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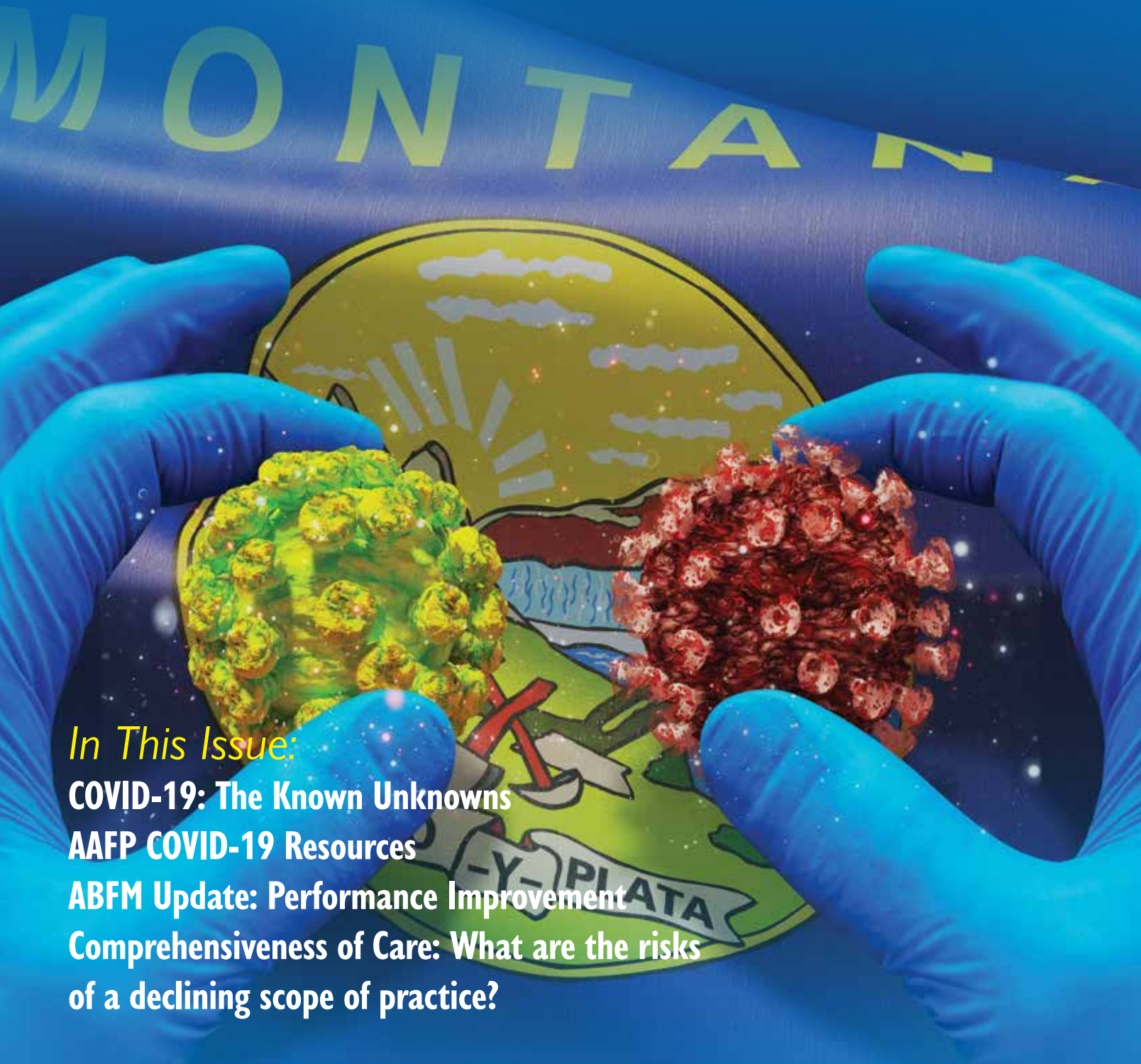
MONTANA FAMILY PHYSICIAN

Summer 2020 – MONTANAAFP.ORG



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MONTANA ACADEMY OF FAMILY PHYSICIANS

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CONTENTS

EDITION 5

*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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MAFP President's Welcome

Amy Matheny, MD, MPH, FAAFP

Greetings Montana family physicians! We at the Montana Academy of Family Physicians hope you are staying safe and well during these uncertain times. A lot has changed since the writing of our last edition, as our worlds have been turned upside-down by the COVID-19 pandemic, both professionally and personally. Many articles circulating in the news and on social media have described our process of coping with the changes, and the losses, of this time as similar to moving through the stages of grief. As you likely recall from medical school training, the Kubler-Ross model of the Five Stages of Grief™ are denial, anger, bargaining, depression, and acceptance. Each of us may be in a different place on that continuum, and sometimes we may circle back to a prior stage. The title of a recent publication in the Harvard Business Review describes it well – "That Discomfort You're Feeling Is Grief."[1]

My intention is not to despair by starting out talking about grief, although I have personally found this analogy very helpful in understanding the progression of my own response throughout this crisis. That being said, it is important for us to find sources of hope in these trying times. David Kessler, along with co-author Elisabeth Kubler-Ross, have written a new book entitled *Finding Meaning: The Sixth Stage of Grief*. They describe "that it's finding meaning beyond the stages of grief most of us are familiar with… that can transform grief into a more peaceful and hopeful experience."[2] For us Family Physicians, the meaning we find through the COVID-19 pandemic may come in different forms. In our practices, we are seeing a chance to force innovation and creativity in deploying telehealth for our patients. We are learning what is critical for us to do face-to-face, and also how we can meet our patients needs remotely, while still inherently *being there* for them. In other ways, this crisis has hit a critical pause button in our hectic lives to help us see what truly matters, and adjust our lives going forward accordingly. Some of us are picking up new hobbies, or noticing new things in our environments as we are forced to slow down. I for one am learning I have a long way to go to improve my fly casting!

My intention is not to despair by starting out talking about grief, although I have personally found this analogy very helpful in understanding the progression of my own response throughout this crisis.

Undoubtedly the practice of Family Medicine will be forever changed as we evolve through this COVID-19 era. At times it can feel overwhelming to have to change when many of us already feel so spread thin in the current system. For others, that may be the motivating factor for change. Let us all work to be leaders in our various settings to force the change that will ultimately be in the best interest of our patients and to uphold the centrality of strong primary care in every health system. This is not going to be easy work. We are going to get exhausted and frustrated with setbacks, and we will still move through stages of grieving as the ground beneath us continues to shift. Then, let us look forward to the meaning in our work during this time to build a system that can be better than the one we have now for our patients and for each other.

As the tenure of my service as the MAFP President comes to an end in June of this year, I again want to thank you for your continued leadership in promoting the health and well-being of our fellow Montanans. I have said it before and will again here – I am inspired by all of you who comprise a network of some of the most passionate, courageous, generous, and kind Family Physicians whom I have ever met. I appreciate your encouragement and kindness over this past year, and I look forward to continuing to serve our state alongside you.

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AAFP COVID-19 Resources

While the understanding and response to the COVID-19 pandemic continues to evolve at a local, state, and national level, the American Academy of Family Physicians remains an excellent resource to provide up-to-date guidance for Family Physicians for all things related to COVID-19. The information available at the links below are vast and are a must-see for all family physicians.

- **AAFP COVID-19 Resource Page** – This page offers an incredibly comprehensive set of resources, vetted by the AAFP, including links to daily updates, financial relief resources for family physicians, CME opportunities, telehealth resources, practice management tools, and advocacy opportunities. https://www.aafp.org/patient-care/emergency/2019-coronavirus.html

- **Financial Relief for Family Physicians**- This page summarizes some of the key provisions of the Coronavirus Aid, Relief and Economic Security (CARES) Act affecting family physicians, including financial relief for small and independent practices and a calculator to help practices estimate COVID-19 related losses. https://www.aafp.org/patient-care/emergency/2019-coronavirus/financial-relief.html

- **AAFP Virtual Town Halls** – Tune in weekly live on Facebook, YouTube, or Twitter, or listen on-demand, and get 1 AAFP prescribed CME credit to learn the most up-to-date information about the AAFP's efforts to support family physicians during the COVID-19 crisis. https://www.aafp.org/cme/cme-topic/all/town-hall-covid-19.html

- **COVID-19 Pandemic Self-Study Package** - Get up to 4.5 AAFP prescribed CME credits with this free CME program including various clinical topics regarding pandemic preparedness, testing, and caring for patients with COVID-19. https://lms.aafp.org/node/42005

- **Telehealth Resources** – Review various telehealth resources including implementation guides, FAQs, coding information, and available platforms. https://www.aafp.org/patient-care/emergency/2019-coronavirus/telehealth.html

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AAFP Direct Primary Care Toolkit: DPC Overview	$30

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The AAFP is committed to:

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Reducing Administrative Complexity

The AAFP is committed to reducing point-of-care administrative functions that detract from your patient care activities. We actively advance reforms to reduce burden around EHR documentation, prior authorizations, and quality measurement to ensure administrative complexities have limited impact on the quality of care provided to patients.

Workforce

The AAFP creates awareness around the importance of family medicine. By advocating for the expansion of graduate medical education and payment reform, the AAFP works to rebalance the composition and distribution of the physician workforce in the U.S. We support workforce growth that is inclusive and representative of those underrepresented in medicine.

Clinical Expertise

The AAFP provides broad scope, personalized learning through a variety of educational venues and formats to equip you with the knowledge and skills to provide high quality, evidence-based care for your patients. We offer tools to help train family physicians to address health disparities as they impact individuals, families, and communities. Our clinical recommendations deliver evidence-based guidance about preventive care, diagnosis and assessment, and management of acute and chronic conditions.

Footnotes:
1. Assumes completion of (2) ABFM Performance Improvement Activities in one year

Last Updated January 2020 | MBR19101365

Montana Asthma Control Program

Asthma continues to be a common, serious chronic disease affecting approximately 94,000 adults and children in Montana. We know that when properly treated and controlled, asthma should not limit a person's daily activities or cause troublesome symptoms. However, 75% of adults and 55% of children with asthma in Montana reported persistent symptoms, indicating that their asthma was not well controlled. Poorly controlled asthma can lead to activity limitation, urgent care or emergency department (ED) visits, self-reported "fair" or "poor" health status, and financial burden. In 2018, there were over 450 hospitalizations in Montana for asthma, at a cost of $3.7 million and over 1,900 emergency department visits at a cost of $3.5 million.[1]

As a primary care provider, we often treat a person's asthma only to have them return with an asthma exacerbation. In an effort to support healthcare providers and to address uncontrolled asthma, the Montana Asthma Control Program (MACP) has developed a home-based asthma program modeled after Centers for Disease Control and Prevention guideline recommendations, called the Montana Asthma home visiting Program (MAP)[2]. MAP is designed to identify and address asthma triggers in the home, provide reinforced asthma self-management education, and to coordinate asthma care in the school, childcare, and work settings, in coordination with you, the person's healthcare provider. The program includes six individualized contacts by a registered nurse or respiratory therapist with advanced asthma training either by phone or in the home.

Your patient may be eligible for MAP if they meet the following criteria:

- A current diagnosis of asthma and at least one of the following:

- An Asthma Control Test (ACT) score[3] of less than 20 in the last year
- An emergency department (ED) visit, hospitalization, or unscheduled medical office visit for asthma in the last year
- A healthcare provider referral

Benefits of participation in MAP include each of the following:

- No cost to the individual for participation in the program
- Six one-on-one contacts with a respiratory therapist or nurse over the course of a year
- Home environmental assessment using the Environmental Protection Agency's (EPA) *Home Environmental Checklist*[4]
- Free allergen-proof mattress and pillow covers
- Free High-Efficiency Particulate Absorption (HEPA) filter (when pets or a tobacco smoker are present in the home)
- Workbook to track asthma control progress and take notes, along with comprehensive education on asthma triggers and medications
- Reinforced, individualized asthma education at each visit including:
  - dedicated time for practicing inhaler technique
  - review of personal triggers; and
  - coordination among a person's asthma healthcare team and other community resources.

This program has documented impressive outcomes for nearly 10 years.[5] At the end of the program, nearly all participants have well-controlled asthma, good inhaler technique, an updated asthma action plan, good asthma knowledge, and they have not missed school or had an urgent visit to a healthcare provider for their asthma. The program was historically restricted to children, however, this successful program is now available to adults with uncontrolled asthma as well.

Consider referring your patients with uncontrolled asthma to your local asthma home visitor program. Visit the *Asthma Community Programs Map* at https://arcg.is/1uP9jm to find your local program's contact information. Together, we can take a comprehensive approach to addressing uncontrolled asthma in Montana communities.

For additional information on asthma in Montana, visit www.dphhs.mt.gov/asthma, or reach out to the Montana Asthma Control Program Manager, BJ Biskupiak, at wbiskupiak@mt.gov.

Greg Holzman, MD, MPH, Montana State Medical Officer, Dept. of Public Health and Human Services

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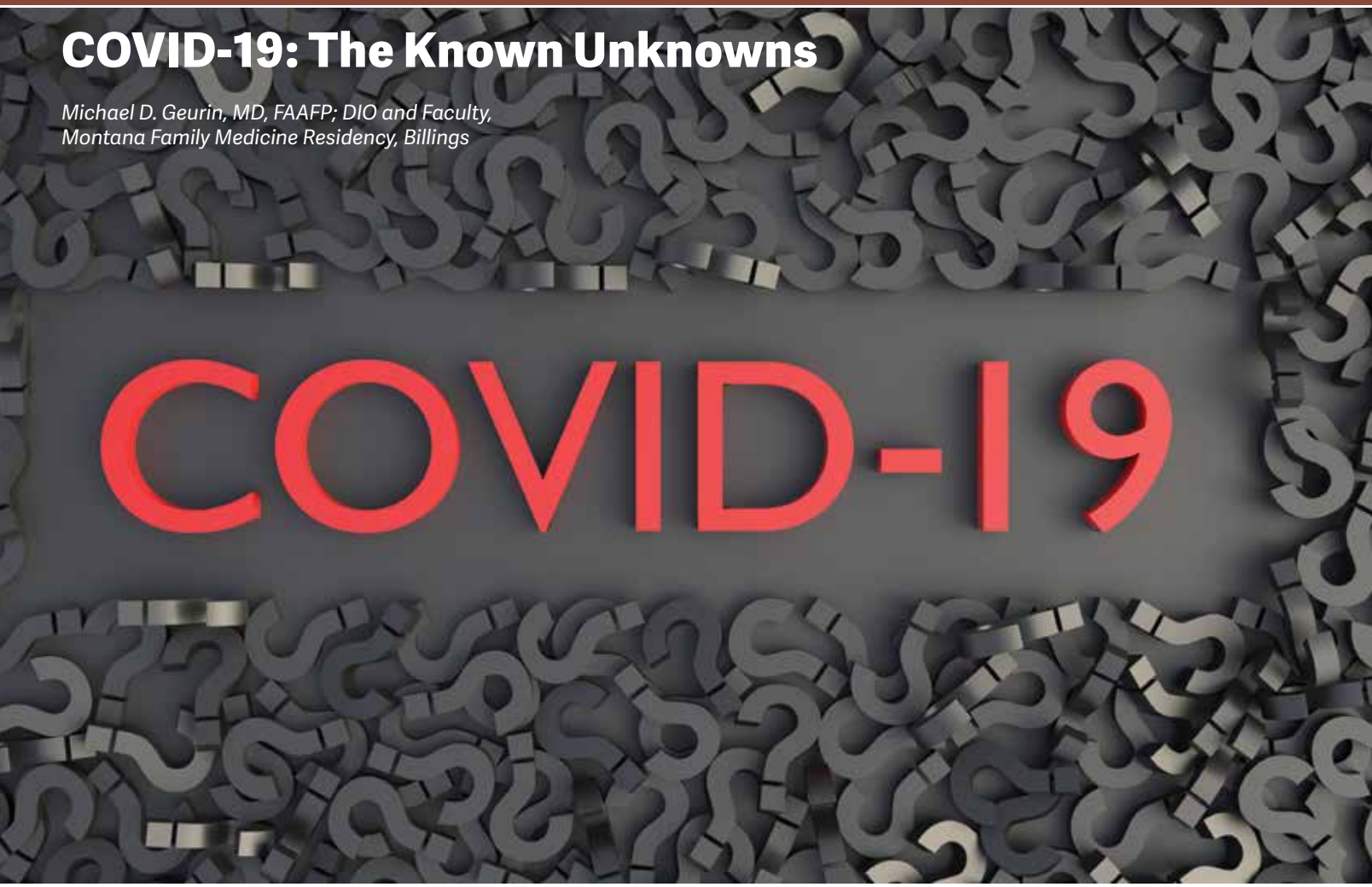
COVID-19: The Known Unknowns

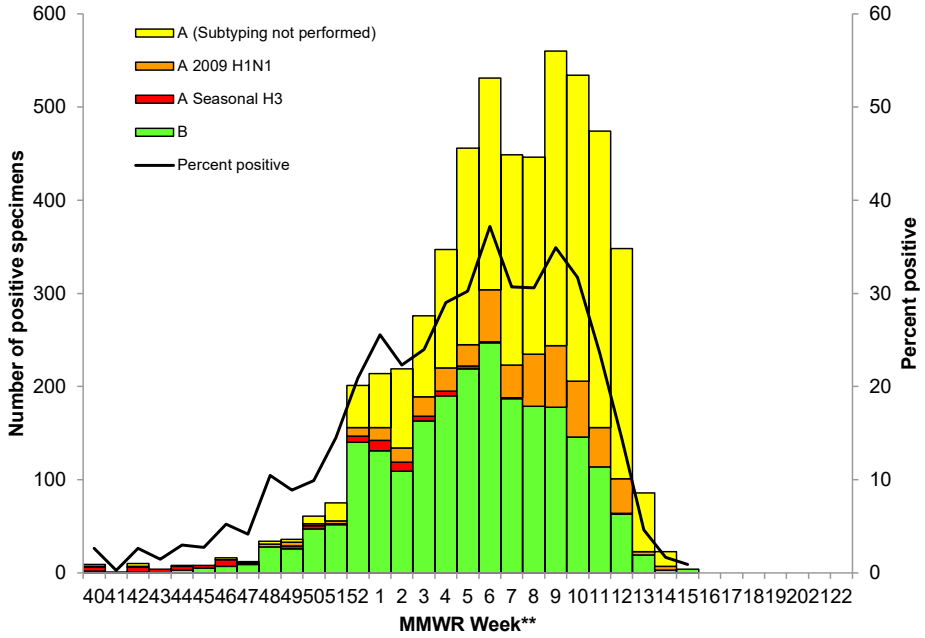
Michael D. Geurin, MD, FAAFP; DIO and Faculty,
Montana Family Medicine Residency, Billings



Soon after I accepted the offer to write about COVID-19 for this issue, I realized this was in many ways a no-win scenario. Every medical journal on the planet is speeding articles into print addressing this new disease. Almost anything I could share today about the clinical management of COVID-19 will likely be outdated by the time this issue reaches your mailbox. Similarly, any purely reflective piece would likewise be outdated—I am sure that you, like me, have experienced the same range of quickly shifting emotions since the arrival of the pandemic to Montana, and who knows where we will be emotionally weeks from now. If adrenergic tone does help encode memory, I am sure none of us will ever need a time capsule in order to remember these last few months.

Instead, I would like to share with you what I will be watching for in the coming months to years, both clinically and philosophically—the things that right now we know we do not know, and likely won't have complete answers to yet by the time you are reading this. Some of the known unknowns are well covered in the press: Does infection provide immunity, and if so, for how long? Will we have an

Figure 4. Influenza positive tests reported by the Montana Public Health Laboratory and partners, 2019-2020 season



**The MMWR week is the week of the epidemiologic year for which the National Notifiable Diseases Surveillance System (NNDSS) disease report is assigned by the reporting local or state health department for the purposes of MMWR disease incidence reporting and publishing. Values for MMWR week range from 1 to 53, although most years consist of 52 weeks.

effective vaccination, and if so, how long will it take to get it distributed? Will we see an even more crippling wave of infection in the fall, as was seen with pandemic influenza in 1918 and 2009? The known unknowns that have my attention, though, are less popularly discussed, at least right now, and more focused on Montana.

The Impact on Montana's Vulnerable Populations

I am writing this on Sunday, May 17. The outbreak that took the lives of six Montanans at Marias Heritage Center in Shelby appears to be over.[1] However, Big Horn County just had its number of confirmed cases double, with several new adolescent cases on one of the county's reservations. We know that American Indians are at elevated risk of complications from influenza; we do not yet know if this is true for SARS-CoV-2, but the large-scale outbreak on the Navajo reservation is concerning. While Montana currently has the lowest infection rate in the nation according to the Web site www.rt.live, that could change if the lockdowns on our reservations are not successful. Also, Montana has the sixth-highest per capita portion of its population age 65 and higher, so if a subsequent pandemic wave were to hit our nursing facilities, the effect could be particularly devastating.[3]

The Impact on Montana's Population with COPD

According to the Centers for Disease Control, Montana is above the national average in its age-standardized per-capita death rate for Chronic Obstructive Pulmonary Disease, which reflects our above-average rate of tobacco use.[4,5] According to one systematic review, patients with chronic respiratory disease were five times more likely to experience critical illness and death due to COVID-19 than patients without chronic respiratory disease [OR = 5.15, 95% CI(2.51, 10.57)].[6] What we do not yet know is how much of that critical illness is due to severe airways disease (alveolar cell destruction and subsequent pneumonia and ARDS), and how much is due to coagulopathy and venous thromboembolic disease, which multiple studies and case reports are now suggesting is associated with more severe presentations of COVID-19. We already know that roughly 1 in 4 patients hospitalized with acute exacerbations of COPD has concurrent pulmonary embolism, based on a meta-analysis showing prevalence of 24.7% (95% CI, 17.9 to 31.4).[7] Will empiric treatment for COVID-19 in patients with COPD include anticoagulation? The Royal College of Obstetricians and Gynaecologists now recommends prophylactic low-molecular-weight heparin for any pregnant or newly postpartum patient with known or suspected COVID-19 (unless birth is expected within the next 12 hours), and consideration of pulmonary embolism if the patient exhibits sudden clinical deterioration.[8] I would not be surprised if we have similar recommendations for patients with COPD, or even all hospitalized patients.

The Impact of First-Trimester Infection on Pregnant Women and Newborns

Currently, we think the first spread of SARS-CoV-2 began in China in December 2019, though there are some data signals that spread may have begun there in November. This means that as I write this, all of our knowledge of COVID-19 in pregnancy is based on infections that occurred in the second or third trimester of pregnancy. What is the impact of COVID-19 on organogenesis and early pregnancy? We know that craniofacial defects, cardiac defects and adverse neurological outcomes are seen with maternal pyrexia in early pregnancy due to other causes. And we do know the early-pregnancy impacts of SARS and MERS, the two other serious coronavirus infections of the 21st Century. With these coronaviruses, we saw increased rates of miscarriage or stillbirth (SARS: 25%, MERS: 18%), IUGR (SARS: 13%, MERS 9%) and preterm birth (SARS: 25%, MERS: 27%), and with MERS there was also a 9% risk of neonatal death.[9] As the COVID-19 pandemic approaches nine months in duration, we should start to see the data on the first-trimester effects of infection.

The Impact on Influenza Management

I am particularly interested to see how we will manage this winter's influenza season. As you know, current CDC guidance during high local influenza activity is to diagnose influenza clinically based on the presence of fever and respiratory symptoms, deferring testing unless hospitalization is required, and treating empirically with an antiviral if indicated. That worked when there was just one kid on the block causing febrile respiratory disease. How will we proceed if we have simultaneous local transmission of COVID-19 and influenza? I

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continued from page 13>

suspect that influenza PCR testing will likely become more common in the outpatient setting; given the low sensitivity of our rapid antigen detection tests (false negative risk), if COVID-19 is in the differential, higher-sensitivity influenza testing in our clinics will be needed. The good news is that social distancing and staying home when ill are proven strategies for influenza outbreak management, and in Montana we saw our influenza activity plummet during the stay-at-home order for COVID-19 (see graph).[10] Americans have become blasé about influenza in their day-to-day lives each winter—perhaps we will treat respiratory illness more carefully in future winters, which could help mitigate the annual morbidity and mortality from influenza.

State and National Security Priorities

In an interview with TIME magazine's Alice Park, former CDC director Dr. Julie Gerberding offered a sobering analysis of how our country has responded to past infectious-disease threats: "What happens unfortunately in our country, and this has been my experience since 2003 [the year of the SARS epidemic], is that we have an outbreak and we react to it. We rev up all our capacities and we address it, usually successfully. But then when the threat goes away, so does the investment, engagement and attention. And we go back into a false sense of security and complacency until the next one comes. My biggest frustration as a public health leader is that we go through this cycle from crisis to complacency and don't sustain a trajectory of preparedness and need. We started some vaccines and antiviral treatments against SARS, but we never did get a vaccine across the finish line. Imagine if we had been able to do that; we would have learned what it takes to make a successful coronavirus vaccine and we could use that knowledge to speed up what we are trying to accomplish now."[11]

In the last two months, the COVID-19 pandemic has taken more American lives than the combined deaths from terrorist attacks and all armed conflicts since the end of World War II. That is staggering. Yet our country spends pennies on the dollar for pandemic preparedness compared to counterterrorism and military expenditures. According to Samantha Power, former U.S. ambassador to the U.N., since 2010, the U.S. has spent an average of $180 billion annually on counterterrorism, but only $2 billion annually on pandemic and emerging infectious-disease programs.[12] And in 2019, Congress appropriated only $7 billion for the CDC, compared to $685 billion for the Department of Defense.[12] Will America's response to COVID-19 be transformational, or merely reactionary?

Unknown Unknowns

In a Department of Defense briefing in 2002, then Secretary of Defense Donald Rumsfeld famously stated, "[T]here are known knowns; there are things we know

we know. We also know there are known unknowns; that is to say we know there are some things we do not know. But there are also unknown unknowns—the ones we don't know we don't know. And if one looks throughout the history of our country and other free countries, it is the latter category that tend to be the difficult ones." It is quite likely that there are things about this virus that we don't know we don't know, and some of those things may be difficult to face and manage. I am heartened, though, to live in a state that has so successfully responded to this threat, and I am grateful to each of you for the work you have done and will be doing to improve—and save—the lives of our fellow Montanans.

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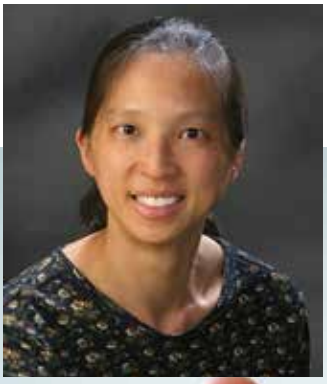

Laurie Carter, MD, FAAP

COVID-19 is Putting More Children at Risk for Abuse

Laurie Carter, MD, FAAP, Pediatric Hospitalist
Community Children's at Community Medical Center

On March 26, Montana governor, Steve Bullock, issued a "stay at home" order for all Montanans, only allowing residents to leave home for certain necessary functions, such as buying food or medicine, going to work at essential businesses, or performing outdoor recreation, as long as everyone maintained physical distance (six feet apart) in these situations. This "stay at home" order extended the closure of schools and essentially closed non-essential businesses, thus vastly increasing unemployment. By April 6, the Department of Health and Human Services (DPHHS) recognized that the number of reports to their hotline (1-866-820-KIDS (5437)) had dramatically decreased from an average of 765 calls a week to 425 calls a week since March 15. Sheila Hogan, Director of DPHHS, said, "Now is when we really need the entire community, no matter if one is a mandatory reporter or not, to really watch out for our kids."[1]

This concern was based on historical data. During the last economic downturn in 2007 to 2009, The Great Recession, the rate of abusive head trauma, formerly known as "shaken baby syndrome," increased by 65 percent in the three years during the downturn compared to the three years before The Great Recession[2]. And current experience is validating this concern. On April 30, the Washington Post reported that in addition to child abuse reports similarly plummeting across the nation, not only were more injuries suspicious of child abuse being treated, but the injuries were more serious.[3]

Why is there this rise in child abuse, which includes physical abuse, sexual abuse, emotional abuse and neglect? Sheltering in place has led to families, who are already burdened by anxiety or unemployment due to the pandemic, having to spend every hour, every day of the week together. Well known risk factors for child abuse are social isolation, parenting stress and family stress – which most likely describes the environment of many homes where the "stay at home" order is being applied. Many of our community partners who provide services for survivors of domestic violence are already working to help this anticipated surge of clients, as reported by Montana Public Radio.[4] These groups include YWCA, HAVEN, and Community Support Center.

So what can we as medical providers do to mitigate this rise in child abuse?

First, we can support and partner with these community agencies who provide services for survivors of domestic violence, as well as our school systems as they struggle to maintain contact with at risk children.

Second, we can support our families directly, through online education such as the American Academy of Pediatrics's HealthyChildren.org website which includes material specific for "Parenting in a Pandemic", or conversations during well child care visits. Research has found that when families are stressed, children are at increased risk of being abused, thus we need to support caregivers to take care of themselves physically and maintain their social connections despite physical distancing.

Lastly, we also need to be alert to red flags during well child care visits, either in person or via telehealth. Community Children's has developed a clinical pathway to help identify historical and physical signs and symptoms of non-accidental trauma, which can be found at www.CommunityChildrens.org → Clinical Pathways → Non-Accidental Trauma Pathway. Multiple studies have found that close to 30% of severe physical abuse in infants were preceded by relatively minor abusive injuries, otherwise known as "sentinel injuries."

With schools providing distance learning, teachers are not interacting with at-risk children in person causing a reduction in calls to the appropriate authorities. As medical providers, we are not only legally responsible to report, we may be the only voice these children have. If you are concerned that someone is at risk of harming a child or if you suspect child abuse, CALL the Child & Family Services Division child abuse hotline: (866) 820-5437

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Community Children's
AT COMMUNITY MEDICAL CENTER

ELIZABETH BAXLEY, ABFM

ASHLEY WEBB, ABFM

ABFM: What's New? Performance Improvement Requirement:

Approaches To Family Medicine Certification

ELIZABETH BAXLEY, ABFM - EXECUTIVE VICE PRESIDENT
ASHLEY WEBB, ABFM - DIRECTOR OF OUTREACH

The goal of the **Performance Improvement** (PI) requirement for certification is to demonstrate that, as a board-certified family physician, you can reflectively look at information about your practice, identify an opportunity for improvement, put an intervention in place, and remeasure to see if that change resulted in an improvement. When first established in 2004, this consisted of Performance in Practice Modules (PPMs) that were downloaded from the Physician Portfolio and completed using patient data and surveys. Today, while a similarly-constructed activity is available for this requirement, we recognize that it is far more common for family physicians to already be engaged in doing quality improvement in practice, and when that is the case, the goal of the PI requirement is already being met. We also appreciate that more options were needed for physicians whose practice scope and environment is different (hospital-based, urgent or emergent care settings, locum tenens, hospice/palliative care, sports medicine, etc.). Finally, for those physicians who are no longer clinically active, it did not make sense to continue to require a clinically based PI activity. As a result, the following changes have been made over the last five years to support greater choice and relevance while eliminating the need for unnecessary redundancy of work:

a. The Self-Directed PI Project is best suited to an individual or small group of family physicians to report on a project already implemented in practice, or to provide a roadmap for creating a quality improvement project that is meaningful to their current scope of practice. As more Diplomates are learning of this option, the trend toward selecting this option has grown and the feedback has been very positive. The application process has been streamlined (averaging ~10 mins to complete) to require only the necessary information to demonstrate the cycle of measure, intervention and remeasure, and to attest to level of participation in the effort. More information about this can be found in your Physician Portfolio. This pathway is ideally suited for family physicians in non-continuity practice, as it allows selection of

any area of improvement they wish to make, regardless of practice setting.

b. For larger groups of family physicians (> 10), the Organizational PI Activity option is worth consideration. If you are participating in an ACO, CIN, health system network, or similarly constructed group of physicians who are working on improving care together, your organization can apply to be a sponsor for reporting your efforts in this work to the ABFM for your PI credit. Information about this option can be found at [https://theabfm.mymocam.com/extsponsor/]. This pathway also allows for state chapters and other organized entities to become sponsors of Performance Improvement activities and to report on your behalf.

c. If you are participating in NCQA recognition programs, a Practice Transformation Network, or CPC+, You may be able to receive credit for a certificate/recognition or award you have achieved for your improvement work (e.g. NCQA, CPC+, Practice Transformation Network, etc.). You can log into your Physician Portfolio and attest to your participation.

d. If you are using ABFM's PRIME registry to help you manage data from your EHR, you can select something you wish to improve on from what is already being measured on your dashboard, implement an intervention, and PRIME will remeasure and seamlessly submit your data to ABFM for PI activity credit using the PI activity within PRIME registry.

e. The Residency Performance Improvement Program (ResPIP) pathway is a means for residency programs to demonstrate their ability to develop and oversee the successful completion of performance improvement (PI) projects for residents and faculty that meet the ABFM Family Medicine Certification requirements. Approved sponsors will be able to develop and oversee PI projects without having to submit an application for each activity for ABFM review. For more information go to https://theabfm.mymocam.com/respip/.

f. Another exciting new option is the Precepting Performance Improvement Program. If you are teaching students or residents in your practice at a level of 180 hours of 1:1 during your 3-year stage, this option, developed through collaboration with the Society of Teachers of Family Medicine, allows you to receive PI activity credit for improving your teaching skills. Linking to an approved academic sponsor, who will help develop, oversee and report PI projects for teaching physicians, provides a pathway to earning your PI activity credit in a new way that supports the clinical preceptor, which is vital to the training of future physicians. More information about the Precepting Program is available at https://theabfm.mymocam.com/precepting/sponsors/.

Family Medicine and Comprehensiveness of Care:

What are the Risks of Declines in Scope of Practice?

By: Elizabeth G. Baxley, MD, Executive Vice President, American Board of Family Medicine; Andrew Bazemore, MD, MPH, Senior Vice President of Research and Policy, American Board of Family Medicine; and Robert Phillips, MD, MSPH, Executive Director, Center for Professionalism and Value in Healthcare.

The following article was shared by the Ohio AFP from the Spring 2020 edition of their publication, The Ohio Family Physician.

The late Barbara Starfield declared comprehensiveness – caring for patients and families across the spectrum of their lives and providing most of the care that they need – to be one of the four foundational virtues of primary care. Family medicine has long prided itself as being the most comprehensive of the primary care disciplines, with training to care for patients across the widest array of health care delivery settings and services, and from "cradle to grave." Many of us cherish this breadth and depth as fundamental to our specialty choice and attribute broad scope of care as one of the things that brings us joy in practice. Despite this, there has been a general reduction in the scope of practice among family physicians over the last 20 years. Fewer family physicians care for pregnant women; see children; and attend to the care of their hospitalized patients.[1,2,3,4] The number of family physicians doing procedures in their practice is also declining.[5] Amidst cries of primary care shortages, rising costs, increasing maternal mortality, and obstetrical deserts, why is this happening and what can be done to reverse this documented decline?

The improvements in outcomes associated with comprehensive care are often not touted in the case-building for family medicine. Numerous studies have produced good evidence that primary care is associated with better health outcomes, lower costs, and greater health equity.[6] These findings should be considered before accepting that declines in broad scope practice are inevitable.

These findings include:

- Higher levels of family physician comprehensiveness of care are associated with lower costs of care and fewer hospitalizations.[7]

- Greater primary care physician supply that includes prevention, diagnosis, and the management and treatment of a wide array of conditions, is associated with lower mortality rates.[8]
- Physicians also benefit. Research has shown that comprehensiveness is associated with less burnout among early career family physicians.[9] If we believe in the Quadruple Aim, which includes caring about, and for, those who provide care; it is critical that we better understand and support the desires of residency graduates, and other family physicians, to provide broad scope care as way to enhance access to quality, affordable care while maintaining physician wellness.

The reasons for declines in scope of practice are many, but particularly result from years of volume-based reimbursement models; underpayment for prenatal, obstetrical, and pediatric care; and obstetrical malpractice. Our residencies continue to prepare family physicians for broad scope care, but graduate practice intentions increasingly run contrary to the opportunities available in a job market dominated by salaried positions in health systems that clearly delineate service lines and the scope of practice tolerated in each.[10,11,12] Given that comprehensive care is valued by physicians and patients, and valuable in a capitated or population-based payment model, the direction of most payment models could mean that broad scope care may become more viable. The concern is that payment change will not arrive fast enough to sustain broad scope training. There is a smoldering argument that training programs should give up broad scope to fit with the current, dominant model of care, and many community-based programs are already challenged to sustain it.

Some attribute the tension around scope of practice to family medicine traditionalists having difficulty letting go of an anachronistic self-image, while others are eager to redefine the meaning of comprehensiveness for family medicine in a system that needs it associated with benefits at the patient, population, and physician levels. For its part, the American Board of Family Medicine is committed to continually exploring the meaning and value of comprehensiveness in this age of rapidly evolving health systems. Given our awareness of the pressures that family physicians face from health systems and other employers, related to providing a more narrow scope of care, we also intend to drive the conversation about the degree to which comprehensiveness is a measure of high-value care, population-based outcomes, and payment programs.

Comprehensiveness is an important differentiator for family medicine from other primary care clinicians. Our greatest risk is not expansion of their scope, but a narrowing of ours. In fact, we should be making the case for having more robust care teams in order to support broadening the capacity of our practices to provide the breadth of care our patients need. The health of the population and the resilience of our physicians are both at risk if we passively allow further reductions to happen and fail to recommit to comprehensiveness. It is not just a legacy tradition of family medicine; it is part of the secret sauce of why we matter.

Rural Medicine and Scope of Practice: Ohio's Family Physicians

Keith Lehman, MD

I have practiced family medicine for 37 years in Archbold, OH, a rural community of 4,500 people, that's located 35 miles west of Toledo. For 27 years I practiced hospital medicine and did obstetrical deliveries. In addition to caring for patients of all ages, I continue as a nursing home director, administer physicals for the Federal Aviation Administration and the Department of Transportation, and do colposcopies and excisions. Providing comprehensive care has been a priority for my practice.

Seeing patients in outpatient, inpatient, and nursing home settings allows for excellent continuity and coordination of care. This has allowed me to develop strong relationships with my patients, which leads to their better care and health outcomes. My relationship with my patients also helps me stay motivated and interested in my practice both personally and professionally.

Limiting the scope of family medicine would certainly make schedules less chaotic, and keep work and family life in better balance. Unfortunately, this comes at a price. Less involvement with the physician leads to more disconnected care for patients. Limiting the broad scope of skills practiced by the physician leads to less practice satisfaction.

As long as relative value units (RVUs) are the primary determinate of the value of care, and the production of RVUs are the sole measure of compensation, it will be difficult for family physicians to provide comprehensive care and still have adequate compensation and a balanced lifestyle.

We need to advocate for the value of longitudinal, comprehensive family medicine with insurers, health systems, and the government on behalf of our patients and for the good of the specialty. We need to do this as individuals and come together collectively as the Ohio Academy of Family Physicians and the American Academy of Family Physicians.

Mary E. Krebs, MD, FAAFP

I practice in a solo, rural, federally qualified health center. Many of my patients struggle with transportation. They often lack a reliable vehicle or cannot afford the gas to travel far. In addition, some of my patients do not have insurance, or if they do, it is typically not accepted by specialists. My scope of practice is critically helpful to these patients, because, as a family physician, I can meet their various needs.

I have training in pediatrics, psychiatry, cardiology, dermatology, and many other areas. When I am able to take care of multiple problems for a patient, it improves their care through continuity and at a lower cost. This also translates to better outcomes because I am well aware of all the patient's problems, as I am the one managing them.

I recently had a patient come in requesting "referrals" to an orthopedic surgeon, a dermatologist, a gynecologist, and a psychiatrist. When I spoke to her, I realized she was frustrated with her hip pain, acne, depression, and needed a pap. I did a proper history and physical, and diagnosed her with trochanteric bursitis, acne, and generalized anxiety disorder. I

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gave her medication for acne and anxiety, counseled her on both; and scheduled her for a pap and an injection of her trochanteric bursa, both to be performed by me. She left my office without any of the referrals she had requested, but was extremely happy.

While it is often easier and quicker to refer to specialists than manage problems, it is so much more satisfying to be a "real doctor" who is often able to meet most or all of my patients' needs.

Evan Howe, MD, MPH, PhD

For the past five years, I have addressed health equity by practicing a broad scope of medicine in my hometown of Jefferson, OH. With a population of 3,100 people, Jefferson is the county seat of rural Ashtabula County. Providing comprehensive care in this community requires me to understand my patients' variety of backgrounds.

The largest barriers I see to health equity are distance and transportation. For some, a trip of 10 miles from their farmhouse to my office is the longest journey that they will undertake all year, and the idea of traveling on the highway to a specialist's office is terrifying. There are times that the cost of gas is too great to be able to travel to the next town over that has X-ray facilities. Having come from this area and continuing to live in the community, I try my best to be aware of what resources are available and how to adjust care plans based on the ability of a patient to travel.

I see patients from the newborn nursery to the nursing home, including office, hospital, and home care. Being able to follow patients between settings and having 24/7 availability have proven invaluable to avoiding unnecessary trips to the emergency room. Frequently, I will encounter patients in the lobby and can clarify plans for medication refills or follow-up appointments, avoiding the need for further travel. I have been able to discharge patients home to their families more quickly by checking-up via phone the next day and having my staff follow-up on necessary testing and equipment. By positioning myself across the care spectrum, I am able to not only provide care, but avoid unnecessary care that is often impractical due to transportation restrictions in my rural setting.

References available online at https://www.ohioafp.org/news-publications/the-ohio-family-physician-references.

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