WASHINGTON

Medical Commission

Licensing. Accountability. Leadership.

Business Meeting
April 26, 2024

FORMAL HEARING SCHEDULE

WASHINGTON Medical Commission
Licensing. Accountability. Leadership.

Hearing	Respondent	Case No.	Location
April 2024			
April 29-30	Shibley, Eric, MD	M2018-443	Virtual
May 2024			
May 7-9	Alhafez, Fadi, MD	M2021-656	Virtual
May 24	Ataee, Sean, MD	M2023-774	Virtual
May 30	Bernales, Wilson, MD	M2023-469	Virtual
June 2024			
June 12-14	Schumer, David S., MD	M2022-991	TBD
June 21	Washington, William, MD	M2021-755	TBD
July 2024			
July 10-12	Apter, Robert, MD	M2022-488	TBD
July 22-24	Ankeney, Geoffrey, MD	M2023-63	TBD
July 31	Pearson, Sean, PA-C	M2024-55	TBD
August 2024			
August 1-2	Oliver, Richard T., PA-C	M2021-896	TBD
August 14-16	Siler, Thomas, MD	M2022-366	TBD
August 19-21	Ilg, Ron, MD	M2022-712	TBD
August 26-27	Nielson, Alex, MD	M2023-645	TBD
September 2024			
September 23	Olsson, Roger, MD	M2023-379	TBD

2024 Meeting Schedule

WASHINGTON Medical Commission
Licensing. Accountability. Leadership.

Date & Time	Location	Meeting Type
January 4 **10 am – 11 am**	Virtual	Policy Committee
January 11 **8:30 am – 5 pm**	Virtual	Case Disposition Personal Appearances
January 19 **9am – 11 am**	Virtual	Business
March 7 **8:30 am – 5 pm**	Hilton Garden Inn Olympia 2101 Henderson Park Lane SE Olympia, WA 98501	Case Disposition Personal Appearances
March 21 **10 am – 11 am**	Virtual	Policy: Interested Parties
April 11 **10 am – 11 am**	Virtual	Policy Committee
April 26 **9 am – 11 am**	Virtual	Business
May 2, 2024 **8:30 am – 5 pm**	Hilton Garden Inn Olympia 2101 Henderson Park Lane SE Olympia, WA 98501	Case Disposition Personal Appearances
May 24 **8 am – 5 pm**	Virtual	Personal Appearances
June 6 **10 am – 11 am**	Virtual	Policy: Interested Parties
June 13 **8:30 am – 5 pm**	Hilton Garden Inn Olympia 2101 Henderson Park Lane SE Olympia, WA 98501	Case Disposition Personal Appearances
June 27 **4 pm – 5 pm**	Virtual	Policy Committee
July 11 **8:30 am – 5 pm**	Virtual	Case Disposition Personal Appearances
July 19 **9 am – 11 am**	Virtual	Business
September 5 **10 am – 11 am**	Virtual	Policy: Interested Parties
September 12 **8:30 am – 5 pm**	Location will be announced soon.	Case Disposition Personal Appearances

Approved: May 26, 2023

Updated: April 15, 2024

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

2025 Meeting Schedule

WASHINGTON Medical Commission
Licensing. Accountability. Leadership.

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

Approved: May 26, 2023

Updated: April 17, 2024

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

Business Meeting Agenda
April 26, 2024

WASHINGTON Medical Commission
Licensing. Accountability. Leadership.

In accordance with the Open Public Meetings Act, this meeting notice was sent to individuals requesting notification of the Department of Health, Washington Medical Commission (WMC) meetings. This agenda is subject to change. The Business Meeting will begin at 9:00 am on April 26, 2024, until all agenda items are complete. The WMC will take public comment at the Business Meeting. To request this document in another format, call 1-800-525-0127. Deaf or hard of hearing customers, please call 711 (Washington Relay) or email doh.information@doh.wa.gov.

Virtual via Teams Webinar: Registration link can be found below.
Physical location: Department of Health, 111 Israel Rd SE, TC2 Rm 153, Tumwater, WA

Time	Friday – April 26, 2024
Open Session	
9:00 am	Business Meeting

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

1.0 Chair Calls the Meeting to Order

2.0 Public Comment

The public will have an opportunity to provide comments. ***If you would like to comment, please limit your comments to two minutes. Please identify yourself and who you represent, if applicable, when the Chair opens the floor for public comment. If you would prefer to submit written comments, send them to amelia.boyd@wmc.wa.gov by April 25, 2024.***

Disclaimer: The WMC accepts written comment into the record as a normal course of the Business Meeting. On a case-by-case basis, the WMC will, at its sole discretion, grant a request to verbally read a comment into the record. Comments containing profanity, discriminatory language, ad hominem attacks on Commissioners or staff, threats of violence, or discussion of active cases or litigation before or involving the WMC will be denied. The comment may still be submitted in writing for consideration and awareness.

2.1 The Chair will call for comments from the public.

3.0 Chair Report

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 Agenda – Approval of the April 26, 2024 Business Meeting agenda. — Pages 7-10

4.2 Minutes – Approval of the January 19, 2024 Business Meeting minutes. — Pages 11-15

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Open Sessions

Rules Hearings

9:15 am General Provisions for Opioid Prescribing

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

General provisions for opioid prescribing and tapering rules for allopathic physicians and physician assistants – WSR #24-07-106

Agenda	Presented By:	Page(s)
Housekeeping	Amelia Boyd	
Hearing opened by Presiding Officer	Karen Domino	
• Introduction		
• Call for questions regarding the rule or hearing process		
• Call for testimony from the public and interested parties regarding proposed language	Proposed language in packet	20-23
• Call for written comments		24-31
• Commissioners discuss comments and proposed language		
• Vote		
CR-102 document	In packet	17-19
Hearing closed by Presiding Officer		

9:45 am Postgraduate Training for Physicians

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

This hearing will begin at 9:45 am or once the previous hearing is concluded, whichever is later.

Postgraduate training for physicians, WAC 246-919-330 – WSR #24-07-107

Agenda	Presented By:	Page(s)
Housekeeping	Amelia Boyd	
Hearing opened by Presiding Officer	Karen Domino	
• Introduction		
• Call for questions regarding the rule or hearing process		
• Call for testimony from the public and interested parties regarding proposed language	Proposed language in packet	34-35
• Call for written comments		36
• Commissioners discuss comments and proposed language		
• Vote		
CR-102 document	In packet	33-34
Hearing closed by Presiding Officer		

Business Meeting Resumes

Open Session

5.0 New Business

5.1 **Joint Operating Agreement** — Action
Kyle Karinen, Executive Director, will present the document for discussion, possible revision, and vote. — Pages 37-55

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5.2 **Nominating Committee** — Update

The chair of the committee will announce the candidates for the following leadership positions:

- Chair
- Vice Chair
- Officer-at-Large

The election of leadership will take place at the July 19, 2024, Business meeting.

The list of committee/workgroup members can be found on page 56.

5.3 **Approved Entities for Accreditation or Certification of Facilities for Office-Based Procedures Under WAC 246-919-601 Requests** — Action

The current list of approved entities is on the Policies page of the WMC website, click here, as well as in this packet. — Page 58

- **Add:** The Accreditation Commission for Health Care (ACHC) has requested to be added to the WMC's list of accrediting entities. — Pages 59-62
- **Remove:** Institute for Medical Quality – no longer in business

6.0 Old Business

6.1 **Bylaws** — Action

Kyle Karinen, Executive Director, will present proposed revisions to the WMC Bylaws. — Pages 63-71

6.2 **Committee/Workgroup Reports** — Update

The Chair will call for reports from the Commission's committees and workgroups. Written reports begin on page 72. See page 58 for a list of committees and workgroups.

6.3 **Rulemaking Activities**

Rules Progress Report provided on page 74. — Update

Amelia Boyd, Program Manager, will request the following:

- Initiate standard rulemaking in response to SB 5184 Concerning licensure of certified anesthesiologist assistants — Action; Memo on page 75
- If the above is approved, a committee be set up for certified anesthesiologist assistants rulemaking. — Action
  - If approved, volunteers for the committee will be needed.
- Initiate CR-105, expedited rulemaking, in response to ESHB 2041 Concerning physician assistant collaborative practice. — Action; Memo on page 76
- Initiate CR-105, Expedited Rulemaking, to do some technical edits to WAC 246-919-945 and WAC 246-918-895. — Action; Memo on page 77

7.0 Policy Committee Report

Christine Blake, Public Member, Chair, will report on items discussed at the Policy Committee meeting held on April 11, 2024. The agenda was as follows: — Report/Action

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7.1 Guidance Document: Medical Records: Documentation, Access, Retention, Storage, Disposal, and Closing a Practice
- Draft revised document with Track Changes — Pages 78-95
- Draft revised document with proposed changes accepted — Pages 96-110

7.2 Procedure: Compensation and Reimbursement for Commission Duties — Pages 111-112

7.3 Procedure: Processing Complaints Against Medical Students, Residents, and Fellows
- Draft revised document with Track Changes — Pages 113-115
- Draft revised document with proposed changes accepted — Pages 116-118

7.4 Proposed Procedure: Approving Accrediting Entities to Accredit or Certify the Use of Anesthesia in Office-Based Surgical Settings — Pages 119-120

7.5 Change to Policy Committee Meeting Day/Time

7.6 Policy Development Request: Recusal

7.7 Policy Development Request: Artificial Intelligence

8.0 Member Reports

The Chair will call for reports from Commission members.

9.0 Staff Member Reports

The Chair will call for further reports from staff.

Written reports on pages 121-135

10.0 AAG Report

Heather Carter, AAG, may provide a report.

11.0 Adjournment of Business Meeting

Informational

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Business Meeting Minutes
January 19, 2024

WASHINGTON Medical Commission
Licensing. Accountability. Leadership.

Virtual Meeting via Teams Webinar
Link to recording: https://youtu.be/AacfJPPgeug?si=xJM9Y7yftugN2MV9

Commission Members

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

WMC Staff in Attendance

Christine Babb, Investigator
Colleen Balatbat, Staff Attorney
Jennifer Batey, Legal Support Staff Manager
Alexander Bielaski, Case Manager
Amelia Boyd, Program Manager
Kayla Bryson, Executive Assistant
Jimi Bush, Director of Quality & Engagement
Carmen Challender, Health Services Consultant
Marisa Courtney, Licensing Manager
Joel DeFazio, Staff Attorney
Sylke Dixon, IMLC Licensing Specialist
Kelly Elder, Staff Attorney
Mike Farrell, Supervising Staff Attorney
Gina Fino, Director of Compliance
Ryan Furbush, Paralegal
Rick Glein, Director of Legal Services
Mike Hively, Director of Operations & Informatics
Jenelle Houser, Investigator
Ken Imes, Information Liaison
Kyle Karinen, Executive Director
Pamela Kohlmeier, MD, JD, Staff Attorney
Joanna Mallard, Health Services Coordinator
Emma Marienthal, Licensing Lead
Stephanie Mason, PR & Legislative Liaison
Micah Matthews, Deputy Executive Director
Lynne Miller, Paralegal
Fatima Mirza, Program Case Manager
Freda Pace, Director of Investigations
Stormie Redden, Legal Assistant
Chris Waterman, Complaint Intake Manager
Trisha Wolf, Staff Attorney
Mahi Zeru, Equity & Social Justice Manager

Others in Attendance

Marlon Basco-Rodillas, Dept. of Health (DOH)
Heather Carter, Assistant Attorney General
Kristin Effland, MCHS Program Director
Deborah Gleisner, ND, LM
Hillary Norris, Policy Analyst, Washington State Medical Association
Bob Runnels, Informed Choice Washington
Jennifer Santiago, DOH
Katherine Sauerlender, LM
Kathy Weed, DOH

1.0 Call to Order

Karen Domino, MD, Chair, called the meeting of the Washington Medical Commission (WMC) to

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order at 9:07 a.m. on October 20, 2023.

2.0 Public Comment

Comments from Lynn Bergeron regarding actions by the WMC were read into the record.

Comments from Tom Vander Sys regarding their healthcare were read into the record.

Bob Runnels, Informed Choice Washington Director, provided comments regarding actions by the WMC.

3.0 Executive Session

At 9:13 am, the Commissioners and some staff went into Executive Session under RCW 42.30.110(1)(i) to discuss a request from the United States Department of Justice. Dr. Domino stated this closed session was scheduled to end at 9:30 am. The end time was extended to 9:35 am. The business meeting was brought back to order at 9:36 am.

4.0 Chair Report

Dr. Domino thanked the Commissioners for the work they've been doing.

Dr. Domino reported that she, along with Kyle Karinen, Executive Director, and Micah Matthews, Deputy Executive Director, recently attended the Federation of State Medical Board's "Symposium on Artificial Intelligence in Health Care and Medical Regulation." She stated it was an interesting meeting. She went on to say that there's much to consider regarding the rapid progress of both generative artificial intelligence (AI) and diagnostic and treatment recommendation AI. She stated that as physicians or physician assistants there is not enough education about AI, and few understand the underlying processes.

5.0 Consent Agenda

The Consent Agenda contained the following items for approval:

5.1 Minutes from the October 20, 2023, Business Meeting
5.2 Agenda for January 19, 2024.

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

6.0 New Business

6.1 Petition for Declaratory Order

Mike Farrell, Supervising Staff Attorney, presented a petition for declaratory order from a licensee. He explained that a declaratory order is "an order issued by an agency that states how an agency is to apply a rule or statute or other law to specific circumstances." He clarified that the licensee is requesting the WMC to officially declare items mentioned in the petition. He further explained that in order to obtain a declaratory order from an agency, a petitioner must meet several requirements, with two being particularly crucial. In this instance, the first requirement is the presence of uncertainty requiring resolution in the case, and the second is that this uncertainty must adversely affect the petitioner. The Commission has the discretion to either issue or reject a declaratory order in this case.

Mr. Farrell further explained that this licensee is currently under investigation by the WMC. In response to a letter from a WMC investigator requesting patient records, they want the WMC to declare its legal jurisdiction to request a patient's medical records before the licensee provides them. The licensee is requesting a detailed account

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substantiating the existence of a complaint that justifies the release of the medical records. They are seeking assurance that their request complies with relevant privacy laws and a citation of legal authority supporting the WMC's request. Additionally, the licensee is asking for the WMC to issue an order confirming its authority to conduct the investigation.

Mr. Farrell stated that while licensees often request statutory authority for WMC actions, typically provided in cooperation letters, this licensee is taking a different approach. They are using a statute in the Administrative Procedures Act that allows the agency to issue a declaratory order. However, since there is no uncertainty in the law, as the WMC's authority and the request's details are clear, and because the WMC adheres to all privacy laws, it is recommended to decline issuing this declaratory order.

Mr. Farrell explained that in addition to a statute, there is a Department of Health (DOH) rule that states the petition for declaratory order must be in a certain format and filed with the adjudicative services unit, which this licensee did not comply with. Mr. Farrell stated that if the petition is denied, there will be a letter sent to the licensee explaining the denial, which would include that the licensee did not comply with the DOH rule.

Dr. Domino opened the floor for the Commissioners to discuss this item. After a robust discussion:

> ***Motion**:* The Chair entertained a motion to decline issuing the declaratory order. The motion was seconded and approved unanimously.

7.0 Old Business

7.1 Committee/Workgroup Reports

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

7.2 Rulemaking Activities

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

Kyle Karinen, Executive Director, requested that the WMC rescind the CR-101, Preproposal Statement of Inquiry, rulemaking regarding Collaborative Drug Therapy Agreements (CDTA). He provided a brief history of this rulemaking and stated the Commissioners have two options: either rescind the rulemaking or choose to continue the rulemaking efforts regarding CDTAs.

Jimmy Chung, MD, provided additional history related to this rulemaking. He recommended there be a group that reviews the current issues with CDTAs and the past issues to see if there is still a need to create a new rule or if the WMC should rescind the rulemaking.

There was not a motion to rescind the CR-101. Rulemaking on this subject will continue.

7.3 Strategic Plan 2023-2025

Jimi Bush, Director of Quality and Engagement, presented the final WMC Strategic Plan for the 2023-2025 biennium and requested that the Commissioners approve the plan.

> ***Motion:*** The Chair entertained a motion to approve the 2023-2025 Strategic Plan.

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The motion was seconded and approved unanimously.

8.0 Policy Committee Report

Christine Blake, Public Member, Policy Committee Chair, reported on the items discussed at the Policy Committee meeting held on January 4, 2024. The agenda was as follows:

Non-WMC Rulemaking: Midwifery Legend Drugs and Devices
Ms. Blake presented draft language from the Midwifery Committee regarding Midwifery Legend Drugs and Devices. She stated that there was no need to vote on these rules and there was no formal motion needed as these are not WMC rules but that the WMC is required by statute to provide feedback on midwifery rules.

Guidance Document: Medical Records: Documentation, Access, Retention, Storage, Disposal, and Closing a Practice
Ms. Blake stated this document was reviewed as part of the WMC's four-year review process. She reported that since the committee meeting on January 4, 2024, additional suggestions have been received for this document. Therefore, it will be revised and brought to a future committee meeting so that the edits can be reviewed.

9.0 Member Reports

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

10.0 Staff Reports

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

Ms. Boyd reminded the Commissioners that there will be a session of the Sexual Misconduct and Response Training and stated that if they have not attended in the past they can hopefully attend the session on February 15, 2024.

11.0 AAG Report

Heather Carter, AAG, had nothing to report.

12.0 Adjournment

The Chair called the meeting adjourned at 10:35 am.

Submitted by

Amelia Boyd, Program Manager

Karen Domino, MD, Chair
Washington Medical Commission

Approved April 26, 2024

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Rules Hearing

General provisions for opioid prescribing

WSR 24-07-106
PROPOSED RULES
DEPARTMENT OF HEALTH
(Washington Medical Commission)
[Filed March 20, 2024, 11:49 a.m.]

Original Notice.

Preproposal statement of inquiry was filed as WSR 23-17-094.

Title of Rule and Other Identifying Information: General provisions for opioid prescribing and tapering rules for allopathic physicians and physician assistants. The Washington medical commission (commission) is proposing amendments to the commission's opioid prescribing rules to exclude patients with sickle cell disease, to clarify tapering considerations, and to clarify the use of biological specimen testing. Amending WAC 246-918-801 Exclusions, 246-918-870 Periodic Review—Chronic pain, and 246-918-900 Tapering considerations—Chronic pain for physician assistants, as well as WAC 246-919-851 Exclusions, 246-919-920 Periodic Review—Chronic pain, and 246-919-950 Tapering considerations—Chronic pain for allopathic physicians.

Hearing Location(s): On April 26, 2024, at 9:15 a.m., virtually. Register for this virtual meeting to be held via Microsoft Teams http://tinyurl.com/5cppd9ea; or in person at the Department of Health, 111 Israel Road S.E., Room 153, Tumwater, WA 98501. To join the commission's rules interested parties email list, please visit https://public.govdelivery.com/accounts/WADOH/subscriber/new?topic_id=WADOH_153.

Date of Intended Adoption: April 26, 2024.

Submit Written Comments to: Amelia Boyd, Program Manager, P.O. Box 47866, Olympia, WA 98504-7866, email https://fortress.wa.gov/doh/policyreview/, by April 19, 2024.

Assistance for Persons with Disabilities: Contact Amelia Boyd, program manager, phone 1-800-525-0127, TTY 711, email medical.rules@wmc.wa.gov, by April 19, 2024.

Purpose of the Proposal and Its Anticipated Effects, Including Any Changes in Existing Rules: On November 3, 2022, the Center for Disease Control and Prevention (CDC) released the Clinical Practice Guideline for Prescribing Opioids for Chronic Pain (https://www.cdc.gov/opioids/healthcare-professionals/prescribing/guideline/index.html) (guideline). This guideline updated the *CDC Guideline for Prescribing Opioids for Chronic Pain—United States, 2016* (2016 Guideline). Since the release of the 2016 guideline, new evidence has emerged on the benefits and risks of prescription opioids for both acute and chronic pain comparisons with nonopioid treatments, dosing strategies, opioid dose dependent effects, risk mitigation strategies, and opioid tapering and discontinuation. The update expands the 2016 guideline to provide evidence-based recommendations for prescribing opioid pain medication for acute, subacute, and chronic pain for outpatients aged ≥18 years, excluding pain management related to sickle cell disease, cancer-related pain treatment, palliative care, and end-of-life care. This update leverages new data to expand content on prescription opioids for acute and subacute pain throughout the recommendations.

RCW 18.71.800 and 18.71A.800 directs the commission to consider the guidelines from the CDC when developing opioid prescribing rules. As such, when the new guideline was released in 2022, the commission contracted with Gregory Terman, MD, to do a comprehensive comparison of the commission's opioid prescribing rules covering physicians (WAC

246-919-850 through 246-919-990) and physician assistants (WAC 246-918-800 through 246-918-835) to the guideline. Dr. Terman is a former pro tempore commissioner of the commission as well as a professor of anesthesiology and pain medicine at the University of Washington in Seattle. Dr. Terman was asked to recommend changes to the commission's opioid prescribing rules based on the differences found between the commission's opioid prescribing rules and the guideline. Dr. Terman provided the commission with a report, titled "Comparing and Contrasting the 2022 CDC Opioid Prescribing Guideline and the 2019 Washington State Prescribing Rules" (report). Based on the recommendations in the report, the commission is proposing amending the rules as follows:

(1) Exempting patients with sickle cell disease.

(2) Stating in rule that not all chronic pain patients need to be tapered off opioids.

(3) Stating in rule that decisions regarding patient treatment should not be based solely on one aberrant biological specimen test.

Reasons Supporting Proposal: The commission is proposing rules based on the following recommendations from Dr. Terman's report:

(1) Exempting patients with sickle cell disease: The guideline exempts sickle cell disease along with cancer and patients receiving palliative or end-of-life care and states that these patients "can be at risk for inadequate pain treatment." The commission's rules already exclude patients with cancer and the provision of palliative, hospice, or other end-of-life care because those patients typically need a different level of care than a patient with chronic pain that is not related to cancer, palliative, or end-of-life care.

(2) Stating in rule that not all chronic pain patients need to be tapered off opioids: Since their opioid rules were updated in 2018, the commission has seen a number of complaints from chronic pain patients who have been tapered too rapidly or their opioid regimen has been discontinued completely. The department of health released a statement on September 20, 2019, that spoke to this issue:

"Neither the Washington State opioid prescribing rules nor the CDC opioid prescribing guideline support rapidly tapering or discontinuing opioids for patients on existing opioid doses exceeding 90 mg MME per day under most circumstances. Abruptly tapering or discontinuing opioids in a patient who is physically dependent may cause serious patient harms including severe withdrawal symptoms, uncontrolled pain, psychological distress, and in rare instances, suicide."

In the Report, Dr. Terman notes: "The CDC states that one of the primary reasons for updating the rules, was 'misapplication of the 2016 CDC Opioid Prescribing Guideline (66), benefits and risks of different tapering strategies and rapid tapering associated with patient harm (68,71–73), challenges in patient access to opioids (6), patient abandonment and abrupt discontinuation of opioids (71)' (page 4). In perhaps the clearest example of the CDC attempting to avoid inflexible interpretations of this version of the guideline, CDC removed all specific doses and durations from all 12 of the 2022 recommendations – relegating the same doses seen in the 2016 recommendations (based largely on the same data) to the supporting text. The rules (commission's rules) attempted to avoid dose-focused inflexibility of care by reassuring prescribers that the "commission will judge the validity of the physician's treatment of the patient based on available documentation, rather than solely on the quantity and duration of medication administration" (WAC 246-919-850). Whether this has been successful in avoiding opioid treatment related patient stigma, abandonment and in-

appropriate discontinuation of opioids is a matter of discussion beyond the scope of this document but the desire to avoid these patient punishments is clearly a similarity between the CDC and the Rules." The commission believes that including in the rule a statement that tapering is not always necessary would be beneficial for achieving this objective.

(3) Stating in rule that decisions regarding patient treatment should not be based solely on one aberrant biological specimen test: In the report, Dr. Terman highlights that both the commission's rules and the guideline recognize biological specimen testing, such as urine toxicology testing, as an effective risk mitigation strategy for subacute and chronic opioid prescribing. He goes on to say that the guideline describes the correct utilization of biological specimen testing involves applying it universally to prevent bias, emphasizing discussions over punishment for unexpected results, and integrating results into broader clinical assessments to formulate action plans following unexpected outcomes. The commission's rules do not address how to handle an unexpected result. Additionally, the commission has received reports that physicians and physician assistants have stopped prescribing opioids and, in some cases, dismissed patients solely based on a single abnormal biological specimen test. This abrupt change in a patient's care greatly raises the risk of patient harm. By providing some guidance in rule regarding biological specimen testing, the commission is working toward reducing patient harm.

RCW 18.71.800 and 18.71A.800 require that the commission consider the Agency Medical Directors Group (AMDG) and CDC guidelines when adopting rules regarding opioid prescribing. The proposed rules implement the statute's goals and objectives by:

(1) Revising the established rules to be consistent with the CDC's guideline; and

(2) Supporting the overarching goals of RCW 18.71.015 by protecting and promoting public health, safety, and welfare.

Statutory Authority for Adoption: RCW 18.71.017, 18.71.800, 18.71A.800, and 18.130.050.

Statute Being Implemented: RCW 18.71.800 and 18.71A.800.

Rule is not necessitated by federal law, federal or state court decision.

Name of Proponent: Washington medical commission, governmental.

Name of Agency Personnel Responsible for Drafting: Amelia Boyd, 111 Israel Road S.E., Tumwater, WA 98501, 360-918-6336; Implementation and Enforcement: Kyle Karinen, 111 Israel Road S.E., Tumwater, WA 98501, 360-236-4810.

A school district fiscal impact statement is not required under RCW 28A.305.135.

A cost-benefit analysis is required under RCW 34.05.328. A preliminary cost-benefit analysis may be obtained by contacting Amelia Boyd, Program Manager, P.O. Box 47866, Olympia, WA 98504-7866, phone 360-918-6336, TTY 711, email medical.rules@wmc.wa.gov.

This rule proposal, or portions of the proposal, is exempt from requirements of the Regulatory Fairness Act because the proposal:

Is exempt under RCW 19.85.025(4).

Explanation of exemptions: The proposed rules do not impact businesses, they only impact providers.

Scope of exemption for rule proposal:

Is fully exempt.

March 18, 2023 [2024]

Kyle S. Karinen
Executive Director

OTS-5085.1

AMENDATORY SECTION (Amending WSR 22-22-039, filed 10/25/22, effective 11/25/22)

WAC 246-918-801 Exclusions. WAC 246-918-800 through 246-918-935 do not apply to:

(1) The treatment of patients with cancer-related pain;

(2) The treatment of patients with sickle cell disease;

(3) The provision of palliative, hospice, or other end-of-life care;

((~~(3)~~)) (4) The provision of procedural medications;

((~~(4)~~)) (5) The treatment of patients who have been admitted to any of the following facilities for more than 24 hours:

(a) Acute care hospitals licensed under chapter 70.41 RCW;

(b) Psychiatric hospitals licensed under chapter 71.12 RCW;

(c) Nursing homes licensed under chapter 18.51 RCW and nursing facilities as defined in WAC 388-97-0001;

(d) Long-term acute care hospitals as defined in RCW 74.60.010; or

(e) Residential treatment facilities as defined in RCW 71.12.455; or

((~~(5)~~)) (6) The treatment of patients in residential habilitation centers as defined in WAC 388-825-089 when the patient has been transferred directly from a facility listed in subsection ((~~(4)~~)) (5) of this section.

AMENDATORY SECTION (Amending WSR 18-23-061, filed 11/16/18, effective 1/1/19)

WAC 246-918-870 Periodic review—Chronic pain. (1) The physician assistant shall periodically review the course of treatment for chronic pain. The frequency of visits((~~, biological testing,~~)) and PMP queries in accordance with the provisions of WAC 246-918-935, must be determined based on the patient's risk category:

(a) For a high-risk patient, at least quarterly;

(b) For a moderate-risk patient, at least semiannually;

(c) For a low-risk patient, at least annually;

(d) Immediately upon indication of concerning aberrant behavior; and

(e) More frequently at the physician assistant's discretion.

(2) During the periodic review, the physician assistant shall determine:

(a) The patient's compliance with any medication treatment plan;

(b) If pain, function, and quality of life have improved, diminished, or are maintained; and

(c) If continuation or modification of medications for pain management treatment is necessary based on the physician assistant's evaluation of progress towards or maintenance of treatment objectives and compliance with the treatment plan.

(3) Periodic patient evaluations must also include:

(a) History and physical examination related to the pain;

(b) Use of validated tools or patient report from reliable patients to document either maintenance or change in function and pain control; and

(c) Review of the Washington state PMP at a frequency determined by the patient's risk category in accordance with the provisions of WAC 246-918-935 and subsection (1) of this section.

(4) If the patient violates the terms of the agreement, the violation and the physician assistant's response to the violation will be documented, as well as the rationale for changes in the treatment plan.

(5) Biological specimen testing should not be used in a punitive manner but should be used in the context of other clinical information to inform and improve patient care. Physician assistants should not dismiss patients from care on the basis of a biological specimen test result alone.

AMENDATORY SECTION (Amending WSR 18-23-061, filed 11/16/18, effective 1/1/19)

WAC 246-918-900 Tapering considerations—Chronic pain. Not all chronic pain patients will need their opioid prescriptions tapered. Relying on medical decision making and patient-centered treatment, the physician assistant shall consider tapering or referral for a substance use disorder evaluation when:

(1) The patient requests;

(2) The patient experiences a deterioration in function or pain;

(3) The patient is noncompliant with the written agreement;

(4) Other treatment modalities are indicated;

(5) There is evidence of misuse, abuse, substance use disorder, or diversion;

(6) The patient experiences a severe adverse event or overdose;

(7) There is unauthorized escalation of doses; or

(8) The patient is receiving an escalation in opioid dosage with no improvement in their pain or function.

OTS-5086.1

AMENDATORY SECTION (Amending WSR 22-22-039, filed 10/25/22, effective 11/25/22)

WAC 246-919-851 Exclusions. WAC 246-919-850 through 246-919-985 do not apply to:

(1) The treatment of patients with cancer-related pain;

(2) The treatment of patients with sickle cell disease;

(3) The provision of palliative, hospice, or other end-of-life care;

((~~(3)~~)) (4) The provision of procedural medications;

((~~(4)~~)) (5) The treatment of patients who have been admitted to any of the following facilities for more than 24 hours:

(a) Acute care hospitals licensed under chapter 70.41 RCW;

(b) Psychiatric hospitals licensed under chapter 71.12 RCW;

(c) Nursing homes licensed under chapter 18.51 RCW and nursing facilities as defined in WAC 388-97-0001;

(d) Long-term acute care hospitals as defined in RCW 74.60.010; or

(e) Residential treatment facilities as defined in RCW 71.12.455; or

((~~(5)~~)) (6) The treatment of patients in residential habilitation centers as defined in WAC 388-825-089 when the patient has been transferred directly from a facility listed in subsection ((~~(4)~~)) (5) of this section.

AMENDATORY SECTION (Amending WSR 18-23-061, filed 11/16/18, effective 1/1/19)

WAC 246-919-920 Periodic review—Chronic pain. (1) The physician shall periodically review the course of treatment for chronic pain. The frequency of visits((~~, biological testing,~~)) and PMP queries in accordance with the provisions of WAC 246-919-985, must be determined based on the patient's risk category:

(a) For a high-risk patient, at least quarterly;

(b) For a moderate-risk patient, at least semiannually;

(c) For a low-risk patient, at least annually;

(d) Immediately upon indication of concerning aberrant behavior; and

(e) More frequently at the physician's discretion.

(2) During the periodic review, the physician shall determine:

(a) The patient's compliance with any medication treatment plan;

(b) If pain, function, and quality of life have improved, diminished, or are maintained; and

(c) If continuation or modification of medications for pain management treatment is necessary based on the physician's evaluation of progress towards or maintenance of treatment objectives and compliance with the treatment plan.

(3) Periodic patient evaluations must also include:

(a) History and physical examination related to the pain;

(b) Use of validated tools or patient report from reliable patients to document either maintenance or change in function and pain control; and

(c) Review of the Washington state PMP at a frequency determined by the patient's risk category in accordance with the provisions of WAC 246-919-985 and subsection (1) of this section.

(4) If the patient violates the terms of the agreement, the violation and the physician's response to the violation will be documented, as well as the rationale for changes in the treatment plan.

(5) Biological specimen testing should not be used in a punitive manner but should be used in the context of other clinical information to inform and improve patient care. Physicians should not dismiss pa-

tients from care on the basis of a biological specimen test result alone.

AMENDATORY SECTION (Amending WSR 18-23-061, filed 11/16/18, effective 1/1/19)

WAC 246-919-950 Tapering considerations—Chronic pain. Not all chronic pain patients will need their opioid prescriptions tapered. Relying on medical decision making and patient-centered treatment, the physician shall consider tapering or referral for a substance use disorder evaluation when:

(1) The patient requests;

(2) The patient experiences a deterioration in function or pain;

(3) The patient is noncompliant with the written agreement;

(4) Other treatment modalities are indicated;

(5) There is evidence of misuse, abuse, substance use disorder, or diversion;

(6) The patient experiences a severe adverse event or overdose;

(7) There is unauthorized escalation of doses; or

(8) The patient is receiving an escalation in opioid dosage with no improvement in their pain or function.

Public Comments

Pulled from:
https://wmc.wa.gov/rule_making_2023/physicians-and-physician-assistants-general-provision-opioid-prescribing-and
on April 17, 2024 at 11:51 am

1. **Savanna (not verified)**-*Sep 10, 2023 08:53 AM*

Hello, thank you for taking the time to hopefully read my email. I have had chronic back pain for 4 years now. What I have experienced with trying to get answers and treatment through this process is beyond disturbing to me. The medical field discriminates and is down right abusive to chronic back pain. The first thing I would like to address is being forced to have procedures or refusal of treatment of any kind. If you go to a pain management in this state with chronic back pain you are automatically pushed to do spinal injections. I am going to paste below what the FDA has on the website and encourage you all to look it up for yourself. The U.S. Food and Drug Administration (FDA) is warning that injection of corticosteroids into the epidural space of the spine may result in rare but serious adverse events, including loss of vision, stroke, paralysis, and death. The injections are given to treat neck and back pain, and radiating pain in the arms and legs. We are requiring the addition of a Warning to the drug labels of injectable corticosteroids to describe these risks. Patients should discuss the benefits and risks of epidural corticosteroid injections with their health care professionals, along with the benefits and risks associated with other possible treatments. Injectable corticosteroids are commonly used to reduce

swelling or inflammation. Injecting corticosteroids into the epidural space of the spine has been a widespread practice for many decades; however, the effectiveness and safety of the drugs for this use have not been established, and FDA has not approved corticosteroids for such use. We started investigating this safety issue when we became aware of medical professionals' concerns about epidural corticosteroid injections and the risk of serious neurologic adverse events.1 This concern prompted us to review cases in the FDA Adverse Event Reporting System (FAERS) database and in the medical literature (see Data Sum Now when I state this to doctors I am told this is a lie. That these injections are FDA approved. When I say we'll I don't feel comfortable and don't want to do them. I am met with aggression and am automatically treated like a drug seeker. First of all lieing to a patient is not right! I should be able to trust my providers and know the risks of procedures that are being pushed on me. Now let's get to the second thing that is pushed on back pain patients in this state. Cymbalta- if you do not know much about this medication I would again encourage you to do your research. It is being pushed by all your providers. Cymbalta has has hundreds of law suits filed against it. For severe withdrawal symptoms that last months. It literally causes brain zaps. There are literally rehabs to get off this medication and support groups. Again when I state this to the pain doctor I saw he got hostile. Told me that chronic pain support groups were for bitter people. Said he would never prescribe something that would cause such things. Again please do your research on this medication. Treatment for chronic back pain. When I started PT they

spasmed and threw my back out so bad I was stuck hunched over couldn't move without severe pain. I called my primary care which was booking out over a month. So me not knowing what do do went to my normal urgent care where I have been taking my kids for years. The provider walked in and her exact words were why are you here what do you want me to do for you we don't give meds! I was confused I went here because I had no idea what was going on what the physical therapist had done to me and was scared. She told me to go home and wait for my primary care appointment. Within 3 days the pain got worse I couldn't shower myself my left side was going numb so I then went to the ER. Again I got a lovely greetings from a provider that started to lecture me. He told me I was not allowed to go to the ER unless I was peeing myself or could not control my bowels. Said they won't do an MRI otherwise and they don't give meds. My mother who is a nurse case Manager in DC had to fly down to help me take care of my children and bathe me while I waited for my primary care appointment. I has a person had never felt so helpless in my entire life. I learned really quick that I was no longer treated as a person but a chronic pain patient. I learned to research everything that was being pushed on me. I am going to counseling for PTSD like symptoms now anytime my pain hits a level 6. I know I will be left bed ridden screaming in pain when my back goes out. Imagine having pain as bad as labor pains for a month and just having to lay like that knowing if you take all the strength you have left to try and see a provider you will get screamed at. I don't want to be on any medication daily all medications have side effects and withdrawals Nerve

meds, antidepressants, steroids, anti- inflammatory, pain meds, muscle relaxers. I should be able to have pain medication for acute flare ups and severe back pain. I have had chronic pain for Four years now I have learned to live with it and except this is what life has thrown at me. I love my life even with the things I cannot do but I want to be able to live it. I need to work remotely as I cannot stand walk or sit for more then 1-3 hours at a time. Yet I cannot get pain control to even go do in-person training to get a remote position. If I'm in a bad flare up and my kiddos have a sport tournament or dance recital I should be able to have pain control to attend the event. Those are the little things that make the struggles worth it. Yet I have to either leave earlier or go to the bathroom and cry instead of injoy seeing my kids grow. If my back goes completely out I should not be left unable to move shower for days dress myself. It's unhuman and down right wrong. I understand that pain meds when taken long term can make you think your in more pain then you actually are. I understand when taken daily they cause withdrawal just like everyother med given for chronic pain. You guys set up the rules so we are forced to have monthly injections or have to take daily meds like Lyrica or cymbalta with dangerous withdrawal there even known to cause brain damage. Instead of being able to take 5 to 10 low dose pain meds a month to manage bad days and give a better quality of life. I have now lived on aleve and Tylenol daily for 4 years do you know what that is doing to my body my stomach my liver. How can you really promote what you are doing. You are causing depression, you are causing more health issues by restricting

and taken away pain medication. Thank you for listening and I really hope you create a change. I fight as my son has identical back issues as I do. I hope to help change things before he hits 30s and has my issues. I could never imagine my child being left to suffer as I have and pray daily things will change. Kind Regards, Savanna

2. JEANNE A ROSNER (not verified)-*Sep 20, 2023 04:22 PM*
Sorry if I missed it... Do these rules for PAs and MDs exclude the prescribing of a long acting opiate e.g. methadone, or a schedule iii medicine such as buprenorphine, when used in the treatment of opiate addiction in an outpatient facility that complies with the SAMHSA regulations for distribution? Otherwise in agreement. Thanks.

3. Yvonne Helmick (not verified)-*Sep 22, 2023 04:24 PM*
Washington patients suffering from rare diseases and medical conditions that cause intractable pain have suffered tremendous harms because physicians fear legal retribution for treating pain patients. Patients have been abandoned or forced tapered and unable to find new practitioners willing to treat them. Many pain patients feel they only have few choices, to live suffering in pain with no quality of life, to move to countries that treat pain, go to the streets and obtain dangerous street drugs or commit suicide. Obviously the best choice is that patients are treated with empathy and compassion and remain under the watchful eye of physicians who treat them.

4. Anonymous (not verified)-*Sep 22, 2023 04:27 PM*

Why is it we have to suffer due to the ones choosing to take a medication not subscribed to them by their physician? Your cutting

5. Anonymous (not verified)-*Sep 22, 2023 04:33 PM*

Why is it we have to suffer due to the ones choosing to take a medication not subscribed to them by their physician? Your cutting off legit pain patients causing them to commit suicide because they have no quality of life left or forcing them to live in extreme pain! The 90MME is rediculious! The limit and milligram should be up to the physician that actually spent years upon years in college to learn how to safely prescribe. You try an go above an beyond protecting the criminal choosing to take things not prescribed at the expense of legit pain patients, when did their life become so much more valuable than ours?? Your sanctioning physicians for doing their jobs.

6. Maria (not verified)-*Sep 22, 2023 04:36 PM*

5 yrs ago The Human Rights Watch team did a year long investigation into how badly pain patients are being treated (mistreated) in this country. This mistreatment has only gotten worse since that report. This country's current overdose crisis is due to illicit and illegal drugs. Prescribing long ago stopped being the problem, yet politicians and the media keep feeding the false narrative. Physicians are afraid to treat patients, they face being arrested and prosecuted. Many have quit practicing, others have closed their clinics. Large health organizations forbid their "employees " (physicians) from doing

their job, which is to “do no harm” So patients are left to suffer agonizing pain, facing limited choices, suffer, commit suicide, move to another country or go to the streets and likely die from laced illicit drugs. When do patients right’s become important again? We definitely need to provide services to those suffering from addiction, but this can be done without causing harm to patients, who by no choice of their own, suffer from diseases and conditions that cause pain America is a great country, but it can do better, treat patients fairly

7. Isaac T Arnett Jr (not verified)-*Nov 22, 2023 09:06 AM*
Recently, my clinic had me sign a waiver agreeing that I am ok with being cut off from opioid meds, without notice and informed me that withdrawal is not life threatening. Frightening, that they would even mention such a thing. My pharmacy will not fill my full prescription and makes me pickup every 2 weeks instead every 28 days. 28 days is the standard, so I have the extra costs of transportation along with having to make the extra time. Even my Dr. askes me what is up with my pharmacist. The contract I am required to sign looks like something that a felony prisoner being released on parole would have to sign. It includes that "I must get better". That is odd due to people my age don't get better with a degenerative disease. I don't think anyone gets better with degenerative spinal stenosis. In a nutshell, I am treated like a criminal and undertreated for pain and my treatment is not individualized. An example for that is take meds as needed with a daily limit. Instead, it is take 1 every 4 hours. a lot of the criminalizing of pain patients comes from NARX scoring. I

recently had to purchase needles for intramuscular injection of hydrocortisone, due to having Addison's Disease. I did notice a difference in treatment at my pain clinic and at my pharmacy right after that. I had to go to a different pharmacy to get the meds and the needles and that because my regular pharmacy told me they couldn't get what I needed. Using more than one pharmacy goes against a person. The reason doesn't matter. Having injectables goes against a person. Living in pain 24/7/365 goes against a person. People living with chronic pain are treated like criminals..., and what looks to me like lab rats in some sci-fi experiment.

Rules Hearing

Postgraduate medical training

WSR 24-07-107
PROPOSED RULES
DEPARTMENT OF HEALTH
(Washington Medical Commission)
[Filed March 20, 2024, 11:52 a.m.]

Original Notice.

Preproposal statement of inquiry was filed as WSR 23-18-005.

Title of Rule and Other Identifying Information: Postgraduate medical training for physicians. The Washington medical commission (commission) is proposing amendments to WAC 246-919-330(4) to remove two requirements that have become a barrier to licensure.

Hearing Location(s): On April 26, 2024, at 9:45 a.m., virtually. Register for this virtual meeting to be held via [Microsoft] Teams http://tinyurl.com/5cppd9ea; or in person at the Department of Health, 111 Israel Road S.E., Room 153, Tumwater, WA 98501. To join the commission's rules interested parties email list, please visit https://public.govdelivery.com/accounts/WADOH/subscriber/new?topic_id=WADOH_153.

Date of Intended Adoption: April 26, 2024.

Submit Written Comments to: Amelia Boyd, Program Manager, P.O. Box 47866, Olympia, WA 98504-7866, email https://fortress.wa.gov/doh/policyreview/, by April 19, 2024.

Assistance for Persons with Disabilities: Contact Amelia Boyd, program manager, phone 1-800-525-0127, TTY 711, email medical.rules@wmc.wa.gov, by April 19, 2024.

Purpose of the Proposal and Its Anticipated Effects, Including Any Changes in Existing Rules: The purpose of this proposal is to amend the rules to align them with current practices and remove barriers to licensure for qualified applicants entering the physician workforce.

Due to the practitioner shortage, multiple pathways to board certification eligibility have been opened by the University of Washington (UW), the Accreditation Council for Graduate Medical Education (ACGME), and the American Board of Medical Specialties (ABMS). Multiple ABMS boards have programs that specifically target international medical graduates and place them in four-year training programs, with only years one and three ACGME accredited. The outcome of these programs would be physicians who are ineligible for a license through the commission, despite four years of postgraduate training through UW.

Separately and recently, applications have come through where the physician has six years of postgraduate training from their efforts to become dually licensed as a physician and a dentist. This clause has resulted in denial of those applications since parts of the training are accredited under ACGME and the rest under the Commission on Dental Accreditation (CODA), the dental profession equivalent of ACGME.

The proposed rule eliminates the requirement for consecutive years of training in no more than two programs which will remove the barrier for qualified applicants to obtain a physician license.

Reasons Supporting Proposal: The proposed rule is necessary for the preservation of public health, safety, and general welfare. Continued demand for health care professionals, especially qualified physicians, make it essential that qualified applicants are able to obtain a license. This proposed rule will result in increasing the quantity of health care professionals able to respond to current and ongoing staffing demands.

In 2023, the commission filed emergency rules originally filed on July 13, 2023, under WSR 23-15-056 and continued under emergency rule filed on November 9, 2023, under WSR 23-23-071. This rule making contains the same language used in the emergency rules and aims to make them permanent.

Statutory Authority for Adoption: RCW 18.71.017 and 18.130.050.

Statute Being Implemented: RCW 18.71.050 [(1)](b).

Rule is not necessitated by federal law, federal or state court decision.

Name of Proponent: Washington medical commission, governmental.

Name of Agency Personnel Responsible for Drafting: Amelia Boyd, 111 Israel Road S.E., Tumwater, WA 98501, 360-918-6336; Implementation and Enforcement: Kyle Karinen, 111 Israel Road S.E., Tumwater, WA 98501, 360-236-4810.

A school district fiscal impact statement is not required under RCW 28A.305.135.

A cost-benefit analysis is required under RCW 34.05.328. A preliminary cost-benefit analysis may be obtained by contacting Amelia Boyd, Program Manager, P.O. Box 47866, Olympia, WA 98504-7866, phone 360-918-6336, TTY 711, email medical.rules@wmc.wa.gov.

This rule proposal, or portions of the proposal, is exempt from requirements of the Regulatory Fairness Act because the proposal:

Is exempt under RCW 19.85.025(4).

Explanation of exemptions: The proposed rules only impact applicants seeking a physician license.

Scope of exemption for rule proposal:

Is fully exempt.

March 20, 2024
Kyle S. Karinen
Executive Director

OTS-4663.1

AMENDATORY SECTION (Amending WSR 20-22-003, filed 10/21/20, effective 11/21/20)

WAC 246-919-330 Postgraduate medical training. (1) Postgraduate medical training means clinical training approved by the commission in general medicine or surgery, or a specialty or subspecialty in the field of medicine or surgery as recognized by the American Board of Medical Specialties listed in the 2017-2018 ABMS Board Certification Report and new specialties or subspecialties approved by the commission.

(2) The commission approves only the following postgraduate clinical training courses:

(a) Programs accredited by the Accreditation Council for Graduate Medical Education (ACGME) at the time of residency.

(b) Programs accredited by the Royal College of Physicians and Surgeons of Canada (RCPSC) or the College of Family Physicians of Canada (CFPC), or programs accredited by the RCPSC or CFPC at the time of residency.

(3) Postgraduate medical training includes, but is not limited to, internships, residencies and medical or surgical fellowships.

(4) A physician must complete two ((~~consecutive~~)) years of postgraduate medical training ((~~in no more than two programs~~)). The physician must acquire this training after completion of a formal course of undergraduate medical instruction outlined in RCW 18.71.055. The commission will accept only satisfactory clinical performance evaluations.

Public Comments

Pulled from: https://wmc.wa.gov/rule_making_2023/postgraduate-medical-training

on April 17, 2024 at 2:17 pm

1. Patrick Delaney, MD (not verified)-Sep 29, 2023 10:54 AM

I applaud the effort to create a pathway for qualified international physicians to obtain a state medical license. As a long time residency program director, I would inject a note of caution about striking the language "...two consecutive years" and "...no more than two programs...". When a resident is not sufficiently medically competent to continue in a program (even if there has been no egregious act), is commonplace for US residency programs to give said resident a year of credit, but to not continue them in the program. The verbiage above was designed to keep poor performing trainees from completing a single year in multiple programs in order to obtain licensure. WA state now puts itself in jeopardy of being the final stop for these problematic physicians. The subsequent draft language requiring "satisfactory clinical performance" may/may not prevent this, as program directors are geerally loathe to commit themselves in writing to ending a trainee's career. One consideration would be to add a requirement for either satisfactory program completion, or for a letter from the last program director attesting to clinical competence. Thank you.

2. LeDeane Stewart (not verified)-Sep 29, 2023 12:05 PM

Hello, There is a more current ABMS Certification Report, 2018-2019. You might want to update that language or change to "the most current ABMS Board Certification Report". Thank you. LeDenae

Joint Operating Agreement-2023

Between the Washington Medical Commission and the Department of Health

Section 1-Introduction

Intent

It is the intent of the Washington Medical Commission (Commission or WMC) and the Department of Health (the Department or DOH) to enter a mutually beneficial Joint Operating Agreement (JOA) to promote efficiency, respect, and best practices in both organizations. Statute requires the Commission and the Department to enter into a JOA and recognizes the successful nature of the Commission and the Department in their respective organizational structures.

The Partnership

The Department and the Commission are interdependent entities within the system of health care regulation, each recognizing the role and expertise of the other. Both must comply with state and federal laws, administrative rules, and policies. The legislature created a partnership in which the Commission:

- sets organizational goals, policies, and procedures;
- has decision-making authority over the regulation and discipline of licenses under its jurisdiction;
- selects the Executive Director and staff, and;
- develops and manages a budget within allocated funds.

This reflects the intent of the legislature to return to the original mandate of the Commission as stated in article XX of the Washington State Constitution and increase the authority of health care regulators as described in the finding published in 2008 (RCW 18.130.020 c134). The Department has decision-making authority over administrative issues and procedures for the services the Commission accepts and in accordance with the remainder of the agreement. The Commission will work with the deputy assistant secretary of the Health Systems Quality Assurance division to provide feedback and input into administrative processes. The department and the commission pledge to maintain a cooperative and collaborative working relationship.

Statutory Requirement

RCW 43.70.240 requires that the Secretary and the Commission enter into a Joint Operating Agreement (JOA). The operating agreements must include, but are not limited to, the following provisions:

- Administrative activities supporting the Commission's policies, goals, and objectives;
- Development and review of the agency budget as it relates to the Commission;
- Commission related personnel issues;
- Use of performance audits to evaluate the consistent use of common business practices when appropriate; and
- Calculating and reporting of timelines and performance measures.

This document fulfills that requirement.

Effective Date and Amendments

When signed by both parties, this joint operating agreement will become effective and will remain in effect until superseded by a new agreement. Both parties agree to review the JOA prior to the end of each biennium. The parties may amend this JOA at any time by written agreement. Either party may initiate amendment of the agreement by requesting a meeting to be held as soon as practical. The request must be answered in writing within ten business days. The response must include the rationale for the decision.

Review

The Executive Director, in consultation with the Commission Chair, shall review this JOA with the Chief of Prevention, Safety and Health or designee by the end of each biennium.

Good Faith

Both parties pledge to act in good faith and use their best efforts to maintain a cooperative and collaborative working relationship. Both parties agree to regular meetings at least quarterly between the appropriate Department staff to discuss business needs or concerns, and the deputy assistant secretary will offer consultations regarding significant policy changes or decisions related to budget, human resources, facilities, records, and information governance.

Disagreements

Per RCW 43.70.240, any dispute between the Commission and the department must be mediated and determined by a representative of the Office of Financial Management (OFM).

Section 2-Definitions

Administrative Services

Services provided by the Department to the Commission in accordance with applicable policies and procedures, state and federal laws, administrative rules, policies, collective bargaining agreements and Governor's executive orders.

Assigned Assistant Attorney General

An attorney, appointed by the Washington State Attorney General under RCW 43.10, to advise the Commission in all matters involving legal or quasi legal questions.

Assistant Secretary

The Assistant Secretary of Health Systems Quality Assurance Division (HSQA). The Assistant Secretary is accountable to the Secretary of Health.

Business Plan or Strategic Plan

A detailed outline of the mission, vision, goals, and objectives for the Commission.

Chief of Prevention, Safety and Health

Executive leader who reports to the Secretary and oversees the following DOH Divisions: Environmental Public Health, Health Systems Quality Assurance, and Prevention and Community Health.

Commission
The Washington Medical Commission, founded in 1881, provided for in article XX of the Washington constitution in 1889, and whose authority is housed in RCW 18.71, 18.71A, and 18.71B is charged by statute with protecting the health and well-being of the public. By statute and function, the Commission is an independent regulatory authority.

Consultation
Providing information and seeking advice to take under consideration prior to making a decision.

Department of Health
The Washington Department of Health, established in 1989 under 43.70 RCW to provide a strong, clear focus on public health programs and issues previously spread across several other agencies.

Deputy Assistant Secretary
The Deputy Assistant Secretary of HSQA.

Chief of Staff
Chief of Staff for the Department of Health.

Executive Director
The Executive Director of the Commission.

Fiscal Officer
The Finance and Operations Manager (FOM) assigned to provide fiscal support to the Medical Commission who reports to the Director of Program Financial Management within Financial Services.

Indirect Charges
Charges for administrative costs that support and are linked to program and/or functional activities and tend to vary with activity level or size, but usually cannot be practically or economically directly charged.

Office Director
The director of an office in the Department.

Office of Human Resources
The Department of Health unit designated to perform human resources functions.

Office of Financial Management
The Office of Financial Management in the office of the governor.

Performance
Outcomes resulting from processes, services, or work relative to the stated benchmark, objective, or goal. Performance is quantifiable and stated in measurable terms.

Secretary
The Secretary of the Department of Health.

Service Unit Charges

Charges by specific units of business against the Commission's budget for services rendered.

Section 3-General Roles and Responsibilities

The primary responsibilities of the Department include:

- Preservation of public health;
- Monitoring health care costs;
- Maintenance of minimal standards for quality in health care delivery; and
- General oversight and planning for all the state's activities as they relate to public health.

The primary responsibility of the WMC is to regulate the competency and quality of its licensees by establishing, monitoring, and enforcing qualifications for licensing, consistent standards of practice, continuing competency, and discipline. Through these activities, the Commission works to improve the health care delivery aspect of public health in Washington.

The Commission's Executive Director is responsible for overseeing all administrative activities, policies and procedures required to ensure the Commission functions effectively.

The Department agrees to provide administrative services including: financial and business services; human resources; risk management; information technology; and emergency preparedness support consistent with OFM guidelines and federal and state law. The Commission agrees to follow all Department policies and procedures associated with the services provided under this operating agreement but reserves the authority to collaborate with the Department in the development of Commission specific standards or practices. The Commission will be charged for these services through the indirect rate plan or through direct chargeback to the Commission.

The Department and Commission will jointly establish performance metrics for administrative services. Performance will be reviewed regularly, by both parties, depending on the availability of data.

The Department's Chief of Prevention, Safety and Health, Assistant Secretary, Deputy Assistant Secretary, and office directors provide a conduit for the Executive Director to access agency internal resources, inform consistent business practices (where applicable), and support services. The Executive Director consults with Department management regarding issues such as rent, supply needs, budget coordination, support services, and human resource needs.

When the Department or the Commission develops recommendations that may change the other's statutory authorities, impact agency activities, or potentially effect professions outside the Commission's authority, both parties agree to provide to the other opportunities to comment on drafts as far in advance as possible. When possible, comments will be included in the recommendations.

Signature Authority

The commission and secretary may each delegate their signature authority. The commission documents and reviews their signature authority and delegations every year. The commission agrees to use the DOH signature authority portal to document delegated signature authority according to DOH procedure.

Section 4-Budget Development

Joint Process

The Executive Director prepares the biennial budget and the Commission, in consultation with OFM and other necessary parties, will propose a Commission budget. The Secretary must submit the Commission budget unaltered to the Office of Financial Management (OFM). All budget decisions rest with the Commission. The Department acts in an advisory, technical role with respect to the Commission's budget, as requested by the Commission.

Spending Authority

The Department notifies the Commission of the Commission's spending authority within 45 days of the date the Governor signs the budget. The Department must present the final biennial budget and/or supplemental budget and allotments for the Commission for approval to the Executive Director no more than 90 days from the start of a new fiscal year. The Commission receives the previous biennium's level of spending authority (known as "carry- forward"), plus or minus any regular adjustments made through the state budget. The Department must document any and all changes to the Commission spending authority. The Commission retains the right of final approval. Any and all spending decisions related to Commission-funds rest with the Commission and its Executive Director regardless of positive or negative spending variances. Any disputes are to be resolved through mediation as described in Section 1 – *Disagreements.*

Additional Spending Authority

As required by RCW 43.70.320(5), the Secretary, at the request of the Commission will seek out additional health professions account spending authority for the Commission to meet unanticipated costs when revenues exceed more than 15 percent over the Department's estimated six-year spending projections for the Commission. The Secretary will first look internal to the agency for this additional authority to allot in the Commission budget. Nothing in this section prohibits the Commission from pursuing additional spending authority through the regular decision package funding or errata process as determined to be necessary by the Commission.

Adoption of Fees

The Secretary will consult with the Commission prior to adopting fees for the professions under the authority of the Commission to be distributed under RCW 43.70.250. The statute requires the cost of each profession be fully borne by members of that profession. These funds are solely dedicated for the work of the Commission to carry out its goals, objectives, and functions.

Section 5-Financial Management

Impact Analyses

When requested by the Commission, Department staff provide financial and funding impact analyses whenever the Department proposes a change that will impact the Commission's budget.

Service Unit Charges of the Department to Commission Budget

At the beginning of each biennium, the Department will review with the Commission the list of service unit costs that includes the cost allocation basis. Service unit expenditures against allotment for the Commission will be included in the monthly (board) financial reports received by the Commission. Billed

hours information will be provided for billed services such as legal and investigative services related to unlicensed or other cases. Both parties recognize that the service unit costs for the Commission may vary from that of other boards and commissions.

Budget Reports

Department staff will prepare regular financial reports which include expenditures against allotments, encumbrances, revenue, and fines collected, and submit them to the Executive Director or designee for review. Items identified for further investigation or correction will be acted on by Department staff.

Indirect Charges

The Department justifies and notifies the Commission of indirect rate charges against the Commission budget. The Department notifies the Commission prior to the start of the new biennium and prior to the new rate adoption.

Section 6-Personnel

The Department will provide support and consultation on human resources activities in accordance with all applicable laws, rules, Department policies and procedures and the collective bargaining agreements between the State of Washington and relevant unions. The Office of Human Resources will designate a point of contact for the Commission for HR activities which include but are not limited to:

- Classification;
- Compensation;
- Labor Relations;
- Corrective/Disciplinary Actions;
- Reductions in Force;
- Performance Development Plans;
- Recruitment;
- Applicable RCW and WAC interpretation;
- Application of collective bargaining language;
- Training and Development;
- Worker's Compensation claims.

The Department's Office of Human Resources (HR) will also partner with the Executive Director to ensure Department employees who work with the Commission are aware of human resource policies, related expectations for employees and how to raise questions and address issues that arise. The Executive Director will use the Department's established human resource processes, procedures, and systems. Concerns regarding HR activities will be raised to the HR point-of-contact for the Commission or the HR Director for discussion and/or action.

To ensure on-going communications, the Executive Director and the HR point of contact for the Commission will meet regularly. When the HR Office becomes aware of any significant workforce issues that might have an impact on the staff of the Commission (such as a reduction in force action), the HR Office will communicate with the Commission as early and often as possible. The HR Office will seek the Executive Director's input into changes impacting Commission staff.

Status of Commission Employees

The Secretary shall employ the Executive Director who is exempt from the provisions of the state civil service law, chapter 41.06 RCW. The Commission selects, hires, evaluates, sets compensation for, and terminates the Executive Director of the Commission. The Executive Director is the appointing authority designated by the Commission to select, hire, evaluate, compensate, and terminate all staff dedicated to the Commission in a manner which promotes retention of quality staff talent. The Department and the HR Office recognize that the Executive Director reports to the Commission and the Executive Director hires and manages the dedicated staff. The Department recognizes that due to the status of the Commission employees and their dedicated fee-based funding source, reductions in force, furloughs, and other Department wide staffing impacts may not apply to Commission staff.

Commission workforce management activities will follow requirements set forth in Washington statutes and rules. The Commission may opt-in to follow Department-unique policies and procedures. HR will work with Commission staff to ensure workflows meet Commission timelines and needs. The Commission will follow state Department of Personnel Civil Service rules, and any applicable collective bargaining agreements. The Department and the Commission will work to identify mutually agreeable solutions for the future of the physical workplace that accommodate hybrid work schedules and those staff members who will primarily work in the office.

Specific Consideration

In consultation with the HR Office, the Commission will determine its staffing based on its specific organizational needs. While understanding that standards and precedents exist within the Department, the Commission makes decisions regarding position establishment, classification, and other position actions in accordance with the state classification and compensation system, Civil Services rules, and applicable collective bargaining agreements. The Commission has authority to require and provide specific training, within existing funding and collective bargaining requirements, to its staff relating to specialization of medical regulation, licensing, staff development, or other needs as identified by the Commission.

Section 7-Core Activities

Credentialing

The Department maintains a single background check unit for the purpose of access to the resources and authority to comply with the Washington State Patrol (WSP) and federal fingerprint background checks. The Commission credentialing unit will continue to perform Washington State Patrol background checks on its applicants. The background check unit will adhere to these performance requirements:

- Scanning cards into WSP-within five business days of receipt;
- Clear FBI workflow and update User Defined Fields within two business days of receipt of report from WSP.

HSQA staff is responsible for creating, modifying and posting applications and other forms used as part of the credentialing application and renewal process. HSQA will follow a consistent and transparent process in making these changes to ensure that online systems dependent on these forms are not impacted. The Commission develops forms and processes related to FSMB services and interstate compact services for its regulated professions. The Commission and HSQA approve these forms and processes before implementation, to ensure that they do not adversely impact Department systems and processes.

Discipline

The Commission and the Department will work together with the other boards and commissions as appropriate to coordinate complaints that involve multiple disciplinary authorities.
The Commission and Department will work together to develop processes that are consistent and supportable by Commission and Department staff when necessary.

Complaint Handling

The Department will forward all complaints to the Commission concerning practitioners under the Commission's authority for initial intake and assessment. The Commission will forward all complaints to the Department concerning practitioners under the Secretary's authority for initial intake and assessment.

Prescription Monitoring Program (PMP)

As a significant user of the PMP in daily regulatory investigative and case work, the WMC has a public health and safety interest in the consistent operation and feature set of a functional PMP. The Department will provide the WMC with a minimum of 90 calendar days' notice and opportunity to provide meaningful and collaborative feedback for any significant operational or feature change in the PMP that is likely to reduce the WMC's access to or use of the PMP. Examples of such changes would be limiting the historical review ability in any way.

Mutual Goals

The Commission and the Department will work together toward the following goals:

- Complete complaint intake and assessment activities within timelines;
- Complete investigations in an efficient and timely manner that facilitates timely case disposition;
- Draft and serve disciplinary actions and other legal pleadings in an efficient and timely manner;
- Ensure that hearings take place when scheduled;
- Ensure that disciplinary orders comply with the sanction rules;
- The Commission and the Department will consider implementing pilot programs for the Commission to improve disciplinary efficiency and effectiveness.

Policy

Legislative Issues

When the Commission identifies issues that require legislative action, the Commission uses its authority to work with legislators to find a solution. The Commission submits request legislation to the OFM and the Governor for the desired solution, with notice to the Department. The Department will provide consultation and technical advice in the development of legislation as requested. The Commission will provide support relating to its request legislation, decision packages, and proposed legislation affecting the Commission. This support includes but is not limited to:

- Identifying, researching and developing legislation;
- Coordinating with stakeholders;
- Providing testimony;
- Educating the Legislative branch;
- Educating the Executive branch;
- Monitoring request legislation progress.

The Commission and the Department will coordinate legislative issues in good faith for the mutual benefit of the organizations. Prior to the legislative session, the Department will provide feedback to the Commission on legislative proposals and any guidance provided by the Secretary, OFM or the Governor. The Department will submit the Commission request legislation unaltered to OFM and the Governor. The role of Department will be technical, advisory consultation, as requested by the Commission. The Department and Commission agree to discuss in advance and attempt to come to an agreement on public positions expressed on any legislative matters.

Strategic decisions on legislative testimony are based on the political context of the issue and the most effective way to convey the agency position on a bill. The Executive Director and/or designee will represent the Commission in agency discussions on legislative issues impacting the Commission. A Commissioner or Commission designated staff may testify on issues directly impacting the Commission.

Contact with Legislature and Legislators

In accordance with RCW 18.71.430, in addition to the authority provided by RCW 42.52.804, the Commission, its members, or staff as directed by the Commission, may communicate, present information requested, volunteer information, testify before legislative committees, and educate the legislature. Both the Commission and the Department acknowledge the ability of the other party to provide testimony and contact the legislature, as they deem appropriate within existing statutes. The parties may provide testimony and contact legislators and legislative staff as authorized under the Public Disclosure Act, chapter 42.56 RCW, and the Executive Ethics Act, chapter 42.52 RCW. The Commission and the Department make every effort to coordinate and/or communicate with each other for the purposes of sharing information.

In issues relating to the Commission or its work that come before the legislature, the executive, the judiciary, or public referendum, the Department will recognize the authority and expertise of the Commission and its staff by soliciting and including Commission opinions and analysis in assessment, educational, or analysis materials. Any constituent inquiries received by the WMC or DOH relating to their respective work will be forwarded to the appropriate entity for response and resolution in a timely manner.

Rule-making Authority

Statutes authorize both the Commission and the Secretary to develop and adopt rules to carry out respective statutory responsibilities. The Secretary is also required to review and coordinate all rules, interpretive statements, policy statements, and declaratory orders proposed by the Commission and provide any comments or suggestions that the secretary deems appropriate.

The Commission and Department agree to work together when developing rules and guidelines that impact one another or another profession not regulated by the Commission. If the Commission, in consultation with the Secretary or designee, determines that the proposed rules or guidelines, or changes to existing rules or guidelines, will negatively impact the Commission's ability to effectively carry out its statutory duties, then the Commission will collaborate with the Secretary to develop alternative solutions to mitigate the impacts. All rulemaking activities must comply with the Administrative Procedure Act, chapter 34.05 RCW.

The Commission will use Department processes, forms, and memos during rulemaking for consistency. When the Commission submits a completed rules package to the rules management system (ESPER), the agency is committed to processing, responding to, and reviewing the package within 30 days. The

Secretary or the Secretary's designee will review rules packages. In addition, the Department is responsible for:

- Filing all forms with the Code Reviser;
- Maintaining the official rulemaking file.

Section 8-Contracts

Unless otherwise prohibited by law, the WMC may enter into contractual agreements for services. WMC will do so in consultation with the department and follow standard agency contract review and filing processes. The department's Contract Unit will:

- Prepare and execute contracts and amendments on behalf of the Commission;
- Provide consultation and technical assistance on contract matters to Commission staff or other operational staff, as needed;
- Conduct solicitation processes to include meeting any requirements of Department of Enterprise Services (DES), negotiate terms and conditions of contracts;
- Ensure the Commission Executive Director is informed of contract-related training opportunities so Commission staff may participate as appropriate.
- Process and prepare contracts for signature;
- Serve as liaison with DES on contractual matters;
- Review and provide comments/recommendations and negotiate directly with or assist in the negotiation with contractors for any required modifications to statement of work and contract terms and conditions;
- Maintain the Enterprise Contracts Management System (ECMS) database so the Commission staff may have access to Commission contract information;
- Serve as the point of contact for the Commission on contractual matters.
- Act as contractual liaison between Commission employees and contractors as needed.

The Department's contacts unit is the primary records custodian for records created in the course of preparing, offering, and executing contracts and amendments. The Commission is the primary custodian of records created during contract management.

Exemptions

- The Commission has the authority to enter contracts to retain expert witnesses.
- The Commission has the authority to enter contracts for external IT services as described in Section 15 of this agreement. The Commission will inform the Department of these contractual arrangements annually or as requested by the Department, for the purposes of accounting and auditing.
- The Commission has the authority to adopt a clinical assessment to determine the readiness of international medical graduates to apply and serve in residency programs and adopt a grant award process for distributing funds in accordance with RCW 18.71.475.

Section 9-Records Management and Public Disclosure

The Washington Medical Commission (Commission) may elect to operate its own separate public records office, in accordance with all applicable RCW 42.56 Public Records Act (PRA) requirements, involving Commission records. If the Commission exercises this option, the date of transfer of PRA responsibilities from the Department to the Commission's newly formed public records office will occur in 2024, but will not be earlier than May 1, 2024, and the Department will remain responsible for responding to and fulfilling any PRA requests received up to that date of transfer in accordance with Section 9b. To ensure a seamless transition in the transfer of PRA responsibilities, the Commission will provide the Department with 60-calendar days prior written notice in which the Commission will affirm that the Commission's public records office is in conformity with RCW 42.56 and will in 60 calendar days commence operating. Until and unless such notice from the WMC to the Department of the data of transfer which activates section (9a) as the controlling section, section 9b will remain in effect as the controlling section.

Section 9a-Records Management and Public Disclosure

Pursuant to the PRA, the Commission will operate its own public records office and do the following:

- Provide the administrative and technical framework for receiving and fulfilling public records requests in accordance with the PRA, and other relevant statutes;
- Publish procedures in the Washington Administrative Code regarding how the Commission will utilize its public records office to respond to public records requests;
- Assume responsibility for awareness of PRA requirements, in addition to initiatives or changes involving records management or public records disclosure that could impact the Commission;
- Appoint its own Public Records Officer who will supervise the handling of public records and public records requests, review assembled records to ensure that exemptions are properly redacted prior to records being released, notify requestors if the Commission is aware of records created by the department in the course of administrative support to the Commission and how to proceed through a separate request to the department, and communicate with the Commission potential PRA compliance issues; and
- Ensure the Commission's compliance with the PRA including, but not limited to, implementing, and maintaining adequate public record retention schedules, redacting exempt information (as deemed applicable by the Commission), and releasing properly requested public records not exempt in a timely manner.

As determined by the PRA, Commission records may be subject to retention, redaction, and release. Commission records include any writing[1] containing information relating to the conduct of government or the performance of any governmental or proprietary function (e.g., licensing, investigative, legal,

[1]Per RCW 42.56.010(4), the definition of "writing" includes "handwriting, typewriting, printing, photostating, photographing, and every other means of recording any form of communication or representation including, but not limited to, letters, words, pictures, sounds, or symbols, or combination thereof, and all papers, maps, magnetic or paper tapes, photographic films and prints, motion picture, film and video recordings, magnetic or punched cards, discs, drums, diskettes, sound recordings, and other documents including existing data compilations from which information may be obtained or translated."

operational, and administrative records) prepared, owned, used, or retained by the Commission pursuant to RCW 42.56.010(3). Any records outside of this definition are considered not identifiable pursuant to RCW 42.56.080(1) and, as such, are not subject to a response by the Commission. Commission records reside in, but are not necessarily limited to, the following locations:

- WMC S:drive;
- WMC X:drive;
- WMC folders located on the Y:drive;
- WMC Email Exchange, Microsoft Sync Center & O365 profiles;
- WMC SharePoint;
- WMC website and social media accounts; and
- WMC administrative records in ILRS and successor solutions.

The Commission will consider recommendations from the Department in creating and maintaining the Commission's records retention schedules. The Commission will recommend to the State Records Committee approval of any changes involving records retention schedules that the Commission recommends adopting, specific to the Commission's work.

Pursuant to the PRA, the department will continue to retain the following roles[2]:

- Provide requestors administrative records not held by the Commission that were created by the department, including but not limited to:
    - Labor disputes,
    - Personnel files,
    - Fiscal records,
    - Contracts, and
    - Payroll;
- Notify requestors of possible records created by the Commission in the course of normal business operations that may be obtained through a separate request to the Commission;
- Assist the Commission, upon the Commission's request, with any requirements (e.g., activities or paperwork) involving the transfer of records to the State Records Center, the State Archives, or the Digital Archives;
- Allow the Commission to request the Department's information technology staff to conduct electronic searches via Service Central or successor systems to accomplish electronic searches pursuant to valid requests under the PRA; [3] and
- Assist the Commission, upon the Commission's request, with the disposition of records that have met their retention period.

[2] The Commission agrees to follow relevant policies and procedures established by the department or developed by the Commission related to this section.

[3] However, the Commission will be responsible for formulating a search plan and working directly with the Department's information technology staff to accomplish the search.

For purposes of liability for public records violations and torts claims related to the PRA, the department and Commission are separate entities. As such, the department and Commission will be legally separate and individually responsible for defense of and remediation of violations. However, the department and the Commission agree that they have a shared, common interest in complying with the PRA, and, at times, may face similar PRA compliance questions and issues. Therefore, the department and Commission agree each party may share attorney-client privileged and work product protected information with the other regarding PRA compliance, applicability of exemptions, or legal claims without waiving attorney-client privilege or work product protection, unless the parties are adverse in a legal claim.

Section 9b-Records Management and Public Disclosure

The Department records management office and public disclosure office will process records and public disclosure requests for the Commission. The Department will inform the Executive Director of the Commission of any initiatives or changes in the areas of records management or public records disclosure that could significantly impact the Commission.

The Department will assist the Commission with the creation and maintenance of records retention schedules, including presenting any recommended changes to the State Records Committee for approval.

- The Commission is the primary custodian for records created in the normal course of Commission business. The Department is the primary records custodian for records created in the course of providingadministrative support (HR, IT, Financial, etc.) to the Commission.
- The Department will assist the Commission, upon request, with any requirements (activities or paperwork) for the transfer of records to the State Records Center, the State Archives, or the Digital Archives, and disposition of records that have met their retention period.
- The Department will inform the Commission's Executive Director of training opportunities in the areas of Records Management and Public Records Disclosure so that Commission staff may participate as appropriate.

The Commission will provide response to records requests by the Department-within 10 business days so that the Department fulfills public records requests within timelines. The Department will allow the Commission to request the Department's information technology staff to conduct electronic searches via Service Central or successor systems to accomplish electronic searches pursuant to valid requests under the PRA.[4] Commission The Department will provide the administrative framework to respond to public records requests consistent with the laws governing public record disclosure.

For purposes of liability for public records violations and torts claims related to the PRA, the Department and Commission are separate entities. As such, the Department and Commission will be

[4] However, the Commission will be responsible for formulating a search plan and working directly with the Department's information technology staff to accomplish the search.

legally separate and individually responsible for defense of and remediation of violations. However, the Department and the Commission agree that they have a shared, common interest in complying with the PRA, and, at times, may face similar PRA compliance questions and issues. Therefore, the Department and Commission agree each party may share attorney-client privileged and work product protected information with the other regarding PRA compliance, applicability of exemptions, or legal claims without waiving attorney-client privilege or work product protection, unless the parties are adverse in a legal claim.

Section 10-Risk Management

The WMC is regularly the recipient of threats against its Governor appointees and its staff. The Department agrees to provide timely consultation, coordination, and Commission approved action based on actual or perceived threats. This support includes timely involvement of law enforcement or other services necessary to protect the safety of the WMC and its staff.

The Department will process claims for damages against the Commission and its employees. This will include, on the Commission's behalf, interaction with the state risk manager, claim settlement, arrangement for defense counsel, and coordination with attorneys general from that agency's tort division. The Department's Risk Manager will consult with the Commission's Executive Director or its designee upon receipt of a claim, and at every major step until the claim is resolved. The Department will not authorize settlement of a claim against the Commission for more than five thousand dollars ($5,000.00) without approval of the Executive Director.

The Commission is included in the Department's tort liability coverage provided through the self-insurance liability fund (Chapter 4.92 RCW). The Department may assess the Commission a proportionate share of its liability insurance premium as if the Commission were a sub-division of the Department. The Commission share may only be based on number of employees, not including Governor-appointed members, and/or its claims history.

The Department will include Commission assets in any commercial property insurance it obtains for the building that houses the Commission. The Commission may be assessed its proportionate share of the Department's premium. The Department will provide safety and other loss-prevention consultation services to the Commission. Commission staff will comply with agency policies on safety and security. The Commission will support employee participation in the safety and emergency response committee.

The Department's information technology staff will conduct electronic searches via Service Central or successor systems to accomplish electronic searches pursuant to active or pending litigation for the Commission.[5] If the department discovers or is notified of lapses or failure in the information technology tools to conduct said searches, the department will inform the WMC within five business days of the issue and its scope as known at that time.

[5] However, the Commission will be responsible for formulating a search plan and working directly with the Department's information technology staff to accomplish the search.

Section 11-Emergency Preparedness

The Department will include the Commission and its staff in campus emergency response plans and Commission staff will participate in emergency response drills and exercises. Commission staff may participate in DOH continuity of operations with the permission of the Executive Director. Commission continuity of operations will take priority.

The Commission shall complete and update as necessary a continuity of operations plan within the division's plan under the guidance of the Department's emergency preparedness staff. The Commission will engage with the Department regarding coordination of the Commission's essential functions. The Commission is encouraged to provide appropriate representatives to the Department's Receipt, Staging and Storage facility, Agency Coordination Center, and other Incident Management Teams that may be established to support the agency's response to emergencies or disasters. In addition, the Commission is encouraged to have each staff clearly identified emergency roles in position description forms.

Section 12-Reports

Department of Health Report

The Department prepares a Health Profession Quality Assurance and Regulatory Activities Uniform Disciplinary Act report to the Legislature and Governor. When the report contains aggregate data and when the Commission's data is not segregated, the Commission will have a timely opportunity to review and submit changes before the Department submits the report. The Commission may submit an addendum to the report according to RCW 18.130.310(2). The addendum may serve as the Commission biennial report.

Timely Submittal of Reports

The Commission and the Department will ensure that all reports are completed and submitted to the appropriate authority on time. The WMC will submit reports to the Governor, Legislature, or other required parties. All Department reviews are informational and must be completed within 45 days or less. WMC reports must be submitted only with Commission approved changes.

Section 13-Extra-Governmental Relations

General

The Commission will increase its identity and visibility with its stakeholders and efforts may include participation in policy groups, development of educational materials for varied stakeholders, establishment of a unique web presence, creation of a unique social media presence, or other methods as they become available to the Commission. The Commission reserves the authority to adopt the communications and publications standards of the Office of the Governor.

Participation

The Commission, in its role relating to medical practice in Washington, will participate in various state, national, or international groups with the intent of improving health care delivery and medical regulation.

Media Relations

The Department will refer to the Commission all media inquiries concerning the Commission or its work. The Commission retains the right of final review on all press releases and media documents issued through the Department's communications office regarding or on behalf of the Commission. The WMC will collaborate with the Department's communications office on issues of mutual concern.

Executive Correspondence

The Department will notify the Commission in response to any high-profile inquiry, also known as Executive Correspondence, relating to the work or other aspects of the Commission. The Commission will make every effort to respond in a timely manner. The Commission will follow Department and division processes to ensure appropriate tracking and timely response.

Section 14-Accounting and Payroll

The Department agrees to:

- Provide expertise in purchasing items, supplies, and services for the Commission;
- Train Commission staff on state purchasing rules and requirements and to ensure that all purchasing transactions are completed properly;
- Track all capital asset inventories for Commission;
- Seek the best pricing for the Commission following all purchasing rules;
- Assure timely payment of duly authorized vendor billings and contract services;
- Assure timely payment of duly authorized travel expenditures for Commission staff and Commission members;
- Process bimonthly payroll and benefits for Commission staff and Commission members;
- Process all cash receipts/revenue received on behalf of the Commission.

Section 15-Information Technology and Business Solutions

The Department provides information technology planning, management, and support services to and as requested by the Commission. The Department recognizes that the WMC has specific needs that must be met to accomplish its statutory duties. The goal of enterprise solutions shall not prevent the WMC from procuring services or solutions, from Office of Innovation and Technology (OIT) or others, that meet the needs of the Commission. The commission will collaborate with OIT to assess the capabilities of enterprise solutions in response to commission business needs, identify gaps and reach agreement on options.

- The Department will assist in assessing and recommending technologies or services that meet State Enterprise and Department standards within the framework set out by this section. The Department will work with the Commission to meet its business needs. This includes information technology consulting services, Business Relationship Management (BRM), solution architecture, IT procurement and asset management, contracts-licensing-vendor management,

service and system support, enterprise architecture, security risk and compliance,project services, IT specific training services. The Commission agrees to purchase standard technologies that can be supported by the Department when appropriate. The commission with collaborate with OIT in order to determine gaps in agency standard solutions.

- The Commission may elect to purchase and pay to support non-standard technologies or provide support following all required policy and procedures as relevant. In these instances, the Commission will coordinate with OIT using the agency process when necessary. The Commission accepts that in these instances that OIT may not offer support of these services or technologies.
- The Department will assist with information technology activities related to applications and data, suchas: service management, testing and quality assurance, data services, application management, software development, enterprise applications, content services, and Geographical Information Services. In addition, OIT will broker services with CTS, vendors, other state agencies and any other needed parties. In those instances where OIT does not have capacity to timely support WMC needs, the Department will rely on WMC staff assessment and expertise.
- The Department will provide desktop services, remote employee support services, network services, infrastructure services, telephony services, mobile services, messaging, and collaboration, including but not limited to; standard hardware and software installation, email support, approved handheld device support, file storage space, voice communications, video conferencing, and web conferencing.
- If WMC determines the need to submit an exception request, OIT will provide business liaison and analyst support. Exception requests will be reviewed and answered within 30 calendar days of submission of a complete request from WMC. The commission acknowledges some requests are more complex in nature, may require external vendor information to process which can impact time to serve. In those cases, OIT will provide status, communication and will collaborate with the commission to process requests.
- The Department currently makes use of the Integrated Licensing Regulatory System as the enterprise system to support the regulation of the health care delivery system. The department is in the process of transitioning to the Healthcare Enforcement and Licensing Management System (HELMS). The Commission shall have full access to any functions in the ILRS system that is needed to support the essential and reasonable functions of the Commission and will have the same level of access when HELMS comes online. The Commission agrees to keep its staff fully trained as needed in the use of the ILRS and HELMS systems consistent with its use throughout the Department and will ensure new staff are trained as quickly as possible.
- -Until a more useful and pertinent system is procured and deployed by the Commission~~,~~ the Commission agrees to use the system in such a way that allows the Department meaningful performance management data extraction. If ad hoc reporting permissions are not provided to WMC staff, the Department will provide the requested ILRS report or data requested by the requested by date or 10 business days, whichever is greater to the fullest extent possible. The commission will utilize escalation for urgent requests within the system support team and OIT when applicable. OIT will communicate and collaborate with the requester to confirmation request requirements, address complexities, limitations, or dependencies of requests as applicable.
- The Department will consult with the Commission prior to making changes to ILRS or successor systems that impact Commission work. The Commission reserves the right to deny any changes that would significantly impact the work of the Commission. The Department is responsible for providing a solution that meets the needs of both HSQA and the Commission. If such a solution

is not possible, the Department will provide all necessary support for the Commission to procure its own solution with the cost for the solution itself being borne by the Commission.

Section 16-Performance Management

Development

In accordance with RCW 18.71.430, the Commission will negotiate with the Secretary to develop performance- based expectations, including identification of key performance measures. The performance expectations will focus on consistent, timely regulation of health care professionals and reasonable performance expectations for the Department in fulfilling its administrative support commitments. The Department will develop, in consultation with the WMC, a comprehensive set of administrative services performance measures to guarantee adequate support and fulfilment of this agreement.

Data Collection by the Department of Health

The Department will provide the Commission with access to the relevant performance data necessary to effectively measure performance and achieve the Commission's goals. Per RCW 43.70.240(5), the parties will agree on the calculation and reporting of timelines and performance measures. The Department and the Commission will review, and update agreed upon performance measures every four years.

Performance Audits

Per RCW 43.70.240(4), the parties will use performance audits to evaluate the consistent use of common business practices where appropriate. The parties will agree on an auditor to conduct a performance audit, the purpose of the audit, and the scope of the audit.

Commission and Department Coordination

The Executive Director and the Department will meet as needed to review performance and discuss issues of common interest. These meetings will focus on accountability for services rendered and promote mutual success. Key business managers may be included as needed in the meetings.

Other Committees and Work Groups

To support cross divisional processes and effective development of shared business practices, appropriate Commission staff will actively participate in the following regular work groups and steering committees including but not limited to:

- Enforcement Steering Committee;
- Credentialing Steering Committee;
- Online Licensing and Information Collection Steering Committee.

Signatures

X

Umair Shah, MD
Secretary, Washington State Department of Hea...

X

Karen Domino, MD
Chair, Washington Medical Commission

Committees & Workgroups

WASHINGTON Medical Commission
Licensing. Accountability. Leadership.

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

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

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

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

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

Healthcare Disparities Workgroup
Dr. Currie, Chair
Dr. Browne
Dr. Jaeger
Christine Blake, PM
Douglas Pullen, PM
Kyle Karinen

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

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

Nominating Committee
Dr. Chung
Arlene Dorrough, PA-C
Dr. Jaeger

Updated: April 17, 2024

Committees & Workgroups

WASHINGTON Medical Commission
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CDTA Workgroup
Dr. Chung
Dr. Lyle
Ed Lopez. PA-C
Kyle Karinen
Micah Matthews
Dr. Fino
Joel DeFazio, Staff Attorney
Amelia Boyd
Pam Kohlmeier, MD, JD, Staff Attorney

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

PM = Public Member

Approved Entities

WASHINGTON Medical Commission
Licensing. Accountability. Leadership.

Approved Entities for Accreditation or Certification of Facilities for Office-Based Procedures Under WAC 246-919-601

The Washington Medical Commission adopted WAC 246-919-601 in 2010 to establish consistent standards for physicians who perform surgical procedures in office-based settings that require moderate sedation or analgesia, deep sedation or analgesia, or major conduction anesthesia. Subsection (5) requires a physician who performs a procedure under this rule to ensure that the procedure is performed in a facility that is accredited or certified and in good standing from an accrediting entity approved by the Commission.

The Washington Medical Commission has approved the following entities to accredit or certify office-based surgery:

The Joint Commission

The Accreditation Association for Ambulatory Health Care

The American Association for Accreditation of Ambulatory Surgery Facilities

The Centers for Medicare and Medicaid Services

Institute for Medical Quality

Planned Parenthood Federation of America

The National Abortion Federation

Rommie Johnson
Associate Program Director
Accreditation Commission for Health Care
139 Weston Oaks Court
Cary, NC 27513
Email: statepayorrelations@achc.org
rjohnson@achc.org

April 12, 2024

Amelia Boyd, BAS
Program Manager
Washington Medical Commission
111 Israel Rd SE
Tumwater, WA 98501
Email: Amelia.Boyd@wmc.wa.gov
HSQA.CSC@doh.wa.gov
Medical.Commission@wmc.wa.gov

Dear Ms. Boyd:

I am writing to respectfully request that the Washington Medical Commission recognize the Accreditation Commission for Health Care, Inc. (ACHC) as an approved accreditor of Office-Based Procedures facilities (otherwise known as Office-Based Surgery practices) under WAC 246-919-601. ACHC has maintained Centers for Medicare and Medicaid Services (CMS) deeming authority for ASCs since 2003 and is a proud accreditor of facilities in the State of Washington, under our Ambulatory Surgery Center, Home Health, Hospice, Pharmacy programs, and others. Additionally, ACHC is currently an approved accreditor of Office-Based Surgery facilities in the following states:

- ✓ Arizona
- ✓ California
- ✓ Indiana
- ✓ Kansas
- ✓ Mississippi
- ✓ Massachusetts
- ✓ New Jersey
- ✓ Ohio
- ✓ South Carolina

ACHC has sustained a constant high standard for patient safety and quality of care for Office-Based Surgery facilities seeking accreditation, as evidenced in the electronic manual linked below:

https://www.achc.org/wp-content/uploads/2023/06/2023_Accred-Req-OBS_FINAL.pdf

The current rule lists four similar accreditors: The Joint Commission, the American Association for the Accreditation of Ambulatory Surgery Facilities (Quad A), the Accreditation Association for Ambulatory Health Care (AAAHC), and the Institute for Medical Quality (IMQ), which has since dissolved its accreditation services. The addition of ACHC to the list of approved accreditors would come as a welcomed option for Office-Based Surgery practices that would like to meet state requirements through our collaborative and patient-centric survey process.

Respectfully,
Rommie Johnson, MPH, PMP

ACHC ASC/OBS Associate Program Director

[Enclosure: Supporting Documents for Approval of Office-Based Surgery Accrediting Organization]

Per Rule **WAC 246-919-601 Section 5b(I – IV)** we are submitting this application for the Accreditation Commission for Healthcare (ACHC) to be recognized as an approved accrediting organization for Office-Based Surgery practices in the Great State of Washington. Enclosed in this packet, you will find the following documents as required by Section 5, sub-section (I) through (IV):

Copy of applicant's current accreditation standards - Section 5(b)(i)
The Office-Based Surgery manual in effect is linked here:
[https://www.achc.org/wp-content/uploads/2023/06/2023_Accred-Req-OBS_FINAL.pdf]

Per *Section 5(b)(i)*, the subsequent chapters outline standards set forth in the regulation and cover aspects of patient care related to:

1. **Patient care**
    a. Chapter 5 – Infection Prevention and Control (pg. 53)
    b. Chapter 6 – Patient Rights (pg. 73)
    c. Chapter 7 – Emergency Management (pg. 87)
    d. Chapter 9 – Patient Assessment and Discharge (pg. 107)
    e. Chapter 10 – Surgical Services (pg. 123
    f. Chapter 11 – Anesthesia Services (pg. 139)
2. **Recordkeeping**
    a. Chapter 2 – Administration (pg. 20 for personnel records)
    b. Chapter 8 – Healthcare Records (pg. 101)
3. **Equipment**
    a. Chapter 5 – Infection Prevention and Control (pg. 53)
    b. Chapter 7 – Emergency Management (pg. 87)
    c. Chapter 15 – Physical Environment (pg. 185)
4. **Personnel**
    a. Chapter 1 – Governing Body (pg. 1)
    b. Chapter 2 – Administration (pg. 13)
    c. Chapter 3 – Professional Staff (pg. 25)
5. **Facilities**
    a. Chapter 15 – Physical Environment (pg. 185)
6. **Other related matters**
    a. Chapter 4 – Quality Assessment and Performance Improvement (pg. 37)
    b. Chapter 12 – Pharmaceutical Services (pg. 149)
    c. Chapter 13 – Laboratory Services (pg. 161)
    d. Chapter 14 – Radiological Services (pg. 175)

Accreditation Process Description Section 5(b)(ii)
The OBS Accreditation Process document detailing the description of the accreditation process, accreditation activities, criteria for determination of compliance and deficiency follow-up activities is linked here:
[https://www.achc.org/wp-content/uploads/2023/07/Accreditation_Process-Office-Based_Surgery.pdf]

Section IV. Accreditation Process Before the Survey (pg. 6) and *Section VI(G). Accreditation Process Post-Survey* (pg. 13) specifically addresses the rule's *Section 5(b)(ii)* requirement on processes that assure a fair and timely review and decision on any applications for accreditation or renewals thereof.

Accreditation Process Description Section 5(b)(iii)
According to the ACHC Accreditation Standards, accredited entities are required to include the ACHC's contact number in their patient information materials to facilitate the reporting of complaints. These complaints must clearly describe the specific facts or situations involved. ACHC rigorously documents and investigates any complaints or allegations against organizations it has accredited, adhering to CMS Complaint Procedure guidelines throughout the investigation process. Furthermore,

ACHC maintains detailed records of all complaints, regardless of the source, especially when there are indications that an accredited organization may be violating ACHC Accreditation Standards. The following sections specifically address the rule's *Section 5(b)(iii)* requirement on processes that assure a fair and timely review and resolution of any complaints received concerning accredited or certified facilities:

1. Section X(A) - Handling of Complaints (pg. 18)
2. Section X(B) - Processing a Complaint (pg. 19)
3. Section X(C) - Immediate Jeopardy (pg. 19)
4. Section X(D) - Non-Immediate Jeopardy – High (pg. 20)
5. Section X(E) - Non-Immediate Jeopardy – Medium (pg. 20)
6. Section X(F) - Non-Immediate Jeopardy – Low (pg. 20)
7. Section X(G) - Administrative Review/Off-Site Investigation (pg. 20)

Adequate Resources for Timely Duty Fulfillment by Accrediting Entity Section 5(b)(iv)

In compliance with requirement *Section 5(b)(iv)*, which mandates sufficient resources for timely duty fulfillment, this section outlines the qualifications and composition of survey teams, along with the criteria for maintaining surveyor status. The Accreditation Commission for Health Care (ACHC) ensures that survey teams are robustly staffed and qualified to conduct thorough evaluations efficiently. We adhere to strict turnaround times, committing to responding to accreditation inquiries within one day and to submit survey reports within 48 hours of the completion of the survey. This rigorous structure supports the ACHC's dedication to maintaining high standards and facilitating prompt accreditation processes.

Composition and Qualifications of Survey Teams

To guarantee comprehensive facility evaluations, the survey team's size and composition are meticulously determined based on several factors:

1. Minimum Team Requirements: Each team includes at least one clinical surveyor, either a registered nurse or a physician. Depending on the application details, the team may expand in number and operational days.
2. Determining Factors for Team Size:
    - Number of operating rooms.
    - Number of surgeons.
    - Complexity of provided services.
    - Number and level of locations providing anesthesia services.

Surveyor Qualifications

Surveyors are selected based on their ability to assess compliance effectively and provide constructive feedback, fulfilling the following criteria:

1. Relevant experience and credentials as per the Independent Contractor Surveyor Agreement.
2. At least five years in their specific field and two years in quality assurance or management.
3. Completion of ACHC's initial training and at least two apprentice surveys; occasionally, one supervised site visit may suffice.
4. Proficiency in reviewing documentation and identifying non-compliance with state, federal, and ACHC standards.
5. Consultative, patient-focused, and data-driven approach to quality assessment.
6. Clear and correct report writing skills based on ACHC standards.

Continuance of Surveying

Surveyors must continually meet specific criteria to maintain their accreditation status:

1. Uphold discipline-specific credentials and stay updated with industry standards.
2. Participate in ongoing education and fulfill all roles in alignment with ACHC's mission and quality policies.

3. Maintain confidentiality as mandated by HIPAA and other privacy laws.
4. Provides accurate and complete survey documentation to ACHC within specified timeframes (48 hours).

Performance Monitoring and Compliance
Surveyor performance is thoroughly evaluated through documentation review, staff feedback, and customer satisfaction surveys. Non-compliant surveyors receive a corrective plan or termination if unresolved issues persist. Compliance and credentialing are monitored by the Human Resources Coordinator, ensuring only qualified surveyors are assigned and scheduled for surveys.
This structured approach ensures that ACHC has the adequate resources needed to perform its duties efficiently and uphold high standards of care and compliance in accredited organizations.

Thank you for considering our application. We are eager to support the state's efforts in ensuring high-quality care in Office-Based Surgery practices and look forward to your affirmative response.

Sincerely,

Rommie Johnson, MPH, PMP
Associate Program Director
Accreditation Commission for Healthcare (ACHC)

Bylaws

Article I: Purpose

The purpose of the Washington Medical Commission (Commission or WMC) is to protect the public by assuring the competency and quality of professional health care providers under its jurisdiction, by establishing and enforcing qualifications for licensure and standards of practice, by educating practitioners and the public, and, where appropriate, by disciplining and monitoring practitioners. The WMC exists to maintain and improve the quality of care provided to the patients of Washington. Rules, policies, and procedures developed by the Commission must promote the delivery of quality health care to the residents of the state of Washington.

Article II: Membership

1. Commission Composition:

The 13 physicians, two physician assistants, and six public members of the Commission are appointed by the Governor to serve a four-year term. The WMC makes recommendations to the Governor concerning such appointments for clinical and public member positions. There must be at least one member from each of the congressional districts as specified in RCW 18.71.015. Commissioners may be appointed by the Governor to a second term. When vacancies occur, the Chair of the WMC shall make recommendations to the Governor to assure appropriate specialties are represented. When the workload requires, the WMC may appoint *pro tempore* members from among those qualified to be members of the Commission. Governor appointed members and *pro tempore* members are considered state officers and eligible for full rights and remunerations due under state law. *Pro tempore* members may vote on discipline and licensing deliberations but are not eligible to vote on any other Commission business.

2. Qualification for voting

a. Only the 21 Governor-appointed members of the Commission are eligible to vote at business meetings of the WMC.

b. All members of committees, subcommittees, *ad hoc* committees, and workgroups are eligible to vote on questions arising during deliberations within those groups.

3. Compensation and Reimbursement for Expenses:

a. The WMC will compensate its members for performing the duties of the Commission in accordance with RCW 43.03.265.

b. The WMC will reimburse its members for travel and other bona fide expenses in accordance with RCW 43.03.050 and 43.03.060

c. The WMC shall adopt a protocol specifying the procedures for carrying out compensation and reimbursement and update it as necessary.

4. Removal:

A Commissioner may be removed from the WMC by the Governor as outlined in RCW 18.71.015.

5. Staff and Operations

a. In accordance with RCW 18.71.430 the WMC selects and manages its own Executive Director, whom is exempt from provisions of civil service law.

b. The Executive Director is responsible for the overall management of WMC staff and operations including but not limited to performing all administrative duties and any other duties as delegated by the WMC.

Article III: Officers

1. Officers:

The officers of the WMC shall consist of the Chair, Vice Chair, Officer-at Large, and the Immediate Past-Chair.

2. Elections/Terms of Office:

a. The WMC shall elect its officers at its regular meeting immediately preceding the month of July.

b. The term of office for all WMC officer positions is one year. A second consecutive term is permitted. Service in an officer position is to assure succession planning and leadership continuity.

c. The new officers begin their terms at the meeting following the election. Upon agreement of the Chair and Chair-elect, terms may begin any time after the election of officers.

3. Duties of Officers:

a. The Chair presides at all meetings of the WMC and has all powers and duties conferred by law, the Bylaws and commonly accepted practice consistent with state statutes. The Chair or a designee shall represent the WMC at official functions. The Chair shall approve and sign correspondence that reflects the position of the WMC on matters that are not purely administrative in nature, including correspondence with the Legislature and other government agencies on matters of policy. The Chair is an ex-officio member of all committees, without vote unless specifically designated a member of the committee.

b. The Vice Chair (and in order, Officer-at-Large, then Immediate Past-Chair) shall act in the capacity of the Chair when the Chair is absent, unavailable, has a conflict of interest, or is otherwise unable to serve.

Vacancies:

If any officer position becomes vacant, the Executive Committee shall fill the vacancy by appointment of a qualified Commissioner, whose appointment, when ratified by the WMC, will be effective until the next election cycle. A qualified Commissioner is a Governor appointee.

Article IV: Meetings

1. Regular Board Meetings:

a. The WMC shall meet not less than four times a year, at such times and places as the Commission deems necessary and/or appropriate.

b. Prior to the beginning of each calendar year the Chair will recommend to the WMC a schedule of dates and locations for regular Commission meetings during the forthcoming year. The WMC may modify the schedule as necessary.

c. All meetings of the WMC shall be held in the letter and spirit of the Open Public Meetings Act, RCW 42.30. It is the intent of the WMC that all meetings of the WMC, other than executive sessions, licensing panels, case review panels, and other adjudicative deliberations, shall be open and public. All persons shall be permitted to attend any other public meetings of the WMC.

2. Special Board Meetings:

a. The Chair may call a special meeting of the WMC at any time.

b. The Commission, by simple majority vote, may call a special meeting at any time.

c. Special meetings must be properly noticed as required by the Open Public Meetings Act, RCW 42.30, and shall be held in accordance with Article IV, 1.c above.

d. The notice of a special meeting must specify the nature of the business to be conducted at the meeting. At a special meeting the WMC may not take final action on any item that is not listed in the public notice.

3. Adjournment:

a. The WMC may postpone a portion of any meeting already in progress and reconvene at another time and/or place by adopting a motion to adjourn. The motion must specify where and when the meeting will resume.

b. A simple majority of the Commission members at a meeting may approve a motion to adjourn, even if there is not a quorum present. If all members are absent from a meeting, the Chair or Commission staff may adjourn the meeting to a stated time and place.

c. Whenever the WMC adjourns a meeting temporarily or prior to completing the agenda scheduled for that meeting, a notice of adjournment shall be posted immediately on or near the door of the room where the meeting was being held announcing the postponing of the meeting and stating when and where the meeting will resume.

d. The WMC must provide notice of when an adjourned meeting is resuming using the same procedure as a special meeting.

4. Rules Hearing Continuances:

a. Any rules hearing being held at any WMC meeting may be continued to any subsequent meeting if the WMC adopts a motion to continue.

b. The WMC must inform the public whether it is continuing to take public testimony or if limited to Commission member discussion and possible action is scheduled. The WMC may choose to take additional testimony only at the discretion of the rules hearing Chair or an appropriate designee. Notice shall be given when the WMC adopts the motion to continue, or in a supplemental CR-102.

c. Any continuance of a WMC rule hearing must be properly noticed in accordance with the Open Public Meetings Act, Chapter 42.30 RCW.

5. Meetings Interrupted by Individuals or Groups of Persons:

a. If the disorderly conduct of a person or a group of people makes it impractical to continue a WMC meeting, the Commission should first order that the individuals interrupting the meeting leave the room. If that fails to restore order, the WMC may clear the room. It can also adjourn the meeting and reconvene at another place selected by a majority of the Commission members.

b. If the WMC clears the room or adjourns to another location, it may only take action on matters that have appeared on the meeting agenda.

c. Representatives of the press or other news media, except those participating in the disturbance, must be allowed to attend if they sufficiently identify themselves as such, even if the room has been cleared or the Commission has reconvened elsewhere.

d. The WMC shall determine how to re-admit individuals who were not disrupting the meeting.

6. Meetings, Minutes, and Agendas:

a. The minutes of all WMC business meetings shall be taken by a member of the Commission staff.

b. The minutes shall accurately capture and record member attendance and the action of the WMC on each question or motion.

c. All minutes will be produced for WMC review and approval at regular meetings.

7. Meeting procedures

a. **Rules of Procedure**:

1) The procedures used to conduct WMC business will be determined by these Bylaws, the Administrative Procedures Act, the Open Public Meetings Act, the Commission's authorizing statute, RCW 18.71 and Article XX of the Washington State Constitution.

2) If a procedural issue arises that is not covered by these Bylaws and applicable state statutes, and the Commission cannot reach consensus on how to proceed, the WMC will follow the procedures contained in the most current version of *Robert's Rules of Order*.

b. **Quorum**:

1) A simple majority of the WMC shall constitute a quorum for the transaction of business at meetings. If there are vacancies on the WMC, a majority of existing Governor appointed members shall constitute a quorum.

2) The WMC may discuss issues and deal with administrative matters in the absence of a quorum, but it may not adopt any resolution, rule, regulation, order, or directive during a meeting unless a quorum first has been established.

3) Any Governor appointed Commissioner participating in the meeting may call for a roll call at any time after a quorum has been established. If WMC staff wish to call for a roll call, such a request must be presented by the Executive Director or appropriate designee in the chain of command.

4) If a quorum is not present at the time of the roll call, no further actions can be taken, unless additional members enter the room and re-establish a quorum.

c. **Order of Business**:

The order of business shall be determined by the posted agenda unless the agenda is altered by the Chair in an open meeting with the concurrence of the WMC.

d. **Public Comment**:

The Chair may solicit public comment on any or all agenda items during regular meetings and all agendas shall include a public comment item. All public comments regarding cases before the WMC or active litigation will be interrupted and overruled by the Chair or presiding officer for reasons of due process and legal risk management.

e. **Motions, Resolutions, and Regulations**:

1) All proposals for actions or decisions of the WMC shall be by motion and/or resolution.

2) A motion or resolution will be deemed "passed" only if it receives the affirmative votes of a simple majority of the members present eligible to vote.

3) No Commission member or employee may use the name, branding, or indicia of the WMC for any reason other than official, Commission sanctioned operations.

4) The Commission and its members/employees may not lobby in support or opposition to legislative proposals. However, in accordance to RCW 18.71.460 and in addition to the authority provided in RCW 42.52.804, Commissioners or staff as directed by the Commission, may communicate, present information requested, volunteer information, testify before legislative committees, and educate the legislature, as the Commission may from time to time see fit. A Commission member/employee may lobby support or opposition to legislative proposals only as a private citizen and only without reference to the WMC or their position with the WMC.

f. **Manner of Voting**:

The voting on elections, motions, and resolutions shall be conducted by voice vote unless a roll call is requested in accordance with section 7 b. 3) of these Bylaws. Proxy voting is not permitted.

Article V: Committees, Subcommittees, Panels, and Workgroups

1. General provisions

a. The WMC may establish standing committees, subcommittees, *ad hoc* committees, panels, and workgroups to assist in executing its work plan.

1) Standing committees are of an enduring nature to deal with matters of long-term ongoing interest and concern to the Commission.

2) Subcommittees are established under the jurisdiction of standing committees for specific purposes, and render their reports to the full Commission through the parent committee. Subcommittees disband at the direction of the parent committee.

3) *Ad hoc* committees are established to study and deal with highly specific issues, and disband upon completion of the assignment or the direction of the Chair.

4) Panels are established to conduct case and licensing application reviews or other Commission business that may be delegated to the panel. Panels function for as long as the assigned task remains. The quorum of a panel is a simple majority of panel members. For standard of care and complex licensing decisions, at least half of the members must be clinicians. Decisions are made by majority vote. Panels should be rotated on a regular basis.

5) Workgroups are composed of Commissioners and non-commissioners possessing particular expertise and/or interest in a particular subject of interest to the Commission, to render recommendations to the WMC regarding possible action about that subject. Workgroups disband upon reporting completion of their assignment.

b. The officers, at the first Executive Committee meeting after election, should choose which standing committees to activate and designate the duties thereof for the ensuing year. The Chair should appoint committee chairs at the first Commission meeting after the election. Commission members shall be given ample opportunity to volunteer to serve on the various committees.

c. Standing committees, subcommittees, *ad hoc* committees, panels and workgroups are composed of commissioners appointed by the Commission Chair, and may include others (such as pro-tem members or non-Commission members) as designated by the Chair. The Executive Committee and the Nominating Committee are exceptions to this process.

d. Chairs of standing committees, subcommittees, *ad hoc* committees, panels and workgroups will be designated by the Commission chair.

e. Appropriate staff shall be identified by the Executive Director to support and advise all standing committees, subcommittees, *ad hoc* committees, panels and workgroups.

f. Each standing committee, subcommittee, *ad hoc* committee, panel and workgroup will function under a written charter, signed by the Commission Chair or Policy Chair, designating the group's composition, purpose, inception and termination date and expectations regarding provision and routing of reports and recommendations. Staff shall create written charters under the approval of the Executive Director or their designee with standard termination date of one year.

g. The termination date of a standing committee, subcommittee, *ad hoc* committee, panel or workgroup can be extended at the discretion of the Commission Chair or by vote of the full Commission.

h. Standing committees, subcommittees, *ad hoc* committees, panels and workgroups are subject to review by the full Commission and may be modified or disbanded by majority vote.

i. Any Commission member may attend any standing committee, subcommittee, *ad hoc* committee, panels or workgroup meeting, but only designated committee members may vote on committee deliberations.

2. Executive Committee

a. The Executive Committee shall be a standing committee of the Commission. Its purpose is to provide clear and direct communication to executive staff, assist in carrying out the administrative direction of the WMC, and act as a resource to executive staff and the Chair of the WMC.

b. The Executive Committee members are the Commission Chair, Vice Chair, Officer-at Large, and the immediate past Chair (if that person remains an eligible member of the Commission) and the Chair of the Policy Committee. At least one member of the Executive Committee must be a public member of the Commission; if one of the named positions is not filled by a public member, a public member shall be elected as an additional member of the Executive Committee.

c. Ex-officio members are the Chairs of Panel A and B.

d. Staff of the Executive Committee as ex-officio are the Executive Director, the Deputy Executive Director, and the advising Assistant Attorney General assigned to the WMC.

e. The Executive Committee functions to provide administrative oversight for the WMC in the intervals between regular meetings and to advise the Executive Director regarding administrative matters and ongoing or urgent/emergent Commission business as necessary.

f. The Executive Committee reports to the full Commission. Any action recommended by the Executive Committee must be approved by the full commission. It cannot take an action on its own that would require full Commission concurrence.

3. Policy Committee

a. The Policy Committee is a standing committee of the Commission.

b. Policy Committee consists of a maximum of 10 Commissioners, designated by the Commission Chair.

c. The Policy Committee is the principal clearinghouse for all matters being considered by the WMC regarding policy, development of procedures, establishment of guidelines, rulemaking, legislative recommendations and support.

d. The Policy Committee reports to the full Commission on a regular basis.

4. Nominating Committee.

a. The Nominating Committee functions to assure effective leadership, diverse representation, and robust succession planning for the WMC.

b. The Chair shall appoint the Nominating Committee a minimum of two regular meetings prior to the scheduled election meeting date.

c. The Nominating Committee shall have a minimum of three members. If still a full member of the WMC, the Immediate Past Chair shall serve on the Nominating Committee.

d. The Nominating Committee reports its recommended slate of candidates for consideration by the full Commission two regular meeting prior to the election. At the election meeting, nominations may be made from the floor providing that the nominee has given prior consent to the nominator.

e. In the event of a contested election, each candidate for office shall be present to state their case for office to the full Commission during open session on the day of the election. Candidates unable or unwilling to state their case for office shall not be considered for election.

f. Candidates for office shall depart the room during deliberations and voting associated with their election.

Article VI: Amendments to the Bylaws

Amendments to the Bylaws may be proposed from the floor at a Commission meeting or by the Executive Committee itself. Proposed amendments shall be circulated to the entire Commission between meetings and voted upon by attendees at the next meeting. A simple majority of those present constituting a quorum is required for approval. Unless otherwise specified, amendments take effect upon adoption.

Jimmy Chung, MD, Chair
Washington Medical Commission
Adopted Date: July 15, 2022

WASHINGTON Medical Commission
Licensing. Accountability. Leadership.

Committee/Workgroup Reports: April 26, 2024

High Reliability Organizations Workgroup – Chair: Dr. Chung
Staff: Mike Farrell

The workgroup met on March 4 and discussed disseminating lessons learned and improving internal processes and communication.

Disseminating lessons learned. We talked about the possibility of partnering with outside entities to disseminate lessons learned. We agreed that themes are important and to consider our audience. Our newsletter lists the disciplinary actions. Can it provide summaries of other errors and close calls? We should consider publishing more papers written by respondents.

Internal processes. We discussed focusing on our internal processes, improving consistency and reducing unnecessary variability in our processes and our outcomes. A respondent should expect the same result regardless of who the RCM or staff attorney is.

- Consistent disciplinary orders. We discussed the need for common language in our orders and STIDs.
- Metrics for Commissioners. We discussed creating metrics for Commissioners. Jimi Bush sent an email with report cards that were once used to measure the Commissioners.
- Communication during negotiations. Commissioners need guidance from staff attorneys during negotiations: what do we normally do with this type of case? The staff attorney needs to attach the proposed order or STID to the email to the Commissioner when forwarding a counterproposal to the RCM.
- Orienting new Commissioners. We need to improve our orientation of new members so that they understand their role and responsibilities.

Healthcare Disparities Workgroup – Chair: Dr. Currie
Staff: Kyle Karinen

The New York Times published a piece several weeks ago about professionalism in medicine. ("The Unbearable Vagueness of Medical 'Professionalism'", March 19, 2024.) There were several aspects of this article that were concerning. Among those aspects, the following caught my attention:

"In 2015-16, 20 percent of trainees dismissed from their residency were Black, although Black students make up only 5 percent of residents, according to unpublished data from the Accreditation Council for Graduate Medical Education, or A.C.G.M.E."

I recommend this article to all of the Commission members. There has been some research into the impact of racial underrepresentation in the physician and physician assistant professions and the subsequent impact on access to medical care.

On the staff side, we are convening a group of staff to discuss some of the implications raised by this piece and review the Commission's guidance document on medical professionalism.

Medical Professionalism (wa.gov)

The plan is to then bring staff feedback at least initially to this workgroup for an initial discussion. If revisions are recommended for the guidance document, then we will work through the Policy Committee.

WMC Rules Progress Report						Projected filing dates		
Rule	**Status**	**Date**	**Next step**	**Complete By**	**Notes**	**CR-101**	**CR-102**	**CR-103**
Collaborative Drug Therapy Agreements	CR-101 filed	7/22/2020	Workshops	TBD		Complete	TBD	TBD
General provision for opioid prescribing and tapering	CR-102 filed	3/20/2024	Hearing	4/26/2024	Informed the other B/Cs	Complete	February 2024	TBD
Standard rulemaking - WAC 246-919-330	CR-102 filed	3/20/2024	Hearing	4/26/2024		Complete	February 2024	TBD
HB 1009 Military Spouse	CR-101 filed	9/12/2023	Workshops	2024		Complete	TBD	TBD
OBS - Use of Nitrous Oxide, WAC 246-919-601	CR-101 approved	10/20/2023	File CR-101	May 2024		May 2024	TBD	TBD
ESSB 5389 - Define Qualified Physician	CR-101 approved	10/20/2023	File CR-101	TBD	Waiting on Board of Optometry rulemaking	TBD	TBD	TBD
SB 5184 - Certified Anesthesia Assistants - New Profession	Request to initiate standard rulemaking	4/26/2024	If approved, file CR-101					
2041 PA Collaborative Practice	Request to initiate rulemaking - CR-105	4/26/2024	If approved, file CR-105					
Technical edits to WAC 246-919-945 and WAC 246-918-895	Request to initiate rulemaking - CR-105	4/26/2024	If approved, file CR-105					

Updated: 4/17/2024

Memo

WASHINGTON Medical Commission
Licensing. Accountability. Leadership.

To: WMC Commissioners

From: Micah Matthews, MPA, Deputy Executive Director

Subject: Rulemaking Authorization Request-Certified Anesthesiologist Assistants (CAAs)

On March 29, 2024, Governor Inslee signed SB 5184 which creates the licensed profession of CAAs under the regulatory authority of the WMC. As part of the process to stand up a new profession and as directed in the bill, the WMC must conduct general standard rulemaking to enact the bill and enforce practice standards for the profession. The goal is to have the rules completed and the profession launched no sooner than January 2025 in the anticipated HELMS system.

I am requesting the WMC vote to initiate rulemaking to implement SB 5184 and create a new WAC chapter for this profession.

Memo

WASHINGTON Medical Commission
Licensing. Accountability. Leadership.

To: WMC Commissioners

From: Micah Matthews, MPA, Deputy Executive Director

Subject: Rulemaking Authorization Request-Physician Assistant Collaborative Practice

On March 13, 2024, Governor Inslee signed HB 2041 which updates RCW 18.71A which governs the practice of physician assistants under the licensing authority of the WMC. The bill updates practice agreement nomenclature to collaborative practice and creates a tiered practice system for PAs to graduate to more autonomous practice based on practice experience.

As a result of the bill, the statutory changes require the WMC to update the rules in WAC 246-918 to change all instances of practice agreement to collaboration agreements and add two definitions added to statute. As these are changes directed by statute, non-discretionary, and non-controversial, I am requesting the WMC authorize expedited rulemaking through the 105P process.

Memo

WASHINGTON Medical Commission
Licensing. Accountability. Leadership.

To: **WMC Commissioners**

From: **Amelia Boyd, Program Manager**

Subject: **Rulemaking Authorization Request-Technical Edits to WAC 246-919-945 & 246-918-895**

While reviewing chapter 246-919 WAC in preparation for upcoming rulemaking, I discovered that in WAC 246-919-945, which is the MD chapter of rule, we reference a Board of Osteopathic Medicine and Surgery WAC that has been rescinded:

"(3) If an osteopathic physician assistant, in accordance with WAC **246-854-330**."

We need to remove the above and then renumber the items after (3).

We also need to revise WAC 246-919-945(2) to remove the reference to "allopathic" since there are no longer "allopathic" or "osteopathic" physician assistants:

"(2) If an allopathic physician assistant, in accordance with WAC **246-918-895**."

Additionally, we need to make related edits to a section in the Physician Assistant chapter, WAC 246-918-895. We need to change (1)(b) in this subsection to remove "allopathic" and everything after the first "physician assistant":

Current – "(b) Credentialed in pain management by an entity approved by the commission for an allopathic physician assistant or the Washington state board of osteopathic medicine and surgery for an osteopathic physician assistant;"

Proposed – (b) Credentialed in pain management by an entity approved by the commission for a~~n allopathic~~ physician assistant ~~or the Washington state board of osteopathic medicine and surgery for an osteopathic physician assistant~~;

Since these are just technical edits, we can use the Expedited rulemaking process, or CR-105. We request that the Commission approve initiating the CR-105, Expedited rulemaking process, to make the technical edits to the WMC's two chapters as proposed in this memo.

Guidance Document

WASHINGTON Medical Commission
Licensing. Accountability. Leadership.

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

Observe, record, tabulate, communicate.

-Sir William Osler (1849-1919)

Introduction

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

Guidance

I. Documentation

A. Purpose of the Medical Record

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

The medical record is a chronological document that:

1. Records pertinent facts about an individual's health and wellness;
2. Enables the treating practitioner~~care provider~~ to plan and evaluate treatments or interventions, making clear the rationale for diagnoses, plans and interventions;
3. Enhances communication between professionals, to help optimize a patient's~~assuring the patient optimum~~ continuity of care;
4. Assists both patient and practitioner in communication with third party participants;
5. ~~-~~Facilitates the practitioner's development of an ongoing quality assurance program;
6. Provides a legal document for verification and/or audit of the delivery of care; and
7. Is available as a source of clinical data for research and education.

B. The Essential Elements of a Medical Record

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

1. The purpose of each patient encounter and appropriate information about the patient's history and examination, the patient's perspective and preferences, the plan for any treatment, and the care and treatment provided;
2. The patient's pertinent medical history including serious accidents, operations, significant illnesses, and other appropriate information;
3. Prominent notation of medications~~medication and other significant allergies~~, or a statement of their absence;
4. Prominent notation of any known allergies to medications and other allergens including the severity of the reaction (e.g., aspirin (hives), bee stings (anaphylaxis)), or a statement of their absence;

~~4. Known or suspected reactions including allergy warnings;~~

5. Clearly documented informed consent obtained from the patient or from a person authorized to consent on behalf of the patient. In some emergency situations, the reason for a lack of informed consent should be clearly documented; and
6. The date of each entry, and the time as appropriate.

C. Additional Elements of a Medical Record

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

1. Each page in the medical record contains the patient's name or ID number~~;~~
2. Personal biographical information such as home address, employer, marital status, emergency contact information and all telephone numbers, including home, work, and mobile phone numbers~~;~~
3. Each entry in the medical record contains the author's identification. Author identification may be a handwritten signature, initials, or a unique electronic identifier~~;~~

4. All drug therapies are listed, including dosage instructions and, when appropriate, indication of refill limits. Prescription refills should be recorded;~~.~~
5. Encounter notes should include appropriate arrangements and specified times for follow-up care;~~.~~
6. All consultation, laboratory, and imaging reports should be entered into the patient's record, reviewed, and the review documented by the practitioner who ordered them. Abnormal reports should be noted in the record, along with corresponding follow-up plans and actions taken;~~.~~
7. An appropriate immunization record is kept up to date by the primary care provider and, ideally, readily accessible by all clinicians caring for the patient, as technology permits;~~.~~
8. Documentation of appropriate preventive screening and services being offered in accordance with accepted practice guidelines, as relevant to the visit and/or the specific provider's role in caring for the patient; and~~.~~
9. Documentation of any other person(s)~~persons~~ present during the encounter.

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

D. Special Considerations When Using an EHR~~Electronic Health Record~~

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

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

1. Recommendations for Practitioners

The patient record in an EHR should reflect the same, or improved content and functionality, as that produced in traditional formats. The following recommendations, which are not necessarily exhaustive, are intended to inform practitioners of the appropriate use of an EHR, and to indicate how the Commission will evaluate a medical record, including records that are the product of an electronic system.

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

a. A practitioner using an EHR must ensure the following:

~~i.~~• Authorized~~authorized~~ use and compliance with state and federal privacy and security legal requirements, ~~law,~~ and with institutional privacy and security policies;

~~ii.~~ • A~~a~~ timely, accurate, succinct, and readable entry;
~~iii.~~ • Consistency~~consistency~~ and accuracy between various aspects of a record; and
~~iv.~~ • Assumption~~assumption~~ of ultimate responsibility for trainees' and scribes' documentation.

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

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

d. Documenting aspects of a practitioner-patient interaction that did not transpire, such as indicating that components of a physical examination were performed when they were not, even when it occurs inadvertently because of EHR design or function, may be considered fraud.

e. When~~Similarly, when~~ documentation about a significant aspect of the practitioner-patient interaction is not present, the assumption is that it did not occur.

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

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

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

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

2. Suggestions for EHR Software Developers and Healthcare Institutions

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

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

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

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

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

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

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

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

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

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

~~a.~~• Lead~~leads~~ to improved patient outcomes;
~~b.~~• Ensure~~ensures~~ safe transitions of patients from one practitioner, facility, or office to another;
~~c.~~• Allow~~allows~~ easy tracking and reporting of patient care metrics and outcomes; and
• Promote~~promotes~~ patient-centered communication between patients and the health care system.[3]

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

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

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

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

II. Handling, Accessing, and Amending Access to Medical Records

A practitioner's handling of practices relating to medical records under theirhis or her control should be designed to protect patient privacy, to benefit the health and welfare of patients, and towhether current or past, and should facilitate the transfer of clear and reliable information about a patient's care. The Commission recognizes that EHR electronic health records systems may not be compatible, which often makes that last goalmaking it challenging when sendingto send records to a practitioner in another EHRelectronic health record system. Practitioners should do the best they can to protect privacy and to provideget medical records to patients, and other practitioners as indicated,subsequent providers in a usable format. Practitioners should be aware of the following recommendations, statutes, and regulations as they address the authority of patients[2] to access, and potentially amend, their medical records.

A. To prevent misunderstandings, the Commission recommends that practitioners ensure that their offices or practices have policies regarding how patients may obtain copies or summaries of medical records. These policies must comply with the law and should be made available in writing to patients when the practitioner-patient relationship begins.

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

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

[2] Legal protections of patients to access or amend their medical records include authorized patient representative(s) acting on the patient's behalf as permitted by law.

~~C.~~D. A patient has a statutory right to submit a concise statement describing a correction or amendment for inclusion in the medical record. RCW 70.02.110.~~To prevent misunderstandings, the practitioner's policies about providing copies or summaries of medical records and about completing forms should comply with appropriate laws and should be made available in writing to patients when the practitioner-patient relationship begins.~~

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

F. The Commission recommends that practitioners review and comply with all federal laws that address accessing or amending medical records including, but not limited to, the Health Insurance Portability and Accountability Act of 1996 (HIPAA) and 45 C.F.R. Section 164.526.

III. Handling Medical Records if a Practitioner Is Involved in Disciplinary Action

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

IV. Storage of Records

A practitioner is responsible for safeguarding and protecting the medical record, whether in electronic or paper format, and for providing adequate security measures. A practitioner may contract with a third party to act as custodian of the medical records. The responsible person, corporation, or legal entity acting as custodian of the records must comply with federal and or state confidentiality laws and regulations.

V. Retention of Medical Records

The Commission appreciates the variety of medical specialties and practices in our state and urges practitioners to exercise reasonable judgment as they apply the following recommendations to their retention of medical records.

A. There is no general law in Washington requiring a practitioner to retain a patient's medical record for a specific period of time.[3]

~~A.~~B. ~~The Commission appreciates the variety of medical practices and urges practitioners to exercise reasonable judgment which may vary by specialty for the retention of medical records.~~ When

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

appropriate, the Commission concurs with the Washington State Medical Association recommendation that practitioners should retain medical records and x-rays for at least:

~~1.~~• Ten~~ten~~ years from the date of a patient's last visit, prescription refill, telephone contact, test or other patient contact;
~~2.~~• Twenty-one (21) years from the date of a minor patient's birth;
~~3.~~• Six~~six~~ years from the date of a patient's death; or
~~4.~~• Indefinitely~~indefinitely~~, if the practitioner has reason to believe:

~~a.~~○ The~~the~~ patient is, or was, incompetent;
~~b.~~○ There~~there~~ are, or were, significant concerns involving ~~any problems with~~ a patient's care; ~~,~~ or
~~c.~~○ The~~the~~ patient is, or is likely to become, ~~may be~~ involved in litigation.

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

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

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

~~IV. Storage of Records~~

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

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

~~V.~~ VI. Disposing of Records

When retention is no longer required, records should be destroyed by a secure means.

A. The Privacy Rule in ~~the Health Insurance Portability and Accountability Act (~~HIPAA~~)~~ prohibits digital and paper records containing confidential information from being thrown away in a public dumpster or recycling bin until they have been rendered unreadable or indecipherable by shredding, burning or other method of destruction.

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

~~VI.~~ VII. Handling Medical Records When Closing a Medical Practice

~~A.~~ The Commission recognizes the complexity of closing a practice and provides this guidance~~obligation to make medical records available~~ to use as a tool. Please note that the~~patients and other providers continues even after a practitioner closes a medical practice.~~

~~B. The~~ recommendations in this section may~~do~~ not apply in the following instances: (1) ~~to:~~

~~1.~~ A practitioner ~~who~~ leaves a multi-practitioner practice and~~. In that instance,~~ the remaining practitioners in the practice ~~typically~~ assume care of the patients and retain the medical records~~;~~.

~~2. A specialist~~ or (2) a~~other~~ practitioner has~~who does~~ not had~~have~~ ongoing relationships with patients, and the patients' records have been provided to their referring~~. These~~ practitioners, the patients' ~~typically provide patient records to the referring practitioner, the patient's~~ primary care providers~~provider~~, or directly to the patients themselves. Otherwise, in preparing to close a practice, a practitioner should do the following:~~patient.~~

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

~~b.~~• Notice~~The notice~~ should be given at least 30 days in advance, with 90 days being the best practice.

~~c.~~• Notice~~The notice~~ should be given by at least one, but preferably all, of the following:

~~1.~~○ Individual~~individual~~ letter to the last known patient address;

~~2.~~○ Electronically~~electronically~~, if this is a normal method of clinical communication with the patient; or

~~3.~~○ Placing~~placing~~ a notice on the practitioner's web site, if the practitioner has a web site.

• If the practitioner is part of an institution or multi-practitioner practice, the institution or practice may provide notice of the closing of the practice, but it is the practitioner's responsibility to ensure those arrangements have been made.

~~d.~~• Notice~~The notice~~ should include the following:

~~1.~~○ The~~the~~ name, telephone number and mailing address of the responsible entity or agent to contact to obtain records or request transfer of records;

~~2.~~○ How~~how~~ the records can be obtained or transferred;

~~3.~~○ The~~the~~ format of the records, whether hard copy or electronic;

~~4.~~○ How~~how~~ long the records will be maintained before they are destroyed; and

~~5.~~○ The~~the~~ cost of recovering records or transferring records as defined in Chapter 70.02 RCW~~Chapter 70.02 RCW~~.

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

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

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

~~b.~~D. The~~Disciplinary action by the Commission, including suspension, surrender or revocation of the practitioner's license, does not diminish or eliminate the~~ obligation to make~~provide~~ medical records available to patients and other practitioners continues even after a practitioner closes a medical practice. ~~.~~

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

-Sir William Osler (1849-1919)

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

Appendix

I. History of the Medical Record

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

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

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

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

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

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

- Tell the patient's unique story as it relates to the patient's concerns ("the patient voice");")
- Document the pertinent history and physical exam findings, in addition to the pertinentDemonstrate diagnostic testing resultsthinking and decision-making processesprocess undertaken by the practitioner, for each patient encounter;.
- Provide other pertinent clinical information to allow covering or consulting colleagues to maintain care and make informed decisions regarding further care;
- Support coordinated longitudinal plans of care and care transitions within and across organizations;
- Provide a clear and easily understood summary of the encounter, including the practitioner's assessmentfindings and plan;
- Document conversations that occur with the recommendations, to the patient or the patient's designated caretaker including but not limited to the risks, benefits and alternatives discussed involving informed consent or shared decision-making;representative
- Provide clinical information to drive accurate Clinical Decision Support
- Support and identify the quality of care provided to patients
- Satisfy reasonable documentation requirements from payers
- Create the legal record of a patient's medical and surgical care;
- Create the legal business record of the practitioner's practice or institution;patient care facility
- Satisfy reasonable documentation requirements from insurers or payers; and
- Support population health data collection and research.

- Create the legal record of a patient's medical and surgical care
- Meet legal, accreditation, and regulatory criteria

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

Table 2: Medical Record Audiences

- Patients and their designated representatives;.[5]
- Fellow practitioners;
- Other members of the health care team;
- ~~Researchers~~Health care systems or institutions;
- State agencies/regulatory bodies including but not limited to the Commission;~~Public health systems~~
- Workers' compensation programs or Social Security;~~Payers~~
- Legal counsels, courts, and juries; ~~counsel~~
- Insurers or payers; and
- ~~Courts, juries and medical review/regulatory bodies~~Researchers.

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

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

- A patient complains that a practitioner documented a complete physical examination in the EHR when only a focused examination of a patient's rash had been performed.
- Under the physical examination section of a patient's EHR, "tympanic membranes within normal limits" is explicitly stated, but in the assessment, the patient is described as having a "right acute otitis media."
- An error in a CT report about a mass in the right kidney is subsequently corrected to indicate that the mass is in the left kidney. The original diagnosis of right kidney mass is carried forward in the EHR problem list, leading to a wrong-site surgery.
- A primary care practitioner forgets to include a patient's bleeding disorder in the EHR problem list following his first appointment with the patient. The incomplete problem list is carried forward without review or update for inclusion in numerous other documents. During major surgery two months later, the patient suffers a massive hemorrhage. The surgeon was unaware the patient had a bleeding disorder.

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

- A practitioner complains that her colleague copies and pastes the assessment portion of patients' EHR, including detailed medical decision-making, from other practitioners' notes and then bills at a higher level than his actual work would support.
- A patient files a medical malpractice claim after a delay in diagnosis of a brain tumor. The practitioner says that she performed a complete neurologic examination, which was normal, but the EHR documentation for the neurologic portion of the examination only states "Patellar reflexes 2+ bilaterally."
- A judge in a medical malpractice case found the EHR inadmissible because it contained so much redundant and irrelevant information.

III. ~~Current~~ EHR Implementation Benefits and Challenges

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

- Legibility: Handwritten notes could be illegible.
- Potentially greater efficiency for practitioners who, under increasing time pressures and facing large volumes of data, need ways to streamline their record keeping.
- Reviewing and documenting in the EHR can be done remotely.
- Within an EHR, there is the capability to transfer important information about a patient from one note to another, reducing the need to rewrite information that has not changed.
- EHR templates save time by displaying information in a standard format and relieving the practitioner of reestablishing a format each time a similar note is needed.
- More efficient computer entry, "real-time," i.e., during a patient encounter, could save time and reduce the need to recall details about the patient visit at a later time, potentially leading to greater accuracy.
- Better system efficiency including data retrieval, remote access, and transfer of information. Electronic access eliminates the cost and time needed to request and locate the hard chart. It also diminishes the chance of lost records, physical space required to store charts, and the need for personnel to assemble, store, and retrieve paper records.
- EHR systems allow multiple providers to simultaneously enter data during a patient encounter. This saves time tracking down and waiting to document in the hard chart.
- The EHR is more readily searched than the hard chart, which often existed in multiple volumes. The EHR is typically indexed by type of record, author, and date.
- EHRs integrate different types of information that at one time were maintained in separate paper files in the inpatient setting (e.g., practitioner orders, nurses and other ancillary staff documentation, prescription and medication administration records, allergies, vital signs, laboratory and radiographic

studies, problem lists, and demographic information), into a single system and allow such information to be imported into electronic clinical notes.

- Real-time reminders and alerts can be incorporated into an EHR system including:
  - reminders about health care maintenance (e.g., immunization timing),
  - education (e.g., link to evidence-based guidelines), and
  - error checks (e.g., alerts about allergies or potential drug interaction or incorrect medication dosing).
- Improved regulatory and security monitoring of the EHR includes "meta-data" (such as date and time stamps) and audit trail information that didn't exist in the legal paper record.
- Ease of quality improvement and research studies electronic data are more readily accessible for quality improvement, public health, and research studies.

Potential challenges with ~~current~~ EHR implementation. The EHR theoretically promises to improve efficiency and communication, reduce errors, and improve quality of care. Yet, every advance brings with it the potential for new problems, and the EHR is no exception. There are serious negative implications to poorly designed EHR systems, suboptimal EHR implementation, or careless EHR use by practitioners. Problematic aspects of~~A~~ poor~~-~~quality EHRs include containing~~medical record, which could be~~ inaccurate, inconsistent, or incomplete information, or obscuring~~obscure~~ important information among unneeded or redundant details. A poor-quality medical record~~detail,~~ may adversely impact current or future patient care, transfers of care, and~~/or~~ medico-legal investigations, while also contributing to practitioner burnout. Practitioners should be aware of the following EHR challenges as they implement the recordkeeping method that works best for their practices. ~~Problematic aspects of current EHRs include:~~

- **Increased workload~~work load~~:** Data entry into the EHR can be time-consuming, particularly for practitioners who do not type well,[6] and is recognized as a major cause of burnout among practitioners.[12]
- **Distraction during patient encounters:** Data entry into an EHR (real-time) during patient encounters by a practitioner may improve efficiency and lessen charting burdens afterhours but may hinder a practitioner's ability to actively listen and to feel "fully present" with their patients.~~[7]~~
- **Copy-paste:** Electronically carrying forward or copying portions of previously written notes and pasting them into a currently drafted note is problematic when it is either:
  - Copying the work of others without attribution ("clinical plagiarism") or without independent confirmation.[8]

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

~~[7] Some practitioners rely on scribes or speech recognition software. Ultimately, the practitioner is responsible for ensuring that the medical record is accurate.~~

[8] The US Department of Health and Human Services and the Office of the Attorney General have expressed concern for fraud resulting from liberal copying-pasting within the EHR and subsequent upcoding, citing "possible abuses including 'cloning' of medical records, where information about one patient is repeated in other records, to inflate reimbursement In 2012, the Obama administration warned against such practice: "There are troubling indications that some providers are using this technology to

- Introducing unnecessary redundancy (see the next bullet-point, "—"note-bloat.").

- **"Note-bloat":** Note bloat refers to unnecessary and redundant expansion of a note's length and complexity. With electronic documentation, it is easy to incorporate large volumes of data into clinical documentation. Inappropriate copy-paste, carry-forward, and computer-aided data entry (auto-filling) increases the risk of lengthy but information-poor notes. Such redundant content detracts from readability, makes it more difficult to interpret and identify pertinent content, and jeopardizes the communication for which clinical notes are intended.
- **"Boilerplate":** Despite the appeal of using templates, "boilerplate" text may add unnecessary detail that detracts from more important information. Furthermore, busy practitioners may carelessly retain parts of a normal review of systems or examination from the template rather than correctly indicating abnormal reports or findings from their interaction with the patient, resulting in inconsistent and erroneous information within the medical record.
- **Differences between the electronic version and paper copy of the EHR:** The printed copy of the EHR may look very different from the electronic version. Specifically, the paper copy of the EHR may differ from the electronic version either by including auto-populated redundant or extraneous information or excluding data that could not be readily printed. Currently, however, when copies of records are requested for patient care, investigative, or discovery purposes; they are typically provided as paper copies, often at a considerable cost to the requesting party, which may be difficult to read or incompletely reflect patient care.
- **"Pseudo-history" and "pseudo-examination":** Some EHRs convert checked symptom boxes into sentences and paragraphs that are then imported into the EHR such that they appear to recount the verbatim report of the patient. However, the generated history is not derived from the patient's actual words; it only represents binary (YES/NO) data processed into standardized phrases. A similar process with checkbox-to-sentence physical examination findings is available. Such technology potentially undermines consideration of each patient as an individual and conceals the nuances of his/her unique history and needs.
- **Errors in the EHR can be perpetuated and difficult to correct:** Some of these errors have serious undesirable implications for subsequent care and patients' health. Providers and patients complain that when an error occurs in the EHR, it can be very difficult to correct. These errors in documentation can be perpetuated over time and may lead to actual medical errors and adverse patient outcomes.
- **Interference with provider-patient relationship:** Real-time EHR entry during a patient visit may interfere with face-to-face contact with the patient, which may reduce active listening, conceal important diagnostic clues, and damage patient-practitioner rapport.
- **Overemphasis on documentation to meet billing specifications:** This issue largely dates back to E&M regulatory efforts, initiated when paper medical records still predominated. However, EHR

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game the system, possibly to obtain payments to which they are not entitled. False documentation of care is not just bad patient care; it is fraud." (Abelson and Creswell, 2012)

systems have also incorporated E&M elements into their electronic templates leading to concern that documentation whose major design objective is to support coding and billing may subvert the true goal of the EHR, which is to promote high-quality, safe, and integrated health care.

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

Observe, record, tabulate, communicate.

-Sir William Osler (1849-1919)

Introduction

The Washington Medical Commission (Commission) provides this guidance document to physicians and physician assistants (practitioners) on the appropriate documentation of a medical record; special considerations for maintaining an electronic health record (EHR); legal requirements involving access, retention, storage and disposal of medical records; and the handling of records if a practitioner is under discipline or closing a practice. The Commission recognizes that in some specialties and practice settings, practitioners may not have control over the records and may not be able to fully implement the recommendations made below. The Commission appreciates the variety of medical specialties and practices in our state and urges practitioners to exercise reasonable judgment in the application of the guidance document. An appendix contains a history of the medical record, illustrative examples of complaints made to the Commission regarding medical records, and additional information on the implementation and management of EHRs.

Guidance

I. Documentation

A. Purpose of the Medical Record

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

The medical record is a chronological document that:

1. Records pertinent facts about an individual's health and wellness;

2. Enables the treating practitioner to plan and evaluate treatments or interventions, making clear the rationale for diagnoses, plans and interventions;
3. Enhances communication between professionals, to help optimize a patient's continuity of care;
4. Assists both patient and practitioner in communication with third party participants;
5. Facilitates the practitioner's development of an ongoing quality assurance program;
6. Provides a legal document for verification and/or audit of the delivery of care; and
7. Is available as a source of clinical data for research and education.

B. The Essential Elements of a Medical Record

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

1. The purpose of each patient encounter and appropriate information about the patient's history and examination, the patient's perspective and preferences, the plan for any treatment, and the care and treatment provided;
2. The patient's pertinent medical history including serious accidents, operations, significant illnesses, and other appropriate information;
3. Prominent notation of medications, or a statement of their absence;
4. Prominent notation of any known allergies to medications and other allergens including the severity of the reaction (e.g., aspirin (hives), bee stings (anaphylaxis)), or a statement of their absence;
5. Clearly documented informed consent obtained from the patient or from a person authorized to consent on behalf of the patient. In some emergency situations, the reason for a lack of informed consent should be clearly documented; and
6. The date of each entry, and the time as appropriate.

C. Additional Elements of a Medical Record

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

1. Each page in the medical record contains the patient's name or ID number;
2. Personal biographical information such as home address, employer, marital status, emergency contact information and all telephone numbers, including home, work, and mobile phone numbers;
3. Each entry in the medical record contains the author's identification. Author identification may be a handwritten signature, initials, or a unique electronic identifier;
4. All drug therapies are listed, including dosage instructions and, when appropriate, indication of refill limits. Prescription refills should be recorded;
5. Encounter notes should include appropriate arrangements and specified times for follow-up care;
6. All consultation, laboratory, and imaging reports should be entered into the patient's record, reviewed, and the review documented by the practitioner who ordered them. Abnormal reports should be noted in the record, along with corresponding follow-up plans and actions taken;

7. An appropriate immunization record is kept up to date by the primary care provider and, ideally, readily accessible by all clinicians caring for the patient, as technology permits;
8. Documentation of appropriate preventive screening and services being offered in accordance with accepted practice guidelines, as relevant to the visit and/or the specific provider's role in caring for the patient; and
9. Documentation of any other person(s) present during the encounter.

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

D. Special Considerations When Using an EHR

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

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

1. Recommendations for Practitioners

The patient record in an EHR should reflect the same, or improved content and functionality, as that produced in traditional formats. The following recommendations, which are not necessarily exhaustive, are intended to inform practitioners of the appropriate use of an EHR, and to indicate how the Commission will evaluate a medical record, including records that are the product of an electronic system.

a. A practitioner using an EHR must ensure the following:
    - Authorized use and compliance with state and federal privacy and security legal requirements, and with institutional privacy and security policies;
    - A timely, accurate, succinct, and readable entry;
    - Consistency and accuracy between various aspects of a record; and
    - Assumption of ultimate responsibility for trainees' and scribes' documentation.

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

c. A practitioner's actions and decision-making should be accurately reflected in the documentation and include a description of any shared decision-making process that was utilized.[1]

d. Documenting aspects of a practitioner-patient interaction that did not transpire, such as indicating that components of a physical examination were performed when they were not, even when it occurs inadvertently because of EHR design or function, may be considered fraud.

e. When documentation about a significant aspect of the practitioner-patient interaction is not present, the assumption is that it did not occur.

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

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

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

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

2. Suggestions for EHR Software Developers and Healthcare Institutions

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

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

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

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

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

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

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

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

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

h. Medical records serve many audiences who need to be considered in the design and implementation of EHR systems. To meet their potential, EHRs should incorporate comprehensive decision support that do the following:

- Lead to improved patient outcomes;
- Ensure safe transitions of patients from one practitioner, facility, or office to another;
- Allow easy tracking and reporting of patient care metrics and outcomes; and
- Promote patient-centered communication between patients and the health care system.[3]

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

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

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

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

II. Handling, Accessing, and Amending Medical Records

A practitioner's handling of medical records under their control should be designed to protect patient privacy, to benefit the health and welfare of patients, and to facilitate the transfer of clear and reliable information about a patient's care. The Commission recognizes that EHR systems may not be compatible, which often makes that last goal challenging when sending records to a practitioner in another EHR system. Practitioners should do the best they can to protect privacy and to provide medical records to patients, and other practitioners as indicated, in a usable format. Practitioners should be aware of the following recommendations, statutes, and regulations as they address the authority of patients[2] to access, and potentially amend, their medical records.

A. To prevent misunderstandings, the Commission recommends that practitioners ensure that their offices or practices have policies regarding how patients may obtain copies or summaries of medical records. These policies must comply with the law and should be made available in writing to patients when the practitioner-patient relationship begins.

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

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

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

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

F. The Commission recommends that practitioners review and comply with all federal laws that address accessing or amending medical records including, but not limited to, the Health Insurance Portability and Accountability Act of 1996 (HIPAA) and 45 C.F.R. Section 164.526.

[2] Legal protections of patients to access or amend their medical records include authorized patient representative(s) acting on the patient's behalf as permitted by law.

III. Handling Medical Records if a Practitioner Is Involved in Disciplinary Action

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

IV. Storage of Records

A practitioner is responsible for safeguarding and protecting the medical record, whether in electronic or paper format, and for providing adequate security measures. A practitioner may contract with a third party to act as custodian of the medical records. The responsible person, corporation, or legal entity acting as custodian of the records must comply with federal and or state confidentiality laws and regulations.

V. Retention of Medical Records

The Commission appreciates the variety of medical specialties and practices in our state and urges practitioners to exercise reasonable judgment as they apply the following recommendations to their retention of medical records.

A. There is no general law in Washington requiring a practitioner to retain a patient's medical record for a specific period of time.[3]

B. When appropriate, the Commission concurs with the Washington State Medical Association recommendation that practitioners should retain medical records and x-rays for at least:

- Ten years from the date of a patient's last visit, prescription refill, telephone contact, test or other patient contact;
- Twenty-one (21) years from the date of a minor patient's birth;
- Six years from the date of a patient's death; or
- Indefinitely, if the practitioner has reason to believe:
    - The patient is, or was, incompetent;
    - There are, or were, significant concerns involving a patient's care; or
    - The patient is, or is likely to become, involved in litigation.

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

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

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

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

VI. Disposing of Records

When retention is no longer required, records should be destroyed by a secure means.

A. The Privacy Rule in HIPAA prohibits digital and paper records containing confidential information from being thrown away in a public dumpster or recycling bin until they have been rendered unreadable or indecipherable by shredding, burning or other method of destruction.

B. A practitioner should give patients an opportunity to claim their records or to have them sent to another practitioner before the records are destroyed. However, for some practitioners, the nature of their specialties may make notifying patients impractical.

VII. Handling Medical Records When Closing a Medical Practice

The Commission recognizes the complexity of closing a practice and provides this guidance to use as a tool. Please note that the recommendations in this section may not apply in the following instances: (1) A practitioner leaves a multi-practitioner practice and the remaining practitioners in the practice assume care of the patients and retain the medical records; or (2) a practitioner has not had ongoing relationships with patients, and the patients' records have been provided to their referring practitioners, the patients' primary care providers, or directly to the patients themselves. Otherwise, in preparing to close a practice, a practitioner should do the following:

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

- Notice should be given at least 30 days in advance, with 90 days being the best practice.
- Notice should be given by at least one, but preferably all, of the following:
    - Individual letter to the last known patient address;
    - Electronically, if this is a normal method of clinical communication with the patient; or
    - Placing a notice on the practitioner's web site, if the practitioner has a web site.
- If the practitioner is part of an institution or multi-practitioner practice, the institution or practice may provide notice of the closing of the practice, but it is the practitioner's responsibility to ensure those arrangements have been made.
- Notice should include the following:
    - The name, telephone number and mailing address of the responsible entity or agent to contact to obtain records or request transfer of records;
    - How the records can be obtained or transferred;
    - The format of the records, whether hard copy or electronic;
    - How long the records will be maintained before they are destroyed; and
    - The cost of recovering records or transferring records as defined in Chapter 70.02 RCW.

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

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

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

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

-Sir William Osler (1849-1919)

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Appendix

I. History of the Medical Record

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

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

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

standards have emerged for documenting various types of encounters between practitioners and patients (e.g., History and Physical, Operative Note, Ambulatory New and Return Patient Notes, Interim and Discharge Summaries).

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

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

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

- Tell the patient's unique story as it relates to the patient's concerns ("the patient voice");
- Document the pertinent history and physical exam findings, in addition to the pertinent diagnostic testing results and decision-making processes undertaken by the practitioner, for each patient encounter;
- Provide other pertinent clinical information to allow covering or consulting colleagues to maintain care and make informed decisions regarding further care;
- Support coordinated longitudinal plans of care and care transitions within and across organizations;
- Provide a clear and easily understood summary of the encounter, including the practitioner's assessment and plan;
- Document conversations that occur with the patient or the designated caretaker including but not limited to the risks, benefits and alternatives discussed involving informed consent or shared decision-making;
- Create the legal record of a patient's medical and surgical care;
- Create the legal business record of the practitioner's practice or institution;
- Satisfy reasonable documentation requirements from insurers or payers; and
- Support population health data collection and research.

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

Table 2: Medical Record Audiences

➢ Patients and their designated representatives;[5] ➢ Fellow practitioners; ➢ Other members of the health care team; ➢ Health care systems or institutions; ➢ State agencies/regulatory bodies including but not limited to the Commission; ➢ Workers' compensation programs or Social Security; ➢ Legal counsels, courts, and juries; ➢ Insurers or payers; and ➢ Researchers.

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

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

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

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

- A patient files a medical malpractice claim after a delay in diagnosis of a brain tumor. The practitioner says that she performed a complete neurologic examination, which was normal, but the EHR documentation for the neurologic portion of the examination only states "Patellar reflexes 2+ bilaterally."
- A judge in a medical malpractice case found the EHR inadmissible because it contained so much redundant and irrelevant information.

III. EHR Implementation Benefits and Challenges

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

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

    - education (e.g., link to evidence-based guidelines), and
    - error checks (e.g., alerts about allergies or potential drug interaction or incorrect medication dosing).
- Improved regulatory and security monitoring of the EHR includes "meta-data" (such as date and time stamps) and audit trail information that didn't exist in the legal paper record.
- Ease of quality improvement and research studies electronic data are more readily accessible for quality improvement, public health, and research studies.

Potential challenges with EHR implementation. The EHR theoretically promises to improve efficiency and communication, reduce errors, and improve quality of care. Yet, every advance brings with it the potential for new problems, and the EHR is no exception. There are serious negative implications to poorly designed EHR systems, suboptimal EHR implementation, or careless EHR use by practitioners. Problematic aspects of poor-quality EHRs include containing inaccurate, inconsistent, or incomplete information, or obscuring important information among unneeded or redundant details. A poor-quality medical record may adversely impact current or future patient care, transfers of care, and medico-legal investigations, while also contributing to practitioner burnout. Practitioners should be aware of the following EHR challenges as they implement the recordkeeping method that works best for their practices.

- **Increased workload:** Data entry into the EHR can be time-consuming, particularly for practitioners who do not type well,[6] and is recognized as a major cause of burnout among practitioners.[12]
- **Distraction during patient encounters:** Data entry into an EHR (real-time) during patient encounters by a practitioner may improve efficiency and lessen charting burdens afterhours but may hinder a practitioner's ability to actively listen and to feel "fully present" with their patients.
- **Copy-paste:** Electronically carrying forward or copying portions of previously written notes and pasting them into a currently drafted note is problematic when it is either:
    - Copying the work of others without attribution ("clinical plagiarism") or without independent confirmation.[7]
    - Introducing unnecessary redundancy (see the next bullet-point, "note-bloat.").
- **"Note-bloat":** Note bloat refers to unnecessary and redundant expansion of a note's length and complexity. With electronic documentation, it is easy to incorporate large volumes of data into clinical documentation. Inappropriate copy-paste, carry-forward, and computer-aided data entry (auto-filling) increases the risk of lengthy but information-poor notes. Such redundant content detracts from readability, makes it more difficult to interpret and identify pertinent content, and jeopardizes the communication for which clinical notes are intended.

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

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

- **"Boilerplate":** Despite the appeal of using templates, "boilerplate" text may add unnecessary detail that detracts from more important information. Furthermore, busy practitioners may carelessly retain parts of a normal review of systems or examination from the template rather than correctly indicating abnormal reports or findings from their interaction with the patient, resulting in inconsistent and erroneous information within the medical record.
- **Differences between the electronic version and paper copy of the EHR:** The printed copy of the EHR may look very different from the electronic version. Specifically, the paper copy of the EHR may differ from the electronic version either by including auto-populated redundant or extraneous information or excluding data that could not be readily printed. Currently, however, when copies of records are requested for patient care, investigative, or discovery purposes; they are typically provided as paper copies, often at a considerable cost to the requesting party, which may be difficult to read or incompletely reflect patient care.
- **"Pseudo-history" and "pseudo-examination"***:* Some EHRs convert checked symptom boxes into sentences and paragraphs that are then imported into the EHR such that they appear to recount the verbatim report of the patient. However, the generated history is not derived from the patient's actual words; it only represents binary (YES/NO) data processed into standardized phrases. A similar process with checkbox-to-sentence physical examination findings is available. Such technology potentially undermines consideration of each patient as an individual and conceals the nuances of his/her unique history and needs.
- **Errors in the EHR can be perpetuated and difficult to correct:** Some of these errors have serious undesirable implications for subsequent care and patients' health. Providers and patients complain that when an error occurs in the EHR, it can be very difficult to correct. These errors in documentation can be perpetuated over time and may lead to actual medical errors and adverse patient outcomes.
- **Interference with provider-patient relationship:** Real-time EHR entry during a patient visit may interfere with face-to-face contact with the patient, which may reduce active listening, conceal important diagnostic clues, and damage patient-practitioner rapport.
- **Overemphasis on documentation to meet billing specifications:** This issue largely dates back to E&M regulatory efforts, initiated when paper medical records still predominated. However, EHR systems have also incorporated E&M elements into their electronic templates leading to concern that documentation whose major design objective is to support coding and billing may subvert the true goal of the EHR, which is to promote high-quality, safe, and integrated health care.

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Compensation and Reimbursement for Commission Duties

Introduction

The Washington Medical Commission (Commission) will compensate its members for performing the duties of the Commission in accordance with RCW 43.03.265 and will reimburse its members for travel expenses in accordance with RCW 43.03.050 and RCW 43.03.060.

Compensation

1. Under RCW 43.03.265, the Commission will compensate its members a maximum amount of $250 for performing the duties of the Commission for eight hours or more in a single day.[1] The Commission will compensate its members at the prorated hourly rate of $31.25 for performing the duties of the Commission for less than eight hours in a single day. The Commission will compensate its members for their time spent on Commission-related work~~,~~ that is incurred in the course of authorized business consistent with the responsibilities of the Commission as established by law including~~,~~ but not limited to:
    - ~~a.~~ Attending Commission meetings;
    - ~~b.~~ Traveling to and from official meetings;
    - ~~c.~~ Reviewing case files and preparing for case presentation, including journals and other research documents;
    - ~~d.~~ Participating in telephone calls and telephone conferences;
    - ~~e.~~ Reviewing complaints for the case management team meetings~~;~~
    - ~~f.~~ Reading the business meeting packet, the compliance packet, the Panel L packet, and other documents necessary to actively participate in Commission meetings;
    - ~~g.~~ Preparing for and participating in settlement conferences;
    - ~~h.~~ Participating on a hearing panel that does not occur at a regular Commission meeting;
    - ~~i.~~ Reviewing agreed orders, stipulations to informal disposition, final orders, notices of required examinations or denials, and other legal documents;
    - ~~j.~~ Administrative and organizational duties requested by the Commission Chair and by members designated by the Chair~~;~~.

[1] However, if an individual "(a) occupies a position, normally regarded as full-time in nature, in any agency of the federal government, Washington state government, or Washington state local government; and (b) receives any compensation from such government for working that day", they are ineligible for compensation as stated in RCW 43.03.265(2).

~~k.~~ • Administrative work by any commission member, including but not limited to e-mail or telephone correspondence; and

~~l.~~ • Other duties expected of commissioners in the performance of their Commission role, including C~~c~~ommission approved talks and educational conferences.

2. Reading journals or articles~~,~~ or conducting research that is not directly related to case reviews may~~,~~ ~~are to~~ be done on the Commission member's own time and will not be compensated.
3. Only Commission members appointed to specific regular and ad hoc committees will be compensated for attendance at those committee meetings.
4. A pro-tem member may be compensated only for their time spent on duties stated in the appointment letter from the Commission's Executive Director.

4.

Reimbursement

1. ~~Under~~Pursuant to RCW 43.03.050, expenses for lodging and meals will be compensated with a per diem rate in accordance with the Office of Financial Management (OFM) regulations.
2. ~~Under~~Pursuant to RCW 43.03.060, automobile mileage will be compensated at the rate set by the Director of OFM~~, pursuant to RCW 43.03.060~~.
3. Other transportation costs will be compensated in accordance with OFM regulations.
4. To be eligible for reimbursement, ~~All~~ airplane flights must be arranged through Commission staff, and hotel arrangements must not be made through a third-party vendor.~~.~~
5. All requests for compensation or other reimbursable expenses including travel should be submitted to Commission staff within 30 calendar days. Any requests for compensation made after 90 calendar days following an otherwise eligible occurrence will be denied.

Date of Adoption:	January 8, 2016
Reaffirmed/Updated:	February 28, 2020
Supersedes:	MD2016-02

Procedure

WASHINGTON Medical Commission
Licensing. Accountability. Leadership.

Processing Complaints Against Medical Students and Resident Physicians

Introduction

In carrying out its disciplinary role to protect the public, the Washington Medical Commission (~~WMC~~Commission) occasionally receives complaints[1] against medical students and resident physicians (residents). Because of the highly -supervised environment in which they practice, the ~~WMC~~ Commission provides~~creates~~ this procedure for processing complaints against medical students and residents.

Medical Students

Medical students are not required to have a license to practice medicine. They are legally permitted to practice medicine in an accredited school of medicine so long as the practice is pursuant to a regular course of instruction or assignments from an instructor, or performed under the supervision or control of a licensed physician.[2] ~~Since m~~Medical students are in the early stages of practicing medicine, have little control over their practice environment, and are monitored ~~learning~~ in a highly structured, ~~and~~ supervised environment. As such, ~~the dean of the~~ medical school deans are~~is~~ often better equipped to address ~~a~~ concerns than the ~~WMC~~ Commission.

However, if the Commission receives a complaint involving reckless behavior or gross misconduct by a medical student, the Commission may choose to investigate the complaint to protect the public.

Residents

Po~~Residents and fellows, who may or may not possess a license to practice medicine,~~[3]stgraduate clinical training programs generally require each of their residents to obtain a limited license which permits them to

[1] For the purpose of this procedure, the term "complaint" includes a mandatory report under RCW 18.130.070 and 18.130.080.
[2] RCW 18.71.030(8). ~~Both residents and fellows are exempt from the license requirement under RCW 18.71.030(8) if they are in a program of clinical medical training sponsored by a college or university or hospital in this state and the performance of medical services are pursuant to their duties as residents and fellows. Although not required, many residents and fellows obtain a full license or a limited license under RCW 18.71.095(3) or (4)(b)~~
[3] ~~RCW 18.71.030(8). Both residents and fellows are exempt from the license requirement under RCW 18.71.030(8) if they are in a program of clinical medical training sponsored by a college or university or hospital in this state and the performance of medical services are pursuant to their duties as residents and fellows. Although not required, many residents and fellows obtain a full license or a limited license under RCW 18.71.095(3) or (4)(b).~~

practice medicine in connection with their duties in the residency program. A limited license does not authorize a resident to engage in any practice of medicine outside of their residency program. Generally, residents practicing medicine within their program have little control over their practice environment which, by design, provides ongoing learning opportunities with continuous evaluation and feedback ~~designed~~ processes to~~to~~ cultivate~~develop~~ the skills necessary to be a competent physician. A~~An a~~ttending physicians and program directors are~~is~~ responsible for training their residents ~~reonas to~~ the ~~proper~~ standard~~s~~ of care and ~~appropriate behavior~~professional conduct involving the practice of medicine. Due to established supervisory roles within training programs, a residency program director is~~The attending physician is~~, thus, generally ~~therefore~~ in a ~~a~~ better position than the Commission to manage concerns involving one of their residents ~~than the WMC~~.

However, a limited license does not shield a resident, their supervising attending physician, or their program director from being investigated or disciplined by the Commission to protect the public. Also, if~~, however,~~ a resident practice~~s~~ medicine outside of their program and independent of the supervision of the attending physician, such as in a moonlighting setting, the ~~WMC~~ Commission is the appropriate entity to address ~~concerns~~complaints, and to take action if necessary.

Procedure

A. Complaints against medical students will be handled in the following manner.

1. The Commission's complaint intake coordinator determines whether the complaint is against a medical student; and, if so, redactions will state "medical student", rather than the typical insertion of "respondent" to alert the Commission to their level of training.
2. A panel of the Commission~~WMC~~ reviews the redacted complaint against the medical student, considers that the student is in training and whether the Commission is aware of previous complaints, and then may decide to proceed in the following manner:
   - Close the complaint;
   - Close the complaint and refer the complaint to the dean of the medical school; or
   - Open an investigation if the panel believes that the medical student ~~breached the standard of care with~~ has engaged in reckless behavior or gross misconduct, and the safety of the public warrants opening an investigation~~the public's safety at risk~~.

B. Complaints against residents will be handled in the following manner.

1. The Commission's complaint intake coordinator determines whether the complaint is against a resident; and, if so, redactions will state "resident", rather than the typical insertion of "respondent" to alert the Commission to their level of training.
2. A panel of the ~~WMC~~ Commission reviews the redacted complaint against the resident, considers that the resident is in training and whether the Commission is aware of previous complaints, and then may decide to proceed in the following manner:
   - Close the complaint;

Commented [PK1]: [need to mention how redactions are to be handled by inserting a new step one if we plan to continue our actual current practice which is this:

"The Complaint Intake Coordinator uses ILRS to determine whether providers mentioned in the complaint are medical students, residents, or fellows." Later it says that if it is, the case may be opened as a Medical Unknown.

Of note, since Medical Unknowns, regardless of whether or not the practitioner is in training, are generally closed largely due to difficulty identifying the practitioner, this seems inaccurate, they are not really unknown, we are just shielding them with this incorrect terminology. Would Respondent be more accurate with something in the CMT summary to reflect their in-training status or redacted with the appropriate label (e.g., resident)?]

Commented [PK2]: [Same comment, we need to mention how redactions are to be handled

Commented [PK3]: [can you figure out how to make the line space between subsection 1 and 2 the same as it is in the medical student section?]

- Close but refer the complaint to the resident's residency program director;
- Open an investigation and consider making a simultaneous referral to the Washington Physicians Health Program (WPHP) if a complaint includes that the resident is impaired or potentially impaired as the result of a health condition. If WPHP determines that a resident may be unable to practice with reasonable skill and safety and that the resident is not following the requirements of the program, WPHP will make a report to the Commission pursuant to its statutory reporting obligations (RCW 18.71.320 and RCW 18.130.175). The Commission may choose to weigh WPHP's experience and expertise, the trust it places in WPHP as the Commission's approved physician health program, and WPHP's statutory reporting obligations, in evaluating the credibility and seriousness of the report;
-
- Open an investigation on the resident, ~~and/or~~the attending physician, and/or the residency program director if the panel believes that the resident breached the standard of care, and the safety of the public warrants opening an investigation~~the public's safety is at risk~~; or
- Treat the resident as it would any traditionally licensed physician if the panel believes that the resident was practicing independently outside of their program and without the supervision of an attending physician, such as in a moonlighting environment.

3. If the Commission takes disciplinary action against the resident's attending physician or program director, the Commission may consider restricting them from the training of residents, though the Commission is not limited to this particular sanction.

~~If the WMC takes disciplinary action against the attending physician, the WMC may consider restricting the attending physician from the training of residents or fellows, though the WMC is not limited to this particular sanction.~~

Processing Complaints Against Medical Students and Resident Physicians

Introduction

In carrying out its disciplinary role to protect the public, the Washington Medical Commission (Commission) occasionally receives complaints[1] against medical students and resident physicians (residents). Because of the highly supervised environment in which they practice, the Commission provides this procedure for processing complaints against medical students and residents.

Medical Students

Medical students are not required to have a license to practice medicine. They are legally permitted to practice medicine in an accredited school of medicine so long as the practice is pursuant to a regular course of instruction or assignments from an instructor, or performed under the supervision or control of a licensed physician.[2] Medical students are in the early stages of practicing medicine, have little control over their practice environment, and are monitored in a highly structured, supervised environment. As such, medical school deans are often better equipped to address concerns than the Commission.

However, if the Commission receives a complaint involving reckless behavior or gross misconduct by a medical student, the Commission may choose to investigate the complaint to protect the public.

Residents

Postgraduate clinical training programs generally require each of their residents to obtain a limited license which permits them to practice medicine in connection with their duties in the residency program. A limited license does not authorize a resident to engage in any practice of medicine outside of their residency program. Generally, residents practicing medicine within their program have little control over their practice environment which, by design, provides ongoing learning opportunities with continuous evaluation and feedback processes to cultivate the skills necessary to be a competent physician. Attending physicians and program directors are responsible for training their residents on the standard of care and professional conduct involving the practice of medicine. Due to established supervisory roles within training programs, a residency program director is, thus, generally in a better position than the Commission to manage concerns involving one of their residents.

[1] For the purpose of this procedure, the term "complaint" includes a mandatory report under RCW 18.130.070 and 18.130.080.
[2] RCW 18.71.030(8).

However, a limited license does not shield a resident, their supervising attending physician, or their program director from being investigated or disciplined by the Commission to protect the public. Also, if a resident practices medicine outside of their program and independent of the supervision of the attending physician, such as in a moonlighting setting, the Commission is the appropriate entity to address complaints, and to take action if necessary.

Procedure

A. Complaints against medical students will be handled in the following manner.

1. The Commission's complaint intake coordinator determines whether the complaint is against a medical student; and, if so, redactions will state "medical student", rather than the typical insertion of "respondent" to alert the Commission to their level of training.
2. A panel of the Commission reviews the redacted complaint against the medical student, considers that the student is in training and whether the Commission is aware of previous complaints, and then may decide to proceed in the following manner:
    - Close the complaint;
    - Close the complaint and refer the complaint to the dean of the medical school; or
    - Open an investigation if the panel believes that the medical student has engaged in reckless behavior or gross misconduct, and the safety of the public warrants opening an investigation.

B. Complaints against residents will be handled in the following manner.

1. The Commission's complaint intake coordinator determines whether the complaint is against a resident; and, if so, redactions will state "resident", rather than the typical insertion of "respondent" to alert the Commission to their level of training.
2. A panel of the Commission reviews the redacted complaint against the resident, considers that the resident is in training and whether the Commission is aware of previous complaints, and then may decide to proceed in the following manner:
    - Close the complaint;
    - Close but refer the complaint to the resident's residency program director;
    - Open an investigation and consider making a simultaneous referral to the Washington Physicians Health Program (WPHP) if a complaint includes that the resident is impaired or potentially impaired as the result of a health condition. If WPHP determines that a resident may be unable to practice with reasonable skill and safety and that the resident is not following the requirements of the program, WPHP will make a report to the Commission pursuant to its statutory reporting obligations (RCW 18.71.320 and RCW 18.130.175). The Commission may choose to weigh WPHP's experience and expertise, the trust it places in WPHP as the Commission's approved physician health program, and WPHP's statutory reporting obligations, in evaluating the credibility and seriousness of the report;

- Open an investigation on the resident, the attending physician, and/or the residency program director if the panel believes that the resident breached the standard of care, and the safety of the public warrants opening an investigation; or
- Treat the resident as it would any traditionally licensed physician if the panel believes that the resident was practicing independently outside of their program and without the supervision of an attending physician, such as in a moonlighting environment.

3. If the Commission takes disciplinary action against the resident's attending physician or program director, the Commission may consider restricting them from the training of residents, though the Commission is not limited to this particular sanction.

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Reaffirmed / Updated:	N/A
Supersedes:	N/A

WASHINGTON Medical Commission
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Approving Accrediting Entities to Accredit or Certify the Use of Anesthesia in Office-Based Surgical Settings

Introduction

Purpose. The Washington Medical Commission (Commission) adopts this procedure for approving entities to accredit or certify the use of anesthesia in office-based surgical settings and creates the list of approved entities.

Background: WAC 246-919-601(5) provides that a physician conducting a procedure under this rule must ensure that it takes place in a facility that is suitably equipped and maintained to guarantee patient safety and that the facility should be accredited or certified by an accrediting entity approved by the Commission. The accrediting entity must demonstrate "to the satisfaction of the Commission that is has all of the following:

a) Standards pertaining to patient care, recordkeeping, equipment, personnel, facilities and other related matters that are in accordance with acceptable and prevailing standards of care as determined by the commission;

b) Processes that assure a fair and timely review and decision on any applications for accreditation or renewals thereof;

c) Processes that assure a fair and timely review and resolution of any complaints received concerning accredited or certified facilities; and

d) Resources sufficient to allow the accrediting entity to fulfill its duties in a timely manner.

Procedure

1. An entity submits a letter to the Commission requesting that the Commission approve it as an entity to accredit or certify the use of anesthesia in office-based surgical settings. The entity must include documentation that it has all of the following:

    a. Standards pertaining to patient care, recordkeeping, equipment, personnel, facilities and other related matters that are in accordance with acceptable and prevailing standards of care as determined by the Commission;

    b. Processes that assure a fair and timely review and decision on any applications for accreditation or renewals thereof;

    c. Processes that assure a fair and timely review and resolution of any complaints received concerning accredited or certified facilities; and

d. Resources sufficient to allow the accrediting entity to fulfill its duties in a timely manner.

2. The Commission reviews the letter and accompanying documentation. If the Commission determines that the entity meets the requirements listed in step 1, the Commission will notify the entity that it has been approved as an entity accredit or certify the use of anesthesia in office-based surgical settings. The Commission will place the entity on the list of approved entities.

3. If the Commission determines that the entity does not meet the requirements listed in step 1, the Commission will notify the entity of the decision.

Approved Entities

The Accreditation Association for Ambulatory Health Care

The American Association for Accreditation of Ambulatory Surgery Facilities

The Centers for Medicare and Medicaid Services

Institute for Medical Quality

The Joint Commission

The National Abortion Federation

Planned Parenthood of America

Date of Adoption:

Staff Reports: April 26, 2024

Kyle Karinen, Executive Director

As a follow-up to the HELMS- and budget-related items in my January staff report and as a supplement to the item mentioned elsewhere, the Commission's budget remains in solid shape. The last legislative session brought in additional measure of funding for the HELMS project from the State's general fund. There remains a gap, however, in the expected final cost of the project and the current appropriated funding. The Commission has an assessment of a little over $243,000 that will come in June of this year. That amount will come out of the Commission's reserves and the Commission remains poised to continue that approach for any future assessments.

Along with a handful of Commission members and staff, I traveled to Nashville last week for the FSMB Annual Meeting. Jimi Bush and I went in a day early for the annual Administrators In Medicine meeting. I was part of a workshop panel discussing the Commission's practices and procedures for investigating and reviewing allegations of sexual misconduct. (Similarly, I have been asked to be part of a similar discussion in a webinar put on by the International Association of Medical Regulatory Authorities.) The invitations are reflective of the work the Commission and Melanie did over the years and, again, I thank the Commission for its commitment and resolve to address this issue.

We are starting to organize a discussion between Commission members and members of the Oregon Medical Board (OMB). The purpose will be to allow an exchange of ideas and to share best practices between the two agencies. For as much as our paths cross and as many licensees that we share with OMB, the fact is that we don't actually know too much about them. I speak periodically with OMB's executive director and staff talks with them at FSMB events, but Commission members? Not so much. The date and timing remains to be determined, but with the input from the Executive Committee we are planning to make this an in-person event and are looking at September or October. If you have items that you would like to have discussed, please let me know.

Finally, as mentioned in the most recent Commission newsletter, there has been another lawsuit filed against the Commission. This lawsuit was against just me individually. As has been the case with lawsuits in the past, there were multiple media requests for comment. As has been in the case, we declined. I realize this can cause heartburn for some, but when cases are active, the Commission needs to allow those cases to proceed without comment from me or any other staff member. If you are directly contacted by the media, please consider referring them to me or Stephanie Mason, the Commission's Public Information Officer.

Micah Matthews, Deputy Executive Director

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

Legislative Session Wrap Up and Implementation

A late breaking item: Virginia was the seventh state to pass the PA Compact bill so that is now active. The Council of State Governments will begin an 18-month process to stand up the new Compact Commission. We will provide updates on this progress as we receive them.

We are starting implementation on the five bills that impact the WMC: PA Compact, PA Collaborative Practice, Certified Anesthesiologist Assistants (CAAs), Uniform Telehealth Act, and Reproductive Fraud. Most of the bill implementations involve some level of IT work and webinars for awareness. As a result, you have two rules initiation request in your packet and corresponding action items on the agenda.

There is also a bill that increases the surcharge from $50 to $70 per year, which goes to fund WPHP. The Office of the Secretary is responsible for all fee setting rules in consultation with the WMC where applicable. In addition to the WPHP surcharge, we are asking DOH to initiate fee rules to establish fees for the PA Compact license/privilege and the CAA license.

There is a Naturopathic Sunrise hearing on the morning of April 24th being held virtually by DOH. The Sunrise is to consider significant scope expansion for Naturopaths to include gaining access to scheduled drugs. The result could result in a bill recommendation to the Legislature in 2025. We do not intend to comment at the hearing and instead plan to reserve comments until the draft report is issued. As a reminder, Commissioners are welcome to participate and comment on any Sunrise process, but you must do so in your individual capacity.

Budget

Budget reports through the end of February show that revenue collections are slightly lower than projected. This is not a significant concern at this point due to the season-based nature of revenue collections and the fact that our expenditures are routinely lower than revenue. We anticipate a slight increase in expenditure related to conference travel to FSMB, CTeL, CLEAR and other conference/training costs through September but will remain well within allotments. Overall, we appear to be underspent by roughly 10 percent, which is considered acceptable.

Legislatively, we did receive some funding to implement bills previously discussed, but nearly all the bills did not provide full funding requested to the WMC. This will end up costing the WMC between $120,000-$210,000 over the course of the biennium. While disappointing, we have the funding and reserves to absorb the cost and perform the work.

Conferences and Presentations

I am attending the Northwest Regional Telehealth Resource Center conference in Seattle at the end of April with Pam Kohlmeier and Stephanie Mason. This is both training and stakeholder work in the aftereffects of Washington passing the Uniform Telehealth Act.

Micah Matthews, Deputy Executive Director continued

I am co-presenting with Licensing Manager Marisa Courtney to the Washington Association Medical Staff Services annual conference April 24 in Centralia on WMC 101 and a deep dive on licensing and upcoming changes due to legislative action.

In mid-May I am scheduled to tour a Clinical Experience site in Puyallup with The International Medical Graduate Academy and Senator Gildon. The goal is to show how these licensees are utilized in preparation for promotion work funded by the Legislature through the Academy.

In mid-June I am presenting on telehealth and recent policy updates at the Center for Telemedicine and e-Health Law. There will also be a panel debate with Pacific Legal Foundation about their case before the Supreme Court regarding expiration of pandemic era restrictions in New Jersey. We are bringing a larger contingent to that conference to educate and train more WMC staff in telehealth state and national issues now that Washington has a statute on telehealth policy.

HELMS

The Department of Health intends to launch "HELMS Lite" on April 24. This will replace the current online licensing portal with two glitch fixes and present a new "skin" to users of the portal. The process for applying for licenses will remain largely the same and there should be minimal impact on applicants.

In anticipation of this launch during our licensing busy season, we reached out to GME programs and hospitals to encourage they submit their newly matched grads early to avoid any potential delays and disruptions. This seems to have largely been done and we do not anticipate significant negative impacts. The next major release for HELMS will be the credentialing module due December 2024.

Amelia Boyd, Program Manager

Recruitment

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

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

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

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

Amelia Boyd, Program Manager continued

The following position expired as of June 30, 2022, and we are awaiting word from the Governor's office staff on the new appointee:

- Public Member – Toni Borlas – not eligible for reappointment

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

On July 1, 2024, we will have the following vacancies:

- One physician representing Congressional District 6 – Claire Trescott, MD, not eligible for reappointment
- One physician representing Congressional District 8 – Harlan Gallinger, MD, eligible for reappointment
- One Physician-at-Large – Karen Domino, MD, eligible for reappointment

In January 2024, recruitment letters were sent to all MDs with an active license and who have been licensed in our state for at least 5 years in Congressional District 6. The application deadline for these three vacancies was March 22, 2024. The applications are currently under review.

Mike Hively, Director of Operations and Informatics

Compulsory Requests Overview:

Between December 12, 2023, and April 8, 2024, the Operations and Informatics team processed eight compulsory records requests, handling approximately 26,401 pages. This involved performing 48,035 redactions and withholding 2,402 pages. The team collaborated closely with the AAG to manage a complex and sensitive DOJ request, successfully sanitizing the records by removing personal identifiers while maintaining the integrity of the records. Currently, there are two active requests, and seven active litigation holds.

Digital Archiving:

- 558 Complaints closed BT
- 485 Active MD licensing applications
- 963 Active PA licensing applications
- 5,530 Demographic census forms
- 222 Closed investigations

Five boxes of PA licenses, totaling 317 applications, were recalled and converted into electronic formats. Once these applications are digitally archived in .PDF/a format, disposition tickets will be submitted for approval.

Data Requests processed include approximately:

- 2,111 open/closed inquiries
    - Each inquiry may include multiple requests

Mike Hively, Director of Operations and Informatics continued

- 881 address changes

Demographics

- Scanned and entered approximately 5,530 census forms to ILRS
- Performed 1,380 secondary census contacts
- Built quarterly aggregate reports

Collaboration with DOH Partners:
We're in the process of collaborating with DOH partners to inventory IT equipment for upcoming commissioner laptop renewals. These efforts also included device selection and facilitation of new laptop issuance and retrieval of devices at the end of their life cycle.

Personal or Professional Email
As a reminder, we request that you restrict the utilization of personal or professional email accounts beyond the official DOH or WMC channels. These alternative means of communication should be reserved for instances where there is a need to notify colleagues of connectivity issues or for non-sensitive communications that carry minimal risk to the WMC (e.g., Can you give me a call when you get a minute?), avoiding discussions of protected information or decision-making processes.

If you'd like assistance in setting up Microsoft Power Automate to facilitate the sending of generic text messages and/or emails to external email accounts, serving as notifications (e.g., "You've Got WMC Email"), please do not hesitate to contact our Information Liaison, Ken Imes.

Gina Fino, MD, Medical Consultant, Director of Compliance

Our CME library for the Practitioner Support Program is growing! Thanks to all the staff and commission members for their recommendations. Compliance staff are working to resolve a bolus of 2024 personal appearances before it becomes a bezoar. Solutions to follow in the next staff report. Special thanks to the investigative unit for performing compliance audits with grace, speed, and precision.

Rick Glein, Director of Legal Services

Summary Actions:
In re Stephen L. Smith, MD, Case No. M2022-722. Dr. Smith owns and operates an integrative medicine practice alongside a nutrition company in Benton County. Dr. Smith has been under an Agreed Order (M2014-409) with the Commission since 2014. The Agreed Order was modified (Modified Agreed Order) in 2020 and, in part, restricts Dr. Smith from treating a patient who is not currently under the care of either a primary care provider (PCP) or a physician who is certified by the American Board of Internal Medicine in a sub-specialty of internal medicine. Furthermore, Dr. Smith is required to wear gloves when administering all injections. In February 2023, the Commission served a Statement of Charges (SOC) alleging Dr. Smith was treating patients not currently under the care of a PCP or physician board

certified in internal medicine as required in the 2014 Modified Agreed Order. On April 2, 2024, the Commission served an Amended SOC alleging that Dr. Smith has not been adhering to the terms of the 2014 Modified Agreed Order in that he has treated numerous patients who are not under the care of a PCP or physician board certified in internal medicine and has not consistently used gloves when administering injections. The Commission is also alleging Dr. Smith has been treating numerous family members and engages in substandard practices which place patients at significant risk of harm and demonstrate an immediate threat to patient safety. An Ex Parte Order of Summary Suspension (Order) was served concurrent to the Amended SOC, suspending Dr. Smith's medical license pending further disciplinary proceedings. Dr. Smith has 20 days from service of the order to request a show cause hearing*. A hearing on the merits of the Amended SOC has not been scheduled as of the writing of this report.

*The license holder must request the show cause hearing within twenty days of the issuance of the order. At the show cause hearing, the disciplining authority has the burden of demonstrating that more probable than not, the license holder poses an immediate threat to the public health and safety. RCW 18.130.135(1).

Orders Resulting from SOCs:

In re Ryan N. Cole, MD, Case No. M2022-207. Final Order.** On January 10, 2023, the Commission filed a Statement of Charges alleging Dr. Cole made numerous false and misleading statements during public presentations regarding the COVID-19 pandemic, COVID-19 vaccines, and the effectiveness of masks and provided negligent care to four patients to prevent or treat COVID-19. The Commission held a virtual hearing September 25-29, 2023. A Final Order was issued in January 2024 which restricts Dr. Cole's medical license and places him on oversight. Dr. Cole is restricted from engaging in the practice of primary care medicine and from prescribing medications for patients. His practice of medicine is restricted to the practice of pathology. Dr. Cole may petition to lift the practice restriction after completing a re-entry course in family medicine. Additionally, Dr. Cole must complete CMEs in the areas of COVID-19; pulmonary and respiratory diseases; medical record-keeping; and telehealth. Dr. Cole shall complete the Professional/Problem Based Ethics (PROBE) program and submit a paper addressing professionalism, truthfulness, and honesty in medicine. Dr. Cole will pay a $5,000 fine and must personally appear before the Commission. Dr. Cole may not seek modification of the Final Order for five years from its effective date.

In re Thomas A. Thorn, MD, Case No. M2022-844. Default Order of Suspension (Failure to Respond).** In October 2023, the Commission issued a SOC alleging Dr. Thorn failed to maintain adequate medical records based off a complaint from Dr. Thorn's employer who discharged him from employment. The Commission further alleged Dr. Thorn failed to respond to the Commission's Letter of Cooperation and has a disciplinary history with the Commission dating back to 2008 that includes failing to cooperate with the Commission. Dr. Thorn did not file a response to the SOC within the time allowed. In January 2024, a HLJ issued a Default Order which concluded sufficient grounds exist to take disciplinary action and ordered Dr. Thorn's medical license be indefinitely suspended.***

In re Robert G. Thompson, MD, Case No. M2021-553. Final Order of Suspension.** On June 24, 2022, the Commission filed a SOC alleging standard of care issues, including opioid treatment, prescribing, and patient monitoring, along with misrepresentations to the Commission. The Commission held a virtual hearing October 26, 2023. A Final Order was issued in January 2024 which indefinitely suspended*** Dr. Thompson's medical license. Dr. Thompson is ordered to complete a competency assessment and pay a $5,000 fine. Dr. Thompson must enroll in the competency assessment prior to petitioning for reinstatement.

In re Rugvedita S. Parakh, MD, Case No. M2022-985. Default Order of Suspension (Failure to Appear).** On March 16, 2023, the Commission served a SOC alleging the Medical Licensing Board of Indiana (Indiana Board) entered an Order finding Dr. Parakh unfit to practice medicine due to a physical or mental disability with the underlying investigation as a result of criminal charges in January 2020 for two assault-related felonies. Allegations further stated the Indiana Board mandated compliance with the Indiana's physical health program, which was subsequently transferred to the Washington Physicians Health Program (WPHP). WPHP notified the Commission that Dr. Parakh had been discharged from the program for non-compliance. In November 2023, the Commission filed an Amended SOC alleging the Indiana Board indefinitely suspended Dr. Parakh's medical license for failing to comply with the Indiana Board Order. An Ex Parte Order of Summary Suspension was served concurrent to the Amended SOC, suspending Dr. Parakh's Washington medical license pending further disciplinary proceedings. A hearing on the merits of the Amended SOC was scheduled for February 8, 2024; however, Dr. Parakh did not file an Answer to the Amended SOC or appear at a status conference. The Health Law Judge (HLJ) issued an Order of Default in January 2024 which Dr. Parakh did not move to vacate. On February 15, 2024, a HLJ issued a Default Order which concluded sufficient grounds exist to take disciplinary action and ordered Dr. Parakh's medical license be indefinitely suspended.***

In re Jane Houtz, MD, Case No. M2023-349. Default Order of Suspension (Failure to Respond).** In January 2024, the Commission filed a SOC alleging Dr. Houtz failed to respond to two patients' written requests for their medical records and also failed to cooperate with the Commission by not responding to the Commission's Letters of Cooperation requiring Dr. Houtz to provide a copy of the patients' medical records. Dr. Houtz did not file a response to the SOC within the time allowed. In February 2024, a HLJ issued a Default Order which concluded sufficient grounds exist to take disciplinary action and ordered Dr. Houtz' medical license be indefinitely suspended.***

In re Monya De, MD, Case No. M2023-235. Agreed Order. In November 2021, under Case No. M2020-936, Dr. De entered into a Stipulation to Informal Disposition (Stipulation) with the Commission based on allegations that Dr. De misrepresented prior training during the application and onboarding process for postgraduate residency. The Stipulation required, among other things, for Dr. De to successfully compete a medical ethics and professionalism course. In January 2023, the Commission filed a SOC alleging Dr. De failed to successfully complete the medical ethics and professionalism course. In March 2024, the Commission accepted an Agreed Order which requires Dr. De to complete an ethics assessment exam, an ethics course, and a reflective paper; pay a $2,500 fine; and personally appear before the

Commission. Dr. De may petition for termination one year from the effective date of the Agreed Order.

In re Gouri Pothini, MD, Case No. M2022-852. Agreed Order of Suspension. In December 2022, the Commission filed a SOC alleging Dr. Pothini wrote prescriptions in another person's name for his own use. The SOC additionally alleges Dr. Pothini was charged with one count of Assault in the Fourth Degree (Domestic Violence), a gross misdemeanor. In March 2024, the Commission accepted an Agreed Order which indefinitely suspended*** Dr. Pothini's medical license. Dr. Pothini shall complete the assessment process with the Washington Physicians Health Program (WPHP). A petition for reinstatement by Dr. Pothini must be accompanied by an endorsement from WPHP stating Dr. Pothini completed the WPHP assessment process and is in compliance with all WPHP recommendations and able to safely practice medicine.

In re Simon Hill, PA, Case No. M2022-198. Agreed Order. In May 2023, the Commission filed an SOC alleging a patient presented to Mr. Hill in the emergency room, and the two were subsequently in a romantic relationship during which time Mr. Hill wrote prescriptions for the patient, but failed to keep medical records. The SOC further alleges a no-contact order was issued prohibiting contact between Mr. Hill and the patient, and Mr. Hill ultimately entered into an Alford plea agreement for gross misdemeanor telephone harassment and violation of a no-contact order. In March 2024, the Commission accepted an Agreed Order which requires Mr. Hill to complete a CME on prescribing and review the Commission's policy on *Self-Treatment or Treatment of Immediate Family Members*. Mr. Hill must also complete an ethics and boundaries course and prepare a paper regarding the topics of prescribing and maintaining appropriate boundaries with patients. Mr. Hill will pay a fine of $5,000 and personally appear before the Commission. Mr. Hill may petition to terminate the Agreed Order after 30 months and completion of the required terms and conditions.

In re Richard Miller, MD, Case No. M2023-249. Default Order of Suspension (Failure to Respond).** In November 2023, the Commission issued a SOC alleging the WPHP submitted a report to the Commission stating Dr. Miller suffers from an impairing health condition which prevented WPHP from endorsing Dr. Miller as having the ability to practice medicine with reasonable skill and safety. The Commission further alleges Dr. Miller did not respond to the Commission's Letter of Cooperation. Dr. Miller did not file a response to the SOC within the time allowed. In March 2024, a HLJ issued a Default Order which concluded sufficient grounds exist to take disciplinary action and ordered Dr. Miller's medical license be indefinitely suspended.***

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

Rick Glein, Director of Legal Services continued

Virtual Hearing:
In re Michael Turner, MD, Case No. M2022-194. On May 4, 2023, the Commission filed a SOC alleging standard of care issues with five patients, including failing to establish a physician-patient relationship prior to prescribing medications; prescribing ivermectin to patients based solely on an online questionnaire and without sufficient evidence it was an effective treatment for COVID-19; failing to discuss the use of vaccines or other treatments to prevent COVID-19; and failing to discuss alternative treatments with patients at high risk of serious illness. The Commission held a virtual hearing March 18-20, 2024. A Final Order is expected to be issued by end of June 2024.****

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

Items of Interest:
Pelvic exam guidelines have changed. Effective April 1, 2024, DHHS/CMS put out new guidelines for any hospital that receives reimbursement from Medicare and Medicaid (most medical institutions) that will require robust written informed consent before sensitive examinations and procedures.

Examinations or invasive procedures conducted by practitioners or for educational and training purposes include, but are not limited to, breast, pelvic, prostate, and rectal examinations, as well as others specified under state law. The informed consent must also specify which training or education observers may be present during the exam. CMS will reinforce hospitals' informed consent obligations particularly on anesthetized patients. Click here to read an article on the new guidelines: Pelvic exam guidelines have changed. Here's what to expect. - The Washington Post Click here for the actual guidelines: guidelines

The Legal team would again like to thank the Commissioners for their participation in hearing panels. We have started using OneDrive in an effort to streamline the process of receiving hearing materials. Rather than uploading the materials to each individual X drive folder, OneDrive will house all hearing materials in a single folder for the entire panel to access. You will receive a link to the folder in your WMC email account once the hearing materials are available. Please do not hesitate to reach out to Stormie Redden or Jennifer Batey if you have difficulty accessing these materials as we transition to using this storage platform.

On February 7, Rick and Trisha participated in Oregon's US Department of Justice Health Care Fraud quarterly meeting to discuss cases and licensees of mutual interest.

On February 20, Jennifer presented an overview of Legal's 2023 performance measures to the DOH Enforcement Steering Committee (ESC). The ESC is comprised of DOH representatives from WMC, WABON, OILS, and CQAC and established to constantly assess, review, and suggest changes, as needed, to the disciplinary process. The presentation analyzed Legal's 2023 performance data and discussed factors influencing performance timelines.

Rick Glein, Director of Legal Services continued

On March 12, Rick and Mike F. had their quarterly virtual meeting with Dr. Bundy of the Washington Physician Health Program (WPHP) to discuss processes which lead to a productive relationship between WMC and WPHP and offer joint feedback in our ongoing mission of patient safety and enhancing the integrity of the profession through discipline and education.

From April 3-6, Rick was a first-time attendee at the American Bar Association (ABA)'s Emerging Issues in Healthcare Law Conference in New Orleans. The conference included 5 sessions on AI in health care. Other sessions addressed challenges in caring for the pregnant patient post-*Dobbs*, the mental health crisis, and navigating DOJ trends in healthcare. Speakers included university professors, lawyers, physicians, risk managers, and former/current FDA, DEA, and DOJ employees.

Freda Pace, Director of Investigations

Complaint Intake – New Complaints

First Quarter Comparison Statistics

	2024		2023		2022	
New Cases	527		420		419	
Authorized	141	26.76%	115	27.38%	115	27.45%
Closed	386	73.24%	305	72.62%	304	72.55%

CMT Sign-up for 2024

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

Remember, if you sign up for a CMT slot and you have a last-minute scheduling conflict, at your earliest opportunity, please promptly notify Chris Waterman at chris.waterman@wmc.wa.gov. This courtesy cancellation notice will allow Chris the opportunity to fill any last-minute vacancy needs. If you have any CMT process questions, please do not hesitate to reach out to me directly – freda.pace@wmc.wa.gov.

Investigator Training

Highlighted in the January Staff Report was a notation that three of our clinical investigators registered and subsequently attended a virtual CME course offered by Case Western Reserve University on **Controlled Drug Prescribing: Essential Aspects of Investigation** on January 26, 2024. The course was designed for clinically trained regulatory investigators, attorneys and other law enforcement professionals. The learning objectives for the course included:

- Compare and contrast safe controlled drug prescribing and dangerous prescribing practices.

Freda Pace, Director of Investigations continued

- List five pitfalls in case investigations.
- Describe the process of bringing an investigation to a licensure or legal action.

Three on-demand videos totaling about 4 hours covered essential topics which included:

1. Mental Health Providers and Controlled Drug Prescribing: Best Practices and Bad Practices
2. Pain Management Clinics: Best Practices and Bad Practices
3. Non-concerning and Concerning Controlled Substance Prescriptions and Prescribing Patterns from a Pharmacy Perspective.

Throughout the course, the emphasis was on distinguishing between safe and risky prescribing practices, offering valuable insights from a pharmacist's viewpoint. Those attending this course were guided through the process of evaluating prescribers' decisions and patterns, including thorough examination of patient history, examination practices, and meticulous review of documentation.

The course also provided invaluable guidance on interpreting Prescription Monitoring Programs (PMPs) and navigating the legal landscape, with insights from both board counsel and defendant counsel. Interactive case presentations and discussions equipped participants with strategies for building robust cases while steering clear of common investigative pitfalls.

Example: When reviewing the patient history consider the following.

- Does it include high risk factors, does the prescribing reflet knowledge of these risk factors.
- What kind of examination is the provider conducting when patients come in for pain medication evaluations?
- Are the exams hands on?
- Is the patient placed in a gown so areas that would be obstructed by street clothes can be examined properly?
- Is the patient asked to ambulate?
- Are contradictions for controlled substances ruled out?
- When reviewing longitudinal prescribing the investigator should review prescribing for all controlled substances.

In March 2024, one non-clinical investigator attended a course entitled **Cognitive Interviewing Workshop** presented by the **BETA Healthcare Group**.

The primary focus of this course was developing and honing techniques to help individuals better remember events during an interview. Because individuals and situations may vary so widely, the training emphasized that witnesses should be able to recreate their version and memories of an event at their own pace. Some techniques included: reinstating the witness's mindset, mood and context of the situation, retelling the events in reverse order, and asking the witness to draw a diagram or sketch of the events.

Freda Pace, Director of Investigations continued

Those attending this course were divided into groups to perform interview simulations, which provided the opportunity to gain perspective as an interviewer, a witness, and an observer.

The simulations showcased how these techniques could be useful in recalling events throughout the simulated interviews, as well as provided an opportunity to observe other investigators in how they interact with witnesses. Overall, a very useful and insightful training.

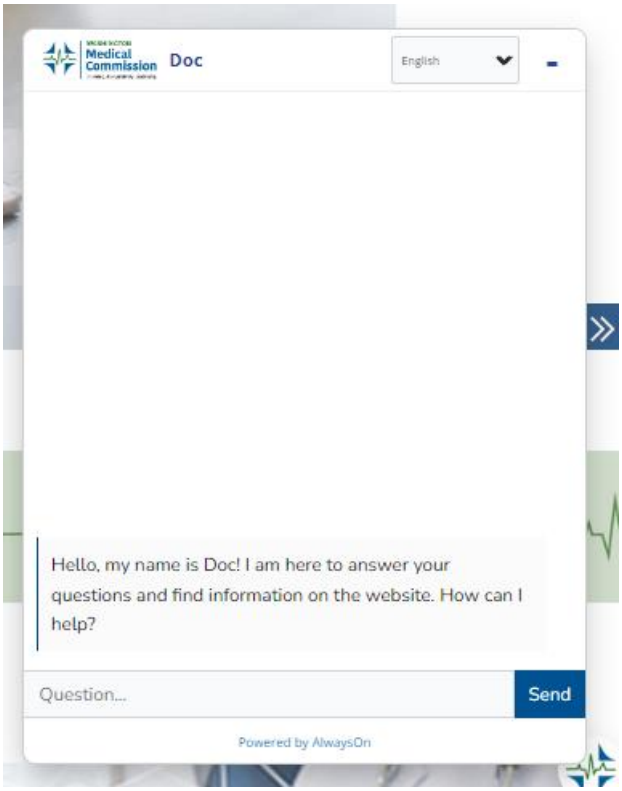
Jimi Bush, Director of Quality and Engagement

Outreach

At the time of this report deadline – We are at FSMB, Nashville where we are presenting a poster on common complaints received broken down by specialty so that the unique complaints for each population can be analyzed. Will provide an update on feedback from FSMB.

Website

We have deployed an AI powered website helper. Also known as Doc – pulls information from the website to answer consumer questions and acts as a directory to find information and policies.



Business Practices and Productivity

Lean Fundamentals training by Anjali Bhatt. The training will be broken into three one-hour sessions and cover Lean basics, problem solving methods and details about the Lean program at the WMC. The training is geared for those who are new to Lean or simply want a refresher. As of April 12, there are 12 staff members that have completed the program and have earned their LEAN white belt: Christopher K., Jeff K., Joe M., Joel D., Kayla B., Ken I., Mahlet Z., Meghan H., Mike P., Shelley K.R., Stormie R., Trisha W.

There will be additional staff eligible after additional sessions at the end of April.

Pam Kohlmeier, MD, JD, Policy Manager

As I am new in my role as Policy Manager for the Commission, this will be a bit longer of a narrative than usual. As a reminder, especially for the newer Commission members, policy development for the Commission has a relatively new 3-step process that started toward the tail-end of 2023 to improve on the Commission's core value of transparency with the public. I

Pam Kohlmeier, MD, JD, Policy Manager continued

encourage each Commissioner, and also the public, to please review the policy-making process which is explained on the Commission's website at Policy Meetings | Washington Medical Commission.

In addition to improving transparency and seeking input, effective policy development requires keeping abreast of advances and challenges that affect the practice of medicine. As such, on April 12th, I (virtually) attended a symposium hosted by American University Washington College of Law in Washington D.C. entitled, "The Therapeutic Use of Psychedelic Drugs: Legal, Policy and Neuroscience Perspectives." The purpose of my attending was to be in the loop as medical research involving psychedelics evolves under FDA regulation. Next up, I will be attending four conferences prior to the July business meeting on topics including telemedicine, rural healthcare innovation, and artificial intelligence:

- April 29-May 1 Northwest Regional Telehealth Resource Center conference in Seattle
- May 7-10 Annual Rural Health Conference and Rural Innovation Summit in New Orleans, LA
- June 4 Foundations of Digital Health Law: A Summit for Legal Professionals (virtual)
- June 12-13 Digital Health Summit in Washington D.C.

The policy committee at its April 11th meeting authorized the drafting of a new Commission policy on artificial intelligence (AI) in healthcare. As such, the four upcoming conferences noted above should be especially helpful to ensure quality policy development as the draft document evolves. If all goes as planned, the next Interested Parties meeting on June 6th will serve as Step One in the Commission's 3-step policy development process for stakeholders and the public to weigh in on the AI draft. Then, Step Two will occur on June 27th when the policy committee meets to review/edit/vote on the post-interested parties/updated draft. Finally, Step Three will occur on July 19th at the business meeting as the full Commission reviews/amends/votes on the policy committee's endorsed (final) draft.

Mahi Zeru, Equity and Social Justice Manager

Published an article on WMC's Spring Newsletter titled "Transformative Role of AI in Medicine" which highlights revolutionary applications of AI and provides resources to providers with upcoming educational opportunities to stay informed.

Attending the 47th annual rural health conference May 7-10 to learn from Public Health experts, state and federal government representatives and academic researchers. Looking forward to being exposed to innovative ideas from diverse perspectives and bringing back new ways of reaching the communities of WA state.

Developing a patient rights pamphlet for use during community outreach events.

Marisa Courtney, Licensing Manager

Total licenses issued from = 01/01/2024-04/16/2024= 1,192

Credential Type	Total Workflow Count
Physician And Surgeon Clinical Experience License	0
Physician And Surgeon Fellowship License	4
Physician And Surgeon Institution License	0
Credential Type	**Total Workflow Count**
Physician And Surgeon License	615
Credential Type	**Total Workflow Count**
Physician and Surgeon License Interstate Medical Licensure Compact	318
Physician And Surgeon Residency License	67
Physician And Surgeon Teaching Research License	5
Physician And Surgeon Temporary Permit	4
Credential Type	**Total Workflow Count**
Physician Assistant Interim Permit	0
Physician Assistant License	178
Physician Assistant Temporary Permit	1
Totals:	**1192**

Information on Renewals: January Renewals- 75.19% online renewals

Credential Type	# of Online Renewals	# of Manual Renewals	Total # of Renewals
IMLC	0	103	103
MD	1066	277	1343
MDRE	1	0	1
MDTR	1	4	5
PA	202	35	237
	75.19%	**24.81%**	**100.00%**

Marisa Courtney, Licensing Manager continued

Information on Renewals: February Renewals- 74.61% online renewals

Credential Type	# of Online Renewals	# of Manual Renewals	Total # of Renewals
IMLC	0	118	118
MD	985	240	1225
MDIN	1	0	1
MDTR	3	2	5
PA	198	44	242
	74.61%	**25.39%**	**100.00%**

Information on Renewals: March Renewals- 74.98% online renewals

Credential Type	# of Online Renewals	# of Manual Renewals	Total # of Renewals
IMLC	0	66	66
MD	996	297	1293
MDRE	3	1	4
MDTR	3	1	4
PA	200	36	236
	74.98%	**25.02%**	**100.00%**

From: Bob Runnells
To: Boyd, Amelia (WMC); WMC Medical Policy
Subject: Comments to the WMC
Date: Friday, January 19, 2024 9:28:56 AM

External Email

Hello Ms. Boyd, Mr. Farrell and the entire Washington Medical Commission.
Please accept these comments verbally delivered on 19January, but these should be entered into the written record for the next possible meetings of both the business meeting and the policy meetings.

Speaking on the topic of doctor's licenses being challenged after the WMC suddenly applied the Federation of State Medical Boards letter issued during the pandemic that threatened disciplinary action if doctors performed their jobs contrary to the one standard of care declared by the CDC.

The notice provided by the WMC is self-contradictory. It begins with "The (WMC) position on COVID-19 prevention and treatment is that COVID-19 is a disease process like other disease processes…"

But every authority on the matter labeled SARS-COV-19 as novel, therefore, COVID the disease needs doctors to bring to bear all available information to treat a novel disease.

It is disingenuous that the WMC would use a notice from the Federation of State Medical Boards as a new criteria by which to enforce its licenses.

It is egregious that the WMC is harassing doctors with a policy not properly passed, based on a letter from a non-Government group that you're not beholden to, yet seem to be.

As a state-level commission, we look to you to protect us from bad federal policies. You should drop any harassing investigations and actions against licensees who were using other resources to help save lives where early treatments needed to be tried during a pandemic from a so-called novel virus.

Thank you.
Bob Runnells, director, Informed Choice Washington