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Washington Medical Commission

Update!

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WASHINGTON Medical Commission
Licensing. Accountability. Leadership.

Focusing on the Patient to Reduce Errors

Jimmy Chung, MD

From a patient perspective—as a consumer of health care services in the United States—it is perplexing that health care continues to be as unreliable and dangerous as it is. According to most reports, an estimated 250,000-400,000 deaths a year are caused by medical errors. Despite the hard work of physicians, clinicians, administrators, policy makers, advocates, investors, and dozens of other stakeholders, medical errors remain the third highest cause of death in this country. According to some accounts, the risk of dying from a medical error in a hospital is greater than dying while climbing Mount Everest. This level of risk translates to about 450 airline crashes in the US *a day*. It is mind boggling that we accept this level of hazard in health care, perhaps because the perception of dying from something else is so much worse that it is worth the risk of walking through the hospital doors. Ironically, unlike the other top causes (heart disease and cancer), which may arguably be considered at least partially uncontrollable and unpreventable, medical errors are entirely preventable.

Prevention, however, is not possible by the action of a single individual but requires the collaboration of all those involved and the system within which individuals operate. This is what is referred to as "Highly Reliable Organizing"—the creation of systems and just culture that predict failures and prevent human beings from making errors that otherwise would be natural consequences of our daily behaviors.

Ever since the 1999 Institute of Medicine (IOM) publication "To Err is Human" released the astonishing statistics into the public spotlight, many organizations have attempted to reduce errors by creating registries to collect outcomes data and developing evidence-based guidelines that would serve as standards of care. Physicians have generally been resistant to adopting guidelines, however, relying instead on personal experience and anecdotal learnings over standardization. In a 2008 study by the New England Healthcare Institute, more than half of physicians surveyed stated that they do not consistently use clinical guidelines. Cardiologists were the most likely to use guidelines (70%) and orthopedic surgeons were the least likely (25%). Some of the reasons for not using guidelines included lack of awareness of guidelines (44%), inconvenience (37%), or not being reimbursed for guideline implementation (20%). Over 2/3 of the physicians stated they are less likely to use guidelines if more effort was required to find or read the guidelines. At least ¼ of the physicians stated that their own experience yields better outcomes than guidelines.

The statistic I found the most interesting, however, was that about 45% of physicians stated that they would be more likely to use guidelines if they knew that their patients were informed of their compliance. Admittedly, I am unsure how to interpret this. While I am glad to see that physicians do care about what patients think, it is unsettling that physicians are willing to take unnecessary risks with their care delivery if no one is watching them. Clearly, if the physicians are concerned with "looking good" to the patient, they must realize that following guidelines is a "good" decision. Thus, if physicians recognize that patients want them to follow guidelines (which are ostensibly created to improve patient outcomes), why would we only do it when someone is watching?

As advocates for both patients and professionals, the Washington Medical Commission is dedicated to reducing errors and helping physicians and physician assistants provide excellent care to optimize the patient experience. We also recognize that over time, clinical guidelines can change and sometimes be reversed as more research is done. However, the primary goal of health professionals is to serve the interests of the patient and do everything possible to prevent errors and patient harm. It is imperative that we remain patient-centered in our decision making and ensure that the patient experience is as reliable and safe as modern air travel. Unfortunately, very little has changed in 24 years since the IOM report, but we must persist and maintain focus on what is most important to the patient.

"Despite the hard work of physicians, clinicians, administrators, policy makers, advocates, investors, and dozens of other stakeholders, medical errors remain the third highest cause of death in this country."

Executive Director Report

You Spoke, We Listened.

Melanie de Leon, JD, MPA

Even before the COVID-19 pandemic, healthcare workers faced higher rates of burnout, depression, anxiety, post-traumatic stress disorder (PTSD), and suicide. Now more than ever we need to support the well-being of our healthcare workforce. The Dr. Lorna Breen Foundation published the following data, and it is sobering:

400

Physicians die by suicide each year.

2X Physicians and nurses die by suicide at 2x the rate of the general population.

↑ 200%

Burnout has been shown to cause a 200% increased risk in medical errors.

62% Of nurses and 42% of doctors are feeling burned out while battling COVID-19.

Practitioners seeking mental health care should not fear career setbacks for getting help. The WMC has joined with 18 other medical boards to remove or change stigmatizing language around mental health in our licensure applications. We urge you to get any mental and physical health care you need without fear that it will impact your livelihood.

Licensing application questions were originally developed with the intent to protect the public, but there is no data demonstrating that these questions protect the public. On the contrary, it is well documented that these questions often lead to clinicians not seeking the care that they need, which can ultimately lead to poor patient care. Ensuring that clinicians, like yourself, can access necessary mental health, substance use and physical health care not only benefits your well-being, but it also benefits your patients and your community.

Be your own best patient and get any help you need. Healthcare practitioners have always carried an enormous burden and it has only increased since the COVID pandemic.

The WMC encourages other medical boards and credentialing committees to take a closer look at their licensing application questions and remove any questions that stigmatize mental health and substance use or abuse and that may actually violate Title II of the American with Disabilities Act.

On March 21, 2023 the WMC held a Coffee with the Commission alongside WPHP to discuss These changes and answer your questions. The recording can be viewed here. If you have any questions or concerns, please reach out to our licensing unit or at 360-236-2750 option #1.

Speak Up!

If you have a suggestion for content of this newsletter or a general comment, let us know!

Contact Us

“I Got Burned for Helping”

Edw. C. Lopez, PA-C

Its 3:00 O’clock in the afternoon and Provider Kildare is two patients behind when he looks down from the Nurse’s station counter to see Nurse Ruby Tuesday looking quite concerned while speaking on the phone. After a couple of minutes Nurse Tuesday promptly hangs up noting that they’re behind on the schedule while expressing a deep sigh and then stands up to face Provider Kildare who then asks her, “Hey…what’s going on?” She reluctantly and quietly says, “That was Bob my husband who said he’s been having increasing difficulty voiding and can’t get in to see his PCP for another month, so I don’t know what to do!” Nurse Tuesday then sighs and quietly asks, “Do you think you can give my Bob something that would help him until he sees his PCP?” Provider Kildare sensing the urgency and frustration in Nurse Tuesday’s request as well as a sense of wanting to help his most trusted clinical partner, promptly reaches into his coat pocket and pulls out his prescription pad and says, “Here you go Ruby, this should help him! This is Tamsulosin 0.4mg. Have him take one each morning and he should start feeling better.” Nurse Tuesday reaches for the prescription and thanks Provider Kildare for his thoughtful kindness and they both proceed with their day.

Two weeks go by, and Provider Kildare asks Nurse Tuesday how her husband Bob is doing, and she says he seems so much better and hasn’t complained of any voiding issues so he decided to not see his PCP since he’s so busy in his contracting business and has been working out of town in Spokane. Nurse Tuesday then asks Provider Kildare if he would call in a script for a 90-day supply of the Tamsulosin so he can continue it through the work season until he can come back to Seattle and have the time to see his PCP. Provider Kildare pauses and thinks about it a moment and agrees that a 90-day script would be fine and convenient for Bob to continue it. So, he reaches for the phone and calls in a 90-day prescription for Bob for the medication at Bob’s preferred pharmacy.

Three months go by, and Provider Kildare recognizes that Nurse Tuesday has been out of the office for over a week and asks the office manager what happened to Ruby. Management lets him know that she has taken a personal leave of absence for an undetermined amount of time.

Two weeks later as Provider Kildare opens his email, he recognizes that he has an email from the Washington Medical Commission. In it he reads with a sense of impending doom that a complaint has been filed against him by someone alleging “malpractice, negligence, neglect of care and treating a patient without ever examining or assessing the patient”. As he reads further in the complaint, he determines that the complainant is the daughter of Nurse Ruby Tuesday & husband Bob. It turns out Bob ultimately did return home a few days sooner than expected due to a sudden onset of “bloody urination with pelvic and back pain” and did indeed get in to see his PCP and then was sent to a urologist who found stage IV bladder cancer.

While this is an amalgamation of fact and fiction, I will spare the reader the lengthy and emotional investigative and adjudicative process details that could involve a case such as this and instead would like to focus on what may have gone wrong here.

While we are all in this profession to provide help & healing to the sick and injured while relieving suffering, we are also bound by the adage to “…First do no harm!”. And while many of us may have fallen into the trap of providing treatment to friends, family and even loved ones without ever establishing a proper patient relationship, we must be aware of the ethical and legal pitfalls of this seemingly “helpful” practice.

“I will spare the reader the lengthy and emotional investigative and adjudicative process details that could involve a case such as this and instead would like to focus on what may have gone wrong here.”

Physician Assistant News

What is the legal definition of a physician-patient relationship?

"(Exceptions are made when emergency care is needed and when refusal to treat is based on discrimination). However, a patient-physician relationship is generally formed when a physician affirmatively acts in a patient's case by examining, diagnosing, treating, or agreeing to do so." AMA Journal of Ethics

According to legal scholars nationwide:
"The physician-patient relationship is regarded as a fiduciary relationship, in which mutual trust and confidence are essential. A physician or [Physician Assistant] is held to a standard of medical care defined by the accepted standards of practice in his or her area of practice. Some of the obligations of a physician's [Physician Assistant's] duty of due care include the obligation to fully inform the patient of his or her condition, to continue to provide for medical care once the physician-patient relationship has been established, to refer the patient to a specialist, if necessary, and to obtain the patient's informed consent to the medical treatment or operation." U.S. Legal.com

And while this Washington Administration Code refers to "Sexual Misconduct" it is pertinent to this topic of what defines a "patient". WAC 246-919-630 (a)

"Patient" means a person who is receiving health care or treatment, or has received health care or treatment without a termination of the physician-patient relationship. The determination of when a person is a patient is made on a case-by-case basis with consideration given to a number of factors, including the nature, extent and context of the professional relationship between the physician [Physician Assistant] and the person."

As you gathered by now there was no "professional relationship" here between Provider Kildare and Bob, the husband of Nurse Ruby Tuesday who had been the friend and colleague of Provider Kildare for several years. And this decision to "help" placed Provider Kildare in a clinically responsible place assuming care and treatment of a man whom he never saw, nor obtained any medical history or review of symptoms from and whom he never examined. And while this complaint would likely emotionally devastate most of us, Provider Kildare learned a painful but valuable lesson and never again prescribed or treated anyone again that he did not see personally nor was able to have a direct contact, conversation or "professional relationship" with. In the end Provider Kildare became a better and much more comprehensive medical provider serving his community with distinction but unfortunately with a very deep emotional cost that he wished he would have never experienced.

In conclusion, the Washington State Medical Commission is here to protect the citizens of Washington while "promoting patient safety and enhancing the integrity of the profession through licensing, discipline, rule making, and education" for both Physicians and Physician Assistants.

Upcoming Meetings

Meeting	Date	Location
WMC Policy Meeting	April 13th, 2023 4:00 PM PST	Virtual options available Capitol Event Center (ESD 113) 6005 Tyee Drive SW, Tumwater, WA
WMC Business Meeting	April 14th, 2023 8:00 AM PST	Virtual options available Capitol Event Center (ESD 113) 6005 Tyee Drive SW, Tumwater, WA
WMC Policy Meeting	May 25th, 2023 4:00 PM PST	Virtual Meeting
WMC Business Meeting	May 26th, 2023 8:00 AM PST	Virtual Meeting
WMC Policy Meeting	July 13th, 2023 4:00 PM PST	Virtual options available Capitol Event Center (ESD 113) 6005 Tyee Drive SW, Tumwater, WA
WMC Business Meeting	July 14th, 2023 8:00 AM PST	Virtual options available Capitol Event Center (ESD 113) 6005 Tyee Drive SW, Tumwater, WA

Rulemaking Efforts

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Amelia Boyd
Program Manager

Health Equity Continuing Education for MDs and PAs

The WMC officially filed a CR-101 with the Office of the Code Reviser on February 10, 2023 as WSR# is 23-05-054. The WMC is considering adopting a new section in chapter 246-918 WAC (physician assistants) and 246-919 WAC (physicians) to meet the requirements of Engrossed Substitute Senate Bill 5229 (Chapter 276, Laws of 2021) regarding health equity continuing education (CE). The Department of Health created model rules, WAC 246-12-800 through 246-12-830, to comply with the bill codified in RCW 43.70.613. The WMC will consider these model rules as part of this rulemaking. The WMC will also consider whether additional CE hours and course topics should be included.

Workshops for this rulemaking will be scheduled in the coming months. Please visit our Rules in Progress page for the current schedule.

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 WMC 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.

More Information

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

Mission

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

Vision

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

Legal Actions

November 1, 2022 -January 31, 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				
Ambati, Balamurali MD MD6068483 Out of state	Order of Summary Restriction	1/6/23	Restriction of license to practice in Utah.	Restricted from performing all types of eye surgery, and from performing experimental or off-label procedures, and from using non-FDA-approved materials.
Haas, Jonathan MD MD60716362 Out of state	Default Order	12/8/22	Inability to practice due to health condition	Indefinite suspension of license.
Pugh, Steven L. MD MD00039278 Spokane County	Order of Summary Suspension	12/20/22	Inability to practice due to health condition	Indefinite suspension of license.
Riyaz, Farhaad R. MD ILMC.MD6110328 Out of state	Order of Summary Suspension	12/23/22	Suspension of license to practice in Virginia.	Indefinite suspension of license.
Formal Actions				
Hu, Chester MD MD00039238 Out of state	Agreed Order	1/12/23	Alaska license placed on probation.	Restricted to treating a patient only in a hospital-based setting with a post-anesthesia care unit. May not treat patients in an ambulatory surgical facility or in a non-hospital-based setting.
Lucke, John C. MD MD60709314 Out of state	Agreed Order	1/12/23	Surrender of Massachusetts license.	Voluntary surrender of license.
Odea, Timothy MD MD00037234 Chelan County	Agreed Order	11/18/22	Impairing health condition.	Voluntary surrender of license.
Parvin, Dara MD MD60139957 Out of state	Final Order	1/23/23	Iowa and Ohio licenses placed on probation.	Reprimand; comply with Iowa and Ohio orders; 30 days prior to renewing expired Washington license, must obtain assessment by WPHP.

Practitioner Credential and County	Order Type	Date	Cause of Action	WMC Action
Informal Actions				
Buckley, Tyler MD MD60942112 Asotin County	STID	11/17/22	Alleged accessing medical records of non-patient.	CME in ethics, boundaries, and HIPAA; paper; costs. May petition to terminate after completing terms.
Buttitta, James MD MD00033961 King County	STID	11/17/22	Alleged changing medication from warfarin to apixaban in patient with a mechanical heart valve.	CME in error prevention; paper; personal appearances; costs. May petition to terminate after one year.
Helwig, Jonathan A. MD MD60091913 Out of State	STID	1/12/23	Discipline of Oregon license.	Comply with Oregon order; enroll in WPHP; personal appearances; costs. May petition to terminate when Oregon terminates Oregon order and WPHP endorses return to practice.
Kregenow, Lily MD MD00048510 Pierce County	STID	11/17/22	Alleged inappropriate documentation of alleged child sexual abuse.	CME in identifying and evaluating child abuse; CME in pediatric medical ethics; paper; personal appearances; costs. May petition to terminate after one year.
Luo, Xin Jie MD MD61114625 King County	STID	1/12/23	Alleged misdiagnosis of diabetic ketoacidosis in emergency department.	CME in diagnosing and treating diabetic ketoacidosis; CME in treating migraine headache; paper; personal appearances; costs. May petition to terminate in two years.
Stone, Christopher PA PA60604965 Pierce County	STID	11/17/22	Alleged prescribing for friends and co-workers without properly documenting case or an examination in medical record.	CME in prescribing; review WMC policy on Self-Treatment or Treatment of Immediate Family Members; paper; personal appearances; costs. May petitioner to terminate in 1.5 years.
Vasin, Dmitri MD MD00038345 Kitsap County	STID	11/17/22	Alleged failure to comply with Governor's order regarding wearing of masks in the office.	Compliance with proclamations and orders issued by Governor, Secretary of DOH, or other health officials; CME in measures healthcare providers can take to help reduce spread of COVID-19; CME in infectious disease; paper; personal appearances; costs. May petition to terminate in two 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 of 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.

WPHP Report

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WPHP Advocacy: A Voice for You

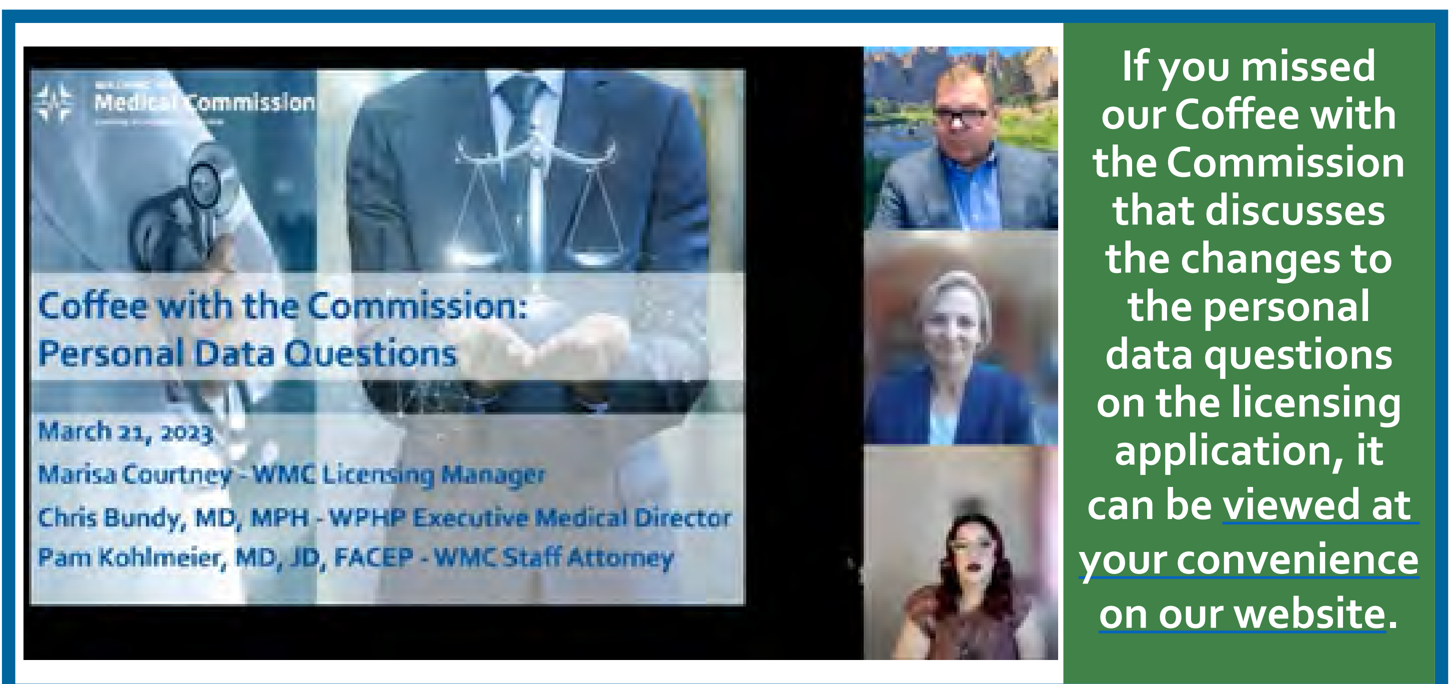
Chris Bundy, MD, MPH
Executive Medical Director, Washington Physicians Health Program

Introduction
For over 30 years, the Washington Physicians Health Program (WPHP) has served as a therapeutic alternative to discipline for physicians and physician assistants with health conditions that could impair their ability to safely practice. While many in our community are familiar with WPHP's mission to assist impaired or potentially impaired colleagues, fewer are aware of WPHP's important advocacy work intended to support the profession more broadly. We would like to take a moment to celebrate and share some of our recent advocacy victories.

Licensure Question Reform
In 2017, WPHP initiated a collaboration with WMC to revise licensing question language so that initial and renewal applicants were no longer required to disclose past mental health or substance use disorder diagnoses under the new "safe haven" provision for those known to WPHP. Recently, WMC went even further and developed an advisory model for the licensing application. Rather than asking any questions about mental health or substance use disorder diagnoses, the advisory educates applicants about professional responsibilities related to impairment, how to obtain help if needed, and the WMC's requirements for individuals that it believes may be impaired.

These reforms have made it easier for health professionals to seek care without fear of adverse professional consequences and demonstrate the WMC's clear commitment to physician and PA well-being. The WMC has now included information on its website to make sure prospective applicants are know that they will not subject to intrusive questions when seeking licensure Washington. Barriers to help seeking are complex and we do not expect that these changes alone will lead to a rush to care. Doctors probably fear their colleagues' negative perceptions and being seen as inferior as much or more than disciplinary involvement. However, such changes are critical first steps in dismantling systems of institutionalized stigma and bias toward individuals with behavioral health conditions and changing the culture of medicine that continues to discriminate against its own.

WPHP is currently collaborating with the other Boards and Commissions of the licensees we serve in order to bring similar reforms to their licensing application language.



WPHP Report

Legislative Reform
In the 2022 legislative session, WPHP introduced SSB 5496 to ensure that the confidentiality protections afforded to WPHP substance use disorder participants were applied equally to WPHP participants with other psychiatric and non-psychiatric health conditions. In addition, this legislation updated, harmonized, and removed stigmatizing language from statutes that support our work. The bill received strong bipartisan support in both houses of the state legislature where it passed early in the session. We are grateful to Washington Senators Muzzall and Cleveland and the Senate Health Care Committee for sponsoring the bill as well as the many organizations, including the Washington State Medical Association, Washington Medical Commission (WMC), and Washington State Hospital Association, for their endorsements.

Credentialing Question Reform
In 2022, WPHP reached out to the Washington Credentialing Standardization Group (WCSG) to propose changes to the 2023 Washington Practitioner Application (WPA). The WPA is the credentialing application accepted by most physician organizations, hospitals, and health plans throughout the state. As with licensure question reform, the goal was to bring the health status attestation questions into alignment with regulatory best practices while protecting credentialing applicants from intrusive questions that were out of alignment with regulatory best practices and the Americans with Disabilities Act (ADA). WCSG was enthusiastically supportive of improving the language and, under the leadership of its chair, Carrianne Dockter, published the updated WPA in December 2023. The updated health attestation includes clearer, more streamlined language that focuses on current impairment and asks only for contact information for any involved monitoring program rather than details around the health condition(s) or circumstances related to impairment. This ensures that no professional's health information ends up on the WPA.

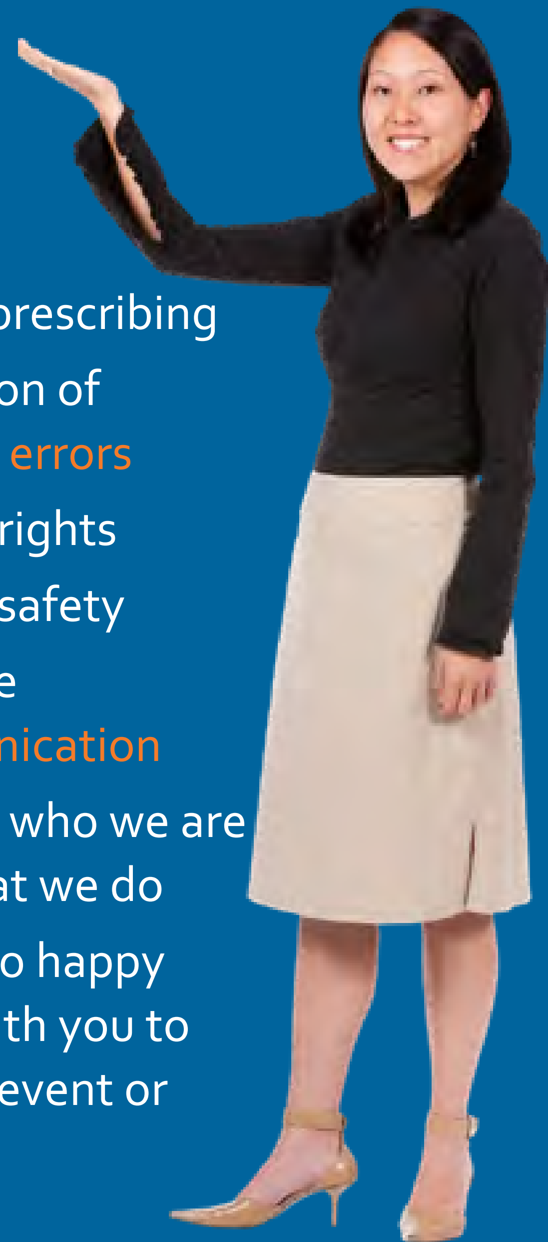
In Closing
We hope this update raises awareness of the many other ways WPHP quietly serves the broader interests of the profession and how we all benefit from these efforts. We hope you will appreciate that we are singing for our supper and that our song has effectively inspired change for the better. In times of continuing challenge, it can be tempting to only look up the mountain at the difficult journey ahead. However, we should occasionally let our gaze drift down the mountain to remind ourselves of that which we have already overcome…

WPHP is grateful that our advocacy work has been graciously recognized by the Washington State Medical Association. You can read more about that here and here.

If you or a colleague need help, please do not hesitate to reach out to us: www.wphp.org 800-552-7236

Need a Speaker?

We provide speakers and subject matter experts on a variety of topics, including:



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We are also happy to work with you to design an event or webinar.

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Special Notice

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Inappropriate Use of Antipsychotic Medications And Erroneous Diagnosis of Schizophrenia in Nursing Homes

Issue

The Centers for Medicare and Medicaid Services (CMS) are responsible for the oversight and health and safety of nursing home residents. Over the past decade, through the work of the National Partnership to Improve Dementia Care, CMS has been monitoring antipsychotic medication use in nursing homes. Though steps have been taken to reduce the use of these drugs, there continue to be concerns that nursing home residents may be inappropriately prescribed antipsychotic medications due to being erroneously diagnosed and coded as having schizophrenia; see the Office of Inspector General report for more information. Antipsychotic medications are dangerous among the vulnerable nursing home population because of their potential side effects, including death.

Efforts to Address the Issue

To increase our focus on this issue, CMS recently announced they will be conducting off-site nursing home audits [1] to assess the accuracy of resident assessments (collected through the Minimum Data Set (MDS)). Specifically, to determine whether or not the facility is appropriately assessing, diagnosing, and coding schizophrenia in the MDS for residents in their facility. These efforts are aligned with the latest actions under The White House Fact Sheet: Protecting Seniors by Improving Safety and Quality of Care in the Nation's Nursing Home. If the audit reveals a pattern of inaccurate coding, this practice will negatively impact a facility's Five-Star Quality Rating System on Nursing Home Care Compare. It is rare for individuals older than 40 years of age to be diagnosed with schizophrenia.[2] Nursing homes should work with their psychiatric providers and medical directors to ensure the appropriate professional standards and processes are being implemented related to diagnosing individuals with schizophrenia.

Note

In addition to CMS' actions, we believe that some of these instances may represent actions that are inconsistent with the expectations of the board of licensure. As such, if there are instances where a practitioner has not followed professionals' standards of practice for diagnosing individuals and prescribing medications, we believe these practitioners should be referred to their respective state medical boards for investigation.

For questions and to obtain more information, please contact DNH_BehavioralHealth@cms.hhs.gov.

1 Updates to the Nursing Home Care Compare Website and Five Star Quality Rating System: Adjusting Quality Measure Ratings Based on Erroneous Schizophrenia Coding, and Posting Citations Under Dispute https://www.cms.gov/files/document/qso-23-05-nh.pdf

2 National Alliance on Mental Illness (NAMI). "Schizophrenia." Accessed March 2, 2021. https://www.nami.org/Learn-More/MentalHealthConditions/Schizophrenia

Changes to the WSF Medical Preferential Loading Program

Improvements to WSF's Medical Preferential Loading program are effective Monday, March 20 and are aimed at making the process easier for patients and their medical providers to use as well as making it easier for our staff to administer and track.

New Application Process

Health care providers will work with their patients to submit an application for them online, from the Medical Preferential Loading webpage, Medical preferential loading | WSDOT (wa.gov). The updated webpage, and the Rules and Regulations document will be available when the online program launches on March 20. Once submitted, the health care provider and customer will both receive a confirmation email. The customer will need a printed copy of this confirmation email and will present it with their ID, or a minor's guardians' ID, when traveling. Providers will no longer need to contact WSF for applications or fax them to terminals.

No More Faxes

The primary change is eliminating the need to fax applications by moving the program online and launching a new webpage for health care providers to submit an application on behalf of their customers. Faxed applications will no longer be accepted starting March 20. A 90-day grace period will be implemented on that date for customers who have their applications faxed in before March 20. Terminal staff will accept these through their individual expiration dates or not after June 18, whichever comes first.

Additional Changes

Several other changes to the Medical Preferential Loading program may affect health care providers and customers. Please review the following changes:

- Single-Day, Multi-Day (30), and Annual Preferential Loading options are available for qualified applicants.
- Customers are required to show their IDs with the confirmation email to verify approved use of the Medical Preferential Loading program.
- The confirmation email will include directions and guidelines for when customers arrive at the terminal, and how to renew with their provider.
- Only doctors, physicians, RNs, and affiliated positions with a professional license number may fill out and submit an application.

We will be distributing information about the program changes to all Medical Preferential Loading customers in the coming weeks. Customers can also call our Customer Service Center Contact Washington State Ferries with any additional questions at 206-464-6400.

Our goal with these changes is to modernize this program, so it is a much smoother and efficient experience for customers, health care providers, and our ferry system.

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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.