Washington Medical Commission

UPDATE!

Vol.12 Summer 2022

In This Issue:

2 Message From the Chair: Thank you and Farewell

3 ED Report: Updated Telemedicine Policy

4 Physician Assistant News: Profession Updates

4 WMC Featured at the FSMB Annual Meeting

5 WPHP Report: Medications for Opioid Use Disorder in Monitored Health Professionals

7 Accessing Family Members Health Records

8 Meeting Updated Requirements of Lead Testing

10 Rulemaking

12 Legal Actions

16 Members

17 New Adult Immunization Recommendations: Hepatitis B, PCV, and Shingrix Dose 1

Washington Medical Commission

Licensing. Accountability. Leadership

Message from the Chair

Thank You and Farewell

John Maldon

This newsletter will be brief providing some reflection, introductions and acknowledgments as I close out my Washington Medical Commission career.

My term as Washington Medical Commission Commissioner and Commission Chair comes to an end on June 30, 2022. Overall, it seems to have been a pretty good run. The last two years of COVID-19 pandemic resulted in being the first and hopefully the last near total virtual Commission Chair. Being a virtual chair is not something I would recommend. Working in a virtual vacuum provides for little acknowledgment of performance other than perhaps the number of complaints received, which is not a good indicator of performance. There have been a few bumps along the way that have been appropriately managed by commission staff and me leaving a relatively smooth surface for the in-coming commission leadership.

A very experienced and capable commission leadership team was elected in May of this year and will assume their responsibilities effective July 1, 2022. Dr. Jimmy Chung will be the new Commission Chair. Dr. Karen Domino assumes the role of Chair Elect and Dr. Terry Murphy fills the Vice Chair position. Christine Blake, Public Member, rounds out the new leadership team as Policy Chair. I will continue to be part of the leadership team in an advisory role as Past Chair. It is my firm belief that the Commission constituents will be well served by this new leadership team.

I want to acknowledge the incredible commission staff under the leadership of Executive Director Melanie de Leon. The Commission staff have continued to outperform their responsibilities while adjusting from working in an office setting to working virtually. Licensing, Investigations, Informatics, Quality and Engagement and Legal staff were able to maintain productivity while continuing their work during these most difficult times.

Lastly, a warm thank you to the dedicated commissioners who give their time to assure quality medical care is delivered to the residents of Washington State.

The Medical Commission has 21 members; 13 physicians, two physician assistants and six public members appointed by the Governor. Commissioners spend endless hours evaluating complaints filed with the Commission regarding patient care, reviewing medical records, formulating standard of care opinions, participating in a variety of public hearings, formulating guidance documents for licensees, participation on work-groups and committees that manage current issues, providing expertise and testimony before the legislature and many more activities dictated by necessity.

Serving on the Medical Commission has been an extremely rewarding experience for me while serving the patients and licensees in Washington. I want to say thank you to all who have supported me for the past eight years. I could not have served my commissioner role without you.

Buprenorphine for OUD and Chronic Pain

July, 21, 2022 - 5:00 PM PST

Register

Topics and Educational Objectives

- Review the pharmacology of buprenorphine and use in opioid use disorder (OUD) and pain.
- Review the legalities of prescribing buprenorphine for OUD and perceived obstacles.
- Empathize with patients taking buprenorphine for OUD

The Federation of State Medical Boards designates this live activity for a maximum of 1.0 *AMA PRA Category 1 Credit*™. Physicians should claim only the credit commensurate with the extent of their participation in the activity.

Executive Director Report

We've Updated our Telemedicine Policy – Take a look!

Melanie de Leon, JD, MPA

The realities of COVID brought to the forefront the need for telemedicine to be thoughtfully included in the practice of medicine from now and into the future. To provide some guidance to practitioners, WMC updated and revitalized their telemedicine policy to provide the most up-to-date information regarding situations that may arise in a telemedicine scenario. The WMC worked with a large group of stakeholders including WSMA, WSHA, DOH, physicians, PAs, and the public to craft a thorough policy. You can find the entire policy here.

In the policy, the WMC defines telemedicine as a mode of delivering healthcare services using telecommunications technologies by a practitioner to a patient or to consult with another health care provider at a different physical location than the practitioner. Telemedicine includes real-time interactive services, store-and-forward technologies, and remote monitoring.

The WMC deems the practice of medicine to take place at the location of the patient at the time of the encounter; however, the WMC does recognize several exceptions exist to the general rule that a practitioner is required to have a license when treating a patient in Washington.

The legislature created a specific exemption to the licensure requirement for telemedicine practitioner-to-practitioner consultations. The consultation exemption permits a practitioner licensed in another state in which the practitioner resides to use telemedicine or other means to consult with a Washington licensed practitioner who remains responsible for diagnosing and treating the patient in Washington. The law does not require real time communication between practitioners.

Additionally, the WMC does not require a license when a patient seeks a second opinion or a consultation with a specialist out of state, such as a cancer center, and sends medical records to the specialist to review and provide input on treatment. In this case, the specialist in the distant state does not need a license to practice medicine in Washington to review the records and provide an opinion, but not treatment, regarding the patient's care.

Another common situation that is not specifically addressed by a statutory exemption is when a patient with an established relationship with a practitioner licensed in another state crosses the border into Washington and requires medical care. In some cases, permitting the physician in the patient's home state to provide temporary continuous care is in the patient's best interest. So long as the out-of-state practitioner provides temporary continuity of care to the patient, the practitioner would not require a Washington license.

This can arise in several common scenarios:

- A patient with an established relationship with a practitioner in the patient's home state travels to Washington for a limited time (e.g., vacation, business, or education) and requires medical care. The patient's out-of-state practitioner may be the best person to provide care via telemedicine while the patient is temporarily in Washington.
- A patient who is receiving treatment for a condition by a practitioner in a distant state moves to Washington and requires immediate medical care for that condition, especially mental health issues, but has not yet established a relationship with a Washington practitioner. Temporary care lasting up to 12 months via telemedicine by the patient's established psychiatrist may be in the patient's best interest until the patient can find a Washington-licensed practitioner to take over the care.
- A Washington resident travels to a distant state to obtain specialty care at a major medical center, then returns home to Washington. The patient may prefer to directly consult via telemedicine with the specialists who provided treatment to the patient in the distant state. Permitting the practitioner at the major medical center to provide follow up care via telemedicine is the most optimal treatment plan for the patient.

Please refer to the entire policy for more information.

Physician Assistant News

WASHINGTON
Medical
Commission
Licensing. Accountability. Leadership.

Profession Updates

Arlene Dorrough PA-C, MCHS/MPH, BCHS

There have been a lot of changes going on with regard to PA practice recently. The National Conference was completed in late May and I was delighted to see a National Fox News segment on YouTube featuring the American Academy of PAs President, Jennifer Orozco. She is discussing mental health and how to promote good mental healthcare for providers and patients after the stresses of the last two years. She discusses the use of PAs as healthcare providers to meet the nation's growing healthcare and mental healthcare needs. She also discusses some of the stressors healthcare providers have undergone over the pandemic and how to cooperate to meet each other's mental health challenges and that will facilitate meeting our patient's needs better. She also discusses administrative barriers that advanced practice providers face that make it harder to meet growing patient populations and medical demands in healthcare.

Now called Physician Associates, we had our national conference last week in Indianapolis and one of the main topics was provider burnout and how to meet the needs of healthcare workers nationwide, who are struggling to meet medical access needs in their state. She stressed creating partnerships with others in medicine and the recent partnership between the Indianapolis Colts and the American Academy of Physician Associates to highlight mental healthcare in the country.

If you want to know more about what it is PAs are doing and stay up to date with your colleagues, or how to support this profession, I highly recommend checking out the American Academy of Physician Associates website.

Hope everyone is having a great summer so far and is doing whatever they can to destress, be productive and spend quality time with the loved ones and friends we missed over the last 2 years.

Cheers!

WMC Featured at the FSMB Annual Meeting

WMC representatives attended the Federation of State Medical Boards (FSMB) annual meeting in April where two important resolutions were passed. We encourage you to take a moment to familiarize yourself with these resolutions and contact us if you have any questions.

The Appropriate Use of Telemedicine Technologies in the Practice of Medicine: There are numerous factors contributing to the increase of telemedicine being used in the practice of medicine. The greatest of these catalysts by far has been the global COVID-19 pandemic and resulting national public health emergency.

Diversity, Equity and Inclusion in Medical Regulation and Patient Care: This report recommends meaningful and achievable steps that state medical boards, the FSMB, and our partners in medical education, regulation and practice may wish to consider as action items to eliminate racism and bias from health care delivery.

Melanie De Leon (Executive Director) spoke on "Diversity, Equity and Inclusion: Are We Making Progress?"
Micah Matthews (Deputy Executive Director) spoke on the "Digital Credentials and the Future of Licensing" panel.

Jimi Bush (Director of Quality of Engagement) was a panelist for the "Communicating with Your Licensees: Strategies for State Medical Boards" session.

WMC featured a poster showcasing our Pathway Program for Internationally Trained Physicians . And finally – Jimi Bush was presented with the **Award of Merit** in recognition of her efforts to strengthen the profession of medical licensure and discipline and enhance public protection.

WPHP Report: Medications for Opioid Use Disorder in Monitored Health Professionals

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

In August 2019, the New England Journal of Medicine (NEJM) published an opinion piece that accused physician health programs (PHPs) of a blanket ban on opioid agonist therapy for physicians under monitoring agreements.[1] The authors went on to speculate as to the causes and consequences of this supposed ban despite the fact that there was no systematic data to support their conclusions, the authors had no experience working in physician health programs, and no effort was made to communicate with the Federation of State Physician Health Programs (FSPHP) to learn about PHP practices.

The article ran alongside another NEJM story about a medical student with opioid use disorder (OUD) who lost his life to an opioid overdose.[2] The moral of this second story might easily have been about how referral to a PHP could have saved the student's life. Instead, the implication was that PHPs were denying physicians lifesaving care with tragic consequences.

A firestorm of self-righteous, polarized, PHP bashing ensued on social media, signaling to the larger media outlets that PHPs might be up to something nefarious. National Public Radio picked up the story and in short order I found myself being interviewed for *All Things Considered*. In my letter to the editor of the NEJM, published somewhat later, I expressed concern that physicians would be discouraged from seeking PHP assistance because of such misinformation, that the article might have done more harm than good.

Fast forward to March of this year when the Department of Justice (DOJ) ruled that the Indiana Nursing Board violated Title II of the Americans with Disabilities Act (ADA) by prohibiting nurses who have been prescribed medications for opioid use disorder (MOUD) from participating in the Indiana State Nursing Assistance Program. That decision put regulators and monitoring programs on notice that blanket policies banning MOUD would probably not hold up under legal challenge. In my opinion, the DOJ was right in its decision. Policies that preclude the use of specific medications are undesirable and difficult to defend.

However, in its ruling, the DOJ overstepped by going out of its way to spotlight methadone and buprenorphine as "safe and effective when taken as prescribed." In so doing, the DOJ risked giving these medications special legal status, perhaps even protection, without the requisite expertise. For example, the ruling failed to acknowledge that opioid agonist/partial-agonist medications are often *not* taken as prescribed and that these medications have unique monitoring risks and challenges compared to long-acting injectable naltrexone (LAI naltrexone, an opioid antagonist). MOUD options are not all created equal when it comes to safety-sensitive workers and the decision often involves consideration of multiple medical and occupational variables. Uninformed opinions and policies, driven by attorneys, regulators, and medical pundits can interfere with sound medical decision-making.

In January of this year, the FSPHP published its position statement, "Safety Considerations for Medication Treatment of Opioid Use Disorders in Monitored Health Professionals." It was developed by a special advisory panel chartered by the FSPHP Board of Directors and involved an extensive review of the literature as well as internal and external reviews and feedback. The position statement provides clarity and guidance to support the rehabilitation and safe practice of physicians with OUD and includes the following conclusions:

In my letter to the editor of the NEJM, published somewhat later, I expressed concern that physicians would be discouraged from seeking PHP assistance because of such misinformation, that the article might have done more harm than good.

1. FDA-approved medications for the treatment of OUD should be available to all patients including healthcare professionals.
2. PHP participants with OUD experience excellent outcomes with and without medication treatment.
3. A treatment provider and patient must always make case-specific, shared decisions that consider the risks, benefits, and alternatives of proposed treatment options for opioid use disorders, including opioid antagonist and agonist/partial agonist medications.
4. Effective communication, collaboration, and accountability among the participant, treatment providers, and the physician health program are critical to addressing the health needs of the medical professional while decreasing the risk of impairment.
5. LAI naltrexone is the preferred medication for monitored health professionals from the perspective of clinical performance and safety to practice. It has an established record of safe and effective use in this population. LAI naltrexone has no abuse potential, adherence is easily verified, there is no evidence to suggest cognitive or functionally impairing side effects, and it is highly protective against a return to opioid use, opioid-related impairment, and overdose.
6. Further research investigating the safety and efficacy of FDA-approved medications and non-pharmacologic treatment modalities for OUD in monitored healthcare professionals is needed.
7. Additional education and outreach is recommended to assist the treatment providers of monitored health professionals to address the unique needs and circumstances of this population.

For a time, I was perturbed by the unfair characterization of PHPs in the NEJM article. However, in retrospect, it did galvanize the FSPHP, its member PHPs, and others to set the record straight. Some programs needed to look carefully at their policies, evaluate the rationale of their practices, and confront some biases. While there never has been a systematic prohibition against opioid agonists among PHPs, there was a lack of clarity and communication regarding best practices that might have prevented a misleading idea from taking hold.

WPHP does not have policies that ban any specific medications for OUD and we strongly support the use of medications for opioid use disorder (MOUD) for all program participants with OUD. We work closely with our participants and their treatment providers to ensure that treatment and monitoring plans are tailored to individual needs. We recognize that LAI naltrexone can be cost-prohibitive for some, cause intolerable side effects, or otherwise may not be the best MOUD option. In those cases, participants can be successfully monitored on buprenorphine without compromising their safety to practice.

Nothing here is intended to suggest the inferiority of buprenorphine for the treatment of OUD in the general population. Without question, buprenorphine is an excellent treatment choice. It decreases the risk of death from overdose, reduces communicable disease transmission from injection drug use, and decreases incarceration for drug-related offenses. In addition, patients are often more successful in initiating treatment with buprenorphine than naltrexone because the latter requires full opioid detoxification prior to starting. However, for health professionals with OUD who usually initiate MOUD in a structured, high-intensity treatment setting, LAI naltrexone induction is highly successful. Once successful induction has occurred, LAI is as effective as buprenorphine. So, for this group, the risk/benefit profile usually favors LAI naltrexone. Recognizing the advantages of LAI naltrexone from a monitoring perspective should not diminish or stigmatize buprenorphine or methadone. That makes about as much sense as saying that wearing gloves stigmatizes mittens.

While I cannot speak for all PHP policies or practices, experience tells me that, like WPHP, most PHPs and other monitoring programs embrace MOUD. In the coming months, FSPHP will be partnering with the American Medical Association and the Federation of State Medical Boards to further study and characterize MOUD practices among PHPs and regulators. Such data can help us evolve best practices and promote consistency and excellence in the management of this complex problem. I look forward to having data, rather than speculation, to guide us forward.

WPHP can provide help and hope for physicians and PAs struggling with opioid addiction. With fentanyl replacing the U.S. heroin supply, resulting in record-high opioid overdose deaths, now is the time to get help and treatment for opioid addiction. Remember, we are always just a click or phone call away.

Web: www.wphp.org

Toll-free: 800-552-7236 (24/7)

1. Beletsky L, Wakeman SE, Fiscella K. Practicing What We Preach — Ending Physician Health Program Bans on Opioid-Agonist Therapy. *New England Journal of Medicine*. 2019;381(9):796-798. doi:10.1056/NEJMp1907875

2. Lucey CR, Jones L, Eastburn A. A Lethal Hidden Curriculum — Death of a Medical Student from Opioid Use Disorder. *New England Journal of Medicine*. 2019;381(9):793-795. doi:10.1056/NEJMp1901537

Accessing Family Members Health Records

WASHINGTON Medical Commission

Licensing. Accountability. Leadership.

Christine Blake, Public Member

Most providers are familiar with the HIPAA violation incurred when a family member's or friend's medical record is accessed without prior approval. "Snooping" is when a medical record is intentionally and inappropriately accessed without a work-related, patient relationship, reason. This type of breach also occurs with celebrities, politicians or any other public figure. The penalty for snooping into a medical record can lead up to termination of employment, as well as being reported to your licensing bureau. As the treating provider, directly involved with the patient's care and treatment, the following is appropriate:

- Access protected health information (PHI) related to your involvement in the care and treatment of the patient.
- Share PHI only with the treatment team.
- Do not share information, including the fact that your family member or acquaintance is a patient, with anyone that is not part of the treatment team.

If you are not directly involved in a family member's or acquaintance's treatment:

- Do not share incidental knowledge, which includes room location and diagnosis with anyone.
- Do not access the record, even out of concern for the patient.
- Do not stop by to visit the patient unless the patient has agreed ahead of time that you are allowed to visit.
- Do not ask anyone involved in the patient's care and treatment for any information.

The electronic medical record has put information at our fingertips, which makes it somewhat easier for documentation purposes. At the same time it also makes it easier to access a medical record. Physicians may also feel free to access a medical record once their care and treatment of that patient has been completed. For example, a physician may treat a patient for a traumatic episode, complete their treatment and documentation, and then access the record again to perhaps confirm that the appropriate care was rendered. While this may not seem like a violation, it may still contravene privacy rules in some instances.

Physicians are often called upon to review a medical record as part of an ongoing peer review assessment. Review of this type is not considered a breach when tasked as a reviewer; however, once that review has been completed, no further access is required unless there is additional review required as part of the initial required review process.

In closing, from the American Medical Association website:

As practices and health care organizations become increasingly digitized, physicians must be aware of HIPAA's Administrative Simplification provisions—and particularly the Privacy, Security and Breach Notification requirements—that protect the confidentiality of their patients' medical information. Physicians need to understand these rules and participate in a formal compliance plan designed to ensure all the requirements are met, including state requirements that go above and beyond federal mandates.

Reach out to your medical staff leadership and administration of your healthcare facilities for education on HIPAA and what role you as a provider play in your practice. Hospitals have learning modules in place that should be available for your review. Your CME Department can provide education on HIPAA. Your medical staff legal counsel can also be an excellent resource.

May Commission Meeting Update:

The WMC moved and voted to hold all meetings for the public access virtually (either on-line or by phone) until the emergency status for COVID was concluded. When the emergency status ends, the WMC will return to providing an in-person option for the public to attend.

The WMC voted on updates to four documents:

- Informed Consent and Shared Decision Making Policy was updated. The portion of the document with the most substantive was regarding "special considerations for surgery and invasive procedures." The update was adopted by vote of all attending commissioners.
- Medical Professionalism Policy was updated. The biggest change was an addition of state laws that restrict medical professionals from having romantic or sexual relationships with past patients. The update was adopted by vote of all attending commissioners
- Practitioner Health guidance document was updated. The update was adopted by vote of all attending commissioners.
- Ownership of Clinics by Physician Assistants Guidance document was updated. The update was adopted by vote of all attending commissioners.

Meeting Updated Requirements of Lead Testing

WASHINGTON Medical Commission

Licensing. Accountability. Leadership.

Mahlet Zeru, MPH
Equity and Social Justice Manager

Background

Lead exposure is an environmental health disaster that disparately impacts minority groups[1]. Low-income and racial minorities have higher rates of hazardous chemical exposure than the general population. Exposure has been linked to neurological, cognitive, physical damage and even death[2,3]. There is no safe level of lead exposure.

Reasons for the disparity include inferior housing built near toxic waste sites, contaminated resources, disparate access to health information and care, lack of screening by providers and a continued lack of education about the prevalence of lead poisoning. It is a recipe for disproportionate burden of disease.

To mitigate the impacts of disproportionate impact, federal regulations mandate that all Medicaid-enrolled children receive lead testing at 12 and 24 months or between 36 and 72 months if not previously tested4. Despite these recommendations, the rate of testing among Medicaid-enrolled children is low5.

Washington State pediatric lead screening rates are among the lowest in the nation. Most recently available data indicates only 4.14% of children under 72 months are screened for lead in Washington compared to Connecticut where 99.9% of children are screened before 36 months.

The equity implication from the lack of lead testing is especially concerning as it undermines children's potential and diminishes their prospects. Pediatric lead exposure is a cumulative neurodevelopmental toxicant. Levels of lead exposure that were previously considered 'safe' have been shown to damage children's health and impair their cognitive development. Even low-level lead exposure is associated with a reduction in IQ scores, shortened attention spans and potentially violent behavior later in life.6 Children with blood lead levels above 5 µg/dL may score 3-5 points lower on intelligence tests than their unaffected peers.7

Widespread cognitive decline, such as those caused by lead exposure, across low-income populations contributes to health disparities and overall decline.

Common Sources of Exposure in WA

Lead based paint and contaminated dust are the primary source of contamination[8]. Buildings constructed prior to 1978 have a higher chance of containing lead-based paint as it was not banned before that year[9]. Chipped lead paint flakes have a sweet taste, so they are particularly likely to be ingested by children[10]. Poisoning can also occur when children inhale lead particles aerosolized during remodeling or from damaged surfaces[11]. A full list of common sources of lead exposure is on the Washington state Department of Health (DOH) website: Common Sources of Lead Poisoning.

Lead Testing Guideline in WA

DOH guideline requires all healthcare providers assess all children for risk of lead poisoning at 12 and 24 months of age[12]. The DOH recommends performing a blood lead test based on the guidance in Table 1. If the parent or caregiver does not know if the child has one of the following risk factors, a blood lead test should be performed. Testing for blood lead levels is the only way to know if a child was exposed to lead.

Testing Methods

According to the World Health Organization, recent exposure to lead is measured in blood samples, while cumulative exposure is measured in teeth or bones[13]. Blood lead testing is the only acceptable laboratory test for screening and confirming lead poisoning. Venipuncture is preferred for specimen collection, but finger stick (capillary) collection is acceptable if care is taken to properly clean and prepare the finger. Capillary samples are easier to contaminate because of the possibility of lead containing dust and dirt on the hand or under the fingernails. Children with capillary specimens testing ≥5 µg/dL on a point of care test should undergo confirmatory testing, ideally with a venous specimen.

All blood lead level results, even if not ≥5 µg/dL, must be reported to the DOH by the lab or clinic if point of care testing was performed. In 2021, CDC lowered the blood lead reference value from 5 to 3.5 µg/dL but DOH guidelines have not been updated to reflect this change[14]. Practitioners should be aware there has been a recall of test kits for the LeadCare II point-of-care testing machine that many pediatricians use in their offices for blood lead testing.

Barriers to Testing

A 2019 study conducted on barriers to lead screening among pediatric providers in King County, Washington sited numerous reasons for lack of lead testing[15]. Misperception about the prevalence of lead poisoning in King County has created uncertainty as to the efficacy of widespread screening. Providers generally do not see elevated blood lead levels, which contributed to providers thinking it is no longer a threat to public health.

Table 1	
Blood Lead Level	**Recommendations on confirmatory screening**
<5 mcg/dL	Repeat the blood lead level in 12 months if the child is at high risk or risk changes during the timeframe.
5-14 mcg/dL	Re-test venous blood lead level within 1-3 months to ensure the lead level is not rising. If it is stable or decreasing, retest the blood lead level in 3 months.
15-44 mcg/dL	Confirm the blood lead level with repeat venous sample within 1 to 4 weeks.
≥45 mcg/dL	Confirm the blood lead level with repeat venous lead level within 48 hours.

Many providers also cited the invasiveness of venous blood draws as a significant barrier, in addition to the number of preventive care actions at well child visits. Lack of knowledge of WA State Guidance on screening children was also cited as a barrier to testing.

Provider Action

Addressing lead exposure requires a coordinated effort such as increasing the DOH capacity to monitor and identify sources of lead contamination. However, providers can have an impact by adhering to Medicaid guidelines to screen every child at 12 and 24 months and being up to date on current diagnosis and management of childhood lead exposure. Pediatric health care providers are responsible for the majority of lead exposure screening and clinical follow up. This includes confirmatory testing, developmental and nutritional screening, ongoing monitoring of blood lead levels, referrals, education, reporting to surveillance programs, coordination with public health agencies and treatment where indicated. All test results need to be communicated to families in a timely and appropriate manner. This process continues until the lead-exposed child has a blood lead levels below threshold and environmental investigations and subsequent responses are complete. Providers can also increase knowledge with the following resources: Promoting Pediatric Lead Screening (PDF) and the Northwest Pediatric Environmental Health Specialty Unit (PEHSU).

Endnotes

1. Bellinger, D. C., & Bellinger, A. M. (2006). Childhood lead poisoning: the torturous path from science to policy. The Journal of clinical investigation, 116(4), 853–857. https://doi.org/10.1172/JCI28232
2. Sanders, T., Liu, Y., Buchner, V., & Tchounwou, P. B. (2009). Neurotoxic effects and biomarkers of lead exposure: a review. Reviews on environmental health, 24(1), 15–45. https://doi.org/10.1515/reveh.2009.24.1.15
3. Centers for Disease Control and Prevention https://www.cdc.gov/nceh/lead/prevention/health-effects.htm
4. Medicaid Lead Screening https://www.medicaid.gov/medicaid/benefits/early-and-periodic-screening-diagnostic-and-treatment/lead-screening/index.html
5. Kemper AR, Cohn LM, Fant KE, Dombkowski KJ. Blood Lead Testing Among Medicaid-Enrolled Children in Michigan. Arch Pediatr Adolesc Med. 2005;159(7):646–650. doi:10.1001/archpedi.159.7.646 https://jamanetwork.com/journals/jamapediatrics/fullarticle/486064
6. American Academy of Pediatrics. Lead Exposure in Children. https://www.aap.org/en/patient-care/lead-exposure/lead-exposure-in-children/
7. Lanphear, B. P., Hornung, R., Khoury, J., Yolton, K., Baghurst, P., Bellinger, D. C., Canfield, R. L., Dietrich, K. N., Bornschein, R., Greene, T., Rothenberg, S. J., Needleman, H. L., Schnaas, L., Wasserman, G., Graziano, J., & Roberts, R. (2019). Erratum: "Low-Level Environmental Lead Exposure and Children's Intellectual Function: An International Pooled Analysis". Environmental health perspectives, 127(9), 99001. https://doi.org/10.1289/EHP5685
8. Lanphear, B. P., Matte, T. D., Rogers, J., Clickner, R. P., Dietz, B., Bornschein, R. L., Succop, P., Mahaffey, K. R., Dixon, S., Galke, W., Rabinowitz, M., Farfel, M., Rohde, C., Schwartz, J., Ashley, P., & Jacobs, D. E. (1998). The contribution of lead-contaminated house dust and residential soil to children's blood lead levels. A pooled analysis of 12 epidemiologic studies. *Environmental research*, *79*(1), 51–68. https://doi.org/10.1006/enrs.1998.3859
9. Dignam, T., Kaufmann, R. B., LeStourgeon, L., & Brown, M. J. (2019). Control of Lead Sources in the United States, 1970-2017: Public Health Progress and Current Challenges to Eliminating Lead Exposure. Journal of public health management and practice : JPHMP, 25 Suppl 1, Lead Poisoning Prevention(Suppl 1 LEAD POISONING PREVENTION), S13–S22. https://doi.org/10.1097/PHH.0000000000000889
10. Jouhadi, Z., Bensabbahia, D., Chafiq, F., Oukkache, B., Guebessi, N. B., Abdellah, E. A., & Najib, J. (2016). Lead poisoning in children: a case report. The Pan African medical journal, 24, 316. https://doi.org/10.11604/pamj.2016.24.316.10352
11. Lanphear, B. P., Matte, T. D., Rogers, J., Clickner, R. P., Dietz, B., Bornschein, R. L., Succop, P., Mahaffey, K. R., Dixon, S., Galke, W., Rabinowitz, M., Farfel, M., Rohde, C., Schwartz, J., Ashley, P., & Jacobs, D. E. (1998). The contribution of lead-contaminated house dust and residential soil to children's blood lead levels. A pooled analysis of 12 epidemiologic studies. Environmental research, 79(1), 51–68. https://doi.org/10.1006/enrs.1998.3859
12. Washington State Department of Health https://doh.wa.gov/public-health-healthcare-providers/healthcare-professions-and-facilities/professional-resources/blood-lead-testing
13. World Health Organization https://www.who.int/news-room/fact-sheets/detail/lead-poisoning-and-health
14. Centers for Disease Control and Prevention https://www.cdc.gov/nceh/lead/data/national.htm
15. Perkins, Alexandria "Barriers to Lead Screening Among Pediatric Providers in King County, WA" http://hdl.handle.net/1773/44801

Rulemaking Efforts

WASHINGTON
Medical
Commission
Licensing. Accountability. Leadership.

Amelia Boyd
Program Manager

Exclusions – Opioid Prescribing

The CR-102 for amending the Exclusions sections in both the MD (WAC 246-919-851) and PA (WAC 246-918-801) chapters to expand the types of patients who are exempt from certain provisions of rule when being prescribed opioid drugs was filed with the Office of the Code Reviser on February 22, 2022. The WSR #22-05-083.

The WMC is proposing exempting patients in long-term acute care (LTAC) facilities, nursing homes, residential habilitation centers (RHC), and residential treatment facilities (RTF) from the opioid prescribing rules. This change will allow physicians and physician assistants in these facilities to continue the patient's pain medications without having to perform a history and physical or wait for a history and physical to be completed on the patient.

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

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

The WMC has also received a comment regarding patients in RHCs, that they are also similarly situated to LTAC and nursing home patients. We received a similar comment about RTFs, that stated RTFs are similar to RHCs except the stay at an RTF is usually short-term. As such, the WMC is also exempting patients in RHCs and RTFs.

In response to the filing, the WMC conducted an open public rule hearing on May 27, 2022. At the hearing, the Commissioners adopted revised draft language. The revised draft language can be found in the hearing packet. The next step in the rules process is the CR-103, or Rulemaking Order. The CR-103 is in progress. The revised language will be in effect 31 days after the filing of the CR-103. The hearing can be viewed on the WMC YouTube Channel.

Collaborative Drug Therapy Agreements

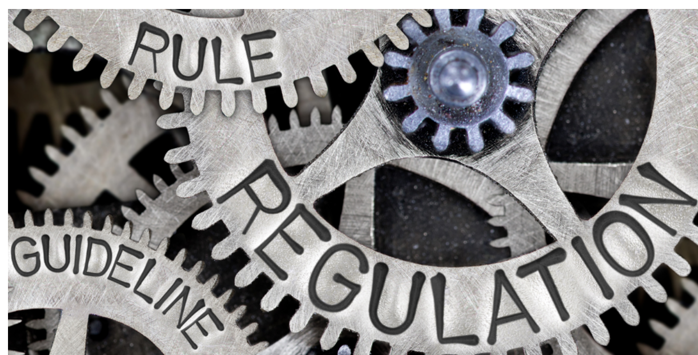
The CR-101 for creating rules related to Collaborative Drug Therapy Agreements was filed with the Office of the Code Reviser on July 22, 2020 as WSR #20-16-008.

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

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

Regulating the use of CDTAs would place the WMC in an active patient safety role. Rulemaking would provide clarity around this issue to help avoid potential discipline and increase patient safety. New sections being considered will potentially benefit the public's health by ensuring participating providers are informed and regulated by current national industry and best practice standards.

Workshops for this rulemaking are ongoing. Please visit our Rules in Progress page for the current schedule and draft language.



Rulemaking Efforts

Senate Bill (SB) 6551 – International Medical Graduates

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

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

The next step in the rulemaking process, the Proposal or CR-102, was approved at the WMC's November 19, 2021 Business meeting and is in the process of being drafted.

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

WMC Meetings and Events Full Schedule Rules in Progress
WMC Policy Meeting July 14th, 2022 4:00 PM Hybrid – Virtual Options Available Capital Event Center (ESD 113) 6005 Tyee Drive SW Tumwater, WA 98512
WMC Business Meeting July 15th, 2022 8:00 AM Hybrid – Virtual Options Available Capital Event Center (ESD 113) 6005 Tyee Drive SW Tumwater, WA 98512
Buprenorphine for OUD and Chronic Pain July, 21, 2022 - 5:00 PM PST CME Webinar - Register Here
WMC Policy Meeting August 25th, 2022 4:00 PM Hybrid – Virtual Options Available Capital Event Center (ESD 113) 6005 Tyee Drive SW Tumwater, WA 98512
WMC Business Meeting August 26th, 2022 8:00 AM Hybrid – Virtual Options Available Capital Event Center (ESD 113) 6005 Tyee Drive SW Tumwater, WA 98512

Connect With The WMC

Website Links

- wmc.wa.gov
- Update your address or email
- Complete your demographics survey

Need a Speaker?

If you would like a WMC speaker please send an email to medical.speakers@wmc.wa.gov

Subscriber Alerts

The WMC uses GovDelivery to notify individuals about items relating to the activities of the WMC via email. visit out website to sign up for specific topics

Newsletter Feedback

Please take a moment to share your thoughts about the WMC newsletter. Do you have a particular section that you like, or an idea on how to improve?
Send us an email to medical.newsletter@wmc.wa.gov

Legal Actions

February 1, 2022 -April 30, 2022

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

Practitioner Credential and County	Order Type	Date	Cause of Action	WMC Action
Summary Actions				
Greenwood, Nick C., MD MD60178937 Out of state	Order of Summary Suspension	2/18/22	Surrender of license to practice in Utah.	Summary suspension of license.
Hyson, Morton I., MD MD60619965 Out of state	Order of Summary Suspension	2/10 22	Surrender of license to practice in Oregon.	Summary suspension of license.
Malan, Jedidiah J., MD MD60225585 Out of state	Order of Summary Suspension	2/18/22	Suspension of license to practice in Alaska.	Summary suspension of license.
Roesler, Paul J., MD MD60316930 Out of state	Order of Summary Suspension	2/9/22	Surrender of license to practice in Florida.	Summary suspension of license.
Sharma, Bhanoo, MD MD60101028 Out of state	Order of Summary Suspension	2/10/22	Surrender of license to practice in Oregon.	Summary suspension of license.
Skelly, Katherine G., PA PA60983012 King County	Order of Summary Suspension	4/18/22	Inability to practice safely due to a health condition.	Summary suspension of license.
Sutton, Joseph A., PA PA60604531 Spokane County	Order of Summary Suspension	2/10/22	Alleged sexual misconduct and negligent care.	Summary suspension of license.
Formal Actions				
Ahsan, Muhammad, MD MD00040932 Out of state	Final Order on Default	3/24/22	Michigan Board of Medicine suspended license. Licensee failed to respond to SOC.	Indefinite suspension of license.
Allen, George S., MD MD00042579 Clark County	Agreed Order	3/4/22	Conviction of three counts of sexual abuse and two counts of harassment in Oregon.	Voluntary surrender of license.
De Jesus Martinez, Jose, MD MD00046505 Out of state	Final Order on Default	3/24/22	Texas Medical Board suspended license. Licensee failed to respond to SOC.	Indefinite suspension of license.
Decato, Edmund, PA PA10002121 King County	Final Order on Default	3/24/22	Failure to cooperate with an investigation. Licensee failed to respond to SOC.	Indefinite suspension of license.

Legal Actions

Practitioner Credential and County	Order Type	Date	Cause of Action	WMC Action
Di Julio, Marc A., MD MD00020524 King County	Agreed Order	3/4/22	While under a 2016 Agreed Order, Licensee retired from the practice of medicine.	Voluntary surrender of license.
Krebs, Richard M., MD MD60647377 Out of state	Final Order on Default	3/24/22	Oregon Medical Board suspended license. Licensee failed to respond to SOC.	Indefinite suspension of license.
Ladenika, Adetokunbo, MD MD60789918 Out of state	Final Order on Default	4/5/22	Virginia Board of Medicine reprimanded Licensee. Licensee failed to respond to SOC.	Indefinite suspension of license.
Lee, Gerald W., MD MD00043750 Lewis County	Agreed Order	3/4/22	Substandard management of three patients and substandard prescribing of opioids, benzodiazepines and other medications.	Restricted from prescribing Schedule II-IV controlled substances and from engaging in solo practice; required to register with PMP, enroll with CPEP or PACE to review Licensee's records and practice; personal appearances; may petition to remove restrictions by completing opioid prescribing CME, addiction CME, and writing a paper. May petition for termination in 3 years.
Lovin, Jeffrey D., MD MD00033709 Out of state	Final Order on Default	3/24/22	Medical Board of California revoked license. Licensee failed to respond to SOC.	Indefinite suspension of license.
Movva, Rajesh, MD MD60733483 Yakima County	Agreed Order	3/4/22	Failure to diagnose ischemic bowel and unwillingness to accept help and collaborate with colleagues.	CME and paper on distressed physicians, personal appearances, and a $5000 fine. May petition for termination in 3 years.
Tepper, Michael, MD MD00043030 King County	Final Order on Default	3/24/22	Failure to cooperate with an investigation. Licensee failed to respond to SOC.	Indefinite suspension of license.
Informal Actions				
Aflatooni, Alfred, MD MD00015674 King County	Stipulation to Informal Disposition	4/14/22	Alleged borrowing money from patient, substandard care to several patients, failure to cooperate with an investigation, failure to adequately supervise staff, violating opioid rules, and failure to comply with WMC order.	Voluntary surrender of license.

Legal Actions

Practitioner Credential and County	Order Type	Date	Cause of Action	WMC Action
Fiks, Vladimir B., MD MD00033049 Out of state	Stipulation to Informal Disposition	3/4/22	Alleged disciplinary action imposed by Oregon Medical Board against Licensee's Oregon license.	Must comply with Oregon order; restricted in Washington from obtaining, purchasing, leasing or using equipment used for the sole purpose of vestibular or balance testing, and from performing allergy testing or treating chronic environmental allergies by desensitizing injections; personal appearances, cost recovery of $1000. May petition for termination when Oregon terminates its order.
Hakala, Sheryl M., MD MD60404309 Out of state	Stipulation to Informal Disposition	3/4/22	Alleged disciplinary action imposed by the Florida Department of Health.	Restricted from prescribing, dispensing or administering, controlled substances; must comply with Florida order; have supervisor if practicing in Washington; pay costs of $1000. May petition for termination when Florida order is terminated.
Healey, William V., MD00025738 King County	Stipulation to Informal Disposition	3/4/22	Alleged inadequate record keeping for prescribing of sedative hypnotic, benzodiazepine, and stimulant medications; and alleged failure to consult with patient's PCP.	CME to meet licensing requirements, professional boundaries course, paper on prescribing controlled substances, personal appearances, costs of $1000. May petition for termination in one year.
Janeway, David W., MD MD00039104 Snohomish County	Stipulation to Informal Disposition	4/14/22	Alleged substandard care given in nursing facility where Licensee served as medical director including poor documentation and the patient receiving the wrong medications for 4 months.	CME is prescribing opioids for chronic pain and record-keeping, a literature review and paper on monitoring and treating hypothyroidism, personal appearances, and costs of $1000. May petition for terminate after 2 years.
Kinahan, Peter J., MD MD00039462 Snohomish County	Stipulation to Informal Disposition	3/4/22	Alleged health condition.	Voluntary surrender of license.
Melody, Kieran F., MD MD60942255 Spokane County	Stipulation to Informal Disposition	3/4/22	Alleged failure to recognize that a patient's appendix was not removed.	CME in appendicitis and perforated appendix, paper on missed appendix, personal appearances, and costs of $1000. May petition for termination in one year.
Ochoa, Kevin A., MD MD00047496 Spokane County	Stipulation to Informal Disposition	3/4/22	Alleged failure to interpret a CT report that revealed a kidney stone, and alleged failure to notify patient of finding and to recommend follow up with urologist.	CME in emergency care, paper on diagnosis, management and disposition of patients with kidney stones and hyponatremia, personal appearances, and costs of $1000. May petition for termination in one year.

Legal Actions

Practitioner Credential and County	Order Type	Date	Cause of Action	WMC Action
Purcell, Shawna E., MD MD60101885 Thurston County	Stipulation to Informal Disposition	4/14/22	Alleged substandard care, failure to maintain patient confidentiality, failure to keep controlled substances secure.	Ethics and boundaries course, CME in safe prescribing, paper on inappropriateness of leaving prescriptions in unsecure area for patient pickup, personal appearances. May petition for termination after one year.
Shaw, David P., MD MD00039104 King County	Stipulation to Informal Disposition	4/14/22	Alleged substandard care and failure to monitor lithium levels for patient with significant mental health issues.	CME in prescribing, medical record-keeping, and communication; paper on pharmacokinetics, lab work for monitoring, record-keeping, and communication; personal appearances; and costs of $1000. May petition for termination after one year.
Soames, Garrett E., PA PA60549796 Kitsap County	Stipulation to Informal Disposition	4/14/22	Alleged removal of equipment and supplies from employer's facility and use of equipment for personal business.	CME on ethics and boundaries; paper on taking items from employer, using employer's resources, replacing clinic's supplies with personally obtained supplies, leaving clinic while patients are waiting in exam rooms, and the impact of such behavior on patients and the reputation of the clinic; personal appearances; costs of $2000. May petition for termination in 3 years.

Order of Summary Suspension: An order suspending a license prior to a hearing based on a determination that the licensee's continued practice represents a danger to the public.

Order of Summary Restriction: : An order restricting an aspect of a licensee's practice prior to a hearing based on a determination that the licensee's continued practice with an unrestricted license represents a danger to the public.

Agreed Order: a settlement resolving a statement of charges. This order is an agreement by a licensee to comply with certain terms and conditions to protect the public.

Final Order: an order issued after a formal hearing before the Commission.

Final Order on Default: an order issued after the licensee fails to respond to a statement of charges.

Final Order-Waiver of Hearing: an order issued after the licensee waives the right to a hearing on a statement of charges by the licensee to comply with certain terms and conditions to protect the public.

Stipulation to Informal Disposition (STID): a document detailing allegations, but with no findings or admissions, and containing an agreement by the licensee to comply with certain terms and conditions to protect the public.

Members

Medical Commission Members
John Maldon - Chair
Claire Trescott, MD - 1st Vice Chair
Jimmy Chung, MD - 2nd Vice Chair

James E. Anderson, PA-C
Michael Bailey
Christine Blake, CPMSM
Toni L. Borlas
Charlie Browne, MD
Diana Currie, MD
Anjali D'Souza, MD
Karen Domino, MD
Arlene Dorrough, PA-C
Harlan Gallinger, MD
April Jaeger, MD
Sarah Lyle, MD
Terry Murphy, MD
Alden W. Roberts, MD
Scott Rodgers, JD
Robert H. Small, MD
Richard Wohns, MD
Yanling Yu, PhD

Update! Editorial Board
Diana Currie, MD
Jimmy Chung, MD
Micah Matthews
Richard Wohns, MD
Jimi Bush, Managing Editor

Links To Our Website

[Pain Management Resources]

[Update your Physical And Email Address]

[News and Announcements]

[Rules and Regulations In Progress]

[Frequently Asked Questions (FAQ)]

[Contact Us]

WMC Mission

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

WMC Vision

Advancing the optimal level of medical care for the people of Washington State.

New Adult Immunization Recommendations: Hepatitis B, PCV, and Shingrix Dose 1

WASHINGTON **Medical Commission**
Licensing. Accountability. Leadership.

The Centers for Disease Control (CDC) recently updated adult vaccine recommendations related to hepatitis B vaccine, pneumococcal vaccine, and Shingrix.

Hepatitis B vaccine is now recommended for all adults aged 19-59 years regardless of risk factors, and anyone 60 years or older with risk factors. Hepatitis B vaccine may also be offered to all adults 60 years and older who wish to be vaccinated. PreHevbrio (VBI) is a new trivalent hepatitis B vaccine licensed in 2021 for use in adults age 18 or older as a 3-dose series given over 6 months.

Pneumococcal vaccines are recommended for all adults aged 65 years or older as well as adults aged 19-64 with certain underlying medical conditions or other risk factors. The new guidelines for PCV15, PCV20, and PPSV23 are listed in the table below as well as in the Adult Pneumococcal Vaccine Administration algorithm.

The new **Shingrix vaccine** guidelines recommend that two doses be given for all adults aged 19 years or older who are immunocompromised or have other risk factors.

Below is a more detailed summary of the updated recommendations with additional resources.

Vaccine	Summary of updated recommendations	Resources
Hepatitis B	• Hepatitis B vaccine is now recommended for all adults 19 years through 59 years, regardless of risk factor. • Adults 60 years or older with risk factors should receive hepatitis B vaccination. • Anyone 60 years or older may receive hepatitis B vaccine. • PreHevbrio (VBI) is a new trivalent hepatitis B vaccine licensed in 2021 for use in adults age 18 or older as a 3-dose series given over 6 months.	• CDC Adult Immunization Schedule • Immunize.org Ask the Experts, Hepatitis B • Hepatitis B vaccine standing orders

Pneumococcal	PCV15 or PCV20 vaccine is now recommended for adults 65 years or older or 19 years or older with immunocompromising conditions. When PCV15 is used, give PPSV23 at least 1 year later. Additional scenarios are described below.
	Adults who qualify for pneumococcal vaccination but have not received any previous pneumococcal vaccines
	• Give 1 dose of PCV15 or PCV20.
	  ◦ If PCV15 is used, give PPSV23 at least one year later.
	  ◦ Minimum interval of 8 weeks for adults with an immunocompromising condition.
	• If PCV20 is used, PPSV23 is NOT indicated.
	Adults who qualify for pneumococcal vaccination and have only received PPSV23
	• May give 1 dose of PCV15 or PCV20 at least one year after the last PPSV23 vaccine.
	• Additional dose of PPSV23 is not recommended.
	Adults who qualify for pneumococcal vaccination and have only received PCV13
	• See Pneumococcal Vaccine Timing for Adults for specific guidance. The incremental public health benefits of providing PCV15 or PCV20 to adults who have received PCV13 only or both PCV13 and PPSV23 have not been evaluated.
	• May give PCV20 if PPSV23 is not available.
		• CDC Pneumococcal Vaccine Who and When to Vaccinate
		• ACIP (Advisory Committee on Immunization Practices) recommendation
		• CDC Adult Immunization Schedule
		• Immunize.org Ask the Experts Pneumococcal
		• Pneumococcal vaccine standing orders
		• Pneumococcal Vaccine Timing for Adults-April 1, 2022 (cdc.gov)
		• Pneumococcal Vaccine Administration Algorithm (wa.gov)

Shingrix	• 2 doses of the Shingrix vaccine is now recommended for adults 19 years or older who are immunocompromised. • Adults 50 years or older who are healthy continue to be recommended to receive 2 doses, including those who received Zostavax in the past.	• ACIP recommendations • CDC Adult Immunization Schedule • Immunize.org Ask the Experts, Zoster