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Of Note…

- **Dr. Neil Brooks** recently completed his term on the AAFP Delegation to the AMA. He received a warm letter from **Dr. Wanda Filer**, AAFP President, thanking him for his leadership and commitment. Dr. Brooks is a Past President of both the AAFP and the CAFP.
- The National Primary Care Week planning committee at the University of Connecticut thanked the CAFP for its past and ongoing support of National Primary Care Week at UConn.
- Attending the 10-State Conference on February 19-21 in Miami, Florida are: **Drs. Sandra Hughes**, **Fonda Gravino**, **Kathy Mueller** and **Ed Kim,** as well as **Mark Schuman** and **Mary Yokose** of the staff.

2016 Advocacy Agenda: Four Things to Know

Shawn Martin, AAFP Senior Vice President of Advocacy, Practice Advancement and Policy.

With 2016 upon us, it's important to outline priority issues and areas of focus for the AAFP heading into the New Year.

As noted in my last posting, 2016 is an election year. Modern history suggests that opportunities to accomplish major policy objectives in an election year are limited, but we believe this year may be different. We also know that we must approach our work with a greater sense of urgency due to the rapid changes that are coming.

To articulate this, I have decided to borrow a catchy phrase from Sesame Street to describe the **AAFP's advocacy outlook for 2016. So here goes: "The AAFP's 2016 advocacy agenda is brought to you by the letters M and A."**

M is for MACRA and Meaningful Use

MACRA -- On April 16, 2015, President Obama signed into law the Medicare Access and Children's Health Insurance Program Reauthorization Act (P.L. 114-10). The enactment of MACRA capped a 15-year effort to repeal the flawed sustainable growth rate (SGR) and set in motion reforms that will more appropriately support new delivery systems and establish a path away from fee-for-service. These new delivery and payment models have an opportunity to end decades of de-valuing primary care by appropriately compensating family physicians and financing the functions of an advanced primary care practices.

The major reform provisions of MACRA -- the Merit-Based Incentive Payment System (MIPS) and the Alternative Payment Models (APMs) -- will not be fully implemented until 2019. However, the regulatory framework must be developed during the next 12 to 18 months, meaning 2016 is going to be a busy year for CMS and the AAFP. The Academy outlined many of its views on the major issues in our response to a 2015 CMS request for information (RFI) on MACRA implementation.

I encourage you to familiarize yourself with the implementation timeline. It is important that you and your practice start thinking about how you will transition into one of the two payment pathways established by MACRA. The AAFP will be rolling out extensive content and resources during the next few months and will feature extensive education opportunities for family physicians.

You can access AAFP content on our MACRA resource web page. We also anticipate publishing extensive related content through *Family Practice Management*.

Meaningful Use -- In late December, Congress passed and the President enacted into law, legislation that will provide a hardship exemption from meaningful use stage 2 requirements for qualifying physicians. CMS has, at the time of this posting, not published the guidelines for how physicians can participate in the hardship program. Once this information is available, the AAFP will use multiple communication platforms to share the details with you to ensure that those who wish to seek the hardship exemption have the necessary information to do so.

On Jan. 12, CMS Acting Administrator Andy Slavitt, in a presentation at the JP Morgan Healthcare Conference, pleasantly surprised (totally shocked) the physician community when he publically stated that the meaningful use program may have "met its goals and served its usefulness," and should be "replaced with something better."

He essentially announced the coming end of the meaningful use program when he said that the "meaningful use program as it has existed will now be effectively over and replaced with something better."

Obviously the details matter, but the AAFP is pleased that our

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ABFP Announces Changes to MC-FP

Several important changes to the MC-FP have been announced. One change that may make members happy-you are no longer required to complete the clinical simulation portion of the Self-Assessment Modules (SAMs) for the MC-FP Part II credit. Members can now complete the 60-question knowledge assessment and immediately receive credit. Completion of the Clinical Simulation is now optional for additional credit.

The 60-question Knowledge Self-Assessment will now be the minimum requirement for MC-FP Part II. The remaining requirements will consist of completing a minimum of one Part IV activity and additional Part II or Part IV activities to reach a total of 50 MC-FP points during the 3-year stage. To learn all of the new improvements, click here to read the full message from ABFM President, James C. Puffer, M.D.

Recognition of Diplomates Over the Age of 70

The American Board of Family Medicine is recognizing the long-standing dedication of our Diplomates over the age of 70 who wish to maintain their certification status. Beginning with payments required for 2016, those Diplomates age 70 and over who are maintaining their certificates will have their MC-FP process payments cut in half. Changes inside the physician portfolio will take a few months to implement, but once complete, the payment options will be appropriately reflected in each physician's portfolio.

2016 Advocacy Agenda: Four Things to Know

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advocacy efforts have resulted in positive action on the part of Congress and CMS.

On that same day, the AAFP wrote to Slavitt, outlining a set of recommendations on how CMS should pursue revisions to the program. Among those recommendations, we prioritize the need to accelerate robust interoperability to support continuity of care and care coordination, the elimination of burdensome requirements on practices that detract resources away from patient care, and alignment of the numerous regulations governing patient care.

A is for Administrative Complexity and Alignment

Administrative Complexity -- Last year I wrote a posting on "Whacking the WAC." The time and energy devoted to the administrative functions of a family medicine practice continues to be daunting if not overwhelming. The most frustrating aspect of this issue is few of the administrative functions required of family physicians have any measurable impact on the quality of care received by patients. Multiple surveys and studies have placed the overall time allotted to administrative functions at 15 percent to 17 percent for most physicians.

This is an astonishing allocation of time both from the perspective of meeting administrative requirements, but also the loss of patient care time that results from these administrative requirements.

The so-called "work after clinic" is a major contributor to physician burnout and, unfortunately, leads many physicians to make career decisions that may not be aligned with their personal and professional goals.

It also contributes to the belief that the intensity of work in primary care is not appropriately compensated by payers. To be blunt, the 15-minute office visit is really a 20-minute visit that is compensated at 15 minutes. This is what is inherently unfair about the system and why we are dedicated to reducing administrative complexity.

Alignment -- One of the greatest frustrations expressed by family physicians is the variation in quality and performance measures used by public and private health care payers. Physicians also express frustrations about the lack of congruency in the definitions and execution of delivery system programs such as the medical home or chronic care management programs. This frustration is completely understandable given that family physicians have such a diverse set of payers.

According to research conducted by the AAFP, 61 percent of family physicians have contractual relationships with seven or more payers, and 38 percent have relationships with 10 or more.

The AAFP places a high priority on this work. We continue efforts to educate and influence the commercial insurance plans through meetings and continuous communications with the leadership of these companies.

We also have a meaningful working relationship with America's Health Insurance Plans (AHIP), which has allowed us to advance policy recommendations that would achieve some level of alignment between payers. We are optimistic that this work with AHIP will be rewarded through the adoption and implementation of a "core (quality) measure set" for primary care. If this comes to fruition, then family physicians would have a single set of quality measures that would be reported to Medicare and all commercial insurers.

I can assure you that this isn't a comprehensive list of issues that we will be working on this year. This list does not include many priority issues. However, this is a solid summary of the major opportunities and challenges we see in family medicine. Nothing, and I

"Nothing, and I mean nothing, is more pressing than these four issues.

"He essentially announced the coming end of the meaningful use program when he said that the "meaningful use program as it has existed will now be effectively over and replaced with something better."

CAFP Mission Statement

The mission of CAFP is to promote excellence in health care and to improve the health of people in Connecticut through the advancement of the art and science of Family Medicine, the specialty of Family Medicine and the professional growth of Family Physicians.

From DSS

2016: Last Chance to Enroll in the Connecticut Medicaid EHR Program Incentive

Program Year 2016 is the final year in which Eligible Professionals (EPs) can begin to participate in the Medicaid Electronic Health Record (EHR) Incentive Program. There are many benefits to program participation, including the following:

- Providers that are eligible to participate can receive up to $63,750 for full participation in the program. This includes a payment in the first participation year of $21,250 to adopt, implement, or upgrade (AIU) to a Certified Electronic Health Record Technology (CEHRT) system.
- Achieve measurable improvements in patient health care delivery and performance to promote better patient outcomes through the use of CEHRT:
  - Diagnostics and patient safety
  - Practice efficiencies and cost savings, including documentation and coding
  - Care coordination, including electronic exchange of clinical information with other designated providers
  - Patient participation/self-management

Am I Eligible?
To participate in the Medicaid EHR Incentive Program, an Eligible Professional (EP) must be one of the following five types of Medicaid providers: physician, dentist, certified nurse-midwife, nurse practitioner, or physician assistant practicing in a Federally Qualified Health Center (FQHC). Other criteria must be met, including Medicaid Patient Volume thresholds. To see if you are eligible, check the CMS' Eligibility Website and then contact 1-855-313-6638 if you have any further questions regarding program eligibility.

How Do I Get Started?
To register and get started with your 2016 Program Year attestation, providers must begin by registering with CMS' EHR Incentive Program Registration and Attestation System, visit https://ehrincentives.cms.gov/.

Additional Resources: For more information on the CT Medicaid EHR Incentive Program, see the EHR Incentive Program Web site or contact Mike Flynn, EHR Program Education and Outreach Coordinator, at Michael.Flynn@ct.gov.

Left, U.S. Congressman Joseph Courtney and Mary Yokose, CAFP Deputy EVP, prior to a recent CAFP Board Meeting at which Mr. Courtney outlined his primary care caucus. The caucus is dedicated to advancing public policy promoting a well-trained, high quality primary care workforce.

Observations On A Second HHI Medical Service Trip To The Dominican Republic

By Pranan Kapoor, M.D., Chief Resident Middlesex Hospital Family Practice Residency

This was my second trip to Puerto Plata with Health Horizons International, but this trip differed in many ways. Our team was much larger this time around, as we had several PA students from Quinnipiac University with us. While their presence is not new to HHI, I was not afforded the opportunity to work with them on my first trip. Their enthusiasm for learning and helping in whatever way possible was energizing and I found having them there for patient visits provided a new dimension of satisfaction for the trip as a whole.

The biggest difference, however, was the fact that all four clinic days were scheduled at the local hospital, Maternidad. In an effort to incorporate local health care providers and, eventually, transition care to local doctors, a team of Dominican physicians would, at times, be present for patient consults. This provided a new set of challenges and exposed disparities between what is considered the standard of care in the U.S. and

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"With implementation came better billing techniques, medical record keeping, and tracking." Jane, Office Manager from an independent practice in Chester, CT

"It's really a great program! The incentives are wonderful….having an EHR is so necessary. I don't even know how we functioned before without it" Cara, Clinical Director from a Behavioral Health Practice in West Haven, CT.

"An EHR is more than just legibility. We are able to track patients who need certain services. The benefits are endless." Renee, Chief Executive Officer from a Primary Care Practice in Vernon, CT.

New CAFP Members

Welcome:

Rachelle Darout, M.D.

Waterford, CT

CONNECTICUT FAMILY PHYSICIAN

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Observations On A Second HHI…

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what is commonly done in the D.R. Included in these challenges are: the length of time the local physician may have been practicing as many inappropriate practices may be ingrained, cultural disparities which, as the "gringo," you try recognize and minimize, and the limited exposure we have with the local physicians. That being said, there were several advantages to the new location: improved patient privacy, reduced noise and the presence of exam tables which improve the reliability of physical examination, cooler temperatures, and immediate access to greater resources in the area.

As a resident balancing the demands of patients, EMRs, administrative needs, quality improvement teams, junior resident development, and finding time for that ever-elusive work-life balance, my week in the Dominican Republic was a way to "reset." I can only hope that I provide as much in my volunteering as I receive in personal and professional growth. The ability to practice humanistic medicine with barebones instruments, relying on the history and physical (and occasionally Epocrates), while providing an underserved community a service they so need and deserve, offers a sense of fulfillment that I have rarely experienced.

Working with the CAFP Physicians who participated on this trip was also extremely rewarding.

Dr. Alan Douglass, Residency Director at the Middlesex Hospital Family Practice Residency, was a Lecturer at the National Institute of Program Director Development.

Letters to the Editor

To The Academy,

On behalf of the team at the Connecticut Institute of Primary Care Innovation I wanted to offer my sincere thanks for helping to support Jonathan Lis to attend the STFM Conference on Practice Improvement.

Our interactive hands-on experience with the Primary Care Office of the Future was extremely successful and a very large part of the conference. Having Jon as a student attend with us and participate as one of our team was very much noticed and appreciated by the audience that attended, including many from the AAFP leadership. He did an outstanding job, and we are very proud of his ability to clearly articulate the value of primary care to the participants.

Thank you again - and we look forward to talking about how we can take some of what we have learned to our own CAFP Symposium next year.

Tom Agresta M.D.
Connecticut Institute for Primary Care Innovation

To The CAFP Board,

I'm writing to express my sincere gratitude for the funding CAFP provided me towards presenting the Primary Care Office of the Future in Dallas, TX for the STFM Conference on Practice Improvement.

Having worked with the Connecticut Institute for Primary Care Innovation (CIPCI) for two and a half years, I consider myself relatively aware of the current climate in primary care. I helped with the inaugural implementation of the Primary Care Office of the Future exhibit in May 2014, and thus I was able to see some workflows, tools, and technology that will be utilized by primary care teams in the near future.

However, presenting at CPI was an entirely new and unique experience for me. Not only was the exhibit more impressive, more innovative, and more practical than in 2014, but the audience was entirely different. Speaking to nearly 300 family practice clinicians and practice administrators about ways they can innovate and improve the primary care experience for the patient and the team was something I enjoyed tremendously. Most inspiring for me was seeing participants become inspired and enthusiastic about tools and topics I presented. I was able to see a twinkle in the eyes of clinicians who felt reinvigorated and energized about their passion: providing quality primary care to patients while enjoying themselves.

I am eternally grateful for the opportunity to teach, to present and inspire others within the field of primary care. Presenting has inspired me as well, and given me hope that primary care is in its dawn, not dusk. I would like to thank CIPCI, University of Connecticut School of Medicine, and, of course, the Connecticut Academy of Family Physicians for helping a loan-ridden medical student pursue his medical passions in Dallas, TX.

Sincerely,
Jonathan B. Lis, MS2