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Washington Family Physician

THE JOURNAL OF THE WASHINGTON ACADEMY OF FAMILY PHYSICIANS

IN THIS ISSUE:

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The Washington Family Physician (WFP) Journal is the official quarterly publication of the Washington Academy of Family Physicians (WAFP). It serves as the primary communication vehicle to WAFP members. Its purpose is to provide timely and relevant information regarding the practice of Family Medicine, and report results of the policies determined by the Board of Directors and activities of members and committees. In addition to regularly published articles from selected Officers, trustees, and committee chairs, WFP welcomes submission of articles on a wide variety of subjects related to the practice of Family Medicine.

WFP also welcomes articles written in a respectful and collegial manner that reflect opinion and editorials if, in our opinion, publishing such articles is timely, relevant, and will be of interest to the general membership of the Academy. Such articles will be clearly identified as an individual writer's opinion or point of view.

The views and opinions expressed by all authors in this publication are their own and do not necessarily reflect those of the Academy. Publication should not be considered an endorsement, expressed or implied, by WAFP.

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Thriving Family Physicians and Patients: WAFP's Hope for the Future

LYDIA BARTHOLOMEW, MD, MHA, FACPE, FAAFP, EDMONDS

If you want to go quickly go alone; if you want to go far, go together.

— African proverb

Every three years or so, we renew our strategic plan. This year is one of those years. The WAFP remains committed to seeing thriving family physicians throughout the state and a similarly thriving and healthy citizenry of Washington, thanks to the work undertaken at our recent strategic planning retreat.

We worked under the guidance of Paul Meyer, president and co-CEO of Tecker International. Several of us have had experience working with Paul at the American Society of Association Executives CEO Symposium, which is attended by the president, president-elect and executive vice president of the WAFP each year, and we were excited to have him work with us in this way. As I am writing, the final draft of our new strategic plan is being prepared for review and discussion at our September Board meeting. By the time you read this, we will have an official new plan and, come January, will be starting work on the tasks that will lead to achieving our goals.

Each strategic planning session begins with a review of our core purpose, values and vision and a discussion of how we will choose the goals of focus for the next few years. We agreed to continue with the concept of unity through diversity, by allowing all to celebrate their passions and positioning the WAFP to assist with those passions. We further agreed to concentrate efforts on the issues that are common to all family physicians in Washington.

We clarified our core purpose: Advance and support family physicians in providing optimal health care for all people in Washington state.

Our core values are unchanged: mission-driven, mutual respect, service excellence, stewardship, evidence-based, and commitment to the belief that everyone deserves a family physician.

Our vision is for thriving family physicians, healthy people and communities in Washington state.

We developed a vivid description of what all of this will look like in the future — but you will have to read the final version for all of that. I am sure that you will find this picture of tomorrow inspiring.

Our goals for the next few years include:

- The WAFP is an influential leader in formulating policies affecting the practice of family medicine.
- Improve the health of the public with a robust collaboration between family physicians and public health stakeholders.
- Family physicians in Washington state are more satisfied with their work and work-life balance.
- A unified message articulating the value of family physicians to Washington state communities has been established and communicated.
- The WAFP influences the pipeline of students and residents into family medicine.
- The WAFP is recognized as a vibrant and well-respected organization with an actively engaged and diverse membership and leadership fulfilling its strategic plan.

There are objectives underneath each of these goals, which can be found in the final document.

We created a series of infrastructure recommendations, in order to make it possible for us to meet these goals. We also created a list of "mega-issues", questions about strategic issues that represent choices facing the organization and profession for discussion at our board meetings.

What was most impressive about this meeting

continued on next page

was the way in which everyone came together to work for the future of the organization, our careers as family physicians, and the health of our patients and communities. A variety of opinions were respectfully put forth, assessed, discussed and incorporated into the final plans. There is so much to work on. I want to encourage you to read the plans, find something that resonates with you and help us work towards these goals. There is room for everyone.

Our Board meetings are open to all, as are our committee meetings, and, in general, all of the work that we do is open to those who wish to participate. We think you all will approve of our strategic plan, goals and objectives and the work that we wish to do. We hope many of you, in fact ALL of you, will want to participate in making those goals a reality. We welcome your thoughts and your passion. We look forward to the future that we will create together.

Coming together is a beginning.
Staying together is progress.
Working together is success.

— Henry Ford

MISSION

Advance and support family physicians in providing optimal health care for all people in Washington State.

VISION

WAFP's vision is to achieve optimal health for everyone in Washington State.

PRINCIPLES OF CARE

WAFP champions these principles of care regarding Family Medicine:

- Essential for individuals, communities and the State of Washington;
- Accessible and equitable for all people;
- Centered on the whole person within the context of family and community;
- Founded on the patient/physician relationship within the health care team;
- Uses science, technology and best available evidence;
- Facilitated by workforce development and lifelong professional learning;
- Grounded in respect and compassion for the individual; and
- Demonstrated by bold leadership, innovation, collaboration and stewardship.


Budget Provisos Affect Health Care in Washington

JONATHAN AND PATRICIA SEIB
WAFP ADVOCACY CONSULTANTS, OLYMPIA

The third special session of the 2017 Washington legislature was gaveled to a close on July 20, on what was the state-record 193rd day of session this year. In total between the regular session and the three special sessions, legislators introduced 2,303 bills and passed 390 through to Gov. Jay Inslee's desk. He subsequently vetoed all or part of 22 of those while signing the remainder.

In our previous column, we identified from among the new laws at that time those most likely to impact family physicians, their practices or their patients, and provided a brief summary of each. Here we will get to two more bills which became law only later, but which are also of significance to WAFP members. As with our previous summaries, you are encouraged to go to the legislature's website (leg.wa.gov) or the budget website (fiscal.wa.gov) for more details and to read enacted legislation in its entirety.

SB 5883 is the state operating budget for the two-year period beginning July 1, 2017. As has become all too common in the past several years, the legislature flirted with at least a partial state government shutdown before the bill was passed and signed by the governor on June 30, within an hour before the start of the new fiscal year.

The $43.7 billion spending plan had lawmakers subsequently arguing to the State Supreme Court that they met their *McCleary* obligations to fully fund basic education (we'll see if the Court agrees later this year). In the health care arena, the budget included some additional funding for foundational public health programs and substantial new investments in the state's behavioral and mental health infrastructure.

But in addition to the major agency appropriations, the budget bill typically includes hundreds of more detailed "provisos" directing agencies to use appropriated dollars in particular ways or for particular purposes, in effect setting policy through program implementation or laying groundwork for policies to be considered in the future. Among the provisos found in sorting through the 621 pages of the 2017-2019 budget:

- Funding for the Health Care Authority (HCA) to contract with the University of Washington tele-pain management program and pain management call center to continue to advance primary care provider knowledge of complex pain management issues, including opioid addiction.
- Funding for a pilot program for substance abuse treatment for inmates at the Snohomish County Jail who are undergoing detoxification from heroin and other opioids and for connecting them with treatment providers in the community upon their release.
- Spending authority allowing the HCA's continued implementation of its Medicaid transformation demonstration project (the Medicaid waiver), which funds incentive-based payments for projects to improve health care delivery and lower costs for Medicaid clients; new services and supports for family caregivers that help people stay in their homes and avoid the need for more intensive services; and supportive housing and employment services for targeted individuals.
- An explicit assumption that the rates paid to Medicaid managed care companies will stay flat in calendar years 2018 and 2019. This could subsequently put pressure on the rates paid by those companies to their network clinicians. However, HCA has already noted that it does not believe the assumed savings are achievable within the requirements of federal law.
- Funding for the State Auditor to conduct a performance audit of the Department of Health (DOH) focused on its fee setting for licensed health professions. The audit, which is due to

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the legislature by December 2018, will include a review of the fee-setting process and how dollars are allocated between the various health profession disciplinary boards and DOH as overhead.

- Funding for the Office of Financial Management (OFM) to conduct a legal and policy review of whether the state's all-payer claims database may collect certain data from drug manufacturers and use this data to bring greater public transparency to prescription drug prices. By Dec. 15, OFM must report to the legislature the results of its review, including any legislation necessary to allow the collection and use of such date.
- Funding for the family medicine residency network at the University of Washington to expand the number of residency slots available in Washington.
- Funding for the University of Washington School of Law to conduct a study on the State Supreme Court's decision in *Volk v. DeMeerleer*, and whether it substantially changed the law on the duty of care for mental health providers and whether it had an impact on access to mental health care services in the state. The WAFP was among a coalition of health care organizations for whom addressing *Volk* was a legislative priority. Although the bill to do so failed to pass, this study will keep the issue alive and provide important information to inform the discussion in 2018. The WAFP is one of the groups with whom the UW is explicitly directed to consult in completing the study, which is due by Dec. 1.
- Funding corresponding to newly authorized billing codes enabling primary care providers serving Medicaid enrollees to bill for collaborative care and integrated behavioral health services.

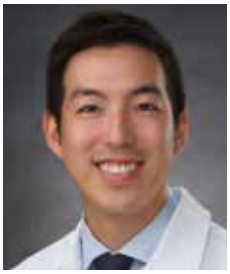
The other bill of note to pass during special session is SB 5975, relating to paid family and medical leave. Supported by the WAFP under a resolution adopted at its 2016 House of Delegates, the bill generally provides eligible employees with paid family leave of up to 12 weeks to bond after the birth or placement of a child or to care for a family member with a serious health condition, and paid medical leave of up to 12 weeks for the employee's serious health condition. The program will be funded through a tax on wages paid by both employers and employees. Benefits will vary depending on an employee's wages and will be paid beginning January 1, 2020.

So what's next for the legislature? Despite the record number of days spent in Olympia so far this year, lawmakers left town without passing a capital budget. As opposed to the operating budget, the capital budget funds long-term investments in buildings and other construction projects around the state. Among the projects proposed for funding this year are those aimed at adding to and enhancing spaces in the state dedicated to mental health and oral health services. Passage of the capital budget has been tied to passage of another bill addressing a difficult water policy issue, with a decent chance that both issues will have the legislature back in Olympia for a fourth special session sometime before year's end.

Family Physicians Can Help Negate the Negative Health Impacts of Homelessness

TREVOR DICKEY, MD; DANIEL LOW, MD; MATT MACKWOOD, MD; AND ANDREW WEI, MD



I was scurrying from room to room, typing furiously as I tried to avoid falling further behind my hectic clinic schedule, when I walked into Mr. Morris' room. Dressed in an oversized trench coat and tattered jeans, he smiled. "Good morning, doctor." We exchanged pleasantries, and I glanced at the EMR, where I saw his HA1C had returned at 13.1. Though one of my favorite patients, Mr. Morris was also one of the most challenging. I asked him how things were going; insulin management was not on his mind, he wanted to talk about a new wound that had developed on his left lower extremity. While I examined his leg, I learned that after an unceremonious break-up with his girlfriend, he had found himself homeless. His cheeks reddened as he told me he had not taken his insulin for three weeks. His medications had been stolen, along with his bag, while he slept outside. He had been trying to manage his blood sugars by eating small, frequent meals, but without a place to store food, he was struggling. In trying to assess whether his developing abscess had matured enough to drain, I began to appreciate the challenge of his wound care and medication management; my medical toolbox was insufficient for his true need.

More than anything, Mr. Morris needed a place to live.

Last month, the AAFP passed our resolution, "Support Housing Access for All." In so doing, the AAFP, along with WAFP, resolved to help folks like Mr. Morris by "[advocating] for policies supporting 'Housing First' approaches … including policies that encourage Medicaid agencies and Medicaid health plans to use funds for such approaches."[1] This is an important step for our organization, but what does it mean to support this at-risk population?

When it comes to housing access, we know that more than 21,000 people in Washington state struggle with homelessness.[2] Tens of thousands more are living in unstable housing, and the crisis is growing.[3] While the need for housing increases, it takes a disproportionate toll on people of color. While blacks make up less than four percent of Washington's overall population, they account for 19.7 percent of the homeless population. Similarly, the percentage of Native Americans who are homeless is nearly 3.5 times larger than the percentage of Native Americans in the general population.[4]

Homelessness is not only a symptom of morbidity and mortality, it is a root cause. And it is an illness that we know how to effectively treat. Multiple studies have demonstrated how stable housing improves the health of the chronically homeless; when housing was given to people with AIDS in San Francisco, mortality dropped by 80 percent over a five-year time period.[5] Doing so is not only the morally just action to take, it is also cost-effective. Providing housing to the chronically homeless in Seattle has demonstrated significant savings in health care and public service use,[6] and this has been repeated across the country.[7] Yet, despite the proven benefits, Washington state, and the U.S. health care system in general, has rarely invested in housing.

As health care leaders in communities affected by homelessness, we are uniquely positioned to ensure that WAFP's commitment to supporting housing access for all is manifested in more than just words. Given the clear link between unstable housing and poor health, we must

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be torchbearers in advocating for our patients' stable housing. A simple screening question for all patients, asking "Do you ever have difficulty making ends meet at the end of the month?", has been shown to be 98 percent sensitive and 40 percent specific for living below the poverty line.[8] In Washington state, where more than 13 percent of the population lives in poverty, such a screening question is critical.[9] A follow-up question inquiring about housing stability is an easy, time-efficient way to identify those most in need of housing resources. In less than a minute of each visit, we are capable of assessing poverty and housing instability — greater risk factors for morbidity and mortality than diabetes or cardiovascular screening — and are well positioned to connect such individuals with support staff and/or social workers who can assist with applications for public housing and other social services. While biophysical screening questions have been a foundational pillar of primary care, it is time for family doctors to incorporate social screening tools in order to assess all of our patients' health needs.

Beyond the clinic, we can simultaneously use our leverage as physicians to make political strides in the housing crisis. We can advocate for Housing First programs that successfully and appropriately prioritize the foundational necessity of safe housing, irrespective of individuals graduating a series of service programs or behavior health programs. Statewide government legislation can be used to expand housing opportunities, as has been modeled in Minnesota, where homeless adults with disabling conditions qualify for a state-funded monthly income supplement to pay for housing expenses, including rent.[10] Private partnerships with hospitals can be effective as well. After recognizing that average hospital costs were $2,559 more expensive for homeless individuals than housed individuals,[11] several hospital systems and a non-profit health care plan in Portland, OR, collaborated to develop 379 new, affordable housing units, including supportive respite care and transitional housing.[12]

Fighting the health inequities inherent to homelessness must be seen as our obligation as health care professionals. Chronic homelessness is associated with a life expectancy 30 years less than the general population.[13] If we could give a pill that would extend our patients' lives by 30 years, we would rush to do so! We must feel that same urgency when it comes to the care of our homeless patients.

1. 2017 Congress of Delegates. Resolution 407 from the Washington Chapter entitled "Support Housing Access for All."
2. Washington State Department of Commerce. Counts of Homelessness: Different Counts and What They Mean 2017 [Internet]. State of Washington Department of Commerce; 2017 [cited 2017 Jan 31]. Available from: http://www.commerce.wa.gov/wpcontent/uploads/2015/11/hau-hlp-counts-of-homelessness-2017.pdf
3. http://www.homelessinfo.org/what_we_do/one_night_count/2016_results.php
4. Population by Race. 2016. http://www.ofm.wa.gov/trends/population/fig306.asp. 2017 Point in Time Count in Washington State Population: Sheltered and Unsheltered Count. http://www.commerce.wa.gov/wp-content/uploads/2017/08/CSHD-HAU-Point-In-Time-August-Update.pdf
5. Schwarz SK, Hsu LC, Vittinghoff E, et al. Impact of housing on the survival of persons with AIDS. *BMC Public Health. 9(220:) 2009.*
6. Larimer M, Malone D, Garner M, et al. Health Care and Public Service Use and Costs Before and After Provision of Housing for Chronically Homeless Persons with Severe Alcohol Problems. JAMA 2009. 301(13): 1349-57.
7. Bamberger J and Dobbins S. A research Note: Long-term Cost Effectiveness of Placing Homeless Seniors in Permanent Supportive Housing. *Cityscape: A Journal of Policy Development and Research. 17(2): 2015.*
8. Brcic V, Eberdt C, Kaczorowski J. Corrigendum to Development of a tool to identify poverty in a family practice setting: A pilot study. Int J
9. Family Med [Internet]. 2015 Sep 21 [cited 2016 Apr 22]; 1-7. doi: 10.1155/2015/418125
10. "Population in Poverty." Census American Factfinder. Office of Financial Management. Updated June 12, 2017. Accessed September 10, 2017. http://www.ofm.wa.gov/trends/social/fig201.asp
11. Innovative Models in Health and Housing. Mercy Housing and The Low Income Investment Fund for The California Endowment and The Kresge Foundation. http://www.liifund.org/wp-content/uploads/2017/07/LIIF_whitepaper_pages.pdf
12. Hwang S, Weaver J, Aubry T, et al. Hospital Costs and Length of Stay among Homeless Patients Admitted to Medical, Surgical, and Psychiatric Services. Medical Care. 2011. 49(4): 350-54.
13. O'Connell, Jim. Premature Mortality in Homeless Populations: A review of the Literature. Nashville: National Health Care for the Homeless Council, December 2005.

Registration now open at wafp.net!

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Student & Resident Retreat

- Developed for family medicine residents and students for FM residents and medical students
- Network with fellow residents and medical students around the state
- Significant others welcome
- Held in beautiful, festive Leavenworth and near numerous outdoor recreation activities
- Anticipated topics include LARC, chronic pain, addiction medicine and other topics
- Relevant panel discussions with invited faculty

January 6-7, 2018

On a Busy Weekend, WAFP Board Holds Leadership Orientation, Committee Meetings and Board Meeting

The WAFP Board of Directors held its annual leadership orientation, along with its twice-yearly committee and Board meetings, on Sept. 22 and 23 at the Radisson hotel in SeaTac.

Friday night's leadership orientation was led by WAFP President-Elect Jeremia Bernhardt, MD. Bernhardt talked about the role of the Board and its members in overseeing the organization. Beyond simply setting strategy for WAFP, Bernhardt discussed a continuous improvement process for the Board as well: Based on "Tribal Leadership" by Dave Logan, John King and Halee Fischer-Wright, the process considers desired outcomes, organizational assets and behaviors, or actions, that utilize those assets to produce the desired outcomes.

The committee meetings on Saturday began early and occurred throughout the morning. The work undertaken covered a range of topics important to WAFP, including potential bylaws changes, advocacy targets, communications channels, student and resident activities, the content of next May's Annual Scientific Assembly, the future of the Practice Transformation Committee, and topics involving public health.

At lunch, WAFP welcomed Jon Brumbach, a senior policy analyst at the Washington State Health Care Authority. Brumbach discussed the state's current efforts surrounding in one area of its current Medicaid transformation demonstration. That area, Initiative 3, is aimed at helping those Medicaid beneficiaries who need stable housing and employment as a way to support their broader health needs.

The afternoon was spent in a Board meeting with a packed agenda. The Board passed a new three-year strategic plan which begins Jan. 1, 2018, and runs through the 2020 calendar year. The plan includes goals in six areas: advocacy, health of the public, practice enhancement, brand development, embracing learners and organizational health. Originally developed at a strategic planning retreat in June, the plan passed unanimously and was met with applause upon its adoption.

Gregg VandeKieft, MD, MA, FAAFP, reported on the Academy's success at the 2017 AAFP Congress of Delegates. WAFP brought forward two resolutions. The first concerned "Housing First" policies, and it was adopted as presented. The other dealt with substance use disorder in jails and prisons and passed with only minor modifications. VandeKieft also discussed the election of new AAFP leadership: John Meigs, MD, FAAFP, moved from the presidency to AAFP Board chair; Michael Munger, MD, FAAFP, of Overland Park, KS, assumed the role of presidency; and John Cullen, MD, FAAFP, of Valdez, AK, was elected to the president-elect position. Others chosen or elected to AAFP positions during the 2017 Congress include:

- **Speaker of the Congress:** Alan Schwartzstein, MD, of Oregon, WI
- **Vice Speaker:** Russell Kohl, MD, of Stillwell, KS
- **Directors:** Sterling Ransone, MD, of Deltaville, VA; Windel Stracener, MD, of Richmond, IN; and Erica Swegler, MD, of Austin, TX
- **New physician Board member:** Benjamin "Frankie" Simmons III, MD, of Concord, ND
- **Resident Board member:** Alexa Mieses, MD, of Durham, NC
- **Student Board member:** John Heafner, MPH, of St. Louis

In addition to the Congress of Delegates report, the Board heard from WAFP's delegates to the Washington State Medical Association, June Bredin, MD, and Amber Farook, MD. WAFP's resolution on substance abuse disorder in jails and prisons will be brought forward to the WSMA House of Delegates, which was to be held Oct. 14 in Seattle.

Presentations were made from representatives of two of the state's medical schools. Jeff Haney, MD, clinical education director for family medicine at Elson S. Floyd College of Medicine, talked about the first month of classes at the new school. Paul James, MD, chair of the Department of Family Medicine at UWSOM, talked about the school's success at getting medical students into the family medicine pipeline.

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Board Wrapup continued

Another key action of the Board was the appointment of Bredin and Matthew Logalbo, MD, to the Board of the Washington FamilyMedPAC (FMP). The appointments are a key point in the reinvigoration efforts of the FMP and arise from the work of a task force appointed in February. The task force also recommended changing the FMP's Board from eight members to five members and to have all FMP Board members appointed by the WAFP Board. The recommendations will help the FMP move forward with fundraising and developing an effective voice for family medicine during the 2018 elections.

The WAFP Board and committees will meet again Feb. 3, 2018, at a location to be determined.

UW Law School to Study Impacts of the *Volk* Decision

The appropriations legislation passed over the summer includes funding dedicated to the University of Washington School of Law to convene a study on the state Supreme Court's decision in the *Volk v. DeMeerleer* case. The study is directed to see if the decision "substantially changed" the law on the duty of care for mental health providers and whether the decision has impacted access to mental health care services in the state.

UWSOL is also required to consult a number of groups, including WAFP. The school's report will include a review of similar laws in other states, the current voluntary and involuntary treatment capacity in Washington, an analysis of any related lawsuits and insurance claims, and whether the state's mental health workforce has changed as a result of the *Volk* decision.

The *Volk* decision holds that a number of providers, including primary care providers, could be held responsible for future actions taken by a patient with mental health issues. Those providers have a duty to warn, the decision held, any potential victim of violence, even those not specifically threatened.

The report must be submitted to appropriate committees of the legislature by Dec. 1.

Qualis Health Launches Quality Payment Program Resource Center

New QPP Tools and Resources Help Washington and Idaho Clinicians Successfully Participate in the Quality Payment Program (QPP)

Qualis Health has launched a Quality Payment Program (QPP) resource center featuring online tools and resources and a telephonic help desk. The resource center is a part of Qualis Health's work funded by the Centers for Medicare & Medicaid Services (CMS) to support thousands of Merit-based Incentive Payment System (MIPS)-eligible clinicians in Washington and Idaho as they prepare for and participate in the new QPP, established by the Medicare Access and CHIP Reauthorization Act of 2015 (MACRA).

The QPP online resource center is designed to be a comprehensive destination for all QPP needs. It includes a variety of helpful tools and resources, quick links to important QPP websites and information, and a curated list of upcoming QPP learning events. Featured Qualis Health QPP tools include:

- An interactive toolkit that dives into the details of the QPP and MIPS, providing a step-by-step process for success.
- The MIPS Minute video podcast series that features 11 brief episodes to help clinicians prepare for and understand the requirements of the QPP.
- An online readiness assessment that allows clinicians to determine where they stand in preparation for QPP participation.
- A MIPS calculator that estimates a practice's MIPS final score and offers valuable information to help the practice target quality measures and improvement activities.

"This significant change in the Medicare payment system can appear to be complex, and launching our resource center is an important step in our commitment to helping practices succeed. What's more, we are here to provide direct technical assistance for practices across Idaho and Washington," said Jonathan Sugarman, MD, MPH, president and CEO of Qualis Health. "For eligible clinicians, it's important to get started in the 2017 performance year, as it can have long-term impact in terms of potential incentives in future years."

The Qualis Health QPP Resource Center is funded by CMS and is coordinated locally with the region's leading provider associations, including the Washington Academy of Family Physicians, Washington State Hospital Association, Washington State Medical Association, Idaho Academy of Family Physicians, Idaho Hospital Association and Idaho Medical Association.

In addition to the QPP online resource center, Qualis Health also provides practices in Washington and Idaho with customized technical assistance that includes regular office hours and webinars, monthly program updates, strategic MIPS planning and access to a QPP help desk.

For a full list of technical assistance offerings, and to view tools and resources, visit the QPP online resource center at www.Medicare.QualisHealth.org/QPP. To contact Qualis Health's team of QPP experts, email QPP@qualishealth.org or call 877-560-2618.

The Countdown to the Quality Payment Program is On

October 2, 2017, is the last day to start a 90-day reporting period and March 31, 2018, is the deadline to attest. Qualis Health can help clinicians prepare for success with the Quality Payment Program. Below are three ways to prepare for success. Be sure to follow Qualis Health on Twitter (@QualisHealth) for QPP updates and #MIPSMondays, helpful MIPS Tips in a bite-size format.

- Visit the online resource center for helpful tools and resources.
- Attend an upcoming webinar.
- Email us directly with your questions.

Submit your Nomination for FPOY and FMEOY Today!

The WAFP is now accepting nominations for the 2018 Family Physician of the Year (FPOY) and 2018 Family Medicine Educator of the Year (FMEOY). Both awards will be presented at the 2018 WAFP Annual Meeting in Spokane on May 4.

Family Medicine Educator of the Year

Nominations for FMEOY are due Jan. 31, 2018. Nominees will be evaluated based upon the following:

- Recognized for exemplary teaching skills and outstanding progression of abilities over several years by medical students, residents or peers; or
- Developed and implemented innovative curriculum, teaching model(s) or program(s) in a variety of educational spheres; and
- Must be a current member of the WAFP/AAFP.

All candidates must be either a full-time or part-time family physician who holds a regular faculty appointment, and teach and practice exclusively in an academic setting. Candidates may also be a volunteer family physician who do not practice in an academic setting but engage in volunteer teaching activities.

Nominations must include a 2018 nomination form (available at http://bit.ly/2018FMEOY); a typed copy of the nominee's current curriculum vitae; and between three and five letters of recommendation. At least two of the letters of recommendation must be submitted from individuals who are current or former students/residents who have been taught by the nominee. Nominations should be emailed to info@wafp.net.

Family Physician of the Year

The Family Physician of the Year Award honors a physician who exemplifies, in the tradition of family medicine, a compassionate commitment to improving the health and well-being of people and communities throughout Washington.

Any WAFP member in good standing, with a few exceptions, is eligible for the award; current members of the WAFP Board of Directors and previous FPOY winners are not eligible. Previous nominees, if they have not won the award, are eligible. Likewise, any current WAFP member is welcome to submit a nomination.

Nominees should exemplify the ideals of family medicine, including providing comprehensive, compassionate services on a continuing basis to his/her community, and possessing personal qualities that make him/her a role model to professional colleagues.

Nominations must include a 2018 nomination form (available at http://bit.ly/2018FPOY); a current curriculum vitae; a head-and-shoulders photo of the nominee; and up to eight pages of supporting letters or documentation. Letters can come from colleagues or patients.

Nominations should be emailed to info@wafp.net.

Politics, Bias and Medicine: Worth a Re-Think?

MEGAN GUFFEY, MD, MPH, FAAFP

As physicians, we have been taught to put aside any bias or political affiliation we might harbor and try to keep it out of the exam room or from coming up with patients. We're taught to be objective, nonjudgmental and sensitive to the needs of our patients. But are we really doing this? And in the current health care climate, where patients have so much to lose, is this really the best policy?

First, let's address bias. We all possess some amount of bias, and it's probably just a matter of how much of it we are consciously aware of in our day-to-day interactions with others. Are we aware of it, and how do we deal with it? Do we overcompensate with someone we know we might be predisposed to have a bias against, and if so, is that good or bad? How can our brains be trained to recognize our own internal biases and then outsmart them? Is there "good" bias? How might this be impacting our relationships with our patients?

In 2016, a small study was published in the Proceedings of the National Academy of Sciences[1] trying to understand if political affiliation spilled over into the exam room. They surmised that this was indeed happening as physicians who were identified as Republicans were more likely to counsel about the harms of abortions and marijuana use. Those who were identified as Democrats were more concerned with firearm safety in homes with small children.

Now, this isn't meant as an indictment, but I write about it here just so each of us has the chance to look at our own practices and analyze our thoughts, behaviors, body language and medical decisions. Do patients of all races or genders get treated the same, and does your own personal data bear that out? Certainly nationally, it does not. Health care disparities and racial inequality of health outcomes are some of the dirty little secrets in medicine.

So there's a problem. Bias is real; we are not as objective and non-judgmental as we think. So, this leads to our second key question: As long as we know we must look for and counteract the negative aspects of bias, must we also strain to keep all personal perspective and bias out of the exam room? If the bad gets in, should we make room for the good too?

Some of us may have a bias that healthcare is a human right. Or that access to automatic and semi-automatic weapons need more regulation. Or that reproductive rights are human rights. Or that a patient's right to die goes against our oath as physicians and healers. Some of us do not. Where is the line between patient education of evidence-based literature on any of these topics and political bias?

The last few months have seen a dramatic and nationwide fight over health care. When Americans were faced with the very real possibility of losing access to health care, they were far more in favor of keeping the Affordable Care Act and improving it, rather than repealing it completely.[2] We physicians, especially family physicians, are on the front lines of health care. We know the potential of greater access to health care — the lower costs, the improved outcomes — and we should not be shy in sharing that knowledge with patients. Other sources of information, namely the media, lack access to this knowledge and experience; reporters work in newsrooms, not the clinic.

In the wake of yet another mass shooting in the United States, where dozens of lives were needlessly taken and hundreds more wounded, we as physicians have the opportunity and the obligation to discuss gun safety with our patients. We know the evidence, and we can translate the scientific literature. We cannot leave it to the media; we know our patients. The media doesn't.

And in an era in which the availability of birth control has again come up for debate and may not be universally granted via health insurance, where are the conversations about the attacks on women's health? The right to control one's own body is enshrined in both domestic and international human rights policy, and yet it seems there are some who would turn back the hands of time to force women to be slaves to their biology.

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The Starfish & The Family Doctor

JIE CASEY, DO
WAFP ALTERNATE RESIDENT TRUSTEE, ELLENSBURG

The health, and health care, of our country is a complex issue. During these tumultuous and divisive times, you'd have a hard time finding someone without a strong opinion — informed or otherwise — on how to best address the issues at hand. The questions and the answers are so complex that even as physicians, finding solutions sometimes seems an insurmountable task. It often reminds me of the parable of the boy who came upon a beach covered in thousands of starfish that had washed ashore. He looked at the sight before him then began throwing them back one by one. A man happened upon him and remarked, "There are thousands of them, how will you ever make a difference?" The boy bent down, picked up a starfish and threw it back into the sea. He looked at the man with a smile and said, "I made a difference to that one."

I can identify with both the man and the boy on a daily basis when dealing with many of the issues we as family physicians face — chronic pain, diabetes and especially opioid addiction. I am both overwhelmed at the enormity of the problem while still willing to make a difference one patient at a time.

One of the greatest privileges I think we have as family doctors is the ability to touch people's lives deeply and in a lasting and meaningful way. We are able to do this for one very simple reason: continuity. It is the cornerstone of our brand of medicine and, over time, we actually become an indelible part of our patients' lives. That allows us a level of trust and insight that specialists who see them on a more limited basis for a narrow complaint won't likely experience. Regardless of how narrow or broad our practice is, we family doctors are privileged — and undeniably challenged — to serve the broadest need in our communities as a function of the scope of our training. A friend of mine who focuses on wound care still approaches the patient from a more holistic mindset regarding multiple physiologic and anatomic systems in her interventions because she is a family physician. When practicing hospital medicine, it is the family doctor, I find, who takes into account the patient's home life, financial and even spiritual and emotional well-being. With that intimate and trusted role comes tremendous responsibility to be community role models and contributors beyond the four walls of our exam rooms.

I chose rural medicine because I recognized it as the last bastion of true, full-spectrum family medicine; the quintessence of what I had imagined a doctor might be since I was a child. That image was reinforced time and again as my journeys through clerkship, subinternship and residency have taken me to small towns around this country. I heard stories and saw examples of doctors whose lives are so inextricably intertwined with their communities it was impossible to imagine one without the other. I am currently on an elective away rotation in Colville with a doctor who is an inspiration and a role model to me. Besides the routine clinical responsibilities, I am reminded daily that medicine is so much more than what was taught in school or tested on a board exam; it's about the human experience. This physician helped establish the presence of an FQHC in a town without a safety net. In addition to full-scope family medicine with surgical obstetrics, he is the largest provider of Suboxone MAT and the only provider of vasectomies and treatment for hepatitis C in the area. Beyond the confines of his clinic he and his wife, a teacher, have devoted themselves to their community. They purchased and donated an Oxford House as a sober and safe form of transitional housing and he continues to serve as the maintenance man – something he considers a privilege. On Friday nights, his wife prepares dinner and they invite a group of single and widowed veterans to break bread at their table. Any guests staying in the bicycle hostel they built on their property are welcome too. Currently, they are involved

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Resident Column continued

in a project to build a tiny home village to provide homes to the homeless. His story is beyond inspiring; it's astonishing.

That is the kind of doctor and human I aspire to be, but the challenge is intimidating — as intimidating as the myriad problems in our health care system. Need is everywhere, and so opportunity is everywhere. As physicians, we have the ability and the occasion to bring about change, and so we are obliged. We already play a tremendous role in solving health care issues through providing access and by treating the broadest patient population. We strive to promote preventive health care rather than reactive disease care. This is our charge and, despite being overburdened and underequipped, we rise to the challenge on a daily basis. I am asking you to give more. To add one more way of giving back that you are uniquely qualified for as a physician. Become active in advocacy for your profession through your specialty college or state society. Be a visible role model in your community through continued volunteerism, teaching or organizing wellness events at your child's school. Run for local office. Call your elected representatives and tell them to keep funding teaching health centers and fund more residency programs. I am asking you to gaze upon the endless starfish on the beach before you and muster the energy to pick up one more. Because, in the end, it will make all the difference.

New Physician Trustee Column continued

Again, we as physicians are uniquely positioned to help patients understand the medical benefits of spaced birthing and contraception. We can help directly, rather than relying on a media messenger.

This all represents a larger conversation about the physician-patient relationship. Are their topics that are "off limits," or is everything game, based on timing and context? What are our responsibilities as physicians to educate patients on topics related to health policy inasmuch as it impacts their health or that of their families and loved ones? We don't always have the answers, but I think it's important we continue to ask ourselves these questions.

1. http://www.pnas.org/content/113/42/11811.full?sid=3766a40a-c84f-44d2-9ba1-45697b2caa69
2. https://www.kff.org/interactive/kaiser-health-tracking-poll-the-publics-views-on-the-aca/#?response=Favorable--Unfavorable&aRange=all

PALI to be Held Jan. 24 in Olympia

WAFP's annual advocacy event, the Policy and Advocacy Leadership Institute – Family Physician Day at the Capitol, will be held Jan. 24, 2018, at the Capitol complex in Olympia.

The event, typically held during the first legislative session, represents a chance for WAFP members to meet with their elected representatives to discuss members of importance to family physicians. The event also typically begins at 8 a.m. and ends around 5 p.m.

During the morning session, attendees hear from advocacy experts, legislators and other officials on relevant topics. A working lunch is used for discussion about current Academy priorities and to answer questions. Legislative appointments are scheduled between 1:30 p.m. and 5 p.m., so participants must keep this time available.

Though free of charge, the event is open only to WAFP members. Registration is required, and the online form is located at http://bit.ly/WAFP_PALI. Registrations must be received by Jan. 12, 2018.

WAFP Welcomes the following New Members from June, July and August:

Active Members

Carly Allen, DO — Tacoma
Jinlin Brendel, DO — Port Angeles
Bradley Cook, MD — Spokane Valley
Arie Dadush, MD — Seattle
Cecilia Dinh, DO — Auburn
Wendy Dryden, MD — Spokane
Pawel Dutkiewicz, MD — South Bend
Mark Flynn, MD, FAAFP — Everett
Manroop Gill, MD — Colbert
Jeffrey Haney, MD — Spokane
David Hudon, DO, MS — Spokane
Shane Jhooty, MD — Seattle
Gayle Johnston, DO — Hermiston, OR
Kunal Joshi, MD — Seattle
Craig Karr, DO — Bremerton
Kyung Lee, MD — Renton
Mark Liu, DO, FAAFP — Seattle
Luis Manriquez, MD — Deer Park
Charles McCormick, MD — Wenatchee
James Merchant, DO — Tacoma
Vanessa Nicholson, MD — Mukilteo
Damilola Oluyitan, MD — Bothell
Helena Orbach, MD — Seattle
Rakshit Patnana, MD — Tacoma
Aaron Reinke, MD — Newport
Tessa Reinke, MD — Newport
Aaron Rhyner, DO — Tacoma
Amelia Sandoe, MD, MPH — Seattle
Karlyn Smoak, DO — Spokane
Nicholas Strasser, DO — Spokane
Heidi Terrio, MD, MPH — Steilacoom
Dinh Tran, MD — Renton
Claudia Tussey, MD — Seattle
Joy Welty, MD — Bellingham
Benjamin Wilson, MD — Yakima
Yang Ye, MD — Camas

Residents

Raymond Aguliar, MD — Marysville
Carly Allen, DO — Tacoma
Zeena Al-Tai, MBBS — Mill Creek
Dustin Brown, DO — Yakima
Bonnie Brown, MD — Seattle
Dustin Cheney, DO — Kennewick
Paige Cummings-Johnson, DO — Port Orchard
Keith Goodman, DO — Pasco
Alissa Goodwin, MD — Richland
Arthur Gorham, DO — Tacoma
Jake Harvey, MD — Richland
Benjamin Keggi, DO — Yakima
John Loomis, MD — Tacoma
Tiffany Mark, MD — Yakima
Arash Mizaie, MD — Bellevue
Mua Ngo, DO — Puyallup
Tuyen Nhan, DO — Seattle
Leonel Oliveros-Rosen, MD — Lynnwood
Cris Perez, DO — Puyallup
Bryan Rhodes, DO — Tacoma
Joel Roberts, MD — Yakima
Micia Roby, DO — Seattle
Stanley Sachak, MD — Kennewick
Aubrey Siegel, DO — Puyallup
Julia Stella, MD — Seattle
Kyle Thomas, MD — Richland
Jayme Thompson, DO — Selah
Puzant Topaljekian, MD — Yakima
Zachary Valadez, MD — Yakima
Ayesha Venkateswaran, MD — Olympia
Sara Wagner, DO — Tacoma
Tad White, DO — Grandview

Students

Gifti Abbo — Spokane
Drew Anderson — Spokane
Brittany Bergam — Spokane
Rebecca Bolla — Yakima
Alicia Burns — Spokane Valley
Vikram Chandra — Spokane
Christine Chen — Spokane
Sonya Chen — Bellevue
Ethan Coffey — Spokane
Emily Cooper — Spokane
Sara Couch — Yakima
Robert Eagle — Spokane
Kyle Ellingsen — Spokane
Michaela Fallon — Spokane
Stephen Ferraro — Spokane
Kelcie Foshag — Great Falls, MT
Demi Galindo — Spokane
Alaina George — Lake Tapps
Cody Gibbons — Spokane
Harminder Gill — Kirkland
James Gillespie — Edmonds
Hadley Gunnell — Spokane
Caitlin Hardin — Great Falls, MT
Blake Henley — Spokane
Kelly Hennessey — Port Angeles
Erin Hixson — Federal Way
Caleb Hood — Spokane
Brett Hulbert — Yakima
Samyon Itzhakov — Nampa, ID
Heather Johns — Spokane
Samuel Josephsen — Spokane
Alexa Kerr — Spokane
Hannah Lampert — Spokane
Rick LeCheminant — Nampa, ID
Peter Loffler — Spokane
Kristine Madsen — Vancouver
Nathan Maris — Spokane
Samantha May — Aberdeen
William Mellor — Colfax
Anna Milliren — Anchorage, AK
Heather Molvik — Spokane
Shahin Mortazavi — Spokane
Lincoln Mosier — Richland
Rahmi Nemri — Spokane
Anndres Olson — Spokane
Kaylee Park — Edmonds
Christopher Phillips — Spokane
Sara Phillips — Spokane
Shawn Poole — Battle Ground
Anthony Recidoro — Anchorage, AK
Eric Reid — Great Falls MT
Courtney Roberts — Spokane
Massoud Saleki — Spokane
Katie Schmidt — Spokane
Homa Shaarbaf — Liberty Lake
Rebecca Sharar — Bainbridge Island
Lane Shish — Spokane
Noah Smith — Spokane
Greta Steeber — Leavenworth
Jordan Takasungi — Spokane
John Wampach — Seattle
Shaman Whitson — Pasco
Hans Wilhelm — Anchorage, AK
Taylor Woo-Sekizaki — Spokane
David Wu — Spokane
Bang Zheng — Spokane
Zhen Zhu — Spokane

Supportive Members

Mary Shepard, MD — Portland, OR

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UPCOMING EVENTS

AAFP State Legislative Conference
Nov. 2-4, 2017 – Dallas, TX

Student & Resident Retreat
Jan. 4-5, 2018 – Leavenworth, WA

2018 Policy and Advocacy Leadership Institute (PALI)
Jan. 24, 2018 – Olympia

19th Annual Winter CME Conference
(Hosted by Inland Northwest Chapter)
Feb. 2-3, 2018 – TBD

WAFP Board and Committee Meetings
Feb. 3, 2018 – SeaTac

AAFP Annual Chapter Leader Forum & National Conference of Constituency Leaders
April 26-28, 2018 – Kansas City, MO

61st Annual House of Delegates
May 3, 2018 – Spokane

69th Annual Scientific Assembly
May 4-5, 2018 – Spokane

Family Medicine Advocacy Summit
May 21-22, 2018 – Washington, DC

National Conference of Family Medicine Residents and Students (NCFMRS)
Aug. 2-4, 2018, Kansas City, MO