WASHINGTON

Medical Commission

Licensing. Accountability. Leadership.

Regular Meeting
January 9-10, 2025

Meeting Agenda
January 9-10, 2025 – 2nd Revised

WASHINGTON Medical Commission
Licensing. Accountability. Leadership.

In accordance with the Open Public Meetings Act, this meeting notice was sent to individuals requesting notification of the Department of Health, Washington Medical Commission (WMC) meetings. This agenda is subject to change. The WMC will take public comment at the Business Meeting. To request this document in another format, call 1-800-525-0127. Deaf or hard of hearing customers, please call 711 (Washington Relay) or email doh.information@doh.wa.gov.

Virtual via Teams Webinar: Registration links can be found below.
Commissioners and staff will attend this meeting virtually.
Physical location: Department of Health, 111 Israel Rd SE, TC2 Rm 153, Tumwater, WA

Time — Thursday – January 9, 2025

Open Sessions

Personal Appearances

8:30 am	Panel A – Meeting Link: 1/9/2025 Panel A	Page 16
8:30 am	Panel B – Meeting Link: 1/9/2025 Panel B	Page 17

Closed Sessions

Case Disposition

10:15 am	Panel A
10:15 am	Panel B

Noon	Lunch Break

Case Disposition

12:30 pm	Panel A
12:30 pm	Panel B

Time — Friday – January 10, 2025

Closed Session

8:30 am	IV Hydration Workgroup

Open Session

9:30 am — Business Meeting

Register for this meeting at: WMC Business Meeting

1.0 Chair Calls the Meeting to Order

2.0 Public Comment

The public will have the opportunity to provide comments. If you wish to speak, please use the Raise Hand function, and you will be called upon. Keep your comments brief, and when the Chair opens the floor, state your name and, if applicable, the organization you represent. If you would prefer to submit written comments, send them to amelia.boyd@wmc.wa.gov by January 5, 2025. ***Please do not use this public comment period to address disciplinary cases or***

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issues that the WMC is currently covering in its rulemaking or policy efforts. If you wish to comment on rules currently under development, to ensure your comments are considered as part of rulemaking, visit our "Rules in Progress" page and select the specific rule from the "Current Rules in Progress" table. We also welcome you to attend and comment at our rulemaking workshops and hearings. The schedule for these meetings can be found on our "Rules in Progress page. For feedback on WMC policies, guidelines, or interpretive statements, you may email medical.policy@wmc.wa.gov or provide verbal comments at one of the upcoming Policy: Interested Parties or Policy Committee meetings. You can find the schedule for these meetings on the Policy Meetings page.

Disclaimer: The WMC accepts written comment into the record as a normal course of the Business Meeting. On a case-by-case basis, the WMC will, at its sole discretion, grant a request to verbally read a comment into the record. Comments containing profanity, discriminatory language, ad hominem attacks on Commissioners or staff, threats of violence, or discussion of active cases or litigation before or involving the WMC will not be read. The comment will still be included in the packet for consideration and awareness.

2.1 The Chair will call for comments from the public.

3.0 Chair Report

4.0 Consent Agenda

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

4.1 Agenda – Approval of the January 10, 2025, Business Meeting agenda. — Pages 2-6

4.2 Minutes – Approval of the October 11, 2024, Business Meeting minutes. — Pages 18-22

5.0 Commissioner Training

5.1 **Outside Inquiries and the Role of the Commissioner**
Kyle Karinen, Executive Director; Micah Matthews, Deputy Executive Director; and Stephanie Mason, Public Information Officer & Legislative Liaison, will deliver this presentation.

6.0 New Business

6.1 **Practitioner Support Program Report – FY 2024** — Update
Mr. Matthews, will deliver the presentation for this report. — Pages 23-30

6.2 **Research Unit Proposal** — **Action**
Jimi Bush, Director of Quality & Engagement, will deliver the presentation for this proposal. — Page 31

7.0 Old Business

7.1 **Committee/Workgroup Reports** — Update
The written reports are on pages 31-32. The Chair will call for additional reports. See page 34-35 for a list of committees and workgroups. — Pages 32-33

New Workgroup: Psychedelic Medications in Behavioral Health Treatment. Charter on pages 36-37.

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7.2 **Rulemaking Activities** — Update/Action

Rules Progress Report provided on pages 38-39.

Amelia Boyd, Program Manager, will request the following:

7.2.1 Initiate rulemaking for the following WACs in the physician's chapter: — **Action** Memo on page 40

- WAC 246-919-010 through WAC 246-919-520
- WAC 246-919-602 through WAC 246-919-700

This rulemaking effort will be to modernize language and align with current standards.

7.2.2 Rulemaking Petition – RE: Opioid Prescribing from Maria Higginbotham — **Action** Memo on pages 41-42

Request to revise approval of petition.

7.2.3 Rulemaking Petition – RE: WACs 246-919-330, 246-919-340, and 246-919-355 from Dr. Alexander Witkowski. — **Action** Petition on pages 43-46

Note: If **item 7.2.1** is approved, these WACs will be included in that rulemaking.

7.2.4 Request approval to proceed with the next step in the rulemaking process, Proposed Rulemaking (CR-102), for the newly recognized profession of Anesthesiologist Assistants. The CR-101, Preproposal Statement of Inquiry, was filed on August 28, 2024, as WSR #24-18-057. — **Action** Memo page 47 Draft language on pages 48-75

7.3 **Lists & Labels Request** — **Action**

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

7.3.1 American Academy of Manipulative Therapy — Pages 76-84

7.3.2 Spectrum Healthcare Resources — Pages 85-94

7.4 **Request for Addition to Approved Office-Based Procedures Entities List** — Pages 95-124

Review and evaluate the request from **Urgent Care Association** to be added to the "Approved Office-Based Procedures Entities" list included in the WMC's Procedure *Approving Accrediting Entities to Accredit or Certify the Use of Anesthesia in Office-Based Surgical Settings*. Commissioners should conduct a thorough review of the submitted materials to ensure compliance with the standards for approved office-based procedures entities.

7.5 **Proposed: Commissioner Recusal Procedure for Managing Conflicts of Interest** — Pages 125-129

This document was previously presented as a proposed policy at a past business meeting, where it was approved to undergo the DOH Secretary review process. Following that review, it was determined that the document does not qualify as a policy. It has since been converted into a procedure, with changes made solely to align it with

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the procedural template.

The request for this document is for Commissioners to review and decide whether to approve or deny its adoption.

8.0 Policy Committee Report

Christine Blake, Public Member, Chair, will report on items discussed at the Policy Committee meeting held on January 2, 2025. The agenda was as follows: Report/Action

8.1 **Proposed Policy: Clinical Experience Assessment** Pages 130-136

At the Policy Committee meeting, Ms. Boyd stated that this could not be a policy but agreed to confirm this information before today's meeting. She has since determined that this document can indeed be a policy. The Committee deferred its decision to the current meeting, and the document, including the proposed changes, now requires review and a vote to decide on its approval.

8.2 **Proposed Guidance Document: Communicating Diagnostic Test Results and Time Critical Information to Patients and Practitioners** Pages 137-140

This proposed document combines two current Guidance Documents:

- Communicating Diagnostic Test Results to Patients, GUI2016-02
- Direct Communication of Time Critical Patient Medical Information Between Health Care Practitioners, GUI2021-01

The Committee recommended approving the proposed document and rescinding the two current documents.

8.3 **Guidance Document: Processing Complaints Against Licensees Enrolled in the Washington Physicians Health Program** Pages 141-144

The Committee recommended approval of the document as presented, with two amendments made to page 3.

8.4 **Guidance Document: Completion of Death Certificates by Physicians and Physician Assistants** Pages 145-146

The Committee recommended approval of the document with the proposed revisions.

9.0 Member Reports

The Chair will call for reports from Commission members.

10.0 Staff Member Reports

Written reports on pages 147-159

The Chair will call for further reports from staff.

The Licensing Manger, Marisa Courtney, report includes references to two attachments:

1. 2024 Annual Report on the USMLE - pages 160-214
2. 2024 USMLE Primer for State Boards - pages 215-237

11.0 AAG Report

Heather Carter, AAG, may provide a report.

12.0 Adjournment of Business Meeting

Informational

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Open Session

Noon **Lunch & Learn**

Register to attend this virtual meeting by visiting this site: https://tinyurl.com/4erpm2ba

Integrating International Medical Graduates (IMGs) into Healthcare Delivery
Dr. Stan Flemming will share insights about his clinic's efforts to integrate International Medical Graduates into the healthcare system, highlighting their contributions and the strategies used to support their successful integration.

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FORMAL HEARING SCHEDULE

WASHINGTON Medical Commission
Licensing. Accountability. Leadership.

DISCLAIMER: THE BELOW HEARING SCHEDULE IS SUBJECT TO CHANGE.

Hearing Date	Respondent	Case No.	Location
January 2025			
January 24	Smith, Stephen, MD	M2022-722	Virtual
February 2025			
February 10-13	Jackson, Ricky, MD	M2022-491	TBD
February 20-21	Shibley, Eric, MD	M2018-443	TBD
March 2025			
March 24-26	Hammel, James F., MD	M2023-493	TBD
March 28	Pao, Dorothy M., MD	M2024-614	TBD
April 2025			
April 3-4	Vassal, Alford, MD	M2024-206	TBD
April 29 - May 1	Siler, Thomas T., MD	M2022-366	TBD
May 2025			
May 14-16	Steneker, Sjardo, MD	M2024-204	TBD

Information on how to observe a hearing can be obtained from the Adjudicative Clerk Office, (206) 391-5193.

2025 Meeting Schedule

WASHINGTON Medical Commission
Licensing. Accountability. Leadership.

January

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1	New Years Day	Holiday – Offices Closed	
2	Policy Committee	4 pm	Virtual
9	Personal Appearances	8:30 am	Virtual
9	Case Disposition	10:45 am	Virtual
10	Committees/Workgroups	8:30 am	Virtual
10	Business	9:30 am	Virtual
10	Lunch & Learn	Noon	Virtual
20	Martin Luther King Day	Holiday – Offices Closed	
30	Policy: Interested Parties	10 am	Virtual

February

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17	President's Day	Holiday – Offices Closed	
27	Policy Committee	4 pm	Virtual

March

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13	Personal Appearances	8:30 am	Hybrid Capital Event Center (ESD 113) 6005 Tyee Drive SW, Tumwater
13	Case Disposition	10:45 am	
14	Committees/Workgroups	8:30 am	
14	Business	9:30 am	
14	Lunch & Learn	Noon	
27	Policy: Interested Parties	10 am	Virtual

2025 Meeting Schedule

WASHINGTON Medical Commission
Licensing. Accountability. Leadership.

April

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17	Commissioner Retreat	8 am	Hilton Seattle Airport 17620 Intl. Blvd.
18	SMART Training	8:30 am	

May

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1	Policy Committee	4 pm	Virtual
8	Personal Appearances	8:30 am	Hybrid Capital Event Center (ESD 113) 6005 Tyee Drive SW, Tumwater
8	Case Disposition	10:45 am	
9	Committees/Workgroups	8:30 am	
9	Business	9:30 am	
9	Lunch & Learn	Noon	
26	Memorial Day	Holiday – Offices Closed	

June

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19	Juneteenth	Holiday – Offices Closed	
26	Policy: Interested Parties	10 am	Virtual

July

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4	Independence Day	Holiday – Offices Closed	
10	Personal Appearances	8:30 am	Virtual
10	Case Disposition	10:45 am	Virtual
24	Policy Committee	4 pm	Virtual

2025 Meeting Schedule

WASHINGTON Medical Commission
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August

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21	Personal Appearances	8:30 am	Hybrid DOH TC2 Rm 166/167 111 Israel Rd SE Tumwater
21	Case Disposition	10:45 am	
22	Committees/Workgroups	8:30 am	
22	Business	9:30 am	
22	Lunch & Learn	Noon	

September

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1	Labor Day	Holiday – Offices Closed	
25	Policy: Interested Parties	10 am	Virtual

October

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2	Personal Appearances	8:30 am	Virtual
2	Case Disposition	10:45 am	Virtual
30	Policy Committee	4 pm	Virtual

2025 Meeting Schedule

WASHINGTON Medical Commission
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November

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11	Veterans Day	Holiday – Offices Closed	
20	Personal Appearances	8:30 am	Hybrid DOH TC2 Rm 166/167 111 Israel Rd SE Tumwater
20	Case Disposition	10:30 am	
21	Committees/Workgroups	8:30 am	
21	Business	9:30 am	
21	Lunch & Learn	Noon	
27	Thanksgiving Day	Holiday – Offices Closed	
28	Native American Heritage Day	Holiday – Offices Closed	

December

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25	Christmas	Holiday – Offices Closed

Association Meetings

Association	Date(s)	Location
Washington Academy of Physician Assistants (WAPA) & Oregon Society of Physician Associates (OSPA) Joint Spring Conference	March 9-11, 2025	Portland, OR
Washington State Medical Association (WSMA) Annual Meeting	September 20-21, 2025	Bellevue, WA
WAPA Fall Conference	TBA (Usually October)	TBA

Other Meetings

Entity	Date(s)	Location
Council on Licensure, Enforcement and Regulation (CLEAR) Winter Symposium	January 15, 2025	Savannah, GA
Federation of State Medical Boards (FSMB) Annual Conference	April 25-26, 2025	Seattle, WA
FSMB International Conference	September 3-6, 2025	Dublin, Ireland
CLEAR Annual Conference	September 15-18, 2025	Chicago, IL
FSMB Board Attorneys Workshop	Tentative: November 6-7	TBA

2026 Meeting Schedule

WASHINGTON Medical Commission
Licensing. Accountability. Leadership.

January

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1	New Years Day	Holiday – Offices Closed	
8	Policy Committee	4 pm	Virtual
15	Personal Appearances	8:30 am	Virtual
15	Case Disposition	10:45 am	Virtual
16	Committees/Workgroups	8:30 am	Virtual
16	Business	9:30 am	Virtual
16	Lunch & Learn	Noon	Virtual
19	Martin Luther King Day	Holiday – Offices Closed	
29	Policy: Interested Parties	10 am	Virtual

February

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16	President's Day	Holiday – Offices Closed	
26	Policy Committee	4 pm	Virtual

March

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12	Personal Appearances	8:30 am	Hybrid Location: TBD
12	Case Disposition	10:45 am	
13	Committees/Workgroups	8:30 am	
13	Business	9:30 am	
13	Lunch & Learn	Noon	
26	Policy: Interested Parties	10 am	Virtual

2026 Meeting Schedule

WASHINGTON Medical Commission
Licensing. Accountability. Leadership.

April

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17	SMART Training	8:30 am	In person Location: TBD
23	Policy Committee	4 pm	Virtual

May

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7	Personal Appearances	8:30 am	Hybrid Location: TBD
7	Case Disposition	10:45 am	
8	Committees/Workgroups	8:30 am	
8	Business	9:30 am	
8	Lunch & Learn	Noon	
25	Memorial Day	Holiday – Offices Closed	

June

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19	Juneteenth	Holiday – Offices Closed	
25	Policy: Interested Parties	10 am	Virtual

July

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3	Independence Day (observed)	Holiday – Offices Closed	
9	Personal Appearances	8:30 am	Virtual
9	Case Disposition	10:45 am	Virtual
23	Policy Committee	4 pm	Virtual

2026 Meeting Schedule

WASHINGTON Medical Commission
Licensing. Accountability. Leadership.

August

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21	Committees/Workgroups	8:30 am	
21	Business	9:30 am	
21	Lunch & Learn	Noon	

September

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7	Labor Day	Holiday – Offices Closed	
24	Policy: Interested Parties	10 am	Virtual

October

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8	Personal Appearances	8:30 am	Virtual
8	Case Disposition	10:45 am	Virtual
29	Policy Committee	4 pm	Virtual

2026 Meeting Schedule

WASHINGTON Medical Commission
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November

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19	Case Disposition	10:30 am	
20	Committees/Workgroups	8:30 am	
20	Business	9:30 am	
20	Lunch & Learn	Noon	
26	Thanksgiving Day	Holiday – Offices Closed	
27	Native American Heritage Day	Holiday – Offices Closed	

December

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3	Policy: Interested Parties	10 am	Virtual
25	Christmas	Holiday – Offices Closed	

Association Meetings

Association	Date(s)	Location
Washington Academy of Physician Assistants (WAPA) & Oregon Society of Physician Associates (OSPA) Joint Spring Conference	TBA	TBA
Washington State Medical Association (WSMA) Annual Meeting	TBA	TBA
WAPA Fall Conference	TBA	TBA

Other Meetings

Entity	Date(s)	Location
Council on Licensure, Enforcement and Regulation (CLEAR) Winter Symposium	TBA	TBA
Federation of State Medical Boards (FSMB) Annual Conference	TBA	TBA
FSMB International Conference	TBA	TBA
CLEAR Annual Conference	TBA	TBA
FSMB Board Attorneys Workshop	TBA	TBA

WASHINGTON Medical Commission
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Panel A
Personal Appearance Agenda

Thursday, January 9, 2025

Meeting Link: https://tinyurl.com/mpctrxbt

Panel Members:	Harlan Gallinger, MD, Panel Chair	Daniel Cabrera, MD	Jimmy Chung, MD	Arlene Dorrough, PA-C
	Anjali D'Souza, MD	Jamie Koop, Public Member	Sarah Lyle, MD	Elisha Mvundura, MD
	Douglas Pullen, Public Member	Scott Rodgers, Public Member		
	Janet Barrall, MD, Pro-Tem	Robert Bernstein, MD, Pro-Tem	Charlie Browne, MD, Pro-Tem	Peter Casterella, MD, Pro-Tem
	Peggy Hutchison, MD, Pro-Tem			

Compliance Officer: Anthony Elders

8:30 a.m.	**David P. McQuivey, PA-C** Attorney: Grant T. Engrav	M2023-61 (2021-12843) RCM: Harlan Gallinger, MD SA: Joel Defazio
9:00 a.m.	**James W. Winde, MD** Attorney: Todd Reichert	M2020-839 (2020-5621) RCM: Charlie Browne, MD SA: Joel Defazio
9:30 a.m.	**Irina N. Case, MD** Attorneys: Michelle Garzon Eron Z. Cannon	M2022-833 (2022-1103) RCM: Harlan Gallinger, MD SA: Colleen Balatbat

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WASHINGTON Medical Commission
Licensing. Accountability. Leadership.

Panel B

Personal Appearance Agenda

Thursday, January 9, 2025

Meeting Link: https://tinyurl.com/4hfjrypm

Panel Members:

Chair: Terry Murphy, MD	Michael Bailey, Public Member	Christine Blake, Public Member	Toni Borlas, Public Member
Po-Shen Chang, MD	Diana Currie, MD	Karen Domino, MD	April Jaeger, MD
Ed Lopez, PA-C	Claire Trescott, MD	Richard Wohns, MD	
David Brecher, MD, Pro-Tem	Matthew Kogut, MD, Pro-Tem	John Maldon, Public Member, Pro-Tem	

Compliance Officer: Mike Kramer

8:30 a.m.	**John S. Edwards, III, PA-C** Attorney: Stephen M. Lamberson	M2023-487- (2022-14579) RCMs: Christine Blake, Public Member SA: Colleen Balatbat
9:00 a.m.	**Allison K. Shuster, PA-C** Attorney: Pro Se	M2023-1003 (2023-8939) RCM: Ed Lopez, PA-C SA: Rick Glein
9:30 a.m.	**Farhaad R. Riyaz, MD** Attorney: Adam G. Snyder	M2022-716 (2022-6604 et al.) RCM: Karen Domino, MD SA: Joel Defazio

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Business Meeting Minutes
October 11, 2024

WASHINGTON Medical Commission
Licensing. Accountability. Leadership.

Virtual Meeting via Teams Webinar
Link to recording: https://youtu.be/WIFs_-idFyY?si=b8SlP2J99XkNomKl

Commission Members

Michael Bailey, Public Member
Christine Blake, Public Member
Toni Borlas, Public Member – Absent
Daniel Cabrera, MD
Po-Shen Chang, MD
Jimmy Chung, MD
Diana Currie, MD
Karen Domino, MD, Chair
Arlene Dorrough, PA-C – Absent
Anjali D'Souza, MD
Harlan Gallinger, MD
April Jaeger, MD – Absent
Jamie Koop, Public Member – Absent
Ed Lopez, PA-C, Officer-at-Large
Sarah Lyle, MD
Terry Murphy, MD, Vice Chair – Absent
Elisha Mvundura, MD – Absent
Robert Pullen, Public Member – Absent
Scott Rodgers, JD, Public Member
Claire Trescott, MD
Richard Wohns, MD

WMC Staff in Attendance

Colleen Balatbat, Staff Attorney
Jennifer Batey, Legal Support Staff Manager
Amelia Boyd, Program Manager
Carolynn Bradley, Mgmt Analyst/Contract Manager
Kayla Bryson, Executive Assistant
Jimi Bush, Director of Quality & Engagement
Adam Calica, Chief Investigator
Carmen Challender, Health Services Consultant
Marisa Courtney, Licensing Manager
Joel DeFazio, Staff Attorney
Gina Fino, Director of Compliance
Ryan Furbush, Paralegal
Rick Glein, Director of Legal Services
Kayla Gregory, Investigator
Mike Hively, Director of Operations & Informatics
Ken Imes, Information Liaison
Kyle Karinen, Executive Director
Sara Kirschenman, Staff Attorney
Christopher Knight, Management Analyst
Mike Kramer, Compliance Officer
Stephanie Mason, Public Information Officer & Legislative Liaison
Micah Matthews, Deputy Executive Director
Lynne Miller, Paralegal
Fatima Mirza, Program Case Manager
Freda Pace, Director of Investigations
Stormie Redden, Legal Assistant
Chris Waterman, Complaint Intake Manager
Trisha Wolf, Staff Attorney
Mahi Zeru, Equity & Social Justice Manager

Others in Attendance

Sunil Aggarwal
Marlon Basco-Rodillas, Dept. of Health (DOH)
Pamela Beall
Rose Bigham, Washington Patients in Intractable Pain (WashPIP)
Alisha Briggs
Chris Bundy, MD, Executive Medical Director, Washington Physicians Health Program
Heather Cantrell, DOH
Heather Carter, Assistant Attorney General
Zach Correia
Maria Higginbotham
Martha Mioni
Hillary Norris, Washington State Medical Association (WSMA)
Susan Olsen

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Others in Attendance continued

Kathy Pfeil
Gina Robertshaw
Jeb Shepherd, WSMA
Sarah Tompkins
Susie Tracy

1.0 Call to Order

Karen Domino, MD, Chair, called the meeting of the Washington Medical Commission (WMC) to order at 9:05 a.m. on October 11, 2024.

2.0 Public Comment

Kathy Pfeil from Olympia, WA, shared her experience with chronic pain management following a car accident when she was 35. Now in her 70s, she noted that for nearly 20 years, pain medications helped her live a full life, allowing her to work, return to college, and even become a minister. However, as regulations around prescribing pain medications changed, she has found that effective treatments are increasingly difficult to access. She highlighted the automatic assumption of tapering patients off these medications, regardless of their success in managing chronic pain. She has been prescribed various alternative treatments, none of which provide the same relief as pain medications. She also raised concerns about the lack of patient support after medication changes, particularly for individuals facing complex, long-term medical needs.

Jeb Shepherd, director of policy at the Washington State Medical Association, expressed gratitude to the Washington Medical Commission. He thanked Micah Matthews and Dr. Fino for attending the association's October annual meeting in Spokane, appreciating their presence and attentiveness to physicians' discussions on resolutions. He also thanked the Commission for addressing concerns regarding the AI interpretive statement, acknowledging Dr. Domino and the staff for their openness to continued dialogue on the matter.

Maria Higginbotham expressed gratitude to the Washington Medical Commission for reviewing their petition on the opioid rules, specifically regarding tapering practices. She highlighted a recent shift across most pain clinics in the state, driven by updates to the opioid dose calculator from the AMDG, leading clinics to initiate tapering for all patients regardless of medical conditions. She explained this shift has destabilized many patients, leaving them unable to function, affecting their families, and straining community resources. She noted that some patients abandon pain management entirely, facing painful choices to endure suffering, risk dangerous street drugs, or even contemplate suicide. She stated she shared with Amelia Boyd, Program Manager, a study from the University of Alabama, "CSI Opioids," which investigates suicides linked to prescription opioid reductions, emphasizing the tragic necessity of such research. She expressed deep appreciation for the Commission's efforts on behalf of chronic pain patients.

3.0 Chair Report

Dr. Domino expressed appreciation for the recent retreat, highlighting its educational value and the opportunity it provided to connect with other Commissioners from both panels and staff. She thanked the staff for organizing the successful event.

4.0 Consent Agenda

The Consent Agenda contained the following items for approval:

4.1 Agenda for October 11, 2024.

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4.2 Minutes from the July 19, 2024, Business Meeting

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

Rules Hearings

Rules hearings were held on the following:

- Military spouse temporary permits, WSR 24-18-041, WAC 246-918-076 (physician assistants) and 246-919-397 (physicians) How to obtain a temporary practice permit—Military spouse proposed updates to incorporate RCW 18.340.020. The proposed language for this rule was approved without any amendments.
- General provisions for opioid prescribing and tapering rules for allopathic physicians and physician assistants, WSR 24-18-091. Proposed amendments to the commission's opioid pre scribing rules to exclude patients with sickle cell disease, clarify tapering considerations and, in this supplemental, to clarify the use of biological specimen testing. The proposed rules amend WAC 246-918-801 Exclusions, 246-918-870 Periodic review—Chronic pain, and 246-918-900 Tapering considerations—Chronic pain for physician assistants, as well as WAC 246-919-851 Exclusions, 246-919-920 Periodic re view—Chronic pain, and 246-919-950 Tapering considerations—Chronic pain for allopathic physicians. The proposed language for this rule was approved without any amendments.

5.0 New Business

5.1 2026 Meeting Dates

Ms. Boyd presented the proposed meeting dates for the year 2026. The Commissioners suggested a change to the date of the Commissioner retreat.

***Motion**:* The Chair entertained a motion to approve the 2026 schedule with the suggested amendment. The motion was seconded and approved unanimously.

6.0 Old Business

6.1 Committee/Workgroup Reports

These reports were provided in writing and included in the meeting packet. There were no additional reports.

6.2 Rulemaking Activities

The rulemaking progress report was provided in the meeting packet. In addition to the written report, Ms. Boyd made the following requests:

- Initiate CR-103 permanent rulemaking to formalize the rules approved through expedited rulemaking (CR-105) concerning physician assistant collaborative practice under ESHB 2041. The CR-105 was filed as WSR #24-15-055.
- Initiate the CR-103 permanent rulemaking to formalize the rules approved through expedited rulemaking (CR-105) removing references to osteopathic physician assistants. The CR-105 was filed as WSR #24-15-054.

***Motion**:* The Chair entertained a motion to initiate the CR-103 for both rulemakings. The motion was seconded and approved unanimously.

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7.0 Policy Committee Report

Christine Blake, Public Member, Policy Committee Chair, asked Micah Matthews, Deputy Executive Director, to report on the items discussed at the Policy Committee meeting held on September 26, 2024.

Mr. Matthews explained that the Committee is requesting three votes. The first is to reaffirm the **Guidance Document: Medical Directors: Roles, Duties, and Responsibilities (GUI2020-02)**. He noted that this document is due for its four-year review and that no substantive changes have been made.

> ***Motion:*** The Chair entertained a motion to reaffirm the document as presented. The motion was seconded and approved unanimously.

The second is to rescind the **Policy: Telemedicine, POL2021-02.** He explained this needed to be rescinded because the uniform telehealth law was passed in Washington, making it the first state to do so. The law includes all the existing policy positions, which are now codified in statute, thereby superseding the original.

> ***Motion:*** The Chair entertained a motion to rescind the policy. The motion was seconded and approved unanimously.

The third is to approve the following documents for DOH Secretary review:

- **Proposed Policy: Processing Complaints Against Medical Students, Residents, and Fellows**
- **Proposed Policy: Commissioner and Pro Tem Recusal Policy to Address Conflicts of Interest**
  Proposed Interpretive Statement: "Qualified Physician" Under Optometry Law
- **Proposed Policy: Artificial/Assistive/Augmented Intelligence (AI)**

Mr. Matthews explained that these four items were to be voted on as a group unless any Commissioner objected, with the goal of approving them for submission to the DOH's Secretary for review. This meant sending the items out for comments from the Department of Health, the Secretary of Health, and other relevant boards and commissions, with feedback to be considered at a future meeting. He clarified for interested parties that this would not be their last opportunity to review or comment on these items. The earliest possible adoption, assuming timely action from the Secretary's office, would be in January. Additionally, he acknowledged receiving extensive feedback on the artificial intelligence document and noted that they would be meeting with various associations later in the month to address concerns and refine the language where needed.

> ***Motion:*** The Chair entertained a motion to approve the documents as presented for DOH Secretary review. The motion was seconded and approved unanimously.

8.0 Member Reports

No member reports were provided.

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9.0 Staff Reports

The report below is in addition to the written reports that were included in the meeting packet.

Jimi Bush, Director of Quality and Engagement, thanked Mr. Lopez and Britta Fisher for their presentation at the Washington Academy of Physician Assistants meeting on the complaint process with the Commission. She reported receiving positive feedback from attendees the following morning and expressed appreciation for their effort in delivering the presentation

10.0 AAG Report

Heather Carter, AAG, had nothing to report.

11.0 Adjournment

The Chair called the meeting adjourned at 10:36 am.

Submitted by

Amelia Boyd, Program Manager

Karen Domino, MD, Chair
Washington Medical Commission

Approved January 10, 2025

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Practitioner Support Program
FY24 Cases

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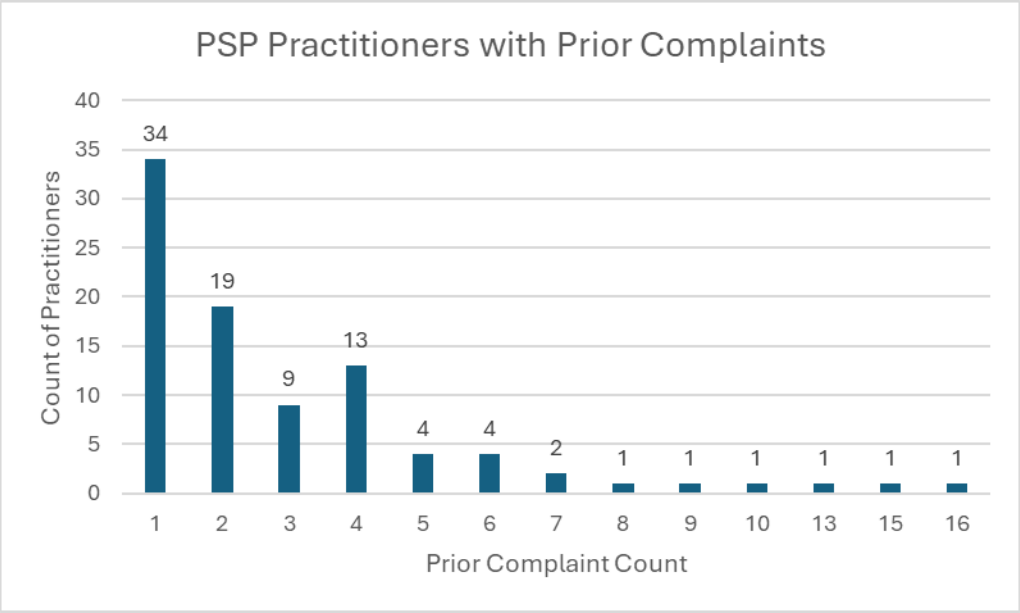
Methodology

When the WMC receives a complaint that does not meet the threshold to authorize an investigation, we have the authority to close the case with a Practitioner Support Program (PSP) designation, where the provider receives resources to enhance their practice based on the alleged issues of the complaint. Between July 1, 2023, and June 30, 2024, 161 cases have been closed with the PSP designation. These cases and their respective practitioners were then analyzed per the following criteria:

- Prior complaints/discipline
- Date of initial licensure
- PSP case natures
- PSP Letter recommendations for CME/programs
- Complaints received after the PSP case was closed
- Practitioner demographics (gender, specialty, medical school, etc.)

Other complaints and discipline prior to PSP closure

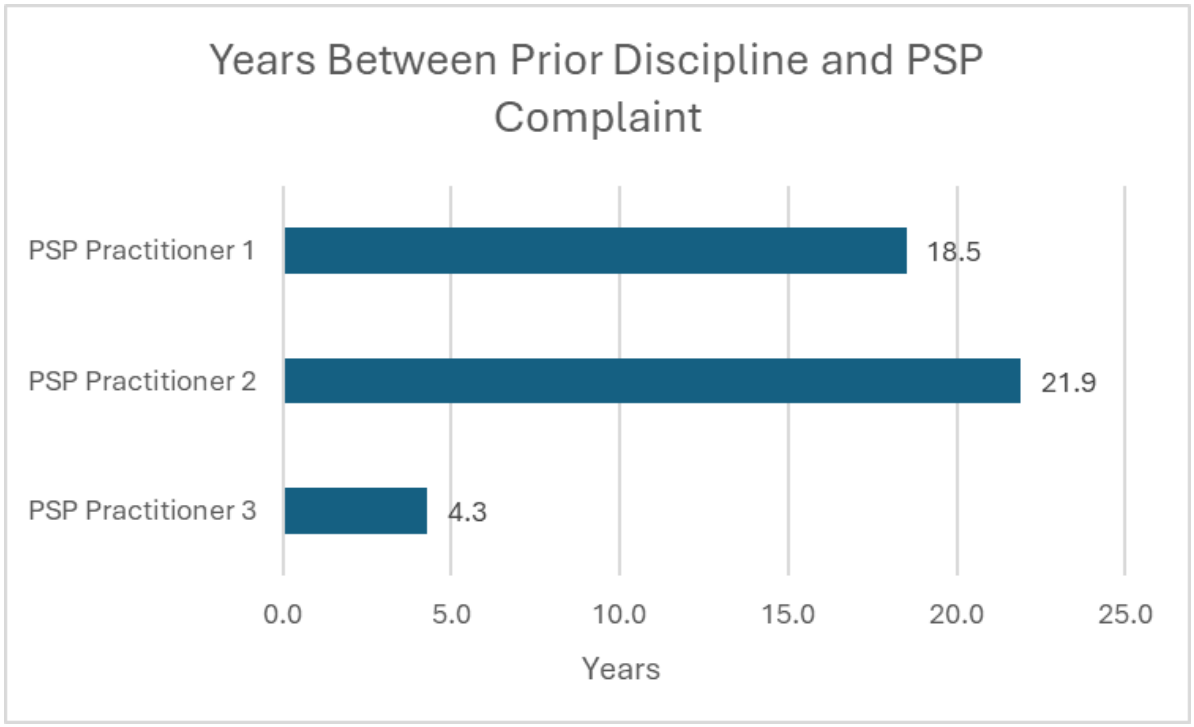
For 70 of the 161 PSP cases (43.5%), it was the practitioner's first complaint filed with the WMC. There were 91 practitioners who had received complaints prior to the PSP case, reflected in the chart below. 72 percent of those who had received complaints prior to PSP had similar case natures and alleged issues as the PSP case.



Among the 161 PSP cases, three practitioners received disciplinary action prior to the PSP complaint. All three had STIDs issued, with one additional STID pending.

Two of the four disciplinary cases had similar case natures to the PSP cases. The two were both "Standard of Care/Services" with "Patient Care" as the alleged issue. As the program matures, it will be interesting to see if there are more PSP cases in which the practitioner has already received discipline for a prior complaint that has a similar case nature.

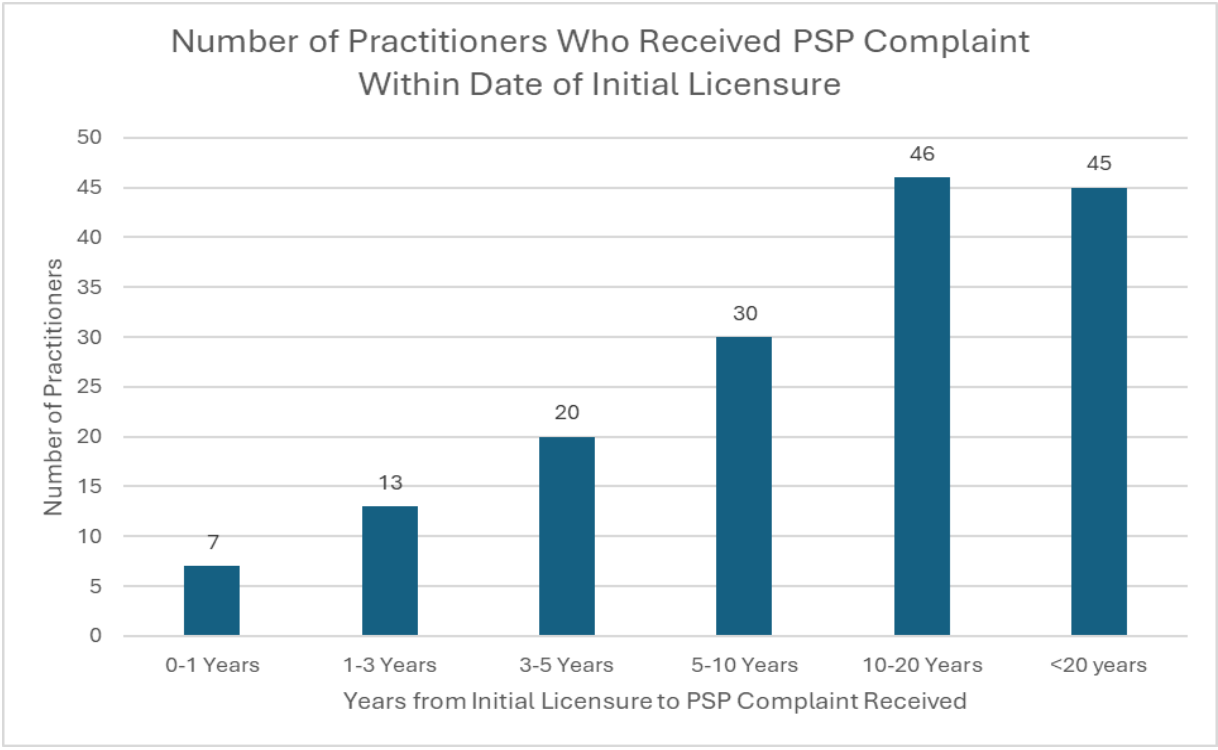
The chart below reflects the number of years from when initial discipline was issued to when the PSP complaint was received.



Two of the above practitioners who had received discipline prior to their PSP complaint have had one complaint filed against them since their PSP cases were closed. One complaint is pending investigation, and the other was closed "complaint unique closure".

Years from initial licensure to complaint that resulted in a PSP closure

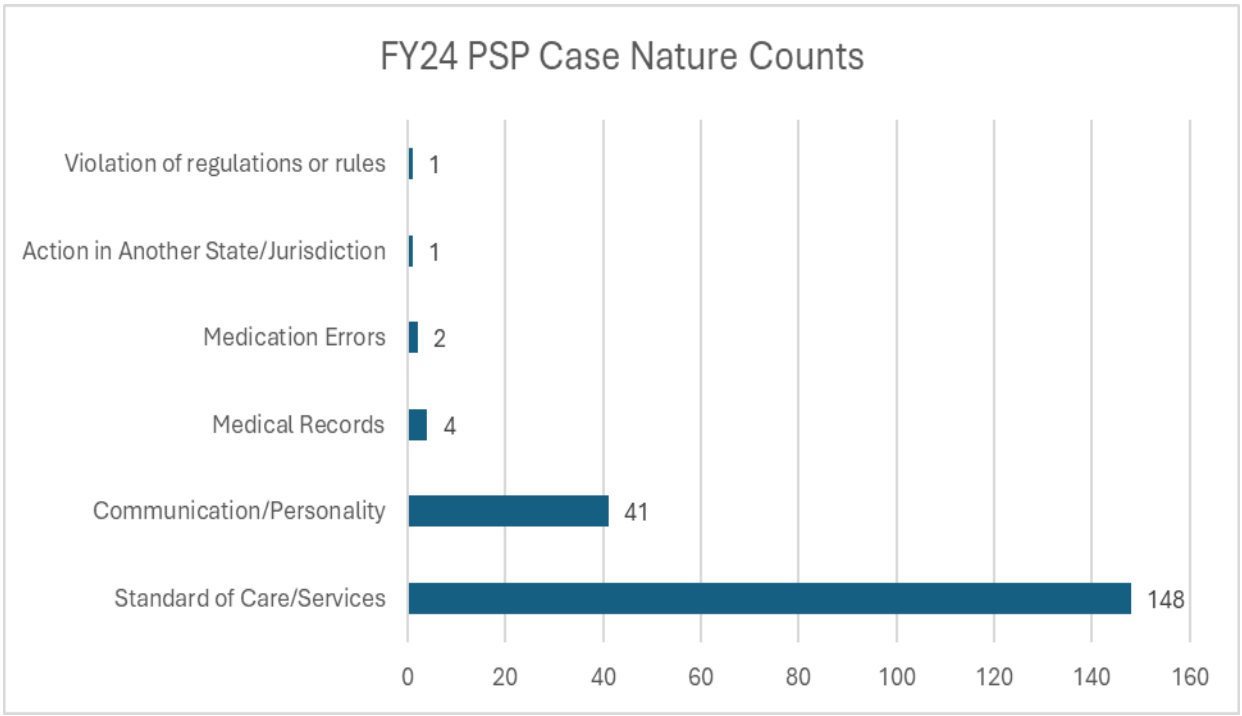
The average time from the practitioners' initial licensure date to the receipt of the PSP complaint was 14.3 years. Please note that the PSP complaint may not be the practitioner's first complaint. The graph on the next page reflects the number of practitioners who received PSP complaints within the distributed time periods.



79 of the 161 PSP practitioners received prior complaints that were not classified as PSP complaints. The average time from initial licensure to the receipt of the first complaint was 9 years.

FY24 PSP Case Natures

75 percent of the PSP cases involved concerns related to the standard of care or services provided by the practitioner. The graph below shows the count of the PSP case natures closed in FY24:



PSP Letter recommendations for CME/programs

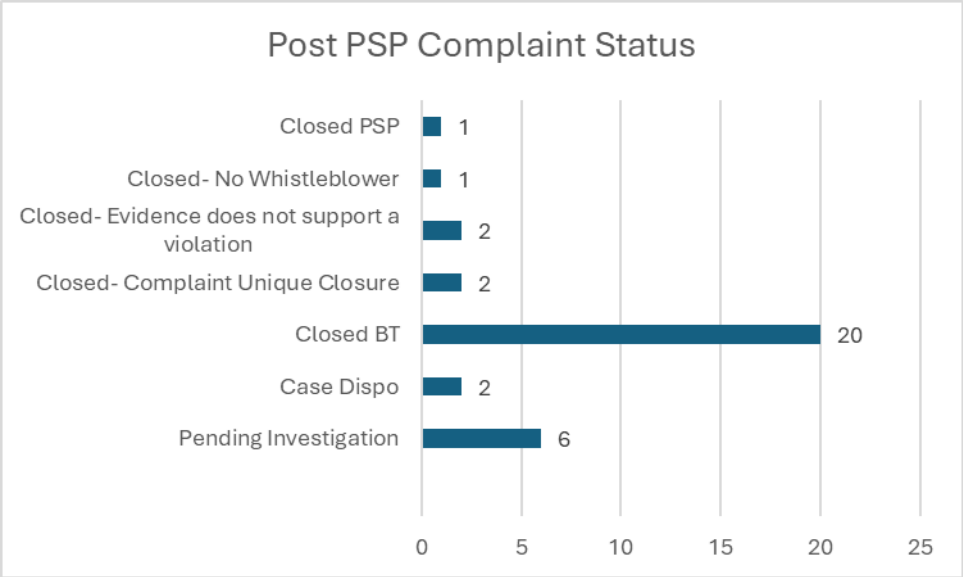
There were 177 instances of Continuing Medical Education (CME) recommended by the WMC. 15 of the 161 PSP practitioners had two different types of CME recommended, meaning that there was more than one issue within the PSP complaint that warranted two unrelated types of CME. For example, in one case a practitioner was recommended CME on communication as well as CME on opioid prescribing. 64% of the recommendations were practitioner-to-patient communications related. The chart below reflects the CME type and the count of those recommended.

CME Type	Count
Communication	113
Difficult Patient Encounters	7
Terminating the Practitioner-Patient Relationship	7
Implicit Bias	5
Empathy	4
Opioid Prescribing	3
Conducting Sensitive Exams	2
HIPPA Rules Summary	2
Medical Professionalism	2
Medical Record Keeping	2
Outpatient Notes	2
Anesthesia	1
Communication in Cancer Care	1
Compassion	1
COVID	1
Documentation	1
EHR Efficiency	1
Emergency Department Diagnosis and Management	1
Endocrinology for Primary Care	1
Establishing Patient-Physician Relationship	1
Ethics	1
HIPAA Privacy Rule	1
Informed Consent	1
Informed Consent in Pediatrics	1
Internal Medicine Review	1
Mandatory Reporting	1
Medication Labels	1
Medication Refills	1
Parkinson's Disease Medication Management	1
Pediatric Assent and Treating Children Over Objection	1
Prescribing	1
Prescribing Rules	1
Prior authorization	1
Pronouns and Advocacy in Medicine	1
Self-Treatment of Treatment of Immediate Family Members	1
Soft Tissue Trauma	1
CME Type Cont.	**Count**

Specialty Referrals	1
Technology in Medicine	1
Telehealth Law & Ethical Issues	1

Complaints received after the PSP case was closed

As of August 8,2024, 25 of the 161 PSP practitioners have received at least one complaint after receiving PSP recommendations. On average, it took 117 days from when the case was closed through PSP to when the practitioner received another complaint. The chart below shows the case outcomes or case status of the total 34 complaints received by the 25 practitioners.



20 of the 25 had a similar case nature to the PSP complaint. Of these 20, the average time from when the PSP letter was sent to when the subsequent complaint was received was 93 days. The majority (18) were classified as "Standard of Care/Services" in case nature.

The chart below shows the CME that was recommended to the 20 practitioners per the initial PSP complaint who subsequently had a complaint with a similar case nature to the PSP complaint.

CME Recommended	Count
Communication	14
Communication in Cancer Care	1
Compassion	1
EHR Efficiency	1
Ethics	1
HIPPA Rules Summary	1
Telehealth Law & Ethical Issues	1

The case nature "Standard of Care/Services" is a broad classification and can cover a variety of complaints. Upon further analysis of the 20 practitioners with post PSP complaints that had similar case

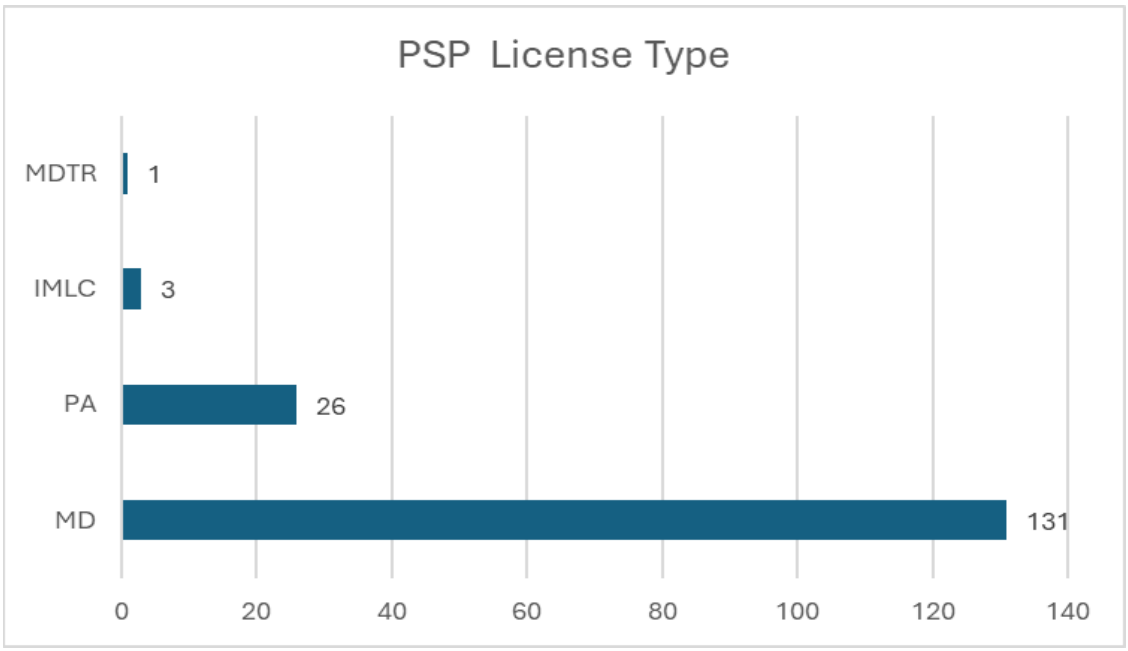
natures, 10 of them would have been able to apply the CME they were recommended from the original PSP case to prevent a future complaint. For example, in one case the original PSP complaint specifically stated that the practitioner "belittles and gaslights complainants concerns of the patient." The WMC recommended CME regarding communication. In reading the post PSP complaint, the complainant stated that the practitioner "was condescending and shamed patient in appointments".

There are 7 post PSP complaints that had similar case natures to the original PSP case still open; 1 in Case Intake status, 4 in Investigations status, and 2 that are pending the enforcement process. Of these, only one case that is pending the enforcement process could have applied the CME from their PSP case to prevent a similar complaint. In this case, both the PSP complaint and post PSP complaint are regarding the practitioner's inability to return phone calls or messages, and the PSP CME was regarding communication.

PSP Practitioner Demographics

Of the 161 PSP practitioners, 69 (43%) identify as female and 92 (57%) identify as male. The average age of the PSP practitioners is 44 years old, the youngest being 32 years old, and the oldest being 94 years old. 46 (28.5%) of the PSP practitioners obtained their medical degree in a foreign country.

The chart below shows the 161 PSP practitioners broken down by license type.

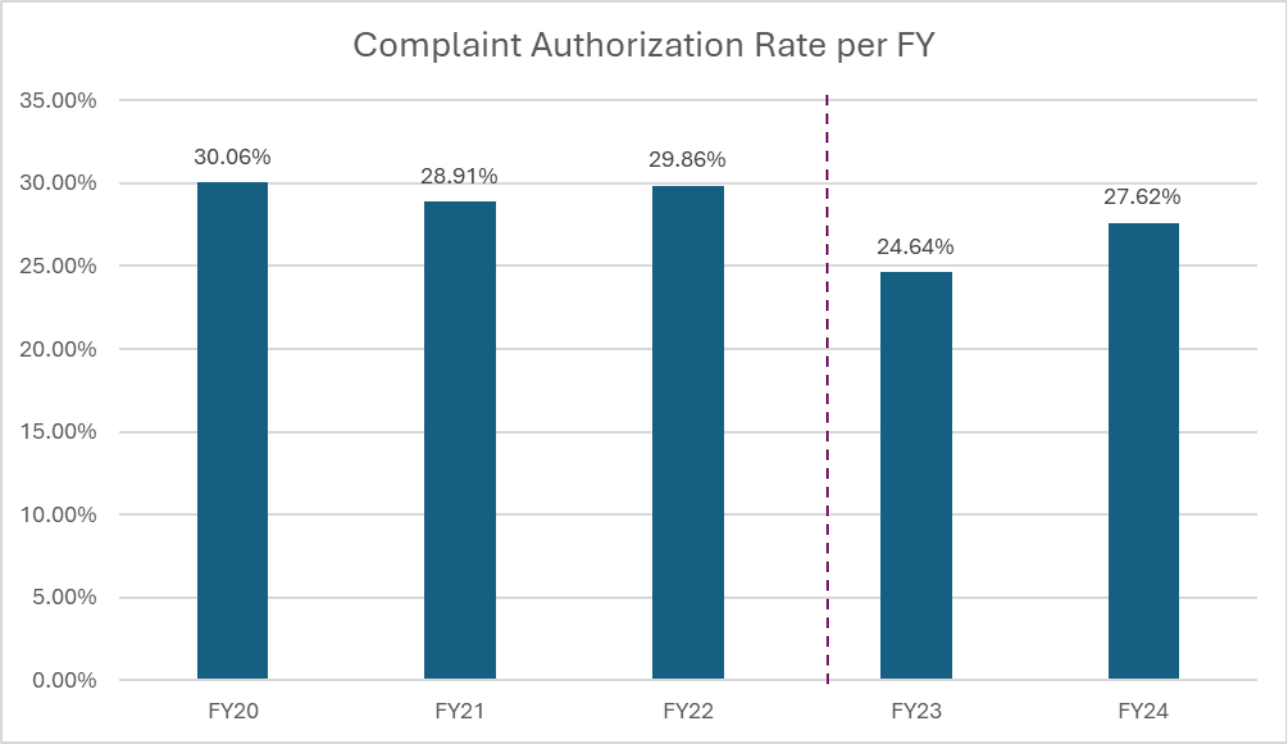


Of the MDs, 101 were ABMS certified. Of the IMLCs, 1 was ABMS certified. Of the PAs, 22 were NCCPA certified. Most PSP practitioners identified their specialty as Family Medicine. The chart below reflects the specialty counts.

Specialty	Count	% of Specialty Population
Family Medicine	34	1.9%
Emergency Medicine	21	2.4%
Internal Medicine	21	0.9%
Pediatrics	11	1.4%
Obstetrics	10	2.3%
Anesthesiology	7	1.1%
Neurology	7	2.2%
Urology	6	4.0%
Orthopedic Surgery	5	1.3%
Psychiatry	5	0.7%
Otolaryngology	4	3.6%
Surgery	4	0.3%
General Surgery	3	0.6%
Occupational Medicine	3	20.0%
Ophthalmology	3	1.7%
Dermatology	2	0.9%
Pain Management	2	4.3%
Unknown	2	N/A
Allergy and Immunology	1	3.8%
Cardiovascular Disease	1	1.0%
Gastroenterology	1	0.9%
Oncology	1	4.8%
Pediatric Emergency Medicine	1	0.09%
Physical Medicine and Rehabilitation	1	0.9%
Radiology	1	0.4%
Reconstructive Surgery	1	0.1%
Rheumatology	1	2.7%
Thoracic and Cardiac Surgery	1	5.0%
Vascular Surgery	1	2.5%

Summary of Findings / Conclusion

The Practitioner Support Program launched in April of 2022, however the case closure code specifying it was a PSP closure was not implemented until March of 2023 in the ILRS database. The data contained in this report is limited to FY24. The chart below shows the FY breakdown of complaints authorized per FY, the jagged line reflecting the point at which the PSP was initially launched.



The criteria analyzed in this report provides a baseline for the future of the PSP program . Ongoing monitoring of FY24 and subsequent PSP practitioners will be conducted to detect any newly filed complaints or disciplinary actions that exhibit similarities to their previously adjudicated PSP cases. Moving forward, we can identify trends in PSP cases and their respective practitioners in order to improve upon this program.

Research Unit Process

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Background

The WMC has a history of submitting original research for peer review publication and poster sessions. These events have increased as demand for qualitative regulatory research has increased. This process aims to formalize the submission and review process to ensure that the high standards of WMC research are met.

Scope

This process is applicable to commissioners and staff members who submit research concepts and abstracts for peer-reviewed publications or official WMC research initiatives. Responsibilities

- Principal Investigator (Jimi Bush): Reviews submitted ideas and provides feedback.
- Research Staff (Sarah Chenvert): Responsible for assisting with data collection and analysis.
- Authors: Responsible for formulating and submitting research ideas.
- Review Committee: Responsible for evaluating research proposals and providing expertise. This committee will also act as the editorial committee before publishing.

Submission Procedure

Initial Preparation

Authors Identify a Research Idea:

1. Ensure the idea aligns with the unit's research focus and objectives.
2. Meet with the PI and research staff to consider feasibility, potential impact, and relevance.

Conduct Preliminary Research:

1. Authors Perform a brief literature review to assess existing work in the area.
2. Authors and research staff identify gaps that the project addresses.

Assemble the Research Committee

1. After the initial literature review has been completed and discussed with the research staff, the following components will be presented at the next commission meeting
    a. Title
    b. Description
    c. Objectives: Outline the primary objectives (bullet points preferred).
    d. Methodology: Briefly describe proposed methods and approaches.
    e. Significance: Explain the potential impact of the research.
    f. References: Include relevant literature or prior work.
2. We will ask the Commissioners for volunteers as to whom would like to be part of the review committee. Having a rotating panel reviewing and editing research mitigates bias, allows for people to participate in the project based on their available time to review and general interest and expertise in the proposed project.

Conducting Research

1. Research is conducted per the guidelines set by the review committee.
2. PI and Research Staff assist as needed.
3. Check-ins with the review committee will be scheduled as scheduling allows.
4. Final research is submitted to the review committee for feedback.
5. Author adjusts text and tone of the paper as directed by the review committee.
6. Author may proceed with submission once approved by the review committee.

Committee/Workgroup Reports:
January 10, 2025

High Reliability Organizations Workgroup – Chair: Dr. Chung Staff: Mike Farrell
Nothing to report.

Healthcare Disparities Workgroup – Chair: Dr. Currie Staff: Kyle Karinen
We have had multiple conversations with a group that runs a program called Advanced Ethics in Leadership. I came across this group through a virtual lecture sponsored by Harvard Medical School. The speaker was a MD who presented a lecture on the history of professionalism in medicine, but was also highlighted in a media piece about how professionalism is taught in medical school and residency. (Recall that piece mentioned a study that showed a disproportionate number of minorities are discharged from residency programs.) The lecture piqued my interest in the rest of the program they were delivering at HMS. Jimi and I talked with their staff a couple of times about developing a daylong curriculum for the Commission and it feels like it could be a good fit for Commission members. The program would run a whole day. The only hesitancy at the moment is that it would run best with a slightly higher number of attendees than what we could likely muster from the Commission ranks alone. I have reached out to the Board of Osteopathic Medicine and Surgery to see if they might be interested in joining you as well as the Oregon Medical Board.

IV Hydration Treatment Workgroup – Chair: Dr. Murphy Staff: Mike Farrell/Jimi Bush
Staff is working diligently to gather as much information from DOH partners and other state medical boards on common/best practices for IV Hydration regulation. Meeting to take place on January 10th to discuss progress and next steps.

Finance Workgroup – Chair: Dr. Domino Staff: Kyle Karinen
Nothing to report.

Finance Workgroup – Chair: Dr. Domino Staff: Kyle Karinen
The WMC has formed a workgroup to look into the current state of psychedelic drugs in behavioral health settings. This effort will be initially aimed at getting Commission staff educated on current uses, best practices, and delve into the clinical research literature. The first workgroup meeting is slated for January 6, 2025. The charter for this workgroup can be found on pages 36-37 of this meeting's packet.

Committees & Workgroups

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Executive Committee
Chair: Dr. Domino
Chair Elect: Dr. Murphy
Officer-at-Large: Ed Lopez, PA-C
Policy Chair: Christine Blake, PM
Immediate Past Chair: Dr. Chung
Ex Officio Member: Dr. Gallinger
Kyle Karinen
Micah Matthews
Heather Carter, AAG

Policy Committee
Christine Blake, PM, Chair (B)
Dr. Domino (B)
Ed Lopez, PA-C (B)
Dr. Lyle (A)
Scott Rodgers, PM (A)
Dr. Trescott (B)
Heather Carter, AAG
Kyle Karinen
Micah Matthews
Amelia Boyd

Newsletter Editorial Board
Dr. Currie
Dr. Chung
Dr. Wohns
Jimi Bush, Managing Editor
Micah Matthews

Legislative Subcommittee
Dr. Chung, Chair
John Maldon, PM. Pro Tem Commissioner
Christine Blake, PM
Dr. Wohns
Kyle Karinen
Micah Matthews

Finance Workgroup
Dr. Domino, WMC Chair, Workgroup Chair
Dr. Murphy, WMC Chair Elect
Kyle Karinen
Micah Matthews
Jimi Bush

Health Equity Advisory Committee
Dr. Currie, Chair
Dr. Browne
Dr. Jaeger
Christine Blake, PM
Douglas Pullen, PM
Kyle Karinen
Mahi Zeru

Panel L
Dr. Chung, Chair
Christine Blake, PM
Arlene Dorrough, PA-C
Dr. Lyle
Dr. Wohns
Dr. Trescott
Dr. Browne, Pro Tem
John Maldon, PM, Pro Tem
Marisa Courtney,
Micah Matthews

High Reliability Workgroup
Dr. Chung, Chair
Dr. Domino
Christine Blake, PM
Dr. Jaeger
Scott Rodgers, PM
Dr. Chang
Ed Lopez, PA-C
Dr. Lyle
John Maldon, PM, Pro Tem
Kyle Karinen
Micah Matthews
Mike Farrell
Jimi Bush
Amelia Boyd

Nominating Committee 2024
Dr. Chung
Arlene Dorrough, PA-C
Dr. Jaeger

Updated: December 19, 2024

Committees & Workgroups

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IV Hydration Treatment Workgroup
Dr. Murphy, Workgroup Chair
Dr. Jaeger
Kyle Karinen
Freda Pace
Dr. Fino
Mike Farrell
Jimi Bush
Taylor Bachrach-Nixon

Psychedelics in Behavioral Health Treatment Workgroup
Dr. Domino, Workgroup Chair
Kyle Karinen
Rick Glein
Dr. Fino
Mike Farrell
Jimi Bush
Marne Nelson
Taylor Bachrach-Nixon
Ex Officio Member: Dr. Chris Bundy, WPHP

CDTA Workgroup
Dr. Chung
Dr. Lyle
Ed Lopez. PA-C
Kyle Karinen
Micah Matthews
Dr. Fino
Joel DeFazio, Staff Attorney
Amelia Boyd

Anesthesiologist Assistants Rule
Dr. Domino
Dr. Currie
Dr. Chung
Ed Lopez, PA-C
Micah Matthews
Marisa Courtney
Amelia Boyd
Heather Carter, AAG
Marlon Basco-Rodillas, Policy Analyst

Please note, any committee or workgroup that is doing any interested parties work or getting public input must hold open public meetings.

PM = Public Member

WPHP = Washington Physicians Health Program

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Workgroup Charter

Psychedelic Medications in Behavioral Health Treatment Workgroup

Purpose

1. To educate the Commission members and staff on the current landscape with the use of psychedelic substances to treat behavioral health conditions.
2. To learn more about the current state of the use of ketamine to treat behavioral health conditions to determine if there are consistent best practices for the prescribing and administration.
3. To coordinate with other disciplinary authorities, including, but not necessarily limited to, the Board of Osteopathic Medicine and Surgery, Washington Board of Nursing and Washington State Pharmacy Quality Assurance Commission, to measure if there are common areas of interest and concerns regarding the use of ketamine to treat behavioral health conditions.
4. Report recommendation(s), if any, to the Policy Committee.

Dissolution

The group will serve at the pleasure of the Commission Chair.

Members

Chair: Karen Domino, MD

Staff:

- Rick Glein, Director of Legal Services
- Gina Fino, MD, Medical Consultant
- Mike Farrell, Supervising Staff Attorney
- Jimi Bush, Director of Quality and Engagement
- Marne Nelson, Clinical Healthcare Investigator
- Taylor Bachrach-Nixon, Management Analyst

Ex-officio:
Chris Bundy, Medical Director, Washington Physicians Health Program

Executive Sponsor:
Kyle Karinen, Executive Director

WASHINGTON
Medical
Commission
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Authorization

☒Commission Chair ☐Policy Chair

Signature: Karen B. Domino Date: 11/21/2024

WMC Rules Progress Report						Projected filing dates			
Rule	**Status**	**Date**	**Next step**	**Complete By**	**Notes**	**CR-101**	**CR-102**	**CR-103**	**CR-105**
Collaborative Drug Therapy Agreements	CR-101 filed	7/22/2020	Waiting on the results of the workgroup	NA		Complete	TBD	TBD	NA
General provisions for opioid prescribing and tapering	Proposed language approved	10/11/2024	File CR-103	February 2025		Complete	Complete	TBD	NA
HB 1009 Military Spouse	CR-103 Filed	12/3/2024	Rules effective	1/3/2025	Keep BoMS updated	Complete	Complete	Complete	NA
OBS - Use of Nitrous Oxide, WAC 246-919-601	Workshop scheduled	1/27/2025	Workshops	In progress	Keep BoMS updated	Complete	TBD	TBD	NA
ESSB 5389 - Define Qualified Physician	CR-101 approved	10/20/2023	Request to change scope of rulemaking	1/10/2025	Board of Optometry approved proposed language 10/11/2024 Keep BoMS updated.	TBD	TBD	TBD	NA
SB 5184 - Anesthesia Assistants - New Profession	Draft language approved for CR-102	12/6/2024	Request initiating next step in rulemaking process, CR-102	1/10/2025		Complete	TBD	TBD	NA

Updated: 12/11/2024

Opioid prescribing for MDs and PAs	CR-101 approved	7/19/2024	Upload CR-101 docs	February 2025	Must wait until General provisions for opioid prescribing and tapering rules are effective to file CR-101.	May 2025	TBD	TBD	NA

Memo

WASHINGTON Medical Commission
Licensing. Accountability. Leadership.

To: **WMC Commissioners**

From: **Amelia Boyd, Program Manager**

Subject: **Rulemaking Authorization Request: Physician's Chapter Sections of Rule, WAC 246-919-010 through WAC 246-919-520, and WAC 246-919-602 through WAC 246-919-700**

Under RCW 43.70.041, the Department of Health (DOH) is required to review its Washington Administrative Code (WAC) rules every five years. In 2024, WMC staff conducted a review of the physician's chapter, specifically WAC 246-919-010 through WAC 246-919-520 and WAC 246-919-602 through WAC 246-919-700. The remaining sections of WAC chapter 246-919 are either scheduled to be addressed through a separate rulemaking process or fall under the authority of the DOH Secretary.

Staff identified several areas where the rule language could be updated or revised to align with current standards. We are requesting approval to initiate rulemaking for WAC 246-919-010 through WAC 246-919-520 and WAC 246-919-602 through WAC 246-919-700.

Memo

WASHINGTON Medical Commission
Licensing. Accountability. Leadership.

To: **WMC Commissioners**

From: **Amelia Boyd, Program Manager**

Subject: **Change to Rulemaking Authorization Request-Opioid Prescribing**

Commissioners, at your July 19, 2024, Business meeting, you reviewed a rules petition submitted by Maria Higginbotham, requesting three revisions to the opioid prescribing rules for both MDs and PAs:

1. "Add the following language: Ordering, prescribing, dispensing, administering, or paying for controlled substances, including opioids, shall not be predetermined by the specific morphine milligram equivalent (MME) guidelines."
2. "Add exemption: Rare diseases-patients who have rare disease, as defined by the National Organization for Rare Disorders (NORD) and/or indicated by the Rare Disease Databases of the National Institutes of Health (NIH) are exempt from the guidelines and/or policies."
3. "Add the following language: Not all chronic pain patients should or must have their prescription opioid medications reduced, tapered, cut, or otherwise decreased. If a patient is stable on opioid therapy and has been compliant with their treatment plan: any such reductions are a violation of State policy, and destabilizing the patient, by decreasing their medication, is below the standard of care and a violation of state law. Treatment plans should not be altered or changed unless a violation occurs."

At that same Business meeting, you approved initiating rulemaking to address additional comments received throughout the rulemaking process related to general provisions for opioid prescribing and tapering. Items #1 and #2 were approved for inclusion in the new rulemaking, while item #3 was approved to be incorporated into the current rulemaking on these provisions. Ms. Higginbotham received a letter notifying her of these decisions.

A rules hearing was subsequently held on October 11, 2024, for the general provisions for opioid prescribing and tapering. However, due to an oversight on my part, the suggested language in item #3 was not presented at the hearing and therefore was not

considered.

Today, I am requesting that the Commissioners approve the inclusion of the suggested language in item #3 to be considered as part of the new rulemaking on opioid prescribing.

A new letter will be sent to Ms. Higginbotham informing her of your decision in this matter.

From: Boyd, Amelia (WMC)
To: Boyd, Amelia (WMC)
Subject: FW: Witkowski - inquiry WMC licensure by endorsement, reciprocity (associate professor)
Date: Monday, November 25, 2024 10:41:30 AM

From: Alexander Witkowski MD, phD <aw@medvice.health>
Sent: Wednesday, November 20, 2024 12:59:07 PM
To: Matthews, Micah T (WMC) <micah.matthews@wmc.wa.gov>; Mohamed Khalif <mohamedk@waimg.org>; Courtney, Marisa J (WMC) <marisa.courtney@wmc.wa.gov>
Subject: Re: Witkowski - inquiry WMC licensure by endorsement, reciprocity (associate professor)

External Email

Dear Mr. Matthews,
Cc: Ms. Courtney,

I am following up on my phone call this morning with Mr. Matthews related to an existing opportunity to collaborate with Tribal Leadership and contribute to health disparity/equity in Washington. The project relates to Dr. Ludzik and I independently directing project(s) to increase skin cancer triage access to underserved Tribal Reservation Communities in Washington State (outside of an academic setting). Per IHS federal rules, both of us would need to obtain full, unrestricted medical licenses in order to offer our expertise, engage in clinical practice, and serve our mission to end death from melanoma and other skin cancers within your State.

We hope that in light of this rural health opportunity — that can make a lasting impact in the lives of the Tribal Communities nationally — the Commission will potentially consider review existing WA statutes (*RCW 18.71.017 ; RCW 18.130.050 ; RCW 18.71.051 ; RCW 18.71.070*), WAC rules, and the exceptional qualifications waiver rule for a **one-time-only waiver** of our USMLE and ECFMG requirements.

Thank you in advance for your sincere patience and willingness to guide us over the past year to find a solution. Before connecting our supporters to the appropriate parties in Washington we look forward to receiving your feedback on the proposed amendments below:

1. **Consideration to adopt an amendment to WAC 246-919-355**
   Examination accepted by the commission.

(4) Examination requirements may be waived on a case-by-case basis for applicants who possess extraordinary clinical ability and meet exceptional qualification waiver requirements in lieu thereof as set forth by the commission.

Statutory authority: RCW 18.71.017 ; RCW 18.130.050 ; RCW 18.71.051 ; RCW 18.71.070

2. **Consideration to adopt an amendment to WAC 246-919-340**
   Additional requirements for international medical school graduates.

   (2) Obtained a certificate with an indefinite status granted by the Educational Commission for Foreign Medical Graduates (ECFMG) or the applicant possesses extraordinary clinical ability and meets the exceptional qualification waiver requirements in lieu thereof as set forth by the commission; or

Statutory authority: RCW 18.71.017 ; RCW 18.130.050 ; RCW 18.71.051

3. **Consideration to adopt an amendment to WAC 246-919-330**
   Postgraduate medical training. Per our previous email exchanges, there may already be a mechanism for this

   (4) Examination requirements may be waived on a case-by-case basis for applicants who possess extraordinary clinical ability, have published a significant body of peer reviewed research in their medical specialty, and receive recommendations from international recognized authorities in lieu thereof as set forth by the commission.

Statutory authority: RCW 18.71.017 ; RCW 18.130.050 ; RCW 18.71.051 ; RCW 18.71.051 (if needed)

References below:

RCW 18.71.051 Application—Eligibility requirements—Foreign graduates—Waivers.

(1)(C)(c) That he or she has satisfactorily passed the examination given by the

educational council for foreign medical graduates or has met the requirements in lieu thereof as set forth in rules adopted by the commission;
(2) An applicant may obtain an exceptional qualification waiver, waiving requirements determined by the commission in rule, if they possess an acceptable body of work related to research, medical excellence, or employment, and have the recommendation of other national or international experts in the same specialty or field.

RCW 18.71.017 Rules by commission—Successor to other boards.
(1) The commission may adopt such rules as are not inconsistent with the laws of this state as may be determined necessary or proper to carry out the purposes of this chapter. The commission is the successor in interest of the board of medical examiners and the medical disciplinary board. All contracts, undertakings, agreements, rules, regulations, and policies continue in full force and effect on July 1, 1994, unless otherwise repealed or rejected by this chapter or by the commission.

RCW 18.130.050 Authority of disciplining authority.
Except as provided in RCW 18.130.062, the disciplining authority has the following authority:
(1) To adopt, amend, and rescind such rules as are deemed necessary to carry out this chapter;
(3) To hold hearings as provided in this chapter;
(10) To use a presiding officer as authorized in RCW 18.130.095(3) or the office of administrative hearings as authorized in chapter 34.12 RCW to conduct hearings.
(15) To grant or deny license applications, ...
(18) To establish panels consisting of three or more members of the board to perform any duty or authority within the board's jurisdiction under this chapter;

RCW 18.71.070 Examination—Record.
With the exception of those applicants granted licensure through the provisions of RCW 18.71.090 or 18.71.095, applicants for licensure must successfully complete an examination administered by the commission to determine their professional qualifications. The commission shall prepare and give, or approve the preparation and giving of, an examination which shall cover those general subjects and topics, a knowledge of which is commonly and generally required of candidates for the degree of doctor of medicine conferred by approved colleges or schools of medicine in the United States. Notwithstanding any other provision of law, the commission has the sole responsibility for determining the proficiency of applicants under this chapter, and, in so doing, may waive any prerequisite to licensure not set forth in this chapter. The commission may by rule establish the passing grade for the examination. Examination

results shall be part of the records of the commission and shall be permanently kept with the applicant's file.

RCW 18.71.051 Application—Eligibility requirements—Foreign graduates—Waivers. (A)(I) Been admitted as a permanent immigrant to the United States as a person of exceptional ability in sciences pursuant to the rules of the United States department of labor; Ref: https://www.uscis.gov/policy-manual/volume-6-part-f-chapter-2

Note: Dr. Witkowski is a U.S. born citizen, Dr. Ludzik is a permanent resident (obtained through marriage). Though, per the USCIS we meet all eligibility requirements as persons of exceptional ability in sciences. Recognition letter from President Joe Biden related to detection of the smallest skin cancer (melanoma) to date available upon request.

Kind Regards,
Alexander Witkowski MD, PhD

Alexander Witkowski MD, PhD

Memo

WASHINGTON Medical Commission
Licensing. Accountability. Leadership.

To: **WMC Commissioners**

From: **Amelia Boyd, Program Manager**

Subject: **Rulemaking Authorization Request: Anesthesiologist Assistants CR-102, Proposed Rulemaking**

On March 29, 2024, Governor Inslee signed SB 5184 which creates the licensed Profession of Anesthesiologist Assistants (AAs) under the regulatory authority of the WMC. As part of the process to stand up a new profession and as directed in the bill, the WMC must conduct general standard rulemaking to enact the bill and enforce practice standards for the profession. The goal is to have the rules completed by August 2025.

In April 2024, the Commissioners approved the initiation of rulemaking. The CR-101, Preproposal Statement of Inquiry, was subsequently filed on August 28, 2024, as WSR #24-18-057. Staff facilitated four rules workshops, during which Commissioners collaborated with the public and other interested parties to develop the draft language following this memo.

We request that the Commissioners review this draft language and approve it to proceed to the next step in the rulemaking process, the Proposed Rulemaking stage (CR-102). The rules hearing is tentatively scheduled for May 9, 2025. As part of the CR-102 process, there will be a five-week public comment period leading up to the hearing. Comments received during this period will need to be addressed at the hearing, with Commissioners determining whether to make changes to the rule based on the feedback or providing a rationale for maintaining the language as drafted.

Chapter 246-921 WAC
ANESTHESIOLOGIST ASSISTANTS—WASHINGTON MEDICAL COMMISSION

NEW SECTION

WAC 246-921-005 Definitions. The definitions in this section apply throughout this chapter unless the context clearly requires otherwise:

(1) "Anesthesiologist" means an actively practicing, board-eligible physician licensed under chapter 18.71, 18.71B, or 18.57 RCW who has completed a residency or equivalent training in anesthesiology.

(2) "Anesthesiologist assistant" or "certified anesthesiologist assistant" means a person who has successfully completed an accredited anesthesiologist assistant program approved by the commission and has successfully passed the certification exam offered by the National Commission for Certification of Anesthesiologist Assistants (NCCAA), or other exam approved by the commission. These individuals, who may be known as "AA" or "CAA," are licensed by the commission to assist in developing and implementing anesthesia care plans for patients under the supervision of an anesthesiologist or group of anesthesiologists approved by the commission to supervise such assistant.

(3) "Assist" means the anesthesiologist assistant personally performs those duties and responsibilities delegated by the anesthesiologist. Delegated services must be consistent with the delegating anesthesiologist's education, training, experience, and active practice. Delegated services must be of the type that a reasonable and prudent anesthesiologist would find within the scope of sound medical judgment to delegate.

(4) "Commission" means the Washington medical commission.

(5) "Commission approved program" means a Commission on Accreditation of Allied Health Education Programs (CAAHEP) accredited education program specifically designed for training anesthesiologist assistants or other substantially equivalent organization(s) approved by the commission.

(6) "Practice medicine" has the same meaning defined in RCW 18.71.011.

(7) "Secretary" means the secretary of health or the secretary's designee.

(8) "Supervise" means the immediate availability of the medically directing anesthesiologist for consultation and direction of the activities of the anesthesiologist assistant. A medically directing anesthesiologist is immediately available if they are in physical

proximity that allows the anesthesiologist to reestablish direct contact with the patient to meet medical needs and any urgent or emergent clinical problems, and personally participating in the most demanding procedures of the anesthesia plan including, if applicable, induction and emergence. These responsibilities may also be met through coordination among anesthesiologists of the same group or department. Supervision through remote or telecommunications methods are not permitted under this definition and rule.

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NEW SECTION

WAC 246-921-100 Application withdrawals. An application for a license may not be withdrawn after the commission determines that grounds exist for denial of the license or for the issuance of a conditional license under chapter 18.130 RCW. Applications that are subject to investigation of unprofessional conduct or impaired practice may not be withdrawn.

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NEW SECTION

WAC 246-921-105 Anesthesiologist assistant—Requirements for licensure. (1) An applicant for licensure as an anesthesiologist assistant must submit to the commission:

(a) A completed application on forms provided by the commission;

(b) Proof the applicant has completed a CAAHEP accredited commission-approved anesthesiologist assistant program and successfully passed the NCCAA examination;

(c) All applicable fees as specified in WAC 246-921-990; and

(d) Other information required by the commission.

(2) The commission will only consider complete applications with all supporting documents for licensure.

(3) Internationally trained individuals do not currently have a pathway to licensure as an anesthesiologist assistant due to ineligibility for the certifying exam offered by NCCAA.

[]

NEW SECTION

WAC 246-921-110 Background check—Temporary practice permit. The commission may issue a temporary practice permit when the applicant has met all other licensure requirements, except the

national criminal background check requirement. The applicant must not be subject to denial of a license or issuance of a conditional license under this chapter.

(1) If there are no violations identified in the Washington criminal background check and the applicant meets all other licensure conditions, including receipt by the department of health of a completed Federal Bureau of Investigation (FBI) fingerprint card, the commission may issue a temporary practice permit allowing time to complete the national criminal background check requirements.

A temporary practice permit that is issued by the commission is valid for six months. A one-time extension of six months may be granted if the national background check report has not been received by the commission.

(2) The temporary practice permit allows the applicant to work in the state of Washington as an anesthesiologist assistant during the time period specified on the permit. The temporary practice permit is a license to practice medicine as an anesthesiologist assistant, provided that a supervision arrangement exists with an anesthesiologist or anesthesiologists of the same group or department as provided in this rule.

(3) The commission issues a license once it receives the national background check report, as long as the report is not negative, and the applicant meets all other licensing requirements.

(4) The temporary practice permit is no longer valid after the license is issued or the application for a full license is denied.

[]

NEW SECTION

WAC 246-921-115 How to obtain an expedited temporary license—Military spouse. A military spouse may receive a temporary license while completing any specific additional requirements that are not related to training or practice standards for anesthesiologist assistants under the following conditions.

(1) An expedited temporary license may be issued to an applicant who is a military spouse and:

(a) Is moving to Washington as a result of the military person's transfer to the state of Washington;

(b) Holds an unrestricted, active license in another state or United States territory that the commission currently deems to have

substantially equivalent licensing standards for an anesthesiologist assistant to those in the state of Washington; and

(c) Is not subject to any pending investigation, charges, or disciplinary action by the regulatory body in any other state or United States territory in which the applicant holds a license.

(2) An expedited temporary license grants the applicant the full scope of practice for the anesthesiologist assistant.

(3) An expedited temporary license expires when any one of the following occurs:

(a) A full or limited license is issued to the applicant;

(b) A notice of decision on the application is mailed to the applicant, unless the notice of decision on the application specifically extends the duration of the expedited temporary license; or

(c) One hundred eighty days after the expedited temporary license is issued.

(4) To receive an expedited temporary license, the applicant must:

(a) Meet all requirements and qualifications for the license that are specific to the training, education, and practice standards for anesthesiologist assistants;

(b) Submit a written request for an expedited temporary license; and

(c) Submit a copy of the military service member's orders and a copy of one of the following:

(i) The military-issued identification card showing the military service member's information and the applicant's relationship to the military service member;

(ii) A marriage license; or

(iii) A state registered domestic partnership.

(5) For the purposes of this section the following definitions shall apply:

(a) "Military spouse" is someone married to or in a registered domestic partnership with a military person who is serving in the United States Armed Forces, the United States Public Health Service Commissioned Corps, or the Merchant Marine of the United States; and

(b) "Military person" means a person serving in the United States Armed Forces, the United States Public Health Service Commissioned Corps, or the Merchant Marine of the United States.

[]

NEW SECTION

WAC 246-921-120 Exemption from licensure—Qualified physician assistant pathway. (1) A physician assistant may practice medicine within the full scope of an anesthesiologist assistant without requiring a separate license under chapter 18.71D RCW if the physician assistant:

(a) Fulfills of the practice, education, training, and licensure requirements specified in WAC 246-918-080;

(b) Graduation from an approved program accredited by the Commission on Accreditation of Allied Health Education Programs (CAAHEP) that is specifically designed to train anesthesiologist assistants;

(c) Has successfully passed and maintains certification through the National Council on Certification of Anesthesiologist Assistants; and

(d) Is supervised according to the requirements in this section and chapter 18.71D RCW by a physician anesthesiologist licensed under chapter 18.71, 18.71B, or 18.57 RCW.

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NEW SECTION

WAC 246-921-125 Renewal, continuing medical education cycle, and maintenance of licensure. (1) Under WAC 246-12-020, an initial credential issued within 90 days of the anesthesiologist assistant's birthday does not expire until the anesthesiologist assistant's next birthday.

(2) An anesthesiologist assistant must renew their license every two years on their birthday. Renewal fees are accepted no sooner than 90 days prior to the expiration date.

(3) Each anesthesiologist assistant shall have four years to meet the continuing medical education requirements as defined by this rule. The review period begins at the second renewal after initial licensure or second renewal after reactivation of an expired license.

(4) An anesthesiologist assistant must complete 200 hours of continuing education every four years as required in chapter 246-12 WAC, Part 7, which may be audited for compliance at the discretion of the commission.

(5) In lieu of 200 hours of continuing medical education, the commission will accept:

(a) Current certification with the NCCAA; or

(b) Compliance with a continuing maintenance of competency program through NCCAA; or

(c) Other programs approved by the commission.

(6) The commission approves the following categories of creditable continuing medical education as accredited by the Accreditation Council for Continuing Medical Education (ACCME) or affiliated education providers. A minimum of 80 credit hours must be earned in Category I.

Category I	Continuing medical education activities with accredited sponsorship through ACCME or recognized affiliated education providers.
Category II	Continuing medical education activities with nonaccredited sponsorship and other meritorious learning experience.

(7) The commission adopts the standards approved by the ACCME for the evaluation of continuing medical education requirements in determining the acceptance and category of any continuing medical education experience.

(8) An anesthesiologist assistant does not need prior approval of any continuing medical education. The commission will accept any continuing medical education that reasonably falls within the requirements of this section and relies upon each anesthesiologist assistant's integrity to comply with these requirements.

(9) A continuing medical education sponsor does not need to apply for or expect to receive prior commission approval for a formal continuing medical education program. The continuing medical education category will depend solely upon the accredited status of the

organization or institution. The number of hours may be determined by counting the contact hours of instruction and rounding to the nearest quarter hour. The commission relies upon the integrity of the program sponsors to present continuing medical education for the anesthesiologist assistant that constitutes a meritorious learning experience.

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NEW SECTION

WAC 246-921-130 Training in suicide assessment, treatment, and management. (1) A licensed anesthesiologist assistant must complete a one-time training in suicide assessment, treatment, and management. The training must be at least six hours in length and may be completed in one or more sessions.

(2) The training must be completed by the end of the first full continuing education reporting period after initial licensure.

(3) The training must be on the model list developed by the department of health under RCW 43.70.442.

(4) The hours spent completing training in suicide assessment, treatment, and management count toward meeting applicable continuing

education requirements in the same categories specified in WAC 246-921-125.

(5) The commission exempts any licensed anesthesiologist assistant from the training requirements of this section if the anesthesiologist assistant has only brief, limited, or no patient contact.

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NEW SECTION

WAC 246-921-135 Health equity continuing education training requirements. (1) An anesthesiologist assistant must complete two hours of health equity continuing education training every four years as described in WAC 246-12-800 through 246-12-830.

(2) The two hours of health equity continuing education an anesthesiologist assistant completes count toward meeting applicable continuing education requirements in the same categories specified in WAC 246-921-125.

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NEW SECTION

WAC 246-921-140 Retired license. (1) To obtain a retired license, an anesthesiologist assistant must comply with chapter 246-12 WAC.

(2) An anesthesiologist assistant with a retired license must have a supervision arrangement with a physician anesthesiologist in order to practice, except when serving as a "covered volunteer emergency worker" as defined in RCW 38.52.180 (5)(a) and engaged in authorized emergency management activities or serving under chapter 70.15 RCW.

(3) An anesthesiologist assistant with a retired license may not receive compensation for health care services.

(4) An anesthesiologist assistant with a retired license may practice under the following conditions:

(a) In emergent circumstances calling for immediate action; or

(b) Intermittent circumstances on a part-time or full-time nonpermanent basis.

(5) A retired license expires every two years on the license holder's birthday. Retired credential renewal fees are accepted no sooner than 90 days prior to the expiration date.

(6) An anesthesiologist assistant with a retired license shall report 100 hours of continuing education at every renewal.

[]

NEW SECTION

WAC 246-921-145 Returning to active status when a license has expired. (1) To return to active status the anesthesiologist assistant must meet the requirements of chapter 246-12 WAC, Part 2, which includes paying the applicable fees under WAC 246-921-990 and meeting the continuing medical education requirements under WAC 246-921-125.

(2) If the license has expired over three years, the anesthesiologist assistant must:

(a) Meet requirements in subsection (1) of this section;

(b) Meet the current licensure requirements under WAC 246-921-105; and

(c) Satisfy any demonstration of competence requirements deemed necessary by the commission. Demonstration of competence may take the form of clinical knowledge examinations or fitness for duty evaluations conducted by commission-approved entities.

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NEW SECTION

WAC 246-921-150 Anesthesiologist assistant identification. (1) An anesthesiologist assistant must clearly identify themselves as an anesthesiologist assistant and must appropriately display on their person identification as an anesthesiologist assistant. An anesthesiologist assistant may identify themselves as an anesthesiologist assistant (AA) or a certified anesthesiologist assistant (CAA).

(2) An anesthesiologist assistant must not present themselves in any manner which would tend to mislead the public as to their title.

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NEW SECTION

WAC 246-921-155 Mandatory reporting. The commission adopts the rules for mandatory reporting in chapter 246-16 WAC.

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NEW SECTION

WAC 246-921-160 Practice limitations and scope of practice. (1) An anesthesiologist assistant is required to have a supervision arrangement with an anesthesiologist or anesthesiologists of the same group or department as provided by this rule. The supervision arrangements are not required to be filed with the commission.

(2) Duties which an anesthesiologist may delegate to an anesthesiologist assistant include, but are not limited to:

(a) Assisting with preoperative anesthetic evaluations, postoperative anesthetic evaluations, and patient progress notes, all to be cosigned by the supervising anesthesiologist within 24 hours;

(b) Administering and assisting with preoperative consultations;

(c) Under the supervising anesthesiologist's consultation and direction, order perioperative pharmaceutical agents, medications, and fluids, to be used only at the facility where ordered including, but not limited to, controlled substances, which may be administered prior to the cosignature of the supervising anesthesiologist. The supervising anesthesiologist may review and if required by the facility or institutional policy must cosign these orders in a timely manner;

For the purposes of this section, an anesthesiologist assistant may place an order for pharmaceutical agents, medications, and fluids

under the consultation, direction, and prescriptive authority of the anesthesiologist. The anesthesiologist assistant does not have independent prescriptive authority.

(d) Changing or discontinuing a medical treatment plan, after consultation with the supervising anesthesiologist;

(e) Calibrating anesthesia delivery systems and obtaining and interpreting information from the systems and monitors, in consultation with an anesthesiologist;

(f) Assisting the supervising anesthesiologist with the implementation of medically accepted monitoring techniques;

(g) Assisting with basic and advanced airway interventions including, but not limited to, endotracheal intubation, laryngeal mask insertion, and other advanced airways techniques;

(h) Establishing peripheral intravenous lines, including subcutaneous lidocaine use;

(i) Establishing radial and dorsalis pedis arterial lines;

(j) Assisting with general anesthesia, including induction, maintenance, and emergence;

(k) Assisting with procedures associated with general anesthesia such as, but not limited to, gastric intubation;

(l) Administering intermittent vasoactive drugs and starting and titrating vasoactive infusions for the treatment of patient responses to anesthesia;

(m) Assisting with spinal and intravenous regional anesthesia;

(n) Maintaining and managing established neuraxial epidurals and regional anesthesia;

(o) Assisting with monitored anesthesia care;

(p) Evaluating and managing patient-controlled analgesia, epidural catheters, and peripheral nerve catheters;

(q) Obtaining venous and arterial blood samples;

(r) Assisting with, ordering, and interpreting appropriate preoperative, point of care, intraoperative, or postoperative diagnostic tests or procedures as authorized by the supervising anesthesiologist;

(s) Obtaining and administering perioperative anesthesia and related pharmaceutical agents including intravenous fluids and blood products;

(t) Participating in management of the patient while in the preoperative suite and recovery area;

(u) Providing assistance to a cardiopulmonary resuscitation team in response to a life-threatening situation;

(v) Participating in administrative, research, and clinical teaching activities as authorized by the supervising anesthesiologist; and

(w) Assisting with such other tasks not prohibited by law under the supervision of a licensed anesthesiologist that an anesthesiologist assistant has been trained and is proficient to assist with.

(3) Nothing in this section shall be construed to prevent an anesthesiologist assistant from having access to and being able to obtain drugs as directed by the supervising anesthesiologist. An anesthesiologist assistant may not prescribe, order, compound, or dispense drugs, medications, or devices of any kind except as authorized in subsection (2) of this section.

(4) Signing authority: An anesthesiologist assistant may sign and attest to any certificates, cards, forms, or other required documentation that the anesthesiologist assistant's supervising anesthesiologist may sign, provided that it is within the anesthesiologist assistant's scope of practice.

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NEW SECTION

WAC 246-921-165 Supervision ratios and group supervision. (1) An anesthesiologist may themselves supervise no more than four anesthesiologist assistants. If a supervision ratio above 4:1 is needed, the anesthesiologist may submit a request for an exception to the commission using a form provided by the commission.

(2) In the exception request, the anesthesiologist must provide:

(a) A descriptive justification of need;

(b) What quality review and improvement mechanisms are in place to maintain the patient safety and the standard of care; and

(c) What escalation and anesthesiologist backup procedures are in place should multiple anesthesiologist assistants require the presence or assistance of the anesthesiologist.

(3) Those submitting exception requests may, at the sole discretion of the commission, be denied. In the event of a request denial, requestors are entitled to appeal the decision utilizing the brief adjudication process as defined in WAC 246-11-425.

(4) The commission permits a group supervision model for anesthesiologist assistants in settings where the anesthesiologist led anesthesia care team:

(a) Operates in a single physical location such as a hospital or clinic;

(b) Does not operate above the 4:1 ratio without a commission granted exemption as required in these rules; and

(c) Has protocols and staffing available to designate backup and on-call anesthesiologists.

[]

NEW SECTION

WAC 246-921-170 Notification of investigation or disciplinary action. The anesthesiologist assistant shall notify their supervising anesthesiologist whenever the anesthesiologist assistant is the subject of an investigation or disciplinary action by the commission. The commission may notify the supervising anesthesiologist or other supervising anesthesiologist of such matters as appropriate.

[]

NEW SECTION

WAC 246-921-305 Sexual misconduct. (1) The following definitions apply throughout this section unless the context clearly requires otherwise.

(a) "Patient" means a person who is receiving health care or treatment or has received health care or treatment without a

termination of the anesthesiologist assistant-patient relationship. The determination of when a person is a patient is made on a case-by-case basis with consideration given to a number of factors, including the nature, extent and context of the professional relationship between the anesthesiologist assistant and the person. The fact that a person is not actively receiving treatment or professional services is not the sole determining factor.

(b) "Key third party" means a person in a close personal relationship with the patient and includes, but is not limited to, spouses, partners, parents, siblings, children, guardians and proxies.

(2) An anesthesiologist assistant shall not engage, or attempt to engage, in sexual misconduct with a current patient or a key third party, inside or outside the health care setting. Sexual misconduct shall constitute grounds for disciplinary action. An anesthesiologist assistant engages in sexual misconduct when they engage in the following behaviors with a patient or a key third party:

(a) Sexual intercourse;

(b) Touching the breasts, genitals, anus or any sexualized body part except as consistent with accepted community standards of practice for examination, diagnosis and treatment and within the health care practitioner's scope of practice;

(c) Rubbing against a patient or client or key third party for sexual gratification;

(d) Kissing;

(e) Hugging, touching, fondling or caressing of a romantic or sexual nature;

(f) Examination of or touching genitals without using gloves;

(g) Not allowing a patient or client privacy to dress or undress except as may be necessary in emergencies or custodial situations;

(h) Not providing the patient or client a gown or draping except as may be necessary in emergencies;

(i) Dressing or undressing in the presence of the patient, client or key third party;

(j) Removing patient or client's clothing or gown or draping without consent, emergent medical necessity or being in a custodial setting;

(k) Encouraging masturbation or other sex act in the presence of the health care provider;

(l) Masturbation or other sex act by the health care provider in the presence of the patient, client or key third party;

(m) Suggesting or discussing the possibility of a dating, sexual or romantic relationship after the professional relationship ends;

(n) Terminating a professional relationship for the purpose of dating or pursuing a romantic or sexual relationship;

(o) Soliciting a date with a patient, client or key third party;

(p) Discussing the sexual history, preferences or fantasies of the health care provider;

(q) Any behavior, gestures, or expressions that may reasonably be interpreted as seductive or sexual;

(r) Making statements regarding the patient, client or key third party's body, appearance, sexual history, or sexual orientation other than for legitimate health care purposes;

(s) Sexually demeaning behavior including any verbal or physical contact which may reasonably be interpreted as demeaning, humiliating, embarrassing, threatening or harming a patient, client or key third party;

(t) Photographing or filming the body or any body part or pose of a patient, client, or key third party, other than for legitimate health care purposes; and

(u) Showing a patient, client or key third party sexually explicit photographs, other than for legitimate health care purposes.

(3) Sexual misconduct also includes sexual contact with any person involving force, intimidation, or lack of consent; or a conviction of a sex offense as defined in RCW **9.94A.030**.

(4) An anesthesiologist assistant shall not:

(a) Offer to provide health care services in exchange for sexual favors;

(b) Use health care information to contact the patient, client or key third party for the purpose of engaging in sexual misconduct;

(c) Use health care information or access to health care information to meet or attempt to meet the anesthesiologist assistant's sexual needs.

(5) An anesthesiologist assistant shall not engage in any of the conduct described in subsection (2) of this section with a former patient or key third party if

(a) There is a significant likelihood that the patient, client or key third party will seek or require additional services from the health care provider; or

(b) There is an imbalance of power, influence, opportunity and/or special knowledge of the professional relationship.

(6) To determine whether a patient is a current patient or a former patient, the commission will analyze each case individually, and will consider a number of factors including, but not limited to, the following:

(a) Documentation of formal termination;

(b) Transfer of the patient's care to another health care provider;

(c) The length of time that has passed;

(d) The length of time of the professional relationship;

(e) The extent to which the patient has confided personal or private information to the anesthesiologist assistant;

(f) The nature of the patient's health problem;

(g) The degree of emotional dependence and vulnerability.

(6) This section does not prohibit conduct that is required for medically recognized diagnostic or treatment purposes if the conduct meets the standard of care appropriate to the diagnostic or treatment situation.

(7) These rules do not prohibit:

(a) Providing health care services in case of emergency where the services cannot or will not be provided by another health care provider;

(b) Contact that is necessary for a legitimate health care purpose and that meets the standard of care appropriate to that profession; or

(c) Providing health care services for a legitimate health care purpose to a person who is in a preexisting, established personal relationship with the health care provider where there is no evidence of, or potential for, exploiting the patient or client.

(8) It is not a defense that the patient, former patient, or key third party initiated or consented to the conduct, or that the conduct occurred outside the professional setting.

(9) A violation of any provision of this rule shall constitute grounds for disciplinary action.

[]

NEW SECTION

WAC 246-921-310 Abuse. (1) An anesthesiologist assistant commits unprofessional conduct if the anesthesiologist assistant abuses a patient. An anesthesiologist assistant abuses a patient when they:

(a) Make statements regarding the patient's body, appearance, sexual history, or sexual orientation that have no legitimate medical or therapeutic purpose;

(b) Remove a patient's clothing or gown without consent;

(c) Fail to treat an unconscious or deceased patient's body or property respectfully; or

(d) Engage in any conduct, whether verbal or physical, which unreasonably demeans, humiliates, embarrasses, threatens, or harms a patient.

(2) A violation of any provision of this rule shall constitute grounds for disciplinary action.

[]

NEW SECTION

WAC 246-921-990 Anesthesiologist assistant fees and renewal cycle. The secretary of the department of health has authority over the fees.

[]

Washington State Department of Health
Health Professions Quality Assurance

Application for Approval to Receive Lists

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

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

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

☐ We are a "professional association"

■ We are an "educational organization."

Primary Contact Name ↴James Dunning	Phone ↴801-707-9056	Email ↴seminars@spinalmanipulation.org

Additional Contact Names (Lists are only sent to approved individuals) ↴Laura Sigler Website URL↴https://spinalmanipulation.org/osteopractor-seminars/

www.

Professional Assoc. or **Educational Organization** ↴	Federal Tax ID or Uniform Business ID number ↴
Street Address ↴445 dexter Ave Suite 4050	City, State, Zip Code ↴Montgomery, AL 36104

1. How will the lists be used? ↴ To inform individuals of upcoming continuing education courses in their area

2. What profession(s) are you seeking approval for? ↴Email contact lists for Washington state PTs and PTAs, DCs, OTs, ATs, NPs, PAs, and DDS

Please attach information that demonstrates that you are a "professional association" or an "educational organization" and a sample of your proposed mailing materials.
Attach completed application to your recent list request using the public portal:
https://www.doh.wa.gov/aboutus/publicrecords

Alternate options: Email to: PDRC@DOH.WA.Gov Mail to: PDRC - PO Box 47865 - Olympia WA 98504-7865

James Dunning 10/24/2024

Signature ↴ Date ↴

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

For Official Use Only

Approved: _____ _____ 5-year one-time

Denied: _____

Authorizing Signature: _____

Printed Name: _____

Title: _____ Date: _____

Get Certified in Dry Needling® and Spinal Manipulation by the Worldwide Leader

The following in-person **AAMT dry needling & spinal manipulation courses** are confirmed. Limited spots are available. All courses meet the requirements set **by Utah DOPL and BOC (NATA**).

SMT-1: HVLA Thrust Spinal Manipulation (15 hrs/CEUs)
SMT-1 Salt Lake City, UT: October 12-13, 2024

DN-2: Dry Needling for Lumbopelvic & Lower Extremity Disorders (27 hrs/CEUs)
DN-2 Salt Lake City, UT: November 15-17, 2024

Certification in Dry Needling® (Cert. DN) is awarded after completion of both DN-1 and DN-2.

DN-2 can be taken prior to DN-1 as each course covers different bodily regions.

AAMT faculty have published more clinical trials on the effectiveness of dry needling for musculoskeletal conditions than any other institute!

A complete listing of all AAMT course dates & locations is listed here.

Kind regards,
James

James Dunning, PhD, DPT, MSc (Manip Ther), FAAOMPT, Dip. Osteopractic

Director, AAMT Fellowship in Orthopaedic Manual Physical Therapy

President, American Academy of Manipulative Therapy
Senior Instructor, Spinal Manipulation Institute & Dry Needling Institute
Owner, Montgomery Osteopractic Physical Therapy & Acupuncture Clinic
445 Dexter Ave, Suite 4050
Montgomery, AL 36104
www.spinalmanipulation.org
www.twitter.com/drdunning
OSTEOPRACTIC PHYSICAL THERAPY - AAMT Fellowship VIDEO

Laura Sigler (Public Records Request #N006458-102424)

Public Records Request Details

Division:	HSQA|
HSQA - Type of Record(s):	Other/Unknown (Provide description below)|
Is this a list request?:	Yes
Describe the Record(s) Requested:	Requesting the contact lists, including emails, of active licensed physical therapists (PTs), physical therapy assistants (PTAs), athletic trainers (ATs), occupational therapists (OTs), dentists (DDS), chiropractors (DCs), physician assistants (PAs) and nurse practitioners (NPs) in Washington to alert them to the availability of continuing education courses from the American Academy of Manipulative Therapy and Dry Needling.
From Date:	
To Date:	

Other Request Information

Preferred Method to Receive Records:	Electronic via Request Center	
Modified Request Description:		Summary of the public record desired that will be visible in the public archive if the request is published.
Internal Status:	List	This status is not visible to the requester.
Extend RCD by:		Select length of extension (Business Days). Selecting 70, 100, and 120 will also update Estimated Completion Date.
Extension Action:		Select 'APPLY EXTENSION' and Save to extend dates.
Multi-Divisional Request:	No	Check if this request has records from multiple divisions
High Profile Request:	No	Check if this request is considered a high profile request.
Request Complexity:		**View Complexity Criteria below...**

Show/Hide Complexity Criteria

Clarifications

Appeal Information

State Reporting Bill

Changed Response Time:	
Clarification Sought:	
Installments:	
Records Provided:	
Scanned Docs:	
Physical Records Provided:	
Actual Completion Date:	
Type of Requester:	Individual

You have requested access to a list or lists of individuals. RCW 42.56.070(8) prohibits agencies from providing access to lists of individuals requested for commercial purposes (with the exception of recognized professional associations or educational organizations).

To receive the requested list, you must complete the declaration contained in Section 1 that you will not use the list for a commercial purpose. At a minimum, "commercial purposes" means that such lists are utilized to contact or affect such individuals to facilitate, in any manner, profit-expecting activity.

Select the boxes below to acknowledge:

I understand that “commercial purposes” means that the person/entity requesting the records intends to use them to facilitate profit-expecting business activity.:	Yes
I understand that the use for commercial purposes of said records may also violate the rights of the individuals named herein and may subject me to liability for such commercial use.:	Yes
I declare that I and/or the entity I represent will not use the requested records for commercial purposes. I also acknowledge it is my affirmative duty to prevent others from using the records for commercial purposes.:	Yes

The Public Records Act at RCW 42.56.080 authorizes agencies to require a requester to provide information as to the purpose of a request “to establish whether inspection and copying would violate RCW 42.56.070(8).”

1. I am requesting the list of individuals on behalf of:	Organization or Business
Name of organization or business:	American Academy of Manipulative Therapy
Website address:	https://spinalmanipulation.org/osteopractor-seminars/
Purpose of organization or business:	Continuing Education for Medical Professionals
The organization or business is a professional association or educational organization recognized by the professional licensing or examination board:	Yes
The request is for a list of applicants for professional licenses and of professional licensees of the subject area of the association or organization:	Yes
2. The purpose in making this request for the list of individuals is:	To inform the individuals of upcoming continuing education courses in their area

3. I or the organization/business intend to generate revenue or financial benefit from using the list of individuals:	Yes
4. I or the organization/business intend to solicit money or financial support from any of the individuals on the list:	No
5. I or the organization/business intend to make individuals on the list aware of business commercial entities, business/financial enterprises or business/financial opportunities:	No
I declare under penalty of perjury under the laws of the State of Washington that the foregoing is true and correct:	Yes

Internal Fields

5 Day Letter Date**:

5 Day Letter Sent*:

***** Please select **Yes** once you have sent the 5 Day letter.
****** If you are not closing this request at the same time the 5 day letter is being sent, you **MUST** update the **Required Completion Date** at the right with an estimated completion date.

Estimated Completion Date:

Days in Status (Internal - Updated Overnight)

Message History

Date

On 10/24/2024 1:05:30 PM, System Generated Message:
Subject: Public Records Request :: N006458-102424
Body:

Dear Laura Sigler:

Thank you for submitting a public records request to the Washington State Department of Health. Your request has been received and is being processed in accordance with the State of Washington Public Records Act, Chapter 42.56 RCW. Your request was received in this office on 10/24/2024 and given the reference number N006458-102424 for tracking purposes. You will receive an official acknowledgement letter within 5 business days from this date.

Not all public documents are available in electronic format. If the document(s) requested are not available electronically, we will make them available for inspection or by paper copy in accordance with the Public Records Act, Chapter 42.56 RCW.

Sincerely,

Washington State Department of Health
Public Records Request
Public Records

To monitor the progress or update this request please log into the DOH Online Public Records Center

Track the issue status and respond at: https://washingtondoh.govqa.us/WEBAPP//_rs/RequestEdit.aspx?rid=150012

On 10/24/2024 1:05:29 PM, Laura Sigler wrote:
Request Created on Public Portal

Request Details

Reference No:	N006458-102424
Create Date:	10/24/2024 1:05 PM
Update Date:	10/24/2024 2:49 PM
Completed/Closed:	No
Required Completion Date:	10/31/2024
Status:	Received

Priority:	Low
Assigned Dept:	Health Systems Quality Assurance
Assigned Staff:	LIA MILLER
Customer Name:	Laura Sigler
Email Address:	laura.sigler@spinalmanipulation.org
Phone:	
Source:	Web

Washington State Department of Health
Health Professions Quality Assurance

Application for Approval to Receive Lists

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

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

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

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

Marilyn Aaland	719-528-7973	Marilyn_Aaland@spectrumhealth.com
Primary Contact Name ⮥	Phone ⮥	Email ⮥

Rachael Froom	www.spectrumhealth.com
Additional Contact Names (Lists are only sent to approved individuals) ⮥	Website URL ⮥

Spectrum Healthcare Resources	43-1698884
Professional Assoc. or Educational Organization ⮥	Federal Tax ID or Uniform Business ID number ⮥

12647 Olive Blvd Suite 600	St. Louis, MO 63141
Street Address ⮥	City, State, Zip Code ⮥

For recruiting healthcare positions for the federal government, DoD, DOL, and FHS

1. How will the lists be used? ⮥

LCSW, Physicians, Nurses, Psychologists, Psychiatrists

2. What profession(s) are you seeking approval for? ⮥

Please attach information that demonstrates that you are a "professional association" or an "educational organization" and a sample of your proposed mailing materials.
Attach completed application to your recent list request using the public portal:
https://www.doh.wa.gov/aboutus/publicrecords

Alternate options: Email to: PDRC@DOH.WA.Gov Mail to: PDRC - PO Box 47865 - Olympia WA 98504-7865

Marilyn Aaland	11/23/2024
Signature ⮥	Date ⮥

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

For Official Use Only

Approved: _____ _____ (5-year / one-time)

Denied: _____

Authorizing Signature: _____

Printed Name: _____

Title: _____ Date: _____

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Who We Are

Spectrum Healthcare Resources (SHR) is a trusted industry leader with over 35 years of experience providing optimal healthcare solutions for the Department of Defense (DOD) and federal agencies.

Our team of over 2,300+ dedicated healthcare professionals provide care in more than 200+ Military and Veteran clinics and other Federal facilities, nationwide and internationally.

Military Medicine

Military medicine is a specialized field dedicated to the medical care and well-being of military personnel, veterans, and their families.

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SHR_marketing@spectrumhealth.com
(314) 744-4100

Visit:

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Healthcare Resources

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At Spectrum Healthcare Resources (SHR), we utilize over thirty-five years of experience providing optimal solutions for federal agencies that are both innovative and cost-effective. We hold ourselves to the highest standard to ensure successful outcomes for the facilities and health care professionals we serve. As a Joint Commission Certified Healthcare Resource, dependability and service are the driving forces of our mission.

Who We Are

Spectrum Healthcare Resources, Inc. is a clinical services organization providing program management, physician and clinical staffing and outcome management to United Defense Health Agency (DHA) Military Treatment Facilities, VA clinics and other Federal Agencies through various contracting vehicles. We provide responsive, innovative services that produce proven, value-added results.

- Military and Government Healthcare Services Division of TeamHealth
- Joint Commission Certified since 2005
- DUNS: 04844181 CAGE: 061T0
- Primary NAICS: 621111, 621399, 622110
- Contracting Vehicles: DHA-MQS, DHA-MSS
- GSA Schedule 621i V797P-2290D

What We Do

Throughout our corporate history we have staffed and managed more than 26,000 healthcare professionals in various professions. This includes Physicians, Advanced Practice Clinicians, Nurses, Ancillary and support staff in multiple specialties to include Primary and Specialty Care, Rehabilitation, Pharmacy, Program Management, Dental and Behavioral Health.

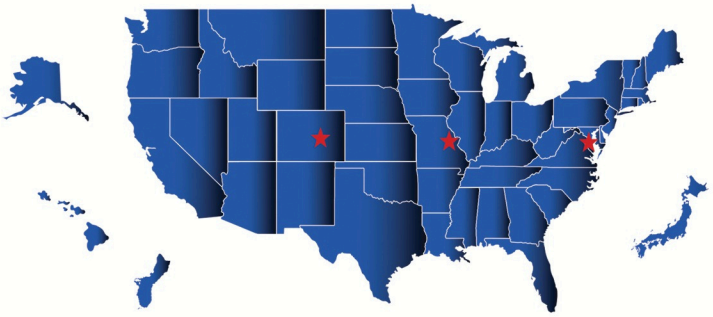
Valued Clients

As a long term stakeholder in Military, Veteran & DHA, Spectrum offers a diverse array of service lines, measured through outcomes that meet our clients' expectations.

Markets We Serve

Spectrum has a dedicated team of 2,624+ healthcare professionals providing care in more than 400 Military and Veteran clinics and other Federal facilities, nationwide and internationally.

★ Strategically located for optimal responsiveness to our customers and clinicians, our headquarters is in St. Louis, Missouri and complimented by regional offices in Colorado and Virginia. These locations increase Spectrum's ability to provide the best customer-focused care.



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shr_marketing@spectrumhealth.com

(314) 744-4100

Scan Here to visit our website

SCAN ME

MARILYN AALAND (Public Records Request #N006704-111124)

Public Records Request Details

Division:	HSQA|
HSQA - Type of Record(s):	Credentialing Documents|
Is this a list request?:	Yes
Describe the Record(s) Requested:	We would like to request a list of Licensed Clinical Social Workers, with email and/or phone numbers for recruiting purposes. We are a healthcare recruiting company that has been staffing for the federal government for over 35 years, serving the military and their families.
From Date:	11/11/2022
To Date:	11/11/2024

Other Request Information

Preferred Method to Receive Records:	Electronic via Request Center	
Modified Request Description:		Summary of the public record desired that will be visible in the public archive if the request is published.
Internal Status:	List	This status is not visible to the requester.
Extend RCD by:		Select length of extension (Business Days). Selecting 70, 100, and 120 will also update Estimated Completion Date.
Extension Action:		Select 'APPLY EXTENSION' and Save to extend dates.
Multi-Divisional Request:	No	Check if this request has records from multiple divisions
High Profile Request:	No	Check if this request is considered a high profile request.
Request Complexity:	1	**View Complexity Criteria below...**

Show/Hide Complexity Criteria

Clarifications

Appeal Information

State Reporting Bill

Changed Response Time:	No
Clarification Sought:	No
Installments:	No
Records Provided:	Yes
Scanned Docs:	No
Physical Records Provided:	No
Actual Completion Date:	11/12/2024
Type of Requester:	Organization

You have requested access to a list or lists of individuals. RCW 42.56.070(8) prohibits agencies from providing access to lists of individuals requested for commercial purposes (with the exception of recognized professional associations or educational organizations).

To receive the requested list, you must complete the declaration contained in Section 1 that you will not use the list for a commercial purpose. At a minimum, "commercial purposes" means that such lists are utilized to contact or affect such individuals to facilitate, in any manner, profit-expecting activity.

Select the boxes below to acknowledge:

I understand that “commercial purposes” means that the person/entity requesting the records intends to use them to facilitate profit-expecting business activity.:	Yes
I understand that the use for commercial purposes of said records may also violate the rights of the individuals named herein and may subject me to liability for such commercial use.:	Yes
I declare that I and/or the entity I represent will not use the requested records for commercial purposes. I also acknowledge it is my affirmative duty to prevent others from using the records for commercial purposes.:	Yes

The Public Records Act at RCW 42.56.080 authorizes agencies to require a requester to provide information as to the purpose of a request “to establish whether inspection and copying would violate RCW 42.56.070(8).”

1. I am requesting the list of individuals on behalf of:	Organization or Business
Name of organization or business:	Spectrum Healthcare Resources
Website address:	www.spectrumhealth.com
Purpose of organization or business:	Healthcare recruitment for the federal government, DoD, DoL, and FHC
The organization or business is a professional association or educational organization recognized by the professional licensing or examination board:	Yes
The request is for a list of applicants for professional licenses and of professional licensees of the subject area of the association or organization:	Yes
2. The purpose in making this request for the list of individuals is:	to staff for the federal government

3. I or the organization/business intend to generate revenue or financial benefit from using the list of individuals:	Yes
4. I or the organization/business intend to solicit money or financial support from any of the individuals on the list:	No
5. I or the organization/business intend to make individuals on the list aware of business commercial entities, business/financial enterprises or business/financial opportunities:	Yes
I declare under penalty of perjury under the laws of the State of Washington that the foregoing is true and correct:	Yes

Internal Fields

5 Day Letter Date**:	11/12/2024
5 Day Letter Sent*:	Yes ***** Please select **Yes** once you have sent the 5 Day letter. ****** If you are not closing this request at the same time the 5 day letter is being sent, you **MUST** update the **Required Completion Date** at the right with an estimated completion date.
Estimated Completion Date:	11/19/2024

Days in Status (Internal - Updated Overnight)

Message History

Date

On 12/17/2024 11:41:09 AM, MARILYN AALAND wrote:
Greetings! I have, attached, all of the documents requested on the application for approval of receiving lists. I will also email it to the email provided, just in case. Thank you so much for your patience, while I gathered this together! Marilyn Aaland

Date

On 11/12/2024 8:57:46 AM, LIA MILLER wrote:

Date

Subject: DOH Public Records Center :: N006704-111124
Body:

Reference # N006704-111124

Dear MARILYN AALAND,

The Department of Health received a public information request from you on November 11, 2024. Your request mentioned:

"We would like to request a list of Licensed Clinical Social Workers, with email and/or phone numbers for recruiting purposes. We are a healthcare recruiting company that has been staffing for the federal government for over 35 years, serving the military and their families."

We have uploaded a list of available information to the DOH Public Records Center for your review.

RCW 42.56.070(8) prohibits disclosure of lists of individuals requested for commercial purposes. However, lists of applicants for professional licenses and of professional licensees may be made available to professional associations or educational organizations approved by the applicable licensing board.
List requests are approved by the specific licensing board and approval can take up to three months.

You may apply for approval to receive lists from the applicable licensing board by completing and submitting an Application for Approval to Receive Lists. The application and additional information can be found here or on the customer public records portal under 'See All FAQs' in the left navigation pane. The completed application can be uploaded directly to this request via the online portal.

You are currently NOT an approved professional association or educational organization with the Washington State Department of Health. Therefore, the requested list cannot be provided to you at this time, and this request is considered closed. This means that the Department of Health will not further address the request, and as of the date of this communication, the PRA' s one-year statute of limitations to seek judicial review starts to run.

Please contact me within 30 days, 12/12/2024 9:01:55 AM, by e-mail at publicdisclosure@doh.wa.gov or by postal mail at: Public Records Officer, Washington State Department of Health, P.O. Box 47808, Olympia, WA 98504-7808, if you have any questions.

If you receive approval from the licensing board you will need to submit a new list request and upload the approval letter.

Under RCW 42.56.520 you may appeal the decision to withhold information contained in the records via a request for review by the Department of Health' s Public Records Officer. When filing an appeal for Public Records, please include your Public Records Request reference number so the correct request can be reviewed. The request must be submitted in writing by one of the following methods:

1. Send an email request to PRRappeals@doh.wa.gov
   OR
2. Mail your request to:

Public Records Officer
Washington State Department of Health
P.O. Box 47808
Olympia, WA 98504-7808

If you have any questions or need additional information, please feel free to respond directly to this email or reach out to the approving licensing board.

Date

Sincerely,

LIA MILLER
Public Disclosure Office
Washington State Department of Health
www.doh.wa.gov

On 11/11/2024 9:56:15 AM, System Generated Message:
Subject: Public Records Request :: N006704-111124
Body:

Dear MARILYN AALAND:

Thank you for submitting a public records request to the Washington State Department of Health. Your request has been received and is being processed in accordance with the State of Washington Public Records Act, Chapter 42.56 RCW. Your request was received in this office on 11/11/2024 and given the reference number N006704-111124 for tracking purposes. You will receive an official acknowledgement letter within 5 business days from this date.

Not all public documents are available in electronic format. If the document(s) requested are not available electronically, we will make them available for inspection or by paper copy in accordance with the Public Records Act, Chapter 42.56 RCW.

Sincerely,

Washington State Department of Health
Public Records Request
Public Records

To monitor the progress or update this request please log into the DOH Online Public Records Center

Track the issue status and respond at: https://washingtondoh.govqa.us/WEBAPP//_rs/RequestEdit.aspx?rid=150593

On 11/11/2024 9:56:14 AM, MARILYN AALAND wrote:
Request Created on Public Portal

Request Details

Reference No:	N006704-111124
Create Date:	11/11/2024 9:56 AM

Update Date:	12/17/2024 11:41 AM
Completed/Closed:	Yes
Close Date:	11/12/2024 8:41 AM
Status:	Closed - Full Release
Priority:	Low
Assigned Dept:	Health Systems Quality Assurance
Assigned Staff:	LIA MILLER
Customer Name:	MARILYN AALAND
Email Address:	marilyn_aaland@spectrumhealth.com
Phone:	7195287973
Source:	Web

URGENT CARE ASSOCIATION

Washington Medical Commission
111 Israel Rd. S.E.
Tumwater, WA 98501

To the attention of the Members of the Commission responsible for approving accrediting bodies:

The Urgent Care Association ("UCA") is requesting that the Commission consider approval of UCA's Urgent Care Accreditation Program as an accrediting entity to accredit or certify the use of anesthesia in office-based surgical settings. This request manifested from an inquiry of a Washington State based Urgent Care organization seeking the ability to perform conscious sedation as well as UCA's confidence in the integrity of its program.

UCA believes that its comprehensive accreditation program addresses all the items cited by the Commission with Standards that exceed or are commensurate with those of the Commission's currently approved accrediting bodies. This letter seeks to demonstrate the sophistication, intensity, and comprehensiveness of the UCA Accreditation Program.

The Urgent Care Association is a 501(c)6 NFP organized in the state of Illinois in 2004. UCA established its Accreditation Program in 2014 in response to feedback from Urgent Care organizations seeking programs nuanced to outpatient, walk-in ambulatory care. At that time, UCA had already established a Certification Program based on scope of care criteria. Certified organizations had to demonstrate that they had the clinical capability and access required to represent the organization as a bona fide Urgent Care center.

The Accreditation program became the next step in the Quality Department's evolution. Development was a collaboration between physicians, clinical personnel and Urgent Care administrators who established criteria that include those of Certification scope but added comprehensive Standards around quality and safety. It was the first to include safety, quality, and Urgent Care *scope* Standards and therefore, differentiated itself from other accrediting body programs. While it has grown in sophistication and intensity year over year, its fundamental areas of focus have remained unchanged. UCA's Accreditation Program and processes are overseen by its Quality Department.

UCA now accredits more Urgent Care centers than any other accrediting body—currently greater than 2400. It has not only been accepted by numerous payors across the country, but some have established it as an in-network participation requirement.

Once awarded, the Accreditation period is for 3 years. Renewal proceedings begin early in the 3rd year to avoid lapses. The survey process may include a virtual component based on the size and expansiveness of the organization (e.g., multi-site, multi-state with a centralized administration), but always includes an onsite surveyor phase.

The Commission's procedure requests that the requesting entity demonstrate that it has all the following which we believe would be readily demonstrated in a review of the 2024 Accreditation Standards Manual. An attachment (Addendum A) has been provided which illustrates sample Standards from each Section to provide context.): **[NOTE: Upon request, UCA will forward a hard copy of the 2024 Standards Manual with the Commission's agreement and assurances that it will strictly use the Manual for the purpose of assessing UCA's Accreditation Program and not reproduce or distribute its contents.]**

A. ***Standards pertaining to patient care, recordkeeping, equipment, personnel, facilities, and other related matters that are in accordance with acceptable and prevailing standards of care as determined by the Commission.***

UCA's Accreditation Standards are assigned into one of the following Key Areas:

- ✓ Certification Criteria/ CC (Scope of Services for an Urgent Care Center)
- ✓ Governance/ GOVA
- ✓ Health Record Management/ HRM
- ✓ Human Resources / HR
- ✓ Patient Care Processes/ PCP
- ✓ Physical Environment
- ✓ Privacy, Rights, and Responsibilities / PRR
- ✓ Quality Improvement

In addition to pursuing UCA Accreditation, applicants may also seek Commendations in Antibiotic Stewardship and Specialty Training.

Specific Standards which we believe would be particularly relevant to the use of in office anesthesia address the following:

- ✓ Clinician privileging to the organization's scope of practice

- ✓ Emergency response Standards, including a requirement for annual mock codes, at minimum, to include all center staff and clinicians
- ✓ Medication management Standards (storage, administration, formulary, controlled substances), including the documentation and follow-up to all errors and near misses
- ✓ Requirements for a comprehensive Infection Control and Prevention Plan (ICPP)
- ✓ Quality Improvement Standards requiring no less than six areas of focus, measurement, goals, and response when goals are not achieved
- ✓ Education and training Standards
- ✓ Basic Life Support certification, at minimum, for all clinicians and clinical staff
- ✓ Comprehensive laboratory Standards for inhouse point of care tests, send outs, and critical levels
- ✓ Staff demonstrated competencies

B. Processes that assure a fair and timely review and decision on all applications for accreditation and renewals, thereof.

Organizations interested in applying are advised that they should plan for a six-month preparation period when they are a new applicant. They are encouraged to apply during this period so the survey can be scheduled. Once the application is complete, staff from the Quality Department reach out to set up the survey process. The applying organization is then provided a survey period 'window,' allowing them to opt out of no more than two weeks. The survey dates are subsequently set in collaboration with a representative from the pool of surveyors' availability.

Renewal surveys are scheduled to 90-120 days prior to expiration such that the Accreditation process is completed without a lapse in Accreditation status.

Once surveyed, the requesting organization are informed that they will receive the results of their survey within 60-75 days, though the average is 30-45 days. Surveyor recommendations for citations are reviewed by the Quality Department, including a review for consistent and fair application across all organizations prior to being forwarded to the applicant. The organization is subsequently allowed 60 days to bring their organization into compliance and submit a response to cited Standards demonstrating achievement. Organizations may also appeal decisions specific to a Standard's interpretation. Based on the results of a survey, the Quality Department may also elect to place an organization on Probation which requires a follow-up survey prior to the termination of the 3-year accreditation cycle.

C. Processes that assure a fair and timely review and resolution of any complaints received concerning accredited or certified facilities.

Anyone wishing to submit a complaint related to an Accredited organization is asked to complete the Complaint Form (Addendum B). Once received, the Quality Department forwards the complaint to the named contact person within the organization. The organization must respond, recognizing that the complaint is to be resolved within a 30-day window from receipt. The UCA Quality Department will follow up until the issue is deemed resolved and closed.

D. Resources sufficient to allow the accrediting entity to fulfill its duties in a timely manner.

The Quality Department is supported by the leadership team and staff at the Urgent Care Association. The Quality Department is composed of an Executive Director of Quality, and 3 full-time staff positions. Additionally, there is a part-time consultant supporting the back end of the survey process and a team of surveyors who are trained, participate in weekly calls and are available to be deployed to surveys across the country. Commitments are tracked and completed on or before the committed dates.

On behalf of the Quality Department, I thank you for your consideration of the UCA 2024 Accreditation process. The program has experienced year over year growth due to interest or mandates from Urgent Care operators and members of the payer community, including international inquiries. We commit that the resources have been applied to, and will continue to be applied, in order to respond to the demand.

My contact information is as follows for questions or to request the hardcopy of the 2024 Standards Manual:

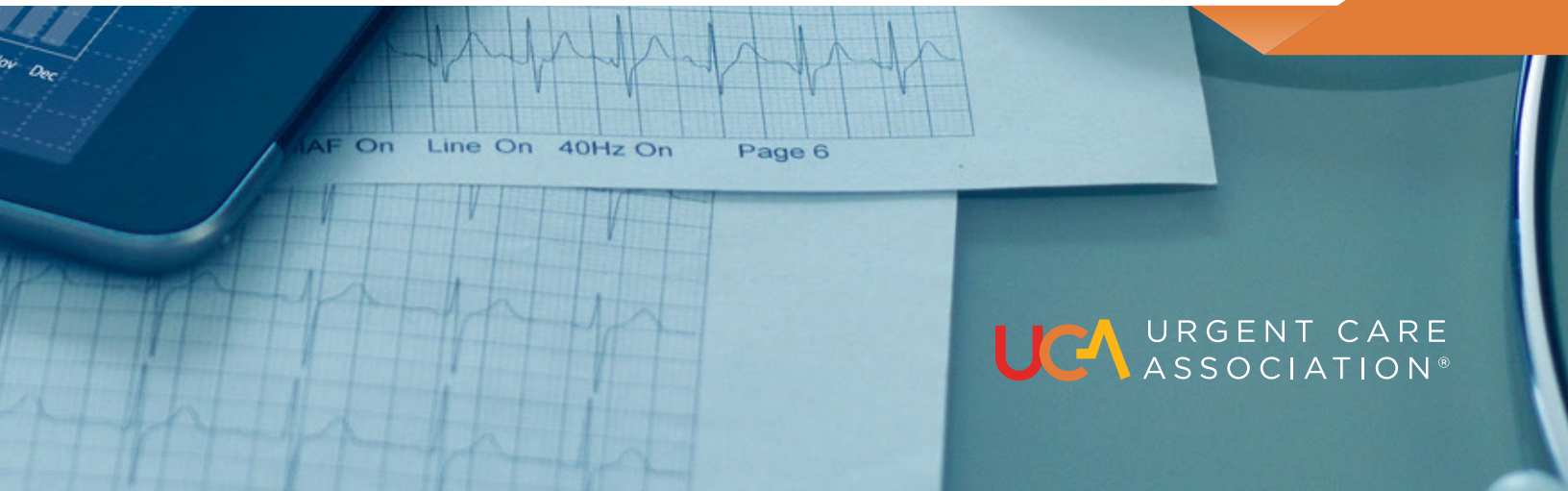
Tracy Patterson, Executive Director, Quality
Quality@urgentcareassociation.org
(480)2016-7765 (c)

Best regards,

Tracy Patterson, MBA, MHSA, CHC
Executive Director, Quality

Safety, Quality, and Scope of Services

2024 Accreditation Standards Manual



URGENT CARE ASSOCIATION®

Safety, Quality, and Scope of Services

2024 Accreditation Standards Manual

INTRODUCTION

To provide as much organizational autonomy as possible, while meeting objectives, UCA does not dictate how to implement many of the Standards set forth but will assess the effectiveness of the processes or actions currently implemented to comply. Listed within some Standards are Success Demonstrators. Success Demonstrators are examples or suggestions for approaching a Standard. While your organization is free to adopt any of these Success Demonstrators, we also encourage you to explore your own methods on how to comply.

Organizations will be surveyed for compliance with current policies approved by the organization. Organizations are required to meet the local, state, and federal regulatory requirements, adhering to the highest standard that applies.

Standards included in this manual are grouped into eight key areas:

1. CC: Certification Criteria
2. GOV: Governance
3. HRM: Health Record Management
4. HR: Human Resources
5. PCP: Patient Care Processes
6. PE: Physical Environment
7. PRR: Privacy, Rights, and Responsibilities
8. QI: Quality Improvement

The UCA Quality Committee meets routinely to update and revise the manual based on input from accredited organizations, questions received from organizations going through the process and changes in recommended practices within the industry. To assist you, a key was created to identify any changes or alterations from the prior manual.

IMPORTANT NOTICES

1. This manual has been revised and approved by the Quality Programs Committee. If a Standard is new or substantially changed in content it is marked as such.

2. Defined terms are underlined with definitions located in the glossary.

3. **Initial Surveys.** Require policies and processes have been established to demonstrate compliance with the Standards **at the time of the initial survey and going forward**. Organizations are not required to demonstrate a history of compliance with many Standards.

4. **Renewal-Repeat Surveys.** Require a demonstrated history of compliance with the Standards. It is recommended that you maintain records of compliance such as logs, drills, education files, credentialing records, meeting minutes, policies, quality plan data, etc. **for a minimum of three years or per state and federal requirements, whichever is longer**.

KEY

Two symbols are used to indicate if the Standard was added or modified from the prior manual. If neither symbol is present, there was no substantial change to the Standard from the prior version. Three symbols indicate if the Standard requires evidence of policy, documentation, and/or public notice. **If none of the three symbols are present, written evidence is not required but may be used to demonstrate compliance, as applicable.**

Standard was substantially changed.

Standard is new.

Standard requires you to have a written policy or written plan.

Standard requires you to have documentation (e.g., license, training record).

Standard requires you to have notice posted to the public, workforce, or patient.

WHAT'S CHANGED?

In this release, the following Standard numbers have been added:
Certification Criteria: 2E, 15, 16
Patient Care Processes: 7C3
Physical Environment: 13A-F, 14A-E
Quality Improvement: 5B

In this release, the following Standards have been modified:
Certification Criteria: 7A
Health Record Management: 4D-E, 4I, 4R
Human Resources: 5, 6, 7A, 9A, 13A, 14, 15
Patient Care Processes: 2G, 5B-F, 5H-K, 6A-E ,6I, 6L, 7B1, 7B2, 7C1, 7C2, 7D, 8A-B, 9B-C
Physical Environment: 1B-D
Quality Improvement: 1, 5A, 7, 7A

To date, the following Standard numbers have been retired:
Certification Criteria: 3B, 6, 8, 10
Health Record Management: 3A-B, 4F, 4V, 7A, 8C, 9C, 12, 16, 20
Human Resources: 2B-C, 5A-F, 6A-C, 8, 10B, 11A, 13I, 14A-I, 15A-D
Patient Care Processes: 4,5G, 5L-N, 5-1B
Physical Environment: 3D-E, 6A-B, 9, 11, 12
Privacy, Rights, and Responsibilities: 1A, 5
Quality Improvement: 1C-I, 2A-B, 3B, 6, 8, 9

GLOSSARY

Defined words are underlined in the Standards.

Accreditation
The act of granting recognition to an organization that maintains a nationally standardized criteria demonstrating their commitment to a comprehensive scope of services, providing quality care consistent with industry best practices, focused patient and workforce safety, human resource onboarding and oversight, and excellent clinical outcomes.

Advanced Practice Clinician (APC)
Physician assistant (PA) or nurse practitioner (NP) who practices medicine under the supervision of a physician in accordance with state regulations. This person may work in the setting of a hospital emergency department or in an acute care center.

Antibiotic Stewardship
The effort to measure and improve how antibiotics are prescribed by clinicians and used by patients.

Clinician
Licensed medical clinicians including MD's, DO's, PA's, and NP's; including employees, contractors, and those supplied through agency/lease agreement.

Clinical Staff
Staff (see Staff) engaged in direct patient care.

Clinician Credentialing
See Credentialing

Competency Assessment
A step-by-step approach of evaluating workforce ongoing ability to perform a job-related task by providing them with information about the task, a demonstration of its performance, an opportunity to imitate the demonstration and obtain subsequent feedback.

Compliance Program, Compliance Plan
Organizations participating in Medicare, Medicaid, or other government funded payment programs are to establish a compliance program as a condition of enrollment. The compliance program establishes governance, internal policies and processes focusing on regulatory compliance. The plan typically covers items such as billing, coding, gifts, anti-kickback regulations, overpayments, fraud, and abuse. The plan is typically separate from other operational policies and procedures, although many interrelate (e.g., billing policies). The plan strives to ensure ethical and professional standards on how it will conduct business. The Office of the Inspector General, U.S. Department of Health & Human Services has established the seven core requirements of an effective compliance program to include: 1) Written Policies, Procedures and Standards of Conduct; 2) Compliance Officer, Compliance Committee and High-Level Oversight; 3) Effective Training and Education; 4)

KEY AREA

Certification Criteria (CC)

CC.1 Licensed clinician (MD/DO/NP/PA) on site during all posted hours of operation

CC.2 Center must be capable of evaluating walk-in patients for all ages for a broad spectrum of illness, injury, and disease during all hours the center is open to patients

.A Pediatric specialty centers are exempt from age requirement if pediatric-only specialization is included in the name, scope, and advertising of the centers

.B Occupational health centers are exempt from age requirement if they only perform work-related treatment and evaluations

.C Adult only specialty centers are exempt from all age requirement if adult-only specialization is included in the name, scope, and advertising of the centers

.D Process on how center will handle patients who seek care outside the center's scope of care (e.g., pediatric patients that present to an adult-only center)

.E 

For centers offering virtual visits, center must be capable of evaluating on-demand patients for all ages for a broad spectrum of illness, injury, and disease during all hours the center is open to virtual patients

CC.3 The following must be available during all posted hours of operation for the center

.A X-ray on site; onsite radiological equipment (imaging modality to perform chest X-rays, c spines, long bone films, abdomen, extremities, etc.) that is easily interpretable and achievable

.C 

CLIA Certificate of Waiver, at minimum, with the performance of on-site testing appropriate to the center's population with one or more waived, moderate, or high complexity tests (e.g., blood glucose)

.D On-site ability with the appropriate state licenses and resources to meet the following scope requirements:
- Order, obtain, and read an EKG and x-ray
- Order and administer oral, inhaled, and injectable medication
- Perform minor procedures (e.g., sutures, splinting)

Note: Pediatric-only centers are not required to obtain and read an EKG.
Recommended Practice: All pediatric centers have an EKG.

.E Specimen collection, with transport to reference laboratory same day including appropriate collection and shipping supplies

CC.4 The following emergency response equipment and workforce trained in its use must be available during all posted hours of operation for the center

.A Automated external defibrillator (AED) or more advanced device

.B Oxygen, bag valve mask, oral airways

.C  Emergency medications stocked appropriately for the patient population, as determined, approved, and documented by the organization's governing body

CC.5 The center's floor plan must include the following

.A No less than two exam rooms

.B Separate waiting area

.C Patient restroom as part of the center

CC.7 An independent practice licensed clinician designated for overall clinical quality (e.g., Medical Director)

.A  Written job description available and acceptance documented

CC.9  For each center, a business license, certificate of occupancy, or equivalent

CC.11 **For organizations accrediting under the occupational health scope**, the following must be available during all posted hours of operation for each center

.A Clinicians on site with the appropriate certification, training, and resources to perform DOT physicals or arrangements to provide the service through another center within the organization

.B Workforce on site with the appropriate certification, training, and resources to provide the following services:
- Urine drug screen (UDS) collections
- Color blindness testing
- Lifting assessments
- Visual acuity testing (eye charts, vision screener)
- Whisper hearing testing

.C Workforce on site with the appropriate certification, training, and resources to provide the following services or arrangements to provide the following services through another center within the organization or third-party vendor:
- Breath alcohol testing (BAT)
- UDS testing including proof of certification for active MRO or agreement with outside vendor
- PFT/Spirometry
- Respiratory Fit testing

.D DME supplies on site; prescribed and dispensed within the visit

CC.12 **For organizations accrediting under the occupational health scope**, the organization's website and advertisements provide clear notification to the public regarding the limited scope of service

CC.13 **For organizations accrediting under the occupational health scope**, centers must include the following

.A UDS compliant restroom; water off-switch and/or dye for toilet water

.B BAT-respiratory fit testing room/area monitored for chemical use (e.g., air fresheners) to prevent pollutants from impacting accuracy of test results

CC.14 **For organizations accrediting under the occupational health scope**, a referral network protocol for providing timely follow-up visits and/or referrals for patient care

CC.15 A+ **For organizations accrediting under the telehealth scope**, a secure, interactive telecommunication platform must be available during all posted hours of operation, that includes

- audio and video equipment permitting two-way real-time communication between the patient and distant site healthcare clinician
- consistent with state and federal regulations

CC.16 A+ **For organizations accrediting under the telehealth scope**, the organization's website and advertisements provide clear notification to the public regarding the limited scope of service

KEY AREA

Governance
(GOV)

GOV.1 D Documentation that the entity is a legally formed organization meeting local, state, federal regulations

.A D Documentation that the organization is in good standing with appropriate state agency or department (e.g., state certificate/registration current)

.B D Documentation that regulatory and legal obligations of the organization are met (e.g., required state DOH licensure)

GOV.2 Evidence of defined governing body responsible for oversight of all functions of the organization, including the following:

.A D Evidence of regular leadership meetings with recorded meeting minutes to address strategy, planning, ongoing business, financial reporting, and operations

.B Mechanisms in place to monitor the financial health of the organization
- Leadership review of statements/records for short-term and long-term financial needs

.C Evidence that leaders set the example for a culture of quality and safety
- Leaders encourage workforce to identify issues related to lapses or potential risks
- Leaders address workforce issues and concerns
- Leaders adhere to organization's policies

.D D Documentation of annual review of policies, plans, and procedures by leadership
- All policies, plans, and procedures, including but not limited to, operating, human resources, clinical, compliance, and safety

Success demonstrator: Review by leadership is documented within 1) meeting minutes, 2) dates on policies, or 3) cover letter in policy manual(s) identifying the date of review and reviewer

.E D Evidence that new and revised policies and procedures are reviewed by applicable workforce once approved

Success demonstrator: Workforce review is documented within 1) meeting minutes, 2) acknowledgement logs, or 3) signatures on policies

KEY AREA

Health Record Management (HRM)

HRM.1 Health records, including records stored off site, are easily accessible, kept in a secure format, and used consistently to document care, treatment, and all other services

.A Paper medical records, logs, and other hard-copy records containing protected health information (PHI) are stored securely with restricted access (e.g., locked room/cabinets, off-site secure storage)

.B Retention and destruction processes
- Permissions and instructions for destruction are defined

.C Protocol available for permissions, users, and passwords including network security for electronic medical records

.D All patient encounters are documented in electronic format

HRM.2 Health records contain patient name, unique patient ID, demographic with contact information, and documentation of all dates of service for every patient

.A Medical record identification includes identification on patient registration, intake, and billing information
- All dates of services linked to a unique ID#

.B Complete organization's defined demographics

HRM.3 Legible, dated entries with identification (e.g., signatures, electronic stamp) of workforce administering care, reviewing records, and making medical record entries

.C 

Policy defines timeframe of entry and completion of the medical record including addendums

HRM.4 

Documentation of care includes the following as appropriate:

.A Chief complaint

.B History of present illness (HPI) relevant to the CC

.C Physical examination

.D 

Review of system (ROS) relevant to the CC and HPI

KEY AREA

Human Resources (HR)

HR.1 Evidence of a designee responsible for Human Resources oversight

HR.2 P Key HR policies with affirmation that workforce has received copies and is accountable for its content

.A P Key policies to include, but not limited to:
- Workforce dress and appearance relating to safety
- Workplace conduct, work performance, discipline
- Discrimination, harassment, hostile, abusive conduct
- Grievance process
- Smoking/vaping
- Drug and alcohol-free workplace
- Attendance and leave of absence, absences due to illness
- Communication, use of technology and personal devices

HR.3 D Evidence of organizational chart
- Chart delineates reporting structure for workforce up to CEO/owner

.A Workforce is knowledgeable on who to access for operations and/or problem resolution

HR.4 P D Policies for performing background checks for workforce as required by state law and organizational policies and evidence of appropriate checks; policy to include:
- Proper consents completed by applicant
- Process to resolve inconclusive background/credit checks
- Disclosure to applicant

.A D The organization performs National Sex Offender Registry checks on all workforce that has direct patient contact and/or access to patient or employee records

KEY AREA

Patient Care Processes (PCP)

PCP.1 Patient Identifiers

.A P Policy defining the organization's specific two (2) patient identifiers
- Policy requires patients/historians to state their two patient identifiers (vs. asked to confirm identifiers stated by workforce)

.B From inception of visit, each patient has been verified with the approved organization's two (2) patient identifiers before providing care, treatment, medication administration, or services:
- Both identifiers are used consistently throughout the encounter
- Used by entire workforce
- Can be reiterated by workforce
- Patient is asked to state their two patient identifiers

PCP.2 Medical Care Services

.A N Evidence that all services offered, and hours of operation are clearly displayed and regularly communicated

Success demonstrators: Hours posted at center entrance or listed in advertisements including website.

.B N Evidence of clear and public display stating the center provides "urgent care," "immediate care" and/or "walk in" services without the need for an appointment during all hours of operations (no limitations posted)

Success demonstrators: Messaging posted at center entrance or included in advertisements such as website or social media.

.C Evidence that patient evaluations include history and physical examination to develop a timely diagnosis and a treatment plan consistent with current medical consensus or evidence-based practice

.D Evidence that recommendations for diagnostic studies are appropriate for the presenting history and physical examination

KEY AREA

Physical Environment (PE)

PE.1 Policy to manage safety risks associated with the physical environment, including both administrative locations and Urgent Care centers

.A.1 Control access to and from areas identified as a safety risk for workforce and patients
- Workforce is aware of how to respond to potential breaches to a safe environment

.A.2 Policy identifies the safety officer and their roles and responsibilities
- Workforce can identify the safety officer

.B Policy includes a process to respond to equipment, supply, and medication, including sample medications, shortages, notices, and recalls
- Patients are notified per manufacturer guidance

.C Ensure safety of center including exterior areas (e.g., entries, parking)
- Utilize hazards warning signage (e.g., wet floors)
- Eliminate slips, falls, burns, and toxic ingestion risks
- Provide adequate lighting and ventilation including emergency lighting for safe evacuation
- Safely store compressed gas tanks (e.g., oxygen tanks)
- Capabilities for eye irrigation for workforce and patients
- Capabilities for spills/hazards cleanup (e.g., spill kits)
- Capabilities for sharps/biohazard materials disposal

.D Center is accessible to individuals with disabilities

PE.2 Manage fire risks at both corporate locations and centers

.A Conduct and document fire drills at least twice a year with no less than one unannounced drill per year
- Fire drills are documented and evaluated
- Workforce understands their role in the event of a fire

Recommended Practice: Fire drills are conducted on all shifts and include use and training of emergency equipment (e.g., fire extinguishers).

.B Maintain unobstructed access to all exits

KEY AREA

Privacy, Rights, & Responsibilities (PRR)

PRR.1  Evidence of written HIPAA privacy policies

.B  Display Notice of Privacy Practices (HIPAA) and inform all patients per law and regulation

.C Evidence that patients have been offered a copy of the organization's current HIPAA privacy notice with signed acknowledgement

.D  Business Associate Agreements (BAA's) are available for non-covered entities that may access PHI
- Common non-covered entities include but are not limited to attorneys, IT contractors, consultants, billing companies

PRR.2 Evidence that the physical environment and patient flow processes take patient privacy into consideration; including, but not limited to:
- Patient registration/intake processes ensures privacy
- Floor plan of patient care area ensures patient privacy
- Computer screen not visible to patients and guests
- Visitors restricted to non-work areas such as staff lounges and lobbies

PRR.3  Documentation of process to disclose workforce credentials and position

.A Workforce can be identified with visible name and credentials

Note: Most often demonstrated by use of name tag/badge.

.B Clinical staff and clinicians introduce themselves with title to patient/family members

PRR.4  Documentation of process to address and respond to patient, family member, and customer complaints

.A Process includes routing of complaints to appropriate department/person

.B Process includes timeframe in which to address complaint

.C Process includes documented follow-up with patient

KEY AREA

Quality Improvement (QI)

QI.1 

Annual Quality Improvement Plan with a minimum of six areas of focus including Patient Feedback/Satisfaction, Medication Stewardship, Infection Control, Workforce Policy/Process Training Effectiveness, and two (2) areas of focus of the organization's choice where there is risk or a history of error or diverging from evidence-based medicine or best practices

Note: Audit of quality and safety policy and process are frequently chosen as the additional two measures, such as, imaging overreads, observation of patient post-injection, handwashing and glove use, supply/medication expiration, and cleaning procedures between patients.

.A 

Plan to include, per area of focus:
- Risk, reason for focus
- Methodology for oversight (e.g., PDSA)
- Frequency of measurement
- Responsible individuals
- Acceptable threshold of performance
- Corrective action plan
- Measurement tools
- How data will be used to improve patient care
- How workforce participates in the process

.B 

Evidence that plan is reviewed, revised, and implemented annually

QI.2 

Champion designated to oversee the quality improvement plan and other quality initiatives for ongoing clinical, service, administrative, or other improvement opportunities

QI.3 

Evidence of the quality monitoring mechanisms, PDSA (Plan, Do, Study, Act) cycle or other, are used to address areas for improvement

.A 

Records of quality improvement initiatives are available

Note: Organizations re-accrediting shall have a minimum of three years of data available for retrospective review.

Reporting a Safety Concern

Please use this form to report a safety concern. Please be aware that the Urgent Care Association (UCA) does not assess specific patient care or its appropriateness. Instead, our evaluation focuses on procedures and processes that are required within our accreditation standards. We encourage you to contact the organization directly for resolution. Issues related to billing, insurance, or labor are not within UCA Accreditation Standards. Unless listed as optional, all information requested is required.

Accredited Organization

(physical location where concern took place)

Business Name	
Street Address	
City, State, Zip Code	
Date of Occurrence	

Your Information

You have the option to submit anonymously. To receive an update, you must provide your personal information. Your name/identity as the source will be kept confidential unless you allow us to share your name with the organization.

Full Name	
Email	
Street Address	
City, State, Zip Code	

Waiver, Disclaimer Notice

We will review your concern and determine how best to proceed. UCA is here to help organizations improve; we will use your report to better understand and assist improvement. This could include contacting the organization about your concern. Should we decide to contact the organization about your concern, please confirm whether you give us permission to: release your name as the source of this concern and send the information you have shared to the organization (select one):

☐ **Yes, I give UCA permission to share my name, as the source of information and share a copy of the information I have sent with the organization. If yes, please provide your personal information above.**

☐ **No, UCA may not share my name as source and a copy of the information may not be shared with the organization.**

- If confidentiality is not waived, we may still act upon your concern following anonymous reporting.
- Permission to share does not guarantee inquiry by UCA.
- Please be aware that we will not provide you with the organization's response should an inquiry be pursued.

Description of Concern

Please use the open space on the next page to provide a brief overview of your concern. Please limit your narrative to the space provided on the next page. Please do not include medical record information.

Thank you for bringing your concerns to our attention and helping improve urgent care.

Procedure

WASHINGTON Medical Commission
Licensing. Accountability. Leadership.

Commissioner Recusal Procedure for Managing Conflicts of Interest

Introduction

Administrative proceedings are to be free from the impression that a participating member pre-judged the matter at hand. In *Washington Med. Disciplinary Bd. v. Johnston*, the Supreme Court of Washington opined, "Under the appearance of fairness doctrine, proceedings before a quasi-judicial tribunal are valid only if a reasonably prudent and disinterested observer would conclude that all parties obtained a fair, impartial, and neutral hearing." [1]

Similarly, the Washington State Executive Ethics Board has issued advisory opinions regarding the Ethics in Public Service Act, Chapter 42.52 of the Revised Code of Washington (RCW), and its application to Boards/Commissions. That guidance has remained grounded in the basic concept that public servants are not to be decision-makers involving matters that personally benefit them. Advisory Opinion number 96-09 includes that boards and commissions may require members to disclose their interests and abstain from voting or attempting to influence votes when there is a conflict of interest.[2]

In compliance with the advisory opinion, the Washington Medical Commission (Commission) Code of Conduct states that Commissioners will, "recuse themselves and proactively disclose when there is a real or potential conflict of interest, or the appearance of such a conflict." This code of conduct aligns with the Federation of State Medical Boards (FSMB) recommendation that boards adopt a conflict-of-interest policy. Such a policy should include that no board member shall participate in the deliberation, making of any decision, or taking of any action affecting the member's own personal, professional, or pecuniary interest, or that of a known relative or of a business or professional associate.

Purpose: The Commission is committed to preventing bias from unjustly influencing Commission activities. The purpose of this procedure is to prevent biases from unjustly impacting licensing, investigations, policy-making, and disciplinary matters.

Case Management Team Meetings

Case Management Team (CMT) meetings include at least three Commissioners who access complaints and determine whether to authorize an investigation. To further prevent bias from impacting Commission activities, staff redact the allopathic physicians (MD) or physician assistants (PA) identifying information including, but not limited to, name, gender or gender identity, and race.

[1] *Matter of Johnston, 99 Wash. 2d 466, 478, 663 P.2d 457, 464 (1983).*
[2] Advisory Opinion on Disclosure Requirements for Boards and Commissions, Number 96-09, approved May 20, 1996, reviewed May 5, 2021, available at https://ethics.wa.gov/sites/default/files/public/AO%2096-09.pdf (Accessed April 8, 2024)

Case Disposition Meetings

Case Disposition meetings involve a panel of Commissioners who hear presentations of cases that have the investigation completed. Each case is presented by a Reviewing Commission Member (RCM) who does not state the identifying details of the MD or PA, including, but not limited to, name, gender or gender identity, and race as part of their presentation. The panel then decides whether to authorize discipline or close the case for each instance.

While these redactions and exclusions are aimed at preventing bias and ensuring fairness, they may inadvertently obscure a Commissioner's immediate recognition of a conflict of interest. The redactions and limited information particularly impede the identification of reasons for recusal during both CMT and Case Disposition meetings. However, once a Commissioner or the Commission's Executive Director becomes aware of a potential conflict of interest involving a Commissioner, this recusal policy offers guidance on proceeding to uphold impartiality and fairness.

This policy is intended to provide guidance for Commissioner and Pro Tem appointees[3] in mitigating conflicts of interest that could compromise the integrity of Commission proceedings.

Legal Authority

United States Constitution

The 14th Amendment of the United States Constitution,[4] provides due process protection for individuals in the U.S., not just practitioners, to protect against biased, unjust governmental adjudications. The United States Supreme Court has clarified that due process protects against a likelihood of decision-maker bias from impacting a fair adjudication,[5] and these protections have been further enhanced through Washington state laws.

Revised Code of Washington

In Washington, Commissioners are considered "state officers", and as such are bound by the Ethics in Public Service Act, chapter 42.52 RCW. Pertinent sections of this statute include the following:

> **RCW 42.52.020 Activities incompatible with public duties.**
>
> No state officer or state employee may have an interest, financial or otherwise, direct or indirect, or engage in a business or transaction or professional activity, or incur an obligation of any nature, that is in conflict with the proper discharge of the state officer's or state employee's official duties.
>
> **RCW 42.52.030 Financial interests in transactions.**
>
> (1) No state officer or state employee, except as provided in subsection (2) of this section, may be beneficially interested, directly or indirectly, in a contract, sale, lease, purchase, or grant that may be made by, through, or is under the supervision

[3] To avoid redundancy, the term "Commissioner" henceforth includes a Commissioner or a Pro Tem appointee.
[4] Available at https://www.archives.gov/milestone-documents/14th-amendment (Accessed May 14, 2024)
[5] "Not only is a biased decisionmaker constitutionally unacceptable, but 'our system of law has always endeavored to prevent even the probability of unfairness.' Where there is merely a general predilection toward a given result which does not prevent the agency members from deciding the particular case fairly, however, there is no deprivation of due process." *Matter of Johnston*, 99 Wash. 2d 466, 475, 663 P.2d 457, 462 (1983) (quoting *In re Murchison*, 349 U.S. 133, 136 (1955)).

of the officer or employee, in whole or in part, or accept, directly or indirectly, any compensation, gratuity, or reward from any other person beneficially interested in the contract, sale, lease, purchase, or grant.

RCW 42.52.160 Use of persons, money, or property for private gain.

(1) No state officer or state employee may employ or use any person, money, or property under the officer's or employee's official control or direction, or in his or her official custody, for the private benefit or gain of the officer, employee, or another.

RCW 42.52.903 Serving on board, committee, or commission not prevented.

Nothing in this chapter shall be interpreted to prevent a member of a board, committee, advisory commission, or other body required or permitted by statute to be appointed from any identifiable group or interest, from serving on such body in accordance with the intent of the legislature in establishing such body.

Guidance on Transparency Involving a Conflict of Interest and Recusal

There must be transparency in the handling of conflicts of interests involving Commission matters. To prevent a conflict of interest involving public duties from compromising fairness, the Commission recognizes that specific prohibitions in chapter 42.52 RCW must be read in conjunction with the exception specified in RCW 42.52.903 and, in limited circumstances, that conflicts of interest may occasionally be unavoidable. A Commissioner's employer or affiliated health systems may not, in and of themselves, create a conflict-of-interest necessitating recusal; however, when any of these affiliations, or others, create a scenario in which that a Commissioner may financially, personally, or professionally benefit, or be harmed, that does necessitate recusal.

The Commission adopts the following guidance:

- Commissioners are responsible for handling conflicts of interest with full transparency at all times and for recusing themselves from cases as soon as reasonably possible if they recognize a conflict of interest that may compromise fairness, impartiality, or the appearance of impartiality;
- No Commissioner may be beneficially interested, directly or indirectly, in a decision in which they are involved;
- No Commissioner may participate, in their official capacity, in a transaction involving the state with a partnership, association, corporation, firm or other entity of which the Commissioner is an officer, agent, employee or member, or in which the Commissioner owns a beneficial interest;
- A Commissioner is encouraged to announce their potential conflict of interest and recuse themselves as soon as they first recognize the potential conflict, and if there is a true conflict they should leave the room or call and not participate in any discussion involving the matter to avoid impartiality or the appearance of impartiality; and
- A Commissioner must abstain from any discussion or vote taken by the Commission involving an action (including contracting, rulemaking, or policy decisions) or transaction with any entity with which the Commissioner may benefit or be harmed (financially, personally, or professionally), and

if a Commissioner abstains from voting because of such involvement, such Commissioner shall announce for the record their reason for their abstention.

Procedure for Commissioner Recusal[6]

Internal Process Among Commissioners

To ensure fundamental fairness, a Commissioner should notify the Panel Chair and the Executive Director of any concerns they have regarding any Commissioner's, including but not limited to their own, inability to be impartial. Disqualification processes and standards are addressed in the Administrative Procedure Act, specifically in RCW 34.05.425[7], in addition to the Model Procedural Rules for Boards, specifically in WAC 246-11-230[8].

Standards for Recusal

A Commissioner should exercise sound discretion in choosing whether to be recused from participation and voting regarding any matter. A Commissioner should choose to be recused if they:

- Have a direct financial interest or relationship with any matter, party, or witness that would give the appearance of a conflict of interest;
- Have a current or past relationship* within the third degree of affinity with any party or witness; or
- Determine that they have knowledge of information that is not in the administrative record of a contested case and that they cannot set aside that knowledge and fairly and impartially consider the matter based solely on the administrative record.

Once a Commissioner believes there may be a conflict of interest that has the potential to cause impartiality, or an appearance of impartiality, the first step is for the Commissioner who recognizes that conflict to alert the Commission Executive Director, or their designee. Then, in consultation with the Commission Executive Director, or their designee, there will be a discussion with the Commissioner with the potential conflict, if possible, to make a clear determination of the following: (1) "must" recuse, (2) "should" recuse, or (3) "unnecessary" to recuse. The determination will err on the side of recusal. If a conflict is recognized late, it will be addressed as soon as reasonably possible.

The fact that a Commissioner participated in another matter regarding a respondent, applicant, attorney, or matter may not by itself mandate the Commissioner's recusal from other matters. If a Commissioner is

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[6] This recusal procedure was heavily influenced by Texas Administrative Code, Rule Section 187.42, with quotation marks omitted, with modifications which incorporate Washington state law and ethics board guidance to ensure impartiality and to protect the public.

[7] "(3) Any individual serving or designated to serve alone or with others as presiding officer is subject to disqualification for bias, prejudice, interest, or any other cause provided in this chapter or for which a judge is disqualified. (4) Any party may petition for the disqualification of an individual promptly after receipt of notice indicating that the individual will preside or, if later, promptly upon discovering facts establishing grounds for disqualification. (5) The individual whose disqualification is requested shall determine whether to grant the petition, stating facts and reasons for the determination. (6) When the presiding officer is an administrative law judge, the provisions of this section regarding disqualification for cause are in addition to the motion of prejudice available under RCW 34.12.050. (7) If a substitute is required for an individual who becomes unavailable as a result of disqualification or any other reason, the substitute must be appointed by the appropriate appointing authority. (8) Any action taken by a duly appointed substitute for an unavailable individual is as effective as if taken by the unavailable individual." RCW 34.05.425.

[8] "(4) Any party may move to disqualify the presiding officer, or a member of the board hearing the matter, as provided in RCW 34.05.425(3)." WAC 246-11-230.

familiar with a respondent or applicant due to serving on a panel or serving as a reviewing commission member, that alone is generally not sufficient to warrant recusal. However, in the event that prior involvement may potentially prejudice the rights of any party to a fair proceeding, the presiding officer (presiding Commissioner or health law judge) may cure any such prejudice by an instruction to Commissioners or members of the hearing panel to not consider the statement during the course of the proceeding or during deliberations or discussion related to the proceeding.

However, if the Commissioner has prior knowledge of a situation from having served as a hospital quality assurance reviewer or as an expert or fact witness or attorney of record on a civil case involving the respondent or applicant, recusal is warranted.

In summary, Commissioners must recuse themselves if there is a conflict of interest and should recuse if there is an appearance of a conflict of interest. Commissioners are expected to use reasonable judgment and should discuss the possible conflict of interest with the Commission's Executive Director, or their designee, and err on the side of recusal.

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Title:	Clinical Experience Assessment		POL2024-01
References:	RCW 18.71.472		
Contact:	Washington Medical Commission		
Phone:	(360) 236-2750	E-mail:	medical.commission@wmc.wa.gov
Supersedes:	NA		
Effective Date:			
Approved By:	Karen Domino, MD ,Chair (signature on file)		

Policy

It is the policy of the Washington Medical Commission (Commission) to consider the attached Clinical Experience Assessment (CEA) as the clinical assessment adopted by the Commission to determine the readiness of international medical graduates to apply and serve in residency programs according to RCW 18.71.472.

Introduction

In 2020, ~~the Washington State Legislature chose to extend the responsibilities of the International Medical Graduate (IMG) Assistance Work Group with the passage of~~ Senate Bill 6551; ~~thus, creating the IMG Implementation Workgroup (Workgroup). The bill also~~ required that the Washington Medical Commission (Commission) "adopt a clinical assessment to determine the readiness of international medical graduates to apply and serve in residency programs and adopt a grant award process for distributing funds" pursuant to appropriation by the legislature and donations received from public and private entities. ~~After meeting monthly throughout 2022, t~~The Workgroup voted to propose the following Clinical Experience Assessment (CEA) form, Attachment A, which meets the requirement set forth by the legislature.

~~Policy~~Instructions

Purpose of the CEA Form. The CEA is intended for physician assessors working with IMGs to prepare them for residency and to determine their overall readiness for residency training. The CEA is not an element of application for residency nor is it a qualification for residency.

Assessment of Residency Preparedness. The CEA is to be used to assess what level of "entrustment" seems appropriate for the IMG to enter a residency and to aid the IMG in successfully gaining a residency position.

Frequency of Assessment. The CEA is to be used as a quarterly assessment tool throughout the program until a passing score on all competencies has been attained, signifying residency readiness.

Monitoring of the CEA Form's Effectiveness. As funding and staffing capabilities permit, the Workgroup should develop a monitoring system to track effectiveness and limitations involving the use of the CEA. Once developed, the Workgroup is to begin tracking progress and challenges of IMGs who utilized the

CEA form, identify where additional education or targeted trainings may be needed, and adjust to optimize the effectiveness of IMG pre-residency training, and of the CEA form itself.

Retention. The CEA form should be retained ~~until [residency placement/6 years/?]~~for four years and be made available upon request.

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Clinical Experience Assessment

Name: Date:

Ranking Guidelines		
1	"I did it."	The licensee required complete guidance or was unprepared or not competent; I had to do most of the work myself.
2	"I talked them through it."	The licensee was able to perform some tasks competently but required repeated directions.
3	"I directed them from time to time."	The licensee demonstrated some independence and competence and only required intermittent prompting.
4	"I was available just in case."	The licensee functioned fairly independently and competently and only needed assistance with nuances or complex situations.
5	"Not observed."	The licensee was not seen or observed completing this task.

1. Gather a History and Perform a Physical Examination					
1	2	3	4	5	Task
					Obtain a complete and accurate history in an organized fashion.
					Demonstrate patient-centered interview skills.
					Demonstrate clinical reasoning in gathering focused information relevant to a patient's care.
					Perform a clinically relevant, appropriately thorough physical exam pertinent to the setting and purpose of the patient visit.

2. Prioritize a Differential Diagnosis Following a Clinical Encounter					
1	2	3	4	5	Task
					Synthesize essential information from previous records, history, physical exam, and initial diagnostic evaluations to propose a scientifically supported differential diagnosis.

1	2	3	4	5	Task
					Prioritize and continue to integrate information as it emerges to update differential diagnosis, while managing ambiguity.
					Engage and communicate with team members for endorsement and verification of the working diagnosis that will inform management plans.
3. Recommend and Interpret Common Diagnostic and Screening Tests					
1	2	3	4	5	Task
					Recommend first-line cost-effective screening and diagnostic tests for routine health maintenance and common disorders.
					Interpret results of basic studies and understand the implication and urgency of the results.
4. Enter and Discuss Orders and Prescriptions					
1	2	3	4	5	Task
					Compose orders efficiently and effectively verbally, on paper, and electronically.
					Demonstrate an understanding of the patient's condition that underpins the provided orders.
					Recognize and avoid errors by attending to patient-specific factors, using resources, and appropriately responding to safety alerts.
					Discuss planned orders and prescriptions with team, patients, and families.
5. Document a Clinical Encounter in the Patient Record					
1	2	3	4	5	Task
					Prioritize and synthesize information into a cogent narrative for a variety of clinical encounters (admission, progress, pre- and post-op, and procedure notes; informed consent; discharge summary).
					Follow documentation requirements to meet regulations and professional expectations.
					Document a problem list, differential diagnosis, and plan supported through clinical reasoning that reflects patient's preferences.

6. Provide an Oral Presentation of a Clinical Encounter					
1	2	3	4	5	Task
					Present personally gathered and verified information, acknowledging areas of uncertainty
					Provide an accurate, concise, well-organized oral presentation.
					Adjust the oral presentation to meet the needs of the receiver.
					Demonstrate respect for patient's privacy and autonomy.
7. Form Clinical Questions and Retrieve Evidence to Advance Patient Care (*only level 3 required)					
1	2	3	4	5	Task
					Combine curiosity, objectivity, and scientific reasoning to develop a well-formed, focused, pertinent clinical question (ASK).
					Demonstrate awareness and skill in using information technology to access accurate and reliable medical information (ACQUIRE).
					*Demonstrate skill in appraising sources, content, and applicability of evidence (APPRAISE).
					*Apply findings to individuals and/or patient panels; communicate findings to the patient and team, reflecting on process and outcomes (ADVISE).
8. Give or Receive a Patient Handover to Transition Care Responsibility					
1	2	3	4	5	Task
					Document and update an electronic handover tool and apply this to deliver a structured verbal handover, using communication strategies known to minimize threats to transition of care
					Provide succinct verbal communication conveying illness severity, situational awareness, action planning, and contingency planning.
					Demonstrate respect for patient's privacy and confidentiality.

9. Collaborate as a Member of an Interprofessional Team					
1	2	3	4	5	Task
					Identify team members' roles and responsibilities and seek help from other members of the team to optimize health care delivery.
					Include team members, listen attentively, and adjust communication content and style to align with team-member needs.
					Establish and maintain a climate of mutual respect, dignity, integrity, and trust; prioritize team needs over personal needs to optimize delivery of care; and help team members in need.
10. Recognize a Patient Requiring Urgent or Emergent Care and Initiate Evaluation and Management (*only level 3 required)					
1	2	3	4	5	Task
					Recognize normal and abnormal vital signs as they relate to patient- and disease-specific factors as potential etiologies of a patient's decompensation.
					Recognize severity of a patient's illness and indications for escalating care.
					*Initiate and participate in a code response and apply basic and advanced life support.
					Upon recognition of a patient's deterioration, communicates situation to attending physician.
11. Obtain Informed Consent for Tests and/or Procedures					
1	2	3	4	5	Task
					Describe the key elements of informed consent: indications, contraindications, risks, benefits, alternatives, and potential complications of the intervention.
					Communicate with the patient and family to ensure that they understand the intervention including pre/post procedure activities.

12. Perform General Procedures of a Physician (*only level 3 required)					
1	2	3	4	5	Task
					*Demonstrate technical skills required for the procedure.
					Understand and explain the anatomy, physiology, indications, contraindications, risks, benefits, alternatives, and potential complications of the procedure.
					Completes expected procedures and keeps log book signed by mentor
13. Identify System Failures and Contribute to a Culture of Safety and Improvement (*only level 3 required)					
1	2	3	4	5	Task
					Identify and report actual and potential ("near miss") errors in care using system reporting structure (event reporting systems, chain of command policies).
					Participate in system improvement activities in the context of learning experiences (rapid- cycle change using plan–do–study– act cycles, root cause analyses, morbidity and mortality conference, failure modes and effects analyses, improvement projects).
					Engage in daily safety habits (accurate and complete documentation, including allergies and adverse reactions, medicine reconciliation, patient education, universal precautions, hand washing, isolation protocols, falls and other risk assessments, standard prophylaxis, time-outs).
					Admit one's own errors, reflect on one's contribution, and develop an individual improvement plan.

Guidance Document

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Communicating Diagnostic Test Results and Time Critical Information to Patients and Practitioners

Introduction

Effective communication is a critical component of medical care. Quality patient care requires that study results are conveyed in a timely fashion to those responsible for treatment decisions and those patients or guardians who must make informed choices. Communication should:

a) Be tailored to satisfy the need for timeliness;
b) Identify and communicate clearly the critical nature of the findings
c) Identify responsibility to inform the patient;
d) Encourage health care practitioner communication; and
e) Minimize the risk of communication errors.

Various factors and circumstances unique to a clinical scenario may influence the methods of communication between those caring for the patient. Timely receipt of the report is as important as the method of verification and delivery method.

The Washington Medical Commission issues this guideline to emphasize the responsibility of all practitioners to identify and responsibly communicate Time Critical Medical Information (TCMI) in a timeframe and manner that assures the usefulness of the information for quality patient care. This guideline also recognizes the shared responsibility of administrators, referring practitioners, treating practitioners and interpreting practitioners to design and use support systems to document the timely communication and receipt of TCMI.

Similarly, patients deserve to receive their test results and an adequate explanation of the results in a timely manner. Failure to do so can cause unnecessary worry and lead to serious consequences for the patient.

The term "test results" in this guideline refers to diagnostic test results. In response to a provision in the 21st Century Cures Act, the Department of Health and Human Services completed a federal rule in 2022 mandating patient access to their health records in electronic format while also prohibiting the practice of information blocking. With the near instant patient access to test results, it becomes essential that practitioners are not only notifying patients of results, but proactively reaching out to make sure there is a clear understanding on the part of the patients. Communication with the patient regarding the implications and the next steps suggested or required by the results should be prioritized for continuity of care.

Guidelines for Practitioner-to-Practitioner Communication

Practitioners who provide TCMI should, in a collaborative fashion with interested parties, identify TCMI and establish transmission and verification policies for TCMI in order to assure timely care and patient safety. Communication of information is only as effective as the system that conveys the information. There is a reciprocal duty of information exchange. The referring practitioner or treating practitioner shares the responsibility for obtaining results of studies ordered. Formulating transmission and verification of test results requires the commitment and cooperation of administrators, referring practitioners, and interpreting practitioners. Practitioners should identify and communicate who will be responsible for informing the patient. In reporting TCMI, the practitioner should expedite the delivery of a TCMI (preliminary or final) in a manner that reasonably assures timely receipt and verification of transmission of the results.

Guidelines for Practitioner-to-Patient Communication

All practitioners should have an effective system that will ensure timely and reliable communication of test results to patients and appropriate follow-up. While the system will vary depending on the type of practice, the Commission recommends that it be in writing and, at a minimum, contain the following elements:

1. Clear definitions to distinguish between test results that are routine and test results that are critical.
2. A mechanism by which the ordering physician is notified of the receipt of critical test results from the diagnosing physician, if not the same practitioner.
3. A process to communicate the test results to the patient in a timely manner—whether in writing, electronic, telephonic or in person (depending on preference indicated by the patient)—that ensures the patient receives the test results.

a. Communication should be in a format and in language that is easily understood by the patient to include communicating at an accessible education level.

b. The medical record should reflect who made the communication, how the communication was made, and when the communication was made.

c. Communication should comply with the privacy requirements of the Health Insurance Portability and Accountability Act and Washington State law.

4. Confirmation that the patient received the test results. Verification of receipt should be documented in the medical record.
5. Clear instructions to the patient to enable the patient to contact the practitioner and ask questions about the test results and schedule a follow-up appointment with the practitioner. The instructions should be documented in the medical record.
6. If the test results indicate that treatment may be necessary, the ordering practitioner should discuss potential options with the patient and initiate treatment.
7. When the ordering practitioner is unavailable, there must be a qualified designee who will assume responsibility to receive test results, notify the patient, and initiate appropriate clinical action and follow up.
8. The system should not depend solely on the attentiveness of human beings but be backed up by technology or processes that prevent test results from being missed, lost or inadequately communicated to the ordering physician or to the patient.

Additional Guidance and Scenarios

Situations that may require non-routine communication

1. **Findings that suggest a need for immediate or urgent intervention**:

   Generally, these cases may occur in the emergency and surgical departments or critical care units and may include diagnostic evidence of a malignancy including new suggestive imaging findings, pneumothorax, pneumoperitoneum, or a significantly misplaced line or tube, critical time sensitive laboratory values, and pathology results that may represent critical or potentially life-threatening medical information.

2. **Findings that are conflicting with a preceding interpretation of the same examination and where failure to act may adversely affect patient health:**

   These cases may occur when the final interpretation is contradictory with a preliminary report or when significant discrepancies are encountered upon subsequent review of a study after a final report has been submitted.

3. **Findings, including imaging studies and laboratory results, that the interpreting physician reasonably believes may be seriously adverse to the patient's health and are unexpected by the treating or referring physician:**

   These cases may not require immediate attention but, if not acted on, may worsen over time and possibly result in an adverse patient outcome.

Methods of communication

Communication methods are dynamic and varied. It is important, however, that non-routine communications be handled in time to provide the appropriate care to the patient. Communication by telephone or in person to the treating or referring practitioner or representative is appropriate and assures receipt of the findings. There are other forms of communication that provide documentation of receipt which may also demonstrate communication has been delivered and acknowledged. The system of communication must identify a responsible person and method to confirm that TCMI was received by an appropriate person involved with the patient's care and by the patient. Merely posting the results in the electronic medical record may not be sufficient in situations where time is critical to a safe and positive outcome.

Documentation of non-routine communications

Documentation of communication of TCMI is best placed contemporaneously in the patient's medical record. Documentation preserves a history for the purpose of substantiating certain findings or events. Documentation may also serve as evidence of such communication, if later contested.

Resources

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Guidance Document

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Processing Complaints Against Licensees Enrolled in the Washington Physicians Health Program

Introduction

The Washington Medical Commission (Commission) provides this guidance document to (1) explain how it handles complaints against physicians and physician assistants (hereafter licensees) who may be impaired by ~~drugs or alcohol (also known as a substance use disorder)~~a health condition and are enrolled in the Washington Physicians Health Program (WPHP), and to (2) enhance consistency and fairness in decision-making in such cases.

The Commission promotes patient safety and enhances the integrity of the profession through licensing, discipline, rule-making and education. To fulfill its mission to enhance patient safety, the Commission reviews and investigates complaints that licensees have engaged in unprofessional conduct or have ~~mental or physical conditions~~ health conditions that affect their ability to practice medicine with reasonable skill and safety.

Commented [CB1]: Mental conditions are physical (brain) conditions, separating them perpetuates stigma. Better to say psychiatric and non-psychiatric health conditions if you want to make a distinction. Preferable to just say heath conditions

The Uniform Disciplinary Act, Chapter 18.130 RCW, sets forth the process by which a disciplinary authority like the Commission may impose disciplinary sanctions upon a licensee who commits unprofessional conduct or has a ~~mental or physical~~health condition that renders the licensee unable to practice with reasonable skill and safety. RCW 18.130.160 states that when a disciplinary authority imposes sanctions, the first priority is to protect the public. Only after the public is protected may the disciplinary authority include requirements designed to rehabilitate the licensee.

RCW 18.130.175 provides that if the disciplining authority determines that the unprofessional conduct may be the result of ~~substance use disorder~~a health condition, the disciplining authority may, in lieu of discipline, refer the license holder to a ~~substance use disorder monitoring~~physician health program approved by the disciplining authority. The licensee must sign a waiver allowing the program to notify the disciplinary authority if the licensee fails to comply with the program or is unable to practice with reasonable skill and safety.

Commented [CB2]: Since this policy was written, statute was revised to apply to any health condition

Commented [CB3]: "Physician health program" is now recognized in statute and differentiated from voluntary substance use disorder monitoring program

The Washington State Department of Health has contracted with the WPHP as the approved ~~substance abuse monitoring~~physician health program for a number of healthcare professions, including physicians and physician assistants. The WPHP is an independent, nonprofit organization that facilitates the rehabilitation of licensees who have ~~physical or mental~~health conditions that could compromise public safety. The conditions include substance use disorder and other behavioral health disorders, as well as ~~physical~~ non-psychiatric medical conditions and cognitive disorders. The Commission fully supports the work of the WPHP and notes that it has had remarkable success in rehabilitating licensees and helping them to manage their illnesses and practice medicine safely.

Most of the licensees enrolled in the WPHP have entered ~~voluntarily~~ confidentially and are unknown to the Commission. As long as the licensee complies with the requirements of the program and is safe to practice under monitoring, the WPHP will not report the licensee to the Commission. Many of these licensees complete treatment and monitoring and go on to practice medicine safely for the remainder of their careers.

While uncommon, ~~S~~some licensees experience ~~a relapse~~illness recurrence or return to substance use while being monitored by the WPHP. ~~Most licensees notify the~~ WPHP assists licensees in addressing recurrence and/or return to use and ~~may~~ will recommend that the licensee cease practice if the illness recurrence or return to substance use poses a risk to patient safety. ~~and come back into compliance with the requirements of the program~~. Some licensees will require additional treatment and then have an opportunity to return to clinical practice under active monitoring by the program, while others may need intensification of health monitoring or treatment services without the need to discontinue clinical practice. ~~Relapse~~Illness recurrence or return to substance use, ~~by~~ in itself, is not an indication that a licensee is not capable of practicing medicine safely. The WPHP has demonstrated an ability to accurately assess licensees who have suffered illness recurrence or return to use ~~a relapse~~ and determine appropriate interventions including whether and when they are safe to continue or return to practice.~~practice~~. The Commission relies on WPHP to determine whether a licensee who has ~~relapsed~~ illness recurrence or return to use should be reported to the Commission as unsafe to return to practice.

When the Commission receives a complaint that a licensee has committed unprofessional conduct or is impaired, and during the investigation the Commission learns that the licensee has signed an agreement~~contract~~ with the WPHP and is compliant with the requirements of the program, the Commission must decide whether to impose discipline or to close the case under RCW 18.130.175. This decision will depend on the facts and circumstances of each case.

The Commission adopts this guidance document to explain how it handles cases against impaired or potentially impaired physicians, and to help ensure consistency and fairness in decision making in these cases. Consistent with its statutory mandate, its mission statement, and the expectation of the public, the Commission will take necessary action to protect the public from licensees who commit unprofessional conduct or are unable to practice with reasonable skill and safety due to a ~~mental or physical~~health condition condition.

Guidance

The Commission may take disciplinary action for certain behavior regardless of the licensees health status or involvement in WPHP~~whether or not the licensee is in current compliance with a WPHP contract~~. The rationale for ~~taking action~~acting against licensees who fall into these categories is not only to protect the public, but to hold licensees accountable for their conduct. The Commission believes that disciplinary action should be determined on a case by case basis, taking into consideration the specifics of the circumstances. The presence of an impairing or potentially impairing health condition and/or involvement in WPHP may or may not mitigate against disciplinary action depending on the nature and specifics of the complaint. ~~a licensee enrolled in the WPHP should be accountable for his or her conduct to the same extent that a non-impaired licensee is accountable for his or her conduct~~.

The Commission may take action in the following circumstances:

1. **A licensee harmed a patient, regardless of whether the harm is due to impairment.** This may include negligent care such as a missed diagnosis, poor judgment or improper technique. It will also include reckless or intentional behavior such as abuse, sexual contact, or assault.

Commented [CB4]: All participants in WPHP are voluntary, though by convention, we classify those under order from the Commission as "mandated" participants. Confidentiality is the more appropriate construct here.

Commented [DB5]: Dr. Bundy edit.

Commented [CB6]: RCW 18.71.300 now uses the term "health condition" per statute change in 2022

2. **A licensee's behavior presented a risk of harm to a patient or to the public, regardless of whether it is due to impairment.** This may include treating a patient or being on call while under the influence of drugs or alcohol, or engaging in behavior unrelated to patient care such as driving erratically, leaving the scene of an accident, or exhibiting threatening behavior.

3. **A licensee engaged in acts of moral turpitude or dishonesty.** This may include any type of dishonest behavior, sexually inappropriate behavior with patients or non-patients, and behavior that lowers the standing of the profession in the eyes of the public.

4. **A licensee engaged in criminal activity regardless of the existence of a conviction.** This may include diversion of a controlled substance or legend drug, forging a prescription, or any other criminal activity. This would also include behavior that resulted in a conviction of a gross misdemeanor or a felony.

In all other circumstances, the Commission may~~, under RCW 18.130.175,~~ choose not to ~~discipline~~ take further action against a licensee The procedure for the referral is as follows:

1. The staff attorney sends a letter to the licensee stating that the panel is referring the licensee to WPHP under RCW 18.130.175. The letter will state that the case will remain open until the Commission receives confirmation that the licensee has met with WPHP.
2. The staff attorney also sends a letter to WPHP informing them of the referral and asking WPHP to notify the staff attorney when the licensee has met with WPHP.
3. When WPHP receives the letter, WPHP will contact the staff attorney to get more information. After the licensee has met with WPHP, WPHP will notify the staff attorney that the meeting has taken place. If the licensee does not make an appointment with WPHP, or does not meet with WPHP, WPHP will notify the staff attorney.
4. When the staff attorney receives confirmation from WPHP that the licensee has met with WPHP, the staff attorney will bring the case back to the panel for potential closure. The panel may close the case with a unique closure. The closure letter should indicate that the reason for the closure is that licensee has been referred to WPHP under RCW 18.130.175~~, and that the Commission expects the licensee to comply with the program requirements~~.

Commented [DB7]: Added 1/2/25 by Policy Committee

Commented [DB8]: Revised 1/2/25 by Policy Committee

~~if all of the following conditions exist:~~

~~the licensee is enrolled in the WPHP;~~

~~the licensee is compliant with the requirements of the program; and~~

~~the licensee's participation in the program will protect the public.~~

The Commission will rely on the WPHP to report to the Commission if the licensee fails to comply with the requirements of the program or if the licensee is unable to practice with reasonable skill and safety. If the Commission receives such a report, the Commission will immediately investigate the matter and take necessary disciplinary action. If a licensee presents an immediate danger to the public, the Commission will suspend the license.

The above principles are designed to provide transparency to the public and WMC licenses. ~~It~~They also serve~~s~~ to guide the Commission in making decisions and are not meant to be ~~inflexible~~uncompromising. The Commission will use its judgment in each case to determine the course of action that first, best protects the public, and second, provides the opportunity to rehabilitate~~s~~ the licensee.

Number:	GUI2020-02
Date of Adoption:	February 12, 2016
Reaffirmed / Updated:	July 10, 2020
Supersedes:	MD2016-03

This document was revised from the previously included version and added to the packet on January 7, 2025.

Completion of Death Certificates by ~~Physicians and Physician Assistants~~Licensees

The Washington Medical Commission (Commission) ~~adopted Guideline MD 2016-01, "Completion of Death Certificates by Physicians and Physician Assistants," in January 2016. In September 2016, the Washington State Department of Health, Center for Health Statistics, adopted Guideline CHS D-10 "Completion of Death Certificates" for all medical certifiers to follow when completing death certificates.~~considers the completion of a patient's death certificate a final act of caring for the patient.

~~From the guidelines (emphasis added):~~

> ~~*"Under RCW 70.58.170, a funeral director or person having the right to control the disposition of human remains must present the death certificate to the medical certifier last in attendance upon the deceased*~~**. The medical certifier then has two business days to certify the cause of death according to his or her best knowledge and sign or electronically approve the certificate, unless there is good cause for not doing so.** ~~*The medical certifier should register cause and manner of death information through the Washington State Electronic Death Reporting System (EDRS). The EDRS facilitates timely registration of the death and rapid collection of cause and manner of death information."*~~

~~Additional information about who the appropriate potential medical certifier of death is discussed in detail along with guidelines on how to certify cause and manner of death is contained in the full guideline published by the Department of Health.~~

~~The Commission rescindeds its guideline, and~~guideline and ~~urges all physicians and physician~~ ensees ~~to follow the guideline issued by the Washington State Department of tatistics. This guideline can be found here:~~

3 re 52.98 201.92 65.9 0.78003 re 18.88 201.92 168 010.20..26 Tm .82 0.6c9.ot1 0. .03 r

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process. Certifiers must use WHALES to register and complete a death record **within 5 days**. For more information about enrolling in WHALES, contact Death.Registration@doh.wa.gov. Please note certifiers must access WHALES through an active Secure Access Washington (SAW) account. For information on SAW, the secure single sign-on application gateway, contact them at https://SecureAccess.wa.gov

Additional information about death certification can be found at WHALES - Washington Health and Life Event System | Washington State Department of Health

In Washington State Coroners and Medical Examiners investigate deaths and conduct postmortem examinations to determine cause and manner of death in unclear, unusual, or traumatic circumstances under RCW 68.50. When a death does not meet criteria for an investigation and postmortem examination, the obligation to complete a death certificate falls upon the treating provider.

While this individual may not have been present at the time of death and the exact cause of death may not be obvious; please consider the completion of a death certificate is based solely upon one's medical opinion, to the best of one's knowledge. The medical opinion would be based upon the patient's medical history, the licensee's knowledge of the patient's health status and medical compliance to issue a probable cause of death.

If you are not the patient's primary care provider and are a covering in that individual's absence, please attempt to access the patient's medical chart that can provide you with the patient's problem list and/or medications to complete the death certificate. Put first:

To assist you further with death certification, the Center for Disease Control has published the following educational materials:

Cause of Death Mobile Application

- A quick reference guide for Apple or Android users.

Writing the Cause-of-Death Statements Training

- How to complete the death certificate and when to refer cases to the coroner or medical examiner.

For licensees with access to **UpToDate,** a comprehensive guide to death investigations and completion of death certificates is included in the subscription.

Number:	GUI2025-01
Date of Adoption:	TBD
Reaffirmed / Updated:	NA
Supersedes:	GUI2017-01

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Staff Reports: January 10, 2025

Kyle Karinen, Executive Director

State government budget

As I am sure many of you have seen, there is a looming deficit for state government. As a result of the projected shortfall, Governor issued a directive to state agencies to put in place a hiring freeze as well as several other measures aimed at limiting spending. The important thing to note is that currently all of those measures are aimed specifically at agencies and expenses that rely on tax revenues (predominantly sales tax) that come from a fund that is generally referred to as General Fund – State (or GFS). The Commission as well as most of the other health profession regulators do not rely on any GFS funding for its operations. As such, the Commission is not – as of the date I am preparing this report – subject to the hiring freeze or other limitations. The Commission has sufficient reserves to meet its short-term operational needs and, as Micah detailed at a previous business meeting, address long-term plans and goals. This status is sort of a moving target because of the general budget process which will also have input from Governor-elect Ferguson and both legislative chambers before all is said and done. Micah, Jimi, and I meet regularly with the Department's budget staff and we are in touch periodically with the Office of Financial Management. Please do not hesitate to ask any questions and we will do our best to answer them.

Dental Quality Assurance Commission (DQAC)

On December 6, along with my counterparts from the Washington Board of Nursing (WABON) and the Washington Chiropractic Quality Assurance Commission, I spoke to DQAC regarding the Commission's quasi-independent status within the larger Department of Health umbrella. Much like the presentation to our pharmacy colleagues last year, the discussion was very broad and far-reaching. The DQAC Commissioners also heard from a representative from the Department's Office of Financial Services about some of the likely costs and savings involved with what they refer to as "partner"-status. It was certainly an interesting conversation and underlined, for me anyway, how innovative and efficient the Commission has become since the original pilot projects started well over a decade ago.

Ketamine prescribing and administration cases

A few months ago, the Commission was approached by our colleagues in WABON and the Pharmacy Quality Assurance Commission to discuss our respective on-going investigations and casework regarding ketamine prescribing in behavioral health settings. Since that initial meeting, we have met one more time (with the Board of Osteopathic Medicine and Surgery (BOMS)) and are scheduled to do so again at the end of January. These meetings have mostly been exchanging notes about what the various disciplinary authorities are seeing. (We have provided a list of recent disciplinary cases along with a list of active matters to them.) Please note elsewhere that Dr. Domino has chartered a workgroup regarding psychedelic drugs in behavioral health settings and one aspect of that

Kyle Karinen, Executive Director continued

workgroup's charter (on page 123 of this packet) is to start to develop some level of institutional expertise in reviewing these complaints and conducting these investigations. Another aspect is to work closely with our aforementioned colleagues regarding ketamine prescribing and administration because we are seeing a rise in ketamine-related complaints and at least comparing approaches seems like a wise endeavor.

FSMB Annual Meeting

As detailed in an email to all Commission members, the annual meeting for the Federation of State Medical Boards will be held in Seattle in April. It is a unique opportunity for the Commission to send as many Commission members as may be interested in attending with the Commission covering travel expenses as well as the cost of registration. The deadline to let us know if you wanted to attend was January 3 and thank you for those of you who responded. If your schedule for that time period changes and you would like to attend, please do not hesitate to contact me. It works easiest if we handle the registration cost upfront. Here is a link to the conference information: HOME - FSMB AM25

Micah Matthews, Deputy Executive Director

Recurring: Please submit all Payroll and Travel Reimbursements within 30 days of the time worked or travelled to allow for processing. Request for reimbursement items older than 90 days will be denied. Per Department of Health policy, requests submitted after the cutoff cannot be paid out. For specific guidance on Commissioner compensation, please refer to the WMC guideline: Compensation and Reimbursement for Commission Duties (wa.gov)

Travel, Conferences, and Presentations

The week of December 10 I traveled to Washington, D.C. to attend and present at the Centers for Telemedicine and e-Health Law and the American Telemedicine Association EDGE Policy meeting. The themes were licensure across barriers and an assessment of state based licensure schemes in the face of compacts and first amendment telemedicine challenges making their way through the courts.

Recruitment

We are in the process of recruiting the now reallocated position for the Policy Manager. If all goes well, I anticipate the successful candidate starting on or around February 16.

Legislative

As of December 18, we have not received approval from the Governor's office for our request legislation. We know for sure that one bill will not move forward and that is the public disclosure prohibition bill relating to licensee information. Additionally, the budget request we submitted was only partially funded in the Governor's budget. We are not clear on the reasoning for this yet, but it does not prevent us from soliciting inclusion of our full request from members of the House and Senate.

Amelia Boyd, Program Manager

Potential WMC Member Q&A Sessions

Starting January 24, 2025, I will host virtual Q&A sessions for potential WMC members. These meetings will take place every other Friday at 11 a.m. The meeting link and schedule are available on the WMC Event Calendar.

Change to AMDG Opioid Dose Calculator

In February 2024, the Agency Medical Directors' Group (AMDG) updated the Opioid Dose Calculator. The WMC released a statement for prescribers about this change: Important Updates to the Opioid Dose Calculator and Implications for Prescribers (govdelivery.com)

Recruitment

We are seeking the MDs in the following specialties to serve as Pro Tem Members:

- Urology
- Radiology
- Neurosurgery/Neurology
- General surgery
- Psychiatry
- Orthopedic surgery
- Ophthalmology

If you know MDs who might be interested in serving as a Pro Tem, please have them email me directly at amelia.boyd@wmc.wa.gov.

The following position expired as of June 30, 2022, and we are awaiting word from the Governor's office staff on the new appointee:

- Public Member – Toni Borlas – not eligible for reappointment

The following positions expired as of June 30, 2023, and we are awaiting word from the Governor's office staff regarding reappointment or new appointees:

- Congressional District 10 – Richard Wohns, MD – eligible for reappointment
- Public Member – Scott Rodgers – eligible for reappointment

The following positions expired as of June 30, 2024:

- One physician representing Congressional District 6 – Claire Trescott, MD, not eligible for reappointment
- One physician representing Congressional District 8 – Harlan Gallinger, MD, eligible for reappointment
- One Physician-at-Large – Karen Domino, MD, eligible for reappointment

The application deadline for these three vacancies was March 22, 2024. The applications, along with the Commissioners' recommendations, are with the Governor.

Amelia Boyd, Program Manager continued

We will have the following vacancies as of June 30, 2025:

- One physician representing Congressional District 1 – Jimmy Chung, MD, not eligible for reappointment
- One physician representing Congressional District 7 – Anjali D'Souza, MD, eligible for reappointment
- One Physician Assistant – Arlene Dorrough, PA-C, eligible for reappointment
- One Public Member – Christine Blake, eligible for reappointment

The application deadline for these four vacancies is March 31, 2025.

For more information about WMC membership, please visit our members page: Medical Commission Members | Washington Medical Commission. If you have questions about serving as a member of the WMC, please contact me at amelia.boyd@wmc.wa.gov.

Mike Hively, Director of Operations and Informatics

Overview of Compulsory Records Requests

Between October 2, 2024, and December 3, 2024, the Operations and Informatics team processed two compulsory records requests. This involved the management of approximately 5,876 pages, executing 1,523 redactions, and withholding approximately 503 pages containing exempt information. The average time taken to fulfill each request was 19.5 days. There are currently nine active litigation holds, two of which required a thorough review and categorization of over 4,807 records obtained through eDiscovery processes.

Digital Archiving

The following digital archiving activities were undertaken:

- Complaints closed below threshold 346
- MD licensing applications 149
- PA licensing applications 228
- A Closures 127 files totaling approximately 73,684 pages
- Verification of 78 physician assistant applications for accuracy
- 2,425 demographic census forms

Nine boxes of medical applications, comprising a total of 406 files, and five boxes of physician assistant applications, containing 276 files, were retrieved from the Records Center and converted into electronic formats. Once archived in PDF/A format, disposition tickets were submitted for approval.

Data Requests Processed

The team processed approximately:

- 1,265 open and closed inquiries
- 538 address changes

Mike Hively, Director of Operations and Informatics continued

Demographic Activities

Demographic data management included:

- Entered 2,425 census forms into the Integrated Licensing and Regulatory System (ILRS)
- Conducting 1,030 secondary census contacts

The Team has begun annual asset inventory and reporting processes in accordance with DOH and state policies, training and procedures. This process includes replacing staff monitors that have reached their end-of-life cycle and are no longer supported by their vendor, manufacturer or the DOH I.T. Service desk.

Lastly, select staff attended Microsoft Power Bi training and are in the initial stages of creating a user-friendly interactive data dashboard using demographic data for our website. While no dates have been selected, our hope is to release our final product later in 2025. More to come!

Gina Fino, MD, Medical Consultant, Director of Compliance

The Federation of State Medical Boards (FSMB) started holding Medical Director Forums every other month this year. As the Commission's Medical Consultant, I was invited and have been able to attend three meetings. These sessions have allowed me to learn how other states regulate physicians and physician assistants in an open format. I've also made connections with medical directors across the country interested in learning about the WMC approach to sexual misconduct, IV hydration clinics, and telehealth access. I look forward to the continuation of these forums in 2025.

Compliance continues to rework the 2025 and beyond personal appearances schedule with help from staff and commissioners. Thank you.

Rick Glein, Director of Legal Services

Summary Actions

In re Anand P. Lalaji, MD, Case No. M2024-619. On October 4, 2024, the Commission issued an Ex Parte Order of Summary Suspension which ordered Dr. Lalaji's medical license be suspended pending further proceedings by the Commission. A Statement of Charges (SOC) concurrently served on Dr. Lalaji alleges the Kentucky Board of Medical Licensure suspended Dr. Lalaji's medical license based on Dr. Lalaji's hospital privileges being suspended for repeatedly misinterpreting MRI brain studies. The Commission further alleges that, based on the Kentucky Order, the Virginia Department of Health Professions issued a mandatory suspension, and the Arizona Medical Board issued an Interim Consent Agreement for Practice Restriction. An Answer to the SOC was not timely filed*, and a default order was issued as described below under "Orders Resulting from SOCs".

In re M. Barbara Burke, MD, Case No. M2024-615. On October 16, 2024, the Commission issued an Ex Parte Order of Summary Suspension which ordered Dr. Burke's medical license

be suspended pending further proceedings by the Commission. A SOC concurrently served on Dr. Burke alleges that the State Medical Board of Ohio suspended Dr. Burke's Ohio medical license based on a failure to comply with a September 2022 Ohio Board Order. An Answer to the SOC has not been timely filed, and the Commission is preparing to file a default order for a Health Law Judge's (HLJ) consideration.*

In re Sjardo S. Steneker, MD, Case No. M2024-204. On October 10, 2024, the Commission served an Ex Parte Order of Summary Restriction which restricts Dr. Steneker from prescribing controlled substances pending further disciplinary proceedings by the Commission. A SOC concurrently served on Dr. Steneker alleges substandard documentation and patient care of 12 patients, including reckless prescribing practices which contributed to two patients' controlled substance addictions, which ultimately contributed to their deaths. A hearing on the merits of the SOC is scheduled for May 14-16, 2025.

*The license holder must file a request for hearing with the disciplining authority within twenty days after being served the statement of charges. RCW 18.130.090.

Orders Resulting from SOCs

In re Jason L. Hanson, MD, Case No. M2022-208. Final Order.** In May 2024, the Commission filed a SOC alleging Dr. Hanson is unable to practice with reasonable skill and safety. The Commission held a virtual hearing September 3-4, 2024. A Final Order was issued on October 2, 2024, which indefinitely suspended*** Dr. Hanson's medical license. Prior to reinstatement, Dr. Hanson must successfully complete intensive residential treatment to stabilize his psychiatric symptoms and gain insight and awareness into his illness before practicing again.

In re Yasmin Pirani, MD, Case No. M2024-506. Default Order (Failure to Respond).** In July 2024, the Commission filed a SOC alleging Dr. Pirani surrendered her California medical license after an evaluator concluded that she was unable to practice medicine with reasonable skill and safety due to a health condition. Dr. Pirani did not file a response to the SOC within the time allowed. In October 2024, a HLJ issued a Default Order which concluded sufficient grounds exist to take disciplinary action and ordered Dr. Pirani's medical license be indefinitely suspended.***

In re Roger B. Olsson, MD, Case No. M2023-379. Agreed Order. On July 10, 2023, the Commission served a Statement of Charges (SOC) alleging Dr. Olsson failed to complete a clinical skills assessment as required under an October 2021 Final Order. On November 7, 2023, the Commission served an Amended SOC adding allegations of accepting prepayment from three patients for cosmetic services and failing to complete the services or refund the patients. An Ex Parte Order of Summary Suspension was served concurrent to the Amended SOC, suspending Dr. Olsson's medical license pending further disciplinary proceedings. In October 2024, the Commission accepted an Agreed Order which indefinitely suspended*** Dr. Olsson's medical license. Prior to reinstatement, Dr. Olsson must attend a clinical competency assessment and complete all recommendations; reimburse three patients for services not rendered; and stay in compliance with this Agreed Order, the 2021 Final Order, and the 2014 Agreed Order. Dr. Olsson must also submit a paper, referring to the clinical competency assessment, and state how he intends to apply what he learned to his practice. Dr. Olsson has agreed to pay a $10,000 fine and personally appear before the Commission.

In re Anand P. Lalaji, MD, Case No. M2024-619. Default Order (Failure to Respond).** As described above, the Commission issued an Ex Parte Order of Summary Suspension and SOC in October 2024. Dr. Lalaji did not file a response to the SOC within the time allowed. In November 2024, a HLJ issued a Default Order which concluded sufficient grounds exist to take disciplinary action and ordered Dr. Lalaji's medical license be indefinitely suspended.***

In re William J. Washington, MD, Case No. M2021-755. Final Order of Revocation.** In January 2023, the Commission filed an initial SOC against Dr. Washington. In July 2024, the Commission filed a Third Amended SOC alleging Dr. Washington was found guilty of the federal crimes of wire fraud, healthcare fraud, conspiring to commit wire fraud and healthcare fraud, and conspiracy to make false statements related to healthcare matters; that Dr. Washington failed to meet the standard of care for transgender patients; that Dr. Washington provided psychiatric care beyond his expertise as a physician trained in emergency medicine; that Dr. Washington's care was substandard in the management of male hypogonadism; that Dr. Washington prescribed growth hormone without documenting growth hormone deficiency; that Dr. Washington violated the Commission's rules governing the prescribing of opioids in the treatment of pain and self-prescribed a controlled substance; that Dr. Washington failed to cooperate with Commission investigations; and that Dr. Washington violated a prior order in that his treatment and involvement with patients was in violation of the Uniform Disciplinary Act and other laws related to the practice of the profession. The Commission held a virtual hearing August 23, 2024, regarding the merits of the Third Amended SOC. A Final Order was issued in November 2024, which found that Dr. Washington can never be rehabilitated and can never regain the ability to practice safely, and ordered Dr. Washington's medical license be permanently revoked. On December 2, 2024, the US District Court, Southern District of New York, handed down its judgment involving the conspiracy and fraud case outlined above. Dr. Washington is to serve 60 months in a federal facility and must pay $475,000 in restitution.

In re William J. Mack, MD, Case No. M2024-613. Default Order (Failure to Respond).** On August 6, 2024, the Commission issued an Ex Parte Order of Summary Suspension which ordered Dr. Mack's medical license be suspended pending further disciplinary proceedings by the Commission. A SOC concurrently served on Dr. Mack alleges the Board of Healing Arts of the State of Kansas issued a Final Order (Kansas Order) suspending Dr. Mack's license to practice as a physician and surgeon in that jurisdiction. The Kansas Order found Dr. Mack failed to comply with an order compelling him to submit to and complete a full fitness to practice evaluation. Dr. Mack did not file a response to the SOC within the time allowed. In November 2024, a HLJ issued a Default Order which concluded sufficient grounds exist to take disciplinary action and ordered Dr. Mack's medical license be indefinitely suspended.***

In re Anne B. Blanchette, PA, Case No. M2024-53. Agreed Order. In May 2024, the Commission filed a SOC alleging Ms. Blanchette failed to fully comply with three Letters of Cooperation from the Commission requesting patient records, her curriculum vitae (CV), records of her last three years of continuing medical education (CME), and a signature from or signed statement from her current supervising physician. The SOC further alleged Ms.

Blanchette did not comply with a final Letter of Cooperation requesting the name of her current supervising physician along with patient records, her CV, and CME records from the past three years. The Commission alleged that Ms. Blanchette did not have a practice agreement on file with the Commission despite a legal requirement to do so since July 1, 2021. In December 2024, the Commission accepted an Agreed Order which reprimanded Ms. Blanchette for failing to comply with the Commission's Letter of Cooperation and ordered Ms. Blanchette to have a Collaboration Agreement on file with the Commission. Ms. Blanchette is restricted from prescribing ivermectin for non-FDA-approved indications to patients in Washington and when using her Washington license. Ms. Blanchette must review the CDC and UpToDate websites for current guidelines for the prevention, treatment, and management of COVID-19 in addition to successfully completing CMEs related to COVID-19, Medical Ethics and Professionalism, and Medical Record Keeping. Ms. Blanchette will prepare a paper describing what she learned from a review of the CDC and UpToDate websites, along with what she learned in the COVID-19 CME course, and describe how she intends to apply what she learned to her practice. Ms. Blanchette has agreed to permit annual compliance audits, pay a $5,000 fine, and personally appear before the Commission. Ms. Blanchette may petition to terminate the Agreed Order after two years.

In re David B. Benson, MD, Case No. M2022-721. Agreed Order. On April 18, 2023, the Commission filed a Statement of Charges (SOC) related to a single complaint of substandard care involving two obstetrical patients and one pediatric patient. At the time, allegations showed a lack of clinical skill, but limited in scope and number of patients. A hearing on the merits of the SOC, scheduled for February 2024, was continued pending service of an Amended SOC. On June 11, 2024, the Commission issued an Ex Parte Order of Summary Restriction which prohibited Dr. Benson from practicing in the areas of obstetrics and newborn care. An Amended SOC concurrently served on Dr. Benson alleged substandard care in thirteen additional obstetric and pediatric patients. In December 2024, the Commission approved an Agreed Order with a practice restriction prohibiting Dr. Benson from practicing in the areas of obstetrics and newborn care. Additionally, Dr. Benson agreed to complete a clinical competency assessment and comply with the recommendations. Upon completion of the assessment, Dr. Benson will enroll in a physician enhancement program which will conduct periodic reviews of his practice. Dr. Benson must pay a $3,000 fine and personally appear before the Commission. The Agreed Order may be terminated five years from its effective date and only after successful completion of all terms and conditions.

**Either party may file a petition for reconsideration within ten days of service of the order. RCW 34.05.461(3); 34.05.470. A petition for judicial review must be filed and served within 30 days after service of the order. If a petition for reconsideration is filed, the 30-day period does not start until the petition is resolved. RCW 34.05.542; 34.05.470(3).

***A person whose license has been suspended under chapter 18.130 RCW may petition the disciplining authority for reinstatement. RCW 18.130.150.

Items of Interest

On October 17, the Legal-Compliance team joined up with the rest of the Commission staff at the Tumwater DOH office to enjoy a day of collaboration, teambuilding, and an insightful training on Secrets to Providing Exceptional Customer Service. Kyle offered an opportunity

Rick Glein, Director of Legal Services continued

for a WMC staff person to design the next WMC name badge, and our own Jen from Legal was voted the winner. Many thanks to our WMC social committee for their work in putting together an engaging and motivational all-staff event.

On November 4, Rick, Mike, and Gina participated in their quarterly virtual meeting with Dr. Bundy of the Washington Physician Health Program (WPHP) to discuss processes which lead to a productive relationship between WMC and WPHP and offer joint feedback in our ongoing mission of patient safety and enhancing the integrity of the profession through discipline and education.

The Federation of State Medical Boards (FSMB) held its Attorney Board Workshop November 7-9 in Reno, Nevada. Our Legal Unit was well-represented, with most of our staff attorneys, a couple AAGs, and one paralegal attending this event. The workshop is designed specifically for attorneys and legal staff of state medical boards and brings together experts in the field of medical licensure and discipline to discuss the current legal issues and trends facing state medical boards. Topics this year included end-of-year legislative updates; implications of recent SCOTUS rulings on regulatory authorities; physician assistant licensure compact – progress and updates; physician health programs (PHPs) and their relationship with state medical boards; physician competency and fitness for duty (FED) assessments; navigating complex disciplinary cases; and ethical use of artificial intelligence by attorneys. Additionally, Mike Farrell moderated a session on the regulatory landscape of IV hydration therapies. The attendees brought back valuable information and knowledge to share with the Legal-Compliance team.

On December 17-18, Rick, Kyle, other WMC staff leaders, Dr. Murphy, Mr. Lopez, and the WABON (Nursing Commission) Executive Director all attended full-day media trainings in Tumwater. The training was put on by Mark Bernheimer of Mediaworks Resource Group. Mr. Bernheimer was formerly with CNN as a national correspondent assigned to Los Angeles. He currently serves as media advisor to leaders at Children's Hospital system in Los Angeles. The WMC training involved two separate small groups who were asked to do individual 5 minute in-person, on-camera interviews on a health care related topic given to them that morning. After the interviews were done the group played back the interviews and Mr. Bernheimer offered constructive critiques. In the afternoon session the group received additional instruction and were allowed 10 minutes to prepare for another round of interviews with questions on the same healthcare topics. Rick described the day as stressful but worthwhile. The group learned communication strategies that can be used in other scenarios where clear and simple messaging is important.

In an effort to continually improve your meeting experience, the Legal-Compliance Unit is researching and attending several software demonstrations for meeting platforms. Even if these platforms do not meet our needs, the demonstrations are introducing us to innovative ways to increase the efficiency and organization of WMC case disposition and personal appearance meetings. We look forward to potentially integrating some new processes in 2025 to adapt to our ever-evolving technological landscape.

Freda Pace, Director of Investigations

CMT Sign-up for 2025

Our 2025 CMT sign up slots are ready, awaiting your name! Please take some time to check out the new CMT calendar to find a vacant slot – there are plenty. We appreciate your continued participation in this very important process. We could not be able to do this work without you and your support!

Remember, if you sign up for a CMT slot and you have a last-minute scheduling conflict, at your earliest opportunity, please promptly notify Chris Waterman at **chris.waterman@wmc.wa.gov**. This courtesy cancellation notice will allow Chris the opportunity to fill any last-minute vacancy needs.

If you have any CMT process or procedural questions, please do not hesitate to reach out to me directly – **freda.pace@wmc.wa.gov**.

Complaint Intake Stats:

Averages	2024	2023	2022
New cases per CMT packet	39.26	34.01	32.38
Cases authorized per week	10.88	9.09	8.67
Cases closed per week	28.38	24.88	23.71

The number of complaints processed to a CMT packet has been steadily rising year to year with the average number of cases authorized to investigation also rising.

Remember, if you sign up for a CMT slot and you have a last-minute scheduling conflict, at your earliest opportunity, please promptly notify Chris Waterman at chris.waterman@wmc.wa.gov. This courtesy cancellation notice will allow Chris the opportunity to fill any last-minute vacancy needs. If you have any CMT process questions, please do not hesitate to reach out to me directly – freda.pace@wmc.wa.gov.

Jimi Bush, Director of Quality and Engagement

2024 CME

As of the penning of this update, we have completed 9 CME webinars in 2024 issuing over 800 Category 1 CME credits to licensees.

2024 Annual Report

Sarah Chenvert is working on the performance report for 2024. If there is a specific data point or analysis that you would like to see included, please let me know.

2024 LEAN Updates

In 2024, we added 35 new processes to our process library. 22 of these processes focus on Administration and Program Management processes. The process library now totals 114 processes that document how we process complaints, credential applicants, conduct investigations, and more. Anjali provided a three-part LEAN Basics training which covered Lean, project management and change management principles. 20 staff members participated, attaining White belt certification in LEAN.

Jimi Bush, Director of Quality and Engagement continued

HELMS Training and Launch

The first phase of the new licensing and enforcement system (HELMS) is scheduled to launch on February 19th. This first phase will mainly affect the licensing system. As commissioners, you will not see a difference in the work that you do for the WMC, unless you are on Panel L. Anjali and Jimi are currently in the HELMS system, performing testing and preparing to train the licensing team on how they will process applications and renewals. Training for both commissioners and the licensing team will take place is February.

February Credentialing Freeze: All licensing and credentialing systems for health professionals and facilities will be unavailable on Friday, February 14 from 5 p.m. until the morning of Wednesday, February 19, 2025, to complete system upgrades. Please complete your applications and renewals now to avoid delays. Please share this information as widely as possible and direct any questions to Jimi Bush.

Mahi Zeru, Equity and Social Justice Manager

Reasonable Accommodation

Complainants with a documented disability have reported challenges in accessing WMC's complaint intake forms specifically due to physical barriers that prevents them from typing or writing their complaints. Currently, WMC does not allow complaints to be received over the phone and lacks accommodation tools, such as speech-to-text transcription, contributing to this accessibility issue. WMC has contracted with a captioning service agency to provide speech-to-text accommodation service and is ready to assist individuals who need these accommodations.

Marisa Courtney, Licensing Manager

Total licenses issued from = 10/01/2024-12/16/2024= 748

Credential Type	Total Workflow Count
Physician And Surgeon Clinical Experience License	2
Physician And Surgeon Fellowship License	0
Physician And Surgeon Institution License	0
Credential Type	**Total Workflow Count**
Physician And Surgeon License	336

Marisa Courtney, Licensing Manager continued	
Credential Type	**Total Workflow Count**
Physician and Surgeon License Interstate Medical Licensure Compact	232
Physician And Surgeon Residency License	8
Physician And Surgeon Teaching Research License	5
Physician And Surgeon Temporary Permit	3
Credential Type	**Total Workflow Count**
Physician Assistant Interim Permit	5
Physician Assistant License	157
Physician Assistant Temporary Permit	0
Totals:	**748**

Information on Renewals: September Renewals- 74.70% online renewals

Credential Type	# of Online Renewals	# of Manual Renewals	Total # of Renewals
IMLC	0	125	125
MD	1094	282	1376
MDRE	4	0	4
MDTR	2	1	3
PA	196	31	227
	74.70%	**25.30%**	**100.00%**

Information on Renewals: October Renewals- 70.56% online renewals

Credential Type	# of Online Renewals	# of Manual Renewals	Total # of Renewals
IMLC	0	145	145
MD	969	297	1266
MDRE	1	0	1
MDTR	2	1	3
PA	183	39	222
	70.56%	**29.44%**	**100.00%**

Information on Renewals: November Renewals- 75.42% online renewals

Credential Type	# of Online Renewals	# of Manual Renewals	Total # of Renewals
IMLC	0	95	95
MD	912	227	1139
MDIN	0	1	1
MDRE	1	0	1
MDTR	2	3	5
PA	174	29	203
	75.42%	**24.58%**	**100.00%**

Marisa Courtney, Licensing Manager continued

Highlights from the 2024 USMLE Reports

This report provides a summary of key updates and insights from the *2024 Annual Report on the USMLE* and the *2024 USMLE Primer for State Boards*. These resources outline the operational, policy, and strategic updates to the United States Medical Licensing Examination (USMLE), a critical assessment tool for medical licensure in the U.S.

Key Highlights

1. **USMLE Overview**
    a. The USMLE, jointly sponsored by the Federation of State Medical Boards (FSMB) and the National Board of Medical Examiners (NBME), assesses medical knowledge and clinical skills through three steps.
    b. As of 2023, 63% of licensed U.S. physicians have taken the USMLE, with 58% completing all three steps.
2. **Recent Policy Changes**
    a. **Step 1 Reporting:** Transitioned to pass/fail as of January 26, 2022.
    b. **Step 3 Passing Standard:** Increased from 198 to 200 on January 1, 2024, after a comprehensive review.
3. **Engagement with State Boards**
    a. In 2024, 44 representatives from 26 state medical boards participated in USMLE-related committees, highlighting the program's integration with state-level licensing efforts.
    b. FSMB and NBME hosted an annual USMLE orientation for state board staff, with topics including eligibility policies and exam updates.
4. **Impact on International Medical Graduates (IMGs)**
    a. Effective July 1, 2025, Canadian medical schools will no longer be accredited by LCME. Graduates will need ECFMG certification to apply for U.S. residencies, aligning with IMG requirements.
5. **Research and Development**
    a. Ongoing research explores associations between USMLE scores and patient outcomes, innovative testing methods, and enhancing exam security.
6. **Resources for Licensing Boards**
    a. State boards can access performance data, standard-setting guidelines, and webinars through FSMB and USMLE websites.

Recommendations

- **Monitoring Changes:** Boards should remain informed about evolving eligibility and policy changes, particularly for IMGs and standard-setting updates.
- **Participation:** Staff and board members are encouraged to engage in future FSMB-hosted orientations and panels to stay aligned with USMLE processes.

Attachments

1. *2024 Annual Report on the USMLE - pages 124-178 of this packet*
2. *2024 USMLE Primer for State Boards - pages 179-201 of this packet*

2024

Annual Report on the United States Medical Licensing Examination® (USMLE)

Prepared for Medical Licensing Authorities in the United States by the Federation of State Medical Boards of the United States and the National Board of Medical Examiners®

Table of Contents

Executive Summary

The United States Medical Licensing Examination® (USMLE®) is a three-step examination sequence for medical licensure in the United States. The USMLE is composed of three complementary Steps: Step 1, Step 2 Clinical Knowledge (CK) and Step 3. The program administers approximately 100,000 Step examinations annually, with more than 3 million total tests administered since implementation in 1992.

Medical licensing authorities and their representatives continue to be key stakeholders and contributors to the USMLE program. In 2024, 44 individuals from 26 state medical and osteopathic boards across the United States participated in USMLE in some capacity. Since implementation of the USMLE in 1992, 360 members and staff from 65 state medical and osteopathic boards have participated in the USMLE program in some capacity.

As of 2023, approximately 63% of the 1,062,460 physicians licensed in the United States have taken all or part of the USMLE sequence; 58% have taken all Steps (1, 2 and 3). This represents a 2% increase in both measures since 2022.

The *Annual Report on the United States Medical Licensing Examination (USMLE)* provides state medical boards with an overview of the USMLE, a jointly owned program of the Federation of State Medical Boards (FSMB) and the National Board of Medical Examiners (NBME). In addition to general information about the examination, the report provides updates on topics of specific interest to the boards and a summary of state medical boards' interactions with the USMLE program. State medical boards participate in USMLE in a variety of capacities, including writing and reviewing test items; serving on governing committees; and participating in standard-setting surveys and on advisory panels. Links to key USMLE resources, articles, research and publications are also provided.

Introduction and Program Overview

The United States Medical Licensing Examination® (USMLE®) was the result of "A Proposal for a Single Examination for Medical Licensure" presented by a Task Force to Study Pathways to Licensure in 1989. A jointly owned program of the Federation of State Medical Boards of the United States, Inc., (FSMB) and the National Board of Medical Examiners® (NBME®), the USMLE instituted a single examination for use by all physicians seeking licensure in the United States.

Before USMLE, multiple examinations (the NBME Parts examination and the Federation Licensing Examination [FLEX]) offered paths to medical licensure. It was desirable to create one examination system accepted in every state, to ensure that all licensed allopathic physicians (MDs) had passed the same assessment standards – no matter in which school or which country they had trained.

Today, all state medical boards utilize a national examination – USMLE for allopathic physicians, COMLEX-USA for osteopathic physicians. Predecessor licensing examinations –FLEX and the NBME Parts – were gradually phased out and replaced with the USMLE in 1992-1994.

The USMLE is a unified examination program for initial medical licensure comprised of three complementary Steps: Step 1, Step 2 Clinical Knowledge (CK) and Step 3. The USMLE Step 2 Clinical Skills, or Step 2 CS, was implemented in 2004 and officially discontinued in January 2021.

Although the USMLE is typically completed over the course of several years in the career of a prospective physician, it constitutes a unitary examination program. Each of the three Steps complements the others; no Step can stand alone in the assessment of readiness for medical licensure, nor can other assessments be substituted to replace one of the Steps.

The USMLE program administers approximately 130,000 Step examinations annually, with more than three million test administrations since implementation of USMLE began in 1992.

As of 2023, approximately 63% of the 1,062,460 physicians licensed in the United States have taken all or part of the USMLE sequence; 58% have taken all Steps (1, 2 and 3). This represents a 2% increase in both measures since 2022.

Breakdown of this data by medical degree and medical education show:

- 67% of licensed MDs have taken part or all of the USMLE; 64% have taken all three Steps.
- 37% of licensed DOs have taken part or all of the USMLE; 1% have taken all three Steps.
- 61% of licensed domestic medical graduates (i.e., graduates of medical schools accredited by the Liaison Committee on Medical Education or LCME) have taken part or all of the USMLE; 54% have taken all three Steps.
- 73% of licensed international medical graduates (i.e., graduates of non-LCME accredited medical schools) have taken part or all of the USMLE; 71% have taken all three Steps.

Mission

The USMLE supports U.S. medical licensing authorities through its leadership in the development, delivery and continual improvement of high-quality assessments across the continuum of physicians' preparation for practice.

The program's goals are:

- To provide to licensing authorities meaningful information from assessments of physician characteristics—including medical knowledge, skills, values, and attitudes—that are important to the provision of safe and effective patient care.
- To engage medical educators and their institutions, licensing authority members, and practicing clinicians in the design and development of these assessments.
- To assure fairness and equity to physicians through the highest professional testing standards.
- To continue to develop and improve assessments for licensure with the intent of assessing physicians more accurately and comprehensively.

The results of the USMLE are reported to medical licensing authorities for use in the decision to grant a provisional license to practice in a post-graduate training program and the decision to grant an initial license for the independent practice of medicine. The USMLE is recognized and utilized by all state medical boards for licensing allopathic physicians and graduates of international medical schools. Many of the osteopathic licensing boards also recognize USMLE for licensing graduates holding the D.O. degree.

Governance

The USMLE is owned by FSMB and NBME. However, USMLE is governed by the USMLE Composite Committee, which consists of representatives from FSMB, NBME, the Educational Commission for Foreign Medical Graduates (ECFMG™) – a Division of Intealth, and the public. The Composite Committee is responsible for the overall direction of the program, identifying and approving procedures for scoring and determining the pass/fail standard, and all significant policies and procedures. The membership of the Composite Committee routinely includes current or former members of state medical boards. **Members from the Florida-Medical, Hawaii, Missouri, Montana and North Carolina boards served on the USMLE Composite Committee in 2024.**

The three USMLE Step examinations are overseen by a Management Committee composed of physicians and scientists from the licensing, practice and medical education communities, and members of the public. **Current and former members of the District of Columbia, Iowa, Missouri, North Carolina and Vermont-Medical boards served on the USMLE Management Committee in 2024.**

Medical Licensing Authorities and the USMLE

USMLE Services to State Medical Boards

In 2023, FSMB registered over 38,000 applicants for the USMLE Step 3, the final examination in the USMLE sequence. Step 1 and Step 2 registration services are provided by NBME for students and graduates of U.S. and Canadian medical and osteopathic schools and by ECFMG for students and graduates of international medical schools.

FSMB also produced and delivered over 108,000 USMLE transcripts in 2023, including nearly 52,000 transcripts produced as part of the Federation Credentials Verification System (FCVS) profile sent to state medical boards for physicians seeking licensure.

The USMLE makes a wide range of informational materials about the program available to medical licensing authorities. FSMB provides a quarterly electronic update on USMLE to all state medical boards, and research and informational articles on USMLE have appeared in FSMB's *Journal of Medical Regulation* (https://meridian.allenpress.com/jmr).

FSMB also hosts web seminars on USMLE-related topics, such as USMLE attempt, time limit, and retake policies; USMLE scoring (such as the transition to pass/fail reporting for Step 1); and USMLE transcripts and irregular behavior. Copies of these presentations are available upon request from FSMB.

State Medical Boards' Participation in USMLE

State medical board members and staff have a long history of involvement with the USMLE program. Since implementation of the USMLE in 1992, 360 members and staff from state medical boards have participated in the USMLE program in some capacity. These individuals represent 65 different medical and osteopathic licensing boards throughout the United States. In 2024, 44 individuals from 26 state medical and osteopathic boards across the United States participated in USMLE in some capacity.

Annual USMLE Orientation for State Board Members and Staff

Since 2007, FSMB and NBME have hosted an annual USMLE Orientation workshop for state board members and staff with an interest in learning about and/or participating in the program. The 2024 workshop was held October 2 at FSMB offices in Euless, Texas. **A total of 21 individuals from 12 different boards – Alabama-Commission, Hawaii, Illinois, Maine-Medical, Indiana, Minnesota, Mississippi, New Hampshire, New Jersey, Texas, Washington-Medical and Washington-Osteopathic – attended the Orientation.**

To date, 229 individuals from 61 medical and osteopathic boards have participated in an orientation workshop. Sixty-six (66) past participants (representing 35 boards) have served subsequently with the USMLE program. This includes participation on standard setting panels and advisory panels, as well as

serving on the USMLE Management Committee, the USMLE Composite Committee, and/or item writing and item review committees. Physician and public members of state medical and osteopathic boards interested in attending this workshop should contact FSMB for more information.

State Board Advisory Panel to the USMLE

In 2011, the USMLE program established the State Board Advisory Panel to the USMLE to bring together board members and staff from state medical and osteopathic boards for in-depth discussions between the primary intended users of USMLE scores - state medical boards - and USMLE program staff. For more than a decade this panel has convened annually as a reactor panel and sounding board offering feedback, advice and input from the medical licensing community on all aspects of the USMLE program.

The State Board Advisory Panel to the USMLE met in person on November 13, 2024, at FSMB offices in Euless, Texas. During the meeting, the panel discussed recent and ongoing USMLE program updates and work and provided updates about issues occurring in their states. Specific topics discussed included examination security; impact of the USMLE attempt limit change; impact of moving Step 1 to pass/fail outcome reporting; impact of the discontinuation of Step 2 Clinical Skills (CS); program updates (research, performance data, new item formats); ECFMG Certification expiration and USMLE eligibility requirements; and impact of the impending 2025 change in accreditation of Canadian medical schools on USMLE eligibility requirements.

Current panel members include staff and board members from the Alabama-Medical Licensure Commission, Idaho, Illinois, Michigan-Medical, New York-Licensure, Pennsylvania-Medical, Texas, Vermont-Medical and West Virginia-Medical boards.

USMLE Policy Exceptions Allowed at the Request of a State Medical Board

There are two USMLE eligibility policies that a state medical board may request an exception to on behalf of an individual examinee - 1) the 4-attempt limit and 2) retake of a previously passed Step. How and why a state medical board may want or need to sponsor an individual for either is detailed below.

USMLE Attempt Limit

The USMLE program imposes a limit of no more than four attempts to pass each of Step. Examinees who have attempted any USMLE Step four or more times (including the discontinued USMLE Step 2 Clinical Skills, or Step 2 CS) and have not passed are ineligible to apply for any USMLE Steps.

The only exception to this policy identified by the USMLE Composite Committee (the governing body of the USMLE program) involves state medical boards. The policy includes a provision to allow examinees who have four or more attempts at a Step to have a single additional attempt if requested by a state medical board that is fully informed of the individual's prior examination history.

This policy exception recognizes that USMLE is intended to support state medical boards' licensing decisions. Therefore, the program will accept a request from a medical licensing authority to allow one

additional attempt for an individual who would be eligible to become licensed in that jurisdiction if they passed that Step after more than four attempts and go on to meet all other licensure requirements. As part of this process, the examinee must request that FSMB send an official USMLE transcript to the medical board.

Examinees are required to pass the state board sponsored attempt at the exam to maintain eligibility to continue with the USMLE exam sequence (i.e., to apply for and take additional Steps).

An official petition form - Petition for Exception to USMLE 4-Attempt Limit Policy - for use by state medical boards to request an exception to the USMLE attempt limit policy was provided to all state medical boards via email. If you need the form resent to your board, please contact FSMB staff (see Contacts toward the end of this report) or email the Office of the USMLE Secretariat (usmlesec@nbme.org).

Retaking a Previously Passed Step

Once an individual passes a USMLE Step, it may not be retaken, except to comply with a time limit imposed by a state medical board for completion of all Steps for licensure purposes or by another authority recognized by the USMLE program. The physician may apply to retake the necessary Step only after the applicable time limit has expired. Individuals who have not yet passed Step 3 and need to retake a previously passed Step 1 or Step 2 CK examination are informed that, if they fail a retake, they will no longer be eligible to take Step 3.

Both the physician (examinee) and the sponsoring state medical board must fill out a form in order for a retake to be considered and granted by the USMLE program. The sponsorship form that state medical boards must complete - the USMLE Retake Sponsorship Form - was distributed to all state medical boards via email. If you need the form resent to your board, please contact FSMB staff (see Contacts toward the end of this report) or email the Office of the USMLE Secretariat (usmlesec@nbme.org).

A new sponsorship form is required for each retake and must be emailed directly from the medical board to the physician's USMLE registration entity.

USMLE and Medical Licensure Requirements

USMLE Recommended Time Limit for Completing USMLE

The USMLE recommends that state medical boards require the dates of passing Step 1, Step 2 CK, and Step 3 to occur within a seven-year period. However, the program recognizes that the recommended seven-year time limit may pose problems for medical licensure for some candidates with a combined degree (i.e., MD/PhD, DO/PhD). For this reason, the USMLE program recommends to licensing jurisdictions that they consider allowing exceptions to the seven-year limit for MD/PhD candidates who meet the following requirements:

1. The candidate has obtained both degrees from an institution or program accredited by the LCME and a regional university accrediting body.
2. The PhD should reflect an area of study which ensures the candidate a continuous involvement with medicine and/or issues related, or applicable to, medicine.

3. A candidate seeking an exception to the seven-year rule should be required to present a verifiable and rational explanation for the fact that he or she was unable to meet the seven-year limit. These explanations will vary and each licensing jurisdiction will need to decide on its own which explanation justifies an exception. Students who pursue both degrees should understand that while many states' regulations provide specific exceptions to the seven-year rule for dual-degree candidates, others do not. Students pursuing a dual degree are advised to check the state-specific requirements for licensure listed by FSMB.

These recommendations are provided on the USMLE website at: https://www.usmle.org/common-questions/general.

State Medical Boards' Time and Attempt Limits for Completing USMLE

Most state medical boards impose both time and attempt limits on the USMLE as part of their requirements for obtaining an initial medical license. Currently, 42 state boards impose some limit on the number of attempts at the USMLE, while 47 state boards impose a time limitation for the completion of the USMLE sequence.

A snapshot of the individual state medical boards' time and attempt limits are available on the FSMB website at: http://www.fsmb.org/step-3/state-licensure/. Board staff are encouraged to review this information and to provide updates to FSMB staff as needed.

Data about each board's composition, governance structure, funding basis, and other procedural and operational details are also available on the FSMB website at: https://www.fsmb.org/u.s.-medical-regulatory-trends-and-actions/state-medical-board-data/

Strategic Communication and Outreach

Below is a summary of communication work undertaken by the USMLE program in 2024, for examinees, medical regulators, medical educators and the public.

Medical Licensing Authorities

Quarterly FSMB Update on USMLE

Since March 2020, FSMB has emailed a Quarterly FSMB Update on USMLE® to all state medical and osteopathic boards' executive directors. The update covers key USMLE developments, policies and meetings, and highlights state board representatives that participate in the USMLE program. Copies of the 2024 updates are provided as **Appendix A**.

Examinees

USMLE Medical Student and Resident Advisory Panel

The USMLE program implemented a Medical Student & Resident Advisory Panel in 2018 to provide a consultative role to the USMLE program. The panel is charged to 1) assist staff in working through operational issues directly impacting the examinee experience of the exam, 2) serve as an additional voice and resource to inform more substantive policy questions from or before the USMLE Management and Composite Committees and (3) serve as informal ambassadors of the USMLE program. The panel consists of 15 members: 14 medical students and residents (MD, DO, MD/PhD and IMG) drawn from all regions of the country, and 1 public member.

A public member from the Minnesota board serves as the public representative on the panel.

Social Media

USMLE also uses Facebook, LinkedIn, and X (formerly known as Twitter) to more directly, efficiently and quickly communicate with applicants and examinees.

USMLE Facebook: https://www.facebook.com/usmle/

USMLE LinkedIn: https://www.linkedin.com/company/usmle/

USMLE X: https://x.com/TheUSMLE

General

Program News

The USMLE website (www.usmle.org) serves as the official communication channel for the USMLE program, providing regular updates and news to examinees and other interested parties. News items

and announcements posted on the USMLE website (www.usmle.org/announcements/) from 2023-2024 are provided in **Appendix B**.

Eligibility for the USMLE Steps

Eligibility Requirements

USMLE is intended to be taken by students and graduates of medical school programs leading to the MD, DO, or equivalent degree (e.g., MBBS degree held by many IMGs).

To be eligible for Step 1 and Step 2 CK, the examinee must be in one of the following categories at the time of application and on test day:

- a medical student officially enrolled in, or a graduate of, a U.S. or Canadian medical school program leading to the MD degree that is accredited by the Liaison Committee on Medical Education (LCME), **OR**
- a medical student officially enrolled in, or a graduate of, a U.S. medical school leading to the DO degree that is accredited by the Commission on Osteopathic College Accreditation (COCA), **OR**
- a medical student officially enrolled in, or a graduate of, a medical school that is outside the U.S. and Canada, listed in the World Directory of Medical Schools as meeting ECFMG eligibility requirements, and that meets other eligibility criteria of the ECFMG.

Step 3 applicants must meet the following eligibility requirements:

- Passing scores on Step 1 and Step 2 Clinical Knowledge; **AND**
- An MD degree or DO degree from an LCME- or COCA-accredited U.S. or Canadian medical school, **OR** the equivalent of the MD degree from a medical school outside the U.S. and Canada that is listed in the World Directory of Medical Schools as meeting ECFMG eligibility requirements, and obtain ECFMG Certification which is valid and unexpired at the time of application and testing; **AND**
- All other eligibility criteria as listed in the USMLE *Bulletin of Information*.

The USMLE program recommends (but does not require) that, for Step 3 eligibility, applicants should have completed, or be near completion of, at least one postgraduate training (PGT) year in an accredited U.S. graduate medical education (GME) program that meets state board licensing requirements.

Impact of Change to Accreditation Body for Medical Schools in Canada Effective in July 2025

Currently, medical education programs in Canada leading to the MD degree are accredited by both the Liaison Committee on Medical Education and the Committee on Accreditation of Canadian Medical Schools (CACMS). Effective July 1, 2025, CACMS will become the sole accrediting body for medical education programs in Canada.

Accreditation by LCME establishes eligibility to take the USMLE and to enter U.S. residency programs accredited by the Accreditation Council for Graduate Medical Education (ACGME). In the absence of

LCME accreditation for Canadian medical education programs, Canadian medical school graduates will establish their eligibility for USMLE and ACGME-accredited residency programs through ECFMG Certification.

This means that individuals who graduate from Canadian medical schools on or after July 1, 2025 will be considered international medical graduates for the purpose of entry into graduate medical education programs in the United States, and, in order for these graduates to enter ACGME-accredited residency programs, the ACGME will require that they either obtain ECFMG Certification or hold a full and unrestricted license to practice medicine in the U.S. licensing jurisdiction in which the ACGME-accredited program is located.

ECFMG Certification is the standard for evaluating the qualifications of IMGs entering the U.S. health care system and includes requirements for medical schools, examination requirements (which include USMLE Step 1 and Step 2 CK among other requirements), and verification of medical education credentials directly with the issuing institution.

Individuals who will graduate from Canadian medical schools on or after July 1, 2025, will be able to apply for ECFMG Certification beginning in late spring 2025, prior to the start of the 2026 residency application cycle in the United States.

Individuals who will graduate from medical schools in Canada on or after July 1, 2025, and who plan to pursue U.S. GME should monitor the ECFMG and USMLE websites for detailed information on applying for ECFMG Certification and USMLE.

Eligibility Policies

In addition to the requirements outlined above, all USMLE examinees must meet the following USMLE eligibility policies.

Sequencing of Steps

Step 1 and Step 2 CK can be taken in any sequence. Step 3 can be taken only after passing Step 1 and Step 2 CK.

Retakes

Examinees may not take the same Step more than three times within a 12-month period. A fourth attempt on any Step must be at least 12 months after the first attempt at that Step and at least six months after the most recent attempt at that Step. This includes incomplete attempts.

Attempt Limit

The total number of attempts allowed per Step is four (4). Examinees who have attempted any USMLE Step four or more times and have not passed are ineligible to apply for any USMLE Steps. Attempts at the formerly administered Step 2 CS count toward the limit. All attempts at a Step are counted toward the limit, regardless of when the examinations were taken. The only exception to this policy identified by the USMLE Composite Committee (the governing body of the USMLE program) involves state medical boards. The policy includes a provision to allow examinees who have four or more attempts at a Step to have a single additional attempt if requested by a state medical board that is fully informed

of the individual's prior examination history. Examinees are required to pass the state board sponsored attempt at the exam to maintain eligibility to continue with the USMLE exam sequence.

Retaking a Previously Passed Step

Once an individual passes a USMLE Step, it may not be retaken, except to comply with a time limit imposed by a U.S. physician licensing authority for completion of all Steps or by another authority recognized by the USMLE program. Individuals who have not yet passed Step 3 and need to retake a previously passed Step 1 or Step 2 CK examination are informed that, if they fail a retake, they will no longer be eligible to take Step 3. To meet the examination requirements for Step 3 eligibility, individuals must have achieved a passing performance on the most recent administration of Step 1 and Step 2 CK.

Physicians Who are Already Licensed in the United States

Individuals who have already been granted a physician license by a US medical licensing authority based on other licensure examinations, including but not limited to the Federation Licensing Examination (FLEX), Medical Council of Canada Qualifying Examination (MCCQE), NBME certifying examinations (NBME Parts), National Board of Osteopathic Medical Examiners (NBOME) Parts or Comprehensive Osteopathic Medical Licensing Examination of the United States (COMLEX-USA), or by exception, may not be eligible to take the USMLE.

Content and Administration

Content Development

Content for the USMLE is prepared by examination committees broadly representing the medical profession. Members of USMLE test committees include biomedical scientists, educators, and clinicians from every region of the United States. Virtually all LCME-accredited medical schools in the United States have been represented on USMLE test committees. USMLE test committee members represent a "national faculty of medicine" drawn from medical schools, state medical boards, and clinical practice settings across the United States. A directory of USMLE test committees and task forces is available at: https://www.usmle.org/about-usmle.

At least two of these committees critically appraise each test item or case before it is used as live (i.e., scored) material on the USMLE. These committees may revise or discard materials for any of several reasons, e.g., inadequate clinical relevance, outdated content, failure to meet acceptable statistical performance criteria, etc.

For a more detailed explanation of content development, contact FSMB for a copy of the 2009 Journal of Medical Licensure and Discipline article, "Developing Test Content for the USMLE". State board members and staff are also invited to attend an annual USMLE Orientation session to learn more about how USMLE is developed.

Step Content and Structure

Step 1 assesses whether a candidate understands and can apply important concepts of the sciences basic to the practice of medicine, with special emphasis on principles and mechanisms underlying health, disease and modes of therapy. It ensures mastery of not only the sciences that provide a foundation for the safe and competent practice of medicine in the present, but also the scientific principles required for maintenance of competence through lifelong learning. Step 1 is constructed according to an integrated content outline that organizes basic science material along two dimensions: system and process.

Step 2 CK assesses an examinee's ability to apply medical knowledge, skills, and understanding of clinical science essential for the provision of patient care under supervision and includes emphasis on health promotion and disease prevention. Step 2 CK ensures that due attention is devoted to principles of clinical sciences and basic patient-centered skills that provide the foundation for the safe and competent practice of medicine under supervision.

Step 3 assesses whether the candidate can apply medical knowledge and understanding of biomedical and clinical science essential for the unsupervised practice of medicine, with emphasis on patient management in ambulatory settings. Step 3 content reflects a data-based model of generalist medical practice in the United States. The test items and cases reflect the clinical situations that a general, as-yet undifferentiated, physician might encounter within the context of a specific setting. It is the final examination in the USMLE sequence leading to a license to practice medicine without supervision. As

such, it provides a final assessment of physicians assuming independent responsibility for delivering general medical care.

Table 1 details the structure and exam day(s) for each USMLE Step.

Table 1: Exam Structure by Step

Exam	Number of Exam Days	Item Format	Total Testing Time	Testing Blocks	Maximum Number of Total Items
Step 1	1	Multiple-choice questions (MCQs)	8 hours	Seven 60-minute blocks	280
Step 2 CK	1	MCQs, including patient scenario format and abstract format	9 hours	Eight 60-minute blocks	318
Step 3	2 Day One: Foundations of Independent Practice (FIP)	Day One: MCQs, including patient scenario format, abstract format, and pharmaceutical advertisement (drug ad) format	Day One: 7 hours	Day One: Six 60-min. blocks	Day One: MCQs: 232
	Day Two: Advanced Clinical Medicine (ACM)	Day Two: MCQs & Computer-based Case Simulations (CCS)	Day Two: 9 hours	Day Two: MCQs: Six 45-min. blocks CCS: Max. 10 or 20 min. of real time (each)	Day Two: MCQs: 180 CCS: 13

Test Administration

Steps 1, 2 CK and 3 are administered by computer at Prometric Test Centers (PTCs). Step 1 and Step 2 CK are given at PTCs around the world. Step 3 is only given at PTCs in the United States and its territories.

All USMLE examinations are proctored and videotaped. Strict guidelines are followed for proper identification of examinees. Efforts are made to reduce the overlap of test content from examinee to examinee and from test administration to test administration when examinees need to retake a Step.

Any significant breaches in security can result in the cancellation of scores/results, suspension of an individual from USMLE, and/or annotation of score reports and official USMLE transcripts.

All Step exams include an optional survey at the end of the final exam day, which can be completed if time allows.

Test Accommodations

Reasonable and appropriate accommodations are provided in accordance with the Americans with Disabilities Act (ADA) for individuals with documented disabilities. The purpose of test accommodations is to provide access to the examination program. While presumably the use of accommodations will enable the individual to better demonstrate his/her knowledge or skill, accommodations are not a guarantee of improved performance, test completion, or a particular outcome. Examinees are informed of the availability of test accommodations via the USMLE *Bulletin of Information*, the USMLE website, and the individual Step applications.

The ADA defines disability as a physical or mental impairment that substantially limits one or more major life activities as compared to most people in the general population. Examples of major life activities include, but are not limited to, walking, seeing, hearing, and learning. Determination of whether an individual is substantially limited in functioning as compared to most people is based on an individualized assessment of the current impact of the identified impairment.

Requests for test accommodations are reviewed by NBME staff trained in clinical and school psychology at the doctoral level or by medical professionals, depending on the basis of the request. Further review of the request and supporting documentation may be provided by external experts in the respective fields of disability with whom NBME consults regarding the presence of a disability and appropriate accommodations. NBME makes decisions regarding appropriate test accommodations for all USMLE Steps.

Examinees with disabilities may be provided with a variety of accommodations, including but not limited to assistance with keyboard tasks, audio rendition, extended testing time and additional break time. Efforts are made to match accommodations to the individual's functional limitations. For example, audio-recorded versions of the computer-based Step examinations are available for candidates with visual or visual processing disabilities. Special tactile versions of visual material for a Step examination may be provided for examinees with severely impaired vision. Items with an audio component may include a visual representation of the sound for hearing impaired examinees.

Scores

Minimum Passing Scores

The USMLE Management Committee establishes a recommended passing standard for all Step examinations (an overview of the standard setting process USMLE uses is provided in the Psychometrics section of this report). Recommended performance standards for the USMLE are based on a specified level of proficiency. As a result, no predetermined percentage of examinees will pass or fail the examination.

In alignment with best practices for licensing and certification exams, a comprehensive review and analysis of the passing standard for each Step exam typically occurs every three to four years but can occur at any time. Periodic review ensures that the passing score is consistent with expectations of the level of content mastery of the knowledge and skills needed to support effective medical practice and licensure. Notice of such review and any adjustments are posted on the USMLE website. More information about the passing score process is provided in the "Standard Setting" section of this report.

A statistical procedure ensures that the performance required to pass each test form is equivalent to that needed to pass other forms; this process also places scores from different forms on a common scale (the three-digit score scale).

Although 2-digit scores are not reported, test results reported as passing would represent an exam score of 75 or higher if a two-digit score were reported.

Current minimum passing scores for each Step are provided in **Table 2** below.

Score Reporting

When examinees take Step 1, Step 2 CK, or Step 3, the computer records their responses, which are then transmitted to NBME for scoring.

Results for Step 1 taken on or after January 26, 2022, are reported as pass/fail only. Results for Step 1 exams taken prior to January 26, 2022, and for all Step 2 CK and Step 3 exams, are reported on a 3-digit scale; reported scores range from 1 to 300.

Table 2 presents performance data for first-time examinees from LCME-accredited medical schools in the United States and Canada who tested in the 2023 calendar year for Step 1 and Step 3, and the 2022-2023 academic year for Step 2 CK. Additional performance data is provided in **Appendix C**.

Table 2. USMLE 2023 Calendar Year Performance for First-Time Examinees from LCME-accredited Medical Schools

Exam	Most Scores Fall Between	Minimum Passing Score	Mean and (Standard Deviation)	Pass Rate
Step 1*	N/A *(reported as pass/fail only)*	194: For exams taken on or before January 25, 2022 196: For exams taken on or after January 26, 2022	Reported as pass/fail only	92%
Step 2 CK	200-275	209: For exams taken on or before June 30, 2022 214: For exams taken on or after July 1, 2022 (to be reviewed in March 2025)	248 (15)	98%
Step 3	185 - 260	198: For exams taken on or before December 31, 2023 200: For exams taken on or after January 1, 2024	227 (15)	97%

*Because of the transition to reporting only a pass/fail outcome, future reviews of the Step 1 passing standard will not be reported in terms of a three-digit score.

Under most circumstances, to receive a score on Step 1, Step 2 CK, and Step 3, an examinee must begin every block of the test. If an examinee does not begin every block and no results are reported, an "incomplete" annotation may appear on the USMLE transcript. If an examinee registers for but does not begin an examination, no record of the test will appear on the examinee's transcript.

Some unscored items and cases may also be included in the Step examinations for research purposes.

Annual performance data for all Step examinations, as well as Score Interpretation Guidelines, are available on the USMLE website at https://www.usmle.org/usmle-updates-research.

Important Notes about the Step 1 Summary Performance

Results indicate a higher fail rate on the Step 1 exam for examinees after the pass/fail transition. It is important to note that factors not present in previous years introduce complexities when comparing this examinee group to previous years. These differences should be considered when interpreting reported data. The factors include:

- Increased passing standard for Step 1
    - The Step 1 pass/fail transition beginning on January 26, 2022, coincided with an increase in the exam's minimum passing standard from 194 to 196. The increase in passing standard accounts for some increases observed in the fail rates.
- Shift in examinee scheduling patterns and volumes
    - The USMLE program has observed shifts in the timing of when examinees tested, particularly around the pass/fail transition date. These changes in test timing patterns suggest that those who tested during this period may not be representative of the typical group that tested during these times in the past. We have also seen changes in the composition of the examinee group. Overall, the volume of Step 1 test takers has increased over time, with a considerable increase in international medical graduates and Osteopathic graduates relative to previous years. These differences complicate comparisons to past performance data.

Conversely, the following factors did not change and should also be considered when interpreting the data:

- Consistency in the construction of USMLE Step examinations
    - Within each Step examination, USMLE creates various forms that are similar in difficulty and content. Each USMLE Step examination includes multiple forms that are similar in difficulty and content for the respective Step. Scores on individual examination forms are made comparable through equating, a psychometric process that adjusts scores based on the difficulty of the questions. This process ensures examinees who take different forms are held to the same passing standard.
- No significant changes to exam specifications for Step 1
    - All USMLE examinations are constructed from an integrated content outline, which organizes content according to general principles and individual organ systems. While not all topics listed in the content outline are included in each Step exam, overall content coverage is comparable among the various examination forms that different examinees of each Step will take. Although foundational science content was recategorized into existing content areas, the test specifications used to construct USMLE Step 1 examinations have not changed substantively since the exam transitioned to pass/fail reporting.
- Consistent style and difficulty for Step 1 exam questions
    - No changes were made to the style and targeted difficulty of the Step 1 exam. USMLE collaborates with a network of medical school faculty and clinicians that come from a variety of educational backgrounds and specialties and throughout the United States to create test items, or questions and cases, that make up the USMLE Step exams. Each year, this network draws on their own experience and expertise to develop high-quality test items with NBME staff that address the topics and challenges that they encounter in their own classrooms and practice based on years of lessons and learned best practices. Participating physicians maintained the standard USMLE item writing approach for the Step 1 exam.

Score Reports and Transcripts

USMLE score reports and transcripts show scores (for Step 1 exams taken prior to January 26, 2022; Step 2 CK; and Step 3) and an indication of whether an examinee passed or failed (for all examinations, including the previously administered Step 2 CS).

If an examinee is found to have engaged in irregular behavior, an annotation to that effect is recorded on the score report or transcript, as well as a copy of the letter to the examinee regarding the finding of irregular behavior. Upon examinee authorization for release of an official USMLE transcript, the same information (i.e., annotation on the transcript, determination letter regarding a finding of irregular behavior, and a report from the FSMB Physician Data Center if applicable) is sent to all transcript recipients, including to medical licensing authorities, for use in making licensure decisions.

Official USMLE transcripts are only provided to individual state medical boards from the FSMB and only upon request of the physician (examinee).

Official USMLE transcripts include the following information/fields:

- All USMLE Steps taken by the physician/examinee, including:
    - Test date
    - Indication of whether an examinee passed or failed (for all examinations, including the previously administered Step 2 CS).
    - Score (only applies to Step 1 exams taken prior to January 26, 2022; Step 2 CK; and Step 3)
    - Minimum passing score in effect on the test date (only applies to Step 1 exams taken prior to January 26, 2022; Step 2 CK; and Step 3)
- Comments
    - If an examinee is found to have engaged in irregular behavior, an annotation to that effect is recorded under Comments on the transcript. A short description of the irregular behavior is included (e.g., security violation) as part of the comment. Additionally, a copy of the determination letter to the examinee regarding the finding of irregular behavior is provided with the transcript. If the irregular behavior finding was reported to the FSMB Physician Data Center (PDC), a report from the FSMB Physician Data Center is also provided.
- Notes
    - All transcripts include a Note regarding the results of the search of the FSMB's Physician Data Center at the time the transcript was requested. If the search reveals that information has been reported to the PDC, the note will state that information was found and a report from the PDC will be provided with the transcript. If no information has been reported to the PDC, the Note will state no reported information has been found for the examinee.
    - Irregular Behavior annotations may also appear under Notes - either alone or in conjunction with an Irregular Behavior annotation under Comments as described above. A short description of the irregular behavior is included (e.g., security violation) as part of the note. Additionally, a copy of the determination letter to the examinee regarding the finding of irregular behavior is provided with the transcript. If the irregular behavior

finding was reported to the FSMB Physician Data Center (PDC), a report from the FSMB Physician Data Center is also provided.

Psychometrics

Score Reliability and Precision

All standardized examinations include some degree of measurement imprecision. Like all high-quality assessments, USMLE utilizes several psychometric measures to monitor and minimize such imprecision. Reliability refers to a score's expected consistency. Candidates' test scores are reliable to the extent that an administration of a different random sample of items from the same content domain would result in little or no change in each candidate's rank order among a group of candidates. In general, long examinations of very similar items administered to a diverse group of examinees yield high reliabilities.

One of the ways that reliability is measured is through metrics of precision that indicate how scores may fluctuate. The standard error of measurement (SEM) provides a general indication of how much a score might vary across repeated testing using different sets of items covering similar content. As a general rule of thumb, chances are about two out of three that the reported score is within one SEM, plus or minus, of the score that truly reflects the examinee's ability (i.e., of the score that would be obtained if the examination were perfectly reliable). Currently, the SEM is approximately 6 points for Step 2 CK and 5 points for Step 3.

The standard error of difference (SED) in scores is an index used to assess whether the difference between two scores is statistically meaningful. If the scores received by two examinees differ by two or more SEDs, it is likely that the examinees are different in their proficiency. Currently, the SED is approximately 8 points for Step 2 CK and 7 points for Step 3.

The standard error of the estimate (SEE) is an additional index of the amount of uncertainty in the scores used to gauge the likelihood of performing similarly on a repeat attempt. If an examinee tested repeatedly on a different set of items covering the same content, without learning or forgetting, their score would fall within one SEE of their current score two-thirds of the time. Currently, the SEE is approximately 8 points for Step 2 CK and 7 points for Step 3.

Decision Consistency

Decision consistency reflects the probability an examinee would be classified in the same category (e.g., pass or fail) on a repeat administration without change in their underlying knowledge. In the context of USMLE, the index quantifies how consistently the respective Step examination categorizes examinees as passing or failing. The index ranges from 0 to 1, where higher values indicate the assessment yields more stable classifications. Decision consistency is generally higher with longer exams – because of the increased reliability – and when most students score far from the passing standard. The most recent decision consistency value is .95 for Step 1, .97 for Step 2 CK, and .97 for Step 3. The high values indicate examinees would almost assuredly receive the same outcome if taking an administration of a different random sample of items from the same content domain without a change in content knowledge.

See **Table 3** for decision consistency, SEM, SED and SEE information for all Steps.

Table 3. Current USMLE Score Precision and Decision Consistency

Exam	Standard error of measurement (SEM)	Standard error of difference (SED)	Standard error of the estimate (SEE)	Decision Consistency
Step 1	Not reported	Not reported	Not reported	.95
Step 2 CK	6 points	8 points	8 points	.97
Step 3	5 points	7 points	7 points	.97

Score Validity

Score validity refers to the extent to which existing evidence supports the appropriateness of the interpretation of test outcomes. The public and state medical boards can reliably conclude that an individual who has passed all examinations in the USMLE sequence has demonstrated the fundamental knowledge and skills for safe and effective patient care.

The best way to support a proposed score interpretation is through accumulation of developmental documentation and research on all components of the test design, delivery, and scoring processes, and through tracking the relationship of examination outcomes with later measures of the individual's ability. The USMLE program has a fairly extensive history of such activity.

A searchable list of NBME and USMLE research published after 2017 can be found at: https://www.nbme.org/research-library.

A list of research citations for studies published from 2009 to 2017, as well as descriptions of many of the USMLE processes, is available on the USMLE website at: https://www.usmle.org/usmle-updates-research.

A recent USMLE-related article published in Academic Medicine - The Associations Between United States Medical Licensing Examination Performance and Outcomes of Patient Care - co-authored by USMLE Vice President Dr. Alex Mechaber shows higher performance on the USMLE exam series was associated with lower in-hospital mortality and shorter length of stay for patients in the Pennsylvania hospital system. In demonstrating higher USMLE performance correlates with improved patient outcomes, this article study further strengthens the evidence that USMLE assesses competencies essential to safe and effective patient care.

Standard Setting

USMLE General Procedures for Standard Setting

The USMLE system for setting standards is established by the USMLE Composite Committee, which includes representatives of the ECFMG, FSMB, NBME and the public. The system specifies the kinds of data to be gathered and how the data are to be gathered, the frequency of reviewing the standards and adjusting them, and assigns the judgment task to the Management Committee. The Management Committee, jointly appointed by the FSMB and NBME, must use the procedures defined by the Composite Committee, but is free to set the standard and revise the standard as it deems necessary. The decision of the Management Committee is final; no superior governing committee is authorized to

alter its decision. The Management Committee includes those with educational, licensing, and clinical practice perspectives, as well as a representative from the public.

Current policy requires that the Management Committee review the effectiveness of Step standards at least annually. A comprehensive review and possible adjustment of the standard must be undertaken approximately every four years. In addition, when there are any major changes to the design or format of the Step examination, the Management Committee is asked to establish new passing requirements for the redesigned components. USMLE believes that there must be an opportunity for review and adjustment of standards in order to reflect the realities of change in the content of medicine, the nature of the test, the characteristics of examinees, and the expectations of stakeholders. Such review of the standard is essential to assure that the judgment inherent in defining the standard reflects current conditions, not those that were pertinent in the past.

Mandated Data Sources Informing the Judgment Process

USMLE policy mandates the use of four categories of data in making judgments about standards. These are:

- Content-referenced judgments of experts. Content experts provide their opinions, based upon review of content and examinee performance, on the appropriate requirements for passing the examination.
- Survey of stakeholders. Expectations of stakeholders for the percent of examinees that should pass the examination.
- Cohort performance trends. Trends in examinee performance over a long period of time and the effect of repeated attempts at the examinations on the failure rate in a defined cohort of examinees.
- Score precision in the region of the cut-score. Estimates of numbers of misclassified examinees based on historical distributions of examinee performance and the measurement error in the scale area under consideration for the cut-score.

Setting the Standard

The Management Committee meets to consider the collected data. As part of this process the committee reviews all of the data collection processes and considers the combined data. Typically, the question posed of the committee is whether the externally collected data, performance trends, and score reliability data suggest that the current standard for a particular Step exam needs to be changed. The committee can allow the standard to remain the same or can vote to make a change. If the latter occurs, the committee identifies the new performance requirements.

Information regarding the timing of the standard setting process and final decisions is posted on the USMLE website.

Data and Research

Aggregate Performance Data

The USMLE program publishes aggregate performance data for all Steps on the USMLE website at www.usmle.org/performance-data.

These data include examinee volume and passing percentages categorized by:

- first-taker and repeater examinees,
- U.S./Canadian and international students/graduates, and
- allopathic and osteopathic examinees.

Passing rates and examinee counts for 2022-2023 for each Step are provided in **Appendix C**.

Research Agenda

Each year, the USMLE program coordinates an operational research agenda to strengthen the evidence supporting USMLE as a tool for medical licensure and guide future program enhancements. Key themes for the 2023 research agenda included:

- Enhancing USMLE security procedures;
- Exploring the association of scores and pass/fail outcomes with patient outcomes;
- Investigating the pass/fail transition's effect on examinee performance, preparation, and scheduling behaviors;
- Understanding how artificial intelligence can be leveraged to improve USMLE through automated scoring of complex item types and item development support; and
- Developing and researching innovative items to enhance clinical skills coverage.

Publications

A listing of recent (2022-2024) USMLE-related publications is available as **Appendix D**.

A list of research citations for studies published from 2009 to 2017, as well as descriptions of many of the USMLE processes, is available on the USMLE website at: https://www.usmle.org/usmle-updates-research.

A searchable list of NBME and USMLE research published after 2017 can be found at: https://www.nbme.org/research-library.

Resources

Websites

- USMLE website (www.usmle.org) provides the most current information on the program.
- FSMB website (www.fsmb.org) contains information specific to USMLE Step 3.
- NBME website (www.nbme.org) contains information specific to registering for USMLE Step 1 and Step 2 CK for students and graduates of U.S. and Canadian medical schools.
- ECFMG website (www.ecfmg.org) provides information on ECFMG certification and registering for USMLE Step 1 and Step 2 CK for students and graduates of international medical schools seeking information.

Written Materials

- USMLE *Bulletin of Information* – provides USMLE policies and procedures and can be accessed from the main page of the USMLE website (www.usmle.org).
- *Journal of Medical Regulation* (previously the *Journal of Medical Licensure and Discipline*) – published by the FSMB, the Journal occasionally provides informational articles summarizing major aspects of the USMLE program. Topics covered include Step 2 Clinical Skills, the development of multiple-choice questions for test content, research, and processes for maintaining program security (see citations below). Past issues are available on the JMR website at https://meridian.allenpress.com/jmr or upon request from the FSMB:
    - "Characteristics and Outcomes of Individuals Engaging in USMLE Irregular Behavior, 2006–2015." Journal of Medical Regulation. Vol. 106, No. 4, 2020.
    - "Implementing Strategic Changes to the USMLE." Journal of Medical Regulation. Vol. 100, No. 3, 2014.
    - "An Assessment of USMLE Examinees Found to Have Engaged in Irregular Behavior, 1992-2006." Journal of Medical Regulation. Vol. 95, No. 4, 2010.
    - "Developing Content for the United States Medical Licensing Examination." Journal of Medical Licensure and Discipline. Vol. 95, No. 2, 2009.
    - "Maintaining the Integrity of the United States Medical Licensing Examination." Journal of Medical Licensure and Discipline. Vol. 92, No. 3, 2006.
    - "The Introduction of Clinical Skills Assessment into the United States Medical Licensing Examination (USMLE): A Description of the USMLE Step 2 Clinical Skills (CS)." Journal of Medical Licensure and Discipline. Vol. 91, No. 3, 2005.
    - "The United States Licensing Examination." The Journal of Medical Licensure and Discipline. Vol. 91, No. 1, 2005.

Key Contacts

The following individuals are key contacts for state medical boards on matters involving the USMLE.

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APPENDIX A
2024 Quarterly FSMB Updates on USMLE

Quarterly FSMB Update on USMLE®

March 2024, Vol.5, No.1

USMLE Score Invalidation

The USMLE program regularly monitors and analyzes examinees' test performances for unusual score patterns or variations, and other information that could raise questions about the validity of an examinee's results. As part of an ongoing investigation, the USMLE program has identified a pattern of anomalous exam performance associated with Nepal, which challenges the validity of test results for a group of examinees. Highly irregular patterns can be indicative of prior unauthorized access to secure exam content. Examinees with results in question are being notified by the USMLE Secretariat's Office that their previous Step score(s) have been invalidated and that they will be required to take a validation exam(s). The USMLE program is working to notify examinees who need to schedule validation exam(s) and to support state medical boards and other score users and stakeholders impacted by the validation exam requirements.

If you or your board have any questions or need additional information, please contact David Johnson, FSMB's Chief Assessment Officer, at djohnson@fsmb.org.

USMLE Standard Setting

The USMLE program is inviting state medical boards to participate in a USMLE standard setting survey. An email was recently sent out to all state board executive directors and chairs/presidents about the survey. Individuals who are interested in participating should complete and submit the survey within the next month.

Change in Step 3 Passing Standard

The USMLE Management Committee met on December 12-13, 2023, and conducted a review of the passing standard – used to determine a Pass or Fail outcome – for USMLE Step 3. As part of the USMLE program's operational procedures and in alignment with best practices for licensing and certification exams, a comprehensive review and analysis of the passing standard for each Step exam typically occurs every three to four years. This ensures that the passing standard is consistent with expectations of the level of content mastery of the knowledge and skills needed to support effective medical practice and licensure.

For the Step 3 review, information from multiple sources was considered, including:

- Recommendations from independent groups of physicians unaffiliated with the USMLE participating in content-based standard-setting panels in September and October 2023;
- Results of surveys of various groups (e.g., state medical board representatives, residency program directors, medical school faculty, examinees) concerning the appropriateness of current passing standards for the Step 3 examination;
- Data on trends in examinee performance; and
- Score precision and its effect on the pass/fail outcome.

The Committee decided that a two-point increase in the passing standard will apply to Step 3 examinees testing on or after January 1, 2024. On the three-digit score scale, the passing standard changed from 198 to 200.

2024 USMLE Meetings Calendar

Budget Committee - April 24

Committee for Individualized Review - May 7-8

Composite Committee - June 7-9

Resources

USMLE.org

Bulletin of Information

FAQs

Contact

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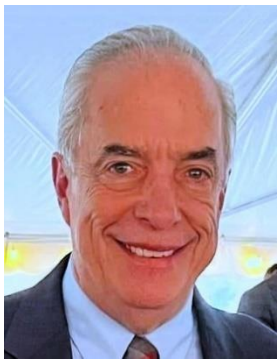
Quarterly FSMB Update on USMLE®

June 2024, Vol. 5, No. 2

USMLE Volunteer Spotlight



Gerard (Gerry) Dillon, PhD
Public Member
Pennsylvania State Board of Medicine

I have been a public member of the Pennsylvania State Board of Medicine for four years. Being a member of a state board has allowed me the opportunity to work with FSMB in several ways. I have represented my board as a delegate to FSMB's annual meeting, am on the Editorial Board for the Journal of Medical Regulation and am currently on the FSMB Ethics and Professionalism Committee.

Prior to joining the board of medicine, I worked at NBME for more than forty years, spending nearly all that time helping to develop examinations to be used in the medical licensing process. I was witness to the hard work and dedication of members of the national faculty of content experts (many of whom were and are members of state medical boards) who develop test materials, set testing standards and provide direction for the USMLE program. I was also witness to the excellence of the testing professionals who strove to make the examinations as reliable and valid as possible. The stated goal was always to provide the best possible assessment tool for the state medical boards to use in the licensing process.

My opportunity to be a USMLE volunteer started with my appointment to the State Board Advisory Panel to the USMLE program. The panel is made up of approximately 10 individuals who are members of state boards from around the country. The panel meets annually and has an opportunity to interact with USMLE program members (including ECFMG, FSMB and NBME staff). USMLE uses the panel as a sounding board for the direction that the program takes in terms of policies, test design, standard setting, score reporting and other issues. The USMLE staff also seeks input from the member states about the pressing issues they encounter locally and how those might impact or be impacted by the examination system. It is also a wonderful opportunity to "compare notes" with colleagues from sister boards on the issues that impact all regulators. This dialogue between and among examination developers and users is enormously important, and I consider myself fortunate to be a part of it.

Finally, one of the many things I have become aware of since becoming a member of a state medical board is how trusting we are of all the excellent partner organizations that contribute to the regulatory process in this country. The USMLE program and its parents, FSMB and NBME, are among some of the most important of these organizations. It is an honor to be a small contributor to this process, and I would encourage my state board colleagues to consider how they might become part of this program.

USMLE Orientation for State Board Members and Staff

Since 2007, FSMB and NBME have hosted an annual USMLE Orientation workshop for state board members and staff with an interest in learning about and/or participating in the program. To date, 209 individuals from 60 medical and osteopathic boards have participated in an orientation workshop. Sixty-five past participants (representing 35 boards) have served subsequently with the USMLE program. This includes participation on standard setting panels and advisory panels, as well as serving on the USMLE Management Committee, the USMLE Composite Committee and/or item writing and item review committees.

If you or any of your board members or staff are interested in attending the Orientation, please contact Frances Cain, FSMB's Director of Assessment Services, at fcain@fsmb.org.

USMLE Composite Committee Update

At the June 2024 USMLE Composite Committee meeting, the committee elected Cheryl Walker-McGill, MD, MBA, (North Carolina) as Chair for a two-year term. Congratulations, **Dr. Walker-McGill**!

The committee met over two days and discussed a revision to the committee's rules of operation, appeals stemming from decisions of the Committee for Individualized Review, appointment of new members, organizational updates, an update on USMLE Management Committee activities, discussions of form design and exam security and a review of plans for an ongoing transformation of the USMLE exam.

Other members of the committee include representatives of FSMB who serve or have served on state medical boards - FSMB Past Chair Jeffrey Carter, MD, (Missouri); FSMB Past Chair Sarvam TerKonda, MD, (Florida-Medical); Kristin Spanjian, MD, (Montana); and Danny Takanishi, Jr., MD, (Hawaii).

2023 USMLE Aggregate Performance Data

2023 performance data are now available for all USMLE Steps. These data include examinee volume and passing percentages categorized by:

- first-taker and repeater examinees
- U.S./Canadian and international students/graduates
- allopathic and osteopathic examinees

Performance data for USMLE administrations dating back to 2013, as well as Score Interpretation Guidelines, are also available on the USMLE website.

Score Reporting Timeline

The USMLE program will no longer implement dedicated score delay periods for the Step examinations. Most exam scores will continue to be reported within four weeks after an examinee completes their test. However, in rare cases, various factors may delay score reporting. Examinees are advised to allow at least eight weeks to receive their score reports.

USMLE Content Outline Updated

To help ensure the relevancy of content on the USMLE, the USMLE program has released an updated content outline. In this update, topics in the previous "General Principles of Foundational Science" category, which focused on foundational science content, have been redistributed into respective organ system categories or included in a new category titled "Human Development."
Learn more about the update with this infographic.

What's the purpose of this update?
The USMLE is created to be clinically relevant by a diverse national faculty of medicine drawn from medical schools, state licensing boards and clinical practice settings from every region of the United States. As practice guidelines evolve or are introduced, the content on the USMLE is reviewed and modified by these experts as needed. All USMLE examinations are constructed from two classification schemes: (1) an integrated content outline, which organizes content according to individual organ systems and (2) a physician tasks and competencies outline. To ensure that foundational science principles are tested in a clinically relevant manner, this latest modification to the content

outline aims to better incorporate these topics into individual organ systems without changing the proportion of foundational science covered within the exams.

What's the impact of this change?
Foundational science knowledge is a critical building block for future physicians to develop clinical skills and reasoning. The foundational science topics included in the updated content outline are not being removed, just recategorized. Additionally, the weighting or proportion of foundational science content included in the Step exams will not change.

How will this influence examinee preparation for Step exams?
Examinees preparing for Step exams should use the updated content outline available on USMLE.org. The content outline provides a common organization of content across all three Step examinations. However, no single examination includes questions on all listed topics.

Follow USMLE on social media

We encourage state board staff to follow USMLE on social media for timely USMLE news and updates!

Facebook LinkedIn X *(formerly Twitter)*

2024 USMLE Meetings Calendar

Patient Characteristics Advisory Panel - May 22
Management Committee - June 4, August 5-7
Composite Committee - June 7-9
Committee for Individualized Review - July 16-17

Contact

Frances Cain, MPA
Director, Assessment Services
Fcain@fsmb.org

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Quarterly FSMB Update on USMLE®

October 2024, Vol. 5, No. 3

USMLE Orientation for State Board Members and Staff

Pictured (L-R): *Erica Lamy, Freda Pace, Tiffany Seamon, Camille Lindsay, Dr. Kenneth Cleveland, Rebecca Robbins, Christopher Palazola*

On October 2, 2024, the FSMB and NBME hosted 21 members and staff from 12 state medical boards at FSMB's offices in Euless, Texas, and virtually for the 18th annual USMLE Orientation for State Board Members and Staff.

The orientation, first held in 2007, provides members and staff from state medical and osteopathic boards with an opportunity to learn about the USMLE program and engage directly with program staff. The goals of the workshop remain: (1) to inform and educate the medical board/regulatory community on the USMLE program, including new developments and key issues; (2) to create and facilitate relationships with USMLE program staff to ensure that state boards have an immediate resource for any USMLE-related questions; and (3) to share opportunities for state board members and staff to participate directly with the USMLE program.

This year's meeting included a brief history of medical licensing examinations, which spotlighted two key principles upholding the value of the medical licensing examination: (1) acting as an independent audit of the medical education/training system and (2) providing a common national standard for the assessment of physicians for purposes of initial medical licensure. The meeting also provided an overview of the USMLE program, research, examination security and how state board members and staff can participate.

Attendees (in-person and virtual) included:

- Rebecca Robbins, Alabama (Commission)
- Tiffany Seamon, Alabama (Commission)
- Randy Ho, Hawaii
- Camile Lindsay, Illinois
- Lynne Weinstein, Maine-Medical
- Valerie Hunt, Maine-Medical
- Rebecca Mueller, MD, Indiana
- Kiko Dixon, Indiana
- Elizabeth Huntley, JD, CMBE, Minnesota
- Kita Nelson, Minnesota
- Kenneth Cleveland, MD, Mississippi
- Erica Lamy, New Hampshire
- Antonia Winstead, New Jersey
- Lawrence Muka, New Jersey
- Christopher Palazola, Texas
- Mandy Moreno, Texas
- Abigail Revuelta, Texas
- Becky McElhiney, Washington-Osteopathic
- Danielle Dooley, Washington-Osteopathic
- Freda Pace, Washington-Medical
- Kyle Karinen, Washington-Medical

Since the creation of USMLE in 1992, more than 209 individuals from 60 medical and osteopathic boards have participated in the USMLE orientation. Sixty-five past participants (representing 35 boards) have served subsequently with the USMLE program. This includes participation on standard setting panels and advisory panels, as well as serving on the USMLE Management Committee, the USMLE Composite Committee, and/or item writing and item review committees.

The USMLE program sincerely thanks all current and past state board volunteers for their participation, which is integral to the success of the program!

Physicians and public members of state medical and osteopathic boards interested in attending the next orientation should contact Frances Cain, MPA, Director of Assessment Services at FSMB, at fcain@fsmb.org.

USMLE Committee Member Social Media Campaign

The USMLE program is launching a social media campaign to feature USMLE committee members. These posts will help to humanize the program by showcasing the many medical educators and regulators who contribute behind the scenes to the success of the USMLE program. Participating is as easy as sharing a headshot and completing a quick questionnaire. The Marketing & Communications team will use these materials to create social media posts. If you're a USMLE committee member, or served previously in this capacity, and are interested in participating in this campaign, please contact Alyssa Yeroshefsky, Communications Manager of the USMLE Program, at ayeroshefsky@fsmb.org.

Anomalous Performance on USMLE Step Examinations

The USMLE program is committed to protecting the integrity of the exam sequence and continues to evaluate and enhance exam security policies and initiatives. Routine analyses are performed as part of the scoring process to detect unusual examinee response behavior. As part of an ongoing investigation, the USMLE program recently took action to invalidate exam scores based on a pattern of anomalous performance detected that indicates prior knowledge of secure examination content. Invalidated scores appear on transcripts as "Score Not Available".

The USMLE program also revised policies applicable to performance data for failing outcomes that raise concerns about an examinees' readiness or motivation to pass the exam. Examinees who meet such criteria may be contacted by the USMLE program and required to allow a twelve (12) month period to pass before attempting USMLE again. The mandatory twelve (12) month bar on access to the exam cannot be appealed and is intended to encourage adequate study time and to pace exam content exposure for individuals who are not performing at a level predictive of passing on the next attempt without additional preparation.

Should an examinee reach out to your board about appealing any USMLE decision, please feel free to contact Frances Cain, MPA, Director of Assessment Services at FSMB, at fcain@fsmb.org to gain clarification.

ECFMG Update Regarding Change to Accreditation Body for Medical Schools in Canada Effective in 2025

According to a recent update from the Educational Commission for Foreign Medical Graduates (ECFMG), a member of Intealth™, individuals who graduate from Canadian medical schools on or after July 1, 2025, will be considered international medical graduates for the purpose of entry into GME programs in the United States. In order for these graduates to enter ACGME-accredited residency programs, the ACGME will require that they either obtain ECFMG Certification or hold a full and unrestricted license to practice medicine in the U.S. licensing jurisdiction in which the ACGME-accredited program is located.

More detailed information is available in this ECFMG update.

2024 USMLE Meetings Calendar

Composite Committee - October 21

State Board Advisory Panel - November 13

Patient Characteristics Advisory Panel - November 22

Management Committee - December 3-4

Committee for Individualized Review - December 3-4

Follow USMLE on Social Media

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Quarterly FSMB Update on USMLE®

December 2024, Vol. 5, No. 4

Reflecting on 2024

As December draws to a close, we want to express our appreciation to the many volunteers from the medical licensing community who devoted their time and effort to support the USMLE program this past year. In particular, we would like to thank those who served on the USMLE Composite and Management Committees in 2024: Andrea Anderson, MD (DC); Jeffrey Carter, MD (MO); Sarvam TerKonda, MD (FL); Danny Takanishi, MD (HI); Nicole Gilg, MD (IA); Jade James-Halbert, MD (MO); Kristin Spanjian, MD (MT); Bryant Murphy, MD (NC); Cheryl Walker-McGill, MD (NC); and Patricia Hunter (VT). We thank these individuals and the many additional volunteers from the state board community who served on other USMLE committees and panels. Their contributions and perspectives are invaluable.

The USMLE program benefited immensely this year from the input of key stakeholders such as our State Board Advisory Panel and Medical Student & Resident Advisory Panel. The same can be said for the participants at our annual USMLE workshop for state medical board members and staff. Their insight and thoughtful input on program activities will continue to help shape our efforts going forward.

We enjoyed the opportunity to inform and update many of you on the USMLE this past summer through the program created and conducted jointly by FSMB and Administrators in Medicine (AIM) for licensing specialists. We are already looking forward to working with the next cohort of licensing specialists registered for the 2025 session.

This year included unique challenges to USMLE governance and staff charged with protecting the security of the USMLE. The enhancements and changes already implemented have further safeguarded the integrity of the USMLE, helping to inform your licensing decisions.

Looking ahead, we remain committed to strengthening USMLE's ability to assess key physician competencies valued by the licensing community. Accordingly, we will keep you apprised of ongoing pilot work on testing formats that can further enhance USMLE assessment of key competencies, e.g., clinical reasoning and communication. At the same time, we will continue exploring new and enhanced ways to keep you informed on USMLE activities.

Finally, we wish all the staff and members at the state medical and osteopathic boards a happy and healthy holiday season.

David Johnson
FSMB Chief Assessment Officer

Alex Mechaber, MD
NBME Vice President of USMLE

USMLE State Board Advisory Panel

The USMLE State Board Advisory Panel met at FSMB's Texas offices on November 13, 2024. The panel brings together board members and staff from state medical and osteopathic boards for in-depth discussions between the licensing community and USMLE program staff. For more than a decade this panel has convened annually as a reactor panel and sounding board offering feedback, advice and input from the medical licensing community on all aspects of the USMLE program.

Current members include the following board staff and members (pictured left to right in the photo above):

- Mustafa Hamed, MD, Michigan-Medical
- Gerard Dillon, PhD, Pennsylvania-Medical
- Maria Laporta, MD, Illinois
- Shami Goyal, MD, Illinois
- Rebecca Robbins, Alabama (Licensure Commission)
- David Herlihy, Esq, Vermont-Medical
- Stephen Boese, New York (Licensure)
- Guillermo Guzman, MD, Idaho
- Stephen Brint Carlton, JD, Texas (not pictured; participated virtually)
- Mark Spangler, MA, CMBE, West Virginia-Medical (not pictured; participated virtually)

Topics discussed during the meeting included examination security; impact of recent USMLE changes, specifically, the attempt limit change, Step 1 pass/fail outcome reporting and discontinuation of Step 2 Clinical Skills (CS); program updates (research, performance data, new item formats); ECFMG Certification expiration and USMLE eligibility requirements; and impact of the impending 2025 change in accreditation of Canadian medical schools on USMLE eligibility requirements.

Annual USMLE Report

The 2024 *Annual Report on the United States Medical Licensing Examination* is now available and has been provided along with this newsletter. The report is distributed via email to all state medical boards and provides a timely snapshot into major developments within USMLE, as well as foundational information explaining the program.

As of 2023, approximately 63% of the 1,062,460 physicians licensed in the U.S. have taken all or part of the USMLE sequence; 58% have taken all Steps (1, 2 and 3). This represents a 2% increase in both measures since 2022. *(Note: Physicians with a partial USMLE sequence include those who took a combination of USMLE and either the previously administered NBME Parts examination or the FLEX examination.)*

Medical licensing authorities and their representatives continue to be key stakeholders and contributors to the USMLE program. In 2024, 44 individuals from 26 state medical and osteopathic boards across the U.S. participated in USMLE in some capacity. Since implementation of the USMLE in 1992, 360 members and staff from state medical boards have participated in the USMLE program in some capacity. These individuals represent 65 different medical and osteopathic licensing boards throughout the country. More detailed information about state boards' involvement with USMLE is provided in the "State Medical Boards Participation in USMLE" section of the report.

State board members and staff who are interested in learning more about USMLE or serving on a USMLE committee, panel or task force can contact Frances Cain, fcain@fsmb.org, for information about participating in the annual USMLE Orientation.

USMLE Meetings Calendar

Management Committee
December 3-4, 2024

Committee for Individualized Review
December 3-4, 2024

Composite Committee
February 11, 2025

Committee for Individualized Review
March 5-6, 2025

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Contact

Frances Cain
Director of Assessment Services
fcain@fsmb.org
(817) 868-4402

APPENDIX B
USMLE Program News 2023 – 2024

Below are excerpts from key USMLE announcements in 2023 - 2024. The full archive of announcements is available on the USMLE website at https://www.usmle.org/announcements

Early Release of USMLE Step 1 2022 Summary Performance (posted February 2023)

In response to requests from LCME schools following the recent policy transition of Step 1 to pass/fail reporting only, USMLE has released Step 1 summary performance data to provide score users with important outcome data earlier than scheduled. The data provides information regarding the performance of all examinees and examinees from LCME-accredited schools.

More information is available at:

https://www.usmle.org/early-release-usmle-step-1-2022-summary-performance

USMLE Program Discusses ChatGPT (posted February 2023)

With the advent of ChatGPT, a large language model developed by OpenAI, there have been growing conversations about the advancements of artificial intelligence (AI) programs and their intersectionality with medicine and medical education. Several studies have been conducted on the use of AI to answer multiple-choice test questions on medical knowledge. Some conversations about these studies seem to suggest that AI tools are correctly answering USMLE test questions and we wanted to provide some additional context.

A review of the MedQA-USMLE database revealed that the study used test preparation materials from a third party unaffiliated with USMLE. Another study examined the results of ChatGPT using practice questions available at USMLE.org. It's not surprising that ChatGPT was successful in answering these questions, as the input material is largely representative of medical knowledge available from online sources.

However, it's important to note that the practice questions used by ChatGPT are not representative of the entire depth and breadth of USMLE exam content as experienced by examinees. For example, certain question types were not included in the studies, such as those using pictures, heart sounds, and computer-based clinical skill simulations. This means that other critical test constructs are not being represented in their entirety in the studies.

Although there is insufficient evidence to support the current claims that AI can pass the USMLE Step exams, we would not be surprised to see AI models improve their performance dramatically as the technology evolves. If utilized correctly, these tools can have a positive impact on how assessments are built and how students learn.

The USMLE co-sponsors (NBME and Federation of State Medical Boards) recognize the importance of these studies and their findings. In the future, we would be very interested in examining the questions that ChatGPT answered incorrectly and the implications of these results. As the technology advances, we will continue to look for ways to enhance the assessment of skills and behavior so that we may evolve in tandem with medical education and potential changes to the practice of medicine. While we are optimistic, we remain mindful of the risks that large language models bring in terms of potential for misinformation and perpetuating harmful biases.

2022 USMLE Performance Data Available Now (posted March 2023)

The USMLE program has released the 2022 examinee performance data for each of its three Step exams. The performance tables show the passing rates for each Step by various examinee groups and are available at: https://www.usmle.org/performance-data.

USMLE Brand Refresh (posted April 2023)

USMLE has refreshed its branding with a new, modernized look and feel that better reflects its relevance to the practice of medicine today.

The new logo features three distinct segments that represent the Step exams that medical school students and graduates take on their journey to medical licensure. It also references a common symbol for health care and medicine – the cross – which represents protection and help at hand.

New Study: USMLE Performance Tied to Better Patient Outcomes (posted November 2023)

A recent article published in *Academic Medicine* explores the correlation between examinee performance on the United States Medical Licensing Examination® (USMLE®) and improved patient outcomes. This new research provides additional support for the validity and importance of USMLE's role in the medical licensure process and the connection between examinee performance and providing safe and effective health care for patients.

The authors conducted a retrospective analysis of nearly 200,000 hospitalizations (with five common inpatient diagnoses) in Pennsylvania over a three-year period with more than 1,750 family physicians and general internists, connecting their USMLE scores with outcomes of in-hospital mortality and

length of stay. Results showed that better physician USMLE performance across the series of exams was associated with lower mortality and shorter length of stay.

Prior studies have documented the link between performance on licensing exams and the number of test attempts with other markers of physician competence – demonstrating associations between USMLE and specialty board exam performance, clinical performance evaluations, and ensuing disciplinary actions by state medical boards. In showing higher USMLE performance connects with improved patient outcomes, this study strengthens the evidence that USMLE assesses competencies essential to patient care.

"The USMLE is designed to ensure that licensed physicians have the necessary knowledge and skills to provide safe and effective patient care," said Alex Mechaber, MD, Vice President, USMLE, NBME. "This latest research further demonstrates the positive correlations between USMLE scores and improved patient outcomes of care,"

For further information about the important and continuing role of independent standardized assessments for medical regulation and the conclusions about trainee/physician performance, read the full paper "The Associations Between United States Medical Licensing Examination Performance and Outcomes of Patient Care" in Academic Medicine.

Change to Step 3 Passing Standard Begins January 1, 2024 (posted December 2023)

At its December 2023 meeting, the USMLE Management Committee, representing a national group of physicians in licensure, medical education, and current practice, and two public members, conducted a review of the USMLE Step 3 passing standard. It was decided that a two-point increase in the passing standard – used to determine a Pass or Fail outcome – will apply to Step 3 examinees testing on or after January 1, 2024. **On the three-digit score scale, the passing standard will change from 198 to 200.**

As part of the USMLE program's operational procedures and in alignment with best practices for licensing and certification exams, a scheduled comprehensive review and analysis of the passing standard for each Step exam typically occurs every three to four years. This ensures that the passing score reflects current expectations concerning knowledge and skills needed to support effective medical practice and patient care.

The Management Committee determined this adjustment to the passing standard through the careful and thorough consideration of information from multiple sources, including:

- Recommendations from independent groups of physicians unaffiliated with the USMLE who participated in content-based standard-setting panels in September and October 2023;
- Results of surveys of various groups (e.g., residency program directors, medical school faculty, state licensing representatives, examinees) concerning the appropriateness of the current passing standard for the Step 3 examination;
- Data on trends in examinee performance; and
- Score precision and its effect on the pass/fail outcome.

The USMLE program provides advanced notice of Step exam passing standard reviews and any adjustments on the USMLE website. Details about the review process also appear in the USMLE *Bulletin of Information.*

The USMLE program updates content outlines for all Step exams (posted January 2024)

To help ensure the relevancy of content on the United States Medical Licensing Examination® (USMLE®), the USMLE program has released an updated content outline for its assessments**.** In this update, topics in the previous "General Principles of Foundational Science" category, which focused on foundational science content, have been redistributed into respective organ system categories or included in a new category titled "Human Development." Learn more about the update with our infographic.

What's the purpose of this update?
The USMLE is created to be clinically relevant by a diverse national faculty of medicine drawn from medical schools, state licensing boards and clinical practice settings from every region of the United States. As practice guidelines evolve or are introduced, the content on the USMLE is reviewed and modified by these experts as needed.

All USMLE examinations are constructed from two classification schemes: (1) an integrated content outline, which organizes content according to individual organ systems, and (2) a physician tasks and competencies outline. To ensure that foundational science principles are tested in a clinically relevant manner, this latest modification to the content outline aims to better incorporate these topics into individual organ systems without changing the proportion of foundational science covered within the exams.

What's the impact of this change?
Foundational science knowledge is a critical building block for future physicians to develop clinical skills and reasoning.

The foundational science topics included in the updated content outline are not being removed, just recategorized. Additionally, the weighting or proportion of foundational science content included in the Step exams will not change.

How will this influence examinee preparation for Step exams?
Examinees preparing for Step exams should use the updated content outline available on USMLE.org. The content outline provides a common organization of content across all three Step examinations. However, no single examination includes questions on all listed topics.

Examinees should continue to study Foundational Science content while preparing for the Step examinations.

When preparing for a Step examination, use the links below for details on which parts of the content outline are emphasized and specific weighting for topics for each Step.
Review Step 1 Exam Specifications
Review Step 2 CK Exam Specifications
Review Step 3 Exam Specifications

USMLE Program Statement on Notification of Invalidated Exam Scores (posted January 2024)

For more than 30 years, the United States Medical Licensing Examination (USMLE) has helped to ensure that physicians licensed to practice medicine in the United States have the knowledge and clinical skills necessary to care for patients safely and effectively. Consequently, ensuring the integrity and validity of the USMLE is paramount. Examinees who take the USMLE agree to uphold the integrity of the testing process, and security measures are in place to detect exam practices or performances that may raise questions of score validity.

The USMLE program regularly monitors and analyzes examinees' test performances for unusual score patterns or variations, and other information that could raise questions about the validity of an examinee's results. As part of an ongoing investigation, the USMLE program has identified a pattern of anomalous exam performance associated with Nepal, which challenges the validity of test results for a group of examinees. Highly irregular patterns can be indicative of prior unauthorized access to secure exam content. Examinees with results in question are being notified by the USMLE Secretariat's Office that their previous Step scores have been invalidated and that they will be required to take a validation exam(s). The USMLE program is working to notify examinees who need to schedule validation exam(s) and to support score users and other stakeholders impacted by the validation exam requirements.

USMLE score reporting timeline update (posted March 2024)

The USMLE program will no longer implement dedicated score delay periods for the Step examinations. Most exam scores will continue to be reported within four weeks after an examinee completes their test. However, in rare cases, various factors may delay score reporting. When selecting your test date and inquiring about results, you should allow at least eight weeks to receive notification that your score report is available.

Important Update: Change in Process for Requesting USMLE Transcripts (posted August 2024)

Effective August 21, 2024, the processing of all United States Medical Licensing Examination® (USMLE®) transcript requests from international medical students and graduates (IMGs) will transition from ECFMG®, a division of Intealth™, to the Federation of State Medical Boards (FSMB), a co-sponsor of the USMLE program. ECFMG will process complete transcript requests received through August 20, 2024. IMGs who wish to request USMLE transcripts after this date must submit their requests and payment to FSMB following the instructions on FSMB's website.

This change does not affect transcripts requested and sent via ERAS. IMGs participating in ERAS 2025 should continue to follow instructions from ERAS for sending their USMLE transcripts to U.S. training programs.

This change streamlines the transcript request process by centralizing all transcript requests (except for ERAS transcripts) with FSMB, which already processes transcript requests from U.S. and Canadian

medical school students and graduates and from certain IMGs (for example, IMGs who want to send a transcript to a U.S. state medical licensing authority).

For more information, please refer to the Important Dates or common questions below.

Important Dates:
August 20, 2024: Deadline for receipt of IMG transcript requests by ECFMG.
August 21, 2024: FSMB begins processing transcript requests for IMGs.

FAQs:

- What's the deadline for an IMG to request a transcript from ECFMG?
    - To help ensure that ECFMG can process your transcript request, the request form and payment must be received by ECFMG no later than August 20, 2024 (U.S. Eastern Time).
- What's the first date to submit a transcript request to FSMB?
    - FSMB will begin accepting transcript requests on August 21, 2024. Please visit FSMB's website and follow the instructions to submit your request and payment.
- I'm an IMG participating in ERAS 2025. Does this change affect electronic transcripts sent to programs via ERAS?
    - No. Electronic transcripts sent to programs for ERAS 2025 are not affected by this change.
- I just submitted a transcript request to ECFMG. Will my transcript be sent? Or do I need to submit a new request?
    - If ECFMG receives your completed transcript request and payment on or before August 20, 2024, your request will be processed, and your transcript will be sent. Please allow several business days for ECFMG to process your request.
    - If your request is received by ECFMG after August 20, 2024, it will not be processed, and you will need to submit a new request and payment to FSMB. To request a refund of transcript fees sent to ECFMG, please contact finance@ecfmg.org.
- How can international medical schools make an institutional request for transcripts for their students and graduates after this change?
    - Institutional requests for transcripts will no longer be offered after August 20, 2024. However, medical students and graduates can still request and pay for their transcripts to be sent directly to their medical school.
- I'm an IMG and will need to request a transcript in September. Where can I find more info on how to do that?
    - To request a transcript after August 20, please visit FSMB's website and follow the instructions to submit your request and payment.
- What is the reason for this change?
    - Currently, multiple organizations receive and process paper transcripts for the USMLE program. This change streamlines the transcript request process by centralizing all transcript requests, except for residency application transcripts (including ERAS), with USMLE co-sponsor FSMB. This change will also allow recipients to receive transcripts more quickly because transcripts will now be delivered electronically via email instead of by mail in paper format.
- Will transcripts still be delivered by mail in paper format?
    - No, after August 20, all transcripts will be delivered electronically via email.

USMLE Fee Assistance Program to Help Learners with Financial Need (posted August 2024)

The United States Medical Licensing Examination® (USMLE®) co-sponsor, NBME, is introducing a new fee assistance program for students with demonstrated financial need who meet the required criteria to use towards the registration cost of the USMLE Step exams. This program will provide aid to approximately 1,300 medical students to cover their fees for USMLE Step 1 or Step 2 Clinical Knowledge (CK) examinations.

Applications for the fee assistance program are open until October 16, 2024. Examinees can learn more at NBME.org.

Scheduled Review of USMLE Step 1 Passing Standard (posted October 2024)

The USMLE Management Committee is scheduled to conduct a review of the passing standard for USMLE Step 1 at its December 2024 meeting.

As part of the USMLE program's operational procedures and in alignment with best practices for licensing and certification exams, a comprehensive review and analysis of the passing standard for each Step exam typically occurs every three to four years. This process ensures that the passing standard aligns with the expected level of content mastery needed to support effective medical practice and licensure.

For the 2024 Step 1 review, information from multiple sources will be considered, including:

- Recommendations from independent groups of physicians and educators unaffiliated with the USMLE participating in content-based standard-setting panels in September and October 2024;
- Survey results of various groups (e.g., state licensing representatives, residency program directors, medical school faculty, examinees) concerning the appropriateness of the current passing standard for the Step 1 examination;
- Data on trends in examinee performance; and
- Score precision and its effect on the pass/fail outcome.

The USMLE program provides advanced notice of Step exam reviews and any adjustments on the USMLE website. The review process also appears in the USMLE *Bulletin of Information*.

If the Committee determines that a change to the passing standard is appropriate, the new recommended passing standard will become effective for all examinees who take the Step 1 examination on or after January 1, 2025. As more information becomes available, updates and the final decision will appear on the USMLE website.

Expiration of ECFMG Certificates and Impact on USMLE Eligibility (posted October 2024)

The USMLE program requires unexpired ECFMG Certification to be eligible for USMLE Step 3. If you have an ECFMG Certificate that is subject to expiration and wish to take Step 3, you must meet the following eligibility requirements:

- Passing scores on Step 1 and Step 2 CK, AND

- An MD degree or the DO degree from an LCME- or COCA-accredited US or Canadian medical school, OR the equivalent of the MD degree from a medical school outside the US and Canada that is listed in the World Directory of Medical Schools as meeting ECFMG eligibility requirements and AND **obtain ECFMG Certification which is valid and unexpired at the time of application and testing,**
- Meet all other eligibility criteria as listed in the USMLE Bulletin of Information.

If you have questions about your eligibility to take Step 3, please contact the FSMB at +1 (817) 868-4041 or usmle@fsmb.org.

If you have any questions regarding the status of your ECFMG Certification, please contact ECFMG at +1 (215) 386-5900 or info@ecfmg.org.

Policy re non-expired ECFMG Certificates and Step 3 eligibility FAQs

1. Am I eligible to apply for and take USMLE Step 3 if my ECFMG Certificate has expired?
   No, applicants must have a valid and unexpired ECFMG Certificate at the time of application and on the testing dates for USMLE Step 3.

2. Can I select an eligibility period that includes dates beyond the date my ECFMG Certificate expires?
   No, applicants must have a valid and unexpired ECFMG Certificate at the time of application and on the testing dates for USMLE Step 3. Therefore, examinees must select an eligibility period with an end date before the expiration date of their ECFMG Certificate.

3. Can I extend my eligibility period beyond the date my ECFMG Certificate expires?
   No, applicants must have a valid and unexpired ECFMG Certificate at the time of application and on the testing dates for USMLE Step 3. Therefore, examinees cannot extend their eligibility period beyond the expiration date of their ECFMG Certificate.

4. I have questions about my ECFMG Certificate expiration and/or renewal process. Who should I contact?
   Please contact ECFMG at info@ecfmg.org with any questions about ECFMG Certification.

Change in Provision of USMLE Service Functions

The co-sponsors of the United States Medical Licensing Examination® (USMLE®), the Federation of State Medical Boards (FSMB) and NBME, are developing plans to centralize all USMLE service functions. As part of these plans, USMLE services currently provided to international medical students and graduates (IMGs) by ECFMG®, a division of Intealth™, will transition to the USMLE co-sponsors.

This change will consolidate all USMLE examinee services, including exam registration, score report delivery, and USMLE customer service, with the USMLE co-sponsors. The goal of this change is to streamline the examinee journey and to create a more consistent and efficient examinee experience.

APPENDIX C
USMLE Aggregate Performance Data 2022-2023

The data tables below are extracted from the performance data provided on the USMLE website at https://www.usmle.org/performance-data. Performance data for USMLE administrations dating back to 2012 are also available on the website.

Table 1.C

2023 STEP 1 ADMINISTRATIONS *
Number Tested and Percent Passing

	# Tested	% Passing
Examinees from US/Canadian Schools that Grant:		
MD Degree	25,146	90%
1st Takers	23,100	92%
Repeaters**	2,046	70%
DO Degree	4,913	86%
1st Takers	4,798	87%
Repeaters**	115	60%
Total US/Canadian	30,059	90%
Examinees from Non-US/Canadian Schools		
1st Takers	22,611	72%
Repeaters**	3,530	47%
Total non-US/Canadian	26,141	68%

*Represents data for examinees that tested in 2023 whose scores were reported through February 21, 2024.
**Repeaters represents examinations given, not number of examinees.

Table 2.C

2022-2023 STEP 2 CK ADMINISTRATIONS *
Number Tested and Percent Passing

	# Tested	% Passing
Examinees from US/Canadian Schools that Grant:		
MD Degree	23,500	98%
1st Takers	23,018	98%
Repeaters**	482	71%
DO Degree	4,712	96%
1st Takers	4,666	96%
Repeaters**	46	61%
Total US/Canadian	28,212	97%
Examinees from Non-US/Canadian Schools		
1st Takers	14,395	88%
Repeaters**	1,411	60%
Total non-US/Canadian	15,806	86%

*Data for Step 2 CK are provided for examinees that tested during the period of July 1, 2022, to June 30, 2023 whose scores were reported through November 8, 2023.
**Repeaters represents examinations given, not number of examinees.

Table 3.C

2023 STEP 3 ADMINISTRATIONS *
Number Tested and Percent Passing

	# Tested	% Passing
Examinees from US/Canadian Schools that Grant:		
MD Degree	22,405	97%
1st Takers	21,703	97%
Repeaters**	702	77%
DO Degree	104	95%
1st Takers	100	95%
Repeaters**	4	†
Total US/Canadian	22,509	97%
Examinees from Non-US/Canadian Schools		
1st Takers	11,500	92%
Repeaters**	1,264	64%
Total non-US/Canadian	12,764	89%

*Represents data for examinees that tested in 2023 whose scores were reported through March 13, 2024.
**Repeaters represents examinations given, not number of examinees.
†Performance data not reported for categories containing fewer than 5 examinees.

APPENDIX D
Program-related Publications by USMLE Staff in 2022-2024

Andriole DA, Grbic D, Jurich DP, Mechaber AJ, Roskovensky L, Young GH. US Medical School Graduates' Placement in Graduate Medical Education: A National Study. *Acad Med*. 2023:10.1097.

Baldwin P, Clauser BE. Historical perspectives on score comparability issues raised by innovations in testing. *J Educ Meas*. 2022;59(2):140-160.

Baldwin P, Mee J, Yaneva V, et al. A Natural-Language-Processing-Based Procedure for Generating Distractors for Multiple-Choice Questions. *Eval Health Prof*. Dec 2022;45(4):327-340. doi:10.1177/01632787211046981

Barone MA, Bienstock JL, Lovell E, et al. How the Quadruple Aim Widens the Lens on the Transition to Residency. *J Grad Med Educ*. 2022;14(6):634-638.

Clauser BE, Yaneva V, Baldwin P, An Ha L, Mee J. Automated Scoring of Short-Answer Questions: A Progress Report. *Appl Meas Educ*. 2024;37(3):209-224.

Cuddy, M. M., Liu, C., Ouyang, W., Barone, M. A., Young, A., & Johnson, D. A. An Examination of the Associations Among USMLE Step 3 Scores and Likelihood of Disciplinary Action in Practice. Academic Medicine. *Acad Med*. Oct 2022;97(10):1504-1510. doi: 10.1097/ACM.0000000000004775

Fan F, O'Donnell F, Morrison C, Durand L, Barone M. Revisiting the Utility of the National Board of Medical Examiners Comprehensive Basic Science Self-Assessment to Gauge Readiness for USMLE Step 1. *Med Sci Educ*. 2024:1-7.

Gierl M, Swygert K, Matovinovic D, Kulesher A, Lai H. Three Sources of Validation Evidence Needed to Evaluate the Quality of Generated Test Items for Medical Licensure. *Teach Learn Med*. Jan-Mar 2024;36(1):72-82. doi:10.1080/10401334.2022.2119569

Harik P, Mee J, Runyon C, Clauser BE. Assessment of clinical skills: a case study in constructing an NLP-based scoring system for patient notes. *Advancing Natural Language Processing in Educational Assessment*. Routledge; 2023:58-73.

Hauer KE, Williams PM, Byerley JS, Swails JL, Barone MA. Blue Skies With Clouds: Envisioning the Future Ideal State and Identifying Ongoing Tensions in the UME-GME Transition. *Acad Med*. Feb 1 2023;98(2):162-170. doi:10.1097/ACM.0000000000004920

Jurich DP, Liu C, Clauser A. To the Editor: Limitations and alternative solutions to a USMLE COMLEX-USA concordance. Journal of Graduate Medical Education. 2022;353-354.

Mee J, Pandian R, Wolczynski J, et al. An experimental comparison of multiple-choice and short-answer questions on a high-stakes test for medical students. *Adv Health Sci Educ Theory Pract*. Jul 2024;29(3):783-801. doi:10.1007/s10459-023-10266-3

Norcini J, Grabovsky I, Barone MA, Anderson MB, Pandian RS, Mechaber AJ. The associations between United States medical licensing examination performance and outcomes of patient care. *Acad Med*. 2024;99(3):325-330.

Rashid H, Runyon C, Burk-Rafel J, et al. Medical Student Well-Being While Studying for the USMLE Step 1: The Impact of a Goal Score. *Acad Med*. 2022;97(11S):S176.

Rubright JD, Jodoin M, Woodward S, Barone MA. Differential Item Functioning Analysis of United States Medical Licensing Examination Step 1 Items. *Acad Med*. May 1 2022;97(5):718-722. doi:10.1097/ACM.0000000000004567

Rubright JD, Ong TQ, Jodoin MG, Johnson DA, Barone MA. Revisiting Retake Policy: Analyzing the Success Rates of Examinees With Multiple Attempts on the United States Medical Licensing Examination. *Acad Med*. Aug 1 2022;97(8):1219-1225. doi:10.1097/ACM.0000000000004713

Runyon CR, Harik P, Barone MA. "Cephalgia" or "migraine"? Solving the headache of assessing clinical reasoning using natural language processing. *Diagnosis (Berl)*. Feb 1 2023;10(1):54-60. doi:10.1515/dx-2022-0047

Swails JL, Angus S, Barone MA, et al. The undergraduate to graduate medical education transition as a systems problem: a root cause analysis. *Acad Med*. 2023;98(2):180-187

Yaneva V, Baldwin P, Jurich DP, Swygert K, Clauser BE. Examining ChatGPT Performance on USMLE Sample Items and Implications for Assessment. *Acad Med*. Feb 1 2024;99(2):192-197. doi:10.1097/ACM.0000000000005549

Yaneva V, Baldwin P, Runyon C. Extracting Linguistic Signal From Item Text and Its Application to Modeling Item Characteristics. *Advancing Natural Language Processing in Educational Assessment*. Routledge; 2023:167-182.

Yaneva V, Clauser BE, Morales A, Paniagua M. Assessing the validity of test scores using response process data from an eye-tracking study: a new approach. *Adv Health Sci Educ Theory Pract*. Dec 2022;27(5):1401-1422. doi:10.1007/s10459-022-10107-9

Yaneva, V., Mee, J., Ha, L. A., Harik, P., Jodoin, M., & Mechaber, A. (2022, July). The USMLE® Step 2 clinical skills patient note corpus. Association for Computational Linguistics.

Yaneva V, North K, Baldwin P, et al. Findings from the first shared task on automated prediction of difficulty and response time for multiple-choice questions. In: *Proceedings of the 19th Workshop on Innovative Use of NLP for Building Educational Applications*. Association for Computational Linguistics; 2024:470-482.

Yaneva V, Suen KY, Mee J, Quranda M, Harik P. Automated scoring of clinical patient notes: findings from the Kaggle competition and their translation into practice. In: *Proceedings of the 19th Workshop on Innovative Use of NLP for Building Educational Applications*; 2024:87-98.

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An Informational Overview from the Federation of State Medical Boards & National Board of Medical Examiners

December 2024

Topics

- What is USMLE?
- Why is USMLE important?
- How is USMLE governed?
- How is the exam developed?
- How is the pass/fail standard determined?
- What enhancements to USMLE are being explored?
- How can I get more information or data?

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What is USMLE?

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United States Medical Licensing Examination (USMLE)

- The USMLE is a jointly sponsored program of
  - Federation of State Medical Boards (FSMB)
  - National Board of Medical Examiners (NBME)

- ECFMG/Intealth is a key collaborator

USMLE℠

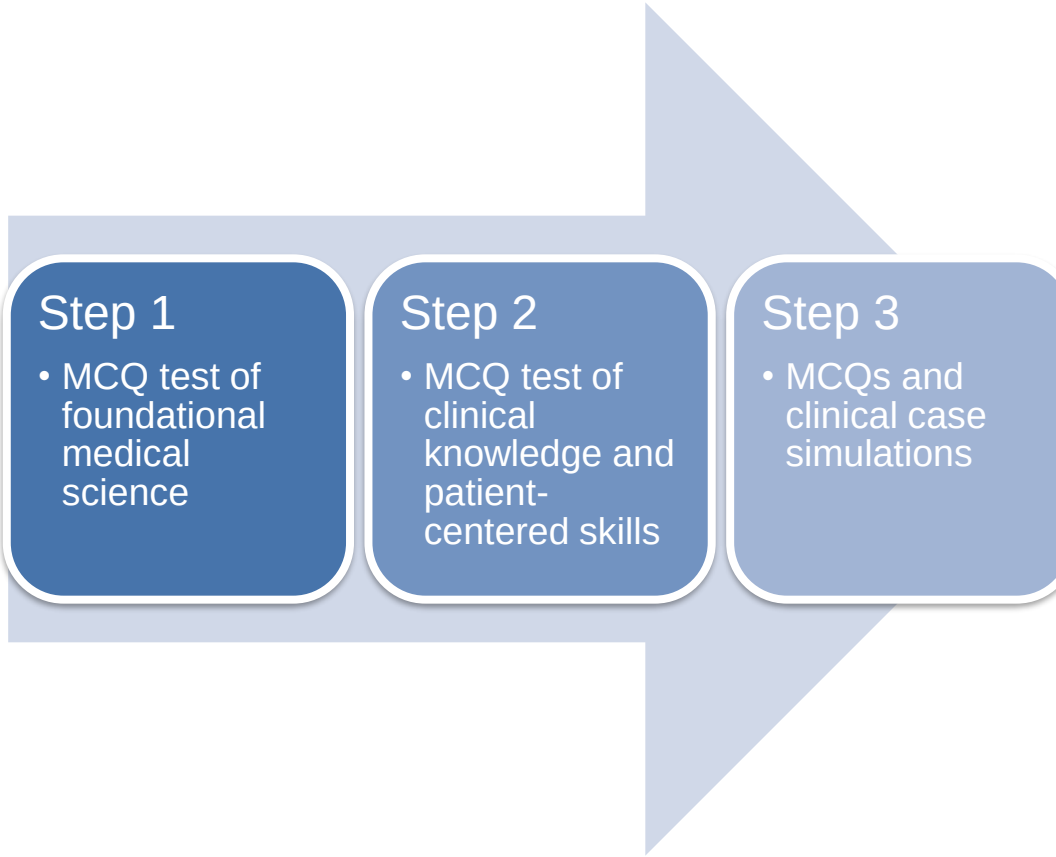
Introduction to USMLE

- Established in 1991… over 3 million test administered to date
- Single exam composed of 3 “Steps”
- Provides state boards with assessment of physician knowledge, clinical and communication skills
- As of 2023, 63% of all licensed physicians in the US have taken all or part of the USMLE sequence
  - 58% have taken all Steps (1, 2 and 3)
  - This is a 2% increase in both measures since 2022
- A required examination for graduates of accredited US medical schools granting MD degree, and all graduates of international medical schools
  - Open to students and graduates of accredited osteopathic medical schools granting DO degree

USMLE℠

USMLE:
A single three Step examination for initial medical licensure

- Assesses physician cognitive, clinical and communication skills
- Provides a national standard
- Assists medical boards in their public protection mission
- Facilitates license portability



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Comparison of USMLE Components

		Step 1	Step 2		Step 3
			CK	CS*	
Eligibility requirements		Medical student/graduate			• MD or DO • Pass Steps 1 & 2 • GME**
Test administration		• Offered year-round • 4 attempt limit per Step • Limited to 3 attempts within a 12-month period • 4th attempt must be 12 months after first attempt & six months from most recent attempt			
Test length (days)		1	1	1	2
Format	MCQ items***	280	318		412
	SP stations			12	
	CCS cases				13

* Discontinued January 2021; attempts and results still reported on official USMLE transcripts

** GME recommended but not required

*** Approximate

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Why is USMLE important?

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Users and Uses of USMLE Results

User	Step 1	Step 2	Step 3
Licensing Jurisdictions	Protecting the health of the public Training and unrestricted licenses		
ECFMG (International graduates only)	ECFMG Certification Entry into GME in the U.S.		
Medical Schools	Promotion & graduation decisions Curriculum evaluation		
Residency Programs	Screening for interviews Ranking of applicants		
LCME	Accreditation (aggregated results)		
Examinees	(all of the above)		

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How is USMLE governed?

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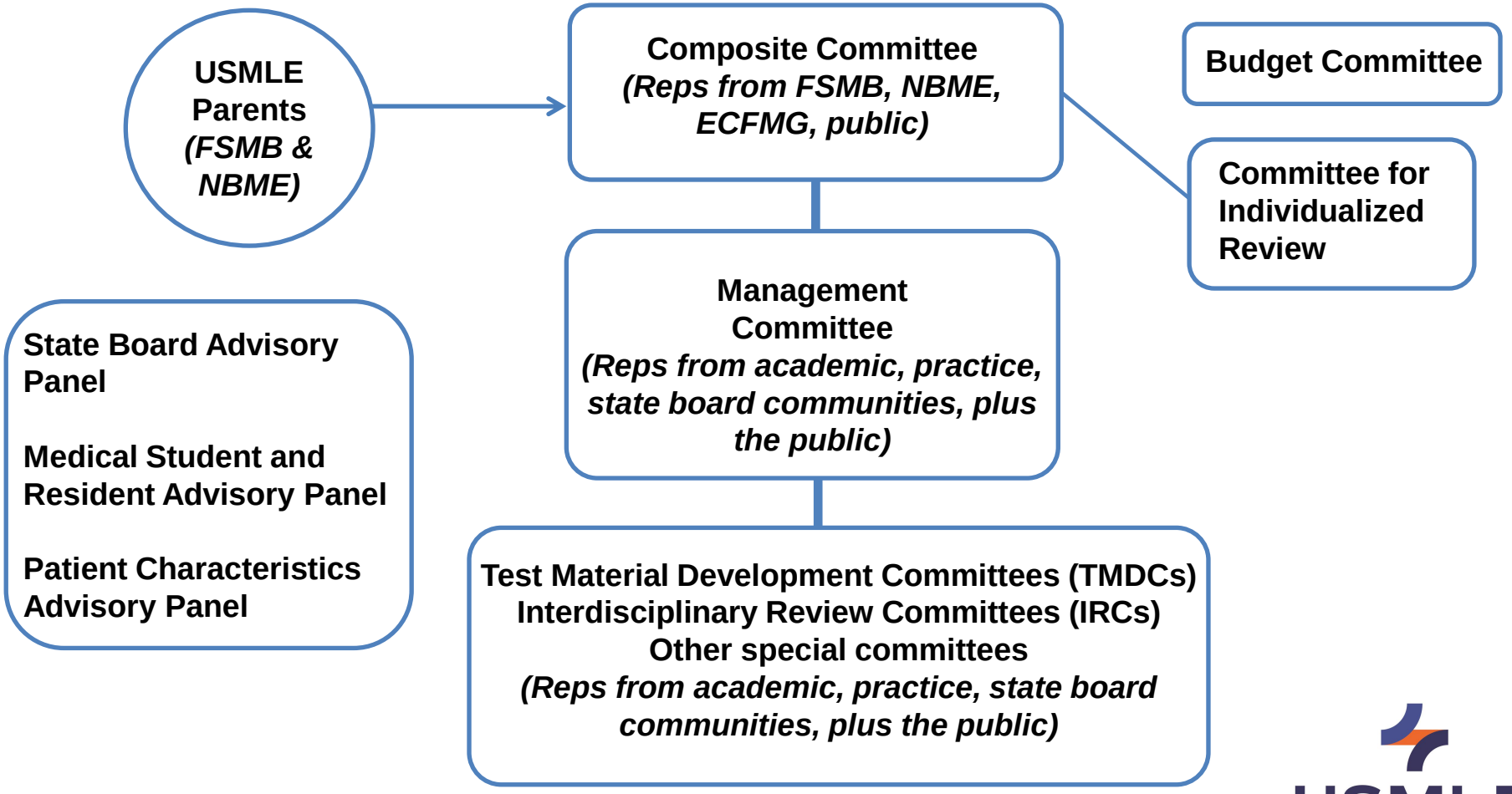
USMLE Committee Structure



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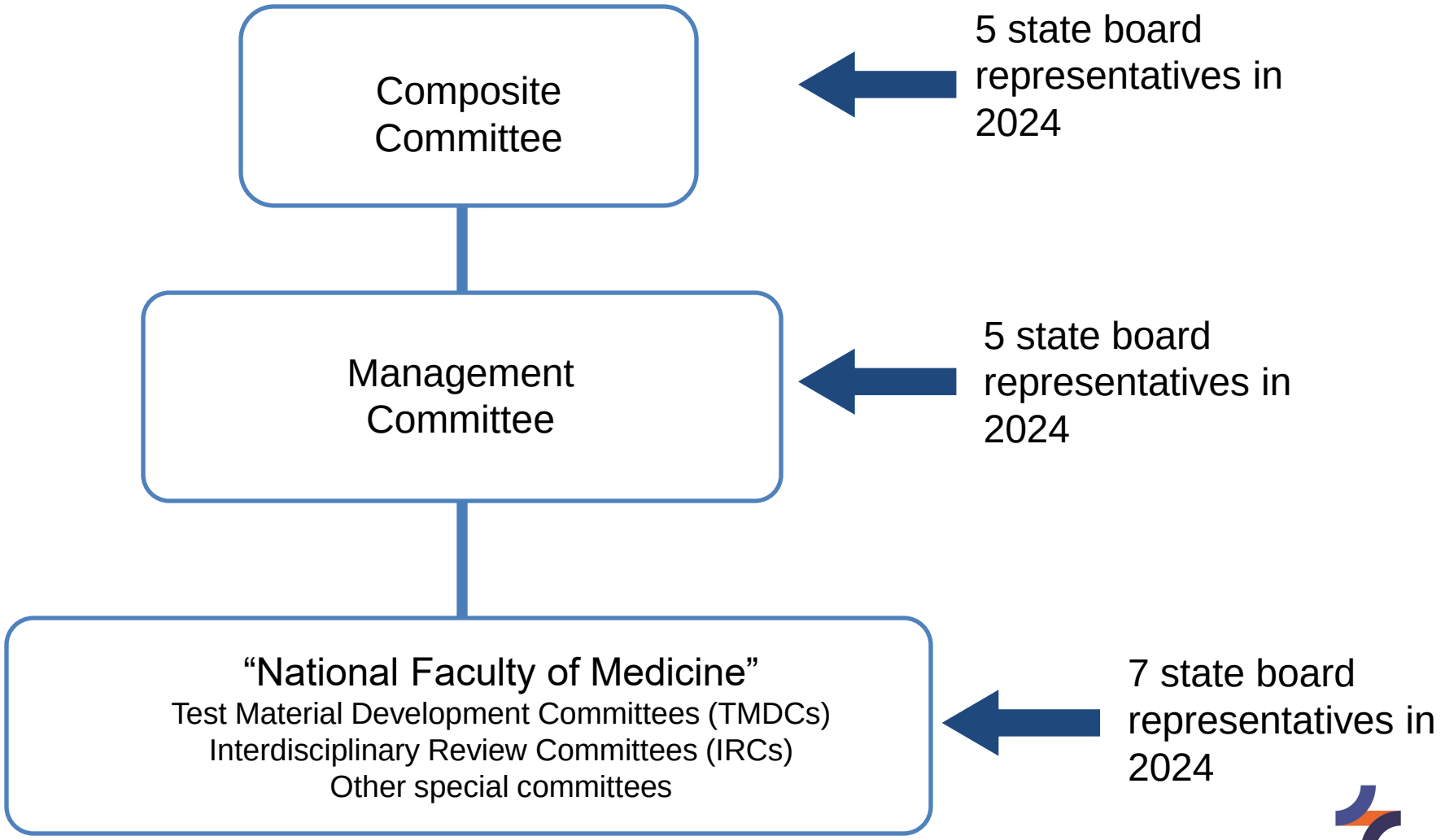
USMLE Committee Structure



How is the exam developed?

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Developing Content for USMLE

- Content is developed by a “national faculty” of physicians and scientists…
  - All volunteers
  - Drawn from the academic, licensing and practice communities
  - 400+ physicians representing specialties and expertise from across the country

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USMLE Test Development

- All items and cases…
  - Are developed and reviewed by content experts
  - Pass through multiple levels of review
  - Are pre-tested prior to use as live (scored) material
- Each Step…
  - Uses multiple test forms
  - Has thousands of items (or hundreds of cases) in the test pool

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How is the pass/fail standard determined?

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Standard Setting
(minimum passing score)

- USMLE uses an “absolute” standard
  - A minimum level of demonstrated proficiency for examinees is established in advance; there is no ‘curve’ applied
- Set by the USMLE Management Committee
- Reviewed approximately every 4 years

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Standard Setting (cont'd)

- Management Committee reviews information & data from variety of sources
  - Results from standard setting exercises involving panels of physician experts unaffiliated with USMLE
  - Survey input from state boards, deans, faculty, students
  - Trends in examinee performance
  - Data on reliability of scores

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How can I get more information or data?

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USMLE Website

https://www.usmle.org/usmle-updates-research

- Performance Data
- Score Interpretation Guidelines
- Research & USMLE-related publications

https://www.usmle.org/what-to-know/exam-security-fairness

- Irregular Behavior

https://www.usmle.org/common-questions

- FAQs

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Other Informational Resources

- Quarterly FSMB Update on USMLE
- Extensive research on USMLE has been published in professional, peer-review journals such as *Academic Medicine*
- FSMB webinars on topics such as.….
  - USMLE scoring
  - Annotating for irregular behavior
  - Communication with state boards
- FSMB publications
  - *Journal of Medical Regulation* (pictured), *eNews, NewsLine*

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USMLE on Social Media

- linkedin.com/company/usmle
- facebook.com/usmle/
- x.com/theusmle

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It has come to the attention of the Washington State Board of Optometry that the Washington Medical Commission intends to issue an interpretive statement recommending that the physician entering an agreement with optometrists for advanced procedures be restricted only to ophthalmologists.

The Board of Optometry would like to comment that a large part of the legislative intent of optometry advanced procedures was to improve access to care especially in the very rural areas of the state. If the legislature intended the term “qualified physician” to be specifically ophthalmologists only, they would have stated that in the law. Other physician groups such as dermatology, emergency medicine as well as others are more than qualified to handle the majority of complications associated with optometry advanced procedures and including them would allow for improved access to care.

The Washington State Board of Optometry would like to see any interpretive statement issued by the Washington Medical Commission regarding optometry advanced procedures that includes a broader range of physician categories than just ophthalmology. Thank you for consideration in this matter.