WASHINGTON

Medical Commission

Licensing. Accountability. Leadership.

Regular Meeting & Rules Hearing

August 21-22, 2025

Meeting Agenda
August 21-22, 2025 – 3rd Revised

WASHINGTON Medical Commission
Licensing. Accountability. Leadership.

In accordance with the Open Public Meetings Act, this meeting notice was sent to individuals requesting notification of the Department of Health, Washington Medical Commission (WMC) meetings. This agenda is subject to change. The WMC will accept public comments at the Business Meeting. To request this document in another format, call 1-800-525-0127. Deaf or hard of hearing customers, please call 711 (Washington Relay) or email doh.information@doh.wa.gov.

These meetings will be hybrid. Participants can attend either in person or virtually.
In-person location: DOH TC2, 111 Israel Rd SE, Tumwater, WA
Virtual via Teams: Meeting and registration links can be found below.

Time	Thursday – August 21, 2025		Room
Open Sessions			
Personal Appearances			
8:30 am	Panel A – Meeting Link: 8/21/2025 Panel A	Page 16	166
8:30 am	Panel B – Meeting Link: 8/21/2025 Panel B	Page 17	167
Closed Sessions			
Case Disposition			
9:15 am	Panel A		166
9:45 am	Panel B		167
Noon	Lunch Break		153
Case Disposition			
12:30 pm	Panel A		166
12:30 pm	Panel B		167

Time	Friday – August 22, 2025	
Closed Session		
8:15 am – 9:15 am	High Reliability Organizations (HiRO) Workgroup	236
Open Session		
	Rules Hearing	
9:30 am	**Establishing the Use of Nitrous Oxide in Office-Based Surgical Settings**	**166/167**

To attend virtually, please register for this meeting at: WMC Rules Hearing

Hearing Notice

Agenda	Presented By:	Page(s)
Housekeeping	Amelia Boyd	

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Agenda continued	Presented By:	Page(s)
• Call for questions regarding the rule or hearing process • Call for testimony from the public and interested parties regarding proposed language	Karen Domino, MD	
• Call for written comments		
○ Washington State Medical Association		18
○ Planned Parenthood Alliance Advocates WA		19-21
○ Cedar River Clinics		22-24
• Commissioners discuss comments and proposed language • Vote		
Hearing closed by Presiding Officer		
CR-102, Proposed Rules, document	CR-102	Pages 25-29

Optional Break The Chair will announce the designated time to reconvene.

Open Session 166/167

Business Meeting

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

1.0 Chair Calls the Meeting to Order

2.0 Public Comment

The public will have the opportunity to provide comments. If you wish to speak, please use the Raise Hand function, and you will be called upon. Keep your comments brief, and when the Chair opens the floor, state your name and, if applicable, the organization you represent. If you would prefer to submit written comments, send them to amelia.boyd@wmc.wa.gov by **August 18, 2025**. ***Please do not use this public comment period to address disciplinary cases or issues that the WMC is currently covering in its rulemaking or policy efforts. If you wish to comment on rules currently under development, to ensure your comments are considered as part of rulemaking, visit our "Rules in Progress" page and select the specific rule from the "Current Rules in Progress" table. We also welcome you to attend and comment at our rulemaking workshops and hearings. The schedule for these meetings can be found on our "Rules in Progress page. For feedback on WMC policies, guidelines, or interpretive statements, you may email medical.policy@wmc.wa.gov or provide verbal comments at one of the upcoming Policy: Interested Parties or Policy Committee meetings. You can find the schedule for these meetings on the Policy Meetings page.***

Disclaimer: The WMC accepts written comment into the record as a normal course of the Business Meeting. On a case-by-case basis, the WMC will, at its sole discretion, grant a request to verbally read a comment into the record. Comments containing profanity, discriminatory language, ad hominem attacks on Commissioners or staff, threats of violence, or discussion of active cases or litigation before or involving the WMC will not be read. The comment will still be included in the packet for consideration and awareness.

2.1 The Chair will call for comments from the public.

3.0 Chair Report

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4.0 Consent Agenda

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

4.1 Agenda – Approval of the August 22, 2025, Business Meeting agenda. Pages 2-6

4.2 Minutes – Approval of the May 9, 2025, Business Meeting minutes. Pages 30-35

5.0 New Business

5.1 **DOH letter regarding the 2025 FIFA World Cup events in Seattle** **Informational**
Kyle Karinen, Executive Director, will present this letter for discussion. Pages 36-37

5.2 **Commissioner Retreat 2026** **Action**
The following dates are proposed to hold the Commissioner Retreat in 2026:

- Thursday, March 11
- Thursday, April 30
- Thursday, June 11
- Thursday, July 30
- Thursday, September 17
- Thursday, October 22

Refer to pages 38-41 of this packet to see how these proposed dates align with our approved 2026 schedule.

5.3 **2026 Request Legislation** **Action**
Micah Matthews, Deputy Executive Director, will present and request approval of the following:

- Open Public Meetings Act Revision Pages 42-43
- Relinquishing a License Pages 44-46
- Certified Anesthesiologist Assistants Surcharges Page 47

5.4 **Delegation of Decision Making to Health Law Judges** **Action**
Mike Farrell, Supervising Staff Attorney, will present this item for discussion and vote. Pages 48-50

6.0 Old Business

6.1 **Committee/Workgroup Reports** Update
The written reports are on page 53. The Chair will call for additional reports. See pages 51-52 for a list of committees and workgroups.

6.1.1 Psychedelic Medications in Behavioral Health Treatment Workgroup Report Update Pages 54-138

6.2 **Rulemaking Activities** Report
Rules Progress Report provided on page 139.

6.2.1 The Preproposal Statement of Inquiry, or CR-101, for chapter 246-919 WAC MD Physicians – WAC 246-919-010 through WAC 246-919-520 and WAC 246-919-602 through WAC 246-919-700 was filed on May 22, 2025, as WSR #25-12-014. Update & Request

Amelia Boyd, Program Manager, will request volunteers from the Commission to serve as panelists for this

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rulemaking effort. At least three Commissioners are needed to participate in the upcoming workshops, the first of which is scheduled for September 25, 2025.

6.2.2 **Rescind Rulemaking Approval** — **Action**

On October 20, 2023, the Commissioners approved initiating rulemaking to add a definition of "qualified physician" to the physician chapter 246-919 WAC. This action was related to the expansion of the optometrist scope of practice. Since then, you have adopted an Interpretive Statement titled *"Qualified Physician" Under Optometry Law* (INS2025-01). We strive to incorporate existing interpretive statements into our rules whenever possible, and many sections of the physician chapter are currently open for revision. We request that Commissioners rescind their prior approval to initiate separate rulemaking on this subject, as we plan to incorporate the interpretive statement into the broader physician chapter rulemaking effort.

Interpretive Statement on pages 140-141

6.3 **Delegation of Signature Authority for Credentialing, Disciplinary and Rulemaking** — **Action**

With the recent election of a new Chair, this document has been updated. Commissioners are asked to review and consider it for adoption.

Pages 142-144

6.4 **Lists & Labels Request**

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)).

6.4.1 Contemporary Psychodynamic Institute — Pages 145-159

7.0 Policy Committee Report

Christine Blake, Public Member, Chair, will report on items discussed at the Policy Committee meeting held on July 24, 2025. The agenda was as follows: — Report/Action

7.1 **Guidance Document: A Collaborative Approach to Reducing Medical Error and Enhancing Patient Safety (GUI2014-02)** — Deferred

This document was reviewed as part of its scheduled four-year review process. The Committee recommended deferring this document for additional work based on comments received.

7.2 **Guidance Document: Medical Professionalism** — Pages 160-164

This document was reviewed as part of its scheduled four-year review process. The Committee recommended approving this document with the noted amendments.

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7.3	**Procedure: Interactive and Transparent Development of Evidence-based Policies and Guidelines (PRO2018-02)** This document was reviewed as part of its scheduled four-year review process. The Committee recommended approving this document with the noted amendments.	Pages 165-167

8.0 Member Reports

The Chair will call for reports from Commission members.

9.0 Staff Member Reports — Written reports Pages 168-179

The Chair will call for further reports from staff.

10.0 AAG Report

Heather Carter, AAG, may provide a report.

11.0 Fiscal Year 2025 Performance Measures — Update

Mr. Karinen will present this item.

12.0 Adjournment of Business Meeting

Informational

Hearing Schedule	Page 7
2025 Meeting Schedule	Pages 8-11
2026 Meeting Schedule	Pages 12-15

Correspondence

FDA letter regarding cagrilintide	Pages 180-181
P3 Alliance Proposed Additions to "Medical Professionalism" Guidance	Pages 182-183

Open Session — Room(s)

Noon Lunch & Learn — **166/167**

Register to attend this virtual meeting here: https://tinyurl.com/mpv4cbd7

Quick Facts Pages 184-185

Washington Physicians Health Program Annual Report

Chris Bundy, MD, Executive Medical Director, will present the 2024 WPHP Annual Report, highlighting the program's impact, participant outcomes, and continued collaboration with the WMC to support clinician health and patient safety through non-punitive, recovery-focused approaches.

WPHP 2024 Report Pages 186-248

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FORMAL HEARING SCHEDULE

WASHINGTON Medical Commission
Licensing. Accountability. Leadership.

DISCLAIMER: THE BELOW HEARING SCHEDULE IS SUBJECT TO CHANGE.

Hearing Date	Respondent	Case No.	Location
August 2025			
NO HEARINGS SCHEDULED THIS MONTH			
September 2025			
NO HEARINGS SCHEDULED THIS MONTH			
October 2025			
October 10	Bunin, Alan, MD	M2024-631	TBD
October 10	Kane, Sean, MD	M2022-835	TBD
October 13-17	Siler, Thomas, T., MD	M2022-366	TBD
October 21-23	Hammel, James F., MD	M2023-493	Hybrid
October 22-24	Steneker, Sjardo, MD	M2024-204	TBD
November 2025			
November 14	Spolar, Trenton J., MD	M2024-1007	TBD
December 2025			
December 3-5	Mulholland, Mark, MD	M2024-199	TBD
December 12	Janson, Vida, MD	M2024-1003	TBD

Information on how to observe a hearing can be obtained from the Adjudicative Clerk Office, (206) 391-5193.

2025 Meeting Schedule

WASHINGTON Medical Commission
Licensing. Accountability. Leadership.

January

S	M	T	W	T	F	S
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5	6	7	8	9	10	11
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1	New Years Day	Holiday – Offices Closed	
2	Policy Committee	4 pm	Virtual
9	Personal Appearances	8:30 am	Virtual
9	Case Disposition	10:45 am	Virtual
10	Committees/Workgroups	8:30 am	Virtual
10	Business	9:30 am	Virtual
10	Lunch & Learn	Noon	Virtual
20	Martin Luther King Day	Holiday – Offices Closed	
30	Policy: Interested Parties	10 am	Virtual

February

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17	President's Day	Holiday – Offices Closed	
27	Policy Committee	4 pm	Virtual

March

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13	Personal Appearances	8:30 am	Hybrid Capital Event Center (ESD 113) 6005 Tyee Drive SW, Tumwater
13	Case Disposition	10:45 am	
14	Committees/Workgroups	8:30 am	
14	Business	9:30 am	
14	Lunch & Learn	Noon	
27	Policy: Interested Parties	10 am	Virtual

2025 Meeting Schedule

WASHINGTON Medical Commission
Licensing. Accountability. Leadership.

April

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18	SMART Training	8:30 am	Hilton Seattle Airport 17620 Intl. Blvd.

May

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1	Policy Committee	4 pm	Virtual
8	Personal Appearances	8:30 am	Hybrid Capital Event Center (ESD 113) 6005 Tyee Drive SW, Tumwater
8	Case Disposition	10:45 am	
9	Committees/Workgroups	8:30 am	
9	Business	9:30 am	
9	Lunch & Learn	Noon	
26	Memorial Day	Holiday – Offices Closed	

June

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19	Juneteenth	Holiday – Offices Closed	
26	Policy: Interested Parties	10 am	Virtual

July

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4	Independence Day	Holiday – Offices Closed	
10	Personal Appearances	8:30 am	Virtual
10	Case Disposition	10:45 am	Virtual
24	Policy Committee	4 pm	Virtual

2025 Meeting Schedule

WASHINGTON Medical Commission
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August

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21	Personal Appearances	8:30 am	Hybrid DOH TC2 Rm 166/167 111 Israel Rd SE Tumwater
21	Case Disposition	10:45 am	
22	Committees/Workgroups	8:30 am	
22	Business	9:30 am	
22	Lunch & Learn	Noon	

September

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1	Labor Day	Holiday – Offices Closed	
25	Policy: Interested Parties	10 am	Virtual

October

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2	Personal Appearances	8:30 am	Virtual
2	Case Disposition	10:45 am	Virtual
30	Policy Committee	4 pm	Virtual

2025 Meeting Schedule

WASHINGTON Medical Commission
Licensing. Accountability. Leadership.

November

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11	Veterans Day	Holiday – Offices Closed	
20	Personal Appearances	8:30 am	Hybrid DOH TC2 Rm 166/167 111 Israel Rd SE Tumwater
20	Case Disposition	10:30 am	
21	Committees/Workgroups	8:30 am	
21	Business	9:30 am	
21	Lunch & Learn	Noon	
27	Thanksgiving Day	Holiday – Offices Closed	
28	Native American Heritage Day	Holiday – Offices Closed	

December

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4	Policy: Interested Parties	10 am	Virtual
25	Christmas	Holiday – Offices Closed	

Association Meetings

Association	Date(s)	Location
Washington Academy of Physician Assistants (WAPA) & Oregon Society of Physician Associates (OSPA) Joint Spring Conference	March 9-11, 2025	Portland, OR
Washington State Medical Association (WSMA) Annual Meeting	September 20-21, 2025	Bellevue, WA
WAPA Fall Conference	October 14-17, 2025	Tulalip, WA

Other Meetings

Entity	Date(s)	Location
Council on Licensure, Enforcement and Regulation (CLEAR) Winter Symposium	January 15, 2025	Savannah, GA
Federation of State Medical Boards (FSMB) Annual Conference	April 25-26, 2025	Seattle, WA
FSMB International Conference	September 3-6, 2025	Dublin, Ireland
CLEAR Annual Conference	September 15-18, 2025	Chicago, IL
FSMB Board Attorneys Workshop	November 6-7, 2025	Philadelphia, PA

2026 Meeting Schedule

WASHINGTON Medical Commission
Licensing. Accountability. Leadership.

January

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1	New Years Day	Holiday – Offices Closed	
8	Policy Committee	4 pm	Virtual
15	Personal Appearances	8:30 am	Virtual
15	Case Disposition	10:45 am	Virtual
16	Committees/Workgroups	8:30 am	Virtual
16	Business	9:30 am	Virtual
16	Lunch & Learn	Noon	Virtual
19	Martin Luther King Day	Holiday – Offices Closed	
29	Policy: Interested Parties	10 am	Virtual

February

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16	President's Day	Holiday – Offices Closed	
26	Policy Committee	4 pm	Virtual

March

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12	Personal Appearances	8:30 am	Hybrid Location: TBD
12	Case Disposition	10:45 am	
13	Committees/Workgroups	8:30 am	
13	Business	9:30 am	
13	Lunch & Learn	Noon	
26	Policy: Interested Parties	10 am	Virtual

2026 Meeting Schedule

WASHINGTON Medical Commission
Licensing. Accountability. Leadership.

April

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17	SMART Training	8:30 am	In person Location: TBD
23	Policy Committee	4 pm	Virtual

May

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7	Personal Appearances	8:30 am	Hybrid Location: TBD
7	Case Disposition	10:45 am	
8	Committees/Workgroups	8:30 am	
8	Business	9:30 am	
8	Lunch & Learn	Noon	
25	Memorial Day	Holiday – Offices Closed	

June

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19	Juneteenth	Holiday – Offices Closed	
25	Policy: Interested Parties	10 am	Virtual

July

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3	Independence Day (observed)	Holiday – Offices Closed	
9	Personal Appearances	8:30 am	Virtual
9	Case Disposition	10:45 am	Virtual
23	Policy Committee	4 pm	Virtual

2026 Meeting Schedule

WASHINGTON Medical Commission
Licensing. Accountability. Leadership.

August

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7	Labor Day	Holiday – Offices Closed	
24	Policy: Interested Parties	10 am	Virtual

October

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8	Personal Appearances	8:30 am	Virtual
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2026 Meeting Schedule

WASHINGTON Medical Commission
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November

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20	Business	9:30 am	
20	Lunch & Learn	Noon	
26	Thanksgiving Day	Holiday – Offices Closed	
27	Native American Heritage Day	Holiday – Offices Closed	

December

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3	Policy: Interested Parties	10 am	Virtual
25	Christmas	Holiday – Offices Closed	

Association Meetings

Association	Date(s)	Location
Washington Academy of Physician Assistants (WAPA) & Oregon Society of Physician Associates (OSPA) Joint Spring Conference	TBA	TBA
Washington State Medical Association (WSMA) Annual Meeting	TBA	TBA
WAPA Fall Conference	TBA	TBA

Other Meetings

Entity	Date(s)	Location
Council on Licensure, Enforcement and Regulation (CLEAR) Winter Symposium	TBA	TBA
Federation of State Medical Boards (FSMB) Annual Conference	TBA	TBA
FSMB International Conference	TBA	TBA
CLEAR Annual Conference	TBA	TBA
FSMB Board Attorneys Workshop	TBA	TBA

WASHINGTON Medical Commission
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Panel A
Personal Appearance Agenda

Thursday, August 21, 2025

Meeting Link: Panel A - Personal Appearances

Panel Members:	Harlan Gallinger, MD, Panel Chair	Daniel Cabrera, MD	Jimmy Chung, MD	Arlene Dorrough, PA-C
	Anjali D'Souza, MD	Jamie Koop, Public Member	Sarah Lyle, MD	Elisha Mvundura, MD
	Douglas Pullen, Public Member	Scott Rodgers, Public Member		
	Penny Reck, MD, Pro-Tem	Robert Bernstein, MD, Pro-Tem	Charlie Browne, MD, Pro-Tem	Peter Casterella, MD, Pro-Tem
	Peggy Hutchison, MD, Pro-Tem			

Compliance Officer: Anthony Elders

8:30 a.m.	**Fadi Alhafez, MD** Attorneys: Natalie A. Heineman Nicole T. Morrow	M2021-656 (2021-3434, 2023-106) RCM: Anjali D'Souza, MD SA: Lisa Krynicki

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WASHINGTON Medical Commission
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Panel B

Personal Appearance Agenda

Thursday, August 21, 2025

Meeting Link: Panel B - Personal Appearances

Panel Members:	Chair: Terry Murphy, MD	Michael Bailey, Public Member	Christine Blake, Public Member	Toni Borlas, Public Member
	Po-Shen Chang, MD	Diana Currie, MD	Karen Domino, MD	April Jaeger, MD
	Ed Lopez, PA-C	Claire Trescott, MD	Richard Wohns, MD	
	Hal Goldberg, MD, Pro-Tem	John Maldon, Public Member, Pro-Tem		

Compliance Officer: Mike Kramer

8:30 a.m.	**Michael K. Turner, MD** Attorneys: Simon Peter Serrano Karen Osborne Emily Ling	M2022-194 (2022-8893 et al.) RCM: April Jaeger, MD SA: Mike Farrell
9:00 a.m.	**Jeong H. Kim, MD** Attorney: Jennifer Smitrovich	M2019-699 (2018-17462) RCMs: Claire Trescott, MD, John Maldon SA: Sara Kirschenman

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From: Billie Dickinson
To: Boyd, Amelia (WMC)
Cc: Jeb Shepard; Susanna Waldman; Hillary Norris
Subject: WSMA support for CR-102 re nitrous oxide/office-based settings
Date: Monday, July 28, 2025 11:08:44 AM
Attachments: image001.png

External Email

Hi Amelia,

Hope the summer is treating you well. Consistent with our previous comments on this rulemaking, the WSMA is supportive of the CR-102 specific to nitrous oxide in office-based settings. The language will ensure patient safety by applying consistent standards for competency and the use of nitrous oxide in office-based settings. We've really appreciated the opportunity to work with WMC commissioners and staff on this rulemaking, as well as revisions to the interpretive statement that previously governed this area of practice, and we look forward to this rule taking effect in the coming months.

Thanks again for all your hard work on this rule and the countless others you facilitate!

-Billie

Billie Dickinson
Associate Director of Policy
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WSMA Washington State Medical Association
Physician Driven, Patient Focused

August 15, 2025

Washington State Medical Commission
P.O. Box 47866
Olympia, WA 98504

Delivered electronically to medical.rules@wmc.wa.gov

Dear Amanda Boyd and the Washington State Medical Commission,

On behalf of Planned Parenthood organizations in Washington state, Planned Parenthood Alliance Advocates – Washington appreciates the opportunity to provide feedback on WSR 25-14-080, Office-Based Surgery Rules for Allopathic Physicians (MD) - Use of nitrous oxide, which proposes to create WAC 245-919-603, Use of nitrous oxide in office-based settings. As currently drafted, we have deep concerns that this regulation will either force health centers like Planned Parenthood to cease providing this critical service or significantly increase the costs of care for patients. This regulation is more restrictive than the previous interpretive guidance from the Medical Commission that has been guiding the safe and effective use of nitrous oxide in clinic settings since 2023. Specifically, the new requirement that a licensed health care provider administer nitrous oxide, in effect requiring two licensed personnel for each procedure, as well as the rigid mandate for a scavenging system, would present a significant barrier for many providers. If implemented with those requirements, some Planned Parenthood health centers may either be forced to cease the service or temporarily stop while investing in new staffing models, driving up health care costs in the process.

For many patients, nitrous oxide is an excellent option for minimal sedation when getting minor procedures like IUD insertions and removals, colposcopy, LEEP, and procedural abortions early in pregnancy. There is growing recognition that these in-office gynecologic procedures cause patients significant pain and that providers have historically underestimated that pain.[1] Indeed, the American College of Obstetricians and Gynecologists recommends that providers undertake "comprehensive pain-management counseling" for in-office procedures, which includes counseling on available sedation and anesthesia options[2].

Nitrous oxide reduces anxiety and pain during in-clinic procedures, is a safe and effective option for patients with substance use disorder, and reduces transportation barriers for patients who do

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[1] Alisha Haridasani Gupta, *Getting an IUD Hurts. Why Aren't More Women Offered Relief?*, N.Y. Times (updated Sept. 5, 2024), https://www.nytimes.com/2023/12/14/well/live/iud-insertion-pain-relief.html

[2] ACOG, Pain Management for In-Office Uterine and Cervical Procedures (July 2025), https://www.acog.org/clinical/clinical-guidance/clinical-consensus/articles/2025/05/pain-management-for-in-office-uterine-and-cervical-procedures

not have a support person to assist them after a procedure. Planned Parenthood health centers are proud to provide this option and urge the Medical Commission to adopt a final regulation that does not harm providers' ability to offer this pain management option.

We request that the requirement for a licensed providers administer nitrous oxide be eliminated to allow other support staff such as medical assistants to administer and monitor patients:

As currently drafted, section (2)(c)(v) mandates that a "licensed healthcare provider" (who is not the physician performing the procedure) administer the nitrous oxide. This portion of the regulation would require significant changes to staffing models for many reproductive health providers, including Planned Parenthood, that are not necessary for patient safety. For simple gynecological procedures, most clinic-based practices do not have both a physician and a licensed provider in the room and mandating that practice is not necessary for patient safety. For these procedures, Planned Parenthood employs non-licensed staff like certified and registered medical assistants to assist physicians and licensed advanced practice clinicians, such as physician assistants, whose scope of practice allows them to perform some gynecologic procedures. These staff are well-trained and routinely staff procedures and monitor patient vitals in clinics. The implementation of this new requirement would cause a major overhaul in staffing models that would disrupt clinic operations and lead to increased operational costs.

This requirement is also more restrictive than current clinic-based practice: the Medical Commission's interpretative statement states that physicians must not also administer or monitor patients, but this guideline does not include the mandate that the administrator be a licensed provider. Under current law, a certified or registered medical assistant, for example, can assist the physician with administration and monitoring. We also note that the proposed rule's prohibition is the same for moderation sedation administration, *see* WAC 246-919-601(10), even though nitrous oxide does not carry the same risks as intravenous sedation.

We urge the commission to eliminate 2(c)(v) and continue with existing guidance that the physician or clinician providing the procedure themselves cannot be the administrator, or otherwise allowing unlicensed, trained medical personnel to assist with administration and monitoring.

We urge the Commission to consider flexible alternatives to the new mandate that providers must use scavenging system to remove excess nitrous oxide from the procedure room:

Section 2(c)(x) introduces a new mandate requiring that clinics have a scavenging system and requires excess nitrous oxide be removed from the procedure room. Such a rigid mandate is not necessary to ensure safe exposure. Indeed, the CDC and OSHA recommend providers consider other controls, including ventilation and certain work practices.[3] The previous interpretative

[3] OSHA, https://www.osha.gov/waste-anesthetic-gases/workplace-exposures-guidelines#:~:text=A%20nonrecirculating%20ventilation%20system%20can,duct%20system%2C%20and%20an%20adsorber; CDC, https://www.cdc.gov/niosh/docs/hazardcontrol/hc3.html

statement did not mandate a scavenging system, and providers have been safely and effectively following that guidance without safety concerns or incidents. The implementation of this rule would require providers to invest heavily in facility renovations and upgrades to provide this very basic service, which could be cost-prohibitive and lead to the cessation of services given the funding constraints faced by safety-net providers. It is also worth noting that dentists, the health care providers who most frequently and routinely administer nitrous oxide, are not subject to the same scavenging system requirement. We encourage the Medical Commission to remove section 2(c)(x) or otherwise allow flexible alternatives to ensure safe exposure to nitrous oxide.

Medical Commission rulemaking on nitrous oxide administration should coincide with the Board of Nursing's rulemaking:

While we understand that the Board of Nursing and Medical Commission operate independently and the commission has been engaging in stakeholder engagement on this rule for over a year, we have concerns that the Department of Health may adopt contradictory regulations on inconsistent timelines. Given that providers are already safely relying on the guidance in the 2023 interpretive statement, we recommend that the Medical Commission pause on issuing a second CR-102 until the Board of Nursing has the opportunity to engage in its own rulemaking. By potentially introducing a regulatory scheme that creates inconsistency and contradictory requirements for physicians and other advanced practice clinicians, medical practices will be in a place of ambiguity around what is permitted in office-based practices.

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Planned Parenthood organizations in Washington are proud to provide nitrous oxide as pain and anxiety management option. Health centers have already invested in equipment, supplies, and training to offer the service. We appreciate that the Medical Commission is moving forward to provide more certainty and guidance around safety measures when administering nitrous oxide in clinic settings, but we have deep concerns that the regulation will curtail the provision of this service — or halt it altogether. As currently drafted, many providers would need to overhaul their staffing model or cease providing the service. Given the tight financial environment for safety-net providers, we fear that it is more likely that clinics will cease the provision of nitrous oxide due to cost and operational constraints. We respectfully urge the commission to issue a second CR-102 that include the adjustments proposed above to ensure time for more stakeholder engagement and appropriate alignment with Nursing Commission rulemaking, which we understand to be underway at the department.

Sincerely,

Jennifer M. Allen
Chief Executive Officer, Planned Parenthood Alliance Advocates – Washington

CEDAR RIVER CLINICS RENTON TACOMA YAKIMA

April 15, 2025

Washington Medical Commission
P.O. Box 47866
Olympia, WA 98504-7866

Dear Washington Medical Commission,

Cedar River Clinics is a reproductive health care provider that offers reproductive and gender affirming care. Cedar River Clinics was founded in 1979 and has locations in Renton, Tacoma, and Yakima and importantly serves as a safety net abortion provider. As such, we use nitrous oxide in our office-based settings and would like to offer the comments below.

Cedar River Clinics offers nitrous oxide to our patients as a modality of pain management. We care for patients who have experienced trauma, either physical, sexual, or with previous medical procedures, and who have anxiety about procedures being performed on their bodies.

The amendments being suggested are clearly aimed at office-based settings that use **continuous** flow nitrous oxide devices. However, thousands of clinics nationwide, such as Cedar River Clinics, use **demand** flow nitrous oxide devices for medical office-based procedures. The proposed rule language, as currently drafted, appears to apply to both continuous flow as well as demand flow nitrous oxide devices which are vastly different in their delivery of nitrous oxide, environmental impact, and sedation level. Without further clarification in the proposed rule, the current proposal would detrimentally impact patients and clinics that use demand flow nitrous oxide devices.

We would like to address two serious issues within the proposed rule for which we ask for both types of devices to be addressed and accounted for.

1. (x) Excess nitrous oxide must be removed from the procedure room to protect staff via a scavenging system;"

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Renton, WA 98055
TEL 425.255.0471
FAX 425.255.0262

TACOMA CLINIC
1401 Martin Luther King Jr. Way
Tacoma, WA 98405
TEL 253.473.6031
FAX 253.475.5949

YAKIMA CLINIC
106 East E Street
Yakima, WA 98901
TEL 509.575.6473
FAX 509.575.0477

FINANCIAL OFFICE
917 Triple Crown Way
Suite 110, Yakima, WA 98908
TEL 509.575.6473
FAX 509.575.0477

APPOINTMENTS 800.572.4223 | **friends@cedarriverclinics.org** | **www.CedarRiverClinics.org**

Scavenging systems are primarily required for continuous flow nitrous oxide devices. Demand flow nitrous oxide devices are manufactured to **not** require a scavenging system because the environmental load of nitrous is low and falls below the OSHA established limits. Demand flow nitrous oxide devices use environmental monitoring (semi-annual nitrous level checks), such as Dosimeter Badges, to ensure we are below OSHA standards.

We ask that the rule change differentiate between the two types of nitrous oxide flow devices. For example: "(x) If a continuous flow nitrous oxide device is used, excess nitrous oxide must be removed from the procedure room to protect staff via a scavenging system; If a demand flow nitrous oxide device is used, environmental monitoring (semi-annual checks) is required to ensure the environmental load of nitrous oxide continues to fall below the established OSHA limits;"

Rational for requested change: Requiring a scavenging system of clinics using demand flow nitrous oxide devices would be unnecessary as they are not needed by manufacturing design. In addition, it would financially impact clinics due to potentially significant construction and/or plumbing costs to add a scavenging system. Forcing clinics to invest in and use a scavenging system, if their environmental levels are well below what is considered safe by OSHA, is a financial burden that does not increase safety. Not accounting and allowing for demand flow nitrous oxide devices would mean that many clinics would lose the ability to provide nitrous oxide to patients. This would be detrimental to patient services, patient choice and experience with pain management, and it would make expensive equipment obsolete.

2. Section C (iii)-(v): The safeguards of the clinic regarding administration of nitrous oxide.

   This section should be written to specify that it is required of continuous flow nitrous oxide devices, but not for demand flow nitrous oxide devices. Demand flow nitrous oxide devices are controlled by the patient while monitored by clinical staff. It is manufactured and used in practice as a form of minimal sedation, and it does not require the same level of monitoring as moderate or deep sedation. For demand flow nitrous oxide devices, it would simply be required that a licensed provider be present in the room while the patient is self-administering the medication.

   Another simpler, straightforward option to address the differences in the two types of nitrous oxide devices would be to provide an introduction note that stipulates, “These rules and criteria apply only to the use of continuous flow nitrous oxide devices when used in office-based settings. If demand flow nitrous oxide devices are being used, they are exempt but are required to use environmental monitoring to establish and document that nitrous

oxide levels remain under the established OSHA guidelines and must follow existing laws and standards regarding minimal sedation (ref. WAC 246-919-601)."

As mentioned above, Cedar River Clinics offers nitrous oxide to our patients for pain management and in particular for patients who have experienced trauma and who have anxiety surrounding the procedures being performed on their bodies. Having a variety of sedation options, including nitrous oxide, gives patients control and choice about how to proceed with their medical care.

We respectfully ask that both types of nitrous oxide devices are accounted for in the rules. Not differentiating between the two types of Nitrous Oxide devices may ultimately prohibit access to this modality of anesthesia and comfort and force patients to receive care without any sedation in some circumstances.

Thank you for your consideration.

Sincerely,

Mercedes Sanchez
Executive Director

WSR 25-14-080
PROPOSED RULES
DEPARTMENT OF HEALTH
(Washington Medical Commission)
[Filed June 30, 2025, 12:41 p.m.]

Original Notice.

Preproposal statement of inquiry was filed as WSR 24-11-104.

Title of Rule and Other Identifying Information: Office-based surgery rules for allopathic physicians (MD)—Use of nitrous oxide. The Washington medical commission (commission) is proposing new WAC 246-919-603 Use of nitrous oxide in office-based settings; and proposing changes to WAC 246-919-601 Safe and effective analgesia and anesthesia administration in office-based surgical settings.

Hearing Location(s): On August 22, 2025, at 9:30 a.m., virtually via Teams at https://tinyurl.com/bdkpf89c; or in person at Department of Health, Town Center 2, Rooms 166/167, 111 Israel Road S.E., Tumwater, WA 98501.

The public hearing will be hybrid. Participants can attend at the physical location, or virtually by registering at https://tinyurl.com/bdkpf89c.

To join the comission's rules interested parties email list, please visit https://public.govdelivery.com/accounts/WADOH/subscriber/new?topic_id=WADOH_153.

Date of Intended Adoption: August 22, 2025.

Submit Written Comments to: Amelia Boyd, Program Manager, P.O. Box 47866, Olympia, WA 98504-7866, email medical.rules@wmc.wa.gov, https://fortress.wa.gov/doh/policyreview/, beginning the date and time of this filing, by August 15, 2025, 11:59 p.m.

Assistance for Persons with Disabilities: Contact Amelia Boyd, program manager, phone 800-525-0127, TTY 711, email medical.rules@wmc.wa.gov, by August 15, 2025.

Purpose of the Proposal and Its Anticipated Effects, Including Any Changes in Existing Rules: The commission is proposing amendments to WAC 246-919-601 and creating new WAC 246-919-603 to establish the use of nitrous oxide by allopathic physicians in office-based surgical settings.

The proposal clarifies the regulatory status of nitrous oxide in office-based settings and establishes safety standards for its use. WAC 246-919-601 does not specify whether nitrous oxide qualifies as minimal sedation; new WAC 246-919-603 addresses this gap by outlining conditions for exemption. It ensures patient safety through physician training, the presence of a basic life support certified provider, patient monitoring, emergency protocols, and special precautions for pediatric patients. By defining safe use conditions, the rule provides regulatory clarity while allowing controlled use of nitrous oxide by allopathic physicians in office-based settings with minimal risk. WAC 246-919-601 is being amended to reference new WAC 246-919-603.

Reasons Supporting Proposal: This proposal provides regulatory clarity by explicitly defining nitrous oxide's status as minimal sedation, ensuring consistent application of rules. It enhances patient safety through physician training, patient monitoring, emergency protocols, and safeguards like scavenging systems and secure storage. Aligning with medical best practices, it allows controlled use of nitrous oxide, a widely accepted, low-risk sedation option. Clear guidelines improve access to safe, office-based sedation while minimizing risks, particularly for pediatric patients.

Statutory Authority for Adoption: RCW 18.71.017 and 18.130.050.

Statute Being Implemented: RCW 18.71.017.

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

Name of Proponent: Washington medical commission, governmental.

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

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

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

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

Is exempt under RCW 19.85.025(4).

Explanation of exemptions: The proposed rule regulates an individual's license, not a small business.

Scope of exemption for rule proposal:

Is fully exempt.

June 27, 2025
Kyle S. Karinen
Executive Director

RDS-6157.1

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

WAC 246-919-601 Safe and effective analgesia and anesthesia administration in office-based surgical settings.

(1) Purpose. The purpose of this rule is to promote and establish consistent standards, continuing competency, and to promote patient safety. The commission establishes the following rule for physicians licensed under this chapter who perform surgical procedures and use anesthesia, analgesia or sedation in office-based settings.

(2) Definitions. The following terms used in this subsection apply throughout this section unless the context clearly indicates otherwise:

(a) "Deep sedation" or "analgesia" means a drug-induced depression of consciousness during which patients cannot be easily aroused but respond purposefully following repeated or painful stimulation. The ability to independently maintain ventilatory function may be impaired. Patients may require assistance in maintaining a patent airway, and spontaneous ventilation may be inadequate. Cardiovascular function is usually maintained.

(b) "General anesthesia" means a state of unconsciousness intentionally produced by anesthetic agents, with absence of pain sensation over the entire body, in which the patient is without protective reflexes and is unable to maintain an airway, and cardiovascular function may be impaired. Sedation that unintentionally progresses to the point at which the patient is without protective reflexes and is unable to maintain an airway is not considered general anesthesia.

(c) "Local infiltration" means the process of infusing a local anesthetic agent into the skin and other tissues to allow painless wound irrigation, exploration and repair, and other procedures, including procedures such as retrobulbar or periorbital ocular blocks only when performed by a board eligible or board certified ophthalmologist. It does not include procedures in which local anesthesia is injected into areas of the body other than skin or muscle where significant cardiovascular or respiratory complications may result.

(d) "Major conduction anesthesia" means the administration of a drug or combination of drugs to interrupt nerve impulses without loss of consciousness, such as epidural, caudal, or spinal anesthesia, lumbar or brachial plexus blocks, and intravenous regional anesthesia. Major conduction anesthesia does not include isolated blockade of small peripheral nerves, such as digital nerves.

(e) "Minimal sedation" means a drug-induced state during which patients respond normally to verbal commands. Although cognitive function and coordination may be impaired, ventilatory and cardiovascular functions are unaffected. Minimal sedation is limited to oral, intranasal, or intramuscular medications.

(f) "Moderate sedation" or "analgesia" means a drug-induced depression of consciousness during which patients respond purposefully to verbal commands, either alone or accompanied by tactile stimulation. No interventions are required to maintain a patent airway, and spontaneous ventilation is adequate. Cardiovascular function is usually maintained.

(g) "Office-based surgery" means any surgery or invasive medical procedure requiring analgesia or sedation, including, but not limited to, local infiltration for tumescent liposuction, performed in a location other than a hospital or hospital-associated surgical center licensed under chapter 70.41 RCW, or an ambulatory surgical facility licensed under chapter 70.230 RCW.

(3) Exemptions. This rule does not apply to physicians when:

(a) Performing surgery and medical procedures that require only minimal sedation (anxiolysis), or infiltration of local anesthetic around peripheral nerves. Infiltration around peripheral nerves does not include infiltration of local anesthetic agents in an amount that exceeds the manufacturer's published recommendations.

(b) Using nitrous oxide under the requirements in WAC 246-919-603.

(c) Performing surgery in a hospital or hospital-associated surgical center licensed under chapter 70.41 RCW, or an ambulatory surgical facility licensed under chapter 70.230 RCW.

(((~~c~~)))(d) Performing surgery utilizing or administering general anesthesia. Facilities in which physicians administer general anesthesia or perform procedures in which general anesthesia is a planned event are regulated by rules related to hospital or hospital-associated surgical center licensed under chapter 70.41 RCW, an ambulatory surgical facility licensed under chapter 70.230 RCW, or a dental office under WAC 246-919-602.

(((~~d~~)))(e) Administering deep sedation or general anesthesia to a patient in a dental office under WAC 246-919-602.

(((~~e~~)))(f) Performing oral and maxillofacial surgery, and the physician:

(i) Is licensed both as a physician under chapter 18.71 RCW and as a dentist under chapter 18.32 RCW;

(ii) Complies with dental quality assurance commission regulations;

(iii) Holds a valid:

(A) Moderate sedation permit; or

(B) Moderate sedation with parenteral agents permit; or

(C) General anesthesia and deep sedation permit; and

(iv) Practices within the scope of their specialty.

(4) Application of rule.

This rule applies to physicians practicing independently or in a group setting who perform office-based surgery employing one or more of the following levels of sedation or anesthesia:

(a) Moderate sedation or analgesia; or

(b) Deep sedation or analgesia; or

(c) Major conduction anesthesia.

(5) Accreditation or certification.

(a) A physician who performs a procedure under this rule must ensure that the procedure is performed in a facility that is appropriately equipped and maintained to ensure patient safety through accreditation or certification and in good standing from an accrediting entity approved by the commission.

(b) The commission may approve an accrediting entity that demonstrates to the satisfaction of the commission that it has all of the following:

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

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

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

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

(c) A physician may perform procedures under this rule in a facility that is not accredited or certified, provided that the facility has submitted an application for accreditation by a commission-approved accrediting entity, and that the facility is appropriately equipped and maintained to ensure patient safety such that the facility meets the accreditation standards. If the facility is not accredited or certified within one year of the physician's performance of the first procedure under this rule, the physician must cease performing procedures under this rule until the facility is accredited or certified.

(d) If a facility loses its accreditation or certification and is no longer accredited or certified by at least one commission-approved entity, the physician shall immediately cease performing procedures under this rule in that facility.

(6) Competency. When an anesthesiologist or certified registered nurse anesthetist is not present, the physician performing office-based surgery and using a form of sedation defined in subsection (4) of this section must be competent and qualified both to perform the operative procedure and to oversee the administration of intravenous sedation and analgesia.

(7) Qualifications for administration of sedation and analgesia may include:

(a) Completion of a continuing medical education course in conscious sedation;

(b) Relevant training in a residency training program; or

(c) Having privileges for conscious sedation granted by a hospital medical staff.

(8) At least one licensed health care practitioner currently certified in advanced resuscitative techniques appropriate for the patient age group must be present or immediately available with age-size-appropriate resuscitative equipment throughout the procedure and until the patient has met the criteria for discharge from the facility. Certification in advanced resuscitative techniques includes, but is not limited to, advanced cardiac life support (ACLS), pediatric advanced life support (PALS), or advanced pediatric life support (APLS).

(9) Sedation assessment and management.

Sedation is a continuum. Depending on the patient's response to drugs, the drugs administered, and the dose and timing of drug administration, it is possible that a deeper level of sedation will be produced than initially intended.

(a) If an anesthesiologist or certified registered nurse anesthetist is not present, a physician intending to produce a given level of sedation should be able to "rescue" a patient who enters a deeper level of sedation than intended.

(b) If a patient enters into a deeper level of sedation than planned, the physician must return the patient to the lighter level of sedation as quickly as possible, while closely monitoring the patient to ensure the airway is patent, the patient is breathing, and that oxygenation, heart rate and blood pressure are within acceptable values. A physician who returns a patient to a lighter level of sedation in accordance with this subsection (c) does not violate subsection (10) of this section.

(10) Separation of surgical and monitoring functions.

(a) The physician performing the surgical procedure must not administer the intravenous sedation, or monitor the patient.

(b) The licensed health care practitioner, designated by the physician to administer intravenous medications and monitor the patient who is under moderate sedation, may assist the operating physician with minor, interruptible tasks of short duration once the patient's level of sedation and vital signs have been stabilized, provided that adequate monitoring of the patient's condition is maintained. The licensed health care practitioner who administers intravenous medications and monitors a patient under deep sedation or analgesia must not perform or assist in the surgical procedure.

(11) Emergency care and transfer protocols. A physician performing office-based surgery must ensure that in the event of a complication or emergency:

(a) All office personnel are familiar with a written and documented plan to timely and safely transfer patients to an appropriate hospital.

(b) The plan must include arrangements for emergency medical services and appropriate escort of the patient to the hospital.

(12) Medical record. The physician performing office-based surgery must maintain a legible, complete, comprehensive, and accurate medical record for each patient.

(a) The medical record must include all of the following:

(i) Identity of the patient;

(ii) History and physical, diagnosis and plan;

(iii) Appropriate lab, X-ray or other diagnostic reports;

(iv) Appropriate preanesthesia evaluation;

(v) Narrative description of procedure;

(vi) Pathology reports, if relevant;

(vii) Documentation of which, if any, tissues and other specimens have been submitted for histopathologic diagnosis;

(viii) Provision for continuity of postoperative care; and

(ix) Documentation of the outcome and the follow-up plan.

(b) When moderate or deep sedation, or major conduction anesthesia is used, the patient medical record must include a separate anesthesia record that documents:

(i) The type of sedation or anesthesia used;

(ii) Name, dose, and time of administration of drugs;

(iii) Documentation at regular intervals of information obtained from the intraoperative and postoperative monitoring;

(iv) Fluids administered during the procedure;

(v) Patient weight;

(vi) Level of consciousness;

(vii) Estimated blood loss;

(viii) Duration of procedure; and

(ix) Any complication or unusual events related to the procedure or sedation/anesthesia.

NEW SECTION

WAC 246-919-603 Use of nitrous oxide in office-based settings.

(1) The purpose of this rule is to promote and establish consistent standards, continuing competency, and promote patient safety. The commission establishes the following rule for physicians licensed under this chapter who perform surgical procedures and use nitrous oxide in office-based settings.

(2) The use of nitrous oxide is exempt from WAC 246-919-601 requirements if the following conditions are met:

(a) Nitrous oxide is administered at a concentration of 50 percent or less;

(b) Nitrous oxide is used without another inhaled anesthetic, sedative, or opioid drug; and

(c) The following safeguards are in place:

(i) The physician performing the procedure must demonstrate competence by completing a continuing medical education course in nitrous oxide administration;

(ii) At least one healthcare practitioner must be present who is certified in basic life support (BLS);

(iii) The physician must be capable of resuscitating a patient from deeper sedation levels and ensure the patient's vital signs are monitored;

(iv) The physician performing the procedure must not administer nitrous oxide or monitor the patient;

(v) The licensed provider administering the nitrous oxide must be different from the physician performing the procedure;

(vi) The facility must have a documented plan for transferring patients to a hospital in case of complications, including arrangements for emergency medical services and appropriate escort of the patient to the hospital;

(vii) The physician must maintain legible, complete, comprehensive, and accurate medical records including the following:

(A) Identity of the patient;

(B) History and physical, diagnosis and plan;

(C) Appropriate lab, X-ray, or other diagnostic reports;

(D) Documentation of nitrous oxide administered or dispensed; and

(E) Documentation of vital signs during the nitrous oxide sedation, including respiratory rate, oxygen saturation, heart rate, and blood pressure;

(viii) The following equipment must be available and include:

(A) Suction equipment capable of aspirating gastric contents from the mouth and pharynx;

(B) Portable oxygen delivery system including full face masks and a bag-valve-mask combination with appropriate connectors capable of delivery positive pressure, oxygen enriched ventilation to the patient;

(C) Blood pressure cuff or sphygmomanometer of appropriate size; and

(D) Pulse oximeter;

(ix) Nitrous oxide must not be administered to any patient under three years of age. For pediatric patients older than three years, a discussion with the parent or guardian is required to address the specific risks associated with nitrous oxide use in cases where the patient:

(A) Is younger than six years old; or

(B) Has airway abnormalities.

This discussion must include reasoning why the pediatric patient can safely receive nitrous oxide in an outpatient environment and any alternatives.

(x) Excess nitrous oxide must be removed from the procedure room to protect staff via a scavenging system;

(xi) Equipment used for monitoring patients must be calibrated or performance verified according to manufacturer's instructions; and

(xii) Nitrous oxide must be stored securely and accessible only by authorized individuals.

(3) The physician shall ensure they assess patient responsiveness using preoperative values as normal guidelines and discharge the patient only when the following criteria are met, except when their prior baseline is below the noted criteria:

(a) Vital signs including blood pressure, pulse rate, and respiratory rate are stable. Vital signs are not required when a pediatric patient is uncooperative or the emotional condition is such that obtaining vital signs is not possible;

(b) The patient is alert and oriented to person, place, and time as appropriate to age and preoperative psychological status;

(c) The patient can talk and respond coherently to verbal questioning as appropriate to age and preoperative psychological status;

(d) The patient can sit up unassisted;

(e) The patient can walk with minimal assistance;

(f) The patient does not have uncontrollable nausea or vomiting and has minimal dizziness.

Business Meeting Minutes
May 9, 2025

WASHINGTON Medical Commission
Licensing. Accountability. Leadership.

Virtual Meeting via Teams Webinar

Link to recording: https://youtu.be/whdKnpE2834?si=LfdfZVhKYLj49C_1

Commission Members

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

WMC Staff in Attendance

Colleen Balatbat, Staff Attorney (V)
Jennifer Batey, Legal Support Staff Manager
Amelia Boyd, Program Manager
Carolynn Bradley, Mgmt Analyst/Contract Mgr (V)
Kayla Bryson, Executive Assistant (V)
Jimi Bush, Director of Quality & Engagement
Carmen Challender, Health Services Consultant
Marisa Courtney, Licensing Manager
Joel DeFazio, Staff Attorney
Anthony Elders, Compliance Officer (V)
Gina Fino, Director of Compliance
Michael Farrell, Supervising Staff Attorney
Rick Glein, Director of Legal Services (V)
Jenelle Houser, Investigator
Ken Imes, Information Liaison
Kyle Karinen, Executive Director
Sara Kirschenman, Staff Attorney (V)
Mike Kramer, Compliance Officer (V)
Lisa Krynicki, Staff Attorney (V)
Stephanie Mason, Public Information Officer & Legislative Liaison
Micah Matthews, Deputy Executive Director
Lynne Miller, Paralegal
Fatima Mirza, Program Case Manager
Freda Pace, Director of Investigations (V)
Stormie Redden, Legal Assistant
Chris Waterman, Complaint Intake Manager (V)
Trisha Wolf, Staff Attorney (V)
Mahi Zeru, Equity & Social Justice Manager

Others in Attendance

Alexa Ankrum (V)
Theresa Bakare (V)
Marlon Basco-Rodillas, Dept. of Health (DOH) (V)
Dee Bender (V)
Troy Bender (V)
Amy Brackenbury (V)
Kelli Camp (V)
Heather Carter, Assistant Attorney General (AAG)
Ai Che (V)
Erik Condon (V)
Melissa Dacumos (V)
Billie Dickinson, Washington State Medical Association (WSMA) (V)
DJ Gonzales (V)
Cyndi Hoenhous, Co-Chair, Washington Patients In Intractable Pain

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Others in Attendance continued

Robert Hsiung (V)
Kayla Kerr (V)
Marsha King (V)
Christine Kohlsaat (V)
Katerina LaMarche, Washington State Hospital Association (V)
Ryan Lilley (V)
Micheal McCarthy (V)
Gail McGaffick (V)
Teddi Mcguire (V)
Nicole Moore, CAA (V)
Senator Ron Muzzall (V)
Hillary Norris, WSMA (V)
Penny Reck, MD, Pro Tem Commissioner
Elizabeth Ross (V)
Andrew Seong (V)
Tami Thompson (DOH) (V)
Susie Tracy (V)
Kevin Van De Wege (V)
Susanna Waldman (V)
Fiona Williams (V)

(V) indicates the participant attended virtually

1.0 Call to Order

Karen Domino, MD, Chair, called the meeting of the Washington Medical Commission (WMC) to order at 10:45 a.m. on May 9, 2025.

2.0 Public Comment

Cindy Hoenhaus, Co-Chair of WashPIP, expressed gratitude for the WMC's amendments to the opioid prescribing rule interpretive statements, stating they align with WashPIP's proposals. She emphasized that morphine equivalent dose (MED) limits and forced tapers are harmful and should only occur for patient health and safety, as outlined in existing rules. She urged that patient care, not provider liability, should guide tapering decisions and requested ongoing representation in opioid policy discussions to ensure appropriate pain care access.

3.0 Chair Report

Dr. Domino delivered her final Chair report with gratitude, saying it had been an honor to serve alongside such dedicated colleagues. She appreciated the diversity of backgrounds on the Commission and how it deepened her understanding of patient safety beyond her own field of anesthesiology and pain medicine.

She highlighted two issues that stood out during her tenure: the opioid epidemic and medical misinformation. Reflecting on the book *Dreamland*, which traces the roots of the opioid crisis, she connected its themes to to challenges she has observed in Washington, as well as in Michigan, where she grew up, and in Pittsburgh, where she previously lived. She also expressed concern over the impact of social media and fragmented news sources in spreading misinformation, especially during the COVID-19 pandemic.

Dr. Domino praised the Commission's emphasis on system-based approaches to medical errors, citing her own experience at Harborview Medical Center as an example. She supported the Communication and Resolution Program process for identifying system flaws and the Practitioner Support Program for helping clinicians improve communication and record-keeping before escalating to disciplinary action.

She also encouraged members to consider participating in the United States Medical Licensing Examination (USMLE) process, where board and commission members can contribute to exam content on ethics, patient safety, and scientific reasoning. She closed by

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thanking everyone for their collegiality and saying the experience had been both meaningful and rewarding.

4.0 Consent Agenda

The Consent Agenda contained the following items for approval:

4.1 Agenda for March 14, 2025

4.2 Minutes from January 10, 2025, Business Meeting

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

5.0 New Business

5.1 Petition for Declaratory Order

Heather Carter, AAG, provided an overview of a request from Dr. Penner for a declaratory order under the Administrative Procedures Act, asking whether conducting independent psychiatric examinations via telemedicine constitutes the practice of medicine in Washington, thereby requiring in-state licensure. The Commission deferred the decision from its last meeting to allow time for public comment, though none were received. Ms. Carter explained that for a declaratory order to be issued, the petitioner must present specific facts, demonstrate legal uncertainty, and show that they are adversely affected. She expressed concern that Dr. Penner's request lacks sufficient detail, such as the type of IME and its purpose, and may not meet the threshold for a binding order. She also noted that enforcement of unlicensed practice is handled by the Department of Health (DOH) Secretary, not the Commission. If the Commission finds the petition insufficient, it must state its reasons in a formal response.

Motion: The Chair called for a motion to deny the petition for a declaratory order. The motion was seconded and passed unanimously.

5.2 Letter from Eli Lilly and Company

Kyle Karinen, Executive Director, presented a letter from Eli Lilly and Company regarding the unauthorized compounding of tirzepatide, the active ingredient in the patented drugs Mounjaro® and Zepbound®. During a recent FDA-declared shortage, compounding of the drug was temporarily allowed. However, the FDA lifted the shortage designation in March, reinstating full patent protections. Eli Lilly is now seeking support from regulatory boards, including the Commission, to help prevent further unauthorized compounding. Mr. Karinen noted that no complaint has been filed and emphasized that compounding enforcement typically falls under the Pharmacy Commission's authority. He recommended that no action be taken unless a specific complaint is received, as the Commission is a complaint-driven body and this matter is largely outside its regulatory scope.

6.0 Old Business

6.1 Committee/Workgroup Reports

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

6.2 Rulemaking Activities

The rulemaking progress report was provided in the meeting packet. In addition to the

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written report, Amelia Boyd, Program Manager, stated the Preproposal Statement of Inquiry, or CR-101, for Opioid Prescribing General Provisions for MDs and PAs, was filed on April 30, 2025. Ms. Boyd requested volunteers to participate in upcoming rulemaking workshops. She explained that a small committee is typically formed for each rule to help coordinate scheduling by having a core group of three or four Commissioners. This makes it easier to align schedules and set up the workshops. She asked that anyone interested in being part of the rulemaking effort email her to express their interest.

6.3 Interpretive Statement: "Qualified Physician" Under Optometry Law

Ms. Boyd presented this document and explained that it had completed its review by the Secretary of the Department of Health and that the proposed changes from that office were included in the meeting packet. She stated that the Commission could either adopt the document as presented or return it for further revisions.

> ***Motion:*** The Chair called for a motion to adopt the document as revised. The motion was seconded and passed unanimously.

6.4 Interpretive Statement: Opioid Prescribing & Monitoring for Allopathic Physicians and Physician Assistants

Ms. Boyd presented this document and explained that it had completed its review by the Secretary of the Department of Health and that the proposed changes from that office were included in the meeting packet. She stated that the Commission could either adopt the document as presented or return it for further revisions.

> ***Motion:*** The Chair called for a motion to adopt the document as revised. The motion was seconded and passed unanimously.

6.5 Interpretive Statement: Opioid Prescribing & Monitoring for Patients

Ms. Boyd presented this document and explained that it had completed its review by the Secretary of the Department of Health and that the proposed changes from that office were included in the meeting packet. She stated that the Commission could either adopt the document as presented or return it for further revisions.

> ***Motion:*** The Chair called for a motion to adopt the document as revised. The motion was seconded and passed unanimously.

6.6 Policy: Visiting Student Learning Opportunity License Exemptions

Ms. Boyd presented this document and explained that it had completed its review by the Secretary of the Department of Health and that the proposed changes from that office were included in the meeting packet. She stated that the Commission could either adopt the document as presented or return it for further revisions.

> ***Motion:*** The Chair called for a motion to adopt the document as revised. The motion was seconded and passed unanimously.

7.0 Policy Committee Report

Christine Blake, Public Member, Policy Committee Chair, reported on the items discussed at the Policy Committee meeting held on May 1, 2025.

7.1 Request for WMC Commissioner Volunteers for Small Workgroup on Medical Marijuana Authorization Guidelines

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Ms. Blake asked Micah Matthews, Deputy Executive Director, to present this request. Mr. Matthews clarified that this request is for Commissioners. He stated that the DOH periodically reviews and revises medical authorization guidelines for cannabis across healthcare boards and commissions. The goal was to update the guidelines based on new research and create a consistent set for approval or adoption by the various boards. He addressed a question about the difference between medical cannabis and recreational marijuana, explaining that medical authorization provides tax exemptions by reducing taxes at the producer, wholesale, and retail levels, making it less expensive for patients.

Commissioners who would like to volunteer for this workgroup should contact Ms. Boyd at amelia.boyd@wmc.wa.gov.

7.2 **Policy: Practitioners Exhibiting Disruptive Behavior (MD2021-01)**

Ms. Blake stated that this document was presented as part of its scheduled four-year review. She stated that the Committee recommended reaffirming the document as written.

> ***Motion:*** The Committee Chair entertained a motion to reaffirm this document. The motion was approved unanimously.

7.3 **Procedure: Interactive and Transparent Development of Evidence-based Policies and Guidelines (PRO2018-02)**

Ms. Blake stated that the Committee recommended deferring this item to a future meeting because a new Policy Manager would be starting soon, and the Committee wanted them to review and suggest revisions to the procedure.

7.4 **Guidance Document: Medical Professionalism**

Ms. Blake stated that this document was presented as part of its scheduled four-year review. She stated that the Committee recommended deferring this document for additional work based on comments received.

7.5 **Proposed: Joint Guidance for Retail Intravenous Therapy Clinics**

Ms. Blake asked Mike Farrell, Supervising Staff Attorney, to present this document. Mr. Farrell explained that four boards and commissions including the WMC, the Washington Board of Nursing, the Board of Osteopathic Medicine and Surgery, and the Pharmacy Quality Assurance Commission, collaborated to address the growing issue of IV hydration clinics and related legal concerns, with a particular focus on absentee medical directors who fail to provide adequate supervision, potentially resulting in pharmacy regulation violations. A workgroup, including WMC Commissioners Dr. Murphy and Dr. Jaeger, developed a draft policy largely based on a joint statement from West Virginia. The four boards and commissions reviewed and provided feedback on the draft. The WMC's Policy Committee incorporated many of these suggestions, aiming to keep the guidance general to assist medical directors and nursing staff in practicing responsibly. Mr. Farrell emphasized that this was an ongoing process and not up for adoption at that time. Rather, he sought feedback to refine the draft before returning it for final approval by the four boards and commissions.

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9.0 Member Reports

No members provided a report.

10.0 Staff Reports

Written reports were included in the meeting packet. No additional reports were provided.

11.0 AAG Report

Ms. Carter had nothing to report.

12.0 Leadership Elections

12.1 Restatement of Nominating Committee Report

Dr. Domino restated the nominations for the following leadership positions:

- Chair – Terry Murphy, MD
- Vice Chair – Ed Lopez, PA-C
- Officer-at-Large – Elisha Mvundura, MD

12.2 Nominations from the Floor

Dr. Domino called for nominations for all positions from the panel of Commissioners. No additional nominations were received.

12.3 Election of Leadership

Dr. Domino stated the slate of candidates was elected by a formal vote.

13.0 Adjournment

The Chair called the meeting adjourned at 11:50 am.

Submitted by

Amelia Boyd, Program Manager

Karen Domino, MD, Chair
Washington Medical Commission

Approved August 22, 2025

STATE OF WASHINGTON
DEPARTMENT OF HEALTH
PO Box 47890 • Olympia, Washington 98504-7890
Tel: 360-236-4030 • TTY Relay: 800-833-6384

April 7, 2025

Dr. Jonathan Drezner, MD
FIFA Venue Medical Officer
Sports Medicine Center at Husky Stadium, UW Medicine
3800 Montlake Blvd NE
UW Box 354060
Seattle, WA 98195-4060
jdrezner@uw.edu

Dr. Katharina Grimm, Medical Lead
Fédération Internationale de Football Association
FIFA-Strasse 20
P.O. Box 8044
Zurich, Switzerland
katharina.grimm@fifa.org

Re: 2025 FIFA World Cup Events in Seattle

Dear Drs. Drezner and Grimm:

The Washington State Department of Health (DOH) received your request for information regarding health care providers with international licenses providing care to players and staff while housed, training, and competing in FIFA Club World Cup 2025 matches in Washington State.

Under the Washington State Law Revised Code of Washington (RCW) 18.71.021, an individual must hold a license issued by Washington State unless an exemption under RCW 18.71.030 applies. Under RCW 18.71.030(1), a Washington State license is not required to furnish medical assistance in cases of emergency requiring immediate attention. Additionally, a Washington State license is not required for the in-person practice of medicine in Washington State by health care practitioners who are licensed by another U.S. state or territory in which they reside, provided that such practitioner does not open an office or appoint a place of meeting patients or receiving calls within Washington State. This latter exemption does not extend to practitioners licensed in other countries.

DOH has discretion under RCW 18.130.190 to take enforcement action to prevent practitioners who do not hold a Washington State license and are not exempt from licensure from providing healthcare services. **DOH will exercise its discretion to allow internationally licensed health care practitioners to provide treatment to players and staff participating in and supporting FIFA Club World Cup 2025 events. Such practitioners will not be required to hold a license from Washington State or another U.S. state or territory.**

DOH wishes you the best for a successful FIFA Club World Cup 2025 event.

If there are any questions, please do not hesitate to contact Melissa Lantz, Director of Operational Readiness and Response within the Executive Office of Resiliency and Health Security at 360-236-4026 or melissa.lantz@doh.wa.gov.

Sincerely,

Jessica Todorovich
Interim Secretary of Health
Washington State Department of Health

cc: Sasha De Leon, Assistant Secretary, HSQA, DOH
Lacy Fehrenbach, Chief, Office of Prevention, Safety & Health, DOH
Kyle Karinen, Executive Director, WMC
Melissa Lantz, Director of Operational Readiness & Response, ORHS, DOH
Judith Morton, Director, Office of Investigative & Legal Services, HSQA, DOH
Kristin Peterson, Chief, Office of Policy, Planning & Evaluation, DOH
Nate Weed, Chief, Office of Resilience & Health Security, DOH

2026 Meeting Schedule

WASHINGTON Medical Commission
Licensing. Accountability. Leadership.

January

S	M	T	W	T	F	S
				1	2	3
4	5	6	7	8	9	10
11	12	13	14	15	16	17
18	19	20	21	22	23	24
25	26	27	28	29	30	31

1	New Years Day	Holiday – Offices Closed	
8	Policy Committee	4 pm	Virtual
15	Personal Appearances	8:30 am	Virtual
15	Case Disposition	10:45 am	Virtual
16	Committees/Workgroups	8:30 am	Virtual
16	Business	9:30 am	Virtual
16	Lunch & Learn	Noon	Virtual
19	Martin Luther King Day	Holiday – Offices Closed	
29	Policy: Interested Parties	10 am	Virtual

February

S	M	T	W	T	F	S
1	2	3	4	5	6	7
8	9	10	11	12	13	14
15	16	17	18	19	20	21
22	23	24	25	26	27	28

16	President's Day	Holiday – Offices Closed	
26	Policy Committee	4 pm	Virtual

March

S	M	T	W	T	F	S
1	2	3	4	5	6	7
8	9	10	11	12	13	14
15	16	17	18	19	20	21
22	23	24	25	26	27	28
29	30	31				

11	Proposed: Commissioner Retreat	8:30 am	In person Location: TBD
12	Personal Appearances	8:30 am	Hybrid Location: TBD
12	Case Disposition	10:45 am	
~~13~~	~~Committees/Workgroups~~	~~8:30 am~~	
~~13~~	~~Business~~	~~9:30 am~~	
~~13~~	~~Lunch & Learn~~	~~Noon~~	
26	Policy: Interested Parties	10 am	Virtual

In this proposal, we would cancel the March 13 meetings.

2026 Meeting Schedule

WASHINGTON Medical Commission
Licensing. Accountability. Leadership.

April

S	M	T	W	T	F	S
			1	2	3	4
5	6	7	8	9	10	11
12	13	14	15	16	17	18
19	20	21	22	23	24	25
26	27	28	29	30		

17	SMART Training	8:30 am	In person Location: TBD
23	Policy Committee	4 pm	Virtual
30	Proposed: Commissioner Retreat	8:30 am	In person Location: TBD

May

S	M	T	W	T	F	S
					1	2
3	4	5	6	7	8	9
10	11	12	13	14	15	16
17	18	19	20	21	22	23
24	25	26	27	28	29	30
31						

7	Personal Appearances	8:30 am	Hybrid Location: TBD
7	Case Disposition	10:45 am	
8	Committees/Workgroups	8:30 am	
8	Business	9:30 am	
8	Lunch & Learn	Noon	
25	Memorial Day	Holiday – Offices Closed	

June

S	M	T	W	T	F	S
	1	2	3	4	5	6
7	8	9	10	11	12	13
14	15	16	17	18	19	20
21	22	23	24	25	26	27
28	29	30				

11	Proposed: Commissioner Retreat	8:30 am	In person Location: TBD
19	Juneteenth	Holiday – Offices Closed	
25	Policy: Interested Parties	10 am	Virtual

July

S	M	T	W	T	F	S
			1	2	3	4
5	6	7	8	9	10	11
12	13	14	15	16	17	18
19	20	21	22	23	24	25
26	27	28	29	30	31	

3	Independence Day (observed)	Holiday – Offices Closed	
9	Personal Appearances	8:30 am	Virtual
9	Case Disposition	10:45 am	Virtual
23	Policy Committee	4 pm	Virtual
30	Proposed: Commissioner Retreat	8:30 am	In person Location: TBD

Proposed Commissioner Retreat dates
Other meeting dates have been approved

2026 Meeting Schedule

WASHINGTON Medical Commission
Licensing. Accountability. Leadership.

August

S	M	T	W	T	F	S
						1
2	3	4	5	6	7	8
9	10	11	12	13	14	15
16	17	18	19	20	21	22
23	24	25	26	27	28	29
30	31					

20	Personal Appearances	8:30 am	Hybrid Location: TBD
20	Case Disposition	10:45 am	
21	Committees/Workgroups	8:30 am	
21	Business	9:30 am	
21	Lunch & Learn	Noon	

September

S	M	T	W	T	F	S
		1	2	3	4	5
6	7	8	9	10	11	12
13	14	15	16	17	18	19
20	21	22	23	24	25	26
27	28	29	30			

7	Labor Day	Holiday – Offices Closed	
17	Proposed: Commissioner Retreat	8:30 am	In person Location: TBD
24	Policy: Interested Parties	10 am	Virtual

October

S	M	T	W	T	F	S
				1	2	3
4	5	6	7	8	9	10
11	12	13	14	15	16	17
18	19	20	21	22	23	24
25	26	27	28	29	30	31

8	Personal Appearances	8:30 am	Virtual
8	Case Disposition	10:45 am	Virtual
22	Proposed: Commissioner Retreat	8:30 am	In person Location: TBD
29	Policy Committee	4 pm	Virtual

Proposed Commissioner Retreat dates
Other meeting dates have been approved

2026 Meeting Schedule

WASHINGTON Medical Commission
Licensing. Accountability. Leadership.

November

S	M	T	W	T	F	S
1	2	3	4	5	6	7
8	9	10	11	12	13	14
15	16	17	18	19	20	21
22	23	24	25	26	27	28
29	30					

11	Veterans Day	Holiday – Offices Closed	
19	Personal Appearances	8:30 am	Hybrid Location: TBD
19	Case Disposition	10:30 am	
20	Committees/Workgroups	8:30 am	
20	Business	9:30 am	
20	Lunch & Learn	Noon	
26	Thanksgiving Day	Holiday – Offices Closed	
27	Native American Heritage Day	Holiday – Offices Closed	

December

S	M	T	W	T	F	S
		1	2	3	4	5
6	7	8	9	10	11	12
13	14	15	16	17	18	19
20	21	22	23	24	25	26
27	28	29	30	31		

3	Policy: Interested Parties	10 am	Virtual
25	Christmas	Holiday – Offices Closed	

Association Meetings

Association	Date(s)	Location
Washington Academy of Physician Assistants (WAPA) & Oregon Society of Physician Associates (OSPA) Joint Spring Conference	TBA	TBA
Washington State Medical Association (WSMA) Annual Meeting	TBA	TBA
WAPA Fall Conference	TBA	TBA

Other Meetings

Entity	Date(s)	Location
Council on Licensure, Enforcement and Regulation (CLEAR) Winter Symposium	TBA	TBA
Federation of State Medical Boards (FSMB) Annual Conference	TBA	TBA
FSMB International Conference	TBA	TBA
CLEAR Annual Conference	TBA	TBA
FSMB Board Attorneys Workshop	TBA	TBA

Proposed Commissioner Retreat dates
Other meeting dates have been approved

Open Public Meetings Act (OPMA) Revision

The OPMA requires public organizations abide by a common set of requirements. While the majority of the provisions are helpful, the pandemic and technological advances have called into question the utility of some requirements. The WMC is asking for approval to develop request legislation to amend the OPMA to allow public meetings to take place either in person or virtually.

For background, every public meeting of the WMC currently requires a physical location that is publicly accessible so that any interested individual may attend and participate. This can range from a staffer securing a room and having a speaker phone to someone running a virtual machine with a projection screen in a hybrid setting. Over the past four years, the WMC has held dozens of public meetings where the Commissioners were virtual, and we provided a room for public attendance. Out of those dozens, there was a single instance of a non-WMC affiliated individual attending and that individual was an assistant attorney general. This represents a significant cost and waste to the WMC in terms of contracts and staff time.

WMC proposes to collaborate with the Governor's Office to update the OPMA to allow for either a physical location or virtual option or both, at the discretion of the organization.

From: Boyd, Amelia (WMC)
To: Matthews, Micah T (WMC)
Subject: Physical Location Comments
Date: Friday, April 18, 2025 3:03:54 PM

Hi Micah,

The OPMA does not explicitly state that a physical location is required for public meetings, but it implies this requirement with the exceptions under certain emergency conditions. This is how Heather explained it to me anyway.

One of the main problems with requiring a physical location for public meetings is when we don't have a free space to use. If we have to spend hundreds of dollars to rent a room, just to meet the implied requirement, even when everyone's joining online, it really doesn't make sense. It's hard to justify that kind of spending, especially when no one from the public ever shows up in person.

Over the past four years, I've facilitated dozens of virtual public meetings and not a single member of the public chose to attend in person. This repeated pattern strongly suggests that the requirement for a physical meeting space is more symbolic than practical. These days, virtual platforms make it easy, affordable, and transparent for the public to take part in meetings. So, is requiring a physical location actually helping the public, or is it just creating extra costs and logistical burdens for no real benefit?

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

Non-Disciplinary License Relinquishment

The Washington Medical Commission (WMC) is requesting authorization to draft legislation that creates a framework for license relinquishment. The process would be conducted through rule-making for all statutory chapters in the Revised Code of Washington (RCW). Therefore, changing RCW's 18.71 (physicians), 18.71A (physician assistants), 18.71B (compact physicians), 18.71C (compact physician assistants), and 18.71D (certified anesthesiologist assistants).

Relinquishment rules are necessary to allow a licensee to relinquish their license, and associated property rights, back to the WMC without the need for a Stipulation to Informal Discipline or Agreed Order and the associated mandatory reports to national databanks. The law would ensure that relinquishment may not be requested by a licensee under disciplinary order or in lieu of discipline. A draft bill from the 2025 effort is included for reference.

BILL REQUEST - CODE REVISER'S OFFICE

BILL REQ. #: Z-0099.3/25 3rd draft

ATTY/TYPIST: CC:eab

BRIEF DESCRIPTION: Creating a nondisciplinary pathway for relinquishing licenses issued by the Washington medical commission.

AN ACT Relating to creating a nondisciplinary pathway for relinquishing licenses issued by the Washington medical commission; and adding a new section to chapter 18.71 RCW.

BE IT ENACTED BY THE LEGISLATURE OF THE STATE OF WASHINGTON:

NEW SECTION. **Sec. 1.** A new section is added to chapter 18.71 RCW to read as follows:

The commission is authorized to conduct rule making for all licenses issued within its authority under this chapter and chapters 18.71A, 18.71B, 18.71C, and 18.71D RCW to allow for the relinquishment of the license. Relinquishment under these rules must be voluntary. The license cannot be relinquished in lieu of discipline or if the licensee is subject to discipline or under investigation by the commission. The relinquishment is not an adverse action and as such is not reportable to any disciplinary databases, the national practitioner data bank, or other websites. Licensees who request this process agree to the permanent relinquishment of the property right and shall have no right to reinstatement or renewal.

--- END ---

Certified Anesthesiologist Assistants License Fee Update

The WMC is proposing development of request legislation to authorize the assessment of surcharges to allow participation in the Washington Physicians Health Program (WPHP) and access to HEAL WA for Certified Anesthesiologist Assistants (CAAs). The current rulemaking for CAA fees does not include language adding CAAs to either program due to this statutory omission.

WPHP provides early intervention and monitoring for healthcare professionals facing health challenges, while HEAL WA offers access to high-quality, evidence-based clinical resources. These are essential services for licensees and all license types regulated by the WMC include these surcharges. The intent of the HEAL-WA surcharge is to add language that covers all licenses under the WMC authority so new legislation won't be needed later.

State of Washington
Department of Health

Delegation of Decision Making to Health Law Judges

I, ~~Jimmy Chung, MD~~ Terry Murphy, MD, Chair of the Washington Medical Commission, acting upon authorization of the commission and under the authority of RCW 18.130.050(8), delegates each of the functions indicated below to a presiding officer serving in the Adjudicative Service Unit:

☐ To serve as the final decision-maker upon review of brief adjudicative proceedings.

☒ Consistent with RCW 18.130.400, to serve as the decision-maker in response to an ex parte motion for summary suspension in which the respondent is alleged to have violated RCW 18.130.050 (8)(b) (DSHS actions).

☒ Consistent with RCW 18.130.370, to serve as the decision-maker in response to an ex parte motion for summary suspension or restriction of a license in which the respondent is alleged to have violated RCW 18.130.050(8)(a) (out of state, federal or foreign jurisdiction actions).

☐ Consistent with RCW 18.130.170(2(b) to serve as the decision-maker in response to a motion for an investigative mental health or physical health examination.

☒ To serve as the final decision-maker in response to a motion for hearing on noncompliance with Orders. (This does not apply to STIDS)

☒ To serve as the final decision-maker in adjudicative proceedings in which a party is in default for failure to submit a request for adjudicative proceeding. This delegation does not include cases pertaining to standards of practice or where clinical expertise is necessary.

☐ To serve as the final decision-maker in adjudicative proceedings in which the respondent is alleged to have violated RCW 18.130.180(5) (suspension, revocation, or restriction of the respondent's license to practice a health care profession in any state, federal or foreign jurisdiction).

☒~~☐~~ To serve as the final decision-maker in adjudicative proceedings where the Department has brought a motion for noncompliance. (noncompliance fast track docket)

☐ To serve as the final decision-maker in adjudicative proceedings in which the respondent is charged with violation of RCW 18.130.180(9) (failure to comply with an order issued by the board or commission or its predecessor).

☐ To serve as the final decision-maker in adjudicative proceedings in which the respondent is alleged to have violated RCW 18.130.180(17). (conviction of a felony or gross misdemeanor related to the practice of his or her profession)

☐ To serve as the final decision-maker in adjudicative proceedings in which the respondent is alleged to have violated RCW 18.130.180(24) (verbal or physical abuse of a client or patient).

☐ To serve as the final decision-maker in adjudicative proceedings in which the respondent is alleged to have violated RCW 18.130.180(23) (current misuse or alcohol, controlled substances, or legend drugs).

☐ To serve as the final decision-maker in adjudicative proceedings in which the respondent is alleged to have violated RCW 18.130.180(6) (diversion or prescribing controlled substances for oneself).

☐ To serve as the final decision-maker in adjudicative proceedings in which the respondent is alleged to have violated RCW 18.130.170 (mental health or physical health).

☐ To approve or deny proposed settlements (in all cases other than those that pertain to standards of practice or where clinical expertise is necessary) that are filed nine (9) calendar days before the scheduled hearing.

☐ To serve as the final decision-maker in proceedings related to reinstatement of a license previously suspended, revoked, or restricted by the board or commission.

☐ To serve as the final decision-maker in proceedings related to modification of any disciplinary order previously issued by the board or commission.

☐ To serve as the final decision-maker for brief adjudicative proceedings if review of an initial decision is requested.

☒ To serve as the final decision maker in proceedings on a case-by-case basis as determined by the board or commission and upon completion by the board or commission, or its designee, a delegation form for the particular case.

This delegation remains in effect until revoked, terminated or modified. To the extent that this delegation conflicts with prior delegations to presiding officers at the Adjudicative Service Unit, this delegation prevails.

DATED this _____ day of _____, 2025.

~~Jimmy Chung~~~~Karen Domino~~Terry Murphy, MD
Chairperson

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Updated: August 14, 2025

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Any committee or workgroup engaging with interested parties or gathering public input must conduct open public meetings.

PM = Public Member

WPHP = Washington Physicians Health Program

Updated: August 14, 2025

Committee/Workgroup Reports
August 22, 2025

High Reliability Organizations Workgroup – Chair: Dr. Chung Staff: Mike Farrell
We will meet on Friday, August 22, to discuss revising the Guidance Document on "A Collaborative Approach to Reducing Medical Error and Enhancing Patient Safety."

Healthcare Disparities Workgroup – Chair: Dr. Currie Staff: Kyle Karinen
Nothing to report.

IV Hydration Treatment Workgroup – Chair: Dr. Murphy Staff: Mike Farrell/Jimi Bush
The Commission approved the draft joint statement on IV Hydration at the May business meeting. We are waiting for the review and feedback from the Washington Board of Nursing and the Pharmacy Commission. The Osteopathic Board has approved the draft.

Finance Workgroup – Chair: Dr. Domino Staff: Kyle Karinen
We will meet next week to discuss the close of FY25 and the Commission's fiscal posture.

Psychedelics in Behavioral Health Treatment Workgroup – Chair: Dr. Domino Staff: Kyle Karinen
Dr. Fino continues to research the use of psychedelics in behavioral health treatment and work on a best practices document.

WMC Workgroup: Psychedelic Medications in Behavioral Health Treatment

Committee Progress Report, 8/14/2025

As you may have already gathered from popular media and medical literature, psychedelic medications for treatment-resistant behavioral health conditions are here to stay and are inconsistently regulated. Enclosed please find our committee's workgroup charter, ketamine facts, a review of the available evidence on ketamine treatement for drug resistent depression, ketamine treatment per UpToDate, the Kaiser Foundation HealthPlan of Washington clinical review criteria for ketamine, and the Department of Veterans Affairs ketamine treatment protocol. The Pennsylvania and New Mexico medical boards have published brief ketamine guidance documents and those are included here also.

This information forms the basis of our work to form a ketamine best practices guidance document for you to consider. That draft is under construction and not ready for review at this meeting. Please peruse the materials in this packet to get a sense of the current landscape. We welcome your input as we continue our work.

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Workgroup Charter

Psychedelic Medications in Behavioral Health Treatment Workgroup

Purpose

1. To educate the Commission members and staff on the current landscape with the use of psychedelic substances to treat behavioral health conditions.
2. To learn more about the current state of the use of ketamine to treat behavioral health conditions to determine if there are consistent best practices for the prescribing and administration.
3. To coordinate with other disciplinary authorities, including, but not necessarily limited to, the Board of Osteopathic Medicine and Surgery, Washington Board of Nursing and Washington State Pharmacy Quality Assurance Commission, to measure if there are common areas of interest and concerns regarding the use of ketamine to treat behavioral health conditions.
4. Report recommendation(s), if any, to the Policy Committee.

Dissolution

The group will serve at the pleasure of the Commission Chair.

Members

Chair: Karen Domino, MD

Staff:

- Rick Glein, Director of Legal Services
- Gina Fino, MD, Medical Consultant
- Mike Farrell, Supervising Staff Attorney
- Jimi Bush, Director of Quality and Engagement
- Marne Nelson, Clinical Healthcare Investigator
- Taylor Bachrach-Nixon, Management Analyst

Ex-officio:
Chris Bundy, Medical Director, Washington Physicians Health Program

Executive Sponsor:
Kyle Karinen, Executive Director

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Authorization

☒Commission Chair ☐Policy Chair

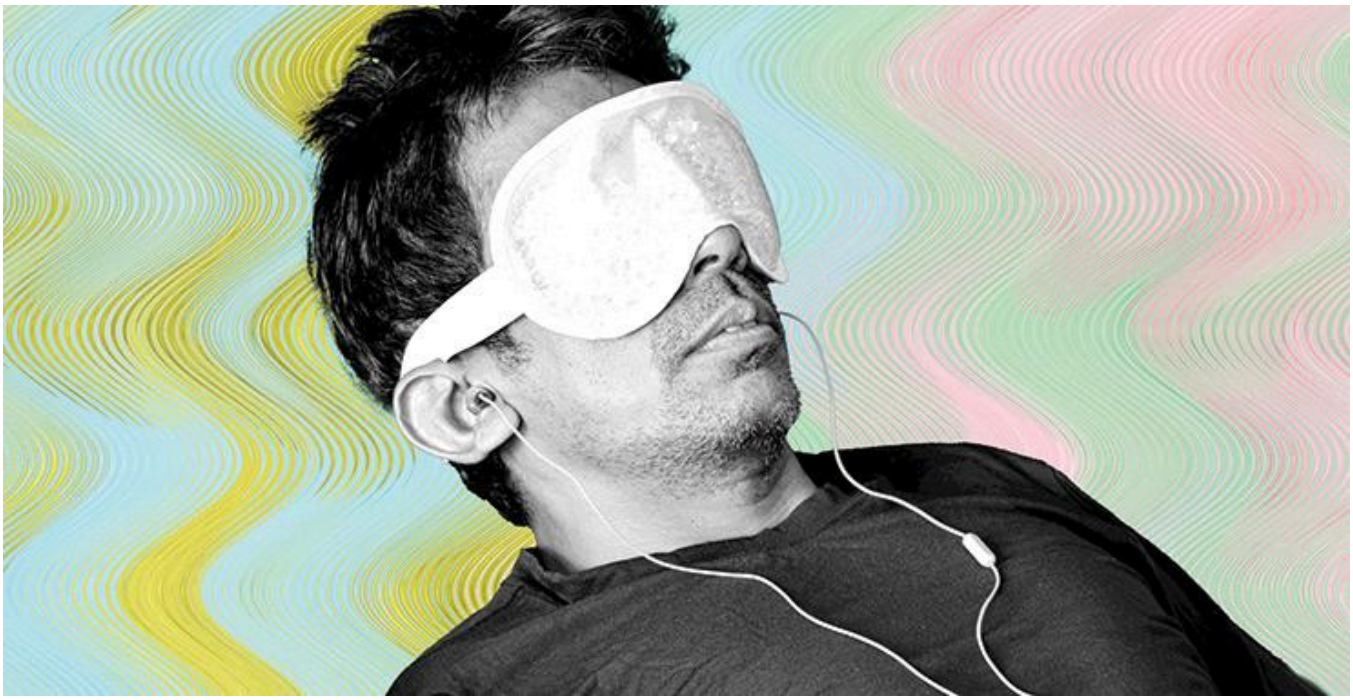
Signature: Karen B. Domino Date: 11/21/2024

FEATURE

The emergence of psychedelics as medicine

A look at the potential of MDMA, ketamine, and psilocybin to help people with treatment-resistant mental health conditions

By Heather Stringer Date created: June 1, 2024 16 min read
Vol. 55 No. 4
Print version: page 50



When researchers recruit participants for studies involving psychedelic drugs, they are often looking for people who continue to suffer from mental health

conditions even after trying current treatments—and there are many people who fall into that category.

An estimated 40%–60% of people with posttraumatic stress disorder (PTSD) do not respond to the selective serotonin reuptake inhibitors (SSRIs) that are first-line medications for the condition, and many do not respond to trauma-focused psychotherapies (Brady, K., et al., *JAMA*, Vol. 283, No. 14, 2000 (https://doi.org/10.1001/jama.283.14.1837) ; Steenkamp, M. M., et al., *JAMA*, Vol. 314, No. 5, 2015 (https://doi.org/10.1001/jama.2015.8370)). About a third of people diagnosed with major depressive disorder experience treatment-resistant depression (Zhdanava, M., et al., *Journal of Clinical Psychiatry*, Vol. 82, No. 2, 2021 (https://doi.org/10.4088/jcp.20m13699)).

While small studies in recent years started to show promising results, regulatory agencies required larger randomized, multisite clinical trials to evaluate the safety and therapeutic efficacy of psychedelic drugs. Now the results are in on the largest studies to date of psilocybin (the compound in "magic" mushrooms) and MDMA (3,4-methylenedioxymethamphetamine, also called Ecstasy or Molly). In response to an application from Lykos Therapeutics, the U.S. Food and Drug Administration (FDA) targeted August 2024 to decide whether MDMA in combination with therapy to treat PTSD would be the first type of psychedelic-assisted therapy approved in the United States.

On Aug. 10, the FDA ruled to reject MDMA for assisted psychotherapy for PTSD, citing insufficient evidence and the need for more research. The ruling is consistent with a letter APA sent the FDA earlier this year that stated that a review of the literature on MDMA-assisted psychotherapy by a multidisciplinary panel of experts determined that there is insufficient evidence to be able to recommend MDMA-assisted psychotherapy for patients with PTSD.

The APA Services Inc. comments to the FDA drew on the expertise and recommendations of the experts who are currently updating APA's 2017 *Clinical Practice Guideline for the Treatment of PTSD in Adults* (/ptsd-guideline) . The comments also pointed out that more high-quality research is needed on

MDMA-assisted psychotherapy to clarify the balance of potential benefits versus potential harms.

Larger studies have also supported the benefits of psilocybin for treatment-resistant depression, and researchers suspect this drug could be the next in line for FDA approval. Evidence is also mounting that psychedelics, which typically produce an altered state of consciousness, could help people suffering from substance use disorders, racial trauma, obsessive-compulsive disorder, and other conditions.

"If we rely on antidepressants for treatment, it can take several weeks before people experience amelioration of symptoms, if at all," said Nora Volkow, MD, director of the National Institute on Drug Abuse. "Psychedelics may offer the opportunity to get a very fast and lasting response, and with some conditions, this could be lifesaving." The latest research findings are also uncovering the potential neurobiological mechanisms that might make it possible for these controlled substances to produce mental health benefits.

While the latest evidence is encouraging, scientists are concerned that the hype in the public is ahead of the evidence. Recent data suggest that the number of people using magic mushrooms recreationally is increasing: Law enforcement seizures of the substance tripled from 2017 to 2022, and calls to U.S. poison control centers related to psilocybin use for adolescents tripled between 2018 and 2022 (Palamar, J. J., et al., *Drug and Alcohol Dependence*, 2024, in press (https://doi.org/10.1016/j.drugalcdep.2024.111086) ; Farah, R., et al., *Journal of Adolescent Health*, 2024, in press (https://doi.org/10.1016/j.jadohealth.2024.01.027)). "I worry that people think they can self-medicate with these drugs," said Joshua Gordon, MD, PhD, director of the National Institute of Mental Health (NIMH). "Existing studies have been conducted with guided psychotherapy along with the treatment, though more research is needed to understand how crucial therapy is in the process."

In one survey of more than 2,300 people who used psilocybin in real-world settings for self-exploration, 11% of the respondents reported persisting negative effects, such as mood fluctuations and depressive symptoms, weeks

or sometimes months after using the drug (Nayak, S. M., et al., *Frontiers in Psychiatry*, Vol. 14, 2023 (https://doi.org/10.3389/fpsyt.2023.1199642)). Psychedelics are also not recommended for people who have a predisposition to or family history of psychotic disorders or bipolar mood. The drugs, which can increase heart rate and blood pressure, are also contraindicated for people with cardiovascular conditions.

Psychologists have played a critical role in clinical studies on psychedelics through their work as clinicians who prepare participants for the "trip," or the experience with the drug, which often lasts many hours, and "integration," or incorporating the key insights gained during the experience into their lives in the weeks and months after the trip. To equip licensed professionals to responsibly incorporate psychedelic medicine into the clinical setting, psychologists are developing education programs focused on the latest research and evidence-based practices. For now, these clinical settings are restricted to research studies, but that could change soon if the FDA approves MDMA-assisted therapy.

"Psychedelics have been illegal for years, and in the next several years there will likely be a significant shift because some of these drugs will be classified as medicine," said Albert Garcia-Romeu, PhD, the associate director of the Center for Psychedelic and Consciousness Research at Johns Hopkins University. "Thousands of doctors, nurses, and psychologists will be lining up to practice with these drugs who have not been trained to use them, and the health care system needs to prepare for this unprecedented change."

Speaking of Psychology

Psychedelic Therapy with Roland Griffiths, PhD

Psilocybin, LSD and other psychedelic drugs were once considered promising treatments for depression, anxiety and other mental health ailments. Now, after a decades-long lull, researchers are…

The brain science of psychedelics

Although psychedelics typically lead to an altered state of consciousness, the experience during the trip can vary based on what drug is used. MDMA, an empathogen, can increase the sense of connection and empathy toward oneself and others, and patients often want to interact with a clinician during parts of the 8-hour dosing session, said Joseph Zamaria, PsyD, an associate clinical professor at the University of California, San Francisco (UCSF) School of Medicine and a faculty member of the Berkeley Center for the Science of Psychedelics. Psilocybin is usually an internal experience with less interaction between the patient and clinician during the trip, which may include vivid visual hallucinations and an altered sense of time, space, and reality. LSD (lysergic acid diethylamide) is a well-known psychedelic, but most of the research on the drug was done in the 1950s–70s. More recently, though, scientists have started studying its therapeutic potential again. In March 2024, the FDA granted breakthrough designation to a form of LSD to treat generalized anxiety disorder based on data from a clinical trial.

One of the recent breakthroughs in psychedelic research is a better understanding of how these compounds work in the brain. Chronic stress, PTSD, and depression can damage brain circuits, particularly in the prefrontal cortex. “This part of the brain talks to other regions that regulate mood, motivation, fear, and reward, and we hypothesized that psychedelics could quickly regrow lost synapses,” said David Olson, PhD, director of the Institute for Psychedelics and Neurotherapeutics at the University of California, Davis. The results in rodents indicated that these compounds stimulated serotonin 2A

receptors to promote neuron growth in the prefrontal cortex (Vargas, M. V., et al., *Science*, Vol. 379, No. 6633, 2023 (https://doi.org/10.1126/science.adf0435)).

"These drugs are not rewiring the brain, but instead repairing damaged circuitry," said Olson. "SSRIs can grow the same neurons, but it takes weeks or months to show therapeutic efficacy and a lot of patients do not respond at all." In other words, psychedelics and SSRIs both promote structural neuroplasticity, but research suggests that psychedelics may act faster.

Ketamine

Ketamine, a legal anesthetic that is increasingly used in lower doses for treatment-resistant depression, also promotes synaptic changes that help neurons communicate with one another, but serotonin receptors are not involved. Instead, the drug inhibits N-methyl-D-aspartate (NMDA) receptors of glutamate, and this strengthens the neural connections weakened during depression. Ketamine can lead to feelings of being outside of one's body and having different types of altered consciousness, but unlike classic psychedelics, the dosing sessions are much shorter. The FDA requires health care providers to monitor patients for 2 hours after administering the nasal spray form of an isomer of ketamine, Spravato. People can also receive ketamine intravenously, and studies have shown that patients usually need multiple doses to prevent relapse of depression. Treatments may initially be more frequent. "The goal is to find the sweet spot for frequency that prevents relapse," said Carlos Zarate, MD, chief of the Experimental Therapeutics and Pathophysiology Branch at NIMH. "Over time, some people may need boosters every month or two."

Although the FDA does not require therapy as part of ketamine treatment, the drug appears to improve the capacity to respond to future interventions, such as therapy or neuromodulation, said Todd Gould, MD, a professor in the departments of psychiatry, pharmacology, and neurobiology at the University of Maryland School of Medicine. "The brain is more prepared to adapt following ketamine, so combining ketamine with CBT [cognitive behavioral therapy] or

other types of therapy could improve outcomes," he said (*Molecular Psychiatry*, advanced online publication, 2024 (https://doi.org/10.1038/s41380-023-02397-1)).

MDMA

Unlike ketamine, talk therapy will likely be required as part of MDMA treatment if MDMA is approved for patients with PTSD. The most recent Phase 3 clinical trial led by researchers at UCSF included three 90-minute preparatory talk therapy sessions before the first dosing and a 90-minute therapy session after each dosing. The participants received MDMA once a month for 3 months, and more than 90% had comorbid major depressive disorder.

"It was remarkable to see how the PTSD and depression scores plummeted after the treatment," said Jennifer Mitchell, PhD, lead author of the study and a professor in the departments of neurology and psychiatry and behavioral services at UCSF. More than 71% no longer met the criteria for PTSD diagnosis, compared with 48% for the placebo group. The MDMA-assisted therapy also significantly decreased symptoms of depression (*Nature Medicine*, Vol. 29, No. 10, 2023 (https://doi.org/10.1038/s41591-023-02565-4)).

About a third of people with PTSD also suffer alcohol use disorder (AUD), and researchers are also exploring whether MDMA-assisted therapy could help this dual diagnosis population. "This patient group seems to be more severe, with high rates of self-harm, suicide, and other crises," said Christy Capone, PhD, a clinical psychologist at Brown University who is involved in a new MDMA study for these co-occurring conditions. "I've also worked with a lot of veterans who are disillusioned with the prescribed medications and stopped taking them."

There are currently no FDA-approved medications to treat PTSD and AUD concurrently, so patients are prescribed different drugs that treat each disorder. Clinical trials for substance use disorder treatments often exclude participants who have comorbidities because the dual diagnosis can be a confounding factor, said Carolina Haass-Koffler, PharmD, PhD, one of the lead researchers for the new study and an associate professor of psychiatry and human behavior at Brown University. The investigators, including clinical psychologist Erica Eaton,

PhD, of Brown University, will study how MDMA-assisted therapy affects AUD and PTSD as well as neuroinflammation, white matter integrity, and functional connectivity between the prefrontal cortex and amygdala.

Psilocybin

Though MDMA is further along in the FDA review process, there has also been an explosion of research on psilocybin in the last several years. The largest Phase 2 trial to date suggested a 25-mg dose of psilocybin with psychotherapy before and after the dosing was associated with a rapid and sustained antidepressant effect, measured by a change in depressive symptom scores (Raison, C. L., et al., *JAMA*, Vol. 330, No. 9, 2023 (https://doi.org/10.1001/jama.2023.14530)).

"We need this as an option for patients because the current pharmacological treatments don't work for everyone and are not well tolerated by many people," said Alan Davis, PhD, director of the Center for Psychedelic Drug Research and Education at The Ohio State University. The current medications for depression can include sexual, mood, weight, cognitive, and other side effects, and it often takes weeks or months of trial and error with different medications to find something that may or may not be effective. Psilocybin has a much more favorable side effect profile: transient headache, which can be treated with over-the-counter medications, and mild to moderate transient anxiety.

Davis has also found that psilocybin can reduce symptoms of racial trauma, such as depression and anxiety, in diverse populations. People of color who participated in a recent study reported reductions in racial trauma symptoms as well as reductions in alcohol and drug use after psychedelic experiences (Haeny, A. M., et al., *Journal of Substance Use and Addiction Treatment*, Vol. 149, 2023 (https://doi.org/10.1016/j.josat.2023.209035)).

Psilocybin also has the potential to help people quit smoking. In a recent study at Johns Hopkins, participants who received one dose of psilocybin followed by CBT showed higher rates of smoking abstinence than those who received a nicotine patch and CBT. "Oftentimes people feel more energetic and optimistic

for a week or two after the dosing, and this is a crucial period that allows them to reset and stop smoking," Garcia-Romeu said. "People sometimes have experiences that are terrifying, like a sense that they are dying or going crazy, but this can also be important fodder for productive conversations in a therapeutic relationship."

After seeing the growing evidence that psilocybin may help people with a variety of mental health disorders, Christopher Pittenger, MD, PhD, director of the Yale Program for Psychedelic Science, was curious if people with obsessive-compulsive disorder (OCD) could benefit from the compound. He and his colleague, Benjamin Kelmendi, MD, launched a controlled long-term study of a single dose of psilocybin for treatment-resistant OCD. The participants received psychological support before, during, and after the dosing session. Preliminary results suggested that half of the patients experienced benefits. "The people who improve typically tell us that while the obsessions are still there, they do not bother them as much," said Pittenger. Kelmendi presented the preliminary findings at the annual American College of Neuropsychopharmacology conference in 2023.

"Psilocybin seems to universally have a beneficial effect for a variety of mental health conditions," Davis said. "In the next 5 years, it may be possible that a clinic providing psychedelic-assisted therapy could help people with substance use, depression, PTSD, and other conditions all in one setting."

Though psilocybin is showing promise for a growing list of conditions, one researcher recently discovered a surprising factor that affected outcomes when the substance was used in an experiment that tested fear memories, which are relevant to understanding PTSD. In the study, adult male and female rats were trained to associate a tone with an electric foot shock. The next day, some of the rats received psilocybin and others received a control substance, and then the rats learned that the tone no longer resulted in a foot shock. In male rats, psilocybin increased the rate of fear extinction compared with the control group, but the opposite was true for the female rats. "We were surprised that in females, the drug slowed the rate of fear extinction and led to greater fear compared to controls," said Phillip Zoladz, PhD, a psychology professor at Ohio

Northern University. He presented the findings in November 2023 at the annual meeting for the Society of Neuroscience. “Nobody has been looking at the sex differences in psilocybin, and we need to take that into consideration in clinical trials of the drug.”

The role of therapy

While the results are encouraging, Mitchell said it is important for the public to recognize that the partnership between the patient and a savvy care team was a critical aspect of the experience in the clinical trial.

“Psychedelics have a tendency to stir the pot emotionally and cognitively, and therapists can help people process what they are feeling,” said Mitchell. “If patients are confronted with something dark about themselves, they need trained providers to create an environment of love and protection.” Rape victims or war veterans, for example, may have memories that are patchy, and when they revisit the memories while taking MDMA, they may feel shame, blame, or embarrassment. “The therapist can help patients reprocess the memories and encode them differently,” Mitchell said.

Mitchell’s team also worked to create a participant pool that was diverse, with more than 24% participants who were Hispanic or Latino. “We do not want this to be a drug [exclusively] for the White upper-middle class,” she said. If the FDA approves MDMA-assisted therapy, she hopes health insurance providers will explore ways to cover the cost. In her most recent Phase 3 study, the cost was $12,000 per participant, which did not include the cost of training the health care providers.

It is also critical for clinicians to allow people to find their own meaning from a psychedelic experience by asking questions rather than interpreting for them. “These sessions can be one of the most meaningful experiences people have in their lives, and I cannot overstate the importance of staying metaphysically neutral,” said Matthew Johnson, PhD, senior researcher at the Center for Excellence for Psilocybin Research and Treatment at Sheppard Pratt, a psychiatric hospital in Baltimore, Maryland. “We should not push any particular

religious beliefs or fall into the trap of being seen as a guru revered by the client."

Though Johnson is adamant about the need for caution, he is eager to increase awareness about the potential benefits of psychedelics for people who are suffering from a variety of conditions. He remembers one participant in a study who could not quit smoking, and she would sit on an air conditioner in the backyard to hide from her family when she smoked. During a psilocybin session, she imagined herself as a vine growing into the sky—a life force that chose to grow and flourish.

"She came to an understanding that smoking was not intrinsic to who she was," he said. "She was far more special, and the behavior was not core to someone who chooses to live and be healthy." She also received CBT as part of the treatment to help her build on the realizations she had during the trip, and she quit smoking. "I have seen how psychedelics can transform the internal narrative and motivational level," he said. "It is powerful to work with people who are astonished that they can actually make changes that seemed impossible."

What are psychedelics?

Scientists are uncovering the therapeutic potential of psychedelics to treat a variety of mental health conditions.

Psilocybin: Research has indicated rapid-acting and enduring antidepressant effects in combination with psychological support. Data also suggest potential efficacy for substance use disorders (alcohol use disorder and nicotine addiction), existential distress, and headache disorders. Still Schedule I in the United States.

MDMA: Studies suggest it can be effective for posttraumatic stress disorder in combination with talk therapy. Other areas are under

investigation (alcohol use disorder, couples therapy, existential distress). Still Schedule I in the United States.

Ketamine: Research has indicated rapid-acting antidepressant effects and suggests potential for treating substance use disorders in combination with therapy. Legally available in the United States under medical supervision.

LSD: Historical evidence indicates therapeutic potential for substance use disorders. Recently granted FDA "breakthrough therapy" designation as a potential treatment for anxiety. Still Schedule I in the United States.

To learn more about psychedelics, sign up for APA's continuing education course The Science of Psychedelics: Research, Risks, and Therapeutic Potentials (/education-career/ce/science-psychedelics) .

Further reading

Psychedelic therapies reconsidered: Compounds, clinical indications, and cautious optimism (https://doi.org/10.1038/s41386-023-01656-7)
Mitchell, J. M., & Anderson, B. T., *Neuropsychopharmacology*, 2024

IUPHAR-review: The integration of classic psychedelics into current substance use disorder treatment models (https://doi.org/10.1016/j.phrs.2023.106998)
Yaden, D. B., et al., *Pharmacological Research*, 2023

Ketamine's acute effects on negative brain states are mediated through distinct altered states of consciousness in humans (https://doi.org/10.1038/s41467-023-42141-5)
Hack, L. M., et al., *Nature Communications*, 2023

Psychedelics and psychedelic-assisted psychotherapy (https://doi.org/10.1176/appi.ajp.2019.19010035) Reiff, C. M., et al., *The American*

Journal of Psychiatry, 2020

Clinical applications of hallucinogens: A review
(https://doi.org/10.1037/pha0000084)
Garcia-Romeu, A., et al., *Experimental and Clinical Psychopharmacology*, 2016

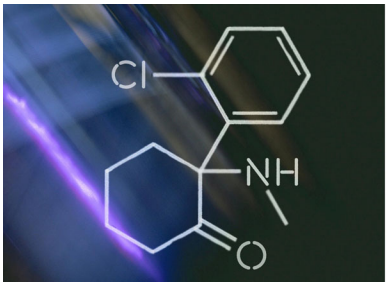
Fact Sheet: Ketamine

Aaron Hunt, Gabriela Murza, Jenna Hawks, and Alyssa Ferrin

03/14/2025

What Is Ketamine?

Ketamine, a general anesthetic developed in the 1960s, is used in medicine to relieve pain and has gained recent attention for its antidepressant e#ects (Li & Vlisides, 2016). It has pain-relieving properties and produces dissociative e#ects among users (Drug Enforcement Administration [DEA], 2020). Ketamine is a Schedule III substance, meaning there is a risk of strong psychological dependency and potential physical dependency (DEA, 2020; National Institute on Drug Abuse [NIDA], 2024; Preuss et al., 2023).



Medical Uses for Ketamine

Ketamine is approved by the Food and Drug Administration (FDA) as a general anesthetic that can be used alone or in combination with other medicines to assist during and prior to surgeries (DEA, 2020; Goordeen et al., 2022; Mayo Clinic, 2025; NIDA, 2024). Ketamine is widely used for its sedation capabilities and ability to relieve acute and chronic pain (DEA, 2020; Goordeen et al., 2022; Orhurhu et al., 2023a). Additionally, ketamine in low dosages is being explored as a treatment for addressing severe depression and decreasing pain caused from long-term opioid use (Ezquerra-Romano et al., 2018; Goordeen et al., 2022; Matveychuk et al., 2020; Orhurhu et al., 2023a). Ketamine's antidepressant and anti-suicidal properties make it a promising option for addressing serious mood disorders and treatment-resistant depression (Matveychuk et al., 2020).

Ketamine Street Names

According to the Addiction Center (2025) and DEA (2020), ketamine street names include:

- Special K
- Super K
- Vitamin K
- Cat valium
- Dorothy
- Purple
- Kit Kat

Impact of Recreational Ketamine Use

Ketamine is also used recreationally for its hallucinogenic and dissociative properties, as it allows users to feel detached from their surroundings and self (Addiction Center, 2025; DEA, 2020; NIDA, 2024). At smaller doses, this can leave a person feeling happy or like they are dreaming/floating, but at larger doses, it can lead to confusion or inability to move or speak (NIDA, 2024). Recreationally used ketamine takes the form of a clear liquid that is injected into the bloodstream or mixed into drinks or a white powder that can be inhaled or smoked (DEA, 2020). The "ketamine street names" box lists common terms for ketamine.

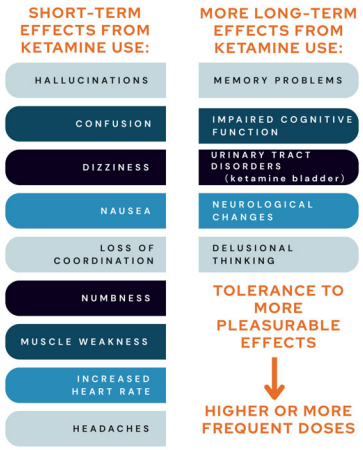


Figure 1. *Short- and Long-Term Signs and Symptoms of Ketamine Use*

Sources: Geo#rion, 2024; Leaver, 2019; NIDA, 2024; Srirangam & Mercer, 2012

Ketamine has a short-duration full-body buzz (or high) but produces a quick tolerance, leading the user to increase

the quantity to reach the same initial e#ect (Addiction Center, 2025). Ketamine's potency poses a risk of forming a moderate to low physical dependency or a high psychological dependency (DEA, 2020; Orhurhu et al., 2023b). Figure 1 shows the short- and long-term e#ects of ketamine use, such as dizziness, headaches, memory problems and impaired cognitive and urinary function.

Risk of Overdose and "K-Hole"

Higher doses of ketamine can cause what is known as "k-hole," where an individual undergoes an out-of-body experience and is completely detached; this can feel like a near-death experience (Addiction Center, 2025). K-hole can be described as taking too much ketamine, resulting in users feeling completely numb or disconnected from the body (San Francisco Aids Foundation, n.d.).

Figure 2.*Signs of a Ketamine Overdose*

Sources: Addiction Center, 2025; San Francisco

Sources: Addiction Center, 2025; San Francisco

It can be unpredictable and di#cult to gauge ketamine quantity, and in some cases, overdose may occur, leading to life-threatening situations and, sometimes, death (Addiction Center, 2025; San Francisco AIDS Foundation, n.d.). Users attempting to reach the "k-hole" may accidentally overdose—especially if other substances and alcohol are also ingested (Addiction Center, 2025).

An individual can experience an overdose even with a small dose of ketamine (Addiction Center, 2025), so it's important to call 9-1-1 immediately and identify the symptoms to the operator if you suspect someone is experiencing an overdose on ketamine. Signs might include severe confusion, drowsiness or unconsciousness, high blood pressure, irregular heartbeat or chest pain, vomiting, and convulsions or hallucinations (Figure 2). You can turn the individual onto their side into the recovery position to keep their airway open and unblocked in case of possible choking.

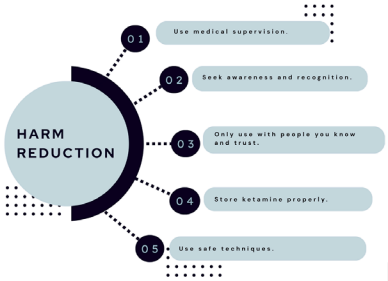


Figure 3.*Harm Reduction Strategies*

Source: San Francisco AIDS Foundation, n.d.

Prevention and Harm Reduction

Harm reduction approaches for substance use are strategies that limit fatal overdoses. Figure 3 displays several harm reduction strategies when using ketamine, including:

- **Use medical supervision.** Always use ketamine under the guidance of a qualified medical provider and ensure it is obtained from a regulated, trustworthy source.
- **Seek awareness and recognition.** Be aware of the signs and symptoms of misuse and ketamine overdose. Seek emergency medical help immediately if you suspect someone has overdosed.
- **Only use with people you know and trust.** Use ketamine with trusted people and ensure it doesn't accidentally get in the hands of someone who is not intending to consume or ingest it.
- **Store ketamine properly.** Ensure that ketamine is properly stored and kept out of reach of others (particularly children) to prevent accidental ingestion.
- **Use safe techniques.** Stay hydrated with lots of water or electrolyte drinks prior to use, use only your prepared drink(s), avoid sharing needles, inject into a muscle only, and avoid sharing devices with others.

Finding Resources and Learning More

- Responding to a Ketamine Overdose (BOCA Recovery Center, 2024).
- SAMHSA's National Helpline: 1-800-662-HELP (4357) (Substance Abuse and Mental Health Services Administration, 2023).

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Synthesizing the Evidence for Ketamine and Esketamine in Treatment-Resistant Depression: An International Expert Opinion on the Available Evidence and Implementation

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Replicated international studies have underscored the human and societal costs associated with major depressive disorder. Despite the proven efficacy of monoamine-based antidepressants in major depression, the majority of treated individuals fail to achieve full syndromal and functional recovery with the index and subsequent pharmacological treatments. Ketamine and esketamine represent pharmacologically novel treatment avenues for adults with treatment-resistant depression. In addition to providing hope to affected persons, these agents represent the first non-monoaminergic agents with proven rapid-onset efficacy in major depressive disorder. Nevertheless, concerns remain about the safety and tolerability of ketamine and esketamine in mood disorders. Moreover, there is uncertainty about the appropriate position of these agents in treatment algorithms, their comparative effectiveness, and the appropriate setting, infrastructure, and personnel required for their competent and safe implementation. In this article, an international group of mood disorder experts provides a synthesis of the literature with respect to the efficacy, safety, and tolerability of ketamine and esketamine in adults with treatment-resistant depression. The authors also provide guidance for the implementation of these agents in clinical practice, with particular attention to practice parameters at point of care. Areas of consensus and future research vistas are discussed.

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The majority of individuals with major depressive disorder who are treated with monoamine-based antidepressants fail to achieve full symptomatic and functional recovery with the index treatment (1). Remission rates in major depression are reportedly less than 15% among patients with two prior conventional treatment or augmentation failures, that is, with treatment-resistant depression (TRD) (2–7). Despite the efficacy of manual-based psychotherapy (e.g., cognitive-behavioral therapy) in major depression, its efficacy as a monotherapy in TRD is not well established (8).

In March 2019, intranasal esketamine, co-initiated with a conventional antidepressant, was approved by the U.S. Food and Drug Administration (FDA) for adults with TRD (9). The European Medicines Agency granted regulatory approval for intranasal esketamine for TRD in December 2019, and additional approvals are expected in other parts of the world. In August 2020, the FDA updated the approval of intranasal esketamine to include adults with major depression and suicidal ideation and behavior (10). The development and regulatory approvals of esketamine for mood disorders occurred pari passu with extraordinary media, public, clinical, and scientific interest in ketamine and related agents (11).

Although increasing access to and availability of treatments such as ketamine and esketamine for persons with TRD is welcome, legitimate concerns have been raised with respect to long-term efficacy, safety, tolerability, patient selection, and risk for precipitating substance use disorder, as well as appropriate personnel and settings for competent and safe administration of ketamine (12–15). These concerns are amplified by the rapid increase in the numbers of practitioners and community-based clinics in the United States that have expanded their scope of practice to include ketamine for TRD (16).

Our overarching aims in this review are twofold: to provide practitioners with a synthesis of the current knowledge

as it relates to ketamine's pharmacology, efficacy, tolerability, and safety; and to review the clinical aspects related to administration of ketamine at point of care. This article is not meant to be an exhaustive review of the literature, which has been done in several recent systematic reviews and meta-analyses of ketamine and esketamine (17–20).

KETAMINE PHARMACOLOGY

Pharmacodynamics

The key pharmacodynamic targets of ketamine and its proposed clinical effects are summarized in Table 1. The prevailing view with respect to ketamine's mechanism of action in TRD is that ketamine facilitates synaptogenesis and synaptic potentiation (21–23). Ketamine exhibits high affinity for the phencyclidine site of the *N*-methyl-D-aspartate receptor (NMDAR) (24, 25). Antagonism of NMDARs on fast-spiking γ-aminobutyric acid (GABA)-ergic interneurons inhibits interneuron tonic firing with a consequent glutamate surge (26).

The glutamate surge activates the ionotropic AMPA receptor (AMPAR), setting in motion a series of intracellular signaling cascades, resulting in an increase in brain-derived neurotrophic factor (BDNF)-TrkB-ERK activity as well as PI3-AKT-mammalian target of rapamycin (mTOR) activation (27, 28). Indirect evidence supporting this pathway includes the observation that pretreatment with the AMPAR antagonist NBQX (2,3-dioxo-6-nitro-7-sulfamoyl-benzo[f] quinoxaline) attenuates antidepressant-like behavioral effects with ketamine (28–30).

Recent studies also suggest that ketamine's mechanism of action may involve effects on the subgenual anterior cingulate cortex (sgACC) (31, 32). Overactivity in the sgACC is a replicated pathological feature of major depressive disorder, and reduction of activity in the sgACC is associated with response to conventional antidepressant treatments (31, 33). Studies in nonhuman primates showed that glutamatergic overactivation of the sgACC led to anhedonic behavior that could be reversed by injection of ketamine directly into the sgACC (32). Consistent with this finding, patients with major depression show hyperactivation of the sgACC during receipt of monetary reward that was reversed by ketamine (31).

In addition to effects on glutamate-GABA systems, evidence suggests that other low-affinity targets may also be relevant to ketamine's mechanism of action in TRD (34). For example, ketamine is reported to activate human-recombinant μ, κ, and δ opioid receptors (35). It is also observed that μ opioid receptors and NMDAR co-localize in the CNS, which may account for the increase in glutamatergic signaling reported with morphine (36, 37). Animal data indicate that the opioidergic system is necessary, but not sufficient, for the antidepressant action of ketamine in rodents (38). Williams et al. observed that pretreatment with naltrexone (50 mg), a nonselective pure opioid antagonist with differential affinity for the μ opioid receptor, attenuated the antidepressant and anti–suicidal ideation effects of a single intravenous infusion of ketamine (0.5 mg/kg) in adults (N=30) with TRD (39, 40). This interesting proof-of-concept study implicates opioidergic systems as a direct and/or indirect target of ketamine treatment in TRD.

The findings of this elegant study need to be considered along with results of a separate small (N=5) open-label pilot study (41) in which adults with major depressive disorder and current alcohol use disorder received pretreatment with injectable naltrexone (380 mg) once every 2–6 days prior to repeat intravenous ketamine infusion (0.5 mg/kg per day). Despite pretreatment with naltrexone, significant antidepressant effects as well as reductions in craving for alcohol consumption were reported. Moreover, a separate post hoc analysis indicated that allelic variation of the μ opioid receptor does not attenuate the anti–suicidal ideation effect of ketamine treatment in TRD (42).

Taken together, the available evidence has not excluded the potential for misuse and/or gateway activity with ketamine or esketamine among patients receiving these treatments for TRD. Indeed, there is an urgent need to refine the potential role of opioid receptors in ketamine's antidepressant effect and safety profile (43). Ketamine's putative effects on other low-affinity targets (e.g., σ receptors, voltage-gated sodium channels, and L-type voltage-dependent calcium channels) are comprehensively reviewed elsewhere (34).

Pharmacokinetics

Ketamine is available in multiple formulations, of which the intravenous and intranasal routes have the most compelling evidence of efficacy in TRD. As summarized in Table 2, the bioavailability of ketamine differs as a function of route of delivery, and a gradient of bioavailability is observed (i.e., intravenous > intramuscular > subcutaneous > intranasal > oral) (34). Ketamine's plasma protein binding is approximately 10%–15%. The elimination half-lives are approximately 2–4 hours for racemic ketamine and 5 hours for esketamine (44). The bioavailability is approximately 100% for intravenous ketamine and approximately 30%–50% for intranasal esketamine. The dosing equivalence of intravenous ketamine and intranasal esketamine is not definitively established. However, as intravenous racemic ketamine comprises an equal molar ratio of *S*- and *R*-ketamine, it is estimated that 0.5 mg/kg of ketamine approaches the bioavailability of approximately 56 mg of esketamine (34).

Ketamine is highly lipophilic and is metabolized primarily through CYP3A4 and CYP2B6 to its principal metabolite, norketamine. CYP3A4 demethylates esketamine at a faster rate than it does *R*-ketamine, and CYP2B6 metabolizes both isomers with equal efficiency (34). The differential efficiency may account for the observation that the ratio of *S*- to *R*-ketamine in individuals with treatment-resistant bipolar depression receiving intravenous racemic ketamine (0.5 mg/kg over 40 minutes) was reported as 0.84 (44). *R*/*S*-norketamine is subsequently converted to hydroxynorketamine and dehydronorketamine (34).

Reports from rodent studies indicate that ketamine has mild and likely clinically insignificant induction and/or inhibitory effects on CYP3A4 (45–48). It is unlikely that the effects described here would be clinically meaningful when ketamine is coprescribed with other agents that are substrates of CYP3A4. Concomitant administration of other drugs that

TABLE 1. Key pharmacodynamic targets of ketamine and esketamine

Target	Pharmacodynamic Effect	Potential Clinical Effect[a]
Glutamate system		
N-methyl-D-aspartate (NMDA) receptor	Strong antagonist	Antidepressant and procognitive effects; acute dissociative effects
α-Amino-3-hydroxy-5-methyl-4-isoxazolepropionic acid (AMPA) receptor	Indirect agonist (through increase glutamate release)	Antidepressant effects
D-Serine site	Antagonist	Antidepressant effects
Glutamate	Increased release	Antidepressant effects
Opioid system		
μ Opioid receptor	Weak agonist	Antidepressant and analgesic effect and potentially acute euphoric effect
μ Opioid 2 receptor	Antagonist	
κ Opioid receptor	Agonist	
δ Opioid receptor	Agonist	
Monoamine system		
Serotonin transporter	Weak inhibitor	Antidepressant effect
Norepinephrine transporter	Weak inhibitor	Antidepressant effect
Dopamine transporter	Weak inhibitor	Antidepressant effect
Dopamine 2 receptor	Agonist	Acute psychotomimetic effects
Serotonin (5-HT_3) receptor	Weak antagonist	Antidepressant effect
Cholinergic system		
Cholinesterase	Inhibitor	Procognitive effects
α7 Nicotinic receptor	Antagonist	Antidepressant effects
α4 β2 Nicotinic receptor	Antagonist	
Muscarinic receptors (M1–3)	Antagonist	Increased blood pressure and heart rate
Other		
σ_1 Receptor	Agonist	Antidepressant and cardiac effects
σ_2 Receptor	Agonist	Antidepressant and cardiac effects
Mammalian target of rapamycin (mTOR)	Downstream activation via glutamate system	Antidepressant effects
Brain-derived neurotrophic factor (BDNF)	Downstream from mTOR increasing BDNF levels	Antidepressant and procognitive effects
$GABA_A$ receptor	Agonist	Acute anxiolytic effects
mTORC1	Activation	Neuroplastic effects

[a] The clinical significance of specific targets remains unclear, and results have been mixed. Potential proposed clinical effects are synthesized and summarized here.

are CYP3A4 and/or CYP2B6 inhibitors or inducers may have effects on the areas under the curve (AUC) and peak serum concentrations (C_{max}) for circulating ketamine and norketamine, but the clinical significance is not determined (49).

KETAMINE AND ESKETAMINE EFFICACY IN TRD

The most studied and compelling formulations and routes of delivery of ketamine in TRD are intranasal esketamine coadministered with a newly initiated antidepressant, or intravenous racemic ketamine administered as monotherapy or adjunctively with preexisting psychotropic regimens. Replicated short-term randomized controlled studies have unequivocally established the rapid and significant efficacy of both formulations and routes of delivery in adults with TRD (17–20, 50). A legitimate criticism, as it relates to interpreting the effect sizes reported with single or repeat-dose ketamine in TRD, is the possibility that nonspecific effects such as functional unblinding (e.g., by patients experiencing dissociation or euphoric responses) and expectancy may inadvertently inflate the efficacy of ketamine (51, 52).

The short-term efficacy of intravenous racemic ketamine has invited the need in most cases for repeated dosing to sustain the therapeutic benefit (53). Studies ranging from 0.1–1.0 mg/kg suggest that higher dosing (i.e., 0.5–1.0 mg/kg) is superior in efficacy at the group level when compared with lower dosing (i.e., 0.1–0.2 mg/kg) 1 day after administration (54). The upper dosing limit for intravenous racemic ketamine in TRD is not established, but evidence from single-dose studies indicates efficacy at doses of 0.5 mg/kg as well as 1.0 mg/kg, with no evidence of superiority of 1.0 mg/kg over 0.5 mg/kg (54). It is also reported that some treatment-emergent adverse events with ketamine (e.g., elevation in blood pressure) are dose dependent (55). Experience with intravenous ketamine administration in adults with TRD receiving care at a community-based clinic also indicates that higher doses of intravenous ketamine are associated with higher rates of treatment-related adverse events (e.g., dissociation) when compared with lower dosing (i.e., 0.75 mg/kg and 0.5 mg/kg, respectively) (56). Clinicians administering ketamine should be aware of the greater propensity to

TABLE 2. Comparison of routes of administration of ketamine and esketamine

Route	Bioavailability	Dose Range (Acute)
Intravenous	100%	0.5–1.0 mg/kg infused over 40–60 minutes twice weekly for 2 weeks
Intramuscular	90%–95%	Not established, likely similar to intravenous
Subcutaneous	90%–95%	Not established, likely similar to intravenous
Intranasal	30%–50% (significant differences between devices and solution)	Esketamine: 56–84 mg intranasally twice weekly for 4 weeks Racemic ketamine: 50–150 mg intranasally twice weekly
Oral	10%–20% (potential variability between capsules and liquid forms)	Highly variable (0.5–7.0 mg/kg daily to once weekly), with 100–250 mg 2–3 times per week most accepted
Sublingual	20%–30%	Not established, likely similar to oral
Transdermal	10%–50% (highly variable by vehicle used)	Not established

adverse events and potential safety concerns when relatively higher doses of intravenous ketamine are administered.

The ideal frequency of intravenous administration has also not been established in adults with TRD. For example, results from a multicenter double-blind study in adults (N=67; ages 18–64 years) with TRD indicated that acute antidepressant efficacy at day 15 did not differ between twice weekly and thrice weekly intravenous administration (0.5 mg/kg) (57).

An initial pilot study demonstrated the antidepressant efficacy and tolerability of intranasal racemic ketamine given as a single administration (50 mg) (58). Thus far, intranasal racemic ketamine has not been definitively established as safe and effective in adults with TRD. Intranasal esketamine was studied in several registration trials prior to regulatory approval. The trial designs for intranasal esketamine studies were unique insofar as intranasal esketamine was co-initiated with a conventional antidepressant and compared with a placebo co-initiated with an antidepressant as the comparator. The effective doses of intranasal esketamine were 56 mg and 84 mg, administered twice weekly for 4 weeks, followed by weekly administration for 4 weeks and every 1–2 weeks thereafter.

A meta-analysis of the efficacy of intranasal esketamine augmentation in TRD (five trials, N=774 patients) reported significant improvement (19). The endpoints in the intranasal esketamine studies were efficacy at 4 hours and at days 8 and 28. The overall standardized mean difference for the Montgomery-Åsberg Depression Rating Scale score change was 0.36 (95% CI=0.24, 0.49, $p<0.0001$). The pooled risk ratios for response and remission were 1.4 and 1.45 (both at $p<0.0001$), respectively. It was further reported that the number needed to treat was 6 for response and 7 for remission. The clinically significant results in that study were apparent despite the high placebo response (i.e., placebo co-initiated with a conventional antidepressant) in the esketamine development program. Nevertheless, it should be highlighted that a secondary subgroup analysis of the intranasal esketamine data indicated that placebo-subtracted differences in some subgroups with intranasal esketamine were not significant (e.g., those with <3 previous antidepressant failures) (59).

In addition to acute efficacy, relapse prevention was established with intranasal esketamine in combination with a conventional antidepressant. Intranasal esketamine combined with a conventional antidepressant decreased the risk of relapse by 51% among persons who had achieved stable remission and 70% among those who achieved a stable response with acute therapy (60). However, it was subsequently noted that one of the participating sites had a 100% relapse rate in the placebo arm, which accounted for a significant overall effect in the positive relapse prevention study result (61). This observation needs to be placed in a broader context, however, as the study was not designed primarily with a view to evaluating site-specific placebo-drug differences.

The efficacy of intranasal esketamine in adults ≥65 years old is not yet established. In one study in adults ≥65 years old, intranasal esketamine was flexibly dosed at 28–84 mg twice weekly and co-initiated with a new antidepressant (62). The overall efficacy of adjunctive intranasal esketamine was not significantly greater than placebo in that study at the prespecified endpoint (i.e., day 28). In addition to this negative study, another study reported nonsignificant differences between adjunctive intranasal esketamine and placebo co-initiated with a conventional antidepressant (63). Notwithstanding, preliminary evidence does suggest that ketamine may be safe and effective in older populations with TRD (64).

Given the absence of an adequately designed head-to-head trial, the relative efficacies of intranasal esketamine and intravenous racemic ketamine are not known (65). Nevertheless, a single study suggested that twice- or thrice-weekly intravenous racemic ketamine (0.5 mg/kg) may be superior to intranasal esketamine co-initiated with an antidepressant (the numbers needed to treat were 2 and 6, respectively, for response at week 2) (57). A recent meta-analysis comparing intranasal and intravenous ketamine formulations was unable to identify a significant difference between formulations as well as routes of delivery in efficacy at 24 hours, 7 days, and 28 days (17). A separate meta-analysis concluded that intravenous ketamine may be superior in efficacy and have lower dropout rates (66). However, it is difficult to draw definitive conclusions from these analyses given the heterogeneity across component studies.

Ketamine's efficacy in TRD using oral, intramuscular, and subcutaneous formulations has also been preliminarily reported. Of these formulations, the oral formulation has

relatively more studies in TRD with evidence suggesting efficacy after repeat dosing, with insufficient data on efficacy within 24 hours (67). Oral ketamine has been commonly prescribed off-label for its analgesic effect and is often compounded into capsules or mixed with juice to increase its palatability (68). Oral ketamine has extensive first-pass metabolism, resulting in a bioavailability of 10%–20% (sublingual ketamine has a bioavailability of approximately 30%) (69, 70). Similar to oral ketamine, the efficacy of subcutaneous and intramuscular ketamine in TRD has not been established with adequately powered, replicated randomized double-blind placebo-controlled studies.

KETAMINE AND SUICIDALITY

Rapid reduction of suicidal ideation with ketamine has been reported (71, 72). Results from systematic reviews and meta-analyses have also reported anti–suicidal ideation effects of ketamine/esketamine with both single and repeat dosing (166). The reduction in suicidal ideation has been reported to endure for up to 7 days from the previous administration (73). Repeat-dose studies also indicate that reduction in suicidal ideation may persist for up to 6 weeks in persons receiving repeat-dose intravenous racemic infusion (0.5 mg/kg) (74). Available evidence also suggests that the reduction in suicidal ideation observed with ketamine may be in part independent of its effect on overall depressive symptoms (18, 75).

A limitation, however, is the lack of evidence demonstrating reduction in suicide completion and whether a more persistent reduction in suicidal ideation is observed beyond 6 weeks for either esketamine or ketamine (74). Of the two formulations, esketamine has been subjected to a more rigorous assessment of its acute antisuicidality effects. For example, although two phase 3 studies and one phase 2 study in adults with major depression at imminent risk for suicide who underwent randomized assignment to intranasal esketamine (84 mg) or placebo co-initiated with conventional antidepressants showed rapid improvement in depressive symptoms as measured by the Montgomery-Åsberg Depression Rating Scale (the primary outcome measure), the studies did not find significant reductions in suicidal ideation compared with placebo at 24 hours after administration and/or 25 days later (76). Notwithstanding the failure to detect a difference in suicidal ideation, the studies provided the basis for the FDA approval of esketamine for the treatment of major depressive disorder with suicidal ideation or behavior (77, 78). No data are available on the effect of maintenance esketamine or ketamine with suicidality as the primary outcome.

KETAMINE TOLERABILITY AND SAFETY

Treatment-emergent adverse events with ketamine and esketamine in major depression may be categorized as psychiatric (e.g., dissociation, psychotomimetic), neurologic/cognitive, hemodynamic, genitourinary, and abuse liability (79). The categories of side effects observed with ketamine and esketamine in major depression are, in some cases, identical with differences in the percentage and severity of events. The differences in the frequency and severity of adverse events are a function of the heterogeneity in ketamine formulation, route of delivery, patient population, concomitant medications, and methodological aspects (e.g., safety assessments) of study designs. A limitation of adverse event reporting is that most adverse events with intravenous ketamine are not systematically reported and are likely subject to reporting bias insofar as there is relatively less data as it relates to long-term ketamine exposure. This is in contradistinction to the safety and tolerability data for esketamine in TRD, where the data collection was systematic and included both short- and long-term data.

Psychiatric Adverse Events

Dissociation. The most common psychotomimetic effects reported with ketamine in TRD are dissociation, perceptual disturbances, abnormal sensations, derealization, and depersonalization (79). Approximately 72% of studies with intravenous racemic ketamine in TRD report dissociation, compared with 36% in non-intravenous racemic ketamine studies, most likely reflecting differences in plasma levels rather than route of administration (79). It is a replicated finding that the percentage of individuals with TRD reporting dissociation decreases with subsequent administration. Dissociation usually peaks within 40 minutes after administration and usually resolves within 1–2 hours. The most commonly used scale to assess the severity of dissociation in TRD is the Clinician-Administered Dissociative States Scale (CADSS).

Although results are mixed with respect to whether dissociation correlates with acute or sustained antidepressant effects, dissociation is neither necessary nor sufficient for antidepressant response (80, 81). Moreover, there is no evidence that adults with treatment-resistant major depression or bipolar disorder differ in their propensity for dissociation (82). Consensus exists that the CADSS, which has been repurposed as a ketamine safety measure, does not provide sufficient coverage of psychotomimetic experiences with ketamine and likely underestimates the frequency of dissociation (83). Unfortunately, a tool specifically validated for measuring dissociation in adults with TRD receiving ketamine is not available at this time for point-of-care implementation.

Psychotomimetic. In this discussion, psychotomimetic is defined as the induction of psychosis and is differentiated from dissociation. Ketamine has long been reported to carry a risk of induction of psychosis, especially in individuals with a preexisting vulnerability. Ketamine, for example, can induce psychotic phenomena in individuals with schizophrenia (84, 85). Nevertheless, it remains possible that selected individuals with a primary psychotic disorder may safely and effectively benefit from ketamine administration (86). It was also reported that individuals with a history of psychosis are more vulnerable to dissociation, but not psychosis, with ketamine administration. Despite the greater propensity for dissociation in those with a history of psychosis, the duration of dissociation did not endure beyond the 40-minute time point (87).

Neurologic/Cognitive

For adults with TRD, no replicated and persistent deficits in cognitive functions in persons treated with racemic ketamine have been reported (88–90). It has been reported that the multidomain cognitive impairment assessed in healthy volunteers (N=24) 40 minutes after esketamine administration (84 mg) was no different from that assessed in the placebo group at 120 minutes (91). Also, 1-year exposure to intranasal esketamine in adults with TRD has not been reported to result in impairment in cognitive function (91).

The most common neurologic side effects are dizziness, drowsiness, and light-headedness. It is not known whether long-term exposure to ketamine results in cellular or molecular evidence of neurotoxicity. Preclinical studies have reported the presence of excitotoxic lesions, including Olney lesions, hyperphosphorylation of tau, and a loss of parvalbumin-containing GABAergic neurons with repeated exposure to ketamine (34). It remains unknown whether such lesions are possible in individuals with TRD receiving maintenance ketamine treatment.

Hemodynamic

Ketamine exhibits cardiac-stimulating effects via central mechanisms (55). The most common hemodynamic adverse event associated with ketamine use in major depression is an increase in heart rate and blood pressure, followed by palpitations, arrhythmias, chest pain, and hypotension (55, 92). It is observed that ketamine-associated blood pressure elevations in adults with TRD are dose dependent (55, 93).

Increases in systolic and diastolic blood pressure are reported in 10%–50% of patients and are usually observed within 20–50 minutes of treatment administration and usually resolve within 2–4 hours. It is also reported that blood pressures exceeding 180/100 mmHg and/or heart rate ≥110 beats per minute affect 20%–30% of persons receiving ketamine (usually intravenous in TRD) (55, 79). It is reported that up to 20% of individuals receiving ketamine for TRD in a community-based clinic may require (depending on clinic-level protocols) pharmacological treatment for intravenous ketamine-induced hypertension (56). The rates of hypertension reported in the esketamine development program in TRD revealed relatively low rates of blood pressure elevations, which were usually transient and asymptomatic, with 2.1% of patients requiring antihypertensive treatment, compared with 1.2% in the placebo group (94). For most individuals, hemodynamic changes are asymptomatic, and they do not usually attenuate with subsequent administration of ketamine.

Genitourinary

Lower urinary tract symptoms in persons receiving ketamine affect approximately 20%–40% of individuals who use ketamine recreationally (95, 96). Lower urinary tract symptoms include nocturia, painful hematuria, dysuria, urinary urgency, and incontinence. Improvement in lower urinary tract symptoms is reported in the majority of individuals upon ketamine discontinuation, although for approximately 5% of individuals, symptoms may persist or progress (97).

The underlying pathology subserving lower urinary tract symptoms includes disruption of the urine–bladder epithelium interface, destruction of the neuromuscular junction at the level of the bladder, nitric oxide synthase–mediated inflammation, and immunoglobulin E–mediated inflammation (98). Bladder cystoscopy reveals bladder wall inflammation. Further investigation also reveals ureter thickening, stenosis, vesico-ureteral reflux, and, in some cases, hydronephrosis (97, 99).

A dose-response relationship is reported between ketamine exposure and probability of experiencing lower urinary tract symptoms, indicating that long-term exposure to ketamine, which is generally required for many individuals with major depression, may be cause for concern in some cases. It is reassuring that a long-term study with intranasal esketamine did not identify a significant percentage of individuals experiencing genitourinary symptoms (100, 101). Other than discontinuation of ketamine, there is no established treatment for ketamine-associated kidney-ureter bladder pathology (167). It is reassuring that, thus far, no evidence of genitourinary toxicity has been reported with repeated-dose esketamine in TRD (98).

Abuse Liability

Ketamine is an abusable substance and, as such, is classified as a schedule III agent in the United States. In healthy volunteers, intravenous racemic ketamine at doses typically administered for TRD (i.e., 0.4–0.8 mg/kg) is associated with increased liking for ketamine, providing the basis for concern about potential misuse and/or sensitization to other drugs of misuse (102–107). Moreover, both intravenous racemic ketamine and esketamine are reported to increase drug liking in recreational polydrug users (34, 108). It is also speculated that evidence reviewed above, in the pharmacodynamics section, suggests that ketamine's effects on opioidergic systems may presage sensitization of drug reward substrates, increasing the possibility of gateway activity (15).

Nevertheless, there is no evidence that racemic ketamine or esketamine administered as single or repeated doses has increased the risk for substance use disorders. For adults who completed the open-label 1-year safety study with intranasal esketamine, there were no reports of new-onset drug or alcohol misuse; however, the status of the study subjects after completion of the study is not known (101). Early clinical studies of opioids for chronic pain also did not identify a public health risk with respect to misuse and diversion, which provides the basis for a cautionary approach with ketamine in adults with TRD (109).

KETAMINE IMPLEMENTATION AT POINT OF CARE

All clinicians are encouraged to consult country-specific regulatory requirements with respect to guidance on ketamine implementation in adults with TRD. In the United

BOX 1. Implementation checklist for ketamine and esketamine in clinical practice

Patient Selection

- Diagnosis of confirmed treatment-resistant depression. Rule out psychosis and other conditions that would significantly affect the risk-benefit ratio.
- Discontinuation and/or holding of contraindicated medications.

Setting, Personnel, Monitoring

- Physical examination is suggested; measurement of body mass index; vital signs monitoring during treatment and posttreatment surveillance; consider urine drug screen if history suggests contributory.
- Setting should have expertise in the assessment, diagnosis, and management of mood disorders.
- Setting should be equipped with appropriate cardiorespiratory monitoring and be capable of psychiatric and medical safety (e.g., hemodynamic instability, respiratory suppression).
- Depressive symptom measurement to be conducted. Additional scales are encouraged to assess anxiety, cognitive function, well-being, and psychosocial function.
- Safety assessments at each visit include cardiorespiratory surveillance and assessment of dissociation and psychotomimetic effects.
- Patients should be monitored until stable (and according to Risk Evaluation and Mitigation Strategies [REMS] where applicable) after treatment to assure cardiorespiratory stability, clear sensorium, and attenuation of dissociative and psychotomimetic effects.
- Patients should arrange for reliable transportation for each appointment and should be instructed not to operate motor vehicles or hazardous machinery without at least one night of sleep.

States, the product monograph or package insert for esketamine requires the implementation of a Risk Evaluation and Mitigation Strategy. Thus, clinicians administering esketamine should consult the product monograph, which provides specific requirements for implementation.

Patient Selection

The evidence with respect to the efficacy, safety, and tolerability of ketamine and esketamine is best established in adults with treatment-resistant major depressive disorder (59, 79). Preliminary evidence from small controlled trials provides preliminary support for the efficacy of intravenous racemic ketamine in adults with treatment-resistant bipolar disorder, obsessive-compulsive disorder, and posttraumatic stress disorder (56, 110–114). Consequently, individuals with TRD as part of major depressive disorder would be appropriate candidates with respect to the evidence base supporting intravenous ketamine and esketamine. Box 1 summarizes patient selection and monitoring.

The high rate of TRD in persons with bipolar disorder, as well as preliminary evidence supporting the safety and efficacy of ketamine, would justify consideration of ketamine as an investigational treatment in bipolar disorder (115). The evidence to date supporting ketamine in obsessive-compulsive disorder and posttraumatic stress disorder is highly preliminary, and use of ketamine in these disorders should be considered investigational and limited to centers with expertise in assessing and managing these conditions. As described earlier, the safety of ketamine administration in patients with TRD and a history of affective psychosis is not yet established, and therefore the treatment is to be used with caution in such patients (116). Preliminary evidence suggests that persons with psychotic depression or a primary psychotic disorder may safely benefit from treatment with intravenous ketamine or esketamine (86, 117).

Most studies in adults with TRD have defined TRD as insufficient response to at least two antidepressants during the index episode. An important observation with respect to ketamine's efficacy in adults with TRD is the possibility of attenuated efficacy in individuals with greater degrees of treatment resistance in some, but not all, studies (59, 118–120). It is not known whether esketamine's efficacy is attenuated in adults with greater degrees of treatment resistance. Available studies suggest that ketamine and esketamine may be considered in patients who have had at least two prior treatment failures.

It is not known whether failure to respond to ECT or repetitive transcranial magnetic stimulation (rTMS) affects subsequent response to ketamine (168). In a study comparing adults with TRD who were nonresponders to ECT (N=17) and adults with TRD who were ECT-naive (N=23) receiving a single dose of intravenous racemic ketamine (0.5 mg/kg), overall, the two groups exhibited similar depressive symptom reduction, with a trend toward favoring ECT-naive patients that did not reach statistical significance (121).

Adults with TRD are a heterogeneous group with respect to phenomenology, patterns of comorbidity, and prior history. Clinicians and patients are especially interested in whether, a priori, they would be more (or less) likely to safely benefit from ketamine administration (122–125). However, no biomarker or biosignature (e.g., pharmacogenomics) or phenomenological presentation has proven to reliably predict outcome with ketamine in TRD (114, 126–128).

The efficacy and safety of ketamine and esketamine in adults with major depression and psychotic features has not been well characterized, but preliminary evidence suggests that it may be an appropriate strategy in some cases (116, 117, 129). Similarly, adults with major depression and comorbid substance use disorders (including alcohol use disorder) have

not been sufficiently studied with respect to ketamine's efficacy and safety profile. It remains a testable hypothesis that some individuals with TRD and comorbid substance use disorders may safely benefit from ketamine. Preliminary evidence suggests that single-dose intravenous racemic ketamine, in combination with manual-based psychosocial treatment, may attenuate alcohol and cocaine craving and consumption (130, 131).

Current psychiatric comorbidities need not be exclusionary as long as major depressive symptoms are the principal focus of clinical concern. However, patients with dementia experiencing TRD have not been sufficiently studied with respect to ketamine administration. Moreover, patients reporting hypersensitivity to ketamine in the past should be excluded from receiving ketamine for TRD. Other individuals who also should be excluded from receiving ketamine treatment are those with uncontrolled hypertension, central aneurysmal disease, significant valvular disease, a recent (within 6 weeks) cardiovascular event (e.g., myocardial infarction), or New York Heart Association class III heart failure (50).

Most patients with TRD will likely receive ketamine or esketamine in combination with their existing psychiatric medication. Intranasal esketamine, as part of its clinical development program, was co-initiated with a concomitant oral antidepressant (i.e., sertraline, escitalopram, duloxetine, venlafaxine). Less evidence is available on combining esketamine with other antidepressants, which will undoubtedly happen in real-world practice. Similarly, intravenous ketamine will likely be prescribed as an adjunctive treatment to the patient's existing regimen. It is also not known whether any particular combination of conventional antidepressant with intravenous racemic ketamine is uniquely effective.

Clinicians need to be aware of potential pharmacodynamic and/or pharmacokinetic drug-drug interactions when administering ketamine in combination with other agents. Concomitant medications that are of potential concern, but not necessarily contraindicated, are nonselective monoamine oxidase (MAO) inhibitors and reversible inhibitors of monoamine oxidase-A (132). Preliminary evidence suggests that in some cases, ketamine may be safely coadministered with MAO inhibitors, but the data on the safety of this combination remain limited (132, 133).

A relative contraindication also exists for psychostimulants and other agents with vasopressor activity. Preliminary evidence suggests, but has not established, attenuated antidepressant efficacy with ketamine coadministered with naltrexone, suggesting that naltrexone should be discontinued prior to ketamine treatment (13). As ketamine and esketamine depend on CYP3A4 and CYP2B6 for biotransformation, concomitant use of other agents that are inducers or inhibitors of these enzymes may have effects on the bioavailability of ketamine. Nevertheless, no clinically significant drug interactions have been reported in the coadministration of ketamine or esketamine with conventional antidepressants, second-generation antipsychotics, lithium, or anticonvulsants that are FDA approved in the treatment of bipolar disorder.

The available evidence suggests that concomitantly administered benzodiazepines may attenuate and/or delay antidepressant response to ketamine (45, 134–137). In addition, lamotrigine, which reduces glutamate release, may in theory interact with ketamine administration. For example, it remains uncertain whether lamotrigine attenuates the dissociative effects of ketamine (138, 139). It is also unknown whether lamotrigine affects the efficacy of ketamine in major depression.

Ketamine Dosing and Frequency

It is recommended that intravenous ketamine be started at 0.5 mg/kg and infused over 40 minutes; doses may be lowered in cases of intolerability with the proviso that efficacy at lower doses may be inferior. For persons who are overweight or obese, dosing ketamine based on ideal body weight is recommended. Parenthetically, preliminary evidence, from some but not all studies, suggests that individuals who are obese may exhibit higher response rates to ketamine (122, 140–142, 169). The differential efficacy in persons in higher body mass index (BMI) categories in some cases may be a function of higher ketamine dosing and/or differential pharmacokinetics or pharmacodynamics in persons of higher weight.

There remains a lack of sufficient evidence to guide dose optimization with intravenous ketamine (54). Upon completion of four to six intravenous infusions, a post-follow-up assessment should be conducted to determine overall efficacy of the intervention. Although the preponderance of data suggest that most individuals with TRD who respond to intravenous ketamine do so after one to two infusions, the possibility remains that there are patients who may not respond to intravenous ketamine until after a higher number of infusions (i.e., four to six infusions). It is generally recommended that if an individual exhibits minimal response (i.e., $\leq$20% improvement from baseline in total depression symptom severity) after four to six ketamine treatments, then the individual can be deemed nonresponsive and subsequent treatments would not be warranted. For adults with TRD, intranasal esketamine should start at 56 mg on day 1 and increase (as per clinician discretion and patient agreement) to 56–84 mg twice weekly for weeks 1–4, and then 56–84 mg once weekly for the following 4 weeks and every 1–2 weeks thereafter. The recommended dosage of esketamine for the treatment of depressive symptoms in adults with major depressive disorder and acute suicidal ideation or behavior in the United States is 84 mg twice per week for 4 weeks. Evidence of therapeutic benefits with esketamine should be determined after week 4 (19). If minimal response to esketamine treatment is observed after 4 weeks, it would be recommended that treatments be discontinued.

The frequency of intravenous ketamine administration where the therapeutic objective is prevention of relapse or recurrence also has not been ascertained and should be determined on an individual basis. Moreover, it is unknown whether the maintenance intravenous ketamine dose should be

identical to the dosing established as efficacious during the acute phase.

Notwithstanding the administration of intravenous ketamine as a maintenance treatment, practitioners should bear in mind that there is insufficient evidence guiding dosing, frequency, and long-term safety and tolerability. It is our opinion that maintenance ketamine treatment with periodic evaluation of need for ongoing treatment on amonthly to bimonthly basis is warranted in selected cases. Evaluation of the relative benefits and risks of maintenance intravenous ketamine, as well as consideration of patient preference and availability of alternative treatment options, should be an ongoing process. In contradistinction to intravenous ketamine, maintenance data do support the efficacy and safety of intranasal esketamine administered approximately weekly to biweekly in adults with TRD (100, 101). The effectiveness of ketamine maintenance treatment will need to be considered along with the probability of tolerance, as well as of relapse or recurrence, in patients on an individual basis.

It remains unknown whether intravenous ketamine or intranasal esketamine is more effective, safer, better tolerated, and/or more cost-effective for adults with TRD. Unfortunately, there have been no rigorous head-to-head comparative studies of the efficacy, tolerability, and safety of both formulations in TRD. Meta-analysis of outcomes comparing disparate routes of administration of ketamine in TRD also fail to adequately inform the decision (17). A major limitation with such comparisons is that whereas a novel antidepressant is often co-initiated with intranasal esketamine, intravenous ketamine is often administered as a monotherapy or as an adjunct to an existing antidepressant.

A related and pragmatic issue is whether some adults with TRD may begin treatment with the intravenous route, followed by transition to intranasal esketamine as a maintenance treatment strategy for those who responded acutely. It is also unknown whether nonresponse or intolerability to intravenous ketamine in TRD predicts outcome with intranasal esketamine or vice versa. Electing either formulation over the other will be influenced by patient preference, personnel, experience, and clinical infrastructure. Clinicians should be aware of the fact that the rigor of evidence supporting esketamine in the short and long term is superior to that for intravenous ketamine. The relative cost-effectiveness of ketamine (available as a generic drug) and esketamine (available only as a branded drug) is another factor that might be considered (143). Although intravenous ketamine is generic, there are additional costs in its administration, often uninsured, that need to be considered with respect to its cost-effectiveness.

Strategies to Prolong Ketamine's Efficacy

Various strategies have been attempted to prolong the efficacy of ketamine in TRD (e.g., lithium, riluzole), but none have been proven effective in replicated randomized controlled studies (139, 144–146). Although not necessarily a strategy to prolong efficacy per se, repeated dosing appears to sustain benefits longer than single dosing (20, 53, 100, 147).

For example, results from meta-analysis indicate that single-dose ketamine administration is effective for 3–7 days (20, 147). Repeated-dose intravenous racemic ketamine has demonstrated efficacy for up to 2–3 weeks (20, 147). Original studies and meta-analyses indicate that most patients relapse within 1 month (median, 18 days) of administration, inviting the need for repeated ketamine administrations (20, 53, 147). Esketamine has demonstrated relapse prevention with repeated dosing as part of the development program for this product (60).

Setting, Personnel, and Monitoring

Ketamine should be administered in a general or specialty setting that has personnel with expertise in the assessment, diagnosis, management, and follow-up of persons with mood disorders. When intravenous ketamine is being administered, at least one member at the point of care should have advanced cardiac life support training (ACLS). The product monograph for esketamine does not explicitly require personnel with ACLS training at the site of implementation. The setting personnel should be able to monitor cardiovascular, hemodynamic, and respiratory function; electrocardiography and measurement of oxygen saturation are essential. Although doses of ketamine greater than 0.5 mg/kg have not demonstrated superior efficacy, safety, or tolerability, capnography should be considered for patients receiving higher doses (e.g., 1.0 mg/kg).

Settings that intend to provide ketamine to multiple patients simultaneously should have sufficient personnel to safely oversee both the psychiatric and physical safety aspects of the administration of ketamine or esketamine intravenously or intranasally. As ketamine administration in some individuals may amplify sensory experiences and/or result in dissociation or psychotomimetic effects, a comfortable and adaptable environment is highly recommended during administration.

Before patients are scheduled for ketamine administration as well as upon completion of ketamine treatment, a psychiatric assessment should be conducted to confirm diagnosis and eligibility as well as response and tolerability after intervention. The psychiatric assessment should be conducted by a psychiatrist or a health care provider with expertise in the assessment and evaluation of adults with mood disorders. Prior to ketamine administration, evaluation of depression symptom severity is a minimum expectation. Although no depression metric is specifically validated for ketamine administration or other rapid-onset treatments, reasonable options include, but are not limited to, the Patient Health Questionnaire–9, the Beck Depression Inventory, and the 16-item Quick Inventory of Depressive Symptomatology–Self-Report.

In addition, the assessment of anxiety (e.g., the Generalized Anxiety Disorder Scale), psychosocial function, self-rated cognitive function (e.g., the Perceived Deficits Questionnaire, 5-item), and well-being (e.g., the five-item World Health Organization Well-Being Index) is encouraged (148, 149). Prior to

BOX 2. Esketamine and ketamine for treatment-resistant depression (TRD): Consensus

- Evidence supports the rapid-onset (i.e., within 1–2 days) efficacy of esketamine and ketamine in TRD.
- Efficacy in TRD is best established for intranasal esketamine and intravenous ketamine; there is insufficient evidence for oral, subcutaneous, or intramuscular ketamine in TRD.
- Intranasal esketamine demonstrates efficacy, safety, and tolerability for up to 1 year in adults with TRD.
- Evidence for long-term efficacy, safety, and tolerability of intravenous ketamine in TRD is insufficient.
- Safety concerns with respect to ketamine and esketamine include, but are not limited to, psychiatric (e.g., dissociation, psychotomimetic), neurologic/cognitive, genitourinary, and hemodynamic effects.
- Esketamine is FDA approved for major depressive disorder with suicidal ideation or behavior but has not been proven to reduce suicide completion.
- Esketamine and ketamine should be administered only in settings with multidisciplinary personnel including, but not limited to, those with expertise in the assessment of mood disorders. A Risk Evaluation and Mitigation Strategy (REMS) is required in some countries administering esketamine (e.g., the United States).

receiving ketamine treatment, all patients should have a physical examination, with measurement of vital signs, cardiorespiratory stability, and BMI. Although mandatory toxicology screening would not be required for all individuals receiving intravenous ketamine or esketamine, it may be considered in cases where concerns about substance misuse are present.

A survey of treatment-emergent adverse events is encouraged. From a safety perspective, all patients should be asked about the presence and severity of dissociative symptoms when intravenous ketamine or esketamine is administered. Although the CADSS has been the most frequently used measure of dissociation in clinical research, its utility at point of care and in clinical practice is not well established, and it cannot be considered, at this time, a standardized safety metric.

According to the Risk Evaluation and Mitigation Strategy established for esketamine, all patients should be monitored for a minimum of 2 hours before discharge from the clinic. Although it is unknown what the minimum adequate duration is for monitoring adults with TRD receiving intravenous ketamine, a similar period of up to 2 hours should be considered. All patients should be monitored for hemodynamic stability, normalization of respiratory functions, clear sensorium, and attenuation of dissociation and any other psychiatric adverse events. Patients should be notified that they should not operate a motor vehicle until they have had at least one night of sleep; patients are required to arrange for reliable transportation from clinic to home.

For patients receiving maintenance ketamine treatment, safety should focus on evidence of drug or alcohol misuse, subjective cognitive complaints, genitourinary pathology (e.g., hematuria), and change in concomitant medication. All individuals receiving ketamine or esketamine for major depression should be queried with respect to suicidal ideation and suicidal behavior as part of the eligibility assessment. Individuals who are discontinuing ketamine or esketamine treatment for major depression should have a transition-of-care plan in place for ongoing surveillance of depressive symptoms, including suicidal ideation and behavior.

Ketamine's Positioning in the Algorithmic Treatment of TRD

Other somatic treatment considerations in adults with TRD are second-generation antipsychotics, combined antidepressants, combination with other agents (e.g., lithium), and neurostimulation (e.g., ECT). Ketamine has been demonstrated to be efficacious in adults with TRD after two prior conventional antidepressants. The recent indication in the United States of esketamine for adults with major depression experiencing suicidal ideation or behavior suggests that not all individuals considered for esketamine, and possibly racemic ketamine, will meet criteria for TRD.

Taken together, results from meta-analyses suggest superiority of intravenous ketamine or esketamine when compared with second-generation antipsychotics (19, 143, 150, 151). However, there have not been studies comparing ketamine or esketamine with second-generation antipsychotics head-to-head in TRD, and there have been significant differences in trial designs, eligibility criteria, and use of concomitant medication. The wider availability, ease of administration, lack of requirement for a Risk Evaluation and Mitigation Strategy, and lower cost of second-generation antipsychotics suggests that they will be prioritized in many cases (143).

It has not been empirically established which somatic treatment is preferred in adults with TRD. Studies under way are seeking to determine the relative efficacies of ECT and ketamine in TRD (152–157). Moreover, the relative efficacies of ketamine or esketamine in combination with second-generation antipsychotics, combined antidepressants, and other treatments in TRD have not yet been established in randomized controlled trials. Of the second-generation antipsychotics, only the combination of olanzapine with fluoxetine has been proven efficacious in adults with TRD, but it is limited by significant weight gain and metabolic liability.

The efficacy of other pharmacological strategies, such as combined antidepressants, lithium, or thyroxine, in adults with TRD has insufficient evidence. A pragmatic approach until such data are available is to consider ketamine or esketamine, or ECT or rTMS, for adults with TRD.

BOX 3. Esketamine and ketamine in TRD: Future research vistas

- Comparative effectiveness data are needed (e.g., intravenous ketamine versus intranasal esketamine; esketamine or ketamine versus neurostimulation; esketamine or ketamine versus second-generation antipsychotics).
- A data commons and/or access to large public or private databases that provide the opportunity to assess serious but infrequent adverse events would provide a fuller understanding of the effectiveness and safety of esketamine and ketamine.
- Integrated measures (e.g., phenomenology, pharmacogenomics) should be used to identify ketamine response predictors as well as safety and tolerability predictors.
- Strategies to prolong the efficacy of esketamine and ketamine in adults with TRD are urgently needed (e.g., pharmacologic, manual-based psychosocial).
- More thorough characterization is needed of the long-term efficacy, safety, and tolerability of intravenous ketamine, as well as the possibility of withdrawal and/or tachyphylaxis/therapeutic tolerance.
- Characterization of the efficacy, tolerability, and safety of administration in less restrictive treatment environments (e.g., in physicians' offices or self-administration at home under certain conditions) is needed.
- Characterization of the relative efficacy, tolerability, and safety of oral, subcutaneous, and intramuscular formulations is needed.
- Further empirical study is needed on the risk for predisposing alcohol and other substance use disorders, as well as withdrawal-emergent suicidality, with esketamine and ketamine.
- Research is needed on the efficacy, safety, and tolerability of esketamine and ketamine in adults with non-treatment-resistant major depression as well as other mental disorders (e.g., major depressive disorder with psychosis, bipolar depression, posttraumatic stress disorder, substance use disorders).
- Integration of esketamine and ketamine with manual-based psychosocial treatments needs to be better characterized across mental disorders.
- The mechanism of action and tolerability of ketamine (e.g., role of opioidergic system), needs to be refined.
- The safety, tolerability, and efficacy of other ketamine derivatives (e.g., *R*-ketamine, *2R/6R*-hydroxynorketamine) remains to be characterized.
- Additional agents capable of rapid-onset antidepressant activity need to be identified.

It is also recognized that the efficacy of ECT may be more compelling than that for rTMS in adults with TRD (158). Preliminary evidence suggests that nonresponse to neurostimulation treatment may not predict nonresponse to ketamine or esketamine in adults with TRD (159). Indeed, patient preference, as well as cost, access, and availability, would also inform treatment selection for adults with TRD.

Ketamine combined with psychosocial interventions is a promising treatment avenue, especially for individuals with substance use disorders. It remains a testable hypothesis whether, in some cases, manual-based psychotherapy could be conceptualized as a maintenance treatment in persons with TRD who respond acutely to ketamine (160, 161).

CONCLUSIONS

The opportunity and hope provided by intravenous ketamine and intranasal esketamine exist alongside the urgent need to clarify the long-term efficacy of these agents as well as significant unanswered questions with respect to safety. It was observed in the esketamine development program that suicides occurred in persons upon discontinuation of the treatment. Postdiscontinuation surveillance of patients who have received ketamine or esketamine treatment would provide a fuller characterization of unintended safety events (e.g., sensitization to other drugs of misuse) (162). Debates as to the safety and efficacy of intravenous ketamine and esketamine in TRD would be informed by familiarity with the totality of the data, which is growing exponentially (51, 163). Data obtained by the FDA Adverse Event Reporting System between March 2019 and March 2020 indicate that esketamine has an unequivocal potential for serious adverse events (164). For example, the reporting odds ratios were significant for dissociation, sedation, "feeling drunk," suicidal ideation, and completed suicide (164). This finding underscores the need for a fuller understanding of any potential safety concerns associated with esketamine (or ketamine) in the treatment of adults with TRD.

Toward the goal of personalized medicine, future research can be expected to provide information on whether any biomarkers (e.g., pharmacogenomics) or other clinical aspects, perhaps augmented with advanced computational models, will be predictive of outcome with ketamine. Moreover, the efficacy of ketamine combined with manual-based psychotherapies in adults with TRD and other mental disorders is a promising avenue that will be informed by rigorous clinical trials (165). A consensus exists with respect to current knowledge and future vistas for ketamine and esketamine (Box 2 and Box 3). In the interim, these agents should be administered only at centers with the appropriate infrastructure and multidisciplinary personnel with expertise in the assessment and treatment of adults with mood disorders.

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Dr. Berk is supported by a National Health and Medical Research Council Senior Principal Research Fellowship (1059660 and 1156072); he has received grant/research support from the a2 Milk Company, Avant, Beyond Blue, the Cancer Council of Victoria, the Cooperative Research Centre, the Harry Windsor Foundation, NIH, the Meat and Livestock Board, the Medical Benefits Fund, the Medical Research Futures Fund, the National Health and Medical Research Council, Rotary Health, the Simons Autism Foundation, the Stanley Medical Research Foundation, and Woolworths and has served as a speaker for Abbott, AstraZeneca, Janssen, Lundbeck, Merck, and Pfizer and as a consultant for Allergan, AstraZeneca, BioAdvantex, Bionomics, Collaborative Medicinal Development, Janssen, Lundbeck, Merck, Pfizer, and Servier. 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Dr. Stahl has served as a consultant for Acadia, Alkermes, Allergan, Arbor Pharmaceuticals, Axovant, Axsome, Celgene, Concert, Clearview, EMD Serono, Eisai, Eli Lilly, Ferring, Impel NeuroPharma, Intra-Cellular Therapies, Ironshore Pharmaceuticals, Janssen, Lundbeck, Merck, Otsuka, Pfizer, Sage, Servier, Shire, Sunovion, Takeda, Taliaz, Teva, Tonix, Tris Pharma, and Viforpharma; he is a board member of Genomind; he has served on speakers bureaus for Acadia, Lundbeck, Otsuka, Perrigo, Servier, Sunovion, Takeda, and Vertex; and he has received grant/research support from Acadia, Avanir, Braeburn Pharmaceuticals, Eli Lilly, Intra-Cellular Therapies, Ironshore, ISSWSH, Neurocrine, Otsuka, Shire, Sunovion, and TMS NeuroHealth Centers. The other authors report no financial relationships with commercial interests.

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Ketamine and esketamine for treating unipolar depression in adults: Administration, efficacy, and adverse effects

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INTRODUCTION

Ketamine is a racemic mixture of two enantiomers, S-ketamine (esketamine) and R-ketamine [1]. Ketamine is a standard anesthetic drug that is also administered for analgesia and sedation [2,3]. In addition, ketamine and esketamine can rapidly and transiently alleviate treatment-resistant unipolar major depression, including suicidal ideation [4,5]. Although use of ketamine to treat depression has increased [6,7], we suggest that clinicians prescribe ketamine or esketamine cautiously for this indication, only after exhausting other recommended non-electroconvulsive therapy (ECT) treatments for resistant depression. This approach is consistent with clinical guidance from the American Psychiatric Association and other experts [8,9].

This topic discusses treatment of resistant depression with ketamine and esketamine, including their administration, efficacy, and adverse effects. Separate topics discuss the general principles of treating resistant depression; choosing a specific treatment for resistant depression; and the epidemiology, risk factors, assessment, and prognosis of treatment-resistant depression, as well as using ketamine to induce general anesthesia.

- (See "Unipolar depression in adults: General principles of treating resistant depression".)
- (See "Unipolar depression in adults: Choosing treatment for resistant depression".)
- (See "Unipolar treatment-resistant depression in adults: Epidemiology, risk factors, assessment, and prognosis".)

- (See "General anesthesia: Intravenous induction agents", section on 'Ketamine'.)

CHEMICAL STRUCTURE

Ketamine is a racemic mixture of two enantiomers that are mirror images of each other and thus not identical in that they cannot be superimposed upon each other (similar to one's hands) [1]. One of the enantiomers, S-ketamine (esketamine), binds more potently to the N-methyl-D-aspartate receptor than the other enantiomer, R-ketamine. (See 'Mechanism of action' below.)

MECHANISM OF ACTION

The mechanism of action for the rapid antidepressant effects of ketamine and esketamine is not known [3]. However, several studies indicate that ketamine has an affinity for multiple receptors [2,10], which has given rise to the hypothesis that the drug binds to, or secondarily affects, different types of receptors that initiate cascading effects acting in concert [10]. The receptors that may be involved include the following:

- **Opioid receptor** – Ketamine is an opioid receptor agonist, which may explain its efficacy for acute pain [2,6,11,12]. Evidence that indicates activation of opioid receptors is involved in ketamine's antidepressant effects includes a randomized crossover trial that compared naltrexone 50 mg with placebo, which were given prior to ketamine 0.5 mg/kg infused over 40 minutes [13]. Naltrexone is an opioid receptor antagonist. Patients with treatment-resistant depression were randomly assigned to the order in which they received each study treatment (naltrexone-ketamine or placebo-ketamine), each study treatment was administered once separated by at least 14 days, and patients were depressed at the time of receiving each study treatment. Among the 12 patients who completed both ketamine infusions, improvement was far less with naltrexone-ketamine than placebo-ketamine on postinfusion days 1 and 3. Use of ketamine for acute pain is discussed separately. (See "Nonopioid pharmacotherapy for acute pain in adults", section on 'Ketamine'.)

- **N-methyl-D-aspartate (NMDA) receptor** – Glutamate is the primary excitatory neurotransmitter in the brain and binds to several types of receptors, including the NMDA receptor [14]. Although it is established that ketamine is an NMDA receptor antagonist, it is not clear whether NMDA antagonism mediates the drug's antidepressant effects [15]. Evidence that suggests NMDA antagonism may be involved includes randomized trials that found intravenous racemic ketamine 0.2 mg/kg was not effective, whereas 0.2 mg/kg of the stereoisomer esketamine, which is more potent at NMDA receptors [2,16], was

effective [16,17] . However, other NMDA antagonists such as memantine are not effective for treatment-resistant depression [4,10]. (See "Unipolar depression in adults: Investigational and nonstandard treatment", section on 'Medications'.)

- **Alpha-amino-3-hydroxy-5-methyl-4-isoxazole propionic acid (AMPA) receptor** – The AMPA receptor is also involved in glutamate neurotransmission, and ketamine's antidepressant effects may be due at least partially to activation of the AMPA receptor by the ketamine metabolite (2R, 6R)-hydroxynorketamine. In a preclinical study, mice received ketamine, the metabolite (2R, 6R)-hydroxynorketamine, or the metabolite (2S, 6S)-hydroxynorketamine [18]. Antidepressant-like effects were assessed using the forced swim test, learned helplessness test, and novelty suppressed feeding test. Ketamine and (2R, 6R)-hydroxynorketamine each generated antidepressant responses that did not occur with (2S, 6S)-hydroxynorketamine. In addition, the investigators found that (2R, 6R)-hydroxynorketamine activates AMPA receptors, but does not bind to or inhibit (antagonize) the NMDA receptor, and that blocking the AMPA receptors blocked the antidepressant effects of the metabolite.

Other studies have examined ketamine's mechanism of action at the level of brain structures. As an example, functional neuroimaging studies in patients with treatment-resistant depression suggest that ketamine may improve depression by activating of the anterior cingulate cortex [19] and by increasing connectivity between the insula and default mode network.

In addition, a rodent study suggested that neuronal vascular endothelial growth factor signaling in the prefrontal cortex may mediate the rapid antidepressant actions of ketamine [20]. Another preclinical study administered ketamine to rodents with depression-like behaviors (eg, immobility in the forced swim test) induced genetically or by exposure to chronic stress, and found that neuronal activity in the habenula diminished to the level observed in control rodents, and that the depressed-like rodents behaved like the control rodents [21].

KETAMINE

Administration

Setting — Randomized trials of intravenous ketamine for treatment-resistant depression have typically occurred in academic hospital settings in which psychiatrists collaborated with anesthesiologists [22-24]. However, ketamine infusions are becoming increasingly available at freestanding outpatient clinics, in which treatment is dispensed by physicians such as often

anesthesiologists, who often have limited to no experience treating depression [6]. In addition, outpatients have been treated with oral ketamine ingested at home [25].

Route (formulation) — The optimal method of administering ketamine for treatment-resistant depression has not been established [26]. Although most studies have given ketamine intravenously, it can also be administered with intramuscular, intranasal, oral, subcutaneous, and sublingual formulations [2,12,25,27-29]. The route of administration affects patient comfort and convenience, as well as bioavailability, serum concentrations, and duration of effect [26,29]. As an example, intranasal delivery can be problematic because of nasal cavity conditions that impede administration or absorption (eg, mucosal inflammation or deviated septum) and patient difficulty with self-administration [30-32].

Currently available oral ketamine formulations, which are relatively convenient, taste bad and have a limited duration of effect [29]. However, an investigational oral formulation appears to be more acceptable and provide a more durable benefit. A phase 2 study enrolled patients with acute treatment-resistant depression and administered open-label, extended-release ketamine tablets; after one week, responders (reduction of baseline symptoms ≥50 percent) were randomly assigned to maintenance treatment with ketamine or placebo twice weekly (n = 69) [33]. Study drugs were administered in a clinic for the first week of the trial, and at home for the remaining 12 weeks. The pills were designed to mitigate concerns about abuse and diversion. After 13 weeks, relapse had occurred in fewer patients with ketamine than placebo (44 versus 70 percent; odds ratio 0.3, 95% CI 0.1-0.9).

Evidence comparing different routes of administration includes one open-label trial that randomly assigned patients (n = 27) with new onset or treatment-resistant major depression to a single dose of ketamine given intravenously 0.5 mg/kg, intramuscularly 0.5 mg/kg, or intramuscularly 0.25 mg/kg; response was comparable across the three groups [34]. However, interpreting the results is difficult due to the small and heterogeneous sample, lack of a placebo control, and lack of blinding.

Dose — The dose of ketamine for treatment-resistant depression varies depending upon the route and frequency of administration [26,29]. For any particular route of administration, no one dose has been established among the different doses tested.

Intravenous — The optimal dose of intravenous ketamine for treatment-resistant depression is not established. Nevertheless, small randomized trials that compared different doses of ketamine suggest that generally, the preferred dose may be 0.5 mg/kg of body weight:

- A one-month trial enrolled 99 patients with treatment-resistant unipolar major depression who were currently treated with antidepressant drugs, and randomly assigned them to

add-on midazolam or four different doses of ketamine [35]. Study drugs were administered as a single intravenous infusion over 40 minutes. Ketamine 0.5 mg/kg and 1 mg/kg were each superior to midazolam 0.045 mg at day 1, whereas ketamine 0.1 mg/kg and 0.2 mg/kg were not. The efficacy of the two higher doses was comparable, but dissociation and elevated blood pressure during infusion each appeared to be worse with ketamine 1 mg/kg than 0.5 mg/kg, suggesting a dose response effect.

- Another one-month trial randomly assigned patients (n = 71) to a single dose of adjunctive ketamine 0.5 mg/kg, ketamine 0.2 mg/kg, or placebo; study drugs were infused over 40 minutes [16]. Improvement was greater with the 0.5 mg/kg dose than placebo, whereas improvement was comparable for the 0.2 mg/kg dose and placebo. However, improvement with the 0.5 mg/kg and 0.2 mg/kg doses was also comparable.

In addition, short-term randomized trials, which compared ketamine with placebo or active controls and established the efficacy of ketamine, typically used 0.5 mg/kg, infused over 40 minutes. (See 'Short-term efficacy' below.)

However, dose adjustments may be appropriate for specific patients [8]:

- A dose of 0.75 or 1 mg/kg may be suitable for patients not responsive to 0.5 mg/kg [29].

- For patients who are obese, as indicated by a body mass index ≥30 kg/m^2 (calculator 1), it may be safer to calculate the dose according to ideal body weight and not the actual weight. Limited evidence supporting this approach includes a pooled analysis of three randomized trials, which included 97 patients who received a total of 205 infusions; transient blood pressure >180/100 mmHg or pulse >110 beats/minute occurred in 30 percent of patients [36]. These changes were more likely to occur in obese patients and patients who received larger average doses of ketamine (46 versus 42 mg).

Although the standard rate of infusion appears to be 40 minutes [8], across different studies the rate has varied from 2 to 100 minutes [29]. Relatively slower rates may mitigate sedation and other adverse effects.

The expected peak serum concentration of ketamine 0.5 mg/kg over 40 minutes ranges from 70 to 200 ng/mL [8].

The intravenous dose used for depression is typically less than the dose used for inducing general anesthesia. (See "General anesthesia: Intravenous induction agents", section on 'Dosing'.)

Other formulations — The dose of oral and intranasal ketamine is as follows:

- **Oral** – The optimal dose of oral ketamine for treatment-resistant depression is not established. In one small randomized trial that compared ketamine with placebo, the dose of ketamine was 1 mg/kg of body weight [25]. (See 'Other formulations' below.)

- **Intranasal** – The preferred dose of intranasal ketamine for treatment-resistant depression is not established. In one small randomized trial that compared ketamine with placebo, the dose of ketamine was 50 mg [28]. (See 'Other formulations' below.)

Frequency — It is not clear how frequently ketamine should be administered [26].

- **Intravenous** – Although the number of times that intravenous ketamine 0.5 mg/kg is administered per week for treatment-resistant depression is not established, the evidence suggests that the drug should be given once or twice per week. In most randomized trials, the drug was given only one time and the benefit appeared to diminish over the following week. In one trial that infused ketamine twice weekly or thrice weekly for up to six weeks, improvement of depression with the two dosing frequencies was comparable [37]. (See 'Repeated intravenous infusions' below.)

- **Oral** – The number of times that oral ketamine is administered per week for treatment-resistant depression is not established (nor is the dose established). One randomized trial administered ketamine 1 mg/kg thrice weekly because of the low and variable bioavailability of oral ketamine [25]. (See 'Other formulations' below.)

Concurrent treatment — The patient's current medications, including prescription, over-the-counter, and complementary or alternative drugs should be reviewed prior to use of ketamine. The psychiatrist, anesthesiologist, or general medical consultant should decide which to continue and which to taper and discontinue.

It appears that ketamine can be used concurrently with most standard antidepressants without reducing efficacy or increasing side effects [38]. Across randomized trials, ketamine has been administered either as monotherapy or as add-on therapy to antidepressants and antipsychotics [4,16,25,35,37,39-41]. However, low quality studies report that concomitant benzodiazepines may interfere with response to ketamine [42,43], and one randomized trial withheld benzodiazepines 24 hours prior to infusing ketamine [41].

Ketamine is metabolized primarily by hepatic cytochrome P450 2B6 and 3A4 [38]. Concomitant drugs that induce these enzymes may decrease exposure to ketamine and drugs that inhibit these enzymes may increase exposure; these effects may necessitate adjusting ketamine doses. Specific interactions of ketamine with other medications may be determined using the drug interactions program included in UpToDate.

During short-term treatment with ketamine, ongoing administration of prestudy antidepressants may help transition patients from ketamine to continuation and maintenance treatment [44]. In addition, concurrent treatment with psychotherapy, such as cognitive-behavioral therapy, may also help the transition [45].

Short-term efficacy — For unipolar major depression, the efficacy of ketamine and esketamine appear to be comparable [1]. However, no head-to-head trials comparing the two drugs have been published.

Randomized trials have demonstrated that intravenous ketamine can rapidly improve treatment-resistant depression, including symptoms of suicidal ideation. However, most trials administered only a single infusion, and the benefit diminished within two weeks. It is not known how efficacy is influenced by serum concentrations and the interplay of different factors related to administration [26].

Single intravenous infusion — Multiple randomized trials demonstrate that for treatment-resistant depression, a single infusion of ketamine produces a rapid and robust response (eg, within 40 to 120 minutes) in at least 50 percent of patients [46-50]. However, the effect dissipates by day 10 to 14. As an example:

- One pooled analysis of seven trials compared ketamine with placebo (saline) or active medication in 172 patients with unipolar or bipolar major depression [4]. A single dose of ketamine (0.5 mg/kg) or the control was administered intravenously (six trials) or intranasally (one trial); most patients received no concomitant therapy. Response (reduction of baseline symptoms ≥50 percent) at multiple posttreatment time points occurred in more patients who received ketamine than the control condition:

  - Two hours – 51 versus 2 percent of patients
  - One day – 53 versus 7 percent
  - Seven days – 31 versus 7 percent

  By day 14, response was present in only 11 percent of the patients who received ketamine.

- A meta-analysis of nine trials compared a single infusion of intravenous ketamine (0.5 mg/kg infused over 40 minutes) with a control condition (typically placebo) in patients with unipolar depression (n = 208) or bipolar depression (n = 26); study drugs were typically administered as add-on therapy [39]. Response was more likely to occur in patients who received ketamine than controls, starting at 40 minutes and persisting at multiple subsequent time points; at day 7, response was three times more likely with ketamine (relative risk 3, 95% CI 2-7).

- A subsequent randomized trial compared a single dose of intravenous ketamine 0.5 mg/kg infused over 40 minutes with placebo in patients who remained depressed despite treatment with at least three successive antidepressants (n = 48) [16]. During the period of one to four days after infusion, response (reduction of baseline depression ≥50 percent) occurred in more patients who received ketamine than placebo (46 versus 13 percent).

There are no well-established clinical predictors or biomarkers of acute response to a single infusion of ketamine [51]. However, response may be more likely to occur in patients who are more severely (intensely) depressed at baseline [16]. In addition, greater dissociation during infusion [52], fewer residual depressive symptoms at day 1 [52], and a positive family history of alcohol use disorder may be associated with antidepressant efficacy [52,53].

Augmentation with ketamine may accelerate response to antidepressant treatment, which often takes 6 to 12 weeks [54]. A four-week randomized trial compared a single infusion of add-on ketamine (0.5 mg/kg) with placebo on day 1 of newly initiated treatment with escitalopram 10 mg/day [55]. The sample consisted of 27 patients with unipolar major depression, approximately half of whom were classified as treatment resistant. Study drugs were administered after a two-week washout of prior pharmacotherapy. Response occurred in more patients treated with adjunctive ketamine than placebo (92 versus 57 percent), and the mean time to response was shorter with ketamine plus escitalopram than placebo plus escitalopram (6 versus 27 days). In addition, more than half of the patients responded within two hours of receiving intravenous ketamine, compared with none of the patients who received placebo. None of the patients discontinued treatment due to adverse effects.

In addition, a prospective observational study found that a single infusion ketamine led to a moderately large reduction of depressive symptoms in patients (n = 17) who had previously not responded to electroconvulsive therapy (ECT) [56]. However, the American Psychiatric Association Council of Research Task Force on Novel Biomarkers and Treatments concluded that ketamine is not an alternative to ECT, because following a successful course of treatment with ketamine or ECT, relapse is nearly two times greater with ketamine [4].

Repeated intravenous infusions — Patients not responsive to a single infusion of ketamine may improve with subsequent infusions, and improvement following a single infusion can be sustained by subsequent infusions [6,29,57]. As an example, a four-week trial randomly assigned patients with treatment-resistant depression (n = 67) to one of four treatments: ketamine two times per week, placebo two times per week, ketamine three times per week, or placebo three times per week [37]. The dose of ketamine was 0.5 mg/kg, and all study drugs were infused intravenously over 40 minutes; current antidepressant drugs were continued. Response (reduction of baseline symptoms ≥50 percent) at day 15 occurred in more patients

who received twice weekly ketamine than placebo (69 versus 15 percent) and more often with thrice weekly ketamine than placebo (54 versus 6 percent of patients). The effect size for the two frequencies of ketamine at day 15 was comparable, and the benefit of ketamine persisted throughout the four-week study period.

In addition, one randomized trial (n = 18) suggests that onset of antidepressant effect may perhaps be faster with repeated infusions of ketamine, compared with repeated treatments with ECT [58]. A retrospective study found that repeated ketamine infusions may help patients who do not respond to ECT [59]. The benefit of repeated intravenous infusions for inducing general anesthesia in patients receiving ECT is discussed separately. (See "Unipolar major depression in adults: Indications for and efficacy of acute electroconvulsive therapy (ECT)", section on 'Ketamine anesthesia'.)

Repeated infusions of ketamine may provide a relatively large, short-term effect compared with other treatments. A network meta-analysis of 31 randomized trials compared the efficacy of different medications, ECT, and repetitive transcranial magnetic stimulation in treatment-resistant depression (sample size not reported); the study used results from direct comparisons between the treatments in head-to-head trials, as well as indirectly comparing treatments through their relative effect with a common comparator (typically placebo) [60]. The largest improvement at two weeks after onset of treatment occurred with ketamine.

Other formulations — The efficacy of intranasal and oral ketamine is as follows:

- **Single intranasal dose** – Short-term improvement of treatment-resistant depression can be achieved with one dose of intranasal ketamine. A randomized crossover trial compared a single dose of add-on ketamine (50 mg) with placebo (saline) in 18 patients [28]. Patients were randomly assigned to the order in which they received each study drug (ketamine-saline or saline-ketamine). In addition, patients received each study treatment separated by at least seven days and were depressed at the time of receiving each study drug. Improvement was greater 40 minutes after administration of ketamine than placebo, and response at 24 hours occurred more often with ketamine than placebo (44 [8/18] versus 6 [1/18] percent of patients). In addition, adverse effects were mild and transient.

- **Repeated intranasal doses** – A four-week, randomized trial initially planned to compare intranasal ketamine (100 mg) with midazolam (4.5 mg) in 10 patients with treatment-resistant depression [30]. However, the study was terminated early after five patients were enrolled because of poor tolerability, including elevated blood pressure, motor incoordination, and psychotomimetic effects. Absorption varied among patients.

- **Repeated oral doses** – For treatment-resistant depression, repeated administration of oral ketamine can provide short-term improvement. A small, three-week randomized trial compared add-on oral ketamine 1 mg/kg with placebo in patients receiving usual care (n = 40) [25]. Most of the patients had melancholic features and comorbid psychopathology. Response (reduction of baseline symptoms ≥50 percent) occurred in more patients who received active drug than placebo (32 versus 6 percent). The number needed to treat was approximately four, meaning that for every four patients treated with ketamine and every four treated with placebo, one additional response occurred with ketamine. Follow-up assessments one week after treatment found that the benefit of ketamine persisted. In addition, adverse effects were mild and transient.

Longer-term efficacy — The benefits and safety of longer-term ketamine treatment are not known, due to the relatively short duration of treatment in high quality studies and the lack of follow-up [8,61]. Only sparse, low quality data are available for continuation and maintenance treatment in patients who respond to acute treatment with ketamine. A prospective observational study of three patients found variable responses during a 12-month course of treatment that included 16 to 34 total infusions 0.5 mg/kg per patient [62]. A second prospective observational study included 14 patients who received 12 to 45 continuation/maintenance intravenous treatments over for 14 to 126 weeks; during two years of follow-up, relapse occurred in all but three patients [63].

Concerns have been raised that tolerance or tachyphylaxis can occur, such that the antidepressant efficacy of ketamine declines over time with repeated use; this may lead to progressively larger doses and increased frequency of administration, and eventually to ketamine dependence [9,64]. The concerns include worries about causing a new drug epidemic [9,65]. (See 'Longer term' below.)

Adverse effects — Adverse effects such as psychotomimetic effects may occur more often with ketamine than esketamine [1]. However, no head-to-head trials comparing the two drugs have been published.

One review of adverse effects in patients treated for resistant depression with ketamine found that side effects occur more often with ketamine than placebo or active controls [12]. However, most side effects resolved spontaneously.

Short term — Short-term ketamine for treatment-resistant depression is generally safe and well tolerated [6,29,36,63]. In a pooled analysis of three randomized trials, which called for either a single infusion of intravenous ketamine 0.5 mg/kg over 40 minutes or multiple infusions over a 12-day period, 97 patients received a total of 205 infusions [36]. During the 205

infusions, early discontinuation due to adverse effects (hypertension, anxiety, or hypotension) occurred in 2 percent.

For patients with treatment-resistant depression who receive intravenous ketamine, side effects peak within two hours [3]. In short-term studies (eg, ≤30 days), transient adverse effects included:

- **Dissociation and psychotomimetic effects** – A review of 60 studies (randomized trials and observational studies with nearly 900 patients) found that dissociation and psychotomimetic effects were reported in more than 70 percent of the studies [12]. Studies of intravenous ketamine were two times more likely to report dissociation and psychotomimetic effects than nonintravenous studies.

  Randomized trials, which typically administered a single intravenous dose of ketamine, indicate that ketamine causes significant, clinically large dissociative and psychotomimetic effects at 40 to 60 minutes after initiating infusion, which subsequently resolved within four hours [4,6,37,39,41,46]. In one trial that administered repeated infusions for up to four weeks, the intensity of dissociative symptoms appeared to diminish with repeated infusions [37]. Results from another trial suggest that dissociation occurs in a dose response manner. (See 'Intravenous' above.)

  Multiple randomized trials studying ketamine for treatment-resistant depression have excluded patients with psychotic features [16,25,28,35-37,41,66].

- **Cardiovascular** – A review of 60 studies (randomized trials and observational studies) found that nearly 40 percent of the studies described cardiovascular changes [12]. In randomized trials, which typically administered a single intravenous dose of ketamine, hemodynamic effects included time-limited increases in blood pressure and heart rate:

  - Systolic blood pressure – In four randomized trials, mean increases in systolic blood pressure ranged from 8 to 19 mmHg within 40 minutes of infusion, which normalized in four hours or less [4,16,41]. In a pooled analysis of three randomized trials that included 97 patients who received a total of 205 infusions, the transient average peak increase was 20 mmHg [36].

  - Diastolic blood pressure – In a pooled analysis of three randomized trials that included 97 patients who received a total of 205 infusions, the transient average peak increase in diastolic blood pressure was 13 mmHg [36]. Two subsequent randomized trials found that mean increases ranged from 8 to 13 mmHg within 40 minutes of infusion, which normalized in two hours or less [16,41].

In addition, a retrospective study included 66 patients with a mean age of 57 years who received an average of 10 ketamine infusions, 0.5 mg/kg over 40 minutes [67]. Essential hypertension controlled by pharmacotherapy was present in 36 percent. An increase in systolic pressure >30 mmHg or in diastolic pressure >15 mmHg during at least one infusion occurred in 50 percent of the patients. Nearly 80 percent of the blood pressure elevations occurred 30 to 40 minutes after onset of the infusion, and all of the elevated readings resolved within 70 minutes of onset.

- Pulse – In one randomized trial, the mean heart rate increased by nine beats/minute within two hours of infusion, which subsequently normalized [16].

Results from randomized trials suggest that elevated blood pressure and pulse occur at higher doses in a dose response manner. (See 'Intravenous' above.)

Other cardiovascular changes that may occur include chest pain, palpitations, and/or pressure, which generally resolved within 90 minutes of receiving ketamine [12].

- **Other** – Other common, transient adverse effects of ketamine in randomized trials included [37,41,54]:
  - Anxiety
  - Blurred vision
  - Dizziness
  - Headache
  - Nausea or vomiting

The transient adverse effects of intravenous ketamine in patients with treatment-resistant depression occurred at subanesthetic doses. The adverse effects of intravenous ketamine when used to induce general anesthesia (table 1) are discussed separately. (See "General anesthesia: Intravenous induction agents", section on 'Disadvantages and adverse effects'.)

Longer term — Longer-term, repeated use of ketamine can lead to:

- **Abuse and addiction** – Ketamine can act as a transient intoxicant/euphoriant/hallucinogenic and is liable to abuse, addiction, and diversion as an illicit recreational drug (street name “Special K”) [6,8]. Thus, multiple randomized trials studying ketamine for treatment-resistant depression have excluded patients with substance related and addictive disorders [16,25,36,37,41,66]. One case report described a patient with treatment-resistant major depression who received intranasal ketamine for self-administration at home and developed ketamine use disorder [11]. Another case

report described ketamine use disorder in a nurse who stole intramuscular ketamine from her hospital for self-medication of major depression that had never been treated with antidepressants [68].

The abuse potential of ketamine may be related to its structural similarity to phencyclidine and its agonist activity at opioid receptors [2,6,11,12]. (See 'Mechanism of action' above.)

- **Neurotoxicity** – Studies in ketamine abusers and rodents have found adverse effects on brain structure and function, including cognitive function [4,6,12,23].
- **Bladder toxicity** – Ketamine abuse is associated with bladder dysfunction that may require surgery [8,12,69,70].
- **Hepatoxicity** – Ketamine abuse is associated with liver injury [12].

ESKETAMINE

Administration — Information about administering intranasal esketamine is available through the prescribing information approved by the United States [71].

Setting — In the United States, intranasal esketamine is available only through a Risk Evaluation and Mitigation Strategy program, in which the drug is sold to certified medical offices for specific patients who are enrolled in a registry [72]. Patients self-administer the drug in the office and are then monitored for at least two hours by clinicians in the office. Esketamine is kept under lock and key and is not allowed to leave the office. This program is intended to ensure safety and prevent misuse and diversion.

Route (formulation) — Esketamine is generally administered as a nasal spray.

Dose — The dose of intranasal esketamine for treatment-resistant depression on day 1 of treatment is 56 mg [71]. Subsequent doses are 56 mg or 84 mg, depending upon efficacy and tolerability.

For acute suicidal ideation or behavior in adults with unipolar major depression, the dose of esketamine is 84 mg [73]. The dose may be reduced to 56 mg, based upon tolerability.

Esketamine may be more potent than ketamine in treating major depression. In one randomized trial, intravenous esketamine 0.2 mg/kg was superior to placebo [17]. By contrast, two other randomized trials found that the benefit of intravenous ketamine 0.2 mg/kg and placebo was comparable [16,35].

Frequency — The recommended frequency of intranasal esketamine for treatment-resistant depression is as follows [71]:

- Weeks 1 through 4 – Two times/week
- Weeks 5 through 8 – Once/week
- Thereafter – Once every one to two weeks

The recommended frequency of intranasal esketamine for acute suicidal ideation or behavior in adults with unipolar major depression is twice weekly for four weeks [73]. After four weeks of treatment with esketamine, its benefit should be evaluated to determine the need for ongoing treatment.

Concurrent treatment — For treatment-resistant depression, esketamine has been administered both as monotherapy and as add-on therapy with antidepressants [17,74,75]. For treatment of suicidal ideation in patients with unipolar major depression, esketamine is combined with an antidepressant.

Efficacy

Short term — For unipolar major depression, the efficacy of esketamine and ketamine appear to be comparable [1]. However, no head-to-head trials comparing the two drugs have been published.

Based upon short-term randomized trials, a single dose of intravenous or intranasal esketamine can ameliorate treatment-resistant depression, including symptoms of suicidality requiring hospitalization, within two to four hours. In addition, response (reduction of baseline symptoms >50 percent) during short-term trials occurs in approximately 25 to 65 percent of patients with unipolar major depression:

- One trial assigned 30 patients to receive intravenous infusions of esketamine 0.2 mg/kg, esketamine 0.4 mg/kg, or placebo [17]. Double-blind treatment occurred during the first week, with infusions on day 1 and day 4, followed by open-label treatment with up to four infusions of esketamine over two weeks, and a subsequent follow-up assessment-only phase for another two weeks. Following the first dose of study drug, improvement with each dose of esketamine occurred within two hours, and response at 24 hours after the infusion occurred in more patients treated with esketamine 0.2 mg/kg or esketamine 0.4 mg/kg than placebo (67 and 64 versus 0 percent). The benefit of active treatment persisted for the entire five weeks of the study. The most common adverse effects of esketamine were dissociation, headache, and nausea; in two cases, esketamine 0.4 mg/kg caused severe dissociation that resolved within four hours.

- A subsequent one-week trial assigned 67 patients treated with antidepressants to add-on intranasal esketamine 28 mg, esketamine 56 mg, esketamine 84 mg, or placebo twice weekly [74]. Exclusion criteria included history of substance use disorder and psychotic disorder. Improvement of depression was greater with each dose of esketamine than placebo, the antidepressant effect began within two hours of the first dose, and larger doses of esketamine provided a greater benefit than smaller doses. Response with esketamine 28 mg, 56 mg, 84 mg, and placebo occurred in 36, 27, 42, and 3 percent of patients. The benefit of active treatment persisted during subsequent open-label treatment (total treatment = 74 days) once per week, as well as eight weeks of post-treatment follow-up. The most common adverse effects of esketamine were dizziness, headache, dissociation, and nausea. In addition, most patients treated with esketamine experienced elevations in systolic/diastolic blood pressure within 40 minutes of administering the drug, with a maximum mean change of 19/10 mm Hg. The elevated values typically returned to baseline within two hours.

- A four-week trial compared twice weekly intranasal esketamine with placebo in 66 patients with unipolar major depression who were initially hospitalized for approximately five days due to imminent risk of suicide [75]. Inclusion criteria did not specify treatment-resistant depression. Exclusion criteria included current substance use disorder and history of psychotic disorder. All patients received standard antidepressants and 24 percent received augmentation pharmacotherapy. The dose of esketamine was 84 or 56 mg, depending upon tolerability.

  Improvement of depression was greater with esketamine than placebo at 4 hours, 24 hours, and 48 hours after the initial dose, and the clinical effects were moderate to large. In addition, remission at day 25 with esketamine and placebo occurred in 60 and 42 percent of patients; although a statistical test was not reported, a difference of this magnitude, if real, would be clinically meaningful. The number needed to treat was six, meaning that one additional remission occurred with esketamine for every six patients treated with esketamine and every six treated with placebo.

  Discontinuation of treatment due to adverse effects occurred nearly five times more often with active drug than placebo (14 and 3 percent of patients [5/35 and 1/31]). Adverse effects that occurred in at least twice as many patients who received esketamine than placebo included anxiety, dissociation, dizziness, nausea, vomiting, paresthesia, and sedation. Dissociation resolved within two hours of onset and was less severe with repeated doses. In addition, elevations in blood pressure occurred each day that study drugs were administered and generally resolved within two hours; the maximum mean

increases of systolic/diastolic pressures with esketamine and placebo were 17/12 and 9/8 mmHg.

Longer term — Among patients with acute major depression who are successfully treated with esketamine plus an antidepressant, maintenance treatment with the combination is more efficacious than antidepressant monotherapy. In one study, patients acutely ill with treatment-resistant, unipolar major depression received open-label oral antidepressant plus intranasal esketamine [76]. Patients who either remitted or responded (reduction of baseline symptoms ≥50 percent without achieving remission) were randomly assigned to maintenance treatment with the antidepressant plus either esketamine (56 or 84 mg) or placebo. Maintenance treatment lasted for approximately 80 weeks, during which adjunctive esketamine or placebo were administered once every week or every other week. Among patients who:

- Remitted (n = 176), relapse occurred in fewer patients who received the combination than antidepressant monotherapy (27 versus 45 percent).
- Responded without remission (n = 121), relapse occurred in fewer patients who received the combination than antidepressant monotherapy (26 versus 58 percent).
- Remitted or responded (n = 297), the most common adverse effects that occurred with adjunctive esketamine were dysgeusia, vertigo, dissociation, somnolence, and dizziness; the incidence of each adverse effect ranged from 20 to 27 percent. By contrast, the incidence of each adverse effect with placebo was <7 percent.

Adverse effects — Adverse effects such as psychotomimetic effects may occur less often with esketamine than ketamine [1]. However, no head-to-head trials comparing the two drugs have been published.

Randomized trials compared intranasal esketamine plus antidepressant with placebo plus antidepressant in a total of 568 patients with treatment-resistant depression [71]. The frequency of adverse effects with adjunctive esketamine versus placebo included the following:

- Anxiety – 13 versus 6 percent of patients
- Increased blood pressure – 10 versus 3 percent
- Dissociation – 41 versus 9 percent
- Dizziness – 29 versus 8 percent
- Hypoesthesia – 18 versus 2 percent

- Lethargy (fatigue) – 11 versus 5 percent
- Nausea – 28 versus 9 percent
- Vomiting – 9 versus 2 percent
- Sedation (somnolence) – 23 versus 9 percent
- Vertigo – 23 versus 3 percent
- Feeling drunk – 5 versus 1 percent

We presume that longer term, repeated use of esketamine can potentially lead to adverse effects that are seen with longer-term, repeated use of ketamine. (See 'Longer term' above.)

SOCIETY GUIDELINE LINKS

Links to society and government-sponsored guidelines from selected countries and regions around the world are provided separately. (See "Society guideline links: Depressive disorders".)

SUMMARY

- **Chemical structure** – Ketamine is a racemic mixture of two enantiomers, S-ketamine (esketamine) and R-ketamine. (See 'Introduction' above and 'Chemical structure' above.)
- **Indication** – Ketamine or esketamine may be indicated for treatment-resistant, severe unipolar major depression without psychotic features, if patients have failed or declined other indicated treatments. Patients receiving ketamine or esketamine should be under the care of a psychiatrist who can determine whether other treatments have been appropriately administered and can monitor the outcome of the ketamine/esketamine trial. (See "Unipolar depression in adults: Choosing treatment for resistant depression".)
- **Mechanism of action** – Although the mechanism of action for the rapid antidepressant effects of ketamine or esketamine is not known, several studies indicate that ketamine has an affinity for multiple receptors. (See 'Mechanism of action' above.)
- **Administration** – If ketamine is used for treatment-resistant depression, clinicians need to determine different aspects of administration, including setting, route of administration, dose, frequency, and use of concomitant medications. (See 'Administration' above.)

- **Efficacy** – Randomized trials have demonstrated that intravenous ketamine and intranasal esketamine can each rapidly improve treatment-resistant depression. (See 'Short-term efficacy' above and 'Short term' above.)

- **Adverse effects**

  - **Ketamine** – In patients treated for resistant depression with ketamine, side effects occur more often with ketamine than placebo or active controls. Short-term adverse effects include dissociation, psychotomimetic effects, and cardiovascular changes such as increased systolic and diastolic blood pressure and increased pulse; most of these side effects resolve quickly. However, ketamine can act as a transient intoxicant and is liable to abuse, addiction, and diversion as an illicit recreational drug. Ketamine abuse is also associated with neurotoxicity and bladder dysfunction. (See 'Adverse effects' above.)

  - **Esketamine** – Adverse effects that occur at least twice as often with intranasal esketamine plus antidepressant, compared with placebo plus antidepressant, include anxiety, increased blood pressure, dissociation, dizziness, nausea, sedation, and vertigo. We presume that longer-term, repeated use of esketamine can potentially lead to adverse effects that are seen with longer-term, repeated use of ketamine. (See 'Adverse effects' above and 'Longer term' above.)

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Topic 119992 Version 18.0

GRAPHICS

Intravenous anesthetic induction agents

Drug	Uses	Suggested induction dose*	Advantages	Potential adverse effects
Propofol	Induction agent of choice for most patients	▪ 1 to 2.5 mg/kg ▪ Older age: 1 to 1.5 mg/kg ▪ Hypovolemia or hemodynamic compromise: ≤1 mg/kg	▪ Rapid onset and offset ▪ Antiemetic properties ▪ Antipruritic properties ▪ Bronchodilation ▪ Anticonvulsant properties ▪ Decreases $CMRO_2$, CBF, and ICP	▪ Dose-dependent hypotension ▪ Dose-dependent respiratory depression ▪ Pain during injection ▪ Microbial contamination risk ▪ Rare anaphylaxis in patients with allergy to its soybean oil emulsion with egg phosphatide
Etomidate	May be selected in patients with hemodynamic instability due to any cause	▪ 0.15 to 0.3 mg/kg ▪ Presence of profound hypotension: 0.1 to 0.15 mg/kg	▪ Rapid onset and offset ▪ Hemodynamic stability with no changes in BP, HR, or CO ▪ Anticonvulsant properties ▪ Decreases $CMRO_2$, CBF, and ICP	▪ High incidence of PONV ▪ Pain during injection ▪ Involuntary myocloni movements ▪ Absence of analgesic effects ▪ Transient acute adrenocortical suppression
Ketamine	May be selected in hypotensive patients or those likely to develop hypotension (eg, hypovolemia, hemorrhage, sepsis, severe cardiovascular compromise)	▪ 1 to 2 mg/kg ▪ Chronic use of tricyclic antidepressants: 1 mg/kg ▪ Presence of profound hypotension: 0.5 to 1 mg/kg ▪ Intramuscular dose: 4 to 6	▪ Rapid onset ▪ Increases BP, HR, and CO in most patients ▪ Profound analgesic properties ▪ Bronchodilation ▪ Maintains airway reflexes	**Cardiovascular effects** ▪ Increases myocardial oxygen demand due to increases in HR, BP, and CO ▪ Increases pulmonary arterial pressure (PAP) ▪ Potentiates cardiovascular

		mg/kg	and respiratory drive ▪ Intramuscular route available if IV access lost	toxicity of cocaine or tricyclic antidepressants ▪ Exacerbates hypertension, tachycardia, and arrhythmias in pheochromocytom ▪ Direct mild myocardial depressant effects **Neurologic effects** ▪ Psychotomimetic effects (hallucinations, nightmares, vivid dreams) ▪ Increases CBF and ICP; may increase $CMRO_2$ ▪ Unique EEG effects may result in misinterpretation o BIS and other processed EEG values **Other effects** ▪ Increases salivatior
Methohexital	Induction for electroconvulsive therapy (ECT) because it activates seizure foci	▪ 1.5 mg/kg	▪ Lowers seizure threshold, facilitating ECT ▪ Decreases $CMRO_2$, CBF, and ICP	▪ Limited availability ▪ Dose-dependent hypotension ▪ Dose-dependent respiratory depression ▪ Involuntary myocloni movements ▪ Pain during injection ▪ Contraindicated in patients with porphyria

$CMRO_2$: cerebral metabolic oxygen requirement; CBF: cerebral blood flow; ICP: intracranial pressure; BP: blood pressure; HR: heart rate; CO: cardiac output; PONV: postoperative nausea and vomiting; EEG:

electroencephalographic; ECT: electroconvulsive therapy.

* Use adjusted body weight or estimated lean body weight for anesthetic drug dosing.

Graphic 102350 Version 13.0

Contributor Disclosures

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Contributor disclosures are reviewed for conflicts of interest by the editorial group. When found, these are addressed by vetting through a multi-level review process, and through requirements for references to be provided to support the content. Appropriately referenced content is required of all authors and must conform to UpToDate standards of evidence.

Conflict of interest policy

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Kaiser Foundation Health Plan of Washington

Clinical Review Criteria
Ketamine for the Treatment of Depression and Other Psychiatric Disorders

Criteria

For Medicare Members

Source	Policy
CMS Coverage Manuals	None
National Coverage Determinations (NCD)	None
Local Coverage Determinations (LCD)	None
Local Coverage Article (LCA)	None
Kaiser Permanente Medical Policy	Due to the absence of an active NCD, LCD, or other coverage guidance, Kaiser Permanente has chosen to use their own Clinical Review Criteria, "***Ketamine for the Treatment of Depression and Other Psychiatric Disorders"*** for medical necessity determinations. Refer to the Non-Medicare criteria below.

For Non-Medicare Members

Ketamine (intranasal, intravenous, or subcutaneous) is considered experimental and investigational as its clinical value has not been established. Non-covered diagnoses include but are not limited to:

- Chronic pain
- Depression
- Generalized anxiety and social anxiety disorders
- Substance use disorder
- Suicidal ideation

Note: Evaluations for the explicit purpose of Ketamine treatment will also be reviewed against clinical criteria for Ketamine treatment.

*Esketamine nasal spray (Spravato) has separate criteria for pharmacy review:
https://wa-provider.kaiserpermanente.org/static/pdf/provider/clinical-review/list-officeinject.pdf

For non-covered criteria

If requesting review for this service please send the following documentation:

- Last 6 months of clinical notes from requesting provider &/or specialist

The following information was used in the development of this document and is provided as background only. It is provided for historical purposes and does not necessarily reflect the most current published literature. When significant new articles are published that impact treatment option, Kaiser Permanente will review as needed. This information is not to be used as coverage criteria. Please only refer to the criteria listed above for coverage determinations.

Hayes Review

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Ketamine Infusion for Treatment-Resistant Bipolar Depression

Conclusion - D[2]

A small body of very low-quality evidence found that ketamine infusion rapidly reduces symptoms of severe bipolar depression. Although the antidepressant effects appear to last for only a few days, this can be clinically significant if it improves the mood of severely depressed, potentially suicidal patients. In all of the studies, only a single dose of ketamine was administered; the safety and effectiveness of repeated administration of ketamine for treatment of bipolar depression is unknown. The evidence suggests that ketamine is reasonably safe. Additional large, well-designed studies with adequate follow-up are needed to evaluate the long-term effects of prolonged ketamine treatment.

Insights

- Ketamine is administered by infusion because it does not have good bioavailability via alternative routes, such as oral or intramuscular injection.
- The low oral bioavailability and potential for abuse makes ketamine an unlikely first- or second-line therapy for bipolar depression.
- Persons with bipolar disorder are more apt to seek medical attention when they are depressed; therefore, a careful medical history must be obtained to avoid misdiagnosis of the patient's disorder as major depression.
- None of the reviewed payers had policies available for the use of ketamine to treat bipolar depression.

Ketamine as Primary Therapy for Treatment-Resistant Unipolar Depression Or Posttraumatic Stress Disorder

Conclusion- C (For ketamine as a treatment for treatment-resistant unipolar depression)

D2 (For ketamine as a treatment for posttraumatic stress disorder (PTSD).

A moderate-size body of low-quality evidence has consistently found that ketamine reduces symptoms of severe treatment-resistant unipolar depression, symptoms of PTSD, or suicidal ideation at short-term follow-up of 1 to 3 days posttreatment; however, the findings at longer-term follow-up of 1 to 4 weeks are mixed. The majority of the studies administered only a single dose of ketamine; the safety and effectiveness of repeated administration of ketamine for treatment of depression or PTSD is unknown. The evidence suggests that ketamine is reasonably safe if complications are properly managed. Additional large, well-designed studies with adequate follow-up are needed to evaluate the long-term effects of prolonged ketamine treatment, to assess simplified ketamine administration via intranasal or subcutaneous routes, to determine the efficacy and safety of ketamine for PTSD treatment, and to evaluate the efficacy and safety of ketamine relative to ECT for unipolar depression.

Insights

- The low oral bioavailability and potential for abuse makes ketamine an unlikely first- or second-line therapy for treatment-resistant unipolar depression or PTSD.
- The reviewed studies found that ketamine is consistently beneficial for 24 hours posttreatment; however, the durability of results at 1 to 4 weeks posttreatment are mixed. Thus, it is unclear whether ketamine provides durable relief of depression or PTSD symptoms.
- As the beneficial effects of ketamine may be limited to 24 hours posttreatment, it is important to establish the safety and effectiveness of repeated administration of ketamine. There is currently a paucity of studies investigating repeated administration of ketamine for unipolar depression or PTSD.
- Several representative payer organizations do not have coverage policies for ketamine monotherapy for unipolar depression or PTSD.

Applicable Codes

Considered Not Medically Necessary - experimental, investigational or unproven:

CPT® or HCPCS Codes	Description
90792	Psychiatric diagnostic evaluation with medical services
J3490	Unclassified drugs
Commonly submitted with CPT code(s) 96365, 96366, 96367, or 96368	
ICD-10 Codes	**Description**
F01-F09	Mental disorders due to known physiological conditions
F10-F19	Mental and behavioral disorders due to psychoactive substance use
F20-F29	Schizophrenia, schizotypal, delusional, and other non-mood psychotic disorders

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F30-F39	Mood [affective] disorders
F40-F48	Anxiety, dissociative, stress-related, somatoform and other nonpsychotic mental disorders
F50-F59	Behavioral syndromes associated with physiological disturbances and physical factors
F60-F69	Disorders of adult personality and behavior
F70-F79	Intellectual disabilities
F80-F89	Pervasive and specific developmental disorders
F90-F98	Behavioral and emotional disorders with onset usually occurring in childhood and adolescence
F99-F99	Unspecified mental disorder
T14.91XA	Suicidal behavior with attempted self-injury
R45.89	Suicidal behavior without attempted self-injury
T65.92XA	Suicidal deliberate poisoning
R45.851	Suicidal ideation
R45.851	Suicidal ideations
R45.851	Suicidal intent
T50.902A	Suicidal overdose
T50.902A	Suicidal overdose, initial encounter
T50.902S	Suicidal overdose, sequela
T50.902D	Suicidal overdose, subsequent encounter
R45.89	Suicidal risk
R45.851	Suicidal thoughts
R45.851	Feeling suicidal
T40.602A	Narcosis due to narcotic, purposeful, non-suicidal
Z71.1	Concern about becoming suicidal without diagnosis
F32.A, R45.851	Depression with suicidal ideation
Z91.52	History of non-suicidal self-harm
Z91.51	History of suicidal behavior
G89.21	Chronic pain due to trauma
G89.22	Chronic post-thoracotomy pain
G89.28	Other chronic postprocedural pain
G89.29	Other chronic pain
G89.3	Neoplasm related pain (acute) (chronic)
G89.4	Chronic pain syndrome
G90.511	Complex regional pain syndrome I of right upper limb
G90.512	Complex regional pain syndrome I of left upper limb
G90.513	Complex regional pain syndrome I of upper limb, bilateral
G90.519	Complex regional pain syndrome I of unspecified upper limb
G90.521	Complex regional pain syndrome I of right lower limb
G90.522	Complex regional pain syndrome I of left lower limb
G90.523	Complex regional pain syndrome I of lower limb, bilateral
G90.529	Complex regional pain syndrome I of unspecified lower limb
G90.59	Complex regional pain syndrome I of other specified site

***Note:** Codes may not be all-inclusive. Deleted codes and codes not in effect at the time of service may not be covered.

****To verify authorization requirements for a specific code by plan type, please use the **Pre-authorization Code Check**.

Date Created	Date Reviewed	Date Last Revised
11/10/2021	12/07/2021[MPC], 12/06/2022[MPC], 12/09/2023[MPC], 12/03/2024[MPC]	06/03/2024

[MPC] Medical Policy Committee

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Revision History	Description
12/07/2021	MPC approved to adopt a policy of non-coverage for IV Ketamine for mental diagnoses including chronic pain, depression, generalized anxiety and social anxiety disorders, substance use disorder and suicidal ideation.
06/21/2022	Updated the 60-day notice to 12/1/2022 and removed “oral” per Pharmacy
06/03/2024	Added code 90792 and language to clarify that evaluations for the explicit purpose of Ketamine treatment will also be reviewed against clinical criteria for Ketamine therapy.

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Ketamine Infusion for Treatment Resistant Depression and Severe Suicidal Ideation

National Protocol Guidance

July 2022

VA Pharmacy Benefits Management Services, Medical Advisory Panel, VISN Pharmacist Executives, and Office of Mental Health Somatic Treatment Field Advisory Committee

Purpose: To provide general guidance on ensuring access to intravenous ketamine for the treatment of treatment resistant major depressive disorder or severe suicidal ideation under a National VA protocol that will facilitate collection of safety and effectiveness outcomes via a prospective medication use evaluation (MUE).

Disclaimer: To be consistent with the purpose of this general guidance and not to be overly proscriptive, this guidance allows facilities the flexibility to exercise modifications to the protocol as necessary to operationalize the use of ketamine for treating treatment-resistant depression or severe suicidal ideation.

Background

Ketamine is a glutamate N-methyl-D-aspartate (NMDA) receptor antagonist approved for general anesthesia. Ketamine has demonstrated a rapid response in persons with MDD following a single infusion. A systematic review and meta-analysis assessed nine, non-electroconvulsive therapy studies that compared ketamine to placebo or midazolam in patients with treatment-resistant depression (n=192)[1]. Compared to controls, patients who received ketamine had significantly greater improvement on global depression scores within 24 hours of administration. Suicidal ideation was reduced in the two studies in which it was assessed. Ketamine's efficacy was maintained in patients on or off antidepressants in all subgroups and sensitivity analyses. A small randomized, double blind trial found ketamine to be as effective as ECT with a more rapid onset of effect[2]. Common side effects included dry mouth, tachycardia, increased blood pressure and the feeling of disassociation. Additional serious side effects include increased intracranial pressure, increased intraocular pressure, and hypersalivation which can lead to upper airway obstruction or laryngospasm. A 2017 meta-analysis reported ketamine rapidly reduced suicidal thoughts in depressed patients with suicidal ideation[3].

Despite these preliminary positive findings in a limited number of studies, many questions remain unanswered[4, 5]. The studies to date have given a single dose of ketamine leaving the number and frequency of doses needed to treat an episode of MDD undetermined. The most common dose has been 0.5 mg/kg of body weight. Higher doses may be more likely to result in cardiovascular adverse effects and no dose ranging studies have been conducted. Ketamine has also not been studied in persons with co-occurring conditions. Thus, the identification of patients who would most benefit from ketamine and the best approach to dosing has not been established.

The American Psychiatric Association Council of Research Task Force on Novel Biomarkers and Treatments reviewed the literature on the use of ketamine infusion for treatment-resistant depression and concluded there is "compelling evidence that the antidepressant effects of ketamine infusion are both rapid and robust, albeit transient"[6]. The Council also recommended seven components of preprocedural evaluation for appropriateness of ketamine treatment which have been included in this

protocol. Also included are the Council's findings and existing protocols being used in VHA pertaining to patient selection, clinical experience and training, treatment setting, medication delivery, follow-up and assessments, safety, and long-term/repeated administration as well as comments submitted by VHA practitioners.

The 2016 update of the VA/DoD Major Depressive Disorder Clinical Practice Guidelines includes the following recommendation, "Given the limited information on ketamine's safety and duration of effect, we recommend against the use of ketamine to treat MDD outside of a research setting" [7]. Additional information has been published since and the interest in providing ketamine infusion for treatment-resistant MDD, pain and other conditions has grown both within and outside VHA [3, 6, 8-11]. The VHA Office of Mental Health FY2015 survey of 140 VA facilities (100% response rate) found 8 sites (6%) were providing ketamine onsite for the treatment of treatment-resistant depression and 22 sites (16%) were providing it off site; another 35 were interested. Only 3 sites were using ketamine under a research protocol.

Departments Affected: Pharmacy, Nursing, Mental Health (Anesthesia on call)

Procedure:

- Patients can either be treated as outpatients or inpatients

Patient Selection

Inclusion Criteria

- Current diagnosis of unipolar, major depressive disorder (MDD) by DSM-5. Patients with MDD with psychotic features were excluded from clinical trials. Psychosis severity should be taken under consideration when deciding if an individual patient is eligible.

- The patient has failed to achieve a full response to four adequate therapeutic trials (dose and duration) of antidepressants including augmentation when appropriate or psychotherapy from different classes (either in combination or succession) in the current episode.
    - Antidepressant treatment and psychotherapy trials are considered "failed" using a standardized scale such as the Antidepressant Treatment History Form

Antidepressant Trial History Form.pdf

OR

- Severe suicidal depression for which a rapid treatment onset is important

- A VA psychiatrist or a VA licensed health-care provider (i.e., CPP, NP, PA) has evaluated the patient and determined and documented that the patient qualifies for ketamine treatment in patient's medical record.
- The patient has a Patient Health Questionnaire-9 (PHQ-9) score of 15 or greater (moderate or severe depression) within the past 30 days. Other scales to measure severity may be used instead of the PHQ-9 such as the Montgomery-Asberg Depression Rating Scale (MADRS) or the Hamilton Rating Scale for Depression (HAM-D).
- The patient has been considered for electroconvulsive therapy (ECT).
- The patient or their legal representative is able to provide verbal informed consent.

- The patient has an adult who can accompany him/her and assist with transportation, or another method of safe transport has been arranged and documented.

Exclusion Criteria

- Current or past history of schizophrenia, schizoaffective disorder, or bipolar disorder
- Dementia
- Current or recent (within the 7 days) delirium
- Current uncontrolled hypertension (systolic blood pressure >160 mm Hg or diastolic blood pressure >90 mm Hg)
- Severe cardiac decompensation
- Pregnant (via positive pregnancy test) or lack of birth control method in women of childbearing potential
- Positive urine drug screen or current or previous abuse of ketamine. Patients prescribed an opioid, benzodiazepine, or barbiturate by a VHA provider (including Community Care) are eligible forketamine; however, it is advised that concurrent use while receiving ketamine may prolong recovery time. Patients in acute intoxication or in need of detoxification should be excludeduntil those issues are addressed.
- Allergy or previous serious adverse effects to ketamine

Screening and Referral

- Each facility will be responsible for developing and operationalizing a procedure to screen and refer potential candidates for treatment with ketamine.
- Screening should be completed no more than 30 days prior to acceptance and administration of the first dose of ketamine.
- Screening will include the following: verbal informed consent, inclusion/exclusion criteria, psychiatric examination including PHQ-9 and evaluation of cognitive status (i.e., Mini-Addenbrooke's Cognitive Examination (M-ACE)), and physical examination including vitals (blood pressure, heart rate, respiratory rate, oxygen saturation, and weight), relevant laboratory measures (including LFTs), and urine toxicology and pregnancy screens.
    - Patients with a SBP >150 mm Hg or a DBP >95 mm Hg at screening should be considered at higher risk and treatment for hypertension should be considered prior to initiating treatment with ketamine. Patients with a diagnosis of hypertension are to be adequately treated prior to receiving an infusion of ketamine.
    - Patients with a history of cardiopulmonary or cerebrovascular disease, recent myocardial infarction, symptomatic ischemic heart disease, dyspnea marked by shortness of breath or wheezing, poor exercise capacity (<6 metabolic equivalent of tasks (METs); bicycling – light effort (10-12 mph) =6.0), or any disease that could be associated with increased risk of acute cardiac demand or blood pressure or respiratory depression should be considered on an individual case basis, considering risk/benefit ratios.
    - Patients with a baseline heart rate of <60 beat per minute (bradycardia) or >100 beats per minute (tachycardia) should be considered on a case-by-case basis for the relative risks of ketamine.
    - SpO_2 at screening should be >94 after mild exertion.
- Other physical and laboratory screening procedures should be determined according to the patient's individual risk factors based on his/her demographics, medical history and review of systems and is the responsibility of the prescribing VA psychiatrist or VA licensed health-care provider (i.e., CPP, NP, PA).

- Whether to obtain medical clearance from the patient's primary care provider or consultation from a cardiologist, anesthesiologist, or other medical specialist should be based on the patient's risk factors and is the responsibility of the prescribing VA psychiatrist or VA licensed health-care provider (i.e., CPP, NP, PA).
- Concurrent use or abuse of CNS depressants
    - In light of ketamine's abuse as a recreational drug, other factors to consider when screening for appropriate patients is a history of substance abuse including ketamine, extent of past and current alcohol use, smoking history, a history of medication misuse or inappropriate medical care, and a positive urine drug screen. There is no clear evidence of recent substance abuse to be associated with the risk of relapse with ketamine. Length of sobriety should be considered when making a decision.
    - Due to the theoretical potential for benzodiazepines and nonbenzodiazepine, benzodiazepine receptor agonists hypnotics (e.g., zolpidem) to attenuate ketamine's antidepressant effects, patients taking benzodiazepines should be allowed adequate time for the last dose of benzodiazepine to washout prior to receiving ketamine.
    - Concurrent use of barbiturates, opioids and other narcotics may delay recovery following ketamine infusion.

Location of Administration, Monitoring and Recovery

- The facility is responsible for identifying a physical location for the infusion of ketamine and monitoring the patient during and after the infusion. The place for administration and recovery should be private and large enough to accommodate the patient and required personnel.
- The treatment setting should be able to provide immediate care if necessary. A crash cart should be readily accessible. The facility must have the means to monitor basic cardiovascular functions (including electrocardiogram and blood pressure) and respiratory function (oxygen saturation or end-tidal CO_2).
- The facility must also be capable of administering oxygen, medication and/or restraints to manage potentially dangerous behavioral symptoms.
- The facility must have a plan to rapidly address any sustained alterations in cardiovascular function including advanced cardiac life support or transfer to a hospital capable of caring for acute cardiovascular events.
- Patients determined to be at high risk for complications based on pretreatment evaluation should be treated at a facility equipped and staffed to manage any cardiovascular or respiratory events that may occur.

Ketamine Procurement and Infusion

- The facility is responsible for determining the procedure that ketamine is ordered, prepared, and transported to the place of administration.
- A VA psychiatrist or VA licensed health-care provider (i.e., CPP, NP, PA) will order the ketamine intravenous infusion and pre-medication and/or concurrent medication to prevent or manage adverse effects (e.g., intravenous lorazepam for agitation).
- The ordering VA psychiatrist or VA licensed health-care provider (i.e., CPP, NP, PA) and an ACLS certified physician or nurse will be present during the infusion. The VA psychiatrist or VA licensed health-care provider (i.e., CPP, NP, PA) can leave once the infusion is completed and the patient consideredstable based on vital signs and cognitive status. The VA psychiatrist or VA licensed health-care provider (i.e., CPP, NP, PA) must return at 120 minutes after the start of the infusion to administer the Clinician-Administered Dissociative States Scale(CADSS), and clear the patient for discharge. An ACLS certified provider is to remain with the patient until

discharge.

CADSS.pdf

- Ketamine infusion timeline
  - T-2 days or sooner: Urine drug screen and pregnancy tests are collected.
  - **T-60**: Intravenous line started by a nurse or other qualified provider. Perform vital signs (sitting/standing blood pressure, sitting/standing pulse, respiratory rate, and oxygen saturation) test. Administer PHQ-9 (or other depression scale), and CADSS (for dissociative state) as baseline measures.
  - **T-0**: Provided vitals are acceptable and urine drug screen and pregnancy tests are negative (See Exclusion Criteria). Administer ketamine 0.5 mg/kg by intravenous infusion using an infusion pump over 40 minutes. For patients with a body mass index $\geq$30 kg/m^2 it is suggested that the dose be calculated using the patient's ideal body weight (Men = 50 kg + (2.3 kg x each inch >5 feet); Women = 45.5 kg + (2.3 kg x each inch >5 feet)) rather than their actual body weight.
  - **T-0 to +40:** Monitor for sedation, dissociation, and other possible adverse events.
  - **T+10, 20, 30 and 40**: Vital signs
  - **T+80**: Vital signs, and check for resolution of sedation, dissociation, and other possibleadverse effects
  - **T+120**: Vital signs, CADSS and readiness for discharge assessment (consider Modified Aldrete or Brief Confusion Assessment Method (bCAM))
- Parameters for stopping infusion
  - Blood pressure should remain <180 mm Hg systolic and < 110 mm Hg diastolic at all times during the infusion. Stopping the infusion often results in a rapid decline in blood pressure.
    - Systolic blood pressure can also drop by >10 mm Hg during the infusion. Should such a drop occur and be accompanied by an increased heart rate or any evidence of distress, then the infusion should be stopped.
  - Heart rate should remain below the age adjusted maximum heart rates of 20 yrs <140 bpm, 30 yrs <133, 40 yrs <126, 50 yrs <119, and 60 yrs <112. For patients 65 years and older the maximum heart rate should be individualized based on exercise capacity and other risk factors.
  - The appearance of any of the following necessitates stopping the infusion: 1) pallor, cyanosis, or any symptoms of poor perfusion, 2) respiratory symptoms such as shortness of breath, wheezing, 3) the appearance of chest, jaw or arm pain suggesting cardiac involvement, or 4) the patient's desire to stop.

Repeat Infusion Schedule

- Ketamine infusion should be repeated no less 3 days apart and not more frequently than twice a week for 2 – 3 weeks
- After 2-3 weeks the frequency of infusion should be once a week to once every 3 weeks with the goal to extend the interval between infusions to as long as possible (usually monthly). This will need to be individualized based on the patient's response, tolerability, and preference/availability.

- In the interest of patient safety, ketamine should be tapered and discontinued. At present this time frame is undefined and will need to be individualized.

Ketamine Treatment Failure/Discontinuation

- Discontinue if patient wishes to for any reason.
- Discontinue if the patient needs to have the infusion stopped more than once due to exceeding the blood pressure or heart rate thresholds.
- After 4 to 6 infusions without an adequate response
    - An adequate response is defined as a 50% or greater decline in the PHQ-9 score from baseline
- Discontinue if pronounced or slow to correct cognitive impairment (M-ACE) or repeated dissociative symptoms.
- Discontinue when dosing cannot be spaced out to a minimum of 1 dose per week by the second month of treatment.

Longitudinal Monitoring of Ketamine Patients

- A PHQ-9 and M-ACE should be completed at the end of the induction phase, every 6 months of treatment, and at the end of treatment course.

Consent Statement for Ketamine Infusion for the Treatment-Resistant Major Depressive Disorder or Severe Suicide Ideation

The following is to be read to and/or given to the patient or person authorized to approve treatments to read. A verbal acknowledgment of consent is required and is to be documented in the patient's medical record.

****

* Your VA psychiatrist or VA mental health provider, or a psychiatrist provided by VA Community Care has recommended that you be treated with a drug called KETAMINE because your depression has not responded to other treatments or your thoughts of harming yourself are severe enough to need urgent treatment. Ketamine is not approved by the U.S. Food and Drug Administration (FDA) for the treatment of depression or suicidal thoughts and its use to treat these conditions is considered "off-label." This is why you are being asked to give verbal consent for treatment with ketamine.

Ketamine is approved by FDA as general anesthetic, a drug that induces deep sleep or an unconscious state during which the patient does not feel pain. General anesthesia is used during surgery. The dose of ketamine used in surgery is much higher than the dose you will receive.

To treat your depression, you will receive a dose of ketamine two times a week for 2 or 3 weeks, at that point your physician will begin to increase the time between treatments to once a week to once every 3 or 4 weeks. This will be done based on your response and how well you tolerate ketamine. If after 4 to 6 treatments your psychiatrist or VA mental health provider determines that you have not responded to ketamine, the treatments willstop, and he/she will discuss other treatment options with you.

What can you expect during the treatment?

Prior to your receiving ketamine, you will be examined to determine if ketamine is safe for you. This will include physical and mental status exams as well as labs and other tests decided on by the examining healthcare provider.

- Patients with certain heart conditions, uncontrolled high blood pressure or breathing conditions may not be eligible for treatment with ketamine.
- Women who are pregnant or who may become pregnant are not eligible for ketamine.
- Many patients who are abusing drugs or have a history of drug abuse may not be eligible for ketamine.

Each ketamine treatment will take approximately 5 hours; this includes your arrival an hour before you receive ketamine so your vital signs (heart rate, blood pressure, and breathing) can be assessed and an intravenous (IV) line started. You will also be given tests to measure your mood and mental state. These will be repeated periodically during your treatment. The remaining 4 hours include the 40 minutes to infuse ketamine and to make sure that you have recovered and are safe to leave. During this time, you will not be alone, a physician, nurse or other qualified health professional will be with you.

Ketamine's antidepressant effect has been reported to be rapid in some, but not all, patients who are depressed or have suicidal thoughts. However, the effect often quickly wears off and symptoms of depression return which is why you will receive repeated doses.

You are advised not to drive for 24-hours after receiving ketamine. Therefore, you will need a driver or another pre-arranged form of transportation to return home.

What are the potential risks or discomforts of ketamine infusion?

When used in general anesthesia ketamine has been reported to increase the risk for certain side effects such as anxiety, panic, fear reactions, hallucinations (such as seeing or hearing things that are not really present), paranoid thinking, agitation, dissociation (to feel disconnected from thoughts, memories, or surroundings), derealization (a sense that things around you are not real), depersonalization (out of body experiences), dream-like states, or agitation upon awakening from general anesthesia. Because ketamine is being used at much lower amounts and delivered over a longer period of time than is typically done in anesthesia practice, it is anticipated that these side-effects, while still possible, are less likely.

Ketamine is a known drug of abuse; in most cases it is swallowed or snorted, at substantially higher dosages and often with other illicit drugs or alcohol. While the dose of ketamine you will receive is generally well-tolerated, repeated doses may increase the side effects described by at risk individuals.

Importantly, there are no known permanent psychological effects reported in patients experiencing the side effects described above. Tolerance (a decreased in effect) to ketamine may develop with repeated use or in susceptible individuals with pre-existing illnesses. Other side-effects, such as high blood pressure and a change in heart rate or rhythm, can occur. You will be frequently monitored for these effects during and after the ketamine infusion.

It is your right to have ketamine discontinued at any time during your treatment –even while receiving the medication.

If you have any additional questions about ketamine or your treatment, please ask your psychiatrist or mental health provider.

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Revised: October 7, 2020

Prescribing Guidelines for Pennsylvania

GUIDELINES FOR SAFE ADMINISTRATION OF LOW-DOSE KETAMINE

Ketamine has been used as an anesthetic agent for decades. In recent years there has been growing interest in the use of low-dose ketamine for the treatment of a variety of conditions, including treatment of acute pain in opioid-tolerant patients, treatment of chronic noncancer pain, treatment of severe depression (including patients who are experiencing suicidal ideation), and in palliative care. The purpose of this document is to provide guidance on the safe use of low-dose ketamine in any treatment setting. This document is not intended to provide guidance on use of ketamine as an anesthetic or for procedural sedation where higher doses of ketamine are often administered, and for which higher levels of monitoring and support are needed.

Low doses of ketamine are those that are not intended to induce moderate to deep sedation or general anesthesia. Clinicians must be vigilant for the effects of concomitant medications that might increase the depth of sedation when low doses of ketamine are administered. There is wide interpatient variability on response to specific doses, but low ketamine doses would generally be infusions of no more than 1 mg/kg/hour or bolus doses of no more than 0.5 mg/kg.

This is not intended to provide guidance on the administration of ketamine by EMS providers, who must adhere to their scope of practice, medication list, and statewide EMS protocols from the Department of Health.

These guidelines are intended to provide best practices related on the safe use of low-dose ketamine. They are intended to help healthcare providers improve patient outcomes and to supplement, but not replace, the individual provider's clinical judgment.

Treatment location

Intravenous ketamine at low doses may be delivered in the inpatient, outpatient, emergency department, and office-based setting as long as the administration location has the equipment and personnel to safely administer the medication.

Except as noted below, the treatment location should have immediate access to the equipment and supplies that may be necessary to treat potentially serious adverse events related to ketamine administration. These include oxygen, bag-valve-mask devices of sizes appropriate to the patient population served, nasal cannula, non-rebreather face masks, nasopharyngeal airways, oropharyngeal airways, and an automated external defibrillator.

Rarely, ketamine infusion in the home setting as part of palliative care at the end of life may be appropriate. The selection and use of patient monitoring and the availability of resuscitation equipment in this setting should be based on patient and family wishes, and treatment goals.

Treatment team

Administration of low-dose ketamine must occur under the direct supervision of a physician or by a certified registered nurse anesthetist (CRNA) who has adequate training and experience to provide this care. Physicians and CRNAs must be aware of and adhere to the regulations, policies and procedures of any practice setting as it pertains to the scope and practice of ketamine administration. The practitioner should be able to demonstrate competency in understanding the basic pharmacology of ketamine, including proper dosing, proper patient selection (including identifying patients requiring a higher level of monitoring), and proper patient monitoring (including identifying and treating adverse effects that include hypoxia, apnea, hypotension, dysphoria, and dysrhythmia). At least one

member of the treatment team that is immediately available must have skills in advanced airway management.

Ketamine administration (infusion initiation and infusion dose changes) may be provided by any licensed practitioner, such as a registered nurse who has competence in administration of low-dose ketamine, under supervision of a physician or a CRNA. Patient monitoring during infusion is to be completed by a licensed practitioner who is trained and credentialed to provide this care, including immediate treatment of emerging adverse effects. There must be adequately trained health care providers immediately available to monitor and respond to adverse events.

Patient selection

It is important to note that patients with complex or life-threating comorbidities may be best cared for in the inpatient setting. Ambulatory and office-based settings are to establish appropriate patient selection criteria that clearly define which patients are eligible to receive ketamine infusions in that specific setting.

Patients with moderate to severe hepatic dysfunction (cirrhosis), high-risk coronary artery disease and poorly controlled psychosis are at increased risk for adverse events following ketamine infusion, and as a result ketamine infusion outside of palliative care for these patient groups are to be limited to the inpatient setting. Clinical trials that enroll patients with cardiovascular, renal, hepatic, psychiatric or neurological diseases who receive low-dose ketamine are still needed to further delineate the safety profile in these patient populations. Additionally, the long-term effects of low-dose ketamine have not been studied in any patient populations, including those with substance use disorders.

Role of ketamine in palliative care

Ketamine has been included in the World Health Organization's list of essential drugs for the treatment of refractory cancer pain. However, a 2017 Cochrane Review of the use of ketamine as an adjuvant to opioids for the treatment of cancer pain reported that current evidence is insufficient to assess the benefits and harms of ketamine use in this setting. Available evidence is of low quality. A recent multi-center, double-blind randomized clinical trial to evaluate the use of a five-day subcutaneous infusion of titrated ketamine verses placebo documented no difference in pain control between the two study groups, but significantly more toxicity in the ketamine arm. Therefore, it appears that use of ketamine in this setting is not associated with improved patient outcomes.

Administration of short-term low-dose ketamine to improve opioid-tolerant cancer pain may be helpful in select patients, but many patients report adverse effects. There have been reports of generalized hyperalgesia and allodynia following sudden discontinuation of a 3-week ketamine infusion.

Role of ketamine in children

There is growing interest in the use of low-dose ketamine for pain management in hospitalized children. Ketamine infusions have been demonstrated to improve pain control and decrease opioid requirements in children, adolescents, and young adults. Ketamine infusions have been administered to children in a variety of settings, including the emergency department for the treatment of sickle cell-related pain, as well as on the hospital floor and in intensive care units. Based on available data, there are no special precautions for the use of low-dose ketamine in the general pediatric and adolescent populations. However, increased monitoring in the specialty setting should be evaluated when considering ketamine infusions in neonates and congenital heart patients.

Ketamine infusion preparation and dosing

The ketamine infusion must be prepared in conformance with state and federal guidelines and regulations. Improper drug preparation is associated with increased risk of life-threatening adverse events. If drug preparation is outsourced, the facility and provider continue to have a responsibility to ensure that the drug to be administered has been prepared and delivered to the facility in a manner that is in conformance with state and federal guidelines and regulations.

The dosing range that constitutes “low-dose” is not consistently defined in the literature. While the package insert for ketamine states that general anesthesia may be induced with a range of 1-4.5 mg/kg (average dose 2 mg/kg), clinical experience has demonstrated that much lower doses may also alter consciousness and cause psychomimetic adverse effects.

In general, bolus dosing should be avoided to reduce the risk of euphoria and psychomimetic effects, particularly in the ambulatory setting. By way of reference, ketamine doses of 0.2-0.5 mg/kg (most commonly 0.3 mg/kg) infused over 10-15 minutes are appropriate for analgesia in the emergency department setting. Ketamine infusion rates of 0.25-0.5 mg/kg/h will produce sufficient analgesia for most pain indications in the acute pain setting for patients being followed by a pain service or critical care team. Treatment of some chronic pain conditions, such as refractory headache or complex regional pain syndrome, may require higher infusion rates to achieve treatment goals. These rates rarely exceed 1 mg/kg/hr. Patients are to regularly be assessed for sedation and asked about psychomimetic adverse effects. Low-dose ketamine infusion rates do not differ between inpatient and outpatient settings.

When ketamine administration in the home or hospice setting is considered, the most commonly studied treatment method for pain management is through a continuous low-dose intravenous or subcutaneous infusion. Administration rates of 0.05 - 0.5 mg/kg/hour have been reported. Subcutaneous or intramuscular absorption is slower than intravenous, but is still extensive, with a bioavailability of 90%.

Patient Monitoring

Ketamine may result in adverse psychomimetic, cardiovascular, hepatic and gastrointestinal adverse effects from its action on several receptors including NMDA, acetylcholine, opioid, monoamine, and histamine. The minimally recommended monitoring for low-dose ketamine administration includes blood pressure, cardiac monitoring/electrocardiogram (EKG), pulse oximetry, and neurological checks which include assessment for level of consciousness. Monitoring is to occur prior to infusion administration, periodically or continuously throughout the infusion, and should not be discontinued until any adverse effects (respiratory, cardiac, neurologic and/or psychometric symptoms) have resolved. The availability of capnography and pulse oximetry is mandatory in the event of respiratory depression requiring an airway intervention to assure adequacy of respiration. Patients with complex health conditions who are considered to be at increased risk for adverse effects may require more frequent and longer duration of monitoring.

Use of Esketamine

In 2019 the Food and Drug Administration (FDA) approved the S-enantiomer of ketamine, esketamine (Spravato), for treatment-resistant depression. The drug is administered as a nasal spray. Patients must be monitored for at least two hours after administration, which must occur in a medical facility. Esketamine has no other approved indications at this time and clinicians are cautioned to avoid "off-label" use as there are no data available to support safety and efficacy for other uses at this time.

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New Mexico Medical Board Ketamine Policy
Adopted: September 23, 2022

Over the past decade, the use of ketamine has expanded beyond anesthesia and pain management in surgical, hospital and emergency departments. Evidence has grown that this medication, as well as an enantiomer, esketamine, seem effective in the treatment of psychiatric disorders.

The use of these medications in the treatment of depression and possibly other mental illnesses is evolving, but usually entails using lower doses administered by IV, IM, subcutaneously, oral and intranasal routes. Guidelines for the use of these medications have been published but still indicate some variability and the need to establish effective dosing and delivery methods.

While ketamine is an approved medication for anesthesia, its use for mental health treatment is off-label so is subject to the clinical and ethical guidelines the NMMB has opined on previously. Ketamine is also a controlled substance, with a risk for abuse and the development of a substance use disorder for extra care in its use is warranted.

It is becoming apparent from the national press and medical publications that ketamine is being provided by medical providers for reasons outside of the treatment of legitimate medical illnesses as well as for illnesses outside their area of expertise.

This is a concern of the board, as we are compelled by the Medical Practice Act to:

> "Protect the public from the improper, unprofessional, incompetent and unlawful practice of medicine…"

Therefore in the interest of promoting the safe, effective and ethical practice of medicine, the NMMB offers the following guidance in the use of ketamine.

1. If ketamine is being offered as a treatment, it must be for the treatment of a legitimate, medically-recognized illness.
2. Ketamine must be offered as a treatment only if there is a reputable research basis for its use for a particular diagnosis, and is administered as outlined per protocols developed by the relevant professional society.
3. Before being considered as a candidate for ketamine treatment, the patient must be evaluated and diagnosed by a physician with expertise in the diagnosis and treatment of the patient's condition.
4. Ketamine must be integrated into a complete treatment plan for the patient's condition.
5. Ketamine should be administered only by a provider that has been trained in its use.
6. Safety measures for the use of this medication must be in place for managing both immediate, short-term and long-term side effects, to include on-going follow-up once ketamine treatment ends.

Using ketamine outside these guidelines may subject licensees to investigation for violations of the Medical Practice Act and its regulations.

WMC Rules Progress Report						Projected filing dates			
Rule	**Status**	**Date**	**Next step**	**Complete By**	**Notes**	**CR-101**	**CR-102**	**CR-103**	**CR-105**
Collaborative Drug Therapy Agreements (CDTA)	CR-101 filed	7/22/2020	Waiting on the results of the Sunrise Review	NA	PQAC Sunrise Review	Complete	TBD	TBD	NA
OBS - Use of Nitrous Oxide, WAC 246-919-601	CR-102 filed	6/30/2025	Hearing	8/22/2025	Keep BoMS updated.	Complete	TBD	TBD	NA
ESSB 5389 - Define Qualified Physician	CR-101 approved	10/20/2023	The Interpretive Statement has been adopted. Request to rescind this rulemaking and, instead, add the IS language to the MD chapter 246-919 WAC rulemaking.	8/22/2025	Keep BoMS updated.	TBD	TBD	TBD	NA
SB 5184 - Anesthesia Assistants - New Profession	CR-103 filed	6/26/2025	Rules effective	7/27/2025		Complete	Complete	Complete	NA
Opioid prescribing--General Provisions for MDs and PAs	CR-101 filed	4/30/2025	Workshops are in progress	NA	Keep BoMS updated.	Complete	TBD	TBD	NA
chapter 246-919 WAC MD Physicians WAC 246-919-010 through WAC 246-919-520 WAC 246-919-602 through WAC 246-919-700	CR-101 filed	5/22/2025	Workshops are in progress	NA		Complete	TBD	TBD	NA

Updated: 8/14/2025

Interpretive Statement

WASHINGTON Medical Commission
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To request this document in another format, call 1-800-525-0127. Deaf or hard of hearing customers, please call 711 (Washington Relay) or email doh.information@doh.wa.gov.

Title:	"Qualified Physician" Under Optometry Law
Interpretive Statement Number:	INS2025-01
References:	Chapter 18.53 RCW; Chapter 18.71 RCW
Contact:	Washington Medical Commission
Phone:	(360) 236-2750
Email:	medical.policy@wmc.wa.gov
Effective Date:	May 9, 2025
Supersedes:	N/A
Approved By:	Karen Domino, MD, Chair (signature on file)

The Washington Medical Commission (WMC) interprets the term "qualified physician under chapter 18.71 RCW" in Enrolled Substitute Senate Bill 5389, chapter 400, Laws of 2023, to mean a physician who meets each of the following criteria:

1. Holds a current license to practice as a physician and surgeon with the WMC;
2. Is not currently under an order or a stipulation to informal disposition with the WMC;
3. Holds a current and unrestricted certification from the American Board of Ophthalmology or is eligible to do so; and
4. Has a surgical suite on site or holds privileges at a local hospital.

On May 9, 2023, Governor Inslee signed Enrolled Substitute Senate Bill 5389, chapter 400, Laws of 2023, amending chapter 18.53 RCW, an act regulating the practice of optometry in Washington. This new law expanded the scope of optometry to include certain advanced procedures:

RCW 18.53.010

(2)(a) The practice of optometry may include the following advanced procedures:

(i) Common complication of the lids, lashes, and lacrimal systems;

(ii) Chalazion management, including injection and excision;

(iii) Injections, including intramuscular injections of epinephrine and subconjunctival and subcutaneous injections of medications;

(iv) Management of lid lesions, including intralesional injection of medications;

(v) Preoperative and postoperative care related to these procedures;

(vi) Use of topical and injectable anesthetics; and

(vii) Eyelid surgery, excluding any cosmetic surgery or surgery requiring the use of general anesthesia.

The new law provides that an optometrist cannot perform these advanced procedures until the Board of Optometry has issued a license endorsement. The Board of Optometry will issue the license endorsement after the optometrist meets "the educational, training, and competence criteria" set forth in the new law.

To receive a license endorsement, the optometrist must successfully complete postgraduate courses as designated by the Board of Optometry, successfully complete a national examination for advanced procedures, and

> (iii) Enter into an agreement with a qualified physician licensed under chapter 18.71 RCW or an osteopathic physician licensed under chapter 18.57 RCW for rapid response if complications occur during an advanced procedure.

The new law does not define the term "qualified physician licensed under chapter 18.71 RCW." Since the WMC licenses allopathic physicians under chapter 18.71 RCW, the WMC is putting forth its understanding of the term "qualified physician." It can be a challenge when laws create opportunities for collaboration between separately regulated professions. In putting forth its interpretation of the term, the WMC is undertaking its commitment to fulfill the Legislature's action and is not seeking to regulate another profession. This interpretation is intended to assist physicians who are contemplating entering into an agreement. Being able to respond rapidly to complications from the procedures listed in the new law requires a high level of competence.

Procedure

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Delegation of Signature Authority for Credentialing, Discipline and Rulemaking

I, ~~Karen Domino~~Terry Murphy, MD, Chair of the Washington Medical Commission, acting upon the authorization of the Commission, hereby delegate signature authority to the following staff for the specific documents as indicated:

- Executive Director
- Deputy Executive Director
- Medical Consultant
- Program Manager
- Licensing Supervisor
- Licensing Lead (*routine applications and practice agreements only)*
- Licensing Health Services Consultant (HSC) 2s (*routine applications and practice agreements only)*
- Director of Investigations
- Director of Legal Services

Licensing

1. Approval of routine licensing applications, limited applications, and physician assistant (PA) applicants and practice agreements as authorized under WAC 246-919-310 and WAC 246-918-070. A routine licensing application is an application without a positive answer to a personal data question, an out-of-state action, or other negative information on the applicant.

   **Licensing Supervisor*Licensing Lead * HSC2 (only as noted above) *Executive Director *Deputy Executive Director **

2. Requests for of approval of more than 10C PAs per physician.

   **Medical Consultants * *Licensing Supervisor * Licensing Lead *Executive Director *Deputy Executive Director*

3. Requests for special accommodations to sit for USMLE examination.

   **Licensing Supervisor *Executive Director *Deputy Executive Director **

4. Approval of applications submitted with the following positive answers, but otherwise routine:

   Medical Consultant * *Licensing Supervisor *Licensing Lead*Deputy Executive Director

- Applicant's medical conditions (Medical Consultants*Deputy Executive Director only)Applications with more than one Medical malpractice report (Medical Consultants*Deputy Executive Director only)
- Minor traffic violations, i.e. speeding,
- DUIs more than 5 years prior to application (Medical Consultants*Deputy Executive Director only)
- Minor misdemeanor offenses, i.e. disorderly conduct
- Brief probation during residency or other training but successfully completed the program.
- Hospital privileges suspended regarding medical records issues more than five years prior.
- PAs with open complaints or the proposed supervising physician with open complaints.
- Applicants with closed complaints in other state boards.
- FBI fingerprint hit more than 10 years prior to application, as long as applicant reports the incident and provides supporting documentation (if any) in the application process.
- Leave of absence during medical school but still successfully graduated.
- Petitions to take any USMLE step outside of current attempt or time limits.

7. Notice of Decision on Application and the Determination for a Brief Adjudicative Proceeding (after authorization by Panel L)

**Executive Director *Deputy Executive Director *Licensing Supervisor*

8. Approval of a request for extension to complete continuing medical education requirements up to one year.

**Executive Director *Medical Consultant *Deputy Executive Director*Licensing Supervisor*Licensing Lead*

Discipline

1. Legal Pleadings (issued after authorization by the Commission*)*

**Executive Director *Deputy Executive Director *Director of Legal Services *Medical Consultant *Director of Investigations*

- Statement of Allegations
- Statement of Charges
- Notice of Opportunity for prompt hearing, regularly scheduled hearing, or settlement
- Notice of Opportunity for Settlement and Hearing
- Notice of Correction
- Withdrawal of Statement of Charges, Statement of Allegations, or Notice of Correction
- Summary Action Order

- Subpoena (*Executive Director, Deputy Executive Director, Director of Legal Services and Director of Investigations)*

Rulemaking

1. Documents filed with the Code Reviser's Office *(*issued after authorization by the Commission*)*

**Executive Director *Deputy Executive Director *Program Manager*

- CR-101 – Statement of Inquiry
- CR-102 – Proposed Rule or Expedited Rule
- CR-103 – Rule Making Order
- CR-105 – Expedited Rule

Other

Granting an extension of no more than six months on Respondent completing compliance requirements.

**Medical Consultant *Executive Director *Deputy Executive Director*

This delegation shall remain in effect until revoked, terminated, or modified by the Commission.

Date of Adoption: ~~October 20, 2023~~August 22, 2025

Washington State Department of Health
Health Professions Quality Assurance

Application for Approval to Receive Lists

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

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

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

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

Elena Steel	509-207-0542	connect@psychodynamicinstitute.com
Primary Contact Name ⮥	Phone ⮥	Email ⮥

Clarissa Hill, Roy Barsness		https://www.psychodynamicinstitute.com/
Additional Contact Names (Lists are only sent to approved individuals) ⮥		Website URL⮥

Contemporary Psychodynamic Institute	88-2650661
Professional Assoc. or Educational Organization ⮥	Federal Tax ID or Uniform Business ID number ⮥

3121 E Madison St. #208A	Seattle, WA, 98112
Street Address ⮥	City, State, Zip Code ⮥

For educational outreach purposes, including sending informational materials, program announcements, and resources related to academic and professional development for students/professionals aligned with our educational mission.

1. How will the lists be used? ⮥

Licensed and pre-licensed mental health professionals, including psychologists (PhD and PsyD), licensed professional counselors (LPCs), marriage and family therapists (MFTs), clinical social workers (LCSWs), and psychiatrists.

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

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

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

[signature]	7-17-25
Signature ⮥	Date ⮥

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

For Official Use Only

Approved: _____ _____
5-year one-time

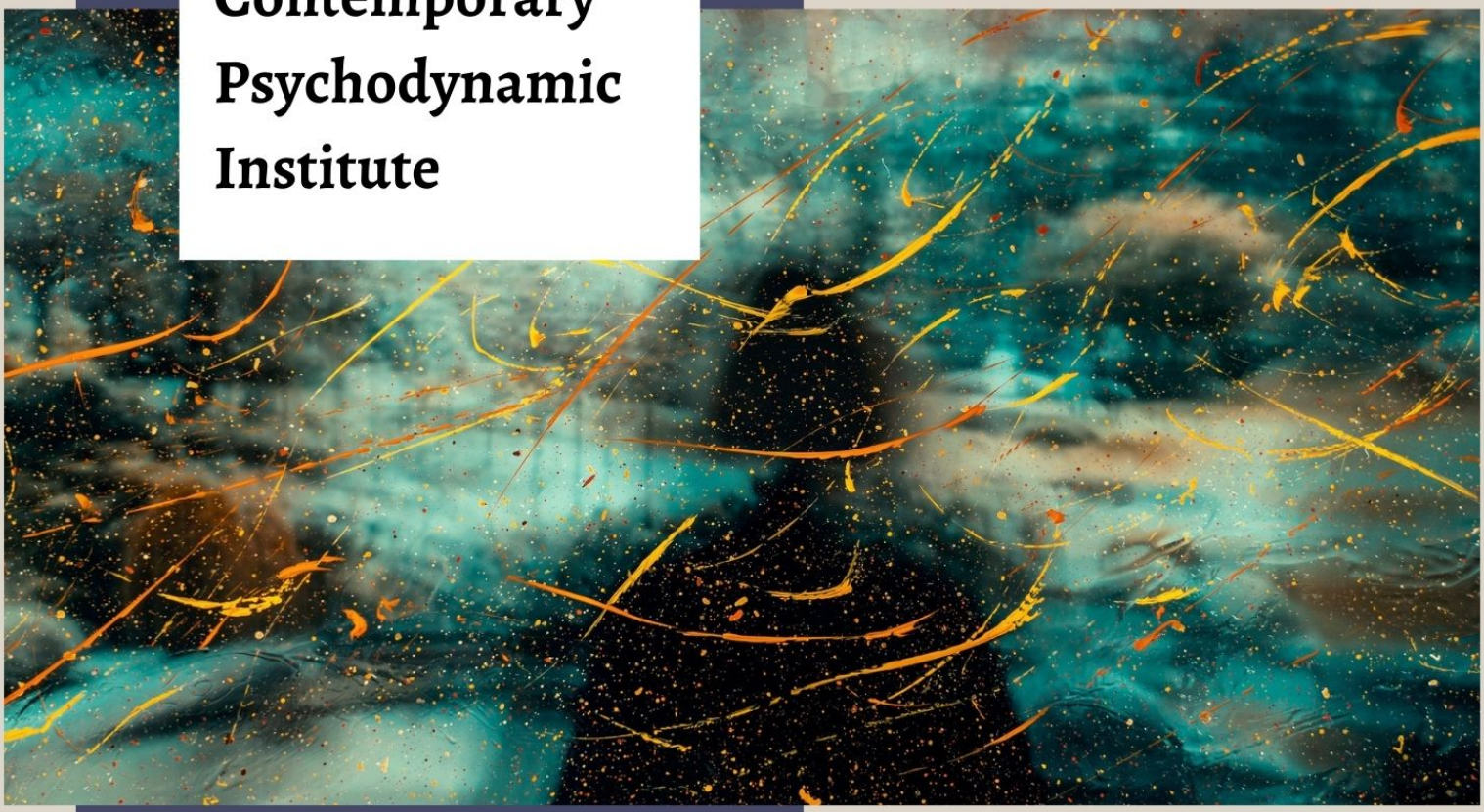
Denied: _____

Authorizing Signature: _____

Printed Name: _____

Title: _____ Date: _____

Contemporary Psychodynamic Institute



Core Competencies in Relational Psychoanalysis with Dr. Roy Barsness

Pulling from the seven core competencies that evolved from his qualitative and quantitative research, this workshop with Dr. Roy Barsness will focus on: therapeutic outcome; therapeutic stance; deep listening/affective attunement; relational dynamics; patterning and linking; conflict; and courageous speech/disciplined spontaneity.

Dr. Roy Barsness

Join Dr. Barsness, Founder and Executive Director of the Contemporary Psychodynamic Institute for an innovative online seminar .

Friday, September 27, 2024

9:30am-12:00pm PST

Earn 2.5 CEUs (optional add-on)

Learn More & Register at:

https://www.psychodynamicinstitute.com/events

Elena Steel (Public Records Request #N010679-070725)

Public Records Request Details

Division:	HSQA|
HSQA - Type of Record(s):	Other/Unknown (Provide description below)|
Is this a list request?:	Yes
Describe the Record(s) Requested:	We are a registered 501(c)(3) nonprofit educational institution requesting current contact information for licensed mental health professionals in Washington State. Specifically, we are seeking names, mailing addresses, license types, and — if available — professional email addresses for outreach related to education, training, and research participation. This request applies to all licensed behavioral health professionals, including but not limited to psychologists, licensed mental health counselors (LMHCs), licensed marriage and family therapists (LMFTs), and licensed clinical social workers (LICSWs). We are not requesting data for any specific region or time period; we would appreciate the most current full dataset available. All data, including email addresses, will be used solely for non-commercial, academic purposes. As a nonprofit organization, we confirm that we will not share, sell, or misuse the information, and that any outreach will be professional, relevant, and fully compliant with all applicable privacy laws and Department of Health policies.
From Date:	
To Date:	

Other Request Information

Preferred Method to Receive Records:	Electronic via Request Center	
Modified Request Description:		Summary of the public record desired that will be visible in the public archive if the request is published.
Internal Status:	List	This status is not visible to the requester.
Extend RCD by:		Select length of extension (Business Days). Selecting 70, 100, and 120 will also update Estimated Completion Date.
Extension Action:		Select 'APPLY EXTENSION' and Save to extend dates.

Special Details

Multi-Divisional Request:	No	Check if this request has records from multiple divisions
High Profile Request:	No	Check if this request is considered a high profile request.
Contains Tribal Records:	No	Check this box if the request contains Tribal records.
Request Complexity:	1	**View Complexity Criteria below...**

Show/Hide Complexity Criteria

Clarifications

Appeal Information

State Reporting Bill

Changed Response Time:	No
Clarification Sought:	No
Installments:	No
Records Provided:	Yes
Scanned Docs:	No
Physical Records Provided:	No
Actual Completion Date:	7/8/2025
Type of Requester:	Other

You have requested access to a list or lists of individuals. RCW 42.56.070(8) prohibits agencies from providing access to lists of individuals requested for commercial purposes (with the exception of recognized professional associations or educational organizations).

To receive the requested list, you must complete the declaration contained in Section 1 that you will not use the list for a commercial purpose. At a minimum, "commercial purposes" means that such lists are utilized to contact or affect such individuals to facilitate, in any manner, profit-expecting activity.

Select the boxes below to acknowledge:

I understand that “commercial purposes” means that the person/entity requesting the records intends to use them to facilitate profit-expecting business activity.:	Yes
I understand that the use for commercial purposes of said records may also violate the rights of the individuals named herein and may subject me to liability for such commercial use.:	Yes
I declare that I and/or the entity I represent will not use the requested records for commercial purposes. I also acknowledge it is my affirmative duty to prevent others from using the records for commercial purposes.:	Yes

---

The Public Records Act at RCW 42.56.080 authorizes agencies to require a requester to provide information as to the purpose of a request “to establish whether inspection and copying would violate RCW 42.56.070(8).”

1. I am requesting the list of individuals on behalf of:	Organization or Business
Name of organization or business:	Contemporary Psychodynamic Institute
Website address:	https://www.psychodynamicinstitute.com/
Purpose of organization or business:	Education and Professional Community

The organization or business is a professional association or educational organization recognized by the professional licensing or examination board:	No
The request is for a list of applicants for professional licenses and of professional licensees of the subject area of the association or organization:	Yes
2. The purpose in making this request for the list of individuals is:	To conduct educational outreach, provide training opportunities, and facilitate research participation among licensed mental health professionals in Washington State. As a registered 501(c)(3) nonprofit educational institution, we seek to support professional development and advance mental health education through non-commercial, academic use of this data. All information will be handled with strict adherence to privacy laws and Department of Health policies.
3. I or the organization/business intend to generate revenue or financial benefit from using the list of individuals:	No
4. I or the organization/business intend to solicit money or financial support from any of the individuals on the list:	No
5. I or the organization/business intend to make individuals on the list aware of business commercial entities, business/financial enterprises or business/financial opportunities:	No
I declare under penalty of perjury under the laws of the State of Washington that the foregoing is true and correct:	Yes

Internal Fields

5 Day Letter Date**:	7/8/2025
5 Day Letter Sent*:	Yes ***** Please select **Yes** once you have sent the 5 Day letter. ****** If you are not closing this request at the same time the 5 day letter is being sent, you **MUST** update the **Required Completion Date** at the right with an estimated completion date.
Estimated Completion Date:	7/15/2025

Days in Status (Internal - Updated Overnight)

Message History

Date

On 7/15/2025 4:49:12 PM, PHYLLIS BARNEY wrote:

Date

Subject: DOH Public Records Center :: N010679-070725
Body:
Reference # N010679-070725

Dear Elena Steel,

The Department of Health received your public records appeal on 07/14/2025, concerning the decision to temporarily withhold information contained in the requested records for the following:

" We are a registered 501(c)(3) nonprofit educational institution requesting current contact information for licensed mental health professionals in Washington State. Specifically, we are seeking names, mailing addresses, license types, and — if available — professional email addresses for outreach related to education, training, and research participation.

This request applies to all licensed behavioral health professionals, including but not limited to psychologists, licensed mental health counselors (LMHCs), licensed marriage and family therapists (LMFTs), and licensed clinical social workers (LICSWs).

We are not requesting data for any specific region or time period; we would appreciate the most current full dataset available.

All data, including email addresses, will be used solely for non-commercial, academic purposes. As a nonprofit organization, we confirm that we will not share, sell, or misuse the information, and that any outreach will be professional, relevant, and fully compliant with all applicable privacy laws and Department of Health policies."

Your appeal states:

" I am writing to respectfully appeal the determination that our organization is not recognized as an approved educational organization by the Washington State Department of Health.
We provide continuing education for licensed healthcare professionals in Washington and partner with an approved CEU certificate provider to ensure that all participants receive valid, board-recognized continuing education credits. I am including the following documentation to support our appeal:
1. A partnership agreement with our CEU certificate provider, confirming our collaboration in offering approved continuing education programs.
2. An excerpt from our organizational bylaws that outlines our educational mission and primary purpose as a nonprofit training and educational institution.
3. An example of a past CE event we hosted, including a flyer or description of the event which was led by our founder.
4. A sample CEU certificate issued for that event, showing our organization as the hosting provider and our CEU partner as the credentialing body.
These materials demonstrate that our organization meets the criteria of an educational organization as defined by the Department, and we ask that our status be reconsidered accordingly.
Thank you for your time and attention. Please let us know if additional information is needed."

The Department of Health is upholding the program's original decision. I will explain further.

Washington State statute in the Public Records Act, RCW 42.56.070(8), states, "*This chapter shall not be construed as giving authority to any agency, the office of the secretary of the senate, or the office of the chief clerk of the house of representatives to give, sell or provide access to lists of individuals requested for commercial purposes, and agencies, the office of the secretary of the senate, and the office of the chief clerk of the house of representatives shall not do so unless specifically authorized or directed by law:* ***PROVIDED, HOWEVER, That lists of applicants for professional licenses and of professional licensees shall be made available to those professional associations or***

Date

***educational organizations recognized by their professional licensing or examination board, upon payment of a reasonable charge therefor*."**

As previously stated in our communication to you on 7/8/2025, you are not currently an approved professional association or educational organization with the Department of Health. You may apply for approval to receive lists from the applicable licensing board by completing and submitting an "Application for Approval to Receive Lists" form. The form is attached for your convenience and can also be found here or on the customer public records portal under 'See All FAQs' in the left navigation pane. The completed application can be uploaded directly to this request via the online portal or emailed to our office at publicdisclosure@doh.wa.gov. You may also mail the completed form to us at

Department of Health
Public Disclosure Office
PO Box 47808
Tumwater, WA 98501-7808

Once we receive the completed application, it will be submitted to the appropriate licensing board for approval. If approved by the licensing board, the requested contact list(s) can be provided to you.

With this communication, we believe the department has responded to your request fully and appropriately and considers your request for public records complete and the related appeal closed. This is our final response. Department of Health does not intend to further address the request, and the PRA's one-year statute of limitations to seek judicial review has started to run as of the date of the original request closure on 7/8/2025.

The attorney general's office is authorized to review a state agency's *claim of exemption* and provide a written opinion. See RCW 42.56.530. *This only applies to state agencies and a claim of exemption.* See WAC 44-06-160. A requestor may initiate such a review by sending a request for review to:

Public Records Review
Office of the Attorney General
P.O. Box 40100
Olympia, Washington 98504-0100
or by email to publicrecords@atg.wa.gov.

You may contact us within 30 days, 08/07/2025, by responding to this message, by e-mail at publicdisclosure@doh.wa.gov or by postal mail at: Public Records Officer, Washington State Department of Health, P.O. Box 47808, Olympia, WA 98504-7808, if you have any questions.
Sincerely,

PHYLLIS BARNEY
Public Records Officer
Washington State Department of Health
www.doh.wa.gov

Date

On 7/8/2025 9:33:30 AM, LIA MILLER wrote:

Date

Subject: DOH Public Records Center :: N010679-070725
Body:
Reference # N010679-070725

Dear Elena Steel,

The Department of Health received a public records request from you on July 07, 2025. Your request mentioned:

"We are a registered 501(c)(3) nonprofit educational institution requesting current contact information for licensed mental health professionals in Washington State. Specifically, we are seeking names, mailing addresses, license types, and — if available — professional email addresses for outreach related to education, training, and research participation.

This request applies to all licensed behavioral health professionals, including but not limited to psychologists, licensed mental health counselors (LMHCs), licensed marriage and family therapists (LMFTs), and licensed clinical social workers (LICSWs).

We are not requesting data for any specific region or time period; we would appreciate the most current full dataset available.

All data, including email addresses, will be used solely for non-commercial, academic purposes. As a nonprofit organization, we confirm that we will not share, sell, or misuse the information, and that any outreach will be professional, relevant, and fully compliant with all applicable privacy laws and Department of Health policies."

We have uploaded a list of available information to the DOH Public Records Center for your review. Please note we do not track where providers work.

RCW 42.56.070(8) prohibits disclosure of lists of individuals requested for commercial purposes. However, lists of applicants for professional licenses and of professional licensees may be made available to professional associations or educational organizations approved by the applicable licensing board.
List requests are approved by the specific licensing board and approval can take up to three months.

You may apply for approval to receive lists from the applicable licensing board by completing and submitting an Application for Approval to Receive Lists. The application and additional information can be found here or on the customer public records portal under 'See All FAQs' in the left navigation pane. The completed application can be uploaded directly to this request via the online portal.

You are currently NOT an approved professional association or educational organization with the Washington State Department of Health. Therefore, the requested list cannot be provided to you at this time, and this request is considered closed. This means that the Department of Health will not further address the request, and as of the date of this communication, the PRA' s one-year statute of limitations to seek judicial review starts to run.

Please contact me within 30 days, 8/7/2025 9:10:31 AM, by e-mail at publicdisclosure@doh.wa.gov or by postal mail at: Public Records Officer, Washington State Department of Health, P.O. Box 47808, Olympia, WA 98504-7808, if you have any questions.

If you receive approval from the licensing board you will need to submit a new list request and upload the approval letter.

Under RCW 42.56.520 you may appeal the decision to withhold information contained in the records via a request for review by the Department of Health' s Public Records Officer. When filing an appeal for Public Records, please

Date

include your Public Records Request reference number so the correct request can be reviewed. The request must be submitted in writing by one of the following methods:

1. Send an email request to PRRappeals@doh.wa.gov
   OR
2. Mail your request to:

Public Records Officer
Washington State Department of Health
P.O. Box 47808
Olympia, WA 98504-7808

If you have any questions or need additional information, please feel free to respond directly to this email or reach out to the approving licensing board.

Sincerely,

LIA MILLER
Public Disclosure Office
Washington State Department of Health
www.doh.wa.gov

Date

On 7/7/2025 4:24:55 PM, System Generated Message:
Subject: Public Records Request :: N010679-070725
Body:

Dear Elena Steel:

Thank you for submitting a public records request to the Washington State Department of Health. Your request has been received and is being processed in accordance with the State of Washington Public Records Act, Chapter 42.56 RCW. Your request was received in this office on 7/7/2025 and given the reference number N010679-070725 for tracking purposes. You will receive an official acknowledgement letter within 5 business days from this date.

Not all public documents are available in electronic format. If the document(s) requested are not available electronically, we will make them available for inspection or by paper copy in accordance with the Public Records Act, Chapter 42.56 RCW.

Sincerely,

Washington State Department of Health
Public Records Request
Public Records

To monitor the progress or update this request please log into the DOH Online Public Records Center

Track the issue status and respond at: https://washingtondoh.govqa.us/WEBAPP//_rs/RequestEdit.aspx?rid=160072

On 7/7/2025 4:24:53 PM, Elena Steel wrote:
Request Created on Public Portal

Request Details

Reference No:	N010679-070725
Create Date:	7/7/2025 4:24 PM
Update Date:	7/18/2025 7:49 AM
Completed/Closed:	Yes
Close Date:	7/8/2025 9:02 AM
Status:	Closed - Full Release

Priority:	Low
Assigned Dept:	Health Systems Quality Assurance
Assigned Staff:	LIA MILLER

Customer Name:	Elena Steel
Email Address:	connect@psychodynamicinstitute.com
Phone:	5092070542
Group:	(Not Specified)

Source:	Web

From:	Miller, Lia M (DOH)
To:	Crawford, Lana A (DOH); Boyd, Amelia (WMC); Delgado, Nancy L (DOH)
Subject:	Application for an organization to receive lists
Date:	Monday, July 21, 2025 7:21:51 AM
Attachments:	GovQA - WASHINGTONDOH - Elena Steel.pdf image001.png image002.png Digital Flyer for Past Event.jpg List Request Application (3).pdf

---

Good Morning,

I am attaching an application for an organization to receive lists. Amelia, I am including you, they asked for Psychiatrist, I know I really can't run that list, but when they ask we send a list of MD and let them know we do not have the ability to run a list by specialty. This is a work in progress, though for those that answer that question on their application.

Lia Miller
Forms & Records Analyst 3
Public Disclosure Office
Center for Facilities Risk & Adjudication
Washington State Department of Health
Lia.miller@doh.wa.gov
doh.wa.gov | 360-236-4836

Guidance Document

WASHINGTON Medical Commission
Licensing. Accountability. Leadership.

Medical Professionalism

Introduction

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

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

Charter on Medical Professionalism

Preamble

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

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

The medical profession everywhere is embedded in diverse cultures and national traditions, but its members share the role of healer, which has roots extending back to Hippocrates. Indeed, the medical profession must contend with complicated political, legal, and market forces. Moreover, there are wide variations in medical delivery and practice through which any general principles may be expressed in both complex and subtle

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

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

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

ways. Despite these differences, common themes emerge and form the basis of this Charter in the form of three fundamental principles, and as a set of definitive professional responsibilities.

Fundamental Principles

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

A Set of Professional Responsibilities

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

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

Commitment to patient confidentiality. Earning the trust and confidence of patients requires that appropriate confidentiality safeguards be applied to prevent disclosure of patient information unless disclosure is legally necessary. This commitment extends to discussions with persons acting on a patient's behalf when obtaining a patient's own consent is not feasible. Fulfilling the commitment to confidentiality is more pressing now than

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

ever given the increasing availability of genetic information and the widespread use of electronic information systems for compiling patient data. However, practitioners recognize that their commitment to patient confidentiality must occasionally yield to overriding legal requirements that protect public health and safety (for example, when patients endanger themselves or others).

Commitment to maintaining appropriate relations with patients. Given the inherent vulnerability and dependency of patients, certain relationships between practitioners and patients must be avoided. Practitioners should avoid exploiting patients for personal financial gain, or other private purpose. For example, state law prohibits practitioners from engaging in sexual or romantic relationships with current patients. This includes behaviors such as soliciting a date or kissing a patient in a romantic or sexual manner.[5] State law also prohibits romantic or sexual relationships with former patients if the practitioner uses or exploits the trust, knowledge, influence or emotions derived from the professional relationship, or uses or exploits privileged information to meet the practitioner's personal or sexual needs.[6] Practitioners should also abide by any ethical restrictions regarding romantic or sexual relationships with former patients that are applicable to their specialties.[7]

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

Commitment to improving access to care. Medical professionalism demands that the objective of all health care systems is the availability of a reasonable and adequate standard of care that is accessible to all patients. Practitioners should individually and collectively strive to reduce barriers to equitable health care. Within each system, the practitioner should help eliminate barriers to access which are often based on education, laws, finances, geography, and social discrimination. A commitment to equity entails the promotion of public health and preventive medicine without concern for the self-interest of the practitioner or the profession.

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

[5] WAC 246-919-630, 246-918-410. See also RCW 18.130.180(24).
[6] WAC 246-919-630(3). For additional guidance, see the WMC Guidance Document on "Sexual Misconduct and Abuse," GUI2017-03.
[7] For example, the American Psychiatric Association takes the position that sexual activity with a current or former patient is unethical. American Psychiatric Association: The principles of medical ethics (with annotations especially applicable to psychiatry), section 2. Arlington, VA: American Psychiatric Association, 2013. https://www.psychiatry.org/psychiatrists/practice/ethics. Accessed May 7, 2019.

practitioner's professional responsibility involving appropriate resource allocation requires scrupulous avoidance of superfluous tests and procedures. Providing unnecessary services not only exposes patients to avoidable harm and expense but also diminishes the resources available for others.

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

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

Commitment to professional responsibilities. As members of a profession, practitioners are expected to work collaboratively to maximize patient care, be respectful of one another, and participate in the processes of self-regulation, including remediation and discipline of members who have failed to meet professional standards. The profession should define and organize the educational and standard-setting process for current and future members. Practitioners have both individual and collective obligations to participate in these processes. These obligations include engaging in internal assessment, offering constructive feedback to peers, and accepting external scrutiny of all aspects of their professional performance. Part of professionalism is being aware of conscious and unconscious bias. ~~and that~~ P~~p~~ractitioners ~~must be sure~~ are obligated to treat all patients with compassion, equity, and respect. ~~Finally,~~ P~~p~~ractitioners also have a professional responsibility to maintain their own health and well-being ~~and to~~ as well as to take appropriate action when a colleague may be impaired. Health issues should be addressed proactively to promote safe, effective, and compassionate care. In the absence of patient harm, concerns for impairment should be addressed through supportive, non-disciplinary pathways such as the Washington Physicians Health Program.

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Summary

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

improve our health care system for the welfare of society. The WMC adopts this Charter on Medical Professionalism to encourage such dedication among practitioners and the profession in general, and to assure the public that the WMC upholds ideals of professionalism in the State of Washington.

Number:	GUI2018-01
Date of Adoption:	January 19, 2018
Revised/Reaffirmed:	May 27, 2022
Supersedes:	N/A

Procedure

WASHINGTON Medical Commission
Licensing. Accountability. Leadership.

Interactive and Transparent Development of Evidence-based Policies

Introduction

The Washington Medical Commission (Commission) develops policies[i] to encourage the medical profession to improve the delivery of medical care and enhance patient safety.[ii] The Commission wishes to better engage the public and the profession by creating an interactive, consistent, and transparent procedure to obtain input to develop evidence-based policies.[iii] This document describes the procedure the Commission uses to develop evidence-based policies.

Procedure

Step One: Determine the need for a policy

Any Commission member, member of the medical profession, organization, or member of the public may ask the Commission's Policy Committee to consider developing a policy in a particular area of medical practice. In general, the Policy Committee will consider developing a policy for an issue that has broad application to practitioners or the public, to respond to an emerging problem, and to fulfill its regulatory charge to protect the public. The Policy Committee may decide that a policy is not necessary, or that the subject is more appropriately addressed by adopting a rule, which has the force of law.

Step Two: Policy Committee

If the decision of the Policy Committee is to develop a policy, the Policy Committee Chair may assign members to a work group to analyze the research and evidence, and to draft the policy. The workgroup will include one or more Commission members and may include subject matter experts on staff. The workgroup may also include subject matter experts outside the Commission.

The Policy Committee also reviews existing policies to ensure that they remain useful and ~~informative, and~~informative and reflect the current state of medical practice and the current view of the Commission.

Step Three: Research and Obtain Evidence

If the Policy Committee decides to develop a policy or guideline, the next step is to research the topic and obtain evidence that will inform the Commission's decision-making. The research may include:

- Reviewing complaints or other patient experiences related to the topic of the proposed policy.
- Conducting a literature review of the latest journal articles and studies.
- Reviewing the positions of appropriate stakeholders.
- Reviewing the positions of other state medical boards and the Federation of State Medical Boards.

- Identifying and researching relevant legal issues, consulting with the Attorney General's Office as needed.

Step Four: Analysis and Drafting

The work group will analyze the research and evidence, relevant law, and draft the policy. For existing policies, the workgroup will review feedback submitted to the Commission via the Commission web site or otherwise. The workgroup will create a first draft of the proposed policy.

Step Five: Policy Committee Review

In a public meeting, the Policy Committee will review the draft policy and proposes revisions. The Policy Committee presents the draft to the full Commission. The Commission provides feedback and then may approve posting the draft policy for public dissemination, including posting the draft on the Commission web site.

Step Six: Solicit Feedback from Public and Profession

Upon approval by the Commission, staff posts the draft policy to the Commission web site and invites members of the public and the profession to post comments on the proposed draft policy. The Commission will notify the public and the profession of the proposed policy by:

- Sending out notice of the draft policy on social media;
- Sending out notice of the draft policy to the Commission listserv;
- Sending the draft policy to stakeholders and interested parties

The Commission accepts comments on the proposed policy for 28 days. The Commission will have discretion to remove comments that do not contribute to a constructive discussion of the relevant issues.

Step Seven: Policy Committee Review of Feedback

In a public meeting, the Policy Committee reviews the feedback and comments from the public and the profession. The Policy Committee considers the extent to which the comments represent the expectations of the profession and are consistent with the Commission's mission to promote patient safety and our vision of advancing the optimal level of medical care for the people of Washington. The draft policy is revised accordingly.

Step Eight: Secretary Review of Policy

The Commission staff sends the proposed policy to the Secretary of the Department of Health for review and comment. Following the Secretary's review, the Policy Committee reviews and discusses the comments from the Secretary in a public meeting. The Policy Committee brings its recommendations to the full Commission. The full Commission reviews the proposed policy in a public meeting and may revise the policy. If the Commission revises the policy, the Commission sends the proposed policy back to the Secretary for review. Once the Commission approves a policy, the policy is filed with the Washington State Code Reviser and it is published in the Washington State Register.

Step Nine: Final Review and Adoption

Once the Policy Committee is satisfied with the proposed policy, it refers the draft to the full Commission with a recommendation to adopt the policy. The full Commission, in a public meeting, discusses the policy

and decides whether to adopt the final version. When the policy is final, the Commission publicizes it through its web site, social media channels, listserv, and newsletter.

Step Ten: Policy Impact review

After the policy is been adopted, in some instances, not all, we can outline how the policies will be monitored and communicated to ensure that it is understood and followed by our licensed practitioners , in providing care to patients.

Emergency Exception

In case of an emergency in which the development of a policy is required in a short time period, one or more of these steps may be waived.

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Date of Adoption: ~~May 19, 2017~~

Date of Revision: ~~August 20,2021~~

[i] RCW 34.05.010(15) defines "policy statement" as "a written description of the current approach of an agency, entitled a policy statement by the agency head or its designee, to implementation of a statute or other provision of law, of a court decision, or of an agency order, including where appropriate the agency's current practice, procedure, or method of action based upon that approach." A policy is advisory only. RCW 34.05.230. Examples of Commission policy statements are "Complainant Opportunity to be Heard Through and Impact Statement," and "Practitioners Exhibiting Disruptive Behavior."

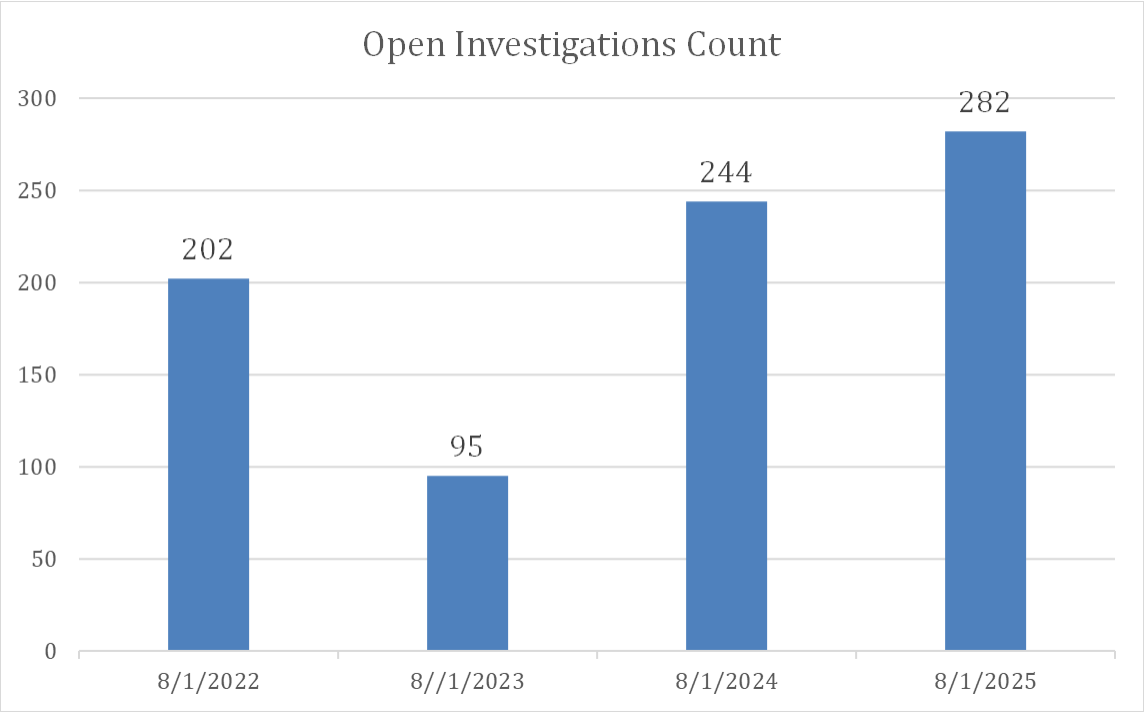
[ii] This procedure does not apply to the development of procedures, which merely establish the proper steps the Commission and staff take to conduct Commission business. Examples include "Consent Agenda Procedure" and "Processing Completed Investigations More Efficiently."

[iii] This process is largely based on the "consultation process" developed by the College of Physicians and Surgeons of Ontario. http://www.cpso.on.ca/Footer-Pages/The-Consultation-Process-and-Posting-Guidelines

Staff Reports: August 22, 2025

Kyle Karinen, Executive Director

Caseloads. In short, caseloads are up. One of the ways we track caseloads is a graph that I will post below. It is a four-year comparison that looks at the number of cases in investigations at the beginning of the month. The rise in caseloads roughly tracks a significant uptick in the number of complaints the Commission has received.



For Commission members, this likely translates to a rise in the number of cases coming out of investigations and being ready for your review beginning at the end of this calendar year and the beginning of 2026.

UW bioethics seminar. During the first week of August, Dr. Chang, Dr. Fino and I attended the 37th Annual Summer Seminar in Healthcare Ethics. It was the better part of three-and-a-half (virtual) days of an introduction to the world of clinical ethic consultants. Each day was highlighted by a small group ethics lab discussion of a hypothetical scenario. Not everything that was discussed is directly applicable to the Commission's work in licensing and regulation. That said, some of the structures that were used to analyze these ethical issues were very interesting. Dr. Fino and I may be presenting on parts of what we learned and what might be applied at the Commission's retreat.

CLEAR speaking engagement. Later this year, I will be co-presenting at a virtual seminar arranged through our colleagues at CLEAR. My co-presenter is Professor Rebecca Haw Allensworth from Vanderbilt University's School of Law. Professor Allensworth focuses her on antitrust law and professional licensing. She is generally critical of the way professional

Kyle Karinen, Executive Director continued

licensing is organized and regulated in the United States and recently authored a book on the subject. (The book focuses on all professional licensing; not just medical professions.) Some of her criticisms are well-taken while some do not quite hold up if they are applied nationally. I will be presenting the counterargument to come of Professor Allensworth's criticisms as well as offering perspective on best practices for state medical boards.

HELMS. The implementation continues. There are some on-going challenges with getting the licensing end of the new system to function reliably and consistently. In the big picture, however, it feels like the majority of the challenges are behind us. Contemporaneous with the end of Friday, August 22, the licensing system will be taken offline until Tuesday, August 26.

FY25 performance measure reports. It has been a challenging year on many fronts for the Commission. I will address this separately at the Commission meeting as well. For the Commission members not able to attend the business meeting, here is the link to the summary report compiled by staff and posted on the Commission's website:

Publications by the Medical Commission | Washington Medical Commission

(Click on WMC Fiscal Year 2025 Performance Report)

Micah Matthews, Deputy Executive Director

Recurring: Please submit all Payroll and Travel Reimbursements within 30 days of the time worked or travelled to allow for processing. Request for reimbursement items older than 90 days will be denied. Per Department of Health policy, requests submitted after the cutoff cannot be paid out. For specific guidance on Commissioner compensation, please refer to the WMC guideline: Compensation and Reimbursement for Commission Duties (wa.gov)

Conferences and Presentations

I was a first-time attendee at the National Conference of State Legislators (NCSL) August 3, which is designed for legislators, legislative staff, and those that work with the legislature. Washington State had a good showing, and numerous members of the delegation were presenters. Topics of note were member safety and security in light of the MN assassination and the state of the states on issues such as health care and transportation. There was also a session on civility as it relates to a functional legislature, which ironically ended in a fairly uncivil manner. The expo center with vendors was especially rich with new options and ideas that we typically don't see at our usual medical regulatory meetings. From numerous AI offerings that would assist the legal process to communications and public affairs platforms.

WMC staff will attend the CLEAR annual conference in Chicago, IL September 15. This is a significant source of professional development that is applicable to all areas of staffing.

I will be attending the WSMA AI symposium on September 19.

Legislative

As of June 2025, the WMC staff submitted the fifth of five annual reports of the

Micah Matthews, Deputy Executive Director continued

International Medical Graduate Workgroup as constituted under SB 6551 of the 2020 legislative session. With this submission, we have completed our five-year obligation to staff and facilitate the workgroup, on which I served as an appointed member.
On July 22, WMC staff organized and presented a work session at the request of Chair Cleveland with the Senate Health and Long-term Care Committee. It was well received, and we were fortunate to have two distinguished presenters in the form of Michael Zimmer, Senior Policy Consultant from World Education Services, and Dr. Hank Chaudhry, President and CEO of the Federation of State Medical Boards. The WMC was capably represented by the Workgroup facilitator, Ms. Fatima Mirza.

Amelia Boyd, Program Manager

Change to AMDG Opioid Dose Calculator

In February 2024, the Agency Medical Directors' Group (AMDG) updated the Opioid Dose Calculator. The WMC released a statement for prescribers about this change: Important Updates to the Opioid Dose Calculator and Implications for Prescribers (govdelivery.com)

Recruitment

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

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

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

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

- Public Member – Toni Borlas – not eligible for reappointment

The following positions expired as of June 30, 2023, and we are awaiting word from the Governor's office staff:

- Congressional District 10 – Richard Wohns, MD – eligible for reappointment
- Public Member – Scott Rodgers – eligible for reappointment

The following positions expired as of June 30, 2024:

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

Amelia Boyd, Program Manager continued

The application deadline for these three vacancies was March 22, 2024. The applications, along with the Commissioners' recommendations, are with the Governor.

The following positions expired as of June 30, 2025:

- One physician representing Congressional District 1 – Jimmy Chung, MD, not eligible for reappointment
- One physician representing Congressional District 7 – Anjali D'Souza, MD, eligible for reappointment
- One Physician Assistant – Arlene Dorrough, PA-C, eligible for reappointment

One Public Member – Christine Blake, eligible for reappointment

The application deadline for these four vacancies was March 31, 2025. The applications, along with the Commissioners' recommendations, are with the Governor.

If you have questions about serving as a member of the WMC, please contact me at amelia.boyd@wmc.wa.gov.

Kaddijatou Keita, Policy Manager

I am honored to serve as the new Policy Manager for the Commission. I hold a master's degree in public policy with a concentration in Health Policy. Prior to this appointment, I gained valuable experience interning with the Governor's Office of Georgia in the Division of Health Strategy and Coordination and serving as a Hatfield Resident Fellow at the Multnomah County Behavioral Health Division in Portland, Oregon.

My primary objective is to advance the development and implementation of sound, evidence-based policies that elevate the quality of our work, uphold patient safety, and support our licensed practitioners.

Interested Parties/Policy Meetings
Since commencing this position on May 16, 2025, I have participated in both a Policy Interested Parties meeting and a Policy Committee meeting. In this capacity, I recently revised the Medical Professionalism and Interactive and Transparent Development of Evidence-Based Policies documents by introducing a new procedural step*: the Policy Impact Review*. This review establishes a structured process for ongoing policy monitoring and communication, ensuring policies are clearly understood and consistently implemented by licensed practitioners in the delivery of patient care. For example, if issues persist despite existing policies, the Policy Impact Review will facilitate a thorough evaluation of practitioner comprehension and guide necessary clarifications or enhancements.

Future policy agendas
I am currently working on the next Policy Interested Parties meeting agenda as we move toward the 2026 policy reviews. If anyone has policy suggestions, please feel free to email me.

Kaddijatou Keita, Policy Manager continued

Conferences

To further strengthen my expertise in medical regulation and compliance, I will be attending CLEAR's 2025 Annual Educational Conference in Chicago from September 15th–19th.

I look forward to collaborating with you all and contributing to the Commission's critical mission.

Mike Hively, Director of Operations and Informatics

Between April 24 and August 11, 2025, the Operations and Informatics team received a total of 3 compulsory records requests completing 2 with 1 ongoing. As a result, 71 files were reviewed with a combined page count of 15,504 applying over 26,751 redactions, and with holding 1,156 pages. We continue to monitor 9 active litigation holds in addition to digital archiving and other daily tasks.

Digital Archiving

The following digital archiving activities were completed:

- Complaints closed below threshold 695
- MD licensing applications 172
- PA licensing applications 269
- A Closure 330 containing a total of 151,983 pages

Approximately 3boxes of hardcopy PA licenses containing 76 applications were scanned into digital format with disposition tickets submitted for the destruction of the paper-based records. Additionally, 6 files containing 1,786 pages were digitized and 4 boxes of previously scanned records were destroyed in accordance with WA State Records Retention and WA State Scan & Toss guidelines.

Data Requests Process

The team processed approximately:

- 1,284 emails received containing approximately 1,882 open/closed inquiries
- 793 address changes

Demographic Activities

Demographic data management included:

- Attaching censuses identified by HELMS as "anonymous" to the individual licensee accounts.
- Identifying duplicate or incomplete censuses received in addition to completed surveys in hardcopy .PDF format and began entering the data into HELMS.
- Designing a draft Census for the new Certified Anesthesiology Assistant license

Mike Hively, Director of Operations and Informatics continued

The team assisted in consolidating the WMC Staff footprint at the DOH campus due to the agency downsizing. Staff monitor replacement is complete as well as 6 staff member laptop renewals.

Lastly, we are gearing up for the end of year DOH equipment inventory of all WMC equipment and assets.

Gina Fino, MD, Medical Consultant, Director of Compliance

2025 Personal Appearance Update

- Regular Appearances Completed 16
- Mini Appearances Completed 5
- Regular Appearances Pending 8
- Mini Appearances Pending 1

Rick Glein, Director of Legal Services

Orders Resulting from SOCs:

In re Michael Stockin, MD, Case No. M2025-299. Agreed Order. On March 31, 2025, the Commission issued a Statement of Charges (SOC) alleging the United States Army commenced an investigation in February 2022 against Dr. Stockin on allegations of sexual misconduct and suspended him from providing patient care. The Commission alleged that the United States Army formally charged Dr. Stockin with 52 sexual abuse offenses, and Dr. Stockin pleaded guilty to 36 charges of abusive sexual contact as well as 5 charges of indecent viewing involving 41 male patients. The allegations state that a military judge accepted Dr. Stockin's plea agreement and sentenced him to confinement for 164 months. In May 2025, the Commission accepted an Agreed Order which concluded Dr. Stockin committed unprofessional conduct and permanently revoked Dr. Stockin's medical license.

In re Eric Ryan Shibley, MD, Case No. M2018-443. Final Order.* On December 30, 2019, the Commission summarily restricted the medical license of Dr. Shibley. The SOC alleges Dr. Shibley 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 alleged inaccurate and delayed charting practices potentially jeopardizing continuity of care with other providers. Despite being restricted from prescribing controlled substances, Dr. Shibley prescribed controlled substances to 40 patients 72 times between January 2, 2020 and July 1, 2020. In August 2020, the Commission served an Amended SOC and an Ex Parte Order of Summary Suspension which summarily suspended Dr. Shibley's medical license pending further disciplinary proceedings by the Commission. A Second Amended SOC was issued in December 2021 which added allegations that Dr. Shibley was convicted of seven felony counts of Wire Fraud, three

felony counts of Bank Fraud, and five felony counts of Money Laundering. The Commission held a hybrid hearing February 20-21, 2025. A Final Order was issued in May 2025 which found Dr. Shibley can never be rehabilitated and ordered that his medical license be permanently revoked.

In re Michael K. Elm, MD, Case No. M2024-523. Agreed Order. In August 2023, the Commission held an expedited CMT review and authorized referral to the DOH Secretary's Office as a sexual misconduct case that did not involve clinical expertise or standard of care issues. In November 2024, the Secretary of Health issued a SOC alleging Dr. Elm had sexual contact with a patient on approximately four occasions at the patient's apartment. In May 2025, a Health Law Judge (HLJ) accepted an Agreed Order suspending Dr. Elm's medical license for at least six years. Prior to petitioning for reinstatement of his license, Dr. Elm shall undergo a multidisciplinary forensic assessment and pay a fine of $2,000. Upon reinstatement, Dr. Elm's medical license will be placed on probation for at least two years during which time he must provide a disclosure of the Agreed Order and the ensuing Reinstatement Order to any patient scheduled for an appointment. After reinstatement, Dr. Elm agreed to unannounced audits of at least ten patient records, up to four times for a period of two years.

In re Claribel L. Kohchet Chua, MD, Case No. M2025-310. Final Order of Default (Failure to Respond).* On April 15, 2025, the Commission issued a SOC alleging Dr. Kohchet Chua's medical license was summarily suspended by the Alaska State Board of Medicine based on a finding that she posed a clear and immediate danger to the public health and safety if she continued to practice medicine. Dr. Kohchet Chua did not file a response to the SOC within the time allowed. In June 2025, a HLJ issued a Final Order of Default which concluded sufficient grounds exist to take disciplinary action and ordered Dr. Kohchet Chua's medical license be indefinitely suspended.**

In re M. Barbara Burke, MD, Case No. M2024-615. Agreed Order. On October 16, 2024, the Commission issued an Ex Parte Order of Summary Suspension which ordered Dr. Burke's medical license be suspended pending further proceedings by the Commission. A SOC concurrently served on Dr. Burke alleges that the State Medical Board of Ohio suspended Dr. Burke's Ohio medical license based on a failure to comply with a September 2022 Ohio Board Order. In June 2025, the Commission accepted an Agreed Order which indefinitely suspended** Dr. Burke's medical license. Dr. Burke may not petition for reinstatement of her Washington license until after reinstatement of her Ohio medical license and completion of a multidisciplinary assessment. An Order of Reinstatement, based on Commission approval or following a hearing, may impose terms and conditions as deemed necessary to protect the public and/or rehabilitate Dr. Burke.

In re Shaun Hedmann, MD, Case No. M2025-304. Final Order (Waiver of Hearing).* On April 15, 2025, the Commission issued a SOC alleging Dr. Hedmann entered into a Stipulated Order with the Oregon Medical Board surrendering his license to practice as a physician and surgeon in that jurisdiction while under investigation for unprofessional

conduct. Dr. Hedmann filed an Answer to the SOC which did not contest the factual allegations and waived his opportunity for a hearing on this matter. In June of 2025, the Commission issued a Final Order concluding that Dr. Hedmann committed unprofessional conduct and ordered his medical license be indefinitely suspended.**

In re Ricky Lee Jackson, MD, Case No. M2022-491. Final Order of Default (Failure to Appear).* On May 17, 2024, a SOC was issued alleging Dr. Jackson inadequately supervised a physician assistant whose license to practice as a physician assistant was permanently revoked in October of 2023. Additionally, the Commission alleged that Dr. Jackson's treatment of patients with COVID-related concerns fell below the standard of care. Dr. Jackson filed an Answer to the SOC, and a hearing was scheduled for July 21-24, 2025. Neither Dr. Jackson nor his attorney could be reached at the time of the scheduled June 3, 2025, prehearing conference. On June 4, 2025, the HLJ issued an Order of Default, ordering that a final order will be entered without further notice to Dr. Jackson and striking the July hearing. On June 30, 2025, the HLJ issued a Final Order of Default concluding that Dr. Jackson committed unprofessional conduct and ordering Dr. Jackson be restricted from entering into Collaboration Agreements with physician assistants; restricted from prescribing ivermectin for non-FDA-approved indications to patients; will complete CMEs and prepare a paper related to COVID-19, ethics, and medical record keeping; enroll in a clinical monitoring program; pay a fine of $15,000; and attend personal appearances before the Commission. Dr. Jackson filed a timely motion for reconsideration. As of the writing of this staff report, the HLJ has not ruled on the motion for reconsideration.

In re Shannon R. Grosdidier, MD, Case No. M2024-1005. Final Order of Default (Failure to Respond).* On March 3, 2025, the Commission issued an Order for Investigative Mental Examination (Order) requiring Dr. Grosdidier to make an appointment for an evaluation within seven days of receipt of the Order. On May 27, 2025, the Commission issued a SOC alleging Dr. Grosdidier committed unprofessional conduct by failing to make an appointment or complete the evaluation. Dr. Grosdidier did not file a response to the SOC within the time allowed. In July 2025, a HLJ issued a Final Order of Default which concluded sufficient grounds exist to take disciplinary action and ordered Dr. Grosdidier's medical license be indefinitely suspended.**

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

Items of Interest:
A round of applause to our own Mike Farrell on being awarded the prestigious Washington State Bar Association (WSBA) Homan Award! This accolade is presented annually by the WSBA to an individual who has demonstrated an outstanding

contribution to the improvement or application of administrative law. The award is named for Frank Homan, a dedicated teacher and mentor who was passionate about improving the law. Mike will be celebrated with honors at a reception later this year.

As part of the 2023-2025 Strategic Plan and in working toward the Commission's ongoing commitment of public outreach, Stormie Redden, WMC Reconsideration Program Coordinator, and Jennifer Batey, Legal Operations Manager, were assigned to create videos that showcase WMC processes. Stormie produced a best practices tutorial, guiding viewers through filing a reconsideration request, while Jen crafted an informational video illuminating the Commission's discipline process. These cinematic gems are now live on YouTube, with links through the WMC website, for enjoyment at your leisure.
Requesting a Reconsideration: Requesting a Reconsideration
What Happens After My Case is Investigated? Process Overview: What Happens After my Case is Investigated?

On August 1, Gina and Rick met with Amy Robertson, PsyD, Professionals Program Director with All Points North based in CO. All Points North (APN): Mind-Body Treatment & Integrative Health. They offer multidisciplinary comprehensive diagnostic evaluations (CDEs), and address sexual misconduct, fitness for duty, substance use, and mental health issues. The meeting was successful. All Points North gives the Commission a geographically closer option instead of sending respondents to Kansas or Mississippi.

On August 6, Mike Farrell made a presentation to the Mississippi State Board of Medical Licensure on the Commission's use of the sanction rules. The Mississippi board is considering developing its own sanction guidelines and wanted to learn about the WMC experience.

Fiscal Year (FY) 2025 Legal Unit Statistics:
Over FY 2025, the Legal Unit closed out 76 cases with disciplinary orders:

Agreed Orders	12
Stipulations to Informal Disposition (STIDs)	47
Default/Waiver Orders	11
Final Orders	6

Other Legal Unit stats for FY 2025:

Summary Actions	11
Statements of Charges (SOCs)	26
Formal Hearings	5

Freda Pace, Director of Investigations

CMT Sign-up in 2025

There are plenty of CMT panel vacancies in October, November, and December 2025. The schedule for 2026 CMT panels should be posted before the end of September 2025. Visit our SharePoint schedule or email Chris Waterman at chris.waterman@wmc.wa.gov for more information. We appreciate your continued participation in this very important process. We could not be able to do this work without you and your support!

Remember, if you sign up for a CMT slot and you have a last-minute scheduling conflict, please reach out to Chris Waterman as soon as you are able to ensure that we have adequate staffing needs.

Jimi Bush, Director of Quality and Engagement

Highlights & Wins

- The 2025 Annual Fiscal Year report on WMC is completed and published to the website. This was a record-breaking year in many areas for the WMC and I encourage you to take a look.
- Jimi Bush has been invited to present "The Art and Science of Surveys – Unlocking Insights Through Thoughtful Design" At the 2025 CLEAR conference in Chicago.
- We received funding from the FSMB to aid in enhancements to the HELMS project. This money will go a long way in making our licensing and enforcement system tailored to the WMC needs without impacting our budget.
- The summer newsletter showed an increase of 16% in views compared to summer of 2024 and 2023. If you have a suggestion for the newsletter or would like to pen an article for an upcoming edition, please email Jimi.

Challenges

- The HELMS project occupies a lot of this unit's time. We are preparing for the enforcement module launch at the end of the year by ensuring that the system is efficient and accessible for both the internal and external user. Preparation for the enforcement launch and bringing the licensing modules up to speed with the capabilities of the WMC licensing team has slowed down other unit duties such as CME and Research abilities.

Mahi Zeru, Strategy Manager

Reasonable Accommodation Update

Complainants with a documented disability have reported challenges in accessing WMC's complaint intake forms specifically due to physical barriers that prevents them from typing or writing their complaints. Currently, WMC does not allow complaints to be received over the phone and lacks accommodation tools, such as speech-to-text transcription, contributing to this accessibility issue. WMC has contracted with a captioning service agency to provide speech-to-text accommodation service and is ready to assist individuals who need these accommodations. Since its launch in January,

Mahi Zeru, Strategy Manager continued

we have fulfilled **21** reasonable accommodation requests and **1** Request for Reconsideration.

Compliant Form

We are in the process of updating the current language and structure of the complaint form as it is difficult for most complainants to navigate and understand. We aim to use plain, everyday language for all complaint categories to help ensure equitable access to everyone.

Marisa Courtney, Licensing Manager

Total licenses issued from 05/01/2025-08/12/2025 = 1497

Credential Type	Total Workflow Count
Physician And Surgeon Clinical Experience License	6
Physician And Surgeon Fellowship License	1
Physician And Surgeon Institution License	0
Physician And Surgeon License	651
Physician and Surgeon License Interstate Medical Licensure Compact	319
Physician And Surgeon Residency License	425
Physician And Surgeon Teaching Research License	4
Physician And Surgeon Temporary Permit	1
Physician Assistant Interim Permit	2
Physician Assistant License	89
Physician Assistant Temporary Permit	0
Totals:	**1497**

Information on Renewals: April Renewals-76.14% online renewals

Credential Type	# of Online Renewals	# of Manual Renewals	Total # of Renewals
IMLC	0	103	103
MD	803	165	968
MDRE	3	1	4
MDTR	1	3	4
PA	179	37	216
	76.14%	**23.86%**	**100.00%**

Marisa Courtney, Licensing Manager continued

Licensing Unit Update – August 2025

Between May 1 and August 12, the Licensing Unit issued **1,497 licenses-** an incredible accomplishment given the unique challenges we faced during this time. This period not only marks our peak licensing season with the influx of incoming residents, but it also coincided with the launch of our new licensing system.

We were the first team to work within the new system during implementation, navigating unforeseen challenges while maintaining our commitment to timely and accurate licensing. I cannot overstate my appreciation for the hard work, adaptability, and dedication each team member demonstrated during this transition. Your resilience ensured we continued to meet the needs of our applicants and uphold the Commission's high standards.

In addition to licensing operations, I had the privilege of presenting at the International Medical Graduate Academy (TIMGA) August Lunch and Learn. My presentation focused on the Limited Physician and Surgeon Clinical Experience (MDCE) License and the new implementations following the bill passed this year. It was a great opportunity to connect with stakeholders and provide clarity on these important changes.

As Vice Chair of the PA Compact, I am pleased to report that we are making steady progress in drafting the Compact's rules and moving forward with the Request for Proposals (RFP) for a Compact Data System. We will continue to provide updates as they become available, with the goal of releasing an official newsletter soon.

While the past few months have tested our capacity and adaptability, they have also showcased the strength, professionalism, and teamwork that define our Licensing Unit. I am proud of what we have accomplished together and look forward to building on this momentum as we move into the next phase of our work.

June 2, 2025

Humayun J. Chaudhry, DO, MACP
President and CEO
Federation of State Medical Boards
400 Fuller Wiser Road, Suite 300
Euless, TX 76309

Dear Dr. Chaudhry:

The purpose of this letter is to bring to the attention of the Federation of State Medical Boards information related to compounded drug products containing cagrilintide, some of which claim to treat obesity and other conditions. FDA believes that health care professionals should be advised about the current regulatory status of compounded cagrilintide.

Sections 503A and 503B of the Federal Food, Drug, and Cosmetic Act (FD&C Act) describe the conditions that must be satisfied for compounded human drug products to be exempt from certain sections of the FD&C Act, including the requirements of premarket approval and labeling with adequate directions for use. Among the conditions of sections 503A and 503B are restrictions on the bulk drug substances (active pharmaceutical ingredients or APIs) that may be used to compound human drug products.

One of the conditions that must be met for a compounded drug product to qualify for the exemptions under section 503A of the FD&C Act is that a licensed pharmacist in a State licensed pharmacy or a Federal facility, or a licensed physician, compounds the drug product using bulk drug substances that: (1) comply with the standards of an applicable United States Pharmacopeia (USP) or National Formulary (NF) monograph, if a monograph exists, and the USP chapter on pharmacy compounding; (2) if such a monograph does not exist, are drug substances that are components of drugs approved by the Secretary; or (3) if such a monograph does not exist and the bulk drug substance is not a component of a drug approved by FDA, appear on a list developed by FDA through regulation ("503A Bulks List") (section 503A(b)(1)(A)(i) of the FD&C Act). Cagrilintide is not the subject of an applicable USP or NF monograph, is not a component of an FDA-approved drug product, and does not appear on the 503A Bulks List. Therefore, compounded cagrilintide products would not at this time qualify for the exemptions under section 503A of the FD&C Act.

One of the conditions that must be met for a drug product compounded by an outsourcing facility to qualify for the exemptions under section 503B of the FD&C Act, is that the outsourcing facility does not compound drug products using a bulk drug substance unless: (1) the bulk drug substance appears on a list established by the Secretary identifying bulk drug substances for

U.S. Food & Drug Administration
10903 New Hampshire Avenue
Silver Spring, MD 20993
www.fda.gov

which there is a clinical need ("503B Bulks List"), or (2) the drug product compounded from such bulk drug substance appears on FDA's drug shortage list in effect under section 506E at the time of compounding, distribution and dispensing (section 503B(a)(2)(A)(i) and (ii) of the FD&C Act). Cagrilintide does not appear on the 503B Bulks List, nor does it appear on FDA's drug shortage list. Therefore, compounded cagrilintide products would not at this time qualify for the exemptions under section 503B of the FD&C Act.

Additionally, FDA has warned companies that have illegally sold unapproved drugs that are falsely labeled "for research purposes" or "not for human consumption."[1] The agency recommends that consumers not purchase products, such as cagrilintide, that do not meet the exemptions of sections 503A or 503B of the FD&C Act, are of unknown quality, and may be harmful to their health. FDA also encourages health care providers to discuss this issue with their patients.

We are also sending this letter to the National Association of Boards of Pharmacy and National Council of State Boards of Nursing to facilitate communication among associations with shared goals regarding these matters.

We look forward to continuing to work with you on matters related to drug compounding. If you have additional questions, please contact the Office of Compounding Quality and Compliance at compounding@fda.hhs.gov.

Sincerely,

Maria Edisa Gozun, PharmD
Division Director, Division of Compounding II
Office of Compounding Quality and Compliance
Office of Compliance
Center for Drug Evaluation and Research

U.S. Food & Drug Administration
10903 New Hampshire Avenue
Silver Spring, MD 20993
www.fda.gov

Proposed Additions to “Medical Professionalism” Guidance to Address Pain Care Stigma and Ethical Responsibilities

April 30, 2025

To the Washington Medical Commission Policy Committee:

We appreciate the Commission’s efforts to regularly review and reaffirm the principles of medical professionalism. As an organization actively engaged in patient-centered advocacy and clinical policy reform, we respectfully submit for your consideration the following additions or clarifications to the Medical Professionalism Guidance Document (agenda item #4, May 1, 2025), specifically to support ethical, evidence-based care for patients experiencing pain.

Due to significant policy shifts over the last decade, more barriers than ever continue to impede appropriate pain care. While we recognize and appreciate all the Washington Medical Commission has done to address this, unfortunately many patients still report being dismissed, distrusted, or denied treatment solely due to their need for medication-based pain relief, particularly opioid therapy. This not only undermines patient welfare but contradicts core principles of professionalism and social justice.

To that end, we request the Commission consider integrating language into the existing document to make the following points clear:

Suggested Additions to the Guidance Document (Page 16–20):

1. Under “Principle of Primacy of Patient Welfare”:

> Practitioners should recognize untreated or undertreated pain as a legitimate and serious medical issue. The ethical duty to alleviate suffering includes

recognizing pain as a condition requiring compassionate, individualized care, free from stigma or bias.

2. Under “Commitment to Social Justice”:

Discrimination in healthcare can occur not only on the basis of race or identity, but also based on a patient’s medical condition or prescribed treatment. Patients who live with chronic pain must not be deprioritized, dismissed, or denied care due to assumptions about drug-seeking behavior.

3. Under “Commitment to Improving Quality of Care”:

Medical professionalism requires practitioners to stay current on the evolving science of pain management and to provide care that reflects individualized patient needs. Practitioners must ensure that external pressures … whether systemic, political, or rooted in misinformation … do not override their professional duty to relieve suffering..

4. Additionally: In the Summary Section

The WMC reaffirms that alleviating suffering is central to the role of a medical professional. Appropriately treating pain, including through use of controlled medications when warranted, is compatible with the highest standards of professionalism.

These additions are in alignment with the WMC’s past interim statements emphasizing that withholding appropriate pain care falls below the standard of care. Adding this language into the professionalism guidance ensures consistency, sets clear expectations, and reduces the chilling effect many patients and practitioners report.

Thank you for your continued leadership on this issue. We would welcome the opportunity to support or discuss these additions further.

Sincerely,

Tamera Lynn Stewart

Tamera Stewart

Policy Director / Founder

Maria Higginbotham

Maria Higginbotham

State Director

WASHINGTON PHYSICIANS HEALTH PROGRAM

WPHP: QUICK FACTS

MISSION

WPHP is Washington's trusted resource for restoring the health of medical professionals. Our confidential support and exceptional outcomes provide reassurance of safe practice and promote workforce sustainability.

VISION

Advancing the health and well-being of our medical community.

WPHP IS EXPERIENCED & HIGHLY EFFECTIVE

We have been serving health professionals and the medical community in Washington for more than 35 years. There is no model of care that approaches the success that PHP participants enjoy.[1]

WPHP IS VOLUNTARY

Participants may self-refer to WPHP or be offered an opportunity to work with WPHP to address health conditions that may negatively impact practice performance.

WPHP IS CONFIDENTIAL

- 90% of WPHP participants are unknown to the Washington Medical Commission or other applicable regulator.
- WPHP records have special confidentiality protections per RCW 18.130.175 which make them exceedingly difficult to obtain by subpoena or court order.
- As long as there are no concerns for patient safety, participant information is kept strictly confidential to WPHP and only released with appropriate consent.

WPHP IS NOT THE MEDICAL/LICENSING BOARD

We are an independent, physician-led, nonprofit organization funded primarily by a license surcharge paid by the licensee groups we serve:

- Allopathic Physicians
- Osteopathic Physicians
- Podiatric Physicians
- Physician Assistants
- Dentists
- Veterinarians

Students and residents of these professions

wphp.org
(206) 583-0127 / (800) 552-7236

[1]Domino JAMA 2005, Knight J Psychiatry Pract 2007, Buhl Arch Surg 2007, McLellan BMJ 2008, Brooks Occ Med 2013.

WPHP IS COMPASSIONATE, FAIR, AND HIGHLY ETHICAL

- 90% of program completers report being treated with courtesy and respect by WPHP staff.
- Full informed consent occurs at the initial interview including limits of confidentiality, risk, benefits, and alternatives to program participation.
- WPHP utilizes a meaningful reconsideration process to resolve disagreements.
- WPHP has a strong conflict-of-interest/anti-kickback policy and receives no funds from evaluation or treatment centers or any entity with a business interest in WPHP.
- WPHP provides need-based scholarships, payment options, and fee deferral agreements. Nobody is turned away due to inability to pay.

WPHP IS A NATIONAL LEADER AMONG PHYSICIAN HEALTH PROGRAMS

Chris Bundy, MD, MPH, WPHP's Executive Medical Director, is also the Chief Medical Officer and a Past President of the Federation of State Physician Health Programs, serving on its Board of Directors since 2015.

WPHP IS ACCOUNTABLE

- Governed by a Board of Directors representing diverse stakeholders. WPHP Board of Directors and Bylaws must be approved by the Executive Committee of the Washington State Medical Association (WSMA) Board of Trustees.
- Quarterly reports to the WSMA Board of Trustees and a comprehensive program report annually to the WSMA House of Delegates.
- Detailed quarterly statistical reporting to Department of Health (DOH) and comprehensive annual program reporting.
- Annual and exit surveys of program participants and stakeholders.
- WPHP plans to be one of the first state PHPs to undergo an external review by the Federation of State Physician Health Programs' national PEER™ program.

wphp.org
(206) 583-0127 / (800) 552-7236

WPHP 2024 Report to the Washington Department of Health

www.wphp.org

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2024 EXECUTIVE SUMMARY

HISTORY

The Washington Physicians Health Program (WPHP) is an independent, physician-led nonprofit organization founded by the WSMA Committee on Physicians with Personal Problems in 1974 to support and assist physicians in crisis, primarily due to concerns about drug or alcohol issues. Since then, WPHP has expanded to serve allopathic physicians, osteopathic physicians, podiatric physicians, physician assistants, dentists, veterinarians, and students and residents of these professions. WPHP has also expanded its scope of services to address any health condition that may cause impairment including substance use, mental health conditions, cognitive disorders, and non-psychiatric medical illnesses. WPHP provides these services to the state of Washington under contract with the Department of Health (DOH) with approximately 83% of operating expenses funded by peer assistance license surcharges supported by the professional groups we serve.

ORGANIZATIONAL LEADERSHIP

WPHP adopted a dual leadership structure in 2010. The Executive Medical Director (Chris Bundy, MD, MPH) and Executive Director (Sheldon Cooper) jointly lead WPHP and report to the WPHP Board of Directors. Dr. Bundy represents WPHP nationally through the Federation of State Physician Health Programs (FSPHP), of which he is the immediate past President and current Chief Medical Officer.

CORE CLINICAL PROGRAM

The WPHP core clinical program includes initial assessment, treatment referral, post-treatment health support verification, and advocacy related to illnesses that may adversely impact practice performance. WPHP utilizes a case management model and each program participant is assigned to a clinical coordinator that manages the professional's progress through the program. In 2024, we saw an increase in program referrals compared to the previous year, with 158 referrals and 81 admissions. Program satisfaction and outcomes, as measured through annual and exit surveys of participants and stakeholders, remains strong. For more detailed information on program statistics and performance in 2024, please refer to the full contents of this report.

EDUCATION AND OUTREACH

WPHP continues a tradition of delivering robust education and outreach to Washington's medical community. In 2024, WPHP provided 50 hours of educational presentations focused on topics related to physician health and well-being, reaching medical students, trainees, practicing physicians, and healthcare leaders both statewide and nationally.

2024 PROGRAM HIGHLIGHTS AND CHALLENGES

- **Recruitment and Retention:** Like many sectors within healthcare, WPHP has faced challenges in recruiting and retaining staff since the COVID-19 pandemic. In 2024, we successfully hired and trained a clinical coordinator and a quality assurance assistant, and promoted a team member to the role of clinical liaison. We are also planning to hire two more clinical coordinators to fully staff WPHP. Our cases continue to be increasingly complex and require clinical staff to be licensed at the master's level with physician oversight. This level of training and expertise adds significantly to our expenses. Additionally, we have engaged Kevin Hallgren, PhD, a research psychologist from the University of Washington Department of Psychiatry and Behavioral Sciences, on upcoming research initiatives including supporting WPHP's

collaboration with FSPHP on the analysis and dissemination of data from the PHP National Program Services survey.

- **Quality Assurance:** WPHP's Quality Assurance (QA) team plays a pivotal role in reducing administrative burdens on clinical staff, enhancing resilience amid staff turnover, and strengthening our quality and performance initiatives. In 2024, we introduced a clinical liaison role to oversee support for workplace and health liaisons, facilitate pre-enrollment responsibilities, and attend enrollments with clinicians. Our QA team has also been exploring ways to better serve our program participants, including evaluating toxicology solutions that offer a high-quality testing program balancing credible advocacy, convenience, and cost.
- **Communications Efforts:** Our communications team has been executing our communications strategy, which has included developing both internal and external communications frameworks. This effort has involved updating the organization's mission, vision, and values, refining key messaging, refreshing our website, conducting media relations, social media management, and creating new WPHP communication materials. Other efforts include providing thought leadership and supporting external engagement with key partners to increase awareness of WPHP.
- **System Redesign:** WPHP is committed to continuous innovation, optimizing systems to streamline workflows and drive operational efficiency, all while improving the experience for participants and staff.
- **Advocacy:** WPHP remains at the forefront of advocacy efforts, driving meaningful reforms in licensing and credentialing as well as safeguarding WPHP protections within the Public Records Act. A key accomplishment in 2024 was WPHP's critical role in providing consultation and technical assistance for credentialing reform, helping UW Medicine align its credentialing procedures with best practices that prioritize the health and sustainability of their workforce. This reform has become a model for other healthcare institutions, both within Washington and nationwide. Our ongoing partnership with the University of Washington also ensures the coverage of costs for PHP-recommended evaluations and toxicology testing for medical students, physician assistant students, residents, and fellows. Additionally, WPHP remains committed to exploring solutions to reduce financial barriers for program participants.

THE YEAR AHEAD

- Continue to streamline processes and reduce administrative burdens on the clinical team.
- Strengthen resilience to staff turnover by hiring two additional clinical coordinators to manage an increase in caseloads and complexity.
- Evaluate opportunities for additional system improvements in toxicology testing and records management.
- Continue to execute our strategic communications plan to enhance awareness of WPHP and advocate for key issues.

SUMMARY:

Success in our mission to promote patient safety and restoring the health of medical professionals is dependent upon your continued support. We hope this report provides a transparent and informative summary of our work while demonstrating our commitment to accountability, consistency, and excellence.

We thank you in advance for taking the time to review our work. Please do not hesitate to reach out with any questions or feedback you may have.

Respectfully submitted,

Chris Bundy, MD, MPH, FASAM
Executive Medical Director

Sheldon Cooper
Executive Director

WASHINGTON
PHYSICIANS
HEALTH PROGRAM

2024

ANNUAL REPORT

A MESSAGE FROM THE DIRECTORS

Dear Friends,

This Annual Report celebrates WPHP's accomplishments and impact in 2024, while honoring our valued partners. Our work is based on a simple and highly-effective model—confidential help, not discipline, best supports a healthy and safe healthcare workforce. WPHP works and truly makes a difference—our program participants, along with their families, patients, and communities, all benefit from our efforts. None of this would be possible without the support of the licensees whose surcharges underwrite our work; the courage and compassion of those who reach out on behalf of themselves or a peer; the collaboration of employers, organizations, professional associations, Boards, and Commissions, with whom we partner; and the dedication of our volunteer Board of Directors who guide our mission. We encourage you to share this report with your teams and partners to help us reach everyone in need across Washington's medical community. Thank you!

Chris Bundy, MD, MPH

EXECUTIVE MEDICAL DIRECTOR

Sheldon Cooper

EXECUTIVE DIRECTOR

OUR MISSION

WPHP is Washington's trusted resource for restoring the health of medical professionals. Our confidential support and exceptional outcomes provide reassurance of safe practice and promote workforce sustainability.

OUR VISION

Advancing the health and well-being of our medical community.

OUR VALUES

COLLABORATION
We honor the role that each person plays in working together.

RESPECT
We believe in the inherent worth of all people and foster a safe and affirming environment.

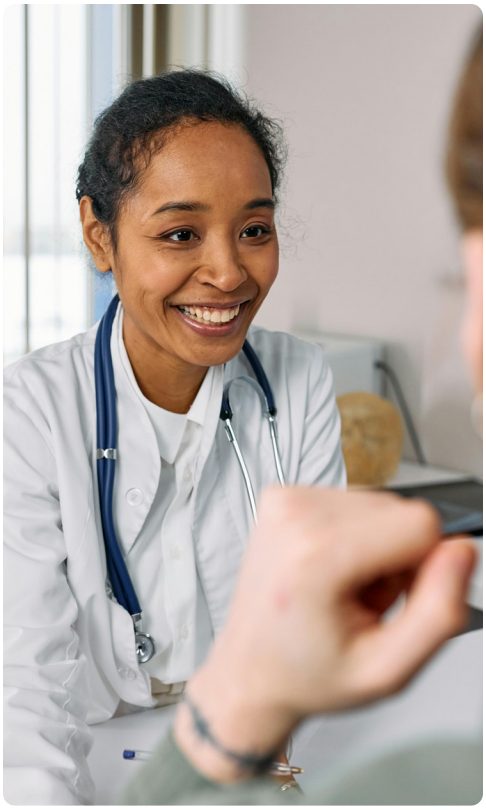
EQUITY
We recognize diverse backgrounds and needs.

ADVOCACY
We champion people and causes that further our mission.

TRANSPARENCY
We build trust through honesty and openness.

EXCELLENCE
We are driven to be the best at what we do.

SERVICE
We are dedicated to providing outstanding support to all we serve.



OUR HISTORY

WPHP was founded in 1986 by a group of concerned members of the Washington State Medical Association who wanted their colleagues to receive treatment, rather than discipline, when illness threatened safe practice. Today, WPHP is an independent, physician-led, nonprofit organization providing critical support to Washington's health professional workforce. With more than 35 years of developed expertise, service commitment, and outstanding outcomes, WPHP has earned the trust and support of the medical community in Washington and the program participants we serve.

HEALTHY DOCTORS, BETTER CARE

- Increased patient safety
- Higher patient satisfaction
- Lower professional liability risk
- Better treatment recommendations and increased treatment adherence
- Better treatment outcomes

"WPHP's greatest strengths are their professional staff who bring depth of expertise and great compassion and commitment to serve physicians and consumer safety."

– WPHP STAKEHOLDER

"WPHP was kind, compassionate, and so helpful. They were professional and supportive all in one. Thank you for all you do for physician health."

– WPHP PARTICIPANT

CONFIDENTIAL HELP, TRUSTED ADVOCACY

90%

of participants receive help without ever being known to their licensing board

WHAT IS WPHP'S PURPOSE?

- Assist in the early detection and treatment of illnesses that could compromise safe practice
- Provide participants with credible verification of health status and program adherence when needed to support continuation or re-entry to practice
- Confront stigma, bias, and discrimination through education, outreach, and advocacy

WHAT DOES WPHP HELP WITH?

- Mental health conditions
- Medical conditions
- Cognitive issues
- Substance use disorders
- Stress and burnout
- ANY health condition

WHO WE SERVE

Allopathic, Osteopathic, and Podiatric Physicians, Physician Assistants, Dentists, Veterinarians, and the residents, students, and family members of these professions

ADVOCACY WORK

WPHP continues to make tremendous strides in advocating for license and credentialing question reforms and addressing other systemic barriers to mental health and well-being.

OUR IMPACT

Saving lives, saving careers, and preserving the healthcare workforce

408 HEALTH PROFESSIONALS SERVED BY WPHP IN 2024

92%
Colleagues report that WPHP is a ***valuable resource*** to the medical community

83%
Colleagues report that WPHP provides ***exceptional service***

88%
Colleagues ***would refer another colleague*** to WPHP

90%
Participants report being ***treated with courtesy and respect*** by WPHP

84%
Participants describe their WPHP experience as ***helpful***

87%
Participants report ***needing and benefiting from WPHP advocacy***

WPHP REDUCES BURNOUT

45%
NATIONAL AVERAGE

17%
WPHP PARTICIPANTS

WPHP participants have consistently reported substantially lower rates of burnout than national averages.

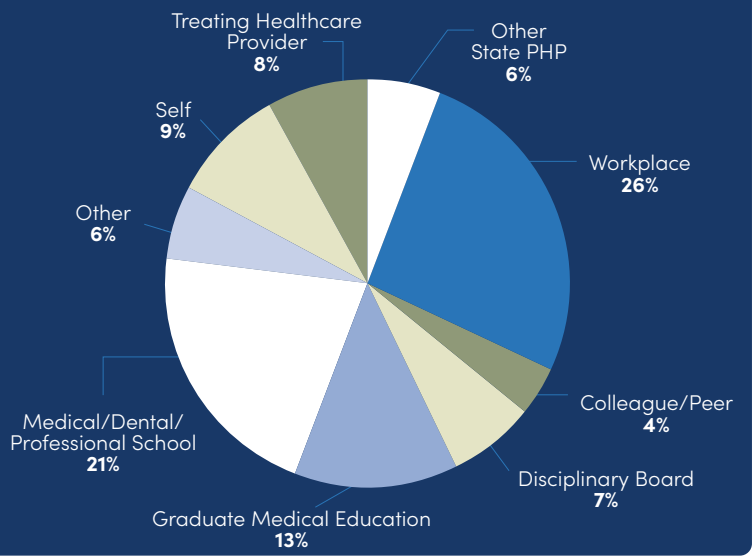
1 IN 5
Report that WPHP saved their life

85%
Working in their field at program completion

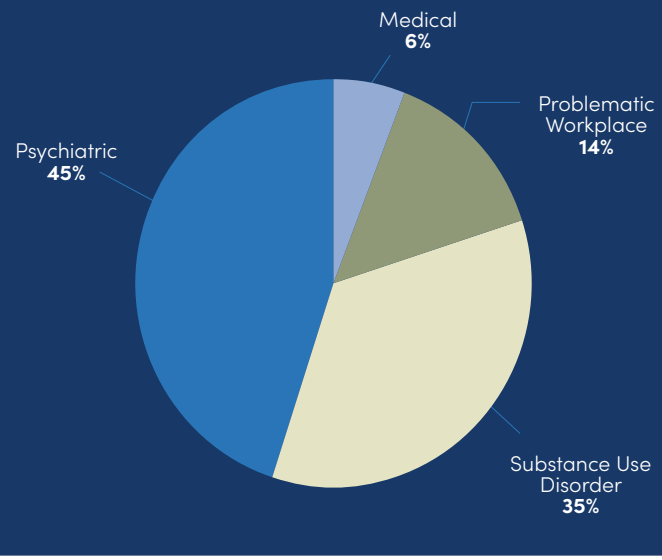
86%
Participants with substance use disorder remain abstinent at 5 years

CONFIDENTIAL REFERRALS TO WPHP

REFERRAL SOURCES



REFERRAL REASONS



158 Health professionals referred to WPHP

138 Health professionals assessed by WPHP

81 Enrolled in a Health Support Agreement

About half of those referred to WPHP receive support and advocacy without the need to enroll in a Health Support Agreement

WPHP REFERRALS BY LOCATION

Washington, by region:

NORTH	4	NORTH CENTRAL	3
NORTHWEST	4	SOUTH CENTRAL	8
PUGET SOUND	79	SOUTHWEST	8
WEST	4	EAST	13

Out of State:

ALASKA	3	MONTANA	7
CALIFORNIA	1	NORTH CAROLINA	2
FLORIDA	3	OHIO	3
IDAHO	4	OREGON	4
ILLINOIS	1	VIRGINIA	1
KENTUCKY	1	WYOMING	1
LOUISIANA	2	OUT OF COUNTRY	1
MICHIGAN	1		

PARTNERSHIP = STRENGTH

EDUCATION & OUTREACH

50
Number of educational presentations

2,899
Professionals reached through presentations

82
Outreach meetings & conferences

16,458
Social media impressions

55,297,722
Newsletter, article & publication impressions

AFFILIATIONS

WPHP is an affiliated training site for the University of Washington Department of Psychiatry and Behavioral Sciences Residency and Swedish Addiction Medicine Fellowship. WPHP is also a liaison member of the board of trustees for the Washington State Medical Association and is an active member of the Federation of State Physician Health Programs, a national membership organization that provides a forum for guidance, education, and research collaboration among state physician health programs.

EDUCATIONAL TOPICS

WPHP offers educational presentations to the Washington medical community, highlighting our programs and services, along with a range of relevant health-related topics.

ORGANIZATIONS WPHP PRESENTED TO IN 2024

- Accreditation Council for Graduate Medical Education
- American Academy of Addiction Psychiatry
- American Dental Association
- Association of American Medical Colleges
- Board of Osteopathic Medicine and Surgery
- Dental Quality Assurance Commission
- Federation of State Medical Boards
- Federation of State Physician Health Programs
- International Doctors in Alcoholics Anonymous
- Kadlec Family Medicine Residency Program
- Medical Board of California
- Medical Professional Liability Association
- Pacific Northwest Dental Conference
- Pacific Northwest Veterinary Conference
- Podiatric Medical Board
- Spokane Teaching Health Center
- Swedish Health Services
- Trios Health
- University of Washington Medicine MEDEX Northwest
- University of Washington Psychiatry Residency
- University of Washington School of Dentistry
- University of Washington School of Medicine
- Veterinary Board of Governors
- Washington Association of Medical Staff Services
- Washington Medical Commission
- Washington State Dental Association
- Washington State Department of Health
- Washington State Hospital Association
- Washington State Medical Association
- Washington State Podiatric Medical Association
- Washington State Veterinary Medical Association

WPHP BOARD OF DIRECTORS

Barbara Schneidman, MD, MPH, Board Chair

Brad McPhee, DDS, Board Vice-Chair

LuAnn Chen, MD, MHA, FAAFP, Treasurer

Carla Ainsworth, MD, MPH, Secretary

Alka Atal-Barrio, MD, MMM, FAAP

Rob Benedetti, MD

Taya Briley, RN, MN, JD

James Brown, MD

Linda Dale, D.H.Ed., PA-C

Lon Hatfield, MD, PhD

Kristin Kenny

Matthew Layton, MD, PhD, FACP, DFAPA

Tom Miller, MD

Jeffrey Sung, MD

WASHINGTON PHYSICIANS HEALTH PROGRAM

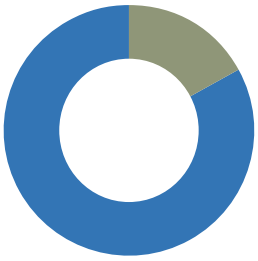
1200 6TH AVE, SUITE 850
SEATTLE, WA 98101

PHONE: (206) 583-0127
TOLL-FREE: (800) 552-7236

WPHP.ORG

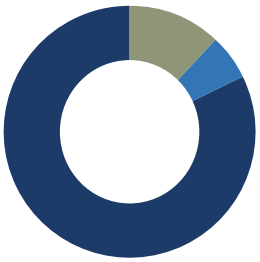
CONNECT WITH US:

2024 FINANCIAL SNAPSHOT



FUNCTIONAL EXPENSES

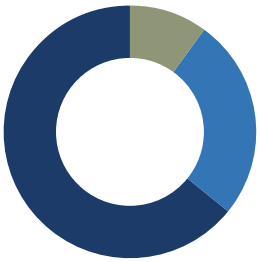
20% MANAGEMENT & GENERAL
80% PROGRAM SERVICES



REVENUE RESOURCES*

12% PARTICIPANT FEES
5% DONATIONS & OTHER
83% LICENSE SURCHARGES

*Excludes WPHP's investment activity.

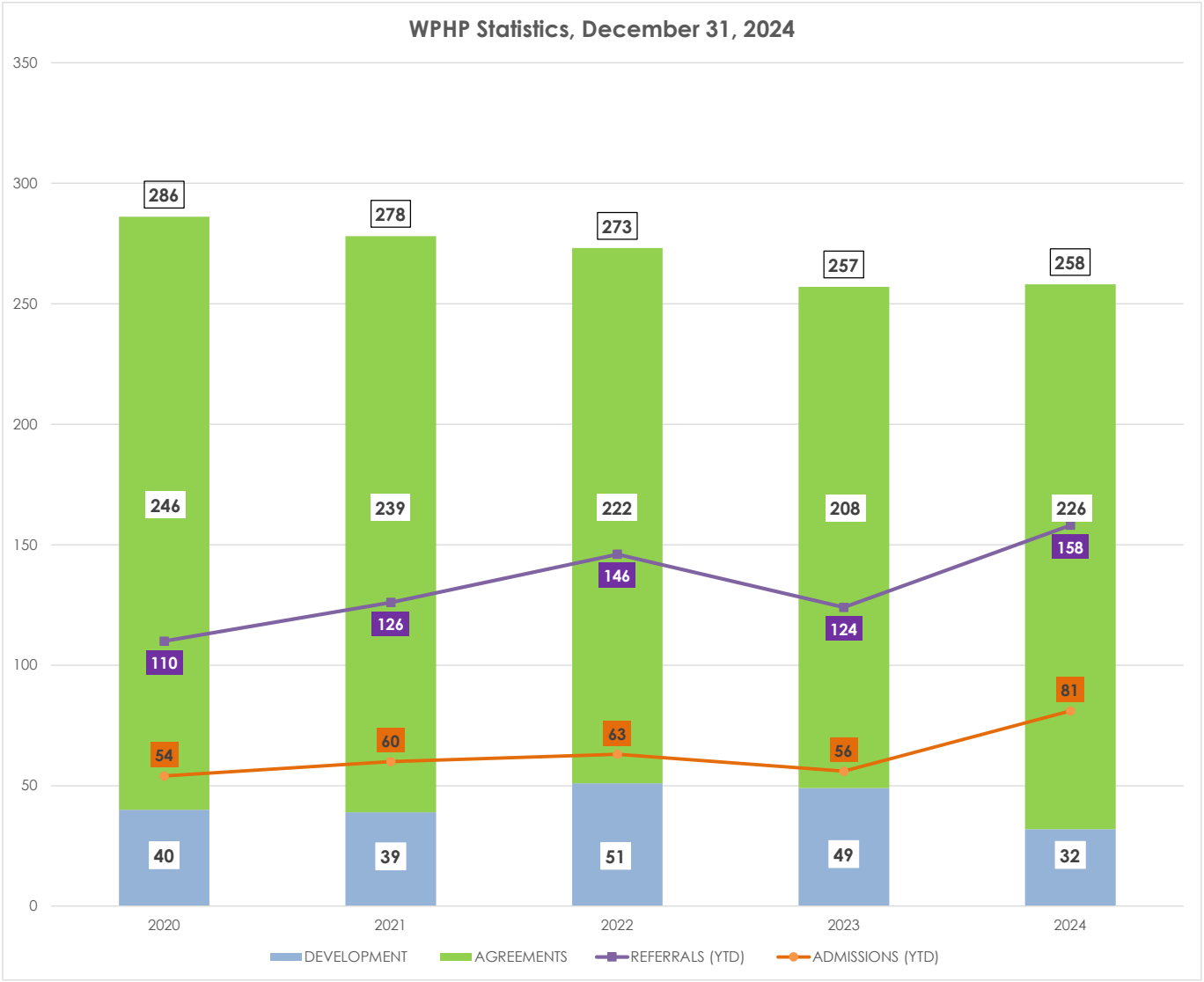


WPHP FINANCIAL AID GRANT SOURCES

10% CHARITABLE DONATIONS
26% UW CONTRACT
64% WPHP ASSISTANCE

WPHP PROVIDED $207,931 IN GRANTS TO 83 PARTICIPANTS IN NEED DURING 2024.

These contributions supported participant access to evaluation and treatment, our Annual Reunion and ongoing WPHP services. We are deeply grateful to our donors for their support.


WPHP Statistics, December 31, 2024
350
300
250
200
150
100
50
0
286
278
273
257
258
246
239
222
208
226
110
126
146
124
158
54
60
63
56
81
40
39
51
49
32
2020
2021
2022
2023
2024
DEVELOPMENT
AGREEMENTS
REFERRALS (YTD)
ADMISSIONS (YTD)

Washington Physicians Health Program
DOH Annual Report 2024

	Q1	Q2	Q3	Q4	YTD	2020 YE	2021 YE	2022 YE	2023 YE
Total Cases in Development End of Prior Quarter	49	62	58	42					
Program Admissions	10	23	20	28	81	54	60	63	56
Cases Resolved	24	24	30	18	96	75	67	72	72
New Referrals	46	43	33	36	158	110	126	146	124
SUD	12	9	15	19	55	42	56	59	45
PSY	26	22	15	9	72	52	47	49	40
MED	3	2	1	3	9	10	13	23	17
PWB	5	10	2	5	22	6	10	15	22
Total Cases in Development End of Current Quarter	61	58	42	32	193				162
Cases in Development Detail									
Initial Assessments	40	32	39	27	138	90	95	118	104
SUD	11	8	15	18	52	34	41	51	38
PSY	20	16	20	7	63	41	37	34	29
MED	3	2	1	1	7	10	11	22	12
PWB	6	6	3	1	16	5	6	11	25
Participants Under Agreement End of Prior Quarter	206	202	212	214					
Program Admissions	10	23	20	28	81	54	60	63	56
Discharges	14	13	18	16	61	73	67	80	69
Participants Under Agreement End of Current Quarter	202	212	214	226					
Agreement Detail as of Current Quarter									
Active (with Advocacy)	167	174	175	185					
SUD	120	121	120	129					
PSY	23	30	28	28					
MED	8	7	7	6					
SUD1	0	0	3	3					
OSA	16	16	17	19					
Non Advocacy (includes GSA)	35	38	39	41					
GSA-SUD	25	32	31	28					
GSA-PSY	0	0	1	1					
Non-Advocacy	10	6	7	12					
Total Participants (Agreement and CID) End of Current Quarter	263	270	256	258					
Program Deaths									
Total	0	0	0	0	0	0	1	1	0
Suicide	0	0	0	0	0	0	0	0	0
Relapse	0	0	0	0	0	0	0	1	0
Other	0	0	0	0	0	0	1	0	0

Glossary of Terms

SUD Substance Use Disorder

PSY Mental health condition predominates without significant SUD co-occurrence

MED Medical - non-mental health related condition

PWB Problematic Workplace Behavior

SUD1 1 year abstinence-based advocacy agreement with toxicology testing for individuals to rule out more significant substance use disorder diagnosis

GSA Graduate Support Agreement - non-advocacy agreement for participants who wish to continue accountability and connection to WPHP as part of ongoing recovery following completion of their monitoring obligation

OSA Out of State Agreement - Participant is monitoried by another state's physician health program under agreement between WPHP and the other

Washington Physicians Health Program
DOH Annual Report 2024

Participants Under Agreement Details

Board Status		Q1	Q2	Q3	Q4	YTD	2020 YE	2021 YE	2022 YE	2023 YE
Professionals										
Voluntary										
	MD	109	119	126	133					
	PA	17	17	16	18					
	DMD/DDS	9	9	9	9					
	DO	17	19	17	17					
	DVM	9	9	9	10					
	DPM	2	2	2	2					
Mandatory										
	MD	18	15	13	12					
	PA	1	1	1	1					
	DMD/DDS	6	6	5	5					
	DO	3	3	3	3					
	DVM	1	1	1	1					
	DPM	0	0	0	0					

Students		Q1	Q2	Q3	Q4	YTD	YE	YE	YE	YE
Voluntary										
	MD	10	11	12	14					
	PA	0	0	0	1					
	DMD/DDS	0	0	0	0					
	DO	0	0	0	0					
	DVM	0	0	0	0					
	DPM	0	0	0	0					

Board Reports	Q1	Q2	Q3	Q4	YTD	YE	YE	YE	YE
Total Board Reports	0	6	7	3	16	12	8	19	6
Intake/Cases in Development	0	5	4	1	10	9	3	10	4
Active Participant	0	1	3	2	6	3	5	9	2

Board Reports		Q1	Q2	Q3	Q4	YTD	YE	YE	YE	YE
Total Board Reports		0	6	7	3	16	12	8	19	6
	WMC	0	4	5	2	11	11	5	15	2
	BOMS	0	2	0	1	3	0	0	3	2
	DQAC	0	0	2	0	2	1	1	0	2
	VBG	0	0	0	0	0	0	2	1	0
	PMB	0	0	0	0	0	0	0	0	0

RETURN TO USE AND SUICIDE DATA 2015-2024

	2024		2023	2022	2021	2020	2019	2018	2017	2016^	2015	10 yr Avg.	
# of Substance Use Disorder Participants	157		146	160	166	170	171	173	189	204	225	176	
# of Mandated Participants	19		24	24	22	21	16	13	13	21	28	20	
# of Voluntary Participants	140		122	136	144	149	155	160	176	183	197	156	
Participants that Returned to Use													
Total	8	5.10%	11	14	7	3	8	8	7	13	13	9	
Mandated	1	12.50%	2	2	1	0	3	3	0	2	3	2	
Voluntary	7	87.50%	9	12	6	3	5	5	7	11	10	8	
Method of Detection for Return to Use													
Self Reported	1	12.50%	2	2	4	1	3	2	2	5	1	2	25.00%
Health Provider	1	12.50%	0	0	0	0	0	0	0	0	0	0	1.09%
Toxicology	6	75.00%	9	10	3	2	5	4	4	9	11	6	68.48%
Workplace	0	0.00%	0	1	0	0	0	1	0	0	0	0	2.17%
Other	0	0.00%	0	1	0	0	0	1	1	1	1	1	5.43%
Disposition for Return to Use													
Re-treatment/Re-Evaluated	6	75.00%	6	7	6	1	2	6	4	9	9	6	60.87%
Intensify Services	2	25.00%	4	3	1	1	4	1	0	3	1	2	21.74%
Other	0	0.00%	1	4	0	1	2	1	3	3	3	2	19.57%
Total At-Risk (Known to WPHP) ^^	392		375	397	404								
At-Risk (Known to WPHP) Suicides	0	0.00%	0	0	0								
Total Engaged Participants* **	349		338	369	377	366	265	292	305	306	318	329	
Engaged Participant Deaths Due to Suicide	0	0.00%	0	1	0	1	0	1	0	0	0	0.30	0.09%

*Return to Use data includes all degree groups that WPHP actively monitors for substance use disorders.

**2014 Client numbers exclude Phase III clients who have successfully completed health support agreements and are not being monitored with the same degree of rigor as Chemical Dependency Phase I and II clients. Phase III clients were included in 2007-2013 client numbers in this document.

^ 2016 methodology changed from average number of SUD clients, mandated and voluntary, to counts

^^All "Active Agreement" participants and CID's (excluding OSA)

*** All agreement participants and CID's who have completed initial assessemnt with WPHP (excluding OSA). Prior to 2020, this was count of end of year participants + CIDs.

WASHINGTON PHYSICIANS HEALTH PROGRAM

ADA GRIEVANCES

WPHP did not receive any ADA grievances in 2024. However, in January 2025, a grievance was submitted regarding an incident that occurred in late 2024. WPHP followed its written ADA Grievance Process and also retained legal counsel specializing in ADA compliance to review the grievance and investigate whether there had been an ADA violation. As part of the investigation, the attorney reviewed the written grievance as well as all relevant documents and conducted interviews with all parties directly involved. The investigation concluded that WPHP was not in violation of any ADA regulations and that no retaliatory action had been taken by WPHP against the complainant. The process concluded with WPHP submitting a letter to the complainant that detailed the steps it had taken to review the grievance, its conclusion that no ADA violation or retaliation had occurred.

The complainant appealed the result of the investigation to the WPHP Board Chair in accordance with WPHP's ADA Grievance Process. The Board Chair, along with the investigator, met with the complainant over zoom to hear the appeal. After hearing the appeal, it was concluded that WPHP was not in violation of any ADA regulations and that no retaliatory action had been taken by WPHP against the complainant. The appeal process concluded with the WPHP Board Chair sending a letter to the complainant that stated its conclusion that no ADA violation or retaliation had occurred.

This marked the conclusion of the WPHP ADA Grievance Process for this complaint as no additional opportunities for appeal are provided.

WASHINGTON
PHYSICIANS
HEALTH PROGRAM

FINANCIAL STATEMENTS

YEAR ENDED JUNE 30, 2024
(WITH COMPARATIVE TOTALS FOR 2023)

CPAs | CONSULTANTS | WEALTH ADVISORS

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WASHINGTON PHYSICIANS HEALTH PROGRAM
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(WITH COMPARATIVE TOTALS FOR 2023)

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CliftonLarsonAllen LLP
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INDEPENDENT AUDITORS' REPORT

Board of Directors
Washington Physicians Health Program
Seattle, Washington

Report on the Audit of the Financial Statements

Opinion

We have audited the accompanying financial statements of Washington Physicians Health Program (a Washington nonprofit corporation), which comprises the statement of financial position as of June 30, 2024, and the related statements of activities and changes in net assets, functional expenses, and cash flows for the year then ended, and the related notes to the financial statements.

In our opinion, the financial statements referred to above present fairly, in all material respects, the financial position of Washington Physicians Health Program as of June 30, 2024, and the changes in its net assets and its cash flows for the year then ended in accordance with accounting principles generally accepted in the United States of America.

Basis for Opinion

We conducted our audit in accordance with auditing standards generally accepted in the United States of America. Our responsibilities under those standards are further described in the Auditor's Responsibilities for the Audit of the Financial Statements section of our report. We are required to be independent of Washington Physicians Health Program and to meet our other ethical responsibilities in accordance with the relevant ethical requirements relating to our audits. We believe that the audit evidence we have obtained is sufficient and appropriate to provide a basis for our audit opinion.

Responsibilities of Management for the Financial Statements

Management is responsible for the preparation and fair presentation of these financial statements in accordance with accounting principles generally accepted in the United States of America; this includes the design, implementation, and maintenance of internal control relevant to the preparation and fair presentation of financial statements that are free from material misstatement, whether due to fraud or error.

In preparing the financial statements, management is required to evaluate whether there are conditions or events, considered in the aggregate, that raise substantial doubt about Washington Physicians Health Program's ability to continue as a going concern within one year after the financial statements are available to be issued.

Auditors' Responsibilities for the Audit of the Financial Statements

Our objectives are to obtain reasonable assurance about whether the financial statements as a whole are free from material misstatements, whether due to fraud or error, and to issue an auditor's report that includes our opinion. Reasonable assurance is a high level of assurance but is not absolute assurance and therefore is not guarantee that an audit conducted is accordance with generally accepted auditing standards will always detect a material misstatement when it exists. The risk of not detecting a material misstatement resulting from fraud is higher than for one resulting from error, as fraud may involve collusion, forgery, intentional omissions, misrepresentations, or the override of internal control. Misstatements are considered material if there is a substantial likelihood that, individually or in the aggregate, they would influence the judgement made by a reasonable user based on the statements.

In performing an audit accordance with generally accepted auditing standards, we:

- Exercise professional judgement and maintain professional skepticism throughout the audit.
- Identify and assess the risks of material misstatement of financial statements, whether due to fraud or error, and design and perform audit procedures responsive to those risks. Such procedures include examining, on a test basis, evidence regarding the amounts and disclosures in the financial statements.
- Obtain an understanding of internal control relevant to the audit in order to design audit procedures that are appropriate in the circumstances, but not for the purpose of expressing an opinion on the effectiveness of Washington Physicians Health Program's internal control. Accordingly, no such opinion is expressed.
- Evaluate the appropriates of accounting policies used and the reasonableness of significant accounting estimates made by management as well as evaluate the overall presentation of the financial statements.
- Conclude whether, in our judgement, there are conditions or events, considered in the aggregate, that raise substantial doubt about Washington Physicians Health Program's ability to continue as a going concern for a reasonable period of time.

We are required to communicate with those charged with governance regarding, among other matters, the planned scope and timing of the audit, significant audit findings, and certain internal control related matters that we identified during the audit.

Report on Summarized Comparative Information

We have previously audited Washington Physicians Health Program's 2023 financial statements, and we expressed an unmodified audit opinion on those audited financial statements in our report dated September 20, 2023. In our opinion, the summarized comparative information presented herein as of and for the year ended June 30, 2023, is consistent, in all material respects, with the audited financial statements from which it has been derived.

CliftonLarsonAllen LLP

Bellevue, Washington
September 18, 2024

WASHINGTON PHYSICIANS HEALTH PROGRAM
STATEMENT OF FINANCIAL POSITION
YEAR ENDED JUNE 30, 2024
(WITH COMPARATIVE TOTALS FOR 2023)

	2024	2023
ASSETS		
CURRENT ASSETS		
Cash and Cash Equivalents	$ 344,367	$ 891,332
Contract Receivables	558,018	523,235
Program and Client Receivables, Net of Allowance for Credit Losses of $12,508 and $9,394, Respectively	127,906	124,493
Prepaid Expenses	86,357	59,722
Total Current Assets	1,116,648	1,598,782
OTHER ASSETS		
Investments	6,612,711	5,703,128
Property and Equipment, Net	359,513	416,806
Operating Right-of-Use Asset	1,068,742	1,231,278
Security Deposit	24,869	24,869
Deferred Compensation Investments	352,917	292,522
Total Other Assets	8,418,752	7,668,603
Total Assets	$ 9,535,400	$ 9,267,385
LIABILITIES AND NET ASSETS		
CURRENT LIABILITIES		
Accounts Payable	$ 99,469	$ 54,034
Accrued Payables	260,162	242,279
Current Portion of Lease Liability - Operating	221,857	209,197
Total Current Liabilities	581,488	505,510
Long-Term Lease Liability - Operating, Net of Current Portion	1,243,696	1,465,553
Deferred Compensation	352,917	292,522
Total Liabilities	2,178,101	2,263,585
NET ASSETS		
Without Donor Restrictions:		
Undesignated	741,819	1,285,672
Board Quasi-Endowment - Client Support Fund	4,419,739	3,688,981
Board Designated for Working Capital	2,192,972	2,014,147
Total Without Donor Restrictions	7,354,530	6,988,800
With Donor Restrictions	2,769	15,000
Total Net Assets	7,357,299	7,003,800
Total Liabilities and Net Assets	$ 9,535,400	$ 9,267,385

See accompanying Notes to Financial Statements.

WASHINGTON PHYSICIANS HEALTH PROGRAM
STATEMENT OF ACTIVITIES AND CHANGES IN NET ASSETS
YEAR ENDED JUNE 30, 2024
(WITH COMPARATIVE TOTALS FOR 2023)

	Without Donor Restrictions	With Donor Restrictions	Total 2024	Total 2023
REVENUE AND SUPPORT				
Contract Revenue	$ 2,788,959	$ -	$ 2,788,959	$ 2,736,389
Program and Client Fees	525,539	-	525,539	507,194
Therapeutic Conferences	10,660	-	10,660	10,620
Investment Return	410,056	-	410,056	252,569
Contributions	8,955	12,780	21,735	58,265
Other	4,319	-	4,319	5,073
Net Assets Released from Restrictions	25,011	(25,011)	-	-
Total Revenues and Support	3,773,499	(12,231)	3,761,268	3,570,110
EXPENSES				
Program Services	2,749,396	-	2,749,396	2,510,974
Management and General	658,373	-	658,373	525,776
Total Expenses	3,407,769	-	3,407,769	3,036,750
CHANGES IN NET ASSETS	365,730	(12,231)	353,499	533,360
Net Assets - Beginning of Year	6,988,800	15,000	7,003,800	6,470,440
NET ASSETS - END OF YEAR	$ 7,354,530	$ 2,769	$ 7,357,299	$ 7,003,800

See accompanying Notes to Financial Statements.

WASHINGTON PHYSICIANS HEALTH PROGRAM
STATEMENT OF FUNCTIONAL EXPENSES
YEAR ENDED JUNE 30, 2024
(WITH COMPARATIVE TOTALS FOR 2023)

	Program Services	Management and General	Total 2024	Total 2023
Employee Compensation and Taxes	$ 1,446,478	$ 401,197	$ 1,847,675	$ 1,731,459
Employee Benefits	230,481	63,926	294,407	269,084
Employee Vacation	101,600	28,180	129,780	120,361
Facilitator Compensation and Taxes	122,926	-	122,926	120,915
Clinical Services	45,818	-	45,818	26,191
Office Rent	182,608	49,370	231,978	221,776
Office Expenses	88,896	23,807	112,703	114,116
Professional Services	128,382	36,281	164,663	152,589
Annual Reunion	85,889	-	85,889	91,606
Depreciation and Amortization	62,648	16,938	79,586	79,193
Bank and Investment Fees	1,564	-	1,564	1,212
Administrative Meetings	-	10,754	10,754	10,410
Client Support	187,718	-	187,718	49,503
Training and Research	33,421	1,033	34,454	30,692
Business Taxes	10,587	-	10,587	10,103
Bad Debts	13,183	-	13,183	135
Physician Education	7,197	-	7,197	4,208
Lobbying	-	24,000	24,000	-
Miscellaneous	-	2,887	2,887	3,197
Total Expenses	$ 2,749,396	$ 658,373	$ 3,407,769	$ 3,036,750

See accompanying Notes to Financial Statements.

WASHINGTON PHYSICIANS HEALTH PROGRAM
STATEMENT OF CASH FLOWS
YEAR ENDED JUNE 30, 2024
(WITH COMPARATIVE TOTALS FOR 2023)

	2024	2023
CASH FLOWS FROM OPERATING ACTIVITIES		
Changes in Net Assets	$ 353,499	$ 533,360
Adjustments to Reconcile Change in Net Assets to Net Cash Provided by Operating Activities:		
Depreciation and Amortization	79,586	79,193
Bad Debts	13,183	135
Noncash Lease Adjustment	(46,661)	(40,448)
Gain on Investments	(254,637)	(125,654)
Decrease (Increase) in Assets:		
Contract Receivables	(34,783)	(281,855)
Program and Client Receivables	(16,596)	(34,484)
Security Deposits	-	1,000
Prepaid Expenses	(26,635)	10,419
Increase (Decrease) in Liabilities:		
Accounts Payable	45,435	11,700
Accrued Payables	17,883	2,274
Net Cash Provided by Operating Activities	130,274	155,640
CASH FLOWS FROM INVESTING ACTIVITIES		
Purchases of Property and Equipment	(22,293)	(26,253)
Purchases of Investments and Reinvested Earnings	(2,007,544)	(957,430)
Proceeds from Sales of Investments	1,352,598	831,298
Net Cash Used by Investing Activities	(677,239)	(152,385)
NET INCREASE (DECREASE) IN CASH AND CASH EQUIVALENTS	(546,965)	3,255
Cash and Cash Equivalents - Beginning of Year	891,332	888,077
CASH AND CASH EQUIVALENTS - END OF YEAR	$ 344,367	$ 891,332

See accompanying Notes to Financial Statements.

NOTE 1 PRINCIPAL ACTIVITY AND SIGNIFICANT ACCOUNTING POLICIES

Organization

Washington Physicians Health Program (WPHP) is a nonprofit organization incorporated in June 1987 to implement a health program as an alternative to discipline, in matters of physician impairment. WPHP's mission is to facilitate the rehabilitation of health care professionals who have physical or mental conditions that could compromise patient safety and to monitor their recovery.

Financial Statement Presentation

WPHP's financial statements are presented on the accrual basis of accounting. Net assets, revenues, expenses, gains, and losses are classified based on the existence or absence of donor-imposed restrictions.

Net Assets

Net assets, revenues, gains, and losses are classified based on the existence or absence of donor- or grantor-imposed restrictions. Accordingly, net assets and changes therein are classified and reported as follows:

Net Assets Without Donor Restrictions – Net assets available for use in general operations and not subject to donor (or certain grantor) restrictions. The governing board has designated, from net assets without donor restrictions, net assets for an operating reserve and board-designated endowment.

Net Assets With Donor Restrictions – Net assets subject to donor- (or certain grantor-) imposed restrictions. Some donor-imposed restrictions are temporary in nature, such as those that will be met by the passage of time or other events specified by the donor. Other donor-imposed restrictions are perpetual in nature, where the donor stipulates that resources be maintained in perpetuity. Gifts of long-lived assets and gifts of cash restricted for the acquisition of long-lived assets are recognized as revenue when the assets are placed in service. Donor-imposed restrictions are released when a restriction expires, that is, when the stipulated time has elapsed, when the stipulated purpose for which the resource was restricted has been fulfilled, or both.

When a restriction expires, net assets with donor restrictions are reclassified to net assets without donor restrictions and reported in the statement of activities and changes in net assets as net assets released from restrictions.

Cash and Cash Equivalents

For the purpose of the statement of cash flows, WPHP considers all cash accounts which are not subject to withdrawal restrictions or penalties, and all highly liquid investments purchased with an original maturity of three months or less to be cash equivalents, except those held as part of its investment portfolio.

NOTE 1 PRINCIPAL ACTIVITY AND SIGNIFICANT ACCOUNTING POLICIES (CONTINUED)

Contract Receivables

Contract receivables consist primarily of a contract from the Washington State Department of Health (DOH). Contract receivables are stated at the amount management expects to collect from the outstanding balances. Contract receivables are due within one year. All receivables are unsecured. No allowance for uncollectible balances for receivables has been established by management based on WPHP's historical experience in the collection of balances due.

Program and Client Receivables and Allowance for Credit Losses

Program and client receivables are stated at the amount management expects to collect from outstanding balances. WPHP's policy does not provide for accrual of interest or other service charges on program and client receivables.

WPHP operates in a nonprofit industry and its program and client receivables relate primarily to contractual amounts due in the ordinary course of business. The allowance estimate is derived from a review of WPHP's historical losses based on the aging of program and client receivables. This estimate is adjusted for management's assessment of current conditions, reasonable and supportable forecasts regarding future events, and any other factors deemed relevant by WPHP. WPHP believes that the composition of program and client receivables at year-end is consistent with historical conditions as credit terms and practices and the client base has not change significantly.

At June 30, 2024, 2023, and 2022, the program and client receivables, net of allowance for credit losses, were $127,906, $124,493, and $90,144, respectively.

Changes in the allowance for credit losses for the years ended June 30, 2024 were as follows:

	2024
Balance, Beginning of the Period	$ 9,394
Provisions	12,000
Write-Offs, Net of Recoveries	(8,886)
Balance, End of the Period	$ 12,508

Investments

Investments are carried at fair value, and realized and unrealized gains and losses are reflected in the statement of activities and changes in net assets. Investment fees have been netted against investment income for financial statement reporting purposes.

NOTE 1 PRINCIPAL ACTIVITY AND SIGNIFICANT ACCOUNTING POLICIES (CONTINUED)

Property and Equipment

Property and equipment are recorded at cost if purchased or at fair value at the date of receipt if donated. WPHP follows the practice of capitalizing all expenditures for property and equipment over $1,000. Depreciation is provided on the straight-line basis over the estimated useful lives of the assets of three years for computer equipment and software and five to seven years for furniture, fixtures, and other equipment. Leasehold improvements are depreciated on a straight-line basis over the shorter of the useful life or the life of the lease.

Revenue Recognition

Contract revenue is derived from the DOH which is conditioned upon certain performance requirements. Amounts received are recognized as revenue under Accounting Standards Codification (ASC) 958 when services are provided to beneficiaries other than the resource providers. Amounts received prior to performing the required services are reported as refundable advances in the statement of financial position. The conditional amount related to the DOH contract cannot be determined at June 30, 2024 or 2023 as the amount of reimbursement is determined by the DOH. No amounts have been received in advance under these contracts.

Program and client fees consist of laboratory and testing fees, monitoring fees, and treatment fees. The revenue is subject to ASC 606, *Contracts with Customers*. The fees are recognized over the period of time in which the underlying services are provided. No funds are received in advance of the service being rendered. Program and client fees are presented separately on the statement of financial position and the statement of activities and changes in net assets.

Federal Income Tax

The Internal Revenue Service (IRS) has determined that WPHP is exempt from federal income tax under Section 501(c)(3) and is classified as an organization other than a private foundation under Section 509(a)(1); accordingly, no provision has been made for federal income tax in the financial statements. WPHP files tax filings with the U.S., state, and various local governments. WPHP's income tax filings are subject to examination by various taxing authorities.

WPHP follows the provisions of uncertain tax positions as addressed in Financial Accounting Standards Board (FASB) Codification Subtopic 740-10, *Income Taxes*. WPHP believes that it has appropriate support for any tax positions taken, and as such, does not have any uncertain tax positions that are material to the financial statements.

NOTE 1 PRINCIPAL ACTIVITY AND SIGNIFICANT ACCOUNTING POLICIES (CONTINUED)

Concentration of Credit Risk

Financial instruments that potentially subject WPHP to concentrations of credit risk consist of cash and cash equivalents and investments. At times, such amounts may be in excess of Federal Insurance deposit Corporation (FDIC) and Securities Investor Protection Corporation (SIPC) federally insured limits. At June 30, 2024, WPHP's deposits were approximately $128,000 over the federally insured limits. WPHP has not experienced any losses in such accounts. WPHP believes it is not exposed to any significant credit risk on cash and cash equivalents.

Approximately 81% and 78% of WPHP's receivables at June 30, 2024 and 2023, were due from the DOH.

Economic Dependency

WPHP received approximately 74% and 77% of its total revenues and support from the DOH for the years ended June 30, 2024 and 2023, respectively.

Functional Allocation of Expenses

The costs of providing various programs and other activities have been summarized on a functional basis in the statement of activities and changes in net assets and the statement of functional expenses. Accordingly, certain costs have been allocated among the programs and supporting services based on the benefits derived. Personnel costs, rent, office expenses, and depreciation are allocated based on personnel time.

Use of Estimates

The preparation of financial statements in conformity with accounting principles generally accepted in the United States of America (U.S. GAAP), requires management to make estimates and assumptions that affect certain reported amounts and disclosures. Accordingly, actual results could differ from those estimates.

Comparative Amounts for 2023

The financial statements include certain prior-year summarized comparative information in total but not by net asset class. Such information does not include sufficient detail to constitute a presentation in conformity with U.S. GAAP. Accordingly, such information should be read in conjunction with WPHP's financial statements for the year ended June 30, 2023, from which the summarized information was derived.

Adoption of New Accounting Standard

In June 2026, the FASB issued guidance, FASB ASC 326, *Financial Instruments – Credit Losses*, which significantly changed how entities will measure credit losses for most financial assets and certain other instruments that are not measured at fair value through net income. The most significant change in this standard is a shift from the incurred loss model to the expected loss model. Under the standard, disclosures are required too provider users of the financial statements with useful information in analyzing an entity's exposure to credit risk and the measurement of credit losses. Financial asset held by WPHP that is subject to the guidance in FASB ASC 326 was client receivables.

NOTE 1 PRINCIPAL ACTIVITY AND SIGNIFICANT ACCOUNTING POLICIES (CONTINUED)

Adoption of New Accounting Standard (Continued)

WPHP adopted the standard effective July 1, 2023. The impact of the adoption was not considered material to the financial statements and primarily resulted in enhanced disclosures only.

Lease

WPHP determines if an arrangement is a lease at inception. Operating leases are included in operating lease ROU assets, other current liabilities, and operating lease liabilities on the statement of financial position.

ROU assets represent WPHP's right to use an underlying asset for the lease term and lease liabilities represent WPHP's obligation to make lease payments arising from the lease. ROU assets and liabilities are recognized at the lease commencement date based on the present value of lease payments over the lease term. As most of leases do not provide an implicit rate, WPHP uses a risk-free rate based on the information available at commencement date in determining the present value of lease payments. The operating lease ROU asset also includes any lease payments made and excludes lease incentives. The lease terms may include options to extend or terminate the lease when it is reasonably certain that the WPHP will exercise that option. Lease expense for lease payments is recognized on a straight-line basis over the lease term. WPHP has elected to recognize payments for short-term leases with a lease term of 12 months or less as expense as incurred and these leases are not included as lease liabilities or right of use assets on the statement of financial position. WPHP does not have short-term leases as of June 30, 2024 and 2023.

WPHP has elected not to separate nonlease components from lease components and instead accounts for each separate lease component and the nonlease component as a single lease component.

WPHP's lease agreements do not contain any material residual value guarantees or material restrictive covenants.

In evaluating contracts to determine if they qualify as a lease, WPHP considers factors such as if WPHP has obtained substantially all of the rights to the underlying asset through exclusivity, if WPHP can direct the use of the asset by making decisions about how and for what purpose the asset will be used and if the lessor has substantive substitution rights. This evaluation may require significant judgment.

The individual lease contracts do not provide information about the discount rate implicit in the lease. Therefore, WPHP has elected to use a risk-free discount rate determined using a period comparable with that of the lease term for computing the present value of lease liability.

NOTE 2 LIQUIDITY AND AVAILABILITY

Financial assets available for general expenditure, that is, without donor or other restrictions limiting their use, within one year of the statement of financial position date, comprise the following:

	2024	2023
Cash and Cash Equivalents	$ 344,367	$ 891,332
Contract Receivables	558,018	523,235
Client Receivables, Net	127,906	124,493
Total	$ 1,030,291	$ 1,539,060

As part of WPHP's liquidity management plan, cash in excess of four months expenditure requirements are transferred to one of the investment accounts. At June 30, 2024, the operating reserve was $2,192,972 and the quasi-endowment fund was $4,419,739. These reserves, established by the board of directors, may be drawn upon, if necessary, to meet unexpected liquidity needs or in the event of financial distress.

NOTE 3 PROPERTY AND EQUIPMENT

Property and equipment consisted of the following at June 30:

	2024	2023
Computer Equipment	$ 105,945	$ 95,641
Software	1,475	1,475
Furniture, Fixtures, and Equipment	83,807	83,807
Leasehold Improvements	544,250	544,250
Total	735,477	725,173
Less: Accumulated Depreciation	(375,964)	(308,367)
Total Property and Equipment	$ 359,513	$ 416,806

NOTE 4 INVESTMENTS

Fair Value Measurements

U.S. GAAP defines fair value, provides a framework for measuring fair value, and requires certain disclosures about fair value measurements. To increase consistency and comparability in fair value measurements, U.S. GAAP uses a fair value hierarchy that prioritizes the inputs to valuation approaches into three broad levels. The hierarchy gives the highest priority to quoted prices in active markets (Level 1) and the lowest priority to unobservable inputs (Level 3).

NOTE 4 INVESTMENTS (CONTINUED)

Valuation Techniques

Financial assets and liabilities valued using Level 1 inputs are based on unadjusted quoted market prices of identical assets and liabilities within active markets. Financial assets and liabilities valued using Level 2 inputs are based primarily on inputs other than quoted prices included within Level 1 that are observable for the asset or liability, either directly or indirectly. These include quoted prices for similar assets or liabilities in active markets, quoted prices for identical or similar assets or liabilities in markets that are not active, inputs other than quoted prices that are observable for the asset or liability, and market-corroborated inputs. Financial assets and liabilities using Level 3 inputs are unobservable inputs for the asset or liability. In these situations, WPHP develop inputs using the best information available in the circumstances. Valuation techniques utilized to determine the fair value are consistently applied.

Following is a description of the valuation methodology used for assets measured at fair value. There have been no changes in the methodologies used at June 30, 2024 and 2023.

Money Market Funds – Valued at cost plus accrued interest, which approximates fair value.

Common Stock and Mutual Funds – Valued at closing price reported on the active market on which the securities are traded.

Corporate Bonds – Valued using recently executed transactions, market price quotations (where observable), bond spreads, or credit default swap spreads.

Annuity Funds – The fair value of participation units in the annuity funds is determined by the asset custodian based on the valuation of the underlying investments at the year-end.

Fair values of investments were as follows at June 30, 2024:

	Level 1	Level 2	Level 3	Total
Money Market Funds	$ 64,354	$ -	$ -	$ 64,354
Mutual Funds	52,694	-	-	52,694
Common Stock	2,225,493	-	-	2,225,493
Corporate Bonds	-	4,270,170	-	4,270,170
Total Investments	$ 2,342,541	$ 4,270,170	$ -	$ 6,612,711

Fair values of deferred compensation investments were as follows at June 30, 2024:

	Level 1	Level 2	Level 3	Total
Fixed Income Annuity Fund	$ -	$ 352,917	$ -	$ 352,917

NOTE 4 INVESTMENTS (CONTINUED)

Valuation Techniques (Continued)

Fair values of investments were as follows at June 30, 2023:

	Level 1	Level 2	Level 3	Total
Money Market Funds	$ 44,027	$ -	$ -	$ 44,027
Mutual Funds	38,146	-	-	38,146
Common Stock	1,926,206	-	-	1,926,206
Preferred Stock	-	24,300	-	24,300
Corporate Bonds	-	3,670,449	-	3,670,449
Total Investments	$ 2,008,379	$ 3,694,749	$ -	$ 5,703,128

Fair values of deferred compensation investments were as follows at June 30, 2023:

	Level 1	Level 2	Level 3	Total
Fixed Income Annuity Fund	$ -	$ 292,522	$ -	$ 292,522

Investment return was as follows for the years ended June 30:

	2024	2023
Dividends and Interest	$ 178,830	$ 148,569
Investment Fees	(23,411)	(21,654)
Investments Gains	254,637	125,654
Total	$ 410,056	$ 252,569

NOTE 5 BOARD-DESIGNATED NET ASSETS

Board-Designated Quasi-Endowment Fund

The board of directors designated funds to function as endowments (quasi-endowment) to support its clients as envisioned in its mission statement in the event of shortfalls in funding or unanticipated need. As required by U.S. GAAP, net assets associated with endowment funds, including quasi-endowments, are classified and reported based on the existence or absence of donor-imposed restrictions.

Changes to endowment net assets were as follows for the year ended June 30, 2024:

Endowment Net Assets - July 1, 2023	$ 3,688,981
Contributions	500,000
Investment Income	114,546
Investment Fees	(15,498)
Net Appreciation	131,710
Endowment Net Assets - June 30, 2024	$ 4,419,739

NOTE 5 BOARD-DESIGNATED NET ASSETS (CONTINUED)

Changes to endowment net assets were as follows for the year ended June 30, 2023:

Endowment Net Assets - July 1, 2022	$ 3,521,960
Investment Income	94,607
Investment Fees	(14,542)
Net Appreciation	86,956
Endowment Net Assets - June 30, 2023	$ 3,688,981

Return Objectives and Risk Parameters

WPHP desires an endowment investment performance that provides reasonable opportunities over the long term for growth of assets and generation of income, while protecting principal to ensure long term sustainability of the programs of WPHP. WPHP has adopted an investment policy in which endowment assets are invested in a manner that is intended to provide a positive rate of return annually. The target investment class allocation is approved by the board of directors based on recommendations from the finance committee and investment consultants.

Strategies Employed for Achieving Objectives

To satisfy its long-term rate-of-return objectives, WPHP relies on an investment strategy that achieves both capital appreciation (realized and unrealized) and current yield (interest and dividends). WPHP targets a diversified asset allocation that can be adjusted by the board of directors based on market conditions.

Spending Policy and How the Investment Objectives Relate to Spending Policy

The endowments are to be thought of as permanent funds. WPHP has adopted a policy whereby all income earned on its quasi-endowment is available to be expended.

Other Board-Designated Net Assets

The board of directors has voted to designate $850,000 for the working capital reserve fund. The purpose of the working capital reserve fund is to ensure the continued high-quality operation of WPHP in pursuit of its mission in times of funding uncertainty or scarcity. The income of the working capital reserve fund shall be reinvested. The board of directors shall authorize any withdrawals from the working capital reserve fund. The balance in this fund was $2,192,972 and $2,014,147 as of June 30, 2024 and 2023, respectively. For the years ended June 30, 2024 and 2023, there were no authorized withdrawals.

NOTE 6 NET ASSETS WITH DONOR RESTRICTIONS

Net assets with donor restrictions of $2,769 are subject to provide assistance for attending the family reunion at June 30, 2024. Net assets with donor restrictions of $15,000 are subject to the passage of time at June 30, 2023.

NOTE 6 NET ASSETS WITH DONOR RESTRICTIONS (CONTINUED)

Net assets were released from donor restrictions by incurring expenses satisfying the restricted purposes or by occurrence of the passage of time or other events specified by the donors as follows for the years ended June 30:

	2024	2023
Expiration of time restrictions	$ 15,000	$ -
Satisfaction of purpose restrictions		
Treatment	3,600	1,775
Reunion	6,411	4,864
	10,011	6,639
Total	$ 25,011	$ 6,639

NOTE 7 COMMITMENTS, CONTINGENCIES AND UNCERTAINTIES

In the normal course of its activities, WPHP may encounter claims in process, matters in litigation, and other contingencies. In management's opinion, the outcome from these matters will not materially impact WPHP's financial position or results of its activities as of June 30, 2024.

NOTE 8 LEASES

WPHP leases office space for a term under a long-term, non-cancelable lease arrangement. The lease expires in March 2030 and provides for renewal option for five years. As of June 30, 2024, there is no expectation that WPHP will exercise the renewal option.

The following table provide quantitative information concerning WPHP's lease for the years ended June 30:

	2024	2023
Lease Costs:		
Operating Lease Costs	$ 208,056	$ 208,056
Other Information:		
Cash Paid for Amounts Included in the Measurement of Lease Liabilities:		
Operating Cash Flows from Operating Lease	$ 254,717	$ 248,504
Right-of-Use Assets Obtained in Exchange for New Operating Lease Liabilities	$ -	$ 1,387,884
Weighted-Average Remaining Lease Term - Operating Lease	5.8 years	6.8 years
Weighted-Average Discount Rate - Operating Lease	2.92%	2.92%

NOTE 8 LEASES (CONTINUED)

WPHP classifies the total undiscounted lease payments that are due in the next 12 months as current. A maturity analysis of annual undiscounted cash flows for lease liability as of June 30, 2024, is as follows:

Year Ending June 30,	Amount
2025	$ 261,085
2026	267,612
2027	274,302
2028	281,160
2029	288,189
Thereafter	220,786
Total Lease Payments	1,593,134
Less: Present Value Discount	127,581
Total Lease Liability	1,465,553
Less: Current Portion	(221,857)
Long-Term Lease Liability	$ 1,243,696

NOTE 9 RETIREMENT PLAN

WPHP has a tax deferred annuity retirement plan under Section 403(b) of the Internal Revenue Code (IRC). Employees are eligible to participate at the date of hire and are eligible to receive the employer contribution upon completing six months of service. Employee contributions are limited to the lesser of 100% of the employee's annual salary or the applicable statutory amounts. Regardless of participant contributions, WPHP contributes an amount equal to 6% of each participant's eligible compensation. For the years ended June 30, 2024 and 2023, the employer contribution to the plan was $98,711 and $97,628, respectively. Employees are immediately vested in the employer contribution.

WPHP has established a nonqualifying deferred compensation plan (the 457 Plan) under Section 457(b) of the IRC for certain key employees. The 457 Plan only allows for employee contributions through payroll deductions. Until the withdrawal date, the contributions to the 457 Plan are legal assets (nontrust) of WPHP and subject to its creditors. Cumulative contributions held are reported separately in the statement of financial position as deferred compensation investments. During the years ended June 30, 2024 and 2023, WPHP recorded a liability for the contributions payable, based on employee deferrals for those fiscal years. WPHP did not contribute to the 457 Plan for the years ended June 30, 2024 and 2023.

NOTE 10 SUBSEQUENT EVENTS

WPHP has evaluated subsequent events through September 18, 2024, which is the date the financial statements were available to be issued.

Washington Physicians Health Program
Statement of Activities
For the Six Months Ending 12/31/2024

	December	Budget	Variance	YTD	Budget	Variance	% of Budget	Previous YTD Actuals
REVENUES:								
State Contract	$293,141	$317,675	($24,534)	$1,784,818	$1,906,050	($121,232)	94%	$1,309,196
University Contract	10,417	10,417	0	62,500	62,502	(2)	100%	62,500
Client Program Fees	24,533	22,568	1,965	144,495	135,408	9,087	107%	142,953
Client Lab Fees	1,929	1,333	596	9,710	7,998	1,712	121%	65,866
Donations	2,625	1,084	1,541	7,730	6,504	1,226	119%	8,600
Investment Returns	(139,769)	11,666	(151,435)	162,951	69,996	92,955	233%	266,482
Other	128	333	(205)	1,705	1,998	(293)	85%	2,006
Total Revenue	193,004	365,076	(172,072)	2,173,909	2,190,456	(16,547)	99%	1,857,603
EXPENSES:								
Payroll Expense	168,499	209,097	40,598	1,118,108	1,254,582	136,474	89%	1,023,292
Employee Benefits	32,261	29,859	(2,402)	161,277	179,154	17,877	90%	135,454
Professional Services	20,387	24,165	3,778	143,372	139,490	(3,882)	103%	66,304
Clinical Services	3,717	1,333	(2,384)	10,662	7,998	(2,664)	133%	24,722
Office Rent	19,890	19,890	0	119,490	119,340	(150)	100%	113,626
Office Expenses	11,252	12,268	1,016	76,472	71,018	(5,454)	108%	59,873
Client Fees Covered	80	208	128	(483)	1,248	1,731	-39%	1,675
Other Client Support	12,817	15,342	2,525	92,683	92,052	(631)	101%	63,985
Other	7,360	18,028	10,668	85,833	115,288	29,455	74%	87,597
Total Expenses	276,263	330,190	53,927	1,807,414	1,980,170	172,756	91%	1,576,528
Increase (decrease) in Net Assets	(83,259)	34,886	(118,145)	366,495	210,286	156,209	174%	281,075

Washington Physicians Health Program
Statement of Position
For the Six Months Ending 12/31/2024

	Current Year	Prior Year	Change
ASSETS			
Checking	$1,088,618	$678,530	$410,088
Interest Maximizer	16,418	211,370	(194,952)
Total Cash	1,105,036	889,900	215,136
Client Receivable	89,003	107,089	(18,086)
University Receivable	31,250	87,500	(56,250)
State Contract Receivable	293,141	405,572	(112,431)
Misc Receivable	0	15,000	(15,000)
Allowance for Bad Debt	(12,025)	(11,192)	(833)
Total Receivables	401,369	603,969	(202,600)
Prepaid Expenses	98,741	107,714	(8,973)
Total Current Assets	1,605,146	1,601,583	3,563
Leasehold Improvements	544,250	544,250	0
Furniture and Equipment	197,073	194,121	2,952
Accumulated Depreciation	(416,724)	(347,121)	(69,603)
Total Property and Equipment	324,599	391,250	(66,651)
Operating ROU Asset	985,140	1,150,776	(165,636)
Baird Acct-Working Capital Reserve	2,216,001	2,119,352	96,649
Baird Acct-Quasi-Endowment Client Support	4,234,652	3,838,849	395,803
Deposits	24,869	24,869	0
Deferred Compensation Investments	352,917	292,522	60,395
Total Long Term Assets	8,138,178	7,817,618	320,560
TOTAL ASSETS	9,743,324	9,419,201	324,123
LIABILITIES			
Accounts Payable	72,386	53,243	19,143
Accrued Wages Payable	87,238	80,202	7,036
Accrued Payroll Related Exp	150,670	136,136	14,534
Total Current Liabilities	310,294	269,581	40,713
Operating Lease Liability	1,356,777	1,572,225	(215,448)
Deferred Compensation Payable	352,917	292,522	60,395
Total Long-Term Liabilities	1,709,694	1,864,747	(155,053)
NET ASSETS			
Prior Year Net Assets	5,161,557	4,974,654	186,903
Temporarily Restricted Funds	2,769	15,000	(12,231)
Board Designated Reserves	2,192,972	2,014,146	178,826
Current Year Net Assets	366,038	281,073	84,965
Total Net Assets	7,723,336	7,284,873	438,463
TOTAL LIABILITIES & NET ASSETS	9,743,324	9,419,201	324,123

Sales Ended

Saturday, April 27

2024 Annual Reunion

Welcome to the 29th Annual WPHP Reunion!

By **Washington Physicians Health Program** • 13 followers

Lots of repeat customers

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Explore similar events

Date and time

April 27, 2024 · 7am - April 28, 2024 · 1:30pm PDT

Location

Cedarbrook Lodge

18525 36th Ave S Seattle, WA 98188

Show map

Refund Policy

Contact the organizer to request a refund.
Eventbrite's fee is nonrefundable.

About this event

Welcome to the 29th Annual WPHP Reunion!

This is a wonderful opportunity to join WPHP program participants, staff, alumni, members of our Board, and their loved ones at the Cedarbrook Lodge in Seattle, Washington as we support each other on the journey of recovery.

The fellowship, personal stories, and educational presentations you will find at this event will enhance your recovery while also providing the newest members of WPHP with support, guidance, and community. It is truly a one of a kind event and we hope to see you this April!

Chris Bundy, MD, MPH

Executive Medical Director, Washington Physicians Health Program

GUEST SPEAKERS

We are delighted to have our special guests highlighted below. For detailed information regarding the event please review our **2024 Program**

Tait Shanafelt, MD – Health Professional Burnout

Dr. Tait Shanafelt is the chief wellness officer, associate dean, and Jeanie and Stewart Richie Professor of Medicine at Stanford University. Dr. Shanafelt is a hematologist/oncologist whose clinical work focuses on the care of patients with chronic lymphocytic leukemia. He served a 7-year term on the National Cancer Institute (NCI) Leukemia Steering Committee from 2014-2020 and has been principle investigator on four R01 grants from the NCI, including two active R01s. He has been the principle investigator on numerous clinical trials testing new treatments for patients with chronic lymphocytic leukemia including two national phase three trials for the Eastern Cooperative Oncology Group (ECOG). He has published over 500 peer review manuscripts and commentaries in addition to more than 200 abstracts and book chapters.

In addition to his leukemia research, Tait is an international thought leader and researcher in the field of physician well-being and its implications for quality of care. His pioneering studies in this area over 20 years ago are credited with helping launch the entire field of organizational efforts to promote physician well-being. He previously served as the founding director of the Mayo Clinic Program on Physician Well-being and served a 3-year term as the president of the Mayo Clinic Voting Staff from 2013-2016. In 2017, he moved to Stanford where he leads the WellMD Center. He served as a member of the National Academy of Medicine Committee on System Approaches to Support Clinician Well-being and now serves on the National Academy Clinician Well-being Steering Committee. He has helped hundreds of organizations and their leaders work to improve burnout and promote professional fulfillment for physicians. Dr. Shanafelt has served as a keynote speaker to the AMA, ACGME, AAMC, and ABIM. Tait's studies in this area have also been cited in *CNN, USA Today, U.S. News,* and the *New York Times*. In 2018, he was named by *TIME Magazine* as one of the 50 most influential people in healthcare.

Mel Pohl, MD, DFASAM – Pain and Addiotion

Dr. Pohl is a Family Practitioner. He is the Senior Medical Consultant of the Pain Recovery Program at The Pointe Malibu Recovery Center. Dr. Pohl is the former Chief Medical Officer of Las Vegas Recovery Center and was a major force in developing Las Vegas Recovery Center's Chronic Pain Recovery Program. He is certified by the American Board of Addiction Medicine (ABAM) Dr. Pohl is a Clinical Assistant Professor in the Department of Psychiatry and Behavioral Sciences at the University of Nevada School of Medicine.

He is a nationally known public speaker and the author of A Day without Pain, revised edition (Central Recovery Press, 2011) and The Pain Antidote - Stop Suffering from Chronic Pain, Avoid Addiction to Painkillers, and Reclaim Your Life (DaCapo, 2015). Dr. Pohl filmed a show for PBS on chronic pain which aired around the country in 2016.

Maggie Knowles – Healing with Money (Workshop)

Maggie Knowles teaches adults about financial literacy and helps seniors with bill-paying and household finances. She belongs to the American Association of Daily Money Managers, whose members provide services such as budgeting, recordkeeping, and fraud detection. Having been in recovery for many years, Maggie is currently writing a book about healing her relationship with money.

She has a B.A. from Swarthmore College, an M.A. from Columbia University Teachers College, and post-graduate work at the University of Washington. Highlights of her career include training 3,000 greeters for an international convention in Seattle, producing television programs in Missoula, Montana, and teaching improv in Lake Chelan. Highlights of her life include trips to Iceland, Northern Ireland, and Brazil.

Courtney Strong, LMHC, SUDP and Lenni Shea, LMHC, SUDP – Mindfulness-based Relapse Prevention (Workshop)

Ms. Strong joined WPHP in 2020. As Clinical Director, Ms. Strong provides training, professional development, and operational oversight of Clinical Coordinators and Facilitators working with WPHP participants. Ms. Strong is also responsible for strengthening partnerships with evaluation and treatment providers and WPHP collaborators while engaging with WPHP leadership to ensure our commitment to accountability, consistency, and excellence. She has a Master of Arts in Counseling Psychology and is a Licensed Mental Health Counselor and Substance Use Disorder Professional who has been working in the behavioral health field for over ten years. Prior to joining WPHP, Ms. Strong served as Director of Edgewood Health Network Seattle. Ms. Strong applies principles of system redesign, organizational health, and relationship building to promote the shared goals of our staff, participants, and community stakeholders.

Lenni is a substance use disorder professional (SUDP) and licensed mental health counselor associate (LMHCA) in the state of Washington. They earned their bachelor's degree in social sciences with a primary emphasis in psychology from Washington State University, a certificate in drug and alcohol counseling from Bellevue College and a master's degree in addiction counseling: integrated recovery for co-occurring disorders from the Hazelden Betty Ford Graduate School of Addiction Studies. They have training in trauma-informed yoga, mindfulness based relapse prevention, Health at Every Size, body liberation, and working with the LGBTGEQIAP+ population. Lenni continues to seek out learning through a social justice mentorship, and opportunities for community-based mutual aid and activism in addition to their formal training.

SCHOLARSHIPS

Thanks to our generous donors, WPHP has scholarship funds available to fully underwrite first time attendees and to assist returning attendees experiencing financial hardship. If you are interested in scholarship support, please apply when registering. You will be asked to provide additional information to determine eligibility. The deadline for scholarship requests is March 8, 2024. Applicants will be notified on March15, 2024. Scholarship awards may not cover the entire cost of Reunion participation.

The WPHP Reunion is only able to accommodate participants and their adult family/key support guests. Please call WPHP directly if you need support with the cost of childcare to facilitate your attendance.

DONATIONS

WPHP has three established donation funds designed to assist program participants:

1. Thomas Hornbein, M.D. Fund

2. The Lynn R. Hankes, M.D. Reunion Scholarship Fund

3. The Daniel O'Neill Family Fund

As is our tradition, last year generous donors stepped forward and underwrote scholarships for 21 participants/key support's who otherwise would not have been able to attend the reunion. WPHP expresses heartfelt gratitude for this strong show of generosity. As you register this year, we encourage you to perpetuate this tradition by donating an amount that is meaningful to you. Thank you so much!

AMBASSADOR PROGRAM

Ambassadors offer warm welcome to new participants and significant others by helping them meet new people throughout the weekend. While first time attendees will automatically be matched to an Ambassador, any attendee is welcome to participate. Just indicate your preference during registration.

ACCOMMODATION/PARKING INFORMATION

WPHP has reserved a room block at the Cedarbrook Lodge for $209/night (+tax) for Friday April 26, 2024 and Saturday April 27, 2024. Cedarbrook is a non-smoking facility with pet friendly rooms; please contact for availability. To receive the group rate, make your reservation online or call and mention our group code 44315 by March 26, 2024.

Cedarbrook has onsite free self-day parking for attendees. Parking for overnight guests is at a discounted rate of $15/day

Address: 18525 36th Ave S, Seattle, WA 98188

Phone: (206) 901-9268

CANCELLATION POLICY

The cancellation fee is $25 on or prior to March 22, 2024. Cancellations after this date will not be refunded.

Q1 Name (optional)

Answered: 19 Skipped: 6

#	RESPONSES	DATE
1	[redacted]	5/2/2024 1:22 PM
2	[redacted]	5/1/2024 6:53 PM
3	[redacted]	5/1/2024 9:01 AM
4	[redacted]	4/30/2024 8:36 PM
5	[redacted]	4/30/2024 1:32 PM
6	[redacted]	4/30/2024 1:03 PM
7	[redacted]	4/30/2024 12:01 PM
8	[redacted]	4/30/2024 10:03 AM
9	[redacted]	4/28/2024 9:33 PM
10	[redacted]	4/28/2024 7:25 PM
11	[redacted]	4/28/2024 4:01 PM
12	[redacted]	4/28/2024 11:55 AM
13	[redacted]	4/28/2024 11:54 AM
14	[redacted]	4/28/2024 11:22 AM
15	[redacted]	4/28/2024 10:28 AM
16	[redacted]	4/28/2024 10:25 AM
17	[redacted]	4/28/2024 10:25 AM
18	[redacted]	4/28/2024 10:21 AM
19	[redacted]	4/28/2024 10:19 AM

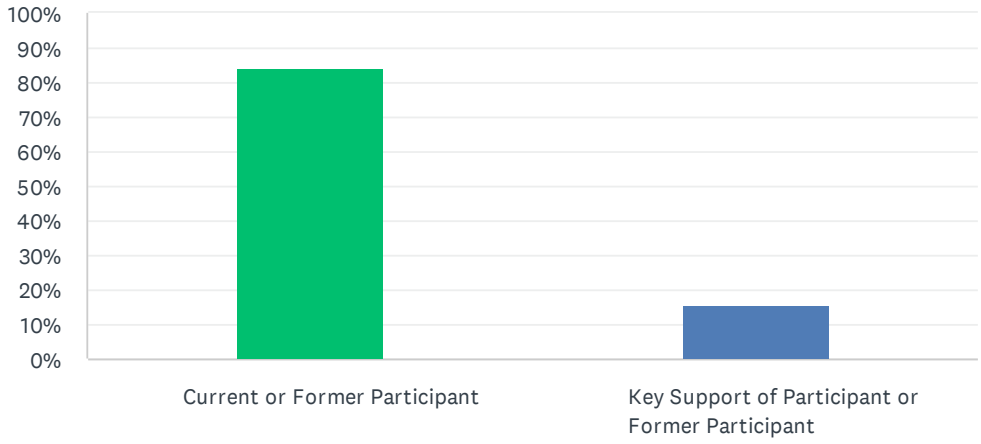
Q2 Profession

Answered: 24 Skipped: 1

#	RESPONSES	DATE
1	Clinical Director	5/2/2024 1:22 PM
2	Physician	5/1/2024 6:53 PM
3	retired SO	5/1/2024 9:01 AM
4	Dentist	4/30/2024 8:36 PM
5	Former Resident Physician; Current Retail Sales	4/30/2024 1:32 PM
6	physician	4/30/2024 1:03 PM
7	MD	4/30/2024 12:26 PM
8	MD	4/30/2024 12:01 PM
9	Physician/ surgeon	4/30/2024 10:32 AM
10	Physician	4/30/2024 10:10 AM
11	Doctor	4/30/2024 10:03 AM
12	PA	4/28/2024 9:33 PM
13	ED doc	4/28/2024 7:25 PM
14	Psych	4/28/2024 4:01 PM
15	m.D.	4/28/2024 11:55 AM
16	Retired doctor	4/28/2024 11:54 AM
17	Physician	4/28/2024 11:22 AM
18	PA-C	4/28/2024 10:29 AM
19	PA	4/28/2024 10:28 AM
20	Internal Medicine	4/28/2024 10:25 AM
21	Massage Therapist	4/28/2024 10:25 AM
22	Radiologist	4/28/2024 10:21 AM
23	Emergency physician	4/28/2024 10:19 AM
24	Physician	4/28/2024 10:08 AM

Q3 Guest Type (check one):

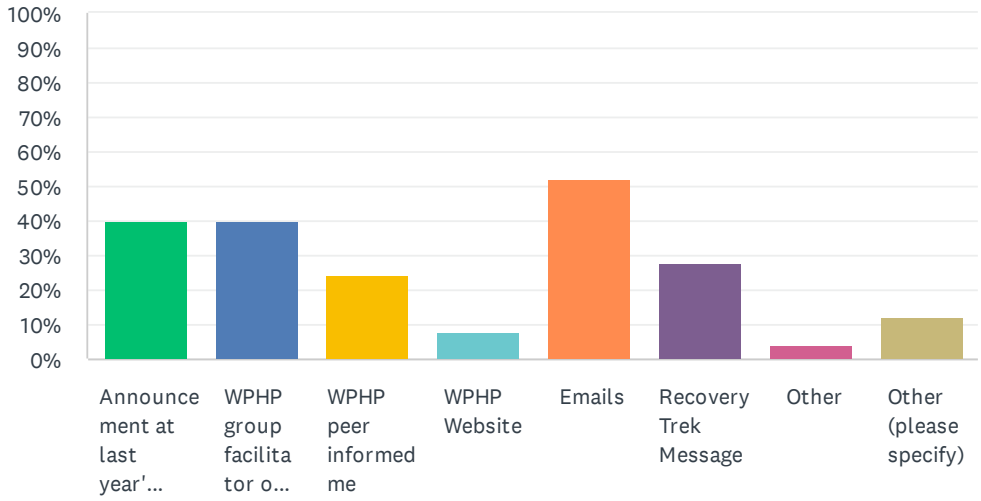
Answered: 25 Skipped: 0



ANSWER CHOICES	RESPONSES	
Current or Former Participant	84.00%	21
Key Support of Participant or Former Participant	16.00%	4
TOTAL		25

Q4 How did you hear about this year's Reunion?

Answered: 25 Skipped: 0

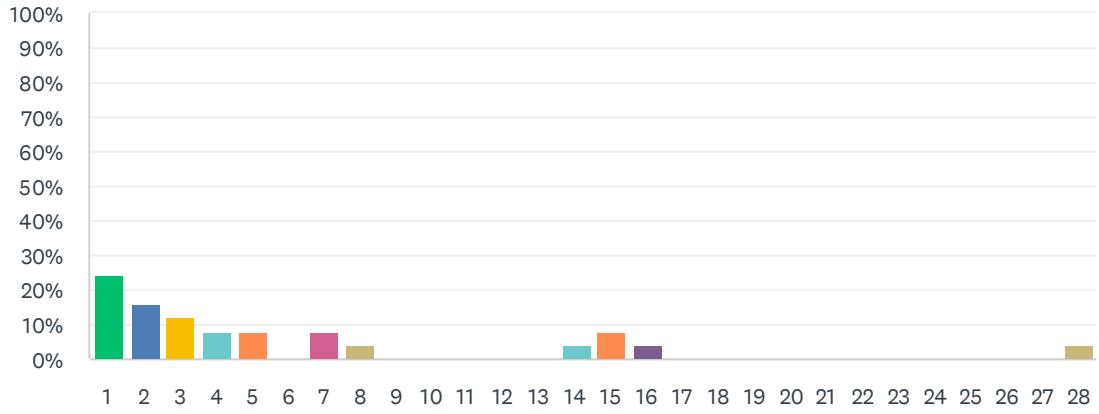


ANSWER CHOICES	RESPONSES	
Announcement at last year's Reunion	40.00%	10
WPHP group facilitator or staff member informed me	40.00%	10
WPHP peer informed me	24.00%	6
WPHP Website	8.00%	2
Emails	52.00%	13
RecoveryTrek Message	28.00%	7
Other	4.00%	1
Other (please specify)	12.00%	3
Total Respondents: 25		

#	OTHER (PLEASE SPECIFY)	DATE
1	Staff	5/2/2024 1:22 PM
2	I've been coming for years and was on the email invite list	4/30/2024 12:01 PM
3	Email	4/28/2024 10:08 AM

Q5 How many WPHP Reunions have you attended? If this is your first Reunion, please select 1.

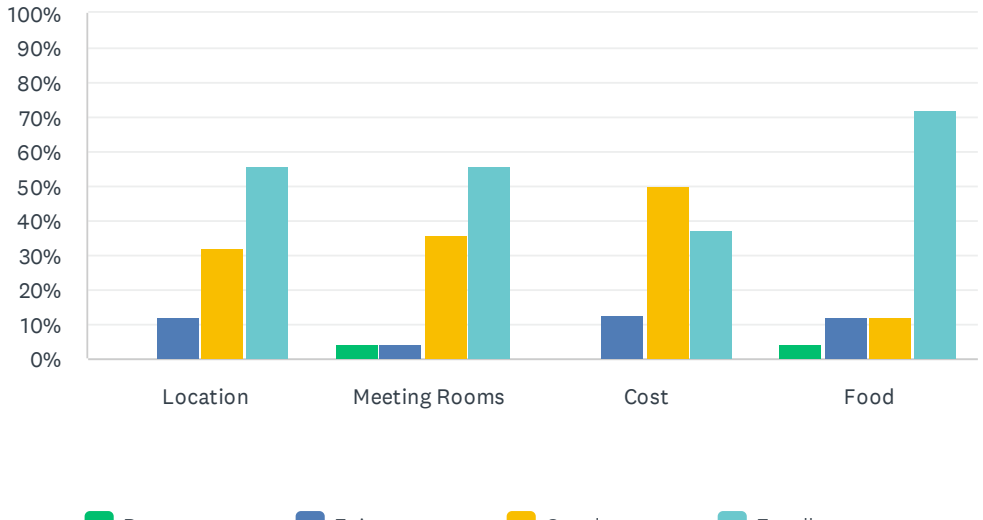
Answered: 25 Skipped: 0



ANSWER CHOICES	RESPONSES	
1	24.00%	6
2	16.00%	4
3	12.00%	3
4	8.00%	2
5	8.00%	2
6	0.00%	0
7	8.00%	2
8	4.00%	1
9	0.00%	0
10	0.00%	0
11	0.00%	0
12	0.00%	0
13	0.00%	0
14	4.00%	1
15	8.00%	2
16	4.00%	1
17	0.00%	0
18	0.00%	0
19	0.00%	0
20	0.00%	0
21	0.00%	0
22	0.00%	0
23	0.00%	0
24	0.00%	0
25	0.00%	0
26	0.00%	0
27	0.00%	0
28	4.00%	1
TOTAL		25

Q6 Please rate the following

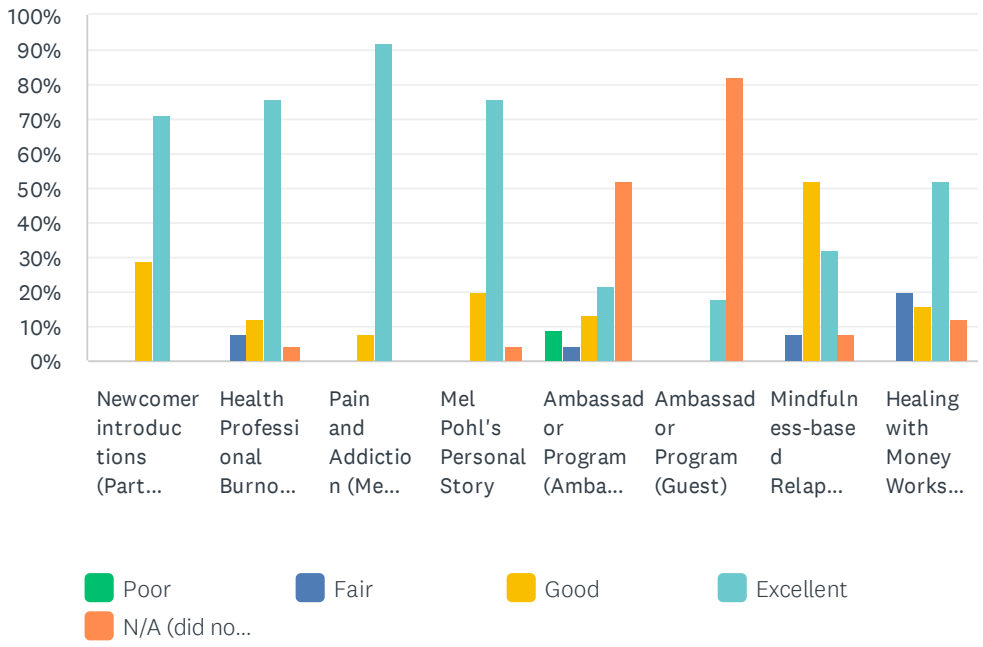
Answered: 25 Skipped: 0



	POOR	FAIR	GOOD	EXCELLENT	TOTAL	WEIGHTED AVERAGE
Location	0.00% 0	12.00% 3	32.00% 8	56.00% 14	25	3.44
Meeting Rooms	4.00% 1	4.00% 1	36.00% 9	56.00% 14	25	3.44
Cost	0.00% 0	12.50% 3	50.00% 12	37.50% 9	24	3.25
Food	4.00% 1	12.00% 3	12.00% 3	72.00% 18	25	3.52

Q7 Please rate the following program elements:

Answered: 25 Skipped: 0



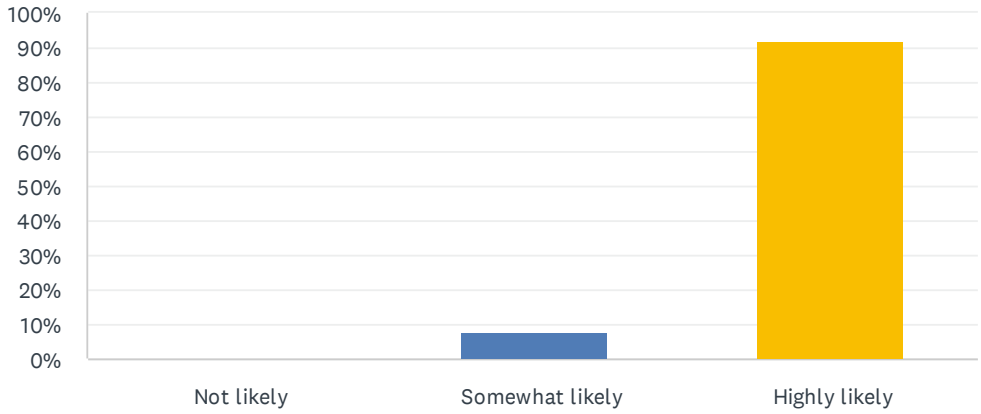
	POOR	FAIR	GOOD	EXCELLENT	N/A (DID NOT ATTEND)	TOTAL	WEIGHTED AVERAGE
Newcomer introductions (Participants)	0.00% 0	0.00% 0	29.17% 7	70.83% 17	0.00% 0	24	3.71
Health Professional Burnout (Tait Shanafelt, MD)	0.00% 0	8.00% 2	12.00% 3	76.00% 19	4.00% 1	25	3.71
Pain and Addiction (Mel Pohl, MD, DFASAM)	0.00% 0	0.00% 0	8.00% 2	92.00% 23	0.00% 0	25	3.92
Mel Pohl's Personal Story	0.00% 0	0.00% 0	20.00% 5	76.00% 19	4.00% 1	25	3.79
Ambassador Program (Ambassador)	8.70% 2	4.35% 1	13.04% 3	21.74% 5	52.17% 12	23	3.00
Ambassador Program (Guest)	0.00% 0	0.00% 0	0.00% 0	17.65% 3	82.35% 14	17	4.00
Mindfulness-based Relapse Prevention Workshop (Courtney Strong, LMHC, SUDP & Lenni Shea, LMHC, SUDP)	0.00% 0	8.00% 2	52.00% 13	32.00% 8	8.00% 2	25	3.26
Healing with Money Workshop (Maggie Knowles)	0.00% 0	20.00% 5	16.00% 4	52.00% 13	12.00% 3	25	3.36

#	COMMENTS	DATE
1	Needed a smaller room or 2 circles for the mindfulness workshop. It was hard to hear. The healing with money session was great. We appreciated all the speakers. Good job!	5/1/2024 9:01 AM
2	I found Dr. Pohl's Personal Story incredibly impactful. He is a captivating speaker, and I appreciated hearing from him. My only feedback regarding the Mindfulness-based Relapse Prevention Workshop would be the proximity to other participants made the practice difficult to	4/30/2024 1:32 PM

	fully embody. I don't see this at all the fault of Courtney or Lenni, as they cannot control the size of the room!	
3	I never was able to make contact with my ambassador assignee. It might be good to have a more formal introduction procedure	4/30/2024 12:01 PM
4	A.) Meat at breakfast B.) Great program, very condense so very little down time or time to enjoy the setting C.) Maybe should start on Friday night? D.) Loved all the presentations, but there should be a 5 min break if one if going to last more than an hour	4/30/2024 10:10 AM
5	Really enjoyed the money and wellness workshop I have never had this topic introduced during my recovery	4/28/2024 9:33 PM
6	This was a stellar group of presenters. I liked that Mel & Maggie were there the whole weekend. Would love to have the slides	4/28/2024 7:25 PM
7	Great group of topics this year! Especially the money talk	4/28/2024 11:54 AM
8	The mindfulness based relapse workshop may benefit from being split into two smaller groups as the size is the room did cause some physical separation from a spiritual connection	4/28/2024 11:22 AM
9	Timing after lunch for Courtney was challenging for me, falling asleep was great. Smaller groups might be better.	4/28/2024 10:28 AM
10	Financial lecture could have been shorter and Mel 1 hour longer.	4/28/2024 10:25 AM
11	I thought dinners were good and breakfasts could have been better.	4/28/2024 10:21 AM

Q8 Based on your experience this year, how likely would you be to encourage someone else to attend a WPHP Reunion?

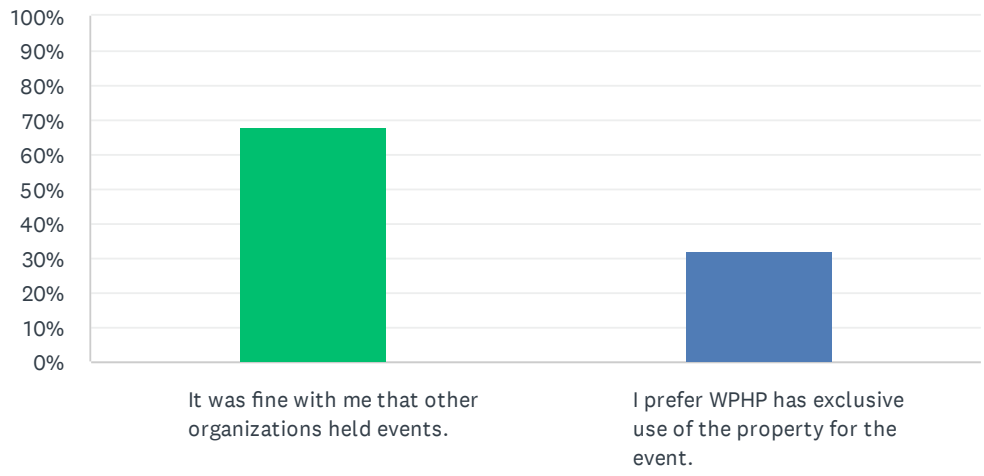
Answered: 25 Skipped: 0



ANSWER CHOICES	RESPONSES	
Not likely	0.00%	0
Somewhat likely	8.00%	2
Highly likely	92.00%	23
TOTAL		25

Q9 At our past Annual Reunion events at Sleeping Lady Resort, we had exclusive use of the entire space. At Cedarbrook Lodge, events by other organizations were also happening. What did you think of this?

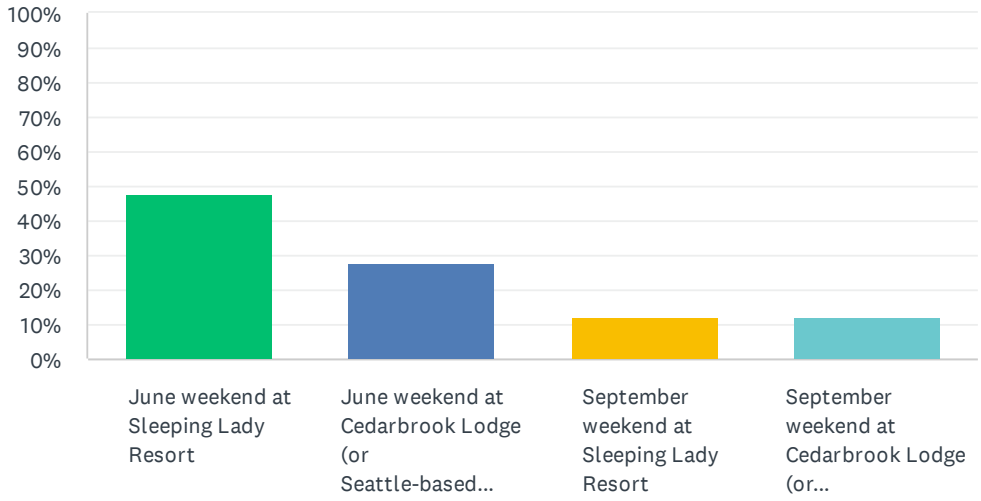
Answered: 25 Skipped: 0



ANSWER CHOICES	RESPONSES	
It was fine with me that other organizations held events.	68.00%	17
I prefer WPHP has exclusive use of the property for the event.	32.00%	8
TOTAL		25

Q10 What is your preference for next year's Reunion?

Answered: 25 Skipped: 0



ANSWER CHOICES	RESPONSES	
June weekend at Sleeping Lady Resort	48.00%	12
June weekend at Cedarbrook Lodge (or Seattle-based location)	28.00%	7
September weekend at Sleeping Lady Resort	12.00%	3
September weekend at Cedarbrook Lodge (or Seattle-based location)	12.00%	3
TOTAL		25

Q11 Do you have suggestions for Reunion speakers or topics you would like to see in the future?

Answered: 11 Skipped: 14

#	RESPONSES	DATE
1	Would love a speaker who somehow focuses on the spiritual side of recovery in a general way	4/30/2024 8:36 PM
2	Stories from doctors who have been through the wphp program and how their journey was Talks about licensure disclosure and career implications	4/30/2024 12:26 PM
3	New trends and modalities in treatment of addiction	4/30/2024 10:32 AM
4	Maybe a presentation by a medical recruiter about challenges and ways to effectively seek employment while being monitored or starting work as a provider in recovery.	4/30/2024 10:03 AM
5	Claudia black	4/28/2024 9:33 PM
6	Trauma informed tx. Generational differences in addiction/treatment.	4/28/2024 4:01 PM
7	Current or recent promising studies in the treatment of professionals with addiction problems	4/28/2024 11:22 AM
8	Case study or ways to engage a provider coullege or peer to peer of engaging recovery treatment	4/28/2024 10:28 AM
9	Father Tom from 2 yrs ago was great and would be a welcome addition	4/28/2024 10:25 AM
10	CME Courses	4/28/2024 10:25 AM
11	None	4/28/2024 10:08 AM

Q12 What did you like most about this Reunion?

Answered: 21 Skipped: 4

#	RESPONSES	DATE
1	Time to chat in between sessions	5/1/2024 6:53 PM
2	Meeting with participants, mindfulness exercises, talk on burn out and pain.	5/1/2024 6:01 PM
3	Always, spending time with other attendees. Newcomer introductions are so very important.	5/1/2024 9:01 AM
4	As always, the fellowship	4/30/2024 8:36 PM
5	The talks were really great, particularly Dr. Pohl.	4/30/2024 1:32 PM
6	the fellowship	4/30/2024 1:03 PM
7	Chance to meet with other participants and get support	4/30/2024 12:26 PM
8	Refuge recovery meeting	4/30/2024 10:32 AM
9	Nice condensed feel	4/30/2024 10:10 AM
10	Ambassador program	4/30/2024 10:03 AM
11	The workshops	4/28/2024 9:33 PM
12	Seeing other PHP friends & reconnecting. The feeling of fellowship is so strong, even with folks I don't know. The program was great, but the feel of all being together is the best part.	4/28/2024 7:25 PM
13	Getting together. Food was remarkably good. Venue was better than expected. Speakers were excellent.	4/28/2024 4:01 PM
14	Seeing people in person since I live out of state now	4/28/2024 11:54 AM
15	The talks were all equally amazing and while varied in topic, had aspects I could internalize and apply to my story	4/28/2024 11:22 AM
16	All of it	4/28/2024 10:29 AM
17	The social breakouts	4/28/2024 10:28 AM
18	It's was very relaxing. The drive from Poulsbo was doable.	4/28/2024 10:25 AM
19	Good speakers, great food	4/28/2024 10:25 AM
20	Seeing old friends and meeting new ones.	4/28/2024 10:21 AM
21	The feeling of overwhelming support	4/28/2024 10:08 AM

Q13 In your opinion, what could we do to improve the Reunion?

Answered: 18 Skipped: 7

#	RESPONSES	DATE
1	It was nice to have a Friday night social gathering in prior years. It was nice to have a physical activity in the morning in prior years.	5/1/2024 6:53 PM
2	A setting where we can be the only group would be best.	5/1/2024 6:01 PM
3	Something missing at Cedarbrook that was at Sleeping Lady-- just walking around the property and constantly running into people and having conversations. Something about being surrounded by nature, a large piece of property, it's peaceful and fills the soul. You can't get that at Cedarbrook with Sea-Tac nearby, although Cedarbrook is lovely. Been there many times.	4/30/2024 8:36 PM
4	It was a long day on Saturday. I did miss the organic "run-ins"/connections with other participants at Sleeping Lady Resort last year during longer breaks throughout the property knowing that everyone present was part of the program. This year, it felt a bit more forced and conference-like.	4/30/2024 1:32 PM
5	Have more mixers for newcomers and ambassadors to bond and get to know one another	4/30/2024 12:26 PM
6	Offer better food	4/30/2024 10:32 AM
7	Start Friday night and have a little free time on Saturday - spa, gym, etc	4/30/2024 10:10 AM
8	Option for childcare during programming	4/30/2024 10:03 AM
9	The Cedarbrook site was fine & convenient, I miss SL it is a spiritually nurturing place, but I don’t have a strong preference. Maybe go there every 2nd or 3rd year? Cedarbrook coffee is terrible.	4/28/2024 7:25 PM
10	Keep’em coming!	4/28/2024 4:01 PM
11	While I know networking and the in person aspect is important, I think if the breaks were shortened by about 15 minutes that would give another opening for a talk. I only bring it up because the talks were so good I want more	4/28/2024 11:22 AM
12	If at sleeping lady would like Fri-Sun	4/28/2024 10:29 AM
13	Walks-> or some type of physical activity.	4/28/2024 10:28 AM
14	As odd as this sounds I miss bacon with my eggs.	4/28/2024 10:25 AM
15	Offer CME courses, have a hike or something similar, later dinner, more marriage/ couples courses	4/28/2024 10:25 AM
16	Dim the lights during slide shows. Second button from the bottom on the dimmer switch.	4/28/2024 10:21 AM
17	CME credits	4/28/2024 10:19 AM
18	None	4/28/2024 10:08 AM

Q14 Testimonial: Please share briefly about your experience as a participant (or key support of a participant) in WPHP. We would love to hear about the impact this program had on your quality of life/work as well as your journey of personal recovery and wellness. By writing this testimonial you agree that your submission may be used for WPHP and/or FSPHP publication and marketing purposes. All submissions will remain anonymous.

Answered: 11 Skipped: 14

#	RESPONSES	DATE
1	I enjoyed having some time on things like mindfulness and money mixed in with talks on recovery.	5/1/2024 9:01 AM
2	WPHP saved my life. I will be forever grateful. If there's anyway I can give back I welcome the opportunity	4/30/2024 8:36 PM
3	WPHP has saved my life	4/30/2024 1:03 PM
4	I appreciate the support and advocacy wphp has given me during my mental health recovery journey.	4/30/2024 12:26 PM
5	Participation is the program has been a key part of my recovery. Without it, my journey would have been less.	4/30/2024 10:10 AM
6	A great retreat and an excellent chance to meet newcomers and fellow DRG members	4/28/2024 9:33 PM
7	I love the WPHP retreat. I see old friends, hear new perspectives & get inspiration to help me recommit to my own recovery. It’s a special experience that goes beyond just the programming which is consistently excellent.	4/28/2024 7:25 PM
8	Renewed again: hope, community, tools.	4/28/2024 4:01 PM
9	I really enjoy the community. It is also good hearing stories of others. I find the relapse stories and people reaching back out to WPHP very valuable as well.	4/28/2024 10:29 AM
10	Better than expected, appreciate the opportunity to network and learn from my peers	4/28/2024 10:28 AM
11	As a spouse, this program has been absolutely amazing for our marriage. Almost feels like a marriage retreat because we come back home with a deeper respect and understanding of each other.	4/28/2024 10:25 AM

2024 Outreach Presentations

Date	Presentation Title	Audience	Location	Number of Attendees
1/18/2024	PMB Licensure Update	Podiatric Medical Board	Seattle, WA (Virtual)	25
1/25/2024	The Power of 10	Washington State Veterinary Medical Association	Olympia, WA	10
1/29/2024	WPHP CA1 Substance Abuse "Wearing Masks"	Virginia Mason Franciscan Health - Seattle	Seattle, WA	20
2/14/2024	Ambassadors for Change	American Dental Association	Seattle, WA (Virtual)	30
2/15/2024	The Washington Physicians Health Program: Partnering to Support the GME Community	University of Washington School of Medicine (UWSOM)	Seattle, WA (Virtual)	50
2/28/2024	WPHP Overview	Kadlec Family Medicine Residency Program	Richland, WA (Virtual)	20
3/9/2024	Effectively Partnering with Physician Health Programs to Support Learners in Difficulty	Accreditation Council for Graduate Medical Education	Orlando, FL	30
3/15/2024	Wellness Survival Guide for Busy Residents	Trios Health - Internal Medicine Residency	Seattle, WA (Virtual)	30
3/19/2024	Nurturing Resident Well-Being through Mental Health support and Crisis Management	University of Washington School of Medicine (UWSOM)	Seattle, WA (Virtual)	88
3/26/2024	Better Together: Physician Health Programs, Liability, and Access	Medical Professional Liability Association	Seattle, WA (Virtual)	30
4/8/2024	Nurturing Resident Well-Being through Mental Health support and Crisis Management	University of Washington School of Medicine (UWSOM)	Seattle, WA (Virtual)	56
4/19/2024	Courageous Compassion: Strategies to Effectively Partner with Graduate Medical Education Programs to Support Trainees in Difficulty	Federation of State Physician Health Programs	Nashville, TN	200
4/24/2024	The Washington Physicians Health Program: Partnering for Success	Washington Association Medical Staff Services	Centralia, WA	110
5/3/2024	Washington Physicians Health Program	Washington State Podiatric Medical Association	Kenmore, WA	45
5/9/2024	Recognizing and Assisting Dental Professional in Navigating Health Challenges?	Washington State Dental Association	Seattle, WA	34
5/15/2024	Physicians Health and Wellbeing	University of Washington School of Medicine (UWSOM)	Seattle, WA (Virtual)	6
5/19/2024	WPHP Annual Report	Washington State Medical Association	Lake Chelan, WA	60

Date	Presentation Title	Audience	Location	Number of Attendees
5/22/2024	WPHP: Resources for Residents (and Program Directors!) in Difficulty	University of Washington School of Medicine (UWSOM)	Seattle, WA	16
5/23/2024	Saving Careers, Saving Lives: WPHP and the Impaired Physician!	University of Washington Psychiatry Residency Training Program	Seattle, WA (Virtual)	26
5/24/2024	Rx for Success: The Washington Physicians Health Program	Medical Board of California	Seattle, WA (Virtual)	70
5/30/2024	Opioid Regulatory Coalition	Federation of State Medical Boards	Virtual	16
6/11/2024	Your Partner in Workforce Wellness	Swedish Health Services	Seattle, WA	23
6/17/2024	Hiding in Plain Sight: Identifying and Addressing Addiction in Health Professionals	University of Washington School of Medicine (UWSOM)	Seattle, WA (Virtual)	190
6/21/2024	Saving Careers, Saving Lives: WPHP and the Impaired Physician	Swedish Cherry Hill Campus	Seattle, WA	60
6/27/2024	Occupational Hazards of Healing Professionals	University of Washington Medicine MEDEX Northwest Seattle	Seattle, WA (Virtual)	159
7/10/2024	Designer Drugs of Abuse	International Doctors in Alcoholics Anonymous	Baltimore, Maryland	75
7/11/2024	2023 Annual Report	Podiatric Medical Board	Tumwater, WA (Hybrid)	12
7/13/2024	Is Sponsorship Necessary for Meaningful and Lasting Recovery?	International Doctors in Alcoholics Anonymous	Baltimore, MA	150
7/16/2024	Introduction to Physician Impairment and WPHP	University of Washington School of Medicine (UWSOM)	Seattle, WA	150
7/16/2024	Introduction to Physician Impairment and WPHP	University of Washington School of Medicine (UWSOM)	Seattle, WA	150
7/16/2024	Introduction to Physician Impairment and WPHP	University of Washington School of Medicine (UWSOM)	Seattle, WA	150
7/25/2024	Physician Health Programs: Partnering for Success	Association of American Medical Colleges	Virtual	40
7/26/2024	2023 Annual Report	Dental Quality Assurance Commission	Tumwater, WA (Virtual)	52
8/8/2024	Saving Lives, Saving Careers: Wellness, Illness, and Impairment in Dental Practice	University of Washington School of Dentistry	Seattle, WA	100
9/9/2024	Reentry to Practice: Insights from the Federation of State Physician Health Programs	Federation of State Medical Boards	Washington DC	25
9/12/2024	2023 Annual Report	Washington Medical Commission	Tumwater, WA	50

Date	Presentation Title	Audience	Location	Number of Attendees
9/13/2024	Strengthening Collaboration	Board of Osteopathic Medicine and Surgery	Olympia, WA (Virtual)	24
9/17/2024	Happy Vets = Happy Pets: A Crash Course on Happiness for Busy Veterinary Professionals	Washington State Veterinary Medical Association	Seattle WA (Virtual)	30
9/24/2024	Better Together: Physician Health Programs, Professional Liability, and Access to Quality Care	Medical Professional Liability Association	Scottsdale, AZ	60
9/25/2024	Physician Suicide and WPHP	University of Washington School of Medicine (UWSOM)	Seattle, WA (Virtual)	33
9/27/2024	Saving Careers, Saving Lives: Update from the Washington Physicians Health Program	Washington State Veterinary Medical Association	Tacoma, WA	8
10/2/2024	Controlled Substances: Keeping Yourself and Your Colleagues Safe	University of Washington Medical Center	Seattle, WA	30
10/3/2024	Making a Difference: Creating a Legacy of Workforce Well-Being	Washington State Hospital Association	Snoqualmie, WA	75
10/14/2024	Wellness, Impairment, and WPHP	Spokane Teaching Health Center	Spokane, WA	14
10/24/2024	The Sick Physician	University of Washington School of Medicine (UWSOM)	Laramie, WY (Virtual)	20
10/25/2024	2023 Annual Report	Board of Osteopathic Medicine and Surgery	Tumwater, WA (Hybrid)	25
10/25/2024	The Sick Physician	University of Washington School of Medicine (UWSOM)	Seattle, WA	40
11/7/2024	Regulation and Rehabilitation: A User Guide to Working with the Washington Physicians Health Program	Washington State Department of Health	Olympia, WA (Virtual)	42
11/9/2024	Legislative and Regulatory Advocacy to Support Physician Wellness	American Medical Association	Lake Buena Vista, FL	60
12/9/2024	2023 Annual Report	Veterinary Board of Governors	Tumwater, WA (Virtual)	80