WASHINGTON

Medical Commission

Licensing. Accountability. Leadership.

Regular Meeting
April 14-15, 2022
1st Revised

2022 Meeting Schedule

WASHINGTON Medical Commission
Licensing. Accountability. Leadership.

Dates	Location	Meeting Type
January 13-14	Virtual Meeting	Regular Meeting
March 3-4	Virtual Meeting	Regular Meeting
April 14-15	Capital Event Center (ESD 113) 6005 Tyee Drive SW Tumwater, WA 98512	Regular Meeting
May 26-27	Virtual Meeting	Regular Meeting
July 14-15	TENTATIVE Capital Event Center (ESD 113) 6005 Tyee Drive SW Tumwater, WA 98512	Regular Meeting
August 25-26	TENTATIVE Capital Event Center (ESD 113) 6005 Tyee Drive SW Tumwater, WA 98512	Regular Meeting
October 6	Virtual Meeting	Case Reviews
November 17-18	TENTATIVE Capital Event Center (ESD 113) 6005 Tyee Drive SW Tumwater, WA 98512	Regular Meeting

Association Meetings

Association	Dates	Location
Federation of State Medical Boards (FSMB) Annual Conference	April 28-30, 2022	New Orleans, LA
WAPA Spring Conference	April 22-25, 2022	Seattle, WA
WSMA Annual Meeting	October 1-2, 2022	Spokane, WA
WAPA Fall Conference	October 27-29, 2022	Cle Elum, WA

Other Meetings

Program	Dates	Location
Council on Licensure, Enforcement & Regulation (CLEAR) Winter Symposium	January 5, 2022	Virtual Event
CLEAR Annual Conference	September 14-17, 2022	Louisville, KY
FSMB Board Attorneys Workshop	November 3-4, 2022	TBD

Approved 11/15/19

Updated: April 12, 2022

2023 Meeting Schedule

WASHINGTON Medical Commission
Licensing. Accountability. Leadership.

Dates	Location	Meeting Type
January 12-13	TBD	Regular Meeting
March 2-3	TBD	Regular Meeting
April 13-14	TBD	Regular Meeting
May 25-26	TBD	Regular Meeting
July 6-7	TBD	Regular Meeting
August 24-25	TBD	Regular Meeting
October 5-7	TBD	Educational Conference
November 16-17	TBD	Regular Meeting

Association Meetings		
Association	**Dates**	**Location**
Federation of State Medical Boards (FSMB) Annual Conference	TBA	TBA
WAPA Spring Conference	TBA	TBA
WSMA Annual Meeting	TBA	TBA
WAPA Fall Conference	TBA	TBA

Other Meetings		
Program	**Dates**	**Location**
Council on Licensure, Enforcement & Regulation (CLEAR) Winter Symposium	TBA	TBA
CLEAR Annual Conference	TBA	TBA
FSMB Board Attorneys Workshop	TBA	TBA

2024 Meeting Schedule

WASHINGTON Medical Commission
Licensing. Accountability. Leadership.

Dates	Location	Meeting Type
January 11-12	TBD	Regular Meeting
March 7-8	TBD	Regular Meeting
April 18-19	TBD	Regular Meeting
May 23-24	TBD	Regular Meeting
July 11-12	TBD	Regular Meeting
August 22-23	TBD	Regular Meeting
October 3-5	TBD	Educational Conference
November 21-22	TBD	Regular Meeting

FORMAL HEARING SCHEDULE

WASHINGTON Medical Commission
Licensing. Accountability. Leadership.

Hearing	Respondent	Specialty	Case No.	Counsel	AAG	Staff Atty	PANEL	Presiding Officer	Location	Panel Composition (as of 3/29/22)
29-Mar										
2022 April		*Commission meeting 4/14/2022*								
20-21 Apri	AFLATOONI, Alfred, MD	BC - Family Medicine	M2018-697	Patrick Trudell George Kargianis	Brewer	Wolf	A	Herington	TBD	
2022 May		*Commission meeting 5/26/2022*								
12-13 May	FRANDSEN, Brad R., MD	BC - Family Medicine	M2021-274	Philip J. VanDerhoef	Pfluger	DeFazio	A	Blye	TBD	
16-May	ENOH, Victor, MD	Non-BC Internal Medicine	M2021-811	Pro Se	Defreyn	Karinen	L	Herington	Via Zoom	
20-May	HEITSCH, Richard C., MD	Non-BC Public Health and Gen. Preventative Medicine	M2021-545	Pro Se	Defreyn	Farrell	A	Blye	TBD	
2022 June		*NO COMMISSION MEETING THIS MONTH*								
NO HEARINGS SCHEDULED THIS MONTH										
2022 July		*Commission meeting 7/14/2022*								
7-8 Jul	KIMURA, Irene K., MD	BC - Family Medicine	M2020-930	Garth Dano	Brewer	Elder	A	Kavanaugh	TBD	
22-Jul	OSTEN, Thomas J., MD	BC - Family Medicine	M2021-652	Pro Se	Bahm	Balatbat	B	Herington	TBD	
2022 August		*Commission meeting 8/25/2022*								
3-5 Aug	WRIGHT, Jonathan V., MD	Non-BC - Family Medicine	M2019-236	James B. Meade, II	Brewer	Wright	A	Kavanaugh	TBD	
8-11 Aug	MILLER, Scott C., PA-C	Phys. Asst.	M2021-272	Klaus O. Snyder	Brewer	Karinen	A	Kuntz	TBD	
2022 September		*NO COMMISSION MEETING THIS MONTH*								
8-9 Sept	EDGERLY, Richard D., MD	Non-BC - Family Medicine	M2022-46	John C. Versnell, III	Bahm	Farrell	A	Herington	TBD	
15-16 Sept	SHARMA, Bhanoo, MD	Non-BC - Cosmetic Surgery	M2021-756	Pro Se	Little	Elder	B	Herington	TBD	
2022 October		*Commission meeting 10/6/2022*								
11-12 Oct	GREENMAN, Christopher G., MD	BC - Internal Medicine & Cardiovascular Disease	M2021-909	Daniel R. Kyler	Defreyn	Elder	B	Kuntz	TBD	

Commission Meeting Agenda
April 14-15, 2022 – 1st Revised

WASHINGTON Medical Commission
Licensing. Accountability. Leadership.

In response to the COVID-19 public health emergency, and to promote social distancing, Open Sessions will have a virtual option. The registration links for each session can be found below.

Capital Event Center (ESD 113), 6005 Tyee Drive SW, Tumwater, WA 98512

Thursday – April 14, 2022

Closed Sessions		Room
8:00 am	Case Reviews – Panel A	Pacific
8:00 am	Case Reviews – Panel B	Grays Harbor

Open Session

Lunch & Learn

Please **register** for this meeting at: https://attendee.gotowebinar.com/register/3456092023094661647
After registering, you will receive an email containing a link that is unique to you to join the webinar.

12:30 pm to 1:30 pm	**Washington Physicians Health Program Annual Report** *Chris Bundy, Executive Medical Director*	**Thurston Room**

Closed Sessions		Room
1:30 pm	Case Reviews – Panel A	Pacific
1:30 pm	Case Reviews – Panel B	Grays Harbor

4:00 pm Policy Committee Meeting **Grays Harbor**

Please **register** for this meeting at:
https://attendee.gotowebinar.com/register/1544881329275859216
After registering, you will receive an email containing a link that is unique to you to join the webinar.

Agenda Items	Presented By:	Page(s)
Proposed Policy: Informed Consent *Presentation, discussion, and possible revisions to proposed policy.*	Mike Farrell	85-91
Guidance Document: Medical Professionalism *Routine review, discussion, and possible revisions to guidance document.*	Mike Farrell	92-100
Guidance Document: Practitioner Competence *Routine review, discussion, and possible revisions to guidance document.*	Mike Farrell	101-106

Friday – April 15, 2022

Open Session		Room
8:00 am –9:30 am	**Business Meeting**	Thurston

Please **register** for this meeting at:
https://attendee.gotowebinar.com/register/1617863613244007 5
After registering, you will receive an email containing a link that is unique to you to join the webinar.

1.0 Chair Calls the Meeting to Order

2.0 Housekeeping

3.0 Chair Report

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4.0 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 March 4, 2022 Business Meeting minutes. — Pages 9-13

4.2 Agenda – Approval of the April 15, 2022 Business Meeting agenda.

5.0 New Business

5.1 **Outstanding Performance Awards**

Melanie de Leon, Executive Director; Rick Glein, Director of Legal Services; and Freda Pace, Director of Investigations, will present the Outstanding Performance Awards to WMC staff.

5.2 **Meeting Dates for 2023** — Action

Discussion and vote on proposed meeting dates for the year 2023. — Page 14

6.0 Old Business

6.1 **Committee/Workgroup Reports** — Update

The Chair will call for reports from the Commission's committees and workgroups. Written reports begin on page 15.

See page 17 for a list of committees and workgroups.

6.2 **Nominating Committee** — Update

Announcement of leadership candidates. The election of leadership will take place at the May 27, 2022 Business Meeting.

6.3 **Rulemaking Activities** — Update

Rules Progress Report provided on page 19.

The rules hearing for the Opioid Prescribing Patient Exemptions scheduled for April 13, 2022, had to be rescheduled as we did not have a quorum. It will now be held on Friday, May 27, 2022, at 4 pm – which is the Friday of the next Commission meeting. ***Commissioners****, please let Amelia Boyd know if you can participate on the new date and time.*

6.4 **Lists & Labels Request**

The Commission will discuss the requests received for lists and labels, and possible approval or denial of these requests. Approval or denial of these applications is based on whether the requestor meets the requirements of a "professional association" or an "educational organization" as noted on the application (RCW 42.56.070(9)).

- Agility COHE SPC - Reconsideration — Pages 20-79
- Frank Madura — Pages 80-84

7.0 Public Comment

The public will have an opportunity to provide comments. ***If you would like to comment during this time, 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.***

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8.0 Policy Committee Report

Dr. Karen Domino, Chair, will report on items discussed at the Policy Committee meeting held on April 14, 2022. See the Policy Committee agenda on page 1 of this agenda for the list of items to be presented.

Report/Action Begins on page 85

9.0 Member Reports

The Chair will call for reports from Commission members.

10.0 Staff Member Reports

Pages 107-112

The Chair will call for further reports from staff.

11.0 AAG Report

Heather Carter, AAG, may provide a report.

12.0 Adjournment of Business Meeting

Open Sessions		Page	Room
9:45 am	Personal Appearances – Panel A	Page 113	Pacific
9:45 am	Personal Appearances – Panel B	Page 114	Grays Harbor
Closed Session			**Room**
Noon to 1:00 pm	Lunch Break		Thurston
Open Sessions		**Page**	**Room**
1:15 pm	Personal Appearances – Panel A	Page 113	Pacific
1:15 pm	Personal Appearances – Panel B	Page 114	Grays Harbor

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 (Commission) meetings. This agenda is subject to change. The Policy Committee Meeting will begin at 4:00 pm on April 14, 2022 until all agenda items are complete. The Commission will take public comment at the Policy Committee Meeting that is related to the documents or topics being presented. The Business Meeting will begin at 8:00 am on April 15, 2022 until all agenda items are complete. The Commission 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.

Business Meeting Minutes
March 4, 2022

WASHINGTON Medical Commission
Licensing. Accountability. Leadership.

Virtual Meeting via GoToWebinar – Link to recording: https://youtu.be/KV1PdW3IUxM

Commission Members

James E. Anderson, PA-C
Michael Bailey, Public Member
Christine Blake, Public Member
Toni Borlas, Public Member
Charlie Browne, MD
Jimmy Chung, MD, 2nd Vice Chair
Diana Currie, MD
Arlene Dorrough, PA-C
Anjali D'Souza, MD – Absent
Karen Domino, MD
Harlan Gallinger, MD
April Jaeger, MD
Sarah Lyle, MD
John Maldon, Public Member, Chair
Terry Murphy, MD – Absent
Alden Roberts, MD
Scott Rodgers, JD, Public Member
Robert Small, MD – Absent
Claire Trescott, MD, 1st Vice Chair
Richard Wohns, MD
Yanling Yu, PhD, Public Member

Commission Staff

Christine Babb, Investigator
Colleen Balatbat, Staff Attorney
Morgan Barrett, MD, Director of Compliance
Jennifer Batey, Legal Support Staff Manager
Amelia Boyd, Program Manager
Kayla Bryson, Executive Assistant
Sarah Chenvert, Performance Manager
Marisa Courtney, Licensing Manager
Melanie de Leon, Executive Director
Joel DeFazio, Staff Attorney
Anthony Elders, Compliance Officer
Michael Farrell, Policy Development Manager
Gina Fino, MD, Investigator
Rick Glein, Director of Legal Services
George Heye, MD, Medical Consultant
Mike Hively, Director of Operations & Informatics
Jenelle Houser, Legal Assistant
Kyle Karinen, Staff Attorney
Shelley Kilmer-Ready, Legal Assistant
Pam Kohlmeier, MD, JD, Attorney
Micah Matthews, Deputy Executive Director
Lynne Miller, Paralegal
Trisha Wolf, Staff Attorney
Gordon Wright, Staff Attorney
Mahlet Zeru, Equity & Social Justice Manager

Others in Attendance

Heather Cantrell, Policy Analyst, Department of Health
Heather Carter, Assistant Attorney General
Mary Curtis, MD, Pro Tem Commissioner
Katerina LaMarche, Washington State Medical Association
Jodi Rook
Theresa Schimmels, PA, Pro Tem Commissioner
Gregory Terman, MD, Pro Tem Commissioner
Francine Wiest

1.0 Call to Order

John Maldon, Public Member, Chair, called the meeting of the Washington Medical Commission (Commission) to order at 8:00 a.m. on March 4, 2022.

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2.0 Housekeeping

Amelia Boyd, Program Manager, gave an overview of how the meeting would proceed.

3.0 Chair Report

Mr. Maldon stated that there is a gender imbalance on the two panels, A and B. He thanked Jim Anderson, PA, and Arlene Dorrough, PA, for their willingness to switch panels to help with the imbalance. He went on to say that there are seven Commissioner terms which will expire in June and there will be more adjustments to panels A and B as new Commissioners are added.

Mr. Maldon introduced the new Public Member Commissioner, Michael Bailey. Mr. Maldon asked Mr. Bailey to give a little background on himself. Mr. Bailey provided a brief history. Mr. Maldon stated that Mr. Bailey has been assigned to Panel B.

Mr. Maldon recognized Jimi Bush, Director of Quality and Engagement, as the recipient of the Federation of State Medical Board's (FSMB) Aware of Merit for 2021. He asked Micah Matthews, Deputy Executive Director, to share about Ms. Bush and this award. Mr. Matthews stated that Ms. Bush is involved in many areas of the WMC. She oversees the Quality and Engagement unit. Ms. Bush oversees the following for the WMC:

- Continuing Medical Education (CME)
- Practitioner Education
- Annual Educational Conference
- *Update!* Newsletter – practitioner focused
- *Commission Connection* – patient focused newsletter

4.0 Consent Agenda

The Consent Agenda contained the following items for approval:

4.1 Minutes from the January 14, 2022 Business Meeting.
4.2 Agenda for March 4, 2022.

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

5.0 Old Business

5.1 Committee/Workgroup Reports

These reports were provided in writing and included in the meeting packet.

In addition to the written reports, Melanie de Leon, Executive Director, reported she has asked the WMC staff to provide topics for the Commission Education Committee's Lunch & Learn sessions. She stated she will also invite FSMB to present at least once a year. She asked if the Commissioners have any topics they would like presented to send her an email.

Mr. Matthews recommended the Executive Committee review the list of workgroups/committees to determine if any can be disbanded. He suggested the Osteopathic Manipulative Therapy Workgroup is one that can be reviewed.

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5.2 Nominating Committee

Alden Roberts, MD, announced the members of the Nominating Committee as follows:

- Alden Roberts, MD
- Christine Blake, Public Member
- John Maldon, Public Member

Dr. Roberts stated that the recommendations at this time are:

Chair – Jimmy Chung, MD
1st Vice Chair – Karen Domino, MD
2nd Vice Chair – to be announced at the April 15, 2022 meeting

Official nominations will be made at the April 15, 2022 meeting and the vote for leadership will be held at the May 27, 2022 meeting.

5.3 Rulemaking Activities

The rulemaking progress report was provided in the meeting packet.

Request to approve the revised draft language and initiating the CR-102 rulemaking process related to Senate Bill 6551 Regarding International Medical Graduates

Ms. Boyd explained that the revised draft language incorporates language from an approved Interpretive Statement, Requiring the Filing of a Practice Agreement Before Beginning to Practice Under and IMG Limited License, INS2021-01, as well as an Interpretive Statement which will be considered for approval during the Policy Committee report of this meeting, Establishing Approval Criteria for Defining Appropriate Medical Practices for IMG Nomination – Page 42 of the March Meeting Packet.

> ***Motion:*** The Chair entertained a motion to approve the revised draft language and initiating the CR-102 rulemaking process. The motion was approved unanimously.

Request to initiate rulemaking regarding a physician's obligation to keep and maintain medical records.

Mike Farrell, Policy Development Manager, explained the WMC has a guideline regarding medical records which discusses the documentation, access, retention, storage, disposal, and closing of a practice. He stated the guideline lays out a physician's obligation to retain medical records for a certain period of time. He stated there is no legal requirement for a physician to retain medical records. He requested that the WMC initiate rulemaking on this subject.

> ***Motion:*** The Chair entertained a motion to initiate rulemaking regarding a physician's obligation to retain and provide medical records. The motion was approved unanimously.

5.4 Lists & Labels Request

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)).

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- Agility COHE SPC

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

- Oregon Chapter American College of Cardiology

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

- Pacific Lutheran University

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

- University of Washington School of Nursing

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

7.0 Public Comment

Jodi Rook, PA, provided comments.

8.0 Policy Committee Report

Dr. Karen Domino, Policy Committee Chair, reported on the items discussed at the Policy Committee meeting held on March 3, 2022:

Proposed Interpretive Statement: Establishing Approval Criteria for Defining Appropriate Medical Practices for IMG Nomination

Dr. Domino stated this document had been approved previously to be sent for Secretary review. It was returned with some minor edits, as seen on the document in the packet. Dr. Domino reported the Committee recommended approval of the revised document.

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

Proposed Policy: Discrimination in Health Care

Dr. Domino stated that this document had been reviewed previously and a workgroup was formed to improve the language. Dr. Domino stated that the Committee made a few minor changes to the revised document and she presented those changes. Dr. Domino reported the Committee recommended approval of the revised document.

Motion: The Chair entertained a motion to approve the policy as revised to be sent for Secretary review. The motion was approved unanimously.

Proposed Guideline: Termination of the Practitioner-Patient Relationship

Dr. Domino stated that this document had been reviewed previously and a workgroup was formed to improve the language. Dr. Domino stated that the document as revised by the workgroup was available in the packet. Dr. Domino reported the Committee recommended approval of the revised document.

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

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Policy: Self-Treatment or Treatment of Immediate Family Members
Dr. Domino stated that this document had been reviewed previously. Dr. Domino presented the proposed revisions. Dr. Domino reported the Committee recommended approval of the revised document.

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

9.0 Member Reports

Yanling Yu, PhD, Public Member, reported that she and her husband were awarded Jacksonville University's Robert L. Wears Patient Safety Leadership Award.

Claire Trescott, MD, reported that the Executive Committee has asked Executive Director, Melanie de Leon, to look into the cost of providing UpToDate and other resources for Commissioners reviewing cases. Jim Anderson, PA, stated that a tool available to practitioners as part of their licensing fees is DynaMed.

10.0 Staff Reports

Micah Matthews, Deputy Executive Director, stated that the 2022 legislative session is coming to a close. He reported the WMC will likely not be impacted by any of the bills that have passed. He wanted to make the Commissioners aware of Substitute Senate Bill (SSB) 5753, an act relating to enhancing the capacity of health profession boards, commissions, and advisory committees. He stated that the revised bill will make executive director employment more uniform across the boards and commissions of the Department of Health.

11.0 AAG Report

Heather Carter, AAG, gave a brief introduction of herself for the benefit of the new Commissioners.

12.0 Adjournment

The Chair called the meeting adjourned at 9:16 am.

Submitted by

Amelia Boyd, Program Manager

John Maldon, Public Member, Chair
Washington Medical Commission

Approved April 15, 2022

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July 2023

Sun	Mon	Tue	Wed	Thu	Fri	Sat
						1
2	3	4 Independence Day Office Closed	5	6 **Approved Meeting Dates**	7	8
9	10	11	12	13 **Proposed Meeting Dates**	14	15
16	17	18	19	20	21	22
23	24	25	26	27	28	29
30	31					

July 04 Independence Day

WASHINGTON Medical Commission
Licensing. Accountability. Leadership.

Committee/Workgroup Reports: April 2022

Reduction of Medical Errors Workgroup – Chair: Dr. Chung
Staff: Mike Farrell

The committee needs to meet to discuss recent developments and to set a plan for 2022.

Annual Educational Conference Workgroup – Chair: Toni Borlas
Staff: Jimi Bush

It has been decided to hold a virtual learning series in lieu of an in-person conference this year.

Holding a virtual conference can be expensive, to contract with a hosting company, so in order to save money and accommodate a variety of schedules, we are going to continue to hold webinars. The goal is to have at least a monthly webinar that is worth CME credits. Here is what I have planned:

Summer CME – Addiction Medicine

1. June: DEA Update
2. July: Washington Society for Addiction Medicine - Addressing the ubiquity of the fentanyl-driven "3rd wave" of the opioid crisis.
3. August:
   - Treating co-occurring chronic pain and SUD.
   - Treatment of separate SUDs such as alcohol, stimulants, and benzodiazepines.

Fall CME: Lessons for Primary Care

1. September: Enabling positive practice improvement through data-driven feedback: A model for understanding how data and self-perception lead to practice change

In Planning

1. Infectious disease in the aftermath of COVID.
2. What do patients lie to their doctor about?
3. How racism creates a systems issue in healthcare.
4. Doctor patient communication.
5. Restorative Justice.

If you have additional speaker suggestions, please let Jimi know.

Webinars During COVID

We began a virtual learning series in July of 2020. Since then, we have executed 15 webinars and provided 1346 Category 1 CME credits on a variety of topics. By comparison – in 2019 we issued 1199 CME credits at the annual (in-person) conference.

Osteopathic Manipulative Therapy Workgroup – Chair: None at this time Staff: Micah Matthews
No activity since 2020. Executive Committee needs to discuss recommendation to continue or disband.

Healthcare Disparities Workgroup – Chair: Dr. Currie Staff: Melanie de Leon
Awaiting the final approval of the Discrimination Policy by Office of the Secretary.

Committees & Workgroups

WASHINGTON Medical Commission
Licensing. Accountability. Leadership.

Executive Committee
John Maldon, Public Member, Chair
Dr. Trescott, 1st Vice Chair
Dr. Chung, 2nd Vice Chair
Dr. Domino, Policy Committee Chair
Dr. Roberts, Immediate Past Chair
Melanie de Leon
Micah Matthews
Heather Carter, AAG

Policy Committee
Dr. Domino, Chair (B)
Dr. Roberts (B)
Christine Blake, Public Member (B)
Jim Anderson, PA-C (A)
John Maldon, Public Member (B)
Scott Rodgers, Public Member (A)
Dr. Trescott (B)
Heather Carter, AAG
Melanie de Leon
Mike Farrell
Amelia Boyd

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

Legislative Subcommittee
Dr. Roberts, Chair
John Maldon, Public Member
Dr. Terman, Pro Tem Commissioner
Christine Blake, Public Member
Dr. Wohns
Melanie de Leon
Micah Matthews

Panel L
John Maldon, Public Member, Chair
Dr. Browne
Dr. Roberts
Christine Blake, Public Member
Dr. Chung
Arlene Dorrough, PA-C
Dr. Trescott
Dr. Barrett, Medical Consultant
Marisa Courtney, Licensing Supervisor
Rick Glein, Director of Legal Services
Pam Kohlmeier, MD, JD, Staff Attorney
Micah Matthews

Finance Workgroup
Dr. Roberts, Immediate Past Chair, Workgroup Chair
John Maldon, Current Chair
Dr. Trescott, 1st Vice Chair
Dr. Chung, 2nd Vice Chair
Melanie de Leon
Micah Matthews
Jimi Bush

Annual Educational Conference Workgroup
Toni Borlas, Chair
Theresa Schimmels, PA-C
Dr. Domino
Jimi Bush, Organizer

Commissioner Education Workgroup
Dr. Domino
Dr. Chung
Dr. Roberts
Toni Borlas, Public Member
Scott Rodgers, Public Member
Dr. Terman, Pro Tem Commissioner
Melanie de Leon
Amelia Boyd
Jimi Bush

Updated: March 24, 2022

Committees & Workgroups

WASHINGTON Medical Commission
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Reduction of Medical Errors Workgroup
Dr. Chung, Chair
John Maldon, Public Member
Dr. Roberts
Dr. Domino
Dr. Jaeger
Christine Blake, Public Member
Scott Rodgers, Public Member
Melanie de Leon
Mike Farrell

Osteopathic Manipulative Therapy Workgroup
Dr. Roberts
Dr. Currie
John Maldon, Public Member
Micah Matthews
Michael Farrell
Amelia Boyd
Heather Carter, AAG

Healthcare Disparities Workgroup
Dr. Currie, Chair
Dr. Browne
Dr. Jaeger
Christine Blake, Public Member
Melanie de Leon

Informed Consent Policy Workgroup
Dr. Roberts
John Maldon, Public Member
Yanling Yu, Public Member
Mike Farrell

Collaborative Drug Therapy Agreements Rulemaking Committee
Dr. Roberts, Chair
Dr. Chung
Dr. Small
John Maldon, Public Member
Tim Lynch, PQAC Commissioner
Teri Ferreira, PQAC Commissioner
Melanie de Leon
Micah Matthews
Kyle Karinen, Staff Attorney
Amelia Boyd
Heather Carter, AAG
Christie Strouse, Deputy Director, PQAC
Lindsay Trant, DOH Rules Coordinator

Opioid Prescribing – Patient Exemptions Rulemaking Committee
Dr. Roberts, Chair
Dr. Small
Dr. Terman, Pro Tem Commissioner
James Anderson, PA-C
Melanie de Leon
Mike Farrell
Amelia Boyd
Heather Carter, AAG

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

Updated: March 24, 2022

WMC Rules Progress Report								Projected filing dates		
Rule	**Status**	**Date**	**Next step**	**Complete By**	**Notes**	**Submitted in RMS**	**SBEIS Check**	**CR-101**	**CR-102**	**CR-103**
Opioid Prescribing - LTAC, SNF patient exemption	CR-102 Filed	2/16/2022	Hearing - to be rescheduled from 4/13/2022	5/27/2022				Complete	Complete	May 2022
Collaborative Drug Therapy Agreements (CDTA)	CR-101 filed	7/22/2020	Workshops	TBD				Complete	TBD	TBD
Emergency Licensing Rules	Secretary Review	3/26/2020	File CR-105	TBD	Holding until proclamation is lifted.					
SB 6551 - IMG licensing	CR-102 Approved	3/4/2022	File CR-102	April 2022				Complete	April 2022	TBD
Medical Records	CR-101 Approved	3/4/2022	File CR-102	September 2022				Sept. 2022	TBD	TBD

Updated: 3/29/2022

Washington State Department of Health
Health Professions Quality Assurance

Application for Approval to Receive Lists

This is an application for approval to receive lists, not a request for lists. You may request lists after you are approved. Approval can take up to three months.

RCW 42.56.070(8) limits access to lists. Lists of credential holders may be released only to professional associations and educational organizations approved by the disciplining authority.

- A "professional association" is a group of individuals or entities organized to:
  - Represent the interests of a profession or professions;
  - Develop criteria or standards for competent practice; or
  - Advance causes seen as important to its members that will improve quality of care rendered to the public.
- An "educational organization" is an accredited or approved institution or entity which either
  - Prepares professionals for initial licensure in a health care field or
  - **Provides continuing education for health care professionals.**

☐ We are a "professional association" ☒ We are an "educational organization."

Ron Wilcox DC	360.481.5209	info@agilitycohe.org
Primary Contact Name ⮥	Phone ⮥	Email ⮥

Additional Contact Names (Lists are only sent to approved individuals) ⮥	Website URL⮥
Agility COHE SPC	87-4216481
Professional Assoc. or Educational Organization ⮥	Federal Tax ID or Uniform Business ID number ⮥
401 Broadway Suite 100	Tacoma WA 98402
Street Address ⮥	City, State, Zip Code ⮥

We would like to acquire contact information (preferably emails, names, location and organizations) to send a survey to licensed eligible providers in WA to determine who might be interested in joining a Center of Occupational Health & Education (COHE) in response to an upcoming contract request by L&I. Services are free and are focused on providing occupational health best practice education and health service support. More information can be found at https://lni.wa.gov/patient-care/provider-partnership-best-practices/centers-of-occupational-health-education-cohe.

1. How will the lists be used? ⮥

Advanced Registered Nurse Practitioners (ARNP), Chiropractor (DC), Naturopathic Physician, Osteopathic Physician & Physician Assistants, Physicians, Physician Assistants, and Podiatric Physicians.

2. What profession(s) are you seeking approval for? ⮥

Please attach information that demonstrates that you are a "professional association" or an "educational organization" and a sample of your proposed mailing materials.
Attach completed application to your recent list request using the public portal:
https://www.doh.wa.gov/aboutus/publicrecords

Alternate options: Email to: PDRC@DOH.WA.Gov Mail to: PDRC - PO Box 47865 - Olympia WA 98504-7865

Signature ⮥ Date ⮥

If you have questions, please call (360) 236-4836.

For Official Use Only

Authorizing Signature: _____

Approved: _____ (5-year) _____ (one-time) Printed Name: _____

Denied: _____ Title: _____ Date: _____

From: Agility COHE
To: Boyd, Amelia (WMC)
Subject: Re: Application for an Organization to Receive lists
Date: Wednesday, January 12, 2022 2:32:11 PM
Attachments: image004.png
image005.png

External Email

Thank you for your clarification.
We are hoping to do an email campaign to the list of providers and the survey being sent is as follows: https://www.cognitoforms.com/AgilityCOHE/DOHProviderQuestionnaire
We had not planned on a mailing as there is limited time before the contract proposal deadline. If mailing is the only option, we can design and submit something to you prior to 2/18 as requested; However, it may be post the RFP submittal deadline and therefore only necessary if the contract is awarded come July 1 2022 at which time we can re-request.
Thank you in advance for helping us work through this!

On Wed, Jan 12, 2022 at 2:18 PM Boyd, Amelia (WMC) <Amelia.Boyd@wmc.wa.gov> wrote:

> Good afternoon,
>
> We have received your request to receive lists, attached. In the application it states, "Please attach information that demonstrates that you are a "professional association" or an "educational organization" and **a sample of your proposed mailing materials**." Please respond to this email with that information included/attached by February 18, 2022 in order for your application to be reviewed at the WMC's March 4, 2022 Commission meeting.
>
> WASHINGTON Medical Commission
> Licensing. Accountability. Leadership.
>
> Amelia Boyd, BAS
> Program Manager
> Washington Medical Commission
> Mobile: (360) 918-6336
>
> Were you satisfied with the service you received today? Yes or No

--
Thank you for your time!
Agility COHE S.P.C.

Agility COHE

Agility COHE SPC, a Washington social purpose corporation

3/23/2022

RECEIVED

MAR 28 2022

MEDICAL COMMISSION

Washington Medical Commission
ATTN: Amelia Boyd
PO Box 47866
Olympia, WA 98504-7866
and
Washington Department of Health
Adjudicative Clerk Office
PO Box 47879
Olympia, WA 98504-7879

To Whom it may Concern:

This is a request for a hearing based on the Commission's intent to deny Agility COHE SPC as an educational organization.

The decision is incorrect as we failed to supply appropriate demonstrations in the initial request. The survey example was a reflection of material used to identify continuing education interest areas instead of material we would utilize for health care professional continuing education.

Attached to this letter is an example of education provided in conjunction with the Department of Labor & Industries with regard to health care professionals determining work relatedness on L&I patient claims. A second example is the initial orientation material presented to Centers of Occupational Health & Education (COHE) enrolled providers to introduce occupational health best practices.

As the primary mission of COHE is education for providers who treat workers compensation patients, Agility COHE SPC fits the definition of an educational organization and RCW 42.56.070(9) allows an appeal for the decision.

Thank you for the opportunity to appeal,

Ron Wilcox
Agility COHE SPC
401 Broadway, Suite 100
Tacoma, WA 98402
info@agilitycohe.org

Attached: Worker Relatedness L&I presentation
COHE Orientation example for occupational health best practice education

Washington State Department of
Labor & Industries

Work Relatedness

Created in part by the
Industrial Insurance Chiropractic
Advisory Committee

Washington State Department of
Labor & Industries

Work-Relatedness

- What is work-relatedness
- How to determine work-relatedness
- How to document work-relatedness
- Why this is important for both the provider and the patient

Washington State Department of
Labor & Industries

Work-Relatedness

- You, the Attending Provider find that:
  - "But For"
  - Greater Than 50%
  - Can Make The Determination Later
  - Determined By The Claim Manager

Washington State Department of
Labor & Industries

Work-Relatedness

- Importance of Work-Relatedness
  - Condition must arise out of work
  - timely care or return to work
    - (eg, job modifications, time loss benefits)
  - Medical, legal, employment and administrative issues

Washington State Department of
Labor & Industries

Work-Relatedness

- **Administrative/legal** may issues include:
  - Where the injury/exposure occurred.
  - In the case of occupational disease (such as asbestos), exposure from previous employers may factor in to apportioning responsibility to employers.

Washington State Department of
Labor & Industries

Work-Relatedness

- How to determine work-relatedness?
  - Patient History, History, History!
    - Thorough documentation of relationship of work activity to onset of the presenting complaint is critical.
    - A careful occupational history, including previous employers when relevant is important.
    - Case must be made for a reasonable cause and effect relationship, on a greater than 50% basis.

Washington State Department of
Labor & Industries

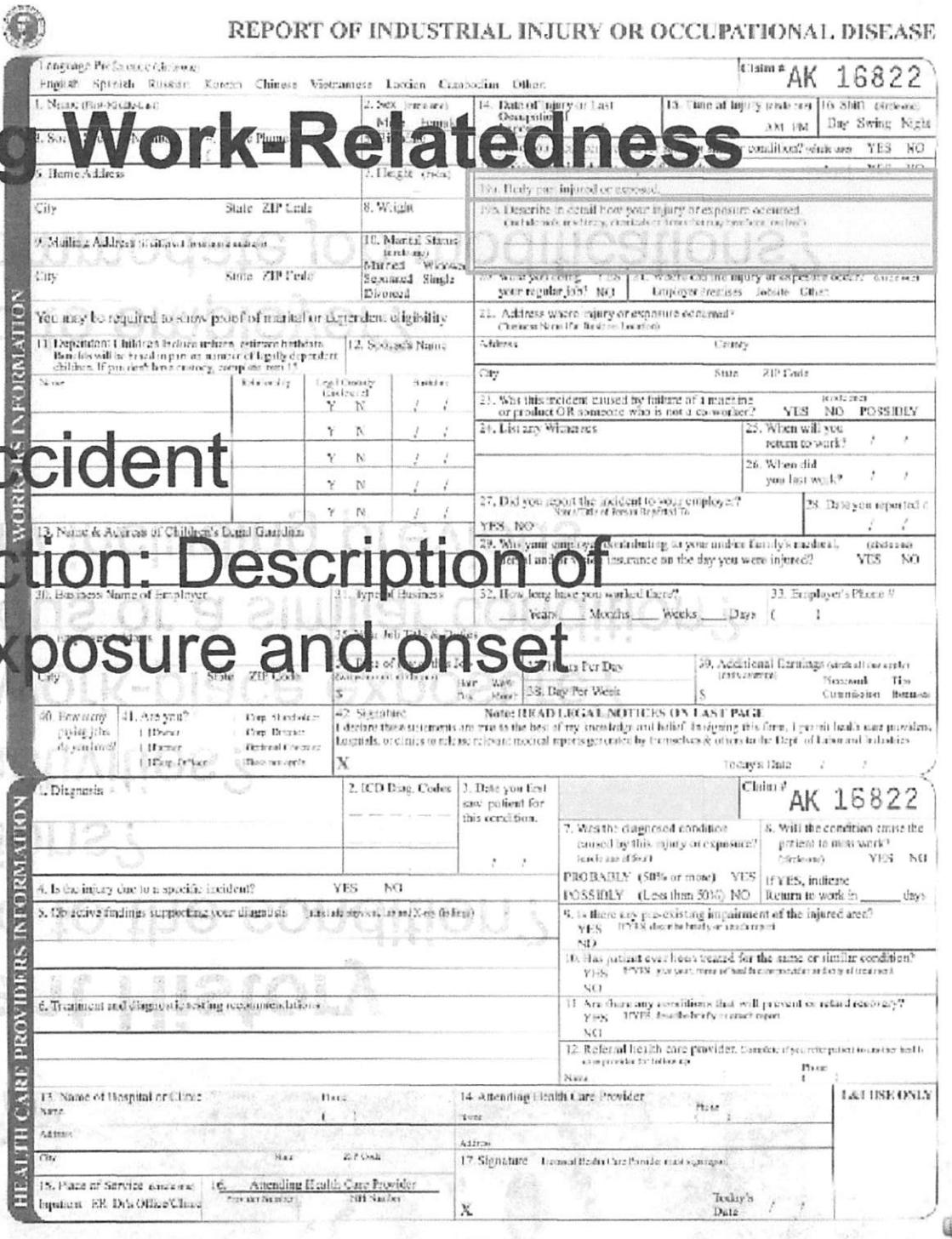
Patient History

- What has contributed to the condition?
  - Pre-existing conditions?
  - Non-work related activities?
  - Timing of onset to work-place exposure?
  - Prior care for previous or a similar condition?
  - Occupational history including previous employers
- Employer Contact
  - Was injury reported to employer?
  - Can employer accommodate job modifications?

Documenting Work-Relatedness

Injured Worker Section

- Report of Accident
  - Worker section: Description of accident/exposure and onset



REPORT OF INDUSTRIAL INJURY OR OCCUPATIONAL DISEASE

Claim # AK 16822

WORKER'S INFORMATION

HEALTH CARE PROVIDERS INFORMATION

Claim # AK 16822

I. & I. COPY

Report of Accident (Workplace Injury, Accident or Occupational Disease)

Claim No. AS 76202

Documenting Work-Relatedness

Injured Worker Section: Report of Accident

- Worker section: Description of accident/exposure and onset

Worker Information

Language preference (check one)
☐ English ☐ Spanish ☐ Russian ☐ Korean ☐ Chinese ☐ Vietnamese ☐ Laotian ☐ Cambodian ☐ Other: _____

Name (First, Middle, Last) | 2. Male ☐ Female | 4. Date of injury or first occupational exposure / / | 5. Time of injury ____ ☐ AM ☐ PM | 6. Shift (check one) ☐ Day ☐ Swing ☐ Night

3. Social Security Number | 4. Home phone ( ) | 5. Birth date month / day / year

Mailing address | 7. Height (Ft-In.) _

City | State | ZIP Code | 8. Weight

9. Mailing address (if different from home address)

City | State | ZIP Code

10. Family status:
☐ Married ☐ Widowed
☐ Separated ☐ Single
☐ Divorced
☐ Registered domestic partnership

Dependent Information

Dependent eligibility *You may be required to show proof of marriage, domestic partnership registration, or dependent eligibility.*

11. Dependent children Include unborn/ estimate birth date. Benefits will be based in part on number of children reported. If you don't have legal custody, complete box.

Name	Relationship	Legal Custody	Birth date
		☐ YES ☐ NO	/ /
		☐ YES ☐ NO	/ /
		☐ YES ☐ NO	/ /
		☐ YES ☐ NO	/ /
		☐ YES ☐ NO	/ /

12. Name of Spouse or Registered Domestic Partner:

13. Name & address of children's legal guardian
Name | Address

City | State | ZIP Code

Your Injury Information

17. Have you ever been treated for the same or similar condition? ☐ YES ☐ NO

18. Is this condition due to a specific incident? ☐ YES ☐ NO

19a. Body parts injured or exposed:

19b. Describe in detail how your injury or exposure occurred.
(Include tools, machinery, chemicals or fumes that may have been involved)

20. Were you doing your regular job? ☐ YES ☐ NO

21. Where did the injury or exposure occur?
☐ Employer Premises ☐ Jobsite ☐ Other: _____

22. Where did the injury/exposure occur? Name of business:
Address | City | County | State | ZIP

23. Injury caused by a faulty machine, product or person other than my employer while I was at work? ☐ YES ☐ NO ☐ POSSIBLY

24. List any witnesses:

25. When will you return to work? / /

26. When did you last work? / /

27. Did you report the incident to your employer? ☐ YES ☐ NO
If "yes" write name and title:

28. Date you reported it: / /

29. Did you have employer-paid health care benefits on day injured? ☐ YES ☐ NO

Employer Information

30. Business name of your employer

31. Type of business

32. How long have you worked there?
____ Years ____ Months ____ Weeks ____ Days

33. Employer's phone ( )

34. Your employer's address

City | State | ZIP Code

35. List your job title and describe your job duties

36. Rate of pay at this job (check one) ☐ Hour ☐ Week ☐ Day ☐ Month ☐ More than 1 rate of pay
$

37. Hours per day

38. Days per week

39. Additional earnings (check all that apply) (daily average)
☐ Piecework ☐ Tips ☐ Regular overtime ☐ Shift diff. ☐ Commission ☐ Bonuses in the last 12 months
$

40. How many paying jobs do you have?

41. I am a:
☐ Owner ☐ Partner ☐ Corp. Officer
☐ Corp. Shareholder ☐ Corp. Director ☐ Optional Coverage ☐ Does not apply to me

42. Signature

Note: READ LEGAL NOTICES ON THE WORKER'S COPY OF THIS FORM

I declare these statements are true to the best of my knowledge and belief. In signing this form, I permit health care providers, hospitals, or clinics to release relevant medical reports, which they or others produce, to the Dept. of Labor & Industries.

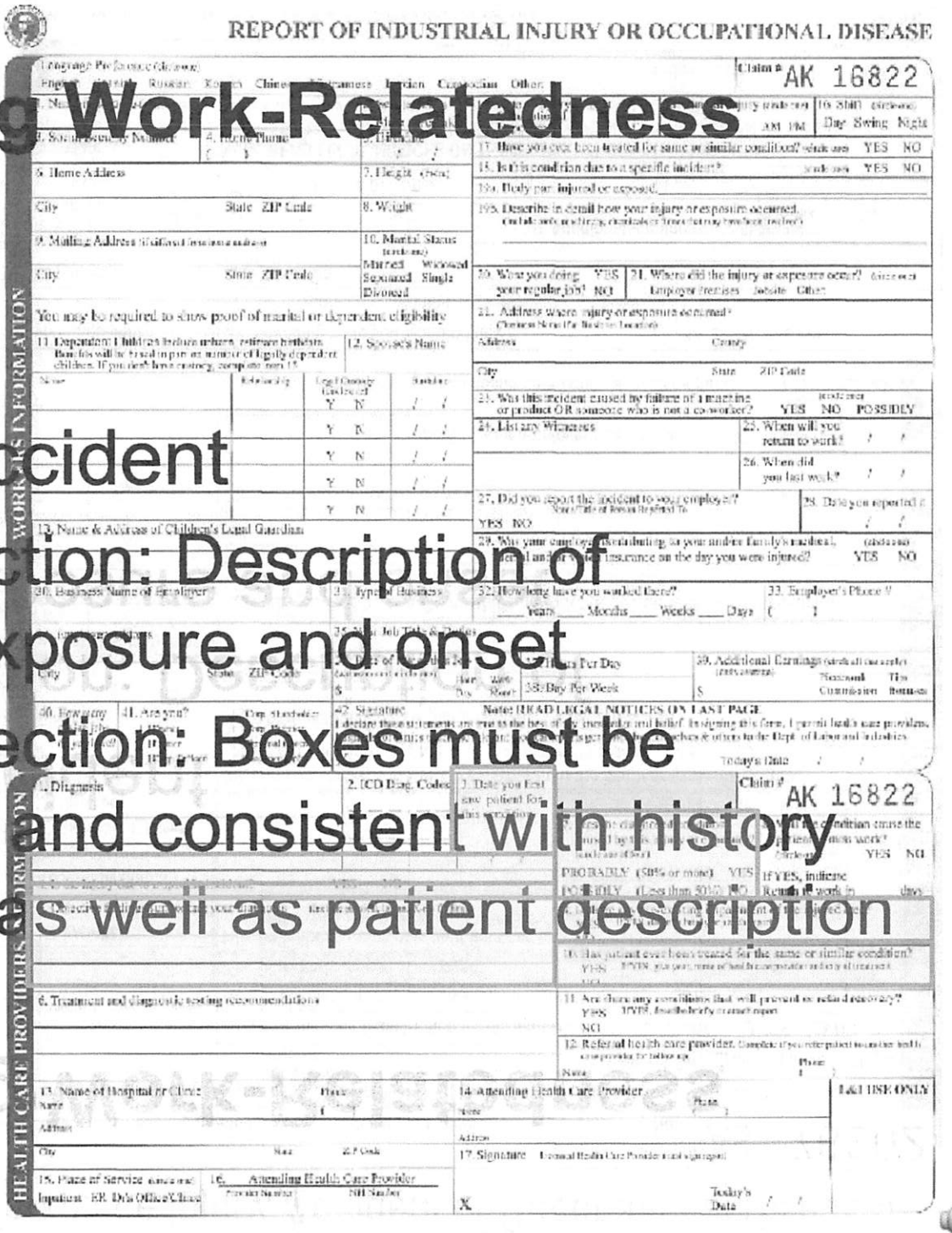
X

Today's date / /

Documenting Work-Relatedness

- Report of Accident
  - Worker section: Description of accident/exposure and onset
  - Provider section: Boxes must be completed and consistent with history and exam as well as patient description

Provider Section


REPORT OF INDUSTRIAL INJURY OR OCCUPATIONAL DISEASE

WORKER'S INFORMATION

HEALTH CARE PROVIDER'S INFORMATION

Claim # AK 16822

I & I COPY

Washington State Department of
Labor & Industries

Work-Relatedness

- Determining work relatedness is very important for good claim flow, which allows for expeditious treatment of injured workers.
- Making sure both the injured worker and you, the attending provider, fully complete your sections of the Report Of Accident helps assure, the claims manager has the necessary information to make a correct determination

Washington State Department of
Labor & Industries

Work-Relatedness

More information can be found at the Department of Labor and Industries website:

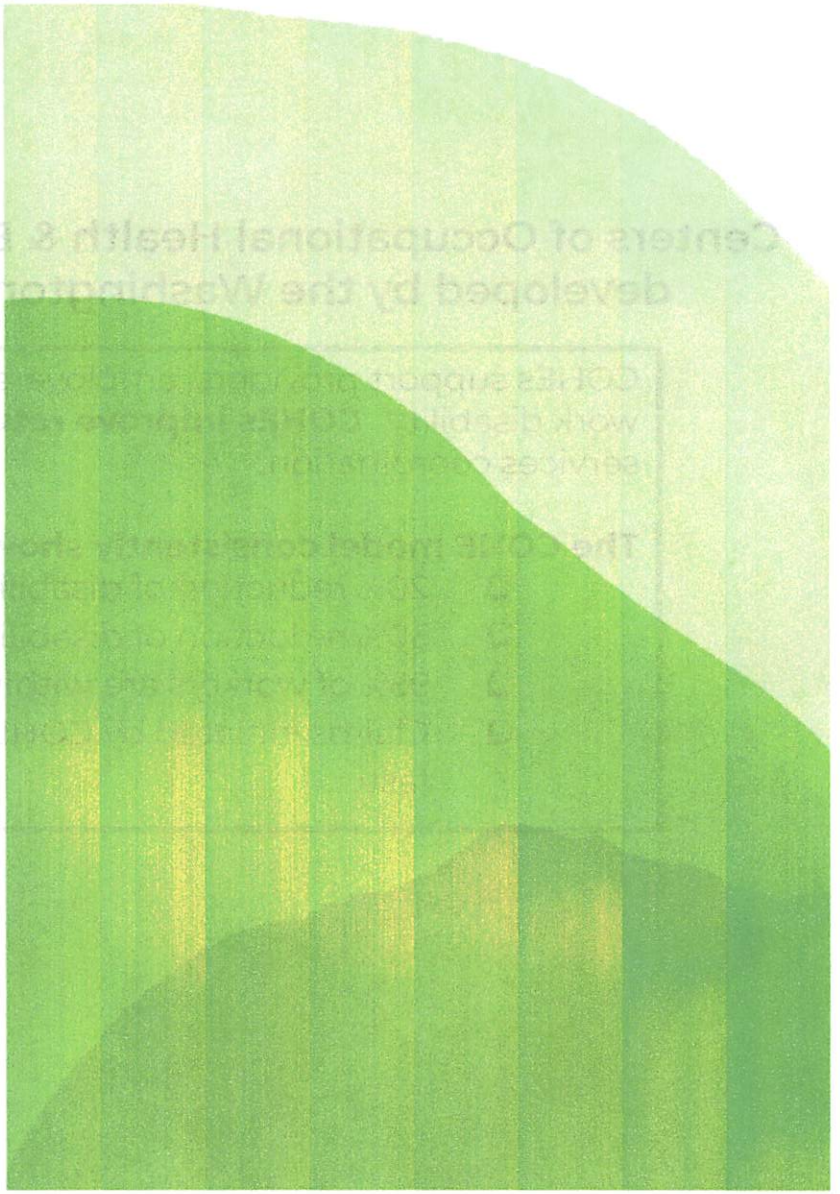
www.Lni.wa.gov

Thank you

Agility COHE

Agility COHE SPC, a Washington social purpose corporation

Provider Orientation



Centers of Occupational Health & Education (COHEs) are a community-based program developed by the Washington State Department of Labor & Industries (L & I).

COHEs support providers, employers, and workers to ensure timely intervention and prevent work disability. **COHEs improve return to work outcomes** through education and health services coordination.

The COHE model consistently shows a positive impact to include:

- ❑ 20% reduction of disability at 1 year.
- ❑ 30% reduction of disability for back injuries at 1 year.
- ❑ 95% of workers are within 15 miles of an occupational health best practice provider.
- ❑ Claims initiated by COHE enrolled providers adjudicate approximately 15 days faster.

TYPES of WORKER COMPENSATION CLAIMS

Before learning more about COHEs, it is important to note there are three types of Worker Compensation Payers regularly encountered:

1. **Washington State Department of Labor & Industries (L&I) State Fund Claims**
Approximately 2/3 of Washington employers and employees pay into a centralized state funded system for worker compensation benefits. A Report of Accident (ROA) form is used to initiate a claim. L&I reimburses providers for services rendered. **Currently, L&I only contracts COHE services for State Funded workers' compensation claims.** https://lni.wa.gov/claims/

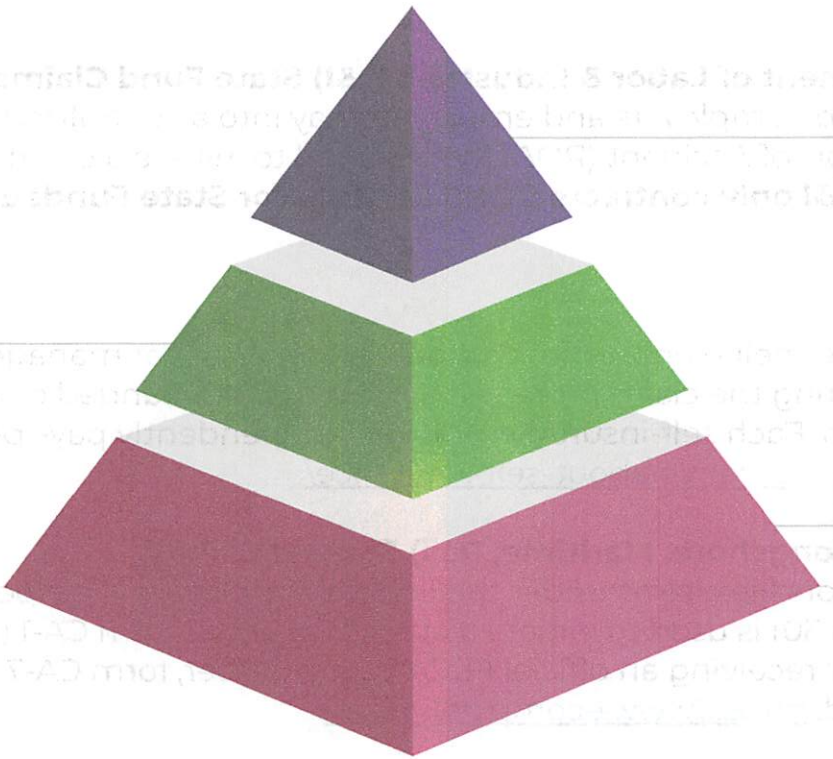
2. **Self-Insured Claims**
Self-Insured employers manage their own worker compensation claims or manage them through a third-party administrator (TPA) while ensuring the claim process is similar to State Funded coverage. Provider Incident Reports (PIR) are used to initiate a claim. Each self-insured employer independently pays providers for services rendered. https://lni.wa.gov/insurance/self-insurance/about-self-insurance/

3. **U.S. Government (OWCP, Longshore, Maritime, Rail) Federal Claims**
Federal Employees or Contractors file claims under the Federal Employees' Compensation Act (FECA). Depending upon the agency, OSHA's Form 301 is used to initiate a claim and either form CA-1 (for traumatic injury) or form CA-2 (for occupational disease). After receiving an official FECA case number, form CA-7 (Claim for Compensation) is used to be paid for services rendered. https://www.ecomp.dol.gov/#/

What do COHEs do?

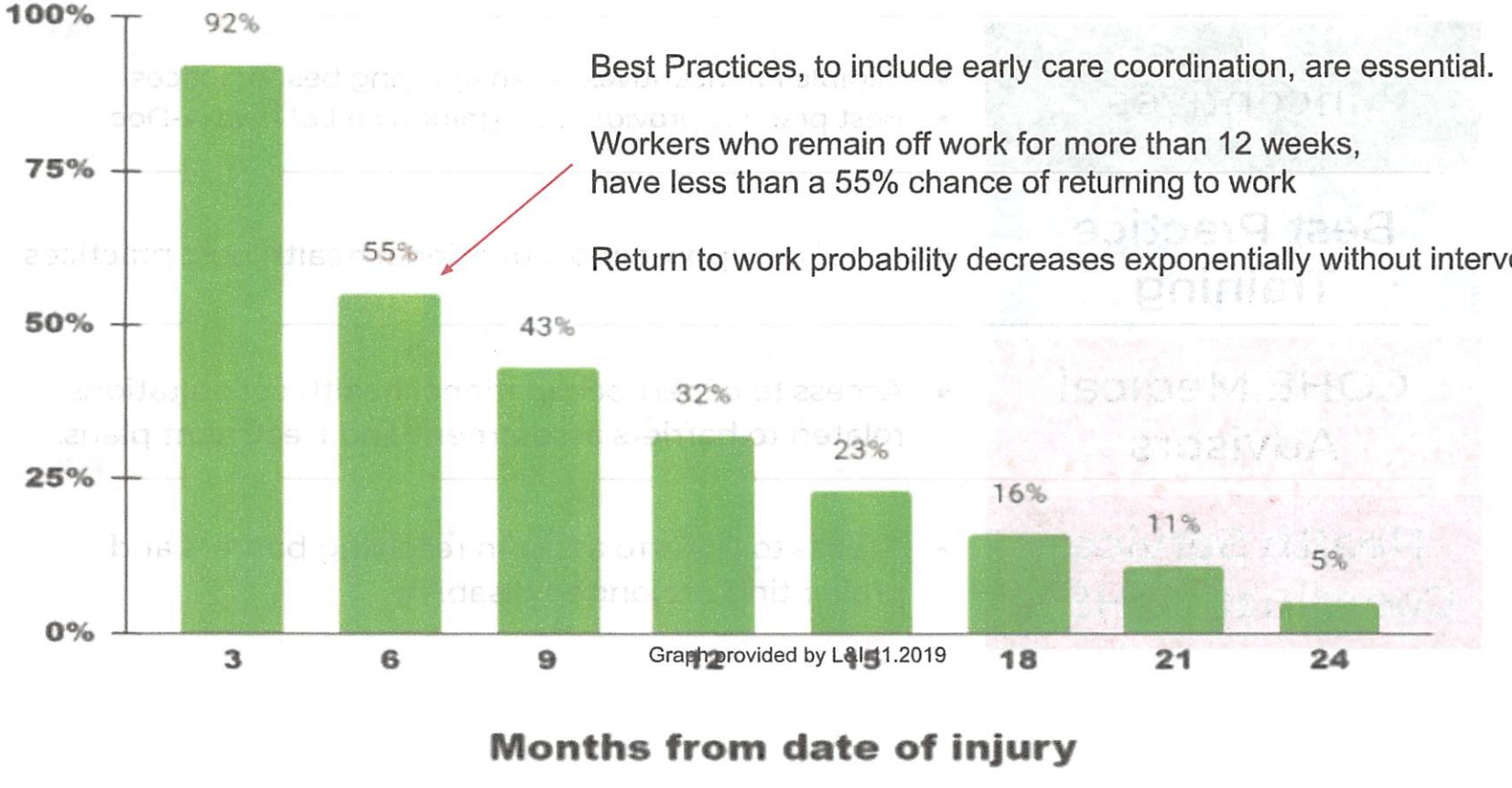
Goal
Provide resources and support for workers, employers and providers navigating Washington State Labor & Industries (L&I) Workers' Compensation claims to prevent disability and promote return to work.

Focus
Educate providers and staff with regard to Occupational Health Best Practices to prevent disability



Foundation
Provide care coordination services on claims for improved return to work outcomes. Services are available up to 12 months from claim established date as needed.

Why do COHEs exist?



Best Practices, to include early care coordination, are essential.

Workers who remain off work for more than 12 weeks, have less than a 55% chance of returning to work

Return to work probability decreases exponentially without intervention.

Graph provided by L&I 1.2019

Why do Providers join COHE?

Incentives	• Eligible for incentives when applying best practices. • Best practice provider recognition on L&I Find-A-Doc.
Best Practice Training	• Receive support in occupational health best practices.
COHE Medical Advisors	• Access to expert occupational health consultations related to barriers assessment and treatment plans.
Health Services Coordinator (HSC)	• Access to HSCs to assist in resolving barriers and preventing prolonged disability.

The Health Services Coordinator (HSC) Role

- HSCs provide early intervention services, up to 12 months, to resolve barriers and reduce prolonged disability for improved claim outcomes.

- HSCs assist Workers, Employers and Providers in navigating worker compensation systems and resources. All parties can call the HSC directly for help to:
  - Educate stakeholders on resources and best practices.
  - Expedite claim adjudication.
  - Monitor Treatment Plan follow up.
  - Assist with return to work efforts.
  - Obtain medical records or facilitate documentation paperwork.
  - HIPAA Privacy Rules are exempt for workers' compensation; therefore patient claim related PHI can be released to the HSC.

- Contact your HSC when you need:
  - ✔ Assistance with a challenging claim.
  - ✔ Answers regarding L&I paperwork or process.
  - ✔ Answers related to the employer or patient care collaboration.

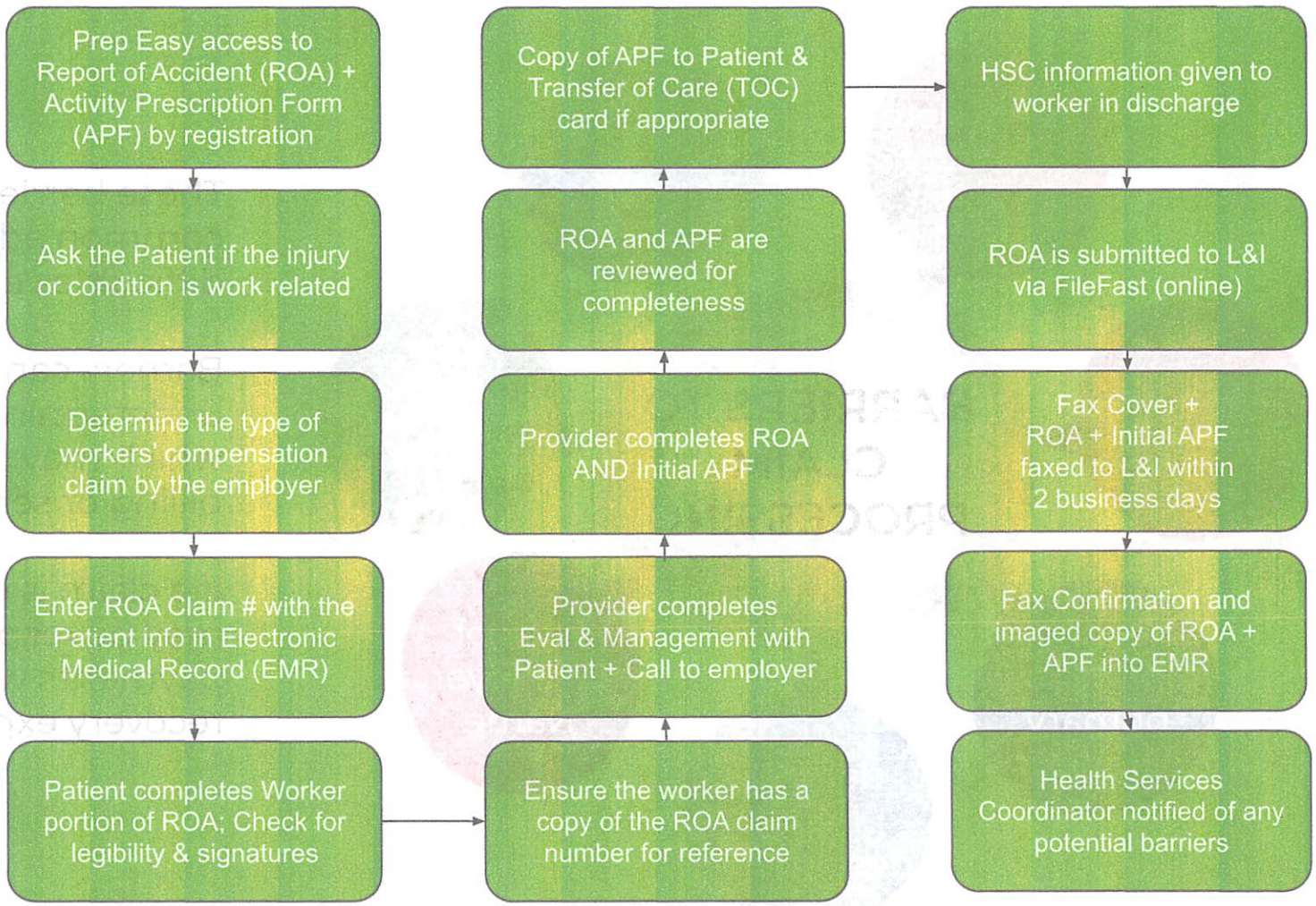
COHE Best Practices

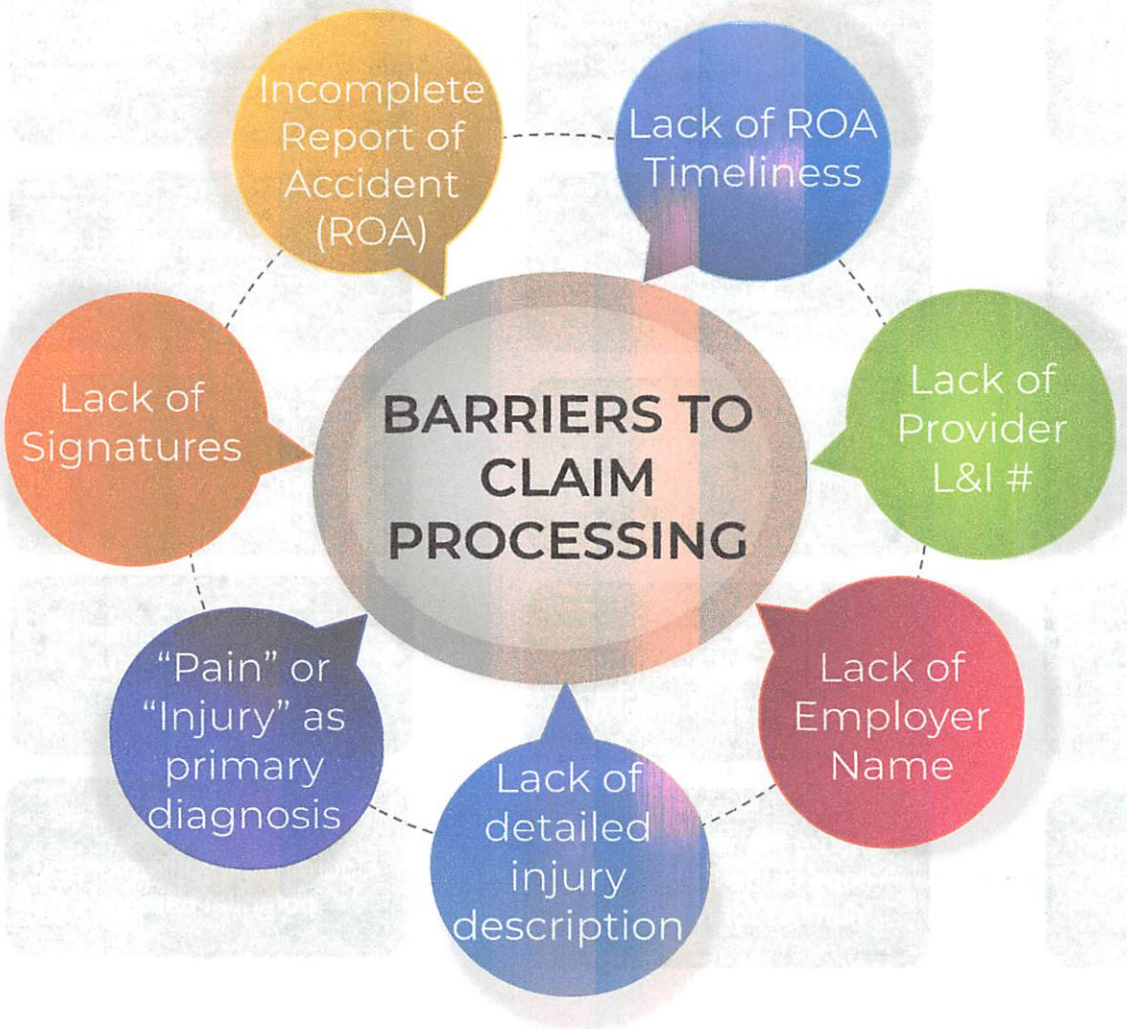
1. Complete & Timely Report of Accident (ROA) *
2. Complete & Timely Activity Prescription Form (APF) *
3. Two-way Communication with Employer
4. Assess Claim Barriers & Identify Treatment Plan
5. Adhere to L&I Opioid Management Guidelines *

COHE Best Practice Focus for Emergency Care Providers *

Best Practices are important because they impact the claims adjudication.

Based on observations, this is a common example of paperwork flow in medical facilities treating L&I patients.

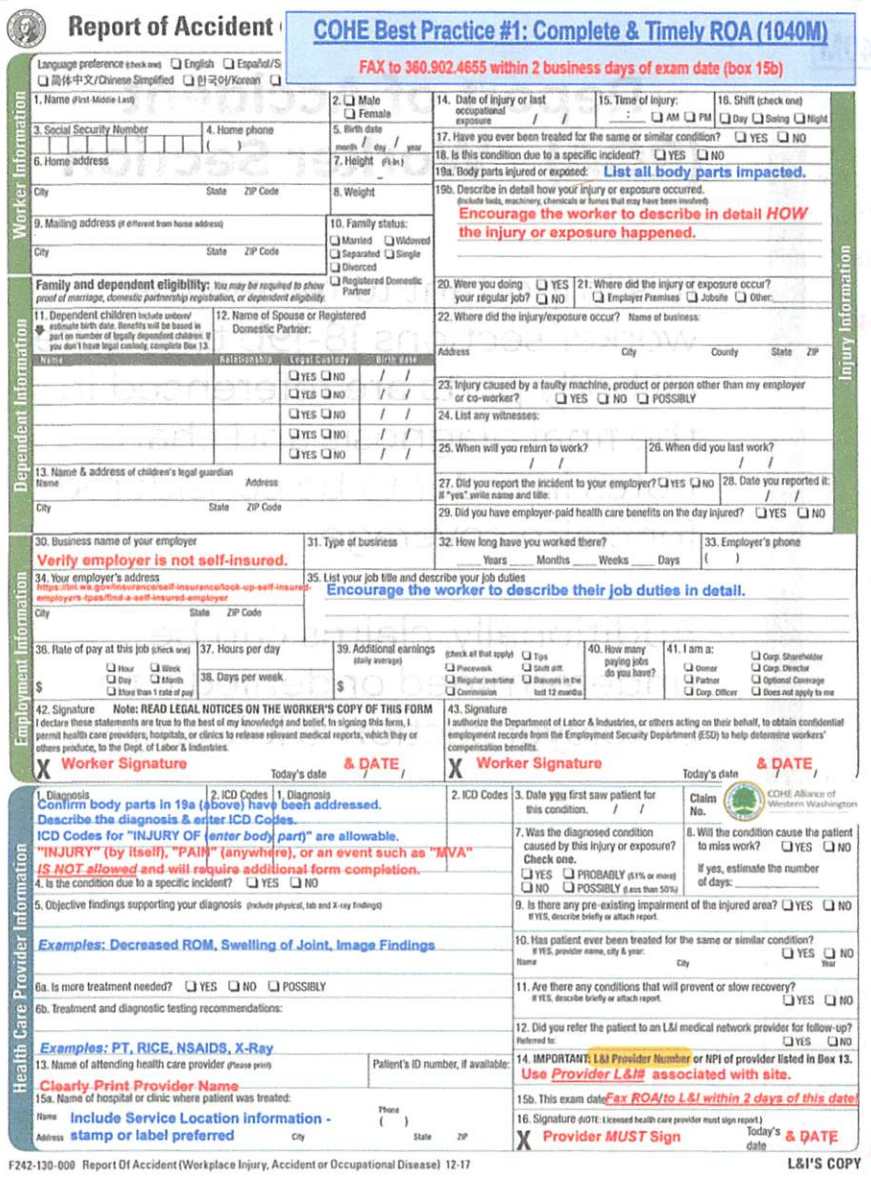




These barriers represent common adjudication difficulties early in a claim.

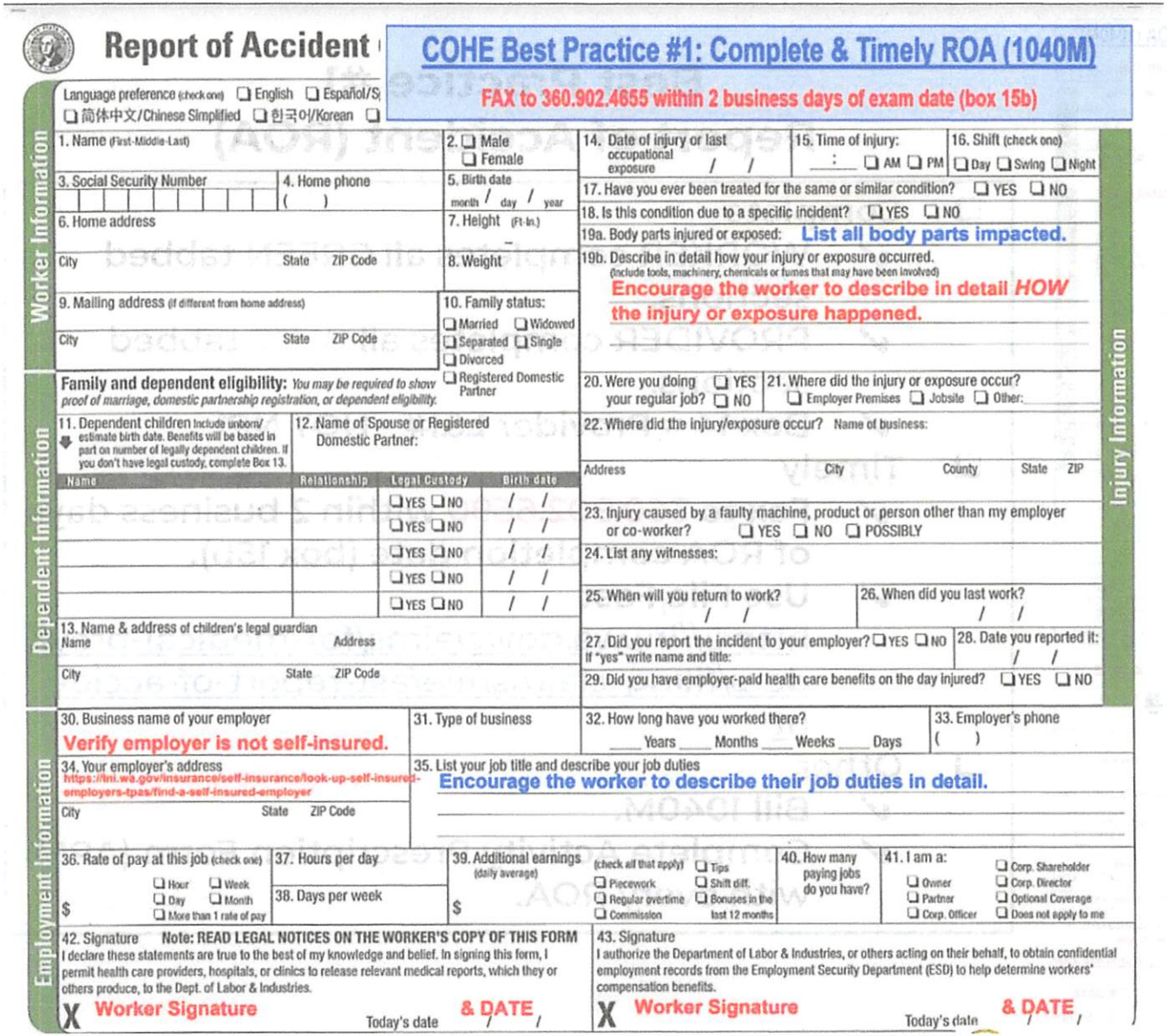
Barriers can lead to undetermined or denied claims which may lead to denied billing or services.

If a claim is denied, the worker may be responsible for payments which impacts their recovery experience.



Best Practice #1
Report of Accident (ROA)

- ❑ **Complete**
  - ✔ WORKER completes all GREEN tabbed sections.
  - ✔ PROVIDER completes all BLUE tabbed sections.
  - ✔ Box 14 = Provider L&I# - NOT NPI.
- ❑ **Timely**
  - ✔ Fax to 360.902.6690 within 2 business days of ROA completion date (box 15b).
  - ✔ Use File Fast https://lni.wa.gov/claims/for-medical-providers/filing-claims/filefast-report-of-accident
- ❑ **Other**
  - ✔ Bill 1040M.
  - ✔ Complete Activity Prescription Form (APF) with every ROA.



Report of Accident

COHE Best Practice #1: Complete & Timely ROA (1040M)

FAX to 360.902.4655 within 2 business days of exam date (box 15b)

Language preference (check one) ☐ English ☐ Español/S ☐ 简体中文/Chinese Simplified ☐ 한국어/Korean ☐

Worker Information

1. Name (First-Middle-Last)
2. ☐ Male ☐ Female
3. Social Security Number
4. Home phone ( )
5. Birth date month / day / year
6. Home address
7. Height (Ft-In.)
City State ZIP Code
8. Weight
9. Mailing address (if different from home address)
10. Family status: ☐ Married ☐ Widowed ☐ Separated ☐ Single ☐ Divorced ☐ Registered Domestic Partner
City State ZIP Code

Dependent Information

Family and dependent eligibility: *You may be required to show proof of marriage, domestic partnership registration, or dependent eligibility.*

11. Dependent children Include unborn/ estimate birth date. Benefits will be based in part on number of legally dependent children. If you don't have legal custody, complete Box 13.
12. Name of Spouse or Registered Domestic Partner:

Name	Relationship	Legal Custody	Birth date
		☐ YES ☐ NO	/ /
		☐ YES ☐ NO	/ /
		☐ YES ☐ NO	/ /
		☐ YES ☐ NO	/ /
		☐ YES ☐ NO	/ /

13. Name & address of children's legal guardian
Name Address
City State ZIP Code

Injury Information

14. Date of injury or last occupational exposure / /
15. Time of injury: : ☐ AM ☐ PM
16. Shift (check one) ☐ Day ☐ Swing ☐ Night
17. Have you ever been treated for the same or similar condition? ☐ YES ☐ NO
18. Is this condition due to a specific incident? ☐ YES ☐ NO
19a. Body parts injured or exposed: **List all body parts impacted.**
19b. Describe in detail how your injury or exposure occurred. (Include tools, machinery, chemicals or fumes that may have been involved)
Encourage the worker to describe in detail *HOW* the injury or exposure happened.
20. Were you doing your regular job? ☐ YES ☐ NO
21. Where did the injury or exposure occur? ☐ Employer Premises ☐ Jobsite ☐ Other:
22. Where did the injury/exposure occur? Name of business:
Address City County State ZIP
23. Injury caused by a faulty machine, product or person other than my employer or co-worker? ☐ YES ☐ NO ☐ POSSIBLY
24. List any witnesses:
25. When will you return to work? / /
26. When did you last work? / /
27. Did you report the incident to your employer? ☐ YES ☐ NO If "yes" write name and title:
28. Date you reported it: / /
29. Did you have employer-paid health care benefits on the day injured? ☐ YES ☐ NO

Employment Information

30. Business name of your employer
Verify employer is not self-insured.
31. Type of business
32. How long have you worked there? ___ Years ___ Months ___ Weeks ___ Days
33. Employer's phone ( )
34. Your employer's address
https://lni.wa.gov/insurance/self-insurance/look-up-self-insured-employers-tpas/find-a-self-insured-employer
City State ZIP Code
35. List your job title and describe your job duties
Encourage the worker to describe their job duties in detail.
36. Rate of pay at this job (check one) $ ☐ Hour ☐ Week ☐ Day ☐ Month ☐ More than 1 rate of pay
37. Hours per day
38. Days per week
39. Additional earnings (daily average) $ (check all that apply) ☐ Piecework ☐ Regular overtime ☐ Commission ☐ Tips ☐ Shift diff. ☐ Bonuses in the last 12 months
40. How many paying jobs do you have?
41. I am a: ☐ Owner ☐ Partner ☐ Corp. Officer ☐ Corp. Shareholder ☐ Corp. Director ☐ Optional Coverage ☐ Does not apply to me

42. Signature **Note: READ LEGAL NOTICES ON THE WORKER'S COPY OF THIS FORM**
I declare these statements are true to the best of my knowledge and belief. In signing this form, I permit health care providers, hospitals, or clinics to release relevant medical reports, which they or others produce, to the Dept. of Labor & Industries.
X **Worker Signature** Today's date **& DATE** / /

43. Signature
I authorize the Department of Labor & Industries, or others acting on their behalf, to obtain confidential employment records from the Employment Security Department (ESD) to help determine workers' compensation benefits.
X **Worker Signature** Today's date **& DATE** / /

Report of Accident (ROA) - Worker Section

It is important to review the worker sections 18-19b to ensure all body parts are referenced in the final diagnosis and chart notes in order to be considered for claim coverage.

Additionally, claims can be undetermined or denied if the employer section is left empty.

Report of Accident (ROA) - Provider Section

Health Care Provider Information

1. Diagnosis | 2. ICD Codes | 1. Diagnosis | 2. ICD Codes

Confirm body parts in 19a (above) have been addressed.
Describe the diagnosis & enter ICD Codes.
ICD Codes for "INJURY OF (*enter body part*)" are allowable.
"INJURY" (by itself), "PAIN" (anywhere), or an event such as "MVA"
***IS NOT allowed* and will require additional form completion.**

4. Is the condition due to a specific incident? ❑ YES ❑ NO

5. Objective findings supporting your diagnosis (Include physical, lab and X-ray findings)

***Examples*: Decreased ROM, Swelling of Joint, Image Findings**

6a. Is more treatment needed? ❑ YES ❑ NO ❑ POSSIBLY

6b. Treatment and diagnostic testing recommendations:

***Examples:* PT, RICE, NSAIDS, X-Ray**

13. Name of attending health care provider (Please print) | Patient's ID number, if available:

Clearly Print Provider Name

15a. Name of hospital or clinic where patient was treated:

Name **Include Service Location information -** Phone ( )

Address **stamp or label preferred** City State ZIP

3. Date you first saw patient for this condition. / /

Claim No.

7. Was the diagnosed condition caused by this injury or exposure? Check one.
❑ YES ❑ PROBABLY (51% or more)
❑ NO ❑ POSSIBLY (Less than 50%)

8. Will the condition cause the patient to miss work? ❑ YES ❑ NO
If yes, estimate the number of days: _____

9. Is there any pre-existing impairment of the injured area? ❑ YES ❑ NO
If YES, describe briefly or attach report.

10. Has patient ever been treated for the same or similar condition? ❑ YES ❑ NO
If YES, provider name, city & year:
Name City Year

11. Are there any conditions that will prevent or slow recovery? ❑ YES ❑ NO
If YES, describe briefly or attach report.

12. Did you refer the patient to an L&I medical network provider for follow-up? ❑ YES ❑ NO
Referred to:

14. **IMPORTANT: L&I Provider Number or NPI of provider listed in Box 13.**
Use *Provider L&I#* associated with site.

15b. This exam date ***Fax ROA to L&I within 2 days of this date!***

16. Signature (NOTE: Licensed health care provider must sign report.)
X **Provider *MUST* Sign** Today's date **& DATE**

F242-130-000 Report Of Accident (Workplace Injury, Accident or Occupational Disease) 12-17

L&I'S COPY

Provider Box 1-3

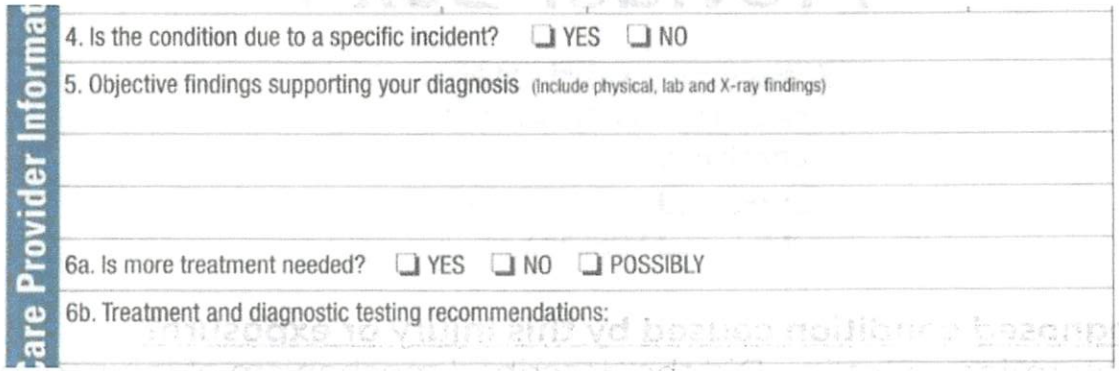
1. Diagnosis	2. ICD Codes	1. Diagnosis	2. ICD Codes	3. Date **you** first saw patient for this condition. / /

DIAGNOSIS & ICD codes (Box 1-2)
The use of "PAIN" anywhere, "INJURY" by itself or an event such as "MVA" is NOT ALLOWABLE as a diagnosis. This will result in delayed claims and denied payments. You may use "Injury of ____" diagnosis (i.e. injury of left knee, injury of right wrist, etc.) but it is best to use specific ICD codes for the injury.

ICD codes ARE REQUIRED when initiating a claim; however, they are reviewed in subsequent treatment and can be adjusted as necessary. Therefore, providers are expected to document the best diagnosis code with description at the time of initiating a claim.

Box 3 Fill in the first date you saw or treated the worker. This can be different than the date of exam (15b) which represents the date the provider is completing the ROA.

Provider Box 4-6



Box 4 & 5 - Specific incident & objective findings

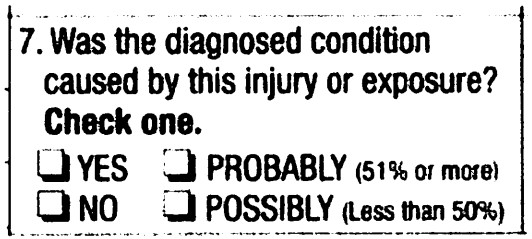
A specific incident = specific date, time, circumstance that caused the injury or condition.

List objective findings to support your diagnosis. Please do NOT indicate "refer to chart note" as L&I relies on the ROA description for claim allowance.

Box 6a & 6b - Treatment recommendations

Check "possibly" if you are uncertain of treatment recommendations. Claims managers will take into account treatment follow up options for the worker with subsequent providers.

Provider Box 7



Box 7 - Was the diagnosed condition caused by this injury or exposure?
This box is to help determine causality. Did the described mechanism of injury or exposure cause the diagnosed condition? Mark "Yes" or "No" when causality is clear.

Mark "Probably" if you are not certain but it is more probable than not. Further medical assessment will be obtained following the initial exam to help the claims manager determine allowance.

Mark "Possibly" if causality is not clear and the worker is requesting a claim be filed. L&I encourages providers to always initiate the claim with a Report of Accident and L&I will determine next steps.

Workers are able to protest a denied claim with further medical to support their claim.

FAILURE TO COMPLETE THIS BOX WILL CAUSE CLAIM & PAYMENT DELAYS.

Provider Box 8-10

8. Will the condition cause the patient to miss work? ❑ YES ❑ NO

If yes, estimate the number of days: _____

9. Is there any pre-existing impairment of the injured area? ❑ YES ❑ NO
If YES, describe briefly or attach report.

10. Has patient ever been treated for the same or similar condition? ❑ YES ❑ NO
If YES, provider name, city & year:
Name City Year

Box 8 - Will the condition cause the patient to miss work?

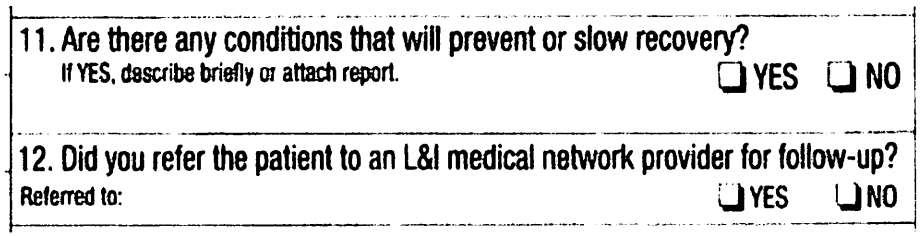
Time off work is only recommended if returning to work would cause harm to the patient. Evidence has shown it is best to return a worker to transitional light duty or fewer hours and reduces work disability better than taking them off more than less than three days.

Staying active is important for recovery. In addition, taking a patient off work for more than three days doesn't always trigger wage replacement and it will impact employer claim premiums.

Box 9 & 10 - Pre-Existing Impairment conditions

These boxes provide information about conditions or injuries in the same area prior to the new injury.

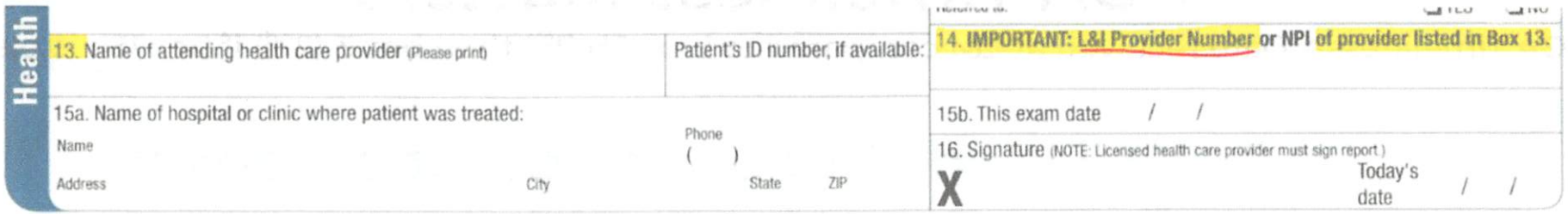
Provider Box 11-12



Box 11 & 12 - Conditions impacting recovery & Follow up Referral for Treatment
Claims managers will not have access to general health conditions and their impact on recovery. It is helpful to note conditions such as diabetes, high blood pressure, etc.

For box 12, if the claim is initiated in an emergency care, please encourage the patient to complete a Transfer of Care (TOC) request to the appropriate primary care or occupational health provider.

Provider Box 13-16



Provider Contact Information and Exam Date:

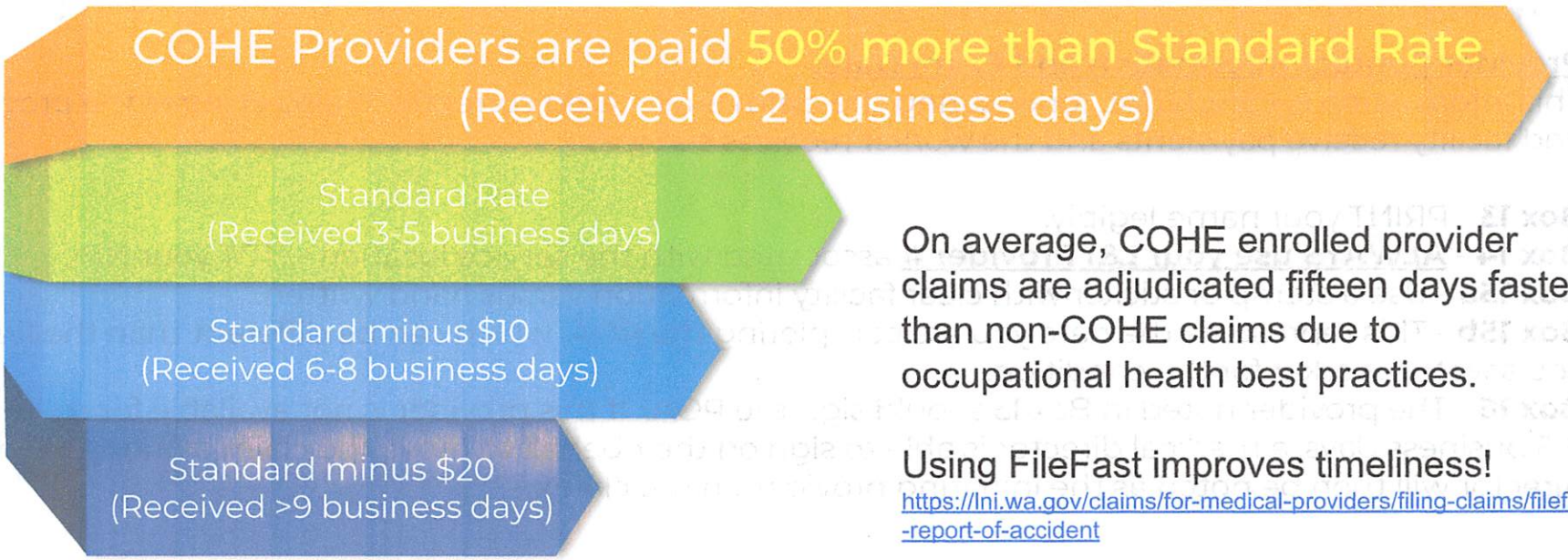
This information is ESSENTIAL for ensuring the claim is allocated correctly. It also ensures the provider and facility receive payments and the worker receives services.

Box 13 - PRINT your name legibly.
Box 14 - **ALWAYS use your L&I Provider #** associated with the service location - NOT your NPI.
Box 15a - Use a stamp or sticker with clear facility information versus hand written.
Box 15b - This represents the date you are completing the ROA, which can be different than the first date you saw the worker for the condition.
Box 16 - The provider noted in Box 13 should sign the ROA. If this provider is not available for more than 3-5 business days, a medical director is able to sign on their behalf to move the claim along. The medical director will then be noted as the initiating provider on the claim.

ROA Timeliness Matters!

ROA Timeliness = Date received at L&I compared to box 15b (1st) then box 3 (2nd) if box 15b is blank.

FILE FAST Adds $10 to any duration below



On average, COHE enrolled provider claims are adjudicated fifteen days faster than non-COHE claims due to occupational health best practices.

Using FileFast improves timeliness!
https://lni.wa.gov/claims/for-medical-providers/filing-claims/filefast-report-of-accident

se the APF to communicate that
ctivity helps Recovery.

learn how to
mplete an APF, go to:
ww.lni.wa.gov/activityRX

COHE Alliance of Western Washington

COHE Best Practice #2:
Complete & Timely
Activity Prescription Form (APF 1073M)
Fax APF with chart notes to 360.902.4567

General info

Worker's Name: | Patient ID: | Visit Date: | Claim Number: Enter Claim # from ROA

Healthcare Provider's Name (please print): | Date of Injury: | Diagnosis:

*** Required: Work status**

☐ Worker **is released** to the job of injury (JOI) without restrictions (related to the work injury) as of (date): ___/___/___
(If selected, skip to "Plans" section below)

☐ Worker **may perform modified duty,** if available, from (date): ___/___/___ to* ___/___/___ (*estimated date) **
☐ If released to modified duty, may work more than normal schedule

☐ Worker **may work limited hours:** _____ hours/day from (date): ___/___/___ to* ___/___/___ (*estimated date) **

☐ Worker **is working** modified duty or limited hours _____

****Start & End Dates Required****

☐ Worker **not released to any work** from (date): ___/___/___ to* ___/___/___ (*estimated date) **

☐ **Poor prognosis for return to work** at the job of injury at any date

* **Required: Measurable Objective Finding(s)** ***(also referred to as Objective Medical Findings)*** (e.g., positive x-ray, swelling, muscle atrophy, decreased range of motion)
Note objective medical findings that support the diagnosis and work capacities.

*** Required: Estimate what the worker can do at work and at home unless released to JOI**

How long do the worker's current capacities apply (estimate)?
☐ **1-10 days** ☐ **11-20 days** ☐ **21-30 days** ☐ **30+ days** ☐ **permanent**
Capacities apply all day, every day of the week, at home as well as at work. **24/7**

Worker can: (Related to work injury) A blank space = Not restricted	Never	Seldom 1-10% 0-1 hour	Occasional 11-33% 1-3 hours	Frequent 34-66% 3-6 hours	Constant 67-100% (Not restricted)
Sit					
Stand / Walk					
Perform work from ladder					
Climb ladder					
Climb stairs					
Twist					
Bend / Stoop					
Squat / Kneel					
Crawl					
Reach Left, Right, Both					
Work above shoulders L, R, B					
Keyboard L, R, B					
Wrist (flexion/extension) L, R, B					
Grasp (forceful) L, R, B					
Fine manipulation L, R, B					
Operate foot controls L, R, B					
Vibratory tasks; high impact L, R, B					
Vibratory tasks; low impact L, R, B					

Complete All Capacities related to diagnosis if restrictions exist.

Lifting / Pushing	Never	Seldom	Occas.	Frequent	Constant
Example	*50 lbs*	*20 lbs*	*10 lbs*	*0 lbs*	*0 lbs*
Lift L, R, B	lbs	lbs	lbs	lbs	lbs
Carry L, R, B	lbs	lbs	lbs	lbs	lbs
Push / Pull L, R, B	lbs	lbs	lbs	lbs	lbs

Other Restrictions / Instructions:

Employer Notified of Capacities? ☐ Yes ☐ No
Modified duty available? ☐ Yes ☐ No
Date of contact: ___/___/___
Name of contact: _____

COHE Best Practice #3: 2-Way Communication
Use modifier (-32) with phone or email codes.

Note to Claim Manager:
Please note if you requested COHE Health Service Coordination (HSC) support.

☐ May need assistance returning to work
New diagnosis: _____
Opioids prescribed for: ☐ Acute pain or ☐ Chronic pain

*** Required: Plans**

Worker progress: ☐ As expected / better than expected
☐ Slower than expected (*address in chart notes*)

Current rehab: ☐ PT ☐ OT ☐ Home exercise
☐ Other (e.g., Activity Coaching) _____

Surgery: ☐ Not Indicated ☐ Possible
☐ Planned Date: ___/___/___
☐ Completed Date: ___/___/___

☐ Next scheduled visit in: ___days ___weeks or Date: ___/___/___
☐ Treatment concluded, Max. Medical Improvement (MMI)
☐ Any permanent partial impairment? ☐ Yes ☐ No ☐ Possibly
If you are qualified, please rate impairment for your patient
☐ Will rate ☐ Will refer ☐ Request IME
☐ Care transferred to: _____
☐ Consultation needed with: _____
☐ Study pending: _____

*** Req: Sign**

☐ Copy of APF given to worker ☐ Discussed three key messages on back of form with patient

Signature: Provider *MUST* Sign _____ & DATE ___ & BEST Contact number
☐ Doctor ☐ ARNP ☐ PA-C — Date — Phone

F242-385-000 Activity Prescription Form (APF) 10-2018 — Index: APF

Best Practice #2
Activity Prescription Form (APF)

- ☐ **Complete**
  - ✔ Restrictions are 24/7.
  - ✔ If there is a full release with no restrictions, *only* the date of release and provider signature required.
  - ✔ Bill 1073M.
- ☐ **Timely**
  - ✔ Fax Initial and Subsequent APFs to 360.902.4567 within 2 business days.
  - ✔ Consider using fillable APF https://lni.wa.gov/forms-publications/F242-385-000.pdf
- ☐ **Other**
  - ✔ Complete a Transfer of Care (TOC) form as needed to ensure the correct attending provider is listed for claim paperwork https://lni.wa.gov/forms-publications/f245-037-000.pdf

APF Tips

Employers, workers, health services coordinators (HSCs) and other stakeholders rely on the APF to provide direction for return to work efforts. Here are some tips to consider:

- ❑ ALWAYS do an APF if you have completed an ROA.
- ❑ ALWAYS write the claim number and provider name on the APF.
- ❑ Restrictions are injury specific and they are 24/7 (i.e. at work and home).
- ❑ Notify the Health Services Coordinator (HSC) or claims manager if there are any limitations or restrictions as soon as possible.
- ❑ Discuss your patient's role in their recovery:
  - Activity speeds recovery and reduces risk of permanent disability.
  - Some discomfort is normal.
  - Discuss the difference of hurt versus harm.
  - Early and safe return to work is important to avoid lost wages and prevent long term disability. It is okay to recover while still working.

State Fund Claim:
Department of Labor and Industries
PO Box 44291 Olympia WA 98504-4291
Fax to claim file: 360-902-4567

Self-Insured Claims: Contact the Self Insured Employer (SIE)/Third Party Administrator (TPA)
For a list of SIE/TPAs, go to www.Lni.wa.gov/SelfInsured

Activity Prescription Form (APF)

Billing Code: 1073M (Guidance on back)

Reminder: Send chart notes and reports to L&I or SIE/TPA as required. Complete this form only when there are changes in medical status or capacities, or change in release for work status.

General info	Worker's Name:	Patient ID:	Visit Date:	Claim Number:
	Healthcare Provider's Name (please print):		Date of Injury:	Diagnosis:

General Info: Please complete all areas in "General Info" including a list of work-related medical diagnosis(es) as indicated by the provider.

Work Status: If a patient is medically able to return to the job of injury (JOI) without restrictions, mark patient as released to JOI, enter the date of the visit, and sign the APF.

	Worker is **released** to the job of injury (JOI) without restrictions (related to the work injury) as of (date): ____/____/____ *(If selected, skip to "Plans" section below)*

Required: Work status		**Required: Measurable Objective Finding(s)** (***also referred to as Objective Medical Findings***) (e.g., positive x-ray, swelling, muscle atrophy, decreased range of motion)
	Worker **may perform modified duty**, if available, from (date): _____/_____/_____ to* _____/_____/_____ (*estimated date) ☐ If released to modified duty, may work more than normal schedule Worker **may work limited hours**: _____ hours/day from (date): _____/_____/_____ to* _____/_____/_____ (*estimated date) Worker **is working** modified duty or limited hours _____	
	Worker **not released to any work** from (date): ___/___/___ **to*** ___/___/___ (*estimated date) **Poor prognosis for return to work** at the job of injury at any date	

Work Status:

- If a patient is able to return to work with modified duty, indicate the start and end date.
- If a patient is medically unable to perform *any work* due to the injury, *estimate* how many days the patient will miss work.
- Ensure there are no time gaps or overlaps in any date ranges.
- Estimated dates should cover a patient until their follow up appointment which generally occurs 3 to 7 business days from ED visit or 3 to 14 days from Urgent Care visit.

Measurable Objective Finding(s): *Be specific and detailed* in your objective findings. L&I CANNOT accept these examples of findings: "Pain", "Tenderness", "See chart notes".

Required: Estimate what the worker can do at work and at home unless released to JOI

How long do the worker's current capacities apply (estimate)?

1-10 days **11-20 days** **21-30 days** **30+ days** **permanent**

Capacities apply all day, every day of the week, at home as well as at work.

Worker can: (Related to work injury) A blank space = Not restricted	Never	Seldom 1-10% 0-1 hour	Occasional 11-33% 1-3 hours	Frequent 34-66% 3-6 hours	Constant 67-100% (Not restricted)
Sit					
Stand / Walk					
Perform work from ladder					
Climb ladder					
Climb stairs					
Twist					
Bend / Stoop					
Squat / Kneel					
Crawl					
Reach Left, Right, Both					
Work above shoulders L, R, B					
Keyboard L, R, B					
Wrist (flexion/extension) L, R, B					
Grasp (forceful) L, R, B					
Fine manipulation L, R, B					
Operate foot controls L, R, B					
Vibratory tasks; high impact L, R, B					
Vibratory tasks; low impact L, R, B					

Lifting / Pushing	**Never**	**Seldom**	**Occas.**	**Frequent**	**Constant**
Example	*50 lbs*	*20 lbs*	*10 lbs*	*0 lbs*	*0 lbs*
Lift L, R, B	lbs	lbs	lbs	lbs	lbs
Carry L, R, B	lbs	lbs	lbs	lbs	lbs
Push / Pull L, R, B	lbs	lbs	lbs	lbs	lbs

Physical Restrictions/Capacities: This section is required if the worker is not fully released without restrictions. Complete applicable parts of the grid as it relates to patient's injury.

Complete restrictions based on 24/7, even when not released to any work, as restrictions also apply at home.

Other Restrictions / Instructions:

Indicate any additional directive. (i.e. keep wound dry). If listing other restrictions be sure to include frequency (i.e. never, seldom, occasionally, etc.)

L&I Weight Reference Sheet

2 lbs. — Hammer

3 lbs. — Toaster

4 lbs. — Traffic cone

10 lbs. — Blower (gas)

12 lbs. — Heavy electric guitar

16 lbs. — Five-gallon shrub (dry)

4.5 lbs. — Two quarts of juice

5 lbs. — Two liter bottle of pop

5 lbs. — Drill

17 lbs. — Infant (4 months)

20 lbs. — Thanksgiving turkey

25 lbs. — Aluminum ladder

5 lbs. — Ream of letter-size paper

7 lbs. — Grass trimmer

8 lbs. — Bag of charcoal

25 lbs. — Fertilizer

26–28 lbs. — Toddler (2 years)

30 lbs. — Kitty litter

9 lbs. — One gallon of milk

9 lbs. — 2"x4" stud (8')

10 lbs. — Metal folding chair

30 lbs. — Metal hand cart

36 lbs. — Child (4 years)

47 lbs. — Water tank jug

50 lbs. — Dog food

65 lbs. — Five gallons of paint

Upon request, foreign language support and formats for persons with disabilities are available. Call 1-800-547-8367. TDD users, call 360-902-5797. L&I is an equal opportunity employer.

PUBLICATION F245-415-000 (10-2019)

Employer Notified of Capacities? Yes No
Modified duty available? Yes No
Date of contact: _____/_____/_____
Name of contact: _____
Notes:

Note to Claim Manager:

May need assistance returning to work
New diagnosis:_____

Opioids prescribed for: Acute pain or Chronic pain

Employer Notified (Best Practice #3): Make notation on the APF when contacting the employer; include the details of the communication in your chart note documentation. SOAP-ER notes are preferred. To capture your contact as meeting a best practice, be sure to use Modifier -32 with the procedure code for billing.

Subjective Report
Objective Findings
Assessment of Evaluation
Plan and Progress
Employment Status
Recovery Restrictions

Note to Claim Manager: Examples are "I am the new AP." or "I have requested HSC Care Coordination support."

Required: Plans

Worker progress: As expected / better than expected
Slower than expected (*address in chart notes*)

Current rehab: PT OT Home exercise
Other (e.g., Activity Coaching) _____

Surgery: Not Indicated Possible
Planned Date: ___/___/___
Completed Date: ___/___/___

Next scheduled visit in: ___days ___weeks or Date: ___/___/__
Treatment concluded, Max. Medical Improvement (MMI)
Any permanent partial impairment? Yes No Possibly
If you are qualified, please rate impairment for your patient
Will rate Will refer Request IME
Care transferred to: _____
Consultation needed with: _____
Study pending: _____

Req: Sign

Copy of APF given to worker Discussed three key messages on back of form with patient

Signature: _____ ____/____/____ ( )____-_____
Doctor ARNP PA-C Date Phone

F242-385-000 Activity Prescription Form (APF) 10-2018 RESET Index: **APF**

Complete Plans section of APF: Please check all that apply in both columns. Sign and date document. Provide a copy of APF to patient at discharge.

Fax a copy of all APFs to L&I within 2 business days to 360.902.4567.

Fax L&I Report of Accidents (ROA) and Activity Prescription Forms (APF)
within 2 business days

ROA Only	360.902.6690 800.941.2976 Toll Free
APF and all other Documentation	360.902.4567
HOT CLAIMS Catastrophic, Hospitalization, immediate surgery	360.902.4980

Best Practice #3 - Employer Contact

Purpose: Communicate with the employer regarding patient's capacities to return to work.

- Add billing modifier -32 to procedure codes to track the best practice payment.
- Document the communication encounter with the following key information:
  - ❑ Name of Employer contact, Title and Phone # or Email
  - ❑ Content discussed – restrictions, modified work, questions, etc.
  - ❑ Action or Treatment Plan
- For complete information, please refer to L&I documentation policy under Case Management Services as appropriate: https://lni.wa.gov/patient-care/billing-payments/fee-schedules-and-payment-policies/fee-schedule#/

Communication	Physician + ARNP CPT	PA-C CPT
1-10 minutes Phone or In Person	99441-32	98966-32
11-20 minutes Phone or In Person	99442-32	98967-32
21-30 minutes Phone or In Person	99443-32	98968-32
Secure Online Message or Email	9918M-32	9918M-32

Best Practice #4 - Assessment of Claim Barriers

Purpose: Identify medical, vocational, claim authorization and or psychosocial barriers to determine a treatment plan. Below are various ways to address barriers on a claim:

1. Functional Recovery Questionnaires (FRQ) are typically completed by an HSC and the provider is notified if treatment interventions should be considered. Providers are able to complete FRQs as well.
2. Barriers to Return to Work (BRTW 1068M) assessments *can be completed by the attending provider or referred to a COHE Advisor* once per life of claim and typically in the first 3-6 months.
3. BRTW must include an action plan.
4. BRTW must be in a SOAP-ER note format:

- ❑ **Subjective Report**
- ❑ **Objective Findings**
- ❑ **Assessment of Evaluation**
- ❑ **Plan and Progress**
- ❑ **Employment Status**
- ❑ **Recovery Restrictions**

COHE Services	L&I Code
Barriers to Return to Work (BRTW) Report	1068M
Referral to COHE Advisor for BRTW completion	1070M
Case Conference, Patient NOT Present - up to 30 minutes	99367

CPT Code Pre-Authorization Check

https://lni.wa.gov/patient-care/authorizations-referrals/authorization/

MRI or Injection Authorization

- Utilization Review by Comagine https://lni.wa.gov/patient-care/authorizations-referrals/authorization/utilization-review
- Contact Comagine if >2 weeks have passed https://www.qualishealth.org/healthcare-professionals/washington-labor-industries/provider-resources

Psych Evaluations

- Pre-authorization by Claims Manager and claim must be allowed.
- Secure message in claim account center (CAC) is preferable https://secureaccess.wa.gov/myAccess/saw/select.do

Physical Therapy Services

- If < 12 PT visits, no pre-authorization required but claim must be allowed.
- If 13-24 PT visits, Claims Manager authorization required.
- If > 24 PT visits, Utilization Review by Comagine required.
- Massage Therapy requires Claims Manager approval and claim must be allowed.

Common Reasons for Comagine Authorization Delays

- The request does not meet the Medical Treatment Guidelines (MTG). https://lni.wa.gov/patient-care/treating-patients/treatment-guidelines-and-resources/
- Order is not submitted electronically through Comagine portal https://www.onehealthport.com/
- Imaging Questionnaire incomplete, incorrect or not enough supporting documentation and exam information from provider.

Best Practice #5 – Opioid Management

Purpose: Reduce long term disability by following evidence based opioid management guidelines.

1. Adhere to L&I Opioid Guidelines: https://lni.wa.gov/patient-care/treating-patients/drugs-and-prescrip
2. FREE CME Category 1 obtained through Claim Account Center access: https://lni.wa.gov/patient-care/workshops-training/continuing-education-for-providers

L&I Services	L&I CPT Code
Initial Opioid Treatment Agreement	1064M
Opioid Progress Report	1057M
Subacute/Chronic Opioid with screening results in medical record	1076M
Subacute/Chronic Opioid with screening results submitted with form	1077M
10-Panel Urinalysis (whole panel)	80100
Confirmation Drug Screen Positives (each)	80102

Concurrent L&I Billing for Providers

- ✔ **L&I allows for concurrent billing** of provider phone calls, email and form completion when E&M (evaluation and management) codes are used. For example, a provider may bill concurrently for the patient encounter, contact with the employer, contact with HSC and form completion activity all during one appointment.
- ✔ **CPT Codes and reimbursement amounts vary by COHE enrollment status and provider type.** Ensure documentation requirements are met by referring to L&I: https://lni.wa.gov/forms-publications/F245-432-000.pdf

Initial Visit

- Initial Patient Encounter
- **1040M** ROA or
- **1041M** Re-Open Claim
- **1073M** APF
- Employer Communication (with modifier -32)
- Phone Calls or Secure Messages to other claim stakeholders
- **1055M** Occupational Disease Work History
- Case Conference, patient present or not present with COHE Advisor, Concurrent Care Provider, HSC, etc.

Follow Up Care

- Established Patient Encounter
- **1073M** APF
- **1074M** Employer or Vocational form response
- Employer Communication (with modifier -32)
- **1038M** Job Analysis (JA) Review (1st)
- **1028M** Each additional JA review
- **1027M** Loss of Earning Power (LEP)
- Case Conference, patient present or not present with other Care Providers, HSC, etc.

Complex Cases

- Prolonged Patient Encounter
- **1068M** Barriers Assessment (1 per life of claim) or
- **1070M** Referral to COHE Advisor for Barriers Assessment
- **1063M** Review IME
- **1065M** Written Non-concurrence IME
- **99080** 60 day Report (Must Be in SOAPER format)
- Case Conference, patient present or not present with COHE Advisor, Concurrent Care Provider, HSC, etc.

Opioid Management

- **1064M** Initial Opioid Treatment Agreement
- **1057M** Opioid Progress Report
- **1076M** Subacute/Chronic Opioid with screening results in medical record
- **1077M** Subacute/Chronic Opioid with screening results submitted with form
- **80100** 10-Panel Urinalysis (whole panel)
- **80102** Confirmation Drug Screen Positives (each)

COHE Provider Annual Education

Face to Face

- COHE Best Practice Presentation
- 15+ minutes

Case Conference

- Claim Specific Review with HSC or Advisor
- Billable Activity

Phone Call

- Best Practice or Claim Specific
- Review with HSC (Billable Activity)

Learning Link

- Request access from COHE

Category 1 CME

- Submit current year CME Category 1 Certificates

July 1st to May 1st Annually

COHE Advisors as a Resource

***Purpose*:** Knowledgeable and experienced experts in occupational health and Washington State Workers' Compensation available to assist in the following areas:

MENTORING: COHE Providers on best practices in cases with complex barriers to treatment.

TRAINING: Development and delivery of occupational health best practices and process training.

QUALITY IMPROVEMENT: Participate in quality improvement efforts related to best practices.

CARE COORDINATION: With providers, auxiliary care, and Health Services Coordinators to reduce disability risks.

REFERRALS: Accept referrals for specialty consultations and second opinions such as BRTW.

RETURN TO WORK: Identify and address barriers to return to work.

Ask your HSC for COHE Advisement on claims and they can help coordinate!

Other Resources

L&I Main website - https://www.lni.wa.gov/

Self Insured Claims - https://lni.wa.gov/insurance/self-insurance/about-self-insurance/

ECOMP for federal claims - https://www.ecomp.dol.gov/#/

Determine Employer Insurance - https://www.lni.wa.gov/insurance/self-insurance/look-up-self-insured-employers-tpas/find-a-self-insured-employer

Provider L&I Resource Page - https://www.lni.wa.gov/for-medical-providers

File Fast - https://www.lni.wa.gov/claims/for-medical-providers/filing-claims/filefast-report-of-accident

Find a Doc - https://lni.wa.gov/claims/for-workers/find-a-doctor/

Activity Prescription Form (APF) - https://lni.wa.gov/forms-publications/F242-385-000.pdf

Transfer of Care - https://lni.wa.gov/dA/6b247847f7/F245-037-000.pdf

Medical Treatment Guidelines and Resources - https://lni.wa.gov/patient-care/treating-patients/treatment-guidelines-and-resources/

Health Services Coordinators (HSCs) are here to help!

Remember, when in doubt, contact your HSC!

COHE Eligibility

- ☒ **Complete a COHE Orientation.**
- ❑ **Be actively participating in the L&I Medical Provider Network**, unless you practice solely in emergency care.
- ❑ **Participate in Annual Education** relevant to occupational health best practices.
- ❑ **Adhere to occupational health best practices** when treating patients.
- ❑ **Refer to the L&I and COHE Fee Schedules** when applicable.
- ❑ **Collaborate care with COHE Health Services Coordinators** early and often.

COHE Enrollment

In order to **finalize your COHE *Enrollment***, scan the QR code to complete a brief COHE Alliance enrollment application:

Agility COHE

Agility COHE SPC, a Washington social purpose corporation

Thank you for your time!

From: Agility COHE
To: Boyd, Amelia (WMC)
Subject: Re: FW: Lists & Labels Application
Date: Monday, April 11, 2022 3:48:49 PM
Attachments: image003.png
image004.png

External Email

Reconsideration please. Thank you!

On Mon, Apr 11, 2022, 12:47 PM Boyd, Amelia (WMC) <Amelia.Boyd@wmc.wa.gov> wrote:

> Good afternoon,
>
> Did you decide which option you'd like to pursue for this request? Either reconsideration or hearing.
>
> WMC Logo
>
> Amelia Boyd, BAS
> Program Manager
> Washington Medical Commission
> Mobile: (360) 918-6336
>
> Were you satisfied with the service you received today? Yes or No
>
> ---
>
> **From:** Agility COHE <info@agilitycohe.org>
> **Sent:** Tuesday, March 29, 2022 8:30 PM
> **To:** Boyd, Amelia (WMC) <Amelia.Boyd@wmc.wa.gov>
> **Subject:** Re: FW: Lists & Labels Application
>
> External Email
>
> Thank you for the update. Much appreciated!

On Tue, Mar 29, 2022, 1:40 PM Boyd, Amelia (WMC) <Amelia.Boyd@wmc.wa.gov> wrote:

> Good afternoon,
>
> We have received your appeal, attached. As your appeal contains new information, the Commission can reconsider your lists and labels request at their April 15, 2022 business meeting. If the Commission denies the request at that meeting, you will be entitled to request an adjudicative proceeding again. You may also choose to proceed with the adjudicative proceeding based on the current denial.
>
> Please let me know what you would prefer by April 8, 2022.
>
> WMC Logo
>
> Amelia Boyd, BAS
> Program Manager
> Washington Medical Commission
> Mobile: (360) 918-6336
>
> Were you satisfied with the service you received today? Yes or No

---

From: Boyd, Amelia (WMC)
Sent: Thursday, March 10, 2022 5:49 PM
To: 'info@agilitycohe.org' <info@agilitycohe.org>
Subject: Lists & Labels Application

Good afternoon,

Your application to receive lists was reviewed on March 4, 2022. Attached is a letter detailing the WMC's decision.

WMC Logo

Amelia Boyd, BAS

Program Manager
Washington Medical Commission
Mobile: (360) 918-6336

Washington State Department of Health
Health Professions Quality Assurance

Application for Approval to Receive Lists

This is an application for approval to receive lists, not a request for lists. You may request lists after you are approved. Approval can take up to three months.

RCW 42.56.070(8) limits access to lists. Lists of credential holders may be released only to professional associations and educational organizations approved by the disciplining authority.

- A "professional association" is a group of individuals or entities organized to:
  - Represent the interests of a profession or professions;
  - Develop criteria or standards for competent practice; or
  - Advance causes seen as important to its members that will improve quality of care rendered to the public.
- An "educational organization" is an accredited or approved institution or entity which either
  - Prepares professionals for initial licensure in a health care field or
  - Provides continuing education for health care professionals.

☐ We are a "professional association" ☐ We are an "educational organization."

FRANK E. MADURA 253-517-5668

Primary Contact Name ⤓ Phone ⤓ Email ⤓

Additional Contact Names (Lists are only sent to approved individuals) ⤓ Website URL ⤓

Professional Assoc. or Educational Organization ⤓ Federal Tax ID or Uniform Business ID number ⤓

Street Address ⤓ City, State, Zip Code ⤓

1. How will the lists be used? ⤓
   TO ACQUIRE EVIDENCE TO BE USED IN COURT,
2. What profession(s) are you seeking approval for? ⤓ MEDICINE

Please attach information that demonstrates that you are a "professional association" or an "educational organization" and a sample of your proposed mailing materials.

Email to: PDRC@DOH.WA.Gov
Mail to: PDRC - PO Box 47865 - Olympia WA 98504-7865
Fax to: PDRC - 360-586-2171

Frank E Madura 08/21/2021

Signature ⤓ Date ⤓

If you have questions, please call (360) 236-4836.

For Official Use Only

Approved: _____ 5-year _____ one-time

Denied: _____

Authorizing Signature: _____

Printed Name: _____

Title: _____ Date: _____

STATE OF WASHINGTON

DEPARTMENT OF HEALTH

Frank Madura
c/o 1504 SW 130th
Burien, WA 98146

Dear Frank Madura:

We received an incomplete application for approval to receive lists on September 1, 2021 from you in the mail. Unfortunately the phone number you provided is a fax machine.

RCW 42.56.070 (8) Prohibits agencies to give, sell or provide access to lists of individuals requested for commercial purposes, with the exception of recognized professional associations or educational organizations.

Commercial Purpose means the list will be used to facilitate profit-making acitivity, including recruitment or solicitation.

If you are requesting a list of individuals for a non-commercial purpose, the list can be located on our website via the link below:

https://data.wa.gov/Health/Health-Care-Provider-Credential-Data/qxh8-f4bd

If you are unable to access the internet or the link does not meet your request, you need to clarify the purpose of your request. Please complete and return the attached declaration stating the intended purpose of your request. Only **one** section of the form can be signed before processing.

Depending on the purpose you indicate on the Commercial Purpose Declaration, we will:

Section 1 – Personal Use requests (for non-commercial purpose) begin the process of compiling the list of indviduals without contact information (address, email, or phone number). You will receive an acknowledgment within 5 busiiness days of receipt of the declaration.

Section 2 – Recognized Professional Associations or Educational Organizations (for commercial business purpose) you will receive an application with additional instruction on applying for approval.

This is not a denial of your request. However, if we do not receive the signed declaration from you within 10 days from the date of this letter, we will consider this request abandoned.

The most efficient way to make a public records request with the Department of Health is to visit our online portal at:

https://washingtondoh.govqa.us/WEBAPP/_rs/(S(vjjtk5wjjsci1i2cr0jspjfg))/supporthome.aspx

DEPARTMENT OF HEALTH
PUBLIC DISCLOSURE AND
RECORDS CENTER

I MAILED THE APPLICATION, IN ACCORDANCE WITH THE LETTER FROM THE STATE OF WASHINGTON, NOT DATED (ENCLOSED), LAST FALL.

I HAVE NO WAY OF KNOWING WHEN THE APPLICATION WAS DUE, AS THERE IS NO DATE ON YOUR CORRESPONDENCE.

IT STIPULATED 10 DAYS WITH NO DISCERNABLE REFENCE POINT, IN TIME (NO DATE ON LETTER)

HAVE YOU HAD THE OPPORTUNITY TO LOOK AT THIS?

THANK YOU
Frank C Madura
FRANK E. MADURA
c/o 1504 - S.W. 130TH
BURIEN, WA.
98146

Washington State Department of Health
Health Professions Quality Assurance

RECEIVED
MAR 52022
PDU

Application for Approval to Receive Lists

This is an application for approval to receive lists, not a request for lists. You may request lists after you are approved. Approval can take up to three months.

RCW 42.56.070(8) limits access to lists. Lists of credential holders may be released only to professional associations and educational organizations approved by the disciplining authority.

- A "professional association" is a group of individuals or entities organized to:
  - Represent the interests of a profession or professions;
  - Develop criteria or standards for competent practice; or
  - Advance causes seen as important to its members that will improve quality of care rendered to the public.
- An "educational organization" is an accredited or approved institution or entity which either
  - Prepares professionals for initial licensure in a health care field or
  - Provides continuing education for health care professionals.

☐ We are a "professional association" ☐ We are an "educational organization."

FRANK E. MADURA 253-517-5668
Primary Contact Name ↴ Phone ↴ Email ↴

Additional Contact Names (Lists are only sent to approved individuals) ↴ Website URL ↴

Professional Assoc. or Educational Organization ↴ Federal Tax ID or Uniform Business ID number ↴

Street Address ↴ City, State, Zip Code ↴
C/O 1504-S.W. 130TH, BURIEN, WA., 98146

1. How will the lists be used? ↴
   TO ACQUIRE EVIDENCE TO BE USED IN COURT,
2. What profession(s) are you seeking approval for? ↴ MEDICINE; M.D.

Please attach information that demonstrates that you are a "professional association" or an "educational organization" and a sample of your proposed mailing materials.

Email to: PDRC@DOH.WA.Gov
Mail to: PDRC - PO Box 47865 - Olympia WA 98504-7865
Fax to: PDRC - 360-586-2171

Frank E Madura 08/21/2021
Signature ↴ Date ↴

If you have questions, please call (360) 236-4836.

For Official Use Only
Approved: _____ 5-year _____ one-time
Denied: _____
Authorizing Signature: _____
Printed Name: _____
Title: _____ Date: _____

STATE OF WASHINGTON

DEPARTMENT OF HEALTH

February 2, 2022

Frank Madura
1504 S.W. 130th
Burien, WA 98146

RE: List Request

Dear Frank Madura:

The Department of Health's Public Disclosure Unit received the enclosed pages in the mail today. It appears there is page missing and we're confused as to where the letter originated from.

List requests cannot be used for commercial purposes. List requests need to be approved by the specific Program.

If you'd like to request a list, please fill out the enclosed forms and return to the Public Disclosure Unit at the Department of Health. Please indicate the specific licenses you'd like a list of, such as MD, RN, etc. Once we're received your paperwork, we will forward to the appropriate Program for approval.

If you have any questions or concerns, please feel free to give us a call or email us at pdrc@doh.wa.gov.

Sincerely,

Julie Carrick, Supervisor
Health Systems Quality Assurance (HSQA)
HSQA/Public Disclosure Unit
111 Israel Road SE, PO Box 47865
Olympia, WA 98504-7865
Phone: (360) 236-4836 Cell: (360) 789-0523
Email: pdrc@doh.wa.gov or julie.carrick@doh.wa.gov

Policy Statement

WASHINGTON Medical Commission
Licensing. Accountability. Leadership.

Title:	Informed Consent and Shared Decision-Making	POL2022-0x
References:		
Contact:	Washington Medical Commission	
Phone:	(360) 236-2750	E-mail: medical.commission@wmc.wa.gov
Effective Date:		
Approved By:	John Malden, Chair (signature on file)	

Introduction

Informed consent to medical treatment is a fundamental part of the practitioner-patient relationship. It is a process of communication, and not merely signing a form. Informed consent involves a dialogue between the practitioner and the patient by which information is exchanged concerning the risks, benefits, and alternatives of the tests or treatments being recommended. The obligation of a practitioner to obtain informed consent from a patient is rooted in the recognition of patients' autonomy. Patents who have decision-making capacity have the right to make decisions regarding their care, even when their decisions contradict their providers' recommendations. The practitioner "must supply the patient with material facts the patient will need to intelligently chart that destiny with dignity."[1]

The Washington Medical Commission (WMC) issues this policy to provide guidance to allopathic physicians and physician assistants to ensure that patients are being adequately informed of the risks, benefits, and alternatives of proposed tests and treatments, such that patients can make informed care decisions that best reflect their goals and preferences in entering the care agreement. This policy serves to ensure that practitioners and patients understand their role in the processes of informed consent and shared decision-making.

Policy

Elements of the Informed Consent Process

A valid process of informed consent has four elements:

1. **Voluntariness**. A patient's decision must be free from coercion or undue influences. For example, if a decision is instead made under duress from a clinician, family member, or

[1] *Miller v. Kennedy,* 11 Wn. App. 272, 281-82, 522 P.2d 852 (1974), *aff'd per curium*, 85. Wn.2d 151 (1975). For a comprehensive review of the legal aspects of informed consent, see Washington Health Law Manual, 4th ed., Chapter 2A.3 (2016).

other third party, a patient's decision is not voluntary and, as such, informed consent cannot be obtained.

2. Disclosure. The practitioner must share all information that "a reasonably prudent person in the position of the patient" would find significant for the patient to make an informed decision,[2] including the nature, character, and anticipated results of the proposed test/treatment; material risks inherent to the proposed test or treatment; and alternative courses of action, including no action, and the benefits and risks of those alternatives.

3. Understanding. The practitioner must ensure that the patient has not only been informed but also understands and appreciates the nature of the proposed test/treatment, in addition to associated risks, benefits, and alternatives. The practitioner has a duty to ensure that informed consent is obtained using a form of communication (e.g., language) that the patient understands. Understanding can be difficult to ascertain with certainty. One way to gauge understanding is for the practitioner to ask the patient to state in their own words what they just discussed and what they understood. The practitioner should be aware that cultural differences can significantly impact understanding

4. Capacity. The practitioner must ensure that the patient has the ability to engage in reasoned deliberation (e.g., comparing the risks and benefits of the procedure with personal life goals). A patient who lacks the ability to engage in reasoned decision-making lacks the capacity to give informed consent.

Lack of capacity can take many forms. One example involves statutory criteria, which are required to determine lack of capacity (e.g., as declared by a court or certain types and numbers of health care providers) regarding advance directives.[3] Outside of specific legal criteria, there are numerous scenarios when patients may lack capacity to make reasoned medical decisions.

Another example involves health literacy. Many patients may not understand complex medical information. Practitioners should explain medical information using plain language that a patient can understand. A patient who is confused by the medical terminology may be able to provide informed consent when these complex terms are explained using more basic terminology.

Another example involves a patient overwhelmed by complexity or volume of information at hand. An overwhelmed patient may lack the capacity to provide informed consent. This may create a challenge for practitioners, as it can be difficult to adequately explain all pertinent risks, benefits, and alternatives without overwhelming the patient. Practitioners should focus on explaining all concepts that a reasonably prudent patient would likely need to know to make an informed decision in a manner that promotes dialogue and understanding.

[2] RCW 7.70.050(2)
[3] RCW 71.32.110

If a practitioner believes that a patient does not have the mental capacity necessary to make an informed decision, the practitioner may consider recommending the patient have a court-ordered guardian ad litem appointed before proceeding with any elective treatment.

Capacity is not an all-or-nothing phenomenon; a patient may have the capacity to make some decisions but not others.[4] The American Medical Association Code of Medical Ethics Opinion 2.1.2 provides excellent guidance to a practitioner who encounters an adult patient who seemingly lacks decision-making capacity.[5]

Shared Decision-Making

Washington became the first state to codify shared decision-making as an alternative to traditional informed consent. The statute, RCW 7.70.060 was first amended in 2012 and then again in 2022. The statute states that shared decision-making is a process in which a practitioner discusses with the patient, or his or her representative, information to make a decision that aligns with the patient's values and goals.

Both the Robert Bree Collaborative in Washington State and the National Institute for Health and Care Excellence have issued excellent guides to implementing shared decision-making into a practitioner's medical practice. As noted in the 2019 Bree Collaborative, "Shared decision making is a key component of patient-centered care, 'a process that allows patients and their providers to make health care decisions together, taking into account the best scientific evidence available, as well as the patient's values and preferences.'"[6]

Shared decision-making takes the traditional notion of informed consent a step further by encouraging practitioners and patients to undertake, not just an informed, but an active role in complex medical decisions that affect the patient's health. Shared decision-making requires a high-quality communication between a practitioner and a patient, and in some cases family members or others, about risks, benefits, values, and goals.

The goal of shared decision-making is to help patients arrive at informed decisions that respect what matters most to them.[7]Shared decision-making is especially useful in complex cases where a patient is faced with multiple options and high stakes decisions need to be made in a narrow window of time, such as the decision-making regarding which treatments to undergo when cancer is diagnosed.[8] Shared decision-making is appropriate for treatments that are

[4] "The Limits of Informed Consent for an Overwhelmed Patient: Clinician's Role in Protecting Patient and Preventing Overwhelm," AMA Journal of Ethics, Vol. 18, no. 9:869-886 (September 2016).
[5] AMA Code of Medical Ethics Opinion 2.1.2.
[6] Dr. Robert Bree Collaborative, Shared Decision Making, 2019, at 3. (hereinafter Bree Collaborative paper) https://www.qualityhealth.org/bree/topic-areas/shared-decision-making/
[7] "The Limits of Informed Consent for an Overwhelmed Patient: Clinician's Role in Protecting Patient and Preventing Overwhelm," AMA Journal of Ethics, Vol. 18, no. 9:869-886 (September 2016).
[8] "Development of a Program Theory for Shared Decision-Making: a realist synthesis," Waldron, et al., BMC Health Services Research 20:59 (2020).

(patient) preference-sensitive and either have (1) high-quality scientific evidence supporting more than one option, which may include no treatment, or (2) a lack of evidence and/or no clinical consensus on what is the best option.[9] The practitioner may encourage the patient to have a patient advocate involved in this process.

Shared decision-making is, however, not appropriate when there is clear evidence of a net benefit, or harm. For example, generally, a clear net benefit of immunization against measles, mumps, and rubella (MMR) excludes MMR vaccination as a shared decision-making opportunity, as does the clear net harm of using antibiotics to treat a common cold.[10]

Shared decision-making can sometimes be assisted with patient decision aids. Certified by one or more national certifying organization[12], the tool provides a balanced presentation of the condition and treatment options, benefits, and harms, including, if appropriate, a discussion of the limits of scientific knowledge about outcomes.[11] A decision aid can be in any format, including written, electronic, audio-visual, or web based. A decision aid is not essential for shared decision-making to occur, but studies have shown that patients who engaged in shared decision-making with a decision aid had a greater knowledge of the evidence, understood better about what mattered to them, had more accurate expectations of the risks and benefits, and participated more in the decision-making process.[12] The commission recommends that any use of patient decision aid be documented in medical record.

Generally, shared decision-making is associated with improved patient satisfaction, improved health outcomes, and better appropriateness of care.[13] When patients participate in decision-making and understand what they need to do, there are benefits to patients: they are more likely to follow through on their treatment plans,[14] there is a reduction in the chance of "preference misdiagnosis,"[15] and there is a reduction in health care disparities.[16] Shared decision-making may also benefit practitioners by improving doctor-patient relationships, improving communication, and providing certain legal protections to practitioners.

Practitioners should document shared decision-making in the patient's medical record as follows:

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[9] Dr. Robert Bree Collaborative, Shared Decision Making, 2019, at 3. https://www.qualityhealth.org/bree/topic-areas/shared-decision-making/

[10] Bree Collaborative paper, at 4.

[11] RCW 7.70.060(4)(a).

[12] Spatz E, Krumholz H, Moulton B, The New Era of Informed Consent: Getting to aa Reasonable-Patient Standard Through Shared Decision Making, Viewpoint, JAMA Vol 315, No 19, May 17, 2016.

[13] Bree Collaborative paper at 4, citing Arterburn D, Wellman R, Westbrook E, Rutter C, Ross T, McCulloch D, et al. Introducing decision aids at Group Health was linked to sharply lower hip and knee surgery rates and costs. Health Aff (Millwood). 2012 Sep;31(9):2094-104; and Stacey D, Légaré F, Col NF, Bennett CL, Barry MJ, Eden KB, et al. Decision aids for people facing health treatment or screening decisions. Cochrane Database Syst Rev. 2014 Jan 28;(1):CD001431.

[14] Shared Decision-Making Fact Sheet, HealthIT.gov, National Learning Consortium (December 2013).

[15] C Brach, "Making Informed Consent an Informed Choice," Health Affairs bog April 4, 2019.

[16] Bree Collaborative paper, at 4-5, citing as an example the increasing rates of total knee replacement for black patients with osteoarthritis to rates closer to those of white patients.

- A description of the services that the patient and provider jointly have agreed will be furnished;
- A description of the patient decision aid or aids that have been used by the patient and provider to address the needs for (a) high quality, up-to-date information about the condition, including risk and benefits of available options and, if appropriate, a discussion of the limits of scientific knowledge about outcomes; (b) clarification to help patients sort out their values and preferences; and (c) guidance or coaching in deliberation, designed to improve the patient's involvement in the decision process;
- A statement that the patient or his or her representative understand: the risk or seriousness of the disease or condition to be prevented or treated; the available treatment alternatives, including nontreatment; and the risks, benefits, and uncertainties of the treatment alternatives, including nontreatment; and
- A statement certifying that the patient or his or her representative has had the opportunity to ask the provider questions, and to have any questions answered to the patient's satisfaction, and indicating the patient's intent to receive the identified services.[17]

The Informed Consent Process Cannot be Delegated

Obtaining informed consent is an interactive process that is integral to the practitioner-patient relationship and cannot be delegated to others. For elective procedures, the treating practitioner is the one primarily responsible for the process of obtaining a patient's informed consent. At the end of that process, the treating practitioner may rely on ancillary personnel to obtain a patient's signature on a consent form. However, the practitioner is responsible for any act or statement made by the ancillary personnel when obtaining the patient's signature.[18] The practitioner retains responsibility for obtaining consent and for communications regarding consent.

Exceptions

There are certain situations in which informed consent is not required. For example, in an emergency when immediate treatment is necessary to preserve life or to prevent serious deterioration of a patient's condition, and the patient is unable to make an informed decision and a surrogate is not available, consent is not required.[19] Informed consent is also not required to detain a child without the consent of the parents when there is an imminent danger to the child,[20] or when disclosure of information would be detrimental to the patient's best interests.[21]

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[17] RCW 7.70.060.
[18] Washington Health Law Manual, 4th ed., Chapter 2A.3 (2016). *See also, Shinal v. Toms*, 640 Pa. 295, 162 A.3d 429 (2017) (Pennsylvania court rules that the physician must obtain informed consent himself).
[19] RCW 7.70.050(4).
[20] RCW 26.44.056(1).
[21] *Holt v. Nelson*, 11 Wn. App. 230, 523 P.2d 211 (1974), *rev denied*, 84 Wn.2d 1008 (1974).

Additionally, a patient may choose not to be informed about the details of a proposed treatment, including risks, benefits, and alternatives. A patient may also refuse treatment, or withdraw consent to treatment, no matter how unreasonable. In these scenarios, the practitioner should accept a patient's wishes and document their decision in the medical record.[22] The practitioner should consider having the patient confirm these types of decisions by documenting them in writing.

Special Considerations for Surgery or Invasive Procedures

When a practitioner proposes a surgery or an invasive procedure, the need for informed consent, or shared decision-making, is amplified. Barring an urgent or emergent situation, dialogue between the practitioner and the patient to discuss the proposed procedure, including the risks, benefits, and alternatives, should generally take place well in advance. Patients are naturally apprehensive and vulnerable on the day of a procedure, and may be reluctant or unable to ask questions, and engage fully in the decision-making process. Thus, for non-urgent procedures, having an informed consent discussion in advance optimizes a patient's ability to consider the information, ask questions, and seek advice from another practitioner, friend, or family member, prior to consenting.

Another special consideration in obtaining consent includes the names and roles of practitioners to whom the patient consent to a procedure. The practitioner should advise the patient of the names of any other practitioners who will perform surgical interventions or other important parts of the procedure, including anesthesia.[23] The primary surgeon may not know who will be involved in the procedure at the time informed consent is obtained, in which case, the primary surgeon should advise the patient that other practitioners may be involved and explain their planned scope of involvement in the procedure. The primary surgeon or practitioner should also discuss any applicable overlapping procedures.

The WMC issued a guideline on Overlapping and Simultaneous Elective Surgeries[24] in 2018, in which the WMC recommended that the primary attending surgeon inform the patient of the circumstances of the overlapping or simultaneous surgery, including:

1. Who will participate in the surgery, including residents, fellows, physician assistants and nurse practitioners who are directly supervised by the surgeon;
2. When the primary attending surgeon will be absent for part of the surgery; and
3. Who will continue the surgery when the primary attending surgeon leaves the operating room.[25]

---

[22] RCW 7.70.060(1)(b).

[23] The Center for Medicare and Medicaid Services has a detailed example of a well-designed informed consent process for surgical procedures. A-0392 Surgical Services, Interpretive Guidelines §482.51(b)(2). https://www.cms.gov/Medicare/Provider-Enrollment-and-Certification/SurveyCertificationGenInfo/downloads/SCLetter07-17.pdf

[24] Overlapping and Simultaneous Elective Surgeries, GUI2018-03, adopted July 13, 2018.

A surgeon should not allow a substitute surgeon to perform the procedure without the patient's consent.[26] According to the AMA Principles of Medical Ethics, patients are entitled to accept or refuse the care of a substitute practitioner,[27] and a patient is only able to do this with prior knowledge of its occurrence.

Regulations and Requirements of Other Regulators and Organizations

In addition to Washington statutes regarding informed consent and shared decision-making, it is important to remember that there may be additional requirements of other regulators or organizations. Healthcare organizations or regulatory bodies may have their own regulations or requirements that also must be followed. For example, a physician needs to honor Department of Health facility regulations, Department of Social and Health Services regulations, Joint Commission requirements, and Center for Medicare and Medicaid requirements regarding consent and shared decision-making. The practitioner is responsible for compliance with all applicable statutes, regulations, and requirements to help ensure that quality patient care is provided in the state.

Conclusion

Informed consent and shared decision-making are integral to a healthy practitioner-patient relationship. Evidence suggests that, following these recommendations, as well as reviewing the resources cited, will enhance communication, improve practitioner-patient relationships, decrease legal risk, and result in better overall patient care.

[25] Washington Medical Commission Guideline GUI2018-03, "Overlapping and Simultaneous Surgeries," adopted July 13, 2018.
[26] AMA Code of Ethics Opinion 2.1.6, *available at* https://www.ama-assn.org/system/files/2019-06/code-of-medical-ethics-chapter-2.pdf
[27] AMA Code of Ethics Opinion 2.1.6, *available at* https://www.ama-assn.org/system/files/2019-06/code-of-medical-ethics-chapter-2.pdf

Medical Professionalism

Introduction

In 2002, the American Board of Internal Medicine Foundation, the American College of Physicians-American Society of Internal Medicine Foundation, and the European Federation of Internal Medicine developed a Charter on Medical Professionalism, and published it simultaneously in the Annals of Internal Medicine and The Lancet.[1] The Charter on Medical Professionalism ~~(Charter)~~ is designed to reaffirm the medical profession's commitment to patients and to the health care system by setting forth fundamental and universal principles of medical professionalism.

The Washington Medical Commission (WMC) largely adopts the Charter on Medical Professionalism (Charter), ~~contained herein~~ , as guidance for Washington physicians and physician assistants in fulfilling their professional responsibilities to their patients and to the public.[2] ~~In this guidance document, the WMC uses the term "practitioner" to refer to both allopathic physicians and physician assistants.~~

Charter on Medical Professionalism

Preamble

Professionalism is the basis of medicine's contract with society. ~~It~~Professionalism demands placing the best interests of patients above those of the practitioner[3], setting and maintaining standards of competence and integrity, and providing ~~expert~~scientifically accurate advice to society on matters of health. The principles and responsibilities of medical professionalism must be clearly understood by both the profession and ~~society. Essential to this contract is~~the public. Public trust in practitioners~~, which~~ depends on the integrity of both individual practitioners and the ~~whole~~ profession as a whole.

At present, the medical profession is confronted by an explosion of technology, ~~changing market forces, problems in health care delivery, bioterrorism~~evolving practice conditions, and ~~globalization~~heightened regulatory obligations. As a result, practitioners find it increasingly difficult to meet their responsibilities to patients and society. In these circumstances, reaffirming the fundamental and universal principles and values

[1] "Medical Professionalism in the New Millennium: A Practitioner Charter." Annals of Internal Medicine, 2002;136(3):243-246, *available at* http://annals.org/aim/article/474090/medical-professionalism-new-millennium-practitioner-charter

[2] This Guidance Document is not identical to the previous Charter on Medical Professionalism. The WMC has edited that previous document in order to conform to state laws and rules. For example, in many places in this document, the WMC has replaced the word "shall" with the word "should," so as not to create mandates outside of the rule-making process.

[3] In this guidance document, the WMC uses the term "practitioner" to refer to both allopathic physicians and physician assistants.

of medical professionalism, which remain ideals to be pursued by all practitioners, becomes all the more important.

The medical profession everywhere is embedded in diverse cultures and national traditions, but its members share the role of healer, which has roots extending back to Hippocrates. Indeed, the medical profession must contend with complicated political, legal, and market forces. Moreover, there are wide variations in medical delivery and practice through which any general principles may be expressed in both complex and subtle ways. Despite these differences, common themes emerge and form the basis of this Charter in the form of three fundamental principles, and as a set of definitive professional responsibilities.

Fundamental Principles

1. *Principle of primacy of patient welfare*. This principle is based on a dedication to serving the interest of the patient. Altruism contributes to the trust that is central to the practitioner–patient relationship. Market forces, societal pressures, and administrative exigencies must not compromise this principle.
2. *Principle of patient autonomy*. Practitioners should respect patient autonomy. Practitioners should be honest with their patients and empower them to make informed decisions about their treatment. Patients' decisions about their care must be paramount, as long as those decisions are in keeping with ethical ~~practice~~principles and do not lead to demands for inappropriate care.
3. *Principle of social justice*. The medical profession should promote justice in the health care system, including the fair distribution of health care resources. Practitioners should work actively to eliminate discrimination in health care, whether based on race, gender, gender identity, sexual orientation, socioeconomic status, ethnicity, religion, or any other social category.

A Set of Professional Responsibilities

Commitment to professional competence. Practitioners should be committed to lifelong learning and ~~be responsible for~~to maintaining the medical knowledge and clinical and team skills necessary ~~for the provision of~~to deliver quality care. More broadly, the profession as a whole must strive to see that all of its members are competent~~,~~[4] and must ensure that appropriate mechanisms are available for ~~practitioners~~the profession to accomplish this goal.

Commitment to honesty with patients. Practitioners should ensure that patients are ~~completely~~adequately and honestly informed before the patient has consented to treatment, and also after treatment has occurred. This expectation does not mean that patients should be involved in every minute decision about medical care; rather, they must be empowered to decide on ~~the~~their course of therapy. Practitioners should ~~also~~

[4] Professional competence refers to "the habitual and judicious use of communication, knowledge, technical skills, clinical reasoning, emotions, values, and reflection in daily practice for the benefit of the individual and community being served." Epstein RM, Hundert EM. Defining and assessing professional competence. *JAMA* 2002; 287(2):226-235), *available at https://jamanetwork.com/journals/jama/article-abstract/194554?casa_token=nY5Pp29vutgAAAAA:fUtkGd2lVdqoe1p1T61lgKV1MYyhQNxUHoO4aEOxeZL21IchaFYoxgdHGC-nwjXoYNQJkhYTK9k6*

acknowledge that in health care, medical errors that injure patients do sometimes occur. Whenever patients are injured as a consequence of medical care, patients should be informed promptly because failure to do so seriously compromises patient and societal trust. Reporting and analyzing medical mistakes provide ~~the basis for~~ opportunities to develop and apply appropriate ~~prevention and improvement~~risk management strategies ~~and for appropriate compensation to~~ that should improve patient care, not only for patients who have been injured ~~parties~~but also to prevent future harm moving forward.

Commitment to patient confidentiality. Earning the trust and confidence of patients requires that appropriate confidentiality safeguards be applied to prevent disclosure of patient information~~.~~ unless disclosure is legally necessary. This commitment extends to discussions with persons acting on a patient's behalf when obtaining ~~the~~a patient's own consent is not feasible. Fulfilling the commitment to confidentiality is more pressing now than ever ~~before,~~ given the increasing availability of genetic information and the widespread use of electronic information systems for compiling patient data~~ and an increasing availability of genetic information. Practitioners~~. However, practitioners recognize~~, however,~~ that their commitment to patient confidentiality must occasionally yield to overriding ~~considerations in the~~legal requirements that protect public ~~interest~~health and safety (for example, when patients endanger themselves or others).

Commitment to maintaining appropriate relations with patients. Given the inherent vulnerability and dependency of patients, certain relationships between practitioners and patients must be avoided. ~~In particular~~Practitioners should avoid exploiting patients for personal financial gain, or other private purpose. For example, state law prohibits practitioners from engaging in sexual misconduct, which is defined in rule and includes behaviors such as soliciting a date or kissing a patient in a romantic or sexual manner~~ among its prohibited activities.[5] Practitioners should also avoid exploiting patients for personal financial gain, or other private purpose.~~.[6]

Commitment to improving quality of care. Practitioners should be dedicated to continuous improvement in the quality of health care. This commitment entails not only maintaining clinical competence but also working collaboratively with other professionals to reduce medical error, increase patient safety, minimize overuse of health care resources, and optimize the outcomes of care. Practitioners should actively participate in the development and application of better ~~measures of~~ quality of care~~ and the application of quality~~ measures to assess routinely the performance of all individuals, institutions, and systems responsible for health care delivery. Practitioners, both individually and through their professional associations, ~~must~~should take responsibility for assisting in the creation and implementation of mechanisms designed to encourage continuous improvement in the quality of care.

Commitment to improving access to care. Medical professionalism demands that the objective of all health care systems ~~be~~is the availability of a ~~uniform~~reasonable and adequate standard of care that is accessible to all patients. Practitioners should individually and collectively strive to reduce barriers to equitable health care. Within each system, the practitioner should ~~work to~~help eliminate barriers to access which are often based on education, laws, finances, geography, and social discrimination. A commitment to equity entails the

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~~[5] WAC 246-919-630, 246-918-410. See also RCW 18.130.180(24).~~

[6] WAC 246-919-630, 246-918-410. See also RCW 18.130.180(24).

promotion of public health and preventive medicine without concern for the self-interest of the practitioner or the profession.

Commitment to a just distribution of finite resources. While ~~meeting the needs of~~ treating individual patients, practitioners should provide health care that is based on the ~~wise and~~ standard of care which considers cost-effective management ~~of~~and limited ~~clinical~~ resources. ~~They~~When medically necessary resources are scarce, such as during a pandemic, practitioners are encouraged to follow guidance from the Washington State Department of Health and local health departments to prioritize the needs of the public when there are not enough resources for all patients. Otherwise, practitioners should be committed to working with other practitioners, hospitals, and payers to develop and implement guidelines ~~for~~ focused on the delivery of cost-effective care. ~~The~~While a practitioner, at times, may be tempted to "overtest" and "overtreat" to decrease their risk of medical malpractice claims, the practitioner's professional responsibility ~~for~~involving appropriate resource allocation ~~of resources~~ requires scrupulous avoidance of superfluous tests and procedures. ~~The provision of~~ Providing unnecessary services not only exposes ~~one's~~ patients to avoidable harm and expense but also diminishes the resources available for others.

Commitment to scientific knowledge. Much of medicine's contract with society is based on ~~the~~ integrity and the appropriate use of scientific knowledge and technology. Practitioners should uphold scientific standards, to promote research, and to create new knowledge and ensure its appropriate use. The profession is responsible for the integrity of this knowledge, which is based on scientific evidence ~~and,~~ practitioner experience, and effective communication.

Commitment to maintaining trust by managing conflicts of interest. Medical professionals and their organizations have many opportunities to compromise their professional responsibilities by pursuing private gain or personal advantage. Such compromises are especially threatening in the pursuit of personal or organizational interactions with for-profit industries, including pharmaceuticals, laboratory services, medical equipment ~~manufacturers,~~, and insurance companies~~, and pharmaceutical firms.~~. Practitioners should recognize, disclose to the ~~general~~ public, and deal with conflicts of interest that arise in the course of their professional duties and activities. Relationships between industry and opinion leaders should be disclosed, especially when the latter determines the criteria for conducting and reporting clinical trials, writing editorials or therapeutic guidelines, or serving as editors of scientific journals.

Commitment to professional responsibilities. As members of a profession, practitioners are expected to work collaboratively to maximize patient care, be respectful of one another, and participate in the processes of self-regulation, including remediation and discipline of members who have failed to meet professional standards. The profession should ~~also~~ define and organize the educational and standard-setting process for current and future members. Practitioners have both individual and collective obligations to participate in these processes. These obligations include engaging in internal assessment, offering constructive feedback to peers, and accepting external scrutiny of all aspects of their professional performance.

Summary

The practice of medicine in the modern era faces unprecedented challenges in virtually all cultures ~~and societies.~~ within our society. These challenges center on ~~increasing~~ disparities ~~among~~ in our health care system, an inability to meet the legitimate needs of patients~~, the available~~ due to insufficient resources ~~to~~

~~meet those needs~~, the increasing dependence on market forces to transform health care systems, and the temptation for practitioners to forsake their traditional commitment to the primacy of ~~patients'~~patient interests~~.~~ for their own personal gain. To maintain the fidelity of medicine's social contract ~~during this turbulent time~~, the WMC believes that practitioners must reaffirm their active dedication to the principles of professionalism, which entails not only their personal commitment to the welfare of their patients but also collective efforts to improve ~~the~~our health care system for the welfare of society. The WMC adopts this Charter on Medical Professionalism to encourage such dedication among practitioners and ~~to promote an action agenda for~~ the profession ~~of medicine that is universal~~ in ~~scope~~general, and ~~purpose~~to assure the public that the WMC upholds ideals of professionalism in the State of Washington.

~~References~~

~~"Medical Professionalism in the New Millennium: A Practitioner Charter." Annals of Internal Medicine, 2002;136(3):243-246 http://annals.org/aim/article/474090/medical-professionalism-new-millennium-practitioner-charter~~

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Medical Professionalism

Introduction

In 2002, the American Board of Internal Medicine Foundation, the American College of Physicians-American Society of Internal Medicine Foundation, and the European Federation of Internal Medicine developed a Charter on Medical Professionalism, and published it simultaneously in the Annals of Internal Medicine and The Lancet.[1] The Charter on Medical Professionalism is designed to reaffirm the medical profession's commitment to patients and to the health care system by setting forth fundamental and universal principles of medical professionalism.

The Washington Medical Commission (WMC) largely adopts the Charter on Medical Professionalism (Charter) as guidance for Washington physicians and physician assistants in fulfilling their professional responsibilities to their patients and to the public. [2]

Charter on Medical Professionalism

Preamble

Professionalism is the basis of medicine's contract with society. Professionalism demands placing the best interests of patients above those of the practitioner[3], setting and maintaining standards of competence and integrity, and providing scientifically accurate advice to society on matters of health. The principles and responsibilities of medical professionalism must be clearly understood by both the profession and the public. Public trust in practitioners depends on the integrity of both individual practitioners and the profession as a whole.

At present, the medical profession is confronted by an explosion of technology, evolving practice conditions, and heightened regulatory obligations. As a result, practitioners find it increasingly difficult to meet their responsibilities to patients and society. In these circumstances, reaffirming the fundamental and universal principles and values of medical professionalism, which remain ideals to be pursued by all practitioners, becomes all the more important.

The medical profession everywhere is embedded in diverse cultures and national traditions, but its members share the role of healer, which has roots extending back to Hippocrates. Indeed, the medical profession must

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[1] "Medical Professionalism in the New Millennium: A Practitioner Charter." Annals of Internal Medicine, 2002;136(3):243-246, *available at* http://annals.org/aim/article/474090/medical-professionalism-new-millennium-practitioner-charter

[2] This Guidance Document is not identical to the previous Charter on Medical Professionalism. The WMC has edited that previous document in order to conform to state laws and rules. For example, in many places in this document, the WMC has replaced the word "shall" with the word "should," so as not to create mandates outside of the rule-making process.

[3] In this guidance document, the WMC uses the term "practitioner" to refer to both allopathic physicians and physician assistants.

contend with complicated political, legal, and market forces. Moreover, there are wide variations in medical delivery and practice through which any general principles may be expressed in both complex and subtle ways. Despite these differences, common themes emerge and form the basis of this Charter in the form of three fundamental principles, and as a set of definitive professional responsibilities.

Fundamental Principles

1. *Principle of primacy of patient welfare*. This principle is based on a dedication to serving the interest of the patient. Altruism contributes to the trust that is central to the practitioner–patient relationship. Market forces, societal pressures, and administrative exigencies must not compromise this principle.
2. *Principle of patient autonomy.* Practitioners should respect patient autonomy. Practitioners should be honest with their patients and empower them to make informed decisions about their treatment. Patients' decisions about their care must be paramount, as long as those decisions are in keeping with ethical principles and do not lead to demands for inappropriate care.
3. *Principle of social justice*. The medical profession should promote justice in the health care system, including the fair distribution of health care resources. Practitioners should work actively to eliminate discrimination in health care, whether based on race, gender, gender identity, sexual orientation, socioeconomic status, ethnicity, religion, or any other social category.

A Set of Professional Responsibilities

Commitment to professional competence. Practitioners should be committed to lifelong learning and to maintaining the medical knowledge and clinical and team skills necessary to deliver quality care. More broadly, the profession as a whole must strive to see that all of its members are competent[4] and must ensure that appropriate mechanisms are available for the profession to accomplish this goal.

Commitment to honesty with patients. Practitioners should ensure that patients are adequately and honestly informed before the patient has consented to treatment, and also after treatment has occurred. This expectation does not mean that patients should be involved in every minute decision about medical care; rather, they must be empowered to decide on their course of therapy. Practitioners should acknowledge that in health care, medical errors that injure patients do sometimes occur. Whenever patients are injured as a consequence of medical care, patients should be informed promptly because failure to do so seriously compromises patient and societal trust. Reporting and analyzing medical mistakes provide opportunities to develop and apply appropriate risk management strategies that should improve patient care, not only for patients who have been injured but also to prevent future harm moving forward.

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[4] Professional competence refers to "the habitual and judicious use of communication, knowledge, technical skills, clinical reasoning, emotions, values, and reflection in daily practice for the benefit of the individual and community being served." Epstein RM, Hundert EM. Defining and assessing professional competence. *JAMA* 2002; 287(2):226-235), *available at* https://jamanetwork.com/journals/jama/article-abstract/194554?casa_token=nY5Pp29vutgAAAAA:fUtkGd2lVdq0e1p1T61lgKV1MYyhQNxUHoO4aEOxeZL21IchaFYoxgdHGC-nwjX0YNQJkhYTK9k6

Commitment to patient confidentiality. Earning the trust and confidence of patients requires that appropriate confidentiality safeguards be applied to prevent disclosure of patient information unless disclosure is legally necessary. This commitment extends to discussions with persons acting on a patient's behalf when obtaining a patient's own consent is not feasible. Fulfilling the commitment to confidentiality is more pressing now than ever given the increasing availability of genetic information and the widespread use of electronic information systems for compiling patient data. However, practitioners recognize that their commitment to patient confidentiality must occasionally yield to overriding legal requirements that protect public health and safety (for example, when patients endanger themselves or others).

Commitment to maintaining appropriate relations with patients. Given the inherent vulnerability and dependency of patients, certain relationships between practitioners and patients must be avoided. Practitioners should avoid exploiting patients for personal financial gain, or other private purpose. For example, state law prohibits practitioners from engaging in sexual misconduct, which is defined in rule and includes behaviors such as soliciting a date or kissing a patient in a romantic or sexual manner.[5]

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Commitment to a just distribution of finite resources. While treating individual patients, practitioners should provide health care that is based on the standard of care which considers cost-effective management and limited resources. When medically necessary resources are scarce, such as during a pandemic, practitioners are encouraged to follow guidance from the Washington State Department of Health and local health departments to prioritize the needs of the public when there are not enough resources for all patients. Otherwise, practitioners should be committed to working with other practitioners, hospitals, and payers to develop and implement guidelines focused on the delivery of cost-effective care. While a practitioner, at times, may be tempted to "overtest" and "overtreat" to decrease their risk of medical malpractice claims, the practitioner's professional responsibility involving appropriate resource allocation requires scrupulous

[5] WAC 246-919-630, 246-918-410. See also RCW 18.130.180(24).

avoidance of superfluous tests and procedures. Providing unnecessary services not only exposes patients to avoidable harm and expense but also diminishes the resources available for others.

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Summary

The practice of medicine in the modern era faces unprecedented challenges in virtually all cultures within our society. These challenges center on disparities in our health care system, an inability to meet the legitimate needs of patients due to insufficient resources, the increasing dependence on market forces to transform health care systems, and the temptation for practitioners to forsake their traditional commitment to the primacy of patient interests for their own personal gain. To maintain the fidelity of medicine's social contract, the WMC believes that practitioners must reaffirm their active dedication to the principles of professionalism, which entails not only their personal commitment to the welfare of their patients but also collective efforts to improve our health care system for the welfare of society. The WMC adopts this Charter on Medical Professionalism to encourage such dedication among practitioners and the profession in general, and to assure the public that the WMC upholds ideals of professionalism in the State of Washington.

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Guidance Document

WASHINGTON Medical Commission
Licensing. Accountability. Leadership.

Practitioner Competence

Assessment Framework

~~The~~ Practitioners[1] have a duty to undergo an ongoing assessment of ~~competent medical~~their competence to practice ~~is~~ medicine, which involves a life-long process ~~and begins with~~over the course of their careers. practitioner~~.~~[2] ~~-~~The Washington Medical Commission (WMC) recommends practitioners participate in regular health evaluations as part of their ongoing professional responsibility. ~~Such~~These health evaluations should include physical, dexterity, cognitive, mental, and ~~cognitive~~substance use components. ~~In most situations, feedback from external sources such as patients and peers are beneficial tools for self-assessment and monitoring.~~

~~Practitioners should start these~~The WMC recommends that practitioners begin regular health evaluations ~~with~~upon completion of their first certification cycle (ABMS for physicians or NCCPA for physician assistants~~) following initial certification.~~). If a practitioner does not pursue certification, the practitioner should initiate ~~an~~a health evaluation ~~after~~upon completing ~~a residency or other~~their postgraduate training. These initial evaluations~~, beginning at around age 30 for most, will~~ may serve as a baseline metric for future comparison during the practitioner's career.

Practitioners may find it convenient to do these assessments in conjunction with their recertification process, which generally occurs every seven to ten years. The WMC generally recommends practitioners ~~reduce~~increase the ~~interval between~~frequency of these evaluations ~~as they age --~~to ~~better detect evolving~~coincide with the increase in risk of developing limitations~~.~~-- as they age. Practitioners with chronic ~~illnesses, lacking specific senses, or~~conditions or with known disabilities should consider increasing the frequency of their assessments, regardless of age, to better enable monitoring of status changes.

Age	Minimum Recommended Frequency of Health Evaluations
~~30-55~~25-54	~~Every~~Health evaluations every 7-10 years~~, appropriate health assessment~~

[1] Practitioner as used in this Guidance Document includes allopathic physicians and physician assistants.

55-~~65~~64	~~Every~~Health evaluations every 5 years~~, appropriate health assessment~~
65-~~75~~74	~~Every~~Health evaluations every 2 years~~, appropriate health assessment~~
>75~~+~~	~~Every year, appropriate health assessment~~Health evaluations every year

Practice Modification

~~Practitioners~~ A practitioner will commonly encounter a point in their practice when their skills begin to decline. Such decline might be due to a physical limitation~~,~~ such as ~~a~~ hearing loss or a tremor, or a ~~disease impacting~~ cognitive ~~function. In many cases~~impairment such as early dementia. While such decline ~~will be~~is often associated with ~~the~~a normal aging process~~. It~~, the decline may inadvertently impact a practitioner's ability to practice safely. Other causes of impairment, such as untreated mental illness and/or substance use disorder, also may create a risk of harm to patients. Regardless of etiology, it is important for both the practitioner, and those in the practitioner's practice setting, to recognize ~~these changes~~signs of impairment and ~~adapt to~~address them for the safety of the practitioner and the patient.

~~The WMC recommends practitioners consider altering their practices when practitioner responsibilities become mentally or physically burdensome or present a risk to patients. Practitioners may consider practice modifications such as reducing or eliminating overnight call schedules, mandated call recovery periods, part time practice, reducing office hours, and eliminating certain strenuous procedures.~~

Practitioners should also be aware of the detrimental effects of burnout, a psychological response to chronic work-related stress, which may similarly impact their ability to practice safely. Burnout may be experienced as irritability, low frustration tolerance, exasperation, fatigue, dreading work, callousness toward patients, interpersonal conflicts, diminished social functioning, and existential doubts about career or life choices. ~~Once~~If signs of burnout are present~~identified~~, the WMC recommends that practitioners take active measures to address ~~burnout.~~issues related to burnout (both cause and effect) as quickly as possible. This may involve identifying contributing sources of burnout in the practice environment and working collaboratively with leadership to ~~resolve the~~mitigate these issues. In ~~other~~certain cases, ~~practice~~burnout may involve mentally or physically burdensome responsibilities that need modifications~~, as outlined above, may be required to~~ to not only alleviate burnout ~~and~~, but also to minimize the health risks ~~it poses for both~~ they may impose on practitioners and their patients.

~~The WMC encourages practitioners to use regular health evaluations to gauge their abilities to practice over the course of their careers. Such evaluations should identify aspects of practitioners' practice that may be at risk and what duties the practitioners might consider altering for the safety of the practitioner and the patient.~~ The Washington Physicians Health Program (WPHP) can provide further evaluation and assistance to practitioners when there is concern that a health condition may threaten the safe practice~~.~~

~~Conversations regarding health-related declines in practitioner competence and potential~~ of medicine. Regardless of the cause (skills decline, mental illness, substance use disorder, or burnout), the WMC recommends practitioners consider altering their practices when practitioner responsibilities become mentally or physically burdensome or present a risk to patients. Practitioners may consider practice modifications, such as reducing or eliminating overnight call schedules, mandating call recovery periods, shifting into part time practice, reducing office hours, and/or eliminating certain procedures. The WPHP encourages practitioners to reach out should they seek further evaluation or assistance in identifying reasonable practice modifications.

Conclusion

~~ideally involve~~The WMC encourages all practitioners to undergo regular health evaluations to gauge their ability to practice safely over the ~~support system~~course of ~~the practitioner to include family, clinical partners, peers, and employment settings.~~ their careers. Additionally, throughout their careers, practitioners should self-monitor and seek evaluation if they develop signs of skills decline, cognitive impairment, mental illness, or substance use disorder. Further, practitioners should monitor for signs of burnout and mitigate issues related to burnout as they arise.

With appropriate consideration of current health, burnout, and ability status, practitioners can usually modify their practices, as necessary, to extend fruitful and satisfying careers ~~regardless of age.~~. The WMC strongly supports all medical practitioners in proactively evaluating their health and competence on a regular, career-long basis, and utilizing ~~the~~ results ~~of such evaluations~~to adapt their practice as needed to maintain patient safety. The WPHP can provide further evaluation and assistance to practitioners to help ~~maintain ongoing~~ensure safe ~~and successful~~ practice.~~-~~

Number:	GUI2018-02
Date of Adoption:	April 13, 2018
Reaffirmed / Updated:	N/A
Supersedes:	N/A

Practitioner Competence

Assessment Framework

Practitioners[1] have a duty to undergo an ongoing assessment of their competence to practice medicine, which involves a life-long process over the course of their careers. The Washington Medical Commission (WMC) recommends practitioners participate in regular health evaluations as part of their ongoing professional responsibility. These health evaluations should include physical, dexterity, cognitive, mental, and substance use components.

The WMC recommends that practitioners begin regular health evaluations upon completion of their first certification cycle (ABMS for physicians or NCCPA for physician assistants). If a practitioner does not pursue certification, the practitioner should initiate a health evaluation upon completing their postgraduate training. These initial evaluations may serve as a baseline metric for future comparison during the practitioner's career.

Practitioners may find it convenient to do these assessments in conjunction with their recertification process, which generally occurs every seven to ten years. The WMC generally recommends practitioners increase the frequency of these evaluations --to coincide with the increase in risk of developing limitations-- as they age. Practitioners with chronic conditions or with known disabilities should consider increasing the frequency of their assessments, regardless of age, to better enable monitoring of status changes.

Age	Minimum Recommended Frequency of Health Evaluations
25-54	Health evaluations every 7-10 years
55-64	Health evaluations every 5 years
65-74	Health evaluations every 2 years
≥75	Health evaluations every year

[1] Practitioner as used in this Guidance Document includes allopathic physicians and physician assistants.

Practice Modification

A practitioner will commonly encounter a point in their practice when their skills begin to decline. Such decline might be due to a physical limitation such as hearing loss or a tremor, or a cognitive impairment such as early dementia. While such decline is often associated with a normal aging process, the decline may inadvertently impact a practitioner's ability to practice safely. Other causes of impairment, such as untreated mental illness and/or substance use disorder, also may create a risk of harm to patients. Regardless of etiology, it is important for both the practitioner, and those in the practitioner's practice setting, to recognize signs of impairment and address them for the safety of the practitioner and the patient.

Practitioners should also be aware of the detrimental effects of burnout, a psychological response to chronic work-related stress, which may similarly impact their ability to practice safely. Burnout may be experienced as irritability, low frustration tolerance, exasperation, fatigue, dreading work, callousness toward patients, interpersonal conflicts, diminished social functioning, and existential doubts about career or life choices. If signs of burnout are present, the WMC recommends that practitioners take active measures to address issues related to burnout (both cause and effect) as quickly as possible. This may involve identifying contributing sources of burnout in the practice environment and working collaboratively with leadership to mitigate these issues. In certain cases, burnout may involve mentally or physically burdensome responsibilities that need modifications to not only alleviate burnout, but also to minimize the health risks they may impose on practitioners and their patients.

The Washington Physicians Health Program (WPHP) can provide further evaluation and assistance to practitioners when there is concern that a health condition may threaten the safe practice of medicine. Regardless of the cause (skills decline, mental illness, substance use disorder, or burnout), the WMC recommends practitioners consider altering their practices when practitioner responsibilities become mentally or physically burdensome or present a risk to patients. Practitioners may consider practice modifications, such as reducing or eliminating overnight call schedules, mandating call recovery periods, shifting into part time practice, reducing office hours, and/or eliminating certain procedures. The WPHP encourages practitioners to reach out should they seek further evaluation or assistance in identifying reasonable practice modifications.

Conclusion

The WMC encourages all practitioners to undergo regular health evaluations to gauge their ability to practice safely over the course of their careers. Additionally, throughout their careers, practitioners should self-monitor and seek evaluation if they develop signs of skills decline, cognitive impairment, mental illness, or substance use disorder. Further, practitioners should monitor for signs of burnout and mitigate issues related to burnout as they arise.

With appropriate consideration of current health, burnout, and ability status, practitioners can usually modify their practices, as necessary, to extend fruitful and satisfying careers. The WMC strongly supports all medical practitioners in proactively evaluating their health and competence on a regular, career-long basis, and

utilizing results to adapt their practice as needed to maintain patient safety. The WPHP can provide further evaluation and assistance to practitioners to help ensure safe practice.

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Supersedes:	N/A

Staff Reports: April 2022

Melanie de Leon, Executive Director

With the social distancing and mask mandates lifted, staff will have the opportunity to transition to work more from the DOH facilities if they so desire, and after the Facilities group has completed some routine maintenance on the buildings. Most staff will continue to work from home the majority of the time.

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 Agency policy, requests submitted after the cutoff cannot be paid out.

Amelia Boyd, Program Manager

Recruitment

We are seeking a Psychiatrist to serve as a Pro Tem Member. 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.

On June 30, 2022 we will have the following vacancies:

- Congressional District 3 – Alden Roberts, MD – not eligible for reappointment
- Congressional District 5 – April Jaeger, MD – eligible for reappointment
- Congressional District 9 – Robert Small, MD – not eligible for reappointment
- Physician-at-Large – Charlie Browne, MD – not eligible for reappointment
- Physician Assistant – James Anderson, PA-C – not eligible for reappointment
- Public Member – Toni Borlas – not eligible for reappointment
- Public Member – John Maldon – not eligible for reappointment
- Public Member – Yanling Yu, PhD – not eligible for reappointment

The application deadline for these positions for MDs and PAs has been extended to April 8, 2022. The application deadline for the Public Member positions has been extended to May 2, 2022. More information about this recruitment, including a link to the application, can be found on our website.

Mike Hively, Director of Operations and Informatics

Operations & Informatics has filled both recruitments for a Non-Perm Forms & Records Analyst 3 and a Management Analyst 4. I am pleased to welcome Ken Imes as the new Information Liaison for the WMC. Ken possesses over three decades of combined I.T. and

Mike Hively, Director of Operations and Informatics continued

consultative experience. Ken will be a valued asset to commissioners and staff regarding I.T. services and workforce/project development.

Unit Accomplishments Include:

Digitally Archiving

- 272 active MD Licenses.
- 365 active PA licenses.
- 107 BT closures.
- Over 2,855 MD licenses have been consolidated on unit shared drives.
    - 1,0688 licenses remain requiring consolidation.
- Approximately 1,400 census forms.

Data Requests/Changes

- Approximately 841 open/closed inquiries.
- Approximately 320 address and/or name changes.

Demographics

- Entered approximately 1,400 census forms into the IRLS database.
- Conducted 622 secondary census contacts.
- Quality checks on census data continues weekly.

Our Demographics and Informatics Specialist created a data dictionary detailing datasets collected in the demographic census and outlined changes made to the survey in 2016. This data requested by and provided to the Board of Osteopathic Medicine and Surgery to analyze and revisit their own census survey. Additional analyses were performed on feedback received from licensees in relation to the survey. This data may be used to explore potential future census and survey tool revisions.

Team members continue to improve compulsory response processes and form templates used to complete related tasks. Our new Forms & Records Analyst is working with our Informatics Tech Specialist to define and develop a litigation hold program that identifies necessary benchmarks while ensuring information requested for litigation is properly protected.

The Ops & Info Digital Archivist provided over five hours of hands-on digital archive training to Ops & Info staff members. This ensured staff competency related to scanning paper-based records and processing them to a digital format in accordance with state retention and conversion standards. The team has all been actively digitally archiving approximately 402 cases for an Eleven Year Review.

Morgan Barrett, MD, Medical Consultant

Nothing to report.

George Heye, MD, Medical Consultant

Nothing to report.

Rick Glein, Director of Legal Services

Orders Resulting from SOCs:

In re Gerald W. Lee, MD, Case No. M2018-495. Agreed Order. In June 2020, the Commission filed a Statement of Charges (SOC) which alleged standard of care violations related to Dr. Lee's documentation, management of scheduled medications, and management of non-pain related medication issues for four patients. On March 4, 2022, the Commission signed an Agreed Order which prohibits Dr. Lee from engaging in solo practice as a medical doctor and prescribing DEA Schedule II-IV controlled substances. Dr. Lee must enroll in a clinical monitoring program and register with the Prescription Monitoring Program. Prior to petitioning for modification, Dr. Lee must also complete CMEs in intensive opioid prescribing and addiction medicine along with writing a scholarly paper discussing the current Washington pain management rules which he should be prepared to discuss at a personal appearance. Dr. Lee may petition to terminate the Agreed Order after three years.

In re George Allen, MD, Case No. M2018-632. Agreed Order. On November 15, 2018, the Commission and Dr. Allen entered into an Interim Stipulated Order in which Dr. Allen agreed not to practice as a physician in Washington state pending adjudication of the matter. Simultaneous to the Interim Stipulated Order, the Commission filed a SOC alleging Dr. Allen was criminally indicted in Oregon with 14 counts – seven felonies and seven misdemeanors – and that Dr. Allen entered into an Interim Stipulated Order with the Oregon Medical Board (OMB), voluntarily withdrawing from the practice of medicine and being placed in inactive status pending the completion of the OMB's investigation. On March 4, 2022, the Commission signed an Agreed Order in which Dr. Allen voluntarily surrendered his Washington state medical license.

In re Rajesh Movva, MD, Case No. M2021-45. Agreed Order. In August 2021, the Commission filed a SOC alleging substandard care of a critically ill patient with multi-system injury, disruptive behavior, an unwillingness to listen to nursing and physician colleagues, and a lack of self-awareness regarding the limits of his own expertise. On March 3, 2022, the Commission approved an Agreed Order in which Dr. Movva must complete a CME regarding distressed physicians and a paper discussing the CME and how he will apply what he learned to his practice. Dr. Movva must also pay a $5,000 fine and personally appear before the Commission. Dr. Movva may petition to terminate the Agreed Order after three years and successful completion of all terms and conditions.

Virtual Hearings:

In re Andrew C. Tsen, MD, Case No. M2021-536. Dr. Tsen is board certified in general surgery and thoracic and cardiac surgery. On September 14, 2021, the Commission filed a SOC alleging unprofessional conduct based on a Oregon Medical Board Stipulated Order which

Rick Glein, Director of Legal Services continued

made findings and conclusions that Dr. Tsen violated the Oregon Medical Practice Act. On February 11, 2022, the Health Law Judge (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 is the issue of sanctions. On March 15, 2022, the Commission filed a Case Specific Adjudication memo delegating decision-making authority of the Final Order to the HLJ. A virtual hearing was held March 25, 2022, regarding sanctions only. A Final Order is expected to be issued by end of June 2022.*

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

Items of Interest:

On March 18, Rick met with Chief Health Law Judge Roman Dixon to discuss best practices during the adjudication process, technology issues, and the possibility of hearings being held in-person again later this year.

On March 21, Rick attended the Drug Response Team (DRT) quarterly meeting with various Department of Health and Health Care Authority staff. The mission of DRT is to provide urgent assistance to local communities in Washington State who experience a drug-related public health event (such as closure of a pain clinic) that exceeds the local capacity to respond. The DRT standard operating guide was reviewed along with a discussion of DRT efforts and next steps.

Mike Farrell, Policy Development Manager

Freda Pace, Rick Glein, and I will make a presentation at the WAMSS meeting on April 29. The topic will be how the WMC processes a complaint.

Freda Pace, Director of Investigations

CMT Sign-up for 2022

Beginning May 4th, we have several vacant slots for CMT through the end of the year. Please remember, if you sign up for a CMT slot and you realize later that you have a schedule conflict, requiring you to remove your name, please immediate notify Chris Waterman via email: chris.waterman@wmc.wa.gov. This courtesy notification will allow Chris an opportunity to fill any last-minute vacancy needs. Thank you all for your participation.

Jimi Bush, Director of Quality and Engagement

Engagement:

At the FSMB conference (end of April) I will be displaying a poster on the WMC's work with International Medical Graduates titled "Building Pathways for Internationally Trained Physicians". I will also participate in a panel of state boards that have been deemed to have 'exemplary' outreach strategies.

Jimi Bush, Director of Quality and Engagement continued

Mike, Rick and Freda will be presenting to the Washington Association of Medical Staff Services on April 29th. They will be walking attendees through a WMC case study in a 'true crime podcast' style.

I have been planning a summer and fall CME learning series. Please see the educational conference committee report for more information.

I am looking for ideas and speakers for our ongoing Coffee with the Commission Series. We are planning to have a discussion on the recently adopted discrimination policy – once we hear back from the Secretary's office. In the meantime, if you have any topic suggestions, please let Jimi know.

Thank you to **Dr. Currie, Mr. Maldon, Dr. Jager, Dr. Trescott, Ms. Blake, Melanie, Micah and Mahi** for participating in our patient focused webinar series leading up to Patient Safety Awareness Week. There were a lot of great topics and information presented. On-demand versions can be viewed here.

Performance

The fiscal year will come to a close on July 1. Our Performance manager, Sarah, will be completing her annual performance manager report at its close. If there is a topic you would like to see addressed, please let me know.

Marisa Courtney, Licensing Manager

Total licenses issued from 02/23/2022 - 03/22/2022= 290

Credential Type	Total Workflow Count
Physician And Surgeon Clinical Experience License	0
Physician And Surgeon Fellowship License	0
Physician And Surgeon Institution License	0
Credential Type	**Total Workflow Count**
Physician And Surgeon License	191
Credential Type	**Total Workflow Count**
Physician and Surgeon License Interstate Medical Licensure Compact	44
Physician And Surgeon Residency License	10
Physician And Surgeon Teaching Research License	1
Physician And Surgeon Temporary Permit	6
Physician Assistant Interim Permit	0
Physician Assistant License	34

Physician Assistant Temporary Permit	4
Totals:	**485**

Information on Renewals: February Renewals- 73.09% online renewals

Credential Type	# of Online Renewals	# of Manual Renewals	Total # of Renewals
IMLC	0	35	35
MD	824	290	1114
MDIN	1	0	1
MDTR	0	2	2
PA	158	35	193
	73.09%	**26.91%**	**100.00%**

WASHINGTON Medical Commission
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Panel A
Personal Appearance Agenda

Friday, April 15, 2022

Panel Members:	Jimmy Chung, MD, Panel Chair	Charlie Browne, MD	Arlene Dorrough, PA-C	Anjali D'Souza, MD
	Harlan Gallinger, MD	Sarah Lyle, MD	Scott Rodgers, Public Member	Robert Small, MD
	Richard Wohns, MD	Yanling Yu, PhD, Public Member		
	Janet Barrall, MD, Pro-Tem	Alan Brown, MD, Pro-Tem	Mary Curtis, MD, Pro-Tem	Robert Golden, MD, Pro-Tem
	Charlotte Lewis, MD, Pro-Tem			

Compliance Officer: Anthony Elders

9:45 a.m.	**Andrew J. Thomas, MD** Attorney: Megan K. Murphy	M2020-925 (2020-8025) RCM: Charlie Browne, MD SA: Kyle Karinen
10:30 a.m.	**Stephen J. Shlafer, MD** Attorney: Jake Winfrey	M2019-249 (2018-10524) RCM: Charlotte Lewis, MD SA: Joel DeFazio
11:15 a.m.	**Joe C. Huang, MD** Attorney: Pro Se	M2020-929 (2020-6081 et al.) RCM: Richard Wohns, MD SA: Kyle Karinen
Lunch Break		
1:15 p.m.	**Charles C. Sung, MD** Attorney: Robert Schulz	M2017-514 (2016-5807 et al.) RCM: Richard Wohns, MD SA: Kelly Elder
2:00 p.m.	**David E. Anderson, MD** Attorney: Pro Se	M2019-254 (2018-11948) RCM: Yanling Yu, MD SA: Gordon Wright

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Panel B

Personal Appearance Agenda

Friday, April 15, 2022

Panel Members:

April Jaeger, MD, Panel Chair	Terry Murphy, MD	Toni Borlas, Public Member	Alden Roberts, MD
Diana Currie, MD	Karen Domino, MD	Claire Trescott, MD	Christine Blake, Public Member
John Maldon, Public Member	James Anderson, PA-C	Michael Bailey, Public Member	
Gregory Terman, MD, Pro Tem	William Brueggemann, MD, Pro Tem	Daniel Flugstad, MD, Pro Tem	Robin Hines, MD, Pro Tem
Bruce Hopkins, MD, Pro Tem	Theresa Schimmels, PA-C, Pro Tem		

Compliance Officer: Mike Kramer

9:45 a.m.	**Bjorn K. Watsjold, MD** Attorney: D. K. Yoshida	M2021-57 (2020-9711) RCM: Terry Murphy, MD SA: Trisha Wolf
10:30 a.m.	**Kevin W. Cardwell, PA-C** Attorney: Pro Se	M2020-831 (2020-5773) RCM: James Anderson, PA-C SA: Colleen Balatbat
11:15 a.m.	**Bingumal R. Manawadu, MD** Attorney: Teresa A. Sherman	M2020-208 (2018-7471) RCM: Karen Domino, MD SA: Mike Farrell
LUNCH BREAK		
1:15 p.m.	**Danacia M. Jones, PA-C** Attorney: Jamie Valentine Molly Marcum	M2020-685 (2020-2072) RCM: Daniel Flugstad, MD SA: Kyle Karinen
2:00 p.m.	**Kevin R. Zimmerman, MD** Attorney: Pro Se	M2020-407 (2018-17640) RCM: Karen Domino, MD SA: Kyle Karinen
2:45 p.m.	**Michael Shannon, MD** Attorney: Ketia Wick	M2019-78 (2018-4636) RCM: Theresa Schimmels, PA-C John Maldon SA: Trisha Wolf

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