WASHINGTON

Medical Commission

Licensing. Accountability. Leadership.

UPDATE!

Vol. 11 Spring 2021

"The Value and Purpose of Risk Management"

"Someone filed a complaint against me - Now what? A Peek Behind the Curtain"

"Washington's New Physician Assistant Practice Laws to Take Effect in July"

"Tapering Long-Term Opioids"

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Message from the Chair

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The Value and Purpose of Risk Management in Healthcare.

John Maldon

Does Risk Management provide value in healthcare? I sure think so. But, my opinion is based on being a former risk management executive for about as long as I can remember. Healthcare administrators may, or may not, agree but if there are dollars to be saved and if patient outcomes are improved, it may be difficult to argue against risk management principles in the healthcare setting.

So, what is risk management anyway? Wikipedia defines risk management as the identification, evaluation and prioritization of risks followed by coordinated and economical application of resources to minimize, monitor and control the probability or impact of unfortunate events.

There is more to the definition, but the above definition provides the basics for this discussion. In more simple terminology for healthcare, it is taking note of something that is out of the norm that either has or has the potential to cause injury or damage, assess what has gone wrong or the probability of something going wrong, do a cost analysis and in most cases, fix it.

Unfortunately, in healthcare something has already gone wrong, maybe more than once before the faulty process or procedure is recognized. A decision is made to do a "root cause analysis", a risk management term, that is simply defined as "what happened"? And why are medical processes and procedures not fixed until something goes wrong? Because no one in healthcare really believes it is possible for things to go wrong until they do. Medical misadventures include a variety of wrong site surgeries including amputation of the wrong limb, right procedure on the wrong patient, foreign body left in a surgical site, mis-sent critical lab results, prescribing and dispensing errors. There are many more examples on the "never event" list. These unfortunate errors still occur despite efforts to prevent these errors from occurring.

There are two risk management disciplines. There are clinical risk management staff who are primarily administrative in a clinical setting. Organizational approaches to clinical risk management all differ. However, common clinical risk management responsibilities may include patient safety, credentialing, policy and procedure development and peer review to name a few.

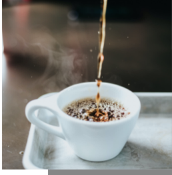
The second risk management discipline focuses on legal and financial matters, risk prevention and hopefully serves in a consultative role serving providers and administration.

So, what is really needed is to make legal/financial risk management more relevant in the healthcare setting? Legal/financial risk management professionals need to be used proactively in the development of processes and procedures as an outsider looking in, rather than what risk managers usually are told "this is how we have always done it".

Risk managers have the benefit of managing many cases resulting in adverse outcomes in a variety of disciplines. Knowledge is gained through investigating what happened, what went wrong, why it went wrong and hiring medical experts to review and provide analyses of what went right and what went wrong. Unfortunately, most of this knowledge goes toward evaluating cases for settlement purposes and not back to the system for procedural improvement.

The value and purpose of legal/financial risk management in healthcare is really influence. Influencing medical leadership by: suggesting educational opportunities, arranging meetings with medical and legal experts, demonstrating what can be changed to improve processes and patient outcomes, provide an understanding of the costs of litigation versus using dollars for preventive measures to reduce legal liability expense and promoting proactive ,rather than reactive, measures for process improvement. The hope is for improved patient outcomes and often substantial financial considerations

UPCOMING EVENTS



Coffee with the Commission: Practicing as a Washington Physician Assistant

April 7, 2021 - 10:00am to 11:00am

WMC Policy Meeting

April 8, 2021 - 4:00 PM

WMC Business Meeting

April 9, 2021 - 8:00 AM

Coffee with the Commission:
Common Mistakes When Applying for a MD and PA license

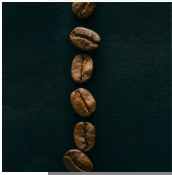
April 14, 2021 - 10:30am to 11:00am

Webinar: Opioid Prescribing 2021 Updates

April 29, 2021 - 4:00 - 5:00 PM

Webinar: Practicing as a Physician Assistant in WA

May 5, 2021 - 12:00 - 1:00 PM



Coffee With the Commission: Legislative Re-Cap

May 12, 2021 - 12:00 PM

WMC Policy Meeting

May 13, 2021 - 4:00 PM

WMC Business Meeting

May 14, 2021 - 8:00 AM

Webinar: Changes to Physician Assistant Practice in WA

June 16, 2021 - 12:00 - 1:00 PM

Event Details can be Found on the WMC Event Calendar

Executive Director Report

Someone Filed a Complaint Against Me – Now What? A Peek Behind the Curtain

Melanie de Leon, JD, MPA

One of the goals of the WMC is to be as transparent as possible regarding our processes and procedures. Over the next few newsletters, I will explain our major processes so that they are no longer a mystery that seem to be hidden away behind a curtain.

Our enforcement process starts when we receive a complaint against a physician (MD) or physician assistant (PA) licensed by the WMC. Complaints can be filed by *anyone*, from *anywhere*, for *any reason*. Most of our complaints are filed through our website but complaints can be mailed, or hand delivered - we take them all.

Complaint Intake staff reviews all complaints and culls out those that regard a person outside of our jurisdiction (these complaints are referred to other boards/ commissions or to facilities for action). Once reviewed, complaints are given a case number and redacted for information that might introduce bias in the reviewing process. Complaint Intake staff do not make any decisions regarding the veracity of the complaint or whether the allegations contained in the complaint should be investigated – those decisions are made by commissioners.

Every week, a panel of at least three commissioners, including one public member, reviews and discusses the complaints processed for that meeting. They decide whether to authorize an investigation or close the complaint without taking any further action.

When a case is closed at this step, both the person who filed the complaint (complainant) and the physician or physician assistant against whom the complaint was filed (respondent) receive a letter notifying them of the closure. At that point, the complainant has the legal right to ask the WMC to reconsider their decision to close the case by providing "new" information with their request. In 2020, we received requests for reconsideration in 3.5% of the complaints closed in this step.

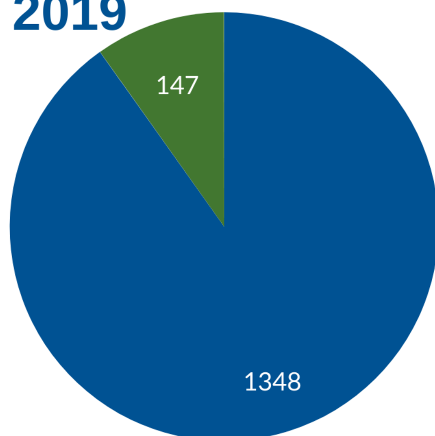
If we receive a request for reconsideration from the complainant, another panel of at least three commissioners reviews the new information and again determines whether to now open an investigation or to keep the complaint closed. In 2020, only two closure decisions were reversed at this step, initiating an investigation. Again, both the complainant and the respondent are notified of this panel's decision. If the panel does not authorize an investigation at this point, the complaint remains closed, and the WMC can take no further action.

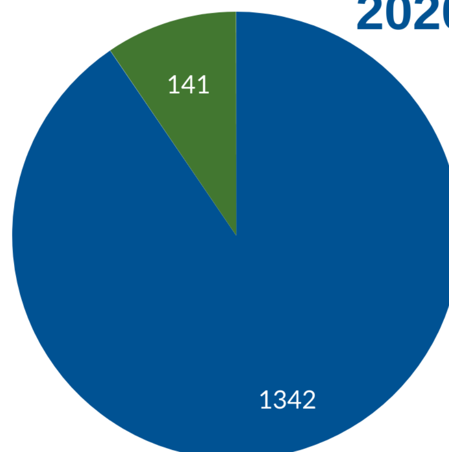
If the panel authorizes an investigation, the complaint is forwarded to Case Management to assign an investigator and begin the investigation phase.

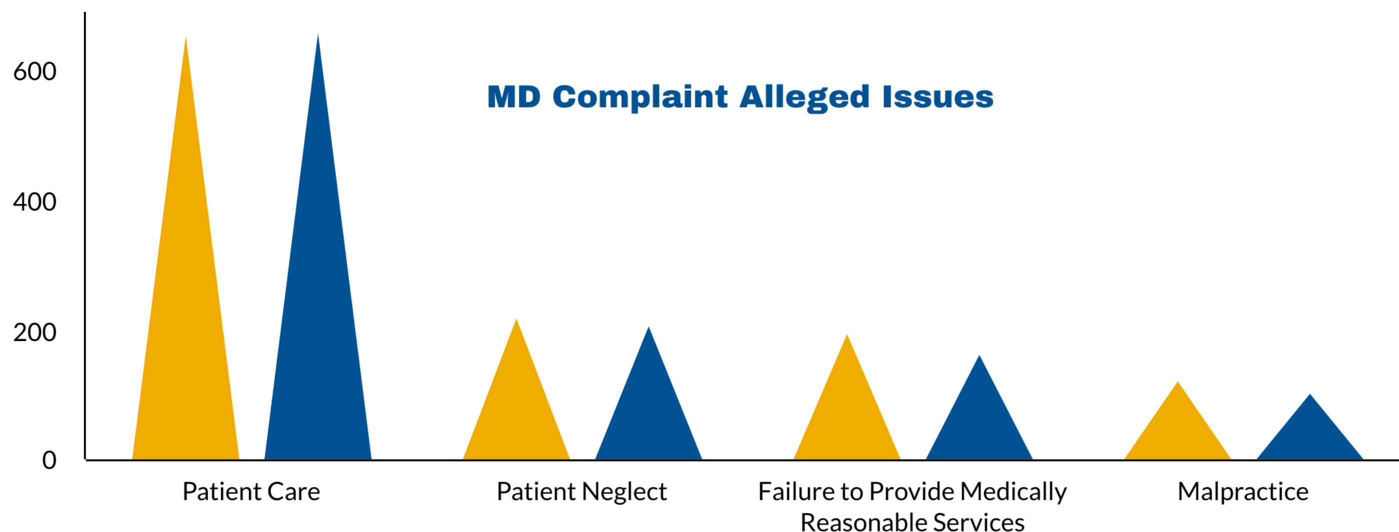
Next quarter's article will explain the investigative process.

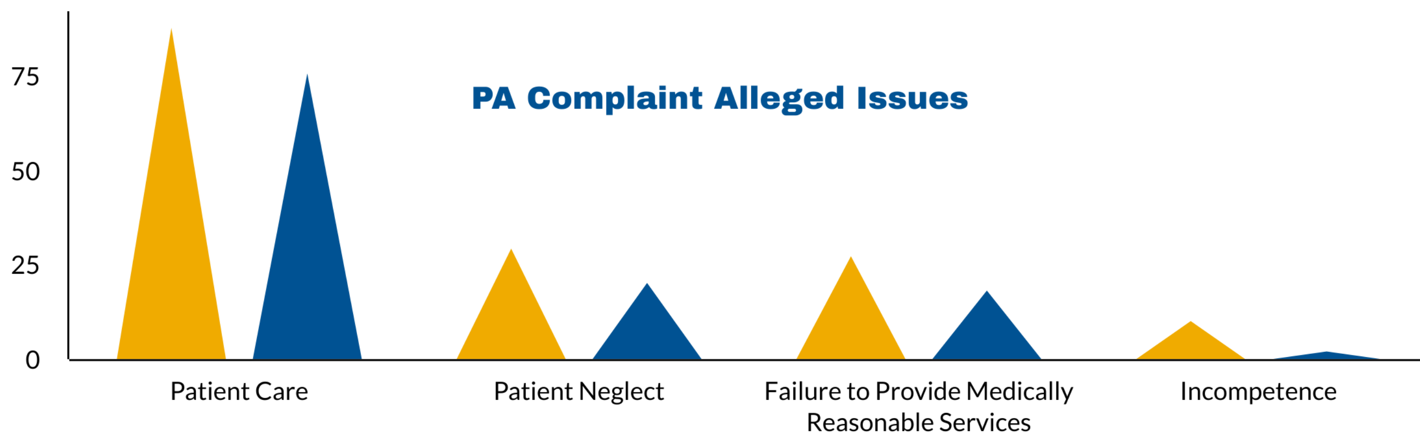
Complaint Report

Number of Complaints Filed









Physician Assistant News

Washington's New Physician Assistant Practice Laws to Take Effect in July

James Anderson, PA-C

In March of 2020, Governor Jay Inslee signed HB 2378, a law that brings numerous improvements to PA practice in the state of Washington.

One of the key improvements will be the termination of the current requirement for the MD-PA agreements to be approved by the Washington Medical Commission (WMC). The effort to pass this law was spearheaded by the Washington Academy of Physician Assistants (WAPA), and had broad support, including from the Washington State Medical Association (WSMA). An indication of strong support for the bill was the final vote tallies from the state House and Senate bodies: The Washington state Senate approved the bill 49-0, and The House of Representatives approved the bill 96-0.

As described by the American Academy of PAs, HB 2378 includes these significant changes:

- Removes requirement that practice agreements be approved by the WMC.
- Removes requirement for WMC approval for an entity to employ or work with a PA.
- Removes WMC approval requirement for PAs to practice in remote sites.
- Increases the MD/PA ratio from 1:5 to 1:10 with the option to request a higher ratio, with the understanding that a MD may not supervise more PAs than they are adequately able to.
- All licensing and regulation of PAs will fall under the allopathic board (WMC) and removes this responsibility from the osteopathic board.

Most provisions of the bill take effect July 1, 2021. As this date approaches, MDs and other medically related agencies have expressed interest in better understanding the details of HB 2378, and what it will mean to their daily practices and interactions with PAs.

The WMC will be conducting the following events to help PAs, MDs, and other participants in the state medical system prepare for the new rules:

Coffee with the Commission: Practicing as a WA PA April 7, 2021 10:00 – 11:00 am

Practicing as a PA in Washington
May 5, 12 – 1:00 PM
Topics Covered:

- Overview of new PA laws and regulation
- Changes in the MD/PA supervision process
- PA ownership of a clinic

Changes to PA Practice in Washington
June 16, 12-1:00
Topics Covered:

- Overview of SB 2378
- Upcoming changes as a result of WMC rulemaking
- What does this mean for your practice?

The goal of these events will be to provide PAs and MDs, related medical agencies, and interested members of the general public and opportunity to learn more about the new rules, in order to properly prepare for the July 1, 2021 kick-off date and subsequent WMC rulemaking changes. Please direct questions about these events to our Director of Quality and Engagement, and check the WMC rule making web page for more information. Rule making hearings and workshops will be announced via our rules GovDelivery.

Local Researchers ATTEND to Physicians Suffering on the Front Lines of COVID-19

Chris Bundy, MD, MPH

Executive Medical Director, Washington Physicians Health Program

President, Federation of State Physician Health Programs

In a recent article in the New York Times, deeply personal stories and emerging data illustrate the accumulating emotional and moral burden of COVID-19 on our health care workforce. These stories underscore concerns about the sustainability of our workforce in the face COVID-19 as well as opportunities to reform the practice environment within this crucible of disruptive change. Unfortunately, aside from anecdotal data and common sense, there is little longitudinal data available to guide interventions to support the workforce both immediately and in the longer term. Experience with combat Veterans tells us that health care workers not only have immediate battlefield needs for protection, rest, and recuperation but are also at risk for delayed, stress- and trauma-related illnesses. Sometimes it is only in the aftermath of battle that the hidden wounds are revealed.

Rebecca Hendrickson, MD, PhD and colleagues at the VA Puget Sound Health Care System and Northwest Mental Illness Research Education and Clinical Center (MIRECC) are using their expertise on the psychological impact of trauma in Veterans, to study the impact of the pandemic on front-line health care workers (HCW) and first responders (FR). To do this, Hendrickson and her team launched the ATTEND Study for Health Care Workers and First Responders, a nationwide observational study back in April of 2020. So far, they have enrolled over 400 participants who receive baseline assessments and follow-up surveys at three, six and nine months. Initial results of the study, available in preprint, confirm a dose-response relationship between COVID-19-related workplace stressors and the development of psychiatric symptoms. The study also points to targets for intervention to reduce the psychological impact of the pandemic on the health care workforce.1 Key insights emerging from their data include:

Systemic demoralization appears to correlate most strongly with the development of depression and post-traumatic stress disorder (PTSD) symptoms. In fact, demoralization was a more potent driver of adverse mental health outcomes than care volume/overwhelm, fears about getting or transmitting COVID-19, or having experienced personal losses from COVID-19, though all had a negative impact on well-being. Inability to provide quality health care for all of one's patients, being asked or expected to take unnecessary personal risks to care for patients, lack of workplace support, providing futile care, and lack of personal protective equipment (PPE) were also listed as demoralizers identified in factor analysis. Demoralization as a key risk factor for the COVID-19 workforce is an important finding because it is also a risk for professional burnout. Strategies that promote autonomy, competence, and interconnectedness (the three pillars of intrinsic motivation) may, therefore, play a dual role in protecting against burnout and pandemic-related psychiatric illness.2

Thoughts of suicide or self-harm are prominent among front line HCWs and FRs with a staggering 19% of FRs and 12% of HCWs reporting thoughts of suicide or self-harm (compared to 3-4% prevalence of such thoughts in the general population). These findings confirm and validate the need for continued momentum in physician suicide prevention efforts and expansion to include other health and human service professionals such as nurses, respiratory therapists, firefighters, paramedics, and police officers. The Dr. Lorna Breen Heroes Foundation, Dr. Lorna Breen Health Care Provider Protection Act, Physician Support Line, Therapy Aid Coalition, Emotional PPE Project, AMA Steps Forward, American Foundation for Suicide Prevention, and National Academy of Medicine are just a few of the initiatives and organizations committed to reducing barriers to help-seeking and mitigating risk of suicide for health care workers. You can find these and other supports on WPHP's Crisis Resource webpage.

PTSD symptoms, especially intrusive and hyperarousal symptoms, may suggest a more sustained or chronic course of psychological dysfunction. Physicians and other HCWs should be alert to these symptoms in themselves, their colleagues, or those they treat. In general, studies suggest that HCWs are most likely to manage COVID-19-related stressors through informal strategies such as peer-support, family and friends, or healthy coping such as exercise, humor, and leisure activities.3 However, recurrent nightmares, intrusive recollections of care-related trauma, insomnia, anger/irritability, feeling keyed-up or on edge with an exaggerated startle response may be clues that more formal treatment is needed.

Psychological distress, especially PTSD symptoms, makes it harder to work and may increase egress from the profession. About one in five HCWs reported difficulty completing usual work tasks or work that was important to them. The same proportion said that COVID-19 work experiences significantly decreased the likelihood that they would continue working in their field.

Dr. Hendrickson's research portrays a sobering picture of the state of the health care workforce one year into the COVID-19 pandemic and points to realistic and attainable goals to help sustain it going forward. And, while the incidence of new COVID-19 infections seems to be attenuated for the moment, we are now faced with the daunting task of rapidly vaccinating an entire nation. The toll COVID-19 has taken on the U.S. health care system will not evaporate with a turn of the calendar page, a new political administration, or the hope of mass vaccinations. It is sadly ironic that the real danger to our health care infrastructure may be in front of us, not behind. I am confident that we cannot tackle tomorrow's problems with yesterday's solutions. However, I am inspired by the work of Dr. Hendrickson, her research team, and others like her, who are doing what they can to build tomorrow's solutions, make a difference, and bring some good to the world.

The ATTEND study continues to enroll study participants. Perhaps we can support this work and each other by helping get the word out.

For more information about the ATTEND study:

- Link to survey
- Link to study Facebook page
- Email: Rebecca.Hendrickson@va.gov

References:

1. Hendrickson RC, Slevin RA, Chang BP, Sano E, McCall C, Raskind MA. The impact of working during the COVID-19 pandemic on health care workers and first responders: mental health, function, and professional retention. *medRxiv*. 2020:2020.12.16.20248325. doi:10.1101/2020.12.16.20248325

2. Hartzband P, Groopman J. Physician Burnout, Interrupted. *New England Journal of Medicine*. 2020;doi:10.1056/NEJMp2003149

3. Muller AE, Hafstad EV, Himmels JPW, et al. The mental health impact of the COVID-19 pandemic on healthcare workers, and interventions to help them: A rapid systematic review. *Psychiatry Res*. Nov 2020;293:113441. doi:10.1016/j.psychres.2020.113441

Licensing Updates

We have recently provided webinars and information sessions regarding our licensing process and updates. You can view the '5 ways to save time when applying for your WA state MD/PA license' and 'You've graduated medical school! Now what?' recordings on our website. On our April 14th Coffee with the Commission, we will be discussing common mistakes when applying for an MD and PA license.

Here is some important information to keep in mind as you navigate your way through the licensing process.

- We are entering our busy season, please have a bit more patience with us as we process our influx of applications.
- We do not require transcripts at the time of application. Please wait for a licensing specialist to contact you before sending us transcripts.
- We have removed many personal data questions from the initial application. We hope this makes your application experience easier to navigate.
- We will no longer be sending paper verifications to domestic programs and entities. Learn how to use the self-serve portal here.
- We send your renewal notice to the contact information we have on file 90 days before expiration. If you have not updated your contact information since your last renewal, now might be a good time to do so. That can be completed on the self-service portal.

Pro Tem Notice of Recruitment

The Washington Medical Commission (Commission) is currently accepting applications from allopathic physicians to serve as pro tempore (Pro Tem) members. Their purpose is to ensure there are enough case reviewers, panel members for hearings, and adequate representation on special committees.

The Commission helps make sure physicians and physician assistants are competent and provide quality medical care. We are looking for people willing to study the issues and make decisions in the best interest of the public. The Commission is seeking the following specialties to serve as Pro Tem members:

- Radiologist
- Psychiatrist
- Ophthalmologist

The Commission meets about eight times a year, usually on Thursday and Friday every six weeks. There is an expectation to review multiple disciplinary cases between meetings, and additional meetings or hearings are often necessary. Additional information regarding commission membership can be found at: https://wmc.wa.gov/medical-commission-membership.

If you are interested in serving on the Commission and would like to learn more about how to apply, please contact Amelia Boyd, Program Manager, by email at amelia.boyd@wmc.wa.gov, or call (360) 236-2727.

Celebrating Anniversaries of UW TelePain and Pain & Opioid Hotline

David Tauben, MD FACP;
Cara Towle, RN MNA;
Christina Bockman, PharmD

UW TelePain and Pain & Opioid Hotline

Happy 10th anniversary of UW TelePain! And soon celebrating the 5th anniversary of UW Pain & Opioid Hotline. Both University of Washington School of Medicine provider-to-provider telehealth programs are designed to support primary care pain management in Washington State.

In 2007 the WA State Agency Medical Directors Group (AMDG) published its first-in-the-nation educational guidance for best-practice opioid prescribing for chronic non-cancer pain. These guidelines highlighted key deficiencies in primary care provider knowledge and competencies regarding opioid prescribing for chronic non-cancer pain as well as a significant shortage of qualified pain specialists. It became clear that a telecommunication technology was needed to facilitate long-distance health-related education in order to provide primary care providers with expert practice management and treatment solutions to reduce over-reliance on the opioid-based management of chronic pain. In anticipation of WA State legislature's opioid prescribing rulemaking (ESHB 2876), UW TelePain began full operations in March 2010.

UW TelePain is a free, CME-accredited, weekly series engaging trainees and community-based primary care providers in urban, suburban, rural and underserved areas with "just-in-time" case-based provider-to-provider multidisciplinary educational consultation. The TelePain consulting panel of specialists share overlapping and unique expertise in pain medicine, family medicine, internal medicine, anesthesiology, rehabilitation medicine, psychiatry, psychology, integrative medicine, and buprenorphine management of pain and opioid use disorders. TelePain attendees contribute their unique experiences and expertise to create a robust and dynamic discussion; as a knowledge network, we learn from each other.

Originally piloted at UW in 2006, UW TelePain was expanded through NIH funding to include rural hospitals and clinics in 2009. It is now funded by the Washington State Health Care Authority supporting a clinician network of community providers serving rural, tribal, suburban, urban, and safety net populations across the region. Since March 2010, technology-enabled, weekly, educational presentations have delivered nearly 25,000 hours of problem-based CME-accredited instruction to over 16,000 attendees extending across 450 unique locations.

UW TelePain "e-Health" Weekly Series

Case-based just-in-time consultation

Multidisciplinary specialists

State-wide community practice sites

Suboxone training and support

Supports Rx guidelines and rules

Continuing Education (medical, nursing, pharmacy & community clinicians)

Core pain and opioid management competencies

48 didactic presentations annually

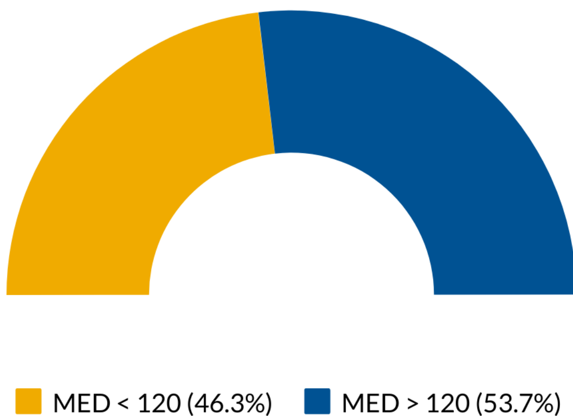
UW TelePain and Pain & Opioid Hotline

UW Pain and Opioid Hotline, a free phoneline consultation service for all healthcare providers in Washington State, was introduced in collaboration with the Health Care Authority in July 2017. This was a response to more than doubling opioid overdose deaths between 2010 and 2015 and pending additional opioid rulemaking by the state legislature (EHSB 1427). "Hotline" calls are answered during the day (excluding weekends and holidays) by a pharmacist with specialized training in pain and opioid management, with pain trained physician oversight available as needed. Urgent calls focus on education surrounding individualized opioid taper plans, recommendations for non-opioid alternatives, triage and risk screening, and clarification of pain management guidelines and/or regulatory requirements regarding opioid medications. Over 400 educational consults have already been provided to primary and specialty care community-based clinicians and pharmacists.

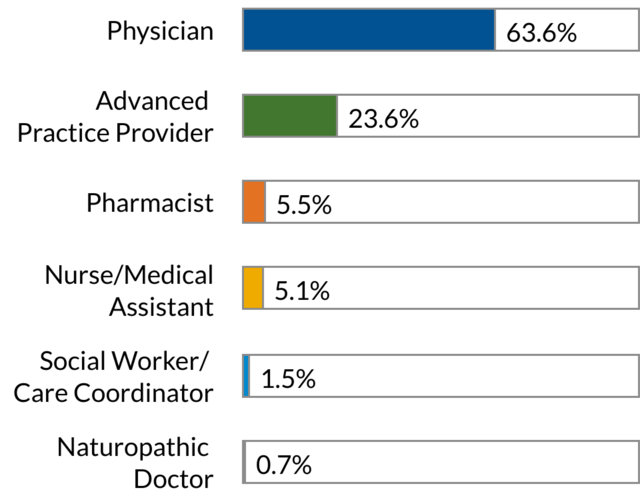
And some breaking news...UW TelePainTracker is a newly introduced web-based patient-reported outcomes tool now available at no cost to community-based providers who have attended UW TelePain. Developed in collaboration between UW Division of Pain Medicine and the UW Clinical Informatics Research Group, PainTracker has been deployed for nearly a decade at the UW Center for Pain Relief with well demonstrated clinical usefulness. Measurement-based care supports a multidimensional clinical diagnosis and directs treatment based on outcomes by providing patient-centered, patient-reported outcome data to support multimodal pain management. Patient reported outcomes assess the impact of treatment, enhances provider-patient communication, and facilitates engagement in case consultation via visual display of multidimensional pain outcomes over time. Contact our UW TelePain team for more information.

TelePain & Opioid Consult Hotline

Hotline Caller's Patients' Opioid Dose



Hotline Callers (types)



Both UW TelePain and UW Pain and Opioid Hotline programs meet Washington Medical Commission expert pain consultation requirements for high-risk patients or when prescribing high-dose opioid for chronic non-cancer pain (in accordance with WAC 246-853-670). Neither constitute establishment of a patient/provider relationship by the UW consultant. UW TelePain also provides easy access low-cost continuing medical education credits necessary for physicians, physician assistants, and advanced practice nurses in order to prescribe opioids for chronic pain (1 hour) or whenever prescribing long-acting opioids (at least four hours.)

Looking forward to seeing you at our next UW TelePain session, held Wednesdays from noon-1:30 pm. You can schedule a TelePain consultation online or contact our UW TelePain team.

Call 1-844-520-PAIN (7246) for same-day help managing your patient's opioid-related concerns.

Rulemaking Efforts

Amelia Boyd
Program Manager

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

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

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

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

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

The WMC will consider rulemaking to address the practice of physicians and physician assistants engaging in telemedicine with Washington patients. Possible subjects the WMC may address are: What, if any requirements for licensure; recordkeeping requirements; establishing a patient-practitioner relationship; prescribing issues; and standard of care. Regulating the use of telemedicine would place the WMC in an active patient safety role.

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

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

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

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

Rulemaking Efforts

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

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

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

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

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

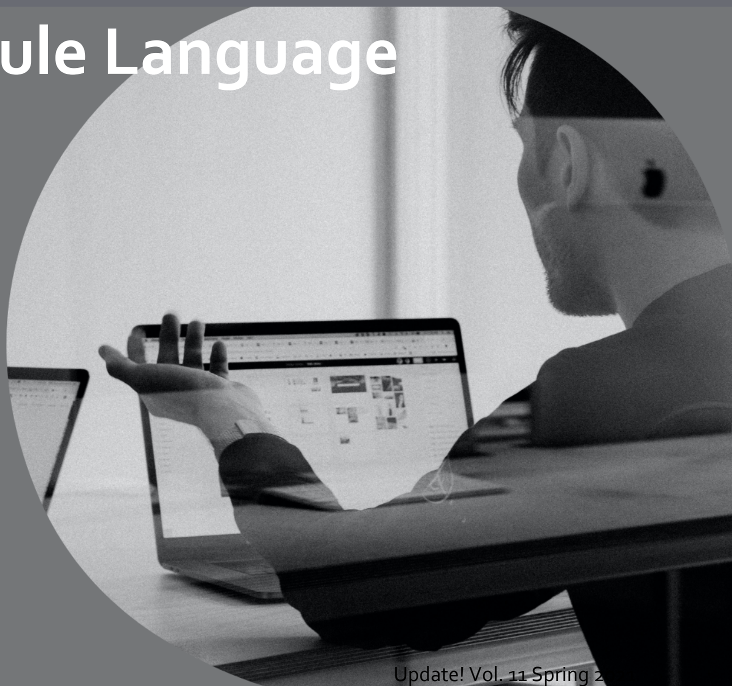
The Pharmacy Quality Assurance Commission has adopted a rule that governs CDTAs from the pharmacy perspective, however there are no statutes or rules that govern a physician's responsibilities under a CDTA. A rule is needed to define the roles and responsibilities of the physician or physician assistant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

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

Senate Bill (SB) 6551 – International Medical Graduates
The CR-101 for creating rules related to integrating International Medical Graduates into Washington's healthcare delivery system was filed with the Office of the Code Reviser on August 6, 2020 as WSR #20-17-024.

Physician Assistant Draft Rule Language Input Requested

On January 13, 2021 the first workshop for rulemaking regarding the physician assistant chapter 246-918 WAC and SHB 2378 was held. The next workshop is tentatively scheduled for Wednesday, April 7, 2021 at 2 pm. We will discuss both the draft and SHB 2378 (the bill analysis can be found here) at the April 7th workshop. You can send your comments to medical.rules@wmc.wa.gov.



Rulemaking Efforts

SB 6551 permits the WMC to issue limited licenses to IMG applicants. 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.

Chapter 246-918 WAC – Physician Assistants and SHB 2378
The CR-101 for revising physician assistant (PA) rules pursuant to Substitute House Bill (SHB) 2378 (Chapter 80, Laws of 2020) and updating PA rules to incorporate current, national standards and best practices was filed with the Office of the Code Reviser on November 19, 2020 as WSR #20-24-015.

The WMC is considering updating the PA chapter to more closely align with current industry standards, modernize regulations to align with current national industry standards and best practices, and provide clearer rules language for licensed PAs.

Included in this rulemaking proposal is incorporating the requirements of SHB 2378 Concerning physician assistants. The WMC is considering adding new sections in accordance with SHB 2378. This bill combines the PA licensing under the WMC effective July 1, 2021 and eliminates the profession of Osteopathic Physician Assistant. The bill instructs the WMC to consult with the Board of Osteopathic Medicine and Surgery (BOMS) when investigating allegations of unprofessional conduct by a licensee under the supervision of an osteopathic physician. The bill also reduces administrative and regulatory burdens on PA practice by moving practice agreements from an agency-level approval process to employment level process. Employers are required to keep agreements on file. The bill requires the WMC to collect and file the agreements. Changes nomenclature from "delegation" to "practice" agreement and from "supervising physician" to "participating physician" agreement.

More Information

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

PREP Act Authorization for Health Care Workers with Expired or Inactive Licenses to Administer COVID-19 Vaccines

The Washington State Department of Health, in partnership with our health profession boards and commissions, is taking action to support retired health care workers or those with inactive licenses to more easily get back into the workforce to administer the COVID-19 vaccine. The goal is to ensure we have a robust workforce to help us bring an end to the COVID-19 pandemic.

Please read the Public Readiness and Emergency Preparedness Act (PREP Act) authorization from Secretary of Health Dr. Umair Shah for health care workers with expired or inactive licenses to administer COVID-19 vaccines under certain circumstances.

Legal Actions

November 1, 2020 – January 31, 2021

Below are summaries of interim and final actions taken by the Washington Medical Commission (WMC) that were reported to the Federation of State Medical Boards between November 1, 2020 and January 31, 2021. Statements of Charges, Notices of Decision on Application (with exceptions), Modifications to Orders (with exceptions), and Termination Orders are not listed. We encourage you to read the legal document for a description of the issues and findings. All legal actions can be found with definitions on the WMC website.

Practitioner Credential and County	Order Type	Date	Cause of Action	Commission Action
Summary Actions				
Aflatooni, Alfred MD00015674 King	Ex Parte Order of Summary Action - Suspension	12/15/20	Alleged prescribing of controlled substances in a dangerous manner, failure to comply with an agreement to cease prescribing opioid therapy treatments, and solicitation of a loan from a patient.	Suspension – pending completion of proceedings.
Barnett, Julia MD60729698 Snohomish	Ex Parte Order of Summary Action - Suspension	11/16/20	Alleged negligent care of inmate patients and failure to adequately supervise medical personnel.	Suspension – pending completion of proceedings.
Green, Roland MD60899657 Out of State	Ex Parte Order of Summary Action - Suspension	12/22/20	Alleged surrender of Respondent's license while under investigation by the New York Board for Professional Medical Conduct.	Suspension – pending completion of proceedings.
Martinez, Jose de Jesus MD00046505 Out of State	Ex Parte Order of Summary Action - Suspension	12/16/20	Alleged suspension, revocation or restriction of Respondent's license by the Texas Medical Board.	Suspension – pending completion of proceedings.
Rose, Mark MD00023797 Out of State	Ex Parte Order of Summary Action - Suspension	12/09/20	Alleged surrender of Respondent's license while under investigation by the Oregon Medical Board.	Suspension – pending completion of proceedings.
Stillner, Verner MD60096393 Pierce	Ex Parte Order of Summary Action - Suspension	12/11/20	Alleged surrender of Respondent's license in lieu of complying with an order by the Alaska State Medical Board.	Suspension – pending completion of proceedings.
Wolin, Jessica MD00037263 Out of State	Ex Parte Order of Summary Action - Suspension	01/28/21	Alleged suspension, revocation or restriction of Respondent's license by the Michigan Department of Licensing and Regulatory Affairs Board of Medicine.	Suspension – pending completion of proceedings.
Interim and Formal Actions				
Bunin, Alan MD00010954 King	Final Order - Default	01/21/21	Negligent diagnosis of a patient's cognition and failure to obtain essential patient records.	Indefinite suspension.

Fineman, Jessica MD00042972 Out of State	Modified Agreed Order	01/15/21	Reinstatement of license after successful completion of prerequisites, and agreement to new practice conditions.	Restriction from the solo practice of medicine, establish and maintain appropriate boundaries with patients, attend and comply with psychotherapy recommendations, quarterly psychotherapy reports, mentor consults, practice reviews, personal appearances, and termination no sooner than two years.
Hermann, Robert MD60620822 Out of State	Agreed Order	12/02/20	Failure to comply with a Commission order.	Indefinite suspension and prerequisites to a petition for reinstatement.
Pascale, Michael MD00031098 King	Agreed Order	01/15/21	Diversion of controlled substances for personal use and falsification of medical records.	Health program monitoring, personal appearances, $1,000 fine, and termination no sooner than discharge by the health monitoring program.
Roodneshin, Hamid MD60462296 King	Final Order - Default	01/07/21	Failure to cooperate with a Commission investigation.	Indefinite suspension.
Said, Mohammad MD00018311 Grant	Final Order	01/28/21	Respondent is unable to practice with reasonable skill and safety due to a health condition.	Indefinite suspension and prerequisites to a petition for reinstatement.
Wenberg, Kenneth MD00025365 Out of State	Final Order - Default	01/07/21	Conviction of a federal felony for tax evasion.	Indefinite suspension.
Informal Actions				
Andersen, Teresa MD00039456 Kitsap	Informal Disposition	01/14/21	Alleged failure to diagnose diabetes resulting in delayed treatment.	Pediatric metabolic emergencies and diagnostic coursework, written research paper, personal appearances, $1,000 cost recovery, and termination no sooner than one year.
Elskens, Daniel MD60614358 Out of State	Informal Disposition	01/22/21	Alleged wrong level spine surgery.	Best practices to avoid wrong site surgery coursework, written research paper, personal appearances, $1,000 cost recovery, and termination no sooner than two years.
Grant, Brenda MD00049240 Grays Harbor	Informal Disposition	01/14/21	Alleged failure to provide opioid medication to a patient during transition to another provider.	Patient abandonment coursework, written research papers, personal appearances, $1,000 cost recovery, and termination no sooner than 18 months.
Gray, Gregory MD60569819 Out of State	Informal Disposition	01/15/21	Disciplinary action by the Medical Board of California alleging negligent prescribing practices.	Probation, compliance with California Board order, personal appearances, practice restriction from supervising mid-level providers in WA, notification of actions to places of employment, provide copies of all documents submitted to the California Board, $1,000 cost recovery, and termination no sooner than termination by the California Board.

Green, Candace MD00044357 Benton	Modified Informal Disposition	01/15/21	Alleged ongoing negligent prescribing of controlled substances.	Restriction on prescribing controlled substances and conditions for future modification, follow recommendations of a clinical competency assessment, and personal appearances.
Imam, Naiyer MD00044683 Out of State	Informal Disposition	01/15/21	Alleged misinterpretation of a patient's abdominal x-ray.	Gastrointestinal radiology coursework, written research paper, personal appearances, $1,000 cost recovery, and termination no sooner than one year.
Lonac, Jennifer PA60061940 King	Informal Disposition	01/15/21	Alleged negligent chronic pain management.	Pain management coursework, medical ethics coursework, written research paper, review of prescribing guidelines, peer group presentation, utilization of PMP, personal appearances, $1,000 cost recovery, and termination no sooner than two years.
Olson, Alicia MD60889676 King	Informal Disposition	01/14/21	Disciplinary action by the Michigan Board of Medicine alleging fraudulent prescribing practices.	Ethics coursework, compliance with health monitoring program, personal appearances, and termination no sooner than discharge by the health monitoring program.
Regimbal, Joseph MD00020157 Pierce	Informal Disposition	01/14/21	Alleged negligent controlled substance prescribing.	Pain management coursework, medical ethics coursework, written research paper, utilization of PMP, practice reviews, personal appearances, $2,000 cost recovery, and termination no sooner than two years.
Reinmuth, Scott MD00038321 Yakima	Informal Disposition	01/14/21	Alleged negligent controlled substance prescribing.	Voluntary surrender.
Urriola, Alina MD00036026 King	Informal Disposition	01/14/21	Alleged failure to adequately supervise mid-level staff.	Prescribing and ethics coursework, written research paper, utilization of PMP, personal appearances, $1,000 cost recovery, and termination no sooner than two years.
Verma, Vishal MD60299803 Out of State	Informal Disposition	01/15/21	Alleged misrepresentation in obtaining a license from the Maryland State Board of Physicians and violation of Maryland telemedicine regulations.	Ethics coursework, written research paper, personal appearances, $1,000 cost recovery, and termination no sooner than completion of all requirements.
Winde, James MD60020421 Island	Informal Disposition	01/15/21	Alleged failure to properly diagnose vision condition and refer to a specialist.	Eye disease, recordkeeping, and communications coursework, written research paper, personal reports, personal appearances, $1,000 cost recovery, and termination no sooner than four years.

Tapering Long-Term Opioids Can Be Both Patient-Centered and Evidence-Based

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Tapering Long-Term Opioids

In 2018 Washington State dispensed 49.3 opioid prescriptions per 100 residents (for comparison, Texas 47.2, California 35.1).[2] Many of these opioid prescriptions were for chronic non-cancer pain (CNCP) despite limited evidence of benefit and abundant evidence of harm. 1 Pain management is challenging, and it is easy to prescribe opioids for a suffering patient from a desire to help. However, we must be certain when we prescribe opioids that they are part of the solution instead of part of the problem, and at the very least that we are prescribing the "lowest effective dose" referred to in the Bree (AMDG 2015 guidelines), CDC (2016 guidelines) opioid prescribing guidelines and in Washington State law (WAC). This may entail tapering of opioid prescriptions in some patients to lower, safer and perhaps more effective doses, or changing to buprenorphine. Recently, a number of evidence-based guidelines have been published to help prescribers with the difficult task of tapering opioid medications in CNCP (Bree, HHS and National Academy of Medicine).

How do we help people like a 54 year-old man on long-term opioids for chronic back pain that continues to have widespread pain and is too disabled to even vacuum his house? My clinic has had early success in actively addressing our CNCP opioid panel. This patient is now having minimal pain and more functional than he's been in over a decade on buprenorphine.

During October 2019, Neighborcare Health prescribed long term opioids to 673 patients, mostly for CNCP. Common issues for all our CNCP opioid patients were variations in evaluating and managing CNCP, as well as knowledge gaps on how to have an effective opioid risk/benefit discussion.

Our Approach

We piloted changes at my clinic with 45 CNCP opioid patients. By simply listing to them, taught us a lot. The most common indications for opioids were back pain/osteoarthritis (47%) or fibromyalgia (18%). Morphine equivalent daily doses (MEDD) were 5-300mg (mean 45mg) and age 33-80 years (mean 62).

We came to consensus as a group about when to continue opioids for CNCP and when to taper, by specifically agreeing on a set of principles for when risks were likely to outweigh benefits (Figure 1). The process occurred through a series of meetings, e-mails and evidence review.[3,4] We agreed everyone would use the PEG scale (Pain, Enjoyment of life, General Activity) for better longitudinal assessment of pain (Figure 2) and adopted the Bree Collaborative's 2020 Long Term Opioid Therapy Report for our standard of care.[5] By establishing clinic consensus, we were able to provide more consistent care for our patients.

Over a period of three months, we scheduled a 30-minute visit with every CNCP patient to do a full opioid re-evaluation and risk/benefit discussion. My initial conversations broaching the subject and counseling when an opioid taper was indicated lasted 30-45 minutes, and over half ended in a positive patient experience and optimism for some improvement. I found most patients had never been counseled on non-overdose risks of opioids, hyperalgesia, or withdrawal.

I use Stanford's BRAVO method to initiate these challenging CNCP opioid discussions.[6-8] Broach the subject (B) of a taper with extra time and up-front acknowledgment of the fear, anxiety and strong negative reactions this discussion brings. Have a risk/benefit conversation (R) about the patient's use of opioids, highlighting what we now know from decades of study that is different from when they first started. Acknowledge addiction happens (A) to some people exposed to opioids, even for those with legitimate pain conditions. This helps prevent stigma and allows providers to be optimistic about treatment because opioid use disorder (OUD) will become apparent in many patients while tapering. (V) is for Validating how difficult tapering can be, and for pointing out that velocity matters, as some patients on long-term opioid therapy may take months and even years to taper off opioids. For example, 40mg/day oxycodone taken by a patient with opioid dependence and chronic pain might be reduced by 5mg a day per month, with a goal of being off opioids in 12-18 months. (O) stands for other skills to manage pain providers can teach within a 15-minute visit. Discussing concerns about CNCP opioids is a dreaded conversation that is easy to avoid. I don't feel this way anymore. The BRAVO method has been a practice-changer.

35 patients (78%) were recommended to taper off opioids due to poor benefit and excessive risk. Continued uncontrolled pain and low functioning are reflected as high PEG scores. Opioid tolerance and withdrawal between doses of short-acting opioids like oxycodone, or the phenomenon of opioid-induced hyperalgesia are possible explanations for persistent pain on long-term opioids. Patients often interpret myalgias, fatigue, dysphoria or insomnia as their underlying pain condition and the opioid helping it. However, improvement with opioid dosing is more likely relieving opioid withdrawal. Though only four (9%) met DSM-5 criteria for opioid use disorder (OUD), most of their lives were adversely impacted by opioids to a similar degree.

We use this clinical algorithm to make taper decisions (Figure 3), developed from published examples of modern pain care.[8-10] If CNCP is poorly controlled or risks are high, a slow medically supervised taper off opioids or rotation to buprenorphine is performed.[1] We rarely initiate a change during this initial visit, but do so during

a 30-minute visit the following month - to allow the patient time to review materials and process the change in their care plan. If a slow and carefully monitored taper is not tolerated, or they have OUD, we transition to buprenorphine.[11]

Further, I find patients focus their risk concerns on overdose death risk - "I've been taking these for 15 years and I haven't died yet." But linking their often-disparate symptoms to known effects of opioids creates understanding.[8] Brain fog, fatigue, sexual problems? Opioids can do that. "You've got such terrible pain you can't even get restful sleep. That must be exhausting. Based on what we now know about how opioids change the brain over time, I worry that what feels like pain relief is probably treating withdrawal from your last dose, rather than your underlying pain condition. To get out of this vicious cycle, we need to get you off opioids or on a longer acting medicine like buprenorphine, which has several potential benefits over what you're taking now."

Buprenorphine for Pain

Buprenorphine is best known for treating OUD but was first FDA approved as a potent opioid analgesic in 1981.[11] Most under appreciate how strong buprenorphine is. A Yale case series of CNCP patients without OUD on 105-390 MEDD stabilized them on 6-12mg/day of buprenorphine. [12] It has a long half-life - giving after repeated dosing more stable analgesia without withdrawal and perhaps fewer cognitive effects. Compared to traditional opioids, buprenorphine has a lower ceiling for its effects (a partial agonist), explaining how it has fewer undesirable effects like respiratory depression, euphoria, sedation, hyperalgesia, constipation, depression and risk of overdose.[11,13] However, buprenorphine is still an opioid and should probably still not be routinely given to opioid naïve patients with CNCP. Rather, it's a harm reduction strategy. Pain patients often need lower amounts (4-12mg/day in divided doses) compared to OUD patients, where 16-24mg daily doses are typical.

In our practice, most patients are doing well with a slow taper. We transitioned eight patients without OUD to buprenorphine. Six were happier with equal or better pain control and fewer side effects, like the case patient at the start. One chose to discontinue opioids completely and one could not finish the induction, due to symptoms. To increase successful inductions to buprenorphine, I recommend a technique called microdosing.

Despite the advantages, buprenorphine can be difficult to start as an outpatient because many regimens require a period of withdrawal. Microdosing involves beginning buprenorphine with tiny doses and increasing these doses slowly to avoid causing withdrawal (Figure 4). Because of its higher affinity for the opioid receptor, buprenorphine will gradually displace other opioids subclinically if started at a low enough dose. For example, starting at 0.5mg twice daily (1/4 tab or film) with slowly increasing increments over a week is one common approach.[12]

Patch-based regimens may be easier because it is more automatic. Transdermal buprenorphine's reliable delivery of low doses has been used in multiple case studies to bridge to sublingual buprenorphine. [14,15] For example, the use of the patch for five to seven days while tapering regular opioids over three to four days can be an effective start, followed by the introduction of sublingual buprenorphine on day three at 1mg BID. Then increasing the sublingual dose without the patch. Barriers for buprenorphine patches are the expense/poor insurance coverage, packaging (packs of four), and needing a pain diagnosis (not indicated for only OUD).

Document the indication for buprenorphine, because the FDA approved indications vary by route of administration. Buccal is approved for pain and available in small doses but has poor insurance coverage. Sublingual is not FDA approved for pain but is frequently used off-label. It is co-formulated with naloxone for OUD and broadly covered by insurance as 2/0.5 or 8/2mg tablets or films. If prescribing for pain, no DEA waiver is needed, but a waiver is required if OUD is diagnosed.

Putting it into Practice

These approaches to assessment and treatment greatly improved my group's confidence in managing CNCP. The clinical algorithm described above helped us apply the evidence to our practice using easy assessment tools like PEG.[1] BRAVO's structured approach to initiating difficult discussions about tapering off opioids for CNCP helped us start having these discussions. Knowledge about buprenorphine and the microdosing technique provided practical alternatives to a slow opioid taper, or when OUD became apparent.

Start the conversation: "I scheduled some extra time today to talk about a difficult subject. I've been thinking a lot about your pain and how best to help you with it. Your pain is still severe, and you're not very functional. Based on what we now know about opioids and pain, I worry it's causing you more harm than good now. This is a scary thing to talk about, but we can figure this out. And know I'll be with you every step of the way."

Figure 1. Our Approach: Situations Where Risks of Opioids May Outweigh Benefits for Pain
Pain remains significant
PEG scores >15/30 consistently
Low functioning
Persistent depression or anxiety
Presence drugs/conditions that increase risk overdose (ex sedatives)
Central/Visceral Pain syndrome that opioids typically worsen (ex fibromyalgia)

Figure 2. PEG Scale Assessing Pain Intensity and Interference (Pain, Enjoyment, General Activity

1. What number best describes your pain on average in the past week?

0 1 2 3 4 5 6 7 8 9 10

No Pain — Pain as bad as you can imagine

2. What number best describes how, during the past week, pain has interfered with your enjoyment of life?

0 1 2 3 4 5 6 7 8 9 10

Does not interfere — Completely interferes

3. What number best describes how, during the past week, pain has interfered with your general activity?

0 1 2 3 4 5 6 7 8 9 10

Does not interfere — Completely interferes

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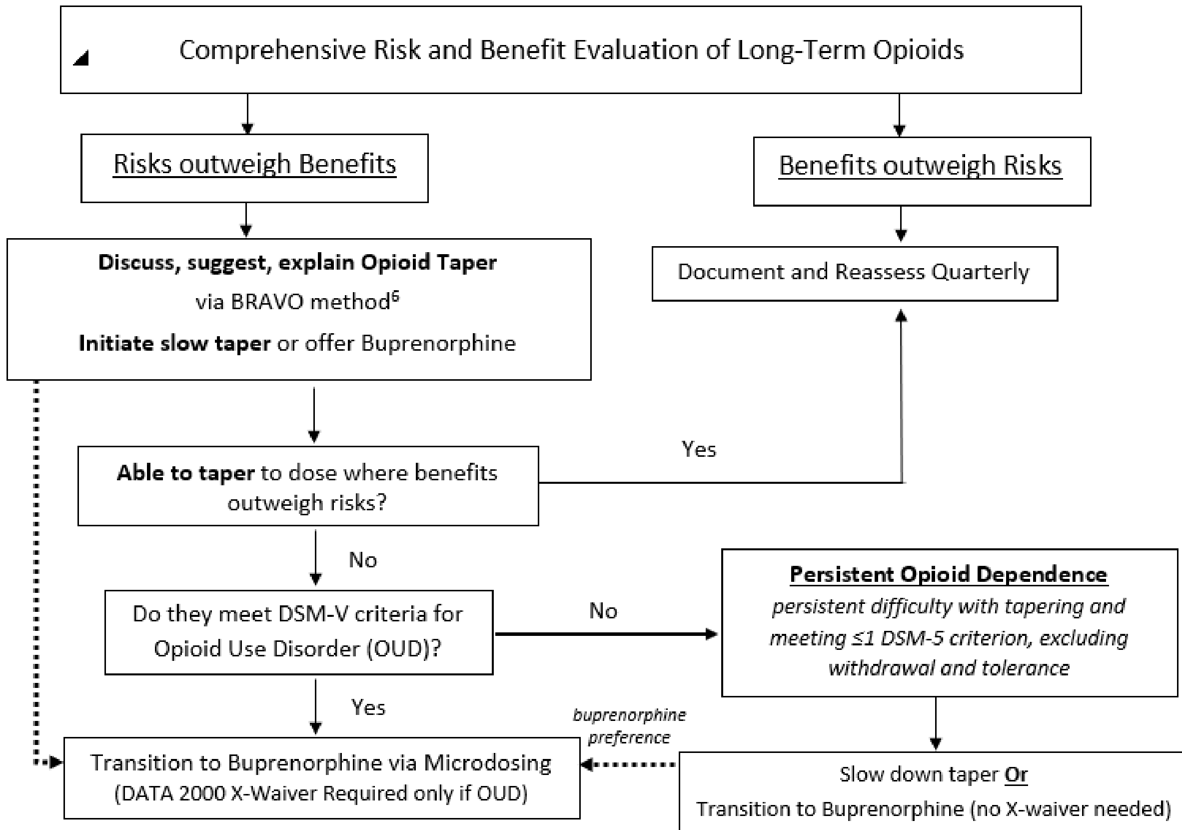
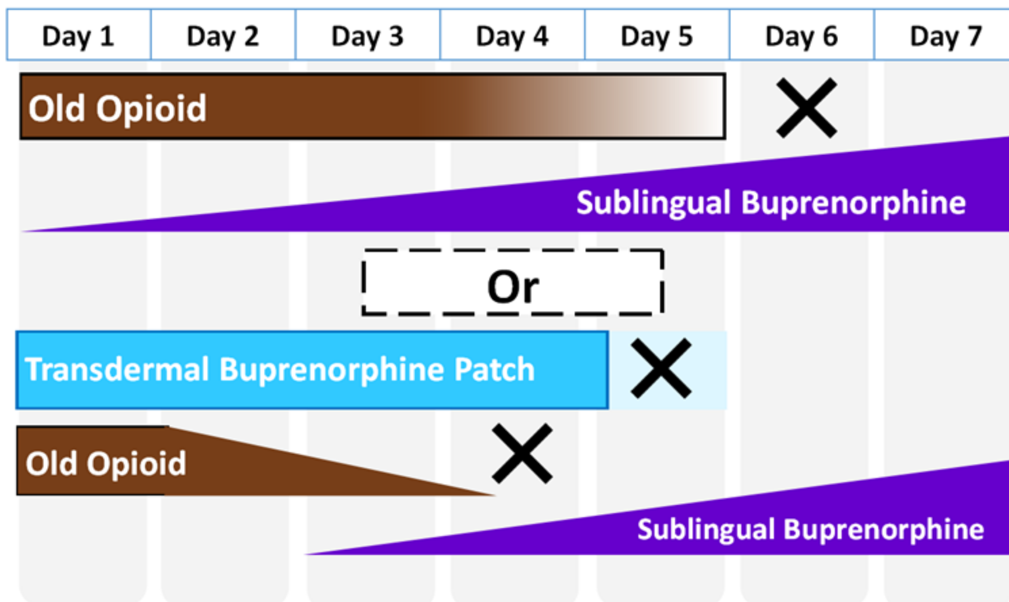


Figure 4. Buprenorphine Microdosing Overview using Sublingual or Patch Method



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COVID-19 Vaccine Ordering and Administration for Dentists

The ordering and administration of the coronavirus disease 2019 (COVID-19) vaccination can be within the scope of practice of a dentist licensed under chapter 18.32 RCW when the treating dentist has appropriate, verifiable training and experience that includes a hands-on component. You can read the full interpretive statement here.

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