WASHINGTON

# Medical Commission

Licensing. Accountability. Leadership.

## Business Meeting
## January 19, 2024

# FORMAL HEARING SCHEDULE

WASHINGTON Medical Commission
Licensing. Accountability. Leadership.

| Hearing | Respondent | Case No. | Location |
|---|---|---|---|
| **2024 February** | | | |
| 22-Feb **through** 23-Feb | Benson, David, MD | M2022-721 | Virtual |
| **2024 March** | | | |
| 1-Mar | Tantuwaya, Lokesh, MD | M2021-382 | TBD |
| 6-Mar **through** 8-Mar | Apter, Robert, MD | M2022-488 | TBD |
| 7-Mar **through** 8-Mar | Adan, John, MD | M2021-757 | TBD |
| 14-Mar **through** 15-Mar | Hill, Simon D., PA | M2022-198 | TBD |
| 15-Mar | Bernales, Wilson, MD | M2023-469 | TBD |
| 18-Mar **through** 20-Mar | Turner, Michael, MD | M2022-194 | TBD |
| 26-Mar **through** 29-Mar | Washington, William, MD | M2021-755 | TBD |
| **2024 April** | | | |
| 8-Apr **through** 10-Apr | Alhafez, Fadi, MD | M2021-656 | TBD |
| 17-Apr **through** 19-April | Lin, Wei-Hsung, MD | M2022-202 | TBD |
| 29-Apr **through** 2-May | Shibley, Eric, MD | M2018-443 | TBD |

| Hearing | Respondent | Case No. | Location |
|---|---|---|---|
| **2024 May** | | | |
| 24-May | Ataee, Sean, MD | M2023-774 | TBD |
| **2024 June** | | | |
| 12-Jun **through** 14-Jun | Schumer, David S., MD | M2022-991 | TBD |
| **2024 July** | | | |
| 22-Jul **through** 24-Jul | Ankeney, Geoffrey, MD | M2023-63 | TBD |
| **2024 August** | | | |
| 7-Aug **through** 9-Aug | Ravasia, Sajid A. MD | M2022-989 | TBD |
| 19-Aug **through** 21-Aug | Ilg, Ron, MD | M2022-712 | TBD |
| 26-Aug **through** 27-Aug | Nielson, Alex, MD | M2023-645 | TBD |

# 2024 Meeting Schedule

WASHINGTON Medical Commission
Licensing. Accountability. Leadership.

| Date & Time | Location | Meeting Type |
|---|---|---|
| **January 4**<br>**10 am – 11 am** | Virtual | Policy Committee |
| **January 11**<br>**8:30 am – 5 pm** | Virtual | Case Disposition<br>Personal Appearances |
| **January 19**<br>**9am – 11 am** | Virtual | Business |
| **March 7**<br>**8:30 am – 5 pm** | Hilton Garden Inn Olympia<br>2101 Henderson Park Lane SE<br>Olympia, WA 98501 | Case Disposition<br>Personal Appearances |
| **March 21**<br>**10 am – 11 am** | Virtual | Policy: Interested Parties |
| **April 11**<br>**10 am – 11 am** | Virtual | Policy Committee |
| **April 18 – to be rescheduled** | New date and a location will be announced soon. | Case Disposition<br>Personal Appearances |
| **April 26**<br>**9 am – 11 am** | Virtual | Business |
| **May 24**<br>**8 am – 5 pm** | Virtual | Personal Appearances |
| **June 6**<br>**10 am – 11 am** | Virtual | Policy: Interested Parties |
| **June 13**<br>**8:30 am – 5 pm** | Location will be announced soon. | Case Disposition<br>Personal Appearances |
| **June 27**<br>**10 am – 11 am** | Virtual | Policy Committee |
| **July 11**<br>**8:30 am – 5 pm** | Virtual | Case Disposition<br>Personal Appearances |
| **July 19**<br>**9 am – 11 am** | Virtual | Business |
| **September 12**<br>**8:30 am – 5 pm** | Location will be announced soon. | Case Disposition<br>Personal Appearances |

Approved: May 26, 2023

Updated: January 11, 2024

| Date & Time | Location | Meeting Type |
|---|---|---|
| **September 19**<br>**10 am – 11 am** | Virtual | Policy: Interested Parties |
| **September 26**<br>**10 am – 11 am** | Virtual | Policy Committee |
| **October 3**<br>**8:30 am – 5 pm** | In-Person<br>Radisson Seattle Airport<br>18118 International Blvd.<br>Seattle, WA 98188 | Case Disposition<br>Personal Appearances |
| **October 4**<br>**8:00 am – 5 pm** | In-Person<br>Radisson Seattle Airport<br>18118 International Blvd.<br>Seattle, WA 98188 | Commissioner Retreat |
| **October 11**<br>**9 am – 11 am** | Virtual | Business |
| **November 14**<br>**8 am – 5 pm** | Virtual | Case Disposition |
| **December 5**<br>**10 am – 11 am** | Virtual | Policy: Interested Parties |

# 2025 Meeting Schedule

WASHINGTON Medical Commission
Licensing. Accountability. Leadership.

| Dates | Location | Meeting Type |
|---|---|---|
| **January 2**<br>**10 am** | Virtual | Policy Committee Meeting |
| **January 9** | Virtual | Case Reviews<br>Personal Appearances |
| **January 10**<br>**9am** | Virtual | Business Meeting |
| **February 13** | In-Person<br>Location TBD | Case Reviews |
| **March 13** | In-Person<br>Location TBD | Case Reviews<br>Personal Appearances |
| **March 20**<br>**10 am** | Virtual | Interested Parties<br>Policy Meeting |
| **April 10**<br>**10 am** | Virtual | Policy Committee Meeting |
| **April 17** | In-Person<br>Location TBD | Case Reviews<br>Personal Appearances |
| **April 25**<br>**9 am** | Virtual | Business Meeting |
| **May 16** | Virtual | Personal Appearances |
| **June 12**<br>**10 am** | Virtual | Interested Parties<br>Policy Meeting |
| **June 19** | In-Person<br>Location TBD | Case Reviews<br>Personal Appearances |
| **June 26**<br>**10 am** | Virtual | Policy Committee Meeting |
| **July 10** | Virtual | Case Reviews<br>Personal Appearances |
| **July 25**<br>**9 am** | Virtual | Business Meeting |
| **September 4** | In-Person<br>Location TBD | Case Reviews<br>Personal Appearances |
| **September 11**<br>**10 am** | Virtual | Interested Parties<br>Policy Meeting |
| **September 25**<br>**10 am** | Virtual | Policy Committee Meeting |

| | | |
|---|---|---|
| **October 2** | In-Person<br>Location TBD | Case Reviews<br>Personal Appearances |
| **October 10**<br>**9 am** | Virtual | Business Meeting |
| **November 14** | Virtual | Case Reviews |
| **December 4**<br>**10 am** | Virtual | Interested Parties<br>Policy Meeting |

# Business Meeting Agenda
# January 19, 2024 – 1st Revised

WASHINGTON Medical Commission
Licensing. Accountability. Leadership.

In accordance with the Open Public Meetings Act, this meeting notice was sent to individuals requesting notification of the Department of Health, Washington Medical Commission (WMC) meetings. This agenda is subject to change. The Business Meeting will begin at 9:00 am on January 19, 2024, until all agenda items are complete. The WMC will take public comment at the Business Meeting. To request this document in another format, call 1-800-525-0127. Deaf or hard of hearing customers, please call 711 (Washington Relay) or email civil.rights@doh.wa.gov.

*The WMC is providing a virtual option for members of the public for the Business meeting.*

**Virtual via Teams Webinar: Registration link can be found below.**
**Physical location: Department of Health, 111 Israel Rd SE, TC2 Rm 145, Tumwater, WA**

| Time | Friday – January 19, 2024 |
|---|---|
| **Open Session** | |
| **9:00 am** | **Business Meeting** |

To attend virtually, **register** for this meeting at: WMC Business Meeting

## 1.0 Chair Calls the Meeting to Order

## 2.0 Public Comment

The public will have an opportunity to provide comments. ***If you would like to comment, please limit your comments to two minutes. Please identify yourself and who you represent, if applicable, when the Chair opens the floor for public comment. If you would prefer to submit written comments, send them to amelia.boyd@wmc.wa.gov by January 18, 2024.***

2.1 Comments from a members of the public will be read into the record by Amelia Boyd, Program Manager. Pages 10-11

2.2 The Chair will call for additional comments from the public.

**Closed Session**

## 3.0 Executive Session

Executive Session under RCW 42.30.110(1)(i) to discuss request from the United States Department of Justice.

**Open Session**

## 4.0 Chair Report

## 5.0 Consent Agenda

Items listed under the Consent Agenda are considered routine agency matters and will be approved by a single motion without separate discussion. If separate discussion is desired, that item will be removed from the Consent Agenda and placed on the regular Business Agenda. Action

4.1 Minutes – Approval of the October 20, 2023 Business Meeting minutes. Pages 12-16

4.2 Agenda – Approval of the January 19, 2024 Business Meeting agenda. Pages 8-9

## 6.0 New Business

6.1 **Petition for Declaratory Order** Action
Mike Farrell, Supervising Staff Attorney, to present. Pages 17-18



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## 7.0 Old Business

7.1 **Committee/Workgroup Reports** — Update

The Chair will call for reports from the Commission's committees and workgroups. Written reports begin on page 19. See page 20 for a list of committees and workgroups.

7.2 **Rulemaking Activities** — Update/Action

Rules Progress Report provided on page 21.

- Request to rescind Collaborative Drug Therapy Agreement rulemaking — Action, Pages 24-25
  - CR-101 on page 22

***Rules Adopted***

The WMC has adopted WAC 246-918-195 (new) (physician assistants) and WAC 246-919-445 (new) (allopathic physicians) to implement Engrossed Substitute Senate Bill 5229 (chapter 276, Laws of 2021). This adoption implements the health equity model rules, WAC 246-12-800 through 246-12-830, for physician assistants and allopathic physicians to comply with RCW 43.70.613. The CR-103P was filed on November 29, 2023, as WSR #23-24-033. **These rules were in effect as of January 1, 2024**.

7.3 **Strategic Plan 2023-2025** — Action, Pages 26-36

Jimi Bush, Director of Quality and Engagement, will present this item for discussion and action.

## 8.0 Policy Committee Report

Christine Blake, Public Member, Chair, will report on items discussed at the Policy Committee meeting held on January 4, 2024. The agenda was as follows: — Report/Action

8.1 Non-WMC Rulemaking: Midwifery Legend Drugs and Devices — Pages 37-79

*Comments from Washington State Medical Association* — Pages 80-83

8.2 Guidance Document: Medical Records: Documentation, Access, Retention, Storage, Disposal, and Closing a Practice — Pages 84-98

*Comments from Washington Advocates for Patient Safety* — Pages 99-100

## 9.0 Member Reports

The Chair will call for reports from Commission members.

## 10.0 Staff Member Reports

The Chair will call for further reports from staff. — Written reports pages 101-114

## 11.0 AAG Report

Heather Carter, AAG, may provide a report.

## 12.0 Adjournment of Business Meeting



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January 3, 2024

To the Washington Medical Commission,

I request this letter be read into the record at your next meeting of your Policy Committee.

I am angered by what you're up to.

First, your witch hunt for health practitioners who do not tow the party line is appalling. With the ever-increasing toxic load we're all exposed to, we desperately need these doctors and the alternative options they *offer* (not *force on*) us. We're not a bunch of dummies that need mommy and daddy government to protect us. We can make our own health care choices. If I choose a practitioner that aligns with my beliefs, that means I've already rejected the medicine you want to limit us to.

Second, you are an unelected and unaccountable body; part of the monstrous administrative state and the cancerous growth of government. We have no way to oust you on election day should we not like how you're spending taxpayer monies. Sweet for you; no recourse for us.

Third… you're wrong. You are condemning good doctors based on outdated dictates from so-called authorities (also part of the administrative state) you claim to take your marching orders from, not to mention bad science and manipulated data. You don't even seem to know what the CDC and FDA are currently saying. They're singing a different tune than two and three years ago.

I doubt you can be ignorant of the truth at this point in the game. I think you know what you're doing, choosing to act in service to the deep state. You're certainly not helping the people you're supposed to serve. Or, perhaps you have been brainwashed, bribed, or blackmailed – all possibilities – in which case, if you can't do the right thing, you should simply resign… before you find yourselves on the wrong side of history at the eventual reckoning that will come.

Seriously and sincerely,

Lynn Bergeron
Cook, WA

## Boyd, Amelia (WMC)

**From:** Kit & Tom Vander Sys <vmntncabiin@icloud.com>
**Sent:** Thursday, January 4, 2024 3:52 PM
**To:** Boyd, Amelia (WMC)
**Subject:** Presentation

**Follow Up Flag:** Follow up
**Flag Status:** Flagged

External Email

Hi.

Here is my 22 year summary of things I have observed.. Any questions please contact me.

I am a retired engineer from the nuclear seLons industry where I held a top secret clearance for 25 years. My career was terminated by a doctor who fractured a 4 level bone grafted fusion on July 8, 2002. In the ensuing 22 years pain mgmnt was provided by hospitals and clinics. During this time I have noticed areas of pain management that I believe need attention to improve doctor/patient outcomes. In 2017 suffered a sub acute fracture caused by an inadequately trained trained CT scan tech. No pain medication was given for this injury and the DOH investigator did not interview the tech who caused this injury nor her supervisor who was in the room at the time of the fracture. Complicating this matter is that there are no means to seek relief. The solution may be to establish a formal line of communication from the patient to the WMC to resolve complaints In real-time. It would also be advantageous to provide more in-depth CME in pain management education for pain practitioners. Two hospitals, one in Vancouver the other in Spokane admitted they had no training in pain management. A Spokane ER doctor and a palliative care provider will not provide adequate pain management for fear of losing their licenses. And since there is expected personnel turnover It may be advisable to the DOH to once again send clarification regarding no opioid prescribing limits similar to September 12, 2019 letter. It should also be noted that a clinic in Lewiston failed to provide help despite sending at least a dozen messages/phone calls. Subsequent to this my Spokane PCP called 911 as did an Urgent Care doctor in Vancouver WA. As you can see from what has been described there are a number of areas that need improvement. It is my opinion also that some doctors are in pain management for financial gain only. Finally, the hiring process should include a thorough background check for opioid prescribing doctors. They are humans too. Thank you from my hospital bed in severe pain.

I was advised by an orthopedist while I was hospitalized that my left leg needed to be amputated bc of a Spokane hospital wound clinic oversight. And although while hospitalized I reported 9-10 level pain and the hospitalist prescribed Tylenol upon leaving.

# Business Meeting Minutes
# October 20, 2023

WASHINGTON Medical Commission
Licensing. Accountability. Leadership.

**Virtual Meeting via Teams Webinar**
**Link to recording:** https://youtu.be/KlfNNtgJMjk?si=oWEG73TiM-vForWb

## Commission Members

Michael Bailey, Public Member – Absent
Christine Blake, Public Member
Toni Borlas, Public Member – Absent
Po-Shen Chang, MD
Jimmy Chung, MD
Diana Currie, MD
Karen Domino, MD, Chair
Arlene Dorrough, PA-C
Anjali D'Souza, MD
Harlan Gallinger, MD – Absent
April Jaeger, MD
Jamie Koop, Public Member – Absent
Ed Lopez, PA-C, Officer-at-Large
Sarah Lyle, MD
Terry Murphy, MD, Chair Elect
Elisha Mvundura, MD
Robert Pullen, Public Member
Scott Rodgers, JD, Public Member
Claire Trescott, MD – Absent
Richard Wohns, MD – Absent

## WMC Staff in Attendance

Christine Babb, Investigator
Taylor Bacharach-Nixon, Admin. Assistant
Colleen Balatbat, Staff Attorney
Amelia Boyd, Program Manager
Kayla Bryson, Executive Assistant
Jimi Bush, Director of Quality & Engagement
Carmen Challender, Health Services Consultant
Marisa Courtney, Licensing Manager
Joel DeFazio, Staff Attorney
Kelly Elder, Staff Attorney
Mike Farrell, Supervising Staff Attorney
Ryan Furbush, Paralegal
Rick Glein, Director of Legal Services
Mike Hively, Director of Operations & Informatics
Jenelle Houser, Investigator
Ken Imes, Information Liaison
Kyle Karinen, Executive Director
Shelley Kilmer-Ready, Legal Assistant
Christopher Knight, Management Analyst
Joanna Mallard, Health Services Coordinator
Emma Marienthal, Licensing Lead
Stephanie Mason, PR & Legislative Liaison
Sherrise Martin, Health Services Coordinator
Micah Matthews, Deputy Executive Director
Joe Mihelich, Health Services Coordinator
Lynne Miller, Paralegal
Fatima Mirza, Program Case Manager
Freda Pace, Director of Investigations
Stormie Redden, Legal Assistant
Mahi Zeru, Equity & Social Justice Manager

## Others in Attendance

Marlon Basco-Rodillas, Dept. of Health (DOH)
Rose Bigham
Chris Bundy, MD, Executive Medical Director, Washington Physicians Health Program
Heather Carter, AAG
Tessa Harvey, DOH
Heather Carter, Assistant Attorney General
Brian Hunsicker, WAFP
Amy McCargar Davis, Multicare
Casey Morris
Hillary Norris, Policy Analyst, WSMA
Rachel Phipps, DOH
Angela Ross, ND, WANP Executive Director
Ledeane Stewart, Kadlec Regional Med. Center

DRAFT



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## 1.0 Call to Order

Karen Domino, MD, Chair, called the meeting of the Washington Medical Commission (WMC) to order at 9:00 a.m. on October 20, 2023.

## 2.0 Public Comment

Angela Ross, ND, Washington Association of Naturopathic Physicians (WANP) Executive Director, stated she would like to be a resource for questions related to the bill the WANP is bringing forward during the next legislative session, Senate Bill 5411.She went on to state the WANP would welcome the WMC's support and collaboration on this bill.

## 3.0 Chair Report

Dr. Domino reported that most of the Commissioners attended the Commissioner retreat which was held recently. She thought the retreat was excellent and that the staff arranged things well. She stated they had really good discussions and a lot of good ideas to modify the new strategic plan.

## 4.0 Consent Agenda

The Consent Agenda contained the following items for approval:

**4.1** Minutes from the July 14, 2023, Business Meeting

**4.2** Agenda for October 20, 2023.

***Motion**:* The Chair entertained a motion to approve the Consent Agenda. The motion was seconded and approved unanimously.

## 5.0 Old Business

**5.1 Senate Bill (SB) 5411 – Increasing the scope of practice of naturopathic physicians**

Kyle Karinen, Executive Director, presented the following:

- SB 5411, Increasing the scope of practice of naturopathic physicians;
- Naturopathy Sunrise Application Report;
- Washington Association of Naturopathic Physicians Comment; and
- MQAC Naturopath Sunrise Comment 2014.

Mr. Karinen provided some history on this item and explained the WMC has two options:

1. Do nothing; or
2. Provide comment to the Sunrise Review committee.

He stated if the Commissioners decide to provide comment, staff would like to have feedback from them on what those comments should be. Micah Matthews, Deputy Executive Director, explained the history of opioid prescribing rules in Washington state as well as the complexities of regulating opioid prescribing. The Commissioners had a robust discussion about the bill. Mr. Matthews explained that staff are requesting the Commissioners to authorize Mr. Karinen to write a letter in response to the sunrise review process.

***Motion:*** The Chair entertained a motion to authorize a letter, which includes the Commissioners comments and concerns regarding the sunrise review, to be



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reviewed by the Executive Committee. The motion was approved unanimously.

## 6.0 Old Business

### 6.1 Committee/Workgroup Reports

These reports were provided in writing and included in the meeting packet. There were no additional reports.

High Reliability Organizations (HiRO) Workgroup
Mike Farrell, Supervising Staff Attorney, presented the Foundation for Health Care Quality Patient Safety Collaboration Statement of Understanding revised document. He explained the history of the document and the revisions.

***Motion:*** The Chair entertained a motion to approve the document as revised. The motion was approved unanimously.

### 6.2 Rulemaking Activities

The rulemaking progress report was provided in the meeting packet. In addition to the written report the following requests were made:

- Amelia Boyd, Program Manager, requested the WMC initiate the next step in the rulemaking process, CR-102, for WAC 246-919-330 Postgraduate medical training. Ms. Boyd explained that emergency rulemaking, filed as WSR 23-15-056 on July 13, 2023, has already been completed on this subject. She went on to say that this request is to make the emergency rules permanent through standard rulemaking and that this rulemaking is removing a barrier to licensure for MDs.

  ***Motion:*** The Chair entertained a motion to initiate the CR-102 process for this rulemaking. The motion was approved unanimously.

- Ms. Boyd requested the WMC initiate the next step in the rulemaking process, CR-102, for Physicians and Physician Assistants general provisions for opioid prescribing and tapering rules. She presented the draft language for review and discussion. The Commissioners proposed a revision to the draft language.

  ***Motion:*** The Chair entertained a motion to approve the proposed revision to the draft language. The motion was approved unanimously.

  ***Motion:*** The Chair entertained a motion to initiate the CR-102 process for this rulemaking. The motion was approved unanimously.

### 6.3 Lists & Labels Requests

The following lists and labels requests were discussed for possible approval or denial. Approval or denial of these requests is based on whether the entity meets the requirements of a "professional association" or an "educational organization" as noted on the application (RCW 42.56.070(9)).

- Recruiting Resources

  ***Motion:*** The Chair entertained a motion to deny the request. The motion was seconded and approved unanimously.



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- Washington State Medical Association

***Motion:*** The Chair entertained a motion to approve the request. The motion was seconded and approved unanimously.

### 6.4 Delegation of Signature Authority

Micah Matthews, Deputy Executive Director, presented the revised document and provided a history of its use.

***Motion:*** The Chair entertained a motion to approve the document as revised. The motion was seconded and approved unanimously.

## 7.0 Policy Committee Report

Christine Blake, Public Member, Policy Committee Chair, reported on the items discussed at the Policy Committee meeting held on October 13, 2023. The agenda was as follows:

**Proposed Interpretive Statement: Application of the Office-based Surgery Rule, WAC 246-919-601, to the Use of Nitrous Oxide**

Ms. Blake stated the committee discussed the document at length. Ms. Blake asked Mike Farrell, Policy Development Manager, to provide more information on this item. Mr. Farrell presented the revisions from the previous document as well as one additional revision. Ms. Blake stated the committee recommended approving the document as well as initiating rulemaking on this subject.

***Motion:*** The Chair entertained a motion to approve the interpretive statement for DOH Secretary review. The motion was approved unanimously.

***Motion:*** The Chair entertained a motion to approve to initiate rulemaking on this subject. The motion was approved unanimously.

**Rulemaking Proposal: Define "Qualified Physician"**

Ms. Blake stated the committee recommended initiating rulemaking to define "qualified physician" under new optometry law: Enrolled Substitute Senate Bill 5389, Chapter 400, Laws of 2023.

***Motion:*** The Chair entertained a motion to initiate standard rulemaking on this subject. The motion was approved unanimously.

## 8.0 Member Reports

Ms. Blake thanked Mike Farrell for his assistance with the Policy Committee and congratulated him on being chosen as the Supervising Staff Attorney.

## 9.0 Staff Reports

The reports below are in addition to the written reports that were included in the meeting packet.

Mr. Karinen reported that the WMC case disposition meeting scheduled for February 15, 2024, will be cancelled as the workload does not warrant 9 case disposition meetings next year.

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## 10.0 AAG Report

Heather Carter, AAG, provided information regarding litigation holds, which is a request to preserve potential evidence related to a lawsuit. She explained that if a Commissioner receives a litigation hold they should read the request, search for any related records they may have, and set those aside in a file. She recommended turning off the auto delete function in their email as well. Once the Commissioner discovers records and puts them aside, let Mike Hively know they have records.

## 11.0 Adjournment

The Chair called the meeting adjourned at 10:26 am.

Submitted by

Amelia Boyd, Program Manager

Karen Domino, MD, Chair
Washington Medical Commission

Approved January 19, 2023

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[redacted]

November 6, 2023

Michael Piechota, Health Care Investigator
Washington Medical Commission
Email: mike.piechota@wmc.wa.gov
[redacted]

***SUBJECT: JURISDICTIONAL CHALLENGE AND REQUEST FOR DUE PROCESS CONSIDERATION REGARDING CASE NO.*** [redacted]

Dear Mr. Piechota,

I am in receipt of your request for medical records dated August 22, 2023, concerning Case No. [redacted] While I am committed to upholding the highest standards of professional conduct, it is imperative to clarify the legal standing and jurisdiction of the Washington Medical Commission (WMC) before complying with such requests.

**Jurisdictional Challenge**

I hereby formally challenge the jurisdiction of the WMC to request these records absent a clear and valid basis for such an inquiry. Pursuant to RCW 34.05.240, I am requesting a declaratory order to confirm the Commission's authority to conduct this investigation, specifically:

1**. Verification of a Valid Complaint:** Provision of a detailed account that substantiates the existence of a formal complaint that necessitates the release of the requested medical records.

2. **Compliance with Privacy Laws:** Assurance that the request adheres to all pertinent privacy laws, including the Health Insurance Portability and Accountability Act (HIPAA) and Washington State health care information access and disclosure laws, to safeguard patient confidentiality.

3. **Establishment of Legal Authority:** A clear citation of the specific legal authority that supports the WMC's request, confirming that such a request falls within the WMC's investigative purview.

## Due Process Consideration

In line with due process rights afforded by the federal and state Administrative Procedure Acts, I assert that any investigation should be predicated upon a transparent validation of the agency's jurisdiction. This includes a detailed disclosure of any rules, statutes, or interagency agreements upon which the WMC is relying to initiate an investigation.

Should the WMC opt to proceed without duly addressing this jurisdictional challenge, I request the provision of the statutory or regulatory authority that the agency believes grants it the right to continue. This measure is to prevent the application of any informal or unpublished policies that could potentially infringe upon due process rights.

## Conclusion

I anticipate a written response from the WMC, outlining your stance on this matter and the procedures that will be followed to address this jurisdictional dispute. I am ready to provide further documentation or engage in discussions as necessary to facilitate a resolution.

Your prompt attention to this matter is appreciated, and I look forward to your detailed response on the next steps to be taken. Please inform me of any specific forms or documentation required to formalize this challenge.

Thank you for your cooperation and understanding.

Sincerely,

WASHINGTON Medical Commission
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# Committee/Workgroup Reports: January 19, 2024

| High Reliability Organizations Workgroup – Chair: Dr. Chung<br>Staff: Mike Farrell |
|---|
| The workgroup met in October to review the revised Statement of Understanding with the Foundation for Health Care Quality that details how the Commission works with the Foundation on CRP certified cases. The Commission approved this. The workgroup will meet again soon. |

| Healthcare Disparities Workgroup – Chair: Dr. Currie<br>Staff: Kyle Karinen |
|---|
| No updates to report. |

# Committees & Workgroups

WASHINGTON Medical Commission
Licensing. Accountability. Leadership.

| Executive Committee |
|---|
| Chair: Dr. Domino |
| Chair Elect: Dr. Murphy |
| Officer-at-Large: Ed Lopez, PA-C |
| Policy Chair: Christine Blake, PM |
| Immediate Past Chair: Dr. Chung |
| Kyle Karinen |
| Micah Matthews |
| Heather Carter, AAG |

| Policy Committee |
|---|
| Christine Blake, PM, Chair (B) |
| Dr. Domino (B) |
| Dr. Trescott (B) |
| Scott Rodgers, PM (A) |
| Ed Lopez, PA-C (B) |
| Dr. Lyle (A) |
| Heather Carter, AAG |
| Kyle Karinen |
| Micah Matthews |
| Pam Kohlmeier, MD |
| Amelia Boyd |

| Newsletter Editorial Board |
|---|
| Dr. Currie |
| Dr. Chung |
| Dr. Wohns |
| Jimi Bush, Managing Editor |
| Micah Matthews |

| Legislative Subcommittee |
|---|
| Dr. Chung, Chair |
| John Maldon, PM. Pro Tem Commissioner |
| Christine Blake, PM |
| Dr. Wohns |
| Kyle Karinen |
| Micah Matthews |

| Healthcare Disparities Workgroup |
|---|
| Dr. Currie, Chair |
| Dr. Browne |
| Dr. Jaeger |
| Christine Blake, PM |
| Kyle Karinen |

| Panel L |
|---|
| Dr. Chung, Chair |
| Christine Blake, PM |
| Arlene Dorrough, PA-C |
| Dr. Lyle |
| Dr. Wohns |
| Dr. Trescott |
| Dr. Browne, Pro Tem |
| John Maldon, PM, Pro Tem |
| Dr. Barrett, Medical Consultant |
| Marisa Courtney, Licensing Supervisor |
| Pam Kohlmeier, MD, JD, Staff Attorney |
| Micah Matthews |

| Finance Workgroup |
|---|
| Dr. Domino, WMC Chair, Workgroup Chair |
| Dr. Murphy, WMC Chair Elect |
| Kyle Karinen |
| Micah Matthews |
| Jimi Bush |

| High Reliability Workgroup |
|---|
| Dr. Chung, Chair |
| Dr. Domino |
| Christine Blake, PM |
| Dr. Jaeger |
| Scott Rodgers, PM |
| Dr. Chang |
| Ed Lopez, PA-C |
| Dr. Lyle |
| John Maldon, PM, Pro Tem |
| Kyle Karinen |
| Mike Farrell |
| Pam Kohlmeier, MD, JD, Staff Attorney |
| Jimi Bush |
| Amelia Boyd |

*Please note, any committee or workgroup that is doing any interested parties work or getting public input must hold open public meetings.*

PM = Public Member



Updated: January 12, 2024

| WMC Rules Progress Report | | | | | | Projected filing dates | | |
|---|---|---|---|---|---|---|---|---|
| **Rule** | **Status** | **Date** | **Next step** | **Complete By** | **Notes** | **CR-101** | **CR-102** | **CR-103** |
| Collaborative Drug Therapy Agreements | CR-101 filed | 7/22/2020 | Workshops | TBD | | Complete | TBD | TBD |
| General provision for opioid prescribing and tapering | CR-102 approved | 10/20/2023 | File CR-102, schedule hearing | February 2024 | Informed the other B/Cs | Complete | December 2023 | TBD |
| Standard rulemaking - WAC 246-919-330 | CR-102 approved | 10/20/2023 | File CR-102, schedule hearing | February 2024 | | Complete | December 2023 | TBD |
| HB 1009 Military Spouse | CR-101 filed | 9/12/2023 | Workshops | 2024 | | Complete | TBD | TBD |
| OBS - Use of Nitrous Oxide, WAC 246-919-601 | CR-101 approved | 10/20/2023 | File CR-101 | April 2024 | | April 2024 | TBD | TBD |
| ESSB 5380 - Define Qualified Physician | CR-101 approved | 10/20/2023 | File CR-101 | April 2024 | | April 2024 | TBD | TBD |

Updated: 1/10/2024

# PREPROPOSAL STATEMENT OF INQUIRY

## CR-101 (October 2017)
## (Implements RCW 34.05.310)

Do **NOT** use for expedited rule making

**CODE REVISER USE ONLY**

OFFICE OF THE CODE REVISER
STATE OF WASHINGTON
FILED

DATE: July 22, 2020
TIME: 9:51 PM

WSR 20-16-008

**Agency:** Department of Health- Washington Medical Commission

**Subject of possible rule making:** Chapter 246-919 WAC, allopathic physicians and chapter 246-918 WAC, allopathic physician assistants. The Washington Medical Commission (commission) is considering creating new rule sections to regulate the use of collaborative drug therapy agreements (CDTA).

**Statutes authorizing the agency to adopt rules on this subject:** RCW 18.71.017, 18.71A.020 and 18.130.050

**Reasons why rules on this subject may be needed and what they might accomplish:** One aspect of the practice of medicine is working with pharmacists to deliver drug therapy to patients. This coordination can take many forms, but the commission's concern involves treating patients under a collaborative drug therapy agreement (CDTA). These arrangements occur pursuant to a written agreement entered into by an individual physician or physician assistant and an individual pharmacist.

The Pharmacy Quality Assurance Commission has adopted a rule that governs CDTAs from the pharmacy perspective, however there are no statutes or rules that govern a physician's responsibilities under a CDTA. A rule is needed to define the roles and responsibilities of the physician or physician assistant who enters into a CDTA, any defined limit to the number of pharmacists who may have a CDTA with any one physician or physician assistant, and how the physician or physician assistant and pharmacist can best collaborate under these agreements.

Regulating the use of CDTAs would place the commission in an active patient safety role. Rulemaking would provide clarity around this issue to help avoid potential discipline and increase patient safety. New sections being considered will potentially benefit the public's health by ensuring participating providers are informed and regulated by current national industry and best practice standards.

**Identify other federal and state agencies that regulate this subject and the process coordinating the rule with these agencies:** Pharmacy Quality Assurance Commission (PQAC) - the commission will collaborate with PQAC on this rulemaking effort.

**Process for developing new rule (check all that apply):**

- ☐ Negotiated rule making
- ☐ Pilot rule making
- ☐ Agency study
- ☒ Other (describe) Collaborative rulemaking

**Interested parties can participate in the decision to adopt the new rule and formulation of the proposed rule before publication by contacting:**

| | (If necessary) |
|---|---|
| Name: Amelia Boyd, Program Manager | Name: |
| Address: PO Box 47866, Olympia, WA 98504-7866 | Address: |
| Phone: (360) 236-2727 | Phone: |
| Fax: | Fax: |
| TTY: 711 | TTY: |
| Email: amelia.boyd@wmc.wa.gov | Email: |
| Web site: wmc.wa.gov | Web site: |

| | |
|---|---|
| Other: | Other: |
| Additional comments: To join the interested parties email list, please visit: https://public.govdelivery.com/accounts/WADOH/subscriber/new?topic_id=WADOH_153 | |
| **Date: July 22, 2020** | **Signature:** Signature on file |
| **Name:** Melanie de Leon | |
| **Title:** Executive Director | |

# Memo

WASHINGTON Medical Commission
Licensing. Accountability. Leadership.

TO: Medical Commission

FROM: Kyle Karinen, Executive Director

DATE: January 12, 2023

RE: CDTA rule-making

The Commission initiated formal rule-making in July 2020. A copy of the CR-101 is included in your materials for review.

In brief, a Collaborative Drug Therapy Agreement (CDTA) provides an avenue for pharmacists to provide legend drugs and controlled substances to patients under the authority of health care providers that have prescriptive authority. In response to several complaints as well as information provided by Pharmacy Quality Assurance Commission (PQAC) staff, the Commission started a work group to better understand the underlying landscape. The work group met several times and members also toured an acute care hospital to see how CDTAs were used in that setting. The work group also met with PQAC Commission members and its executive director.

With the benefit of this feedback, the Commission floated draft rule language that outlined the Commission's expectations for PAs and MDs that enter into these agreements. The draft rule was carefully drafted to focus solely on the expectations and requirements the Commission would have for physicians and physician assistants and expressly avoided any attempt to regulate the practice or conduct of pharmacists. Additionally, the draft language exempted CDTAs that were put in place for vaccine therapy as well as any CDTA that applied in acute care hospital settings. Subsequent feedback from PQAC questioned the need for any rule-making by the Commission and was uniformly negative toward the draft rule language.

During the time when the work group was active, the Commission received an Attorney General Opinion that it had requested. In that opinion, the Attorney General's Office reached the conclusions that under a CDTA: 1) it is permissible for a pharmacist to diagnosis a patient's condition if the CDTA allows it; and 2) there is not a statutory requirement that requires direct contact between a physician or physician assistant and a patient.

The combination of the feedback received from PQAC and then the pandemic lead to a pause on moving the rule making along. During the pandemic a number of provisions that regulate the practice of pharmacy were suspended in an effort to make sure vaccines were readily available to any individual seeking them. In general, the additional flexibility that pharmacies were granted during the pandemic was seen as positive.

**Recommendation**

This rule-making has been authorized for over three years and given changes in underlying circumstances, I ask the Commission to consider withdrawing the CR-101. We have not had a complaint, let alone investigation, on this issue in several years. Additionally, the experience of the pandemic has

undoubtedly refined the approach pharmacists and pharmacies take when entering into CDTAs. If further complaints are made with regard to CDTAs that involve physicians or physician assistants, the Commission still has available remedies to address instances of unprofessional conduct by licensees that it regulates.

2023 - 2025

# WMC Strategic Plan 2023-2025

Washington Medical Commission

WASHINGTON Medical Commission

Licensing. Accountability. Leadership.

2023 - 2025

# CONTENT



Washington Medical Commission

2023 - 2025

Washington Medical Commission

# Message from WMC Leadership

**Karen Domino, MD, MPH**
WMC Chair

**Kyle Karinen, J.D., LL.M**
WMC Executive Director

The Washington Medical Commission (WMC) is responsible for ensuring that physicians and physician assistants in Washington state provide quality healthcare to the public. The WMC does this by setting standards for licensure, practice, and continuing competency. On behalf of the WMC and the MD/PA profession(s), we are excited to share the 2023-2025 WMC Strategic Plan.

The WMC's focus in the 23-25 plan on creating enduring partnerships is key to our success. By working together with other stakeholders, the WMC can develop and implement effective strategies to promote patient safety. We are particularly focused on the WMC's commitment to creating a more efficient organization and building better communication channels. These are essential steps for our organization to be successful in the 21st century.

In the 2023-2025 strategic plan, we are committed to:

- Reducing licensing timelines and improving customer satisfaction during the licensing process.
- Enhancing the WMC's ability to identify and address emerging trends in healthcare.
- Promoting diversity, equity, and inclusion in the WMC procedures and enforcement process.

This plan not only showcases the bright future that lies ahead for the WMC but also demonstrates our commitment to protect the public and the integrity of the MD and PA professions.

The 2023-2025 strategic plan is ambitious and challenging, but we believe that the WMC is well-positioned to achieve its goals and continue to provide high-quality healthcare to the people of Washington.

2023 - 2025

# Vision and Mission

## Core Values

### Thoughtful

We are mindful of our impact on our stakeholders, customers, colleagues and consider their unique needs.

### Positive

We recognize that mistakes are human and approach all situations with kindness, respect and a readiness to achieve common goals.

### Transparent

We proactively communicate, set achievable timeframes and carry out operations openly.

### Innovative

We embrace change and use dynamic problem solving to find better ways to approach our work.

## Mission

Promoting patient safety and enhancing the integrity of the profession through licensing, discipline, rule making, and education.

## Vision

Advancing the optimal level of medical care for the people of Washington State.

Washington Medical Commission

2023 - 2025

# Strategic Priorities

As Commissioners and Staff of the Washington Medical Commission we are creating a strategic plan that works toward:

- Using Data to Guide Decision Making and Establish Priorities.
- Working in Partnership to Reduce and Eliminate Waste.
- Integrate diversity and inclusion principles in WMC culture, systems, and policies.
- Letting Go of Old Paradigms and Embracing New Methodology.

# Strategic Goals

## Licensing
Protect Washingtonians by enforcing requirements for licensure and efficiently issue licenses to individuals meeting Washington requirements.

## Enforcement
Protect the health and safety of the public by effectively investigating complaints, enforcing the Uniform Disciplinary Act, and helping licensees improve their practice through education and training.

## Administration
Protect the health, safety, and privacy of stakeholders by facilitating and supporting the work of WMC staff and commissioners in the modernization of regulations, policies, procedures, and legislation.

## Outreach
Provide education and resources for the public, licensees, and partners to increase awareness about the Commission and laws governing the safe practice of medicine in Washington.

## Commission
Uphold organizational success through proper governance, effective leadership, and responsible management.

Washinton Medical Commission

2023 - 2025

# Licensing

Protect Washingtonians by enforcing requirements for licensure and efficiently issue licenses to individuals meeting Washington requirements.

## Priority One

Complete the intake step for all applications within seven days.

## Priority Two

Create a video tutorial for the completion of each license type.

## Priority Three

Provide a status update to the applicant within 15 days of Panel L meeting.

Washington Medical Commission

2023 - 2025

Washington Medical Commission

# Enforcement

Protect the health and safety of the public by effectively investigating complaints, enforcing the Uniform Disciplinary Act, and helping licensees improve their practice through education and training.

1. Develop a program pairing investigative and legal staff with a new commissioner to support one another's WMC work.
2. Explore opportunities for respondents to provide feedback regarding the Practitioner Support Program (PSP).
3. Evaluate additional opportunities for mandatory self-reporting found in WAC 246-16 to determine if statutory changes/updates need to be made.
4. Evaluate and consider updates to the "Processing Complaints Against Medical Students, Residents and Fellows" Procedure.
5. Create a video tutorial for best practices for filing a complaint.
6. Create an informational video explaining the discipline process.
7. Create a best practices tutorial for filing a reconsideration request.

2023 - 2025

Washington Medical Commission

# Administration

Protect the health, safety, and privacy of stakeholders by facilitating and supporting the work of WMC staff and commissioners in the modernization of regulations, policies, procedures, and legislation.

1. Develop a long-term strategy to increase our Equity, Diversity and Social Justice efforts.

2. Create a formal procedure for licensees to solicit resources and advice about systems concerns and general practice.

3. Partner with the Foundation for Health Care Quality to create a comprehensive patient safety plan.

4. Dedicate WMC resources to creating and disseminating original research.

5. Collaborate with the other WA boards and commissions to analyze the Uniform Disciplinary Act (UDA) RCW 18.130 and determine what changes and updates are necessary at the statutory level and what can be achieved via rulemaking.

6. Create a patient liaison position to work with WMC complainants to address individual health literacy, misunderstanding about what to expect from a provider and what to expect from the WMC.

7. Conduct a feasibility study of the Public Records Act (PRA).

8. Evaluate and consider updates to the case review process to improve effectiveness and consistency with public protection.

9. Collaborate with the Department of Health (DOH) to analyze and discuss updates to the Performance Measures found in WAC 246-14.

10. Research the feasibility of integrating an AI customer service tool into the WMC website.

2023 - 2025


# Outreach

Provide education and resources for the public, licensees, and partners to increase awareness about the Commission and laws governing the safe practice of medicine in Washington.

1. Relaunch a WMC Education Series.

2. Relaunch the WMC website to meet the modern needs of our stakeholders.

3. Collaborate with and expand communication and education to community organizations supporting vulnerable populations.

4. Launch a multi-prong, modern communications strategy.

2023 - 2025

# Commission

Uphold organizational success through proper governance, effective leadership, and responsible management.

## Priority One

Each commissioner should identify one new stakeholder group for the WMC to meet with to discuss how the WMC can support their members.

## Priority Two

Each commissioner should interact with a stakeholder group, in their official capacity, before the end of FY25.

## Priority Three

Increase WMC visibility and recruitment by attending in person meetings and community events.

Washington Medical Commission

# Strategic Plan 2023 - 2025

2023 - 2025

Commission

WASHINGTON Medical

Licensing. Accountability. Leadership.

Washington Medical Commission

## THANK YOU

@WAMedCommission

@WAMedCommission

@WAMedCommission

wmc.wa.gov

medical.commission@wmc.wa.gov

AMENDATORY SECTION (Amending WSR 17-15-024, filed 7/7/17, effective 8/7/17)

**WAC 246-834-010 Definitions.** The following definitions apply throughout this chapter unless the context clearly indicates otherwise:

(1) "Active practice" means ((~~twenty~~)) 20 hours per month in prenatal and postpartum clinical care, or minimum of six births annually as the primary midwife;

(2) "Administer" means to dispense, apply, and manage drugs, medical devices, and implants;

(3) "Department" means the Washington state department of health;

((~~(3)~~)) (4) "Directly assisted" means the act where a student midwife is learning the skills of a midwife through hands-on clinical experience in gradually increasing degrees of responsibility while under supervision of a licensed midwife or other obstetric provider;

((~~(4)~~)) (5) "Lactation care and services" means evaluation, problem identification, treatment, education, and consultation regarding lactation and ((~~breastfeeding~~)) chest feeding to ((~~mothers~~)) gestational parents and neonates;

((~~(5)~~)) (6) "Nursing education" means completion of courses for credit in a school that is approved to train persons for licensure as registered nurses or licensed practical nurses, or courses in other formal training programs which include instruction in basic nursing skills, excluding nursing assistant training;

((~~(6)~~)) (7) "Postpartum" means the 12-month period beginning on the last day of the pregnancy.

(8) "Practical midwifery experience" means performance of tasks within the midwifery scope of practice, that is verified by affidavit, testimony or other sworn written documentation that verifies that the experience and its documentation is equivalent to that required of students enrolled in an accepted midwifery education program;

((~~(7)~~)) (9) "Preceptor" means a licensed midwife or other obstetric practitioner licensed by their state or jurisdiction to provide maternity care who assumes responsibility for supervising the practical (clinical obstetric) experience of a student midwife;

((~~(8)~~)) (10) "Primary attendant" means a student midwife who acts as primary midwife making intrapartum clinical decisions while under supervision of a licensed midwife or other obstetric provider;

((~~(9)~~)) (11) "Secretary" means the secretary of the Washington state department of health;

((~~(10)~~)) (12) "Supervision" means the observation and evaluation of a student midwife's practical performance. A supervisor must be physically present on-site and available to intervene when a student midwife performs any clinical care task at births and prenatal and postpartum care exams.

[Statutory Authority: RCW 18.50.010, 18.50.040, 18.50.050, 18.50.135, and 2014 c 187. WSR 17-15-024, § 246-834-010, filed 7/7/17, effective 8/7/17. Statutory Authority: RCW 18.50.135 and 18.50.045. WSR 92-02-018 (Order 224), § 246-834-010, filed 12/23/91, effective 1/23/92. Statutory Authority: RCW 43.70.040. WSR 91-02-049 (Order 121), recodified as § 246-834-010, filed 12/27/90, effective 1/31/91. Statutory Authority: RCW 18.50.135. WSR 85-23-044 (Order PL 566), § 308-115-050, filed 11/18/85; WSR 82-19-079 (Order PL 406), § 308-115-050, filed 9/21/82.]

AMENDATORY SECTION (Amending WSR 17-15-024, filed 7/7/17, effective 8/7/17)

**WAC 246-834-062 Initial or reinstating application for individuals who have not been in the active practice of midwifery.** This section applies to applicants for an initial license as a

licensed midwife, or reinstatement of a midwifery license, who have not been in the active practice of midwifery prior to initial or reinstatement license application.

(1) Any applicant who has not been engaged in the active practice of midwifery for more than three years but less than five years prior to the date of application shall, in addition to the requirements for licensure as specified in WAC 246-834-030 and 246-834-060 ((~~and 246-834-140~~)):

(a) Provide documentation of a minimum of ((~~ten~~)) 10 births while acting as a birth assistant under the supervision of a preceptor within the last ((~~twelve~~)) 12 months; and

(b) Provide documentation of completion of continuing education for the three years prior to application that meets the requirements of WAC 246-834-355.

(2) Any initial or reinstating applicant who has not been engaged in the active practice of midwifery for five or more years prior to the date of application shall, in addition to the requirements for licensure as specified in WAC 246-834-030 and 246-834-060 ((~~and 246-834-140~~)):

(a) Provide documentation of a minimum of ((~~fifteen~~)) 15 births while acting as a birth assistant under the supervision of a preceptor within the last ((~~twelve~~)) 12 months;

(b) Provide documentation of completion of continuing education for the three years prior that meets the requirements of WAC 246-834-355; and

(c) If applying for reinstatement, retake and pass the current Washington state midwifery licensure examination.

(3) This section does not apply to any applicant who has been enrolled in a recognized educational program under WAC ((~~246-834-135~~)) 246-834-020 or 246-834-065.

[Statutory Authority: RCW 18.50.010, 18.50.040, 18.50.050, 18.50.135, and 2014 c 187. WSR 17-15-024, § 246-834-062, filed 7/7/17, effective 8/7/17.]

AMENDATORY SECTION (Amending WSR 17-15-024, filed 7/7/17, effective 8/7/17)

**WAC 246-834-065 Application for examination—Foreign trained.**

An applicant for a midwife license who graduated from a foreign educational institution on midwifery outside of any U.S. jurisdiction

may sit for the licensing examination provided the applicant completes all requirements in this section:

(1) Complete application requirements for licensure in WAC 246-834-060;

(2) Provide proof of a certificate or diploma from a foreign institution on midwifery of equal requirements conferring the full right to practice midwifery in the country in which it was issued. The diploma must bear the seal of the institution from which the applicant graduated. If applicable, the candidates must, at ((~~her or his~~)) the individual's own expense, present with the application a certified translation of the foreign certificate or diploma ((~~made by and under the seal of the consulate of the country in which the certificate or diploma was issued~~));

(3) Submit proof of completing at least three years of midwifery training including the study of basic nursing that meets the requirements under WAC ((~~246-834-140~~)) 246-834-030(1);

(4) Submit proof of meeting minimum educational requirements under WAC ((~~246-834-140~~)) 246-834-030 (2)(a) and (b);

(5) Submit to the department documentation of attendance at ((~~one hundred~~)) 100 births that meets the requirements of WAC ((~~246-834-140~~)) 246-834-030 (3)(a);

(6) Submit to the department documentation of prenatal care examinations of ((~~fifty women~~)) 50 individuals and early postpartum care examinations of ((~~fifty women~~)) 50 individuals that meets the requirements of WAC ((~~246-834-140~~)) 246-834-030 (3)(b); and

(7) Demonstrate competency in the use and administration of legend drugs and devices described in RCW 18.50.115 and WAC 246-834-250. The applicant shall submit documentation of competency to the department on a department supplied form. A licensed health care professional who, within ((~~his or her~~)) the individual's scope of practice, is qualified in the use and administration of legend drugs and devices described in RCW 18.50.115 and WAC 246-834-250 must sign the form.

[Statutory Authority: RCW 18.50.010, 18.50.040, 18.50.050, 18.50.135, and 2014 c 187. WSR 17-15-024, § 246-834-065, filed 7/7/17, effective 8/7/17. Statutory Authority: RCW 43.70.280. WSR 98-05-060, § 246-834-065, filed 2/13/98, effective 3/16/98. Statutory Authority: RCW 43.70.040. WSR 91-02-049 (Order 121), recodified as § 246-834-065, filed 12/27/90, effective 1/31/91. Statutory Authority: RCW 18.50.135. WSR 89-16-037 (Order PM 856), § 308-115-065, filed 7/25/89, effective 8/25/89.]

AMENDATORY SECTION (Amending WSR 15-20-049, filed 9/30/15, effective 10/31/15)

**WAC 246-834-066 Certified professional midwife (CPM) licensure requirements.** An applicant who holds a current North American Registry of Midwives (NARM) certified professional midwife (CPM) certification may apply for a Washington state midwife license by completing all requirements in this section.

(1) To be eligible for a midwife license an applicant holding a CPM shall:

(a) Complete all application requirements for licensure in WAC 246-834-060.

(b) Ensure that proof of the CPM certification is sent to the department directly from NARM.

(c) Submit to the department documentation of attendance at ((~~one hundred~~)) 100 births of which:

(i) At least ((~~thirty~~)) 30 births where the applicant was the primary attendant under supervision of a qualified attendant;

(ii) At least ((~~twenty~~)) 20 births where the applicant directly assisted;

(iii) At least ((~~fifty~~)) 50 births that the applicant observed in addition to births counted in (c)(i) and (ii) of this subsection; and

(iv) Documentation for (c)(i) through (iii) of this subsection must include at least the date, client identifier, the applicant's role at each birth, and the signature or initials of the qualified attendant at the birth of either: A licensed midwife, a CPM preceptor, a certified nurse midwife, or a practitioner licensed by their state or jurisdiction to provide maternity care. The applicant shall submit to the department the name and contact information of each signatory, if available. The department may approve exceptions to the required documentation in this subsection.

(d) Submit to the department documentation of prenatal care examinations of ((~~fifty women~~)) 50 individuals and early postpartum care examinations of ((~~fifty women~~)) 50 individuals. The same ((~~women~~)) individuals need not be seen for both examinations. Documentation must include at least the date, client identifier, and the signature or initials of the qualified attendant at the care examination of either: A licensed midwife, a CPM preceptor, a certified nurse midwife, or a practitioner licensed by their state or jurisdiction to provide maternity care. The applicant must submit to the department the name and contact information of each signatory, if

available. The department may approve exceptions to the required documentation in this subsection.

(e) Demonstrate competency in the use and administration of legend drugs and devices described in RCW 18.50.115 and WAC 246-834-250. The applicant shall submit documentation of competency to the department on a department supplied form. A licensed health care professional who, within ((~~his or her~~)) the individual's scope of practice, is qualified to use and administer legend drugs and devices described in RCW 18.50.115 and WAC 246-834-250 must sign the form.

(f) Successfully complete courses on epidemiology and obstetric pharmacology from:

(i) An institution that is accredited by an agency recognized by the Council for Higher Education Accreditation (CHEA) and included in their database of institutions on programs accredited by recognized United States accrediting organizations;

(ii) An institution that is accredited by an agency recognized by the United States Department of Education (USDOE) and included in their database of accredited postsecondary institutions and programs; or

(iii) A curriculum or program approved by the department.

(2) Applicants applying under this section who have a current CPM but do not meet all of the requirements listed in subsection (1)(c) through (f) of this section may apply to the department for a trainee permit under WAC 246-834-068. The trainee permit authorizes the applicant to complete subsection (1)(c) through (e) of this section, under the supervision of a preceptor as described in WAC 246-834-067. [Statutory Authority: RCW 18.50.065, 18.50.135, and 18.50.040. WSR 15-20-049, § 246-834-066, filed 9/30/15, effective 10/31/15.]

AMENDATORY SECTION (Amending WSR 15-20-049, filed 9/30/15, effective 10/31/15)

**WAC 246-834-067 Preceptor for certified professional midwife (CPM) licensure program.** This section defines the role of a preceptor as used in WAC 246-834-066. A certified professional midwife (CPM) applicant for licensure as a midwife may use more than one preceptor to meet the requirements for licensure under WAC 246-834-066.

(1) A preceptor for clinical requirements including observed, managed, and assisted births, and prenatal and postpartum examinations must:

(a) Have a current Washington state license as a midwife under chapter 18.50 RCW, physician under chapter 18.71 RCW, osteopathic physician under chapter 18.57 RCW, or certified nurse midwife under chapter 18.79 RCW; and

(b) Have actively practiced obstetrics for at least three consecutive years or attended at least ((~~one hundred fifty~~)) 150 births.

(2) A preceptor for legend drugs and devices must have a current Washington state credential and be, within ((~~his or her~~)) the individual's scope of practice, qualified to use and administer legend drugs and devices described in RCW 18.50.115 and WAC 246-834-250. [Statutory Authority: RCW 18.50.065, 18.50.135, and 18.50.040. WSR 15-20-049, § 246-834-067, filed 9/30/15, effective 10/31/15.]

AMENDATORY SECTION (Amending WSR 17-15-024, filed 7/7/17, effective 8/7/17)

**WAC 246-834-080 Examination failures.** (1) An applicant who has failed the NARM examination or the Washington state licensing examination, or both, shall retake and pass the examination(s) which he or she failed.

(2) The applicant who fails the Washington state licensing examination may sit for the reexamination if ((~~he or she~~)) the individual:

(a) Applies to the department at least ((~~fourteen~~)) 14 days prior to the next scheduled examination; and

(b) Pays the required fee as specified in WAC 246-834-990.

(3) An applicant who fails the NARM or Washington licensing examination three consecutive times shall submit evidence to the secretary of completion of an individualized program of study approved by the department prior to retaking the examination.

[Statutory Authority: RCW 18.50.010, 18.50.040, 18.50.050, 18.50.135, and 2014 c 187. WSR 17-15-024, § 246-834-080, filed 7/7/17, effective 8/7/17. Statutory Authority: RCW 18.50.060. WSR 99-03-064, § 246-834-080, filed 1/18/99, effective 2/18/99. Statutory Authority: RCW 18.50.135 and 18.50.045. WSR 92-02-018 (Order 224), § 246-834-080, filed 12/23/91, effective 1/23/92. Statutory Authority: RCW 43.70.040. WSR 91-02-049 (Order 121), recodified as § 246-834-080, filed 12/27/90, effective 1/31/91. Statutory Authority: RCW 18.50.135. WSR 82-19-079 (Order PL 406), § 308-115-080, filed 9/21/82.]

AMENDATORY SECTION (Amending WSR 17-15-024, filed 7/7/17, effective 8/7/17)

**WAC 246-834-140 Eligibility for state licensing examination.** Candidates for the state licensing examination shall meet the following conditions, unless applying under WAC 246-834-066 Certified professional midwife (CPM) licensure requirements:

(1) Midwifery training shall be at least three academic years, and shall consist of both didactic and clinical instruction sufficient to meet the educational standards of the school and this section. However, the length of required training may be shortened, but not to less than two academic years, after consideration of the student's documented education and experience in the required subjects, if the applicant is a registered nurse or practical nurse licensed under chapter 18.79 RCW, or has had previous nursing education or practical midwifery experience.

(2) The applicant must receive instruction in the following educational areas:

(a) Midwifery, basic sciences (including biology, physiology, microbiology, anatomy with emphasis on female reproductive anatomy, genetics and embryology), normal and abnormal obstetrics and

gynecology, family planning techniques, childbirth education, nutrition both during pregnancy and lactation, ((~~breast~~)) chest feeding, neonatology, epidemiology, community care, and medicolegal aspects of midwifery; and

(b) Basic nursing skills and clinical skills including, but not limited to, vital signs, perineal prep, catheterization, aseptic techniques, administration of medications both orally and by injection, local infiltration for anesthesia, venipuncture, administration of intravenous fluids, infant and adult resuscitation, and charting.

(3) The applicant must undertake the care of not less than ((~~one hundred women~~)) 100 individuals in the intrapartum period. No less than ((~~fifteen~~)) 15 of the ((~~one hundred women~~)) 100 individuals must be cared for in the intrapartum period while the applicant was enrolled in the school from which the student graduates.

(a) The applicant shall submit to the department documentation of attendance at ((~~one hundred~~)) 100 births of which:

(i) At least ((~~thirty~~)) 30 births where the applicant was the primary attendant under supervision of a qualified attendant;

(ii) At least ((~~twenty~~)) 20 births where the applicant directly assisted;

(iii) At least ((~~fifty~~)) 50 births that the applicant observed in addition to births counted in (d)(i) and (ii) of this subsection; and

(iv) Documentation for (a)(i) through (iii) of this subsection must include at least the date, client identifier, the applicants role at each birth, and the signature or initials of the qualified attendant at the birth of either: A licensed midwife, a CPM preceptor, a certified nurse midwife, or a practitioner licensed by their state or jurisdiction to provide maternity care. The applicant shall submit to the department the name and contact information of each signatory, if available. The department may approve exceptions to the required documentation in this subsection.

(b) The applicant shall submit to the department documentation of prenatal care examinations of ((~~fifty women~~)) 50 individuals and early postpartum care examinations of ((~~fifty women~~)) 50 individuals. The same ((~~women~~)) individuals need not be seen for both examinations.

(i) No less than ((~~fifteen women~~)) 15 individuals must be cared for in the prenatal and postpartum periods while enrolled in the school from which the student graduates.

(ii) Documentation must include at least the date, client identifier, and the signature or initials of the qualified attendant at the care examination of either: A licensed midwife, a CPM

preceptor, a certified nurse midwife, or a practitioner licensed by their state or jurisdiction to provide maternity care. The applicant must submit to the department the name and contact information of each signatory, if available. The department may approve exceptions to the required documentation in this subsection.

(4) The applicant shall demonstrate competency in the use and administration of legend drugs and devices described in WAC 246-834-250. The applicant shall submit documentation of competency to the department on a department supplied form. A licensed health care professional who, within his or her scope of practice, is qualified in the use and administration of legend drugs and devices described in RCW 18.50.115 and WAC 246-834-250 must sign the form.

[Statutory Authority: RCW 18.50.010, 18.50.040, 18.50.050, 18.50.135, and 2014 c 187. WSR 17-15-024, § 246-834-140, filed 7/7/17, effective 8/7/17. Statutory Authority: RCW 18.50.135 and 18.50.045. WSR 92-02-018 (Order 224), § 246-834-140, filed 12/23/91, effective 1/23/92. Statutory Authority: RCW 43.70.040. WSR 91-02-049 (Order 121), recodified as § 246-834-140, filed 12/27/90, effective 1/31/91. Statutory Authority: RCW 18.50.135. WSR 87-21-011 (Order PM 686), § 308-115-140, filed 10/9/87; WSR 85-23-044 (Order PL 566), § 308-115-

140, filed 11/18/85; WSR 82-19-079 (Order PL 406), § 308-115-140, filed 9/21/82.]

AMENDATORY SECTION (Amending WSR 22-13-079, filed 6/10/22, effective 7/11/22)

**WAC 246-834-160 Student midwife permit.** (1) A student midwife permit may be issued to any individual who has:

(a) Successfully completed an accredited midwifery program as specified in WAC ((~~246-834-135~~)) 246-834-020, or is foreign trained as specified in WAC 246-834-065(1);

(b) Obtained a minimum period of midwifery training of at least three academic years as required by WAC ((~~246-834-140~~)) 246-834-030;

(c) Met the minimum education requirements required in WAC ((~~246-834-140~~)) 246-834-030 (2)(a) and (b);

(d) Documentation of undertaking the care of not less than 50 ((~~women~~)) individuals in each of the prenatal, intrapartum and early postpartum periods as required by RCW 18.50.040 (2)(c);

(e) Satisfactorily completed the NARM examination required by WAC 246-834-050; and

(f) Filed a completed application for student midwife permit under WAC 246-834-060 and accompanied by a nonrefundable fee as specified in WAC 246-834-990.

(2) The student midwife permit authorizes the ((~~individuals~~)) student to practice and observe ((~~women~~)) individuals in the intrapartum period under the supervision of a licensed midwife under 18.50 RCW, an allopathic physician under chapter 18.71 RCW, an osteopathic physician under chapter 18.57 RCW or certified nurse midwife under chapter 18.79 RCW.

(3) Once all application requirements including clinical components are completed the applicant may be eligible to sit for the Washington state licensure examination as required in WAC 246-834-050.

[Statutory Authority: RCW 18.50.135, 18.50.115, 18.50.060, and 2020 c 76. WSR 22-13-079, § 246-834-160, filed 6/10/22, effective 7/11/22. Statutory Authority: RCW 18.50.010, 18.50.040, 18.50.050, 18.50.135, and 2014 c 187. WSR 17-15-024, § 246-834-160, filed 7/7/17, effective 8/7/17. Statutory Authority: RCW 18.50.135 and 18.50.045. WSR 92-02-018 (Order 224), § 246-834-160, filed 12/23/91, effective 1/23/92. Statutory Authority: RCW 43.70.040. WSR 91-02-049 (Order 121), recodified as § 246-834-160, filed 12/27/90, effective 1/31/91.

Statutory Authority: RCW 18.50.135. WSR 82-19-079 (Order PL 406), § 308-115-160, filed 9/21/82.]

NEW SECTION

**WAC 246-834-165 Application requirements for a licensed midwife seeking a limited prescriptive license extension, a license extension for medical devices, or a license extension for implants.** (1) A licensed midwife seeking a limited prescriptive license extension shall:

(a) Submit evidence of completion of 15 additional obstetrical pharmacology didactic training hours. The additional hours must include the prescription classifications listed in WAC 246-834-250(4) and provide skills and knowledge beyond entry-level skills or knowledge in antibiotics and contraceptives; and

(b) Submit evidence of completion of additional training on family planning and treating common, low risk prenatal and postpartum conditions. Such training must be either:

(i) A clinical experience of at least 20 cases reviewed in consultation with a licensed health care professional who, within their scope of practice, is qualified to use and administer legend

drugs and devices described in RCW 18.50.115 and WAC 246-834-250. The licensed health care professional must attest to the applicant's knowledge and skills by signing a form provided by the department; or

(ii) A clinical training course or courses approved by the department.

(2) A licensed midwife seeking the license extension for medical devices or the license extension for implants shall:

(a) Submit completion of the requirements in subsection (1) of this section;

(b) Submit evidence of completion of training as required by the medical device manufacturers, or an equivalent. The training must include at least three simulated medical device insertions under direct supervision;

(c) Submit evidence of completion of training as required by the implant device manufacturers, or an equivalent. The training must include at least three simulated removals under direct supervision; and

(d) Submit evidence of completion of additional training on medical devices or implants, or both that includes:

(i) A clinical experience of four inserted medical devices and one medical device removal under direct supervision;

(ii) A clinical experience of one inserted implant and three implant removals under direct supervision;

(e) The clinical experience in (d) of this subsection must be supervised by a licensed health care professional who, within their scope of practice, is qualified to administer medical devices and implants and has at least two years of experience. The health care professional must attest to the applicant's knowledge and skills by signing a form provided by the department.

(f) A licensed midwife may pursue all three license extensions. The training on prescriptive, medical devices, and implants in subsections (1) and (2) must be completed within five years from the date of application.

(3) The license extensions referenced in this section do not apply to newborn care.

[]

AMENDATORY SECTION (Amending WSR 22-13-079, filed 6/10/22, effective 7/11/22)

**WAC 246-834-250 Legend drugs and devices.** A licensed midwife shall have a procedure, policy or guideline for the use of each legend

drug and device. A midwife may not administer or prescribe a legend drug or use a legend device for which they are not qualified by education, training, and experience.

(1) A licensed midwife may purchase and use legend drugs and devices as follows:

(a) Dopplers, syringes, needles, phlebotomy equipment, sutures, urinary catheters, intravenous equipment, amnihooks, airway suction devices, electronic fetal monitors, jada system, tocodynamometer monitors, oxygen and associated equipment, glucose monitoring systems and testing strips, neonatal pulse oximetry equipment, hearing screening equipment, centrifuges, and nasopharyngeal or nasal swabs for appropriate testing;

(b) Nitrous oxide as an analgesic, self-administered inhalant in a 50 percent blend with oxygen, and associated equipment, including a scavenging system;

(c) Ultrasound machine used in the real time ultrasound of pregnant uterus for the confirmation of viability, first trimester dating, third trimester presentation, placental location, and amniotic fluid assessment; and

(d) Neonatal and adult resuscitation equipment and medication, including airway devices and epinephrine for neonates.

(2) Pharmacies may issue ((~~breast~~)) the following as ordered by a licensed midwife: Lactation pumps, compression stockings and belts, maternity belts, diaphragms and cervical caps, glucometers and testing strips, iron supplements, prenatal vitamins, and recommended vaccines as specified in subsection (3)(e) through (j) of this section ((~~ordered by licensed midwives~~)).

(3) In addition to prophylactic ophthalmic medication, postpartum oxytocic, vitamin K, Rho (D) immune globulin, and local anesthetic medications as listed in RCW 18.50.115, licensed midwives may obtain and administer the following medications:

(a) Intravenous fluids limited to Lactated Ringers, ((~~5%~~)) five percent Dextrose with Lactated Ringers, and 0.9% sodium chloride;

(b) Sterile water for intradermal injections for pain relief;

(c) Magnesium sulfate for prevention or treatment of ((~~maternal~~)) peripartum seizures pending transport;

(d) Epinephrine for use in ((~~maternal~~)) peripartum anaphylaxis and resuscitation and neonatal resuscitation, pending transport;

(e) Measles, Mumps, and Rubella (MMR) vaccine to nonimmune postpartum ((~~women~~)) individuals;

(f) Tetanus, diphtheria, acellular pertussis (Tdap) vaccine for use in pregnancy;

(g) Hepatitis B (HBV) birth dose for any newborn administration;

(h) HBIG and HBV for any neonates born to a hepatitis ((~~B+ mothers~~)) B positive gestational parent;

(i) Influenza vaccine ((~~for use in pregnancy~~));

(j) Any vaccines recommended by the Centers for Disease Control and Prevention (CDC) advisory committee on immunization practices for ((~~pregnant or postpartum people or~~)) infants in the first two weeks after birth((~~, as it existed on the effective date of this section~~)) or pregnant or postpartum people;

(k) Terbutaline to temporarily decrease contractions pending emergent ((~~intrapartal~~)) intrapartum transport;

(l) Antibiotics for intrapartum prophylaxis of Group B ((~~beta hemolytic~~)) Streptococcus (GBS) per current CDC guidelines; ((~~and~~))

(m) Antihemorrhagic drugs to ((~~control~~)) treat postpartum hemorrhage including, but not limited to, intravenous tranexamic acid, oxytocins, misoprostol, methylergonovine maleate (oral or intramuscular), and prostaglandin F2 alpha; and

(n) Nifedipine for indication of preterm labor pending transport.

(4) A licensed midwife with a limited prescriptive license extension may prescribe, obtain, and administer the items in subsections (1) through (3) of this section, and the following

medications and therapies for the prevention and treatment of outpatient conditions that do not constitute a significant deviation from normal per RCW 18.50.010 during pregnancy or postpartum based on current evidence and practice:

(a) Antibiotics;

(b) Antiemetics;

(c) Antivirals;

(d) Antifungals;

(e) Low-potency topical steroids;

(f) Antipruritic medications and therapies;

(g) Other medications and therapies including, but not limited to:

(i) Galactagogues;

(ii) Topical analgesia for anal, vulvar, and perineal pain;

(iii) Preterm labor preventatives;

(iv) Stool softeners;

(v) Vitamins and minerals for preventing and treating deficiencies;

(vi) Over-the-counter medications as needed;

(vii) Nonopioid medication for therapeutic rest;

(viii) Medications for ~~SAB~~ miscarriage prevention and completion;

(ix) Smoking cessation;

(x) Prescription referrals for IV iron infusions; and

(h) Hormonal and nonhormonal family planning methods.

(5) Pursuant to RCW 18.50.010, a licensed midwife with a license extension that includes medical devices or implants, or both may prescribe, obtain, and administer hormonal and nonhormonal family planning method devices including, but not limited to, copper or other nonhormonal intrauterine devices (IUD), IUDs with levonorgestrel or other progestin, implants or as consistent with current evidence and practice so long as they have a license extension to perform the task.

(6) The client's records must contain documentation of all medications and devices prescribed, ordered, and administered.

[Statutory Authority: RCW 18.50.135, 18.50.115, 18.50.060, and 2020 c 76. WSR 22-13-079, § 246-834-250, filed 6/10/22, effective 7/11/22. Statutory Authority: RCW 18.50.135 and 18.50.115. WSR 19-15-005, § 246-834-250, filed 7/5/19, effective 8/5/19. Statutory Authority: RCW 18.50.115. WSR 05-06-118, § 246-834-250, filed 3/2/05, effective 4/2/05. Statutory Authority: RCW 43.70.040. WSR 91-02-049 (Order 121), recodified as § 246-834-250, filed 12/27/90, effective 1/31/91. Statutory Authority: RCW 18.50.040(3) and 18.50.115. WSR 88-12-040 (Order PM 732), § 308-115-250, filed 5/27/88.]

AMENDATORY SECTION (Amending WSR 17-15-024, filed 7/7/17, effective 8/7/17)

**WAC 246-834-255 Elements of care for the newborn.** The customary scope of care of a newborn up to two weeks of age by a licensed midwife includes, but is not limited to, clinical assessment, treatment, education, support and referral as described in this section. Newborn care shall not go beyond the scope of the midwife's education, training and experience.

(1) Immediate newborn care includes, but is not limited to:

(a) Appearance, pulse, grimace, activity and respiration (APGAR) assessment;

(b) Stabilization and monitoring of the newborn for a minimum of two hours postpartum;

(c) Early initiation and facilitation of ((~~breast or bottle~~)) infant feeding;

(d) Complete physical examination;

(e) Education for parents regarding care and monitoring of the normal newborn; and

(f) Physician consultation, referral and/or transfer of care in the event of significant deviations from normal.

(2) Other support may include:

(a) Neonatal resuscitation; and

(b) Legend drugs and devices allowed in RCW 18.50.115 and WAC 246-834-250.

(3) Subsequent care may include, but is not limited to:

(a) Evaluating the newborn for well-being such as jaundice, weight loss, and adequate feeding and elimination patterns;

(b) Newborn metabolic screening per RCW 70.83.020;

(c) Critical congenital heart disease screening per RCW 70.83.090;

(d) Lactation care and services; and

(e) Consultation ((~~and/or~~)) and possible referral to pediatric care for any significant deviation from normal.

[Statutory Authority: RCW 18.50.010, 18.50.040, 18.50.050, 18.50.135, and 2014 c 187. WSR 17-15-024, § 246-834-255, filed 7/7/17, effective 8/7/17.]

AMENDATORY SECTION (Amending WSR 15-24-092, filed 11/30/15, effective 12/31/15)

**WAC 246-834-345 License renewal.** A licensed midwife must renew their license every year on ((~~his or her~~)) the individual's birthday. To renew a license, a licensed midwife shall comply with the requirements in:

(1) RCW 18.50.102 License renewal;

(2) RCW 18.50.108 Written plan for consultation, emergency transfer, and transport;

(3) WAC 246-12-030 How to renew a credential;

(4) WAC 246-834-355 Continuing education;

(5) WAC 246-834-360 Quality improvement program;

(6) WAC 246-834-370 Data submission; and

(7) WAC 246-834-990 Midwifery fees and renewal cycle.

[Statutory Authority: RCW 18.50.102 and 18.50.135. WSR 15-24-092, § 246-834-345, filed 11/30/15, effective 12/31/15.]

AMENDATORY SECTION (Amending WSR 15-24-092, filed 11/30/15, effective 12/31/15)

**WAC 246-834-355 Continuing education.** (1) A licensed midwife shall complete ((~~thirty~~)) 30 hours of continuing education (CE) every three years and must comply with ((~~chapter 246-12 WAC, Part 7~~)) WAC

246-12-170 through 246-12-240. CE course work must contribute to the professional knowledge and development of the licensed midwife.

(a) A minimum of ((~~twenty-five~~)) 25 hours must be directly related to the clinical practice of midwifery. A licensed midwife who has a license extension shall complete a minimum of three hours of CE relevant to the license extension or extensions they hold as part of the 25-hour requirement.

(b) In addition to the 25 hours of clinical practice CE in (a) of this subsection, a licensed midwife shall complete two hours of health equity CE every four years per chapter 43.70 RCW and in compliance with WAC 246-12-800 through 246-12-830.

(c) Any remaining hours may be in professional development activities that enhance the practice of the licensed midwife.

(2) A licensed midwife shall obtain CE hours through one or more of the categories listed below. Documentation for all activities must include licensee's name, date of activity, and number of hours. Additional specific documentation is defined below:

(a) Acceptable CE course work. A minimum of ((~~ten~~)) 10 hours is required per reporting period in acceptable CE course work. For the purposes of this section, acceptable CE course work means courses offered or authorized by industry recognized local, state, private,

national and international organizations, agencies or institutions of higher learning. The department will not authorize or approve specific CE courses. The required documentation for this category is a certificate or documentation of attendance.

(b) Course work or classes offered by an accredited college or university. The course work must provide skills and knowledge beyond entry-level skills. The required documentation for this category is a transcript or documentation of attendance. A maximum of ((~~ten~~)) 10 hours is allowed per reporting period for this category.

(c) Research, writing, or teaching. The required documentation for this category is a two-page synopsis for each activity written by the licensee. A maximum of ((~~fifteen~~)) 15 hours is allowed per reporting period for this category.

(d) Documented self-study or life experience. The required documentation for this category is a two-page synopsis of each activity written by the licensee. A maximum of five hours is allowed per reporting period for this category.

(e) Serving on a professional board, committee, disciplinary panel, or association. The required documentation for this category is a letter or other documentation from the organization. A maximum of five hours is allowed per reporting period for this category.

(f) Professional manuscript review. The required documentation for this category is a letter from the publishing organization verifying review of the manuscript. A maximum of ((~~ten~~)) 10 hours is allowed per reporting period for this category.

(g) Professional conference or workshop. The required documentation for this category is a certificate or documentation of attendance. A maximum of ((~~ten~~)) 10 hours is allowed per reporting period for this category.

(3) Continuing education credit will not be given for the following:

(a) A cardiopulmonary resuscitation course;

(b) A neonatal resuscitation course; or

(c) Participation in data submission on perinatal outcomes.

(4) ((~~Verification of~~)) The department may verify completion of continuing competency hours ((~~will begin on January 1, 2019~~)).

[Statutory Authority: RCW 18.50.102 and 18.50.135. WSR 15-24-092, § 246-834-355, filed 11/30/15, effective 12/31/15.]

AMENDATORY SECTION (Amending WSR 15-24-092, filed 11/30/15, effective 12/31/15)

**WAC 246-834-360 Quality improvement program.** (1) As a condition of renewing a license, a licensed midwife shall:

(a) Participate in a Washington state coordinated quality improvement program peer review process that complies with the requirements in RCW 43.70.510.

(b) Attest every two years that the midwife has completed peer review for a minimum of five of the midwife's clinical cases over the course of those two years.

(2) A midwife may be excused from or granted an extension of participation in a peer review process due to illness or other extenuating circumstances. The department, upon request, will determine if the requirements may be waived or if an extension may be granted.

(3) For auditing purposes, written confirmation of participation in a peer review process from the approved coordinated quality improvement program shall suffice. The midwife must keep ((~~her/his~~)) their participation records; records must not be sent to the department.

(4) Verification of completion of participation in a peer review process will begin on January 1, 2018.

[Statutory Authority: RCW 18.50.102 and 18.50.135. WSR 15-24-092, § 246-834-360, filed 11/30/15, effective 12/31/15.]

AMENDATORY SECTION (Amending WSR 22-13-079, filed 6/10/22, effective 7/11/22)

**WAC 246-834-370 Data submission.** (1) As a condition of renewing a license, a licensed midwife shall report data on all courses of care for every ((~~mother~~)) gestational parent and newborn under the midwife's care to a national or state research organization approved by the department. If the ((~~mother~~)) gestational parent declines to participate in the collection of data, the midwife shall follow the protocol of the approved national or state research organization.

(2) The licensed midwife shall verify compliance by submitting an attestation to the department annually with the license renewal. For good cause, the secretary may waive reporting requirements.

(3) For auditing purposes, written confirmation of full participation in data collection from the approved state or national research organization shall suffice.

(4) The midwife must keep ((~~her/his~~)) their data and participation records; data and participation records will not be submitted directly to the department.

[Statutory Authority: RCW 18.50.135, 18.50.115, 18.50.060, and 2020 c 76. WSR 22-13-079, § 246-834-370, filed 6/10/22, effective 7/11/22. Statutory Authority: RCW 18.50.102 and 18.50.135. WSR 15-24-092, § 246-834-370, filed 11/30/15, effective 12/31/15.]

AMENDATORY SECTION (Amending WSR 19-15-005, filed 7/5/19, effective 8/5/19)

**WAC 246-834-400 Expired license.** A midwife licensed under this chapter may reinstate an expired license or license extension.

(1) If a midwife's license ((~~under this chapter~~)) has been expired for less than three years, ((~~to reinstate the license~~)) the practitioner shall meet the requirements of ((~~chapter 246-12 WAC, Part 2~~)) WAC 246-12-040.

(2) If a midwife's license ((~~under this chapter~~)) has expired and the practitioner has been engaged in the active practice of midwifery in another United States jurisdiction or territory, or other location

approved by the department, ((~~to reinstate the license~~)) the practitioner shall:

(a) Submit verification of active practice; and

(b) Meet the requirements of ((~~chapter 246-12 WAC, Part 2~~)) WAC 246-12-040.

(3) If a midwife's license ((~~under this chapter~~)) has been expired for three years or more but less than five years at time of application, and the practitioner has not been actively engaged in midwifery, the practitioner shall:

(a) Work as a birth assistant under the supervision of a department-approved preceptor for a minimum of ((~~ten~~)) 10 births; and

(b) Meet the requirements of ((~~chapter 246-12 WAC, Part 2~~)) WAC 246-12-040.

(4) If a midwife's license ((~~under this chapter~~)) has been expired for more than five years at time of application, and the practitioner has not been actively engaged in midwifery, the practitioner shall:

(a) Work as a birth assistant under the supervision of a department-approved preceptor for a minimum of ((~~fifteen~~)) 15 births;

(b) Retake and successfully pass the Washington state licensing examination; and

(c) Meet the requirements of ((~~chapter 246-12 WAC, Part 2~~)) WAC 246-12-040.

(5) A proposed preceptor shall:

(a) Hold an active license without restriction, current discipline, or conditions as a midwife under chapter 18.50 RCW, a certified nurse midwife under chapter 18.79 RCW, an allopathic physician under chapter 18.71 RCW, or an osteopathic physician under chapter 18.57 RCW;

(b) Have actively practiced at least three consecutive years or attended at least ((~~one hundred fifty~~)) 150 births; and

(c) Have demonstrated ability and skill to provide safe, quality care.

(6) If a midwife's license extension has expired and the practitioner has been engaged in the active practice of midwifery prescriptive or medical devices and implant practice in another United States jurisdiction or territory, or other location approved by the department, the practitioner shall:

(a) Submit verification of active practice of prescriptive, devices, or implant practices; and

(b) Meet the requirements of WAC 246-12-040.

(7) A licensed midwife with an expired license extension for less than five years at the time of reactivation and has not been actively practicing in midwifery prescriptive, medical devices, and implants practice, the individual may submit their records for their initial training as required in WAC 246-834-165 and meet the requirements in WAC 246-12-040.

(8) A licensed midwife with an expired license extension for five years or more at the time of reactivation, and has not been actively engaged in midwifery prescriptive or medical devices and implant practice, the practitioner shall retake the required training in WAC 246-834-165.

[Statutory Authority: RCW 18.50.135 and 18.50.115. WSR 19-15-005, § 246-834-400, filed 7/5/19, effective 8/5/19. Statutory Authority: RCW 18.50.010, 18.50.040, 18.50.050, 18.50.135, and 2014 c 187. WSR 17-15-024, § 246-834-400, filed 7/7/17, effective 8/7/17. Statutory Authority: RCW 43.70.280. WSR 98-05-060, § 246-834-400, filed 2/13/98, effective 3/16/98.]

AMENDATORY SECTION (Amending WSR 19-15-005, filed 7/5/19, effective 8/5/19)

**WAC 246-834-450 Inactive license.** (1) A licensed midwife may obtain an inactive license by meeting the requirements of ((~~chapter 246-12 WAC, Part 4~~)) WAC 246-12-090.

(2) An inactive license must be renewed every year on the midwife's birthday according to WAC 246-12-100 and by paying the fee required under WAC 246-834-990.

(3) A midwife with an inactive license may return to active status.

(a) A midwife with an inactive license for three years or less who wishes to return to active status must meet the requirements of ((~~chapter 246-12 WAC, Part 4~~)) WAC 246-12-110.

(b) A midwife with an inactive license for more than three years, who has been in active practice in another United States jurisdiction or territory or other location approved by the department and wishes to return to active status ((~~must~~)) shall:

(i) Submit verification of active practice; and

(ii) Meet the requirements of ((~~chapter 246-12 WAC, Part 4~~)) WAC 246-12-110.

(c) A midwife with an inactive license for more than three years but less than five, who has not been in active practice and wishes to return to active status must:

(i) Work as a birth assistant under the supervision of a department-approved preceptor for a minimum of ((~~ten~~)) 10 births; and

(ii) Meet the requirements of ((~~chapter 246-12 WAC, Part 4~~)) WAC 246-12-110.

(d) A midwife with an inactive license for more than five years who has not been in active practice and wishes to return to active status ((~~must~~)) shall:

(i) Work as a birth assistant under the supervision of a department-approved preceptor for a minimum of ((~~fifteen~~)) 15 births;

(ii) Retake and successfully pass the Washington state licensing examination; and

(iii) Meet the requirements of ((~~chapter 246-12 WAC, Part 4~~)) WAC 246-12-110.

(4) A proposed preceptor shall:

(a) Hold an active license without restriction, current discipline, or conditions as a midwife under chapter 18.50 RCW, a certified nurse midwife under chapter 18.79 RCW, an allopathic physician under chapter 18.71 RCW, or an osteopathic physician under chapter 18.57 RCW;

(b) Have actively practiced at least three consecutive years or attended at least ((~~one hundred fifty~~)) 150 births; and

(c) Have demonstrated ability and skill to provide safe, quality care.

(5) A licensed midwife with an inactive license extension who has been engaged in the active practice of midwifery prescriptive or medical devices and implant practice in another United States jurisdiction or territory, or other location approved by the department, and wishes to return to active practice shall:

(a) Submit verification of active practice of prescriptive, devices, or implant practices; and

(b) Meet the requirements of WAC 246-12-110.

(6) A licensed midwife with an inactive license extension for less than five years at the time of reactivation, and has not been actively practicing in midwifery prescriptive, medical devices, and implants practice, the individual may submit their records for their initial training as required in WAC 246-834-165 and meet the requirements in WAC 246-12-040.

(7) A licensed midwife with an inactive license extension for five years or more at the time of reactivation, and who has not been actively engaged in midwifery prescriptive or medical devices and implant practice, shall retake the required training in WAC 246-834-165.

[Statutory Authority: RCW 18.50.135 and 18.50.115. WSR 19-15-005, § 246-834-450, filed 7/5/19, effective 8/5/19. Statutory Authority: RCW 18.50.010, 18.50.040, 18.50.050, 18.50.135, and 2014 c 187. WSR 17-15-024, § 246-834-450, filed 7/7/17, effective 8/7/17.]

NEW SECTION

The following sections of the Washington Administrative Code are decodified and recodified as follows:

| Old WAC Number | New WAC Number |
|---|---|
| 246-834-080 | 246-834-055 |
| 246-834-135 | 246-834-020 |
| 246-834-140 | 246-834-030 |

Washington State Medical Association
Physician Driven, Patient Focused

December 6, 2023

Amelia Boyd
Program Manager
Washington Medical Commission

Nariman Heshmati, MD, MBA, FACOG
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Katina Rue, DO, FAAFP, FACOFP
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Bridget Bush, MD, FASA
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Matt Hollon, MD, MPH, MACP
*Secretary-Treasurer*

Jennifer Hanscom
*Chief Executive Officer*

Dear Amelia,

On behalf of the Washington State Medical Association (WSMA), we wanted to share information specific to the midwives' legend drugs and devices item on the December 8 interested parties policy meeting agenda. WSMA began work on this issue when it was under sunrise review by the Department of Health (Department), as well as when SSB 5765 was in front of the legislature. Throughout the subsequent rulemaking, WSMA has worked with relevant stakeholders to improve patient safety, remove inconsistencies, and maintain legislative intent.

For the commission's reference, I've included WSMA's and the Washington Chapter of the American College of Obstetrics and Gynecologists' (WA-ACOG) most recent correspondence with the Midwifery Advisory Committee (MAC) recommending edits to a draft of the rule we received on September 13. We would direct the commission's attention to the section specific to nifedipine which is included in the updated draft of WAC-246-834-250:

*We are also deeply concerned about the inclusion of nifedipine in WAC 246-834-250. Nifedipine is used to treat preterm labor or hypertension – both of which are outside of the "…the prevention and treatment of common prenatal and postpartum conditions" this rulemaking is specific to. If the prescription of nifedipine delays referral to a physician, potential complications may include significant hypotension, pre-eclampsia, organ damage, or failure to get steroids necessary for fetal lung maturity. It is critical to both the patient and the fetus that this provision be removed from the draft. When a patient presents with preterm labor or hypertension, immediate patient referral is the appropriate and responsible next step.*

The recommendation to remove this specific drug comes directly from WSMA and WA-ACOG member physicians. We request the WMC to share this and any other concerns with the MAC.

With regards to the training on medical devices and implants in WAC 246-834-165, DOH staff has shared that the concerns outlined in our September 13 letter have been at least partially resolved. This area of draft WAC has improved immensely since initial iterations were shared in the late Spring.

Thank you for the opportunity to share our concerns specific to this rulemaking. Should you have any follow-up questions, please contact WSMA Associate Policy Director Billie Dickinson.

Sincerely,

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*Billie Dickinson*

Billie Dickinson
Associate Policy Director
Washington State Medical Association

Washington State Medical Association
Physician Driven, Patient Focused

October 4, 2023

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Kathy Weed
Program Manager
Department of Health

RE: Midwives limited prescriptive authority rulemaking

Dear Ms. Weed,

On behalf of the Washington State Medical Association (WSMA) and the Washington Chapter of the American College of Obstetrics and Gynecologists (WA-ACOG), thank you for the opportunity to provide comment on the rulemaking implementing SSB 5765 regarding limited prescriptive authority for licensed midwives. Both WSMA and WA-ACOG are grateful for our continued partnership with licensed midwives and their contributions to the care team. We also appreciate the Midwifery Advisory Committee (MAC) considering our recommendations on the previous draft of this WAC. While the draft received on September 13 is much improved, additional changes will improve patient safety, remove inconsistencies, and maintain legislative intent.

As written, draft WAC 246-834-165 is inconsistent with regards to the manufacturer's training – requiring it for implants, but not for medical devices. The training provided by the manufacturer is critical to understanding the nuances of any medical device or implant, as well as its successful insertion and/or removal. The draft WAC also requires simulated medical device insertions to be done under direct supervision, but no such requirement exists for simulated implant removals. Expert opinion agrees that the removal of an implant is the most technical procedure contemplated in this draft – supervision, guidance, and feedback is imperative to ensuring patient comfort and safety. As such, we recommend the following changes to draft WAC 246-834-165:

*(1) Licensed midwives seeking an additional license extension that includes medical devices or implants, or both shall:*
- *(a) Submit completion of the requirements in subsection (1) above;*
- *(b) Submit evidence of completion of training as required by the medical device manufacturers, or an equivalent. The training must include at least three simulated medical device insertions under direct supervision;*
- *(c) Submit evidence of completion of training as required by the implant device manufacturers, or an equivalent. The training must include at least 3 simulated removals under direct supervision; and*

We are also deeply concerned about the inclusion of nifedipine in WAC 246-834-250. Nifedipine is used to treat preterm labor or hypertension – both of which are outside of the "…the prevention and treatment of common prenatal and postpartum conditions" this rulemaking is specific to. If the prescription of nifedipine delays referral to a physician, potential complications may include significant hypotension,

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pre-eclampsia, organ damage, or failure to get steroids necessary for fetal lung maturity. It is critical to both the patient and the fetus that this provision be removed from the draft. When a patient presents with preterm labor or hypertension, immediate patient referral is the appropriate and responsible next step.

Our organizations have appreciated the opportunity to provide comment on this rulemaking throughout the process. We look forward to offering our support for this rulemaking once the issues noted above have been resolved. Should you have any follow-up questions, please contact WSMA Associate Policy Director Billie Dickinson.

Sincerely,

Washington State Medical Association
Washington Chapter of the American College of Obstetrics and Gynecologists

# Guidance Document

WASHINGTON Medical Commission
Licensing. Accountability. Leadership.

# Medical Records: Documentation, Access, Retention, Storage, Disposal, and Closing a Practice

*Observe, record, tabulate, communicate.*
-Sir William Osler (1849-1919)

## Introduction

The Washington Medical Commission provides this guidance document to physicians and physician assistants (practitioners) on the appropriate documentation of a medical record; special considerations for maintaining an electronic health record; providing access to medical records; the retention, storage and disposal of medical records; and handling records when closing a practice. The Commission recognizes that in some practice settings, practitioners may not have control over the records and may not be able to fully implement the recommendations made below. The Commission appreciates the variety of medical practices and urges practitioners to exercise reasonable judgment which may vary by specialty in the application of the guidance document. An appendix contains a history of the medical record, illustrative examples of complaints regarding medical records made to the Commission, and additional information on the implementation of electronic health records.

## Guidance

### I. Documentation

#### A. Purpose of the Medical Record

As part of delivering high-quality, safe, and integrated medical care, it is critically important that each practitioner maintains accurate, clinically useful, timely, and consistent medical records. A practitioner should maintain a medical record for each patient for whom he or she provides care. Notes, either handwritten, typed or dictated, must be legible. Dictation must be transcribed, reviewed, and signed within a reasonable time. The practitioner must ensure that the transcription of notes is accurate, particularly when using dictation or voice-recognition software.

The medical record is a chronological document that:

1. Records pertinent facts about an individual's health and wellness;
2. Enables the treating care provider to plan and evaluate treatments or interventions, making clear the rationale for diagnoses, plans and interventions;
3. Enhances communication between professionals, assuring the patient optimum continuity of care;

4. Assists both patient and practitioner in communication with third party participants;
5. Facilitates the practitioner's development of an ongoing quality assurance program;
6. Provides a legal document for verification and/or audit of the delivery of care; and
7. Is available as a source of clinical data for research and education.

### B. The Essential Elements of a Medical Record

The practitioner should include the following elements in all medical records:

1. The purpose of each patient encounter and appropriate information about the patient's history and examination, the patient's perspective and preferences, plan for any treatment, and the care and treatment provided;
2. The patient's pertinent medical history including serious accidents, operations, significant illnesses, and other appropriate information;
3. Prominent notation of medication and other significant allergies, or a statement of their absence;
4. Known or suspected reactions including allergy warnings;
5. Clearly documented informed consent obtained from the patient or from a person authorized to consent on behalf of the patient. In some emergency situations, the reason for a lack of informed consent should be clearly documented; and
6. The date of each entry, and the time as appropriate.

### C. Additional Elements of a Medical Record

The following additional elements reflect commonly accepted standards for medical record documentation:

1. Each page in the medical record contains the patient's name or ID number.
2. Personal biographical information such as home address, employer, marital status, emergency contact information and all telephone numbers, including home, work, and mobile phone numbers.
3. Each entry in the medical record contains the author's identification. Author identification may be a handwritten signature, initials, or a unique electronic identifier.
4. All drug therapies are listed, including dosage instructions and, when appropriate, indication of refill limits. Prescription refills should be recorded.
5. Encounter notes should include appropriate arrangements and specified times for follow-up care.
6. All consultation, laboratory, and imaging reports should be entered into the patient's record, reviewed, and the review documented by the practitioner who ordered them. Abnormal reports should be noted in the record, along with corresponding follow-up plans and actions taken.
7. An appropriate immunization record is kept up to date by the primary care provider and, ideally, readily accessible by all clinicians caring for the patient, as technology permits.
8. Documentation of appropriate preventive screening and services being offered in accordance with accepted practice guidelines, as relevant to the visit and/or the specific provider's role in caring for the patient.
9. Documentation of other persons present during the encounter.

Where possible, the practitioner should avoid judgmental language in the medical record. The practitioner should consider that patients increasingly have access to and will read their own medical record. The practitioner should also be aware that a patient has a statutory right to submit a concise statement describing a correction or amendment for inclusion in the medical record. RCW 70.02.110. For a history of the medical record, see Appendix, Part I.

### D. Special Considerations When Using an Electronic Health Record

An electronic health record (EHR), a digital version of the traditional paper-based medical record, documents health care that took place within a practitioner's office, single health care facility or health care system as well as all other communications (records of phone calls, emails, etc.) between the health care team and the patient. [1] The ideal EHR is designed to contain and share information among all involved providers, patients, and their designated caretakers.

The EHR offers a number of potential benefits over the paper medical record. However, as with any innovation, there are challenges and potential hazards in its meaningful use. The Commission recognizes several problematic documentation practices while using an EHR that in some instances interfere with delivery of high-quality, safe, and integrated medical care; impede medico-legal or regulatory investigation; or are fraudulent.

1. Recommendations for Practitioners

The following recommendations, which are not necessarily exhaustive, are intended to inform practitioners of the appropriate use of an EHR, and to indicate how the Commission will evaluate a medical record, including records that are the product of an electronic system.

The patient record in an EHR should reflect the same or improved content and functionality as that produced in traditional formats, and will be held to essentially the same standard.

a. A practitioner using an EHR must ensure:

   i. authorized use and compliance with state and federal privacy and security legal requirements, law, and with institutional privacy and security policies;
   ii. a timely, accurate, succinct, and readable entry;
   iii. consistency and accuracy between various aspects of a record; and
   iv. assumption of ultimate responsibility for trainees' and scribes' documentation.

b. Retention or re-entry of inaccurate, inconsistent, or outdated information in the EHR from historic entries should be avoided. Original information needs to be retrievable from a separate location in the EHR via a secure and permanent audit trail.

c. A practitioner's actions and decision-making should be accurately reflected in the documentation. The record will include a description of any shared decision-making process, when appropriate.[1]

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[1] EHRs have the potential to support shared decision-making. Studies show that EHRs that have incorporated shared decision-making tools result in improved clinical outcomes. *The Promise of Electronic Health Records to Promote Shared Decision Making: A Narrative Review and a Look Ahead*, Medical Decision Making, Vol. 38(8) 1040-1045 (2018). For more information on shared decision making, see the Washington State Health Care Authority web site on shared decision making, and the Bree Collaborative web site describing its work on this topic.

d. Documenting aspects of a practitioner-patient interaction that did not transpire, such as indicating that components of a physical examination were performed when they were not, even when it occurs inadvertently because of EHR design or function, may be considered fraud. Similarly, when documentation about a significant aspect of the practitioner-patient interaction is not present, the assumption is that it did not occur.

e. It is important to distinguish those portions of the history that were obtained by the note writer from those that were copied or carried forward from another practitioner's note. [2] The practitioner must recognize that "carry forward" or "cut-and-paste" functions, even when done automatically by the EHR software, represent significant risks to patient safety. Concerns about "clinical plagiarism" or fraudulent billing may arise when appropriate and accurate attribution of copy-paste or carry-forward information is missing from an EHR note. Practitioners should carefully review and edit any EHR-generated note to assure its accuracy prior to authenticating it.

f. Laboratory and imaging data should only be brought into the practitioner's note when pertinent to the decision making process for the patient. Wholesale importation of laboratory data and imaging data that is already documented elsewhere in the chart is to be avoided as such practice can make interpretation of medical records by subsequent caregivers extremely difficult.

g. The practitioner should assure that problem lists and medication lists are kept current, and that they are not cluttered with outdated information.

Examples of complaints received by the Commission relating to EHRs can be found in Appendix, Part II.

2. Suggestions for EHR Software Developers and Healthcare Institutions

The fruitful evolution of the EHR will require collaboration between entities that develop and purchase EHR systems and practitioners who use the EHR. The primary goal of the EHR is to promote high-quality, safe, and integrated health care. Other roles, such as documentation to support coding and billing, are secondary. It is unfortunate that, in general, these roles seem reversed in current EHR systems. With this in mind, the Commission offers suggestions about potential EHR improvements for software developers and health care institutions, and believes that practitioners should be involved in collaborative efforts with those entities to improve the EHR.

a. Practitioners and clinical information specialists have an important role to play in development, decision-making, evaluation and improvement of EHR systems.

b. EHR systems should result in a patient record that is organized, concise, and easily-readable. Lengthy and redundant information in the EHR, a source of common practitioner complaint, makes it difficult for other practitioners to identify data within the EHR that is relevant to actual patient care.[3]

c. EHR systems should also include tools to support the clinician to use best practices when available as well as shared decision-making.

d. An ultimate goal of the EHR universe should be widely compatible systems allowing seamless transfer and sharing of electronic medical information within and among practitioners, medical offices and clinics, hospitals and other health care institutions, as well as patients and their caregivers.

e. It is essential to have capacity within EHR systems to correct errors as soon as they come to light, and thereby prevent their perpetuation. The original documentation must be retrievable in the EHR via secure and permanent audit trail.

f. As patients increasingly have access to their EHR, they will undoubtedly find information within the medical record that is erroneous or with which they disagree. There should be a mechanism in place within healthcare institutions to respond to patients' questions and concerns that arise from review of their EHR, and to allow patients to submit a correction or amendment for inclusion in the medical records. RCW 70.02.110.

g. Software supporting EHR clinical documentation should be designed and constructed for the type of provider who will use it (e.g., specialty, training) and the context in which it will be employed (e.g., admitting, consulting, ambulatory). It should automatically attribute information to each author.[4]

h. The medical record serves many audiences who need to be considered in the design and implementation of EHR systems. To meet their potential, EHRs should incorporate comprehensive decision support that:

   i. leads to improved patient outcomes;
   ii. ensures safe transitions of patients from one practitioner, facility, or office to another;
   iii. allows easy tracking and reporting of patient care metrics and outcomes; and
   iv. promotes patient-centered communication between patients and the health care system.[3]

i. Health care institutions should consider having mechanisms in place to monitor documentation quality and practitioner satisfaction with the EHR, and to identify changes to support improved usability, validation, integrity, and quality of data within the EHR.[4]

j. The EHR should be designed for maximum portability and interoperability of information to benefit the patient and the public health. Full integration into the Washington State Health Information Exchange provides benefit to the patient requiring treatment when away from their medical home and provides meaningful data to assess population health. Technology vendors should design their systems with these functions as standards and institutions should mandate these functionalities as standard requirements for their implemented systems.

k. The EHR should support rapid, minimally complicated integration with the state's prescription monitoring program to facilitate inquiry in those systems.

For additional information on the implementation of an EHR, see the Appendix, Part III.

## II. Access to Medical Records

A practitioner's practices relating to medical records under his or her control should be designed to benefit the health and welfare of patients, whether current or past, and should facilitate the transfer of clear and reliable information about a patient's care. The Commission recognizes that electronic health records systems may not be compatible, making it challenging to send records to a practitioner in another electronic health record system. Practitioners should do the best they can to get medical records to patients and subsequent providers in a usable format.

A. Per RCW 70.02.080, a practitioner is legally obligated to make medical records available to a patient to examine or copy within 15 days of the request. A practitioner may deny the request under circumstances specified in RCW 70.02.090.

B. Except for patients appealing the denial of social security benefits, the practitioner may charge a reasonable fee for making records available to a patient, another provider, or a third party and is not required to honor the request until the fee is paid. RCW 70.02.030(2). What constitutes a reasonable fee is defined in WAC 246-08-400. The practitioner cannot, however, withhold the records because an account is overdue or a bill is owed.

C. To prevent misunderstandings, the practitioner's policies about providing copies or summaries of medical records and about completing forms should comply with appropriate laws and should be made available in writing to patients when the practitioner-patient relationship begins.

~~C.~~D. A patient has a statutory right to submit a concise statement describing a correction or amendment for inclusion in the medical record. RCW 70.02.110.

~~D.~~E. The failure to provide medical records to patients in violation of RCW 70.02 can result in disciplinary action by the Commission.

## III. Retention of Medical Records

A. There is no general law in Washington requiring a practitioner to retain a patient's medical record for a specific period of time.[2] The Commission appreciates the variety of medical practices and urges practitioners to exercise reasonable judgment which may vary by specialty for the retention of medical records. When appropriate, the Commission concurs with the Washington State Medical Association recommendation that practitioners should retain medical records and x-rays for at least:
   1. ten years from the date of a patient's last visit, prescription refill, telephone contact, test or other patient contact;
   2. 21 years from the date of a minor patient's birth;
   3. six years from the date of a patient's death; or
   4. indefinitely, if the practitioner has reason to believe:
      a. the patient is incompetent;
      b. there are any problems with a patient's care, or
      c. the patient may be involved in litigation.

B. A practitioner should consider whether it is feasible to retain patients' medical records indefinitely.

C. A practitioner should verify the retention time required by their medical malpractice insurer.

D. A practitioner should inform patients how long the practitioner will retain medical records.

## IV. Storage of Records

A. A practitioner is responsible for safeguarding and protecting the medical record, whether in electronic or paper format, and for providing adequate security measures.

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[2] RCW 70.02.160 requires a health care provider to maintain a record of existing health care information for at least one year following receipt of an authorization to disclose that health care information and during the pendency of a patient's request either to examine or copy the record or to correct or amend the record. For hospital medical record retention requirements, see RCW 70.41.190.

B. A practitioner may contract with a third party to act as custodian of the medical records. The responsible person, corporation, or legal entity acting as custodian of the records must comply with federal and or state confidentiality laws and regulations.

## V. Disposing of Records

A. When retention is no longer required, records should be destroyed by secure means. The Privacy Rule in the Health Insurance Portability and Accountability Act (HIPAA) prohibits digital and paper records containing confidential information from being thrown away in a public dumpster or recycling bin until they have been rendered unreadable or indecipherable by shredding, burning or other destruction.

B. A practitioner should give patients an opportunity to claim records or have them sent to another provider before records are destroyed. For some practitioners, the nature of their specialty will make notifying patients impractical.

## VI. Handling Medical Records When Closing a Medical Practice

A. The obligation to make medical records available to patients and other providers continues even after a practitioner closes a medical practice.

B. The recommendations in this section do not apply to:

1. A practitioner who leaves a multi-practitioner practice. In that instance, the remaining practitioners in the practice typically assume care of the patients and retain the medical records.
2. A specialist or other practitioner who does not have ongoing relationships with patients. These practitioners typically provide patient records to the referring practitioner, the patient's primary care provider, or directly to the patient.

C. Prior to closing a practice, a practitioner should notify active patients and patients seen within the previous three years.

D. The notice should be given at least 30 days in advance, with 90 days being the best practice.

E. The notice should be given by:

1. individual letter to the last known patient address;
2. electronically, if this is a normal method of clinical communication with the patient; or
3. placing a notice on the practitioner's web site, if the practitioner has a web site.

F. The notice should include:

1. the name, telephone number and mailing address of the responsible entity or agent to contact to obtain records or request transfer of records;
2. how the records can be obtained or transferred;
3. the format of the records, whether hard copy or electronic;
4. how long the records will be maintained before they are destroyed; and
5. the cost of recovering records or transferring records as defined in Chapter 70.02 RCW.

G. The practitioner is encouraged to provide notice to the local medical society, whether the practitioner is a member or not.

H. If the practitioner practices as part of an institution, the institution may provide the notice of the closing of the practice.

I. If the practice closes due to the practitioner's death, the practitioner's estate becomes the owner of the medical records and is encouraged to provide this notification to patients.

J. Disciplinary action by the Commission, including suspension, surrender or revocation of the practitioner's license, does not diminish or eliminate the obligation to provide medical records to patients.

*There is no more difficult art to acquire than the art of observation, and for some it is quite as difficult to record an observation in brief and plain language.*

-Sir William Osler (1849-1919)

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|---|---|
| Number: | GUI2020-01 |
| Date of Adoption: | January 17, 2020 |
| Reaffirmed: | N/A |
| Supersedes: | Retention of Medical Records GUI2017-02; and Physician and Physician Assistants' Use of the Electronic Medical Record MD2015-09 |

# Appendix

## I. History of the Medical Record

The medical record, as an entity documenting an encounter between a patient and a practitioner, is a relatively new concept. Prior to the turn of the 20th century, patient case reports were written retrospectively, primarily for the purpose of teaching [5], with less emphasis on continuity of care. In the early 1900's, real-time documentation describing patient history and treatment was an emerging format, but patient care data were scattered and disorganized. A first step towards improving the quality and utility of medical documentation occurred in 1907 when assigning a unique number to each patient and consolidating all data for that patient into a single record was introduced. [5]

As medical education and the medical profession progressed following the Flexner Report in 1910 [2], it became necessary to document a patient's history for continuity of care and to accommodate growing involvement of medical and surgical specialists. In 1918, the American College of Surgery initiated a requirement that hospitals maintain records on all patients so that their content could be used for quality improvement. [5]

Throughout the 20th century, standards for formatting of the medical record continued to evolve. The Problem Oriented Medical Record (POMR) was introduced by Dr. Lawrence Weed in 1968. [5] The initial intent of the POMR was as an educational tool to help trainees organize their decision-making and treatment plan around each of a patient's separate medical problems. [6] [7] However, the POMR gained widespread acceptance among practitioners at all levels as did the SOAP (Subjective-Objective-Assessment-Plan) note format, which was derived from the POMR. [8] Additionally, within health care institutions and specialties, standards have emerged for documenting various types of encounters between practitioners and patients (e.g., History and Physical, Operative Note, Ambulatory New and Return Patient Notes, Interim and Discharge Summaries).

Requirements for clinical documentation were dramatically altered by release of the Evaluation and Management (E&M) guidelines by the Centers for Medicare & Medicaid Services (CMS) in 1995 and 1997. [8] Intended as a measure of cognitive (as opposed to procedural) services, the E&M guidelines specified the format and necessary components to be included in the medical record to support specific CPT codes for billing. The complexity of these requirements led many practitioners to rely on medical record templates, which were designed to promote compliance with E&M guidelines.

Until the late 20th century, the medical record was largely recorded on paper, either written longhand, or dictated and then subsequently transcribed. In part driven by approximately $30 billion of federal incentive payments over the last five years, the rate of EHR adoption has since risen quickly, [9] such that practitioners and health care institutions not currently using EHR are now outliers. The EHR has specific goals (Table 1) and serves the needs of a variety of audiences (Table 2).

**Table 1: Goals of the Medical Record[3] (as informed largely by Shoolin, et al [4])**

- Tell the patient's unique story as it relates to the patient's concerns ("the patient voice")
- Demonstrate diagnostic thinking and decision-making process undertaken by the practitioner.
- Provide clinical information to allow covering or consulting colleagues to maintain care and make informed decisions regarding further care
- Support coordinated longitudinal plans of care and care transitions within and across organizations
- Provide a clear and easily understood summary of the encounter, including findings and recommendations, to the patient or the patient's designated representative
- Provide clinical information to drive accurate Clinical Decision Support
- Support and identify the quality of care provided to patients
- Satisfy reasonable documentation requirements from payers
- Create the legal business record of the patient care facility
- Support population data collection and research
- Create the legal record of a patient's medical and surgical care
- Meet legal, accreditation, and regulatory criteria

[3] These goals are similar to the intentions of "Meaningful Use." For additional background, refer to: http://www.healthit.gov/providers-professionals/meaningful-use-definition-objectives

**Table 2: Medical Record Audiences**

| |
|---|
| ➢ Patients and their designated representatives.[4] |
| ➢ Fellow practitioners |
| ➢ Other members of the health care team |
| ➢ Researchers |
| ➢ Public health systems |
| ➢ Payers |
| ➢ Legal counsel |
| ➢ Courts, juries and medical review/regulatory bodies |

## II. Examples of Complaints Received by the Commission Relating to EHRs

After reviewing many complaints about EHRs, the Commission is concerned about problematic features of EHR implementation and use and offers the following examples of EHR-related problems, which are based on cases reviewed by the Commission:

- A patient complains a practitioner documented a complete physical examination in the EHR when only a focused examination of a patient's rash had been performed.
- Under the physical examination section of a patient's EHR, "tympanic membranes within normal limits" is explicitly stated, but in the assessment, the patient is described as having a "right acute otitis media."
- An error in a CT report about a mass in the right kidney is subsequently corrected to indicate that the mass is in the left kidney. The original diagnosis of right kidney mass is carried forward in the EHR problem list, leading to a wrong-site surgery.
- A primary care practitioner forgets to include a patient's bleeding disorder in the EHR problem list following his first appointment with the patient. The incomplete problem list is carried forward without review or update for inclusion in numerous other documents. During major surgery two months later, the patient suffers a massive hemorrhage. The surgeon was unaware the patient had a bleeding disorder.
- A practitioner complains that her colleague copies and pastes the assessment portion of patients' EHR, including detailed medical decision-making, from other practitioners' notes and then bills at a higher level than his actual work would support.
- A patient files a medical malpractice claim after delay in diagnosis of a brain tumor. The practitioner says that she performed a complete neurologic examination, which was normal, but the EHR documentation for the neurologic portion of the examination only states "Patellar reflexes 2+ bilaterally."

[4] With implementation and expansion of the EHR and EHR, patients either already have or soon will have greater access to their own health information.

- A judge in a medical malpractice case found the EHR inadmissible because it contained so much redundant and irrelevant information.

## III. Current EHR Implementation

**Potential benefits and advantages of the EHR.** There are potential benefits of the EHR, particularly as compared to paper medical records. Certain capabilities of the EHR may present both the potential for improving and for interfering with optimal documentation and patient care, which reinforces the importance of thoughtful and careful EHR planning, implementation, and use.

- Legibility: Handwritten notes could be illegible.
- Potentially greater efficiency for practitioners who, under increasing time pressures and facing large volumes of data, need ways to streamline their record keeping.
- Reviewing and documenting in the EHR can be done remotely.
- Within an EHR, there is the capability to transfer important information about a patient from one note to another, reducing the need to rewrite information that has not changed.
- EHR templates save time by displaying information in a standard format and relieving the practitioner of reestablishing a format each time a similar note is needed.
- More efficient computer entry, "real-time," i.e., during a patient encounter, could save time and reduce the need to recall details about the patient visit at a later time, potentially leading to greater accuracy.
- Better system efficiency including data retrieval, remote access, and transfer of information. Electronic access eliminates the cost and time needed to request and locate the hard chart. It also diminishes the chance of lost records, physical space required to store charts, and the need for personnel to assemble, store, and retrieve paper records.
- EHR systems allow multiple providers to simultaneously enter data during a patient encounter. This saves time tracking down and waiting to document in the hard chart.
- The EHR is more readily searched than the hard chart, which often existed in multiple volumes. The EHR is typically indexed by type of record, author, and date.
- EHRs integrate different types of information that at one time were maintained in separate paper files in the inpatient setting (e.g., practitioner orders, nurses and other ancillary staff documentation, prescription and medication administration records, allergies, vital signs, laboratory and radiographic studies, problem lists, and demographic information), into a single system and allow such information to be imported into electronic clinical notes.
- Real-time reminders and alerts can be incorporated into an EHR system including:
    - reminders about health care maintenance (e.g., immunization timing),
    - education (e.g., link to evidence-based guidelines), and
    - error checks (e.g., alerts about allergies or potential drug interaction or incorrect medication dosing).
- Improved regulatory and security monitoring the EHR includes "meta-data" (such as date and time stamps) and audit trail information that didn't exist in the legal paper record.

- Ease of quality improvement and research studies electronic data are more readily accessible for quality improvement, public health, and research studies.

**Potential challenges with current EHR implementation**. The EHR theoretically promises to improve efficiency and communication, reduce errors, and improve quality of care. Yet, every advance brings with it the potential for new problems, and the EHR is no exception. There are serious negative implications to poorly designed EHR systems, suboptimal EHR implementation, or careless EHR use by practitioners. A poor quality medical record, which could be inaccurate, inconsistent, incomplete, or obscure important information among unneeded or redundant detail, may adversely impact current or future care, transfers of care, and/or medico-legal investigations. Problematic aspects of current EHRs include:

- **Increased work load:** Data entry into the EHR can be time-consuming, particularly for practitioners who do not type well.[5]
- **Copy-paste:** Electronically carrying forward or copying portions of previously written notes and pasting them into a currently drafted note is problematic when it is either:
  - Copying the work of others without attribution ("clinical plagiarism") or without independent confirmation.[6]
  - Introducing unnecessary redundancy (see next point—"note-bloat.").
- **"Note-bloat":** Note bloat refers to unnecessary and redundant expansion of a note's length and complexity. With electronic documentation, it is easy to incorporate large volumes of data into clinical documentation. Inappropriate copy-paste, carry-forward, and computer-aided data entry (auto-filling) increases the risk of lengthy but information-poor notes. Such redundant content detracts from readability, makes it more difficult to interpret and identify pertinent content, and jeopardizes the communication for which clinical notes are intended.
- **"Boilerplate":** Despite the appeal of using templates, "boilerplate" text may add unnecessary detail that detracts from more important information. Furthermore, busy practitioners may carelessly retain parts of a normal review of systems or examination from the template rather than correctly indicating abnormal reports or findings from their interaction with the patient, resulting in inconsistent and erroneous information within the medical record.
- **Differences between the electronic version and paper copy of the EHR:** The printed copy of the EHR may look very different from the electronic version. Specifically, the paper copy of the EHR may differ from the electronic version either by including auto-populated redundant or extraneous information or excluding data that could not be readily printed. Currently, however, when copies of records are requested for patient care, investigative, or discovery purposes; they are typically provided as paper copies, often at a considerable cost to the requesting party, which may be difficult to read or incompletely reflect patient care.

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[5] Some practitioners rely on scribes or speech recognition software. Ultimately, the practitioner is responsible for ensuring that the medical record is accurate.

[6] The US Department of Health and Human Services and the Office of the Attorney General have expressed concern for fraud resulting from liberal copying-pasting within the EHR and subsequent upcoding, citing "possible abuses including 'cloning' of medical records, where information about one patient is repeated in other records, to inflate reimbursement In 2012, the Obama administration warned against such practice: "There are troubling indications that some providers are using this technology to game the system, possibly to obtain payments to which they are not entitled. False documentation of care is not just bad patient care; it is fraud." (Abelson and Creswell, 2012)

- **"Pseudo-history" and "pseudo-examination"*:*** Some EHRs convert checked symptom boxes into sentences and paragraphs that are then imported into the EHR such that they appear to recount the verbatim report of the patient. However, the generated history is not derived from the patient's actual words; it only represents binary (YES/NO) data processed into standardized phrases. A similar process with checkbox-to-sentence physical examination findings is available. Such technology potentially undermines consideration of each patient as an individual and conceals the nuances of his/her unique history and needs.
- **Errors in the EHR can be perpetuated and difficult to correct:** Some of these errors have serious undesirable implications for subsequent care and patients' health. Providers and patients complain that when an error occurs in the EHR, it can be very difficult to correct. These errors in documentation can be perpetuated over time and may lead to actual medical errors and adverse patient outcomes.
- **Interference with provider-patient relationship:** Real-time EHR entry during a patient visit may interfere with face-to-face contact with the patient, which may reduce active listening, conceal important diagnostic clues, and damage patient-practitioner rapport.
- **Overemphasis on documentation to meet billing specifications:** This issue largely dates back to E&M regulatory efforts, initiated when paper medical records still predominated. However, EHR systems have also incorporated E&M elements into their electronic templates leading to concern that documentation whose major design objective is to support coding and billing may subvert the true goal of the EHR, which is to promote high-quality, safe, and integrated health care.

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Mike Farrell
Manager of Policy Committee
Washington Medical Commission

Jan. 2, 2024

Dear Mr. Farrell and the Policy Committee,

Washington Advocates for Patient Safety would like to take this opportunity to comment on the proposed update to the commission's policy on medical records.

Throughout our patient experiences of seeking medical care, many of us have encountered inaccuracies in our medical records. Some of these errors were minor, but some were serious enough to affect our care. When requesting corrections or amendment to correct records, many of us have also experienced difficulties and frustration, due to the fact that not all providers fully understood or followed the state and federal laws governing patients' right to correct or amend their medical records.

As patients and families, we understand that it is imperative to have accurate medical records for patients to receive safe and high-quality care. It is also critically important for patients to be able to amend their medical records in case of inaccuracy. Therefore, we strongly support the added language under section "***Access to Medical Records***" to explicitly spell out the patient's right to submit a correction or amendment for inclusion in the medical record. Meanwhile, we would like to suggest the following minor changes in the proposed policy update.

1. On page 6 of 8, **item D** under "***Access to Medical Records***", we suggest that the federal HIPAA Privacy Rule 45 CFR § 164.526 be added, in additional of listing the state law, RCW 70.02.110. This HIPAA law protects patients' civil right, allowing them to request an amendment to their health information. If the request is denied, the provider must provide a written denial, stating

the basis of the denial, indicating the patient's rights to review the denial, and preparing a written rebuttal that will be provided to the individual who submitted the record amendments.

2. On page 6 of 8, **item E** under "***Access to Medical Records***", we suggest that a wording be added, so that the failure to comply with the HIPAA Rule 45 CFR § 164.526 can also result in disciplinary action by the Commission.

3. Similarly, on page 5 of 8, **item f** under "***D. Special Considerations When Using an Electronic Health Record***" and "***2. Suggestions for EHR Software Developers and Healthcare Institutions***", we suggest that the HIPAA rule 45 CFR § 164.526 be added, in addition to the state law, RCW 70.02.110.

4. On Page 10 of 8, in ***Table 1: Goals of the Medical Record*** --- We suggest that the following new item be added to the list:
   - Document accurately the conversation with the patient or designated caretaker about diagnosis, treatment options, care plans, and any discussions on informed consent/shared decision-making.

Again, we appreciate the opportunity to comment on the proposed update on the medical record policy.

Sincerely,

Yanling Yu, PhD
Washington Advocates for Patient Safety
2yanlingyu@gmail.com

# Staff Reports: January 19, 2024

## Kyle Karinen, Executive Director

**Budget.** The final budget numbers for the 2023-25 budget were received in November. In general, the Commission's budget remains in good, if not great, shape. The Commission's reserves remain projected at the mark agreed to by the Department and the Office of Financial Management. As detailed in the next item, there is some uncertainty with future obligations. That said, the Commission remains well-positioned to respond to those events with minimal disruption to operations. If any Commission member wants additional information on the budget, please do not hesitate to ask.

**HELMS.** The Department of Health's implementation of a successor database to ILRS is scheduled to start this spring. There is still development work that is on-going, but a finalized implementation schedule was voted upon and approved in November. In short, the Department's outward facing licensing portal will be the first part to be replaced, followed by replacement of the licensing portion of ILRS and then the enforcement portion with the work to be completed in 2025. This project began in 2018 and has encountered multiple difficulties along the way. The approved implementation schedule does require additional funding. A request for that funding to come from the state's general fund is included in the supplemental budget proposed by Governor Inslee. The Commission has funded the project to date in the amount of $2.1 million, which has come exclusively from our reserves. (That total does not include the salary and benefits for a Commission employee that was seconded to the HELMS team in 2018 and remain on the HELMS team.) If there are additional assessments to the Commission, our expectation is they will continue to come out of reserves and not the operating budget.

**Personnel.** There are a couple of transitions in Commission staff that are worth noting. With Mike Farrell's departure to take the Supervising Staff Attorney position in the Legal Unit, he left behind a key role as legal advisor to the Policy Committee. Dr. Pam Kohlmeier agreed to step into the role and work with Amelia and the Policy Committee. This required some revisions to Pam's other work and we will go back to using the Attorney General's Office as the primary legal resource for Public Records Act-related issues as well as subpoena and discovery response. Pam will remain the primary staff attorney working with Panel L.

Additionally, Dr. Morgan Barrett will be on leave for the foreseeable future. In his absence, Dr. Gina Fino will be stepping into the role of Director of Compliance. While Gina's absence will certainly be felt in the Investigations Unit, her transfer will allow the Commission to continue to rely on her clinical acumen and teamwork in to provide guidance and support to respondents in the compliance process. Gina's first day in this role was January 16.

**Dr. Alan Brown and Dr. Dan Flugstad.** Lastly, a special thank you goes out to Dr. Brown and Dr. Flugstad. Both Dr. Brown and Dr. Flugstad both completed their fourth (and final) terms pro tem terms with the Commission at the end of December. Both Dr. Brown and Dr.

## Kyle Karinen, Executive Director

Flugstad came to the Commission right before the pandemic began and provided invaluable insight and expertise as Reviewing Commission Members as well as serving on hearing panels. Please join me in thanking them for their service. They will both be missed.

## Micah Matthews, Deputy Executive Director

**Recurring**: Please submit all Payroll and Travel Reimbursements within 30 days of the time worked or travelled to allow for processing. Request for reimbursement items older than 90 days will be denied. Per Department of Health policy, requests submitted after the cutoff cannot be paid out.

**Legislative Session**

We are in full swing with a short 60-day session in Olympia. We have seen several retirements and new Chairs of key committees. As this is a short session, bills introduced last session will be reintroduced and they will be retained at the last step they achieved in the previous session. The Legislative Team met for opening ceremonies and to tour the Mobile Work Center provided by the Governor's office. Finally, we are testifying on four bills in the first week which is a record for us.

This seems to be the session of PAs, AI, and Telemedicine. We are monitoring 20+ bills already and anticipate quite a bit of action in advance of an election year which could result in a party change in the Governor's Office.

**Conferences/Presentations**

I traveled to Washington, DC twice in December to present to two organizations, Center for Telemedicine & e-Health Law and the American Telemedicine Association, on regulatory and workforce issues related to telemedicine. The evolution over the past several years of the WMC Telemedicine policy becoming more of a national model through FSMB and the Uniform Laws Commission has started to become noticed and resulted in more interest nationally.

The week of January 17 I will be traveling with Dr. Domino and Kyle for a one day summit on AI in medical regulation. This is especially timely as there are rumors of a significant number of Washington State bills addressing AI use in the state.

**Media**

We were featured in a KUOW article about one of our disciplinary cases. We felt this was a well-researched and evenhanded piece covering a difficult topic and situation: KUOW - Patients of former UW doctor accused of fertility fraud grapple with uncertainty, tough choices

Due to a change in how LinkedIn administers its business pages, we must create a new WMC page on that platform. We are almost done creating it and accepting affiliations from staff, current and former commissioners. We have added domain recognition so anyone who uses the WMC email should be automatically affiliated once they request it: https://www.linkedin.com/company/medicalcommission

## Amelia Boyd, Program Manager

### Recruitment

We are seeking the following specialties to serve as Pro Tem Members:

- Urology
- Radiology
- Neurosurgery/Neurology
- General surgery
- Psychiatry
- Orthopedic surgery

If you know anyone who might be interested in serving as a Pro Tem, please have them email me directly at amelia.boyd@wmc.wa.gov.

In November of 2023 we began recruiting for the following positions:

- One physician representing Congressional District 6 – Dr. Trescott's position, not eligible for reappointment.
- One physician representing Congressional District 8 – Dr. Gallinger's position, eligible for reappointment.
- One Physician-at-Large – Dr. Domino's position, eligible for reappointment.

The application deadline for these positions is March 22, 2024. Dr. Gallinger and Dr. Domino have been notified they are eligible for reappointment and can apply. We recently sent recruitment letters to all MDs in Congressional District 6 with an active license and who have been licensed in our state for at least 5 years.

Public Member, Scott Rodgers' first term expired on June 30, 2023. Mr. Rodgers is eligible for reappointment. We are waiting to hear back about this position. The recommendations were sent to the staff at the Governor's Boards and Commissions Office on June 21, 2023.

Public Member, Toni Borlas' second and final term expired on June 30, 2022. We continue to await word from the Governor's office staff on the new appointee.

We have a true vacancy for an MD representing Congressional District 9. In early April 2023, recruitment letters were sent to all MDs with an active license and who have been licensed in our state for at least 5 years in that district. The application deadline for that position was May 19, 2023. Our recommendations for the position were sent to the staff at the Governor's Boards and Commissions Office on September 18, 2023.

## Mike Hively, Director of Operations and Informatics

This report includes the 12-month review of 2023.

Between January 1, 2023 – December 8, 2023, Operations & Informatics processed 15 compulsory records requests totaling roughly 54,712 pages reviewed and around 15,697 redactions performed. The Litigation Hold Program is monitoring 6 active holds and has conducted 21 Electronic Records Discovery searches returning more than 73,000 records that

## Mike Hively, Director of Operations and Informatics continued

resulted in over 15,000 responsive records after irrelevant and duplicate findings were removed.

**Digital Archiving**

- 1,410 Complaints Closed BT
- 4,516 Active MD licensing applications
- 2,673 Active PA licensing applications
- 13,671 Demographic census forms
- 6 Closed investigations (ask Joe for numbers from Oct 10 – current).
- 1,950 Complaint summaries

We've recalled 26 boxes of MD and 11 boxes of PA paper-based applications from the state records centers, totaling approximately 2,137 applications, converted them to electronic formats, and submitted approvals for disposition of the paper-based records. Also, we've reviewed and verified the contents of over 5,900 PA digital licenses ensuring each record is complete and functional.

**Data Requests Processed include approximately:**

- 5,110 open/closed inquiries (please keep in mind a single requestor can request multiple datasets).
- 3,134 address changes

**Demographics**

- Entered approximately 17,074 census forms in ILRS.
- Performed 5,718 secondary contacts.
- Revised quarterly reports to display age/sex in a population pyramid.

The Demographic Census was analyzed in anticipation of a new survey tool by reviewing census survey participant comments, and where appropriate incorporating external data sets based on findings.

External datasets reviewed include:

- The National Commission on Certification of Physician Assistances (NCCPA) 2021 Statistical Profile of Board Certified PAs By State
- Office of Superintendent of Public Instruction 2017 Race & Ethnicity Student Data Task Force Legislative Report.
- The Healthcare Regulatory Research Institute's (HRRI) National Cross Profession Minimum Data Set (NCPMDS)

Our Information Liaison, Ken Imes, was able to update the WMC telecommunications call center by revising current messaging prompts and combining complaint intake & investigation options into a single point of inquiry. Lastly, Ken successfully processed three exception requests for Biteable, Mobilize, and HeyOrca to enhance WMC visual presentations and social media presence.

## Gina Fino, MD, Medical Consultant, Director of Compliance

On January 16, I started in Compliance while Dr. Morgan Barrett is on leave. Mike Kramer and Anthony Elders are introducing me to compliance work and helping me transition. We all are pleased to now be part of the Legal Unit.

## Rick Glein, Director of Legal Services

*Happy New Year from the Legal Team!*

**Summary Actions:**

*In re Roger B. Olsson, MD,* Case No. M2023-379. On July 10, 2023, the Commission served a Statement of Charges (SOC) alleging Dr. Olsson failed to complete a clinical skills assessment as required under an October 2021 Final Order. On November 7, 2023, the Commission served an Amended SOC adding allegations of accepting prepayment from three patients for cosmetic services and failing to complete the services or refund the patients. An Ex Parte Order of Summary Suspension was served concurrent to the Amended SOC, suspending Dr. Olsson's medical license pending further disciplinary proceedings. A hearing on the merits of the Amended SOC has not yet been scheduled at the time of this report.

*In re Rugvedita S. Parakh, MD,* Case No. M2022-985. On March 16, 2023, the Commission served a SOC alleging the Medical Licensing Board of Indiana (Indiana Board) entered an Order finding Dr. Parakh unfit to practice medicine due to a physical or mental disability with the underlying investigation as a result of criminal charges in January 2020 for two assault-related felonies. Allegations further stated the Indiana Board mandated compliance with the Indiana's physical health program, which was subsequently transferred to the Washington Physicians Health Program (WPHP). WPHP notified the Commission that Dr. Parakh had been discharged from the program for non-compliance. In November 2023, the Commission filed an Amended SOC alleging the Indiana Board indefinitely suspended Dr. Parakh's medical license for failing to comply with the Indiana Board Order. An Ex Parte Order of Summary Suspension was served concurrent to the Amended SOC, suspending Dr. Parakh's Washington medical license pending further disciplinary proceedings. A hearing on the merits of the Amended SOC was scheduled for February 8, 2024; however, Dr. Parakh did not file an Answer to the Amended SOC or appear at a status conference. The Health Law Judge (HLJ) issued an Order of Default in January 2024. Dr. Parakh has seven days to file a Request to Vacate the Order of Default. If a Request to Vacate is not filed and granted, the Commission will issue a Final Order in the absence of Dr. Parakh and without additional notice.

**Orders Resulting from SOCs**:

*In re Scott C. Miller, PA,* Case No. M2023-352. Default Order of Revocation (Failure to Respond).* In October 2022, the Commission issued a Final Order under Case No. M2021-272 indefinitely suspending Mr. Miller's physician assistant license subject to completion of a fitness for duty evaluation, completion of an ethics and boundaries course, as well as several other conditions. In August 2023, the Commission filed a SOC alleging a complaint was received that Mr. Miller was providing treatment to patients while suspended, and he did not substantively respond to the Commission investigator's request to address the allegation. The Commission also alleged Mr. Miller failed to provide treatment records to a patient's

parents and declined to provide a copy to the Commission investigator. Mr. Miller did not file a response to the SOC within the time allowed. In October 2023, a HLJ issued a Default Order which concluded sufficient grounds exist to take disciplinary action and ordered Mr. Miller's physician assistant license be permanently revoked.

*In re William M. Bauer, MD,* Case No. M2022-53. Agreed Order. In October 2022, the Commission issued a SOC alleging standard of care issues including record-keeping, clinical documentation, limited examinations, and a profound lack of clinical judgment in a treatment-related decision. The SOC also alleges Dr. Bauer failed to obey all federal, state, and local laws and all administrative rules governing the practice of medicine in Washington as required under a February 2021 Stipulation to Informal Disposition Dr. Bauer entered into with the Commission. In November 2023, the Commission accepted an Agreed Order which requires Dr. Bauer to complete a clinical competency assessment. Dr. Bauer may petition for termination of the Agreed Order after successful completion of the assessment.

*In re James A. Saadi, MD,* Case No. M2022-838. Final Order of Suspension.* In February 2023, the Commission suspended Dr. Saadi's medical license pending further disciplinary proceedings. A SOC was issued concurrently alleging the Missouri Board of Registration for the Healing Arts issued an order revoking Dr. Saadi's medical license after he failed to comply with an order to undergo a multidisciplinary examination. In September 2023, the HLJ issued an Order on Partial Summary Judgment in which he granted the Commission's Motion and found there was no genuine issue of material fact. The sole remaining issue for hearing was the issue of sanctions. The Commission delegated decision-making authority of the Final Order to the HLJ, and a sanctions-only hearing was held in October 2023. A Final Order was issued in November 2023 which indefinitely suspended Dr. Saadi's medical license.** Dr. Saadi may petition for reinstatement upon compliance with each requirement in the Missouri order, payment of a $5,000 fine, and attendance at personal appearances.

*In re Farhaad R. Riyaz, MD,* Case No. M2022-716. Agreed Order. In December 2022, the Commission suspended Dr. Riyaz' medical license pending further disciplinary proceedings. The SOC includes allegations that the Virginia Department of Health Professions issued an Order of Mandatory Suspension in March 2022, suspending Dr. Riyaz' license to practice as a physician and surgeon in that jurisdiction. The underlying conduct for the Virginia Order is substantially equivalent to unprofessional conduct in Washington state under RCW 18.130.180(1). The SOC further alleges Dr. Riyaz pled guilty in March 2022 to one count of felony mail fraud in Virginia. In November 2023, the Commission accepted an Agreed Order which indefinitely suspended Dr. Riyaz' Washington medical license.** Dr. Riyaz may petition for reinstatement upon completing a CME in ethics, payment of a $5,000 fine, and attendance at a personal appearance.

*In re James W. Rice, Jr., MD,* Case No. M2021-286. Agreed Order. In December 2022, the Commission issued a SOC alleging standard of care issues related to a patient who died due to arteriosclerotic cardiovascular disease that led to cardiac arrhythmia and sudden death. The SOC also alleged violation of pain rules and substandard care of a patient with a history of substance use disorder who died of acute myocardial infarct and focal coronary artery

atherosclerotic with other conditions contributing to death: hypertrophic obstructive cardiomyopathy and intoxication by alprazolam and oxycodone. In November 2023, the Commission accepted an Agreed Order restricting Dr. Rice from prescribing, administering, ordering or providing, or directing others to prescribe, administer, order or provide Schedule II, III, and IV medications to patients. The Agreed Order also requires Dr. Rice complete a clinical skills assessment upon which Dr. Rice may petition for modification of the restriction. Dr. Rice has also agreed to complete a CME on outpatient cardiac management, submit a paper, permit compliance audits, attend personal appearances, and pay a $1,000 fine. Dr. Rice may petition to terminate the Agreed Order three years from its effective date.

*In re David P. McQuivey, PA,* Case No. M2023-61. Agreed Order. In May 2023, the Commission issued an Ex Parte Order of Summary Restriction which ordered Mr. McQuivey be restricted from prescribing or managing hormones pending further disciplinary proceedings by the Commission. A SOC concurrently served on Mr. McQuivey alleges prescribing excessively high dosages of testosterone, failing to document rationale for exceeding standard dosages, and failing to counsel patients regarding potential adverse side effects. An Agreed Order was accepted by the Commission in November 2023 which indefinitely restricts Mr. McQuivey from prescribing testosterone medications to any patient without oversight and approval of a supervising physician or consultant. The Agreed Order further requires Mr. McQuivey to undergo a clinical competency assessment; complete CMEs regarding prescribing testosterone, treating hypogonadism, informed consent and record-keeping; submit a paper; permit compliance audits; pay a fine of $1,500; and attend personal appearances. Mr. McQuivey may petition to terminate the Agreed Order four years from its effective date.

*In re Jonathan V. Wright, MD,* Case No. M2019-236. Agreed Order. The Commission issued a SOC in September 2021 alleging standard of care issues of a patient with hypothyroidism. The SOC additionally alleged Dr. Wright recommended or prescribed potentially harmful and non-evidence-based medical therapies to the patient and failure to adequately supervise a medical assistant. An Agreed Order was accepted by the Commission in November 2023 requiring Dr. Wright to complete CME courses on thyroid management and ethics; submit a paper; pay a $5,000 fine; and attend personal appearances. Dr. Wright may petition to terminate the Agreed Order one year from its effective date.

*In re Emil A. Saify, MD,* Case No. M2022-855. Default Order of Suspension (Failure to Respond).* The Commission issued a SOC in September 2023 alleging the Medical Board of California revoked Dr. Saify's Physician's and Surgeon's Certificate, but further stayed the revocation and placed his Certificate on probation for two years with a restriction prohibiting Dr. Saify from supervising physician assistants and advance practice nurses. Dr. Saify did not file a response to the SOC within the time allowed. In December 2023, a HLJ issued a Default Order which concluded sufficient grounds exist to take disciplinary action and ordered Dr. Saify's medical license be indefinitely suspended.**

*In re Eric C. Welling, MD,* Case No. M2023-492. Default Order of Suspension (Failure to Respond).* The Commission issued a SOC in August 2023 alleging the Wyoming Board of Medicine suspended Dr. Welling's medical license for failure to comply with an order to undergo an alcohol, substance, and mental health examination. The SOC further alleged Dr. Welling failed to comply with assessment recommendations from a neurocognitive assessment following the suspension of his clinical privileges at a Utah hospital in September 2021. The Commission concurrently served an Ex Parte Summary Action indefinitely suspending Dr. Welling's Washington medical license pending further disciplinary proceedings. Dr. Welling did not file a response to the SOC within the time allowed. In January 2024, a HLJ issued a Default Order which concluded sufficient grounds exist to take disciplinary action and ordered Dr. Welling's medical license be indefinitely suspended.**

*Either party may file a petition for reconsideration within ten days of service of the order. RCW 34.05.461(3); 34.05.470. A petition for judicial review must be filed and served within 30 days after service of the order. If a petition for reconsideration is filed, the 30-day period does not start until the petition is resolved. RCW 34.05.542; 34.05.470(3).
**A person whose license has been suspended under chapter 18.130 RCW may petition the disciplining authority for reinstatement. RCW 18.130.150.

**Virtual Hearing**:
*In re James A. Saadi, MD,* Case No. M2022-838. A sanctions-only hearing was delegated to a HLJ and held on October 16, 2023. A Final Order was issued on November 7, 2023. The case and final decision are described above.

*In re Robert G. Thompson, MD,* Case No. M2021-553. On June 24, 2022, the Commission filed a SOC alleging standard of care issues, including opioid treatment, prescribing, and patient monitoring, along with misrepresentations to the Commission. The Commission held a virtual hearing October 26, 2023. A Final Order is expected to be issued by end of January 2024.***

***The HLJ has 90 days after the conclusion of the hearing to issue a decision. RCW 34.05.461.

**Items of Interest:**
Rick, Mike, Colleen, Lisa, and Jen attended the FSMB Board Attorneys Workshop November 30 – December 1 in Louisville, KY. Our own Mike Farrell co-presented the session "When Does Using Social Media Become Unprofessional Conduct?". Other topics included end-of-year legislative updates; strategic development of sexual misconduct cases; the role of comprehensive independent evaluations; navigating the artificial intelligence (AI) frontier; shared experiences and themes across the states; update from the National Practitioner Data Bank (NPDB); and an ethics session with featured speaker Jim Blackburn, the former lead prosecutor in the 1979 trial of Dr. Jeffrey MacDonald who was convicted for the brutal murders of his pregnant wife and two daughters. Mr. Blackburn's legal career ended in 1993 when he was found guilty of several ethical violations and spent time in state prison. He spoke candidly about depression, substance abuse and mental health, the harms it can do,

## Rick Glein, Director of Legal Services continued

and the consequences for those who have it in its most serious forms. The attendees brought back valuable information and knowledge to share with the Legal team.

Rick and the entire Legal staff extend a warm welcome to the Compliance team which will be moving into Legal effective January 16. Joining us will be Gina Fino, MD, as the new interim Director of Compliance, and the stellar and stalwart Compliance Officers Mike Kramer and Anthony Elders.

The Legal team would like to extend its appreciation to all Commissioners who participated on our hearing panels last year. We anticipate hearings will remain virtual throughout 2024 and trust this provides some flexibility to your busy calendars. Please don't hesitate to reach out to Rick (Rick.Glein@wmc.wa.gov) if you have any questions about your role as a hearing panelist.

## Freda Pace, Director of Investigations

**Case Western Reserve University** is offering a CME course on **Controlled Drug Prescribing: Essential Aspects of Investigation** January 26, 2024, in Cleveland, Ohio. The course is designed for clinically trained regulatory investigators, attorneys and other law enforcement professionals. The learning objectives include:

- Compare and contrast safe controlled drug prescribing and dangerous prescribing practices.
- List five pitfalls in case investigations.
- Describe the process of bringing an investigation to a licensure or legal action.

Three of our clinical investigators have registered to attend this training virtually. The hope is that this training will help us better assess, investigate, and adjudicate controlled drug prescribing complaints. We look forward to hearing feedback on lessons learned.

**Recurring:**
**CMT Sign-up for 2024**
Our 2024 CMT sign up slots are ready, awaiting your name! Please take some time to check out the new CMT calendar to find a vacant slot – there are plenty. We appreciate your continued participation in this very important process. We could not be able to do this work without you and your support!

Remember, if you sign up for a CMT slot and you have a last-minute scheduling conflict, at your earliest opportunity, please promptly notify Chris Waterman at chris.waterman@wmc.wa.gov. This courtesy cancellation notice will allow Chris the opportunity to fill any last-minute vacancy needs.

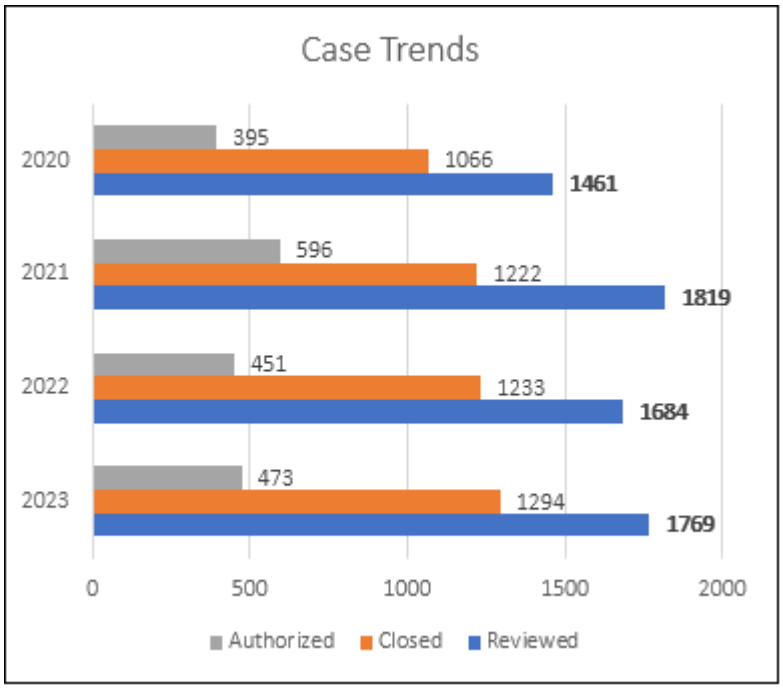
CMT Review Statistics
**Year in review**

For 2023, Case Management Team (CMT) reviewed approximately 1769 cases during regular weekly meetings.

- CMT closed approximately 1294 cases (73.15%)
- CMT authorized approximately 473 cases (26.74%) for investigation
- CMT reviewed approximately 85 more cases than in 2022

## Freda Pace, Director of Investigations

- The percentage of cases closed and authorized compared to 2022 is nearly identical (73.22% closed; 26.78% authorized).




## Jimi Bush, Director of Quality and Engagement

**Newsletter**

Innovation in Healthcare – at the Commissioner retreat, it was noted that they would like to see an ongoing segment regarding advancements in health care technology and/or a general sit rep on tech advancements. I am looking for topic ideas that you are seeing in your field. For the spring edition of the newsletter I want to kick off this segment with an article about AI and its impact in health care. **If you have personal experience or a story to share with AI** in your work, please reach out to me.

Lessons From WMC Panels: Avoiding Missteps – We are going to have a 3-part series about how cases are reviewed and examples of issues that frequently come before the Panels but don't often result in public action. Our hope in highlighting these topics is to help licensees avoid problems and ensure they meet appropriate professional obligations. We will be sharing these examples from 3 perspectives: Clinical Commission Member, Public Member and Staff Member. **I am looking for a public member** to write an article about their lessons learned. I will be here to help with any data or research you need. Please reach out to me if you are interested in penning an article for the newsletter.

**Upcoming Webinars**

Please share the following webinars with your circles – More information here

Post COVID-19 Conditions: Diagnosis and Management Options
CME Webinar

## Jimi Bush, Director of Quality and Engagement continued

January 12, 2024
12:00 PM PST

Optimizing Care for People Experiencing Homelessness
CME Webinar
January 18, 2024
12:00 PM PST

Communication and Resolution Program Certification: The Value of Collaboration to Improve Patient Safety after Adverse Events
Coffee with the Commission
February 7, 2024
11:00 AM PST

WMC 2023 Legislative Update
February 8, 2024
10:00 AM PST
More Information and Registration

**Business Practices and Productivity**

We have mapped 80 processes to date. Mapping out our processes clarifies roles and responsibilities in our daily work, creates an opportunity for the workforce to identify pain points and find solutions to minimize or eliminate waste, or steps that don't add value for our customers. In 2023, we added eight process maps to SharePoint including processes for onboarding staff and Commissioners, off-ramping cases, and a mentorship program for new Commissioners.

**2023 Performance Year in Review**

| Performance Measure | 2022 | 2023 |
|---|---|---|
| Licenses Issued. | 4,265 | 4,385 |
| Average time to issue a license (days). | 33.3 | 32.6 |
| Percentage of Licenses issued within 14 days of receiving all materials. | 99% | 99% |
| Percent of cases in which the intake and assessment steps are completed within 21 days. | 99% | 98% |
| Complaints received. | 1,682 | 1,805 |
| Investigations authorized. | 456 | 467 |
| Percent of cases in which the investigation step is completed within 170 days. | 79% | 91% |
| Average percentage of investigations that exceed 170 days | 8% | 3% |
| Percent of cases in which the case disposition step is completed within 140 days. | 85% | 83% |
| Average percentage of cases in case disposition that exceed 140 days. | 27% | 29% |
| Percent of cases completed within 360 days. | 96% | 94% |
| Reconsideration Requests Received. | 46 | 55 |
| Reconsideration Requests Authorized. | 7 | 4 |
| Number of STIDS completed. | 34 | 50 |
| Number of Final Orders completed. | 5 | 7 |
| Number of Agreed Orders completed. | 9 | 15 |

## Mahi Zeru, Equity and Social Justice Manager

Developed a 1-page document to call attention to the barriers complainants face to obtain their medical records. To stay in alignment with WMC's values of ensuing equitable practices, when information contained in the medical record is the essential data lacking in a complaint being assessed, commissioners are advised to defer to the complainants' experience and authorize an investigation to obtain and evaluate the medical record. *1-pager will be an attachment to the weekly CMT email and is on page 112 of this packet.

Contributed an article for the winter newsletter Culturally and linguistically appropriate care summarizes recent studies that highlight deficiencies in the quality of care received by those with access and functional needs and concludes by providing strategies physicians and physician assistants can implement to increase accessibility in their respective practices.

## Marisa Courtney, Licensing Manager

Total licenses issued from = 10/10/2023- 12/31/2023= 719

| Credential Type | Total Workflow Count |
|---|---|
| Physician And Surgeon Clinical Experience License | 4 |
| Physician And Surgeon Fellowship License | 0 |
| Physician And Surgeon Institution License | 0 |
| **Credential Type** | **Total Workflow Count** |
| Physician And Surgeon License | 320 |
| **Credential Type** | **Total Workflow Count** |
| Physician and Surgeon License Interstate Medical Licensure Compact | 245 |
| Physician And Surgeon Residency License | 6 |
| Physician And Surgeon Teaching Research License | 2 |
| Physician And Surgeon Temporary Permit | 1 |
| **Credential Type** | **Total Workflow Count** |
| Physician Assistant Interim Permit | 5 |
| Physician Assistant License | 135 |
| Physician Assistant Temporary Permit | 0 |
| **Totals:** | **719** |

## Marisa Courtney, Licensing Manager continued

### Information on Renewals: October Renewals- 72.46% online renewals

| Credential Type | # of Online Renewals | # of Manual Renewals | Total # of Renewals |
|---|---|---|---|
| IMLC | 0 | 98 | 98 |
| MD | 992 | 300 | 1292 |
| MDCE | 0 | 1 | 1 |
| MDIN | 0 | 1 | 1 |
| MDTR | 2 | 1 | 3 |
| PA | 177 | 44 | 221 |
| | **72.46%** | **27.54%** | **100.00%** |

### Information on Renewals: November Renewals- 76.41% online renewals

| Credential Type | # of Online Renewals | # of Manual Renewals | Total # of Renewals |
|---|---|---|---|
| IMLC | 0 | 91 | 91 |
| MD | 991 | 232 | 1223 |
| MDTR | 2 | 3 | 5 |
| PA | 170 | 33 | 203 |
| | **76.41%** | **23.59%** | **100.00%** |

### Information on Renewals: December Renewals- 73.75% online renewals

| Credential Type | # of Online Renewals | # of Manual Renewals | Total # of Renewals |
|---|---|---|---|
| IMLC | 0 | 110 | 110 |
| MD | 864 | 218 | 1082 |
| MDTR | 4 | 1 | 5 |
| PA | 146 | 32 | 178 |
| | **73.75%** | **26.25%** | **100.00%** |

# Addressing Inequitable Barriers

## ACCESS TO MEDICAL RECORDS

## Overview

Washington Medical Commission does not require complainants to provide medical records for review. Complainants may provide supporting evidence such as medical records along with their initial complaint.

Requiring the complainant to provide medical records may create an undue burden for priority populations which are economically or socially disadvantaged population groups. The practice of disparately requesting complainants to provide medical records to fill gaps in information undermines WMC's equitable practices.

## Barriers to Acquiring Medical Records

| | |
|---|---|
| **Policies** | Hospitals have varying policies that are not standardized across all facilities and practices. Under the best of circumstances, patients struggle to navigate the complex systems. |
| **Cost** | WAC 246-08-400 – cost limitation is set by legislation. However, access to smartphones, computers, and broadband require an additional fee to gain medical records access. |
| **Time Constraint and Administrative Complexity** | Obtaining medical records can take more than a month for people without access to electronic medical records. Understanding the best method to obtain medical records is burdensome to complainants who do not use electronic medical records (EMR). In-person or telephone access have authorization request forms that must be completed and returned, adding to the administrative complexity. |
| **Communication Barriers** | Complainants with limited English proficiency and access/functional needs may have increased difficulty obtaining their medical records. Navigating the web of automated message systems may be an additional challenge and require additional assistance. |

## Recommendations

When medical record is the essential data lacking in a complaint being assessed, commissioners are advised to defer to the complainants' experience and authorize an investigation to obtain and evaluate the medical record.