WASHINGTON
Medical
Commission

Licensing. Accountability. Leadership.

Rules Workshop

Clinical Support Program

August 9, 2021 – 1:00 pm to 3:00 pm

GoToWebinar

WASHINGTON Medical Commission
Licensing. Accountability. Leadership.

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Rule Workshop Notice

WASHINGTON Medical Commission
Licensing. Accountability. Leadership.

Rulemaking
The Washington Medical Commission (commission) has officially filed a CR-101 with the Office of the Code Reviser on February 22, 2018. The WSR# is 18-06-007.

The commission is considering creating two new rule sections, and revising related rule sections as appropriate, to establish a clinical support program (program), its criteria and procedures for allopathic physicians and physician assistants. The intent of the program is to assist practitioners with practice deficiencies related to consistent standards of practice and establish continuing competency mechanisms that will protect patients proactively through a plan of education, training and/or supervision. The commission may resolve practice deficiencies through the program at any point in a practitioner's period of licensure.

Proposed Clinical Support Program Rules Workshop Meeting
In response to the filing, the Commission will conduct an open public rules workshop on Monday, August 9, 2021, from 1:00 pm to 3:00 pm via GoToWebinar.

Please register for this workshop at:
https://attendee.gotowebinar.com/register/7665333690282480654
After registering, you will receive a confirmation email containing information about joining the webinar.

This meeting will be open to the public.

In response to the COVID-19 public health emergency, and to promote social distancing, the Medical Commission will not provide a physical location for this meeting. A virtual public meeting, without a physical meeting space, will be held instead.

The purpose of the rules workshop will be to:

- Invite committee members and members of the public to present draft rule language;
- Discuss comments received; and
- Discuss next steps

Interested parties and the general public are invited to participate in the rules workshops or provide comments on draft rules. For continued updates on rule development, interested parties are encouraged to join the Commission's rules GovDelivery.

For more information, please contact Amelia Boyd, Program Manager, Washington Medical Commission at (360) 236-2727 or by email at amelia.boyd@wmc.wa.gov.

*CR means Code Reviser

Rules Workshop Agenda

WASHINGTON Medical Commission
Licensing. Accountability. Leadership.

In response to the COVID-19 public health emergency, and to promote social distancing, the Medical Commission will not provide a physical location for this meeting. A virtual public meeting, without a physical meeting space, will be held instead. The registration link can be found below.

Monday, August 9, 2021 – 1:00 pm to 3:00 pm

Clinical Support Program Pre-Proposal Rules

- Housekeeping
- Open workshop
- Discuss submitted comments
  - J. Kimber Rotchford, MD
  - David Behar
  - Jennifer Van Atta, PA-C
  - Stephanie Yang, MD
    President, Washington State Society of Anesthesiologists
- Discuss draft language
- Discuss draft procedure, "The Clinical Support Program"
- Discuss draft form
- Other comments
- Next steps
- Close workshop

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WSR 18-06-007
PREPROPOSAL STATEMENT OF INQUIRY
DEPARTMENT OF HEALTH
(Medical Quality Assurance Commission)
[Filed February 22, 2018, 4:37 p.m.]

Subject of Possible Rule Making: WAC 246-919-XXX allopathic physicians and 246-918-XXX allopathic physician assistants, the medical quality assurance commission (commission) is considering creating two new rule sections that will establish a clinical assistance program to resolve practice deficiencies that may not rise to the level of a license sanction or revocation through a plan of education, training, and/or supervision for allopathic physicians and physician assistants. The commission will consider amending other related rules as needed.

Statutes Authorizing the Agency to Adopt Rules on this Subject: RCW 18.71.017, 18.71.002, and 18.130.050.

Reasons Why Rules on this Subject may be Needed and What They Might Accomplish: The commission is considering creating two new rule sections, and revising related rule sections as appropriate, to establish a clinical support program (program), its criteria and procedures for allopathic physicians and physician assistants. The intent of the program is to assist practitioners with practice deficiencies related to consistent standards of practice and establish continuing competency mechanisms that will protect patients proactively through a plan of education, training and/or supervision. The commission may resolve practice deficiencies through the program at any point in a practitioner's period of licensure.

The program would allow for quick identification of issues requiring clinical support, through practitioner or employer inquiry, referral, and including complaints that may not rise to the level of a license sanction or revocation. These issues could be resolved with voluntary participation from the allopathic physician or physician assistant in the program. The commission is considering education, training, supervision, or a combination of the three as part of the program. Issues appropriate for clinical support would likely include but are not limited to practice deficiencies such as a failure to properly conduct a patient assessment or document treatment. This also allows an allopathic physician or physician assistant a structured process to quickly improve his or her clinical skills.

Finally, participation in this program places the commission in an active patient safety role.

Other Federal and State Agencies that Regulate this Subject and the Process Coordinating the Rule with These Agencies: None known.

Process for Developing New Rule: Collaborative rule making.

Interested parties can participate in the decision to adopt the new rule and formulation of the proposed rule before publication by contacting Daidria Amelia Underwood, P.O. Box 47866, Olympia, WA 98504-7866, phone 360-236-2727, fax 360-236-2795, TTY 360-833-6388 or 711, email daidria.underwood@doh.wa.gov.

Additional comments: Interested persons may sign up for the commission's interested parties list (GovDelivery) at https://public.govdelivery.com/accounts/WADOH/subscriber/new. All commission rule-making notices will be emailed via GovDelivery and

interested parties will be invited to participate in public rule meetings and submit written comments for consideration.

February 22, 2018
Melanie de Leon
Executive Director

From: Staff OPAS
To: Boyd, Amelia (WMC)
Subject: Written Feedback Proposed Clinical Support Program
Date: Thursday, July 1, 2021 10:04:19 AM

External Email

Ms. Boyd,

The following are some general comments for the Washington State Medical Commission as they consider rule changes:

1. Regarding clinical care provided by a physician, I suggest eliminating the word "risk" by itself in determining whether licensee's behavior is professionally acceptable. Replace risk with "unreasonable risk" based on current evidence and understandings. The best of medical care as I suggested always infers risks to one degree or another. The question to answer I believe is consistent with the question regarding professional conduct vis a vis malpractice. That is: What would a reasonable and prudent physician do?

2. To properly answer question 1 contextual variables are essential to take into consideration: established expertise and experience, risk/benefit assessment, access issues, let alone a host of contextual variables unique to a given patient are important contextual variables. To justly address question one "peer" review is essential. I and other colleagues who have been judged deficient or potentially deficient in their conduct have commonly been judged so by colleagues with limited expertise or experience in the clinical context in which the care was delivered. If the clinical context is not deemed essential as to determining reasonable risk, then critical thinking and associated justice and outcomes are compromised.

Example: Previously my care was judged worthy of a STID based on the review by a psychiatrist. The psychiatrist, while seasoned, bright, and competent in his field, had little or no experience in outpatient specialized addiction medicine, let alone any acknowledged expertise in addiction medicine. Consequentely, what he or other members would consider "reasonable" care is understandably different than what I would consider reasonable care. Indeed, the index care I delivered was published in British Medical Journal as a case report. The care was acknowledged as worth publishing in arguably the most prestigious journal for case reports, and was consistent with current literature and understandings that I am confident the reviewing psychiatrist was unaware of or had biases about. I agreed and reviewers agreed that in issues related to opioids and prescribing same, given quite striking cultural biases, it is wise to document extensively to avoid regulatory concerns. Mea Culpa!

3. When clinical care is judged on "documentation" or lack thereof and a STID is justified based solely on the documentation, I consider this unprofessional. Documentation is a means to a professional end ie, good patient outcomes. There is little evidence to support the documentation standards currently imposed have to do with the best of patient outcomes. The overwhelming evidence is that the documentation requirements largely satisfy third party billing and legal requirements. If one is confident that the billing and regulatory requirements are consistent with the best of clinical care, ie patient outcomes, they can and should be used as reasonable surrogate markers of competent and professional care. Otherwise, I suggest that physician members of the commission limit the emphasis on "documentation" to determine unprofessional conduct. Contextual issues matter! The legal reality of "if not documented it

didn't happen" or vice versa is not a clinical reality and any competent critically thinking physician will acknowledge this. In part this is why it is best to assess professional care by medical peers and limit legal criteria as the means to establish professional medical care. By their nature rules and laws do a poor job of taking into account contextual issues, unintended consequences, and place the emphasis on means rather than "outcomes".
Laws also do a poor job of keeping up with medical advances regarding outcomes and may contribute to limited access to indicated medical care. I believe my CV and publications give me some justification to have an opinion on these matters.

4. I heard from panel members their frustration with having little options for dialogue and suggestions for support being given to their colleagues, from whence the clinical support program. We commonly make mistakes in medicine. That is why I so grieve the loss and review of the "autopsy report" If a physician's care was to be questioned it was based on hard evidence and this was adequate to "teach" a physician. We didn't have to report the mistakes, even when they had life-threatening consequences, to the data bank or punitive measures. We simply provided objective evidence as to the deficit in care and that was enough. If that isn't enough how can we consider ourselves professionals? Of course based on illnesses(including SUDs), personality disorders, character flaws including inappropriate boundary violations there are times when the commission needs to step in to make sure professional standards are maintained. When the nature of professional care is based on adherence to laws and rules, and not patient outcomes, I think we have a serious system's problem. More and more we are going along with a "system" that rewards "process" over outcomes. Cross the T's and dot the i's and you are successful and make money. Hmmm? Furthermore, knowing the rules and laws, let alone interpreting them has become so problematic for physicians more of their time and energy is spent there. I suspect this is contributing to burnout for there is in my opinion little satisfaction in crossing t's and dotting i's compared to the meaning and satisfaction of focusing on patient well-being both present and future patients. That's why while humbling and onerous, we all could justify and appreciate the "autopsy report" Perhaps that's the answer, rather than a letter of concern etc with all the "legal" implications, the commission could simply publish an "autopsy" report of findings with all complaints. Make no comment as to "concerns" or need for further education etc...but just provide the facts and implications for improved patient outcomes and limit the "hammer" to egregious cases where outcomes have clearly suffered based on standards of medical care not being respected. **Given the "hammer" and cost implications of the STID process I suggest it be eliminated unless there is clear and unequivocal evidence as to it improving patient outcomes.** I'm confident that for me any progress in patient outcomes was minimal and quite expensive in view of time and money as a result of the STID process. And then there are the unintended consequences such as: when should I share my notes with colleagues if based on their lack of expertise they possibly will report me to the WMC rather than call and discuss the case. It is humanly impossible to write a case report for each clinical case that is a bit unusual or a colleague may have trouble appreciating. Goodness sakes, a well qualified seasoned psychiatrist was highly critical care, despite the evidence and clinical outcomes supporting my professional care. I have worked in residential facilities and am pretty savvy regarding the outcomes in the population I serve. I challenge any outpatient care to document outcomes superior to those obtained by patients under my care despite the challenges associated with the lack of access to comprehensive and collaborative care.

5. Human nature being what it is I am starting to wonder if competition in healthcare is undermining long standing professional ethics. Some of the complaints registered to the WMC I'm confident would not have happened if I were a member of the hospital staff and was

not in such a position to be critical of care being provided. The lack of diagnoses of substance use disorders is glaring among colleagues, even specialists. These diagnoses are life threatening, and especially so if not adequately managed/treated. The public health consequences are enormous. Do I report my colleagues despite the most horrendous of outcomes regarding their ignorance and incompetence? I haven't in part because I can appreciate the context in which they practice and there are cultural/conditioning factors that contribute to them missing the diagnosis and failing to treat. They have already complained openly at hospital staff meetings they are already too busy simply caring for the diabetics and hypertensives, let alone those critically ill? Given documentation/EHR/third party and other challenges it is easy for me to be empathetic. I am ready to educate them, provide autopsy reports if you like. They are sadly not interested. I expect there will always be a place for the hammer in assuring healthy behavior, but I am confident that it is rarely the most cost-effective means. Just look at the number of mentally ill or those with SUDs who end up in our punitive and shaming legal system. Are more and more laws, consequences, and prisons the answer? I think not and I find the evidence for this opinion overwhelming. Yet I heard and saw in the discussions yesterday distinct inclinations to use fear of consequences as the vehicle to promote better care. I was relieved to hear some colleagues question the inordinate inclination to "discipline" nonetheless, based on my experience and the consequences I regularly see, I lost sleep. My wife suggested I write you. It does help to express one's perspectives let alone the strong feelings I have.

Thank you for all your efforts to improve/maintain standards of professional medical care and the outcomes for Washington State residents.

J.K. Rotchford, M.D.
--
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MAIL ADDRESS
2023 E Sims Way #282
Port Townsend, WA 98368

360-385-4843 Phone
360-379-1441 Fax

From: Kimber Rotchford
To: WMC Medical Rules
Subject: Comments on Clinical Support Program Rules Workshop
Date: Tuesday, July 13, 2021 8:13:16 PM

External Email

Selection for becoming a licensed physician is testimony to a physician's willingness and ability to learn and be competent. My experience is that members of board are not always prepared to evaluate professional behavior based on a host of contextual variables including specialized training and experience. In some areas of clinical care documentation available in the patient chart will never adequately cover all the factors involved in clinical care. For legal reasons the documented care reflects the care otherwise it remains a problematic because of he said she said discussions. When there are untoward outcomes and a physician has the opportunity to explain to a jury the reasons or not for care provided, guilt regarding malpractice is only established when all the jurors agree after due process has been assured with the physician able to bring forth expert witnesses etc in defense of their conduct and outcomes. Accountability is assured and trust in professional care is so promoted.

In contrast, the process of a complaint to the WMC may be initiated by those entirely naive to standards of care, whether colleagues or not, and can be evaluated by colleagues without adequate expertise or experience in managing similar patients in similar contexts. Currently a STID can be initiated even when the care provided results in the best of outcomes and can be based solely on documentation factors considered pertinent to the investigator. The investigatormay be well qualified but be relatively naive regarding certain clinical contexts and have personal biases and prejudices that the greater commission are not able to readily appreciate.

I appreciate the attempts to mitigate the undue "punitive" aspects of the STID with often significant professional and financial liabilities. Physicians, must be encouraged by colleagues to practice medicine not out of fear but out of professional concern and well-being for their patients. Fears of malpractice have been trumped by regulatory concerns or behavior/documentation required for third party payments. This all I find grievous.

Impaired physicians exist and must be identified and managed for public health concerns and their well-being. Flagrant disregard regarding appropriate professional conduct must be formally addressed. I see this as the the role of the commission. Minor administrative oversights, particularly ones that do no harm and possibly were therapeutic are to acknowledged and colleagues informed but nothing more. (I vote for truth and mercy) In contrast, when a colleague has issues with the quality of care of another colleague they should be invited to express those concerns and it is appropriate to assume that the colleague will consider such concerns, if not necessarily agree. To oblige a colleague to agree on very subjective measures of quality of care, or to provide punitive measures when a physician's behavior is judged to only reflect minimal risk is ludicrous. Almost everything one does clinically as a physician reflects minimal risk but there it is in the statutes!!. Benefits vs risk assessment often remains an art and differences of opinions are to be expected, especially given the variety of contextual variables possible. For colleagues to judge professional care on documentation is primarily a consequence of administrative and regulatory statutes that are

dependent on documentation to assure payment and adequacy of care, let alone malpractice litigations. I am not aware of any formal evidence as to what is required to be included in medical documentation to assure the best of outcomes for patients regarding current or future care. I expect it to be highly varied based on clinical context. The irony is that the burdens of documentation have become so onerous and regulatory in nature that physicians will not even bother to review records. I regularly share notes with other providers who never receive or read them, let alone call and request clarifications if there are questions or concerns. I consider it unprofessional/problematic for us to put the emphasis on "legal" and payment concerns ahead of cost-effective patient care and outcomes. I resent having had to somewhat succumb to these pressures.

Legally physicians are liable for making the wrong diagnosis and patients suffering as a result. To make physicians liable for "improper diagnoses" when the diagnoses provided for good outcomes is preposterous. Chinese Medicine has a host of quite different diagnoses from our Western ones. If a physician treats using a Chinese diagnosis, a western ICD 10 code, or other diagnostic criteria and the outcomes are good, why promote liabilities? Diagnostic criteria are constantly evolving. I was previously judged "guilty" by not documenting that DSM V criteria were formally met . The irony is that we use ICD-10 codes and the cross-over with DSM 5 does not reflect identical diagnoses. Few colleagues appreciate that diagnoses are clinically but a means to an end. We have become overly fixed on payment and regulatory issues rather than patient outcomes. If we encourage physicians to forget that their primary job is to promote patient well-being, function, and length of life, and we become mired in surrogate markers that often mislead or worse cause harm, and we are satisfied because we did our job of correctly labelling, I grieve. The autopsy report was historically one of our "grounding" rituals to teach humility around our assumptions and presumed diagnoses. The formal and objective autopsy report and its reflection on patient care and outcomes has been replaced by legal scrutiny of patient charts. I consider this most grievous to the profession and public health.

In conclusion, I support eradicating the STID process as it currently stands with its obvious flaws and undue punitive measures imposed without reasonable due process. The Clinical Support Program attempts to limit the "injustices" in our current processes while promoting better patient care and outcomes. While I support the intent, based on legal restraints the unintended consequences legally, socially, and for patient care are likely to be significant. I suggest that the WMC attempt to eliminate the STID statutes entirely. If a physician is not able or willing to obtain indicated CME or change behavior then let them be formally charged if/when their behavior reflects significant impairment or incompetence, let alone professional standards that have stood the test of time. As to punitive measures to meet another colleague's criteria of adequate documentation (entirely subjective in my opinion) I protest especially given common biases and prejudices present even in the best of physicians.

The following reference reflects my acknowledged expertise in matters that appeared to not be fully appreciated by the investigator in my STID case as well as discusses the role of cultural biases/concerns in the oversight/assessment of professional medical care. In terms of case reports the BMJ is arguably the most prestigious journal in the world. I find the report confirms some of my above opinions.

Rotchford JK. 2019 Acute Suicidal Ideations Responsive to Hydromorphone BMJ Case Rep 2019;12:e228824.doi:10.1136/bcr-2018-228824 https://casereports.bmj.com/.

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J. Kimber Rotchford, MD MPH
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From: David Behar
To: Boyd, Amelia (WMC)
Cc: WMC Medical Rules; Brian Moquin; Jeremy Schaller; James Schaller; Brittany J. Behar; Ambrosini,Paul
Subject: Re: Clinical Support Program
Date: Tuesday, July 6, 2021 12:19:47 PM
Attachments: image003.png
image004.png

External Email

I have been subjected to investigations for having a patient followed by a private detective for 3 months. I have been investigated for refusing to physically force a patient to have a brain MRI, as requested by his mother, after he refused, after I decided it was not clinically useful, after the opinion of an independent neurologist agreed, it was not medically necessary. It goes on like that. You are empowering gossip mongers, addicts, psychotics, criminals and disgruntled people of all kinds, including the woke, to intimidate doctors, to drive them out. Doctors should begin to return this campaign of lawfare being conducted against them. I will try to reverse the Hans decision and to open the floodgates of state lability to its own citizens, as expressly permitted by the Eleventh Amendment. The latter is a diversity of standing Amendment. It is not a state sovereign immunity amendment. You think you are safe from accountability. You and your kind will be deterred.

On Tue, Jul 6, 2021 at 1:13 PM Boyd, Amelia (WMC) <Amelia.Boyd@wmc.wa.gov> wrote:

> Good morning,
>
> Your comments will be included at the next workshop, which may be scheduled for sometime in August.
>
> WASHINGTON Medical Commission
> Licensing. Accountability. Leadership.
>
> Amelia Boyd, BAS
> Program Manager
> Washington Medical Commission
> Office: (360) 236-2727
> Mobile: (360) 918-6336
>
> Were you satisfied with the service you received today? Yes or No
>
> ---
>
> **From:** David Behar <dbehar322@gmail.com>

Sent: Friday, July 2, 2021 1:31 PM
To: WMC Medical Rules <Medical.Rules@wmc.wa.gov>
Cc: Brian Moquin <bmoquin@lawprism.com>; Jeremy Schaller <jeremyschllr@gmail.com>; James Schaller <jameslschallermd@gmail.com>; Brittany J. Behar <bjbehar@gmail.com>; Ambrosini,Paul <pa28@drexel.edu>
Subject: Re: Clinical Support Program

External Email

My duty to report misconduct is not limited to that seen in PA. From the PA MEDICAL PRACTICE ACT OF 1985 Act of Dec. 20, 1985, P.L. 457, No. 112; Section 4 f) "Any person or facility who reports pursuant to this section in good faith and without malice shall be immune from any civil or criminal liability arising from such report. Failure to provide such report within a reasonable time from receipt of knowledge of impairment shall subject the person or facility to a fine not to exceed $1,000. The board shall levy this penalty only after affording the accused party the opportunity for a hearing, as provided in Title 2 of the Pennsylvania Consolidated Statutes (relating to administrative law and procedure)." Please, note, no jurisdiction of the misconduct is cited. It is anywhere that it occurs.

If you fail to put in the restrictive language to preclude the witch hunting of physicians by disgruntled people, and by licensing board enablers, I will be reporting the Washington Licensing Board to itself, as bullies and as disruptive physicians. I will be specifying the extensive workup of the clinical conditions that put a doctor at risk for such misconduct, and demanding the Board members undergo these extensive evaluations and treatments if necessary. These demands will be copied word for word from your very clear and easy to understand: Practitioners Exhibiting Disruptive Behavior Policy, MD2021-01

On Fri, Jul 2, 2021 at 1:10 PM WMC Medical Rules <Medical.Rules@wmc.wa.gov> wrote:

> Good morning,
>
> The Washington Medical Commission only has jurisdiction in Washington State and is the licensing authority for physicians and physician assistants in this state. As such, the Washington Medical Commission would have no jurisdiction in matters in Pennsylvania.

Amelia Boyd, BAS
Program Manager
Washington Medical Commission
Office: (360) 236-2727
Mobile: (360) 918-6336

Were you satisfied with the service you received today? Yes or No

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From: David Behar <dbehar322@gmail.com>
Sent: Friday, July 2, 2021 4:22 AM
To: WMC Medical Rules <Medical.Rules@wmc.wa.gov>; David <dbehar322@gmail.com>; Brian Moquin <bmoquin@lawprism.com>; Jeremy Schaller <jeremyschllr@gmail.com>; James Schaller <jameslschallermd@gmail.com>; Brittany J. Behar <bjbehar@gmail.com>; Ambrosini,Paul <pa28@drexel.edu>
Subject: Clinical Support Program

External Email

You requested a comment:

To avoid harassing physicians and resulting litigation, the standard of probable cause of a physical injury to a patient from doctor misconduct should be established before an investigation is initiated. Complaints not involving a patient's physical injury, and not meeting the legal standard of probable cause should be summarily dismissed without investigation.

Probable cause means, there is more evidence for an action than against, and it is the basis for most police actions such as arrests, searches and entry.

Complaints not involving an act of medical practice should be dismissed without investigation. You should not even inform the physician about receiving one. Complaints involving personal relationships and physician viewpoints should not be investigated. They subvert the licensing board to becoming an agent of retaliation, hostility, and conflict with the physician by disgruntled people. The licensing board should dismiss all complaints involving political

viewpoints, political correctness, rudeness, arguing, or controversies in medicine, in the absence of a patient's physical injury. Doctor cursed at a neighbor. Doctor beat up a neighbor. Not an act of medical practice. Go elsewhere with that complaint. Such intimidation of the doctor violates the Free Speech rights of the physician. The stress pressures physicians to leave practice, to the detriment of the population of Washington. They induce the impetus to sue the licensing board, detracting money, time and resources from its primary mission, the physical safety of the public. You want to stay out of divorce conflicts. You want to avoid complaints about postings on social media. You want to dismiss complaints about political incorrectness that have not resulted in a patient's physical injury. Doctor refused to mask, and the patient got COVID. Prove it came from the doctor before starting an investigation.

If you fail to do so, you deserve to be sued and to be ruined, and totally hamstrung by litigation. If you fail to incorporate these limits, I will submit a complaint against each of the members of the Washington licensing board for being disruptive physicians, asking for a full examination, and referral for treatment of each one of you. You would be bullies, and disruptive. My complaint would not involve the probable cause of a patient's physical injury. My complaint would have no physical safety problem or injury. It would be because you offended me. See how you like it.

My complaint would be immunized by the duty to report professional misconduct in the Pennsylvania Medical Practice Act. It subjects me to multiple fines of $1000 for failing to report each one of you. You must honor that duty and immunity under the Full Faith and Credit Clause of the constitution.

From: Jennifer Van Atta
To: WMC Medical Rules
Subject: Comments on Draft CSP language
Date: Tuesday, July 6, 2021 12:58:13 PM
Attachments: Outlook-dka5tsfu.png

External Email

Good afternoon,

Based on my understanding of the intent of this program, I have taken the liberty of offering some suggestions for wording below. Most are in the interest of transparency and clarity. Clearly, my understanding may be limited, but these reflect questions PAs in my company would be likely to have if approached by the WMC with a plan.

Draft Policy Suggestions

(1) The purpose of the clinical support program is to proactively support physician assistants to address practice concerns through education or practice changes, or both. A practice concern is conduct that, has been reported to the Commission via complaint or mandatory report, that, if continued, could result in a violation of the uniform disciplinary act.

(3) A clinical support plan is a written and signed agreement between the physician assistant and the commission listing steps the physician may take to change the practice to resolve the practice concern.

(2) The commission may resolve an alleged practice concern through the clinical support program following an investigation of a complaint or a mandatory report.

(4) The commission shall use the following criteria to determine eligibility for the clinical support program:
(a) The alleged practice concern does not pose an imminent threat to the life or safety of patients under the practitioner's care
(b) The alleged practice concern may be corrected by education or practice changes, or both, and is unlikely to reoccur;
(c) Education or practice changes, or both, are sufficient to ensure patient protection;
~~(d) The physician assistant agrees to participate in the clinical support program;~~
and (e) The commission has not authorized disciplinary action for the identified practice concern under RCW 18.130.172, RCW 18.130.170, or RCW 18.130.090.

Note on the strikethrough of (d) above - To my understanding, PA agreement would not be a criteria for offering the clinical support program. The recommendations would be offered regardless of whether the PA agrees to perform.

(6) The commission shall use the following process to implement the clinical support program: (a) After an investigation identifies an alleged practice concern and eligibility for the program, the commission will develop recommendations and timelines to address the deficiencies ~~apply criteria in subsection (4) of this section to determine eligibility for the clinical support program;~~
(b) Plan will be submitted to the Physician Assistant for acknowledgement and agreement. If the Physician Assistant declines to sign the acknowledgement within stated timeframes, the plan will be considered declined, and will be noted as such in the investigative file . ~~If all the criteria are met, and the commission determines that the physician assistant is eligible for participation in the clinical support program, the commission may propose a clinical support plan to the physician assistant; and~~ (c) When the commission determines that the physician assistant has successfully completed the clinical support plan, the commission will notify the Physician Assistant of accepted completion and close the matter without further action. (7) Participation in the clinical support program is not disciplinary action and is not reportable to the National Practitioner Data Bank or the Federation of State Medical Boards.

Draft procedure comments:

1. This procedure reads as though a single incidence of stated behavior would be addressed with a plan by the CSP committee. Is the intention? If not, I'd suggest that a phrasing incorporating "pattern of" or similar. Alternately, it could suggest a numerical or severity threshhold which would trigger a review by the CSP
2. Name badge - generally not required; however it is required that a PA identify themselves as a PA. An embroidered lab coat with name and title often suffices. If this is a requirement for PAs, it should be a requirement for all practitioners.
3. Re: mailed and signed within 14 days of mail date (postmark?). In this day and age, this policy should allow for electronic communications and document signatures
4. If the PA declines to sign the plan, the plan should not be withdrawn, but recorded as declined.
5. If the PA declines to sign, does it then become reportable?
6. Is there a mechanism for notifying SPs of PA CSPs? Or should there be? What is likely to be the impact on PA supervisory/delegation agreements of notifications and is there a way to mitigate damage?
7. Upon completion practitioner should be notified in writing that they have met conditions
8. What is the mechanism for follow up if the behavior continues?

Draft form comments:

1. Wording should reflect practitioners, not just PAs or physicians.
2. If the CSP is a public record, transparency suggests that this be followed by the phrase,

"and is discoverable as such," whether or not the practitioner attests to the plan (if this is true).

3. To separate the body of the plan from practitioner response, I suggest a heading of "Acknowledgement" before the attestation.

Thank you for your time.
Best regards,

Jennifer Van Atta, MS, PA-C

C 503.421.1636
jennifer.vanatta@gohealthuc.com

LEGACY HEALTH | GoHealth
URGENT CARE

Washington State Society of Anesthesiologists

August 2, 2021

Ms. Amelia Boyd
Washington Medical Commission, Department of Health
P.O. Box 47866
Olympia, WA 98504-7866

Re: Clinical Support Program Rulemaking

Dear Members of the Washington Medical Commission:

On behalf of the Washington State Society of Anesthesiologists (WSSA), thank you for the opportunity to provide comment on the proposed rules to create a Clinical Support Program. We recently became aware of this issue, although we know it has been part of an ongoing discussion for several years.

We appreciate the Commission's interest in exploring a non-disciplinary approach to resolve practice concerns that do not warrant disciplinary action. However, we share many of the same concerns as our colleagues in the Washington State Medical Association (WSMA) about the current form of the draft rules.

WSSA believes the lack of appropriate confidentiality protections is a major cause for concern with the proposed rules. Failure to protect the personal privacy of physicians by allowing the disclosure of Clinical Support Program documents and proceedings could harm their professional reputations, and it will deter provider participation in the program. When the Legislature considered this proposal in 2016, the provider community was supportive while the confidentiality provisions remained in the bill. We urge the Commission to seek legislative protection from disclosure before implementing a Clinical Support Program.

Whether participation in the program is truly voluntary is another major concern for WSSA. The proposed language says providers must agree to participate, but comments from Commission staff at the most recent Rules Workshop on this topic indicate this would be a veiled disciplinary proceeding for alleged deficiencies that do not meet the standard for action under the UDL.

While we may be supportive of this program in concept, the WSSA has serious concerns with the program as proposed and respectfully request the WMC rescind the CR-102.

2150 N. 107th Suite 205, Seattle, WA 98133 206-209-5266
office@wa-anesthesiology.org www.wa-anesthesiology.org

We appreciate your consideration of these comments. With questions, please don't hesitate to reach out to Louise Miller, WSSA Executive Director, at office@wa-anesthesiology.org.

Sincerely,

Stephanie Yang, MD
President, Washington State Society of Anesthesiologists

New Section

Physicians

246-919-650
Clinical Support Program

(1) The purpose of the clinical support program is to proactively support physicians to address practice concerns through education or practice changes, or both. A practice concern is conduct that, if continued, could result in a violation of the uniform disciplinary act.

(2) A clinical support plan is a written and signed agreement between the physician and the commission listing steps the physician may take to change the practice to resolve the practice concern.

(3) The commission may resolve an alleged practice concern through the clinical support program following an investigation of a complaint or a mandatory report.

(4) The commission shall use the following criteria to determine eligibility for the clinical support program:

(a) The alleged practice concern may be corrected by education or practice changes, or both, and is unlikely to reoccur;

(b) Education or practice changes, or both, are sufficient to ensure patient protection;

(c) The physician agrees to participate in the clinical support program; and

(d) The commission has not authorized disciplinary action for the identified practice concern under RCW 18.130.172, RCW 18.130.170, or RCW 18.130.090.

(5) The commission has sole discretion to offer a clinical support plan to an eligible physician to resolve a complaint.

(6) The commission shall use the following process to implement the clinical support program:

(a) After an investigation identifies an alleged practice concern, the commission will apply criteria in subsection (4) of this section to determine eligibility for the clinical support program;

(b) If all the criteria are met, and the commission determines that the physician is eligible for participation in the clinical support program, the commission may propose a clinical support plan to the physician; and

(c) When the commission determines that the physician has successfully completed the clinical support plan, the commission will close the matter without further action.

(7) Participation in the clinical support program is not disciplinary action and is not reportable to the National Practitioner Data Bank or the Federation of State Medical Boards.

New Section

Physician Assistants

246-918-380
Clinical Support Program

(1) The purpose of the clinical support program is to proactively support physician assistants to address practice concerns through education or practice changes, or both. A practice concern is conduct that, if continued, could result in a violation of the uniform disciplinary act.

(2) A clinical support plan is a written and signed agreement between the physician assistant and the commission listing steps the physician may take to change the practice to resolve the practice concern.

(3) The commission may resolve an alleged practice concern through the clinical support program following an investigation of a complaint or a mandatory report.

(4) The commission shall use the following criteria to determine eligibility for the clinical support program:

(a) The alleged practice concern may be corrected by education or practice changes, or both, and is unlikely to reoccur;

(b) Education or practice changes, or both, are sufficient to ensure patient protection;

(c) The physician assistant agrees to participate in the clinical support program; and

(d) The commission has not authorized disciplinary action for the identified practice concern under RCW 18.130.172, RCW 18.130.170, or RCW 18.130.090.

(5) The commission has sole discretion to offer a clinical support plan to an eligible physician assistant to resolve a complaint.

(6) The commission shall use the following process to implement the clinical support program:

(a) After an investigation identifies an alleged practice concern, the commission will apply criteria in subsection (4) of this section to determine eligibility for the clinical support program;

(b) If all the criteria are met, and the commission determines that the physician assistant is eligible for participation in the clinical support program, the commission may propose a clinical support plan to the physician assistant; and

(c) When the commission determines that the physician assistant has successfully completed the clinical support plan, the commission will close the matter without further action.

(7) Participation in the clinical support program is not disciplinary action and is not reportable to the National Practitioner Data Bank or the Federation of State Medical Boards.

Procedure

WASHINGTON Medical Commission
Licensing. Accountability. Leadership.

The Clinical Support Program

Introduction

The Washington Medical Commission adopted a rule creating the clinical support program. The intent is to improve the quality of patient care by proactively supporting physicians and physician assistants (collectively practitioners) to address practice concerns through a plan of education or practice change, or both, before disciplinary action is necessary to protect the public. A practice concern is conduct that, if continued, could present a risk of harm to patients. The Commission issues this procedure to establish when and how the Commission will offer a practitioner the opportunity to participate in the clinical support program by signing a clinical support plan.

Procedure

Type of cases appropriate for a clinical support plan

Per WAC 246-919-xxx and WAC 246-918-xxx, a practitioner is eligible for the clinical support program when the Commission identifies a practice concern that can be corrected within three months and patient protection does not require practice limits. A clinic support plan is intended for minor practice concerns that can be quickly corrected. It is not meant for behavior that amounts to dishonesty, boundary violations, acts of moral turpitude, impairment or any conduct that presents a risk of harm to patients.

Examples of cases in which a clinical support plan may be appropriate are:

- A failure to provide records pursuant to a patient request in a reasonable time.
- A failure to complete a death certificate in a timely manner
- A failure to communicate with a patient or another practitioner in a timely manner
- A physician assistant not wearing a name badge
- A failure to issue a prescription electronically and no exception applies
- A failure by a physician assistant to file a practice agreement filed with the Commission
- A failure to comply with state reporting requirements
- A failure to complete required continuing medical education

When a clinical support plan may be offered

The Commission may offer a clinical support plan only prior to commencing a disciplinary action. Once the Commission orders that a Statement of Allegations and a Stipulation to Informal Disposition be offered to a practitioner, or orders that a Statement of Charges be served on a practitioner, the practitioner is not eligible for a clinical support plan, even if the Commission subsequently withdraws the Statement of Allegations or the Statement of Charges.

A clinical support plan is non-negotiable

When the Commission sends a practitioner a proposed clinical support plan to resolve a practice concern, the terms of the clinical support plan are non-negotiable. A practitioner may not ask to modify the plan offered by the Commission. The practitioner may decline to sign the document, but the practitioner may not make a counterproposal.

A clinical support plan must be signed within 14 calendar days

The practitioner must sign and the proposed clinical support plan within 14 calendar days of the date the proposed clinical support plan was placed in the mail to the practitioner. The Commission will not extend the time period. If the practitioner does not return a signed clinical support plan within the prescribed time period, the proposed action plan is considered to be withdrawn, and the practitioner is no longer eligible for the program.

A clinical support plan is a public document, but is not reportable

A clinical support plan is not disciplinary action and is not reportable to either the National Practitioner Data Bank, the Federation of State Medical Boards, or other entities. A clinical support plan will not be placed on the Department of Health web site, will not be put into a press release, and will not be placed in the Commission's newsletter. A clinical support plan is a public document and is subject to disclosure under Chapter 42.56 RCW, the Public Records Act.

Completion of the action plan and closure of the case.

When a practitioner submits proof of completion of the clinical support plan, the Commission will close the complaint. If a practitioner fails to complete the clinical support plan within the required time period, the Commission will notify the practitioner of the failure to complete the plan and will consider whether disciplinary action is necessary. Disciplinary action will be based on the evidence obtained in the investigation of the original complaint; it will not be based on the failure to complete the clinical support plan.

Number:

Date of Adoption:

Reaffirmed / Updated:

WASHINGTON Medical Commission
Licensing. Accountability. Leadership.

Clinical Support Plan
John Doe, MD
License No. MD0001234

The Washington Medical Commission has determined that you meet the criteria for the Commission's Clinical Support Program. The purpose of the clinical support program is to improve the quality of patient care by proactively supporting physicians to quickly address practice concerns through education or practice changes, or both.

Participation in the Clinical Support Program is voluntary. The Clinical Support Program is designed to help you improve your practice. If you participate in the Clinical Support Program and satisfactorily complete the Clinical Support Plan, detailed below, the Commission will close the current complaint against you.

Clinical Support Plan

> **Respondent agrees to complete three hours of continuing medical education in the area of medical record-keeping. Respondent will submit proof of completion to the Commission by June 1, 2022.**

Participation in the Clinical Support Program is not an admission of any conduct or behavior. It is not discipline and is not Commission action. The Clinical Support Plan is not reportable to the National Practitioner Data Bank or the Federation of State Medical Boards. The Clinical Support Plan will not be posted on the Department of Health web site and will not be listed in the Commission newsletter. However, it is a public document under the Public Records Act, chapter 42.56.

I have read and understand this entire document. I agree to participate in the Clinical Support Program and agree to complete the Clinical Support Plan, above. I understand that my participation in the Clinical Support Program is voluntary. I understand that this document is a public record and may be disclosed to any person upon request. It will remain part of the investigative file and will be remain for the time period required by the state record retention law.

Signed: _____ Date: _____