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WFP POLICY AND PURPOSE:

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.

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.

The WFP Journal is distributed to 3,500 WAFP members in Washington State, plus the other constituent chapter Offices of the AAFP throughout the United States.

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EDITORIAL DEADLINES:

February 15, 2019: April, 2019 Issue
May 15, 2019: July, 2019 Issue
August 15, 2019: October, 2019 Issue
November 15, 2019: January, 2020 Issue

Printed on recycled paper with soy inks
Within his keynote address at the 2018 AAFP FMX, Zubin Damania, MD, referenced a concept called moral injury as a better characterization of the problem many of us know as burnout. The concept of moral injury has been around for several years and primarily has been used to understand the problems that soldiers experience as they wrestle with the psychological trauma they have faced during combat. Specifically, this trauma arises from the experience of dissonance between soldiers’ personal morals and what they witness or experience in a combat setting. In the literature, moral injury has been defined as “perpetrating, failing to prevent, or bearing witness to acts that transgress deeply held moral beliefs and expectations”.1 Almost exclusively studied and written about in the context of caring for veterans, moral injury is the subject of 98 articles on PubMed; of them, only slightly more than 10 percent discuss the issue among civilians. Recently the concept has gained some popularity after two posts on Stat News last summer were the first to discuss moral injury among physicians.2,3 The authors argue that physicians working within the health care system today are exposed to moral conflict arising from the dissonance between the values that brought them to the “calling” of health care and the realities built into a health care system that, at its core, values profit and productivity above all else. Talbot and Dean go on to suggest that moral injury is the cause of physician burnout.2

Essentially, moral injury is to burnout what cardiac ischemia is to chest pain.

In this way, moral injury functions as a diagnosis for our ailing health care workforce, while burnout merely describes the symptoms. Taking the analogy further, our efforts to date at addressing burnout seem similar to treating angina exclusively with nitroglycerin. Mindfulness will help us understand how our bodies are reacting to our mental angst, fear or despair. Balint will help us put words to our struggles and help create an environment in which we build a community of colleagues who understand our plight. These solutions do help alleviate our pain; however, they are inadequate at fully addressing the underlying disease that is breaking health care, a disease contributing to a suicide rate among physicians that is twice that of the general population.4 Understanding moral injury as one of the underlying problems leading to burnout offers us a better way to design solutions that make a difference.

“The health care system that clinicians imagined they would be working in when they began their professional training is not only markedly different than what they had hoped for, it is at odds with their internal sense of morality.”

– Morris-Singer, Pollack, and Lewis3

continued on next page
The health care system we all imagined ourselves a part of when we entered training does not exist as our hopes and dreams intended. The health care system is not going to fix itself, and there is no clear sign that those who have accumulated the most power in our system are inclined to fix it for us. That leaves it up to us, our patients or both. I think the concept of moral injury offers us a shift in perspective that can help us focus our efforts at addressing the root of our problem and leads us to a path where physicians can thrive in our health care system and in life.


How You Can Help the Primary Care Investment Task Force

The 2018 House of Delegates adopted a resolution calling for the formation of a task force to “develop a strategic initiative promoting the spending of at least 12 percent of health expenditures on primary care, exclusive of mental health and dental costs.”

In the months since the adoption of that resolution, the task force has been formed and its work is well underway. Chaired by Tony Butruille, MD, who also serves as the Eastside alternative delegate to the AAFP Congress of Delegates, the task force includes expertise in policy building, health care financing and advocacy. Currently, the task force — known as the Primary Care Investment Task Force, or PCITF — has developed draft legislation and is finalizing strategies to advance the aims of this legislation.

However, the process of moving this draft legislation into codified law will require sustained, extensive effort.

Though the 2019 legislative session started on Jan. 14, the biennial budget bill will be the most important piece of legislation produced in the session. Even if the legislature adheres to its typical schedule — and in any given budget year, that’s no given — final passage out of the legislature would be April at the earliest. At the latest, Gov. Jay Inslee would sign a budget package in early summer. That means, at minimum, three months’ worth of that sustained, extensive advocacy effort will be required. (Recall that in 2017, it took three special legislative sessions to pass a budget; Inslee signed the bill on July 1.)

Because of the effort needed, advocacy reporting from the WAFP to its membership will be different than in the recent past. Legislative updates will be posted every two weeks, while the content of those updates will be predominantly about the PCITF, its activities and bills related to the objective of the PCITF. Though the WAFP will be following a wide array of issues, our resources are limited because of the primacy of the PCITF.

The updates will include what you as constituents can do. WAFP’s greatest organizational asset is its members. An effort such as the PCITF requires the active engagement and participation of you as a member.

Do you know your legislators? More importantly, do your legislators know you?

When you, as a physician, explain to them that health care delivery improves while also costing less when our primary care infrastructure is strengthened, they will hear you. When you explain how this looks in your clinic, how this affects your patients, and how one of your patients has been positively affected by good primary care, they will listen.

They will listen because you are the expert. Of the 147 elected state legislators, only three — three — say that they have provided health care in a clinic-based setting. Only 14 list any professional experience in the health care industry. And they will listen because we are coming to them with solutions.

For the 2019 legislative session, the task force is proposing legislation to determine the baseline spend on primary care and investigate the most effective way to strengthen that system. This will lay the groundwork for action moving forward to reinforce and strengthen our primary care infrastructure moving forward.

WAFP’s annual Policy & Advocacy Leadership Institute (PALI) will serve as a critical advocacy opportunity to support the primary care spending legislation as well as other Academy priorities. We need many voices to reach all corners of the Capitol; if you haven’t already, sign up for PALI today at http://bit.ly/WAFP_PALI. There is no cost for Academy members.

If you are an accomplished advocate and your legislators do know you, consider serving as a key contact. Email us at info@wafp.net for more information.

More information, including suggested talking points to use with your delegation, will be available in the coming weeks. Keep an eye on your inbox!
Draft WAFP 2019 Legislative Agenda

During the 2019 Legislative session, the Washington Academy of Family Physicians will:

Support legislation reinforcing the essential role of primary care in the physical and mental health of Washington residents, including any to:
- Measure overall spending on primary care and identify options for its systematic improvement.
- Increase Medicaid reimbursement for family physicians.
- 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 under the Affordable Care Act.
- Sustain Community Health Centers, Rural Health Clinics and Teaching Health Centers.
- Create incentives for medical school students to go into primary care.
- Increase graduate medical education funding for family medicine residencies.

Support legislation addressing social determinants of health and strengthening the public health system, including any to:
- Sufficiently fund core public health services.
- 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.

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.
- Reduce funding to crucial safety net health care programs.
The 2018 AAFP Congress of Delegate (COD) met in New Orleans from October 7-10, just prior to the 71st annual Family Medicine Experience (FMX). 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 physicians and our patients.

Washington State 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 Jeremia Bernhardt, MD, and other WAFP leaders including Drs. Kevin Wang, Jonathan Wells, Angie Sparks, Jeanne Cawse-Lucas, Kristin Larson, and Matt Logalbo; WAFP Executive Vice President Karla Graue Pratt; and Simoné Mansor and Brian Hunsicker, staff. Team Washington, including Drs. Mark Beard, Julia Sokoloff, Kevin Martin, Don Solberg, Matthew Burke, and recent member Erika Roshanravan, was there in force to help support AAFP Director Dr. Carl Olden’s bid to become president-elect of the AAFP. Though Dr. Olden was an excellent candidate with an excellent speech and team, Dr. Gary LeRoy of Dayton, OH, was elected as president-elect. We, as members of the AAFP, will be well served by Dr. LeRoy.

The delegation was pleased to see the AAFP’s follow-up on the 2017 resolutions offered by the WAFP and adopted by the COD. For instance, a new policy statement on Housing First (item 34 https://www.aafp.org/content/dam/AAFP/documents/about_us/congress/restricted/2018/BoardReportH-PolicyStatementReview.pdf) was issued and, in response to the treating substance use disorder in prisons and jails resolution, a new positions paper was released in April 2017, Incarceration and Health: A Family Medicine Perspective (https://www.aafp.org/about/policies/all/incarcerationandhealth.html).

Four resolutions passed by the 2018 WAFP House of Delegates were taken to the AAFP Congress. Two were adopted and two referred to the Board:

1. Medical Aid in Dying — Adopted
The final substitute resolution that was adopted reads:

RESOLVED, That the American Academy of Family Physicians adopt a position of engaged neutrality toward medical-aid-in-dying as a personal end-of-life decision in the context of the physician-patient relationship, and be it further

RESOLVED, That the American Academy of Family Physicians reject the refrain from use of the phrase “assisted suicide” or “physician-assisted suicide” in formal statements or documents and direct the AAFP’s American Medical Association (AMA) delegation to promote the same in the AMA House of Delegates.

This resolution broke ground for the AAFP. Our AAFP code of ethics follows the AMA code of ethics. The changes to neutrality required a 2/3 vote of the congress. The vote for this resolution was unanimous and carried on a voice vote.

continued on next page
2. Treating Opioid Use Disorder in Hospitals and Drug Treatment Facilities — Referred to the Board

The resolution had strong supportive testimony, yet given the multiple national organizations involved in such a process (AMA, SAMHSA, insurers, and the AHA) the resolution was referred to the Board. As one member noted, this is forward progress on an important public health issue.

The resolved portion of the resolution, as referred to the Board, is noted below:

**RESOLVED**, That the American Academy of Family Physicians endorse a position that hospitals should treat opioid use disorder as a chronic disease, including identifying patients with this condition; providing multiple evidence based treatment options in the inpatient, obstetric, peri-operative, and emergency department settings; establishing appropriate discharge plans; and participating in community-wide systems of care for patients affected by this chronic disease, and be it further

**RESOLVED**, That the American Academy of Family Physicians advocate for legislation that eliminates barriers to, increases funding for, and requires access to opioid agonist or partial agonist therapy at all state-certified drug treatment facilities and hospitals, and be it further

**RESOLVED**, That the American Academy of Family Physicians collaborate with relevant organizations to encourage hospitals in the United States to treat opioid use disorder as a chronic disease, including evidence-based inpatient, obstetric, peri-operative and emergency department settings; establishing appropriate discharge plans; and participating in the development of community-wide systems of care for patients affected by this chronic disease.

3. Removing REMS Categorization on Mifepristone — Adopted

This was one of several resolutions the delegation thought might generate some contentious discussion in reference committee and on the COD floor, but science and sensibility appeared to sway the day. Our co-sponsored resolution passed unanimously.

**RESOLVED**, That the American Academy of Family Physicians engage in efforts to overturn the Risk Evaluation and Mitigation Strategies (REMS) classification on mifepristone.

4. Climate CME had very little discussion, with supportive testimony from WAFP member Matt Burke and one recommendation from the Montana delegation to change human-caused climate change to climate change. The reference committee accepted this proposal, and it passed unanimously.

**RESOLVED**, That the American Academy of Family Physicians proactively expand its continuing medical education offerings that prepare physicians to identify, manage, and prevent health conditions related to climate change.

5. Support National Paid Family Leave — Referred to the Board

This resolution generated mixed testimony, primarily opposed by physicians in independent practices who were concerned with the fiscal burden this would place on them. Dr. Sugarman noted to the reference committee, as well as to the COD during debate, that there is no language that the practice would bear the expense. The reference committee further noted that under the FMLA employee groups of more than 50 must provide leave, but not pay. The substitute resolution, that initially had a recommendation that greatly watered down the original resolution, was extracted. After debate that paralleled the reference committee debate, it was referred to the Board.

**RESOLVED**, That the American Academy of Family Physicians support a comprehensive national paid family and medical leave program that guarantees at least 12 weeks of paid family leave after the birth or adoption of a child in accordance with the employer standards of the Family Medical Leave Act (FMLA).

6. Increase percentage of Women’s Reproductive Health Topics was a resolution adopted by our HOD that, after discussion with its authors, we did not take forward as a sponsor. Preliminary work informed us that the cap and percentage changes had already been modified. Two other states brought it forward. The reference committee felt that tying the hands of

*continued on page 9*
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
Who can author a resolution?

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 of resolutions to be considered by the 2019 House of Delegates is Feb. 22, 2019. 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.

AAFP Delegate Report continued

the Curriculum Advisory Panel might have adverse unintended consequences but allowed staff to look at opportunities to increase women’s reproductive health topics. The substitute resolution that was adopted reads:

**RESOLVED, That the American Academy of Family Physicians seek opportunities to optimize women’s reproductive health topics in future CME events while balancing the other educational needs in the full spectrum of family medicine.**


As noted above, there were changes in the AAFP leadership. Dr. John Cullen (Alaska) assumed the presidency of the AAFP. Dr. Michael Munger (Kansas) is now the Board of Directors’ chair.

Three new directors — Dr. James A. Ellzy (Washington, DC), Dr. Dennis Gingrich (Pennsylvania) and Dr. Tochi Iroku-Malize (New York) — were elected to three-year Board terms. Dr. LaTasha Seliby Perkins (Washington, DC) was elected as new physician representative to the Board. Dr. Michelle Byrne (Illinois) was elected as resident representative to the Board. And Mr. Chandler Stisher (Alabama) was elected as medical student representative to the Board.

Dr. Alan Schwartzstein (Wisconsin) was re-elected Speaker, and Dr. Russell Kohl (Oklahoma) was re-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, largely due to the engagement and participation of our members and leadership.

*Note: The delegation wishes to thank Jonathan Sugarman, who concludes his term as delegate, for his many years of service on behalf of the WAFP. We will miss his insight, vision and leadership at future meetings.*
At its October 2018 Congress of Delegates meeting, the American Academy of Family Physicians adopted a stance of “engaged neutrality” toward medical aid in dying. The Washington state delegation was instrumental in this change. Working with colleagues from other states where medical aid in dying is legal or legalization is being considered, WAFP members advanced a resolution adopted by the WAFP House of Delegates in May, “Adopting an Independent AAFP Policy on Medical Aid in Dying.” The testimony in reference committee was overwhelmingly in support of the WAFP resolution, and the following substitute resolution was adopted by the Congress:

**RESOLVED,** that the American Academy of Family Physicians adopt a position of engaged neutrality toward medical-aid-in-dying as a personal end-of-life decision in the context of the physician-patient relationship, and be it further

**RESOLVED,** that the American Academy of Family Physicians rejects the use of the phrase “assisted suicide” or “physician-assisted-suicide” in formal statements or documents and direct the AAFP’s American Medical Association (AMA) delegation to promote the same in the AMA House of Delegates.

Medical aid in dying became legal in Washington state in March 2009 when voters approved the nation’s second Death with Dignity Act. A nearly identical law was passed in Oregon in 1996 and took effect in 1998. This gives us 10 years of experience in Washington and nearly 20 years in Oregon. Based on data collected by the state health departments, there has been no disproportionate use by vulnerable populations: the elderly, the uninsured, the poor, the disabled. It is used rarely: less than 0.5 percent of deaths in Oregon and Washington are under the provisions of medical aid in dying. It has opened up important conversations about end-of-life care, increased hospice referrals and — most importantly — given patients with terminal illness a sense of control over the end of their lives. Knowing that they have an option gives many people great comfort at a very vulnerable time.

In lieu of crafting its own comprehensive code of ethics, the AAFP endorses the AMA’s “Code of Medical Ethics.” The AMA remains firmly opposed to medical aid in dying, stating in its Code of Ethics that “physician-assisted suicide” is “fundamentally incompatible with the physician’s role as healer, would be difficult or impossible to control, and would pose serious societal risks.” This does not reflect the views of the majority of U.S. physicians. A large 2016 Medscape poll showed that physicians support medical aid in dying by nearly a 2-to-1 margin. Other smaller polls have had similar findings. Fewer than 20 percent of AAFP members also belong to the AMA, and only 10 percent of delegates to the AMA House of Delegates are family physicians.

As family physicians, we interact closely with our patients around birth, death and everything in between; the nature of those relationships provides a deeply informed perspective on what is important to our patients. Our leadership on this issue allows us to speak out on a topic that disproportionally affects family physicians, and about which we have a unique and valuable viewpoint. During testimony at the Congress of Delegates, many members spoke of how important having some control over the timing and manner of their death is to their patients with terminal illness; for many of us, the ability to engage in these conversations has become an important part of providing patient-centered care. With the AAFP’s change in policy, we have an opportunity to influence this important dialogue at a national level.

**Why “medical aid in dying”?’**

Language can be powerful. The term “physician-assisted suicide” conjures up images of a depressed, hopeless person who wants to end their life. But most people with terminal illness do not want to die. They want to live, but unfortunately, that’s not an option for them; they have a terminal illness from which they will die within weeks to months. They are asking for help with that process, including the choice to control...
the timing of their death within those last few weeks or months. Redefining this as “medical assistance with dying” rather than “suicide” is more accurate and more respectful.

**Respect for differing perspectives on a complex issue**

In testimony, several members said that while they personally did not feel comfortable providing medical aid in dying for their patients, they had no objection to their colleagues participating. They could understand why the current label of “unethical” is problematic. The mutual respect among colleagues with differing points of view was evident — and very refreshing! At the end of the testimony, Dr. Tony Butruille, AAFP Eastside alternate delegate from Washington, commended us all for the civil discourse and respect shown for differing points of view, pointing out that this is sorely lacking in our national politics.

**Get involved!**

Our state chapter is known for having a large and effective presence at the AAFP and this year was no exception. The resolution process offers a rare opportunity for a small group of individuals to have an impact on a national organization. We encourage WAFP members with an interest in affecting the public policy positions of the WAFP and AAFP to consider similar initiatives. Helpful resources include the members of our AAFP delegation (see their separate report in this issue), the leaders of the WAFP House of Delegates, any Board or Executive Committee member, and of course one can participate in numerous leadership development opportunities sponsored by our chapter or the AAFP.

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**Serve as a Delegate and Advance the Work of the Academy**

The WAFP is propelled forward by you, the member. Academy policy and areas of focus are all driven by Academy members in the form of the annual House of Delegates.

2019 marks the 62nd such gathering and represents a chance for you to shape the direction of your Academy. By writing a resolution or serving as a delegate or alternate delegate, you have the opportunity to directly impact the direction of the Academy.

If there are issues that are impacting your patients, or if you feel the Academy should be more vocal on a topic, then write a resolution to make that happen. If you can find another WAFP member to cosign your resolution, it will be taken up at the House of Delegates. Some resolutions are voted on by local chapters, who then bring them to the House of Delegates. Either way, you have the power to make change.

You can learn more about writing resolutions in the article on page 8. The deadline for submitting resolutions is Feb. 22, 2019.

But the House of Delegates cannot function without delegates, and that is another important way you can make your voice heard. WAFP bylaws stipulate a formula that determines how many delegates it may send to the House of Delegates. Those delegates then represent their local chapter and exercise voting privileges for resolutions and leadership elections. If you’re interested in serving as a delegate, contact your local chapter leadership; information is available on the Chapters section of the WAFP website.

The House of Delegates is not limited to delegates, however; all WAFP members are encouraged to attend. Any WAFP member can testify in the reference committee hearings, and you’re afforded the chance to network with colleagues from around the state.

Make your voice heard at the House of Delegates meeting on May 9, 2019, at the Coeur d’Alene Resort. WAFP’s website, wafp.net, will be kept up to date with resolutions and more information about this, the guiding body of the Academy.
In May 2018, the WAFP aligned with several other medical organizations — including the AAFP, the American Academy of Pediatrics and the American College of Physicians — to endorse systematic, clinic-based assessment of patients for social determinants of health (SDOH). These “conditions under which people are born, grow, live, work and age” include factors such as housing, education, access to healthy food, legal rights, employment, financial stability, transportation, and personal safety and dignity, and have long been recognized as a major contributor to health. In fact, it is estimated that SDOH account for more than 40 percent of health outcomes in the United States, whereas direct clinical care accounts for less than 20 percent. And yet, when some family physicians hear about SDOH assessments, they imagine the following:

You look at your schedule and it is “that kind of day”: multiple new complex patients, hospital discharges, procedures that will run long, etc. And now your first patient of the day is running late. Not only that, but she also has a stack of uncompleted paperwork that you are supposed to review. On the top of the pile is a new SDOH questionnaire, and the patient has checked “yes” to everything from food insecurity to homelessness. You feel like your visit and your clinic has suddenly been derailed. Now what?

If you envisioned this, you aren’t alone. A recent AAFP survey showed that although the vast majority of family physicians agree that we should identify and address social needs, asked about barriers to making her appointment and when she mentioned transportation, they provided her with information on the local bus line and a nonprofit that supports elders with transportation needs. They also offered her an appointment later in the month, knowing that many patients rely on the funds from their monthly benefits checks to pay for transportation to appointments. They flagged her as someone who could benefit from a SDOH questionnaire. She arrived at the clinic on time thanks to these interventions and completed the questionnaire while in the waiting room. On rooming her, the MAs noted that she had screened “yes” on several items and asked her if any of these were urgent safety issues, or if the resource navigator could contact her later. She agreed to the latter. When addressing her diabetes, you were already aware that she had food insecurity and were able to streamline your conversation on healthy food to focus on how to achieve that with low-cost options and food bank items. After the visit, a trained nurse was able to reach out to her and provide her with local resources, including times when the mobile food bank is parked outside the clinic — a partnership between the food bank and the clinic born out of the realization that food insecurity was identified as one of the major SDOH challenges faced by patients.

The key to addressing SDOH is to recognize that they matter and to have an efficient system in place that distributes the burden so that it isn’t all on us as providers. We know intuitively that SDOH impact our patients’ outcomes but feel overwhelmed and undertrained to address these factors. But just like many other complicated medical problems, there are times when we as individual providers need to rely on our colleagues, whether they be medical specialists, behavioral counselors, social workers or community partners. When it comes to SDOH, these networks, in many areas, are in their infancy. So where do you start?

continued on next page
1. **Goal Setting and Stakeholder Engagement:** In most places, SDOH assessment already aligns with the established mission of the clinic because at its core, it is simply a systematic way to identify and address many of the root causes of our patients’ illnesses — both at the individual and clinic population level. Understanding these issues helps us to start on the same page as our patients, which ultimately improves care and efficiency of clinic visits. It is important to ensure that all staff are involved throughout the design process, which allows for the most effective and efficient system and promotes buy-in from all involved. In a larger hospital system, engaging administration can help identify additional system-wide goals that might garner further support (financial or otherwise).

<table>
<thead>
<tr>
<th>ACTIONS</th>
<th>EXAMPLES</th>
</tr>
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<tbody>
<tr>
<td>Prioritize Primary Goals</td>
<td>To better understand the clinic’s patient population and needs.</td>
</tr>
<tr>
<td>To better connect patients with community services.</td>
<td></td>
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<tr>
<td>To identify high-risk patients at risk of poor outcomes.</td>
<td></td>
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<tr>
<td>Identify Secondary Goals/Benefits</td>
<td>To guide funding and development of future projects.</td>
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<tr>
<td>To help recruit new passionate physicians and boost clinic morale.</td>
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<tr>
<td>To demonstrate the importance of primary care to the larger health system.</td>
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<tr>
<td>Engage Stakeholders</td>
<td>Utilize nursing, MA and front-office expertise to design the workflow.</td>
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<tr>
<td>Ask for support from administrators and align your goals with theirs.</td>
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<tr>
<td>Form partnerships with community organizations or the public health department.</td>
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<tr>
<td>Bring in medical or social work students to contribute.</td>
<td></td>
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<tr>
<td>Consider a pilot study</td>
<td>Implementation by one pod in a larger clinic.</td>
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<tr>
<td>Implementation for a particular set of high-risk patients.</td>
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2. **Choosing an Assessment:** Based on stakeholder input, design your assessment to be tailored to your clinic’s needs and goals, or consider the ease of using a predesigned questionnaire.

<table>
<thead>
<tr>
<th>CHARACTERISTICS</th>
<th>EXAMPLES</th>
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<tbody>
<tr>
<td>Content</td>
<td>Broad questions to screen for any needs, with further assessment if positive.</td>
</tr>
<tr>
<td>Comprehensive assessment to characterize the patient population.</td>
<td></td>
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<tr>
<td>Focused assessment on the SDOH that most impact specific health outcomes.</td>
<td></td>
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<tr>
<td>Standardization</td>
<td>Standardized, such as from the PRAPARE study or CMS (Medicare/Medicaid)</td>
</tr>
<tr>
<td>Use of a pre-built questionnaire in the EMR (such as the EPIC SDOH tool)</td>
<td></td>
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<tr>
<td>Non-standardized, uniquely tailored for your clinic population</td>
<td></td>
</tr>
<tr>
<td>Format</td>
<td>Computerized questionnaire (imported directly by staff into the EMR)</td>
</tr>
<tr>
<td>Paper questionnaire</td>
<td></td>
</tr>
<tr>
<td>MyChart or letter-based questionnaire</td>
<td></td>
</tr>
<tr>
<td>Length</td>
<td>A few questions to a comprehensive review</td>
</tr>
<tr>
<td>Frequency</td>
<td>Annually or at wellness exams at a particular age</td>
</tr>
<tr>
<td>At all well-child checks</td>
<td></td>
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<tr>
<td>For all new patients</td>
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*continued on page 14*
3. **Workflow Design**: Optimize implementation by designing an assessment that fits into the clinic’s pre-existing workflow or that utilizes time the patient already spends waiting for a provider.

<table>
<thead>
<tr>
<th>WORKFLOW</th>
<th>EXAMPLES</th>
</tr>
</thead>
</table>
| Who administers it?           | Non-clinical staff (patient navigators, advocates, front office staff)  
Nursing staff  
Care coordinators or social workers |
| Where is it administered?     | In the waiting room  
In the exam room  
In the care coordinator or social worker’s office |
| When is it administered?      | Prior to arrival (virtual message or phone call)  
Prior to being roomed  
During the rooming process  
At check-out |
| Who reviews positive assessments? | Nurse or MA provides a premade resource handout  
Physician adds to the problem list and incorporates SDOH into the care plan  
Care coordinator or social worker offers individualized resources |

4. **Creating the Referral Network/Intervention**: Being able to refer our patients when necessary not only improves patient care but also saves us time in the long run. Determine what resources are available and start by building off of those. If resources are scarce in both the clinic and the community, start by raising awareness of the needs. If resources such as non-profits, food banks, shelters, etc. exist in the community but the clinic resources are limited, start by connecting patients to those existing resources and building a referral network that way. If the community has limited resources, work to create some partnerships that build off of the clinic’s resources.

<table>
<thead>
<tr>
<th>INTERVENTION</th>
<th>EXAMPLES</th>
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| Raise awareness of SDOH needs and services | Providers use information to better understand the clinic’s patient population.  
Administrators make funding decisions and quality improvement interventions.  
Local organizations develop new community projects around known needs. |
| Partner with and refer to local organizations | Aunt Bertha or another app-based referral system connects patients to existing resources.  
A social worker or RN is trained to connect patients to existing resources.  
A list of existing resources is available for handout to patients. |
| Create services in-house          | Clinic funds are available for financial assistance for qualifying patients.  
An in-house food bank or used clothing closet is made available for patients. |
| Form coalitions and advocate for policy change | Partnership with a mobile food bank allows distribution at your clinic.  
Advocacy from providers improves city transportation services for patients.  
Partnership with local legal organizations creates a medical-legal partnership. |

**Interventions Based on Amount of Resources Needed**

- **Health Center Resources**
  - Create services in-house
  - Form coalitions with community partners and advocate for policy change

- **Community Resources**
  - Raise awareness of SDOH needs and services
  - Partner with and refer to local community organizations and services

*continued on next page*
5. Documentation & Coding: SDOH screening can be used for both clinic quality improvement and individual patient care planning so design your documentation accordingly. Designed properly, it doesn’t need to add to provider burden. Adding Z-codes can increase the complexity of your visit and in the future may actually be reimbursed by certain Medicare/Medicaid plans (currently being piloted in certain Accountable Communities of Health across the country).

<table>
<thead>
<tr>
<th>METHOD</th>
<th>EXAMPLES</th>
</tr>
</thead>
<tbody>
<tr>
<td>Coding</td>
<td>Z55: Problems related to education and literacy</td>
</tr>
<tr>
<td></td>
<td>Z56: Problems related to employment and unemployment</td>
</tr>
<tr>
<td></td>
<td>Z59: Problems related to housing and economic circumstances</td>
</tr>
<tr>
<td>Documentation</td>
<td>Document screening in the note or other searchable text</td>
</tr>
<tr>
<td></td>
<td>Use an EMR-based tool that allows documentation in a form or other toolbox</td>
</tr>
<tr>
<td></td>
<td>Keep track of the data in an alternative database that is analyzed at the clinic level</td>
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Resources:

Websites & Toolkits

- The EveryOne Project: AAFP toolkit designed to assist family physicians and their practice teams in screening patients for social determinants of health, identifying community-based resources, and working with patients to develop an action plan that encompasses social needs to help them overcome health risks and improve outcomes. http://bit.ly/EveryOneAAFP
- PRAPARE Toolkit: A national collaboration to help community health centers and providers collect and apply the data they need to better understand their patients’ SDOH, transform care to meet the needs of their patients and ultimately improve health and reduce costs. http://bit.ly/PRAPARE
- Oregon Primary Care Association SDH Tools & Resources: Includes curriculum for learning more about SDOH, tools for developing a workflow in your clinic and many national and online resources for addressing food insecurity, homelessness, literacy issues and legal needs. http://bit.ly/OR-SDOH

Articles & Evidence


continued on page 16
Special thanks to the following people for their contributions and input: Tony Bell, MD (Tacoma Family Medicine PGY-3 and SDOH Committee Lead); Natalie Nunes, MD (Tacoma Family Medicine Clinic Medical Director and Population Health Lead); Molly Parker, MD, MPH (Population Health Lead at Jefferson Healthcare in Port Townsend); Emily Less, MPH; and Kate Cranfield, MN, RN (Pierce County Public Health Department).

a. While many organizations and much of the literature refer to this as SDOH “screening,” the WAFP has opted to instead use the term “clinic-based assessment” to acknowledge that more research is needed to produce outcome and cost-effectiveness evidence, which would further guide endorsement of such an assessment as an appropriate “screen.”


PALI to be Held Feb. 20 in Olympia

WAFP’s annual advocacy event, the Policy and Advocacy Leadership Institute – Family Physician Day at the Capitol, will be held Feb. 20 at the Capitol complex in Olympia.

The event, typically held early in the 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 Feb. 6.
Represent WAFP at the 2019 National Conference of Constituency Leaders

Let your passion for family medicine show. Let your voice be heard.

As a member of one of the special constituencies, you have a chance to make change and shape the specialty for years to come. At the 2019 National Conference of Constituency Leaders — held April 25-27, 2019, in Kansas City, MO — you'll join colleagues from across the country, coming together for the betterment of the specialty.

If you are selected to represent the WAFP as a delegate to NCCL, the Academy will reimburse eligible expenses (with submission of a delegate report and original receipts).

As the WAFP representative for one of the five constituencies, you'll discuss issues facing family medicine and propose policy directions for the AAFP. It's your chance to influence the future work of the Academy on behalf of family medicine.

The constituencies include:

- **International medical graduates** (from schools outside of the U.S., Canada and Puerto Rico)
- **Lesbian, gay, bisexual and transgender** (LGBT) physicians or physician allies
- **Minority family physicians**: an active member of the WAFP/AAFP who is African-American, Asian, Native Hawaiian or other Pacific Islander, American Indian, Alaskan Native, Latino, or other
- **New physicians** (those who have been in practice fewer than seven years)
- **Women physicians**

Past feedback from attendees has been universally positive.

To apply, visit the WAFP website at wafp.net and look for the registration icon on the front page.

The WAFP is proud to have a tradition of sending a representative for each of the five constituencies, and we hope you'll join us in 2019.

**Residents: There are opportunities for you too!**

The WAFP has established three scholarships for third-year residents to attend NCCL. Residents also have the chance to network with other residents and diverse constituents from across the nation, as well as AAFP and WAFP leaders attending the Annual Chapter Leadership Forum.

The application is available in the resident section of the WAFP website: http://bit.ly/NCCLResidents. Resident scholarship criteria includes:

- Membership in the WAFP
- In good standing with residency program
- Leadership experience

**All nominations and supporting materials are due by Feb. 8, 2019.** Materials will be reviewed by the WAFP Diverse Constituencies Subcommittee which will select up to three recipients. For more information, visit the residency section of the Academy website or email us at info@wafp.net.
Nominate Your FP of the Year, FM Educator of the Year!

“Through her words and by example, [she] masterfully motivates her students to find their calling and to be whole, joyous and inspired physicians.”

That description was part of a testimonial from the 2018 winner of the WAFP Family Medicine Educator of the Year. It exemplifies what’s special about the winners of the Family Physician of the Year and the Family Medicine Educator of the Year award. Others who provided testimonials used words like “stellar,” “visionary,” “passionate,” “selfless” and “dedicated.”

Who in your practice is stellar? Who in your organization is a visionary?

Which colleague do you strive to be like?

WAFP wants to know. These annual awards showcase the best our specialty has to offer, but we need your help. The nomination process is only three steps:

Family Physician of the Year
- Complete a short, one-page basic information form.
- Solicit letters of recommendation explaining how the physician provides compassionate care, is involved in the community, and effectively represents family medicine.
- Submit a copy of the nominee’s curriculum vitae and any supporting documents (letters, awards, news articles, etc.).

Family Medicine Educator of the Year
- Complete a short, one-page basic information form.
- Solicit three to five letters of recommendation explaining the candidate’s exemplary teaching skills, development of innovative teaching models, or implementation of outstanding educational programs. Two letters must be from current or former pupils.
- Submit a copy of the nominee’s curriculum vitae and supporting documents (letters, awards, news articles, etc.).

Nomination forms are available by clicking on the icon on the WAFP homepage at wafp.net.

AAFP’s Danielle Jones Confirmed as Mead Lecture Speaker

Danielle Jones, MPH, manager of the AAFP’s Center for Diversity and Health Equity, will deliver the William F. Mead Lecture at WAFP’s 2019 Annual Scientific Assembly. Jones is scheduled to speak about how family medicine can advance health equity.

The ASA will be held May 10 and 11, 2019, at the Resort at Coeur d’Alene in Coeur d’Alene, ID.

Washington State Secretary of Health John Wiesman, DrPH, MPH, will deliver a plenary speech on public health in the state. Other confirmed plenary sessions include immunization hesitancy, obesity, student-athlete pre-participation screening and medical aid in dying.

Confirmed workshop topics include nutrition, osteopathic manipulation, incarcerated patients, e-cigarettes, positional vertigo, obstetrics, teaching medical students, adverse childhood experiences, and virtual care.

Registration for the 2019 ASA will be available in the coming weeks.
Family Physicians on the Front Lines of an Epidemic

LUCINDA GRANDE, MD, LACEY

Our patients know how devastating the opioid crisis has become. Addiction may have struck them personally, or they may have watched helplessly as the life of a family member, neighbor or co-worker deteriorated. They may have felt guilt, pity or disgust as they stepped over someone living on the streets, or horror when their child was exposed to a used needle in a public park. Many are frustrated that their tax dollars are being spent on incarceration for drug-related crimes and on hospital costs to treat overdoses and infections among uninsured people who inject drugs.

As family physicians, we recognize the impact of these blights on the physical and mental health of our patients. We also appreciate the public health perspective: by harming a great many individuals, epidemics such as diabetes, obesity, HIV and opioid use disorder also endanger whole communities.

A powerful weapon available to family physicians is the buprenorphine waiver, the authorization to prescribe this highly effective medicine for patients with opioid use disorder. Prescribers are starting to catch on. The number of new waivers in the state has quadrupled in the past three years to more than 600 in 2018.

Having a waiver is quickly approaching standard of care for family physicians in Washington State. But using the waiver—prescribing buprenorphine to help patients achieve and maintain recovery—is the crucial step needed to actually make a difference. Some family physicians are wielding their waivers to fight the epidemic itself.

John Asriel, MD, WAFP’s 2018 Family Physician of the Year, has taken on opioid addiction treatment as his latest passion. After obtaining his waiver and getting some experience, he propagated that service by offering an annual waiver-training class at the Central Washington Family Medicine Residency Program in Ellensburg. He also recruited recalcitrant program faculty.

“I identified a doctor … who voiced interest, and gently reminded him when we were around each other. He dragged his feet, but eventually got his waiver as I kept mentioning it. It then took a little while for him to start seeing patients, but once he did, he became a strong advocate,” John said. “Now, his entire clinic staff of providers has obtained waivers and should be open to seeing more patients soon.”

His advice on making a difference? “I think persistence is helpful along with targeting the best fit.”

The Swedish Cherry Hill Family Medicine Residency Program in Seattle has played a seminal role in building the deep addiction treatment expertise in this state. Sam Cullison, MD, Program Director for 16 years until 2013, started the residency down this path. Under his leadership, Cherry Hill took over the addiction treatment program at Swedish Ballard in 2001 and created what has become one of the nation’s premier inpatient programs for pregnant women with substance use disorders. Faculty and graduates of the Cherry Hill Residency and/or its Addiction Medicine Fellowship (started in 2003) include many of the pioneers described below, each identified with an asterisk.

Charissa Fotinos, MD,* Deputy Chief Medical Officer of the Washington State Health Care Authority, ran the Swedish Ballard unit during its early days. She is now fighting the opioid epidemic at a systems level. We can thank her for our state’s national leadership in access to buprenorphine for Medicaid patients: Washington State was among the first to eliminate prior authorizations, time limits to prescriptions and the requirement for counseling, and very recently, to bring Medicaid payment up to the Medicare level for treating opioid use disorder.

Paul Gianutsos, MD,* current Program Director at Cherry Hill, has been an ardent advocate for addiction medicine training of residents since he joined the program in 2002. Paul points out, “The expertise within the program [and thus the state] grew out of Sam’s leadership and Charissa’s interest and enthusiasm.” He is now organizing the WWAMI family medicine residency...
Jim Walsh, MD,* personally served for years as an informal, one-person addiction crisis service for providers across the Northwest faced with pregnant women in distress. Now a nationally recognized expert, his trainees have taken over the crisis hotline. Jim co-authored a 2018 paper in the Journal of Addiction Medicine in which his Swedish Ballard and Cherry Hill colleagues mined 16 years of their data. Their surprising conclusions will likely lead to widespread practice changes. First, higher buprenorphine doses can be prescribed to pregnant women without increasing the severity of neonatal abstinence syndrome. Second, breastfeeding is both safe and beneficial for infants of mothers on buprenorphine treatment and should be encouraged.

Abi Plawman, MD,* started a spinoff program in 2016 at MultiCare’s Good Samaritan Hospital and East Pierce Family Medicine Clinic in Puyallup. Among Abi’s fellows in obstetric and neonatal addiction medicine is Doug Borst, MD, who stayed on as faculty. Abi and Doug are now branching out into correctional medicine, providing buprenorphine treatment to prisoners at the Puyallup City Jail.

Rob Epstein, MD, and Ned Hammar, MD,* at the North Olympic Healthcare Network in Port Angeles dug into the challenge of treating incarcerated patients in 2015. Working with the medical and corrections team at the Clallam County Corrections Facility, they developed one of the first programs in the nation to integrate medical treatment of opioid use disorder inside and outside the walls. They now field questions from communities across the region.

According to Rob, “Originally I really was working with opioid affected OB moms, some in the jail and that is how I got connected with the jail and the staff there.” Ned added, “[Rob] and I both attribute a great deal of our inspiration, motivation, and ongoing success to Jim Walsh.” An article about the program in the local Peninsula Daily News prompted providers at other local clinics to get waivered and join in care.

Laura Morgan, MD,* combines primary care and addiction treatment in the unique Re-Entry Clinic she founded in 2018 at Country Doctor Community Clinic in Seattle to smooth the road for recently incarcerated individuals returning to the community.

Adam Kartman, MD, of Cascade Medical Advantage, organized a hub-and-spoke treatment network in Bellingham involving residential and outpatient programs, the Lummi and Swinomish tribes, and the PeaceHealth St. Joseph Medical Center. The foundation for this gargantuan undertaking was laid by his advocacy for the overdose reversal drug naloxone, even before Washington’s 2010 Good Samaritan law.

Since training and supplying over 1,000 law enforcement officers, EMTs, syringe exchange staff, and family and friends of individuals at risk, his team has documented

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more than 185 saves in Whatcom County. Rachel Wood, MD, MPH, is aiming to achieve similar results by training first responders in Thurston and Lewis Counties, where she is Public Health Officer.

Matt Perez, MD,* of Neighborcare Health at Meridian in Seattle and Eric Olson, MD, of Wenatchee Valley Hospital have personally waiver-trained 410 prescribers between them. They crisscrossed the state in 2017 and 2018 to run a total of 29 classes in 11 counties. Matt commended Richard Waters, MD, for developing protocols and mentoring at Neighborcare. Four years into it, they have 27 buprenorphine prescribers treating 350 patients. Matt explained, “Treating opioid addiction is the easiest and most rewarding part of my primary care job.”

Matt’s and Eric’s zeal for waiver-training is reminiscent of the late Roger Rosenblatt, MD, MPH, of the University of Washington’s Department of Family Medicine, whose outreach in the Rural Opioid Addiction Management (ROAM) Project resulted in training of 120 prescribers in 2010 and 2011, at a time when the opioid crisis had barely breached the surface. Project ROAM spawned several influential publications. Laura-Mae Baldwin, MD, MPH, of UW Family Medicine, wrote the ROAM grant and many others contributed.

Shawn Andrews, MD, of Summit Pacific Medical Center, WAFP’s 2013 Family Physician of the Year and a personal inspiration to me, drove development of an opioid treatment network in Elma which received a 2019 State Opioid Response grant to connect her hospital and local clinics.

Kari Lima, MD, on the faculty at Providence St. Peter Family Medicine Residency in Olympia, squeezed an addiction treatment curriculum into a busy residency program, waiver-trained 24 residents and guided their first steps as waivered prescribers.

Kari and I (as a representative of the WAFP Thurston-Mason-Lewis Chapter) collaborated to waiver-train 85 prescribers in two community-wide classes in 2017 and 2018. Springboarding off her annual resident waiver training, we broadened the appeal. We obtained co-sponsorship from the Thurston-Mason County Medical Society, with assistance from its then President, WAFP member Daniel Stein, MD. We obtained leadership support from Providence St. Peter Hospital to recruit hospital medical staff, and the ARNP’s United of Washington State to recruit their membership.

Our trainees included MDs, DOs and NPs across the specialties of internal medicine, hospital medicine, infectious disease, hematology-oncology, obstetrics and gynecology, neurosurgery, emergency and acute care medicine, and rehabilitation medicine, as well as family medicine. We plan to do it again in 2019.

I have identified a way for those newly waivered prescribers to get some crucial experience. Nearly a third of the 2018 waiver-training class is among the rotating staff of 28 waivered prescribers at the new Olympia Bupe Clinic (OBC) where I serve part-time as Medical Director, while continuing primary care at Pioneer Family Practice in Lacey.

OBC is located at Capital Recovery Center, which also houses the downtown Olympia syringe exchange. The clinic aims to provide low-barrier short-term access to treatment for patients at high risk of morbidity and mortality from illicit opioid use, such as those who are homeless, recently incarcerated or recently hospitalized.

OBC provides same-day, on-site dispensing of buprenorphine for up to seven days without cost, commitment to abstinence, or required counseling; urine testing is performed only to confirm buprenorphine. On-site peer recovery coaches serve as care navigators for patients who would like help obtaining services. Interested patients will get warm handoffs for longer-term treatment at any suitable program in Thurston or surrounding counties.

To be fully effective, the activist physicians above need your collaboration. Obtain your waiver and use it, and get to work healing your community.

You can find waiver-training classes and mentorship at pccsnow.org and getstr-ta.org, or contact Mary Catlin at Mary.Catlin@doh.wa.gov. If you know of strong work being done by a family physician in your community, please send me an email at cgrande@pioneerfamilypractice.com.
I recently reunited with a close group of medical school friends in Austin. As we soaked in the warm sun rays, we checked in on how the past few years of residency had impacted us. We all admitted we weren’t great at keeping in touch with each other. Our scattered locations throughout the country and variable time zones didn’t help. Yet once we were all together, each of us revealed the extensive self-doubt, depression and anxiety since residency started.

Starting from day one of medical school, we physicians in training are constantly exposed to a host of new, stressful experiences. Support from family and friends are crucial but may be limited if one is in a completely new environment. Once one becomes comfortable in one city, life gets disrupted as students move yet again to pursue residency.

According to a systematic review published 2016 in JAMA,1 27 percent of medical students reported depression or depressive symptoms. Of the students who screened positive for depression, 15.7 percent sought psychiatric care. More shocking, more than 1 in 10 students (11.1 percent) reported experiencing suicidal ideation within the past two weeks to 12 months. Third- and fourth-year medical students reported higher rates of suicidal ideation than first- and second-year students. Despite increasing awareness of the need for mental health resources, the prevalence of suicidal ideation hasn’t changed for the past 10 years.2

The same JAMA authors published a separate systematic analysis examining the prevalence of depression or depressive symptoms among residents. The pooled rate remained about the same; approximately 28.8 percent of residents met criteria. However, individual studies of reported depression ranged from 20.9 percent to 43.2 percent.3 Residency is a major psychosocial stressor. Having to master an ever-growing body of medical knowledge while facing feared inadequacy or failure creates a demanding emotional climate for physicians in training.

Although both medical students and residents are more likely to experience mental health issues, we’re also less likely to seek help.4 One commonly cited reason is stigma. Earlier in our lives we were somehow molded to react uncomfortably to topics such as depression, schizophrenia, substance use or suicide. The medical culture then builds up high expectations where weakness is not accepted. Some of us believe if one discloses his or her mental health condition, one would be viewed as an incompetent physician.

How can we address this problem?

The first step is awareness. Mental health isn’t always easily recognizable. Symptoms may be subtle, such as a sudden change in punctuality or increase in irritability. We — fellow residents and faculty — have to look out for each other. We need to have an open community to foster these difficult but honest conversations with each other.

Some residents who realize they are depressed may be tempted to self-diagnose and self-prescribe or obtain informal consultation from peers or family members who are physicians. However, the best treatment for depressed residents is to provide the same meticulous, excellent and thoughtful care one would provide to any non-physician patient — by establishing professional mental health care.

Fostering access to counseling and confidential mental health services for residents has been an ongoing challenge. Many interventions focus on reducing stress while promoting physician wellness through educational workshops rather than explicitly treating depression or suicidal ideation.5 Oregon Health and Science University demonstrated that establishing a comprehensive wellness and suicide prevention program on campus is indeed feasible and utilized.5 Using GME funds, the institution hired a small team of psychologists and a psychiatrist who had no direct involvement with the performance of residents or faculty. They provided brief, evidence-based

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counseling approaches instead of the traditional longer sessions in order to accommodate people’s schedules. They were able to provide pharmacotherapy without requiring referral to a community psychiatrist, which furthered treatment response and continuity of care. However, they admit barriers to treatment still existed, including scheduling.

Alternatively, for the programs who cannot afford to hire professional staff, faculty should know when to guide residents to confidential counseling and psychological support services. Yet the same barriers still exist. A busy residency schedule prevents one from scheduling an appointment during normal clinic hours. Some residents are fortunate enough to have administrative time to schedule these, but others end up using sick days.

Multiple national organizations and residency programs are creating programs to try to prevent depression. The American Medical Association offers several online modules and lists several solutions taking place within residency programs nationwide on its website. The literature for evidence-based solutions specific for medical residents is still ongoing, but it’s unclear if and when there will be answers.

As my friends and I continued to absorb as much light therapy as possible to slightly decrease our risk of seasonal affective disorder, eventually, one of us broached the sad news of a friend’s recent suicide. We reflected on his struggle with mental health throughout medical school. Even then he struggled to seek mental health services. Once he started residency, he attempted to self-medicate. When his suicidal ideation returned, our close friends brought him to the emergency department. When he had his first manic episode, another friend called the police for help. Ultimately, no matter how much we tried to help, it wasn’t enough. He still took his life.

This is a strong reminder that we future physicians are not invincible. It is acceptable for us to be honest about our well-being and to prioritize seeking professional help. Yet there still isn’t a great solution to address this. We have to remind ourselves: if we cannot care for ourselves, how can we care for our patients?

Who Delivers Washington’s 90,000 Babies Each Year? OB/GYNs and Family Physicians

MEGAN GUFFEY, MD, MPH, FAAFP, WAFP NEW PHYSICIAN TRUSTEE, MANSON

A few months ago I was alerted to a newspaper article about the lack of prenatal care available to women in rural areas by a Facebook group of female family physicians. The story was originally published in Wyoming, but it was picked up by the Associated Press and published nationally. The American College of Obstetricians and Gynecologists included it as the top story in one of their daily member bulletins on health care headlines. In it, the author describes how some women lack any access to care and others “have to rely on family practitioners.” The implication was clear: family doctors were less qualified to take care of these patients than obstetricians. The OB/GYN quoted in the story goes on to encourage women with the means to travel to an OB/GYN for pregnancy care to do so, indicating it could be the difference between life and death for her unborn child.

I was enraged. All of the female family physicians in the Facebook group were livid, especially given it’s a group of family medicine physicians who provide obstetrical care. Had this OB physician ever worked with a family physician who practices OB? Where was the data to support the arrogant presumption that prenatal care and delivery management is categorically better when performed by an OB? Do we have worse outcomes? Lower patient satisfaction scores? Higher complication rates? Not a single statistic was cited.

In fact, more than 90,000 babies were born in Washington state in 2016 (the most recent data available), with nearly 93 percent of those born in hospitals (according to state Department of Health data). Unfortunately the agency doesn’t collect delivery data by type of provider, only location. It appears Clark, King, Kitsap, Pierce and Snohomish counties account for approximately 63 percent of the state’s deliveries. In 2013, Washington’s Office of Financial Management published a profile on OB/GYNs in the state based on 2011 data: 73 percent of these OB/GYNs practice in Clark, King, Pierce and Snohomish counties. According to an ACOG 2017 report, 49 percent of U.S. counties lack a single OB/GYN, and more than 10 million women live in those predominantly rural counties. No mention on ages or reproductive status. The University of Washington published a report on the state’s physician workforce in 2016, which found there were more than 3,000 family medicine physicians compared to just 843 OB/GYNs in the state. UW reports the overwhelming majority of both specialties practice in urban locations. So … what’s my point? Not all of these babies are being delivered by OB/GYNs.

While not all family physicians practice obstetrics, there is a strong corps of us who do and find it a very rewarding part of our practice. I accept that I’m not able to deliver all women in my rural location due to certain high-risk issues or prematurity of the infant that requires NICU services, but I don’t think it’s fair to insinuate that rural women are just “stuck having to rely” on me for pregnancy and delivery management. I think family medicine physicians have more to offer the average pregnant woman because of our robust training in whole-person care, the ability to see a woman as more than her pregnancy, management of non-pregnancy issues, and care for her child. We may also be caring for her parent(s), spouse and other children. That context may in turn help us provide her better care.

Obstetrical providers in Washington state are doing a good job. Our maternal mortality rate is nearly half the national average. We had 9.0 deaths per 100,000 live births in 2014-2015 (DOH), compared to the 17.3 for the US in 2013 (CDC data). And our rates have been fairly steady over time, unlike the dramatic increase in maternal mortality seen nationally. This is in the face of increasing health risks of pregnancy in Washington mothers such as gestational diabetes and pregnancy-associated hypertension.

I don’t mean to categorize all OB/GYNs as anti-family medicine because of the statement of one quoted physician, even if ACOG chose to highlight that story continued on next page
to all of its members. In fact, most of my obstetrical training in fellowship came from wonderful OB/GYNs who were gifted and patient teachers and completely supportive of family medicine physicians providing obstetrical care. My rural practice has a GYN surgeon who is perfectly happy to let family medicine handle all the local OB business. And I know there are more of them out there.

What bothers me the most is the disrespect — the assumption that I am somehow less competent or less skilled because I chose family medicine as a specialty. I confess, it wasn’t just this AP news article that created this wound, but rather a steady stream of experiences from residency on that all somehow belittle my specialty. This article was just the jar of salt, tipped over and spilling into my wound. Family medicine, and we should all take care to make others call it family MEDICINE (not practice), was our choice. This is not the specialty of default or those who couldn’t make it elsewhere. This is the specialty of comprehensive medicine.

I work every day to make sure my patients feel cared for, listened to and advised on how best to maintain their health. I take care to provide the best, safest and most up-to-date obstetrical care that I can, and I love being there to watch a baby take its first breath or see parents look upon their newborn for the first time. I’d like to think our patients don’t see us as their last resort, but as a wise choice.
“Are there any guns in the home?” I did my best to ask the question in the non-judgmental, open manner that my mentors had demonstrated during my clinical skills class. The patient, a 16-year-old boy with concerns that he “might be kind of depressed or something,” looked to his father, who leaned back in his chair.

“Why?” the father asked.

“Oh, it’s a standard question we ask.” I diligently maintained my indifferent demeanor.

“Yes … I own a couple guns.” Arms and legs crossed. Chin raised. I worried that the rapport I had developed with the patient and his father was fading with this one question.

“OK. And are they in a safe place?”

“Yeah, he’s got them locked up somewhere,” the patient replied, biting his already short thumbnail.

“What’s that got to do with why we’re here?” His father asked, knee bouncing up and down. I tried to give an understanding nod.

“This might be uncomfortable, I know. I’m not judging. I’m just getting information. Just trying to do what I’ve been trained to do. I highly doubt that a couple quick head nods and a (hopefully) gentle and accepting facial expression, conveyed my inner thoughts to the increasingly tense people in front of me.

“I know that these might seem like odd questions, but they really are part of a normal patient interview. And, given your son’s concern that he’s depressed, I just want to make sure everyone is safe.”

The father made a seemingly unhappy sound: “Hmm. Well, it kinda seems like you’re trying to get political. Guns aren’t always an issue.”

There it was: The father’s concern, possibly accusation, that I was overstepping my boundaries. That I was leaving the realm of a budding medical professional and entering the one of a hopeful politician. I felt that I was doing the best I could to ensure that the patient and family were safe. In front of me was a depressed young man. His father shared that back at home were two young daughters, ages 6 and 8. They were not in front of me, but I saw them in my mind: innocently roaming their home, aimlessly looking for interesting objects under pillows and couch cushions, and in drawers, and in closets. Unfortunately, the patient’s father may not have perceived my questions as standard, safety-oriented and evidenced-based. Instead, he seemed to feel that I was perhaps being biased, pushing my views onto him and his son, straying from my vague, metaphorical lane.

If that was what the patient’s father was thinking, he would not be alone. On Nov. 7, 2018, the National Rifle Association tweeted the following: “Someone should tell self-important anti-gun doctors to stay in their lane. Half of the articles in Annals of Internal Medicine are pushing for gun control. Most upsetting, however, the medical community seems to have consulted NO ONE but themselves.” This statement, unsurprisingly, unleashed the ire of physicians around the country: Pictures of blood-soaked scrubs, blood-spattered shoes and blood-covered operating room floors abounded. Many of the stories and pictures of tragedy that doctors shared on social media sites were accompanied by the hashtag, #ThisISMyLane or #ThisISOurLane. Mental health providers, rightfully, shared their tragic stories too.

I do not think that any of us future or current doctors ever want to misuse our voices or our influences in society. Medical providers in this country are afforded the invaluable gift of being trusted and respected by the public, and we need to honor that trust and respect. However, we cannot fail to follow evidence-based practices because we fear controversy. We cannot hesitate to ask difficult or uncomfortable questions when patient safety is at risk. Given the tense and divisive political climate in our country, it can feel scary to address topics that are complex and emotionally charged. I was scared in that room with the patient and his father: scared that they would leave after the visit, upset and offended, and choose not to return. Scared that I was being perceived
as another “self-important anti-gun” provider. But there were other fears too. Fears that felt more pressing. Maybe if I had not asked about guns, my mentor would have. But what if she did not? What if, somehow, the question was forgotten, omitted or dropped after an unclear and unsatisfactory answer out of discomfort? What might have happened then? Might we find out that the patient had committed suicide with one of the guns? Very possible. Research has shown that access to guns can be a major risk factor for suicide. 5,6 Or maybe we would have read a news story with a headline similar to this one, from the U.S. News and World Report, “4-Year-Old Boy Finds Gun Under Couch, Kills Himself With It.” 7 The risk of either occurrence was too great to ignore, so I inquired about guns in the home when I was with my patient and his father. Although the energy in the room was tense, I learned that the father had two guns in a lockbox, and that he was the only one with the key to open it. He kept the key hidden. It was a relief to hear. It may have been my imagination, or my own false reassurance of a desire not to be perceived badly, but I thought that after the patient and his father realized that I was not going to lecture them about guns, or share my personal opinions, they relaxed. That too was a relief.

In order to provide high-quality medical care, we must keep asking the essential questions and giving the safest recommendations we can, even if we experience pushback. When in doubt—when we are with a patient, and we are not quite sure whether we are straying from our lane—we should follow the mantra embedded in us during our medical training: practice evidence-based medicine. Our patients’ well-being, and indeed their lives, depend on it.

References:

1. National Rifle Association, @NRA. “Someone Should Tell Self-Important Anti-Gun Doctors to Stay in Their Lane. Half of the Articles in Annals of Internal Medicine Are Pushing for Gun Control. Most Upsetting, However, the Medical Community Seems to Have Consulted NO ONE but Themselves. Https://T.co/oCR3uiLs7.” Twitter, 7 Nov. 2018, twitter.com/NRA/status/1060256567914909702.


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

Active Members
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William Bacon, MD, Mill Creek
Kiran Bhandari, MD, Seattle
Kimberley Blewett, DO, Clarkston
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Evan Kroe, MD, Federal Way
Edwin Kwon, MD, MBA, Tacoma
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Alexa Lindley, MD, Seattle
Jose Manuel, MD, University Place
Sean McLaughlin, MD, Mukilteo
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Adrian DeLeon, Moscow
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Chelsea Denney, Spokane
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