

UPDATE!

Washington Medical Commission Vol. 9, Fall 2019

Message From The Chair: Annual Report

Alden Roberts, MD, MMM, FACS



The 2019 Fiscal Year Performance Report is now available for the Washington Medical Commission (WMC), and I'd like to devote this message to presenting what I think is important in the report. Our mission is to promote patient safety and enhance the integrity of the profession through licensing, discipline, rule making, and education. What follows is an assessment of our performance based on the data collected over the past fiscal year (July to June), as compared to data from the last 5 years.

Licensing

We currently have about 31,000 licensed physicians and 4100 licensed PA's in the state. Last fiscal year, the WMC issued 2283 new physician licenses and 459 new PA licenses. Most of licensing occurs behind the scenes and is very routine. Only the problem applications are brought to the attention of commissioners.

For new license applications, our goal is to have at least 77% of all **completed** applications issued within 14 days. For the last 5 years, we have greatly surpassed that goal, completing 96% or greater within 14 days. That's great; however, standard MD and PA applications currently take up to 12 weeks from when the WMC **receives** the application to licensure. The big hold-up is generally the required FBI background check, but other reasons for delay include transcript problems or other incomplete portions of the application. While our performance is currently on par with other states (Oregon takes 8-12 weeks from receipt of the application), the WMC has traditionally done considerably better. This increase in processing time arose from unexpected technical, personnel changes and from an increase in the number of applications. A number of steps have been taken to resolve these issues, so I don't expect this to be a problem for much longer.

All bets are off for non-standard license applications. A panel of commissioners was created earlier this year to manage new applications that are not straight forward. Additional information is often required in order to decide if licensure is appropriate. Occasionally, the panel decides that it is not in the best interest of the residents of the state of Washington for the applicant to be licensed in this state, and the application may be denied.

The average time required to process delegation agreements for PA's is 9 days and has been 8-9 days for the past 5 years.

In This Issue

[Fiscal Year 19 Performance](#)

[Executive Director Report: Cultural Competency](#)

[WPHP Report: Setting the Record Straight, Part 1](#)

[Legislative Update: Balance Billing](#)

[Legislative Update: MMR Vaccine Exemption Law Change Rulemaking Efforts](#)

[PA News: PA Certifying Body Pilots Alternative Recertification Testing](#)

[License Renewal Reminder](#)

[Legal Actions](#)

Links To Our Website

[Pain Management Resources](#)

[Update your Physical And Email Address](#)

[Update your Physician Census](#)

[Frequently Asked Questions \(FAQ\)](#)

[Contact Us](#)

WMC Mission

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

Message From the Chair

Discipline

Complaints: Complaints to the WMC can originate from anyone. Last year, we received 1390 complaints, which is considerably less than the 1820 complaints the prior year. Complaints are assessed by a Case Management Team of commissioners, who authorized 46.9% of the complaints received for investigation. The rest were closed as being below threshold for many different reasons, such as billing complaints (which are outside of our jurisdiction) or communications problems (which are usually impossible to adjudicate).

Cases authorized for investigation: In the last 5 years, the percent of cases opened for investigations has varied from a high of 61% in 2017 to a low of 47% last year. While the WMC takes every complaint that we receive very seriously, we also recognize that opening an investigation is very hard on the Respondent (the MD or PA being investigated) and should not happen unless there is enough concerning information in the complaint to warrant opening an investigation. Investigations are thorough and can take a long time.

Number of days to complete investigations: Our goal is to have less than 23% of cases that are authorized for investigation to still be in the investigation stage after 170 days. We have surpassed that goal every year for the last 5 years.

Number of days from authorizing and investigation to close: WMC has a goal to close 77% of cases within 360 days. We have surpassed that goal every year for the past 5 years.

As you can see, this is not a quick process. While we recognize and would like to minimize the angst that an investigation can cause, our primary mission is to promote patient safety and to enhance the integrity of the profession.

Cases Resulting in Disciplinary Actions: Last year only 11% of authorized investigations resulted in disciplinary actions. We are required by law to consider prior complaints when deciding whether or not to authorize an investigation. Patterns of complaints and the number of complaints appear to be significant predictors of a disciplinary action. Practitioners with 10 or more complaints who received yet another complaint last year were disciplined 72% of the time. Practitioners with 5-9 complaints who received a complaint last year were disciplined 46% of the time. The WMC recognizes that some specialties are more likely to generate complaints

than others. Over the last 10 years, 2.4% of licensed physicians in Washington received some form of a disciplinary action. Last year, the WMC only revoked one license. The most common disciplinary actions taken by WMC are educational. A smaller number are practice restrictions which can be temporary or permanent. The WMC commissioners and pro-tems who assess cases and deliberate regarding disciplinary actions are MDs, PAs and public members. They are peers evaluating complaints based on the information provided by the complainant, the respondent, witnesses and the medical chart. Due process is afforded those who disagree with the recommended actions.

Rule Making and Education

The opioid prescribing and monitoring rules went into effect on 1 January 2019. A large educational effort designed to educate clinicians about these rules was launched in July of 2018 and continues to this day. The WMC also sponsored a 2 day educational meeting last October entitled *Engaging Patients: The Road Ahead*. There were 119 participants who attended the sessions, which was a 21% increase over the year prior. Staff and commissioners spoke at a number of conferences around the country on topics such as engaging the public, your rights as a patient, sexual abuse, getting to know the WMC, process, regulations and other gems. The WMC won the Administrators in Medicine *Best of Boards* award. The WMC received several awards from the Federation of State Medical Boards (FSMB). Past WMC Chair, Dr. Warren Howe, received the FSMB *John H. Clark, MD Leadership* award, Mike Farrell, JD received the Award of Merit, and Amelia Boyd (WMC Program manager) received the Award of Merit.

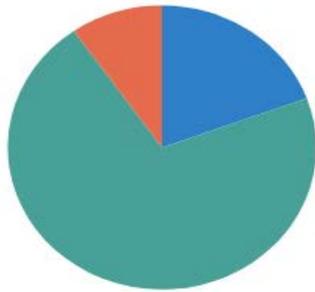
Finally, I would also like to note the work of Washington Physicians Health Program (WPHP). They are completely independent of any of the licensing boards and commissions, although they do work closely with us. Their [annual report](#) is amazing, which is why I want to bring it to your attention. First, 95% of participants receive help without ever being known to the regulatory boards. That is ideal. 90% of participants are still working in their field at completion of their program and 80% of substance use disorder participants are relapse free at 5 years. There is no other program in the surrounding states that comes close to this. There are a number of other remarkable accomplishments by that organization described in their annual report. We are truly fortunate to be able to work with this dedicated group of professionals.

FY19 Discipline Demographics



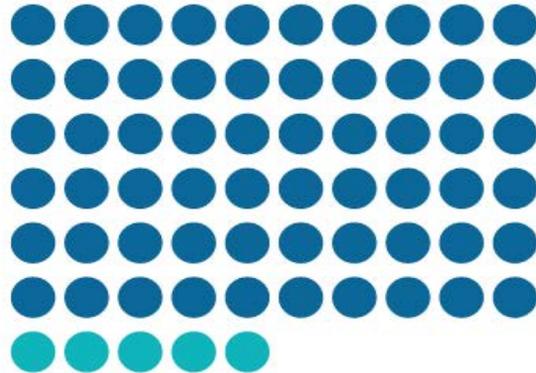
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Where Did They Receive Their Degree?



In State (19.35%) Out of State (70.97%) Foreign (9.68%)

Of The Professions That Have Received Discipline:



MDs (92.31%) PAs (7.69%)

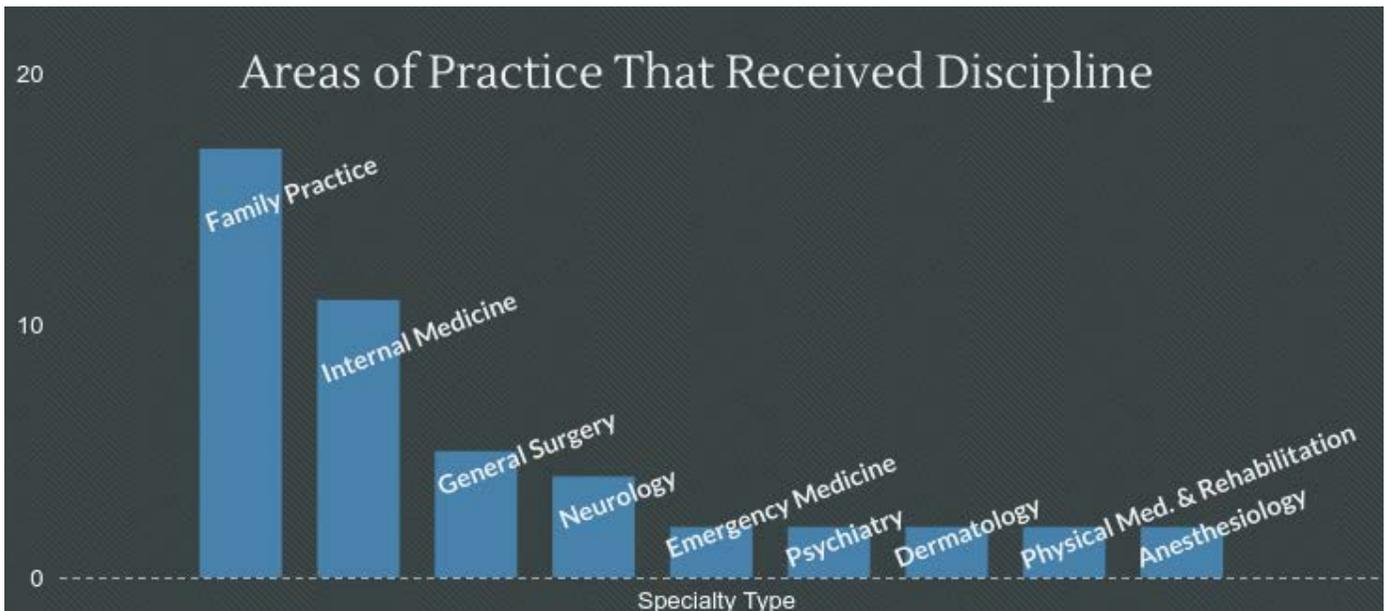
20% Are Female

Range Between the Ages of 30-67



80% Are Male

Range Between the Ages of 38-78

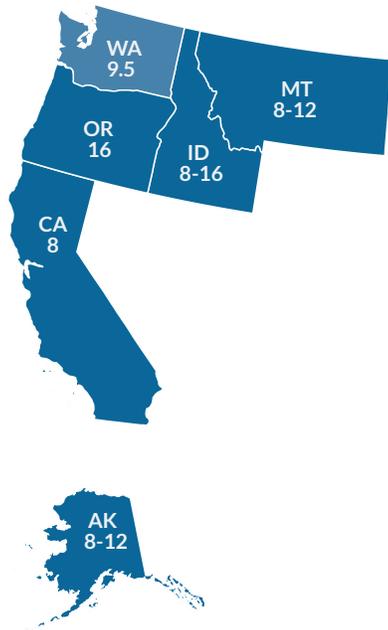


FY19 Licensing Demographics

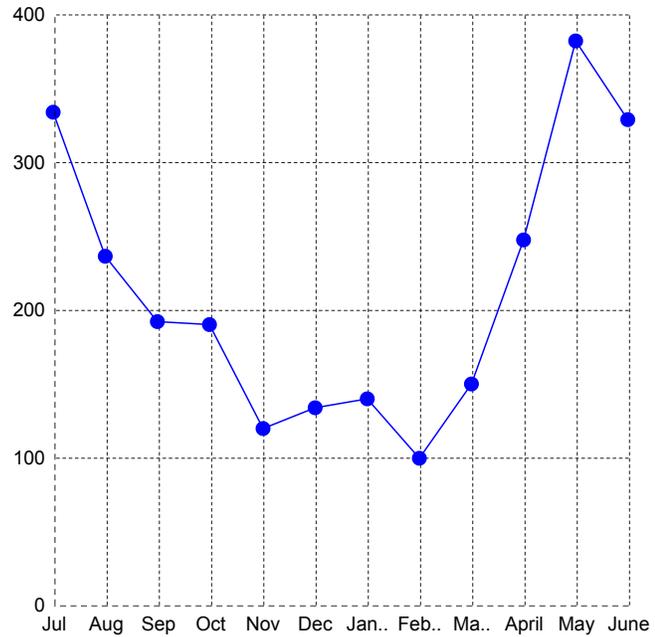


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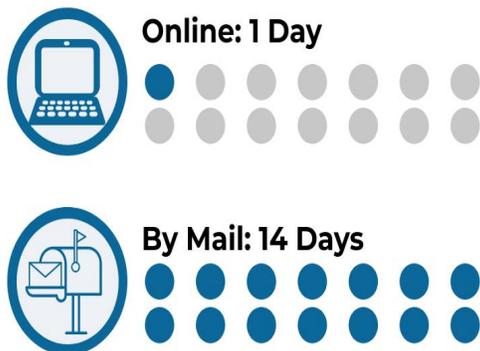
Average Initial Licensing Time (Weeks)



Number of Licenses Issued by WMC by Month



Average Renewal Processing Time



Number of MD and PA Licenses Issued



Executive Director Report: Cultural Competency



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Melanie de Leon, JD, MPA Executive Director

In *Conversations in Cultural Competency's* blog post on March 15, 2018, the author discusses unconscious bias and its impact in healthcare settings. The author explains that our brains process information quickly to allow us to make decisions and take actions, and a majority of this processing takes place in the background, so you don't have to think about most of your actions. For example, you probably don't consciously think about walking across a room to answer a phone.

Unconscious (or implicit) bias occurs when this automatic processing is influenced by stereotypes, which in turn, impact your actions and judgments. A stereotype can be a belief that associates a group of people with certain traits or characteristics or a pre-judgement of a person based on a group they may be associated with, and tend to be fixed and oversimplified images or ideas.

We have all been exposed to messages that define groups of people throughout our life and careers and these messages are repeated by media, teachers, family members and other influencers. Once these messages are internalized, these stereotypes shape our thoughts and actions. And while you may think that you have no prejudice, research indicates that unconscious bias shapes us all.

Unconscious bias can lead to negative outcomes for minority groups in healthcare settings, which contributes to health disparities and a real difference in the access to adequate healthcare. While health disparities are often seen as a racial or ethnic issue, there are many other factors on which unconscious bias is based, such as:

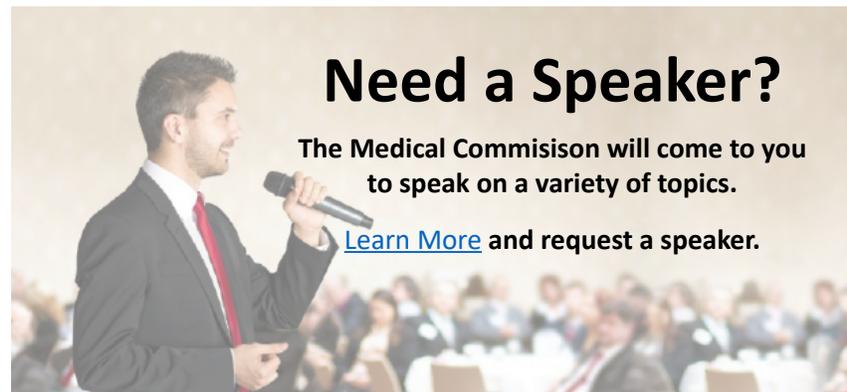
- Sex
- Sexual identity
- Socioeconomic status
- Education level
- Age
- Disability
- Geographic location

To overcome unconscious bias, first you must acknowledge that it exists and no one is immune from its influence. Once acknowledged, you can take steps to control it by recognizing stereotypical thoughts as they occur and discounting them. Instead of relying on assumptions, you train yourself to focus on the individual as your primary source of information.

Strategies to overcome unconscious bias:

1. Recognize stereotypical thinking
2. Replace biases and assumptions
3. Understand the individual
4. Explore a new perspective
5. Increase opportunity for positive contact

Bedford, Megan, "[Unconscious Bias in Healthcare.](#)"
Conversations in Cultural Competency, 15 March 2018



WPHP Report: Setting the Record Straight, Part 1



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Chris Bundy, MD, MPH Executive Medical Director, Washington Physicians Health Program

Since 1986 the Washington Physicians Health Program (WPHP) has served as the legally qualified professional support program in Washington for licensed physicians and physician assistants. We are a small, independent, physician-led, non-profit organization that is contracted with the Department of Health to provide assessment, treatment referral, post-treatment monitoring and advocacy for professionals with health conditions that may impair their ability to safely practice. This is largely possible through laws in Washington that allow WPHP to work with professionals confidentially and without notification or involvement of the disciplinary authority. We endeavor to assist our colleagues, who are often suffering silently, obtain help before a career or life altering event occurs. The decision to refer oneself or a colleague to WPHP can be an internal struggle, fraught with tension and uncertainty. However, we believe that making a good-faith referral to WPHP is a courageous act of compassion for a colleague whose life and career may be at risk.

The work we do at WPHP is both rewarding and challenging. We are granted the privilege of confidentially assisting our brothers and sisters in medicine with the understanding that we will always act in a manner that places public safety first. Protecting this privilege means that the help a physician needs may not always be the help they want. Physicians are generally uninformed regarding national guidelines for the evaluation, treatment and post-treatment monitoring of safety-sensitive health professionals [1-6] or the evidence that supports these recommendations [7-17]. Physicians are rarely (if ever) trained to take care of other physicians and are often unaware of the unique needs of this special population.

Despite a lack of objectivity and absence of expertise in physician health, doctors and other health professionals are often possessed of a misplaced confidence in their ability to assess their own health status and care needs. This is especially troubling when it comes to substance use or mental health concerns, areas in which most physicians are similarly underprepared to assist their patients, much less themselves. Unrealistic expectations of physician perfection, reinforced by the profession and society, greatly intensify the shame, stigma, and fear that can further cloud thinking and judgement. Avoidance, minimizing, rationalization and denial are some of the common defenses mobilized by physicians under such circumstances, deployed with a sophistication that is

directly proportional to their highly developed intellects.

It is therefore not surprising when physicians underestimate or downplay the severity of their health problems and initially resist well-intentioned recommendations that can facilitate healing while keeping the public safe. Earning a skeptical physician's trust, helping them let go of animosity and counter-productive ideas, guiding their adherence to appropriate treatment, creating structured accountability and advocating for their return to practice is often a high-stakes, complex, and emotionally exhausting affair. It is, however, the price of admission to the miraculous transformations we have the privilege to witness along the way. While physicians may be harder to engage in treatment than most, once engaged, they flourish. Through the process we develop enduring relationships with our participants and their families, many of whom stay connected to us and each other years after discharge through our graduate support program and annual reunions. The gratitude our participants express toward us as they overcome their difficulties and begin experiencing lives they and their loved ones never thought possible is one of the most fulfilling rewards of our mission.

In 2018, less than half (44%) of professionals referred to WPHP were recommended to enter into monitoring agreements. In most cases, help and support were offered and concerns of impairment were put to rest. 80% of WPHP program completers describe their experience as "extremely useful" or "life-saving" and 90% are working in their profession at discharge. Only 5% of WPHP participants are known to their disciplinary authority, with about half having been referred to WPHP by the disciplinary authority when an investigation revealed a concern for impairment. This means that WPHP referrals to the disciplinary authority are rare, occurring in only about 2.5% of cases.

While these are impressive outcomes by any measure, there remains a small minority of physicians who are not willing or able to effectively engage with their state physician health program (PHP). Such cases are often complicated and heart-breaking, resulting in a cascade of distressing personal and professional consequences that can irrevocably impact the physician, colleagues, patients and families. Under these circumstances, it is not surprising that a few will become disgruntled, intent on unfairly disparaging PHPs and the PHP model. Their public protestations and allegations are shielded

from scrutiny by strict confidentiality protections that preclude PHPs from responding with facts that might prove illuminating. These one-sided stories can generate sympathetic support from well-intentioned, but often misguided, champions of perceived injustice who draw upon these anecdotes as evidence that PHPs mistreat physicians and that the PHP model is broken. This phenomenon is not new or unexpected given the nature of our work and, because most know otherwise, it has not appreciably tarnished WPHP's reputation or weakened our stakeholders' support.

However, we are now living in a time where the politics of divisiveness and derision seem to have replaced rational deliberation. Baseless opinions are validated and amplified by sensationalistic journalism and social media wherein the truth is unnecessary or irrelevant. Opposing views are categorically dismissed as signs of ignorance, stupidity or even evil. Sadly, we are all susceptible to this false and counterproductive thinking, even those of us trained to use science as the basis of reasoned inquiry. These days, physicians struggling with potentially impairing health conditions may be discouraged from seeking care due to increasing exposure to wider varieties of polarized and unverified opinions masquerading as facts. Getting help is more confusing than ever.

We should not dismiss the concerns of PHP naysayers, for much can be learned from paying attention to our critics, including patience and tolerance. However, I would call upon my medical colleagues with a plea to be ever vigilant in discerning valid and credible sources from those that are not - to use science over supposition. This is how we light the path for those who still suffer while staying attuned to opportunities for our continued betterment.

A core component of WPHP's mission is to provide education and outreach to the medical community we serve. We have an obligation to disseminate accurate information about our mission, outcomes, and the stories of those we have helped. Physicians and concerned others who may need assistance but are paralyzed by disparate portrayals of PHPs deserve a clear view of who we are, what we do and how we do it. In Part II of "Setting the Record Straight" (Update! Winter 2019), I will dive more deeply into the nuances of our program and provide answers to common questions about our policies and practices. If you have questions or concerns you would like to see addressed in future editions of this column, please feel free to submit them through our [website contact form](#).

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Balance Billing

Ariele N. Page Landstrom, JD

WMC Staff Attorney

During the 2019 Legislative Session, the Legislature passed a bill ([2SHB 1065](#)) aimed to protect patients from charges by out-of-network health care providers or out-of-network facilities—a practice called “surprise billing” or “balance billing.” An example of balance billing occurs when a patient visits a hospital emergency room they believe is covered under their insurance plan as an in-network facility; however, the patient is seen by an out-of-network emergency room physician and then is billed the difference between the physician’s rate and the amount that was paid by the insurer.

The new law requires that an insurer must cover emergency services provided by an out-of-network hospital emergency department. An out-of-network provider or facility may not balance bill a patient for emergency services. Additionally, they may not balance bill a patient for non-emergency services provided at an in-network hospital or an in-network ambulatory surgical facility if the services are provided by an out-of-network provider and involve surgical or ancillary (anesthesiology, pathology, radiology, lab, or hospitalist) services. Additionally, an insurer may not seek reimbursement from a patient due to balance billing when the emergency services are provided by an out-of-network hospital in Oregon or Idaho.

What happens if there are violations of this new law? If the Office of the Insurance Commissioner (OIC) believes that any health care provider, hospital, or ambulatory surgical facility has engaged in a pattern of unresolved violations of the new law, the Insurance Commissioner may submit information to the Department of Health for investigation; if the information is regarding a physician or physician assistant, that information would come to the Medical Commission. If the Medical Commission determines a provider has committed a violation, the Medical Commission may levy a fine or cost recovery upon the provider and any other action as permitted under the Uniform Disciplinary Act.

The new law takes effect January 1, 2020. Patients with complaints regarding balance billing on or after this date must file reports with the OIC. For more information, visit the [OIC’s website](#).

MMR Vaccine Exemption Law Change 2019

Kathy Bay DNP, RN, CENP

**Clinical and Quality Assurance Section Manager
Office of Immunizations and Child Profile**

Washington State Department of Health

In 2019, the Washington State Legislature passed a bill that removes the personal and philosophical option to exempt children from the MMR (measles, mumps, and rubella) vaccine required for school and child care entry. It also requires employees and volunteers at child care centers to provide MMR vaccination records or proof of immunity. The bill went into effect on July 28, 2019.

Practitioners see a wide variety of parental approaches during appointments. The one underlying theme that is almost consistently present is the goal by the parent to make the best decisions and protect their child. When there is a disagreement about the best plan of care, the conversation can become very challenging. Specifically related to management of immunizations and vaccine-preventable diseases, the role can be even more fraught with issues. Scientific research has documented the reduction of vaccine-preventable disease due to immunizations. Unfortunately, research also indicates that people are influenced by anecdotal stories and misinformation they may read about online or hear about through non-healthcare sources. Given the impact of the House Bill 1638, the new Washington state immunization law removing personal and philosophical belief exemptions, parent conversations about exemptions may be more difficult.

Some practitioners reported concerns there might be a huge influx of visits causing scheduling difficulties or leaving some children unprotected. It’s good to remember that this law will not affect most students. Almost 9 out of 10 kindergartners in Washington are complete with both doses of MMR vaccine, and overall, only three percent of K-12 students have an exemption to MMR. Students who are complete for their immunizations, along with those who have medical or religious exemptions, are not affected by the new exemption law.

What Changed

- Washington state law no longer allows a personal/philosophical option to exempt children from the requirement to be fully immunized against measles, mumps and rubella diseases for school and child care entry.

Legislative Update

- The law applies to both public and private schools and licensed child cares.
- The law also requires employees and volunteers at licensed child care centers to provide immunization records indicating they have received the MMR vaccine, or provide proof from a practitioner that they are immune to measles or have a medical contraindication.

What Did Not Change

- The new law did not change religious or medical exemptions.
- The list of vaccines required for school and child care entry did not change.
- Personal/philosophical exemptions are still available for all vaccines except MMR.

What's the Practitioner's Role?

The recent measles outbreaks in Washington and the ongoing outbreaks across the United States demonstrate why the change to the vaccine exemption law was enacted to help keep Washington healthy and safe from three serious diseases. The Department of Health and healthcare practitioners must work to help parents and the public understand the safety record of vaccines and the critical role they have in saving lives.

Patients who are students

- Offer all recommended and age-appropriate immunizations to your patients to protect them from serious diseases.
- Help parents and guardians understand the safe, proven protection of vaccines and why you are recommending them.
- If a parent or guardian asks for an exemption for personal or religious reasons, counsel them on the benefits and risks of immunizations. Your signature on the exemption form indicates you have done this education; it does not mean you have assessed their beliefs or religion.

A medical exemption may be used to exempt a child from one or more vaccine requirements if in your judgment, a specific vaccination is not advisable for the child for medical reasons. Find the Advisory Committee on Immunization Practices' "Guide to Vaccine Contraindications and Precautions" [here](#). Medical contraindications to a vaccine are rare.

Patients who are child care workers or volunteers

- The new law requires that staff and volunteers at licensed child care facilities provide one of the following options:
 - Immunization records showing they have received the MMR vaccine.

- Proof of immunity to measles through documented lab evidence of antibody titer.
- A healthcare provider's attestation of the person's history of measles sufficient to provide immunity against measles. (The provider may consider CDC guidance for evidence of immunity, including for those born before 1957.)
- Written certification, signed by a Washington-licensed MD, ND, DO, ARNP, or PA, that the MMR vaccine is not advisable for that person.
- If a child care worker can't find their records, the Centers for Disease Control and Prevention recommends repeating the vaccine if there is no medically verified record that the shot was given.
- If the worker doesn't have records and declines vaccination or revaccination, they may ask for your help obtaining another qualifying option as listed above, such as a titer test. Consult with your patient to determine the best option for them in your medical judgment.
- Staff and volunteers may not be exempted from the requirement to provide documentation of immunity for personal and religious reasons.

More Information

To help answer questions and share the current status, DOH has created an [exemption law change webpage](#). This page contains information and resources on school and child care immunization requirement changes, including frequently asked questions you can use to find answers to what you hear most often from your patients. The page is updated as more questions are submitted.

If you'd like to know more about school immunization requirements or the Certificate of Exemption, visit the department's [School and Child Care Immunization website](#).

Washington Clarification Letter on 2017 Opioid Rules

Washington State Boards, Commissions and the Department of Health have composed a letter to clarify the 2017 opioid prescribing rules. We have received reports of patients on chronic opioid therapy whose opioids have been rapidly tapered or discontinued. We are also hearing reports of patients on chronic opioid therapy who are unable to find providers willing to care for them. The purpose of this letter is to help you better understand the existing rules around prescribing opioids and managing existing patients on chronic opioid therapy so that you feel comfortable continuing to care for these individuals. [Read the letter](#) in its entirety and [contact us](#) if you have any questions.



Amelia Boyd Program Manager

Substitute Senate Bill 5380 – Concerning opioid use disorder treatment, prevention, and related services. [Substitute Senate Bill \(SSB\) 5380](#) was passed by the legislature on April 16, 2019. The bill is concerning opioid use disorder treatment, prevention, and related services and mandates that the WMC adopt rules for both allopathic physicians and physician assistants. A stakeholder workshop was held on July 10, 2019. On July 12, 2019 the WMC approved initiating the next step in the rulemaking process, Proposed Rule Making (CR-102).

For more information about these rules, please visit our [website](#)

Chapter 246-919 WAC

The [CR-101](#) for Chapter 246-919 WAC was filed with the Office of the Code Reviser on January 2, 2018 as WSR #18-02-079.

The WMC is considering updating the chapter to more closely align with current industry standards and provide clearer language for licensed allopathic physicians. In addition, RCW 43.70.041 requires the WMC to review its administrative rules every five years to ensure that regulations are current and relevant.

Rule amendments being considered will potentially benefit the public's health by ensuring participating providers are informed and regulated by current national industry and best practice standards.

On July 12, 2019 the WMC approved initiating the next step in the rulemaking process, Proposed Rule Making (CR-102).

For more information on this rule, please visit our [rulemaking site](#).

Clinical Support Program

The [CR-101](#) for WAC 246-919-XXX Physicians and WAC 246-918-XXX Physician Assistants was filed with the Office of the Code Reviser on February 22, 2018 as WSR #18-06-007.

The WMC is considering creating two new rule sections, and revising related rule sections as appropriate, to establish a clinical support program (program), its criteria and procedures for allopathic physicians and physician assistants. The intent of the program is to assist practitioners with practice deficiencies related to consistent standards of practice and establish continuing competency mechanisms that will protect patients proactively through a plan of education, training and/or supervision. The WMC may resolve practice deficiencies through the program at any point in a practitioner's period of licensure.

The program would allow for quick identification of issues requiring clinical support, through practitioner or employer inquiry, referral, and including complaints that may not rise to the level of a license sanction or revocation. These issues could be resolved with voluntary participation from the allopathic physician or physician assistant in the program. The WMC is considering education, training, supervision, or a combination of the three as part of the program. Issues appropriate for clinical support would likely include but are not limited to practice deficiencies such as a failure to properly conduct a patient assessment or document treatment. This also allows an allopathic physician or physician assistant a structured process to quickly improve his or her clinical skills.

Finally, participation in this program places the commission in an active patient safety role.

For more information on this rule, please visit our [rulemaking site](#).

More Information

For continued updates on rule development, interested parties are encouraged to join the WMC [rules GovDelivery](#).



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PA News: PA Certifying Body Pilots Alternative Recertification Testing



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James Anderson, PA-C Physician Assistant Member

What's happening in the PA profession related to recertification (aka Maintenance of Certification (MOC)) is a microcosm of the larger medical/nursing landscape. For decades, the model has been to take a high-stakes certification test when starting practice, and then repeating every X years. But a few years ago, there started to be a revolt in the medical/nursing world about this model. Many providers who are required to take some sort of recertification exam started to say enough is enough.

There are many effective arguments against high-stakes, expensive recertification exams. As always in medicine, everyone's got their own data, but there's precious little convincing data that high-stakes recertification tests are actually effective measures of a provider's ability to practice, and there is also a body of data that suggests standard CME is every bit as effective in skill-maintenance as studying for a gargantuan exam.

I've been a PA for over 19 years, and I have yet to spend one day in primary care, instead finding myself in addiction/pain medicine for most of my career. This has made the high-pressure, high-stakes recertification exams a nightmare for me and other specialty PAs. The last such exam I took was over six years ago, and after spending six months studying all the medicine that I have never practiced, I walked into the exam center practically hallucinating with pressure and information-overload, magnified by the knowledge that if I failed this exam, I might not be able to continue to work as a PA. It was not pretty.

As the test began, I tried to have my game face on, ready to rock and roll. This was until I had never heard of any of the conditions in the first five question. "I'm toast," I thought. "It's over." I must admit that this is the way I have felt for every certification-recertification test I have ever taken, and somehow (computer error?) I've managed to eke out passing scores on them all. Go figure.

There are many PAs/NPs/MDs who have faced the same predicament, and many have been standing up and saying "enough." There's been a year's long revolt from members of the American Board of Internal Medicine, with members calling foul over being required to take expensive and high-stakes recertification exams. A 2018 [Newsweek piece](#) noted: "Why should doctors be forced to keep ladling out cash and spending time away from their practices studying useless information..."

Based on ongoing concerns amongst PAs, the national PA association the American Academy of Physician Assistants

(AAPA) has undertaken a vigorous collaboration with the independent PA certifying body the [National Commission on Certification of Physician Assistants](#) (NCCPA) to look at possible alternative to the 200-question exam serial exams. While from the outside it appears that some of this collaboration has been a little rocky, the result has been for NCCPA to create a model [pilot project](#) that could significantly alter the PA recertification model. Rather than going to a testing center and taking a 200-question exam once every ten years, the model has PAs taking 25-question tests every quarter, with a total of eight such exams completed in two years. PAs can take the 25 question exam all at once or in chunks, since the exam can be taken on any computer with internet access. Test-takers are also allowed to use reference material to answer the question, although the time to answer the questions is not much, ranging from three to five minutes per question.

The pilot started in January of 2019, and will last through December 2020. Those who fail the exam will be given a year from that time to complete the standard 200 question recertification test.

More than [18,500 AAPA members](#) signed up for the pilot project, reflecting a clear desire by many PAs to move to more user-friendly recertification project. I'm one of them, and while we're just 3/8 of the way through the two year process, I have found the pilot model to be much less stressful, as well as more compatible with learning from such an exam.

Results from the first quarterly set of 25 questions showed interesting results, providing evidence of how this model may be a better way for PAs to integrate exam taking into their practice.

While there are many PAs who assert that the data does not support the usefulness of any ongoing recertification models, this is a big-step toward re-thinking the role and process of PA recertification. Once the pilot is completed, there will be consideration of making such a recertification option permanent, giving PAs who want an alternative to the 200-question testing model a choice that may better fit their learning and testing style.

I'd love to hear from APRNs about the how these issues are playing out in the nursing world. [Send the WMC an email](#) to comment.



May 1, 2019 – July 31, 2019

Below are summaries of interim and final actions taken by the Medical Commission. Statements of Charges, Notices of Decision on Application (with exceptions), Modifications to Orders (with exceptions), and Termination Orders are not listed. We encourage you to read the legal document for a description of the issues and findings. All legal actions can be found with definitions on the Medical Commission [website](#).

Practitioner Credential and County	Order Type	Date	Cause of Action	Commission Action
Summary Actions				
Olsson, Roger MD00015303 Snohomish	Ex Parte Order of Summary Action - Restriction	05/10/19	Alleged failure to document any rationale for administering testosterone injections in an unproven and unapproved manner, at a high frequency and at high dosages.	Restriction – no prescribing hormones; prior prescribing restrictions remain in place.
Interim and Formal Actions				
Boyd, Richard MD00016580 Yakima	Final Order	06/05/19	Respondent is unable to practice with reasonable skill and safety due to a health condition.	Indefinite suspension.
Ferrin, Lance MD00042068 Spokane	Agreed Order	05/16/19	Failure to properly document and manage a suspected polyp. Performance of an unnecessary procedure on a patient recovering from surgery.	Written research paper, practice reviews, personal appearances, \$2,000 fine, and termination no sooner than two years.
Holland, Robert MD00037746 Pierce	Final Order - Waiver	05/22/19	Sexual misconduct.	Suspension for no less than one year. Payment of \$500 fine and psycho-sexual evaluation prior to petitioning for reinstatement. Restrictions for no less than five years once reinstated.
Pearson, Sean PA60610092 King	Final Order	06/13/19	Respondent is unable to practice with reasonable skill and safety due to a health condition.	Indefinite suspension.
Informal Actions				
Bailey, Christopher MD00041575 King	Informal Disposition	07/11/19	Alleged failure to properly manage a patient's medication dosage.	Develop and implement a written protocol, personal appearances, \$1,000 cost recovery, and termination no sooner than completing requirements.
Carlson, Robert MD00036284 King	Informal Disposition	07/11/19	Alleged failure to properly manage a patient's medication dosage.	Clinical coursework, written research paper, practice reviews, consult with prescribing providers before changing medication orders, personal appearances, \$1,000 cost recovery, and termination no sooner than 18 months.

Dienst, William MD00025927 Pacific	Informal Disposition	05/16/19	Alleged clinical negligence, below standard recordkeeping, failure to perform assessments and diagnoses, and substance misuse.	Voluntary surrender.
Larsen, L. Royce MD60528249 Stevens	Informal Disposition	07/11/19	Alleged inappropriate use of hospital computers.	Ethics coursework, written research paper, personal appearances, \$1,000 cost recovery, and termination no sooner than one year.
Lasselle, Donald MD00035782 Yakima	Informal Disposition	07/11/19	Alleged failure to properly respond to a patient's post-partum hemorrhaging and to properly direct other staff.	Evaluation by physician health program and compliance with recommendations, self-reports, personal appearances, \$2,000 cost recovery, and termination no sooner than four years or discharge by PHP.
Leinweber, Eldon PA10004217 Douglas	Informal Disposition	07/11/19	Alleged negligent prescribing and recordkeeping.	Voluntary surrender.
Nair, Shalini MD60447974 King	Informal Disposition	07/11/19	Alleged under treatment of an acute pain patient.	Acute pain management coursework, review of AMDG opioid prescribing guidelines, written research paper, peer group presentation, utilization of PMP, personal appearances, \$2,000 cost recovery, and termination no sooner than 1 year.
Overstreet, Frederica MD00037897 King	Informal Disposition	05/08/19	Alleged failure to comply with a Commission order.	Compliance with PHP monitoring, pain management rules, self-reports, personal appearances, \$1,000 cost recovery, and termination no sooner than discharge by PHP.
Rosenfeld, Justin MD60166751 Out of state	Informal Disposition	07/11/19	Alleged negligent communications with a patient and premature ordering of diagnostic testing.	Acute headache coursework, patient communications coursework, written research paper, peer group presentation, personal appearances, \$1,000 cost recovery, and termination no sooner than 2 years.
Ryan, Patrick MD00035330 King	Informal Disposition	07/11/19	Alleged delayed diagnosis.	Clinical coursework, written research paper, peer group presentation, personal appearances, \$1,000 cost recovery, and termination no sooner than 2 years.
Song, Bonnie MD00046439 Clark	Informal Disposition	07/11/19	Alleged improper delegation of duties beyond the scope of support staff.	Written research paper and protocol regarding administration and pediatric dental anesthesia and scope of practice of support personnel, practice reviews, personal appearances, self-reports, \$1,000 cost recovery, and termination no sooner than 2 years.
Tan, Lynne MD060148552 Pierce	Informal Disposition	05/16/19	Alleged delayed diagnosis and testing.	Written research paper, peer group presentation, at least one personal appearance, \$1,000 cost recovery, and termination no sooner than completion of all requirements.

Todd, Mari PA10003883 King	Informal Disposition	05/16/19	Alleged misrepresentation of study results, misrepresentation of lab results, and inappropriate workplace behavior.	Boundaries coursework, written research paper, personal appearances, \$2,000 cost recovery, and termination no sooner than 18 months.
Trevino, Maria MD00038461 Ferry	Informal Disposition	04/11/19	Respondent allegedly signed prescriptions for another physician without performing patient examinations.	Ethics coursework, written research paper, practice reviews, personal appearances, recordkeeping restriction, \$2,000 cost recovery, and termination no sooner than 2 years.

Stipulated Findings of Fact, Conclusions of Law, and Agreed Order: A settlement resolving a Statement of Charges, and containing an agreement by the licensee to comply with certain terms and conditions to protect the public.

Stipulated Findings of Fact, Conclusions of Law, and Final Order: An order issued after a formal hearing before the Commission imposing certain terms and conditions to protect the public.

Stipulation to Informal Disposition (STID): A settlement resolving a Statement of Allegations., and containing an agreement by the licensee to comply with certain terms and conditions to address the Commission’s concerns.

Ex Parte Order of Summary Action: An order summarily restricting or suspending a licensee’s practice of medicine. The licensee has an opportunity to defend against the allegations supporting the summary action.

