# November 14-15, 2019

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

WASHINGTON
Medical
Commission

Licensing. Accountability. Leadership.

# 2020 Meeting Schedule

WASHINGTON Medical Commission
Licensing. Accountability. Leadership.

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

**Association Meetings**

| Association | Dates | Location |
|---|---|---|
| Federation of State Medical Boards (FSMB) Annual Conference | April 30-May 2, 2020 | San Diego, CA |
| WAPA Spring Conference | TBA | TBA |
| WSMA Annual Meeting | TBA | TBA |
| WAPA Fall Conference | TBA | TBA |

**Other Meetings**

| Program | Dates | Location |
|---|---|---|
| Council on Licensure, Enforcement & Regulation (CLEAR) Winter Symposium | January 8-10 | San Diego, CA |
| CLEAR Annual Conference | TBA | TBA |
| FSMB Board Attorneys Workshop | TBA | TBA |

# 2021 Meeting Schedule

WASHINGTON Medical Commission
Licensing. Accountability. Leadership.

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

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

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

# FORMAL HEARING SCHEDULE

WASHINGTON Medical Commission
Licensing. Accountability. Leadership.

| Hearing | Respondent | SPEC | Case No. | Counsel | AAG | Staff Atty | PANEL | HLJ | Location | Panel Composition (as of 11/6/19) |
|---|---|---|---|---|---|---|---|---|---|---|
| 6-Nov | | | | | | | | | | |
| **2019 November** | | | | | | | | | | |
| 18-19 Nov | OLSSON, Roger B., MD | BC- Family Medicine | M2017-527 | Gerald Tarutis | Brewer | Page Landstrom | A | Dixon | DOH/Tumwater Rm 158 | **Lewis; Howe; Rodgers; Fairchild PANEL FULL - THANK YOU!** |
| **2019 December** | | *(NO COMMISSION MEETING THIS MONTH)* | | | | | | | | |
| 16-Dec | WASHINGTON, William J., MD | Non-BC Emergency Medicine | M2018-697 | Pro Se | Brewer | Page Landstrom | B | Kuntz | TBD | **Roberts; Jaeger; Hearst PANEL FULL -THANK YOU!** |
| 17-20 Dec | MARKUS, Stephen P., MD | Non-BC Psychiatry | M2018-94 | Doug Yoshida | Brewer | Glein | A | Herington | TBD | |
| **2020 January** | | | | | | | | | | |
| ***NONE AT THIS TIME*** | | | | | | | | | | |
| **2020 February** | | | | | | | | | | |
| 3-4 Feb | NGUYEN, Dung X., MD | Non-BC Family Medicine | M2018-716 | Lance M. Hester | Defreyn | Karinen | A | Donlin | TBD | |
| 19-20 Feb | SMITH, Stephen L., MD | Non BC - Internal Medicine | M2017-523 | Stephen D. Rose | Brewer | Berg | A | Donlin | TBD | |
| **2020 March** | | | | | | | | | | |
| 23-26 Mar | SCHULZ, Ona L., PA-C | Phys. Assistant | M2018-641 | Elizabeth Leedom Rhianna Fronapfel | Anderson | Wolf | B | Kuntz | TBD | Fairchild; Terman |
| **2020 April** | | | | | | | | | | |
| 30 Mar - 4 Apr | BAUER, William M. | BC-IM | M2017-1115 | Jennifer Smitrovich | Brewer | Berg | B | Herington | TBD | |
| **2020 May** | | | | | | | | | | |
| ***NONE AT THIS TIME*** | | | | | | | | | | |
| **2020 June** | | *(NO COMMISSION MEETING THIS MONTH)* | | | | | | | | |
| ***NONE AT THIS TIME*** | | | | | | | | | | |
| **2020 July** | | | | | | | | | | |
| ***NONE AT THIS TIME*** | | | | | | | | | | |
| **2020 August** | | | | | | | | | | |
| ***NONE AT THIS TIME*** | | | | | | | | | | |
| **2020 September** | | *(NO COMMISSION MEETING THIS MONTH)* | | | | | | | | |
| ***NONE AT THIS TIME*** | | | | | | | | | | |

# Commission Meeting Agenda
# November 14-15, 2019

WASHINGTON Medical Commission
Licensing. Accountability. Leadership.

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

## Thursday – November 14, 2019

### Closed Sessions

| | | |
|---|---|---|
| 7:00 am | Breakfast | Thurston |
| 8:00 am-Noon | Case Reviews – Panel A | Pacific |
| 8:00 am-Noon | Case Reviews – Panel B | Grays Harbor |
| Noon-12:30 pm | Lunch | Thurston |

### Open Session

| | | |
|---|---|---|
| 12:30 pm | *A Long & Colorful History of the Commission*<br>*Mike Farrell, JD, Policy Development Manager* | Thurston |

### Closed Sessions

| | | |
|---|---|---|
| 1:30 pm | Case Reviews – Panel A | Pacific |
| 1:30 pm | Case Reviews – Panel B | Grays Harbor |

4:00 pm **Policy Committee Meeting** Grays Harbor

| Agenda Items | Presented By: | Page #: |
|---|---|---|
| **Electromyography (EMG) – Needle and Surface, MD2000-01**<br>*Discussion of current interpretive statement, possible revisions or recension.* | Mike Farrell | 31 |
| **EHR & Medical Records**<br>*Discussion of draft guideline and possible revisions.* | Mike Farrell | 34 |
| **Allopathic Scope of Practice Relating to Osteopathic Manipulation Therapy Interpretive Statement**<br>*Discussion of draft interpretive statement, revisions, and possible approval for Secretary review.* | Micah Matthews | 49 |
| **Practitioner Competence Guideline**<br>*Discussion of current guideline and possible revisions.* | Micah Matthews | 52 |
| **Practitioners Exhibiting Disruptive Behavior Policy**<br>*Discussion of revised policy, revisions, and possible approval for Secretary review.* | Mike Farrell | 55 |
| **Elective Educational Rotations**<br>*Discussion of revised policy, revisions, and possible approval for Secretary review.* | Mike Farrell | 58 |
| **Stem Cell Rulemaking Timeline** | Amelia Boyd | N/A |
| **Clinical Support Program Rulemaking**<br>*Request to approve draft language and initiate CR-102 process.* | Amelia Boyd | 60 |



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## Friday – November 15, 2019

### Closed Session

| | | |
|---|---|---|
| 7:00 am | Breakfast | Thurston |

### Open Session

| | | |
|---|---|---|
| 8:00 am –9:30 am | **Business Meeting** | Thurston |

## 1.0 Chair Report

## 2.0 Consent Agenda

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

2.1 Minutes – Approval of the August 23, 2019 Business Meeting minutes. — Page 9

2.2 Agenda – Approval of the November 15, 2019 Business Meeting agenda.

## 3.0 Old Business

3.1 **Committee/Workgroup Reports** — Update

The Chair will call for reports from the Commission's committees and workgroups. — Written reports begin on page 14

See page 16 for a list of committees and workgroups.

3.2 **Rulemaking Activities** — Report

Report provided on page 20

The rules hearing for SSB 5380 – Patient Notification is scheduled for December 12 at 3:30. We still need 5 Commissioners for this hearing panel. There will be a call-in option. Please contact Amelia Boyd if you are able to participate.

3.3 **Lists & Labels Request** — Action

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

- Lahai Health dba Puget Sound Christian Clinic — Pages 22-26

## 4.0 New Business

4.1 **Training – Presentations by Commissioners**

Jimi Bush, Director of Quality & Engagement, will present on the ins and outs of presentations by Commissioners.



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4.2 **Meeting Dates for 2022** — Pages 28-29
Discussion of proposed meeting dates for year 2022.

4.3 **Federation of State Medical Boards (FSMB) Presentation** — 45 minutes
*Scott A. Steingard, DO – FSMB Board of Directors Chair*
*Mike Dugan, MBA – FSMB Chief Operating Officer*

## 5.0 Public Comment

The public will have an opportunity to provide comments.
***If you would like to comment during this time, please be sure to write "Yes" on the sign-in sheet.***

## 6.0 Policy Committee Report

Dr. Karen Domino, Chair, will report on items discussed at the Policy Committee meeting held on November 14, 2019. See the Policy Committee agenda for the list of items to be presented. — Report/Action Begins on page 31

## 7.0 Member Reports

The Chair will call for reports from Commission members.

## 8.0 Staff Member Reports

The Chair will call for further reports from staff. — Written reports begin on page 67

## 9.0 AAG Report

Heather Carter, AAG, may provide a report.

## 10.0 Adjournment of Business Meeting

### Open Sessions

| | | | |
|---|---|---|---|
| 10:30 am | Personal Appearances – Panel A | Pacific | Page 76 |
| 10:30 am | Personal Appearances – Panel B | Grays Harbor | Page 77 |

### Closed Sessions

| | | |
|---|---|---|
| Noon to 1:30 pm | Lunch available | Thurston |
| 12:00 pm to 1:00 pm | Citizen Engagement Workgroup | Pacific |
| 12:00 pm to 1:00 pm | Commissioner Education Committee | Cowlitz |

### Open Sessions

| | | | |
|---|---|---|---|
| 1:00 pm | Personal Appearances – Panel A | Pacific | Page 76 |
| 1:00 pm | Personal Appearances – Panel B | Grays Harbor | Page 77 |

In accordance with the Open Public Meetings Act, this meeting notice was sent to individuals requesting notification of the Department of Health, Washington Medical Commission meetings.

Times and Order:
The Policy Committee Meeting will begin at 4:00 pm on November 14, 2019 until all agenda items are complete. The Commission will take public comment at the Policy Committee Meeting.

- The Business Meeting will begin at 8:00 am on November 15, 2019 until all agenda items are complete. The Commission will take public comment at the Business Meeting. ***If you would like to comment at the Business Meeting, please be sure to write "Yes" on the sign-in sheet.***



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This agenda is subject to change.

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

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



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# Business Meeting Minutes
# August 23, 2019

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

## Commission Members

James E. Anderson, PA-C
Toni Borlas, Public Member – Absent
Charlie Browne, MD
Jimmy Chung, MD
Diana Currie, MD – Absent
Karen Domino, MD
Harry Harrison, Jr., MD
Christine Hearst, Public Member
Warren Howe, MD
April Jaeger, MD
Charlotte Lewis, MD – Absent
John Maldon, Public Member, 1st Vice Chair
Terry Murphy, MD
Alden Roberts, MD, Chair
Scott Rodgers, JD, Public Member
Theresa Schimmels, PA-C
Robert Small, MD
Claire Trescott, MD, 2nd Vice Chair – Absent
Candace Vervair, Public Member
Richard Wohns, MD
Yanling Yu, PhD, Public Member

## Commission Staff

Morgan Barrett, Director of Compliance
Jennifer Batey, Legal Support Staff Manager
Larry Berg, Staff Attorney
Amelia Boyd, Program Manager
Jim Burkholder, Investigator Supervisor
Jimi Bush, Director of Quality & Engagement
Sarah Chenvert, Performance Manager
Anna Clavel, Staff Attorney
Melanie de Leon, Executive Director
Mike Farrell, Policy Development Manager
Ryan Furbush, Paralegal
Rick Glein, Director of Legal Services
George Heye, MD, Medical Consultant
Mike Hively, Information Liaison
Jenelle Houser, Legal Assistant
Kyle Karinen, Staff Attorney
Becca King, Administrative Assistant
Kayla LaRue, Executive Assistant
Stephanie MacManus, Public Relations & Legislative Liaison
Micah Matthews, Deputy Executive Director
Ariele Page Landstrom, Staff Attorney
Freda Pace, Director of Investigations
Trisha Wolf, Staff Attorney
Gordon Wright, Staff Attorney

## Others in Attendance

Heather Carter, Assistant Attorney General (AAG)
Cori Tarzwell, DOH Policy Analyst

## Call to Order

Alden Roberts, MD, Chair, called the meeting of the Washington Medical Commission (Commission) to order at 8:01 a.m. on August 23, 2019, at the Capital Event Center, 6005 Tyee Drive SW, Tumwater, WA 98512.

## 1.0 Chair Report

Dr. Roberts welcomed everyone to the meeting. He announced the following new Commissioners and asked that they each introduce themselves:

- Christine Hearst, Public Member
- Scott Rodgers, Public Member

- Candace Vervair, Public Member

Dr. Roberts reminded the members to be sure to check their Commission email at least every other day.

He presented information about the October 3-5, 2019 Educational Conference.

He stated that we are recruiting for Pro Tems in the following areas:

- General Surgery
- Internal Medicine
- Orthopedics

He asked that if the members know any physicians in these areas who would be willing to serve on the Commission to please let Amelia Boyd, Program Manager know and she will reach out to them.

He presented information about the most recent Executive Committee meeting.

He reported about his experience when he attended the Board of Osteopathic Medicine and Surgery meeting in June.

He explained that cases will no longer be authorized for a focused investigation and the reasons why this will no longer occur.

He presented the Panel Case Decisions metrics from the Staff Report in the packet and opened the floor for discussion of the information.

## 2.0 Consent Agenda

The Consent Agenda contained the following items for approval:

**2.1** Minutes from the July 12, 2019 Business Meeting.
**2.2** Agenda for August 23, 2019.

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

## 3.0 Old Business

### 3.1 Committee/Workgroup Reports

Jimmy Chung, MD, Reduction of Medical Errors (ROME) Committee Chair, stated members of the committee recently attended a Foundation of Healthcare Quality meeting. Dr. Chung went on to report the details of that meeting.

### 3.2 Rulemaking Activities

There was nothing further to report.

### 3.3 Lists & Labels Request

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

- Relias LLC

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

## 4.0 New Business

### 4.1 RCM Assessment Document Training

Dr. Roberts presented the new RCM Assessment document and provided guidelines for completion.

## 5.0 Public Comment

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

## 6.0 Policy Committee Report

Dr. Karen Domino, Policy Committee Chair reported on the items discussed at the Policy Committee meeting held on August 22, 2019:

**Panel Consent Agenda Procedure, MD2015-12**

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

***Motion:*** The Chair entertained a motion to approve the procedure with the noted revisions. The motion was approved unanimously.

**EHR & Medical Records Guideline**

Dr. Domino presented the revisions to the guideline and stated the Committee recommended approving the document with the amendments. After discussion, more edits were needed and the guideline was deferred to a future meeting.

**Approving Entities That Credential Pain Management Specialists Procedure**

Dr. Domino presented the draft procedure and stated the Committee recommended approving the document.

***Motion:*** The Chair entertained a motion to approve the procedure. The motion was approved unanimously.

**Physician Assistants Ordering Patient Restraint and Seclusion, MD2015-02-IS**

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

***Motion:*** The Chair entertained a motion to approve the interpretive statement with the noted revisions. The motion was approved unanimously.

**Treating partners of Patients with Sexually Transmitted Chlamydia and Gonorrhea, MD2015-13**

Dr. Domino presented the guideline and stated the Committee recommended reaffirming the document as written.

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

## 6.0 Member Reports

Jim Anderson, PA-C, reported he was appointed to the Federation of State Medical Boards Education Committee.

## 7.0 Staff Member Reports

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

Freda Pace, Director of Investigations, introduced Teri Simpson, a new employee in Complaint Intake.

## 8.0 AAG Report

Heather Carter, AAG, had nothing to report.

## 9.0 ADJOURNMENT

The Chair called the meeting adjourned at 9:28 am.

Submitted by

Amelia Boyd, Program Manager

Alden Roberts, MD, Chair
Washington Medical Commission

Approved November 15, 2019

# Old Business

# Committee/Workgroup Reports: November 2019

**Telemedicine Workgroup – Co-Chairs: Toni Borlas, Dr. Browne**
**Staff: Micah Matthews**

The Telemedicine Workgroup is meeting for a rules workshop on November 13 to consider what, if any, rules should be adopted relating to telemedicine practice in Washington. As we have had a guideline and policy on the books for numerous years, it is time to consider adding them as rules language. We have had several requests in the past few years to add clarity through rules. It is an opportune time to consider other issues relating to artificial intelligence, clinical decision making support tools, and continuity of care issues.

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

For a detailed report of attendee feedback, please review the conference infographic here.

- Total Attendees: 137 (+ 19% from 2018).
- CME Credits Issued: 1199 (+54% from 2018).
- Monetary value of CME Credits Claimed: $124,496 (+152.5% from 2018).
- 69% of those who answered the feedback survey were 1st time attendees.
- We saved $12,000 by switching CME providers from WSMA to FSMB who provides Category 1 CME free of charge

**What Attendees Liked the Most**
The attendees cited the relevance of the topics, the structure of the conference and the fact that this is provided for free as their favorite parts of the conference. Having a "working lunch" was something we tried for the first time and was received very well.

**Ways to Improve the Conference**
The most common suggestion for improvement was a facility with better parking.

**How You Can Help**:
Please send Jimi Bush any ideas you have for the 2020 conference. If you did NOT attend the conference, please let Jimi know why. Was there a scheduling issue? Were you not interested in the topic? You feedback can help us shape next year's conference.

**Citizen Engagement Workgroup – Co-Chairs: Yanling Yu, John Maldon**
**Staff: Jimi Bush**

Meeting will be held on 11/15/2019 at 12:00 PM in the pacific room. We will be recapping the efforts of the CEW and looking for next steps in our work. All commissioners are

encouraged to attend, especially the new public members. We are always looking for a way to increase engagement with the general public and would love to hear your ideas.

| Reduction of Medical Errors Subcommittee – Chair: Dr. Chung<br>Staff: Mike Farrell |
|---|
| |

| Practitioner Competence Workgroup – Chair: Dr. Roberts<br>Staff: Micah Matthews |
|---|
| |

| Warm Handoff Workgroup – Chair: Dr. Trescott<br>Staff: Melanie de Leon |
|---|
| Still awaiting information on what other jurisdictions are doing and how the state is already doing this through local navigation teams. |

| Collaborative Drug Treatment Agreement Workgroup – Chair: Dr. Roberts<br>Staff: Melanie de Leon |
|---|
| Awaiting response from AGO on request for Attorney General's Opinion. |

| Commissioner Education Committee – Chair: None at this time<br>Staff: Melanie de Leon |
|---|
| Retreat scheduled for November 16th. Agenda and focus developed by committee, with input by Executive Committee. Committee to meet in Cowlitz room on Friday Nov. 15th noon-1 pm to discuss lunch & learn ideas. |

# 2019 Educational Conference Recap

WASHINGTON Medical Commission
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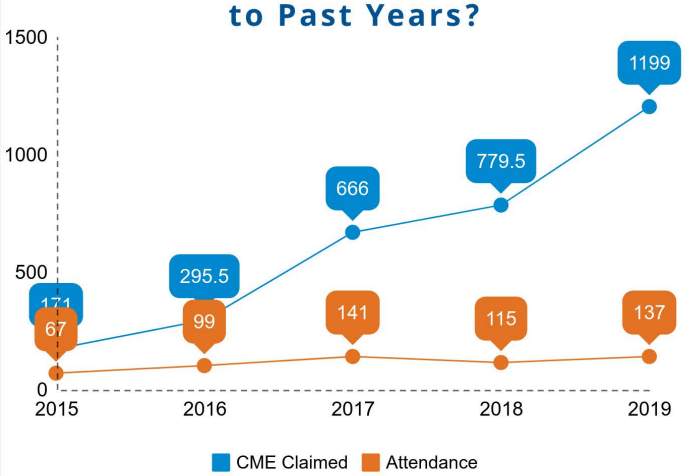
**Total Attendees**
137
(+19%)

**CME Credits Issued**
1199
(+54%)

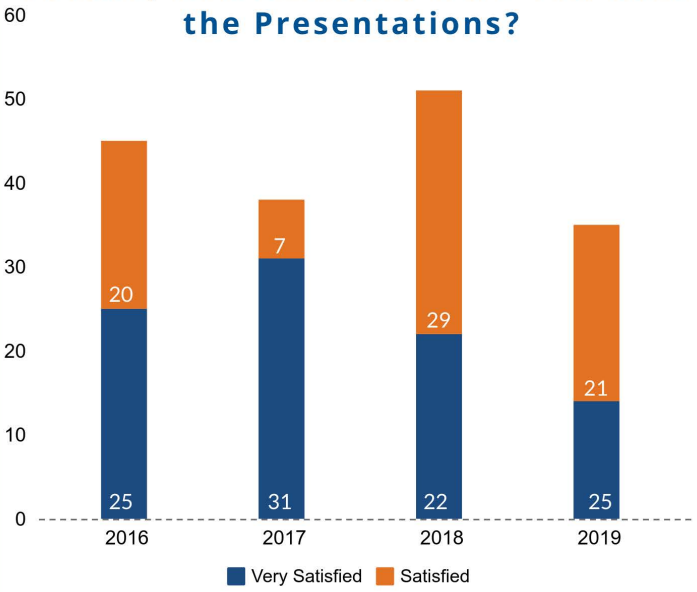
**Value of CME to Licensees**
$124,496
(+152.5%)

**Saved**
$12,000
By Switching CME providers

## How Does our Attendance Compare to Past Years?




## Overall, How Satisfied Were You With the Presentations?

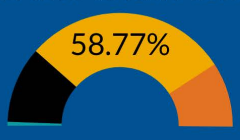



## How Would You Rate This Conference Compared to Other Conferences That You Have Attended?

Excellent (24.39%) Very Good (60.98%)
Average (14.63%) Poor (0%) Very Poor (0%)

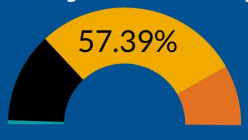
## How has the Following Changed Due to This Conference?

### Communication with Vaccine Resistant Parents




Decreased (0.88%) No Change (21.93%)
Increased (58.77%) Significantly Increased (18.42%)

### Understanding of Health Disparities




Decreased (0.87%) No Change (25.22%)
Increased (57.39%) Significantly Increased (16.52%)

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| Executive Committee |
|---|
| Dr. Roberts, Chair |
| John Maldon, 1st Vice Chair |
| Dr. Lewis, 2nd Vice Chair |
| Mimi Winslow, Policy Committee Chair |
| Dr. Howe |
| Melanie de Leon |
| Micah Matthews |
| Heather Carter (AAG) |

| Newsletter Editorial Board |
|---|
| Dr. Hopkins, Pro Tem Commissioner |
| Dr. Harrison |
| TBD, Public Member |
| Jim Anderson, PA-C |
| Jimi Bush, Managing Editor |
| Micah Matthews |

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

| 2019 Nominating Committee |
|---|
| Dr. Howe |
| Dr. Domino |
| Dr. Harrison |

| Reduction of Medical Errors Subcommittee |
|---|
| Dr. Chung, Chair |
| Dr. Howe |
| John Maldon |
| Dr. Roberts |
| Dr. Domino |
| Dr. Jaeger |
| Melanie de Leon |
| Mike Farrell |

| Policy Committee |
|---|
| Dr. Domino, Chair (B) |
| Mimi Winslow (A) |
| Dr. Roberts (B) |
| Dr. Howe (A) |
| Jim Anderson, PA-C (A) |
| John Maldon (B) |
| Harry Harrison, Jr., MD (A) |
| Heather Carter (AAG) |
| Melanie de Leon |
| Mike Farrell |
| Amelia Boyd |

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

| Annual Educational Conference Workgroup |
|---|
| Toni Borlas, Chair |
| Theresa Schimmels |
| Dr. Harrison |
| Jimi Bush, Organizer |

| Commissioner Education Committee |
|---|
| Dr. Domino |
| Dr. Chung |
| Dr. Roberts |
| Dr. Harrison |
| Toni Borlas |
| Dr. Terman, Pro Tem Commissioner |
| Melanie de Leon |
| Amelia Boyd |
| Jimi Bush |

| Panel L |
|---|
| John Maldon, Public Member, Chair |
| Dr. Browne |
| Dr. Roberts |
| Dr. Howe |
| Dr. Ashleigh, Pro Tem Commissioner |
| Theresa Schimmels, PA-C |
| Dr. Barrett, Medical Consultant |
| Kimberly Romero |
| Ariele Page Landstrom |
| Micah Matthews |

| Citizen Engagement Workgroup |
|---|
| John Maldon, Co-Chair |
| Yanling Yu, Co-Chair |
| Toni Borlas |
| Dr. Howe |
| Jimi Bush |
| Melanie de Leon |

| Warm Handoff Workgroup |
|---|
| Dr. Trescott, Chair |
| Jim Anderson, PA |
| Kyle Karinen, Staff Attorney |
| Jimi Bush |
| Melanie de Leon |

| Collaborative Drug Treatment Agreement Workgroup |
|---|
| Dr. Roberts, Chair |
| Dr. Chung |
| Dr. Small |
| John Maldon |
| Melanie de Leon |
| Micah Matthews |
| Kyle Karinen, Staff Attorney |

| Telemedicine Workgroup |
|---|
| Toni Borlas, Co-Chair |
| Dr. Browne, Co-Chair |
| Dr. Howe |
| Dr. Ashleigh, Pro Tem Commissioner |
| Dr. Roberts |
| Dr. Lewis |
| Mike Farrell |
| Micah Matthews |

| Practitioner Competence Workgroup |
|---|
| Dr. Roberts, Chair |
| Dr. Howe |
| Dr. Cheung |
| Dr. Small |
| Theresa Schimmels, PA-C |
| Dr. Johnson, Pro Tem Commissioner |
| Micah Matthews |
| Mike Farrell |

WASHINGTON Medical Commission
Licensing. Accountability. Leadership.

# Rule Making Committees

| Clinical Support Program |
|---|
| John Maldon |
| Dr. Howe |
| Dr. Small |
| Yanling Yu |
| Heather Carter (AAG) |
| Melanie de Leon |
| Mike Farrell |
| Amelia Boyd |

| Chapter 246-919 WAC |
|---|
| Dr. Howe, Chair |
| Mimi Winslow |
| John Maldon |
| Dr. Small |
| Dr. Roberts |
| Heather Carter (AAG) |
| Melanie de Leon |
| Amelia Boyd |

| Opioids: Prescribing & Monitoring |
|---|
| Dr. Roberts, Chair |
| Jim Anderson, PA-C |
| Dr. Marsh |
| Dr. Trescott |
| Dr. Small |
| Dr. Terman, Pro Tem |
| Heather Carter (AAG) |
| Melanie de Leon |
| Micah Matthews |
| Amelia Boyd |

| Telemedicine |
|---|
| Volunteers needed – Contact Amelia |
| Theresa Schimmels, PA-C |
| Heather Carter (AAG) |
| Melanie de Leon |
| Micah Matthews |
| Amelia Boyd |

| Stem Cells |
|---|
| Volunteers needed – Contact Amelia |
| Yanling Yu |
| Dr. Browne |
| Heather Carter (AAG) |
| Melanie de Leon |
| Micah Matthews |
| Amelia Boyd |

| WMC Rules Progress Report | | | | | | | | Projected filing dates | | |
|---|---|---|---|---|---|---|---|---|---|---|
| **Rule** | **Status** | **Date** | **Next step** | **Complete By** | **Notes** | **Submitted to RMS** | **SBEIS Check** | **CR-101** | **CR-102** | **CR-103** |
| Clinical Support MDs & PAs (formerly Technical Assistance) | Draft language revised | 10/10/2019 | Present draft language from 11/13 workshop to full Commission. | 11/15/2019 | Keep Osteo updated. Workshop to discuss draft language scheduled for 11/13. | CR-102: 4/22/2019 | | Complete | On Hold | Unknown |
| Chapter 246-919 WAC Update | Submitted CR-102 to OS review | 9/18/2019 | OS review | 11/20/2019 | Include **MD** Military Spouse rules. | CR-102: 11/6/2019 | | Complete | December 2019 | January 2020 |
| Telemedicine | CR-101 filed | 9/17/2019 | Workshops | Unknown | Keep Osteo updated. | | | Complete | Unknown | Unknown |
| Stem Cells | CR-101 submitted for review | 8/28/2019 | Discuss the filing timelines with Commission at November meeting | 11/15/2019 | Keep Osteo updated. | | | On Hold | Unknown | Unknown |
| SSB 5380 - Opioid Prescribing | CR-102 filed | 10/22/2019 | Hearing | 12/12/2019 | | | | Complete | October 2019 | December 2019 |
| Opioid Prescribing - LTAC, SNF patient exemption | CR-101 approved | 11/9/2018 | File CR-101 | December 2019 | | | | December 2019 | March 2020 | June 2020 |
| Ch. 246-918 WAC - Name change | CR-105 filed | 9/17/2019 | CR-103 | January 2020 | | | | CR-105 Completed | | January 2020 |

# Lists & Labels

Washington State Department of Health
*Health Professions Quality Assurance*

# Application for Approval to Receive Lists

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

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

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

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

| David Eller | 206-899-4762 | Davide@lahai.org |
|---|---|---|
| Primary Contact Name ↴ | Phone ↴ | Email ↴ |

| Janelle Kono | | Janellek@lahai.org |
|---|---|---|
| Additional Contact Names (Lists are only sent to approved individuals) ↴ | | Website URL ↴ |

| Lahai Health dba Puget Sound Christian Clinic | 33-1052418 |
|---|---|
| Professional Assoc. or Educational Organization ↴ | Federal Tax ID or Uniform Business ID number ↴ |

| 19820 Scriber Lake Rd Suite #2 | Lynnwood, WA 98036 |
|---|---|
| Street Address ↴ | City, State, Zip Code ↴ |

Soliciting volunteers for our medical and dental clinics.
1. How will the lists be used? ↴

Medical Providers, Nurses, Dentists, and Dental Hygeinists
2. What profession(s) are you seeking approval for? ↴

medical Providers = M.D. + P.A.

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

Email to: PDRC@DOH.WA.Gov
Mail to: PDRC - PO Box 47865 - Olympia WA 98504-7865
Fax to: PDRC - 360-586-2171

David Eller 9/18/19
Signature ↴ Date ↴

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

For Official Use Only Authorizing Signature: _____
Approved: _____ (5-year) _____ (one-time) Printed Name: _____
Denied: _____ Title: _____ Date: _____

Lahai HEALTH

SERVING COMMUNITY

# MEDICAL CLINIC VOLUNTEERS

**To serve patients in need throughout Puget Sound, we depend on a diverse group of volunteers for each weekly clinic (mobile or fixed). Below, you can find descriptions of the unique roles where volunteers can serve.**

Volunteers typically sign up to serve 1-2 times monthly for a 5-hour shift during a clinic's operating hours. We ask for a 1-year commitment from volunteers and provide training specific to the position, including: Patient Confidentiality (HIPPA) & Blood-borne Pathogens training, Electronic Health Record (EHR) software training, and shadowing opportunities alongside an experienced volunteer in your desired position.

**For more information, please contact our Volunteer Coordinator at (206) 899-4754, or email volunteer@lahai.org. Our volunteer application is available on our website at lahai.org.**

## Patient Care Coordinators
### *(Receptionists/Schedulers)*

Patient Care Coordinators facilitate a positive experience for everyone. They can volunteer in reception, patient scheduling or *both!* In reception, they set-up the front end patient area prior to the start of the clinic, greet patients, collect donations, ensure patient paperwork is completed correctly, enter new patient information into our EHR program, answer phones, and schedule follow-up appointments. In scheduling, they ensure our patients secure an appointment. They accept incoming clinic calls, review patient messages, return phone calls promptly, screen patients for eligibility, ensure the care they are seeking is available at **Lahai** and schedule the patients accordingly. This is done in collaboration with **Lahai** staff in the office for support. Patient Care Coordinator applicants should be organized, detail oriented, friendly, patient, work well with others, have excellent phone skills, and possess basic computer skills.

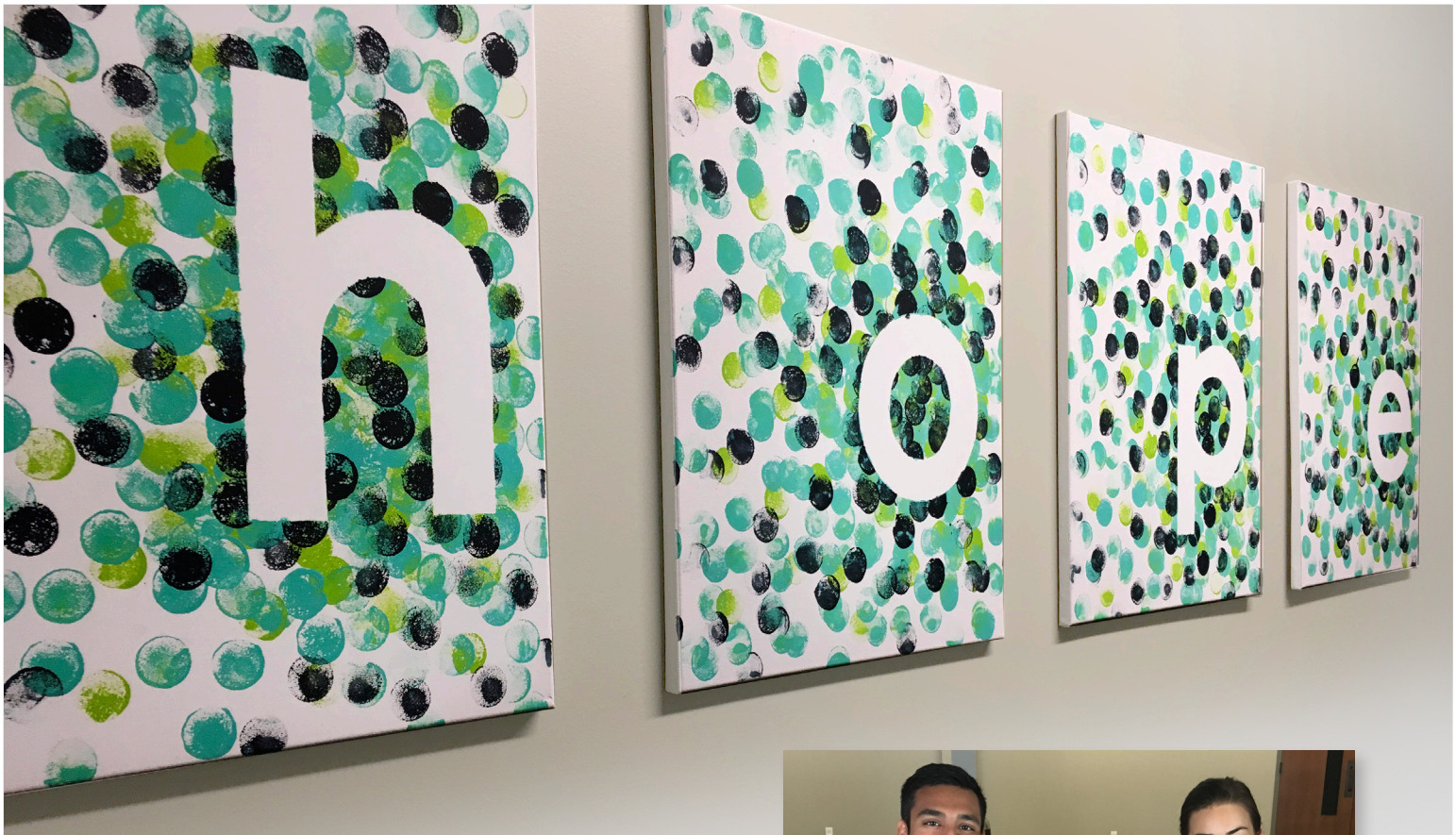
## Patient Advocates

Patient Advocate volunteers serve during clinic hours and address our patients' holistic needs. Primary responsibilities include listening to patient concerns, praying with patients, and connecting patients with additional resources within their community (i.e. food banks, shelter, utility bill assistance programs, local churches, etc.). Patient Advocate volunteers should be kind, compassionate and comfortable connecting with patients on a deeper level.

## Medical Providers and Specialty Providers

Medical Providers provide primary health care during clinic hours. **Lahai** providers are family physicians, internists, nurse practitioners, and physician's assistants. We also have providers who specialize in podiatry, cardiology, physical therapy, optometry, chiropractic care and nutrition/diabetic education. All providers must be licensed and have malpractice insurance. **Note:** For licensed volunteers who do not have malpractice insurance, it is available free of charge through WHAA. **Lahai** will assist our volunteer providers in obtaining this insurance.

THANK YOU FOR SUPPORTING YOUR COMMUNITY




## Nurses/MA/CNA

Nurses provide nursing services to patients during clinic hours and assist with special events like health fairs screening in the community. RN's, LPN's, MA's, CNA's are needed. All nurses must be licensed and have malpractice insurance. **Note:** For licensed volunteers who do not have malpractice insurance, it is available free of charge through WHAA. **Lahai** will assist our volunteer providers in obtaining this insurance.

## Case Managers

Case Managers help our patients access lab tests, diagnostic tests, and specialty care. Volunteer opportunities for this position occur during both clinic and non-clinic hours. Generally, case managers are nurses or have some medical knowledge/background.

## PAP Assistants

Pharmacists, pharmacy technicians, and even non-pharmacy professionals help our patients access lower cost prescription medications. Most often, this involves helping the patient to complete the Patient Assistance Program (PAP) forms necessary to obtain medication through pharmaceutical companies. Patient advocates must possess basic computer skills, basic phone skills, be detail oriented, and work well with others.

## Translators

We serve many patients that have specific language needs. Our translators help at clinic with reception, as a patient advocate, and medical translation during the medical appointments. Outside of clinic hours, translators are needed to assist with patient scheduling and translation of patient materials.

## Site Coordinators

The Site Coordinator is a liaison between **Lahai** and the host site from which the mobile clinic operates in a given community. Responsibilities of the Site Coordinator include communication with partner organizations in the community, ensuring smooth operations of the clinic, and scheduling volunteers for the clinic at their assigned site. Each site has two to three coordinators who partner with each other.

## Off-site Clinic Volunteers

There are many tasks that must get done both prior to and after clinic hours. Many off-site opportunities are available including providing meals/snacks for volunteers, administrative assistance or volunteer program support.

***The above positions are our most common needs but not necessarily all of the volunteer opportunities available. If you have a suggestion for something you would like to bring to the clinic, do not hesitate to contact us!***

**From:** David Eller
**To:** Boyd, Amelia (WMC)
**Subject:** RE: Application to receive lists
**Date:** Tuesday, October 22, 2019 4:05:28 PM
**Attachments:** image001.jpg
image002.jpg
image007.png
image008.png
image003.jpg
Medical-Clinic-Volunteer flyer.pdf

---

Amelia Boyd,

Thank you for requesting more information. Attached is a medical clinic flyer about volunteering with Lahai Health. Volunteering to serve the health needs of their community is of interest to your members and directly improves the quality of care rendered to the public. We are providing opportunities for medical professionals to volunteer through a nonprofit to use their skills to provide health care for those not able to access the current system.

Thank you for your consideration,
Dave

David Eller
Executive Director, Lahai Health
206-899-4762
Lahai-logos-small

---

**From:** Boyd, Amelia (WMC) [mailto:Amelia.Boyd@wmc.wa.gov]
**Sent:** Tuesday, September 24, 2019 2:58 PM
**To:** David Eller <davide@lahai.org>
**Subject:** Application to receive lists

Good afternoon,

The Medical Commission has received your attached application to receive lists and labels for allopathic physicians and allopathic physician assistants. As stated on the application: “Please attach information that demonstrates that you are a "professional association" or an "educational organization" and a sample of your proposed mailing materials.” If we receive these materials before November 5th, the Commission will review your application packet on November 15. If we receive the materials after November 5th, your application packet will be reviewed at a future meeting.

Thank you

Amelia Boyd
(formerly Daidria Amelia Underwood)
Program Manager
Washington Medical Commission
Office: (360) 236-2727
Mobile: (360) 918-6336

Were you satisfied with the service you received today? Yes or No

# New Business

# 2022 Meeting Schedule

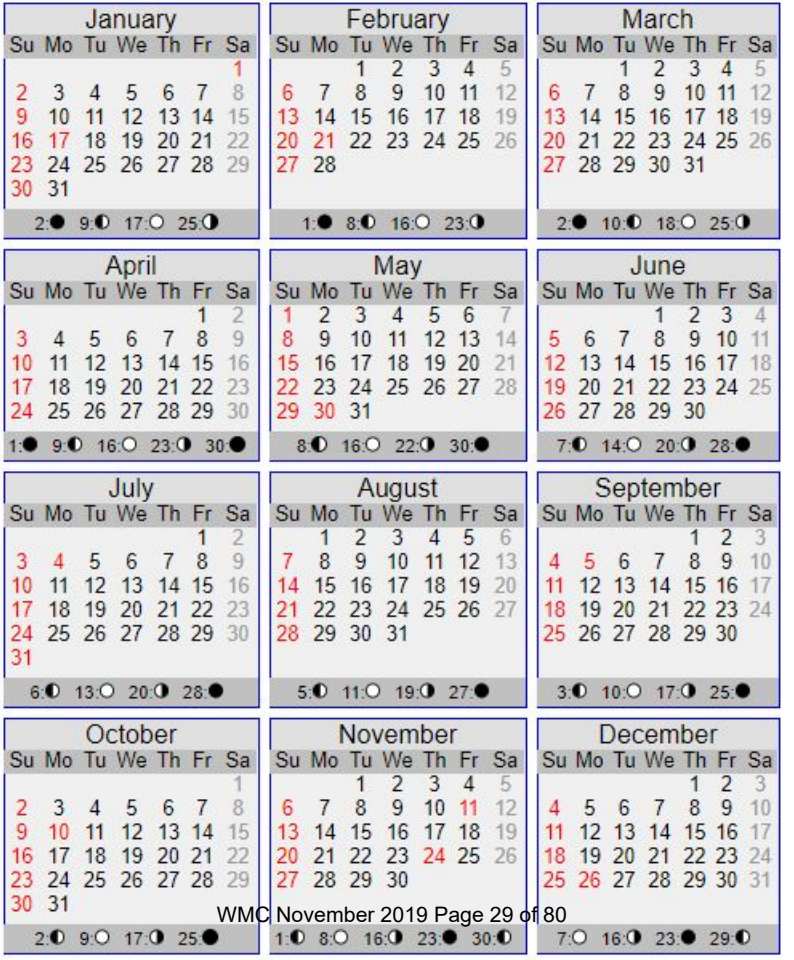
WASHINGTON Medical Commission
Licensing. Accountability. Leadership.

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

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

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

# Calendar for Year 2022 (United States)



## January

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## December

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# Policy Committee

State of Washington
Washington Medical Commission

# Interpretive Statement

| | |
|---|---|
| Title: | Needle Electromyography (EMG) ~~– Needle and Surface~~ ~~MD2000-01~~ |
| References: | RCW 18.71.011(3) |
| Contact: | Washington Medical Commission |
| Phone: | (360) 236-2750 E-mail: medical.commission@wmc.wa.gov |
| Effective Date: | ~~June 2, 2000, Reaffirmed as written May 19, 2017~~ |
| Supersedes: | MD2000-01, adopted June 2, 2000. |
| Approved By: | ~~Jan Paxton, PA-C, Vice Chair (Signature on file)~~ |

## ~~Description of the Issue~~

~~Are the practices of needle electromyography (EMG) and taped surface EMG the practice of medicine?~~

The Washington Medical Commission (Commission) interprets RCW 18.71.011, to conclude that the practice of needle electromyography is the practice of medicine.

> RCW 18.71.011 provides in part:
>
> Definition of practice of medicine—Engaging in practice of chiropractic prohibited, when.
>
> A person is practicing medicine if he or she does one or more of the following:
>
> ...
>
> (3) Severs or penetrates the tissues of human beings;
>
> ....

## ~~Background Information~~

~~The American Association of Electrodiagnostic Medicine (AAEM) posed the above question. They had asked the same question in 1995 and are requesting a current statement of the Washington Medical Commission's (commission) position.~~

~~According to AAEM, numerous developments have occurred in the area of EMG in recent years. "In addition to the traditional needle EMG, there is now also a technology called surface EMG.~~

~~Needle EMG is the study of the insertional, spontaneous, and voluntary electrical activity of muscle, performed by insertion of a needle electrode into the muscle and recording its electrical activity at rest and during voluntary contraction. Needle EMG is used to exclude, diagnose, describe, and follow diseases of the peripheral nervous system and muscles, and has a proven and long established place in the diagnosis and treatment of disorders of nerve and muscle. The accuracy of needle EMG testing is very dependent on the skill of the examiner. The diagnostic interpretation of the needle EMG examination takes place during the performance of the test. For these reasons, the AAEM has long held the position that needle EMG should only be performed by physicians who have comprehensive knowledge of neurological and musculoskeletal disorders to assure accurate interpretation and diagnosis. This position is supported by the American Medical Association, American Academy of Neurology, American Academy of Physical Medicine and Rehabilitation, American Neurological Association, Department of Veterans Affairs, and many state medical examining boards."~~

~~"Surface EMG refers to a recording of electrophysiologic signals from skeletal muscles. The recording is made using electrodes placed on the surface of the skin overlying the muscle to be studied, and consists of motor unit action potential discharges. The electrical activity is only observed when the muscle is activated; it does not include any monitoring of externally stimulated muscle activity. Surface EMG is a relatively new technique, particularly in comparison to needle EMG, and many current uses of surface EMG are still considered to be investigational. The AAEM does not currently have a position regarding who may perform surface EMG."~~

## ~~Analysis~~

Electromyography is a diagnostic procedure to assess the health of muscles and the nerve cells that control them (motor neurons). The results can reveal nerve dysfunction, muscle dysfunction or problems with nerve-to-muscle signal transmission. An EMG may uses electrodes to translate these signals into graphs, sounds or numerical values, that are then interpreted by a specialist. During a needle EMG, a needle electrode inserted directly into a muscle records the electrical activity in that muscle.

~~September 14, 1995 Dr. Robert R. Miller, Commission Medical Consultant wrote on behalf of the Commission:~~

> ~~*The Medical Quality Assurance Commission (former name of the Commission) considered the request of your association at the August 24, 1995 meeting. You are referred to the Law Governing Physicians and Surgeons in which the definition of the*~~

~~*practice of medicine is stated in RCW 18.71.011(3) the severing or penetrating of human tissue is the practice of medicine, so that the use of needle electrodes (as opposed to taped surface electrodes) would place needle electrode procedures into the medical practice field. The Commission's rationale is dictated by the wording of the law.*~~

## ~~Stakeholders~~

- ~~Physicians~~
- ~~Consumers~~
- ~~Companies that provide electromyography equipment~~

## ~~Position~~

~~The commission maintains its previous position. The Medical Practice Act, RCW 18.71.011(3), states that severing or penetrating the tissues of human beings is the practice of medicine. Therefore the use of needle electrodes (EMG) is the practice of medicine.~~

~~The commission declines to take a position on whether taped surface electromyography (EMG) is the practice of medicine.~~

Since needle electromyography involves penetrating tissue, it falls within the definition of the practice of medicine in RCW 18.71.011. This interpretive statement covers only electromyography using needles, and does not address the use of electromyography using surface electrodes or other noninvasive modalities.

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

*Observe, record, tabulate, communicate.*

-Sir William Osler (1849-1919)

## Introduction

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

## Guideline

### I. Documentation

#### A. Purpose of the Medical Record

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

The medical record is a chronological document that:

1. Records pertinent facts about an individual's health and wellness;
2. Enables the treating care provider to plan and evaluate treatments or interventions, making clear the rationale for diagnoses, plans and interventions;
3. Enhances communication between professionals, assuring the patient optimum continuity of care;

4. Assists both patient and practitioner in communication with third party participants;
5. Facilitates the practitioner's development of an ongoing quality assurance program;
6. Provides a legal document for verification and/or audit of the delivery of care; and
7. Is available as a source of clinical data for research and education.

**B. The Essential Elements of a Medical Record**

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

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

**C. Additional Elements of a Medical Record**

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

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

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

### D. Special Considerations When Using an Electronic Health Record

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

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

1. Recommendations for Practitioners

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

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

a. A practitioner using an EHR must ensure:

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

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

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

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

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

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

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

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

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

2. Suggestions for EHR Software Developers and Healthcare Institutions

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

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

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

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

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

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

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

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

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

   i. leads to improved patient outcomes;
   ii. ensures safe transitions of patients from one practitioner, facility, or office to another;
   iii. allows easy tracking and reporting of patient care metrics and outcomes; and
   iv. promotes patient-centered communication between patients and the health care system.[3]

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

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

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

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

## II. Access to Medical Records

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

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

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

C. To prevent misunderstandings, the practitioner's policies about providing copies or summaries of medical records and about completing forms should comply with appropriate laws and should be made available in writing to patients when the practitioner-patient relationship begins.

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

## III. Retention of Medical Records

A. There is no general law in Washington requiring a practitioner to retain a patient's medical record for a specific period of time.[†] As stated earlier, ~~T~~the Commission appreciates the variety of medical practices and urges practitioners to exercise reasonable judgment based on its specialty for the retention of medical records. When appropriate, the Commission encourages practitioners to be familiar~~concurs~~ with the Washington State Medical Association recommendation that practitioners should retain medical records and x-rays for at least:

1. ten years from the date of a patient's last visit, prescription refill, telephone contact, test or other patient contact;
2. 21 years from the date of a minor patient's birth;
3. six years from the date of a patient's death; or
4. indefinitely, if the practitioner has reason to believe:
    a. the patient is incompetent;
    b. there are any problems with a patient's care, or
    c. the patient may be involved in litigation.

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

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

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

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

## IV. Storage of Records

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

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

## V. Disposing of Records

A. When retention is no longer required, records should be destroyed by secure means. The Privacy Rule in the Health Insurance Portability and Accountability Act (HIPAA) prohibits digital and paper records containing confidential information from being thrown away in a public dumpster or recycling bin until they have been rendered unreadable or indecipherable by shredding, burning or other destruction.

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

## VI. Handling Medical Records When Closing a Medical Practice

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

B. The recommendations in this section do not apply to:

1. A practitioner who leaves a multi-practitioner practice. In that instance, the remaining practitioners in the practice typically assume care of the patients and retain the medical records.
2. A specialist or other practitioner who does not have ongoing relationships with patients. These practitioners typically provide patient records to the referring practitioner, the patient's primary care provider, or directly to the patient.

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

D. The notice should be given at least 30 days in advance, with 90 days being the best practice.

E. The notice should be given by:

1. individual letter to the last known patient address; ~~and~~or
2. electronically, if this is a normal method of clinical communication with the patient; ~~and~~or
3. placing a notice on the practitioner's web site, if the practitioner has a web site.

F. The notice should include:

1. the name, telephone number and mailing address of the responsible entity or agent to contact to obtain records or request transfer of records;
2. how the records can be obtained or transferred;
3. the format of the records, whether hard copy or electronic;

4. how long the records will be maintained before they are destroyed; and
5. the cost of recovering records or transferring records as defined in Chapter 70.02 RCW.

G. The practitioner ~~should also~~is encouraged to provide notice to the local medical society, whether the practitioner is a member or not.

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

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

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

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

-Sir William Osler (1849-1919)

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Date of Adoption:

Supersedes: Retention of Medical Records GUI2017-02; Physician and Physician Assistants' Use of the Electronic Medical Record MD2015-09

# Appendix

## I. History of the Medical Record

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

As medical education and the medical profession progressed following the Flexner Report in 1910 [2], it became necessary to document a patient's history for continuity of care and to accommodate growing involvement of medical and surgical specialists. In 1918, the American College of Surgery initiated a

requirement that hospitals maintain records on all patients so that their content could be used for quality improvement. [5]

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

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

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

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

- Tell the patient's unique story as it relates to the patient's concerns ("the patient voice")
- Demonstrate diagnostic thinking and decision-making process undertaken by the practitioner.
- Provide clinical information to allow covering or consulting colleagues to maintain care and make informed decisions regarding further care
- Support coordinated longitudinal plans of care and care transitions within and across organizations
- Provide a clear and easily understood summary of the encounter, including findings and recommendations, to the patient or the patient's designated representative

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

- Provide clinical information to drive accurate Clinical Decision Support
- Support and identify the quality of care provided to patients
- Satisfy reasonable documentation requirements from payers
- Create the legal business record of the patient care facility
- Support population data collection and research
- Create the legal record of a patient's medical and surgical care
- Meet legal, accreditation, and regulatory criteria

**Table 2: Medical Record Audiences**

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

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

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

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

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

- A judge in a medical malpractice case found the EHR inadmissible because it contained so much redundant and irrelevant information.

## III. Current EHR Implementation

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

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

- Ease of quality improvement and research studies electronic data are more readily accessible for quality improvement, public health, and research studies.

**Potential challenges with current EHR implementation**. The EHR theoretically promises to improve efficiency and communication, reduce errors, and improve quality of care. Yet, every advance brings with it the potential for new problems, and the EHR is no exception. There are serious negative implications to poorly designed EHR systems, suboptimal EHR implementation, or careless EHR use by practitioners. A poor quality medical record, which could be inaccurate, inconsistent, incomplete, or obscure important information among unneeded or redundant detail, may adversely impact current or future care, transfers of care, and/or medico-legal investigations. Problematic aspects of current EHRs include:

- **Increased work load:** Data entry into the EHR can be time-consuming, particularly for practitioners who do not type well.**
- **Copy-paste:** Electronically carrying forward or copying portions of previously written notes and pasting them into a currently drafted note is problematic when it is either:
  - Copying the work of others without attribution ("clinical plagiarism") or without independent confirmation.††
  - Introducing unnecessary redundancy (see next point—"note-bloat.").
- **"Note-bloat":** Note bloat refers to unnecessary and redundant expansion of a note's length and complexity. With electronic documentation, it is easy to incorporate large volumes of data into clinical documentation. Inappropriate copy-paste, carry-forward, and computer-aided data entry (auto-filling) increases the risk of lengthy but information-poor notes. Such redundant content detracts from readability, makes it more difficult to interpret and identify pertinent content, and jeopardizes the communication for which clinical notes are intended.
- **"Boilerplate":** Despite the appeal of using templates, "boilerplate" text may add unnecessary detail that detracts from more important information. Furthermore, busy practitioners may carelessly retain parts of a normal review of systems or examination from the template rather than correctly indicating abnormal reports or findings from their interaction with the patient, resulting in inconsistent and erroneous information within the medical record.
- **Differences between the electronic version and paper copy of the EHR:** The printed copy of the EHR may look very different from the electronic version. Specifically, the paper copy of the EHR may differ from the electronic version either by including auto-populated redundant or extraneous information or excluding data that could not be readily printed. Currently, however, when copies of records are requested for patient care, investigative, or discovery purposes; they are typically provided as paper copies, often at a considerable cost to the requesting party, which may be difficult to read or incompletely reflect patient care.

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

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

- **"Pseudo-history" and "pseudo-examination"*:*** Some EHRs convert checked symptom boxes into sentences and paragraphs that are then imported into the EHR such that they appear to recount the verbatim report of the patient. However, the generated history is not derived from the patient's actual words; it only represents binary (YES/NO) data processed into standardized phrases. A similar process with checkbox-to-sentence physical examination findings is available. Such technology potentially undermines consideration of each patient as an individual and conceals the nuances of his/her unique history and needs.
- **Errors in the EHR can be perpetuated and difficult to correct:** Some of these errors have serious undesirable implications for subsequent care and patients' health. Providers and patients complain that when an error occurs in the EHR, it can be very difficult to correct. These errors in documentation can be perpetuated over time and may lead to actual medical errors and adverse patient outcomes.
- **Interference with provider-patient relationship:** Real-time EHR entry during a patient visit may interfere with face-to-face contact with the patient, which may reduce active listening, conceal important diagnostic clues, and damage patient-practitioner rapport.
- **Overemphasis on documentation to meet billing specifications:** This issue largely dates back to E&M regulatory efforts, initiated when paper medical records still predominated. However, EHR systems have also incorporated E&M elements into their electronic templates leading to concern that documentation whose major design objective is to support coding and billing may subvert the true goal of the EHR, which is to promote high-quality, safe, and integrated health care.

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Department of Health
Washington Medical Commission

# Interpretive Statement

| | | |
|---|---|---|
| Title: | Allopathic Physicians Scope of Practice Relating to Osteopathic Manipulative Therapy | INS2019-0X |
| References: | RCW 18.71.011; 18.57.001(4); 18.25.005 | |
| Contact: | Washington Medical Commission | |
| Phone: | (360) 236-2750 E-mail: medical.commission@wmc.wa.gov | |
| Effective Date: | | |
| Approved By: | | |

The Washington Medical Commission (Commission) interprets RCW 18.71.011, RCW 18.57.001(4) and RCW 18.25.005 to permit an allopathic physician to perform a musculoskeletal physical examination, regardless of the anatomy being examined, and to perform any treatment of a patient's back or spine, including osteopathic manipulative therapy, so long as it does not involve manual adjustment of the spine that would be considered the practice of chiropractic.

RCW 18.71.011 defines the practice of allopathic medicine:

> A person is practicing medicine if he or she does one or more of the following:
>
> (1) Offers or undertakes to diagnose, cure, advise, or prescribe for any human disease, ailment, injury, infirmity, deformity, pain or other condition, physical or mental, real or imaginary, by any means or instrumentality;
>
> (2) Administers or prescribes drugs or medicinal preparations to be used by any other person;
>
> (3) Severs or penetrates the tissues of human beings;
>
> (4) Uses on cards, books, papers, signs, or other written or printed means of giving information to the public, in the conduct of any occupation or profession pertaining to the diagnosis or treatment of human disease or conditions the designation "doctor of medicine," "physician," "surgeon," "m.d.," or any combination thereof unless such designation additionally contains the description of another branch of the healing arts for which a person has a license: PROVIDED HOWEVER, That a person licensed under this chapter shall not engage in the practice of chiropractic as defined in RCW 18.25.005.

RCW 18.57.001(4) describes the scope of practice of an osteopathic physician as follows:

> (4) "Osteopathic medicine and surgery" means the use of any and all methods in the treatment of disease, injuries, deformities, and all other physical and mental conditions in and of human beings, including the use of osteopathic manipulative therapy; ….

RCW 18.25.005 defines the scope of chiropractic practice. It provides, in part:

> "Chiropractic" defined.
>
> (1) Chiropractic is the practice of health care that deals with the diagnosis or analysis and care or treatment of the vertebral subluxation complex and its effects, articular dysfunction, and musculoskeletal disorders, all for the restoration and maintenance of health and recognizing the recuperative powers of the body.
>
> (2) Chiropractic treatment or care includes the use of procedures involving spinal adjustments and extremity manipulation. Chiropractic treatment also includes the use of heat, cold, water, exercise, massage, trigger point therapy, dietary advice and recommendation of nutritional supplementation, the normal regimen and rehabilitation of the patient, first aid, and counseling on hygiene, sanitation, and preventive measures. Chiropractic care also includes such physiological therapeutic procedures as traction and light, but does not include procedures involving the application of sound, diathermy, or electricity.
>
> …
>
> (5) Nothing in this chapter prohibits or restricts any other practitioner of a "health profession" defined in RCW 18.120.020(4) from performing any functions or procedures the practitioner is licensed or permitted to perform, and the term "chiropractic" as defined in this chapter shall not prohibit a practitioner licensed under chapter 18.71 RCW from performing medical procedures, except such procedures shall not include the adjustment by hand of any articulation of the spine.

It is clear from the above statutes that only osteopathic physicians and chiropractors can perform manual adjustment of the spine. Allopathic physicians are specifically excluded. The Commission understands there is uncertainty about what other procedures involving the spine that allopathic physicians can legally perform. The Commission wishes to clarify this issue.

Allopathic physicians frequently evaluate and treat patients for back pain. Standard treatment involves a diagnostic physical examination that includes assessing the patient's ability to sit, stand, walk and lift their legs, as well as having the patient rate their pain and describe how they are functioning with the pain. The physical examination typically also includes palpating the patient's back, including the spine, to help determine the area of the pain. All of this is done to properly diagnose the cause of the pain, decide if additional testing is required, and determine an appropriate plan of treatment. Treatment can include physical therapy, exercise, medication,

and, in some cases, surgery. This treatment may involve manual adjustment of the spine, but it is the practice of medicine and is not considered the practice of chiropractic.

The confusion may arise because the legal scope of practice for osteopathic physicians, RCW 18.57.001(4), permits osteopathic physicians to perform osteopathic manipulative therapy (OMT). The osteopathic practice act does not define OMT. According to the American Osteopathic Association, OMT "is a set of hands-on techniques used by osteopathic physicians (DOs) to diagnose, treat, and prevent illness or injury. Using OMT, a DO moves a patient's muscles and joints using techniques that include stretching, gentle pressure and resistance." OMT involves much more than a manual adjustment of the spine.

The Commission is cognizant of the increasing blurring of the distinction between allopathic and osteopathic physicians. Osteopathic physicians and allopathic physicians are training in the same residency programs on an increasing basis. In 2020 accreditation for allopathic and osteopathic residencies will transition from two separate accreditation systems into a single accreditation system with the Accreditation Council for Graduate Medical Education. In these residencies, osteopathic physicians are teaching allopathic physicians to perform OMT as they have been for years. The Commission supports any physician doing what he or she has been trained to do. This may include OMT depending upon the training and experience of the physician.

The Commission interprets RCW 18.71.011, RCW 18.57.001(4) and RCW 18.25.005 to permit an allopathic physician to perform a musculoskeletal physical examination, regardless of the anatomy being examined, and to perform any treatment of a patient's back or spine, including osteopathic manipulative therapy, so long as it does not involve manual adjustment of the spine that would be considered the practice of chiropractic. Manipulation of the spine that is incidental to the treatment of the patient is not considered the practice of chiropractic.

State of Washington
Medical Quality Assurance Commission

# Guideline

| | | |
|---|---|---|
| Title: | Practitioner ~~Competence~~Wellness | GUI2018-02 |
| References: | AMA Code of Ethics 9.3.1 Physician Health & Wellness; RCW 18.71.050; RCW 18.130.170 | |
| Contact: | Medical Commission Licensing Unit | |
| Phone: | (360) 236-2750 | E-mail: medical.commission@doh.wa.gov |
| Effective Date: | April 13, 2018 | |
| Approved By: | ~~Warren Howe~~, MD, Chair (signature on file) | |

## ~~Assessment~~ Screening Framework

The ongoing assessment of competent medical practice is a life-long process and begins with the health and wellness of the practitioner. The Washington Medical Commission (WMC) recommends practitioners participate in regular health screenings ~~evaluations~~ as part of their professional responsibility. Such ~~evaluations~~ screenings should include physical~~, ,dexterity~~, mental, ~~and~~ cognitive components such as the MicroCog or MOCA, and dexterity if a proceduralist. In most situations, feedback from external sources such as patients and peers are beneficial tools for self-assessment and monitoring.

Practitioners should commence these ~~evaluations~~ screenings starting with their first certification cycle (ABMS for physicians or NCCPA for physician assistants) following initial certification. If a practitioner does not pursue certification, the practitioner should initiate a~~n evaluation~~ screening ~~-~~after completing a residency or other postgraduate training. These initial ~~evaluations~~screenings, beginning at around age 30 for most, will serve as a baseline metric for future comparison during the practitioner's career. ~~It is recommended to~~Practitioners should receive the physical and mental screening from an appropriate practitioner ~~that~~who does not serve as their primary care practitioner.

Practitioners may find it convenient to do these ~~assessments~~ screenings in conjunction with their recertification process, which generally occurs every seven to ten years. The Commission generally recommends practitioners reduce the interval between these ~~evaluations~~ screenings as they age to better detect evolving limitations. Practitioners with chronic illnesses, lacking specific senses, or known disabilities should consider increasing the frequency of their ~~assessments~~ screenings regardless of age to better enable monitoring of status changes.

**Commented [FM(1]:** If we are limiting the document to screenings and not evaluations, then this sentence seems out of place.

**Commented [MTM2R1]:** Originally this sentence was placed here in lieu of 360 assessment language. It is not strictly describing what a full clinical assessment actually is. I would argue it could bring benefit.

| Age | Recommended Frequency |
|---|---|
| 30-55 | Every 7-10 years, appropriate health assessment |
| 55-65 | Every 5 years, appropriate health assessment |
| 65-75 | Every 2 years, appropriate health assessment |
| 75+ | Every year, appropriate health assessment |

## Practice Modification

Practitioners will commonly encounter a point in their practice when their skills decline. Such decline might be due to a physical limitation, such as a hearing loss, or a disease impacting cognitive function. In many cases such decline will be associated with the normal aging process. While skills may decline for various reasons, the knowledge, experience, and general wisdom gained by practitioners may still be applied to good medical practice. It is important for both the practitioner and those in the practitioner's practice setting to recognize these changes and adapt to them for the safety of the practitioner and the patient.

The ~~Medical Commission~~WMC recommends practitioners consider altering their practices when practitioner responsibilities become mentally or physically burdensome or present a risk to patients. Practitioners may consider practice modifications such as~~–~~ reducing or eliminating overnight call schedules~~,~~ and mandated call recovery periods, changing to part time practice, reducing office hours, and eliminating certain strenuous procedures.

**Commented [FM(3]:** Just trying to be consistent. We could also just say "Commission."

Practitioners should also be aware of the effects of burnout, a psychological response to chronic work-related stress. Burnout may be experienced as irritability, low frustration tolerance, exasperation, fatigue, dreading work, callousness toward patients, interpersonal conflicts, diminished social functioning and existential doubts about career or life choices. Once identified, the ~~Medical Commission~~WMC recommends that practitioners take active measures to address burnout. This may involve identifying sources of burnout in the practice environment and working collaboratively with leadership to resolve the issues. In other cases, practice modifications, as outlined above, may be required to alleviate burnout and the health risks it poses for both practitioners and patients.

## Conclusion

The Commission encourages practitioners to use regular health ~~evaluations~~ screenings to gauge their abilities to practice over the course of their careers. Such ~~evaluations~~ screenings should identify aspects of practitioners' practice that may be at risk and what duties the practitioners might consider altering for the safety of the practitioner and the patient. The Washington Physicians Health Program can provide further evaluation and assistance to practitioners when there is concern that a health condition may threaten safe practice. The WMC can provide a list

of resources for practitioners to contact for cognitive screening.

Conversations regarding health-related declines in practitioner ~~competence~~ wellness and potential modifications should ideally involve the support system of the practitioner to include family, clinical partners, peers, and employment settings. With appropriate consideration of current health status and ability ~~status~~, practitioners can usually modify their practices, as necessary, to extend fruitful and satisfying careers regardless of age. The Commission strongly supports all medical practitioners proactively evaluating their ~~competence~~ wellness and its impact on competence on a regular, career-long basis and utilizing the results of such ~~evaluations~~ screenings to help maintain ongoing safe and successful practice.

State of Washington
Washington Medical Commission

# Policy

| | | | |
|---|---|---|---|
| Title: | Practitioners Exhibiting Disruptive Behavior | | POL2019-XX |
| References: | N/A | | |
| Contact: | Washington Medical Commission | | |
| Phone: | (360) 236-2750 | E-mail: | medical.commission@wmc.wa.gov |
| Effective Date: | November 15, 2019 | | |
| Supersedes: | MD2012-01 | | |
| Approved By: | | | |

## ~~Conclusion~~Background

Disruptive behavior by physicians and physician assistants is a threat to patient safety and clinical outcomes.[1] ~~The Washington Medical Commission (commission) will take appropriate action regarding practitioners who engage in disruptive behavior.~~

## ~~Background~~

~~Disruptive behavior by physicians has long been noted but, until recently, there has been little consensus that such behavior has an adverse effect on patient safety or clinical outcomes, and therefore the behavior has often been tolerated. This was particularly true when the physician appeared to be clinically competent. However, in the past ten years it has been generally recognized that disruptive behavior poses a potential threat to patient safety~~.[2] The Joint commission has said that "intimidating and disruptive behaviors can foster medical errors, contribute to poor patient satisfaction and to preventable adverse outcomes, increase the cost of care, and cause qualified clinicians, administrators, and managers to seek new positions in more professional environments."[3]

## ~~Definition and Examples~~

The American Medical Association has defined disruptive behavior as "Personal conduct, whether verbal or physical, that negatively affects or that potentially may negatively affect patient care. (This includes but is not limited to conduct that interferes with one's ability to

[1] Williams, B. W., and Williams M.V., The Disruptive Physician: A Conceptual Organization, Journal of Medical Licensure and Discipline, Vol. 94, No. 3, 12-20, 2008.

[3] The Joint Commission, Sentinel Event Alert, Issue 40, July 9, 2008.

work with other members of the health care team.)"[4] The Joint Commission describes intimidating and disruptive behaviors as including overt actions such as verbal outbursts and physical threats, as well as passive activities such as refusing to perform assigned tasks or quietly exhibiting uncooperative attitudes during routine activities.

Dr. Kent Neff, a psychiatrist and recognized expert in this field, describes disruptive behavior as "an aberrant style of personal interaction with physicians, hospital personnel, patients, family members, or others that interferes with patient care or could reasonably be expected to interfere with the process of delivering good care."[5] Examples of disruptive behavior may include:

- Profane or disrespectful language
- Demeaning behavior
- Sexual comments or innuendo
- Inappropriate touching, sexual or otherwise
- Racial or ethnically oriented jokes
- Outbursts of anger
- Throwing instruments or charts
- Criticizing hospital staff in front of patients or other staff
- Negative comments about another physician's care
- Boundary violations with staff or patients
- Comments that undermine a patient's trust in a physician or hospital
- Inappropriate chart notes, e.g., criticizing a patient's hospital treatment
- Unethical or dishonest behavior
- Difficulty in working collaboratively with others
- Failure to respond to repeated calls
- Inappropriate arguments with patients, families
- Poor response to corrective action

Most health care professionals enter their discipline for altruistic reasons and have a strong interest in caring for and helping other human beings. The majority of physicians carry out their duties professionally and maintain high levels of responsibility. However, several studies and surveys identify the prevalence of disruptive behavior among physicians as somewhere between 1 and 5%.[6] "The importance of communication and teamwork in the prevention of medical errors and in the delivery of quality health care has become increasingly evident."[7] Such behavior disrupts the effectiveness of team communication and has been shown to be a

[4] American Medical Association, E-9.045 Physicians with disruptive behavior (Electronic Version). AMA Policy Finder 2000. Cited in Williams and Williams, J. Med. Lic. & Disc.
Vol. 94, No. 3, p.12, 2008
[5] Neff, K., Understanding and Managing Physicians with Disruptive Behaviors,
pp. 45 – 72
[6] Op. cit., Williams and Williams, p. 13
[7] Ibid.

root cause in a high percentage of anesthesia-related sentinel events.[8] The consequences of disruptive behavior include job dissatisfaction for staff, including other physicians and nurses, voluntary turnover, increased stress, patient complaints, malpractice suits, medical errors, and compromised patient safety. Moreover, disruptive behavior may be a sign of an illness or condition that may affect clinical performance. Studies have shown that physicians demonstrating disruptive behavior have subsequently been diagnosed with a range of Axis I and II psychiatric disorders such as major depression, substance abuse, dementia, and non-Axis I and II disorders such as anxiety disorder, attention-deficit hyperactivity disorder, obsessive-compulsive disorder, sleep disorder, and other illnesses, most of which were treatable.[9]

## Policy

When the practitioner exhibiting disruptive behavior is part of an organization where the behavior can be identified, the organization should take steps to address it early before the quality of care suffers, or complaints are lodged. The best outcome is frequently accomplished through a combination of organizational accountability, individual treatment, education, a systems approach, and a strong aftercare program.[10] The Joint Commission has developed a leadership standard that addresses disruptive and inappropriate behaviors by requiring a code of conduct that defines unacceptable, and disruptive and inappropriate behaviors as well as a process for managing such behaviors.[11]

When the commission receives a complaint concerning a practitioner exhibiting ~~inappropriate or~~ disruptive or inappropriate behavior, the commission will consider such behavior as a threat to patient safety that may lead to ~~violations of standards of~~substandard care or other medical error. The commission may investigate such complaints and take appropriate action, including possible suspension, to promote and enhance patient safety.

[8] Ibid.
[9] Williams and Williams, p. 14.
[10] Williams and Williams, p. 17.
[11] Op. cit.,The Joint Commission.

State of Washington
Washington Medical Commission

# Policy

| | | | |
|---|---|---|---|
| Title: | Elective Educational Rotations | | POL2019-XX |
| References: | RCW 18.71.030(6) and (8), RCW 18.71.230, Chapter 18.130 RCW | | |
| Contact: | Washington Medical Commission | | |
| Phone: | (360) 236-2750 | E-mail: | medical.commission@wmc.wa.gov |
| Effective Date: | November 15, 2019 | | |
| Supersedes: | MD2011-09 | | |
| Approved By: | | | |

~~**Description of the Issue:**~~

~~Individuals in residency programs and residency programs themselves request a decision that would allow the out-of-state resident physicians to complete a 1 or 2 month elective educational rotation to a facility within Washington State without requiring licensure.~~ Individuals completing an elective educational rotation in the state of Washington are exempt from licensure for the specific purpose of completing the rotation.

RCW 18.71.030 ~~states~~ lists exemptions to the requirement to have a license to practice medicine, and states, in part:

> ~~"~~Nothing in the chapter shall be construed to . . . prohibit:~~-~~
>
> ...
>
> (6) The practice of medicine by any practitioner licensed by another state or territory in which he or she resides, provided that such practitioner shall not open an office or appoint a place of meeting patients or receiving calls within this state~~;." And "~~
>
> ...
>
> (8) The practice of medicine by a person serving a period of postgraduate medical training in a program of clinical medical training sponsored by a college or university in this state or by a hospital accredited in this state, however, the performance of such services shall be only pursuant to his or her duties as a trainee.~~"~~

Per RCW 18.130.230, any person practicing in the state of Washington under exemptions in RCW 18.71.030(5) through (12) is subject to disciplinary action by the Commission.

~~**Background**~~

~~The Washington Medical Commission (commission) receives requests from individuals in residency programs in other states who wish to complete a 1 to 2 month elective educational rotation to facilities within Washington State. A one-time statement would facilitate these requests for both commission staff and the programs or individuals requesting exemption.~~

## ~~Stakeholders~~

- ~~Resident physicians~~
- ~~Residency programs in other states~~
- ~~Hospitals, managed care organizations, and clinics~~

## ~~Position~~

~~It is the finding of the commission that i~~Therefore, individuals completing an elective educational rotation in Washington State are exempt from licensure for the specific purpose of completing the rotation. ~~Although these individuals are exempt from licensure, any practice of medicine in the state of Washington is subject to disciplinary action under the Uniform Disciplinary Act (UDA) Chapter 18.130 RCW as specified in RCW 18.71.230 "A right to practice medicine and surgery by an individual in this state pursuant to RCW 18.71.030 (5) through (12) shall be subject to discipline by order of the commission upon a finding by the commission of an act of unprofessional conduct as defined in RCW 18.130.180 or that the individual is unable to practice with reasonable skill and safety due to a mental or physical condition as described in RCW 18.130.170."~~

**New Section**

**Physicians**

**246-919-650**
**Clinical Support Program**

(1) The purpose of the clinical support program is to address practice deficiencies identified in the course of an investigation. The clinical support program may include education, training, and monitoring to improve the quality of care and reduce the risk of patient harm.

(2) "Clinical support plan" means a written and signed agreement between the physician and the commission listing steps the physician may take to resolve any practice deficiencies. A plan may include, but is not limited to, practice alterations, training, continuing medical education, or follow-up monitoring of the physician's clinical practice by the physician's current employer or other practice monitor approved by the commission. This definition applies throughout this section unless the context clearly requires otherwise.

(3) The commission may resolve an allegation of a practice deficiency or deficiencies through the clinical support program following an investigation.

(4) The commission shall use the following criteria to determine eligibility for the clinical support program:

(a) Practice limitations are not needed to ensure patient protection;

(b) The identified practice deficiency or deficiencies may be corrected by education, training, monitoring, or any combination of these, and are unlikely to recur;

(c) The physician agrees to participate in the clinical support program; and

(d) The commission has not authorized disciplinary action for the identified practice deficiency or deficiencies under RCW 18.130.172, RCW 18.130.170, or RCW 18.130.090.

(5) The commission may offer a clinical support plan to resolve an eligible complaint. Nothing in this section requires the commission to offer a clinical support plan. A physician who accepts a clinical support plan waives any right to a hearing to modify the clinical support plan or challenge the commission's decision regarding successful completion of the clinical support plan.

(6) The commission shall use the following process to implement the clinical support program:

(a) After an investigation identifies a practice deficiency or deficiencies the commission deems appropriate for the clinical support program, the commission shall apply criteria in subsection (4) of this section to determine eligibility for the clinical support program;

(b) If all of the criteria are met, and if the commission determines the physician is eligible for participation in the clinical support program, the commission may propose a clinical support plan to the physician;

(c) The commission shall evaluate whether the practice deficiency or deficiencies have been corrected and are unlikely to recur;

(d) The commission may conduct additional investigation and consider disciplinary action if additional facts become known or circumstances change such that the physician is no longer eligible based on the criteria in subsection (4) of this section; and

(e) If the physician complies with the agreed clinical support plan, the commission may consider the physician's completion of the clinical support plan as grounds to close the matter without further action.

**New Section**

## Physician Assistants

### 246-918-450
### Clinical Support Program

(1) The purpose of the clinical support program is to address practice deficiencies identified in the course of an investigation. The clinical support program may include education, training, and monitoring to improve the quality of care and reduce the risk of patient harm.

(2) "Clinical support plan" means a written and signed agreement between the physician assistant and the commission listing steps the physician may take to resolve any practice deficiencies. A plan may include, but is not limited to, practice alterations, training, continuing medical education, or follow-up monitoring of the physician assistant's clinical practice by the physician assistant's current employer or other practice monitor approved by the commission. This definition applies throughout this section unless the context clearly requires otherwise.

(3) The commission may resolve an allegation of a practice deficiency or deficiencies through the clinical support program following an investigation.

(4) The commission shall use the following criteria to determine eligibility for the clinical support program:

(a) Practice limitations are not needed to ensure patient protection;

(b) The identified practice deficiency or deficiencies may be corrected by education, training, monitoring, or any combination of these, and are unlikely to recur;

(c) The physician agrees to participate in the clinical support program; and

(d) The commission has not authorized disciplinary action for the identified practice deficiency or deficiencies under RCW 18.130.172, RCW 18.130.170, or RCW 18.130.090.

(5) The commission may offer a clinical support plan to resolve an eligible complaint. Nothing in this section requires the commission to offer a clinical support plan. A physician who accepts a clinical support plan waives any right to a hearing to modify the clinical support plan or challenge the commission's decision regarding successful completion of the clinical support plan.

(6) The commission shall use the following process to implement the clinical support program:

(a) After an investigation identifies a practice deficiency or deficiencies the commission deems appropriate for the clinical support program, the commission shall apply criteria in subsection (4) of this section to determine eligibility for the clinical support program;

(b) If all of the criteria are met, and if the commission determines the physician is eligible for participation in the clinical support program, the commission may propose a clinical support plan to the physician;

(c) The commission shall evaluate whether the practice deficiency or deficiencies have been corrected and are unlikely to recur;

(d) The commission may conduct additional investigation and consider disciplinary action if additional facts become known or circumstances change such that the physician is no longer eligible based on the criteria in subsection (4) of this section; and

(e) If the physician complies with the agreed clinical support plan, the commission may consider the physician's completion of the clinical support plan as grounds to close the matter without further action.

# Staff Reports

# Staff Reports: November 2019

## Melanie de Leon, Executive Director

We recently reviewed our list of Pro Tems and find that we are in need of additional Pro Tems in the following specialties:

- Orthopedics
- General internal medicine
- General surgery

If you know of physicians we can reach out to who have the time and interest in reviewing cases for WMC in these specialties, please provide their contact information to Amelia. She can be reached at amelia.boyd@wmc.wa.gov

**Fees update**. The Secretary approved new fees, effective February 1, 2020 as follows: $824 for physician renewals (plus $132 for HEAL-WA and WPHP); $247 for PAs (plus HEAL-WA and WPHP). Initial application fees did not change.

**CLEAR Educational Conference.** Held in Minneapolis in September. Both Jimi Bush and I presented sessions that were well received. Jimi spoke about the impact of millennials on healthcare and I spoke about professionalism.

- Takeaways:
- The keynote speaker talked about the role of the board/commission and encouraged boards to "turn their agenda on its head," by using the "FICKS" approach:

Creating value

- F – Future focus should take up 30% of the boards time
- I – Issues identification – understanding the current environment, spotting trends, communicating with stakeholders so they understand what the board does - 30%

Preserving value

- C – Compliance – monitor the risk the board faces – 15%
- K – Key performance Indicator monitoring, but don't spend time at every meeting to talk about the same performance measures and the budget – 15%

Adding value

- S – Succession and skills – 10%

- Risk factors common to those who receive discipline – what is the deficit? Is it clinical skills or professional issues? How do we remediate professional deficits? Can we be proactive versus reactive to bad behavior? What is the schematic for a healthy practice?
- What is the minimum regulatory action needed to manage the risk to the public? Sanction guidelines are outdated and regulatory boards need to make a paradigm shift to remediation versus discipline.

## Micah Matthews, Deputy Executive Director

**General Information**

- Please be thinking about ideas for how we conduct case disposition in advance of the Commissioner retreat on Saturday. Ask yourself this question: "*If the only legal requirement is to have three or more Commissioners to make a decision, how could we do this better?*"
- The CLEAR annual educational conference will be September 2020 in Seattle! I was named Program Chair by the new Board Chair from Australia. Please let Melanie, Jimi, or myself know if you have a regulatory proposal to submit for consideration at this conference. Deadline is November 30.
- We are pursuing a partnership with FSMB to utilize their A.I. tools on our complaint and discipline data. FSMB representatives will have more information at the meeting on this exciting project.

**Meetings**

- I am traveling on scholarship to West Virginia November 10 to the Administrators in Medicine Executive Director's Academy and Fall Workshop. Items to be addressed are the Medical License Compact and board technology evolution.
- I am traveling on scholarship to Washington, D.C. to the Federation of State Medical Boards Physician Assistant Licensing Summit on November 19. The likely result of this meeting will be a PA interstate license compact.
- I am presenting at the Center for Telemedicine Law Fall Summit in Washington, D.C. on our Telemedicine and Continuity of Care policy with Stephanie McManus our PIO. We will be giving training on how to organize influence efforts at the state level to change regulatory telemedicine policy with medical boards.
- I am attending the CLEAR symposium and mid-year meeting in California January 8. The symposium is looking at big data and A.I. in regulatory applications. The mid-year meeting is the formal planning meeting for the CLEAR 2020 September educational conference in Seattle.

**Telemedicine**

- I am unable to attend the telemedicine rules workshop, but I encourage the rules workshop members to review the Telemedicine Guideline and Policy in advance. The goal should be to consider what updates need to be made and what should be moved to rule. The Telemedicine Workgroup met a few months ago to discuss potential items including app based medicine, A.I. derivatives, clinical support software, and practitioner responsibilities. We also should have written comments for consideration from stakeholders and vendors in advance of this meeting for your consideration.

## Amelia Boyd, Program Manager

### Recruitment

The following Commissioner terms end June 30, 2020:

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

A recruitment notice for these positions will be posted in the winter newsletter as well as on our website in December.

At the end of October, we sent a recruitment letter to all of the licensed Orthopedists in Washington. Our hope is to appoint two applicants to Pro Tem Commissioner positions. The application deadline is November 30. Applications will be reviewed in December and our hope is to appoint the two members early next year.

## Melissa McEachron, Director of Operations and Informatics

## George Heye, MD, Medical Consultant

## Morgan Barrett, MD, Medical Consultant

## Rick Glein, Director of Legal Services

**Legal Unit Staff Updates:**

Staff Attorney Anna Clavel left the Medical Commission shortly after October's meeting. We thank Anna for her high quality work and dedication to the Commission. We wish her much success in her new position as Assistant Attorney General in the Labor and Industries Division of the Attorney General's Office.

Sara Wibowo joined the Legal Unit on November 1 as a Paralegal 1. Sara has been a civil paralegal at the Lewis County Prosecuting Attorney's Office for the past year and half. Prior to that, she worked as a subrogation paralegal in Illinois. Sara has an Associate's degree in Paralegal Studies and received her Bachelor's degree in Legal Studies from the University of Central Florida.

**Conference and Meeting Attendance:**
Ariele Page Landstrom attended the CLEAR Annual Educational Conference in Minneapolis September 17-20.

Rick was invited to speak at the U.S. Attorneys Healthcare Fraud Task Force on October 28 in Seattle. He gave an overview of the Commission's responsibilities, jurisdiction, and disciplinary statistics. He also led a discussion regarding cases WMC has in common with the Department of Justice, Department of Health and Human Services – Office of Inspector General, Heath Care Authority, private insurers, and other entities.

Rick, Kyle, Larry, Trisha, and Mike Farrell participated in the FSMB Board Attorney Workshop held on November 7-8. Mike moderated a session on the Corporate Practice of Medicine Doctrine. Kyle was one of the two invited panel speakers for that session.

**Summary Action:**
*In re Robert S. Norton, MD*, Case No. M2019-368. On October 3, 2019, WMC summarily restricted the medical license of Dr. Norton. The Statement of Charges alleges Dr. Norton performed three gallbladder removal surgeries within an eight-day period, all of which resulted in serious common bile duct injuries. Pending final outcome of this matter, Dr. Norton is restricted from performing surgery functioning as a primary surgeon.

**Orders Resulting from SOCs:**
*In re Susan L. Reese, MD*, Case No. M2018-775. Final Order of Default (Failure to Respond). On November 8, 2018, Dr. Reese was served with a Statement of Charges and Ex Parte Order of Summary Suspension based on allegations of failing to continue treatment as required in a January 2018 Stipulation to Practice under Conditions. Dr. Reese did not respond to either the Statement of Charges or Order of Summary Suspension within the time allowed. On December 5, 2018, the Adjudicative Clerk Office issued a Notice of Failure to Respond. The matter came before a Health Law Judge (HLJ) in September 2019. The HLJ concluded that Dr. Reese engaged in unprofessional conduct in violation of RCW 18.130.180(9) and ordered that Dr. Reese's medical license be indefinitely suspended.

*In re Ross L. McMahon, MD*, Case No. M2019-242. Final Order of Default (Failure to Respond). Dr. McMahon is board certified in general surgery. His medical license expired in March 2018 and is subject to renewal until March 2020. On May 1, 2019, the Commission filed a Statement of Charges alleging unprofessional conduct and failure to cooperate with an investigation. Dr. McMahon did not file a response to the Statement of Charges within the time allowed. The matter came before a HLJ in August 2019. The HLJ concluded sufficient grounds existed to take disciplinary action against Dr. McMahon's license and ordered that his medical license be indefinitely suspended.

*In re Brenda L. Smith, MD*, Case No. M2019-509. Final Order of Default (Failure to Respond). Dr. Smith is board certified in Obstetrics-Gynecology. On July 24, 2019, the Commission filed a Statement of Charges alleging unprofessional conduct and failure to maintain a current address on file with the Department. Dr. Smith did not file a response to the Statement of Charges within the time allowed. The matter came before a HLJ in October 2019. The HLJ concluded sufficient grounds existed to take disciplinary action against Dr. Smith's license and ordered that her medical license be indefinitely suspended.

*In re Gerald W. Lee, MD,* Case No. M2018-239. Final Order. In October 2017, a Commission CMT panel referred this matter to the Secretary's Office as the complaint of sexual misconduct did not involve clinical expertise or standard of care issues. On May 22, 2018, an Expedited Case Management Team filed a Statement of Charges against Dr. Lee alleging unprofessional conduct and sexual misconduct. A hearing was held in the matter on February 8, 2019. An Initial Order was served in March 2019 in which the HLJ concluded the Department of Health proved by clear and convincing evidence that Dr. Lee committed unprofessional conduct and sexual misconduct. The Initial Order suspended Dr. Lee's medical license for at least 18 months and imposed Commission oversight for at least 24 months after being reinstated. Dr. Lee timely filed a petition for review of the Initial Order. On June 27, 2019, the HLJ issued a Final Order adopting the Findings of Fact and Conclusions of Law and affirming the suspension and reinstatement sanctions outlined in the Initial Order. Dr. Lee has filed a petition for reconsideration. The matter is set for trial in January 2020 in King County Superior Court.

**Hearings:**

*Anton S. McCourtie, MD*, Case No. M2018-704. On May 14, 2019, the Commission filed an Amended Statement of Charges alleging unprofessional conduct, sexual misconduct, and abuse of a patient. Dr. McCourtie filed a timely Answer to the Statement of Charges, and a hearing was held before a Commission panel in Wenatchee during the week of October 14, 2019. The HLJ has 90 days after conclusion of the hearing to issue a decision.

**Petition for Judicial Review:**

*Johnny B. Delashaw, Jr. v. State Health, Medical Quality Assurance Commission*, Thurston County Case No. 18-2-04912-34. Dr. Delashaw's license was suspended by an Ex Parte Order of Summary Suspension dated May 5, 2017. A nine-day hearing regarding allegations of unprofessional conduct was held between April 23 and May 4, 2018. The August 31, 2018, Amended Final Order concluded Respondent committed unprofessional conduct under RCW 18.130.180(4). Dr. Delashaw's license was reinstated and he was required to undergo an evaluation of disruptive behavior. He is on Commission oversight for a period of at least three years during which time he is restricted from holding a medical leadership position. On

August 30, 2019, this matter came before the Thurston County Superior Court on Dr. Delashaw's Petition for Judicial Review. On November 1, 2019, the Court filed an Order affirming the Commission's Final Order. Dr. Delashaw will have until December 2, 2019, to file an appeal of the November 1, 2019 Order.

## Freda Pace, Director of Investigations

Top (3) useful tips when assessing whether to ***close*** or ***authorize*** an investigation during a Case Management Team (CMT) meeting. Ask yourself the following questions:

1. What is the allegation?
2. What is the Uniform Disciplinary Act (UDA) violation, if any?
3. How can we remediate the issue?

These (3) tips can be useful in making a clear determination as whether our resources will be utilized appropriately and how the decision to authorize an investigation will impact the licensee. More emphasis in this specific area will be discussed at the Commission Retreat scheduled later this year. Please, don't forget to sign up for any vacant CMT slots for 2020!

CMT Quarterly Statistics — Third Quarter 2019

July

| Date | New Cases | Closed BT | BT % | Authorized | Auth % |
|---|---|---|---|---|---|
| 7/3/2019 | 23 | 17 | 73.9% | 6 | 26.1% |
| 7/10/2019 | 33 | 12 | **36.4%** | 21 | **63.6%** |
| 7/17/2019 | 42 | 27 | 64.3% | 15 | 35.7% |
| 7/24/2019 | 32 | 18 | 56.3% | 14 | **43.8%** |
| 7/31/2019 | 37 | 23 | 62.2% | 14 | 37.8% |
| **TOTAL** | 167 | 97 | 58.1% | 70 | **41.9%** |

August

| Date | New Cases | Closed BT | BT % | Authorized | Auth % |
|---|---|---|---|---|---|
| 8/7/2019 | 33 | 22 | 66.7% | 11 | 33.3% |
| 8/14/2019 | 30 | 22 | 73.3% | 8 | 26.7% |
| 8/21/2019 | 31 | 13 | 41.9% | 18 | **58.1%** |
| 8/28/2019 | 24 | 16 | 66.7% | 8 | 33.3% |
| **TOTAL** | 118 | 73 | 61.9% | 45 | 38.1% |

September

| Date | New Cases | Closed BT | BT % | Authorized | Auth % |
|---|---|---|---|---|---|
| 9/4/2019 | 24 | 16 | 66.7% | 8 | 33.3% |
| 9/11/2019 | 28 | 15 | 53.6% | 13 | **46.4%** |
| 9/18/2019 | 37 | 23 | 62.2% | 14 | 37.8% |
| 9/25/2019 | 35 | 27 | 77.1% | 8 | 22.9% |
| **TOTAL** | 124 | 81 | 65.3% | 43 | 34.7% |
| | | | | | |
| Qtr TOTAL | 409 | 251 | 61.4% | 158 | 38.6% |

Lastly, we currently have two vacancies to fill in the Investigative Unit - Investigators Supervisor and a Clinical Investigator position. We are actively recruiting for both positions.

## Mike Farrell, Policy Development Manager

## Jimi Bush, Director of Quality and Engagement

**New Staff**

Anjali (Young) Bhatt has joined us as our Business Practices and Productivity Manager. She will be working on streamlining our processes, making them more efficient and effective.

**Outreach**

We will be starting a quarterly event, tentatively called “Coffee with the Commission”. The objective is to hold regular, short, webinars on various topics. These topics would be of interest to the Public and Licensees alike. Proposed titles as of now:

- Licensing information
- Patient information about the use of opioids

If you would like to participate in these short conversations or have a suggestion for a topic, please let Jimi know.

The Conference was one of our most successful events ever. We issued 1199 Category 1 CME credits. We provided over $124,000 worth of CME to our licensees. That is a value of over $908 per person… which pays for a 2 year renewal of their MD license. Email Jimi if you have a suggestion on how to improve the 2020 conference.

**Update! and Commission Connection**

If you have suggestions for articles for our clinical newsletter (Update!) or the patient focused newsletter (Commission Connection) please email them to Jimi.

| WMC Performance Measures | | |
|---|---|---|
| | Fiscal Year 19 Q1 | Fiscal Year 20 Q1 (Current) |
| **Licensing** | | |
| Applications Received | 677 | 607 |
| New Licenses Issued | 660 | 853 |
| % of Licenses Issued Within 14 Days | 95.12% | 71.47% |
| Average Licensing Time | 10.5 weeks | 5.8 weeks |
| **Intake** | | |
| Complaints Received | 364 | 382 |
| % of Complaints brought before CMT within 21 days | 99% | 96% |
| % of Cases Authorized for Investigation at CMT | 43% | 37% |
| Reconsiderations Received | 9 | 13 |
| Reconsiderations Authorized | 2 | 2 |
| **Investigations** | | |
| % of Investigations completed within 170 days | 74.25% | 77.17% |
| % of open cases over 170 days | 14.98% | 4.95% |
| **Legal** | | |
| % of case dispositions completed within 140 days | 85.49% | 94.71% |
| % of open cases over 140 days | 21.53% | 33.21% |
| SOAs Authorized | 30 | 22 |
| SOCs Served | 7 | 3 |
| **General** | | |
| Cases Completed within 360 Days | 91.89% | 94.02% |
| STIDs Accepted | 15 | 17 |

## Kimberly Romero, Licensing Manager

We would like to Welcome our new PA Specialist Teri Simpson. Teri started with the licensing department right as our PA peak season began and has taken on the challenge by picking up our processes quickly all whilst having a smile and a great attitude. We look forward to Teri's contributions to the Commission.

**September: 1444 total renewals 62% of renewals were processed online**

| Credential Type | Online | Manual | Total |
|---|---|---|---|
| IMLC | 0 | 6 | 6 |

| | | | |
|---|---|---|---|
| MD | 763 | 456 | 1219 |
| MDFE | 0 | 1 | 1 |
| MDRE | 0 | 5 | 5 |
| MDTR | 0 | 4 | 4 |
| PA | 138 | 71 | 209 |

**October: 1413 total renewals 63% of renewals were processed online**

| Credential Type | Online | Manual | Total |
|---|---|---|---|
| IMLC | 0 | 21 | 21 |
| MD | 772 | 434 | 1206 |
| MDRE | 0 | 1 | 1 |
| MDTR | 0 | 10 | 10 |
| PA | 127 | 48 | 175 |

**Total number of licenses issued from 9/1/2019- 10/31/2019: 504**

| Credential Type | Total Workflow Count |
|---|---|
| Physician And Surgeon County/City Health Department License | 0 |
| Physician And Surgeon Fellowship License | 0 |
| Physician And Surgeon Institution License | 0 |
| Physician And Surgeon License | 310 |
| Physician and Surgeon License Interstate Medical Licensure Compact | 49 |
| Physician And Surgeon Residency License | 12 |
| Physician And Surgeon Teaching Research License | 1 |
| Physician And Surgeon Temporary Permit | 5 |
| Physician Assistant Interim Permit | 1 |
| Physician Assistant License | 125 |
| Physician Assistant Temporary Permit | 0 |

WASHINGTON Medical Commission
Licensing. Accountability. Leadership.

# Panel A

## Meeting Agenda

Friday, November 15, 2019 at 10:30am
Capital Event Center - Pacific Room
6005 Tyee Drive SW, Tumwater, Washington 98512

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

| | | |
|---|---|---|
| **10:30am** | Petition for Reinstatement<br>**Deborah Cahill, MD**<br>Attorney: Pro Se | M2014-951 (2014-5571)<br>RCM: Yanling Yu, PhD<br>SA: Trisha Wolf |
| **11:15am** | Personal Appearance<br>**Andrew L. Kominsky**<br>Attorney: John C. Peick | M2017-52 (2017-7448 et all)<br>RCM: Charlotte Lewis, MD<br>SA: Ariele Page Landstrom |
| **LUNCH BREAK** | | |
| **1:15 pm** | Personal Appearance<br>**Mark D. Kline, MD**<br>Attorney: Jessica Creager | M2017-54 (2016-1296)<br>RCM: Robert Small, MD<br>SA: Kyle Karinen |
| **2:00 pm** | Petition to Terminate<br>**Mohammad Ashori, MD**<br>Attorney: Pro Se | M2019-90 (2018-10618)<br>RCM: Warren Howe, MD<br>SA: Trisha Wolf |
| **2:45 pm** | Petition to Terminate<br>**Gene R. Conley, MD**<br>Attorney: Pro Se | M2014-956 (2014-5910)<br>RCM: Warren Howe, MD<br>SA: Trisha Wolf |

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

WASHINGTON Medical Commission
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# Panel B

## Meeting Agenda

Friday, November 15, 2019 at 10:30am
Capital Event Center - Grays Harbor Room
6005 Tyee Drive SW, Tumwater, Washington 98512

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

| | | |
|---|---|---|
| **10:30 am** | Petition to Terminate<br>**Alexander M. Ortolano, MD**<br>Attorney: Christopher J. Mertens | M2013-584 (2017-7541 et al.)<br>RCM: Theresa Schimmels, PA-C<br>SA: Colleen Balatbat |
| **11:15 am** | Personal Appearance<br>**Allen R. Skidmore, MD**<br>Attorney: Stephen M. Lamberson | M2018-581 (2017-15538)<br>RCM: Claire Trescott, MD<br>SA: Larry Berg |
| **LUNCH BREAK** | | |
| **1:15 pm** | Personal Appearance<br>**Justin K. Yoon, MD**<br>Attorney: Rando B. Wick | M2016-858 (2016-835)<br>RCM: Toni Borlas<br>SA: Gordon Wright |
| **2:00 pm** | Personal Appearance<br>**Richard B. Goodman, MD**<br>Attorney: Ronald A. Van Wert | M2018-319 (2017-11583)<br>RCM: Peter Marsh, MD<br>SA: Larry Berg |
| **2:45 pm** | Personal Appearance<br>**Romeo S. Puzon, MD**<br>Attorney: Pro Se | M2018-85 (2017-8777)<br>RCMS: Alden Roberts, MD<br>Toni Borlas<br>SA: Kyle Karinen |

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# For Your Information

# Pro Tem Appointments

## Background

The Washington Medical Commission (Commission or WMC) is committed to protecting the health and safety of the citizens of Washington.

RCW 18.71.015 gives the Commission the authority to request the Department of Health Secretary (Secretary) or designee to appoint pro tem members whenever the workload of the commission requires.

## Procedure

The Executive Director has been delegated the authority by the Secretary to appoint pro tem members. Appointments are made for one year, and an appointee can serve four consecutive one year terms. The Executive Director, in coordination with the Program Manager will oversee this process.

Pro-tem candidates must meet the same minimum qualifications as governor appointed members. Each candidate must complete and submit the governor's application and provide a current CV.

The Program Manager will review the candidate's application packets for statutory requirements, check the database regarding their current licensure status and review any current or past disciplinary actions. The Program manager will consult with the Medical Consultant regarding needed specialties.

The Commission's Executive Committee will review Pro tem applications prior to appointment and provide comments, if applicable, to the Program Manager within a one week period of receiving the applications.

Upon approval, the Executive Director or designee will process appointment papers for each approved pro tem candidate. Completion of an orientation will take place prior to the pro tem member being assigned cases for review, unless the pro tem member has previously served as a governor-appointed Commissioner.

Pro tem members will be compensated for their time and expenses as follows:

- **Case Management Team (CMT) participation.** Time spent reviewing the CMT packet and time participating on the CMT call.
- **Formal hearing panels.** Time spent reviewing files, sitting on the panel and participating in the drafting of the final order and all travel expenses.
- **Case reviews and case presentations.** Upon appointment by the Executive Director and completion of the orientation, if required, the Medical Consultant will assign cases for review and presentation to a case review panel. Pro tem members may present their cases in person during Commission case review panels or via phone. Pro tem members will be paid for time participating in the case review process, including travel and per diem at State rates.

- **Personal appearances.** Pro tem members are encouraged to participate in personal appearances (compliance appearances) for their cases via phone unless there is a necessity to participate in person. Pro tem members will be paid for the time expended during the personal appearance. If the pro tem is required to participate in person, the Commission will pay all travel expenses.

Pro Tem members will have all the powers, duties, and immunities, and are entitled to all the emoluments, including travel expenses, per diem, and board pay of a regular member when acting at the request of the Commission.

Pro Tem members are always welcome to attend the Commission's business meeting on their own time and at their own expense, however, as set forth in the by-laws, pro tem members cannot vote on Commission business.

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Number: PRO2019-XX

Date of Adoption: November 15, 2019

Revised: November 15, 2019

Supersedes: PRO2018-03