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

310 Israel Road SE, Suite 153
Tumwater, Washington

DATE: Thursday, May 8, 2014
REPORTED BY: Gloria C. Bell, CCR

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JOINT PHYSICIAN ASSISTANT RULES COMMITTEE:

Shannon Markegard, DO
Sharon Gundersen, PhD
Tom Green, MD
Mark Johnson, MD
Mike Concannon, JD
Athalia Clower, PA-C
Theresa Schimmels, PA-C
Linda Dale, PA-C

COMMITTEE STAFF:

George Heye, MD
Dawn Thompson
Julie Kitten
Maura Craig
Brett Cain

FACILITATOR:

Tami Thompson, Regularoty Affairs Manager,
Department of Health

LEGAL ADVISOR:

Heather A. Carter, Assistant Attorney General

1 TUMWATER, WASHINGTON; THURSDAY, 14 MAY 2014

2 9:06 A.M.

3 --o0o--

4 MS. T. THOMPSON: So, welcome, everyone.
5 I know we're a little late getting started, but I think
6 we're ready to get started.

7 My name is Tami Thompson. I am the
8 regulatory affairs manager for the Department of
9 Health. And I have been asked to help facilitate these
10 rule workshop meetings with the Board of Osteopath and
11 the Medical Commission.

12 We have our board committee members
13 sitting at the table and everything in this meeting is
14 being recorded. We have a court reporter recording.
15 And we do have people on the phone.

16 And, Theresa, can you just make sure
17 that you can hear my voice since I'm a little bit
18 farther away.

19 MS. SCHIMMELS: No, I can hear you fine,
20 Heather.

21 MS. T. THOMPSON: All right. Thank you.
22 And what I'm going to do real quick is I want to just
23 keep it on track. I want to view the agenda real quick
24 and just some of the logistics.

25 Logistics are -- the bathrooms are --

1 hopefully you noticed them as you walked in the door,
2 but if you go out this door right here and at the
3 hallway you turn to your left and the bathrooms are on
4 your left.

5 This is a closed building to others.
6 And staff should not be able to go upstairs. They have
7 to stay down in the general area.

8 There is a coffee shop across the
9 street, kind of on the far corner of the parking
10 garage. If you don't want coffee, there is a 7-11 down
11 at the corner of the intersection and there's a Chevron
12 station just kind of on the other side of the campus
13 here.

14 Okay. So, I'm going to try really hard
15 to stay on track with our agenda. My goal for today
16 for the committee members is to make sure that all of
17 your comments and concerns are heard and addressed one
18 way or another.

19 And my ultimate goal for you all is that
20 you will be able to walk away from this meeting today
21 with a product that you believe that you can support
22 and take to your respective board and commission on
23 your board and commission meeting dates, which is the
24 16th of this month. So, that's our hope and prayer
25 that we can get there.

1 Just to go over the agenda real quick.
2 We potentially have some remaining issues of concerns
3 on PA ownership. So, I'd like to address that first
4 off. And then we're going to jump right in to
5 continuing and finishing up the review of our draft
6 ruling, which addresses the assignments that the
7 committee has assigned to staff to address.

8 And then, since we sent out our draft,
9 we received additional comments from the committee
10 members. And I want to make sure that those comments
11 and concerns have our address. And so, I'm going to be
12 asking the committee members to bring those up as we
13 go.

14 And if we make it through all of that,
15 then we will have one more look at the delegation
16 agreement form. And then we'll talk about where we are
17 at, at the end of the day and next steps.

18 The court reporter has asked that if --
19 she will have the names of the committee members, but
20 if the audience or someone else wants to speak, that
21 you speak very clearly and that you say who you are and
22 spell your name so that she has that for the report.

23 All right. So, it's been brought to my
24 attention that there potentially are some remaining
25 issues of concern about PA ownership. I believe my

1 recollection is that when we were in Yakima, this
2 Committee voted to be silent on this issue. That you
3 had your AAG note that the Board Commission really does
4 not have the authority to regulate businesses.

5 And so the question that I have for the
6 Committee is: Do you want to address this -- this --
7 any additional concerns that address this issue again?
8 Or do you want to remain with the -- my understanding
9 the decision to remain silent on this and move on?

10 MS. DALE: The only thing that we have
11 is there's several physician assistant owners who've
12 come today basically for informational purposes to let
13 this Committee know how they handle the supervising
14 physician as an employee. And so there's a few that
15 would like to address the Committee just for
16 informational purposes.

17 MS. T. THOMPSON: If that's agreeable to
18 the Committee, then we can -- we can ask if you're
19 willing so speak and?

20 MR. CONCANNON: Sure.

21 MS. T. THOMPSON: Okay. So, I will go
22 with a show of hands who would like to speak to the
23 Committee and address this.

24 Okay. We're going to start with this
25 gentleman right here, because he's first.

1 DR. RAMZI: Should I stand or sit?

2 MS. T. THOMPSON: You can do whatever
3 you want -- whatever you want.

4 DR. RAMZI: If you don't mind, I'm gonna
5 sit. I'm actually not a physician assistant owner, I'm
6 actually physician employed by a physician assistant.
7 So --

8 MR. CAIN: Could you introduce yourself
9 for the court reporter too, please? Thank you.

10 DR. RAMZI: I was about to do that. My
11 name is Dino William Ramzi, R-a-m-z-i.

12 So I'd like to -- this could make a
13 little more sense if I tell you a little bit about me,
14 so I hope that I got a couple of minutes.

15 First off, I graduated from McGill
16 University in Canada and I moved to the states in 1996
17 to teach at Emory University. I was a family medicine
18 residency faculty. Our department also taught PAs,
19 that was my first contact with physicians assistants.
20 So I was faculty to PA school as well.

21 I got a master's in public health while
22 I was at Emory. And actually managed to pull off two
23 concentrations of -- by getting out of some of the
24 epidemiology, so I got health policy and I got
25 management.

1 Subsequent to that, I kinda shuffled
2 through a lot of managerial positions, a medical
3 director and CMO of highly qualified health centers and
4 at a Providence clinic as well, and was profoundly
5 unhappy, I might add.

6 Until I found a like-minded
7 practitioner, who saw the value of primary care to the
8 health care system, the value to the community, the
9 social capital of the community that has to go to
10 primary care access and the fundamental cost saving
11 role within the health care system of primary care.
12 And, yes, he was a PA. And the that's kind of the
13 point.

14 Physician assistants and primary care
15 providers of all stripes tend to be aligned with that
16 kind of philosophy. We want to help to system, we want
17 to give back to communities, we want to make it better.

18 Therefore, an apparent conflict of
19 interest regarding the supervision and the paycheck
20 tends to, I think, become a shadow and not a real
21 concern.

22 And I want to take it one step further
23 because I think there are some real concerns in terms
24 of the governance of the primary care practitioners of
25 all stripes.

1 I think the big issue is with the
2 consolidation of large health care systems. I was
3 miserable at some of the larger systems, because I had
4 to see too many patients, I couldn't deliver the value
5 of primary care. I was being evaluated on the basis of
6 customer service. Yes, please, here's your Vicodin.
7 Not on the basis of those elements of the health care
8 system that are improved by primary care.

9 So I think there are conflicts of
10 interest within the governance and the way that
11 physicians, physicians assistants, nurse
12 practitioners -- that whole group of providers that
13 kinda clusters along saving the system money, as
14 opposed to generating consults, imaging, and
15 procedures, which tends to drive costs.

16 The health care system has these two
17 large -- I know I'm oversimplifying, but these are two
18 large interests within the health care system that tend
19 to be somewhat opposed.

20 I think we need to remember that when
21 we're trying to safeguard the health of the population,
22 we should also be trying to make it easier for primary
23 care to do their jobs. And smart, simple regulation
24 particularly regarding supervision, regarding
25 accountability is more than welcome, smart and simple.

1 And the heavier the burden that's
2 imposed on those elements in the health care system
3 that provide this type of value, the worse our health
4 care system is going to be overall. That's my point,
5 thank you.

6 MS. T. THOMPSON: Okay.

7 DR. JOHNSON: So do you have some
8 suggestions about what should or shouldn't be in the
9 rules that we're drafting having to do with your
10 points?

11 DR. RAMZI: One of the things that
12 caught my eye is that we're -- there was a suggestion
13 of -- correct me, if I'm wrong, is that physician
14 assistants need to have a written agreement with their
15 supervising provider as to which outside providers
16 they're permitted to speak to. I just kind of caught
17 that briefly. I could give you the reference later,
18 it's kinda lower down. Someone's scrolling through
19 right now.

20 I think that with the PA who employs
21 me -- I mean, he comes to me when he's got questions
22 pretty easily. And if I happen to not be around that
23 particular day, my plan is you can call anybody you
24 want.

25 In fact, half the time I am telling him

1 that when he comes to me with a question, that maybe
2 it's really a specialty-orientated question. You need
3 to call the urologist, you need to call the
4 cardiologist, or you need to send the patient to the
5 emergency room. It would actually be cumbersome.

6 I think my -- my solution -- what I
7 would do if I were required to do that is I would say
8 anybody you want. That would be my rule. And
9 particularly important is we're independent, so we're
10 not associated with any particular health care system.
11 So it's not like, oh, you know, Vancouver Clinic
12 doesn't want the consults to go to PeaceHealth or --
13 I'm just throwing something out. They're -- they're
14 kind of fairly close.

15 But I don't think you're gonna have that
16 sort of -- that sort of an issue where a PA is being
17 told not to consult somebody because of financial
18 issues.

19 DR. JOHNSON: So to speak about your
20 concern about -- in the rules saying that it prohibits
21 PAs to speak to anyone. I think that might be a
22 misinterpretation on your part.

23 DR. RAMZI: On -- you know --

24 DR. MARKEGARD: On the form they do have
25 you ask a primary supervisor, but then in your absence,

1 if you're on vacation for two weeks in Europe or
2 whatnot, then who in the same field, will serve as that
3 supervisor position for that PA? Is that restrictive
4 on who's making calls for consultations or questions or
5 whatnot? Who's the primary?

6 And I think when I talked about the PAs
7 and ownership of the business, you know, the main
8 concern is if you, as the record physician, makes a
9 mistake, gets reported to the Board, they're sanctioned
10 on your license.

11 Now, what does the PA do as an owner of
12 a company whose record physician has now not been able
13 to practice and lost your license?

14 MS. SCHIMMELS: Brett, who's talking?

15 MR. CAIN: That's Dr. Markegard from the
16 Osteo Board.

17 MS. SCHIMMELS: Okay. I'm just having a
18 hard time hearing her.

19 MR. CAIN: Oh, I'm sorry.

20 DR. MARKEGARD: So do you have any
21 concerns, questions, or comments regarding that
22 specifically on the PA ownership of the business that
23 would be, you know, interesting to hear?

24 DR. RAMZI: I would think that if that
25 ever happened then the physician assistant owner would

1 have to find someone else. I mean, it would be very
2 straight forward.

3 DR. MARKEGARD: Clearly --

4 DR. RAMZI: If the physician's
5 sanctioned --

6 DR. MARKEGARD: All right.

7 DR. RAMZI: -- or has their license
8 curtailed in any way, I think, you know, that is -- I
9 think -- I think it would be clearly understood that
10 that would impact the physician assistant owner's
11 ability to continue practicing.

12 DR. MARKEGARD: And the other concern
13 regarding that, that was brought up in the last
14 meeting, was if the PA found that you were doing
15 something that maybe wasn't so beneficial to your
16 patients, then would that prevent the PA from reporting
17 you, you know, because that relationship? They depend
18 on that relationship for that business to remain open
19 to serve those patients. So that's where there's a
20 conflict of interest with a PA ownership.

21 DR. RAMZI: Yeah. I think -- I think
22 that's -- you know, it's kind of interesting. I think
23 medicine in general, as I'm sure you know, there's a
24 very collaborative approach and we're not quite as
25 confrontational as in other fields.

1 I think that -- I -- I don't know think
2 in a way where I've got to have all the lines drawn
3 out. So no, I'm always working with people. So that
4 if I was working with somebody and I was progressively
5 becoming not happy with what they were doing, then we
6 would work together to find a solution, including going
7 apart.

8 And I think that is what people do and I
9 have knowledge of that. I think, you know, if you're
10 unhappy with whoever it is, you kinda, like, figure it
11 out and move -- move on.

12 DR. HEYE: I would be interested in --
13 in comments about the potential conflict that was
14 brought up. Because we've received a lot of input
15 expressing concern about restricting ownership of
16 physicians assistants. Nobody here has any problem
17 with that. But we do have real life examples of the
18 type of conflict that was just brought up.

19 And if you have comments to make about
20 this particular subject related to these rules, it
21 would be nice to know your thoughts about it, because
22 that's our real life problem.

23 MR. LEINWEBER: I think I can. My name
24 is Eldon Leinweber, spelled E-l-d-o-n,
25 L-e-i-n-w-e-b-e-r. I think I can help you with that

1 because I am a physician assistant who owns a company.
2 I own North Central Washington Health. I am the CEO
3 and the major stockholder in that company. I have a
4 doctor with me who has the other part of -- we actually
5 have a couple more.

6 We resolve this a little bit
7 differently. As a company, we are the company. When
8 we were working, he is the physician, I am his
9 assistant. We live in an extremely remote, Mansfield,
10 Brewster, Omak area, as you well know, is way out
11 there. Okay.

12 If you run in -- and I made a couple of
13 notes here, so. And I'm going to kinda go down what
14 we've just had here. We were talking first about a
15 conflict of interest. And I ran into to this prior to
16 becoming the owner of company when I worked at another
17 place.

18 I'm going to use an example. Had the
19 doctor who was my supervising physician had a patient
20 come in and that patient for four years complained of
21 back pain, complained of other pains. And the doctor
22 got to the point, well, he just wants pain meds, that's
23 all.

24 I reviewed the chart that had been
25 handed over to me, never once did I see an x-ray, okay.

1 I take an x-ray, I find out that this guy has malignant
2 cancer through his spine, into his liver, into his
3 brain, everywhere.

4 I bring the point back to the doctor --
5 and excuse me for saying this, but the first thing he
6 said to me was, "Oh, gee, that's too bad. I feel sorry
7 for the son of a bitch."

8 Now, who do I report that to? Because
9 that is not good care.

10 So in my company when we set this up, we
11 contract with our doctor for our supervision,
12 providers. And they understand we are going to look at
13 both sides. They're going to look at mine, I'm going
14 to look at theirs. And we have a very good working
15 relationship.

16 There's times he will come to me and ask
17 me about the patient that he wants me to review.
18 There's times -- a lot of times I have him -- because
19 we have some multiple issues up there.

20 However, if he would not tell me, Hey,
21 Eldon, I think you're doing wrong something wrong on
22 this patient, I would fire him. Because that's what I
23 have him hired for. And the same thing goes on his
24 side. He's has told me he would quit if I don't sit
25 there and tell him about that.

1 To go to your next point, I have a
2 secondary physician that I have an agreement with, that
3 if my physician -- supervising, primary physician
4 becomes -- either quits or is asked to leave the
5 practice, he will step right in.

6 So we try to the keep that type of
7 situation. And a lot of it I think is territorial
8 because in that area we almost have to.

9 I have a clinic in Mansfield, I have a
10 clinic in Brewster, and -- and a clinic that's opening
11 in Wenatchee, and we're going to be hiring more people.
12 Right now, we do have a couple part time. We have to
13 watch out for this ruling of three per -- three PAs per
14 physician. And we're also hiring some -- some ARAMPs,
15 as well as trying to get another doctor on board.

16 But I think it takes some common sense
17 here. You've got to make sure that you have this down
18 in writing, that you have where you're going to go.
19 And if I found that my physician did something
20 drastically wrong in my practice, I'm going to sit him
21 down and talk him to say, Hey, you blew this. As he's
22 going to come to me and say, Hey, you blew this. And
23 if it is at the point that it's detrimental, am I going
24 to turn him in? I'm sorry, I am.

25 DR. HEYE: So what is it that you put in

1 writing because that's what we're about here. We're
2 putting --

3 MR. LEINWEBER: Well, we contract --

4 DR. HEYE: -- the contract in writing.

5 MR. LEINWEBER: -- we put in the
6 contract. In our contract we have it so that -- so
7 that there is no -- he can't just get up tomorrow
8 morning and walk off. He has to give me X amount of
9 time.

10 There is an agreement that if we find
11 that within that time that there is a conflict -- a
12 patient conflict, then we, as a company, get
13 together -- we sit down, we talk about it. And if this
14 is a drastic position, we make changes to take care of
15 that situation.

16 Or if we feel that it's gonna go as far
17 to have a QA, we both agree that, I guess we're going
18 to have to have a QA and it's reported. Usually,
19 you're going to find your patient's gonna report it
20 before most doctors do.

21 But you do the same thing in yours, how
22 do you, in your practice, report your doctor that's
23 your partner?

24 MR. CONCANNON: I'm totally lost.

25 Totally lost --

1 DR. JOHNSON: Me too.

2 DR. HEYE: Me too.

3 MR. CONCANNON: -- on this discussion.

4 All right. Let me just ask you ten
5 questions fast.

6 MR. LEINWEBER: Go ahead.

7 MR. CONCANNON: Are you a physician?

8 MR. LEINWEBER: No, I'm a PA.

9 MR. CONCANNON: You're a PA. And you
10 own several practices -- you own several sites?

11 MR. LEINWEBER: I own the North Central
12 Washington Health, which is a limited liability
13 company.

14 MR. CONCANNON: You're the hundred
15 percent shareholder?

16 MR. LEINWEBER: No. I -- I just -- 74
17 that I have, I am the majority stockholder. I own
18 65 percent and the doctor owns 35 percent.

19 MR. CONCANNON: All right. So you
20 control the voting in it as the PA? You're the 65
21 percent shareholder?

22 MR. LEINWEBER: Yes, basically.

23 MR. CONCANNON: All right. And you
24 employ other PAs?

25 MR. LEINWEBER: Not at this time. I

1 said we're -- we're in the process of getting other PAs
2 to come on board.

3 MR. CONCANNON: But don't you have a few
4 sites?

5 MR. LEINWEBER: We don't run them
6 everyday. We don't have -- we run -- our area is so
7 small, that we do two days at one site, two days
8 another, and two days at another.

9 MR. CONCANNON: All right. So you
10 employ doctors -- physicians?

11 MR. LEINWEBER: Yes.

12 MR. CONCANNON: How many?

13 MR. LEINWEBER: The doctor that's my --
14 supervising with, also my partner.

15 MR. CONCANNON: He's the 35 percent?

16 MR. LEINWEBER: He's got 35, yes.

17 MR. CONCANNON: All right. You have the
18 right to fire him if you're unhappy with the way he
19 practices?

20 MR. LEINWEBER: We have a contract that
21 says either way, yes.

22 MR. CONCANNON: All right. Do you get
23 more money out of the practice than him since you're
24 the 65 percent owner?

25 MR. LEINWEBER: No. Because we set it

1 up to where we have our company that we are employees
2 of and we work off of RVUs.

3 MR. CONCANNON: Off of what?

4 MR. LEINWEBER: RVUs. In other words,
5 we get a --

6 UNKNOWN 3: Productivity.

7 MR. LEINWEBER: Yeah, productivity.

8 MR. CONCANNON: And for some reason
9 something happens to him, you've have to find another
10 supervisor?

11 MR. LEINWEBER: Correct. I have a
12 secondary physician in case he's gone. And that
13 secondary has agreed that if something happens, he'll
14 step in.

15 MR. CONCANNON: And that happens from
16 time to time?

17 MR. LEINWEBER: Yeah.

18 MR. CONCANNON: Yeah. And you,
19 yourself, are practicing in these couple places?

20 MR. LEINWEBER: Correct.

21 MR. CONCANNON: And the doctor
22 practicing in these couple places?

23 MR. LEINWEBER: Correct.

24 MR. CONCANNON: And sometimes the
25 doctor's with you and sometimes the doctor's in one of

1 the other places?

2 MR. LEINWEBER: Agreed.

3 MR. CONCANNON: Right.

4 MR. LEINWEBER: We have to do both
5 sites.

6 MR. CONCANNON: All right. That's all.

7 MS. T. THOMPSON: Dr. Johnson.

8 DR. JOHNSON: Both of you have me
9 confused, because it sounds like what you're doing is
10 practicing independent medicine. And you're using the
11 rules of having a supervisor to -- to a delegation of
12 responsibility just to allow you to practice medicine
13 on your own.

14 Both of -- both -- and just let me
15 finish, I'm just trying to get around because that's
16 the question I asked from the very beginning of this
17 process is: Do PAs want to have independent practices?
18 And the answer is no, no, no, no.

19 I'm hearing that in your relationships,
20 you guys are running the show. Not you, but the PA
21 that you're now employed with. That you have hired a
22 doc to complement your practice and is willing to work
23 under your guidance. Which is really a different model
24 then what I've believed that the rules were set out to
25 make.

1 This doesn't have anything to do with
2 ownership of the practice. It has everything to do
3 with how does a practice run day-to-day. You're
4 coequal members of a health care community, I get it.
5 But that's a little bit different model, I believe,
6 than I was thinking and has been the discussion item
7 that we've held for a long time.

8 I'm not saying I'm in disagreement with
9 that, but I'm certainly thinking that the model you're
10 proposing, if it's promulgated across the state, we
11 have to rethink exactly what we mean by a delegation
12 agreement.

13 Because, in your example, your
14 delegation agreement says I'm going to let him do
15 whatever he wants to do. I'm not going to define
16 anything more than that. And the delegation agreement
17 in the ruling require definition.

18 Even to the point if you're practicing
19 with different specialists. Tom and I talked about
20 this on the way down today. You have -- I threw out an
21 example, if you have primary care physicians in a
22 smaller group practice -- peds, family practice, and
23 internal medicine -- you need three different
24 delegations because they're different specialities.
25 Even though they're really practicing primary care.

1 One with just adult medicine, one over
2 acts with kids and adults, and the last one with kids.
3 They're just taking care of primary care. I'm not sure
4 I know what the difference is.

5 But what I'm hearing from you is a very
6 different model than I think these rules are
7 describing. And I think we have to be thoughtful about
8 that. I don't have an answer. But I'm hearing
9 something that's an independent practice coming out of
10 your guy's mouth that hasn't been stated as a goal
11 amongst the PA group. That's -- that's what I have to
12 say.

13 DR. RAMZI: So actually I think, you
14 know, I think the model we've been talking about has
15 already been promulgated across the country of a
16 foundational element of what a PA is in primary care.
17 That model, I think, subsequently got picked up by
18 speciality.

19 And in a specialty environment, it's
20 much more rigidly controllable, appropriately so. That
21 physician is going to tell the PA exactly what he or
22 she wants and exactly how it will be done.

23 In primary care, it is much more of a
24 collaborative effort. It is a parallel practice. I am
25 a resource to every PA and nurse practitioner at our

1 practice. But the perfection of the nurse
2 practitioners that I supervise quote/unquote does not
3 require a physician supervisor.

4 Whereas the foundational element of
5 physician assistant says, we want to work with docs.
6 We don't want to be totally independent. We don't want
7 somebody telling us -- you know, we want somebody
8 telling us what we can and can't do.

9 So it's already there. And I think the
10 issue is establishing maybe some parameters over how to
11 assure that the physician is "clinically" in charge and
12 the owner, if he's a majority owner, is "business" in
13 charge.

14 Basically, if I go to my -- my PA and I
15 tell him I really think we should be doing CT scans on
16 lung cancer patients, it's going to happen. But if I
17 wanted to renovate the front office, it ain't gonna
18 happen unless he wants to do it.

19 So I think those are very clear, and
20 perhaps as I think about it, implicit boundaries
21 between physicians and PAs.

22 You know, I think the majority of
23 physicians would not put themselves in a situation
24 where they're employed by a PA, unless they understood
25 the boundaries of that relationship and how it would

1 work. And if they didn't, it ain't gonna last. I
2 think you'd agree with me on that. Yeah, it's just not
3 gonna last.

4 DR. JOHNSON: We're going to run out of
5 time and I --

6 MR. LEINWEBER: If I could just make one
7 comment.

8 I think where we're -- we're coming here
9 is we have an umbrella here that is that company. Then
10 that company has developed clinics. However, when we
11 are in the clinic, the physician is the authority. The
12 physician is the person. It's no different than if I
13 was working for somebody else.

14 But as a company, we make those decision
15 for the overall good of the company together. And yes,
16 I may own the majority of it, but it's -- it's usually
17 mutual agreement.

18 So I think we have a split of what this
19 business is up here to what each once of these clinics
20 is. Because within those clinics, the physician is the
21 physician, the PA is the PA and they follow under those
22 rules.

23 DR. GREEN: So one last question: I
24 haven't heard anybody say anything about what they
25 think should or shouldn't be in the rules. Or whether

1 or not any of you have a problem with the rules being
2 silent on the issue.

3 MR. LEINWEBER: I don't have a problem
4 with it being silent. What we were told was that there
5 was a question as to conflict of interest within the
6 clinic. And in my situation I can't say because we
7 work so well together, that there's ever going to be
8 that type of conflict of interest.

9 DR. GREEN: So how would you determine
10 whether or not there was? Somebody here is going to
11 sit and look at a delegation agreement and they may
12 decide that there is. How would you determine that?
13 Or can you?

14 MR. LEINWEBER: That's a good question,
15 it really is.

16 DR. GREEN: That's the problem.

17 MR. LEINWEBER: It's a very good
18 question.

19 DR. GREEN: That's the problem.

20 DR. JOHNSON: And it is our problem. If
21 the supervising physician is in trouble as an event, we
22 have responsibilities, that are not your business, that
23 we've to make decisions on, and that's the nuts of the
24 problem.

25 Is that -- is -- is -- is the PAs,

1 because they own the business and are so dependent on
2 their employed physician, are they going to be honest
3 enough in every case to share conflicts that might come
4 to our attention that we then have to deal with because
5 the business is then in jeopardy?

6 MS. GUNDERSEN: I think it works both
7 ways.

8 DR. JOHNSON: And the other thing I'll
9 add is the rules are set out that the PAs working under
10 the auspices of the delegation agreement or the
11 supervisor, and within the scope of practice within the
12 supervising physician -- within the -- within that
13 frame work. And that, you know, I think there's a
14 conflict.

15 DR. RAMZI: Yeah.

16 JOHN JOHN: There's an inherent
17 conflict.

18 MS. T. THOMPSON: We have two more
19 people.

20 DR. JOHNSON: Are there other people?

21 MS. T. THOMPSON: Yeah. There are two
22 more people that I think want to speak.

23 I feel like -- and I know you guys are
24 going to tell me I'm wrong. I feel like this
25 conversation has digressed from -- from writing rules

1 around whether or not we are going to write rules
2 around ownership and the relationship of partial
3 ownership and ownership between PAs and doctors and the
4 delegation agreement and what should be in the
5 delegation agreement.

6 And so I need to pull us back to the
7 discussion at hand. And this discussion is if there's
8 any remaining concerns about whether or not the Board
9 and commission members want to address PA ownership or
10 partial ownerships in these rules or remain silent.

11 And the AG's opinion and advice on this
12 is that you're putting yourself at risk when you want
13 to write language around how someone's going to
14 regulate their business.

15 Now, with that being said, and where we
16 are, there's two more people, I believe, that want to
17 speak on this ownership thing. And I think we need to
18 respect that and hear them.

19 We are off schedule a little bit and
20 that's totally okay. But those two people, I'd like to
21 hear from them. So I don't know who was the first one.

22 MR. BLAIR: I'm one.

23 MS. T. THOMPSON: Okay. Go ahead.

24 MR. BLAIR: My name is Jim Blair,
25 B-l-a-i-r. I have an urgent care clinic in Port

1 Townsend. And it's been in business since 2006. It's
2 a collaborative agreement within the -- with the
3 physician-PA relationship is a --

4 DR. JOHNSON: You a PA or a physician?

5 MR. BLAIR: I'm a PA.

6 DR. JOHNSON: Thank you.

7 MR. BLAIR: I have not had any -- I have
8 not had any conflict. I do have a supervising
9 physician and an alternate at the times when one's
10 gone. I do agree that there is a business entity and
11 there's a medical entity. And the persons, my
12 preceptors, who I -- who are my preceptors, I'm -- the
13 business decisions come that need to be made; for
14 example, like, renovate the front office or buy new
15 computers or update the EHR, those decisions are
16 different than our practice decisions that we make.

17 And I guess I would count myself lucky
18 that I've had two excellent preceptors. For the period
19 of time, I haven't had any type of conflict that was
20 brought up by the physician earlier about someone being
21 impaired or questions of that region. But I do -- I
22 can tell that it's -- we service a good need. And it
23 has worked out for -- for -- for the people in the
24 community and my patients and for us.

25 MR. CONCANNON: You own the clinic?

1 MR. BLAIR: I do.

2 MR. CONCANNON: A hundred percent of the
3 clinic?

4 MR. BLAIR: A hundred percent.

5 MR. CONCANNON: And you employ two
6 physicians? Or one?

7 MR. BLAIR: Yeah. There are -- there
8 are two physicians and, you know, whenever they're --
9 whenever -- it's productivity. And so whenever --
10 that's how they do it.

11 MR. CONCANNON: Well, I mean, there's --
12 there's a physician, your primary sponsor's on site
13 with you all the time -- almost all the time.

14 MR. BLAIR: No. I'm a remote site --
15 remote site practice.

16 MR. CONCANNON: Oh, all right.
17 That's -- again, that's not a problem for this rule.
18 Again, let's be clear here. It's not a question of
19 whether the rule should be silent or not. If the rule
20 is silent, we presume that the Commission is not going
21 to be able to deny a delegation agreement based on
22 physician-PA ownership of the practice, even if the PA
23 is the employing sponsor. If the rule is silent, PAs
24 presumably can do that.

25 The question is: Should PAs be

1 permitted to do that. If they shouldn't be, the
2 rule -- there will have to be a rule that says they
3 can't do it. All right. It's crystal clear.

4 Now, the question is: Should the rule
5 prohibit it?

6 MS. DALE: No.

7 MR. CONCANNON: Which means there should
8 be no rule on it.

9 MS. DALE: Correct.

10 MR. BLAIR: Remain silent.

11 MR. CONCANNON: I disagree, but that's
12 where you are.

13 DR. JOHNSON: I've really got to weigh
14 in. I'm hearing a primary care practice that you own
15 and run and you have a remote site. You have a remote
16 site supervisor, who is not part of your organization
17 except writing the delegation agreement, who may or may
18 not show up 10 percent of the time and review a certain
19 percentage of your charts that are in the rules.

20 You have -- what I'm hearing you say, is
21 you own your own practice. You've got a building that
22 you control. And you have a clinic and you have a --
23 you have a stable of patients that come to you all the
24 time and you provide great care. But you have a remote
25 site physician, they don't have a remote site PA, is

1 what I'm hearing in your practice.

2 MR. CONCANNON: I don't know. What's
3 the distinction there?

4 DR. JOHNSON: I'm trying to figure out
5 the difference. Because that's a -- once, again, it's
6 a different model than PAs when they came out of the
7 medics program and they signed on to work with a
8 physician or group in Omak. You know, in a small,
9 rural community.

10 And now, we're allowing the more remote
11 site PAs to be -- but there's still a delegation
12 agreement that says PA -- I'm responsible for that PA
13 and all the things they do. And I have to be there
14 10 percent of the time. And I'm not sure that that's
15 happening in -- I'm not accusing.

16 MR. CONCANNON: But you don't know.

17 DR. JOHNSON: I don't know. I'M not
18 accusing.

19 MR. CONCANNON: Right.

20 DR. JOHNSON: Just listening to the way
21 you got your business plan set up.

22 MR. CONCANNON: Well, where does your MD
23 work five days a week, physically, what city?

24 MR. BLAIR: Lake Chelan.

25 MR. CONCANNON: And how often does the

1 MD come into your practice?

2 MR. BLAIR: Over ten percent of the
3 practice time.

4 MR. CONCANNON: One day, five hours?

5 MR. BLAIR: No. It's -- it's usually
6 three days, four days -- four days a month. Four days
7 a month that they're there.

8 MR. CONCANNON: Comes from Lake Chelan?

9 MR. BLAIR: Correct.

10 MR. CONCANNON: Lake Chelan? Isn't that
11 over east of the mountains?

12 DR. JOHNSON: Lake Chelan to Port
13 Townsend?

14 MR. BLAIR: Port Townsend.

15 DR. JOHNSON: Um-hmm.

16 MR. CONCANNON: And why is this primary
17 supervisor willing to be your supervisor since he's in
18 Lake Chelan?

19 MR. BLAIR: I've been with him since
20 1993. We've had a relationship and he's willing to do
21 it.

22 MR. CONCANNON: And how does he get
23 paid?

24 MR. BLAIR: He's get paid productivity
25 and he gets paid an hourly rate on top of that.

1 MR. CONCANNON: Productivity of what?
2 He has no patients in your clinic; right?

3 MR. BLAIR: No. He sees patients when
4 he's here.

5 MR. CONCANNON: Oh. But the 10 percent
6 of the time he's there --

7 MR. BLAIR: Yes.

8 MR. CONCANNON: -- he happens to have
9 patients that are only his?

10 MR. BLAIR: It's an urgent care -- it's
11 an urgent care clinic.

12 MR. CONCANNON: And the alternate
13 physician, where is that person physically located?

14 MR. BLAIR: Also in Lake Chelan.

15 MR. CONCANNON: In Lake Chelan?

16 MR. BLAIR: Um-hmm.

17 MR. CONCANNON: Well.

18 MS. DALE: I think we have a -- this is
19 an access to care issue. And they all have -- we've
20 got one more to -- to speak. But they have the
21 supervising physician and it meets the remote site
22 requirement.

23 MR. CONCANNON: Right.

24 MS. DALE: As by rule.

25 MR. CONCANNON: That's right.

1 MS. DALE: And they've all talked about
2 how the business is a separate decision than the
3 medical. And the autonomy for which the PAs work -- I
4 work in a position, and I'm sure that Athalia can tell
5 you the same, that I worked in a clinic where I didn't
6 need the talk to my physician for a week. I was in one
7 hall, they were in the other, and I was seeing patients
8 and they were seeing patients.

9 And so even though we were under the
10 same roof, I practiced independently, if you want to
11 call it, with autonomy, if you want to call it; within
12 my scope of practice, if you want to call it.

13 But when I had a question, I walked
14 around the hall to where my doc was practicing. They
15 get on the phone or they Skype and they ask the
16 question. So, you know, you're not going to have
17 physicians in these little tiny towns.

18 MR. CONCANNON: Oh, no, no. I'm not
19 proposing otherwise. What you described is permitted
20 now. And what you described would be permitted under
21 the rule that I'm talking about. Because what I'm
22 saying is, if you own the practice, like you do, you
23 can't employ the physician on site. It has to be a
24 remote site. Somebody comes in.

25 MS. DALE: No, no. There is a physician

1 assistant in Prosser -- I'm sorry, but there is a
2 physician assistant in Prosser who took over the
3 practice because that supervisor -- his supervising
4 physician was leaving. He found a physician who came
5 and worked with him 40-hours a week or whatever.

6 But that physician did not want to have
7 anything to do with the business. They had a lot of
8 educational things, they were buying a house, they were
9 putting the wife through school, whatever. They did
10 not to have the headaches of business ownership. They
11 worked with that physician assistant.

12 And then now, eventuality, he has
13 retired and sold it to the Yakima Farm Workers Clinic.
14 But they're -- so it can be both ways. It can be on
15 site with productivity with an hourly wage or whatever.
16 So it's -- it's -- it's flexible.

17 MS. LANDRY: My name is Donna Landry.
18 I'm a physician assistant. I have a small clinic in
19 Olympia and mine is a little less controversial.

20 About two and a half years ago, I met --
21 I'd been in practice for over 20 years and I wanted to
22 start a clinic with a doc that I had worked with. So
23 we both kind of moved together and started a practice
24 together.

25 We're 50/50 partners in this clinic. We

1 overlap some parts of the week and then each of us
2 takes different days and it works very well. We make
3 decisions together, medically and business wise. So
4 very symbiotic.

5 When I heard you talk about the conflict
6 of interest part of what would happen if the physician
7 did something, would the PA be hesitant to turn it in,
8 I kind of feel it works both ways. I mean, I don't see
9 a difference if a physician did something wrong or the
10 PA did something wrong. I feel like the process would
11 be the same.

12 DR. JOHNSON: The difference is if the
13 physician loses his ability to practice, you don't
14 have -- you can't practice.

15 MS. LANDRY: Unless you get another one.
16 Well, I mean --

17 DR. JOHNSON: Well, it sounds like it's
18 difficult to get it if you have to go all the way down
19 from Port Townsend to Chelan to get some supervisor.

20 MS. LANDRY: Well, I mean --

21 DR. JOHNSON: Tells me that there's
22 difficulty. And I really --

23 MR. BLAIR: These are people that I've
24 had relationships with for a long, long time.

25 DR. JOHNSON: I'm not denying that. I'm

1 not trying to cast judgment. I'm talking about if we
2 get a case -- I'm really hearing independent practices
3 in reality. You can call it what you want, but you're
4 practicing all by yourself day after day and you may or
5 may not have contact.

6 And I would like to know if something
7 happened and the investigators came to your clinic,
8 what documentation do you have that you're being
9 supervised?

10 MR. BLAIR: The --

11 DR. JOHNSON: I'm not gonna -- this is
12 time, we need to move on. I just want you to know we
13 that have different concerns. They come from if there
14 was a issue. And I'm not sure I've had my questions
15 answered today, but we need to move on to more
16 delegation on the responsibilities and stuff.

17 MS. T. THOMPSON: Okay. So we are away
18 from our time and I want to be precise. And I want to
19 make sure you guys got what you needed.

20 The question at hand is: Does this
21 committee want to go back and reiterate whether or not
22 we are going to try to draft up some language about PA
23 ownership or partial ownership of clinics? Or are we
24 going to not have rules at the current time?

25 Knowing all of the facts that you know,

1 you know your AG opinion, you know what your risks are,
2 what does the committee want to do? And do we want to
3 vote? Or do you just want to make that decision?

4 DR. JOHNSON: I'd like to ask George
5 what his thoughts are on this.

6 DR. HEYE: I'm against it.

7 DR. JOHNSON: Against what?

8 DR. HEYE: Putting in something about
9 PAs owning clinics and hiring I suppose.

10 MS. T. THOMPSON: So remain silent, is
11 that what you're saying?

12 DR. HEYE: I'm saying nothing about it.

13 MS. T. THOMPSON: What I'm seeing, I
14 know there's one opposition, but what I'm seeing is the
15 majority of the committee wants to remain silent and
16 leave it alone.

17 MS. SCHIMMELS: This is Theresa. I'd
18 agree with that, too.

19 MS. T. THOMPSON: And Theresa -- Theresa
20 Schimmels agrees.

21 Okay. We're ready to move on. But
22 before we move on, I had one little error in my
23 facilitation. I did not introduce the commission
24 members. And so I would like each of you to go and say
25 who you are and who you represent so that the audience

1 knows who you are.

2 DR. MARKEGARD: Shannon Markegard, I'm
3 an osteopathic physician, family physician, work in
4 Maple Valley.

5 MS. GUNDERSEN: I'm Sharon Gundersen.
6 I'm the public member on the Osteopathic Board.

7 MS. CLOWER: My name is Athalia Clower.
8 I'm one of the physician's assistant and I represent
9 the Medical Quality Assurance Commission.

10 DR. GREEN: Tom Green, physician member
11 of MQAC.

12 DR. JOHNSON: Mark Johnson, physician
13 member of MQAC.

14 DR. HEYE: George Heye. I'm a
15 consultant for the Commission.

16 MR. CONCANNON: Mike Concannon. And I'm
17 a public member of MQAC.

18 MS. DALE: Linda Dale. I represent the
19 Washington Academy of Physician Assistants.

20 MS. T. THOMPSON: Okay. Sorry. So --
21 okay. We are ready. We're only -- oh, and Theresa --

22 MR. CAIN: Oh, yeah, Theresa.

23 MS. T. THOMPSON: -- on the phone.
24 Theresa?

25 MS. SCHIMMELS: Oh, yeah. Theresa

1 Schimmels, physician assistant with the dogs barking in
2 the background. Sorry. MQAC.

3 MS. T. THOMPSON: Theresa with her dogs.
4 Okay. So we are at the place where the committee in
5 Yakima gave the staff some assignments. And the first
6 one was to work with Dr. Green and Linda Dale a little
7 bit on continuing education language.

8 And so I'm going to just -- let's have
9 them both up there. We usually work from medical just
10 because they've had more and we use that as our basis
11 to start with.

12 So we have the language up there. I
13 know that we talked about whether or not we could
14 require certification with the national -- national
15 certification where our statute does not allow us to
16 require it. We could use it as a secondary option. So
17 I believe that's how we drafted up the language. I
18 know that we were talking about cleaning it up and make
19 it a little more clear and less restrictive.

20 So I'm opening up the discussion by the
21 --

22 DR. JOHNSON: So at the FSMB -- Theresa,
23 you can help me on this -- this is Mark. I was under
24 the assumption that if the PA has to be certified to be
25 able to get a license. But there's a lot of PAs in our

1 state that once they are certificated, they let -- they
2 let their certification lapse, but they still were
3 licensed.

4 And so we're dealing now with a changing
5 paradigm of maintenance of certification that will then
6 tie into maintenance of licensure. And we do not have
7 this yet in allopathic rules, but I think they should
8 be there. So we're starting off the PAs.

9 And I was led to believe at the last
10 meeting that there was no venue if a PA lost -- became
11 noncertified, and they couldn't use PA-C in their
12 initials, that you could just be PA.

13 That there was no avenue for them to
14 be -- to maintain some certification that we could then
15 use for MOL. Turns out, that's not true. It turns out
16 PAs, even if they're not certified, can take an
17 examination and I think the term Theresa calls
18 regaining -- can you hear me, Theresa?

19 MS. SCHIMMELS: Yes. I think that's
20 what it was called.

21 DR. JOHNSON: There's a term called
22 regainer or regaining that allows a PA, who's not
23 certified, to still take the exam, would then serve as
24 a -- as a document for the -- for relicensure.

25 MS. DALE: Right.

1 DR. JOHNSON: And I would you suggest
2 that some term that's correct be -- be put in there
3 that would guide PAs, who are no longer certified,
4 towards the maintenance of certification concept.

5 Because we know that CME alone doesn't
6 really do a great job. And we're trying to expand the
7 ability from -- in the relicensure issue to make sure
8 the doc is doing the right thing.

9 So my understanding is there is an
10 avenue for noncertified PAs to take a test and
11 demonstrate the things is that would be otherwise if
12 their -- I don't believe they can get a certification
13 now.

14 MS. DALE: They actually -- they
15 actually -- if they have graduated from a accredited
16 program, they can take the NCCPA certification under
17 that -- I think it is called recertification or --

18 DR. JOHNSON: Regainer was the term.

19 MS. DALE: Regaining, yeah. And it kind
20 of depends on how many years they've not been
21 certified, what steps they have to do. And they can
22 take a recertify under the national certification in
23 the NCC- --

24 DR. JOHNSON: I'm not sure they can
25 recertified. But they can take -- I'm -- that -- but I

1 would just -- I'm just making a comment that I think we
2 should have some terminology that reflects that concept
3 in the rules, as an encouragement for all in whatever
4 specialty we are to maintain MOC concept.

5 MS. DALE: So are you saying that you're
6 going to require physicians in Washington State to
7 continue to be certified or board -- you know, board
8 certified in their specialty, be it family medicine,
9 emergency medicine, any?

10 DR. JOHNSON: I don't think we can
11 require certification. We want a maintenance of
12 certification concept. You can't have hospital
13 privileges without being certified. You can't --
14 several insurance companies won't -- you have to be
15 certified. So I think there's other pressure to
16 maintain certification than just licensure.

17 This is a national issue. It was
18 discussed at great length at the FSMB. And I'm using
19 this as Step No. 1 in the rule making to look at PAs
20 and say, is there a way we can encourage PAs?

21 Because there's a lot of docs who are
22 not certified, MDs who are not certified, we still get
23 relicensed. And how are we going to make sure they are
24 being -- maintenance and certification concept, you
25 know, we don't know yet.

1 I'm using this as Step 1, because if we
2 can get this right, then we can work on the other side.
3 So if there was a way for PAs to take the test and show
4 the -- all the different facets without being -- then
5 so if there's some way we can have this written into
6 the rules, I think it would be a useful.

7 I don't really see a reason not to have
8 it in the rules as an opportunity, not a mandatory, but
9 encouragement.

10 MS. DALE: Okay. So you're saying not a
11 mandatory, but encouraged?

12 DR. JOHNSON: Well, if they don't do it,
13 then they have to fulfill other requirements. The
14 advantage of maintenance and certification concepts,
15 it's not just going and sitting and showing I do 50
16 CMEs a year and go to some -- and I'm also doing other
17 things that are showing my ability to be a good
18 physician.

19 It's beyond the scope of just CMEs. And
20 that's what a noncertified PA is able to do. And we
21 have no way, within the commission and relicensure, to
22 know that they're really keeping up. How do they tell
23 us? How do we know? Because we are having to do the
24 maintenance of certification. We're allowing the PA
25 National Board to be our eyes and ears to that process.

1 MS. DALE: And one of the things that
2 you had -- had asked me before was whether the
3 Washington Academy of PAs would have some method of
4 having those 300 noncertified to log in their CMEs.
5 And we have found a program. We're still -- we're
6 still looking at others to try to find one. So we
7 think that with would be able to offer a logging method
8 for those 300 noncertified to at least log their CMEs.

9 And one of the things the NCCPA is doing
10 now requiring self-reflection and specific types of
11 things. So you know, that could be one thing that they
12 would need to do if you decide to --

13 DR. JOHNSON: That's that whole point,
14 Linda. It's taking career -- that's an awkward -- to
15 do that, they would have to do those things --

16 MS. DALE: Right.

17 DR. JOHNSON: -- to get their
18 certification. You know, I don't know whether they
19 feel the need to be a PA-C again, that doesn't matter.
20 What matters is are they doing what is the current
21 paradigm shift for what we think is useful for
22 relicensure.

23 MS. DALE: Right.

24 DR. JOHNSON: That's the issue.

25 MS. DALE: Right.

1 DR. JOHNSON: And I think that using
2 that as a -- having that in the rules as a law, it says
3 other programs approved, I think we could have a line
4 that specifically defines what that program is. And
5 then they can have other programs.

6 MS. SCHIMMELS: Doctor, you're talking
7 about --

8 DR. JOHNSON: Yeah, Theresa.

9 MS. SCHIMMELS: Dr. Johnson, you're
10 talking about putting that other member -- we need
11 other programs approved by the Commission such as a --
12 whatever that name is -- re-entry program or whatever
13 it was Doctor was talking about doing.

14 DR. JOHNSON: I think it's an
15 opportunity -- like you and I talked at the meeting, of
16 using that concept and having it in the rules as a
17 specific opportunity for PAs to -- when they
18 relicensure to show that they're doing the essential of
19 a PA-C of a recertification, using the term regaining
20 or regainer, which -- whatever the -- whatever that
21 term is, have it in the rules as a specific, you know,
22 have a C and then have another D --

23 MS. DALE: Yeah, big D.

24 DR. JOHNSON: Right. Just figure out
25 what the right rule -- right term is, put it in there,

1 done.

2 MS. SCHIMMELS: Right.

3 DR. JOHNSON: Do you disagree with that,
4 Theresa?

5 MS. SCHIMMELS: Yeah, I do, exactly.
6 Linda, did you say there were 300 out of how many PA
7 licensed in the state that aren't certified?

8 MS. DALE: Well, I pulled notes from a
9 couples of meeting ago and we did the math. And we
10 found that there was somewhere between 300 and 380
11 depending on whose numbers you use, that did not
12 maintain certification, but yet were practicing in
13 Washington.

14 MS. SCHIMMELS: So -- and excuse me, my
15 feeble brain today, how many PAs are practicing in the
16 state?

17 MS. CARTER: How many practicing PAs?

18 MS. DALE: About 2700 practicing PAs
19 and -- let me grab my available stats.

20 MS. SCHIMMELS: That's okay. You know,
21 one of the -- the FSMB numbers that aren't certified
22 and there was something that was like 880,000
23 physicians practicing in the United States. But only
24 440 or -- you know, approximately only half of us, that
25 maintained their board certification.

1 So these numbers to me are more than
2 discouraging, because I think that those physicians are
3 requiring certification for the PA to practice in their
4 hospital or clinic or whatever.

5 DR. GREEN: So isn't Mark's suggestion
6 included in those ones above it? If you regained your
7 certification by some process, you're considered
8 certified.

9 Another comment I would make -- excuse
10 me -- is that the physician side of this equation only
11 has CME in it presently, but probably within -- how
12 long is it going to take to change that? I mean, this
13 is the way the physicians are going to end up with
14 something just like this, so they're being pretty
15 equivalent. And as time goes on, people who are not
16 certified, it is anticipated will go away.

17 But leaving that first one in, is
18 intended to give people who are not certified a way to
19 get relicensed without having these things. And vice
20 versa, the people who are involved in maintenance
21 certification don't have to do something in addition.
22 That it qualifies both of these equally.

23 MS. T. THOMPSON: So, yeah, exactly. To
24 move along and get us going. So like Dr. Green,
25 stated, so we have the certified PAs and we have these

1 noncertified PAs. We have two options up there that
2 allow both PAs to continue to get continuing education
3 credits.

4 Dr. Johnson brings up a really good
5 point in that he's looking at the future and where he
6 wants to go. You have a C up there that allows for the
7 Commission and these rules -- the Boards are similar,
8 to approve other similar programs that would allow for
9 this.

10 And I think that my suggestion would be
11 for the committee to consider that taking Dr. Johnson's
12 concept -- and once you have that concept, that
13 program, and done your research and have it all pulled
14 together -- then that's your opportunity to maybe open
15 up this rule again, and provide, yet another
16 opportunity to adjust it as you feel fit once you have
17 that concept solidified.

18 I think you have two options: If you
19 want to continue to delay to do a little bit more
20 research to put a more language in there; or if we put
21 C up there, do you have enough leverage to work another
22 program. And then you could adopt it specifically to
23 the rule later.

24 Does that make sense?

25 MS. SCHIMMELS: Do we have to be

1 specific? Or can other programs approved by the
2 Commission just use the language?

3 MS. T. THOMPSON: This time, you know,
4 as long as they are substantially equivalent to your 1
5 and 2, I think you're okay. Heather?

6 MS. CARTER: I agree.

7 DR. JOHNSON: The point I'm making is
8 No. 1 is what we've traditionally done all the time,
9 and the whole world is going way past that.

10 MS. T. THOMPSON: We want to phase it
11 out.

12 DR. JOHNSON: So No. 1 will be
13 inadequate at some point in the future.

14 The trouble for the Commission is we
15 have no way of really keeping track of it. We don't
16 have a mechanism to do that. So when people reapply
17 for a licensure, whether it's allopathic or PA, there
18 is no auditing done on the quality of the CMEs.
19 There's just attestational statements.

20 The value of the PA-C concept -- or the
21 MOC concept, excuse me, is that someone else, a
22 certifying specialty organization, has taken on the
23 responsibility to not only say you're going to go see
24 me, but you're going to take an exam and you're going
25 to do some other things that show you're enhancing your

1 practice. It's bigger than just going on CME.

2 So I think No. 1 is the least important.
3 It, at some point, should disappear and be replaced by
4 the alternatives. Either recertify, in which they have
5 to maintain it. If you're not certified, there is
6 another way to do it. Let's define it. It's got a
7 name. And I might be wrong on the name, but if we had
8 it there and we still had other programs, that would be
9 the encouragement, not a mandatory, but an
10 encouragement for noncertified PAs to do what we all
11 should be doing. That's all I'm saying.

12 MS. T. THOMPSON: And my question to you
13 then is: So that do we have that other mechanism ready
14 to put in here to move on? Or should we notify the
15 Commission --

16 DR. JOHNSON: I think we can move on if
17 we -- I think we cannot belabor this any longer and
18 allow -- Theresa knows the input person, we were
19 standing talking with you -- and get the exact language
20 and let it -- put it in there.

21 DR. GREEN: I would suggest that it's
22 covered in there in the current -- because if you
23 regain your certification that's current certification.

24 DR. JOHNSON: They --

25 DR. GREEN: Seems to me that's covered.

1 DR. JOHNSON: They will not necessarily
2 regain their recertification, Tom.

3 DR. GREEN: Well --

4 DR. JOHNSON: Because they take this
5 regainer thing does not mean they'll get their C back.
6 They'll still be -- that was my understanding.

7 MS. SCHIMMELS: You know, that's --
8 that's incorrect, Mark. If they go through the
9 regainer program, then they will again be able to be
10 eligible to take the test. And the whole idea of it is
11 they'll take the test and their C back.

12 MS. DALE: Right.

13 DR. JOHNSON: Oh, I misunderstood that
14 then.

15 DR. GREEN: So then you don't need to
16 change what's written there and we can move on.

17 DR. JOHNSON: Let's move on.

18 MS. T. THOMPSON: Okay.

19 DR. HEYE: Can you just add the other
20 MOC programs?

21 DR. JOHNSON: You could do something
22 simple like that.

23 DR. HEYE: Just add MOC before programs.

24 DR. GREEN: Just incorporate C into B
25 and get rid of C.

1 MS. CARTER: Well, I think if you leave
2 it as a C, you have more flexibility and not just
3 having it be a MOL or MOC program. If there are other
4 certifications that come around in the future or
5 something.

6 So if you leave it as a C, you could,
7 you know, approve -- evaluate and approve, you know, as
8 many programs as you wanted in the future. So I think
9 if you leave it as a C, you're giving yourself more
10 flexibility.

11 MS. SCHIMMELS: I agree, Heather. I
12 think that's -- leave it as a C.

13 DR. JOHNSON: Okay. Go on.

14 MS. T. THOMPSON: Okay. So -- but
15 before we move, I gotta make sure the Osteo Board is
16 good with their language.

17 MR. CAIN: It's the same. It's the same
18 language.

19 DR. MARKEGARD: It's the same language.
20 Our language is awesome.

21 MS. T. THOMPSON: Sweet. So I gotta
22 backtrack just -- up there to the section before, which
23 talks about renewal and continuing medical education
24 cycle.

25 And we have -- basically, I think we

1 took the -- these requirement haven't changed. We've
2 just -- I think we've drafted them so that they -- so
3 that's a little bit more clear how the process works.
4 And is everyone okay with how it's drafted?

5 Is that, you know, wonky? A little.
6 But to get your -- your license within 90 days of your
7 birthday you have this leeway or -- so that you don't
8 have to have your renewal right away. You have that
9 90-day window.

10 MS. DALE: Is the osteopathic rule going
11 to remain -- remain at one year, 50? Because you're on
12 a one-year cycle for PAs renewels? Or are we on a
13 one-year cycle for physician renewal also?

14 MS. T. THOMPSON: Okay. So that -- that
15 language then will be for PAs renewal 50 per year.

16 MR. CAIN: Yeah.

17 MS. T. THOMPSON: Okay.

18 DR. MARKEGARD: They have to do 50 CMEs,
19 renew every two years.

20 MS. T. THOMPSON: Yes, they do that.

21 DR. MARKEGARD: Okay.

22 MS. T. THOMPSON: We're okay? Okay.

23 Moving on to -- so we're going -- I
24 think it everyone's okay with it, we're skipping over
25 kind of all the surgical procedures, surgical assistant

1 duties. There was no changes, no issues, no concerns.

2 We have to keep that language, although
3 Dr. Heye gave me that look. Did you have something?
4 So -- yes, Dr. Heye.

5 DR. HEYE: I don't know if you talked
6 about this but, you know, 180, where is says "current
7 certification." Did you talk about that as meeting the
8 medical education requirements?

9 MS. D. THOMPSON: We have not.

10 MS. T. THOMPSON: No.

11 DR. HEYE: And with the MD regulation,
12 if you're certified and you're -- that's only good for
13 one four-year period. Okay. And if the PAs are
14 reporting every two years and they're certification
15 goes on seven years now or -- I don't know.

16 MS. DALE: It will be ten. We're moving
17 from six to ten. But we still have to have -- every
18 two years have to have a hundred hours every two years
19 logged in to NCCPA to maintain that. We just test
20 every ten years.

21 DR. HEYE: Right. But this -- this
22 looks like an alternate -- No. 2A looks like an
23 alternate to No. 1, which says "in the lieu of that a
24 current certification." So that seems to be a conflict
25 that you could be currently certified for ten years and

1 not do any CMEs, so.

2 MS. D. THOMPSON: No.

3 MS. DALE: No, that's wrong. I'm sorry.
4 No, it's a misunderstanding.

5 DR. HEYE: Well, I know certification
6 requires that. But I'm just talking about the language
7 here.

8 MS. DALE: I agree. Because NCCPA to
9 maintain -- even though you pass your exam, you cannot
10 maintain your certification without needing that 100
11 CME every two years. If I don't meet my hundred CME
12 every two years, I will lose my certification no matter
13 where I am in that retesting cycle.

14 DR. HEYE: I understand that.

15 MS. DALE: So then -- so really this is
16 accurate, because it's current certification. So if
17 I -- I have to retest next year, if I didn't complete
18 my hundred hours, I will lose my certification, no
19 matter when I'm supposed to retest.

20 DR. HEYE: But then it doesn't make
21 sense to put in lieu of one hundred hours --

22 MS. SCHIMMELS: It's the year that
23 you're in, Mark. So like right now, I'm in year four
24 of my six year. And at the end of this year, I have to
25 pay my money to NCCPA and I have to have logged my

1 hundred hours for the last two years. And then that
2 keeps my certification going. That means that I have
3 done the CME that I'm supposed.

4 So even though it's going to change to a
5 ten-year cycle, every two years we're responsible for
6 reporting the NCCPA that we are current.

7 MS. T. THOMPSON: So -- okay. So --
8 okay. The statute does not allow this conversation.
9 That statute does not allow the Commission or the Board
10 to require certification with another entity for
11 recertification. So I think that we have in lieu --
12 we're saying the standard is a hundred hours, but to
13 give you another option, you can maintain certification
14 with these.

15 And what you're saying is that "in lieu
16 of" is where the hang up is?

17 DR. HEYE: Well, the current
18 certification requires a hundred hours.

19 MS. T. THOMPSON: Right.

20 DR. HEYE: So it's the same thing.

21 MS. T. THOMPSON: It is the same thing.
22 But say tomorrow they say that the current
23 certification for NCCPA is 150 hours or you know. So
24 as a Commission or a Board, they would be saying, well,
25 that's substantially equivalent or that covers it,

1 we're okay with that.

2 Does that answer your question?

3 MR. CAIN: The Osteo Boards, same
4 section, it just says "in lieu of the continuing
5 medical education requirements." And it doesn't put an
6 hour there.

7 MS. T. THOMPSON: Well, it says "50
8 hours" in one --

9 MR. CAIN: Yeah, I know. I'm saying --
10 Dr. Heye's saying it's repetitive because of the
11 hundred hours. If you just say "in lieu of the CME
12 requirements," the Commission will accept that instead
13 of putting in, "in lieu of the hundred hours."

14 MS. T. THOMPSON: Okay.

15 DR. GREEN: He's saying that the
16 certification is good for a longer period than the
17 relicensing cycle. Isn't that your concern?

18 DR. HEYE: Yeah. But as part of the
19 certification, they've built in an MOL kind of thing.

20 DR. GREEN: Which meets the
21 requirements?

22 DR. HEYE: Which is the same requirement
23 as No. 1.

24 MS. CARTER: One thing I could see, if
25 you were audited, it would be much easier to show I'm

1 currently certified with the NCCPA, then finding all
2 your certificates. So it's makes -- you know, that's
3 one thing that may be easier for the PA to prove their
4 compliance.

5 DR. HEYE: Well, see B under there is
6 compliance with continuing maintenance of
7 certification. That's, again, the same thing, so.

8 MS. DALE: My copy says "maintenance of
9 competency." And so I think -- I think that was
10 different. I think that's what Dr. Johnson was talking
11 about as far as MOC, maintenance of competency,
12 programs.

13 DR. HEYE: Okay. Is there such a thing?

14 MS. T. THOMPSON: It's not just
15 continuing education. It's continuing education, which
16 includes a show of competency. Is that what you're
17 saying?

18 MS. DALE: (Moves head up and down.)

19 DR. HEYE: Okay.

20 MS. T. THOMPSON: So do you -- for the
21 medical it says "in lieu of 100 hours." Do you want it
22 to say "in lieu of the continuing medical education
23 requirements" or?

24 MR. CAIN: Or vise versa.

25 MS. T. THOMPSON: Or vise versa.

1 MR. CAIN: Put 50 in or out?

2 MS. T. THOMPSON: Or put 50 in or out,
3 yeah.

4 DR. MARKEGARD: I kinda like the way
5 ours is worded.

6 MS. T. THOMPSON: Maybe you could do it
7 in lieu of the requirements of subsection 1 of this
8 section.

9 MS. DALE: Now, you --

10 MS. T. THOMPSON: To back up --

11 MS. DALE: Are you talking legally?

12 MS. T. THOMPSON: It totally is.

13 MS. DALE: Yeah.

14 MS. T. THOMPSON: All right.

15 DR. HEYE: We can move on. We can work
16 on that language, if you want.

17 MS. T. THOMPSON: Okay.

18 MR. CONCANNON: Is it -- I'm paying very
19 little attention to this. I'm trying to save my energy
20 for --

21 MS. T. THOMPSON: I know -- I know you
22 are, I feel it.

23 MR. CONCANNON: -- bigger fights later
24 on. Is it clear to everybody that if somebody is going
25 to be licensed by both boards as a PA, what the CME

1 requirements are? Is it clear what they are?

2 MS. DALE: I think No. 1 outlines that
3 on both.

4 MR. CONCANNON: All right. That's all.

5 MS. T. THOMPSON: Okay. So can we check
6 off continuing medical education for both osteo and
7 medical?

8 MS. DALE: Yes.

9 MS. T. THOMPSON: We may tweak it a
10 little bit with Dr. Heye without changing the intent.

11 Okay. So then the next piece that is up
12 for grabs is the acupuncture section.

13 So acupuncture in medical, we believe,
14 in our research, that the Commission could repeal this
15 section. So acupuncturists are now licensed as an East
16 Asian medical practitioner.

17 Go ahead, Heather.

18 MS. CARTER: So just -- I don't know if
19 many people know, but there were acupuncturist PAs in
20 the past that were, I think, foreign medical graduates
21 that came to this country and wanted to perform
22 acupuncture. And it was before the East Asian Medicine
23 and Acupuncture profession came into existence.

24 So there's still is both osteo and the
25 MD statute saying that any physician assistant

1 acupuncturist, who is currently licensed, can continue
2 to do acupuncture without getting their East Asian
3 medicine credential.

4 So I don't know that the definition is
5 necessary in the ruling, you've got it in the statute.
6 And now, there's an acupuncture profession that we
7 have.

8 MS. T. THOMPSON: Right.

9 MS. CARTER: So I don't -- I don't know
10 that it's necessary. And osteo does not have a set of
11 rules for it.

12 DR. MARKEGARD: Osteo has a whole set of
13 rules -- chapter on acupuncture.

14 MS. T. THOMPSON: There are rules on
15 acupuncture.

16 DR. MARKEGARD: So we're -- we just
17 covered that.

18 MR. CAIN: And we can't delete that as
19 part of this process, because it's a chapter. But it's
20 something that following this project, we're going to
21 look at.

22 MS. T. THOMPSON: We're going to work at
23 reviewing it.

24 DR. JOHNSON: So is there any need to
25 keep it?

1 MS. CARTER: I don't see any need.

2 DR. JOHNSON: Let's get rid of it.

3 MS. T. THOMPSON: Okay. So moving right
4 along.

5 MS. CLOWER: I need to stop.

6 MS. T. THOMPSON: Oh, yeah, go ahead.

7 MS. CLOWER: On practicing medicine and
8 surgical procedures, did you already discuss that?

9 MS. T. THOMPSON: We skimmed right over
10 it because we have to keep it because we do have some
11 licensed practitioners and licensed surgical
12 assistants. And there was no proposed changes to the
13 ruling; which I think we're working on phasing them
14 out, kinda.

15 MS. CLOWER: Could there be an
16 explanation of what those people that are phasing out
17 are doing and will be doing, so the employers don't get
18 confused that that's a regular PA.

19 MS. T. THOMPSON: So we have basic
20 physician assistant-surgical assistant duties. And I'm
21 walking through what a surgical assistant's duties are.

22 MS. CLOWER: Where are you reading?

23 MS. T. THOMPSON: That is in section
24 246-918-250, the next -- the next section.

25 MS. CLOWER: Yeah. But maybe if you put

1 in parenthesis not NCCPA eligible or something to
2 distinguish between a regular physician assistant in
3 this category. Because it's confusing if you're not
4 familiar with the profession.

5 MS. T. THOMPSON: Okay.

6 MS. CARTER: I think the first sentence
7 of 250, if you wanted to clarify more, you could just
8 take that first sentence, maybe, or part of it as an --
9 an introduction, which says "the basic physician
10 assistant-surgical assistant who is not eligible to
11 take the NCCPA certifying -- or was not eligible." You
12 could just add that, if you feel you need the
13 clarification.

14 MS. T. THOMPSON: Okay.

15 MS. CARTER: But it does say it in the
16 next provision. It's just a --

17 MS. DALE: When --

18 MS. T. THOMPSON: Okay. Oh, sorry.

19 MS. DALE: When we discussed this before
20 there -- there was a year. Because we -- we -- we were
21 concerned that there could be more of these and you
22 said, "No, there's only eight. And when they're done
23 and they retire, there's not going to be any more."
24 Where is that date? I'm skimming and I can't find it.

25 MS. T. THOMPSON: In the definitions.

1 MS. CARTER: Yeah, in the definitions.

2 MS. DALE: Oh, in the definitions.

3 And could we then maybe put a sentence
4 about that on that -- on that chapter, so then
5 there's -- then it's more clear. Oh, yeah. Here it
6 is, B2(c), an individual who was licensed as a
7 physician assistant between September 30, 1989 and
8 December 31, 1989, to function in the limited extent.

9 So could we put that on this first line
10 on 250?

11 MS. T. THOMPSON: Well, you could. But
12 you're repeating yourself; right? So the intent is to
13 define what it is, the definition section. That
14 definition will follow through for every section that
15 it's used in. So the sections are standalones; right?

16 MS. DALE: Right.

17 MS. T. THOMPSON: So if you do it for
18 one, you're going to do it for all of them.

19 MR. CAIN: So can you just put in the
20 title practice of medicine physician assistant-surgical
21 assistant, surgical procedures, that way people know
22 that that's what they're talking about? Because I
23 understand Athalia's point. If you read 230 alone, you
24 don't know they're talking about PA/SA until you go to
25 the next section.

1 MS. T. THOMPSON: So say what you said
2 again.

3 MR. CAIN: Just put their name in the
4 title of the section.

5 MS. T. THOMPSON: Of 230?

6 MS. CLOWER: Yeah.

7 MR. CAIN: Because the next section says
8 "basic PA/SA duties." So you know they're talking
9 about there PA/SAs there.

10 MS. CLOWER: Yeah.

11 MR. CAIN: I don't know that you
12 necessarily know that just looking at 230 standalone.

13 MS. T. THOMPSON: Okay.

14 MS. CLOWER: And then on the same
15 section, 246-918-005, of the definitions, up under B,
16 is No. 1 correct or not?

17 MR. CAIN: It could very well be
18 incorrect.

19 MS. CLOWER: But I question --

20 MS. DALE: Which one was that, 1(b)?

21 MS. CLOWER: Yes, b(1) or b(i). Is
22 eligible for the NCCPA examination, and was licensed
23 prior to 1999. So I'm not sure -- I'm questioning
24 whether that's out the period or not.

25 MS. D. THOMPSON: But there's two

1 different types. There's a noncertified PA, and then
2 you have PA/SA.

3 MS. T. THOMPSON: Right.

4 MS. D. THOMPSON: So the definition
5 distinguishes between all of this. And when we refer
6 to a noncertified -- there are individuals who did not
7 graduate from an accredited program and were not
8 eligible to be certified. And we have -- what was the
9 total those? -- 30 of those. And then we have 9
10 PA/SAs. There's technically three types of PAs
11 currently working in Washington.

12 MS. CLOWER: Okay.

13 MS. D. THOMPSON: The regular PA that
14 graduated from an accredited program, they either are
15 or are not certified. They were certified at one point
16 to get a license here. And then you have the PAs that
17 are not certified and can never be certified. And,
18 again, as they age and retire, they will be phased out
19 and cannot be those currently. They were only issued
20 up to a certain date. So the licenses that were issued
21 prior to 1999.

22 MS. CLOWER: Right. But it says "prior
23 to 1999, you cannot be eligible for the NCCPA
24 examination." So I don't think I've been aware they
25 weren't eligible.

1 MS. D. THOMPSON: Oh, so number -- the
2 three i's.

3 MS. DALE: No --

4 MS. CARTER: If you --

5 MS. T. THOMPSON: That says "graduated
6 from an international medical school and was licensed
7 prior to July 1, 1989."

8 MS. D. THOMPSON: Correct.

9 MS. DALE: Does that not capture the
10 ones you're thinking of, Athalia?

11 MS. CLOWER: I'm not sure. I just want
12 to make sure that I'm correct because it's confusing
13 for me that I'm a PA and I can't imagine for somebody
14 to hire a PA and in trying to hire a PA, you know. It
15 could be more clear.

16 MS. T. THOMPSON: We'll, they are --

17 MS. D. THOMPSON: Well, we actually --

18 MR. CONCANNON: All right. I'm on the
19 fringe -- on the fringe when it comes to this, since I
20 don't -- I haven't been following it. But as I look at
21 246-918-230, this is supposed to be applying to
22 physician assistant-surgical assistants.

23 MS. DALE: Yes.

24 MR. CONCANNON: Why shouldn't be saying
25 the following duties constitute the practice of

1 medicine under 1871 and 1871(a), if performed by
2 PA/SAs, colon. What's the reason for all the -- all
3 that gibberish that's after that?

4 MS. T. THOMPSON: As long as PA/SA is
5 defined somewhere.

6 MR. CONCANNON: You've defined it. You
7 pointed it out. It's at the very beginning.

8 MS. T. THOMPSON: So there is no reason
9 why we can't shorten that up.

10 MR. CONCANNON: If performed by PA/SA,
11 physician assistant-surgical assistants, colon. And
12 then you're defining what they can do.

13 MS. T. THOMPSON: Well, but our
14 definition of a PA/SA is an individual that's licensed
15 as a physician assistant between these dates who's
16 functions is limited extent and authorized in 250.

17 MS. DALE: 230.

18 MS. T. THOMPSON: 230 talks about
19 persons who are nonregistered -- not registered,
20 certified, or licensed by an agency of the state. So
21 that's important information.

22 MS. CARTER: I think is what they're
23 trying to do is say the PA/SA can't do these things?
24 Is that what it's saying?

25 MR. CONCANNON: What's the purpose of

1 230?

2 MS. CARTER: It seems --

3 MR. CONCANNON: Is it supposed to be
4 trying to say what PA/SAs can do? Or can't do?

5 MR. CAIN: The following duties
6 constitute the practice of medicine.

7 MR. CONCANNON: If it constitutes the
8 practice of medicine, is that a good thing or a bad
9 thing in determining what PA/SAs can do?

10 MS. T. THOMPSON: If you're practice --
11 well, I think it's clarifying that what practice is and
12 if you do these things and we haven't clarify that it's
13 practicing medicine, then the Commission can go after
14 somebody for not -- for practicing medicine without the
15 authority, without the -- the certification.

16 MR. CONCANNON: Well, this -- without
17 regard to whether it constitutes the practice of
18 medicine, is the purpose of 230 to say that these are
19 five things that PA/SAs can do.

20 MS. DALE: No, no.

21 MR. CONCANNON: Are those the only five
22 things they can do?

23 MS. DALE: Exactly.

24 MR. CONCANNON: Are those the only five
25 things PA/SAs can do? Is that the reason why they

1 exist?

2 MS. T. THOMPSON: If you read it -- so
3 it says, "if performed by persons who are not
4 registered, certified, or licensed." It constitutes
5 practice of medicine if they're performed by these
6 people who are not. So this, to me, is they cannot do
7 one, they cannot do two, they cannot do three, they
8 cannot do four, they cannot do five.

9 Is that -- lawyers?

10 MS. CARTER: Yeah. No, I think it's
11 very poorly worded --

12 DR. HEYE: No kidding.

13 MS. CARTER: -- but this is what we had
14 for years. But I agree that these are the things they
15 can't do.

16 MS. CLOWER: Cannot?

17 MS. CARTER: I believe so.

18 MS. D. THOMPSON: And I don't know that
19 has anything to do with PA/SAs.

20 MS. CARTER: Right.

21 MS. D. THOMPSON: I think that these are
22 things cannot do if you are not registered, certified,
23 or licensed by the agency of the state. So this would
24 be anybody. So I can't step into a surgical suite,
25 gown up, and hold something for the doctor because I'm

1 not licensed.

2 MS. CLOWER: So why is that there?

3 MS. D. THOMPSON: I don't know.

4 MR. CAIN: I don't know.

5 MS. T. THOMPSON: I think it just falls
6 in there because it's saying the practice of medicine
7 for surgical procedures they use, this is what surgical
8 procedures are. And if you look down to talk about
9 what a physician assistant-surgical assistant can do.

10 MS. CARTER: Well, I think my guess
11 would be that there were some problems at some point of
12 nonlicensed people were assistants in the surgical
13 suite doing these things. So the Commission thought it
14 was important to explicitly state you can't go in --
15 unless you're licensed, certified, or registered, you
16 cannot do these things, and we will charge you with
17 unlicensed practice of medicine. That would be my
18 guess.

19 MS. T. THOMPSON: We have had to do that
20 with some people's tattooing, scarring. We've had to
21 state this is what the practice of medicine is to help
22 clarify the situation.

23 MS. CARTER: I agree. I think this is
24 setting the stage of what the practice of medicine is.

25 MS. DALE: If we change the title to say

1 unlicensed practice of medicine, surgical procedures.
2 Would that further clarify this, if we have to keep
3 this here?

4 DR. GREEN: You know, throughout these
5 rules things are stated in the negative fashion that is
6 confusing. And I think this is one example of it.
7 There are multiple.

8 And I think it would be -- I think if
9 you have to have this, if you just change this to a
10 positive statement, you must be licensed if you're
11 going to perform these things, you could do it in one
12 sentence and it would become clearer. This is very
13 confusing, I think. And the part -- and the reason for
14 it is, it's stated in a negative as opposed to a
15 positive.

16 MS. T. THOMPSON: Okay. So would you
17 like staff to --

18 DR. GREEN: And I would just reword in
19 that sense, and I think it will be okay.

20 MS. T. THOMPSON: Okay.

21 DR. GREEN: That's my suggestion.

22 MS. T. THOMPSON: Okay. Does the
23 Committee agree?

24 DR. GREEN: You if don't need it, I'd
25 get rid of it.

1 MS. T. THOMPSON: I see heads shaking.

2 DR. HEYE: I don't see why it's in here.

3 DR. GREEN: Huh?

4 DR. HEYE: I don't see why it's in here.

5 DR. GREEN: I don't either. That's why
6 I said, if you don't need it, I would just change it to
7 a positive statement.

8 DR. HEYE: Because 250 actually lists
9 the things PA/SAs are allowed to do.

10 MS. T. THOMPSON: Um-hmm. Okay.

11 DR. GREEN: Yeah. But 230 covers other
12 people.

13 DR. HEYE: Yeah. But that's more of a
14 general -- under a general law anyway.

15 DR. GREEN: I know. There's -- there's
16 a lot of redundancy. That's the other thing.

17 DR. JOHNSON: Do certified surgical
18 techs -- are they allowed to assist in opening
19 incisions?

20 MR. CAIN: No. They're registered.
21 There's no formal requirements for surg tech. They
22 register with the state.

23 So they can -- they can -- the closest
24 thing they can do is operate a staple gun when the
25 physician's actually holding tissue together, but they

1 can't do deep tissue stapling.

2 DR. JOHNSON: What about retracting the
3 skin to allow the incision?

4 MR. CAIN: I don't believe that's within
5 their scope.

6 DR. JOHNSON: They're not allowed to do
7 that. I would not walk around operating rooms in the
8 State of Washington with surgical techs as a first
9 assistant waiting for the PA to show up.

10 MR. CONCANNON: So when you cut --

11 DR. JOHNSON: I would never walk in. So
12 I think we have to be careful.

13 MR. CONCANNON: When you cut to the
14 chase on this, is there any reason for 230 to be in a
15 PA rule?

16 MS. T. THOMPSON: If there's no reason,
17 then we can repeal it.

18 MS. CARTER: The only reason I can think
19 of -- I prosecute the unlicensed practice of medicine
20 cases that are reported to the Department. And if I
21 had someone doing these things, it would be much easier
22 to point to this as say you violated this. But other
23 than that, I can't think of a --

24 MR. CONCANNON: But it didn't say --
25 what's this got to do with it. I mean, it needs to be

1 somewhere in the WAC. There is no reason why it should
2 be in the PA rule.

3 MS. CARTER: It could be in the MQAC
4 rule.

5 MR. CONCANNON: Unless it has to do
6 physician assistant-surgical assistant. But you're
7 saying that's not what it's for.

8 DR. GREEN: The problem that I see with
9 this is that it opens the door to having to write down
10 every single thing that constitutes the practice of
11 medicine --

12 MR. CONCANNON: Practice of medicine.
13 And there's just --

14 DR. GREEN: -- which is defined
15 somewhere else as perforating the skin.

16 MR. CONCANNON: Yeah, yeah.

17 DR. GREEN: That's a dangerous path to
18 go down. It leads to -- if you haven't got it written
19 down then maybe it doesn't apply.

20 MR. CONCANNON: So unless this is
21 supposed to either define or limit what PA/SAs do, it
22 doesn't belong here.

23 MS. T. THOMPSON: Okay.

24 MR. CONCANNON: My thought, anyway.

25 MS. T. THOMPSON: With that thought --

1 DR. GREEN: If you don't need it, get
2 rid of it.

3 MR. CONCANNON: What do you think,
4 Dr. Heye?

5 DR. HEYE: I've just been assaulted.

6 MS. DALE: Where's a lawyer, quick.

7 DR. HEYE: I'd agree. I'd take it out.
8 I don't think it adds anything.

9 MS. T. THOMPSON: Okay. Going once,
10 going twice. Okay. We're going to pull it unless --

11 DR. GREEN: Unless the lawyers say we
12 can't.

13 MS. T. THOMPSON: -- something weird
14 comes up and then we'll let you know.

15 Could -- maybe we should have you look
16 and see if it could be moved somewhere else rather than
17 just dropping it.

18 MS. CLOWER: Oh, no, no, no, no.

19 DR. GREEN: Get rid of it.

20 MS. T. THOMPSON: No, no, no.

21 DR. GREEN: Get rid of it.

22 MS. CARTER: At the posture we're at
23 now --

24 DR. GREEN: It's not about PAs.

25 MS. CARTER: -- we can only do it in the

1 PA rules, so.

2 MS. T. THOMPSON: Okay. Yeah.

3 DR. GREEN: And it's not about PAs.

4 That's --

5 MS. T. THOMPSON: Okay. All right. Any
6 other questions on those surgical duties?

7 MS. CLOWER: Yes, I did. I'm sorry. If
8 I could just get clarified that title. Maybe
9 indirectly, they're not NCCPA eligible -- for the
10 person who's not here and not talking about this and
11 they're reading this for the first time.

12 MS. T. THOMPSON: You mean in 250?

13 MS. CLOWER: Right.

14 MS. T. THOMPSON: Well, the very first
15 sentence says "this person who is not eligible to take
16 the NCCPA certifying exam."

17 MS. CLOWER: But the title -- I mean, I
18 know it's helps. But, you know, you got to think about
19 that -- people doing that job. They're going come up
20 and say, oh, we're a PA -- I don't know.

21 DR. MARKEGARD: I think they can just
22 read the next sentence. And if they can't figure it
23 out, then perhaps they shouldn't be working.

24 MS. CLOWER: But there's a lot of
25 people like that, you know, they're just going through

1 the rules and they see it's confusing, they can say,
2 Well, we're not going to hire the PAs because it's too
3 much to read and -- but that's okay.

4 MS. DALE: PA/SA --

5 MS. CLOWER: Huh.

6 MS. DALE: -- quote, in current
7 parenthesis, see definition.

8 MS. CLOWER: Yes.

9 MS. T. THOMPSON: Okay. So is the
10 consensus to add something to the title or not? The
11 staff will do whatever the Committee wants.

12 MR. CONCANNON: I don't know what you
13 would add. What would you add, Athalia?

14 MS. CLOWER: PA update.

15 MR. CONCANNON: I'm sorry. PA and say
16 basic physician assistant-surgical assistant duties.

17 MS. CLOWER: Yeah. And then in
18 parenthesis after basic -- basic physician
19 assistant-surgical assistant, parenthesis, PA/SA
20 duties.

21 So if somebody is hiring a PA-C, they
22 don't need to stop there because they're a PA/SA, and
23 not a PA-C.

24 MS. DALE: So like that? That's four
25 letters?

1 MR. CONCANNON: PA/SA.

2 MS. CARTER: Whatever.

3 DR. GREEN: Yeah, why not.

4 MS. CLOWER: Thank you.

5 DR. GREEN: PA/SA.

6 MS. T. THOMPSON: Okay. All right.

7 MR. CONCANNON: Are we breaking for tea
8 soon?

9 MS. T. THOMPSON: In 15 --

10 DR. GREEN: Are there cookies or
11 anything?

12 MS. CARTER: I brought chocolate.

13 DR. GREEN: All right. Let's keep
14 going.

15 DR. JOHNSON: For yourself? Or others?

16 MS. CARTER: No, for everyone.

17 MS. T. THOMPSON: I was going to, like,
18 I don't know, wait for the hearing or something. Okay.
19 Acupuncture, are we -- Dr. Heye, yes,
20 sir.

21 DR. HEYE: I was just wondering if we
22 were going on to 60?

23 MS. T. THOMPSON: Yes, 260, sorry. What
24 you got for me? Anyone? Yeah, we put the title there,
25 PA/SA. Is there any other concerns or anything?

1 MS. DALE: Oh, can we go ahead and use
2 on B -- 3(b), strike badge and just say "shall wear
3 identification." The same way that we did before?
4 Because again, the whole issue of kids ripping off
5 badges. They're with scrubs, we can't -- with that
6 misconception, just say shall wear identification.

7 MS. T. THOMPSON: Because they have it
8 on their uniform already; right?

9 MS. DALE: Yeah.

10 MS. T. THOMPSON: Yeah. That's fine.
11 Okay. Anything else? Okay.

12 And then the acupuncture, we're going to
13 pull out of medical. Osteo doesn't have it. Before
14 I -- really quickly, before I move back around to the
15 definitions.

16 Osteo, because we're at the end of
17 your -- there is the added move to clarify fixed
18 language that's going to make your laser light rules
19 near MQAC. So they -- they are now consistent.

20 It's basically changing your standard a
21 little bit, you know, a little bit higher.

22 MR. CAIN: Do you remember,
23 Dr. Markegard, if we're putting it in the physician
24 rules where -- in the -- in the LRP rules? Currently,
25 it refers to someone licensed by the Department of

1 Health and removing that language and mirroring MQAC
2 and allow LRP --

3 DR. MARKEGARD: Yes.

4 MR. CAIN: -- to also delegate to a
5 physician or people who are licensed by the Department
6 of Health or licensed by the Department of Licensing.

7 DR. MARKEGARD: Yep.

8 MS. T. THOMPSON: Okay. With that --
9 yes, Dr. Heye?

10 DR. HEYE: You're looping around to the
11 beginning.

12 MR. CAIN: We're going to the beginning.
13 That's all right.

14 MS. T. THOMPSON: Well, my notes say to
15 go to the definitions and then we're going to do
16 retired active. I can't remember why we were going to
17 do definitions first.

18 MR. CAIN: The definitions of sponsoring
19 an alternate supervisor physician --

20 MS. T. THOMPSON: Okay.

21 MR. CAIN: -- need some fine tuning.

22 MS. T. THOMPSON: Okay.

23 DR. HEYE: Did you talk about section
24 150?

25 MR. CONCANNON: We haven't talked about

1 anything, Dr. Heye.

2 MS. T. THOMPSON: Well, we may have --
3 oh, we're not there yet. We're going to loop back
4 around and then.

5 MR. CAIN: We started at CMEs because
6 that's where we left off in Yakima.

7 DR. HEYE: Okay.

8 MR. CAIN: We wanted to make sure we got
9 through everything.

10 MS. T. THOMPSON: Okay. Definitions.
11 The definitions, the challenge there was to pull
12 together the terms, get rid of licensee, use the
13 correct terminology, and so it's married up with the
14 terminology in the statute. And I believe we landed on
15 supervising physician, alternate physician, and --

16 MR. CAIN: Sponsoring.

17 MS. T. THOMPSON: And sponsoring
18 physician. Do we have sponsoring physicians? Still
19 have sponsoring physicians?

20 MR. CONCANNON: Wait.

21 MS. DALE: What language --

22 MR. CONCANNON: Wait.

23 MS. DALE: -- is the statute?

24 MR. CONCANNON: Wait.

25 MS. CARTER: Sponsoring is a statute, as

1 well as supervising.

2 MR. CONCANNON: Dr. Green sent you
3 information on this, I sent you information on this.
4 You can call them whatever you want, but there's no
5 consistency at all in this rule with these definitions.
6 So it has to be -- call them whatever to want, but you
7 got to be consistent. Because it's going to effect
8 everyone of these sections.

9 DR. JOHNSON: I think the suggestions I
10 made, as far as I can tell reading through it, it is
11 consistent if you use those words. That was part of --
12 part of the reason for the suggestions I had, which I
13 don't have a copy of in front of me, and they're noted
14 there.

15 DR. HEYE: Your suggestion?

16 DR. JOHNSON: Yeah.

17 DR. HEYE: I have a copy.

18 DR. JOHNSON: Good. It goes back to
19 some old terminology. But if you read through all of
20 the other places where it refers to supervising or all
21 the other where it's they're sponsoring a physician
22 assistant or physician, it is consistent as far as I
23 can tell.

24 MR. CONCANNON: All right. So what's
25 the definition of --

1 DR. HEYE: Well, your suggestion was --
2 excuse me, Mike.

3 MR. CONCANNON: Yeah.

4 DR. HEYE: Your suggestion was to drop
5 out the definition of supervising physician, just leave
6 the term in, and then go to A and B?

7 DR. JOHNSON: Yeah. There are two kinds
8 of supervising physicians.

9 MS. T. THOMPSON: And I believe that
10 supervising physician means either sponsoring --

11 DR. JOHNSON: It's okay. You can --

12 MS. DALE: -- or an alternate.

13 MS. T. THOMPSON: We have what
14 supervising -- or sponsoring physician means, and then
15 what alternate supervision means.

16 MR. CAIN: So do we want to get rid of
17 the word supervisor there in there so that the terms
18 match?

19 MS. T. THOMPSON: We left those in there
20 for a reason.

21 MR. CAIN: And I -- after reading back
22 through it, I remember why I didn't take it out. I
23 didn't want to take it out until the group decided.

24 MS. T. THOMPSON: Okay.

25 MR. CAIN: But that was in my head, too,

1 that there was a reason why I couldn't.

2 MS. T. THOMPSON: Can't remember why?

3 MR. CAIN: Couldn't place it. The word
4 supervisor here and referring to these who didn't have
5 supervisor there and it's confusion.

6 DR. JOHNSON: So if you just put
7 supervising after alternate and cross out everything
8 after either under 4, then you have it all.

9 MS. T. THOMPSON: Because you've got A
10 and B and you don't need --

11 DR. JOHNSON: And then the terminology
12 that's used everywhere else will refer appropriately to
13 those definitions.

14 DR. MARKEGARD: Are you saying take out
15 sponsoring physician?

16 DR. JOHNSON: No.

17 MS. T. THOMPSON: Right up there --

18 DR. JOHNSON: You put supervising after
19 sponsoring and after alternate.

20 MR. CAIN: Which we don't need; right?

21 DR. JOHNSON: Because one is -- and the
22 only difference between those two is one of them has
23 the administrative responsibility.

24 MS. T. THOMPSON: Is it because when we
25 were talking through scenarios, you have a sponsoring

1 physician, but your sponsoring physician may not be
2 your supervising physician for that daytime event for
3 whatever reason?

4 DR. JOHNSON: Yeah. It's defined now in
5 B that covers that.

6 DR. MARKEGARD: Is that language then --
7 seems that it's not consistent with the language that's
8 used on the -- these agreements -- the delegation
9 agreements, because it says "primary supervising
10 physician," not primary sponsoring physician.

11 I don't --

12 DR. HEYE: That may need -- that may
13 need to be changed. The delegation agreement may need
14 to be changed.

15 MS. DALE: Yeah.

16 DR. JOHNSON: I didn't look at those
17 when I made those suggestions.

18 MS. DALE: It would be easier to change
19 the delegation agreement than to go through all the
20 rules and change that.

21 DR. JOHNSON: These things aren't
22 defined in statutes, are they?

23 MS. DALE: Right.

24 DR. JOHNSON: So these could be changed
25 easily to match the terminology on there?

1 DR. HEYE: Yeah.

2 DR. JOHNSON: George, you have to work
3 with these all the time, what is your --

4 DR. HEYE: Well, I agree. The
5 delegation agreement language is --

6 DR. JOHNSON: But as far as what's
7 written up there.

8 DR. HEYE: Yeah. I can't turn around
9 and look at that.

10 MS. DALE: So to clean up the language,
11 what you're saying, Dr. Green, on No. 4, supervising
12 physician means either?

13 DR. JOHNSON: And delete the rest of 4.

14 MS. DALE: Or a semicolon.

15 DR. JOHNSON: Sponsoring supervising
16 physician or B, an alternate supervising physician.

17 MS. DALE: Right.

18 DR. JOHNSON: One has administrative and
19 supervising roles and the other only has supervising
20 roles in place or in lieu of No. A -- letter A.

21 MS. T. THOMPSON: Now, on A, did you
22 want sponsoring supervising physician or --

23 DR. JOHNSON: Yep.

24 MS. DALE: Pardon?

25 DR. JOHNSON: Yes. Put supervising

1 after sponsoring and after alternate.

2 MS. T. THOMPSON: Okay. We have a
3 question or the comment from the audience.

4 MR. CAIN: And those are the terms that
5 are used throughout the chapter.

6 DR. JOHNSON: Every other place where
7 you talk about a sponsoring physician or an alternate,
8 it will make sense according to those definitions, I
9 believe. Somebody else can read through it, but that's
10 what I tried to do.

11 MS. T. THOMPSON: And are we consistent
12 with the statutes that -- yeah, the statute?

13 And there's a question from the
14 audience.

15 MR. ANDERSON: Hello. I'm Matt
16 Anderson. I'm a PA in Seattle. And I'm just wondering
17 why we're still using the word "supervisor"?

18 MS. DALE: It's in the statute. Which
19 means a law change. Because I know there's a
20 question -- I've gotten a lot of emails this last
21 couple weeks about changing to collaborative or
22 collaborating physicians. But it's in statute, so we'd
23 have to take it back in front of a legislator to get
24 that changed.

25 MR. BLAIR: Is that process going to be

1 considered?

2 MS. DALE: Not -- not yet. It probably
3 will be, but it's not at this good time.

4 MR. BLAIR: Would this Commission
5 enforce that if it came to pass?

6 DR. JOHNSON: We can't lobby, but you
7 can. There's a lot of things we would like to do.

8 DR. MARKEGARD: It also, I think, if I
9 remember from the first meeting that you were in, that
10 I don't see a problem with having -- it's called the
11 supervising position. As a PA, you are being
12 supervised.

13 MR. ANDERSON: I still don't think that
14 really reflects what's going on in modern practice.
15 Especially when we started this meeting and you had
16 several PAs talking about being at remote sites and
17 functioning with -- you know, you even kind of joked
18 about it when you called -- I need to call it this.

19 Whatever label you put on it, you've got
20 PAs that there's somebody that's out here in Zillah and
21 their supervising physician is in Lake Chelan.

22 So whatever the word that's put on it,
23 you choose supervising or what words to use because
24 there's not -- not so much that supervision isn't a
25 necessity in that collaboration of business and

1 probably what a necessity is.

2 But because after 40 plus years as a PA
3 practice and, you know, that should stand as a
4 testament to PA competency to deliver care with the
5 level of autonomy and independence that these remote
6 site PAs are offering.

7 That it really does an inservice to call
8 it supervision that's not needed or in reality, being
9 provided.

10 DR. MARKEGARD: If supervision isn't
11 what's happening, it doesn't mean that it's not
12 happening and we just take their word and say it's not,
13 they still have to have them supervised. I mean, still
14 they need to up their game and do better supervision
15 and as per their delegation agreement. So just because
16 it isn't happening, doesn't mean it shouldn't be
17 happening.

18 And as a PA, you are supervised by a
19 physician and that -- that's what this word
20 "supervising" -- and the sponsoring physician doesn't
21 say they supervise the PA.

22 MR. ANDERSON: But it sounds like
23 legislatively there's a pathway to change it to a
24 different words, such as collaboration.

25 DR. JOHNSON: But with regard to doing

1 these at a distance, I see it as an available option.
2 Your point is taken and not ignored.

3 MS. T. THOMPSON: Okay. So it's --
4 sorry.

5 MR. BERGSTEIN: My name's Len Bergstein,
6 and I represent ZoomCare. The last time we got on this
7 discussion, we talked a little about supervising
8 positions or potentially a supervising organization
9 that would be able to oversee PAs as well.

10 We have a business model that has
11 sponsoring physicians and we also have supervising
12 physicians that are in an organization as opposed to
13 just an alternate physician identified. Is that --

14 DR. MARKEGARD: On the delegation
15 agreement where it has physician group?

16 MR. BERGSTEIN: Right. I just want to
17 make sure that's good. From what I understood when I
18 raised the issue last time, you said that's
19 contemplated by the rules and is an acceptable
20 practice.

21 DR. JOHNSON: This coverage of the
22 delegation agreement? Or something else?

23 DR. HEYE: I think so. I think the RCW
24 talks about groups also.

25 MS. T. THOMPSON: So it's 2:30, and so I

1 have to promise my court reporter a break. So we're
2 going to take a break until 2:45. And then we'll come
3 back and try to wrap up this part. All right?

4 (Off the record.)

5 MS. T. THOMPSON: Okay. We landed on
6 supervising physician means, either sponsoring
7 physician or alternate physician.

8 Are we ready to move on past this?
9 We're good with this? All right.

10 MR. CONCANNON: So supervising physician
11 is the generic term for both of them?

12 MS. T. THOMPSON: Yes.

13 MR. CONCANNON: It really means either
14 or both of; right?

15 MS. T. THOMPSON: Right.

16 MR. CONCANNON: It means either or both
17 of?

18 MS. T. THOMPSON: Um-hmm. Is everybody
19 cool with that?

20 MS. DALE: There's actually only two
21 places in the -- I found two places just right now were
22 we need to pull out sponsoring and put in supervising
23 in the MQAC. It would be very clear which one it would
24 mean.

25 MS. T. THOMPSON: Excellent. Thank you.

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MS. DALE: And I think we talked about this now, I would just like to one more time to go through this one more time and make sure that when we say supervising physician, it appropriately means either/or. And if we need specifics, we'll go back to the specifics.

So was there any other definitions that we needed to look at?

MR. CONCANNON: All right. So the ZoomCare man asked whether alternate physician could be a group, and, if so, it needs to be in the definition. An alternate physician can be a group.

MS. T. THOMPSON: Don't you have to designate who is in the group?

MS. CARTER: Not on the delegation agreement. By statute --

MS. T. THOMPSON: Oh.

MS. CARTER: -- you can have a group that's an alternate. So in some -- maybe we should add it, but in some cases you're really needing that actual person, not the group.

MS. T. THOMPSON: Oh. Currently, throughout the rules --

MS. CRAIG: Isn't that why we add an S

1 after physician to address the group scenario?

2 MR. CONCANNON: I'm sorry.

3 MS. DALE: Right. We added an S.

4 MS. CRAIG: Yeah.

5 DR. JOHNSON: The delegation agreement
6 has a place for physician, too -- as well.

7 MR. CONCANNON: Well, alternate
8 physicians doesn't necessarily mean a group. You can
9 have two or three or four alternate physicians that are
10 not part of any group; right?

11 DR. JOHNSON: Right.

12 DR. HEYE: Yeah.

13 MR. CONCANNON: Where are you? Who's
14 jumping around here? Where are we?

15 MR. CAIN: Sorry. I was just -- I'd can
16 to go back -- all of this -- I was changing it for us.

17 DR. JOHNSON: You could also have an MD
18 supervising an osteopathic PA on a particular day in a
19 group environment.

20 MS. DALE: Right.

21 DR. JOHNSON: Or visa versa.

22 MS. DALE: Right.

23 DR. JOHNSON: And is that --

24 MR. CAIN: Yeah --

25 DR. JOHNSON: -- the verdict of --

1 MR. CAIN: -- 257 and 487 --

2 MR. CONCANNON: That's covered in
3 another place.

4 DR. JOHNSON: Okay.

5 MS. CARTER: Those two are the MD and
6 osteo statutes.

7 MR. CAIN: That's MD and that's --

8 DR. HEYE: That's -- that covers it.
9 Got it. Okay.

10 MR. CONCANNON: All right.

11 MS. T. THOMPSON: So do we got a
12 solution?

13 MR. CONCANNON: No, no, no, no. So,
14 again, you're saying alternate physicians does not have
15 to have the word group in there somewhere?

16 MS. T. THOMPSON: Um-hmm.

17 MR. CONCANNON: It's not necessary?

18 MS. T. THOMPSON: Legal?

19 MS. CARTER: Well, I think it's going to
20 depend on how we -- how we use the term. But we may
21 need to add means any physician like blah, blah, blah
22 or physician group who provides clinical oversight.

23 DR. MARKEGARD: I think that would be
24 best.

25 MR. CONCANNON: But, again, you're

1 changing this now on the fly as if -- as if, in the
2 magical world of today, you have something clear at the
3 end of the day.

4 MS. T. THOMPSON: Um-hmm.

5 MR. CONCANNON: So you either change it
6 or you don't change it, but there's no sense in yapping
7 about it too much.

8 MS. T. THOMPSON: Well, no. We need
9 to -- we need to come up with the language that we're
10 going to change it to.

11 MR. CONCANNON: What you just said;
12 right?

13 MS. CARTER: Right. You could add or --
14 or the -- I think they use the term physician group, so
15 I would stay consistent.

16 MR. CONCANNON: Or physician group.

17 MS. T. THOMPSON: And then that would be
18 clarified in the delegation agreement; correct?

19 MS. CARTER: Right.

20 MS. T. THOMPSON: Okay. Yes, sir?

21 MALE AUDIENCE MEMBER: I assume that any
22 physician group actually has a person who is
23 responsible for the medical issues, either a CMO or a
24 medical director. So I would think you wouldn't want a
25 physician group without a medical director. And that

1 you could, basically, say that the alternate physician
2 could be anyone or the medical director of a physician
3 group; therefore, narrowing down and identifying a
4 particular person.

5 MR. CAIN: Because you have to have a
6 person responsible.

7 DR. JOHNSON: You still gotta have a
8 sponsor.

9 MALE AUDIENCE MEMBER: You still got to
10 have a sponsor even if you have an alternate.

11 DR. JOHNSON: I see the conflict coming
12 up in the delegation with the multiple specialities.

13 MR. CONCANNON: Yeah.

14 DR. JOHNSON: How do we deal with that
15 because a group can be --

16 DR. GREEN: Yeah. I wouldn't put group
17 in there, it's problematic.

18 MS. DALE: You've got the S, so that
19 means multiple. So is it multiple in one group or one
20 individuals.

21 DR. JOHNSON: Well, you're still going
22 to have to identify the individuals.

23 MS. DALE: Right. Well --

24 DR. JOHNSON: You need to add some
25 pieces of paper to the application.

1 MR. CONCANNON: What is the reason on
2 the delegation form of having a place to put physician
3 group as opposed to naming a bunch of alternate
4 physicians? What's the reason to put physician in the
5 group?

6 DR. JOHNSON: Because when the
7 delegation agreement is created -- and the Group Health
8 doc isn't here today -- but when he was here, they
9 talked about they have changing people all -- you know.

10 MR. CONCANNON: Are they going to have
11 to be named?

12 DR. JOHNSON: That's the question. And
13 the reason not to name them is because within the
14 confines of the urgent care group of Group Health. It
15 seemed reasonable to let their medical director assume
16 that. But he may not be there that day or --

17 DR. GREEN: George, is that the way you
18 understood that? Because that's the way I understood
19 it.

20 DR. HEYE: What's that?

21 DR. JOHNSON: Explain it. Well, I'm
22 just trying to figure out of I was head of emergency
23 services at Group Health and had multiple clinics and
24 multiple PAs, multiple docs that might be at different
25 sites on different days, who is responsible that day in

1 that situation for the PA? That's -- who's
2 responsible?

3 Well, it's the group then. In their
4 delegation agreement defines that there will be a
5 triage -- there will be someone who's at the head of
6 the table for that day, in that urgent care, for that
7 PA.

8 DR. GREEN: But I -- he's saying --

9 MR. CONCANNON: It's written into the
10 delegation.

11 DR. GREEN: He's saying -- he's saying
12 that that method, you didn't have to specify the
13 individual physicians in the delegation agreement.

14 And I'm saying I don't -- you -- you
15 wouldn't want to just delegate situations of people who
16 were unidentified, would you?

17 DR. HEYE: Yeah. We leave it up to the
18 delegation agreement. Or it could just be practice one
19 never ask for identification past the sponsor. If it's
20 a group, it's just said, if it's a group, you don't
21 have to identify.

22 Now, sometimes there's only one
23 alternate, but if there's multiple alternates, you
24 don't want to know who they are.

25 DR. GREEN: So like -- like the groups

1 that I was in, if I sponsored two PAs but the reality
2 is they worked with ten other people --

3 DR. HEYE: Right.

4 DR. JOHNSON: -- more than they did me.

5 DR. HEYE: Yeah, that's the problem.

6 DR. GREEN: And those ten other people
7 aren't identified to you?

8 DR. HEYE: No.

9 DR. GREEN: And you don't care who they
10 are.

11 DR. HEYE: Because they could change all
12 the time. It would be a nightmare to keep track of it.

13 DR. GREEN: Okay. Well --

14 DR. HEYE: We figure it's up to the
15 group that has the PAs to do that and to make sure
16 there's always somebody that they're answerable to.

17 DR. JOHNSON: And that is then
18 written -- then they'll have a policy that they can
19 refer to in the delegation agreement. And it settles
20 it.

21 DR. HEYE: Okay.

22 DR. JOHNSON: And we can always go to
23 them and say where's your delegation -- where's your
24 policy?

25 DR. HEYE: We don't -- we don't even do

1 that.

2 DR. JOHNSON: No, no. But we could if
3 there was a issue?

4 DR. HEYE: Well, yeah. If there was a
5 problem that came up, they would have to be able to
6 identify.

7 DR. JOHNSON: Yeah, that's their
8 responsibility.

9 DR. HEYE: That's their responsibility.

10 DR. JOHNSON: We don't have to create it
11 for them.

12 MS. T. THOMPSON: Okay. Dr. Markegard,
13 question and comment.

14 DR. MARKEGARD: No. I was just
15 clarifying the same with the Group Health gentleman who
16 came today. I think having a group suffices as an
17 alternate. And you don't have to say all the names
18 because that changes. The changes where they are at
19 shift.

20 If there is a complaint that comes in on
21 that patient, they can look and see who the -- their
22 alternate physician was for that day and time period.

23 MR. CONCANNON: Again, let's just -- we
24 have to keep going back to this. What Heather was
25 mentioning, too, the statute says that a physician

1 group could be -- could be the supervisor for a PA.
2 Not only the alternate supervisor, but the prime
3 supervisor.

4 MS. CARTER: Right. But --

5 MR. CONCANNON: Correct?

6 MS. CARTER: Correct. But the
7 Commission has interpreted that as we need a live body,
8 you know, on the line though.

9 MR. CONCANNON: And the Commission
10 interpreted that how and when?

11 MS. CARTER: Through the rule. And I
12 don't know, probably from the beginning. I don't know
13 when.

14 MR. CONCANNON: Yeah. So -- and you're
15 saying that the Commission is content with the
16 physician group at the alternate, but not as a the
17 prime?

18 MS. CARTER: Right.

19 MR. CONCANNON: And the physician group,
20 who signs on behalf of the physician group, when
21 there's a delegation agreement?

22 DR. GREEN: Sponsor.

23 MR. CONCANNON: Who signs it?

24 DR. GREEN: Supervising physician.

25 DR. JOHNSON: The medical director.

1 MR. CONCANNON: No, no, no. There's a
2 prime and he or she has to sign. And then there's
3 signature of an alternate physician and it says "not
4 applicable if group practice."

5 MS. D. THOMPSON: Correct. Nobody
6 signs.

7 MR. CONCANNON: If a physician group is
8 named, who signs?

9 MS. D. THOMPSON: Nobody signs.

10 MS. T. THOMPSON: Nobody.

11 MS. D. THOMPSON: Nobody, no one.

12 That's what it said on the thing.

13 MR. CONCANNON: Nobody has to sign?

14 MS. D. THOMPSON: Nobody signs it.

15 MR. CONCANNON: So the PA can submit a
16 delegation agreement where he names a physician group
17 as his alternate, but no one in the physician group
18 ever had to agree to it. Because no one had to sign
19 it; right?

20 MS. D. THOMPSON: The primary signs it.

21 MR. CONCANNON: The primary could be
22 somebody else.

23 DR. JOHNSON: No.

24 MR. CONCANNON: He doesn't have to be in
25 the group?

1 DR. JOHNSON: No.

2 MS. D. THOMPSON: No.

3 MR. CONCANNON: The primary could be
4 outside the group.

5 DR. JOHNSON: No.

6 MS. CARTER: No.

7 MR. CONCANNON: The primary can't be an
8 individual?

9 DR. HEYE: No. The primary has to be an
10 individual.

11 MS. T. THOMPSON: In the group.

12 DR. HEYE: In the group.

13 MR. CONCANNON: Oh, does it say that?
14 That he has to be in the group?

15 DR. JOHNSON: Well, wait a minute. I'm
16 listening to what you're saying.

17 MR. CONCANNON: Yeah, yeah, yeah.

18 DR. JOHNSON: But the group, for
19 example, I use, you know, ZoomCare. They -- you
20 wouldn't mind having one of your physicians be the
21 primary signature and then the group's the alternate;
22 is that correct?

23 MR. BERGSTEIN: That's correct.

24 DR. JOHNSON: And that's what Group
25 Health said, too. That would be useful for my surgical

1 group and Tom's, is there still is a supervising doc in
2 the group whose name is there. And then the group is
3 the back.

4 MR. CONCANNON: And he has to be in the
5 group?

6 MS. D. THOMPSON: Right.

7 MR. CONCANNON: He can't be independent
8 of the group?

9 MS. D. THOMPSON: Right; correct.

10 MR. CONCANNON: So if the only time
11 there's going to be a physician group is if the primary
12 supervisor is part of that group?

13 DR. JOHNSON: Yeah.

14 MS. D. THOMPSON: That's correct.

15 DR. JOHNSON: Yes. Do we need to say
16 that? Is that what you're asking?

17 MR. CONCANNON: Well, the rule doesn't
18 say that.

19 DR. JOHNSON: No, no.

20 MR. CONCANNON: All right. I'm just
21 telling you.

22 DR. JOHNSON: No. But that's the
23 reality.

24 MS. CARTER: Yeah.

25 DR. JOHNSON: Do we have to say that?

1 MR. CONCANNON: For 1871, I do. This is
2 the revision and there's the original.

3 MS. CARTER: I don't think it's a
4 problem.

5 MR. CONCANNON: In any event -- see, I'm
6 going to give you a headache.

7 MS. T. THOMPSON: Yep.

8 MR. CONCANNON: See. I can tell by
9 looking at you. And we're just getting started.

10 MS. T. THOMPSON: I know. Who fed you?

11 MS. CLOWER: It was the junk food.

12 MR. CONCANNON: Once you start getting
13 involved in the definitions in this, it's gets very
14 hard. It's very particularized.

15 MS. T. THOMPSON: Okay. Here would be
16 my question: What is our risk of putting group --
17 physician group in? And what is our risk of not and
18 continue to implement as we are? That's my question.

19 MS. CARTER: So I'm not sure if this is
20 going to answer your question, but in looking through
21 the rest of the rules, most to the places that we have
22 alternate supervision -- excuse me, alternate
23 supervisor, it's actually referring to the actual
24 physician and not the group. Because it's saying the
25 alternate supervisor -- is their practice is limited,

1 then so is the PAs.

2 So you wouldn't want to say the group --
3 the group's practice can't be limited by a disciplinary
4 action, but.

5 So I think -- I'm not sure if we want
6 "or physician group" as a definition for the meanings
7 of these rules.

8 MS. T. THOMPSON: I like that answer.
9 Anybody else?

10 MR. CONCANNON: Whatever. I think --

11 MS. CARTER: But we would have to look
12 at every instance it's used and make sure the context
13 is correct.

14 MR. CONCANNON: All right.

15 MS. DALE: Because in the other rules is
16 it -- is it written alternate physician meaning that
17 physician who is your alternate supervising physician
18 for that day?

19 MS. CARTER: It can mean that, yes.

20 MS. DALE: Because that's kind of how I
21 look at it as I might have a group, but for this day,
22 this doc is my supervisor -- alternate supervising
23 physician. Therefore, if his practice has limitations,
24 I can't do it.

25 MS. CARTER: Right.

1 UNKNOWN 3: Find another doctor.

2 MS. DALE: So that day, on Wednesday, I
3 can't this and such because he or she is my alternate
4 supervisor that day. But on Thursday I can, because
5 the other doc this is in the group is my supervising
6 physician and there's no limitations.

7 MS. CARTER: I agree with that.

8 MS. DALE: Okay.

9 DR. JOHNSON: So under B, would it be
10 appropriate though, because you got a plural on
11 physicians after physician and board physician group.

12 MS. T. THOMPSON: No.

13 DR. JOHNSON: No.

14 MS. T. THOMPSON: I think that I heard
15 her say -- Heather say, no?

16 DR. JOHNSON: Well, because that -- that
17 implies that an alternate physician is a singular
18 physician.

19 MS. DALE: Can we put, like, a subset
20 paragraph in there the explain that alternate physician
21 can also mean a group under certain circumstances?

22 MS. CARTER: I think the only time, and
23 I can't say this for certainty, that we are talking
24 about the groups is when we're talking about the
25 delegation agreement and how that's filled out.

1 Mostly, in the rules, we're talking
2 about what the alternate supervisor's responsibilities
3 are or what -- how those relate back to the PA, that
4 specific, human doctor at this point.

5 So we may just need to look at the
6 context of each time we use alternate physician. And
7 if we're meaning a group in that situation, say for
8 physician group instead of trying to define alternate
9 physician as also a group.

10 MS. T. THOMPSON: So what I heard
11 Heather say is, let's not alter the alternate physician
12 definition. And in the rule language, if it's
13 appropriate, to say alternate physician or physician
14 group, then we will do so as appropriate.

15 And that it appears on the surface of
16 this group situation applies to the delegation
17 agreement. The delegation agreement, how you fill it
18 out, all that content is not defined within the detail
19 in the rule. So there is flexibility there in how you
20 fill out your delegation agreement and how it gets
21 approved.

22 DR. JOHNSON: So then take out the S in
23 physician.

24 MS. T. THOMPSON: Well, you could have
25 more than one alternate physician.

1 MR. CAIN: You could have three
2 alternate physicians listed that aren't --

3 DR. JOHNSON: But that has nothing to do
4 with the definition. Whether there's one or more than
5 one. All that's telling you is what an alternate
6 physician is.

7 MS. T. THOMPSON: But I need to
8 reiterate there is the use of the plural in the rules
9 somewhere.

10 MS. CARTER: But it could be the use of
11 the plural.

12 MS. T. THOMPSON: I don't -- I don't
13 think it can just be alternate physician.

14 MR. CONCANNON: All right. Let's go
15 back to mundane stuff. No. 3, what happened to No. 3?

16 DR. JOHNSON: Did you get seasick there,
17 Mike?

18 MR. CONCANNON: Yeah. I think in the --
19 in the last phrase should be for any successor
20 accrediting organizations.

21 MS. CARTER: Agreed.

22 MR. CONCANNON: Successor, not
23 successive.

24 No. 4, is there any reason for two
25 asterisks at the beginning of this thing?

1 MR. CAIN: No. We just wanted to make
2 sure we talked about it.

3 MR. CONCANNON: Should supervising
4 physician mean either/or -- either/or? It's going to
5 affect the definitions as we go through this thing.
6 Does it mean either/or?

7 MR. CAIN: It does.

8 MR. CONCANNON: Or either, both of, or
9 whatever?

10 MS. T. THOMPSON: So I would probably
11 and the proper way to do it is probably is B colon A,
12 blah, blah, blah, blah, blah. Or B. It could be this,
13 that, or both. Okay.

14 MR. CONCANNON: And/or.

15 MS. T. THOMPSON: You don't want to say
16 and/or because then it's confusing.

17 MR. CONCANNON: Is a term supervising
18 physician going to have meaning in the rule? As we go
19 through it, is it going to have meaning? Or is it
20 always going to be either a sponsoring physician or an
21 alternate physician?

22 MS. D. THOMPSON: Correct.

23 MS. T. THOMPSON: When you use it -- it
24 could be --

25 MR. CONCANNON: Okay.

1 MS. T. THOMPSON: -- well, if it's going
2 to mean both, then I believe we had talked about
3 putting both in there. I mean -- I'm sorry, no.

4 MR. CONCANNON: All right. Let's --
5 let's move to No. 5. Those stars go away at the
6 beginning?

7 MR. CAIN: Yes.

8 MS. CARTER: Yes.

9 MR. CONCANNON: So a delegation
10 agreement means a collaborated agreement between a
11 physician assistant and a sponsoring physician and/or
12 alternate physician; is that right?

13 MS. T. THOMPSON: No.

14 DR. JOHNSON: No.

15 DR. GREEN: No. The "or" would make it
16 incorrect.

17 MR. CONCANNON: There could be a
18 delegation agreement that's just with an alternate
19 physician that comes along three months after the first
20 delegation agreement was signed up.

21 MS. D. THOMPSON: No.

22 MR. CONCANNON: When he signs up an
23 alternate physician.

24 DR. HEYE: You mean another physician?

25 MR. CONCANNON: Another physician.

1 DR. HEYE: Not an alternate.

2 DR. JOHNSON: Now, there's two.

3 DR. HEYE: Bet that takes guts to do
4 that.

5 MR. CONCANNON: No.

6 DR. JOHNSON: Yes.

7 MR. CONCANNON: The alternate physician
8 is not chosen by the primary sponsor; right?

9 DR. HEYE: No. But if you modify your
10 delegation agreement, it has to be done through the
11 sponsor.

12 MR. CONCANNON: If -- if the PA submits
13 a delegation agreement between him and a primary
14 sponsor, two months from now he could submit another
15 one between him and an alternate; right?

16 MS. D. THOMPSON: No.

17 MS. DALE: Right. But your primary has
18 to sign off on it.

19 MR. CONCANNON: Does he or she?

20 MS. DALE: Yes.

21 MS. D. THOMPSON: Because you're
22 changing the original agreement. We actually have a
23 form to add or change an alternate supervisor. And it
24 requires all three signatures, the PA, the sponsor, and
25 the alternate.

1 MR. CONCANNON: So the primary has to
2 agree with any alternates that a PA comes up with?

3 MS. D. THOMPSON: Yes.

4 MR. CONCANNON: But it could be a new
5 delegation agreement that does that? Or does it amend
6 an old one? Is it a new delegation agreement?

7 MS. D. THOMPSON: It could be either/or.
8 So, in other words, most of them, if they are just
9 adding or changing the alternate that's on the original
10 form on the plan, they will submit the one-page form to
11 add or change the alternate. It still requires all
12 three signatures at the bottom.

13 Or if they were just changing more than
14 just the alternate, they could actually submit the
15 four-page delegation plan. And, again, all three of
16 them must sign that plan saying they pre-approve it.

17 MR. CONCANNON: All right. So
18 delegation agreement means what in the terms of the
19 definitions there? A sponsoring physician -- what did
20 you say? Or alternating physician?

21 MS. D. THOMPSON: No, just an "and."

22 MS. DALE: And.

23 MS. CARTER: It has too many.

24 MR. CONCANNON: You have to use the term
25 sponsoring physician and alternate physician. Those

1 are the defined terms. It's not shortcut it; right?

2 Defined terms, Heather?

3 MS. CARTER: Yeah. We can put it in --

4 MS. T. THOMPSON: Right.

5 MR. CONCANNON: You can't shortcut it.

6 MS. CARTER: Right. Sponsoring,
7 supervising --

8 MR. CONCANNON: No. Sponsoring
9 physician, alternate physician, those are the magic
10 terms.

11 MS. CARTER: Well, I --

12 DR. JOHNSON: But, if any, doesn't
13 necessarily -- an alternate physician --

14 MR. CONCANNON: Or --

15 MS. DALE: There's a question back here.

16 MR. BERGSTEIN: You're getting to an
17 important point. But I think if you go back to the
18 term supervising physician that always draws you back
19 to A and B.

20 MS. T. THOMPSON: Right.

21 MR. BERGSTEIN: What you're trying to do
22 so you don't have to keep repeating sponsoring
23 physician and alternate.

24 MS. T. THOMPSON: But, in it --

25 MR. BERGSTEIN: As long as you say

1 supervising physician you get back to the definition
2 section that you're trying to get to.

3 MR. CONCANNON: A collaborative
4 agreement between a physician assistant and a
5 supervising physician.

6 MS. T. THOMPSON: Period.

7 MR. CONCANNON: Period.

8 MR. BERGSTEIN: But then you have to go
9 back and figure out whether it says sponsor.

10 MS. T. THOMPSON: But it makes it
11 unclear. Because when we say supervising physician,
12 does it mean that has to be signed -- is it between the
13 sponsoring or the supervising.

14 This way you've made it very clear. It
15 has to be between the PA and the sponsoring physician
16 and an alternate physician. All three of them have to
17 sign the form.

18 DR. JOHNSON: But George said that he
19 didn't care who the alternate physicians were. You
20 could mean the group.

21 MS. D. THOMPSON: Correct. If they name
22 the group -- if you look at the delegation form and
23 they name a group at the bottom, then they're not
24 naming a specific alternate. And you can have a
25 planning approved without naming a specific alternate

1 because the plan is then with --

2 DR. JOHNSON: But not if you put that
3 that there.

4 MS. CARTER: Yeah.

5 DR. JOHNSON: Because that tells you,
6 you have to.

7 MS. D. THOMPSON: We don't require it.

8 MS. T. THOMPSON: It can't be or.

9 DR. JOHNSON: Maybe you should take it
10 out.

11 MS. T. THOMPSON: I think that the --

12 DR. JOHNSON: I think that --

13 MS. T. THOMPSON: Well, I don't know. I
14 would say that you have this or that and that and then
15 Dr. Heye and the physician group is in there and Dr.
16 Heye waives the requirement to have the alternate
17 physician inked on paper.

18 MR. CAIN: But you don't need an
19 alternate physician.

20 MS. D. THOMPSON: You don't have to have
21 one.

22 MS. T. THOMPSON: You don't have to have
23 one.

24 MR. CONCANNON: The sponsoring
25 physician --

1 MS. T. THOMPSON: Did you want to add
2 something, Dr. Johnson?

3 MR. CONCANNON: Go ahead.

4 DR. JOHNSON: The primary relationship
5 for a license for a PA is to have a sponsoring
6 physician, period. That's the deal. One-on-one.

7 Then there's opportunities -- you know,
8 we've been talking group practices, but I'm thinking
9 now of rural Washington -- and the doc leaves for
10 vacation, there is an alternate 5-miles away, 25-miles
11 away who will there -- be there to back up the PA, so
12 the clinic doesn't close.

13 The clinic's still functioning even
14 though the sponsoring physician is in Hawaii. So
15 there's an alternate that week, that day, whatever.

16 If the relationship between the PA and
17 the alternate changes, that doesn't change the
18 relationship to the sponsors. That's still prima
19 facia. That's it, that's the big deal. Everything
20 else --

21 DR. GREEN: It does change the
22 delegation agreement.

23 DR. JOHNSON: Yeah. That would change.
24 But the alternate --

25 DR. GREEN: And it's still the sponsor

1 that's responsible for --

2 DR. JOHNSON: It's ultimately the
3 sponsor. Always, ultimately, the sponsor.

4 MS. T. THOMPSON: So I think that -- a
5 simple solution, I think the comma is in the wrong
6 place. I think you need to say between a physician
7 assistant and a sponsoring physician, comma, and
8 alternate physician, if any.

9 DR. JOHNSON: What does 055 say?

10 MS. T. THOMPSON: What I heard you guys
11 say is that it has to be between the physician
12 assistant and the sponsoring physician. And, then, if
13 there are any alternate physicians, then they have to
14 sign it. Does that make it correct?

15 MR. CONCANNON: Yeah. I think that
16 makes it correct.

17 MS. T. THOMPSON: Yes, Linda?

18 MS. DALE: To match the definitions as
19 proposed by Dr. Green, you need to go ahead and put
20 supervising after sponsoring. It should say
21 sponsoring, supervising --

22 MR. CONCANNON: Oh, no.

23 MS. DALE: -- physicians and alternate
24 supervising physicians.

25 MR. CONCANNON: The word supervising is

1 not even part of anything any more. It's not in the
2 definition anymore other than the topic. Sponsoring
3 physician means primary, alternate, if it means --

4 MS. DALE: But that's not what Dr. Green
5 put forward. I thought we were --

6 MR. CONCANNON: No, no, no.

7 MS. DALE: Okay.

8 MR. CONCANNON: They already changed all
9 that. I mean, that's what --

10 MS. DALE: Okay.

11 DR. JOHNSON: I think that's all right
12 the way it is.

13 MS. DALE: Okay.

14 DR. JOHNSON: I mean, it says "that's
15 the one that adds the responsibility for administrative
16 oversight," which is the sponsoring part.

17 MR. CONCANNON: Once you get to a remote
18 site, again, you changed the words again. Means
19 sitting physically separate from the -- I guess,
20 supervising physician.

21 DR. JOHNSON: But --

22 MR. CONCANNON: Supervising physician.

23 DR. JOHNSON: But what I don't -- I
24 don't follow here is that it says "the delegation
25 agreement is between the physician assistant and the

1 alternate physician, as well as the sponsoring
2 physician." But under definitions, it assigns the
3 responsibility of administrative oversight, which is,
4 to me, the delegation agreement, to the sponsoring
5 physician, not the alternate. So to me that's
6 inconsistent.

7 And then we're also saying that if you
8 have a group, you don't even identify who the
9 alternates are. But in that definition, you're
10 requiring that the alternate be part of the agreement.

11 DR. HEYE: They are -- or it is or he
12 is, she is.

13 DR. JOHNSON: Well, if you have an
14 agreement between -- what does that mean? An agreement
15 between a physician assistant and one of those two
16 entities, does that mean they write down their names
17 and they sign it and agree to it? Or what does that
18 mean?

19 DR. HEYE: Well, at least two people --

20 DR. JOHNSON: I thought you just said
21 no.

22 DR. HEYE: -- have to sign off on it.
23 Two people have to sign off on a delegation agreement.
24 And there could be more people, but you have to have at
25 least two. And that's got to be the sponsor and the

1 PA. Anything else after that is extra.

2 DR. JOHNSON: So then does the alternate
3 physician or group belong in the definition of the --

4 DR. HEYE: Yeah. Because it's part of
5 the delegation agreement in a lot cases. The
6 delegation agreement is a open-ended as far as how many
7 people can be an alternate.

8 DR. MARKEGARD: And I think that would
9 be confusing. I would like the policy to read
10 sponsored physician and alternate physician, if any.
11 Leave out the physician group. We just discussed
12 physician groups in here and the alternate physicians.
13 Just put group there.

14 MS. CLOWER: No. I think the physician
15 group should be there and alternate physician or
16 physician group, because otherwise people are going to
17 say we are going to have to have a name here.

18 MR. CONCANNON: See if this is a correct
19 sentence. If you have 5 the way it is, and you add a
20 sentence. If a physician group is named in a
21 delegation agreement, the sponsoring physician must be
22 a member of that group.

23 DR. JOHNSON: That's easy.

24 MS. T. THOMPSON: Sounds like a true
25 statement.

1 MR. CONCANNON: That's true; right?

2 DR. JOHNSON: That's true. That's what
3 we want.

4 DR. MARKEGARD: Does that belong in the
5 definition section? Or does that actually belong in
6 the section to the delegation agreement?

7 MR. CONCANNON: I would put it there,
8 just because I'm still thinking.

9 DR. MARKEGARD: So --

10 MS. DALE: Here's the -- here's an what
11 if. What if I have a practice in Tonasket with a solo
12 doc, and my alternate, when he goes on vacation, is
13 Wenatchee Valley Clinic group. So that -- my solo doc
14 is not part of that group, but Wenatchee Valley group
15 has agreed to be my alternate when he's in Hawaii.

16 DR. JOHNSON: You probably need to have
17 a different delegation agreement with Wenatchee.
18 Separate.

19 MR. CONCANNON: The reason why I wrote
20 the sentence is just because of that they said earlier.
21 They said that -- they said that the --

22 MS. DALE: That it had to be.

23 MR. CONCANNON: -- primary had to be
24 part of the group. So I figured all right, if that's
25 what you're saying, then that's what you're saying.

1 MS. DALE: Why do -- why do -- why do we
2 have to be part of the group?

3 DR. JOHNSON: Well, because now you're
4 dealing with two -- in Tom and my example is we have a
5 partnership group that we work together with or an
6 urgent care or ZoomCare. It's a partnership group.
7 Everybody's on the same page, same rules, same
8 everything.

9 But now you're bringing in another
10 entity. Whether that person is a -- has a solo,
11 primary care practice, two separate clinics, they're
12 separate, they're not related.

13 And if you're going to have an alternate
14 that's a sole practitioner, separate in another town,
15 or another Wenatchee clinic or group in primary care, I
16 think that's -- I don't know. I'm thinking in George's
17 head, maybe you'd want to have a -- make sure that
18 group is signed on to do the work that they're asked to
19 do.

20 MS. DALE: What about a little slight
21 difference. What if one doc in that group agrees to be
22 the alternate?

23 DR. JOHNSON: It could be. He has to be
24 there then.

25 MS. DALE: Right.

1 DR. JOHNSON: He can't be going to
2 Hawaii with the other guy.

3 MS. DALE: Well, right. But I'm stumped
4 to see why -- just a for instance.

5 DR. JOHNSON: No. I don't -- that would
6 be -- if they're not related in some kind of a -- in
7 the professional relationship, they need different
8 delegation. That allows -- I mean, that's okay. You
9 can have 15.

10 I had an issue that if an alternate has
11 a -- has a restriction in his practice, whether they're
12 in the group or not, and you're running -- you're a PA,
13 you're in a primary care, small, group practice in
14 rural somewhere, and you're primary sponsor's gone and
15 the alternate's covering you, but they're over there
16 and you're going to work every day.

17 Let's say they have narcotic
18 prescription restriction, are you - are we really
19 saying that the PA can't write a prescription that
20 day -- that day because the alternate is the only
21 supervising guy. I'm not sure we want to say that.

22 MS. DALE: That comes in later. I'm
23 going to have --

24 DR. JOHNSON: I don't think we want to
25 say that, do we? Anyway, I'm -- I'm throwing that out

1 there because of how we define what the alternate's
2 responsibility is. How's that defined and what's the
3 impact on the PA if there's an outcome event. With
4 these is -- and it's complicated.

5 MS. CLOWER: Well, in that sense too,
6 you're putting more limitations on the physician that
7 has a PA, because it says that the physician has to be
8 part of that sponsoring physician group.

9 And, for example, in the case of my
10 husband, he works for an ENT, MD, and she's solo
11 practice. When she goes on vacation, the whole ENT
12 group of the hospital covers for my husband. So he can
13 contact any of the ENT to consult with them.

14 But if this was the case, she cannot
15 have anybody covering for her because she has to be
16 part of a group, and she's not.

17 DR. JOHNSON: No, no. But she could --
18 the group -- the other group could be the alternate.

19 MS. CLOWER: Right.

20 MS. D. THOMPSON: But she's not part of
21 them.

22 MS. CLOWER: Yes.

23 DR. JOHNSON: I know. But she as
24 been -- your husband has to get a delegation agreement
25 with the ENT. But in the circumstances that the

1 primary is gone, there is a defined relationship
2 covering your husband.

3 MS. CLOWER: Right. But he puts --

4 DR. JOHNSON: That's easy.

5 MS. CLOWER: But he puts the group in
6 that section. What I mean is, she needs to be part of
7 that physician group?

8 DR. JOHNSON: No, no.

9 MS. CARTER: Could you --

10 DR. JOHNSON: It doesn't say that.

11 MS. CARTER: Could you solve it by
12 saying if the physician group is named as the alternate
13 and the sponsored physician is not part of that group,
14 you need some sort of buy off by the group, someone in
15 the group? That's what you're saying, is you want to
16 make sure the group understands they're the alternate.

17 ?So do we need a separate agreement or?

18 DR. HEYE: No, I wouldn't think so. I
19 think you can add after supervising, alternate
20 supervising physician or group, if any.

21 I mean, you can word it that way. And
22 if the -- if the sponsor is part of the group, it's
23 usually pretty obvious from the delegation agreement.

24 If it's not, there would usually be some
25 explanation this person or group is only coming into

1 the picture when the sponsor is gone. And people will
2 do that. Or they will call and say, Hey, look, my
3 sponsor's gonna be in Hawaii for two weeks and I don't
4 have an alternate, but what about Dr. So-and-So or
5 group so-and-so while he's gone for two weeks? And if
6 they're agreeable to it, we just say fine, send us an
7 addendum to that effect, we'll put it in the file.

8 DR. JOHNSON: But -- but they sign off
9 on it?

10 DR. HEYE: Yeah. The other group signs.

11 DR. JOHNSON: Of course.

12 MS. DALE: Right. So we can't put that
13 sentence up there, because there's going to be
14 instances where the physician solo practice is not of
15 the part of the group.

16 I mean, what happens in Yakima is they
17 share -- I mean, if there's different individual
18 practices and they share rounds. And so my doc could
19 be doing rounds at the hospital and I'm covering with
20 someone else because they're off site, so. But we're
21 not in groups or individual practices.

22 MS. CLOWER: So that sentence needs to
23 be deleted.

24 MS. DALE: Needs to be out.

25 MS. CLOWER: Yeah.

1 MR. CAIN: All right. I'm going to do
2 it.

3 MS. T. THOMPSON: Okay. Are we all
4 okay? Or we may not love it, but can we live it with?

5 MS. CARTER: You could just add
6 something to the delegation agreement that says, you
7 know, if alternate is a group and, you know, the
8 sponsor's not part of that group, we need a signature,
9 you know, for the alternate where normally you wouldn't
10 need a signature for the alternate physician group.

11 I don't know if that's helpful.

12 DR. JOHNSON: So the reality is that the
13 key to this is George, or whoever's sitting in his
14 chair, sorts it all out properly. I mean, because
15 that's -- that's how it all works in reality. Whatever
16 we write down here is not going to substitute for
17 his --

18 DR. HEYE: Well, it should be clear to
19 anybody that picks it up and reads it.

20 DR. JOHNSON: I understand. But
21 ultimately the person in your position is the one who
22 sorts out all these nuances of these different
23 relationships?

24 DR. HEYE: Yeah.

25 DR. JOHNSON: And makes sure that

1 they're adequate to have appropriate oversight?

2 DR. HEYE: Yeah. And it's got to be
3 broad. It's got to be --

4 DR. JOHNSON: And this can't tie your
5 hands too much.

6 MS. DALE: Well, here's the other thing.
7 On the alternate -- on the delegation agreement, you
8 say it's not applicable as a group package. Could you
9 just -- couldn't you just say signature of alternate
10 physician or representative of group practice. Then
11 you've got --

12 DR. JOHNSON: We're going to go over --

13 MS. DALE: -- a buy in. Okay.

14 DR. JOHNSON: -- over this later.

15 MS. DALE: Okay.

16 DR. JOHNSON: And those are all things I
17 think we ought to talk about.

18 MS. T. THOMPSON: That's probably a good
19 idea. So write that down so you remember.

20 MR. CONCANNON: What's a remote site?
21 Go ahead. What's a remote site?

22 MS. T. THOMPSON: What's a remote site?

23 MR. CONCANNON: Yeah. Means physically
24 separate from the group.

25 MS. D. THOMPSON: Did we just take that

1 directly from the RCW?

2 DR. MARKEGARD: We did.

3 MS. D. THOMPSON: Okay. The one -- this
4 is one of those things that's in the statute?

5 DR. JOHNSON: So we can't --

6 MR. CONCANNON: No. But I'm talking
7 about the definition. No, forget about the statute.
8 For the sponsoring or supervising physicians primary
9 place could mean maintenance.

10 MS. T. THOMPSON: Okay. I believe that
11 the remote-type definition came straight out of the
12 statute. And I can see that Heather's looking.

13 MS. CARTER: Yeah. It is word-for-word.

14 MR. CONCANNON: Well, you have to adapt
15 the thing to the rule in terms of the words that we're
16 using.

17 MS. CARTER: Sure. We can add
18 sponsoring physician. I mean, that doesn't change the
19 meaning.

20 MR. CONCANNON: Or alternate physician?

21 MS. DALE: Or alternate supervising?

22 MS. CARTER: Can you practice -- is it a
23 remote site if you're alternate?

24 MR. CONCANNON: That's the question.

25 MS. CARTER: It is?

1 MR. CONCANNON: I mean, that's a fair
2 question. I mean, to put it another way. Can I be the
3 alternate supervisor for many different people in
4 remote sites? Not just three, many.

5 MS. DALE: Three at any one time?

6 MR. CONCANNON: That's a question I've
7 asked for months.

8 MS. DALE: Three at any one time?

9 MR. CONCANNON: No, no. Can I be an
10 alternate for many? I know I can only be the primary
11 for three. Can I be the alternate for more than three?

12 Also how often is an alternate
13 supervisor allowed to be the person who's really the
14 person doing the supervising? 10 percent of the time?
15 3 percent of the time? 28 percent of the time? That's
16 not discussed.

17 DR. JOHNSON: Or should it be?

18 DR. MARKEGARD: No.

19 DR. HEYE: No.

20 MR. CONCANNON: No, no, no. I'm just --
21 I'm just telling you.

22 DR. HEYE: When you take a definition
23 out of the RCW, I wouldn't change it. I would just
24 leave it.

25 MS. D. THOMPSON: Agreed.

1 MS. T. THOMPSON: Okay. So are we okay
2 with it now? Are we okay with the definition section?
3 We are way off track today. So are you guys are all in
4 agreement and are okay with the definition section?

5 MR. CONCANNON: So the term "remote
6 site," because of what you just did, had nothing to do
7 with alternate physicians? It has nothing to do with
8 alternate physicians?

9 MS. CARTER: Well, we've --

10 MR. CONCANNON: Because you've just used
11 words that don't -- that are not in this rule.

12 MS. CARTER: Well, the way we clarified
13 supervising physician, though it can include an
14 alternate.

15 MR. CONCANNON: And what does the word
16 "sponsoring" mean? The primary one?

17 MS. T. THOMPSON: Primary.

18 MS. CARTER: Primary.

19 MR. CONCANNON: And "supervising" means
20 either one of them?

21 MS. CARTER: Right.

22 MR. CONCANNON: All right.

23 MS. T. THOMPSON: All right. I
24 promised -- if we're okay with the definition section,
25 I promised Dr. Heye that I would briefly go back to --

1 MR. CONCANNON: Oh, God.

2 MS. T. THOMPSON: Briefly, he begged me,
3 to go back to the terms --

4 DR. HEYE: 250 and 260.

5 MS. T. THOMPSON: And so the request is,
6 is that the sentence -- the first sentence that is in
7 Section 250, the physician assistant-surgical -- I
8 mean -- yeah, "surgical assistant who is not eligible
9 to take the NCCPA certifying exam," that be put into 60
10 also to make it quite clear. And that the definition
11 of physician assistant-surgical that we reference both
12 250 and 260.

13 MS. CLOWER: Yay, Dr. Heye.

14 DR. HEYE: That wasn't my idea, but I
15 agree with it. It was Athalia's idea. I agree with
16 it.

17 MR. CAIN: So just got there. I'm
18 sorry.

19 MS. T. THOMPSON: Okay. So -- okay. In
20 that first sentence.

21 MR. CAIN: Yes.

22 MS. T. THOMPSON: Basically, it says the
23 physician assistant-surgical assistant who is not
24 eligible to take the NCCPA certifying exam, that be put
25 into 60.

1 MS. D. THOMPSON: As well?

2 MS. T. THOMPSON: As well.

3 MS. CARTER: But that's not a sentence.

4 MS. T. THOMPSON: Well, that concept.

5 Jeez, it's a hard crew today.

6 DR. HEYE: And the reason to do that is
7 people have misread 260, and so it's reasonable to
8 clarify it.

9 MS. T. THOMPSON: A physician
10 assistant-surgical assistant is not eligible to take --

11 MS. CARTER: Or a physician who is not
12 eligible.

13 MS. T. THOMPSON: Physician assistant
14 who is not eligible to take it.

15 MS. CARTER: Right.

16 MS. T. THOMPSON: We might have to
17 massage this.

18 DR. JOHNSON: Just put the following:
19 "The following applies to physician assistant-surgical
20 assistant who is not eligible to take the NCCPA
21 certifying exam," and list these. That's the way you
22 have to say it if you put it in. The following do not
23 apply to the physician assistant or the following apply
24 to the physician assistant-surgical assistant, and then
25 you list these things; is that right?

1 MS. CLOWER: Yes.

2 DR. JOHNSON: Because they're trying to
3 make sure you distinguish the physician
4 assistant-surgical assistant from the PA-C.

5 MS. CLOWER: Yeah.

6 DR. JOHNSON: The title does. But the
7 description is ambiguous in that way.

8 MS. T. THOMPSON: Yeah. Okay. And then
9 in the definition, we'll just add Section 260 also, so
10 it references both sections.

11 MR. CONCANNON: Was that it for you,
12 Dr. Heye?

13 DR. HEYE: What?

14 MR. CONCANNON: Was that it? Is that
15 the end of the diversion?

16 DR. HEYE: For the moment.

17 MS. T. THOMPSON: Okay. Going back to
18 "retired active." We, the Committee, tasked you with
19 getting -- pulling the language. We have existing
20 standard boilerplate language that we use for all of
21 our providers so we went and captured that. And Brett
22 put together a draft section that would apply to osteo
23 PAs and medical PAs.

24 MR. CAIN: Well, kinda. I just pulled
25 the language. I was just going to put it in now. I

1 didn't want to change anything until the group was
2 here.

3 MS. T. THOMPSON: And so when we grabbed
4 it -- and so basically, all it does is really talk
5 about -- talks from the statute. It talks about here's
6 the process, here's what needs to happen; right.

7 And so the one conversation we had was
8 that there's just a little snafu that Heather has
9 researched very well and we probably have a solution to
10 the problem.

11 So with the PAs, they have to have a
12 delegation agreement. And when you're volunteering in
13 an retired active status, it's not a big deal, because
14 you would fill out a delegation agreement with
15 whatever -- with whoever you're volunteering with.

16 The issue comes up in the emergent
17 circumstances when you need to go and act for a day,
18 two days, three days and it's an emergency situation;
19 right. We're not putting together a delegation
20 agreement, et cetera. So, Heather?

21 MS. CARTER: So the statute requires
22 that a PA have a delegation agreement approved by the
23 Board or the Commission in order to practice. We can't
24 waive that requirement.

25 So the retired active is gonna have to

1 have a statement in there that they can't practice
2 without an approved delegation agreement.

3 When -- when I was looking at trying to
4 figure out, well, how do we do that quickly if there's,
5 you know, an earthquake or something.

6 So one solution is under the emergency
7 preparedness statutes. When an emergency is declared,
8 the scope of practice and licensing requirements of
9 medical professionals are waived or suspended. So if a
10 physician assistant is a registered emergency worker,
11 that requirement for a approved delegation agreement
12 would not be required.

13 So what we're suggesting is that we
14 include on the retired active application kind of an
15 encouragement that the PA, they're willing to volunteer
16 in emergencies, that they pre-register with the
17 Washington Emergency Preparedness Group. And then they
18 will call you up to an emergency. So you may get a
19 call, we need you somewhere and you can practice
20 without that delegation agreement.

21 That's really the only way I can see
22 that they can practice without a delegation agreement
23 is if it's under that -- under that system. So there
24 is a pre-registration or you can register, I suppose,
25 when the emergency happens.

1 But trying to figure out a quick way to
2 get a delegation agreement approved. But that's really
3 the only waiver that I can find.

4 Of course, there's the Good Samaritan
5 Statute, but that only waives your liability in the
6 tort claim. So it wouldn't waive licensure
7 requirements. So I mean if you came upon a car
8 accident, of course, you can help out in an emergency
9 situation. But you wouldn't be able to go practice.

10 DR. JOHNSON: So does No. 5 apply to
11 No. 3?

12 MS. CARTER: I think both are
13 requirements of the licensed retired active.

14 DR. JOHNSON: Well, what do you mean
15 both?

16 MS. CARTER: Well, it's required under
17 the statutes that the retired active license only
18 allows you to practice in emergent or intermittent
19 circumstances. That's written into the authorizing
20 statute. But then specific to PAs, they need a
21 delegation agreement.

22 DR. MARKEGARD: So do you further
23 clarify No. 3, saying "intermittent"?

24 MS. T. THOMPSON: In intermittent
25 circumstances.

1 MS. DALE: Or in an immediate --

2 MS. CARTER: So the WAC 246-12-120,
3 which -- oh -- it does define intermittent or it gives
4 you a 90-day cap; is that right? So you could leave
5 that 90-day cap in. MQAC, when they adopted their
6 rule, waived or said it doesn't apply. The 90-day cap
7 doesn't apply to them. You can adopt that same --

8 MR. CAIN: It says C and D and -- it
9 says C and D is the 90 days? Or the examples of
10 emergencies?

11 DR. MARKEGARD: So -- but you still need
12 to practice a delegation agreement if you work less
13 than 90 days; correct?

14 MS. CARTER: Correct.

15 DR. MARKEGARD: So that's if -- up above
16 they're stating they can -- if they're retired active
17 license, can practice in an emergent or immediate
18 situations or circumstances.

19 Then is that where you think we should
20 clarify saying, you know, unless you're pre-registered
21 with the blah, blah, blah.

22 MS. T. THOMPSON: No, no. I think what
23 we need to do is say a physician -- okay. So if you're
24 practicing in an intermittent circumstance, you must
25 have a delegation agreement. If you are practicing

1 only in emergent situations, which is a declared
2 emergency, then you wouldn't necessarily have to have
3 one.

4 MS. CARTER: Right. You would fall
5 under the protection of the Military Department
6 Emergency Preparedness Group.

7 DR. JOHNSON: So then you should move 5
8 up above 2 and 3, and add what you just said about
9 military to 3, shouldn't you? In other words, I don't
10 know what all the requirements are in 1 that are listed
11 is there.

12 MR. CAIN: That's this section.

13 DR. JOHNSON: That's that. So none of
14 that is relevant to the other things in what's above
15 there. So it seems to me No. 5 should be No. 1.

16 MS. CLOWER: Yes.

17 DR. JOHNSON: And then No. 3, the
18 exception, the condition that you described with
19 emergency services --

20 MS. CARTER: Right.

21 DR. JOHNSON: -- is that they don't
22 really have a delegation agreement?

23 MS. CARTER: Is what happens is, if an
24 emergency is declared by the Governor, the licensing of
25 the practice are waived or suspended for all medical

1 providers. So you can get all sorts of people.

2 DR. JOHNSON: So No. 5 should have an
3 exception as stated in No. 3; isn't that right? With
4 the exception of No. 3. And No. 3 should include what
5 you just about how you do it under emergency
6 circumstances. No, wait a minute, 4. The numbers have
7 changed.

8 MS. DALE: If you look at --

9 MR. CAIN: I'm sorry. I changed them.

10 DR. JOHNSON: That's okay.

11 MS. DALE: Could you just -- on No. 4,
12 could you just say a physician assistant -- if a
13 physician assistant is registered under the blah, blah,
14 blah emergency thing, they may practice in a declared
15 emergency without the delegation agreement. I mean,
16 just spell it out.

17 DR. JOHNSON: That isn't true, No. 4, is
18 it? Where it says "only"? Because you could practice
19 otherwise, up to 90 days if you don't receive
20 compensation.

21 MS. D. THOMPSON: Which would be your
22 intermittent circumstances.

23 MS. DALE: But the only's in the wrong
24 place.

25 DR. JOHNSON: It says "only in emergent

1 or intermittent circumstances."

2 MS. DALE: So you can practice
3 intermittent or emergent, you can't do both? Only one
4 or the other the way that sentence is written.

5 MS. T. THOMPSON: It's not, no. You can
6 do both.

7 MS. D. THOMPSON: You can do both.

8 MS. DALE: I know. But the way that --
9 it looks like it says only in emergent or in
10 intermittent.

11 DR. HEYE: Yeah.

12 DR. MARKEGARD: Separate the two
13 sentences. Just say the physician assistant with a
14 retired active license may practice in emergent
15 situations.

16 MS. D. THOMPSON: If registered.

17 DR. MARKEGARD: If they are registered
18 during that period. You know, it indicated
19 intermittent circumstances or intermittent practice.
20 Whatever.

21 DR. JOHNSON: So is that intermittent
22 meaning to intend the 90 day -- 90-day limitation?

23 MS. DALE: And that's really covered
24 under 2.

25 DR. JOHNSON: And so why not get rid of

1 intermittent and then add your condition for emergency
2 practice in No. 4.

3 MS. CARTER: I think we need to keep
4 intermittent in there. Because the statute that
5 authorizes us to create a retired active credential,
6 it's the same for all professions. And it says
7 specifically to only practice in emergent or
8 intermittent circumstances.

9 Then what happens is the Department of
10 Health adopted a rule saying intermittent meaning 90
11 days or less. But in your rule, you're saying we're
12 not going to hold you to the 90-day rule?

13 DR. JOHNSON: Well, are we?

14 MR. CAIN: I don't know, that's the
15 question. It's taken from the Medical Commission's
16 statutes.

17 MS. CARTER: You need to decide that.

18 MS. CLOWER: Can you make it two
19 sentences? One for emergent and one for intermittent
20 circumstances.

21 MS. SCHIMMELS: This is Theresa. I have
22 a question.

23 MR. CAIN: Hi, Theresa.

24 MS. SCHIMMELS: Hello there. And so
25 maybe I missed you guys talking about it. We're

1 talking about only in emergent or intermittent
2 circumstances.

3 So let's say, like, the House of Charity
4 downtown, they have a free clinic, and I'm not -- I'm a
5 retired PA, can I go down and work down under this
6 statute with a retired active license?

7 MS. CARTER: You could, if you submitted
8 a practice plan -- or, sorry, delegation agreement.

9 MS. SCHIMMELS: Okay. So that would
10 fall under intermittent circumstances then?

11 MS. CARTER: Right.

12 MS. SCHIMMELS: Okay. I just want to
13 make sure that that's how that's worded. Because I
14 know that's going to come up. I've got some people
15 here in Spokane that I know are thinking about retiring
16 and volunteering for that kind of stuff. So I just
17 wanted to make sure I understood that language.

18 DR. JOHNSON: Why would you want to
19 restrict somebody from volunteering if they're not
20 paid?

21 MS. DALE: Right.

22 MS. SCHIMMELS: Yeah, exactly.

23 MS. DALE: So okay. If you said I want
24 to work Tuesdays and Thursdays at the -- at the
25 homeless shelter, then that's a 104 days instead of 90,

1 so I can't work Tuesdays.

2 MS. CARTER: I think that's why in this
3 rule, in No. 2, the reference to the rule says, we're
4 not, you know, took out the 90-day requirement because
5 to statute that authorizes you to create this
6 credential says the person may practice only in
7 emergent and intermittent circumstances as defined by
8 the rule established by the discipline authority. So
9 that's you. You get to define emergent and
10 intermittent.

11 MS. T. THOMPSON: And so here's the
12 background.

13 There have been potentially -- I guess
14 my understanding is, there's been situations where a
15 licensed practitioner puts their license -- they don't
16 want to pay the full -- the full licensing dollar
17 amount and do all, you know, everything they have to
18 do.

19 So if they say, well, I'm pregnant and I
20 want to take five years off, I'm having a kid, and work
21 intermittently while I raise my child to age five or
22 whatever. So they go after the retired active license,
23 which is cheaper. And they get to work two days a week
24 or better.

25 MS. D. THOMPSON: They don't get money

1 for it.

2 MS. T. THOMPSON: Well, they don't get
3 money for it, but they can keep their license up and
4 they can keep, you know, practicing or whatever.

5 And then that kids turns six and they
6 decide I want to be a licensed whatever again, and so
7 then they go back. And people believe -- but that's
8 not the intent of a retired active license.

9 The intent of the retired active license
10 is, I'm done working as a full-time employee and I want
11 to retire. But I want to -- I still want to volunteer
12 and do some work. So those are some of the
13 circumstances that other professions have toyed with.

14
15 MS. DALE: Well, is that a problem if
16 they're working these two days a week maintaining their
17 competency, that kind of thing? Because if they take
18 that time off, then they have to re-enter through
19 retraining, residency, testing, all that kind of stuff,
20 whereas if they continue -- so is that a bad thing or?

21 MS. CARTER: CE is required. In fact,
22 it's required by the statute that you maintain the CE
23 requirements.

24 MS. DALE: Right. So if you maintain --
25 if you continue the pay your license and not have to

1 work right, so I'm just saying is this a bad thing to
2 let them work a couple days a week while their child is
3 growing? You know, I don't know if there's a problem
4 with that.

5 DR. MARKEGARD: I think it's a great
6 idea.

7 MS. DALE: I think it's a great idea.

8 DR. MARKEGARD: I wish I had done that.

9 MR. CONCANNON: What's the reason to
10 seek a retired license? To save money? Is that the
11 only reason to call your license a retired license?

12 MS. T. THOMPSON: There's a lot of
13 providers that still want to have that status of having
14 a license.

15 MR. CONCANNON: Yeah.

16 MS. T. THOMPSON: They don't want to pay
17 the full dollar amount. And they don't want to work
18 all the time.

19 MR. CONCANNON: But no --

20 MS. T. THOMPSON: That's why it was
21 created.

22 MR. CONCANNON: -- I mean, if I'm PA,
23 the reason I want to have a retired active license is
24 because I don't want to pay the full fee. That's the
25 only reason. That's the only benefit.

1 MS. DALE: There's no reduction in a PA
2 fee, because I have tried to find out. There's no
3 reduction, it's still the \$200.

4 MS. D. THOMPSON: Well, because we don't
5 have a retired active at the point.

6 MS. T. THOMPSON: Okay.

7 MS. D. THOMPSON: We only have a active
8 license.

9 DR. JOHNSON: So physicians, they have a
10 reduced fee?

11 MS. D. THOMPSON: Yes. There will be a
12 reduced fee. And it is --

13 MS. DALE: Okay.

14 MS. D. THOMPSON: They pay a reduced
15 fee.

16 MS. CLOWER: And you still have to
17 complete CE requirements?

18 MS. D. THOMPSON: They still have the
19 same exact CE requirements.

20 DR. JOHNSON: So when the --

21 MS. D. THOMPSON: They pay the substance
22 abuse fee. They still have to pay a fee.

23 MS. T. THOMPSON: Yeah. If they don't
24 pay the retired active fee, they waive; right?

25 MS. D. THOMPSON: Yeah.

1 MS. T. THOMPSON: I mean, that's in the
2 statute.

3 MR. CAIN: Money's the --

4 MR. CONCANNON: So what's the reason?

5 MS. T. THOMPSON: In this statute where
6 it talks about a retired active license.

7 MR. CONCANNON: Yeah.

8 MS. T. THOMPSON: You will pay a reduced
9 fee. We are required to not to charge the same dollar
10 amount as a full licensure. However, with MDs, I think
11 it's just with the MDs, in the statute, if you are
12 working and licensed in Washington State, you don't pay
13 a fee at all for the retired active license.

14 MS. D. THOMPSON: Well, except that they
15 do.

16 MS. T. THOMPSON: Well, they pay
17 different fees, but not for the license.

18 MS. D. THOMPSON: That's true. But they
19 would beg to differ, because they still have to write a
20 check.

21 MS. T. THOMPSON: Yeah.

22 MS. D. THOMPSON: They don't care where
23 the money goes. They still have to write a check.

24 DR. JOHNSON: I'm not clear what you're
25 saying. They pay, like for a WPHP and other things

1 that are part of the licensing fee, but they don't pay
2 the licensing.

3 MS. D. THOMPSON: Correct. So I don't
4 get any money when you send me your retired active.
5 All the money we collect goes to the WPHP.

6 DR. JOHNSON: The WPHP.

7 MS. D. THOMPSON: Exactly.

8 MS. T. THOMPSON: Say you're a nurse,
9 because I know they have retired active, they pay all
10 those other fees and then they pay another fee to have
11 a retired active license on top of it.

12 DR. MARKEGARD: All right.

13 MS. T. THOMPSON: So it's not a big
14 deal. So anyway, let's go back to emergent or
15 intermittent and whether or not you want to redefine
16 intermittent as something other than --

17 DR. JOHNSON: So what are we allowed to
18 change here and what aren't we allowed to?

19 MS. CARTER: You can define emergent or
20 intermittent. So you can define that. You can say we
21 think intermittent means -- you know, the Department
22 said 90 days a year, you can say nothing and kind of
23 leave it up to a person's own interpretation; which is
24 what the medical doctors -- physicians have done. They
25 just say emergent or intermittent. It doesn't define

1 either of those there.

2 MR. CONCANNON: Are you saying
3 intermittent has to be in there?

4 MS. CARTER: Yes.

5 MR. CONCANNON: Even though it doesn't
6 matter what it means?

7 MS. CARTER: It talks about in the
8 statute that allows this, it says, an individual
9 credentialed by the disciplinary authority who is
10 practicing only in intermittent or emergent
11 circumstances as defined by rule as established by the
12 disciplinary authority.

13 MR. CONCANNON: So it doesn't matter
14 what it means?

15 MS. DALE: We have to define it.

16 MS. T. THOMPSON: Well, it has to be
17 something less than full time.

18 MR. CONCANNON: Yeah. So you're saying
19 intermittent means less than 1600 hours a year.

20 MS. D. THOMPSON: Okay. But you, as the
21 Medical Commission, have not put a definition on it for
22 your MDs. So MDs can work as much as they want for no
23 compensation.

24 MR. CONCANNON: Right.

25 MS. D. THOMPSON: So why do we want to

1 limit the PAs if the MDs aren't limited. That's all
2 I'm indicating.

3 MR. CONCANNON: How can MDs not be
4 limited if the word intermittent has to be defined
5 somewhere for MDs?

6 MS. D. THOMPSON: It's not defined.

7 MS. CARTER: And the rule for MDs just
8 states for emergent or intermittent circumstances. It
9 does not define those terms.

10 MR. CONCANNON: Yeah. But if I'm a
11 doctor or if I'm a PA, I'm not going to go volunteer
12 five days a week and say that's intermittent.

13 MS. CARTER: Right.

14 MR. CONCANNON: And I'm not going to
15 volunteer four days a week and say that's intermittent,
16 and I'm not going to volunteer three days a week and
17 say that's intermittent, because it isn't.

18 MS. CARTER: Unless it's one month of
19 that.

20 MR. CONCANNON: It's regular, it's
21 routine. it's every week.

22 MS. T. THOMPSON: And nobody's going to
23 call it unless there's a complain. And then the
24 complaint goes to the Commission and the Commission has
25 to say five days a week, every day -- I mean, every

1 month, you know, is not intermittent.

2 MR. CONCANNON: But not five days a week
3 every month is not intermittent. But like Theresa was
4 asking, Theresa was saying, you know, can I -- can
5 someone go down to the clinic and just volunteer?

6 MS. CARTER: Right. As long as it's
7 intermittent.

8 MR. CONCANNON: But is it? It isn't
9 intermittent if it's part of your routine, week in/week
10 out, month in/month out schedule. And, therefore,
11 you're at risk if you try to call it intermittent. You
12 meaning the licensee. You're at risk.

13 DR. JOHNSON: So that sentence there,
14 physicians is still wrong, too, where it has or. So go
15 back to the -- what you started for the delegation
16 agreement.

17 MS. DALE: There's a definition for
18 intermittent.

19 MR. CONCANNON: Nonpermanent basis.

20 MS. DALE: Part time or full time, but
21 not nonpermanent.

22 MS. T. THOMPSON: There we go. There is
23 a definition in the rules.

24 MS. SCHIMMELS: I think that helps a
25 lot.

1 DR. JOHNSON: Part time or full time,
2 nonpermanent basis. We're all on a nonpermanent basis.

3 MR. CONCANNON: You're permanent.

4 DR. JOHNSON: No, no. I quit already.
5 So my suggestion would be to put No. 2 where No. 1 is,
6 put 1 after it. And then put that "physician assistant
7 with a retired active license." Leave No. 3. Put
8 No. 4 "physician assistant with retired active license
9 may practice under the following circumstances: A,
10 intermittent; B, an emergent circumstances with the
11 condition of the exception for the delegation
12 agreement."

13 MS. CARTER: Right.

14 DR. JOHNSON: And I would reference
15 that exception in No. 1.

16 MS. CARTER: Yeah.

17 DR. JOHNSON: Except as specified in
18 4(b). That's what I would do.

19 MS. CARTER: Right. I would put the
20 exception to the delegation agreement in the section
21 with the delegation agreement where ever that's at.

22 DR. JOHNSON: Then you've got everything
23 people have been talking about.

24 MR. CONCANNON: I have no idea what you
25 just said.

1 DR. JOHNSON: Try to keep up there,
2 Mike.

3 MR. CONCANNON: All I know for sure is
4 that -- I mean, I assume there's no delegation
5 agreement required for someone who wants to practice in
6 emergent circumstances.

7 MS. DALE: Right. They just have to
8 register with the responders.

9 MS. CARTER: Yeah.

10 DR. JOHNSON: Yeah.

11 MS. CARTER: The Emergency Medical Corp
12 or something I think they call it.

13 DR. JOHNSON: And then practice under
14 the following circumstances, colon, A.

15 MS. T. THOMPSON: I have a solution --
16 not a solution, I have an idea. That's what I'm
17 looking for.

18 DR. JOHNSON: Intermittent.

19 MS. T. THOMPSON: At four o'clock we're
20 supposed to be taking a break, maybe during the break
21 we can work with Brett to wrap up your idea; right?

22 DR. JOHNSON: He's already got it,
23 separate A and B.

24 MS. T. THOMPSON: Oh, he got it.

25 DR. JOHNSON: That's fine. We can still

1 take a break.

2 MS. T. THOMPSON: Well, we can finish
3 this. I was just -- were --

4 DR. JOHNSON: So A -- no, don't put
5 "only," put "and emergent."

6 MR. CAIN: I'm not. It's already there.

7 DR. JOHNSON: Emergent circumstances and
8 then I don't know how to specify what you said about
9 the exception for the need for a delegation agreement.

10

11 MS. CARTER: So I would leave emergent
12 circumstances and take those definitions that we just
13 saw and kind put them in there. Not meaning the
14 definitions, meaning -- I think there was emergent.

15 But then I would add the exception to
16 the delegation agreement up in section two. Maybe
17 another sentence there that says or except when
18 volunteering as part of the -- we'll get the formal
19 name and the statute that it falls under.

20 DR. JOHNSON: And then put "intermittent
21 circumstances as defined" where ever that is.

22 MS. CARTER: Sure.

23 DR. JOHNSON: And then intermittent and
24 emergent circumstances, and then you've got it.

25 Then do you need to define emergent

1 circumstances?

2 MR. CONCANNON: No.

3 MS. DALE: Well, the emergent
4 circumstances or declared emergencies, is that a
5 Governor's declared emergency?

6 MS. CARTER: Well, I -- no. I think
7 emergent said something about natural disasters or
8 something. I'm in the wrong book.

9 MR. CONCANNON: You'll never have
10 trouble with emergent.

11 DR. JOHNSON: Circumstances calling for
12 immediate action. There you go.

13 MR. CONCANNON: Like drinking beer at
14 five o'clock.

15 DR. JOHNSON: There you go.

16 MS. T. THOMPSON: We're getting close to
17 that.

18 MR. CONCANNON: Where do we go after
19 this, whatever this is?

20 MS. T. THOMPSON: We can go to --

21 MR. CONCANNON: We just got to start at
22 the statute.

23 MS. T. THOMPSON: We go to your part --

24 MR. CONCANNON: Yeah --

25 MS. T. THOMPSON: -- and then --

1 MR. CONCANNON: -- yeah --

2 MS. T. THOMPSON: -- Dr. Green and --

3 MR. CONCANNON: -- yeah.

4 MS. T. THOMPSON: -- then Linda's stuff.

5 MR. CONCANNON: The headache is just
6 beginning here.

7 MS. DALE: It's just that I have to
8 leave at 5:00. I have to be at Bellevue at 7:00.

9 MS. T. THOMPSON: Okay. Can we take a
10 break?

11 (Off the record.)

12 MS. T. THOMPSON: Here is our dilemma.

13 DR. JOHNSON: The audience is thinning
14 out.

15 MS. T. THOMPSON: Yeah, the audience is
16 gone, so. We have until five o'clock. Linda needs to
17 leave at five o'clock. We roughly have until
18 five o'clock to figure out how we're get through all of
19 remaining concerns that may come up.

20 We, as staff, went back through all of
21 the comments that we had received to date to make sure
22 that we hadn't forgotten anything, addressed
23 everything, or tried to address things, or went that's
24 a great comment that, you know, it covers the statute
25 or we don't believe we can do this, that, or whatever.

1 So with that being said, there was also
2 comments Dr. Green and Linda had sent us we were not
3 able -- we didn't have time to incorporate into this
4 draft because we had to get this draft out before we
5 could incorporate all those; right.

6 So how do you guys want to go about the
7 concerns? We can go section by section, we can go
8 person by person.

9 And I'm thinking at this point in the
10 game, we're going to have to schedule one more meeting
11 finish up and then have to go to your Board Commission.
12 I don't think we're going to be able to take things --
13 a final product to the Board Commission on the 16th.

14 MS. CLOWER: Section by section.

15 MS. T. THOMPSON: So section by section.
16 All right. Here we go.

17 So the definition section, I believe we
18 are done. We conquered that today. I'm just starting
19 with physician, just because that's what we've always
20 done.

21 So definition, okay. Application
22 withdrawals, any issue with that one? It's 007.

23 DR. JOHNSON: No.

24 MS. T. THOMPSON: No. Okay. Going to
25 the next one. It is.

1 MS. DALE: 0235.

2 MR. CONCANNON: Yeah. Lots of things on
3 prescriptions.

4 MS. T. THOMPSON: Okay. Hold on.
5 Prescriptions, here we go. Prescription issues.

6 MR. CONCANNON: So if a PA is allowed to
7 prescribe legend drugs and controlled substances only
8 if consistent with -- how is it consistent or
9 inconsistent with the scope of practice or delegation
10 agreement? How is that a limiting term on their
11 ability to prescribe?

12 DR. MARKEGARD: I would think that if
13 you're a -- if you're working under a dermatologist and
14 you wanted to use Percocet or ADD medication, it
15 doesn't necessitate the scope of the practice in the
16 delegation agreement.

17 MR. CONCANNON: So that's what it is?

18 DR. MARKEGARD: Right.

19 MR. CONCANNON: So like general
20 description; right?

21 MS. CLOWER: But I think it's too
22 limiting, because I work with a dermatologist and I do
23 a procedure where there's going to be pain and hurt and
24 I prescribe for a narcotic, you know.

25 How do you define what the scope of the

1 practice --

2 DR. MARKEGARD: That's under the scope
3 of your practice. You treating pain that's associated
4 with a procedure that is the practice. But you
5 wouldn't necessarily give that patient Ritalin to treat
6 ADD with that limited scope there of practice.

7 MS. CLOWER: Right. In a family
8 practice and I see a dermatology patient and -- I don't
9 know, it's limiting.

10 MS. SCHIMMELS: I hear something about
11 dermatology and PA or dermatology PA and I can't
12 understand what you're guys ask are saying.

13 MS. CLOWER: Huh?

14 DR. JOHNSON: So what they're saying is
15 to capture, if you're practicing within a dermatology
16 environment -- and Athalia said if she does a minor
17 surgical procedure that does produce pain, you can
18 write a pain pill. But you're probably not going to
19 write Ritalin out of a dermatology practice; right?

20 MS. SCHIMMELS: That would be correct.

21 DR. JOHNSON: Yeah.

22 MS. SCHIMMELS: Again --

23 DR. JOHNSON: So it's within the scope
24 of the practice. It's within the scope of the practice
25 that you're doing.

1 MS. SCHIMMELS: Yeah, exactly. If my
2 doctor's not writing Ritalin, then I'm not writing
3 Ritalin.

4 MS. CLOWER: But I think it limits.

5 DR. MARKEGARD: Again, but then if
6 you're working a job under a family practice physician,
7 then that's under the scope of the family practice
8 physician. You're doing skin incisions, you're doing
9 Ritalin, you're going paps, and all that other stuff.

10 But if your delegation agreement is
11 strictly for a specialist, and they're not treating
12 that particular issue, then it's not -- then you
13 shouldn't be doing it.

14 And if you have two jobs and you're
15 working one job at a dermatologist and another job with
16 a family practice doctor, they usually have two
17 different delegation agreements.

18 DR. JOHNSON: Exactly. And I don't
19 think we should get involved in trying to --

20 MR. CONCANNON: Right.

21 DR. JOHNSON: -- waive out a whole bunch
22 on conditions --

23 MR. CONCANNON: Right.

24 DR. JOHNSON: -- because when you start
25 doing that, where do you stop?

1 MR. CONCANNON: Fine point, Tom.

2 MS. CLOWER: All right. So then why
3 don't we take out the word "only." Only sort of
4 limiting.

5 DR. JOHNSON: Where is that?

6 MR. CAIN: So take out only in F and G.

7 MS. CLOWER: Only F.

8 DR. MARKEGARD: I think it should be
9 limited.

10 DR. JOHNSON: That does limit it.

11 DR. MARKEGARD: It's limited by your
12 delegation agreement.

13 MR. CONCANNON: Well, what Athalia's
14 saying is the word only seems a little bit harsh given
15 the judgment factor that's going to go into this;
16 right. "Controlled substances, if consistent with the
17 scope of practice in the delegation agreement," period.
18 We don't have to say as approved by the Commission.
19 That's all goofy language.

20 DR. JOHNSON: I think that's okay.

21 MS. DALE: Yeah.

22 MR. CONCANNON: And the physician
23 assistant has an active DEA registration, that's it.
24 The rest of this I think -- we don't have to say that
25 the prescriptions apply to state and federal

1 prescription regulations. Everything has to prescribe
2 with every regulation.

3 We don't have to say that their
4 privileges have been limited, because later on we're
5 going to say it. If the supervising physician's
6 practice has been limited, then your practice is
7 limited.

8 MS. T. THOMPSON: Well, you're right.
9 But --

10 MR. CONCANNON: Prescribing is just one
11 little part of it; right?

12 MS. T. THOMPSON: Well, I think that --
13 I believe that the discussion that happened with it
14 clarifying -- and there was an issues that your
15 prescription or your prescriptive authority is limited
16 to your supervising physician prescribing privileges.

17 MR. CONCANNON: And your supervising
18 physician or whatever the term we're using now is --
19 sponsoring physicians cannot treat female patients,
20 then you cannot treat female patients.

21 MS. DALE: But we put on there unless
22 otherwise authorized.

23 MR. CONCANNON: And that's another I
24 would say, what does that mean?

25 MS. DALE: That means that this

1 Commission has the ability to say that this PA's
2 working the this site --

3 DR. JOHNSON: You can supersede that
4 restriction.

5 MR. CONCANNON: So this Commission has
6 the right to authorize in writing anything and we don't
7 have to put it there; right?

8 DR. GREEN: I don't think so.

9 DR. JOHNSON: Well, expect if I was a PA
10 and I -- and it didn't have that last comma "unless
11 otherwise authorized," I would assume I had no other
12 alternative.

13 MS. DALE: Right, exactly.

14 DR. JOHNSON: This allows me to know I
15 can call George and say, George, we have a -- do I have
16 to limit my practice exactly the way that order for a
17 supervisor is? Or is there an alternative?

18 MR. CONCANNON: And so we're going to
19 put the burden on the medical consultant on a
20 case-by-case basis to determine --

21 DR. JOHNSON: Yes.

22 MS. DALE: Yep.

23 MR. CONCANNON: -- prescribing practices
24 for a given PA?

25 DR. JOHNSON: Yes.

1 MS. DALE: Yes.

2 DR. JOHNSON: But you don't want to
3 limit -- if you have a two-person PA, primary care doc
4 in a rural clinic and you are now limiting the total
5 practice to a large group of patients, are we really
6 wanting to do that?

7 DR. GREEN: The delegation agreement has
8 to be approved.

9 DR. JOHNSON: Or because the supervising
10 doc screwed up? Are we going to limit the availability
11 of good medicine to that practice group that the PA
12 could provide and the PA's never done anything wrong.
13 Are we going to limit that? Because we're really
14 limiting the community. I don't think we want to do
15 that.

16 MS. DALE: Yeah. And within that
17 decision, you know, you guys -- the Commission or
18 whoever writes it can say you X amount of time to find
19 an alternate physician who will allow -- which will
20 allow to continue whatever --

21 DR. JOHNSON: You know, I don't think
22 it's going to come up very often.

23 MS. T. THOMPSON: Okay. So while it's
24 not wrong to have it in there, it's not necessary. And
25 so this Committee has landed where?

1 MS. SCHIMMELS: Do we have to put the
2 word "if" in front of consistent? I would get rid of
3 that.

4 MS. DALE: What -- which word?

5 MS. CARTER: If in front of consistent.

6 MS. T. THOMPSON: What's she saying?

7 MS. CARTER: If consistent with.

8 MR. CONCANNON: Also "only if" would
9 come out. Theresa, only if would come out?

10 MS. SCHIMMELS: Yeah. Get rid of both
11 of those. That's just -- that's just word garbage.

12 DR. JOHNSON: Word pollution, exactly.

13 MS. SCHIMMELS: Thank you.

14 DR. JOHNSON: I agree.

15 MR. CONCANNON: Do you agree that all
16 prescriptions don't have to comply with state and
17 federal prescription regulations? That that is extra,
18 poofy language?

19 DR. MARKEGARD: I like the extra, poofy
20 language.

21 MS. DALE: Me, too.

22 DR. HEYE: Yeah. That was an attempt to
23 summarize a whole bunch of stuff that was in the
24 original language --

25 MS. DALE: Right.

1 DR. HEYE: -- about how you sign a
2 prescription and all that stuff.

3 MR. CONCANNON: So then in the 918-035,
4 the only change you're making is, only if comes out,
5 everything stays the way it is?

6 MS. DALE: No. The last part of the
7 sentence of No. 1, in a delegation agreement, period.

8 MR. CONCANNON: All right.

9 MS. DALE: And then that is "approved by
10 the Board" should come out.

11 MR. CONCANNON: That i"s approved by the
12 Commission," yeah.

13 MS. T. THOMPSON: I got a little excited
14 you guys are following directions, and now we're back
15 tracking because --

16 MR. CAIN: Just working along here for a
17 moment.

18 DR. JOHNSON: He revised it, now I made
19 him undo it.

20 MS. T. THOMPSON: You were putting
21 forward there a pretty good statement there for a
22 minute.

23 MR. CAIN: I was convinced.

24 MS. D. THOMPSON: So are we going to
25 submit the word approved delegation treatment then?

1 MR. CONCANNON: Well, there is no
2 delegation agreement unless it's approved.

3 MS. D. THOMPSON: Oh, they can write
4 them up as much as they want. It's a delegation
5 agreement.

6 MR. CONCANNON: But they have no meaning
7 unless it's approved; right? It has no meaning.

8 MS. D. THOMPSON: I beg to differ.

9 MS. CRAIG: Yeah.

10 MS. D. THOMPSON: People are thinking
11 just because they're not approved they have --

12 MR. CONCANNON: Delegation agreements
13 that aren't approved have no meaning; right? They have
14 no meaning --

15 MS. T. THOMPSON: Okay.

16 MR. CONCANNON: -- until they're
17 approved?

18 MS. T. THOMPSON: Okay. Clarification,
19 are we okay with that as is on the screen?

20 DR. JOHNSON: You didn't suck them in
21 much, Mike.

22 MR. CONCANNON: No, no. That's all
23 right.

24 MS. T. THOMPSON: You -- you -- you
25 sucked in Brett there for minute.

1 MR. CONCANNON: Yeah, yeah.

2 MS. T. THOMPSON: You need to wheel him
3 back out.

4 MR. CONCANNON: Interim permits, I think
5 Linda and I both brought up -- and I think you guys
6 probably reflected on this. 050 and 080, you're
7 supposed to come together some how.

8 050 and 080 -- an interim permit as I
9 understand it is -- any one who wants an interim permit
10 has to do everything -- everything that someone who
11 wants a permanent license has to do, expect they
12 haven't passed the test. That's it. So whatever's in
13 080, 4, 5, and 6 should be in 050, except the notion of
14 passing a test.

15 So an interim permit's going to have
16 to -- and, again, most of 080 not important. The
17 Commission will only consider complete applications
18 with all supporting documents for licensure. Really?
19 Is that all we'll consider? Yeah. But we don't have
20 to say that.

21 DR. JOHNSON: I think I had some of the
22 same concerns or the same suggestions, but I didn't.

23 MR. CONCANNON: "A physician assistant
24 may not begin practicing without written Commission
25 approval of the delegation agreement for each working

1 relationship." Yeah. In fact, you're not allowed to
2 practice without a delegation agreement. No reason for
3 that to be in there that I see. But if it is in there,
4 it has to be in 050.

5 MS. T. THOMPSON: Okay. Well, I think
6 the reason we left 050 separate from 080 because it's
7 easier to find it. So when you're looking for an
8 interim permit, it's easier to find when you have to
9 defend something. 050 references 080, so all the
10 requirements in 080 apply in addition to clarifying
11 what an interim permit is in 050.

12 MR. CONCANNON: Where does 050 reference
13 080?

14 MS. T. THOMPSON: In subsection 3.

15 MS. DALE: The second page, right here.

16 DR. JOHNSON: The very last reference.

17 MS. T. THOMPSON: Sometimes more is
18 better, just because it outlines the process and it
19 outlines all the details a little bit more clear.

20 MS. CRAIG: And we discussed this last
21 time.

22 DR. MARKEGARD: Yes, we did.

23 MS. T. THOMPSON: So this was a
24 discussion that has happens. In order to keep this
25 moving along, if -- I mean, if it's flawed and totally

1 and completely wrong, I think we need to address it.
2 If it's a matter of way too much information; well, is
3 it really too much information? Because sometimes less
4 is more and sometimes more is better. I know that's
5 bad English.

6 But my point is that when you write a
7 rule and you don't have enough detail in there and
8 there's a complaint and we go back five years later and
9 go why is it even in there.

10 So my question, I guess, to the
11 Committee is, is there anything wrong with 050? Or is
12 it okay?

13 MR. CONCANNON: Yeah.

14 MS. T. THOMPSON: You can live with it?

15 MR. CONCANNON: I withdrawal my
16 complaint about that.

17 MS. T. THOMPSON: Okay.

18 MR. CONCANNON: 050, sorry.

19 MS. T. THOMPSON: Okay. 055 -- wait,
20 anybody else have anything on 050? No? Okay.

21 055, delegation agreement. A whole new
22 section.

23 DR. JOHNSON: So what about the -- did
24 you go by background checks?

25 MS. T. THOMPSON: No, not there yet.

1 DR. JOHNSON: Okay.

2 MS. T. THOMPSON: So 055, is there any
3 concerns?

4 MR. CONCANNON: So delegation
5 agreements, if a physician assistant and the defined
6 term, whatever that is, and the --

7 MS. CARTER: I think it's sponsoring.

8 MR. CONCANNON: And sponsoring physician
9 or alternate physician, I guess. Those are the terms
10 right? Will be working together must submit a joint
11 delegation agreement. This delegation agreement when
12 approved will constitute a delegation agreement between
13 the physician assistant and the sponsoring physician or
14 alternate physician as the case may be.

15 I guess I'm not trying to get Brett to
16 do this on the fly, I'm just rattling off words and
17 seeing if we agree.

18 MS. DALE: Can't we just use the
19 supervising physician --

20 MR. CONCANNON: And the supervising.

21 MS. DALE: Just say supervising
22 physician.

23 MR. CAIN: Supervising.

24 MR. CONCANNON: Means both.

25 MS. DALE: Yeah, it means both.

1 MR. CONCANNON: Yeah, and the
2 supervising physicians -- you know, parenthesis S. 2,
3 the delegation agreement shall specify that names and
4 the Washington license number of the physician who will
5 assume the sponsoring physician and alternate physician
6 roles for the physician assistant.

7 MS. CLOWER: What about the group
8 practice for the alternate?

9 MR. CAIN: It just needs the
10 supervisor's name.

11 MS. CARTER: But if it's a group, we
12 don't need the name and license number of all the
13 people; right?

14 MS. CLOWER: Right.

15 MS. CARTER: So I think we're good.

16 MR. CONCANNON: B, C, and D look fine to
17 me.

18 Again, I'm just talking and keep moving,
19 y'all -- y'all just jump in.

20 No. 3, the sentence looks fine. The
21 sponsoring physician or is it the -- some other kind of
22 physician defined?

23 MS. D. THOMPSON: No. Sponsoring, it is
24 sponsors.

25 MR. CONCANNON: Which is the sponsoring?

1 The primary one?

2 MS. D. THOMPSON: Yes.

3 MR. CONCANNON: The primary one. So
4 that's the primary one?

5 DR. JOHNSON: So what does that mean if
6 you already --

7 MR. CONCANNON: No, no. I use that as
8 my own definition, my own words. Sponsoring means
9 primary. So the word sponsoring is the right word to
10 use there?

11 DR. HEYE: Yes.

12 MS. D. THOMPSON: Yes.

13 MR. CONCANNON: No. 4, physician
14 assistant scope of practice may not exceed the scope of
15 practice of the -- which one? Sponsoring or
16 supervising?

17 MS. DALE: Supervising slash --

18 MS. D. THOMPSON: Sponsoring or
19 alternate.

20 MS. DALE: Because supervising
21 encompasses both.

22 MR. CONCANNON: So if, on this
23 particular day of the week, a PA is being supervised by
24 an alternate, then his scope of practice cannot exceed
25 the scope of the practice of the alternate?

1 MS. DALE: Correct.

2 MS. D. THOMPSON: Correct.

3 MR. CONCANNON: Because the prime guy is
4 in Hawaii?

5 MS. D. THOMPSON: Right.

6 MS. DALE: Correct. And where we get
7 into trouble with that -- which is why I'm glad the DO
8 rules are going to side by side, is when in the past
9 where they weren't able to do certain things under the
10 DO alternate as they were with the allopathy sponsoring
11 physician.

12 So I'm glad we're going through this.

13 MR. CONCANNON: No. 5, physician
14 assistant practicing in a multi-specialty organization
15 must have an approved delegation agreement for each
16 specialty worked in. I didn't quite get that.

17 MS. CLOWER: Can I ask a question,
18 please?

19 MR. CONCANNON: Go ahead.

20 MS. CLOWER: Okay. Real quick. No. 4
21 The physician assistant's scope of practice may not
22 exceed the scope of practice of the supervising
23 physician. What about may not differ because exceed
24 doesn't -- what does exceed mean?

25 MR. CONCANNON: Well, it could differ

1 from it, but it just can't be broader. May not be
2 broader than.

3 MS. T. THOMPSON: Can't be more than.

4 MS. CLOWER: Because that's confusing in
5 C.

6 MR. CONCANNON: Would broader be better?
7 May not be. I don't know.

8 MS. T. THOMPSON: I think C is fine. It
9 can't be more than what the supervising physician will
10 be fine.

11 MR. BERGSTEIN: I think it will be fine.

12

13 MS. T. THOMPSON: Yes, Dr. Johnson?

14 DR. JOHNSON: So we've seen a letter
15 twice or more from the headache PA in Anacortes.

16 MS. T. THOMPSON: In Anacortes?

17 DR. JOHNSON: We've seen this letter.

18 It came -- it was sent around just recently. The PA
19 who has a specialty in headaches whose supervising
20 physician is a family practitioner, who had an interest
21 also in headaches, but is semi-retired, and who's
22 currently serving as a medical director in the PA owned
23 practice.

24 And what I don't know -- and George has
25 maybe seen the delegation agreement -- is, is the PA's

1 practice exceeding the practice of the family
2 practitioner had. The family practitioner may have had
3 an interest in headaches, but not to the degree that
4 the PA does.

5 The PA, by his letter, said, I'm the
6 best in the state and I was trained at the Mayo Clinic.
7 And there's nobody else in the state that can do what
8 I'm doing.

9 So my question is: Is that PA exceeding
10 the scope of the practice of his supervising doc? And
11 I think maybe so based on that definition.

12 And I talked to a couple of PAs here in
13 the breaks about their supervision and remote site
14 institution and getting other people. Nobody in their
15 community will supervise them, so they're picking up
16 somebody in Chelan. And I think we got problems.

17 MS. DALE: Well, part of the reason that
18 gentleman has a Chelan, is because he worked there with
19 him a number of years and had quite the relationship.

20 DR. JOHNSON: But he's not there
21 anymore, Linda. His reality is he's in Port Townsend.

22 MS. DALE: Right. Do you throw away
23 that relationship with someone who knows you and get
24 someone brand new?

25 DR. JOHNSON: I don't think they're

1 looking at them 10 percent of the time. I don't think
2 they're reviewing charts. I don't think they're
3 talking on -- I think they're skirting the edges of the
4 definition. I'm not blaming them, but I think that
5 they're definitely taking the concept and pushing it to
6 the limit.

7 And I don't know what we're going to do
8 if there's a problem. And I talked to him about, I
9 said, Why don't you have somebody in Port Townsend?
10 Well, because they are in another group.

11 MS. DALE: Competition.

12 DR. MARKEGARD: So for this you think it
13 exceeds that fine line?

14 DR. JOHNSON: I think it's a problem.

15 DR. GREEN: Competition with who?

16 DR. JOHNSON: I think it's a real
17 serious problem.

18 MS. T. THOMPSON: I think we need to get
19 back to task.

20 DR. JOHNSON: I know, I know. But we're
21 getting back to what's the definition of --

22 MS. CLOWER: Exceeding.

23 DR. GREEN: Exceeding the scope of
24 practice.

25 DR. JOHNSON: What's in the scope of

1 practice. And I'm not sure if we have the wherewithal
2 in our rules to deal with this.

3 The letter that came from Anacortes,
4 where I think -- I suspect, if one wanted to get really
5 down deep, that that primary care practitioner is --
6 has a sole practice, and he's just got a medical
7 director to play the roles.

8 I'm not blaming him. But I think that
9 they're skirting the -- the -- the sense of what these
10 rules are all about. They're not really being
11 supervised. And that may be okay, if we agree with it.
12 But I'm struggling with it as a concept right now.

13 MR. CONCANNON: But it's a philosophical
14 concept, it's not a rule making concept. It's a
15 philosophical -- it's something we have to deal with at
16 the Commission when the complaint comes in as opposed
17 to something --

18 DR. JOHNSON: Well, we have to set the
19 rules up so that people know ahead of time that they
20 can't have an alternating physician be from Delaware,
21 if we have multistate licenses.

22 MR. CONCANNON: Well, again, they have
23 to comply with the rule on the 10 percent and the 25
24 percent and all that.

25 DR. JOHNSON: Well, I know that.

1 MR. CONCANNON: And if they don't do it,
2 they're violating the law; right? We, you and I, are
3 suspicious as to whether they're doing it.

4 DR. JOHNSON: We are.

5 MR. CONCANNON: But it's a complaint
6 driven business; right?

7 DR. JOHNSON: Yeah, we are.

8 MR. CONCANNON: So we couldn't go out
9 and investigate this man based on his appearance today;
10 right?

11 DR. JOHNSON: No, I wouldn't do that.
12 Not today.

13 MR. CONCANNON: Yeah. But I think --
14 and that's why I didn't want PAs to be owning practices
15 and hiring their own physicians.

16 DR. JOHNSON: Yeah, let's move on.

17 MR. CONCANNON: That's philosophical.

18 MS. DALE: I have a question about
19 "exceeds." I guess to me, like, if I worked in a
20 dermatology practice and learned a better way to --
21 better way to treat something, and then I go back to my
22 family medical practice and I know, with my knowledge
23 of dermatology now, exceeds that family medicine doc.

24 So does that mean I can't treat that
25 rash? I mean, it's under the purview of the family

1 medicine doc, but -- so I'm kinda with Athalia, I think
2 we should maybe put differ.

3 MS. T. THOMPSON: You don't want it to
4 say differ because if your practice as a PA is not up
5 to par with that doc, it's going to differ.

6 MS. DALE: Nope. But isn't this that if
7 I'm a -- I'm working pediatrics, I work in pediatrics.
8 If I'm in derm, I work in derm. I don't work in derm
9 if I'm working pediatrics or that kind of thing. Isn't
10 that what this particular one means?

11 DR. MARKEGARD: No, I don't think so.
12 Because it's still within the realm of pediatrics,
13 you're still doing dermatology as primary care. So I
14 think it could be different, like, scope -- it's within
15 my scope of practice with the family practice doctor to
16 do dermatology, to do ADD, to do all that stuff. But
17 it's not in my scope of practice to do a, I don't
18 know --

19 MS. DALE: Cardiac cath.

20 DR. MARKEGARD: Right. So --

21 MS. DALE: To the --

22 MS. D. THOMPSON: So even if you as a PA
23 had the training and the experience, she can't allow
24 you to do that in her office.

25 MS. DALE: Right.

1 MS. D. THOMPSON: Because it's beyond
2 her scope of practice.

3 MS. DALE: Which is why I think the word
4 is differ, not exceed.

5 MS. D. THOMPSON: Except what they were
6 trying to say if -- if your -- your doctor, your
7 physician, if his speciality is highly specialized and
8 you, as a PA, are not highly specialized, he's going to
9 have your scope of practice defined or differ on the
10 delegation agreement because maybe you cannot do the
11 same as he does. Because you don't have the training
12 yet or the experience.

13 MS. DALE: Right.

14 MS. D. THOMPSON: Actually, they will
15 differ. Your scope of practice will differ from his,
16 and that's okay.

17 MS. DALE: Okay.

18 MS. D. THOMPSON: And that's why where C
19 is, we don't want you doing something that's outside of
20 their normal scope of practice. But it could be that
21 yours differ in some ways. Does that make sense?

22 MS. CLOWER: So then use -- then use
23 outside -- outside.

24 MS. DALE: Outside.

25 DR. HEYE: I'm going to argue for exceed

1 because all the -- Mark's example and Tom and I had a
2 experience with both of these. When the practice was
3 set up, the headache practice was very -- talked with
4 PA exactly about the kind of issues that you're talking
5 about. Because I wanted to make sure that the sponsor
6 was really the sponsor. And unless that practice has
7 changed and I don't know about it, it was okay.

8 DR. JOHNSON: Right.

9 DR. HEYE: And then I called Tom about a
10 practice where a PA wanted to do something that the
11 sponsor didn't do as part of the practice. And it had
12 to do with injecting joints in patients. And so
13 they -- so when we talked to the sponsor, well, yeah.
14 I know how to do it but I don't usually do that kind of
15 stuff. To me, that exceeds the practice.

16 DR. JOHNSON: Right.

17 DR. HEYE: So that was not approved.
18 Now, if they had a retired orthopedist who wanted to
19 oversee that practice, that would be a different story.
20 But that's not who they got. They got some generalist
21 who doesn't really do that sort of thing.

22 DR. JOHNSON: Right.

23 DR. HEYE: So I think exceed is a
24 perfect word. You know, the skill levels for the two
25 people involved are very important.

1 MS. T. THOMPSON: All right.

2 DR. GREEN: I agree. I don't have a
3 problem with that.

4 So I have two things. One, in No. 3,
5 why is the second sentence necessary? It doesn't
6 affect -- they both sign the delegation agreement that
7 attests to the fact they made that decision or not. It
8 seems to me that second sentence is unnecessary.
9 That's one comment.

10 If they both signed it, they -- they're
11 both saying they've determined that that's the case, in
12 my opinion.

13 MS. D. THOMPSON: But I was going to say
14 in this section, Dr. Green, are we not trying to
15 describe what's in the delegation agreement?

16 DR. GREEN: What's in the delegation
17 agreement is "services they're competent to perform
18 based on their education, training, and experience."

19 MS. T. THOMPSON: Well, the conversation
20 I think went is, So today, I want you to do procedure X
21 under my supervision. Six months from now, you can do
22 that potentially on your own, because I know that
23 you're skilled in that. And this is where it sets up
24 those parameters.

25 DR. GREEN: Well, then the description

1 for the supervision process for the practice -- I mean,
2 to me, that's all redundant.

3 MS. T. THOMPSON: Yeah.

4 DR. GREEN: You know, to me, it doesn't
5 make any difference. It's just the same kind of thing
6 Mike is talking about. So if you want to leave that
7 in, that's okay.

8 MR. CONCANNON: I agree.

9 DR. GREEN: I'm just saying it doesn't
10 add any meaning to the other terms.

11 DR. HEYE: Well, the first sentence
12 talks about the PA's skill level, and the second
13 sentence talks about what the PA's actually going to be
14 allowed to do based on what the sponsor agrees that
15 they can do. That's the way I read this. And I agree
16 that, you know, they both have to put these --

17 DR. GREEN: Well --

18 DR. HEYE: -- together.

19 DR. GREEN: -- but a detailed
20 description of the scope of practice what he's going to
21 do. I'm just saying you're repeating in there. That's
22 not important. There's a lot of redundancy in these,
23 but if that helps people, then that's fine.

24 The only comment I would have is the
25 physician assistant's scope of practice, No, 5, "The

1 physician assistant practicing in a multi-specialty
2 organization. That sentence ends with a preposition."
3 My grammar teacher told me never to do that. And I
4 made a suggestion in here how to word it, if you want
5 to accept it, that's all.

6 MS. DALE: Just say "for each
7 specialty," period. Maybe.

8 MR. CONCANNON: Yeah. And in No. 3, as
9 long as you're getting into grammar, you either have to
10 say "physician assistants may only provide those
11 services they are competent to perform," or "a
12 physician assistant may only provide services that he
13 or she is competent to perform."

14 MS. T. THOMPSON: Okay.

15 DR. HEYE: Yeah.

16 MR. CONCANNON: So, you know, the tense.

17 DR. GREEN: He or she is.

18 MR. CONCANNON: He or she is.

19 DR. HEYE: I think -- and I agree with
20 you. Some of this is redundant. But I think it was
21 redundant because this was an area that causes a lot of
22 problems. It's, like, you know, beating over the head
23 more than once. Okay, I got the hint.

24 DR. GREEN: Okay. That's fine.

25 DR. HEYE: Whatever you guys want.

1 DR. GREEN: Whatever the people are more
2 comfortable with that, that's fine. We spent so much
3 time reading this, it's hard not to be -- notice all
4 that.

5 MR. CONCANNON: So in No. 4, is
6 "supervising" the right word because it can mean either
7 of the two?

8 MS. DALE: Yes.

9 MR. CONCANNON: Right.

10 MS. DALE: Yes.

11 MR. CONCANNON: And, again, No. 5, I
12 didn't know that physician assistants needs delegation
13 agreements based on specialities. I thought they
14 needed them based on who was supervising them. I don't
15 know what that means; in other words, I don't know what
16 No. 5 means.

17 MS. DALE: Well, the reason that was
18 brought up was because of the Group Health situation
19 where they would primarily be working in emergency.
20 But if they get called in to work at another area, like
21 family medicine, that they have to have somebody with
22 the delegation agreement to work in family medicine. I
23 think that was what --

24 DR. GREEN: If they cross speciality
25 lines, they have to have an separate definition of

1 what's in these agreements.

2 MS. DALE: I think that's why we put
3 that in there.

4 DR. GREEN: If you work in the ER, you
5 don't do the same things that a family medicine doc
6 does. And so you wouldn't have the scope of practice
7 and the supervision requirements in that delegation
8 agreement. So if you cross specialty lines, you need a
9 separate agreement for each one.

10 DR. JOHNSON: But I argued in -- not
11 argued, but I threw out a what if, you have a
12 relatively smaller primary care group that included
13 family practitioners, internal medicine, pediatrics in
14 the group. And the PAs come out of school trained to
15 take care of all ages. So in that scenario, does
16 the -- does the PA delegation agreement from the
17 internist, the family practitioner? I mean separate
18 and all?

19 DR. GREEN: If they're all the same you
20 don't need it.

21 DR. JOHNSON: And the pediatrics?

22 DR. GREEN: If they're all the same --

23 DR. JOHNSON: They're all the same.

24 DR. GREEN: -- then they don't need it.

25 DR. JOHNSON: But they practice -- they

1 practice -- they're all different specialties. And is
2 that -- so I ask that question.

3 DR. GREEN: Well, you could put a
4 qualification unless the scopes of practice are
5 identical.

6 MS. DALE: Or do family medicine,
7 because they covers all of the above.

8 DR. JOHNSON: Well, I know it does cover
9 them, but I'm just trying to be critical about that
10 statement.

11 And I think the same is true if you --
12 and Tom and I differed a little bit on is this. I
13 think assisting in the operating room -- our PAs have
14 helped the orthopods, they gynecologists, the
15 urologists, and the general surgeon, but primarily with
16 us. But they do fill in and help out. They don't have
17 a delegation agreement with the other subspecialists.
18 They are different specialists.

19 MR. CONCANNON: But again --

20 DR. JOHNSON: But they are very
21 competent in the operating room.

22 MR. CONCANNON: Again, a number of
23 specialities does not dictate a number of delegation
24 agreements. Unless I'm totally wrong on the way that
25 you're functioning, the number of specialties does not

1 dictate the number of delegation agreements. That's
2 what No. -- No. 5 says that it does.

3 DR. JOHNSON: It does.

4 MR. CONCANNON: I'm saying does it
5 really?

6 DR. JOHNSON: Well, that's my question.

7 MR. CONCANNON: And you have six
8 delegation agreements with six specialities with one
9 physician?

10 DR. JOHNSON: Right.

11 MR. CONCANNON: Can't you have one
12 physician who has six specialists?

13 DR. GREEN: No, no, no.

14 DR. JOHNSON: Well, you've got one
15 supervising.

16 MR. CONCANNON: Board specialities?

17 MS. T. THOMPSON: Dr. Markegard has a
18 comment.

19 DR. MARKEGARD: I think in your case
20 when you're doing surgical assist in all specialities,
21 surgical assist is surgical assist. You retract the
22 same for an ortho as you do for someone else. And I
23 think if the task is the same, you don't need various
24 delegations to all your surgical subspecialists.

25 But let's say you're in a group where

1 there's, you know, a, you know, general surgeon and you
2 also have your ENT. And ENT PA is going to be
3 practicing a lot differently than the surgical --

4 DR. JOHNSON: I understand that.

5 DR. MARKEGARD: -- in the outpatient
6 world.

7 DR. JOHNSON: I understand that.

8 DR. MARKEGARD: I would be delegated to
9 you.

10 DR. JOHNSON: I understand that. But it
11 doesn't say that, it says each specialty. That means
12 ortho, that means peds, family practice, internal
13 medicine. That's what it means to me, if we want to be
14 so specific. And I don't know -- I'm just suggesting
15 that.

16 There are situations where you don't
17 have to get three different delegation agreements, when
18 they're -- they're really working with adult medicine
19 primary -- you know, and peds as an aggregate group.

20 MS. T. THOMPSON: Here's a question for
21 legal.

22 So we have this statement that talks
23 about specialty groups or whatever. And so how we
24 implement it in our delegation agreement.

25 DR. HEYE: How does it change it, Mark?

1 MS. T. THOMPSON: To me, it's about the
2 implementation of -- of asking for a delegation
3 agreement for each specialty and how we're implementing
4 that specialty.

5 DR. JOHNSON: Right.

6 MS. CARTER: I agree. But I think this
7 sets up the expectations for the PA that they're going
8 to have to have all these delegation agreements. And I
9 guess I think we need to work on this and clarify it a
10 little more to say what we're trying to relate.

11 MS. T. THOMPSON: There ya go.

12 MS. CLOWER: How about board-related
13 specialties? Because urgent care and family practice.

14 DR. JOHNSON: Well, that was the -- that
15 brought this on because there is a difference between
16 urgent care and an office-based primary care.
17 Whether -- there's a difference.

18 MS. CLOWER: Yeah.

19 DR. JOHNSON: And emergency room is
20 different than an urgent care practice. And so I don't
21 disagree with needing definition. I just wondered
22 through some examples where --

23 DR. GREEN: Well, how would you
24 separate -- the question then is how would you separate
25 in this circumstance when you need a separate --

1 DR. JOHNSON: I know.

2 DR. GREEN: -- delegation agreement for
3 one when you don't --

4 DR. JOHNSON: I know.

5 DR. GREEN: -- when you're crossing
6 specialty lines?

7 DR. JOHNSON: I understand.

8 DR. GREEN: Because I believe there are
9 circumstances --

10 DR. JOHNSON: Yes.

11 DR. GREEN: -- when you do. And I agree
12 with you, there are circumstances when you don't.

13 DR. JOHNSON: Right.

14 DR. GREEN: And I think we agree. But I
15 think there's a needs for some differentiation
16 definition.

17 DR. JOHNSON: Some better definition.

18 MS. T. THOMPSON: So the consensus is we
19 need to work on that sentence?

20 DR. GREEN: What do you think, George?

21 DR. HEYE: No, I agree. Just if you
22 have a suggestion on changing the language.

23 DR. GREEN: Can we think about that and
24 work on it?

25 DR. HEYE: Okay. We'll work on it.

1 DR. GREEN: And not get too hung up on
2 it here.

3 MS. T. THOMPSON: We'll work on it but
4 we're going to have to have one more meeting.

5 DR. JOHNSON: We already knew that. I
6 knew that.

7 MS. T. THOMPSON: I think -- okay. It's
8 a quarter to five and I don't know how much we have on
9 this section. We either just finish this section and
10 call it a day --

11 DR. MARKEGARD: Yeah.

12 MS. T. THOMPSON: Does that work for
13 everyone? And then we can have a talk about next
14 steps.

15 DR. HEYE: And we can take out some of
16 the redundancies, if you'll sleep better.

17 DR. GREEN: No. You know, I -- I think
18 it's fine. If it's -- if people feel better with
19 having that clarification, I don't have a problem with
20 it. I was just pointing it out. Because sometime you
21 get tired of reading this stuff. And you just kind of
22 blank it out because it's --

23 MS. T. THOMPSON: Well, we can turn
24 through it again and we can always kind of analyze and
25 see, you know, is this really redundant and figure out

1 a way to shorten it a little bit.

2 MR. CONCANNON: No. 6, "It's the joint
3 responsibility of physician assistant and the"?

4 MS. T. THOMPSON: The supervising
5 physician.

6 MR. CONCANNON: The supervising
7 physician, parenthetically "s", to notify of
8 significant changes. And then, George Heye -- it
9 doesn't have his name here, but we'll just say
10 George -- will evaluate the changes and whether a new
11 delegation agreement is required. And I guess that's
12 true, right, Dr. Heye?

13 DR. HEYE: Yeah.

14 MR. CONCANNON: Yeah.

15 MS. D. THOMPSON: Yes.

16 MR. CONCANNON: So now we're on 7.

17 MS. T. THOMPSON: No, wait.

18 DR. MARKEGARD: On the -- so if you
19 could delete the names of the delegation agreement --
20 it's just I don't think we need that there.

21 MS. D. THOMPSON: Wouldn't there be a
22 new delegation agreement anyway?

23 DR. MARKEGARD: Well, if you just said
24 during the -- responsibility of a physician assistant
25 and a supervising physician to notify --

1 MR. CONCANNON: To notify.

2 DR. MARKEGARD: To notify.

3 MR. CONCANNON: To notify. That's
4 right.

5 DR. MARKEGARD: You don't have to name
6 names or a building.

7 MR. CONCANNON: That's right. That's
8 right. You're right about that.

9 MS. D. THOMPSON: Oh, okay.

10 MR. CONCANNON: And that's right.
11 That's a good change.

12 No. 7, the -- "within 30 days of the
13 termination of the working relationship the"?

14 MS. DALE: Supervising physician.

15 MS. T. THOMPSON: Supervising physician.

16 MR. CONCANNON: I guess it could be
17 either working relationship; right? It could be either
18 of those two working relationships?

19 MS. D. THOMPSON: It's usually the
20 sponsoring PA.

21 MR. CONCANNON: Should it be the --

22 MS. D. THOMPSON: The alternate doesn't
23 contact them.

24 MR. CONCANNON: Should it be the
25 sponsoring one?

1 DR. HEYE: It's the sponsoring one.

2 MR. CONCANNON: It's the sponsoring one.

3 MS. D. THOMPSON: It is the sponsoring
4 one.

5 MR. CONCANNON: So you don't care about
6 alternate terminations?

7 MS. D. THOMPSON: We don't care about
8 alternates.

9 MR. CONCANNON: So the word "sponsor's"
10 the right word then; right?

11 DR. HEYE: Yes.

12 MR. CONCANNON: Shall submit a letter.
13 The second sentence seems goofy to me. I don't care
14 what the letter includes. We don't have to tell
15 them --

16 DR. HEYE: Yeah, what does that mean?

17 MR. CONCANNON: It's just goofy.

18 DR. HEYE: Okay. Here's what I'm
19 going --

20 MR. CONCANNON: Well, what does it mean,
21 Doctor?

22 DR. HEYE: If a PA is doing something
23 that leads to them loosing the job.

24 MR. CONCANNON: Right.

25 DR. HEYE: And if you were the receiving

1 of that PA at the next job, would you want to know
2 about the performance at the previous job?

3 MS. DALE: You would get a letter of
4 reference.

5 DR. JOHNSON: Yes.

6 MR. CONCANNON: You're going to have to
7 find out about that.

8 DR. GREEN: Wouldn't it be better to
9 say --

10 MS. DALE: The reason.

11 DR. GREEN: -- it should include the
12 basis for the termination's.

13 DR. HEYE: Well, no. Because a lot of
14 terminations are I'm moving off --

15 DR. GREEN: I know.

16 DR. HEYE: I'm going to another place.
17 But if that's all you say, you're going to another job
18 if it was for disciplinary or unsatisfactory
19 performance reasons --

20 MS. D. THOMPSON: 98 percent of them are
21 simply two or three sentences, you know. This PA and
22 this MD are no longer working. They left the practice.
23 They've terminated this relationship with the date, you
24 know. I mean, we rarely get a summary of the working
25 relationship.

1 But if we put it in there, they may
2 include it, then it gives them the right to actually
3 indicate why it was terminated if they want to include
4 it. We've had some individuals say do I have to? I
5 say, no.

6 DR. JOHNSON: Most lawyer and HR people
7 would tell you not to be very specific. Because the
8 offended party could come back and raise some
9 litigations events. That seems like a terrible thing,
10 but that's the risk.

11 DR. HEYE: No. I understand the risk.
12 We can't require people to say why they're
13 terminating --

14 DR. JOHNSON: Right.

15 DR. HEYE: -- I mean, I don't think they
16 would do that.

17 DR. GREEN: If they don't have to do it,
18 why do we have to put it in a rule?

19 MR. ANDERSON: Agreed.

20 MR. CONCANNON: There's lots of things
21 the letter could include. And I think they figure that
22 out when they write the letter. If they want to
23 complain about their physician, they're going to
24 complain about their physician.

25 DR. HEYE: Or vice verse.

1 MS. D. THOMPSON: Yes. But it's usually
2 the other way.

3 MS. DALE: And if you saying the PA
4 didn't do this or the doc didn't do that, they you only
5 hear one side of the story. You're only getting one
6 side of the story. So you're going to base your
7 decision on whether or not to let that clinician work
8 with some other PA or physician --

9 DR. GREEN: Maybe you ought to ask both
10 of them to --

11 MS. DALE: -- based on what that letter
12 says.

13 DR. GREEN: -- notify because you might
14 get different stories.

15 MS. DALE: We went to -- or because I
16 found out myself that my physician never -- when I
17 changed physicians, I wrote the letter, but they never
18 did. So on here, oh, you're still working for this
19 doctor. I go, No. That was terminated like six years
20 ago. And they never wrote the letter.

21 MR. CONCANNON: Oh, no. The word -- the
22 "or" is good.

23 MS. DALE: I know.

24 MR. CONCANNON: "But the letter may
25 include a summary of the work relationship" just seems

1 like surplusage to me.

2 MS. T. THOMPSON: You have to leave it.

3 MR. CONCANNON: Because it may include
4 lots of different things; right? It may require
5 further investigation but we'll find out when you get
6 the letter.

7 DR. GREEN: Leave it in.

8 DR. HEYE: What's the vote?

9 MS. DALE: Like what are you going to do
10 with the letter. What would you do with the letter, I
11 guess, is my question.

12 MS. D. THOMPSON: It goes in a file.

13 DR. GREEN: In goes in a file.

14 DR. HEYE: It goes in a file and if
15 somebody wants to ask for it, they can get it. We can
16 leave it out. This is a let the buyer beware kind of
17 thing.

18 MR. CONCANNON: Well, yeah. If I'm
19 about to be a sponsoring physician for a PA, I'm going
20 to look him up without regard to what letters someone
21 wrote two months. I'm going to find out about them.

22 DR. GREEN: Call the people they worked
23 for.

24 DR. HEYE: Call the former sponsor.

25 MS. DALE: You'd call them.

1 MR. CONCANNON: Is No. 8, I don't know
2 why that's important. There's lots of ways -- if a
3 physician assistant's doing lots of things that are
4 wrong, including inconsistent with their delegation
5 agreement, we may take action. I don't know what that
6 would be there for.

7 As if the delegation agreement is all --
8 the only thing they have to comply with.

9 DR. HEYE: I'm not read into that. It
10 can go away I think?

11 MR. CONCANNON: What do you think,
12 Heather? Heather, Heather, Heather. No. 8, does it
13 mean anything one way or the other to you?

14 MS. CARTER: Legally, no.

15 MR. CONCANNON: Okay.

16 MS. CARTER: If you want to put it in
17 there just as a warning. I mean, that's up to you.

18 DR. HEYE: We don't do that.

19 DR. GREEN: Well, I mean, I can
20 understand the reason to put it there just to --

21 MS. T. THOMPSON: Give due notice.

22 DR. JOHNSON: Puts them on notice and it
23 follows the delegation agreement.

24 DR. MARKEGARD: Okay. Keep it in.

25 DR. JOHNSON: It emphasizes the

1 importance of the delegation agreement I think.

2 MS. T. THOMPSON: All right.

3 DR. GREEN: So this section, I had a
4 question about -- maybe it's a concern. According to
5 the way I read this, somebody with a criminal
6 background could go unnoticed for a year. Because you
7 can get an interim permit for a year, and its says that
8 you do a federal background may take up to a year.

9 MS. T. THOMPSON: Yep.

10 DR. GREEN: And that's just something we
11 don't have any control over.

12 MR. CONCANNON: There's lots of things
13 in this section that I think are strange the way it
14 reads. But that's for another day, isn't it?

15 MS. T. THOMPSON: Our hands are tied on
16 all that stuff. Yes, okay.

17 DR. HEYE: We look at their picture.

18 MS. T. THOMPSON: Just Google them.

19 MR. CONCANNON: This guy's gone 20 years
20 without being detected.

21 MS. T. THOMPSON: So next step, I do not
22 believe -- maybe I'm wrong, but I do not believe that
23 we are in a place where either the Commission or the
24 Board Committee members feel like they can go to your
25 Board and Commission and say, this is a product that I

1 would to seriously consider to go forward from here.

2 MR. CONCANNON: You are correct.

3 MS. T. THOMPSON: Exactly. So the next
4 step would be to hold one more meeting to finish
5 walking through this and get us to a place where we can
6 do that.

7 DR. GREEN: Can I ask a question? What
8 can we do and what can't we do without having a public
9 meeting?

10 And related to that, is there some way
11 of making some changes like we did today, reviewing
12 them, making suggestions, and doing them again, so that
13 when we present it in this public forum we don't keep
14 coming up with -- in other words, how much can we do
15 with that without coming here to one of these meetings?

16 Because that seems, to me, that delays a
17 lot of this.

18 MS. T. THOMPSON: I have to defer to
19 legal.

20 MS. CARTER: So you can send all your
21 comments like you have been to Julie and Brett and they
22 can circulate those. You can then send your comments
23 of the comments to Julie and Brett, and the staff can
24 come up with a consensus.

25 DR. GREEN: I would consider, as much as

1 possible, to do that before there's any other meeting.
2 Because I think that would flush a lot of this out and
3 we could --

4 MS. T. THOMPSON: But the problem -- I
5 have to say -- I mean, it's a great idea, but the
6 problem is that we get these comments and then we have
7 to -- we, the Department, which is not our rule, but
8 we, the Department staff, are taking into consideration
9 your comments or concerns or whatever and when there's
10 conflict or when you say this, we notice that and we
11 never really get anywhere. So we still have to bring
12 it back and discuss it.

13 DR. GREEN: My thought about that is,
14 that you guys do this in isolation and without
15 concurrent input from us. And that's the way your
16 process is. And to me, it would be different if it
17 wasn't that way. I'm not complaining. I'm just
18 observing.

19 MR. CONCANNON: Well, unlike prior
20 meetings here, we were definitely deferring lots of
21 different things to some other time.

22 What was done today, if Brett had to
23 produced a draft of what was done today, it wouldn't be
24 hard, because he was producing most of it right there.

25 DR. GREEN: Right.

1 MS. T. THOMPSON: Because we're getting
2 down to that point where it's really fine tuning.

3 MR. CONCANNON: At least the first
4 several sections; right?

5 MS. T. THOMPSON: Yes.

6 MR. CONCANNON: At this point, it seems
7 to me the thing to do would be produce a draft, get it
8 out to people pretty soon, let people comment on it.
9 Then produce a draft for the next meeting based on what
10 Linda or Dr. Green or anyone says.

11 DR. GREEN: Don't do it right before the
12 meeting, because then we'll inevitably come here --

13 MR. CONCANNON: Then produce a second
14 draft based on, you know, whatever.

15 DR. MARKEGARD: Well, that is a lot of
16 work for the staff. Because then say they deleted
17 this, comma'd off one section, and used a comma in one
18 section, they're changing, not changing, different
19 colors. They still have to bring it in for us to hash
20 out. It seems like a lot of work that is nonvalue
21 added.

22 MR. CAIN: Let's just see the colors,
23 look at that rainbow.

24 DR. GREEN: You know what, here's my
25 complaint. I had no colors.

1 MR. CAIN: We sent two out.

2 DR. GREEN: Huh?

3 MR. CAIN: We sent one with and one
4 without --

5 DR. GREEN: Well, all I'm telling you, I
6 had no colors. And I never saw them or received them.

7 MR. CAIN: Because of the scanning.

8 DR. JOHNSON: I wrote to Julie and said
9 I can't see Tom's, she said, they're in pink. And I
10 tried to make pink and I didn't get pink.

11 MR. CAIN: So what I can do -- and I
12 apologize for that, we have a color scanner and I think
13 color -- I probably pressed black and white.

14 DR. JOHNSON: Yeah. Mine was all black
15 and white and Linda's I never saw.

16 MR. CAIN: I can color scan it and we
17 can send it out it color. Honest, we can.

18 DR. JOHNSON: Because otherwise I
19 couldn't tell. You understand what I'm saying.

20 MR. CAIN: Sure, sure.

21 DR. JOHNSON: Because I looked down and
22 go where's Tom's comments.

23 DR. MARKEGARD: How about just send a
24 draft without the changes. And then we can focus on
25 these conceptions we're going to focus at the next

1 meeting and bring your comments to the meeting and we
2 can do it at the meeting then.

3 MS. T. THOMPSON: Send another clean
4 copy?

5 DR. MARKEGARD: Yes.

6 MS. DALE: This one today?

7 MS. T. THOMPSON: Right.

8 DR. MARKEGARD: And focus on certain
9 sections and bring our comments here to hash out.

10 MS. D. THOMPSON: We just want to focus
11 on stuff that we didn't already cover.

12 DR. GREEN: All right. How much notice
13 do you need for a public meeting?

14 MS. CARTER: 24 hours.

15 DR. GREEN: Would it be inappropriate to
16 try to go through this again all next week?

17 MS. T. THOMPSON: Oh, on the 16th?

18 DR. GREEN: Oh, I sorry. I won't be
19 here next week with you people.

20 MS. CARTER: "You people," what does
21 that mean?

22 MS. DALE: Yeah. I don't be either.

23 MR. CAIN: We'll be in Kent.

24 MS. DALE: It's my grandson's fourth
25 birthday and I'm not missing it.

1 DR. MARKEGARD: What day is that? I'm
2 sorry.

3 DR. GREEN: Well, our Commission meets
4 Thursday and Friday next week.

5 DR. MARKEGARD: Where next Friday?

6 MR. CAIN: Here.

7 DR. MARKEGARD: Oh, here.

8 MR. CAIN: But we're in Kent.

9 MS. CLOWER: Can we meet here?

10 MR. CONCANNON: So you're just going to
11 set a date in the future, four or five weeks from now?

12 MS. CRAIG: We have secured a place just
13 in case this happened. And it's here, back here at
14 Tumwater in TC 2, June 13th, from 11:00 until about
15 4:00.

16 MS. DALE: Let's see, there's a --

17 DR. JOHNSON: You've already secured a
18 place?

19 MS. DALE: Brett, isn't that the
20 clinical -- Brett, isn't that the Clinical Affiliation
21 Agreement day?

22 MR. CAIN: June 13th.

23 MS. DALE: June 13th, oh, I'm sorry.

24 MR. CAIN: May 13th.

25 DR. JOHNSON: That's a Friday?

1 MS. CRAIG: (Moves head up and down.)

2 MS. DALE: From what time to what time?

3 MS. CRAIG: About 11:00 to 4:00. I
4 think I scheduled the -- conference rooms are very,
5 very difficult to secure here, but I got it from 11:00
6 to about 4:00. We can probably extend to 5:00.

7 DR. JOHNSON: Should I write this into
8 my calendar?

9 MS. CRAIG: It's up to staff if they
10 chose and you agree. I just reserved the room in case
11 we needed more meeting so.

12 MR. BERGSTEIN: Is there an alternate
13 date?

14 MS. CRAIG: We'll have to go off campus.
15 It's up to the staff if you guys want to do something
16 different.

17 MS. DALE: Maybe do it the --

18 MR. CAIN: Looks like a good
19 possibility.

20 MS. DALE: Yes.

21 MS. T. THOMPSON: Okay. What I'm
22 hearing is that we want to send out this document for
23 comments. Give you some time to comment, write
24 comments back to us. We draft up those comments again
25 and then we come together one more time and see if we

1 can finalize it. And it's going to be June 13th or
2 maybe something a little different if we can get
3 another place or date everybody can be here.

4 MR. CAIN: What day?

5 MS. CLOWER: Mondays are bad.

6 MR. CAIN: I hear Mondays are bad a lot.

7 MS. CRAIG: We will provide comments but
8 we are not going to file. We're just going to discuss
9 it on or try to.

10 MS. T. THOMPSON: Of course. We're
11 sending the draft out. The draft will be kind to have
12 shaved out of today. And then are you providing
13 comments for us to try to incorporate or providing
14 comments to bring to the next meeting?

15 DR. GREEN: I --

16 DR. MARKEGARD: Bring my own.

17 DR. GREEN: I think the suggestion was
18 you could send the draft back with comments of
19 everybody, and then we can review those and make
20 comments on each others comments. And then from the
21 meeting -- you know, if you have time to reflect on
22 what other people have said, that's helpful in my
23 opinion. So somehow I think we can --

24 MS. CRAIG: We can exile --

25 DR. GREEN: So people look at it and

1 make their comments and we can all see what that is
2 before there's a meeting.

3 MS. T. THOMPSON: Before the next
4 meeting.

5 DR. GREEN: And have time to think about
6 it before. However you do that, I don't know, but I
7 think that makes more sense --

8 MS. CRAIG: It would help.

9 DR. GREEN: -- to me.

10 MR. CAIN: Well, I think based on what
11 was discussed today, there's -- I mean, where we're at
12 now, there isn't a whole lot except plugging in the
13 retired active. We could get the product from today
14 out quickly, and then welcome feedback. We'd give
15 probably like a week deadline. Take that feedback and
16 the we could probably produce something.

17 MS. CRAIG: The problem is different
18 committee members have different opinions and leaving
19 it up to the discretion of the staff to figure it out.

20 MR. CAIN: Well, what you're going to do
21 is --

22 DR. GREEN: That's why if you just let
23 us know what they are, we can --

24 MR. CAIN: Comment that section so we
25 know were they are and leave it as is.

1 MS. CRAIG: Oh, I see. Okay.

2 MS. T. THOMPSON: And then we compile
3 the comments and bring them to the meeting to discuss
4 them.

5 DR. GREEN: But somehow send to comments
6 out ahead of time so people have a chance to reflect on
7 those as well.

8 MS. T. THOMPSON: Okay.

9 DR. GREEN: Don't try to incorporate
10 them into the draft.

11 MS. CRAIG: Please send your comments to
12 Julie and Brett.

13 MR. CAIN: Or those mailboxes.

14 MS. CRAIG: Or those mailboxes only. If
15 they go to other staff, we don't see them. Then the
16 expectation is that we're acting upon it and we don't
17 know about until the very end, if at all.

18 MS. T. THOMPSON: Okay. Good work,
19 everyone. Thank you.

20 (Proceedings concluded at 5:02 p.m.)

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I, Gloria C. Bell, CCR ,court reporter within and for the state of Washington, do hereby certify that I attended the foregoing joint physician assistant rules committee meeting in its entirety, that I wrote the same in stenotype, and that the foregoing pages constitute a full, true and accurate transcript of said proceedings to the best of my skill and ability.

IN WITNESS WHEREOF, I have hereunto affixed my signature at Rainier, Washington, this 20th day of May 2014.

GLORIA C. BELL, CCR
CCR No. 3261

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