Washington State Medical Commission

The Medical Quality Assurance Commission promotes patient safety and enhances the integrity of the profession through licensing, discipline, rule making, and education.

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Warren B. Howe, MD, Bellingham	Family Medicine	Congressional District 2
Leslie M. Burger, MD, Vancouver	Internal Medicine	Congressional District 3
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Bruce G. Hopkins, MD, Spokane	Obstetrics/Gynecology	Congressional District 5
Mimi Pattison, MD, University Place	Hospice and Palliative Care	Congressional District 6
Ronald Schneeweiss, MBChB, Seattle	Family Medicine	Congressional District 7
William Gotthold, MD, Wenatchee	Emergency Medicine	Congressional District 8
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Executive Summary

In Chapter 137, Laws of 2008 (4SHB 1103), the Legislature created a pilot project to evaluate whether granting the Medical Quality Assurance Commission greater authority over its staffing and budget would result in more timely, consistent and effective regulation of allopathic physicians (MDs) and physician assistants (PAs). The data presented in this report shows the increased autonomy resulted in more effective regulation of the complex, highly specialized work of allopathic physicians and physician assistants.

The Medical Commission embraced the Legislative change and created a new organizational model, reforming the Commission's structure and streamlining its work. The Executive Director is now appointed by, and is directly accountable to, the Commission. Under this model, the Commission's staff works as a co-located team, collaborating and supporting each other's work on licensure, investigations, discipline, compliance, education, outreach, and data analysis. The Commission developed expertise by focusing exclusively on matters related to MDs and PAs and by addressing prominent issues such as chronic noncancer pain management, office-based surgery and medical marijuana.

In the new model, investigators, attorneys and Commission members work as a team on complaints from the public, medical professionals, hospitals, insurers, and other regulatory and law enforcement authorities. The investigators, predominantly clinically trained nurses or PAs, use their professional training to evaluate medical records and conduct interviews on the complex issues brought to the Commission. Staff attorneys work closely with investigators and Commission members. The team of investigator, staff attorney and Commissioner collaborate to craft resolutions to protect the public that are medically and legally sound. This team approach eliminates the inefficiencies of "hand offs" and creates ownership for each case, further motivating staff and Commissioners to arrive at appropriate resolutions. The team model is responsive and able to keep pace with the rapidly evolving medical profession. The Medical Commission's new model contributed to national recognition, enhanced patient safety, superior performance and increased transparency.

The Medical Commission received national recognition for its work:

- The Administrators in Medicine Best of Boards Award 2012 for Pain Rules Education;
- Improved from 44th to 9th in Public Citizen's ranking of state medical boards.

The Medical Commission enhanced patient safety:

- Established rules governing the prescribing of opioids for chronic, noncancer pain;
- Developed a rule to protect the increasing number of patients undergoing office-based surgery;
- Created communication networks with stakeholder organizations to reduce medical errors.

The Medical Commission increased transparency:

- Crafted more clear, consistent, and transparent disciplinary orders;
- Increased awareness and deterrence by distributing disciplinary actions through a listserv and the Commission newsletter;
- Designated time for public input at Commission business meetings.

The Medical Commission improved performance in its licensing and disciplinary processes:

- 99 percent of licenses issued were within timelines, to more expediently and effectively meet the demand for qualified health care providers;
- 99 percent of complaints reviewed by the Commission were within timelines, guaranteeing rapid response to patient complaints and potential consumer safety issues;
- 92 percent of opened complaints were investigated within timelines in the last fiscal year;
- Investigation backlog eliminated;
- 92 percent of legal cases acted on within timelines in the last fiscal year;
- 99 percent of disciplinary orders complied with sanction rules, resulting in consistent discipline.

These accomplishments validate the Medical Commission's new model and the pilot project. The result is a safer patient, a respected profession, and a modern medical board.

The Medical Commission suggests the Governor and Washington State Legislature make permanent the provisions of 4SHB 1103 with the enhancements detailed in Section Five: Conclusions. The Commission extends its sincere appreciation to the Governor and the Washington State Legislature for their trust, and to the Department of Health for its cooperation during this pilot project.

Section One: Accomplishments

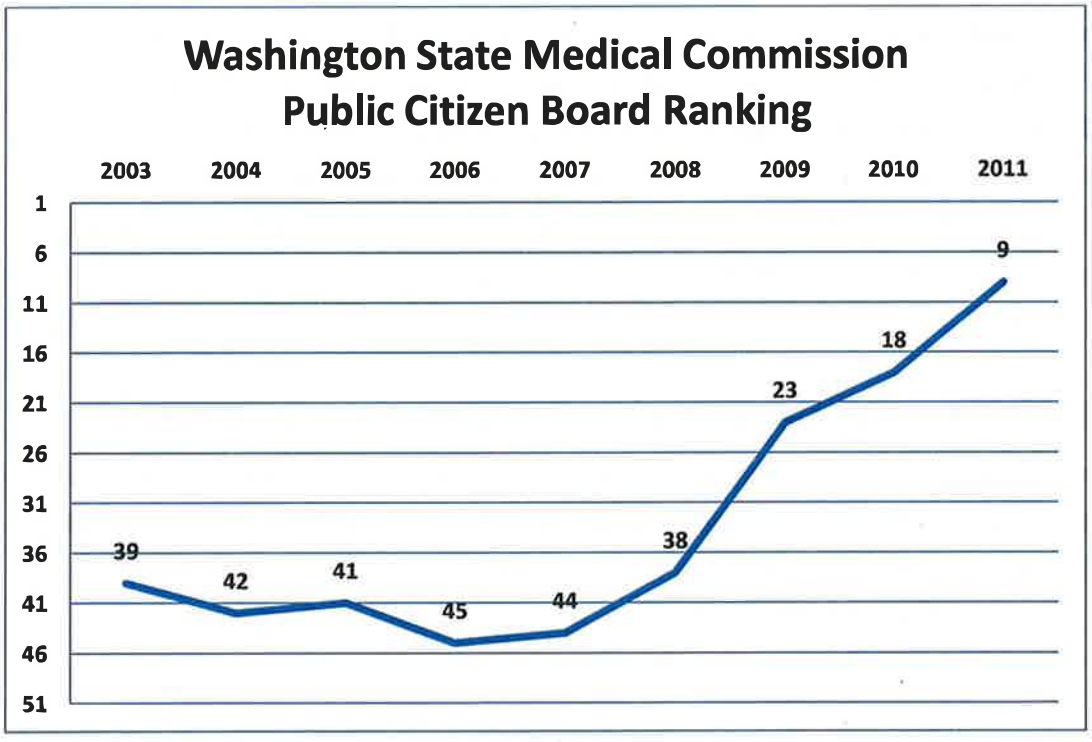
The Medical Commission Received National Recognition.

Administrators in Medicine Best of Boards Award

The Commission received the "Best of Boards Award" from the Administrators in Medicine (AIM) in 2012 for its education program during the implementation of the Pain Management Rules. The Commission designed a comprehensive program to educate the medical profession and the public on the requirements of the new rules and to assist practitioners in providing better pain care to patients. The Commission is humbled to be the recipient of this highest, national honor from its peers.

Improved Public Citizen Medical Board Ranking

Each spring, Public Citizen, a national consumer advocacy organization founded by Ralph Nader, ranks state medical boards. The Commission improved its ranking from 44th to 9th during the pilot. Public Citizen recognized the Medical Commission as one of the most improved states in its 2012 report.[i]



Public Citizen bases its annual board ranking on the number of serious disciplinary actions per 1,000 licensees over a three-year period.

In the report, Public Citizen recommends that medical boards will do a better job disciplining physicians if the medical boards:

- Receive adequate funding (all money from license fees going to fund board activities instead of going into the state treasury for general purposes);
- Have adequate staffing;
- Engage in proactive investigations, rather than only reacting to complaints;
- Use all available/reliable data from other sources such as Medicare and Medicaid sanctions, hospital sanctions and malpractice payouts;
- Have excellent leadership;
- Are independent from state medical societies;
- Are independent from other parts of the state government.

Commissioners and Staff Honors, Awards, Appointments

Individual members of the Commission and staff are highly engaged in national organizations to improve medical regulation and patient safety on a national level. Honors, national awards, numerous appointments, and recognition evidence this engagement. The Federation of State Medical Boards recognized past Commission Chair Samuel Selinger, MD, with the John H. Clark Leadership Award in 2011. Mimi Pattison, MD, the current Chair of the Commission, was awarded the 2010 Sojourn award from the Regence Foundation, Regence Health Plan. This award came with a $50,000 grant, which Dr. Pattison donated to support a program for people with mental illness who need palliative medicine and end-of-life care with the Franciscan Hospice and Palliative Care organization. Full details on other honors, awards and appointments are listed in the appendix. (*See Appendix A*)

The Medical Commission Met and Exceeded its Performance Goals.

The Commission streamlined processes to grant licenses faster, responded more quickly to complaints about patient safety, and performed consistently across all performance measures. For complete details please see Section Three of the report.

The Medical Commission Enhanced Patient Safety.

The Commission proactively addressed prominent patient safety issues by setting standards in three growing, high-risk areas of medicine, by creating patient-safety focused policies, and by working with the medical profession to reduce medical errors. The authority granted during the Pilot Project allowed the Commission to efficiently utilize staff to contribute to these significant improvements in patient safety.

Management of Chronic Noncancer Pain Rules

This state and the nation faced what the Centers for Disease Control deemed an "epidemic" of prescription opioid overdoses that were killing more Americans everyday than overdoses from heroin and cocaine combined. Recognizing the critical and emergent nature of this issue, the legislature passed Engrossed Substitute House Bill 2876 (ESHB 2876), which required the boards and commissions regulating controlled substance prescribers to create rules that require consultation with a pain specialist at a threshold dose. With the mandate created by this crisis and the direction the legislature provided, the Commission led the workgroup that was assembled to create rules designed to stem the tide of tragic prescription opioid deaths.

The Medical Commission members participating in the workgroup were key in developing rules that were ultimately adopted, in nearly identical form, by all five of the boards involved. The rules spearheaded by the Commission do require consultation with a pain specialist when opioid doses reach dangerous levels. However, the rules go much further by creating a mandated framework that directs physicians in providing safe pain care when opioids are used, from initial visit to discharge. In adopting these rules, the Commission became the first state medical board in the nation to have rules that establish minimum practice standards regarding chronic pain care for individual physicians. It is anticipated that these rules, assisted greatly by the deployment of a prescription monitoring program, will save lives that may have been lost due to the proliferation of prescription opioids. Since the statute (ESHB 2876) was passed, the state has seen a 35 percent decrease in the number of opioid-related deaths.[ii]

The Commission delayed the effective date of these rules in order to develop and implement a robust educational program. The educational program was designed to not only educate physicians about the requirements of the pain rules, but by reaching out to them and addressing their questions and concerns, the Commission sought to secure their compliance and calm fears that might lead them to discharge or refuse chronic pain patients. The very extensive and personal outreach of this educational program has proven very successful, as measured by the lack of cases alleging non-compliance, the number of participants in the live presentations and in the on-line CME, and countless anecdotes from individual providers who have appreciated this effort. The Commission earned a national award for the

pain rules educational program. In April 2012, the Administrators in Medicine (AIM) awarded its "Best of Boards Award," AIM's highest honor, to the Medical Commission for this work. The following are highlights of the Commission's pain rules education program:

- Giving dozens of on-site presentations to more than 3,400 providers statewide;
- Developing a free, four-hour on-line Continuing Medical Education (CME) with the Agency Medical Directors Group;
- Developing a web based opioid dosage calculator for use on smart phones and tablets
- Developing an interpretative statement explaining the intent of the rules, clarifying misconceptions, providing guidance to the profession, and promoting access to care;
- Creating a pain management information brochure for patients;
- Sending a letter to all licensees providing information on the pain rules;
- Setting up a dedicated e-mail address for licensees and members of the public to submit questions and receive individualized responses directly from the Commission;
- Designating a staff attorney as a subject champion for a personalized, single point of contact;
- Developing a comprehensive web page devoted to the pain rules with a section for frequently asked questions and resources for patients, providers, and legal entities.[iii]

The Commission has received numerous testimonials and comments from practicing physicians and physician assistants thanking the Commission for the framework and guidelines established by the pain rules. These rules and their associated education efforts have resulted in a paradigm shift in Washington regarding the treatment of pain and triggering a broader national conversation about appropriate opioid usage. This is an area of practice that will undergo further evolution in the coming years and the Washington State Medical Commission will be engaged in this process.

Office-Based Surgery Rule

The Commission created a rule governing office-based surgery, establishing standards in a growing and potentially dangerous area of medicine. The Commission now requires physicians to have their offices accredited by a national accrediting entity. Recent publicized deaths in office-based practices occurred in offices with no accreditation. The Commission requires physicians to ensure that someone certified in advanced resuscitative techniques is present, that the physician can rescue a patient who goes into a deeper level of sedation than intended, that a provider other than the surgeon monitor the patient, and that the physician can transfer the patient to the hospital in an emergency.[iv] The Commission's regulations are a major step forward in enhancing patient safety in our state. The Georgia Composite Board of Medicine used the Commission's rule as a model for its own rule.[v]

Non-Surgical Medical Cosmetic Procedures Rules (Medi-Spas)

The Commission established rules addressing the fast-growing medical spa industry, ensuring there is adequate supervision over cosmetic procedures and that appropriately licensed and trained providers are performing these procedures. This rule ensures that in this highly profitable industry, the safety of the patient-- not profit-- is paramount.[vi]

Policies and Guidelines to Reduce Medical Errors

The Commission developed two policies to work with the medical profession to reduce medical errors. First, the Commission adopted a guideline on wrong-site surgery to require physicians who perform wrong-site, wrong-procedure, or wrong-patient surgery to make a presentation to their peers, explaining how the error was made and how to prevent the error from re-occurring.[vii] Second, the Commission adopted a policy designed to prevent medical errors by providing summaries of actual Commission cases involving systemic medical errors, with key learning components, to the Washington State Hospital Association (WSHA). This communication of systemic problems and possible resolutions to the WSHA makes this information available to all 97 Washington State hospitals to reduce medical errors system-wide.[viii] These two policies reflect the conclusion of the Commission that peer-to-peer education is the most effective method to reduce medical errors.

The Commission also adopted practice guidelines on the Transmission of Time Critical Medical Information (TCMI). TCMI typically involves lab values, diagnostic tests, or pathology results that need to be communicated to a physician so that the health of the patient is not adversely affected. The guidelines communicate the importance of physicians collaborating to establish procedures for transmitting TCMI to assure timely care and patient safety.[ix]

Finally, the Commission adopted a policy on Physicians Exhibiting Disruptive Behavior, i.e., behavior that negatively affects patient care and interferes with the ability to work as part of a care team. In this policy, the Commission requests that organizations address this threat to patient safety by engaging in early intervention of the disruptive physician to prevent patient harm. The Commission warns that it considers this behavior a threat to patient safety and will take disciplinary action, including suspension, if warranted.[x]

Commission Disciplinary Cases Communicate Standards and Influence Institutions

The Medical Commission views its disciplinary function as more than just imposing sanctions on a single physician. Through discipline, the Commission communicates standards and expectations to the individual disciplined and to the entire profession. Individual physicians and institutions most often respond to disciplinary action with improved practices. What follows are two recent examples where Commission action led to known institutional or industry improvement:

The Commission addressed the growing and dangerous practice of physicians prescribing human growth hormone for anti-aging purposes. In 2010, the Commission disciplined a physician for this practice, setting forth the particular conditions and requirements that must be met before prescribing this dangerous hormone. In taking this action, the Commission was recognized as one of three state medical boards that have taken leadership action, which resulted in publicized standards for prescribing human growth hormone.[xi]

In another case, the Commission's action led to improvements in the internal communication protocol at a major Seattle hospital. The hospital's credentialing committee was aware that a surgeon, to whom they granted privileges, had performed a wrong-site surgery at a prior hospital. However, when that same surgeon subsequently performed a second wrong-site surgery, internal protocol did not direct the credentialing committee to inform the peer review committee about the previous event. The peer review committee therefore did not recommend action due to the misperception that this was an isolated incident. Because of the Commission's investigation and disciplinary action, the hospital recognized and remedied this communication gap, leading to better provider oversight and patient protection.

The Medical Commission is More Transparent and Patient Friendly.

The Medical Commission firmly believes that increasing transparency increases accountability and is an important step toward improving patient safety.

The Medical Commission made a focused effort to make its disciplinary orders—the most visible aspect of its work—more clear, consistent and transparent. The Commission made a focused effort to issue orders that are written to be understandable to a member of the public. First, in 2008 the Commission added a section to its orders explaining how the Commission determined what sanctions were necessary to protect the public and protect their safety by preventing reoccurrence. This section also explains how the sanctions comply with the sanction guidelines (now rules) that were created to maintain consistency among orders. The order then lists the mitigating and aggravating factors to determine the length of monitoring and other sanctions necessary to protect the public. This change made the Commission's decision-making more transparent to the public. The Department of Health adopted this approach and it is now part of the sanction rules. Second, the Commission made an effort to use consistent language in orders, particularly in stating the status of the license. Third, the Commission created headings in bold for each sanction to make orders easier to navigate. A major health insurer thanked the Commission for improving the clarity of its orders. (*See Appendix K)*

The Medical Commission created a listserv to quickly and efficiently inform the public of its legal actions. Twice each month, the Commission sends a list of its orders and statements of charges to members of the public, media, health care systems and other interested parties via the listserv.[xii] The Commission takes every opportunity to promote the service to potential subscribers, many of whom depend on the information to make decisions for their organizations.

The Medical Commission re-launched its newsletter in 2011. The budget authority granted by 4SHB 1103 allowed the Commission to employ this very effective tool. The newsletter is a medium for the Commission to communicate with the entirety of the provider population it regulates. This quarterly publication addresses topics such as enhancements to Commission services, future trends in medical practice, meeting schedules, and disciplinary actions. The newsletter is mailed to all MD and PA licensees and posted on the Commission's website. The Commission created a newsletter listserv for digital distribution of the publication in anticipation of going to paperless production in the near future.

The Medical Commission is proactive in educating health professionals in Washington. The Commission greatly expanded its education program during the pilot. The Commission made presentations to nearly every county medical society in the state, staffed an educational booth and provided a pain rules update at the state medical society annual meeting. The Commission made dozens of presentations to over 3,400 health professionals to educate the profession on the pain rules. The Commission collaborates with stakeholder organizations on web trainings, which are recorded and accessible on demand on the Commission web site. Finally, the Commission created a Speakers Bureau to facilitate stakeholder and public requests for education. The Speakers Bureau has a dedicated web page, email, suggested presentation topics, and speaking request form.

The Medical Commission encourages public input at its meetings. In the interest of obtaining more input from the public, the Commission established time at its business meeting to invite members of the public to provide input and a public perspective on the Commission's work. The Commission also engages in dialogue with members of the public at its policy committee meetings.

The Medical Commission implemented 2011 Substitute Senate Bill (SSB) 1493, the transparency bill. The Commission enhanced its process of working with complainants who request that the Commission reconsider its decision to close a complaint. The Commission also developed a procedure to encourage complainants to provide details on the impact of a practitioner's conduct.

The Medical Commission is more responsive to complainants. The Commission recently implemented a practice to inform complainants of the completion of the investigation, and of the specific progress of the complaint as it moves through the legal process.

Section Two: Current Projects

The Commission continues work to enhance patient safety.

Demographics

With the help of the Legislature passing SSB 5480 in 2011, the Medical Commission now collects demographic information from licensees for the purposes of workforce planning. This data will help stakeholders in many ways, including addressing physician shortages, emergency planning, research, and assisting county medical societies with patient referral data. The Commission worked closely with the National Center for Health Workforce Analysis Director Ed Salzburg at the Health Resources and Services Administration to harmonize its census with the federal minimum data set. The most recent demographics report is located in the appendix. (*See Appendix D*)

Annual Medical Commission Workshop/Conference

Every year the Medical Commission meets for two days to educate the Commission members, staff, and interested parties on topics of relevance to the Commission and medical regulation. This workshop model has served the Commission well as a forum to work on difficult policy issues or hear from nationally known speakers. At the workshop in 2011, aviation expert John Nance, author of *Why Hospitals Should Fly*, spoke about how aviation safety principles can be applied to improve patient safety in hospitals. In 2012, the Commission successfully transitioned from the workshop model to the educational conference model. Attendees came from across Washington, and the presenters were nationally and internationally known experts in their fields.[xiii] Topics included patient safety, the latest opioid research, social media and professionalism. The Commission plans to expand the offerings for the conference in coming years as a public service to all licensees, the public and other interested parties.

Board-to-Board Discussions

In an effort to gain perspective outside the organization and exchange best practices, the Medical Commission began a program called Board-to-Board. This is a scheduled call between the Commission and other state medical boards with a discussion guide and fact sheet distributed in advance. The Board-to-Board discussions helped the Commission to become more efficient in its processes, including modernizing licensure requirements, reforming its expert witness program, and revising its structure. (*See Appendix B*)

The Medical Commission Plans for the Future of Health Care.

The Medical Commission continues to seek ways to become more efficient, transparent and responsive in order to enhance patient safety. The Commission's future plans include:

- Proposal to the Legislature to update the licensing requirements to reflect current medical training standards, attract qualified practitioners to Washington, and address existing and projected shortages;
- Reforming and enhancing the expert witness program;
- Modernize Commissioner Information Technology business tools to current professional standards, which will streamline and make more efficient how the Commissioners do their work;
- Developing guidelines on the use of social media by physicians and physician assistants;
- Tracking national telehealth and telemedicine trends, and develop new guidelines or rules to facilitate the expansion of telemedicine to address shortages while ensuring patient safety and medical quality;
- Working with the medical profession to discern and implement the most effective intervention for physicians with disruptive behavior;
- Continuing teleconferences with sister boards to share best practices;[xiv]
- Conversion of all core business functions to paperless, and automation of functions.

Section Three: Performance

The Medical Commission collaborated with the Nursing Commission (NCQAC) and the Department of Health to develop performance measures in the areas of credentialing, discipline, human resources, rule making, and budget. The pre-pilot period runs from fiscal years 2004 through 2008. The Pilot Project period runs from fiscal years 2009 through 2012. The Commission incorporated these measures into its strategic plan, which is updated every 18 months. The Commission improved its performance in all measures during the Pilot Period. The Medical Commission performed highest in eight of the eleven performance measures relating to licensing and discipline. Highlights include:

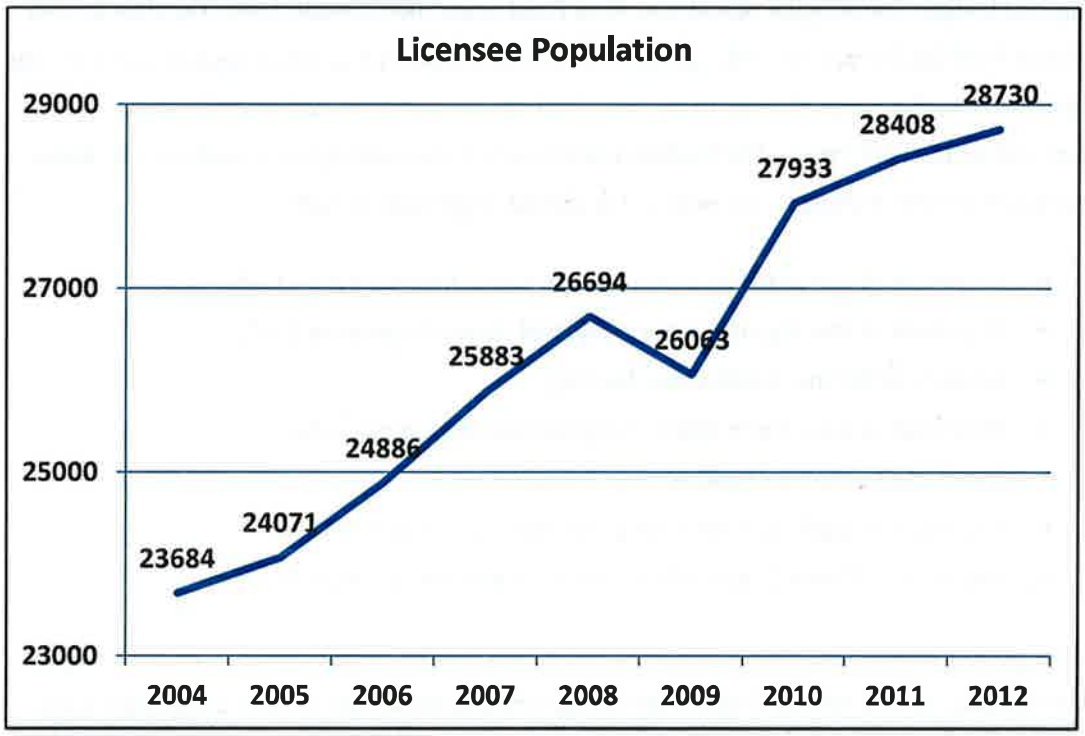
- 99 percent of completed applications were issued licenses within 14 days;
- 92 percent of investigations were completed within timelines in 2012;
- Eliminated the investigation case backlog;
- 99 percent of disciplinary orders complied with the sanction rules;
- 74 percent of the legal backlog was eliminated;
- 92 percent of legal cases were completed within timelines in 2012;
- 100 percent of sexual misconduct cases were transferred within timelines.

These performance improvements occurred with more complex license applications and discipline cases, with licensees who have the highest rate of legal representation, do not have a duplicate license, and rarely default or walk away from their licenses.[xv]

The hypothesis tested by the pilot projects in 4SHB 1103 is that greater Commission autonomy will result in more efficient, effective regulation of healthcare professionals. A comparison of the Medical Commission with non-pilot disciplinary authorities before and during the pilot period suggests that, with respect to the Medical Commission, the hypothesis is true. Many factors contributed to the Commission's pilot project success. Perhaps the most significant distinction afforded by 4SHB 1103 autonomy is the Commission's ability to design a fully integrated business model where investigators and staff attorneys work side-by-side, dedicated to Commission work alone, and develop the expertise necessary to regulate the complex multi-specialty medical profession. The performance measures that follow illustrate the success of the Commission's model and of the pilot project created by 4SHB 1103. Full descriptions of the measures and summary of the data by the Medical Commission may be found in the Appendix. (*See Appendix E*)

Credentialing

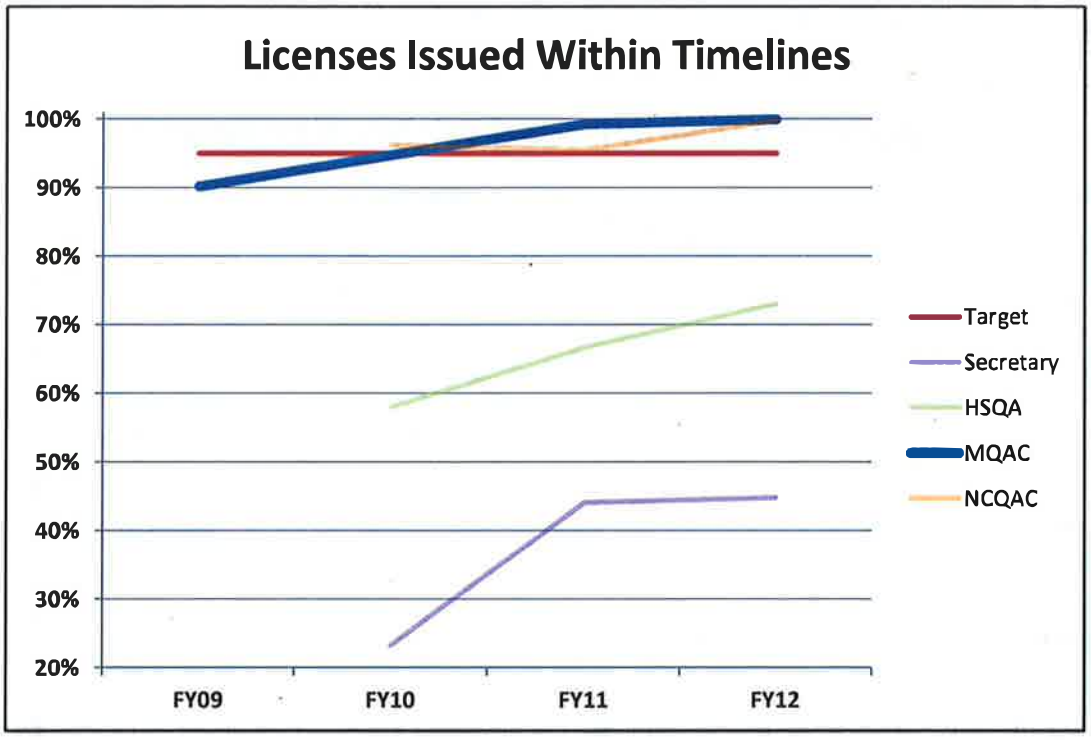
The Medical Commission's licensee population has grown 21 percent since 2004 and 10 percent during the pilot. There have been no staff increases in the credentialing unit during the pilot.



The Medical Commission's credentialing process became more consistent and efficient after the Commission adopted the Federation of State Medical Boards (FSMB) Credentials Verification Service[xvi], the FSMB Uniform Application[xvii], and Veridoc[xviii] for automated license verifications. Online renewals for the medical profession began in September 2012. All of these improvements allow Commission credentialing staff to focus on quality control and specialization as opposed to data entry and tasks related to file tracking for dozens of professions.

The Commission issued 99 percent of its licenses on time.

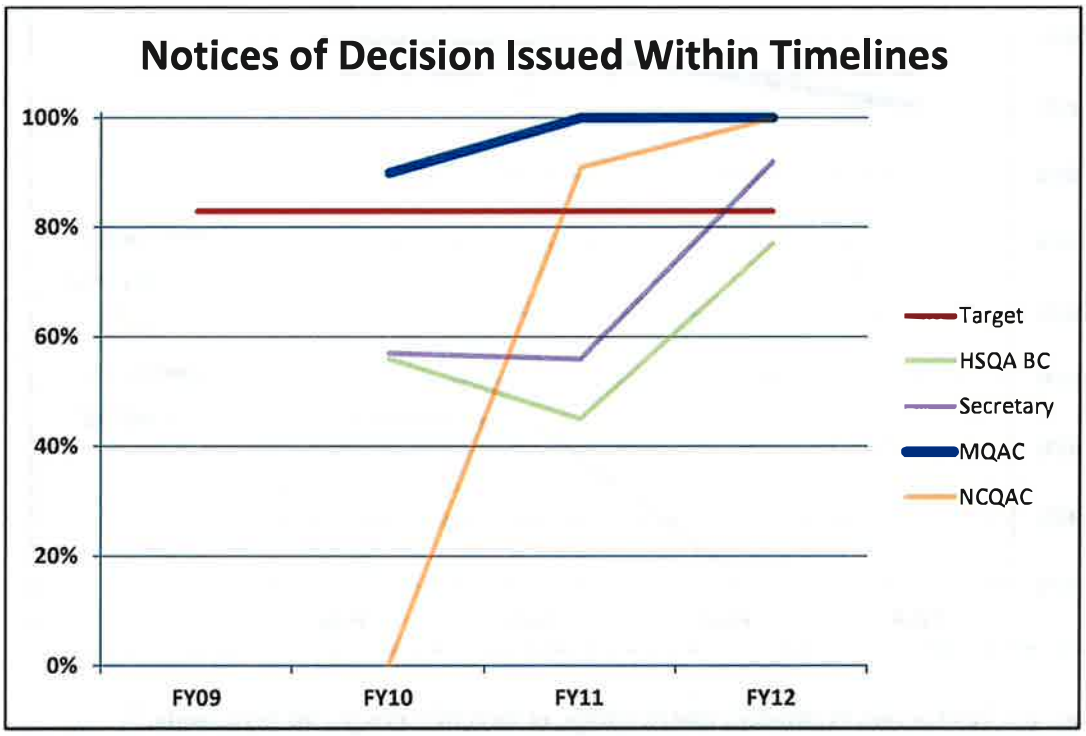
The Medical Commission maintained a performance of 99 percent or better for the last two fiscal years. The Commission excelled in this measure because it established an internal credentialing unit with control over 95 percent of credentialing functions. The credentialing unit is highly effective because staff understands and takes ownership of the entire credentialing process, not just certain functions. The target performance in this measure is 95 percent.



Measure 1.1: Health care credentials issued within 14 days of receiving all documents.[xix]

The Commission denied 100 percent of unqualified applicants on time in the last two fiscal years and exceeded the performance target during the pilot period.

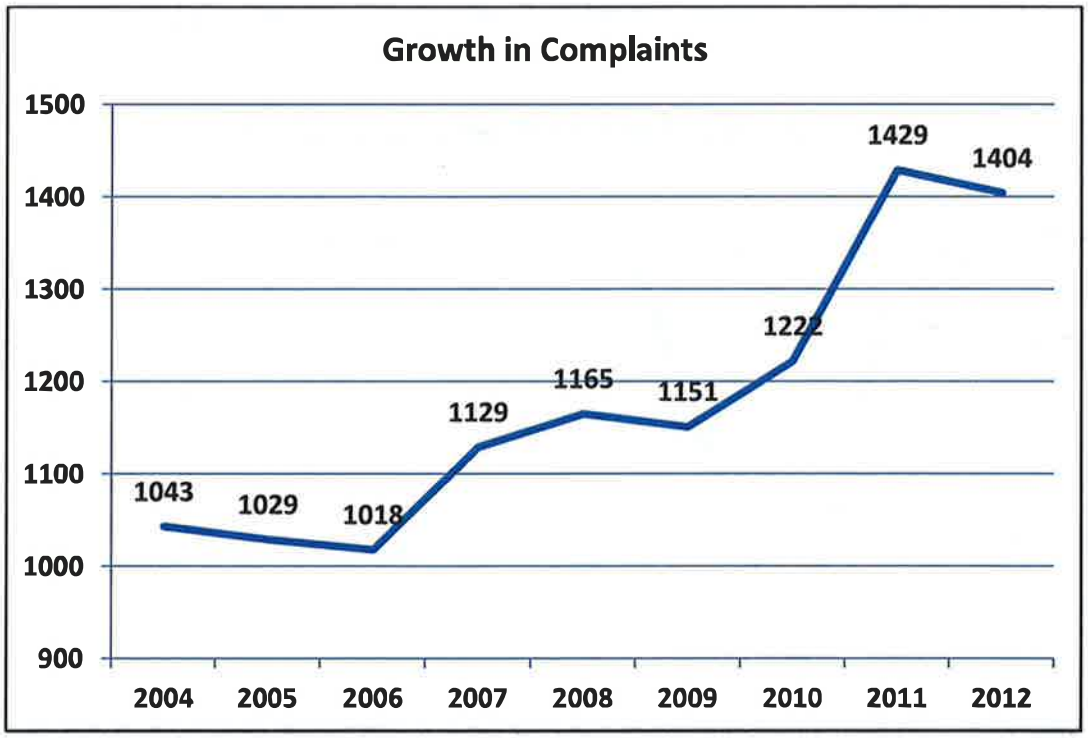
The Medical Commission has improved its performance in this measure each year, achieving 100 percent performance in the last two fiscal years. The Commission has maintained the highest overall performance in this measure. This is due to good communication between the Commission's credentialing manager and legal unit manager. They meet twice a month to discuss non-routine applications. The target in this performance measure is 83 percent.



Measure 1.2: Percent of applications in which a notice of decision on application is issued within 30 days of the decision of the disciplinary authority to deny the license or grant with conditions.

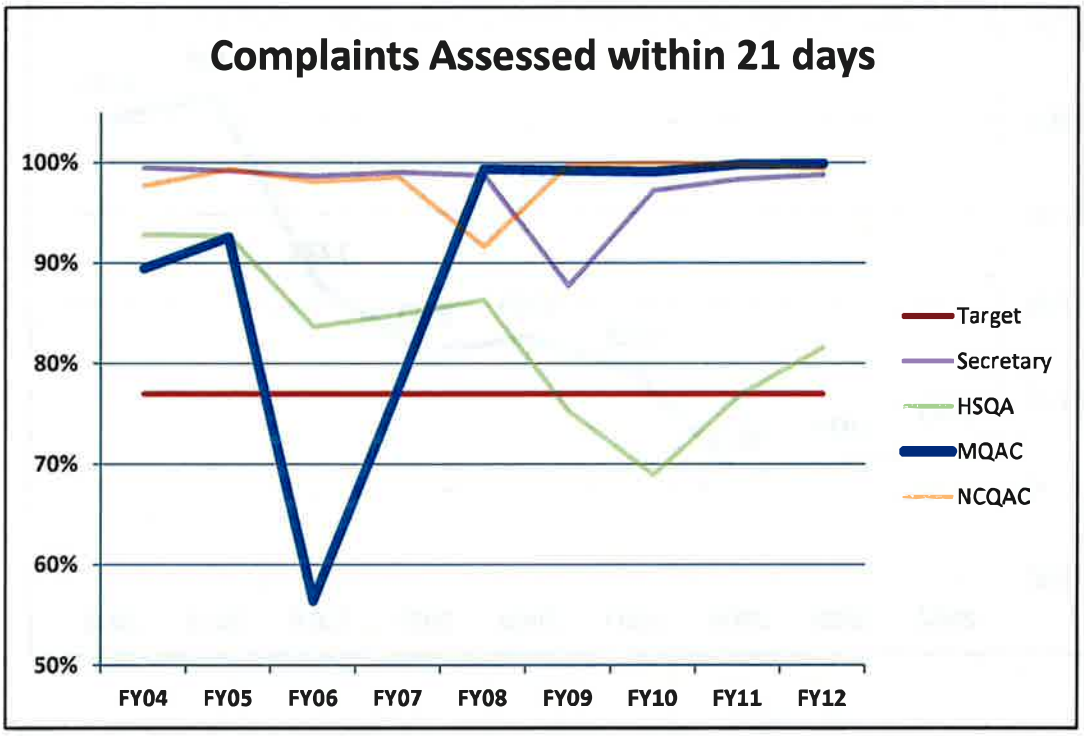
Discipline: Complaints

The number of complaints received against MDs and PAs increased 20.5 percent during the pilot. There have been no staff increases in the complaint intake process.



The Commission assessed 99 percent of complaints on time.

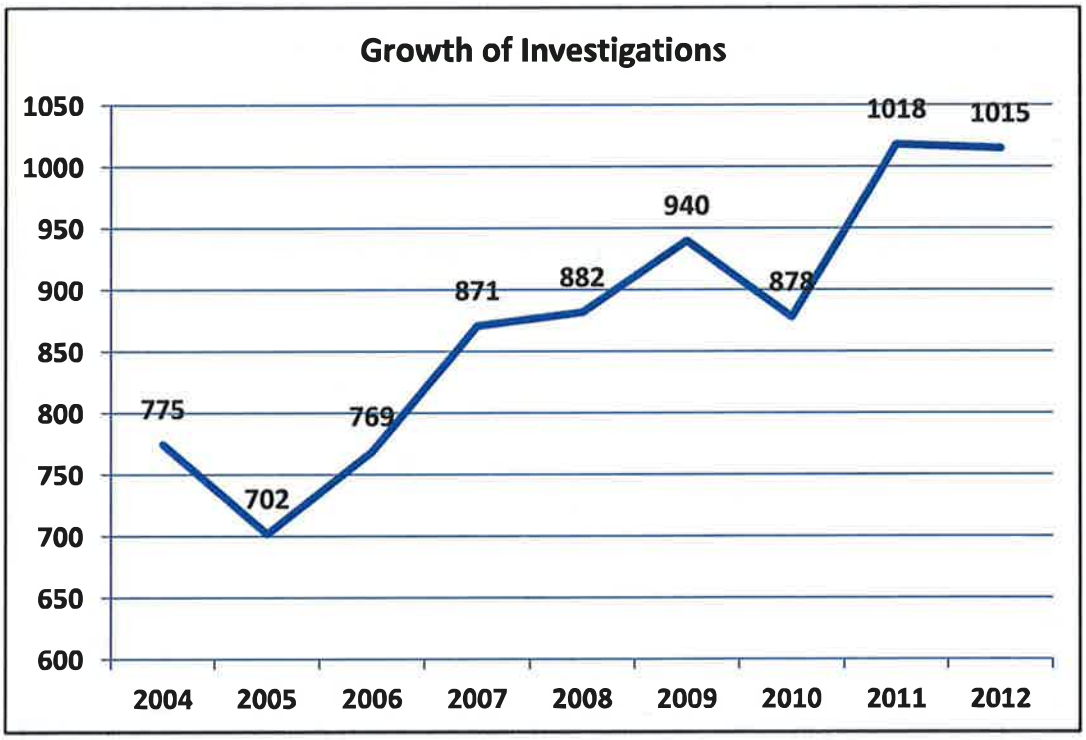
Since the pilot began, the Medical Commission meets the timeline 99 to 100 percent of the time. The Commission's high performance is due to regaining control over the complaint intake process in 2008. Since that time, the Commission assesses and decides whether to investigate a complaint within timelines 99 percent or better in this measure. The target performance in this measure is 77 percent.



Measure 2.1-Percent of cases in which the intake and assessment steps are completed within 21 days.

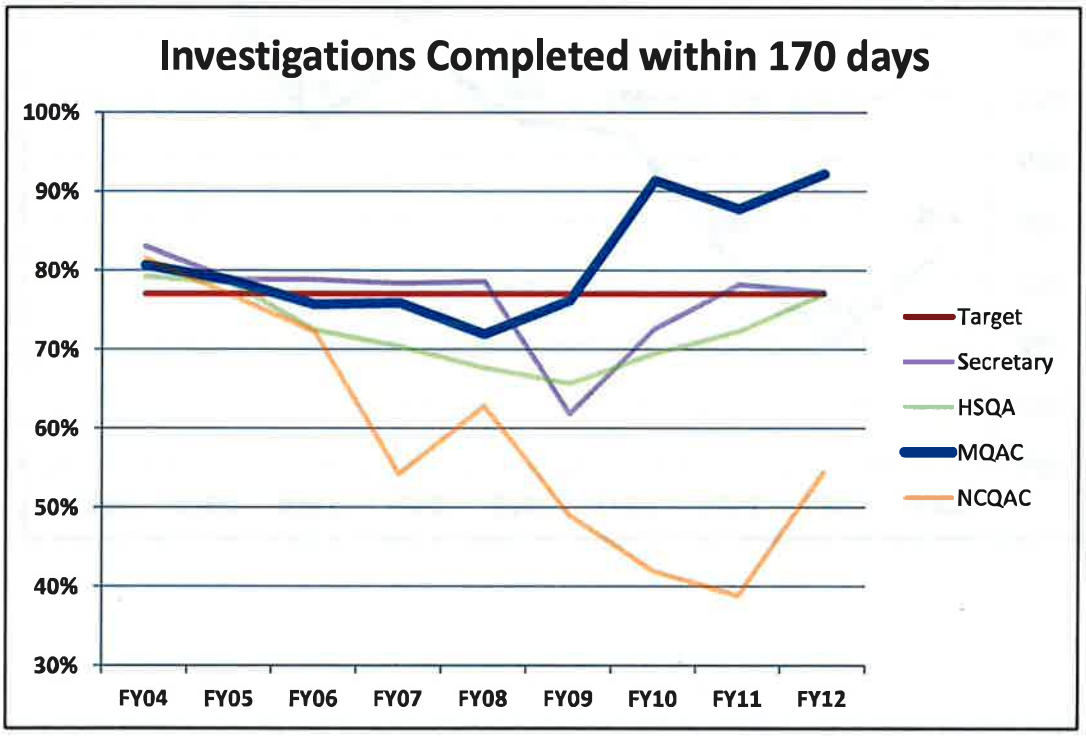
Discipline: Investigations

Since the beginning of the Pilot Project, the number of investigations has increased 15 percent. The Commission added one part-time, non-clinical investigator to the investigations unit in fiscal year 2011.



The Commission completed 90 percent of investigations on time.

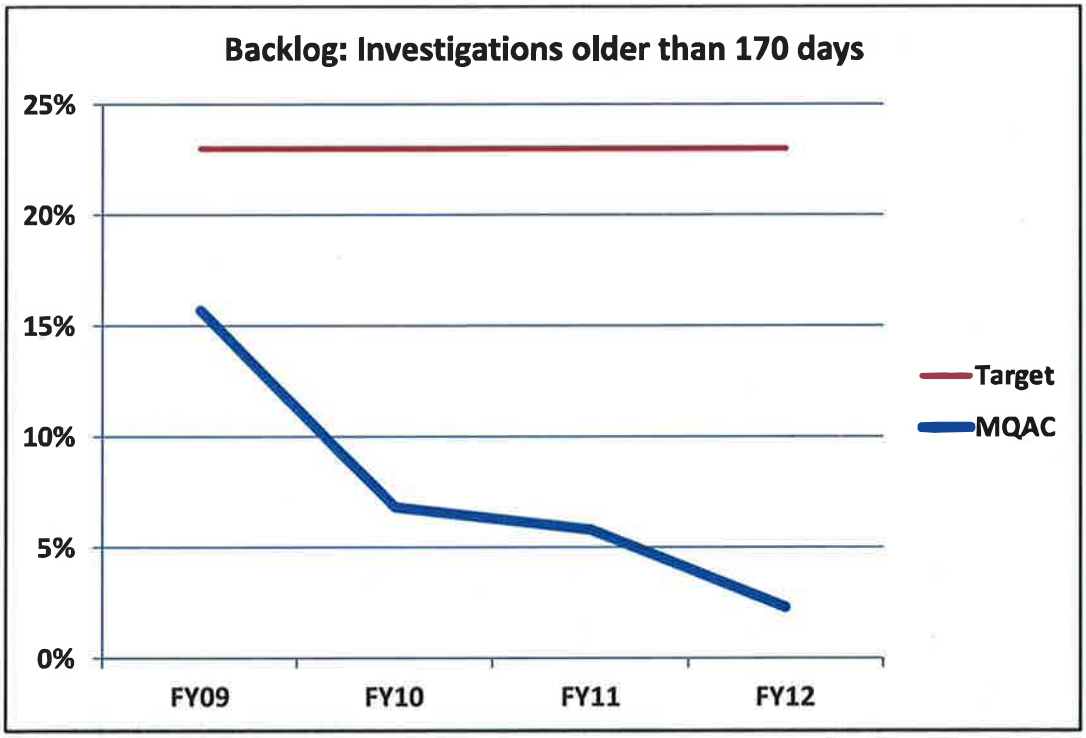
The Medical Commission immediately increased its performance with the start of the Pilot Project in fiscal year 2009. In fiscal year 2012, the Commission completed 92 percent of its investigations within timelines. The Medical Commission has the highest performance for the measure and is the only disciplinary authority to consistently exceed the target. The Medical Commission is the only disciplinary authority to improve in this measure between the pre-pilot and pilot periods.[xx] The goal is to perform higher than the target of 77 percent.



Measure 2.2-Percent of cases in which the investigation step is completed within 170 days.

The Commission eliminated its investigations backlog.

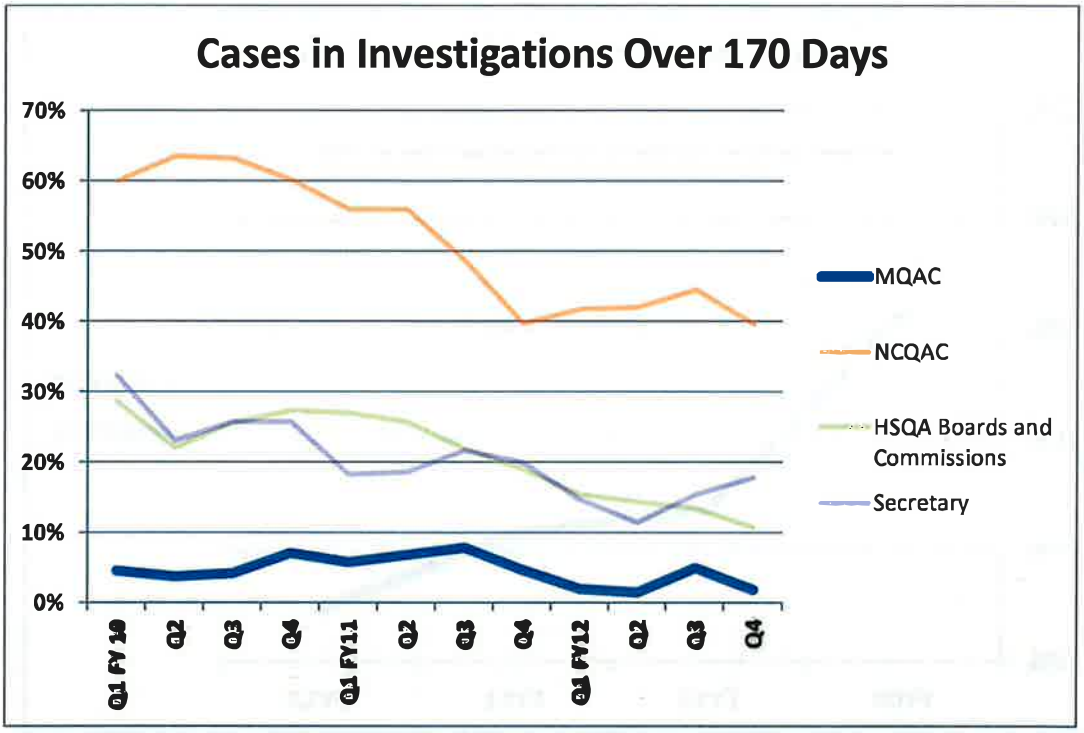
The Medical Commission dramatically reduced the investigations backlog in the first year of the Pilot Project and effectively eliminated it by the end of fiscal year 2011. In this measure, the goal is to reduce the backlog lower than the target of 23 percent.



Measure 2.4: Percent of open cases currently in the investigation step that are over 170 days.

The Commission investigation performance is consistent.

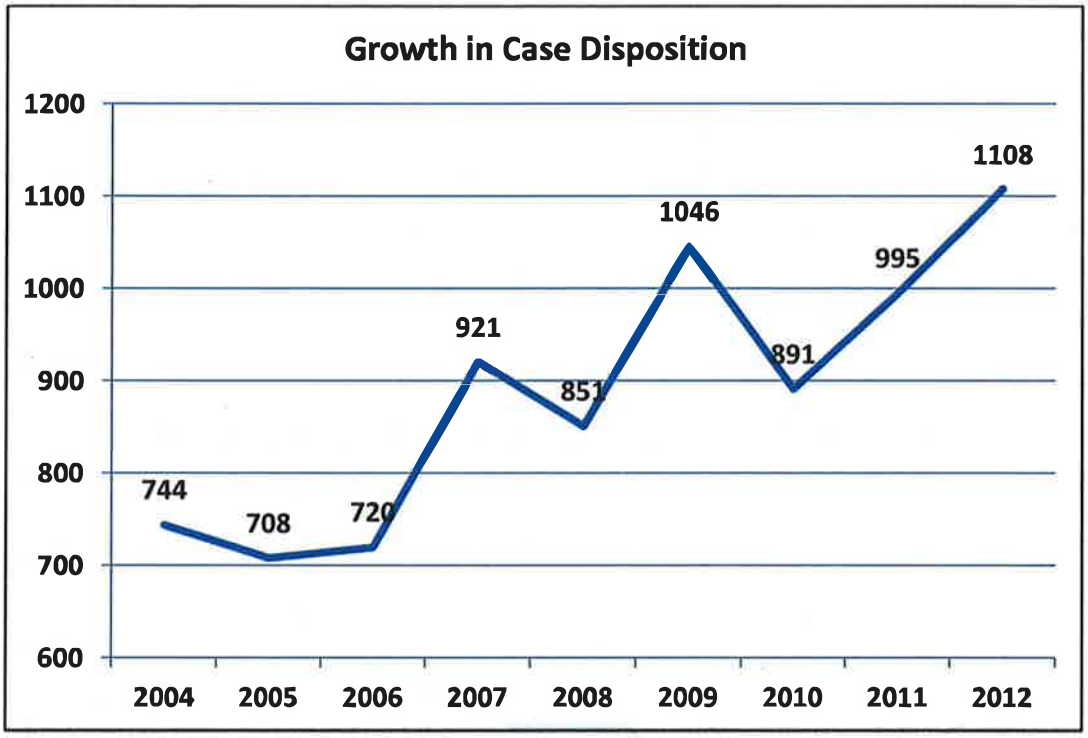
The Medical Commission has turned in the best performance in the Department of Health for this measure. Note that fiscal year 2009 is not in this graph because some entities did not track this measure until fiscal year 2010. In this measure the goal is to reduce the backlog below the target of 23 percent.



Measure 2.4: Percent of open cases currently in the investigation step that are over 170 days.

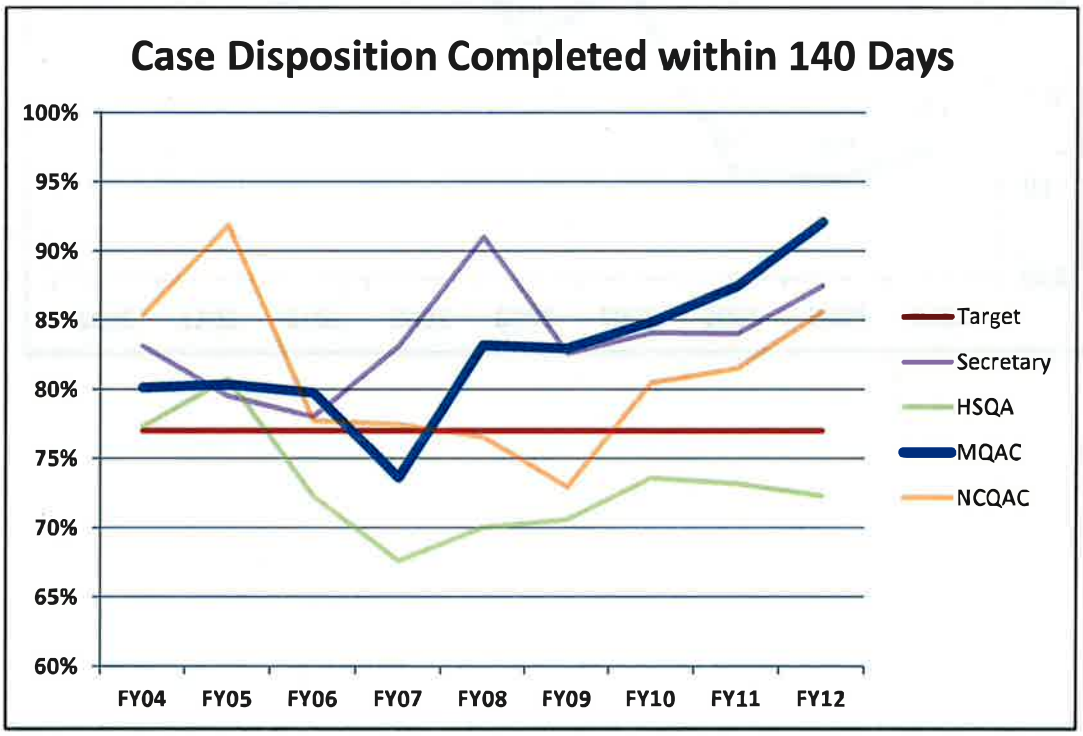
Discipline: Case Disposition

Since the Pilot Project began, the number of cases annually completing the case disposition step has increased 30 percent. There have been no staff increases in the legal unit.



The Commission completed 92 percent of legal steps on time in 2012.

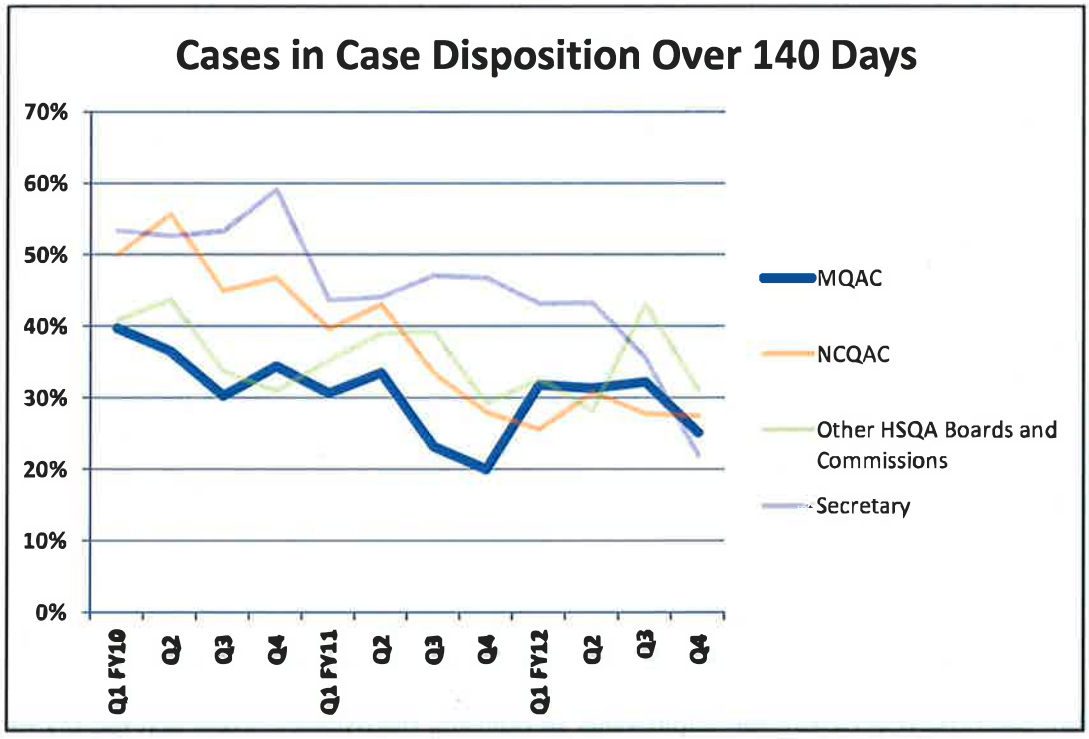
The Medical Commission's integrated legal unit is highly efficient in resolving cases. The Commission has shown marked improvement in the last three years, culminating in completing this step on time in 92 percent of the cases in fiscal 2012. There are three reasons for this. First, the Commission's model creates an environment conducive to efficiency. Staff attorneys and investigators literally work side-by-side, working with Commissioners as a team, improving communication and collaboration on complex cases. Second, the Commission created a new procedure designed to ensure that cases are presented in a timely fashion.[xxi] Third, the Commission created an early review and consent agenda for closing cases, making meetings more efficient. The Medical Commission has the best performance of the four disciplinary authorities in this measure during the Pilot Project. In this measure the goal is to perform higher than the target of 77 percent.



Measure 2.3: Percent of cases in which the case disposition step is completed within 140 days.

The Commission eliminated 74 percent of the legal backlog.

The Medical Commission reduced its legal case backlog from 119 cases to 32 cases during the Pilot Period. The Medical Commission has seen a drop in this measure, from over 40 percent to 20 percent, which was a first for all disciplining authorities being compared. The Commission did not add staff attorneys during the Pilot Period. The Commission recognizes that this backlog is still too large and is continually working to reduce it further. In this measure the goal is to reduce the backlog lower than the target of 23 percent.

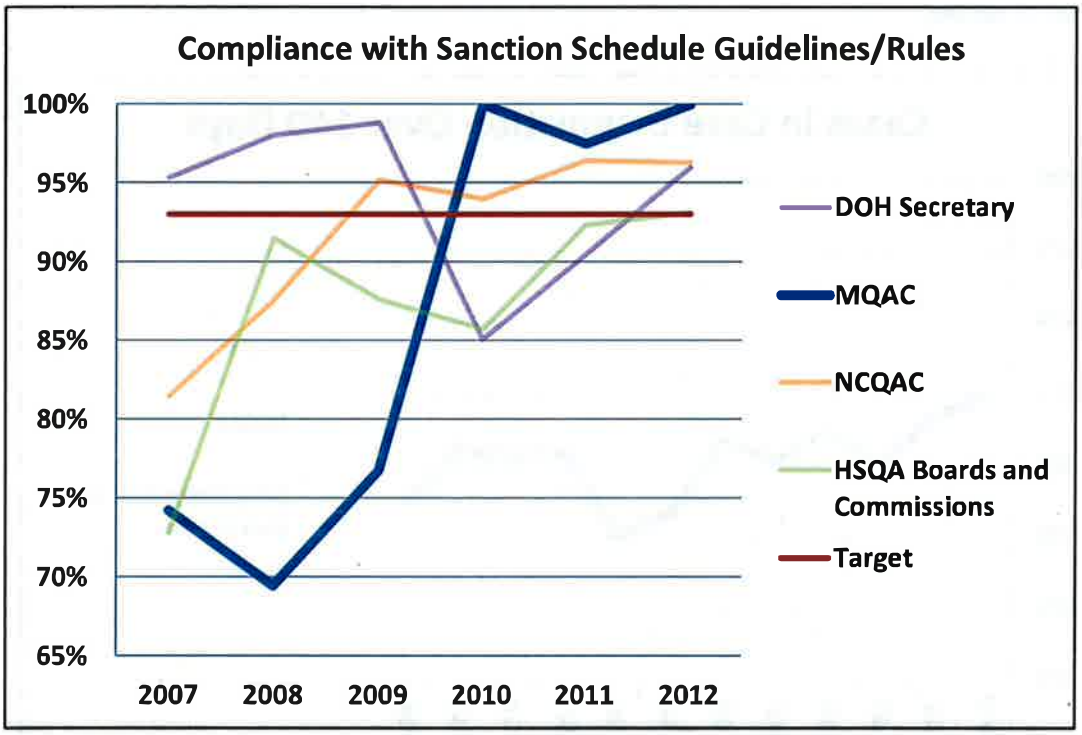


Measure 2.5: Percent of open cases currently in the case disposition step that are over 140 days.

The Commission imposed consistent discipline:

99 percent of Commission orders complied with the Sanction Rules.

The graph shows that once the Sanction Rules were in place in January 2010, the Medical Commission complied with the Sanction Rules in 99.2 percent of its orders. This is the highest rate of compliance for all of the disciplinary authorities. This is the result of the Commission's effort to make its orders clear, consistent, and transparent.



Measure 2.6: Percent of Orders and Stipulations To Informal Disposition (STIDs) that comply with the sanction schedule.

The Commission transferred 100 percent of sexual misconduct complaints on time.

The Medical Commission recognizes the importance of processing sexual misconduct complaints and transferred 100 percent of its non-clinical sexual misconduct cases within one day of the decision, well within the 14-day timeline. The Commission works well with the Secretary of Health staff to ensure seamless transfer of cases, including cases that are transferred back to the Commission when clinical issues arise.

The Commission excelled in other performance measures.

The Medical Commission also excelled in performance measures covering human resources, rule making, and budget. The Commission completes employee performance evaluations on time, adopted the pain management rules on time, and kept within its allotted budget during the pilot period. Full performance details can be found in the Appendix. (*See Appendix E*)

Performance Conclusion

The Medical Commission's dedicated, focused and integrated business model performed at a higher level during the Pilot Project than during the pre-pilot period, when the Commission staff were spread out in pooled, functionalized units and not dedicated to the work of the Commission. The Medical Commission excelled in the pilot and performed more consistently through internal business innovations and with no staff increases in licensing or discipline.[xxii] The Medical Commission is pleased with its aggregate performance of 94.6 percent[xxiii] and is thankful to the Governor and the Washington State Legislature for placing their trust in the Medical Commission during this pilot.

Section Four: National Research

4SHB 1103 required the Commission to review summaries of national research and data regarding regulatory effectiveness and patient safety.

National Bureau of Economic Research Paper on Medical Board Discipline

The National Bureau of Economic Research issued a paper entitled "Medical Licensing Board Characteristics and Physician Discipline: An Empirical Analysis," in 2009. In this paper, two economists studied the relationship between the characteristics of medical boards and the frequency of discipline. Specifically, the authors analyzed the effect of organizational and budgetary independence, public oversight, and resource constraints on rates of physician discipline.

The authors concluded that medical boards with greater resources and greater organizational autonomy had higher rates of discipline. The authors state that these findings are broadly consistent with theories of regulatory behavior that emphasize the importance of autonomy for effective regulatory enforcement.

These findings are consistent with the Commission's improvement in the pilot project and the increase in national board ranking by Public Citizen.

The Urban Institute Study

In February 2006, a case study report was published concerning the discipline of physicians. The study, conducted by Randall Bovbjerg of the Urban Institute on behalf of the U.S. Department of Health and Human Services, examined six case study states, including Washington. Two years after publication of the U.S. Department of Health and Human Services-Urban Institute report, the Medical Commission created its dedicated and integrated model for the Pilot Project. This model addressed some of the budget, staffing, and sanction consistency impediments listed in the report.

The report noted effective practices for improving complaint-based discipline:

- More effective intake and triage of complaints;
- Tracking of trends in malpractice and "below threshold" cases to direct proactive discipline;
- Enhancements to staff capacity relating to investigation and case oversight;
- Improved access to medical expertise throughout the disciplinary process;
- Maintaining regulatory autonomy;
- More modern information technology;

- Reducing "handoffs" by creating unified teams to handle cases;
- More centralization of case oversight to reduce fragmentation of responsibility;
- Standardization of sanctions to improve consistency;
- More active leadership;
- Additional budgetary resources;
- Develop proactive pathways to discipline and remediation through collaboration with health care stakeholders, to address potential practice issues before there is harm;
- Develop internal reviews of cases and conduct self-evaluations on the Board.

Structural factors identified in this report as enablers to disciplinary performance:

- More funding and unrestricted access to the full budget allotment;
- More public Board members;
- More professional staff;
- A team approach throughout the discipline process;
- Investigators dedicated to medical investigations;
- Database systems that are specialized to the needs of the Board;
- Independence from state medical societies and other parts of government;
- Broader authority, sanctions;
- Move to a "sunset review" system.

The Commission feels an updated analysis is needed to determine if the changes made as a result of the Pilot Project are effective in addressing the impediments listed in the 2006 report. The Medical Commission received a grant to conduct a small-scale follow up of the 2006 study on physician discipline. The Urban Institute will provide the follow up report in early 2013.

Recidivism

In 2007, the Journal of Health Politics, Policy and Law published a study entitled "Sanctions and Recidivism: An Evaluation of Physician Discipline by State Medical Boards."[xxiv] The authors studied data from 1994-2002 to discern how often physicians disciplined in the past receive discipline in the future. The authors found that 9.6 percent of physicians disciplined in the time period 1994 to 1998 were disciplined again in the time period 1999-2002.

The Commission studied its recidivism rate for the time period 2004 to 2012 and found it to be nine percent. The Commission's rate is below the national rate, though it is from a different time period. The Commission believes its relatively low recidivism rate is due to its comprehensive compliance program. A compliance officer monitors each practitioner for the duration of the order. An investigator conducts

practice reviews on-site during the compliance period. In some situations the Commission mandates a preceptor for the practitioner under compliance. The strongest component of this program is the requirement for each practitioner under formal discipline to appear personally before the Commission periodically to demonstrate compliance with the order. The Commission currently monitors 181 practitioners. In fiscal 2012, 60 practitioners personally appeared before the Commission and 48 successfully completed their compliance programs. As of July 2012, the Washington Physicians Health Program monitored 248 physicians and physician assistants, 24 of those are mandated into the program by the Commission. The Commission is the only disciplinary authority in Washington that requires personal appearances as a standard component of discipline.

Public Citizen-Hospital Actions

In 2011, Public Citizen published a study on the relationship between hospital privileging actions and the lack of subsequent medical board disciplinary actions.[xxv] Public Citizen asked 32 state medical boards to provide data on the reasons the board failed to take disciplinary action against physicians who have had their hospital privileges restricted or terminated. The Medical Commission analyzed data on hospital actions over the past ten years and provided the requested information. Public Citizen told the Commission it provided one of the best responses.

In participating in the Public Citizen study, the Commission learned how to improve further. First, not all hospitals or clinics were reporting privileging actions to the Commission. The Commission wrote to the facilities that failed to report actions to the Commission inquiring about the failure to report. The Commission also wrote to all 97 hospitals in Washington State, reminding them of their obligation to report hospital-privileging actions to the Commission. Second, the Commission did not always document the reason for not taking action in a particular case. The Commission now documents the rationale for the closure of each case in the file. This project helped the Commission to improve transparency, improve accountability and improve patient safety.

Section Five: Conclusions

The Washington State Medical Commission dramatically improved by every established metric. From performance efficiency and transparency, to engaging with the medical profession to enhance patient safety, the Commission embraced the challenge of self-improvement through positive organizational change at every level. This improvement has been recognized by our stakeholders across the region and nationally by our peers and critics alike. The Commission's ability to address complex professional health and safety issues will continue to generate public awareness and national recognition.

The Medical Commission's performance and accomplishments over the past five years is directly related to the thoughtful autonomy granted in 4SHB 1103. This legislation enabled the Commission to organize its staff into an interdisciplinary team and establish a productive work environment, which developed attitudes of ownership and collaboration. The Commission's model of a dedicated and integrated work environment will continue to foster shared values and collaboration among its personnel, enabling the Commission to remain at the forefront of modern medical boards. By integrating licensing, investigative, legal, compliance, administrative, data, and policy operations the Commission created a model that can effectively respond to complex medical issues facing public health and the medical profession.

The Washington State Medical Commission will continue to become more efficient, transparent and responsive, effecting positive change to promote patient safety and enhance the integrity of the profession.

Solutions for Success

The Medical Commission looks forward to continuing to work in partnership with the Department of Health, the medical profession, and health care organizations to better protect the public and enhance patient safety in our state. To accomplish this work the Commission suggests the following:

Make permanent the provisions of 4SHB 1103 with the following enhancements:

- **Establish direct accountability.** The Commission will submit a report at the end of each fiscal year summarizing its licensing and disciplinary activity and will undergo a sunset review every five years. The Commission is committed to continually assessing its structure and performance to become more efficient, transparent and responsive. The public and the profession of Washington benefit from a Commission structure that has the authority to continue improved performance. The Medical Commission will be directly accountable to the Governor and the Legislature.

- **Increase budgetary autonomy.** The Pilot Project provided the Medical Commission with more control over its budget. By law, the commission is fee supported. The 2011-13 Biennium Cumulative Fee Revenue Report indicates the commission is at 99 percent of expected revenue. Program expenditures have remained within allotment throughout the pilot. The commission and its leadership have actively participated with the executive director in the development and review of biennium budgets and supplemental decision packages. Decision Packages approved by the Legislature from July 1, 2008 to June 30, 2012 funded:
    - Retention of staff to maintain the legal workforce identified by the 2006 audit staffing model;
    - Addition of a full time management analyst position to manage data collection and analysis of performance measures identified by the department and the commission and to conduct national research and determine performance outcomes for the 4SHB 1103 report mandated by the Legislature;
    - Addition of two full time employees to support the legislative mandate to implement a survey sent to all physicians and physicians assistants at the time of renewal in order to collect, analyze and disseminate demographic workforce information; and
    - Education efforts of the commission to develop a quarterly newsletter and other educational tools for distribution to health care providers, the public and other stakeholders.

  The Commission suggests full authority and access to its budget and reserves within legal requirements, not dependent on a legislative schedule. 4SHB 1103 granted additional authority to the Commission to access budgetary reserves when needed. This reality of this provision was nothing more than a second budget request process tied to the legislative schedule. The Commission believes the intent of the Legislature was not met for this provision and suggests a process be established to access reserve funds on an as-needed basis.
- **Establish direct communication with the Office of Financial Management (OFM).** The Commission suggests a single, direct point of contact in OFM for budget and legislation requests. This model of communication currently exists as a pass-through for budget matters. The Commission suggests that the same model be applied to the request-legislation process. Budget decision packages and legislation requests will require only the approval of the Commission in a public meeting to be submitted for consideration by the Governor.
- **Change the name.** The public and the medical profession will better recognize the Commission's role as the state medical board with the name, Medical Commission of Washington (MCW).

[i] Public Citizen's Health Research Group Ranking of the Rate of State Medical Boards' Serious Disciplinary Actions, 2009-2011, May 17, 2012, Sidney M. Wolfe, M.D., Cynthia Williams, Alex Zaslow.

[ii] See Appendix I for data on reduced deaths in Washington since 2010.

[iii] http://www.doh.wa.gov/LicensesPermitsandCertificates/MedicalCommission/MedicalResources/PainManagement.aspx

[iv] http://apps.leg.wa.gov/WAC/default.aspx?cite=246-919-601

[v] http://medicalboard.georgia.gov/sites/medicalboard.georgia.gov/files/imported/GCMB/Files/OBS%20Guidelines.pdf

[vi] In 2010, the Commission set standards for licensees who inject medication or substances for cosmetic purposes or using prescription devices for cosmetic purposes. The rules require physicians to, among other things, take a history, perform a physical exam, obtain informed consent, to delegate procedures only to ARNPs, PAs and RNs, and to provide adequate supervision. http://www.doh.wa.gov/Portals/1/Documents/3000/CR-103P-5-5-2010.pdf

[vii] Preventing Wrong-Site, Wrong-Procedure, Wrong-Person Surgery, MD 2011-08, September 30, 2011. http://www.doh.wa.gov/Portals/1/Documents/3000/MD2011-08%20Preventing%20Wrong%20Site%20Surgery%20%28signed%29%20.pdf

[viii] Reducing Medical Errors: Developing Commission Case Studies for Hospitals and Other Entities, MD 2012-04, February 24, 2012. http://www.doh.wa.gov/Portals/1/Documents/MD2012-04.pdf

[ix] Transmission of Time Critical Medical Information, Medical Commission. Medical Commission policy 2011-05, September 30, 2011; http://www.doh.wa.gov/Portals/1/Documents/3000/MD2011-05%20TCMI%20Adopted%209-30-11.pdf

[x] Practitioners Exhibiting Disruptive Behavior. Medical Commission policy 2012-01, February 24, 2012; http://www.doh.wa.gov/Portals/1/Documents/3000/MD2012-01%20Practitioners%20Exhibiting%20Disruptive%20Behavior%20(signed).pdf

[xi] "State Medical Board Actions and the Standard of Care for Prescribing hGH," William J. Stilling, RPh, M.S., J.D., e-Journal of Age Management Medicine, Legal Briefs, April 2010. http://www.agemed.org/AMMGejournal/April2010/LegalBriefsApril2010.aspx

[xii] This listserv provided timely information to persons and entities that rely on the Commission's work to make important decisions on such things as hospital privileges and participation on health insurance panels.

[xiii] Agenda, links to presentations, and biographies for the 2011 and 2012 workshops may be found in Appendix C.

[xiv] See Board-to-Board section in Appendix B.

[xv] Details on default orders, duplicate cases, and representation of medical cases may be found in Appendix G.

[xvi] The Federation of State Medical Boards' Federation Credential Verification Service establishes a permanent, lifetime repository of primary-source verified core credentials for physicians and physician assistants. The FCVS keeps a record of everything from medical diplomas to passports so that physicians and physician assistants do not have to go through the time and effort of assembling and forwarding this information every time they need to be licensed or credentialed. http://www.fsmb.org/fcvs.html

[xvii] The Uniform Application for Physician State Licensure (UA) is a Web-based application that standardizes, simplifies and streamlines the licensure application process for physicians. Physicians fill out the UA online application once, and then use the application whenever they apply for licensure in another state that accepts or requires the UA for the rest of their careers. http://www.fsmb.org/ua.html

[xviii] Veridoc expedites the process of verifying the status of a physician's medical license. Physicians who hold one or more medical licenses in the United States and need to have verification of their licensure status sent to another state medical or osteopathic board can use this service. https://www.veridoc.org/overview.aspx

[xix] Due to a change in the licensing database in 2008, only date from 2009 is available for the licensing measures.

[xx] Please see Appendix E for aggregate performance tables for all compared groups.

[xxi] Processing Completed Investigations More Efficiently, MD 2011-07, June 3, 2011. http://www.doh.wa.gov/Portals/1/Documents/3000/MD2011-07.pdf .

[xxii] See Appendix E.

[xxiii] The aggregate performance for fiscal year 2012 is calculated by taking the total potential performance of percentage based performance measures and dividing by the actual Medical Commission performance in those measures. In fiscal year 2012 potential performance totaled 900 and Commission performance totaled 851. Please see Appendix F for detailed discussion of aggregate performance and case timelines.

[xxiv] "Sanctions and Recidivism: An Evaluation of Physician Discipline by State Medical Boards," Grant and Alfred, Journal of Health Politics Policy and Law, vol. 32, no. 5, October 2007.

[xxv] Link to Public Citizen hospital actions study: http://www.citizen.org/hrg1937

Washington State Medical Quality Assurance Commission

Fourth Substitute House Bill 1103 Pilot Project Report Appendices

SECTION 2

Contents

Appendix A: Commission Members and Staff Receive National Awards, Honors, and Appointments

Individual Commission members and staff have been honored as follows:

- Past Commission Chair, Samuel Selinger, MD, won the FSMB's John H. Clark Leadership Award in 2011 for his contributions to the Commission and the medical profession in Washington. He also gave a Technology, Entertainment, and Design (TED: Ideas Worth Spreading) talk on professionalism. (http://www.youtube.com/watch?v=rcktyGjOW-Q)

- Mimi Pattison, MD, the current Chair of the Commission, was awarded the 2010 Sojourn award from the Regence Foundation, Regence Health Plan. This award came with a $50,000 grant, which Dr. Pattison donated to support a program for people with mental illness who need palliative medicine and end-of-life care with the Franciscan Hospice and Palliative Care organization.

- Leslie Burger, MD, Immediate Past Chair is a member of the FSMB Foundation. The Foundation undertakes educational and scientific research projects designed to expand public and medical professional knowledge and awareness of challenges impacting health care and health care regulation.

- Public Member Frank Hensley was appointed to the FSMB Finance Committee.

- Staff Attorney Larry Berg was appointed to the FSMB Editorial Board for the Journal of Medical Regulation.

- Physician Assistant Member Ellen Harder was appointed by the FSMB as a representative to the National Commission on Certification of Physician Assistants (NCCPA).

- Executive Director, Maryella Jansen was invited by the FSMB to attend a tri-regulator symposium related to the Uniform Application Process and a meeting in Washington, D.C. to address the future of medical regulation.

- Staff Attorney Jim McLaughlin asked to present on the Commission's pain rules at FSMB state medical board attorney national conference.

- Legal Unit Manager, Michael Farrell, served on an Administrators in Medicine assessment team to evaluate the North Carolina Medical Board.

Appendix B: Board-to-Board Program

Washington State Medical Commission Board to Board Discussion: AL

2/21/12

1. Please describe the structure and composition of your board.

   a. Number of members: **BME: 15 MDs elected by MD leadership of AL, Licensure Comm: 7 MDs, 1 PM (2 from speaker of house, 2 from Lt. Gov, 2 from Gov, 1 from ?)**

   b. Number of staff: **31, all at-will employees. Larry is of the opinion that more independence leads to less turnover in staff-specifically EDs, due to not having to serve two masters.**

   c. Licenses regulated: **MD, DO, PA, Special Purpose (telehealth), Anesthesiologist Asst.**

   d. Number of licensees: **738 Dos, 14,361 MDs (10k in-state), 596 PAs, 25 Spec., 21 An Asst.**

   e. Type of model: Functionalized, **Vertical**, Hybrid

   f. Autonomy: Umbrella, **Independent**, Hybrid

2. How would you describe your level involvement with FSMB? **High. Current Board Member, Three past presidents, four past BoDs, Larry was one of the first certified execs.**

3. Do you use the FSMB Universal Application? **No.**

   a. What level of integration do you have? (PDF, Excel, web service)

   b. What is your satisfaction level with this system? **85% renew online, but still have paper initial apps due to FBI prints.**

4. Do you use a government licensing/regulation database solution? **Yes.**

   a. Whom do you use? **Lundlan & Assoc., (ALDA)**

   b. What aspects of your business does the database software perform? **All. Licensing, investigations, litigation, accounting, budget, CME audits.**

   c. How long have you had the system? **Since 2006, switched from CAVU. Most recently the operation changed to one man and this has worked better for customization.**

   d. What is your satisfaction level with the system? **High.**

   e. Do you host your own servers? **Yes. Three in-house and then they outsource the email.**

   f. Do you have dedicated IT staff? **Yes, 1 (Carl Martin)**

5. Do you have performance measures in place in your organization? **Not really. The oversight exercised by the Board works better than performance measures.** a. If so, what are your targets? **Same day verifications.**

b. If not, have you considered implementing them?

6. Is your organization taking action regarding prescription of long acting opioids for chronic non-cancer pain? **Board has developed guidelines and is in the process of putting forward a rule.**

7. Is Telehealth an issue your organization has addressed? What was that process and solution? **Yes. They have a special purpose license that allows cross state lines practice if there is a reciprocal law in other state. Still working on addressing the issue of in-state telehealth. They have specific circumstances in place for prison and mental health situations that involve a lower level medical professional to be there and guide the exam.**

8. Other:

- **Biggest challenges: 1. Staying independent and 2. Dealing with Pill Mills/ glorified drug dealers.**
- **Complaints per year: 500-750**
- **Investigate per year: 125-150**
- **Board members and staff all have laptops**
- **Board members all now have iPads**
    - **Dedicated log in on the website to get and download the documents for meetings**
    - **Use good reads to open, view and edit**
    - **BoardBook program to create the board books**
- **Must have an Alabama Controlled substances certificate prior to getting DEA license** o **$160/year/licensee**
- **CME is offered to their Board members for their annual workshop**

Washington State Medical Commission Board to Board Discussion: AZ

01/10/12

1. Please describe the structure and composition of your board. a. Number of members: **12: 8 MD, 4 PA, 1 RN**

   b. Number of staff: **36, down from 51 three years ago. Includes part time 6 investigators and 4 part time MD investigator/reviewers.**

   c. Licenses regulated: **MD, PA**

   d. Number of licensees: **21k MD, with 16k in-state, 2,400 PA**

   e. Type of model: Functionalized, **Vertical**, Hybrid

   f. Autonomy: Umbrella, **Independent**, Hybrid

   10% of revenue goes to general fund. Referred to as 90/10 Boards.

2. How would you describe your level involvement with FSMB?

   High level. AZ has two members on Board of Directors and the ED is on one workgroup.

3. Do you use the FSMB Universal Application? **No, looking to implement soon.**

   a. What level of integration do you have? PDF, Excel, web service

   b. What is your satisfaction level with this system? **Use veridoc and very satisfied with the system once it went live.**

4. Do you use a government licensing/regulation database solution? **Yes.**

   a. Whom do you use: **GL Solutions**

   b. What aspects of your business does the database software perform? **All investigation, case disposition, and some administrative.**

   c. How long have you had the system: **Three years.**

   d. What is your satisfaction level with the system? **Described as a troubled marriage, but both parties want to work on it. Issue revolves around communication, both from GL to AZ and within GL internally.**

   e. Do you host your own servers? **Yes.**

   f. Do you have dedicated IT staff? **Yes. Four staff currently but may be looking to reduce.**

5. Do you have performance measures in place in your organization? **Yes.**

   a. If so, what are your targets? **Investigations-Number of open investigations at or around 300, Length of investigations. Licensing-time to produce deficiency letters, time to issue approval letters CIRC-Internal investigation review committee: they prepare the case and make disciplinary recommendations to be presented to the board at the next meeting. Also**

procures expert reviews. AZ gets experts on all investigations. They pay $150 each and provide CME credit to the MD. There is training available on the AZ website for expert reviews.

b. If not, have you considered implementing them?

6. Is your organization taking action regarding prescription of long acting opioids for chronic noncancer pain? **Adopted FSMB guidelines. Need for action on education but AZ does not know what it will look like at this point.**

7. Is Telehealth an issue your organization has addressed? What was that process and solution? **They are in the research and development stage. They have in-state Telehealth (rural applications) but have yet to address interstate issues.**

8. Other: **Legislative session started on 1/10/12. Legal: 75 actions per year, 24% involved prescribing**

- **PAs: Two years ago the law changed to delegation agreement, which would be kept at the clinical level. So far, AZ has not seen an issue.**

Washington State Medical Commission Board to Board Discussion: CA

09/04/2012

1. Please describe the structure and composition of your board.

    a. Number of members: **15; eight MD and seven public. Members do not review cases until charges presented. Staff assesses and determines if investigation is warranted.**

    b. Number of staff: **271, 50 part-time, 70 percent enforcement**

    c. Licenses regulated: **124k MD, 6k midwives, PAs Psych, spectacle lens, Polysomnographers**

    d. Number of licensees:

    e. Type of model: Functionalized, **Vertical**, Hybrid **MBC controls all functions of discipline and collaborates with AGO to prosecute.**

    f. Autonomy: Umbrella, **Independent**, Hybrid **Dependent on Department of Consumer Affair for admin support, but completely autonomous on policy, legislation, and budget.**

2. How would you describe your level involvement with FSMB? **Former members on FSMB board and Foundation. Participate but don't mandate FCVS.**

3. Do you use the FSMB Universal Application? **No**.

    a. What level of integration do you have? PDF, Excel, web service

    b. What is your satisfaction level with this system?

4. Do you use a government licensing/regulation database solution? **Yes**.

    a. Whom do you use? **Old multi-database system. Moving to a new off the shelf/custom system by Iron Data.**

    b. What aspects of your business does the database software perform? **Should do everything from licensing to enforcement.**

    c. How long have you had the system? **Should be live December 2012.**

    d. What is your satisfaction level with the system? **Unable to answer for new system, but unsatisfied with old. No pay until live with new system.**

    e. Do you host your own servers? **Yes, in 12 district offices.**

    f. Do you have dedicated IT staff? **Yes, 30 dedicated for MBC, more for Dept. of Consumer Affairs.**

5. Do you have performance measures in place in your organization? **Yes**.

    a. If so, what are your targets? **Licensure and enforcement targets. Currently take about a year to resolve a case. This is an improvement. They use an average timeframe with investigations and case disposition combined. Board members are not involved in complaints or**

investigations. Board members perform role of judicial review.

b. If not, have you considered implementing them?

6. Is your organization taking action regarding prescription of long acting opioids for chronic noncancer pain? **Yes, on a case by case basis. Working on a prescribing summit with Board of Pharmacy in February 2012. Under prescribing is rare.**

7. Is Telehealth an issue your organization has addressed? What was that process and solution? **2290.5 requires MD owned clinics, telehealth statute requires informed consent of the patient for that treatment modality.**

8. Other:

- **Medical Cannabis, they have recommendations but do not approve exemptions.**
- **Expert reviewers are compensated at $150/hr. If performing exam on licensee then usual and customary. $200/hr. for hearing. Training program for expert reviewers (over 1000) for bias, timeliness, and testimony training. Get CME for the training.**
- **High profile cases. Press is the issue and it snowballs into the legislature. Legislation and public information is one office for this reason.**
- **MOL. Manager assigned to track. 20 percent or more do not have board certification. Playing a waiting game for national movement.**
- **IMG legislation. If institutional pathway chosen, they would need to know that it is for Washington only. Would not be eligible for full licensure in another state.**

Washington State Medical Commission Board to Board Discussion: GA

3/20/2012

1. Please describe the structure and composition of your board.
   a. Number of members: **13 MD, 2 Consumer, 1 PA (ex-Officio)**
   b. Number of staff: **25, down from 32 due to budget**
   c. Licenses regulated: **MD (Allo/Osteo), PA, Resp, Profu, Accu, Othot, Prescriptive Auth of ARNP**
   d. Number of licensees: **32k MD, 3.4k PA**
   e. Type of model: Functionalized, **Vertical**, Hybrid
   f. Autonomy: Umbrella, **Independent**, Hybrid
2. How would you describe your level involvement with FSMB? **Accept FCVS, USMLE**
3. Do you use the FSMB Universal Application? **No, but planning to look at it in May.**
   a. What level of integration do you have? PDF, Excel, web service
   b. What is your satisfaction level with this system?
4. Do you use a government licensing/regulation database solution? **Yes.**
   a. Whom do you use? **Iron Data-Versa**
   b. What aspects of your business does the database software perform? **Licensing, enforcement, backbone of daily ops**
   c. How long have you had the system? **Twelve Years**
   d. What is your satisfaction level with the system? **Like it more through upgrades.**
   e. Do you host your own servers? **Yes. Also have a centralized tech system, similar to DES.**
   f. Do you have dedicated IT staff? **Yes. One who does multitude of things.**
5. Do you have performance measures in place in your organization? **Yes. The Governor required them several years ago.**
   a. If so, what are your targets?
      i. **Decrease processing time, once application hits the door.**
      ii. **Complaints are open and acknowledged within three days.**
      iii. **Next five days are triage by Chief Investigator**
      iv. **30 day, 60 day, 90 day review of progress in cases**

v. **No investigative timeline, but do a weekly status report sent to all investigators and management.**

vi. **They have a legal services attorney for dealing with public disclosure, but no staff attorney unit. Prosecution done at the AGO.**

vii. **2,000 complaints per year with around half investigated.**

b. If not, have you considered implementing them? **NA.**

6. Is your organization taking action regarding prescription of long acting opioids for chronic noncancer pain? **Yes. Modeled their pain clinic rules after WA and FL rules. Are working to craft rules to head off legislation.**

7. Is Telehealth an issue your organization has addressed? What was that process and solution? **They are looking at a complete re-working of the rule with a focus on H&P existing between patient and provider. Very often getting presentations from companies about how Telehealth could work for a business model.**

8. Other: **Just did the OBS rule, copied from WA model directly. They are a general fund state. They can retain non-application charges.**

Washington State Medical Commission Board to Board Discussion: ID

12/6/11

1. Please describe the structure and composition of your board.

   a. Number of members: **4 MD, 1 Public on advisory. BoM is 2 Public, Director of Law Enforcement, 6 MD, 1 DO**

   b. Number of staff: **13.8**

   c. Licenses regulated: **MD, DO, PA, AT, DIET, RT, ATHL, POLY SOMN**

   d. Number of licensees: **10K, 9.2K without training licenses**

   e. Type of model: **Functionalized**, Vertical, Hybrid

   f. Autonomy: Umbrella, **Independent**, Hybrid

2. How would you describe your level involvement with FSMB? **Extensive, paid consultant through the license portability grant.** Do you use the FSMB Universal Application? **Yes.**

   a. What level of integration do you have? PDF, Excel, **web service**

   b. What is your satisfaction level with this system? **Not as quick as anticipated. Cannot account for the delay between staff and applicant processes.**

3. Do you use a government licensing/regulation database solution? **Yes.**

   a. Whom do you use? **Custom in-state solution**

   b. What aspects of your business does the database software perform? **Everything. Licensing, discipline, litigation, notifications in administration functions. Web service integration and website coordination.**

   c. How long have you had the system? **2003.**

   d. What is your satisfaction level with the system? **Very high. Very responsive to their needs.**

   e. Do you host your own servers? **Hosted by state IT, but has limited access.**

   f. Do you have dedicated IT staff? **1 for database, 1 for web services**

4. Do you have performance measures in place in your organization? **Yes, they are outcome based.**

   a. If so, what are your targets? **Improve licensing process to 90% online, No paper apps but will print UA if no internet, Succession plans.**

   b. If not, have you considered implementing them? **Not very specific PMs like MQAC has relating to processes.**

5. Pre-Litigation Hearing Panels

a. **Function is to take all malpractice claims before the panel to determine if they have merit to proceed** i. **Composed of attorney (chair), MD member, Public member, lawyer for claimant, MD or hospital rep as expert.**

ii. **These are not discoverable in legal and not reportable to the Board**

iii. **$600 per hearing to the chair that is not reimbursed**

iv. **This process does not prevent litigant from going forward to the courts**

b. **$250k malpractice cap, non-economic damages have a different limit**

c. **60-70 percent of cases brought before this panel are found to have no merit**

d. **Acts as a screening tool in malpractice**

6. Is your organization taking action regarding prescription of long acting opioids for chronic noncancer pain? **Adopted the FSMB statement on the issue. Opioids are a major problem in the state, specifically wholesaler issues. (WA could be affected by cross border runs on the east side. A PMP is in existence in ID.**

7. Is telemedicine an issue your organization has addressed? What was that process and solution? **Yes and it is not unique practice. Same standards apply but the process is expedited based on a non-derogatory practice history with a five-year timeframe.**

8. FMG's **Established a criteria in law to determine whether a international medical school is recognized. (In existence for 15 years, with first graduate coming 15 years ago). They have three-year progressive training requirement, recognize CAN, and have authority to recognize others on an individual basis. Have recognized U.K. and AUS so far.**

Washington State Medical Commission Board to Board Discussion: KS

7/19/11

1. Please describe the structure and composition of your board.

   a. Number of members: **n/a**

   b. Number of staff: **n/a**

   c. Licenses regulated: **RN and social sciences**

   d. Number of licensees: **17k including out of state**

   e. Type of model: Functionalized, Vertical, **Hybrid**

   f. Autonomy: **Umbrella**, Independent, Hybrid

2. How would you describe your level involvement with FSMB? **N/A** Do you use the FSMB Universal Application? **Yes**

   a. What level of integration do you have? **PDF**, Excel, web service

   b. What is your satisfaction level with this system? **Needs work to be efficient.**

3. Do you use a government licensing/regulation database solution? **Yes.**

   a. Whom do you use? **GL Solutions**

   b. What aspects of your business does the database software perform? **Credentialing and discipline**

   c. How long have you had the system? **2007**

   d. What is your satisfaction level with the system? **Very dissatisfied**

   e. Do you host your own servers? **Yes.**

   f. Do you have dedicated IT staff? **Yes.**

4. Do you have performance measures in place in your organization? **No.**

   a. If so, what are your targets?

   b. If not, have you considered implementing them?

5. Is your organization taking action regarding prescription of long acting opioids for chronic noncancer pain? **N/A**

6. Is telemedicine an issue your organization has addressed? What was that process and solution? **N/A**

7. Other:
   - **Receive 2,400 complaints per year**
   - **Receive malpractice when it is filed, not settled. 7% of those turn into investigations.**

Washington State Medical Commission Board to Board Discussion: NC

2/7/11

1. Please describe the structure and composition of your board.
   a. Number of members: **12; 8MD, 1PA, 3 Public**

   b. Number of staff: **55**

   c. Licenses regulated: **MD, PA, DO, Anest. Assist, Perfusionist, ARNPs (jointly), Clinical Pharm (jointly),**

   d. Number of licensees: **32, 644 MD, DO. 4,458 PA, 2,455 Residency**

   e. Type of model: Functionalized, **Vertical**, Hybrid

   f. Autonomy: Umbrella, **Independent**, Hybrid

2. How would you describe your level involvement with FSMB? **Very involved. Dr. Rhyne is FSMB chair and is past member of NCBOM, most staff are certified medical XXX (Executive, investigator, attorney)**

3. Do you use the FSMB Universal Application? **No. In-house online apps exist.**

   a. What level of integration do you have? PDF, Excel, web service

   b. What is your satisfaction level with this system?

4. Do you use a government licensing/regulation database solution?

   a. Whom do you use: **GL Solutions**

   b. What aspects of your business does the database software perform? **Licensing, enforcement, online applications, renewals, administration**

   c. How long have you had the system: **Since 2004**

   d. What is your satisfaction level with the system? **It gets better over time. Started with CAVU and those that complain do not remember the difficulties of CAVU. A large issue is that the eLicensing market is small and limited so there is not the clear guidelines and development available to refine the offerings.**

   e. Do you host your own servers? **GL hosts servers**

   f. Do you have dedicated IT staff? **One for non GL servers, Operations Director and a .5 FTE for software.**

5. Do you have performance measures in place in your organization? **They are informal and non-specific.**

   a. If so, what are your targets? **If an investigation has not been completed in 6 months, then a status report must be sent to complainant. All cases over one year must be reported to the Board.**

b. If not, have you considered implementing them?

6. Is your organization taking action regarding prescription of long acting opioids for chronic noncancer pain? **They have a physician statement from FSMB that has been in place. NC is familiar with the WA rules but the Board does not seem to have a desire to go that route. NC does require use of PMP if under compliance, but it is based on the honor system. PMP has been in place or five years. It is clunky, has a mandatory attestation about being for professional use only, which creates issues for offices doing multiple doc entry. Also issues with large offices just putting one doc as prescriber to save data entry time.**

7. Is Telehealth an issue your organization has addressed? What was that process and solution? **Very active and ongoing issue. Primary problem is getting approached by vendors for approval of new business models.**

8. Other: **NC expert review system is 300 individuals who volunteer or check box on renewal to volunteer. Charge is $150 per hour and each case is two-four hours for each case. NC is spending about $10k/month on external review.**

Washington State Medical Commission Board to Board Discussion: OH

3/6/12

1. Please describe the structure and composition of your board.

   a. Number of members: **12-9 MD, 1 DO, 1 PD, 3 Public**

   b. Number of staff: **87 but down to 79 due to budget**

   c. Licenses regulated: **MD, DO, PD, Anest. Assist, RA**

   d. Number of licensees: **65k, 42k MD**

   e. Type of model: Functionalized, **Vertical**, Hybrid

   f. Autonomy: Umbrella, **Independent**, Hybrid

2. How would you describe your level involvement with FSMB? **High. First with FCVS adoption, many offices held on BoD, many trained in SMB training prog.**

3. Do you use the FSMB Universal Application? **No.**

   a. What level of integration do you have? PDF, Excel, web service

   b. What is your satisfaction level with this system? **Would like it to be improved.**

4. Do you use a government licensing/regulation database solution?

   a. Whom do you use: **Cavu**

   b. What aspects of your business does the database software perform? **Licensing. Was using enforcement module but had to drop it and revert to paper.**

   c. How long have you had the system: **2004**

   d. What is your satisfaction level with the system? **Extreme dissatisfaction.**

   e. Do you host your own servers? **No.**

   f. Do you have dedicated IT staff? **Centralized agency.**

5. Do you have performance measures in place in your organization?

   a. If so, what are your targets? **Yes. Email will follow detailing. We consider performance measures to be light flashing on the dashboard.**

   b. If not, have you considered implementing them?

6. Is your organization taking action regarding prescription of long acting opioids for chronic noncancer pain? **Ohio addressed the issue of pill mills and prescription practices. The overall understanding is that we need to get a better understanding of appropriate pain management. Regarding communication strategies; brought in outside entities, newsletter, website, associations of Ohio. Gave 105 presentations on it since Jan (?), and have a dedicated Education**

consultant.

7. Is Telehealth an issue your organization has addressed? What was that process and solution? **This issue has always been percolating but in the last three months it has raised up to be a major issue. Largely due to a company called Health Spot. What needs to be nailed down is what is essential for an exam, which leads to more technical questions.**

8. Other: **Legislators meet year round. Expert witness: they go to the medical association and sell it like medical jury duty. Use of nurses: Ohio has a Quality Intervention Panel (QIP) that looks to standard of care violations, all are referred to this panel with education being the goal. This seems similar to the NCQAC Early Remediation program. Nurses also act as reviewers for investigative files. All investigators are law enforcement background.**

Washington State Medical Commission Board to Board Discussion: OR

11/8/11

1. Please describe the structure and composition of your board.

   a. Number of members: **12**

   b. Number of staff: **40**

   c. Licenses regulated: **MD, DO, PA, Podi, Accu**

   d. Number of licensees: 17k including out of state

   e. Type of model: Functionalized, **Vertical**, Hybrid

   f. Autonomy: Umbrella, **Independent (under exec with Legislative budget control)**, Hybrid

2. How would you describe your level involvement with FSMB? **On AIM and re-entry panel, IAMRA**

3. Do you use the FSMB Universal Application? **No. They have their own.**

   a. What level of integration do you have? PDF, Excel, web service

   b. What is your satisfaction level with this system?

4. Do you use a government licensing/regulation database solution? **Yes.**

   a. Whom do you use? **GL Solutions. Spent $500k on start up. Very automated.**

   b. What aspects of your business does the database software perform? **All**

   c. How long have you had the system? **2010**

   d. What is your satisfaction level with the system? **Good. Likes it.**

   e. Do you host your own servers? **Yes**.

   f. Do you have dedicated IT staff? **3: 1 trouble shoots and 1 business apps. Remainder is a double fill.**

5. Do you have performance measures in place in your organization? **Yes.**

   a. If so, what are your targets? **License processes (Internal), Days to renew, cases upheld on appeal, customer service, board best practices (informing board members), Recidivism (5% have a complaint within five years), Law says case goes to board in 120 days with possible 30-day extension granted by the ED.**

   b. If not, have you considered implementing them?

6. Is your organization taking action regarding prescription of long acting opioids for chronic noncancer pain?

7. Is telemedicine an issue your organization has addressed? What was that process and solution?

Telemedicine license, consultation is not considered telemedicine. Zoom care has started a Skype service that is in limited test in Portland.

8. Other: **Medical Director sends systems letters when requested to address issues that BOM cannot take definitive action on.**

Appendix C: Educational Conference/Workshop

Every year the Medical Commission meets for two days to educate the Commission members, staff, and interested parties on topics of relevance to the Commission and medical regulation. This workshop model has served the Commission well as a forum to work on difficult policy issues or hear from nationally known speakers. At the workshop in 2011, aviation expert John Nance, author of *Why Hospitals Should Fly*, spoke about how aviation safety principles can be applied to improve patient safety in hospitals. In 2012, the Commission successfully transitioned from the workshop model to the educational conference model. Attendees came from across Washington, and the presenters were nationally and internationally known experts in their fields. Topics included patient safety, the latest opioid research, social media and professionalism. The Commission plans to expand the offerings for the conference in coming years as a public service to all licensees, the public and other interested parties.

The Medical Commission assembles informational packets for the annual workshops to be downloaded by the attendees.

- 2012:http://www.doh.wa.gov/Portals/1/Documents/3000/MQACWorkshopPacket2012.pdf
- 2011:http://www.doh.wa.gov/Portals/1/Documents/3000/Washington%20State%20Medical%20Quality%20Assurance%20Commission%20Workshop%20Reading%20Materials.pdf

Complete biographies for the 2012 workshop presenters can be found on the Medical Commission website.

- http://www.doh.wa.gov/Portals/1/Documents/3000/Medical%20Commission%202012%20Workshop%20Speaker%20Biographies.pdf

Washington State Medical Commission Educational Workshop 2012

Into the Future: Designing Better Patient Safety Systems

WEDNESDAY – August 22, 2012 – Capital Event Center	
Breakfast Provided in Main Rooms	
8:15 a.m.	Welcome: Mimi Pattison, MD, Chair and Secretary of Health Mary Selecky
8:30 a.m.	**Dennis Turk, PhD** John & Emma Bonica Professor of Anesthesiology & Pain Research University of Washington *Evidence Based Practice*
9:30 a.m.	**Break**
9:45 a.m.	**Jon Thomas, MD, MBA** President, MN Board of Medical Practice, Chair-elect FSMB *Social Media and Medical Practice*
10:45 a.m.	**Jane Ballantyne, MD** Professor of Education and Research University of Washington *Managing Bill 2876*
12:00 p.m. **Lunch Provided**	**Presentation: RADM Patrick O'Carroll, MD** Assistant Surgeon General, USPHS, Region X *The Affordable Care Act* Introduction: Karen Jensen, JD, MS Assistant Secretary, Department of Health
1:30 p.m.	**Networking Break**
2:00 p.m.	Breakout 1 1. **Commission efforts:** Chehalis A *Pain Rule, Demographics, Pilot to Date* 2. **Jon Thomas, MD, MBA:** Chehalis B President, MN Board of Medical Practice, Chair-elect FSMB *Telehealth innovations in Minnesota*
3:00 p.m.	Breakout 2 1. **Commission efforts:** Chehalis A *Pain Rule, Demographics, Pilot to Date* 2. **Jon Thomas, MD, MBA:** Chehalis B President, MN Board of Medical Practice, Chair-elect FSMB *Telehealth innovations in Minnesota*
4:00 p.m.	**Break**
4:15 p.m.	Wrap up and discussion from breakouts, general day wrap

THURSDAY – August 23, 2012 – Capital Event Center	
	Breakfast Provided in Main Rooms
8:15 a.m.	Welcome: Mimi Pattison, MD, Chair
8:30 a.m.	**Gary Kaplan, MD** Chairman and CEO, Virginia Mason Health System *Seeking Zero Defects: Creating a Patient Safety Culture*
9:30 a.m.	**Break**
9:45 a.m.	**Lisa Robin, MLA** Chief Advocacy Officer with Federation of State Medical Boards *Challenges to State Based Licensure*
10:45 a.m.	**Barbara Schneidman, MD, MPH** Clinical Professor of Psychiatry and Behavioral Sciences University of Washington *Sexual Boundary Violations and Board Diversity*
12:00 p.m. **Lunch Provided**	**Presentation: Margaret O'Kane, MHA** President, National Committee for Quality Assurance *Protecting Patients within and without Systems*
1:30 p.m.	**Networking Break**
2:00 p.m.	**Interactive Demonstration:** *Time Out*
2:45 p.m.	Breakout 1 1. **Stuart Freed, MD:** Chehalis A Chief Medical Officer, Wenatchee Valley Medical Center ***Systematic Approach to patients with Chronic Non-Malignant Pain*** 2. **Lisa Robin, MLA:** Chehalis B ***Legislative trends: State level and Federal***
3:30 p.m.	Breakout 2 1. **Stuart Freed, MD:** Chehalis A Chief Medical Officer, Wenatchee Valley Medical Center ***Systematic Approach to patients with Chronic Non-Malignant Pain*** 2. **Lisa Robin, MLA:** Chehalis B ***Legislative trends: State level and Federal***
4:15 p.m.	**Break**
4:25 p.m.	**Closing:** *Workshop Debriefing and Wrap-up*
FRIDAY – August 24, 2012- PPE, Rooms 152 and 153 – Closed Sessions	
8:00 a.m.-12:00 p.m.	Case Reviews

2012 Workshop Speakers

Jane C. Ballantyne, MD

Professor of Education and Research

University of Washington Medicine

Dr. Jane Ballantyne is the University of Washington Medicine Professor of Education and Research in the Department of Anesthesiology and Pain Medicine. Born in Bristol, United Kingdom, Dr. Ballantyne graduated with her medical degree from the Royal Free Hospital School of Medicine in London. She is a member of the Royal College of Surgeons for Otolaryngology and Anaesthesia. She is also a member of the Royal College of Anaesthetists. In 1997, she became a Diplomate of the American Board of Anesthesiology.

Stuart D. Freed, M.D.

Medical Director

Wenatchee Valley Medical Center

Stuart D. Freed, MD is the current Medical Director of Wenatchee Valley Medical Center. Dr. Freed attended Pacific Lutheran University for his undergraduate studies and received his medical degree from University of Washington in 1984. Dr. Freed completed his residency in 1987 at the University of Washington/Tacoma Family Medical Center and received his Board Certification from the American Board of Family Practice the same year. Dr. Freed specializes in Sports Medicine.

Karen A. Jensen, JD, MS

Assistant Secretary to the Department of Health

Health Systems Quality Assurance

Karen Jensen was appointed as an Assistant Secretary to the Department of Health in August 2008. She leads the Health Systems Quality Assurance Division. This is the department's largest division, with nearly 400 employees. Among other responsibilities, the division licenses more than 300,000 health professionals in Washington State. Karen began working with the department in May 2000 when she was still with the Attorney General's Office. Karen formally joined the department in 2004 and assumed responsibilities as one of the supervising staff attorneys in the division's Legal Service Unit. She worked most recently as the division's policy director and legislative coordinator. Karen has a Bachelor's degree and Master's degree in microbiology from Washington State University, as well as a Juris doctor from Seattle University.

Gary S. Kaplan, MD

Chairman and CEO

Virginia Mason Health System

Gary S. Kaplan, MD, FACP, FACMPE, FACPE, has served as chairman and CEO of the Virginia Mason Health System since 2000. He is a practicing Internal Medicine physician at Virginia Mason.

During Dr. Kaplan's tenure as chairman and CEO, Virginia Mason has received significant national and international recognition for its efforts to transform health care.

Dr. Kaplan received his medical degree from the University of Michigan and is board certified in internal medicine. He is a Fellow of the American College of Physicians (FACP), the American College of Medical Practice Executives (FACMPE) and the American College of Physician Executives (FACPE).

RADM Patrick O'Carroll, MD, MPH

Assistant Surgeon General, U.S. Public Health Service Regional Health Administrator, Region X, Seattle

States: Alaska, Idaho, Oregon, and Washington

RADM Patrick O'Carroll, a career Commissioned Officer in the U. S. Public Health Service (USPHS), has served as Regional Health Administrator for Region X since January 2003. As RHA, Dr. O'Carroll serves as the Region's senior physician and scientist representing the Assistant Secretary for Health, the Secretary, and the U.S. Department of Health and Human Services.

Margaret E. O'Kane, MHA

President

National Committee for Quality Assurance

Since 1990, Margaret E. O'Kane has served as President of the National Committee for Quality Assurance (NCQA), an independent, non-profit organization whose mission is to improve the quality of health care everywhere. Under her leadership, NCQA has developed broad support among the consumer, employer and health plan communities. About three-quarters of the nation's largest employers evaluate plans that serve their employees using Healthcare Effectiveness Data and Information Set (HEDIS®) data. In recent years, NCQA has received awards from the National Coalition for Cancer Survivorship, the American Diabetes Association and the American Pharmacists' Association. Ms. O'Kane began her career in health care as a respiratory therapist and went on to earn a master's degree in health administration and planning from the Johns Hopkins University.

Lisa A. Robin, MLA

Chief Advocacy Officer

Federation of State Medical Boards

For more than 17 years, Lisa Robin has been active in leading the Federation of State Medical Boards in developing and promulgating policy on a broad range of issues supporting state medical boards in their mission of public protection. Under her oversight, the FSMB has addressed the issues of physician impairment, telemedicine, pain management, scope of practice, professional conduct and ethics, Internet prescribing, the regulation of office-based surgery, and complementary and alternative medicine. Lisa established and currently leads the FSMB's Washington D.C. advocacy office.

Barbara S. Schneidman, MD, MPH

Clinical Professor of Psychiatry and Behavioral Sciences

University of Washington School of Medicine

Barbara S. Schneidman, MD, MPH was the Vice President of Medical Education at the American Medical Association from 2002-2008. Prior to this position she served as the Associate Vice President of the American Board of Medical Specialties (ABMS), from 1993-1998. During 2009 she served as the Interim CEO and President of the Federation of State Medical Boards.

Mary C. Selecky

Secretary of Health

Washington State

Mary C. Selecky has been Secretary of the Washington State Department of Health since March 1999, serving under Governor Chris Gregoire and former Governor Gary Locke. Prior to working for the state, Mary served for 20 years as administrator of the Northeast Tri-County Health District in Colville, Washington.

Jon V. Thomas, MD, MBA

President, Minnesota Board of Medical Practice

Chair-elect, Federation of State Medical Boards

After completing residency at Mayo Graduate School of Medicine in Otolaryngology-Head and Neck Surgery in 1993, Dr. Thomas joined a group of 3 Otolaryngologists in St. Paul, MN. Over the ensuing decade, the group of 3 has grown to a group of 21 through acquisition and merger. Since 2006, Dr. Thomas has served as President and CEO of the combined entity, Ear, Nose & Throat SpecialtyCare of Minnesota. In 2001 Dr. Thomas earned an MBA in Medical Group Management from the University of St. Thomas in St. Paul, MN.

Dennis C. Turk, PhD

John and Emma Bonica Professor of Anesthesiology and Pain Research

University of Washington

Dennis C. Turk, PhD, is the John and Emma Bonica Professor of Anesthesiology and Pain Research, Director of the Center for Pain Research on Impact, Measurement, & Effectiveness (C-PRIME) at the University of Washington, and a Special Government Employee within the US Food and Drug Administration. He is currently Editor-in-Chief of The Clinical Journal of Pain, Co-director of the Initiative on the Methods, Measurement, and Pain Assessment in Clinical Trials (IMMPACT), and Associate Director of the Analgesic, Anesthetic, and Abuse Clinical Trials Translations, Innovations, Opportunities, & Networks (ACTTION) and FDA-sponsored public-private partnership. His research has been funded continuously by NIH since 1977 and has been funded by the National Center for Health Statistics, the National Center for Medical Rehabilitation Research, as well as by a number of private companies and foundations. Dr. Turk has published over 500 journal articles and chapters in scholarly texts, and has written and edited 20 volumes, most recently, The Pain Survival Guide: How to Reclaim Your Life and Chronic Pain: An Integrated Biobehavioral Approach.

Appendix D: Demographics Report

Demographic Census Report

Allopathic Physicians and Physician Assistants

The Medical Quality Assurance Commission recognizes the value having accurate information on physicians and physician assistants licensed in Washington. In 2011, the Washington State legislature passed SB 5480 allowing the Medical Commission to collect demographic data for physicians and physician assistants.

The Medical Commission created an individualized demographic census for physicians and physician assistants. Each census includes questions on practice settings, medical specialty, and certifications. The Commission will share the demographic data with our state and federal partners as part of workforce planning efforts and minimum-data-set reporting requirements.

The Medical Commission began collecting data in March 2012 for physicians and in July 2012 for physician assistants. Currently, physicians and physician assistants receive the demographic census with their license renewal reminder. An on-line version of the census will be available in January 2013.

The Medical Commission also developed a Demographic Census Report for physicians and for physician assistants. These reports compile answers to the census questions and display the data using a variety of formats. The Physician Demographic Census Report for March 1, 2012 through November 30, 2012 is included for reference.

In Washington, physician and physician licenses are valid for 2 years. The Medical Commission will complete the first full cycle of data collection in March of 2014 for licensed physicians and July 2014 for licensed physician assistants.

Physicians Demographic Census Report

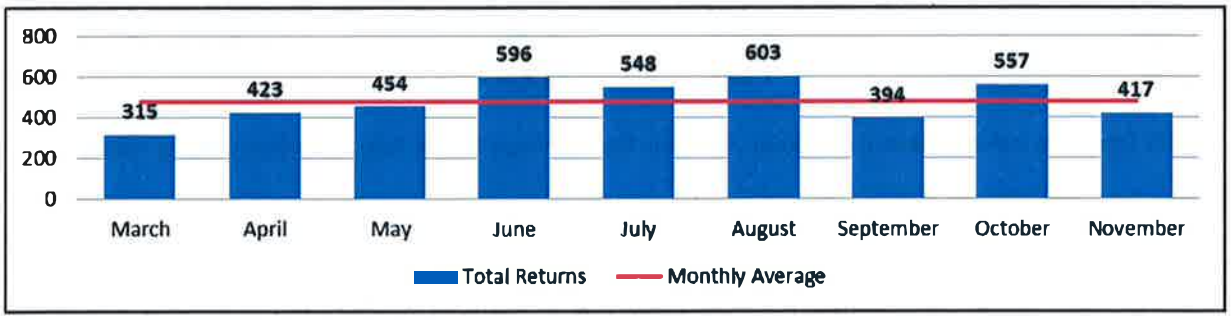
I – Physician Information

Census start date:	**3/1/2012**	**Created on:**	**12/3/2012**
Census end date:	**11/30/2012**	**Total returns:**	**4,307**

Gender			**Status**		
Male	2,987	69.4%	Retired	145	3.4%
Female	1,320	30.6%	Retired Active	48	1.1%

Date of Birth	Total	Percentage	Male	Male %	Female	Female %
1900-1945	600	13.93%	543	90.50%	57	9.50%
1946-1964	2,408	55.91%	1,735	72.05%	672	27.91%
1965-1982	1,296	30.09%	707	54.55%	589	45.45%
1983-2001	3	0.07%	1	33.33%	2	66.67%

Number of Census Forms Returned by Month and the Average:



6. In what US state or foreign country did you obtain your physicians degree?

Washington State:	686	15.93%
Other US State:	2,833	65.78%
US Territories*:	5	0.12%
Unknown US:	147	3.41%
Foreign Country:	591	13.72%
Unknown:	45	1.04%

7a. Do you currently reside in Washington State?

Yes	3,283	76.2%
No	1,024	23.8%

7c. Home State if not Washington:

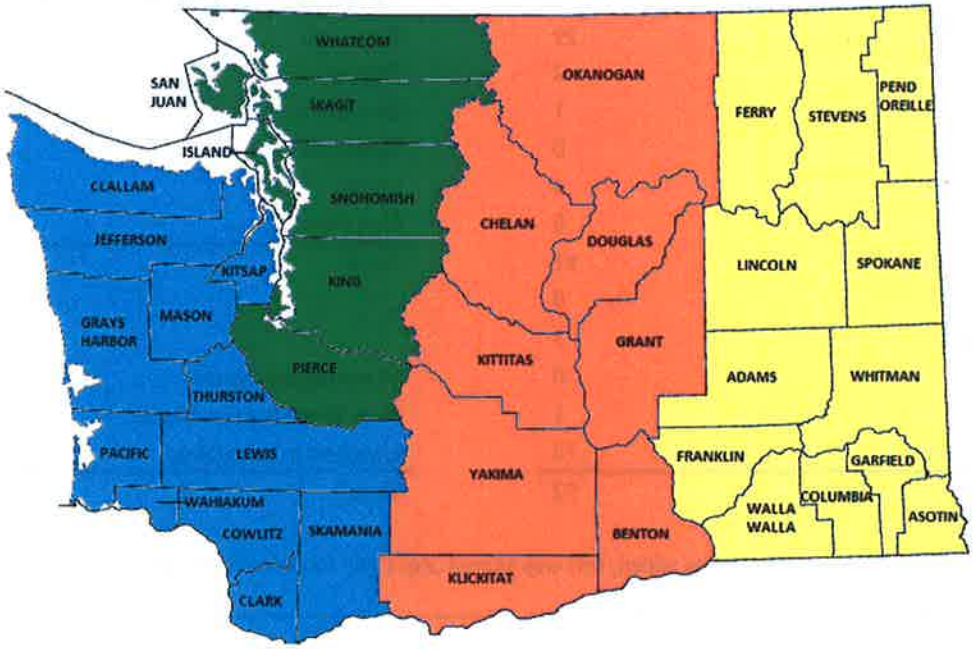
Alabama	12	Illinois	10	Montana	11	Rhode Island	0
Alaska	11	Indiana	6	Nebraska	5	South Carolina	2
Arizona	34	Iowa	6	Nevada	11	South Dakota	1
Arkansas	1	Kansas	4	New Hampshire	0	Tennessee	11
California	155	Kentucky	6	New Jersey	6	Texas	50
Colorado	13	Louisiana	2	New Mexico	5	Utah	8
Connecticut	2	Maine	1	New York	15	Vermont	1
Delaware	0	Maryland	8	North Carolina	11	Virginia	11
District of Col.	4	Massachusetts	7	North Dakota	5	West Virginia	1
Florida	32	Michigan	8	Ohio	13	Wisconsin	16
Georgia	7	Minnesota	9	Oklahoma	7	Wyoming	2
Hawaii	15	Mississippi	2	Oregon	274	British Columbia	8
Idaho	46	Missouri	9	Pennsylvania	11	Other foreign	39

8a. Do you currently practice in Washington State?

Yes	3,283	76.2%
No	1,024	23.8%

*US Territories include: Puerto Rico, Guam, American Samoa, Virgin Islands (US), and minor outlying islands

9a. Primary Site Zip (Note: some zip codes cross county lines)



Northwest Washington	
Island	20
King	1,359
Pierce	312
San Juan	5
Skagit	60
Snohomish	209
Whatcom	92
Total	2,057

Central Washington	
Benton	74
Chelan	47
Douglas	1
Grant	9
Kittitas	5
Klickitat	3
Okanogan	17
Yakima	74
Total	230

Southwest Washington	
Clallam	35
Clark	192
Cowlitz	37
Grays Harbor	15
Jefferson	10
Kitsap	88
Lewis	20
Mason	13
Pacific	4
Skamania	0
Thurston	121
Wahkiakum	0

Eastern Washington	
Adams	3
Asotin	9
Columbia	1
Ferry	1
Franklin	17
Garfield	0
Lincoln	3
Pend Oreille	1
Spokane	261
Stevens	8
Walla Walla	37
Whitman	14

Total	535
Oregon Border Counties	
Clackamas	29
Clatsop	2
Columbia	1
Gilliam	0
Hood River	4
Morrow	0
Multnomah	81
Sherman	0
Umatilla	3
Wallowa	0
Wasco	1
Washington	32
Total	92

Total	355
Idaho Border Counties	
Benewah	0
Bonner	3
Boundary	0
Kootenai	14
Latah	4
Nez Perce	10
Total	31
Washington State:	3,177
Non Washington State:	774
Unknown Location:	356
Total:	4,307

Map Source: Census.wa.gov. Color was added, text was altered. Zip Code source: altiusdirectory.com

10a1. Have you completed a residency accredited by ACGME?

Yes	3,951	91.7%
No	356	8.3%

10a2. Residency Specialty

Allergy and Immunology	2
Anesthesiology	283
Colon and Rectal Surgery	0
Dermatology	51
Emergency Medicine	136
Family Medicine	637
Internal Medicine	864
Medical Genetics	2
Neurological Surgery	24
Neurology	71
None Listed	391
Nuclear Medicine	2
Obstetrics and Gynecology	163
Ophthalmology	104
Orthopaedic Surgery	147
Otolaryngology	37
Pathology - Anatomic/Clinical	115
Pediatrics	364
Physical Medicine and Rehab.	64
Plastic Surgery	26
Preventative Medicine	31
Psychiatry	232
Radiation Oncology	30
Radiology-Diagnostic	281
Surgery	188
Thoracic Surgery	10
Urology	52
Total:	**4,307**

10b1. Board Certified by ABMS?

Yes	3,887	90.2%
No	420	9.8%

10b2. ABMS Specialty

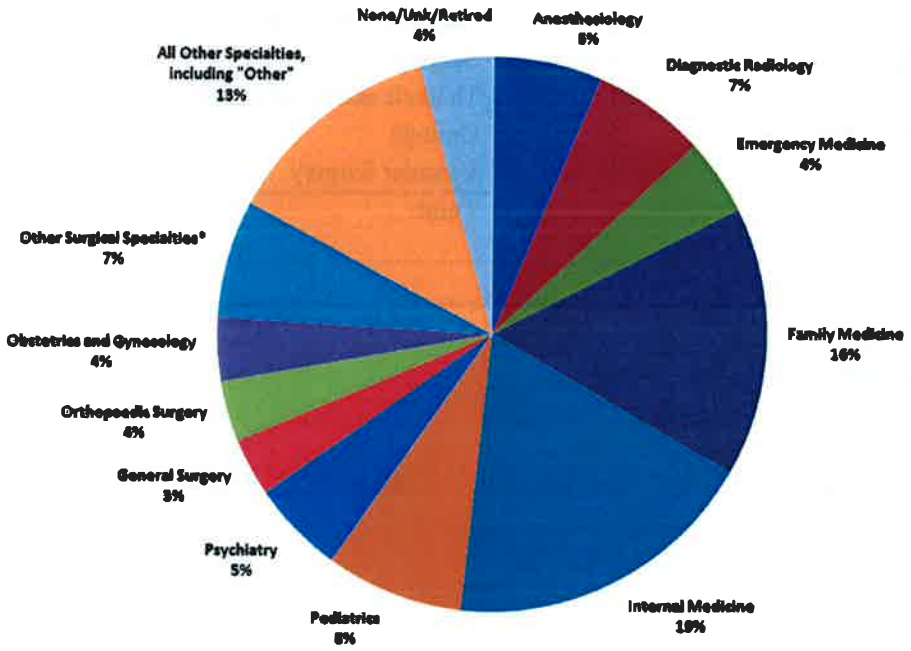
Aerospace Medicine	3	Obstetrics and Gynecology	161
Allergy and Immunology	6	Occupational Medicine	9
Anesthesiology	272	Ophthalmology	102
Clinical Biochemical Genetics	0	Orthopaedic Surgery	149
Clinical Cytogenetics	1	Otolaryngology	36
Clinical Genetics	3	Pathology - Anatomic/Clinical	99
Clinical Molecular Genetics	0	Pathology - Anatomic	5
Colon and Rectal Surgery	0	Pathology - Clinical	5
Dermatology	54	Pediatrics	350
Diagnostic Radiology	294	Physical Medicine and Rehab.	59
Emergency Medicine	172	Plastic Surgery	31
Family Medicine	625	Psychiatry	198
Internal Medicine	865	Public Health and Gen. Prev. Med.	25
Medical Physics	0	Radiation Oncology	28
Neurological Surgery	29	Surgery	153
Neurology	61	Thoracic and Cardiac Surgery	17
Neurology-Qualif. in Child Neur.	1	Urology	53
None Listed	434	Vascular Surgery	6
Nuclear Medicine	1	**Total:**	**4,307**

10b4. Other Certification:

Yes	73	1.7%
No	4,234	98.3%

11a. What is your current area of practice?

Aerospace Medicine	2	Occupational Medicine	22
Allergy and Immunology	12	Ophthalmology	109
Anesthesiology	274	Orthopaedic Surgery	151
Clinical Biochemical Genetics	0	Other (e.g. Hospitalist)	151
Clinical Cytogenetics	1	Otolaryngology	37
Clinical Genetics	2	Pathology - Anatomic	7
Clinical Molecular Genetics	1	Pathology - Clinical	5
Colon and Rectal Surgery	3	Pathology - Anatomic/Clinical	96
Dermatology	58	Pediatrics	349
Diagnostic Radiology	288	Physical Medicine and Rehab.	65
Emergency Medicine	193	Plastic Surgery	33
Family Medicine	677	Psychiatry	236
Internal Medicine	796	Public Health and Gen. Prev. Med.	28
Medical Physics	0	Radiation Oncology	31
Neurological Surgery	26	Surgery (General)	146
Neurology	68	Thoracic and Cardiac Surgery	24
Neurology-Qualif. in Child Neur.	1	Urology	56
None/Unknown/Retired	187	Vascular Surgery	11
Nuclear Medicine	1	**Total:**	**4,307**
Obstetrics and Gynecology	160		



*Other Surgical Specialties includes: Colon and Rectal Surgery, Neurosurgery, Ophthalmology, Otolaryngology, Urology, Plastic Surgery, Thoracic and Cardiac Surgery, and Vascular Surgery.

II – Practice Information

12a. For patient related activities, indicate your applicable practice arrangement/size of group

Practice Arrangement	Group size	Percentage
Solo Practitioner:	568	13.2%
Single Specialty Group:	1,115	25.9%
Multi-Specialty Group:	815	18.9%
Employee of Hospital or Clinic:	866	20.1%
State or Federal Employer:	385	8.9%
Other:	558	13.0%
Total:	4,307	100.0%

12b. Single Specialty Size of Group

Size of group	Number	Percentage
1-10	500	55.6%
11-25	203	22.6%
26-50	117	13.0%
51-100	62	6.9%
100+	18	2.0%

12c. Multi-Specialty Size of Group

Size of group	Number	Percentage
1-100	220	41.8%
101-500	224	42.6%
501-1,000	64	12.2%
1,000+	18	3.4%

13a-13c. Is your clinical practice primarily:

Clinical Practice	Number	Percentage
Office based:	1,814	42.1%
Hospital based:	1,074	24.9%
Both:	960	22.3%
Neither:	343	8.0%
Unknown	116	2.7%

14a. Do you practice Telehealth/Telemedicine?

Answer	Number	Percentage
Yes	407	9.4%
No	3,900	90.6%

14c. Hours per week in this setting:

Hours	Number	Percentage
<30*	242	82.3%
31-40	29	9.9%
40+	23	7.8%

15a. Do you have hospital clinical privileges?

Answer	Number	Percentage
Yes	3,212	74.6%
No	1,095	25.4%

15b. Hospital privileges outside HAC system?

Yes: 1,065

16a-16f. In a typical work week, indicate the number of hours dedicated to:

Hours	<10*	11-20	21-35	36-45	46-60	60+	Avg Hrs*
Clinical:	307	397	804	1,141	934	225	38.5
Research:	481	93	72	46	29	4	13.5
Administrative:	1,839	206	91	64	29	1	8.3
Education:	1,366	112	28	13	7	1	6.1
Volunteering:	484	19	4	2	2	4	5.4
Other:	140	33	18	15	4	4	14.3
Total weekly hrs:	120	135	333	810	923	489	47.1

*Does not include zero hours

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17. Approximately how many weeks did you work as a physician during the last 12 months?

Weeks	Number	Percentage
<30*	395	9.2%
31-39	140	3.3%
40-47	1,216	28.2%
48-52	2,267	52.6%
Unk or zero	289	6.7%

18. Do you perform office based surgery requiring more than minimal local anesthesia in your practice?

Answer	Number	Percentage
Yes	180	4.2%
No	4,127	95.8%

19a. Do you prescribe opioids for patients with chronic non-cancer pain?

Answer	Number	Percentage
Yes	1,385	32.2%
No	2,922	67.8%

19b. If Yes, # of Patients?

Patients	Number	Percentage
1-10	488	44.4%
11-20	226	20.6%
21-50	217	19.7%
51-100	93	8.5%
101-250	47	4.3%
250+	28	2.5%

*Does not include "0"

20a. Do you practice nontraditional medicine?

Answer	Number	Percentage
Yes	92	2.1%
No	4,215	97.9%

21a-21e. What languages besides English are spoken at your practice?

Language indicated on the census	Total number of forms	Percentage of all languages	Percentage of total forms
Spanish	1,144	41.92%	27%
Russian	362	13.26%	8%
Korean	198	7.26%	5%
French	196	7.18%	5%
Mandarin Chinese	314	11.51%	7%
Other Language(s)	515	18.87%	12%
Do Not Know	209	n/a	5%

Number of forms where any language was entered:*

Number of forms: 1,392
Percentage: 32.32%

*Does not include "Do Not Know"

Physician Primary Area of Practice by County - Northwest Washington

	Island	King	Pierce	San Juan	Skagit	Snohomish	Whatcom	Total
Aerospace Medicine								**0**
Allergy and Immunology		7				2		**9**
Anesthesiology	1	78	22	1	3	13	5	**123**
Clinical Biochemical Genetics								**0**
Clinical Cytogenetics		1						**1**
Clinical Genetics		2						**2**
Clinical Molecular Genetics								**0**
Colon and Rectal Surgery		2	1					**3**
Dermatology		27			1	4	2	**34**
Diagnostic Radiology	1	57	19		3	18	1	**99**
Emergency Medicine	1	36	21		6	13	1	**78**
Family Medicine	4	187	49	4	15	49	29	**337**
Internal Medicine	2	294	48		11	32	20	**407**
Medical Physics								**0**
Neurological Surgery		10	1			2		**13**
Neurology		24	5			5	3	**37**
Neurology-Qualif. in Child Neur.		1						**1**
Nuclear Medicine		1						**1**
Obstetrics and Gynecology	1	58	9		2	2	7	**79**
Occupational Medicine		6	1			1		**8**
Ophthalmology		26	5		2	9	2	**44**
Orthopaedic Surgery	1	49	19		3	10	3	**85**
Otolaryngology		16	2		1	2		**21**
Pathology - Anatomic		4				1		**5**
Pathology - Clinical		3						**3**
Pathology - Anatomic/Clinical		32	6			3	2	**43**
Pediatrics	3	147	35		2	10	5	**202**
Physical Medicine and Rehab.		28	4			2	1	**35**
Plastic Surgery	1	13	3				3	**20**
Psychiatry		103	21		2	7	4	**137**
Public Health/Gen. Prev. Med.		9	4			1		**14**
Radiation Oncology		8	3		1	1	1	**14**
Surgery		47	11		1	5	1	**65**
Thoracic and Cardiac Surgery	1	8				1	2	**12**
Urology		16	5		3	3		**27**
Vascular Surgery		5				1		**6**
Other (e.g. Hospitalist, Admin)	3	40	15		4	9		**71**
None Listed or Unknown	1	14	3			3		**21**
Total:	**20**	**1359**	**312**	**5**	**60**	**209**	**92**	**2057**

Physician Primary Area of Practice by County - Southwest Washington

	Clallam	Clark	Cowlitz	Grays Harbor	Jefferson	Kitsap	Lewis	Mason	Pacific	Skamania	Thurston	Wahkiakum	Total
Aerospace Medicine											1		**1**
Allergy and Immunology													**0**
Anesthesiology	2	12	2	1		9	1				6		**33**
Clinical Biochemical Genetics													**0**
Clinical Cytogenetics													**0**
Clinical Genetics													**0**
Clinical Molecular Genetics													**0**
Colon and Rectal Surgery													**0**
Dermatology	2	2									1		**5**
Diagnostic Radiology		13	2			6	2		1		8		**32**
Emergency Medicine	1	8	1			6	3	4	2		5		**30**
Family Medicine	11	32	7	5	2	18	4	6	1		29		**115**
Internal Medicine	5	49	11	3	2	21	1				27		**119**
Medical Physics													**0**
Neurological Surgery		2											**2**
Neurology		2									2		**4**
Neurology-Qualif. in Child Neur.													**0**
Nuclear Medicine													**0**
Obstetrics and Gynecology		15	2			1					6		**24**
Occupational Medicine											1		**1**
Ophthalmology	2	8		1		2	3				1		**17**
Orthopaedic Surgery	4	1	1		1	4					4		**15**
Otolaryngology			1			1					1		**3**
Pathology - Anatomic													**0**
Pathology - Clinical													**0**
Pathology - Anatomic/Clinical	1	6	3			2					1		**13**
Pediatrics	2	19	2			7	3	1			5		**39**
Physical Medicine and Rehab.		1	1			2					1		**5**
Plastic Surgery		1									1		**2**
Psychiatry	1	6	2		2	5					6		**22**
Public Health/Gen. Prev. Med.						1	1						**2**
Radiation Oncology	1	1									1		**3**
Surgery	1	5	2	3	1	1					5		**18**
Thoracic and Cardiac Surgery													**0**
Urology	1	2					1				2		**6**
Vascular Surgery						1					1		**2**
Other (e.g. Hospitalist, Admin)	1	7		2	2	1					3		**16**
None Listed or Unknown							1	2			3		**6**
Total:	**35**	**192**	**37**	**15**	**10**	**88**	**20**	**13**	**4**	**0**	**121**	**0**	**535**

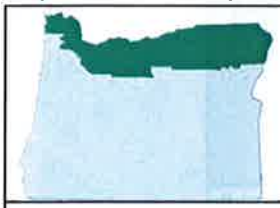
Physician Primary Area of Practice by County - Central Washington

	Benton	Chelan	Douglas	Grant	Kittitas	Klickitat	Okanogan	Yakima	Total
Aerospace Medicine									**0**
Allergy and Immunology	1			1					**2**
Anesthesiology	9	2						5	**16**
Clinical Biochemical Genetics									**0**
Clinical Cytogenetics									**0**
Clinical Genetics									**0**
Clinical Molecular Genetics									**0**
Colon and Rectal Surgery									**0**
Dermatology									**0**
Diagnostic Radiology	4	1				1			**6**
Emergency Medicine	3	3		1			1	1	**9**
Family Medicine	15	6	1	2	2	1	10	17	**54**
Internal Medicine	17	14		2	1	1	1	19	**55**
Medical Physics									**0**
Neurological Surgery									**0**
Neurology		1						1	**2**
Neurology-Qualif. in Child Neur.									**0**
Nuclear Medicine									**0**
Obstetrics and Gynecology	1	2					2	6	**11**
Occupational Medicine	3	1						2	**6**
Ophthalmology	4	2						2	**8**
Orthopaedic Surgery	3	1						3	**7**
Otolaryngology									**0**
Pathology - Anatomic		1							**1**
Pathology - Clinical									**0**
Pathology - Anatomic/Clinical		1						1	**2**
Pediatrics	4	3		1	1		1	8	**18**
Physical Medicine and Rehab.	1	1						1	**3**
Plastic Surgery	1								**1**
Psychiatry	1	1						2	**4**
Public Health/Gen. Prev. Med.									**0**
Radiation Oncology		1							**1**
Surgery	3	3		1	1		1		**9**
Thoracic and Cardiac Surgery									**0**
Urology	1	1						1	**3**
Vascular Surgery									**0**
Other (e.g. Hospitalist, Admin)	3	1		1				5	**10**
None Listed or Unknown		1					1		**2**
Total:	**74**	**47**	**1**	**9**	**5**	**3**	**17**	**74**	**230**

Physician Primary Area of Practice by County - Eastern Washington

	Adams	Asotin	Columbia	Ferry	Franklin	Garfield	Lincoln	Pend Oreille	Spokane	Stevens	Walla Walla	Whitman	Total
Aerospace Medicine													**0**
Allergy and Immunology													**0**
Anesthesiology		1							16		2		**19**
Clinical Biochemical Genetics													**0**
Clinical Cytogenetics													**0**
Clinical Genetics													**0**
Clinical Molecular Genetics													**0**
Colon and Rectal Surgery													**0**
Dermatology									6		1		**7**
Diagnostic Radiology		1							22		2		**25**
Emergency Medicine			1		4				10		2	2	**19**
Family Medicine	2	1		1	4		3	1	44	5	9	6	**76**
Internal Medicine		3			2				48	2	6	2	**63**
Medical Physics													**0**
Neurological Surgery									2				**2**
Neurology									4		2		**6**
Neurology-Qualif. in Child Neur.													**0**
Nuclear Medicine													**0**
Obstetrics and Gynecology		1			2				13		2	1	**19**
Occupational Medicine					1				1				**2**
Ophthalmology									9				**9**
Orthopaedic Surgery		1							11		3		**15**
Otolaryngology									3				**3**
Pathology - Anatomic													**0**
Pathology - Clinical													**0**
Pathology - Anatomic/Clinical		1							4				**5**
Pediatrics									19	1	1	2	**23**
Physical Medicine and Rehab.					1				6		1		**8**
Plastic Surgery									3				**3**
Psychiatry					1				11		1		**13**
Public Health/Gen. Prev. Med.	1								2		1		**4**
Radiation Oncology									2		1		**3**
Surgery									7		1		**8**
Thoracic and Cardiac Surgery									3				**3**
Urology									1		1	1	**3**
Vascular Surgery													**0**
Other (e.g. Hospitalist, Admin)					1				8		1		**10**
None Listed or Unknown					1				6				**7**
Total:	**3**	**9**	**1**	**1**	**17**	**0**	**3**	**1**	**261**	**8**	**37**	**14**	**355**

Physician Primary Area of Practice by County - Oregon Border

	Clackamas	Clatsop	Columbia	Gilliam	Hood River	Morrow	Multnomah	Sherman	Umatilla	Wallowa	Wasco	Washington	Total
Aerospace Medicine													**0**
Allergy and Immunology													**0**
Anesthesiology	1						9					2	**12**
Clinical Biochemical Genetics													**0**
Clinical Cytogenetics													**0**
Clinical Genetics													**0**
Clinical Molecular Genetics													**0**
Colon and Rectal Surgery													**0**
Dermatology	1											2	**3**
Diagnostic Radiology	4						8		1		1	1	**15**
Emergency Medicine							4						**4**
Family Medicine	1	1			1		2					5	**10**
Internal Medicine	8	1					13		1			3	**26**
Medical Physics													**0**
Neurological Surgery													**0**
Neurology	1											3	**4**
Neurology-Qualif. in Child Neur.													**0**
Nuclear Medicine													**0**
Obstetrics and Gynecology							2					3	**5**
Occupational Medicine					1							1	**2**
Ophthalmology	3						8						**11**
Orthopaedic Surgery	2		1				1					2	**6**
Otolaryngology	1											1	**2**
Pathology - Anatomic													**0**
Pathology - Clinical													**0**
Pathology - Anatomic/Clinical							3						**3**
Pediatrics	3						10					2	**15**
Physical Medicine and Rehab.					1		3						**4**
Plastic Surgery													**0**
Psychiatry	2				1		3					3	**9**
Public Health/Gen. Prev. Med.							1						**1**
Radiation Oncology							2						**2**
Surgery	1						4					3	**8**
Thoracic and Cardiac Surgery							1						**1**
Urology	1						1		1				**3**
Vascular Surgery							1						**1**
Other (e.g. Hospitalist, Admin)							2						**2**
None Listed or Unknown							3					1	**4**
Total:	**29**	**2**	**1**	**0**	**4**	**0**	**81**	**0**	**3**	**0**	**1**	**32**	**153**

Physician Primary Area of Practice by County - Idaho Border

	Benewah	Bonner	Boundary	Kootenai	Latah	Nez Perce	Total
Aerospace Medicine							**0**
Allergy and Immunology							**0**
Anesthesiology						1	**1**
Clinical Biochemical Genetics							**0**
Clinical Cytogenetics							**0**
Clinical Genetics							**0**
Clinical Molecular Genetics							**0**
Colon and Rectal Surgery							**0**
Dermatology					1		**1**
Diagnostic Radiology							**0**
Emergency Medicine		1		1			**2**
Family Medicine				2	1		**3**
Internal Medicine		1		5	1	4	**11**
Medical Physics							**0**
Neurological Surgery						1	**1**
Neurology							**0**
Neurology-Qualif. in Child Neur.							**0**
Nuclear Medicine							**0**
Obstetrics and Gynecology		1					**1**
Occupational Medicine							**0**
Ophthalmology							**0**
Orthopaedic Surgery				1			**1**
Otolaryngology						1	**1**
Pathology - Anatomic							**0**
Pathology - Clinical							**0**
Pathology - Anatomic/Clinical							**0**
Pediatrics					1		**1**
Physical Medicine and Rehab.							**0**
Plastic Surgery						1	**1**
Psychiatry				2			**2**
Public Health/Gen. Prev. Med.							**0**
Radiation Oncology				1			**1**
Surgery							**0**
Thoracic and Cardiac Surgery				1			**1**
Urology						2	**2**
Vascular Surgery							**0**
Other (e.g. Hospitalist, Admin)				1			**1**
None Listed or Unknown							**0**
Total:	**0**	**3**	**0**	**14**	**4**	**10**	**31**

Secondary contact via email

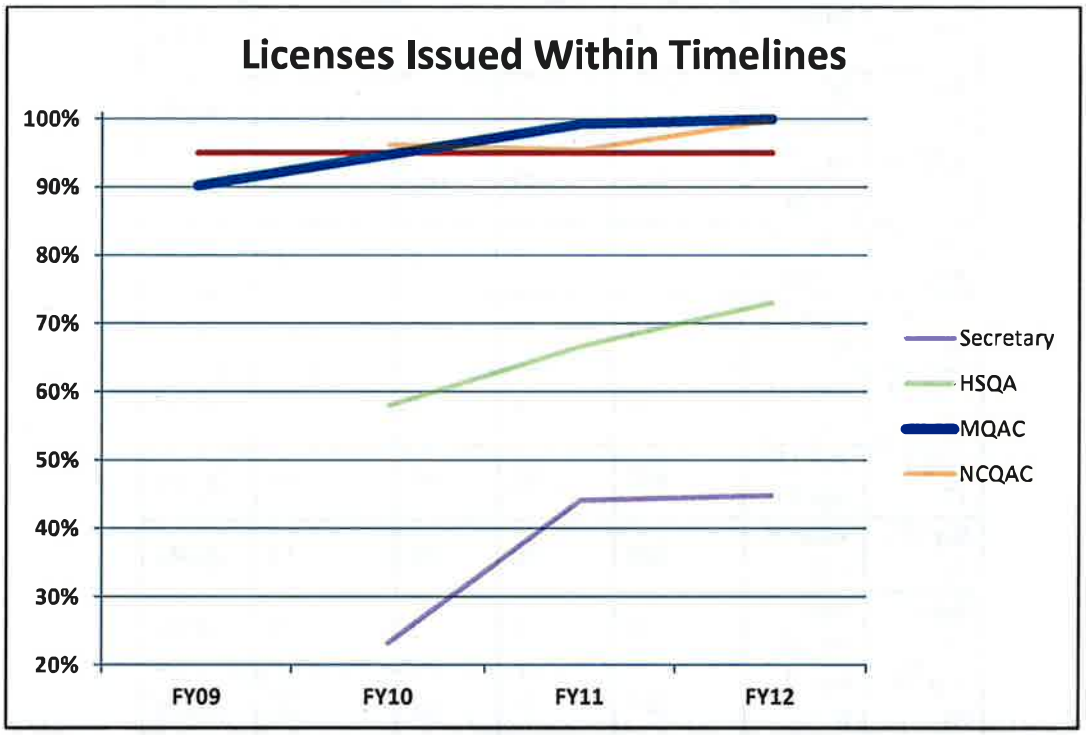
Week the census was emailed	License renewal print dates	Active with no census returned	With email address	Total emails sent	Total responses	Return rate
June 18-22	March 19-30	289	167	22	9	40.9%
June 25-29	April 9-May 3	494	172	46	6	13.0%
July 2-6	May 7-11	0	8	7	1	14.3%
July 9-13	May 14-18	0	5	5	2	40.0%
July 16-27	May 21-25	487	127	102	24	23.5%
July 30-Aug 3	May 29 - June 1	0	2	1	0	0.0%
Aug 6-10	June 4 - 8	213	73	62	12	19.4%
Aug 13-17	June 11 - 15	0	3	1	0	0.0%
Aug 13-17	Feb 15 - Apr 17	987	223	182	47	25.8%
Sep 10-14	June 18 - 22	228	80	68	14	20.6%
Sep 17-21	June 25- 29	0	2	2	0	0.0%
Sep 24-28	July 2 - 6	254	74	64	27	42.2%
Oct 8-12	July 16-20	265	75	68	10	14.7%
Oct 29-Nov 2	July 30 - Aug 3	224	88	77	14	18.2%
Totals:		**3166**	**972**	**707**	**166**	**23.48%**

Practitioners that did not return a census form and have a listed email address are contacted. They are provided with a PDF copy of the census to complete. Secondary contact email messages are sent approximately four weeks after their license is renewed.

Response rate increase: 3.81%

Appendix E: Performance Measures Defined

The licensing of allopathic physicians and physician assistants is a complex and specialized process, requiring interaction with entities all over the world and many primary source documents sent directly to Commission staff for review and verification. This measure tracks how quickly the credentialing unit of the Commission issues licenses on applications considered complete and ready for review. Due to a change in the licensing database in 2008, the only available data is from fiscal year 2009 forward. The target for this measure is 95 percent. Since the start of the pilot in fiscal year 2009, the Commission has maintained a performance of 99 percent or better in this measure.

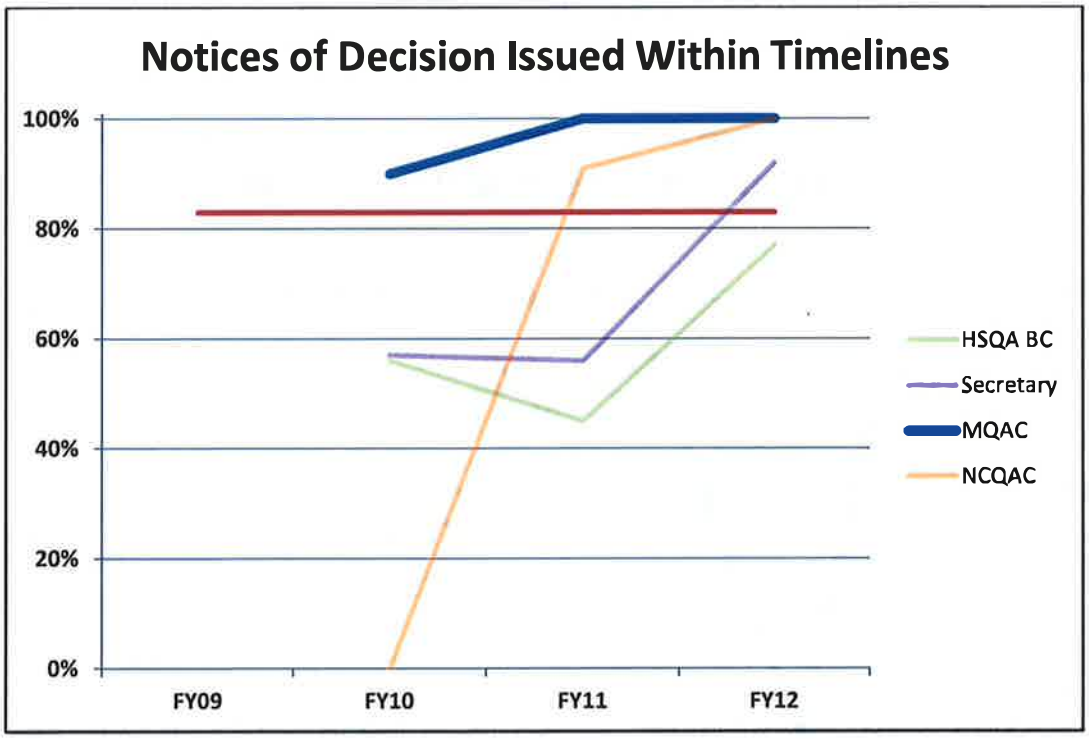


Measure 1.1: Health care credentials issued within 14 days of receiving all documents.

COMPARISON GROUP	FY 2010		FY 2011		FY 2012	
	Credentials Issued	% in timelines	Credentials Issued	% in timelines	Credentials Issued	% in timelines
MQAC	2,135	95%	2,266	99%	2,203	100%
NQAC	7,612	96%	9,080	95%	12,354	100%
Other HSQA Boards and Commissions	9,400	58%	7,053	67%	6,102	73%
HSQA Secretary Professions	33,976	23%	20,568	44%	17,831	45%

Table 1.1 Number and annual percentage of credentials issued meeting Performance Measure 1.1

The Medical Commission licenses the majority of applicants without issue or delay. However, if an applicant does not meet the requirements or has a history of unprofessional conduct or impairment, the Commission must decide whether to approve, deny, or grant the license with conditions. Once this decision is made the applicant must be notified within 30 days. The Commission has maintained a 100 percent performance for the past two years in this measure.



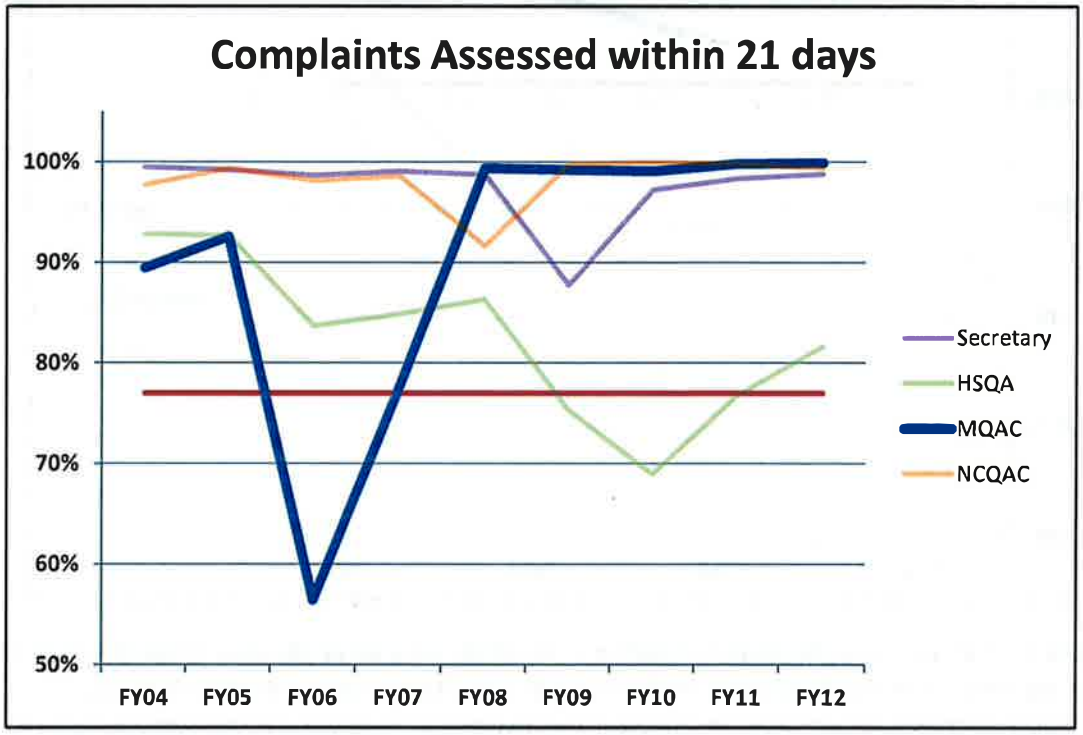
Measure 1.2: Percent of applications in which a notice of decision on application is issued within 30 days of the decision of the disciplinary authority to deny the license or grant with conditions.

COMPARISON GROUP	FY 2010		FY 2011		FY 2012	
	NOD Issued	% in timelines	NOD Issued	% in timelines	NOD Issued	% in timelines
MQAC	10	90%	8	100%	2	100%
NQAC	1	0%	11	91%	25	100%
Other HSQA Boards and Commissions	34	56%	56	45%	69	77%
HSQA Secretary Professions	267	57%	263	56%	157	92%

Table 1.2 Number of notices of decision (NODs) issued in fiscal years 2010, 2011 and 2012 and percent issues within 30 days meeting Performance Measure 2.1.

Commission staff enters each complaint into the licensing database, summarizes the complaint, and places it into an electronic packet in preparation for the weekly case management team (CMT) meeting. At the weekly CMT meeting a panel of four Commission members assess each complaint and vote to close or authorize an investigation. The performance target for this measure is 77 percent.

Since the pilot began the Commission meets the timeline 99 to 100 percent of the time. The Medical Commission's high performance is due to regaining the complaint intake functions when the pilot began in 2008. Since that time, the Medical Commission has consistently maintained a performance of 99 percent or better in this measure.

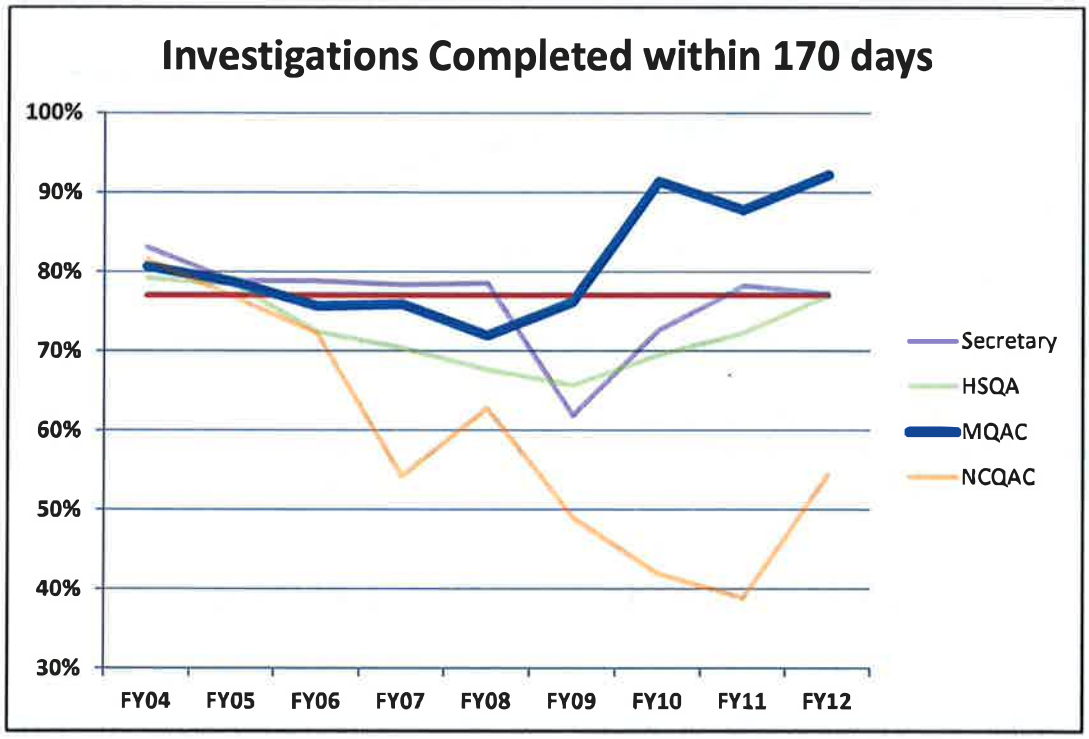


Measure 2.1-Percent of cases in which the intake and assessment steps are completed within 21 days.

Intake & Assessment Steps Completed within 21 Days	MQAC	NCQAC	Other HSQA Boards / Commissions	Secretary Professions
Pre-Pilot Performance (FY 2004-2008)	83.1%	97.1%	88.1%	99.0%
Pilot Period Performance (FY 2009-2012)	99.5%	99.8%	76.1%	95.5%

Table 2.1 -Percent of cases in which the intake and assessment steps are completed within 21 days during fiscal years 2004 through 2012.

The Medical Commission authorizes an investigation in approximately 70 percent of complaints. The Commission staff has 170 days to investigate the complaint and deliver the results to the Reviewing Commission Member (RCM). The RCM presents the investigations to the Commission. The Commission then decides the case and votes to close or take disciplinary action. The performance target for this measure is 77 percent. With the start of the pilot in fiscal 2009, the Commission immediately increased its performance. In fiscal year 2012 the Commission completed 92 percent of its cases within timelines.

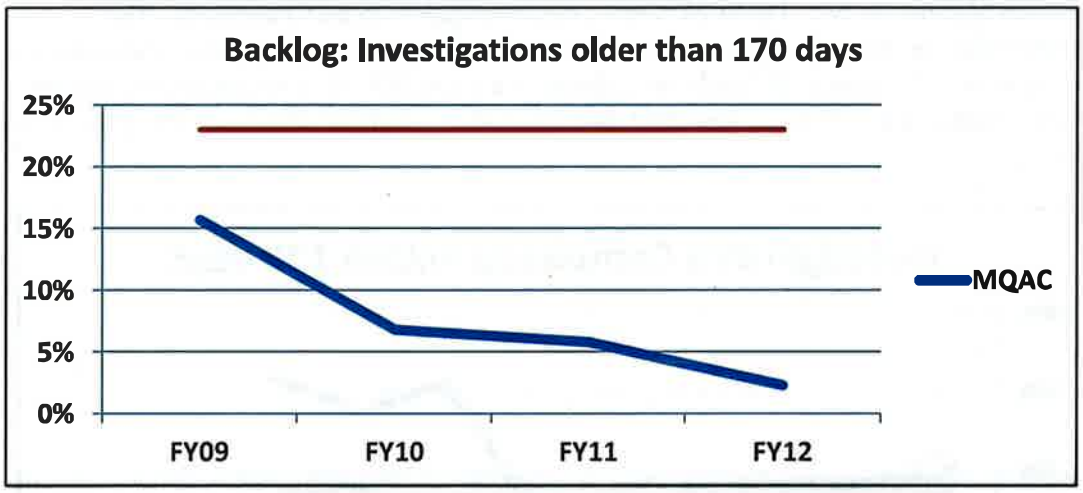


Measure 2.2-Percent of cases in which the investigation step is completed within 170 days.

Investigation Step Completed within 170 Days	MQAC	NCQAC	Other HSQA Boards / Commissions	Secretary Professions
Pre-pilot Performance (FY 2004-2008)	76.6%	69.5%	73.6%	79.5%
Pilot Period Performance (FY 2009-2012)	86.9%	45.9%	71.5%	71.7%

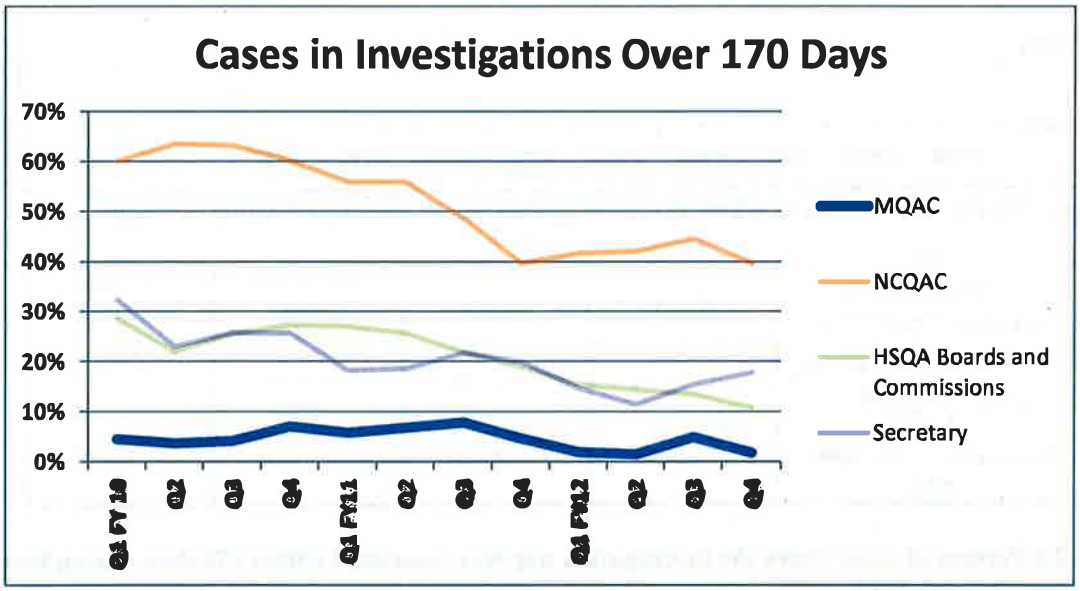
Table 2.2 Percent of cases where the investigation step was completed within 170 days during fiscal years 2004 through 2012.

This measure tracks the progress the Medical Commission makes in reducing its backlog in the investigation step. The performance target for this measure is 23 percent.



Measure 2.4: Percent of open cases currently in the investigation step that are over 170 days.

The Commission dramatically reduced the investigations backlog in the first year of the pilot and effectively eliminated it by the end of fiscal year 2011. This improvement is due to specialized training, direct management, and focused investigations.

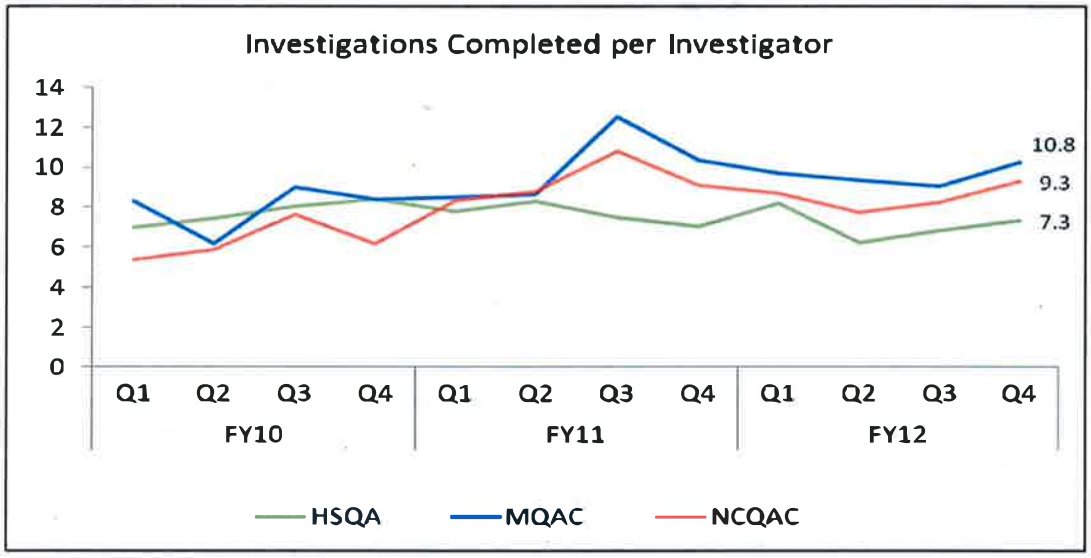


Measure 2.4: Percent of open cases currently in the investigation step that are over 170 days.

Investigation Step Exceeded 170 Days	MQAC	NCQAC	Other HSQA Boards / Commissions	Secretary Professions
FY 2010 Performance	4.9%	61.8%	25.9%	26.7%
FY 2011 Performance	6.3%	50.0%	23.4%	19.6%
FY 2012 Performance	2.5%	42.0%	13.5%	14.8%

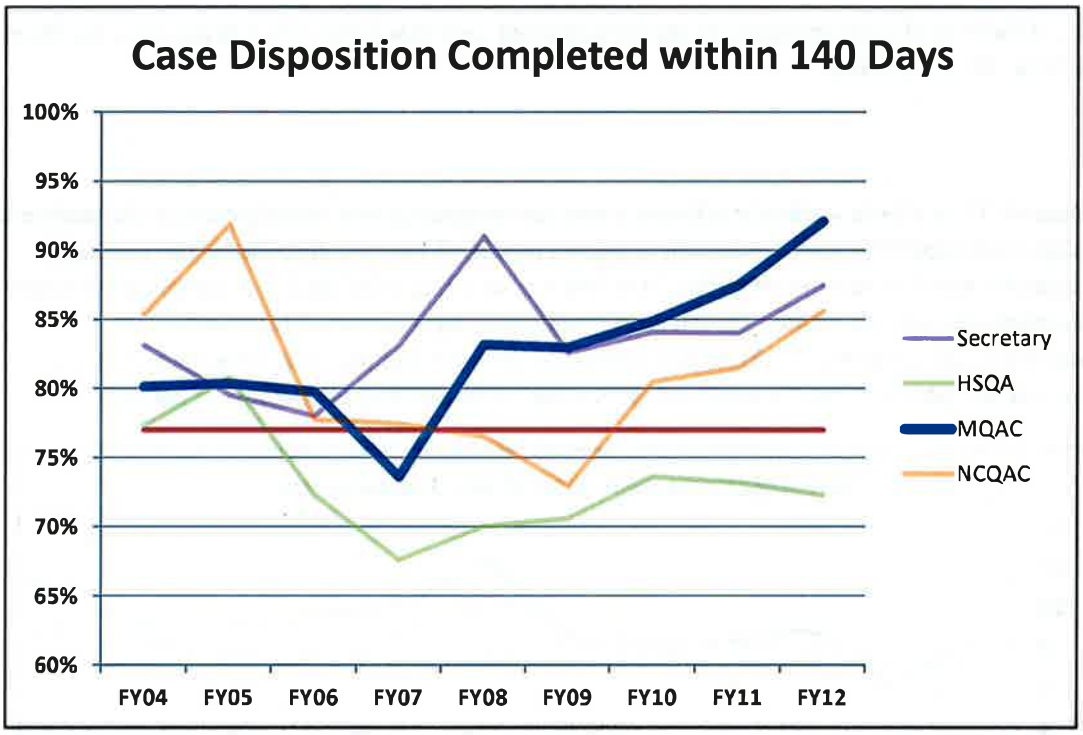
Table 2.4 Percent of open currently in the investigation step that were over 170 days during fiscal years 2010, 2011, and 2012.

Measure 3.1 is a basic workforce efficiency measure comparing total investigations to the number of investigators employed by the Commission in a given month. While it is described at the number of investigations each investigator completes, in reality it is an average designed to measure the efficiency of the investigations unit as a whole. The Medical Commission has maintained historically high productivity in this measure. The Medical Commission does not feel that an average greater than 11 cases per investigator is a feasible workload to maintain while avoiding the burnout of personnel.



Measure 3.1: Number of completed investigations versus number of investigators.

The case disposition step runs from the end to the investigation to the beginning of the adjudicative process. The completed investigation file goes to a staff attorney and a reviewing commission member for review and presentation to the Commission. If the Commission votes to take disciplinary action, the staff attorney drafts the legal documents. If the Commission votes to issue formal charges, the draft charges go to the Office of the Attorney General for review and approval. This entire process, some of which the Commission does not have direct control, must be completed within 140 days or less. The performance target for this measure is 77 percent. The Commission has shown marked improvement in the last three years, culminating in completing this step on time in 92 percent of the cases in fiscal 2012.



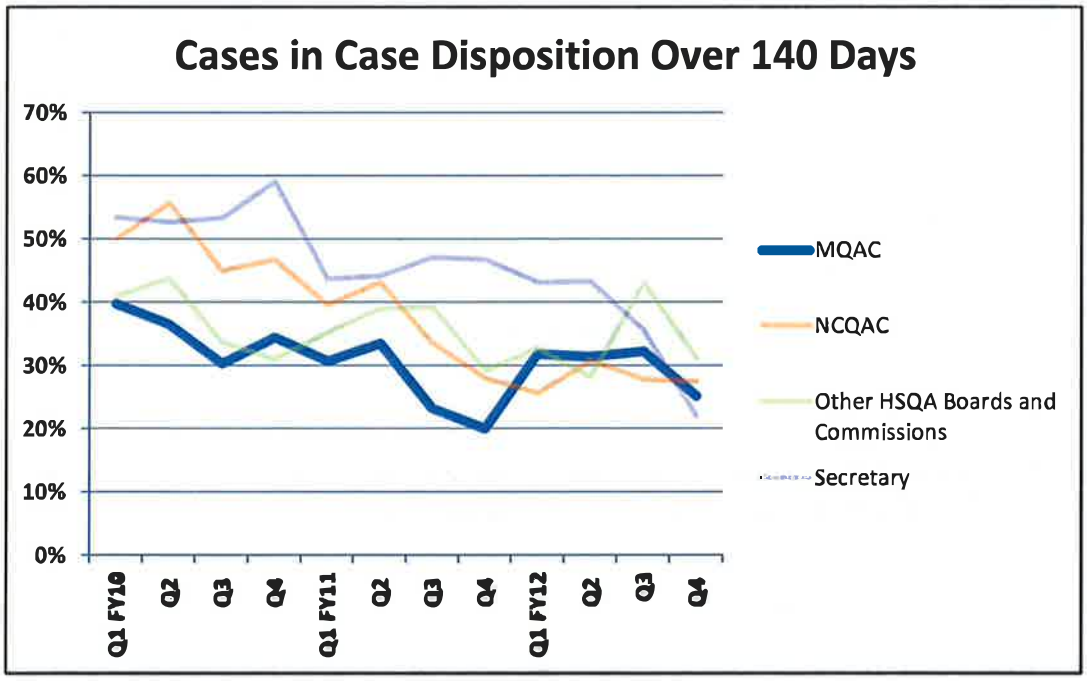
Measure 2.3: Percent of cases in which the case disposition step is completed within 140 days.

Case Distribution Step Completed within 140 Days	MQAC	NCQAC	Other HSQA Boards / Commissions	Secretary Professions
Pre-pilot Performance (FY 2004-2008)	79.4%	81.8%	73.6%	83.0%
Pilot Period Performance (FY 2009-2012)	87.0%	80.3%	73.3%	84.4%

Table 2.3 Percent of cases in which the case disposition step was completed within 140 days during fiscal years 2004 through 2012.

While in the case disposition step the Commission staff use this measure to track the progress of case disposition workload and those cases that have gone over timelines. The performance target for this measure is 23 percent. Since the start of the pilot in fiscal year 2009 the Commission has made steady progress in addressing the backlog of legal cases. Fiscal year 2012 saw an decrease in the performance of this measure, but quarterly reports of fiscal year 2012 show positive performance resuming.

The Medical Commission has seen a drop in this measure from over 40 percent to 20 percent, which was a first for all disciplining authorities being compared. By quarter four of fiscal year 2012, three out of four disciplining authorities had either met or come within several percentage points of the performance target. During the pilot period the Medical Commission has not added staff attorneys to its organization.

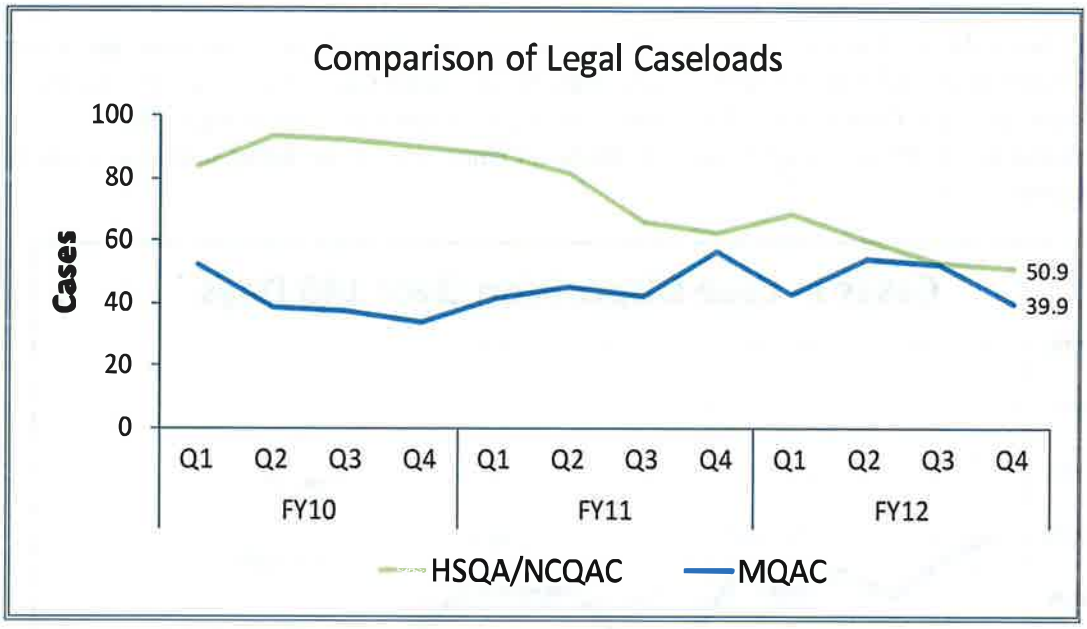


Measure 2.5: Percent of open cases currently in the case disposition step that are over 140 days.

Case Disposition Step Exceeded 140 Days	MQAC	NCQAC	Other HSQA Boards / Commissions	Secretary Professions
FY 2010 Performance	35.2%	49.4%	37.4%	54.6%
FY 2011 Performance	26.9%	36.1%	35.7%	45.4%
FY 2012 Performance	30.1%	28.0%	33.8%	36.0%

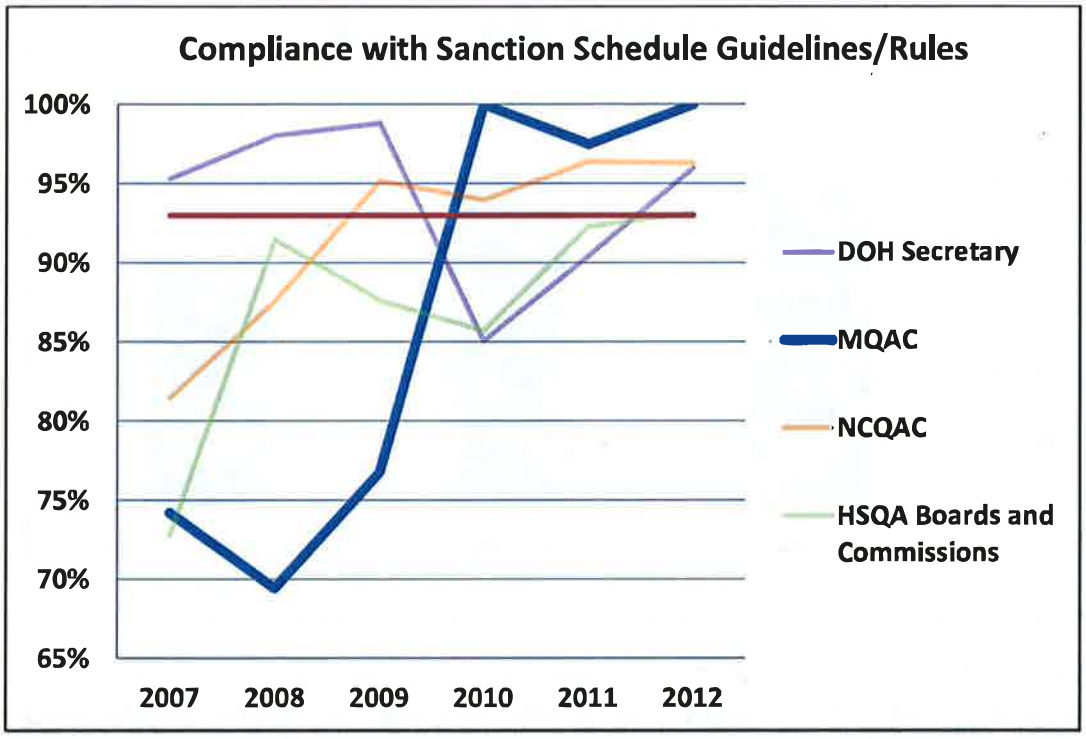
Table 2.5: Percent of open cases currently in the case disposition step that were over 140 days.

Measure 3.2 is a basic workforce efficiency measure comparing total cases in the legal unit to the number of staff attorneys employed by the Commission in a given month. While it is described as the number of legal cases assigned each staff attorney, in reality it is an average designed to measure the efficiency of the legal unit as a whole. The Commission believes the target of 65 cases per staff attorney is too large a case load for medical cases and the complexities they entail.



Measure 3.2: Number of completed investigations that are assigned to a staff attorney for legal review or production of documents versus the number of staff attorneys.

The Department of Health created sanction guidelines in 2006. In 2009, the Legislature directed the Department to develop sanction rules to ensure consistent outcomes across professions. This measure is designed to measure the Commission's compliance with the sanction rules. The performance target for this measure is 93 percent. The graph shows that once the Sanction Rules were in place the Medical Commission complied with the Sanction Rules in 99.2 percent of its orders.

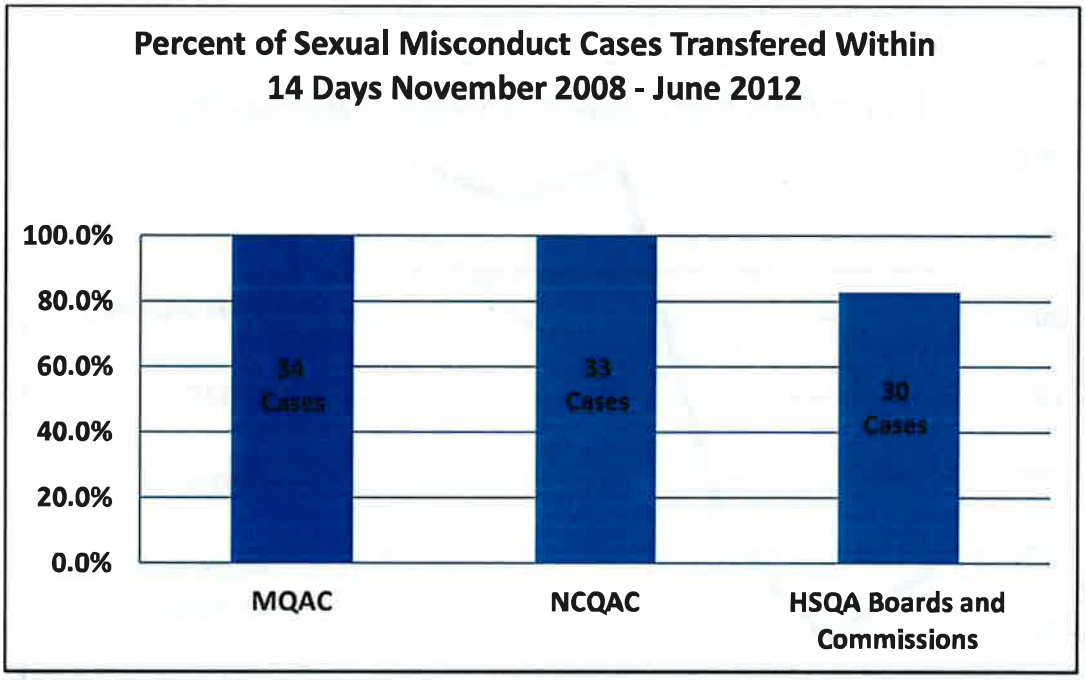


Measure 2.6: Percent of Orders and STIDs that comply with the sanction schedule.

Final Orders or Stipulations to Informal Disposition Complying with Guideline Rule	MQAC	NCQAC	Other HSQA Boards / Commissions	Secretary Professions
Pre-Pilot Compliance with Guidelines (FY 2007-2008)	60.0%	84.8%	82.3%	97.0%
Pilot Period Compliance with Rules (FY 2009-2012)	99.2%	95.7%	90.7%	90.6%

Table 2.6: Percent of orders or stipulations to informal dispositions that comply with the sanction schedule during fiscal years 2007 through 2012.

The Commission has 14 days to transfer a complaint of sexual misconduct that does not contain clinical issues to the Secretary for disciplinary action. The performance target for this measure is 95 percent. The Medical Commission transferred 100 percent of their cases within one day of the decision to transfer, well within the 14 day timeline.



Measure 2.7: Percent of cases involving sexual misconduct where the board of commission determines it does not involve standard of care or clinical expertise and transfers it to the Secretary within 14 days.

	MQAC	NCQAC	Other HSQA Boards / Commissions
Sexual misconduct cases identified	34 cases	33 cases	30 cases
Cases transferred to the secretary within 14 days	34 cases (100%)	33 cases (100%)	25 cases (83.3%)
Cases returned to board or commission due to clinical expertise or standard of care issues	7 cases (20.6%)	10 cases (30.3%)	3 cases (10%)

Table 2.7: Cases involving sexual misconduct where the board or commission determines it does not involve standard of care or clinical expertise and transfers the case to the secretary within 14 days, November 2008 through June 2012.

Measure 5.1 examines how effective the Commission is in its rulemaking process. The rules counted are standard rules that follow the three-stage rulemaking process. Performance is measured starting from the date of filing the CR-101 with the Office of the Code Reviser to the date the CR-103P notice is filed. The performance target for this measure is 75 percent or higher.

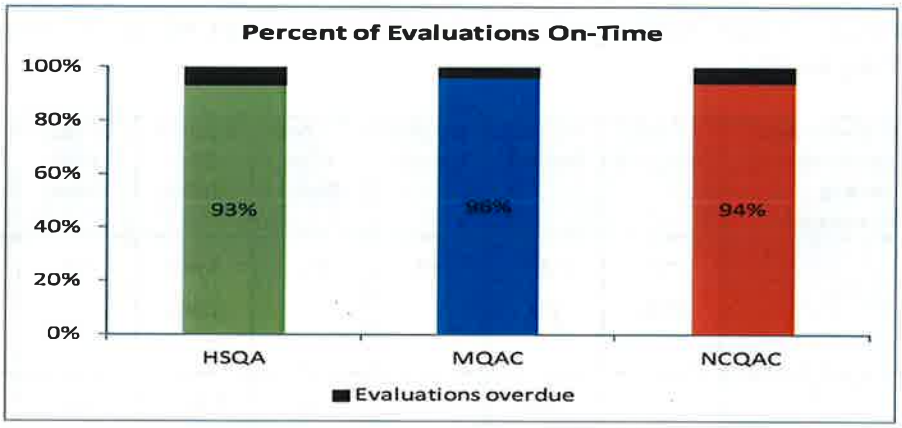
The Medical Commission enacted three rules prior to the pilot with two meeting the 18 month target and one falling outside the target for a total pre-pilot performance of 66.7 percent. During the pilot the Medical Commission completed the legislatively mandated pain rule within timelines for a 100 percent performance during the pilot.

Rules adopted based on fiscal year initiated, and Percent of adopted rules meeting Performance Measure 5.1	FY 2006 Pre-pilot	FY 2007 Pre-pilot	FY 2008 Pre-pilot	FY 2009 Pilot Period	FY 2010 Pilot Period	FY 2011 Pilot Period	FY 2012 Pilot Period
MQAC Rules	2 rules 100%	1 rule 0%	n/a	n/a	1 rule 100%	n/a	n/a
NCQAC Rules	n/a	1 rule 100%	2 rules 50%	1 rule 100%	4 rules 100%	n/a	n/a
Other HSQA Boards/Commissions Rules	16 rules 66.8%	6 rules 100%	11 rules 72.7%	4 rules 75%	9 rules 88.9%	1 rule 100%	1 rule 100%
Secretary Profession and Cross-Profession Rules	4 rules 50%	4 rules 100%	7 rules 89%	5 rules 60%	3 rules 100%	1 rule 0%	n/a

Measure 5.1: Percent of Rules in place within 18 months of filing a CR-101.

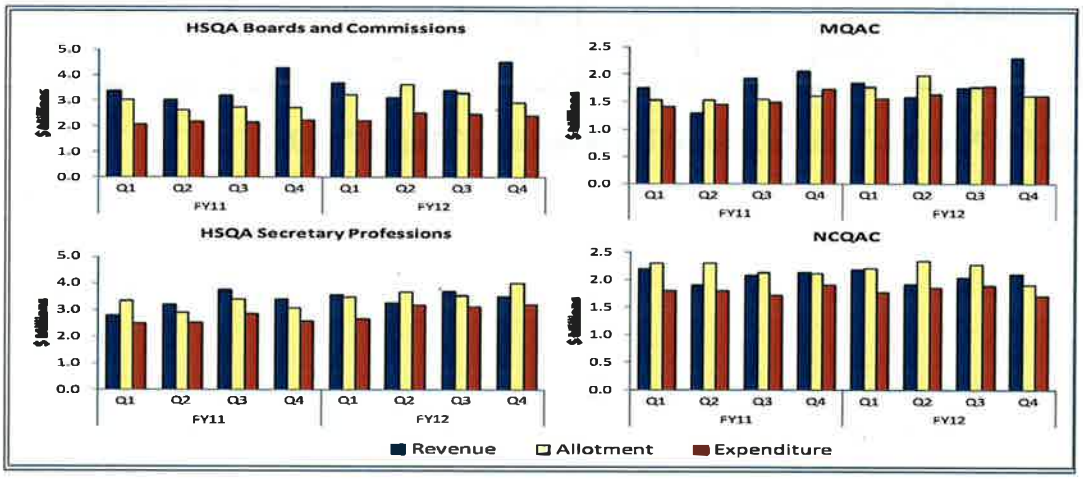
Management: Human Resources and Budget

When an employee completes a probationary, trial service, annual review, or WMS review performance period, the supervisor of that employee must submit performance assessments to the Office of Human Resources within ten calendar days. The performance target for this measure is 100 percent. During the measurement period, no disciplinary authority met the target of 100 percent. However, at 96 percent the Medical Commission performed the highest in this measure.



Measure 3.3: Percent of evaluations completed on time.

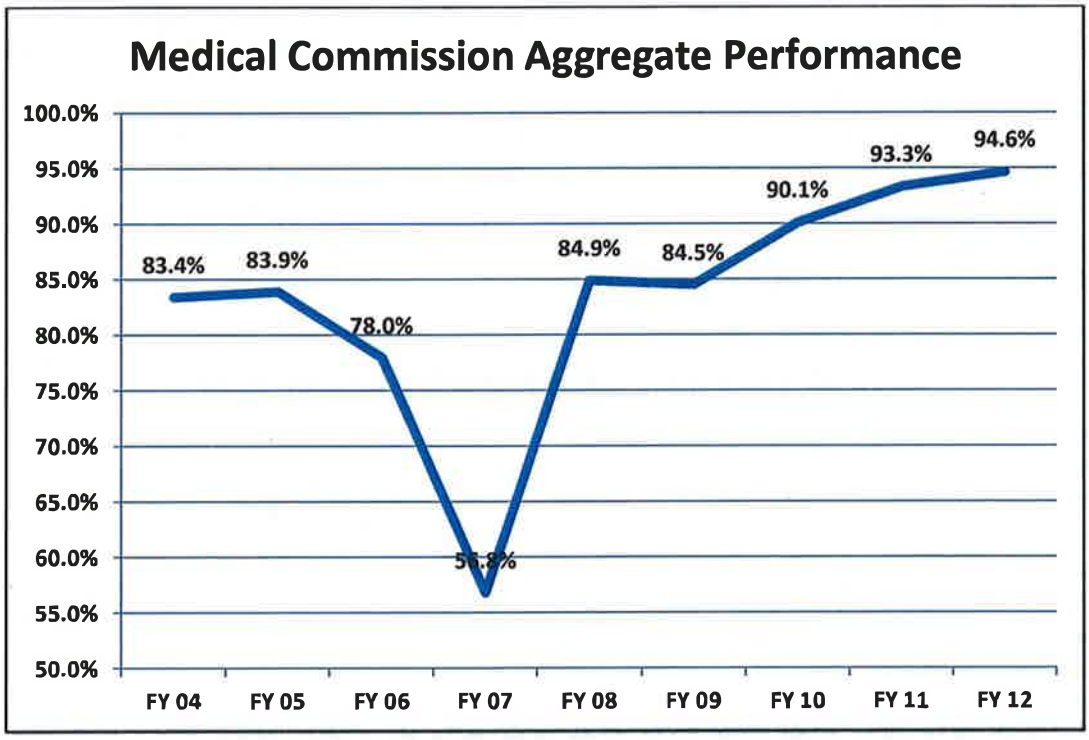
Two measures were developed to monitor programs' budget management. The first compares spending to allotment, the second compares spending to revenue. The Commission reviews budget data on a quarterly basis with a goal that spending be less than revenue and allotment. All comparison groups spent less than their allotment and revenue.



Measure 4.1: Operating expenditure v. actual budget
Measure 4.2: Revenue generated v. operating expenditures

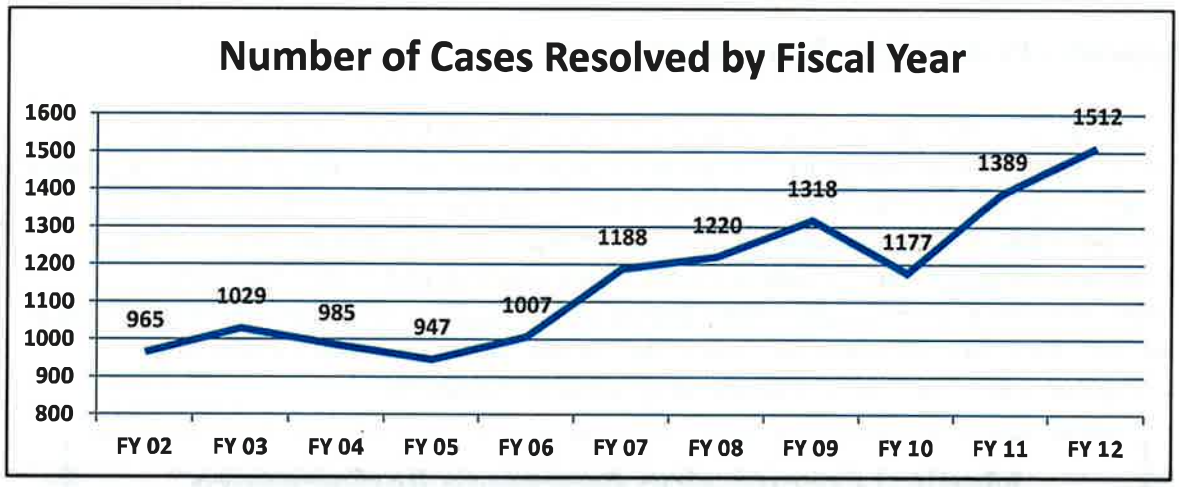
Appendix F: Aggregate Performance

In an effort to make the performance measures more transparent to the Commission members and staff, a simple aggregate measure has been created to gain a snapshot of overall performance. To generate this percentage, the performance measures relating to licensing, discipline, and rulemaking that are calculated in percentages are combined for the total actual performance. Measures related to human resources and budgets are not included in this calculation. This is divided by the total possible performance, which results in a percentage representing total aggregate performance. In the case of fiscal year 2012, the actual combined performance of the Commission is 851.64, with a total possible performance of 900. The resulting aggregate performance is 94.6 percent.

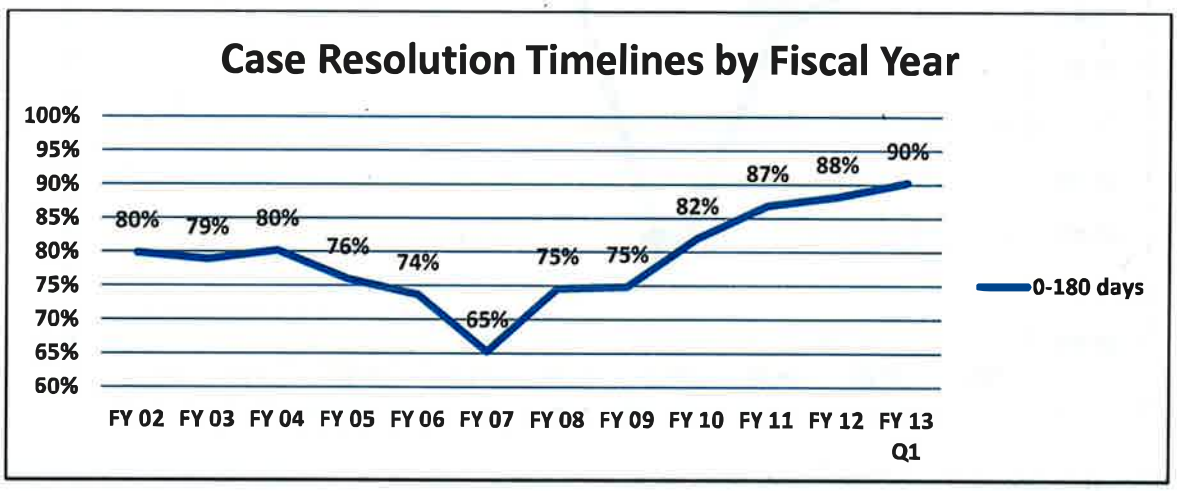


Case Timelines

The Medical Commission is aware that the agreed upon performance measures for the Pilot Project are a departure from the standard measurement of case timelines in the realm of medical regulation. Many state medical boards measure the full disciplinary process as opposed to single steps. A typical measurement is how many cases are resolved within 180 days of receiving the complaint. As part of the research efforts associated with this report and the Urban Institute research grant, Commission staff compiled information on closed cases from fiscal year 2002 through fiscal year 2012. In that time the cases resolved by fiscal year increased by 57.1 percent.



Between fiscal year 2005 and fiscal year 2008, the Commission resolved 72.1 percent of cases within 180 days. Between fiscal year 2009 through fiscal year 2012, the Commission resolved 82.4 percent of complaints within 180 days. Cases that require 361 days or more to resolve tend to be the most complex and resource intensive. Between fiscal year 2005 and fiscal year 2008, 9.2 percent of complaints took more than 360 days to reach resolution. Between fiscal year 2009 and fiscal year 2012, 6.4 percent of complaints took more than 360 days to reach resolution.

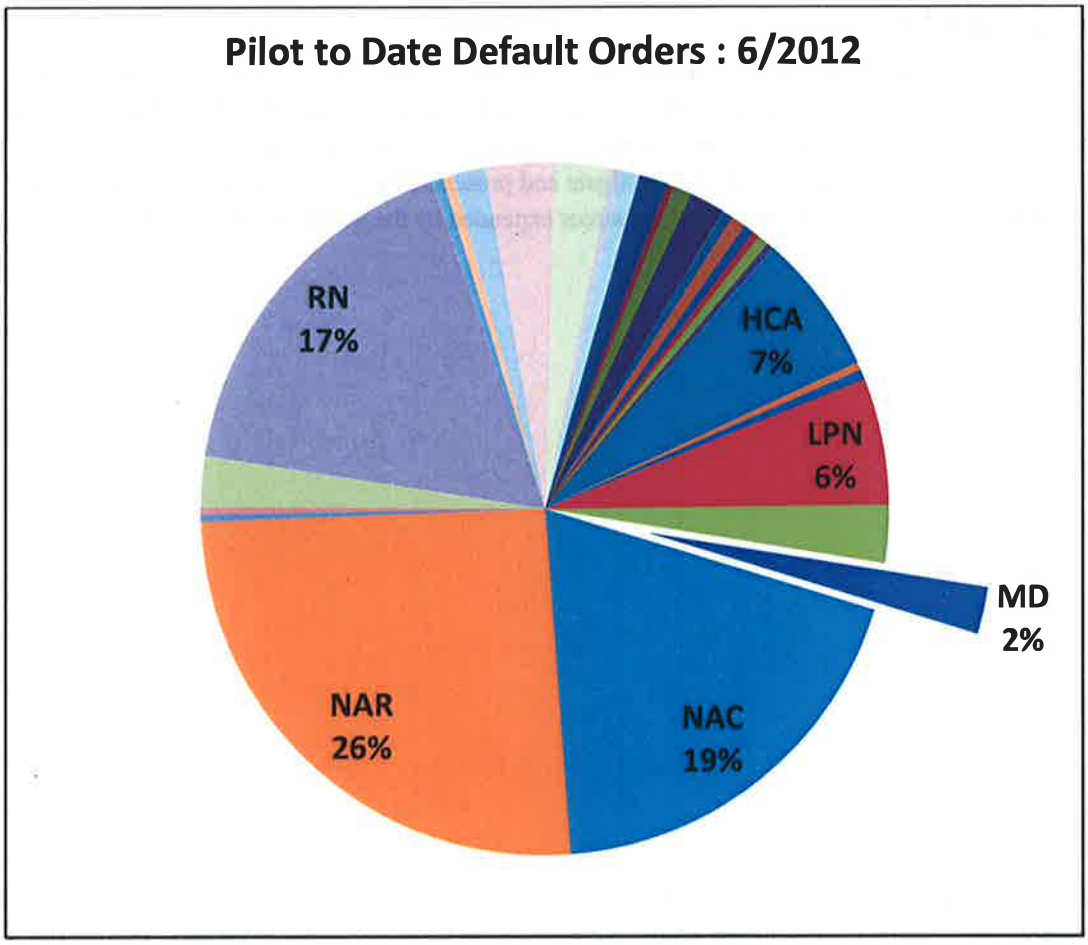


These data and the chart above would appear to support performance data indicating the period of functionalization beginning in fiscal year 2005 was detrimental to overall Commission performance. The data would also appear to support the hypothesis that an integrated structure not only benefits Commission performance, but a model with greater autonomy delivers greater performance than an integrated model with less autonomy. The timelines data, the performance data presented in the report, and the national research summaries all appear to support the hypothesis that greater autonomy in an integrated model results in higher performance in all areas. This performance occurred with increased case loads and minimal staffing increases.

Appendix G: Defaults, Duplicate Cases, and Representation

Defaults

A default case or order occurs when a licensee is notified of impending legal action on their license, but instead of responding the licensee simply walks away from their license. The result is a quick and relatively easy disciplinary action on the license. Medical Commission licensees rarely default on their license. There are many reasons for this, but the most obvious is the reporting of a suspension to the National Practitioner Data Bank and the reciprocal suspension actions that would be taken by other state medical boards where the respondent is licensed. Alternatively, if the licensee was licensed only in Washington no other state would license them as a medical doctor until the discipline is resolved in Washington.



Over 700 default orders have been issued since the start of the pilot. Two percent of those 700 involved Medical Commission cases. The other 98 percent of default orders for all health professions in the Department of Health are the responsibility of one unit, the Office of Legal Services.

Duplicate Cases

In Medical Commission cases, there is one license holder to a license. A physician assistant or someone holding a physician and surgeon license typically will not hold any other active licenses.

By contrast, the very nature of training pathways under the Nursing Commission (nursing technician to Licensed Practical Nurse to Registered Nurse to Advanced Registered Nurse Practitioner), guarantees that most licensees will have more than one license. One hundred percent of the 5,492 Advanced Registered Nurse Practitioners licensed in Washington are required to have both the ARNP license and the Registered Nurse license to legally practice. Other licensees, such as counselors, dentists and nursing assistants can have multiple licenses. If a case involves a licensee with more than one credential it does not represent a significant workload increase, but the increased case counts do represent an inflated workload measurement. In the Medical Commission discipline functions it is one license, one case.

Representation

Due to the advanced level of training and increased income potential, most Medical Commission licensees have greater resources than the licensees of other professions within the Department of Health. Medical Commission licensees typically retain legal counsel at the outset of an investigation. Commission cases are more difficult to investigate and prosecute because most attorneys vigorously defend physicians, resulting in additional resources expended by the Medical Commission investigative and legal units.

Appendix H: History of the Medical Commission

The territorial legislature in Washington passed a Medical Practice Act in 1881, eight years before Washington became a state. The Washington Territorial Governor at the time was William Newell, M.D., who entered politics after many years of medical practice, including serving as Abraham Lincoln's private physician. As governor of Washington Territory, Dr. Newell was a supporter of progressive legislation regarding public health and vital statistics as well as laws that established medical examining boards to license physicians, surgeons and pharmacies. When Dr. Newell's term of office expired, he became closely involved with efforts to upgrade the quality of Washington's practitioners and served on the Washington State Medical Examining Board in the 1890s.

On July 4, 1889, 75 citizens including 43 Republicans, 29 Democrats, and three Independents met in Olympia to draft the new Washington State Constitution. Among the delegates was a group of physicians who worked diligently for effective medical legislation for the new state. Article XX of the Constitution — requiring a board of health, bureau of vital statistics and regulations concerning medicine, surgery and pharmacy - passed on Aug. 12, 1889, with no dissenting votes and no amendments. The Washington State Medical Society, in an official resolution, commended the committee for its diligence, noting, "The State of Washington alone possesses a constitutional clause requiring medical legislation."

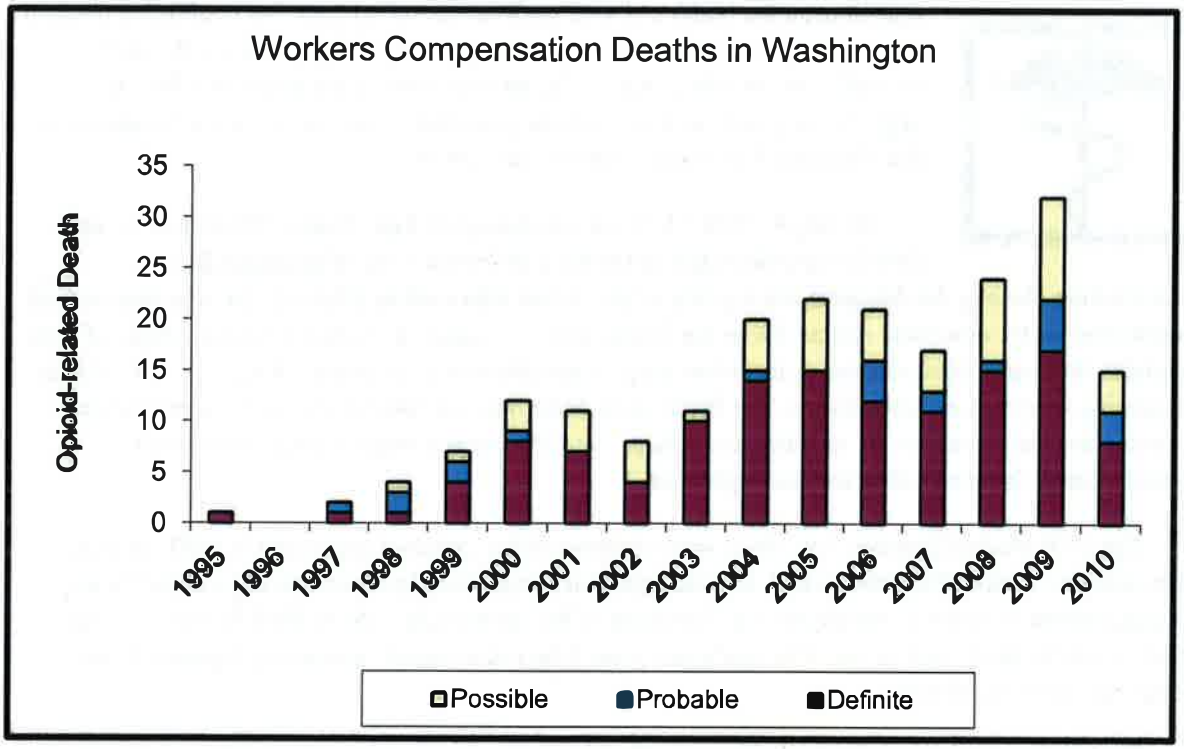
The 1890 Medical Practice Act, which was a revision of the territorial legislation of 1881, created a nine-member Board of Examiners to determine applicant competency by administering a scientific and practical exam in anatomy and physiology. Violation of the act brought a $50 to $100 fine or 10 to 90 days in jail. In 1894, only 12 out of 34 applicants passed the exam, despite possessing diplomas from reputable medical colleges.

The law was amended in 1901 to require proof of graduation from an authorized college with a three-year course in medicine. In 1905, the law was amended to require a four-year education. In 1919, practitioners were required to have a diploma from a school approved by the Association of American Medical Colleges and the AMA Council on Medical Education and Hospital, and show evidence of a one-year internship in a 25-bed hospital that included six weeks of maternity service.

In 1955, the Medical Disciplinary Board was established and located within the Department of Licensing along with the Board of Examiners. In 1971, physician assistants were licensed for the first time. The Medical Disciplinary Board and the Board of Medical Examiners moved in 1989 to the newly created Department of Health. Five years later, the legislature abolished both medical boards and created the Washington Medical Quality Assurance Commission with the authority to license and discipline allopathic physicians and physician assistants.

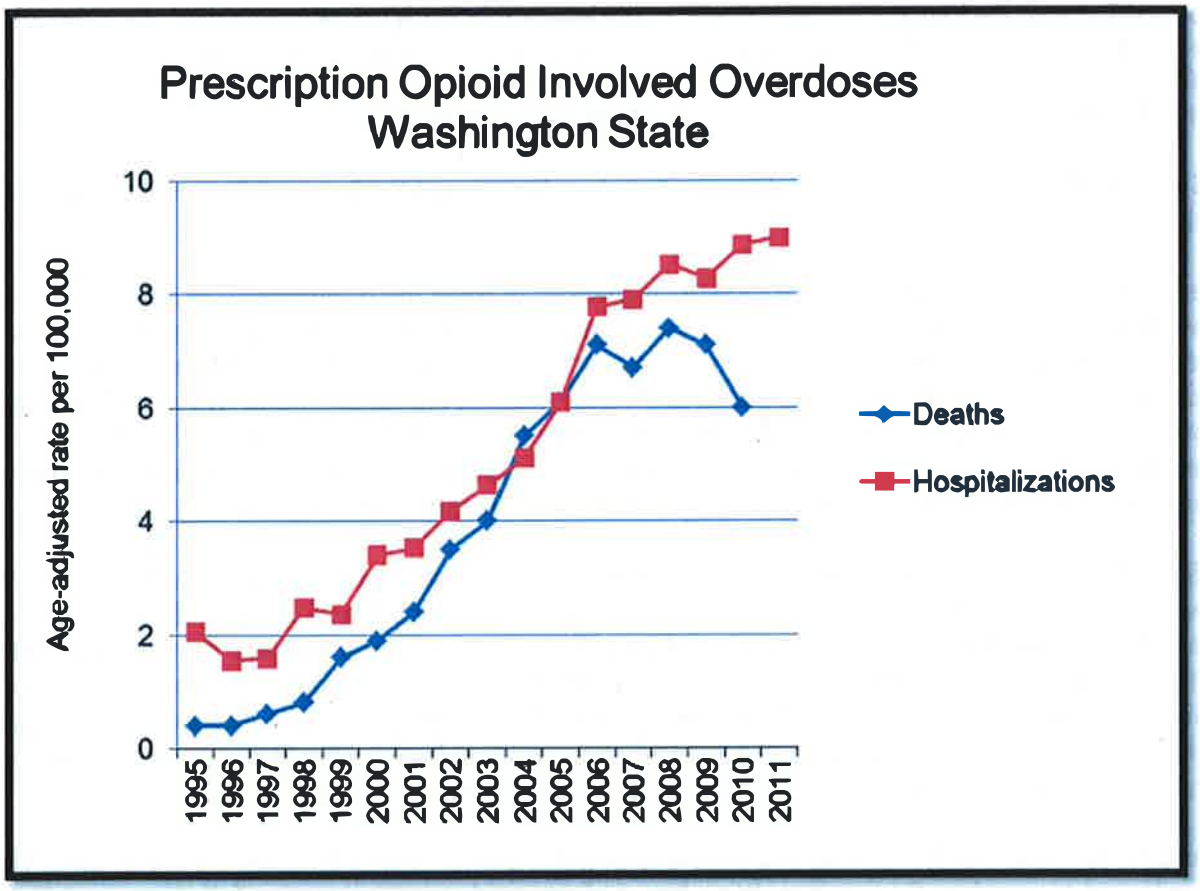
Appendix I: Reduction in Opioid Deaths in Washington

The Commission has been closely monitoring opioid death data as it is published. In 2010, a steep decline in opioid related deaths appeared to occur. While the Commission cannot directly credit the pain rules with this decline, the threat of the rules and the awareness brought by the media exposure of the problem certainly had an impact on the behavior of patients and providers.



In 2011, the State of Washington experienced a decline in the rate of opioid involved overdoses. While the death rate decreased the rate of hospitalizations increased. Several reasons have been suggested for the trends; among them are a broader awareness of opioid dangers among patients and practitioners. This awareness has been generated by media coverage, the pain rules, and a general better understanding of risks relating to opioid therapies. The increase in hospitalizations could be an indication of specialization or acquired skill, with the result of fewer deaths but those that did not die were hospitalized.

Anecdotally, the Commission has received feedback and appreciation for the framework of the rules relating to prescribing limits. There have been confirmed reports from major health care institutions around the state that significant opioid MED reductions have occurred with little to no negative impact on quality of care. Whether these changes in behavior resulted in the decreased death rate cannot be determined at this time.



Federation of STATE MEDICAL BOARDS 1912 –2012

Appendix J: FSMB Letter of Support

December 6, 2012

The Honorable Christine Gregoire
Washington State Governor
P.O. Box 40002
Olympia, WA 98504-0002

The Honorable Jay Inslee
Washington State Governor-Elect
210 11th Ave. SW
Olympia, WA 98501

The Honorable Karen Keiser
The Honorable Randi Becker
Senate Health & Long-Term Care Committee
P.O. Box 40466
Olympia, WA 98504-0466

The Honorable Eileen Cody
The Honorable Joe Schmick
House Health Care & Wellness Committee
P.O. Box 40600
Olympia, WA 98504-0600

Dear Governor Gregoire, Governor-Elect Inslee, Senators Keiser and Becker, and Representatives Cody and Schmick:

The Federation of State Medical Boards (FSMB) is pleased to have the opportunity to support the quality improvement measures implemented by the Washington State Medical Commission pursuant to the pilot project made possible by 4SHB 1103. As the national non-profit organization representing the seventy (70) state medical boards of the United States and its territories, one of the many ways the FSMB seeks to promote excellence in medical regulation is by facilitating the widespread adoption of best practices. We believe that the passage of 4SHB 1103 in 2008 properly empowered the Medical Commission to improve its operations and we urge the permanent adoption of the principles contained therein.

The FSMB has long recognized that state medical boards require proper organization and effective empowerment in order to successfully discharge their important responsibilities to the public. To guide the state boards as they seek to identify and implement appropriate policies that afford maximum protection to the public, the FSMB has developed a number of legislative policy documents and resources, including its *Elements of a State Medical and Osteopathic Board* which was developed to serve as a blueprint of the structure and function of a modern state medical board. The *Elements* details the powers, duties and protections that are basic **to a state medical board**'s structure and function.

With respect to 4SHB 1033, the *Elements* provides that the Board should be empowered to determine its staff needs and to employ, fix compensation for, evaluate and remove its own full-time, part-time and temporary staff in accordance with the statutory requirements of the state in which it sits. The *Elements* further provides that the Board should develop and adopt its own budget. These provisions, and the *Elements* in its entirety, are intended to assure that each state board is properly authorized to evaluate its

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existing structure and function to determine if its operations may be improved and when appropriate, revise those structures and functions accordingly. The *Elements* seeks to encourage the public, state legislators, medical boards, medical societies and others who have an interest in the regulation of the medical profession to reexamine existing practice acts as they relate to the composition, structure, functions, responsibilities, powers and funding of medical boards.

The FSMB believes that the Washington State Medical Commission, in its pilot project, has engaged in the type of thoughtful deliberations that result in greater protection of the public. The Commission's report to which this letter of support is an addendum puts the Commission's achievements on full display by plainly illustrating the numerous ways the granting of increased authority has resulted in greater efficiencies and increased effectiveness in its operations. The FSMB hopes that your office recognizes the Medical Commission's successes and responds by permanently empowering the Commission and staff to continue their important work in the most thorough and efficient means possible.

Thank you in advance for your consideration.

Best regards,

Humayun J. Chaudhry, DO, FACP
FSMB President and CEO

Appendix K: Regence Letter of Support

Regence

Regence BlueShield is an Independent Licensee of the Blue Cross and Blue Shield Association

May 16, 2011

Michael L. Farrell
Legal Unit Manager
Department of Health/MQAC
16201 E. Indiana, Suite 1500
Spokane, WA 99216

Dear Michael L. Farrell,

Thank you for the opportunity to provide feedback on the Medical Quality Assurance Commission (MQAC) Listserv and the improvements made the MQAC Disciplinary Orders.

Regence has found the Listserv service to be useful in indentifying actions that are not published in the Department of Health News Releases. The list is easy to read, and provides the necessary information needed to update our credentialing files. The addition of the county in which the provider resides has been helpful in confirming the practice location of providers, especially for those that are located out of state.

Regence would like to see the other Washington State licensing boards create this type of notification. We understand this is not within the authority of MQAC; however we have found this service to be of such great value in identifying legal action in a timely manner.

The Regence Credentialing Committee has provided positive feedback regarding the changes made to the MQAC Disciplinary Orders that I would like to pass on to you. Our Credentialing Committee members have found that by including the mitigating and aggravating factors within the order, it is easier for them in understanding how the Board came to their conclusions and decisions, and how the disciplinary action was applied to the provider.

Again, thank you for the opportunity to provide this information. If additional input is needed, please feel free to contact me directly at (206) 332-2860 or by email at Hattie.Clabby@Regence.com.

Sincerely,

Hattie Clabby, CPCS
Manager, Credentialing
Regence