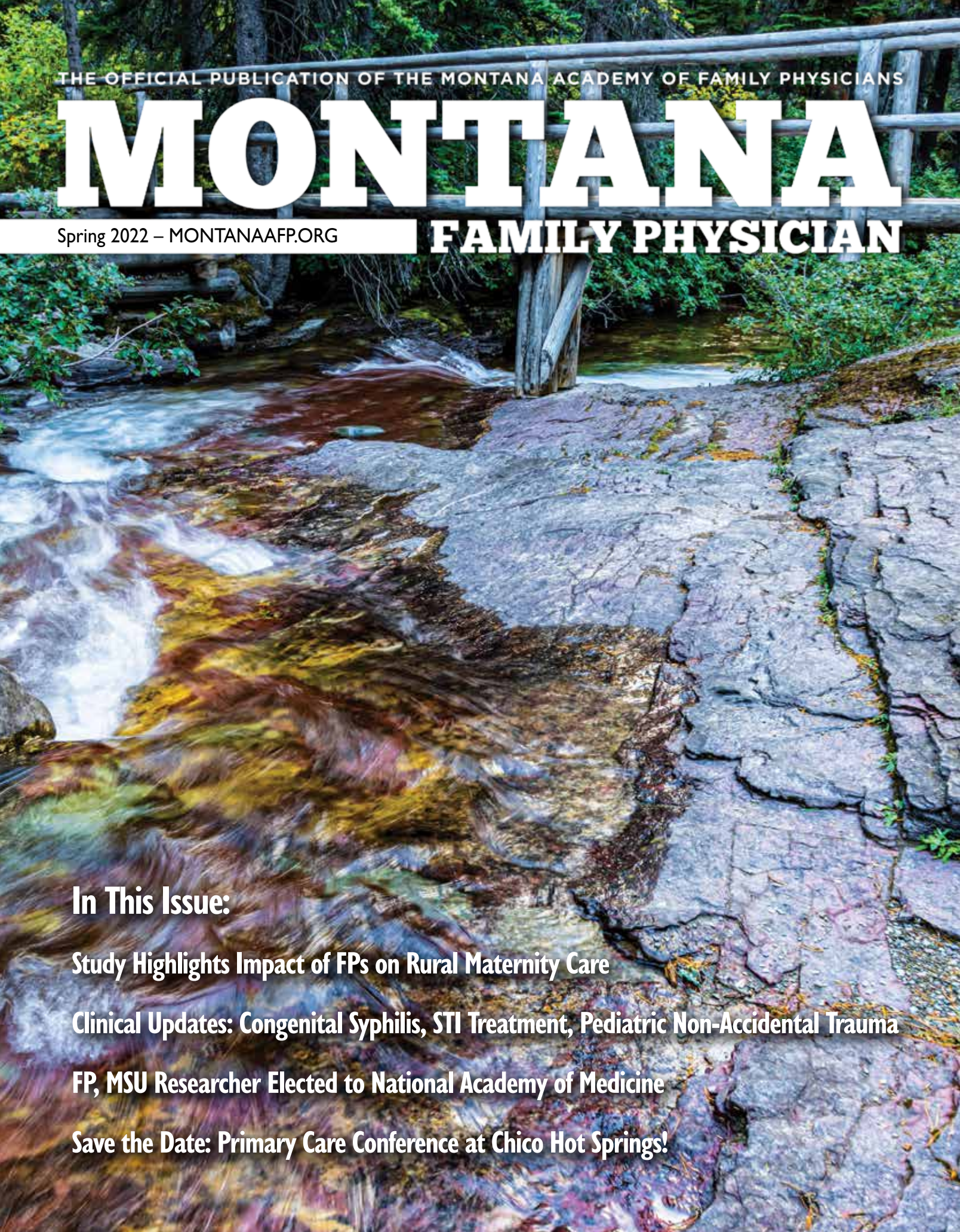
THE OFFICIAL PUBLICATION OF THE MONTANA ACADEMY OF FAMILY PHYSICIANS

MONTANA FAMILY PHYSICIAN

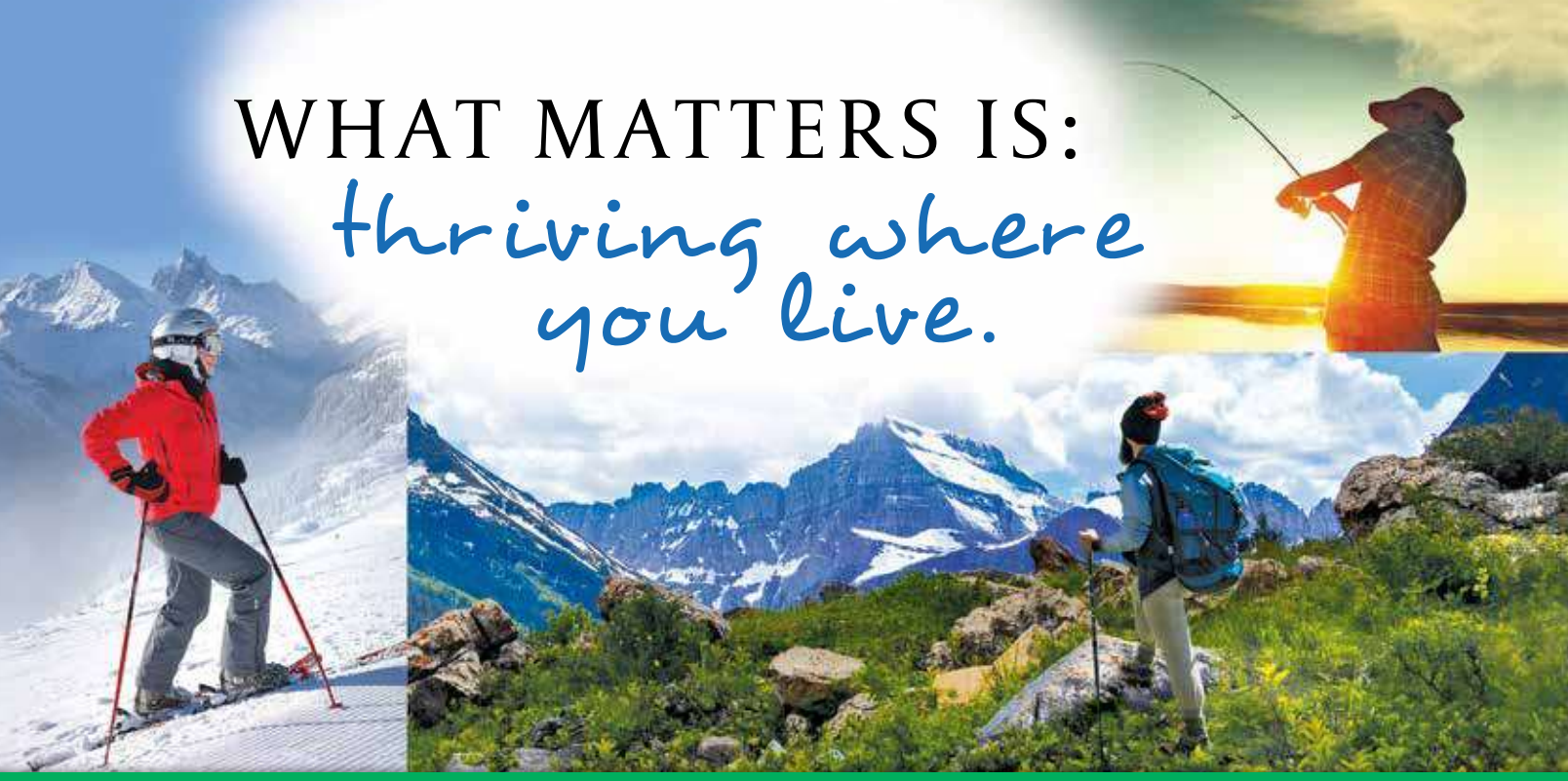
Spring 2022 – MONTANAAFP.ORG



In This Issue:

WHAT MATTERS IS:

thriving where you live.



The Great Falls Clinic is seeking physicians in a variety of specialties to join a robust, respected and successful team in a multi-specialty group practice.

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MONTANA ACADEMY OF FAMILY PHYSICIANS

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CONTENTS

EDITION 12

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

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Created by
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David Brown, *President*
dbrown@pcipublishing.com
1-800-561-4686 ext. 103

For advertising info contact
Jesseca Youngblood
jyoungblood@pcipublishing.com
1-800-561-4686, ext. 115

Edition 12

MAFP President's Welcome

Michael Temporal, MD

Who would have thought that into 2022 we would still have COVID as a major issue?

Hopefully you have had a chance to see the web materials that your MAFP partnered with Montana Medical Association and our healthcare colleagues to encourage childhood COVID vaccinations. Https://www.yourbestshotmt.com/ has video and other messaging that hopefully will be well received by you and your patients. This is an example of family doctors as advocates and there are two great examples that your MAFP Board, and you, should find interesting.

First, the Congress of Delegates had its policy making session the weekend of January 22-23, with final reports presented Feb 4-5. Through resolutions, family docs route ideas and action requests through the state chapter for national consideration. Whether that be advocacy for payment reform, equity across primary and specialty care regarding care delivery, equity for the patients we serve and many other issues – the actions from the Congress of Delegates direct the policies that our Academy promotes. You can get a sense of the policies at https://www.aafp.org/about/policies.html. Additionally, the MAFP sends representatives to our National Conference for Chapter Leadership and the Family Medicine Advocacy Summit and State Legislative Conference (May 22-24, 2022) to network and strategize on favorable legislation for the practice of family medicine, including payment, education, practice support and patient care. Sharing best practices and model legislation helps promote our values for better healthcare delivery.

With family physicians representing more than one-quarter of all physicians in Montana, we are in an enviable and unique role to advocate for our patients.

With family physicians representing more than one-quarter of all physicians in Montana, we are in an enviable and unique role to advocate for our patients. That being said, your Montana AFP is all about service to its members and providing access to continuing medical education. Whether that be our live events (see you in Chico soon?) or web or print materials (which you have access to free or at a discount as a member of the AAFP), hopefully you find that you can get high quality, evidence based and practical information. This can be helpful to you as a doctor, as a teacher, or as an informed citizen. And hopefully this education will fit your lifestyle offering the flexibility to learn and maintain work/family/life balance. With that, please stay well and make sure you are making time for your own recharging and for those important to you. As family physicians we embrace that the individual is part of a system and that all the aspects need to be considered and attended. Thanks for reading. Please make plans to attend our Summer CME session in June (COVID willing)!

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MONTANA ACADEMY OF FAMILY PHYSICIANS

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Are you interested in getting involved with the Montana Academy of Family Physicians Board of Directors or committees? Please reach out to our chapter executive, Linda Edquest, at linda@montanaafp.org, for more information.

Getting 'Back to Normal' Is Going to Take **All of Our Tools**

If we use all the tools we have, we stand the best chance of getting our families, communities, schools, and workplaces "back to normal" sooner:

Get vaccinated.

Wear a mask.

Stay 6 feet from others, and avoid crowds.

Wash hands often.

www.cdc.gov/coronavirus/vaccines

12/09/20

Katrina Maher, MD

I was born and raised in Helena, where I grew-up hiking, camping, backpacking, skiing and exploring Montana. As a child, I remember going on rounds with my dad, who was a family physician. I knew from a young age that medicine was something that I was interested in. However, the lifestyle of a family physician can be challenging so I took time to explore other interests. After I graduated from Helena High School, I went to Willamette University in Salem, OR. There I majored in Biology and Art History. I would still argue that art history classes prepared me more for certain aspects of medicine than the biology classes. While living in London after college, I realized that my love of art history would allow me an excuse to travel, but medicine my was future.

I went to Wayne State University School of Medicine in Detroit, MI for medical school. At that time, Detroit was on the brink of bankruptcy and there were large portions of the city that were abandoned or burned down. It was a challenging place to learn medicine, but provided me with a lot of hands-on experience and gave me invaluable patient skills. I found that everything interested me and I wanted a specialty that allowed me to return to Montana and practice anywhere. Family medicine seemed to be a good fit and it led me back home for residency at the Montana Family Practice Residency in Billings, MT. After doing my previous schooling out of state, it was great to be home for this training. Being able to explore the Beartooth mountains was great as I had not spent much time there while growing up.

After residency, I spent 8 months as a GP in an Accident and Emergency (the equivalent of an urgent care), in Whanganui, New Zealand. My hobby for photography began with a new camera and a country known for beautiful countrysides and epic vistas. I had a great time driving, hiking and exploring the area. I then did another locum position in Colville, WA with Providence Clinic. My goal had always been to return to Helena to practice and I had an opportunity to join St. Peter's Health in March of 2020. Starting a practice in COVID has been a challenge, but it is great to be home. I have enjoyed taking care of patients who had previously seen my dad and people I knew when I was younger.

My love of travel has been somewhat curtailed by the past 2 years, but I still enjoy hiking, skiing and exploring the area. I realize that most of my hobbies are just methods to get to a good photography location. So instead of traveling, I spend a lot of time with family, friends and being an awesome auntie.

Madison Valley Medical is seeking a Board Eligible Full-time Family Medicine physician. We are a 10-bed, critical access hospital and rural health clinic in the heart of southwest Montana. Enjoy living in the small, rural town of Ennis with a population of 860 and where the Madison Valley Hospital District has a primary service area of approximately 3,800 patients.

This is a full-spectrum, Family Medicine position responsible for caring for patients in the rural health clinic, the emergency department, and the hospital. Enjoy the benefits of a small community with a large medical staff and a great call schedule.

Our generous compensation package includes a very competitive salary, plus health, life disability, dental, vision, and 401(k) benefits plan.

Work in an organization where physician leadership is essential to its success. Lead a care team of advanced practice clinicians, nurses, medical assistants, and other ancillary staff to care for our community.

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or contact the HR Dept at **(406) 682-6636** to discuss this excellent opportunity.

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1/2 ad to come

Congenital Syphilis and Centers for Disease Control and Prevention (CDC) Sexually Transmitted Infection (STI) Guidelines

The frequency of congenital syphilis has risen in the United States from 12.4 cases per 100,000 live births in 2012 to 48.5 cases per 100,000 live births in 2019. This is an overall increase of 291% in a seven-year span. In Montana, there were 100 cases of all stages of syphilis in 2020 and 230 cases in 2021, representing an overall increase of 130% in a year. These case counts include two congenital syphilis cases in 2020 and nine congenital cases in 2021, representing a 350% increase from 2020 to 2021. Of the nine congenital syphilis cases, there were two syphilitic stillbirths and an infant demise shortly after birth. Prior to 2021, the most recent syphilitic stillbirth on record in Montana was in 1995.

The 2021 CDC *STI Treatment Guidelines*, provide current evidence-based diagnostic, management, and treatment recommendations, and serves as a clinical guidance resource for managing STIs.[1] Syphilis is included among the updated guidelines, including considerations for infection during pregnancy and congenital syphilis. The updated guidance offers expanded risk factors for syphilis testing among pregnant patients. CDC guidelines recommend testing all expectant mother during their first prenatal visit. Mothers at high risk for syphilis infection should be retested at their 28-week appointment and at delivery. For mothers who are unlikely to return for multiple visits or those who lack access to healthcare, syphilis screening is recommended at the time of pregnancy testing and followed by treatment, if clinically indicated. Mothers with a positive treponemal screening test should also have nontreponemal testing because titers are essential for monitoring treatment response. Benzathine penicillin G is the only known effective antimicrobial for treating fetal infection and preventing congenital syphilis. The timing of repeat testing following treatment is based on gestational age. When the mother is treated before 24 weeks' gestation, serologic titers should be repeated 8 weeks after treatment and at the time of delivery. If the mother is treated after 24 weeks' gestation, serologic titers should be repeated at delivery.

If the mother is diagnosed with syphilis during the second half of the pregnancy, a fetal sonogram is recommended to evaluate for congenital syphilis. Sonographic signs of fetal or placental syphilis indicate a greater risk for fetal treatment failure and an obstetric specialist may recommend a second dose of benzathine penicillin after the initial dose in these cases. The CDC recommends that the mother's serologic status be confirmed prior to hospital discharge and that all mothers with stillbirths after 20 weeks' gestation should be tested for syphilis prior to leaving the hospital. Please see the full CDC *Syphilis*, *Syphilis During Pregnancy*, and *Congenital Syphilis* guidelines for more complete diagnostic and treatment information.[2,3,4]

All exposed partners of patients with confirmed syphilis should be tested and begin treatment as quickly as possible. Individuals who have sexual contact within 90 days of their partner receiving a diagnosis of primary, secondary, or early latent syphilis should be treated presumptively for early syphilis. In the setting of sexual activity beyond 90 days of a partner's diagnosis, the individual should be treated presumptively if tests results are not immediately available and follow up is uncertain. See the CDC *Syphilis* guideline for additional details.[1]

Please see the complete 2021 CDC *STI Treatment Guidelines* for updates to other guidelines, including chlamydia, gonorrhea, and pelvic inflammatory disease, among other conditions.[1] These guidelines present timely, evidence-based information on the appropriate management of STIs and offer provider resources for more efficient clinical practice.

References

1. 2021 CDC STI Treatment Guidelines - https://www.cdc.gov/std/treatment-guidelines/default.htm
2. CDC Syphilis - https://www.cdc.gov/std/treatment-guidelines/syphilis.htm
3. CDC Syphilis During Pregnancy - https://www.cdc.gov/std/treatment-guidelines/syphilis-pregnancy.htm
4. CDC Congenital Syphilis - https://www.cdc.gov/std/treatment-guidelines/congenital-syphilis.htm

MAPPS - Project Echo FP ad to come

FP Researcher Elected to National Academy of Medicine

Alexandra Adams, M.D., Ph.D., developed an interest in global and Indigenous health during her training at the University of Illinois College of Medicine at Urbana-Champaign, but her combined M.D.-Ph.D. program left little time for international work. Adams instead spent a month on the Rosebud Indian Reservation in South Dakota at the end of her third year of medical school, and her time with the Sicangu Sioux people changed the course of her career.

More than 20 years later, Adams is still partnering with Indigenous communities, and her pioneering work in community-engaged research recently earned her election to the National Academy of Medicine.

"I really fell in love with the people," said Adams, professor in the Department of Sociology and Anthropology and director of the Center for American Indian and Rural Health Equity at Montana State University. "My Native friends and colleagues taught me how to listen, how to really sit in a group and listen and learn from the community. They've taught me so much about resilience just by being with them and watching what they have to put up with — everyday racism, dealing with historic trauma and current trauma and all kinds of socioeconomic disparities, as well as the powerful work they are doing in community revitalization."

Adams was getting her Ph.D. in nutrition during her family medicine rotation on the Rosebud Reservation. She recalled being "horrified" by the quality and quantity of processed foods consumed there.

"I saw the commodity food being shipped in," she said, "and then I saw the doctors coming in to deal with the diseases that the commodity foods caused. That really opened my eyes to the huge health equity issues that occurred in Indian country."

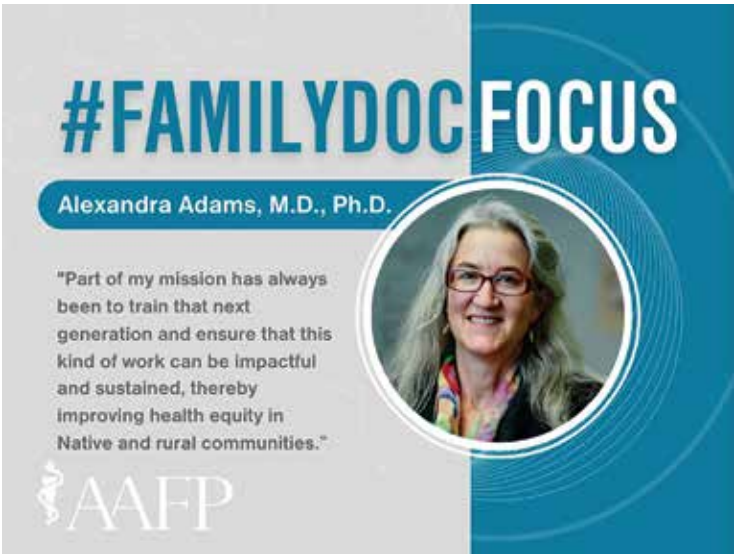
Adams continued her training as a family medicine resident at the University of Wisconsin School of Medicine and Public Health, where she was subsequently faculty for nearly two decades, including roles as a professor in the Department of Family Medicine, founding director of the Collaborative Center for Health Equity and director of the Cancer Center's Cancer Health Disparities Initiative.

Her residency training had a rural rotation requirement, so Adams spent six weeks on the Menominee Indian Reservation, which evolved into the longest-running of her many partnerships with tribal communities.

"I am so grateful for their teachings in our ongoing work together during our over 20-year partnership," she said.

Although Adams initially practiced full-spectrum family medicine, the time and travel demands of her research eventually ended her clinical work. She now views herself as a bridge between the Native communities and academia.

"I think one of the most important things I've learned through this journey is that it's really important to be flexible and to be able to pivot," she said. "And that's one of the reasons I chose family medicine, because I knew that it was much more flexible than other specialties, especially academic family medicine. It has really allowed me to both be of service to individual families, using my medical knowledge and skills directly with patient care, but then also feel like I'm a doctor serving the larger community. It was hard to give up my practice when I left Wisconsin, but I knew it was time to do different, larger things."



After nearly two decades at Wisconsin, Adams took her work to Montana State in 2016. In 2019, she secured a five-year, $10.7 million National Institutes of Health grant for CAIRHE, which works to reduce health disparities in Native and rural communities through community-based participatory research partnerships. She and CAIRHE also collaborate with other public health stakeholders across the state and region. For example, Adams was lead author of a landmark special report on climate change and human health in Montana produced with climate scientists, physicians and state and tribal leaders.

CAIRHE also mentors junior faculty with the aim of developing independently funded researchers.

Adams, who remains emeritus professor of family medicine at Wisconsin, said one of the hardest parts of changing jobs was leaving behind the UW researchers she had worked with for more than a decade. She has mentored four postdoctoral scholars and dozens of undergraduate, master in public health, medical and graduate students as part of her research team. She also has mentored more than 20 UW and MSU junior faculty in community-based research, career advancement and grant writing.

Her mentoring isn't limited to family medicine or even health care.

"At MSU, I mentor faculty in a wide variety of disciplines, from psychologists to nurses to sociologists, and

even an engineer," she said, "so it's a huge variety of types of projects. It depends on the investigator's expertise, and it depends on what the community needs."

CAIRHE teaches researchers how to build equitable community partnerships and maintain them, how to write grant proposals, how to manage budgets and how to do community-based research within the context of a university.

"We teach them how to do that by giving them opportunities to write small grants for us," she said. "We then review them, provide different levels of funding, and then they can go on to seek bigger outside grants."

The relationship is circular, with mentees eventually becoming mentors.

"I feel like one of my roles is to help inspire people who want to do community-engaged work, community-based participatory research, to really understand that it's possible to learn the best ways to do that and to find the best mentors and places for themselves to thrive," she said. "Part of my mission has always been to train that next generation and ensure that this kind of work can be impactful and sustained, thereby improving health equity in Native and rural communities."

Adams' mentees include Erik Brodt, M.D., an associate professor of family medicine and assistant dean for Native American health at the Oregon Health & Science University. Brodt also was recently elected to the National Academy of Medicine for his work in increasing Native American representation in the health care workforce.

Brodt launched the Native American Center for Health Professions under the umbrella of Adams' Collaborative Center for Health Equity at Wisconsin. He now directs OHSU's Northwest Native American Center of Excellence.

"I have many people I've mentored and am proud of," Adams said. "It's been my great privilege."

Finally, Adams is working with community partners and Native elders to create a program called Turtle Island Tales that produces videos and other resources that model healthy behaviors in a year-long program for families with young children.

"This program is working to disseminate our wellness research to families and bring it into their world," she said. "Learning from and partnering with Native communities in research and dissemination is a joy and an honor that I never take for granted."

Montana WWAMI Faculty Development Conference

We are looking forward to hosting the 10th annual Montana WWAMI Faculty Development Conference, April 15-17, 2022 at Chico Hot Springs Resort. This event gathers WWAMI teaching faculty from around the state, providing an engaging platform in which to share ideas on how to be effective clinical educators. With over 500 WWAMI teaching faculty in Montana, continued efforts to create and support a culture of teaching at our WWAMI sites is paramount.

This year's conference will focus on best practices for teaching in a clinical setting, teaching to learners at different levels, efficiency in teaching, and providing effective feedback. As well, given the ongoing commitment of Montana's faculty through the last two years of upheaval due to Covid, student, resident, and physician burnout will also be explored. The Friday evening plenary will feature Gilbert Welch, MD, and his talk: *Thyroid Cancer Overdiagnosis & Overtreatment.*

More information about the conference can be found at https://healthinfo.montana.edu/events-training/wwami-fdc/index.htmlorby emailing mtassist@uw.edu. This annual conference is brought to you by Montana WWAMI and Montana TRUST in partnership with the Montana State University's Office of Rural Health.

UM's Family Medicine Residency Placement in Rural Areas Ranks High

The University of Montana's Family Medicine Residency of Western Montana was recently ranked second in the nation among surveyed residency programs for graduating the most family physicians that go into rural practice.

The Rural Training Track Collaborative conducts an annual survey of residency programs to recognize programs that consistently produce a high number of rural doctors on a three-year rolling average. The 2021 survey found that UM's medical residency program produces an average of seven new rural doctors each year. The University of Kansas ranked first with 10 doctors.

"From the beginning of our program, we have focused on recruiting and training family doctors for rural Montana," said Dr. Darin Bell, associate director for rural education. "We have a dedicated network of rural hospitals and clinics who help out with that process. We couldn't be happier to see that our efforts and those of our partner institutions continue to produce such high numbers of rural doctors coming out of our program."

Montana suffers from a shortage of primary care physicians with one prediction from a national health policy center showing almost 200 new doctors will be needed in the state by 2030. UM's family medicine residency program was created in 2013 – the same year Montana had the lowest number of residency positions of any state in the country – to develop family physicians who are compassionate, clinically competent and motivated to serve patients and communities in rural and underserved areas of Montana.

Residency training location is one of the largest factors determining where physicians choose to practice and the populations they choose to serve. For this reason, UM's program strives to train more residents in rural areas during their training years.

The program accepts 10 new residents each year from about 800 medical student applicants. The three-year training program prepares them to practice rural family medicine, with a goal of having them stay in Montana.

So far, UM's program has graduated six classes, and 72% have gone on to practice in rural or underserved areas, with 70% remaining in Montana communities, including Browning, Helena, Lewistown, Libby, Polson, Red Lodge, Ronan, Butte, Miles City, Columbia Falls and Whitefish, Missoula and Kalispell.

"We are pleased to have been recognized again for our successful training of rural physicians," said Dr. Rob Stenger, UM's residency program director. "Congratulations should be extended to all our partners who help train our residents and connect them to the communities they are going to serve after graduation."

The residency program is sponsored by Missoula's Providence St. Patrick Hospital and Community Medical Center, as well as Logan Health in Kalispell. Resident and faculty physicians have outpatient clinics at Partnership Health Center in Missoula and Greater Valley Health Center in Kalispell. All residents spend a significant portion of their time working and training at a network of 15 rural hospitals and clinics throughout western Montana.

RTTC is a network of medical schools and primary care residencies across the United States dedicated to increasing the training and development of doctors who practice primary care medicine in rural areas.

MFMR Delivers Top-Notch Patient Care and Resident Education for 27 Years

By Garth Brand, MD
Montana Family Medicine Residency Program Director

For more than a quarter century, the Montana Family Medicine Residency has prioritized serving vulnerable populations and preparing our residents for rural practice. Those missions have been super important to MFMR ever since we became the first residency based in Montana.

To prepare our residents for rural practice, we emphasize identifying barriers to care and figuring out how to overcome them. Those barriers may differ for rural and urban patients.

Our residents handle 15 to 20 hospital inpatients daily between St. Vincent Healthcare and Billings Clinic. That busy, high-acuity training is important. Our residency offers great emergency rotations, including a pediatric emergency rotation in Salt Lake City. Our residents also practice response to high-acuity, low-frequency cases in the medical simulation bus and at Billings Clinic's simulation center.

We regularly place our residents in rural rotations. Two third-year residents, Dr. Tom North and Dr. Ian Coe, currently are working in Hardin. Previous placements have included Miles City, Lewistown, Roundup, Red Lodge, Deer Lodge, Dillon, Columbus and the Blackfeet Indian Health Service.

MFMR offers a wilderness medicine track that complements our rural focus on triage, stabilization and transfer to definitive

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continued from page 15>

care. The wilderness medicine experience reinforces skills for working in resource-limited environments.

Ninety-six Montana Family Medicine Residency graduates are working now in Montana communities large and small – from Thompson Falls and Cut Bank to Lewistown, Sidney, Miles City, Billings, Bozeman and Missoula. They comprise about 13% of Montana's entire primary care physician workforce. More than 75% of our graduates are still working in the region.

My own history with MFMR started in 2011 when, as a medical student, I arrived in Billings for clinical rotations sponsored by the Eastern Montana Area Health Education Center at RiverStone Health. The Billings rotations provided a much better learning environment than my rotations in New York City. Montana was the first place I had been as a medical student that prioritized education. In Billings, we were able to care for patients really well and focus on education in day-to-day clinic.

I decided to stay in Billings for my family medicine residency. When I graduated in 2015, my wife and I had a new baby. We chose to make Billings our home. I joined the MFMR faculty and have been here ever since.

I became MFMR program director in June 2020, just as the program turned 25 and in the midst of the COVID-19 pandemic. I'm only the fourth program director in the residency's history.

The first director, Dr. Frank Michels, had the vision to create a Montana-based residency. Then Dr. Roxanne Fahrenwald spearheaded MFMR's transformation from a nascent startup into a nationally recognized program. Dr. Fahrenwald and John Felton, RiverStone Health president and CEO, integrated the health center and residency by focusing on the crucial goal of taking the best care of patients while training doctors for Montana. Dr. Fahrenwald's successor, Dr. Jim Guyer, guided the residency well for six years and serves as associate program director today.

The first medical residency bringing doctors to Billings actually started in the 1970s when the University of Washington and WWAMI created a Montana rotating residency. Residents who traveled here for specialty rotations were more likely to stay and practice in Montana.

In 1995, after years of discussion, the first residency based in Montana started in Billings, the state's largest medical center. RiverStone Health, a Federally Qualified Community Health Center, was chosen as the residency home to provide residents experience at the community health clinic and to maximize their interactions with both local hospital systems.

At that time, having a residency in a Community Health Center was very unusual. It was an innovative model then and our program continues to evolve as a cutting-edge educational and patient care provider. MFMR thrives on the collaboration of RiverStone Health, Billings Clinic and St. Vincent Healthcare. Each organization is represented on our board and has equal say in the residency governance.

Initially, our residency started with six physicians in each class year with the first graduation in 1998 and the first full class graduating in 1999.

When the Affordable Care Act of 2007 was written, RiverStone Health was one of only 11 Community Health Centers with a medical residency. The bill drafters looked at the community clinics and enshrined in the legislation the concept of a Teaching Health Center. As a result, our model has spread across the nation. Now there are more than 100 Teaching Health Centers.

The Affordable Care Act provided funds to train more primary care physicians, allowing us to add two slots per class with the residents who began training in 2011.

We strive to give our residents enough autonomy in patient care that they're ready to get out there and hit the ground running. We get feedback that they're doing well.

We're expanding our residency again in 2022. The class that starts training in June will have 10 residents, instead of eight. The Health Resources and Services Administration awarded MFMR a grant from federal Teaching Health Center expansion funds.

MFMR welcomes the newer residencies based in Missoula and Billings to train primary care physicians, psychiatrists and surgeons. Our program has been strengthened by their presence. Montana still has relatively few residency slots compared with other states.

This year we are again preparing to do all our residency applicant interviews virtually. Pandemic precautions required us to do virtual interviews last year and the process worked very well. We matched one of the most diverse classes of eight residents we've ever had.

We strive to give our residents enough autonomy in patient care that they're ready to get out there and hit the ground running. We get feedback that they're doing well.

MFMR is here to care for the most vulnerable. That it is what motivates us to keep working every day. We are here to train the next generation of family physicians to be ready to go to any part of this state and be successful. The evidence of our success is the great things our graduates are doing all across Montana.

Community Children's Clinical Pathways

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

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

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

Community Children's

Non-Accidental Trauma (NAT) Pathway

Presence of Concerning HISTORY for NAT

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

Presence of Concerning INJURY for NAT

BRUISES

"TEN-4 FACESp"

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

BURNS/BITES

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

FRACTURES

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

RECOMMENDED INITIAL EVALUATION:

Laboratory testing

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

Radiologic testing

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

Consultations

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

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

Newly-Published Study Documents Importance of Family Physicians in Rural Maternity Care

Rural families face barriers when accessing prenatal care and delivery due to many factors, creating "maternity care deserts." In some locations, the rural hospital has stopped delivering babies due to economic or staffing deficiencies. In others, the rural hospital has closed entirely. Fortunately, Family Physicians are the most widely-distributed physicians throughout the U.S. and are therefore best positioned to maintain maternity care access. The degree to which rural communities depend on Family Physicians for much or all of their maternity care has not been well documented until now.

We formed a collaborative group of researchers to answer these questions:

1. Who are the clinicians, including Family Physicians, delivering babies in rural hospitals?

2. What is the relative contribution of different types of clinicians, including Family Physicians, to rural maternity care access?

3. What are the types and numbers of locations where Family Physicians are the ONLY clinicians providing maternity care?

4. What would be the impact on rural families if Family Physicians stop providing maternity care?

We studied access to rural maternity care in ten states. There were 216 rural hospitals in those ten states and we were able to obtain the necessary data for 185 (85.6%) of those hospitals. We defined hospitals as rural if they were located in a county or census tract designated as rural by the Health Resources & Services Administration (HRSA). Of those 185 hospitals, 116 were Critical Access Hospitals (CAH). (CAH have no more than 25 inpatient hospital beds, are located more than 35 miles from the nearest other hospital (15 miles if by mountainous or secondary roads), have an average length of stay no more than 96 hours and offer 24/7 emergency services.) We collected data covering a 5-year period (2013-2017) including the

State	# Hospitals in study sample	Average # Beds per Hospital (Range)	# Critical Access Hospitals in study sample	%(N) Hospitals where FPs and other physicians deliver	%(N) Hospitals where FPs are the ONLY delivering physicians
Alaska	13	27 (11-74)	9	92.3% (12)	38.5% (5)
Colorado	19	37 (9-100)	11	73.7% (14)	21.1% (4)
Idaho	7	22 (15-25)	7	85.7% (6)	57.1% (4)
Minnesota*	38	23 (12-25)	38	97.4% (37)	42.1% (16)
Missouri	24	74 (18-244)	7	54.2% (13)	8.3% (2)
North Carolina	37	137 (21-452)	9	16.2% (6)	5.4% (2)
Oregon	22	45 (21-176)	14	59.1% (13)	18.2% (4)
Utah	13	25 (9-54)	9	92.3% (12)	46.2% (6)
Washington*	10	25 (.)	10	90.0% (9)	70.0% (7)
Wyoming	2	25 (.)	2	100.0% (2)	0.0% (0)
Overall	185	57 (9-452)	116	67.0% (124)	27.0% (50)

*Minnesota and Washington provided data for Critical Access Hospitals (CAH) only

hospital size, maternity services provided, number of births and whether Obstetricians, Family Physicians or Certified Nurse Midwives provided them. We also collected data on the distance to the nearest hospital where maternity services would be available if not provided locally including vaginal delivery, vaginal birth after cesarean (VBAC) and cesarean delivery (CS).

The table below summarizes our findings regarding the rural hospitals where maternity care services are provided and who provides those services. During the study period, a total of over 12,000 births occurred annually at the rural hospitals and the percentage of those babies delivered by Family Physicians remained relatively constant at 54% to 56% each year. In 67% of hospitals, babies were delivered by Family Physicians and Obstetricians. In 27% of hospitals, Family Physicians were the ONLY physicians providing maternity care; the majority of those hospitals are CAH.

VBAC was offered in 77 of the 185 hospitals (43%) and family physicians provided VBAC in 33 of those 77 hospitals. There was a wide range in the percentage of hospitals offering VBAC, from 16% in Colorado to 60% in Washington. Nearly all hospitals offered CS with these exceptions: Alaska 62%, Minnesota and North Carolina 92%, Oregon 96%, Washington 80%. Overall family physicians provided CS in 46% of hospitals overall, ranging from 11% in North Carolina to 100% in Wyoming.

In the case of hospitals that did not offer VBAC or CS, we determined the distance to the nearest hospital that provided those services. In 32% of such cases, VBAC was available 26 to 50 miles away, in 31% the distance was 51 to 100 miles away and 31% more than 100 miles.

A main aim of this study was to determine the impact on access to maternity care if Family Physicians would stop delivering babies in the locations where they now do so. Family Physicians delivered babies in 124 of the 185 hospitals in this study (67%) delivering nearly 7000 each year. Even more significantly, FPs were the ONLY physicians providing maternity care in 50 of those 124 (40%). To further describe the impact on access to maternity care if Family Physicians did not deliver babies in locations where they are the ONLY physicians delivering, we analyzed driving distance to the nearest hospital offering maternity care. We were able to do this driving distance analysis for 29 hospitals, excluding some for which data was not available and excluding the most remote hospitals in Alaska which would require air transport rather than automobile driving. In the case of those 29 hospitals alone, the round-trip distance to nearest care averaged 86 miles, would impact 2958 births per year and would require over two million miles of driving for prenatal care and delivery.

Our study was not designed to examine outcomes or quality of rural versus urban maternity care nor to compare care provided by Family Physicians to that of Obstetricians. Previous studies have documented comparable outcomes in rural and urban locations and equal outcomes by Family Physicians and others, including CS.

This study demonstrates that Family Physicians are essential to rural maternity care access and that rural Family Physicians are providing important access to VBAC and CS. In the most rural locations, Family Physicians constitute the ONLY solution to maternity care access since Obstetricians rarely locate there. We found only eight locations where Family Physicians and Certified Nurse Midwives practice together, but that model could increase the rural maternity care workforce by jointly providing prenatal care and vaginal births with surgically-capable Family Physicians available to perform CS when needed.

Based on this study, we recommend:

- Medical schools must admit and support more students interested in practicing rural Family Medicine
- Family Medicine residencies must continue training residents in both uncomplicated and complicated maternity care
- Recruitment and retention of Family Physicians who provide maternity care must be a priority of rural hospital administrators and workforce planners.
- Obstetrics and Family Medicine training programs should collaborate to provide surgical training for Family Physicians who commit to rural practice

Mark Deutchman MD
Professor, Dept. of Family Medicine
Director, Rural Program, School of Medicine
Associate Dean for Rural Health
Mail Stop F-496 Academic Office 1, Room 3617
12631 East 17th Ave. Aurora, CO 80045
303-724-9725
Mark.deutchman@cuanschutz.edu

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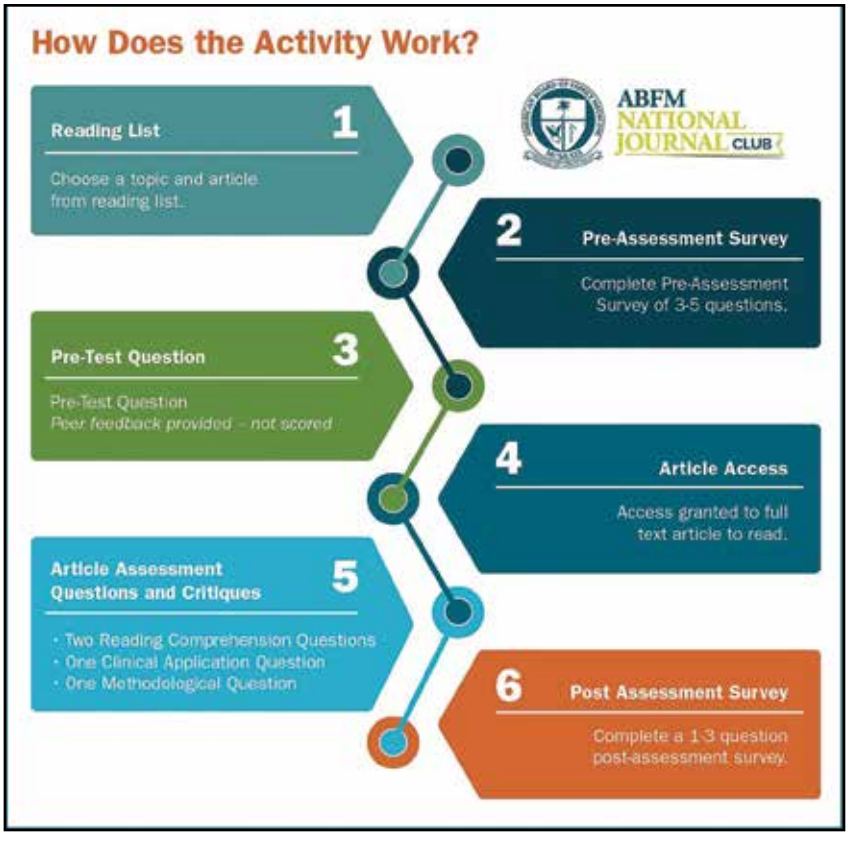

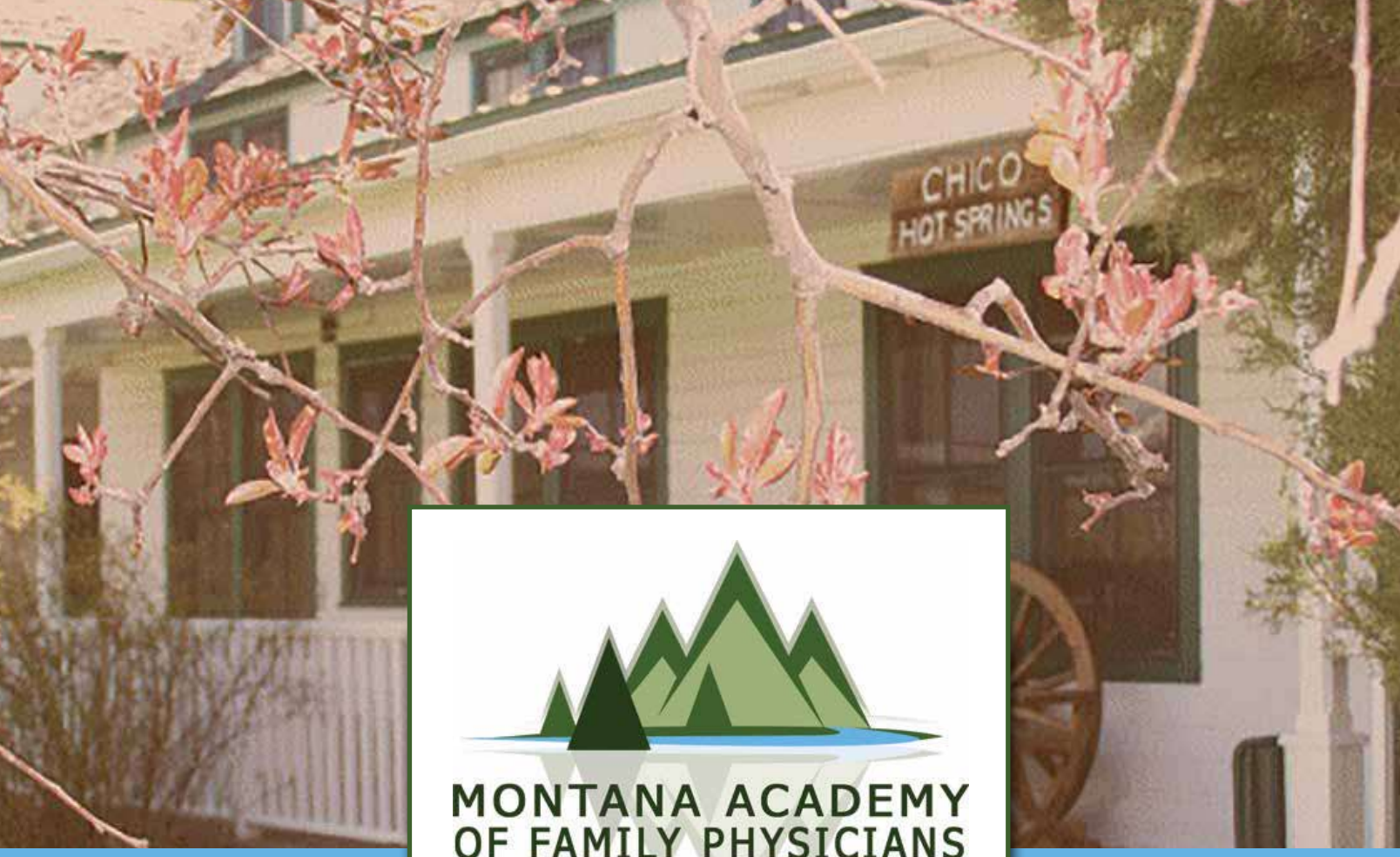

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71st Annual

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

June 9-10, 2022

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To learn more about the study, contact

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