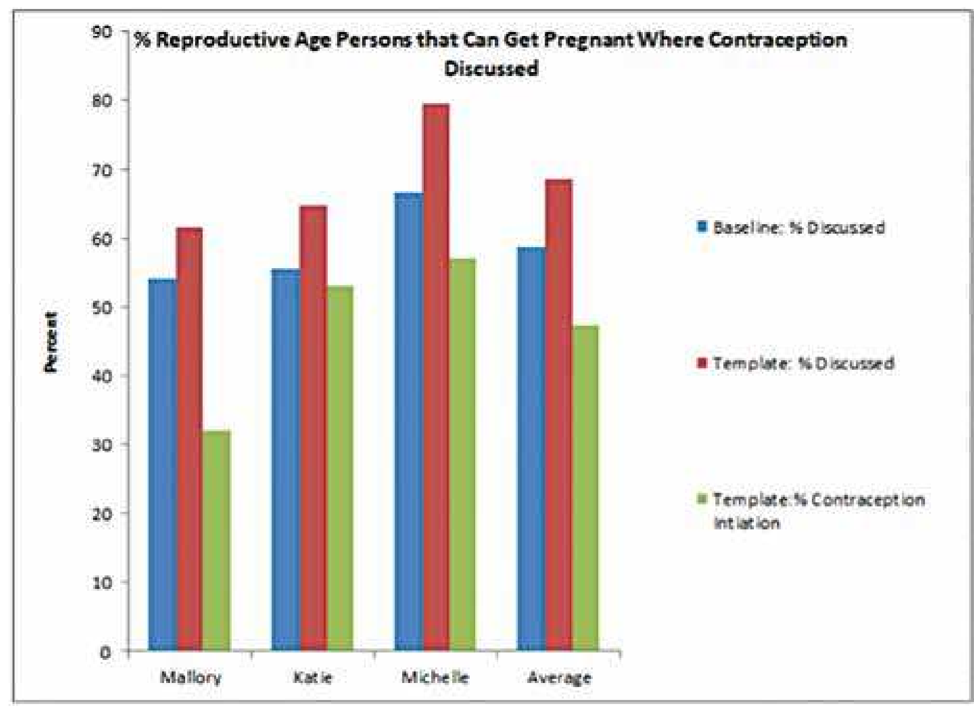
- Vaccinations: Have you received COVID and flu?

-Nutrition and physical exercise counseling

The template also automatically loaded a prescription for prenatal vitamins.

Process of Gathering Information: Each author collected baseline data by individually reviewing patient panels to see how often contraception was discussed with persons of reproductive age who can become pregnant over a 2 month time period (Aug 2020-Sept 2020). Our intervention included presenting OKQ and the templates at a clinic meeting, asking our colleagues to consider using the templates. We then collected data on frequency of template use by all clinic physicians and APPs.

Analysis and Interpretation: Chart 1 shows how often contraception was discussed by the authors with the targeted patient population before and after incorporating the initial contraception template into the electronic medical record.



For all 3 authors there was an increase of about 10% in contraception discussions after creation of the template.

Given this improvement in contraception discussions after template incorporation for the authors we wanted to see how often our three new templates were utilized by other clinic providers.

The plan was to see how often our templates were integrated into provider's notes between 03/22/2022 and 04/30/2022. However, at the time of data collection it was found that the templates did not have an unique identifier integrated into them and unfortunately were not able to be tracked by the Informatics Department.

Effect of Change: Unfortunately, we were unable to produce objective data as noted above. Anecdotally, each of the 3 authors felt there was improvement in the frequency of discussions about reproductive healthcare they had with their patients. The OKQ template was used effectively to initiate conversations about pregnancy and reproductive health. The templates also allowed for increased efficiency with both conversation and documentation. Lastly, the laminated resources were a helpful visual aid which improved patient understanding regarding contraception options.

Lessons Learned: We were unable to use our templates to collect numerical data, in the future, we would plan to perform a mid-point evaluation to identify problems in our process at a time where an intervention could allow for adjustments. Anecdotally, we learned that standardized processes can help to increase frequency of discussions about contraception and pregnancy. This is extremely important as contraception and/or preconception counseling should be topics addressed frequently- studies have found that at a Federally Qualified Health Center 75% of patients with unintended pregnancies had an office visit within the last 3 months. Our templates helped prompt discussions about pregnancy, contraception, and preconception counseling especially during complicated visits. Lastly, we also learned how important OKQ truly is. The answer to OKQ and education provided as follow-up to that question can change someone's life, whether they choose pregnancy or not.

Sources:

1. Finer, L. B., & Zolna, M. R. (2016). Declines in unintended pregnancy in the United States, 2008–2011. Obstetrical & Gynecological Survey, 71(7), 408-409.

2. Powertodecide.org

Why Family Physicians Need to Know Their Legislators

Dr. Chris Baumert and Dr. Trent Taylor
Montana Family Medicine Residency

As physicians, we understand the importance of preventative healthcare. That starts with how we Montanans take care of each other. Money we invest in the health of our citizens helps everyone, a tide to lift all boats. The 2023 Montana Legislature will be critical to the health of our patients. While the session convenes in January, the politicians running for election will soon be knocking on our doors. As physicians caring for their constituents, our legislators value our perspective. We call on Montana family physicians to speak up now to preserve patient coverage, protect physician autonomy, and preserve telehealth options to improve care for all Montanans.

Medicaid coverage

Since the advent of Medicaid expansion, Montanans who were previously uninsured have made major strides in healthcare access. Patients who were previously unable to see specialists are now getting in on a regular schedule. Access to timely care reduces costs in the long run and avoids shifting higher costs to taxpayers and those with private insurance. Unfortunately, legislative decisions may reverse those changes. Reimbursement rates, covered services and eligibility requirements are some of many ways the legislature has power to decrease access. Hard-working Montanans on Medicaid may not be aware that these changes are on the docket. Living paycheck to paycheck does not allow time for focusing on public policy debates. As physicians, we must communicate these concerns and advocate for our patients and our practices.

Pediatric patients and their families are at high risk of losing coverage. A large majority of the children and pregnant women we see at RiverStone Health Clinics are Medicaid enrollees. Most have incomes below poverty level. Among our pediatric patients, 66% rely on Medicaid (through Healthy Montana Kids) and 10 percent have no insurance. The parents of our pediatric patients are also likely to rely on Medicaid through the state expansion from 2016. This population includes many essential workers in food service, construction and healthcare support staff.

Every provider can recall patients who have benefited from Medicaid coverage. At RiverStone Health, Medicaid covers nearly 40% of adult patients. One patient in particular was a 60-year-old woman with a new diagnosis of liver cirrhosis complicated by ascites. Medicaid covered the imaging, procedures, lab work and alcohol cessation treatment she needed to regain her health. If Medicaid restrictions worsen, she and many patients like her may lose their coverage and their ability to live a happy, healthy, productive life.

With the current housing crisis, homelessness and displacement is becoming all too common. Some of our patients change addresses often. It may be very difficult to send mail to patients. Unnecessary red tape and paperwork may result in them losing their coverage without receiving any notification. Like other Community Health Centers in the state, RiverStone does not deny care to those who cannot pay. We have had great success in finding Billings specialists to accept Medicaid patient referrals. We have been less successful in finding specialists who will see uninsured patients who self-pay. We are concerned that loss of Medicaid will walk back the clock on our patients' healthcare. Uninsured people have lower life expectancies and are more likely to become disabled. Children, parents and those suffering from homelessness can all benefit from continued coverage through Medicaid without governmental red tape and restrictions. By talking to politicians in your area, you can protect the health of Montana's most vulnerable populations.

Medical practice mandates

The 2023 Montana Legislature is likely to see bills proposing to tell physicians how to practice medicine. When legislators get between patients and doctors, there will be unintended consequences and patient harm.

Legislators may want to reduce a medical topic to something that is black or white. As physicians, we know that each case is unique. These nuanced conversations we have in the exam room can't be boiled down to a law. We need physicians to use their best judgement to apply their knowledge to the patient's situation. Having a relationship with your representatives will open doors to clarify these circumstances. If our legislators know a doctor in their district who they can contact, they are less likely to handcuff physician practices without physician input.

Continuing telehealth

After the COVID-19 pandemic generated patient interest in telehealth, we continue to offer telehealth visits. Montana is a uniquely large state. Many patients may travel more than two hours for a single visit. Telehealth is an extraordinary tool, particularly useful in our state. Our legislators may choose to end some of the emergency funding available for telehealth reimbursement in the upcoming session. We can protect this service if we work with our legislators to maintain adequate reimbursement rates in our state.

Take the time to visit with your legislators and legislative candidates before the November 8 elections. Invite a legislator to coffee or talk with candidates at local events. Offer to be a contact for them on healthcare issues before and during the legislative session. Advocacy may be an uncomfortable and unfamiliar role in our busy lives. Yet your advocacy for primary care and patient access could have a huge impact on our ability to practice medicine without burdensome government interference.

Go to the AAFP website to learn how to contact your lawmaker or visit the Montana Legislature website at leg.mt.gov. We are happy to talk with anyone who wants to advocate for family medicine. Email Chris Baumert at Chris.Bau@riverstonehealth.org or Trent Taylor at Trent.Tay@riverstonehealth.org.

Dr. Trent Taylor is a third-year resident in the Montana Family Medicine Residency (MFMR). Dr. Chris Baumert, MFMR faculty member and director of the Public Health & Advocacy Track, serves on the Montana Academy of Family Physicians Legislative Committee.

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Determination of credit is pending.

Bridging the Gap: Montana Health Equity Task Force

Grace Behrens, MPH
Project Coordinator, Montana Office of Rural Health and Area Health Education Center

Overview of the COVID-19 Health Equity Grant

The Montana Health Equity Task Force is funded by the CDC grant: National Initiative to Address COVID-19 Health Disparities Among Populations at High-Risk and Underserved, Including Racial and Ethnic Minority Populations and Rural Communities. This grant was awarded to the Montana Department of Public Health and Human Services (DPHHS) in June of 2021. The Montana Office of Rural Health and Area Health Education Center (AHEC) was awarded a portion of this grant to specifically target COVID-19 and health disparities in Montana's rural communities.

The heavy impact of COVID-19 on Montana's communities and it's intrinsic link with social determinants of health and community wellness sparked the idea for a Health Equity Task Force. As illuminated by the COVID-19 pandemic, health disparities do not affect all Montanans equally and played a large role in the severity of illness and death caused by the virus. The Montana Health Equity Task Force works to identify health disparities and possible solutions in a regional structure by facilitating partnership development and community conversations. The task force has over 100 members across the state with varying disciplines spanning physicians, public health departments, non-profits, and educational institutions, among others.

Regions

The task force operates in five Area Health Education Center (AHEC) regions and state wide (Figure 1). These regions are Western, North Central, South Central, Eastern, and North Eastern. While a regional approach is in line with the operation of Montana AHEC it also allows for the differences in health experiences across our state to be highlighted and examined. Further, taking a regional approach has allowed space for folks in more rural areas of the state that are not always included in the conversation.

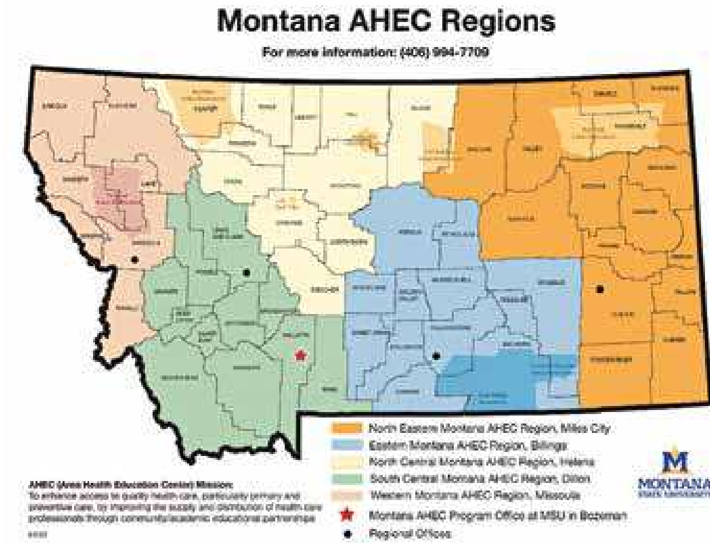

Figure 1: Montana AHEC Regions

Data

The task force began by examining social determinants of health-related data by region. Data from the U.S. Census Bureau, Montana's Critical Access Hospitals, and Health and Human Services was analyzed to provide a regional look at social determinants of health in Montana.

Quarter 1 – SWOT

Quarter one began by conducting a Strengths, Weakness, Opportunities, and Threats (SWOT) analysis of health equity and health disparities in each of the five regions. Participants were encouraged to share stories with examples from their communities and their personal and professional lives to explain what health disparities look like in their communities and their work. (Figure 2)

Figure 2: Statewide SWOT Analysis findings

Quarter 2 – American Indian Health Equity and Defining Priorities

The second quarter of the task force kicked off with a presentation from Montana's Director of American Indian Health, Stephanie Iron Shooter. Stephanie presented to the statewide group on American Indian Health Equity in Montana including information on the sovereign tribal nations in Montana, differences between western and native ways, and cultural humility in a health care context. Stephanie also shared about Native ways of life and suggestions for how to effectively partner with Native communities and organizations in Montana. Stephanie explains what the task force means to her in her work. "I'm so appreciative to be included in the process that will no doubt assist the Office of American Indian Health (OAIH) in identifying the most urgent health disparities and forming culturally significant strategies to address them. We have developed an internal OAIH team focusing on current DPHHS processes to examine what is working and what needs improved. These efforts are in the spirit of improved customer service regarding our collaborations with Tribal programs and all those we serve."

To further explore the relationships between Native and non-Native folks in Montana, Stephanie Iron Shooter (DPHHS), Crystal Hickman (Office of Public Instruction), and Chelsea Bellon (Western MT AHEC) led the regional groups in circle discussions around what participants have learned about Montana's American Indian communities through the task force so far, and what hesitations may be holding them back from collaborating with the Tribes more often. Chelsea Bellon explained the rewards of this work, "The most rewarding aspect is participating and listening to the hard conversations about the gaps and needs for the people of Montana, it proves that health equity is a priority and there are passionate members in our state doing important work."

In the last month of this quarter, participants of the regional task forces were asked to choose three priority areas they want to focus on as a group for the duration of the task force. This included conversations around how many people in Montana are affected by certain issues, not wanting to duplicate on-going efforts in the state, and focusing on priorities that impact the health of our most vulnerable Montanans. The regional priority areas are as follows:

Western Priorities:

- Behavioral Health
- American Indian Leadership in Health Equity
- LGBTQIA+ Education in Healthcare

South Central Priorities:

- Service Coordinators
- Behavioral Health /SUD Mental Health
- Aging Services

North Central Priorities:

- Transportation
- Aging Population
- American Indian Leadership in Health Equity

Eastern Priorities:

- American Indian Leadership in Health Equity
- Access to care
- Behavioral Health/SUD and Mental Health

North Eastern Priorities:

- Behavioral Health/SUD and Mental Health
- Workforce
- American Indian Leadership in Health Equity

So far, the task force has illuminated differences across the state in health disparities through data and through conversations with communities. For example, in the eastern and north eastern regions barriers to care like travel times, workforce shortages, and lack of internet access have come up frequently as issues that impact the health of the individuals and families in the regions. In north and south central Montana health equity topics have more surrounded coordination of services, mental and behavioral health, and housing. The western side of the state has focused on LGBTQIA+ health care, American Indian health equity, and how greatly opioids have affected communities. (Figure 3)

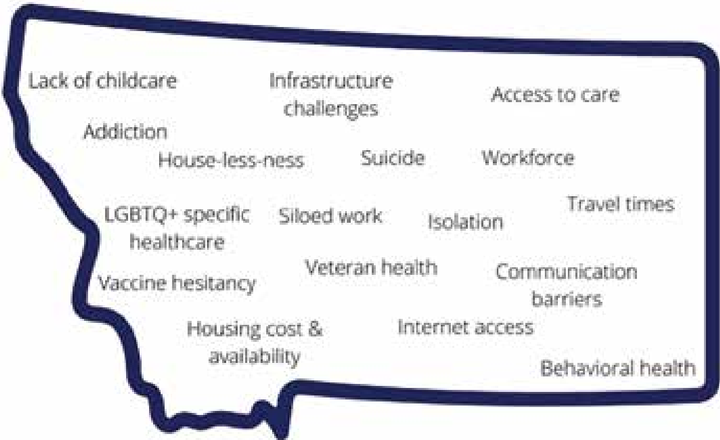

Figure 3: Popular health equity topics by in different areas of the state

Staff who facilitate task force meetings and build partnerships throughout their regions find the task force powerful but acknowledge many participants, especially from our rural communities, are fatigued professionally. Maggie Hodges from South Central Montana AHEC explained, "One of the most rewarding parts (of the task force) has been getting to connect different community organizations across counties, everyone is desperate for resources and the task force has shown how many great options there are across Montana. A challenge has been asking for participation when so many people are at max capacity." Chloe Marsh, who facilitates the North Central region echoed Maggie's remarks, "It is rewarding to connect organizations in the region with each other and individuals with resources available through said organizations. Our open dialogues surrounding health inequities within the region provide the opportunity to listen to lived experience surrounding health disparities which is valuable."

Moving forward, the regional task forces aim to further explore their chosen priority areas by looking into more data surrounding the topics and examples of the programs that effectively address the topics.

The Montana Health Equity Task Force welcomes people to join on an ongoing basis. If you would like to join the task force email: gracebehrens@montana.edu

Simulation in Motion Montana

Sara Kaull, SIM-MT Executive Director

Picture this.

A pilot of a small ultra-light aircraft is enjoying a flight through rural Montana's Big Sky country. The sky is blue. The sun is bright. The mountains stand majestic nearby. It's a perfect day.

Until it isn't.

In a split second, the pilot catches a glimpse of a power line that was momentarily invisible in the sun. There is no time to react and he braces for a hard landing. The impact is intense but he survives, shaking with adrenaline and nerves. He may be injured, but doesn't dfeel any pain.

As he catches his breath and begins to climb out of the aircraft to assess damage, he grabs its metal frame and touches the ground; realizing too late that he's completed the circuit as the high-voltage current travels through his body, causing intense pain. And then, his world goes dark.

Preparing for the Uncommon

In rural Montana, this type of severe medical event rarely occurs. Smaller communities simply have fewer critical incidents. The low frequency occurrence understandably impacts responders' skills; be it the precipitous delivery, multi-vehicle crash, bar shooting, or traumatic brain injury.

With low call volume, there is a challenge to maintain skills and knowledge current, practiced, and instinctual.

High risk, low occurrence events make the need for high fidelity simulation medical training in rural Montana essential.

Past to Present Day Medicine

Healthcare simulation training has been around for centuries. Some sources note that medical simulation occurred as early as 800 BC when an Indian surgeon encouraged students to practice incision, ligation, and suturing on pieces of leather or lotus leaves. As the centuries passed, simulation experiences changed. In Peru, excavators uncovered skulls from 1000-1250 CE featuring post mortem incisions, suggesting they were used to practice performance.

In China around 1027 CE, records indicate human statues were created to teach anatomy and acupuncture to physicians.

Each passing decade brought advancement, but it wasn't until the 18th century that mannikins were used to teach specific medical events, beginning with a French midwife using a life-sized female pelvis covered in fabric and a small doll to teach the art of childbirth to hundreds of midwives.

Despite advancements, modern medical mannikins didn't arrive until 1960, when Peter Safar and Asmund Laerdal, a toy manufacturer from Norway, joined forces to build Resusci-Annie after Peter's 11 year old daughter died from an asthma attack. Resusci-Annie allowed practitioners to practice mouth-to-mouth

and eventually cardiac massage for the first time, and continues to provide opportunities for many to learn the essentials of CPR today.

Each decade, healthcare manikins become more sophisticated and realistic as the principle, "Never the first time on a patient" gains ground and technology advances. Today, high-fidelity manikins set a new standard of healthcare training because they closely resemble human patients.

They bleed. They cry.

They give birth.

They track your movements with their eyes. They dilate their pupils.

They have measurable pulses. They talk.

They turn cyanotic.

Participating in the Experience

Simulation experts control the manikins' responses dynamically, and on-the-fly, as care is provided, giving practitioners instant feedback as to the quality of their care. Rather than looking to an instructor for feedback and vitals, students participating in high-fidelity training gather information from their simulated scenario as they would during a real patient encounter.

Science confirms the importance and impactful nature of simulation training on medical skill retention. And, there are positive documented results; including reducing medical errors, improving patient outcomes, increasing team performance, preparing teams for high consequence care, and identifying latent patient care threats.

In addition to the science, communities report higher staff recruitment and retention as well as job satisfaction when a facility includes frequent training, especially when it includes high fidelity simulation training.

Priming Your Community

While simulation training is important in every medical setting, it is especially valuable in rural areas where low call frequency can lead to skill erosion and increased emotional pressure on staff when high impact events occur.

And yet, the facilities who could use the training the most, often have the least access to simulation education. Budget constraints, reduced staffing, and distance from a training center intertwine to keep simulation training just out of reach for many medical professionals in rural areas.

To address this inequity, in 2015 Montana's Department of Public Health and Human Services approached the Helmsley Charitable Trust to explore the idea of creating mobile high-fidelity simulation labs designed to travel the state; bringing simulation training to rural agencies.

Helmsley Charitable Trust agreed to provide the necessary funding and partnered with DPHHS to create Simulation in Motion Montana (SIM-MT), the first mobile healthcare simulation program in the state.

In 2018, three large semi truck simulation labs hit the road, criss-crossing the state providing high quality simulation education to medical teams in every community. SIM-MT's commitment to promote equity in care between rural and urban environments while bringing high-fidelity simulation training to the front doors of rural facilities has had a direct impact on team performance statewide and has positively affected patient outcomes.

Like the patient who flew his aircraft into power lines.

Planning for the Unplanned

As luck would have it, a local EMS crew spotted the aircraft heading for the power line and responded immediately; stabilizing the pilot and transporting him to the local community access hospital.

A true story.

The EMS crew and community hospital team had just trained with SIM-MT two weeks prior on an electrocution/burn simulation scenario.

When the patient arrived at the hospital, they were prepared with refreshed skills, practiced teamwork, and confidence. One of the responding clinicians shared, "*There was an entry point on his left shoulder and an exit point at his left ankle. We were concerned for cardiac arrhythmias, fluid resuscitation, hypothermia and pain.* ***All areas we practiced during our simulation****. We were able to quickly identify injuries, address the injuries and contact the burn center in Utah for consultation and quick transfer. The patient was intubated and flown to Utah. The patient spent several months at the burn center and was eventually able to return home. I am absolutely convinced that our simulation training regarding electrocution helped save this patient's life*."

SIM-MT is a resource created by Montanans for Montanans. If you're interested in hosting a simulation training event for your team, visit the SIM-MT website for more information or to fill out a request form at : www.simmt.org/request-a-simulation.

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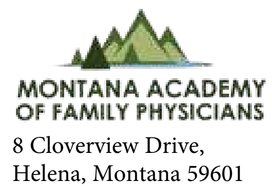

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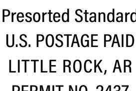

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