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WFP POLICY AND PURPOSE:

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

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

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

The WFP Journal is distributed to 3,300 WAFP members in Washington State, plus the other constituent chapter Offices of the AAFP throughout the United States.

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EDITORIAL DEADLINES:
August 15, 2016:  October, 2016 issue
November 15, 2016:  January, 2017 issue
February 15, 2017:  April, 2017 issue
May 15, 2017:  July, 2017 issue
Printed on recycled paper with soy inks
During the Board meeting the evening prior to our May 2016 House of Delegates, our Secretary-Treasurer delivered his report to the Board and presented the 2016-2017 budget. To sum up the financial report we heard that night, our Academy continues to be financially sound. We were able to adopt a modestly negative budget to support the priorities of our strategic plan. Dr. Mark Johnson, the Academy’s Secretary-Treasurer, took a moment to reflect on the stability of WAFP’s investments over more than a decade.

While I’m excited to be writing to you as your new Academy president, I’m also proud to have been your Secretary-Treasurer from 2007 – 2011, and to have participated in updating WAFP’s financial plan. During my one-year term as Assistant Secretary-Treasurer, then during my two terms as Secretary-Treasurer, I often joked that my primary qualification was that my personal checkbook always balanced! It took nearly two years, and the combined experience and insight of the Finance/Executive Committees, along with staff support, to restructure our reserves into a conservative investment portfolio. Along the way, I learned much more than how to read a financial statement, or how to construct and present a budget. I learned about the programs and member passions that each line item represented. I learned that programs could go dormant if there was no VOLUNTEER member time devoted. I realized that even more than finances, every minute of member time was valuable. An asset to be used wisely, not wasted.

During the process of updating the investment policy, key WAFP leaders lent business acumen and experience. Several past presidents proved invaluable – particularly Drs. Jonathan Sugarman, Don Solberg, Steve Albrecht, Gregg VandeKieft, and John McCarthy. Years later, you will still find them gifting the Academy with their talents – in roles including AAFP Delegate/Alternate, in Practice Transformation activities, and on our Foundation Board (as well as Don and Steve’s quintessential role as our auctioneering team at the WAFP Banquet!).

Our Academy is blessed to have many members making deposits of their time, talent and energy. This is the real wealth of our Academy. Washington’s reputation as an effective state chapter, rests primarily in multiple contributions, large and small, of member insight, energy, and effort. This year’s slate of 18 House of Delegate resolutions says as much. The 2016 annual meeting showed an increase in delegates as more and more local chapters are coming alive to support family physicians and their communities. The dividends paid are immense.

Other Academy activities are also experiencing the wealth of member involvement. WAFP’s Family Medicine Day at the Capitol always has high turnout, while no fewer than twelve members traveled to Washington, DC to meet with legislators and advocate for family medicine at the annual AAFP Family Medicine Congressional Conference. Attendance at committee meetings continues to grow; and the student and resident retreat sells out nearly every year, all due to the quality of presenters – regular family docs like you – who are willing to give of their time and share their knowledge with the next generation of family docs.

Purely by reading this article, you too are engaging with your Academy, a modest deposit of your time. I’d challenge you to read on, and search for an opportunity that will pay even more personal and specialty-wide dividends on time invested. Here are a number of ways:

ATTEND A LOCAL CHAPTER MEETING. Local chapters are the foundation of the WAFP. They help develop Academy policy by sending delegates to the annual House of Delegates meeting, build membership, connect medical students, residents and practicing physicians. Visit your local chapter page on the WAFP website to contact the president for information about meetings and events in your region, or to serve as a delegate or alternate delegate at the WAFP House of Delegates. If your chapter does not have a leader, contact the WAFP office for help with getting your chapter reinvigorated.

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JOIN A COMMITTEE (or drop into a committee meeting). WAFP leadership is always interested in expanding participation in its committees; and there are some openings for 2016-2017. A great deal of committee work is accomplished by e-mail and the occasional conference call, thus eliminating the need for frequent meetings.

- **The Bylaws Committee** is the “keeper” of WAFP’s bylaws. It evaluates resolutions and proposed bylaws changes for the House of Delegates.
- **The Governmental Affairs Committee** educates, promotes legislative efforts and advocates for the health of the people of Washington.
- **The Membership Committee** and its sub-committees oversees communication efforts and assists in devising programs promote membership interest and active participation.
- **Annual Scientific Assemblies (ASA) Subcommittee** plans, coordinates and conducts the Annual Scientific Assembly, and other continuing education programs of the WAFP.
- **Diverse Constituencies Subcommittee** represents the interests of WAFP’s under-represented members to include women, minority physicians, new physicians, physicians who are international graduates, as well as gay, lesbian, bisexual, and transgender physicians.
- **The Leadership Development Subcommittee/Local Chapters Subcommittee** is focused on developing leadership events and training opportunities, and assists local chapters that wish to become more active and involved.
- **The Pipeline Committee** encourages medical schools, and residencies in developing and maintain adequate programming and facilities for the education and training of family physicians.
- **The Resident & Student Subcommittee** promotes the participation of students and residents in the affairs of the Academy, and is instrumental in planning for the annual WAFP Foundation Student and Resident Retreat and the Student-Resident education track of the Annual Scientific Assembly.
- **The Practice Transformation Committee** focuses on assisting family medicine practices in the state with efforts to adopt practice change and re-design initiatives, and coordinates activities within the Academy to make implementation more effective.
- **The Public Health Committee** works on issues related to public health and family medicine research.

WAFP Board and Committee meetings are scheduled September 10, 2016 in Sea-Tac, WA. All members are welcome.

BE A MENTOR. The **WAFP PRE-MED STUDENT MENTORSHIP PROGRAM** connects students with a physician mentor who can offer discussion and advice, and possible observation time in an actual clinic. The program is flexible and designed to give the student and physician mentor the ability to customize the experience so that it meets the needs of the student, while enabling the mentor to volunteer for what is realistic in the context of his/her practice. The mentorship can be a phone conversation, a meeting for coffee or a meal, or a more comprehensive series of shadowing experiences. The point of the program is to facilitate one-on-one communications between a family physician and interested student, and the experience will leave you re-energized about being a family physician!

Attend the **POLICY ADVOCACY and LEADERSHIP DEVELOPMENT INSTITUTE** – Family Medicine Day at the Capitol. Held annually during the legislative session, WAFP members spend the day at the Capitol hearing from legislators, agency heads and the governor’s staff about key issues for primary care, and later meet with legislators and relevant agency staff to discuss issues of importance to family medicine.

CONTRIBUTE AN ARTICLE. Guest articles are always welcome to the WFP journal or monthly newsletter. Members may contribute an essay about work in their community or their family medicine experience.

NOMINATE A COLLEAGUE FOR AN AWARD. All across Washington there are extraordinary family physicians doing amazing work, and having an enormously positive impact on their community or educational institution. Consider taking the time to recognize them for their work. Nominate a colleague for Family Medicine Physician of the Year or Family Medicine Educator of the Year. These prestigious awards offer special recognition to two outstanding Academy members. The winners are presented the award in person at the Annual Scientific Assembly.

And of course – Attend the **ANNUAL SCIENTIFIC ASSEMBLY** and/or serve as a Delegate to the 2017 **HOUSE OF DELEGATES** May 4, 5 and 6, 2017 at Skamania Lodge.

Here’s hoping it will be a celebration of dividends!
The WAFP House of Delegates, the primary source of power and authority in the Academy, held its 59th annual meeting on May 12 at the Historic Davenport Hotel in Spokane. This was truly a banner year for the Academy! Due to the enthusiasm and passion of members and local chapters, there were an unprecedented number of resolutions submitted to the House: 18 resolutions along with 3 bylaws amendments. Three resolutions of condolence were also presented. Nine chapters sent full delegations, and a number of smaller chapters increased their delegate numbers from 2015, including the Chelan-Douglas, Kitsap, Columbia Basin, and Snohomish chapters. In total, 94 delegates were present, an increase over the 84 delegates present in 2015. Special guests this year included AAFP Board member, Dr. Mike Munger, and professional parliamentarian, Dr. Ann McCartney.

WAFP staff, Vice-Speaker Jeanne Cawse-Lucas, and I worked intensely in the two months leading up to the meeting to try to ensure a smooth and efficient process. Special thanks go to WAFP staff, who did the bulk of the research and preparation gathering the background information provided and attached to each resolution, enabling knowledge-based decision-making. To accommodate the volume of work, a fourth reference committee was added, and time limits were enforced during member testimony. Despite the large number of resolutions, the business of the House proceeded surprisingly smoothly. Thanks to the professionalism of members giving testimony, the House concluded on time after thoughtful and passionate discussion and deliberation.

I continue to be impressed with the broad range of ideas presented at the House, and the depth to which we consider issues relevant to our specialty and our patients. I hope you will join us and make next year another record year at Skamania Lodge on May 4, 2017!

Below are the outcomes of the 17 resolutions adopted or referred to the Board by 2016 House of Delegates:

### Prior Authorization Juggernaut

**Referred to the Board**

- **RESOLVED**, that the Washington Academy of Family Physicians (WAFP) work with health organizations such as the Washington State Medical Association, Medical Group Management Association Washington, the American Hospital Association and the American College of Pharmacy in their efforts to affect local legislation for repeal of the prior authorization process and re-imbursement for physicians for the increasing administrative burdens they entail, and be it further

- **RESOLVED**, that the WAFP work with the Washington State Insurance Commissioner and the Office of Insurance Commission to develop a standardized and streamlined prior authorization process, and be it further

- **RESOLVED**, that the WAFP take to the AAFP Congress of Delegates a resolution to develop a policy statement regarding the prior authorization process, and educate its members as to 1) its ongoing efforts to address the prior authorization burden, and 2) any prior authorization resources currently available for family physicians.

### Insurance-Driven Formulary Changes

**Adopted**

- **RESOLVED**, that the Washington Academy of Family Physicians (WAFP) partner with the Washington State Medical Association to advocate for patients currently stable on medications and ensure that they are not subjected to formulary changes and delayed fills, and be it further

- **RESOLVED**, that the Washington Academy of Family Physicians (WAFP) ask the American

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Academy of Family Physicians to advocate federally for patients currently stable on medications and ensure that they are not subjected to formulary changes and delayed fills, and be it further

- **RESOLVED**, that the WAFP work closely with the Washington State Pharmacy Association to allow equivalent interchanges be made without a new physician prescription or prior authorization by helping to establish a statewide database for Collaborative Drug Therapy Agreements.

**Protecting the Physician-Patient Relationship**

*Reaffirmed as Current Policy*

- **RESOLVED**, that the Washington Academy of Family Physicians (WAFP) oppose any legislation that interferes with patient education and health counseling and medical decisions made by patients in consultation with their physicians, which would include opposing any state laws that would require physicians to restrict their health discussions with patients or provide non-evidence based recommendations, and be it further
- **RESOLVED**, that the WAFP take a resolution to the 2016 American Academy of Family Physicians Congress of Delegates to oppose any legislation that interferes with the physician-patient encounter by restricting health related discussions between patients and their physicians and forcing physicians to provide non-evidence based medical care and counseling, and be it further
- **RESOLVED**, that the WAFP work with other medical organizations, including the Washington State Medical Association to oppose legislative interference in any aspect of the physician-patient relationship so that physicians and their patients may have open and honest discussions that are scientifically sound and evidence-based.

**Support for Independent Practices**

*Adopted*

- **RESOLVED**, that the Washington Academy of Family Physicians (WAFP) draft and publish a statement in support of family physicians in private practice, and be it further
- **RESOLVED**, that the WAFP delegates to the AAFP take a resolution to the Congress of Delegates requesting that the AAFP develop and update educational materials to support family physicians in private practice and educate young physicians about options for developing or joining a viable private practice.

**Safer Injection Facilities**

*Adopted*

- **RESOLVED**, that the Washington Academy of Family Physicians (WAFP) send a letter to the state agencies implementing the Washington State Interagency Opioid Working Plan advocating they explore the potential role for and feasibility of several medically supervised safer injection facility pilots in the state, and be it further
- **RESOLVED**, that the WAFP include at the 2017 Annual Scientific Assembly a session on harm reduction strategies for substance use disorders, including a review of the peer-reviewed evidence on medically supervised safer injection facilities.

**Coal and Fuel Transport**

*Adopted Substitute Resolution*

- **RESOLVED**, that WAFP support legislation and regulations that work to prevent or minimize the transport of coal and oil by train through Washington State, and be it further
- **RESOLVED** that WAFP support legislation and regulations that work to minimize the health risks associated with any coal and oil that is transported through Washington State, and be it further
- **RESOLVED**, that the WAFP consider submitting comments expressing health and safety concerns in those public processes related to proposals for coal and oil terminals and related infrastructure in our state.

**Gun Industry Investment and Public Health**

*Referred to the Board*

- **RESOLVED**, that the Washington Academy of Family Physicians (WAFP) recommend to all WAFP members to divest from the gun industry and encourage their healthcare organizations to do the
same, by way of an educational information sheet provided to membership, and be it further

- **RESOLVED**, that the WAFP submit this resolution before the American Academy of Family Physicians (AAFP) Congress of Delegates, recommending to all AAFP members to divest from the gun industry and encourage their healthcare organizations to do the same, by way of an educational information sheet provided to membership.

**Support for Paid Parental Leave**

*Adopted Substitute Resolution*

- **RESOLVED**, that Washington Academy of Family Physicians advocate for addressing the dearth of state funding for a parental leave policy that provides working parents job-protected time with their newborn or adopted child.

**Removing Sugary Beverages from SNAP**

*Adopted Substitute Resolution*

- **RESOLVED**, that the Washington Academy of Family Physicians submit a resolution to the American Academy of Family Physicians Congress of Delegates recommending the development of policy that commits the American Academy Family Physicians to working towards the removal of sugar- and artificially-sweetened beverages from the Supplemental Nutrition Assistance Program (SNAP) and be it further

- **RESOLVED**, that the Washington Academy of Family Physicians submit a resolution to the American Academy of Family Physicians Congress of Delegates recommending that the American Academy Family Physicians author a white paper to send to the U.S. Department of Agriculture asking for the alignment of SNAP policy with the Dietary Guidelines for Americans.

**A Sustainable Future**

*Referred to the Board*

- **RESOLVED**, that the AAFP, as a professional organization of family physicians concerned for the well-being of our patients, families and communities, study the impact of the following upon our patients, families and communities, and take appropriate action comprising educating our members, alerting the public, calling upon our government at all levels to take action, and seeking collaborative partners in such action:

1. The threat that climate change, caused by carbon dioxide emissions from the burning of fossil fuels, poses to all life on Earth, and the benefits of transitioning away from all fossil fuel burning as soon as possible.

2. The grave and well-documented threat that the current level of wealth inequality, nationally and internationally, poses to the health of individuals and to the stability of our communities and nations, especially in the context of the de-stabilizing effects of the social upheaval, armed conflict, undue burden on women and children, historic and ongoing exploitations of marginalized populations, further population growth accompanied by lack of access to reproductive rights, massive species loss, and climate change that we are already witnessing, and which we can expect to worsen for decades to come.

3. The above factors of human-caused climate change, armed conflict over Earth’s finite resources, unprecedented levels of wealth inequality, the historic and ongoing exploitation of marginalized populations, population growth, lack of reproductive rights, and food production, as all being linked, and compelling humankind as a species to embark on an unprecedented agenda of global cooperation.

**Climate Change**

*Adopted Substitute Resolution*

- **RESOLVED**, that WAFP endorse that climate change is a critical public health issue, and be it further

**Oral Health is Good for Overall Health**

*Reaffirmed as Current Policy*

- **RESOLVED**, that the Washington Academy of Family Physicians promote existing educational resources to help members identify and treat caries and other oral health problems in pregnant women, mothers, infants, children, and people with diabetes, and be it further

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RESOLVED, that the Washington Academy of Family Physicians work with other primary care specialties, public health entities, dentists, local service groups and other providers to train family physicians to identify, treat, and appropriately refer pregnant women, mothers, infants, children, and people with diabetes for their oral health issues, and be it further

Adopted Substitute Resolution

RESOLVED, that the WAFP take resolutions to the Washington State Medical Association and the American Academy of Family Physicians to support the identification and treatment of oral health problems by primary care physicians within their scope of practice by increasing education and advocacy efforts, and be it further

RESOLVED, that the Washington Academy of Family Physicians support adequately funded dental coverage aimed at reducing the burden of disease in vulnerable populations.

Promoting Physician, Resident, and Medical Student Wellness

Adopted Substitute Resolution

RESOLVED, that the Washington Academy of Family Physicians (WAFP) promote greater member awareness about physician, resident, and medical student depression, burnout, and suicide, and reduce the stigma and barriers to seeking mental health support by including a session at the 2017 WAFP Foundation Student and Resident Retreat and at the 2017 WAFP Annual Scientific Assembly, and be it further

RESOLVED, that the WAFP provide resources for active and retired physicians, residents, and medical students experiencing depression and/or burnout, including prevention and early intervention, on its website and address the issue through an article published in the quarterly journal, and be it further

RESOLVED, that WAFP Delegates to the American Academy of Family Physicians (AAFP) take a resolution to the Congress of Delegates to expand upon the current AAFP position paper on physician burnout by writing a new position paper about well-being and mental health that also addresses issues specific to medical students and residents and promotes greater nationwide awareness about physician depression and suicide. This paper should include, but not be limited to prevention of, and early intervention for, physician burnout, and attempt to reduce the stigma and barriers to seeking mental health support by providing suggestions of live, online, and printed resources for individuals and healthcare institutions alike.

Increasing the Physician Workforce in Washington

Referred to the Board

RESOLVED, that the Washington Academy of Family Physicians advocate, such as via a resolution to the Washington State Medical Association, for the completion and implementation of a state loan program that includes interest-rate incentives for practicing in Washington State, particularly in primary care and in underserved communities, which would be open to any student enrolled at a Washington medical school, and prioritizes students who do not have adequate access to other loans, and be it further

RESOLVED, that the Washington Academy of Family Physicians submit a resolution to the American Academy of Family Physicians to publish a white paper on extending National Health Service Corps eligibility to undocumented students.

Health Insurance Coverage for Legal Migrants from Micronesia

Adopted Substitute Resolution

RESOLVED, that the Washington Academy of Family Physicians (WAFP) partner with other organizations to advocate for a Washington State solution to lack of access to health insurance for legal migrants from Compact of Free Association states (Micronesia) in the absence of relief at the federal level, and be it further

RESOLVED, that the WAFP educate its membership regarding the vulnerabilities of the population of legal migrants from Compact of Free Association states (Micronesia) in terms of the social determinants of health and social justice.

Transgender Cultural Competency

Adopted

RESOLVED, that the Washington Academy of
Family Physicians offer educational opportunities to its members discussing transgender health disparities and clinical and cultural competencies necessary for transgender health care, and be it further

- **RESOLVED**, that the Washington Academy of Family Physicians (WAFP) write a letter requesting that the American Academy of Family Physicians (AAFP) include a session discussing transgender health disparities and clinical and cultural competencies necessary for transgender health care at the 2017 AAFP National Conference of Family Medicine Residents and Medical Students, and be it further

- **RESOLVED**, that the WAFP write a letter requesting that the American Academy of Family Physicians (AAFP) include a session discussing transgender health disparities and clinical and cultural competencies necessary for transgender health care at the 2017 AAFP Family Medicine Experience.

### Transgender Use of Public Facilities

**Adopted Substitute Resolution**

- **RESOLVED**, that the Washington Academy of Family Physicians (WAFP) endorse existing state-specific anti-discrimination laws protecting people from discrimination based on gender expression and identity AND oppose initiatives and proposed legislation that would compromise the safety and health of transgender people, and be it further

- **RESOLVED**, that the WAFP take a resolution to the AAFP Congress of Delegates (COD) asking the AAFP to oppose initiatives and proposed federal and state legislation that would compromise the safety and health of transgender people.

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**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.
When I was 15 years old I chopped down my first tree with an ax. It took me all afternoon. Most of the time my swing was weak, the blade bouncing off the trunk instead of biting deep. I was in Guatemala on a mission trip, helping to clear a road through a portion of the jungle. The theory goes that if you cut a wedge into the tree, it will weaken the tree on that side, and the tree will fall towards the weakened side. But sometimes the tree is already leaning too far in another direction. Sometimes you can’t overpower nature and gravity, to force the tree where you want it to fall. Organizations and the people within them can also be like that, leaning in another direction, resisting attempts to change their trajectory.

As I have progressed through my medical education, I’ve begun to be included in more administrative capacities. I’ve been a member of committees. I’ve been to board meetings and department meetings. I’ve seen the struggles of organizations trying to achieve their goals. Two years ago I attended the House of Delegates for the first time, eager and not knowing what to expect. I remember positive outcomes, discussions that were easy, resulting in conclusions with little debate. This year was my second time and I came with a more critical eye. This time I sought out debate. I intentionally chose to attend discussion of resolutions that I didn’t understand or that I disagreed with. I wanted to see how good leaders managed disagreements and directed members for a positive outcome. My favorite statement of the day was, “speaking in favor of the spirit of the resolution, but against the phrasing in this particular instance”. I was impressed by how this choice of words allowed a supportive discussion to take place around a controversial issue.

The WAFP has a long history of advocacy and action resulting from these resolutions. The staff made a phenomenal addition to the manual this year by including background information on each of the resolutions. Many topics had already been addressed as resolutions in previous years. Knowing this, the delegates could focus on necessary updates or simply reaffirm a resolution as already existing policy. Seeing that background information helped me appreciate the extent of the WAFP’s advocacy over the decades.

One workshop session I found particularly valuable was Driving Safety in Older Adults. This workshop was in fact the result of a House of Delegates resolution from last year calling for more education for physicians on this topic. I knew that driving safety can be a divisive subject for families, and I wasn’t sure how I would go about evaluating a patient for this. I am grateful for the training and for being connected with other additional resources.

I also valued being able to table train at the osteopathic manipulation session. Our osteopathic school is a relatively new addition to the state, and it was rewarding to be able to share some of our techniques and philosophies with other physicians. The school is planning an additional program to help educate more physicians about osteopathic techniques, and how to precept students and residents in clinic.

I also attended the workshop on understanding buprenorphine. I had been aware of the medication, but I was mostly unaware of the controversy surrounding its use. This session changed my perspective. I was struck by the stories of patients with opioid-induced sensitivities who were able to maintain a productive life on low doses of medications. As I move into residency I will seek out more training and experience in this area, and will consider buprenorphine prescribing in my practice.

The House of Delegates pairs with the Scientific Assembly. Policies discussed and needs expressed are addressed in upcoming Scientific Assembly workshops. Family Medicine is not just Medicine for Families. It is a Family of Medical Professionals holding each other up, supporting each other, calling each other to account for the improvement of the Family Group. It is here that we set the tone for how we want to practice. We are encouraged to keep searching for answers, to go one more day chopping through the trees to clear a path for ourselves and others.
Under our state constitution, the regular session of the legislature begins on the second Monday in January, and in each even-numbered year may run no more than 60 days. This year, however (and for the sixth time in the past seven years), the legislature failed to finish its work as scheduled and went into overtime. With the regular session ending March 10, Governor Inslee immediately called a special session to have Legislators focus on the state’s supplemental operating budget, done each year to address unanticipated developments affecting the state’s underlying biennial budget. The budget passed, and the special session was gaveled to a close on March 29.

But for the extra time, which many thought would be avoided, this year’s meeting of lawmakers generally played out as expected for a 60-day, supplemental budget, election-year session: some follow-up from last year, a few significant accomplishments, and a whole lot of positioning for next year’s session and the campaigns leading up to it. WAFP emerged from the 2016 legislative sessions unscathed, with incremental but important progress in at least a few areas.

What follows is a brief description of some of the bills passed by the 2016 legislature in which WAFP played an active role or which otherwise may be of interest to family physicians and their patients. For ease of reference, we’ve listed the bills in numerical order simply as “Senate Bill” (SB) or “House Bill” (HB) rather than the more cumbersome notation (such as “Engrossed Second Substitute House Bill”) that reflects procedural steps taken by a given bill to get through the process. We've also noted parenthetically, the particular legislator who was the prime sponsor of the bill when introduced. If no effective date is specified in a bill, it takes effect ninety days after final adjournment of the legislative session in which it is enacted, which was June 9, 2016, for laws enacted during the 2016 regular session.

These brief summaries are taken from information compiled by legislative staff, and include only those sections of the legislation likely to matter to primary care and family medicine. We encourage you to go to the legislative website (leg.wa.gov) for more details and to read enacted legislation in its entirety.

**HB 1682: homeless students (Fey)**
- Authorizes a school nurse, school counselor, or homeless student liaison to provide informed consent for health care for a homeless child or youth under certain conditions.

**HB 2335: health care provider credentialing (Cody)**
- Requires health care providers and insurance companies to use a single credentialing database.
- Effective June 1, 2018, requires insurance companies to make credentialing determinations within 90 days of receiving a complete application; and by June 1, 2020 the average response time must not exceed 60 days.

**HB 2350: administration of medication by medical assistants (Cody)**
- Specifies that a medical assistant’s existing authority to “administer” medications includes both the retrieval and application of the medication.

**HB 2432: substance abuse monitoring for osteopathic physicians and surgeons, and osteopathic physician assistants (Riccelli)**
- Places in statute the requirement that the Board of Osteopathic Medicine and Surgery contract with a substance abuse monitoring program.
- Increases the osteopath license surcharge to pay for program costs to $50.

**HB 2730: the prescription monitoring program (Peterson)**
- Expands access to the Department of Health's prescription monitoring program.

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SB 5143: childhood immunization resources for expecting parents (Becker)
- Requires the Department of Health to develop resources for expecting parents regarding recommended childhood immunizations.

SB 5689: the diabetes epidemic in Washington (Becker)
- Requires relevant state agencies to develop plans to reduce the incidence of diabetes in Washington, improve diabetes care, and control medical complications and financial impacts associated with diabetes.
- Requires the agencies to submit a coordinated report to the Legislature every two years beginning December 31, 2019. The report must include information on agency efforts to control and prevent diabetes as well as ways to control costs of the disease.

SB 5728: screening for HIV (Darneille)
- Requires clinicians to screen for HIV infection for all patients who are 15 through 65 years of age. Patients must be informed of the screening and provided an opportunity to decline.
- Prohibits clinicians from denying services or treatment to a patient who declines HIV screening.

SB 5857: pharmacy benefit managers (Parlette)
- Establishes oversight for pharmacy benefit managers within the Office of the Insurance Commissioner.

SB 6421: epinephrine auto-injectors (Ranker)
- Allows health care providers to prescribe epinephrine auto-injectors in the name of an authorized entity such as a restaurant, sports arena, university, or recreation camp.
- Requires authorized entities with a prescription for an epinephrine auto-injector to follow training, storage, maintenance, and use requirements.
- Allows trained employees of authorized entities to administer an epinephrine auto-injector to a person believed to be having an allergic reaction.

SB 6519: telemedicine (Becker)
- Establishes a collaborative for the advancement of telemedicine to make recommendations on improving reimbursement and access to health services provided through telemedicine.
- Effective January 1, 2018, modifies the list of sites where a patient may receive telemedicine services to include “home.”

Of note about this year’s supplemental budget is that it included no new taxes on physician services. Overall, it increased biennial state spending by $190 million, much of which will go to cover unexpected costs to Medicaid driven by increased prescription drug prices. $40 million of the total will go to significant new investments for mental health services.

The WAFP also engaged on several bills in 2016 which failed to pass. Two of these the Academy actively opposed: HB 2304 (DeBolt) would have expanded the prescriptive authority of naturopaths; HB 2343 (Cody) would have allowed medical school graduates who have not completed a residency program to engage in the supervised practice of medicine as “associate physicians.”

Bills failing to pass which WAFP supported include:
- HB 2307 (Farrell)/SB 6149 (Keiser) requiring reasonable accommodations in employment for pregnancy, childbirth, or pregnancy-related health conditions;
- HB 2313 (Orwall)/SB 6157 (Miloscia) raising the smoking/vaping age from 18 to 21;
- HB 2363 (Cody)/SB 6417 (Ranker) promoting transparency of prescription drug pricing and costs;
- HB 2515 (Pettigrew)/SB 6272 (Becker) requiring Medicaid to pay for primary care services at a rate no lower than Medicare; and
- HB 2931 (Stanford) restricting the use of non-competition agreements.

Each of these issues will likely be before the Legislature again in 2017. WAFP will need to decide how much of its time and effort to commit toward supporting them both during the interim and through the 2017 session.
I’ve heard it repeatedly said that NCCL, the National Conference of Constituency Leaders, (formerly known as the National Conference of Special Constituencies), is the heart of the AAFP. But what exactly is this conference of constituency leaders, you ask? That requires a bit of a history lesson.

Years ago, members of underrepresented groups needed a forum to discuss issues that mattered to them. The meeting was first convened in August 1990 as the National Conference of Women, Minority, and New Physicians. This initial meeting was a forum where members of these groups could network and, most importantly, make specific recommendations to the AAFP Board of Directors and our Congress of Delegates. Realizing that this wasn’t enough, the AAFP Congress of Delegates gave our constituency groups representation in our Congress. The conference name was subsequently changed to the National Conference of Special Constituencies and in 2001, International Medical Graduates (IMG) were given equal representation with a forum in 2000; the GLBT constituency (gay, lesbian, bisexual, transgender) was added as the fifth and final constituency group in 2001. In 2015, the conference was renamed the National Conference of Constituency Leaders (NCCL) as the AAFP realized that this is more than just a conference for discussion of ideas and concerns, but was also a forum for the development of leadership skills that can be taken back to local chapters to effect change in our communities.

This all sounds great, but I’m sure you’re asking yourself the same question I asked myself before I started my addiction to NCCL – does anything actually happen at this conference, or is this just a place where our concerns fall on deaf ears? After starting my NCCL journey back in 2006, I can honestly tell you that our voices are heard loud and clear. AAFP Board Members, Speaker, Vice Speaker, President, President-Elect and Board Chair are all very interested in what we have to say. It’s not uncommon for members of our leadership to get involved in discussions and gently guide our members in crafting resolutions that may ultimately become AAFP policy – going down the appropriate paths, of course.

Now again, you’re probably telling yourself that this is simply lip service coming from a guy who’s had a bit too much of the Kool-aid. You’re partially correct. But let me give you an example of what we’ve been able to accomplish.

The GLBT constituency, with amazing support from our other constituencies, (New Physicians, International Medical Graduates, Women and Minority, Medical Students & Residents), worked hard to convince the AAFP to support marriage equality. It’s certainly not without controversy, but our NCCL body knew the important impact this sort of policy can have on patients and the physicians who provide care to GLBT patients. After repeated years of failing to pass at our Congress of Delegates, and after constant support from our AAFP leadership combined with the support of NCCL and medical student and resident delegates to our Congress, it overwhelmingly passed at our 2012 Congress of Delegates in Philadelphia, PA. As a family physician and self-identified gay male, it was amazing to know that our specialty supports me as a physician and, more importantly, as a person who should have equal rights and privileges.

This is why our leadership describes NCCL as the heart of our Academy. But this is a small example of what NCCL can accomplish. NCCL is where the voices of historically underrepresented groups come together to send a strong message to our national Academy.

And your WAFP brought passionate voices to represent all of you at NCCL last May. Washington was well represented by five family physicians who brought key issues that matter to all of us. Dr. Megan Guffey represented the IMG constituency, Dr. Heather Kinsel-Evans represented Women; Dr. Meghan Lelonek represented New Physicians, Dr. Jessica Guh represented the Minority constituency, and I had the opportunity to represent the GLBT constituency. And our very own Dr. Megan Guffey was also elected to help run the IMG section of NCCL in 2017! Just like at our WAFP House of Delegates and the AAFP Congress of Delegates, continued on next page

Washington Family Physician
we craft resolutions that are separated by our different commissions – Advocacy, Health of the Public and Science, Education, Practice Enhancement along with Organization & Finance. Here are just a few things we talked about this year:

**Advocacy**
- Improving Medicare Financing Through Parts A, B, C and through Medigap Consolidation
- Educating a Diverse Physician Workforce

**Education**
- Unconscious Bias Training in Residency and for AAFP Members
- Necessary Changes to the ABFM MC-FP Process
- Racism and Bias Education for Family Physicians

**Health of the Public & Science**
- Oppose Transphobic Legislation Regarding the Use of Public Facilities
- Care and Support of Transgender and Gender Nonconforming Youth
- Promotion of Parity in Insurance Coverage for Transition-Related Transgender Care

**Organization & Finance**
- Public Reporting of Diversity Data for Race & Ethnicity
- Better Parental Leave Policies for Family Physicians
- Upgrading to Diversity and Inclusion Version 3.0
- Increasing the Pipeline of Underrepresented Physicians to Address Diversity & Inclusion

**Practice Enhancement**
- Direct-to-Consumer Advertising
- Systemic Solutions to Physician Burnout

There is one other thing that NCCL provides and it’s more than just learning how AAFP develops policy or sharpening your leadership skills, although that, too, is very important! At NCCL, you meet the most amazing people from all over the nation with varying backgrounds and experiences, who just happen to be family physicians. These are people you start to recognize at other AAFP and local chapter events. It starts off with a handshake, followed by collaboration on a resolution that may end up with a partnership on a commission or a committee. This is where I found my family within the AAFP, and I feel fortunate that I’ve been able to develop deep bonds with the most amazing people!

In short, NCCL provides you with an opportunity to have your voice heard. NCCL prepares you for the, “real world” by giving you leadership skills that can be used in your clinic, community, local and state chapters. NCCL gives you the opportunity to build the most amazing relationships with some pretty fantastic people. Without NCCL, and the WAFP, I wouldn’t be the leader I am today. And it all started with signing up for a conference I didn’t really know about in 2006!

So before I sign off, I challenge you to see where your leadership potential will take you in your career as a family physician. I dare you to join me at NCCL 2017!

For more information on NCCL, check out the website at [http://www.aafp.org/events/acfp-nccl/nccl.html](http://www.aafp.org/events/acfp-nccl/nccl.html) where you can learn more about its history and the work done to represent you at our Academy!
During the course of most family physicians’ practices we will encounter both those who have served time in our state’s prisons and jails as well as their family and significant others. Our current justice system’s orientation toward jail being a punitive consequence of criminal misconduct has implications for the health of not just our patients and their families, but our society as a whole.

From 1972 to the present, both the total number of people being imprisoned and the rates of incarceration have increased six fold. The United States’ current rate of incarceration, 716 inmates per 100,000 residents, is the highest in the world – exceeding that of many totalitarian regimes, including Russia and China. Viewed another way, while the US has 4.4% of the world’s population, our imprisoned population is 22% of the world’s total prison/jail population. All told, more than 2.4 million people reside in US prisons and jails at the federal, state and local levels. The State of Washington has 12 state correctional facilities and 32 county jails. The state prison system, as of December 31st, held 18,417 people of whom 92% were male. While 17% of prison inmates are African-American and 13% are Hispanic, only 3.4% of our state’s population is African-American and 11.2% Latino. Scholars differ on the reasons for this enormous increase in our prison population. Most point to several causes, including a marked increase in arrests and imprisonment for drug related offenses, and changes in sentencing that mandate longer prison terms: mandatory minimum terms, the 3 strikes laws and uniform sentencing guidelines. Also, there has been a general trend in regarding prison as a place to punish and isolate offenders from society rather than a place for rehabilitation.

Funding for counselors, doctors, educational programs and other prison services has been in decline for the past 25 years. Despite funding cuts, prisons and jails remain an expensive line item for the federal government, states and local governments. Nationally in 2014, our government spent over $80 billion to provide beds, staff, food and facilities. In the State of Washington’s prison system for 2015, approximately $35,000 was spent per inmate per year, or about $95 per inmate per day.

During the past 40 years there has been a marked change in the prison population’s demographics and the problems accompanying inmates as they enter jails and prisons. Minorities are disproportionately represented in the prison system mostly because of their involvement in the drug trade and the violence that accompanies those crimes as well as their inability to afford strong legal representation. Prison inmates are frequently addicted to one or more drugs and often undergo withdrawal during their prison terms. Mental health problems are rampant. One commonly cited measure is that 63% of the prison population has a DSM diagnosable illness. In addition to drug addiction and mental health problems, infectious diseases such as HIV, Hepatitis C, STDs and TB are relatively common. Inmates are, more often than not, poorly educated, financially bereft and have fragile social support systems. Because of this, inmates have often not seen any kind of health care provider for years, if at all.

In addition to the problems facing inmates before they arrive in prison, life in prison is harsh. Inmate on inmate violence occurs frequently. Gang affiliations and conflict are common. Illicit drugs are smuggled into the jails and are available for a price. Mental health problems are exacerbated by imprisonment. Those deemed mentally ill and at risk for suicide are placed in continuously lit, frequently monitored bare cells. While isolation deprives suicidal inmates of opportunities for self-harm, such environments are bereft of any comfort, warmth or sense of normalcy. Despite these precautions, suicides are common in county and state prisons.

There is a large secondary societal impact when people are taken to jail. Inmates are husbands, wives, sons, daughters, parents and significant others. While in jail, inmates cannot fulfill their responsibilities to their families including child care, care of elderly relatives and support for their families financially and emotionally. According to the Ella Baker Center for Human Rights, when someone goes to jail nearly 65% of their families are no longer able to afford basic necessities including food and shelter. Approximately 70% of those families compromised by the incarceration of a family member have children under the age of 18.

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Health care services in the jails are funded by the federal, state or county governments, depending on the prison. At the county level, midlevel practitioners provide the bulk of the standard medical and mental health care. Those inmates who have medical problems at their arrests are usually allowed to continue to receive the medications they took prior to being incarcerated. However, those identified while in jail as needing medications face long delays in obtaining the needed drugs. Also, because of the extensive health care needs of the prison population, medical care is essentially rationed and triaged with those who are most ill receiving more prompt attention.

On release inmates must surmount still more hurdles. Their jobs, if they had one at incarceration, have often been filled by others, and a prison record makes obtaining a job much more difficult. Certain occupations, including healthcare, childcare and the care of the elderly, are not an option for those with a felony conviction. Finding food and shelter is difficult due to a lack of financial resources and a criminal record disqualifies most from obtaining public housing. When they enter prison those on Medicaid lose their insurance and must reapply after release, a process which can often take months. Fines are levied on those jailed by both the jail and the court system. Eighty-five percent of inmates leave prison with a criminal justice debt. The average cost for an attorney, bail bondsman, court fees and restitution was $13,607 in 2014. Donations for transport and clothing are often needed at prison discharge, as many inmates may not have had shoes, coats or underwear at the time of their arrest and do not have money to get themselves back to their hometowns.

Politicians and governments have been slow to recognize the problems inherent in our current system of imprisonment. However, special courts for those with drug and mental health problems are making small inroads at reducing imprisonment and preventing repeated incarcerations. Laws legalizing possession of small amounts of marijuana have the potential to reduce arrests and imprisonment for low level drug offenders. As family physicians we have become accustomed to dispassionately evaluating tests, treatments and other interventions based upon level of evidence guidelines. Perhaps we should employ the same methods in evaluating societal policies such as imprisonment. As family physicians we are uniquely positioned and trained to understand and advocate for our patients and our society about the problems arising from our country’s prison system.
The Washington Academy of Family Physicians held its 67th Annual Scientific Assembly at the Historic Davenport Hotel in Spokane, WA on May 13-14, 2016. The WAFP meeting last convened at the Davenport on May 1, 2009 for “WAFP Practice Enhancement Day”, following the 52nd House of Delegates meeting. Remarks about the venue were wonderful with some additionally appreciating a downtown atmosphere for outside exploring.

The event drew a total of 159 participants, 16 of whom were first time attendees. The educational portion of the conference featured 6 plenary sessions, 13 workshops, and 2 lunch presentations. A well-rounded student and resident track planned by the WAFP Resident & Student Subcommittee, featured workshops on advocacy, ultrasound basics, and interpersonal and professional communications.

Feedback on the event was overwhelmingly positive. The assembly kicked off with the William F. Mead, MD Lecture, delivered by Christopher Koller, President of the Milbank Memorial Fund, an endowed foundation founded in 1905 that works to improve the health of populations by connecting leaders and decision makers with the best available evidence and experience. His inspiring keynote address, “Acting on the Evidence: The Role of Primary Care Physicians in Making the Case for Primary Care Investments” spoke to many on the important role primary care physicians play, and made the case for significant investment in primary care delivery. His presentation was well received by attendees, one of whom commented that it was “an excellent presentation leaving us with a true challenge” in working to obtain a larger investment of resources in primary care.

Other special guests included Shawn Martin, AAFP Senior Vice President, Advocacy Practice Advancement and Policy, who delivered an in depth presentation on MACRA (Medicare Access and CHIP Reauthorization Act of 2015), MIPS (Merit-Based Incentive Payment Systems) and APMs (Alternative Payment Models). These are important, complex, new policy changes that may have family physicians confused about new proposed payment models. The Academy is fortunate to have speakers on hand to provide concise presentation on the subject, and attendee feedback echoed that it was timely, relevant and well presented.

In an effort to address health care delivery changes ahead which recognize pay for performance models, Saturday featured a panel discussion on Washington’s four Practice Transformation Networks (PTNs) with representatives from three of the PTNs working to help transform practices in our state - Sue Deitz from the National Rural Accountable Care Consortium, Dr. Beth Harvey of the Pediatric-Transforming Clinical Practice Initiative, and Dr. Freddy Chen, representing UW Medicine. Other faculty included Gary Garrety who provided a presentation on the Washington Prescription Monitoring Program, and Dr. Michael Munger, AAFP Board Member, who addressed the House during the annual House of Delegates, conducted the swearing in of newly elected WAFP Leaders at the WAFP Annual Banquet on Friday night, and acted as the AAFP official for the 2016 Convocation of Fellows on Saturday.

Both plenary sessions and individual workshops ranged in topic, with an intense focus on addressing knowledge gaps and practice implementation applications. Plenaries garnering the most positive feedback included the “Mead Lecture”, “Update on Lipid Guidelines”, and “Communication Strategies to Improve Acceptance of Childhood Vaccines”. Praise also goes to Shawn Martin for skillfully educating members about payment reforms ahead. According to one attendee, “Martin was maybe my favorite as he did an excellent job revealing and explaining components of MACRA - and doing so with optimism.”

Workshops having the most impact focused on the physiological effects of marijuana use, team-based health, and public health threats. High marks went to Dr. Alex Brzezny for his style, passion and humor during his presentation on Emerging Public Health Threats; to Dr. Paul Costello, who led attendees through an engaging Self-Assessment Module on Mental Health; continued on next page
and Dr. Devin Sawyer, who brought his entire team for a workshop entitled, “It takes on Orchestra to Create a Symphony: The Future of Patient-Centered Chronic Disease Management and the Patient”. The presentation was so unique and effective that one attendee remarked, “having the whole team there, and your succinct PowerPoint really made the session work. Best session of the day! Thank you everyone for coming, and for wearing the dorky outfits (it made the point!).”

Three Self-Assessment Module (SAM) workgroups were offered by WAFP’s very seasoned group of facilitators. SAM workgroups remain popular and provide attendees with a practical and interactive learning method while meeting ABFM requirements for maintenance of certification. One notable remark, “this group method is by far the best way to get useful information and learning out of it. I learned from the various doctors’ comments more than the test itself.”

The WAFP Foundation Auction raised over $13,000. A very special thanks to our auctioneert/announcer team, Drs. Steve Albrecht and Don Solberg. Proceeds from the auction help the Foundation support practices that must transform to achieve value-based reimbursement systems and to become facile with the necessary reporting requirements. The Foundation further provides support for a campaign to help Washingtonians understand who family physicians are, and the important role family medicine must play in health care system reforms. Our pre-auction warm-up game was the Heads-or-Tails competition led by Resident co-trustees, Drs. Erin Locke and Radha Sadacharan, who powered through with their accident-prone coin toss technique. Special thanks is given to the UW Medical Student Education Section for donating the basket of wine and chocolate for the lucky winner.

Auction donors were extremely generous this year while giving of their time and talent. A sweater emblazoned with the WAFP logo, hand embroidered by Dr. Richard Hawkins made its way to the live auction, as well as the popular Guided Mushroom Expedition and Cabin Stay led by Drs. Kristin Larson and Russell Maier. A special thank you to all of our donors this year, without whom, the auction would not be possible.

I would also like to give special recognition to the Annual Scientific Assemblies Subcommittee for their hard work in developing a content-rich program for 2016. The committee includes Lydia Bartholomew, MD; June Bredin, MD; Amanda Kost, MD; Russell Maier, MD; Pamela Pentin, MD; Patricia Read-Williams, MD; Jean Riquelme, MD; Jerry Yorioka, MD; Erin Locke, MD – Resident Trustee and Radha Sadacharan – Alt. Resident Trustee; and students, Caitlin Reed Lund, OMS3 and Lara Wilson, MS2.

The WAFP is very pleased to have offered quality, evidence-based programming. Attendees were able to earn up to 12.50 Prescribed credits through the regular ASA sessions; with additional credits from one or more SAMs, and AAFP Translation to Practice® CME, a total of 45.00 Prescribed Credits were available to attendees this year.

We hope you can join us in 2017 for our annual meeting. The 2017 House of Delegates meeting is scheduled for Thursday, May 4, and the Annual Scientific Assembly will be held Friday, Saturday, May 5-6, 2017 at Skamania Lodge in Stevenson, WA along the Columbia River. Please save the dates and make sure you join us next year!
59th House of Delegates, 67th Annual Scientific Assembly

Outgoing WAFP President, Dr. Tony Butruille welcomes incoming President, Dr. June Bredin.

The A team: Announcer & Auctioneer – WAFP Past Presidents, Dr. Don Solberg (L) and Dr. Stephen Albrecht (R).

WAFP, new student co-trustees, Katherine (Kat) Arkwright, OMS2 (L), and TaReva Warrick-Stone, OMS2 (R) sell raffle tickets to ASA Subcommittee Chair, Dr. J. Mark Board.

Installation of officers – L-R: TaReva Warrick-Stone, OMS2; Katherine Arkwright, OMS2; Tony Butruille, MD; Jaime Klippert Fajardo, DO; AAFP Dignatary, Michael Mungen, MD, FAAFP; Lydia Bartholomew, MD, MHA, FACPE, FAAFP; Jeremia Bernhardt, MD; Angela Sparks, MD; Lillian Wu, MD, FAAFP; Diana King, MD; Patrick McLaughlin, MD.

WAFP’s new student co-trustees, Katherine (Kat) Arkwright, OMS2 (L), and TaReva Warrick-Stone, OMS2 (R) sell raffle tickets to ASA Subcommittee Chair, Dr. J. Mark Board.

Collaborative bidding results in two lucky winners, Dr. Lillian Wu and Dr. Angela Sparks.

Installation of officers – L-R: TaReva Warrick-Stone, OMS2; Katherine Arkwright, OMS2; Tony Butruille, MD; Jaime Klippert Fajardo, DO; AAFP Dignatary, Michael Mungen, MD, FAAFP; Lydia Bartholomew, MD, MHA, FACPE, FAAFP; Jeremia Bernhardt, MD; Angela Sparks, MD; Lillian Wu, MD, FAAFP; Diana King, MD; Patrick McLaughlin, MD.

From left: Dr. Richard Bunch, of Othello accepting his award from WAFP President, Dr. Tony Butruille.

50 year member, Richard Bunch, of Othello accepting his award from WAFP President, Dr. Tony Butruille.

Finalists for the Heads-or-Tails raffle make their selection in advance of the next toss.

Attendees take in a plenary at the Scientific Assembly.

Shawn Martin, AAFP Senior Vice President, Advocacy, Practice Advancement and Policy fills knowledge gaps through an in-depth presentation on MACRA, MIPS and APMS.

Board members discuss resolutions and reports at the WAFP Board of Directors meeting, Thursday, May 11.

WAFP Resident Trustee, Dr. Erin Locke conducts an energetic coin-toss for the Heads-or-Tails raffle.

President, Dr. Tony Butruille, honors outgoing Student Trustee, Caitlin Lund, OMS3.
2016 Annual Banquet and Auction

WAFP Elected Leaders Sworn In

President – June Bredin, MD
President-Elect – Lydia Bartholomew, MD, MHA, FACPE, FAAFP
Vice President – Jeremia Bernhardt, MD
Speaker – Lillian Wu, MD, FAAFP
Vice Speaker – Jeanne Cawse-Lucas, MD
Assistant Secretary Treasurer – Angela Sparks, MD
New Physician Trustee – Jaime Klippert Fajardo, DO
West Side Trustee – Diana King, MD
East Side Trustee – Patrick McLaughlin, MD
Resident Trustee – Radha Sadacharan, MD
Student Co-Trustee – Katherine Arkwright, OMS ll
Student Co Trustee – TaReva Warrick-Stone, OMS ll
AAFP Eastside Delegate – Russell Maier, MD, FAAFP
AAFP Eastside Alternate Delegate – Tony Butruille, MD

Honored and in Attendance at the Annual Banquet

WAFP Past Presidents
Bill Marsh, MD 1995-1996
Dan Austin, MD 2000-2001
Don Solberg, MD 2005-2006
Jerry Yorioka, MD 2006-2007
Gregg VandeKieft, MD 2007-2008
John McCarthy, MD 2009-2010
Stephen Albrecht, MD 2010-2011
Carl Olden, MD 2011-2012
Kevin Martin, MD 2013-2014
Chris Gaynor, MD 2014-2015

Past WAFP Family Physicians of the Year
Richard Bunch, MD 1993
Raye Maestas, MD 1994
William Phillips, MD 1999
William Marsh, MD 2008
John McCarthy, MD 2012
Carl Olden, MD 2014

50 Year Members Honored
Norman Elmer Staley, MD, FAAFP
Richard P. Bunch, MD, FAAFP
David Myron Gimlett, MD, FAAFP
David Stephen Hopkins, MD, FAAFP
Nola Mae Moore, MD, FAAFP
Glenn S. Skinner, MD

Washington Family Physician
Practicing rural family medicine is tough work. It requires a broad range of skills including strong intellect, compassion and an unparalleled commitment to serve. Geoff Jones embodies what it takes to be an excellent rural clinician. He practices full spectrum family medicine, including operative obstetrics, staffs the Emergency Department, provides endoscopic service and manages a patient panel demanding active acute and chronic care. He balances clinical and administrative obligations while protecting time to for his real passion, his wife and family. Geoff would say that he is just a regular family physician; we think he is among the best.

Geoff graduated from Pacific Lutheran University and then attended the University of Washington School of Medicine, graduating with honors in 1996. He did his residency training with Family Medicine Spokane, and upon graduation he left Washington for Bethel, Alaska for several years, returning to Newport with his wife (who is also a family physician), where he has practiced since 2002. He became an integral part of the Newport community, serving as treasurer and chairman of the Board of Directors for Habitat for Humanity since 2005. He almost single handedly kept the local chapter alive through his dedication to purchase land and build homes for people in need. He is a champion for Hepatitis C care, working with the University of Washington through the Project Echo program. He facilitates a Teddy Bear Clinic every year for all kindergarten children to become more comfortable if needing a hospital experience. And he still finds time to attend numerous community, sporting, and church events, while carefully balancing his professional and family life. He and his wife respect the importance of their careers in family medicine, but always make their children a priority, spending time off volunteering in their classes.

Geoff has an incredible passion to teach. When asked to undertake a longitudinally integrated rural clerkship, he was happy to do so. Geoff loves working with students, and included “college mentor,” to his already full agenda exposing students to what we want them to see – highly competent, skilled, multi-faceted family doctors.

However, Geoff did not stop there. Being passionate about medical education and family medicine, Dr. Jones joined the UWSOM admissions committee and ultimately its Executive Committee; a huge additional time commitment, because it was the right thing to do.

In Newport, he is the lead preceptor for both the RUOP and TRUST/RITE programs. His energy seems limitless, and the students always remark about his immense passion for being a family physician.

In summary, Geoff truly represents what a family physician can and should be in this challenging time for health care delivery. He is knowledgeable, skilled, and always cares for others above self. He has the constellation of attributes which we as family physicians need to foster in our specialty. He is among the best of us, demonstrating what a caring and compassionate family physician represents to his patients, community and family. Geoff Jones truly embodies what it means to be Family Physician of the Year.

The WAFP is honored to recognize Geoff Jones for his dedication to teaching and serving as a role model for future doctors, for his dedication to bringing the best and brightest to the field of family medicine, and for his immense passion for being a family physician.
Raye Maestas is the preeminent educator of educators. She has been directing and teaching students since 1986, rising from clinical instructor to full professor. Raye occupies several important and prominent leadership roles in the University of Washington Department of Family Medicine, including Head of the Denali College, Associate Chair of the Introduction to Clinical Medicine course for first year medical students, Co-Director of the Primary Care Practicum, and she was recently named as Assistant Dean of Student Affairs at UWSOM. Her leadership has been particularly instrumental in the launch of the curriculum renewal. Her extensive work with the curricular design and development of the colleges program has connected UWSOM with similar mentoring programs nationwide. Her work in the Clinical I course includes development of student self-paced and digital distance learning. Her most recently published research encompasses development of preceptor bedside teaching working with early learners. She has presented on this topic as part of the WRITE regional curriculum and is a sought-after presenter, both on the national and regional levels.

Raye is a superb leader. She does an outstanding job of guiding and mentoring the teaching faculty in the Denali College. She is an excellent communicator and is meticulous in gathering the thoughts and perspectives of her faculty and conveying them to the leadership team where her honesty and integrity helps to inform the group’s discussions. In addition, she provides outstanding leadership to the College Dean’s Advisory Committee on Professionalism (in which she has served since its inception as one of the founding members). This is arguably the most active of the College working groups, having produced both curricular material as well as excellent educational scholarship. Her leadership in developing the curriculum on professionalism has been a model for other medical schools. She has also been active in a national group of pre-clerkship clinical skills directors within the Association of American Medical Colleges. She has written and presented workshops both regionally and nationally on clinical skills training, on cultural competency, and on professionalism training.

Raye is a superb teacher. She shines both in small group teaching at the bedside, and in the lecture hall. She is nurturing, yet challenging, and visibly takes pride in her students successes. She clearly puts forth the path to follow, leads by example, and sets her students free …or in the words of one of her students, “Dr. Maestas is 100% amazing!” She has been a strong role model for minority and women students throughout her career, but in reality she fills this role for any student. She, in fact, has a long history of commitment to working with the underserved and promoting cross-cultural understanding in medicine. She currently serves on the Department of Family Medicine Diversity Committee and the Committee on Minority Faculty Affairs.

And finally, an excellent teacher conveys adeptness at her profession while also modeling poise in other aspects of life. Raye takes an avid interest in her student’s educational, professional and personal lives. She regularly hosts students for dinner at her home with her family. She models a healthy, balanced lifestyle, by delicately weaving patient care, students’ needs and her family’s needs.

Over the years, Raye has received many awards including Family Physician of the Year in 1994, and obtaining full professorship at the University of Washington Medical school last year, but the recognition she cherishes most are those given by her students, who are enriched from her direct guidance on clinical skills and professionalism, and who, regardless of their choice whether it be surgical or subspecialty, will have a greater understanding of primary care’s role because of her influence.

Raye is a tireless advocate for those from disadvantaged backgrounds at UWSOM. She is a person of the highest integrity and great personal humility, and is a highly respected and valued member of the Academy and the UW community.

The Washington Academy of Family Physicians is pleased to honor Ramoncita Raquel Maestas, MD with the 2016 Family Medicine Educator of the Year award.
2016 WAFP Awards

Resident & Student Scholarships

Diverse Constituencies Scholarship
The Diverse Constituencies Scholarship is awarded to two first year medical students interested in working with diverse populations and underserved communities, and who have demonstrated an interest in the Family Medicine specialty.

Yanni Michelle Chang, MS2 - UWSOM

Yanni’s mother immigrated to the U.S. when Yanni was only five years old, but unable to support her daughter, Yanni remained in China with her grandparents until she was ten. Linfen, China, where Yanni grew up, is a city covered in perennial smog from coal burning plants. Respiratory illnesses and infectious diseases were rampant among poor communities. At the age of seven, Yanni was hospitalized with a severe lung disease, but because her grandmother did not have money to pay the customary bribe, the doctor avoided her questions and ignored Yanni’s discomfort. While a deeply troubling experience, it also ignited a passion in Yanni, to work with marginalized individuals. In her own words, “I aspire to be a family physician who connects environmental health, patient and community engagement and healing to reach underserved and vulnerable populations. Seeking to further explore health disparities and the physician-patient relationship, Yanni interned at an inner city county hospital in Oakland California, and later in a rural village of India. In both settings she witnessed the vulnerability of patients first hand. For three and half years she volunteered at the Berkley Free Clinic to provide basic medical care, education and referrals to patients who lacked housing, did not speak English, did not trust the healthcare system, or who had no idea where to begin. Yanni could see the importance of communication and trust, remembering the fears of an unknown disease as a child. She learned to meet patients where they are, to understand their values and incorporate motivational interviewing and harm reduction tools. As a health coach, she connected patients with chronic conditions to medical homes, helped them navigate our complex healthcare system, and empowered them to take ownership of their health. Explains Yanni, “It is crucial to assess patients’ health literacy, and provide accessible and tailored health education so they can make informed health decisions. Having been in the position of many of the underserved in my community, I understand how hard it is to be poor, to choose between food and healthcare. I know how difficult language barriers can be, to have a diagnosis you don't understand.

Adds, Yanni, –“In my native China, where gender-selective abortions are routine, I was only allowed to be born due to a mistake on an ultrasound result. My life experiences have provided me a strong sense of purpose and responsibility, and I am passionate about becoming a community physician leader to provide quality, culturally competent care to the underserved.

Melissa Rangel, MS2 - UWSOM

Studying at UWSOM has proven to be a dynamic experience for Melissa with both rewards and challenges. One of the most difficult challenges is navigating a professional setting with a marked lack of diversity, however the experience has reaffirmed to her that she is meant for a career in primary care, specifically working with underserved communities. Her passion for working with these populations began with her work at Harborview Medical center where she was encouraged to apply to the University of Washington’s Targeted Rural and Underserved Track (TRUST). “In TRUST, I have been given the opportunity to be mentored by and spend extra clinic time with a family physician in rural Washington. This has been an incredible learning opportunity. At the same time, it has given me a unique perspective into the inequality of care and misrepresentation that exists in rural medicine,” she explains.

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Melissa believes that for physicians to successfully support a healthy community, they must be a diverse group of individuals, with a collective and comprehensive understanding of the many determinants of health.

Together with a fellow classmate, Melissa is currently organizing a panel discussion through “UW Med for Ed”. The panel will consist of medical students providing information to undergraduates, focusing on the diverse experiences of those in medical school and trying to relay the message that medical school is for everyone, with a special emphasis on rallying those that are historically underrepresented in medical school.

As a Mexican-American woman, Melissa knows that she is underrepresented in medicine both by her heritage and her gender, but as a future doctor, she also knows she will have the power to bring awareness about diversity issues directly into the physician workforce. According to Melissa – “it is a challenge I am excited to take on.”

**Dr. Roy H. Virak Memorial Scholarship**

This WAFP Foundation award was established to honor Roy Virak, whose professional and personal life was dedicated to serving his patients and his community. Dr. Virak demonstrated the old-fashioned values of the family doctor while working to develop public and professional recognition of Family Medicine as a medical specialty. Each year, the WAFP Foundation presents the Virak scholarship to a deserving second year Family Medicine resident to both reward and encourage the quest to serve as a shining example of a family physician.

**Hailey Wilson, MD**

Hailey is a proud member of the Nez Perce Tribe from northern Idaho. She feels fortunate to have been raised in a community where there was not only the encouragement to help others, but an expectation that, despite what little you had, you would help provide for and take care of those around you. She is currently a 2nd year resident at Swedish Family Medicine Cherry Hill, and is working as a continuity resident at the Seattle Indian Health Board. But Hailey’s journey to date has been a decade-long endeavor of service, mentorship and leadership supporting Native Americans on the pathway to careers in medicine. She started her journey in a pre-nursing program. She matriculated to UWSOM in 2010 and joined the program as an intern in 2014. She distinguished herself for her work as a board member of the Medicine Wheel Society and by her participation on the Indian Health Pathway. She was an exemplary intern who provided excellent care on the wards, labor and delivery, and in clinic. As a second year resident, she has moved into more leadership and teaching roles. She has been a leader on the diversity and faculty applicant review meetings, provided critical input and helped improve diversity recruitment within the program. She is also the resident leader of Swedish Medical Center’s participation with the Alliance of Independent Academic Medical Centers; Swedish is one of 20 hospitals across the country selected participate in the initiative: *Improving Community Health and Health Equity through Medical Education*. Hailey leads a group of residents and faculty in developing a plan for improving health and safety outcomes among non-English speaking patients. Working under her leadership, Swedish will revamp and expand its services to non-English speaking patients. As importantly, Hailey has helped organize focus groups and organizations such as Asian Counseling and Referral service to better understand what is lacking at Swedish. Despite her demanding schedule, she remains involved with her community, sits weekly with the Diabetes Patient Group and with the Elders Group at the Health Board, and still manages to work afterhours at the Chief Seattle Club which caters to the homeless. To Hailey though, service to others is merely a way to find oneself. “In our ability to help others, we are always reminded of the fortune we have, what we should continue to be thankful for, and the opportunities to continue to learn more about ourselves. I chose the field of medicine as a way to give back, and I chose family medicine because it felt like the best way to be immersed in the community and be an advocate for health.” Hailey’s ultimate goal is to be a family physician in a rural Native American community. As the physician in a small town, she hopes to focus on broader health of the public, serving as an advocate for her patients and the community, and being a role model for others, for whatever their endeavors might be.

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Alfred O. Berg M.D. Award for Excellence in Family Medicine Research

The Alfred O. Berg Student Award for Excellence in Family Medicine Research is awarded each year to a fourth year Washington State medical student. Award recipients research projects are reviewed annually against criteria that assesses; the scientific rigor, clear reporting, relevance to family medicine, and potential impact on patient care, policy, public health, or education.

Dallas Clark, MS4, UWSOM

Dallas is a fourth year student at the University of Washington School of Medicine. She completed her first year at UW-Spokane, and will graduate in 2016.

Dallas has earned special recognition for her body of work in research related to primary care and mental health. Her research led to two scientific reports (published under Williams, her maiden name):

- Perspectives of behavioral health clinicians in a rural integrated primary care/mental health program, - Journal of Rural Health, 2015; and
- The Utility of a caseload registry; Perceptions of behavioral health clinicians working in an integrated primary care and mental health program, General Hospital Psychiatry, 2015.

Throughout her medical school career she has worked with distinguished members of the UW Department of Psychiatry and Behavioral Sciences. Dallas however, took primary responsibility for the intellectual content and conduct of the research for these projects, including identifying the research question, designing and carrying out study procedures, analyzing the data, and reporting results. The topic is relevant to family medicine and has potential to impact the care of patients with mental health problems, particularly those living in rural areas. Dallas has been involved with the Academy throughout medical school. She plans on a career as a family physician serving a rural community with the full scope practicing including maternity care and a special interest on primary care management of mental health.

Endowed Family Medicine Scholarship

The Endowed Family Medicine Scholarship is awarded to fourth year medical students who are from Washington State and are committed to Family Medicine, and plan to practice in rural or underserved communities. The Scholarship winners are selected by the UWSOM Dean with advisory participation from representatives of the Department of Family Medicine and the WAFP Foundation.

The Foundation is pleased to recognize Alexandra Zaballa & Téah Caine as the recipients of the 2016 UWSOM Endowed Family Medicine Scholarship. These two outstanding UWSOM graduating medical students received their scholarship awards earlier this year.

Alexandra entered medical school with a strong interest in primary care and family medicine. To her, family medicine encompasses her passion for longitudinal relationships, and for leadership and advocacy. She continues to envision herself providing care to the underserved communities she grew up in and being a voice to draw recognition to the inequities she has experienced and witnessed. She is excited to be joining the Swedish Cherry Hill Family Residency program next year, and her continuity clinic, Sea Mar Community Health Clinic, where she can continue serving the Latino community. Alexandra is thankful for the unique opportunity to attain a medical education and offers her sincerest thank you for the generosity.

Since her journey began 8 years ago, Téah has visualized herself in a primary care setting, working with the disenfranchised, undocumented, and often, misunderstood members of our communities. Her desire to care for the underserved is a reflection of her own upbringing, and the communities she has “adopted”. Working on outpatient medicine for 5 months in rural southern Idaho, and serving the urban poor of Seattle has reaffirmed her commitment to family medicine. Fourth year has been a transition from seeing all of the options during third year, to falling further in love with family medicine and realizing all of the amazing opportunities the specialty has to offer. Téah is “beyond grateful” for the contribution, and plans to repay by contributing to generations in the future.
Twelve Washington Family Medicine Advocates Travel to the Other Washington; AAFP FMCC

Family Medicine arrived on Capitol Hill during the AAFP Family Medicine Congressional Conference, April 18-19. The AAFP reported record attendance with 244 family physicians, family medicine residents and medical students attending.

The twelve members of the Washington delegation represented a record number as well!

Representing Washington this year were: WAFP President, Tony Butruille, MD; President-Elect, June Bredin; Immediate Past-President, Christopher Gaynor, MD, FAAFP; WAFP Advocacy Committee Co-chair, Jeremiah Bernhardt, MD; and members: Paige Kasai, MD; Kevin Martin, MD, FAAFP; Dino Ramzi MD, MPH, FAAFP; residents – Radha Sadacharan, MD, MPH; and Byron Doepker, MD, Ashlin Mountjoy, MD, MPH, and David Bauman, PsyD, a behavior health faculty member from the Central Washington Family Medicine Residency Program and a fabulous addition to the WAFP FMCC team.

Finding solutions to the nation’s out-of-control prescription drug abuse problem was at the top of this year’s agenda, as was the need to secure a permanent funding solution for America’s teaching health centers (THCs) a proven primary care focused thriving graduate medical education approach.

Another area of focus – for attendees visiting House member offices – was to encourage legislators to join the Congressional Primary Care Caucus – a bipartisan caucus created in October 2015 to bring greater attention to primary care issues.

Other topics covered during the information sessions included:

- chronic care management
- prescription drug use
- new payment models under MACRA
- direct primary care
- mental health integration
- update on FamMedPAC activities.

During the conference, attendees were prepped about pressing issues relevant to family medicine, and given coaching about how to effectively communicate points to their senators and representatives.

On the second day of the conference, attendees visited congressional offices sharing important information with lawmakers and their staff members.

WAFP members met with Congresspersons; Adam Smith, Rick Larsen, Derek Kilmer, Denny Heck, Dan Newhouse, Jim McDermott, Jaime Herrera Beutler, as well as Senators Patty Murray and Maria Cantwell.
Where to? What next?
Medicare’s New Payment System

Like many fields, the volume of change in healthcare has been immense, overwhelming for many. But the changes ahead may prove to be even more significant to family physicians, with long term effects to Medicare reimbursement rates. These changes are a result of the repeal of the flawed Sustainable Growth Rate (SGR) formula which healthcare organizations rallied against for years. You will recall that the Medicare Access and CHIP Reauthorization Act of 2015 (MACRA), removes SGR’s threat to broader Medicare cuts, and implements value-based payments.

Likely by now, terms such as “value-based care models”, and the acronyms, MACRA, MIPS and APMs are beginning to filter into your lexicon, and they are worth getting to know. If you were among the lucky members attending the 2016 WAFP Assembly to hear the MACRA presentation by Shawn Martin, AAFP Senior Vice President of Advocacy, Practice Advancement and Policy, you caught perhaps the most important plenary offered this year. Others may have explored the AAFP’s resource page, “MACRA Ready” for answers and clarity. If you haven’t yet, please do so. As CMS implements MACRA and value-based reimbursement, physician payment will be impacted.

What is MACRA

First, MACRA permanently repealed the flawed sustainable growth rate (SGR) formula that calculated payment cuts for physicians, which prevented a 21 percent cut to Medicare reimbursement rates in 2015 and extended the Children’s Health Insurance Program (CHIP) for two years.

Most significantly however, the law shifts Medicare Physician Fee Schedule payment to two value-based payment tracks. The first track, “MIPS” consolidates and expands pay-for-performance incentives in the fee-for-service system. The second, “APMS” provides bonus

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Convocation of Fellows

On May 14, five Washington Family Physicians were present to be awarded the Degree of Fellows of the American Academy of Family Physicians at the WAFP Annual Scientific Assembly at the Historic Davenport Hotel, in Spokane, WA. This year, Douglas Albert Pople, MD, FAAFP, Everett; Christian Herter, MD, FAAFP, Edmonds; Jennifer Knowles, MD, FAAFP, Puyallup; Nona Hanson, MD, FAAFP, Anacortes; and Richard Bunch, MD, FAAFP, Othello were conferred by visiting AAFP dignitary, Michael Munger, MD, FAAFP, AAFP Board Member.

AAFP Fellows are recognized as champions of family medicine who have distinguished themselves through service to family medicine and ongoing professional development. Criteria for receiving the honorary degree consists of a minimum of six years of membership in the organization, extensive continuing medical education, participating in public service programs outside one’s medical practice, conducting original research and/or serving as a teaching in family medicine. With the inclusion of this year’s recipients, Washington State currently has 455 fellows among its Active and Life members.

If you are pursuing a Degree of Fellow and would like to be conferred at the ceremony during next year’s assembly (May 7, 2017), please contact the WAFP office.
payments for physicians with sufficient participation in “alternative payment models” (APMs) that hold providers financially accountable.

Initially physicians can choose between the two programs. If they make no choice or are deemed to be ineligible for an alternative payment model payments, they will be assigned to MIPS.¹

**MIPS – The Merit-Based Incentive Payment System – Combines Quality Programs**

The MIPS program, is a hybrid design, including the fee-for-service model. The program deviates from current practice of paying for all services on the standard Medicare physician fee-schedule. To begin, MIPS consolidates three existing quality performance programs already underway: the Physician Quality Reporting System (PQRS), the Value-based modifier (VBM), and Meaningful Use (MU)). An additional performance category will be added called Clinical Practice Improvement Activities* (CPIA) which will measure access, patient engagement, population health management, care coordination, and patient safety.

Beginning in 2019, physicians participating in MIPS will be eligible for positive or negative Medicare payment adjustments - on a per physician basis - based on their use of four designated performance categories: Quality; Resource Use; Meaningful Use of Electronic Health Record; and Clinical Practice Improvement Activities*. Physicians in MIPS will be required to report performance measures to CMS. Each physician’s MIPS score will be compared to a “performance threshold” to determine how Medicare will adjust the physician’s payments each year. High-scoring physicians will get a bonus and low –scoring physicians will see their fees reduced. (Of note, if a physician is part of a “certified” patient-centered medical home* (PCMH), they will receive the highest score for the CPIA category – however the term “certified” has not yet been defined).

Equally important to note is that the threshold for these payment adjustments will be the mean or median composite score for all MIPS-eligible professionals during the previous performance period.

- Physicians who score at the threshold will receive no payment adjustment.
- Physicians whose composite score is above the mean will receive a positive payment adjustment on each Medicare Part B claim for the following year.
- Physicians whose composite score is below the mean will receive a negative payment adjustment on each Medicare Part B claim for the following year.

Maximum bonuses and penalties will be 4% in 2019, 5% in 2020, 7% in 2021 and 95 in 2022 and beyond. As you consider MIPS, keep in mind that MIPS bonuses have the potential to be sizable, but so do the penalties.²

Weighting of the performance categories will change from year to year also:

<table>
<thead>
<tr>
<th>MIPS Category</th>
<th>2019</th>
<th>2020</th>
<th>2021</th>
</tr>
</thead>
<tbody>
<tr>
<td>Quality</td>
<td>50%</td>
<td>45%</td>
<td>30%</td>
</tr>
<tr>
<td>Resource Utilization</td>
<td>10%</td>
<td>15%</td>
<td>30%</td>
</tr>
<tr>
<td>Meaningful Use</td>
<td>25%</td>
<td>25%</td>
<td>25%</td>
</tr>
<tr>
<td>Clinical Practice Improvement</td>
<td>15%</td>
<td>15%</td>
<td>15%</td>
</tr>
</tbody>
</table>

**Why is this important now?**

As mentioned, it is anticipated that CMS will use the two previous years as “the previous performance period” to determine payments. This means that payments for 2019 will be based on performance in 2017. Payments in 2020 will be based on performance in 2018 and so on.

So, while the first year for Medicare’s new payment system is 2019, physicians are advised to be ready by 2017.

In order to potentially increase your net revenue and to prepare yourself and your practice to become MACRA ready you should:

- Prepare to report data on quality measures through the Physician Quality Reporting System (PQRS);
- Know your Quality and Resource Use Report (QRUR);
- Use your electronic health record (EHR) and attest to meaningful use (MU); and

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If your practice doesn’t provide chronic care management (CCM) services, consider starting now. If PQRS is off the table for your practice, you should at least understand how to report quality measures; the AAFP has resources to help. (Search AAFP using the term “Basics of Quality Improvement”)

Are there any exemptions from the MIPS program?
Yes. The law established three exemptions from participation in the MIPS program. Those exemptions are:

- The physician is participating in the Medicare program for the first time. Under this scenario, the physician is exempt from MIPS for the first year of Medicare participation.
- The physician does not see a large enough number of Medicare patients and falls below the established volume threshold for participation.
- The physician is participating in an eligible alternative payment model (APM) – read on!

The Alternative Payment Model
Physicians choosing the alternative payment model will have to join an accountable care organization or an approved patient-centered medical home, or otherwise be in an alternative payment model entity.

A qualifying APM is any of the following:

- A Medicare Shared Savings Program Accountable Care Organization;
- A medical home model expanded under the CMMI, that is not a Health Care Innovation Award recipient;
- A project under either the Medicare Health Care Quality (MHCQ) Demonstration Program or Medicare Acute Care Episode Demonstration Program; or
- An undefined “demonstration required by federal law.”

Like participants of the MIPS program, APM participants must also meet criteria to secure a payment which includes:

- Use of quality measures comparable to those in the MIPS program,
- Use of a certified EHR, and
- Assuming more than a “nominal financial risk” – or be in a medical home expanded under CMMI.

Physicians who join a CMS-approved alternative payment model will get an annual 5% bonus in their fees from 2019 – 2024, and starting in 2026, physicians in an APM will receive an annual across-the-board fee increase of 0.75%. (Physicians participating in MIPS will get a 0.25% annual increase).

(One caveat – if your practice meets APM qualification, you must have an increasing percentage of payments or patients coming through the APM. Eligible professionals not meeting volume thresholds are considered “partial qualifying” APM participants. They will avoid MIPS penalties, but will not receive financial bonuses).

The AAFP views the APM as the best opportunity for family physicians primarily due to the fact that it promotes new delivery and payment models that migrate away from fee-for-service and compensates for comprehensive and coordinated patient care.

In fact, it’s clear that Congress wants the majority of physicians over time to join the alternative payment entities as well. That’s consistent with the Obama administration’s approach under the ACA and with bipartisan laws and marketplace dynamics over the past fifteen years promoting integration and a shift away from fee-for-service. Larger potential bonuses (compared to MIPS) and fee increase are also inducements to take the alternative payment model path.

Assistance for small practices
CMS has pledged, and AAFP is working to ensure, that small practices will not be left out in the cold.

Practices with fewer than 15 eligible providers as well as those in rural or health professional shortage areas can receive help in transitioning to an APM or improving their MIPS score. MACRA allocates $20 million annually, from 2016 until 2020, to provide free technical assistance to these practices through Quality Improvement Organizations and Regional Extension Centers. Rules for how this assistance is distributed are being developed.

The CMS fact sheet, titled “Flexibilities continued on next page
and Support for Small Practices,” details the accommodations and support available to small practices and practices in rural or health professional shortage areas. For instance, CMS highlights proposals that are small practice-friendly, such as:

- Low-volume exclusions from the MIPS payment adjustment for clinicians or groups who have $10,000 or less in Medicare charges and 100 or fewer Medicare patients;
- Flexibility in MIPS scoring if there are not sufficient measures and activities applicable and available in a MIPS performance category;
- Group reporting that allows solo and small practices to join “virtual groups” and combine their MIPS reporting;
- Administrative burden reduction in that CMS would remove unneeded measures and reduce administrative burden but still provide meaningful rewards for high-quality health care; and
- Simplified reporting made possible through a single reporting mechanism.

Lastly, the Health Care Payment Learning and Action Network (hcp-lan.org) - a public-private partnership designed to align efforts to move toward new payment systems - provides a place where small practices can discuss ideas and share best practices on how they are moving toward alternative payment models.5

As a last resort, small practices may wish to opt out of Medicare, in which case, MACRA is simplifying the process. Before the law went into effect, opt-out affidavits had to be renewed every two years for the opt-out status to continue. Beginning with valid opt-out affidavits signed on or after June 16, 2015, the affidavits will now renew automatically every two years. (Physicians who don’t want their affidavit to automatically renew need to notify in writing all Medicare Administrative Contractors (MACs) with which they filed an affidavit. This notification must occur at least 30 days before the start of the next opt-out period).6

MACRA is a work in progress.

The implementation of MACRA is in process through CMS rulemaking. The AAFP is fully engaged and has filed hundreds of pages of comments to ensure that MACRA is implemented to the benefit of primary care. But now is the time to be proactive.

Get educated. Visit the MACRA Ready pages on the AAFP website and begin to investigate the different payment options, including the APM options.

Do not wait to implement quality improvement and other initiatives because your 2019 MIPS payment adjustment may depend on your past performance beginning in 2017.

The repeal of the SGR is a triumph. Much of the victory is due to the strong work of primary care physicians who regularly visited Capitol Hill and/or called and emailed legislators. The enactment of MACRA brings to a close one of the more frustrating and disruptive health policies of modern times, but the jury is still out as to how effective the law will be in maintaining access to care while supporting physicians who provide it.

*Term has not yet been completely defined by CMS.

2. MIPS: A Primer on the New Payment Model http://blogs.aafp.org/cfr/inthetrenches/entry/mips_a_primer_on_the
4. APMs: A Primer on the New Payment Model http://blogs.aafp.org/cfr/inthetrenches/entry/apms_a_primer_on_the
As a National Health Service Corps Scholar completing my residency in Pierce County and searching for a job, I was certain that the only qualifying work locations in Washington State would be in rural areas. I was well aware of the need that existed back in the Yakima Valley and Columbia Basin where I had completed my medical education and clinical rotations, but I was surprised to find a number of practice opportunities within Pierce and King counties that qualified as healthcare physician shortage areas—a welcome surprise since I planned on staying in the area for family reasons.

As a new physician, both in my career and in the area, I was excited to work near Seattle, one of the healthiest cities in the country, thinking surely that would make my job easier. Having trained in Yakima, one of the most obese cities in the country, my belief was that my patients in King County would generally be healthier and more active. This belief was quickly shattered by the reality that the benefits of good health are not shared by all in King County. In fact, King County’s health inequities are among the worst in the nation. A combination of rent hikes, gentrification, educational barriers, increasing poverty rates and declining middle class are some of the factors thought to be playing into this.

The Affordable Care Act has at least improved healthcare disparity, decreasing the uninsured by nearly 40 percent from 2012 to 2014. However, the health disparities still remain. For example, the King County average for diabetes is 6.4%, while community clinics in south King County report anywhere from 14-24% of patients with diabetes. Smoking in King County averages 12%, yet in south King County from 25-30% of patients smoke. Births to teenage mothers averages 4% in King County, compared to 22-24% in southern parts of the county. South King County sees almost double the national average of pediatric asthma hospitalizations.

Because of large populations of refugees and immigrants in the area, many patients are also linguistically isolated.

These scenarios of disparity exist across this state, within our communities and even in our offices. The social determinants of health are often impacted by economics, education and demographics. According to the Health and Human Services Transformation report, only 10% of health is dictated by provision of health care services. The rest is driven by behaviors, genetics, social and environmental factors. As a new practitioner, it is admittedly depressing and overwhelming to know that my day-to-day work will only affect my patients’ health by a small fraction. Even when I am living in a county that includes one of the healthiest cities in the country, top-rated medical services and innovative community-based social and human services, health disparities will continue to exist amongst my patients largely due to the social determinants that exist outside of my office walls.

If family physicians all work strictly at the individual level, changing patients’ lives one appointment at a time, we will have done noble work. This work is exhausting and often pushes us toward burnout, yet we have the privilege of directly impacting a person’s life for better health. The exhaustion and burnout comes from fighting the “unfair fight” as Dike Drummond, MD calls it; we battle not just against our patients’ health woes but also EMR inefficiency, formulary changes, prior authorization and appeals, paperwork, litigation, etc. It is reasonable that many of us find the “work of the day” to be sufficient to fill our plate (and if we are honest, a few plates).

But because we know the battles that also exist outside of our office doors (poor social determinants of health, senseless healthcare policy, frivolous insurance approval hoops, etc.) which actually affects our daily work, it seems impossible for us not to try and take them on as well. Consider if we each pick one battle outside of our day-to-day care, one issue that speaks to our heart or mind for which we become a champion. Whether it’s improving health disparity in south King County continue on page 33
The End of the Beginning

RADHA SADACHARAN, MD, MPH, SEATTLE

Seven years ago, while I was working towards my MPH and working at the Breastfeeding Center in Boston, I went to do a home visit for a mother-baby dyad we had enrolled in a study looking at breastfeeding rates. The family’s living situation was appalling – five people living in two cramped rooms, cockroaches crawling on the newborn’s car-seat which was sitting on the kitchen table, a non-functional oven, and one sink that worked. I couldn’t stop thinking about the disparity in living circumstances in the United States, a developed country, and the negative outcomes on health that this must have had. Knowing the rich amount of resources our own country has, and being face to face with the inequity of resource distribution, I thought a public health degree would help me address the social injustices that plague our country through advocating for change with data to support my notions. I was especially drawn to maternal and child health, and to our vulnerable aging population. So, I started my master’s, focused on biostatistics. I quickly learned that the skillset I would develop with a public health degree could help me to make change at a policy level, possibly locally or nationally, but I would never know the individual gains. I needed a medical degree to make change on the ground.

Family medicine was a perfect fit for me. I could achieve clinical autonomy, identify my patient’s health burdens within the setting of their community, and work towards change on an individual and population-based level. In medical school, at every turn I found a deeper love and respect for family medicine. My mentor in the Urban Underserved Program at Jefferson Medical College (now Sidney Kimmel Medical College), Dr. Patrick McManus, instilled in me a strong sense of purpose in delivering care to vulnerable populations. As a fourth year medical student, mostly out of sheer curiosity of other geographical areas, I was able to secure a sub-intern position at Swedish Family Medicine – First Hill. I was struck by the broad scope of family medicine that physicians were practicing in Seattle, and the seat at the table that family physicians held. The faculty members were stellar, and deeply involved in advocacy. I knew a program like Swedish First Hill would prepare me to be an excellent clinician and an engaged community member.

Fast-forward to six months into intern year: my first lobbying day as a resident in Olympia. I was a ball of nerves. I rehearsed, in my head, the Washington Academy of Family Physicians asks from the one-pager provided, and reviewed my sparse patient interactions as a resident which supported our queries. In retrospect, I had no reason to be so nervous and concerned. The legislators and staffers we talked with wanted to hear about the resident perspective, and WAFP attendees (especially Karla) encouraged us to speak up. I repeated this positive experience on a larger level at the Family Medicine Congressional Conference this year. I am still reveling in the exposure to health policy as a family medicine resident that I could never have imagined with a public health degree alone.

As I start my last year of residency at Swedish First Hill, I can’t help but feel that this part is bittersweet. I’ve discovered a profession in which I can immerse myself. I have amazing faculty and co-residents to look up to and call family. My continuity clinic, Downtown Public Health Center is a humbling daily affirmation of why I chose family medicine, and why I am at Swedish First Hill. Sure, I’m excited to not be a resident anymore. With that freedom though, I also won’t have the daily access to fantastic role models like Carla Ainsworth, and won’t have Maureen Brown precepting at Downtown Public Health Center to ask about the curious rash I just saw. I won’t ‘balint’ with my fellow residents about difficult patient encounters, and the bumpy road of residency. I will, however, continue to see the individual gains patients make, that I had been yearning for when I started in public health.

Recently, I had a patient whose A1C had hovered between 13 and 15 had just dropped down to below 11 for the first time since he could remember. His alcohol dependence and depression had negatively affected his health for years. He had refused to see an ophthalmologist even though his vision was worsening. He used to love playing basketball, and seemed to miss a sense of community that he had when he used to play. Over the last few months with some constant nudging on my part, he had been playing pick-up games of basketball, and found himself wanting to drink less so that he could feel better while he was being active. He

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Rapid Changes in Graduate Medical Education

KATHERINE ARKWRIGHT, OMS-3, YAKIMA

Change is necessary and opens the door for growth, but rapid changes in Graduate Medical Education (GME) have me excited, and a little nervous. Some contributing factors to all the recent changes include growth in the body of knowledge, advances in technology, and changes in demands on physicians, all requiring medical schools to adapt.

Up until very recently, the American medical school model was largely based on the Flexner Report from 1910. In the late 1800s medical schools varied widely in their teaching quality and methods, and as a result, there was an excess of subpar physicians. A group of leaders formed the Hopkins Circle and decided that there needed to be reform. They chose Abraham Flexner, (an expert on educational practices), to survey American medical schools. He compared them to his gold standard, Johns Hopkins Medical School, as well as the German medical school model, and made his recommendations. His report, with contribution from others in the Hopkins circle, was then enforced through state licensing laws. Some physicians at the time, including the neurosurgeon Harvey Cushing, were concerned that his report would narrow the focus of medicine by placing scientific advancement above all else; some speculate that the climate resulting from the Flexner Report may have contributed to such unethical practices as the Tuskegee syphilis study or the Henrietta Lacks tragedy. Yet on the whole, the report was credited with greatly improving and standardizing the quality of education.

The Flexner report began a century long model of two years of labs and classes followed by two years of clerkships. Today, that is starting to change. More than 75% of American medical schools are touting big changes to their curriculum, including Johns Hopkins. These changes frequently include a shift toward early clinical experience with longitudinal integrated clerkships, utilizing standardized or simulated patients, and case-based learning or other types of small group discussion. There also seems to be a real effort to change the narrative to one of caring for patients rather than diseases, and placing emphasis on primary care – something I believe we are very successful at here in Washington.

Technology is also driving change. Advances in testing and genetics means ever-changing coursework, and electronic records drive early exposure to EMRs for students. The technology we use to learn medicine is also evolving. Books have been largely replaced by iPads and Inkling eBook accounts. Even anatomy is taught with CT-like imaging over the traditional cadaver lab at some schools, and the search for innovative ways to incorporate technology is ongoing. We are frequently reminded of this by competitions like the AMA’s Healthier Nation Innovation Challenge, which offers $50,000 grants for top ideas. Supplemental sources include YouTube videos, open source materials from other schools, purchasable videos, and let’s be realistic, even Wikipedia. In some ways, I believe all the open source materials ensure that all students have access to high quality resources, but the good comes with the bad, and the responsibility falls to the student to verify that what they are reading on the Internet is legitimate.

The major limitations I see to curriculum changes are boards, which will keep any school from straying too far from the pack, and accreditation. When students must know a certain body of information at certain points in their training, schools are restricted in the changes they can make. In fact, the closer it got to the end of second year, the harder it was for our professors to engage us in curricula not directly tested on boards. As a classmate recently reminded me, however, the MCAT has in fact recently undergone big changes and I have to wonder if the USMLE and COMLEX will follow.

It is also worth mentioning the changes required to fit into a market-driven medical environment. When physicians are being pushed to increase volume and third party payers will not accept higher bills from teaching hospitals as they previously did, there are fewer and fewer clinical faculty available to serve as mentors. This can result in students becoming observers rather than active participants, or diverting time away from patients to help with charting. This is one change that really concerns me as a student about to begin clerkships, and I am eternally grateful for the physicians willing to take on the challenge of meeting productivity demands while furthering my education.

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Perhaps this is also impacting the availability of residencies. The data tell us that the number of residencies available are growing, but not keeping pace with the increasing numbers of students entering the pipeline. Of greater concern, the number of subspecialty positions is outpacing the growth of primary care residencies. This has me worried as a future family physician, but more importantly, seems out of alignment with the needs of the public. I believe medical school and organizations like the WAFP are doing a great job attracting students to family medicine, but what good will it do if there is a residency shortage?

Ultimately, I see schools coming up with their own innovative new approaches to teaching medicine and meeting today's challenges, and I think they are doing a good job. I believe diversity among curricula will lead us to exciting new places, but I also wonder if we will need a new Flexner Report to ensure that quality is universal. Alternatively, things may continue to change too rapidly for anything to have such a lasting effect, and we will simply need to be very good at adapting, as long as residencies can keep up. Although change can be scary and no one wants to be a guinea pig, I have to say that I am excited by most of what is happening and I hope it will help us produce more thoughtful physicians that are prepared for what lies ahead.

http://www.ncbi.nlm.nih.gov/pmc/articles/PMC3178858/
https://www.aamc.org/initiatives/cir/curriculumreports/

had recently visited the ophthalmologist. We were both thrilled with the decrease in his A1C, and he felt like he was taking control of his health. While an A1C of 11 would not be a positive outcome in a larger dataset, for me, it marked a turning point for my patient's health. These victories for my patients represent the individual parts that make up the population health outcomes I strive to change. While this year marks the end of my intensive family medicine training, and of having a resident voice in health policy, I see this as the beginning of a well-suited lifelong profession that works towards social justice through both public health and clinical medicine.

or partnering with an organization to fight obesity in Yakima County or finding an issue in Olympia to advocate for, pick a battle that is worth the fight. There are likely as many battles to choose from (e.g. movements, programs and policies) as there are patients. So if the options seem too broad, partner with the WAFP in its various social, public health and policy efforts.

As a new physician in practice, it's a humbling reality to have the title and the tools to change lives, only to have your work hampered by forces outside of your office walls. But just because they are outside of your walls, does not mean that they are outside of your influence or ability to make a change.

7. King County Health and Human Services Transformation Panel. Human and Health Services Transformation Plan, page 15. (June 6, 2013). King County, WA.
Professional satisfaction is becoming increasingly elusive for many physicians, faced with the demands and daunting challenges of a changing health care system – struggling with myriad data metrics, encountering frustrations with electronic health records and navigating seemingly endless insurer requirements just to name a few.

Research shows these burdens are leaving physicians struggling to find joy in their work. And by now we know what can result: increased risk of serious physical and psychological harm, threats to patient safety and ultimately more doctors leaving practice. As physicians, we are front-line workers, and changing our massive health care system has placed an enormous burden on our shoulders.

A recent study showed 54 percent of physicians surveyed in 2015 with at least one symptom of burnout, compared to 45 percent in 2011. If you put that increase next to a timeline of the Affordable Care Act’s implementation, you’ll see a correlation. Physicians already have high-demand, stressful jobs, but with so much change in health care at both the state and federal level, burnout can seem all but inevitable.

Into this already volatile mix, you then add an industry newly committed to achieving the triple aim in health. The triple aim seeks better population outcomes at lower costs while improving patient experience. While supporting those objectives, the WSMA is also focusing on preventing physician burnout via what is known as the “quadruple aim” – taking the objectives of the triple aim and adding an improved clinician experience.

To that end, the WSMA, through our two-year Healthy Doctors, Healthier Patients initiative, has been working to alleviate burdens for physicians on a number of fronts, seeking legislative, regulatory and market-based solutions. Reducing the increasing stress felt by physicians while renewing the love we have for the important work we do was my signature goal when I was sworn in as president of the WSMA last fall. As I reach the final months of my term and Healthy Doctors, Healthier Patients approaches its first anniversary, I’m proud to highlight the successes we’ve achieved to date.

**Passing a bill standardizing the timeline and process for physician credentialing.** Under existing law, there’s no standard way to credential a physician. It can take four days or 204 days, and that’s problematic. While physicians are waiting to get credentialed, they can’t bill insurance companies for the services they provide to patients under those plans. This is administratively burdensome and compounds our state’s patient access to care issue. Thanks to the bill we worked to pass, starting in 2018, insurance companies must credential physicians and other providers within 90 days upon receipt of a complete application (with a 60-day average for all applications starting in 2020).

Physicians also have to fill out paperwork (or use some kind of unique process) for each insurance company they want to do business with. As a result of this bill, there will be a single state database for submitting credentialing information.

This legislation is a major success, one that will have a tangible impact by reducing administrative burden and improving patient access to care.

**Passing a bill allowing group entry of physicians into the state’s prescription monitoring program.** Until now, an individual physician would have to register his or herself in a system often described as clunky and cumbersome. Now groups of five or more prescribers can register on behalf of its physicians and other providers. Not only does this alleviate administrative burden, but it also encourages more physicians to register to use the prescription monitoring program. As an opioid epidemic unfolds across the state and the nation, improving and encouraging use of this under-utilized tool for combating prescription drug abuse and overdose is of paramount importance.

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Leading high-level discussions on the impact of insurers’ prior authorization processes on physician and patients. The WSMA has met with state Insurance Commissioner, Mike Kreidler to discuss the current state of prior authorization. He now recognizes the onerous requirements that burden physicians and how the belabored process affects consumers. As a result of WSMA’s advocacy, there is anticipated rulemaking around prior authorization. We expect to see a proposed rule later in the summer. I’m pleased with our progress so far on this critical issue, one we know is of great importance to our members.

In addition, WSMA staff has met with leaders of several major state health insurance companies this spring to advocate for easing the burden which prior authorizations currently put on physicians. After some frank conversations, there was an acknowledgement these processes can be improved. We’re now working with these insurers on a number of prior authorization projects—a very promising development.

It has given me great satisfaction to lead the WSMA during this particularly tumultuous time in health care, and to help harness the strength of our membership and the power of our advocacy to affect changes that will have a real impact on the profession and in the lives of my colleagues. Most of all, I’m proud to have encouraged the understanding that it is our own health and well-being which will serve as the best bulwark against the mounting pressures of a changing industry. Healthier doctors truly does mean healthier patients—a dynamic that is essential to the continued growth of Washington as a state that leads the way in serving both our patients and our profession.
WAFTP Welcomes the following New Members from March, April and May:

**Active Members**
- Jordan Abel, MD – Olympia
- Azreen Ali, MD – Tacoma
- Nathan Armerding, DO – Spokane
- Amir Atabaygi, MD – Olympia
- Erica Barrows-Nees, MD – Tacoma
- Leah Baruch, MD – Seattle
- Mallory Beale, MD – Spokane
- Ashley Bleker, MD – Tacoma
- Camela Billick, MD – Gig Harbor
- Janelle Billig, MD – Seattle
- Gelar Biscoaro, DO – Grandview
- Laura Blinkhorn, MD – Seattle
- Daniel Breseford, MD – Renton
- Megan Bright, MD – Tacoma
- Ronan Cahill, MD – Seattle
- Maureen Campbell, MD – Kettle Falls
- Stephen Campbell, MD – Everett
- Maria Pia Castillo, MD – Seattle
- Meenadchi Chelvakumar, MD – Seattle
- Maurine Cobabe, MD – Tacoma
- Megan Curtis, MD – Seattle
- Seth Curtis, MD – Seattle
- Blythe Anne Darnton, MD – Seattle
- Ryan David, DO – Yakima
- Samuel Davis, MD – Tacoma
- Trina Davis, MD – Seattle
- Kathryn Dean, MD – Olympia
- Pili-Chung Delcampo, MD – Gig Harbor
- Kelly DeMeyer-Coursey, MD – Tacoma
- Byron Doepker, MD – Seattle
- Catherine Dong, DO – Richland
- Adam Drechsler, MD – Seattle
- Elise Duggan, MD – Seattle
- Geoffrey Dunn, MD – Yakima
- Emily Dy, DO, DNP – Seattle
- David Escobar, DO – Mount Vernon
- Samira Farah, MD – Renton
- Radhika Farwaha, MD – Yakima
- Tala Firestein, MD – Seattle
- Cody Franzen, MD – Olympia
- Daniel Frederick, MD – Silverdale
- Claire Frost, MD – Kirkland
- Thomas Garges, MD – Bellingham
- KayCee Gardner, MD – Tacoma
- Christy Gibson, MD – Sammamish
- Matthew Graf, MD – Seattle
- Julia Hamilton, DO – Yakima
- Kami Harless, MD – Seattle
- Michael Healey, MD – Olympia
- Rebecca Hendryx, MD – Olympia
- Vanessa Herrig, DO – Yakima
- Mai Vi Ha Hoang, MD – Renton
- Julie Hubble, MD – Seattle
- Erin Hunt, MD – Tacoma
- Nan-shing Hsu, MD, FAAFP – Phoenix
- Katherine Hurd, MD – Seattle
- Laura Ireland, MD – Seattle
- Brandon Isaacs, DO, FAAFP – Yakima
- Veronica Jessick, MD – Spokane
- Leanne Jones, MD – Renton
- Ravi Kalwani, MD – Tacoma
- David Kanze, DO – Bellingham
- Peijman Kharazi, MD – Tacoma
- Anuj Khattri, MD – Seattle
- Aaron Killpack, DO – Richland
- Nathan Kittle, MD – Seattle
- Bobbie Kumar, MD, MBA – Brier
- Marissa Kummerling, MD – Seattle
- Brian Lay, DO – Puyallup
- Teresa Lee, MD – Seattle
- Vivian Lee, MD – Puyallup
- Melissa Leedle, MD – Seattle
- Andie Lesowske, MD – Seattle
- Nathaniel Lila, DO, Med – Yakima
- Isabel Lind, MD – Waco
- Mark Litton, DO – Arlington
- Erin Locke, MD, MPH – Tacoma
- Libby Loft, MD – Seattle
- Socia Love-Thurman, MD – Seattle
- Brian Lowell, MD – Vancouver
- Stacy Lundstedt, MD – Seattle
- Angelica Macias, MD – Colville
- Nina Maistera, MD – Seattle
- Rebecca Mandell, MD – Tacoma
- Michael Marshall, DO – Puyallup
- Colin McClune, MD – Seattle
- Justin Medlock, DO – Seattle
- Rosita Miranda, MD, MS – Spokane Valley
- Siyavash Mohandessi, MD – Vancouver
- Lindsay Newlon, MD – Tacoma
- Hanh Nguyen, MD – Seattle
- Mimi Nguyen, MD – Seattle
- Tricia Nielsen, DO – Issaquah
- Adaobi Okonkwo, MD – Garfield
- Miriam Olson, MD – Seattle
- Preethy Pankaj, MD, MBBS – Puyallup
- Sowmya Paturi, DO – Auburn
- Nelya Pavlenko, MD – Vancouver
- Stephanie Penalver, MD – Yakima
- Anna Maria Pletz, MD – Tacoma
- Jennifer Pontarolo, DO – Yakima
- Steven Poyn, MD – Seattle
- Sarah Rice, MD – Bainbridge Island
- Michael Robinson, MD – Spokane
- Caroline Roeder, DO – Vancouver
- John Rudolph, DO – Spokane
- Heather Readhead, MD, MPH – Spokane
- David Sapienza, MD – Seattle
- Melanie Schaffer, MD – Seattle
- Devin Schock, MD – Renton
- Samantha Shira, MD – Vancouver
- Faisal Siddiqui, MD – Yakima
- David Siebert, MD – Seattle
- Benjamin Simpson, MD – Spokane
- Tiffany Snyder, DO – Seattle

**Residents**
- Joanne Boisvert, MD – Spokane Valley
- Rose Foster, MD – Yakima
- Anne Gayman, MD – Seattle
- Carla Graichen, MD – Portland
- Eric Li, MD – Seattle
- Dominique Nguyen, MD – Yakima
- Sukhdeep Kaur, MD – Yakima
- Alina Satterfield, MD – Portland
- Clint Thompson, DO – Yakima
- Kristi Trickett, DO – Yakima
- Christina Vietor, DO – Seattle

**Students**
- Katherine Arkwright – Yakima
- Glen Bennion – Yakima
- Lynsey Bernfeld – Seattle
- Sarah Bewley – Yakima
- Taylor Brown – Yakima
- Thomas Hanna – Kirkland
- Rachel Horton – Yakima
- Jennifer Humble – Yakima
- Genevieve Kussmeyer – Yakima
- Seth Minton BS, MA – Yakima
- Jeff Northey – Seattle
- Robie Sterling, MD – Seattle
- Elizabeth Stover, MD – Renton
- Corey Sullivan, MD – Olympia
- Alyce Suitko, MD – Seattle
- Yue Teng, MD – Olympia
- Shelly Theobald, MD – Vancouver
- Andrea Tremaine, MD – Vancouver
- Anna Tubman, MD – Vancouver
- Laura Turgano, DO – Olympia
- Gregory Van Epps, DO – Seattle
- Haritha Vankireddy, MD – Sammamish
- Patrick Vigil, MD, PhD – Yakima
- Kathleen Wakeham Barnes, MD – Seattle
- Shahe Wali, DO – Kennewick
- Lisa Walker, MD – Gig Harbor
- Katherine Wollner, MD – Seattle
- Stephanie Works, DO, MPH – Vancouver
- Lasley Xiong, DO – Carnation
- Christopher Yee, MD – Seattle
- Aaron Zabriskie, MD – Vancouver
- Emily Zaragoza, MD, MMM, FAAFP – Seattle
- Angela Zhang, DO – Renton
- Ying Zhang, MD – Seattle

**Residents**
- Afarid Zia, MD – Yakima
- Mark Zierler, MD – Seattle
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September 9, 2016 - SeaTac, WA

WAFP Board & Committee Meetings
September 10, 2016 - SeaTac, WA

AAFP Congress of Delegates
September 19-21, 2016 - Orlando, FL

AAFP Family Medicine Experience (FMX)
September 20-24, 2016 - Orlando, FL

Family Medicine Practice Management Seminar & Resident Career Fair (Hosted by King County Chapter)
October 21-22, 2016 - Valley Medical Center Conference Center, Renton, WA

AAFP State Legislative Conference
October 27-29, 2016, Phoenix, AZ

WAFP Foundation’s Student & Resident Retreat
January 7-8, 2017, (Location TBA)

WAFP Board & Committee Meetings
February 11, 2017, SeaTac, WA

AAFP - Annual Chapter Leader Forum & National Conference of Constituency Leaders
April 27-29, 2017, Kansas City, MO

60th House of Delegates Meeting
May 4, 2017, Skamania Lodge, Stevenson, WA

68th Annual Scientific Assembly
May 5-6, 2017, Skamania Lodge, Stevenson, WA