Nursing Care Quality Assurance Commission (NCQAC)
Meeting Agenda
November 18, 2022
8:30 AM- 5:00 PM

Register in advance for this meeting:
https://us02web.zoom.us/meeting/register/tZAvdeyrpz4uGtUN-DEpjsGVOZ8pskFqLDQx
After registering, you will receive a confirmation email containing information about joining the meeting.

This is a virtual meeting, if you would like to participate in the virtual meeting and you don't have computer or phone access you may attend at:
Labor & Industries: 7273 Linderson Wy SW, Tumwater, WA 98501, Room S117.

Masks are required for in person attendees.

Commission Members:	Yvonne Strader, RN, BSN, BSPA, MHA, Chair Helen Myrick, Public Member, Vice-Chair Adam Canary, LPN, Secretary/Treasurer Jonathan Alvarado ARNP, CRNA Quiana Childress, GCertHealthSc, BS, LPN Ella B. Guilford, MSN, M.Ed., BSN, RN Joan Madayag, LPN Judy Loveland-Morris, Public Member Dawn Morrell, RN, BSN, CCRN MaiKia Moua, RN, BSN, MPH Sharon Ness, RN Emerisse Shen, RN, ARNP Kimberly Tucker PhD, RN, CNE
Assistant Attorney General:	Sierra McWilliams, Assistant Attorney General
Staff:	Paula R. Meyer, MSN, RN, FRE, Executive Director Chris Archuleta, Director, Operations and Finance Gerianne Babbo, Ed.D, MN, RN, Director, Education Shad Bell, Assistant Director, Operations Amber Bielaski, MPH, Assistant Director, Licensing Debbie Carlson, MSN, RN, CPM, Director, Practice Mary Sue Gorski, PhD, RN, Director, Advanced Practice, Research and Policy Karl Hoehn, JD, FRE, Assistant Director, Discipline – Legal Grant Hulteen, Assistant Director, Discipline – Investigations and WHPS Bethany Mauden, Administrative Assistant Kathy Moisio, PhD, RN, Director, Nursing Assistant Programs Catherine Woodard, Director, Discipline and WHPS

If you have questions regarding the agenda, please call the Nursing Care Quality Assurance Commission (NCQAC) office at 360-236-4713. Agenda items may be presented in a different order. If you wish to attend the meeting for a single item, contact our office at the number listed above and request a specific time scheduled for that item. If you have limited English language expertise, call 360-236-4713 before November 10, 2022.

This meeting is accessible to persons with disabilities. Special aids and services can be made available upon advance request. Advance request for special aids and services must be made no later than November 10, 2022. If you need assistance with special needs and services, please leave a message with your request at 1-800-525-0127 or, if calling from outside Washington State, call 360-236-4052. TDD may also be accessed by calling the TDD relay service at 711. If you need assistance due to a speech disability, Speech-to-Speech provides human voicers for people with difficulty being understood. The Washington State Speech to Speech toll free access number is 1-877-833-6341.

This meeting will be digitally recorded to assist in the production of accurate minutes. All recordings are public record. The minutes of this meeting will be posted on our website after they have been approved at the January 13, 2023, NCQAC meeting. For a copy of the actual recording, please contact the Public Disclosure Records Center (PDRC) at PDRC@doh.wa.gov.

If attending remotely, please mute your connection in order to minimize background noise during the meeting.

Smoking and vaping are prohibited at this meeting.

I. 8:30 AM Opening – Yvonne Strader, Chair – DISCUSSION/ACTION

II. Call to Order

A. Introductions
B. Order of the Agenda
C. Land Acknowledgement – Dr. Kimberly Tucker
D. Announcements

III. 8:40 AM Consent Agenda – DISCUSSION/ACTION

Consent Agenda items are considered routine and are approved with one single motion

A. Approval of Minutes

1. NCQAC Business Meeting
    a. September 8, 2022
    b. September 9, 2022
2. Advanced Practice Subcommittee
    a. August 17, 2022
    b. September 21, 2022
3. Discipline Subcommittee
    a. No minutes to review
4. Consistent Standards of Practice Subcommittee
    a. August 5, 2022

III. Consent Agenda – DISCUSSION/ACTION, continued

5. Education Subcommittee
    a. October 3, 2022
6. Licensing Subcommittee
    a. August 9, 2022
    b. September 2022 – No meeting
7. Research Subcommittee
    a. July 18, 2022

B. Letter from NCSBN President Jay Douglas

1. October 10, 2022
2. October 12, 2022

C. Performance Measures

1. Investigations
    a. August 2022
    b. September 2022
    c. October 2022
2. Legal
    a. August 2022
    b. September 2022
    c. October 2022
3. Washington Health Professional Services (WHPS)
    a. August 2022
    b. September 2022
    c. October 2022
4. Nursing Assistant Program Approval Panel (NAPAP)
5. Nursing Program Approval Panel (NPAP)

D. Licensing Report to the Governor's Office

E. Washington Center for Nursing/NCQAC monthly meetings

1. September 6, 2022
2. October 25, 2022

F. Out of State Travel Reports

1. Summit on Well Being and Resilience in Health Care, John Furman, September 28 – September 30, Columbus OH
2. Federated Association of Regulatory Boards, Karl Hoehn, Miranda Bayne, Jeff Lippert, Bethany Mauden, September 29 – October 1, Reston VA
3. National Association of Drug Diversion Investigators, Barb Justice, Kristl Pohl, Rashelle Beal, October 4-7, Indianapolis IN
4. Tri Regulator Meeting, Paula Meyer, October 13, Alexandria VA
5. Advanced Practice in Primary Care National Conference, Mary Sue Gorski, Emerisse Shen, October 27, Seattle WA

IV. 8:45 AM – 9:00 AM NCQAC Panel Decisions – DISCUSSION

The NCQAC delegates the authority as provided by law for certain decision to a panel of at least three members. A member of the NCQAC must chair panels. Pro tem members of NCQAC may serve as panel members. The following decisions are provided for information.

A. Nursing Program Approval Panel (NPAP)

1. September 1, 2022
2. September 15, 2022
3. October 6, 2022
4. October 27, 2022
5. November 3, 2022

B. Nursing Assistant Program Approval Panel (NAPAP)

1. September 12, 2022
2. October 10, 2022

V. 9:00 AM – 9:45 AM Chair Report – Yvonne Strader – DISCUSSION/ACTION

A. Search Committee
B. Joint Operating Agreement
C. Dates and location of NCQAC meetings through December 2023
D. NCQAC Annual Evaluation summary
E. Nominations committee – appoint members

9:45 AM – 10:00 AM Break

VI. 10:00 AM – 10:45 AM Executive Director Report – Paula Meyer – DISCUSSION/ACTION

A. Budget Report – Adam Canary, Chris Archuleta
B. Strategic Plan Update

1. Academic Progression
2. Communications
3. Nursing Assistants
4. WHPS

C. Rules Update – Jessilyn Dagum
D. HELMS Update
E. Decision packages

1. Student Nurse Preceptor Grant technical correction
2. Licensing staffing

VII. 10:45 AM – 11:45 AM Sub-committee Report – DISCUSSION/ACTION

A. Advanced Practice – Jonathan Alvarado, Chair

1. Legislative Decision Package – APRN Title Protection

VIII. 10:45 AM – 11:45 AM Sub-committee Report – DISCUSSION/ACTION Continued

A. Consistent Standards of Practice – Sharon Ness, Chair
1. SB 5183 Forensic Nurse Examiner Training Summary Report to Legislature – Shana Johnny
2. Advisory Opinion Request: Endoscopy Procedures: Licensed Practical Nurse Scope of Practice – Sharon Ness

B. Discipline – Adam Canary, Chair
1. No report

C. Licensing – Dawn Morrell, Chair
1. No report

D. Research – Sharon Ness, Chair
1. New employees

E. Education – Kimberly Tucker, Chair
1. Defining quality simulation

11:45 AM – 1:00 PM Lunch

IX. 12:00 PM – 1:00 PM Education Session

Katie Haerling, PhD, RN, CHSE, Professor, University of Washington Tacoma School of Nursing and Healthcare Leadership, Pro Tem Member Nursing Care Quality Assurance Commission, will present preliminary findings of her work titled; "Informing evidence-based regulation of simulation in nursing education"

X. 1:00 PM – 1:15 PM Public Comment

This time allows for members of the public to present comments to the NCQAC. If the public has issues regarding disciplinary cases, please call 360-236-4713.

XI. 1:15 PM – 2:00 PM Education – Dr. Gerianne Babbo, Dr. Kathy Moisio - DISCUSSION/ACTION

A. Student Nurse Preceptor Grant Program – Victoria Hayward
B. Clinical Placement Updates
C. Updates on the Nursing Assistant Curriculum, Rules, and Testing
D. Progress Report: LPN Registered Apprenticeship – Marlin Galiano

2:00 PM – 2:15 PM Break

XII. 2:15 PM – 3:00 PM State Auditor Office, Prescription Monitoring Program audit results – Paula Meyer – DISCUSSION/ACTION

The State Auditor Office (SAO) performed an audit of the Prescription Monitoring Program (PMP). The audit report and a summary are included in the packet of materials for this meeting. Ms. Meyer provides an overview of the PMP, the results of the audit, and potential actions. Ms. Carly Bartz-Overman is the PMP manager and will be attending the meeting for any questions.

XIII. 3:00 PM – 3:30 PM Long Term Care Workforce and Economic Trends and Conditions– Carma Matti-Jackson – DISCUSSION/ACTION

Ms. Matti-Jackson describes the current economic status of long-term care in Washington State. Carma's presentation includes information on nurse staffing and its impact on the ability for long term care facilities to provide services for residents.

XIV. 3:30 PM – 4:00 PM Legislative Panel – Helen Myrick – DISCUSSION/ACTION

A. Nurse Delegation in Community Based and In Home Care Settings and Children with Tracheostomies/Ventilator Dependent
B. Meeting dates and times

XIV. 4:00 PM – 4:15 PM Meeting Evaluation

XV. 4:15 PM Closing

Nursing Care Quality Assurance Commission (NCQAC)
Meeting Minutes
September 8, 2022
8:30 AM – 3:00 PM

Commission Members:	Yvonne Strader, RN, BSN, BSPA, MHA, Chair Helen Myrick, Public Member, Vice-Chair Adam Canary, LPN, Secretary/Treasurer Jonathan Alvarado ARNP, CRNA Ella B. Guilford, MSN, M.Ed., BSN, RN Joan Madayag, LPN Judy Loveland-Morris, Public Member Dawn Morrell, RN, BSN, CCRN MaiKia Moua, RN, BSN, MPH Sharon Ness, RN Kimberly Tucker PhD, RN, CNE
Excused:	Quiana Childress, GCertHealthSc, BS, LPN Emerisse Shen, RN, ARNP
Assistant Attorney General:	Sierra McWilliams, Assistant Attorney General
Staff:	Paula R. Meyer, MSN, RN, FRE, Executive Director, excused Chris Archuleta, Director, Operations Gerianne Babbo, Ed.D, MN, RN, Director, Education Shad Bell, Assistant Director, Operations Amber Bielaski, MPH, Assistant Director, Licensing Debbie Carlson, MSN, RN, CPM, Director, Practice Mary Sue Gorski, PhD, RN, Director, Advanced Practice, Research and Policy Karl Hoehn, JD, FRE, Assistant Director, Discipline – Legal Grant Hulteen, Assistant Director, Discipline – Investigations and WHPS Bethany Mauden, Administrative Assistant Kathy Moisio, PhD, RN, Director, Nursing Assistant Programs Catherine Woodard, Director, Discipline and WHPS

I. 8:30 AM Opening – Yvonne Strader, Chair – DISCUSSION/ACTION

II. Call to Order

A. Introductions
B. Order of the Agenda

ACTION: Mr. Canary moved to amend the order of agenda as Ms. Meyer was unable to attend. The motion was seconded by Ms. Guilford. The motion passed.

C. Land Acknowledgement – Dawn Morrell

D. Announcements

III. 8:40 AM Consent Agenda – DISCUSSION/ACTION

Consent Agenda items are considered routine and are approved with one single motion. **ACTION**: Dr. Tucker motioned to approve the consent agenda. The motion was seconded by Ms. Guilford. The motion passed.

A. Approval of Minutes

1. NCQAC Business Meeting
    a. July 7, 2022
    b. July 8, 2022
2. Advanced Practice Subcommittee
    a. May 18, 2022
    b. June 2022 – Cancelled
    c. July 2022 – Cancelled
3. Discipline Subcommittee
    a. June 21, 2022
4. Consistent Standards of Practice Subcommittee
    a. June 3, 2022
5. Licensing Subcommittee
    a. June 21, 2022
    b. July 2022 – No Meeting
6. Research Subcommittee
    a. June 21, 2022
    b. August 2022 – Cancelled
7. Education Subcommittee
    a. July 25, 2022

B. Letter from NCSBN President Jay Douglas

C. Performance Measures

1. Investigations
2. Legal
3. Washington Health Professional Services (WHPS)
4. Nursing Assistant Program Approval Panel (NAPAP)
5. Nursing Program Approval Panel (NPAP)

D. Licensing Report to the Governor's Office

E. Washington Center for Nursing/NCQAC monthly meetings

1. July 26, 2022

IV. NCQAC Panel Decisions – DISCUSSION

The NCQAC delegates the authority as provided by law for certain decision to a panel of at least three members. A member of the NCQAC must chair panels. Pro Tem members of NCQAC may serve as panel members. The following decisions are provided for information and are available in the packet.

A. Nursing Program Approval Panel (NPAP)

1. July 13, 2022
2. July 21, 2022
3. August 4, 2022
4. August 11, 2022

B. Nursing Assistant Program Approval Panel (NAPAP)

1. July 11, 2022
2. August 8, 2022

V. Chair Report – Yvonne Strader – DISCUSSION/ACTION

A. Search Committee -

Ms. Strader reported on the Search Committee progress. The position description for the executive director has been posted and advertised. Several applications had been received at the time of the meeting. Committee members are developing interview questions. **Next NCQAC meetings: November 18, January 13**
Ms. Strader discussed future NCQAC meeting locations in November and January. Due to DOH not being open to the public and weather concerns, the NCQAC determined the meetings will be held virtually with a small conference room at DOH where members of the public can access a computer to be present at the meeting.
ACTION: Ms. Moua moved to hold the next two meetings virtually with a space for the public to participate. Mr. Canary seconded the motion. The motion passed.

B. Joint Operating Agreement

The officers and staff will be meeting with the Department Of Health (DOH) in the future for negotiations.

C. NCQAC Annual Survey

Ms. Strader discussed the NCQAC Annual Survey. Typically, the survey is held in March, but will take place in September and October. Ms. Strader requested two members work with Ms. Laura Christensen on the survey. Ms. Guilford and Ms. Moua volunteered.

D. Research Subcommittee members

Ms. Strader appointed Dr. Judy Loveless-Morris to the research subcommittee.

E. Executive Director Leave Approval Procedure J 22.01

ACTION: Ms. Ness moved to adopt the Executive Director Leave Approval Procedure J22.01, Ms. Guilford seconded the motion. The motion passed.

VI. 9:45 AM – 10:30 AM Executive Director Report – Paula Meyer – DISCUSSION/ACTION

Ms. Woodard gave the Executive Director Report for Ms. Meyer.

A. Budget Report – Adam Canary, Chris Archuleta

Mr. Archuleta presented the budget report. The report covers the period of July 1, 2021, through July 31, 2022, thirteen months into the biennium, with eleven months remaining. The NCQAC budget is underspent by 6.5% and the current revenue balance is $2.8M.

REVENUES:

The recommended revenue balance or "reserve" should be 12.5% of biennial budgeted allotments, or approximately $3.7 million. NCQAC revenue balance dipped below the recommended reserve balance for the first time in many years. This was due to the most recent HELMS withdrawal of $2.8M on June 30, 2022. Recent revenues continue to exceed projections by approximately 9%, or just over $1.3M. This is due in part to the continued high volume of endorsement applications and volunteer nurses applying for nurses to remain in Washington after the emergency.

BUDGET/ALLOTMENTS:

Due to the fiscal year end closeout, the agency was not able to post service unit or indirect charges at the time of this report; therefore, this report contains estimates.

Highlights:

o The AG bill continues to come in above budget due to ongoing litigation.

o Salaries and Benefits now trend below allotment due to the addition of the allotments granted to the NCQAC in the 2022 supplemental budget in response to the legislative mandate to process licenses in seven days or less and delays in filling new positions.

o FBI Background Checks are charged based on actual files processed and now trending higher than projected due to the increased volume of endorsement applications.

o Health Profession Investigations and Public Disclosure – service unit charges based on actual hours or files reviewed for unlicensed practice cases and sexual misconduct cases that do not have a practice element. The DOH uses historical data from the previous biennium to estimate use. To date actual use appears to be lower than last biennium.

FISCAL OUTLOOK:

With the recent HELMS withdrawal, the combination of revenues exceeding projections, and underspending, the revenue balance fell just below the recommended reserve balance. We anticipate revenues to continue to exceed projections and the new fee increase will be implemented on December 1, 2022. The final HELMS withdrawal, $2.4M, will take place at the end of June 2023, at which time we expect the revenue balance to drop below the recommended reserve once again.

As a result, the revenue balance will rebound and will approach recommended levels for the remainder of FY23.

B. Strategic Plan Update

Academic Progression - Updated August 2022

Goals: Evaluate the demand for licensed practical nurses and registered nurses in the state. Continue the discussion of the appropriate degree preparation for PNs.

1. Identify barriers and strengths identified by employer organizations of current models for consistent academic preparation for LPNs - Completed
2. Develop a report using workforce data, stakeholder group input, and national collaboration. - Data gathered, focus group summaries reviewed
3. Explore outcomes of existing LPN education models and expand employer input. - Trend data compiled and grid of LPN programs completed.

Communications – Updated August 2022

Goals:

• Provide exceptional communications internally and externally.

• Develop and implement a strong and meaningful identity for NCQAC, to include mission, vision statement, and logo.

• Ensure accessibility and inclusivity in all aspects of communication with the public and our stakeholders.

NCQAC Communications identified three overarching goals. Year One of the biennium was spent doing the work to achieve these goals. Year two spent evaluating our success/progress, as well as finalizing any work that supports the goals.

Nursing Assistants – Established August 2021 (for 2021-2023) – UPDATED AUGUST 26, 2022

Goal: Streamline nursing assistant training and testing processes, expand capacity through use of technology, and support progression into nursing as evidenced by the following outcomes:

• New training program applications consistently reviewed in 7-10 days;

• Statewide first-time test-taker pass rates (average, annualized) improved to 75% for 2023 and to 80% by 2024;

• Testing capacity increases to 22,932 test-takers per year (119% increase) through use of a virtual approach;

• Quantitative ratings of >3.7 on a 5-point scale on electronic surveys regarding the new curriculum by training programs and students at 6-, 12-, and 18-months post-implementation; and

• The LPN Registered Apprenticeship Program (LPN RAP):

o Enrolls 45 students (15 at each pilot site) in three different geographical areas in 2023; and

o The completion rate for students in the pilot is >85%.

1—Pilot, evaluate, and refine the new nursing assistant training curriculum. - Rollout of the new curriculum is underway.

2—Establish a steering committee, workgroup, and workplan for the LPN Apprenticeship Pathway; hire a Nurse Consultant to lead the LPN Apprenticeship Pathway work; and host a statewide LTC Summit to gain statewide stakeholder input on developing the pathway. – Completed

3—Conduct public rules meetings to gather input on nursing assistant rules revisions that address curriculum and testing changes and other needed updates. - Preparation in progress; dates are still TBD

4—Testing plan or contract in place for 2022, including timelines for phasing in revisions recommended from the LTC Workforce Development Steering Committee and Testing Workgroup (virtual skills testing within training programs at point of graduation, new evaluation approach, etc.). – Recommendations are included in the contract on a phase-in schedule (2022-2023). Contract completed/signed timely
5—Develop nursing assistant curriculum into an online-capable format. - Completed by June 30, 2022
6—Finalize nursing assistant rules revisions, incorporating stakeholder input. - Work to finalize a draft and identify public meeting dates in progress
7—Develop the communication/roll-out plan regarding curriculum, testing, and rules changes for launch in September 2022. - Curriculum rollout began in July 2022 with weekly online orientation sessions through August for existing and new programs to go through orientation, gain access to materials, and complete application form for approval to begin using if they choose. Orientation sessions will continue in September and onward as needed.

WHPS Updated August 26, 2022
Goal: Increase the number of nurses enrolled in the Washington Health Professional Services (WHPS) program voluntarily and in lieu of discipline (with an emphasis on in lieu of discipline) by 25% every two years through education, early identification, referral to treatment, and advocacy. NCQAC and WHPS promote the just culture model and employment retention.
The WHPS program determined that voluntary enrollment in the program is not as successful as being required by the NCQAC in lieu of discipline. Enrollment in the program has been dropping.

C. Rules Update – Shad Bell
Mr. Bell introduced Ms. Jessilyn Dagum as the new rules coordinator.
Ms. Dagum gave a update on rules. The Governor's Proclamation 20-32 will be rescinded on September 27, 2022. Ms. Dagum is drafting an announcement with the information included in the emergency rules.

Upcoming rule work includes Nurse Delegation of glucose monitoring, glucose testing, and insulin injections, health equity and continuing competency.

D. HELMS Update
Ms. Bielaski and Mr. Hoehn reported on HELMS. The vendor is about four weeks behind schedule for the deliverables. The HELMS team anticipated a Go Live Date in June 2023.

E. NCSBN Finance Committee – Chris Archuleta appointed
Ms. Woodard notified NCQAC of Mr. Archuleta's appointment to the NCSBN Finance Committee.

F. Department of Health Patient Safety Improvement Task Force
Ms. Woodard reported on the DOH Patient Safety Improvement Task Force. The goals of the task force are to reduce the timeline to process sexual misconduct cases and recommend changes to better inform the public about disciplinary cases to help patients make more informed decisions when selecting a health care provider.

Work already underway:
Monthly and bi-monthly meetings of subject matter experts at DOH to improve and monitor enhanced management oversight practices for sexual misconduct cases.
Quarterly meetings of DOH and AGO leaders to review sexual misconduct cases that exceed timelines to identify and address root causes of delays.
Begin an education campaign using various communication tools and social media platforms to inform the public about DOH's Provider Credential Search tool and how to file complaints against providers.
Apply for new funding to support a sustained public education effort to increase awareness about DOH's Provider Credential Search tool and how to file a complaint against a provider.
Conduct outreach to partner agencies, boards, and commissions to establish a workgroup with the goal of implementing the process improvements based on the recommendations of the task force. Short- and Long-term goals were developed. The full report is available on request.

VII. Subcommittee Report – DISCUSSION/ACTION

A. Advanced Practice – Jonathan Alvarado, Chair

1. Mr. Alvarado deferred to the Scope of Practice hearing to be held on Friday, September 9.

B. Consistent Standards of Practice – Sharon Ness, Chair

1. Ms. Ness reported that the Mentor-New Member content was reviewed and approved. No motion was needed to accept the packet.

C. Discipline – Adam Canary, Chair

1. Mr. Canary reported on the personal data questions (PDQs) for nursing applicants. Applicants for nurse licensure must answer a series of PDQs related to medical conditions that may limit safe nursing practice, background relating to criminal activity, indicators of substance use disorder, and actions against any license in another state. Updated questions generally reflect not only criminal convictions, but current, ongoing criminal investigations, charges, and/or potential prosecution. The updated language also includes pending investigations or charges from another state for violating state or federal law regulating practice. The expanded questions serve to flag applications that may have been able to answer they had no convictions or disciplinary action and would therefore not have been subject to NCQAC review.
   The updated PDQs will be uploaded into the current use case documents for the online application portal and incorporated into the new licensure and enforcement (HELMS) database.
   The Licensing subcommittee reviewed the PDQs, legal made additional edits, and the questions forwarded to the Discipline subcommittee for review and recommendation.
   ACTION: Mr. Canary moved to adopt the updated PDQs for use in nurse licensing applications. The motion was seconded by the Discipline Subcommittee. The motion carried.

ACTION: After discussion post a public comment, the NCQAC made recommendations to remove the examples within Medical Conditions and adjust accordingly. Further discussed in Item IX.

2. **NCSBN Guiding Nursing Regulation Philosophy and Disciplinary Decision Pathway for consideration when analyzing cases.**
   Mr. Canary reported on the Disciplinary Decision Pathway Tool and its design to help inform nursing regulatory body (NRB) decisions in cases of practice errors or unprofessional conduct.
   Process:
   1. Examine the investigatory evidence through a series of questions about the behavioral choices by the nurse leading to a determination of error accountability by the nurse (human error, at risk behavior, reckless behavior, or bad intent).
   2. Determine the proportionate and appropriately balanced NRB action using the analysis of behavioral choice and aggravating and mitigating factors leading to a decision whether no action, non-disciplinary or disciplinary action is warranted.

D. Licensing – Dawn Morrell, Chair

1. The subcommittee had no actions to report.

E. Research – Sharon Ness, Chair

1. Ms. Ness briefly reported on the Simulation Survey Results. Dr. Katie Haerling will present the report at the next research subcommittee and would like to have her present at November Business Meeting during the lunch portion.

F. Education – Kimberly Tucker, Chair

1. Ms. Tucker did not have a report but stated the next quarterly meeting is scheduled in October.

VIII. Education – Dr. Gerianne Babbo, Dr. Kathy Moisio - DISCUSSION/ACTION

Dr. Babbo gave nursing program updates.

1. Nursing Education Program 2020-2021 Annual School Report
2. Dr. Babbo presented the report. The report included a comparison of faculty salaries. The full report will be posted to the NCQAC website.

   ACTION: Ms. Guilford moved to accept the report, Ms. Ness seconded the motion. The motion passed.

3. Nursing Education Updates
   a. Clinical Placements
      1. Specialty Clinical Placement Survey June 2022
      2. Clinical Placement Summit Outcomes
         Recommendations to promote positive relationships with clinical partners and education:
         1. Nursing Commission offer opportunities to connect with regional partners with quarterly summits.
         2. Completion of a study (by existing other entities) that the schools indicate their clinical placement needs.

This study is recommended to include:

- Clinical hours
- Clinical placements utilized (shifts, acute care, simulation, specialty)
- What do they need to support clinical?

3. Involve already existing entities whose work already coincides with clinical placement such as the State Board of Community and Technical Colleges, Washington Achievement Council, and Independent Colleges of Washington.
4. Support a bill to support the CPNW to help reduce the cost to students and encourage participation by industry, education, and LTC facilities.

b. Faculty shortages
c. Nursing program enrollments
d. Deans/Directors

4. Preceptorship Grant Update
   Dr. Hayward gave an update on the current progress in creating the infrastructure for the grant payments and processes.
5. Education Subcommittee Oct 3, 2022
   a. Simulation
   b. NCLEX passing rates

IX. Public Comment

J. Reinedahl – in the chat commented that they did not understand why HIV status was included and also asked why specific learning disabilities was included as required information to be reported on the PDQ on the applications.

ACTION: Mr. Canary moved to move back to discussion the PDQ to address public question. Ms. Morrell seconded the motion. The motion passed.

On discussion, the NCQAC recommended removing the examples from the questionnaire.

ACTION: Mr. Canary moved to remove the examples from the "medical conditions" PDQ to address public question. Ms. Morrell seconded the motion. The motion passed.

X. Nursing Assistant Updates

Dr. Moisio reported on the Nursing Assistant curriculum.

1. New Curriculum Roll-Out
   Dr. Moisio reported that several programs are using the new curriculum.

2. Mass Examination Plan for nursing assistant certification examination
   Dr. Moisio reported the mass examination plan began. Bates Technical College, Big Bend Community College, Green River Community College, Shoreline Community

College, Peninsula Community College, Olympic College, and Wenatchee Community College, are just a few participating in the mass examination plan. Of the 16,000 slots for testing, only 745 have been used. Pass rates have not yet been received. Extending of the public health emergency would assist in completion of the testing.

Credentia is working on moving the skills testing remotely in October.

3. Rules Work

   Ongoing rules work for the Nursing Assistant as reported in the Rules update.

XI. Out of State Travel Reports

A. NCSBN Annual Meeting, August 17-19, Chicago IL

The NCQAC members and staff gave a brief report of their experiences at the NCBSN Annual Meeting: Gerianne Babbo, Sarah Bear, Erin Bush, Adam Canary, Ella Guilford, Lori Underwood, Grant Hulteen, Paula Meyer, Dawn Morrell, MaiKia Moua, Sharon Ness

XII. 2:40 Closing. Meeting will be continued on September 9, 8:30 am.

Nursing Care Quality Assurance Commission (NCQAC)
Meeting Minutes
September 9, 2022
8:30 AM- 2:30 PM

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I. 8:30 AM Reconvene – Yvonne Strader, Chair – DISCUSSION/ACTION

II. Call to Order

A. Introductions
B. Order of the Agenda

III. Signature Authority – Karl Hoehn, Sierra McWilliams - DISCUSSION/ACTION

Mr. Hoehn and Ms. McWilliams explained the ability for the NCQAC to delegate certain signatures. A table of the delegation was presented.

NCQAC periodically updates Procedure H16 to clarify signature authority of staff. The draft procedure H16.02 was updated to reflect current authorities. An additional column has been added to distinguish between situations where decision-making is delegated to staff from those situations where staff is authorized to sign documents only after a panel has approved the action.

ACTION: Ms. Morrell moved that the NCQAC approve the updated Procedure H16.02, Signature Authority Delegation. The motion was seconded by Mr. Canary. The motion passed.

IV. Health Equity Rules – Shana Johnny, Karl Hoehn, Sierra McWilliams - DISCUSSION/ACTION

In 2021, the legislature passed Engrossed Substitute Senate Bill 5229, requiring health professionals credentialed under RCW 18.130.040. RCW 43.70.613(3)(c), to complete two hours of health equity continuing education (CE) training every four years as written in RCW 43.70.613 and required the Department of Health (DOH)to develop model rules for Health Equity education for all health professions. Dr. Johnny presented the model rules for LPNs and RNs.

Mr. Hoehn and Ms. McWilliams presented the issue of applicability for nursing assistants. The NCQAC discussed the requirements for nursing assistants and work with Health Systems Quality Assurance.

The draft model rules established minimum standards for health equity CE training for health care professionals to include instruction on skills to address structural factors, such as bias, racism, and poverty that manifest as health inequities. The proposed rule requires that implicit bias training be part of the two CE hours health professionals must complete.

ACTION: Ms. Ness moved, with a second from the Consistent Standards of Practice subcommittee, to open a CR101 for WAC 246-840-220 and other relevant continuing competency rule sections to develop rules for minimum standards for health equity education training. The motion passed.

V. Communications – Chris Archuleta, Shad Bell, Amy Sharar, Margaret Holm - DISCUSSION/ACTION

A. Live demonstration of new website – went live on September 1st.
Mr. Bell, Ms. Dagum, and Ms. Holm gave a live demonstration of the website, https://nursing.wa.gov. It was noted that any search in relation to nursing and Washington will link to the new website. The website has already received compliments on ease of use and how much quicker it was to use versus the old site. The new website has also been scaled to be usable via mobile devices to increase accessibility.

B. Public Advocacy Outreach
The NCQAC maintained a master stakeholder (interested parties) list that included contact for many public advocacy groups due to the work on public safety. Ms. Holm discussed the movement from the master stakeholder (interested parties) list and how to use the list. Social media was discussed as an outreach source. The NCQAC members requested an email with the information.

VI. Board Pay Summary – Bethany Mauden – DISCUSSION/ACTION

Ms. Mauden presented a summary of the board pay for the previous. Ms. Mauden presented the summary of hours by topics such as Education, Discipline, NCSBN, Subcommittees, WHPS, Leadership and more. Ms. Mauden also reminded the members to submit their board pay no later than the 10th of each month.

VII. NCSBN International Center for Regulatory Scholarship (ICRS) – Dr. Gerianne Babbor - DISCUSSION/ACTION

Dr. Gerianne Babbo and Tracy Rude (pro tem member) both completed their ICRS certificate in April 2022. NCSBN produced a video for the program. Dr. Babbo is featured in the video. The video was shown and is available on the NCSBN website.

VIII. Education Session – Impact of COVID panel

Susan Stacey, Providence Sacred Heart Hospital
Sam Clark, Spokane Community College
Joan Owens, Gonzaga University
Anne Mason, Washington State University
Lynnette Vehrs, Washington State Nurses Association
Sofia Aragon, Washington Center for Nursing

Summary of Key Findings

To better understand the impact of COVID-19 on the nursing workforce in Washington State, Survey Information Analytics (SIA) surveyed 1,298 nurses who held active nursing licenses about their experiences during 2021. Among them:

- **9%** were **laid off or furloughed** from one or more nursing/healthcare jobs.
- **54%** thought about or made **plans to leave** the field of nursing.
- **70%** reported moderate or extreme COVID-19 related **staffing concerns**.
- **64%** reported moderate or extreme concern for their friends'/family's **safety**.
- **67%** believed their employers provided adequate **quarantining** for employees who may have been/were exposed to COVID-19.

Additionally, the following themes emerged from SIA's 12 follow up in-depth interviews:

- ❖ Staffing issues and the focus on travel nurses to the detriment of other nurses
- ❖ Mental and behavioral issues
- ❖ Workload and monetary compensation
- ❖ Diversity/equity in relation to the workforce.

IX. Public Comment

No members of the public presented comments.

X. ARNP Scope of Practice Rules Hearing – DISCUSSION/ACTION

The purpose of the hearing was to solicit comments for the proposed rules filed with the Code Reviser's Office on July 18, 2022, and in the Washington State Register as WSR# 22-15-078. The NCQAC proposed amendments to WAC 246-840-300 to create consistency with national Advanced Registered Nurse Practitioners (ARNP) standards, WAC 246-840-700 and WAC 246-840-710 to update gender pronouns for Registered Nurses (RNs) and Licensed Practical Nurses (LPNs), and other housekeeping and grammatical changes.

The proposed amendments to WAC 246-840-300, ARNP Scope of Practice, serve three purposes:

- Provide an increased level of guidance for those practicing as an ARNP in WA state.
- Update the language to remain consistent with current ARNP national standards.
- Incorporate more inclusive language.

Testimony 1:41pm -
Dr. Dawn Deprisse – Against removing language of "medical acupuncture"
Kathleen Errico – Support
Lindsey Frank - Support
Charis Wolf – Against (mode of medicine)
Vanessa Patricelli – none
Shannon Fitzgerald – Support
Megan Kilpatrick – Support

ACTION: Mr. Alvarado moved, with a second from the Advanced Practice subcommittee, to adopt the proposed changes to WAC 246-840-300, 246-840-700 and 246-840-710. The motion passed.
Rules hearing closed – 2:03pm

XI. Meeting Evaluation

XII. 2:15 PM Adjournment

Nursing Care Quality Assurance Commission (NCQAC)
Advanced Practice Subcommittee Meeting Minutes
August 17, 2022 7:00 p.m. to 8:00 p.m.

Committee Members: Jonathan Alvarado, ARNP, CRNA, Chair
Emerisse Shen, MSN, CNP, FNP, ARNP
Laurie Soine, PhD, ARNP
Shannon Fitzgerald, MSN, ARNP
Lindsey Frank, CD, OB-RNC, ARNP, CNM
Megan Kilpatrick, MSN, ARNP-CNS, AOCNS
Wendy E. Murchie, DNP, CPNP-AC
Bianca Reis, DNP, MBA, ARNP, PMHNP-BC
Tatiana Sadak PhD, ARNP, RN, GSAF, FAAN
Kimberley A. Veilleux, DNP, RN, ANP-BC

Staff: Mary Sue Gorski, PhD, RN, Director, Advanced Practice and Research
Karl Hoehn, JD, FRE, Assistant Director, Discipline – Legal
Jessilyn Dagum, Research Assistant

I. 7:00 PM Opening – Jonathan Alvarado, Chair
Call to order

- Introduction
- Public Disclosure Statement
- Roll Call
  - Jonathan called the meeting to order at 7:00 PM. The Advanced Practice subcommittee members and staff were introduced. The new subcommittee members we introduced and welcomed. The Public Disclosure Statement was read aloud for the meeting attendees.
  - Mary Sue announced that Jessilyn will be moving into a different position, and this would be her last Advanced Practice subcommittee meeting.

II. Standing Agenda Items

- Announcements/Hot Topic/NCQAC Business Meeting Updates
- Review of Advanced Practice Draft Minutes: May 18, 2022
  - Reviewed with consensus to bring to the September 8th and 9th, 2022 commission meeting for approval.

III. Old Business

- None

IV. New Business

- Welcome New Members
  - The new subcommittee members were welcomed, and the Advanced Practiced Subcommittee Position was reviewed by the group.
  - Karl noted that under 'Duties and Responsibilities of the Subcommittee,' it lists that the subcommittee meet two weeks prior to the NCQAC business meetings. He suggested this be changed to three

weeks in order for subcommittee items to be include in the business meeting packet.

- Review APSC Work Plan
  - The draft APSC Work Plan was presented to the subcommittee by staff. The group reviewed the work plan with instruction to bring edits and additional items to the next subcommittee meeting.
- Rules Update
  - Jessilyn presented the rules update. Mary Sue presented a brief update on the ARNP Scope of Practice rules. The ARNP Scope of Practice rules hearing is scheduled for September 9, 2022, at 1:15 PM. Meeting information was shared with the group. The subcommittee has two other rule sets that staff is working on. They have not reached the CR-102 phase yet, but possible hearing dates are anticipated for November 2022 or January 2023. The subcommittee and attendees were directed to forward any rules questions to Jessilyn at jessilyn.dagum@doh.wa.gov.

V. Ending Items

- Public Comment
- Review of Actions
- Meeting Evaluation – All
- Date of Next Meeting – September 21, 2022
- Adjournment – 7:45 PM

Nursing Care Quality Assurance Commission (NCQAC)
Advanced Practice Subcommittee Meeting Minutes
September 21, 2022 7:00 p.m. to 8:00 p.m.

Committee Members:	Jonathan Alvarado, ARNP, CRNA, Chair Emerisse Shen, MSN, CNP, FNP, ARNP Laurie Soine, PhD, ARNP Shannon Fitzgerald, MSN, ARNP Lindsey Frank, CD, OB-RNC, ARNP, CNM Megan Kilpatrick, MSN, ARNP-CNS, AOCNS Bianca Reis, DNP, MBA, ARNP, PMHNP-BC Wendy E. Murchie, DNP, CPNP-AC Tatiana Sadak, PhD, ARNP, RN, GSAF, FAAN
Absent:	Kimberley A. Veilleux, DNP, RN, ANP-BC
Staff:	Mary Sue Gorski, PhD, RN, Director, Advanced Practice and Research Holly Palmer, Administrative Assistant Jessilyn Dagum, Policy Analyst

I. 7:00 PM Opening – Jonathan Alvarado, Chair

Call to order

- Introduction
- Public Disclosure Statement
- Roll Call
  - Jonathan called the meeting to order at 7:00 PM. The Advanced Practice Subcommittee members and staff were introduced. The Public Disclosure Statement was read aloud for the meeting attendees.

II. Standing Agenda Items

- Announcements/Hot Topic/NCQAC Business Meeting Updates
  - The Nursing Care Quality Assurance Commission (NCQAC) approved the proposed language for ARNP Scope of Practice after the rules hearing on September 9, 2022
  - The new NCQAC website was launched on September 1, 2022, located at www.nursing.wa.gov
- Review of Advanced Practice Draft Minutes: August 17, 2022
  - Reviewed, with consensus to bring to the November NCQAC business meeting for approval

III. Old Business

- Review Updated APSC Position Description
  - Jessilyn updated the subcommittee regarding the minor change in verbiage in the position description

IV. New Business

- Rules Update
    - Jessilyn updated the subcommittee regarding the September 9, 2022 ARNP scope of practice rules hearing. The proposed language was approved, now working with legal team to file with the code reviser's office
    - After the filing is complete, work will begin on the inactive and expired license rules, as well as the opioid rules. Those are in the currently in the CR-102 stage and will be reviewed at the January NCQAC business meeting
- Review APSC Work Plan
    - The format of the work plan was reviewed
    - The subcommittee's focus is prioritizing the order in which the various topics will be focused on
    - The work plan is a living document and will evolve with time, brought forward at each meeting for review
    - Mary Sue reviewed items five through ten on the work plan and provided historical background on each
- NCAO 12.00 Medical Acupuncture Update
    - There was a comment during the business meeting regarding this; the Commission is still in the research phase of this work
    - There are several individuals prepared to participate in a workgroup to help update wording and guidelines of the Advisory Opinion

V. Ending Items

- Public Comment
    - The public was given the opportunity to comment on the agenda items.
- Review of Actions
- Meeting Evaluation – All
- Date of Next Meeting – October 19, 2022
- Adjournment
    - The meeting was adjourned at 7:46 PM

Nursing Care Quality Assurance Commission (NCQAC)
Consistent Standards of Practice Subcommittee Meeting
Minutes August 5, 2022 12:00 p.m. – 1:00 p.m.

Committee Members: Sharon Rott Ness, RN, Chair
Helen Myrick, Public Member
Tiffany Randich, RN, LPN
Ella Guilford, MSN, Med, BSN, RN
Jamie Shirley, PhD, RN

Absent:

Staff: Shana Johnny, DNP, NM, RN
Holly Palmer, Administrative Assistant
Karl Hoehn, JD, FRE, Assistant Director, Discipline – Legal
Seana Reichold, JD, Staff Attorney
Miranda Bayne, JD, Staff Attorney
Bonnie King, Rules Consultant

I. 12:00 p.m. Opening

- Introduction
- Public Disclosure Statement
- Roll Call
  - Ms. Ness called the meeting to order at 12:00 p.m. The Consistent Standards of Practice subcommittee members and staff were introduced. The Public Disclosure Statement was read aloud to the meeting attendees.

II. Standing Agenda Items

- Announcements/Hot Topic/NCQAC Business Meeting Updates
  - NCQAC has created a search committee in response to Paula Meyer's upcoming retirement in June 2024; the committee's focus is on finding a replacement for Ms. Meyer over the following months.
- Review of Draft Minutes: June 3, 2022
  - Minutes were reviewed with a consensus to bring to the September commission meeting for approval.
- Subcommittee Work Plan Review – Ms. Johnny will add projects to the work plan and provide an update at the October 3, 2022, subcommittee meeting.

III. Old Business

- Jurisprudence (JP) Module Update
  - Holly Palmer provided an update; currently being created in a new learning module program; the plan is to have it ready to release concurrently with the new NCQAC website in September 2022.
- ESSB 5229 Health Equity Rules – Ms. Johnny provided an update; Legislation requires healthcare professionals to obtain continuing education in specific content areas listed in the model rules. The Nursing Assistant Program Approval Panel (NAPAP) will be meeting Monday, August 8, 2022, to discuss if Nursing Assistants (NAs) should be included in this requirement. The consensus was reached for the CSPSC to draft a motion to move forward with CR-101 to bring to the September NCQAC meeting.
- Forensic Nurse Training – Ms. Johnny provided an update; a lengthy report was received on August 4, 2022, and so was not available for review before this meeting. Ms. Johnny will prepare a summary of that report for the subcommittee to review at the October 3, 2022, subcommittee meeting.
- Sexually Transmitted Infections and Hepatitis B Legislative Advisory Group Updates.
  - Congenital Syphilis Proviso Workgroup Update provided in the packet for committee members.
  - Sexually Transmitted Infections Infrastructure Workgroup – Ella Guilford provided an update; the group has identified cost concerns; however, it is ready to move forward to the legislature.
- Vent/Vent-Trach Models of Care for Pediatric Patients Consortium – Update provided in the packet for committee members.

IV. New Business/Public Comment

- Advisory Opinion Request – Licensed Practical Nurse (LPN) Scope of Practice in Performing Endoscopy Procedures
    - Local endoscopy center requesting clarification if an LPN can function as a circulating nurse during services that include deep sedation,
    - Discussion included the staff of endoscopy center; NCQAC legal staff; and commissioners,
    - There are potential exceptions in the ambulatory center rules that facilities may utilize,
    - Consensus reached to collaborate with Ambulatory Surgery Facilities (ASFs) and obtain data regarding the number of facilities affected and their staffing situations.
- Mentor-New Member Guidelines and Resources – Draft version shared with subcommittee with a request for review and feedback from the Commission.

V. Ending Items

- Review of Actions
    - Update Subcommittee Workplan – Ms. Johnny
    - Draft motion to move forward with CR-101 to take to NCQAC September meeting – Ms. Johnny & Commissioner Ness
    - Forensic Nurse Training report summary – Ms. Johnny
    - Research regarding ASFs' and LPNs performing as circulating nurses. Coordinate efforts with NCQAC legal team and inquire with facilities licensing team on ASFs'
    - Forward discussion on nurse delegation of glucose monitoring
- Meeting Evaluation - None
- Date of Next Meeting –October 7, 2022
- Adjournment – 1:10 p.m.

Nursing Care Quality Assurance Commission (NCQAC)
Education Subcommittee Agenda
October 3, 2022 12:00 to 1:00 p.m.

Join the Meeting
from your computer, tablet or smartphone

Join Zoom Meeting
https://us02web.zoom.us/j/87431751958

Meeting ID: 874 3175 1958

Committee Members:
Kim Tucker PhD, RN, CNE, Chair
Laurie Soine PhD, ARNP Member
Renee Hoeksel PhD, RN, ANEF, FAAN Pro Tem
Julie Benson MHA, MN, RN, CNE Pro Tem
Fionnuala Brown, DNP, MSN, FNP-C, RN Pro Tem

Staff:
Gerianne Babbo, EdD, MN, RN, Director of Nursing Education
Sarah Bear, EdD, MSN, RN, Nursing Education Consultant
Margaret Holm, JD, RN Nursing Education Consultant Practice
Tim Talkington, NCQAC Attorney
Sara Kirschenman, NCQAC Attorney
Janell Sparks, Education Administrative Assistant

If you have questions regarding the agenda, please call the Nursing Care Quality Assurance Commission (NCQAC) office at (360) 236-4744. Agenda items may be presented in a different order. If you wish to attend the meeting for a single item, contact our office at the number listed above and request a specific time scheduled for that item. If you have limited English language expertise call (360) 236-4744 before **September 19, 2022**.

This meeting is accessible to persons with disabilities. Special aids and services can be made available upon advance request. Advance request for special aids and services must be made no later than February. 28,2022 If you need assistance with special needs and services, please leave a message with your request at 1-800-525-0127 or, if calling from outside Washington State, call 360-236-4052. TDD may also be accessed by calling the TDD relay service at 711.

If you need assistance due to a speech disability, Speech-to-Speech provides human voicers for people with difficulty being understood. The Washington State Speech to Speech toll free access number is 1-877-833-6341.

I. 12:00 PM Opening – Kim Tucker Chair
Call to order

- Introduction
- Public Disclosure Statement
- Roll Call

II. Standing Agenda Items

- Announcements/Hot Topics
  1. None
- Review of Draft Minutes
  1. None

III. Old Business

- None

IV. New Business

1. Presentation by Dr. Carrie Miller: Conceptualizing Quality in Nursing Simulation Education

Summary: Simulation-based experiences in nursing education have become commonplace. There is a general understanding of the benefit of simulation; however, the measure of simulation quality is evolving. This presentation discusses the essentials of defining simulation quality using INACSL's Healthcare Simulation Standards of Best Practice. These include best practices of simulation facilitation, prebriefing, debriefing, and professional integrity. Implementing simulation best practices into nursing curricula can impact patient outcomes and safety. Simulation-based education quality can promote nurse graduates' readiness for clinical practice.

2. Discussion with Education Subcommittee Members

One recommendation from the presenter was for a Nursing Simulation taskforce at the Nursing Commission level. A question was asked about whether the recommendation was envisioned as a separate task force from the Washington State Simulation Plan (WSSP) task force. The response was the vision was for a separate task force to include experts in nursing regulation and other entities who could move the simulation work forward. WSSP envisioned itself as part of a new task force.

It was noted that national and international simulation research is ongoing. The WSSP is aware of and supports the national and international research while as the same time is conducting parallel work. Dr. Katie Haerling's work on simulation was recognized as part of the parallel work.

A question was raised about the recommendation to open WAC 246-840-534, Simulation, and what specifically about this WAC may put students or the public at risk. What really needs to be updated to ensure public protection? The response was WAC 246-840-534 was excellent when created but so much as been learned since 2016 including that

simulation can be done exceptionally poorly. A definition of quality simulation was suggested be added to WAC 246-840-534 to support public safety.

Public Comments:

A question was asked about where to find quality simulation scenarios in addition to those found at the National League for Nursing Simulation Innovation Research Center. Ideas presented included Open-RN, Canadian Alliance of Nurse Educators Using Simulation, and the Nursing Simulation Library at Montgomery College, Maryland as well as searching the internet for other options.

Discussion about funding simulation for nursing programs included partnering with college/university administration, demonstrating how the program is incorporating simulation into the curriculum, and sharing simulation utilization reports.

It was noted Big Bend Community College previously offered a simulation technician program. This program was based on grant funding and is no longer offered. It was questioned if it was time to start a conversation about a simulation technician program in the state of Washington.

Discussion occurred about this being the right time to request funding from the state and the federal government to support simulation. The question was asked if there was a financial model or if one could be developed for simulation funding? How much money would be needed to develop a model and scale up to get ahead of the ongoing nursing staff and faculty shortages. The comment was made that healthcare is part of the infrastructure of the United States and should be funded as such, since simulation is a model that works. Dr. Katie Haerling's current work on simulation cost analysis was referenced. It was noted the various stakeholders (education, healthcare agencies) should speak out statewide and nationally with one voice. Dr. Haerling's research outcomes will be presented at a communications meeting in the near future for nursing program deans/directors.

An idea was presented asking if schools of nursing should be required to have simulation in the curriculum which would generate funding from colleges/universities since it was part of the curriculum. The idea of standardized simulation across the state was noted as an option and ongoing discussion on this topic would be interesting.

V. Ending Items

- Public Comments
- Date of Next Meeting –Nov. 22, 2022
- Adjournment

This meeting will be digitally recorded to assist in the production of accurate minutes. All recordings are public record. The minutes of this meeting will be posted on our website after they have been approved at the September 9, 2022, NCQAC meeting. For a copy of the actual recording, please contact the Public Disclosure Records Center (PDRC) at PDRC@doh.wa.gov.

If attending remotely, please mute your connection to minimize background noise during the meeting. Time permitting, comments from the public will be taken at the end of the meeting. Use the question box on the meeting control panel to submit questions. Smoking and vaping are prohibited at this meeting.

Nursing Care Quality Assurance Commission (NCQAC)
Licensing Subcommittee Minutes
August 9, 2022 1: 00 pm to 2: 00 pm

Committee Members: Dawn Morrell, BSN, CCRN, RN, Chair
Adam Canary, LPN
Helen Myrick, Public Member
MaiKia Moua, RN, BSN, MPH

Staff: Amber Zawislak-Bielaski, MPH, Assistant Director of Licensing
Shana Johnny, MN, RN, Nurse Practice Consultant, Ad- Hoc
Karl Hoehn, JD, Assistant Director of Discipline- Legal Services
Lori Underwood, Licensing Supervisor

This meeting was digitally recorded to assist in the production of accurate minutes. All recordings are public record. The minutes of this meeting will be posted on our website after they have been approved at the **September 9, 2022**, NCQAC meeting. For a copy of the actual recording, please contact the Public Disclosure Records Center (PDRC) at PDRC@doh.wa.gov.

I. 1:00 PM Opening – Dawn Morrell, BSN, CCRN, RN Subcommittee Chair

- **Roll Call**
- **Call to Order** - Commissioner Dawn Morrell, Commissioner Adam Canary, Commissioner Helen Myrick, Commissioner Yvonne Strader, Ms. Amber Zawislak-Bielaski, Dr. Shannon Johnny, Mr. Karl Hoehn, Ms. Lori Underwood

II. Standing Agenda Items

- **Announcements/Hot Topic/NCQAC Business Meeting Updates** - Commissioner Morrell asked the committee if there were any topics to be discussed. Commissioner Morrell shared with the committee that she had the opportunity to join the Licensing unit for their summer potluck and was able to meet licensing staff and their families. Commissioner Morrell spent some time visiting with staff and thanking them for their hard work. No other topics were brought forward.

- **Approve Minutes for June 21, 2022** - Commissioner Myrick moved with a second from Commissioner Strader to approve the minutes for June 21, 2022.

III. Old Business

- **Florida School Issues and Current Actions** – Ms. Underwood shared with the committee that there were no new updates.

- **Temporary Practice Permit Rule**s – Ms. Zawislak-Bielaski advised the committee that another Rules Workshop was held last Thursday, August 4, 2022. She shared that there were a few attendees, and it went well. There were no comments from the public at this workshop. Ms. Zawislak-Bielaski advised

the committee that there will be one more Rules Workshop before we bring this information to the full Commission.

IV. New Business

- Governor's Weekly Report – Ms. Underwood reviewed the Governor's report explaining that our average pending applications are slowly declining. She pointed out that the applications were down to nine hundred, twenty-three last week. Ms. Underwood also shared that the average days to process applications and issue a Temporary Practice Permit was at nine days. She explained that we have hired an additional five non-perm staff to assist with the workload. Ms. Zawislak-Bielaski added that our trend is appearing to head in a downward direction compared to March and April. Commissioner Morrell asked the committee if there were any questions regarding the report. Commissioner Myrick inquired if the calls are slowing down. Ms. Zawislak-Bielaski replied that the volume of calls tends to correlate directly with how many applications we have pending and how many days we are at for processing time. Ms. Zawislak-Bielaski also shared that because we have additional phone staff, they answer on average about forty calls per day. This is good in comparison to earlier in the year when we would have fewer staff on phones, and they would average eighty to ninety calls each per day. Commission Myrick wanted to acknowledge that although the numbers were going down, they were still quite high, and she thanked the staff for continuing to work hard.

  Commissioner Morrell wanted to review the second chart. Ms. Underwood pointed out that this second chart addresses the renewals and applications. Ms. Zawislak-Bielaski reviewed the second chart with the committee and explained that this chart displays the output. She explained that the first chart reflects what's coming in, and the second chart focuses on how many applications we are issuing. Commissioner Morrell inquired about the Emergency Volunteers and if we were still seeing these. Ms. Underwood confirmed that WAserv was still sending lists of volunteers for us to provide a credential check. She further explained that although we are continuing to see 70.15 Volunteer lists to review, there aren't many on these lists. Commissioner Morrell questioned why we continue to see this volunteer lists even as we are headed towards the end of the Emergency. Ms. Underwood offered her thoughts that it is the staffing agencies telling these travel nurses to submit their volunteer application with WAserv and submit their online application with the Nursing Commission to see which would get through quicker. Ms. Zawislak-Bielaski added that as soon as the Governor lifts the state of Emergency, these nurses practicing under the 70.15 volunteer program would not be able to practice without a Washington state license. For applicants who have a Temporary Practice Permit, those are only good for six months with a one-time extension. These applicants would have needed to complete their FBI fingerprint background checks before we can issue their full license. Ms. Zawislak-Bielaski also added that the six-month timeframe is what we are reviewing in the Rules Workshop. We are looking at what the timeframe should be now that we are issuing the temporary permits at a much quicker turnaround. Ms. Zawislak-Bielaski continued to explain that with how quickly the fingerprint process can be completed, it would be in our best interest to limit the number of days of a Temporary Practice Permit down to sixty or ninety days, and perhaps a thirty-day extension. These are being discussed in the Rules Workshop.

Commissioner Morrell asked the committee if anyone had heard anything about the ending of the Emergency proclamation. No one in the committee had a reply. Ms. Zawislak-Bielaski did share that she had a meeting with Ms. Kim Butowicz, who works with the Volunteer Management Team and Ms. Butowicz advised that they were hopeful to receive notice from the Governor's office with enough time to sunset their program and demobilize. She would then share that information with our licensing unit. Mr. Hoehn added to this conversation that we have been asked certain questions regarding the Governor's Declaration and how it affects our current waivers and Emergency rules. Commissioner Morrell asked Mr. Hoehn if it was decided how it would affect the licensing. Mr. Hoehn explained that he was not seeing much. There are several waivers that the Governor made back in 2020 that we would just rather it go away. He further explained that he had not seen anything that looked worrisome.

Commissioner Strader had a follow up question regarding the Volunteer 70.15 program. She was concerned about what happens when the program ends. Commissioner Strader inquired on what time frames the nurse will have to finish up their assignment. Would there be a set deadline, or would there be a few months' notice? Ms. Zawislak-Bielaski explained the Volunteer 70.15 program and that we had been sending out communication since earlier in the year that encouraged nurses to submit their application because when the Emergency ends, they will no longer be able to practice. She referenced the first chart where we saw a huge spike in applications. We believe these high numbers were a result of the communication we sent out. Commissioner Morrell asked the committee if there were any other questions. There were no other questions.

- **Using NURSYS NCLEX Registration Data tab for missing education information when reviewing endorsement applications** – Ms. Underwood provided some background to this issue. She explained that this issue pertains to endorsement applications. On the NURSYS verification report, it provides the verification of the applicant's exam state, all their licenses, any discipline issues, and their education. We use this report to confirm their license and education information. This issue we have is regarding the education provided on the NURSYS verification report. Ms. Underwood continued to explain that sometimes the exam state will not provide the complete education information on the verification report. They may have left off the degree awarded when they completed their program, or they may have left off the graduation date. When this occurs, we will send a speed memo via NURSYS to the exam state Board of Nursing. Many times, we do not see a reply to these requests for quite a while. This information that we are trying to obtain may also be found on the NCLEX data tab of NURSYS. Quite a few years back, we had reached out to NCSBN to confirm that we could use the education listed on the NCLEX data tab to complete the missing education information on the report. We have been using the education information found on the NCLEX data tab in the review, rather than waiting for the speed memo replies, which sometimes took several weeks to receive. This would allow us to push the files through review and be able to issue their temporary permit or license. Most recently, we discovered that the education listed on the NCLEX data tab was not provided by the exam state; rather, it is provided by the applicant. Ms. Underwood also explained that this impacts about thirty-five to forty percent of the endorsement applications. We brought this issue to Executive Director, Ms. Paula Meyer, and she directed

us to present this issue to the Licensing subcommittee for recommendation. Should we continue the process as we have been following for the past years, or revert to sending speed memos and wait for their responses? Commissioner Morrell asked the committee for any comments. Commissioner Myrick inquired if we have confidence in the reliability of using the NCLEX data tab for the education information. Ms. Underwood responded that we do have confidence in the education provided in the NCLEX data tab as we cross reference the application and the education tab in NURSYS as well. Commissioner Myrick commented on how thorough our review is of the application; however, she questioned if we legally have authority to decide if we just want to continue with the same process. Commissioner Morrell asked Mr. Hoehn for his recommendation. Mr. Hoehn advised that this may be addressed in the Executive Officer meeting happening later this month. Commissioner Morrell asked additional questions on how review staff review education to ensure it is not fraudulent. Ms. Underwood explained the review process in more detail. Mr. Hoehn also added how vigilant our licensing review staff is since these questionable schools surfaced. Commissioner Canary suggested we continue with the same process until after the Executive Officer meeting, then we could talk about this again. Commissioner Myrick and Commissioner Strader agreed with Commissioner Canary. Commissioner Morrell added that she also agreed.

Commissioner Morrell advised of another licensing issue to discuss. Ms. Zawislak-Bielaski explained that this relates to the personal data questions included on the applications. She further explained that we wanted to add this to the agenda for discussion as it needs to be reviewed for HELMS because the project management team is currently in the process of building these applications. Ms. Zawislak-Bielaski pointed out that these questions need to be reviewed and if there were any updates, it would need to be changed now before these applications are added in the new system. Ms. Zawislak-Bielaski shared the application document with the personal data questions for the committee to review and edit. Each question was read aloud, reviewed and any edits were noted. Ms. Zawislak-Bielaski advised that this document with the edits would be forwarded to the Discipline subcommittee. Then it will be brought to the full Commission in September.

V. Ending Items

- **Public Comment** - Commissioner Morrell asked if there were any questions from our guests. Mr. Peumeu stated that he is a staffing coordinator and had questions regarding the processing time of four nurses from Florida. He hired these nurses through WAserv, and they have been waiting for about three months to be licensed. He inquired if there was a different process because they came from Florida. Mr. Hoehn responded to his question by explaining that if he was inquiring about any cases, it is dealt with other panels of the Commission. Mr. Hoehn also explained the two pathways for which a nurse could practice, RCW 70.15 and applying for licensure. He also explained that if the nurse applied for a Washington credential, their application will be reviewed and a decision would be made, but it would not be appropriate to discuss in a public meeting. Mr. Peumeu replied that he was not inquiring about the individual nurses, rather, the processing of their application. Are these applications processed different because they are coming from Florida? Ms.

Zawislak-Bielaski replied to his question by explaining the licensing review process and requirements. Mr. Peumeu thanked Ms. Zawislak-Bielaski for her explanation.

- **Review of Actions** - None
- **Meeting Evaluation** - None
- **Date of Next Meeting** - October 18, 2022
- **Adjournment**: 2:20 PM

Nursing Care Quality Assurance Commission (NCQAC)
Research Subcommittee Meeting Minutes
July 18, 2022 5:00 p.m. to 6:00 p.m.

Committee Members:	Sharon Ness, RN, Chair Yvonne Strader, RN, BSN, BSPA, MHA Jamie Shirley, PhD, RN Katie Haerling, PhD, RN, CHSE Deb Smith DNP, ARNP, FNP-BC
Excused:	Mary Baroni, PhD, RN
Staff:	Mary Sue Gorski, PhD, RN, Director of Advanced Practice and Research John Furman, PhD, MSN, CIC, COHN-S, Washington Health Professional Services (WHPS) Liaison/Research Jessilyn Dagum, Research Assistant

I. 5:00 PM Opening – Sharon Ness
Call to order

- Introduction
- Public Disclosure Statement
- Roll Call
  - Sharon called the meeting to order at 5:00 PM and introduced the Research Subcommittee members and staff. The Public Disclosure Statement was read aloud for the meeting attendees.

II. Standing Agenda Items

- Announcements/Hot Topic/NCQAC Business Meeting Updates
- Review of Draft Minutes: June 21, 2022
  - Reviewed with consensus to bring to the September 9, 2022, business meeting for approval.

III. Old Business

- Review Work Plan
  - The subcommittee briefly reviewed the work plan. Status updates were provided by staff.

IV. New Business

- Critical Gaps Work and the Research Subcommittee
  - Mary Sue gave the update. A link between the Research Subcommittee and the Critical Gaps Work is in progress but not yet finalized.
- Student Engagement Program Exit Survey
  - Jessilyn presented a preview of the student engagement program data and exit survey. The full report will come to the subcommittee in August.

V. Ending Items

- Public Comment
- Review of Actions
- Meeting Evaluation – All
- Date of Next Meeting – August 15, 2022
- Adjournment – 5:55 PM

Letter FROM THE President

POST-BOARD MEETING UPDATE

Oct. 12, 2022

Dear Colleagues,

The Board of Directors (BOD) met in Chicago Sept. 27-28 for our regularly scheduled meeting, aware that the weather is starting to turn and fall is upon us. The months have certainly flown by.

Every year at the September meeting, after the new board is seated, all members of the BOD participate in orientation facilitated by an outside consultant and NCSBN's legal counsel. This half-day session, held prior to our business agenda, includes a review of the duties of loyalty, care and obedience, sound governance and the BOD's legal and fiduciary roles. This informative session was followed by an introduction to not-for-profit finance.

We began our business agenda with an environmental scan that revealed themes of nursing staff shortages, faculty issues, LPN scope of practice challenges, board staff vacancies, multi-jurisdictional mobility, nurse aide public health emergency waivers and testing issues, advancements and challenges related to APRN regulation, compounding issues, and hydration clinics. Updates were provided concerning communication from the APRN Presidents Group, the World Health Organization regulatory reform work, Nursys® Canada accomplishments and an example of an innovative education-workforce grant in Missouri which has resulted in increased funding for scholarships.

The BOD conducted a preliminary debrief of the first hybrid NCSBN Annual Meeting. The comments about the meeting were positive with the board noting a high degree of participation virtually and in person. The BOD commended the staff for their work in supplying both the coordination, technical expertise and excellent content, acknowledging that this format is resource intensive. Participant survey results will be analyzed and presented at a future meeting.

The BOD acted on reports and recommendations from the Finance Committee which included:

- Acceptance of a report of financial position and budget variance analysis for the nine-month period ending June 30, 2022.
- Approving the FY23 budget proposal which included a three-year financial forecast. The proposal took into consideration that the value of the fund balance is projected to continue to provide healthy financial reserves over the next few years. However, a steadily declining fund balance value is forecasted, consistent with the state of the U.S. economy and global markets. There is no immediate concern about the organization's financial position.
- Accepting a report of performance of NCSBN Investments. As this financial report demonstrates, the NCSBN treasurer, chief financial officer and the Finance Committee work diligently to analyze the financial aspects of the organization and in doing so bring realistic mission-focused recommendations to the BOD.

Letter FROM THE President

POST-BOARD MEETING UPDATE, CONTINUED

The BOD also appointed new members and reappointed board liaisons to the 45th Anniversary Committee, the Examination Committee (NEC) and the NCLEX® Item Review Subcommittee. The BOD is appreciative of departing members' contributions to committee work. Once again, this year the board experienced the positive challenge of having more volunteers than open committee slots.

The NCSBN Resource Fund was discussed, and the board voted to increase the per request cap in response to the increase in travel costs. The resource fund is a program that provides support in the form of financial assistance to U.S. and Exam User members for the development of programs and services to promote the mission of NCSBN.

An overview of the draft—Thematic Analysis of Health Professions Sunset Reports: Foci, Gaps, Impacts and Best Practices—was provided by the CEO. This work is an output of the Strategic Objective One workgroup and will soon be published as a supplement to the *Journal of Nursing Regulation*. Additionally, an update was provided by the COO on the significant and deliberate work being done on remote proctoring.

On a regular basis the leadership bodies of the Nurse Licensure Compact and NCSBN meet to discuss issues of mutual interest with the goal of enhancing collaboration. As our September meetings coincided, the two groups met virtually during the BOD meeting. Agenda topics included the NLC grant process, NCSBN organization restructuring, APRN Presidents communication and the NCSBN 45th Anniversary.

Looking to the future and an opportunity to acknowledge the rich history and accomplishments of NCSBN, the BOD was pleased to act on recommendations from the 45th Anniversary Committee. Approvals were given for the proposed reception and award ceremony dinner venues in Chicago that will allow the membership to fellowship and celebrate in style.

The BOD also considered recommendations for the 2023 NCSBN Midyear Meeting and Annual Meeting theme and education content. The theme selected for the coming year is "Shine Through: Shaping a Brilliant Future."

As I think about the last couple of years, I am aware that as nursing regulators we have certainly taken many opportunities to "shine" as we continue to work towards regulatory structures that are both sound and agile. Thank you for all the work you do every day in this regard.

Warm regards,

Jay Douglas, MSM, RN, CSAC, FRE

President
804.516.9028
jay.douglas@dhp.virginia.gov

NCSBN
Leading Regulatory Excellence

111 E. Wacker Drive, Suite 2900 · Chicago, IL 60601-4277

October 10, 2022

Dear Members,

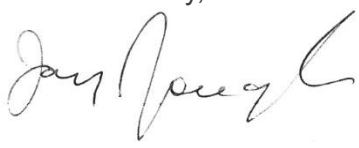
The Board of Directors would like to announce that David Benton, Chief Executive Officer, has decided not to seek a further extension to his contract when it expires at the end of September 2023. David has decided that he wants to spend more time with his wife Denise and have the flexibility to visit their kids who are in the United Kingdom and Australia.

We are grateful for David's vision and his significant contributions to the organization since 2015 that have brought NCSBN and nursing regulation to a higher level on the domestic and international stage.

The Board of Directors are embarking on a global search for David's successor and further information on the process will be provided soon. However, at this stage the Board of Directors wish to notify you, our members, of this development. After this announcement more detailed and public information will be provided in due course.

David will continue to work in his current role, and he looks forwards to collaborating with you to make further progress on the work of NCSBN for the remainder of this current fiscal year.

Yours sincerely,



Jay P. Douglas, MSM, RN, CSAC, FRE
NCSBN Board President

312.525.3600
ncsbn.org

INVESTIGATIVE PERFORMANCE MEASURES	Aug-21	Aug-22	% of Change		Jul-22	Aug-22	% of Change
Cases Reviewed at CMT	**169**	**196**	**16%**		**157**	**196**	**25%**
Cases Opened to Investigation	**76**	**87**	**14%**		**52**	**87**	**67%**
Open Cases in Investigation Queue	**470**	**437**	**-7%**		**411**	**437**	**6%**
Average Caseload per Investigator	**43**	**40**	**-7%**		**37**	**40**	**6%**
Total Investigations Completed	**88**	**69**	**-22%**		**65**	**69**	**6%**
Percentage of Cases Completed w/in Time Lines Target 77% PM 2.2	**65%**	**71%**	**6%**		**72%**	**71%**	**-1%**
Percentage of Investigations Opened Beyond 170 days Target 23% PM 2.4	**63%**	**53%**	**-10%**		**55%**	**53%**	**-2%**
Investigations Completed per Investigator *PM 3.1*	**8.0**	**6.3**	**-21%**		**6.5**	**6.3**	**-3%**
Task Back Assigned	**10**	**7**	**-30%**		**2**	**7**	**250%**
# of COVID Cases Reviewed/Opened at CMT	13/6	**1/1**			**6/1**	**1/1**	

INVESTIGATIVE PERFORMANCE MEASURES	Sep-21	Sep-22	% of Change	Aug-22	Sep-22	% of Change
Cases Reviewed at CMT	**192**	**183**	**-5%**	**196**	**183**	**-7%**
Cases Opened to Investigation	**87**	**64**	**-26%**	**87**	**64**	**-26%**
Open Cases in Investigation Queue	**499**	**428**	**-14%**	**437**	**428**	**-2%**
Average Caseload per Investigator	**45**	**39**	**-14%**	**40**	**39**	**-2%**
Total Investigations Completed	**67**	**85**	**27%**	**69**	**85**	**23%**
Percentage of Cases Completed w/in Time Lines Target 77% PM 2.2	**63%**	**53%**	**-10%**	**71%**	**53%**	**-18%**
Percentage of Investigations Opened Beyond 170 days Target 23% PM 2.4	**60%**	**57%**	**-3.0%**	**53%**	**57%**	**4.0%**
Investigations Completed per Investigator *PM 3.1*	**6**	**7.7**	**28%**	**6.3**	**7.7**	**22%**
Task Back Assigned	**8**	**8**	**0%**	**7**	**8**	**14%**
# of COVID Cases Reviewed/Opened at CMT	**36/18**	**8/4**		**1/1**	**8/4**	

INVESTIGATIVE PERFORMANCE MEASURES	Oct-21	Oct-22	% of Change	Sep-22	Oct-22	% of Change
Cases Reviewed at CMT	**155**	**153**	**-1%**	**183**	**153**	**-16%**
Cases Opened to Investigation	**73**	**44**	**-40%**	**64**	**44**	**-31%**
Open Cases in Investigation Queue	**517**	**412**	**-20%**	**428**	**412**	**-4%**
Average Caseload per Investigator	**52**	**41**	**-20%**	**39**	**41**	**6%**
Total Investigations Completed	**59**	**70**	**19%**	**85**	**70**	**-18%**
Percentage of Cases Completed w/in Time Lines Target 77% PM 2.2	**73%**	**60%**	**-13%**	**53%**	**60%**	**7%**
Percentage of Investigations Opened Beyond 170 days Target 23% PM 2.4	**60%**	**57%**	**-3%**	**57%**	**57%**	**0%**
Investigations Completed per Investigator *PM 3.1*	**5.9**	**7**	**19%**	**7.7**	**7**	**-9%**
Task Back Assigned	**1**	**9**	**800%**	**8**	**9**	**13%**
# of COVID Cases Reviewed/Opened at CMT	39/25	1/0		8/4	1/0	

Nursing Care Quality Assurance Commission
Legal Unit Performance Measures
FY 2023 (Q1)
Karl Hoehn, Legal Manager

Type of Measure	Month	Baseline	July	Aug	Sept	Q Avg.
Caseload/ Case volume	Average Caseload per Attorney	**45.92**	51	55	41	**49.00**
	Cases Assigned to Legal	**41.33**	68	61	40	**56.33**
	TOTAL Finalized Cases	**56.33**	35	45	31	**37.00**
Performance	Average of Finalized Cases per Attorney (Target 10 per month)	**14.08**	5.00	15.50	4.40	**8.30**
	Percentage of Legal Reviews Sent to RCM in 30 Days or less (Target 77%)	**78.33%**	90%	63%	90%	**81%**
	Document drafting time: Percentage of Drafts to AAG or SOA Served in 30 Days or less (Target 77%)	**86.67%**	10%	10%	0%	**7%**
Work Type/Complexity	Percentage of Cases involving an ARNP	**6.00%**	15%	14%		**10%**
	Number of Cases forwarded to AAG	**10.67**	8	9	4	**7.00**
	Finalized with Legal Review only	**21.00**	25	32	24	**27**
	Finalized by Default or Final Order After Hearing	**12.00**	4	1	3	**3**
	Finalized by STID, AO or APUC (Settlements)	**19.00**	2	5	0	**2**
	Other (releases, reinstatements)	**4.33**	4	7	4	**5.00**

Nursing Care Quality Assurance Commission
Legal Unit Performance Measures
FY 2023 (Q2)
Karl Hoehn, Legal Manager

Type of Measure	Month	Baseline	Oct	Nov	Dec	Q Avg.
Caseload/ Case volume	Average Caseload per Attorney	**45.92**	62			**62.00**
	Cases Assigned to Legal	**41.33**	60			**60.00**
	TOTAL Finalized Cases	**56.33**	33			**33.00**
Performance	Average of Finalized Cases per Attorney (Target 10 per month)	**14.08**	4.70			**4.70**
	Percentage of Legal Reviews Sent to RCM in 30 Days or less (Target 77%)	**78.33%**	54%			**54%**
	Document drafting time: Percentage of Drafts to AAG or SOA Served in 30 Days or less (Target 77%)	**86.67%**	0%			**0%**
Work Type/Complexity	Percentage of Cases involving an ARNP	**6.00%**	13%			**13%**
	Number of Cases forwarded to AAG	**10.67**	8			**8.00**
	Finalized with Legal Review only	**21.00**	14			**14.00**
	Finalized by Default or Final Order After Hearing	**12.00**	7			**7.00**
	Finalized by STID, AO or APUC (Settlements)	**19.00**	6			**6.00**
	Other (releases, reinstatements)	**4.33**	6			**6.00**

WHPS Monthly Report - August 2022

Stage

	New Intake		Current Monitoring	
License Type	2021	2022	2021	2022
ARNP			17	19
RN/LPN	5	7	272	225
NT				
Total	5	7	289	244

Referral Type - Monitoring (In-State)

	APUC		Order		Pending		RC		STID		Voluntary	
License Type	2021	2022	2021	2022	2021	2022	2021	2022	2021	2022	2021	2022
ARNP	2	2	1		1	2	7	7			3	5
RN/LPN	12	9	61	52	1	3	109	90	27	26	35	26
NT												
Total	14	11	62	52	2	5	116	97	27	26	38	31
Total Monitoring	259	222										

Referral Type - Monitoring (Out-of-State)

	APUC		Order		Pending		RC		STID		Voluntary	
License Type	2021	2022	2021	2022	2021	2022	2021	2022	2021	2022	2021	2022
ARNP					1		1	2				1
RN/LPN	2	1	7	5	2	1	10	7	6	5	1	
NT												
Total	2	1	7	5	3	1	11	9	6	5	1	1
Total Monitoring	30	22										

Discharge Type

	Not Appropriate		Offered/ Refused		Referred Back to NCQAC		Pending Discipline		Voluntary Withdrawal		Successful Completion		Deceased		Medically Discharged	
License Type	2021	2022	2021	2022	2021	2022	2021	2022	2021	2022	2021	2022	2021	2022	2021	2022
ARNP										1						
RN/LPN	1			1	2		1		2	1	3	5		1		
NT																
Total	1	0	0	1	2	0	1	0	2	2	3	5	0	1	0	0
Total Discharge	9	9														

Performance Measures

		2021	2022
Case Manager Caseload (Intake & Monitoring)	Melissa Fraser	105	53
	Heidi Collins	100	52
	Lori Linenberger	100	48
	Shelley Mezek	N/A	50
	Alicia Payne	N/A	52
Average from Inquiry to Intake - Target 7 Days		7	3
Average from Intake to Monitoring - Target 45 Days		36	35

Employment Measures (In-State)

	2021		2022	
License Type	Employed	Unemployed	Employed	Unemployed
ARNP	12	2	14	2
RN/LPN	192	53	163	43
NT				
Total	204	55	177	45
Percentage - Target 72%	79%	21%	80%	20%
Grand Total	259		222	

Washington Health Professional Services Non-Compliance Report - August 2022

No.	Case ID#	Program Start Date	Entry Reason	Anticipated Completion Date	Incident Date	Incident Type	Drug(s)	WHPS Action(s) Taken	Referred to SUDRP	Drug of Choice @ Program Entry	SUDRP Decision/Notes
1	15-12-S/RN-05780	2/10/2016	Referral Contract	8/17/2024	8/17/2022	Positive Drug Screen	Methadone	Additional Test Scheduled; Ceased/Removed from Practice; Contract Extended; Counselor Notified; Medication Restriction Reinstated; PSG Facilitator Notified; Referred for Evaluation; Referred to SUDRP	8/31/22	Opioids	Add second positive test to SOC previously file; continue in WHPS
2	16-5-S/RN-05215	7/25/2016	Referral Contract	8/16/2024	8/5/2022	Positive Drug Screen	Fentanyl	Additional Test Scheduled; Ceased/Removed from Practice; Contract Extended; Counselor Notified; Medication Restriction Reinstated; PSG Facilitator Notified; Referred for Evaluation; Referred to SUDRP; Correspondence with WSM	8/26/2022	Opioids	Extend contract and reamin under current RC in WHPS
		7/25/2016	Referral Contract	8/16/2024	8/10/2022	Positive Drug Screen	Fentanyl	Ceased/Removed from Practice; Contract Extended; Counselor Notified; Medication Restriction Reinstated; Referred for Evaluation; Referred to SUDRP; Correspondence with PSG; Correspondence with WSM			
		7/25/2016	Referral Contract	8/16/2024	8/16/2022	Positive Drug Screen	Fentanyl	Ceased/Removed from Practice; Contract Extended; Counselor Notified; Medication Restriction Reinstated; Referred for Evaluation; Referred to SUDRP; Correspondence with Nurse; Correspondence with PSG; Correspondence with WSM			
3	18-9-PO/RN-05405	11/8/2018	APUC	8/24/2024	8/24/2022	Positive Drug Screen	Alcohol	Additional Test Scheduled; Ceased/Removed from Practice; Contract Extended; PSG Facilitator Notified; Referred for Evaluation; WSM Notified; Correspondence with PSG	9/13/2022	Alcohol	Will be reviewed at 9/22/2022 SUDRP
4	1962-09-0853	4/28/2022	Order	4/27/2025	8/8/2022	Positive Drug Screen	Cannabus Tramadol	Additional Test Scheduled; Ceased/Removed from Practice; Referred for Evaluation; WSM Notified; Correspondence with Nurse; Correspondence with PSG	9/14/2022	Alcohol	Will be reviewed at 9/22/2022 SUDRP
5	1969-05-2845B	3/16/2022	Order	3/15/2023	8/9/2022	Positive Drug Screen	Alcohol	Ceased/Removed from Practice; Contract Extended; PSG Facilitator Notified; Referred for Evaluation; Referred to SUDRP; WSM Notified; Correspondence with Nurse; Correspondence with PSG; Correspondence with WSM	8/25/2022	Alcohol	Extend contract for two years and nurse is to refrain from any alcohol-based products during the duration of her contract. 9-8-22 SUDRP: Nurse requested to be seen @ SUDRP as she does not agree with contract extension. SUDRP agrees only if nurse completes SUDRP evaluation and completes a Neg Peth test by 9/16/2022.
6	1971-11-4508F	8/4/2022	Order	8/3/2027	8/25/2022	Positive Drug Screen	Cannabus Tramadol	Counselor Notified; PSG Facilitator Notified; Correspondence with Nurse	N/A	Alcohol Cannabus	Positive drug screen within first 90 days of program entry; not required to be referred to SUDRP per procedure
7	1978-11-3383B	5/28/2020	Referral Contract	5/20/2025	8/26/2022	Positive Drug Screen	Alcohol	Ceased/Removed from Practice; Counselor Notified; PSG Facilitator Notified; Referred for Evaluation; Referred to SUDRP; Correspondence with Nurse; Correspondence with WSM	9/9/2022	Opioids	Will be reviewed at 9/22/2022 SUDRP
8	1986-06-9418	8/19/2021	STID	9/23/2026	8/4/2022	Positive Drug Screen	Cocaine	Additional Test Scheduled; Counselor Notified; PSG Facilitator Notified; Referred for Evaluation; WSM Notified;	9/7/2022	Opioids Cocaine	Will be reviewed at 9/15/2022 SUDRP
9	1986-11-4238	7/2/2019	Order	6/27/2024	8/22/2022	Positive Drug Screen	Alcohol	Additional Test Scheduled; Ceased/Removed from Practice; PSG Facilitator Notified; Referred for Evaluation; WSM Notified	Pending	Alcohol	Due to be sent to SUDRP by 10/2/2022 per procedure (30 days from reported date)
10	1992-03-4219	2/21/2020	RC	2/20/2025	8/18/2022	Positive Drug Screen	Alcohol	Additional Test Scheduled; MRO Review Requested; Correspondence with Nurse	9/12/2022	Benzodiazepines Opioids	To be reviewed at 9/22/2022 SUDRP

Washington Health Professional Services Graduation Report - August 2022					
Case ID#	**Entry Reason**	**Drug of Choice**	**Program Entry Date**	**Program Completion Date**	**License**
1980-01-9498B	RC	Alcohol	8/14/2021	8/29/2022	RN
17-7-S/RN-50306	RC	Opioid	8/10/2017	8/23/2022	RN
1983-09-7480	STID	Alcohol	5/25/2021	8/9/2022	RN
17-8-V/RN-50312	Voluntary	Alcohol	8/28/2017	8/28/2022	RN
17-8-V/RN-50313	Voluntary	Sedative/Hypnotic	8/28/2017	8/27/2022	RN

WHPS Monthly Report - September 2022

Stage

	New Intake		Current Monitoring	
License Type	2021	2022	2021	2022
ARNP	1		19	19
RN/LPN	9	4	268	223
NT				
Total	10	4	287	242

Referral Type - Monitoring (In-State)

	APUC		Order		Pending		RC		STID		Voluntary	
License Type	2021	2022	2021	2022	2021	2022	2021	2022	2021	2022	2021	2022
ARNP	2	2	1	1	1		7	8	1		4	5
RN/LPN	12	9	55	52	22	2	97	90	27	25	31	25
NT												
Total	14	11	56	53	23	2	104	98	28	25	35	30
Total Monitoring	260	219										

Referral Type - Monitoring (Out-of-State)

	APUC		Order		Pending		RC		STID		Voluntary	
License Type	2021	2022	2021	2022	2021	2022	2021	2022	2021	2022	2021	2022
ARNP	1	1			1		1				1	
RN/LPN			7	5	2		8	11	6	5		1
NT												
Total	1	1	7	5	3	0	9	11	6	5	1	1
Total Monitoring	27	23										

Discharge Type

	Not Appropriate		Offered/ Refused		Referred Back to NCQAC		Pending Discipline		Voluntary Withdrawal		Successful Completion		Deceased		Medically Discharged	
License Type	2021	2022	2021	2022	2021	2022	2021	2022	2021	2022	2021	2022	2021	2022	2021	2022
ARNP																
RN/LPN		1	1		1	1	1		1	1	7	4				
NT																
Total	0	1	1	0	1	1	1	0	1	1	7	4	0	0	0	0
Total Discharge	11	7														

Performance Measures

		2021	2022
Case Manager Caseload (Intake & Monitoring)	Melissa Fraser	105	52
	Heidi Collins	114	48
	Lori Linenberger	96	48
	Shelley Mezek	N/A	50
	Alicia Payne	N/A	54
Average from Inquiry to Intake - Target 7 Days		7	1
Average from Intake to Monitoring - Target 45 Days		52	47

Employment Measures (In-State)

	2021		2022	
License Type	Employed	Unemployed	Employed	Unemployed
ARNP	11	5	14	2
RN/LPN	192	52	160	43
NT				
Total	203	57	174	45
Percentage - Target 72%	78%	22%	79%	21%
Grand Total	260		219	

Washington Health Professional Services Non-Compliance Report - September 2022

No.	Case ID#	Program Start Date	Entry Reason	Anticipated Completion Date	Incident Date	Incident Type	Drug(s)	WHPS Action(s) Taken	Referred to SUDRP Date	Drug of Choice @ Program Entry	SUDRP Decision
1	1973-01-8928	10/11/2021	RC	10/10/2026	9/2/2022	Positive Drug Screen	Alcohol	Additional Test Scheduled; Ceased/Removed from Practice; PSG Facilitator Notified; Referred for Evaluation; Referred to SUDRP; WSM Notified; Correspondence with Nurse	9/29/2022	Alcohol	Remain in WHPS w/no further action
2	1974-03-0509	3/25/2020	Voluntary	4/16/2025	9/7/2022	Relapse	Alcohol	Counselor Notified; Correspondence with Nurse	N/A	Alcohol	Voluntary nurse in WHPS and not required to report to SUDRP
					9/19/2022	Positive Drug Screen	Alcohol	Ceased/Removed from Practice			
3	1975-08-9237	8/26/2020	Pending	9/15/2025	9/28/2022	Relapse	Alcohol	Additional Test Scheduled; Counselor Notified; PSG Facilitator Notified; Referred for Evaluation; Correspondence with Nurse	10/18/2022	Alcohol	Will be reviewed by SUDRP @ 10/27 meeting
					9/28/2022	Missed Test/No Show		Additional Test Scheduled; Counselor Notified; PSG Facilitator Notified; Correspondence with Nurse	10/18/2022		
					9/30/2022	Missed Test/No Show		Additional Test Scheduled; Correspondence with Nurse	10/18/2022		
4	1977-03-9675B	5/12/2021	Order	5/11/2026	9/1/2022	Other Non-compliance		Contract Extended; Counselor Notified; PSG Facilitator Notified; Referred to SUDRP; Terminated from Employment; Correspondence with WSM	9/29/2022	Alcohol	Other: Non-compliance; Nurse was incarcerated for three months; Remain in WHPS with three months added @ the end of contract
5	1978-03-4803	7/17/2019	Referral Contract	9/24/2024	9/16/2022	Urine Drug Screen Tampering		Additional Test Scheduled; PSG Facilitator Notified; Correspondence with PSG	Pending	Alcohol	Pending: Due to be submitted to SUDRP by 10/29/2022
6	1979-06-4609B	7/13/2021	Order	7/8/2026	9/9/2022	Missed Test/No Show		Additional Test Scheduled; Referred for Evaluation	N/A	Fentanyl	2nd Missed Drug Screen in one year period. Referred for SUD Eval. Not required to be referred to SUDRP per procedure W43.01
7	1982-05-1286	2/3/2021	RC	2/2/2026	9/16/2022	Missed Test/No Show		Self Test	N/A	Oxycodone	1st missed test. Not required to be referred to SUDRP per procedure W43.01
8	1984-07-1733	9/28/2020	Referral Contract	9/28/2025	9/19/2022	Positive Drug Screen	Alcohol	Additional Test Scheduled; Ceased/Removed from Practice; PSG Facilitator Notified; Referred for Evaluation; Referred to SUDRP; WSM Notified; Correspondence with Nurse	9/29/2022	Opioids	Remain in WHPS w/no further action
9	1986-08-3609	11/10/2021	Order	12/2/2026	9/28/2022	Positive Drug Screen	Alcohol	Additional Test Scheduled; PSG Facilitator Notified; Referred for Evaluation; Correspondence with Nurse	Pending	Alcohol	Pending: Due to be submitted to SUDRP by 11/5/2022
10	1987-09-8584	2/9/2021	Referral Contract	9/3/2024	9/3/2022	Relapse	Alcohol	Additional Test Scheduled; Ceased/Removed from Practice; Contract Extended; Counselor Notified; PSG Facilitator Notified; Referred for Evaluation; Referred to SUDRP; Correspondence with Nurse; Correspondence with WSM	9/9/2022	Opioids	Remain in WHPS with two year contract extension
11	1992-12-7471	4/28/2022	Voluntary	4/27/2023	9/19/2022	Missed Test/No Show		Additional Test Scheduled; WSM Notified; Correspondence with Nurse	N/A	No Use Reported	1st missed test. Not required to be referred to SUDRP per procedure W43.01

)SC Non-Compliance Spreadsheet

:d By: Alicia Payne 10/19/2022 6:06 PM
WHPS

Washington Health Professional Services Graduation Report - September 2022					
Case ID#	**Entry Reason**	**Drug of Choice**	**Program Entry Date**	**Program Completion Date**	**License**
17-9-RN-50325	RC	Alcohol	12/5/2017	9/20/2022	RN
17-7-V/RN-05214B	Voluntary	Alcohol	9/6/2017	9/19/2022	RN
1972-10-4531	STID	Fentanyl	6/19/2020	9/30/2022	RN
1987-10-2496	RC	Opioids	11/7/2019	9/2/2022	LPN

Graduation Report

Confidential Information - Do Not Distribute
Generated By: Alicia Payne 10/19/2022 6:17 PM
WHPS

Washington Health Professional Services Graduation Report - October 2022					
Case ID#	**Entry Reason**	**Drug of Choice**	**Program Entry Date**	**Program Completion Date**	**License**
17-01-PO/ARNP-50267	APUC	Alcohol	4/26/2017	10/31/2022	ARNP
18-8-V/RN-05397	Voluntary	Alcohol	8/30/2018	10/3/2022	RN
1959-06-3752	Order	Alcohol	10/20/2020	10/20/2022	RN
1976-11-7122	STID	Alcohol	3/23/2021	10/27/2022	RN
17-9-V/RN-50323	Voluntary	Alcohol	10/3/2017	10/17/2022	RN

WHPS Monthly Report - October 2022

Stage

	New Intake		Current Monitoring	
License Type	2021	2022	2021	2022
ARNP			18	19
RN/LPN	7	7	262	222
NT				
Total	7	7	280	241

Referral Type - Monitoring (In-State)

	APUC		Order		Pending		RC		STID		Voluntary	
License Type	2021	2022	2021	2022	2021	2022	2021	2022	2021	2022	2021	2022
ARNP	2	2	1	1	1		7	8			4	5
RN/LPN	12	9	49	53	25	1	97	90	26	26	29	24
NT												
Total	14	11	50	54	26	1	104	98	26	26	33	29
Total Monitoring	253	219										

Referral Type - Monitoring (Out-of-State)

	APUC		Order		Pending		RC		STID		Voluntary	
License Type	2021	2022	2021	2022	2021	2022	2021	2022	2021	2022	2021	2022
ARNP	1	1		2							1	1
RN/LPN		6	6	8	3		9		7	4		
NT												
Total	1	7	6	10	3	0	9	0	7	4	1	1
Total Monitoring	27	22										

Discharge Type

	Not Appropriate		Offered/ Refused		Referred Back to NCQAC		Pending Discipline		Voluntary Withdrawal		Successful Completion		Deceased		Medically Discharged	
License Type	2021	2022	2021	2022	2021	2022	2021	2022	2021	2022	2021	2022	2021	2022	2021	2022
ARNP												1				
RN/LPN			1	1	1	1			2	1	10	4		1		
NT																
Total	0	0	1	1	1	1	0	0	2	1	10	5	0	1	0	0
Total Discharge	14	9														

Performance Measures

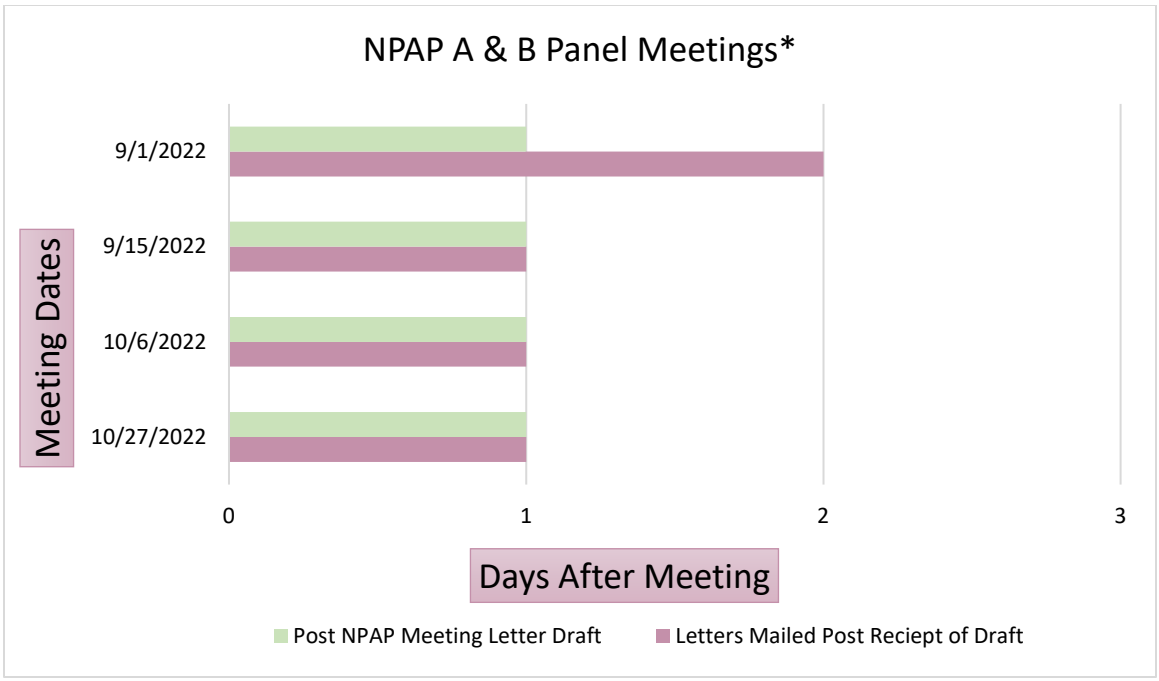
		2021	2022
Case Manager Caseload (Intake & Monitoring)	Melissa Fraser	101	52
	Heidi Collins	97	46
	Lori Linenberger	98	48
	Shelley Mezek	N/A	51
	Alicia Payne	N/A	52
Average from Inquiry to Intake - Target 7 Days		5	1
Average from Intake to Monitoring - Target 45 Days		22	61

Employment Measures (In-State)

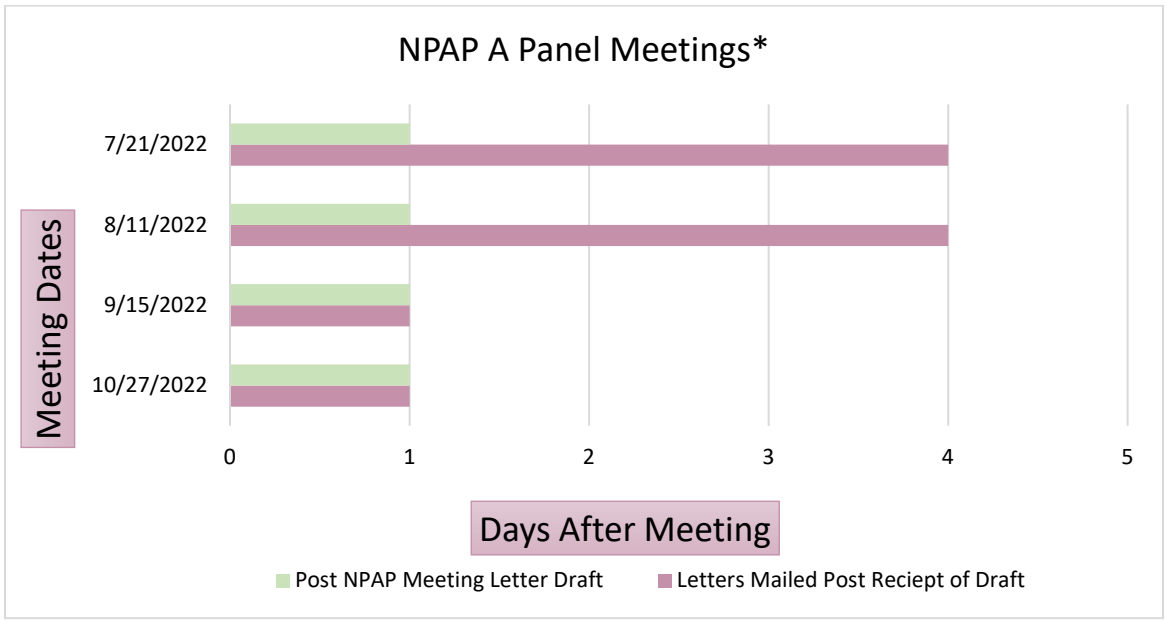
	2021		2022	
License Type	Employed	Unemployed	Employed	Unemployed
ARNP	10	5	14	2
RN/LPN	180	58	156	47
NT				
Total	190	63	170	49
Percentage - Target 72%	75%	25%	78%	22%
Grand Total	253		219	

Washington Health Professional Services Non-Compliance Report - October 2022

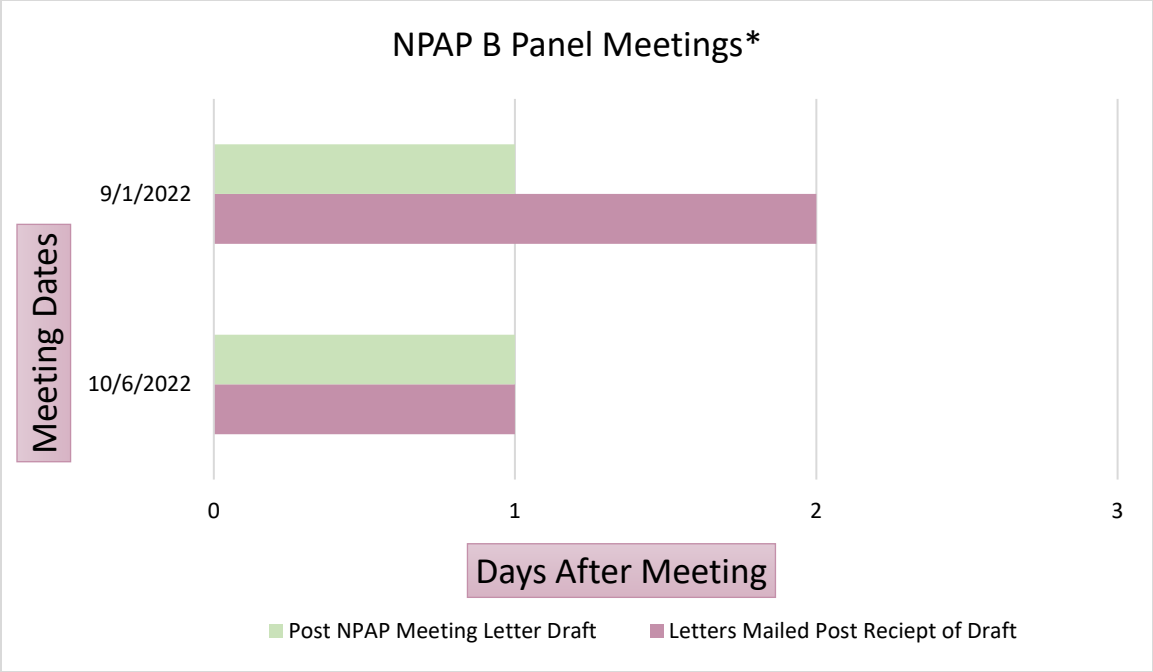
No.	Case ID#	Program Start Date	Entry Reason	Anticipated Completion Date	Incident Date	Incident Type	Drug(s)	WHPS Action(s) Taken	Referred to SUDRP	Drug of Choice @ Program Entry	SUDRP Decision
1	14-S/RN-05215	7/25/2016	Referral Contract	10/3/2024	10/3/2022	Positive Drug Screen	Kratom	Additional Test Scheduled; Contract Extended; Counselor Notified; Medication Restriction Reinstated; PSG Facilitator Notified; Referred for Evaluation; Referred to SUDRP; Correspondence with Nurse; Correspondence with PSG	10/19/2022	Opioids	Continue in WHPS under current RC
2	18-3-S/RN-05365	5/4/2018	Referral Contract	5/3/2023	10/13/2022	Missed Test/No Show	N/A	Additional Test Scheduled; Referred for Evaluation; WSM Notified; Correspondence with Nurse; Correspondence with WSM	Pending	Stimulant	3rd missed test in two year period; Due to SUDRP by 11/14/2022
3	1962-09-0853	4/28/2022	Order	4/27/2027	10/7/2022	Missed Test/No Show	N/A	Self Test; Testing Frequency Increased	N/A	Alcohol	1st missed test; not required to send to SUDRP
4	1968-11-9036D	10/14/2019	Order	7/6/2023	10/12/2022	Positive Drug Screen	Tramadol	Additional Test Scheduled; Correspondence with Nurse	Pending	Cannabis	Due to SUDRP by 11/27/2022
					10/25/2022	Missed Test/No Show	N/A	Correspondence with Nurse			
5	1972-09-1221D	4/28/2020	Order	5/4/2025	10/25/2022	Missed Test/No Show	N/A	Additional Test Scheduled	N/A	Amphetamine	1st missed test; not required to send to SUDRP
6	1978-03-4803	7/17/2019	Referral Contract	9/24/2024	10/10/2022	Positive Drug Screen	Alcohol	MRO Review Requested; PSG Facilitator Notified; Referred for Evaluation; WSM Notified; Correspondence with Nurse; Correspondence with WSM	Pending	Alcohol	Due to SUDRP by 11/18/2022
					10/17/2022	Missed Test/No Show	N/A	Ceased/Removed from Practice; WSM Notified; Correspondence with Nurse			
7	1978-10-9772	4/6/2022	Referral Contract	4/5/2025	10/11/2022	Positive Drug Screen	Alcohol	Counselor Notified; PSG Facilitator Notified; Referred for Evaluation; Testing Frequency Increased; WSM Notified; Correspondence with Nurse; Correspondence with PSG; Correspondence with WSM	Pending	Sedative/Hypnotic	Due to SUDRP by 11/18/2022
8	1978-11-3383B	5/28/2020	Referral Contract	5/20/2025	10/4/2022	Missed Test/No Show	Alcohol	Additional Test Scheduled; Correspondence with Nurse	Pending	Opioids	Due to SUDRP by 1/1/2023
					10/24/2022	Positive Drug Screen		Additional Test Scheduled			
9	1980-05-0486	10/7/2022	Order	10/6/2027	10/28/2022	Missed Test/No Show	N/A	Additional Test Scheduled; WSM Notified; Correspondence with Nurse	N/A	Opioids	1st missed test; not required to send to SUDRP



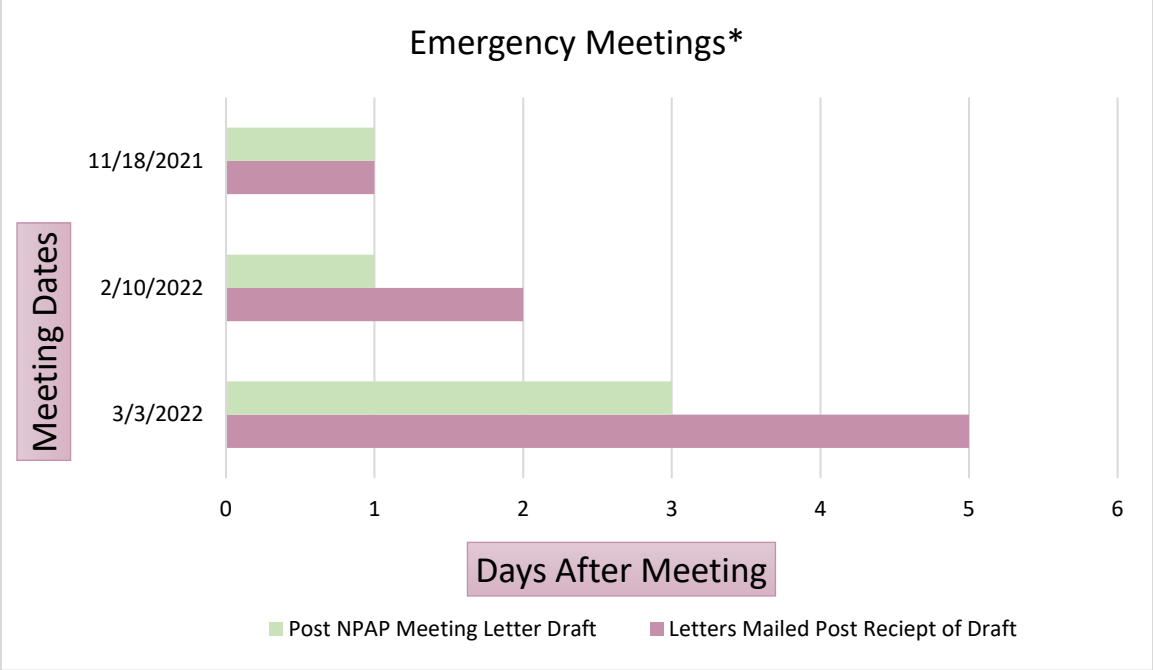
**Letters mailed within 30 days of NPAP meeting*



**Letters mailed within 30 days of NPAP meeting*



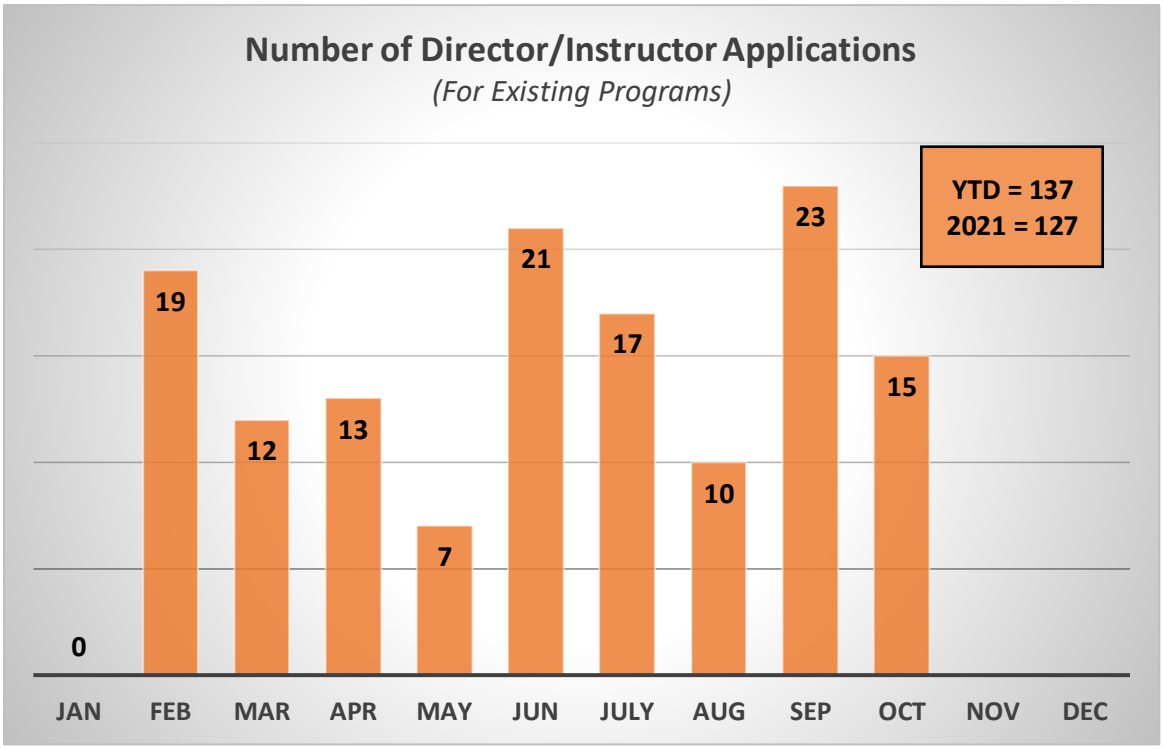
**Letters mailed within 30 days of NPAP meeting*



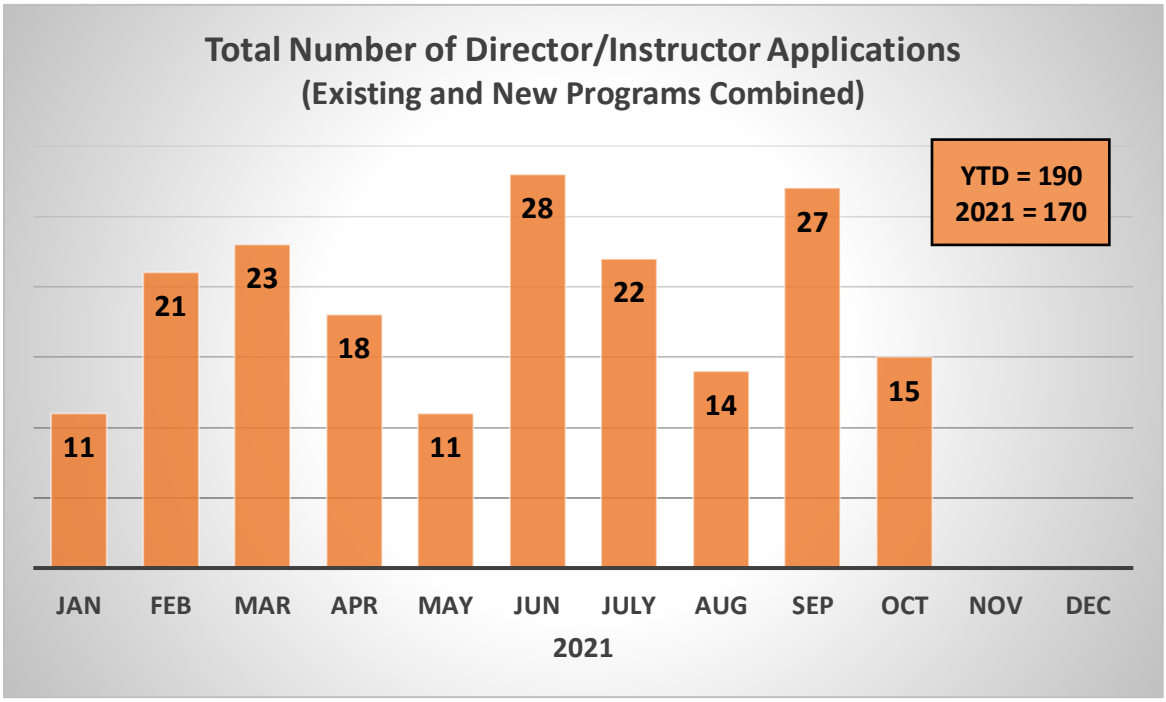
**Letters mailed within 30 days of NPAP meeting*

Data and Performance Measures Related to Nursing Assistant Training Programs

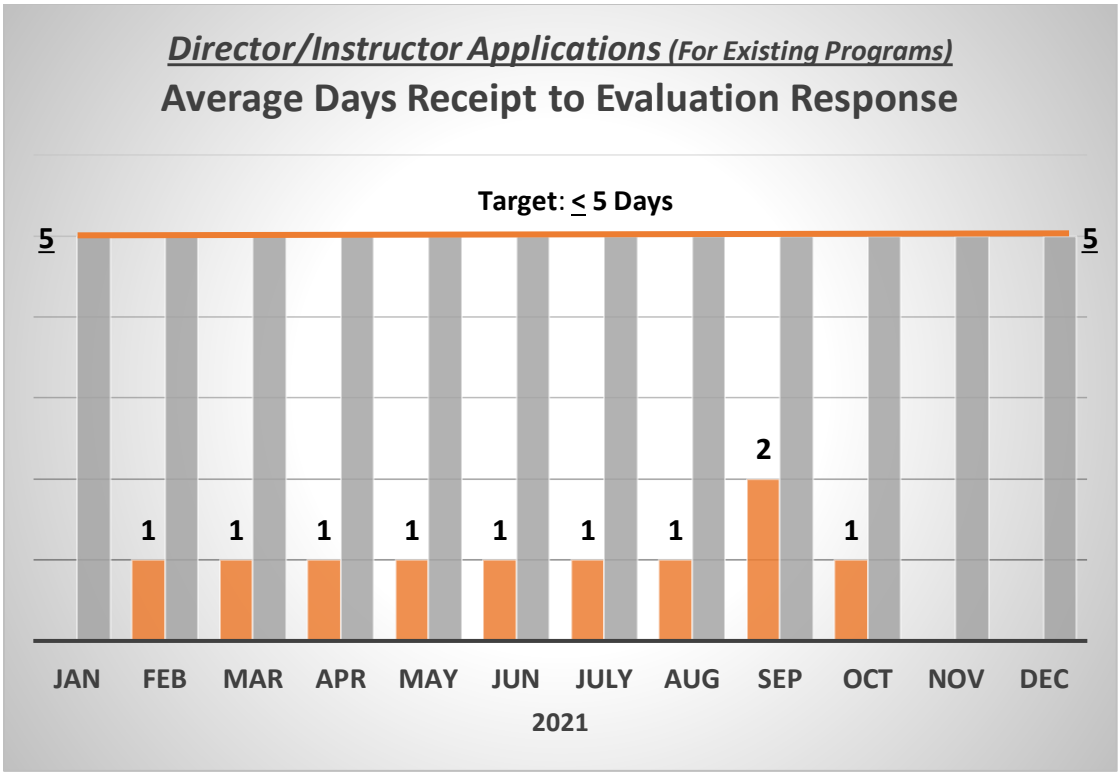
Descriptive Data:



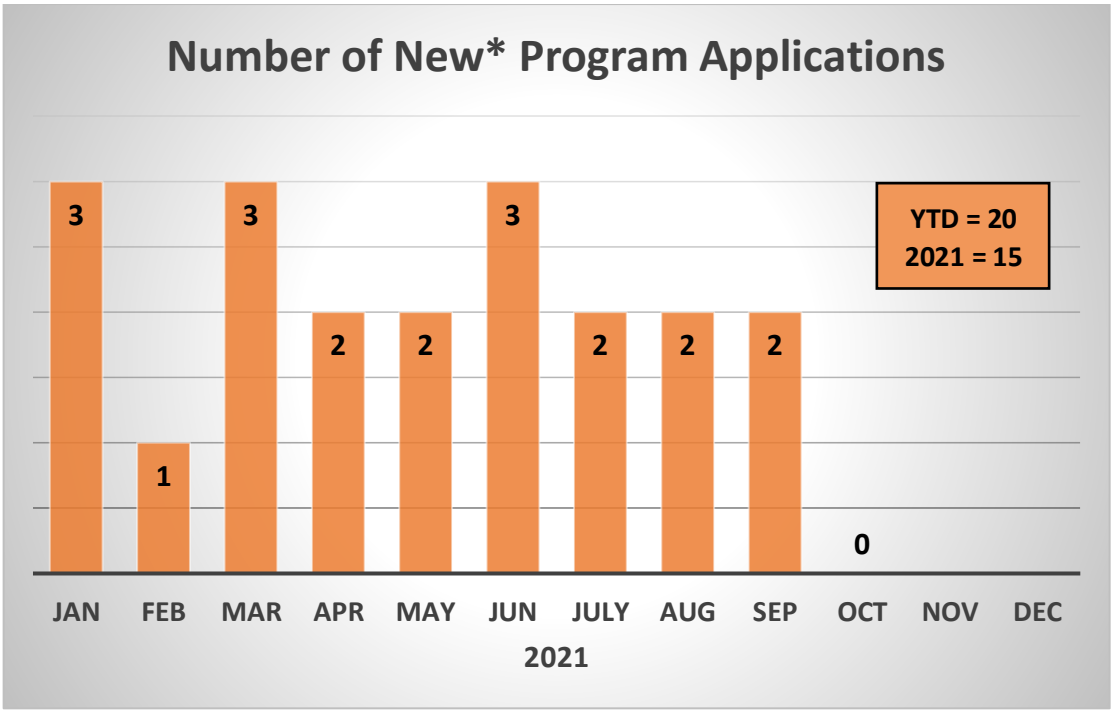
Descriptive Data:



Performance Measure:

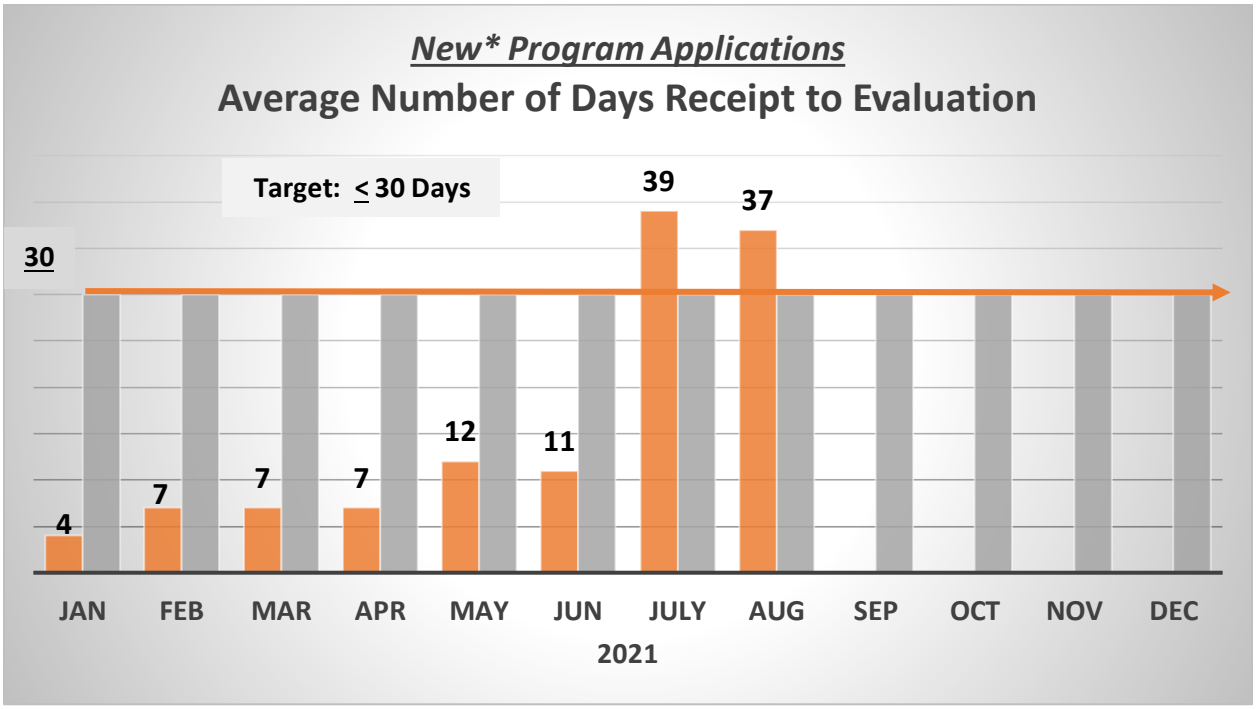


Descriptive Data:



*Does not include 2nd/subsequent reviews of revised applications

Performance Measure:



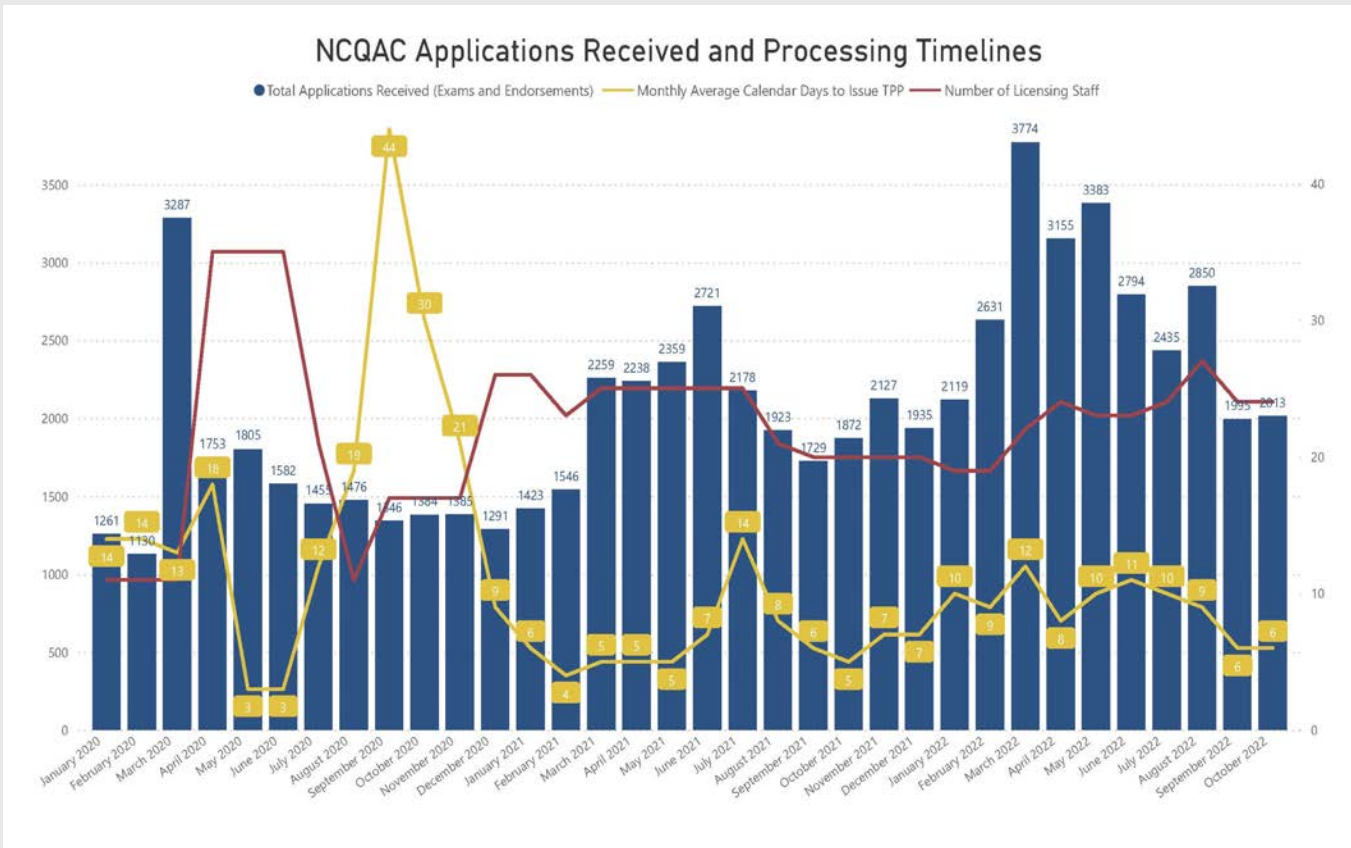
*Does not include 2nd/subsequent reviews of revised applications

Nursing Care Quality Assurance Commission (NCQAC)
COVID-19 Response for Nurse Licensure

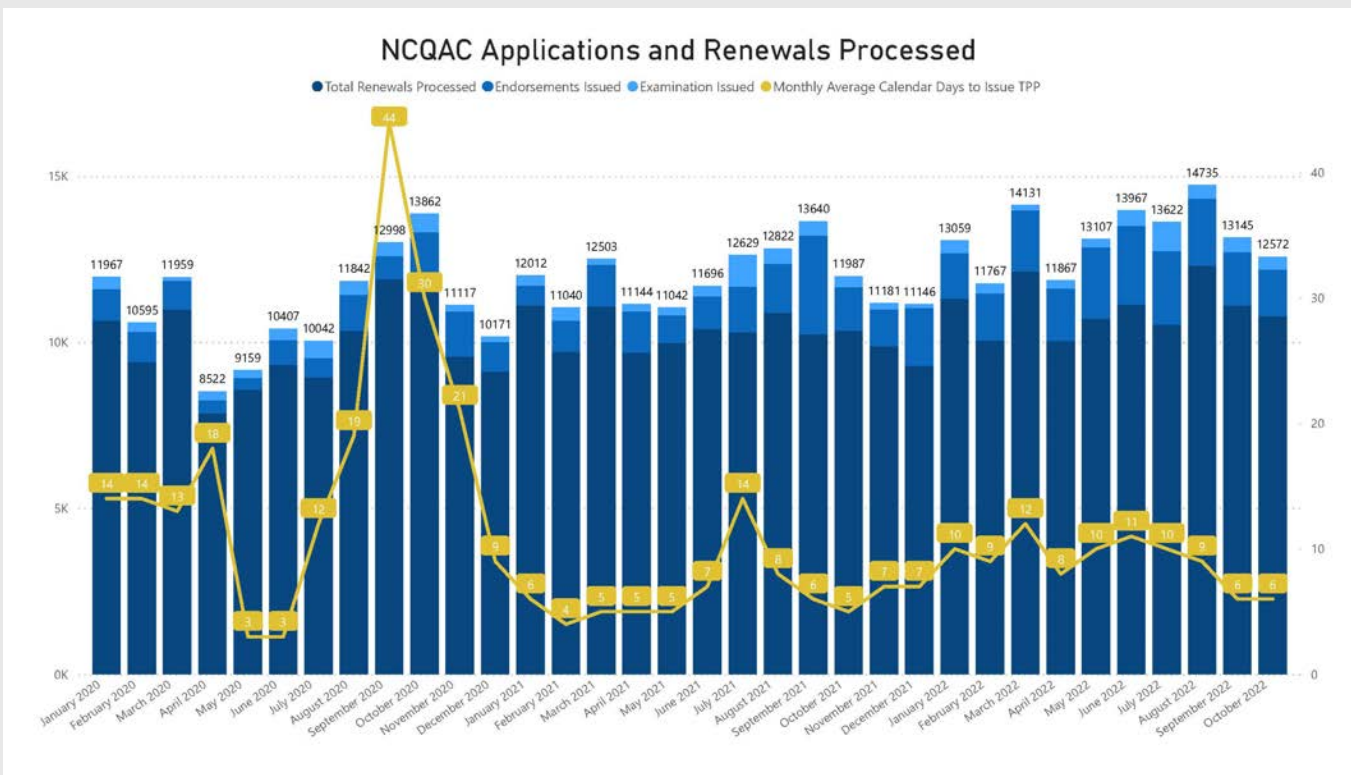
Weekly Update: Monday, October 31, 2022

As of October 31, 2022, the current processing time to issue a complete temporary practice permit (TPP) is five days (including weekends and holidays). The NCQAC hired temporary staff and shifted resources to meet the seven-day licensure mandate by the beginning of September 2022.

The first chart below reflects the monthly nursing application volumes, application processing times, and staffing levels for NCQAC since January 2020. The NCQAC received 1,995 new applications during September 2022. Additionally, in comparing January through September of 2021 to 2022, the NCQAC received 18,376 new applications in 2021 compared to 25,136 new applications in 2022 (37% increase).



The second chart on this report reflects the monthly outputs from the NCQAC. In August 2022, the NCQAC issued a total of 2,067 new nursing licenses. In addition, 11,110 nursing renewals were completed.



Note: **Temporary practice permits (TPP)are issued to nursing applicants who meet all licensure requirements, except for the FBI fingerprint background check. A preliminary background check is completed on all applications received by the NCQAC.*

WCN/NCQAC CHECK IN Meeting
September 6, 2022 9:00 AM
Agenda

Present: Sofia Aragon, Paula Meyer, Bethany Mauden, Frank Kohel

Topics	Discussion	Action Needed
Call to order		9:00am
1. Member to work with Barbara Trehearne and Dawn Morrell on deliverables	Barbara is in her fourth and final term as a pro tem member. It would be nice to have someone appointed as new pro tem to work with Barbara and Dawn on the evaluation of deliverables prior to June 30, 2023, the end of Barbara's term.	To be further discussed at a future meeting.
2. Rules review for equity	Someone from WCN board or diversity critical gap group. NCQAC members will be MaiKia Moua and Judy Loveless-Morris	To meet same standards as other rules. To be discussed at the WCN Meeting.
3. Rural Critical Gap Group	A. Leader for the group: Brenda Senger B. RONE	Possibly add Cheri Osler to the Rural Critical Gap Group
4. HELMS supply data collection	Communications for testing. Testing will take place, suggest Brenda and Amy are to meet to discuss further. DOH is waiting for the questions to be finalized.	Sofia will request Brenda reach out to Amy. Paula will reach out to Teresa regarding the timeline.
5. Surcharge projections	Jonnita has new staff; we have not received the projections.	
6. Sept. 9 COVID presentation	What other panelists would like to share? Big summary of what is found. What can be done better in preparation for next health crisis.	

7. University faculty meeting with Governor's office	We are waiting to hear back from the Governor's office with availability. The pay gap between University and CC is less then previously thought. The disparity is with clinical practice salaries. The NCQAC needs to be very clear with the Governor's office on the amounts as well as faculty concerns. WSNA will work with the legislature if NCQAC works with the Gov office.	To be further discussed post meeting.
Next Meeting –	September 27, 2022	

Approved:

WCN/NCQAC Meeting

Tuesday, October 25, 2022 (4:00 pm to 5:00 pm)

Washington Center for Nursing Office
Minutes

Present: Sofia Aragon, Paula Meyer, Angelina Flores-Montoya, Bethany Mauden

Topics	Discussion	Action Needed
	Meeting called to order at 4:10 pm.	
Multicultural Nurse Organizations – Does WCN have a list of MCNOs with a contact person and contact information?	Paula not sure she has them all. Do we have a list? WCN has regular contacts and WCN has those that are on the WCN Diversity Committee. WSNA has recruited several of WCN's former Diversity Committee Members on their Practice Advisory Group. Angelina spoke to the Washington Chapter of the Hispanic Nurses Association that disbanded. Noted faculty at Green River that was part of the Hispanic group. NCQAC calls the MCNOs for public advocacy groups and tries to keep track. The WCN Diversity Committee is posted on the WCN website. Paula congratulated Sofia nomination for the Most Influential Filipina Women in the World, awarded by the Filipino Women's Network at their annual Global Summit in Lisbon, Portugal. Sofia noted this comes with the opportunity at award ceremony to promote support for our work.	https://www.wcnursing.org/diversity-equity-in-nursing/wcn-diversity-advisory-committee/
January 2023 NCQAC Update	January 13, 2023 is the date for the WCN Update to NCQAC. Materials for the members packet are due December 19, 2022.	WCN materials for the NCQAC members packet are due December 19, 2022, to NCQAC.
University Faculty	The university faculty, meeting scheduled with the Governor's Office is Wednesday, November 2, 2022, at 8:00 am. Discussion about a possible Medicaid match through Sue Birch's work. Sue	

	could support ARNP residencies that take Medicaid money. Paula noted John Altman has something for NCQAC to do. She noted the number of people approaching her about nursing faculty. We want to hear what he has to say. What do we need to take to meeting? Sofia spoke with Angelina and Patricia on what we need. Kristen Swanson at Seattle University has done a per nurse faculty number. Noted that salary is pre Covid and salary rates have gone up and we want to be competitive. We don't want to compare between the groups. How do you think we can get there? Any idea about faculty? WCN had 2019/20 numbers and Angelina received 2020/21 data for vacancy rates. She showed what we do have now. We have retiring faculty numbers, and we have recent vacancy rates and ages through numbers. Can look at both numbers and percentages? Can do some data visualization and current salaries. $88,000 for an RN average and faculty is around the same with $88,000 the high end of the salary range. We have the chart with the ARNPs and most faculty is master prepared. Not enough salary to pull someone away from their staff positions. It was noted most nurses only have one position; most don't do two positions. Equitable playing field is needed. Noted the looming crisis because of retirements. At the meeting, Paula will do brief introduction. Angelina next with the data, then to Sue for her ideas. Sue is also good for ARNP focus and the need for ARNPs. Angelina has put together a fact sheet. Are we missing an ask number? Discussion about what is the ask number. $40 million? Gap in the salary multiplied by number of four-year faculty. Discussion about almost same number of students and graduate students with two-year and four-year schools. Should it be an equal amount of money? More when	

	you add grad students, another big talking point. Many faculty teach both pre and post licensure. OFM is invited to the meeting as well. Do we need to run the ask number by Kristin? We want a credible number. Could Angelina and Patricia reach out to her for Kristin's response to the number. Sofia spoke to the history of the 40 million number. Discussion about the number. We can't accept more nursing students because we don't have faculty. Increasing slots want matter without faculty. Angelina to send slides to Paula and will add the 2020 data in the next couple of days. Also talking to Katherine Weiss at WSNA. Discussion about private vs public schools might go to student to make it equitable. How many private students are part of the hole? Look at RN and graduate students, could be a follow up. List of Nursing Schools in Washington State attached. Is sue coming to the prep meeting on Tuesday? She has been invited. Kristin's chart will need to go to them as well. Angelina will also have slides and charts to share. We want to check with WSNA to make sure we are working toward the same goals. Governor has a soft spot for nurses and having a second meeting is good news. Noted some in the legislature may want to move on.	Angelina – Is reaching out to Kristin Swanson about $40 million ask number. Angelina - Update data and send slides to Paula. Angelina - Update Katherine Weiss and see if she has any updates. See if she can update the student number in private institutions.
HELMS	Are we testing in the HELMS system in the near future? Paula gave an update noting Sales Force has staff turnover issues that is prolonging deadlines. The integrator is another group writing the code and have lots of turnover in the last year. Longer than anticipated and longer to get to the testing point. Now going live later in 2023. The testing of the supply data questions will be 2023. Theresa Corrado will be in change and have someone to shadow testers when the testing happens. Can WCN Board of Director Members put the time in? They might have to be in Olympia in person for testing. They will try make testing virtually. They will try to find out which month for testing. Discussion to keep the	

	messaging going during this time while testing and developing. Do we need to do a sample in between and discussion about contract.	
Next Meeting	4:53pm adjourned. The next meeting is November 29, 2022, at 4:00 pm.	

Submitted by: Frank Kohel

Approved:

Out of State Travel Report

Ohio State University Colleges of Nursing and Medicine

Third National Summit on Promoting Well-being and Resilience in Healthcare Professionals
September 28-30, 2022, Columbus Ohio

John Furman PhD, MSN, COHN-S

PURPOSE:

"Clinician burnout and its major symptoms – stress, anxiety, depression, compassion fatigue and suicidal ideation – had already reached epidemic proportions before COVID-19. Since the Pandemic, burnout rates and mental health problems in clinicians have skyrocketed. That is why conversations (regarding these issues) are so critical. We need urgent, evidence-based solutions.

The summit gathered some of the nation's brightest minds, leaders, expert practitioners, and renowned motivational speakers to share their successes and lessons learned, and to inspire to create meaningful change to improve our population's health and well-being outcomes. The Summit showcases investments that organizations should make in resources, programming and culture that will optimize the health and well-being of clinicians and learners."

OUTCOME:

Highlighted Learning Activities:

Healthy Nurse, Healthy Nation: Hope, Holism, and Healing - Research points to a mental health crisis among nurses. Nurses are under unprecedented stress. This session will share current nurse mental health and well-being data, focusing on data collected during the COVID-19 pandemic. Specifics on free, evidence-based resources to assist nurses on well-being and mental health will be discussed. Cutting edge solutions for the nurse well-being crisis will be examined with dialogue involving the audience and nurse forums.

Strategies to Enhance Wellness and Resilience in Interprofessional Health Sciences Students - The question of how best to address the wellness needs of health sciences students is an urgent priority, especially in light of the national epidemic of clinician burnout. In this workshop, interdisciplinary presenters from

The Ohio State University Health Sciences Colleges will review effective academic strategies that create opportunities for students to maintain wellness, implement self-care, and build resilience. Preparing students to be resilient clinicians requires educators to integrate wellness academic programming into curricula.

Supporting Staff in Uncertain Times: Implementation of Brief Emotional Support Teams - This session will examine a number of activities implemented by the Stress Trauma and Resilience (STAR) Program before and during the pandemic to support staff. This presentation will highlight the implementation of Brief Emotional Support Teams (BEST) which grew to include over 850 trained hospital staff peer supporters during the pandemic. The BEST teams became the primary tool of the BEST programing providing approximately 2,000 peer support interventions per month during the height of the pandemic. Participants will understand the individual components of BEST including brief psychological stabilization, crisis intervention, elements of cognitive behavioral therapy and cognitive processing therapy and elements of motivational interviewing.

Making the Business Case for Clinician Health and Well-being - This panel presentation will describe how poor clinician wellbeing impacts medical errors, presenteeism, absenteeism, and healthcare costs. Panels also will discuss the return on investment and value of investment for fixing system issues and providing wellness cultures, programs and resources to support clinician health and well-being.

From Awareness to Action: The Dr. Lorna Breen Heroes' Foundation - The mission of the Dr. Lorna Breen Hero Foundation is to reduce burnout of health care professionals and safeguard their well-being and job satisfaction. We envision a world where seeking mental health services is universally viewed as a sign of strength for health care professionals. The Foundation began in the summer of 2020 in response to the outpouring of concerns expressed by the healthcare workforce following the suicide of the Foundation's namesake, Dr. Lorna Breen, an emergency medicine physician in NYC. The Foundation has served to catalyze change across the industry including securing the first federal law focused on supporting the wellbeing of the healthcare workforce known as the Dr. Lorna Breen Health Care Provider Protection Act.

Workplace Wellness and Suicide Prevention - This panel presentation will describe worksite risk factors that place clinicians at risk for suicide. Key tactics to reduce risk for clinician suicide will be discussed along with workplace strategies

following a clinician suicide. The panel will discuss workplace wellness, mental health of healthcare professionals, suicide and suicide prevention amongst healthcare professionals. The Healer, Assessment and Referral (HEAR) program at UC San Diego, is highlighted. HEAR is a program for suicide prevention amongst healthcare professionals recently recognized by the American Academy of Nurses as an Edgerunner, a model for replication.

RECOMMENDATION:

The National Summit on Promoting Well-being and Resilience in Healthcare Professionals provides evidence-based resources, information, strategies, and action items to incorporate into your organizational culture. These best practices will help to prevent clinician burnout, build stronger wellness cultures, and improve the overall health and well-being of our healthcare workforce. The summit also offered interdisciplinary networking and educational opportunities in the health science fields including dentistry, medicine, nursing, optometry, pharmacy, social work, and veterinary medicine.

This is a strong opportunity to learn strategies to overcome stressors in healthcare. The information and resources provided provide a roadmap for organizations to address current and future challenges and are applicable across the clinical, administrative, and regulatory areas.

Respectfully submitted,

John Furman PhD, MSN, COHN-S October 4, 2022

Federation of Associations of Regulatory Boards

2022 Regulatory Law Seminar

September 29 - October 1, 2022

Hyatt Regency Reston in Reston, Virginia

Attended by Bethany Mauden

Purpose

The FARB RLS welcomes all who seek a legal immersion into all aspects of professional licensing regulatory boards. This is a learning and networking opportunity for Attorneys General representatives, federation attorneys, board members, and board staff where the presentations encourage collaborative education and insight into matters affecting the professions. Gaining traction on emerging trends, gain insight on best practices, stay ahead of new legislation, and learn from each other through presentations.

Presentations of Note for me

- **Regulatory Legislative Update** - Speaker: Ronald Jacobs, Venable LLP, Washington, DC
- **Regulatory Board Advisory Opinions**: **To Advise or Not To Advise** - Speaker: Sarah A. Bradley, Nevada State Board of Medical Examiners - Provide an overview of advisory opinions, including the process for requesting and drafting them; Discuss the pitfalls of advisory opinions, as well as possible scenarios where they may be appropriate; and Discuss issues related to advisory opinions such as guidance provided in newsletters and frequently asked questions
- **Public Records Requests as Both a Shield and a Sword** - Speaker: Jeff Gray, Bailey & Dixon, LLP, Raleigh, NC - All public records laws have exemptions, categories of information that the state agency is not required to produce.
- **Emerging from the Pandemic: Current State of Telehealth** - Moderator: Mark R. Brengelman, Attorney At Law PLLC, Frankfort, KY – expiring rules in relation to telehealth is a concern as states end the emergency orders.
- **Mobility Models: Interstate Compacts, Universal Licensure and Expedited Endorsements** - Moderator: Mai Lin Petrine, Federation of State Massage Therapy Boards, Overland Park, KS – concerning as these compacts can override rules in the state they are approved unless there are alternative avenues for endorsement and licensure.
- **Sexual Misconduct** - Speakers: Christopher Luke Gerard, Washington Office of the Attorney General, Olympia, WA. Sophia Long, Nevada State Board of Massage Therapy, Reno, NV – it was great to have our state highlighted for our policy on sexual misconduct.
- **Top Regulatory Cases** - Speaker: Jennifer Ancona Semko, Baker and McKenzie, LLP, Washington, DC - top regulatory case of note was for rooms scans during online testing that was determined to be unconstitutional by a federal judge in Ohio.

Recommendation

This was my first opportunity to attend a conference for the NCQAC and I attended the FARB conference which was open not only to attorneys, but also board members and staff. While some of the conference was towards attorneys it was fascinating for me as a staff member, and I would love to continue attending. One thing I would like to do with this information is verify that our FAQ page to see if we link to state laws.

Travel Report
2022 Federation of Associations of Regulatory Boards
Regulatory Law Seminar

29 September – 1 October 2022
Reston, Virginia

Karl Hoehn

PURPOSE: The Regulatory Law Seminar is an annual conference sponsored by the Federation of Associations of Regulatory Boards. The intended audience is legal practitioners working in the regulatory field. It covers current legal and other issues relevant to regulatory boards and the practice of advising and litigating regulatory board administrative law cases. It also counts toward Continuing Legal Education requirements for lawyers.

OUTCOME: I attended all the sessions. Among the issues discussed were:

1. Describe who is the client.

2. Review multiple employment models and roles for legal services.

3. Discuss competency in the law and minimal competency in technology.

4. Outline open meetings, open records, and attorney-client privilege with the agency.

5. Analyze the ethics of advisory opinions and agency FAQ.

6. Discuss responsibilities of supervisors/subordinates and responsibilities over non-lawyers.

7. Diversity, equity, and inclusion – a review of the new ABA model rule and its fallout

8. Review ethics of legislation and dealing with legislators.

9. Discuss misconduct outside the profession that gets attorneys in trouble.

10. Identify the role of an Office of Administrative Hearings about Professional Licensing Board actions.

11. Review common issues in litigation before an Office of Administrative Hearings.

12. Discuss specific Professional Licensing Board cases before an Office of Administrative Hearings.

13. Identify how to best respond to recommended decisions from an Office of Administrative Hearings.

14. Review the District of Columbia system for Licensing Boards.

15. Discuss the powers and limitations of the Licensing Boards as to licensed professionals.

16. Review the D.C. Office of Administrative Hearings, its history, its jurisdictional powers and limitations, and its role in providing hearings to licensees when facing adverse licensing actions.

17. Review how state public records laws are used as “discovery tools” in administrative (and tort) litigation against occupational and professional licensing boards.

18. Discuss practical advice on using statutory exemptions or rules of civil procedure and evidence codes to shield the board.

19. Identify examples, based in case law, to lessen the impact of public records law requests.

20. Review Witness preparation.

21. Discuss the use of affidavits in hearings.

22. Discuss opponents use of public records requests to circumvent discovery.

23. Review how state medical boards addressed the demand for telehealth services during the pandemic with a focus on the challenges and successes.

24. Identify the current state of telehealth practice and how medical boards are addressing it's expanded use.

25. Describe the historical development of telehealth in various health care regulated professions.

26. Review the evolution of telehealth in response to the COVID-19 pandemic and the use of various governmental "tools" for quick implementation.

27. Forecast future trends in telehealth as the pandemic fades.

28. Discuss the enactment of the Universal Recognition of Occupational Licenses Act (Mississippi Model).

29. Discuss pros and cons associated with the enactment of the Act.

30. Discuss the future for the landscape of the legislation.

31. Discuss the immediate differences between compacts and the Act.

32. Identify sexually harassing behavior and what to do about it.

33. Discuss the most noteworthy court decisions related to licensure and regulation of the past calendar year.

34. Review the constitutional, statutory, and other legal issues faced by licensing agencies and regulatory boards.

RECOMMENDATION: In my opinion, this is perhaps the single most valuable training opportunity in the country for our staff attorneys. I would recommend continued participation by sending as many NCQAC legal staff as possible to both attend and present at the conference.

Travel Report
2022 Federation of Association of Regulatory Boards
Regulatory Law Seminar

28 September – 2 October 2022
Reston, Virginia

Jeffery Lippert

PURPOSE: This is an annual conference primarily for legal practitioners in which attendees participate in presentations designed to inform, update, and instruct regulatory board legal practitioners on current legal and other issues relevant to regulatory boards and the practice of advising and litigating regulatory board administrative law cases.

OUTCOME: The above participants attended all conference sessions and achieved the following learning objectives:

1. Describe who is the client.

2. Review multiple employment models and roles for legal services.

3. Discuss competency in the law and minimal competency in technology.

4. Outline open meetings, open records, and attorney-client privilege with the agency.

5. Analyze the ethics of advisory opinions and agency FAQ.

6. Discuss responsibilities of supervisors/subordinates and responsibilities over non-lawyers.

7. Diversity, equity, and inclusion – a review of the new ABA model rule and its fallout

8. Review ethics of legislation and dealing with legislators.

9. Discuss misconduct outside the profession that gets attorneys in trouble.

10. Identify the role of an Office of Administrative Hearings about Professional Licensing Board actions.

11. Review common issues in litigation before an Office of Administrative Hearings.

12. Discuss specific Professional Licensing Board cases before an Office of Administrative Hearings.

13. Identify how to best respond to recommended decisions from an Office of Administrative Hearings.

14. Review the District of Columbia system for Licensing Boards.

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16. Review the D.C. Office of Administrative Hearings, its history, its jurisdictional powers and limitations, and its

role in providing hearings to licensees when facing adverse licensing actions.

17. Review how state public records laws are used as "discovery tools" in administrative (and tort) litigation

against occupational and professional licensing boards.

18. Discuss practical advice on using statutory exemptions or rules of civil procedure and evidence codes to shield the board.

19. Identify examples, based in case law, to lessen the impact of public records law requests.

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31. Discuss the immediate differences between compacts and the Act.

32. Identify sexually harassing behavior and what to do about it.

33. Discuss the most noteworthy court decisions related to licensure and regulation of the past calendar year.

34. Review the constitutional, statutory, and other legal issues faced by licensing agencies and regulatory boards.

RECOMMENDATION: Continue to support this conference by sending NCQAC legal staff to both attend and present at the conference. Consider expanding available slots to allow all NCQAC attorneys to attend the conference in the future.

2022 Federation of Association of Regulatory Boards
Regulatory Law Seminar

28 September – 2 October 2022
Reston, Virginia

Miranda Bayne

PURPOSE:

The Federation of Associations of Regulatory Boards (FARB) is a membership-based organization, bringing together the latest learning and development in the arena of professional regulation, across the country. The Regulatory Law Seminar is the premier educational event for attorneys working in this arena.

OUTCOME:

This conference included a series of excellent presentations on a variety of topics relevant to our work. The conference opens with an ethics training session, which addresses a series of ethical issues unique to the work of attorneys working with regulatory boards. The main conference began the next morning, with updates on legislation, as well as a look at trends around exams and exam security.

Insights and practice tips on several topics followed, including an in-depth look at issues around whether to issue or not to issue formal advisory opinions, considerations for practicing in the age of public records requests, and how to best protect board interests in these scenarios. In addition, there were two presentations with detailed practice tips for pre-hearing investigative tools, as well as more general litigation tips for practice before administrative tribunals.

The third day opened with a look at the current state of telehealth, as the country emerges from the pandemic. This presentation examined limitations on telehealth, as related to professional licensure issues, as well as examining ethical concerns for practitioners as the state of the practice moves forward. Relatedly, there was a review of the various licensure portability approaches – interstate compacts, universal licensure and expedited endorsements, and the different approaches to the issue of mobility for licensees in different states. Sexual misconduct rounded out the topics for review at this conference, with a presentation by a Washington AAG, who detailed the state of the law in Washington under RCW 18.130.062 and the sexual misconduct rules, and laid out strategies and approaches.

The final presentation was a review of the top regulatory cases for the last year. This is always an interesting and entertaining review of the state of the law in this arena.

RECOMMENDATION:

This is always an excellent conference, providing opportunities to network and learn about other states' approaches to common issues in our work.
I highly recommend that the Commission continue to send staff attorneys to this excellent educational conference.

2022 NADDI 33rd Annual Training Conference Agenda

October 3-7, 2022
Indianapolis, Indiana

Trip Report
Kristl Pohl, Investigator
Rashelle Beal, Investigator

PURPOSE:
The event offered nursing regulators, law enforcement partners and healthcare facilities to come together to network, share insights and learn about new trends related to drug diversion across the country.

OUTCOME:
Event highlights included:

- The Changing Faces of Healthcare Fraud
- Social Media Investigations
- Pharmacy Fraud Trends
- Keynote: *A Memoir of Addiction, Recovery and Redemption in Professional Football*
- Keynote: *Steered Straight – Vaping Me Crazy*

RECOMMENDATION:

NCQAC should continue to send new investigators to this or a similar conference. It was important for us to learn the breadth of the problem on a national level to see different trends occurring in different parts of the county as we will undoubtedly see them in Washington at some point. It was also a great networking opportunity to meet other nursing regulators and investigators for possible future collaboration.

TRI REGULATOR SYMPOSIUM

OCTOBER 13-15, 2022

ALEXANDRIA, VIRGINIA

PAULA R. MEYER MSN, RN, FRE

PURPOSE: The National Association of Boards of Pharmacy (NABP), the Federation of State Medical Boards (FSMB) and the National Council of State Boards of Nursing (NCSBN) comprise the Tri Regulators. NCSBN supported executive directors of all boards of nursing to attend this event. The purpose of the Tri Regulator Symposium is to support health care professional regulation and coordinate on issues impacting health care regulation. The current chair of the Tri Regulator is Dr. Al Carter, the president of NABP.

OUTCOME: One of the presentations was from William England, Phd, Office of Advancement of Telehealth, Health Resources Services Administration (HRSA). Dr. England presented a fascinating history of the development and acceleration of telehealth during the COVID 19 pandemic. Dr. England described the 1135 waivers enacted during the pandemic allowing for patient care to continue without in person interactions. Dr. England introduced telehealthHHS.gov and explained the documentation of his program's work on the website. Dr. England explained the commerce clause of their agency may say telehealth is federally regulated, there continues to be state regulation of health care. HRSA continues to be involved in many interstate compacts, like nursing and medical compacts, because of the interstate actions occurring within healthcare organizations and increased travel in the United States by beneficiaries. Dr. England described a quasi-Framingham study on the data collected by our personal devices, such as steps per day, heart rate, blood oxygenation, etc. This is a HUGE amount of data that requires artificial intelligence to analyze.

Dr. England also explained the emphasis on audio telehealth and video telehealth, related to reimbursement regulations for insurance purposes, both private and public. Audio only is allowed with the federal waiver. Broadband coverage issues exist with demand in rural areas of the country. The Federal Communications Commission and the Federal Trade Commission are working with rural communities and releasing money to support this work, up to $48 million. Each state will submit applications to access this money. With the expansion of networks, there has also been some detection of fraud. HRSA Office of Inspector General and the Government Accounting Office detected fraud in the past several years.

In early November 2022, HRSA will release a telehealth physician fee schedule. This fee schedule includes reimbursement for direct patient monitoring within home therapeutics.

Dr. England stated that tele prescribing will remain a hot topic for pharmacies due to the Dobbs and Ryan Haight decision.

The Telehealth Resource Center is sponsored by HRSA and included state specific information. There are Telehealth Policy and Technology Resources centers for each state. The resources centers include information on accessing federal funds to build affordable telehealth systems to rural and underserved areas. The grants will pay for a phone and home internet service for $30 per month.

RECOMMENDATION: Dr. England's presentation explained not only the history of telehealth, the federal regulatory responsibilities of this HRSA division of telehealth, and the COVID 19 waivers, but the necessity to quickly change our health care system to effectively use telehealth. In speaking with Kathy Russell, NCSBN, we agreed this presentation needs to be repeated at a future NCSBN event for all nurse regulators.

Pacific Northwest 45th Annual National Conference
Advanced Practice in Primary Care

OCTOBER 27-28, 2022

Seattle, WA

Mary Sue Gorski, RN, PhD

PURPOSE: Joint providers Seattle Pacific University and Seattle University joined co-sponsors Washington State Nurses Association and University of Washington School of Nursing to host this Annual conference. The conference provided updates in select clinical areas with multiple sessions provided simultaneously providing continuing education hours for many nurse practitioner specialty areas.

OUTCOME: The keynote speaker Alic Shook is a faculty member from Seattle University who provided an overview of care to the transgender population titled, "Reaching Forward, Reaching Back: Storytelling Listening and the Power of Witnessing." These updates were not only invaluable and timely for clinical practice. They were also even more powerful because they included the personal story of the presenter.

The conference gave a good overview of topics that are new and changing in primary care such as substance use disorder (Rx). This presentation went over the various medications available to help with this challenge. Another timely topic was, "Coaching Patients in Self Management of Chronic Pain for the PCP". Pam Davies gave step by step advice on how to assist patients with their self management of pain and why this can work well for many. The final topic reflective of current clinical trends was fatty liver disease. Johanna Taniguchi reviewed current standards of care and the importance of weight management and exercise.

RECOMMENDATION: Incorporate some of the storytelling methods shared by the key note speaker into my every day interactions with others. The information provided was invaluable to me to keep current with Advanced Practice clinical issues.

Washington State Nursing Care Quality Assurance Commission

NPAP DECISION SUMMARY REPORT **Date:** September and October 2022 Updated 10/31/2022

Actions	Number Added for this reporting period	2022 Panel Actions YTD	2021 Totals	2020 Totals	Instate Approved Programs	Out of State Approved Programs
Letter of Determination:					7 LPN Programs	5 ADN Programs
					25 ADN Programs	2 LPN-BSN Programs
Intent to Withdraw Approval					18 RNB Programs	12 BSN Programs
Conditional Approval		1	2		17 BSN Programs	25 RNB Programs
Deny Approval			3		123 Post BSN Programs	38 Total BSN Programs
Letter of Decision:					3 Refresher Programs	286 MSN Programs
Approval – Programs	1	19	30	43		129 DNP Programs
Approval – Sub Change	3	30	20	47		1 EdD Nursing Education Program
Plan of Correction (POC) Required	1	4	2	4		1 Refresher Programs
Acceptance of Submitted Documents or POC	1	46	64	65		
Additional Documents or Actions Required			4	29		
Deferred Action		7	12	30		
Removal of Conditional Approval				1		
Limit Student Enrollment		1	1	2		
Voluntary Closure			1	2		
Require Monitoring Report		8		2		
Site Visit Report		9	3	10		
Removal of Moratorium on admissions				1		

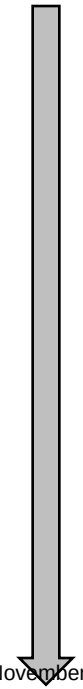
Covid-19 Curriculum Adjustments			7	92
Other		2	2	5
Letter of Concern		1		
Approvals-Miscellaneous (non-program)	1	3	2	3
Monitoring Report:				
Accept		1		5
Not Accept				1
Deferred				
Out-of-State DL Student Waivers:				
Accept				5
Deny				
Deferred				
Complaints:				
Open		2	3	3
Closed		3	3	11
Defer				
Complaint Investigation Reviewed:				
Accept Investigation Report			3	4
No Action Required		1		3
Action required				2
Licensing Education Exemption (Waiver) Request:				
Exemption Request Approved		4	5	8
Exemption Request Denied		1	1	2

Snapshot of Approved Nursing Assistant Training Programs (October 2022)

Number of Nursing Assistant Training Programs (All Types)	194
• Traditional Programs	152
• Home Care Aide Alternative/Bridge Programs	21
• Medical Assistant Alternative/Bridge Programs	10
• Medication Assistant Certification Endorsement (MACE) Programs	11

Trend Indicator in Program Numbers: ___ Notable Increase _X_ Stable ___ Notable Decrease

Comments: Program numbers have ranged 180-200 total over last six years, but increased to >200 as 2019 came to a close and in early 2020. With the impact of COVID-19, the number of programs decreased temporarily to <200. They gradually climbed above 200 again in June 2022. Then, with a few nursing home sanctions and the 2-year program renewal process (where several inactive programs opted to close)-- the number is again slightly below 200.



NAPAP REPORT 2022

Activity	JAN 10+20	FEB 14+28	MAR 14	APR 11	MAY 9	JUNE 13	JULY 11	AUG 8	SEP 12	OCT 10	NOV 14	DEC 12	YTD
Programs Applications Approved	**3**	**3**	**2**	**1**	**1**	**1**		**2**		**1**			**14**
Program Applications Deferred	**2**		**1**			**3**							**6**
Program Applications Denied													
Program Change Requests Approved			**2**		**1**		**1**			**1**			**5**
Program Change Requests Deferred													
Program Change Requests Denied													
Program Complaints Reviewed				**3**			**1**		**1**				**5**
Program Complaints Opened				**1**									**1**
Program Complaints Closed	**2**			**2**			**1**						**5**
Site Visit Summaries Reviewed				**1**									**1**
Investigative Reports Reviewed	**2**								**1**				**3**
POC/DPOC or Program Condition Reviewed	**2**				**1**		**1**			**2**			**6**
Additional Documents/Program Actions Required	**2**	**1**	**2**		**3**		**3**			**1**			**12**
Intent to Change Program Status *(Full to Conditional or Conditional to Full)*													
Intent to Withdraw Program Approval					**1**								**1**
Program Director/Instructor Applications Requiring Panel Review										**3**			**3**
Other Review or Process Decisions	**6**	**9**	**6**	**6**	**6**	**10**	**4**	**8**	**7**	**8**			**70**

*Program approvals for January 2022 adjusted from 2 to 3 for a program approved pending completion, which occurred at a later date.

Washington State Nursing Care Quality Assurance Commission

Position Description

Nominations Committee

Purpose:

1. Select members of the Nursing Care Quality Assurance Commission (NCQAC) who are qualified and willing to serve in leadership positions.
2. Select members of the NCQAC and staff to be nominated for awards. Complete applications as necessary.

Membership:

1. At least three members of the NCQAC appointed by the Chair.
2. No member should serve more than two consecutive years on the nominations committee.

Duties and Responsibilities:

1. Select at least two candidates each for the position of NCQAC Chair, Vice Chair, and Secretary/Treasurer.
2. Nominate NCQAC members and staff for awards, such as the NCSBN annual awards. Complete and submit applications.

Timeline for leadership nominations and elections:

1. November meeting --
   NCQAC Chair appoints new members to the Nominations Committee.
2. January meeting –
   Announces opening for nominations for the NCQAC annual award.
3. March meeting –
   a. Verbally presents the slate of candidates to the NCQAC. The NCQAC approves the slate of candidates.
   b. Candidates may speak to the NCQAC
4. May meeting –
   a. Election of the Officers, according to Procedure H02.
5. July meeting –
   a. New officers take office
   b. Presents the NCQAC annual award.

Staff:

Executive Director or designee

Adopted: 7/06, 7/08
Revised: 6/08, 9/10, 11/11, 3/13, 3/17
Approved: 7/06, 7/08, 3/13, 3/17

2023 NCQAC Meetings & Workshops
Locations & Venues
Planning Guide

Date	Time	Location (Zoom, Hybrid, or In Person)	Audio	Food & Beverage	Lodging	Noon Education Topic	Workshop Topic / Notes
January 13, 2023	8:30 AM	Virtual + Tumwater/L&I	N/A	N/A	N/A	TBD	
March 10, 2023	8:30 AM	In Person/Hybrid Marriott / SeaTac Airport	SpiritBorne	Marriott	Marriott	TBD	Special Meeting 3/9 for ED Candidates
May 12, 2023	8:30 AM	In Person/Hybrid SeaTac	TBD	TBD	TBD	TBD	
July 13 & 14, 2023	8:30 AM	In Person/Hybrid Tumwater	TBD	TBD	TBD	TBD	L&I an option at no cost
September 7 & 8, 2023	8:30 AM	In Person/Hybrid Spokane	SpiritBorne	TBD	TBD	TBD	
November 17, 2023	8:30 AM	Virtual + Tumwater/L&I	N/A	N/A	N/A	TBD	Veteran's Day Observed November 10

NURSING BUDGET STATUS REPORT – September 2022

2021-2023 BIENNIUM:

This report covers the period of July 1, 2021, through September 30, 2022, fifteen months into the biennium, with nine months remaining. The NCQAC budget is underspent by 6.7% and the current revenue balance is $3.3M.

REVENUES:

The recommended revenue balance or "reserve" should be 12.5% of biennial budgeted allotments, or approximately $3.7 million. NCQAC revenue balance had a slight rebound during this reporting period, however, remains below the recommended reserve balance. Revenues continue the trend of exceeding projections and currently outpace projections by approximately 8%, or just over $1.4M. This is due in part to the continued high volume of endorsement applications and volunteer nurses applying for licensure to remain in Washington after the emergency. Application volume should moderate for the remainder of the fiscal year, however, we anticipate at levels higher than projected at the time the budget was prepared.

EXPENDITURES:

The agency was not able to post service unit charges at the time of this report, however, we were able to add them manually, highlighted in yellow. Report does reflect actuals and not estimates.

Highlights:

- AG allotments were adjusted (increased) in FM14, however expenditures continue to come in above budget due to ongoing litigation.
- Salaries and Benefits remain below allotment due to the additional allotments granted in the 2022 supplemental. Delays in filling new positions also contributed to the savings.
- FBI Background Checks are charged based on actual files processed and continue to trend higher than projected due to the increased volume of endorsement applications.
- Several service units are now exceeding projections due to expenditures associated with an increase in staffing levels.
- Indirects are charged based on biennial allotments. Indirect allotments increased with the approval of our decision packages combined with the reduction of rates in FY23 resulted in significant savings to date.

FISCAL OUTLOOK:

We anticipate revenues to continue to exceed projections with the new fee increase being implemented on December 1, 2022. Additionally, savings with indirects is expected to continue through the remainder of the biennium. Direct expenditures and service units will accelerate as more staff are onboarded and as travel is reinstated, however we do not anticipate reaching full expenditure by the end of the biennium. As a result, the revenue balance will rebound and will approach and exceed recommended levels for the remainder of FY23. The final HELMS withdrawal, $2.4M, will take place at the end of June 2023, at which time we expect the revenue balance to drop below the recommended reserve once again.

Nursing Care Quality Assurance Commission
2021-23 Budget Status Report (Health Professions Account)
For the period of July 1, 2021 through September 30, 2022

EXPENDITURES TYPES	BIENNIAL BUDGET	EXPENDITURES THROUGH	ALLOTMENT PREVIOUS	EXPENDITURES PREVIOUS	ALLOTMENT CURRENT	EXPENDITURES CURRENT	BUDGET/ALLOTMENT TO-DATE	EXPENDITURES TO-DATE	VARIANCE TO-DATE	% SPENT TO-DATE
DIRECT EXPENDITURES:		**FM13**	**FM14**	**FM14**	**FM15**	**FM15**				
FTEs (average)	81.33	75.97	83.89	79.00	83.89	81.62	81.33	76.75	4.57	94.38%
Staff Salaries & Benefits	$16,788,320	$8,522,922	$683,576	$708,221	$766,757	$745,603	$10,386,599	$9,976,746	$409,853	96.05%
Commission Salaries	$604,615	$282,301	$25,384	$25,745	$25,384	$29,789	$376,152	$337,835	$38,317	89.81%
Goods & Services	$597,803	$376,818	$25,385	$21,392	$25,385	($18,932)	$369,327	$379,278	($9,951)	102.69%
Rent	$830,031	$307,454	$35,654	$43,277	$35,654	$22,142	$509,151	$372,873	$136,278	73.23%
Attorney General (AG)	$1,592,958	$857,206	$101,987	$55,516	$77,247	$78,527	$924,582	$991,250	($66,668)	107.21%
Travel	$180,000	$33,349	$7,665	$2,770	$7,665	$9,996	$111,015	$46,115	$64,900	41.54%
Equipment	$111,696	$49,883	$5,300	$2,455	$5,300	$3,299	$63,996	$55,637	$8,359	86.94%
IT Support & Software Licenses	$367,476	$129,665	$16,191	$14,575	$16,191	$28,562	$221,754	$172,802	$48,952	77.93%
TOTAL DIRECT	**$ 21,072,899**	**$ 10,559,598**	**$ 901,142**	**$ 873,952**	**$ 959,583**	**$ 898,987**	**$12,962,576**	**$12,332,537**	**$630,039**	95.14%
SERVICE UNITS:										
FBI Background Checks	$527,013	$286,676	$22,524	$92,621	$22,524	$33,658	$324,297	$412,955	($88,658)	127.34%
Office of Professional Standards	$435,023	$203,927	$20,223	$16,574	$20,223	$19,658	$251,513	$240,159	$11,354	95.49%
Adjudication Clerk	$213,498	$58,623	$9,147	$6,177	$9,147	$2,722	$131,175	$67,522	$63,653	51.47%
HP Investigations	$86,601	$36,034	$3,865	$7,365	$3,865	$6,766	$51,816	$50,166	$1,650	96.81%
Legal Services	$39,570	$22,097	$1,783	$1,478	$1,783	$1,275	$23,523	$24,851	($1,328)	105.64%
Call Center	$164,978	$77,381	$7,354	$15,790	$7,354	$6,685	$98,792	$99,857	($1,065)	101.08%
Public Disclosure	$382,476	$166,221	$16,400	$26,741	$16,400	$10,447	$234,876	$203,409	$31,467	86.60%
Revenue Reconciliation	$180,909	$99,513	$7,761	$16,806	$7,761	$6,982	$111,060	$123,301	($12,241)	111.02%
Online Healthcare Provider Lic - Staff	$305,352	$170,969	$13,022	$0	$13,022	$38,126	$188,154	$209,095	($20,941)	111.13%
Online Healthcare Provider Lic - Contract	$195,792	$127,488	$8,158	$0	$8,158	$0	$122,370	$127,488	($5,118)	104.18%
Suicide Assessment Study	$40,800	$8,650	$1,700	$2,265	$1,700	$651	$25,500	$11,566	$13,934	45.36%
TOTAL SERVICE UNITS	**$ 2,572,012**	**$ 1,257,579**	**$ 111,937**	**$ 185,819**	**$ 111,937**	**$ 126,970**	**$1,563,076**	**$1,570,368**	**($7,292)**	100.47%
INDIRECT CHARGES:										
Agency Indirects (16.9% in FY1 - 15.3% in FY2)	$3,964,221	$1,758,109	$169,858	$160,817	$179,735	$123,076	$2,435,238	$2,042,002	$393,236	83.85%
HSQA Division Indirects (11.3% in FY1 - 9.7% in FY2)	$2,648,714	$1,204,814	$113,492	$101,897	$120,096	$78,004	$1,627,112	$1,384,715	$242,397	85.10%
TOTAL INDIRECTS (28.2% in FY1 - 25% in FY2)	**$ 6,612,936**	**$ 2,962,922**	**$ 283,350**	**$ 262,714**	**$ 299,830**	**$ 201,081**	**$4,062,349**	**$3,426,716**	**$635,633**	84.35%
GRAND TOTAL	**$30,257,847**	**$14,780,100**	**$1,296,429**	**$1,322,484**	**$1,371,350**	**$1,227,037**	**$18,588,001**	**$17,329,621**	**$1,258,380**	93.23%

Actuals posted after FM close

NURSING REVENUE

BEGINNING REVENUE BALANCE	$ 4,257,147
21-23 REVENUE TO-DATE	$ 19,266,199
21-23 HELMS ASSESS. TO-DATE	$ 2,887,402
21-23 EXPENDITURES TO-DATE	$ 17,329,621
ENDING REVENUE BALANCE	**$ 3,306,323**

Academic Progression - Updated August 2022

Goals: Evaluate the demand for licensed practical nurses and registered nurses in the state. Continue the discussion of the appropriate degree preparation for PNs.

Objectives	Responsibility	Resource projections (time, staff, money, etc.)	Deadlines	Progress
1) Identify barriers and strengths identified by employer organizations of current models for consistent academic preparation for LPNs	Mary Sue Gorski, Jessilyn Dagum	Expand interested party discussions statewide and nationally to include broader range of employer organizations.	Expanded employer groups to convene **Fall 2022**	NCSBN leadership presentation held on April 19, 2021; LPN to RN Educators and LPN Employers focus groups May 2021; Convene representatives of interested states and provinces May/June 2021. October 2021 Completed LPN educator group addition LPN LTC employer Commission members
2) Develop a report using workforce data, stakeholder group input, and national collaboration.	Paula Meyer, Mary Sue Gorski, Gerianne Babbo	Pull together NCSBN input, workforce data analysis, and stakeholder input to develop a full report of progress to date	**Fall 2022**	Data gathered focus group summaries reviewed
3) Explore outcomes of existing LPN education models and expand employer input.	Paula Meyer, Mary Sue Gorski, Gerianne Babbo	Compare education outcomes identified in the Annual Education Program report across current LPN programs over four years 2017-2022 to explore trends	**February 2022 through February 2024**	Trend data compiled and grid of LPN programs completed. Preliminary outcomes data by **June 2022.**

Communications – Updated October 2022

NCQAC Communications has identified three overarching goals, and the objectives listed in the table below directly support these goals. Objectives will be met through specific tasks outlined in our separate workplan. Year One of the biennium will be spent doing the work to achieve these goals, and year two will be spent evaluating our success/progress, as well as finalizing any work that supports the goals. Evaluation methods will be determined for each objective prior to Year Two.

Goals:

- **Provide exceptional communications internally and externally.**
- **Develop and implement a strong and meaningful identity for NCQAC, to include mission, vision statement, and logo.**
- **Ensure accessibility and inclusivity in all aspects of communication with the public and our stakeholders.**

High Level Objectives	Responsibility	Resource projections (time, staff, money, etc.)	Deadlines	Progress
Construct a new, streamlined website	NCQAC Communications, Communications Task Force	NCQAC Communications/WaTech staff, unit input Lead: Shad	Fall 2022	New website live www.nursing.wa.gov
Revamp SharePoint for internal use by staff to include a landing page for information sharing	NCQAC Communications	NCQAC Communications/DOH IT staff, unit input Lead: Shad	Spring 2023	Waiting on DOH for next phase.
Develop and implement style guide and publication standards	NCQAC Communications	NCQAC Communications, leadership input Lead: Amy	Spring 2022, most work to occur in tandem with website build	To be completed in tandem with website build
Develop and ensure that Language Access Plan requirements are met for publications that have	NCQAC Communications, Communications Task Force	NCQAC Communications, leadership input Lead: Laura	Spring 2023	DOH revamping process. Working with them to make

accessibility requirements.				sure NCQAC complies.
Develop and implement agency templates for a variety of purposes, such as GovDelivery PowerPoint, MS Word, Excel, Teams/Zoom meetings, etc.	NCQAC Communications	NCQAC Communications, leadership input Lead: Amy	Spring 2022	To be completed once identity is defined, which will happen in initial phase of website build
Complete the communications visions submitted by each division.	NCQAC Communications, Communications Task Force	NCQAC Communications, leadership input All	Fall 2022	Some completed with new website, remainder need to be reviewed
Determine evaluation methods for objectives supporting goals.	NCQAC Communications, Communications Task Force	NCQAC Communications, leadership buyoff Lead: Amy	Summer 2022	Transition project from Rebecca to Jessilyn
Evaluation Period	NCQAC Communications, Communications Task Force	NCQAC Communications, leadership buyoff All, Amy	Spring 2023	To be completed prior to July 1, 2023

Nursing Assistants – Established August 2021 (for 2021-2023) – UPDATED October 26, 2022

Goal: Streamline nursing assistant training and testing processes, expand capacity through use of technology, and support progression into nursing as evidenced by the following outcomes:

- New training program applications consistently reviewed in 7-10 days;
- Statewide first-time test-taker pass rates (average, annualized) improved to 75% for 2023 and to 80% by 2024;
- Testing capacity increases to 22,932 test-takers per year (119% increase) through use of a virtual approach;
- Quantitative ratings of >3.7 on a 5-point scale on electronic surveys regarding the new curriculum by training programs and students at 6, 12, and 18 months post-implementation; and
- The LPN Registered Apprenticeship Program (LPN RAP):
    - Enrolls 45 students (15 at each pilot site) in three different geographical areas in 2023; and
    - The completion rate for students in the pilot is ≥85%.

Objectives	Staff Responsibility	Resource projections (time, staff, money, etc.)	Deadlines	Progress
1—Pilot, evaluate, and refine the new nursing assistant training curriculum.	Kathy Moisio	Porsche Everson is contracted to support pilot preparation; members of the LTC Workforce Development Steering Committee and Workgroups are eager to pilot. NAPAP to review and make decisions re feedback/refinements.	• To be completed in **SPRING 2022**	• **Completed April-June 2022**
2—Establish a steering committee, workgroup, and workplan for the LPN Apprenticeship Pathway; hire a Nurse Consultant to lead the LPN Apprenticeship Pathway work; and host a statewide LTC Summit to gain statewide stakeholder input on developing the pathway.	Kathy Moisio with new hire taking over the leadership role once hired	Dr. Mary Baroni has been instrumental in making connections to support the foundational work for a successful launch.	• To be completed in **FALL 2021**	• **Completed Timely**
3—Conduct public rules meetings to gather input on nursing assistant rules revisions that address curriculum and testing changes and other needed updates.	Bonnie King and Kathy Moisio	Online meetings will be used maximally to provide efficiencies of time and cost and maximize stakeholder participation.	• To be completed in **FALL 2022**	• In progress (7 meetings Oct-Feb)
4—Testing plan or contract in place for 2022, including timelines for phasing in	Kathy Moisio in coordination with	Completion represents a challenge with other activities, but must be	• To be ready for implementation **JAN 1, 2022.**	• Recommendations are included in the contract on a

Objectives	Staff Responsibility	Resource projections (time, staff, money, etc.)	Deadlines	Progress
revisions recommended from the LTC Workforce Development Steering Committee and Testing Workgroup (virtual skills testing within training programs at point of graduation, new evaluation approach, etc.).	Contracts Unit, Paula Meyer, possibly legal staff, and the other agencies involved: DSHS and DOH/HSQA	finished by 12/31/2 to avoid interruptions to testing. NAPAP considers, makes decisions re: final plans.		phase-in schedule (2022-2023) • **Contract completed/signed timely**
5—Develop nursing assistant curriculum into an online-capable format	Kathy Moisio	Legislative allocations are available to support this development as a means of assuring smooth progression from NAC toward LPN as part of the LPN Apprenticeship Pathway. Also, members from the LTC Workforce Development Steering Committee and Workgroups have expressed interest in participating. NAPAP participates and/or reviews, makes decisions re: final plans.	• To be completed in **SPRING 2022**	• **Completed by June 30, 2022**
6—Finalize nursing assistant rules revisions, incorporating stakeholder input.	• Bonnie King with support from Kathy Moisio and others (legal staff, DOH/ HSQA staff, etc.)	NAPAP reviews, makes decisions re: final version.	• To be completed after public meetings held (see item #3)— **WINTER/ SPRING 2023**	• Public meeting dates are in progress
7—Develop the communication/roll-out plan regarding curriculum, testing, and rules changes for launch in September 2022.	Kathy Moisio with support from Communications staff	Online meetings will be used maximally to provide efficiencies of time and cost and maximize stakeholder participation.	• To be completed in **SUMMER-FALL 2022**	• Curriculum roll-out began in July 2022 with frequent online orientation sessions through October and will continue as needed.
8—Continue LPN Apprenticeship Pathway development with steering committee and	Marlin Galiano	• Legislative allocations cover the FTE for the new Nursing	• To continue through **SPRING**	• **Completed the planning phase timely--**

Objectives	Staff Responsibility	Resource projections (time, staff, money, etc.)	Deadlines	Progress
workgroup members according to timelines established in the workplan.		Consultant and for the costs of planning activities, contracts, etc.	**2022 to JUNE 30, 2022 deadline**	**Implementation phase in progress**
9—Participate actively in legislative session in relation to the Decision Package (DP), re-introducing HB 1124 (glucometer testing by nursing assistants), and support for LPN Apprenticeship Pilot funding.	Paula Meyer and others as directed	• There is stakeholder support for re-introducing HB 1124. Senator Conway sponsored the LPN Apprenticeship Pathway planning and has expressed interest in supporting the piloting; federal grant submission may lead to funding to support piloting at one site.	• To occur in **WINTER 2022**	• Decision Package Passed • HB 1124 Passed • Federal Grant Passed (Yakima Valley College) • **These Milestones Completed Timely**
10—Implement the communication/roll-out plan for curriculum/testing/rules revisions	Kathy Moisio, Alana Llacuna, New Staff via Decision Package (starting in Sept. 2022)	NAPAP members and members of the LTC Workforce Development Curriculum and Testing Workgroups may have interest in participating; online presentations will be used maximally for time/cost efficiency and ease of participation by stakeholders.	• To begin in **SUMMER 2022**	• Curriculum roll-out underway timely • Testing revisions on hold during implementation of the Mass Examination Plan • Public meetings began in October; 7 meetings scheduled Oct-Feb.
11—Begin LPN Apprenticeship Pathway approval processes (NCQAC and LNI)	Marlin Galiano	NPAP and LNI will provide review and decisions; NCQAC and LNI staff may also provide technical assistance as needed; steering committee and workgroup support revision work as needed.	**• To begin in after plan is developed – deadline for planning is JUNE 30, 2022**	• Development of a plan and timelines for work July 1-onward are in progress

Objectives	Staff Responsibility	Resource projections (time, staff, money, etc.)	Deadlines	Progress
12—Launch new nursing assistant curriculum and testing revisions with corresponding rules effective; Provide ongoing support, evaluation, continuous quality improvement	Kathy Moisio, Alana Llacuna, New Staff via Decision Package (starting in Sept. 2022)	Contracted testing vendor or implementing entities provide direct testing services with staff overseeing performance; stakeholder feedback and NPAP review and decisions provide support for continuous quality improvement.	• **SEPTEMBER 2022 –Onward with goal of having rules revisions in place Sept 2023**	• Curriculum is on-target and available as of July 2022 to programs who want to launch voluntarily • A rolling phase-in process is in place with a goal of all programs using as of Sept. 2024 • Testing revisions paused as we implemented the Mass Examination Plan • A series of public meetings for rules began in Oct. (Oct-Feb)
13—Launch LPN Apprenticeship Pathway pilot in 1-3 sites (in accordance with funding, if received)	New Nursing Consultant	NPAP and LNI will provide review and decisions; NCQAC and LNI staff may also provide technical assistance as needed.	• **GOAL: A timeline for the work is in development**	• Work to launch this is in progress

WHPS Updated November 1, 2022

Goal: Increase the number of nurses enrolled in the Washington Health Professional Services (WHPS) program voluntarily and in lieu of discipline (with an emphasis on in lieu of discipline) by 25% every two years through education, early identification, referral to treatment, and advocacy. NCQAC and WHPS staff do this by promoting the just culture model and employment retention. Focus on in-lieu-of-discipline enrollment per September 2022 commission decision.

Baseline from 2019: 300 nurses Projected 2021: 375 nurses Projected 2023: 469 nurses Projected 2025: 587 nurses

Will require an additional case management team for each 100 nurses added to the program.

Objectives	*Responsibility*	*Resource projections*	*Deadlines*	*Progress*
Provide educational resources, including but not limited to lectures, brochures, web sites, publications/articles, newsletters, display booths, on-site consultations…	Dr. Furman WHPS staff NCQAC Communication task force		2. WHPS materials reviewed and updated – December 2021	Tool kit, BONcast, new information, resources, posted on nursing.wa.gov. Blog posted June 2022. Dr. Furman is distributing new posters.
Host a SUD-related educational conference every two years.	Dr. Furman to coordinate 2023 SUD conference with Amy Sharer and Shad Bell.		Begin conference prep December 2022	Next conference Fall 2023
Develop education courses, modules and toolkits for interested party use.	Dr. Furman WHPS staff	Work with Communications Task Force and C4PA to develop resources to include on the new NCQAC/WHPS web site.		Blog posted beginning June 2022. Virtual toolkit on website. WHPS BONcast on

				nursing.wa.gov under About Us/Who We Are, or under Quicklinks on home page.
Support professional workforce reentry and increase employment retention by 10% through education and cooperative approach to worksite monitoring, prioritizing patient safety.	Dr. Furman WHPS staff	N/A	10% annual goal, reportable in March of each year beginning in 2022. (annual report) Also found in performance measures.	Dr. Furman has approached WSNA, SEIU, and UFCW to gauge current interest. Ongoing effort.
Reduce the number of nurses who withdraw from monitoring due to financial limitations by 50%.	Dr. Furman – WHPS Liaison	Explore options for making scholarship funds available for nurses in financial straits.	On hold during pandemic. Goal to reach 50% reduction in withdraws by November 2024.	Dr. Furman negotiating with nursing associations. To shift focus to other organizations.
Develop a Substance Use Disorder Review Panel (SUDRP) as an organization-based intervention tool for nurses. This will take the place of the Substance Use and Abuse Team and will connect nurses in WHPS with commission members (both disciplinary and for achieving milestones). The intent is to reduce noncompliance and recidivism rates and increase program completion rates.	Discipline Subcommittee; Assistant Director, Discipline – WHPS (lead on project).		Annual updates at July commission meetings beginning 2023.	July 2022 SUDRP fully implemented.

Nursing Care Quality Assurance Commission
Washington Administrative Code (Rules) Agenda
Updated: 10/31/2022

#	Profession	Staff Content Experts Rules Staff assigned	WAC Sections	Purpose for Rule Making	CR-101 Preproposal	CR-102 Proposal & CR-105 Expedited	CR-103P Permanent	CR-103E Emergency 120-day limit WSR means Washington State Register
1	RN, ARNP, NA (Emergency rulemaking)	Kathy Moisio Jessilyn Dagum	9/9/2022: Revised 246-840-930 246-841-405 3/14/2022: Original: 246-840-930 246-841-405	Amending specific training requirements for Nursing Assistants Registered (NARs) and Home Care Aides (HCAs). The Nursing Care Quality Assurance Commission (commission) is adopting an emergency rule to allow a registered nurse delegator to delegate nursing tasks to a NAR or HCA based on evidence as required by DSHS and in accord with timing set by DSHS in rule. To align with the corresponding NAR rule, the commission is adopting emergency language to correspond. (Emergency rules expire every 120 days and must be re-filed, if necessary).				WSR: File: 1/6/2023 WSR: 22-19-066 Filed: 9/9/2022 WSR: 22-15-020 Filed: 7/12/2022 WSR: 22-07-046 Filed: 3/14/2022
2	NT, LPN, RN, ARNP Nurses (Emergency rulemaking)	Debbie Carlson, Gerianne Babbo, Mary Sue Gorski Jessilyn Dagum	9/9/2022 Revised: 246-840-365, 367 5/13/2022 Revised: 246-840-365, 367, 533 1/14/2021 Revised: 246-840-010, 365, 367, 533, 840	Amend specific credential and license requirements for Nurse Technicians (NT), Licensed Practical Nurses (LPN), Registered Nurses (RN), and Advanced Registered Nurse Practitioners (ARNP) in response to the COVID-19 pandemic and the critical demand for healthcare professionals. (Emergency rules expire every 120 days and must be re-filed, if necessary).				WSR: File: 1/6/2023 WSR: 22-19-008 Filed: 9/9/2022 WSR: 22-11-047 Filed: 5/13/2022 WSR: 22-03-056 Filed: 1/14/2022 WSR: 21-19-092 Filed: 9/17/2021 WSR: 21-12-012

#	Profession	Staff Content Experts Rules Staff assigned	WAC Sections	Purpose for Rule Making	CR-101 Preproposal	CR-102 Proposal & CR-105 Expedited	CR-103P Permanent	CR-103E Emergency 120-day limit WSR means Washington State Register
			9/17/2021 Revised: 246-840-010, 365, 367, 533, 840, 930 4/24/2020 Original: 246-840-010, 125, 210, 240,361, 365, 367, 533, 534, 840, 930					Filed: 5/20/2021 WSR: 21-04-005 Filed: 1/20/2021 WSR: 20-22-024 Filed: 10/23/2020 WSR: 20-14-065 Filed: 6/26/2020 WSR: 20-10-014 Filed: 4/24/2020
3	NAR, NAC Nursing Assistants (Emergency rulemaking)	Kathy Moisio Jessilyn Dagum	1/14/2022 Revised: 246-841-420, 470, 490, 500, 510, 555 6/26/2020 Original: 246-841-405, 420, 470, 490, 500, 510, 555	Amend specific training requirements for Nursing Assistant Certified (NAC) and Nursing Assistant Registered (NAR) in response to the COVID-19 pandemic and the critical demand for healthcare professionals. (Emergency rules expire every 120 days and must be re-filed, if necessary).				WSR: File: 1/6/2023 WSR: 22-19-007 Filed: 9/9/2022 WSR: 22-11-049 Filed: 5/13/2022 WSR: 22-03-055 Filed: 1/14/2022 WSR: 21-19-091 Filed: 9/17/2021 WSR 21-12-011 Filed: 5/20/2021 WSR 21-04-004 Filed: 1/20/2021 WSR 20-22-023, Filed: 10/23/2020 WSR 20-14-066

#	Profession	Staff Content Experts Rules Staff assigned	WAC Sections	Purpose for Rule Making	CR-101 Preproposal	CR-102 Proposal & CR-105 Expedited	CR-103P Permanent	CR-103E Emergency 120-day limit WSR means Washington State Register
								Filed: 6/26/2020
4	NA Standards of Practice & NAC Training Program Standards (Standard rulemaking)	Kathy Moisio Bonnie King	Chapter 246-841 WAC (amend) Chapter 246-842 WAC (repeal)	Legislated work by NCQAC with key interested parties in 2018-2020 resulting in a final Long-Term Care Report to the Legislature (June 2021) confirmed the need for updating rules. The coronavirus disease 2019 (COVID-19) pandemic magnified the need and urgency for changes to eliminate barriers to career advancement for nursing assistants to help address the nursing assistant shortage in health care. NCQAC believes standardizing curriculum in training programs will also result in standardizing scope of practice across work settings.	WSR: 21-05-021 Filed: 2/8/2021 Note: The Nursing Assistant Program Approval Panel (NAPAP) is reviewing draft language with interested parties in seven public workshops between October and February.			
5	NA Secretary Authority Rules (Standard rulemaking)	Ross Valore (HSQA) Kathy Moisio Bonnie King	246-841-520, 720	Chapter 246-841 WAC is being revised. Within the chapter are three sections which are under the authority of the DOH Secretary: WAC 246-841-520 Expired licenses, 720 Mandatory reporting, 990 Fees. WAC 246-841-520 and 720 need revisions to align with the rest of the chapter revisions which are ongoing. See # 4 above.	WSR: 22-08-019 Filed: 3/28/2022			
6	ARNP Scope of Practice (Standard rulemaking)	Mary Sue Gorski Jessilyn Dagum	246-840-300, 700, 710	The rules were opened in response to an April 3, 2018, petition about scope of practice for advanced registered nurse practitioners. The proposed amendments to WAC 246-840-300, WAC 246-840-700 and 246-840-710 introduce new and revised language that clarify the ARNP scope of practice, update gender pronouns, and include other housekeeping changes.	WSR: 19-01-002 Filed: 12/5/2018 Note: Workshops on the concepts were held 1/22, 23, 24/2019. The Advanced Practice Subcommittee drafted language. Additional public workshops were	WSR: 22-15-078 Filed: 7/18/2022 Note: Hearing was held on 9/9/2022 Business meeting at 1:15 PM.		

#	Profession	Staff Content Experts Rules Staff assigned	WAC Sections	Purpose for Rule Making	CR-101 Preproposal	CR-102 Proposal & CR-105 Expedited	CR-103P Permanent	CR-103E Emergency 120-day limit WSR means Washington State Register
					held 1/26 and 2/7/2022.			
7	ARNP 2018 Opioid Prescribing (Standard rulemaking)	Mary Sue Gorski Jessilyn Dagum	WAC 246-840-463 and 246-840-4659	The rules were opened to address concerns expressed by Washington state long-term care associations and advanced practice nursing associations about the implementation of the 2018 opioid prescribing rules. On December 21, 2018, the NCQAC adopted Interpretive Statement (NCIS 2.00), Application of WAC 246-840-4659 to nursing homes and long-term acute care hospitals. Interpretive statements are not enforceable and not subject to discipline under the Uniform Disciplinary Act. Opening the rule provides the opportunity for additional stakeholder engagement, rule clarification, and possible amendments to address identified concerns.	WSR: 19-15-092 Filed: 7/22/2019 Note: Interested Parties Workshop held 6/21/2022 and 6/30/22.			
8	ARNP Inactive and Expired Licenses (Standard rulemaking)	Mary Sue Gorski Jessilyn Dagum	246-840-365, 367	Concerns expressed at the 3/11/2022 CR-102 rules hearing (see Emergency to Perm Rules below effective 9/9/2022) caused the commission to remove 365 and 367 from consideration. They voted to begin a new CR-101 process and consider adding other rule sections.	WSR: 22-12-090 Filed: 6/1/2022 Note: The NCQAC approved filing a Preproposal at the 3/11/2022 meeting. Interested Parties Workshop held 6/21/2022 and 6/30/22.			

#	Profession	Staff Content Experts Rules Staff assigned	WAC Sections	Purpose for Rule Making	CR-101 Preproposal	CR-102 Proposal & CR-105 Expedited	CR-103P Permanent	CR-103E Emergency 120-day limit WSR means Washington State Register
9	NT, LPN, RN, ARNP Temporary Practice Permits (Standard rulemaking)	Amber Zawislak, Debbie Carlson, Gerianne Babbo Jessilyn Dagum	246-840-095	When the department and commission first began completing FBI fingerprint background checks on out-of-state applicants the process took several months. To remedy this delay in licensure, the commission issues a temporary practice permit after the applicant meets all other licensure requirements, allowing the nurse to begin working in Washington State. Under WAC 246-840-095, the temporary practice permit is valid for 180 days or until the commission issues a permanent Washington State license to the nurse. WAC 246-840-095 also allows for an additional 180-day extension of the temporary practice permit if the department has not received the fingerprint results during the initial 180-day period. The commission intends to engage in rulemaking to shorten the length of a temporary practice permit and to align the internal NCQAC process with WAC language.	WSR: 22-06-057 Filed: 2/25/2022 Note: NCQAC approved filing a Preproposal in a 2017 commission meeting. Interested parties' workshops scheduled for: 7/7/22, 8/4/22, and 9/19/22.			
10	RN, ARNP, NA Delegation Legislation SHB 1124 Governor signed 3/11/22 Effective 7/1/2022 (Standard rulemaking)	Debbie Carlson, Jessilyn Dagum	246-840-010, 700, 910, 920, 930, 940, 950, 960	1124-S.PL.pdf (wa.gov) **Nurse Delegation of Glucose Monitoring, Glucose Testing, and Insulin Injections** (c) Except as authorized in (b) or (e) of this subsection, a registered nurse may not delegate the administration of medications. Except as authorized in (e) or (f) of this subsection, a registered nurse may not delegate acts requiring substantial skill and may not delegate piercing or severing of tissues. Acts that require nursing judgment shall not be delegated. (e) For delegation in community-based care settings or in-home care settings, a registered nurse may delegate nursing care	WSR: Filed: Note: At a commission meeting held on May 13, 2022, the commission voted to begin the rulemaking process for nursing rules.			

#	Profession	Staff Content Experts Rules Staff assigned	WAC Sections	Purpose for Rule Making	CR-101 Preproposal	CR-102 Proposal & CR-105 Expedited	CR-103P Permanent	CR-103E Emergency 120-day limit WSR means Washington State Register
				tasks only to registered or certified nursing assistants under chapter 18.88A RCW or home care aides certified under chapter 18.88B RCW. (v) When delegating insulin injections under this section, the registered nurse delegator must instruct the individual regarding proper injection procedures and the use of insulin, demonstrate proper injection procedures, and must supervise and evaluate the individual performing the delegated task (()) as required by the commission by rule. If the registered nurse delegator determines that the individual is competent to perform the injection properly and safely, supervision and evaluation shall occur at (()) an interval determined by the commission by rule. (f) The delegation of nursing care tasks only to registered or certified nursing assistants under chapter 18.88A RCW or to home care aides certified under chapter 18.88B RCW may include glucose monitoring and testing.	Note: NA rules in progress will incorporate language for NAs. See #4 above.			

#	Profession	Staff Content Experts Rules Staff assigned	WAC Sections	Purpose for Rule Making	CR-101 Preproposal	CR-102 Proposal & CR-105 Expedited	CR-103P Permanent	CR-103E Emergency 120-day limit WSR means Washington State Register
11	RN, LPN, ARNP, NA, NT Equity Education Legislation ESSB 5229 effective 7/25/2021 (Standard rulemaking)	Debbie Carlson, Shana Johnny, HSQA Jessilyn Dagum		5229-S.SL.pdf (wa.gov) **Health Equity & Continuing Competency** The law, effective 7/25/2021, in Section 2 requires rule-making authorities for each health profession to adopt rules requiring a licensee to complete health equity continuing education training at least once every 4 years. The new law is very prescriptive. DOH is to develop model rules in consultation with boards and commissions by 1/1/2023 with minimum standards for continuing education. Information about available courses must be available to licensees by 7/1/2023 and include a course option that is free of charge.	Note: 9/9/2022 Commission votes to begin NCQAC rule making.			
Rules Effective 2021-2022								
1	NT Nursing Technician Definition (Expedited rulemaking)	Gerianne Babbo Tim Talkington Bonnie King	246-840-010	The commission Education Subcommittee determined the proposed rules are needed to align rule language with the statute, RCW 18.79.340 regarding requirements for nursing program approval.		**Expedited** WSR: 22-12-092 Filed: 6/1/2022 Public comment period ends 8/1/2022. CR-105 expires 180 days after publication. Must file CR-103P Before 11/28/2022	WSR: 22-17-144 Filed: 8/23/2022 **Effective 9/23/2022**	

#	Profession	Staff Content Experts Rules Staff assigned	WAC Sections	Purpose for Rule Making	CR-101 Preproposal	CR-102 Proposal & CR-105 Expedited	CR-103P Permanent	CR-103E Emergency 120-day limit WSR means Washington State Register
2	NT, LPN, RN, ARNP Fees (Standard rulemaking)	Chris Archuleta Fiscal Staff (HSQA) Bonnie King	246-840-990	The Secretary of the Department of Health in consultation with NCQAC is considering an increase in licensure fees for professions under its regulation. A fee increase is needed to address the increasing costs associated with the agency's new Healthcare Enforcement and Licensing Modernization Solution (HELMS) database, the need to increase staffing levels to meet the new legislative mandate to process nurse licenses in seven days or less, and an increase in workload associated with implementing solutions addressing the nursing assistant and long-term care crisis.	WSR:21-23-053 Filed: 11/10/2021 Note: The NCQAC voted at the 9/9/2021 meeting to begin the standard rulemaking process.	WSR: 22-10-104 Filed: 5/4/2022 Note: The DOH hearing is scheduled for 6/13/2022 at 2 pm.	WSR: 22-15-074 Filed: 7/18/2022 Note: **Effective 12/1/2023** to allow time for 90 day advance notice about the fee change.	
3	NT, LPN, RN, ARNP Emergency to Permanent Rules (Standard rulemaking)	Debbie Carlson, Gerianne Babbo, Mary Sue Gorski, Shana Johnny Jessilyn Dagum	3/11/2022 246-840-533, 930 9/17/2021 Original 246-840-365, 367, 533, 930	Create permanent rules from some of the previous emergency rules. The NCQAC first adopted emergency rules in response to COVID-19 in April 2020. They were refiled multiple times while permanent language is being developed.	WSR: 21-19-104 Filed: 9/17/2021 Note: Public workshops held 11/3 & 11/8/2021. CR-102 hearing scheduled for 3/11/2022.	WSR: 22-04-081 Filed: 1/31/2022 Note: CR-102 hearing held 3/11/2022. WAC 246-840-365, 367 removed and will be included in a new CR-101.	WSR: 22-12-026 Filed: 5/23/2022 Note**: Effective 9/9/2022** to coincide with expiration of emergency rule.	
4	LPN/NT Practice Opportunities (Standard rulemaking)	Debbie Carlson, Gerianne Babbo, Shana Johnny Jessilyn Dagum	246-840-010, 840, 850	Allow LPN students practice opportunities. NCQAC's legislative panel completed a review of the benefits of apprenticeship programs. The panel recommended opening rules to grant LPN students the same opportunity as registered nurse (RN) students to obtain a nurse technician credential.	WSR: 20-11-044 Filed: 5/18/2020 Note: Workshops 10/5, 9/2020. NCQAC approved rule language for (CR-102) on 3/12/2021.	WSR 21-20-058 Filed: 9/28/2021 Note: Hearing held 11/12/2021. CR-103 to be filed with an effective date of 5/15.	WSR: 22-04-082 Filed: 1/31/2022 Note**: Effective 5/13/2022** to coincide with expiration of emergency rule.	

#	Profession	Staff Content Experts Rules Staff assigned	WAC Sections	Purpose for Rule Making	CR-101 Preproposal	CR-102 Proposal & CR-105 Expedited	CR-103P Permanent	CR-103E Emergency 120-day limit WSR means Washington State Register
5	NT, LPN, RN Continuing Competency (Standard rulemaking)	Amber Zawislak, Shana Johnny, Debbie Carlson, Gerianne Babbo, Mary Sue Gorski Bonnie King	WAC 246-840-111, 120, 125, and 200 through 260	The Nursing Care Quality Assurance Commission (commission) is adopting amendments to the continuing competency rules and requirements for active, inactive, expired, and retired active credential statuses. This reduces the continuing education hours from 45 hours to eight hours, the active practice hours from 531 to 96 hours and the reporting period from a three-year cycle to an annual cycle. These changes applied to the retired active rule, the active credential rule, the reactivation from expired rule, and the reactivation from inactive rule. The commission also adopted changes that now allow the commission to choose to audit licensees based on a random audit, or as part of the disciplinary process and the language for extensions is removed as it is no longer needed.	WSR: 19-01-001 Filed: 12/5/2018	WSR: 21-04-096 Filed: 2/1/2021	WSR: 21-11-032 Filed: 5/12/2021 **Effective 6/12/2021**	
6	NT, LPN, RN, ARNP, NA Aids Education & Training (Expedited rulemaking)	Debbie Carlson, Gerianne Babbo, Mary Sue Gorski, Kathy Moisio Bonnie King	WAC 246-840-025, 030, 045, 090, 539, 541, 860, 905, 246-841-490, 578,585 and 610	Section 22, paragraph (11) of ESHB 1551 repeals RCW 70.24.270-Health Professionals-Rules for AIDS education and training. This repeal no longer requires health professionals to obtain AIDS education and training as a condition of licensure. The amendment of the impacted rules is to help reduce stigma toward people living with HIV/AIDS by not singling out AIDS as an exceptional disease requiring special training and education separate from other communicable health conditions.		**Expedited** WSR: 20-18-045 Filed: 8/28/2020	WSR: 21-04-016 Filed: 1/22/2021 **Effective 2/22/2021**	
Future Rulemaking from Legislation								

2023 SECOND SUPPLEMENTAL DECISION PACKAGE

Agency: 303 – Department of Health

DP code/title: M1 – Nurse Preceptor Grant
A descriptive title limited to 35 characters. This will appear on Decision Packages and Recommendation Summary reports.

If your request is related to the Clean Buildings Performance Standard (CBPS), begin your DP title with "CBPS."

Budget period: 2023 Second Supplemental

Budget level: ML

Cost Type: Ongoing

Activity Code: A015

Agency RecSum text: A brief description of your proposal. A cogent "elevator pitch" including a concise problem statement, proposed solution and outcomes affected by the proposal. Agencies should strive not to exceed 100 words. Summary text need not include references to financial or FTEs data, which is displayed directly below in the fiscal detail.

Governor Inslee initiated, and the legislature passed, the Nurse Preceptor Grant to incentivize working nurses who precept nursing students by providing personal instruction, training, and supervision to nursing students. The Nursing Care Quality Assurance Commission (NCQAC) requests a correction regarding Nurse Preceptor Grant expenditure authority. This correction will align appropriations with NCQAC's ability to expend funds in the correct fiscal year.

Fiscal detail

Operating Expenditures	FY 2022	FY 2023	FY 2024	FY 2025
Fund 001-1	($3,000)	$3,000	0	0
Fund BBB-Y	0	0	0	0
Total Expenditures	0	0	0	0
Biennial Totals	$0		$###,###,###	

Staffing	FY 2024	FY 2025	FY 2026	FY 2027
FTEs	0	0	0	0

Average Annual	0		0	
Object of Expenditure	FY 2022	FY 2023	FY 2024	FY 2025
Obj. A -Salaries	(25)	180	zzz	Aaa
Obj. B -Benefits	(11)	65	zzz	Aaa
Obj. C -Person Svc Contract	0	0	zzz	Aaa
Obj. E -Goods & Services	(6)	15		
Obj. G -Travel	0	0		
Obj. J -Equipment	0	6		
Obj. N – Grants & Client Svc	(2958)	2723		
Obj. S – Inter-Agency	0	0		
Obj. T – Intra-Agency	0	11		
Revenue	FY 2022	FY 2023	FY 2024	FY 2025
Fund AAA-X	x.y	x.y	x.y	x.y
Fund BBB-X	x.y	x.y	x.y	x.y
Total Revenue	Xxx	yyy	zzz	aaa
Biennial Totals	$###,###,###		$###,###,###	

Package description

Your detailed package description should expand upon the RecSum description provided above. This detailed description should provide the Governor, the Legislature, OFM and the public an understanding of the problem you are addressing, your proposed solution and anticipated outcomes or consequences.

To thoroughly describe the package and its justification, agencies are strongly encouraged to use:

- Detailed narrative descriptions
- Informative tables
- Charts and graphs
- Logic models
- Timelines
- Flowcharts
- Maps or other graphics

High-quality narrative descriptions whether for an addition, or a reduction will address the following questions:

What is the problem, opportunity, or priority you are addressing with the request?

- Describe in detail the problem you propose to solve.
- What is the relevant history or context in which the DP request is made?
- Why is this the opportune time to address this problem?
- Have you previously proposed this request? If so, when and how was it

received in the budgeting process at that time?

What is the problem, opportunity, or priority you are addressing with the request?

Nurse Preceptor Grant

ENGROSSED SUBSTITUTE SENATE BILL 5693 Chapter 297, Laws of 2022, Section 222

(54) $3,000,000 of the general fund—state appropriation for fiscal year 2022 and $3,000,000 of the general fund—state appropriation for fiscal year 2023 are provided solely for the Washington nursing commission to manage a grant process to incentivize nurses to supervise nursing students in health care settings. The goal of the grant program is to create more clinical placements for nursing students to complete required clinical hours to earn their nursing degree and related licensure.

Funding was provided to set up a grant program to provide incentives to nurses who provide personal instruction, training, and supervision to nursing students in health care settings. NCQAC requests an adjustment to the appropriation received to effectively implement the plan.

Funding provided in FY22 could not be spent due to the time from funding appropriation until the end of FY22. This program did not exist at the time funding was appropriated and requires significant planning to establish and implement. There was not adequate time to hire program staff, plan, establish, implement program, and disperse funds by the end of FY22. Therefore, NCQAC requests FY22 funding be reappropriated to FY23. Funding for FY23 would total $6M. Annually thereafter, the total would be $3M.

Dollars in thousands

Fiscal Year	Appropriation Needed (Fund)	Appropriation Received (Fund)	Difference (Fund)
2022	$0 (001-1)	$3,000 (001-1)	-$3,000 (001-1)
2023	$3,000 (001-1)	$3,000 (001-1)	$6,000 (001-1)

The definition of a preceptor comes from the WAC 246-840-533 (1) (a) A nursing preceptor means a practicing licensed nurse who provides personal instruction, training, and supervision to any nursing student, and meets all requirements of subsection (4) of this section.

(4) A nursing preceptor may be used in nursing education programs when the nursing preceptor:

(a) Has an active unencumbered nursing license at or above the level for which the student is preparing.

(b) Has at least one year of clinical or practice experience as a licensed nurse at or above the level for which the student is preparing.

(c) Is oriented to the written course and student learning objectives prior to the beginning the preceptorship.

(d) Is oriented to the written role expectations of faculty, preceptor, and student prior to beginning the preceptorship.

(e) Is not a member of the student's immediate family, as defined in RCW 42.17(A).005(27); or have a financial, business, or professional relationship that is in conflict with the proper discharge of the preceptor's duties to impartially supervise and evaluate the nurse.

Importance of enough preceptors:

- Without enough preceptors, there will be a delay in having trained nurses enter the workforce pipeline in a timely manner. Students cannot meet academic criteria for graduation without completing their preceptorship and obtaining their clinical hours as set in the nursing curriculum. This could potentially affect graduation timeframe thus having fewer nurses enter the workforce.
- Washington state is in a critical nursing shortage due to many factors. Currently, hospitals are reporting over 6000 nursing positions open. This does not include other types of clinical settings such as long-term care, home health, hospice, and other various clinics.
- Nurses are working with less staff and increased workload. Having the preceptorship program will provide nurses an incentive to invest their time and clinical expertise to educate future nurses for safe and clinically competent nursing care for our local community.

Estimated Numbers of Preceptors:

- In the Nursing Education Programs 2020-2021 School Report: Statistical Summary and Trend Analysis Report showed a total number of 5,373 graduates for fiscal year 2020-2021.
- Some schools are increasing enrollment as of academic year 2023. We estimate 5500 as a good starting point for the upcoming grant program.
- This demonstrates the need for qualified preceptors at the clinical sites. The needs are increasing with the additional enrollment. Doctorate of Nursing Practice (DNP) programs will be increasing in the future with the emphasis on Advanced Registered Nurse Practitioner-DNP programs with a decrease in Master of Science of Nursing programs.

The following charts demonstrate the increasing number of nursing students graduating:

Undergraduate Programs

Year	Practical Nurse (LPN)	Associate Degree (ADN)	Baccalaureate of Science in Nursing (BSN)/GE/Other	Registered Nurse to Baccalaureate	Total
2020-2021	315	1689	1124	1310	4438
2019-2020	238	1561	941	1209	3949
Increase Graduation	77	128	183	101	489

Graduate Programs

Year	Master of Science in Nursing (MSN)/ADMIN/Non ARNP	MSN/ARNP/Post Masters Certificate Nurse	PHD/DNP	Total
2020-2021	353	132	450	935
2019-2020	264	101	382	747
Increase Graduation	88	31	68	187

What is your proposal?

- How do you propose to address this problem, opportunity, or priority?
- Why is this proposal the best option?
- Identify who will be affected by this DP and how.
- How many clients will or will not be served? Served by whom?

What are you purchasing and how does it solve the problem?

- What will this funding package buy, reduce, or eliminate?
- What services and/or materials will be provided, reduced, or eliminated,
  - When and to whom will these service level changes impact?
- How will these service level changes achieve the desired outputs, efficiencies, and outcomes?

What is your proposal? What are you purchasing and how does is solve the problem?

This is a request to adjust expenditure authority by moving funding from FY22 to FY23 to meet legislative intent to set up a grant program to provide incentives for nurses to supervise nursing students in health care settings.

How is your proposal impacting equity in the state?

- Which target populations or communities benefit from this proposal? How will the population/community benefit? Include both demographic and geographic communities.
- Describe how your agency conducted community outreach and engagement by relationally partnering with communities and populations who have historically been excluded and marginalized by governmental budget decisions.
- How did your agency revise this proposal based upon the feedback provided through your community outreach and engagement?
- Which target populations or communities are not included, would be marginalized, or disproportionately impacted by this proposal? Explain why and how these equity impacts will be addressed.

How is your proposal impacting equity in the state? Be sure to address this question in the three sections specified similar to the 2023-25 Bien.

Target populations and communities

All communities statewide who benefit from access to nursing care are impacted by this proposal. This includes tribal, urban, and rural communities. The ability to incentivize qualified nurses to be preceptors allows nursing students to fulfill all academic and clinical requirements to obtain their degrees and ultimately licensure in the state. All communities with a nursing shortage will benefit from this program and will help to better address the nursing shortage by increasing the nursing population pool.

Community outreach and engagement

Limited outreach has taken place due to the short timeframe since funding appropriation was granted. However, we frequently receive feedback from nursing programs, students, and employers impacted by the lack of preceptors available to assist students meet academic criteria for graduation and obtaining their clinical hours as set in the nursing curriculum. Resulting in delays for trained nurses from entering the workforce pipeline timely and could affect graduation timeframes.

Disproportional impact considerations

With the current nursing shortage in Washington state and around the nation, increasing the nursing pool and improving access to care through this decision package should not unintentionally marginalize or disproportionately impact any populations or communities. On the contrary, the program will target nurses in underserved communities and populations.

What alternatives did you explore and why was this option chosen?

- What are the consequences of not funding this proposal?
- Describe the pros/cons of alternatives. Explain why this proposal, whether for an enhancement or a reduction, is the best option.
- What other options did you explore? For example, did you consider:
  - » Options with lower costs.
  - » Services provided by other agency or unit of government.
  - » Regulatory or statutory changes to streamline agency processes.
  - » Redeployment of existing resources to maximize efficient use of current funding.
  - » Option to maintain the status quo.

What alternative did you explore and why is this option chosen?

No alternatives were explored. The funding was provided through Engrossed Substitute Senate bill 5693 and is mandated for the commission. This will be the first program of its kind for nursing in the state.

Assumptions and calculations

You must clearly display the caseload/workload/service-level changes and cost/savings assumptions and calculations supporting proposed expenditure and revenue changes. An attached electronic version (Excel) of detailed fiscal models and/or fiscal backup information in addition to the DOH Financial Calculator (FNCal).

The intent here is not to repeat the fiscal detail summarized in the package description above, but to expand and provide all underlying assumptions and calculations associated with this proposal. All calculations must include impacts to the 2021-23 *and* 2023-25 biennia and must support the fiscal summary detail.

Expansion, reduction, elimination or alteration of a current program or service

Where a proposal is an expansion, reduction, elimination or alteration of a *current program or service*, provide detailed historical financial information for the prior two biennia (2017-19 and 2019-21).

Detailed assumptions and calculations

- Provide detailed caseload/workload and cost information associated with adopting this proposal.
- Identify discrete expenditure/revenue calculations. Many DPs contain multiple components to achieve a desired outcome. If this package contains discrete funding proposals, the fiscal models or details must break out the complete costs/savings of each component part.
- Clearly explain all one-time expenditure or revenue components.
- Clearly describe the numbers in your FNCal

What are your assumptions? How did you arrive at your estimated costs? Are you expanding, reducing, or changing a program or service? Be sure to address BOTH above questions.

Expansion or alteration of a current program or service:

This is not a request to expand or alter a current program or service. This request is necessary to implement legislation passed and correct existing errors in fund balances and appropriations.

Detailed assumptions and calculations:

Details regarding the calculations informing this request are available in the support document titled. "Preceptor Grant Technical Correction DP v.2"

Workforce assumptions

Include FTE information by job classification, including salary and benefits, startup costs and any additional staff related ongoing costs.

See attached financial calculator (FNCal).

Strategic and performance outcomes

Strategic framework

- Describe how this package relates affects the Governor's Results Washington goal areas and statewide priorities?
- How does the package support the agency's strategic plan?
- Identify how this proposal affects agency activity funding by amount and fund source.

This request supports the Governor's Results Washington in the following goals:

- Healthy and Safe Communities

» Create more clinical placements for nursing students to produce more nurses and meet the increase demand for nurses in the state
» Ensuring Access to Quality Healthcare

This request supports the department's Transformational Plan, Priority 2: All Washingtonians are well served by a health ecosystem that is robust and responsive, while promoting transparency, equity, and trust.

Performance outcomes

- Describe and quantify the specific performance outcomes you expect from this funding change.
- What outcomes and results, either positive or negative will occur?
- Identify all Lean initiatives and their expected outcomes.
- Include incremental performance metrics.

This request will allow NCQAC to implement enacted legislation with the corrections to existing spending authority.

Other collateral connections

Intergovernmental

Describe in detail any impacts to tribal, regional, county or city governments or any political subdivision of the state. Provide anticipated support or opposition. Impacts to other state agencies must be described in detail.

This request does not affect tribal, regional, county or city governments.

Stakeholder impacts

Agencies must identify non-governmental stakeholders impacted by this proposal. Provide anticipated support or opposition.

There has been considerable public interest in the development of the grant program, the funds available, and the disbursement. The Advanced Registered Nurse Practitioner community is interested in funds being available for advanced practice preceptors as well as preceptors for registered nurses and licensed practical nurses. The nursing education programs and employers are also interested in this grant. The kidney dialysis companies are interested due to the number of nursing students in their facilities and preceptors.
The staff have been hired and are exploring methods to identify preceptors, the number of preceptors, and monetary amounts for precepting. Models from other states have been evaluated to determine if they should be applied in Washington. Payment methods will need to be evaluated.

Legal or administrative mandates

Describe in detail if this proposal is in response to litigation, an audit finding, executive order or task force recommendation.

This request is not a response to litigations, audit findings, executive orders, or task force recommendations.

Changes from current law

Except for appropriations acts, describe in detail any necessary changes to existing statutes, rules, or contracts. Where changes in statute are required, cabinet agencies must provide agency request legislation as an attachment to this DP *and* submit the request through BATS.

This request does not require changes to state statutes.

State workforce impacts

Describe in detail all impacts to existing collective bargaining agreements or statewide compensation and benefits policy.

This request does not create impacts to the state workforce.

State facilities impacts

Describe in detail all impacts to facilities and workplace needs (See Chapter 9 - Leases and Maintenance). Describe in detail all impacts to capital budget requests.

This request will not change facilities or workplace needs.

Puget Sound recovery

If this request is related to Puget Sound recovery efforts, see Chapter 13 of the budget instructions for additional instructions.

N/A

Other supporting materials

Attach or reference any other supporting materials or information that will help analysts, policymakers and the public understand and prioritize your request.

Information technology (IT)

Does this DP include funding for any IT-related costs including hardware, software (to include cloud-based services), contracts or staff? If the answer is yes, you will be prompted to attach a complete IT addendum. (See Chapter 10 of the budget instructions for additional requirements.)

Does this DP include funding for any IT-related costs, including hardware, software (including cloud-based services), contracts, or ITS staff?

☒ No

☐ Yes

If yes is selected, please download the IT-Addendum Form, and follow the directions on the bottom of the addendum to meet requirements for the OCIO review. After completing the IT addendum, please upload the document to continue.

2023-25 BIENNIAL BUDGET DECISION PACKAGE

Agency: 303 – Department of Health

DP code/title: CODE/Staffing Solutions to Address Increase Demand for Nurses
A descriptive title limited to 35 characters. This will appear on Decision Packages and Recommendation Summary reports.

If your request is related to the Clean Buildings Performance Standard (CBPS), begin your DP title with "CBPS."

Budget period: 2023-25 Biennium

Budget level: ML

Cost Type: Ongoing

Activity Code:

Agency RecSum text: A brief description of your proposal. A cogent "elevator pitch" including a concise problem statement, proposed solution and outcomes affected by the proposal. Agencies should strive not to exceed 100 words. Summary text need not include references to financial or FTEs data, which is displayed directly below in the fiscal detail.

The Nursing Care Quality Assurance Commission (NCQAC) requests adequate spending authority to support staffing solutions addressing the increasing demand for nurses. No additional funds or fee increase is needed to support this request. The increasing demand significantly impacts licensing, discipline, education, and regulations. The 2022 legislature increased the number of nursing student positions in education programs and the use of simulation. Implementing new processes requires new and updated regulations with valuable interested party participation. With an increase in the number of nurses practicing in Washington, there is a corresponding increase in the number of disciplinary actions and associated administrative workload.

Fiscal detail

Operating Expenditures	FY 2024	FY 2025	FY 2026	FY 2027
Fund 02G	$1,147,000	$1,129,000	$1,129,000	$1,129,000
Total Expenditures	$1,147,000	$1,129,000	$1,129,000	$1,129,000
Biennial Totals	$2,276,000		$2,258,000	
Staffing	**FY 2024**	**FY 2025**	**FY 2026**	**FY 2027**
FTEs	10.6	10.6	10.6	10.6
Average Annual	10.6		10.6	

Object of Expenditure	FY 2024	FY 2025	FY 2026	FY 2027
Obj. A Salaries	$719,000	$716,000	$716,000	$716,000
Obj. B Benefits	$306,000	$304,000	$304,000	$304,000
Obj. E, JA, & T	$122,000	$109,000	$109,000	$109,000
Revenue	FY 2024	FY 2025	FY 2026	FY 2027
Fund 02G	$0	$0	$0	$0
Total Revenue	$0	$0	$0	$0
Biennial Totals	$0		$0	

Package description

Your detailed package description should expand upon the RecSum description provided above. This detailed description should provide the Governor, the Legislature, OFM and the public an understanding of the problem you are addressing, your proposed solution and anticipated outcomes or consequences.

To thoroughly describe the package and its justification, agencies are strongly encouraged to use:

- Detailed narrative descriptions
- Informative tables
- Charts and graphs
- Logic models
- Timelines
- Flowcharts
- Maps or other graphics

High-quality narrative descriptions whether for an addition, or a reduction will address the following questions:

What is the problem, opportunity, or priority you are addressing with the request?

- Describe in detail the problem you propose to solve.
- What is the relevant history or context in which the DP request is made?
- Why is this the opportune time to address this problem?
- Have you previously proposed this request? If so, when and how was it received in the budgeting process at that time?

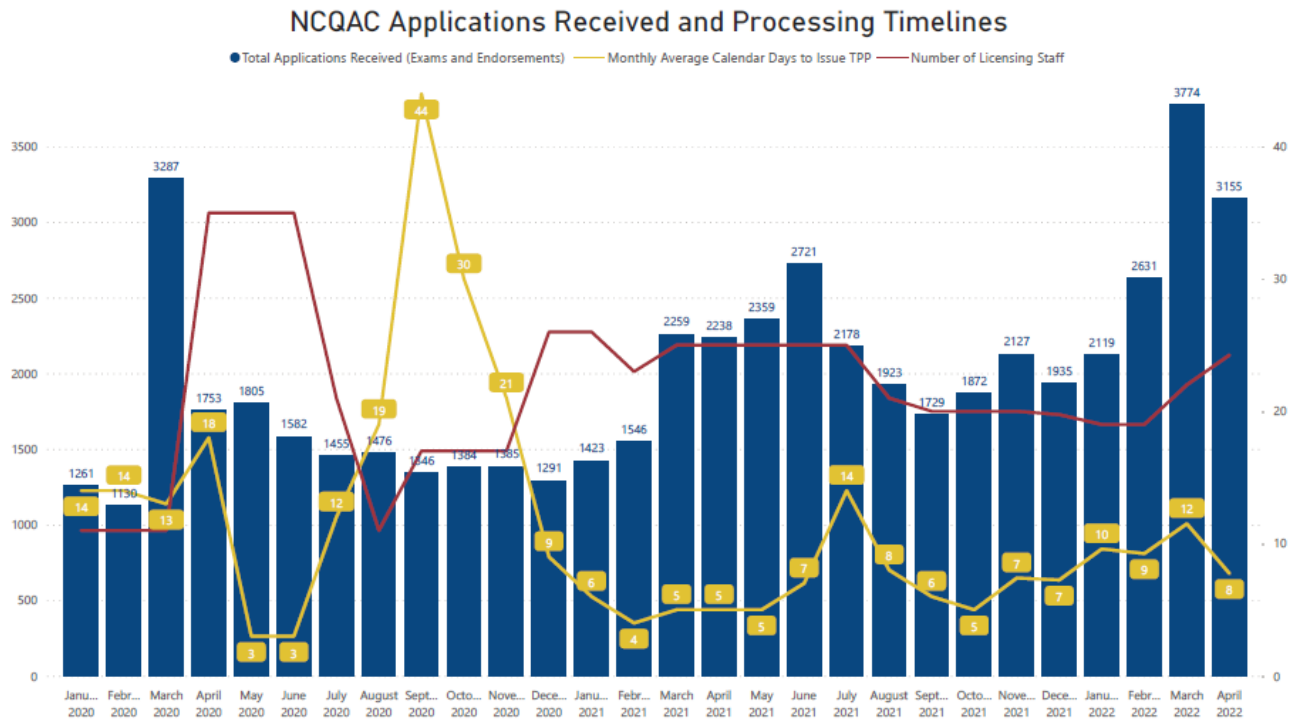
Over the past two years, the increasing demand for more nurses in our state has hit record numbers of applications and corresponding renewal of nursing licenses. Last year, the governor and legislature supported NCQAC in adding licensing staff to address this demand and decrease the time needed to process out-of-state applications. The licensing staff also embraced numerous process improvements during the pandemic to achieve 100% remote work, leading the way in health professions regulation. This increased efficiencies, productivity, and staff morale. A major improvement was the transition to online applications, increasing the number of nurses applying online instead of mailing paper applications to NCQAC. Online applications reach NCQAC an average of two weeks faster than a mailed application. The increased use of the online portal also resulted in an increase in online renewals after the nurse is issued a Washington state license and decreased the number of nurses renewing their licenses at the last

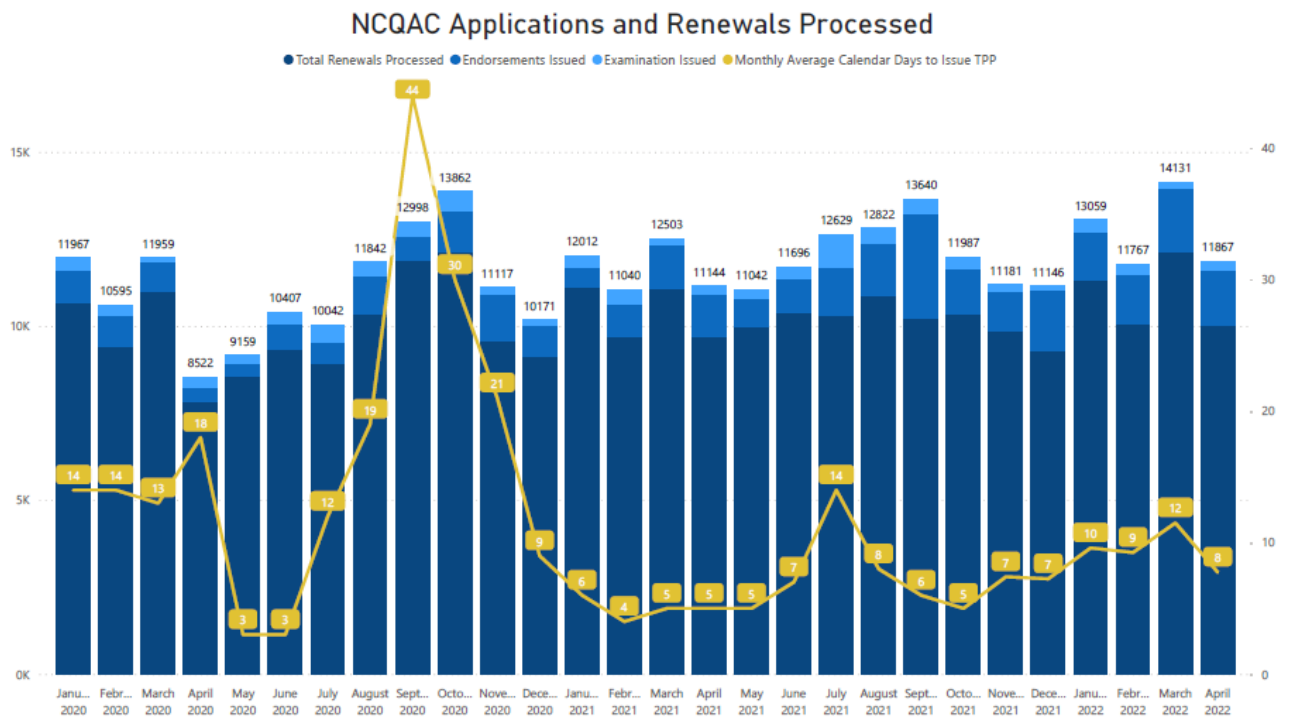
minute. The use of the online portal for new nursing applications increased from 8% online application submission in 2019, to 98% online application submission in 2022.

New Nursing Applications	2019	2020	2021	2022
% Online Applications	8%	79%	96%	98%
% Paper Applications	92%	21%	4%	2%

Another improvement was the streamlining of the FBI fingerprinting process. Paper fingerprint card packets are no longer mailed to applicants. NCQAC now emails nursing applicants fingerprinting directions one day after applying to complete the fingerprint process and submit electronically. Due to improved credentialing processing time, phone calls and email volumes have significantly dropped. The improved processes and addition of ten FTEs addressed the projected and realized workload. In addition to innovating and improving processes, NCQAC staff is preparing for the implementation of the Health Enforcement and Licensing Management System (HELMS) for all health professions.

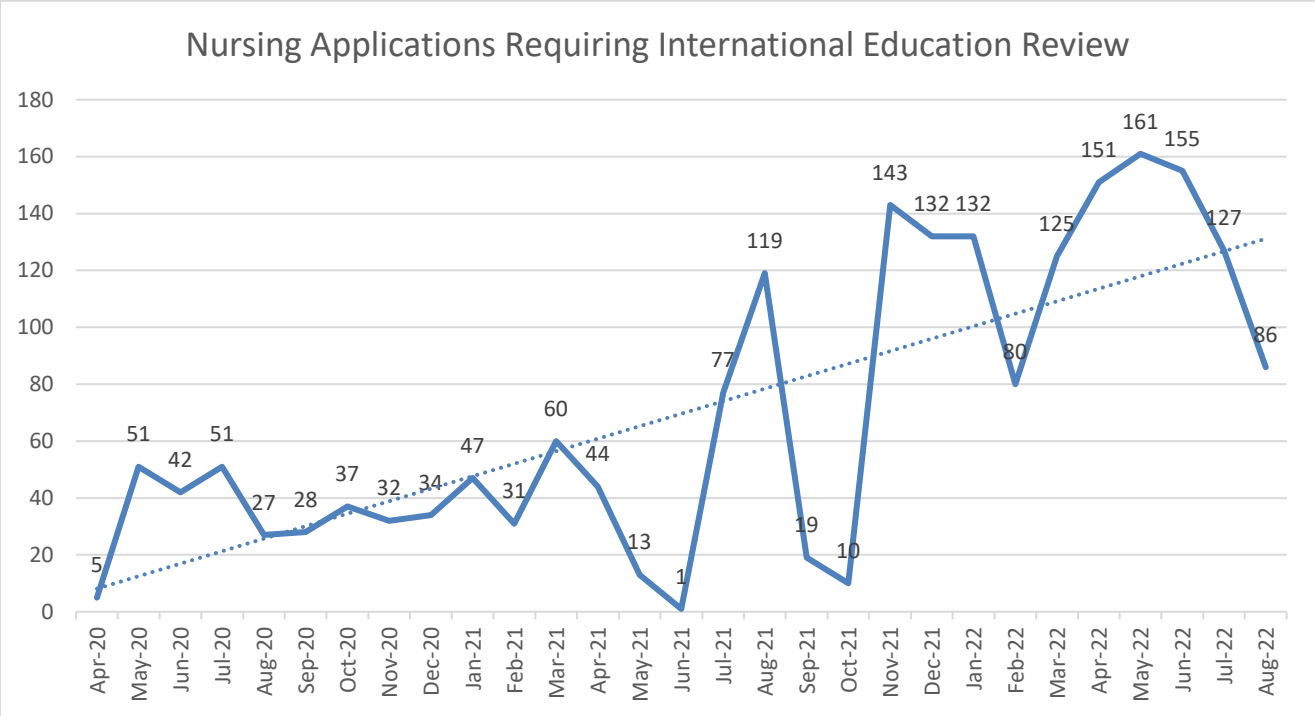
The actual workload in the past year far exceeded projections. The two charts below are sent to the governor's office each week to provide an update on nursing application volume, average days to issue a complete temporary practice permit (TPP), NCQAC Licensing Unit staffing levels (including temporary seasonal staff), and the number of renewals and applications issued by NCQAC.





The overall volume of new nursing applications being submitted to NCQAC over the past two years notably increased. NCQAC received a total of 19,006 new applications in 2020 and received a total of 24,134 applications in 2021. This represents a 27% increase of applications in one year. Additionally, from January through August of 2021, NCQAC received 16,544 new applications and has already received 22,953 new applications for the same period of 2022. In comparing new applications received in January through August of 2021 to 2022, this is a 39% increase in new nursing applications submitted to the NCQAC.

The increase in the number of applications results in increased administrative work to process the applications and issue nursing credentials. While most applicants now submit documentation electronically, applications must be evaluated to assure they meet regulatory requirements: minimum education from an approved nursing education program, criminal and licensing background checks, licensing examination passing scores, and assistance with out-of-state and internationally educated applicants. The number of nursing applications requiring an international education review from a licensing international review specialist and a nurse education consultant increased from 392 (Jan-Aug of 2021) to 1,017 (Jan-Aug of 2022). This is a 159% increase in international education application reviews in the last year and this continues to trend upwards. Employers have increased recruitment of internationally educated nurses to meet the growing number of vacancies in health care facilities. Evaluation of the applications for internationally educated nurses requires more time and expertise to determine if curriculum and clinical requirements are equivalent to Washington state standards. Each applicant must supply additional documents from primary sources for their transcripts, credential evaluation, and tests of English comprehension or work verification from another US state.



NCQAC looks forward to the implementation of HELMS in 2023, which will automate additional processes within the licensing review of nursing applications. Until then, there is a need to increase licensing staff to meet the seven-day turnaround required in Chapter 334, Laws of 2021, ESSB 5092.

Demands on nursing education programs have increased due to the demand for more nurses. The 2022 legislature expanded many of the nursing programs student slots and provided money for simulation equipment. As a result of COVID, and a lack of clinical placements available to students, nursing programs rapidly provided faculty professional development to support increased use of simulation. The use of simulation in nursing education is an area of national interest and research efforts. The National Council of State Boards of Nursing (NCSBN) and NCQAC supported the research of Dr. Katie Haerling from the University of Washington; Haerling, K., Kmail, Z., & Buckingham, A. (20XX). *Informing regulation of simulation in nursing education: A comparison of traditional clinical, mannequin-based simulation, and virtual simulation*. Submitted for peer review. This research adds knowledge about the effectiveness of simulation as an educational strategy for nursing students.

NCQAC evaluates 42 nursing education programs in Washington to assure the programs are adequately resourced to meet the increasing demands. NCQAC also evaluates the curriculum and educational outcomes to assure new graduates meet the minimum standard for patient safety. The NCLEX examination is the only approved licensing examination used by all boards of nursing to assess minimum safety for new graduates. The nursing education programs prepare the students who then apply for the examination and state licensure. The nursing licensing staff review the applications for compliance with the requirements and authorize the new graduates to take the examination. Each nursing program receives the number of graduates who pass the examination. A required nursing education outcome requires an 80% pass. The nursing education staff perform site visits with every nursing education program to confirm programs meet the requirements, which is an important indicator that their new graduates meet minimum safety standards to practice nursing. Washington needs nursing programs to meet standards, so graduates are safe, competent practitioners when entering the workforce. This requires nursing education staff to survey and support nursing education programs to achieve program outcomes.

The nursing education staff also investigate public complaints against nursing programs or nursing faculty. These complaints may be from students or the public related to the nursing education program. The complaints range from faculty issues to financial issues, to adequacy of clinical experiences.

NCQAC also approves clinical experiences for nursing students from out of state programs. If a nursing student is completing their clinical experience in Washington but the nursing education program is in another state, the clinical faculty must be licensed in Washington state. The has been an increase in the number of students from out-of-state programs due to enforcement by the US Department of Education requiring approval of out-of-state program experiences. The students are often from Washington state who attend an out-of-state nursing education program. Related to the shortage of nurses, these experiences have also increased.

NCQAC initiated an Education Subcommittee in the past year to discuss nursing education issues in open public meetings. The issues have been related to use of simulation, faculty salaries, faculty vacancies, and requirements for faculty.

In the past two years, NCQAC has held many summit meetings and issued reports addressing clinical placements with the nursing education programs and employers:

- Long Term Care Summit 2020
- Long Term Care Summit 2021
- Critical Gap Groups 2020
- Clinical Placements Summit 2022
- Veterans Administration and nursing students: Linda Tieman's report 2022
- Multiple Virtual Communications meetings with Nursing Program Deans/Directors

The increase in nursing education issues related to COVID increased the regulatory oversight of nursing education programs. This translates to increased hours for staff to gather evidence to present to NCQAC members for decisions. The staff must coordinate and schedule the meetings, provide the evidence for sound decisions, and professionally communicate decisions to the nursing education programs. NCQAC members and staff worked diligently on nursing education rules during COVID. The staff provided communication with the deans and directors of the nursing education programs. This work continues to increase.

As the number of licensees increases, so does the disciplinary work of NCQAC. The number of investigators and legal staff are sufficient since the addition of staff resulting from a decision package which addressed rising caseloads in 2018. However, administrative staff to support the work of the investigative, case management, and legal staff has not increased since 2008. NCQAC received 1980 complaints in 2021 and determined 36% of these complaints required investigation. Processing and documenting the complaints requires administrative work to meet requirements defined in the Uniform Disciplinary Act, RCW 18.130.

A large portion of the work occurs on a weekly cycle, as staff must log every complaint into the licensing and discipline data base. A panel of NCQAC members attend weekly Case Management Team meetings to authorize complaints for investigation, refer to another disciplinary authority, or close the case. At each step, administrative staff must perform tasks to support the work, such as receiving and logging complaints, scheduling the weekly case management team meetings, scheduling emergency case management meetings for imminent harm cases, scheduling NCQAC members to attend, recording meetings and entering actions in the data base. For those cases opened to investigation, the administrative

staff work with the investigators to build electronic case files, maintain paper records according to retention protocols until cases are adjudicated, send notification and whistleblower letters, request facility and medical records and legal documents, retrieve and scan mail, communicate with external requests for information and public disclosure requests, transfer electronic files, monitor the investigative timeline for each open case, process bills related to investigative needs. Once the investigation is completed, the administrative staff process the investigation for closure and assigns a reviewing commission member (RCM) to evaluate the evidence. The administrative staff sends the investigative material to NCQAC members and tracks the timeline for both the legal review and RCM. Administrative staff maintain awareness of timelines throughout the investigative and case disposition process according to Mandatory Timelines as defined in WAC 246-16-200 through 270. Management oversight must occur for any phase that exceeds mandatory timelines. An RCM and staff attorney complete an evaluation of each case and collaborate to determine if evidence supports or refutes the allegations that form the basis of the complaint. The RCM presents their recommendation to a case disposition panel where the panel decides what action NCQAC will take, whether to discipline the nurse or close the case. The administrative staff must coordinate and schedule the case disposition meetings, capture their decisions, and enter into expert witness contracts when necessary.

In addition to regular duties that support the discipline unit, administrative staff also supports the regularly occurring Discipline Subcommittee, which considers all matters related to discipline and brings recommendations to the full NCQAC for action. This requires scheduling meetings, creating agendas, sending meeting notifications, building the packet of information relevant to the agenda, and distributing the information to the subcommittee members and interested parties. Discipline staff also supports the Interagency Roundtable, which is a confidential data sharing group comprised of seven state agencies united for the common purpose of protecting the public through sharing investigative and disciplinary information related to health professionals. One administrative position is no longer sufficient to perform all the associated duties related to supporting the discipline unit.

Washington Health Professional Services (WHPS) is the NCQAC-approved monitoring program for nurses with substance use disorder that provides accountability for nurses and enables them to remain in safe practice. In July 2022, NCQAC implemented the Substance Use Disorder Review Panel (SUDRP). The SUDRP, empowered with decision-making authority, was initiated to directly engage NCQAC members with non-compliant nurses who participate in the monitoring program either because of discipline or in lieu of discipline. NCQAC members may also choose to meet with graduates of the program. Administrative staff must coordinate and schedule meetings, produce the agenda and minutes, and retain all records as required for all disciplinary proceedings.

NCQAC worked tirelessly to adopt emergency rules for nursing education during the pandemic. Over the past two years, NCQAC evaluated the need to keep the emergency rules, modify rules, or return to original rules. This necessitated following the proclamations, the state and federal waivers, the emergency rules processes, and now, the rules that need to be modified to reflect current requirements or revert to the previous rules. Currently, a non-permanent staff member is completing the rules process for NCQAC. In addition, there was considerable legislation related to nursing education and nursing in the 2022 legislative session. The increased demands for nurses will continue to drive legislative action for the coming years. NCQAC works with the governor's office to answer questions and attend meetings related to nursing at all levels and in all workplaces. This represents an increased workload for nimble responses to legislation and legislators. There is also a need to track the implementation of legislation such as continuing education requirements, nursing education, nursing preceptors, and simulation.

As the demand for nurses in the state continues to increase, so does the need for improving and

increasing NCQAC communications with the public and interested parties, supporting current and new NCQAC staff, maintaining connections with lawmakers, and monitoring upcoming legislation impacting the nursing profession.

What is your proposal?

- How do you propose to address this problem, opportunity, or priority?
- Why is this proposal the best option?
- Identify who will be affected by this DP and how.
- How many clients will or will not be served? Served by whom?

What are you purchasing and how does it solve the problem?

- What will this funding package buy, reduce, or eliminate?
- What services and/or materials will be provided, reduced, or eliminated,
  - When and to whom will these service level changes impact?
- How will these service level changes achieve the desired outputs, efficiencies, and outcomes?

Staffing requested to address the issues of increased demand for nurses described above:
10.6 FTE.

Education (2 FTE):

- Nurse Consultant Public Health
- Health Services Consultant 2

Licensing (2 FTE):

- Health Services Consultant 1
- Health Services Consultant 1

Discipline (1 FTE):

- Health Services Consultant 1

Operations (3 FTE):

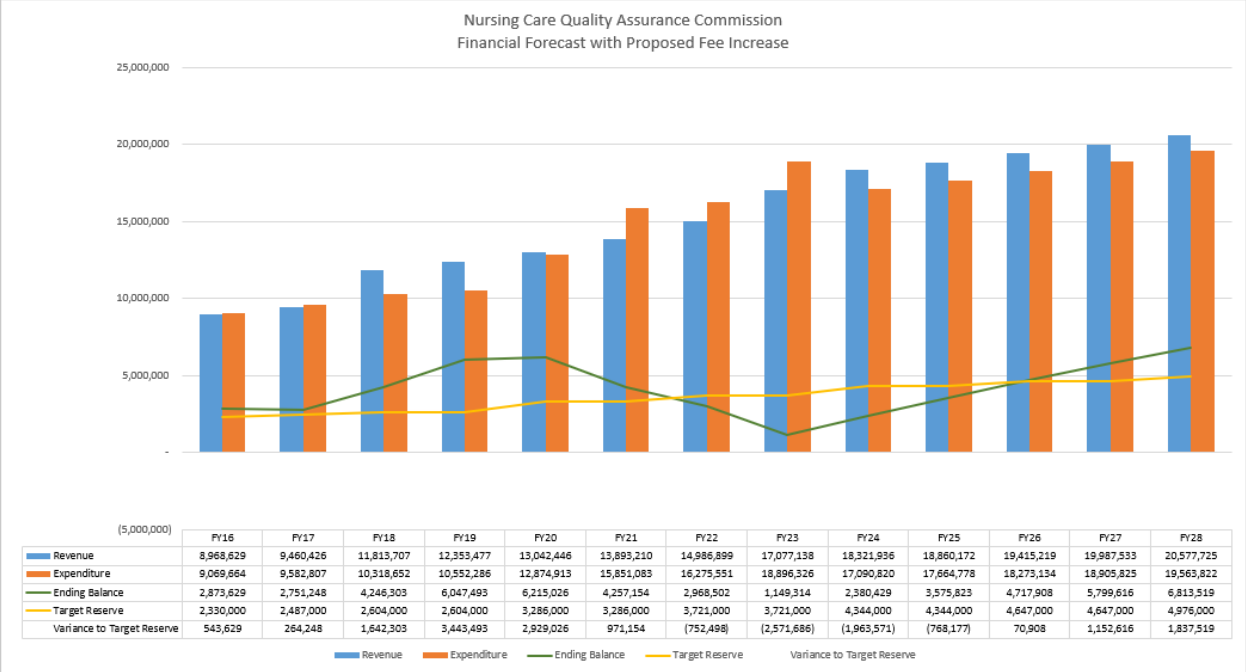
- Washington Management Service 2
- Communication Consultant 4
- Administrative Assistant 3

Division and Agency Indirects:

- 2.6 FTE

NCQAC is requesting additional spending authority to fund the above-described positions. NCQAC conducted a comprehensive fee study and analysis in 2021-22, resulting in a small fee increase to cover unanticipated costs of the new HELMS database solution, the legislated mandate to process nurse licenses in seven days or less, and to address the crisis in long term care. This fee increase, effective December 1, 2022, along with an unprecedented influx of out-of-state applications in the past year, enables NCQAC to fully fund the requested positions with granted additional spending authority with NO fee increase anticipated in the foreseeable future.

Profession	Fee Type	Current Fees	Proposed Fees	HEAL-WA Surcharge	WCN Surcharge	Total Fee
Advanced Registered Nurse Practition	Applications	$125	$130			$130
(ARNP renewal is every 2 Years)	Renewals	$125	$130			$130
Licensed Practical Nurse	Applications	$64	$69	$16	$5	$90
	Renewals	$64	$69	$16	$5	$90
Registered Nurse	Applications	$99	$114	$16	$5	$135
	Renewals	$99	$114	$16	$5	$135
Nursing Technician	Applications	$25	$25			$25
	Renewals	$25	$25			$25



	FY16	FY17	FY18	FY19	FY20	FY21	FY22	FY23	FY24	FY25	FY26	FY27	FY28
Revenue	8,968,629	9,460,426	11,813,707	12,353,477	13,042,446	13,893,210	14,986,899	17,077,138	18,321,936	18,860,172	19,415,219	19,987,533	20,577,725
Expenditure	9,069,664	9,582,807	10,318,652	10,552,286	12,874,913	15,851,083	16,275,551	18,896,326	17,090,820	17,664,778	18,273,134	18,905,825	19,563,822
Ending Balance	2,873,629	2,751,248	4,246,303	6,047,493	6,215,026	4,257,154	2,968,502	1,149,314	2,380,429	3,575,823	4,717,908	5,799,616	6,813,519
Target Reserve	2,330,000	2,487,000	2,604,000	2,604,000	3,286,000	3,286,000	3,721,000	3,721,000	4,344,000	4,344,000	4,647,000	4,647,000	4,976,000
Variance to Target Reserve	543,629	264,248	1,642,303	3,443,493	2,929,026	971,154	(752,498)	(2,571,686)	(1,963,571)	(768,177)	70,908	1,152,616	1,837,519

How is your proposal impacting equity in the state?

- Which target populations or communities benefit from this proposal? How will the population/community benefit? Include both demographic and geographic communities.
- Describe how your agency conducted community outreach and engagement by relationally partnering with communities and populations who have historically been excluded and marginalized by governmental budget decisions.
- How did your agency revise this proposal based upon the feedback provided through your community outreach and engagement?
- Which target populations or communities are not included, would be marginalized, or disproportionately impacted by this proposal? Explain why and how these equity impacts will be addressed.

All communities statewide who benefit from access to nursing care are impacted by this proposal. This includes tribal, urban, and rural communities. The ability for NCQAC to process qualified nurses in a timely manner allows all communities with a nursing shortage to better address the shortage with the available nursing population pool. State agencies that hire nurses will also benefit: Department of Social and Health Services, Labor and Industries, Department of Corrections, and Department of Health.

Additionally, with the 159% increase between 2021 and 2022 of internationally educated nurses applying for licensure in Washington state, increasing NCQAC staffing to the education and licensing units supports improved application processing times for this population of applicants. Current Washington state law requires a review of transcript evaluation and English proficiency for those healthcare professionals

educated outside of the United States. This is to ensure that minimum requirements are met to ensure the safety of those who will receive care from these healthcare professionals. With the recent dramatic increase in international applications, the application review processing time has been negatively impacted since there are limited staff available to perform this detailed analysis, comparing educational requirements of other countries to those of Washington state.

We frequently hear from employers, state representatives, and international nursing applicants who are impacted by the delays in reviewing international applications due to the lack in resources. This decision package will address the needs of these populations, while also maintaining our role as a regulatory agency to ensure competency of the nursing population. Improving application processing times will assist in expediting these reviews and issue credentials more expediently to qualified international applicants so they may work in the United States.

With the current nursing shortage in Washington state and around the nation, increasing the nursing pool and improving access to care through this decision package should not unintentionally marginalize or disproportionately impact any populations or communities.

What alternatives did you explore and why was this option chosen?

- What are the consequences of not funding this proposal?
- Describe the pros/cons of alternatives. Explain why this proposal, whether for an enhancement or a reduction, is the best option.
- What other options did you explore? For example, did you consider:
  - » Options with lower costs.
  - » Services provided by other agency or unit of government.
  - » Regulatory or statutory changes to streamline agency processes.
  - » Redeployment of existing resources to maximize efficient use of current funding.
  - » Option to maintain the status quo.

The consequence of not funding this proposal is that NCQAC will be unable to keep up with the growing nursing population and continued demand for nurses within Washington state. As the volume of nurses and nursing applicants continues to grow, the impact is felt on each unit within NCQAC. Licensing staff will need to process a larger volume than initially projected with stagnant staffing or be subject to not meeting the legislatively mandated seven-day licensure processing timeline. Discipline staff will be proportionately impacted by the increase in exception application reviews and complaints submitted to NCQAC. The nursing shortage will continue to drive the need for increased nursing education programs and nursing assistant training programs, impacting NCQAC Education staff. Failure to fund this proposal will impact NCQAC's ability to effectively communicate changes in the nursing profession to the public and nurses. Additionally, maintaining adequate communication with the governor's office and legislature will be impacted, affecting NCQAC's ability to remain current with legislative discussion and to effectively regulate. Without additional spending authority and associated FTEs, the NCQAC will have to shift resources to prioritize work and determine which areas will fall below acceptable performance levels.

NCQAC exhausted all known improvements to be made with processes and software solutions to gain efficiencies. This leaves increasing staff as the desired solution to meet the demands on NCQAC that the increase in demand for nurses in the state has created.

Assumptions and calculations

You must clearly display the caseload/workload/service-level changes and cost/savings assumptions

and calculations supporting proposed expenditure and revenue changes. An attached electronic version (Excel) of detailed fiscal models and/or fiscal backup information in addition to the DOH Financial Calculator (FNCal).

The intent here is not to repeat the fiscal detail summarized in the package description above, but to expand and provide all underlying assumptions and calculations associated with this proposal. All calculations must include impacts to the 2021-23 *and* 2023-25 biennia and must support the fiscal summary detail.

Expansion, reduction, elimination or alteration of a current program or service

Where a proposal is an expansion, reduction, elimination or alteration of a *current program or service*, provide detailed historical financial information for the prior two biennia (2017-19 and 2019-21).

Detailed assumptions and calculations

- Provide detailed caseload/workload and cost information associated with adopting this proposal.
- Identify discrete expenditure/revenue calculations. Many DPs contain multiple components to achieve a desired outcome. If this package contains discrete funding proposals, the fiscal models or details must break out the complete costs/savings of each component part.
- Clearly explain all one-time expenditure or revenue components.
- Clearly describe the numbers in your FNCal

See charts in narrative above and attached documents:

- Data for Gov Reports
- Licensing Work Orders for International Education Review
- NCQAC Application and Renewal Trend Data
- Staffing Solutions to Address Increase Demand for Nurses DP

Workforce assumptions

Include FTE information by job classification, including salary and benefits, startup costs and any additional staff related ongoing costs.

Personnel: 10.6 FTE

1 WMS 2
1 NURSE CONSULTANT PUBLIC HEALTH
3 HEALTH SERVICES CONSULTANT 1
1 HEALTH SERVICES CONSULTANT 2
1 COMMUNICATIONS CONSULTANT 4
1 ADMINISTRATIVE ASSISTANT 3
2.6 FTE for Division and Agency Indirects

Financial: $2,276,000 for the 23-25 Biennium

FY2024 = $1,147,000
FY2025 = $1,129,000
FY2026 = $1,129,000
FY2027 = $1,129,000

Strategic and performance outcomes

Strategic framework

- Describe how this package relates affects the Governor's Results Washington goal areas and statewide priorities?
- How does the package support the agency's strategic plan?
- Identify how this proposal affects agency activity funding by amount and fund source.

This package contributes to meeting the Governor's Results Washington goals by working to improve access to care for healthy and safe communities and addressing the increased demand for nurses in the state. The Department of Health's current strategic plan is focused on developing an organizational culture surrounding outward mindset, innovations, improvements to public health funding, and creating a diverse and inclusive workplace. This package relates to the Department of Health's strategic plan by increasing NCQAC staffing to address the public health needs of Washington state communities for more timely access to qualified licensed nurses.

Performance outcomes

- Describe and quantify the specific performance outcomes you expect from this funding change.
- What outcomes and results, either positive or negative will occur?
- Identify all Lean initiatives and their expected outcomes.
- Include incremental performance metrics.

NCQAC is currently required to meet performance measures established in coordination with the Health Systems Quality Assurance (HSQA) in the Joint Operating Agreement. NCQAC is also currently expected to meet legislatively mandated seven-day application processing time for all complete nursing applications. This performance measure has resulted in positive outcomes for the nursing community and the public of Washington state; however, adequate staffing in NCQAC is necessary to continue to achieve this performance measure. NCQAC also began processing all application types electronically instead of the previous paper process. This Lean initiative was necessary to enact during the initial stages of the COVID-19 pandemic to remove the handling of paper applications in the office and replace with electronic and remote review of all applications. NCQAC continues to improve upon the Lean initiative.

Other collateral connections

Intergovernmental

Describe in detail any impacts to tribal, regional, county or city governments or any political subdivision of the state. Provide anticipated support or opposition. Impacts to other state agencies must be described in detail.

All communities statewide who benefit from access to nursing care are impacted by this proposal. This includes tribal, urban, and rural communities. Appropriate staffing directly impacts NCQAC's ability meet the purpose defined within RCW 18.79.010 in regulating the competency and quality of professional health care providers under its jurisdiction by establishing, monitoring, and enforcing qualifications for licensing, consistent standards of practice, continuing competency mechanisms, and discipline. Other state agencies who will benefit include Department of Social and Health Services, Labor and Industries, Department of Corrections, and Department of Health.

Stakeholder impacts

Agencies must identify non-governmental stakeholders impacted by this proposal. Provide anticipated support or opposition.

Nurses, hospitals, long term care employers, and associations support this proposal as it supports increased access to nursing care and works to address the nursing shortage in the state.

Legal or administrative mandates

Describe in detail if this proposal is in response to litigation, an audit finding, executive order or task force recommendation.

Appropriate staffing directly impacts NCQAC's ability meet the purpose defined within RCW 18.79.010 in regulating the competency and quality of professional health care providers under its jurisdiction by establishing, monitoring, and enforcing qualifications for licensing, consistent standards of practice, continuing competency mechanisms, and discipline.

Changes from current law

Except for appropriations acts, describe in detail any necessary changes to existing statutes, rules, or contracts. Where changes in statute are required, cabinet agencies must provide agency request legislation as an attachment to this DP *and* submit the request through BATS.

N/A

State workforce impacts

Describe in detail all impacts to existing collective bargaining agreements or statewide compensation and benefits policy.

The WMS 2 position is non-represented.

The nursing consultant public health position is a member of the SEIU/1199 union. All other proposed positions are members of the Washington Federations of State Employees union.

State facilities impacts

Describe in detail all impacts to facilities and workplace needs (See Chapter 9 - Leases and Maintenance). Describe in detail all impacts to capital budget requests.

There will be limited impact on facilities and workplace needs with this proposal since NCQAC staff is able to work remotely. New staff can receive remote training and telework.

Puget Sound recovery

If this request is related to Puget Sound recovery efforts, see Chapter 13 of the budget instructions for additional instructions.

N/A

Other supporting materials

Attach or reference any other supporting materials or information that will help analysts, policymakers and the public understand and prioritize your request.

Information technology (IT)

Does this DP include funding for any IT-related costs including hardware, software (to include cloud-based services), contracts or staff? If the answer is yes, you will be prompted to attach a complete IT addendum. (See Chapter 10 of the budget instructions for additional requirements.)

Does this DP include funding for any IT-related costs, including hardware, software (including cloud-based services), contracts, or ITS staff?

☒ No

☐ Yes

If yes is selected, please download the IT-Addendum Form, and follow the directions on the bottom of the addendum to meet requirements for the OCIO review. After completing the IT addendum, please upload the document to continue.

SB 5183 Executive summary Excerpt

In 2021, the Legislature passed Second Substitute Senate Bill 5183, which concerned forensic nurse examiners (FNE) and the medical response to nonfatal strangulation assault. A report conducted in 2019 revealed that nine counties in Washington have no hospitals that provide FNE services.

The Department of Commerce (Commerce) & Office of Crime Victims Advocacy (OCVA) worked to develop strategies to make FNE training available to nurses in all state regions. Below are the findings from the workgroup meetings.

Key Findings

Barriers preventing access to FNE training:

- Having to use vacation time to attend training
- Health care facilities' costs to excuse nurses for training
- Total out-of-pocket cost (including program fees, travel, lodging, childcare, and lost wages) *
- Insufficient opportunities for mentorship, which are particularly impactful for nurses in smaller or rural health care facilities
- Incompatible times/locations for currently available training
- Increasing Access to FNE Training

*Harborview Trauma Center observed that attendance is more substantial when offering FNE training for free. Regional training is offered but still not enough locally available training.

Recommendations

1. Establish comprehensive, long-term, sustainable funding to make training available statewide. Consensus on whether health care facilities or state funding will cover the cost of a high-quality supportive program is a discussion. Regardless, coverage should include:
   - Nurses' training costs (registration fees, travel costs).

2. Cover health care facilities' costs to excuse nurses for training (overtime costs for staff needed to back-fill)
   - Training programs' costs to develop and deliver training.

3. Develop a telenursing program to provide mentorship and continuing education to trained forensic nurse practitioners statewide.

4. Create a forensic nursing coordination center at a state agency that could implement and administer the recommendations in this report.

5. Form a forensic nursing workgroup for one year that would have responsibilities including, but not limited to:
   - Make recommendations on the content, implementation, and requirements for minimum standards of care for onsite emergency assault services at Washington state health care facilities.

6. Make recommendations on the content, implementation, and requirements for Washington state health care facilities' minimum standards of care for facilities that do not provide emergency assault services.
   - Develop statewide standard FNE protocols, forms, and evidence collection procedures.
   - Develop statewide standard FNE training curriculum requirements.

7. Collaborate with Washington FNE training programs to develop innovative training opportunities and ensure that adequate FNE training is available at a variety of times during the year in all regions of the state.

8. Make recommendations for designing and implementing the statewide telenursing program described above.

9. Make recommendations on strategies to ensure access to timely forensic medical exams, especially in smaller health care facilities or those in rural areas.

10. Require Washington state health care facilities' minimum standards of care for forensic medical exams for:
    - Health care facilities providing emergency assault services onsite.
    - Health care facilities that do not provide emergency assault services.

Cost estimates are removed from the report.

WHPS Monthly Report - October 2022

Stage

	New Intake		Current Monitoring	
License Type	2021	2022	2021	2022
ARNP			18	19
RN/LPN	7	7	262	222
NT				
Total	7	7	280	241

Referral Type - Monitoring (In-State)

	APUC		Order		Pending		RC		STID		Voluntary	
License Type	2021	2022	2021	2022	2021	2022	2021	2022	2021	2022	2021	2022
ARNP	2	2	1	1	1		7	8			4	5
RN/LPN	12	9	49	53	25	1	97	90	26	26	29	24
NT												
Total	14	11	50	54	26	1	104	98	26	26	33	29
Total Monitoring	253	219										

Referral Type - Monitoring (Out-of-State)

	APUC		Order		Pending		RC		STID		Voluntary	
License Type	2021	2022	2021	2022	2021	2022	2021	2022	2021	2022	2021	2022
ARNP	1	1		2							1	1
RN/LPN		6	6	8	3		9		7	4		
NT												
Total	1	7	6	10	3	0	9	0	7	4	1	1
Total Monitoring	27	22										

Discharge Type

	Not Appropriate		Offered/ Refused		Referred Back to NCQAC		Pending Discipline		Voluntary Withdrawal		Successful Completion		Deceased		Medically Discharged	
License Type	2021	2022	2021	2022	2021	2022	2021	2022	2021	2022	2021	2022	2021	2022	2021	2022
ARNP												1				
RN/LPN			1	1	1	1			2	1	10	4		1		
NT																
Total	0	0	1	1	1	1	0	0	2	1	10	5	0	1	0	0
Total Discharge	14	9														

Performance Measures

		2021	2022
Case Manager Caseload (Intake & Monitoring)	Melissa Fraser	101	52
	Heidi Collins	97	46
	Lori Linenberger	98	48
	Shelley Mezek	N/A	51
	Alicia Payne	N/A	52
Average from Inquiry to Intake - Target 7 Days		5	1
Average from Intake to Monitoring - Target 45 Days		22	61

Employment Measures (In-State)

	2021		2022	
License Type	Employed	Unemployed	Employed	Unemployed
ARNP	10	5	14	2
RN/LPN	180	58	156	47
NT				
Total	190	63	170	49
Percentage - Target 72%	75%	25%	78%	22%
Grand Total	253		219	

PERFORMANCE AUDIT

Report Highlights

Office of the Washington State Auditor
Pat McCarthy

Prescription Monitoring Program: Evaluating system processes and program oversight

When prescription medications are misused or overprescribed, they can contribute to dangerous drug interactions, substance use disorder, overdoses and deaths. Prescription monitoring program (PMP) databases offer medical professionals a tool to help them reduce overprescribing of opioids and other controlled substances. By accessing their state's PMP system, medical professionals can review medications their patients received in the past before prescribing or dispensing new or additional medicines.

Washington's PMP began operating in 2011 and is administered by the Department of Health (DOH). State law requires pharmacies to submit to the PMP system all Schedule II-V controlled-substance prescriptions that have been given to a patient. In addition, most medical professionals must check the PMP before prescribing controlled substances. The Washington State Hospital Association and the Washington State Medical Association jointly oversee the Better Prescribing, Better Treatment Collaborative, which uses PMP system data from DOH to create opioid prescribing reports. The Collaborative distributes these reports to educate medical professionals about their prescribing practices and how they compare to their peers.

DOH needs a more comprehensive process to ensure PMP data is sufficiently complete and timely to meet the needs of prescribers who are making decisions about patient care

To ensure medical professionals have complete information when prescribing, it is important to monitor whether pharmacies have promptly submitted prescription records. DOH does not monitor PMP data to see if pharmacies submit prescription records within one day of distributing a prescription. Until recently, DOH did not contact pharmacies that failed to correct records with errors that the PMP system automatically blocked from uploading. And because DOH does not ensure that pharmacies correct records with errors, prescribers may not have access to complete PMP data. In addition, DOH lacks a process to determine whether pharmacies have submitted all required prescriptions to the PMP system. Overall, DOH has not prioritized monitoring pharmacy compliance with PMP reporting rules.

Improving and expanding opioid prescribing reports to more medical professionals could help provide better patient care

Opioid prescribing reports help some of Washington's medical professionals understand their own prescribing activity and how it compares to their peers. Since 2019, the Collaborative has used PMP data to send opioid prescribing reports to medical professionals. Further enhancements to the reports could increase their usefulness to prescribers. Expanding the prescribing reports to other health care professions would require engagement with their associations and additional resources. As the lead state health agency, DOH can bring together stakeholders to help the Better Prescribing, Better Treatment Collaborative improve the reports and expand their reach.

State law does not allow DOH to share PMP identifiable data for the purpose of independent oversight of the program

State law restricts access to PMP data to protect patients, prescribers and pharmacies. The restrictions curtail independent oversight that might identify opportunities for improvement. Auditors in other states used PMP data to identify prescribing and dispensing patterns of concern, which we could not replicate due to the data restrictions. In addition, our ability to examine certain system processes was limited. These restrictions in state law inhibited our ability to complete this planned audit work. Furthermore, neither DOH nor the regulatory licensing boards and commissions analyze PMP data in search of those concerning patterns.

State Auditor's Conclusions

More than 9,000 Washington residents have died from opioid prescription drug overdoses over the last two decades, according to Department of Health data. Many more have had their lives affected by opioid-use disorders. In 2020, more than a quarter of opioid-related deaths in Washington involved commonly prescribed opioids, according to the Addictions, Drug and Alcohol Institute at the University of Washington. The Department of Health's Prescription Monitoring Program began operating more than 10 years ago to improve patient care, reduce the abuse of controlled substances and help medical professionals reduce overprescribing. Through this independent, in-depth performance audit, our Office has identified detailed steps that will help the relatively small program – it currently has a staff of seven – improve the effectiveness of this system.

Checks to ensure compliance with the program should be improved, such as confirming available prescription information is complete and checking the appropriateness of waivers granted to non-participating pharmacies. Importantly, select independent oversight agencies should be allowed to access prescription data. One goal of this audit was to identify problematic prescribing and dispensing patterns, but we could not perform that analysis due to legal restrictions on program data. State and legislative auditors in other states, such as Colorado, Louisiana and Oregon, have used their access to this type of data to identify instances of doctor and pharmacy shopping by patients, severe cases of overprescribing by health care providers, and prescriptions involving dangerous drug combinations. That level of accountability is needed in Washington, to help prevent drug misuse, overdose and tragedy.

Recommendations

We recommended DOH perform additional compliance activities and update its administrative rules in the WAC to help ensure pharmacies submit all required prescriptions records in a timely manner. We recommended DOH participate in a workgroup with the Better Prescribing, Better Treatment Collaborative to help improve and expand opioid prescribing reports to more medical professionals. We also recommended the Pharmacy Commission make some additions to pharmacy inspection processes that will help ensure completeness of PMP data. Finally, we made a recommendation to the Legislature to amend state law so that independent auditors can have the authority to access identifiable PMP data.

PERFORMANCE AUDIT

Office of the Washington State Auditor
Pat McCarthy

Prescription Monitoring Program: Evaluating system processes and program oversight

October 7, 2022

Report Number: 1031260

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Executive Summary

State Auditor's Conclusion (page 36)

More than 9,000 Washington residents have died from opioid prescription drug overdoses over the last two decades, according to Department of Health data. Many more have had their lives affected by opioid-use disorders. In 2020, more than a quarter of opioid-related deaths in Washington involved commonly prescribed opioids, according to the Addictions, Drug and Alcohol Institute at the University of Washington. The Department of Health's Prescription Monitoring Program began operating more than 10 years ago to improve patient care, reduce the abuse of controlled substances and help medical professionals reduce overprescribing. Through this independent, in-depth performance audit, our Office has identified detailed steps that will help the relatively small program – it currently has a staff of seven – improve the effectiveness of this system.

Checks to ensure compliance with the program should be improved, such as confirming available prescription information is complete and checking the appropriateness of waivers granted to non-participating pharmacies. Importantly, select independent oversight agencies should be allowed to access prescription data. One goal of this audit was to identify problematic prescribing and dispensing patterns, but we could not perform that analysis due to legal restrictions on program data. State and legislative auditors in other states, such as Colorado, Louisiana and Oregon, have used their access to this type of data to identify instances of doctor and pharmacy shopping by patients, severe cases of overprescribing by health care providers, and prescriptions involving dangerous drug combinations. That level of accountability is needed in Washington, to help prevent drug misuse, overdose and tragedy.

Background (page 6)

When prescription medications are misused or overprescribed, they can contribute to dangerous drug interactions, substance use disorder, overdoses and deaths. Prescription monitoring program (PMP) databases offer medical professionals a tool to help them reduce overprescribing of opioids and other controlled substances. By accessing their state's PMP system, medical professionals can review medications their patients received in the past before prescribing or dispensing new or additional medicines.

Washington's PMP began operating in 2011 and is administered by the Department of Health (DOH). State law requires pharmacies to submit to the PMP system all

Schedule II-V controlled-substance prescriptions that have been given to a patient. In addition, most medical professionals must check the PMP before prescribing controlled substances. The Washington State Hospital Association and the Washington State Medical Association jointly oversee the Better Prescribing, Better Treatment Collaborative, which uses PMP system data from DOH to create opioid prescribing reports. The Collaborative distributes these reports to educate medical professionals about their prescribing practices and how they compare to their peers.

DOH needs a more comprehensive process to ensure PMP data is sufficiently complete and timely to meet the needs of prescribers who are making decisions about patient care (page 15)

To ensure medical professionals have complete information when prescribing, it is important to monitor whether pharmacies have promptly submitted prescription records. DOH does not monitor PMP data to see if pharmacies submit prescription records within one day of distributing a prescription. Until recently, DOH did not contact pharmacies that failed to correct records with errors that the PMP system automatically blocked from uploading. And because DOH does not ensure that pharmacies correct records with errors, prescribers may not have access to complete PMP data. In addition, DOH lacks a process to determine whether pharmacies have submitted all required prescriptions to the PMP system. Overall, DOH has not prioritized monitoring pharmacy compliance with PMP reporting rules.

Improving and expanding opioid prescribing reports to more medical professionals could help provide better patient care (page 25)

Opioid prescribing reports help some of Washington's medical professionals understand their own prescribing activity and how it compares to their peers. Since 2019, the Collaborative has used PMP data to send opioid prescribing reports to medical professionals. Further enhancements to the reports could increase their usefulness to prescribers. Expanding the prescribing reports to other health care professions would require engagement with their associations and additional resources. As the lead state health agency, DOH can bring together stakeholders to help the Better Prescribing, Better Treatment Collaborative improve the reports and expand their reach.

State law does not allow DOH to share PMP identifiable data for the purpose of independent oversight of the program (page 31)

State law restricts access to PMP data to protect patients, prescribers and pharmacies. The restrictions curtail independent oversight that might identify opportunities for improvement. Auditors in other states used PMP data to identify prescribing and dispensing patterns of concern, which we could not replicate due to the data restrictions. In addition, our ability to examine certain system processes was limited. These restrictions in state law inhibited our ability to complete this planned audit work. Furthermore, neither DOH nor the regulatory licensing boards and commissions analyze PMP data in search of those concerning patterns.

Recommendations (page 37)

We recommended the Department of Health perform additional compliance activities and update its administrative rules in the WAC to help ensure pharmacies submit all required prescriptions records in a timely manner. We also recommended DOH participate in a workgroup with the Better Prescribing, Better Treatment Collaborative to help improve and expand opioid prescribing reports to more medical professionals. We also made recommendations to the Pharmacy Commission that it make some additions to pharmacy inspection processes that will help ensure completeness of PMP data. Finally, we made a recommendation to the Legislature to amend state law so that independent auditors, such as the Office of the Washington State Auditor and the Joint Legislative Audit and Review Committee (JLARC), can have the authority to access identifiable PMP data.

Next steps

Our performance audits of state programs and services are reviewed by the Joint Legislative Audit and Review Committee (JLARC) and/or by other legislative committees whose members wish to consider findings and recommendations on specific topics. Representatives of the Office of the State Auditor will review this audit with JLARC's Initiative 900 Subcommittee in Olympia. The public will have the opportunity to comment at this hearing. Please check the JLARC website for the exact date, time, and location (www.leg.wa.gov/JLARC). The Office conducts periodic follow-up evaluations to assess the status of recommendations and may conduct follow-up audits at its discretion. See **Appendix A**, which addresses the I-900 areas covered in the audit. **Appendix B** contains information about our methodology. See the **Bibliography** for a list of references and resources used to develop our understanding of prescription monitoring programs.

Background

The evolving nature of the opioid epidemic continues to be a concern in Washington

The opioid epidemic across the nation has had far-reaching health and social consequences. It affects not only the people who use the drugs, but the lives of those around them. As a class of drugs, opioids include some prescription medicines commonly referred to as painkillers as well as street drugs such as heroin. When prescription drugs are misused or overprescribed, they can contribute to dangerous drug interactions, substance use disorder, overdoses and deaths. And Washington has not been spared the consequences of opioid misuse.

Over the past two decades, Washington experienced this epidemic in three distinct waves. The state's Opioid and Overdose Response Plan for 2021-2022 reported that the rate of overdose deaths involving prescription opioids significantly increased during the first wave, which started in 1999-2000. Then, an increase in deaths related to heroin and synthetic opioids occurred during the second and third waves, which began in 2010 and 2016, respectively. More than 9,000 Washington residents have died from opioid prescription drug overdoses over the last two decades, according to Department of Health (DOH) data.

Prescription medicines are no longer considered the top contributor to opioid-related deaths in Washington. For example, by 2021, the rate of patients prescribed opioids in our state had dropped by 45 percent since its height in 2015, when nearly one in 10 people were prescribed an opioid. Nonetheless, more than a quarter of opioid-related deaths in 2020 involved commonly prescribed opioids, according to the Addictions, Drug and Alcohol Institute at the University of Washington.

As the Centers for Disease Control and Prevention points out, improving the way opioids are prescribed can still help to reduce the number of people who misuse, abuse or overdose from them. Prescription monitoring programs can be used to help ensure patients retain access to safe, effective pain management while reducing opioid over-prescribing.

State-operated prescription monitoring programs offer medical professionals an important tool to help reduce overprescribing of opioids and other controlled substances

Prescription drug monitoring programs use electronic databases that collect information on those prescription drugs pharmacies must report when they dispense them to patients. State laws vary on which specific prescriptions must be reported to the database, but they typically include drugs assigned to schedules II through IV from the federal Controlled Substances Act. The Act assigns drugs to one of five schedules based on its medical use, potential for abuse and risk of dependence. **Exhibit 1** lists some examples in each of the five schedules. Washington's Prescription Monitoring Program (PMP) also includes drugs in Schedule V.

Exhibit 1 – U.S. Schedules I-V for controlled substances, with examples of drugs in each category

Schedule	Description	Examples
Schedule I	No accepted medical use, high potential for abuse	Heroin, LSD, ecstasy
Schedule II	Accepted medical use, high potential for abuse, potentially leading to severe psychological or physical dependence	Codeine, Demerol, Hydrocodone, morphine, OxyContin, Percocet; psychostimulants such as Adderall and Ritalin
Schedule III	Accepted medical use, less potential for abuse than Schedule I or II drugs, with a moderate to low potential for physical and psychological dependence	Anabolic steroids, ketamine, testosterone, Tylenol with codeine
Schedule IV	Accepted medical use, lower potential for abuse than Schedule III drugs and low risk of dependence	Benzodiazepines such as Xanax, Valium and Ativan
Schedule V	Accepted medical use, lower potential for abuse than Schedule IV drugs	Medicines containing small amounts of certain narcotics, including some cough syrups and pain relievers

Source: Auditor created from sources including U.S. Drug Enforcement Administration (https://www.dea.gov/drug-information/drug-scheduling) and United States Government Accountability Office Report, GAO-21-22, October 2020.

PMP databases contain information about the medical professionals who wrote the prescriptions, the drugs prescribed, the number of times refilled, the pharmacy that dispensed them, and the patient concerned. Due to the sensitive nature of the information contained in these databases, state laws restrict who may view this data in order to protect prescriber, pharmacy and patient privacy.

Health care professionals can use this data to help inform their decisions about patient care

PMP databases allow medical professionals, including pharmacists, to review medicines patients previously received before prescribing or dispensing prescriptions for opioids and other controlled substances. The information is particularly important for professionals such as doctors and nurses because patient records usually reflect only the prescriptions written within their office, hospital or medical group. These internal patient records generally do not include prescriptions written by those outside the group, and a patient may not remember to tell the new doctor about all the medicines they take. The PMP system ideally captures all controlled prescription drugs written and dispensed for a particular patient, and can thus guide the prescriber's decisions about what medicines are safe to prescribe. This helps ensure the prescriber does not duplicate controlled substance prescriptions written by someone else or write a new prescription that might cause a dangerous drug interaction if it is combined with opioids.

Federal agencies have supported the development of PMPs across the United States

Since 2003, the U.S. Department of Justice has supported states as they established and improved their PMPs through the Harold Rogers Prescription Drug Monitoring Program Grant Program, administered by the Bureau of Justice Assistance. Since then, federal grants have also been made available through the Centers for Disease Control and Prevention, the Substance Abuse and Mental Health Services Administration, and the Centers for Medicare and Medicaid Services. As of September 2021, the Prescription Drug Monitoring Program Training and Technical Assistance Center reported that there are 54 operational prescription monitoring programs across America and three U.S. territories. This includes 49 states; St. Louis County, Missouri; the District of Columbia; and Guam, the Northern Mariana Islands and Puerto Rico. (See the Bibliography for a link to the report: *PDMP Policies and Capabilities: Results From 2021 State Assessment*.)

Washington's Prescription Monitoring Program, under DOH, gives health care professionals access to essential statewide data

The state Legislature established Washington's Prescription Monitoring Program (PMP) in 2007 under RCW 70.225.020, to improve patient care, reduce the abuse of controlled substances and help medical professionals reduce overprescribing. The PMP's electronic database was to store prescription records for Schedule II-V controlled substances and make that information available to medical professionals

as a patient care tool. It designated the Department of Health (DOH) as the lead state agency to administer and oversee the program. The agency put the PMP data system for the program into full operation in 2011.

Funding for the PMP had been assembled from multiple federal grants; this created uncertainty about the level of services the program could continue to offer over time. Then, during the 2021 legislative session, the program was allocated dedicated funding to ensure it had a sustainable source of funding moving forward.

DOH makes PMP de-identified data available on its website for public health purposes. The agency withholds some information so the data cannot be used to identify individual patients, prescribers or pharmacies. The dataset is also confined to the prescription level. It can be used to identify the total number of prescriptions in the state, the number by type of drug prescribed, and the total quantity prescribed. However, it is not suitable for audit analyses seeking to identify prescribing or dispensing patterns that may suggest areas of concern.

DOH assigns a director and a staff of seven to support the program. This includes a program manager, a compliance officer and two other staff who are dedicated to customer service, day to day operations, compliance and policy work. There are also three epidemiologists that focus on analyzing public health data for DOH's website. One of the seven staff positions was vacant during the audit period.

In the 2019-2021 biennium, the program reported an operational budget of $2.8 million. About $1 million of this funding was paid to Bamboo Health, the third-party vendor that owns and operates the PMP data system, over a three-year period (July 1, 2019 – June 30, 2022). In addition, many other businesses, organizations and agencies play essential roles in multiple PMP processes. They include hospitals, pharmacies and the vendors that develop the pharmacy systems used to track the prescription drugs they give to patients.

Pharmacies must report all sales of Schedule II-V controlled substances in the PMP system promptly

Pharmacies are an integral part of ensuring that prescribers using the PMP database see the most current information available. Pharmacists must be registered to upload data into the PMP system. State law requires that each pharmacy report all Schedule II through V controlled substances in the PMP system as soon as information – listed in **Exhibit 2** – about the prescription is readily available, but no later than one business day from the day of distributing the drug to the patient.

Exhibit 2 – RCW 70.225.020 specifies the data pharmacies must upload to the PMP system "as soon as readily available"

(a) Patient identifier

(b) Drug dispensed

(c) Date of dispensing

(d) Quantity dispensed

(e) Prescriber

(f) Dispenser name

Additional information is required by DOH (WAC 246-470-030)

Source: Revised Code of Washington.

Pharmacies log dispensed drugs in the business's own computer system. Many pharmacies program their systems to automatically upload controlled prescription drug records to the PMP system, but a manual data-entry process is available for those pharmacies that need or prefer it. The PMP system then runs automated checks to ensure all required data is present and valid before accepting or rejecting the prescription record. The PMP system automatically transfers complete records into the database that prescribers use, and sends pharmacies notifications about the status of uploaded records and whether errors prevented any records from transferring to the database.

Organizations regulating health care professionals require prescribers to check the PMP database before prescribing certain medicines

The role of health care professional boards and commissions is to protect public health and to act as the licensing, rulemaking and disciplinary bodies for professionals licensed to practice in the state. They also serve as an educational resource for their members. Investigators from medical boards and commissions may use data from the PMP system when conducting an investigation, which may include examining the medical professional's prescribing practices.

In 2017, the Legislature took another step in the state's efforts to reduce the number of people who become addicted to opioids, involving all boards and commissions overseeing health care professions with prescribing authority (listed in the sidebar). The laws required them to adopt rules establishing requirements around the prescribing of opioids, and to have the rules in place by January 1, 2019. These rules are intended to ensure prescribers check the PMP to get the patient's prescription history before making decisions about patient care.

These rules vary between the different boards and commissions since each is a separate governing body that has oversight authority over particular professions. The Nursing Care Quality Assurance Commission, for example, requires nurse practitioners to check the PMP system at several checkpoints during treatment. These checkpoints include: the first time the nurse practitioner prescribes an opioid for a patient; at the first refill; during transitional periods; pre-operatively; and whenever the patient reports chronic pain. The Medical Commission requires physicians in practices where electronic health records have been integrated with the PMP system to check it when they write any prescription for opioids; those who lack this access must check it upon the first refill.

In addition, all health care professionals wishing to prescribe opioids in Washington are required by rule to register to access the PMP system or demonstrate proof they can access it some other way, such as through their hospital or group practice account.

Washington boards and commissions overseeing health care professions with prescribing authority

Dental Quality Assurance Commission

Medical Commission

Nursing Care Quality Assurance Commission

Board of Osteopathic Medicine and Surgery

Podiatric Medical Board

PMP-driven prescriber reports help medical professionals evaluate their own prescribing practices and how it compares to their peers

Helping health care professionals understand their own opioid prescribing practices is a key tool in promoting safer practices. Data drawn from prescription monitoring programs and distributed in confidential reports can help medical professionals reevaluate their prescribing practices when they see how they compare to their peers in similar fields of health care. Such detailed reports can also alert a prescriber to possibly fraudulent prescriptions issued in their name, by showing that a pharmacy filled a prescription they know they did not write. Such cases might be a simple mistake remedied by a call to the pharmacy, but it may prompt a report to law enforcement.

Many states use prescribing reports to help inform prescribers' behavior

Thirty-six states, including Washington, and the District of Columbia have developed reports to help medical professionals who prescribe opioids understand their prescribing behavior. In Washington, opioid prescribing reports are developed and distributed by a peer quality-improvement program known as the Better Prescribing, Better Treatment Collaborative (referred to as the Collaborative). The Collaborative is composed of representatives from the Washington State Medical Association and Washington State Hospital Association, DOH and the Health Care Authority.

The Collaborative currently sends opioid prescribing reports to health care professionals who meet two criteria:

- Have written at least one prescription for an opioid medication that must be reported to the PMP system in the last quarter
- Work in a hospital or medical group that has signed up to receive the reports

The Hospital Association's subscribers are primarily chief medical officers for hospitals. The Medical Association sends out reports to individual prescribers and medical groups. These reports show considerable detail. For example, one metric shows how often someone has prescribed more than seven days of an opioid medication to an adult patient with acute pain who had not taken any opioids in the prior 105 days. (The seven-day limit on prescriptions is based on a prescribing guideline set by the Health Care Authority's opioid clinical policy.) The report displays how the prescriber's results on this metric compares to others in that

See the Bibliography for links to the websites of the Washington State Medical Association and Washington State Hospital Association, which contain information about the opioid prescribing reports and other work they do on opioid stewardship.

specialty – both at the state level and within their hospital or medical group. After reviewing the report, prescribers can contact the Medical Association to speak with a clinical expert who answers questions about the report, and can suggest alternative prescribing approaches if a prescriber needs advice

After initial challenges in content and distribution, the Collaborative's reports on opioid prescribing are now the primary source of provider peer comparisons

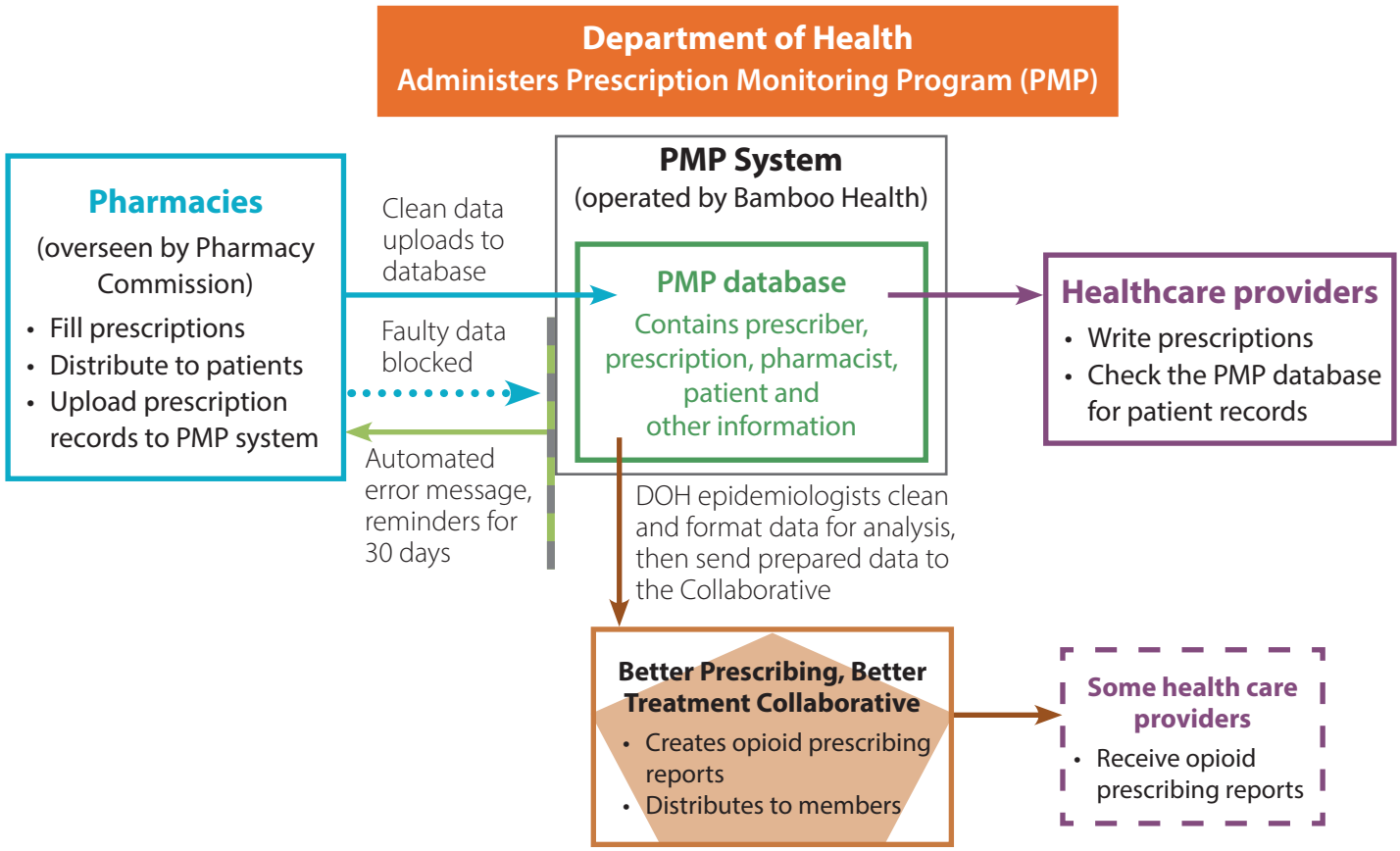
The hospital and medical associations began sending opioid prescribing reports in 2017. At that time, the reports covered Medicaid prescribing only and used Medicaid data supplied by the Health Care Authority rather than PMP data supplied by DOH. In 2019, DOH also began sending opioid prescribing reports using PMP data. Those receiving them were confused by the two overlapping reports. Some prescribers who received reports from DOH did not think the comparisons made were very helpful, or feared regulatory action might be taken because the reports came from a regulatory agency. Within the same year, DOH decided to stop its own efforts around the reporting aspect of prescriber opioid education, as the Collaborative continued to issue its reports.

Since then, DOH's only contribution to the opioid prescribing reports has been to supply prepared PMP data to the Collaborative. For that reason, when we refer to the Collaborative throughout this report, we are speaking about its most active participants: the hospital and medical associations.

Whether prescribing, dispensing or reporting about controlled prescription drugs, all participants in the PMP need system data to be complete, timely and accurate

If prescribers are to make the best decisions when prescribing opioids or other controlled prescription drugs, the data they use in the PMP system must be complete, timely and accurate. The diagram in **Exhibit 3** (on the following page) illustrates some key users of the PMP system and how they interact with the data and each other.

Exhibit 3 – Some key users of the PMP system and its data



Source: Auditor created.

This audit examined how to improve data quality for prescribers and reduce the risk of overprescribing of prescription opioids

We conducted this audit due to the importance of health care professionals having access to prescription data to help inform their decisions about patient care. The audit answered the following questions:

- Is program data sufficiently complete, accurate and timely to meet the needs of prescribers and other users when making decisions about patient care?
- Could the state's PMP system be used to monitor opioid prescribing and dispensing patterns and help reduce opioid abuse and misuse?

The first section of the report (pages 15-24) discusses opportunities for DOH to strengthen its monitoring process to ensure PMP data is sufficiently complete and

timely to meet the needs of prescribers who are making decisions about patient care. The second section (pages 25-30) focuses on how to improve and expand opioid prescribing reports to more medical professionals to help them provide better patient care. The final section (pages 31-35) discusses the limitations to the types of analyses and reviews we could perform in this audit due to legal restrictions around access to certain PMP data.

RCW 70.225.040 limits the situations in which individuals or organizations are allowed to access PMP data. RCW 70.225.040(3) specifies who the department may provide PMP data to. The State Auditor's Office is not included in any of these confidentiality exemptions, which severely limited the types of analyses we could perform in this audit.

Audit Results

The Department of Health (DOH) needs a more comprehensive process to ensure PMP data is sufficiently complete and timely to meet the needs of prescribers who are making decisions about patient care

Results in brief

To ensure medical professionals have complete information when prescribing, it is important to monitor whether pharmacies have promptly submitted prescription records. DOH does not monitor prescription monitoring program (PMP) data to see if pharmacies submit prescription records within one day of distributing a prescription. Until recently, DOH did not contact pharmacies that failed to correct records with errors that the PMP system automatically blocked from uploading. And because DOH does not ensure that pharmacies correct records with errors, prescribers may not have access to complete PMP data. In addition, DOH lacks a process to determine whether pharmacies have submitted all required prescriptions to the PMP system. Overall, DOH has not prioritized monitoring pharmacy compliance with PMP reporting rules.

To ensure providers have complete information when prescribing, it is important to monitor whether pharmacies have promptly submitted prescription records

Three essential requirements for a successful prescription monitoring program call for the data it contains – about the drug, patient, prescriber and pharmacist – to be complete, accurate and available to prescribers in a timely manner. These three elements are tightly interwoven, each contributing information that is useful to prescribers. For example, a pharmacy's data upload that lacks several required prescriptions could mislead a prescriber into ordering medicine for a patient who is already taking that drug. Similarly, an incomplete record, regarded by the PMP system as an error and not transferred to the database, may not be corrected and resubmitted promptly by the pharmacy, which denies the prescriber

a complete view of the patient's medicines. The Prescription Drug Monitoring Program Training and Technical Assistance Center, at the nonprofit Institute for Intergovernmental Research, offers PMP administrators guidance on best practices they should use to help ensure their PMP data meets those requirements.

The audit identified three main issues with DOH's current process for monitoring whether pharmacies are complying with PMP reporting rules and reasons why those issues are occurring. Specifically, we found:

- DOH does not monitor whether pharmacies promptly submit prescription records
- DOH does not ensure that pharmacies correct submission errors
- DOH lacks a process to determine if pharmacies have submitted all required prescriptions to the PMP system

DOH does not monitor PMP data to see if pharmacies submit prescription records within one day of distributing a prescription

As the administrator of the PMP, DOH is responsible for monitoring whether pharmacies submit prescription information to the PMP system. RCW 70.225.020(3)(b) states: "…each dispenser must submit the information as soon as readily available, but no later than one business day from the date of distributing..." The Prescription Drug Monitoring Program Training and Technical Assistance Center suggests PMP administrators crosscheck the date prescriptions were filled against the date they were uploaded to the PMP system to see which pharmacies submitted information outside of the statutory timeframe.

DOH does not currently assess whether pharmacies have uploaded their data to the PMP within one day of distributing. Instead, starting in January 2022, DOH initiated a process to check for pharmacies that have not submitted any prescription records to the PMP on a given day. The agency performs this review a couple of times a month. DOH then contacts some of the pharmacies that have not submitted data for the highest number of consecutive days, alerting them to the gap in reporting dates and helping them resolve the issue.

Although this strategy can prompt some delinquent pharmacies into regular reporting, it does not allow DOH to see if the prescriptions themselves are late. Nor does it allow DOH to identify trends, such as pharmacies that miss multiple, non-consecutive days of reporting. As a result of using this analytical method, DOH cannot identify which pharmacies most often take more than one business day to upload data on the prescriptions they have sold.

DOH has yet to address conflicting interpretations of submission requirements and consequent data inconsistencies

DOH has been hesitant to conduct an analysis on the timeliness of prescription record submissions to the PMP because DOH officials said pharmacies were inconsistent in how they fill in the date fields needed for the analysis. The pharmacies inconsistent use of these fields is likely due to conflicting interpretations about how to comply with data submission requirements. There are two issues that lead to conflicting interpretations.

- **First, agency rules do not align with state law.** Statute currently requires pharmacies to submit records within one business day of "distributing" a prescription. DOH administrative rules do not clearly reflect this: instead, WAC 246-470-030(3) requires records to be submitted within one day of "dispensing." DOH officials said pharmacists might interpret "dispensing" as either when filled behind the counter or when sold to the patient, and this may impact how they complete the "date filled" for the prescription record. Regardless of their interpretation of the term "dispense," the WAC and RCW should align.
- **Second, prescription records do not require pharmacies to fill in both the "date filled" and the "date sold" field.** Currently, the PMP database software only requires pharmacies to enter the "date filled" when they upload a record. Ideally, a pharmacy should also fill in the "date sold" field to record the date the drug was actually given to the patient. Our analysis of PMP data found 28 percent of records did not include data in the "date sold" field. This leaves DOH uncertain about if and when the prescription was actually given to the customer.

Amending its rules to align with state law, and clarifying the conditions in which pharmacies should enter "date sold" data, would make it easier for DOH to interpret the fields when conducting a timeliness analysis. Additionally, DOH could work with its vendor to make the "date sold" field in the PMP system situationally required, so that a pharmacy would be required to complete it once the drug was distributed to the patient.

A quarter of prescription records were not submitted within one day of distributing as required

To assess the timeliness of records submitted to the PMP, we conducted an analysis to determine whether pharmacies uploaded prescription records to the PMP system in the required timeframe. After analyzing PMP system data for March 13, 2022, to April 13, 2022, we found about 25 percent of prescription records had been uploaded late. About 4 percent of the records were late by three or more days, which represents about 27,000 records that were not available to prescribers during

that time. We could not determine whether any specific pharmacies had persistent issues with timely reporting due to PMP data restrictions, as discussed on page 34. For additional detail about our methodology, see Appendix B.

DOH also does not systematically identify significant variations in the number of records pharmacies submit to the PMP system over time. For example, a pharmacy that goes from uploading a large number of records every day to reporting a small number could indicate the pharmacy is not submitting all its prescriptions – either for one day or over a longer period. Such an issue would not necessarily be treated as a compliance problem, because a change in a pharmacy's operations might produce changes in its submission volume. Nonetheless, the change might indicate broader problems that can be corrected. DOH can follow up and help the pharmacy if technical assistance is needed or identify the cause of fewer submissions if it is aware of the changed submissions pattern. The practice of identifying submission variations over time is recommended by the Prescription Drug Monitoring Program Training and Technical Assistance Center. Furthermore, ensuring that information about medications is available to prescribers as soon as possible after the pharmacy has filled the prescription is critical to helping health care professionals make the best decisions about patient care.

Because DOH does not ensure that pharmacies correct records with errors, prescribers may not have access to complete PMP data

After pharmacies upload prescription data to the PMP system – but before that data is transferred to the actual PMP database – the system performs automated checks to identify missing, invalid or incorrectly formatted data. The PMP system automatically blocks problematic records from uploading to the database and notifies the pharmacy that uploaded the information of the errors. Pharmacies then receive an email notification every day, for up to 30 days, until they correct those errors.

We tested these automated system checks and notifications, as well as other system controls described in Appendix B, and found that they worked as intended. These processes alone cannot guard the system from all inaccurate data, but they do help to improve the quality of data prescribers see when they turn to the PMP system for their patients' prescription histories.

Until recently, DOH did not contact pharmacies that failed to correct records with errors, and still lacks a documented process to periodically review errors

In the past, DOH did not monitor PMP data to ensure pharmacies were correcting records rejected by the system due to errors. However, in April 2022, DOH reported staff had begun to identify and contact the pharmacies with the greatest number of uncorrected errors; this is recommended as a leading practice by the Prescription Drug Monitoring Program Training and Technical Assistance Center. The Center also suggests PMP administrators identify the most commonly made types of errors in order to help pharmacies make those errors less often, which DOH does not do. Nor did DOH have established policies and written procedures during our audit period to help ensure this monitoring work continues even if it hires new staff to conduct reviews. However, an official from DOH reported that they have started to develop a protocol for this review.

We analyzed PMP data on prescription records that did not upload to the PMP database due to outstanding errors. We identified approximately 12,000 uncorrected records out of an estimated 12 million uploaded to the PMP system in the past year. This is about 0.1 percent of records submitted in a year.

Our analysis found around half of pharmacies with an uncorrected error had fewer than five prescription records that were not added to the PMP database for this reason. Additionally, roughly half of records with uncorrected errors came from just eight pharmacies. As an example, one pharmacy had about 2,800 records with uncorrected errors in December 2021 but only six in the entire rest of the year. An established process to monitor errors periodically would have detected this anomaly, and possibly given PMP administrators information they could use to help other pharmacies make similar errors less often.

DOH officials said monitoring PMP data for uncorrected errors is a relatively low-priority activity because only a very small percentage of records uploaded to the PMP system are rejected for errors. However, given that most errors came from a small number of pharmacies, reaching out to just the handful of pharmacies with the most errors would lead to the correction of thousands of errors, with that many more records available to prescribers within the PMP system.

Because pharmacies are not required to correct errors in a timely manner, some errors are never corrected

Pharmacies are responsible for correcting errors; however, neither the statute (RCW 70.225.020) nor the administrative rules (WAC 246-470-030) governing the PMP submission have clearly established a requirement to do so in a certain amount of time. Furthermore, for egregious cases, the state lacks a way to hold a pharmacy accountable for repeatedly failing to correct errors.

The Prescription Drug Monitoring Program Training and Technical Assistance Center advises PMP administrators to notify the appropriate state authority if a pharmacy fails to correct errors within the specified timeframe.

The automatic notifications the PMP system sends to pharmacies regarding data submissions with errors cease after 30 days. From that point, pharmacies receive no further reminders to correct the data from either the automated system or from DOH. Unless the pharmacy discovers the problem through its own internal reconciliation processes later in the year and corrects it, the error is likely to remain uncorrected and absent from the PMP database.

DOH lacks a process to determine whether pharmacies have submitted all required prescriptions to the PMP system

DOH cannot determine whether pharmacies have uploaded all required prescriptions without the help of the Pharmacy Commission

In order to identify prescription records that are missing from the PMP database, DOH or the Pharmacy Commission would need to compare a pharmacy's own files against the records it has uploaded to the PMP system. DOH cannot do this on its own because it cannot access pharmacies' files, and so cannot verify what drugs a pharmacy has actually dispensed. Although the Pharmacy Commission can access pharmacy files during its routine inspections of pharmacies, the Commission does not perform any checks concerning what data pharmacies have or have not uploaded to the PMP system.

Pharmacies can compare the total number of controlled prescription drugs they have sold against the number they have uploaded to the PMP system, but DOH does not require them to reconcile these numbers. The Federal Information System Controls and Audit Manual recognizes the need to reconcile data between the source and target application to ensure that the data transfer is complete and accurate, and recommends such reconciliations as a best practice.

A Pharmacy Commission official said it is unlikely pharmacies would dispense drugs without that information being submitted to the PMP, noting that most pharmacy systems are automated. This means the software is programmed to automatically upload files with prescription data without hands-on involvement from pharmacists, which reduces the likelihood of human error or data manipulation.

Because neither DOH nor the Commission has established requirements for pharmacies to perform an independent review and reconciliation, the state lacks an assurance pharmacies submit all the records they should. Furthermore, failed uploads due to technical problems – such as server connectivity issues, computer crashes, power outages or problems with vendor software – can go undetected. This means prescribers may lack prescription records they need to inform their decisions about patient care.

DOH grants waivers to pharmacies that do not dispense controlled substances, but no one performs checks to ensure the waivers are warranted

Pharmacies can request an annual waiver from reporting prescription information to the PMP if they do not dispense any scheduled drugs Washington requires they report. As part of the request, the pharmacy must attest that it qualifies for the waiver and that, if it starts dispensing controlled prescription drugs, it will cancel the waiver. Agency officials said that roughly two-thirds of in-state pharmacies with waivers are hospitals with internal policies that allow them to dispense no more than one day's supply of medicines to an outpatient. As of June 2022, 18 percent of the more than 2,300 pharmacies licensed to practice in Washington held reporting waivers issued by DOH.

We interviewed PMP administrators in these states

- Colorado
- Connecticut
- Iowa
- Kentucky
- Maryland
- Massachusetts
- Minnesota
- New Jersey
- Oregon
- Wisconsin

See Appendix B for more information.

DOH does not validate a pharmacy's reason for requesting a waiver before excusing it from reporting prescription information to the PMP system. When a pharmacy applies for or renews its annual waiver, DOH approves the request without seeking any additional information to verify that the pharmacy does not dispense controlled prescription drugs. We spoke with PMP administrators in 10 other states (listed in the sidebar), and eight said they issue waivers. Of the eight, three conduct checks to see if the pharmacy requesting a waiver has reported any controlled substances to their PMP systems. If it has, administrators said they either rescind the waiver or contact the pharmacy to determine if it should actually have an exemption from reporting.

Once DOH grants a waiver, the system will identify the pharmacy as exempt from reporting to the PMP until the annual waiver expires. Once marked as exempt in the PMP system, a pharmacy with a waiver could dispense prescriptions for controlled prescription drugs without reporting them, which could lead to records missing from the PMP. Even if DOH checked the PMP system for prescriptions a pharmacy sold in the past before approving a waiver request, the agency could not detect the more concerning cases: those pharmacies with waivers that should legally report prescriptions to the PMP but do not.

The Pharmacy Commission is not involved with the PMP waiver process. The Commission has not performed checks to see if any pharmacies dispensing controlled drugs had received a waiver from DOH. The Commission said that if DOH supplied a list of pharmacies with waivers, then its pharmacy inspectors

could perform such checks during their regular inspections and inform DOH of their findings, so DOH could determine if it needs to cancel waivers for pharmacies that should not have them.

The Prescription Drug Monitoring Program Training and Technical Assistance Center notes that validating a pharmacy's reasons to obtain a waiver from reporting is a leading practice. Furthermore, it states the pharmacy's reasons should be independently confirmed by the agencies with authority to perform inspections at the pharmacy's location or by PMP staff. This should occur before the waiver is issued and at least once during each waiver period.

DOH has not prioritized monitoring pharmacy compliance with PMP reporting rules

DOH has not prioritized the compliance activities that would help ensure pharmacies submit all required prescription records. Agency officials pointed to three areas that they said limited their ability to assign this work a higher priority.

- Limitations in current levels of staffing
- Limitations in PMP system analysis tools
- The agency's lack of authority to enforce compliance with reporting rules

Staffing limitations. DOH said that a primary reason the agency does not conduct more PMP compliance activities is the additional staff time it would require to do the work. The PMP team at DOH currently has seven employees, which includes a supervisor and three epidemiologists who analyze public health data for DOH's website. The team's compliance officer is responsible for activities related to ensuring pharmacies submit controlled substances information to the PMP system, and has other duties in addition to compliance duties. DOH also said that addressing some items – such as dealing with the small proportion of PMP records with uncorrected errors – was not an effective use of staff time given other priorities competing for the compliance officer's time.

Other DOH employees cannot easily step in to perform these activities because DOH lacks written procedures for any of its compliance work pertaining to the PMP. Compliance efforts would effectively halt if the compliance officer were to go on extended leave or abruptly leave the position.

Limitations in analysis tools to monitor compliance. DOH said that the PMP system lacks the analysis tools to easily monitor compliance. Agency officials said they have been working with the vendor, Bamboo Health, to implement three changes to the PMP system. They anticipate the changes may help improve some of the compliance issues we identified on pages 16-22.

- *Automatically invalidating waivers.* This update to the PMP system would reconfigure the system so it invalidates a pharmacy's waiver from reporting if that pharmacy uploads prescription information to the PMP. This update was a long-standing request, and DOH expects this enhancement will be functional in 2023.
- *Improved error correction tool.* DOH has been using a software tool to identify pharmacies that have not corrected errors in the records they submitted to the PMP, but says the tool is not user friendly, especially for copying and exporting data. DOH is working with the vendor to improve the tool.
- *Improved tool to track submission timeliness.* The dashboard tool the compliance officer currently uses to see if pharmacies are uploading prescription information to the PMP system provides only limited information, such as how many pharmacies were delinquent two days in the past. DOH acknowledged this inadequate dashboard limits staff's ability to conduct certain types of analysis. DOH expects the vendor to release a new dashboard in summer 2022.

  Previously, DOH had access to a different tool – a Tableau-based feature supplied by Bamboo Health – that provided a more comprehensive picture of pharmacy compliance. This tool stopped working in the middle of 2020. DOH officials said they have been working with Bamboo Health to fix the tool, but issues remain, and so the agency must rely instead on the dashboard for tracking compliance. If the Tableau tool were to begin reliably working again, DOH said it might make it easier for them to complete the compliance work, making staff capacity less of an issue.

  Using the old tool, DOH could see data for each licensed pharmacy in the state for the previous 30 days, including:

  - Number of days a file was uploaded to the PMP system
  - Number of days without a file uploaded to the system
  - Number of records with errors
  - Error rate
  - Total records uploaded

Lack of authority to enforce compliance. DOH is responsible for ensuring that pharmacies submit prescription information as state law requires. While DOH can conduct certain monitoring activities, the department does not have the authority to enforce pharmacy compliance. If DOH finds a pharmacy has not complied with PMP rules, it can refer the case to the Pharmacy Commission. The Commission, as the pharmacy regulatory body, has the authority to enforce regulations through sanctions on pharmacies. However, a representative from the Commission said its only options are to deny, suspend or revoke a pharmacy's license: it lacks any options for less extreme enforcement actions such as a fine. DOH officials said they have not referred any cases to the Pharmacy Commission in recent years.

Given the limits of DOH's authority, the agency must work closely with the Pharmacy Commission to ensure pharmacies are following the law and submitting prescription information to the PMP as required. However, the Pharmacy Commission has expressed concerns about its own limited staffing and authority to help with the tasks we suggest on pages 20-22. It has said it would need additional resources to carry out this work.

Improving and expanding opioid prescribing reports to more medical professionals could help provide better patient care

Results in brief

Opioid prescribing reports help some of Washington's medical professionals understand their own prescribing activity and how it compares to their peers. Since 2019, the Washington State Hospital Association and Washington State Medical Association, which jointly oversee the Better Prescribing, Better Treatment Collaborative, have used PMP data to send opioid prescribing reports to medical professionals. Further enhancements to the reports could increase their usefulness to prescribers. Expanding the prescribing reports to other health care professions would require engagement with their associations and additional resources. As the lead state health agency, DOH can bring together stakeholders to help the Better Prescribing, Better Treatment Collaborative improve the reports and expand their reach.

Opioid prescribing reports help some of Washington's medical professionals understand their own prescribing activity and how it compares to their peers

Since 2019, the Washington State Hospital Association and Washington State Medical Association, which jointly oversee the Better Prescribing, Better Treatment Collaborative, have used PMP data to send opioid prescribing reports to medical professionals. Since then, the prescribing reports have been distributed through an opt-in program: prescribers are enrolled when their hospital or medical group's chief medical officer signs them up. The associations said they have enrolled every hospital in the state, but they have not yet enrolled some of the smaller, independent clinics and medical groups that are not affiliated with those hospitals. The program began allowing prescribers to enroll on an individual basis in January 2022, but none have done so yet. Once enrolled, prescribers receive a tailored report that shows how their prescribing compares against others in their same specialty – both at the state level and within their hospital or medical group.

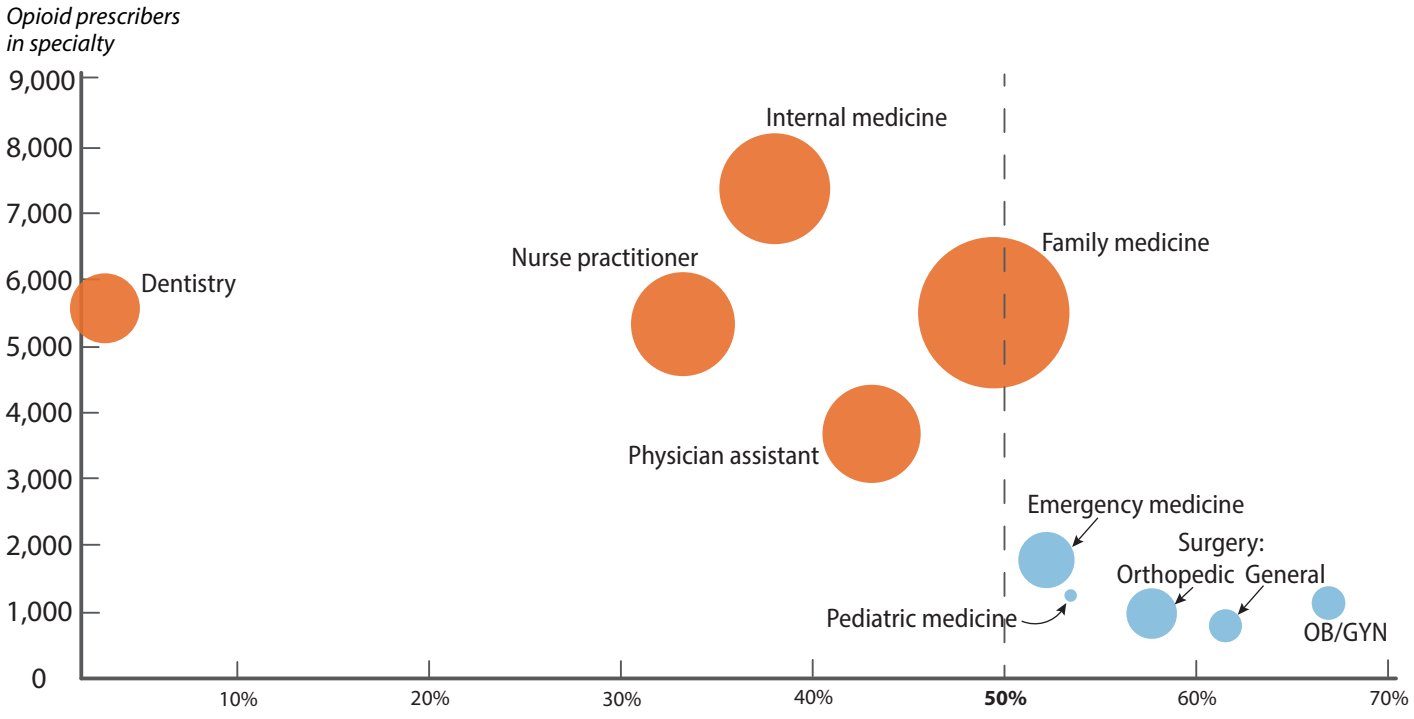
About 39 percent of all opioid prescribers receive these reports and participation varies by profession

The Hospital Association provided a table summarizing the number of opioid prescribers who receive these reports, covering a three-and-a-half-year period. We found that of the state's approximately 40,500 opioid prescribers, around 15,800 (39 percent) received these reports. This accounted for about 51 percent of opioid prescriptions written in the state.

Participation varies widely by profession. For example, 67 percent of the obstetrics/gynecology professionals who prescribe opioids receive the report, compared to only 1 percent of the opioid prescribers in dentistry. Nurse practitioners prescribe the third-highest number of opioids, yet just 32 percent of these prescribers receive a report. **Exhibit 4** illustrates the top 10 opioid-prescribing professions in the state by specialty and the percent of prescribing professionals who received the reports. (**Appendix C** lists the top 30 professions.)

Exhibit 4 – Fewer than half of the nurse practitioners, dentists and internal medicine doctors who prescribe opioids received opioid prescribing reports

Bubble size indicates the number of opioid prescriptions written between January 2018 and September 2021. Orange indicates more than 1 million prescriptions.



Note: Percentages calculated based on unaudited data provided by the Washington State Hospital Association.

Source: Washington State Hospital Association.

Professionals unaffiliated with a hospital or medical group do not receive these reports

The primary reason prescribers do not receive opioid prescribing reports is that they are unaffiliated with a hospital or medical group that signed up to receive the reports. Individual prescribers can now sign up to receive reports, but may not be aware that they can do so. Additionally, some very high prescribers do not receive reports because the Collaborative does not send reports to those who only treat chronic pain.

Further enhancements to the reports could increase their usefulness to prescribers

We identified opportunities for the Collaborative to make their reports more useful to more prescribers. We interviewed representatives from the hospital, medical and other associations for their perspectives on the opioid prescribing reports. (See sidebar for a list of other associations we interviewed.)

Their suggestions to improve the reports coalesced around four areas:

- Improve peer comparisons to make them more meaningful for different professions
- Expand the reports to include data from, and comparisons for, providers treating patients with chronic pain
- Include data on prescribers' co-prescribing practices
- Provide more guidance to medical professionals on best practices related to opioid prescribing

Below, we summarize briefly the results of the conversations in each area.

List of other associations we interviewed

- Advanced Registered Nurse Practitioners United of Washington
- Dental Association
- Podiatric Medical Association
- Optometric Physicians of Washington

Improve peer comparisons to make them more meaningful for different professions

In our interviews with associations that are not involved with the Collaborative, yet represent health care professionals who prescribe opioids, two out of four said that meaningful peer comparisons are critically important. Some expressed concerns that existing peer comparisons in the reports are too broad to be useful to them. For example, most medical doctors receive reports that compare them to peers in their specialty, such as oncology or pediatrics, but advanced registered nurse practitioners are treated as one peer group regardless of the specialty they work in. Representatives of the Collaborative said that they are open to creating smaller specialty peer-comparison groups, but would need more information from the other associations about their members to do so. The Collaborative would need to engage with the newly enrolled associations to ensure the comparison data was meaningful.

Expand the reach of reports to providers treating patients with chronic pain

The Collaborative would like to enhance opioid prescribing reports to provide information that supports professionals caring for patients with chronic pain. The current reports only address prescribers treating acute pain, usually treated with short courses of medicine. Chronic pain patients often take higher dosages of opioids over a longer period of time, which makes prescribing for them more complex. To address this complexity, the Collaborative would want to develop peer comparisons that are clinically relevant. Otherwise, medical professionals who prescribe for chronic pain could easily appear as outliers compared to other groups that only treat acute pain. The Collaborative has estimated reports with information on chronic prescribing could reach roughly 1,000 opioid prescribers in the state.

Include data on prescribers' co-prescribing practices

Patients taking a combination of opioids and psychostimulants or benzodiazepines have much higher rates of lethal drug overdoses than prescription opioids alone. (See the Bibliography for an analysis by DOH on this topic: "Prescription-related Risk Factors for Prescription Opioid Overdose Deaths in Washington State.") Representatives of the Collaborative said they would like to enhance the reports to call these dangerous combinations of drugs to prescribers' attention. For example, a prescriber may inadvertently prescribe opioids to a patient already taking a benzodiazepine because the information was not in the patient's health records and he or she did not check the database before writing the new prescription. Additionally, if a prescriber did not realize the combination was dangerous in the first place, then receiving a report highlighting it could prompt them to ask questions and reevaluate their prescribing practices.

Provide more guidance to medical professionals on best practices related to opioid prescribing

Another way to make opioid prescribing reports more useful to medical professionals is to ensure those who want to adjust their prescribing practices have sufficient information to do so. The Medical Association said it intended to start a coaching program for groups that are interested, but was unable to pursue doing so during the COVID-19 pandemic. The Medical Association has also expressed an interest in identifying those who prescribe the greatest number of opioids and proactively contacting them to provide guidance on best practices related to opioid prescribing. Given Washington does not monitor PMP data for overprescribing (as described in the next section of this report), this effort on the part of the Collaborative could be an important mechanism to improve patient safety by identifying and working with health care professionals whose prescribing activity raised concerns.

Expanding the prescribing reports to other health care professions would require engagement with their associations and additional resources

The hospital and medical associations said they would need additional support and funding in order to expand the distribution of opioid prescribing reports to more prescribers and increase the utility of the reports. Expanding the program in both these ways would require resources that the Collaborative currently lacks. These resources include inter-organizational cooperation, certain specialized knowledge and staff.

The Collaborative has limited interactions with prescribers who are not involved with the hospital and medical associations. Broad though their membership may be, these two associations do not include every health care professional who prescribes opioid medicines. The Collaborative would need to work with organizations like Advanced Registered Nurse Practitioners United and the Washington State Dental Association to promote the opioid prescribing reports to their members. All four associations we spoke with said they would be willing to encourage their members to sign up for the reports, either currently or if the reports were made more useful for their members in the ways described above. Individual prescribers can now sign up to receive the reports, but may not be aware that they can do so; contacting them through their professional associations could raise awareness and prompt them to enroll.

The Collaborative would need input from other medical professional associations to make meaningful peer comparisons in the reports. In addition to reaching their members, other associations would need to supply expertise on how their members prescribe and the types of specializations within their profession. Without this help, the Collaborative would struggle to offer meaningful peer comparisons. Such cooperation would likely require the associations to identify staff or volunteers to work with the Collaborative as it develops new reports. For example, a doctor with the Medical Association volunteers his time to develop meaningful comparisons using specialty information and to respond to prescriber questions about the reports. Adding new professions to the reports would require a person with similar expertise for each field to serve in this role.

The Collaborative has limited capacity to expand and improve the reports. Representatives from the Collaborative said they have limited resources available to expand the reports to more prescribers and to make other improvements that would increase their utility and adoption. The Collaborative is entirely funded and staffed by the hospital and medical associations with no support from the state to produce the reports. Across these two associations, several employees work on the opioid prescribing reports in addition to their other duties. Their work adds up to about .75 FTE at the Medical Association and 1.5 FTE at the Hospital Association, not including volunteer time.

Association representatives said that to begin expanding the reach of the reports to other professions, such as dentistry professionals, the hospital and medical associations would need half a full-time equivalent position at each organization. These staff would be needed to enroll new prescribers, maintain contact and prescriber specialty information, prepare the reports, and answer prescriber questions. Additional staffing may be needed to enhance their reports about chronic and co-prescribing. Representatives from both the hospital and medical associations added that a sustaining budget allocation would be needed to expand the program to cover the additional work.

DOH can bring together stakeholders to help the Collaborative improve the reports and expand their reach

DOH is in a unique position to help the Collaborative expand the reach and scope of opioid prescribing reports. Officially, DOH is already a member of the Better Prescribing, Better Treatment Collaborative, but their role is limited to providing PMP data to the Washington State Hospital Association. As the lead state health agency, DOH could bring together multiple parties in a workgroup to assist the Collaborative. PMP staff also have a deep understanding of the PMP and know about state and federal resources that might help the hospital and medical associations administer the Collaborative. DOH can also provide necessary assistance in reviewing the data-sharing agreement for the coordinated quality improvement program. In doing so, the workgroup partners may determine that a statutory change would be needed to broaden the reach of the reports to other health care providers.

In turn, representatives from the Collaborative expressed interest in partnering further with DOH, with the goal of bringing partner organizations together to promote, expand and improve the prescriber reports. Partner organizations would of course include those other health care professions outside the reach of the current Collaborative, allowing their input on prescriber-report content and distribution.

DOH can take the lead in assembling a consistent working group with current and new stakeholders; the workgroup provides the venue for systematically developing ways to promote the program, obtain stable funding, facilitate connections and share data. A workgroup can move the Collaborative forward in a way that the hospital and medical associations on their own cannot. Without the involvement of DOH and these important stakeholders, the Collaborative would likely find it difficult to establish a clear strategic direction that helps ensure the opioid prescribing reports grow and develop in a manner that most effectively serves prescribers and ultimately patients in Washington.

State law does not allow DOH to share PMP identifiable data for the purpose of independent oversight of the program

Results in brief

State law restricts access to PMP data to protect patients, prescribers and pharmacies. The restrictions curtail the independent program oversight that could identify opportunities for improvement. Auditors in other states used PMP data to identify prescribing and dispensing patterns of concern, which we could not replicate due to the data restrictions. In addition, our ability to examine certain system processes was limited. These restrictions in state law inhibited our ability to complete this planned audit work. Furthermore, neither DOH nor the regulatory licensing boards and commissions analyze PMP data in search of those concerning patterns.

State law restricts access to PMP data to protect patients, prescribers and pharmacies

State law limits access to data in the PMP to protect medically sensitive data which might disclose details about a person's health and the physicians treating them from anyone without a legitimate reason to know. In addition to identifying prescribing health care professionals and pharmacies, PMP data directly identifies the patient and shows exactly what drugs a patient receives and in what quantities. In turn, that can reveal information about a person's medical conditions and private life. Since this data is very sensitive, it is logical that prescription monitoring statutes would put strong guardrails around who may have access to it and why. The statute further protects data in the PMP that can indirectly identify a patient without having the patient's name, which might include their health care team or pharmacy location. Ultimately, these restrictions are in place to protect patients.

The restrictions curtail the independent program oversight that could identify opportunities for improvement

Performance audits use all types of data, some of which is confidential or proprietary, to address the efficiency and effectiveness of government programs with the aim of improving them. These audits typically result in a report that makes

recommendations to the audited agency. Auditors are routinely given access to confidential information so they can conduct audit analyses. Data analyzed during an audit is presented in aggregate to support our findings and recommendations, but is not released to the public.

Current state law (RCW 70.225.040) concerning access to PMP data specifies who DOH can permit to access different types of data in the PMP and for what purposes. The law was written to exclude any agency or organization unless named in the section. It does not name auditors, program oversight, or any other kind of external review of the program, including the State Auditor's Office or the Legislature's Joint Legislative Audit and Review Committee (JLARC). It thus restricts auditors from obtaining information needed for audits like this one.

One provision of the PMP statute does allow access to some data that can be used to conduct audits. RCW 70.225.040(5)(a) allows DOH to release de-identified data for research or educational purposes. "De-identified" means it cannot include any information that could be used to directly or indirectly identify a prescriber, dispenser or patient. We were able to obtain some prescription monitoring data to assess certain aspects of program performance because that data did not include any patient, prescriber or dispenser identifiers. However, we were unable to conduct the other work we had planned because it involved PMP data that would directly or indirectly identify these people and businesses.

Such restrictions on data access consequently limit the type of external oversight that can be conducted with PMP data, including opportunities to identify improvements in the PMP or its system. Because the law is so specific and inhibited our ability to conduct intended reviews (described below), it may likewise affect JLARC's ability to do similar work. This is because JLARC, like our Office, is not listed in the statute as an entity authorized to receive data. It is important to note that the statutory language granting access to records is different for JLARC and our Office, so it is not entirely clear whether JLARC would be prevented from accessing the same information.

These restrictions inhibited our ability to complete planned audit work

Due to legal restrictions preventing us from viewing identifiable data in the PMP database, we could not entirely answer our second audit question: *Could the state's PMP system be used to monitor opioid prescribing and dispensing patterns and help reduce opioid abuse and misuse?* To answer this question, we would have sought patterns in Washington's data that suggested potentially dangerous or illegal prescribing or dispensing was occurring. That is, if there were a nexus of extreme outliers based on people who received prescriptions from many health care providers, the providers who wrote those prescriptions, and the pharmacists who

filled them. We would have provided a summary of the results of this analysis to DOH and the Legislature so they could determine if monitoring PMP data in this way would be an effective approach to improving patient and public safety.

The analysis we planned would not have required patient names, addresses or other personal information that would have directly disclosed a patient's identity. Nor would it have required the names or identification numbers of providers, such as their drug enforcement agency number. Unique identifiers can be substituted for such data to anonymize people's identities. However, our analysis would have required other protected information that was not available to us, such as health care provider and pharmacy addresses.

Additionally, to help inform our analysis and interpretation of the data, we had planned to contract with a clinician familiar with opioid prescribing for acute and chronic pain. Any analysis we performed would have had limitations, as making a full determination as to whether prescribing is inappropriate would likely require a full review of the medical record by a regulatory board or commission.

Auditors in other states used PMP data to identify prescribing and dispensing patterns of concern, which we cannot replicate

Other states do not restrict audit access to prescription monitoring data as Washington does. For example, certain audits conducted in three states – Colorado, Louisiana and Oregon – could not be performed in Washington. These state and legislative audits used prescription monitoring data that identified issues such as:

1. Potential instances of doctor shopping
2. Unusually high quantities of opioids prescribed
3. Dangerous combinations of drugs prescribed

Brief descriptions of how audits helped identify these areas of concern using PMP system data follow.

1. **Doctor and pharmacy shopping.** People seeking to acquire more of a controlled prescription drug than a health care provider would authorize often resort to one of two common tactics. In doctor shopping, patients seek prescriptions from multiple health care providers simultaneously; in pharmacy shopping, patients bounce from pharmacy to pharmacy in hopes of getting multiple prescriptions filled without anyone detecting illicit activity. Prescription monitoring programs help prevent both tactics by giving prescribers a tool that reveals if patients have been obtaining controlled prescription drugs from other prescribers.

   All three state audits conducted independent analyses and identified potential doctor and pharmacy shopping. These audits found patients who had received many prescriptions from many different doctors. (See **Appendix D** for some additional detail on these audit results.)

2. **High quantities of opioids prescribed.** Opioids are dangerous in high quantities, but some chronic pain patients build up a tolerance to opioids that requires they take higher doses than would be prescribed for a typical acute-pain patient. Health care providers who specialize in hospice or palliative care, pain management, oncology or surgery may be justified in prescribing high quantities due to the nature of their patients' condition.

   In Colorado, auditors identified 85 providers who prescribed at least 26 times the number of opioids as the average for all other prescribers but did not practice any of the specialties listed above. Performing an analysis comparable to Colorado's would require access to patient identifiers and prescriber identifiers, which Washington statute prohibits.

3. **Dangerous drug combinations.** There are many medications that should not be mixed with each other, but opioids have some particularly dangerous combinations. Psychostimulants and benzodiazepines may be particularly dangerous when combined with opioids. DOH's own research (see the bibliography for the DOH analysis, "Prescription-related Risk Factors for Prescription Opioid Overdose Deaths in Washington State") suggests that taking either of these categories of drugs with opioids increases the risk of overdose-related death by three to four times. PMP databases allow prescribers to check whether a patient has received these medicines from another prescriber to avoid inadvertently prescribing these drug combinations.

   Audits in Colorado and Oregon conducted independent analyses of PMP data and identified thousands of instances in which health care providers prescribed certain dangerous drug combinations. (See Appendix D for some additional detail on these audit results.)

Data restrictions also limited our ability to examine certain system processes

The same data restrictions also curtailed our analysis of the timeliness of pharmacy submissions, part of our first objective. The data we were allowed to view lacked information identifying the pharmacy, and so we could not determine whether some pharmacies were persistently late in uploading their prescription records. Access to pharmacy identifiers would have enabled us to identify the days that pharmacies were engaging in business activities. This would have allowed a more comprehensive evaluation.

In addition, we could not review the pharmacy table that identifies all dispensers who are required to upload data to the PMP system. DOH officials said they review this table and fill in missing fields, but we could not confirm they do so. This review and correction process is a foundational aspect of the PMP system because the names and contact details in this table feed the system's automated messages including delinquency notices or warnings when prescription records fail to upload.

Neither DOH nor the regulatory licensing boards and commissions analyze PMP data for unusual prescribing and dispensing patterns

Although DOH conducts epidemiological analysis using PMP data, neither DOH nor the state's regulatory licensing boards and commissions analyze PMP data in such a way as to identify patients, prescribers and pharmacists who are acting against the interests of patients and the public.

The PMP program staff at DOH believe that the PMP system should be used only as a repository for data, and that using it as an enforcement tool against prescribers is inappropriate. They fear doing so would lessen prescriber trust in the PMP and be ineffective, as such analyses might flag legitimate prescribing activity. Determining whether a prescriber's decision was appropriate or not would likely require a full review of the medical record by a regulatory board or commission. Moreover, in our conversations with boards and commissions, we were told that they would have to open a formal investigation in order to assess someone's prescribing practices. These officials also said that the PMP data might not have sufficient detail to justify opening a formal investigation because other factors regarding the patient's medical condition are not in the PMP database but only in the patient's record. Additionally, one commission said that they did not have the staff and resources needed to conduct such an analysis and do not believe they have the legal authority to do so. We could not assess whether the detail in the PMP would be sufficient because we were not able to access the data that might confirm or refute these concerns.

State Auditor's Conclusions

More than 9,000 Washington residents have died from opioid prescription drug overdoses over the last two decades, according to Department of Health data. Many more have had their lives affected by opioid-use disorders. In 2020, more than a quarter of opioid-related deaths in Washington involved commonly prescribed opioids, according to the Addictions, Drug and Alcohol Institute at the University of Washington. The Department of Health's Prescription Monitoring Program began operating more than 10 years ago to improve patient care, reduce the abuse of controlled substances and help medical professionals reduce overprescribing. Through this independent, in-depth performance audit, our Office has identified detailed steps that will help the relatively small program – it currently has a staff of seven – improve the effectiveness of this system.

Checks to ensure compliance with the program should be improved, such as confirming available prescription information is complete and checking the appropriateness of waivers granted to non-participating pharmacies. Importantly, select independent oversight agencies should be allowed to access prescription data. One goal of this audit was to identify problematic prescribing and dispensing patterns, but we could not perform that analysis due to legal restrictions on program data. State and legislative auditors in other states, such as Colorado, Louisiana and Oregon, have used their access to this type of data to identify instances of doctor and pharmacy shopping by patients, severe cases of overprescribing by health care providers, and prescriptions involving dangerous drug combinations. That level of accountability is needed in Washington, to help prevent drug misuse, overdose and tragedy.

Recommendations

For the Legislature

To allow greater oversight of the PMP by independent state auditors, as described on pages 31-35, we recommend the Legislature amend state law so that independent state auditors, including the Office of the Washington State Auditor and the Joint Legislative Audit and Review Committee, can have the authority to access identifiable PMP data.

For the Department of Health (DOH)

To ensure pharmacies are submitting prescriptions records timely and have clear guidance, as described on pages 16-18, we recommend DOH:

1. Continue to work with the Prescription Monitoring Program (PMP) system vendor to develop other methods to monitor pharmacy submissions over time in order to identify pharmacies with recurring problems.
2. Conduct periodic analyses of PMP data to identify pharmacies that have:
    a. Not regularly submitted prescriptions to the PMP within one business day of distributing
    b. Significant reductions in the number of prescription records uploaded to the PMP compared to their normal activity
3. Once DOH has completed the analyses in recommendations 1 and 2,
    a. Follow up with these pharmacies and provide guidance to help educate them on submission requirements.
    b. Develop a process to determine what steps DOH will need to take to educate pharmacies, how the agency will determine if it is ineffective, and when a complaint should be forwarded to the Pharmacy Commission.
4. Update administrative rules [WAC 256-470-030(3)] to align with state law [RCW 70.225.020(3)(b)] to require pharmacies upload data within one business day of *distributing* prescriptions.
5. Update both rules [WAC 256-470] and the dispenser guide to require pharmacies to include data in the "date sold" field if the prescription has already been sold prior to the time of upload.

To ensure errors that prevent pharmacy data from appearing in the PMP database are addressed in a timely manner, as described on pages 18-20, we recommend DOH:

6. Establish a process to monitor errors to:
    a. Ensure pharmacies that have a significant number of errors correct them in a timely manner
    b. Identify common types of errors and determine whether it would be appropriate to provide training or additional guidance to pharmacies
    c. Notify the Pharmacy Commission if a pharmacy displays a history of excessive errors or fails to correct errors within the required timeline
7. Establish a timeframe in agency rules to ensure pharmacies correct prescription records in a timely manner. Automatic notifications sent to pharmacies should include the requirements for correcting errors and the consequences for noncompliance.

To ensure the agency can perform this additional monitoring to periodically check the completeness of the PMP data, described in recommendations 1-6, we recommend DOH:

8. Assess the resources needed to perform this monitoring, and determine whether additional funding is needed and should be requested
9. Clearly document policies and procedures for monitoring pharmacies for compliance, and ensure DOH staff understand and follow them

To ensure pharmacies that request waivers do not dispense controlled substances, as described on pages 21-22, we recommend DOH take the following steps to improve the waiver process:

10. Before approving any waiver, check the PMP system to see if the requesting pharmacy has reported distributing any controlled substances in the past
11. Give the Pharmacy Commission a list of the approved waivers

As an alternative to revising the waiver process, DOH can instead stop offering waivers and require pharmacies to submit zero-data reports attesting that they have no prescriptions to submit to the PMP for that day.

To ensure pharmacies submit all required prescription records to the PMP, as described on pages 20-21, we recommend DOH:

12. Consult with the agency's assistant attorney general to determine whether DOH has the authority to require pharmacies to perform a reconciliation between the records submitted to the PMP system and their own records.
    - If DOH has that authority, amend WAC 246-470 to require this reconciliation.
    - If DOH does not have the authority, then work with the Legislature to update state law to obtain this authority.
13. Ensure all licensed Washington pharmacies receive the system reports needed to ensure that the pharmacy system reconciles to the PMP system.

Once DOH implements recommendations 12 and 13, the Pharmacy Commission will be able to complete the next step. This is documented in the recommendations for the Pharmacy Commission on page 40.

To help improve and expand opioid prescribing reports to more medical professionals, as described on pages 25-30, we recommend DOH:

14. Establish a workgroup to discuss the needs of the Better Prescribing, Better Treatment Collaborative. DOH should serve in an advisory role to this workgroup, and explore how it could help it achieve its goals. This workgroup should:
    - Involve the Washington State Hospital Association and Washington State Medical Association as owners of the Collaborative
    - Engage organizations representing Advanced Registered Nurse Practitioners and dentists so the program can be expanded to these professions. It should include other organizations if the workgroup determines it is valuable to do so.
    - Determine roles and responsibilities of workgroup members
    - Evaluate the funding needed to expand the Collaborative and potential funding sources, such as federal grants and state funding
    - Develop and set a strategic plan for expanding and further improving the Collaborative. The plan should address:
        - How to involve a professional with expertise from other associations to develop meaningful comparisons in the reports
        - Identifying strategies to enroll new prescribers, including prescribers not affiliated with hospitals or medical groups
        - Identifying process improvements, such as verifying prescribers' email addresses

- How to provide meaningful reports to prescribers treating chronic pain patients
- Enhancing reports by including potentially dangerous drug combinations
- Developing educational activities on safe opioid prescribing
- In the long term, determine whether there is value in making participation in receiving opioid prescribing reports an opt-out program and if so, what resources would be required.

For the Pharmacy Commission:

To ensure pharmacies that request waivers do not dispense controlled substances, as described on pages 21-22, we recommend the Pharmacy Commission:

15. Establish a process to review controlled substance dispensing and PMP waivers in its inspections and report back to DOH so that PMP program staff can determine the appropriateness of individual waivers once DOH has implemented the step above in recommendation number 11.

To ensure pharmacies submit all required prescription records to the PMP, as described on pages 20-21, we recommend the Pharmacy Commission:

16. Incorporate a review of whether pharmacies have completed this reconciliation in its inspections once DOH has implemented the two steps in recommendations 12 and 13.

To ensure the Commission can perform the additional work described in recommendations 15 and 16:

17. Assess the resources needed to perform this work, and determine whether additional funding is needed and should be requested.

Agency Responses

STATE OF WASHINGTON

September 29, 2022

The Honorable Pat McCarthy
Washington State Auditor
P.O. Box 40021
Olympia, WA 98504-0021

Dear Auditor McCarthy:

Thank you for the opportunity to review and respond to the State Auditor's Office performance audit on the Prescription Monitoring Program (PMP). The Department of Health, prescribing boards and commissions, and the Office of Financial Management worked together to provide this response.

While we appreciate the work of the performance audit team, we sharply disagree with your recommendation to change state law to gain access to Washingtonians' personally identifiable health information from the PMP. As we shared with your team while they scoped the audit, the Legislature deliberately prescribed *in law* who can access this personally identifiable health information and under what conditions. We believe the legislative intent, the statute, and supporting case law are clear.

The PMP was designed as a tool for prescribers and dispensers to access patient Schedule II-V prescription history to make informed prescribing decisions.

The SAO's audit objective, *Could the state's PMP system be used to monitor opioid prescribing and dispensing patterns and help reduce opioid abuse and misuse,* attempts to evaluate the PMP against a purpose for which it was not intended.

According to the Washington State Agency Privacy Principles guidance, public agencies have an obligation to handle personal information about Washington residents responsibly and in a fair and transparent way. We do not believe that this recommendation meets the principal intent of this guidance. As we shared with your team, access to the PMP alone would not provide the information SAO needs to make the determinations implied in the audit objective. Investigators with training and experience in investigating health care provider discipline cases need access to medical records to gather pertinent information. This information must then be shared with board and commission members with medical expertise who can make informed decisions on the appropriateness of a provider's prescribing practice. Without access to medical records and these subject matter experts, amending state law to allow expanded access to the sensitive, personally identifiable information contained in the PMP would undermine the existing protections of this highly sensitive personal data while failing to achieve the SAO's stated audit objective.

Importantly, the governor, Legislature, state agencies, boards, commissions and many other stakeholders have worked to find a balance between regulating and safely dispensing opioids. Pursuing a change in law may have far reaching unintended consequences. These include upsetting this delicate balance, breaking trust among these stakeholders who have worked diligently toward finding solutions that improve patient outcomes while protecting personal information, and ensuring the safe dispensing of opioids, when appropriate.

Page 2

We acknowledge that the PMP has opportunities to improve reporting compliance. However, we strongly disagree that expanding access to PMP data is an appropriate or effective recommendation. Please thank your team for their work on this audit.

Sincerely,

Umair Shah, MD, MPH
Secretary of Health

David Schumacher
Director
Office of Financial Management

Teri Ferreira, R.PH, Chairperson
Washington State Pharmacy Quality Assurance Commission

Kim Morgan, LVT, Chairperson
Veterinary Board of Governors

Dr. Lyle McClellan, Chairperson
Washington State Dental Commission

Dr. Chat D. Aschten, N.D. FABNO, Chairperson
Board of Naturopathy

DJ Wardle, DPM, Chairperson
Board of Podiatric Medicine

Dr. Alexander W. Sobel, DO, FAACS
Washington State Osteopathic Medical Board

Paula R. Meyers, MSN, RN, FRE
Executive Director
Nursing Care Quality Assurance Commission

Micah T. Matthews
Deputy Executive and Legislative Director
Washington Medical Commission

Glen Owen, OD, Chairperson
Board of Optometry

cc: Jamila Thomas, Chief of Staff, Office of the Governor
Kelly Wicker, Deputy Chief of Staff, Office of the Governor
Nick Streuli, Executive Director of Policy and Outreach, Office of the Governor
Emily Beck, Deputy Director, Office of Financial Management
Mandeep Kaundal, Director, Results Washington, Office of the Governor
Tammy Firkins, Performance Audit Liaison, Results Washington, Office of the Governor
Scott Frank, Director of Performance Audit, Office of the Washington State Auditor

Official State Cabinet Agency Response to the Performance Audit on the Washington State Prescription Monitoring Program – September 29, 2022

The Washington State Department of Health (DOH), the Pharmacy Quality Assurance Commission (PQAC), the prescribing boards and commissions, and the Office of Financial Management provide this management response to the State Auditor's Office (SAO) performance audit report received on September 8, 2022.

SAO Performance Audit Objectives

The SAO's audit addressed two objectives:

- Is the program data sufficiently complete, accurate and timely to meet the needs of prescribers and other users when making decisions about patient care?
- Could the state's Prescription Monitoring Program (PMP) system be used to monitor opioid prescribing and dispensing patterns and help reduce opioid abuse and misuse?

SAO Recommendation to the Legislature in brief:

1. We recommend the Legislature amend state law so that independent state auditors, including the Office of the Washington State Auditor and the Joint Legislative Audit and Review Committee (JLARC), can have the authority to access identifiable PMP data.

STATE RESPONSE: We disagree with the recommendation to amend state law so that independent state auditors can access identifiable PMP data.

Using PMP data for enforcement, as the SAO suggested, is not in line with the Legislature's intent to establish a PMP as a database for prescribers and dispensers. The intent is stated in RCW 70.225.020(1):

> ***"…with the intent of eventually establishing an electronic database available in real time to dispensers and prescribers of controlled substances."*** (Chapter 259, Laws of 2007)

We believe the intent of the legislation is clear: the Legislature created the PMP to be an electronic database available to prescribers and dispensers to ensure they are aware of a patient's Schedule II-V prescription history so they can make informed prescriptive decisions.

In 1999, The Institute of Medicine produced the report, *"To Err is Human: Building a Safer Health System."* The report's focus on medication errors led to the PMP. The PMP was designed for prescribers to voluntarily use because they feared reporting to regulatory bodies. That fear is recognized in the 1999 report and consideration of it continued as we initiated and evaluated the PMP.

The performance audit report states that a goal of the audit was to identify problematic prescribing and that the SAO could not achieve that because of the restriction on access to PMP data. PMP data alone cannot accurately identify if a provider's prescribing practice is inappropriate. Subject matter experts (SME) from prescribing professions, PMP epidemiologists, and board and commission members have said to definitively determine if inappropriate prescribing or doctor shopping has occurred, both PMP data and a patient's medical record must be analyzed. Without access to a patient's medical record, PMP data cannot be used to achieve the SAO's stated goal.

The law states that boards and commissions cannot access a patient's medical record without an open investigation into an individual prescriber (RCW 18.71.015 and RCW 18.130.050(11) and (18)). This

limitation on access has been upheld in two court cases (*Seymour v. DOH* and *Yoshinaka v. DQAC*). If Washington begins opening disciplinary cases against providers who prescribed over an arbitrary threshold, many chronic pain and hospice providers and their patients may be disproportionately harmed by these investigations. Additionally, if DOH opens investigations against providers who prescribe over an arbitrary threshold, other important disciplinary cases may take longer as board and commission caseloads increase. Finally, the 2021 American Medical Association (AMA) Overdose Epidemic Report urged the Centers for Disease Control to consider the harm arbitrary thresholds cause pain patients.

Additionally, the performance audit report points to audits in Colorado, Oregon, and Louisiana where auditors could access PMP data to identify potential doctor shopping as an example of why auditors should have access to PMP data. Yet, the SAO's report does not identify the outcomes of those audits and whether there was proof that doctor shopping or better results for patients resulted. As we stated above, PMP data alone cannot identify potential doctor shopping. Using PMP data to identify potential doctor shopping criminalizes patients and harms individuals with substance use disorder without further protecting Washington residents.

According to harm reduction SMEs, there are negative impacts related to the criminalization of drug use that further exacerbate the overdose epidemic. A neuropsychopharmacy article from the National Library of Medicine recognizes that addiction should be treated, not penalized. It also notes that inequitable enforcement targets communities of color, that punishment is ineffective at eliminating substance use disorder, and that there is inequitable access to substance use treatment. An article from World Psychiatry, also from the National Library of Medicine, recommends a public health — rather than criminal justice — approach to drug use disorders. Finally, an article from the National Institute on Drug Abuse outlines how punishing drug use heightens stigma and leads to negative outcomes for many Americans.

PMP data is highly sensitive, perhaps the most sensitive data possessed by the state. It is important to ensure that when access to PMP data expands, that access increases protections for Washington residents and is in line with the law's original intent. Patients have an expectation to privacy when meeting with their healthcare provider.

We do not believe that this recommendation meets Washington State Agency Privacy Principles guidance or is in line with the original intent of the law. Of note, during the opioid prescribing rulemaking to implement ESHB 1427 (Chapter 297, Laws of 2017), pain advocates raised strong concerns that an unintended consequence of opioid regulation is that fewer prescribers are willing to prescribe controlled substances. This can leave many patients without access to legitimately needed pain medications. The rules for this law went into effect on January 1, 2019. Since that time, the Washington Medical Commission (WMC) received 44 complaints of under prescribing, and 35 of these occurred immediately after the rules became effective. We saw similar impacts on patient access when the chronic non-cancer pain prescribing rules went into effect in 2013 and an entire community health system discharged their chronic pain patients and refused to prescribe opioids. Regulatory action in the prescribing arena has demonstrable impacts on practitioner action and patient access in Washington.

Additionally, the SAO report uses the audits in the three other states as examples of why the Legislature should amend Washington's statute to allow SAO access to PMP data. However, those states have significant differences in structure and experience.

When we reference the Oregon state audit, we see that law enforcement agencies (LEA)s can only obtain PMP data when there is an active investigation and a valid court order. And, the Colorado state audit shows that regulatory boards and LEAs can only access PMP data with a court order or subpoena. This is not the case in Washington. Our laws state that LEAs, the Drug Enforcement Administration (DEA), and health professional licensing, certification, and regulatory agencies can look up PMP data as part of an investigation without requiring a court order or subpoena.

DOH could not find any outcomes of the audit findings in these other states, on whether the state licensing bodies found that prescribers identified in the audits as overprescribing were ultimately determined to be overprescribing, or if the patients identified as doctor shopping were *actually* doctor shopping. Without compelling outcomes that point to an improvement in patient safety, we do not believe that expanding access to PMP data is in the best interest of Washington residents.

The report notes that auditors could not assess if PMP data alone would be sufficient to identify inappropriate prescribing or doctor shopping. DOH believes that if the PMP data is sufficient, then the other state audits would have included data to demonstrate that.

SAO states a goal of gaining access to PMP data is to identify dangerous prescribing combinations. While experts traditionally say opioids, benzodiazepines, and sleep aids are considered dangerous and higher risk when prescribed together, the Washington prescribing rules do not prohibit co-prescribing these substances. While they require documentation of the medical decision-making, there are numerous clinical reasons why such combinations would be necessary. Almost none of the data contained in the PMP would explain the reasoning for co-prescribing such combinations.

Recommendations to the Department of Health:

SAO Recommendations 1-5: To ensure pharmacies are submitting prescription records timely and have clear guidance, we recommend DOH:

1. Continue to work with the Prescription Monitoring Program (PMP) system vendor to develop other methods to monitor pharmacy submissions over time to identify pharmacies with recurring problems.
2. Conduct periodic analyses of PMP data to identify pharmacies that have:
    a. Not regularly submitted prescriptions to the PMP within one business day of distributing
    b. Significant reductions in the number of prescription records uploaded to the PMP compared to their normal activity
3. Once DOH has completed the analyses in recommendations 1 and 2,
    a. Follow up with these pharmacies and provide guidance to help educate them on submission requirements.
    b. Develop a process to determine what steps DOH will need to take to educate pharmacies, how the agency will determine if it is ineffective, and when a complaint should be forwarded to the Pharmacy Commission.
4. Update administrative rules [WAC 256-470-030(3)] to align with state law [RCW 70.225.020(3)(b)] to require pharmacies upload data within one business day of *distributing* prescriptions.
5. Update both rules [WAC 256-470] and the dispenser guide to require pharmacies to include data in the "date sold" field if the prescription has already been sold prior to the time of upload.

STATE RESPONSE: DOH agrees to continue collaborating with the PMP vendor around enhancing compliance and identifying pharmacies with recurring problems. DOH also agrees that receiving data in a timely manner is important for two reasons. One, to ensure prescribers have access to a patient's Schedule II-V prescriptions. And two, to conduct periodic analysis of PMP data to identify pharmacies that have not regularly submitted prescriptions within two business days of distributing.

However, between the varying definitions of 'date filled,' not knowing the business schedule of the pharmacies, and the limited tools available to the PMP staff, there are many complexities around tracking one business day uploading.

The PMP system does not currently have the functionality to track what days pharmacies are open. With over 2,300 pharmacies reporting to the Washington PMP, tracking and maintaining pharmacy hours would take a significant amount of staff time. Since there isn't the functionality to track this in the PMP system itself, this would be a manual and inefficient process for staff. It is unclear how much additional staff would be necessary to take on this work. Currently 90% of submissions are received within two business days and only 4% are received past three days. The PMP will prioritize following up with pharmacies that take more than two business days to report dispensing drugs.

DOH agrees to explore this potential functionality with the PMP vendor to determine its feasibility, implementation timeline, and cost to DOH. We agree that pharmacy education is important and pharmacies that refuse to come into compliance should be referred to the Pharmacy Quality Assurance Commission. These compliance processes are in place and are part of the standard compliance work of PMP staff.

DOH will continue to provide guidance to delinquent pharmacies to help educate them on submission requirements. The PMP will also continue to work with the PMP vendor to develop and refine features that will further develop compliance processes within the PMP.

DOH will continue to develop, document, and refine compliance processes. We will explore the best approach to clarifying that pharmacies must upload prescriptions to the PMP within one business day of distributing a prescription. And, to explore the best approach to ensure dispensers report the date they distributed a prescription to a patient.

Action Steps and Time Frame:

- Continue to work with the PMP system vendor to explore new methods to monitor pharmacy submissions and develop and refine the compliance module available in the PMP system. *By July 31, 2023.*
- Conduct periodic analysis of PMP data to identify pharmacies not regularly submitting prescriptions to the PMP within two business days. *By July 31, 2023.*
- Work with the PMP vendor to explore the feasibility of new functionality that could track variations in dispenser uploads. *By July 31, 2023.*
- Continue to develop, document, and refine PMP compliance processes and pharmacy education to improve pharmacy submission rates and data accuracy in the PMP. *By July 31, 2023.*
- Review, revise, and document the process for educating uploaders and Pharmacy Commission complaints. *By Jan. 31, 2023.*
- Explore the best approach to clarify to pharmacies that they must upload prescriptions within one business day of dispensing. *By Sept. 30, 2023.*
- Explore the best approach to ensure dispensers report the date a prescription was distributed to a patient. *By Sept. 30, 2024.*

SAO Recommendations 6-7: To ensure errors that prevent pharmacy data from appearing in the PMP database are addressed in a timely manner, we recommend DOH:

6. Establish a process to monitor errors to:
    a. Ensure pharmacies that have a significant number of errors correct them in a timely manner.
    b. Identify common types of errors and determine whether it would be appropriate to provide training or additional guidance to pharmacies.
    c. Notify the Pharmacy Commission if a pharmacy displays a history of excessive errors or fails to correct errors within the required timeline.

7. Establish a timeframe in agency rules to ensure pharmacies correct prescription records in a timely manner. Automatic notifications sent to pharmacies should include the requirements for correcting errors and the consequences for noncompliance.

STATE RESPONSE: DOH agrees that PMP error corrections are important for the safety of Washington residents. We will explore developing the functionality to track pharmacies with a significant number of uncorrected errors so that we can increase compliance from pharmacies with the PMP vendor.

DOH agrees to identify the most common error types and provide pharmacy education. As a result of this audit, PMP staff analyzed the most common errors they saw. We determined that the three most common errors involved data fields that are not required in RCW or WAC, are not seen by providers, and are not used by epidemiologists. Based on this analysis, we decided to make those data fields optional, which will significantly diminish the number of existing errors in the system. To date, all outstanding prescriptions with these error types, roughly 7,300, have been pushed into the PMP system by the vendor. DOH appreciates the SAO staff for bringing this to light and will continue to analyze common errors to determine the best course of action to decrease the system error rate.

DOH also agrees to notify the Pharmacy Quality Assurance Commission of pharmacies with excessive uncorrected errors. And, DOH will explore the best approach to set and clarify the timeframe for pharmacies to correct submission errors.

Action Steps and Time Frame:

- Establish a new process for tracking errors based around the new compliance tracker from the PMP vendor due in fall of 2022. By *March 31, 2023.*
- Analyze error submissions to determine other common errors and how to best correct them. *By March 2023.*
- Provide training and guidance to pharmacies on common errors and how to avoid and correct them. *By July 31, 2023.*
- Notify PQAC of pharmacies that have excessive errors and fail to correct them. *By March 2023.*
- Begin working with the PQAC to explore guidelines around "excessive errors" for pharmacies and a reporting process. *By July 31, 2023.*
- Explore the best approach to set and clarify a timeframe for error corrections. *By March 31, 2024.*

SAO Recommendations 8-9: To ensure the agency can perform this additional monitoring to periodically check the completeness of the PMP data, described in recommendations 1-6, we recommend DOH:

8. Assess the resources needed to perform this monitoring and determine whether additional funding is needed and should be requested.
9. Clearly document policies and procedures for monitoring pharmacies for compliance, and ensure DOH staff understands and follows them.

STATE RESPONSE: DOH agrees to assess the resources it needs to undertake new compliance monitoring work. We also agree to continue to document and train staff on policies and procedures for monitoring pharmacies for compliance.

Action Steps and Time Frame:

- Assess new compliance module functionality and determine necessary staff resources based on new features available in the module. *By July 1, 2023.*

- Review, revise, and train staff on existing procedures. Establish new procedures as new functionality and features are available. *By March 31, 2023.*

SAO Recommendations 10-11: To ensure pharmacies that request waivers do not dispense controlled substances, as described on Pages 21-22, we recommend DOH take the following steps to improve the waiver process:

10. Before approving any waiver, check the PMP system to see if the requesting pharmacy has reported distributing any controlled substances in the past
11. Give the Pharmacy Commission a list of the approved waivers

STATE RESPONSE: DOH disagrees with the recommendation that staff should look at a pharmacy's uploading history before it approves a waiver. In the past we have performed spot checks for this and have found no violations. Pharmacies often change business practices; thus, past upload history is not a good indicator of current dispensations. The PMP has worked with the vendor to develop features that would enhance the waiver process. We expect a tool by the end of June 2023, that would look for uploads from pharmacies that hold a waiver and withdraw the waiver if any dispensations are uploaded. We will provide the Pharmacy Quality Assurance Commission with a list of pharmacies with these waivers.

Action Steps and Time Frame:

- Work with the vendor to schedule the development and release of the waiver withdrawal tool. *By July 1, 2023.*
- Conduct a work session with the PQAC inspectors and the PMP team to develop a system whereby the inspectors can relay the information obtained during their inspections. *By March 31, 2023.*
- Begin providing the Pharmacy Commission with a list of pharmacies that have a waiver from reporting to the PMP because they do not dispense Schedule II-V drugs. *By March 31, 2023.*

SAO Recommendations 12-13: To ensure pharmacies submit all required prescription records to the PMP, as described on Pages 20-21, we recommend DOH:

12. Consult with the agency's assistant attorney general to determine whether DOH has the authority to require pharmacies to perform a reconciliation between the records submitted to the PMP system and their own records.
    - If DOH has that authority, amend WAC 246-470 to require this reconciliation.
    - If DOH does not have the authority, then work with the Legislature to update state law to obtain this authority.
13. Ensure all licensed Washington pharmacies receive the system reports needed to ensure that the pharmacy system reconciles to the PMP system.

STATE RESPONSE: DOH agrees to consult with its assistant attorney general to determine if DOH has authority to require pharmacies to perform a reconciliation between the records submitted to the PMP and its records. However, it is unclear if this recommendation is feasible for pharmacies when we consider staff resources and workload. It is also unclear how feasible it would be for DOH and PQAC staff to monitor these reconciliations. Most pharmacies have contracted uploaders who upload daily all records to the corresponding state PMP. DOH is unclear about how this technology functions as each pharmacy chain manages its own processes, contracted uploaders, and software. A statutory change may be necessary for PQAC or DOH to have enforcement authority over non-resident pharmacies for non-compliance with PMP regulatory obligations.

DOH will work with PQAC to explore the feasibility of this recommendation both in terms of pharmacy and PQAC resources. We will also work with the Legislature and PQAC to provide relevant information on the feasibility of requiring these reconciliations.

DOH disagrees with this recommendation to provide reports to pharmacies for reconciliation. It is unclear if it is feasible because each independent or pharmacy chain manages its own processes, contracted uploaders, and software. These entities have independent systems, processes, and procedures, which DOH and PQAC do not have insight into. It is unclear where these system reports would come from or if the software pharmacies use can generate these kinds of reports. Pharmacy processes are independent of DOH and PQAC. There are too many unknowns to determine the viability of this recommendation.

Action Steps and Time Frame:

- Consult with an assistant attorney general to determine who has the authority to require pharmacies to perform the recommended reconciliation. *By March 1, 2023.*
- Begin to explore the feasibility of requiring PMP reconciliations with PQAC. *By July 1, 2023.*

SAO Recommendation 14: To help improve and expand opioid prescribing reports to more medical professionals, as described on Pages 25-30, we recommend DOH:

14. Establish a workgroup to discuss the needs of the Better Prescribing, Better Treatment Collaborative. DOH should serve in an advisory role to this workgroup and explore how it could help it achieve its goals. This workgroup should:
    - Involve the Washington State Hospital Association (WSHA) and Washington State Medical Association (WSMA) as owners of the Collaborative.
    - Engage organizations representing Advanced Registered Nurse Practitioners and dentists so the program can be expanded to these professions. It should include other organizations if the workgroup determines it is valuable to do so.
    - Determine roles and responsibilities of workgroup members.
    - Evaluate the funding needed to expand the Collaborative and potential funding sources, such as federal grants and state funding.
    - Develop and set a strategic plan for expanding and further improving the Collaborative. The plan should address:
        - How to involve a professional with expertise from other associations to develop meaningful comparisons in the reports
        - Identifying strategies to enroll new prescribers, including prescribers not affiliated with hospitals or medical groups
        - Identifying process improvements, such as verifying prescribers' email addresses
        - How to provide meaningful reports to prescribers treating chronic pain patients
        - Enhancing reports by including potentially dangerous drug combinations
        - Developing educational activities on safe opioid prescribing
        - In the long term, determine whether there is value in making participation in receiving opioid prescribing reports an opt-out program and if so, what resources would be required

STATE RESPONSE: DOH disagrees with this recommendation. The Better Prescribing, Better Treatment (BPBT) Collaborative is an independent body, that is not under the authority of DOH. The Department does not have the resources or expertise to establish a workgroup to discuss the strategic vision for the BPBT Collaborative. As an independent collaborative, it is not bound to follow any suggestions that any convened workgroup by DOH would recommend. Prescriber feedback reports

produced by the BPBT Collaborative are entirely funded by the Washington State Medical Association (WSMA) and Washington State Hospital Association (WSHA) and DOH cannot guarantee funding support. Additionally, as the law is currently written, only WSMA and WSHA can receive the raw PMP data required to develop prescriber feedback reports.

Recommendation to the Pharmacy Commission:

SAO Recommendation 15: To ensure pharmacies that request waivers do not dispense controlled substances:

15. Establish a process to review controlled substance dispensing and PMP waivers in its inspections and report back to DOH so that PMP program staff can determine the appropriateness of individual waivers once DOH has implemented the step above in recommendation number 11.

STATE RESPONSE: PQAC agrees with the recommendation to include in the inspection process whether a pharmacy has a PMP waiver and dispenses controlled substances and report this information back to the PMP program.

Action Steps and Timeframe:

- Conduct a work session with the PQAC inspectors to develop a system to ensure they note whether the pharmacies they inspect dispense controlled substances and whether the pharmacies have a waiver. *By Jan. 31, 2023.*
- Conduct a work session with the PQAC inspectors and the PMP team to develop a system whereby the inspectors can relay the information obtained during their inspections. *By March 1, 2023.*
- Ensure PQAC stakeholders are aware of this component of the inspection process. *By March 15, 2023.*
- Implement these processes. *By March 30, 2023.*

SAO Recommendation 16: To ensure pharmacies submit all required prescription records to the PMP:

16. Incorporate a review of whether pharmacies have completed this reconciliation in their inspections once DOH has implemented the two steps in recommendations 12 and 13.

STATE RESPONSE: PQAC disagrees with the recommendation to review in its inspections whether pharmacies have completed this reconciliation once DOH has implemented the two steps in Recommendations 12 and 13.

Pharmacies do not have enough staff to manage current workloads of filling prescriptions, dispensing prescriptions, providing counseling, and administering vaccinations. The additional workload of ensuring all responsible pharmacy managers receive a file status report each day that the pharmacy submits information to the PMP, and that the pharmacy performs a daily reconciliation, is a near impossible task for pharmacies and responsible pharmacy managers to complete. If they had to do this, it would take away staff and time from other tasks and will negatively impact patient care. Adding another component to the inspection process will cause each inspection to take longer, and the commission already does not have enough staff to keep up with its inspections as the number of pharmacies and other pharmaceutical firms in our state has grown while our inspection staff has remained constant.

PQAC must be self-sustaining through its fees. See RCW 43.70.320. This recommendation and those associated with it are broader than the licensing activities of PQAC. (RCW 43.70.320(2))

SAO Recommendation 17: To ensure the Commission can perform the additional work described in recommendations 15 and 16:

17. Assess the resources necessary to perform this work and determine whether additional funding is needed and should be requested.

STATE RESPONSE: PQAC disagrees with the recommendation to assess the resources necessary to perform this work and determine whether additional funding is needed and should be requested.

As referenced in our response to Recommendation 16, PQAC must be self-sustaining through its fees. In addition, PQAC disagrees that pharmacies should have to complete a daily PMP reconciliation and that its inspectors should audit this during inspections. Therefore, there is no need to assess the resources necessary to perform this work.

It is important to note that PQAC cannot assess and evaluate the financial impact that Recommendation 16 would have on pharmacies and their staff as they are independent businesses.

Washington State Hospital Association

September 29, 2022

The Honorable Pat McCarthy
Washington State Auditor
P.O. Box 40021
Olympia, WA 98504-0021

RE: Prescription Monitoring Program Performance Audit Report

Dear Auditor McCarthy,

On behalf of the Washington State Hospital Association (WSHA), thank you for the opportunity to provide feedback on the Prescription Monitoring Program (PMP) Performance Audit report. WSHA represents over 100 hospitals and health systems in our state, and our hospital members range from large statewide health care delivery systems to small rural hospitals that are the only health care safety net serving rural, remote communities. WSHA has been a leader in reducing harm related to opioid misuse by living by its' mission. We are a trusted collaborative partner and innovator that advances important elements in acute prescribing, prevention and treatment programs across the state.

The PMP is a vital tool for health care providers to prevent medication misuse. We appreciate the Office of the Washington State Auditor's (SAO) work to identify potential improvements to the PMP program. We are grateful for your engagement with WSHA staff during the audit process. We offer the following feedback on the report:

- WSHA opposes the recommendation for SAO to access "identifiable" PMP information;
- WSHA supports the recommendations to enhance the opioid prescribing reports issued by the Better Prescribing, Better Treatment Collaborative (BPBT);
- WSHA disagrees with the recommendation for a Department of Health (DOH)-led workgroup; and
- SAO's report lacks important information about the opioid stewardship work conducted by BPBT and WSHA.

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WSHA Opposes the Recommendation for SAO to Access "Identifiable" PMP Information
WSHA is very concerned about the recommendation on pages 5, 31-35, and 37 to change statute to allow SAO access to "identifiable" PMP information and urges the legislature to reject the recommendation.

PMP information is sensitive and should not be accessible to individuals or entities lacking the necessary clinical background, training and education. The PMP data available to WSHA and WSMA is evaluated through a safety and quality perspective and Coordinated Quality Improvement Program with the intent of providing information to prescribers to inform their clinical decision-making. The professionals compiling and reviewing the prescribing reports possess the necessary expertise to contextualize prescription data and distinguish between care scenarios. They are also aware of the broader trends in addressing prescription drug misuse and overdose prevention.

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DOH and WSHA agree PMP information should continue to be used for quality improvement, not enforcement. SAO implies in its' report and stated during the exit conference with WSHA and WSMA on September 14, 2022 that PMP data could be provided to licensing boards and commissions for enforcement actions. This would be a major departure from the current quality improvement focus of BPBT and the prescribing reports. WSHA is not alone in our opposition to this. The report states on page 35, "The PMP program staff at DOH believe that the PMP system should be used only as a repository for data and that using it as an enforcement tool against prescribers is inappropriate." The report also states on page 35, doing so "would lessen prescriber trust in the PMP and be ineffective, as such analysis might flag legitimate prescribing activity." Using PMP data for enforcement actions could deter prescribers from prescribing opioids and other controlled substances to patients in order to avoid an investigation by their licensing board. This would chill patients' access to medications and may exacerbate health care inequities in communities with few prescribers willing to prescribe opioids or other controlled substances. Additionally, DOH acknowledged that such an arrangement could potentially burden them with unwarranted investigations into individual prescribers' "legitimate prescribing activity."

The recommendation raises strong concerns about data privacy. Granting SAO access to "identifiable" PMP information potentially adds sensitive health and clinical information to the public record. SAO does not address this issue in the report, which is deeply concerning. Adding such information to the public record would raise significant concerns for patients, prescribers, pharmacists and other stakeholders who expect the data to be confidential.

SAO does not have clinical expertise nor is clinical evaluation within its' mission. SAO's mission is to "[provide] citizens with independent and transparent examinations of how state and local governments use public funds, and develops strategies to make government more efficient and effective." Given this explicit mission, we don't believe accessing sensitive information fits within that scope. Furthermore, the report does not address the long-term plan or vision of what SAO would do with this data. SAO stated during our September 14, 2022 exit conference that a future audit could be conducted using PMP information. But that possibility alone is insufficient justification to make such a significant law change. It could also duplicate the work conducted within the BPBT Collaborative that WSHA and WSMA support with analyzing PMP data for prescribers working within this peer-driven clinical improvement program.

SAO's recommendation contradicts the legislature's intent. The PMP law contains a quality improvement process driven by relevant professional associations to change prescriber behavior based on best practices and current science set within a non-punitive, just culture practice. An evidence-based approach is used to sustain significant improvement. Inserting SAO into this is a clear contradiction of the legislature's intent and would place at risk current and future progress and provider engagement***.***

It is unclear what SAO intends to replicate from other states if the legislature grants SAO PMP access. On pages 3 and 33-34 SAO justifies this recommendation based on laws in Colorado and Oregon, with minimal details. The report says that the auditors "have used their access to this type of data to identify instances of doctor and pharmacy shopping by patients, severe cases of overprescribing by doctors, and prescriptions involving dangerous drug combinations." However, the report does not provide any details other than the brief descriptions on page 33-34 and the table on pages 53-54. SAO also states on page 53, "Please note that we did not examine the subsequent outcomes of these audits and whether the recommendations were implemented." This lack of examination raises many questions that should be

answered before changing state law, such as:

- Why are state auditing agencies performing this function?
- How do auditing agencies in those states conduct their audits?
- What have been the outcomes from state audits?
- How did the auditing agencies acquire the necessary expertise to conduct their audits?
- Do the agencies apply a quality improvement or enforcement lens to their audits?

SAO's recommendation is redundant when viewed in the context of the full report. Pages 25-30 and 39-40 contain SAO's recommendations to improve the prescribing reports issued by BPBT. The report also recommends steps on pages 15-24 and 37-40 for DOH to take to ensure accurate information is provided by pharmacies into the PMP. SAO should allow BPBT, DOH and the stakeholders identified in the report to act on the recommendations before proposing such a drastic change to upend the carefully crafted PMP law that has shown demonstrated improvement in prescribing outcomes.

WSHA Supports the Recommendations to Enhance the Opioid Prescribing Reports Issued by BPBT
WSHA supports the recommendations listed on pages 27-29 and 39-40 to enhance BPBT's work. In particular, WSHA agrees with the recommendations to:

- Enhance prescribing reports by including potentially dangerous drug combinations;
- Identify new strategies to enroll new prescribers in the prescribing report program; and
- Examine the feasibility of shifting the prescribing report program to an opt-out program.

These are practical measures to increase BPBT's reach to build on its' prior successes. However, the success of these recommendations will depend on available resources to fund the expansion of BPBT's work. Because of this, we appreciate SAO recommending DOH "[e]valuate the funding needed to expand the Collaborative and potential funding sources, such as federal grants and state funding" and encourage the legislature to allocate resources to support BPBT.

WSHA Disagrees with the Recommendations for a DOH-Led Workgroup
WSHA disagrees with the recommendation on pages 30 and 39 for a DOH-led workgroup "to discuss the needs of the [BPBT]." This recommendation could hinder BPBT's successes with peer-driven, non-punitive clinical improvement work and place in jeopardy protection from disclosure and discovery under CQIP that are key to providers having open and safe improvement-oriented discussions. SAO's recommended "advisory role" implies that DOH would direct and lead the workgroup. This would depart from the current arrangement where WSHA and WSMA staff lead opioid stewardship work based on trends and emerging best practices. This could chill open discussions within BPBT about prescribing practices or even result in the loss of confidentiality among workgroup participants. Additionally, mandating the agency responsible for licensing and enforcement to lead the workgroup may create a perception among prescribers that punitive or other heavy-handed changes could be forthcoming from DOH. We do not consider this recommendation to be value added or to meet the intent of the program. DOH cannot ensure that its' expanded role in BPBT and opioid stewardship would not hinder BPBT's ongoing progress in creating peer-driven advancements in opioid stewardship.

SAO's Report Lacks Important Information about the Work Conducted by BPBT and WSHA
The report's narrative regarding BPBT and WSHA provides limited information about the totality of the work undertaken by BPBT and WSHA. Unfortunately, this description does not convey the scope and

breadth of the work, nor does it convey the successes achieved to-date. Because of this, we recommend SAO add additional context about BPBT and WSHA to provide readers a clear understanding of the opioid stewardship work being conducted in Washington State.

BPBT is a collaboration between WSHA, the Washington State Medical Association (WSMA), Washington DOH, and the Washington Health Care Authority. Commencing in 2019, HB 1427 extended PMP access to WSHA and WSMA for data analysis and peer-driven, non-punitive clinical improvement in reducing above guidelines with acute opioid prescribing.

BPBT has empowered providers to be good stewards of acute opioid prescribing patterns by informing prescribing providers in our hospitals with quarterly reports. These reports enable members to engage and leverage the prescribing patterns of clinical peers for learning and reducing above guideline prescribing. BPBT also promotes sharing of evidence-based best practices in reducing harm related to above guideline prescribing. Although BPBT is relatively "young" since inception, the program has empowered Washington State providers to be good stewards of acute opioid prescribing patterns with notable improvement in pediatric, adult and adults 65 years and older.

BPBT's key success is that above guidelines acute opioid prescribing has reduced over the last 4 years. Pediatric above guideline acute opioid prescribing has reduced from 34% (2018) to 18% (2021), adults from 14% (2018) to 6% (2021) and adults 65 years/>, 19% (2018) to 9% (2021).

WSHA continues to serve as a trusted leader, collaborator, and convener of efforts to reduce opioid misuse. WSHA has been instrumental in not only providing informative quarterly reports that identify prescribing patterns, but also in evaluating opportunities that include education, awareness, and best practices for safe acute opioid prescribing. Some of WSHA's successes include:

- Preparing quarterly reports for hospital chief medical officers that support and inform on statewide and individual hospital prescribing practices in pediatrics and adults. Chief medical officers are also able to stratify data across provider specialties and trend patterns over time;
- Engaging hospital chief medical and quality officers with above guideline prescribing quality improvement strategies. This engagement has included quarterly educational webinars on how to utilize PMP data via the secured/opt-in, facilitated quality improvement discussions, support for safe storage and Safe Medication return programs, and the sharing of information for prescription take back day and opioid overdose awareness day;
- Surveying hospital chief medical officers on the best strategies to support data collection and dissemination of data to promote meaningful action;
- Engaging with key state stakeholders to review and promote synergy within the state's opioid response plan that includes acute prescribing, prevention and treatment. This strategy to connect and convene has provided all Washington State hospitals support within the Starts with One campaign, the state's safe medication return program, Safe Storage, MED-Project and other activities. Hospitals are most receptive to customizable campaign materials for their campuses. Notably, several hospital clinical leaders in both rural and larger health systems have engaged in the Starts with One campaign's development of a provider toolkit. This toolkit, underpinned in an equitable approach, supports our prescribing providers with communication resources to engage patients and care givers with information on alternatives to opioid treatment and safe practices when opioid prescribing is needed in acute pain scenarios; and

- WSHA has been supportive and engaged in CoMagine Health's opioid stewardship aims within the US Centers for Disease Control and Prevention's Opioid Data to Action Peer-to-Peer initiative. WSHA served as a panelist for a multi-state stakeholder learning event. WSHA spoke about BPBT, improvement trajectory with supporting prescribing patterns, and how sharing feedback in a quality improvement, non-punitive manner has facilitated improvement.

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Thank you again for the opportunity to comment on the PMP Performance Audit report. Should you have additional questions on WSHA's recommendations, please contact David Streeter via email at DavidS@wsha.org.

Sincerely,

Darcy Jaffe
Senior Vice President, Safety and Quality
Washington State Hospital Association

Chelene Whiteaker
Senior Vice President, Government Affairs
Washington State Hospital Association

Washington State Medical Association
Physician Driven, Patient Focused

September 29, 2022

The Honorable Pat McCarthy
Washington State Auditor

Delivered electronically

Dear Auditor McCarthy,

On behalf of the Washington State Medical Association (WSMA) representing over 12,000 physician and physician assistants, thank you for the opportunity to provide feedback on the Office of the Washington State Auditor's (SAO) performance audit, *Prescription Monitoring Program: Evaluating system processes and program oversight.*

While the WSMA supports the intent of this audit – to improve the effectiveness of Washington state's Prescription Monitoring Program (PMP) – and believe several recommendations would be beneficial, **we are deeply troubled by the recommendation that the Legislature amend state law to permit the SAO access to sensitive identifiable PMP data.** We are concerned a blunt approach that seeks to identify prescribing "outliers" absent any patient-specific clinical context and referring those "outliers" to regulatory authorities will accelerate the well-documented problem of patients struggling to access appropriate pain medications. These concerns were expressed to SAO throughout the audit process but are not reflected in the final report. As such they are discussed at length in this letter.

Our state has been a national leader in responding to the opioid epidemic. With the help of many stakeholders, physician experts and public policy makers, we have established and implemented policies and programs that have led to a significant decrease in prescription opioid dispensing. At the same time these efforts have allowed for appropriate, evidence-based access to opioid medication. The approach recommended in the draft report to permit SAO access to identifiable PMP data is counter to that spirit.

Washington state has led the nation

The prescription contribution to the opioid epidemic was first identified in Washington state in the 2000s. Since then, lawmakers and policy makers in partnership with physicians and hospitals, have led the nation in innovative approaches that seek to reduce inappropriate opioid prescriptions *while ensuring access to appropriate care.*

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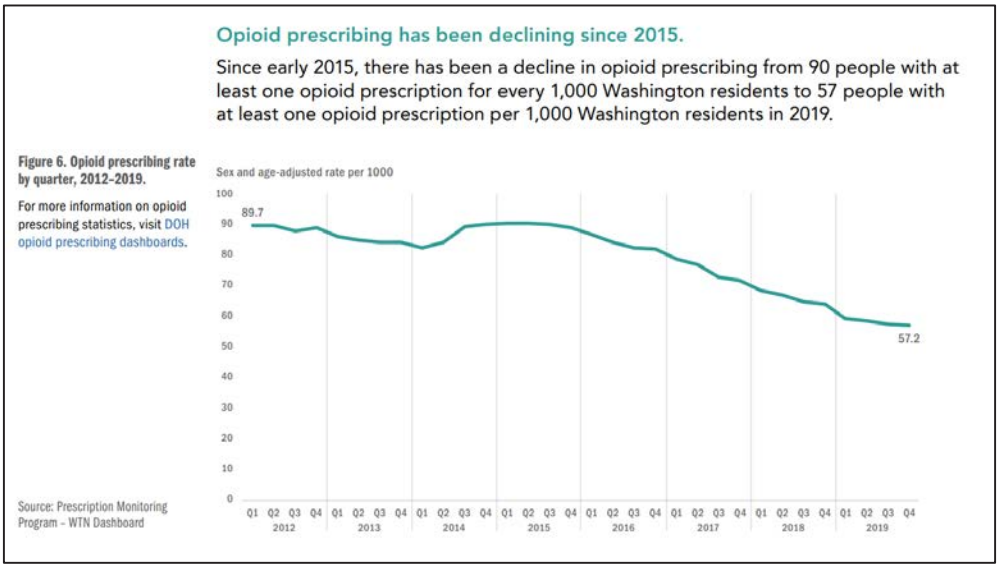
These initiatives include:

- Publication of first opioid prescribing guideline by the Agency Medical Directors Group (2007, 2015)
- Legislature repeals permissive intractable pain laws (2010)
- Legislature requires new standards for prescribers, including chronic pain rules as required by the HB 2876 (2010)
- Legislature creates Washington state Prescription Monitoring Program (PMP) (2011)
- Legislature sets forth seven best practices aimed at reducing unnecessary emergency department use in HB 2127. "ER is for Emergencies" is created, a program that has been replicated in states across the country and includes implementation of opioid prescribing guidelines for acute pain and the first integrations of PMP data into electronic health records (2012)
- The Health Care Authority (HCA) implements acute opioid prescribing policies as component of the Better Prescribing, Better Treatment (BPBT) Collaborative (2018)
- Legislature creates drug take-back program. For the first time residents have statewide access to disposing of unwanted or unneeded household prescriptions with the goal of decreasing diversion – the number one source of prescription drug abuse ("friend or relative") according to SAMHSA.
- Legislature requires promulgation of new standards for prescribers for all phases of pain (acute, subacute, chronic) (implemented 2019)
    - Requires physicians and other prescribers to check the PMP at clinically targeted intervals.
    - Includes pill limits for acute prescribing with exemption for clinical judgement.
    - Requires documentation of decision making around opioid prescribing in the medical record.
    - This legislation also gave WSMA access to PMP data for the purposes of conducting quality improvement under the BPBT Collaborative.
- HCA implements PMP check before prescribing a controlled substance to Medicaid patients (2021)
- Legislature passes PMP integration mandate and requirements for electronic prescribing of controlled substances (implemented 2022)

These efforts and others have led to a sustained reduction in the number of opioids prescribed:



Washington state should continue to lead through policy innovations that seek to reduce inappropriate prescribing while maintaining access to appropriate pain medications for patients that need them and avoid adopting non-patient centered approaches simply because other states have done so – as recommended in the audit.

Concerns with recommendation

According to the DOH, Washington's PMP was created by the Legislature to improve patient care and decrease prescription drug abuse by making controlled substance dispensing information available to physicians and other medical providers as a *patient care tool*, not a disciplinary or enforcement mechanism. As such the Legislature has historically restricted who can access the data to protect prescriber, pharmacy, and patient information. State law permits local, state, federally recognized tribes, or federal law enforcement to obtain PMP information for a bona fide investigation involving a designated person.

In its audit, the SAO recommends that the Legislature amend the law so that the SAO can access identifiable PMP data. SAO notes they would use the data to identify "1. Potential instances of doctor shopping 2. Unusually high quantities of opioids prescribed. 3. Dangerous drug combinations."

The report is silent on what criteria or metrics would be used in analyzing this data, as well as how state auditors (without clinical expertise) would determine medical appropriateness. For example, an oncologist would typically prescribe more opioids than an allergist – but simply looking at raw outlier data would not provide that critical context. While the SAO report makes a brief mention of contracting with a clinician "familiar with opioid prescribing for acute and chronic pain," such a clinician would not have access to patient medical records, and as such would have no way to contextualize the data and distinguish between care scenarios. The ability to meaningfully interpret prescribing patterns from PMP data would require significantly more resources than is contemplated in the report. This is acknowledged where it is noted that a full determination as to whether prescribing is inappropriate would likely require a full review of the medical record by a regulatory board or commission.

To be clear, the WSMA is deeply concerned that mining PMP data in this fashion and then referring it to disciplinary boards will contribute to further limiting access to appropriate pain treatment and could be detrimental to patient care.

Patient access to appropriate medications

While opioids are powerful drugs that can be associated with abuse, addiction, and diversion, they are also the most effective medications for relief from human pain and suffering when prescribed and utilized appropriately. Clinical experience has demonstrated that adequate and appropriate pain management leads to enhanced functioning and quality of life, while uncontrolled pain contributes to disability and despair. Unrelieved pain continues to be a serious health concern for the general population.

The state recognizes that the diagnosis and treatment of pain is integral to the practice of medicine and this concept was key when the boards and commissions drafted opioid prescribing rules in accordance with HB 1427. The intent and scope section of rules for allopathic physicians and physician assistants acknowledges the delicate balance that must be struck between preventing inappropriate treatments while ensuring patients that require them have access:

The Washington state medical quality assurance commission (commission) recognizes that principles of quality medical practice dictate that the people of the state of Washington have access to appropriate and effective pain relief. The appropriate application of up-to-date knowledge and treatment modalities can

serve to improve the quality of life for those patients who suffer from pain as well as reduce the morbidity, mortality, and costs associated with untreated or inappropriately treated pain. For the purposes of these rules, the inappropriate treatment of pain includes nontreatment, undertreatment, overtreatment, and the continued use of ineffective treatments.

Despite our best efforts, it is well documented that the regulatory environment in Washington state and across the country created by the response to the opioid epidemic has generated barriers to patients accessing appropriate pain medications.

We hear from patients and prescribers across the state that some practices are tapering patients off opioids, discharging them from their practices, or refusing to see new pain patients out of fear of facing serious sanctions. Those sanctions include malpractice liability, medical board discipline ranging from reprimand to revocation of their medical license, exclusion from federal and state programs, breach of contract actions from insurance carriers, hospital peer review, and criminal convictions.

These anecdotes are supported by reporting of this issue:

- Seattle Times: Amid pressure to prescribe fewer opioids, doctors struggle to ease patients' pain:
  - *He's largely stopped prescribing opioids — in part, he said, because his focus on procedures, like injections and implanted pumps, is taking up all his time; and in part because providers today have to wonder with every prescription whether they're leaving themselves open to a lawsuit or a visit from the Drug Enforcement Administration (DEA).*
- Human Rights Watch: Not Allowed to Be Compassionate" Chronic Pain, the Overdose Crisis, and Unintended Harms in the US:
  - *But in March 2018, Higginbotham's medical provider said he would be reducing her opioid medications by 75 percent to get her down to a dose he said was recommended in a guideline from the US Centers for Disease Control: 90 milligram equivalents of morphine. He told Human Rights Watch he believed Higginbotham had done well on the medication, but that his clinic was implementing a new policy over fears they could be held liable for high-dose opioid prescriptions:*
- National Cancer Institute: Opioid Use Drops among Cancer Patients at End of Life
  - *People with cancer nearing the end of their life are not getting needed opioids to control their pain, a new study indicates.*
  - *Beginning in the 2010s, many US states began enacting regulations to curb inappropriate opioid prescribing amid a growing epidemic of opioid overdose deaths. An unintended consequence of these regulations is that it became much harder for people with cancer to access pain medications, even at the end of life.*

From an economic standpoint, third parties often do not reimburse for the time and expertise to treat pain patients properly and effectively, creating a debilitating challenge for chronic pain patients. While addressing these systemic issues is outside the purview of this audit, we strongly urge you to consider how the recommendation to give the SAO access to clinical data might hasten the chilling effect on the treatment of pain patients in our state.

Fund a better approach: Better Prescribing, Better Treatment Collaborative (BPBT)

The BPBT collaborative is a peer-to-peer, clinician-driven, patient-centered, quality improvement program that promotes safe, appropriate prescribing to curb opioid misuse and overdose. The program is an innovative, public-private collaboration between Washington's Health Care Authority, the state Department of Health, the WSMA and the Washington State Hospital Association (WSHA).

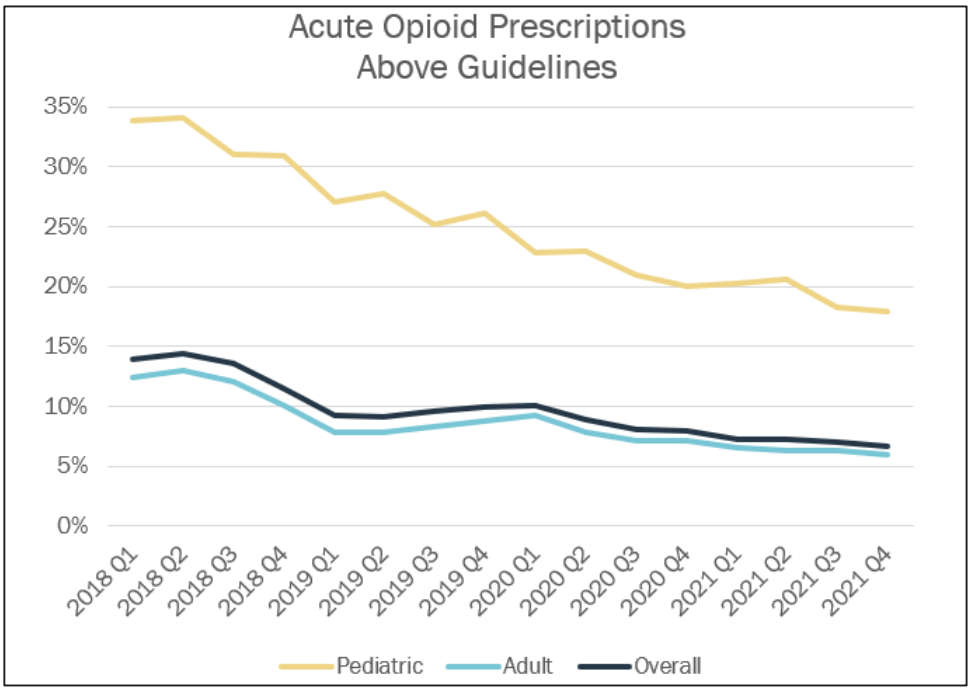
The Collaborative has significantly improved opioid prescribing behaviors and resulting patient care and outcomes by focusing upstream on acute prescribing and preventing inappropriate transitions to subacute and chronic prescribing.

The BPBT program promotes safe prescribing in three ways:

- **Washington State Opioid Prescribing Reports:** Each quarter, the WSMA sends prescribers in the state that are members of the Collaborative an opioid prescribing feedback report. Using data from the state PMP, the report shows how their opioid prescribing practices compare to others in their hospital, health system, or medical group, as well as within their specialty. Understanding where their prescribing patterns are relative to peers forces critical thinking and conversations around improving pain management.
- **Opioid Management Coaching Program:** In partnership with the University of Washington Six Building Blocks program, the WSMA offers coaching services on improving systems in primary care clinics to deliver more evidence-based chronic pain care and opioid management.
- **CMO Reports:** The collaborative disseminates reports to chief medical officers who want to understand the prescribing practices of their staff and implement focused plans to improve outcomes for patients.

The initiative encompasses 11,000+ prescribers with 60 hospitals, health systems, and medical groups in the state.

Collectively, opioid prescriptions above guidelines have been reduced by 46% since 2018. Pediatric above guideline acute opioid prescribing has reduced from 34% (2018) to 18% (2021), adults from 14% (2018) to 6% (2021) and adults 65 years/>, 19% (2018) to 9% (2021).



Despite the proven success of this collaborative, the SAO does not recommend to the Legislature that it fund the work to sustain and expand a program that seeks to reduce inappropriate prescribing while maintaining access for patients that need them.

Instead, the SAO includes a recommendation to the DOH that it create a work group to explore how to expand the program to include more provider types in more settings, and work on co-prescribing of controlled substances, and chronic pain management. These are goals the collaborative shared with the SAO and have been working toward for several years. The barrier to expanding the program is not the lack of a work group; it is a lack of funding. WSMA urges the Legislature to fund this patient-centered approach to improving pain management outcomes.

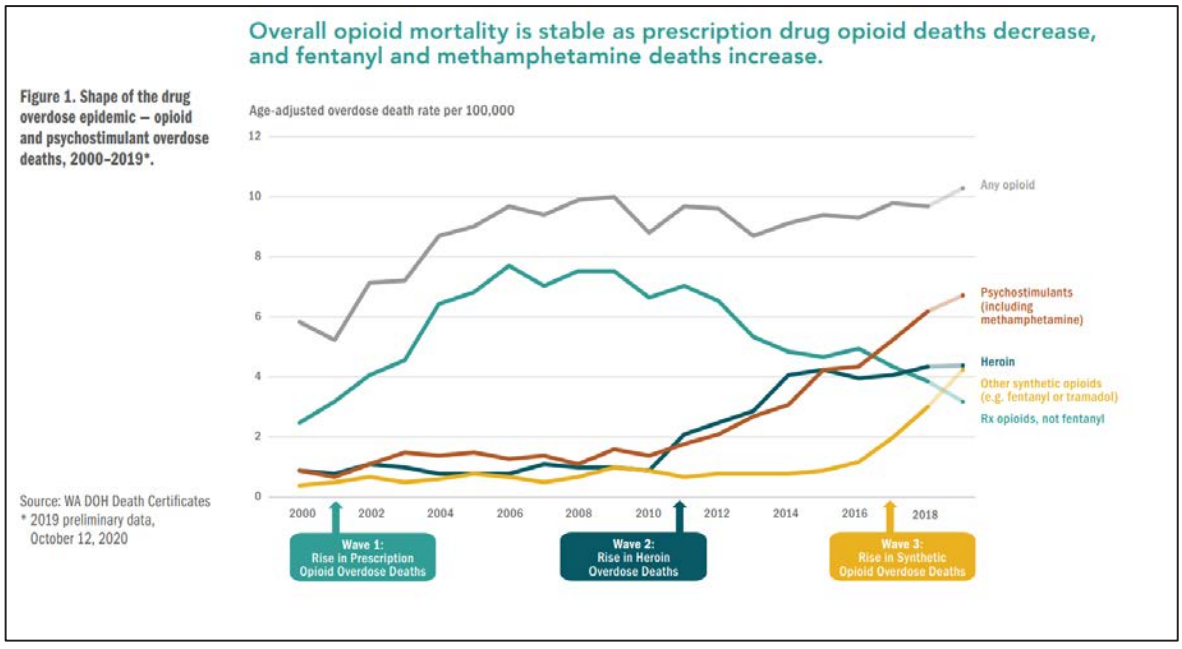
<u>The epidemic is evolving</u>

State efforts going forward should acknowledge the evolving nature of the opioid epidemic and pinpoint effective policies that reduce inappropriate opioid prescribing without creating barriers for patients who benefit from appropriate pain management that may include the use of opioids.

It should also be noted that emerging data is challenging the long held popular narrative of people starting on prescription drugs and then moving to heroin. According to a 2017 study released by Addictive Behaviors in 2005 only 8.7% of opioid initiators started with heroin, but this sharply increased to 33.3% ($p<0.001$) in 2015, with no evidence of stabilization. The use of commonly prescribed opioids, oxycodone and hydrocodone, dropped from 42.4% and 42.3% of opioid initiators, respectively, to 24.1% and 27.8% in 2015, such that heroin as an initiating opioid was now more frequently endorsed than prescription opioid analgesics.

The authors concluded as *the most prescribed opioids -hydrocodone and oxycodone - became less accessible due to supply-side interventions, the use of heroin as an initiating opioid has grown at an alarming rate. Given that opioid novices have limited tolerance to opioids, a slight imprecision in dosing inherent in heroin use is likely to be an important factor contributing to the growth in heroin-related overdose fatalities in recent years.*

This trend is supported by Washington DOH data:



Inappropriate utilization of opioids is still a contributing factor to the epidemic that must be addressed by leveraging data, continued education, and improved pain management techniques the state currently supports. The intervention recommended by the SAO does not consider recent trends and mischaracterizes the epidemic as it exists today. At this stage in the epidemic, attention and resources must be allocated to stemming the supply of illicit opioids.

We understand the SAO's desire to help address the challenges created by the opioid epidemic. However, we believe the recommendation to give the SAO access to clinical data in the PMP and allowing the agency to "identify trends" without disclosing metrics or methods, with no access to the medical record, and referring physicians and other practitioners to their respective disciplinary body is the wrong approach. Enacting such a recommendation does not heed any of the lessons policy makers and the physician community have learned trying to address the opioid epidemic over the past decade.

Our continued success as a community at ensuring pain is treated appropriately in our state is contingent on adequately supporting and funding the programs and strategies currently in place, such as the BPBT collaborative. We urge the Legislature to fund these initiatives and reject the SAO's request for access to clinical data.

Thank you for the opportunity to provide comment. Should you have any questions, please never hesitate to reach out to WSMA Director of Policy Jeb Shepard at jeb@wsma.org.

Sincerely,

Jennifer Hanscom
Executive Director/CEO
Washington State Medical Association

State Auditor's Response

As part of the audit process, our Office provides a final draft of reports to audited entities and offers management an opportunity to respond. For this audit, these organizations were:

- The Department of Health, including the prescribing boards and commissions
- The Washington State Hospital Association
- The Washington State Medical Association

Those responses are included in every published audit report. In this case, the responses expressed some areas of concern and disagreement, which are included on pages 42-64 of this report. We summarize these concerns below, with our responses.

Granting SAO access to identifiable PMP data

In response to Recommendation No. 1, management from each of the entities involved in the audit stated they have concerns about the State Auditor's Office obtaining access to identifiable PMP data.

Auditor's Response

We appreciate and acknowledge the concerns each organization raised about the sensitivity of identifiable PMP data. We have a statutory mandate to conduct performance audits of government programs. This often requires us to access sensitive and confidential data from a variety of government agencies. In this audit, we identified two types of analyses that we could not conduct because we could not access the necessary data. First, we could not assess some system controls or fully identify pharmacy processes used to comply with PMP mandates. Second, we could not assess data trends to identify potential cases of overprescribing and doctor shopping. When auditors have access to such data, the public is assured of an independent review of government systems that are essential to supporting public health and safety.

Due to the level of their concern, we want to provide further clarity on certain areas.

1. **SAO will not publicly disclose any confidential health or clinical information received through the PMP program**

   When the Auditor's Office works with sensitive data such as health records, it is not added to the public record because such data is already protected health information under the Healthcare Insurance Portability and Accountability Act and Washington's data classification system. Consequently, this information would not be released to the public nor to any other unauthorized personnel within our agency or state government. Additionally, public records request protections for PMP data that are in place for DOH also apply to our Office: we cannot disclose any PMP data that DOH cannot disclose. Furthermore, while our audit activities require examining confidential data, we report only summary results that protect confidentiality. We have protocols in place to ensure we safeguard any data provided for audit, following the Office of the Chief Information Officer standards and properly disposing of it after the required records retention period.

2. **SAO would hire a subject matter expert with clinical expertise to assist with an analysis of overprescribing and doctor shopping**

   SAO has a practice of ensuring audits are informed by professionals with expertise in their fields, and have done so in the past when auditing medical or other highly technical fields. For any future audit of prescription monitoring records, for example, we would anticipate hiring a subject matter expert (SME) with clinical expertise to help inform our analysis and interpretation of the data.

3. **SAO could use the data to evaluate DOH oversight and identify concerning prescribing and dispensing patterns in the data**

   How we use the data in the future would depend on the audit's objectives. Access to this data would allow us or another outside auditor to examine issues such as potential instances of doctor shopping, unusually high quantities of opioids prescribed, or dangerous combinations of drugs prescribed.

   At the end of such an audit, we would review the results of this analysis with DOH. Audits are time-bound, so any audit review of the data would not be ongoing. The State Auditor's role is to identify issues and make recommendations for the Legislature and audited agency to consider. It is possible the Legislature or audited agency could determine that monitoring PMP data in this way would be an effective approach to improving patient and public safety.

4. **SAO was not able to examine the outcomes of audits in other states due to how recently they had been conducted**

   This audit did not examine the outcomes of other states' audit recommendations related to opioid prescription monitoring because the audits were conducted quite recently. The other states' audit results themselves, however, indicate potential areas for examination that Washington could benefit from.

Establishing a workgroup to discuss the needs of the Better Prescribing, Better Treatment Collaborative

In response to Recommendation No. 14, management from each audited organization disagree with the recommendation for the Department of Health (DOH) to establish a workgroup to discuss the needs of the Better Prescribing, Better Treatment Collaborative and to serve in an advisory role.

Auditor's Response

We understand each organization's perspective about the clear delineation of roles in that DOH is the lead state health agency. As we envisioned this workgroup, DOH's role would be limited to coordinating the workgroup and consulting with members when needed to help it achieve its goals. The Collaborative would lead the workgroup discussions and decide when to seek out advice or state-level resources from DOH. One of the workgroup's key functions would be to involve other professions to help expand the reports to other health care providers. We think not moving forward with this recommendation would be a missed opportunity to help expand and further enhance the opioid prescribing reports that help prescribers reflect on and adjust their prescribing behaviors.

Reviewing a pharmacy's uploading history before approving a waiver

In response to Recommendation No. 10, management from DOH disagrees with the recommendation that agency staff should review a pharmacy's uploading history before it approves a waiver.

Auditor's Response

We understand DOH's concerns and agree that having a system solution in place would supersede the need for staff to look at a pharmacy's uploading history. However, because such a solution does not currently exist, we recommend the agency implement the process until such time as an automated system is in place.

Providing reports to pharmacies so they can perform a reconciliation and the Pharmacy Commission can review them during their inspections

In response to Recommendations No. 13, 16 and 17, management from DOH disagree with the recommendation to provide reports to pharmacies so they can perform a reconciliation between the records submitted to the PMP system and their own records. In addition, the Pharmacy Commission disagrees with the recommendations to review in its inspections whether pharmacies have completed this reconciliation and to assess the resources needed for this review.

Auditor's Response

We understand DOH's and the Pharmacy Commission's concerns and acknowledge that DOH does plan to work with the Pharmacy Commission to explore the feasibility of this recommendation in terms of Commission and individual pharmacy resources. In Washington, most pharmacies use an automated process to upload their prescription records to the PMP. Consequently, having a process in place to reconcile the number of controlled substance records in the pharmacy system to the PMP system would allow a pharmacy to detect and address any system issues early on.

Appendix A: Initiative 900 and Auditing Standards

Initiative 900 requirements

Initiative 900, approved by Washington voters in 2005 and enacted into state law in 2006, authorized the State Auditor's Office to conduct independent, comprehensive performance audits of state and local governments.

Specifically, the law directs the Auditor's Office to "review and analyze the economy, efficiency, and effectiveness of the policies, management, fiscal affairs, and operations of state and local governments, agencies, programs, and accounts." Performance audits are to be conducted according to U.S. Government Accountability Office government auditing standards.

In addition, the law identifies nine elements that are to be considered within the scope of each performance audit. The State Auditor's Office evaluates the relevance of all nine elements to each audit. The table below indicates which elements are addressed in the audit. Specific issues are discussed in the Results and Recommendations sections of this report.

I-900 element	Addressed in the audit
1. Identify cost savings	**No.** This audit focused on public health and safety, and did not identify cost savings directly related to the Prescription Monitoring Program (PMP).
2. Identify services that can be reduced or eliminated	**No.** This audit did not identify services that can be reduced or eliminated.
3. Identify programs or services that can be transferred to the private sector	**No.** The Department of Health (DOH) already contracts with Bamboo Health in the private sector to provide data-management software for the PMP system.
4. Analyze gaps or overlaps in programs or services and provide recommendations to correct them	**Yes.** This audit looked for gaps or overlaps in interactions between multiple agencies and organizations, including: DOH as the administrator of the PMP; the boards and commissions that are the regulatory authorities of the medical professions; the hospital and medical associations that oversee the Better Prescribing, Better Treatment Collaborative, which distributes opioid prescribing reports to some prescribers.

I-900 element	Addressed in the audit
5. Assess feasibility of pooling information technology systems within the department	**No.** The PMP system already connects to the Health Information Exchange at the Health Care Authority.
6. Analyze departmental roles and functions, and provide recommendations to change or eliminate them	**Yes.** This audit looked at the completeness, accuracy and timeliness of PMP data, which is designed to give health care providers the information they need to make good decisions about patient care. It also looked at whether opioid prescribing reports in the Better Prescribing, Better Treatment Collaborative can be expanded to other professions.
7. Provide recommendations for statutory or regulatory changes that may be necessary for the department to properly carry out its functions	**Yes.** The audit reviewed DOH's administrative rules to see if changes are needed to make the program more effective.
8. Analyze departmental performance data, performance measures and self-assessment systems	**No.** The audit did not review performance measures.
9. Identify relevant best practices	**Yes.** The audit looked at leading practices related to prescription monitoring programs.

Compliance with generally accepted government auditing standards

We conducted this performance audit under the authority of state law (RCW 43.09.470), approved as Initiative 900 by Washington voters in 2005, and in accordance with generally accepted government auditing standards as published in *Government Auditing Standards* (July 2018 revision) issued by the U.S. Government Accountability Office. Those standards require that we plan and perform the audit to obtain sufficient, appropriate evidence to provide a reasonable basis for our findings and conclusions based on our audit objectives. We believe that the evidence obtained, with one exception described below and on pages 31-35, provides a reasonable basis for our findings and conclusions based on our audit objectives.

As discussed in that section of our report, state law limited our access to data that included individual pharmacies, patients and prescribers. As a result, we were not able to fully perform audit testing to obtain evidence about whether the state's PMP system could be used to monitor opioid prescribing and dispensing patterns. In addition, we were not able to review whether some pharmacies were persistently late in our analysis of submission timeliness, nor could we review DOH's process for updating pharmacy contact information in the PMP system.

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Appendix B: Objectives, Scope and Methodology

Objectives

The purpose of this performance audit was to identify potential improvements to the Prescription Monitoring Program (PMP) that would improve data quality and help reduce the risk of misuse and abuse of prescription opioids. The audit addressed two objectives:

- Is the program data sufficiently complete, accurate and timely to meet the needs of prescribers and other users when making decisions about patient care?
- Could the state's PMP system be used to monitor opioid prescribing and dispensing patterns and help reduce opioid abuse and misuse

For reporting purposes, the audit results have been organized into key findings as follows:

1. The Department of Health (DOH) needs a more comprehensive process to ensure PMP data is sufficiently complete and timely to meet the needs of prescribers who are making decisions about patient care.
2. Improving and expanding opioid prescribing reports to more medical professionals could help provide better patient care.
3. State law does not allow DOH to share PMP identifiable data for the purpose of independent oversight of the program.

Scope

For objective 1, this audit examined issues of PMP data quality and completeness by assessing DOH's compliance activities, analyzing de-identified PMP data, and other activities.

- This audit could not determine how many prescription records were missing from the PMP or how accurate PMP records were because doing so would require comparing PMP records to pharmacies' records. We had limited access to the former, and no access to the latter.
- We analyzed PMP data to determine the overall timeliness of PMP submissions. However, we could not determine if late record submissions were concentrated among a small number of pharmacies or were a broader phenomenon because we could not obtain data with pharmacy identifiers, as described on pages 17-18 and 34.

- We could not confirm that DOH reviews the pharmacy table and fills in missing fields for pharmacies due to data restrictions. This review is a foundational aspect of the PMP system because the names and contact details in this table feed the system's automated messages that are sent to pharmacies (as described on page 34).
- We could not observe how pharmacists enter and upload prescription information to the PMP. This is because doing so would have required us to look at their computer screens, which contain identifiable information we were not authorized to view.

For objective 2, this audit examined ways that opioid prescribing reports can be improved or expanded, primarily through interviews with the Better Prescribing, Better Treatment Collaborative and DOH. The reports fit under objective 2 because they were designed to help medical professionals monitor their own prescribing practices and make safer prescribing decisions.

- We took this approach because we could not legally access PMP data with patient and prescriber identifiers, as described on pages 31-33, and so we could not conduct the analysis we had originally planned.

In addition, this audit did not look at general PMP usage or access. For example, we did not determine how many prescribers use the PMP with what frequency, or what systems prescribers use to access the PMP database. Nor did this audit look at DOH's compliance activities around requirements that prescribers check the PMP when prescribing controlled substances.

Methodology

We obtained the evidence used to support the findings, conclusions and recommendations in this report during fieldwork conducted during October 2021 through May 2022, with some additional follow-up work afterward. We have summarized the work performed to address the audit objectives in the following sections.

Objective 1: Is program data sufficiently complete, accurate and timely to meet the needs of prescribers and other users when making decisions about patient care?

To determine whether PMP data was complete, accurate and timely to meet the needs of prescribers and other users, we first evaluated the system controls in place. We interviewed staff at DOH and at Bamboo Health and had them demonstrate the system's operations to determine if it had controls in place to prevent problematic data entering the system. These controls serve to limit mistakes such as leaving required fields blank and duplicating patient information. We did not review any pharmacy systems in this audit to evaluate how they process information. We limited our review to examining what happens once the data is uploaded to the PMP system, and how the system processes records and sends automated notifications to pharmacists.

Next we interviewed staff at DOH and at the Pharmacy Commission to determine what processes were in place to ensure pharmacies were submitting data, correctly and on time. Then we obtained data from DOH and its PMP contractor to evaluate whether pharmacies submitted data on time, the number of uncorrected errors outstanding in the system, and the number of waivers granted to pharmacies.

Submission timeliness

To evaluate pharmacy submission timeliness, we obtained data from DOH that showed the date a prescription was filled, the date it was sold, the date the information was submitted to the PMP, the date the information was uploaded to the PMP, and the date of the prescription record's last update. The data had two limitations:

- First, the data did not include any direct or indirect pharmacy identifiers, so we had to make assumptions about when a pharmacy would be open.
- Second, about a quarter of the records did not include a "sold at" date. This is because Washington does not require pharmacies to include this date when submitting records to the PMP. We do not know if the pharmacies that did not include a "sold at" date used the "filled at" date to represent when they gave the prescription to the customer or when they filled it behind the counter. Further, a pharmacy could have submitted a prescription to the PMP prior to giving it to the customer. These are important distinctions because Washington law requires prescriptions to be submitted to the PMP within one business day of "distributing," which we understood to mean giving the prescription to the customer. Pharmacies can submit records before distributing prescriptions.

To address these limitations, we created a high-end range and a low-end range for submission timeliness. The number reported on page 17 is the median of these two ranges.

Low-end estimate: We excluded any record from our analysis that was missing data in the "date sold" field. The estimate also assumed most pharmacies were only open Monday through Friday. However, if the prescription was filled, sold or submitted to the PMP system on a Saturday or a Sunday, we considered these business days because the weekend activity indicated the pharmacy was open. Similarly, if we observed activity on a Sunday, we considered Saturday a business day as well. Because we did not have any pharmacy identifiers, we could not identify if a particular pharmacy had activity on a given day to indicate it was open, only if that specific prescription had activity. Therefore, this is an ***underestimate*** of late records.

To determine the reasonableness of the assumptions in the low end of the range, we sampled 50 pharmacies and used web searches to determine their operating hours. In our sample, only one pharmacy was closed on any regular weekday, and nearly 80 percent of pharmacies were open on Saturday. Sixty percent of pharmacies were open on Sunday, and all pharmacies that were open on Sunday were also open on Saturday.

High-end estimate: We included all records in the analysis, whether they had data in the "date sold" field or not. If the record was missing data in the "date sold" field, we treated the "date filled" date as the "date sold" date. We also considered all pharmacies to be open seven days a week, so one business day equalled one day. Since we know that only about 60 percent of pharmacies are open on Sunday, and that "date filled" does not always equal "date sold," this is an ***overestimate*** of the number of late records.

Using this approach, we determined that between 21 percent and 28 percent of records could be considered late because they were submitted to the PMP two or more days after the prescription was sold. On page 17, we use the median of these two numbers: 25 percent.

Waivers

DOH provided a report on the number of waivers applied for and granted. We used this report to determine the number of active PMP submission waivers in the state.

Interviews with other states

We interviewed prescription drug monitoring program administrators in ten other states (listed in **Figure 1**) to learn about their programs.

We selected this sample based on a targeted mixture of practices identified by nationwide studies, the existence of audit reports that were comparable to our own, and similarity to Washington in terms of population and severity of the opioid epidemic. We learned eight states will provide pharmacies that do not dispense controlled substances with a waiver from reporting. Three of these states perform some type of monitoring to see if the pharmacies should receive or maintain a waiver.

Figure 1: Interviewed state PMP programs

State	Issues waiver from reporting	Monitors to verify waiver status
Colorado	Yes	Yes
Connecticut	No	Not applicable
Iowa	Yes	No
Kentucky	Yes	No
Maryland	Yes	No
Massachusetts	Yes	Yes
Minnesota	Yes	Yes
New Jersey	Yes	No
Oregon	No	Not applicable
Wisconsin	Yes	No

System controls evaluation

We tested a selection of automated system controls with assistance from staff from Bamboo Health to determine if they were working effectively. These are automated system checks that provide some assurance that prescription records are complete and accurate, based on system specifications, before being uploaded to the PMP database with the exception of the patient consolidation process that occurs after it is uploaded. We conducted this work in a test environment set up by Bamboo Health. This allowed us to test different scenarios in the system to see if they were working as intended. We tested the following automated system checks:

- Error detection processes that identify and isolate missing or invalid data
- Data normalization tools that use lookup tables to populate provider and prescriber names and addresses based on their Drug Enforcement Agency number ensuring consistency of data
- Patient consolidation processes that combine records under one patient ID when certain criteria are met

Additionally, we confirmed that the system sends emails to notify pharmacies of the status of their submissions. The system has built-in alerts to ensure that pharmacists are notified about both the

status of the file they submitted or that no file has been received. We tested the following automated notifications related to the file submissions:

- File submission failure – This alerts the submitter that the entire file failed to process due to an incorrect file format.
- File status – This notifies the submitter that the file processed. It also includes a list of errors and the number of records received by the system.
- Delinquency in submitting prescription data – This notification is emailed when a pharmacy has not submitted a file within a 24-hour period.

Uncorrected errors

We received a report from DOH and its contractor, Bamboo Health, showing the number of errors that had not yet been corrected in the system at a given point in time. The system wipes records that are more than a year old, so the report only showed errors that remained uncorrected for up to one year. We used that report to determine the total number of uncorrected errors and the distribution of errors by date and pharmacy.

Objective 2: Could the state's PMP system be used to monitor opioid prescribing and dispensing patterns and help reduce opioid abuse and misuse?

To address this objective, we conducted three activities:

1. Interviews with key stakeholders
2. Conducted background research on the history and method of opioid prescribing reports in Washington
3. Examined information on the percentage of prescribers who receive opioid reports

Interviews with key stakeholders

We sought to understand the Better Prescribing, Better Treatment Collaborative, how it operates, and how many prescribers it serves. To do this, we interviewed staff at DOH, the Washington State Medical Association and the Washington State Hospital Association. To learn if other prescribing professions were receiving and valued opioid prescribing reports, we contacted several state associations and ultimately spoke with four: Advanced Registered Nurse Practitioners United of Washington, Washington State Dental Association, Washington State Podiatric Medical Association and Optometric Physicians of Washington. We also asked the regulatory licensing boards and commissions that oversee the professions that prescribe opioids (listed in the sidebar with the relevant RCWs) for their perspectives on opioid prescribing reports.

Washington boards and commissions overseeing health care professions with prescribing authority

Dental Quality Assurance Commission (RCW 18.32.800)

Medical Commission (RCW 18.71.800 and RCW 18.71A.800)

Nursing Care Quality Assurance Commission (RCW 18.79.800)

Board of Osteopathic Medicine and Surgery (RCW 18.57.800)

Podiatric Medical Board (RCW 18.22.800)

Additionally, we interviewed prescription drug monitoring program managers in 10 other states (listed in Figure 1) to determine whether they use provider reports and how beneficial they find them.

Conducted background research on the history and method of opioid prescribing reports in Washington

We reviewed documents on the internet about how opioid prescribing reports currently work, as well as their history.

Examined information on the percentage of prescribers who receive opioid prescribing reports

We requested data from the Washington State Hospital Association that showed the number of prescribers who received opioid prescribing reports compared to the number of prescribers who had prescribed opioids in our state. The data we received had some limitations, including that it is self-reported and covers a long timeframe (January 2018 through September 2021). We were not able to verify this data independently. For these reasons, we recognize there may be some variation in the numbers reported.

Work on internal controls

We evaluated the internal controls around pharmacy submissions in this audit that were significant to our first audit objective. First, we evaluated the system controls as discussed above to determine if the system was designed to effectively prevent erroneous or incorrectly formatted data from entering the PMP and also to send automated notifications to pharmacists. Then we interviewed representatives from the Pharmacy Commission and DOH to determine their monitoring practices over pharmacy submission compliance.

Appendix C: Percent of providers receiving opioid prescribing reports

Figure 2 presents the top 30 opioid prescribing professions in the state and the total number of opioid prescriptions written from January 2018 through September 2021. Across all professions, an average of 39 percent of prescribers received reports from the Better Prescribing, Better Treatment Collaborative, which includes specialties not listed in the table. Some specialties that have a high amount of opioid prescribing, including internal medicine, nurse practitioners and dentistry, receive opioid prescribing reports below the average rate of 39 percent.

Figure 2: Percent of providers receiving opioid prescribing reports

Specialty	Total opioid prescriptions	Percent of providers receiving reports	Total providers prescribing opioids
Family Medicine	5,039,474	49%	5,456
Internal Medicine	2,859,228	37%	7,335
Nurse Practitioner	2,662,480	32%	5,254
Physician Assistant	2,275,769	42%	3,646
Dentistry	1,073,736	1%	5,516
Emergency Medicine	752,895	52%	1,752
Pain Medicine	587,571	46%	147
Surgery Orthopedic	576,126	57%	948
Physical Medicine And Rehabilitation	416,614	48%	391
Obstetrics / Gynecology	280,936	67%	1,115
General Surgery	262,014	61%	777
Hematology Oncology	143,472	83%	187
Pharmacist	139,182	5%	305
Surgery Otolaryngology	132,046	59%	365

Figure 2: Percent of providers receiving opioid prescribing reports, *continued*

Specialty	Total opioid prescriptions	Percent of providers receiving reports	Total providers prescribing opioids
Podiatry	119,245	68%	397
Surgery Urologic	116,169	59%	346
Anesthesia	98,393	44%	268
Surgery Plastic	87,842	57%	183
Psychiatry	87,270	23%	595
Neurology	56,601	60%	343
Surgery Neurologic	40,108	59%	177
Pediatric Medicine	37,792	53%	1,222
Ophthalmology	37,315	64%	443
Other (Unable to Classify)	33,165	4%	553
Gastroenterology	25,070	69%	398
Surgery Vascular	24,088	50%	217
Dermatology	20,850	73%	313
Radiology	20,010	56%	284
Certified Nurse Midwife	17,646	64%	345
Cardiology	16,256	68%	459

Source: Washington State Hospital Association.

Appendix D: Audits in other states

We found that auditors in other states used PMP data to identify prescribing and dispensing patterns of concern. Audits conducted in Colorado, Louisiana and Oregon used prescription monitoring data to identify issues such as potential instances of doctor and pharmacy shopping and dangerous combinations of drugs prescribed. Please note that we did not examine the subsequent outcomes of these audits and whether their recommendations were implemented. Our Bibliography provides links to the original audit reports.

Three audits conducted in other states identified potential instances of doctor and pharmacy shopping. **Figure 3** shows the audit approach, findings and data required to conduct these analyses.

Figure 3: Audits in three states identified doctor and pharmacy shopping

State	Approach	Finding	Data required that is not available to SAO
Colorado	Looked at patients who received opioids from 10+ prescribers in two years	8,700 patients who filled opioid prescriptions	1. Prescriber identifiers 2. Patient identifiers
Louisiana	Looked at patients who received controlled substance prescriptions written by 4+ prescribers and filled by 4+ pharmacies in one month	1,393 patients with controlled substance prescriptions	1. Prescriber identifiers 2. Patient identifiers 3. Pharmacy identifiers
Oregon	Looked at patients who received controlled substance prescriptions from 30+ prescribers filled by 15+ pharmacies over 3 years	148 patients with controlled substance prescriptions	1. Prescriber identifiers 2. Patient identifiers 3. Pharmacy identifiers

Two audits conducted in other states identified potentially dangerous co-prescribing. **Figure 4** shows the audit approach, findings and the data required to conduct these analyses.

Figure 4: Audits in two states examined the frequency of co-prescribing with drugs that can be dangerous when mixed with opioids

State	Approach	Finding	Data required that is not available to SAO
Colorado	Looked at patients prescribed a benzodiazepine who already had an opioid from a different prescriber and patients prescribed an opioid who already had a benzodiazepine from a different prescriber	12,839 who were on an opioid prescribed a benzodiazepine 17,420 who were on a benzodiazepine prescribed an opioid	1. Prescriber identifiers 2. Patient identifiers
Oregon	Looked at patients who were prescribed opioids, benzodiazepines, and muscle relaxers within a one-month period	4,270 prescribed all three within a one-month period	1. Patient identifiers

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Washington State Department of Health. Prescription-related Risk Factors for Prescription Opioid Overdose Deaths in Washington State. By Jian Gong, Fan Xiong, and Mariana Rosenthal. Olympia, W.A., publication date not available. Report available upon request from the Department of Health.

Washington State Health Care Authority. 2021-2022 Washington State Opioid and Overdose Response Plan. Olympia, WA, 2021. https://www.hca.wa.gov/assets/program/WashingtonStateOpioidandOverdoseResponsePlan-final-2021.pdf

"Our vision is to increase **trust** in government. We are the public's window into how tax money is spent."

– Pat McCarthy, State Auditor

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Presented by:
Carma Matti-Jackson
President/CEO
Washington Health Care Association
T (800) 562-6170, ext. 101

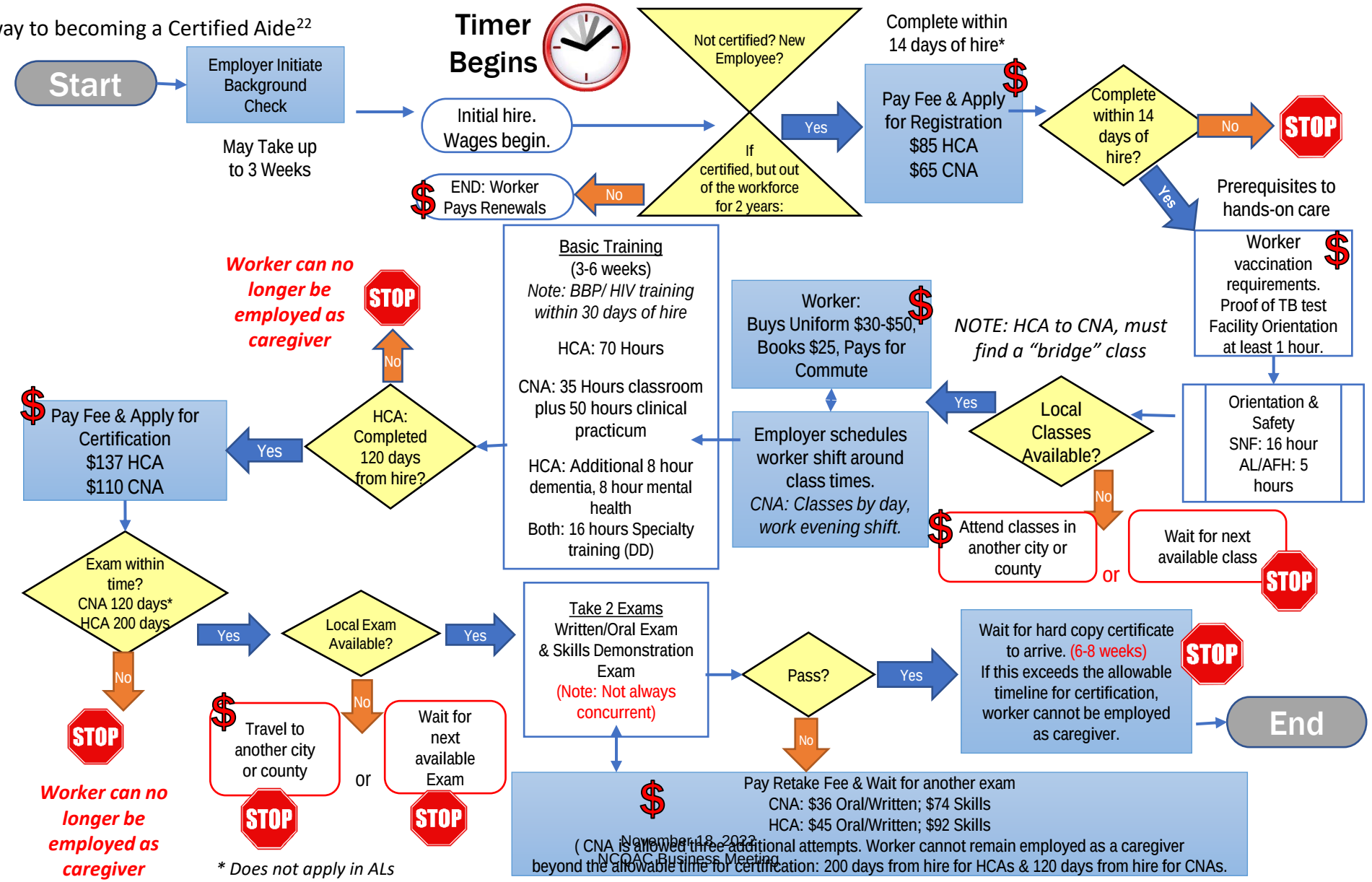
Long-term Care Workforce & Economic Trends & Conditions

Nursing Care Quality Commission
November 18, 2022

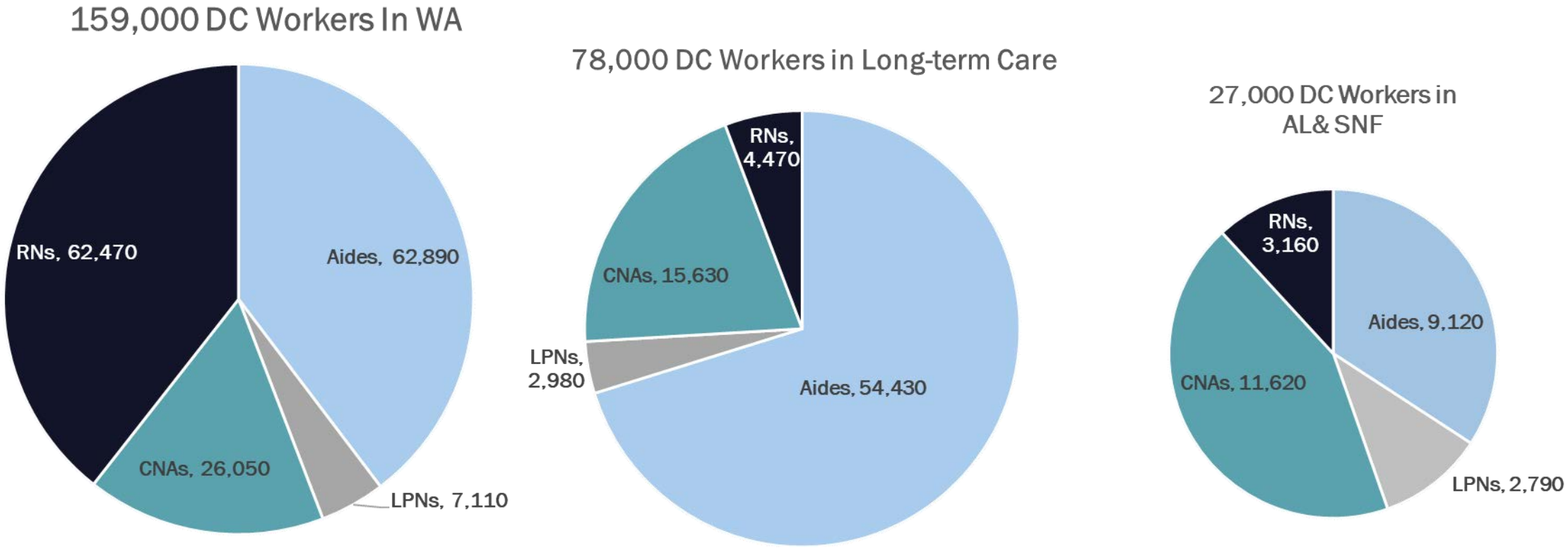
Remember When?

"The LTC Workforce Pipeline is Complicated"

Example: Pathway to becoming a Certified Aide[22]



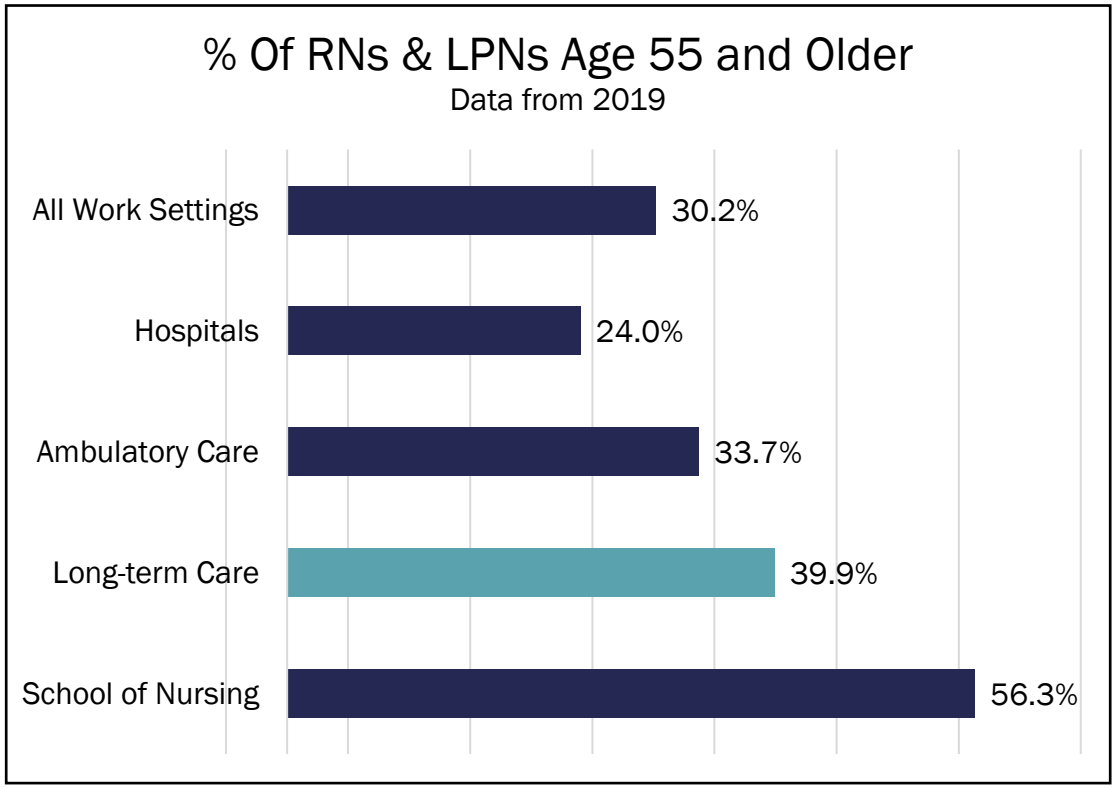
Long-term Care Accounts for 49% of Washington's Direct Care Workforce

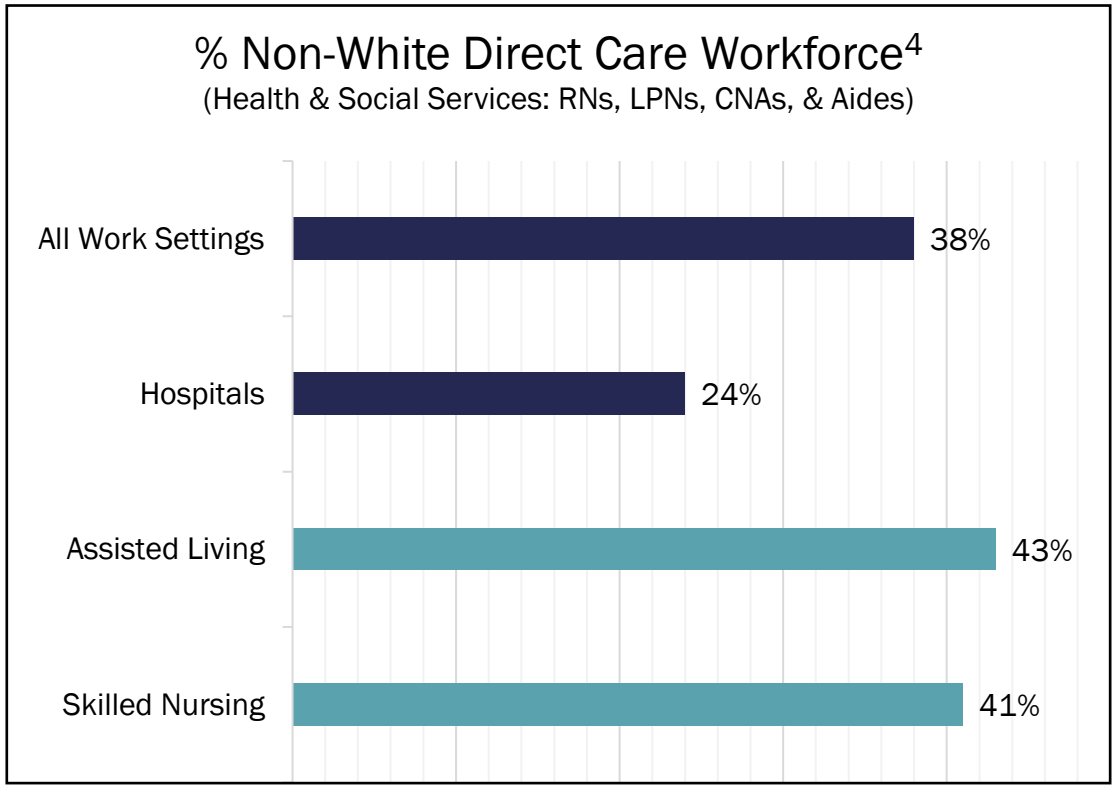


Source: May 2021, Occupational Employment & Wage Statistics, Bureau of Labor Statistics
Direct Care (DC) workers include: Homecare & Personal Care Aides (Aides), Nursing Assistants (CNAs), Licensed Practical Nurses (LPNS), & Registered Nurses (RNs)

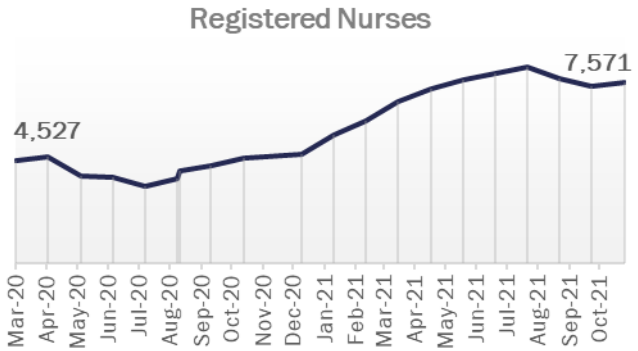
WA's Long-term Care Workforce is More Diverse and Aging More Rapidly Than Other Work Settings

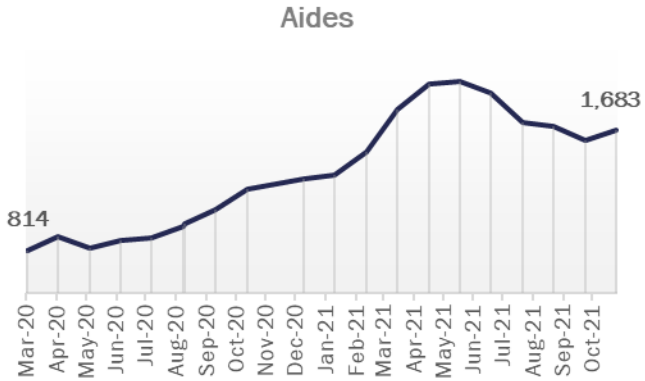
WA's SNF/AL workforce is 88% female[2], highly diverse, and experiencing large scale retirements at a pace that is more rapid than healthcare as a whole.

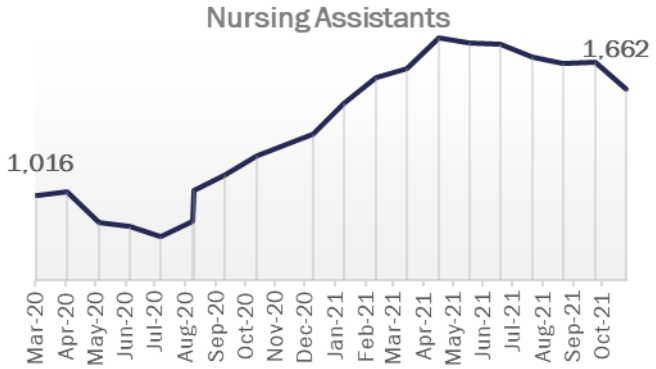


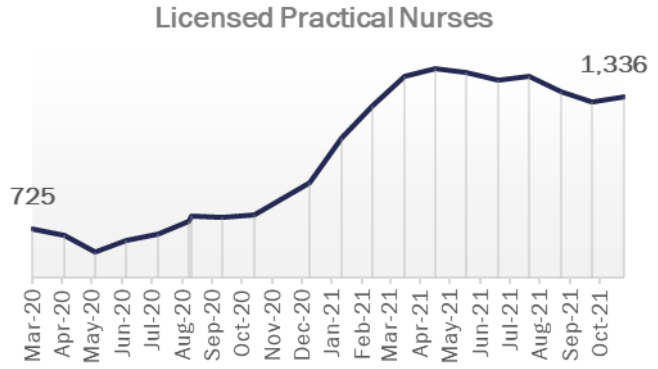


With COVID, Monthly Postings for Direct Care Workers Has Grown Significantly









Job Openings Have Grown Since March of 2020 By:

67% for RNs

84% for LPNs

64% for CNAs

107% for Aides

Source: Employment Security Department, Labor Market & Economic Analysis. Total Job Postings March 2020 – November 2021.

The Conference Board® Burning Glass® Help Wanted OnLine™ data series.

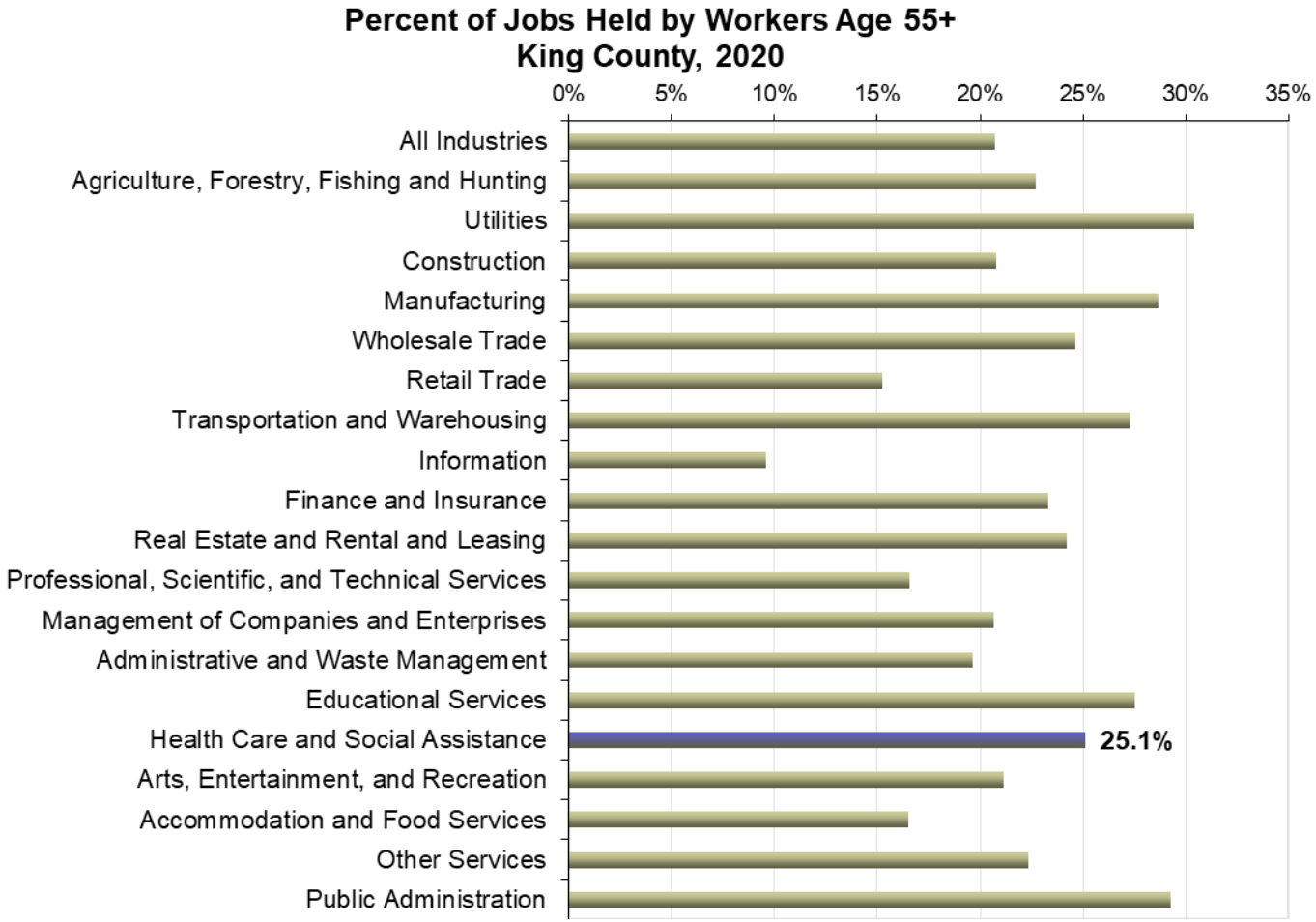
Providers Struggle With High Turnover Rates in Washington

Occupational Title	Estimated Employment 2021Q2	Average Annual Total Openings 2019Q2-2021Q2	Average Annual Openings Due to Replacement 2019Q2-2021Q2	Estimated Annual Rates of Turnover
Registered Nurses	61,845	17,188	16,088	**26%**
Licensed Practical Nurses	8,408	3,024	2,972	**35%**
Personal Care Aides	68,139	26,926	25,578	**38%**
Certified Nursing Assistants	36,520	13,782	13,413	**37%**
Total	**174,912**	**60,920**	**58,051**	**33%**

- **The "Great Resignation"**- Rates of Retirement Doubled in 2020.
- **Market Place Competitors**
  - Better Pay
  - More Flexibility
  - Less Training
  - Less Intense Lines of Work
- **It's an Employee's Market**
  - Life Balance. Ample career choices and workplaces.
- **Employee Burnout**
  - The more the employee pool is stretched, the more stressful these jobs become: Overtime, double shifts, pandemic fatigue, childcare challenges

Source: Employment Security Department, Data Architecture, Transformation, and Analytics.
Jeff Robinson, Current Labor Force Statistics Manager. File: "LongTermCare_ESD Information_2021"

31,000 Health Care & Social Service Workers in King County are Nearing Retirement



7% of King County Health Care and Social Services Workers are 65 or Older. That's just under 13,000 workers.

Source: Local Employment Dynamics Database, Housing Department Reports. King County Labor Market Profile Spring 2021

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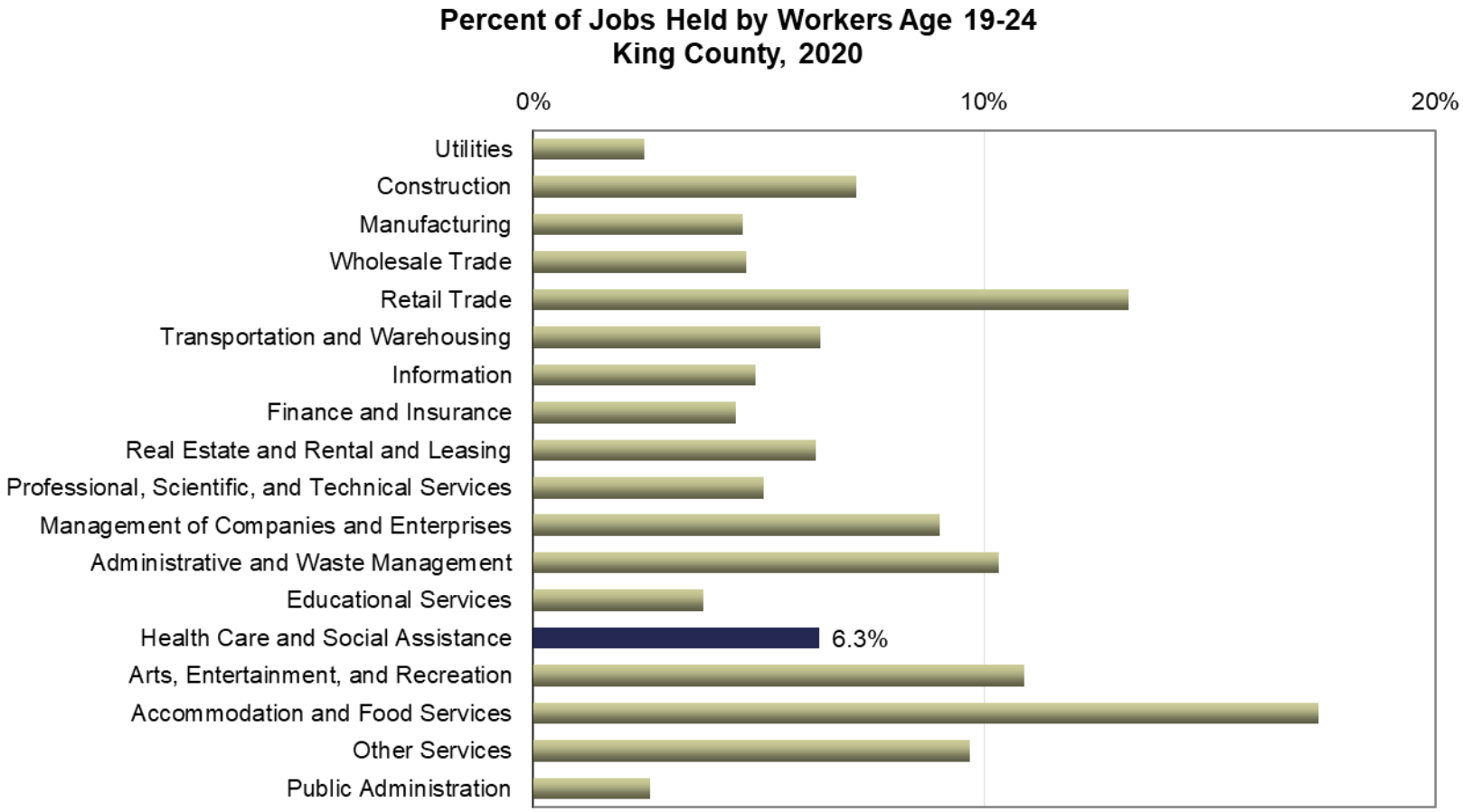
Few Young Workers are Entering the Health Care & Social Assistance Workforce



Source: Local Employment Dynamics Database, Housing Department Reports. King County Labor Market Profile Spring 2021

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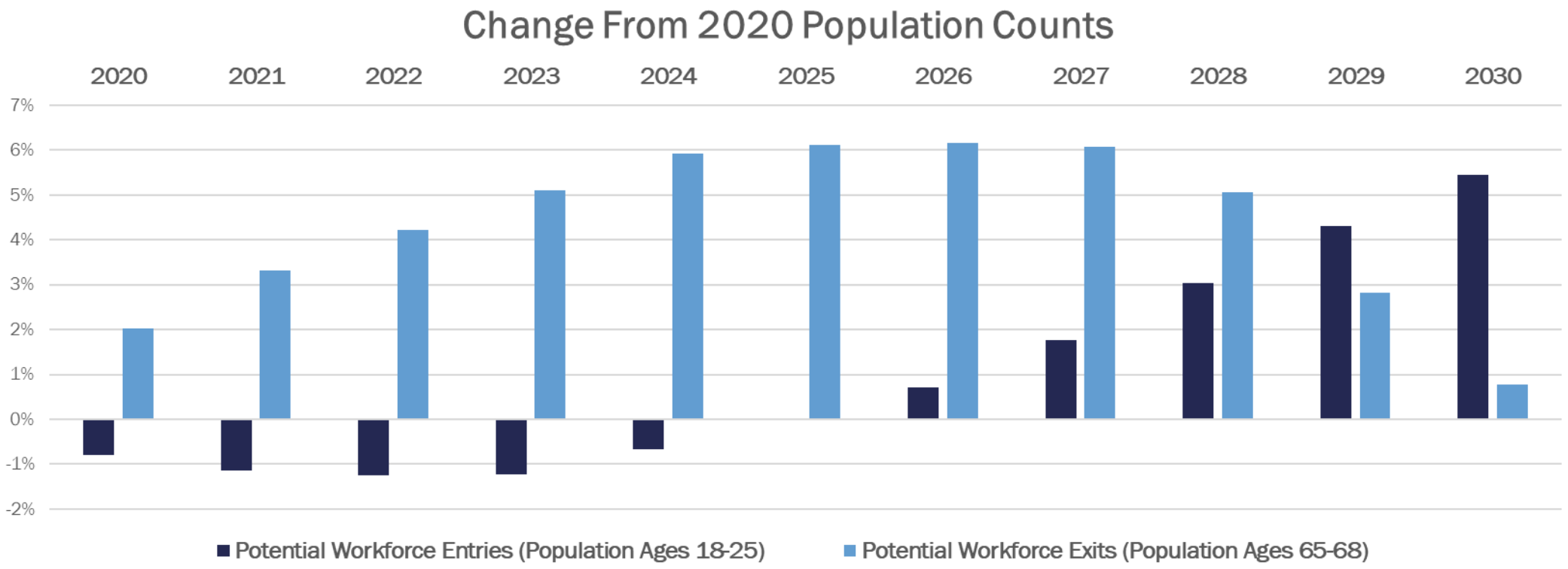
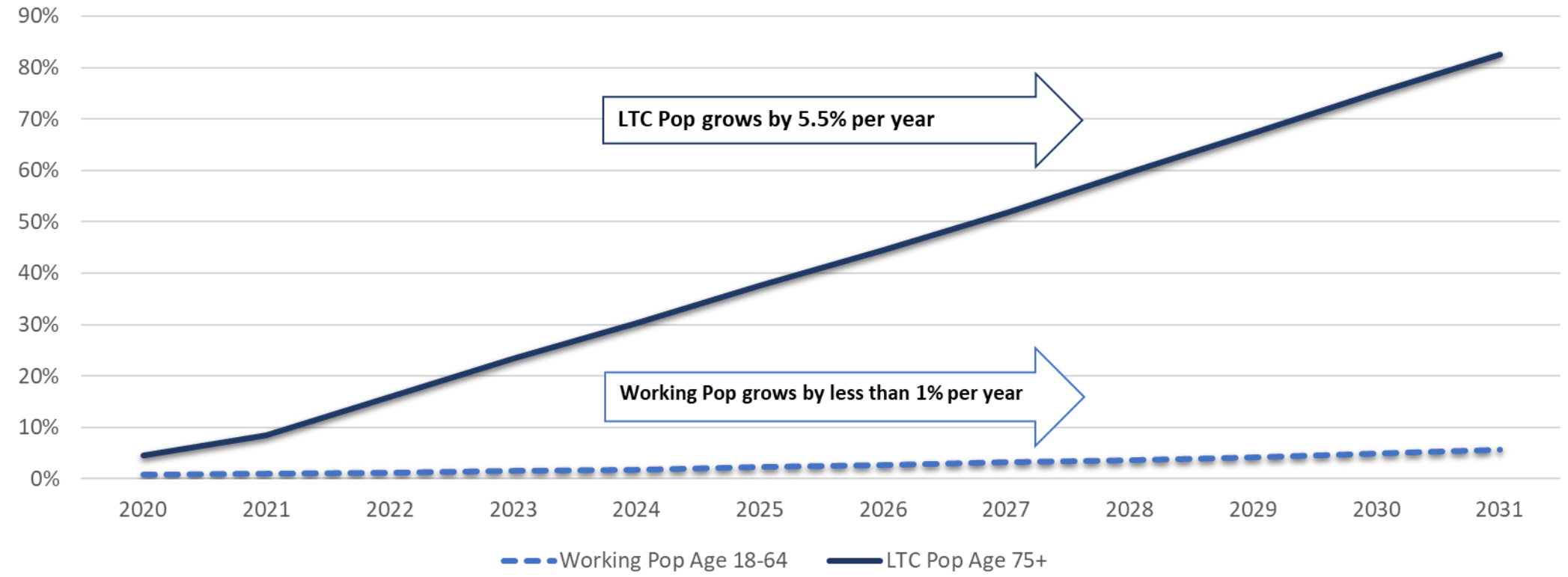
Based on WA's Population Forecast, the Next Seven Years Will be Exceptionally Challenging for Growing the Workforce



Data Source: Washington Office of Financial Management Population Forecast, November 2021.

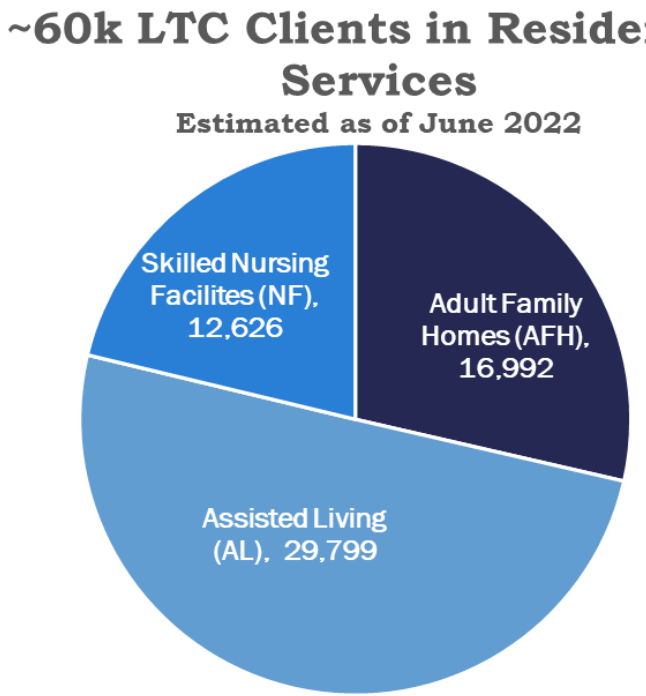
Demand for Long-term Care In WA is Already Outpacing the Supply of Workers, and This is Expected to Get Worse



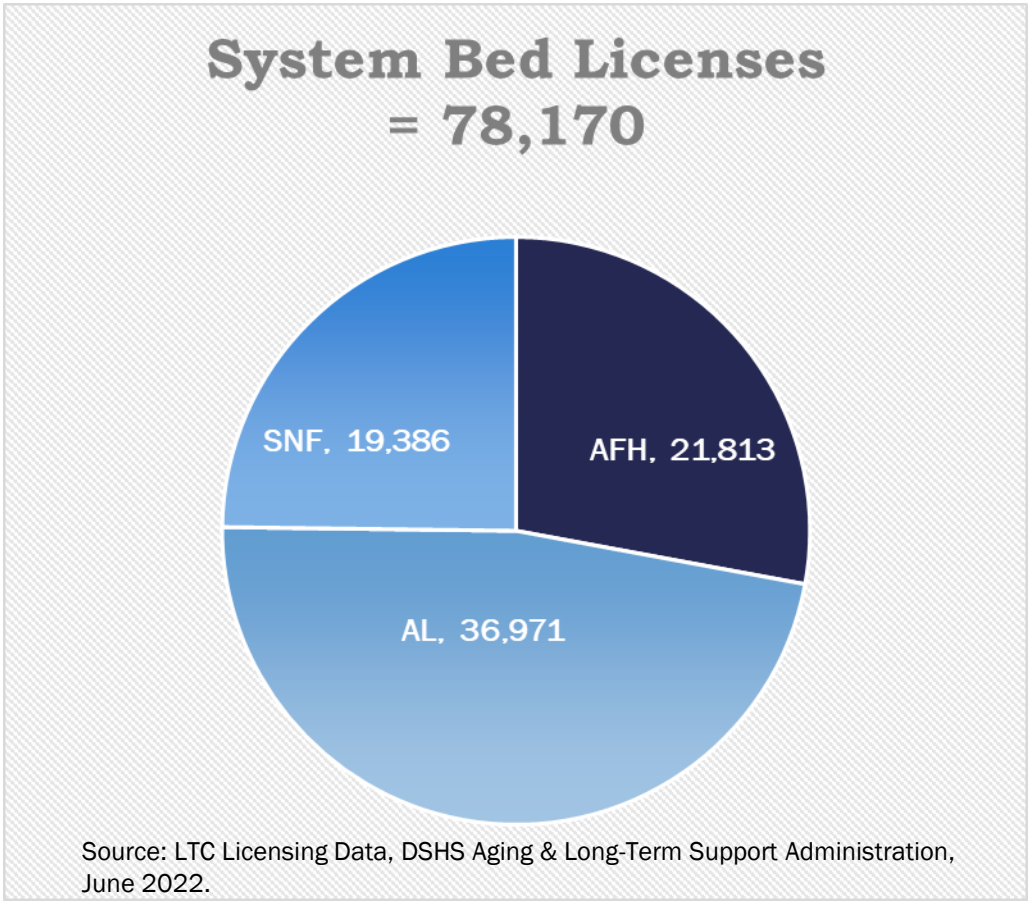
Data Source: Washington Office of Financial Management, WA State Population Forecast November 2021

WA's LTC System Is Currently Serving Roughly 11% as a Proportion of the Population Age 75 and Older

(2022 Estimated 75+ Population = 556,963)



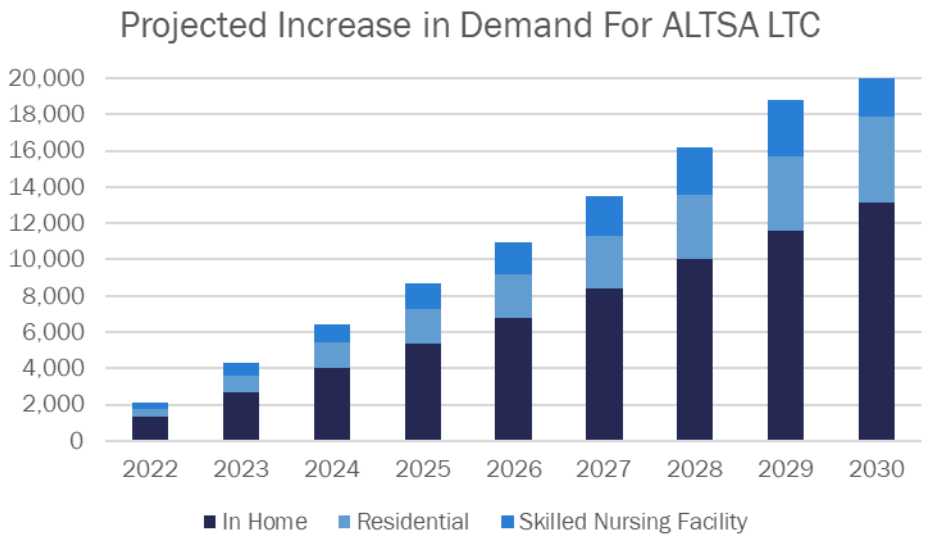
Number of clients in residential services was based on June 2022 estimated occupancy percentages by settings. Source data includes: NIC, NHSN Network Data, and input from the AFH Council.



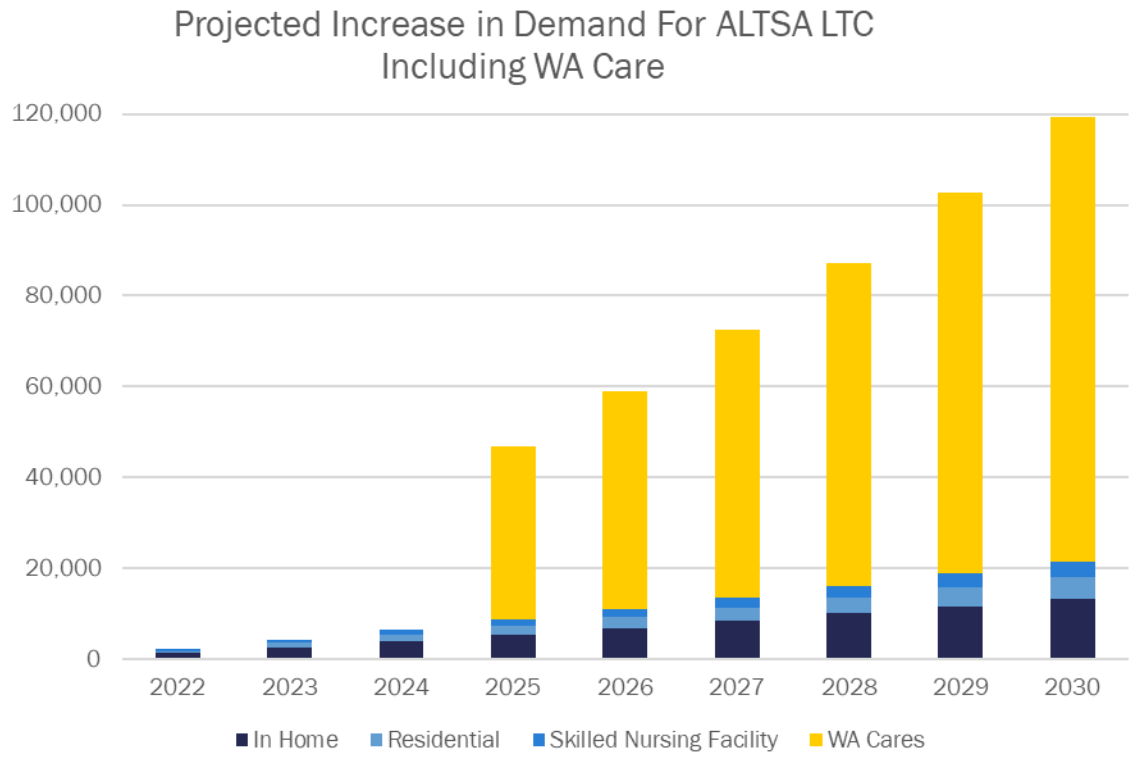
Source: LTC Licensing Data, DSHS Aging & Long-Term Support Administration, June 2022.

Based on the Age Wave, DSHS is on Target to Outgrow Licensed Capacity Within the Next 6-8 Years

The New WA Cares Benefit Program Accelerates this Projection to 2025

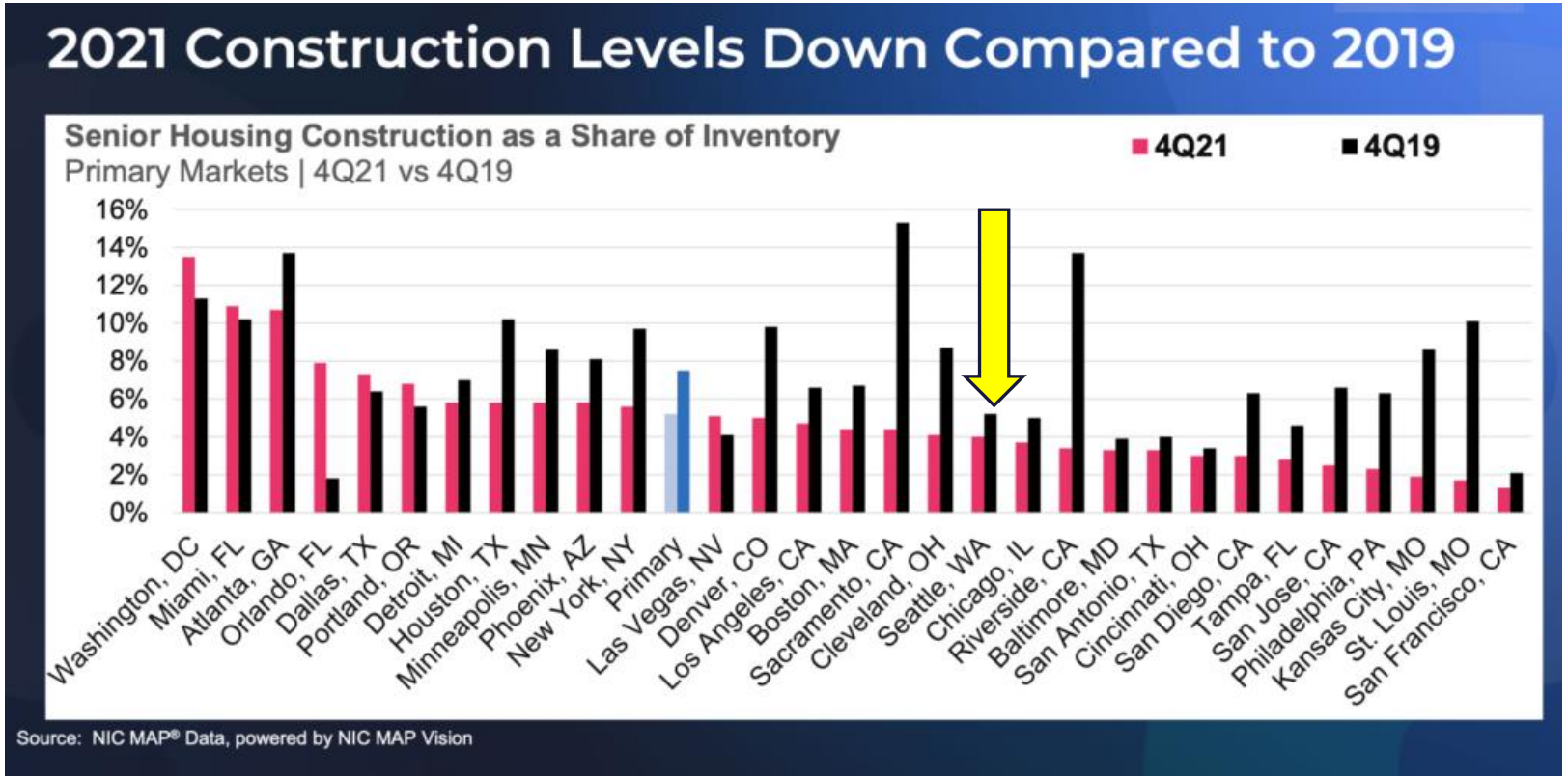


Source: DSHS RDA: Selected Population and Aging Service Utilization Forecast, Washington State. Updated August 23, 2021



Source: Milliman Report, "2020 Long-term Services and Supports Trust Actuary Study," Exhibit 4.

The Growth in Stock for Senior Housing Has Not Rebounded to Pre-Pandemic Levels



Q1 2022 NIC Report:

"(Senior Housing) Inventory growth was the weakest since 2013 as the impact of the pandemic on development pipelines in 2020 are evident in 2022 data."

Source: National Investment Center for Seniors Housing & Care (NIC), April 29, 2022.

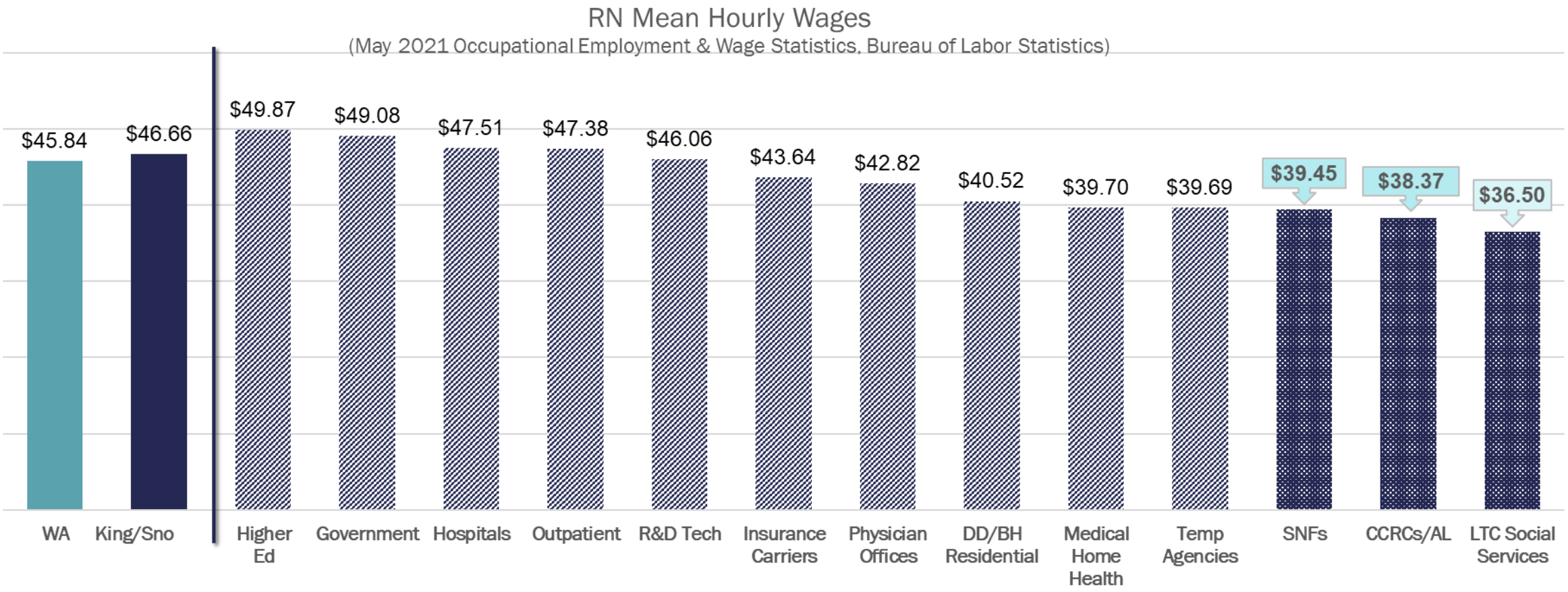
Washington's LTC Direct Care Wages are Some of the Highest in the Nation

Assisted Living Wages Compared Across all States	
Occupation	Ranking from the Highest in the Nation
RN	4th
LPN	2nd
CNA	4th
PCA	2nd

Skilled Nursing Facility Wages Compared Across all States	
Occupation	Ranking from the Highest in the Nation
RN	3rd
LPN	1st
CNA	3rd

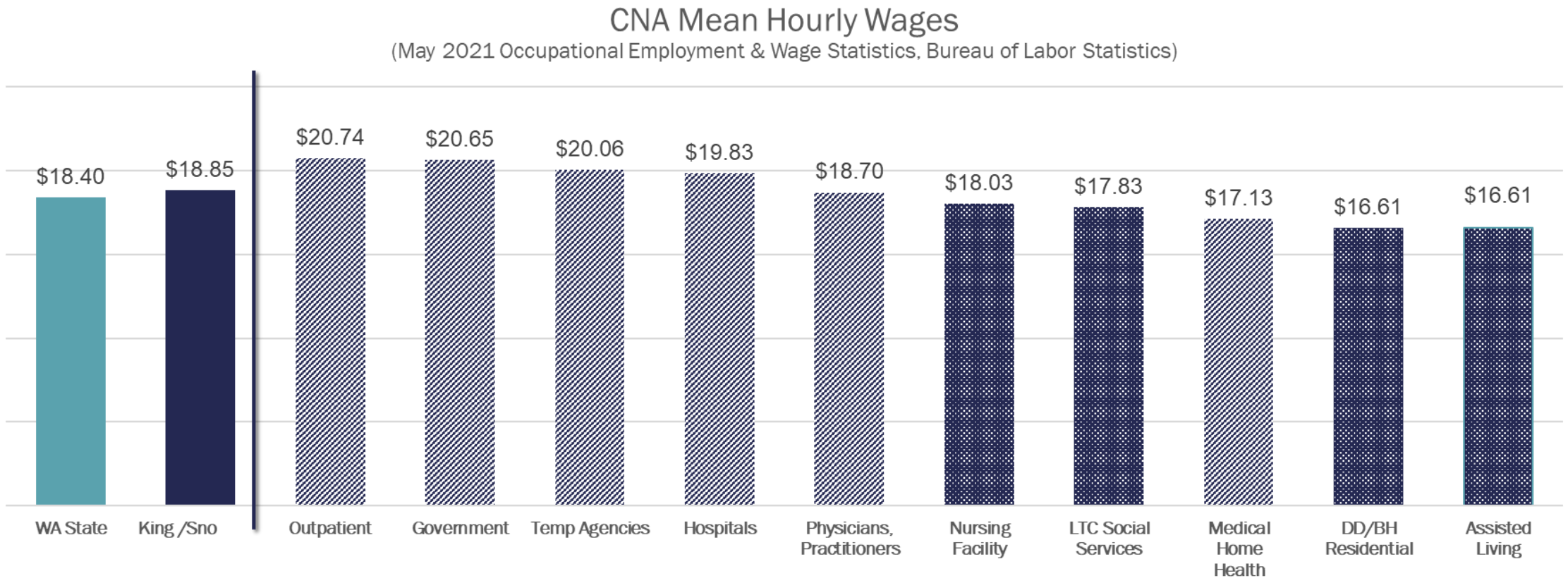
Source: May 2021 Occupational Employment & Wage Statistics, Bureau of Labor Statistics. Research Estimates by State & Industry. Mean Hourly Wages.

High Reliance on Medicaid Revenue Contributes to Low RN Wages for LTC Providers, Making it Very Difficult to Hire and Retain During Staffing Shortages

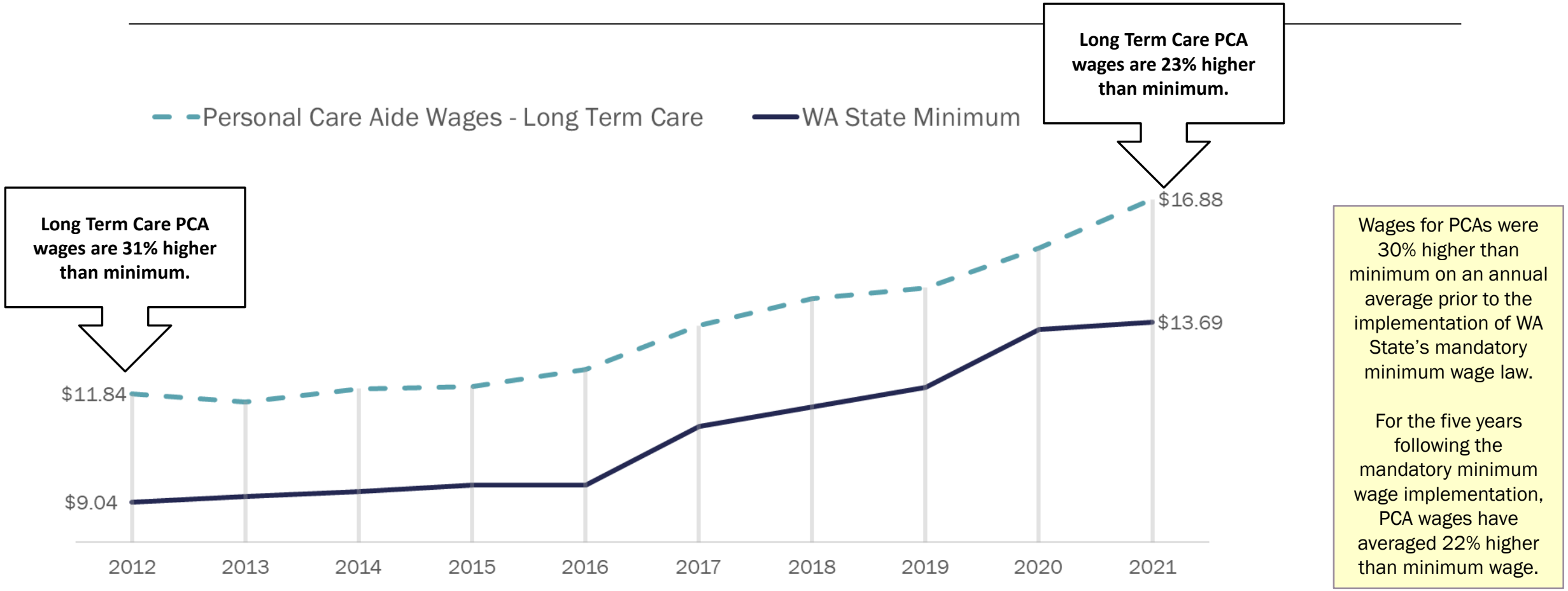


LTC Providers Struggle to Pay Prevailing Wages While Not Being Reimbursed by Medicaid for Labor Costs

SNFs and AL are the 2nd and 3rd largest employers of CNAs, yet wages fall below the statewide average



High Minimum Wages Drive Up All Wages, but the Value of Many Jobs, Including Personal Care Aides (PCAs), is Declining When Compared to the Minimum



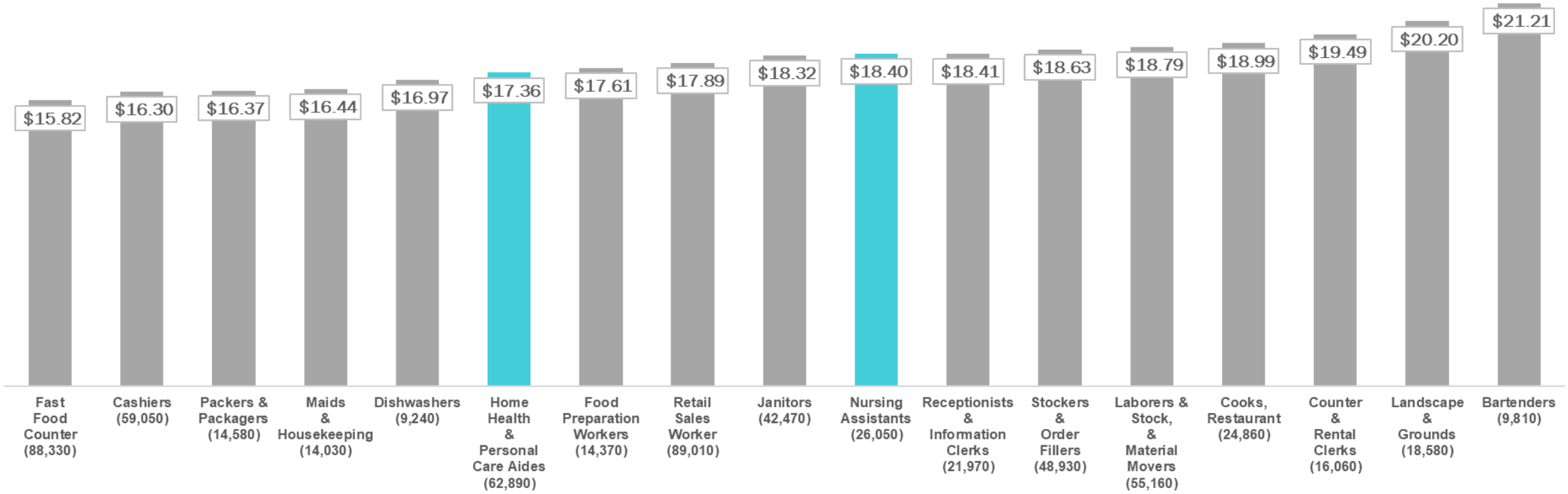
Wages for PCAs were 30% higher than minimum on an annual average prior to the implementation of WA State's mandatory minimum wage law.

For the five years following the mandatory minimum wage implementation, PCA wages have averaged 22% higher than minimum wage.

LTC PCA wages are the average of 62300 (Nursing & Residential Care Facilities) & 62400 (Social Assistance) calculated from May 2021 Occupational Employment and Wage Statistics, Bureau of Labor Statistics

Market Place Competitors Contribute to LTC Staffing Challenges

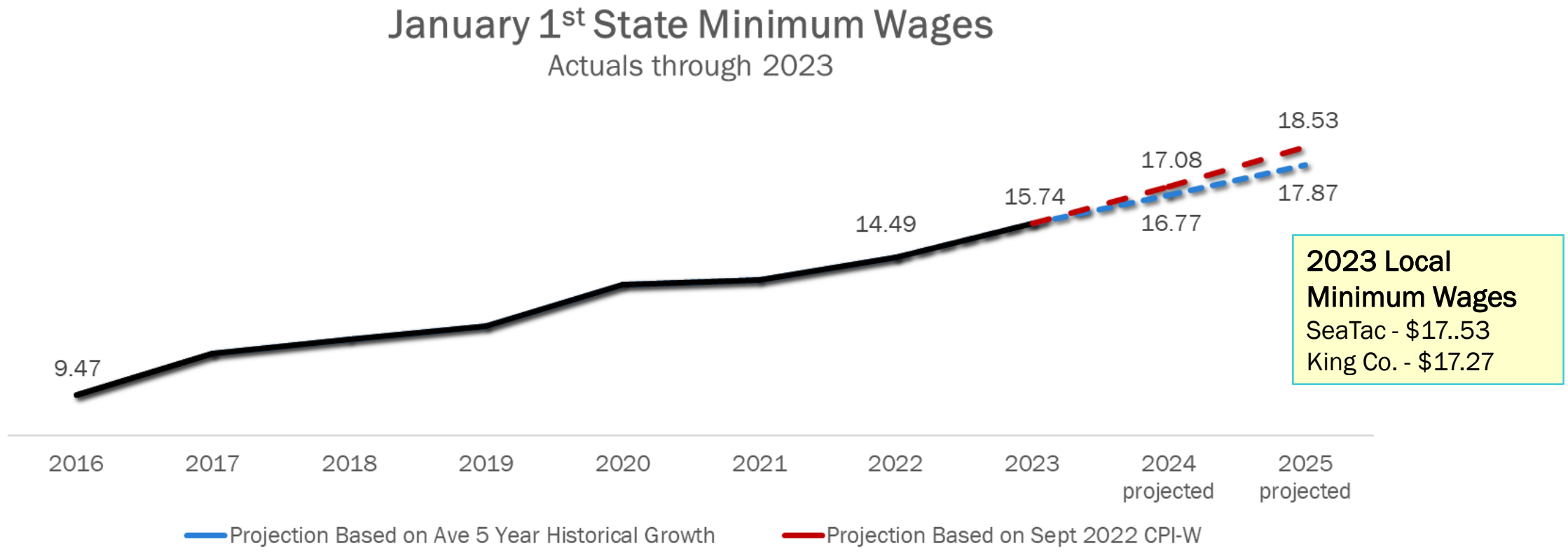
Washington Occupations With Similar Average Hourly Wages PCAs/Homecare Aides
Employment counts are provided in parenthesis. Occupations were selected based on the number of workers within the occupation.



Data Source: May 2021 State Occupational Employment and Wage Statistics. Bureau of Labor Statistics Department of Labor. File Name: "state_M2021_dl"
https://www.bls.gov/oes/tables.htm

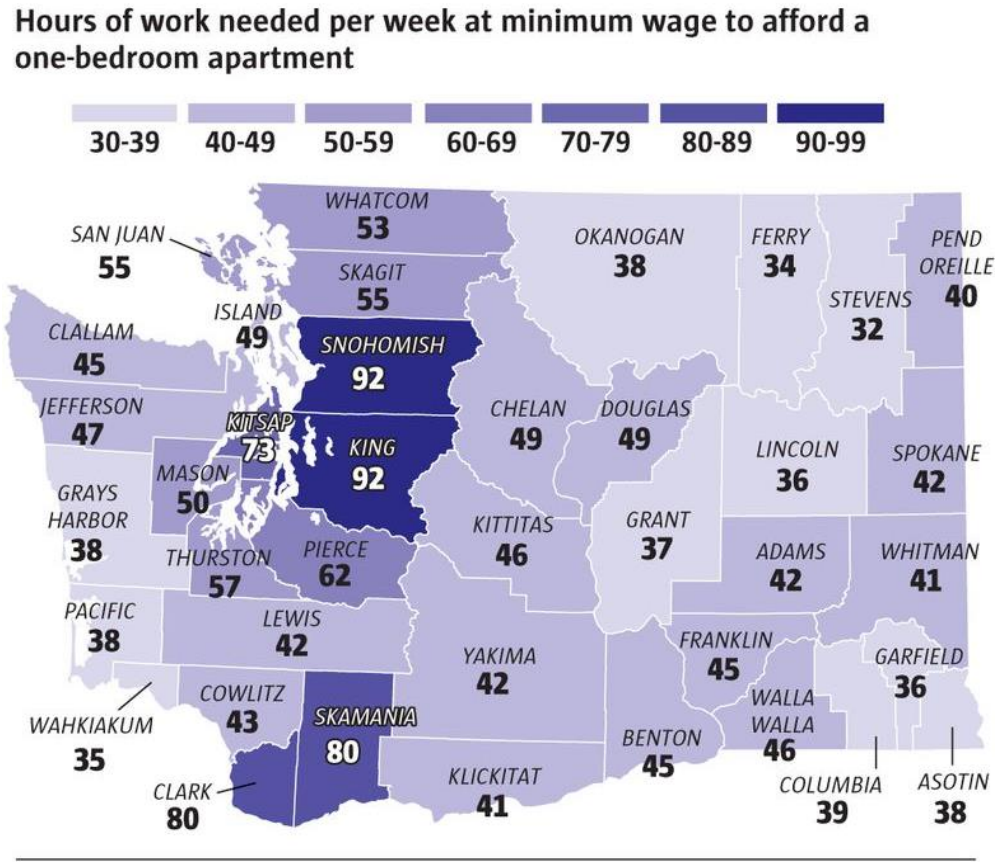
NOTE: Wages for PCAs and CNAs are shown here as the cross-industry, statewide averages paid in WA (includes all medical and all LTC provider types).

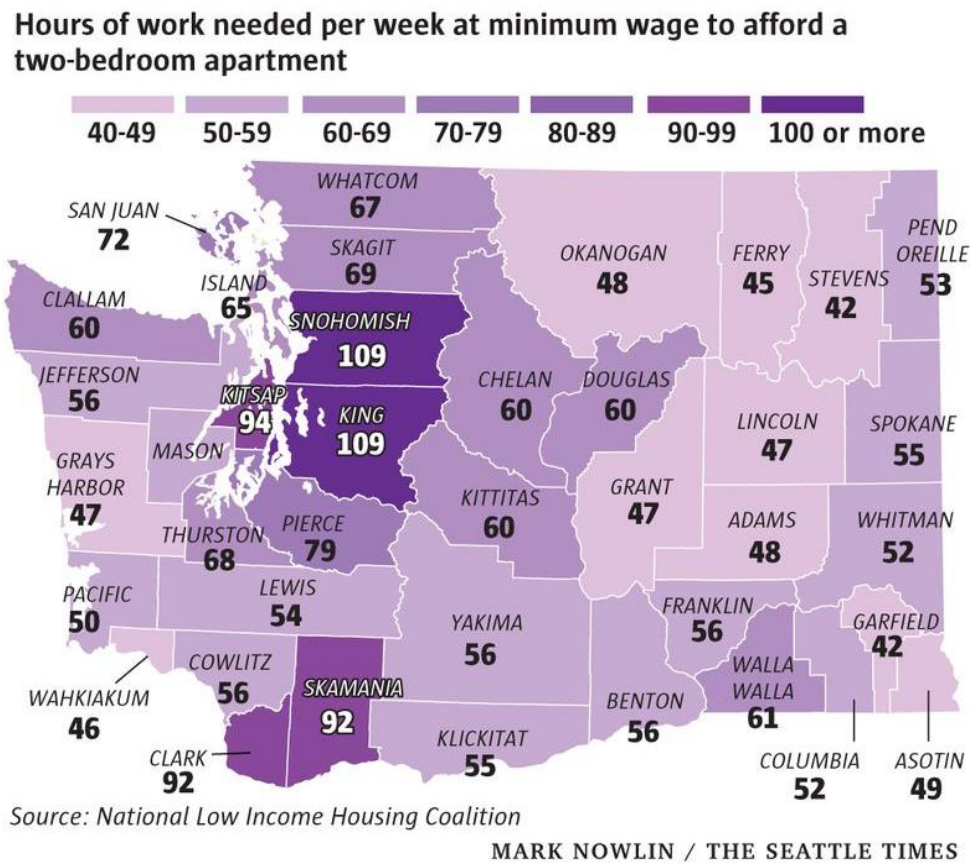
State Mandatory Minimum Wages Are Taking a Big Jump During the 2023-25 Biennium



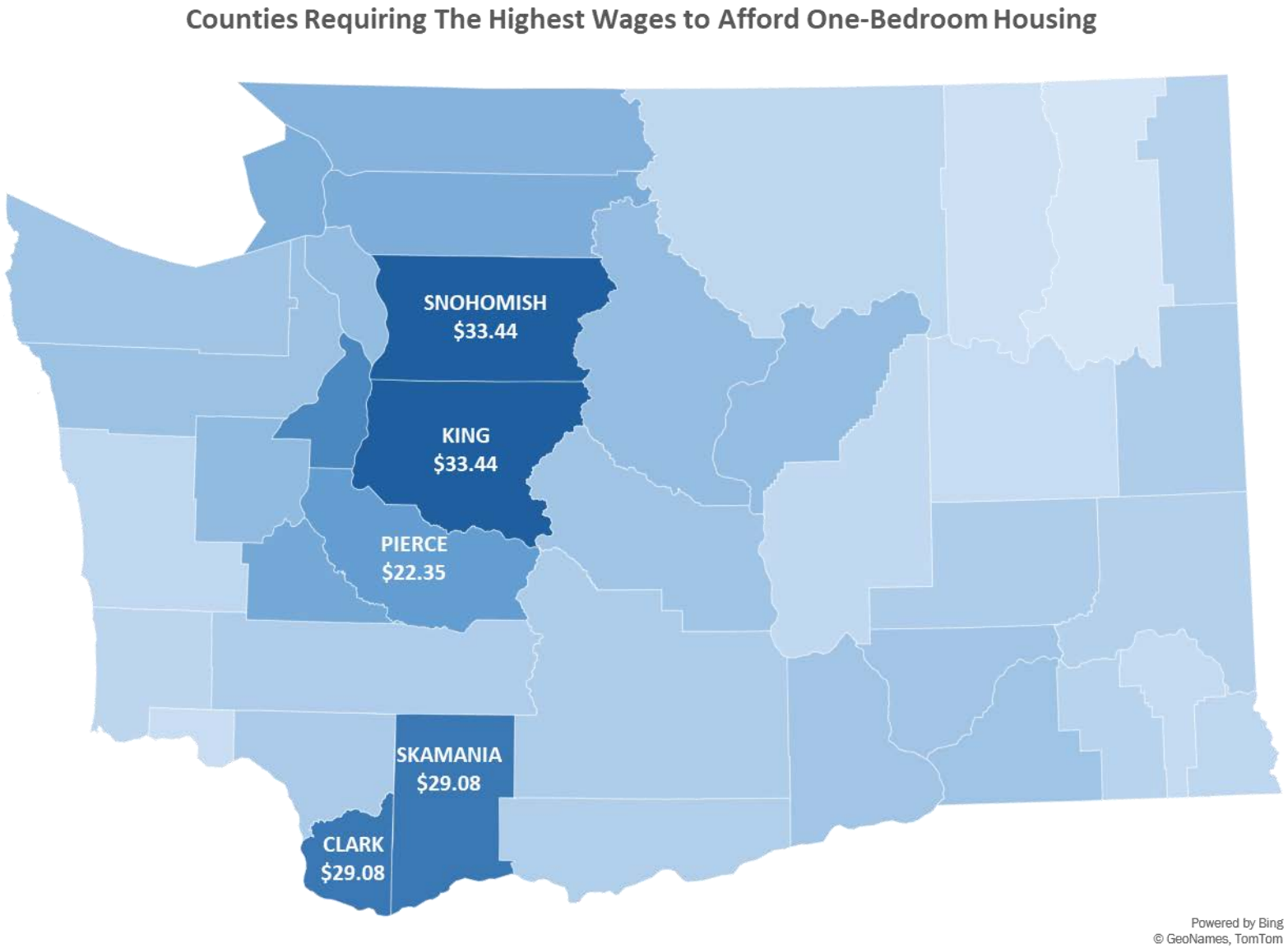
Department of Labor & Industries will review the Consumer Price Index for Urban Wage Earners and Clerical Workers (CPI-W) and set the Minimum Wage in September of each year. As of September 2022, the CPI-W increased 8.5% over the last 12 months. The historical annual wage growth averaged over the past 5 years was 6.5%.

Even With the Highest Minimum Wages in the Nation, These Have Not Kept Pace with the Cost of Living in Washington State





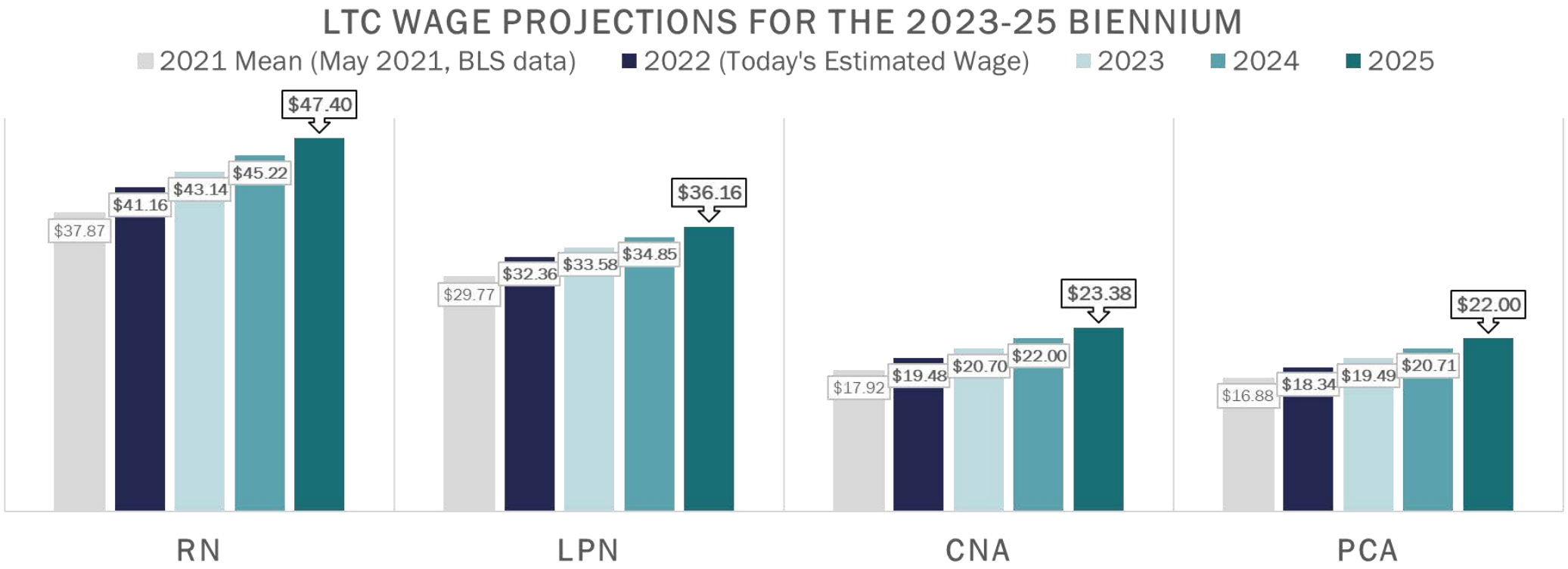
Source: https://www.seattletimes.com/business/real-estate/wa-tenants-need-to-work-72-hours-a-week-at-minimum-wage-to-afford-rent/



The Average Wage Needed in WA to Afford One-Bedroom Housing is $25.96/Hour. Some Counties are Even Higher

Assumes Rent should be no more than 30% of annual income. Source: HUD Fair Market Rent by County for 1-Bedroom Housing Divided by 30%.

To Keep Pace, Medicaid Rates Need to Recognize Wages Trended to the End of the Biennium



NOTES: Wages for 2022 are May 2021 wages inflated by the August 2022 CPI-W of 8.7%. Wages for 2023 to 2025 are inflated annually by the five-year historical average wage growth. For RNs this is 4.8%, For LPNs this is 3.8%, and for CNAs and PCAs this is 6.3%.

The AL Medicaid Payment Methodology Provides an Hourly Wage of $21.15

If funded, this Hourly Wage Would Recognize the 2020 Labor Costs For Our Professional Workforce

67%

Nursing Staff- RNs, LPNs, & CNAs

6%

Social Work & Activities

13%

Food Services, Housekeeping, & Laundry

3%

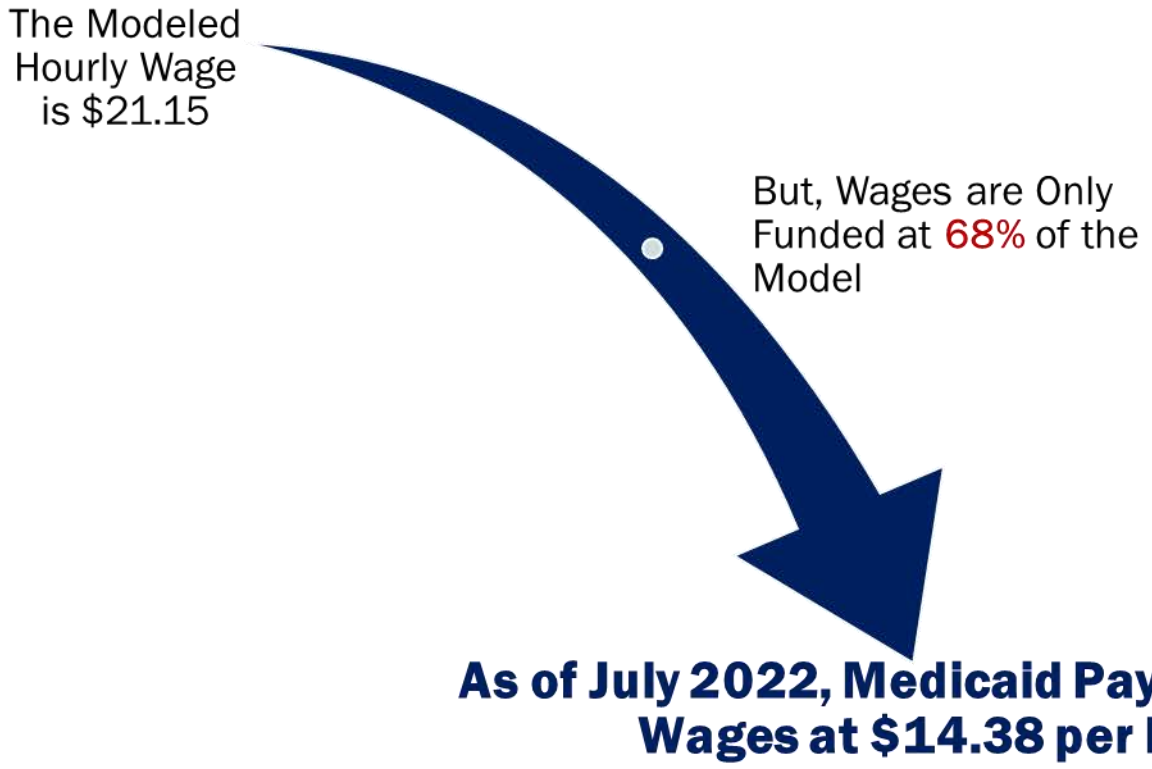
Building & Grounds Repair & Maintenance

11%

Reception, Accounting, & Administration

Note: The current hourly benchmark wages used to set rates are calculated from 2020 BLS wage data. This is updated every even year.

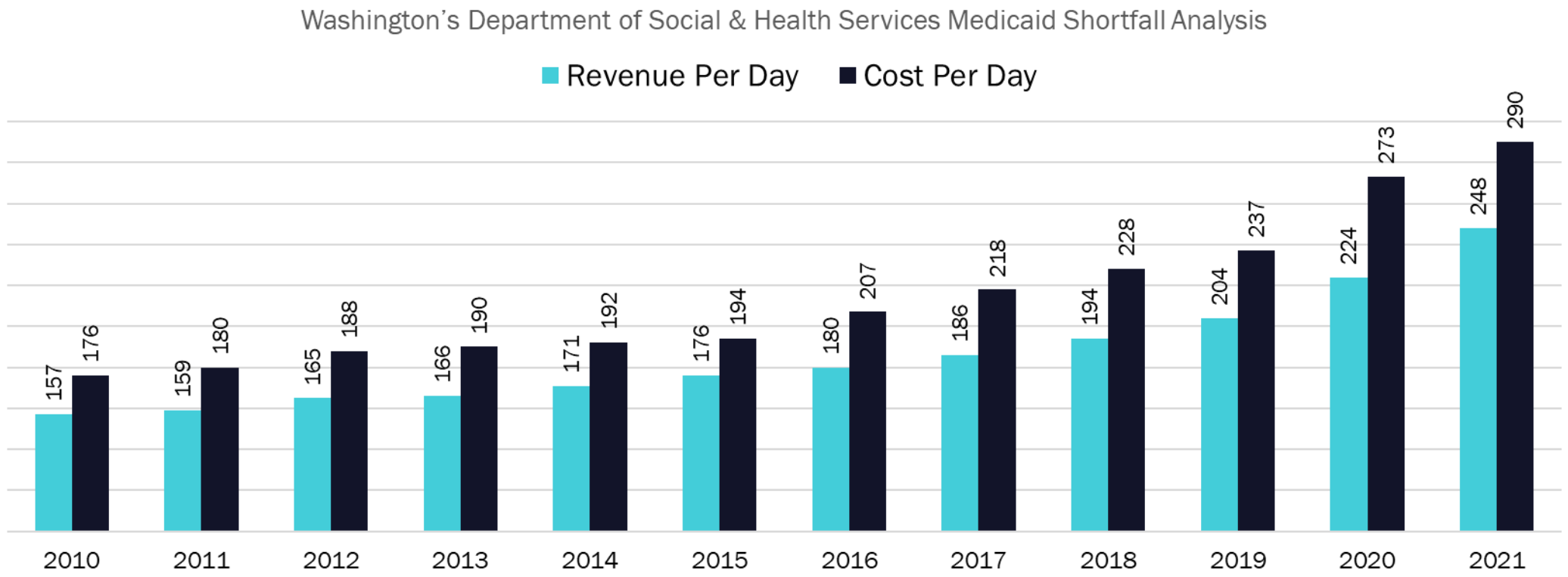
Funded Wages Fall Below Minimum Wage in AL Medicaid Rates Although Providers are Expected to Cover the Cost of Staffing Non-Minimum Wage Jobs



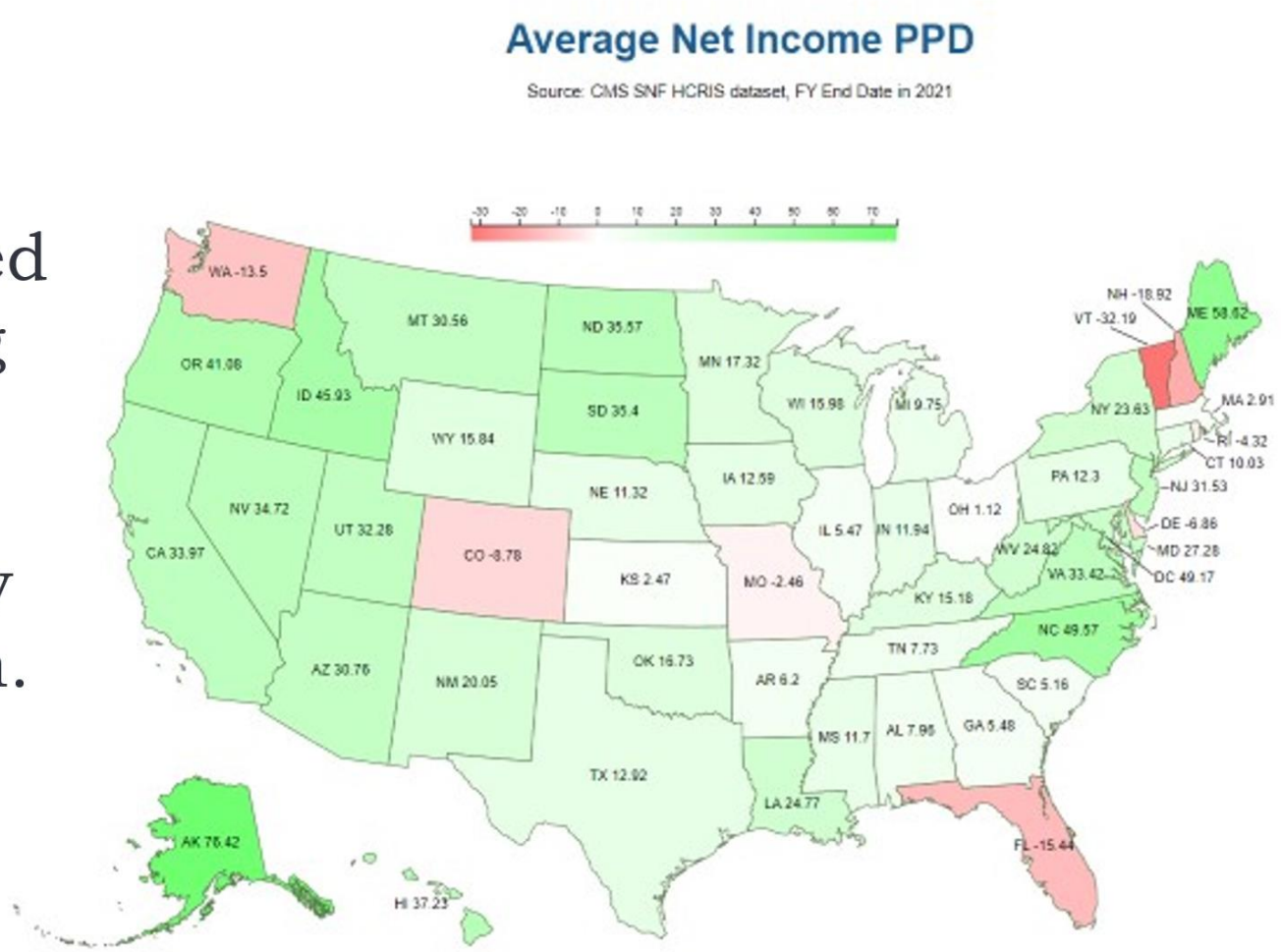
January 2023
State Minimum Wage
of $15.74

SNF Medicaid Revenue *Continues* to Fall Chronically Behind the Cost of Medicaid Services

The System has been Underfunded on Average by $124 Million Per Year For the Last Five Years



When All Fund Sources Are Factored in, Skilled Nursing Facility Daily Costs Still Exceed Revenue by About $61.5 Million.



Source: Consolidated Billing Services, Inc. . Extracted from CMS Medicare Cost Report Data.

WA is Ahead of the Nation When it Comes to Staffing Requirements in Skilled Nursing Facilities

In 2016, WA established mandatory staffing minimums in law.

	State Law 74.42.360	Federal Law 42 C.F.R. § 483.70(e)
HPRD	Mandatory 3.4 HPRD	None New requirements were enacted in 2016 for "sufficient numbers" of RNs, LPNs, and CNAs on a 24-hour basis to provide nursing care to all residents according to acuity, assessed needs, and care plans.
RN Requirement	Mandatory 24 hours a day, 7 days a week	At least 8 hours a day, 7 days a week.

Note: In a 2001 report to Congress, CMS suggested a 4.1 nursing hprd to prevent harm or jeopardy to residents based on a simulation model.[9] However, this suggestion was not adopted into Federal law in 2016.

SNF Contracted Labor Costs Disallowed by Medicaid Have Grown Dramatically in 2021

30%*

In Contracted Labor Costs

Are NOT paid for by Medicaid and must be supplanted by the providers.

Disallowed Contracted Labor Costs (Dollars in Millions)		
2019	2020	2021 Projected^
- $10.7	- $13.6	- $26.2

Source: Consolidated Billing Services

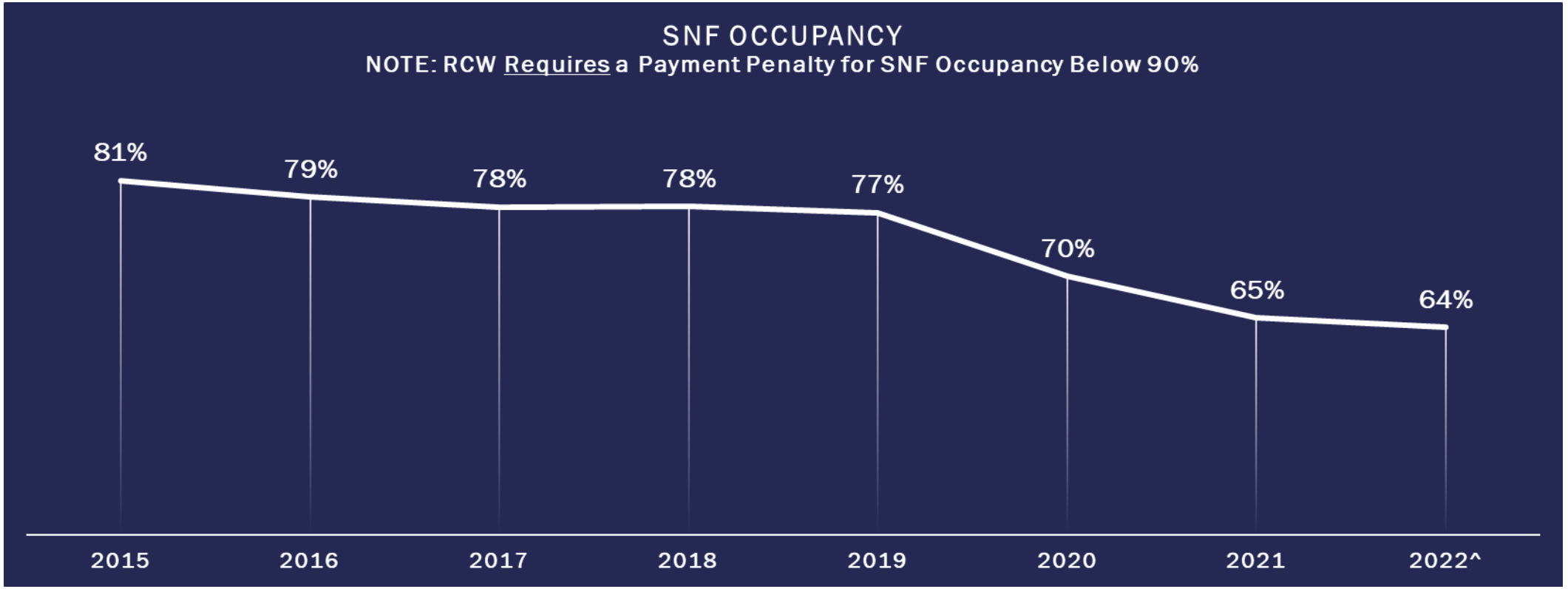
^2021 projections are based on a survey of costs from 60 providers. Participating facilities represent 34% of the SNF resident population in WA.

*30% is based on the trends of disallowed contracted staffing costs from 2019 and 2020.

2019 and 2020 data are actuals provided by DSHS- ALTSA.

SNF Occupancy in WA is the 9th Lowest in the Nation

While Hospitals Reach Diversion Status, the Lack of Staff Needed to Keep Beds Open Continues to Drive Down SNF Capacity



Data Source: 2015-2021 Data is provided by DSHS. ^2022 is taken from KFF analysis of

Finding Relief for Staffing Challenges

- The end of the statewide emergency declaration on October 31 did not change the statewide emergency in LTC staffing. Current, unrelenting staff shortages are impacting providers' ability to accept new admissions from hospitals, homes and other community-based care settings.

- Given the demographics of aging and the lack of immediate access to workers in the pipeline, we believe it will be critical for the Nursing Commission, the Governor, and the Legislature to advance proposals that would allow out-of-state licensed professionals to go to work expeditiously in Washington health care settings.

- We are also seeking federal support to extend the 120-day certification requirement for certified nursing assistants.

- While it appears that participation in the Nurse Compact Act is not politically viable at this time, we do urge the Commission to continue to consider the advantages to doing so.

Funding Priorities

General Fund-State Dollars

Support Worker Wages

- $96M to fund 100% of the worker wage component of the AL Model.
- $23M to provide a $75 rate add-on to the AL Specialty Dementia Care providers. This add-on specifically recognizes differentials in staffing and physical plant requirements.
- $36M to maintain SNF funding at 111% of the direct care median. This funding provided a wage increase of up to $4.00 an hour for low-wage workers. If this funding is not maintained, providers cannot continue paying the higher wages.

Long-term, Structural Rate Fixes for SNF Rates

- $94M for annual rate rebases, consistent inflationary adjustments, and a more accurate methodology for addressing minimum occupancy.
- $9M to fill a shortfall and stabilize the Safety Net Assessment portion of the SNF rates.
- $5M for Nursing Home Specialty Rates that incentivize and recognize the higher cost of care for ventilators, tracheotomy, behaviors, and traumatic brain injuries.

Impacts based on 2023-25 DSHS decision package: 050- PL– SB Medicaid Provider Rates