

MEETING IN RE:
MEDICAL QUALITY ASSURANCE COMMISSION AND BOARD OF
OSTEOPATHIC MEDICINE AND SURGERY RULES FOR CHAPTER 246-918
AND CHAPTER 246-854 WAC PHYSICIAN ASSISTANTS
Before
JOINT PHYSICIAN ASSISTANT RULES COMMITTEE

20425 72nd Avenue South, Building 2, Suite 310
Kent, Washington

DATE: Wednesday, February 12, 2014

REPORTED BY: Ronald L. Cook
CCR, RDR, CRR

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JOINT PHYSICIAN ASSISTANT RULES COMMITTEE:

Shannon Markegard, DO
George Heye, MD
Mark L. Johnson, MD
Michael Concannon, JD, Public Member
Thomas M. Green, MD
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Heather A. Carter, Assistant Attorney General

1 KENT, WASHINGTON; WEDNESDAY, FEBRUARY 12, 2014

2 9:06 A.M.

3 --o0o--

4
5 MS. THOMPSON: So good morning, everyone.

6 I am Tami Thompson, and I am with the Department of
7 Health, and I will be facilitating the meeting this
8 morning.

9 So we are just a little bit behind so I'm
10 going to cruise through the agenda so we can get going
11 right away.

12 We have put together an agenda. We'll do
13 the housekeeping things first off, and then we're
14 going to just dive right in to going through -- we,
15 the Department, have heard some really good feedback
16 and comments from this committee and participants, and
17 so staff have worked really hard to try to capture
18 those comments. We'll spend the first little over an
19 hour working through the sections, and what we would
20 like to do, if at all possible, is the sections that
21 we have no controversy, no concerns about, we would
22 like to be able to check those off and have the
23 committee members from the Medical Commission and the
24 committee members from the Osteo Board to say, Yea,
25 that's what I would like to take forward to my full

1 board or my full commission, that we agree with that
2 draft language as it is today. And if we can't do
3 that, that's okay. And the sections that we are not
4 ready to do that with, we won't. Okay?

5 We'll take about a 15-minute break, and
6 then we'll dive back in to work for another hour, take
7 another break, and then we have set aside about 45
8 minutes to discuss the Commission's and the Board's
9 delegation agreement forms.

10 One of the comments that we received was
11 that the delegation agreement plans will be a major
12 part of this rule making, and we have recognized that
13 the Commission's delegation form and the Osteo Board's
14 delegation form are not exactly the same, and that one
15 of the ideas that we came up with is if those forms
16 could be substantially very similar, then the PAs
17 could be using one form or very substantially similar
18 forms that they could be using when they want to do --
19 to hold that dual license.

20 And the quicker -- you know, obviously,
21 the quicker we can move through some of this other
22 stuff, we will have more time at the end, and then
23 we'll just talk about next steps and about the meeting
24 in Yakima and what our intent is for that.

25 So that's the agenda.

1 Meeting logistics is that we do have one
2 person on the phone.

3 MR. CAIN: Yes. Carl, can you hear okay?

4 MR. NELSON: Yeah, I can hear pretty
5 good.

6 MR. CAIN: Okay, good.

7 MS. THOMPSON: So we'd just ask that you
8 speak up.

9 And is there anything, Ron, that you need
10 from the people at all?

11 THE REPORTER: Maybe one person speaking
12 at a time.

13 MS. THOMPSON: Okay. So we try to be
14 very respectful, have one person speaking at a time,
15 because we do have a court reporter trying to capture
16 all of this.

17 DR. GREEN: Who is on the phone?

18 MR. CAIN: Carl Nelson, from the WSMA and
19 WAPA.

20 MS. THOMPSON: Okay.

21 And then housekeeping, I believe the
22 restrooms are out on the other side of the --

23 MS. CARTER: Go back to the guard
24 station, right out here in the lobby, and there's a
25 sign. They're just to the right.

1 MS. THOMPSON: And there's -- Alki Bakery
2 is --

3 MS. KITTEN: It's across the parking lot,
4 across the bridge.

5 MS. THOMPSON: So we're not going to stop
6 for lunch, but you guys are more than welcome to come
7 and go as you need to.

8 Okay. So I think -- unless anybody has
9 any other questions or concerns, I think let's get
10 started and let's get moving, as much as possible.

11 So do we want to start with the
12 definitions of positions?

13 MR. CAIN: Let's do that.

14 MS. THOMPSON: Okay.

15 And these documents that Brett has up on
16 the screen are the documents that we sent out to you
17 all a week ago.

18 MR. CAIN: And there's handouts up by the
19 door that's the exact same thing. I understand that
20 the screen isn't the clearest. I can barely read it
21 from here. So if you just want to follow along with
22 your paper documents.

23 MS. THOMPSON: Okay. So we have the
24 definitions, and we have a very small definition
25 section for the Osteo side. I think we've tried to --

1 MR. CAIN: We didn't have the
2 definitions.

3 MS. THOMPSON: That's right. The Osteo
4 Board didn't even have definitions.

5 We've recognized the fact that there was
6 probably some terms that are used throughout the
7 entire chapter that needed to be defined. Does anyone
8 have any concerns, questions, comments, about the
9 definitions section, on either side, Osteo or Medical?

10 MS. SCHIMMELS: Just one. There was a
11 note in here -- see if I can find it -- about putting
12 something from one section into the other -- into the
13 definitions section.

14 MS. DALE: In Osteo, it says can -- the
15 term -- see where it's at.

16 MS. SCHIMMELS: I marked it. Now I can't
17 find it.

18 MS. DALE: 010, here's a comment. I
19 can't see on this printed section where that comment
20 line is leading to, but it says "Can in turn be
21 confused with remote site."

22 MS. THOMPSON: It's in the --

23 MR. CAIN: Yeah. It's -- it says "remote
24 location." And so we were wondering -- is that the
25 same thing?

1 Staff didn't necessarily know whether
2 there's such thing as a remote site and a remote
3 location or if those terms are interchangeable.
4 Because I think that's the only place in the chapter
5 that it refers to a remote location.

6 MS. SCHIMMELS: I think it needs to be
7 changed to "site," because that's what it is
8 throughout.

9 MR. CAIN: That's what it is. Okay.

10 MS. THOMPSON: So consensus would be we
11 use "remote site" throughout the chapter.

12 MR. CAIN: I can't read that very well.

13 MS. DALE: Then in the allopathic rules,
14 you have "sponsoring physician," and if we delete
15 that, we need to go through everything and delete
16 "sponsoring physician," which there's a few places
17 that that was not done, so we would just need to go
18 back through and make sure --

19 MS. THOMPSON: Do another scrub through
20 to make sure all of them are gone?

21 MS. DALE: Right.

22 MS. THOMPSON: Okay.

23 MS. SCHIMMELS: And then the last one is
24 under 246-918-120. It's about, oh, I don't know, five
25 or six pages back, about "Remote site--Utilization--

1 Limitations," and the comment down there, h7, says,
2 "Should this definition be in the general definitions
3 section? The term is used in 918-120 and 918-130,"
4 and see "A remote site is defined as a setting
5 physically separate from the supervising physician's
6 primary care." I don't know if that needs to be moved
7 up into definitions or if it can just stay there.

8 In the osteopathic it's also in the same
9 place for remote, so it wouldn't necessarily need to
10 be moved, because it's in the same spot in both of
11 the -- in both of the rules.

12 MS. THOMPSON: Okay. So logistically we
13 would ask -- and, I mean, I'm not well versed on these
14 yet, so logistically we would say if the term is used
15 in more than one section of the rule, the standard and
16 practice is to put it in the definitions section,
17 because then it applies throughout the chapter. If
18 it's only in one section, then we can leave it in that
19 section.

20 MS. SCHIMMELS: Okay. I'll have to look
21 at that, and I'll --

22 MS. THOMPSON: And we can look at that
23 too.

24 MS. SCHIMMELS: Yeah. Okay.

25 MS. DALE: Well, the term "remote site"

1 is used throughout the document.

2 MS. THOMPSON: So then we should probably
3 move it to the definitions section.

4 And, Dr. Green, you -- you're good?

5 DR. JOHNSON: I'm good. Thank you.

6 MS. THOMPSON: You're good. Okay.

7 Yes, Dr. Heye.

8 DR. HEYE: Actually, the -- you know, the
9 physician assistant is defined in the RCW.

10 MS. THOMPSON: Yes.

11 DR. HEYE: But it's not the same
12 definition that we have.

13 MS. THOMPSON: Okay. So the question
14 would be the Department of Health would recommend that
15 we use the same definition as in the RCW.

16 Is there -- I guess I would need to ask
17 why is there a variation. Are we providing further
18 clarity and have we jumped outside the scope, the
19 intent?

20 MR. DICKSON: What does the RCW define?

21 MS. CARTER: I can read the RCW. This is
22 in the Medical Commission allopathic PA.

23 "Physician assistant means a person who
24 is licensed by the Commission to practice medicine to
25 a limited extent, only under the supervision of a

1 physician as defined in Chapter 18.71 RCW, and who is
2 academically and clinically prepared to provide
3 healthcare services and perform diagnostic therapeutic
4 preventative and health maintenance services."

5 Very general.

6 MS. SCHIMMELS: This one just says
7 "Physician's assistant means an individual licensed
8 under Chapter 18.71A RCW who works in collaboration
9 with the physician or group of physicians according to
10 a delegation agreement approved by the Commission."

11 George, do you think that that will be
12 something that you would want to take the RCW and put
13 it in here or just leave this?

14 MS. THOMPSON: I don't know. This
15 definition in here is pretty -- is pretty good. I
16 mean --

17 MR. CAIN: It just can't conflict.

18 MS. THOMPSON: It can't conflict.

19 That's -- and we can't --

20 MS. CARTER: Osteo has a different
21 definition, so I can read that. Osteo PAs. So an
22 osteopathic physician assistant means a person who has
23 satisfactorily completed a Board-approved training
24 program designated to prepare persons to practice
25 osteopathic medicine to a limited extent.

1 DR. JOHNSON: That's RCW definition?

2 MS. CARTER: Yes.

3 MS. THOMPSON: So I know that when we
4 defined -- when we defined "providers" in our own --
5 we like to say "licensed under the RCW," tying it to
6 that authority to license that particular provider,
7 because that's where the Department Board Commission's
8 authority lies.

9 DR. GREEN: So Heather just read the RCW,
10 right?

11 MS. THOMPSON: Yes.

12 DR. GREEN: So in this definition it
13 refers to that, so do we need to -- I mean, in essence
14 aren't they the same, in the sense that it refers to
15 it? Do we need to repeat everything she said here?

16 I mean, I don't --

17 MS. CARTER: I think one of the reasons
18 that we had decided to define "physician assistant,"
19 especially in allopathic rules, is because we also
20 wanted, then, to define "certified" and
21 "noncertified." So we had had a general term for
22 anyone licensed under the chapter, and then we broke
23 it down to certified and noncertified. Osteo does not
24 have any noncertified, so we just left theirs general.

25 I mean, we could just cut and paste the

1 RCW definition into there. It's probably the
2 cleanest. And then leave our specific certified and
3 noncertified definitions. Or you could just be very
4 general and say "Physician assistant means an
5 individual licensed under Chapter 18.71A RCW," period,
6 because all those things that talk about works in
7 collaboration are required under that chapter anyway.

8 MS. SCHIMMELS: I like that. I think
9 that's just simple. "Physician assistant means an
10 individual licensed under Chapter 18.71A RCW," period.
11 I think it's just easy and simple, and then there's
12 no --

13 MS. CARTER: And then you don't have to
14 cut and paste that whole definition over.

15 MS. SCHIMMELS: Mm-hmm.

16 MS. THOMPSON: Yeah, Dr. Green.

17 DR. JOHNSON: I do have my question,
18 because it gets back to the different categories of
19 PAs, the ones that were licensed before certification.
20 There are lots of MDs that are non-Board certified.
21 They're grandfathered in in their hospitals, their
22 insurance pools and everything. Do we need to
23 separate them out now?

24 They've been -- the ones that are still
25 surgical assistant PAs by that definition have been

1 practicing in our state for twenty-some years. Do we
2 really need to make them a separate entity, or can we
3 just push them over?

4 They're never going to be PA-Cs, just
5 like someone practicing OB who never got OB
6 certification is still delivering babies at their
7 hospital, because they're grandfathered. So I'm just
8 asking, do we need to separate out those definitions
9 any longer, just for that smaller group of PAs? I
10 don't know the answer.

11 MS. THOMPSON: We do have -- we have
12 eight that are licensed as a certified PA, right? Or
13 noncertified.

14 MS. KITTEN: Noncertified, we have
15 approximately 40.

16 MS. THOMPSON: 40 noncertified.

17 DR. JOHNSON: I actually know one who is
18 probably practicing in a role that's expanded from the
19 definition. I'm not going to name names or anything,
20 but the definition that's farther down in the book
21 doesn't apply to this person. We've been -- you know,
22 so I'm wondering if we really need to separate them
23 out.

24 MS. CARTER: So legally I would say
25 probably not, unless there are different practice

1 restrictions or requirements for the noncertified
2 versus certified. If there still are differences in
3 how they practice or what restrictions need to be on
4 them, then we probably need to separate them out.
5 Otherwise not.

6 DR. JOHNSON: I would like to hear from
7 other people.

8 MS. BALLWEG: So putting on the
9 institutional memory hat again, so there's two groups
10 we're talking about. One are the surgical assistant
11 PAs, who do not have formal training as PAs. They
12 were surgical assistants who got expanded roles. They
13 don't have any prescribing -- training in prescribing,
14 and so their job is defined as being only
15 interoperative. So if somebody's doing something that
16 is not that, then they're not in compliance with what
17 the rules are. And there were hearings that went on
18 and on about this. So -- but they really don't have
19 the training to be prescribing, for example. So
20 that's one group.

21 So that's the eight people, it sounds
22 like, are the surgical, and then there's 40 of these
23 noncertified. And some of them were in sort of
24 shorter PA programs but the largest group of those are
25 international medical graduates who came to the U.S.,

1 and so there's a question about their training as
2 well. But they're two different groups, and I think
3 the surgical assistants really are a very different
4 category.

5 DR. JOHNSON: So over the course of 20
6 years they haven't been educated to expand their --

7 Well, the answer is they have been
8 educated.

9 I'm not going to say that I have an
10 answer. I'm just suggesting that we MDs are allowed
11 to expand their practices without certification.

12 MS. BALLWEG: But I guess the difference
13 is they're not graduates of board-approved programs,
14 so they really -- they were mostly informally trained
15 people.

16 I pretty much know who they all are, and
17 the docs (inaudible) how to prescribe the drugs
18 they're doing. That should not have happened.

19 DR. JOHNSON: I understand. I'm just
20 talking about -- then it sounds like we need to leave
21 the definitions as they are.

22 MS. BALLWEG: And the idea was that over
23 time, time would solve the problem, and eventually all
24 those people would retire, and then when that sort of
25 happened, then we close the door on that. That's how

1 we thought about it.

2 MS. DALE: There's actually, I think, a
3 third group, maybe those who have not retaken their
4 NCCPA certification board, who have allowed that to
5 lapse. So they would then be PAs, not have the C
6 after their name, and so there's lots of times there's
7 nothing -- and in our law it says -- or in the rules,
8 anyway, it says initial certification. It doesn't say
9 anything about maintaining certification. So there
10 are a lot of -- and maybe that's some of this 40 we're
11 talking about, that maybe were initially certified but
12 have lapsed.

13 MS. BALLWEG: Those aren't the same
14 people. These are the people that were never
15 certified PAs.

16 MS. DALE: Okay.

17 MR. DICKSON: State law, which is
18 consistent with almost all the state laws, it
19 basically says that you would have to initially be
20 certified. It doesn't mean you have to keep that C.
21 So that's -- that's what you're talking about. The
22 law also states that.

23 MS. DALE: Mm-hmm.

24 MR. DICKSON: Not just the rules.

25 So if you drop the C, you know, or don't

1 recertify, you still practice as a certified PA in our
2 state, because you passed it initially.

3 MS. THOMPSON: Can we get your name?

4 MR. DICKSON: Sure. Randall Dickson.

5 MS. THOMPSON: One thing I'm going to ask
6 is that people in the audience who don't have name
7 tags, say your names for the record, so the gentleman
8 on the phone and the court reporter can pick up the
9 names.

10 Thank you. Okay.

11 DR. GREEN: So --

12 MS. THOMPSON: Yes, Dr. Green.

13 DR. GREEN: Couple of comments and
14 questions. Starting with the certification issue,
15 only -- to get a license, you only need initial
16 certification. What about when we get to the renewal
17 process?

18 MR. DICKSON: It's not required.

19 DR. GREEN: Well, this is something to
20 think about, because most everybody else at some point
21 requires it.

22 MR. DICKSON: Nationwide, though, it's
23 very few states require it. Hospitals, on the other
24 hand -- some hospitals require that you continue, even
25 some clinics.

1 DR. GREEN: I'm just bringing it up as a
2 question that I think we're going to have to deal
3 with, and that is whether or not we're going to
4 require maintenance certification.

5 MS. DALE: There are the CME
6 requirements, the hundred hours every two years.
7 That's the only thing that's really required as far as
8 that's concerned.

9 DR. GREEN: Yes. And as -- I'm aware of
10 that. The requirement for physicians is going to
11 transform into something else very shortly, and I'm
12 just pointing out that I think that the way the world
13 is going, there's going to be a change of that
14 requirement. So it's just something to consider in
15 these definitions, I guess.

16 And the second point is that if you take
17 this definition, "Physician assistant means an
18 individual licensed under RCW," period, somebody is
19 going to go look up RCW. As this is written, it's a
20 pretty functional definition that somebody would get
21 the idea of what it is without having to go to another
22 reference. Is that inappropriate to leave that that
23 way, even though it's out of line with your rule or
24 policy of -- because it doesn't say anything different
25 than RCW, but it allows somebody to read this and

1 understand what it is without having to go refer to
2 it.

3 MS. THOMPSON: So one of the things
4 that -- I mean, you're right. And we -- as a
5 department, with all of our providers and all of the
6 authorities, we do it both ways.

7 DR. GREEN: I guess I would just argue
8 for leaving it so you could read it and make some
9 sense out of it. That's all I'm saying.

10 MS. THOMPSON: Yeah. One of the things
11 that you think about is what are we using these rules
12 for. So these rules -- for some professions the rules
13 are kind of the guidelines, and they really do use the
14 rules to help them work through their scope of
15 practice, what they can and can't do on a more
16 day-to-day basis. Other providers and other
17 professions don't. They have other resources
18 available to them, and the rules are really just the
19 legal piece that the attorneys use.

20 So, I mean, you have to -- I guess we
21 have to look at who's using them, how they're using
22 them, and what you guys want to do. And it really is
23 up to the Board and the Commission what you all want
24 to do. Neither one of them are right or wrong, in
25 essence.

1 MS. CLOWER: I agree with Dr. Green.
2 Because the employers are reading it, it will be
3 easier for them.

4 MS. THOMPSON: Okay.

5 So consensus would be to kind of leave it
6 as is, but yet because it's still referencing the RCW
7 and making that connection there? Because --
8 regardless, they still have to comply with the
9 statute.

10 MS. SCHIMMELS: I'm okay with that.

11 MR. DICKSON: Couldn't we just repeat
12 what the RCW says, as RCW da, da, da, says, this is
13 what a PA is. And so they have the reference right
14 there.

15 DR. GREEN: Yeah.

16 MR. DICKSON: Same thing. It's just
17 repeating --

18 DR. GREEN: In essence, it says the same
19 thing in a shorter --

20 MS. THOMPSON: And legally it's probably
21 safer, because you're not trying to interpret and
22 mixing. You're just restating.

23 MR. DICKSON: I do find this more clear.

24 MS. THOMPSON: So maybe we've come full
25 circle now, and we're back to taking the statute and

1 basically adopting it into the definitions section so
2 that the definition in the RCW is the definition with
3 the rule, so that it's the exact same.

4 I'm seeing a lot of nodding heads.

5 MS. DALE: Yes.

6 MS. SCHIMMELS: Yes.

7 MS. THOMPSON: Yay.

8 It's all right. That what's we do. We
9 talk these things through, and sometimes that's what
10 happens.

11 Was there any other comments, concerns,
12 questions, about the definitions section?

13 And could we, committee members, for
14 Osteo and Medical, maybe put a checkmark by this one
15 and say this is what we'd like to bring forward to our
16 respective Board and Commission.

17 And you're not being held to that,
18 because I think at the Yakima meeting we'll have one
19 more public meeting, and if something came up, you
20 know, it's not -- we're not being held to that quite
21 yet. We even still have -- each of you have a public
22 hearing that you have to, and your boards and
23 commissions have to, you know, comment. So there is
24 still room for "Oh, yeahs" later, but if we can check
25 this off --

1 I'm seeing a lot of nodding heads.

2 DR. JOHNSON: Were you looking for a
3 motion?

4 MS. DALE: We have a question.

5 MS. THOMPSON: Yes.

6 MS. DALE: Legally, if a physician
7 assistant did not maintain their certification, they
8 can't sign PA-C. So I think we need to add something
9 in there, like maybe on the definition of a
10 noncertified physician assistant, we could put
11 graduate from an international medical school,
12 whatever, in that section, that first section under 1,
13 and state something like "Not" -- "Has not maintained
14 their certification." NCCPA certification.

15 MR. DICKSON: That changes the rules. I
16 mean, because the rules for noncertified and certified
17 is different. The State only requires initial
18 certification. So according to State, you're always
19 certified once you've passed the initial board. Even
20 though NCCPA doesn't let you put a C after that, the
21 State still says you legally can do this.

22 MS. DALE: Okay.

23 MS. BALLWEG: Yeah, you would really
24 limit people if you do that, because they're not in
25 that category. And I wouldn't want to put IMGs

1 specifically in there because you wouldn't want that
2 door to be opened.

3 MS. DALE: Okay. So basically, then, the
4 State is okay with their maintaining that C even
5 though they only initially certified?

6 MS. CARTER: I don't think the Board or
7 Commission would say you can still put the C. I mean,
8 I think that designation is part of the national
9 accreditation. They would say you -- but under these
10 rules you were certified initially, so that means that
11 you follow the rules, which allow you to do more
12 things with a little bit, you know, less signature or
13 what -- so you're still operating under the certified
14 rules.

15 MS. SCHIMMELS: And this also
16 grandfathers in those other people because this refers
17 back to prior to July 1st, 1989. So it would
18 grandfather those folks in without inviting new IMG,
19 noncertified, not trained.

20 MS. DALE: Yeah.

21 MR. CONCANNON: Let's see, now.
22 You're -- this definition has "licensee" in it, right?
23 Am I looking -- I'm looking at the right draft?
24 Item 3 is licensee?

25 MS. THOMPSON: Let's see.

1 MS. CARTER: It does, yeah.

2 MR. CAIN: Yeah.

3 MR. CONCANNON: And so "licensee" is
4 being used later in this statute -- I mean, in these
5 rules as a term of art?

6 MR. CAIN: This is a good question.
7 Let's see.

8 MR. CONCANNON: "Licensee" is a word that
9 I had stuck in my thing.

10 MS. THOMPSON: Yeah.

11 MR. CONCANNON: But I don't know if
12 that's --

13 MS. THOMPSON: So it's No. 3 in the
14 Osteo -- I mean, I'm sorry, the medical definition
15 No. 3.

16 MR. CAIN: Yeah, they use -- there's
17 "licensee" throughout the chapter, it looks like.

18 MR. CONCANNON: All right. So "licensee"
19 means all these people, and these people are
20 apparently of three different types: a certified PA, a
21 surgical assistant PA, and a noncertified PA. So the
22 licensee has to say credentialed as a certified PA,
23 noncertified PA, or physician assistant. So you need
24 the word "noncertified" there.

25 MS. THOMPSON: Good point.

1 MR. CONCANNON: All right.

2 MS. THOMPSON: Good catch.

3 MR. CONCANNON: That's all.

4 DR. MARKEGARD: Is it -- is there
5 anything we need to do to make these definitions more
6 congruent between DO and MD? Because the Osteo one
7 seems so nicely clear and crisp, simple.

8 Am I missing something on these?

9 I don't want to complicate this any,
10 but --

11 MR. CAIN: The one thing is that there
12 are these other two types of licensees under the
13 Commission that Osteo doesn't have, so Osteo doesn't
14 have a PA SA and Osteo doesn't have noncertified PAs.
15 So those don't need to be defined otherwise.

16 DR. MARKEGARD: So the PAs can't do
17 assist under a --

18 MR. CAIN: No, it's actually a different
19 designation of a credential. It's way back in '99, I
20 think.

21 MR. MARESH: There are some folks who did
22 some other works and put into PA category but
23 (inaudible) but they have not been allowed to move
24 from allopathic to osteopathic.

25 DR. MARKEGARD: And is that what you're

1 trying to fix?

2 MR. MARESH: It's just my understanding.

3 DR. GREEN: Is there a restriction?

4 MS. CARTER: I think there weren't any,
5 and so they didn't have to grandfather them in. So
6 now --

7 DR. GREEN: So theoretically or
8 hypothetically, one of these -- a physician assistant
9 who comes from one of these other categories could
10 apply for a practice agreement with an osteopathic
11 physician.

12 MS. CARTER: They wouldn't be allowed to
13 get a license from the Osteo Board.

14 DR. GREEN: Then the question is whether
15 that's something they want. If it isn't, then you
16 don't need to have it in there. If it is, then you
17 need to have it in there. Isn't that right?

18 MS. CARTER: Right. Yeah. If the board
19 wants to allow those 48 people --

20 DR. GREEN: Right.

21 MS. CARTER: Yeah.

22 DR. GREEN: But if we are trying to make
23 mobility, which is one of the things that was brought
24 up, easy as possible, I would think you would want to
25 allow that possibility. It's just my thought.

1 DR. MARKEGARD: Yeah. The board.

2 DR. GREEN: So if that's the case, then
3 this nice crisp bunch of definitions would need to be
4 expanded if you want to be able to do that.

5 DR. MARKEGARD: Can we do that?

6 Because I agree with you that we need to
7 make it so it's more -- it's easier for the PAs,
8 right? Wouldn't you want --

9 MS. CARTER: Yeah, I don't -- because
10 your RCW requires initial certification, I don't think
11 the Board can make a rule to then allow that.

12 DR. MARKEGARD: Oh, so we can only have
13 PA-Cs, we can't have the PAs, who never took that
14 initial certification.

15 MR. DICKSON: Correct.

16 DR. MARKEGARD: And the surgical PAs
17 don't take certification?

18 MR. DICKSON: No. They're totally
19 separate.

20 MR. CAIN: There's only eight of them.

21 DR. MARKEGARD: And so at some point they
22 won't --

23 MR. DICKSON: There's only --

24 MS. BALLWEG: This is at another time,
25 and we're just protecting them till they go away over

1 time.

2 DR. MARKEGARD: So we don't need to
3 change anything, then.

4 MR. DICKSON: They're all in their late
5 sixties.

6 DR. MARKEGARD: We can keep it crisp.
7 Okay.

8 MS. CARTER: Right, your RCW wouldn't
9 allow them to be licensed.

10 DR. MARKEGARD: Okay.

11 MS. THOMPSON: So we are as lined up as
12 we possibly can with our current --

13 DR. MARKEGARD: Yes. Thank you.

14 MS. THOMPSON: No. That's a good
15 question.

16 Okay. Any other -- I hate to say this.
17 Any other questions or --

18 MR. DICKSON: Is it lunchtime yet?

19 MS. THOMPSON: Can we move --
20 Going once? Twice?

21 We're moving. We're going say yea to
22 those for right now.

23 Okay. Moving on to the next piece.

24 MR. CONCANNON: Let's take a look here
25 for a second.

1 MS. THOMPSON: Okay.

2 MR. CONCANNON: Again, just using the
3 words you're using here, a supervising physician is a
4 physician who's responsible for supervising,
5 consulting, and reviewing the work of a --

6 MS. CARTER: You're right, we should say
7 "licensee."

8 MR. CONCANNON: "Licensee."

9 MS. THOMPSON: Oh, good one. Good catch.

10 MS. CLOWER: And a question. Could that
11 supervising physician have a delegate physician? For
12 example, there is somewhere talk about the medical
13 director being the supervising physician but
14 delegating some of that authority to a delegate
15 physician.

16 MS. SCHIMMELS: I think it's back here,
17 into -- it's somewhere else back in here.

18 MS. THOMPSON: Covered in the actual
19 rules, not in the definitions?

20 MS. SCHIMMELS: I don't think it has to
21 be put in the definition.

22 MS. THOMPSON: If we can do that, then it
23 would have to be in the actual rules. It shouldn't be
24 in the definitions section. You know, the definitions
25 sections define and clarify terms used throughout the

1 chapter. The rules actual sections are where you can
2 specifically tell the licensee what they can and can't
3 do, where you put the restrictions are not.

4 So can we maybe table that question until
5 we get to that section?

6 MS. CLOWER: Perfect.

7 MS. THOMPSON: Okay. Yes, Dr. Heye.

8 DR. HEYE: Maybe I'm missing something,
9 but "licensee" -- every time you use "PA" or
10 "physician assistant" you don't have to change that to
11 "licensee," because we've already defined a physician
12 assistant as a very broad category, and then under
13 that are some subcategories.

14 MS. THOMPSON: I was -- that's funny,
15 because I was actually kind of thinking that too. It
16 appears that we have two terms that we're kind of
17 using interchangeably, and maybe one of the things
18 that we need to sit back and look at is can we use one
19 term throughout the chapter for all of it, rather than
20 using "licensee" and "physician assistant," because
21 once you become licensed, yes, you're a licensee, but
22 then you can use that term "I am a physician
23 assistant" so you are a licensee.

24 So I don't know. I think it's something
25 that maybe we need to look at.

1 Thoughts?

2 It's a pretty easy -- maybe.

3 Heather.

4 MS. CARTER: I think you're right. I
5 think when we changed the definition of "physician
6 assistant" and then broke it out into two, we
7 encompassed all three. Licensee also encompasses all
8 three.

9 MS. THOMPSON: So maybe one of our tasks
10 at the Department will be to go back and look at where
11 the terms are used throughout the chapter and see if
12 we can just use one term instead of both. Because I
13 think that is a good point, because I was kind of
14 thinking that too.

15 DR. GREEN: Can we leave it to you to
16 take a crack at that so we don't have to --

17 MS. THOMPSON: Yes, the Department will
18 take a crack at that.

19 DR. GREEN: Otherwise we may be here till
20 dinner.

21 MS. THOMPSON: Exactly. Exactly. But it
22 was a very good point.

23 You got that, Brett?

24 MR. CAIN: I'm getting there.

25 MS. THOMPSON: Here, I'll make a note

1 too. We're taking notes as well.

2 We're still moving past that one.

3 All right. I'm looking at the PA --
4 physician -- MQAC rules. Application withdrawals. I
5 don't believe there's any suggested changes in that
6 section.

7 Anybody have any concerns? Do we have
8 a --

9 MS. CARTER: Do we want to add that to
10 Osteo, or is that --

11 MS. THOMPSON: Yes, do we want to add
12 that to Osteo?

13 DR. MARKEGARD: What does it mean?

14 MS. CARTER: So if someone applied to be
15 a PA with the Board or Commission, and through the
16 course of their application you discover there's
17 something in their history that would disqualify them,
18 say, for licensure, and they find out -- you say,
19 Well, you thought, you know, eight criminal
20 convictions of abusing a patient, and so they say, Oh,
21 never mind, I don't want to be licensed here, and they
22 try to pull it back because they don't want the mark
23 on their data bank as having a license denied for some
24 reason.

25 This is saying if you can't withdraw your

1 application if we find that. We want to be able to
2 alert everyone else in the United States that this
3 person may have a problem.

4 DR. MARKEGARD: So yes.

5 MS. THOMPSON: That keeps it on the
6 record at the Department.

7 MR. CAIN: Doesn't say Commission there
8 so it should be good.

9 MS. THOMPSON: Okay. Are we good with
10 that? Can we mark those off too?

11 Yes.

12 Moving on. No. 2, done.

13 Okay. So then the next section that we
14 have for medical is 030, which is prescriptions issued
15 by physician assistants, and the recommendation is to
16 delete that section because --

17 MR. DICKSON: It's confusing.

18 MS. THOMPSON: Because -- did we capture
19 that --

20 MR. CAIN: The next section --

21 MS. THOMPSON: Okay, yeah, we -- that's
22 right, we pulled it down into the next section.

23 MR. CAIN: They comply with relevant
24 laws.

25 MS. THOMPSON: Okay. I'm like I can't

1 remember now.

2 Okay. So then we would go to 035, right?

3 Section 035?

4 MR. CAIN: Which is where that new
5 language is.

6 MS. THOMPSON: Where is where we put the
7 new language.

8 MR. CAIN: Right here. Just this one
9 sentence.

10 MS. THOMPSON: And we have even
11 simplified that, so we're down to like one sentence.

12 MS. SCHIMMELS: Perfect.

13 MS. THOMPSON: And so equivalent side of
14 Osteo.

15 MR. CAIN: I don't --

16 MS. CARTER: Osteo is 030. And we have
17 deleted a bunch, but we had left in --

18 MR. CAIN: And the only reason -- okay,
19 so 030, the only reason it's not exactly the same is
20 because we're in the process of confirming 100 percent
21 by pulling all 47 osteopathic PAs and making
22 100 percent sure that there are no noncertified
23 osteopathic PAs. What we have to do is get all their
24 application material and figure out when they were
25 licensed to see whether or not -- I talked to the

1 credentialing people. They're 90 percent sure that
2 there aren't any, but before we delete this section
3 that talks about the difference between a certified
4 and noncertified in relation to prescriptions, because
5 it says that noncertified can't do Schedule II drugs.

6 And then, even so, that's a decision that
7 the Court can come -- I mean, I don't know if that
8 statute anywhere says that they can't do Schedule II
9 drugs or if this is just a Board rule.

10 MS. CARTER: It does not say in the
11 statute.

12 MR. CAIN: I didn't think it did.

13 MS. THOMPSON: So this is a higher
14 standard, in essence, that the Board is putting on the
15 PAs, right?

16 MR. CAIN: Yes. The noncertified. If
17 there are any, which we're almost sure that that
18 work's almost done to absolutely confirm it
19 100 percent.

20 DR. MARKEGARD: And 100 percent go to
21 language that --

22 MR. CAIN: We can get rid of that.
23 Talking about that they can't do
24 Schedule IIs because there aren't any of them.

25 DR. MARKEGARD: And if there is one or

1 two that are still, once hydrocodone goes to
2 Schedule II, if optometrists are able to do at that
3 point, if that rule goes through, then I can't see why
4 a PA can't do that if they're already doing that.

5 MR. CAIN: That's something the Board can
6 decide, is whether or not you want to mirror what MQAC
7 has proposed.

8 DR. MARKEGARD: Yes.

9 MS. CARTER: And that would streamline
10 and make, you know, the PAs --

11 MR. DICKSON: Even if you have
12 noncertified, you don't know -- that one line that
13 MQAC put in makes sense whatever state and federal
14 law.

15 DR. MARKEGARD: Yes.

16 MS. THOMPSON: Okay. Linda, you had a
17 question.

18 MS. DALE: So I'm confused, because I
19 thought in the RCW it said that there could be no
20 noncertified osteopathic PAs.

21 MR. CAIN: From this point, right?

22 MS. CARTER: Yeah, there have not been
23 since -- there could be. They don't think so, but
24 they want to confirm a hundred percent. We don't
25 think there are any, but -- there's only 47, so

1 they're just going to go in -- but if you wanted to
2 change that anyway, just to --

3 DR. MARKEGARD: I do.

4 MS. CARTER: Okay.

5 MS. THOMPSON: Dr. Johnson?

6 No?

7 MR. CONCANNON: So the sentence on
8 prescriptions in 35, the simple sentence, if that
9 sentence wasn't even in these rules, where would you
10 be? What's the purpose of it?

11 MS. CARTER: I think you could remove it.
12 I'm trying to think through if you were charging
13 someone with a violation of their prescribing
14 practices, you could charge -- but you would have
15 to -- you're going to have to go back to the state and
16 federal regulations anyway.

17 MR. CONCANNON: A physician assistant
18 must comply with all current federal and state
19 regulations for everything.

20 MS. CARTER: Right.

21 MR. CONCANNON: For everything.

22 MS. THOMPSON: Clarification. I would
23 say my opinion would be it's simply in there for
24 clarification, that because they can do prescriptions,
25 it just --

1 MR. CONCANNON: All right.

2 MS. THOMPSON: But you're right. I
3 mean --

4 MR. CONCANNON: No, no. Let it go. I'm
5 just asking.

6 MS. THOMPSON: Okay. So we landed with,
7 I believe, we like Medical's one-liner, and Osteo is
8 going to double-check numbers, and if there are none,
9 we're going to use the one-liner from MQAC.

10 DR. MARKEGARD: We're going to change it
11 regardless.

12 MS. THOMPSON: Okay. So then they're
13 going to be exactly the same.

14 DR. MARKEGARD: Yes.

15 MS. THOMPSON: Okay.

16 And is everybody good with that?

17 MS. CARTER: Yeah, she's the only Osteo.

18 DR. MARKEGARD: Only need one.

19 I'll get the job done. Don't worry.

20 Easier to make decision on the side.

21 MS. THOMPSON: It totally is.

22 MR. CAIN: The other person on the
23 committee is out of the country so she couldn't make
24 it today.

25 MR. DICKSON: Ah. So she doesn't exist.

1 MS. THOMPSON: Is that person going to be
2 in Yakima?

3 MR. CAIN: Yeah.

4 MS. THOMPSON: Okay. So we're moving.
5 Look at us. We're cruising now.

6 Okay. So we've done 035 -- okay. 50,
7 "Physician assistant qualifications effective
8 July 1st, 1999." Are we -- and what's the equivalent
9 over here with our little Osteo?

10 MS. CARTER: I don't think there is.

11 MS. THOMPSON: Okay.

12 DR. JOHNSON: Term permit, license? What
13 is the correct word?

14 Interim permit and interim license?
15 What's the correct --

16 MS. THOMPSON: I think they're permits.
17 They're use permits.

18 MR. CAIN: That's what they call it,
19 permit.

20 DR. JOHNSON: Is that what physicians
21 get? Do we get a permit? Do we get a license?

22 MS. THOMPSON: You get a license.

23 DR. JOHNSON: Why do they only get a
24 permit?

25 MS. THOMPSON: Because it's in between.

1 DR. JOHNSON: Well, we're in between too.
2 When we finish our medical school and start our
3 internship and we get licensed --

4 MS. CARTER: You get a residency license,
5 yes.

6 DR. JOHNSON: Right. So can they get a
7 license that's a limited license, just like a
8 resident? Because then we have to pass our boards,
9 but we're not required to pass our boards to get a
10 medical license. We are required to get our boards in
11 the timeliness to have hospital privileges, but not
12 for our state license.

13 MS. CARTER: It could -- and I can --
14 I'll double-check, but --

15 DR. JOHNSON: I'm just curious.

16 MS. CARTER: It could be how the RCW
17 defines it, because they do define "resident license,"
18 so --

19 DR. JOHNSON: That's my question.

20 MS. THOMPSON: And what tends to happen
21 is from legislative session to legislative session,
22 depending on who is drafting the bills and the terms
23 that they use.

24 DR. JOHNSON: Okay.

25 MS. THOMPSON: And we try sometimes to

1 get them to be the same, but sometimes it just doesn't
2 work out.

3 Besides looking at the term --

4 Oh. Yes?

5 DR. JOHNSON: So just a clarification.

6 If I were taking my -- so for me, I had to take
7 oral -- written, written, written, written, and then
8 an oral, and that went over a number of years. And I
9 had three chances to pass my last written and three
10 chances to pass my last orals. During that whole time
11 I was still licensed and privileged. This says one
12 year for a PA. What if they don't pass it and that
13 one year they're still trying to pass the exam?
14 Because not everybody passes.

15 MS. BALLWEG: Four times in one year to
16 pass it.

17 DR. JOHNSON: Is that the current rule?
18 Four times in one year?

19 MS. BALLWEG: Yeah. And a maximum of six
20 times before they can never take it again.

21 DR. JOHNSON: Okay. That's a good
22 clarification for me. Thank you. I don't need any
23 more. That helps. Thank you.

24 MS. BALLWEG: Mm-hmm.

25 MS. CARTER: Do we want to get rid of the

1 phrase "effective July 1st, 1999"? Just clean it up?

2 MR. CAIN: Yeah, do we need to still say
3 that?

4 MS. CARTER: I don't think so.

5 MS. THOMPSON: I don't think so, but --

6 MS. CARTER: It used to be there were
7 two.

8 MS. SCHIMMELS: I think that probably
9 related to the physician assistant noncertified and
10 the certified.

11 MS. CARTER: Right. There were two
12 paths.

13 MS. SCHIMMELS: Yeah. And if we're going
14 to get rid of that path, I think we can get rid of
15 that language.

16 MS. THOMPSON: Yes, Dr. Green.

17 DR. GREEN: Taking -- or considering
18 Mark's comments, would it be appropriate to pick up
19 that last sentence and just make a statement that they
20 are certified or eligible for the NCCPA exam, so that
21 allows them, whatever their time frame is -- even if
22 it changes, so if they're eligible and are in the
23 process of taking the exam, they have that amount of
24 time, but if they -- if their rule is they get six
25 chances, what happens then?

1 MS. BALLWEG: They can't ever take it
2 again. They'd have to go back to school.

3 DR. GREEN: So then they would never be
4 certified. What do you do then?

5 MR. DICKSON: Remove their license.

6 DR. GREEN: Okay. But my point is --
7 just make a statement, because that's the way most
8 licensing things are for physician -- or credentialing
9 is for physicians. You're board certified or board
10 eligible.

11 So maybe if we put a statement that they
12 are certified or eligible for taking the certification
13 examination. That way it allows for changing the
14 processes by the licensing organization -- or
15 certifying organization, I'm sorry. Because it
16 varies -- at least in medicine it varies quite a bit
17 from specialty to specialty.

18 MS. CARTER: So we would add some --
19 delete the last sentence? Is that what you're saying?

20 DR. GREEN: Yeah, delete it, because that
21 just puts a one-year deadline, and I think Mark was
22 speaking to that, and I think that's an appropriate
23 concern. So -- and if you substituted the sentence
24 that they are certified by NCCPA or eligible for their
25 certifying examination. And if they go past the

1 deadline, they're no longer eligible. If they have --
2 and then they aren't eligible for license. Doesn't
3 that make sense?

4 MS. THOMPSON: Let me translate. Are you
5 saying that when they -- when we issue the interim
6 permit, that's giving them the ticket to -- to take
7 the exam?

8 DR. GREEN: If they have an interim
9 license and they -- that license has effect -- as long
10 as -- until they are certified or as long as they are
11 eligible for the certifying exam.

12 MR. DICKSON: So that would make it
13 longer than a year, correct?

14 MS. DALE: Yes.

15 MR. DICKSON: Is there an RCW that says
16 it has to be a year?

17 I agree with what you're saying. As long
18 as --

19 DR. GREEN: Yeah.

20 MR. DICKSON: After six times they're not
21 eligible.

22 MS. BALLWEG: They can stretch that out.
23 The average pass rate for the NCCPA example -- if
24 somebody hasn't passed it by the fourth time at the
25 end of a year, ain't going to happen, you know.

1 MS. CARTER: And we can check, but it
2 could be possible -- we need to check, but that you
3 could -- I don't know if you can renew an interim
4 permit for another year.

5 MS. BALLWEG: I don't think so. We'll
6 check on that but we don't think so.

7 MS. CARTER: It's one year for the
8 interim permit. For regular renewals, once you have a
9 license, it's two.

10 DR. GREEN: So then that effectively gets
11 you back to a year.

12 MS. CARTER: Right.

13 MS. BALLWEG: Well, a lot of states don't
14 have an interim permit at all, and the reason is that
15 the NCCPA gets your results within two weeks of when
16 you passed. It used to be it was four months, and so
17 within two weeks of taking the exam, which you can
18 take 10 days after school, you get the results.

19 So the whole idea of a year, there are
20 some states that don't allow it at all, and some have
21 shorter periods of time. So I think stretching it
22 out, in today's technology, probably not necessary.
23 And I don't think most PAs would think it was a good
24 idea that it go beyond a year. If they haven't done
25 it by a year, and, again, knowing who some of those

1 people are, there's a problem.

2 DR. JOHNSON: So are you suggesting --

3 MS. BALLWEG: I think one year is plenty.

4 DR. JOHNSON: Oh.

5 MR. CONCANNON: We're mixing and
6 matching, you know, a lot of different ideas when it
7 comes to interim permits and approved training and
8 completing the exam. So let me just ask how it really
9 works. There's something called training, and
10 apparently it ends at some point. And I guess there
11 would be a date put on that.

12 MS. BALLWEG: Correct.

13 MR. CONCANNON: You ended your training
14 on this date because you completed the class.

15 MS. BALLWEG: And people submit their
16 certificate along with their licensure forms.

17 MR. CONCANNON: And once they complete
18 the class, they may or may not apply to begin
19 practicing. They may or may not apply. They may go
20 on vacation for nine months.

21 MS. BALLWEG: Or have a baby, more
22 commonly.

23 MR. CONCANNON: Right. All right.

24 Then they apply. So the -- the one-year
25 date's from when?

1 MS. BALLWEG: From when they get the
2 interim permit.

3 MR. CONCANNON: And they're allowed to
4 get an interim permit as long as they've completed
5 their training?

6 MS. BALLWEG: Yeah.

7 MR. CONCANNON: And at some point in the
8 future, it could be two years from now, they apply for
9 an interim permit. They fell asleep for two years.
10 They can do that?

11 MS. BALLWEG: Mm-hmm. I'm not saying
12 it's a good idea, but that --

13 MR. CONCANNON: But they can do that.

14 And once they apply for that interim
15 permit and get it, they've got to complete the exam
16 within a year or they're out of business. They're
17 going to be fired from whatever job they were approved
18 for, correct?

19

20 MS. BALLWEG: Correct.

21 MR. CONCANNON: No matter how many times
22 they take the exam within a year. The one year as
23 deadline.

24 MS. BALLWEG: Right.

25 MR. CONCANNON: I would think you'd want

1 to make that clear. Once you have --

2 MR. DICKSON: They have six times to try.
3 Once they do pass it, they can reapply to the State
4 for a license or -- a license. It's not that once the
5 State says, "No, you didn't pass it," one year is
6 gone, you're done for the rest of your life. We can
7 reapply and say, "Okay, I passed the boards. Here I
8 am."

9 MR. CONCANNON: But whatever job you have
10 after that year, you're out of, and you're not allowed
11 to continue in it.

12 MS. BALLWEG: Correct.

13 MR. CONCANNON: And you might want to
14 make that clear if that's the case.

15 MS. THOMPSON: Linda, you had a question.

16 MS. DALE: So tagging on to that, if we
17 leave this -- the interim permit may be issued for one
18 year to allow for completion of the exam. We need to
19 change that, because if someone, like he says, goes
20 asleep for two years, they've missed their
21 opportunity. So --

22 MS. THOMPSON: For the physician rules.

23 MS. DALE: So maybe it needs to be
24 interim permit may be issued for one year following
25 the application of initial whatever we want to call

1 it.

2 DR. MARKEGARD: But if it's -- the
3 interim permit is to allow them to practice until they
4 pass their boards and get the license, but if that one
5 person decides to go on a mission trip for two years,
6 then they don't have to have an interim permit for
7 that time; they can then take the certification exam
8 or whatever, the licensing exam, and then apply to the
9 State or the Board or whomever for their license, and
10 they don't even need an interim permit, right?

11 MR. DICKSON: Right.

12 DR. MARKEGARD: These are people who want
13 to practice now, as they're trying to pass the test.

14 MR. DICKSON: Certainly.

15 MS. CARTER: Osteo has a rule on this at
16 055 in Osteo rules. It's quite detailed. I don't
17 know if --

18 MS. THOMPSON: But it seems to --

19 MS. CARTER: -- which version.

20 MS. THOMPSON: Here's what I picked up
21 on, is -- and maybe I mis -- but -- MQAC -- sorry.
22 MQAC's rules say that you have to get that permit
23 within one year of getting your training.

24 Or, I'm sorry. It's good for one year,
25 right?

1 Osteo seemed to be silent on that, which
2 would allow somebody to go two years before they
3 wanted to -- or -- you know, so it feels like there's
4 a little bit of discrepancy in the interpretation of
5 how long after your training that you are allowed to
6 go get that permit. Am I misreading it?

7 MR. CAIN: I don't know that the medical
8 says that they have to get. It just says that once
9 the permit -- it's good for one year, right? That's
10 all it says?

11 MS. CARTER: Yeah.

12 MS. THOMPSON: But it says the interim
13 permit may be issued for one year following the
14 completion of the approved training, so to -- I don't
15 know. I think that there might be some wiggle room
16 there that --

17 MS. CARTER: It's a little ambiguous. I
18 mean, Osteo is clear and says interim permit holders
19 will have one year from issuance of the interim permit
20 to successfully pass the NCCPA exam.

21 MS. BALLWEG: So it might be interesting
22 to know that both Oregon and Alaska have the rule that
23 you get it from the time that you're issued -- that
24 you issue the exam, not from the time you finish
25 school. So not that we have to match up with them,

1 but --

2 MS. THOMPSON: There's another option
3 that we could play with.

4 MR. CONCANNON: In the statute -- in the
5 statute -- forget about the rule. In the statute for
6 PAs, the requirement shall include completion of the
7 training program approved by the Commission, and
8 within one year successfully take and pass an exam.

9 MS. THOMPSON: There you go.

10 MR. CONCANNON: So that's the end of it.
11 The clock is ticking. When the training is done,
12 they've got a year.

13 MS. THOMPSON: So we might want to --

14 MR. CONCANNON: They've got a year.
15 Whether they apply for an interim permit or not,
16 they've got a year. If they apply six months in, then
17 they've only got six months.

18 MS. BALLWEG: Again, many states don't
19 have this at all. So we're being generous as it is,
20 just to be clear.

21 And there are some people in the
22 profession that think we ought to throw this out
23 altogether. I'm not saying we should, but just so you
24 know. It's not universally loved.

25 MS. THOMPSON: Yeah, but the statute

1 trumps.

2 DR. JOHNSON: Mike, could you rephrase?
3 Did you say that's in the statute?

4 MR. CONCANNON: In the statute.

5 DR. JOHNSON: Then we don't have any
6 conversation, right?

7 MS. THOMPSON: We just need to make sure
8 that our rules are clear and they match up with the
9 statute.

10 DR. JOHNSON: The only way to change that
11 is to go back to the Legislature to make the
12 exceptions to what we're talking about.

13 MS. THOMPSON: Absolutely.

14 MR. DICKSON: Why don't we use the RCW
15 definition?

16 MS. THOMPSON: The language right from
17 the RCW to -- because it seems pretty clear.

18 MR. DICKSON: It is very clear.

19 MS. THOMPSON: Thoughts from the
20 committee members?

21 DR. MARKEGARD: And that doesn't address
22 this, but that's the same thing with an interim
23 permit, so you have to define what an interim permit
24 is?

25 MR. CONCANNON: An interim permit may be

1 granted by the Department of Health for one year,
2 provided the applicant meets all other requirements.

3 DR. MARKEGARD: One year from what?

4 MR. CONCANNON: One year from when they
5 completed their training.

6 MS. SCHIMMELS: I think -- we've -- I
7 mean, I think that that's -- Randall Dickson just said
8 let's put that, the statute language, in there. I
9 agree with that. There's no question then.

10 MS. BALLWEG: That's fine.

11 MS. THOMPSON: Mm-hmm. It's very clear.

12 Are you all okay with that from the
13 medical side?

14 Osteo, what do you want to do?

15 DR. MARKEGARD: Yes. And also, to do
16 that, when we have our interim permits, that also adds
17 seven clock hours of AIDS training and additional
18 stuff.

19 MS. THOMPSON: Mm-hmm.

20 DR. MARKEGARD: Can we get rid of that?

21 MR. CAIN: That was one of the questions.

22 MS. SCHIMMELS: We have that in here.

23 It's in the allopathic.

24 MR. DICKSON: Is that an RCW or is that a
25 rule?

1 MS. CARTER: Those are in RCW. It was a
2 requirement by the Legislature that all healthcare
3 professionals -- it was in the 90 thing.

4 MR. DICKSON: I understand when and all
5 that. So to go back and change the law.

6 MS. CARTER: To get rid of the AIDS
7 training, yeah.

8 DR. MARKEGARD: But is this an
9 appropriate place to have that under the interim
10 permit of the Osteo section of the rules?

11 MS. CARTER: I think what that rule is
12 trying to say is you need to do the AIDS training
13 before you can get your interim permit, rather than
14 you just have to have it before you get your actual
15 license. So it's up to -- up to the Board whether or
16 not you want to have it there or -- I mean, you can
17 just say "meets all requirements" and you'd be fine.

18 DR. MARKEGARD: I like that.

19 And then I think there's also -- just to
20 go down a little rabbit hole, there's a question on
21 the Osteo rules that MQAC has four hours or seven
22 hours, so what does it say in the --

23 MS. THOMPSON: You get to decide. You
24 the Commission get to decide if it's going to be four
25 hours or seven hours.

1 Sorry. Your options are four or seven.

2 DR. MARKEGARD: Four.

3 MS. CARTER: If you want to match MQAC,
4 it will be four.

5 MR. CAIN: That was one of the questions
6 from the --

7 MS. THOMPSON: Most provider licensees
8 that have the more fuller education -- how do I say
9 that politely --

10 DR. MARKEGARD: Why don't we say in the
11 RCW. Does it just say you have to some have some
12 amount of --

13 MS. CARTER: Approved by the Board.

14 MR. CAIN: And it's four or seven.
15 Where does two, four, six, 12 come from?

16 MS. DALE: It's in MQAC 080, if you're
17 looking for the same AIDS education. It can take four
18 clock hours.

19 DR. MARKEGARD: I'd like that to match
20 the MQAC, please.

21 MS. DALE: 080(1)(b).

22 MR. CAIN: Okay. Four clock hours.

23 MR. CONCANNON: All right.

24 Again, let's just -- this is really for
25 Heather to focus on or for you guys to focus on, given

1 what the statute says, and you all can check to see
2 what the statute says, right?

3 MS. THOMPSON: Mm-hmm.

4 MR. CONCANNON: What is the reason for
5 246-918-050 at all? At all?

6 The statute fixes the requirements. This
7 is just a bunch of gibberish repeating -- we've
8 defined earlier what a noncertified PA is, someone who
9 got an interim permit, da, da, da, da, da. Now we've
10 got this thing. Because this physician assistant
11 qualifications -- the rule is not setting physician
12 assistant qualifications. The statute already did it.

13 MS. THOMPSON: I think I would go back to
14 what the Osteo rule says. The Osteo rule is more
15 of -- if I remember right, it's more of a process. It
16 says you can get an interim permit, and here's the
17 process to go about getting it. And I think that --
18 because you're absolutely right. The statute gives
19 the authority to have the interim permit.

20 The question would be how do I go about
21 getting it. The rule would outline the process for
22 them to get the interim permit.

23 MR. CONCANNON: You're talking about
24 Osteo?

25 MS. THOMPSON: For Osteo.

1 So I would say Medical may want to
2 consider looking at what Osteo has, and taking that
3 process and put -- if necessary, maybe they have it
4 somewhere else, because their rules are just a little
5 bit different.

6 Sometimes I have a hard time chasing the
7 two -- between the two, but consider putting that
8 process in place over in the Medical.

9 MS. CARTER: And I think the answer to
10 some of your question is it's not really a legal
11 requirement. It's more people go to the rules and
12 they don't -- you know, a lot of people just go to one
13 spot and get kind of all the information just this one
14 place, so for ease, I guess.

15 MS. THOMPSON: Everything in one place,
16 so you're not jumping back and forth.

17 MS. CLOWER: So 246-918-050, couldn't
18 that be called interim permit instead of physician
19 assistant qualifications, like he said?

20 MR. CAIN: That would make it clearer,
21 yeah.

22 MS. THOMPSON: Mm-hmm.

23 DR. GREEN: We lost you.

24 MS. CARTER: If we kind of mirrored
25 Osteo's, I think the one thing we need to clarify,

1 which Mike had stated -- and it's in both, I just
2 checked; it's in Osteo's rule as well -- is that
3 interim permit is issued one year from the completion
4 of your training. So I think we need to make that
5 more clear so people know there's a clock ticking.
6 You need to do it if you want that interim permit.
7 Otherwise you just can't practice until you take the
8 exam.

9 MR. CONCANNON: Right.

10 MS. CARTER: So maybe -- Osteo's language
11 kind of goes through the process, but it also says one
12 year from issuance of the interim permit. I think we
13 need to say one year from completion of training.

14 MR. CAIN: We've have to check with
15 credentialing about that too, how they do that.

16 DR. GREEN: That's because the RCW says
17 that; is that correct?

18 MS. CARTER: Correct.

19 MS. THOMPSON: Correct.

20 DR. GREEN: I would favor matching the --
21 if we need to put it in the rules, I would favor using
22 the Osteo Board's statement, which seems to be clear.
23 If that one changed. One year from the --

24 DR. MARKEGARD: That change, and the
25 seven hours to four hours.

1 DR. GREEN: Yes, I agree with you. That
2 needs to be as minimal as possible.

3 MS. THOMPSON: And the process is
4 acceptable and fits with the Medical Commission's
5 application process?

6 MS. CARTER: I think -- yeah. We can
7 double-check with credentialing, MQAC, but it pretty
8 much sets out what you need to include with your
9 application.

10 MS. THOMPSON: Dr. Heye, you're not
11 seeing an issue?

12 DR. HEYE: No. I'm trying to catch up.

13 MS. THOMPSON: Oh. Sorry.

14 DR. MARKEGARD: I have a question on that
15 last part of that. On the osteopathic physician may
16 not begin practice without written Board approval, the
17 delegation agreement, and that's still -- that still
18 has to be approved by the Board for them to practice.

19 MR. CAIN: Right.

20 MS. CARTER: Yeah, that's in the statute.

21 MS. THOMPSON: Okay.

22 So on this piece, I think what I would
23 say is because we're making some significant changes
24 to the medical side, maybe we do that, and then at the
25 next meeting we just kind of look through those again

1 and make sure that when you actually see it on paper
2 and see what it says, that you're okay with it. Does
3 that sound acceptable?

4 Because I don't want you guys just to say
5 yea based on conversation.

6 DR. MARKEGARD: And then on the Osteo
7 ones -- because for the MQAC ones it's on the one
8 section, but on Osteo it's separate. Can you just
9 make those changes on the clock hours, again, for that
10 as well?

11 MS. THOMPSON: Yeah.

12 MR. CAIN: We'll go through and make sure
13 it says four instead of seven.

14 MS. THOMPSON: Okay.

15 So the delegation agreement piece is
16 next, and I kind of want to skim over that because we
17 have a whole 45 minutes to an hour set aside just to
18 discuss that piece.

19 If I go to 070 on MQAC's.

20 So 070, we are proposing to just get rid
21 of that section in its entirety, because I believe
22 that information is captured somewhere else.

23 MS. SCHIMMELS: Yes.

24 MS. THOMPSON: Right?

25 MS. SCHIMMELS: Yes.

1 MS. CARTER: I have a question, kind of
2 going back to the one we were just at, where it had
3 qualifications, and then we decide to use Osteo's
4 interim permit procedure. I mean, not really -- it's
5 following the RCW procedure. They also have a rule,
6 which is qualifications and requirements for
7 licensure, which goes through basically that same
8 procedure but for the full license. Is that something
9 that the Medical Commission -- I don't know if there's
10 another rule that goes through that. If you want to
11 mirror that so that you've got the process for the
12 licensure as well.

13 DR. GREEN: Where is that?

14 MS. CARTER: Theirs is at 080 in the
15 Osteo rules.

16 DR. MARKEGARD: On those -- are we also
17 going to delete that after July 1, 1999, as we did in
18 the other part of the --

19 MS. CARTER: I think that would be a good
20 idea.

21 MS. THOMPSON: So when you do the title
22 for these -- like for MQAC's, right? It says
23 physician assistant qualifications effective. Let's
24 maybe do physician assistant qualifications for
25 interim permit, because if you make a major change to

1 a title of a section, the code reviser's office
2 sometimes freaks out a little bit and they think that
3 you are totally changing it and it's appropriate, so
4 if we're just providing clarification to the title,
5 they won't get so freaked out.

6 MS. SCHIMMELS: So are you saying, Tami,
7 then, to change 050 and the allopathic to physician
8 assistant qualifications for interim permits?

9 MS. THOMPSON: Yeah, just trying to keep
10 the bulk of the title of that section.

11 Because what happens is the code
12 reviser's office -- who we file our rules with, right?
13 They kind of do a checks and balance with us, right?

14 So you can't take an existing section and
15 go from -- you can't mix apples and oranges, right?
16 You can't go from an interim permit to make it -- I
17 don't know -- continuing education or sexual
18 misconduct. You can't change it that drastically.

19 Which we're not. But we have to just be
20 gentle in how we change the titles so that it doesn't
21 appear that we're making this major change, because we
22 really aren't. We're just going to clarify, is what
23 we're going to do.

24 Are we good?

25 MS. SCHIMMELS: So are we talking about

1 changing -- on the -- putting in in 050 what is in the
2 080 Osteopathic?

3 MR. CAIN: 085, I think.

4 MS. CARTER: 080 and 085 in the Osteo
5 rules set out one's a license and one is -- so I don't
6 know if -- so maybe you want to put that all into 050
7 or put one of them into 050 and then create a new
8 section, 051.

9 DR. GREEN: I thought you said we
10 couldn't do that.

11 MS. THOMPSON: You can. You can. What
12 we can do is --

13 DR. GREEN: Because if we can combine
14 those some way, why even have it repeated? The only
15 thing different is interim and license.

16 MS. CARTER: And you were already
17 addressing interim and licensed in that section, so we
18 can --

19 DR. GREEN: So can you guys put them
20 together?

21 MS. THOMPSON: We can do that.

22 DR. MARKEGARD: For both of them?

23 DR. GREEN: Yeah.

24 MR. CAIN: So 080 and 085. Combine those
25 puppies.

1 MS. CARTER: I think that's better. It
2 can be separate sections, but --

3 MS. THOMPSON: No, that's fine. We'll
4 just go -- it can be separated or together.

5 MR. CAIN: I don't know exactly what I'm
6 typing, so we'll see when we --

7 MS. THOMPSON: What Heather said. That's
8 what you're going to say.

9 MR. CAIN: I'm typing that, but I don't
10 know that it's -- I can't read what I'm typing, so --

11 MS. THOMPSON: Oh, no. Because if you
12 make it bigger --

13 DR. GREEN: Instrument flight rules.
14 Instrument typing rules.

15 MS. SCHIMMELS: Put a hood on them.

16 MS. THOMPSON: So are we comfortable and
17 ready to move on?

18 Oh, Dr. Heye. Yes.

19 DR. HEYE: Are you moving the Osteo 080
20 to the -- I mean, are you replacing the MD 080 with
21 that section? We both have an 080 section.

22 MS. THOMPSON: Oh, yeah.

23 MS. DALE: So basically we're talking
24 about putting the interim permit all together with the
25 qualifications for licensure, just putting it all

1 under one, just calling it qualifications? And then
2 have qualifications for interim and then -- is that
3 what you're talking about?

4 MS. THOMPSON: Yes.

5 DR. MARKEGARD: I guess you could
6 separate them. You could just say qualifications for
7 licensure, and then another section that said in
8 addition to above, then you have to do this for
9 interim.

10 MS. THOMPSON: I am still wondering if we
11 want to keep them separate. Sometimes when you
12 combine too many subject matters, it is confusing and
13 hard to find.

14 On the other hand, sometimes if you just
15 keep repeating the same thing over and over again
16 really, is that helpful too. So -- exactly. The
17 answer is no, really.

18 So maybe what we offer up is the
19 Department and Heather will sit down and we'll like
20 really weigh the odds of do we combine them or keep
21 them separate and bring a proposal to you guys at the
22 next meeting.

23 DR. GREEN: Yes.

24 MS. THOMPSON: Does that work for you
25 guys?

1 MS. CARTER: So one question I would have
2 about 080 is --

3 MS. DALE: Which 080?

4 MS. THOMPSON: Sorry.

5 MS. CARTER: Sorry.

6 MS. DALE: 854.080 or 918 --

7 MS. CARTER: 910.080. Sorry. There's a
8 section that is not included in Osteo that talks about
9 changes or editions in supervision. I think that
10 might be important to add to the end of those for all
11 four, actually, the two interim and regular MQAC and
12 interim and license in Osteo, to talk about if there's
13 a change in your supervision, that you need to submit
14 a new practice. I think it's just helpful for people
15 to see that as much as possible, because I don't think
16 it happens as often as it should.

17 DR. GREEN: That's also stated somewhere
18 else.

19 MS. SCHIMMELS: Mm-hmm. It is, yeah.

20 DR. GREEN: So it's --

21 MS. SCHIMMELS: Duplicated.

22 MS. DALE: You should just take No. 3 out
23 of this section, because we address it in the
24 supervision section.

25 MS. CARTER: Okay.

1 MS. DALE: I mean, that's just my
2 thought.

3 DR. GREEN: Which one are you referring
4 to?

5 MS. DALE: On 918.080, where it talks
6 about No. 3, changes or additions in supervision, we
7 already addressed that in a different section of the
8 supervision, so do we need it here? When it's -- It's
9 supposed to be application requirements. We're just
10 supplying, you're not changing supervision already.

11 DR. GREEN: I agree. That's why I say,
12 that's already stated somewhere else. I'm not sure
13 why it needs to be here. I would agree with what she
14 said.

15 MR. CONCANNON: Are you talking about
16 918.080?

17 I thought you all were still doing the
18 Osteopathic whatever, and you were trying to make it
19 conform on the interim permit and all that. So now
20 you're looking at 918.080?

21 MS. CARTER: We're talking about whether
22 or not you needed the change in supervision there or
23 just in the supervision section.

24 MR. CONCANNON: Change in supervision?
25 Where is that?

1 DR. GREEN: No. 3.

2 MR. CONCANNON: Well, yeah, that -- I
3 think that's what Linda was just saying, right?

4 Yeah, because whatever Section 3 is, it
5 probably should be with the rest of the stuff on
6 delegation agreements.

7 DR. GREEN: Right.

8 MS. SCHIMMELS: And it is.

9 MR. CONCANNON: All right.

10 MS. THOMPSON: So it's duplicative? Is
11 that what you're --

12 MS. CARTER: Yeah.

13 MS. THOMPSON: Okay.

14 All right. So, are we good for a second?

15 Okay. So it's 10:25. I'm going to
16 propose we just take like a quick 10-, 15-minute break
17 and then come back, instead of waiting till 10:30.

18 Maybe take a 10-, 15-minute break, come back about --

19 How long do you guys want? Do you want
20 10, 15?

21 MS. SCHIMMELS: 10.

22 MS. THOMPSON: 10? Okay.

23 So let's come back at 10:35.

24 (Short recess.)

25 MS. THOMPSON: Okay, everyone. Let's get

1 started and get moving.

2 So the next piece, skipping the
3 delegation agreement, because we're going to come back
4 to that because we have time devoted to that, in the
5 physician MQAC section, there's the background check,
6 temporary practice permit. We have recognized that
7 Osteopath rules don't have that, and we need to
8 basically do a copy and paste and add it to the Osteo
9 rules.

10 Pretty much most professions have
11 language that is substantially if not identical to
12 what MQAC has. They actually were the leader in
13 getting the first set of language adopted for us, and
14 so all professions use that as standard language. So
15 we're going to add that to the Osteopath --

16 DR. MARKEGARD: How long does it take to
17 get that completed, on average?

18 MS. CARTER: What's happening is for
19 out-of-state applicants, people who have been licensed
20 out of state -- in-state applicants don't have to do
21 the FBI fingerprints but people coming from out of
22 state do. So what was happening is some people --
23 there was a backlog for a while at the FBI for the
24 fingerprint, you know, background checks to come back,
25 and also some people were having a really hard time

1 getting fingerprints that were suitable for reading or
2 whatever they do with them, so it was taking a long
3 time. People who probably could have been licensed
4 but just were waiting for their FBI background check
5 were just sitting and sitting and sitting.

6 So in order to streamline that, as long
7 as you have everything else completed and
8 appropriately done, then they'll issue you a temporary
9 permit so you can practice while the FBI figures out.

10 DR. MARKEGARD: And hope they're not a
11 bad person.

12 MS. CARTER: Right. If it comes back
13 bad, it would be -- that would be revoked and go
14 through the full process.

15 MS. THOMPSON: Okay?

16 So the next piece is application
17 requirements for licensure, and we have already talked
18 about maybe potentially combining the interim permit
19 or not. We're going to take a look at that.

20 Is there any other language that is of
21 concern or comment that anybody feels like they need
22 to address?

23 And, again, we won't approve this section
24 at this -- and say we're ready to move on until we
25 pull it together or do whatever we need to do at the

1 Department, and at the next meeting you guys can take
2 a look at it. But are there any other requirements in
3 that section that anybody has any concerns with, or do
4 we want to move on?

5 Moving on. Okay.

6 So then for MQAC, I have expired license.
7 It's very short, sweet, and to the point.

8 Let's see.

9 Anybody have any concerns there? Does
10 Osteo have any concern?

11 DR. MARKEGARD: We don't have that.

12 MS. CARTER: No, I don't think so.

13 MS. THOMPSON: You don't have any
14 language?

15 MS. CARTER: Hmm-mm.

16 DR. GREEN: What's 246.12?

17 MS. THOMPSON: 246.12 is the process, so
18 it basically says to renew your expired license you
19 have to -- here's the fees you have to pay, turn in an
20 application. If your -- if your profession requires
21 continuing education, you must be up to date on your
22 continuing education. It's the standard process.

23 DR. GREEN: Is that somewhere else in
24 here?

25 MS. THOMPSON: The 246.12?

1 DR. GREEN: Yeah.

2 MS. THOMPSON: No. It's within Title 246
3 of the Department of Health. 246.12 is a overarching
4 process-type chapter that talks about processes for
5 applications, et cetera, for the Department of Health
6 and for all professions. So they all kind of go to
7 that and use that as a universal process.

8 MR. CAIN: The physician chapter doesn't
9 have expired license either. We're entering the 102
10 stage to get those in there, so --

11 MS. THOMPSON: The physicians are?

12 MS. CARTER: Osteo did.

13 MR. CAIN: The Board is doing expired and
14 they're doing reentry to practice and doing a little
15 cleanup in their chapter as well. So that was one of
16 the things they figured through this process we would
17 do.

18 MS. THOMPSON: I would highly
19 recommend --

20 MS. CARTER: MQAC has -- you guys have
21 discussed at length reentry to practice issues, and
22 that is something that Osteo has been doing as well.
23 They're updating the rules for physicians.

24 So if you wanted to mirror what you had
25 for physicians in the PA, that -- because they were

1 requiring more than just CE. If you'd been out of
2 practice for more than three years, I think, Osteo was
3 saying you had to either complete a -- be Board
4 certified or you could take an exam that was approved
5 by the Board, go through a retraining approved by the
6 Board, that sort of thing. So there was just a little
7 more than just up on your CE.

8 MS. THOMPSON: It's kind of a process.
9 It's less than three years, three years or more. Some
10 professions even go a step in between all of that.
11 It's up to you guys.

12 MS. CARTER: Yeah. If you want, we can
13 bring the Osteo physician language that would maybe
14 want to copy into Osteo PA rule, and the Medical
15 Commission can look at that and see if it's something
16 you want to use or -- because it's a little more than
17 just what is here now, and I know that's sort of where
18 you're moving.

19 MR. CAIN: And it gives four options, and
20 all four options say qualify that it's Board approved,
21 so it's like an exam, it's retraining, it's working
22 under the supervision of another training plan -- or I
23 don't remember what the exact language is, but it's
24 all Board approved, Board improved, Board approved.

25 MS. THOMPSON: Does Osteo -- maybe I'm

1 thinking of another profession I just looked at. Some
2 of them talk about if you held a license -- or hold a
3 license in another state and you've let your
4 Washington state license expire but you want to come
5 back, there's a provision for that because you've
6 actually actively -- is that in yours?

7 MR. CAIN: We don't have that.

8 MS. THOMPSON: Okay. Some of the
9 professions have done that.

10 MR. CAIN: It makes sense, I guess.

11 DR. JOHNSON: Let me make a comment.
12 This is reference to a specific case where a woman
13 surgeon chose to take some time off for family, and --
14 but she took a longer time off than she might have
15 recognized the rules, like five years. And all of a
16 sudden she wants to come back and practice. And now
17 she can't get a license, because she doesn't qualify
18 under the three-year thing, and can get a -- to go to
19 get a -- get updated for surgical privileging, even
20 though she's a very competent person, smart and good
21 surgeon, finding a program, all of a sudden it's like
22 a dead-end job, and I don't -- that's not going to be
23 something we can make a rule about.

24 MS. THOMPSON: Right.

25 DR. JOHNSON: But it's just like that one

1 year when you finish your PA school and you've got one
2 year for interim. Somehow, you know, I'm not sure how
3 smart I was when I first came out, so I didn't even
4 know I had to apply for hospital privileges. Nobody
5 even told me, you know. All of a sudden they're, "Why
6 aren't you applying for privileges?" I thought I'd
7 just go to work. Pretty naive.

8 And I think that we have -- I'm not -- we
9 can't protect everybody, but that's a recent example
10 that I had to help with.

11 And, George, what do we do to help this
12 person get back to practice? And I don't know if
13 there's some way we can say asterisk, watch out, or,
14 you know, beware. You know, I don't think we can
15 really do that, but I'm just bringing up an example
16 where for all the right reasons she took some time
17 off, and we want her to get back, and it's a struggle
18 to fit the rules.

19 MS. THOMPSON: Sometimes that is really
20 about communication, and -- you know what I mean?

21 The communication that we put out with
22 our licenses --

23 DR. JOHNSON: I don't want to belabor the
24 point. The rules -- we want to make sure we can get
25 people back to practice if there's a way to do that.

1 But then there's --

2 DR. GREEN: Yeah, but helping them
3 reenter is a different matter than dealing with the
4 problem of reentering related to being absent for a
5 while. The federation discussed this at the -- all
6 the meetings that I've been to, and in some countries
7 they feel people need reentry after going on vacation.

8 So the point -- I guess the point I'm
9 making is that being out of practice for a while, in
10 terms of our responsibility, is a significant issue.
11 Protecting the practitioner from the consequences of
12 leaving practice for a while, I'm not sure how far --
13 or what our job is there. It's not an insignificant
14 matter.

15 DR. JOHNSON: That's why I brought it up.

16 DR. MARKEGARD: So, Heather, your idea is
17 good, to do that with our rules or range of practice,
18 request bring that back so we can see if we can kind
19 of mirror that.

20 MS. THOMPSON: We can bring what Osteo
21 has and bring other -- maybe a few other options what
22 some other professions have done for you guys to look
23 at.

24 DR. GREEN: Maybe you could take a crack
25 at reminding them what is in both and something that

1 we can both feel good about.

2 MS. THOMPSON: Sure. I think that's
3 pretty easy. I think we have a lot of professions
4 that we can just cut and paste some language,
5 especially when Osteo has just proposed some language.

6 MR. CAIN: Yeah, the Board just approved
7 the language their last meetings.

8 MS. THOMPSON: Awesome.

9 Okay. So expired license, we're going to
10 come back at the next meeting with proposed language
11 for both sides of the committee to consider.

12 So the next piece I have is
13 requirement -- so I have 918.082, requirements for
14 osteopathic physician licensure, and it's really just
15 a one-liner, just letting them know that they can
16 apply for a physician -- an MQAC -- I'm going to say
17 MQAC; it's easier for me. MQAC physician can apply
18 for a license as an osteopath. MD can do a DO.

19 DR. MARKEGARD: Yeah.

20 DR. GREEN: So there's a comment here
21 that says this section is to allow for expedited
22 processing, but it doesn't say anything about
23 expedited processing. It just says that you can apply
24 for a license. Well, they could apply for a license
25 even if they didn't have a license.

1 MS. THOMPSON: Right.

2 DR. GREEN: So I'm not sure what the
3 point of that statement is.

4 MS. THOMPSON: Well, I think that this
5 one is -- this would be your leading sentence for the
6 section, and so I think what staff is looking for is
7 do we -- can we come up with a process that is
8 ultimately, I think, the intent of this legislation
9 that makes it very easy for an MD to become a DO or DO
10 MD, physician assistant, obviously. Crossover.

11 DR. GREEN: I can explain, I think, a
12 major reason that this is important. It has to do
13 with the responsibility of Osteopathic Board and the
14 Medical Commission related to discipline.

15 If you -- more and more I think there are
16 PAs working in groups that have both osteopathic and
17 allopathic physicians, so if you have a PA that's
18 licensed by the Commission and works in a combined
19 group of MDs and osteopaths, and there happens to be
20 an incident that arises in the form of a complaint
21 related to the PA licensed by the Commission, and the
22 supervising physician for the incident or index of
23 care is an osteopath, you have a divided authority or
24 responsibility, and it seems to me that we need to
25 consider the way we're set up currently, how, under

1 those circumstances, we can facilitate combined
2 licensure for both the Osteopathic Board and the
3 Medical Commission, regardless of whether the PA
4 applied to the Osteopathic Board or to the Medical
5 Commission. I think one or the other ought to have
6 authority over that circumstance. It shouldn't be a
7 divided authority. That's my own opinion.

8 And I think it ought to lie with the --
9 you can decide whether it lies with the -- where the
10 physician is licensed or -- I don't know. But it's
11 something that I think we need to sort out.

12 DR. MARKEGARD: So you're saying also
13 like if -- so say that PA that you're talking about
14 and their delegation agreement, they're under a
15 supervising physician that's MD. MD is on vacation,
16 and you put -- this is for you. You're on vacation,
17 and you notify -- you listed me as the secondary
18 person when you're on vacation. If the event happens
19 you're on vacation, I am then the supervising
20 physician during that time. If there's an event
21 during that time, then the DO Board gets that
22 complaint.

23 Or are you saying that we just combine
24 forces and investigate and do the complaint together?

25 DR. GREEN: I'm not sure how to do it,

1 but I'm just bringing up what I consider to be a bit
2 of a challenge in terms of divided authority the way
3 we exist now. And it may be not as clear as that.

4 For example, where I practice and with a
5 group of eight PAs, you know, in the course of a day
6 any given physician assistant would work with several
7 of the physicians, so maybe a DO or an MD. But if a
8 certain incident occurred and it happened where you
9 have -- you know, the authorities are across the line,
10 I think we need to make it clear how we're going to
11 deal with that. And I think there are different
12 possible ways of doing it.

13 It just strikes me that we ought to -- I
14 don't think we ought to have two authorities dealing
15 with one incident. Maybe -- I don't know.

16 MS. CARTER: We are legally restricted
17 because they're two separate -- the Board and
18 Commission are two separate legal entities and have
19 two separate legal authorities over their licensees.
20 So if a person only holds a PA license from the
21 Commission, the DO Board doesn't have any legal
22 authority to discipline them.

23 That doesn't mean that if the Medical
24 Commission knows that there was an incident and
25 they're investigating the PA who holds an MQAC PA

1 license, that they couldn't also refer that case to
2 the alternate DO -- to the DO Board because they had
3 an alternate supervisor that happened to be a DO that
4 day or covered that case. But we are restricted,
5 because they're two separate entities, on
6 investigating or disciplining someone who is not
7 actually licensed by that Board or Commission.

8 DR. GREEN: So the other way of -- I
9 don't know whether it's simplifying it or complicating
10 it, is -- under those circumstances where a PA is
11 working with a mixed group of physicians, have some --
12 some way of facilitating the licensure of the PA by
13 both the Board and the Commission, so that they are
14 under the authority of both. And the responsibility
15 for discipline may lie with the involved physician,
16 which is still going to be attached to the PA because
17 they have -- they also have a license with that Board.

18 So I don't know -- this is one of the
19 things that I understood the PAs were asking for, was
20 some facility in license -- in their license to move,
21 but this isn't exactly moving, it's just solving a
22 problem where they have a mixed group of physicians.

23 Now, the other way of solving this
24 problem, and I'm hesitant to bring it up, is if we had
25 one board responsible for all of this, and I'm just

1 going to say that, and not anymore, but that would
2 solve all of these problems.

3 DR. MARKEGARD: Yet another way to solve
4 the problem is when they fill out their delegation
5 agreement, if you have that mixed DO/MD -- you have
6 one as a supervising physician and then your
7 alternate -- you get creative and put a DO in there as
8 alternate. And so then you do have dual coverage in
9 both boards, depending on where the incident happens.

10 DR. GREEN: Yeah, but there isn't one
11 board that has authority over -- over both the
12 physician and the PA.

13 MR. MARESH: That's the way the
14 statutes --

15 DR. GREEN: You end up with divided
16 authority when the PA is involved with an osteopathic
17 physician, because the Osteopathic Board has authority
18 over the physician and the Commission has authority
19 over the PA, or it may be the reverse if it's the PA
20 that was licensed by your board but was working in a
21 group that had MDs and DOs involved in the supervising
22 agreement.

23 It's just something I -- I think that we
24 need to figure out how we're going to deal with it.

25 I think we have had cases -- George, you

1 maybe should comment because you've been -- or have
2 you been involved with -- haven't we had some -- or I
3 thought you said that we had.

4 DR. HEYE: We have a current case.

5 DR. GREEN: We have a current case. So
6 we can't talk about it.

7 But -- so -- and I think the reality is,
8 you know, the population of DO physicians is going to
9 increase, and we will have more and more mixed groups
10 of physicians supervising PAs, which I consider to be
11 a good thing, but I think we ought to figure out a way
12 to simplify for all of us, especially the PA, how
13 we're going to deal with it.

14 MS. THOMPSON: So there was a question,
15 comment.

16 MS. KAMINSKI: My name is Anna Kaminski.

17 Having signed quite a few of these in the
18 past, I mean, there is a line that says these
19 supervising and then there's the alternate, and why
20 doesn't it just fall -- no matter who was on that day,
21 because usually these incidents are not unique --
22 they're not isolated; there's usually multiple
23 incidences that will bring something to a disciplinary
24 hearing or, you know, discovery.

25 DR. JOHNSON: What Tom is talking about

1 is it's not that they can't have alternates in
2 different MD, DO. That's not the issue. It's that if
3 it's a PA DO, you know, license, and an MD super --
4 happens to be the supervising doc that day, then
5 you've got two different boards dealing with an
6 incident trying to figure out how are we going to deal
7 with this problem, because if it's an MQAC PA, MQAC
8 physician, we'll -- and let's just say it's an outcome
9 event that the PA's -- we'll look at the PA and then
10 we ask the question, what's going on with supervision,
11 maybe we need to investigate the supervising doc. If
12 it's a DO, we don't have any authority to investigate
13 the DO doc. If it's --

14 DR. GREEN: Is that true?

15 MS. CARTER: It is true.

16 You could refer it, but you'd still have
17 two --

18 DR. JOHNSON: Well, we could, but we're
19 not -- we may have different -- I'm not suggesting
20 that there are different standards, but the way we
21 approach it might be different, and it's not fair.
22 And I think it's a real serious potential problem that
23 needs to be, between the Board and the Commission,
24 figured out, how are we going to handle that. Because
25 you're looking at the same incident, but you might

1 look at it with different eyes. We always do that.

2 I don't know that we need to belabor it
3 right now, but I think it's something to communicate
4 with and work on as two different commissions.

5 MS. SCHIMMELS: And one other thought is
6 so if you're in the allopathic MQAC physician license
7 and yet your alternate is a DO, do you then have to
8 apply for a DO PA license?

9 MS. CARTER: Not if it's just an
10 alternate.

11 MS. SCHIMMELS: So, again, this comes
12 back to who is going to govern the incident if
13 something happens. Does it go to the --

14 MS. CARTER: It goes to whatever the
15 Board or Commission -- the person where their license
16 is. The only hook the Board and Commission have is
17 that the person is licensed, and that makes them
18 under -- under that authority to be disciplined --
19 under that umbrella. So because -- you know, a lot of
20 states the MD and DO boards are one.

21 MS. SCHIMMELS: Right.

22 MS. CARTER: Some are -- I don't know the
23 split, but there is a, you know, conflict.

24 I think some of it can be done informally
25 with, you know, communication and with staff attorneys

1 and stuff on status of cases, but I don't think that
2 solves -- solves the problem, and I think some of this
3 might require some legislation to create some sort
4 of -- I don't know -- more sort of reciprocity in
5 discipline between the Board and --

6 I don't know. I don't think it's
7 something we can solve in a rule.

8 DR. GREEN: Is there a way, under those
9 circumstances, of simplifying -- create a dual
10 licensure for the PA?

11 MS. CARTER: That would require
12 legislation. I suppose it could be done.

13 DR. GREEN: I don't even know if that's a
14 good idea or --

15 MS. CARTER: I mean, if the PA were duly
16 licensed with both, that solves it, but we can't
17 require that the PA get both licenses, you know.

18 DR. GREEN: Well --

19 MS. CARTER: I mean, you could, but then
20 you'd lose a lot of flexibility.

21 DR. GREEN: What if we facilitated it?
22 There can be an application for dual licensure where
23 you --

24 DR. JOHNSON: That question came up at
25 the first meeting we had in Renton. Someone in the

1 audience raised the question. I recall the
2 conversation. And what they were -- didn't want to
3 have to do is pay two fees. We didn't know what to
4 do.

5 MS. CARTER: Yeah.

6 DR. JOHNSON: It created a conundrum for
7 someone who wanted to have a DO -- PA being both DO
8 and MQAC certified.

9 DR. GREEN: We couldn't create a dual
10 licensure category here without legislation?

11 MS. CARTER: No. All the licensure
12 categories have to be established by statute, which is
13 the Legislature, so we can't create a new license.

14 DR. GREEN: So if we wanted to, could we
15 create a pathway for a PA to become licensed by both
16 boards in a simplified way if we both agreed to it?

17 MS. CARTER: I think some of that, yeah.
18 And we've talked about sort of streamlining the
19 process. But still have to pay fees to both entities.
20 But I think -- they've talked about -- internally I
21 think some of the complaint has been that the
22 Osteopathic Board takes much longer to get the
23 license, and so we've been working internally with the
24 Department on speeding that up, but also I think --
25 part of what this kind of placeholder in this rule was

1 to put something in there to say, Okay, if you're
2 already licensed and in good standing with the Medical
3 Commission as a PA, and you now want to also -- or
4 just get a license as a DO PA, that you shouldn't have
5 to send in all your primary source documents again,
6 you shouldn't -- I mean, those should be recognized.
7 They're in the same building, you know. It
8 shouldn't --

9 So we wanted to add some language here to
10 say, Let's streamline the process. If you're in good
11 standing with the Medical Commission, all you need to
12 do, really, is submit a new practice plan, and you
13 should, you know, pay the fee, and that should, you
14 know, be about it.

15 You attest -- you know, the MQAC and
16 Osteo should communicate so that that can happen more
17 quickly.

18 DR. GREEN: So, Linda, you brought up --
19 when we were talking about this matter, there was
20 quite a time delay for getting an Osteo license. Are
21 there other issues related to this that you can see
22 from the PA's perspective?

23 MS. DALE: Well, it has taken -- in the
24 example that I talked to Dr. Green about in the break
25 was that a PA who worked I believe about eight years

1 under an allopathic physician wanted to move to work
2 with an osteopathic physician, and it took -- because
3 of research into the licensure and all this kind of
4 stuff, it took months. And eventually she gave up and
5 went back with an allopathic physician.

6 And this is why we have this here,
7 because we were asking for some kind of fluid
8 movement, reciprocity, whatever, to -- if the PA has
9 been working in good standing in one, that -- like you
10 just suggested, that it's a matter of delegation
11 agreement, changing the fees to work under the other
12 board, and then move across.

13 And then my -- I had another comment
14 before this, but can we, under rules, change the fee
15 if someone wanted to be dually licensed, if we had
16 this? Or are the dues set?

17 MR. MARESH: By legislation.

18 MS. THOMPSON: Yeah. So the Legislature
19 gives the Department, so -- right, so the Department
20 of Health has to set those fees. They give them the
21 authority and they set the limit. So without
22 legislative authority, we can't -- we can't. We have
23 to have legislative authority.

24 MR. MARESH: Nor could you create a new
25 fee to --

1 MS. THOMPSON: Yeah, we can't create a
2 new fee without legislative authority, and that's
3 ultimately what that would be. I know it sounds funny
4 but --

5 MS. CRAIG: You can reduce fees without
6 legislative approval.

7 MS. DALE: So if you could reduce the
8 fee -- say, for instance, if a PA was licensed under
9 MQAC and because they're working with DOs, MDs,
10 simultaneously, they wanted to be dual licensed,
11 could, then, the other board reduce the fee for a
12 person to be duly licensed under the two boards?

13 DR. MARKEGARD: That's an interesting
14 thought, but also, that's their choice to do that, and
15 so if it's their choice, then they can also choose to
16 pay the extra fee for that.

17 And so I just think, you know, that,
18 again -- I think the fee should be more aligned, but I
19 don't think that they should get a discount just
20 because they decide that they want to -- as an option,
21 to have that. If it's an option, they should pay
22 whatever money it is. It's not that expensive.

23 MR. MARESH: We also penalize the second
24 board that also has fees -- I mean, costs that they
25 have to --

1 MS. THOMPSON: So we have to remember
2 that when you pay a fee, right? The fee -- it's an
3 application fee, right?

4 But it covers -- part of it covers the
5 Department staff time to do the -- process the fee,
6 right? That's a small portion of it. But also that
7 fee goes toward the disciplinary piece, which takes up
8 a huge amount of the fees.

9 And so ultimately what would happen is if
10 you had an allopathic physician assistant license and
11 you paid the higher fee over here, and then what would
12 happen if you paid a lesser fee for the Osteo piece
13 and then the disciplinary piece came under the Osteo,
14 Osteo kind of gets --

15 MS. DALE: Sure. I understand.

16 MS. THOMPSON: Yeah. I mean, it's a
17 great idea.

18 MS. DALE: Just asking the question.

19 MS. THOMPSON: Yeah. It's a great idea.
20 Yeah.

21 DR. GREEN: So what you're saying is the
22 only way that we can facilitate -- or expedite dual
23 licensure is by the administrative process, not the
24 fee?

25 MS. THOMPSON: Correct.

1 DR. GREEN: So should we develop a way of
2 doing that?

3 MS. THOMPSON: So what I'm hearing -- and
4 I can throw this out as a proposal for you guys to
5 consider. I mean -- and we would have to, I think,
6 also go back and check with the credentialing staff
7 for both.

8 It's too bad that Dawn isn't here,
9 because she's really sharp on it.

10 It appears that it would be maybe a
11 condensed kind of application, not the full
12 application but a more of a condensed application,
13 right?

14 So we always have to have on file a
15 record that you've applied for a license, right? So
16 we have like a condensed application, pay the fee and
17 a delegation agreement. Those three things, if you're
18 in good standing with whatever side you're on.

19 Does that make sense?

20 DR. GREEN: Yeah.

21 So there's already an application. If
22 none of the information has changed and if they're --
23 since that application was submitted, there is no
24 intervening violation of any laws or any, you know,
25 problems, then that license would be -- could be

1 accepted by the opposite authority with the submission
2 of an application testifying to that and a fee.

3 MS. THOMPSON: Yup.

4 MS. BALLWEG: And I believe that could
5 happen within a week or something. Because as it is
6 now -- I know it doesn't happen, that's why I'm saying
7 that, but I think that's -- I think what PAs would
8 like to see, because you either have a legitimate
9 license by the State or you don't, and I don't know if
10 you need to build into a designated person who
11 personally carries the file from one place to another,
12 but I know when we've talked about this before, it was
13 at that level that the problem existed.

14 MS. THOMPSON: I hear you.

15 DR. MARKEGARD: So we should have some
16 kind of an agreement within like the back -- the
17 credentialing office of how long would that take and
18 hold them accountable that it's only going to take
19 that long, instead of years down the road they think,
20 Well, gosh, it's taking six months to get this done.

21 MS. BALLWEG: And it could go both
22 directions. I think you want -- we're sounding like
23 the DO people are slow, but we want to have -- that's
24 really not the situation. We want to go both
25 directions.

1 DR. GREEN: We want to make it easy for a
2 PA to do whatever.

3 MS. DALE: We agreed that it's not the --
4 the situation is that the Department of Health -- the
5 applications for the DO Board get mixed into every
6 other application.

7 MR. CAIN: Yeah, 82 other professions.

8 MS. DALE: Yeah. So that's where it gets
9 missed and where it gets backlogged. So it's not that
10 the Board is slow, it's just that the process at the
11 DOH.

12 DR. MARKEGARD: There a way -- so there,
13 of course, is going to be a delay in getting that
14 hand-carried to that person to get that done. Is
15 there a way, then, to have the language in the rules
16 that there is, then, a temporary license or permit to
17 practice in that case, as -- just as we do with the
18 delay in FBI fingerprinting?

19 DR. GREEN: They had some kind of
20 endorsement that is in effect until the process is
21 completed, so the process doesn't delay the license.

22 MS. DALE: Similar to the language maybe
23 in 918.075, where you've got the temporary practice
24 permit while you're waiting for the background check?

25 DR. GREEN: Yeah.

1 MS. CARTER: The problem is the interim
2 permits and the temporary permits are created by
3 statute, and we can't create any temporary permits or
4 licenses or anything that aren't in statute. So
5 that's where those came from.

6 What -- so we -- and I think on Osteo's
7 side, a temporary permit would probably take just as
8 long as the licensure. I'm not sure if they'd be any
9 faster. So you might as well just go for the full
10 licensure.

11 My suggestion is that for the next
12 meeting, at least in 082 in the MQAC side and then 081
13 in Osteo, we take some of that procedural language
14 that we were talking about for the -- either the full
15 licensure or temporary permit, and plop it in there,
16 but take out the parts where it talks about you shall
17 furnish proof of the following. You have to prove
18 that you have your exam, prove that you've got all
19 this. Just prove that you're licensed in good
20 standing by MQAC or Osteo, and that would be an
21 internal check so you can just attest, Yes, I am in
22 good standing, I sign off on it, and DOH will check so
23 you won't have to -- that will help somewhat. It's
24 not going to be overnight but I think it will help.

25 MS. THOMPSON: They're not doing all this

1 other --

2 MS. CARTER: Right.

3 MS. CLOWER: So clarification, then. For
4 reciprocity, the only issue would be the fee and
5 nothing else, correct?

6 MS. CARTER: It would be fee and
7 delegation agreement, and probably just an abbreviated
8 application, you know, that have all your name and
9 address and all of that stuff, your MQAC or Osteo
10 license number so we could double-check that, and then
11 probably an attestation that, Yes, I've graduated from
12 school and I'm certified in blah, blah, blah. You
13 would just sign off on it, submit your practice plan
14 and your fee -- or sorry -- delegation agreement.

15 MS. CLOWER: Thank you.

16 MS. THOMPSON: That will be the proposal
17 that the staff is going to draft up and bring back to
18 you all at the next meeting. And we'll do some
19 checking with credentialing too to make sure that
20 that's all kosher with them.

21 MR. CONCANNON: What is the fee to be a
22 PA for a certain number of years, about?

23 Somebody knows. What does it cost to be
24 a PA for a few years?

25 MS. CLOWER: \$200. A hundred. Something

1 like that.

2 MR. CONCANNON: Osteopathic would be
3 more, I assume.

4 MS. CARTER: Osteopathic physician
5 application is 300, and 325.

6 MS. DALE: I couldn't hear that.
7 300 for osteo.

8 MR. CAIN: For application. Renewal,
9 325.

10 DR. GREEN: Same for the Commission?

11 MS. CARTER: And for the Commission, it's
12 less. Let's see. Osteo -- let's see. Physician
13 assistant's application is 125 from MQAC, and two-year
14 renewal is 220, so it's 110. Osteo has an annual
15 renewal and Medical Commission has two-year renewal.
16 So it's 325 a year or 110 a year if you were looking
17 at comparing a apples to apples.

18 The reason for the fee difference, I
19 would speculate, is because the osteopathic profession
20 is so much smaller. There's about 1,300, I think.
21 And so their operating costs are much more to -- for
22 discipline and all of that proportionately.

23 MS. THOMPSON: Does the statute drive the
24 one-year versus two-year renewal, do we know?

25 I'm thinking if you get them on the same

1 page, but I don't know -- financially it might not
2 work, either.

3 MS. CARTER: I think that was part of --
4 I think Osteo did look at -- did look at two-year
5 renewal, but because their fees are so high, I
6 think --

7 MS. THOMPSON: It was too much.

8 MS. CARTER: Yeah.

9 MS. THOMPSON: It's all right. I was
10 just trying to think of one more way we could make
11 them a little more consistent, but we don't want to
12 put up a barrier by doing that.

13 MR. CAIN: And, Tami, very quickly, while
14 we're on fees, there was language in the Osteo rules
15 under 015 that referenced the delegation agreement
16 fee.

17 MS. THOMPSON: Yes.

18 MR. CAIN: And that fee went away
19 January 1 so I deleted that part. I just wanted to
20 make note of that.

21 MS. THOMPSON: So did everybody hear what
22 Brett said?

23 So osteopaths used to have to pay for a
24 practice plan delegation agreement fee.

25 MR. CAIN: \$70 fee.

1 MS. THOMPSON: It was a \$70 fee.

2 And one of the things that the Department
3 proactively did prior to this, it was kind of after
4 the legislation passed, though, is did the analysis
5 about what money coming in and was it really relevant,
6 and what we ended up doing was getting rid of it,
7 basically. So now there was no fee, because
8 ultimately it just gets wrapped up in your application
9 fee, so there was not a need to pay an extra fee for
10 the delegation agreement. So that's gone away.

11 It's already gone, right?

12 MR. CAIN: Yeah, January 1st.

13 MS. THOMPSON: Yeah. I remember doing
14 that.

15 Okay. So this requirement for osteopath
16 physician assistant licensure and vice versa. So I
17 believe the agreement is that we're going to come back
18 with some proposed language that basically talks about
19 condensed application, pay the fee, delegation
20 agreement. We'll do some double-checking with the
21 credentialing staff to ensure that there's nothing
22 we're missing. And we'll come back with some proposed
23 language.

24 MR. CONCANNON: Yeah. And, again, your
25 language in that section would need to be -- if you're

1 looking at it from the Medical Commission point of
2 view, what you're talking about is not if somebody
3 holds an active physician assistant license may apply
4 for an osteopathic license. It's the other way
5 around. If you're going to put a rule in the Medical
6 Commission saying in the event somebody has an active
7 osteopathic physician assistant license and wishes to
8 apply for license with us, this will be the procedure.

9 MS. THOMPSON: Yes.

10 MR. CONCANNON: And the fee will be
11 reduced.

12 MS. THOMPSON: Yes.

13 MR. CONCANNON: And if it's the reverse,
14 the Medical Commission will provide its file to the
15 Osteopathic Board when its people -- you know, you
16 need to put an incumbent obligation on each Commission
17 or Board to cooperate with the other, I assume.
18 Paperwork-wise.

19 MS. CARTER: Right.

20 MS. THOMPSON: Right.

21 Okay. Are we ready to move on to --
22 okay. So are we ready to move on to physician
23 assistant and certified physician assistant
24 utilization in Section 246.918.090?

25 MR. CONCANNON: Yeah. That's a simple

1 sentence, which I think is just the beginning of a
2 very lengthy discussion.

3 MS. THOMPSON: All right.

4 MR. CONCANNON: So it's not --

5 MS. DALE: This is now in statute.

6 MR. CONCANNON: That's right. It's in
7 the statute. It's in the statute, and, again, there's
8 no absolute ability for a physician to serve as a
9 supervisor for five licensees. There's no right to
10 serve as a supervisor for five licensees.

11 MS. THOMPSON: Okay.

12 MR. CONCANNON: What the statute says is
13 you can only -- you have to have a delegation
14 agreement. It has to be approved by the Commission.
15 And no -- and you can't serve as a supervisor for any
16 physician assistant unless you can adequately
17 supervise them.

18 MS. THOMPSON: Okay.

19 MR. CONCANNON: All right?

20 So when I see a sentence like that, as a
21 lawyer, I'm sitting there saying, I'm a PA -- or I'm a
22 physician, and apparently I have the right to serve as
23 the primary supervisor for five licensees.

24 DR. MARKEGARD: You have the option.

25 MS. THOMPSON: "Shall" is you have the

1 duty to.

2 MR. CONCANNON: Yeah.

3 MS. THOMPSON: So no physician has the
4 duty to serve as a primary supervisor for more than
5 five licensees.

6 MR. CONCANNON: In fact --

7 MS. THOMPSON: Without authorization --

8 MR. CONCANNON: No physician shall serve
9 as primary supervisor for more licensees than the
10 commission allows them to serve as a supervisor for.
11 That's what the law is, as I read it.

12 It could be three, it could be two, it
13 could be four, it could be seven, but certainly no
14 more than you can adequately supervise.

15 And if you put in the number five, that
16 sounds like an absolute ability, to submit delegation
17 agreements for five, and get them approved. And I
18 don't think that's true.

19 MS. THOMPSON: Okay.

20 MR. CONCANNON: But that's -- you know,
21 I'm just --

22 MS. SCHIMMELS: So does the word "shall"
23 need to be changed to something different? Because
24 that's what the new law -- the new statute --

25 MS. DALE: Someone have that new statute?

1 MS. SCHIMMELS: I don't have the new
2 statute in front of me, but --

3 MR. CONCANNON: A physician may enter
4 into delegation agreements with five physician
5 assistants, but may petition for a waiver. However,
6 no physician may have under his or her supervision
7 more than three in a remote site or more physician
8 assistants than the physician can adequately
9 supervise.

10 MS. SCHIMMELS: Maybe that's the language
11 that needs to be put there.

12 MR. CONCANNON: I don't think you need
13 language like this in any sort of rule, because you
14 have it in the statute, and you don't repeat line by
15 line from statutes into rules. What you do need to
16 put in the rule is how is the Commission going to
17 decide whether to approve delegation agreements?
18 What's the criteria for approving? Other than
19 submitting names and addresses. That's the crux of
20 this process. I think.

21 But, again, that's big picture; that's
22 hours and hours of discussion. That's, you know,
23 George Heye and osteopathic -- that's big stuff.

24 But simple sentences like this are
25 dangerous and inaccurate, I think.

1 MS. THOMPSON: Okay.

2 MR. CONCANNON: I defer.

3 MS. THOMPSON: Okay. So what would the
4 committee like to do?

5 MR. CONCANNON: Well, like I said, that
6 sentence is just the beginning of a lengthy
7 discussion. You know, you take it from there.

8 MS. THOMPSON: And this -- you know, this
9 language is from 1996, so apparently it is very old.
10 And the standard has now changed, so -- and this is
11 our opportunity to make this better. I mean, he's
12 absolutely right. When you have the ability to deny
13 somebody something or approve them of something, and
14 so in this case authorizing supervision of more than
15 five physicians or adequately supervising less than
16 five, the criteria that the Board and Commission uses
17 so that it's not -- and I'm going to use the words
18 "arbitrary and capricious," right?

19 It really does need to be in a rule, that
20 it clearly outlines this is what the Board or
21 Commission is using as the criteria for approving or
22 disapproving the delegation agreements.

23 MS. CLOWER: That criteria needs to
24 include the different practice styles.

25 MS. THOMPSON: I'm pretty sure that the

1 Board and the Commission has criteria of some sort
2 that they've been using in the past.

3 MR. CONCANNON: Again, George Heye deals
4 with it all the time. I dealt with it in my own way
5 when I did my own drafting. The question is am I
6 getting too detailed in the analysis.

7 MS. DALE: My gut response would be if we
8 put it in rule, is that going to tie something like
9 Dr. Heye's using his experience -- is that going to
10 tie his hands in making his decision.

11 Dr. Heye, any thoughts?

12 DR. HEYE: This is pretty broad for the
13 Commission and the rule. I don't see how it -- I
14 don't see how it binds us to anything. We look at the
15 practice plan and make a decision. And if we don't
16 think that somebody is going to make an adequate
17 supervisor for so many people, we go back and say,
18 This doesn't look like something that you're going to
19 be able to do.

20 This is -- this is a process we go
21 through all the time with practice plans.

22 DR. MARKEGARD: There seems to be a lot
23 of variables in making that decision also. I'm not
24 sure if you can put all those different variables down
25 in writing.

1 DR. GREEN: Exactly.

2 MS. DALE: This, again, gives the
3 experience room to move, rather than tying them down
4 to something that is so spelled out that could bind
5 them. I think general is better.

6 DR. MARKEGARD: Go ahead.

7 DR. GREEN: Please.

8 DR. MARKEGARD: I was just going to look
9 at you on the Commission side. There's one sentence,
10 and then on the Osteo side there's a page and a half
11 under something similar. So much for being crisp.

12 DR. GREEN: So I agree with
13 Mr. Concannon's comments. I also agree that it should
14 be kept simple and not get into a lot of detail.

15 And my thought is, as suggested by
16 Mr. Concannon, that you need to have some criteria,
17 and I think the criteria for -- what is it? Supervise
18 only as many as you can -- whatever it was. The
19 criteria ought to be spelled out in the delegation
20 agreement for what -- for evaluating what is
21 appropriate or not.

22 The thing about these -- one -- somewhere
23 in here we also say that the delegation agreement is
24 to be outlined on forms provided by the Department, so
25 they can guide the applicant into providing

1 information that is felt necessary to make that
2 determination. Do these things, the delegation
3 agreement forms -- do they need to go through this
4 process to be modified?

5 MS. CARTER: I think the Board or
6 Commission has authority to amend those, so --

7 DR. GREEN: The point I'm getting at is,
8 if you refer to this as your guidance, and that's what
9 George uses, is the information on these, as I
10 understand it from talking with him, you also have the
11 ability, I think, more easily to modify these as
12 appropriate.

13 MS. CARTER: Sure. I think that's what
14 we were going to discuss for the --

15 DR. GREEN: I know, but I'm just saying,
16 in terms of this discussion, that's how I would
17 establish the criteria. And that leaves it flexible
18 for the physician and the PA to outline what they feel
19 they can do and justify in the agreement.

20 DR. MARKEGARD: If you look at the Osteo,
21 the 246.854.015, under the utilization, it has all --
22 on there in detail what's expected from that
23 supervisor -- supervising physician. And so it seems
24 as though if you have like your expectations written
25 out of what does it mean to be a supervising

1 physician, then it's up to you as a supervising
2 physician to say, Gosh, can I do all of this for three
3 PAs, for five PAs, can I do it for 10? I need to ask
4 for more, you know, leeway from the Board or the
5 Commission.

6 So it might be, you know, something like
7 this -- I'm not sure what the Commission thinks about
8 all these details, but maybe that would serve a
9 purpose.

10 MS. CLOWER: It seems too specific.

11 MS. SCHIMMELS: I mean, I would agree
12 with that. We want to keep it broad. We don't want
13 to put --

14 DR. MARKEGARD: That your chart should be
15 reviewed in a certain period of time.

16 MS. SCHIMMELS: Right. There's
17 already -- it talks about you have to have so many --
18 that's all decided in the delegation site. That's all
19 put in there. I think this is too specific. The
20 allopathic one is broad, and I think we wanted to keep
21 it broad. If we start spelling it out, then we're
22 going to go into each thing and we're going to have to
23 do A, B, C, D, E, F, G for every little thing, and
24 what we'll do is we'll micromanage it to the point
25 where I don't think the Commission is going to be able

1 to make any decisions about it.

2 George, what do you feel about that?

3 We talked about this when we did the --
4 when we changed the delegation agreement about 12, 13
5 years ago, and we were talking about the rules then.
6 Remember? Do you remember that?

7 That's been awhile ago. I barely
8 remember it. And I'm just a couple years younger than
9 you are.

10 But, remember, we -- I mean, one of the
11 things is once you start micromanaging it and you get
12 it too specific -- and I'm not saying that yours are
13 too specific, but I would not want to put the language
14 into the allopathic to make it be more specific.

15 DR. MARKEGARD: I think there has to be
16 like some kind of -- you can't say you just do
17 whatever you want to do.

18 MS. SCHIMMELS: I agree with that.

19 DR. MARKEGARD: I understand take out
20 some of the specifics that you have to have your
21 x-rays and EKGs reviewed within 24 hours and those
22 kind of things. It makes it easier to do that now in
23 the EMR world today as compared to 10 years ago, but I
24 don't think to erase all of this to make it as broad
25 as one sentence in the Commission would be

1 appropriate, either.

2 MS. DALE: Well, the thing is "shall
3 have," and, again, this is something that we really --
4 we, meaning WAPA, would really like to see, is that
5 the delegation agreement is what spells out how that
6 physician who hired me is going to supervise me, and
7 if you look at the MQAC delegation agreement on
8 Page 3, it says, "Describe the plan for supervision,
9 such as face to face discussion, chart review, joint
10 rounding, conference calls, performance evaluations,
11 etc."

12 Because one physician that I work with
13 might want to make sure that they sign every one of my
14 charts. Another physician might say, I'm going to
15 sign 10 percent of your charts. Or maybe 10 years
16 from now they're going to say, I only want to see one
17 percent of your charts, and it's only the ones that
18 are having difficulty.

19 So if we spell it out in rule, that
20 doesn't allow that relationship, that trust, to occur,
21 and the training. So then it ties that physician down
22 to signing all of those within seven days, whereas, as
23 I work with him for 20 years, they know that they
24 don't have to sign those.

25 DR. MARKEGARD: This doesn't have the

1 details that you've been working there for 20 years.
2 This says if you're an interim permit holder, if
3 you've been within 30 days initially. So it doesn't
4 say after you've been practicing for 20 years, you
5 still have to have all your x-rays and everything
6 reviewed within a certain period of time.

7 MS. SCHIMMELS: Where are you at, Linda?

8 I don't have a Page 3.

9 MR. CAIN: She's looking at the
10 delegation agreement.

11 MS. DALE: I'm looking at the delegation
12 agreement.

13 MS. SCHIMMELS: Oh, I'm sorry. No
14 wonder.

15 MS. DALE: Where does it say interim?

16 I'm looking at 854.015.

17 Because when I read this, it doesn't -- I
18 don't see -- because it says a licensed osteopathic
19 physician or interim permit holder.

20 DR. MARKEGARD: In number (i) -- letter
21 (i), excuse me, "All charts of the licensed
22 osteopathic physician assistant within seven working
23 days for the first thirty days of practice and
24 thereafter ten percent of their charts...within seven
25 working days."

1 So maybe there could be a compromise with
2 that.

3 I have no problem, though, if you have a
4 new person, that that's -- you have a little tighter
5 reins on that new person. I'm not worried about you,
6 with your experience. I'm worried about the new PAs
7 that we're hiring right out of school.

8 MS. DALE: But, again, if we allow that
9 physician and PA to make that decision, if we just say
10 charts will be reviewed, then that way, as that PA
11 grows -- I mean, because if I train someone who's been
12 a military medic for 15 years and has battleground
13 experience and everything else, and they're working in
14 an emergency room department, they have a lot more
15 experience than someone else who has been a CNA for
16 two years, then got into PA school, graduated from PA
17 school, and is now working in emergency room.

18 DR. MARKEGARD: Right. So the depth of
19 your review of those charts should be quite easy.

20 MS. DALE: Well, but, again, I'm saying
21 you're trying to tie them down when you're comparing
22 apples and oranges.

23 Couldn't we just say that they need to --
24 that they have chart review? And then let the
25 physician and PA decide.

1 MS. CLOWER: I can tell that you this
2 description here has discouraged many DOs from
3 supervising physician assistants in my organization,
4 because there has to be somebody who is looking at,
5 okay, is it 30 days? What if we go 31 days?

6 So I agree that the delegation agreement
7 should be the place where all these specifics should
8 be.

9 DR. MARKEGARD: I think having some
10 guideline is important, so then that DO who chooses
11 not to do supervising physician, they know that they
12 can't -- they shall not be able to supervise five PAs,
13 right? And so they can have a -- this is what the
14 expectations are in general for supervising a PA. Can
15 you do this or not? Can you do that for one, five,
16 three?

17 So that's -- I think you have to have
18 some guideline on what they can do and what they can't
19 do. And I agree with having, you know, 10 percent
20 after that time. I think that is great for the
21 delegation agreement, but I don't think just to have
22 one sentence on that is enough.

23 MS. CLOWER: I totally agree with you,
24 but that multiple sentences should be on the
25 delegation agreement and not in the rules. My

1 opinion.

2 DR. MARKEGARD: Where are there
3 guidelines written anywhere that states what is
4 expected of a supervising physician of a PA?

5 MS. CLOWER: Well, I don't know that
6 there are any such guidelines, but that PA and the
7 physician, the DO, can sit down and come up with
8 those. But if we put them in the rules, it's very
9 difficult to follow those rules exactly as recorded.

10 DR. MARKEGARD: But I think there should
11 be some even more -- not as specific but some broad
12 guideline that would help the pair fill out the
13 delegation agreements. Great, that says here that I
14 need to have chart review. Okay, this is how I'm
15 going to do my chart review. This is how I'm going to
16 review your x-rays.

17 So I just feel like there has to be
18 something, or else how does that supervising physician
19 know what's expected by the Commission or Board? What
20 is meant by "supervising physician"?

21 MS. CLOWER: It's the same when
22 supervising physician or supervising an RN. There's
23 no guideline that the physician has to do with
24 supervising an RN?

25 DR. MARKEGARD: But the RN is practicing

1 under their scope of practice. It's entirely
2 different.

3 MS. CLOWER: But it's the responsibility
4 of the physician.

5 I think we're talking about the same
6 thing but in different places, because there are so
7 many different practice arrangements. Like if you are
8 my supervising physician but we're in a remote site,
9 where there's no other doctor, you know, then if I'm
10 in an institution where there's 10 doctors that see
11 everything I do.

12 So there's different places to do that,
13 and you can have two different places, you have to do
14 it in a separate place, where it can be modified as
15 needed.

16 MS. THOMPSON: So I think -- so I think
17 we can agree that Medical's one-liner is maybe just
18 not enough, right?

19 There really is no criteria there for
20 anything, other than this one-liner.

21 And Osteo's, maybe some feel that it is a
22 little too detailed.

23 So in the delegation agreements, I
24 believe there are topics. I mean, there are specific
25 topics that need to be addressed in the delegation

1 agreement, and I know that we're going to talk about
2 the delegation agreements a little bit later and try
3 to potentially get them on maybe a more similar page.
4 I don't know how off they are or how close they are,
5 but at least visually they look different at this
6 point.

7 So maybe the compromise is that in the
8 rules, here are the topics that must be addressed in
9 the delegation agreement or in the -- in this case
10 the -- when the board is making a determination about
11 supervision or expanding the number of PAs that can be
12 supervised, not getting maybe so much into the details
13 but the topics that must be addressed.

14 Dr. Green.

15 DR. GREEN: One of the items in the
16 delegation agreement is supervision. The detail in
17 the osteopathic rules having to do with supervision is
18 entirely oriented, I think, towards an outpatient
19 practice. As a surgeon working with PAs, none of this
20 really applied to what I did, with the physician
21 assistants that I worked with.

22 My suggestion -- sitting here with Ruth
23 Ballweg earlier, there was a bit of a discussion about
24 supervision, and she discussed general kinds of
25 supervision, and I -- in listening to her, these were

1 categories of supervision, not detailed ways of doing
2 it. My suggestion would be if we want to put
3 something in a rule, that we maybe specify these -- I
4 can't repeat them from listening to her, but I think
5 they could be very --

6 DR. JOHNSON: She actually spoke about
7 prospective, concurrent, and retrospective.

8 DR. GREEN: Right.

9 DR. JOHNSON: And those are three
10 different ways to look at supervision.

11 DR. GREEN: And I think all the
12 supervision -- all these things can be put into one of
13 those categories.

14 Maybe if we want to put it in the rule,
15 it would be better to request that they specify, you
16 know, how is this kind of supervision going to be
17 applied to the practice, which type of supervision are
18 you going to use.

19 I also have a bit of a problem of
20 specifying numbers, and the reason that I do is that
21 nobody really keeps track of it, and I think, you
22 know, there are certain things I would never need to
23 review in any number, depending on what I was doing.
24 And what I do varies from day to day. And once you
25 get that detailed -- and I don't disagree with, you

1 know, your assertion that there needs to be some
2 direction, but I have a problem when it goes into that
3 much detail.

4 MS. THOMPSON: Well, one option -- and
5 it's just an option, right? So one option is is that
6 you may have experienced supervising physicians --
7 right? -- that don't need the guidelines, but maybe
8 you have newer supervising physicians, and maybe each
9 side, the Commission and the Board, put together a set
10 of guidelines, that these are best practices. You
11 don't hold them to that; it's some guidelines that
12 they can use when they're supervising. Especially as
13 new supervisors.

14 DR. GREEN: I'm not saying that -- you
15 know, even experienced people shouldn't account for
16 how they're supervised. I'm not saying that in any
17 way.

18 MS. THOMPSON: Right. But the details --

19 DR. GREEN: Are they arguing for a more
20 general statement. I'm really not.

21 The reality is, just using my own
22 practice for an example, I mean, I directly supervise
23 the people I work with all day long every day because
24 we're physically together. And, you know, that comes
25 under one of the categories of supervision. And so to

1 state that I think is simply all one needs to do under
2 those circumstances.

3 If it's an outpatient practice, I think
4 they can do the same type of thing in a more general
5 way, but you specify a different kind of supervision
6 that you have, in general how you're doing it, and --

7 I don't know. George, you're the one
8 that ends up reviewing these. I think it would help
9 to know what your thoughts are.

10 DR. HEYE: Well, they're all different,
11 because all these practices are different, and some
12 people -- again, if they're in a hospital practice,
13 they're making rounds together or post-op, and all
14 these sort of things are oftentimes just referred to
15 as hospital rounds, face-to-face. If they're in a
16 clinic together, it's clear on the first page that
17 they're not a remote site, so they're working
18 together, and a lot of times they just say chart
19 reviews, each discussion as necessary, that sort of
20 thing. It's very vague.

21 If it's a remote site, a lot of times it
22 says we have EMRs, and I can check the records any
23 time of the day, continual contact, and they may get
24 together once a week as required, face-to-face at the
25 clinic.

1 Again, they're all -- and I look at it,
2 and does this sound reasonable for somebody with that
3 PA. And if it's too vague, we go back and we say,
4 Well, who's at this remote site? If you're never
5 there, who's there?

6 And it turns out most of the time there
7 are other doctors there who are alternates or could be
8 the supervisor, and so that makes me more comfortable
9 with approving a remote site.

10 If it's someplace like in the middle of
11 northeastern Washington, where there's nobody else in
12 that clinic, well, then you have to decide, is there
13 even -- does that make sense for the doctor to go out
14 there once a week basically to see nobody, because
15 it's a very lightly used clinic. There may be only
16 one exam room, so to have two people there doesn't
17 serve any purpose.

18 But as long as they're communicating back
19 and forth and that's the only PA in that town, maybe
20 that's -- that's the kind of leeway we have in
21 approving these sorts of things.

22 DR. MARKEGARD: And I agree with having
23 less detail than the numbers, because who is going to
24 police that, but do you think we should just, then --
25 under this section, just copy and paste what it says

1 in the thing?

2 MS. SCHIMMELS: In the statute?

3 DR. MARKEGARD: In the statute?

4 Or do we need to have more language to --
5 because -- the rules aren't just a copy and paste what
6 this says, right? Because then we could just read it.
7 So what language would we have to have under there
8 that would make this section even applicable or
9 important for us?

10 MS. CARTER: So if you were talking about
11 maybe just a suggestion -- this is just throwing
12 something out there. So first of all, the MQAC rule
13 is just on utilization, it's not supervision, so
14 that's probably why it's so short. Osteos is
15 utilization and supervision. And I'm not sure MQAC
16 has a supervision section at all. But something -- I
17 think some of these topics or general ways of
18 supervision would be maybe important to include in the
19 rule.

20 Something -- you know, supervision should
21 consist of, you know, case reviews, chart reviews, as
22 appropriate, you know, determined by the physician as
23 appropriate. So then it can be customized. But at
24 least give them these are some ways of supervision.
25 You can do face-to-face, you can do telephone, you can

1 do all of these things, and, you know, they're going
2 to determine, like Dr. Heye said, you know, how often
3 is appropriate for --

4 DR. MARKEGARD: And put details in the
5 agreement --

6 MS. CARTER: And put details in the
7 practice plan, but at least list out some general ways
8 that PAs are supervised.

9 DR. HEYE: Those things are all listed in
10 the delegation agreement as suggestions.

11 MS. DALE: So could we just say, you
12 know, supervision as outlined in the delegation
13 agreement?

14 Because, again, it's -- if you look at
15 the delegation agreement, it does have plan for
16 supervision, face-to-face discussion, chart reviews.
17 You can certainly add in there diagnostic procedures
18 and labs if -- you know, if that's something that you
19 want to add in there. Joint rounding, conference
20 calls. So put it in the delegation agreement, and
21 then in rules refer to it.

22 Because, again, that doesn't tie us
23 down -- one size does not fit all in this profession.
24 And so if we could just say refer to the delegation
25 agreement or as outlined in the delegation agreement.

1 DR. GREEN: If you read the definition of
2 a physician assistant, it already says this. I mean,
3 this exactly says the same thing over again.

4 MS. DALE: It does. Yeah, that's right.

5 DR. GREEN: So if you have it in the
6 delegation agreement and that guidance, which is where
7 I think it would be good to put it, because I think
8 that's also more easily modified or updated, then
9 you've got it.

10 MS. CLOWER: Plus also supervision can
11 change with technology. Like nowhere we see here tell
12 health or electronic medical records or the robot that
13 goes around and shows the physician everything. So if
14 we put things that are so specific in the rules, when
15 technology changes supervision, we cannot change it,
16 but if it's in the delegation plan, we can.

17 DR. MARKEGARD: Another suggestion I
18 think -- do you think -- chart review as, you know,
19 needed or -- that doesn't say how you're going to do
20 your chart review. That's pretty broad. It would fit
21 your, you know -- on your list, but then it has
22 something instead of just referring to the delegation
23 agreement.

24 DR. GREEN: But that's one of the
25 categories of supervision -- general categories that

1 Ruth Ballweg discussed, and that would be under the
2 retrospective chart reviews. But she had really, I
3 thought, three very good categories that were very
4 general, and, you know, you could -- if you want to
5 put something in rule, again, my suggestion would be
6 to use those and require that they, you know, specify
7 what kinds of supervision in general they're using in
8 detail.

9 DR. JOHNSON: I've gotten lost.

10 MR. CONCANNON: Yeah. Again --

11 DR. JOHNSON: I'm going back to what
12 Mike -- I really got lost.

13 MR. CONCANNON: There's a lot of jumping
14 around, there's a lot of pleasant talk, there's a lot
15 of pleasant discussion about different ways to do
16 things. All I've learned in the last 15 minutes is
17 that there are these people called osteopathic
18 physician assistants, and there's a -- there's been a
19 WAC that governs them for years, and those physician
20 assistants require, under their WAC, a lot of
21 supervision, a lot of detail. There are requirements.
22 And Medical has none of that. That's all I know.
23 There's a lot of it here.

24 Now, I don't know if you're suggesting to
25 Dr. Markegard that she should -- or that the

1 Osteopathic Board should do away with that WAC. But
2 it certainly isn't going to be tinkered with. It's
3 either going to be done away with or kept. But she
4 can't tinker with that because the sort of detail that
5 an Osteopathic Board requires of a physician assistant
6 in terms of supervision is tremendous.

7 DR. MARKEGARD: Is that in the WAC? Like
8 these details here --

9 MS. CARTER: That's correct.

10 MR. CONCANNON: This is what you guys
11 were reading from. That's -- that's the way your
12 board apparently deals with physician assistants.
13 Totally different than whatever the Medical Board
14 does. Totally different. Not even close.

15 I'm sitting here reading this thinking,
16 Now, this is supervision. Now, this is supervision.
17 I'm not saying that's what you need, but this is
18 supervision.

19 DR. HEYE: Some of that's supervision,
20 but some of it's just suggested things that people
21 should do in a normal practice, such as, you know,
22 wearing a badge that identifies you as a PA. Well,
23 that used to be in ours. We took it out. But, I
24 mean, that -- but that was part of it.

25 I have nothing -- I have no problem with

1 that. I mean, I still think that's a good idea.

2 MR. CONCANNON: 854.015, the osteopathic
3 Subsection 5, the osteopathic physician assistant and
4 supervising physician shall ensure that there's timely
5 review of all reports and significant deviations,
6 including the chart; the charts of all patients are
7 immediate and properly documented; all telephone
8 advice is documented; the supervising provides
9 adequate supervision review of the practice. Okay.
10 All charts of the osteopathic PA within seven days for
11 the first 30 days of -- I mean, that is detailed.

12 Now, why do they do that? Why did the
13 Osteopathic Board do that? Is it because there's
14 different training? No. Apparently not. Different
15 qualifications? No. But that's what they did.

16 And now I guess you're saying the mandate
17 is -- or the request is to make these things almost
18 the same. Osteopathic and allopathic. Make them kind
19 of almost the same. That's a big difference.

20 DR. JOHNSON: But I think also to -- one
21 of the reasons we're here is because someone said
22 instead of just having three PAs you're going to
23 supervise, we should have five. And three remote
24 and -- and there's some kind of ruling about that.
25 But somebody decided we needed to do five. And so

1 what we don't want to have is arbitrary and capricious
2 decision making for George, or whoever sits in
3 George's seat, or the Osteo Board to approve it; there
4 needs to be some guidelines.

5 Now, we can choose to have the guidelines
6 in the delegation agreement and refer to that. I read
7 the -- Brett, you set out the VA -- one of the
8 attachments --

9 MR. CAIN: I believe so. That was one of
10 the two, yeah.

11 DR. JOHNSON: That was pretty cool,
12 because they went through some detail. And I -- I
13 recognized that we didn't have any detail. We don't
14 have detail. I hadn't read the Osteo. I apologize.
15 But now I know there's lots of detail. And we've got
16 to find that balance. And I'm not sure we're going to
17 hammer it out today. We've got to find a balance,
18 because it makes sense, and especially if someone's
19 going to expand in number, I'm trying to think, you
20 know, what -- Tom and my experiences are so different
21 because we're in the surgical world, and pretty much
22 hospital based.

23 I was sitting there going, you know, if I
24 was a primary care doc and I had a team of PAs and I'm
25 going to expand it and they're going to be seeing 30

1 patients a day each, and then I've got three out there
2 30 miles away, and they're going to see 20 patients a
3 day, and I'm going to be seeing my own, how am I going
4 to do this? How am I really going to supervise and
5 justify it to George?

6 It can't be have chart in 30 days. It's
7 not going to happen. You're setting somebody up for
8 failure and major discipline if they don't do it
9 right. You want to create opportunities to expand
10 practices.

11 If you're running a dermatology clinic or
12 an aesthetic clinic with some satellites, that's a
13 whole different oversight experience than something
14 else, you know.

15 I don't know how we're going to solve
16 this. I'm muddled right now in my own head.

17 MS. THOMPSON: And I want to be
18 respectful of time, and we're at that 12 o'clock hour
19 where we've really set aside some time to talk about
20 the delegation agreement. Here we go, you know. What
21 would the committee like to do?

22 I mean, this is a topic where I think we
23 recognize that we're on kind of polar opposites, and
24 we kind of need to try to come to some kind of more
25 common ground -- okay. To be honest, we want to come

1 to a common ground, but they're separate boards and
2 commissions and they have their individual authority,
3 and so we have to recognize the fact that maybe we're
4 not going to get exactly to that common ground, but
5 that's our goal, right? To get to that common ground.
6 What does the committee have to do?

7 We have another committee. Does the
8 committee want the Department to try to come up with
9 some common language to bring for you all to look at
10 and chew on? Do you want to send Brett and Julie some
11 ideas? Do --

12 I don't know. What does the committee
13 want to do?

14 MS. SCHIMMELS: I'm just going to throw
15 it out there. First one comment first. A lot of what
16 is in 015 for the Osteopathic is on your practice plan
17 already. So that's kind of cool. I was looking
18 through it. Well, a lot of that's right here anyway.
19 It's spelled out for the supervision. I just wanted
20 to point that out.

21 Number two, second comment. On 090, we
22 need to get rid of -- it needs to be just physician
23 assistant and not certified physician assistant
24 utilization. It should just be physician assistant
25 utilization, because we're getting rid of PA and

1 certified.

2 MR. CAIN: In the title?

3 MS. CARTER: In the title, yeah.

4 MS. SCHIMMELS: And lastly, I think that
5 the -- the PA profession has been around for 50 years
6 now, and I'm not sure if the use -- I know Athalia
7 was -- how many years ago was that?

8 MS. CLOWER: 19.

9 MS. SCHIMMELS: Yeah, so 20 years ago.
10 So osteopathic PAs have been around 20 years. And I
11 have great respect for the boards on both sides, and,
12 being the new person, I would say let the respective
13 boards decide or keep their language for this.

14 My only suggestion would be to get rid of
15 dates and times and numbers on it. But I have no
16 problem with where it's at on the allopathic and I
17 have no problem with where it's at on the osteopathic.
18 My only concern with the osteopathic is just the
19 numbers, saying you have to have 10 or you have to
20 have 30 days or two days or whatever.

21 Because, again, I agree with Mark, and
22 Dr. Green. I think that sets them up for failure.
23 And I think it discourages them from hiring a PA.

24 DR. MARKEGARD: Can I ask the staff to do
25 my work for me?

1 MS. THOMPSON: Brett?

2 MR. CAIN: Yeah.

3 DR. MARKEGARD: On that same section, to
4 keep essentially all of this information except for
5 take out the ones that's had like the 10 percent, the
6 seven days, and keep all the other items in there.

7 When it gets down to No. 8, the
8 supervising osteopathic physician should advise the
9 board of termination of a -- you know, of their
10 agreements with other relationship within a certain
11 period of time, within 30 days. I think that's fine
12 to keep.

13 And then there's the one sentence in here
14 that know why it's in here. And that same section
15 towards the end, "Board approval of the new
16 relationship is required before the osteopathic
17 physician assistant may begin practice under the new
18 supervising physician. A physician assistant being
19 supervised by an allopathic physician must be licensed
20 and have an approved practice plan as provided in
21 chapter" -- do we need that sentence?

22 MR. CAIN: Which number? I'm sorry.

23 DR. MARKEGARD: Well, it's 95. There's a
24 5 somewhere. Under 9. The last sentence of 9. Do we
25 have to have that?

1 MR. CAIN: I don't know. That's already
2 a requirement.

3 MS. CARTER: Yeah, I think it was maybe
4 just informational, that if you're going to go work
5 for an MD you need to get an MD license. I don't know
6 that it's necessary there.

7 DR. MARKEGARD: Okay.

8 MS. THOMPSON: Just one second.

9 DR. MARKEGARD: Maybe it was less detail
10 but more agreeable.

11 MS. THOMPSON: Wait one second. Somebody
12 we haven't heard from.

13 DR. VANDERGRIFT: I'm John Vandergrift.
14 I'm an MD working with Group Health.

15 One point that I want to follow up on is
16 that I do think that it is important to keep in mind
17 that not only is there an issue with some of these --
18 if it's too proscriptive with this and too
19 micromanagement type, not only is it set up for
20 failure, but, once again, as you mentioned, there is
21 an economic with this as well, because if the
22 oversight is too onerous it's really going to
23 discourage physicians and physician groups from
24 wanting to hire PAs, because you can get into a
25 situation where you can say, Gosh -- for example, for

1 me, at Group Health, where we do employ a large number
2 of PAs, if I get into a situation where things are
3 proscribed so deeply as this, I can be in a situation
4 of saying, Gosh, you know, I have to hire six more
5 physicians just to do the reviews. And when we're
6 looking at the economic impact of the cost of
7 healthcare in the nation, as we are right now, that's
8 a significant impact, because that's a very
9 significant cost of doing business.

10 And so I'd really petition everyone here
11 on both boards to please bear that in mind, that --
12 and also when we're looking at a situation where we do
13 have many of our PAs who have been working side by
14 side, elbow to elbow, with their physicians, sponsors
15 and supervisors, for 20-plus years in many cases, they
16 know their practices inside and out, and doing, for
17 example, a 10 percent chart review at that point is
18 probably overkill.

19 Yes, supervision does need to be done.
20 Yes, this needs to be accounted for someplace. Yes,
21 it needs to be monitored. But I do beg for
22 reasonableness.

23 MS. THOMPSON: You guys pick and choose.

24 MS. DALE: All right. This is -- and --
25 this is about the wearing badges at all times, which

1 is right in the osteopathic law, (e), under this same
2 015. It's under 5(e). And in the allopathic it's
3 actually in a different rule. It's 918.130.

4 And the reason I'm bringing that up is
5 because can we -- instead of saying a badge -- I
6 worked in pediatrics for 20 years. I've had more
7 shirts ripped off of me, and we switched to the
8 medical -- or to the magnet, and then the kids grab
9 that and stuff it in their mouth. No matter how much
10 the mom, dad, and I try to prevent it. So can we just
11 say must be identified as a PA?

12 Because the other thing is in surgery.
13 You're wearing scrubs. A lot of different
14 organizations have you wearing this badge with the
15 little magnetic thing to get you in and out. So
16 instead of saying -- again, being very proscriptive
17 and saying badges, can we just say identified?

18 Because, again, if you're so proscriptive
19 to follow the letter of the law, you know -- like I
20 said, I had a lot of shirts ripped and magnets
21 disappear and everything else. So it would be better
22 just to allow us to figure out how we can identify
23 ourselves in a reasonable manner.

24 MS. THOMPSON: Okay.

25 And, Athalia, did you have something

1 else?

2 MS. CLOWER: Yes. Just as a practicing
3 PA, I just don't want to jeopardize where we are with
4 the allopathic physicians to include more language
5 there that's going to restrict us.

6 MS. THOMPSON: Okay.

7 So here's where I am. I'm trying to --
8 I've got to cruise here. So I think I have clear
9 direction for staff from Osteopathic. Medical, we
10 have a few more committee members. I guess I need to
11 hear from the committee members the direction that
12 they want the Department to do for this. Do you want
13 to leave it as is or do you want to -- staff to try to
14 come up with something or --

15 I mean, we can work with Dr. Heye. Where
16 does the MQAC committee want to land on this one?

17 MR. CONCANNON: What are you talking
18 about?

19 MS. THOMPSON: For -- I'm sorry. For
20 the -- well, you know, it's kind of that -- physician
21 assistant -- I don't know, you guys call it --

22 MS. SCHIMMELS: 98-010.

23 MS. THOMPSON: You guys call it
24 utilization.

25 MR. CONCANNON: I mean, there's nothing

1 to work on. That's a sentence. A sentence that's not
2 necessary. And that whole section could be
3 eliminated. That's just a detail in this whole
4 discussion.

5 DR. GREEN: I agree.

6 MR. CONCANNON: The discussion is
7 delegation agreements, what are they going to require,
8 what is the rule going to require the delegation
9 agreements to provide.

10 You already pointed out some of that
11 stuff, but we haven't talked about it because we've
12 deferred talking about it.

13 DR. GREEN: I wouldn't say -- I wouldn't
14 put a bunch more stuff.

15 MS. THOMPSON: So do you want to get rid
16 of that section? Is that what Medical wants to do?

17 MR. CONCANNON: It's not a question of
18 whether we want -- I mean, the section is just a
19 sentence that says, "No physician shall serve as
20 primary supervisor for more than five licensees."
21 That sentence could be in the delegation agreement
22 section, right?

23 MS. THOMPSON: Absolutely.

24 MR. CONCANNON: So in that sense, I'd
25 say, yeah, get rid of it. Not because it's stupid,

1 just because it has no --

2 MS. SCHIMMELS: It's redundant.

3 MS. THOMPSON: And in the RCW.

4 DR. GREEN: So it isn't necessary.

5 MR. CONCANNON: It isn't necessary. And,
6 again, you don't want people to think they have the
7 right to get delegation agreement approved for four
8 licenses. They don't have the right to get them
9 approved.

10 DR. GREEN: So my vote would be to just
11 get rid of it. If we need to agree on what
12 supervision is, I think we ought to do it on the
13 section on the delegation agreement where that's one
14 of the items.

15 MS. SCHIMMELS: Agreed.

16 MS. THOMPSON: Okay.

17 So our attorney brought up one question.
18 So Osteopath has a piece in there that talks about how
19 you would apply for -- to do more than five. Does
20 Medical feel like they need a process put in their
21 rules?

22 MS. CARTER: They have just a paragraph
23 under utilization that they may supervise five. The
24 Board makes it a request to supervise more than five,
25 which is part of the statute, and they base that

1 decision on individual qualifications of the
2 supervising physician and PA, community need, and
3 review mechanisms identified in the delegation
4 agreement.

5 MS. SCHIMMELS: It's in here, just in a
6 different spot. It's already in there, just in a
7 different spot.

8 MS. THOMPSON: Okay.

9 MR. CONCANNON: That's -- what you just
10 read from, Heather, is just a -- it's a carry-over of
11 their rule. They change three to five, and then
12 you --

13 MS. SCHIMMELS: And it's in there in just
14 a different spot.

15 MS. THOMPSON: Okay. I need to grab a
16 copy of the delegation agreement so that I have them.

17 DR. GREEN: Before we leave that, can I
18 ask one question?

19 MS. THOMPSON: Uh-huh.

20 DR. GREEN: This is Section 854.015, and
21 it's No. 9, where it says physician assistant -- it's
22 where it is supervised by an allopathic physician must
23 be licensed.

24 DR. MARKEGARD: We talked about that and
25 deleted it.

1 DR. GREEN: Okay.

2 Because I thought that -- where you have,
3 again, a mixed group of supervising physicians. I
4 thought you were saying they needed to have both
5 licenses.

6 Okay. So you've left that out, then?

7 Okay. Sorry for the interruption.

8 MS. THOMPSON: Okay. So I'm going to
9 dedicate the next 45 minutes -- I know we're going to
10 push the last few minutes over, but we've got to get
11 going on this.

12 So we have -- hopefully everybody has the
13 physician assistant delegation agreement for MQAC and
14 then also the osteopathic one.

15 One of the suggestions was that maybe we
16 could make these forms substantially similar, so that
17 either, A, they're using the exact same form for
18 whichever they want to use it for, whichever license,
19 just an option, or if we have to have two separate
20 forms, which is fine, they still are substantially
21 similar.

22 The front pages of both are pretty much
23 just the basics.

24 MR. CONCANNON: You're just talking about
25 the forms?

1 MS. THOMPSON: The forms.

2 MR. CONCANNON: Dr. Heye, this form that
3 we have is dated July 2013. So it was revised, then,
4 based on the new statutes? Did it change much?

5 DR. HEYE: No.

6 MR. CONCANNON: The format of it?

7 DR. HEYE: No. It's the form we've been
8 using for a long time.

9 MS. THOMPSON: And I see that Osteo's was
10 September 2013. So they're both very current.

11 So the first page is just, you know,
12 name, address, supervising, alternate supervising. I
13 think it's the same pretty much on both.

14 The next page, for medical, is --

15 DR. MARKEGARD: I'm sorry. On Page 1?

16 MS. THOMPSON: That's all right. Go
17 ahead.

18 DR. MARKEGARD: It doesn't have the
19 certification number. Is that useful?

20 MS. SCHIMMELS: Yes. Yeah, you can
21 actually go on -- you could go on the site and look at
22 the PA that you're going to hire, and it will give you
23 their current CME credits, make sure that they're
24 certified, and make sure that they're up to date with
25 whatever else they need to be doing as far as the C on

1 their license.

2 DR. MARKEGARD: Okay.

3 MS. DALE: And particularly, since you
4 require that they be certified, that's something you
5 might want to --

6 MS. SCHIMMELS: You want to put that on
7 there, probably. Because it's readily accessible
8 to -- anybody in the public can go look up somebody by
9 their license number -- or by their certification
10 number.

11 DR. MARKEGARD: Because there's a license
12 number and NCCPA certification number. I didn't know
13 the difference between those.

14 MS. SCHIMMELS: Yeah. So your NCCPA is
15 your certification number. That's something that is
16 the C at the back of our name. So you would want to
17 have that number on there.

18 DR. HEYE: Also, on our first page, under
19 the supervising physician, there is a place for
20 specialty on our form. I found it very helpful in
21 trying to decide whether the practice plan made sense.

22 DR. MARKEGARD: I like your form. Under
23 alternate it has MD or DO. It would be nice to have
24 that on our form too.

25 MS. DALE: I like the definitions as

1 well.

2 Although if we change the definition of
3 noncertified in the rule, we have to make sure that
4 this is current.

5 DR. MARKEGARD: And for the DO, we don't
6 need the certified/noncertified, right, because we
7 don't allow noncertified.

8 MS. SCHIMMELS: Right.

9 DR. MARKEGARD: Okay.

10 MR. CONCANNON: And, again, these forms
11 are being looked at in this open session just for
12 information purposes? This is not required, this is
13 not part of the rule?

14 Each board can change their form whenever
15 they want to, right?

16 MS. CARTER: Yes.

17 MR. CONCANNON: So we're just doing this
18 just to compare notes and see the way the other guy's
19 doing.

20 DR. MARKEGARD: And to get on the same
21 page and to make them easier.

22 MS. CARTER: I think also it can play
23 into what you require the rule to be.

24 MR. CONCANNON: It's like a means to an
25 end.

1 MS. CARTER: Yes.

2 MR. CONCANNON: So obviously the
3 osteopathic delegation agreement, once you get to
4 Page 2, gets involved in detail, right?

5 MS. THOMPSON: Mm-hmm.

6 MR. CONCANNON: Lots of detail.
7 Consistent with its rule.

8 DR. JOHNSON: I like something on the
9 osteopathic Page 1 on the physician group. I think
10 they are asking a physician group to define their
11 responsibility as a group in supervision. Am I
12 reading that correct?

13 Whereas we're not quite -- I don't know
14 that we're quite doing that.

15 And I would think it would be useful to
16 put the onus on Group Health or regional clinics or
17 wherever -- Virginia Mason, to tell us what they're
18 going to -- how they're going to oversee it, rather
19 than us to guess.

20 And so I like the concept of requiring
21 the group to put something in there how they're going
22 to oversee as a group, whether it's an ER, outpatient
23 environment, surgical thing. I'm not sure we're
24 seeing that in the MQAC one as well.

25 DR. MARKEGARD: Is it helpful to have the

1 last supervising physician when you review these? On
2 the last page?

3 MS. DALE: I saw that, and I was
4 wondering why would that be necessary.

5 DR. MARKEGARD: Right. That's what I'm
6 asking.

7 DR. HEYE: It's just their file, and then
8 we ask for all -- on Page 3 we ask for all current
9 supervisors. A lot of people have more than one
10 practice -- delegation agreement.

11 MR. CONCANNON: What does last
12 supervising physician mean? The person that was the
13 supervisor before this plan?

14 DR. MARKEGARD: Right.

15 MR. CONCANNON: Before this plan?

16 DR. MARKEGARD: Correct. That's what I'm
17 assuming. I didn't make the form. Never used the
18 form.

19 DR. GREEN: What does the sentence above
20 that mean?

21 MR. CAIN: Should be is, for one thing.

22 MS. DALE: Sounds like that could
23 probably be struck, then.

24 DR. MARKEGARD: Right.

25 MR. CONCANNON: Does every delegation

1 agreement have to have an alternate supervisor?

2 No?

3 DR. JOHNSON: Don't have to.

4 MR. CONCANNON: Doesn't have to?

5 MS. DALE: It's up to -- again, the
6 physician PA, because they're in an office where it's
7 just the two of them and the physician goes on
8 vacation for a month, then that means that office
9 closes and the PA can't work anymore. So most
10 practices I would assume would have some kind of an
11 alternate so that that practice can stay open and that
12 PA can continue to see patients during vacation.

13 MR. CONCANNON: And there's no particular
14 time limits on -- or the amount of patients that the
15 alternate can be involved with? Could be 20 percent
16 of all the patients, it could be once a year, it could
17 be three times a month, it could be -- we don't have
18 rules on that, we don't have restrictions on that.

19 Once you name an alternate, you can use
20 that alternate as indistinguishable from the
21 supervisor, based on need or want --

22 DR. JOHNSON: Isn't that one of the
23 complexities that's been brought up in this meeting,
24 is that if you're a single site provider and PA --
25 physician -- or MD and a PA and the MD goes on

1 vacation, who is the alternate, and there have been
2 some -- I think I've heard this. There are some
3 environments where it's difficult to get an alternate.

4 MR. CONCANNON: Right.

5 DR. JOHNSON: That's not a remote site.
6 The remote site meaning that the alternate is 10 miles
7 away, 30 miles away, and the PA is having trouble
8 getting that alternate, for some reason.

9 Someone can explain it better than I.

10 MS. DALE: The case that was brought up
11 to me was that this PA was not hired, a nurse
12 practitioner was hired, because the physician in solo
13 practice wanted to hire the PA but they -- when they
14 went on vacation, the closest alternate was 10 or
15 15 miles away, and then they'd have to go through all
16 of the rigmarole, is what they said, to be, then, a
17 remote site. So the PA was not hired, a nurse
18 practitioner was hired.

19 So the PA was on my phone yelling at me,
20 Why is this happening?

21 And so then the question came up, Do they
22 fall under that remote site category if they're
23 alternate? Is it a different office? And have to
24 meet the remote site? Or how does that play out?

25 And so that was a case I brought at our

1 first meeting.

2 DR. JOHNSON: So how do we resolve that?

3 MS. CLOWER: We also have that in
4 rheumatology and dermatology in Tri-Cities, where
5 there's not many physicians -- there's not another
6 rheumatologist. The nearest one is in Spokane.

7 DR. HEYE: This is a good example of the
8 kind of problems that we're faced with sometimes. In
9 a situation where somebody goes on vacation and it's a
10 remote site and there's nobody available, you know, I
11 say go ahead and use the doc who is 30 miles away, and
12 I'd just give them a waiver of having the doctor at
13 that clinic. Why do I want to close a clinic down?
14 You know, I don't want to do that. Nobody wants to do
15 that.

16 So the nice thing about the variations
17 that the language allows in these delegation
18 agreements is we can do those sorts of things.

19 DR. MARKEGARD: I have a question. On
20 physician group, does a physician group have a license
21 number?

22 MR. MARESH: Hmm-mm.

23 DR. GREEN: No, I think just the
24 individuals.

25 MS. SCHIMMELS: Did you guys already get

1 the typo, if alternate supervision is being --

2 MR. CAIN: Yeah.

3 MS. SCHIMMELS: Okay. Good. Sorry.

4 DR. JOHNSON: I have a question on Page 2
5 for Osteopathic. Why do you differentiate between
6 major and minor surgery? Why do you first and second
7 assisting? I mean, is there a rationale for those
8 differentiations?

9 DR. MARKEGARD: Not that I know of.

10 DR. JOHNSON: That's my point. So I'm
11 just wondering if we're going to try to get things
12 closer together, I wouldn't have any of those.

13 DR. MARKEGARD: Already made changes to
14 make it look like yours. That's Page 1.

15 DR. JOHNSON: I'm just looking at yours
16 and saying if I had -- I'd go -- I don't even know how
17 you define major and minor surgery, let alone check a
18 check box. So I'm just wondering if you really
19 need -- what's the purpose of it for --

20 DR. MARKEGARD: I appreciate the
21 critique. No.

22 MS. THOMPSON: Just combine it, just say
23 surgical procedures?

24 DR. MARKEGARD: Surgical. Assisting the
25 surgeon.

1 MR. CAIN: And then one check box,
2 assisting in surgery?

3 DR. MARKEGARD: Yes. And same thing for
4 minor/major.

5 MS. DALE: On that assisting in the
6 following surgical procedures, are you asking, then,
7 for a laundry list of what the PA is going to be
8 doing?

9 DR. JOHNSON: I don't think you want to
10 do that.

11 DR. MARKEGARD: Where are you?

12 MS. DALE: On that same page, under
13 assisting in surgery, then the next one down says PA
14 will be assisting in the following surgical
15 procedures.

16 I mean, if you leave that in, then you
17 would have to put in a laundry list of everything, and
18 that's going to be prohibitive to try to keep up with.

19 MS. SCHIMMELS: Are you talking about
20 lining out PA will be assisting in the following?

21 MS. DALE: Yeah, I would just say take
22 the whole thing out, because you've already got
23 assisting in surgery.

24 MR. CAIN: So the PA will be assisting in
25 surgery check box.

1 Dr. Markegard, what about the ER?

2 DR. MARKEGARD: Sounds dumb.

3 MS. THOMPSON: We're just going to clean
4 these right up, aren't we?

5 Sometimes -- you know, sometimes forms --
6 they get set and then people just keep accepting them
7 without really reading them, and so this is probably a
8 good thing. Let's read the forms. Is it a useful
9 checkbox, is it not, and then maybe we can get down to
10 what's the same and what's not the same.

11 DR. JOHNSON: There was another example
12 that -- I think this is a Group Health example, that
13 was brought up at a meeting or two ago, where the PA
14 was -- I'm going to screw it up a little bit, but
15 maybe in an emergency -- in a family practice in Group
16 Health, but then they needed help in the emergency
17 room. They were short. Or urgent care or something.

18 MS. DALE: It was vice versa. Randall
19 brought that up.

20 DR. JOHNSON: Because there wasn't a
21 delegation agreement with this other arm of the same
22 institution, somehow didn't cap him when they really
23 needed a person to take care of patients, and all of a
24 sudden they were stymied because of paperwork.

25 And so one of the things I hope we can

1 deal with is within institutions. And that's where I
2 like the thing on the osteopathic, is a physician
3 group or an institutional group, somehow there's some
4 clarification that within the institution they can
5 have an oversight and appropriate utilization within
6 relatively like specialties.

7 So it doesn't make a lot of sense if, you
8 know, somebody's only doing cardiac surgery and
9 they're asked to do dermatology. I wouldn't do very
10 good in a dermatology office myself. I'd go, I have
11 no idea; call a dermatologist. Let's take a picture,
12 mail it someplace, you know.

13 But to have the institution not be
14 stymied by the rules and allow some creativity, I
15 guess is what I'm thinking.

16 DR. VANDERGRIFT: I want to thank you for
17 bringing that up, because one of the sections for
18 which we had a lot of concern actually was -- it was
19 the new added section that I think it was 246-918-055,
20 Section -- or Item 4 Subpoint (a), is that it seemed
21 kind of unclear to us, because we do run into not just
22 that but -- and I specifically oversee the urgent care
23 system for Group Health. But we have situations, for
24 example, where I will have a PA who is functioning,
25 and I'll pick out my site in Tacoma, and one of my PAs

1 will go to fill in a shift, say, for our site in
2 Olympia.

3 And one of our questions was, Gosh, even
4 within the urgent care (inaudible) delegation
5 agreement for being at that other site when it's the
6 same practice, the same group of providers, same group
7 of physicians, in the same company, doing the same
8 sorts of things. And that was a point of
9 clarification that we really wanted with this. We had
10 felt that that Point (a) in this section 4(a) was
11 what's kind of unclear.

12 DR. JOHNSON: Yeah.

13 DR. VANDERGRIFT: I think you addressed
14 that nicely.

15 DR. HEYE: Part of the issue I think with
16 this kind of a situation was you had a PA who was
17 practicing like in a family practice setting, all of a
18 sudden wanting to be used in emergency room setting.
19 And I -- who's at risk here? Is it -- do we know that
20 that PA is capable of working in that ER setting? I
21 don't know.

22 DR. VANDERGRIFT: My opinion and what my
23 practice is within my group -- or within Group Health,
24 is that if I have a PA who's functioning who maybe has
25 their primary practice, we'll say, in family practice,

1 for example -- or you could pick orthopedics or
2 whatever. If they're coming to work in the urgent
3 care and provide coverage there, they need a
4 delegation agreement with a physician who's in the
5 urgent care, practicing in urgent care.

6 Does that address the question that you
7 had?

8 DR. HEYE: I mean, with your
9 organization, usually the remote sites are a list of
10 10 or 15 different places, which all make sense
11 because they're all supervised. So I don't have any
12 problems with those at all. But if none of those are
13 emergency room settings, then if all of a sudden you
14 want to move somebody from a family practice to
15 emergency, do you think there should be a separate
16 delegation for that?

17 DR. VANDERGRIFT: Yes.

18 DR. HEYE: As if you would move them to
19 surgery all of a sudden.

20 DR. GREEN: Isn't that what that says?

21 DR. VANDERGRIFT: Either the -- well,
22 what was unclear to me in the section -- I know we're
23 digressing from the form a little bit, but what was
24 unclear to me from this is whether -- well, just to
25 read it, it says "works with more than one physician

1 or group of physicians (separate practices or
2 specialties), there must a separate application and
3 delegation agreement submitted for each physician or
4 group of physicians."

5 And so what is unclear to me with that is
6 is this defining, gee, the group of physicians being
7 the cluster of physicians I have, for example, working
8 really almost exclusively in my urgent care in Olympia
9 versus Tacoma versus Silverdale, et cetera, or is that
10 interpreted as the larger group practice of Group
11 Health physicians?

12 DR. HEYE: I could be clearer. Okay.

13 DR. JOHNSON: So part of that is in the
14 delegation agreement, and that's why I like the
15 Osteopathic when they say how is the group going to
16 supervise the physician. I love that. It puts the
17 onus on Group Health to define it.

18 Then if you're going to potentially have
19 them go to different specialties, how are you going to
20 define that and make sure this is an adequate
21 supervision and delegation and appropriateness.
22 Should that be our responsibility to define it? And
23 I'm saying I don't think so. We want you to design
24 it, and then we'll decide if it's an okay delegation,
25 and if we don't, you can't do it.

1 DR. HEYE: Well, because if that PA goes
2 from your clinic to the ER, then you're not the
3 supervisor anymore.

4 DR. VANDERGRIFT: Correct. That's why my
5 personal practice, especially for my service line, and
6 I think it's been pretty much the practice across
7 Group Health, is that if that PA is going to provide
8 medical care and services in an area of a different
9 discipline, they need to have the delegation agreement
10 in that -- with a physician in that discipline.

11 DR. GREEN: So that was the intent of
12 that statement.

13 You could help rephrase it if you think
14 it isn't clear. Because it says different specialties
15 practices, and it sounds like in your situation, even
16 though the people that you have a responsibility for
17 go to different places, that's accounted for in the
18 agreement.

19 DR. VANDERGRIFT: I'm -- the thing is the
20 concern I had in looking at it is how that's
21 interpreted as the practice, whether it's the larger
22 group practice that we have under Group Health
23 physicians or is it the practice at that specific
24 site, that geographic site. And that's what -- that
25 was the point that was a bit unclear to me as I read

1 through this section.

2 MS. DALE: So it should be -- you're
3 saying, then, it should be within the discipline
4 across all sites, would be the way to word that?

5 DR. VANDERGRIFT: Mm-hmm.

6 For the court reporter, yes.

7 MS. THOMPSON: Okay, so let me rephrase,
8 because I feel like I'm a little lost. So what you're
9 saying is that if they have a supervision -- or a
10 delegation agreement for a specialty, that that
11 applies to that specialty in any site that they are
12 at, for example, with Group Health, and if they go to
13 a different specialty, then they have to have a
14 separate delegation agreement?

15 DR. VANDERGRIFT: Yes.

16 MS. CARTER: And is "specialty" the right
17 word, or do we need to say "discipline or specialty"?

18 DR. HEYE: We're talking about a scope of
19 practice. Because scope of practice for urgent care
20 is pediatrics, family practice, internal medicine.
21 All those things fall under your clinics.

22 DR. VANDERGRIFT: It's effectively
23 emergency medicine.

24 DR. JOHNSON: That's very well said.

25 MR. CAIN: You're going to have to help

1 me with that.

2 MS. CARTER: It's going to be hard to
3 reword it but we'll do it.

4 MS. THOMPSON: You have the gist of it,
5 right?

6 MS. CARTER: Yes. I think the key is at
7 any site within the group. But we'll work on
8 language.

9 MS. THOMPSON: And everybody feels
10 comfortable with that idea?

11 MS. CARTER: Please, if you can help us
12 come up with the language.

13 DR. VANDERGRIFT: I will. Thank you.

14 MS. THOMPSON: Okay.

15 I don't know. What else?

16 Did you guys want to go back to the -- I
17 have no problem going back and forth between the
18 language and the forms. I just think that the
19 delegation agreement forms are just a good place to
20 help us capture ideas that then go back to the draft
21 language that we want to use.

22 Yes, Dr. Heye?

23 DR. HEYE: Up in this 055, Section 1 up
24 there, it says names and license identification of
25 physician who will assume a supervising role of PA.

1 We're talking about a delegation agreement there, and
2 that's really -- it's going to be signed by one person
3 along with the PA, so I was wondering whether we
4 should put the word "primary" in front of
5 "supervising," because there's going to be somebody's
6 name on that agreement along with the PA. We can't
7 put down Group Health as the, you know, primary
8 supervisor. It's got to be --

9 MS. THOMPSON: Somebody has to have
10 the --

11 DR. HEYE: It's got to be an identified
12 person.

13 DR. GREEN: Include maybe a statement
14 that says that a physician or one of the physicians in
15 the supervising group assumes responsibility for
16 signing and maintaining the delegation agreement?

17 DR. HEYE: We have to know who that is.

18 DR. GREEN: Well, that's what they have
19 to specify.

20 MS. SCHIMMELS: Doesn't it already say
21 that there?

22 DR. JOHNSON: In your group, Tom, if you
23 had eight PAs -- and you had how many ortho guys?

24 DR. GREEN: 10, 11.

25 DR. JOHNSON: So would one -- would the

1 chief of ortho division sign for all of them or would
2 you --

3 DR. GREEN: We each had two or three.

4 DR. JOHNSON: That's what we've done too,
5 is we kind of spread it out.

6 It's possible that the chief of that
7 division could -- you have to get George's approval if
8 it's more than five, but could be the one, if they
9 wanted. I'm not sure they want it.

10 DR. HEYE: Well, and this is a problem,
11 because the person whose name is on the delegation
12 agreement may hardly ever work with this PA in the
13 systems that we're talking about.

14 DR. JOHNSON: Talking about institutions.

15 DR. HEYE: So although there's a name on
16 the piece of paper, it may not be the supervisor most
17 of the time, so --

18 DR. GREEN: But regardless of that, don't
19 you think it ought to be one of the -- if it's a
20 group, one of the physicians in the group that is
21 named in the delegation agreement? As opposed to an
22 administrator --

23 DR. HEYE: Yeah, I agree. I'm not trying
24 to get rid of the primary, but what does the primary
25 end up being primary for?

1 He fills out the paperwork and -- he or
2 she fills out the paperwork and sends it in, and then
3 the PA goes to a dozen different places in the next
4 month or two, and all with different supervisors,
5 which is okay, still being supervised, but the primary
6 supervisor is just a paperwork kind of delegation,
7 like the VA system has. They call it something else,
8 but -- they call it a supervisor, but not really
9 supervising most of the time.

10 DR. GREEN: But if you just said that
11 one -- well, I don't know. Just one of the
12 supervising physicians assume responsibility with the
13 PA --

14 DR. HEYE: It's already happened.

15 DR. GREEN: Yeah. Because one person
16 signs it. It isn't the whole group that signs it.

17 DR. HEYE: Right. But, I mean -- as far
18 as telling how that PA is doing from week to week or
19 day to day. That information is spread out in the
20 whole group.

21 MS. THOMPSON: The Group Health has a
22 comment. May be helpful.

23 DR. VANDERGRIFT: From a pragmatic
24 standpoint, I am really very, very sensitive to the
25 comments that you've made, and speaking in my position

1 as basically the assistant medical director for our
2 urgent care system and having, oh, gosh, probably 20,
3 30 PAs or so, I really don't want to be signatory as
4 the supervising physician for all of them.

5 What our intent is and what we really
6 wish to do philosophically in Group Health, at least,
7 is we want to share the wealth with this, and I don't
8 even want my local chiefs being the ones who have all
9 the PAs at their site reporting to them. They are
10 already doing monitoring and doing annual performance
11 reviews, with not just the PAs but also with all the
12 physicians in each of their areas. Then we review
13 those annually in a larger sense.

14 What we wish to do with this, and what
15 would really be our preference, is to share these
16 delegation agreements among the physicians that we
17 have in our practice so that all of our physicians are
18 participating with this to a greater or lesser agree.
19 You know, obviously some are going to have a few PAs,
20 some are going to have maybe one, maybe two. But by
21 sharing this, I think the overall supervision and
22 monitoring of our PAs can be more equitably
23 distributed among our physicians.

24 And so we really don't want this to be,
25 A, the supervising physician, quote, unquote, is the

1 group practice. As it is, these delegation agreements
2 are not really with Group Health but they are the
3 three parties, so the supervising physician, the
4 physician and the state. Group Health then keeps
5 track of who those are, but that monitoring need is
6 within that relationship of the PA, the physician and
7 the state, and that's in addition to the monitoring
8 that we do with our annual meetings.

9 So I would -- my recommendation would be
10 that this -- it should not be our group practice as
11 the supervising physician but as an alternate.

12 Does that make sense?

13 DR. GREEN: So a member of the group of
14 physicians in the delegation agreement -- any one of
15 them could be responsible with the PA for submitting
16 the delegation agreement, signing it, and maintaining
17 it current, with any changes as required?

18 DR. VANDERGRIFF: Correct.

19 DR. GREEN: That would be my suggestion.

20 DR. JOHNSON: But are you suggesting -- I
21 like what you said, but there is a physician that's
22 supervising to that PA. Below that, there is
23 alternates. Now, are you suggesting the alternates be
24 named, or are you suggesting the group be named within
25 the -- and then you have a written description of what

1 that group's responsibility is?

2 Because a supervisor's not going to be
3 there every day, anyway, nor is -- the PA might go
4 over there. So how are you going to help -- how are
5 you -- we need help in defining this.

6 DR. VANDERGRIFT: And, quite frankly,
7 what you just described there is what my preference
8 would be, is that because -- functionally the way I'd
9 want it to be is I don't want to have a PA with a
10 supervising physician with a delegation agreement
11 being somebody who is at a completely different site.
12 That doesn't work. You're not really a supervising
13 physician then. But the supervising physician needs
14 to be at the primary site for that PA as predominantly
15 functioning, and thus is participating and working
16 alongside and actually supervising that PA's practice.

17 That PA may go elsewhere and be at other
18 places or, just as you mentioned, for example, in our
19 situation, because we do shift work, it may be a
20 situation where that PA is practicing in that same
21 site on a day when the sponsor -- when the supervising
22 physician has a day off. And so with that, with the
23 changeover that we can have within our ranks -- I have
24 like a hundred providers in my service line of
25 physicians and PAs combined. That is where for us it

1 makes sense to have our group practice listed as the
2 alternate. And so it's not just a physician and, Oh,
3 my gosh, if the supervising physician and the
4 alternate aren't there, then that PA can't work. That
5 allows us to actually function operationally.

6 DR. JOHNSON: Then we would expect you to
7 define that group responsibility that would come to
8 George and the Board, so they would exactly know what
9 you're going to do.

10 DR. VANDERGRIFT: I think that's quite
11 reasonable.

12 DR. MARKEGARD: In an impact case, you
13 list the group. If there is an event that happens and
14 needs to be reported or is reported, then if that
15 group is listed, then would that -- you propose that
16 event be listed under the physician that was in charge
17 of that PA for that day, and if it's an MD, then it
18 goes to the Commission, or if it's DO it goes to the
19 Board? For disciplinary reasons, right?

20 To have like the group --

21 DR. VANDERGRIFT: To me that would seem
22 reasonable, yes.

23 DR. HEYE: We already do that, because
24 the primary is named and then the -- we just put a
25 checkmark by alternate. If it's a group practice,

1 it's just checked as yes. We don't ask for any names,
2 we don't ask for day to day who is doing that. We
3 figure that's up to the group to take care of that.

4 It seems to me -- I mean, the RCW
5 requires a named sponsor, but in reality the group is
6 becoming the named sponsor, even though the law
7 doesn't allow us to do that at this point. If we got
8 the law changed, would you be in favor of that?

9 DR. VANDERGRIFT: I'm not sure that I'm
10 quite fully following.

11 DR. HEYE: Where the PA was attached to a
12 group rather than a person, as identified responsible
13 entity.

14 DR. VANDERGRIFT: You mean as the
15 alternate?

16 DR. HEYE: As the primary.

17 DR. VANDERGRIFT: I think the primary
18 needs to be an individual physician.

19 DR. HEYE: Why is that?

20 DR. VANDERGRIFT: I think that the
21 primary -- because, as I mentioned earlier, it helps
22 us spread the supervision so that we can help assure
23 that it's occurring and that it's not just one
24 individual.

25 For example, what can happen if the group

1 is listed as the primary, then that's -- arguably that
2 could be a situation where I am then sponsoring and
3 technically supervising all the 20 or 30 PAs that I
4 have in my service line, which is not realistic.

5 I think that it's important --

6 DR. HEYE: Not doing that -- it wouldn't
7 change what you're doing on a day-to-day basis, but
8 whatever clinic that PA is working at, there may be
9 five different doctors in the day that that PA uses as
10 a resource. Those are all supervisors. I'm arguing
11 to do away with the primary, but I know we can't do
12 that by law.

13 DR. GREEN: Well, the requirement that
14 you're looking for is whose name is on the delegation
15 agreement and who's responsible for maintaining that
16 with the PA, right? So that would be an individual;
17 it can't be the group.

18 DR. HEYE: I know. The way the law is
19 written can't be an individual, but what I'm saying is
20 most of the time in those kind of practices that
21 individual isn't working with that PA, because they're
22 going from clinic to clinic to clinic, maybe. And
23 you're assigning to clinics regardless of who is on
24 the delegation agreement.

25 I'm not saying that you should change

1 what you're doing, I'm just -- that's the reality of
2 practice.

3 DR. VANDERGRIFT: What we do have
4 functionally is that we have our -- we tend to have a
5 group of physicians that -- as well as PAs that stay
6 pretty constant geographically at any given site, and
7 so we -- they're not -- it's not a constant churn that
8 we have.

9 I'm the only physician in our urgent care
10 system who actually practices physically in all six of
11 our urgent cares. And that's so that I can keep the
12 supervision and monitoring going that I need to keep
13 in touch with all of those practices. However, at any
14 given site, really, the group of physicians that's
15 there pretty much just practices in that geographic
16 site. The group of PAs that practices there is pretty
17 much just in that geographic site. So it's actually a
18 smaller cluster of physicians and PAs that are working
19 with each other predominantly, and it's the occasional
20 situation where they are -- where the PA would be in a
21 different site. It's not a regular routine rotating
22 situation of moving them all around geographically.

23 DR. HEYE: But the primary sponsor may
24 not be in the cluster that the PA is in.

25 DR. VANDERGRIFT: The primary sponsor, as

1 far as I operate things -- and I can speak
2 specifically for my service line. The primary sponsor
3 for that PA, who holds the delegation agreement, needs
4 to be at that site where the PA is primarily
5 practicing. So it's both the physician and the PA
6 that are primarily at that same site.

7 DR. JOHNSON: Most of the time.

8 DR. VANDERGRIFF: Most of the time.

9 DR. HEYE: That would make sense.

10 DR. JOHNSON: Whereas in my group, where
11 we had seven general surgeons and three PAs, I would
12 love to have just our surgical group be primary, just
13 our group. And the way we always did it is the
14 on-call surgeon was the one -- they worked with the
15 PA.

16 I mean, for example, if I wasn't -- if
17 I'm here and I got inpatients to see, the PAs see
18 them. If they have any questions, they know who to
19 talk to, and that's the on-call surgeon. That's the
20 responsible surgeon that day in place of me or whoever
21 else. And it was -- we could easily define that and
22 send it in. And so instead of my name or my partner's
23 name, it would be our group. And we would define
24 exactly how that responsibility was shared. Each of
25 our PAs. You know, make it simple.

1 I understand you're more complex, but
2 it's still having a supervising doc and then a group,
3 and then you in your group define how is this shared
4 on each day, because -- that would make our job
5 easier.

6 MS. DALE: I think this -- it speaks to
7 how one plan does not suit all. Both plans are great.
8 So I think we need to look at that delegation
9 agreement, and, again, let the decision be made at the
10 practice site how that supervisory role is going to be
11 taken care of. Because both are great. There's
12 nothing wrong with either one of them. And if we sit
13 here and try to make the rules and say his is right,
14 everybody has to do his, that's not going to work.

15 So I think, again, keeping this general
16 and letting the physician and the -- and group and PA
17 write it out -- I think that says what we need to do,
18 is keep it general.

19 DR. GREEN: So the way it's written, it's
20 general.

21 MS. DALE: Yeah.

22 DR. GREEN: Does that work all right for
23 you?

24 MS. DALE: And, again, that's why I kind
25 of pushed toward the MQAC Page 3, because, again, the

1 practice arrangements, instead of being very
2 prescriptive and pushing in one way or the other,
3 allows the practice plan -- the delegation agreement
4 to be made at the practice site level between the
5 physician and the PA.

6 DR. MARKEGARD: Ask the board to already
7 make changes to make it more like the Commission one,
8 and to make it more simplified and kind of more
9 universal.

10 I have one question, though. On that
11 Page 3, when it says hours spent at each setting,
12 should it be hours you think are more useful or set of
13 time? Or does it matter?

14 Because they were having them define like
15 the remote site as at -- if they're -- if the
16 supervising physician is at that site 25 percent -- I
17 don't remember exact numbers but percentage, should we
18 kind of keep it in line for percents for all these
19 times spent at different locations?

20 DR. HEYE: Sometimes percent works and
21 sometimes it doesn't. It depends how they've
22 described the practice.

23 And that's probably the one part of
24 this -- you go back to the most to try and figure out
25 what people are talking about, because I had one last

1 week where adding up all the hours, the way it was
2 written down here was like 80 hours a week for the
3 doctor and for the PA, which clearly was not correct.

4 So we go back and say, What -- you've got
5 all these hours written down here. Well, they were
6 counting -- they were putting down remote site hours
7 that were only used part of the time.

8 In other words, some of the time they
9 were going to be at a remote site, which would have
10 been 40 hours a week, but the way it was written,
11 primary site had 40 and the remote had 40, and it
12 was -- and maybe in percentage -- either one wouldn't
13 have worked in a situation like that.

14 I use both, but occasionally I go back
15 and say, This percentage doesn't make sense. What
16 exactly number hours are we talking about here? And I
17 haven't found a form yet that everyone understands and
18 fills in correctly.

19 MS. SCHIMMELS: And I think hours
20 sometimes works, because you either work an eight-hour
21 day or 10-hour day or a 12-hour day or a four-hour
22 shift or a six-hour shift or something, and so they
23 can put, Yes, I'm going to be doc home visits for six
24 hours on every Monday so they can put six hours there.

25 DR. MARKEGARD: But of your week -- if

1 I'm going to review this form, I'm not going to get
2 out the calculator and add up everyone's hours.

3 MS. SCHIMMELS: And I would do it hours
4 and not percentages, just because that's the way my
5 mind thinks.

6 DR. MARKEGARD: I'd like the onus to be
7 on the person who filled out this form to do the
8 calculation for me so I don't have to do that.

9 DR. VANDERGRIFT: Would it be helpful to
10 have both?

11 DR. MARKEGARD: Sure.

12 DR. JOHNSON: I only have to go see my
13 probation officer once a month, so . . .

14 DR. MARKEGARD: One percent of the time.
15 Okay?

16 MS. SCHIMMELS: Is that what the
17 correctional facility is for?

18 DR. JOHNSON: Yeah. That's for me. Just
19 for me.

20 DR. GREEN: Time spent.

21 MS. THOMPSON: Okay. So we are at
22 one o'clock. I believe that this discussion probably
23 is not done yet, but I think we are making progress.

24 I know that Dr. Markegard has made some
25 changes to the DO form, that maybe we can do and bring

1 to the next meeting. I know that we have --
2 potentially have some suggestions on how to maybe make
3 some of the proposed rule language for the delegation
4 agreement supervising rule maybe just a little bit
5 more clear, so we're going to work on that. We've
6 worked up to this part.

7 Is there anything else -- I'm looking for
8 suggestions of where the committee wants to be for our
9 next meeting in Yakima, which is next month, right?

10 MR. CAIN: Yeah, March 21st.

11 MS. THOMPSON: March 21st.

12 DR. MARKEGARD: At 9 o'clock?

13 MR. CAIN: At 9 o'clock, yes.

14 We will send out official stuff within
15 the next week or so. Within the next week.

16 MS. THOMPSON: So this will definitely be
17 a topic of discussion at the next meeting, because we
18 need to get this resolved as best as we can. And we
19 have some other assignments that we've been tasked
20 with.

21 Are people feeling comfortable where we
22 are? Things that they definitely would like to be
23 considered for the agenda for next time?

24 DR. JOHNSON: Can I ask a question just
25 to speed up next meeting? All this nonsurgical,

1 cosmetic and laser -- is that going to be necessary to
2 have? Are we getting rid of it?

3 MS. THOMPSON: We're not getting rid of
4 it. It's not up for discussion.

5 DR. JOHNSON: We're not going talk about
6 it next time?

7 MS. CARTER: Laser rules --

8 DR. JOHNSON: But this has to stay in?

9 MS. THOMPSON: Yes.

10 DR. JOHNSON: Okay, thank you. I won't
11 bring it up again.

12 MS. CARTER: Stay in, but not discuss it
13 at all.

14 MS. THOMPSON: We really are cruising, I
15 think, at this point.

16 DR. JOHNSON: You know, for all the time
17 we spend, I think this is so much better than sitting
18 on a webinar. I'll tell you what --

19 MS. SCHIMMELS: I agree.

20 DR. JOHNSON: I was --

21 MS. THOMPSON: Frustrated.

22 DR. JOHNSON: You understand.

23 MS. THOMPSON: No, we understand.

24 DR. JOHNSON: I don't think I got
25 anything out of -- for four hours. I honestly say

1 that, because this -- like I can watch people's faces
2 and reaction. This is valuable. We can really get
3 something done. We got a lot done.

4 MS. THOMPSON: We did. We have gotten a
5 lot done.

6 DR. JOHNSON: But the webinar, I'm sorry.

7 MS. THOMPSON: The next one is in person
8 again.

9 DR. JOHNSON: I've got a grandbaby due
10 that day, though.

11 MS. THOMPSON: Oh. Is it a first?

12 DR. JOHNSON: It all depends on what the
13 labor does. So I may or may not be there.

14 MS. THOMPSON: So historically they're
15 late, but --

16 MR. CAIN: Carl Nelson says thank you and
17 good-bye, everyone. He signed off.

18 MS. THOMPSON: Okay.

19 So next steps is Brett will probably be
20 sending out date and location of the next meeting,
21 which is March 21st in Yakima. And we will be
22 providing for the next meeting -- just updated
23 materials. I think we need to -- the Department needs
24 to come together with what our assignments are and
25 where we are, and we'll come up with some updated

1 information and material and get it out to you.

2 DR. GREEN: Before the meeting.

3 MS. THOMPSON: Before the meeting, yes.

4 Definitely before the meeting.

5 MR. CAIN: A week before the meeting.

6 We'll shoot for a week for the main stuff.

7 MS. SCHIMMELS: That would be great.

8 MS. THOMPSON: Okay. Thank you,
9 everyone, for coming and participating and moving
10 along.

11 (The proceedings were concluded at
12 1:02 p.m.)

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I, Ronald L. Cook, CCR, RDR, CRR, court reporter within and for the state of Washington, do hereby certify that I attended the foregoing joint physician assistant rules committee meeting in its entirety, that I wrote the same in stenotypy, and that the foregoing pages constitute a full, true and accurate transcript of said proceedings to the best of my skill and ability.

IN WITNESS WHEREOF, I have hereunto affixed my signature at Seattle, Washington, this 3rd day of March, 2014.

RONALD L. COOK, CCR, RDR, CRR
CCR No. 2523

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