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Washington Family Physician

THE JOURNAL OF THE WASHINGTON ACADEMY OF FAMILY PHYSICIANS

IN THIS ISSUE:

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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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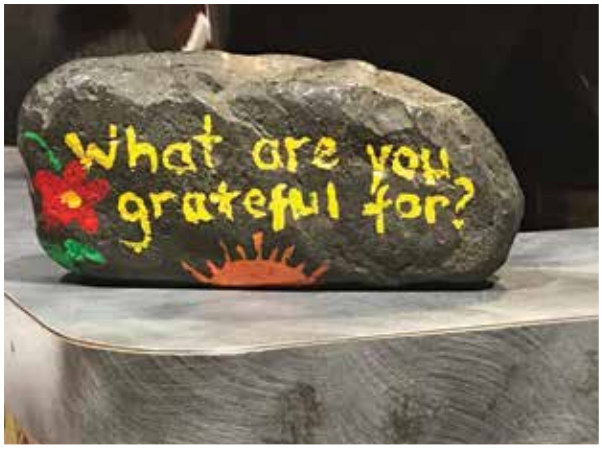
On Gratitude

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

There is so much attention focused on physician burnout these days. Everywhere we look there are suggestions, programs, articles, speeches, books, websites and consultants offering words of wisdom, ways to change our thinking and perspective, and develop resiliency. Every meeting I have been to this year in a number of states has devoted time to this topic. But all of these options require effort and time in an already crowded space. And if we don't follow the program as presented, will it be effective?

I decided to find the suggestion that seemed to require the least amount of work and give it a go. One frequently mentioned option is the practice of gratitude: The more one thinks about what one has to be grateful about, the more grateful one becomes, and the more positive impact this has on your thoughts and deeds. Even thought leaders such as the Studer Group — the organizational culture and leadership consultants and winners of the Malcolm Baldridge National Quality Award — promote this concept, so there must be something to it! (See reference note below.)



The standard program involves reflecting at the end of the day on three good things that happened and writing them down in a journal for at least two weeks. But this, for me, is too much work; at the end of the day, I am exhausted and can't think. So I modified the program to include no writing and doing this in the morning when I wake up before getting out of bed, in reference to the day before.

The first few days were surprisingly tough. I lay there a long time before I could remember anything to be grateful for that first day. I had to start small. I was grateful that there was a day to wake up to. That I could still see that day. That I had made it through that day before at work. Gradually, it became easier to find things to be grateful for, it took less time, and I started to have some of those grateful moments during the day, at work. And eventually, the words of Buddha began to make sense: "Let us rise up and be thankful, for if we didn't learn a lot today, at least we learned a little, and if we didn't learn a little, at least we didn't get sick, and if we got sick at least we didn't die; so, let us all be thankful." There is always something to be grateful for, and there is always a pristine moment worth treasuring in every day, if we are willing to be open to seeing it.

And so my little experiment would seem to have succeeded. It's been a few months, and I am still finding my three things to be grateful for every morning. And during really tough moments in the day, sometimes I will re-remember them. I'm reminded that whatever is going on now is not everything in my life. There is a balance.

But what about the bigger picture? Is there a role for gratitude in, for example, how we work together in serving our patients? Or in family medicine within our organization and within the industry? I decided to try the same exercise

continued on next page

with this bigger focus. Here is what came to mind:

I am grateful that we can voice disagreement, because without disagreement there is no progress;

I am grateful that we have our own perspectives, because putting ourselves in each other's shoes leads to understanding;

And I am grateful that we have choice, because we can choose to collaborate and open ourselves to a broader range of solutions.

For me, that creates a different platform from which to advocate and move forward. It supports our goals of celebrating our diversity and working together on what we have in common as we implement our strategic plan. And it gives us a way to approach the unexpected that we face in these chaotic times.

I hope that you will consider an exercise in gratitude. Whatever, however you choose, you will receive more than you give.

"Gratitude can transform common days into thanksgivings, turn routine jobs into joy and change ordinary opportunities into blessings."

-William Arthur Ward

Reference:

How Gratitude Can Reignite Your Passion. Rich Bluni, RN. Studer Group website, accessed Nov. 3, 2017. https://www.studergroup.com/resources/articles-and-industry-updates/insights/june-2012/how-gratitude-can-reignite-your-passion

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.


Preparing for the 2018 Legislative Session

JONATHAN AND PATRICIA SEIB
WAFP ADVOCACY CONSULTANTS, OLYMPIA

The 2018 legislative session got underway on Monday, Jan. 8. Our state constitution limits this even-year regular session to no more than 60 days, while allowing as always the calling of an unlimited number of "special sessions." Perhaps even more so than in most years, a dynamic political and policy environment — and a significant number of uncertainties — make the outcome of this year's legislature and its impact on family physicians difficult to predict. Nonetheless, some thoughts on what we are expecting:

The most obvious factor shaping this session is the November election of Democrat Manka Dhingra to the State Senate in the 45th District east of Seattle, resulting in a rare mid-biennium switch of the Senate majority. Among other things, this means that Senate standing committees, where the fate of legislation is often determined, will now be chaired by Democrats. It also marks the first time since Gov. Jay Inslee took office that the Democrats will control both chambers of the legislature and the governor's office. This has some anticipating a flood of activity as legislation previously backlogged in the Senate now finds its way to the governor's desk. That's very likely to happen on a few high-profile issues like contraceptive coverage and voting rights; we'd otherwise suggest these expectations be tempered. For one, the new majority seems to be taking very seriously the idea that with complete control, they will be harshly judged if they don't get done and get out of Olympia on time — and there is only so much that can be accomplished in 60 days. That 2018 is an election year, with the partisan balance in both the House and Senate still very close, is also likely to bring more caution than might otherwise be the case.

Also hanging over the 2018 legislature will be unfinished business from 2017. Most notable is that lawmakers left town last July having failed to pass the state's 2017-2019 capital budget, which funds major infrastructure and other construction projects. That failure is tied by politics to its failure to reach agreement on separate water rights legislation. The Supreme Court also ruled this fall that the legislature was still moving too slowly in addressing the state's obligations to basic education under *McCleary*. This may have lawmakers searching for approximately $1 billion more to spend on schools this biennium — money they thought would not be required until later. While such funding searches can always put health care programs at risks (and the capital budget has some direct impact on health care) the more significant question for 2018 is the extent to which the legislature's preoccupation with these three items will keep it from taking up other issues.

Bringing further uncertainly to the 2018 legislature is what might be done, or not done, in Washington, DC, to which the state will need immediately respond. As of this writing, open questions remain at the federal level about the future of Medicaid, the Affordable Care Act, the Children's Health Insurance Program and Community Health Clinics. Typically, the state's short, even-year legislative sessions deal only with a "supplemental budget" intended to make relatively minor adjustments to the underlying biennial budget adopted in the previous year. With *McCleary* and other factors already threatening to make the 2018 session atypical, gaps in any of these major health care programs resulting from actions in the nation's capital will bring significantly greater challenges to the state capital. This is something that we'll be watching closely for the Academy given its potential to dramatically affect family physicians and their patients.

Another factor with potential to shape the 2018 session as it effects family physicians and their patients is the recent and substantial change in leadership at the state Health Care Authority (HCA), the state agency responsible for the Medicaid program and public employee health benefits. Since the conclusion of the 2017 session, the HCA has brought on board a new director, a new policy chief and a new chief financial officer. Yet to be seen is what changes, if any, they will

continued on next page

bring to the HCA's approach and policies. This includes the components of Healthier Washington, such as accountable communities of health and their Medicaid transformation projects. How the legislature reacts to and works with this new leadership and the changes they bring is also something to keep an eye on beginning with the 2018 session.

Within this general environment, our role for the Washington Academy of Family Physicians remains largely unchanged from years past: working with your Government Affairs Committee and other Academy leadership, reviewing legislation for its potential to uniquely impact family physicians or your patients, and helping design and implement an advocacy strategy making best use of Academy resources, including its members, to support or oppose that legislation. In addition to those already mentioned, some of the issues we expect to weigh in on this year include:

- **Opioids.** The legislature is likely to consider both the enhancement of public programs to treat those with addictions and prevent addiction in the first place. The challenge will be to assure these efforts are coordinated statewide, are evidence-based, and do not unreasonably burden family physicians or interfere with their ability to appropriately treat patients.
- **Tobacco products.** WAFP has previously supported legislation brought by the Attorney General to raise the age at which a person in the state may purchase cigarettes and other tobacco products from 18 to 21. The legislation failed but will be back in 2018. This is an issue where the change in the Senate majority may make a difference.
- **Physician liability.** A focus last session was on a legislative remedy to our State Supreme Court's decision in *Volk v. DeMeerleer* regarding the duty to warn attached to treating patients with mental health conditions. This led to a formal interim study by the UW School of Law, the results of which suggest that further consideration by the legislature is merited.

We'll conclude by reminding you, as we have many times before, that as WAFP representatives in Olympia, we can speak for you but we cannot speak as you. Legislators are most attentive and responsive to the concerns of family physicians when they hear directly from you telling them how what they are considering will affect your practice and your patients — their constituents. We'll do our best to help keep you informed, and we strongly encourage your ongoing involvement in WAFP's advocacy efforts.

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WAFP 2018 Legislative Agenda

During the 2018 Legislative session, the Washington Academy of Family Physicians will:

Support legislation acknowledging the central role of primary care in the physical and mental health of Washington residents, and making it easier to maintain such a practice, including any to:

- Match the increased expectations of family physicians under Healthier Washington with increased reimbursement.
- Provide family physicians with the resources and expertise needed to transform their practices to deliver integrated, patient-centered care.
- Reduce the legal, administrative, and tax burden imposed on family physicians.

Support legislation improving Washington residents' access to high quality primary care services, including any to:

- Maintain or improve the health care coverage provided under the Children's Health Insurance Program and the Affordable Care Act.
- Help sustain Community Health Centers and Teaching Health Centers.
- Further allow and encourage the use of telemedicine.
- Create incentives for medical school students to go into primary care.
- Increase Graduate Medical Education funding for family medicine residencies.
- Restrict the use by hospitals and health systems of unreasonable non-compete agreements.

Support legislation addressing social determinants of health and strengthening the public health system, including any to:

- Sufficiently fund core public health services.
- Promote health equity and protect the well-being and civil rights of all residents.
- Tackle the opioid epidemic in a thoughtful, balanced, and evidence-based fashion.
- Provide meaningful housing options for the homeless and near-homeless.
- Reduce the number of people who use tobacco and nicotine products (smoke, smokeless, vape, etc).

Oppose legislation diminishing the role of or reducing access to family physicians, or making it harder to maintain such a practice, including any to:

- Impose inappropriate new programs or requirements on family physicians.
- Mandate additional training or continuing education.
- Reduce quality or increase risks to patients receiving care.
- Impose additional unfunded responsibilities on family physicians under Medicaid.
- Reduce funding to crucial safety net health care programs.

WAFP Delegation Report, 2017 AAFP Congress of Delegates




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The 2017 AAFP Congress of Delegate (COD) met in San Antonio from Sept. 11-13, just prior to the 70th annual Family Medicine Experience (or FMX, previously known as the AAFP Scientific Assembly). The Congress, comprised of 119 voting members, is the AAFP's policy-making body and elects of the AAFP Board of Directors and Officers. The COD addresses a broad range of clinical, public policy and financial issues affecting family doctors and our patients.

Washington was represented at the Congress of Delegates by delegates Jonathan Sugarman, MD, MPH (Seattle) and Russell Maier, MD (Yakima) along with alternate delegates Gregg VandeKieft, MD, MA (Olympia) and Tony Butruille, MD (Leavenworth).

WAFP officers attending the COD included WAFP President Lydia Bartholomew, MD, MHA, and President-Elect Jeremia Bernhardt, MD. They were joined by other WAFP members including Drs. Lucinda Grande, Kevin Wang and Lillian Wu and WAFP Executive Vice President Karla Graue Pratt. In addition to fulfilling his many obligations as an AAFP Director, Carl Olden, MD (Yakima) joined the WAFP delegation on a number of occasions during the COD.

The Delegation was pleased to see the AAFP's follow-up on the 2016 resolutions offered by the WAFP and adopted by the COD. For instance, the new policy statements on prior authorizations, support for independent practice, and oral health education and advocacy — directed by our resolutions last year — were approved by the AAFP Board in April and July.

Two resolutions passed by the 2017 WAFP House of Delegates were taken to to the AAFP Congress. One was adopted as presented and the other in a slightly modified form. Outcomes for the resolutions were as follows:

1. Support Housing Access for All: Adopted

The resolution on Housing First approaches read as follows:

> RESOLVED, That the American Academy of Family Physicians advocate for policies supporting "Housing First" approaches (such as permanent housing with community-based, integrated treatment, rehabilitation and support services), including for policies that encourage Medicaid agencies and Medicaid health plans to use funds for such approaches.

Nearly all the testimony supported the resolution, and the COD concurred with the reference committee's recommendation that it be adopted without modification.

2. Treating Substance Use Disorder in Jails and Prisons

The testimony presented to the reference committee supported the resolution. Dr. Grande (a WAFP member who co-authored the Thurston-Mason-Lewis chapter resolution that became the WAFP resolution) offered a modification based on a resolution that was also submitted to the Washington State Medical Association in the hope that it will become American Medical Association policy as well. The reference committee recommended a substitute resolution, the text of which follows, that preserved the intent of the resolution passed by the WAFP House of Delegates.

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Good Policy Starts With a Good Resolution

Most members are aware that a major function of the Academy is to define policy which helps guide family physicians and drives the Academy's agenda and allocation of resources. What many may not know is the process by which policies are developed, or that a major policy decision may evolve as a single idea from an ordinary, but inspired, WAFP member. Those single ideas are first molded into a resolution.

What is a resolution?

A resolution is a specifically structured proposal asking the WAFP to take a position or act on an important issue. In their final forms, resolutions are presented to the House of Delegates at the WAFP annual meeting, debated — possibly revised — and voted on by the House of Delegates to become part of WAFP's policy and work plan. The key to a resolution's success however, is how well it presents ideas and defines Academy action to be taken.

How to write a resolution

Before authoring a resolution, first research the resolutions archive posted on the Academy website (http://bit.ly/wafpresolutions) to determine if the issue has already been presented. Current policy may exist which addresses the issue in question, negating the need for duplicate resolutions.

Next, to help clarify the mission and scope of a resolution, carefully consider the following:

- What is the purpose of the resolution?
- Is the depth and breadth of the problem evident and clearly understood?
- Is the issue of unique interest to family medicine in Washington?
- How will the resolution benefit family physicians and their patients?
- Is the resolution consistent with the mission and priorities of the WAFP?
- Is the resolution timely? Does it accurately reflect current law and circumstance? Does it anticipate a longer-term WAFP commitment?
- Does the resolution allow flexibility for the Academy to achieve the intended purpose, i.e. to either pursue alliances, administrative action or legislative initiatives?

Resolutions which will require a substantial allocation of WAFP resources (money or staff time) should include a fiscal note. WAFP staff will be happy to help you develop an appropriate fiscal note.

Resolution Format

Resolutions have a specific format and should include the following elements:

- A title, concisely reflecting the action for which the resolution calls
- An author
- Whereas clauses
- Resolved clauses
- A fiscal note (if applicable)

Whereas clauses should carry a message and develop a set of statements that requires a solution. Essentially, the whereas clauses should paint a picture of why the topic should be addressed. Whereas clauses will not be voted upon. Instead, they offer an explanation and the rationale of the resolution.

Collect relevant facts to form the basis of the Whereas section of the resolution. Whereas clauses should be succinct — no more than one sentence long — and include only a few of these facts as their purpose is to outline a problem, not to provide an exhaustive discussion. Statements of fact should be footnoted, in which case the resolution should followed by citations in a reference section in APA style.

Resolved clauses should address what the Academy should do or what position the WAFP should take on the identified topic. They may ask that WAFP representatives to other bodies, such as WSMA or AAFP, take resolutions forward however, they should NOT ask for action by specific committees or task forces by groups other than the WAFP.

Resolved clauses should be simple and direct. Only one issue should be addressed in each resolved clause. It is important to note that resolved clauses must make sense as standalone statements. If a resolution is adopted, **only the Resolve clauses remain and become WAFP policy**.

Sample resolutions are posted on the WAFP website under "writing a resolution," (http://bit.ly/writearesolution) showing both good and poor examples.

continued on next page

AAFO Delegate Report continued

RESOLVED, That the American Academy of Family Physicians advocate for legislation, standards, policies and funding that increase access to evidence-based treatment of opioid use disorder, including initiation and continuation of medication assisted treatment, in correctional facilities, within the United States, and be it further

RESOLVED, That the American Academy of Family Physicians advocate for legislation, standards, policies and funding that encourage correctional facilities within the United States to work in ongoing collaboration with addiction treatment providers, case managers, social workers, and pharmacies in the communities where patients are released to offer post-incarceration treatment plans for opioid use disorder, including education, medication for addiction treatment, and medication for preventing overdose deaths, and be it further

RESOLVED, That the American Academy of Family Physicians update its position statement "Incarceration and Health: A Family Medicine Perspective" to include utilization of medication assisted treatment as an evidence-based best practice for inmates with opioid use disorder.

The resolution was adopted without dissent by the COD.

The complete summary of the proceedings of the 2017 COD can be accessed at www.aafp.org/content/dam/AAFP/documents/about_us/congress/restricted/2017/SummaryofActions2017.pdf.

Dr. Michael Munger (Kansas), assumed the presidency of the AAFP. The Congress elected Dr. John Cullen (Alaska) as the Academy's president-elect.

Three new directors — Dr. Sterling Ransone, Jr. (Virginia), Dr. Windel Stracener (Indiana) and Dr. Erica Swegler (Texas) — were elected to three-year Board terms. Dr. Alan Schwartzstein (Wisconsin) was elected Speaker, and Dr. Russell Kohl (Oklahoma) was elected Vice-Speaker.

Thank you for the privilege of representing Washington State at the AAFP. Washington continues to be one of the most active, effective and highly respected AAFP state chapters in the nation.

HOD continued

Who can author a resolutions?

Resolutions to the HOD usually come from local chapters. If you have an idea for policy or a project for the WAFP, check the WAFP website or contact your local chapter president to find out when your local chapter will meet to consider resolutions to forward to the House of Delegates. Other resolutions come from WAFP Committees. Individuals may submit resolutions to the House of Delegates, however, this requires that two members sign on to the resolution.

Resolutions are submitted directly to the WAFP office. They are reviewed for content and proper formatting by the Speaker of the House before being published in the House of Delegates manual. The deadline for submission is 60 days prior to the annual House of Delegates meeting (March 4, 2018) to be included in the House of Delegates manual. Resolutions received after the deadline will have to be introduced as late resolutions and presented for acceptance on the floor of the House of Delegates. (Late resolutions are discouraged and should be limited to issues that were not knowable in time to be prepared in advance AND that require action by the House in the current year, as opposed to waiting for the following year.)

You may be asked to supply some additional information in support of your resolution in order to assist the House of Delegates in its deliberations. WAFP staff will assist with any further questions that may apply to a resolution.

Why should you make the effort?

Participating in the policy making process is a powerful benefit of WAFP membership. Resolutions not only help to guide the policy decisions of the Academy but can also raise awareness of issues of importance to the practice of medicine and caring for patients in our state. Reference committee debate over a resolution can reveal and enlighten both sides of an issue, and strengthen a resolution's chance to become Academy policy. A resolution may also make its way through the House of Delegates and be carried the AAFP Congress of Delegates to potentially become policy at the national level.

Authoring a resolution is also an excellent way to get involved in the Academy and enjoy the satisfaction of being a change agent for the improved health of Washington citizens and of health care in our state.

Opioid Crisis Takes Center Stage in Legislature, State Government

Between current laws taking effect and proposed legislation in the Washington Legislature, the opioid crisis will be the primary focus of a significant portion of the state government.

The Department of Health's ESHB 1427 implementation continues, and the statewide tour of meetings to develop draft rules for comprehensive opioid prescribing is nearly complete. The final meeting will be held at the state Labor and Industries Department in Tumwater on March 14.

In the nascent legislative session, no fewer than nine bills relate directly to opioids; and, in a sign of the focus of lawmakers, nearly half of both the Senate and the House is cosponsoring at least one opioid-related bill. Reps. Beth Doglio (D-Olympia) and Nicole Macri (D-Seattle) each have cosponsored five bills.

A look at each of the new bills under consideration this session:

- S.B. 6150 and H.B. 2489 would direct the Department of Health to promote medication therapies and other evidence-based strategies to combat the opioid epidemic; it would also ask the DOH to partner with other agencies to develop an approach to using Medicaid funding to treat opioid addiction.
- H.B. 2390 establishes protocols for opioid overdose medications at primary and secondary educational institutions.
- H.B. 2447 would require practitioners to discuss risks and alternatives to opiates prior to a patient's first prescription for opiates.
- S.B. 6050 and H.B. 2272 would place limits on opioid prescriptions: a three-day supply for anyone under 21 or a seven-day supply for those over 21, except in cases of cancer and end-of-life care. The proposal also imposes mandates on practitioners who issue a prescription for more than a three-day supply.

Several other bills — S.B. 5839 on repealing a tax to use in combating opioids in high-need areas; S.B. 5811 on expanding involuntary treatment to combat heroin abuse; S.B. 5248 on PMP access; and H.B. 1505 on establishing a naloxone access grant program — are holdovers from the 2017 legislative session.

Medical Student and Resident Retreat Held in Leavenworth

The WAFP Foundation hosted more than 110 registrants at Icicle Village Resort in Leavenworth for the 2018 Medical Student and Resident Retreat on Jan. 6 and 7.

Attendees took advantage of 14 workshops that covered a range of topics: chronic pain; a basic osteopathic session for MD students and an advanced session for DO students; family medicine advising; harm reduction; transgender health; residencies and clerkships; addiction medicine; casting; OB procedures; IUDs; derm procedures; palliative care and hospice; and contracts and resumes.

Several faculty members also participated in a panel on finding passion in family medicine. Questions were provided by the attendees. The panel was followed by a meet-and-greet with residencies represented at the retreat and a social hour.

Sunday's keynote presentation was delivered by Darcy Constans, MD, of Seattle, who spoke on mindfulness.

Feedback on this year's event has been almost universally positive.

61st WAFP House of Delegates

Help shape the direction of your Academy! Join us for the 2018 House of Delegates meeting on May 3 in Spokane. Delegates can weigh in on proposed resolutions (including potential changes to WAFP bylaws) and elect the Board of Directors that will serve until the 2019 House of Delegates meeting. To be considered as a delegate, return the form below to WAFP. If your local chapter elects delegates, WAFP will pass your information along to your local chapter leadership for consideration.

Name _____ Degree _____

Address _____

City _____ State WA Zip _____

Local Chapter (Reminder: Residents and medical students have their own chapters.) _____

Email _____

Demystifying Year Two of the Quality Payment Program: Seven Steps to Success in MIPS

On November 2, 2017, the MACRA Final Rule was published by the Centers for Medicare & Medicaid Services (CMS) to outline the second year of the Quality Payment Program. There have been several key changes for the 2018 performance year that may affect your organization. This article is intended to be an overview of the Merit-based Incentive Payment System (MIPS). We'll review some of the major changes to MIPS and outline some steps you can take in order to ensure that you are positioned to meet your quality improvement goals and to increase your Medicare Part B payments for the 2020 payment year.

Step One: Determine if you are a MIPS eligible clinician

If you were a MIPS-eligible clinician in the 2017 transition year, you'll still want to check your status in 2018. For the 2018 performance year the low-volume threshold has increased. In order to be eligible to participate in MIPS, clinicians must receive more than $90,000 per year in Medicare Part B payments and provide care for more than 200 Medicare patients a year.

Image by: CMS

There is a very easy way to check. CMS will send eligibility letters to each organization (tax identification number) that will show eligibility at both the clinician and the group level. Watch for these letters around mid-March.

Step Two: Shop for your measures

If you are a MIPS-eligible clinician, the next step is to shop for your measures … soon! Unlike last year, test participation is no longer an option. In 2018, the Quality Performance Category requires participation for a full year. Data for your quality measures is needed from Jan. 1 to Dec. 31. In addition for 2018, the Improvement Activities and the Advancing Care Information Categories require at least 90 days of data.

Image by: CMS

Another big change for 2018 is how each of the performance categories is weighted. The quality category will be weighted at 50 percent to make room for the cost category, which will now be weighted at 10 percent of your final score. Like the quality performance category, the cost category also requires a full year of participation. The good news is that CMS will determine your score in the cost category from your submitted claims, so no action is needed on your part.

Image by: CMS

When you choose your measures we encourage you to pay attention to the details. There are several things to consider:

- Are you reporting as an individual or a group?
- What reporting mechanism do you want to use?
- What are your EHR capabilities?
- What measures are you working on already?
- How can you reduce administrative burden?
- What measures can be applied to other programs that you are participating with?

continued on page 14

These are tough questions. The CMS website has a full list of measures and their specifications. Yet, if you are having trouble determining the best path to follow, Quails Health can help.

Step Three: Maximize your score

While you shop for your measures you can also look for ways to maximize your score. For 2018, the potential payment adjustment has increased from 4 percent to 5 percent. There are also additional ways to improve your score and increase your payment adjustment for the 2020 payment year. A few are listed below.

First, a new feature for 2018 is the addition of Improvement Scoring for the Quality and Cost Performance Categories. Improvement scoring will look at the rate of improvement of your quality and cost score and will provide more points to those providers who have not previously performed well. For quality there are up to 10 percentage points available and, for cost, there is one percentage point available.

Secondly, there are new special considerations for MIPS-eligible clinicians in small practices. The increase in the low volume threshold mentioned in Step One is good news for small practices. There is more good news: For the 2018 performance year, small practices automatically receive five bonus points added to their final score if they submit data on at least one performance category. Small practices will also receive up to five bonus points for treating complex patients as measured by the dual eligibility ratio and the average Hierarchical Condition Category (HCC) risk score. In addition, for small practices that are unable to meet data completeness requirements, those practices will continue to receive three points for measures in the quality performance category.

Finally, one of the most important changes is that there is a new MIPS Extreme and Uncontrollable Circumstances Policy. CMS recognizes that due to natural disasters, practices just may not be able to participate in MIPS. Thus, CMS will automatically reweight to the quality, advancing care information and the improvement activities categories for clinicians impacted by hurricanes Irma, Harvey and Maria and other natural disasters in the 2017 performance year.

Beginning with the 2018 performance period, CMS will accept hardship exception applications based on extreme and uncontrollable circumstances that prevented participation in all MIPS performance categories, including quality. Applications for hardship exceptions are due Dec. 31 of the performance period.

Step Four: Collect your data

There are measure specifications for each performance category on the CMS website. For instance, if you are attesting for an improvement activity or advancing care information performance, you will want to know exactly what documentation you need to track and keep in order to demonstrate your good work, but also in case of audit. You can find measure specifications at http://qpp.cms.gov.

Step Five: Submit your data

As mentioned earlier in Step Two, there are multiple ways to submit your data. As shown in the table below, there are variations in data submission methods based on the performance category and if you chose to participate in MIPS as an individual or part of a group.

Determining your strategy is important. Take a look at your resources and consider how you can best utilize them to gather data accurately and to reduce the administrative burden of data submission.

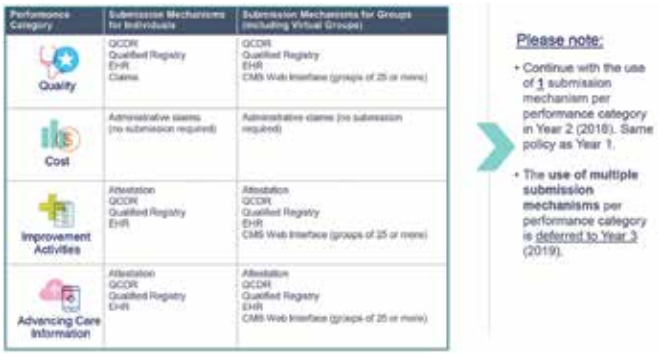

Image by: CMS

Step Six: Look to the future

As you develop strategic plans, consider how you can align your practice to meet the goals of MIPS. For instance, one strategic objective that CMS has identified is to increase Advanced Alternative Payment Model (APM). Consider how your practice could meet this goal as part of the effort to move toward value-based care.

Additionally, CMS initiated the option of participating in virtual groups starting in 2018. CMS

continued on next page

defines a virtual group as a combination of two or more TINs assigned to one or more solo practitioners or one or more groups consisting of 10 or fewer eligible clinicians that elect to form a virtual group for a performance period for a year. If you would like to form a virtual group, it is too late for 2018. The good news is that you can make preparations to participate in a virtual group for the 2019 performance period.

Step Seven: Press the Easy Button

This overview article and following the steps above can put you on the path to QPP success to meet your quality improvement goals and to increase your Medicare Part B payments for the 2020 payment year. But there's so much more to it! We know it's easy to get lost in the details of the QPP. Qualis Health is here to help.

Qualis Health provides practices in Washington with customized technical assistance that includes regular office hours and webinars, monthly program updates, strategic MIPS planning and access to a QPP helpdesk at no cost to you. In addition to technical assistance, the Qualis Health 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.

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.

References:

Executive Summary: Medicare Program; CY 2018 Updates to the Quality Payment Program; and Quality Payment Program: Extreme and Uncontrollable Circumstance Policy for the Transition Year." Accessed December 24, 2017. https://www.cms.gov/Medicare/Quality-Payment-Program/Resource-Library/QPP-Year-2-Executive-Summary.pdf.

Medicare Program; CY 2018 Updates to the Quality Payment Program; and Quality Payment Program: Extreme and Uncontrollable Circumstance Policy for the Transition Year, 82 FR 53568 (Centers for Medicare & Medicaid Services 2017).

What is the Quality Payment Program?

The Quality Payment Program improves Medicare by helping clinicians focus on care quality and the one thing that matters most — making patients healthier.

Who's in the Quality Payment Program?

You're a part of the Quality Payment Program in 2017 if you are in an Advanced APM or if you bill Medicare more than $30,000 in Part B allowed charges a year and provide care for more than 100 Medicare patients a year.

How do I learn more about the Quality Payment Program and how it will impact me?

For more information about the Quality Payment Program and find measure specifications, visit qpp.cms.gov.

For a full list of technical assistance offerings, and to view tools and resources, visit Qualis Health's 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.

Practice options in the new family medicine: Finding our own paths to happiness

BY MEGAN GUFFEY, MD, MPH, FAAFP, MANSON

If you asked someone what a family medicine practice looked like 20 years ago, what do you think their response would have been? A doctor in a solo practice, perhaps working in a small town, and practicing full-spectrum care? That always seems like the "Norman Rockwell" version of family medicine to me. Or even working in a multiple-provider clinic, outpatient only, in Anytown, USA? But the truth is it's hard to describe a family medicine practice today because we have so much variety in our specialty. I think the variety is being driven not only by how patients want to receive care, and how best to ensure high-quality care, but what makes us happy? How do we want to practice? What does professional fulfillment look like to the new generation of physicians?

Some family medicine physicians continue to work traditionally, with a full-spectrum practice while others have cut back on hospital work, nursing home care and obstetrics. Some of our colleagues are working shift work in rural ERs, urgent care clinics and as hospitalists. Others have transformed their outpatient clinic into a concierge practice that better meets both their own needs as well as those of their patients. Still others are leaving clinical practice to work as consultants, medical directors or advisors within pharmaceutical or insurance companies. And what else will the future bring?

In addition to this variety, I would be remiss not to comment on the uprising of the "gig" economy, even in medicine. Businesses like Nomad Health are cropping up to allow physicians access to side gigs that can supplement their income or, if done significantly, could become their main source of income — not to mention the number of physicians branching out into side gigs outside of medicine completely.

The central theme here is that new physicians place a higher premium on happiness at work or a better work-life balance than our predecessors. At least, it's my theory that this is true. I've certainly seen evidence of it in my own practice. I have three partners, and all of us are at different stages of both our professional and personal lives. And I think we each want something different from our day-to-day family medicine practice. It seems almost a linear relationship between years of practice and the importance of having more time for our personal lives. The longest practicing physician works some of the longest clinic hours and is more willing to sacrifice his personal time than me, the newest physician in the practice. I have no interest in living to work, but would rather work to live.

Is this a reaction to the increasing demands of family medicine? The bloated bureaucracy and increasing insanity of prior authorizations, formulary changes and other demands for more and more specific documentation? Or is it something about us as newer physicians, from a different generation, who just don't want to practice 12-hour outpatient practice days anymore or give up our practice autonomy to insurance companies and outside regulators? Whichever the case, it's a fact that the tent that is family medicine practice is getting larger and larger — trying to accommodate more and more individuals striving to find their own professional fulfillment.

In closing, I would just ask you to consider what about your job do you find fulfilling? What about your job might you change to increase your level of fulfillment? Or what kind of family medicine job would bring you the most happiness? I hope you find it.

Our Collective Backyard

MIRA NELSON, MS-4
WAFP MEDICAL STUDENT CO-TRUSTEE, SEATTLE

It is no secret to family physicians that one of our top national public health crises is opioid addiction. However, as reported by the CDC earlier this year, the numbers can feel truly staggering. 142 Americans die every day from drug overdose, making them more lethal than gun homicides and car crashes combined [1]. Between 1999 and 2015 well over half a million have died preventable deaths from opioid overdose, a population roughly the size of the city of Atlanta [2]. These numbers have served as a call to action for legislators, law enforcement, medical providers, and community members to band together to build a holistic and united front to do our part in the management of chronic pain, opioid addiction, and overdose prevention. The interim report submitted by the Commission on Combating Drug Addiction and the Opioid Crisis (CCDAOC) to the President this past July includes eight concrete steps to combat opioid addiction and called for the declaration of a public health emergency, to which the president has informally agreed [2]. This has been seen by many as a promising start to tackling an issue which has long been bipartisan in nature.

Washington State has not been immune to this crisis, with 700 individuals dying of opioid overdose in 2015 [3]. In response Governor Inslee signed an executive order in 2016, which highlighted and enacted key proposals from the Washington State Opioid Response plan, which parallels many of the recommendations made by the CCDAOC. Although the number of overdoses due to prescribed opioids has decreased by 37%, primarily due to tighter regulations around opioid prescriptions, a recent survey indicated that 57% of those who use injection heroin first became addicted to prescription opioids before they began to use heroin [3, 4]. Statistics like these highlight the need for a thoughtful multi-faceted approach to opioid addiction as studies have shown that tightening regulations around opioid prescriptions need to be balanced with adequate resources and support for those already addicted. Unfortunately, without these measures, individuals who are not able to connect with substance use treatment are at much more susceptible to illicit sources of opioid drugs, often associated with higher risk methods of delivery, higher potency and subsequently higher risk of overdose. Particularly shocking is the increase in overdose due to fentanyl, up to 50-100 times more powerful than heroin. A study published by the Washington Department of Health showed an 83% increase in the number of deaths due to fentanyl overdose since 2015 [5]. The startling numbers call for future physicians such as myself to think critically about their role in how we can use our voices to advocate for legislation that prevents opioid overdose and create a medical system that puts patients on the road to sustainably and effectively managing their pain.

Unfortunately, the Office of National Drug Control Policy estimates that "apart from federal prescribers... fewer than 20% of the over one million prescribers licensed to prescribe controlled substances have training on how to prescribe opioids safely." [2] How can physicians feel prepared to interact with and manage chronic pain if we aren't seeking or receiving training on how to effectively manage this issue? During my third year of medical school I witnessed many interactions between patients and physicians that further shed light on the intricacies around addiction and the many environmental factors at play when approaching the pain management needs of individuals. As one of my mentors once told me "we enter this profession to heal the hurt, to soothe the afflicted and, most of all, the intention to 'fix." Many providers I've worked with, however well intentioned, dread an appointment with a 'chronic pain patient.' This is because, most often, there is no simple fix. Research, however, is showing that, with proper support and training physicians can serve as allies to empower these patients rather than ending an appointment with both patient and physician feeling frustrated and at odds in their goals. To this end, the first prong of the Washington State Opioid Response Plan mirrors the CCDAOC's interim report, which asks to mandate medical education training in opioid prescribing and risks of developing a substance abuse disorder [3]. In reading the 2016 and 2017

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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

continued on next page

Student Column continued

Washington Interagency Opioid Working Plan Updates the results are encouraging. The UW School of Medicine has increased its didactic pain education curriculum from 6 to 25 hours and Washington State has implemented a requirement of a one-time 4-hour education credit for providers who prescribe long-acting opioids [4, 5]. Admittedly these can seem like small steps, but they are taking us closer to the goal of providing consistent, knowledgeable, and compassionate services for those with opioid addiction.

My hope is that with the Governor's executive order and the interim report we will see the groundswell of support so desperately needed to take on the opioid crisis. It is one thing to be able to screen for and manage what can be accomplished in the outpatient setting. However, it is with the increase in funds and advocacy for this problem that I look forward to seeing the type of broad sweeping changes necessary to support the family physician's ability to connect any individual with comprehensive addiction medicine services. This includes supporting the development of new Medication Assistance Treatment options, advocating for the price regulation of naloxone, which has seen an egregious increase in price for all forms over the past five years and, among many other strategies for success, development of community campaigns to soften the deep-seated stigma of addiction [7].

As a medical student applying to family medicine residency programs this fall, my goal will be to develop the tools and knowledge base to be a force for positive change in this growing epidemic. It is imperative for us all to engage in the recommendations made by the Washington Interagency Working Opioid Plan because, as the CCDAOC's interim report states to the President and to the American people- "if this scourge has not found you or your family yet, without bold action by everyone, it soon will." [2]

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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.

WAFP Welcomes the following New Members from September, October, November and December:

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