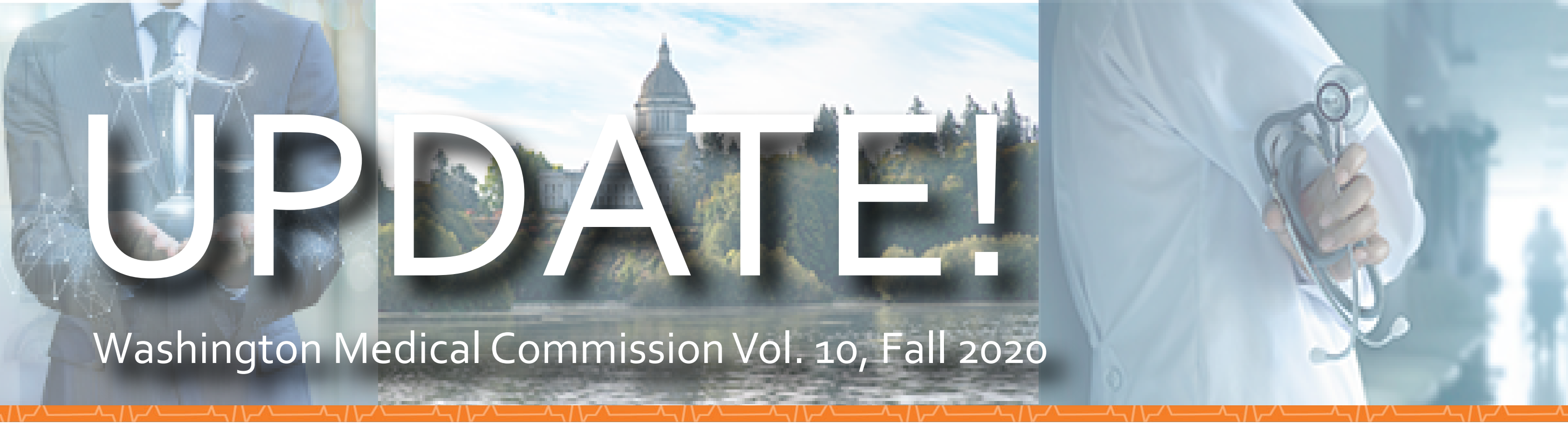


UPDATE!

Washington Medical Commission Vol. 10, Fall 2020

Message From The Chair: Introductions

John Maldon

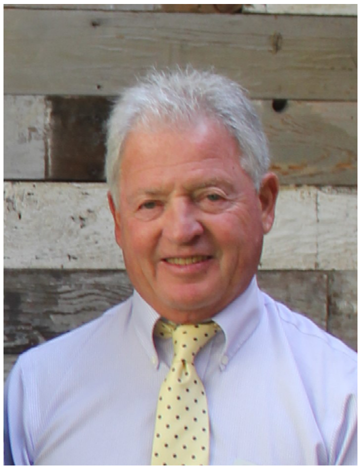
I am John Maldon, newly elected (July) Chair of the Washington Medical Commission (WMC). One might wonder why a non-physician public member is qualified to chair a regulatory agency that oversees physicians and physician assistants. And, why for the first time in over 15 years, a non-physician was elected WMC chair. I would like to introduce myself and provide a brief overview of my background that may provide a rationale for my recent elevation to chair of the WMC.

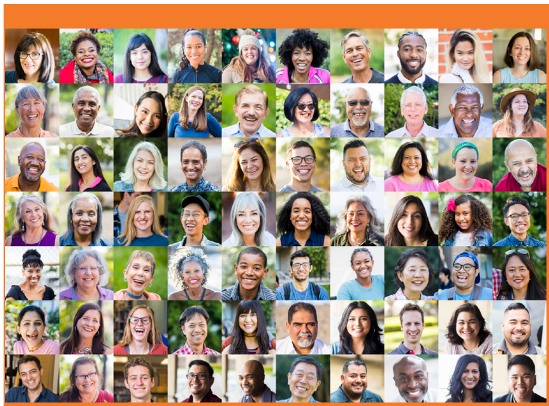
I was appointed to the WMC in 2014. I became an officer of the WMC in 2017, then being elected to 2nd Vice Chair followed by election to 1st Vice Chair in 2018 and 2019. These elected positions came with appointment to the Executive Committee with responsibilities for contributing to and overseeing overall governance of the WMC. Three years of Executive Committee participation and six years of daily commission business provided the experience and insight to ultimately ascend to Chair by vote of my commission colleagues.

Prior to retirement, the last fourteen years of employment were with the former Group Health of Washington, where I was the Executive Director of Risk Management. Responsibilities of the position included: management and supervision of medical professional liability, workers compensation, general liability, property, risk finance, and a committed consultant to Group Health Permanente physicians.

My career began with a large multiline insurance carrier where I had the opportunity to learn broad based liability that ultimately led to specializing and leading a medical malpractice unit that managed medical, hospital and dental litigation.

During my career in healthcare risk management, I have managed and supervised thousands of medical malpractice cases. The interesting aspect of this work is each case has its unique character, but the anatomy, medical terminology and treatment regimen (in general) remain relatively the same. At the end of each case, you learn all there is to know about the disease process, treatment, surgical technique and terminology that is at issue with each case. Fortunately, a fair amount of this knowledge has been retained.





In This Issue:

WMC Mission

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

Message From the Chair

This background has been invaluable to me when participating in WMC complaint management and adjudication of investigated complaints.

My background includes significant exposure to legal processes. I have been deposed many times, sat in on hundreds of depositions, testified at several trials and have been sued in work related litigation. While I did not go to law school, I enrolled in course work for three years in legal theory and processes. This experience fits well into the WMC daily work.

Midway through my career in risk management, I was recruited to work for a newly formed county agency. This appointment was seemingly far from my past employment experience but became an invaluable work experience providing a wide range of learning opportunities including how to do business in the public sector.

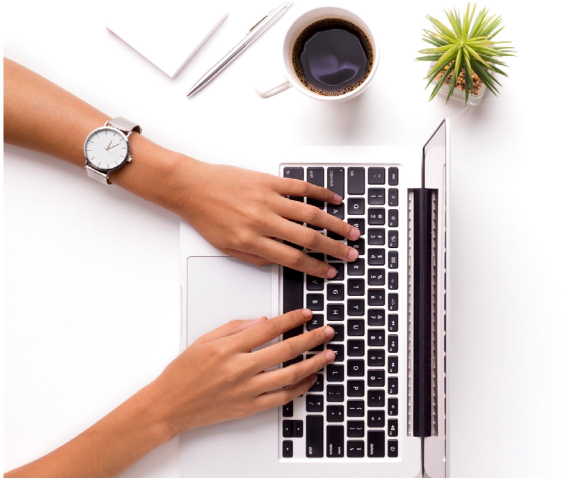
In summary: healthcare risk management, practical legal knowledge, administrative and supervisory responsibilities and public sector experience fit well with the mission of the WMC.

What I hope to accomplish as chair of the WMC
When I joined the WMC, it seemed to me that the focus of physician discipline was punitive. This thought process struck me as wrong. Prior to being appointed to the WMC, my work with physicians focused on improving the delivery of medicine, learning from adverse events, changing protocols and procedures as a result of an adverse medical outcome, transparent conversations with patients about what went wrong while employing "Just Culture" principles when working with physicians. The WMC has moved in this direction but more "Just Culture" thinking needs to be employed during the adjudication process. It is my hope to further these thought processes.

The WMC works diligently to bring cases to a conclusion. But, there is room for improvement by staff and commissioners. I can recall many counseling sessions with physicians who received the dreaded WMC letter. The anguish of not knowing what patient, not knowing what motivated the complaint and not knowing the impact on their future as physicians. Process transparency is now in place. Licensees can now contact investigators and learn about the process and timing of bringing their cases to conclusion. This is a significant change and should help to alleviate some anxiety.

Unfortunately, the practitioner-commission relationship is adversarial by process. We hope that in cases of medical error, the process can become more collaborative. A step in this direction, currently in development, is a procedure for publishing selected respondent scholarly papers in this newsletter. The thought is to share the respondent's learning with our many readers who may have an opportunity to use the information in their practices. Working collaboratively may be wishful thinking, but if the goal is improved medical delivery and patient safety, then why not?

You may notice that in this edition of Update! we are focusing on disparities present in healthcare. The executive committee published a statement on racism being a public health issue over the summer, and we are taking this work very seriously. At the WMC, we believe that everyone should have the same access and opportunities for the best possible outcomes. This belief is tied to our mission to protect the public by ensuring quality healthcare is provided by physicians and physician assistants. It is important to acknowledge that institutional racism has created inequities in our healthcare system that result in health disparities. Healthcare equity isn't owned by one department or leader – everyone shares responsibility. We can all take action in our own spheres of influence and in the work we control. New committee work at the WMC includes a Healthcare Disparities Workgroup and a Healthcare Equity Advisory Committee. We are creating webinars that focus on providing care to marginalized communities. Expect to hear more about this work in the coming months and let us know if you have ideas on how we can improve.



Links To Our Website

Pain Management Resources

Update your Physical And Email Address

News and Announcements

Rules and Regulations In Progress

Frequently Asked Questions (FAQ)

Contact Us

Executive Director Report: WMC Progress to Eliminate Implicit Bias

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Melanie de Leon, JD, MPA

Executive Director

In our summer newsletter, the WMC Executive Committee published a statement entitled, "Racism in all of its forms is a public health issue" where we stated that we were taking steps to minimize the effect of implicit bias in disciplinary actions. We are also taking these steps in our general internal business processes and I want to share some of our progress.

- Staff hiring process. We are now redacting the personal information on all applications and resumes received for staff vacancies as well as having "blind" first interviews. These changes mean that the interview panel cannot see the applicant (easy to do during virtual interviews) nor does the interview panel have access to the applicant's personal information such as age, name and address. We hope that taking these steps will reduce, if not eliminate, any implicit bias in our hiring process.
- Complaint Summary Document. We have removed the complainant's name, the name of the physician or physician assistant against whom the complaint is filed and any other information that may introduce implicit bias into the complaint review process. The Commissioners reviewing these complaints will not have this information any longer on the summary document and we are working to redact the entire complaint file to remove this type of information. This is still a work in progress.
- All commissioners received implicit bias training at their August meeting.
- The WMC established a new Healthcare Disparities Workgroup whose purpose is to:
    - To research and gather data regarding healthcare disparities with a focus on disparities in four areas: maternal mortality, breast cancer, heart disease and pain assessment.
    - Assess information, data gathered and determine action plans for the WMC to address and affect systemic racism in the healthcare system - from getting into medical school, to residency, to practice, as well as patient safety.
    - Collaborate with stakeholders, other commissions, associations, medical schools and other entities to determine steps to improve patient outcomes and address systemic racism in the healthcare system.
- The WMC also created the Health Equity Advisory Committee and its purpose is to:
    - Create a multi-disciplinary committee of clinicians, faculty, administrators, students, community and system leaders to review WMC rules, policies, procedures and guidelines to ensure healthcare equity for all patients regardless of race, ethnicity, language, religion, age, spiritual practice, sexual orientation, gender identity or expression, socioeconomic class and mental or physical status.
    - Identify educational opportunities for the advancement of healthcare equity.

Our journey is just beginning, but we have taken some big steps to look into our own processes to determine how we can be better. There will be more to come as this journey progresses.

Newsletter Survey

Please take a moment to share your thoughts about the WMC newsletter. Do you have a particular section that you like, or an idea on how to improve our publication? We want to hear from you. Click the link below to take the survey

WMC Newsletter Survey

Coffee with the Commission

One of the most interactive tools the WMC has ever introduced is our "Coffee with the Commission" series. This is a time to take a break and join the WMC for an informal conversation on a variety of topics. Check our event calendar, and follow us on Facebook to be notified of future topics and dates. If you have a topic that you would like to suggest we discuss, you can email us your suggestions.

Black Maternal Mortality: America's Other Pandemic

WASHINGTON Medical Commission
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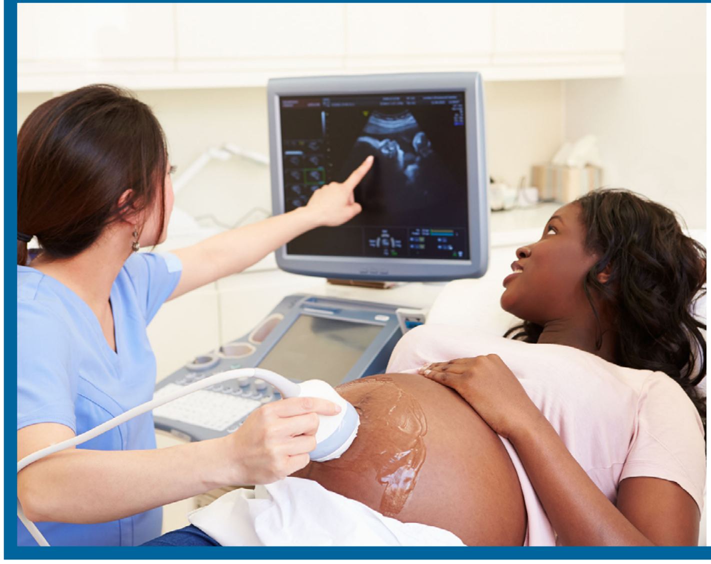
Willie Parker, MD, OB/GYN
Guest Columnist

There is a United States (US) public health crisis that has been hiding in plain sight for the last 30 years, maternal mortality (MM). Defined as the death of a woman or pregnant person directly attributable to pregnancy or the lethal exacerbation of a pre-existent medical condition by it, MM is a long established metric of population-based health used to compare human well-being between countries. Atypical for an affluent country, MM began to rise in the US around 1990. The most recent Centers for Disease Control (CDC) estimates show that between 700 to 900 new and expectant mothers die in the U.S. each year, and an additional 500,000 women experience life-threatening postpartum complications, becoming sick enough to die but who don't. Equally alarming about the rise in MM is the troubling reality that this increase is disparate across the various racial and ethnic groups that make up our nation. More specifically, researchers have found that Black, American Indian, and Alaska Native (AI/AN) women are two to three times more likely to die from pregnancy-related causes than white women – and this disparity increases with age. This is not new information, but is no less unsettling. More importantly, most pregnancy-related deaths are preventable or have factors that are alterable, making warranted the effort to identify at-risk populations and determinants of this phenomenon.

Despite medical, technological advances and international goal- setting for MM reduction by policy makers, women worldwide still die in pregnancy and childbirth from age-old scourges such as: hemorrhage, pre-eclampsia and increasingly from complications related to chronic diseases, obesity, and advanced maternal age. Anecdotal accounts of maternal death make sense to audiences when the setting is a developing country like Liberia, but not Los Angeles or Baltimore. Domestically, the rising national consciousness about racial and ethnic health disparities demonstrably linked to institutionalized racism have led to efforts to center pregnant black women, as the population most vulnerable to MM in the US, in efforts to mitigate its occurrence and to resolve disparities.

Investigation of the causes of MM and its racially disparate outcomes has taken various approaches. Early on, researchers exploring racial differences in health outcomes looked at: genetics or constitutional reasons, behavioral and cultural differences, healthcare access issues related to pregnancy and childbirth to explain MM. The finding of such studies usually leads to the conclusion that MM is multifactorial, with aspects of both individual and systemic factors at play. More recently, researchers have looked at how structural inequality in American society causes disparate outcomes in the health of different groups, as well as the degree to which patient awareness of marginalization and mistrust affect healthcare utilization. Combined, these factors possibly result in creating missed opportunities to detect and intervene in antenatal, intrapartum, and postpartum factors identified as significant in the occurrence of MM.



> **"Domestically, the rising national consciousness about racial and ethnic health disparities demonstrably linked to institutionalized racism have led to efforts to center pregnant black women, as the population most vulnerable to MM in the US, in efforts to mitigate its occurrence and to resolve disparities".**

Whatever the cause of MM, steps can and must be taken to reach an irreducible minimum in its occurrence and the erasure of race and ethnic disparities that should be unacceptable in a society thus diversified.

In closing, a rising maternal mortality ratio in a nation as affluent as the US reveals a health-wealth paradox that commands national attention. The presence of the racial and ethnic disparity associated with MM, like the epidemic of disproportionate loss of Black life at the hands of law enforcement that brought about the creation of the Black Lives Matter Movement, reveals the inability or the failure of our society and healthcare system to protect the most vulnerable amongst us. Prioritizing the reduction of MM is the first step in turning the tide, but reducing disparities will require impact in multiple systems to address key determinants of this unacceptable outcome. Towards that end, the following recommendations "Eliminating Racial Disparities in Maternal and Infant Mortality" have been set forth in a comprehensive policy blue print by the Center for American Progress. The authors outline policy strategies in five areas and make the following recommendations to address the ongoing threat to African American mothers and their infants:

Improved access is critical:

- Strengthen existing health programs and support reproductive healthcare.
- Screen and treat women at risk for preterm birth.
- Eliminate maternity care deserts.
- Offer African American women tools to navigate the healthcare system.

Improve the quality of care provided to pregnant women:

- Train providers to address racism and build a more diverse healthcare workforce.
- Create standardized assessments for mothers and infants.
- Adopt new models of care and link payment to quality.

Address maternal and infant mental health:

- Identify barriers to accessing maternal mental health services.
- Dismantle care barriers with a comprehensive approach.
- Screen for and address infant and early childhood mental health issues.

Enhance supports for families before and after birth:

- Invest in and expand access to policies and programs that support families' basic needs.
- Invest in community programs that offer one-stop comprehensive services.
- Simplify enrollment across public benefit programs.
- Invest in home visiting.
- Fund community-based education and communications initiatives to support families.

Improve data collection and oversight:

- Standardize birth and death certificate data.
- Mandate and fund fetal and infant mortality review committees
- Ensure equity in the review process.

As a final thought, Elizabeth Dawes Gay of Black Mommas Matter, a collective dedicated to the issue, expresses the aspirations of many seeking a resolution to the loss pregnant Black women:

> *"Those of us who want to stop black mamas from dying unnecessarily have to name racism as an important factor in black maternal health outcomes and address it through strategic policy change and culture shifts. This requires us to step outside of a framework that only looks at healthcare and consider the full scope of factors and policies that influence the black American experience. It requires us to examine and dismantle oppressive and discriminatory policies. And it requires us to acknowledge black people as fully human and deserving of fair and equal treatment and act on that belief."*

Resources:
"America is Failing It's Black Mothers" Harvard Public Health. Winter, 2019

"The U.S. finally has better maternal mortality data. Black mothers still fare the worst." Elizabeth Gluck NBC News, January 29, 2020

"Racial and Ethnic Disparities Continue in Pregnancy-Related Deaths." Morbidity and Mortality Weekly Report (MMWR). Sept. 5, 2019

"Eliminating Racial Disparities in Maternal and Infant Mortality: A Comprehensive Policy Blueprint." Center for American Progress. May 2, 2019.

Safety First:
The Importance of Interpreters & Translated Documents in Preventing Patient Harm

WASHINGTON Medical Commission
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Jamilia Sherls-Jones, DNP, MPH, RN, CDP, CPN
Guest Columnist

The population in Washington state is getting more diverse each year. Language diversity is no exception. From 1990 to 2018, the percentage of residents who speak a language other than English in their home has risen from 9% to 20%[4]. While language diversity greatly enhances our state culture, it can also present challenges. Communication barriers between providers and limited English proficiency (LEP) or non-English proficiency (NEP) patients during health care delivery is a major safety concern. Poor, ineffective communication can lead to patient dissatisfaction, misunderstanding about treatments, and, even worse, poor health outcomes and patient harm[1]. Studies even suggest that adverse events experienced by LEP patients are more likely to be caused by communication issues when compared to English proficient patients[2].

Therefore, it is important for providers to immediately identify language needs amongst their patients and access the appropriate language services to ensure the best possible outcomes for their LEP and NEP patients. Under Title VI of the Civil Rights Act of 1964, providers and health care institutions that receive federal funding cannot discriminate on the basis of race, color or national origin, which includes language[3]. Providers must arrange for interpreter services, at no cost to the patient, once a need has been identified.

Here are four steps for providers to take to ensure successful communication with LEP and NEP patients:

1) Assess for interpreter need.
2) Determine the best method for providing language service.
3) Apply best practices for working effectively with interpreters.
4) Ensure translation of patient education and vital clinical documents.

Assess for Interpreter Need

Again, providers and health care institutions that receive federal funding must provide interpreter services to patients who need them. How should providers assess whether a patient needs an interpreter? Providers should ask all patients and accompanying family members if they would like an interpreter, and, if so, for what language. Asking some patients and families for interpreter needs while not asking others based on bias or assumptions can be considered discriminatory. If the patient does not speak English at all, providers should then show them "I Speak" cards, developed by the US Census Bureau, or a language identification sheet where they can point to their preferred language.

There will be times when providers encounter an LEP or NEP patient who refuses an interpreter or prefers to use someone in the family as an interpreter. Family and friends of the patient should not be used as interpreters, as there is no way to ensure they understand how to interpret medical terminology[1]. There is also the risk that critical information may not be disclosed by the family member[1]. In this situation, the provider should communicate to the patient that they (the provider) need a professional interpreter to ensure understanding so they (the patient) can receive the best care possible.

Determine the Best Method for Providing Language Service

After the provider determines the need for an interpreter and the requested language of service, another decision must be made. What is the best way to provide language assistance for this clinical encounter? Should an in-person interpreter, video remote interpreter (VRI), or over-the-phone interpreter be used? Or are there staff at the worksite who are qualified bilingual interpreters, meaning they have received a training and passed a test that ensures their language proficiency in English and their language of service?

In-person interpreters are best to use if providers have access to them, whether they are certified medical interpreters, often contracted with an agency, or qualified bilingual staff. If there are qualified bilingual staff interpreters at the clinic or hospital, the provider may want to consider using them first, since they are accessible and convenient. If the provider is a qualified bilingual interpreter, they may act as their own interpreter. However, if qualified staff are not available, the provider should consider a certified interpreter. These interpreters are usually scheduled in advance of the appointment and may not be the most convenient option in cases of impromptu visits, such as an urgent care setting. In-person interpreters are best to use for longer appointments and more complex visits. They help establish rapport with patients and allow for better communication during stressful situations.

If a provider has a patient arriving for just a brief appointment, they might want to consider using VRI. With this modality, interpreting occurs over a computer or iPad using a webcam. Interpreters are usually available immediately upon demand and can be another quick, convenient option for language service. One caveat is that VRI usually depends on wi-fi connection, so it is crucial to have strong wi-fi connectivity. If internet capability is not sufficient, there could be interpreting delays which become communication barriers, especially for those patients who use American Sign Language (ASL).

The final option is interpreting over the telephone, which can also be useful for quick interpreting needs. However, this option is least desirable for interpersonal aspects of communication. This method of interpreting should use a phone with a speaker, so that both parties can hear what is being communicated at the same time.

Apply Best Practices for Working Effectively with Interpreters

At the beginning of the visit, the interpreter will greet both the provider and the patient, then introduce themselves. To help set the interpreter up for success, it is usually a good idea for the provider to give a brief summary of the clinical situation. Providers do not have to be very detailed, but an overall picture of what is going on can be helpful for the interpreter. During the visit with the patient, providers must be sure to speak and make eye contact with the patient - not the interpreter. They should speak in first-person and use short and complete phrases, which will help the interpreter interpret accurate information to the patient. There may also be a point during the visit where the provider will encounter linguistic and cultural issues. This is a good time to ask the interpreter to do some cultural brokering – explaining the patient's cultural beliefs and practices, which will help the provider understand how that might influence the patient's perspectives on health and wellness. The provider should take what is learned into consideration when designing intervention or treatment plans and verify with the patient that what they learned is true for that individual. At the end of the interpretation, it is important to make sure the patient understood the highlights of the visit and use the teach-back method, with assistance from the interpreter. Finally, it is important for providers to document interpreter usage and the modality in the patient's chart.

Ensure Translation of Patient Education and Vital Clinical Documents

Written communication with patients is just as important as verbal communication. Providers should make sure patient education materials, after visit or discharge summaries, and legal forms, such as informed consent, are translated in the top three or five languages in their service area. It is critical that LEP and NEP patients understand all the information necessary to make informed decisions about their care and know how to care for themselves when they return home to reduce the chances of hospital or ED readmissions and poor health outcomes.

Conclusion

When used effectively, interpreters and translated documents not only enable providers to communicate with their LEP and NEP patients, but also help promote patient safety by preventing medical errors and patient harm, which will minimize health disparities within this population. LEP and NEP patient experiences and satisfaction will also improve, since open communication channels with their provider allows these patients to truly be in the center of their care – care that is delivered in a culturally sensitive way.

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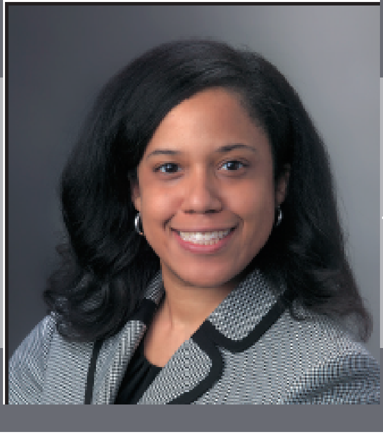

Free Webinar Opportunity

The WMC is proud to host Dr. Sherls-Jones in our webinar series. This webinar series is replacing the in-person annual conference. Dr. Sherls-Jones will be providing a one hour webinar, expanding on her article topic, "Safety First: The Importance of Interpreters & Translated Documents in Preventing Patient Harm". This activity has been approved for *AMA PRA Category 1 Credit*™. More information and registration can be found on our website.

Wednesday, October 7th at 12:00 pm

Responding to Disparities in LGBTQ+ Health Care

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Ginny Weir, MPH

Director, Bree Collaborative, Guest Columnist

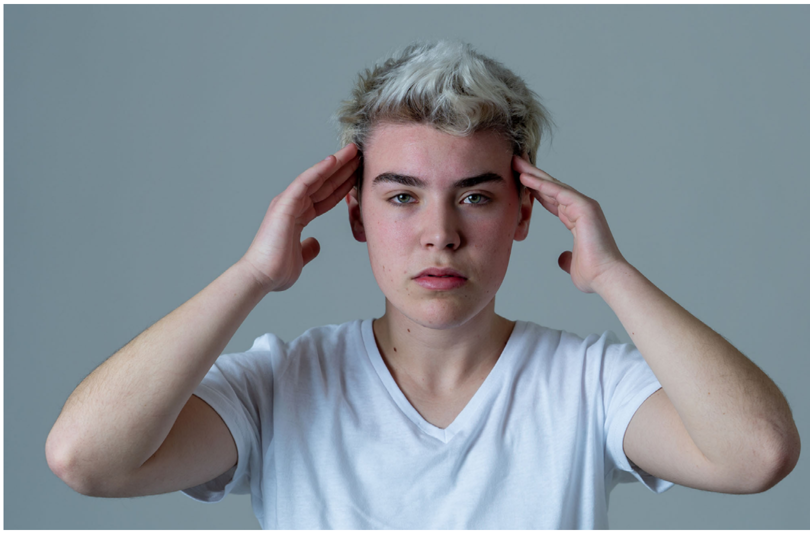
Our health care system continues to struggle with disparities in access to care, in how care is delivered, and in our individual health outcomes. Places where there is documented disparity or variation or a lack of equity are indicators for the Bree Collaborative that our community needs to act. Our public/private group chooses health care services annually to make clinical recommendations with the goal of improved health care quality, outcomes, and affordability. In 2018, we created community consensus recommendations around the delivery of care for those who are Lesbian, Gay, Bisexual, Transgender, and Queer or Questioning. Part of our effort to help lead our health care system to true health equity is through focusing improvement efforts on historically marginalized populations. Targeted efforts allow us to develop solutions to barriers to care that are informed by evidence and the lived experience of those receiving and delivering care.

About 3.5% of us identify as LGBTQ with 0.3% of us being transgender. While we know that all people share baseline health care needs, we have also seen that those who are part of the LGBTQ population can be at a higher risk for specific medical issues. Research shows that LGBTQ persons experience higher rates of depression, sexual abuse, smoking, and other substance use.[1] Lesbian women are less likely to undergo certain screening tests for cancer (e.g., mammography to test for breast cancer, papanicolaou (pap) test for cervical cancer) and both men and women in same sex relationships are less likely to have insurance coverage. Men who have sex with men (MSM) and transgender persons who have sex with men are at elevated risk for human immunodeficiency virus (HIV) and other sexually transmitted infections (STIs). LGBTQ youth have higher rates of STIs (e.g., gonorrhea, chlamydia) due to increased likelihood of engaging in high-risk sexual behaviors.

The community consensus recommendations that we developed in 2018 are based in a whole-person framework, acknowledging that a person has many ways of identifying that contribute to their health. This intersectionality between and within population groups informs how a person who is Black and has a disability, or a person who is indigenous and queer, might experience day-to-day life, racism, ableism, or homophobia, and have differential access to un-biased, quality health care differently than someone who is Black and queer. These intersecting identities inform a person's experience with health care, their life experiences, their goals, and their health care needs broadly.

Knowing this, we grouped the changes we want to see in three broad areas:

- Communication, language, and inclusive environments including specific changes such as using the person's preferred pronouns, using non-stigmatizing language, onsite-gender neutral bathrooms;
- Screening and taking a social and sexual history including integrated behavioral health, how to ask about past sexual partners and sexual behavior; and
- Areas requiring LGBTQ-specific standards and systems of care such as HIV pre-exposure prophylaxis based on risk assessment, appropriate referrals, targeted cancer screening for underserved populations, and gender confirmation procedures.



"Targeted efforts allow us to develop solutions to barriers to care that are informed by evidence and the lived experience of those receiving and delivering care."

Ours is an all-sectors on deck approach and we include checklists for delivery systems, individual providers, health plans, and others. We have summarized our recommendations in a checklist for delivery systems here, you can also read our longer recommendations here. We are also helping to support the Washington Patient Safety Coalition and the Washington State Medical Association in their October 9th webinar on LGBTQ Health Care that "will educate physicians and physician assistants on strategies to align care delivery with existing evidence-based, culturally sensitive standards of care for LGBTQ people in Washington state to decrease health disparities" scheduled from 12:00 – 1:00. Register here.

Building out LGBTQ standards also helped inform one of our current workgroups focused on improving quality, equity, and cultural appropriateness of reproductive and sexual health care services especially for those who are Black, indigenous, people of color, immigrants or refugees, have experienced violence including human trafficking, people with disabilities, and LGBTQ. Here our goal is to move our health care system to orient around increased access, appropriate care, patient-centeredness, and cultural humility. These four areas become the framework from which we built our checklists for delivery systems, plans, and others. You can learn more about this work here and look for our announcement about public comments later this fall. Another new opportunity to get involved is with a new workgroup focused on the role for clinical care in the social determinants of health. This group will start meeting September 17th and monthly thereafter. More information on all our meetings is here.

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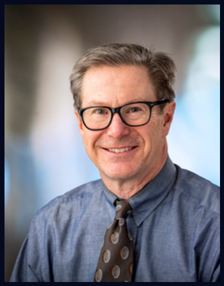
WMC Webinar Series

In order to provide continuing education for our licensees, the WMC is developing a webinar series to replace our in-person annual conference. Visit our conference page for registration details and follow us on Facebook to be notified as additional webinars are added.

LGBTQ+ Healthcare Needs

Wednesday, October 21 at 12:00 pm

Dr. Diana Currie and Dr. Chelsea Unruh will discuss the gaps in healthcare amongst LGBTQ+ patients. This free webinar will educate providers on strategies to align care delivery with existing evidence-based, culturally sensitive standards of care for LGBTQ+ people to decrease health disparities. This activity has been approved for *AMA PRA Category 1 Credit*™.



UW Studies COVID-19 Presence to Inform Smart Policy Decisions

Wednesday, November 4 at 12:00 pm

Dr. Keith Jerome will be discussing research at UW to determine the percentage of Washingtonians who have been infected by COVID-19. UW Medicine's Virology Laboratory will conduct the study in close partnership with state and local public health agencies, sampling across rural and urban populations throughout the state and within racially, ethnically and socioeconomically diverse communities. Dr. Jerome will provide a one hour webinar on the study methods and preliminary findings.

fsmb FOUNDATION

The Washington Medical Commission gratefully acknowledges the unrestricted educational grant from the FSMB Foundation in the amount of $10,000 to support this activity.

Double Vulnerability: Identifying and Tackling Disparities in Behavioral Health Among Minority Communities

Lindsay Shea, SUDP, RYT Clinical Coordinator, Washington Physicians Health Program
Cynthia Morales, LMHC Clinical Coordinator, Washington Physicians Health Program

Just as policing has been tasked to untangle and dismantle the roots of racism and inequity, so too are other systems being called to face and dismantle these issues within our society. As we watch police forces address the perpetuation of white supremacy, we have a responsibility to critically view our field and where inequity, inequality and bias have flourished. Behavioral health as a discipline has a long history of pathologizing normal behaviors observed in minority groups, including: racial, gender identity, sexual identity, disability, and body size communities. From homosexuality being included in the DSM until 1987, the over diagnosis of psychotic disorders in Black men who may express understandable "paranoia" in relating to white dominant culture, the lack of access to resources and appropriate care among gender and sexual minorities, misdiagnosis of fat bodies, to social workers removing Black and Brown children more often from their families, it is time we explore these issues within the behavioral healthcare field. We must work to dismantle the systemic issues of oppression within ourselves, our workplaces and the larger field to offer appropriate, culturally humble care to all who need support and treatment.

The foundation of behavioral health is inextricably tied to white supremacy, reflecting the larger culture of the US. The reference used to diagnose and treat all individuals, the Diagnostic and Statistics Manual, Fifth Edition (DSM-5) is based on studies primarily conducted on white, affluent individuals living in industrialized, Western societies. Therefore, our conceptualizations of behavioral health issues are largely limited to cis-gender white men. This leads to a lack of effective and culturally appropriate care for individuals of various minority statuses, including racial minorities, sexual and gender minorities, women and fat-bodied individuals. For instance, consider cognitive behavioral therapy (CBT), a well-studied and evidence-based treatment for a multitude of conditions. CBT focuses on changing internal thoughts and associated behaviors for relief from symptoms. But what if your struggle is based on society's view of who you are? Is CBT effective or harmful if the struggle is due to systemic oppression based on race, sexual identity, gender identity or your body? This issue can be termed "therapeutic bypassing" and is very similar to spiritual bypassing. It involves ignoring the larger systemic issues and focusing on an individual changing their internal experience or response, without addressing the external contributing factors. Cognitive "reframing" is not a solution to discrimination and bias. Individuals in a minority group have a high likelihood to discontinue treatment due to the pattern of therapeutic bypassing in traditional behavioral healthcare.

Disparity in behavioral healthcare outcomes are seen for racial minorities. Minority individuals often discontinue therapy, up to 50% after just one session, due to the lack of culturally appropriate care from someone within their community. Over 50% of Black individuals suffering from severe mental illness do not receive treatment or care for their mental health. Black and African American men are less likely than their white counterparts to consume alcohol or suffer from substance-related disorders, yet they face more legal issues and consequences due to their use. Disparities in behavioral healthcare also exist among other ethnic groups. One study examined the utilization of mental health care services across racial and ethnic minority groups in a nationally representative study. Researchers found that ethnic minority groups reporting severe suicidal ideation were less likely to receive treatment. The study went on to explore barriers to accessing mental health services for these groups, including differences in health care coverage, lack of interpreter services, and culturally/linguistically relevant resources. Less than a quarter of graduate-level or higher behavioral healthcare professionals are from a minority community, and 70-90% of those who work in substance use disorder treatment are white.

> **"Behavioral health as a discipline has a long history of pathologizing normal behaviors observed in minority groups, including: racial, gender identity, sexual identity, disability, and body size communities".**

Two spirit, lesbian, gay, bisexual, transgender, queer, intersex, asexual (2SLGBTQIA+) individuals face discrimination in many areas of life, including their ability to find gainful employment, trans-affirming healthcare, insurance coverage, housing, and other services that offer affirming and inclusive care, including behavioral health care. Individuals in the 2SLGBTQIA+ community have higher rates of mental health and substance use issues than the general public and die at significantly higher rates from suicide. These disparities are directly linked to minority stress and the oppression faced within this community. Such individuals are less likely to stay engaged in therapy and treatment if they are not provided with affirming care that takes into consideration the unique challenges and stressors of their identity.

Eating disorders affect men and women at equal rates, yet it is most often diagnosed among young, thin, upper-middle class white women. Black individuals are at a higher likelihood of suffering from an eating disorder, which is often left undiagnosed or treated, due to systems that uphold white ideals of body type. Stigma and bias about fatness also perpetuate health disparities. People with fat bodies are more likely to be given the diagnosis of binge eating disorder, even in the face of a more predominant restricting pattern. Fat bodied individuals and those with binge-eating disorder are often placed in separate treatment groups from thin-bodied individuals in eating disorder treatment, reinforcing food and diet culture's hierarchy of bodies and, inadvertently, the antecedents of disordered eating. Eating disorder therapists prioritize image over health when they promise fearful clients that they won't get fat, despite evidence that chronic dieting, weight loss and repeated metabolic insults lead to higher weights over time. Finally, over-reliance on body mass index (BMI) to define individual health, despite BMI being a statistical population measure, may reflect anti-fat bias while also potentiating confusing and unrealistic expectations for overall health, which does not equate to weight. It is noteworthy that anorexia nervosa is the only eating disorder that has BMI as part of the diagnostic criteria (and that is to define underweight patients).

Disabilities, physical and cognitive, can also play a role in the accessibility of care as well as the outcomes. One would think these issues are covered by the Americans with Disabilities Act, but that does not guarantee service sensitivity or accessibility. Those who are disabled and seek out needed behavioral health treatment often report dissatisfaction due to lack of training of behavioral healthcare providers, higher rates of over-use of sedating medication, and physical injury to staff and clients. It takes effort to adjust and adapt treatment to be more accessible for a range of disabilities.

It is easy to feel overwhelmed with the prospect of providing affirming and inclusive care within a system that continues to reinforce inequity and the norms of white supremacy. It takes significant self-education, intention, and commitment to provide anti-racist and affirming to care to individuals from all minority-status communities that honors the intersection of those identities. There are frameworks that have been created to help assess the accessibility and equity of behavioral healthcare programs. Social justice theory and feminist theory provide a foundation for bringing understanding and exploration of the larger cultural and systemic biases within which we and our patients exist. Using these intentional frameworks for behavioral healthcare, instead of teaching clients to internally bypass the very real experiences of oppression and marginalization they face, will provide true healing and care.

Above all, ask! Ask people their pronouns, their gender identity, their cultural and racial identities and how you can incorporate those into their treatment and care. We can empower ourselves and each other to bring these topics into healthcare while also recognizing that the dynamics of power, patient to health professional, minority to majority, will often impact the degree of psychological safety a patient feels in discussing these matters. When you ask, do not place the burden of education on the patient, but use the information they provide to self-educate. When incorporating what you have learned, ask if it fits, as no community's experience is an absolute. Patients may not respond much when first asked these questions, but it sets the stage where these conversations are welcomed and considered, which can go an incredible distance in providing culturally humble care. When we create a system that allows disabled, severely mentally ill, addicted Black trans women to thrive, we will have a system that is accessible and equitable to all. If we can create space where the most marginalized community member can get the most skillful, culturally humble and appropriate care, we will all benefit from that system. We who hold the power must create the space and prioritize those we have, until now, either ignored or pushed to the margins of care and society.

PA News: Is it Race or Racism That is Killing Black People?

James Anderson, PA-C

Physician Assistant Member

Data has consistently shown that Black Americans die at higher rates than white Americans related to specific health problems. For example, data shows that Black mothers die over twice as frequently as white mothers related to childbirth. Data has also demonstrated the Black Americans die at approximately three times the rate as their white counterparts related to COVID-19.

Throughout the history of medicine, there has been much effort trying to identify something unique and genetic about being Black that would cause poorer health. When I was in PA school, one of my Black colleagues would often groan when we were given data from lecturers noting higher rates of morbidity and mortality from specific illnesses for Black patients. "Not again," he would mumble.

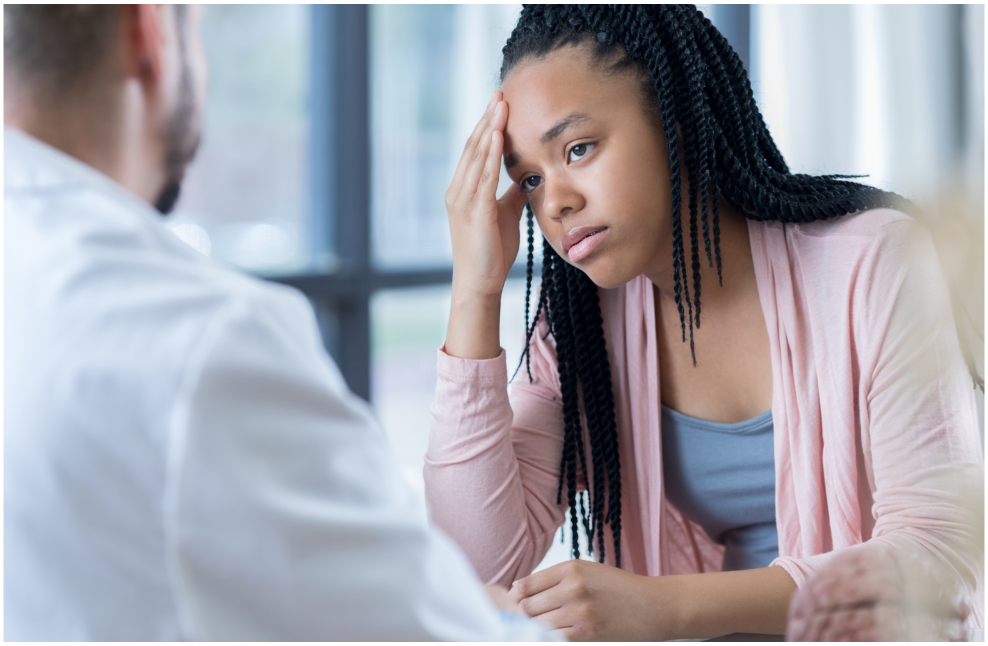
But research and study looking at racism, and not race, as the cause of these discrepancies has gained increasing acceptance in recent years. Researchers Arlene Geronimus and David Williams have been focusing on this issue for decades, and their work continues to receive increased attention and acceptance in the medical community.

Geronimus was one of the first to describe the concept of "weathering." Weathering describes the greater prevalence of maternal morbidity among Black women. In 2006, she proposed the "weathering" hypothesis, asserting that Black communities and individuals experience premature health deterioration due to the cumulative effects of racism including social, economic, and political oppression. She noted that accumulation of stress from ongoing racial trauma leads to changes in the body that "weather" and erode the physical well-being of non-white communities, predisposing them to accelerated aging and DNA mutation, leading to premature mortality.

David Williams has also explored the impact of racism, vs race, on health. One of his most significant observations has been that the health impact of racism is distinct from looking for genetic make-up of specific races, noting; "In recent decades, there has been remarkable growth in scientific research examining the multiple ways in which racism can adversely affect health. This interest has been driven in part by the striking persistence of racial/ethnic inequities in health and the empirical evidence that indicates that socioeconomic factors alone do not account for racial/ethnic inequities in health. Racism is considered a fundamental cause of adverse health outcomes for racial/ethnic minorities and racial/ethnic inequities in health."

Finally, another intriguing insight into understanding the role of racism and health is a proposal that the medical community began to view and treat racism as a chronic disease. The Baylor University African American Center for Medical Ethics and Health Policy discussed this in a blog post about this framework of racism; "Racism is not new. It's unceasing with no treatment or vaccine in sight. A more appropriate diagnosis would be racism as a chronic disease, like cancer or diabetes. But this particular chronic disease does not destruct the body of the individual who is infected. Instead, in America, its effects are felt throughout the entire Black community and are not only physical, but also emotional and social".

The work of Geronimus, Williams and others offers a fresh and exciting area of examination. Their observations have done much to decrease and dismiss what can only be called racist assertions about the cause of poorer health of Blacks when compared to whites. It is ironic that it now appears to be true that it's not race, but racism itself, that has played a key role in health inequality.



Rulemaking Efforts

Washington Medical Commission
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Amelia Boyd

Program Manager

Chapter 246-919 WAC

The CR-102 for WAC 246-919-010 through 246-919-770 (relating to allopathic physicians), was filed with the Office of the Code Reviser on June 25, 2020 as WSR #20-14-048.

The purpose of this proposal is to more closely align the chapter with current industry standards and provide clearer rule language for licensed allopathic physicians (MDs). Proposed revisions include:

- Changing the name of the WMC pursuant to SB 5764;
- Updating definitions to reference new terminology or clarify their meaning;
- Rescinding sections which are no longer relevant, utilized, or are referenced in other chapters;
- Updating references to periodicals;
- Updating physician licensing requirements to align with current standards;
- Updating section titles to more clearly state the purpose of the section; incorporating language from WMC interpretive statements;
- Adding a new section on how a military spouse may obtain a temporary practice permit pursuant to RCW 18.340.020;
- Adding a new section on the administration of deep sedation and general anesthesia by a physician in a dental office;
- Updating the timelines required for cooperating with an investigation.

A hearing was held on August 19, 2020 to review the draft language and discuss comments from stakeholders. The WMC approved the draft language on August 21, 2020 and the next step in the rules process, CR-103, which will make the language permanent. The filing of the CR-103 is pending.

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 their clinical skills.

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

Telemedicine

The CR-101 for Telemedicine was filed with the Office of the Code Reviser on September 17, 2019 as WSR #19-19-072.

The WMC will consider rulemaking to address the practice of physicians and physician assistants engaging in telemedicine with Washington patients. Possible subjects the WMC may address are:

- Any requirements for licensure;
- Recordkeeping requirements;
- Establishing a patient-practitioner relationship;
- Prescribing issues;
- Standard of care.

Regulating the use of telemedicine would place the WMC in an active patient safety role.

Exclusions – Opioid Prescribing

The CR-101 for amending the exclusions sections in both the MD (WAC 246-919-851) and PA (WAC 246-918-801) chapters to expand the types of patients who are exempt from certain provisions of rule when being prescribed opioid drugs was filed with the Office of the Code Reviser on March 25, 2020.

As part of the WMC's rule making for ESHB 1427, enacted in 2017 and codified as RCW 18.71.800, the WMC received comments that adhering to the opioid prescribing rules for patients admitted to long-term acute care (LTAC) and nursing homes, is onerous. Specifically, the rules require a history and physical as well as a check of the prescription monitoring program (PMP) be completed prior to prescribing opioids. It has been stated that patients transferred to LTACs and nursing homes had a history and physical while in the previous facility and that practitioners in LTACs and nursing homes can rely on that assessment.

Inpatient hospital patients are currently exempt from the opioid prescribing rules. The WMC recognizes that patients in LTACs and nursing homes are similarly situated to hospital patients receiving inpatient treatment.

Since the rules related to ESHB 1427 became effective January 1, 2019, the WMC has continued to receive comments related to LTAC and nursing home patients. To address this issue, the WMC filed an interpretive statement Exempting Patients in Nursing Homes and Long-Term Acute Care Hospital from the Opioid Prescribing Rules. While the interpretive statement has helped to curb the comments and concerns from prescribers, the WMC feels this important exemption should be in rule. Furthermore, this could allow us to rescind the interpretive statement.

The WMC has also received a comment regarding patients in Residential Habilitation Centers (RHC) that they are also similarly situated to LTAC and nursing home patients. As such, the WMC may also consider exempting patients in RHCs.

Stem Cell Therapy

The CR-101 for creating rules related to Stem Cell Therapy was filed with the Office of the Code Reviser on April 21, 2020 as WSR #20-09-132.

The WMC has received complaints from licensees, stakeholders, and the public about the use of stem cells. The complaints have been regarding the advertising related to stem cell therapy, practitioners using non-FDA approved stem cell therapy, as well as concerns stem cell therapy not being within a practitioner's scope of practice. Regulating the use of stem cell therapy would place the WMC in an active patient safety role. Rulemaking would provide clarity around this emerging medical technology and procedure to help avoid potential discipline and increase patient safety. New sections 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.

Collaborative Drug Therapy Agreements

The CR-101 for creating rules related to Collaborative Drug Therapy Agreements was filed with the Office of the Code Reviser on July 22, 2020 as WSR #20-16-008.

One aspect of the practice of medicine is working with pharmacists to deliver drug therapy to patients. This coordination can take many forms, but the WMC's concern involves treating patients under a collaborative drug therapy agreement (CDTA). These arrangements occur pursuant to a written agreement entered into by an individual physician or physician assistant and an individual pharmacist.

The Pharmacy Quality Assurance Commission has adopted a rule that governs CDTAs from the pharmacy perspective; however, there are no statutes or rules that govern a physician's responsibilities under a CDTA. A rule is needed to define the roles and responsibilities of the physician or physician assistant who enters into a CDTA, any defined limit to the number of pharmacists who may have a CDTA with any one physician or physician assistant, and how the physician or physician assistant and pharmacist can best collaborate under these agreements.

Regulating the use of CDTAs would place the WMC in an active patient safety role. Rulemaking would provide clarity around this issue to help avoid potential discipline and increase patient safety. New sections 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.

Senate Bill (SB) 6551 – International Medical Graduates

The CR-101 for creating rules related to integrating International Medical Graduates (IMG) into Washington's healthcare delivery system was filed with the Office of the Code Reviser on August 6, 2020 as WSR #20-17-024.

SB 6551 permits the WMC to issue limited licenses to IMG. The bill also directs the WMC to establish requirements for an exceptional qualification waiver in rule as well as establish requirements for a time-limited clinical experience license for IMG applicants. Establishing these requirements would reduce barriers for IMG applicants obtaining residency positions in Washington.

More Information

Please visit our rulemaking site and for continued updates on rule development, interested parties are encouraged to join the WMC's rules GovDelivery.

Legal Actions

WASHINGTON
Medical
Commission
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May 1, 2020 – July 31, 2020

Below are summaries of interim and final actions taken by the Washington Medical Commission (WMC) that were reported to the Federation of State Medical Boards between May 1, 2020 and July 31, 2020. 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.

Practitioner Credential and County	Order Type	Date	Cause of Action	Commission Action
Summary Actions				
Brown, Michael MD00028042 King	Ex Parte Order of Summary Action - Restriction	06/11/20	Alleged mismanagement of chronic pain patients.	Restriction – no prescribing controlled substances pending completion of proceedings.
Jutla, Rajninder MD00047987 King	Ex Parte Order of Summary Action - Suspension	06/23/20	Revocation of license to practice by the Oregon Board of Medicine in March 2020 for failure to meet the standard of care while treating chronic pain patients.	Suspension – pending completion of proceedings.
Said, Mohammad MD00018311 Grant	Ex Parte Order of Summary Action - Suspension	05/01/20	Alleged inability to practice with reasonable skill and safety due to a health condition.	Suspension – pending completion of proceedings.
Sterling, Ronald MD00038889 King	Ex Parte Order of Summary Action - Restriction	05/08/20	Alleged moral turpitude, failure to comply with a Commission order, misrepresentation or fraud, patient abuse, and sexual misconduct.	Restriction – no treating female patients pending completion of proceedings.
Informal Actions				
Sassone, Justin PA60238234 Spokane	Informal Disposition	05/14/20	Alleged failure to appropriately and timely manage an inmate patient's life threatening condition contributing to a delay in emergency department care.	Managing difficult patients and treating acute intoxication coursework, written research paper, personal appearances, $1,000 cost recovery, and termination no sooner than one year.
Shannon, Michael MD00042625 Thurston	Informal Disposition	05/20/20	Alleged boundary violations.	Boundaries coursework, written research paper, multi-disciplinary evaluation and comply with all recommendations, personal appearances, $1,000 cost recovery, and termination no sooner than two years.
Silverman, Burton MD00032130 Out of State	Informal Disposition	05/14/20	Oregon Board of Medicine order in July 2019 stating that Respondent retired his license while under investigation.	Voluntary surrender.

Swyer, Mark MD00019726 Snohomish	Informal Disposition	05/20/20	Alleged fraudulent prescribing and failure to maintain appropriate medical records.	Voluntary surrender.
Washington, Sherman MD60404594 Out of State	Informal Disposition	07/16/20	Alleged improper telemedicine prescribing without any contact with patients, moral turpitude, and failure to cooperate with the Commission's investigation.	Review telemedicine guidelines, ethics coursework, written research paper, personal appearances, $1,000 cost recovery, and termination no sooner than one year.

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.

Members and Meetings

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Update! Editorial Board

Diana Currie, MD	Jimmy Chung, MD
Richard Wohns, MD	Micah Matthews
Jimi Bush, Managing Editor	

Email us with your questions and comments.

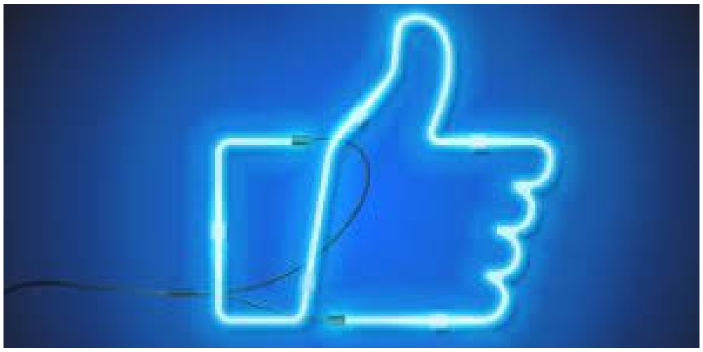
2020/21 WMC Meeting Dates

Date	Location
November 12 - 4:00 PM	Virtual Policy Meeting
November 13 - 8:00 AM	Virtual Business Meeting
January 14-15 2021	Capital Event Center (ESD 113) 6005 Tyee Drive SW Tumwater, WA 98512*
March 4-5 2021	Capital Event Center (ESD 113) 6005 Tyee Drive SW Tumwater, WA 98512*
April 8-9 2021	Capital Event Center (ESD 113) 6005 Tyee Drive SW Tumwater, WA 98512*
* Subject to Change	

Policy meetings usually take place on the Thursday of the commission meeting at 4:00 pm.

Business meetings usually take place on the Friday of the commission meeting at 8:00 am.

Policy, business meetings and lunch time presentations are open to the public. Sign up to have the agenda emailed to you as it becomes available.



Follow us on Facebook for all upcoming webinars and special meetings.