

January 16-17, 2020

Hotel Interurban
223 Andover Park E
Tukwila, WA 98188
(206) 278-7800



WASHINGTON
Medical
Commission

Licensing. Accountability. Leadership.

Commission Meeting Agenda

January 16-17, 2020



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Hotel Interurban: 223 Andover Park E, Tukwila, WA 98188, (206) 278-7800

Thursday – January 16, 2020

Closed Sessions

7:00 am	Breakfast	Mount Si Rm
8:00 am	Case Reviews – Panel A	Olympic Rm
8:00 am	Case Reviews – Panel B	Baker Rm
Noon	Lunch	Mount Si Rm

Open Session

12:30 pm	<i>Panel Composition</i> <i>Kyle Karinen, Staff Attorney</i>	Mount Si Rm
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Closed Sessions

1:30 pm	Case Reviews – Panel A	Olympic Rm
1:30 pm	Case Reviews – Panel B	Baker Rm

4:00 pm

Policy Committee Meeting

Baker Rm

Agenda Items	Presented By:	Page #:
Rescind Approval of CR-102 for Clinical Support Program Rule <i>Due to comments received, requesting that the Commission rescind their approval to initiate the CR-102 process for the Clinical Support Program rule so additional workshops can be held.</i>	Amelia Boyd	N/A
Medical Records Guideline <i>Discussion of possible revisions.</i>	Mike Farrell	45
Compensation and Reimbursement for Commission Duties Procedure, MD2016-02 <i>Discussion of current procedure and possible revisions.</i>	Mike Farrell	59
Communication with Patients, Family, and the Health Care Team Guideline, MD2016-04 <i>Discussion of current guideline and possible revisions.</i>	Mike Farrell	61
Practice of Medicine and Body Art Interpretive Statement, MD2009-01 <i>Discussion of current interpretive statement and possible revisions.</i>	Mike Farrell	67
Proposed Procedure – Consent Agenda for Policy Committee <i>Discussion of proposed procedure.</i>	Mike Farrell	72

Friday – January 17, 2020

Closed Session

7:00 am

Breakfast

Mount Si Rm

Open Session

8:00 am –9:30 am

Business Meeting

Mount Si Rm

1.0 Chair Report

2.0 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

2.1 Minutes – Approval of the November 15, 2019 Business Meeting minutes.

Page 10

2.2 Agenda – Approval of the January 17, 2020 Business Meeting agenda.

3.0 Old Business

3.1 Committee/Workgroup Reports

Update

The Chair will call for reports from the Commission's committees and workgroups.

Written reports begin on page 16.

See page 18 for a list of committees and workgroups.

3.2 Rulemaking Activities

Report
&
Request

Amelia Boyd, Program Manager, will request volunteers to participate in a committee to discuss upcoming proposed draft language related to the Pharmacy Quality Assurance Commission's (PQAC) e-prescribing rulemaking. Rules language from Iowa is provided on page 21 – PQAC's language may be similar.

Rules Progress Report provided on page 20.

3.3 Lists & Labels Request

Action

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

- Benton Franklin County Medical Society

Pages 24-41

4.0 New Business

4.1 Training – Bates Stamping and Investigative Reports

Freda Pace, Director of Investigations

- 4.2 **November 2020 Meeting Dates** Page 43
Ms. Boyd, will propose new dates for the November 2020 Commission meeting.
- 4.3 **Panel Composition** Action
Discuss and vote on proposed panel composition.

5.0 Public Comment

The public will have an opportunity to provide comments.

If you would like to comment during this time, please be sure to write "Yes" on the sign-in sheet.

6.0 Policy Committee Report

Dr. Karen Domino, Chair, will report on items discussed at the Policy Committee meeting held on January 16, 2020. See the Policy Committee agenda for the list of items to be presented.

Report/Action
Begins on
page 45

7.0 Member Reports

The Chair will call for reports from Commission members.

8.0 Staff Member Reports

The Chair will call for further reports from staff.

The Compliance Exit Survey Results begin on page 81.

Written
reports begin
on page 73

9.0 AAG Report

Heather Carter, AAG, may provide a report.

10.0 Adjournment of Business Meeting

Open Sessions

9:45 am	Personal Appearances – Panel A	Olympic Rm	Page 87
9:45 am	Personal Appearances – Panel B	Baker Rm	Page 88

Closed Sessions

Noon to 1:30 pm	Lunch available	Mount Si Rm
12:00 pm to 1:00 pm	Reduction of Medical Errors Workgroup	TBD

Open Sessions

1:00 pm	Personal Appearances – Panel A	Olympic Rm	Page 87
1:00 pm	Personal Appearances – Panel B	Baker Rm	Page 88

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 meetings.

Times and Order:

The Policy Committee Meeting will begin at 4:00 pm on January 16, 2020 until all agenda items are complete. The Commission will take public comment at the Policy Committee Meeting.

- The Business Meeting will begin at 8:00 am on January 17, 2020 until all agenda items are complete. The Commission will take public comment at the Business Meeting. ***If you would like to comment at the Business Meeting, please be sure to write "Yes" on the sign-in sheet.***

This agenda is subject to change.

Please note: Meals are provided for Commissioners and Commission staff only.

Accessibility: These meetings are accessible to persons with disabilities. Special aids and services can be made available upon advance request. Advance request for special aids and services must be made no later than five days before the meeting. If you would like general information about this meeting, please call the program at 360-236-2727. If you need assistance with special needs and services, you may leave a message with that request at 1-800-525-0127 or, if calling from outside Washington State, call (360) 236-4053. TTY users dial 711 for Washington State Relay Service. If you need assistance due to a speech disability, Speech-to-Speech provides human voices for people with difficulty being understood. The Washington State Speech-to-Speech toll free access number is 1-877-833-6341. **Smoking is prohibited at these meetings.**

FORMAL HEARING SCHEDULE

Hearing	Respondent	SPEC	Case No.	Counsel	AAG	Staff Atty	PANEL	HLJ	Location	Panel Composition (as of 1/3/2020)
3-Jan										
2020 January										
NONE AT THIS TIME										
2020 February										
3-4 Feb	NGUYEN, Dung X., MD	Non BC - Family Medicine	M2018-716	Lance M. Hester	Defreyn	Karinen	A	Donlin	TBD	Rodgers; Yu
20-22 Feb	MARKUS, Stephen P., MD	Non-BC Psychiatry	M2018-94	Doug Yoshida	Brewer	Glein	A	Herington	TBD	
2020 March <i>(NO COMMISSION MEETING THIS MONTH)</i>										
18-20 Mar	SHUEY, Jackie S., PA-C	Phys. Assistant	M2018-589	Jennifer Merringer Veal	Brewer	Wolf	A	Herington	TBD	
23-26 Mar	SCHULZ, Ona L., PA-C	Phys. Assistant	M2018-641	Elizabeth Leedom Rhianna Fronapfel	Anderson	Wolf	B	Kuntz	TBD	Fairchild; Terman; Rodgers WE NEED 1 REGULAR (non-ProTem) COMMISSIONER FOR THIS HEARING TO MOVE FORWARD
2020 April										
30 Mar - 4 Apr	BAUER, William M.	BC-IM	M2017-1115	Jennifer Smitrovich	Brewer	Berg	B	Herington	TBD	Roberts; Trescott; Blake PANEL FULL - THANK YOU!
2020 May										
11-13 May	NORTON, Robert S., MD	BC - Surgery	M2019-368	Jessica Creager	Pagan	Page Landstrom	B	Kuntz	TBD	
18-May	SMITH, Stephen L., MD	Non BC - Internal Medicine	M2017-523	Stephen D. Rose	Brewer	Berg	A	Donlin	TBD	Yu;
2020 June <i>(NO COMMISSION MEETING THIS MONTH)</i>										
NONE AT THIS TIME										
2020 July										
NONE AT THIS TIME										

2020 Meeting Schedule



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Dates	Location	Meeting Type
January 16-17	Hotel Interurban 223 Andover Park E Tukwila, WA 98188	Regular Meeting
February 27-28	The Heathman Lodge 7801 NE Greenwood Dr. Vancouver, WA 98662	Regular Meeting
April 9-10	Capital Event Center (ESD 113) 6005 Tye Drive SW Tumwater, WA 98512	Regular Meeting
May 14-15	Capital Event Center (ESD 113) 6005 Tye Drive SW Tumwater, WA 98512	Regular Meeting
July 9-10	Capital Event Center (ESD 113) 6005 Tye Drive SW Tumwater, WA 98512	Regular Meeting
August 20-21	Capital Event Center (ESD 113) 6005 Tye Drive SW Tumwater, WA 98512	Regular Meeting
October 1-3	Doubletree 18740 International Blvd S Seattle, WA 98188	Educational Conference
November 12-13	Capital Event Center (ESD 113) 6005 Tye Drive SW Tumwater, WA 98512	Regular Meeting

Association Meetings		
Association	Dates	Location
Federation of State Medical Boards (FSMB) Annual Conference	April 30-May 2	San Diego, CA
WAPA Spring Conference	April 25-28	Seattle
WSMA Annual Meeting	September 26-27	Spokane
WAPA Fall Conference	TBA	TBA

Other Meetings		
Program	Dates	Location
Council on Licensure, Enforcement & Regulation (CLEAR) Winter Symposium	January 8-10	San Diego, CA
CLEAR Annual Conference	September 23-26	Seattle
FSMB Board Attorneys Workshop	November 5-6	Miami, FL

2021 Meeting Schedule



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Dates	Location	Meeting Type
January 14-15	TBD	Regular Meeting
March 4-5	TBD	Regular Meeting
April 8-9	TBD	Regular Meeting
May 20-21	TBD	Regular Meeting
July 8-9	TBD	Regular Meeting
August 19-20	TBD	Regular Meeting
Sept 30-Oct 2	TBD	Educational Conference
November 18-19	TBD	Regular Meeting

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

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

2022 Meeting Schedule



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Dates	Location	Meeting Type
January 13-14	TBD	Regular Meeting
March 3-4	TBD	Regular Meeting
April 14-15	TBD	Regular Meeting
May 26-27	TBD	Regular Meeting
July 7-8	TBD	Regular Meeting
August 25-26	TBD	Regular Meeting
October 6-8	TBD	Educational Conference
November 17-18	TBD	Regular Meeting

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

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

Business Meeting Minutes

November 15, 2019



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Capital Event Center: 6005 Tyee Drive SW, Tumwater, WA 98512, (360) 464-6700

Commission Members

James E. Anderson, PA-C
Toni Borlas, Public Member
Charlie Browne, MD
Jimmy Chung, MD
Diana Currie, MD
Karen Domino, MD
Harry Harrison, Jr., MD
Christine Hearst, Public Member
Warren Howe, MD
April Jaeger, MD – Absent
Charlotte Lewis, MD

John Maldon, Public Member, 1st Vice Chair
Terry Murphy, MD
Alden Roberts, MD, Chair
Scott Rodgers, JD, Public Member
Theresa Schimmels, PA-C
Robert Small, MD
Claire Trescott, MD, 2nd Vice Chair
Candace Vervair, Public Member
Richard Wohns, MD – Absent
Yanling Yu, PhD, Public Member

Commission Staff

Morgan Barrett, Director of Compliance
Jennifer Batey, Legal Support Staff Manager
Colleen Balatbat, Staff Attorney
Larry Berg, Staff Attorney
Amelia Boyd, Program Manager
Anjali Bhatt, Bus. Processes & Productivity Manager
Jimi Bush, Director of Quality & Engagement
Sarah Chenvert, Performance Manager
Melanie de Leon, Executive Director
Mike Farrell, Policy Development Manager
Ryan Furbush, Paralegal
Rick Glein, Director of Legal Services
George Heye, MD, Medical Consultant
Jenelle Houser, Legal Assistant

Kyle Karinen, Staff Attorney
Becca King, Administrative Assistant
Kayla LaRue, Executive Assistant
Micah Matthews, Deputy Executive Director
Melissa McEachron, Director of Operations & Informatics
Stephanie McManus, Public Relations & Legislative Liaison
Ariele Page Landstrom, Staff Attorney
Amanda Weyrauch, Compliance Officer
Sara Wibowo, Paralegal
Trisha Wolf, Staff Attorney
Gordon Wright, Staff Attorney

Others in Attendance

Heather Carter, Assistant Attorney General (AAG)
Chris Bundy, MD, WPHP
Mike Dugan, MBA, FSMB Chief Operating Officer

Katie Meehan, Department of Health (DOH)
Scott A. Steingard, DO, FSMB Board of Directors

Call to Order

Alden Roberts, MD, Chair, called the meeting of the Washington Medical Commission (Commission) to order at 8:01 a.m. on November 15, 2019, at the Capital Event Center, 6005 Tyee Drive SW, Tumwater, WA 98512.

1.0 Chair Report

Dr. Roberts reported that the Commission's annual Educational Conference held in October was

phenomenal. He praised Jimi Bush, Director of Quality & Engagement, for doing such a great job choosing the topics and presenters for the conference.

He stated he recently attended the Washington State Medical Association's (WSMA) annual meeting. He went on to speak about the effects on patients and practitioners when a complaint is authorized for investigation.

He spoke about a letter that was sent to the Governor from the WSMA stating that the licensing process is taking too long. He asked Kimberly Romero, Licensing Manager, to speak about this issue. Ms. Romero provided information and statistics related to the licensing unit.

He stated the Pro Tem Procedure had been updated and was available in the packet.

2.0 Consent Agenda

The Consent Agenda contained the following items for approval:

2.1 Minutes from the August 23, 2019 Business Meeting.

2.2 Agenda for November 15, 2019.

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

3.0 Old Business

3.1 Committee/Workgroup Reports

There was nothing further to report.

3.2 Rulemaking Activities

There was nothing further to report.

3.3 Lists & Labels Request

The following lists and labels request was discussed for possible approval or denial. Approval or denial of this request is based on whether the entity meets the requirements of a "professional association" or an "educational organization" as noted on the application ([RCW 42.56.070\(9\)](#)).

- Lahai Health dba Puget Sound Christian Clinic

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

4.0 New Business

4.1 Training – Presentations by Commissioners

Ms. Bush spoke about presentations to the public and other stakeholders and the guidelines around these types of presentations.

4.2 Meeting Dates for 2022

Amelia Boyd, Program Manager, presented the proposed meeting dates for 2022.

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

4.3 Federation of State Medical Boards (FSMB) Presentation

Scott A. Steingard, DO, FSMB Board of Directors Chair and Mike Dugan, MBA, FSMB

Chief Operating Officer presented the FSMB's 2019 annual report.

5.0 Public Comment

No member of the public was signed up to speak therefore no public comment was given.

6.0 Policy Committee Report

Dr. Karen Domino, Policy Committee Chair reported on the items discussed at the Policy Committee meeting held on November 14, 2019:

Electromyography (EMG) – Needle and Surface, MD2000-01

Dr. Domino stated the committee recommended rescinding the interpretive statement.

Motion: The Chair entertained a motion to rescind the interpretive statement. The motion was approved unanimously.

EHR & Medical Records Guideline

Dr. Domino presented the revisions to the guideline and stated the Committee recommended approving the document with the amendments.

Motion: The Chair entertained a motion to approve the guideline with the noted revisions. The motion was approved by majority.

Allopathic Scope of Practice Relating to Osteopathic Manipulation Therapy Interpretive Statement

Dr. Domino stated the interpretive statement will be referred to a workgroup for further work.

Practitioner Competence Guideline

Dr. Domino presented the revisions to the guideline. She stated that the committee recommended returning the guideline to the Practitioner Competence Workgroup for further work on the language.

Motion: The Chair entertained a motion to approve the guideline with the noted revisions. The motion was approved by majority.

Elective Educational Rotations Policy

Dr. Domino presented the revisions to the policy and stated the committee recommended approving the policy with the noted revisions.

Motion: The Chair entertained a motion to reaffirm the document as amended. The motion was approved unanimously.

Stem Cell Rulemaking Timeline

Dr. Domino asked Amelia Boyd, Program Manager, to present on this item. Ms. Boyd stated that the Commission has already approved the CR-101 process for this rule. In the initial review of the CR-101 rules package, there was some concern as to when the CR-101 would be filed with the Code Reviser and it was suggested that the package be filed once the 2020 Legislative Session is completed. Dr. Domino stated the committee agreed with the recommendation that the CR-101 be filed after the completion of the 2020 Legislative Session.

Motion: The Chair entertained a motion to file the CR-101 after the 2020 Legislative Session is complete. The motion was approved unanimously.

Clinical Support Program Rulemaking

Dr. Domino presented the amendments to the rule language and stated the committee recommended approving the draft language to move forward with the CR-102 process.

Motion: The Chair entertained a motion to begin the CR-102 process. The motion was approved unanimously.

6.o Member Reports

Yanling Yu, PhD, stated that recently she participated in a patient panel regarding diagnostic errors.

Theresa Schimmels, PA-C, stated she has been asked to speak at the 50th anniversary of the MEDEX Northwest Physician Assistant Program.

7.o Staff Member Reports

Staff member reports are provided in writing prior to the meeting. The information below is in addition to the written reports.

In addition to his written report, Micah Matthews, Deputy Executive Director reported on the following:

- The International Medical Graduate workgroup report was submitted to the Legislature and the Governor ahead of the December deadline. Mr. Matthews thanked Becca King, Administrative Assistant; Sarah Chenvert, Performance Manager; and Stephanie McManus, Public Relations and Legislative Liaison for their efforts on the report.
- A bill will be proposed at the next legislative session by the Washington Academy of Physician Assistants to reform the Physician Assistant Practice Act.
- Recently he collaborated with Dr. James Babington from Swedish Medical on a journal article on physical medicine and rehabilitation. The article should be published by the end of November.
- An artificial intelligence project has begun to use our complaint data with a natural language processing project. The objective is to find patterns in complaints to allow for categorization and potential risk scoring.

Ms. Bush introduced the new Business Processes & Productivity Manager, Anjali Bhatt.

Rick Glein, Director of Legal Services, introduced a new Paralegal, Sara Wibowo.

8.o AAG Report

Heather Carter, AAG, had nothing to report.

9.o ADJOURNMENT

The Chair called the meeting adjourned at 10:02 am.

Submitted by

Amelia Boyd, Program Manager

Alden Roberts, MD, Chair
Washington Medical Commission

Approved January 17, 2020

Old Business



Committee/Workgroup Reports: January 2020

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

The Foundation for Healthcare Quality is holding a stakeholder meeting on February 7. The subcommittee has been invited and will give a presentation addressing its review of CRP applications last November, and what the WMC would like to see as the certification program evolves.

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

Meeting to be held at 7:30 am on 1/16/2020. Will discuss topics and themes for 2020 including any keynote speakers. Will also review the 2019 conference and look for areas of improvement. If you would like to comments or provide a suggestion for the 2020 conference, please contact [Jimi](#).

Commissioner Education Committee – Chair: None at this time Staff: Melanie de Leon

This committee met and developed the schedule for the Lunch & Learn series for the 2020 meeting year. Here are the topics to be presented:

Panel Composition

Malpractice

Washington Physicians Health Program Annual Report

What do other Boards/Commissions do?

Past, Present and Future of Outpatient Spine Surgery

Artificial Intelligence

Collaborative Drug Treatment Agreement Workgroup – Chair: Dr. Roberts Staff: Melanie de Leon

Awaiting response from AGO on request for Attorney General's Opinion. To begin rulemaking in 2020.

Practitioner Competence Workgroup – Chair: Dr. Roberts Staff: Micah Matthews

Meeting rescheduled to after the January 2020 WMC meeting with intent to bring updated and agreeable guideline update to the Policy Committee in February 2020.

**Warm Handoff Workgroup – Chair: Dr. Trescott
Staff: Melanie de Leon**

Still awaiting information on what other jurisdictions are doing and how the state is already doing this through local navigation teams.

**Osteopathic Manipulative Therapy Workgroup – Chair: None at this time
Staff: Micah Matthews**

Gaining feedback from Commissioners and stakeholders.

**Telemedicine Workgroup – Chair: Christine Hearst
Staff: Stephanie McManus**

Workgroup is still working on draft language to bring back before the rules workshop. Anticipate completion of review and revision by March 2020.

Executive Committee

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

Newsletter Editorial Board

Dr. Hopkins, Pro Tem Commissioner
Dr. Harrison
Candy Vervair, Public Member
Jim Anderson, PA-C
Jimi Bush, Managing Editor
Micah Matthews

Finance Workgroup

Dr. Howe, Immediate Past Chair, Cmte Chair
Dr. Roberts, Current Chair
John Maldon, 1st Vice Chair
Melanie de Leon
Micah Matthews
Jimi Bush

2020 Nominating Committee

Dr. Howe
Dr. Domino
Dr. Harrison

Reduction of Medical Errors Workgroup

Dr. Chung, Chair
Dr. Howe
John Maldon, Public Member
Dr. Roberts
Dr. Domino
Dr. Jaeger
Christine Hearst, Public Member
Melanie de Leon
Mike Farrell

Policy Committee

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

Legislative Subcommittee

Dr. Roberts, Chair
Dr. Howe
Dr. Terman, Pro Tem Commissioner
Christine Hearst, Public Member
Melanie de Leon
Micah Matthews

Annual Educational Conference Workgroup

Toni Borlas, Chair
Theresa Schimmels, PA-C
Dr. Harrison
Jimi Bush, Organizer

Commissioner Education Workgroup

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

Panel L**John Maldon, Public Member, Chair****Dr. Browne****Dr. Roberts****Dr. Howe****Dr. Ashleigh, Pro Tem Commissioner****Theresa Schimmels, PA-C****Dr. Barrett, Medical Consultant****Kimberly Romero****Ariele Page Landstrom****Micah Matthews****Collaborative Drug Treatment Agreement Workgroup****Dr. Roberts, Chair****Dr. Chung****Dr. Small****John Maldon, Public Member****Melanie de Leon****Micah Matthews****Kyle Karinen, Staff Attorney****Practitioner Competence Workgroup****Dr. Roberts, Chair****Dr. Howe****Dr. Chung****Dr. Small****Theresa Schimmels, PA-C****Micah Matthews****Mike Farrell****Warm Handoff Workgroup****Dr. Trescott, Chair****Jim Anderson, PA-C****Kyle Karinen, Staff Attorney****Jimi Bush****Melanie de Leon****Osteopathic Manipulative Therapy Workgroup****Dr. Howe****Dr. Currie****John Maldon, Public Member****Micah Matthews****Michael Farrell****Amelia Boyd****Telemedicine Workgroup****Christine Hearst, Public Member, Chair****Toni Borlas, Public Member****Dr. Howe****Dr. Ashleigh, Pro Tem Commissioner****Dr. Roberts****Dr. Lewis****Dr. Wohns****Stephanie McManus****Mike Farrell****Micah Matthews**

WMC Rules Progress Report								Projected filing dates		
Rule	Status	Date	Next step	Complete By	Notes	Submitted to RMS	SBEIS Check	CR-101	CR-102	CR-103
Clinical Support MDs & PAs (formerly Technical Assistance)	CR-102 process approved	11/15/2019	File CR-102	January 2020	Keep Osteo updated.			Complete	May 2020	September 2020
Chapter 246-919 WAC Update	Working on non-substantial changes to draft language due to comments during OS review	1/2/2020	File CR-102	February 2020	Include MD Military Spouse rules.	CR-102: 11/6/2019		Complete	February 2020	May 2020
Telemedicine	CR-101 filed	9/17/2019	Workshops	Unknown	Keep Osteo updated.			Complete	TBD	TBD
Stem Cells	File CR-101 in May 2020	11/15/2019	File CR-101	May 2020	Keep Osteo updated.			May 2020	TBD	TBD
SSB 5380 - Opioid Prescribing	Submitted CR-103 to OS review	12/24/2019	File CR-103	February 2020				Complete	Complete	February 2020
Opioid Prescribing - LTAC, SNF patient exemption	CR-101 approved	11/9/2018	File CR-101	March 2020				March 2020	June 2020	September 2020
Ch. 246-918 WAC - Name change	CR-105 filed	9/17/2019	CR-103	February 2020				CR-105 Completed		February 2020

Updated: 1/3/2020

pursuant to rule 657—21.9(124,155A) shall be exempt from the electronic prescription mandate only for the duration of the approved exemption. Upon expiration of an approved exemption, the prescriber, medical group, institution, or pharmacy shall either comply with the electronic prescription mandate or timely petition the board for renewal of the exemption pursuant to rule 657—21.9(124,155A).

[ARC 4580C, IAB 7/31/19, effective 9/4/19]

657—21.9(124,155A) Exemption from electronic prescription mandate—petition. A prescriber, medical group, institution, or pharmacy that is unable to comply with the electronic prescription mandate in rule 657—21.8(124,155A) prior to January 1, 2020, may petition the board, on forms provided by the board, for an exemption from the requirements based upon economic hardship; technical limitations that the prescriber, medical group, institution, or pharmacy cannot control; or other exceptional circumstances. A prescriber, medical group, institution, or pharmacy seeking an exemption beginning January 1, 2020, shall submit a completed petition no later than October 1, 2019. A timely petition for renewal of a previously approved exemption shall be submitted at least 60 days in advance of the expiration of the previously approved exemption.

21.9(1) Petition information. A petition for exemption from the electronic prescription mandate shall include, but not be limited to, all of the following:

- a. The name and address of the prescriber, medical group, institution, or pharmacy seeking the exemption. For medical groups and institutions, a list of the names, professional license numbers, and CSA registration numbers of all prescribers who would be covered by the exemption.
- b. Whether the petitioner is seeking an exemption for controlled substance prescriptions, non-controlled substance prescriptions, or both.
- c. The petitioner's current electronic prescribing capabilities.
- d. The reason, such as economic hardship, technological limitations, or other exceptional circumstances, the petitioner is seeking exemption.
- e. Supporting documentation to justify the reason for the exemption, including the following mandatory documentation:
 - (1) For economic hardship petitions, a copy of the petitioner's most recent tax return showing annual income and at least two quotes documenting the cost of implementing electronic prescribing.
 - (2) For technological limitation petitions, documentation showing the available Internet service providers, the speed and bandwidth available from each provider, and any data caps imposed by the Internet service provider, and documentation showing the minimum technological requirements from at least two electronic prescribing platform vendors.
- f. Anticipated date of compliance with the electronic prescription mandate.
- g. If the petition seeks renewal of a previously approved exemption, information relating to the petitioner's actions during the previous exemption period to work toward compliance with the electronic prescription mandate or an explanation as to why no progress has been made.

21.9(2) Criteria for board consideration of a petition. The board shall consider all information provided in a petition seeking exemption to the electronic prescription mandate and shall approve or deny a petition for exemption based on the following criteria:

- a. If the reason for exemption is economic hardship, whether the cost of compliance with the electronic prescription mandate would exceed 5 percent of the petitioner's annual income as reported on the petitioner's most recent tax return.
- b. If the reason for exemption is technological limitations, whether the Internet service providers available have the technological capabilities required by the electronic prescribing platform.
- c. If the reason for exemption is other exceptional circumstances, examples of exceptional circumstances include, but are not limited to, whether the petitioner is a free or low-income clinic, whether the petitioner had a bankruptcy in the previous year, whether the petitioner intends to discontinue practice in Iowa prior to December 31, 2020, and whether the petitioner has a disability that limits the ability to utilize an electronic prescribing platform. All other exceptional circumstances will be evaluated on a case-by-case basis.

d. If the petition seeks renewal of a previous exemption to the electronic prescription mandate, the number of exemptions previously granted and updated information as it relates to the petitioner working toward compliance with the electronic prescription mandate or the explanation as to why no progress has been made.

21.9(3) *Duration of approved exemption.* The board may approve an exemption, or the renewal of an exemption, to the electronic prescription mandate for a specified period of time not to exceed one year from the date of approval.

[ARC 4580C, IAB 7/31/19, effective 9/4/19]

657—21.10(124,155A) Automated medication distribution system (AMDS). Any pharmacy that utilizes an AMDS shall comply with these rules in addition to all applicable federal and state laws, rules, and regulations.

21.10(1) *Policies and procedures.* Pursuant to the requirements regarding policies and procedures in 657—subrule 8.3(5), each pharmacy utilizing an AMDS shall have policies and procedures that address all aspects of the operation of the AMDS to include, at a minimum:

- a.* Access to drugs and patient information,
- b.* Pharmacy personnel training in the proper operation of the AMDS,
- c.* Methods to ensure accurate stocking of the AMDS pursuant to subrule 21.10(2),
- d.* Confidentiality of patient information,
- e.* Routine and preventative maintenance of the AMDS according to manufacturer recommendations,
- f.* Packaging and labeling of prescription drugs loaded into or dispensed from the AMDS that is in compliance with federal and state laws, rules, and regulations, and
- g.* Security and control of the prescription drugs maintained and utilized in the AMDS to include:
 - (1) Drug loading, storage, and records.
 - (2) Drugs removed from system components but not used.
 - (3) Inventory.
 - (4) Cross contamination.
 - (5) Lot number control.
 - (6) Wasted or discarded drugs.
 - (7) Controlled substances.

21.10(2) *Stocking the AMDS.* The pharmacy shall have adequate procedures in place to ensure the accurate stocking of drugs into an AMDS using barcode scanning technology. Only a pharmacy technician, pharmacist-intern, or pharmacist shall be allowed to participate in the stocking of the AMDS.

21.10(3) *Pharmacist verification of drugs dispensed from AMDS.*

a. When an AMDS only dispenses drugs that were prepackaged and verified by a pharmacist prior to being stocked in the AMDS and there was no further manipulation of the drug or package other than affixing a patient-specific label, such drugs shall not require additional pharmacist verification prior to administration or dispensing to the patient or authorized representative.

b. When a drug is stocked in an AMDS and undergoes further manipulation, such as counting and packaging, such drugs shall require pharmacist verification prior to dispensing to the patient. Such verification shall be documented.

21.10(4) *Placement of AMDS.*

a. An AMDS placed outside a pharmacist's direct supervision shall only dispense pharmacist-verified packages in compliance with paragraph 21.10(3) "a."

b. An AMDS that manipulates, including but not limited to counting, packaging, or labeling, prescription drugs for subsequent patient dispensing shall only be utilized in a pharmacy under the direct supervision of a pharmacist, except in an approved telepharmacy pursuant to 657—Chapter 13.

[ARC 3640C, IAB 2/14/18, effective 3/21/18]

657—21.11(124,155A) Pharmacist verification of controlled substance fills—daily printout or logbook. The individual pharmacist who makes use of the pharmacy prescription application shall provide documentation of the fact that the fill information entered into the pharmacy prescription

Lists & Labels



Application for Approval to Receive Lists

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

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

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

☒ We are a "professional association"

☒ We are an "educational organization."

Nicole Austin
Primary Contact Name ↑

509-943-8817
Phone ↑

Nicole@bfcms.org
Email ↑

Website URL ↑
Www.bentonfranklincms.com

Additional Contact Names (Lists are only sent to approved individuals) ↑

Benton Franklin County Medical Society
Professional Assoc. or Educational Organization ↑

91-6057863
Federal Tax ID or Uniform Business ID number ↑

713 Jadwin Ave. Rm. 6
Street Address ↑

Richland, WA 99352
City, State, Zip Code ↑

This will be used to share information about our upcoming annual CME seminar.

1. How will the lists be used? ↑

MD/PA/DO/ARNP


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

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

Email to: PDRC@DOH.WA.Gov

Mail to: PDRC - PO Box 47865 - Olympia WA 98504-7865

Fax to: PDRC - 360-586-2171


Signature ↑

12-17-19
Date ↑

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

For Official Use Only

Authorizing Signature: _____

Approved: _____ Printed Name: _____

5-year one-time

Denied: _____ Title: _____ Date: _____

**BENTON FRANKLIN COUNTY MEDICAL SOCIETY
BYLAWS**

**AMENDED MARCH 2019
AMENDED MAY 2017
AMENDED OCTOBER 2015
AMENDED APRIL/MAY 2013
AMENDED SEPTEMBER 2012
AMENDED OCTOBER 2009**

1 **ARTICLE I – NAME**

2
3 The name of this organization is: Benton Franklin County Medical Society (BFCMS).
4

5 **ARTICLE II – OBJECTIVES**

6
7 The objectives of this Society are (1) to promote the art, science and practice of
8 medicine and the practitioners who pursue these goals; (2) to promote the care and
9 well being of the patients of Benton and Franklin counties; (3) to protect and improve
10 the health of the public; (4) to provide medical education and (5) to provide
11 leadership for the members of the Society.
12

13 **ARTICLE III – MEMBERSHIP**

14
15 Section 1. Classes of Membership

16
17 The membership of this Society shall be composed of:

- 18
19 A. Active Members
20 B. Active-Limited Members
21 C. Retired Members
22 D. Honorary Members
23 E. Medical Student, Intern and Resident
24 F. Ex-Officio Members
25 G. Physician Assistant Members
26

27 Section 2. Active Members

28
29 An active member shall be one who:

- 30
31 A. Holds the degree of Doctor of Medicine, Doctor of Osteopathy, or Bachelor of
32 Medicine which has been issued by an institution accepted by the
33 Washington State Board of Medical Examiners
34 B. Is currently licensed by the State of Washington to practice as a Doctor of
35 Medicine or Doctor of Osteopathic Medicine, or is practicing in the State of
36 Washington with a federal waiver (i.e., research, administration, etc.)
37 C. Maintains a practice or resides in Benton or Franklin County or in a
38 neighboring county if it is more convenient to attend the meetings of BFCMS
39 D. Abides by the principles of medical ethics as defined by the Washington State
40 Medical Association (WSMA) and the American Medical Association (AMA) or
41 the Washington Osteopathic Medical Association (WOMA) and the American
42 Osteopathic Association (AOA)
43 E. Does not practice or claim to practice any school or system of sectarian
44 medicine or healing

1 F. Active members of BFCMS must maintain current dues and assessments,
2 and will be considered a provisional member for one year following the
3 membership election date.
4

5 Section 3. Active-Limited Member
6

7 An active-limited member shall be one who is otherwise qualified for active
8 membership and who limits the practice of medicine to less than twenty hours per
9 week. An active-limited member shall have all the rights and privileges of an active
10 member. An active-limited member shall pay dues and assessments as determined
11 by the Board of Trustees.
12

13 Section 4. Retired Member
14

15 A retired member shall be one who has been a member of the Society or of another
16 component Society of the AMA/AOA or WSMA/WOMA for at least twenty-five years
17 and has retired from active practice. A retired member shall have all the rights and
18 benefits of the Society including the right to vote and hold office. A retired member
19 shall pay dues and assessments as determined by the Board of Trustees.
20

21 Section 5. Honorary Member
22

23 An honorary member shall be one who is not otherwise qualified for active
24 membership and who has been specifically recognized because of some
25 outstanding service to the profession and/or achievement in the community. An
26 honorary member shall be recommended for such status by the Board of Trustees of
27 this Society and elected to honorary membership by a vote of the majority of the
28 Society members present at any regular meeting. Honorary members will be
29 entitled to all privileges of active membership with the exception of voting. An
30 honorary member shall not be subject to payment of dues or assessments.
31

32 Section 6. Medical Student and Resident Members
33

34 A medical student, resident or other physician who is in training in an institution
35 which is appropriately qualified in the judgment of the Society may be elected to this
36 category of membership. Medical students shall have the rights and benefits of the
37 Society, except the right to vote and hold office. Such members shall pay dues and
38 assessments as determined by the Board of Trustees.
39

40 Section 7. Ex-Officio Members
41

42 The County Health Officer is an Ex-Officio member for the duration of his/her office.
43 Ex-Officio members of the Board of Trustees shall be voting members.
44
45
46

1 Section 8. Physician Assistant Members

2
3 A Physician Assistant Member shall be one who:

- 4
5 A. Has graduated from an accredited program which is approved by the
6 Washington State Board of Medical Examiners
7 B. Is currently licensed by the Washington State Board of Medical
8 Examiners
9 C. Shall practice or reside in Benton or Franklin County or in a neighboring
10 county if it is more convenient to attend the meetings of BFCMS
11 D. Shall abide by the principles of medical ethics as defined by the
12 Washington Academy of Physician Assistants or American Academy of
13 Physician Assistants
14

15 Physician assistant members have the right to vote and hold office and may vote as
16 a delegate or alternate to the House of Delegates.
17

18 Section 9. Application for Membership and Admission Process

- 19
20 A. A candidate for membership, including transfers from other counties, shall
21 make application on the form provided by the BFCMS and agree to the terms
22 therein.
23 B. The applicant shall have the burden of providing all documentation and
24 information required in the application and as may be requested by the
25 Society and verifying the authenticity of such data. Upon notification of the
26 need for additional documentation or information the applicant shall satisfy
27 this request within sixty (60) days unless determined otherwise by the Board
28 of Trustees.
29 C. A resume of each applicant shall be published in two subsequent Society
30 newsletters. Such publication shall be deemed official notice to the general
31 membership of the applicant's intent.
32 D. Any individual who has information of a derogatory nature concerning an
33 applicant's moral or ethical conduct, medical qualifications, or other requisites
34 for membership shall assume the responsibility of conveying that information
35 to the Board of Trustees.
36 E. If the Board of Trustees receives such information, the Board will refer the
37 applicant's file to the Credentials Committee. During a review; the
38 committee may require the applicant's presence at any time and shall always
39 request the applicant's presence before submitting a negative
40 recommendation. Since the purpose of such a meeting is to resolve intra
41 professional matters bearing on professional and personal competency and
42 conduct, neither the applicant nor the Credentials Committee shall be
43 represented by counsel.
44 F. The committee shall provide the applicant with opportunity to review all the
45 material considered by the credentials committee and respond to any adverse

- 1 information. The Committee will report its recommendation to the Board of
2 Trustees.
- 3 G. The Board of Trustees shall review the application together with the
4 recommendation of the Credentials Committee. The Board may request that
5 the applicant be present during the review. The outcome will be decided by a
6 vote of the Board of Trustees and the applicant notified by certified mail. The
7 applicant may appeal the decision of the Board by filing notice with the
8 Society within thirty (30) days after receipt of the notice. If an appeal to the
9 decision is received, a hearing of an Appeals Board shall be conducted.
- 10 H. The Appeals Board shall consist of three Past-Presidents, appointed by the
11 President, who have not been previously involved in deliberation of the same
12 issue and who are not in direct competition with the physician involved. At the
13 hearing, the applicant shall be entitled to submit, orally or in writing, the
14 argument against the adverse decision of the Board of Trustees. No new
15 evidence shall be considered by the Appeals Board in ruling on the appeal.
16 Legal counsel may be present.
- 17 I. Following the hearing, the Appeals Board shall either; (1) uphold the decision,
18 in which case such decision shall be final; or (2) reverse the adverse decision,
19 in which case the applicant is elected to membership.
- 20 J. During the application process, Society counsel may be consulted to assure
21 civil immunity is provided by federal statute.

22 23 Section 10. Transfers

24
25 Any physician accompanying his application with a transfer letter from another
26 component county society of this or any other state within sixty (60) days of the
27 issuance of said letter is eligible for membership in the same manner as a new
28 member. No annual fees for the current year will be charged, with the exception of
29 dinner assessments which shall be charged against such member provided that
30 same have been paid to the Society from which the applicant transfers.

31
32 Any member of this Society in good standing who is free from indebtedness to the
33 Society and against whom no charges are pending, wishing to transfer, shall be
34 granted a transfer letter. This letter shall state the date the member associated
35 himself with this Society and the date of the issuance of the letter. This shall be
36 signed by the Secretary/Treasurer or Executive Director.

37 38 **ARTICLE IV – DISCIPLINE**

39 40 Section 1. Grounds for Disciplinary Action

41
42 A member committing any of the following acts may be subjected to censure,
43 suspension or expulsion as provided in Article IV, Section 2:

- 44
45 A. Incompetence, misconduct or unethical behavior
46 B. A criminal offense involving moral turpitude

- C. A violation of the *Principles of Medical Ethics* of the WSMA
- D. Willfully committing an act tending to defeat the aims, purposes and objectives of this Society or to bring the Society into disrepute
- E. Refusal to obey the Bylaws of this Society
- F. Gross misconduct as a physician or as a citizen
- G. Engaging in questionable medical practices which do not conform to accepted medical standards and practices
- H. Misrepresenting any material fact in his or her application for membership in this Society
- I. Narcotic and dangerous drug violations

Section 2. Procedures for Disciplinary Action

Charges involving acts outlined in Article IV, Section 1, against a member may be presented, in writing, by any member of the Society to the President. Charges may be made by any member of the Society or committee of the Society or by any other person or persons. Such charges shall be reviewed as indicated by any appropriate officer, committee, or other person(s) representing the Society, as selected by the President. Such a representative of the Society shall make an effort to resolve the issue by kindly efforts at conciliation and reformation. If such efforts fail, the matter shall be referred to the Ethics and Grievance Committee. This committee shall make an investigation concerning the matters alleged and shall use kindly effort in the interest of peace, conciliation or reformation, so far as possible and expedient.

If after investigation the Ethics and Grievance Committee believes the charges warrant further proceedings, it shall report the matter, with specification of charges to the Board of Trustees, which shall cause a written copy of the charges to be served on the accused member at least two weeks prior to the date the Board of Trustees proposes to hold a hearing on the charges, which hearing may be adjourned from time to time as is necessary.

At the hearing the Ethics and Grievance Committee shall present the evidence it has pertaining to the charges and a full opportunity shall be afforded the accused member to present witnesses and other evidence in defense and to cross examine the witnesses and to rebut evidence presented to sustain the charges. Any recommendation to the Board shall include the basis of such recommendation.

The recommendation shall be considered by the Board of Trustees. The involved member shall be notified of the Board's decision and the basis for the decision. If that decision is adverse, the member may request a hearing before the Board by filing such request with the Society within thirty (30) days of receipt of that notice. Upon receipt of a request, the Board shall schedule a hearing or include such hearing in a regularly scheduled Board meeting. At the hearing, the member shall be entitled to present orally or in writing, arguments against the adverse recommendation. Both the member and the Society may be represented by counsel or other persons of their choosing at this hearing.

1
2 If the disciplinary action has been voted by the Board, the member shall have the
3 right to appeal to the appropriate committee or council of the WSMA and the Judicial
4 Council of the AMA under such rules as those two bodies may adopt. The action
5 voted by the Board shall be suspended during the pending of such appeal or
6 appeals.
7

8 No member whose license to practice medicine has been suspended or revoked or
9 who is under sentence, suspension or exclusion shall be entitled to any of the rights
10 or benefits of this Society. Said member will not be permitted to take part in any of
11 the Society's proceedings until the license has been restored. This shall not apply to
12 physicians who have surrendered their licenses because of retirement under
13 provisions of the Medical Practice Law.
14

15 A member in arrears with respect to dues or assessments shall be automatically
16 suspended. A member shall be considered in arrears if full payment has not been
17 received by the first day of April in each fiscal year. The Society may drop from
18 membership any member who has been in arrears with respect to dues or
19 assessments for six months or more without giving notice or holding a hearing as
20 above provided.
21

22 A suspended or expelled member shall be reported to the State Disciplinary Board
23 by the President of the Society as required by WAC 320-20-040, with the exception
24 of a member suspended for non payment of dues or assessments. A suspended
25 member automatically becomes a member in good standing at the expiration of the
26 term of suspension. An expelled member may make application for membership two
27 (2) years or more after the date of expulsion.
28

29 **ARTICLE V – FINAL AUTHORITY**

30

31 The Society shall be the sole judge of the moral, ethical and professional
32 qualifications of members and applicants.
33

34 **ARTICLE VI – OFFICERS**

35

36 **Section 1. The Officers**

37

38 Officers of the Society shall be:

- 39 A. President (One year term)
- 40 B. President-Elect (One year term)
- 41 C. Secretary-Treasurer (One year term)
- 42 D. Two Immediate Past Presidents (Two year term)
- 43 E. Three Trustees-at-Large (Three year term, one re-elected every year)
- 44 F. Chair of the CME Committee (Two year term)
- 45 G. Resident (One year term)
- 46 H. Public Health Officer (No term limit)

1 I. Physician Assistant (Two year term)

2
3 These officers shall constitute BFCMS Board of Trustees.
4

5 Section 2. General Powers
6

7 The Board of Trustees shall carry out the mandates and policies of this Society.
8 Subject to the provisions of these bylaws, the Board has full and complete power
9 and authority to perform all acts and to transact all business for or on behalf of the
10 Society and to manage and conduct all the property, affairs and activities of the
11 Society.
12

13 Section 3. Qualifications
14

15 Only members that have been active or senior members in good standing for at least
16 two years immediately preceding election are eligible to hold office in the Society.
17 Exceptions to this qualification may be made.
18

19 Physician Assistants may only serve in the Physician Assistant role on the board.
20 They are not eligible to serve in other officer positions on the board.
21

22 Society Officers shall be encouraged to hold and maintain a current membership
23 with WSMA while serving as a BFCMS Board or Trustee member.
24

25 Section 4. Duties of Officers
26

27 A. The President shall:
28

- 29 1. Preside at all meetings of the general membership.
- 30 2. Serve as chairman of and preside at all meetings of the Board of
31 Trustees.
- 32 3. Appoint all committees not otherwise provided for by theses bylaws
33 and fill all vacancies in such committees.
- 34 4. Call "Special" meetings according to Article VII, section 1 (b), of these
35 bylaws.
- 36 5. Be an ex-officio member of all committees
- 37 6. Serve as delegate to the House of Delegates of the WSMA.
- 38 7. Perform such other duties of this Society as custom and parliamentary
39 procedure may require.
40

41 B. The President-Elect shall:
42

- 43 1. Serve as a member of the Board of Trustees.
- 44 2. Serve as a Delegate to the WSMA House of Delegates.
- 45 3. Perform the duties of the President in the event of temporary absence
46 of the President.

- 1 4. Perform other such duties as assigned to him/her by the President or
2 the Board of Trustees.

3
4 C. The Secretary-Treasurer shall:
5

- 6 1. Attend all Board of Trustees meetings and keep minutes of their
7 respective meetings.
- 8 2. Be custodian of all records, books and papers belonging to the Society
9 and of the Society.
- 10 3. Carry on the official correspondence of the society, including such
11 matters as notifying members of meetings, officers of their election,
12 committees of their appointment and duties and all notices required by
13 the constitution and bylaws or by law.
- 14 4. Keep a roster of all members grouping of the members according to
15 the class of membership held, and noting with respect to each
16 member's full address, date of birth, professional college and date
17 of graduation, date of member's license to practice in this state, and
18 such other information as the Secretary- Treasurer of the WSMA may
19 require.
- 20 5. Note in a separate record the same facts with respect to each licensed
21 physician in the two counties who is not a member of the Society.

22
23 D. The Two Immediate Past President's shall:
24

- 25 1. Serve as members of the Board of Trustees.
- 26 2. Serve as delegates or alternates to the WSMA House of Delegates.
- 27 3. Perform such other duties as may be assigned to them by the
28 President of the Board of Trustees.

29
30 Section 5. Election and Tenure
31

- 32 A. The nominating committee shall consist of the Board of Trustees.
- 33 B. The committee shall submit a slate of candidates consisting of at least one
34 nominee for each vacancy to be filled in the elective office. No person shall be
35 nominated without his/her consent. By September 1, members will receive
36 notification of the opportunity to submit nominations for open positions.
37 Members may submit nominations to the Board of Directors or Executive
38 Director. Members will be given 14 days notice of the deadline to submit
39 nominations.
- 40 C. The slate of nominees and ballot will be mailed to the membership with the
41 October Newsletter by no later than October 5th of each year. Ballots may be
42 returned by scan/email, or US mail by the deadline of November 5th. A
43 simple majority of returned ballots will decide the vote. The outcome of the
44 vote will be announced at the November General Membership
45 Meeting/Annual Meeting and in the December Newsletter.

- 1 D. Term limits are specified above. Each officer shall assume office at the
2 close of the annual meeting and shall hold office until his/her
3 successor assumes office.
- 4 E. The goal of the Nominating committee shall be to the extent practical, to
5 optimize the geographic and specialty distribution of its members within the
6 executive structure of the Society.

7

8 Section 6. Delegates

9

10 The President, Immediate Past President and President-elect shall serve as
11 delegates from the Society to the WSMA House of Delegates. Any necessary
12 additional delegates or alternates shall be appointed from the active or senior
13 membership by the President.

14

15 Section 7. Vacancies

16

17 If, before the expiration of the term of which he/she was elected, the President
18 resigns, is removed or disqualified, or becomes disabled, the President-Elect shall
19 succeed to the office vacated with all the prerogatives and duties pertaining to that
20 office as though he/she had been elected President in the first instance. Vacancies
21 created by death, illness, resignation, removal, or disqualification of other officers
22 and vacancies due to contingencies not herein provided for shall be filled if the
23 Board of Trustees deems advisable by the appointment by the Board of Trustees.
24 This appointment is to be confirmed by a majority vote of the membership present at
25 the next regular meeting of the Society.

26

27 Section 8. Indemnification

28

29 Any present or future Trustee officer, agent, or employee or the executor,
30 administrator, or other legal representative of any such trustee, officer, agent, or
31 employee shall be indemnified by the Society against reasonable cost, expenses,
32 counsel fees, judgments, fines, and amounts paid or incurred in connection with any
33 action, suit, or proceeding, whether civil, criminal, administrative, or other, to which
34 any such trustee, officer, agent, or employee or his executor, administrator, or other
35 legal representative may hereafter be made a party by reason of his being or having
36 been such trustee, officer, agent, or employee of the Society, or at the request of the
37 partnership, joint venture, trust, other enterprise, or employee benefit plan.

38

39 The foregoing right of indemnification shall be to the fullest extent permitted by the
40 laws of the State of Washington, provided that the action causing such suit or
41 procedure was taken without malice and in good faith in compliance with the bylaws
42 of the Society. The BFCMS will maintain insurance at its expense to protect itself
43 and any Trustee, officer or agent of the Corporation.

44

45

46

ARTICLE VII – MEETINGS

Section 1. General Membership Meetings.

The Society shall hold general membership meetings during the year at times and places designated by the Board of Trustees.

Section 2. Other Meetings

- A. Annual Meetings – A general membership meeting held during November shall be known as the Annual Meeting. The Society shall elect and install new officers at the annual meeting
- B. Special Meetings – Special meetings may be called by order of the President or by direction of the Board of Trustees. Special meetings shall be called on written request signed by twenty five (25) active or senior members of the Society
- C. Notice – Notice stating the date, time, agenda, and place of any regular or special meeting shall be delivered to such place designated by the individual member not less than ten, not more than forty days before the date of the meeting. Such notice if mailed shall be deemed to be delivered when deposited in the United States mail addressed to the member at his/her address as it appears in the records of the Society or sent via email if that is the preferred communication as stated by the member. The notice of a special meeting shall state the purpose or purposes of the meeting.
- D. Quorum – At any regular or special meeting of the Society ten percent of the active, active-limited and senior members shall constitute a quorum
- E. If a quorum is not present at a regular/special meeting and a member has business that would require a vote of the membership, a mail vote of the membership will be conducted or the matter may be referred to the Board for a decision.
- F. The membership may be polled electronically at the discretion of the Board of Trustees. To allow for deliberation and discussion of issues, members must be notified of the vote a minimum of 7 days prior to the opening of the vote and the vote shall remain open for 7 days. To validate the vote, a quorum must respond (see section D).

ARTICLE VIII – BOARD OF TRUSTEES

Section 1. Composition

The Board of Trustees shall consist of the President, President-Elect, Secretary-Treasurer, the two Immediate Past-Presidents and three elected Trustees-at-Large. Any delegates to the WSMA/WOMA, AMA/AOA, WSMA/WOMA House of Delegates, AMA/AOA House of Delegates, or officers or members of the Board of

1 Trustees of the WSMA/WOMA or AMA/AOA are to be included as a Trustees of this
2 Society.

3
4 A. General Power

- 5 1. The Board of Trustees shall carry out the mandates and policies of the
6 Society as determined by the voting members or by the BFCMS.
- 7 2. Subject to provisions of these bylaws, to all resolutions and
8 enactments of the voting members and to the authority of the
9 BFCMS, the Board of Trustees has full and complete power and
10 authority to determine policies and to transact business for or on behalf
11 of the Society and to manage and conduct all the property, affairs,
12 work, and activities of the Society.
- 13 3. The Board of Trustees shall have supervision and control of the
14 finances of the Society and investment of its funds and shall perform
15 such other duties and exercise such other rights as may be set forth in
16 these bylaws or as are prescribed by the laws of the State of
17 Washington relating to the directors of such organization.
- 18 4. The Board of Trustees shall have the power to employ an Executive
19 Director whose duties shall be to assist the officers of the Society in
20 their official duties and otherwise as may be directed by the Board of
21 Trustees.
- 22 5. The Board of Trustees shall employ a certified public accountant who
23 shall make a careful examination of the Society's finances and do a
24 formal review with report of the same to the Board at the end of the
25 fiscal year.

26
27 Section 2. Meetings

28
29 A. Board of Trustees

- 30
31 1. The Board of Trustees shall meet at least nine times each calendar
32 year at the time and place designated by the President. The President
33 may call a meeting upon written request of three or more members of
34 the Board of Trustees.
- 35 2. The majority of the eligible voting members of the Board of Trustees
36 shall constitute a quorum.
- 37 3. Notice of any meeting of the Board of Trustees and the agenda must
38 be given to each member of the Board orally, in writing or via email at
39 least 48 hours before the time set for the meeting. Notice in writing
40 shall be deemed to have been given 72 hours after the date it is
41 deposited in the United States mail, addressed to the Trustees'
42 address as it appears on the records of the Society with postage
43 prepaid.
- 44 4. The President of the Society may request at any time a special vote of
45 the Board of Trustees. A vote may be conducted by email or by
46 phone and may be coordinated by the President or appointed agent.

5. Any current BFCMS member in good standing may present agenda items for inclusion/deliberation by the Board at Board meetings provided that the request is submitted within 2 business days of the meeting and that a brief rationale/explanation for inclusion is attached. The presenting member may be requested to remain present for deliberations, or excused/recused from the discussion.
6. The BFCMS President, or presiding officer, may request that the Board Meeting enter into executive session for deliberations of a sensitive nature and shall be documented in the Board Meeting minutes as such. Non-Board members, including, but not limited to, CME Committee members, may, at the discretion of the presiding officer, be requested to remain for deliberations, or to be excused.

ARTICLE IX – FINANCES

Section 1. Raising of Funds

Funds for the conduct of the affairs of this Society may be raised by:

- A. Such annual dues from and such special assessments on members of the Society which may from time to time be determined by the Board of Trustees
- B. Voluntary contributions, devices, bequests, and other gifts
- C. Any other means determined by the Society or the Board of Trustees

Section 2. Appropriations

- A. Society funds may be appropriated only for such purposes as will permit the proper conduct of the activities of the Society and will tend toward the attainment of its objectives.
- B. An annual budget shall be prepared by the Finance Committee and/or Executive Director and approved by the Board of Trustees before the beginning of the fiscal year. The budget may not be altered without approval of the Board of Trustees.

Section 3. Fiscal Year

The fiscal year of this Society is from January 1 to December 31, inclusive.

ARTICLE X – COMMITTEES

Section 1. Standing Committees

The standing committees of the Society shall be: Continuing Medical Education (CME).

1 Section 2. Composition and Duties of Standing Committees

- 2
- 3 A. The CME Committee shall consist of a minimum of five members and chaired
4 by a member appointed by the President. It shall plan and organize the
5 programs for the general membership meetings and special CME Seminars.
6 The Chairperson of the CME Committee will also be a voting member of the
7 Board of Trustees. Members will serve a three year term, reappointed as
8 necessary, at staggered one year intervals.
9

10 Section 3. Special Committees/Ad-Hoc Committees

11

12 Special committees or ad-hoc committees shall be appointed by the President or
13 Board of Trustees for specific assignments and shall continue their assignments until
14 completed at which time they will be dissolved. A committee may act for the Society
15 only with the authorization of the Board of Trustees. Examples of Special
16 Committees/Ad-Hoc Committees include: Bylaws, Credentials, Ethics and
17 Grievance, Finance, and Nominating Committees.
18

- 19 A. The Bylaws Committee shall consist of two or more members appointed by
20 the President. It shall review the bylaws at east every five years and shall
21 perform the functions described in these bylaws.
- 22 B. The Ethics and Grievance Committee shall consist of at least three members
23 and a chairman appointed by the President. This committee will review
24 grievances brought to the Society and will work to resolve concerns between
25 the involved parties. If justified, the magnitude of the grievance may be
26 forwarded directly to the Washington State Medical Quality Assurance
27 Commission at the discretion of the President and/or the Committee
28 Chairman.
- 29 C. The Nominating Committee shall consist of the Board of Trustees, the
30 President who shall serve as Chairman. It shall perform the duties described
31 in Article VI, Section 4.
32
33

34 **ARTICLE XI – CONSTRUCTION**

35

36 Unless some other meaning is apparent from the context, plurals shall include the
37 singular and vice versa, and masculine, feminine, and neuter words shall be used
38 interchangeably.
39

40 **ARTICLE XII – AMENDMENTS**

41

42 The society may amend any article of this constitution by a two-thirds vote of the
43 members present at any regular meeting who are eligible to vote, or an email vote,
44 provided that such amendment(s) are not in conflict with the Constitution and Bylaws
45 of the BFCMS, and provided that such amendment(s) will have been read in open

- 1 session at a previous regular meeting or will have been distributed to each member
- 2 ten days in advance of the meeting at which final action is to be taken.



Benton Franklin County Medical Society

proudly presents our

36th Annual CME Seminar

7.75 AMA PRA Category 1 Credit(s)™



Friday, February 21, 2020

8:00 AM-5:00 PM

**Three Rivers Convention Center
Kennewick, WA**

Registration

	Full Day Registration by 2/16	Full Day Registration After 2/16	Half Day Registration by 2/16	Half Day Registration After 2/16
MD/DO County Medical Society Member (any county)	\$150.00	\$175.00	\$100.00	\$125.00
MD/DO Non-Member	\$200.00	\$225.00	\$150.00	\$175.00
PA Member	\$100.00	\$125.00	\$75.00	\$100.00
PA Non-Member	\$120.00	\$145.00	\$90.00	\$115.00
ARNP/RN	\$120.00	\$145.00	\$90.00	\$115.00
Student/Resident	\$50.00	\$50.00	\$50.00	\$50.00
TOTAL		\$		

Half day registration includes either the AM classes **only** or the PM classes **only**. Does NOT include lunch. Please indicate which portion (AM or PM) you are attending.

AM (8:00-12:30) PM (1:00-5:00)

Name: _____ MD DO PA ARNP RN Other _____

Address: _____

Phone: _____ Email for confirmation: _____

Payment Information

Make check payable to BFCMS and return to address listed below.

Credit Card #: _____ Exp. Date.: _____

Billing Zip Code: _____

3 digit code on back of card: _____ If AMEX, 4 digit code on front of card: _____

Name on Card: _____ Signature: _____

Credit card payments will be charged a 3% convenience fee. Return completed registration to **BFCMS, 713 Jadwin Ave., Ste. 6, Richland, WA 99352**. You can scan/email credit card registrations to Nicole@bfcms.org. Please call 943-8817 with questions. Refunds minus \$25.00 administrative fee before 2/20/19. No refunds after 2/20/19. **\$25.00 will be added to all day of registrations.**

Course Objectives	Agenda	Agenda, Cont.	Planning Committee
<p>Review the most commonly performed bariatric procedures and their possible short term post-operative complications. Identify potential nutritional and metabolic consequences that can occur after bariatric surgery. Discuss nutritional requirements of post-bariatric patients and possible nutritional deficiencies to be aware of. Discuss possible long term complications associated with bariatric surgery.</p> <p>List indications for estrogen replacement therapy. Discuss the risks and benefits associated with hormone replacement therapy and consider a woman’s symptoms and medical history to determine whether taking hormones is the best option for her. Educate patients regarding their increased risk of coronary artery disease and osteoporosis following menopause and how to take preventive measures, including diet and exercise.</p> <p>Identify patients at highest risk for adverse drug events and the effects of polypharmacy. Recognize medications which are most likely to cause adverse drug events. Implement strategies for reducing adverse drug events.</p> <p>Discuss the cost associated with unnecessary medical treatment and testing and discuss the Choosing Wisely recommendations for primary care.</p> <p>Identify factors involved in climate change and the scientific basis of climate change. Discuss how climate change disproportionately impacts vulnerable populations. Identify specific health effects of climate change that impact Eastern Washington.</p> <p>Review the most current information regarding etiology, pathogenesis and treatment of rheumatologic disorders. Review the differential diagnosis for possible rheumatologic disorders and the appropriate work-up in the primary care setting. Identify patients that can be managed in primary care practices and patients that need to be referred to rheumatology.</p> <p>Describe some of the major health care disparities facing transgender and gender nonconforming patients, including provision of medically necessary hormonal therapy.</p>	<p>7:00-8:00 AM <i>Registration/Exhibits</i></p> <p>8:00-9:00 AM <i>Bariatric Surgery Patients: Post-Operative/Long Term Management</i> Wanda Good DO, Bariatric Surgeon, Lourdes Health, Pasco, WA</p> <p>9:00-10:00 AM <i>Postmenopausal Hormone Replacement Therapy: Evidence Based Review</i> Anita Showalter DO, FACOOG, Associate Dean for Clinical Education, Pacific NW University, Associate Professor and Chief for Women’s Health, PNWU, Yakima, WA</p> <p>10:00-10:15 AM <i>Break</i></p> <p>10:15-11:30 AM <i>Polypharmacy: Reducing Adverse Drug Events in the Chronically Ill and Elderly Populations</i> Angela Stewart, Pharm D, Associate Dean, Yakima Extension of the Doctor of Pharmacy Program, Clinical Associate Professor, Pharmacotherapy, Washington State University, Yakima, WA</p> <p>11:30-12:30 PM <i>Reducing Inappropriate and Unnecessary Testing, Choosing Wisely</i> Speaker being confirmed</p> <p>12:30-1:15 PM <i>Lunch Provided</i></p> <p>1:15-2:15 PM <i>Health Impacts of Climate Change in Eastern Washington</i> Sara Cate, MD, Faculty, Central Washington Family Medicine Residency Program, Family Practice Physician, Ellensburg, WA</p>	<p>2:15-3:15 PM <i>Rheumatology for Primary Care in an Underserved Community</i> Amish Dave MD, MPH, Rheumatologist, Virginia Mason Medical Center, Seattle, WA</p> <p>3:15-3:30 PM <i>Break</i></p> <p>3:30-5:00 PM <i>Optimizing Primary Care for Transgender Patients: Medical and Pharmacological Perspectives</i> Colin Fields, MD, Medical Director, Gender Health Program, Kaiser Permanente, Seattle, WA</p>	<p>Larry Jecha MD, Chair</p> <p>Scott Ferris MD</p> <p>Erick Isaacson MD</p> <p>Amy Person MD</p> <p>Anjan Sen MD</p> <p>Margery Swint MD</p> <p>Farion Williams MD</p> <p>Nicole Austin</p>
		<div>CME Accreditation</div> <p>The Benton Franklin County Medical Society is accredited by the Washington State Medical Association to provide continuing medical education for physicians.</p> <p>The Benton Franklin County Medical Society designates this live activity for a maximum of 7.75 <i>AMA PRA Category 1 Credit(s)</i>™. Physicians should claim only the credit commensurate with the extent of their participation in the activity.</p> <p>This activity meets the criteria for up to 7.75 hours of Category I CME to satisfy the relicensure requirements of the Washington State Medical Quality Assurance Commission.</p> <p>*****</p> <p>Physician Assistants and Nurse Practitioners may submit <i>AMA Category I Credits</i>™ to your Boards for approval. Registered Nurses: The American Nurses Credentialing Center and the State of WA accept <i>AMA Category I Credits</i>™ for CE Competency Compliance.</p>	<div>From Previous Attendees</div> <p>“Excellent, speakers were all top notch. Feel fortunate to have come to this conference. Learned a great deal.”</p> <p>“This was a superior learning experience- thank you.”</p> <p>“Excellent seminar- important clinical topics- best CME for the money and right here at home.”</p> <p>“Really good topics. I enjoyed all the topics. Great to have such quality speakers to come to us and bring us up to date.”</p>
			<div>Related Information</div> <p>Wi-fi and charging stations will be available at the venue. You may wish to bring a sweater or dress in layers– the Convention Center tends to be cold.</p> <p>Approximately one week before the seminar you will be sent an email with instructions on downloading the presentations for the activity.</p>

New Business



November 2020

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

Policy Committee



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

Observe, record, tabulate, communicate.

-Sir William Osler (1849-1919)

Introduction

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

Guideline

I. Documentation

A. Purpose of the Medical Record

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

The medical record is a chronological document that:

1. Records pertinent facts about an individual's health and wellness;
2. Enables the treating care provider to plan and evaluate treatments or interventions, making clear the rationale for diagnoses, plans and interventions;
3. Enhances communication between professionals, assuring the patient optimum continuity of care;
4. Assists both patient and practitioner in communication with third party participants;
5. Facilitates the practitioner's development of an ongoing quality assurance program;

6. Provides a legal document for verification and/or audit of the delivery of care; and
7. Is available as a source of clinical data for research and education.

B. The Essential Elements of a Medical Record

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

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

C. Additional Elements of a Medical Record

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

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

Where possible, the practitioner should avoid judgmental language in the medical record. The practitioner should consider that patients increasingly have access to and will read their own medical record. The practitioner should also be aware that a patient has a statutory right to submit a concise statement describing

a correction or amendment for inclusion in the medical record. [RCW 70.02.110](#). For a history of the medical record, see Appendix, Part I.

D. Special Considerations When Using an Electronic Health Record

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

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

1. Recommendations for Practitioners

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

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

a. A practitioner using an EHR must ensure:

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

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

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

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

* 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.

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

- e. It is important to distinguish those portions of the history that were obtained by the note writer from those that were copied or carried forward from another practitioner's note. [\[2\]](#) The practitioner must recognize that "carry forward" or "cut-and-paste" functions, even when done automatically by the EHR software, represent significant risks to patient safety. Concerns about "clinical plagiarism" or fraudulent billing may arise when appropriate and accurate attribution of copy-paste or carry-forward information is missing from an EHR note. Practitioners should carefully review and edit any EHR-generated note to assure its accuracy prior to authenticating it.
- f. Laboratory and imaging data should only be brought into the practitioner's note when pertinent to the decision making process for the patient. Wholesale importation of laboratory data and imaging data that is already documented elsewhere in the chart is to be avoided as such practice can make interpretation of medical records by subsequent caregivers extremely difficult.
- g. The practitioner should assure that problem lists and medication lists are kept current, and that they are not cluttered with outdated information.

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

2. Suggestions for EHR Software Developers and Healthcare Institutions

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

- a. Practitioners and clinical information specialists have an important role to play in development, decision-making, evaluation and improvement of EHR systems.
- b. EHR systems should result in a patient record that is organized, concise, and easily-readable. Lengthy and redundant information in the EHR, a source of common practitioner complaint, makes it difficult for other practitioners to identify data within the EHR that is relevant to actual patient care. [\[3\]](#)
- c. EHR systems should also include tools to support the clinician to use best practices when available as well as shared decision-making.
- d. An ultimate goal of the EHR universe should be widely compatible systems allowing seamless transfer and sharing of electronic medical information within and among practitioners, medical offices and clinics, hospitals and other health care institutions, as well as patients and their caregivers.
- e. It is essential to have capacity within EHR systems to correct errors as soon as they come to light, and thereby prevent their perpetuation. The original documentation must be retrievable in the EHR via secure and permanent audit trail.
- f. As patients increasingly have access to their EHR, they will undoubtedly find information within the medical record that is erroneous or with which they disagree. There should be a mechanism in place within healthcare institutions to respond to patients' questions and

concerns that arise from review of their EHR, and to allow patients to submit a correction or amendment for inclusion in the medical records. [RCW 70.02.110](#).

- g. Software supporting EHR clinical documentation should be designed and constructed for the type of provider who will use it (e.g., specialty, training) and the context in which it will be employed (e.g., admitting, consulting, ambulatory). It should automatically attribute information to each author. [\[4\]](#)
- h. The medical record serves many audiences who need to be considered in the design and implementation of EHR systems. To meet their potential, EHRs should incorporate comprehensive decision support that:
 - i. leads to improved patient outcomes;
 - ii. ensures safe transitions of patients from one practitioner, facility, or office to another;
 - iii. allows easy tracking and reporting of patient care metrics and outcomes; and
 - iv. promotes patient-centered communication between patients and the health care system. [\[3\]](#)
- i. Health care institutions should consider having mechanisms in place to monitor documentation quality and practitioner satisfaction with the EHR, and to identify changes to support improved usability, validation, integrity, and quality of data within the EHR. [\[4\]](#)
- j. The EHR should be designed for maximum portability and interoperability of information to benefit the patient and the public health. Full integration into the Washington State Health Information Exchange provides benefit to the patient requiring treatment when away from their medical home and provides meaningful data to assess population health. Technology vendors should design their systems with these functions as standards and institutions should mandate these functionalities as standard requirements for their implemented systems.
- k. The EHR should support rapid, minimally complicated integration with the state's prescription monitoring program to facilitate inquiry in those systems.

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

II. Access to Medical Records

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

- A. Per [RCW 70.02.080](#), a practitioner is legally obligated to make medical records available to a patient to examine or copy within 15 days of the request. A practitioner may deny the request under circumstances specified in [RCW 70.02.090](#).
- B. Except for patients appealing the denial of social security benefits, the practitioner may charge a reasonable fee for making records available to a patient, another provider, or a third party and is not required to honor the request until the fee is paid. [RCW 70.02.030\(2\)](#). What constitutes a reasonable

fee is defined in [WAC 246-08-400](#). The practitioner cannot, however, withhold the records because an account is overdue or a bill is owed.

- C. To prevent misunderstandings, the practitioner's policies about providing copies or summaries of medical records and about completing forms should comply with appropriate laws and should be made available in writing to patients when the practitioner-patient relationship begins.
- D. The failure to provide medical records to patients in violation of RCW 70.02 can result in disciplinary action by the Commission.

III. Retention of Medical Records

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

IV. Storage of Records

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

[†] [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](#).

V. Disposing of Records

- A. When retention is no longer required, records should be destroyed by secure means. The Privacy Rule in the Health Insurance Portability and Accountability Act (HIPAA) prohibits digital and paper records containing confidential information from being thrown away in a public dumpster or recycling bin until they have been rendered unreadable or indecipherable by shredding, burning or other destruction.
- B. A practitioner should give patients an opportunity to claim records or have them sent to another provider before records are destroyed. [For some practitioners, the nature of their specialty will make notifying patients impractical.](#)

VI. Handling Medical Records When Closing a Medical Practice

- A. The obligation to make medical records available to patients and other providers continues even after a practitioner closes a medical practice.
- B. The recommendations in this section do not apply to:
 - 1. A practitioner who leaves a multi-practitioner practice. In that instance, the remaining practitioners in the practice typically assume care of the patients and retain the medical records.
 - 2. A specialist or other practitioner who does not have ongoing relationships with patients. These practitioners typically provide patient records to the referring practitioner, the patient's primary care provider, or directly to the patient.
- C. Prior to closing a practice, a practitioner should notify active patients and patients seen within the previous three years.
- D. The notice should be given at least 30 days in advance, with 90 days being the best practice.
- E. The notice should be given by:
 - 1. individual letter to the last known patient address;
 - 2. electronically, if this is a normal method of clinical communication with the patient; or
 - 3. placing a notice on the practitioner's web site, if the practitioner has a web site.
- F. The notice should include:
 - 1. the name, telephone number and mailing address of the responsible entity or agent to contact to obtain records or request transfer of records;
 - 2. how the records can be obtained or transferred;
 - 3. the format of the records, whether hard copy or electronic;
 - 4. how long the records will be maintained before they are destroyed; and
 - 5. the cost of recovering records or transferring records as defined in [Chapter 70.02 RCW](#).
- G. The practitioner is encouraged to provide notice to the local medical society, whether the practitioner is a member or not.
- H. If the practitioner practices as part of an institution, the institution may provide the notice of the closing of the practice.
- I. If the practice closes due to the practitioner's death, the practitioner's estate becomes the owner of the medical records and is encouraged to provide this notification to patients.

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

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

-Sir William Osler (1849-1919)

Date of Adoption:

Supersedes: Retention of Medical Records GUI2017-02; 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[‡] (as informed largely by Shoolin, et al [4])

<ul style="list-style-type: none"> ➤ Tell the patient's unique story as it relates to the patient's concerns ("the patient voice") ➤ Demonstrate diagnostic thinking and decision-making process undertaken by the practitioner. ➤ Provide clinical information to allow covering or consulting colleagues to maintain care and make informed decisions regarding further care ➤ Support coordinated longitudinal plans of care and care transitions within and across organizations ➤ Provide a clear and easily understood summary of the encounter, including findings and recommendations, to the patient or the patient's designated representative ➤ Provide clinical information to drive accurate Clinical Decision Support ➤ Support and identify the quality of care provided to patients ➤ Satisfy reasonable documentation requirements from payers ➤ Create the legal business record of the patient care facility ➤ Support population data collection and research ➤ Create the legal record of a patient's medical and surgical care ➤ Meet legal, accreditation, and regulatory criteria

[‡] 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.[§]
- Fellow practitioners
- Other members of the health care team
- Researchers
- Public health systems
- Payers
- Legal counsel
- Courts, juries and medical review/regulatory bodies

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

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

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

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

III. Current EHR Implementation

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

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

Potential challenges with current EHR implementation. The EHR theoretically promises to improve efficiency and communication, reduce errors, and improve quality of care. Yet, every advance brings with it

the potential for new problems, and the EHR is no exception. There are serious negative implications to poorly designed EHR systems, suboptimal EHR implementation, or careless EHR use by practitioners. A poor quality medical record, which could be inaccurate, inconsistent, incomplete, or obscure important information among unneeded or redundant detail, may adversely impact current or future care, transfers of care, and/or medico-legal investigations. Problematic aspects of current EHRs include:

- **Increased work load:** Data entry into the EHR can be time-consuming, particularly for practitioners who do not type well.^{**}
- **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.^{††}
 - Introducing unnecessary redundancy (see next point—“note-bloat.”).
- **“Note-bloat”:** Note bloat refers to unnecessary and redundant expansion of a note’s length and complexity. With electronic documentation, it is easy to incorporate large volumes of data into clinical documentation. Inappropriate copy-paste, carry-forward, and computer-aided data entry (auto-filling) increases the risk of lengthy but information-poor notes. Such redundant content detracts from readability, makes it more difficult to interpret and identify pertinent content, and jeopardizes the communication for which clinical notes are intended.
- **“Boilerplate”:** Despite the appeal of using templates, “boilerplate” text may add unnecessary detail that detracts from more important information. Furthermore, busy practitioners may carelessly retain parts of a normal review of systems or examination from the template rather than correctly indicating abnormal reports or findings from their interaction with the patient, resulting in inconsistent and erroneous information within the medical record.
- **Differences between the electronic version and paper copy of the EHR:** The printed copy of the EHR may look very different from the electronic version. Specifically, the paper copy of the EHR may differ from the electronic version either by including auto-populated redundant or extraneous information or excluding data that could not be readily printed. Currently, however, when copies of records are requested for patient care, investigative, or discovery purposes; they are typically provided as paper copies, often at a considerable cost to the requesting party, which may be difficult to read or incompletely reflect patient care.
- **“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

^{**} Some practitioners rely on scribes or speech recognition software. Ultimately, the practitioner is responsible for ensuring that the medical record is accurate.

^{††} 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)

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. 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 time spent:
 - a. Attending Commission meetings;
 - b. Traveling to and from official meetings;
 - c. Reviewing case files and preparing for case presentation;
 - d. Participating in telephone calls and telephone conferences;
 - e. Reviewing complaints for the case management team meetings
 - f. Reading the business meeting packet and the compliance packet;
 - 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, and other legal documents;
 - j. Administrative and organizational duties requested by the Commission Chair and by members designated by the Chair.
2. Reading journals or articles, or conducting research that is not directly related to case reviews, 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 time spent on duties stated in the appointment letter from the Commission's Executive Director.

Reimbursement

1. Under [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 [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. All airplane flights must be arranged through Commission staff.

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Communication with Patients, Family, and the Health Care Team

Introduction

Purpose

The Medical Quality Assurance Commission provides these guidelines to help practitioners learn to communicate effectively, prevent complaints to the Commission, and provide better care to patients.ⁱ

Background

Effective communication is critical to the delivery of high-quality, safe and integrated health care. Research shows that quality, collaborative communication results in increased patient satisfaction, treatment adherence, increased practitioner job satisfaction and, most important, better patient outcomes.^{ii,iii} Conversely, studies demonstrate that poor communication leads to patient and provider dissatisfaction, and bad outcomes.^{iv, v} Communication was a root cause of 79% of sentinel events reported to the Joint Commission in 2015.^{vi}

Ineffective communication is also a primary cause of complaints filed with the Commission. In many cases, the complainant expresses more dissatisfaction with the interaction with the practitioner than with the medical care provided. In others, it becomes clear during the investigation that a communication breakdown among members of the health care team contributed to the incident being complained about. In either case, the results of miscommunication can be devastating to the patient, family, and practitioner.

Guidelines for Communicating with Patients and Family Members

While there are many models of communication and each practitioner will have his or her own unique communication style, there are fundamental principles of good communication that a provider can use in every patient encounter. The Commission provides general principles to assist practitioners to communicate effectively in three areas that are frequently the subject of complaints: the office visit, the difficult patient, and the seriously ill patient.

The Office Visit

The routine office visit is the source of many complaints to the Commission. The following principles come from several sources.^{1,vii, viii}

1. **The Opening:** A good opening is essential to establishing a positive relationship with the patient. The opening builds the foundation of the relationship.
 - a. **Take a deep breath and knock on the door.**
 - b. **Use the patient's preferred name.** State your name and role.
 - c. **Say hello to guests. Ask their names.**
 - d. **Get to know the patient personally.** Consider asking "What is important that I know about you so I can give you the best care?"
 - e. **Start with an open-ended question, such as "Tell me what is happening," or "How can I help you?"**
2. **Interviewing the Patient:**
 - a. **Sit down, lean forward and make eye contact.** Avoid crossing your arms.
 - b. **Give the patient your complete attention.** Stop talking. Allow the patient 1-2 minutes to speak.
 - c. **Find out what the patient understands.** We encourage clinicians to not use the word understand—adults often feel like they are being tested and do not like that. We encourage "In your own words can you tell me what you have heard from the other doctors about your condition?"
 - d. **Ask before you tell.** Every patient will want a different level of detail of information about their condition or treatment. Ask the patient for the amount of information desired before providing the information.
 - e. **Be empathetic.** Acknowledge a patient's emotions explicitly. This is essential to the therapeutic relationship. This may actually shorten the visit by putting the patient at ease.
 - f. **Slow down.** Provide information slowly and deliberately to allow time for the patient to comprehend the new information and to give the patient an opportunity to formulate questions which can help the physician provide targeted information.
 - g. **Keep it simple.** Use short statements and explanations. Avoid long monologues. Tailor information to the patient's desired level of information. Avoid medical jargon.
 - h. **Tell the truth.** Do not minimize the impact of the information.
 - i. **Avoid "why" questions.** Ask "how" questions.
 - j. **Never answer a feeling with a fact.**
 - k. **Watch the patient's body and face.** Most of physician-patient communication is a two-way exchange of non-verbal information. Be attentive to and respond to a patient's facial expressions. Face the patient when conversing with the patient.
 - l. **Be prepared for a reaction.** When delivering bad news, it is important for the practitioner to be prepared, recognize the response by the patient, allow sufficient time for a display of emotions, and listen quietly and attentively.
3. **The Closing:** The last moment of the interaction will reflect on the entire experience the patient just had.
 - a. **Keep track of personal comments.** If the patient mentions a big event coming up, mention this item in closing.
 - b. **Use the patient's name** to create a personalized ending to the visit.

- c. **Make a positive statement.** Show the patient you hope for the best outcome. For example, “I hope this new medication will help you feel better.”
- d. **Make a partnership statement.** This is a statement indicating that you and the patient are working as a team. For example: “I know this is happening to you, but we’ll face it together.” Or, “We’ll work on this together.”

Handling the Difficult Patient

Every practitioner has had encounters with the difficult patient. If not handled properly, the interaction can leave both the practitioner and the patient feeling frustrated.

The best approach is prevention. To avoid difficult interactions, first acknowledge and address underlying mental health issues in your patient early in the relationship. Second, be aware that the greatest source of discontent for patients is feeling that they don’t matter or that they are not heard. Third, consider your body language while you are interacting with the patient; sit and look at them when they are providing their history. Fourth, be aware of your own emotional state; it is often the first clue of a potential conflict.

If a patient encounter becomes tense, there are two things you can do to de-escalate the situation:

1. **Remain professional.** If you feel your own emotions getting the better of you, step outside the room and take a few deep breaths. While you are cooling down, ask yourself what the patient is really asking. Put yourself in their shoes. Anger is most often an outward expression of fear, and recognizing this can restore your sense of compassion.
2. **Engage in active listening.** Set aside your agenda and give the patient your full attention. Summarize what the patient has said and acknowledge the emotion they are expressing.

By taking these steps, you will help maintain a therapeutic relationship with the patient, as well as greatly reduce the likelihood the patient will file a complaint with the Commission.^{ix}

Communicating with Seriously Ill Patients

Interacting with seriously ill patients takes special care and attention. The Commission recommends following these principles:

1. Spend at least a moment giving the patient your complete, undivided attention.
2. Start with the patient’s agenda.
3. Track both the emotion and the cognitive data you get from the patient.
4. Stay with the patient and move the conversation forward one step at a time.
5. Articulate empathy explicitly.
6. Talk about what you can do before you talk about what you can’t do.
7. Start with big-picture goals before talking about specific medical interventions.⁷

If you follow these steps, you will build strong relationships with your patients, reduce the chances of a complaint to the Commission, and provide better care to your patients.

The Need for Formal Communication Training

Effective communication is becoming a standard part of practitioner training. Many medical schools teach communication skills. Both the American College of Graduate Medical Education and the National Commission on Certification of Physician Assistants lists communication skills as a core competency.

Once in practice, however, the busy practitioner may not give quality communication the attention it deserves. Communication skills are like any other set of skills used in practicing medicine. The Commission strongly encourages all practitioners to develop and maintain this skill set through formal training and practice.

Health care organizations play an essential role in improving communication in healthcare. Healthcare organizations should advocate for and fully support communication training for all employees who have contact with patients, including non-clinical staff. Every employee can help improve the patient experience and healthcare outcomes with good communication, even if they are not involved in patient care.

The amount and type of training will depend on the employee's job responsibilities. Employees with clinical responsibilities should receive the most in-depth training. Ideally, training will address implicit bias and its effects on perception and communication with people from different backgrounds.^x

Whenever possible, training should focus on team members who work together rather than training that isolates people based on professional discipline. This approach helps establish a culture of effective communication in which multi-disciplinary team members can reinforce the same skills working with one another during day-to-day activity.

Communication training will be most effective if the organization requires active practice and reinforcement at regular intervals. A simple seminar on effective communication without the opportunity to practice, get feedback, and refine skills is not likely to result in meaningful change.^{xi}

Resources for Communication Training

The Commission does not approve or endorse specific trainings and encourages practitioners to take training most relevant to their practice. The Commission offers this list of courses and books that may be helpful.

Trainings:

- American Academy on Communication in Healthcare has an on-line communication curriculum, "DocCom," with training modules that address a range of communication and relationship-centered topics. Interactive videos demonstrate interactional skills with standardized patients and provide text and video commentary.
<http://www.aachonline.org/DocCom>
- The Center for Healthcare Communication offers programs, webinars and written materials designed to increase patient satisfaction and safety and decrease communication-related medical errors.
<http://www.communicatingwithpatients.com/index.html>

- Vital Talk is a non-profit with the mission of nurturing healthier connections between patients and clinicians. It offers in-person communication courses and will soon offer on-line training. www.vitaltalk.org
- The Center to Advance Palliative Care has a web-based communications curriculum with interactive video modules and webinars. <https://www.capc.org/providers/courses/>
- The Institute for Healthcare Communication offers a wide variety of in-person communication workshops. <http://healthcarecomm.org/>
- The Physician Assessment and Clinical Education Program (PACE) at the University of San Diego offers a one day course in “Clinician-Patient Communication to Enhance Health Outcomes.” PACE offers an interactive program in which participants analyze video-taped reenactments of actual cases. <http://www.paceprogram.ucsd.edu/CPD/PatientCom.aspx>
- The Center for Personalized Education for Physicians (CPEP) offers a two-day advanced course in clinician-patient communication. CPEP’s course helps clinicians refine and enhance their communication skills using personalized learning, practice with simulated patients, and individualized coaching. <http://www.cpepdoc.org/programs-courses/clinician-patient-communication>

Books:

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Conclusion

Effective, collaborative communication is critical to the delivery of high-quality health care. The Commission encourages all practitioners to take training in effective communication, practice the skills learned, and reinforce those skills in day-to-day practice, both with patients and with other providers on the health care team. Health care organizations can support training that includes active practice and reinforcement. A practitioner who communicates effectively creates stronger relationships with patients, reduces the risk of complaints to the Commission, and provides safer care.

The Commission would like to thank Larry Mauksch, M.Ed., Clinical Professor Emeritus, Dept. of Family Medicine, University of Washington, for providing suggestions and advice for this guideline.

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ⁱ The Commission has adopted several guidelines in the past few years that address specific aspects of communication in health care. These guidelines may be of interest to practitioners seeking specific advice in these areas:

Transmission of Time Critical Medical Information (TCMI) "Passing the Baton" Guidelines, MD2015-02, adopted in 2011 and revised in 2015.

The Commission adopted these guidelines to emphasize the responsibility of consultants and practitioners to identify and responsibly communicate time-critical medical information in a timely and effective manner for quality patient care. The Commission revised the guidelines in 2015.

Professionalism and Electronic Media Guidelines, MD2014-02, adopted in 2014.

The Commission adopted these guidelines to assist practitioners to adhere to standards of professionalism in using electronic media, or social media, for personal, non-clinical purposes.

Physician and Physician Assistants' Use of the Electronic Medical Record Guideline, MD2015-09, adopted in 2015.

The Commission issued these guidelines to assist practitioners in the appropriate use of electronic medical records.

A Collaborative Approach to Reducing Medical Error and Enhancing Patient Safety, MD1015-08, adopted in 2015.

The Commission issued this guideline to combine three existing policies designed to help reduce medical error. This guideline (1) expressed support for just culture principles, (2) encouraged institutions to adopt Communication and Resolution Programs and summarized a protocol the Commission adopted in 2013 for handling complaints of medical error; and (3) set up a collaboration with the Foundation for Health Care Quality to disseminate lessons learned.

ⁱⁱ Travaline J, Ruchinskas R, D'Alonzo G, Physician-Patient Communication: Why and How. *JAOA*. 2005;105(1): 13-18.

ⁱⁱⁱ "Impact of Communication in Healthcare," Institute for Healthcare Communication, <http://healthcarecomm.org/about-us/impact-of-communication-in-healthcare/> accessed March 2, 2016.

^{iv} Woolf S, Kuzel A, Dovey S et al. A String of Mistakes: The Important of Cascade Analysis in Describing, Counting and Preventing Medical Errors. *Annals of Family Medicine* 2004 Jul; 2(4): 317-326.

^v Improving Diagnosis in Health Care, Institute of Medicine, National Academy of Sciences 2015.

^{vi} Sentinel Event Data, Root Causes by Event Type 2004-2015, The Joint Commission, <http://www.jointcommission.org/issues/article.aspx?Article=1AF4aJclzvBc%2bAMu%2fi5RwBBiJDoM0RWvmjtlqwp6HM%3d&j=2829096&e=jkumar@hcpro.com&l=94 HTML&u=73636271&mid=1064717&jb=51>.

^{vii} For more information on these steps, see Back A., Arnold R., Tulskey, J. *Mastering Communication with Seriously Ill Patients*. New York, NY: Cambridge Univ Press; 2009.

^{viii} Leigh E, "Engaging Your Patients," The Center for Healthcare Communication. 2016 webinar. http://www.communicatingwithpatients.com/prog_engaging.html accessed February 29, 2016.

^{ix} C. Peine, Dealing with Difficult Patients. *The Report, Idaho State Board of Medicine*. Volume 1, Issue I, 2015.

^x Chapman E., Kaatz A., Carnes M., Physicians and Implicit Bias: How Doctors May Unwittingly Perpetuate Health Care Disparities. *J Gen Intern Med* 2013; 28(11):1504-10.

^{xi} The Denver Health Medical Center, an urban public safety-net hospital, studied the implementation a comprehensive provider/team communication strategy and published the results in 2008. They also developed a toolkit that can be used in other settings. Dingley C, Daugherty K, Derieg MK, et al. Improving Patient Safety Through Provider Communication Strategy Enhancements. In: Henriksen K, Battles JB, Keyes MA, et al., editors. *Advances in Patient Safety: New Directions and Alternative Approaches* (Vol. 3: Performance and Tools). Rockville (MD): Agency for Healthcare Research and Quality (US); 2008 Aug. Available from <http://www.ncbi.nlm.nih.gov/books/NBK43663/> accessed May 26, 2016.

State of Washington
Medical Quality Assurance Commission

Interpretive Statement

Title:	Practice of Medicine and Body Art – Other severing or penetrating of human tissue	MD2009-01
References:	RCW 18.71.011 (3)	
Contact:	Michael Farrell, JD, Policy Development Manager	
Phone:	(509) 329-2186	Email: michael.farrell@doh.wa.gov
Effective Date:	December 4, 2009; Reaffirmed as written February 12, 2016	
Supersedes:	N/A	
Approved By:	W. Michelle Terry, MD, FAAP, Chair (signature on file)	

Description of the Issue

Does scarification, branding, tongue splitting, insertion of body hooks, and body art implants in the practice of body art also constitute the practice of medicine?

Background Information

A complaint dated April 28, 2008 requests that the Medical Quality Assurance Commission (Commission) determine whether tattooing, piercing, scarification, branding, tongue splitting, insertion of body hooks, and body art implants constitute the practice of medicine pursuant to [Chapter 18.71 RCW](#). Although the complaint identifies several businesses that engage in these activities in Washington State, the essence of the complaint is a request for an advisory opinion. Accordingly, the Commission chooses to respond to the complaint by issuing interpretive statements pursuant to [RCW 34.05.230](#).

[RCW 18.71.011](#)(3) states, in relevant part:

[RCW 18.71.011](#) Definition of practice of medicine — Engaging in practice of chiropractic prohibited, when.

A person is practicing medicine if he does one or more of the following:

...

(3) Severs or penetrates the tissues of human beings;

...

Therefore, in general, a person is practicing medicine if s/he severs or penetrates the tissues of a human being. This is consistent both with the plain language of [RCW 18.71.011](#) and with a

liberal construction of the definition to protect public health. *Creelman v. State Bd. of Registration for Architects*, 73 Wn.2d 298, 300, 438 P.2d 215 (1968).

The Legislature, by adopting more specific statutes granting authority to some groups to sever or penetrate human tissue, may carve such practices out of the definition of the practice of medicine¹. Therefore, other health care providers may also be authorized to sever or penetrate the tissue of human beings, just as they also may be authorized to “diagnose, cure, advise or prescribe for any human disease, ailment, injury, infirmity, deformity, pain or other condition, physical or mental, real or imaginary, by any means or instrumentality.” See [RCW 18.71.011](#)(1). For example, osteopathic physicians are authorized to use “any and all methods in the treatment of disease, injuries, deformities, and all other physical and mental conditions in and of human beings, including the use of osteopathic manipulative therapy.” See [RCW 18.57.001](#).

The state of Washington has enacted some state-level regulation of tattooing facilities and practices, including standards for sterilization and infection control; however, prior to the 2009 Legislative session, no such legislation had been adopted relating to other forms of body art, even though many of the same health concerns applied.

Senate Bill 5391², a bill regulating tattooing and body piercing, was signed into law on May 7, 2009 with an effective date of July 26, 2009. In enacting this law, the Legislature has carved out what it defines as “body piercing”, “tattooing” and “Body Art” from what would otherwise constitute the practice of medicine. The new law defines “Body Art” in relevant part as “the practice of invasive cosmetic adornment including the use of branding and scarification... [and also] includes the intentional production of scars upon the body.” Chapter 412, Laws of 2009, Section 2. All other examples of severing or penetrating the tissues of a human being remains within the definition of the practice of medicine without separate, specific legislative direction otherwise.

Analytical Outline

The various forms of body art referred to in the complaint involve differing procedures to sever or penetrate human tissue. They also raise distinct health risks. These risks are best addressed in separate interpretive statements. Clarification of the practice of medicine in the context of body art is divided into two parts³:

- Piercing; and
- Other severing or penetrating of human tissue, including scarification, branding, tongue splitting, insertion of body hooks, and body art implants.

¹ “It is a fundamental rule that where the general statute, if standing alone, would include the same matter as the special act and thus conflict with it, the special act will be considered as an exception to, or qualification of, the general statute, whether it was passed before or after such general enactment.” *Id.*; See *State v. Conte*, 159 Wn.2d 797, 803, 154 P.3d 194 (2007), *cert. denied*, --- U.S. ---, 128 S.Ct. 512, 169 L.Ed.2d 342 (2007).

² Chapter 412, Laws of 2009.

³ The Commission has decided not to address Tattooing by interpretive statement.

These interpretive statements advise the public of the Commission's current opinions and concerns regarding these practices.

Definitions of Extreme Body Art Procedures

- **Scarification** means altering skin texture by cutting the skin and controlling the body's healing process in order to produce wounds, which result in permanently raised wheals or bumps known as keloids.
- **Branding** means inducing a pattern of scar tissue by use of a thermal material (usually metal) to the skin, making a serious burn, which eventually becomes a scar.
- **Tongue splitting** means splitting the front portion of tongue in two with a scalpel, string, or burning tool.
- **Insertion of body hooks** means the insertion of hooks driven through skin or fastened to existing piercings to enable the suspension of a person for minutes to hours.
- **Body art implant** means an object or other inert material that is implanted under the skin between the fascia and epidermal layers. There are two forms of implants: *subdermal* implants are completely covered by skin; and *transdermal* implants begin under skin but then protrude outside.

Public Protection Issues⁴

The extreme body art procedures defined in this statement raise wide-ranging public health, safety and welfare issues: medical complications; infection and infectious disease transmission; bio-hazardous waste disposal; obtaining accurate medical history and informed consent; and procedures performed on minors. Issues include, but are not limited to, the examples below.

Medical Complications

Different extreme body art procedures incur different complications. Branding is complicated because skin spreads as it heals and requires compensation. Complex brands do not work well on human flesh. Branding requires proper training and experience. Scarification is not a precise art. To scar, the cut must penetrate the second layer of skin. Scarification involves risk that certain physiological structures may be unintentionally cut. There are many variables: skin type, depth of incision, and wound treatment. Cutting or burning too deeply can cause serious problems. Proper healing requires the same level of health care oversight as treatment for traumatic cuts and burns. Implants raise risks of anesthesia complications, damage to blood vessels, and adverse immune system reactions. The tongue is a very complicated and vital body organ and is a major site for bacteria. Oral infections are particularly dangerous due to the potential for cardiac complications and proximity to the brain.

⁴ The Commission recognizes that scarification and branding, as defined by the Legislature in Chapter 412, Laws of 2009, has been carved out of the definition of the practice of medicine. Nevertheless, the below health concerns remain valid.

Infection and Infectious Disease Transmission

Whenever the skin barrier is severed or penetrated there are increased risks for serious infection unless procedures are performed in medically sterile and professional environments. Localized infection from improper sterilization or aftercare can lead to illness, deformity, and unintended scarring. The two most common bacterial infections are Staphylococcus (skin bacteria that can cause death if it enters the blood stream) and Pseudomonas (bacteria that thrives in warm, moist areas causing irritation and more serious infection, if not treated properly), and the more serious and fast spreading staph infection – MRSA – can easily be contracted through a body art portal causing permanent injury or death. Further, serious viral infections can incur, including Hepatitis B, Hepatitis C, and HIV/AIDS. Diseases such as tetanus and tuberculosis can also be contracted through open or slow healing wounds.

Bio-hazardous Waste Disposal

Bio-hazardous waste, also called infectious waste or biomedical waste, is any waste containing infectious materials or potentially infectious substances such as blood. Of special concern are sharp wastes such as needles or blades that can cause injury during handling. Infectious wastes must either be incinerated or treated prior to final disposal. The appropriate handling and processing of bio-hazardous waste is essential.

Obtaining Accurate Medical History and Informed Consent

Body art practitioners must be skilled at obtaining and knowledgeable about preexisting health conditions (e.g., diabetes, hemophilia, allergies) that may increase health risks associated with receiving a body art procedure. The taking of patient histories and vital signs are fundamental aspects of health care practice. Informed consent is the process by which fully informed patients participate in choices about their health care, including body art procedures. It is generally accepted that complete informed consent includes a discussion of the following elements: the nature of the decision or procedure; reasonable alternatives to the proposed intervention; the relevant risks, benefits, and uncertainties related to each alternative; assessment of patient understanding; the acceptance of the intervention by the patient; and instructions for after-care and treatment of complications.

Procedures Performed On Minors

[RCW 26.28.085](#) makes tattooing of minors under age 18 a misdemeanor, excluding medical procedures performed by licensed physicians. The extreme body art procedures defined in this statement are more permanent and irreversible than tattooing. The same rationale for prohibiting the tattooing of minors also applies to extreme body art procedures.

Pain Management

The Joint Commission on Accreditation of Healthcare Organizations' (JCAHO) guidelines on pain management state, "Patients have the right to appropriate assessment and management of pain."

Maintain Records of Items Inserted and Composition

Body art practitioners should document and maintain records identifying the items used to penetrate human tissue when performing extreme body art procedures, including the composition of the items, in the event that allergies occur, or items are implanted or break and are retained in the body during the procedure.

Conclusion

As the Legislature has recognized by the current legislative definitions of the practice of medicine and body art, the public health, safety and welfare dictates that extreme body art practices that fall out side of the definition of body art in Chapter 412, Laws of 2009, (i.e. tongue splitting, insertion of body hooks, and body art implants be recognized as the practice of medicine pursuant to [RCW 18.71.011](#)(3) and should only be performed by licensed and trained medical professionals within their scope of practice.

Consent Agenda for Policy Committee

Introduction

Purpose. The Washington Medical Commission (WMC) adopts this procedure to make review of policies, guidelines, and procedures by the WMC Policy Committee and by the full Commission more efficient.

Background. The WMC adopts policies, guidelines, procedures and interpretive statements (collectively referred to as “policies” for the purpose of this procedure) to fulfill its statutory obligation to protect the public. The WMC Policy Committee reviews policies every four years to determine if the policies should be rescinded, revised or re-approved. The WMC Policy Committee then makes a recommendation to the full Commission as to whether a policy should be rescinded, revised or re-approved.

Procedure

1. Prior to each WMC meeting, Commission staff review current policies and determine which policies are up for a four-year review. Commission staff review these policies and make an initial recommendation whether the policies should be rescinded, revised or re-approved.
2. With input from WMC staff, the Chair of the Policy Committee sets the agenda for the Policy Committee Meeting. As part of the policy committee meeting agenda, the Chair may create a consent agenda. The consent agenda will consist of the existing policies that do not need revision or rescission.
3. Prior to the Policy Committee meeting, Commission staff sends the Policy Committee meeting agenda with the policies and relevant documents to the Commission members for review. This includes the Policy Committee meeting consent agenda.
4. At the Policy Committee meeting, the members of the Policy Committee vote whether to accept the consent agenda. The committee may vote to remove policies from the consent agenda for discussion by the committee. The committee then discusses the policies that were removed from the consent agenda.
5. At the following business meeting, the Chair of the Policy Committee presents the recommendations of the Policy Committee to the full WMC. This will include the consent agenda for the policies that the Policy Committee is recommending that the WMC re-approve with no changes.
6. The WMC may vote to accept the consent agenda, or it may decide to remove one or more policies from the consent agenda for discussion.

Date of Adoption:

Staff Reports



Staff Reports: January 17, 2020

Melanie de Leon, Executive Director

Fees. The new fees are scheduled to go into effect on February 1, 2020. Dr. Roberts provided a great article in the last *Update!* explaining the reasons for the fee increase and the article may be helpful to you if you get asked questions regarding the increase.

Renewal applications. In an effort to streamline the renewal process, we have removed questions regarding the licensee that less than 1% answered in the affirmative and required staff to manually input the answers into our system adding staff costs and time to the renewal process. By removing these questions, we can provide same-day renewals.

Micah Matthews, Deputy Executive Director

Legislative session began January 13. This is a 'short' session so it will end Thursday March, 12. This means the best way to reach me is by email or mobile as I will more often than not be on the legislative campus.

- **A review of how the WMC approaches legislative work generally:**
 - As Legislative Director, I take positions when necessary on behalf of the WMC based on your existing body of adopted rules, policy, guidelines, and interpretive statements.
 - The WMC has a Legislative Committee that provides weekly feedback to the DOH on specific bills impacting health professions and regulation.
 - If faced with a bill that does not fall within the existing official WMC positions, I will consult the Legislative Committee, Executive Committee, or specific Commissioners if it is a specialty specific question.
 - Stephanie will be placing a running digest on the WMC SharePoint site under the Legislative Committee tile. Feel free to look at what we are watching.



(look for Bill on SharePoint for more information)

- **Things to remember about legislative session:**
 - If you are going to submit comment, testify, or otherwise be involved you may not act in your capacity as a WMC member in any way without a discussion with me or Stephanie McManus.
 - If you would like to be involved in WMC legislative work, please let me know. We are always looking for ways to incorporate appointed Commissioners in this process.
 - There are specific legal prohibitions to your acting as a Commissioner in the legislature and your liaison staff act to protect you in that capacity. If you testify, have contact with a legislator or staff, or express a position in any way in your WMC capacity or note that you are on the WMC, you are legally required to report that time through the DOH to the Public Disclosure Commission. Again, this is why we try to filter all of this work through Stephanie and me.
 - Positions taken on bills are just as often done to show support for organizations as they are for supporting the policy. Not taking a position on a bill is frequently done for reasons unrelated to policy positions. This is to say that sometimes what we do may not make sense on the surface, but our actions are always intentional. To quote a great legislative philosopher, "If you see a turtle on the fencepost, someone put it there."
- **Other legislative impacts of note:**
 - The Balanced Billing act is now in effect. Please see the update from Director Pace for details.
 - The Washington Paid Family Leave program is now active and accessible for state employees.
 - The WMC submitted its International Medical Graduates [workgroup report](#) to the legislature on time last decade (December 2019). Expect legislation in 2020 related to the recommendations.

External Events

- **Center for Telemedicine Law:** Stephanie and I travelled to the Fall Summit in Washington, D.C. to present on our Continuity of Care policy and give a grassroots influence training session to approximately 100 attendees from across the U.S. The session was well received and we have received a request to help lead a group to move the policy effort forward nationally. We also met with outgoing Congressman Denny Heck and staff for Senator Cantwell. We discussed telemedicine issues and WMC existing efforts in the area of telemedicine practice.
 - Also of note: Shortly after this meeting the U.S. Congress passed and the President signed an act requiring the VA to comply with records requests from state health professional regulators. This is a huge advance for our work on the discipline side and probably unrelated to our visit to D.C.

Micah Matthews, Deputy Executive Director continued

- Trivia note: Our visits with elected officials coincided with the day articles of impeachment were considered hearings in various committees (everyone distracted). The year prior, our Hill visits coincided with the funeral of President George H.W. Bush (D.C. was a ghost town). The year prior we met in the Mayflower hotel, the site of the now infamous meetings with the Russian ambassador (tried not to accidentally commit espionage).
- CLEAR Winter Symposia and Mid-Year Meetings:
 - I attended a symposia on data technology in professional regulation intended to boost regulatory efforts and knowledge in A.I. functions.
 - The CLEAR Mid-Year meeting is where the various proposals for the Annual Educational Conference are vetted, approved, and the programming is completed. As a reminder, this year the conference is in Seattle in September!

Amelia Boyd, Program Manager

Recruitment

The following Commissioner terms end June 30, 2020:

- Congressional District 6 – Dr. Trescott’s position, eligible for reappointment
- Congressional District 8 – Dr. Harrison’s position, eligible for reappointment
- Physician-at-Large – Dr. Domino’s position, eligible for reappointment

The application deadline for the above positions is March 20, 2020.

Melissa McEachron, Director of Operations and Informatics

1. **Data Sharing Agreements:** Ops and Informatics completed the following Data Sharing Agreements and successfully transferred requested data:

- a. **University of Washington, Latino Center for Health.** The University of Washington, Latino Health Center was tasked by the Washington Legislature to identify and describe the current supply of Latino physicians in Washington and to disseminate policy recommendations to meet the State’s growing need for Latino physicians.

One of the data sources identified for this cross-sectional study is our physician and physician assistant census data. The data agreement outlines what data is requested, how our data will be used, along with provisions designed to safeguard data including: access, storage, security, re-disclosure, and retention and destruction.

- b. **DOH Communicable Disease Epidemiology, Healthcare-Associated Infections & Antimicrobial Resistance.** The Communicable Disease Epidemiology Division requested physician contact information for pathologists and neurologists working in Washington. As part of a CDC grant, Washington State Department of Health, DCHS/CDE is required to work collaboratively with pathologists, neurologists, and other appropriate professionals within the state to ensure that

Melissa McEachron, Director of Operations and Informatics continued

these professionals are aware of the state's prion disease surveillance as well as prion disease-related resources available to support them.

2. Information Requests and Subpoenas for Records: In 2019, Operations and Informatics received, reviewed, redacted, and securely transferred approximately 50 Cases and Application files.

- 5 subpoenas for records =
 - Law firms,
 - DEA, and
 - Disability Rights Washington;
- 2 Public Record Request Appeals (DOH Appeals Unit);
- 2 from the Medicare Fraud Control Division Unit, Office of the Attorney General (Memorandum of Understanding); and
- 1 Medical Records Search Warrant;

I also assist the public disclosure unit weekly with unique document searches. The searches are used to determine if WMC has documents responsive to a public disclosure request.

Congratulations to Kimberly Romero! Kim was recently promoted to a Health Services Consultant 4. The Licensing Unit provides licensing and renewal services to over 35,000 physicians and physician assistants, and serves as the WMC's HR designated call center. Kim graciously accepted additional duties to implement key licensing initiatives, such as Panel L and the Interstate Medical Licensing Compact.

George Heye, MD, Medical Consultant

Nothing to report.

Morgan Barrett, MD, Medical Consultant

Please find the **Respondent Exit Survey** results for January – December 2019 (bookmarked) in your meeting packet. Given that being subject to compliance monitoring is inherently stressful, the survey participation rate is reasonably good. We encourage you to review the comments and scores of the survey.

Data for January 1 – December 31, 2019

50 Respondents Terminated

43 surveys sent (7 did not have email or returned undeliverable)

12 responses received

28% survey participation rate

Kimberly Romero, Licensing Manager

Licensing data will be reported in the February meeting packet.

Summary Action:

In re Eric R. Shibley, MD, Case No. M2018-443. On December 30, 2019, WMC summarily restricted the medical license of Dr. Shibley. The Statement of Charges (SOC) alleges Dr. Shibley has placed several patients at risk of over-sedation and overdose through his prescribing of controlled substances without documented legitimate medical justification despite known risk factors, against the advice of other providers, and despite a patient's desire to stop using controlled substances. The Commission also alleges inaccurate and delayed charting practices potentially jeopardizing continuity of care with other providers. Pending final outcome of this matter, Dr. Shibley is restricted from prescribing controlled substances.

Hearings:

In re Roger B. Olsson, MD, Case No. M2017-527. Dr. Olsson specializes in family medicine, but is not board certified. Dr. Olsson's license is restricted under an Agreed Order entered on November 6, 2014, in which Dr. Olsson agreed to no longer treat chronic pain patients or prescribe opioids for chronic pain patients; limit prescribing opioids for acute pain; limit prescribing benzodiazepines for anxiety; and not provide prescriptions or medical care to family members except in emergent circumstances. On May 8, 2019, the Commission issued a SOC, along with an Ex Parte Motion for Order of Summary Action, alleging Dr. Olsson's practice with regard to prescription of hormones (including testosterone, a controlled substance) and evaluation and management of possible endocrinological conditions was outside the standard of care. On May 10, 2019, the Commission signed an Ex Parte Order of Summary Restriction which additionally restricts Dr. Olsson from prescribing hormones pending the outcome of a hearing which was held before a Commission panel November 18-19, 2019. A Final Order is expected to be issued by the Health Law Judge (HLJ) by the end of February 2020.

In re Jennifer L. Rice, MD, Case No. M2018-454. Dr. Rice holds a residency license to practice as a physician and surgeon and specializes in anesthesiology. On October 12, 2018, the Commission issued an Order for Investigative Mental and Physical Examinations requiring Dr. Rice to submit to a multidisciplinary evaluation with regard to medical, chemical, and mental health. On May 31, 2019, the Commission filed a SOC alleging Dr. Rice had not made an appointment or received the ordered evaluation. The matter was delegated to a HLJ for final decision-making and the hearing was held on November 25, 2019. The HLJ has 90 days after conclusion of the hearing to issue a decision.

In re William J. Washington, MD, Case No. M2018-697. Dr. Washington is not board certified, but specializes in emergency medicine. On May 2, 2019, the Commission filed a SOC based on the standard of care of a patient Dr. Washington treated in his emergency department. The SOC alleges incompetence, negligence, or malpractice which results in injury to a patient or which creates an unreasonable risk that a patient may be harmed. A hearing was held before a Commission panel on December 16, 2019. A Final Order is expected to be issued by the HLJ by mid-March 2020.

Rick Glein, Director of Legal Services continued

Meetings and Events:

On December 2, the Legal Unit attorneys met with counterparts at the Attorney General's Office for our quarterly check-in. We discussed the organization of evidence, use of expert witnesses, and minimizing the length of hearings.

On December 4, Legal staff volunteered at the Thurston County Food Bank as our holiday teambuilding activity. Many thanks to our Legal Assistant, Jenelle Houser, for coming up with the idea and coordinating this charitable event at a Combined Fund Drive organization whose mission is to eliminate hunger in Thurston County.

On December 17, Rick attended DOH's Enforcement Steering Committee with staff from Health Systems Quality Assurance (HSQA)/Office of Investigative and Legal Services (OILS), Nursing Commission, Facilities, and the Adjudicative Clerk Office. This Committee identifies and prioritizes improvement projects and establishes Work Activity Groups to design effective, efficient work flow processes using a team approach where appropriate.

Freda Pace, Director of Investigations

Starting Jan. 1, 2020, a new Washington state law became effective protecting individuals from surprise or balance billing if they receive emergency care at any medical facility or when they were treated at an in-network hospital or outpatient surgical facility by an out-of-network provider.

After Jan. 1, 2020, individuals cannot be surprise billed for certain services. If they get a surprise bill, they are being advised to contact their provider or facility and tell them they believe they have been wrongly billed. They can also file a complaint with the Office of the Insurance Commissioner (OIC), and they will investigate on the individual's behalf.

The Washington Medical Commission (WMC) will only process surprise or balance billing complaints after the provider has shown a pattern of complaints (2 or more) with OIC. At that time, OIC will refer the matter to WMC as an official complaint. We don't anticipate seeing any referrals from OIC but if we do, they will be included in a CMT packet.

Lastly, I would like to announce our newest addition to the Investigative Unit, Britta Fischer – Clinical Health Care Investigator. Britta joined the Commission on January 2nd. She is a 26-year Board Certified – Physician Assistant specializing in Hematology/Oncology with a focus in bone marrow transplant. She loves the outdoors, including hiking, snowshoeing and enjoys riding her Harley motorcycle! Please join me in welcoming, Britta!!!

Mike Farrell, Policy Development Manager

Working with ROME subcommittee to prepare presentation for stakeholder meeting. Working on proposed clinical support rule by collecting case examples that may fall under rule. Researching telemedicine rules in other states for proposed rule. Converting history talk to a written narrative.

2020 Event Calendar

I am working on putting together an outreach and education calendar for the 2020 year. If you know of an opportunity for the Medical Commission to provide a presentation, submit a poster or attend an event, please let me know. The earlier I can begin contacting coordinators and contributors, the more successful these events and activities are.

2020 Webinars

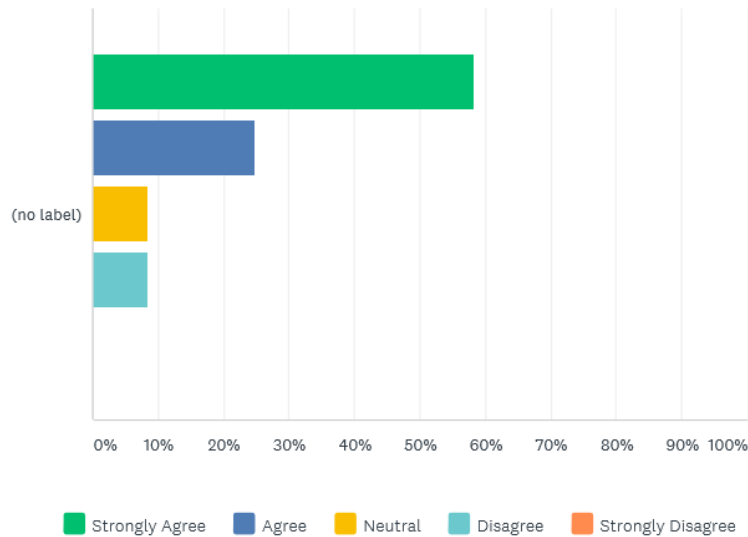
I am going to begin to provide more CME learning opportunities for our licensees in 2020 via live webinars. If you have an idea for a topic, please let me know.

Performance Measure Report		
Metric	2018 (Calendar Year)	2019 (Calendar Year)
Licensing		
New Credentials Issued	2,873	3,055
Percent of health care credentials issued within 14 days of receiving all documents.	97%	86%
Investigations		
Percent of cases in which the intake and assessment steps are completed within 21 days.	98%	98%
Percent of cases in which the investigation step is completed within 170 days.	61%	67%
Percent of cases currently in investigations that are over 170 days.	19%	12%
Completed investigations per investigator.	80.7	78.9
Legal		
Percent of cases in which the case disposition step is completed within 140 days.	86%	83%
Percent of cases in case disposition that are over 140 days.	23%	32%
Percent of Orders and STIDS that comply with the sanction schedule.	90%	100%
Formal Hearings Completed.	9	8
Compliance		
Licensees under monitoring.	151	156
Licensees released from order.	65	42
Personal appearances completed.	74	64
General		
Percent of cases completed within 360 days.	92%	91%
Total cases reviewed at CMT.	1,499	1,560
Percent of cases reviewed at CMT authorized for investigation.	48%	36%
Reconsiderations requested.	62	54
Reconsiderations approved.	7	7

Exit Survey Responses January 1 – December 31, 2019

The Compliance Orientation conference call and PowerPoint helped me clearly understand my sanction requirements.

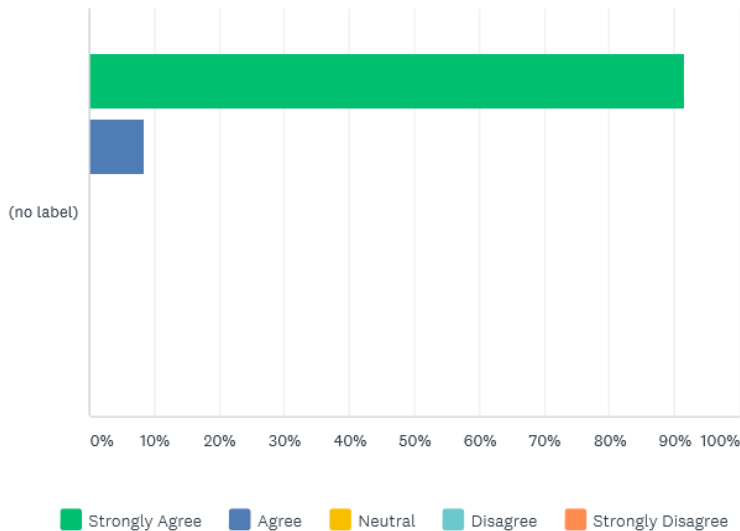
Answered: 12 Skipped: 0



	STRONGLY AGREE	AGREE	NEUTRAL	DISAGREE	STRONGLY DISAGREE	TOTAL	WEIGHTED AVERAGE
(no label)	58.33% 7	25.00% 3	8.33% 1	8.33% 1	0.00% 0	12	4.33

The Compliance Team treated me with courtesy and respect throughout my term.

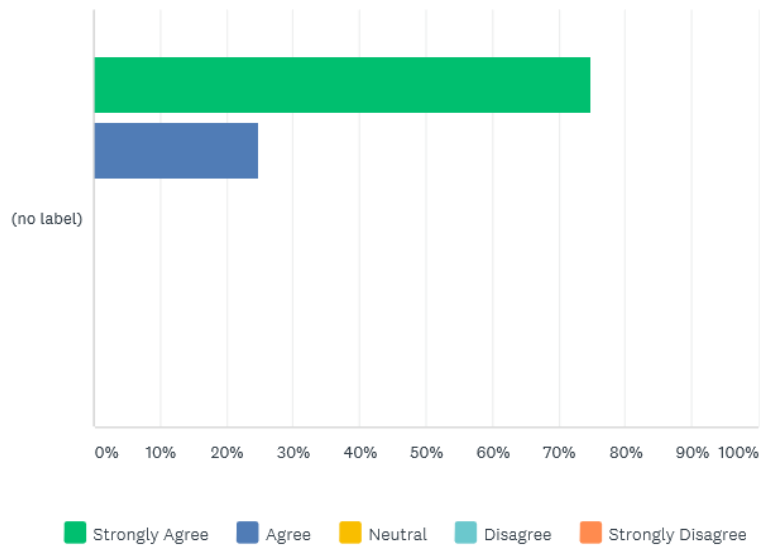
Answered: 12 Skipped: 0



	STRONGLY AGREE	AGREE	NEUTRAL	DISAGREE	STRONGLY DISAGREE	TOTAL	WEIGHTED AVERAGE
(no label)	91.67% 11	8.33% 1	0.00% 0	0.00% 0	0.00% 0	12	4.92

The Compliance Team promptly and appropriately addressed my questions and concerns.

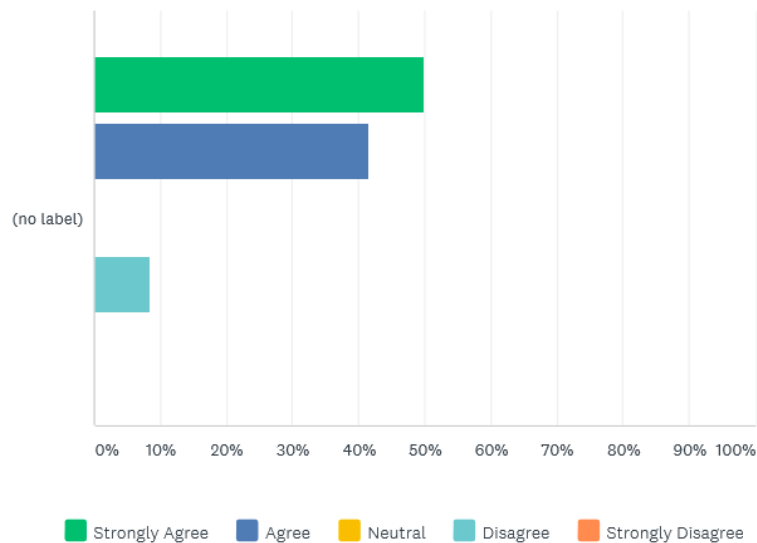
Answered: 12 Skipped: 0



	STRONGLY AGREE	AGREE	NEUTRAL	DISAGREE	STRONGLY DISAGREE	TOTAL	WEIGHTED AVERAGE
(no label)	75.00% 9	25.00% 3	0.00% 0	0.00% 0	0.00% 0	12	4.75

The Pre-Personal Appearance conference call and Power Point helped me prepare for my Personal Appearance.

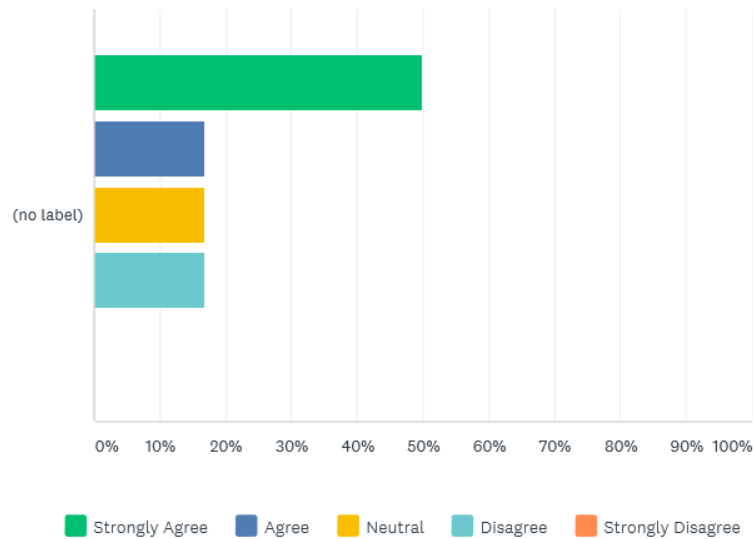
Answered: 12 Skipped: 0



	STRONGLY AGREE	AGREE	NEUTRAL	DISAGREE	STRONGLY DISAGREE	TOTAL	WEIGHTED AVERAGE
(no label)	50.00% 6	41.67% 5	0.00% 0	8.33% 1	0.00% 0	12	4.33

The Personal Appearance before the Commission Panel was constructive and informative.

Answered: 12 Skipped: 0



	STRONGLY AGREE	AGREE	NEUTRAL	DISAGREE	STRONGLY DISAGREE	TOTAL	WEIGHTED AVERAGE
(no label)	50.00% 6	16.67% 2	16.67% 2	16.67% 2	0.00% 0	12	4.00

What did you appreciate most about the Compliance Monitoring Program and why?

Answered: 11 Skipped: 1

Showing 11 responses

☐ Courteous and professional communication.

1/7/2020 6:19 PM

[View respondent's answers](#)

☐ Mike was very helpful and very reassuring, as was the physician assigned to me.

1/7/2020 1:11 AM

[View respondent's answers](#)

☐ Incredible amount of respect for me as a licensee.

1/6/2020 7:11 PM

[View respondent's answers](#)

☐ all the structure and support put in place with my monitoring agreement helped enormously in getting back on my feet professionally and personally

1/3/2020 2:26 AM

[View respondent's answers](#)

☐ The compassion and respect they showed me were very helpful.

1/3/2020 1:43 AM

[View respondent's answers](#)

☐ Clear instructions

1/2/2020 8:45 PM

[View respondent's answers](#)

☐ X

6/5/2019 9:14 PM

[View respondent's answers](#)

☐ I appreciated the compassion that the Mr. Kramer and Dr. Barrret displayed to me as I went through the process.

5/31/2019 11:38 AM

[View respondent's answers](#)

☐ It was clear and well organized

☐ I felt was a constructive,not a punitive, process from the beginning to the and of the process.

5/31/2019 1:28 AM

[View respondent's answers](#)

☐ The willingness of everyone to help, or answer questions.

5/30/2019 8:46 PM

[View respondent's answers](#)

What improvements would you recommend for the Compliance Monitoring Program?

Answered: 11 Skipped: 1

☐ My limited experience revealed no issues with the compliance program.

1/7/2020 6:19 PM

[View respondent's answers](#)

Ac

☐ After my presentation, it seemed like the panel felt that the complaint that led to the stipulation was overstated, and that I was not a risk to patients (as demonstrated by being released early). It seems like a panel approach/personal approach prior to outlining the discipline may be more appropriate.

1/7/2020 1:11 AM

[View respondent's answers](#)

Ac

☐ Can't think of any.

1/6/2020 7:11 PM

[View respondent's answers](#)

Ac

☐ I am currently taking an online ABPN MOC board review course through American Physician Institute. It is comprehensive and I think it would be a good option for those who were out of practice like I was

1/3/2020 2:26 AM

[View respondent's answers](#)

Ac

<input type="checkbox"/>	This went more smoothly than I ever imagined possible.	1/3/2020 1:43 AM	View respondent's answers	Add
<input type="checkbox"/>	None	1/2/2020 8:45 PM	View respondent's answers	Add
<input type="checkbox"/>	X	6/5/2019 9:14 PM	View respondent's answers	Add
<input type="checkbox"/>	I don't have any recommendations on how to improve what is really a very stressful and anxious experience for anyone that goes through it. I greatly appreciated the recommended courses the Dr. Barret provides to me as part of my plan as that is one of the most beneficial parts of the experience.	5/31/2019 11:38 AM	View respondent's answers	Add
<input type="checkbox"/>	I was told a follow up meeting would occur in a year but did not get any verification and thought the meeting was not scheduled. I was informed I needed to appear and had to cancel out of town plans. A verification of the second appearance a couple of months before would have been nice.	5/31/2019 5:46 AM	View respondent's answers	Add
<input type="checkbox"/>	none that I can think of.	5/31/2019 1:28 AM	View respondent's answers	Add
<input type="checkbox"/>	Better accessibility to information online.	5/30/2019 8:46 PM	View respondent's answers	Add

Please add any other feedback you'd like to share with the Compliance Team.

Answered: 10 Skipped: 2

<input type="checkbox"/>	None	1/7/2020 1:11 AM	View respondent's answers
<input type="checkbox"/>	Thank you all so much for allowing me the opportunity to get back to work.	1/3/2020 2:26 AM	View respondent's answers
<input type="checkbox"/>	Thank you for the kindness and consideration you showed me.	1/3/2020 1:43 AM	View respondent's answers
<input type="checkbox"/>	Thanks	1/2/2020 8:45 PM	View respondent's answers



X

6/5/2019 9:14 PM

[View respondent's answers](#)

[Add tag](#)



I understand the need to be disciplinary in nature, but the confrontational approach (particular of the lawyers in the board) was a little excessive.

5/31/2019 11:38 AM

[View respondent's answers](#)

[Add tag](#)



I would like to thank ,all the members that helped me through the process

5/31/2019 1:28 AM

[View respondent's answers](#)

[Add tag](#)



I think it is important to recognize that every case is different and needs adjustment in procedures for all parties.

5/30/2019 8:46 PM

[View respondent's answers](#)

[Add tag](#)

Optional: Add your name to be identified with your feedback.

Answered: 6 Skipped: 6



Emma Grabinski

1/7/2020 1:11 AM

[View respondent's answers](#)



Patricia O'Rourke, MD

1/3/2020 1:43 AM

[View respondent's answers](#)



David W Newell

1/2/2020 8:45 PM

[View respondent's answers](#)



X

6/5/2019 9:14 PM

[View respondent's answers](#)



Richard Zahn MD

5/31/2019 1:28 AM

[View respondent's answers](#)



Ricardo Melendrez

5/30/2019 8:46 PM

[View respondent's answers](#)

Panel A

Meeting Agenda

Friday, January 17, 2020 at 9:45 am
Hotel Interurban - Olympic Room
223 Andover Park E, Tukwila, Washington 98188

Panel Members: Jimmy Chung, MD, Panel Chair Charlotte Lewis, MD Jason Cheung, MD
Charlie Browne, MD Warren Howe, MD Robert Small, MD
Yanling Yu, PhD, Public Member Harry Harrison, Jr., MD James Anderson, PA-C
Scott Rodgers, Public Member Candace Vervair, Public Member Richard Wohns, MD

Compliance Officer: Amanda Weyrauch

9:45am	Personal Appearance Ray F. Smith, MD Attorney: Pro Se	M2018-593 (2018-4031) RCM: Harry Harrison, MD SA: Ariele Page Landstrom
10:30am	Personal Appearance Charles C. Sung, MD Attorney: Robert G. Schultz	M2017-514 (2016-5807 et al.) RCM: Jason Cheung SA: Ariele Page Landstrom
11:15am	Personal Appearance James K. Rotchford, MD Attorney: Jennifer Smitrovich	M2017-1016 (2016-12817 et al.) RCM: Robert Small, MD SA: Kyle Karinen
LUNCH BREAK		
1:15pm	Personal Appearance Joseph I. Webb, PA-C Attorney: Christopher J. Mertens	M2019-364 (2018-5731) RCM: Jimmy Chung, MD SA: Kyle Karinen
2:00pm	Personal Appearance Johnathan R. Perry, MD Attorney: Christopher J. Mertens	M2019-366 (2018-5735) RCM: Jimmy Chung, MD SA: Trisha Wolf
2:45pm	Personal Appearance Christopher J. Godbout, MD Attorney: Pro Se	M2017-823 (2016-11981) RCM: James Anderson, PA-C SA: Trisha Wolf

NOTICE THIS MEETING IS ACCESSIBLE TO PERSONS WITH DISABILITIES. SPECIAL AIDS AND SERVICES CAN BE MADE AVAILABLE UPON ADVANCE REQUEST. FOR INFORMATION AND ASSISTANCE, CALL 1-800-525-0127 OR, IF CALLING FROM OUTSIDE WASHINGTON STATE, CALL (360) 753-2870. TDD MAY ALSO BE ACCESSED AT THE 800 NUMBER ABOVE (PLEASE WAIT TO BE TRANSFERRED) OR BY CALLING (360) 236-4791. SMOKING IS PROHIBITED AT THIS MEETING.

Panel B

Meeting Agenda

Friday, January 17, 2020 at 9:45 am
Hotel Interurban - Baker Room
223 Andover Park E, Tukwila, Washington 98188

Panel Members: April Jaeger, MD, Chair Alden Roberts, MD Toni Borlas, Public Member
Diana Currie, MD Theresa Schimmels, PA-C Claire Trescott, MD
Terry Murphy, MD Karen Domino, MD John Maldon, Public Member
Christine Hearst, Public Member
Compliance Officer: Mike Kramer

9:45 am	Personal Appearance John F. Gillman, MD Attorney: John E. Turner	M2015-406 (2014-8152 et al.) RCM: Tony Borlas SA: Rick Glein
10:30 am	Personal Appearance Rachel M. Knox, MD Attorney: Pro Se	M2017-1018 (2016-8584) RCM: Theresa Schimmels, PA-C SA: Gordon Wright
11:15 am	Personal Appearance David G. Knox, MD Attorney: Pro Se	M2017-1020 (2016-8585) RCM: Theresa Schimmels, PA-C SA: Gordon Wright
LUNCH BREAK		
1:15 pm	Personal Appearance John C. Chen, MD Attorney: Pro Se	M2014-1098 (2013-8298) RCM: Peter Marsh, MD SA: Trisha Wolf

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For Your Information





December 24, 2019

Washington Medical Commission
Chris Waterman
111 Israel Rd SE
Olympia, WA 98501

Dear Friends:

We're so grateful for your thoughtful donation of hygiene items and blankets to SafePlace. We couldn't do this without you- survivors are able to access the services, shelter and advocacy they need because of your gift. We are so thankful to share community with people like you.

Because of your donation, SafePlace is able to offer holistic, creative support to survivors through services like our Housing Program. "Janet" recently sent a note to a SafePlace case manager who helped her find stable housing for her family. She wrote:

"We moved into a duplex. The kids are in a good school district, a safe area and lots of nature! I'm about halfway through my schooling program!!! It's been a tough road but I am so thankful for everything SafePlace did for my children and I, and especially you going above and beyond for us. I will never forget it!! It will come back to you and the organization. Thank you so much!"

Your support has a direct impact on the lives of people like "Janet" and her family. Your gift gives survivors the freedom, space and resources to heal from the trauma of abuse and start their lives in a new, peaceful direction. Thank you for helping survivors who use our services grow, thrive and find safety. We treasure you.

Best wishes in the New Year,

Ellie Parrish
Development Coordinator

For your tax records:

Date Received: 12/24/2019

Please consider including SafePlace in your will, trust or estate plan.
SafePlace is a non-profit organization as described in IRS code 501(c)(3).
No goods, benefits or services were provided in return for this contribution.

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JAN 08 2020