Issue

Investigating care that is provided by multiple practitioners licensed and disciplined by different boards, commissions or colleges has proven to be difficult. Many times complaints are filed against only one practitioner, even if that practitioner was not the person actually providing the care discussed in the complaint. If multiple complaints are filed against several types of practitioners, each licensing entity may choose to investigate or close the complaint without any regard for how the other entities are handling their complaints making it very confusing for patients and unfair for practitioners.

Further, when a disciplinary entity does take action, especially swift, summary action that suspends or restricts a physician's ability to treat patients, an entire patient population can be left with no health care options. While many regulators may believe that their only responsibility is to remove substandard providers to ensure patient safety, patient advocacy groups have pushed back holding the regulator also responsible for mitigating the impact of their actions on patients.

In the following case, the Washington State Medical Commission faced two dilemmas: 1) working with multiple state and federal agencies all interested in the same physician as well as a host of other types of licensees; and 2) determining and mitigating the impact on a population of up to 25,000 pain patients.

Case

The physician specialized in pain management and was the Medical Director and sole shareholder of a series of pain clinics located in eight different areas across the state. It was reported that over 25,000 patients in the region were treated at these clinics. The clinics represented themselves as pain management treatment centers focused on "finding treatment alternatives to narcotic pain medications" by incorporating "emerging best practices." The

clinics employed five fellowship-trained physicians, both allopathic and osteopathic, and mid-level practitioners with Advanced Registered Nurse Practitioner (ARNP) and Physician Assistant (PA) licenses.

Patient records revealed that the physician and these clinic providers repeatedly maintained clinical practices that were an extreme departure from the standard of care in chronic pain management and the practice of medicine. The physician established a business model that hired newly licensed mid-level practitioners without training or expertise in pain management, allowed newly hired practitioners to treat patients before establishing insurance accreditation, sought out Medicaid enrolled chronic pain patients, and billed Medicaid the maximum allowable amounts for excessive quantities of unnecessary urine drug screen tests, durable medical equipment and patient office visits.

As the owner of and employer for all the clinic providers, the physician established the business model, treatment protocols and training for treating chronic pain patients. Under the physician's management and ownership, sixty identified clinic patients died between 2010 and 2015; the Medical Commission investigated the physician's treatment of eighteen of those patients (Patients A through R).

The death certificates of Patients A, B, C, D, E, F, G, H, I, J, K, L, M, N, O and R listed acute drug intoxication as a cause or likely contributing cause of death. Patient P died from a vehicle accident and Patient Q died from a stroke; however, Patients P and Q had multiple serious health conditions that the clinics disregarded during opiate therapy. It was the opinion of the Medical Commission that Patients A through R's medical records revealed an egregious pattern of substandard medical care and disregard by the physician and clinic providers for patient health and safety.

During the course of the investigation, the Medical Commission discovered that over 40 ARNPs and five PAs were either working or had worked in one of the eight clinics during the time patients died. Further, the Drug Enforcement Administration (DEA) took steps to revoke the physician's DEA registration and insurers from Medicaid to private plans wanted to remove the physician from their provider lists. As a final and unexpected step in this matter, after the summary action was taken by the Commission, the physician closed and locked the doors of all of the clinics, effectively cutting off all of the clinic's patients from treatment until they could find another provider.

Key Issue

This case crossed multiple state and federal agencies as well as three different licensing boards. While the Medical Commission was the lead on this case, there were competing interests from the Medicaid fraud unit, Labor and Industries, Health Care Authority, DEA, Department of Justice, local law enforcement and public health. A new reality to health care investigations is that a new approach was needed when care is provided by a host of different types of licensees and investigations, historically done by separately siloed units, need to be done as a team.

Assumption

Other mid-level practitioners would remain at the clinic during their investigations and provide treatment to current patients even though the Medical Director was not able to prescribe controlled substances, thus mitigating any immediate adverse impact on patient care.

Key areas of concern

1. When issues arise that adversely impact patient outcomes, in team-based medicine, who does the regulator hold responsible and how does a diverse group of regulatory bodies (medical commissions, nursing commissions, *et al*.,) investigate and discipline the "team" equability and timely?
2. When state and federal agencies have interests in the same case, how do the regulators keep each other informed and ensure every agencies' needs are met?
3. When a regulator takes an action that removes a health care provider from providing care, how does the regulator mitigate the impact their action has on the affected patient population?

Actions taken to address above concerns

1. To address the complexities of regulating team-based medicine, to make the process as lean as possible and to make any resulting disciplinary as fair as possible across different types of practitioners, the Washington State Medical Commission drafted a procedure that details how the different disciplining authorities (licensing boards) must work together from the initial complaint filing through to determination of discipline by the separate boards. The purpose of the procedure is to coordinate the complaint response process among boards, commissions and programs by sharing information at various points in the process: intake, investigations, case disposition, imposition of discipline, and compliance. This coordination will improve efficiency, provide more information to regulatory authorities when making decisions, and lead to more fair and consistent outcomes.

Under this new procedure, when any complaint intake staff receive a complaint that details any kind of team-based care, the intake staff send a copy of the complaint to the other disciplinary boards for review. If multiple boards open an investigation, board investigators must meet to develop a coordinated investigatory plan to insure the same witnesses are not interviewed by multiple investigators and records that may be needed by several different boards are only requested once.

Further, after an investigation is completed, the members of the separate disciplinary boards may discuss the possible violations to insure that any discipline is fair and equitable across the health care "team."

2. To keep other state and federal agencies abreast of how the case unfolded, the Medical Commission designated one staff member to be the single point of contact for all matters regarding this case, including working with the federal agencies and communicating with the Medicaid Fraud Unit. This staffer was also the media contact.

A core team, including staff from the Health Care Authority, Department of Labor and Industries, public health, the other disciplining authorities, the Department of Health, Governor's office and met almost every day to update each other on movement in the case, to try to anticipate and mitigate any adverse patient impacts and develop media talking points.

Once the Medical Commission took the summary action and the physician closed all of the clinics, displacing almost 8,000 patients, the Department of Health established an Incident Command Center to help patients find other practitioners who could continue their treatment. The Medical Commission also issued a letter to all physicians explaining the pain rules and encouraging them to help treat these displaced patients.

3. To ensure future summary actions taken by the commission do not adversely impact patients, a team of commissioners and staff developed a summary action plan. This plan identifies the practitioner's practice type and patient population, the geographic location and whether there are any other like practitioners within a reasonable radius for any potentially displaced patients.

This plan requires that impacted physicians send a letter out to all of their patients explaining the Commission's action and providing the contact information of at least two other physicians who could provide the patient with continuity of care. This plan also provides a list of entities/agencies that need notification of the summary action. This list includes the Governor's office, local health jurisdictions/medical societies and the state's Public Health Officer in certain cases.

Results/Outcome

1. During the next summary restriction on another physician overprescribing pain medications, the Summary Action Plan enabled the Commission to proactively speak to a county health district who was able to assist displaced patients find alternative providers without any break in treatment.

2. In three recent cases, the Commission opened cases involving other types of licensees, including an issue with a facility and was able to coordinate their investigation with the other disciplining authorities to insure all of the information was shared, the needed documents were requested only once and witnesses were interviewed only once and by an integrated team of investigators. The new procedure has improved communication between disciplining authorities, decreased the number of different investigators a patient or other witness needs to

speak with and decreased the number of requests for records a hospital or other entity must respond to in the course of an investigation.

References

RCW 18.130.050(8)

RCW 18.130.080

WAC 246-919-850-863

Multi-Authority Complaint Response Process

Summary Action Plan