

1 COMMITTEE MEMBERS:

2 MR. MIKE CONCANNON, Public member of the Commission
DR. MARK JOHNSON, M.D.
3 DR. SHANNON MARKEGARD, D.O.
MS. ATHALIA CLOWER, PA-C
4 DR. GEORGE HEYE
DR. TOM GREEN, M.D.
5 MS. LINDA DALE, PA-C, Representative from Washington Academy of Physician
Assistants
MS. THERESA SCHIMMELS, PA-C, (via phone)

6 STAFF PRESENT:

7 MR. BRETT CAIN, Program Manager for Osteopathic Board
8 MS. HEATHER A. CARTER, AAG, legal advisor for both the
Board and the Commission
9 MR. MICAH MATTHEWS, Performance and Outreach Manager
for the Commission
10 MS. JULIE KITTEN, Operations Manager for the
Commission
11 MS. MAURA CRAIG, Policy Office for the Department of
Health
12 MS. CECE ZENKER, Program Support

13 PUBLIC PRESENT:

14 MR. RANDALL CLOWER, PA-C
MR. DAVID WOOD, PA-C
15 MR. LEONARD BERGSTEIN, PA-C, ZoomCare
MS. JAMERA THOMPSON, PA-C
16 DR. MARTY BRUEGGEMANN

17 PUBLIC PRESENT VIA SPEAKER PHONE:

18 MS. ALEX MATHISON, Group Health
DR. JOHN VANDERGRIFT, Group Health
19 MS. CATHY ELWEST, Group Health
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1 FACILITATOR THOMPSON: Welcome, everyone.
2 My name is Tami Thompson, and I will be facilitating
3 today's meeting.

4 We have a court reporter that is recording the
5 meeting. And so if you are here or you were in Kent
6 with us, we're going to be doing things just a little
7 bit different.

8 For the audience, if you would like to speak,
9 that's fine. Remember just to kind of raise your hand
10 so we know you have something to say, but we're going
11 to ask you to come up to the podium and state your
12 name and then go ahead and speak your piece. It's
13 just so the court reporter can make sure that she gets
14 your name and can hear you.

15 So we would like to start out by going around the
16 table and everybody introducing themselves, again so
17 the court reporter can make sure she gets everyone's
18 name.

19 MS. CLOWER: Athalia Clower, Physician
20 Assistant.

21 DR. HEYE: George Heye, physician with MQAC.

22 DR. GREEN: Tom Green. I'm an orthopedic
23 surgeon and on the Medical Commission.

24 MS. DALE: Linda Dale, Physician Assistant,
25 and here for the Washington Academy of Physician

1 Assistants.

2 DR. MARKEGARD: I'm Shannon Markegard, DO,
3 on the Osteopath Board.

4 DR. JOHNSON: I'm Mark Johnson on the MQAC,
5 and I'm a general surgeon.

6 MR. CONCANNON: I'm Mike Concannon. I'm a
7 public member of the Commission.

8 MR. CAIN: I'm Brett Cain. I'm the Program
9 Manager for the Osteo Board.

10 MS. CARTER: I'm Heather Carter, and I'm the
11 legal advisor for both the Board and the Commission.

12 MS. KITTEN: I'm Julie Kitten. I'm the
13 Operations Manager for the Commission.

14 MS. CRAIG: I'm Maura Craig, and I'm from
15 the Policy Office for the Department of Health.

16 MR. MATTHEWS: Micah Matthews, Performance
17 and Outreach Manager for the Commission.

18 DR. BRUEGGEMANN: Dr. Marty Brueggemann.
19 I'm an emergency medicine physician and member of the
20 Commission.

21 FACILITATOR THOMPSON: In the back.

22 MS. THOMPSON: Jamera Thompson, Physician
23 Assistant at Kadlec Clinic in Richland.

24 MR. CLOWER: Randall Clower. I'm a PA.

25 MR. WOOD: David Wood, Physician Assistant

1 with WAPA.

2 MR. BERGSTEIN: Leonard Bergstein. I
3 represent ZoomCare.

4 MS. DINKER: Cece Dinker, program support.

5 FACILITATOR THOMPSON: Okay. And then we
6 have a few people on the phone. And so for the people
7 on the phone, we would like for you to state your name
8 also so that we can get that on the record.

9 MS. SCHIMMELS: Theresa Schimmels, Physician
10 Assistant, member of the Commission and of the
11 Committee. Are you having trouble hearing me?

12 MR. CAIN: We can hear you fine, no.
13 Thanks, Theresa.

14 MS. SCHIMMELS: Okay, good.

15 MR. CAIN: And, Alex, did you want to
16 introduce yourself and anyone else in the room.

17 MS. DALE: He's mooted.

18 MR. CAIN: They were there earlier.

19 Alex, can you hear us?

20 DR. VANDERGRIFT: And Alex Mathison is with
21 us here. Can you hear us?

22 MR. CAIN: Yes. Thank you. Can you
23 introduce everyone in the room, please. We didn't
24 catch any of that.

25 DR. VANDERGRIFT: Okay, yeah. We have Alex

1 Mathison. This is from Group Health. Alex Mathison,
2 Cathy Elwest, and I'm Dr. John Vandergrift.

3 Do you do need spellings of any of those?

4 MR. CAIN: Sure.

5 DR. VANDERGRIFT: Okay. Alex Mathison is
6 M-A-T-H-I-S-O-N.

7 MR. CAIN: Dr. Vandergrift, it's fine. We
8 can get the court reporter the spelling.

9 DR. VANDERGRIFT: Okay. That will work.

10 MR. CAIN: Thanks.

11 FACILITATOR THOMPSON: Okay. So I want to
12 get us going as quickly as possible. Just quickly
13 we'll go over briefly the agenda.

14 What we would like to do today is to -- So at the
15 last meeting at Kent we started through the rule
16 language. There were several places that department
17 staff told the Committee that we would go back and
18 draft up some language and ideas and whatnot based on
19 input from the committee, so staff did that. And then
20 we have a few sections of the rules that we haven't
21 even touched yet.

22 So what we would like to do is kind of start
23 where we left off and go through the sections that we
24 haven't done yet, then go back to the sections that we
25 as staff told you as a committee that we would go

1 draft some language, we'll look at that. Take a
2 break.

3 Then maybe after lunch we will go over the
4 Delegation Agreements. We have worked on revising
5 those a little bit for the committee to consider.

6 And then kind of closer to the end of the day
7 what we would like to do is -- staff have talked about
8 that it's probably a wise idea for us committee
9 members if you could start introducing some of the
10 draft language to your board and commission and give
11 them an opportunity -- instead of a lump sum, give
12 them an opportunity section by section, those sections
13 that we as a committee can agree that this is the
14 language that we like.

15 So maybe we can agree to some of those sections
16 that you guys can take forward to your board and
17 commission, just to start digesting so that it's not
18 last minute, because at the actual board and
19 commission meeting is when your board and commission
20 has to in open public meeting approve the language
21 that we will move forward with and do the paperwork
22 for your formal public hearing.

23 So we want to make sure that we give the board
24 and commission as a whole, each of them, an
25 opportunity to hear what you as committee members have

1 to say about the process and the language that we have
2 all worked together to draft up. So I would like to
3 get us started very quickly here.

4 So where we left off -- And I'm going to just
5 kind of try to keep the theme that we did last time.
6 We always worked off the medical commission rules and
7 then we found the osteo rules and made sure that we
8 were speaking on the same. So we would like to start
9 with the continuing education piece, so Section 180.
10 And then for osteopaths it's Section 110.

11 So let's just open up the discussion. Is this a
12 place where -- the Medical Commission and Osteo Board,
13 are you okay with what your continuing education
14 requirements are? How different are they from
15 osteopaths?

16 MR. CAIN: They're very different.

17 FACILITATOR THOMPSON: They're very
18 different. They are different. Explain it.

19 DR. JOHNSON: Mark Johnson. So I think this
20 is a time to introduce the concept of maintenance and
21 certification and just relook totally different at the
22 way this section is conceived and thought about. And
23 so I'm just going to bring it up as a topic that the
24 whole concept of continuing medical education is going
25 to be passing us by. Nearly all specialties will

1 be -- and even on our commission we're looking at
2 maintenance of licensure, which would be tied to
3 maintenance of certification. So I think this is an
4 opportunity in rulemaking to just change course and
5 rethink what CME really means because I think it is
6 already an outdated concept.

7 FACILITATOR THOMPSON: Anyone else have
8 anything?

9 DR. GREEN: I agree.

10 FACILITATOR THOMPSON: Okay, that's two
11 medical commission agreements.

12 DR. MARKEGARD: Could you propose in the
13 language, instead of focus on CME, just say that you
14 have to maintain your maintenance of certification and
15 maintenance of licensure in order to practice?
16 Because I agree, but what do you propose then to --
17 how do you want to change it.

18 DR. GREEN: Well, I'm not sure why there's a
19 separate section having to do with this, but under
20 relicensure, or renewing the license, I think that
21 there should be an accounting of some options
22 requirements, including maintenance of competency.
23 That's usually going to be done through a specialty
24 organization or certifying organization that's
25 approved.

1 There are some physician assistants who are not
2 certified, so we'll still need to provide for an
3 alternative pathway, whether it's CME or not, a focus
4 CME related to practice, some requirement of that
5 sort. It seems to me that the specific section
6 related to CME ought to be tied to that and maybe can
7 be eliminated and incorporated into that.

8 The other comment that I would make, it's just
9 for information and awareness. The physicians,
10 allopathic physicians, don't have -- all they have
11 right now for relicensure or renewing license are CME
12 requirements. I think that that will change in the
13 near future. I'm not sure of the timeline and I'm not
14 sure of the exact outcome, but it will be something
15 along the lines of what I just described.

16 And I think that we ought to end up with
17 something similar for physicians and physician
18 assistants. The difficulty is the exact format of
19 what the physicians have isn't known, but I think it's
20 going to be something along the lines of what I
21 mentioned.

22 Linda and I have talked about this, and also Ruth
23 Ballweg has had some input into this. And maybe you
24 would care to summarize what we talked about.

25 MS. DALE: Sure. A little bit of history

1 that Ruth shared was that a lot of the PAs in the
2 early days didn't necessarily trust the
3 recertification type exams, and that's why many of
4 them didn't recertify. But NCCPA has grown, which is
5 the National Certification for Physician Assistants.
6 They have cleaned up their act, shall we say, and now
7 it's a well-trusted, well-respected organization. So
8 those of us who graduated more recently do maintain
9 the license or the certification.

10 And the thing that we are concerned about is that
11 in many other states they don't require maintenance of
12 certification for the reasons I've just stated, that
13 many of the practicing PAs have not maintained their
14 certification. Part of that could be because that
15 exam is a generalist exam and many PAs have
16 specialized. And so if you've specialized and you are
17 working in orthopedic surgery, why should you then
18 maintain knowledge and education on pediatrics or OB,
19 when you are going to be practicing in orthopedics.
20 So that's been one of the reasons why many PAs don't
21 recertify.

22 So I think -- You know, if we decide to have
23 maintenance of certification, we need to remember
24 those PAs who have not maintained it at this time and
25 not kick them out of clinical practice, as it were,

1 because you will lose a lot. I think we tried to
2 figure out how many there were, and I don't know if we
3 ever really got a good number. Here at this meeting
4 last time there was we were told 300 or 400. So, I
5 mean, that's a huge number to just kick out if we
6 require maintenance of certification.

7 One more thing before I move on. I do want you
8 to know that in our definition we said Certified PA
9 was one who initially passed, and I think NCCPA would
10 have problems with us continuing to use Certified PA
11 unless they maintain that certification. So we either
12 need to strike that definition or bring it up to what
13 it means in the rest of the nation.

14 FACILITATOR THOMPSON: We'll make note of
15 that, because I know we're going to go back to the
16 definitions. So remind us again when the definition
17 part comes up.

18 MS. DALE: Okay. Sure.

19 Athalia, did you have anything?

20 MS. CLOWER: No.

21 FACILITATOR THOMPSON: Did you want to say
22 something?

23 DR. JOHNSON: Well, I'm thinking.

24 FACILITATOR THOMPSON: Okay. So while you
25 are thinking, I'm going to check with our attorney.

1 So we are required to do continuing education of
2 some sort, right, in the statute, but are there
3 parameters around it?

4 DR. GREEN: No. I think just that the board
5 and commission should establish continuing competency.

6 FACILITATOR THOMPSON: Okay. I just wanted
7 to make sure that you didn't have parameters that you
8 were locked into that you had to work with, so.

9 MS. DALE: Part of the recertification
10 process through the national organization is a hundred
11 hours every two years. And then we have begun a
12 ten-year cycle. We used to have to recertify every
13 six years, but now they are cycling in, now that we
14 will be recertifying every ten years, so we have
15 specific things to do every two years.

16 We do self assessment and a lot of these other
17 things. So we're logging on and meeting these
18 requirements in between that ten-year examination.

19 DR. MARKEGARD: So then if we had something
20 to the effect that kept part of this, that you have to
21 have some annual CME requirement or met qualifications
22 for maintenance of licensure. Because then that would
23 satisfy your PAs that aren't certified and will never
24 again recertify, because they just have to do the CME.
25 And then those that are doing the maintenance of

1 licensure, they don't have to do additional CME, it
2 could just be an or.

3 DR. JOHNSON: So Linda, can I have a
4 clarification? At the very first meeting in Renton I
5 asked the question of everyone in the audience, How
6 many PAs think that they're going to ever be
7 independent? And the second question I asked was, How
8 many think they're going to be going to a specialty
9 board format? Because I know that that's a discussion
10 amongst in the national organization.

11 MS. DALE: Right.

12 DR. JOHNSON: And my recollection was no one
13 thought they should be -- a PA should be independent.
14 And second, there was no push towards specialty
15 practices in PAs, even though we know that that
16 happens.

17 So that gets back to the issue of how do you
18 define adequate CME and MOC, whether you're certified
19 or not? I know for physicians we don't have a
20 language yet, but it will happen that we will have an
21 MOC definition. And for the non-board physicians,
22 board of physicians, we will have to have some other
23 alternative way to demonstrate current, up-to-date
24 practice. CME has never been very effective at that.

25 So I think our challenge today is to think of the

1 concept, not the work, but the idea of just 50 hours
2 of CME every year is an outdated concept that we need
3 to be moving beyond it and incorporate the concept of
4 MOC, and then figure out how are we going to keep the
5 specialist PAs and the generalist PAs up to date, and
6 what are we going to do, how are we going to define
7 that nationally, but really we can only think of
8 locally, state-wide.

9 I don't have an answer. I don't have language.
10 I just think that since we're making rules, this is
11 the time to incorporate. And I don't know that we'll
12 resolve it today, but I'm bringing it up as a
13 challenge to us that when we are ready to create the
14 rules and bring them back to our boards, we will set
15 the model that will probably maybe be used by the
16 osteopaths and by the MQAC when we address the same
17 issue for the physicians. So I think we have an
18 opportunity to be creative.

19 I don't have wording, but that's my point, is not
20 worry about specialists. Everybody has to -- Because
21 of the way the PAs are presenting themselves, at least
22 to me, they need to be generalists, even if they're in
23 the specialty thing, unless there's a change in
24 philosophy. So that's all I have to say. That's what
25 I was thinking, my thoughts.

1 FACILITATOR THOMPSON: Okay.

2 DR. GREEN: Tom Green. There's some
3 suggested language for license renewal that includes
4 CME that we can put out, but I'm not sure then, going
5 back to the original discussion of Section 180, why
6 that would be needed in addition. I would just delete
7 it.

8 FACILITATOR THOMPSON: So I think -- Are you
9 talking like in 170, Section 171? Or no.

10 DR. GREEN: Well --

11 FACILITATOR THOMPSON: No? Something else?

12 DR. GREEN: Isn't there a renewal of --

13 MS. DALE: Recertification.

14 DR. GREEN: Isn't there a section in here
15 having to do with license renewal?

16 DR. JOHNSON: It's the one above it, 171,
17 Renewal and CME Cycle.

18 DR. GREEN: Okay. Well, yes. Then that's
19 the one.

20 DR. JOHNSON: And it refers to CMEs in it.

21 DR. GREEN: Yeah, right.

22 FACILITATOR THOMPSON: So 171 basically just
23 tells a physician when they have to -- or what they
24 have to do as part of the renewal. And as part of
25 their renewal is they have to maintain continuing

1 education or complete continuing education
2 requirement. And if you don't, then you will not --
3 your license will not be renewed.

4 So could the two sections be combined? Yes. But
5 I think that -- Maybe I'm totally misunderstanding,
6 but I still think that for the continuing education
7 piece, you still have to outline for the provider what
8 it is that they have to do, because otherwise it's a
9 free for all. Does that make sense? Am I not
10 understanding what you're saying? Are we not on the
11 same page?

12 DR. GREEN: Well, to me, I would just reduce
13 it to the following, both sections: License renewal
14 should be required every two years according to the
15 cycle set forth by the commission or the board, or
16 whatever dictates. At least one of the following is
17 required for license renewal: One hundred hours of
18 approved or accredited category, or one CME.
19 Compliance with a continuing maintenance of competency
20 program by or approved by the AAPA or NCCPA.
21 Recertification in the past two years.

22 FACILITATOR THOMPSON: So basically you're
23 saying is just combine the two and get rid of one.
24 And I think that's reasonable.

25 DR. GREEN: It seems to me that covers all

1 the things you're talking about.

2 FACILITATOR THOMPSON: Athalia?

3 MS. CLOWER: Couldn't that be left open,
4 sort of like a Delegation Agreement, where it can be
5 changed as times change, going with what Dr. Johnson
6 is saying? So you can say according to the latest
7 policy from the Medical Quality Assurance Commission
8 or the Board of Osteopath?

9 MS. CARTER: The only thing, you would need
10 requirement in the rule if you want to be able to
11 legally require it.

12 DR. GREEN: Enforce it.

13 FACILITATOR THOMPSON: Enforce it, yes.
14 Because a policy is not legally binding. It's just
15 advisory. So we would need the actual requirement in
16 a rule in order to enforce it.

17 MS. CLOWER: Can we keep those requirements
18 a little bit broad, so that when things change, like,
19 for example, when the maintenance or the
20 recertification or like the specialty training, that
21 we could go to that so we don't have to go back and
22 change the rules later?

23 FACILITATOR THOMPSON: I suppose you could
24 leave some flexibility regarding the organization, so
25 if the AAPA or the National Certification Board

1 happened to develop some other certification program
2 or specialty program, that you could say any
3 maintenance or certification through --

4 DR. GREEN: That's what this says.

5 MS. CLOWER: That's what it says, yeah.

6 FACILITATOR THOMPSON: Okay. I mean, that
7 would be some flexibility. But I think you need to
8 have that requirement if you want to be able to
9 enforce it.

10 DR. GREEN: The intent of this language was
11 to provide for the non-certified PAs that are going to
12 disappear before too long and not place additional
13 demands on the requirements on the certified people
14 who are already participating in some kind of
15 maintenance of competency or licensure program, but
16 expecting that all of those people who are originally
17 certified are so doing.

18 MR. CONCANNON: But the language you were
19 just reading is your own?

20 DR. GREEN: Yes.

21 MR. CONCANNON: It's not in this draft,
22 right?

23 DR. GREEN: No.

24 MR. CONCANNON: Okay.

25 DR. GREEN: And it is based on some

1 discussion with Linda and Ruth.

2 MR. CONCANNON: Yeah.

3 DR. GREEN: The intent is what I just
4 described.

5 FACILITATOR THOMPSON: Go ahead.

6 MS. DALE: Linda Dale again. I have been in
7 contact with AAPA, which is American Academy of
8 Physician Assistants, and they strongly recommend that
9 we don't require certification maintenance, but we do
10 require some type of competency.

11 So this language does allow for those -- I think
12 he was mentioning those who are not maintaining
13 certification, but are certainly competent in their
14 field. So this language kind of leaves it so that we
15 can continue to assure quality and competent PAs out
16 there without requiring that certification.

17 DR. JOHNSON: Someone can correct me if I'm
18 wrong, but whether you're a DO, a PA or an MD, the
19 number of people -- when you certify that you're up to
20 date on your CMEs, the audit of the number that are
21 actually doing that is probably really low, maybe
22 zero, on an annual renewal basis. And so we have a
23 responsibility to make sure to the public that,
24 whether it's a physician or a PA or DO, that they are
25 competent and up to date. And we are not doing a very

1 good job of that amongst all of our specialty
2 organizations.

3 So the specialty organizations in medicine have
4 taken this on because they're worried about the same
5 thing. And they know that in my specialty I would
6 take an exam every ten years, which had me taking a
7 test on transplant surgery. I don't do transplant
8 surgery, but I have to answer the questions.

9 They have now focused it better on my field. And
10 I still have to take an exam every ten years, but
11 within that now there is a rollover of MOC that, even
12 though now I'm retired, I have to somehow meet a
13 requirement, even though I'm board certified.

14 And so it's not the certification that's critical
15 in this. It's the MOC. It's how do you -- how are we
16 going to talk to the public that we have set a rule
17 that guarantees that, whether you're a certified PA or
18 not, doesn't matter, that you are keeping up.

19 And we know that CMEs really have -- I know that
20 they have very little meaning to anything. So I'm
21 challenging us to rethink the concept. And if you're
22 a non-certified PA, what can you come to me as a
23 commission member and say, I am up to date, even
24 though I'm not taking my certification exam anymore
25 because I got mad at them. It's not my problem.

1 If I was an institution, head of an institution,
2 I would want to make sure that PA is certifying or get
3 them certifying. And if they have lapsed -- If I
4 lapsed my board of surgery, I don't get to practice
5 anymore. I don't have that option. If I want to set
6 up an outpatient clinic that's independent of a
7 hospital, I could do it, I suppose.

8 But I'm challenging us to rethink the concept.
9 Because whatever we come up with, this we can apply to
10 the physician rules when it's our time to tackle that.
11 It's a huge challenge.

12 But the advantage we have -- And that's why I'm
13 asking you, Linda, is what is the PA nationally -- are
14 they coming up with an MOC concept that we can then
15 point to and say, even if you're not certified, you're
16 doing -- and the national organization says yes, you
17 are -- we don't then have to be the audit trail. We
18 can depend on the national organization or the state
19 organization or something to say, yes, we certify
20 our -- we as this organization are saying that you,
21 Linda Dale, are keeping up current MOC. That will
22 then satisfy us to continue your license.

23 We don't have to do that work if we write that
24 wording. But we've got to have someplace to turn to
25 that the PAs are being kept up. Because right now

1 we're not auditing your CMEs. I know we're not.

2 FACILITATOR THOMPSON: Can I ask a question?

3 So when you say MOC --

4 DR. JOHNSON: Maintenance of certification.

5 FACILITATOR THOMPSON: Okay. And we're
6 talking about maintenance. Are we talking because
7 there is a test that they're taking that will show or
8 is it the hands-on piece or is it a combination of?

9 DR. JOHNSON: Well, it's all of the above.
10 And, you know, within general surgery there is a --
11 it's the cases you're doing, the keeping up on -- at
12 your meetings, you're going to relevant meetings and
13 actually taking a test, not just spending your weekend
14 on the beach.

15 FACILITATOR THOMPSON: Okay. Okay.

16 DR. JOHNSON: So it's a more formalized
17 program that is still evolving. I'll admit we don't
18 have all the answers yet. But I'm just challenging us
19 in this rulemaking process to be thinking forward, so
20 we don't have to come back and rewrite the rules, that
21 we allow for the non-certified people, but they have
22 to -- you know, I guess the question ultimately is, Am
23 I going to be the decider that that PA is doing an
24 adequate job of their CME or can we look to another
25 organization?

1 We're going to have the same problem with
2 physicians who are not certified. There's a lot that
3 are not certified.

4 MR. CONCANNON: I accept your challenge.

5 DR. JOHNSON: Take it on, Mike.

6 MR. CONCANNON: There's a gun to my head.

7 This has to be done in the next two minutes.

8 DR. JOHNSON: Yes.

9 MR. CONCANNON: All right? Two minutes, two
10 minutes, two minutes. That's all we have is two
11 minutes to finish this up. There's a gun to my head.

12 Based on what I'm listening to, the notion of
13 CMEs is not going to be thrown out of the rule.

14 FACILITATOR THOMPSON: No.

15 MR. CONCANNON: So most of 171 and 180, as
16 they exist, will continue to be part of a rule.
17 Whether they're combined or not doesn't matter. 171
18 and 180, most of which deals with CMEs, are going to
19 remain in a final rule.

20 180, number (2) says, "In lieu of one hundred
21 hours of continuing medical education the commission
22 will accept a current certification with"
23 ba-ba-boo-boo "and will consider approval of other
24 programs as they are developed." If you add one or
25 two intelligent sentences into this; in other words,

1 Dr. Green and Linda Dale's sentences on the
2 alternative to CMEs, you've got it, right? Right
3 there. Gun to your head, it's got to be done in a
4 minute.

5 If you had to put a sentence or two right there
6 and then reorder the CME stuff that's three and four
7 and five and six, all has to do with CMEs, that could
8 be reordered, but you're either going to have to have
9 CMEs, you're going to have maintenance of
10 certification as developed by the national
11 organization, or you're going to have to have this.
12 And it's done. If you had to do it in two minutes.
13 And I'm under two minutes.

14 MS. CLOWER: Can you reread those two
15 sentences again, please?

16 MR. CONCANNON: Well, Dr. Green had
17 something, and you all can -- But the two sentences
18 can be done, you know, quick enough.

19 DR. GREEN: I would even replace both of
20 these with one sentence: One hundred hours approved
21 or accredited Category I CME every two years. Why do
22 you need all of this?

23 MR. CONCANNON: No, no, no.

24 MS. DALE: (3), (4), (5).

25 MR. CONCANNON: Oh, you mean the (3), (4),

1 (5) and all that stuff?

2 DR. GREEN: Yeah.

3 MR. CONCANNON: Oh, I don't know.

4 MS. DALE: Because all that has changed
5 nationally. And actually if you say 40 credit hours
6 must be Category I, that's not what our national --

7 MR. CONCANNON: All right. Well, then just
8 get rid of it.

9 MS. DALE: So we can just get rid of that.

10 MR. CONCANNON: Get rid of whatever you want
11 to get rid of and then add whatever Dr. Green was
12 talking about, and Linda Dale. It's her quote too.

13 DR. GREEN: Complying with continuing
14 maintenance of competency program approved by the AAPA
15 or NCCPA, with recertification in the past two years.

16 MR. CONCANNON: Those are three alternative
17 ways that you're going to be allowed to renew your
18 license every two years.

19 DR. GREEN: And in the second one, putting
20 in something about something that is approved by or is
21 yet to be developed. I don't remember what your word
22 was, but it could be easily added to that to account
23 for what you want, which is a way to not have to
24 change things if something else comes along that is
25 approved.

1 MR. CONCANNON: Yeah. Item (2) right now
2 says, "will consider approval of other programs as
3 they are developed."

4 DR. GREEN: Just add that on to the
5 second --

6 MR. CONCANNON: Just add that to the two
7 specifics in addition to the CMEs and there's your
8 alternatives, and boom, boom, boom.

9 MS. SCHIMMELS: This is Theresa Schimmels.
10 Can you hear me?

11 MR. CAIN: Yes. Hi, Theresa.

12 MS. SCHIMMELS: I think that was
13 Mr. Concannon that was talking, and I agree with what
14 he said. I think that's a great idea, use just what
15 he said to do, especially add in the approval of the
16 other programs as they are developed. I think that
17 that's great. It covers us for now until we -- you
18 know, as Dr. Green and Dr. Johnson said, until we can
19 see what's going to happen in the future, I think that
20 this covers it for now. I think that's a great idea.

21 MS. CARTER: And with that language, the
22 approval, you can do that approval outside of the
23 rulemaking and just maintain a list. So the
24 commission could consider as a whole, you know, at a
25 business meeting.

1 There's a new program the AAPA has out on
2 maintenance of certification. Do we like it; do we
3 think it meets our needs? Yes, okay. And you can
4 maintain that in a policy.

5 MS. DALE: As far as auditing the national
6 NCCPA, when you log on, you log your hours, and it's
7 Category I, Category II, and they do audit that. I've
8 been audited only once, but another PA friend of mine
9 has been audited three times. It's just the luck of
10 the draw.

11 DR. JOHNSON: No, I understand. But what
12 about the non-certified ones?

13 MS. DALE: Well, that's the thing. Now, if
14 we wanted to require that, we could ask them to log
15 it, but that would not require a certification, to my
16 knowledge. But I would like to check that first.

17 DR. JOHNSON: Yeah. Would the national
18 organization allow that, though?

19 MS. DALE: Well, the thing is there's a cost
20 involved with that.

21 DR. JOHNSON: That's okay.

22 MS. DALE: I think it's \$80 for logging your
23 CME. But I don't know -- I'm going to have to find
24 out for sure if they can log it without going through
25 that process and getting their certification exam. So

1 I'll find out.

2 FACILITATOR THOMPSON: Okay. So can you
3 find out that, because we recognize that we're going
4 to probably have to have one more meeting kind of as a
5 result of this meeting to come back and kind of go
6 through these last minute details. We'll work at
7 using Dr. Green's language and pulling something
8 together.

9 I need to make sure that osteo is comfortable
10 with this concept and this idea. And then I also need
11 to make sure that you all feel like maybe we need to
12 have option two, that if they can't log in their
13 credits, what other mechanism do you want to use to
14 ensure that -- And there's different ways we can do it
15 because different professions all do something, so we
16 could come up with something. And that there's enough
17 information in the rule that we're giving notice to
18 those non-certified that they understand what they
19 need to do to renew. Those would be my comments to
20 the Committee to make sure that you feel comfortable
21 with that.

22 So osteo, are you okay?

23 DR. MARKEGARD: Yes. I just have a
24 question. It says for the allopathic that the
25 recertification, it's a hundred hours every two years,

1 so recertification is every two years. Ours is every
2 year. Is that true, they have to re-license every
3 year?

4 MS. CARTER: Yes.

5 DR. MARKEGARD: And so that would be just
6 the same. Or can we change that?

7 MS. CARTER: Well, you have to renew your
8 license every year. You could do the CME requirements
9 every two years if you wanted to, or every -- however
10 many years.

11 DR. MARKEGARD: However many you want.

12 MS. CARTER: But you must renew your license
13 annually on your birthday for osteopath.

14 DR. MARKEGARD: And I don't think that even
15 has that in here. I didn't find it.

16 MS. CARTER: Well, we'll make sure.

17 DR. MARKEGARD: Okay.

18 FACILITATOR THOMPSON: It's probably in the
19 fee section.

20 DR. MARKEGARD: Oh, in the fee section, got
21 it.

22 FACILITATOR THOMPSON: I know the 990s are
23 the fee chart.

24 MS. CARTER: But if you want to hear the
25 MQAC rules regarding CEs and when you can take --

1 DR. MARKEGARD: Yeah, copy and paste.

2 MS. CARTER: Okay. Then you can do that.
3 You don't have to require CME reporting every year.
4 It could be every other.

5 DR. MARKEGARD: Okay. And as to the next
6 section, 115, the Categories of creditable continuing
7 professional education activities, I don't think
8 that's even something we need to have in the rules.
9 Don't you think?

10 MS. DALE: Yes. I'm sorry, but that's
11 really difficult to kind of figure out when you've
12 got, you know, half a credit hour per issue and all
13 that kind of stuff.

14 DR. MARKEGARD: Yeah, that's crazy. So
15 delete that.

16 MS. CARTER: Okay.

17 MR. CAIN: That's the audiotape.

18 MS. CARTER: I think if you just mirrored
19 the proposed MQAC rule, it would just be a hundred
20 hours on Category I. You can get rid of all of that.

21 DR. MARKEGARD: Done.

22 FACILITATOR THOMPSON: Yeah. And then
23 change your annual reporting to every two years.

24 DR. MARKEGARD: Yup.

25 DR. HEYE: This is George Heye. The

1 discussion keeps talking about a hundred hours of CME,
2 but Tom says a hundred hours of Category I, that's
3 different than a hundred hours of I and II, because a
4 lot of hospitals do CME, but it's not Category I
5 because they can't go through the hoops to get it
6 registered as Category I. So this has to be worked
7 out. If you're going to make it all Category I,
8 that's a big change.

9 FACILITATOR THOMPSON: Okay.

10 DR. GREEN: Whatever is appropriate. I
11 don't know.

12 DR. JOHNSON: So I really agree with Mike's
13 two minutes, and I'm going to -- and I would emphasize
14 the MOC concept first, with the fall-back on CMEs,
15 because we want people to keep up and we want their
16 CMEs to be appropriate for their specialty. And who's
17 going to monitor that?

18 MS. DALE: I would say that the supervising
19 physician would monitor that.

20 MS. CLOWER: No, no, no, no.

21 DR. JOHNSON: Oh, boy. You just opened up a
22 whole new paragraph.

23 MS. DALE: No. But I'm just saying, if I'm
24 a physician and I want my PA to learn a new technique,
25 I'm going to send them to learn that.

1 DR. JOHNSON: It may not be CME accredited.

2 MS. DALE: Oh, okay. Well.

3 MS. CLOWER: We don't want to give more
4 responsibility to the physician.

5 MS. DALE: Right, I understand that. But
6 I'm just thinking, well, if you're working with the PA
7 all the time.

8 DR. JOHNSON: The supervising doc has no
9 ability to guarantee the CME accreditation. That's
10 not the rule.

11 FACILITATOR THOMPSON: So who audits that
12 part for osteopath?

13 DR. GREEN: Nobody.

14 FACILITATOR THOMPSON: Nobody is auditing.
15 Nobody is going in and --

16 DR. JOHNSON: If anybody, we do, but the
17 reality is we don't.

18 FACILITATOR THOMPSON: Nobody is going in
19 and taking five percent and --

20 DR. JOHNSON: Unless you get into trouble.

21 FACILITATOR THOMPSON: Unless you get into
22 trouble. Okay. So for the osteo side, it would come
23 out in the audit. You know, their specialty is, I
24 don't know, whatever, dermatology. And if they are
25 not getting their continuing education in dermatology

1 or some related field to that, then it's going to c.

2 Ome out in the audit. And then there's an
3 issue because they are not complying with the rules.

4 Medical is the same except for it's going to come
5 up in the disciplinary more than --

6 DR. JOHNSON: That's the only time it comes
7 up.

8 FACILITATOR THOMPSON: Because you're not
9 physically auditing their stuff.

10 Yes, sir.

11 DR. GREEN: Tom Green. The Category I and
12 II requirements can be changed however it's
13 appropriate.

14 The other thing, given the understanding about
15 the effectiveness or lack of effectiveness of CME,
16 would be to put a requirement that it's focused,
17 practice focused or specific. In other words, that
18 it's relevant to what the practice is. You're not
19 going off and --

20 FACILITATOR THOMPSON: Let me just say this:
21 What I keep hearing coming up is that the continuing
22 education needs to be specialty focused to a point.
23 And so what I have seen other professions do is they
24 say a percentage or a number of the credits -- you
25 have a hundred credits, but a portion of them -- and

1 they are pretty specific, you know, 50 of them it,
2 half of them, whatever -- must be in the specialty
3 that you practice in. I mean, that's an option that
4 you can put on them.

5 DR. MARKEGARD: That section that I just
6 deleted, it does say -- whoops -- Category I, a
7 minimum of thirty credit hours are mandatory, and then
8 a max of 20 hours in Category II. So it does put
9 limits on how much, if you want them to make sure they
10 get so many in Category I or not have it all Category
11 II.

12 FACILITATOR THOMPSON: State your name,
13 please.

14 MS. THOMPSON: My name is Jamera Thompson.
15 I'm a physician assistant and I work in the OB/GYN
16 department, but I certify my boards in family
17 practice. So when I go in for CME, I'm worried about
18 what I have to maintain on my board, not what I'm
19 doing every day that's wrote in memory that I have
20 done for nine years. So I still consider myself a
21 family practice PA. I just happen to be hanging out
22 in the girly department.

23 Secondly, I don't understand why non-certified
24 PAs don't have to maintain the same requirements.
25 They just don't have to take the exams.

1 I'm the first cycle of this new ten-year thing.
2 Just like physicians have to log in under their
3 specialty, when I log my cases, they're going to be
4 under the OB/GYN board because that's all I do, is my
5 OB/GYN. It doesn't make any sense to go into family
6 practice and submit all my annuals or OB/GYN cases.

7 At least -- I haven't tried it yet because this
8 will be my new cycle. But I board certify this year,
9 and then from now on there's really specific
10 requirements on how much CME, of what time type you
11 have to do, and how many cases you have to require.
12 And it seems to me that if you're not certified, you
13 still should have to do that, because the physicians
14 have to do it. I've got to do it. Why aren't they
15 doing it? Just a thought.

16 FACILITATOR THOMPSON: Thank you.

17 DR. GREEN: Maybe we should get rid of the
18 CME requirement altogether.

19 FACILITATOR THOMPSON: You can't quite do
20 that because the statute requires you to write rules
21 on CMES, so. I think. Right? I mean, something.
22 You have to have something.

23 MS. CARTER: Yeah. It talks about
24 continuing competency.

25 DR. MARKEGARD: But can't that just be an

1 MOC.

2 DR. GREEN: She's arguing that it shouldn't
3 be an option and that those people ought to have -- be
4 required to do the same things to demonstrate their
5 competency. That's my understanding. Is that your
6 point?

7 DR. MARKEGARD: Yes, absolutely.

8 DR. GREEN: So if that's the case, then --

9 DR. MARKEGARD: Except for the exam.

10 MS. DALE: Like I said, I'll find out if
11 NCCPA will allow us to log these things.

12 And, again, they're going -- exactly like
13 Ms. Thompson said, that we're rotating to this
14 ten-year cycle where there's a lot off self-evaluation
15 cases and that kind of thing, so if we require them to
16 do that same thing. But I'll just find out if NCCPA
17 will allow some kind of maintenance logging as an
18 audit that will still allow them not to retake their
19 certification, if they so choose, so then at least
20 we'll have that saying they're somewhat competent
21 according to this.

22 DR. GREEN: So I have a question, Linda. Do
23 these organizations that have these maintenance of
24 competency programs allow participation of
25 non-certified people?

1 DR. JOHNSON: That's what she's going to try
2 to find out.

3 DR. GREEN: Well, just logging things is one
4 thing. But say I wanted to be part of the designated
5 maintenance of competency program, can you sign up and
6 participate in it as a non-certified PA?

7 MS. DALE: I've never seen anything where
8 you sign up that asks if you're certified or not.

9 DR. GREEN: So the point of that question is
10 there isn't any barrier of doing what the last -- I'm
11 sorry, I forget your name.

12 MS. THOMPSON: Jamera.

13 DR. GREEN: -- what Jamera is suggesting.
14 In other words, you could require them possibly to
15 participate and demonstrate their competency that way
16 for license renewal.

17 FACILITATOR THOMPSON: Okay. So I want to
18 be respectful of your guys' time and the fact that we
19 have one more subject and we've spent like 45 minutes
20 on this one.

21 So are we at a place where we kind of have the
22 concept and the committee would like to assign the
23 department with a task of maybe taking Dr. Green's
24 language and kind of trying to make sure that we've
25 got it all together to bring back to you all at the

1 next meeting with maybe --

2 DR. GREEN: Yes.

3 FACILITATOR THOMPSON: Yes, okay.

4 Athalia?

5 MS. CLOWER: I still have one question. I
6 don't find the requirement in the statute.

7 FACILITATOR THOMPSON: In the statute?

8 MS. CARTER: I think it's -- Well, there's
9 no requirement in the PA statute, but in the -- if you
10 look at the MQAC statute, it says the commission can
11 write rules on continuing -- I don't know what it
12 says -- or educational requirements for renewal for
13 the professions it regulates. So I don't think it's
14 in the PA. It's in the MD or the commission
15 established.

16 MS. CLOWER: Do you have a number?

17 DR. JOHNSON: Off the record?

18 FACILITATOR THOMPSON: Yes.

19 (AN OFF-THE-RECORD

20 DISCUSSION WAS HAD).

21 MS. DALE: I'll also verify the Category I,
22 Category II requirements because I think it's 60
23 Category I and 40 Category II, but I want to be -- Is
24 it 50/50? I don't know. Athalia?

25 MS. CLOWER: It is 50/50.

1 MS. SCHIMMELS: Are we talking about NCCPA
2 requirements?

3 MS. DALE: Yes.

4 MS. SCHIMMELS: It's 50/50. I'm on the
5 website. It's 50/50.

6 MS. DALE: Okay. So 50 hours of each.

7 MS. CLOWER: On 18.71.080 there's the
8 language that we should be looking at because it
9 doesn't say CME.

10 DR. GREEN: What are you looking at?

11 MS. DALE: 171 or does that --

12 MS. CARTER: The board and commission each
13 have authority to establish what continuing competency
14 is required. So that can be CME or it could be
15 something else. I mean, those are your rules to
16 determine what field is best to protect the public.

17 FACILITATOR THOMPSON: So old school way of
18 thinking is continuing education requirements are book
19 and going to conferences. And continuing competency
20 is the hands on piece, right? So that's kind of --
21 They have switched over the years in the statutes and
22 we've started seeing continuing education and
23 continuing competency, right?

24 But there's really -- Like Heather said, there's
25 really nothing to say that if you want your continuing

1 education to be all competency, hands on, or a
2 combination thereof. And if your legal advisor is
3 saying there's nothing against you doing both or one
4 or the other, then you just need to do something.

5 Okay. So --

6 DR. GREEN: Is that two minutes, Concannon?

7 FACILITATOR THOMPSON: We went over our two
8 minutes, but I was being respectful of that two
9 minutes. I'm going, Come on.

10 MR. CONCANNON: I'm breaking for lunch soon.
11 I mean, the two minutes is long gone.

12 FACILITATOR THOMPSON: So we know what our
13 assignment is. We're going to get the information and
14 we're going to draft up something, and at the next
15 committee meeting we're going to have something to
16 show you.

17 Okay. So the last piece that we recognize that
18 we have not given this group the opportunity to speak
19 to is the surgical piece.

20 DR. GREEN: 230?

21 MS. CARTER: 230 and 250 and 260. All
22 right. So Practice of Medicine - Surgical Procedures.

23 So I see a note for Section 230, history and
24 relevance of this section. Do we still need to hash
25 that out?

1 MS. SCHIMMELS: I don't think we need this
2 anymore. I mean, this was old. This was when we had
3 to do those surgical -- I'm sorry. This is Theresa
4 Schimmels talking.

5 This was set up for when we had just PAs that did
6 just surgery. It was an old group of people that had
7 specific training and they didn't do really anything
8 else other than just surgery, and they don't do that
9 anymore. We don't have these type of PAs anymore.

10 Linda, I think you can confirm that. I know this
11 was addressed when we talked about this in the past.

12 MS. CARTER: So Julie Kitten, the Program
13 Manager, is telling me there's still eight PA-surgical
14 assistants that are practicing.

15 So my recommendation would be to keep these, and
16 then probably the next time you go through the cleanup
17 of the rules you could eliminate them. I would assume
18 by then those people would have retired.

19 MS. DALE: What title do they use? Is it
20 surgical physician?

21 MS. SCHIMMELS: I think they use surgical
22 assistant.

23 MS. KITTEN: It says in here basic physician
24 assistant-surgical assistant. So PA-surgical
25 assistant is what I'm thinking. I would have to

1 actually look them up in the database to see that.
2 But my last report was they have eight. And I believe
3 they all work for one facility.

4 FACILITATOR THOMPSON: So we have to keep
5 them.

6 MS. DALE: Is there a way for that group to
7 find more? Because if these PA-surgical assists are,
8 quote, "legal in other states," are being trained in
9 other states, can they then come and practice under
10 this, so we'll never get away from those eight?

11 MS. CARTER: Because to get your initial
12 license now, you must be eligible to take the exam, so
13 these --

14 MS. DALE: Right, as a PA.

15 MS. CARTER: Right.

16 MS. DALE: But I mean will this surgical
17 assistant slide in under these rules if we allow them?
18 Do you see what I'm saying?

19 MS. CARTER: Yeah, I see what you're saying.
20 Let me read this.

21 MS. DALE: Is there anything in I guess
22 licensure that would allow for just a surgical
23 assistant to be licensed under that?

24 FACILITATOR THOMPSON: So they would fall
25 under the basics of the rules. And we could get rid

1 of these three sections because they fall under the
2 rest of the rules.

3 MS. DALE: And they would be just renewing
4 and coming from other states possibly, or whatever?

5 FACILITATOR THOMPSON: Reciprocity.
6 Athalia?

7 MS. CLOWER: I just have some comments from
8 a PA that works in the area where I work. And he
9 wasn't able to come here, so he requested that I read.

10 FACILITATOR THOMPSON: Okay.

11 MS. CLOWER: May I?

12 FACILITATOR THOMPSON: Yes.

13 MS. CLOWER: The person is Jared Collett and
14 he says: I am not sure what to make of the sections
15 regarding Physician Assistant-Surgical Assistants. Do
16 the rules in Section 246-918-260 only apply to those
17 who are not NCCPA certified, as is implied in the
18 previous section labeled 246-918-250.

19 And then he says, quote, unquote, "Basic
20 physician assistant-surgical assistant duties." Are
21 there any restrictions or changes to the rules
22 regarding PA-Cs in surgery? If the people in these
23 sections are not PA-Cs, can we change the language in
24 those sections to not call them Physician Assistants-
25 Surgical Assistants, or PASAs, because calling them

1 such introduces confusion, especially if their scope
2 of practice is more limited, which is apparent from
3 their definition. They should just be called Surgical
4 Assistants.

5 The surgical assistants and the scope of practice
6 described in these sections sounds a lot like the
7 scope and duties of RNFAs or other assistants who
8 cannot perform surgical procedures independently, such
9 as ventriculostomy placement, tube thoracostomy
10 placement, I&D, biopsies, etcetera; who cannot use
11 cautery except under direct supervision; who must have
12 the surgeon in the operating suite while closing. It
13 would be very unfortunate for there to be confusion
14 about what my surgical PA-C colleagues and I are
15 allowed to do, or for there to be confusion about what
16 a PASA is because Physician Assistant-Surgical
17 Assistant sounds too much like Physician Assistant.

18 So he keeps going on. I don't know if you guys
19 want a copy of this.

20 As regards to supervision and the delegation
21 agreement, I favor language that leaves the decision
22 regarding PA responsibilities and supervisory
23 requirements subject to interpretation and
24 implementation at the supervising physician-PA level.

25 That's another subject, but that's -- And he

1 works in surgery, so.

2 One more comment from him: Finally, it is my
3 opinion as a PA practicing neurosurgery, that the
4 language regarding supervision and delegation
5 pertaining to surgery should likewise be flexible
6 based on the judgment of the supervising surgeon.

7 That's about it. But he does not like that this
8 can confuse him with the non-certified physician
9 assistant.

10 FACILITATOR THOMPSON: So, in summary, I
11 think what I heard you say was that, in that person's
12 opinion, that they could just be considered a PA and
13 the Delegation Agreement would outline exactly what
14 they could and couldn't do based on -- because they
15 only do the surgical piece.

16 MS. DALE: What I heard him say is that they
17 are just to be surgical assistants and not PA-surgical
18 assistants.

19 FACILITATOR THOMPSON: Okay, right, not PA.
20 Just surgical assistants.

21 I don't know. Can we legally do that?

22 DR. MARKEGARD: I don't see why that is even
23 an issue. If they are PAs and they're surgical
24 assistants, they want to remove the PA? If you're an
25 RN, you can't remove their -- you know.

1 MS. DALE: These people are not PAs.

2 DR. MARKEGARD: Oh, they're not.

3 MS. DALE: They are not PAs, no.

4 FACILITATOR THOMPSON: Okay. Dr. Green.

5 DR. GREEN: I have a question. Is there
6 some other certification that may cover these people?
7 I mean, in the operating room there are surgical techs
8 and assistants that must have some certification that
9 are not these people. And if that's true, could these
10 people not be covered as far as the requirement for
11 some certification under those, as opposed to needing
12 to maintain these rules?

13 MR. CAIN: The surg techs that the
14 Department of Health credential, it's a registration
15 and there's no formal requirement to actually get the
16 registration from the department. There are training
17 programs out there, and a lot of hospitals won't hire
18 a surg tech without proper training.

19 But as far as credentialing purposes for the
20 department, it's the lowest form of credentialing. So
21 you just show that you graduated high school and that
22 you've done your HIV/AIDS training and you can get
23 that registration.

24 And they don't do surgical procedures. They pass
25 the instruments, they set up the sterile field, that

1 type of thing. I think what's listed here would be
2 far beyond the scope of a surg tech registration
3 that's issued.

4 DR. GREEN: Are there more of these people
5 coming along?

6 MS. DALE: That was my question.

7 MS. CARTER: No. And there shouldn't be
8 because -- And we can check with Don in credentialing.
9 There aren't any for DOs. There's just the eight of
10 them at Swedish that I would imagine are soon -- They
11 were kind of grandfathered in. So there shouldn't be
12 anyone else getting a PA license that isn't graduated
13 from an approved school and isn't eligible to take the
14 national exam.

15 So there won't be any more coming in. We just
16 have these eight kind of left over that I would think
17 you would want to keep some of the restrictions on
18 their practice in the rule until they are no longer
19 practicing.

20 FACILITATOR THOMPSON: Dr. Green.

21 DR. GREEN: So Section 230, I'm not clear on
22 the point of that, as many times as I've read it. It
23 says that these things are the practice of medicine.
24 Is the point of that that then they have to be under
25 the responsibility of somebody that has the

1 credentials to practice medicine?

2 FACILITATOR THOMPSON: So the practice of
3 medicine, I want to say, and I'm just going to kind of
4 throw this out there, but I believe we've had some
5 stuff that the practice of medicine is when you
6 actually are breaking the skin, right?

7 MS. CARTER: Yes, breaking or penetrating.

8 DR. GREEN: That's the definition of the
9 practice of medicine.

10 MS. CARTER: I think this is probably in
11 there for enforcement and disciplinary purposes so
12 that the secretary can take action for these
13 unlicensed people for performing these tasks. That
14 would be my guess. There are other -- You know,
15 that's sort of what the laser rules are about as well,
16 to make sure that unlicensed people that didn't have
17 the training.

18 DR. JOHNSON: So, in other words, that
19 doesn't have anything to do with PA per se. It's just
20 a general statement.

21 MS. CARTER: Correct.

22 DR. JOHNSON: So we don't really care.

23 DR. MARKEGARD: Right.

24 DR. JOHNSON: We can just leave it and not
25 worry about it.

1 MS. CARTER: That would be my --

2 DR. JOHNSON: And it doesn't have anything
3 to do with the --

4 MS. CARTER: No. It's just sort of defining
5 that we think these things are definitely the practice
6 of medicine. And say a case came that a surg tech was
7 doing some of these things, we could discipline them
8 and say, See, it is the practice of medicine; you were
9 beyond your scope.

10 DR. JOHNSON: Okay. So we don't really
11 care.

12 DR. BRUEGGEMANN: Marty Brueggemann. I was
13 suggesting that we just change the language slightly
14 to add clarification so other people reading this will
15 know what you just discussed. So people that read
16 this don't say, Well, what the heck does this say. So
17 it's more user friendly for the average person.

18 DR. GREEN: I still don't understand.

19 FACILITATOR THOMPSON: So there lies the
20 problem.

21 MS. DALE: So the lead-in sentence on 250
22 says, "The physician assistant-surgical assistant who
23 is not eligible to take the NCCPA certifying exam
24 shall:" And it lists the duties. So perhaps that
25 sentence maybe should also be put in 230 because in

1 230 it goes on to say who "are not otherwise exempted
2 by," and it gives another RCW. So then to really
3 understand, you have to go to that RCW.

4 So maybe if someone like the last speaker, maybe
5 we should put the sentence from 250 up by 230 so that
6 we know what this whole section is about.

7 FACILITATOR THOMPSON: Okay, clarification.

8 MS. DALE: But somehow word it so that they
9 don't have to go tracking through all the RCWs to find
10 out what the heck it is.

11 FACILITATOR THOMPSON: It needs a leader
12 sentence or paragraph.

13 Okay. Athalia?

14 MS. CLOWER: So please clarify for me. This
15 right here is only for those eight Swedish?

16 FACILITATOR THOMPSON: Yes.

17 MS. CLOWER: Okay. So can we write that as
18 well in there so everybody knows that the employers --
19 I'm thinking with the thought of the employers -- that
20 there's only eight physician assistants left over, or
21 something to that effect? Because when people read
22 this, they're thinking that it's for all PAs that are
23 in surgery. And that's what the writer is concerned
24 about, and others are concerned as well. We want to
25 avoid confusion to the employers.

1 FACILITATOR THOMPSON: So my recommendation
2 would be probably not, you know, target Swedish.

3 MS. CLOWER: No, no, no. Of course not.

4 FACILITATOR THOMPSON: But I think that --
5 Yes, I think that if we put some clarification in
6 there that better details what this is meant for and
7 meant to be focused on, yes.

8 MS. CLOWER: Thank you.

9 FACILITATOR THOMPSON: And these are old.
10 These are from '91.

11 DR. JOHNSON: But if Linda says these are
12 really not even PAs --

13 MS. DALE: They're not.

14 DR. JOHNSON: -- then the way it's titled is
15 erroneous as well. It's misleading because they're
16 not PAs to begin with, if they're not.

17 FACILITATOR THOMPSON: So we can work on the
18 titles too.

19 DR. BRUEGGEMANN: Isn't the confusion here,
20 you know, these were considered PAs by different
21 definitions back when these people where certified.
22 That's the problem.

23 FACILITATOR THOMPSON: Yeah.

24 DR. BRUEGGEMANN: So to them they are PAs.
25 But under our current understanding of what a PA is,

1 they are not.

2 And so unless you change what they view
3 themselves as, this is how they view themselves or how
4 they are used to calling themselves.

5 I think that your suggestion is the best. So
6 just include as a header -- take out that very first
7 paragraph and just say: The following duties
8 constitute the practice of medicine, or Chapters 18.71
9 and 18.71A. And, therefore, physician assistant-
10 surgical assistant who is not eligible to take the
11 NCCPA certified exam shall not, and then include those
12 things.

13 MR. CAIN: And is that what it is saying,
14 they cannot do those things, that PASAs cannot do
15 those things?

16 DR. GREEN: Because in the next section it
17 says that they can.

18 MR. CAIN: Because in the next section it
19 lists some of those things in that section saying that
20 they do do those things. I read it as saying that
21 they can do those things.

22 MS. DALE: What does the RCW say? Because
23 that's what we need to find out.

24 MR. CAIN: It probably just says
25 exemption --

1 MS. CARTER: That's the exemption for people
2 who are in training in school. The military doctors
3 that don't have to have a license here, just as long
4 as they are licensed somewhere in the U.S.

5 MR. CAIN: Med students.

6 MS. CARTER: This practice of medicine one I
7 don't think is there for probably any purpose related
8 to the surgical assistant or the PA. It's just to
9 define --

10 MS. DALE: To define practice of medicine.

11 MS. CARTER: Yeah. I think -- I would
12 imagine they probably back in '91 had some issues with
13 unlicensed practice and some discipline issues, so
14 they put it in there to deal with that specific issue.
15 That would be my guess.

16 MR. CONCANNON: But it doesn't belong there.

17 MS. DALE: Right.

18 MR. CONCANNON: It doesn't belong there and
19 should no longer be there. It should no longer be
20 anywhere in these PA rules.

21 MS. CARTER: It's not necessary.

22 FACILITATOR THOMPSON: Right.

23 DR. HEYE: Historically these were people
24 who had training in other countries as MDs and
25 couldn't get licensed in Washington as an MD because

1 they -- for whatever reason. Mostly because they
2 couldn't pass the exam. And they allowed this group
3 of people to be called PASAs so they could work sort
4 of in medicine. I think that's the history behind
5 this.

6 Those people are not -- No one after '91 is
7 eligible to be in this group. Because if they take
8 the -- if they're in a PA course, they're eligible to
9 take the PA exam. So everybody after that could not
10 be in this group. So it's a self-limited thing that's
11 going to go away.

12 MR. CONCANNON: Yeah. But these PA-Surgical
13 Assistants, they have to comply with CMEs? They have
14 to comply with all --

15 MS. CARTER: Yes.

16 MR. CONCANNON: They have to do everything
17 that a PA has to do in terms of maintaining their
18 license and all that?

19 MS. CARTER: Yes.

20 MR. CONCANNON: Right. So --

21 DR. HEYE: I don't know about that.

22 MS. CARTER: In order to renew their
23 license --

24 DR. HEYE: They're not PAs.

25 MR. CONCANNON: Well, wait a minute. But

1 they're called PAs.

2 DR. HEYE: I know. And it's a PA who's
3 really not a PA by our definition, which is what Marty
4 just said.

5 MR. CONCANNON: But they are defined in this
6 new rule and they continue to be defined as something
7 called a PA-Surgical Assistant. And it's a very --
8 and it's a group of people that were licensed back in
9 1989 to function to a limited extent. That's who they
10 are. Apparently there's eight of them still around,
11 right?

12 MS. DALE: But there's no CME in these
13 sections. There's nothing about CME in these
14 sections.

15 MR. CONCANNON: No, no. But CMEs apply to
16 all PAs, right?

17 MS. DALE: But they're not PAs.

18 MS. CARTER: But I think they hold a PA --
19 Well, maybe it's designated PASA, but the whole
20 chapter would still -- I mean, the CE --

21 MR. CONCANNON: Would apply to them.

22 MS. CARTER: -- would still apply on renewal
23 to them.

24 MR. CONCANNON: Yeah.

25 MS. CARTER: Okay, yeah.

1 MR. CONCANNON: So they're stuck.

2 MS. CARTER: So they would still do --

3 DR. GREEN: So what would happen if these
4 things were just deleted? What would happen when
5 those people went to renew their license?

6 FACILITATOR THOMPSON: They couldn't renew
7 them.

8 DR. GREEN: Why?

9 FACILITATOR THOMPSON: Because there would
10 be -- Well --

11 DR. GREEN: Who looks at this when the
12 license is renewed?

13 MS. CARTER: I think they could renew, but
14 then you would sort of -- I think you can delete 230.

15 DR. GREEN: Yeah.

16 MS. CARTER: But 250 does give some
17 restrictions, and I would think you would want to keep
18 those. Otherwise you open their world up.

19 MR. CONCANNON: Yeah. 250 is important,
20 it's substantive and it applies to eight people, and
21 continues to apply to those eight people, and there's
22 no reason to change it. 230 has got nothing to do
23 with anything.

24 DR. GREEN: So get rid of it.

25 MR. CONCANNON: I mean, that's my --

1 DR. GREEN: And I'll feel a lot better,
2 because I just can't understand it.

3 FACILITATOR THOMPSON: So we've defined
4 physician assistant, and we're going to look at that
5 very, very shortly. So because we've defined
6 physician assistant and now we have this PASA, do we
7 need to define what a PASA is so that --

8 MS. DALE: Yes.

9 MR. CONCANNON: They are.

10 DR. HEYE: It's already in there.

11 FACILITATOR THOMPSON: Oh, it is. Okay.
12 And it's relevant. And it's appropriate in this
13 conversation.

14 DR. HEYE: It's in the definition section
15 already.

16 FACILITATOR THOMPSON: Okay.

17 MR. CONCANNON: That was easy.

18 FACILITATOR THOMPSON: So the proposal is to
19 get rid of 230. We're going to keep 250 and 260.

20 DR. MARKEGARD: And so for those eight, if
21 they ever wanted to be under an osteopath, that's just
22 not allowed because that's in our rules, correct?

23 MS. CARTER: Yes.

24 FACILITATOR THOMPSON: Correct. You're off
25 the hook.

1 require maintenance of certification from this day
2 forward on those people who are newly certified in the
3 state.

4 The concern we have is there are some states who
5 do not require -- or require certification
6 maintenance. So say if a PA in that state was
7 initially certified, but then could not pass a
8 recertification exam, they could then come here and
9 work, and we would then be getting a PA who's not
10 competent. And so do we want to leave that open? And
11 I know the national group says don't put the wording
12 in, but we have to protect our population.

13 And so would you, you know, think about somehow
14 wording it so that certification is maintained from
15 those who graduate or those who come in from this date
16 forward? That would allow the ones who were
17 non-certified who are currently in the state to
18 continue as is, but any new PAs from here forward
19 would have to maintain certification.

20 We still have the audit question, though, because
21 now we know that NCCPA won't let us do that.

22 Dead silence.

23 DR. GREEN: And they can't participate in a
24 maintenance program formally, as a certified person
25 would, if they're not certified?

1 MS. DALE: I don't know of another
2 maintenance program. AAPA used to be able to log
3 CMEs, but now they're no longer allowed to. NCCPA has
4 taken that all over.

5 DR. GREEN: Is all they do is CMEs now?

6 MS. DALE: Yeah. NCCPA is the one that
7 basically is like -- they're the ones that figure out
8 what your Category I, Category II is, and maintain
9 competency by the certification, then recertification
10 exams, that kind of thing.

11 DR. JOHNSON: WSMA, Washington State Medical
12 Association, has proposed becoming a clearinghouse for
13 CME, MOC concepts. I'm adding MOCs in parentheses
14 because it was specifically CMEs that was talked about
15 at our last board meeting. It was tabled because
16 there was confusion about, Well, I still have to do it
17 with my specialty society. Why would I also want WSMA
18 to do it?

19 WSMA would not be charging for it, but are using
20 it as a tool to encourage participation in WSMA, and
21 PAs are part of WSMA. So that potentially could be a
22 resource to look to as a -- you know, I'm speaking for
23 the commission now.

24 We don't have the staffing, the funding, or the
25 wherewithal to verify all the CMEs, and that's a

1 reality. And so we're looking to other societies and
2 functionaries to help us guarantee that Mark Johnson
3 is keeping up to date.

4 So now the PAs, we have the issue with doctors,
5 MDs, as well, that there are some that are
6 non-specialty certified, so we're wrestling with that.
7 So I'm just challenging us to come up with a good
8 solution, whether it's to move forward from day one,
9 today, or all certified. You know, all of the
10 currently certified PAs are going to fall into the new
11 cycle next time they come up. That happened to me in
12 my surgical thing. Once I re-certified, I was forced
13 into the MOC, no choice.

14 So we don't have to go -- So we could say all
15 current certified. The problem becomes what do we do
16 with the non-certified. Where do we get the
17 appropriate -- So what's WAPA? Can WAPA do it?

18 MS. DALE: Well, I was thinking about that.
19 So I'll find out. And funding will be hard for us as
20 well because we're even smaller.

21 DR. JOHNSON: But if we required some
22 auditing, that would be an expense. So the current
23 PAs that are not certified. They're not paying into
24 any specialty. They're not paying like you are for
25 your certification. That could be a requirement. If

1 we required some outside agency to do the auditing,
2 they would -- that individual PA would have to go find
3 it. And it could be WAPA, and then they would join
4 WAPA.

5 MS. DALE: And they would have to -- maybe
6 that -- If they're non-certified they have to pay a
7 fee for auditing.

8 DR. JOHNSON: Yeah. I mean, I'm just trying
9 to -- That's enough. That's something to keep kicking
10 around the block.

11 DR. GREEN: Concannon, it's gone past two
12 minutes.

13 FACILITATOR THOMPSON: I'm sorry. Just for
14 you I had to go back. They were begging me.

15 MS. DALE: I'm sorry, but I thought we
16 should bring that forward now rather wait.

17 FACILITATOR THOMPSON: Okay. So now we know
18 that, but we can still work on drafting some language
19 based on Dr. Johnson's -- Green's -- Sorry.
20 Green-Johnson, Johnson-Green. You guys are such a
21 great team, I'm just likely to call you the
22 Johnson-Green team.

23 So we'll still work on that. And then the
24 committee will have some -- we'll have to figure out
25 how we go the next step.

1 MR. CONCANNON: Why are you all so
2 concerned, especially you, Dr. Johnson, about auditing
3 requirements on CE? We have to file federal income
4 taxes every year. The chances of you ever getting
5 audited are minuscule. Everybody does it. It's the
6 law. If you get audited, you better have done it.

7 With CEs, the chances of you being audited by the
8 Medical Commission are minuscule. If we want to audit
9 them, we can. And we will audit them if there's a
10 job.

11 DR. JOHNSON: Here's my answer, Michael:
12 The public expects us to do this. They are not
13 satisfied that the previous ways of the American
14 College of Surgeons and American Board of Surgeons
15 guaranteed that I was keeping up was adequate. They
16 don't think the way we did it before was appropriate,
17 and so we changed. And we changed because the public
18 demanded it.

19 And now I'm suggesting we do the same in these
20 rulemaking. The public expects us to do this work.
21 If there wasn't, we wouldn't be here.

22 MR. CONCANNON: Well, we have the power --
23 "we" the Medical Commission -- have the power to go
24 audit any way we want.

25 DR. JOHNSON: You're guaranteeing that

1 Athalia is up to date, and right now we have no
2 mechanism to guarantee that.

3 MR. CONCANNON: Well, continuing education
4 doesn't guarantee anything. It just means that you
5 showed up and went to continuing education.

6 DR. JOHNSON: That's the point I'm making.

7 MR. CONCANNON: Okay.

8 DR. JOHNSON: Is that the current way the
9 rules are written doesn't allow us to guarantee the
10 public that we're doing our job. And that's my whole
11 point.

12 And so we're challenged -- I'm challenged
13 thinking about how do we do it, since the certified
14 PAs have a mechanism just like I do. But whether it's
15 an MD, a DO who's not no longer boarded, or PA, we
16 don't have a mechanism, and so we're going to have to
17 come up with one for MDs. And I'm just trying to beat
18 the bushes right now to deal with PAs so we can roll
19 it over into the MD world.

20 MR. CONCANNON: You're saying certified PAs,
21 there is a mechanism now.

22 MS. DALE: Yeah.

23 MR. CONCANNON: What percentage of the PAs
24 in the state are certified?

25 DR. JOHNSON: It's a pretty high number.

1 MS. DALE: Yeah.

2 MR. CONCANNON: So all you're doing is
3 looking for the non-certified PAs in terms of how do
4 you maintain -- how do you ensure their competency?

5 MS. DALE: Right. And the number that was
6 mentioned last time was like three to four hundred
7 non-certified.

8 MR. CONCANNON: But all PAs, certified and
9 non-certified, right now have continuing education
10 requirements, right?

11 MS. DALE: Yes.

12 DR. JOHNSON: Yes.

13 DR. GREEN: I thought the number of
14 non-certified ones was more like 40.

15 MS. KITTEN: I think the initial, the ones
16 that have been certified and non-certified, there's
17 been 40, 47, something like that. That might be ones
18 that haven't, possibly. I don't -- There was no way
19 of knowing. That hasn't been tracked in our database,
20 whether they continue to recertify.

21 MS. DALE: Bruce did some research as far as
22 finding out. We have the total number of PAs in the
23 state and how many are certified through NCCPA, and I
24 think roughly the number is around three to four
25 hundred, but I can't remember.

1 MR. CONCANNON: All right. But, again,
2 these are the grandfathered, non-certified 1989, not
3 the ones on interim permit. The only other
4 non-certified PAs are the ones that you were just
5 mentioning way back then.

6 MS. DALE: So it's 40 something that were
7 grandfathered in, then were eligible to take the exam.
8 Then there's -- The rest all took the initial exam.
9 About three to four hundred of those have not renewed
10 their certification or re-certified.

11 MR. CONCANNON: Got it.

12 MS. CARTER: What's the total PAs?

13 MS. KITTEN: About 2,700 total.

14 DR. JOHNSON: And those can work for the
15 next 20 years or 30 years. And there are general
16 surgeons who pass the American -- that take their
17 boards and pass it and never recertify.

18 Now, for hospital privileging, almost all
19 hospitals require certification. But I know from
20 chart reviews there's some that let their surgical
21 boards lapse and they are still practicing surgery in
22 some fashion. How am I going to guarantee that they
23 are current under the current ideas of MOC? How do I
24 do that? I don't know how to do that. I'm trying to
25 figure that out using our PAs as our guinea pig.

1 MR. CONCANNON: Don't use my PAs as your
2 guinea pig.

3 DR. JOHNSON: This is my chance.

4 But, anyway, that's my point, is the public
5 expects us to make sure that they're competent. And I
6 don't know how better to do it than to beat this bush
7 a little bit until we figure it out, is look to the
8 PAs to come up with a solution to help us. We don't
9 have to figure it out today.

10 FACILITATOR THOMPSON: So I think that, you
11 know, we have a small assignment, the department does,
12 and then of course you know we're always welcoming
13 e-mail comments and stuff. So if over the course of
14 the next few weeks you guys have some good ideas, then
15 you know how to e-mail them into Brett and Julie.

16 So at the last meeting we made a promise to the
17 committee that there were certain topics that we would
18 go back and work through and bring back to the
19 committee for you all to look at. So the first
20 section with the MD rules -- or the Medical Commission
21 rules, the 246.918, I think it was in the definition
22 section, and so I'm asking staff to kind of help me on
23 this a little bit too.

24 So I believe that we eliminated -- So there was,
25 did we need a definition of supervising physician and

1 licensee? It was kind of redundant. And so I think
2 that the idea was to get rid of licensee and then
3 define supervising physician.

4 Am I wrong, Brett? Physician assistant? That
5 was something we did before, right?

6 MR. CAIN: Uh-huh.

7 FACILITATOR THOMPSON: All right. So I
8 think that what we need to focus on, unless there's
9 something else in this section you want to focus on
10 the supervising physician's definition.

11 Linda, yes.

12 MS. DALE: Before we leave that, the
13 certified physician assistant, this is what I brought
14 up earlier, that if we continue to say that it has
15 only passed the initial board exam, but not
16 maintained, then NCCPA will probably have something to
17 say about that. Because just allowing that C after
18 the PA's name means that they have maintained
19 certification by NCCPA. So I just want to alert you
20 to that; that if NCCPA figures it out, they could come
21 after us with a lawsuit to allow that.

22 FACILITATOR THOMPSON: Okay. So to fix that
23 problem we need to add some language.

24 MS. DALE: It would be has maintained
25 certification by the national board exam.

1 DR. MARKEGARD: But that's not necessarily
2 true, right? Because they can take the initial exam
3 and be a PA-C, but they don't necessarily have to
4 maintain to remain a PA-C.

5 MS. DALE: They do. To be able to have the
6 "C" after that initial, they have to maintain
7 certification.

8 DR. MARKEGARD: As an NCCPA?

9 MS. DALE: Yeah, NCCPA.

10 DR. MARKEGARD: And they're monitoring that
11 and making sure that if we see a PA-C come across our
12 desk or to our office, we know that they have
13 maintained.

14 MS. DALE: I don't know that they're
15 monitoring that on an individual basis, but we're a
16 state, and they do monitor all the rule changes. The
17 national -- Some people from the national board are
18 telling me when there's new rule changes and new law
19 changes coming up in Washington State. They are
20 monitoring everything that we do or say.

21 And so if -- just the fact that they know these
22 rules are being changed, everybody -- everyone in the
23 U.S. is watching our rule changes. And so if we leave
24 that in, I think that, you know, it could bring it up
25 to their level and they might have something to say

1 about it.

2 MS. CARTER: Well, I agree that this is an
3 issue we need to address because you're right, you
4 can't put a "C" after your name unless you are
5 currently certified.

6 What we're going to have to do -- Because how our
7 rules are written, they talk about the certified
8 physician assistant being anyone who's passed the
9 initial boards. And then there's different
10 requirements for those people who are non-certified
11 and never were eligible or took the exam. So I don't
12 know --

13 MR. CAIN: But is this the term that the
14 NCCPA uses or do they use Physician Assistant-
15 Certified.

16 MS. DALE: It's PA -- well, you have to --
17 That's right. You add certified.

18 MR. CAIN: So if we use Certified Physician
19 Assistant and they don't use that term, we can define
20 it however we want.

21 MS. DALE: I think that might fly.

22 MR. CAIN: But if we call it Physician
23 Assistant-Certified, that's the name that they have
24 their --

25 MS. DALE: Or you can say Initially

1 Certified Physician Assistant.

2 MR. CAIN: Because we went through this with
3 medical assistants where the AAMA calls them certified
4 medical assistants. The state credential has to be
5 Medical Assistant-Certified because the AAMA certifies
6 medical assistants. And it looks similar here, to
7 where the NCCPA calls them PA-Certified. So if we
8 refer to them as Certified PA, then there isn't
9 that --

10 MS. CARTER: Do we want to put a caveat in
11 the definition talking about for the purposes of these
12 rules only, you know? That might help. I don't know
13 if it gets rid of all the confusion.

14 FACILITATOR THOMPSON: We do have at the
15 beginning, you know --

16 MS. DALE: In terms of this chapter.

17 FACILITATOR THOMPSON: We're going to change
18 that just a little bit because we have a better
19 standard, but would that work, or do you want it to be
20 more specific?

21 MS. CARTER: I think it's a valid concern,
22 so I think we need to address it somehow.

23 FACILITATOR THOMPSON: Somehow. So from a
24 legal perspective, even though we have this
25 boilerplate language at the very beginning of our

1 definitions from a legal perspective?

2 MS. CARTER: I think you might want to call
3 it out.

4 FACILITATOR THOMPSON: Call it out, okay.

5 MS. CLOWER: Why don't we say completed and
6 maintained?

7 DR. GREEN: Why can't you just put certified
8 by the National Commission on Certification of
9 Physician Assistants? Is currently certified, that
10 means -- I mean, if they don't maintain it and it
11 drops off, and they have to be currently certified
12 according to the definition to be a PA, then that
13 takes care of it, doesn't it?

14 MS. THOMPSON: I thought you couldn't
15 practice in the State of Washington without the "C."

16 DR. GREEN: That means you're a physician
17 assistant.

18 MS. THOMPSON: I don't believe I can
19 practice in the State of Washington without the "C."

20 MS. DALE: You can.

21 MS. THOMPSON: Because I'm not
22 grandfathered.

23 MS. DALE: You can.

24 MS. THOMPSON: So that's changed in the time
25 I've been a PA.

1 MS. DALE: Well, this says right here,
2 Allows you -- if you have passed the initial exam,
3 then you can practice under the heading with all the
4 rights as a certified physician assistant under these
5 rules. That's the way this is defined.

6 MS. THOMPSON: But is that what you want to
7 happen?

8 MS. DALE: No.

9 MS. THOMPSON: Then you have to change the
10 rules.

11 DR. GREEN: She's saying something
12 different.

13 MS. THOMPSON: My understanding is is that
14 if I don't pass my boards, I cannot practice medicine
15 until I pass my boards. I have a window of
16 opportunity to pass my boards. And if I don't pass in
17 that time, I can go through a process of regaining my
18 certification or I can -- or I won't be able to
19 practice.

20 MS. DALE: Is that your employer's
21 requirement?

22 MS. THOMPSON: No. That's my understanding
23 of the law and my licensure in the State of
24 Washington. My employer says that I have to follow
25 the State of Washington rules, whatever that is.

1 MS. DALE: So this rule right here says, Has
2 passed the initial national board exam. It has not
3 said passed and maintained.

4 MS. THOMPSON: But why would anyone want to
5 recertify if they didn't have to?

6 MS. DALE: Right.

7 MS. THOMPSON: I wouldn't. It's a lot of
8 money, it's a lot of hassle, it messes up my life.
9 And now it's going to mess me up worse with the new
10 rules. So if that doesn't say I have to, why would I?
11 Because you don't get paid more.

12 DR. GREEN: It says under requirements for
13 licensure --

14 MS. CARTER: Yeah, the statute -- I think
15 what Dr. Green is reading doesn't require maintenance
16 of the certification.

17 DR. GREEN: It says, "has successfully
18 passed the National Commission on Certification of
19 Physician Assistants exam." That's what is required
20 for licensure.

21 MR. CLOWER: But if you're not certified,
22 you still have to have the provider on site. My
23 understanding was the big deal about being certified
24 is the provider doesn't have to be on site. You can
25 be in a remote site or could go to Europe or whatever,

1 as long as you have an alternative.

2 But if you're not certified, the provider has to
3 be on site, the sponsoring physician, is my
4 understanding.

5 MS. DALE: That's the old rules.

6 MR. CLOWER: Back in the stone age.

7 Yeah, if we don't have to recertify, screw that
8 noise. So, I mean, if you did it once, then hooray.
9 If you don't have to do it again, that's a bigger
10 hooray.

11 FACILITATOR THOMPSON: And so, in reality,
12 you want them to maintain certification.

13 MS. CLOWER: Yes.

14 MR. CLOWER: Then codify it.

15 FACILITATOR THOMPSON: You have the
16 authority to require that, right?

17 MS. CARTER: Yes.

18 FACILITATOR THOMPSON: So it's this
19 committee's --

20 MR. CONCANNON: Well, wait, wait, wait,
21 wait, wait. How many certified physician assistants
22 in this state do not recertify?

23 MS. DALE: Okay. How many did you say we
24 have total? 2,700?

25 MS. CARTER: 2,700. And there's three to

1 four hundred that we estimate that have not maintained
2 their certification.

3 MS. DALE: Right. Because I actually have
4 the numbers here. NCCPA says in the State of
5 Washington we have 2,317.

6 DR. GREEN: Certified or PAs?

7 MS. DALE: PA-Certified. So then that means
8 you've got 383 who are not certified through NCCPA,
9 but are working here in the state.

10 Now, if you take out the eight who are surgical
11 assistants and you take out --

12 MS. CLOWER: Ones that have kept their
13 license but they're not living here, or they're out of
14 state and they keep their license here, do you have
15 that number, by any chance?

16 DR. GREEN: How many have their license but
17 are living out of state,

18 MS. DALE: Well, that's what we're trying to
19 get at. So there's 383, by those numbers. But,
20 again, take out the eight surgical assistants which we
21 know of. So now you're down to 375. And then you
22 said there are 30 or something who never will be able
23 to certify because they're --

24 MS. KITTEN: Possibly 40.

25 MS. DALE: Possibly 40. So there's down to

1 335 now. But then, as Athalia mentioned, there could
2 be some that are maintaining certification in this
3 state, but are working in Oregon, but they want to
4 keep this in case they move back over here. So it's a
5 nebulous number, but somewhere around, you know, maybe
6 350.

7 MR. CONCANNON: But I thought that included
8 PAs that were never certified.

9 MS. DALE: Right, they do. It does.

10 MR. CONCANNON: All right. And I asked how
11 many certified PAs have not renewed what you're
12 talking about.

13 MS. DALE: That's what I'm saying. I'm
14 thinking there's about 335 maybe.

15 MR. CONCANNON: They were at one time
16 certified and are no longer certified?

17 MS. DALE: (Nodding head affirmatively).

18 DR. JOHNSON: They didn't take their
19 reexamination.

20 MR. CONCANNON: Aren't there some that were
21 never certified?

22 MS. DALE: That's that 40 we're talking
23 about.

24 MR. CONCANNON: And then the surgical is the
25 eight.

1 MS. DALE: The surgical that are the eight.

2 MS. SCHIMMELS: Can I jump in here for a
3 second? So part of this, these two definitions, one
4 and two, with the physician assistant and certified
5 physician assistant, came back from the good old days
6 when we had the -- We went through this when we did
7 the PA changes, tried to change the rules about 15
8 years ago.

9 The physician assistant definition in number (1)
10 was set up for those people that were foreign medical
11 grads that were acupuncturists, that were the surgical
12 PAs, the other types of PAs prior to the -- I can't
13 remember the date exactly. It was 1999 or whatever,
14 1989. Whatever that date is, it's in here somewhere
15 else, where it's grandfathered. There it is, July
16 1st, 1989. So that's what the physician assistant
17 meant.

18 When they put in the certified physician
19 assistant, that was all the people that had passed
20 initially the NCCPA certifying exam. So when we did
21 those numbers -- And I think, George, I think we
22 talked about this, Dr. Heye, a couple meetings ago or
23 maybe last meeting, that there are approximately 30 or
24 so PAs -- maybe Ruth has this number -- that are still
25 practicing in the state underneath that old

1 grandfathered physician assistant definition, the
2 number (1) definition.

3 So that's a little background for that. I just
4 wanted to put that in perspective because that's just
5 kind of one of those time capsule things.

6 FACILITATOR THOMPSON: So legal counsel, you
7 know, she's been looking. So it's been brought to our
8 attention that your statute very clearly states that
9 to be -- for initial certification, that the
10 requirement to be certified, there's that authority.

11 The authority for renewals and to maintain, you
12 know, to maintain your license and to recertify, it is
13 not clear that you could require them to maintain, and
14 so you are putting yourself at a level of risk.

15 MS. DALE: Okay.

16 MS. CARTER: So your statute is clear, for a
17 license it requires initial certification. There's
18 nowhere in your statute, either osteo or medical, that
19 talks about maintaining or recertification, keeping
20 your certification current.

21 Could you say that it's required as continuing
22 competency? Possibly. I think that's probably risky
23 because someone could come and say, Look, it's not
24 required for licensure.

25 DR. GREEN: Can we require it?

1 MS. CARTER: I don't know that there's a
2 bright line answer. It's not in the statute to
3 require it, licensure.

4 DR. GREEN: No. But, I mean, I thought that
5 was -- Is that within our discretion or not?

6 MS. CARTER: All I can say is it's not a
7 requirement for licensure. You could possibly frame
8 it as a continuing competency requirement for renewal.

9 DR. JOHNSON: Well, that's what we did.

10 DR. GREEN: That's what we've already
11 discussed.

12 MS. CARTER: Well, I think you said it's one
13 possible way. It's not the only way. So that's the
14 difference.

15 MR. CONCANNON: Right.

16 MS. CARTER: If you said you must for
17 renewal, that's a different requirement than saying
18 it's an option.

19 FACILITATOR THOMPSON: And one of the
20 historical for other professionals is, and this is a
21 little bit different, but you don't have the right to
22 require somebody basically to maintain with another
23 organization, whatever. You know, to be --

24 DR. MARKEGARD: Board certified.

25 FACILITATOR THOMPSON: Well, not board

1 certified. But when you have organizations and to be
2 a member of that organization, you can't require that
3 to be a part of your licensure. So this is kind of
4 that gray area that you have to be gentle with.

5 So Mike, go ahead.

6 MR. MATTHEWS: Just a couple of things on
7 what you just said. The ARPAs in the state, they tie
8 a certification and licensure to that. So that is a
9 current practice.

10 As far as the requiring maintenance of
11 certification, that would -- if you did that in the
12 renewal section, that would mirror exactly what you
13 have in your MD licensure law for renewal. It says,
14 In lieu of, we will accept maintenance of
15 certification from an ABMS certifying body.

16 DR. JOHNSON: American Board of Medical
17 Specialties.

18 MS. CARTER: Well, it's an option. It's not
19 required.

20 MR. CONCANNON: Right.

21 Then the other thing I wanted to talk about
22 numbers as far as PAs, as of February 3rd the total
23 returns on this are 1,250, so we're having to
24 extrapolate a little bit. Residing in state, that's
25 88.6 percent; that's 1,108 respondents. So obviously

1 there's 11.4 out of state.

2 And then with regard to the certifying question,
3 10A is, Are you certified? 1,213, or 97 percent,
4 responded yes; 37, or three percent, said no.

5 Do you continue to recertify? 1,172, or 93.8
6 percent, said yes; 78, or 6.8 percent, said no. At
7 least you can do something with those numbers.

8 MR. CLOWER: Randall Clower. As a
9 practicing physician assistant, do you have to be
10 board certified currently, up to date, with NCCPA in
11 order to be in a remote site or not have your primary
12 on site with you?

13 My understanding was the certification in the
14 State of Washington allows you to either be in a
15 remote site or to be -- when your primary left town,
16 your alternate did not have to be on site with you.

17 DR. HEYE: The only people that are not
18 allowed to be on a remote site are those with an
19 interim license. So that means that somebody right
20 out of school that hasn't been licensed yet, they
21 can't be used at a remote site. That's the only
22 restriction on remote.

23 MR. CLOWER: So you don't have to be
24 currently up with NCCPA to either be in a remote site
25 or be in a clinic by yourself, if your primary goes on

1 vacation?

2 DR. GREEN: So in Section 120, Remote Site -
3 Utilization, there's nothing that I read in there that
4 speaks to your question. So I think the answer to
5 your question is no, as far as how I read these.

6 MS. DALE: Number (2) says, "Approved by the
7 commission or its designee." And so that would be the
8 only thing, is if the commission decided that you
9 needed to be certified, that would allow that
10 latitude, but there's nothing in the statute or in
11 the RCWs that say you have to be certified.

12 MR. CLOWER: So then the devil's advocate
13 would say, Why would I want to take the time and the
14 bother and expense to recertify?

15 MS. THOMPSON: Exactly.

16 MR. CLOWER: I see no advantage of doing it.

17 MS. THOMPSON: I don't think people
18 understand it that way. I mean, we've been practicing
19 a long time and our understanding is we need to be
20 certified to practice in the State of Washington. If
21 that's not true, the I can guarantee people are not
22 going to be certified because it is a pain in the rear
23 end and there's no monetary incentive for your job, if
24 you don't have to be certified.

25 And so you're going to lose, through your

1 oversight. If you allow people to continue to
2 understand that they don't have to be certified, I
3 think what you'll find is you won't have very many
4 certified PAs in the State of Washington.

5 MS. DALE: Especially going to the ten-year
6 cycle. Because the ten-year cycle, with everything
7 they have to do, it's a real pain. It's a nightmare.

8 MR. CLOWER: So as a practicing physician
9 assistant, my recommendation is to co-define, if
10 that's what you want to do, you have to be currently
11 up to date with NCCPA, and that will help with your
12 auditing bit and that will help clean out all the ones
13 who come in who aren't. Because, if not --

14 MS. THOMPSON: Why should we do it?

15 MR. CLOWER: Yeah. Especially with the
16 ten-year cycle that starts, it's going to be a
17 humongous pain in the butt. Not just for the PA, but
18 especially for the primary. It's going to put an
19 extra burden on the primary with all this new stuff
20 they're coming up with.

21 FACILITATOR THOMPSON: Dr. Green.

22 DR. GREEN: So I guess I would go back to
23 the suggestion I made earlier, which is under (a), the
24 definition of the certified physician assistant, is to
25 say that they have completed an accredited and

1 commission approved physician assistant program and
2 are currently certified by NCCPA. Does that not take
3 care of it? That would require that they maintain
4 their certification.

5 MS. DALE: But is that okay within the
6 statute?

7 MS. CARTER: Yeah, that would be creating a
8 new requirement for licensure, and I'm not sure under
9 the statute that you have that authority to require
10 the maintenance.

11 Right now you've got three to four hundred
12 people, probably closer to 400, that don't have that.

13 MS. DALE: But they could practice under the
14 physician assistant title.

15 MS. CARTER: Those are only the people
16 who --

17 DR. GREEN: Got their license in this
18 grandfather period.

19 MS. CARTER: Right. So, I mean, you could
20 have I guess three definitions. The certified
21 physician assistant, who is someone who maintained it.
22 But we also have those 400 people, and, you know, it
23 could be more, that took the initial board, but then
24 didn't maintain it. And their practice limitations
25 are different from those who were grandfathered in.

1 Or they don't have the practice limitations, I guess I
2 should say.

3 DR. GREEN: So what you're saying is, to
4 require ongoing certification, requires an act of the
5 legislature.

6 MS. CARTER: That would be the safest way,
7 yes.

8 DR. HEYE: This has come up a lot. And the
9 reason we've always stayed away from trying to enforce
10 that is because we don't do it with MDs. MDs can get
11 a license without being certified, but the MD has to
12 take a national exam. And the PA exam I think is the
13 equivalent of the national exam for MDs, and that's
14 why it's required to begin with. But after that, the
15 doctors and -- neither one is required to recertify.

16 DR. JOHNSON: Correct.

17 DR. HEYE: Or to re-exam.

18 DR. JOHNSON: Correct.

19 DR. HEYE: Change that. Certification is a
20 whole different issue for MDs than it is for PAs.

21 DR. GREEN: So the qualification for license
22 renewal allows you to specify their part of the
23 maintenance of competency program. But also that if
24 they do recertify, that qualifies them.

25 MS. CARTER: Sure. Right.

1 DR. GREEN: Okay. So you can do it there by
2 giving them an alternative.

3 MS. CARTER: Correct.

4 DR. JOHNSON: And that would be successful.
5 We don't have to change this current unless you think
6 there's a legal issue with it.

7 MS. CARTER: Yeah, we might want to tweak it
8 just because of the conflict with the sort of -- they
9 may have sort of a --

10 MS. DALE: Trademark.

11 MS. CARTER: Well, trademark protection on
12 the certified. And so we can --

13 DR. JOHNSON: But that's a -- And we don't
14 have to -- we can leave it alone now.

15 MS. CARTER: Right.

16 DR. JOHNSON: And then we can look back at
17 the re-licensure thing and really emphasize -- we can
18 may make that a very strong statement?

19 MS. CARTER: Correct, you could. Yeah.

20 DR. JOHNSON: Yeah, that's what I led that
21 discussion off with, really try to get that focused,
22 so that, you know, if you don't get recertified,
23 you've got an obligation to show you're doing MOC.
24 How are you going to do it and put it on the
25 individual. Because if they can't do it, they're not

1 going to get re-licensed.

2 MS. CARTER: And I think a lot of people
3 recertify because the institution they're working for
4 requires it.

5 DR. JOHNSON: Yeah.

6 MS. CARTER: And that's a lot. That's a lot
7 of them.

8 DR. JOHNSON: But he's talking about the
9 rural, one-on-one doc/PA situation.

10 MR. CLOWER: Since this has to go to the
11 legislature, the way around this would be you cannot
12 practice if you're not certified by yourself without
13 the provider on scene. And that would put notice on
14 the PA to stay certified. Because if their doctor
15 goes on vacation, they stay home too. Do you see what
16 I'm saying?

17 DR. JOHNSON: Yeah. Yeah, for sure.

18 MR. CLOWER: And I don't know if that would
19 need that, but I don't see why you couldn't put that
20 in the law. If you're not certified, your primary has
21 to be on site or your alternative has to be on site.

22 MS. DALE: In the remote site language or
23 remote site rules.

24 MR. CLOWER: Well, but technically, I mean,
25 since it's just my preceptor and myself, if she goes

1 on vacation, I'm now a remote site. So if I'm not
2 certified, she's not there, neither am I. You could
3 get around this by making sure everybody stays
4 certified by just throwing that in there.

5 MS. CARTER: Well, I don't think a physician
6 going on vacation creates a remote site. Remote site
7 is specific in the statute about how often the
8 physician is present. So I don't think there's a
9 problem with that. I mean, that doesn't create a
10 remote site just because the physician is not present
11 for maybe a week or something.

12 DR. HEYE: There has to be an alternate to
13 keep practicing.

14 MS. CARTER: Right. And in statute the
15 physical presentation of the physician is not required
16 for --

17 MR. CONCANNON: Ten percent.

18 We're in the weeds. We're in the weeds.

19 FACILITATOR THOMPSON: Okay. So we've got
20 like five minutes until we're supposed to go to lunch.

21 MR. CONCANNON: I'm telling you, we're in
22 the weeds here.

23 MS. DALE: We have to do it right.

24 FACILITATOR THOMPSON: No, you're right.
25 You're absolutely right. We have to do to right.

1 So for the physician assistant definition, we're
2 going to tweak it a little bit to make sure that we
3 are not in conflict with the national organization and
4 we don't have any kind of conflict there.

5 MR. CONCANNON: Wait, wait, wait. And
6 you're going to tweak it by changing the word
7 certified to something else?

8 MS. CARTER: No. I think we were just going
9 to put in a little phrase talking about just for the
10 purpose of these rules. I think that will help
11 clarify that we're not saying just because you were
12 initially certified, now you can use that title.

13 MR. CONCANNON: And, oh, by the way, it's
14 possible that the national organization is not going
15 to deem you certified if you haven't been doing your
16 renewals; that's what you're saying? They're not
17 going to deem you as being a certified person?

18 MS. DALE: Right. Because you're not
19 supposed to sign your name PA-C unless you've
20 maintained certification by NCCPA.

21 MR. CONCANNON: The PA-C is their
22 designation?

23 MS. DALE: Yes.

24 MR. CONCANNON: Otherwise they just have
25 the --

1 MR. CAIN: Digits of a certified PA.

2 MR. CONCANNON: And as the man in the back
3 of the room would say, that has nothing to do with his
4 ability to practice in this state.

5 MS. DALE: Absolutely.

6 MR. CONCANNON: It's just he might not be
7 able to put "C" after his name, according to NCCPA.

8 MS. CARTER: I think also there's a place
9 where it talks about designation, and we can clarify
10 that as well. It talks about name tag.

11 MR. CONCANNON: Because it's coming up in
12 here, designation.

13 MS. CARTER: Yeah. So we can add something
14 there saying you can only designate yourself as PA-C
15 if in fact you are currently certified.

16 MS. CLOWER: Because I think people put it
17 in on there and it never gets changed.

18 FACILITATOR THOMPSON: Okay. And your
19 concerns would deal with that.

20 Moving ahead, supervising physician definition.
21 That was one of those definitions that staff had an
22 assignment to go and draft some language. So as a
23 committee --

24 DR. GREEN: Which section is this?

25 FACILITATOR THOMPSON: It's still the

1 definition section. It's number (4), Section 005. We
2 are moving right along.

3 MS. CLOWER: On number (2), where it says
4 physician assistant-surgical assistant, did we agree
5 that there was going to be a phrase there explaining
6 that there aren't many left in the state?

7 MR. CONCANNON: No. Because it says right
8 there it's only people who were licensed in a three-
9 month period. That's who they are. Those are the
10 only people that they are. Right?

11 DR. HEYE: Right.

12 MR. CONCANNON: Definitionally. Right,
13 Athalia?

14 MS. CLOWER: Yes.

15 MR. CONCANNON: So that's it. Those are the
16 people. They're never going to change. It is never
17 going to exist again. Those are the people.

18 MS. CLOWER: We know that, but I don't think
19 people reading this --

20 MR. CONCANNON: They have got to be able to
21 read it and say they were licensed between those three
22 months, period.

23 DR. GREEN: If you can't read that --

24 MR. CONCANNON: Those are the only people.
25 Not afterwards. Right?

1 FACILITATOR THOMPSON: We can't say you're
2 at Swedish.

3 MS. CLOWER: No, no. I know.

4 MS. CARTER: So would it be helpful,
5 Athalia, if we talked about -- went back to surgical
6 assistant and put that at the beginning, like a
7 phrase, This applies to PA-surgical assistants
8 licensed through these dates, and just put that
9 sentence there?

10 MS. CLOWER: Yes, that would be great.

11 MS. CARTER: That's easy enough to do.

12 MR. CAIN: One more thing in definition.
13 The word commission is used throughout the chapter,
14 but it's not defined anywhere in definitions. But
15 just to say commission means the Washington State
16 Medical Quality Assurance Commission in these
17 definitions would be good.

18 MS. DALE: And then in osteopathic rules, do
19 you have "board" defined?

20 MR. CAIN: We do.

21 FACILITATOR THOMPSON: We're not forgetting
22 about your little board.

23 DR. MARKEGARD: I'm good.

24 FACILITATOR THOMPSON: Okay.

25 MS. CRAIG: In a previous discussion, I

1 think you guys had repealed 230, so I think it would
2 be 250.

3 FACILITATOR THOMPSON: We're going to have
4 to go through and we'll have to scrub through the
5 rules and make sure that all of the site references
6 are accurate.

7 MR. CONCANNON: And, again, presumably
8 because the surgical assistants, even though they're
9 not PAs, are PAs, because they're being what, licensed
10 as PAs, presumably then definitionally you've got (1),
11 you've got (a), you've got (b), and physical
12 assistant-surgical assistant should be (c). Those are
13 the three types of PAs, right?

14 MS. CARTER: Right.

15 MR. CONCANNON: As limited as they are, as
16 opposed to number (2).

17 MR. CAIN: I'm sure it is, working from this
18 track changes, when you un-track them.

19 MR. CONCANNON: So that's (a), (b) and (c).

20 FACILITATOR THOMPSON: Yeah. We'll have to
21 scrub that too, yes. Perfect.

22 MS. DALE: You've got a non-certified one,
23 though, sir.

24 MR. CONCANNON: Sorry?

25 MS. DALE: There's a non-certified. There's

1 a definition that says non-certified physician
2 assistant means an individual who.

3 MR. CONCANNON: Right. That's (b). And now
4 the surgical assistant is (c), not (2).

5 MS. DALE: Okay.

6 MR. CONCANNON: Now, supervising physician,
7 which is (4), which will end up being (3), because (3)
8 will end up being (2), right? But supervising
9 physician, primary supervising physician defined,
10 alternate supervising physician. A supervising
11 physician means either the primary or the alternate.
12 Alternate supervising physician identified in the
13 delegation agreement, if any. That's my suggestion.

14 FACILITATOR THOMPSON: Are you saying too
15 many words?

16 MR. CONCANNON: In other words, the primary
17 supervising physician is the way you describe them.

18 FACILITATOR THOMPSON: Oh, I see.

19 MR. CONCANNON: And the alternate
20 supervising physician is the person identified in the
21 delegation agreement, if any. There may be one, there
22 may not be one. As opposed to "responsible for
23 supervising the work of a physician assistant pursuant
24 to a delegation agreement approved by the commission."

25 FACILITATOR THOMPSON: Okay.

1 DR. GREEN: Do you want to put the "if any"
2 after physician, rather than delegation agreement?
3 Otherwise it sounds like it's referring to the
4 delegation.

5 MR. CONCANNON: Alternate supervising
6 physician, if any, identified in the delegation
7 agreement.

8 DR. BRUEGGEMANN: And under that it
9 shouldn't matter if they're allopath or not.

10 MR. CONCANNON: That's just a suggestion.

11 FACILITATOR THOMPSON: So the same thing
12 will happen in the DO rules unless we hear otherwise.

13 MR. CONCANNON: Delegation agreement, number
14 (5), which will end up being number (4), formerly
15 known as a practice plan, means it is between a
16 physician assistant and a primary physician,
17 supervising physician, parenthetically, or alternate
18 supervising physician, right, that the delegation
19 agreement also includes something with that alternate?

20 MS. DALE: Do we even need to say "formally
21 known as"? Because we now have delegation agreement.

22 MR. CONCANNON: That's superfluous language,
23 you're right. It was just done for explanation
24 purposes just to kind of help people along.

25 MR. CAIN: Mike, one more time. Delegation

1 agreement means a collaborative agreement --?

2 MR. CONCANNON: Between a physician
3 assistant and a primary and/or alternate supervising
4 physician, as the case may be.

5 MR. CAIN: They need a primary, right?

6 MR. CONCANNON: Right. And/or.

7 FACILITATOR THOMPSON: Yes, say "and."

8 MR. CAIN: And supervising physician, if
9 any.

10 MR. CONCANNON: If there is any for the
11 alternate.

12 DR. JOHNSON: Was there going to be a
13 discussion resumed or with Group Health or other type
14 organizations where there isn't a named physician but,
15 rather, an organization? And I thought there was
16 going to be a discussion about that within the
17 definitions that provide some better clarification for
18 the real world today. And, if so, what were those
19 words going to be?

20 MS. CARTER: I think we addressed some of
21 that later on, because, if I recall correctly, under
22 the statute it allows an alternate to be a group. So
23 I think you're okay with this definition because an
24 alternate can be a group.

25 DR. JOHNSON: So I'm speaking now asking the

1 other organizations, are they comfortable to always
2 named (a) number (1) supervising physician, and then
3 using the group as the backup?

4 MS. DALE: The gentleman from ZoomCare is
5 here.

6 DR. JOHNSON: Is that the plan?

7 FACILITATOR THOMPSON: Please come to the
8 podium, and state your name.

9 DR. VANDERGRIFT: This is John Vandergrift
10 from Group Health. Can you hear me?

11 DR. JOHNSON: Yes.

12 DR. VANDERGRIFT: From our standpoint, one
13 question I have is whether it would be helpful in the
14 statute and whether it would be more clear if we were
15 to state somewhere in this under the definitions that
16 an alternate supervising physician may be a medical
17 group, and perhaps defined further as within the same
18 practice group as the -- and I don't know if we want
19 to necessarily say within the same practice group as
20 the primary supervising physician or not. I leave
21 that for debate.

22 MR. BERGSTEIN: Hi. My name is Len
23 Bergstein. In Oregon what we did was we attempted to
24 change the statute so it would have a supervising
25 physician organization. That also had an impact on

1 the ratios, so it has a double implication. We would
2 like to make sure that there's clarity and in fact
3 that what you're establishing by rule is a supervising
4 physician organization, and that you have to name that
5 a primary physician. That would be the person that
6 you would look to. But that in fact the supervising
7 physician organization would be the key thing in your
8 rules. And then that would have an impact on your
9 ratios also. I would be glad to help you with the
10 language.

11 DR. HEYE: Oregon still requires a primary
12 person to be named.

13 MR. BERGSTEIN: Right.

14 DR. HEYE: It's not just, you know, Group
15 Health or Virginia Mason or whatever.

16 MR. BERGSTEIN: Yeah.

17 DR. MARKEGARD: I don't see how that would
18 change the ratio, though. Because if you have your
19 primary supervising physician and your alternate is
20 the group, then still the primary physician is
21 responsible for covering that five PAs, right?

22 MR. BERGSTEIN: What we found was that the
23 ratio was arbitrary. And by having a physician
24 supervising organization, you may have multiple
25 physicians who would be responsible for multiple

1 clinics, multiple PAs, and so the ratio of one to
2 four, in our case it was one to one when the statute
3 started off, we felt that it was important to make
4 sure that there really wasn't kind of an arbitrary
5 number of one to one or one to three or one to four.

6 We figured the impact and the purpose of the
7 statute, which was to make sure that there was
8 supervision, qualified supervision, was the thing that
9 was important, not necessarily the ratio.

10 DR. MARKEGARD: So then it's okay -- So it
11 doesn't make a difference if one provider, one
12 physician, supervises five or fifty? To you that
13 doesn't matter; it's just irrelevant.

14 MR. BERGSTEIN: No, it's not irrelevant. It
15 doesn't work out that way. In fact, the number is
16 around one to six or something like that, depending on
17 the number of --

18 DR. MARKEGARD: So it's not an arbitrary
19 number.

20 MR. BERGSTEIN: Well, it is an arbitrary
21 number because it sets a number of one to four or one
22 to five. We let the practice -- We think the practice
23 would set the supervision, as opposed to a specific
24 ratio.

25 DR. MARKEGARD: So then that is identified

1 in your delegation agreement.

2 MR. BERGSTEIN: Right.

3 DR. MARKEGARD: And that gets approved or
4 not approved by the board.

5 MR. BERGSTEIN: The board looks at it,
6 exactly. Right.

7 DR. JOHNSON: We have statute that says one
8 to five, so we're stuck with that.

9 MR. BERGSTEIN: I understand.

10 MS. DALE: So if you have a group with six
11 physicians, then your supervising physician group or
12 organization would supervise 16 PAs. Because then
13 that still -- you know, under that one to four level,
14 but -- Or whatever my math is. But, anyway --

15 MR. BERGSTEIN: No one specific physician is
16 identified with any one or several PAs. That's the
17 purpose of that.

18 DR. VANDERGRIFT: This is John Vandergrift
19 again. One of the things I would like to clarify from
20 our standpoint, we still support actually the primary
21 delegation agreement being between one specific
22 identified physician and the specific PA, but the
23 designation of an alternate supervising agreement, the
24 alternate could be the medical group.

25 MR. BERGSTEIN: Right. And again, slightly

1 different again -- Len Bergstein -- we believe that
2 the medical director has got their name on the line.
3 They're the person who's -- You know, there's a
4 primary physician that will be in fact called to task,
5 and it's not necessary that there be a tie between any
6 other physician. The organization is the one that's
7 responsible for the quality of the PAs.

8 DR. GREEN: What if, in caring for a
9 patient, there is a problem and one of the alternate
10 physicians is supervising? They don't become
11 primarily responsible?

12 MR. BERGSTEIN: Well, I can't tell you what
13 the specific might be in that situation, but all of
14 our physicians are tightly bound by the model to the
15 medical director, and so there's a primary physician
16 responsible in all cases. There's a supervising
17 physician also responsible. So it's a -- In fact,
18 it's kind of a double, if you will, kind of a --

19 DR. GREEN: I think I understand what you're
20 saying. Thank you.

21 FACILITATOR THOMPSON: Yes, we are supposed
22 to be going to lunch. So do we want to table this, do
23 we want to -- Dr. Heye, go ahead.

24 DR. HEYE: Well, I would like to table this
25 until after lunch because --

1 FACILITATOR THOMPSON: Because you're
2 hungry.

3 DR. HEYE: I'm not hungry. But the use of a
4 primary as supervising physician was something that I
5 suggested, and I'm going to make an argument if we're
6 going back to that being called a sponsoring
7 physician.

8 FACILITATOR THOMPSON: Okay.

9 DR. HEYE: Because that's what the law uses
10 all the time.

11 FACILITATOR THOMPSON: That's right. We had
12 that conversation.

13 DR. HEYE: And we can talk about that when
14 we come back from lunch.

15 MR. CAIN: Do we want that on there or not
16 now? Physician or group of physicians? I added that.

17 MS. CARTER: I think the statute allows that
18 the alternate can be identified as a medical group.
19 So, you know, if you have your one primary sponsor or
20 supervisor who's sort of the person signing your
21 delegation agreement, then you can for your
22 alternates. That's allowed in statute to have a
23 group.

24 MS. DALE: Can I ask a question of the Group
25 Health person on the phone?

1 If your physician assistant gets in trouble while
2 being supervised by an alternate supervising
3 physician, what would happen in a Group Health case?

4 DR. VANDERGRIFT: This is John Vandergrift
5 again. What my expectation would be is that if the PA
6 gets into trouble and happens to be another alternate
7 physician there by the FDA from the group practice,
8 that it would be that specific physician supervising
9 that PA on that day who would be the one responsible.

10 MS. DALE: Okay. That's my understanding.
11 Thank you.

12 MS. CLOWER: One more question. So if the
13 primary physician is gone and the organization is the
14 alternate, does the organization have to say who's
15 going to be that day primary to be able to be tied to
16 the responsibility, or how does that work in Group
17 Health?

18 DR. JOHNSON: But that would be written up
19 in the delegation agreement, how that organization
20 would make that decision process. I don't think it
21 needs to be so tightly defined. I mean, that's
22 something real important, I think, that we let each
23 organization understand how they're going to
24 supervise.

25 MS. CLOWER: Okay.

1 DR. JOHNSON: And hold their feet to the
2 fire as an organization. But we don't really care, as
3 long as it's in the delegation agreement that they are
4 responsible.

5 MS. CLOWER: Yeah. I totally agree. But in
6 the event that that happened, you know, if it comes to
7 the Medical Quality Assurance Commission and they say
8 the supervising physician was on vacation and the
9 group practice was supervising, does then -- you know,
10 but they'll -- I see.

11 DR. JOHNSON: But we can turn to the medical
12 director, and ultimately his feet will be on fire if
13 he can't figure out someone else to shift the blame
14 to. We don't care. We've got somebody. We don't
15 care. We just need somebody.

16 FACILITATOR THOMPSON: Okay. So we are
17 about 15 minutes off schedule. So we're going to
18 break for lunch. We'll come back at 12:15. I will do
19 my best to get us back on track. We have some room at
20 the end, I think. But like Linda pointed out, it's
21 important that we do this right. So break until
22 12:15.

23 (A LUNCH RECESS WAS HAD AT
24 11:43 A.M. UNTIL 12:15 P.M.)

25 FACILITATOR THOMPSON: So we finished sort

1 of up with the definitions, but Dr. Heye has some
2 important information that he would like to share with
3 us, so I'm going to let him share his information
4 first.

5 DR. HEYE: Well, just to repeat, when we
6 started looking at these rules, part of the issue
7 people wanted to get rid of was the confusion between
8 supervising and sponsoring physicians, because the old
9 WAC used one for non-certified PA and the other word
10 for certified PA, but in common usage they were mixed
11 together.

12 So I originally tried to get rid of using either
13 one of them, and that was where the language of
14 primary sponsoring physician came in. But the RCW
15 consistently uses the phrase sponsoring or supervising
16 physician, so I thought -- I don't think it's
17 confusing to use sponsoring physician, because we're
18 pretty much getting rid of the non-certified PAs
19 anyway.

20 So under the definition of supervising physician,
21 what I did was I tried making a general definition of
22 a supervising physician. And then under that I put
23 sponsoring and alternate physicians and defined those.
24 Now, they're not in your paper because I just wrote
25 those this morning.

1 Anyway, my suggestion for supervising physician
2 is any physician providing clinical oversight for a PA
3 pursuant to a delegation agreement. So that would be
4 the main number (4) or (3), whatever the number is
5 going to be. And then under that, instead of primary,
6 I said, The sponsoring supervising physician is any
7 physician identified in a delegation agreement as
8 providing the primary, clinical and administrative
9 oversights for an physician assistant. So that's the
10 doctor's name that goes on the delegation agreement as
11 the number (1) sponsoring or supervisor.

12 And then the alternate supervising physician I
13 said, Any physician providing clinical oversight of a
14 PA in place of or in addition to the sponsoring
15 physician. So in that second one, we can put
16 something in there if you want about a group, if you
17 think that's necessary. But the law allows the
18 sponsor to be a group, the RCW that's in there, so
19 it's not new.

20 DR. JOHNSON: Sounds good.

21 MR. CAIN: And you have that that you can --

22 DR. HEYE: (Indicating a paper).

23 MR. CAIN: Because I just put "Get language
24 from Dr. Heye."

25 DR. HEYE: That's why I wrote it down for

1 you.

2 FACILITATOR THOMPSON: Comments, concerns,
3 thoughts?

4 DR. VANDERGRIFT: This is John Vandergrift
5 from Group Health. And I support that quite a bit. I
6 think that is very logical and I like that, going with
7 that language.

8 FACILITATOR THOMPSON: Okay. So we will get
9 that on paper and get that out to everyone.

10 Okay. Moving on to what I believe is the next
11 piece that the department said that we would work on
12 is in 035. And I believe we had talked about drafting
13 up language about physician assistants and their
14 prescribing authority, making it very clear in the
15 rules. So this is the language that, based on what
16 you all told us, what we came up with.

17 MS. CARTER: And this one, Brett, we need to
18 change "board" to "commission."

19 MR. CONCANNON: All right. Let's look at
20 this. Number (1), it talks about what the physician
21 assistant may prescribe, and it says "only within the
22 scope of practice outlined" -- in, I assume -- in "a
23 delegation agreement." So is the scope of practice so
24 particularly defined that a physician assistant could
25 be prescribing two, three, four and five controlled

1 substances that are outside his scope of practice?

2 MS. DALE: Well, for example, I worked in
3 pediatrics, and in the clinic where I worked it was
4 pretty much agreed that I wouldn't order any kind of
5 narcotic pain control or whatever for a child without
6 talking to my supervising physician. I never had to
7 do it anyway, but that was one of the things that we
8 felt strongly about, is that in that specific
9 situation in pediatrics that we would discuss it
10 before we ordered any kind of pain medication. So
11 that's what that would fall under.

12 MR. CONCANNON: But that's internal.

13 MS. DALE: Right.

14 MR. CONCANNON: I'm talking about in terms
15 of the law and our rule and a scope of practice.

16 MS. DALE: I guess it's outlined in the
17 delegation agreement.

18 DR. MARKEGARD: That would mean that, also,
19 if you have an orthopedic PA, you know, they probably
20 shouldn't be prescribing birth control pills because
21 it's not -- I would assume that's not in the scope of
22 your practice.

23 DR. GREEN: That's what we're getting at.

24 DR. JOHNSON: But does that have to be
25 defined in a rule or even in a delegation agreement?

1 I mean, do you have to be that specific in the
2 delegation agreement, you're saying which drugs you
3 can prescribe and which not?

4 DR. HEYE: No. The scope of practice means
5 that the PA can only prescribe within the practice of
6 the sponsor or the supervisor.

7 DR. JOHNSON: I understand that. I
8 understand that, but it seems like this rule is --
9 you're going to have to write it -- Are we asking them
10 to write it into the delegation agreement, like Linda
11 said, or that I'm not going to have my PA write
12 chemotherapy drugs because -- Do I have to write that
13 or is it assumed that, I'm a surgeon, and we're not
14 going to give chemo drugs?

15 DR. HEYE: The language needs to be changed
16 to be more representative. What we're trying to say
17 is you can't write prescriptions for your family or
18 friends if they're not part of the practice that
19 you're part of as a PA.

20 DR. MARKEGARD: So you can also just have on
21 there just controlled substances only within the scope
22 of practice or under the scope of practice of your
23 supervising physician.

24 DR. HEYE: That's the idea.

25 DR. MARKEGARD: You can just cross out the

1 delegation agreement part.

2 DR. JOHNSON: Yeah.

3 DR. HEYE: I was trying to make it clear
4 because we have a number of PAs get into problems with
5 this. They start prescribing for other people that
6 are not related to the practice, and then say, Well, I
7 didn't realize I couldn't do that.

8 DR. JOHNSON: We have physicians that do
9 that, too.

10 DR. HEYE: We're picking on PAs today.

11 MR. CONCANNON: They can prescribe all these
12 things if it is consistent with --

13 MS. DALE: Their scope.

14 MR. CONCANNON: -- their practice plan and
15 scope of practice as set forth in the delegation
16 agreement. If it's consistent with it, as opposed to
17 if it's within it, I guess. Because within it almost
18 sounds like there's a scope of practice that's going
19 to be pretty well defined in terms of what you can and
20 can't prescribe, as I read it.

21 DR. HEYE: Yeah, that's probably reading it
22 too narrowly. But you're right.

23 MR. CONCANNON: If it's consistent with it.
24 If it's not consistent with it, then they can't do it.
25 Or come up with something, you know, even --

1 DR. HEYE: I thought I would play with the
2 language a little bit on that.

3 MR. CONCANNON: Yeah. All right. And
4 then --

5 FACILITATOR THOMPSON: Athalia had a
6 question, I think.

7 MS. CLOWER: In my notes from the prior
8 meeting I thought we were going to write: A physician
9 assistant must comply with all current federal and
10 state regulations for prescribing and dispensing
11 legend and controlled substances, period.

12 DR. HEYE: We did. That's not enough.

13 FACILITATOR THOMPSON: Because apparently
14 there's a problem that needs to be resolved.

15 DR. HEYE: Yeah. That's why I added the
16 rest of this, to fill in for what used to be a fairly
17 long section of the WAC that talked about prescribing
18 under both certified and non-certified PAs.

19 And when I added this other language, the top
20 sentence becomes repetitive, the first two lines up
21 there, because they're included in number (2). The
22 numbering is wrong also.

23 MR. CAIN: Yeah.

24 DR. HEYE: But number (2) is all
25 prescriptions comply with state and federal

1 regulations. That really falls under the fact that
2 you can prescribe if you have a delegation agreement
3 that allows you to prescribe, provided that you do (1)
4 and (2). And (1), you have to have your own DEA if
5 you're going to do schedule. And then (2) is you have
6 to comply with the regulations.

7 And then the other part, number -- the last part
8 of that says, If the primary supervising physician,
9 and so on. And I just scratched that out and said:
10 If the supervising physician's prescribing privileges
11 have been limited by a state or federal action, the
12 physician assistant will be similarly limited. And
13 that's been a rule for a long time.

14 MS. CLOWER: So here comes my question. If
15 I'm a practicing physician assistant, couldn't I be
16 prescribing those prescriptions through my alternate
17 physician or my group practice instead of my primary
18 physician?

19 DR. HEYE: Well, we can talk about this. If
20 your primary is somebody who is not allowed to
21 prescribe, most of the time the PA being sponsored is
22 not allowed to prescribe because the doctor is
23 supposed to be supervising the PA. And if the doctor
24 has lost prescribing privileges, the PA can't be a
25 substitute for that.

1 MS. CLOWER: So I could change?

2 DR. HEYE: Change primaries.

3 MS. CLOWER: Change primaries.

4 And then here with number (1), I think -- And I'm
5 just thinking of employers probably will be looking at
6 this, so do we have to delineate in the delegation
7 plan what the PA can prescribe?

8 DR. HEYE: No.

9 MS. CLOWER: Outline in the delegation
10 agreement. So the delegation agreement, are you
11 requiring the delegation agreement to explain what
12 prescriptions I can write?

13 MR. CONCANNON: Well, that's what I was
14 bringing up in terms of it -- He has to tinker with
15 that wording in some fashion to make it consistent
16 with the delegation agreement.

17 DR. HEYE: Yeah, I think what we did is I
18 think we put some language in the delegation
19 agreement. We haven't got to that yet.

20 MR. CAIN: Yeah, it's there already.

21 FACILITATOR THOMPSON: Dr. Green?

22 DR. GREEN: So, Mark, I'm surprised you
23 didn't bring up your point, but I will.

24 Section 105 talks about disciplinary action of
25 the supervising physician, and basically says the same

1 thing that you did about prescribing drugs, but in
2 general. And the question comes up about, you know,
3 whether to have those kinds of prohibitions in
4 different places related to specific things or whether
5 to segregate out just the prescribing of controlled
6 substances, because there are some opinions here in
7 the room that the restriction in general shouldn't be
8 included in the rules.

9 MS. CLOWER: Yeah, thank you. Thank you for
10 saying that.

11 DR. GREEN: So it's just a consideration of
12 how to deal collectively with the notion of how a
13 physician's disciplinary restriction may affect a PA,
14 because it's more than just as a problem with
15 narcotics or controlled substances.

16 FACILITATOR THOMPSON: So did I hear you say
17 you're thinking those two sections should be combined
18 together?

19 DR. GREEN: I'm raising a question whether
20 to deal with the collective issue in 105, because 105
21 stands by itself and would cover what Dr. Heye just
22 said. But, on the other hand, if, as some people in
23 the room believe, not all restrictions on a physician
24 should lead to restrictions of a PA similarly, then we
25 need to do something different. So I'm just bringing

1 it up for -- Mark, maybe you have a different view.

2 DR. JOHNSON: Well, I brought it up in an
3 e-mail I sent around because I sat there and wondered,
4 if you're in a relatively rural part of the state and
5 there is one physician and one PA, if the physician
6 has any kind of restriction, whether it's
7 prescription, prescribing practices, or chaperoning,
8 and you then put the same restrictions on the PA who
9 wasn't involved in the adverse event, you are now
10 limiting the opportunity for that clinic to manage
11 patients. And Tom recalls sometimes in orders that
12 there's specific wording about, if you're supervising
13 a PA, they are also involved. I don't recall that in
14 many of the orders I've been involved with.

15 DR. GREEN: The orders usually excluded them
16 from supervising PAs.

17 DR. JOHNSON: And it might exclude them,
18 but, you know, part of this is we're protecting -- you
19 know, we want to keep the PAs involved in practicing
20 and not have them restricted if we don't have to
21 restrict them.

22 And so Tom's point is well taken, that if there's
23 restrictions on the doc to supervise, then the PA has
24 got to go look for another job. But if they're going
25 to stay within their community in their smaller

1 clinic, we've got to be careful we don't make it so
2 onerous that the PA can't function. And I don't know
3 how to better say what I'm thinking, but at least I'm
4 trying to deal with the dilemma.

5 FACILITATOR THOMPSON: I think that -- I
6 thought that legally, based on the statute, that if
7 the physician has restrictions, then automatically the
8 PA that they supervise has restrictions.

9 DR. JOHNSON: That might be. I didn't look
10 at that statute.

11 MS. DALE: Is it a state statute or is it
12 rule?

13 MS. CARTER: I don't think it's explicit in
14 the statute except for it does talk about physicians
15 assistants can only work within the scope of what the
16 physician can do. So, you know, you couldn't have a
17 physician who's a pediatrician employ a PA that's now
18 doing dermatology.

19 DR. JOHNSON: Oh, I understand that.

20 MS. CARTER: So I think it's --

21 DR. JOHNSON: But let's say, just using
22 chaperoning as an example, because of some event that
23 the physician got caught up in, now they have to have
24 a chaperone for every patient, every minor or every
25 woman, okay? Does that also apply then to the PA? Is

1 that what our intention is? If the PA was not
2 involved in that event.

3 MS. CARTER: And to me that is different
4 than like the prescribing because it's not a scope of
5 practice. You know, you haven't limited the scope.

6 DR. JOHNSON: So you're in an office and
7 someone comes in with a broken leg and the provider/
8 supervisor, because of their error, has now got some
9 limitations on prescribing, I'm not going to let the
10 PA run a -- and they have a valid DEA, you're not
11 going to write a narcotic prescription? Is that
12 really what we're trying to say?

13 I'm struggling with that because you're
14 limiting -- you're really limiting the opportunity to
15 take care of patients.

16 MS. THOMPSON: That was my question at the
17 last meeting. I'm Jamera Thompson. I'm a PA and I
18 work in a group practice. I worked in a family
19 practice where one of the doctors was limited in
20 narcotic prescribing abilities. At the time, he
21 didn't happen to be my direct supervisor, but he was
22 one of the associates.

23 My concern is, being a PA who does surgical
24 assisting, that sometimes surgeons -- and recently
25 there was one in the community that was limited in the

1 procedures that he could do, you know. And I'm in an
2 OB/GYN practice and I work for 11 surgeons, and so
3 does that mean I can't just -- you know, if you say
4 this doc can't do this surgical procedure, it has to
5 be through the disciplinary project, and he just
6 happens to be my supervising physician, does that mean
7 I can't assist everybody? I mean, you take me out of
8 surgery for a whole practice, whereas it wasn't -- I
9 wasn't participating in the original thing.

10 And that's my concern about this particular
11 statute, is that it could really limit -- Like we have
12 a cardiothoracic department and they have one PA for
13 three surgeons. Well, you know cardiothoracic surgery
14 can have issues, right?

15 So the thing is is that if you wipe out the
16 assist, or the PA, is there a petition? Can we
17 petition to change the supervising physician in that
18 situation so there's a grace period maybe for the PA
19 so that they don't limit the whole practice?

20 DR. GREEN: Isn't it the case that if
21 you're -- if one physician in a group is restricted,
22 they're not going to be doing the surgery, so you
23 certainly wouldn't operate with them. But that
24 doesn't preclude you from working with another
25 physician member of your group.

1 MS. CLOWER: But he's my primary physician.

2 DR. GREEN: But you can also be supervised
3 by other members of the group.

4 MS. THOMPSON: I think that's what Athalia
5 just asked and was told no, that she would be limited
6 in her practice because the other ones were
7 supervising physicians and not primary.

8 DR. GREEN: George, you're the one that
9 deals with this in a practical sense.

10 DR. HEYE: Well, it's open for discussion,
11 you know. But typically this comes up with
12 prescribing issues, and you certainly can't have the
13 PA filling in for the sponsor in a chronic pain
14 patient if the sponsor can't do that.

15 DR. JOHNSON: So should we deal with that on
16 an individual order basis or should we do it as a
17 broad rule, is the question we talked about coming
18 over here?

19 DR. HEYE: I don't know.

20 DR. JOHNSON: Yeah, I don't know either.

21 DR. GREEN: The thought that I have, and I
22 don't know if it's possible, is to have the commission
23 establish a policy that if they restrict the practice
24 of a physician who is supervising physician
25 assistants, that part of the order include what should

1 happen to the physician assistant as a result of that
2 restriction. That allows it to be done on a
3 case-by-case basis.

4 DR. MARKEGARD: But also -- Because I don't
5 know if the orders that we've done that -- I don't
6 know that that physician is or is not supervising PAs.
7 I'm not sure if I'm supposed to know that, so that
8 wouldn't have been included in the order.

9 And let's just say, for instance, we decide to do
10 that as a case-by-case basis, maybe some of the orders
11 that were done before that put the provider on
12 restriction for five years, and we change the rules
13 now, then is now the -- I mean, because there is like
14 a little time kind of lapse also, there might be
15 confusion for PAs that are out there practicing.

16 And it seems like it's more relevant to the
17 prescribing than it is for anything else. Right? I
18 mean --

19 MS. CLOWER: And if we're going to do
20 something like that, I agree with Dr. Green that the
21 limitations should go somewhere else and not here,
22 because the employers -- And I just go back to that.
23 But since now institutions are hiring us, the more
24 restrictions or the more little things that they have
25 to look upon, the less they are going to be interested

1 in hiring us, because it's more bureaucracy. How do
2 you interpret this; how do you interpret that? So
3 it's subjected to interpretation. It's limiting for
4 our practice.

5 FACILITATOR THOMPSON: What do you guys want
6 to do? So we could keep the prescription piece and
7 get rid of the general. We could combine the two and
8 the prescription piece, but the general piece we could
9 say that that would be on a case-by-case basis and
10 done through orders, although I think logistically
11 there was a good point that you would have to know who
12 all that person supervised. So that communication
13 would have to be somehow documented so that everybody
14 knows, you know, your delegation agreement now has
15 been altered because -- You know.

16 DR. GREEN: I'm not sure that we always know
17 that either, Shannon. But maybe that is something
18 that we ought to know if we feel -- I mean, if we
19 don't know it and we're writing orders, how do we
20 know --

21 FACILITATOR THOMPSON: That they know.

22 DR. GREEN: That the physician assistant may
23 need to be restricted.

24 DR. BRUEGGEMANN: If we put together these
25 limitations, can't you make that part of the --

1 Presumably if you get someone in a situation, you have
2 the big long form, can't you put that as one of the
3 legal lines under that as part of this you must
4 disclose any delegation agreements you're in? In
5 which case then we will know what they have in place,
6 and then you can contact the physician assistant.

7 MS. CLOWER: The commission should know the
8 delegation agreements. I mean, there's no doubt about
9 that.

10 MS. KITTEN: They're in the database.

11 DR. BRUEGGEMANN: So when that name pops up,
12 it will flag that they're in a delegation agreement or
13 it's an easy search?

14 MS. KITTEN: It's an easy search.

15 DR. HEYE: I mean, the basis here is that
16 the scope of practice of a PA cannot exceed that of
17 the sponsor or the supervisor. However you want to
18 get something under that, I don't know how you do
19 that.

20 MS. CLOWER: Maybe that phrase that you just
21 said.

22 DR. HEYE: Well, I mean, that's what that
23 one section says, 105 says. It's a general statement
24 and it's there for everybody.

25 DR. JOHNSON: I know. I brought it out as a

1 point of conversation, but I have no good answer.

2 DR. GREEN: But you're saying that if the
3 primary physician is restricted, the PA has to, even
4 if there are other supervisors that fit that group?

5 DR. HEYE: If you want to write that in, I
6 suppose you could do that. A lot of times the sponsor
7 practices very little with the PA on a regular basis
8 because the alternates are doing most of the
9 oversight. And that to me would make sense, but
10 that's a conflict. How to get around that.

11 DR. GREEN: What would make sense? I'm not
12 sure. When you say it would make sense, you mean
13 restrict the PA based on a sponsoring physician?

14 DR. HEYE: If there's no alternate, then you
15 don't have any choice. But if there's an alternate,
16 then you could, if the PA is working under an
17 alternate supervisor at any particular time, then
18 doesn't the PA's scope fit that particular supervisor
19 at the time?

20 DR. GREEN: That's why I think it ought to
21 be done on a case-by-case basis and reviewed by the
22 disciplinary panel.

23 FACILITATOR THOMPSON: Linda?

24 MS. DALE: Yeah. I've got an actual -- If
25 we just want to add both in this prescriptive piece

1 and on 105, if you just put -- So on 105 it says, "the
2 physician assistant's practice is similarly limited
3 while working under that physician's supervision" or
4 unless otherwise indicated by the commission slash
5 board.

6 And if you use that, unless otherwise indicated,
7 then that would allow the board or the commission the
8 latitude to say, you know, this PA has been working
9 here for 30 years, he's not stubbed their toe, and we
10 can go ahead and let them continue to work without a
11 chaperone, even though the supervising physician has
12 to have a chaperone. You can then look case by case
13 and decide, no, this is really part of their scope of
14 practice, so the PA needs to move on. But that would
15 give you the latitude.

16 DR. JOHNSON: What do you think, George?

17 DR. HEYE: It's up to the group.

18 DR. JOHNSON: I know. I mean, you're the
19 one getting most of the phone calls.

20 DR. HEYE: Well, the last thing I want to
21 tell the PA is you don't need a chaperone. I know
22 it's just an example.

23 DR. JOHNSON: I know.

24 MS. CARTER: Well, I think that's a good
25 suggestion, to say generally we're going to say you

1 are limited, but we'll look at it. And if we think
2 you don't need a chaperone, you know, that that can be
3 outlined then in the order.

4 FACILITATOR THOMPSON: And do you want the
5 two sections together or do you want to keep them
6 separate, the prescription separate from the general
7 disciplinary?

8 DR. JOHNSON: It sounds like they should be
9 separate, based on George's experience.

10 FACILITATOR THOMPSON: So we're going to
11 keep them separate. In 105 we're going to add that
12 little extra that basically goes back to if there's --
13 that the orders are going to identify what can and
14 can't happen. And then the prescription piece needs
15 to be tweaked just a little bit, Dr. Heye?

16 DR. GREEN: Could you not add the same
17 qualification to that? How would you feel about that?
18 The same qualification that they just added to this
19 one about, in general, we're going to restrict
20 prescribing the same way as the physician, except --

21 MS. DALE: Except or unless otherwise
22 indicated by the commission.

23 MS. CARTER: I would say authorized.

24 MR. DALE: Or authorized, all right.

25 DR. MARKEGARD: And then add a statement.

1 You may want to suggest -- maybe suggest that you get
2 another primary physician.

3 MS. DALE: Well, and that would certainly
4 be -- Yeah. Again, I'm thinking single doc, single PA
5 out somewhere, maybe not a broken leg, but it's, you
6 know, a bad ankle strain.

7 DR. JOHNSON: They own their home. It's not
8 easy to pick up and move when they've devoted their
9 whole time and life to a community, and now you're
10 restricting them. Do we want to keep people
11 practicing health care?

12 MS. DALE: Yeah.

13 DR. JOHNSON: And even though there's
14 some -- Even with the doc that's under some
15 supervision, we want to keep them working if it's
16 possible. We don't want to limit them so much that it
17 takes them out of the community, unless they are
18 onerous.

19 DR. GREEN: I would recommend the same
20 qualification on the prescribing one as for the one in
21 105. Does that seem right to you?

22 DR. HEYE: Yeah, we can try the language and
23 see if everyone agrees the next go-around.

24 FACILITATOR THOMPSON: Okay. Yeah, we're
25 moving on.

1 MS. DALE: We've got a twofer this time.

2 FACILITATOR THOMPSON: We got a twofer. And
3 osteo is okay with it, right?

4 DR. MARKEGARD: Yes.

5 FACILITATOR THOMPSON: So the next section,
6 Physician Assistant Licensure - Qualification and
7 Requirements, it's a whole new section. I don't have
8 any notes. Is that one that the department had a task
9 to work on?

10 DR. GREEN: Which number is it?

11 FACILITATOR THOMPSON: It doesn't have a
12 number, but it immediately follows 035. So it's
13 question mark, question mark, question mark.

14 DR. GREEN: Question marks. Okay, got it.

15 MR. CAIN: Most of this language I believe
16 was brought over from the hospital.

17 FACILITATOR THOMPSON: Yes. Yeah, this is
18 new for you guys.

19 MS. DALE: His has been cut and moved over
20 from osteo to here.

21 FACILITATOR THOMPSON: Okay. So this is one
22 that we need you all to look at and see if it's
23 working for you.

24 Yes, sir.

25 DR. HEYE: Further Section 080 --

1 FACILITATOR THOMPSON: You're skipping
2 ahead.

3 DR. HEYE: -- is almost identical.

4 DR. GREEN: Yeah, I was going to say this is
5 redundant.

6 FACILITATOR THOMPSON: Did we get it in
7 there twice?

8 DR. HEYE: I think we tried to create a new
9 one and it turns out to be very similar to one already
10 in here.

11 FACILITATOR THOMPSON: Oh.

12 MS. DALE: It can be one or the other, but
13 not both.

14 FACILITATOR THOMPSON: We wanted to make it
15 very clear.

16 MR. CONCANNON: 080 repeats the question
17 mark one?

18 FACILITATOR THOMPSON: Yes.

19 MR. CONCANNON: And it also repeats the one
20 that's after that, 050. 918-050. A lot of that stuff
21 is --

22 MS. DALE: Well, 050 is for interim.

23 MR. CONCANNON: Yeah. And look at what it
24 says under 050, and then look at what 080 says.

25 DR. HEYE: Yeah. And what I suggested is

1 taking one line out of the interim one and sticking it
2 in 080 under (4) or (5)(b). I liked 080 the way it
3 was, and then I made a one-line insertion there.

4 MR. CONCANNON: 050 and 080 are redundant,
5 so however you want to deal with it.

6 FACILITATOR THOMPSON: I think -- The
7 question I have as a note is do we want to keep them
8 together or was it better and more clear to have them
9 separate? I know it would be redundant. But somebody
10 in the rule looking for the interim permit piece,
11 would they know to go and look in here? Or do we keep
12 to keep them separate so it's very clear what applies
13 to who, even though they are very similar? It's your
14 guys' choice.

15 MS. CLOWER: I would say keep them separate
16 so somebody can go to the title and look for interim
17 permit. Don't you think?

18 MR. CONCANNON: Where is the title for
19 interim permit?

20 FACILITATOR THOMPSON: In 050. And then --.

21 MR. CONCANNON: 080, Requirements For
22 Licensure, including interim permits.

23 FACILITATOR THOMPSON: It doesn't say that.

24 MR. CONCANNON: It would. It would, it
25 could. In a perfect world, it would. It could, it

1 would. You can dream. I can dream.

2 FACILITATOR THOMPSON: You like less, right?
3 Less is more to you?

4 MR. CONCANNON: Yeah.

5 DR. HEYE: The RCW for PAs sticks the
6 interim permit sentence right in the middle of all the
7 requirements. It's on 18.71.020.

8 FACILITATOR THOMPSON: Okay.

9 DR. HEYE: Which is why we just followed
10 along with that and stuck it in there, because all the
11 requirements for licensing would be all the same for
12 all those people.

13 FACILITATOR THOMPSON: Either way is
14 correct. If it's not a problem and we don't have
15 issues with people coming out and saying, I don't know
16 what my requirements are as an interim permit holder
17 and I don't know where to find them, then I would say,
18 if you want to keep them together, it's totally fine.
19 There's nothing wrong with that. It's less. It's
20 less in your chapter. But if as a group you feel like
21 it needs to be separate because it needs to be easy to
22 identify, then separate them.

23 DR. MARKEGARD: I like the osteo's separate.

24 FACILITATOR THOMPSON: Osteo's will be
25 separate in this.

1 DR. MARKEGARD: It just seems more clear.

2 MS. CLOWER: I would go for clarity for
3 people who are not sitting here and later reading it,
4 yes.

5 DR. MARKEGARD: Because is there a separate
6 application paper for an interim permit?

7 MR. CAIN: I think they check. They just
8 check on the application.

9 MR. CONCANNON: They check in a box.

10 FACILITATOR THOMPSON: I know what one -- I
11 have a one to one, a 50/50 vote for medical. And I
12 think Dr. Heye is going with the combined, so I think
13 it's two to one. You guys decide how you want to
14 decide.

15 MR. CAIN: So this new section, it's already
16 there. We don't need this.

17 FACILITATOR THOMPSON: Yeah. I think that
18 can go away. We'll just double check and make sure
19 there is nothing missing, but I think that can go
20 away.

21 DR. HEYE: I don't mind having a section
22 entitled Interim Permits, and all you need to do is
23 put in the same application requirements apply to the
24 interim permit as it does for the other.

25 DR. GREEN: What is the difference?

1 DR. JOHNSON: The difference is you have one
2 year to get your certification. And so you could just
3 have a subsection in -- You could have one section and
4 subsection that says, For interim permit holders, you
5 have one year to complete your certification.

6 DR. HEYE: Yeah. But I think what we're
7 talking about is having its own separate section.

8 DR. JOHNSON: I understand.

9 DR. HEYE: So people looking at the
10 beginning can find it easy. I don't care. Either
11 way, as long as it's in there.

12 FACILITATOR THOMPSON: Okay. Linda.

13 MS. DALE: I think what we could do is
14 strike everything on the interim permit, 050, strike
15 anything after (4). And in (3) it says, An applicant
16 applying for a physician assistant interim permit, and
17 you must submit application or whatever, you could
18 just say, MUST submit application as outlined on 080.
19 And then that way they go to 080, and then that tells
20 everything about AIDS instruction and all that kind of
21 stuff.

22 MR. CONCANNON: That is the solution. That
23 is the solution.

24 FACILITATOR THOMPSON: I was like I think
25 we're going to have a great solution here.

1 MR. CONCANNON: This portion has been
2 answered. All right?

3 FACILITATOR THOMPSON: Yup. Are you guys
4 okay with that?

5 MR. CONCANNON: That is the solution.
6 Perfect.

7 FACILITATOR THOMPSON: But you want to keep
8 yours separate.

9 MS. MARKEGARD: I agree with that.

10 FACILITATOR THOMPSON: Okay.

11 MR. CONCANNON: The one before that that has
12 a question mark, you're talking about just deleting
13 the whole thing?

14 MS. DALE: Out, yes. Take that out.

15 FACILITATOR THOMPSON: Okay. So both osteo
16 and medical are going to do the same thing. We're
17 going to just add a little sentence that leads them to
18 the permit application and keep the permit application
19 piece there. We are moving on.

20 MS. CARTER: And are we going to say
21 something about the one year?

22 FACILITATOR THOMPSON: Yes.

23 MS. DALE: Number (2) is already there about
24 the one year.

25 FACILITATOR THOMPSON: I believe that in my

1 notes, and I could be totally off, but in my notes the
2 next piece that we said that we would come back and
3 bring you guys language is in the new Section 082.
4 And yes, that's skipping some sections, but I think
5 082 was the next one that we had an assignment on.
6 And it's just a little -- and that was that language
7 that --

8 MR. CONCANNON: Yeah, 082 is a brand new
9 section.

10 MS. CARTER: So this was sort of the
11 cooperation between the osteopathic board and the
12 medical commission to sort of speed up or have an
13 abbreviated application process, so that if you are
14 already licensed under the medical commission you can
15 get your license faster under the osteopathic.

16 MR. CONCANNON: Strangely enough, 082 is new
17 and it's creative and it's right.

18 FACILITATOR THOMPSON: Yeah.

19 MR. CONCANNON: It's right, right? Is 082
20 right?

21 DR. JOHNSON: No.

22 FACILITATOR THOMPSON: Oh, come on.

23 DR. JOHNSON: Well, wait a minute.

24 MR. CONCANNON: 082.

25 DR. JOHNSON: What does (1) read? So this

1 is an osteopathic PA.

2 MR. CONCANNON: Who wants to become an
3 allopath.

4 DR. JOHNSON: Okay. What does (1) say?
5 Verification of an unrestricted license as issued by
6 the MQAC. We didn't issue it. The board does.

7 MS. DALE: Yeah, that's the typo that I saw
8 too.

9 FACILITATOR THOMPSON: Oh, okay.

10 MS. DALE: So it needs to say issued by the
11 osteopathic board, or Board of Osteopath.

12 FACILITATOR THOMPSON: We got the idea. The
13 concept was there.

14 MR. CAIN: It was a cut and paste thing.

15 MR. CONCANNON: It was a glitch.

16 FACILITATOR THOMPSON: So good catch.

17 DR. MARKEGARD: And then on the osteopath,
18 it does say that, just to make sure. On then on
19 number (1), verification of an active, unrestricted
20 license as an osteopathic physician assistant issued
21 by the Washington State Medical Commission. So it's
22 not osteopath physician assistant issued. It should
23 be allopathic.

24 DR. GREEN: It should the other way around.

25 FACILITATOR THOMPSON: So are we good with

1 that one too?

2 DR. GREEN: Yes.

3 FACILITATOR THOMPSON: So my notes show that
4 that was all the new stuff that we came back. So we
5 have -- We kind of have two options, right?

6 So one of the options is, on our agenda we said
7 that we were going to revise and work on the
8 delegation agreement forms, and this is the time to
9 talk about those. But if there's something -- And
10 we'll go back and look at the language and see if we
11 can identify some sections that were like totally and
12 completely done with and maybe you guys are ready to
13 take to your board or commission.

14 But if you want to talk about some of these
15 sections again, if you have additional thoughts, we
16 can ramble through those sections to talk about that.
17 That's acceptable. You guys decide.

18 MS. DALE: My only concern is that on the
19 Remote Site - Utilization, which is 120, that the way
20 this wording is I feel does not really reflect what
21 the statute now says. Because it says, "The
22 commission will consider each request on an individual
23 basis," but, let's see, just prior -- I'm looking at
24 (c), (2)(c). "Physician demonstrates that adequate
25 supervision is being maintained by an alternate

1 method." And, you know, I don't know if we need to
2 use the word: Such as telecommunication to more
3 closely reflect the statute. That's the only concern
4 because --

5 FACILITATOR THOMPSON: Where are you?

6 MS. DALE: So 120, Remote site. So under
7 (2)(c), "The responsible supervising physician spends
8 at least ten percent" blah, blah, blah. But if you
9 look second to the last line, "the supervising
10 physician demonstrates that adequate supervision is
11 being maintained by an alternate method." And the
12 statute really says that it authorizes
13 telecommunication be used in lieu of that ten percent
14 time, so do we need this rule to more closely reflect
15 what was in statute?

16 FACILITATOR THOMPSON: So that's existing
17 language, and you're saying that potentially is
18 incorrect.

19 MS. DALE: Well, I'm just asking, should it
20 be more reflective of the statute language?

21 MS. CARTER: So this is -- I don't think
22 we -- I'm not looking at the track changes.

23 FACILITATOR THOMPSON: Yeah, I think it's
24 existing.

25 MS. CARTER: Well, it's something that we

1 can certainly revisit because of the changes in the
2 statute.

3 DR. HEYE: The RCW had "such as
4 telecommunication" after it.

5 MR. CAIN: Yeah. So should we add that?

6 DR. HEYE: Such as.

7 FACILITATOR THOMPSON: Oh. Would you like
8 to have it in there as including, but not limited to?

9 MS. DALE: Well, again, if a potential
10 employer is looking at this, then that perhaps would
11 indicate the alternate method that would be
12 acceptable. Because then the commission will consider
13 each request on an individual basis. Then they -- you
14 know, it might set them -- might put them off of doing
15 that. So I'm just asking.

16 FACILITATOR THOMPSON: But we don't want to
17 limit it to just that.

18 MS. DALE: But you have to say "such as,"
19 which is what the statute reads.

20 FACILITATOR THOMPSON: I would say "such
21 as." I would say "including, but not limited to,"
22 right?

23 DR. MARKEGARD: I don't think osteo has that
24 language.

25 MS. DALE: That was passed in the statute

1 before.

2 MR. CAIN: Yeah, it says "such as" in the
3 statute.

4 MS. DALE: I mean, the osteo should have it
5 because that was included in the statute changes.

6 MR. CAIN: And that is the Remote Site -
7 Utilization.

8 MR. CONCANNON: Well, most off 918-120 is
9 the statute. And the question is why is there a
10 918-120 that repeats word for word, sentence for
11 sentence, what the statute says, as a question of
12 rulemaking, Ms. Heather?

13 MS. CARTER: I think it's in there just to
14 be -- really it does mirror the statute, and you could
15 say you don't need it if you want to just rely on the
16 statute. I think it's probably helpful for people,
17 PAs, going to one source document, to have all the
18 information in one place, but that's, you know, a
19 preference. It's not a legal requirement.

20 FACILITATOR THOMPSON: Your other option
21 would be to keep the section, but just have a little
22 sentence that says, you know, must comply with RCW
23 blah, blah, blah. You're not repeating what's in the
24 statute. Every time the statute doesn't change. But,
25 like Heather says, they have to go to a different

1 source.

2 So that's something you all have to weigh the
3 pros and cons of and decide. Because you're right,
4 every time the statute changes, you have to go and
5 update your rule. I don't think that's a bad thing
6 because it gets you to looking at your rule and making
7 sure that it's up to date, but it is up to you.

8 MR. CAIN: It is there in osteo?

9 DR. MARKEGARD: Uh-huh.

10 MR. CAIN: So I don't know if we want that
11 or not.

12 DR. MARKEGARD: I just didn't know if we had
13 to say that in there. I think alternate method
14 seems --

15 MR. CAIN: Because it's the same language in
16 the statute, but the statute now says that
17 telecommunication piece. So I don't know that one way
18 or the other. This is what the statute says.

19 FACILITATOR THOMPSON: It's up to you all as
20 a recommendation to your peeps.

21 DR. HEYE: If you're going to quote from the
22 statute, I would rather keep the words in rather than
23 dropping out words because I think the statute is --

24 DR. GREEN: Is easily confusing.

25 DR. HEYE: It is what it is.

1 FACILITATOR THOMPSON: And if you want it to
2 be identical and say "such as," that's not
3 unacceptable. That's fine. I think it's unclear to
4 say it that way. It's just a different writing style.

5 Typically the department in our -- we say
6 including, but not limited to. But whoever drafted
7 this bill, they just used a different writing style,
8 and it's fine.

9 MS. CLOWER: I like that, included, but not
10 limited to, because it makes people think okay, so
11 there are other ways. And something else that will
12 come up with new technology that we don't know about
13 will be included there.

14 FACILITATOR THOMPSON: Okay. So the million
15 dollar question on the table is do we keep this
16 section, (1), do we keep this section with a repeat of
17 the statute language, or do we keep this section and
18 just reference the RCW and not have all the language
19 in there? Your choice.

20 DR. MARKEGARD: I think actually the
21 language is fine.

22 FACILITATOR THOMPSON: You like the
23 language.

24 DR. MARKEGARD: And I'm not usually into
25 more words, but I think this is good, especially since

1 the remote site - utilization is such a big deal. So
2 I think we need to reiterate that when possible.

3 FACILITATOR THOMPSON: So osteo is going to
4 keep the language. Medical?

5 DR. GREEN: I vote for that.

6 FACILITATOR THOMPSON: Not that you have to
7 vote.

8 DR. GREEN: But I'm in favor of it, what she
9 just said.

10 FACILITATOR THOMPSON: Okay.

11 DR. JOHNSON: I think it's critical that
12 it's very legible.

13 FACILITATOR THOMPSON: Okay. So is there
14 anything else that you guys want to go back and look
15 at? Yes, Dr. Green?

16 DR. GREEN: Under delegation agreements,
17 Section 055, number (2), it talks about providing
18 services that they are competent to perform based on
19 their education, blah, blah, blah, and then it
20 switches over and starts talking about procedures.
21 And my suggestion would be to change the word
22 "procedures" in the last sentence to "services,"
23 because there are things they do that are not
24 procedures, and I think that is intended to apply to
25 everything they do, not just procedures.

1 MR. CONCANNON: You're in delegation
2 agreements, Dr. Green?

3 DR. GREEN: Yes.

4 MR. CONCANNON: Because we haven't discussed
5 any of that yet.

6 DR. GREEN: Are we going back to that?

7 DR. HEYE: This is in 055.

8 MR. CONCANNON: Isn't that delegation
9 agreements?

10 DR. HEYE: Yeah, but there's a delegation
11 agreement page.

12 DR. GREEN: We're talking -- We're going to
13 discuss the form, not this section. If you're going
14 to go back to it, I'm sorry, I didn't know that.

15 FACILITATOR THOMPSON: No, no, you're fine.

16 MR. CONCANNON: Oh, hold it. The section
17 itself hasn't been discussed yet either, has it?

18 DR. GREEN: Just try to keep up.

19 MR. CONCANNON: Today?

20 FACILITATOR THOMPSON: Not today.

21 MR. CONCANNON: I haven't even started
22 dealing with the delegation agreements. I mean, I
23 gave you all sorts of comments about delegation
24 agreements before.

25 FACILITATOR THOMPSON: Yes.

1 MR. CONCANNON: Which you have continued to
2 ignore.

3 FACILITATOR THOMPSON: No, we are not
4 ignoring.

5 MR. CONCANNON: So if we're ready to get
6 into that, we might as well just --.

7 FACILITATOR THOMPSON: Okay. And then the
8 question on the table would be do you want to discuss
9 the rule language or do you want to discuss the forms,
10 and then based on the forms, then they could lead to
11 modify the rule language so that we are in sync.

12 MR. CONCANNON: What would you like to do?

13 DR. VANDERGRIFT: This is John Vandergrift
14 from Group Health. We have a question also in this
15 same action in paragraph (6) where it describes if
16 there's a significant change, and it seems like the
17 term significant change is a bit vague. And actually
18 we spoke with our counsel for Group Health, and we
19 were wondering if there can be some clarification of
20 that or like what construes a significant change that
21 should be sent to the board.

22 Like, for example, what it could be construed to.
23 We have changes in membership of our medical group.
24 Is that something that would make a needed change for
25 change of discipline for a PA? Really some of

1 guidance with that is something that would be helpful
2 to us.

3 FACILITATOR THOMPSON: Okay. And the
4 question would be, going on that, do you want to put
5 those significant changes -- And I understand what
6 you're saying. But do you want those in rule, where
7 you have to, or do you want guidance where you could
8 do it in policy.

9 DR. VANDERGRIFT: I think it would help us
10 really as much as anything just to have some guidance
11 so that we know the mindset of the board, for what the
12 significant change and what something that's not so
13 significant is really you would not be expecting us to
14 report to you.

15 DR. JOHNSON: So John, this is Mark Johnson,
16 and I came up with a thought about the same thing.

17 So as health care is evolving and changing,
18 urgent care offices are being opened up at different
19 sites, does each new site have to be then notified by
20 address to the commission where a PA might be sent to
21 because there's a staffing issue?

22 Or as institutions integrate together and,
23 instead of two separate institutions, become one
24 institution or have an umbrella institution, how much
25 of that needs to -- for each PA and each delegation

1 agreement, how much do we expect to be notified?

2 And certainly broad big changes might be
3 important. I'm not sure if Group Health or Zoom or
4 Virginia Mason opens up another urgent care office
5 someplace, that the commission really cares, as long
6 as they're licensed under that entity. I don't know
7 what George thinks about it.

8 But how much -- how many times -- or you add --
9 Anyway, that's the thought I've been kicking around,
10 is how much do we expect them to report back to us
11 every time there's some change.

12 DR. MARKEGARD: Yeah, you're right. And I
13 don't think it's necessary to report all those changes
14 because I'm not sure we really care. But if you list
15 the group as the second, as your alternate, then it's
16 that group, whether that group is now 20 physicians
17 and it was ten or now there's ten sites instead of
18 eight, it's still in that group. So I don't think
19 it's necessary to report that change.

20 DR. HEYE: I agree.

21 MS. CARTER: What if it's cross specialty?

22 DR. HEYE: I think if there's a significant
23 change in the PA's practice, and I think that's a good
24 example. For example, if the PA goes from working in
25 a primary care clinic to an ER, I think that's a

1 significant change. Or goes to work in general
2 surgery or orthopedics, that's a big change for the
3 PA. It ought to be in the file that we are at least
4 told about it.

5 FACILITATOR THOMPSON: Or would it be like
6 if the clinic is no longer doing a service or not
7 providing a service, and it's a major service, we're
8 no longer doing -- Is that something?

9 DR. HEYE: (Shaking head negatively).

10 FACILITATOR THOMPSON: No, okay.

11 MS. DALE: This is actually dealing with the
12 delegation agreement. And like Dr. Heye said, if we
13 just put in there any significant changes in PA
14 practice, then that might -- then that takes away all
15 of your questions about, well, this group or that
16 group. We're talking about the practice of the PA.
17 Or would that be reflective of what you wanted?

18 DR. GREEN: Scope of practice maybe.

19 DR. VANDERGRIFT: I think that would give us
20 the kind of clarification that we're looking for. So
21 that's helpful.

22 MR. CONCANNON: What, notify in writing of
23 any significance changes in the scope of practice of
24 the PA under the delegation agreement?

25 MS. DALE: Or just like he has delegation

1 agreement, to notify significant changes in the
2 physician assistant scope of practice.

3 MR. CONCANNON: Yeah, because that is really
4 what you're interested in.

5 MS. DALE: I think so.

6 MR. CONCANNON: As opposed to the internal
7 workings of Group Health.

8 DR. MARKEGARD: If there's a significant
9 change in scope of practice, you are doing primary
10 care family practice and then you go to do OB or
11 surgery, wouldn't you then have a difference -- a new
12 primary sponsored physician, so you're going to change
13 the delegation agreement anyway?

14 MS. DALE: Right, you would. But say where
15 you're working urgent care and your supervising
16 physician is already an ER doc, but you're working
17 urgent care hallway, and then they decide you need to
18 go over to the emergent care hallway, then that would
19 be maybe a scope of practice change.

20 DR. MARKEGARD: But if you have the same
21 primary sponsoring physician and you've still been
22 working under the scope of that doctor --

23 MS. DALE: That's true.

24 DR. MARKEGARD: -- then it shouldn't need it
25 to be changed.

1 FACILITATOR THOMPSON: We have a comment.

2 MS. THOMPSON: I'm Jamera Thompson. I can
3 come up with an example in our own practice where we
4 have a PA who spends a lot of time in surgery, but
5 there is an ENT who sometimes needs a surgical assist.
6 And under the current, the way they are interpreting
7 it is, because they got permission from the overseeing
8 primary, it is okay to allow their PA to assist the
9 ENT. We're an OB/GYN group. Is it okay?

10 As a PA, I felt uncomfortable with that because
11 that's not how I interpret it. I think there should
12 be a separate or maybe two primaries in different
13 fields where 80 percent of your time you're in this
14 field and 20 percent of your time you're in this
15 field, and when you're over here this guy is
16 overseeing you and when you're over here this person
17 is overseeing you.

18 I think in a -- Because it can happen. It's in
19 our scope of PAs to be able to do that. And I think
20 big organizations like to be able to move their PAs
21 around, but I always feel uncomfortable that I'm going
22 to get moved somewhere that I'm legally not really
23 covered.

24 DR. GREEN: That's number (5) currently in
25 the proposed language.

1 MS. THOMPSON: Okay.

2 DR. VANDERGRIFT: Agreed. That's actually
3 how we operate at Group Health, is that if we have a
4 PA who's providing services in more than one medical
5 discipline, that PA is required, for us at least, is
6 required to have a sponsor in each of those
7 disciplines in which that PA practices.

8 MR. CONCANNON: All right. So we're in the
9 wording now of 055? Is that what we're talking about,
10 in general?

11 FACILITATOR THOMPSON: As long as everyone
12 agrees with that, that's where we can start. It's up
13 to you.

14 MR. CONCANNON: 8-055, number (2), second
15 line, "and which are consistent with," I assume that
16 probably should say "the delegation agreement," as
17 opposed to "this delegation agreement." With the
18 delegation agreement.

19 In number (4), "The delegation agreement, at a
20 minimum, shall specify," is that good wording, (c),
21 "An accounting of the supervision process for the
22 practice"? What does that mean?

23 DR. HEYE: Why don't we say detailed
24 description.

25 MR. CONCANNON: Detailed description of the

1 supervision.

2 DR. HEYE: I never liked that word.

3 MR. CONCANNON: I feel like we should be
4 adding up numbers or something. Detailed description
5 of the supervision process.

6 DR. HEYE: Or you can just say description.

7 MS. DALE: Yeah. How detailed is detail?
8 So just say description.

9 DR. HEYE: Well, the biggest problem with
10 that section is the description is too vague. But
11 that's okay, it doesn't matter.

12 MR. CONCANNON: But your form is going to
13 pick up what you want from them, right?

14 DR. HEYE: Hopefully.

15 MS. DALE: Yeah.

16 MR. CONCANNON: Once we get to that.

17 (D), "The location of the practice including
18 remote sites and the amount of time spent by the
19 physician assistant" and sponsoring or supervising
20 physician at each site, whatever the word is, sponsor/
21 supervisor, whatever Dr. Heye is coming up with.

22 DR. MARKEGARD: Does it need to say that?
23 Because if it's at a remote site -- by definition, a
24 remote site --

25 MR. CONCANNON: You've got to know how much

1 time they're spending there, though.

2 DR. MARKEGARD: But by definition, the PA --
3 Because I think on the forms it does say that the PA
4 has to say what percent of time they're spending at
5 their location. But, by definition, if it's a remote
6 site, then the sponsoring physician is spending less
7 than 25 percent of their time at that site, right?

8 DR. GREEN: You've already got that in (c),
9 which you wanted to change.

10 MR. CONCANNON: (C)?

11 DR. GREEN: Yes. The description of the
12 supervision process for the practice, not an
13 accounting. Supervision.

14 MR. CONCANNON: Supervision process.

15 DR. GREEN: Yes. Isn't that what you're
16 asking for?

17 MR. CONCANNON: Is that description going to
18 get to the amount of time?

19 DR. HEYE: Well, the delegation agreement
20 form asks for the amount of time.

21 MR. CONCANNON: There you go.

22 MR. CAIN: So do they want that in?

23 DR. HEYE: It's important because the law
24 says it's supposed to be ten percent, but that can be
25 waived. And a lot of people write down zero because

1 it's a specialized practice only a few hours a month.
2 There's all kinds of things that enter into it.

3 FACILITATOR THOMPSON: Okay.

4 MR. CONCANNON: I guess we could throw it
5 away.

6 FACILITATOR THOMPSON: It was a good idea,
7 though.

8 MR. CONCANNON: Number (6) has been dealt
9 with by discussion.

10 Number (7), If there's a termination of the
11 working relationship, a letter should be submitted
12 indicating the relationship has been terminated,
13 period.

14 MS. DALE: Yeah.

15 MR. CONCANNON: And may summarize their
16 observations? What is this, some short of mooshy
17 gooshy stuff?

18 Except as may be authorized by commission? When
19 would we authorize such an exception? You've got to
20 know it's been terminated. They can talk all they
21 want about it.

22 MS. DALE: Because actually by law, if
23 there's any inappropriate conduct, that we should be
24 reporting that anyway, so.

25 MR. CONCANNON: Oh, yeah.

1 FACILITATOR THOMPSON: So are we okay with
2 that, everyone?

3 MR. CONCANNON: Should be terminated.

4 DR. MARKEGARD: Yeah.

5 MR. CONCANNON: And I think this is a
6 section where you continue to ignore the fact that
7 this is the section that's ultimately going to have to
8 say that no delegation agreement is going to be
9 approved if the licensee has as ownership interest in
10 the practice that employs the sponsoring commission.

11 DR. MARKEGARD: No.

12 MS. CLOWER: Yeah.

13 MR. CONCANNON: It's my prediction that the
14 commission is not going to approve anything that
15 allows the PA to employ his sponsor. That's my
16 opinion.

17 MS. CLOWER: I contacted one PA in
18 Tri-Cities. He has several clinics and he is
19 co-partner with physicians, so. And he has one in
20 Walla Walla, two in --

21 MR. CONCANNON: He's a great entrepreneur,
22 he's a great physician assistant. He's not allowed to
23 employ his supervisor. He now allowed to employ him,
24 control him.

25 MS. CARTER: I can give you just one -- a

1 couple of things. So there are statutes set by the
2 legislature that allow professionals to incorporate
3 together, so there's professional service corporations
4 and LLCs for health care professionals. PAs are
5 specifically listed as being able to incorporate
6 either by themselves or with a physician, and they can
7 practice and own together. So we have no authority to
8 change that --

9 MR. CONCANNON: Right.

10 MS. CARTER: -- and restrict business
11 entities.

12 So could it be possible to frame this as a
13 supervision issue or conflict issue? Possibly. But I
14 think there is some risk in trying to delineate who
15 can own what business and how the businesses are run.

16 MR. CONCANNON: They can own all the
17 businesses they want, Heather. They cannot employ
18 their supervisor. That's all I'm trying to get at.
19 They can't control their supervisor. They cannot open
20 up a PA practice and control the pay and the hours and
21 the hiring and firing of the person that's supposed to
22 supervise them. They are going to have to get
23 somebody that's going to have to be at a remote site.
24 You are going to have to get somebody off site to come
25 in and supervise them. That's where I'm saying the

1 conflict is.

2 MS. CLOWER: Yeah, you're going to have to
3 get a person from off site to come in and supervise
4 them, but they still have to pay them.

5 MR. CONCANNON: If they have to pay them,
6 they have to do what -- Again, it's their decision
7 whether they want to open up a practice, it's their
8 decision whether they want to incorporate, make money,
9 do whatever they want, but they cannot employ their
10 supervisor.

11 MS. CLOWER: In reality, they will employ
12 their supervision because that person is not going to
13 do it for free.

14 MR. CONCANNON: Oh, no, no, no, no, no. But
15 the supervisor has got his own practice elsewhere.
16 He's not dependent on the PA in order to eat every
17 day.

18 MS. CLOWER: Yeah, but that's part of the --
19 that's the business of the supervision physician, not
20 of the PA. Am I explaining myself?

21 If you're my supervising physician and I want to
22 hire you and you agree to it --

23 MR. CONCANNON: If I have a practice and I'm
24 a PA and I've employed -- and I have as an employee an
25 MD, and that MD is stealing drugs, and I'm supposed to

1 report that to the commission, I have an incentive not
2 to report it because, if I report it, I have closed my
3 own practice down.

4 MS. CLOWER: No, no, because I know what
5 he's doing. I'm going to call Dr. Heye and say, Hey,
6 he's doing this; can you get me another preceptor?

7 MR. CONCANNON: Well, no, no, he can't get
8 another preceptor. You have to go get another
9 preceptor.

10 MS. CLOWER: And I've done that. Actually
11 I've done that. I had a supervising physician who
12 tried to commit suicide, and she was my only
13 supervisor. So I took her to a mental health
14 hospital, I went to a hospital and I said, I need
15 another supervisor because I'm in a remote site. And
16 they got me another doctor, you know.

17 MR. CONCANNON: I'm talking about who owns
18 the practice.

19 DR. JOHNSON: But Mike's position is making
20 a different statement. He's saying that if you own
21 the practice and your ability to keep the doors open
22 is to keep that supervising physician working so that
23 you can keep working, you're less -- you might have a
24 conflict. You might have a conflict.

25 And Mike's position is not to say you can't own a

1 business, but he's making a real I think valid
2 argument that you shouldn't be employing your
3 supervisor, supervising physician. He's not saying
4 you can't own the business or the practice, but the
5 supervising physician either has to be equal or --

6 MR. CONCANNON: Above.

7 DR. JOHNSON: -- above. Otherwise how can
8 they supervise.

9 MS. CLOWER: Yeah. But how can I have a
10 supervising physician in my practice if I don't pay
11 them? You know, I don't employ them. Because they're
12 not going to do it as a favor.

13 DR. MARKEGARD: Right. But there's the
14 problem. So you should own it and just not work
15 there. Right? You can own the practice.

16 But that's a conflict, then, because then you
17 can't -- if your supervising physician gets into
18 trouble and you have to fire that person, then you
19 can't keep your doors open without scrambling for
20 another person that you again have to hire and pay.
21 It's a conflict of interest.

22 MS. CLOWER: Didn't she just say that state
23 law says that you can do it?

24 DR. BRUEGGEMANN: They're different.

25 DR. MARKEGARD: State law says you can own a

1 practice.

2 MR. CONCANNON: You can own a practice.

3 DR. MARKEGARD: But it would probably be
4 best for you to own the practice and make money from
5 the ownership of the practice, but just not work in
6 the practice where you have to have a supervising
7 physician.

8 MR. CONCANNON: Again, just go back to the
9 way the statute is written. If the PAs want to get
10 this whole thing changed, they can go to the
11 legislature and change it. They didn't do that.

12 A physician assistant licensed in this state
13 shall apply to the commission for permission to be
14 employed or supervised by a physician or physician
15 group.

16 Now, you're saying that does not contemplate --
17 not only are they applying for permission to be
18 employed by a physician, they're going to own the
19 practice and employ the physician. The physician is
20 supposed to be employing the -- the MDs employ the PA,
21 not the other way around.

22 MS. CLOWER: Right. But the problem is that
23 if a physician assistant wants to open a practice, a
24 physician assistant cannot open a practice without a
25 physician.

1 MR. CONCANNON: You bet they can't. And
2 that's probably a constraint on their ability to open
3 up practices. I agree with that in the real world.

4 MS. DALE: Okay. So then this supervising
5 physician who lives out in -- with a PA and he has
6 gotten in trouble with MQAC because he wrote
7 narcotics, and we just talked about how if we can
8 allow that sole provider of health care in that
9 community, you're now saying that physician can't
10 write the prescriptions. So what's going to happen?
11 That guy is going to leave town. So here's a PA left.

12 And this is what happened in Prosser. So he then
13 had kept that clinic opened and then hired someone to
14 be his supervising physician. They came to town. It
15 was a couple. Eventually they bought him out. But
16 during that time, he was the provider of medicine in
17 that clinic in Prosser, or outside of Prosser. But,
18 anyway, so that's why, you know, we can't just assume
19 that there's going to be a conflict.

20 If you would pull up Dr. Ramsey's letter, it's
21 not just a PA/physician relationship that can go bad.
22 If you look at how -- In some organizations it's just
23 a crank them out, crank out the patients, because the
24 owner of that clinic doesn't care, you know, about
25 care of the patient. They want their numbers, they

1 want their money. How is it different?

2 It's still -- you're going to have unscrupulous
3 people doing this. So why handcuff someone who -- You
4 know, if a physician and a physician assistant can't
5 have a collegial relationship -- I mean, I don't think
6 I can hire a physician to come oversee me unless they
7 know me and want to help me out in my office. Why
8 would they? Why would they put themselves at risk.
9 They're going to be really careful about entering that
10 partnership.

11 You know, this has gone over for years. This has
12 been, you know, a situation. How many times has it
13 become a conflict in front of either of the boards?
14 Are we worrying about something -- I mean, because the
15 physician, if they're feeling like they are not able
16 to manage or supervise that PA, aren't they going to
17 walk with their feet? There are plenty of other jobs
18 that that physician could get to.

19 MS. CLOWER: Yeah.

20 MR. CONCANNON: I don't know. I don't need
21 to say any more about it. I've given you my opinion.
22 I've told you what I think is going to happen. You
23 all can, you know --.

24 FACILITATOR THOMPSON: So, I mean, it's the
25 group's decision of what they want to do.

1 So we have one opinion where we maybe should be
2 drafting some language that puts a limitation on the
3 PA/supervisor's business relationship. We have legal
4 opinion that we under your statutory authorities
5 really can't limit or dictate how somebody runs their
6 business. So, as a committee, you all need to decide
7 what it is you want to take forward to your board and
8 commission.

9 MR. MATTHEWS: Clarification. Is it that
10 they don't have the statutory authority to dictate how
11 they run their business or the fact that they can
12 incorporate their business? It's two different
13 things.

14 FACILITATOR THOMPSON: Well, they don't have
15 authority and it would be contrary to the other
16 statute to say that they couldn't be a majority owner
17 or something in a medical practice. I mean, that is
18 set in statute that they could be in practice with
19 another physician or two physicians, or what have you.
20 So it explicitly lists PAs and MDs in those corporate
21 statutes.

22 You know, is it possible to frame this -- I think
23 you would have to be very careful in how you framed
24 this issue if you wanted to go forward with it as a
25 conflict issue and a supervision issue, rather than a

1 business entity issue, because I think you would run
2 into some real opposition and problems with the
3 business community. And there are risks involved in
4 doing that.

5 DR. GREEN: I would leave it out.

6 MS. CARTER: I think if you wanted to do --
7 you know, you could always do a policy on conflicts of
8 interest and outline, you know, here are some
9 scenarios we think are problematic, and watch out for
10 this watch out for that, if you wanted to.

11 DR. GREEN: My reason for saying that is
12 that this argument will go on endlessly. It won't be
13 resolved. And in the end, Mr. Concannon may be right
14 that no such practice agreement may ever be approved,
15 because ultimately it's going to come through these
16 forms and it's going to set in front of this guy
17 (indicating Dr. Heye) and he's going to make a
18 decision about it.

19 And I think that's the way it ought to be
20 handled, and I don't think we ought to put it in these
21 rules. I think it will create more problems than it
22 will help.

23 MR. CONCANNON: I don't think his delegation
24 form is going to ask people who owns the practice. Or
25 does it?

1 DR. HEYE: It doesn't.

2 MR. CONCANNON: It doesn't. And if it did
3 and you were to deny people a license -- I mean, if
4 you were to deny the delegation based on the fact that
5 they own their own practice, they're going to kill
6 you.

7 DR. HEYE: They haven't so far.

8 MR. CONCANNON: Have you denied it based on
9 the fact that they owned their own practice?

10 DR. HEYE: No.

11 MR. CONCANNON: I don't think so.

12 Anyway, that's just one little item out of this
13 055.

14 FACILITATOR THOMPSON: So we have like --

15 DR. VANDERGRIFT: This is John Vandergrift.
16 I do have one more question on paragraph (7). Where
17 it states that "Upon termination of the working
18 relationship, the primary supervising physician and
19 the physician assistant are each required to submit a
20 letter to the commission indicating the relationship
21 has been terminated," is it necessary for both to do
22 that or is it adequate for one party to submit that
23 letter of termination?

24 DR. MARKEGARD: One.

25 FACILITATOR THOMPSON: I have a vote for

1 one. Osteo Board votes for one.

2 MS. CARTER: And these rules are written
3 focused on regulating physician assistants, not
4 physicians, so it might be prudent to just say that
5 it's the PA's responsibility.

6 FACILITATOR THOMPSON: Good point.

7 DR. MARKEGARD: Yeah.

8 MR. CONCANNON: Make sure he heard you.

9 DR. VANDERGRIFT: One of the concerns that
10 my colleagues here just raised is that if it's
11 necessary for only the PA to do that, but it's not
12 adequate for the physician to do so, we occasionally
13 have had situations in Group Health where we have had
14 the PA go out on leave and very difficult to get ahold
15 of, if not virtually impossible, and then it becomes
16 challenging for us to terminate the agreement there,
17 which would free up the physician to sponsor other
18 PAs. And so our question would be, is it satisfactory
19 for either the PA or the sponsoring physician to
20 submit the letter?

21 MS. MATHISON: This is Alex Mathison at
22 Group Health. Realistically, the Department of Health
23 has been allowing both the MD or the PA to terminate
24 the plan so far. So my point is, if that is the rule
25 and the current practice, it seems like either should

1 suffice.

2 MS. CARTER: But I think if you read the
3 rules, either person can terminate the relationship.
4 I mean, it's an agreement between the two. But we're
5 just requiring the PA to notify us. The physician of
6 course can on their own notify if the PA hasn't, but I
7 think in this rule you're just saying, PA, you have to
8 do it; MD, you can. I mean, it's discretionary if you
9 want to.

10 FACILITATOR THOMPSON: And when you open up
11 the MD rules, you could always put that requirement in
12 there too.

13 DR. HEYE: Can you write this as an and/or?

14 DR. BRUEGGEMANN: What if you have a bad
15 situation where the PA gets fired and then refuses to
16 write the letter?

17 FACILITATOR THOMPSON: Do we know that the
18 MD rules do not also say that they have to submit?

19 MS. CARTER: No.

20 FACILITATOR THOMPSON: They don't.

21 MS. CARTER: I don't believe -- I think
22 they're silent to any of this.

23 DR. MARKEGARD: Is the goal just to make
24 sure that we are all notified that that delegation
25 agreement no longer exists?

1 MS. CARTER: Uh-huh.

2 DR. MARKEGARD: Then it shouldn't matter who
3 sends us the letter. And I think and/or would be
4 fine.

5 DR. GREEN: I agree.

6 DR. VANDERGRIFT: Yeah, I think and/or would
7 serve our purposes for what we actually see occurring.

8 MS. CARTER: This rule wouldn't put any
9 legal requirement on a physician. I mean, you can put
10 it in there and hope that it works, but this rule
11 regulates PAs.

12 MS. DALE: But by the same token, we're
13 talking about delegation agreements between a
14 physician and a physician assistant, so that's not
15 really saying anything to that physician either if you
16 look at that narrow definition.

17 MS. CARTER: I mean, I think if you want to
18 say either one party to the delegation agreement will
19 notify the commission it's been terminated, that's
20 fine, but I don't think -- you would never be able to
21 zing a physician for not doing it, I think.

22 FACILITATOR THOMPSON: Basically it would be
23 telling the physician assistant that they are required
24 to and be giving notice that the MD or DO --

25 MS. DALE: Could.

1 FACILITATOR THOMPSON: -- could also. Which
2 is totally fine.

3 DR. BRUEGGEMANN: It seems like this is
4 putting a real restriction on the PA that they have to
5 do it. If the other person has done it, if the
6 physician has already submitted a letter, I don't know
7 why we're required, which this is what this is saying,
8 is requiring the physician assistant to do the same
9 thing.

10 MS. CLOWER: There's no timeline after the
11 termination of the working relationship, so when do I
12 do this? Never mind.

13 DR. MARKEGARD: Right. Within 30 days of
14 something like that.

15 MS. CLOWER: Yeah. Because otherwise it's
16 like I could do it a week later, two weeks later.
17 Thank you.

18 FACILITATOR THOMPSON: Others have done
19 that. I think other professions do that, they say
20 within 30 days of termination.

21 DR. MARKEGARD: That's a good idea.

22 MR. CAIN: So are we saying and/or?

23 MS. DALE: Yeah.

24 FACILITATOR THOMPSON: Say or.

25 DR. MARKEGARD: Or.

1 MS. DALE: And then you want to take out
2 "each"?

3 DR. GREEN: Why don't you put shall submit.

4 DR. HEYE: The reality is that frequently
5 neither party tells us.

6 FACILITATOR THOMPSON: That would be a
7 problem too.

8 MS. DALE: So maybe you should put within a
9 certain period of time.

10 MR. CONCANNON: So, Dr. Heye, you can punch
11 a button under a physician's name and know how many
12 PAs they're sponsoring today, whether it's one, two,
13 three, four, five?

14 MR. CAIN: Yes. In the licensing system you
15 can look up the physician and also who he provides --

16 DR. HEYE: I don't have any idea.

17 MR. CONCANNON: And know how many PAs
18 they're sponsoring?

19 MR. CAIN: Yes.

20 DR. GREEN: He can't, but Julie can.

21 DR. VANDERGRIFT: Thank you.

22 FACILITATOR THOMPSON: Okay. So we now have
23 like 15 minutes. And I can go a few minutes longer if
24 we're not going to get in trouble by the hotel form
25 keeping the room, but do you guys want to tackle those

1 delegation agreement forms?

2 DR. MARKEGARD: That should be easy.

3 FACILITATOR THOMPSON: Okay. So these are
4 the forms that Brett sent out --

5 MR. CAIN: Just yesterday. I'm sorry.

6 FACILITATOR THOMPSON: -- yesterday.
7 There's copies in the back if anybody needs them.

8 I believe the group worked really hard at getting
9 the osteopath and the medical piece, the two forms, to
10 be very, very similar. Right?

11 MR. CAIN: Yes. So there's new language on
12 both forms about supervision on the second page. And
13 then we just tried to match them up as well as we
14 could. And these do have draft water marks on them,
15 but they sure didn't print very well, so.

16 FACILITATOR THOMPSON: Okay.

17 MR. CONCANNON: When would the physician
18 Group box on the front page be filled in? If there's
19 a primary physician, and let's say there's an
20 alternate physician somewhere else, is physician group
21 just information stuff, as opposed to supervisor
22 people?

23 DR. MARKEGARD: If the alternate is the --
24 if the group is the alternate.

25 MR. CONCANNON: If the group is an

1 alternate? Or is this -- I'm just curious in terms of
2 the way it gets filled in.

3 DR. JOHNSON: So in my previous group, one
4 of us surgeons might be selected as the sponsoring
5 physician, and then the group in total would be the
6 alternate, and it would be listed. Instead of listing
7 each of our names, it would list the group. And that
8 would be true whether it's Zoom, Group Health, an OB
9 practice.

10 That limits -- I mean, that just makes it easier.
11 And then the delegation agreement would then define
12 how that supervision is going to happen. But you
13 wouldn't have to list all the members that are all
14 potential of this, whether they're MDs or DOs.

15 DR. MARKEGARD: For clarity, do you think on
16 the form we need to say Physician Group and then on
17 there have "If used as an alternate"?

18 MR. CONCANNON: If used as an alternate. Is
19 that what you're getting at, Dr. Heye?

20 DR. HEYE: Yes.

21 DR. JOHNSON: That's a good suggestion.

22 DR. HEYE: The Physician Group at the bottom
23 section, is that what you're talking about?

24 MR. CONCANNON: Yes.

25 DR. HEYE: That's more of a business group

1 in terms of a lot of times the primary or the
2 sponsoring physician works for a group, but that
3 doesn't mean that there's a group of people. That's
4 a -- We don't use that except for --

5 DR. GREEN: So it would be like Virginia
6 Mason or Group Health or Seattle Fracture Clinic?

7 DR. HEYE: We had a business group recently
8 that was based out of Portland. The sponsoring
9 supervisor was going to be in Seattle at the time the
10 practice was taking place.

11 DR. JOHNSON: So then under Alternate
12 Supervising Physician we could say physician and/or
13 group, physician group?

14 DR. HEYE: Yeah. Or you could say -- A lot
15 of times they will list one name. But on page 2, if
16 you look on page 2 where it says Practice Site down at
17 the bottom there, "The PA will be in the same
18 practice..." When the PA is on duty, the supervising,
19 the sponsoring or alternate or MD member of the group
20 practice will be available, that's where the group
21 practice comes in.

22 MS. DALE: Then that makes it really
23 confusing because it looks like we should put that
24 physician group on the front page instead of listing
25 the 30 or 40 alternating physician names.

1 DR. HEYE: No, we're not asking for people
2 to identify an endless number of people. If there's
3 somebody more than the primary sponsor, it can be one
4 or twenty other people, we only ask that the
5 alternate -- the first alternate, if there is one.
6 But if the first alternate is a big group, then we
7 don't ask for anybody to fill that in.

8 MS. DALE: So that's not clear on this.

9 DR. JOHNSON: Yeah, I think I would
10 encourage clarity, because previously our PAs had to
11 list every single one of us. One would be supervising
12 and then each one of us that were an alternate was
13 listed.

14 DR. HEYE: Yes, okay. Most of the time that
15 doesn't happen, Mark. Some groups will send in a list
16 of names, but most of them don't, and we don't ask for
17 it. We can make this clear.

18 DR. JOHNSON: Well, I was going to suggest
19 that it would be clearer if we just say in that second
20 line where it says alternating supervising physician
21 or group, period. You know, that way they can list
22 Skagit Regional surgeons, period.

23 MS. DALE: So combine that physician --

24 DR. JOHNSON: No. George's reason for the
25 bottom one is legitimate, I think, saying this is

1 Skagit Regional Clinic. Within that there's a
2 surgical group of PAs and surgeons that work together.

3 DR. GREEN: It's not even asking for an
4 individual's name.

5 MS. DALE: Right.

6 DR. GREEN: Business name.

7 DR. HEYE: Frequently the primary business
8 address on the bottom one are the same.

9 DR. JOHNSON: No, I know. To deal with the
10 issue that has been discussed, I think we just add
11 alternating physician or group. That way --

12 DR. HEYE: Yeah, that's no problem.

13 DR. JOHNSON: That would be easy to deal
14 with and would help, I think.

15 MR. CONCANNON: Is there any circumstance
16 where you're going to have three different physicians
17 signing this document? Three physicians.

18 DR. JOHNSON: I can imagine --

19 DR. HEYE: Yeah, we have only room for two,
20 two supervisors.

21 DR. JOHNSON: I was just thinking about a --
22 You know, getting back to a surgical subspecialty
23 assistant, within our organization, our PAs spend 99
24 percent of the time with general surgery, but then
25 periodically they're asked to help in gynecologic

1 procedures, stat C-sections, orthopedic procedures,
2 plastic procedures. And what I would hope is they
3 don't have to sign a delegation agreement for each one
4 of those separate. Because we're all one larger
5 group, we're in the operating room working together,
6 and we're helping each other.

7 I'm trying to not make it onerous for either the
8 PA or the group to comply with our requirements. And
9 if we make it too many delegation agreements for each
10 PA that would have to do ENT and -- that gets goofy.
11 Because scope of practice in assisting in surgery
12 isn't that different. The procedures are different,
13 but when you really think about what we do in the
14 operating room, they're not that different.

15 MS. DALE: Yeah. But I think this would
16 happen like if I worked in pediatrics for two days a
17 week and I worked OB a day a week, and then I wanted
18 to volunteer at Union Gospel Mission, and so I had a
19 delegation agreement there.

20 DR. JOHNSON: Well, those are very
21 different.

22 MS. DALE: And I think that's what the next
23 question is, isn't it?

24 DR. JOHNSON: No, I understand.

25 MS. DALE: Okay.

1 DR. JOHNSON: I think it's how you nuance
2 the differences. How big of differences do we need
3 versus limited.

4 DR. HEYE: On page 3 where it says Practice
5 Arrangements, you have a PA that's part of a surgical
6 group. Usually what they do is they will list the
7 various surgical areas that they're going to scrub in.
8 We don't need all the different doctors.

9 DR. JOHNSON: No, I understand. I'm talking
10 about specialty, subspecialty, you know, the PAs
11 versus OB.

12 DR. HEYE: What I mean is like part of the
13 time they may scrub with orthopedics and part of the
14 time with general or ENT or whatever, and they usually
15 list those if that's what they're going to be doing.

16 DR. JOHNSON: Right. But the Union Gospel
17 Mission is very different, totally different than peds
18 and OB.

19 MS. DALE: Right.

20 MR. CONCANNON: Is there a way for a Group
21 Health physician who never signed anything getting
22 stuck being designated for the day as the alternate
23 supervisor for a PA who gets into trouble?

24 MS. CARTER: Yes.

25 MR. CONCANNON: He never signed anything,

1 the Group Health physician.

2 DR. VANDERGRIFT: I would say from the
3 standpoint of the way -- This is John Vandergrift. I
4 would say from the standpoint of how we function with
5 our practice, I would say yeah, but I would also
6 consider that part of the understanding of how our
7 practice functions.

8 For example, if I -- I'm an emergency physician
9 who works in our urgent care system. If I happen to
10 be on duty on a day working with a PA whom I do not
11 directly sponsor, with whom I do not have a delegation
12 agreement, that PA screws up, to use your words, I'm
13 supervising the PA that day, I don't have a signed
14 agreement per se, but I am a member of the group
15 practice and I am the physician supervising that PA
16 for the day, that's on my dime.

17 MR. CONCANNON: And the medical group
18 that -- In other words, who in the medical group signs
19 these delegation agreements? The medical director?

20 DR. GREEN: Whoever they can get ahold of
21 and wants to mail them in.

22 DR. VANDERGRIFT: No. They would need the
23 primary sponsor of that PA would be one who signs the
24 delegation agreement.

25 MR. CONCANNON: But I mean if there's

1 alternates.

2 DR. GREEN: Whoever they can get ahold of.

3 DR. VANDERGRIFT: Okay. Now, on last page
4 under the Certification of Document, page 4 of this,
5 one of the things it states there is that the listing
6 of everybody there is not applicable if this is a
7 group practice.

8 DR. JOHNSON: The third signature.

9 DR. MARKEGARD: It's on that signature line
10 that we don't have to have -- If a group practice is
11 serving as an alternate, we don't have to have them
12 sign the form at all, correct. And so can we add
13 that, Brett, on the osteo form?

14 MR. CAIN: Yes. And it alludes to that, but
15 I like what it says better here. It says "Only
16 required if single alternate supervisor is listed."

17 DR. MARKEGARD: Right.

18 MR. CAIN: That should say "Not applicable
19 if group practice."

20 DR. MARKEGARD: And the back page of that
21 front page, are we adding anything? You said the
22 alternating physician or group data?

23 MR. CAIN: Yes.

24 DR. MARKEGARD: And then instead of
25 "physician name," just put "name"?

1 DR. HEYE: You just put the group's name
2 down there.

3 DR. MARKEGARD: Yeah.

4 MR. CAIN: So under alternate supervisor,
5 just put "name"?

6 DR. MARKEGARD: Right.

7 FACILITATOR THOMPSON: So, Dr. Heye, how
8 many of these come in under the practice arrangements
9 that actually use the lines, or do they always attach
10 paper, instead of using the three lines to describe
11 their general duties or whatever?

12 DR. HEYE: Most of them just use this.

13 FACILITATOR THOMPSON: Oh, they do?

14 DR. HEYE: Yes.

15 FACILITATOR THOMPSON: Okay.

16 DR. HEYE: That's if you can read it.

17 FACILITATOR THOMPSON: Well, and that was
18 another. I was like, well, if you just required them
19 to attach, maybe they would have somebody type it.

20 DR. HEYE: They do. Some of the groups will
21 just, you know, attach a page or a couple of pages and
22 list 12 remote sites or something.

23 MR. CONCANNON: And, again, this gets to
24 something I asked last time. Page 3, item 3, I don't
25 see the reason for a statement like that in this sort

1 of information agreement that's coming to you. We
2 don't have to tell them how many -- "No MD may
3 supervise more than five PAs without written
4 authorization by the Commission." They don't have the
5 right to supervise any PAs without the written
6 authorization of commission. None, zero.

7 MS. DALE: I think in the second sentence
8 there is why that's there.

9 MR. CONCANNON: I know. But, again, the
10 next page asks the -- asks how many -- what's the
11 names of all the PAs that you currently supervise. So
12 we can count, you can count how many there are. And
13 you can make a decision based on the prior delegation
14 agreements that you will then go pull and look at each
15 one of them to decide whether or not to approve this
16 one, because you don't have the right to have five.
17 You don't have the right to have any.

18 We know there has to be a waiver if there's more
19 than five, I guess, but you don't have the right to
20 have any. And this is making it seem like you have
21 the right to get five. I don't think you do. That's
22 why you ask for all these details. You have the right
23 to deny it.

24 FACILITATOR THOMPSON: So are you suggesting
25 that be removed or are you suggesting that we rephrase

1 that?

2 DR. GREEN: Take it out.

3 MR. CONCANNON: I'm suggesting that this be
4 removed. Because, again, this is not the place to be
5 giving them citations to the law about how many PAs
6 they have the right to supervise.

7 MS. DALE: So strike that sentence in No. 3,
8 then, and just leave: If approval of this delegation
9 agreement results in the supervision of more than
10 five, explain here why.

11 MR. CONCANNON: I don't even know if I would
12 put that in there. Because, again, the medical
13 commission is going to have to be sitting there
14 looking at a bunch of delegation agreements to see if
15 they should approve the latest one.

16 DR. GREEN: The national association doesn't
17 recommend putting anything like that in. They don't
18 recommend having any numbers in the rules or laws, I
19 believe.

20 MS. DALE: Right.

21 DR. GREEN: Am I right?

22 MS. DALE: Yes.

23 MR. CONCANNON: Oh, you're talking about in
24 terms of national practice for PAs?

25 DR. GREEN: Right, in terms of their

1 recommendations of what we should be doing. So they
2 agree with you.

3 MR. CONCANNON: Well, but, you see, the PAs
4 think they got something with this last legislation,
5 where they got to go from three to five or whatever.
6 And I'm saying, once they put in, You can't do it
7 without authorization of the commission, they didn't
8 get anything. And you can't lead them to believe they
9 get something by putting something like that in a form
10 like this.

11 DR. MARKEGARD: On this form is it
12 reasonable or necessary to have -- do they have to --
13 do you use the names that are listed on there of other
14 PAs they supervise or other doctors that serve as
15 supervising physicians for this provider? Is that
16 useful information when you're reviewing these?

17 Or is it better just to have -- or do you need to
18 have, you know, if this is, you know -- I mean,
19 someplace they have to explain if there's more than
20 five in some format, right? So is this a place where
21 you say, you know, does the primary sponsoring
22 physician, you know, have a practice agreement with
23 five others? You know, a way to put a check in a box.
24 And if so, explain why or reason why this is
25 additional? I know that's really confusing.

1 DR. HEYE: No. 1, where it says list all PAs
2 you currently supervise or sponsor, the advantage of
3 that is that it turns out a lot of those practices are
4 defunct and they have never told us, so it's a chance
5 to upgrade the file. Oh, I haven't worked with this
6 PA for a year.

7 MR. CONCANNON: Yeah, I think that's a good
8 question.

9 DR. MARKEGARD: Oh, a cross check.

10 DR. HEYE: Because a lot of people, they
11 only have maybe zero or one other PA they're
12 sponsoring.

13 I don't have any problem with dropping that No.
14 3.

15 DR. JOHNSON: But the other thing, George,
16 is that the physician may sponsor up to five, but it
17 also says what -- or even more by exception. But
18 whatever he can handle or whatever he can handle isn't
19 defined very well, and you may have access to
20 information that handling two is too many for that
21 particular physician.

22 DR. HEYE: Or one.

23 DR. JOHNSON: But you'll have that
24 through -- Or none, yeah, for example.

25 MR. CONCANNON: In other words, you, meaning

1 the Commission, Dr. Heye, have to be safe in denying a
2 delegation agreement if you don't see what you want to
3 see based on, for instance, other delegation
4 agreements, as opposed to some lawyer for a PA or
5 doctor suing you, suing the commission, saying, We
6 have got the right to have five. He only has four.
7 What the hell is your problem? That's what I'm
8 talking about.

9 We have got the right to have five. No, you
10 don't have the right to have five. You have the right
11 based on the facts and circumstances. And your
12 answers to all these questions, we will decide if it's
13 a good practice plan, I think. Or delegation
14 agreement.

15 DR. MARKEGARD: So where on the form does it
16 need to say or does it need to say an explanation or
17 give an explanation of why this may be PA number six
18 or seven or eight? When do you get that information?

19 MS. DALE: In that page 4, No. 1.

20 DR. HEYE: Or sometimes it's No. 3 that
21 you're dropping. In a rare occasion it's filled out
22 by somebody who has maybe 10 or 12, because the PAs
23 only work one day a month at a walk-in clinic or free
24 clinic or something like that. And on any one day,
25 there may be three PAs at that clinic.

1 So the sponsor is always there, yet the sponsor
2 has agreements with 15 or 20 PAs, but they only each
3 work one day a month. So it's an alternate practice
4 for all these PAs. It's a volunteer practice.

5 DR. MARKEGARD: So where on the form would
6 you know that information?

7 DR. HEYE: Probably on No. 3 there. It
8 would show up on page 4 anyway.

9 DR. MARKEGARD: Can you just kind of
10 reorganize these where, instead of having that three
11 up there, that if you go next to the periods of
12 absence, if you are planned for a period of absence,
13 other current practice plans, list by names, blah,
14 blah, blah, and then have a section, you know, if
15 applicable, give reason why -- whatever language
16 sounds appropriate?

17 FACILITATOR THOMPSON: You mean if this is a
18 request to supervise more than five physicians, please
19 explain why?

20 DR. MARKEGARD: Please explain why.

21 FACILITATOR THOMPSON: Because that's what
22 it is, it's a request to the commission.

23 DR. MARKEGARD: And you leave out that they
24 may or shall or might be able to supervise more than
25 five.

1 DR. GREEN: Why can't that -- should it be
2 put in No. 2, describe the plan for supervision?

3 DR. HEYE: I prefer to leave that alone
4 because that's an important part of the form.

5 DR. GREEN: That's my point.

6 DR. HEYE: You should leave the three and
7 just reword it. It will show up in either place.

8 MS. DALE: Which is why I think the first
9 sentence in No. 3 should be struck and the second
10 sentence left there.

11 DR. MARKEGARD: Right.

12 DR. GREEN: But you'll get him upset.

13 DR. MARKEGARD: No. It's a compromise,
14 because you take away the part that he doesn't like.

15 DR. GREEN: I know.

16 FACILITATOR THOMPSON: Instead of maybe
17 saying "If approval of this delegation agreement," you
18 know, say "If this is a request to."

19 DR. MARKEGARD: Right.

20 FACILITATOR THOMPSON: Because isn't that
21 your point? Your point is that this is -- it's not
22 just something given to you. It's a request. And if
23 the medical commission or the osteo board says it's
24 okay, then you get to supervise more than five.

25 DR. GREEN: You get to.

1 FACILITATOR THOMPSON: You get to. You get
2 that privilege.

3 DR. HEYE: Could I have the floor for a
4 minute?

5 MR. CONCANNON: Yeah. You got the floor,
6 Heye. You got the floor.

7 FACILITATOR THOMPSON: Whatever you want.

8 DR. HEYE: On page 2 I just wanted to ask,
9 in the big block on the top where it says Standardized
10 Procedures, right in the middle of that it says, An
11 Interim Permit holder, and so on and so forth, may not
12 practice in remote sites. And then there's a
13 sentence, "All charts of a non-certified PA must be
14 reviewed and countersigned by the supervising MD
15 within two working days."

16 MR. CONCANNON: Which is from the old rule.

17 DR. MARKEGARD: Yeah. So just delete that
18 one, right?

19 DR. HEYE: Do you still do that?

20 DR. MARKEGARD: No.

21 DR. HEYE: Do we want to keep that or
22 delete?

23 DR. MARKEGARD: Delete.

24 MS. DALE: Because you changed that in your
25 rules already.

1 DR. MARKEGARD: Uh-huh.

2 DR. HEYE: Well, we got rid of the rule that
3 required it, so.

4 MR. CAIN: And then the next section, it
5 talks about supervision, there's just a slight
6 discrepancy in the medical and osteo, where medical
7 uses "should" and osteo says "must."

8 This was kind of some advice from Blake, who said
9 that if you're going to put -- the executive director
10 of the Osteo Board, that if you're going to put a
11 requirement for them to do something in a form, that
12 you shouldn't use language like "should." You should
13 use language directing them that they need to.

14 MS. DALE: Must agree upon.

15 DR. HEYE: Where are you at?

16 MR. CAIN: Under the new language under
17 supervision.

18 DR. GREEN: The last sentence.

19 MR. CAIN: Instead of "should," use "must."

20 DR. GREEN: The plan "must" reflect.

21 MS. DALE: It's right here. The primary
22 supervisor and the physician assistant "must" agree
23 upon a plan of supervision.

24 MR. CAIN: And on the medical form it says
25 "should." And it's three different uses. So I just

1 wanted to marry them up and see if people had feelings
2 one way or the other.

3 DR. JOHNSON: "Must" sounds good to me.

4 MS. DALE: And so in the second sentence
5 now, it says they "may" be part of the plan.

6 MR. CAIN: "Shall."

7 MS. DALE: No. You have "must."

8 MR. CAIN: Yes.

9 DR. HEYE: Well, you mean the sentence
10 "Specified record reviews," and so on?

11 MR. CAIN: Yes.

12 DR. HEYE: Those are suggestions.

13 MR. CAIN: So keep that "may"?

14 MS. DALE: "May."

15 DR. HEYE: And the last one says,
16 "Adjustments to the plan should reflect." I'm trying
17 to make this so that, as the PA -- Just like when
18 they're hired, sometimes it's a hundred percent chart
19 review, in three months it's 25, and then after that
20 it may be ten or it may be five or something else.
21 But it's okay to have a plan that adjusts down
22 depending on the PA's experience and what goes on.
23 That's why I put "should," because adjustments in the
24 plan should -- if the PA is doing well, the
25 adjustments are broader and less restrictive.

1 MR. CAIN: But either way, that would
2 reflect the change.

3 MS. DALE: But the thing is, if you make
4 them put it in writing that they will do fifty percent
5 chart, ten percent chart review, two percent, but that
6 PA isn't progressing and you want to keep it at fifty
7 percent for a while longer, if you put it in that
8 practice plan that you will reduce down by that in
9 such and such a time, that locks you into it. Whereas
10 with this one saying "should," then that allows the
11 flexibility to keep them on that.

12 MR. CAIN: Okay. I'll change this one to
13 "should."

14 FACILITATOR THOMPSON: We're over our time
15 limit, but, I mean, it's up to you all if you want to
16 keep going and finish up these forms.

17 DR. JOHNSON: We don't need an answer. Just
18 a thought for a question. When a PA reapplies for
19 re-licensure, would that be an appropriate time for
20 them to re-address their delegation agreement? So
21 every -- What is it? Every two or three years.

22 DR. MARKEGARD: Two years.

23 MS. DALE: Two for us and one for osteo.

24 DR. JOHNSON: Because they fill this out
25 once and it's got -- it's really the interim because

1 they're just starting to work. And then they get
2 certified and they never re-address this form, when,
3 in reality, the relationship with them and their
4 supervisor or group has changed. And so that might be
5 an opportunity for the group and the PA to reflect on
6 their practice and rewrite the delegation agreement.
7 Just look at it and reapply, you know.

8 DR. HEYE: When somebody redoes their
9 license, it goes to a different division. They send
10 it in. They fill out the form, send it in and the
11 license gets mailed out.

12 DR. JOHNSON: I know. Because we could do
13 it online and nobody looks at it. I understand that.
14 I'm just throwing it out as a suggestion because this
15 is a living document, it's not a static document. Or
16 the practice is a living. This is static. And the
17 reality is it's a living, evolving relationship.

18 DR. HEYE: I would lobby not to do that.

19 DR. JOHNSON: There you go, okay.

20 DR. MARKEGARD: Or, I mean, you could put it
21 under responsibility, another sentence under this
22 part. You know, we recommend that you review this on
23 an ongoing basis to make sure the information is up to
24 date and current.

25 DR. GREEN: There's also a requirement in

1 the rule that they update it with significant changes.

2 MR. CONCANNON: I seem to remember that.

3 DR. JOHNSON: And that could reflect reduced
4 supervision. Is that what we're hearing from each
5 other?

6 DR. HEYE: Well, a lot of these practice
7 plans, they write that in there. They start off at
8 this, and then within so many months we plan to be
9 here.

10 DR. JOHNSON: That's why I even bring it up
11 as what is the current practice. Thank you.

12 MR. CONCANNON: Anyway.

13 FACILITATOR THOMPSON: Okay. So there's
14 this Remote Site form. Are we good with that or are
15 we ready to --

16 MR. CONCANNON: Well, are we still supposed
17 to be thinking here?

18 FACILITATOR THOMPSON: It's up to the group
19 because it is -- Oh, yes.

20 DR. BRUEGGEMANN: I may have missed this.
21 Under the Practice Site on both forms, the second
22 sentence on part A, it says, "When the PA assistant is
23 on duty."

24 MR. CAIN: No.

25 DR. BRUEGGEMANN: It should say PA or

1 physician assistant.

2 DR. GREEN: Yeah, you're right.

3 MR. CAIN: What page are you on?

4 DR. BRUEGGEMANN: Page 2 of 4.

5 MR. CAIN: Okay.

6 FACILITATOR THOMPSON: It's 2:15. Do you
7 want to try to get through this last form?

8 DR. MARKEGARD: Yes.

9 FACILITATOR THOMPSON: Okay, let's do this
10 last form. It's the Remote Site form.

11 MR. CAIN: These are a little different
12 based on a couple conversations.

13 DR. JOHNSON: So on page 1 of 2 on the
14 Remote Site, alternate supervising physician or group.

15 MS. CLOWER: Under restrictive authority,
16 maybe we should make it reflect what the rules said on
17 page 2 of 4 in the allopath.

18 FACILITATOR THOMPSON: Oh. On the
19 standardized one?

20 MS. CLOWER: Yes.

21 MR. CAIN: So just have it sync up with what
22 the other one says?

23 MS. CLOWER: Yeah.

24 DR. JOHNSON: When we're asking them to list
25 all sites, all remote sites, are we really asking them

1 every address or are we saying all urgent care clinics
2 within our or all emergency rooms or all hospitals?

3 Well, they're not going to be working a remote
4 hospital. But what are we asking them to provide us?

5 DR. HEYE: We're asking for all remote
6 sites. And if there's a lot of them, more than one or
7 two, usually they type it out and send it in.

8 DR. JOHNSON: Typed sheet, okay. Just to
9 clarify that.

10 DR. HEYE: And what we're looking for with
11 most of these is -- the first question I go back to,
12 Are there any doctors at the remote sites? Because if
13 the sponsoring physician is not going to be there and
14 it says I'm only going to be there like two hours, I
15 want to know is somebody else there all the time. And
16 so we don't -- That's not on here, but that's the most
17 common e-mail question back to somebody: Who else is
18 at that remote site?

19 DR. JOHNSON: Got it.

20 MR. CONCANNON: And do you find that out
21 from this form?

22 DR. HEYE: No. They send back the answer.
23 And if they don't, we send them another e-mail.

24 DR. GREEN: George, did you look at the
25 osteopathic remote site form? And the reason I ask is

1 that on page 2, to me there's some pertinent questions
2 relevant to the remote site practice, and I just
3 wondered if you think they are helpful and we should
4 consider them. On the back of the page.

5 DR. HEYE: I don't think I have the same one
6 you have. Are you on the remote site or the regular
7 one?

8 DR. GREEN: No, on the remote site one.
9 There it is. Yeah, that one on the very back.

10 MS. DALE: Dr. Heye, on the back page. Very
11 back. There you go.

12 DR. GREEN: So like questions three and
13 four.

14 MS. DALE: You know, I wonder, though, about
15 the community need. What was the thinking on putting
16 the explanation of community need in there, for the
17 utilization of the osteopathic physicians?

18 MR. CAIN: That's in their rule. And that's
19 on the form currently, so that's --

20 MS. DALE: Yeah. And that, I think I forget
21 to ask about that because we were dealing so much with
22 the allopathic. But I guess I was wondering why do
23 they have to outline the need to hire a PA for that
24 site if care is needed. I mean, I guess I'm just
25 trying to find out -- figure out why you would want to

1 know that.

2 DR. MARKEGARD: I've never reviewed these
3 ever on anyone, so this is from before. I don't think
4 it's a question that is irrelevant. I think it's
5 important to know if there is a reason why a PA is
6 needed at that remote site.

7 DR. HEYE: The RCW actually requires if
8 there's a demonstrated need for the utilization. I
9 never use that.

10 DR. MARKEGARD: I never review these. So
11 the people who review these, that may be necessary for
12 someone else. I don't know.

13 MS. DALE: Yeah. Because I was thinking, if
14 they were going to hire one, then just the fact that
15 they're looking to hire one is a need.

16 DR. HEYE: That's the way I look at it too.

17 MS. DALE: Okay.

18 DR. GREEN: So No. 4, which is the --

19 MS. DALE: I like No. 4.

20 DR. GREEN: -- which has to deal with
21 communication or supervision in emergent situations.

22 DR. HEYE: I don't want to know that.

23 DR. GREEN: Okay. Well, it seems like
24 that's part of the problem with remote sites.

25 DR. HEYE: Well, most times they say, you

1 know, I have -- if I'm not there, I have communication
2 available whenever, you know, I'm not there. I just
3 have to trust that.

4 DR. GREEN: Okay. Greet.

5 MR. CAIN: What do you think, Dr. Markegard,
6 do you like those? Again, they don't have to be the
7 same.

8 DR. MARKEGARD: Yeah, I like 4. I think
9 that's an important thing to have on there. And, if
10 nothing else, it makes them think about what their
11 plan is in an emergency and to reiterate that
12 specifically on the form.

13 And I really am indifferent about No. 3, so. I
14 see what it says.

15 MR. CAIN: We're going to talk about these
16 next Friday. Or somebody else from your board.

17 DR. MARKEGARD: I'm sure someone else on my
18 board will have an opinion.

19 MS. DALE: Well, I just throw that out there
20 because, again, you know, if they are wanting to hire
21 a care provider, then there is obviously a need or
22 they wouldn't be hiring them just to sit and knit or
23 whatever. So I was just thinking that's kind of --

24 DR. MARKEGARD: Redundant.

25 MS. DALE: Uh-huh.

1 MR. CONCANNON: All right, Dr. Heye, back to
2 my favorite item, item 3, page 3, Practice
3 Arrangements. Listening to Linda and Shannon, if you
4 got rid of the "no MD" thing --

5 DR. HEYE: Hang on a minute, Mike. Are you
6 on MD or osteo?

7 MR. CONCANNON: MD. I'm still not sure what
8 osteopaths are.

9 DR. MARKEGARD: Don't get me started.

10 MR. CONCANNON: I know. Don't get me
11 started.

12 DR. HEYE: And you're on which?

13 MR. CONCANNON: Page 3.

14 DR. HEYE: The regular delegation agreement?

15 MR. CONCANNON: Yeah. About the five PAs
16 without written authorization.

17 DR. HEYE: Okay, got it.

18 MR. CONCANNON: If you get rid of that and
19 you say --

20 DR. HEYE: Except the second sentence.

21 MR. CONCANNON: -- If approval of this
22 delegation agreement, combined with any prior
23 delegation agreements, results in the supervision by
24 the primary supervising physician of more than five
25 physician assistants, please explain the necessity.

1 Right?

2 DR. HEYE: Yeah.

3 MR. CONCANNON: Because they may say, No,
4 no, this doesn't result in supervision. There's only
5 one PA. Anyway, those are just words, clarification.

6 FACILITATOR THOMPSON: Okay. So are we
7 good?

8 MR. CONCANNON: We're never good.

9 FACILITATOR THOMPSON: Well, we're good
10 enough for right now, right?

11 MR. CONCANNON: But we're done.

12 FACILITATOR THOMPSON: Okay. So here are
13 the next steps. So what we would have liked to have
14 done was identify those sections of each of the
15 chapters that we felt like, as committee members, you
16 could take forward to your respective board and
17 commission and start sharing with them so that they
18 could start getting the flavor of what this committee
19 has worked so hard on.

20 I don't know -- I don't think you guys want to
21 stay actually to do that. So we have a committee
22 meeting set up for May 8th in Tumwater. I think that
23 we'll have to kind of talk logistics, internal
24 logistics, with Brett and Julie and see what we can
25 do.

1 MR. CAIN: And see if that room is available
2 before one if we want to.

3 FACILITATOR THOMPSON: Yes. Oh, yes, and
4 see if we can just have a longer period of time. We
5 may not use that, but at least we would have that
6 longer period of time.

7 DR. JOHNSON: So we're scheduling us to meet
8 May 8th in Tumwater?

9 FACILITATOR THOMPSON: Yes.

10 MS. CRAIG: It's actually available from
11 twelve o'clock noon on.

12 MS. CARTER: It is? So the morning is
13 booked?

14 MS. CRAIG: I didn't check the morning.

15 FACILITATOR THOMPSON: Okay. We'll do some
16 checking on that.

17 So this is the process that I would recommend,
18 and Heather can chime in. So this is a committee,
19 right? And this committee, the board and commission,
20 you have to have a quorum to, you know, vote on the
21 ruling to go forward.

22 So the way the process should technically work is
23 that, as a committee, each of you should respectively
24 take your draft proposed language to your respective
25 board or commission, forward them as a group in an

1 open public meeting to vote on and approve the draft
2 language for us to go forward with our hearings.

3 And I would ask and I would hope that the members
4 of this committee would champion and strongly support
5 the language that you guys have worked so hard on to
6 get there.

7 We will continue to work through the process.
8 When we get to the hearing, just to throw it out
9 there, we have talked about this internally, each of
10 you have your own kind of respective authority and you
11 do your own hearings under your own authority, but
12 what we would kind of like to do is, because these
13 rules have marched down these paths together so
14 closely -- and while they may be a little bit
15 different, they are very close -- that we hold the
16 hearings on the same day relatively at the same time,
17 so when you -- if you get comments from the public
18 that you need to consider as part of your
19 board/commission meeting, that you can have time also
20 to share those comments with the other
21 board/commission, so that each of you know what each
22 one said, and then you can vote.

23 One of the things that we heard when we worked on
24 those pain management rules is that with seven
25 independent authorities, each one was adopting rules

1 and nobody knew what happened at the other hearing.
2 And so because there's only two authorities, we
3 thought this might be an opportunity that we can
4 logically try to work it so that you guys can have
5 your hearings at the same venue, same time period, so
6 that you guys can share comments before you vote
7 respectively on the final version.

8 So just some things that we've been thinking
9 about logically to try to make this happen.

10 MS. DALE: How soon can we get copies of
11 final wording that we said today? Because I'm going
12 to present this to WAPA. I know I don't have a vote,
13 but I would like to present it to WAPA with the
14 cleaned up language as it is that we worked on.

15 You're looking stressed. But, I mean, you know,
16 three weeks?

17 MS. CARTER: I don't think we made a whole
18 lot of changes.

19 MS. DALE: And you were tweaking it as we
20 went along.

21 MR. CAIN: Yeah.

22 MS. CARTER: And there was no major
23 portions, right?

24 MS. DALE: The major portions were
25 eliminating.

1 MR. CAIN: Maybe a little direction. It's
2 difficult when we're going in and doing track changes
3 on four different computers and track changes in four
4 different colors, probably five colors now. That's
5 difficult to read.

6 But, at the same time, if you get a totally clean
7 version, it's not easy to see what changes were
8 actually made. So that's one of the challenges we
9 have been working with. That's why we're giving you
10 so much paperwork. Because you have one document with
11 track changes, one clean.

12 Would you like -- I mean, is that -- are people
13 able to work with what we're producing now?

14 MS. DALE: Or could you go through and get
15 rid of all the changes -- or either adopt the things
16 that we've eliminated and just keep the tweaking that
17 we did today?

18 MR. CONCANNON: We didn't go through the
19 whole lot today and tweak everything that needed to be
20 tweaked.

21 MR. CAIN: No.

22 MR. CONCANNON: We just did certain things.

23 MS. DALE: Yeah.

24 MR. CONCANNON: I mean, you're acting --
25 you're all talking as if we're about to distribute

1 this for approval by somebody.

2 MS. DALE: Right.

3 MR. CONCANNON: I mean, I've got other
4 things which I have sent to you. I figure it's going
5 to be at the next meeting that we will deal with that.

6 DR. JOHNSON: Our next commission meeting is
7 April 3rd, April 4th, and then we won't have another
8 one until June.

9 MR. CONCANNON: Is it June or May?

10 DR. JOHNSON: May.

11 FACILITATOR THOMPSON: May 8th.

12 DR. JOHNSON: Yeah. But after May 8th.

13 MR. CONCANNON: We've got lots of time.

14 DR. JOHNSON: We won't have a lot of time.

15 FACILITATOR THOMPSON: I think, you know, at
16 the May 8th meeting, what I'm thinking potentially is
17 that we're going to take this and do like one last
18 kind of scrub through and talk about is there any
19 issues left standing that we need to address as a
20 group and come to an agreement where this committee's
21 recommendation is going to be to your respective
22 authorities.

23 MR. CAIN: Linda, to address your question,
24 I mean, our goal has been to get the documents that
25 are used in the meeting a week before the meeting.

1 Are you asking if potentially we could give you
2 more than a week? Because if it's May 8th, I would
3 say May 1st. So it's five weeks.

4 MS. DALE: Okay.

5 MR. CAIN: Does that work?

6 MS. DALE: Yeah. I just wanted to run what
7 we have done so far by WAPA because I can't vote on
8 the final product, and so all I can do is nag at you
9 now. And so I want to make sure that I am
10 representing WAPA and not just my own thoughts, and so
11 that's why I would like to be able to present that,
12 what we have so far, in case I have missed something
13 or they look at it totally different than I'm looking
14 at it.

15 MR. CAIN: Because some of that might change
16 after May 8th.

17 MS. DALE: Right. But what we have so far.

18 I'll just take the track changes that we have and
19 then what I've written on here on my copy. I'll do
20 that.

21 MR. CAIN: Okay.

22 MS. DALE: Thank you.

23 FACILITATOR THOMPSON: Are we all
24 comfortable with that and the attentive plan?

25 MR. CAIN: And folks from Group Health, is

1 anyone still there? Thank you for calling in. We're
2 going to disconnect now, if you haven't already.

3 MS. MATHISON: Okay. Thank you so much.
4 We're signing out. It worked great.

5 MR. CAIN: Thank you. Good. Take care.

6 MS. MATHISON: All right.

7 DR. VANDERGRIFT: Good bye.

8 FACILITATOR THOMPSON: Bye.

9

10 (OPEN PUBLIC MEETING CONCLUDED
11 AT 2:29 P.M.)

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