WASHINGTON OSTEOPATHIC ASSOCIATION MEDICAL WOMA

Washington D.O.

Spring 2015

4700 42nd SW, Suite 530 / P.O. Box 16486 Seattle, WA 98116-0486
(206) 937-5358 FAX (206) 933-6529 / www.woma.org

SGR Fix

The 24% Medicare SGR payment reduction was avoided and physicians will get a 0.5% pay increase each year for 5 years under a deal by a bipartisan team of House and Senate negotiators. To be eligible for higher payments, providers will need to document and adhere to a number of different quality standards.

The provisions are necessary due to the sheer complexity involved in transforming an antiquated physician payment system developed back in 1997.

The legislation is not perfect; however, it aligns well with the osteopathic principle of providing quality patient-centered care. It moves us from a fee-for-service system to one that is based on quality care for patients. The system finally provides predictability in physician payments, positive payment incentives via annual updates for five years, and incentive payments through participation in the patient-centered medical home or other alternative payment models.

Additionally, the legislation combines and streamlines the currently disjointed quality reporting programs into one program to alleviate some of the administrative burden on physicians. In doing so, physicians will now be eligible for positive payment updates for participating in quality reporting, which is not the case under current law. Only penalties exist in the current system for lack of or poor participation.

Providers will also have the chance to accrue financial bonuses by participating in innovative care delivery models like the patient-centered medical home (PCMH). The legislation makes it easier for providers to participate in the newly unified Merit-Based Incentive Payment System (MIPS), which streamlines participation in existing EHR Incentive Programs, Physician Quality Reporting System (PQRS), and Value-Based

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Return to Semiahmoo

The 102nd Annual Northwest Osteopathic Convention, hosted by the Washington Osteopathic Medical Association, will take place June 25-28 at the Semiahmoo Resort in Blaine. The hotel has a new owner and has recently completed a multi-million dollar restoration inspired by its seaside location. Semiahmoo Spit (separating Semiahmoo Bay and Drayton Harbor) is also home to Semiahmoo County Park, which boasts more than 300 acres of tideland and approximately 1.5 miles of level pathways ideal for outdoor adventures such as walking, biking, rollerblading, kayaking, clamming, sand sculpting, kite flying and picnicking.

The program has been approved by the AOA for 24 Category 1-A credits and 24 osteopathic family medicine specialty credits. Osteopathic specialty credits have been applied for applicable presentations in internal medicine, dermatology, NMM, addiction medicine, neurology, psychiatry, infectious disease and pediatrics. The program is being reviewed and is pending approval of 24.00 Prescribed credits by the American Academy of Family Physicians. A maximum number of 25 specialty credits may be earned from an AOA-affiliated state osteopathic society in the current AOA 2013-2015 CME cycle. If you still need AOA 1-A credits, this is a great program from which to earn them.

Though we take our CME very seriously, we also understand that quality family – activity-relaxation time is necessary and this venue is great for that.

You may print out a brochure and/or register online at www.woma.org. You can save if your register before May 15th. And don't forget to reserve your hotel room before the May 18th room block release. Use the link on the WOMA website, choose your dates, select "check availability", then select "view available rooms". Choose your room and proceed to checkout.

Saturday evening we will continue the tradition of the annual auction to benefit the Washington Osteopathic Foundation programs. Dr. Scott Fannin will entertain us with his auctioneering skills and colorful commentary. It is always a fun event. Auction items are greatly appreciated and tax deductible. If you are interested in donating an item or helping with the auction, please contact Kathie Itter at kitter@woma.org or call 206-937-5358.

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WOMA
5220 California Ave SW, Suite B
PO Box 16486
Seattle, WA 98116
(206) 937-5358
Fax (206) 933-6529
www.woma.org

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Meetings Notice
WOF Board
8:30 a.m. June 25, 2015
WOMA Board Breakfast
9:00 a.m. June 25, 2015
Annual Meeting Lunch
12:30 p.m. June 26, 2015
Semiahmoo Resort
9565 Semiahmoo Parkway
Blaine, WA

WOMA Welcomes New Members

At its quarterly meeting held March 21, 2015, the WOMA Board of Governors approved the following applications for membership:

Active
Patricia Coyman, DO KCUMB'96
Thomas Fotopoulos, DO NSUCOM'00
Jeffrey Hedge, DO CCOM'93
David Kanze, DO PCOM'05
Kylie Kanze, DO PCOM'06
Wayne Kim, DO COMP'90
Oanh Nguyen, DO MSUCOM
Paula Renzi, DO PCOM'07

Retired
Kevin Ware, DO DMU'73

Residency Update

By David Escobar, DO

Skagit Valley Hospital has filled its incoming intern class for the coming academic year; 6 internal medicine and 5 family medicine residents. A graduation ceremony for our senior residents is scheduled for the evening of June 27 at Skagit Valley Casino Resort. Three graduating seniors are staying in Washington to practice primary care medicine in rural/underserved areas after residency, and one is going on to neuromusculoskeletal (NMM) fellowship.

2016 WOMA Board Nominees

Following is the proposed slate of WOMA Board Members for 2016. Elections will take place on Friday, June 26th at the WOMA annual meeting luncheon at 12:30 p.m. at Semiahmoo Resort in Blaine. Harold Agner, DO will serve as Immediate Past President

Executive Committee
Term 1/1-12/31/2016
President
Scott Fannin, DO
President-elect
Michael J Scott, III, DO
Vice President
Mischa Coleman, DO
Secretary
David Farrell, DO
Treasurer
Mark Hunt, DO
Trustees
Terms 1/1/2016–12/31/2017
District 1
Nathanael Cardon, DO
District 2
Jeanne Rupert, DO
District 3
Rose-Marie Colombini, DO
David Lukens, DO
District 4
Paul Emmans, Jr, DO
District 5
David Hofheins, DO
Institutional Member
Marc Cote, DO
Postgraduate Member
TBA
Student Representative
TBA
AOA Delegates
David Lukens, DO
Paul Emmans, Jr, DO
Harold Agner, II, DO
Paul Emmans, III, DO
Scott Fannin, DO
Amber Figueroa, DO
Anita Showalter, DO
Alternate Delegate
Michael J Scott, III, DO

Nominations for all positions will be open from the floor. The Board of Governors meets quarterly in March, June, September and December. The Executive Committee meets with the Public Affairs Committee in the interim months to conduct business.

Governor Seeks Board Applicants

The Department of Health will be accepting applications until May 15, 2015 to fill the unexpired term of Peter Kilburn, DO on the Washington State Board of Osteopathic Medicine and Surgery . Dr. Kilburn retired from active practice on January 1st and is no longer eligible to serve. The term is through July 1, 2017 and can be reappointed for two full five-year terms.

Applicants must be in active practice for at least five years and be willing to study the issues and make decisions in the best interest of the public. Selection will reflect the diversity of the profession and representation throughout the state.

The board meets about six times a year, usually on Fridays. There is an expectation to review disciplinary cases between meetings. Participation in additional conference calls and hearings are often necessary.

If you have questions about serving on the board, please contact Program Manager Brett Cain at DOH by email at brett.cain@doh.wa.gov or call 360-236-4766.

Getting to Know You

WOMA is pleased to welcome the following new Active members:

Patricia Coyman, DO is a 1996 graduate of KCUMB. Her postgraduate training includes an Internal Medicine Residency at St Joseph Medical Center in Ypsilanti, MI, a Family Medicine Residency at Sparrow/MSU and a Geriatric Fellowship at Sun Health/St Joseph Medical Center in Sun City/ Phoenix AZ. She currently practices in Yakima.

Thomas Fotopoulos, DO graduated from NSUCOM in 2000. His postgraduate training includes an OMM/NMM Fellowship at NSUCOM in 1997-2000; an Osteopathic Family Medicine Track Internship at Florida Hospital East Orlando in 2000-2001; a PM&R Residency program in 2001 and an NMM/OMM residency at Osteopathic Medical Center of Texas, Ft Worth in 2002-3004. He is currently the Chair – Dept. of OPP/ Associate Clinical Professor of OPP at PNWU.

Jeffrey Hedge, DO is a 1983 graduate of MWU/CCOM. His postgraduate training includes a flexible internship at CCOM and General Psychiatry residency at UHS Chicago Medical School where he served as Chief Resident in 1990-1991. He is in the private practice of general psychiatry in Spokane.

David Kanze, DO graduated from PCOM in 2005 and completed a Family Practice/OMM residency at Botsford Hospital in 2009. He currently serves as Family Medicine Residency Director and Interim Director of Medical Education at Skagit Regional Health in Mt. Vernon.

Kylie Kanze, DO is a 2006 graduate of PCOM, including a one year OMM Fellowship. Her postgraduate training includes an internship at Henry Ford Bi-County Hospital/Children's Hospital of Michigan and a pediatric residency at Children's Hospital of Michigan.

Oanh Nguyen, DO graduated from MSUCOM. She practices general neurology with a sub-specialty in sleep medicine at St. Joseph Hospital in Tacoma.

Paula Renzi, DO is a 2007 graduate of PCOM. She completed a rotating internship in 2008 and an Internal Medicine residency in 2010 at PCOM/ Lankenau Hospital. She practices Internal Medicine/Geriatrics in Yakima.

PNWU Benefits from Ursa Gift

From left, James Keene, DO, Thomsas Fotopoulos, DO and Loren H Rex, DO

Many of you are familiar with Loren H Rex, DO (Bear) and the Ursa Foundation. For those who are not, Bear (author of over one hundred "Bear Dropping" columns featured in every Washington DO newsletter since 1990) joined WOMA as an intern at Waldo Hospital in 1974. He has served WOMA in several capacities, including the longest-serving appointee to the L&I Medical Advisory Committee, Public Affairs Chair and three terms as President. He has also served many years on the Washington Osteopathic Foundation board for which he raised thousands of dollars as the auctioneer at the annual June fundraiser. In addition to his OMM practice, Bear and his friends created the Ursa Foundation in 1976, a non-profit teaching institution providing continuing professional education in manual medicine techniques to health care providers with statutory authority to apply the techniques learned.

Upon Bear's retirement, the Ursa Board voted to dissolve the Foundation and distribute its assets to non-profit organizations supporting manual medicine education.

The Foundation possessed many valuable teaching aids, including five demonstration skulls of natural human bone, eight demonstration human spines (plastic), one human torso anatomy model (15 slices) and one muscular model. The entire collection, valued at over $12,000 was donated to the PNWU OMM lab.

On Friday, April 3rd, OP&P Department Chair Thomas Fotopoulos, DO, Assistant Professor of OP&P James Keene, DO and Darlene Keene ventured from the PNWU campus to Dr. Rex's residence in Edmonds and carefully packed up the fragile cargo to travel back to PNWU. Bear was pleased that future osteopathic physicians will be able to benefit from the gift.

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Modifier (VBM) programs, allowing providers to attest only once on regularly updated clinical quality measures.

These delivery reforms promote population health management, better care coordination, and the increased use of health information exchange and clinical analytics for patient risk stratification and more comprehensive preventative care. The SGR repeal allows for a five percent bonus for those providers who will accrue at least a quarter of their Medicare revenue through alternative care models and value-based reimbursement arrangements by 2018.

In recognizing that each individual is unique, the new payment system incentivizes delivery models which are not one size fits all as was the case with the sustainable growth rate formula based system. Physicians will be able to choose the model that suits them best based upon their specialty, practice blend, and their patients.

PMP Rules Project

To review the PMP Rules (chapter 246-470 WAC) please go to http://app.leg.wa.gov/wac/default.aspx?cite=246-470.

DOH Rule Proposed Amendment Areas: Based on experience so far, the Prescription Monitoring Program is considering the exploration of revisions in the following areas:

Frequency of data collection (WAC 246-470-030): With the connection to electronic health record systems and use by the Emergency Department Information Exchange we would like to examine the possibility of providing data that is more up to date.

1) The PDMP TTAC reports (http://www.pdmpassist.org/content/pdmp-data-collection-frequency) that 12 states require daily reporting currently and at recent meetings it appears more are headed this direction.

2) The PDMP Center of Excellence recommends increasing frequency of data collection as one of the best practices for PDMPs. - http://www.pdmpexcellence.org/sites/all/pdfs/Brandeis_PDMP_Report.pdf.

3) The Injury and Violence Prevention (IVP) Program was assessed by the State Technical Assessment Team (STAT) Program. Some PMP related recommendations came out of their assessment including increasing reporting frequency.

4) RCW 70.225.020 states: "improving controlled substance prescribing practices with the intent of eventually establishing an electronic database available in real time to dispensers and prescribers of controlled substances".

Clarification on zero reporting (WAC 246-470-030): Currently dispensers report zero if no controlled drugs were dispensed during the reporting period. Our rules currently do not provide guidance in this area and we would like to explore the possibility of language to assist with this.

Better Patient Identification (WAC 246-470-030): One of the significant challenges we have had with running an efficient system is having to cluster patient records together from pharmacies entering patient information differently. We would like to potentially explore ways to ensure data is entered more uniformly.

Adding Data Fields (WAC 246-470-030): We would like to explore potentially adding other data fields that would help enhance the system. For example we currently do not require NPI to be provided and have found it difficult to assist Medicaid with their use of the system as they track providers by NPI and not DEA number.

1) The PDMP TTAC has a guide for additional fields to consider: http://www.pdmpassist.org/pdf/TAG_Additional_Data_Fields_FINAL.pdf

Parent/Guardian Access (WAC 246-470-040): Our rules currently do not clearly outline access to patient information for parent/guardian scenarios. We would like to possibly consider clarifying language in this section.

Delegates for Pharmacists (WAC 246-470-050): Our rules currently do not allow a pharmacist to delegate querying to a Pharmacy Technician or other credentialed pharmacy staff. We would like to explore the possibility of adding this ability.

Clarifying Storage of data from the program into the patient medical record (TBD): We get a lot of questions on whether or not PMP data can be put into a paper or electronic medical record. We would like to explore language that might help clarify this.

Department of Health Rule Review Questions: As a valued stakeholder you are invited to review the following questions used for the rule review.

1. Need – is there a need for this rule?
2. Reasonable and Clear – is this rule clear, concise and reasonable?
3. Authority and Intent – Does the rule have statutory authority or meet the legislative intent?
4. Stakeholder Coordination – How was the review coordinated?
5. Streamlining Identified – Can this rule be streamlined? Or are there other streamlining opportunities available?
6. Reporting Requirements - Does the rule require individuals or entities to report information to the department?
7. Achieved Intended Results - Does the rule achieve the results originally intended?
8. Staff Conclusions – Repeal/ Retain without changes/Amend?
9. Barriers - Does the rule or related processes create barriers to individuals/entities seeking to become licensed or to renew their license (not including acceptance of military health care occupation training or experience)?
10. DOH/Government Coordination - Was review of this rule coordinated with other HSQA professions or offices, other DOH programs, or other public agencies or governments (state, county, local, or tribal)?
11. Cultural Competency - Does the rule present a barrier to promoting cultural competency?
12. Petitions - Was the rule reviewed or revised as a result of a rule-making petition?

Providing Comments: Please send any comments/questions you have for this rule review (including ideas for amendments) to prescriptionmonitoring@doh.wa.gov or you can call 360.236.4806.

A First for Seattle King County Public Health

Jeanne Rupert, DO is believed to be the first osteopathic physician to work for Seattle King County Public Health. Dr. Rupert is the Medical Director of the Community Health Services Division, Public Health Seattle & King County. Her areas of responsibility are: Primary Care clinics, Family Planning clinics, School-Based Health Centers, Mobile Medical Van, and Maternity Support services.

The primary care clinics also include Immunization services and Refugee Screening. She supervises about 30 providers and oversees clinical policies, and participates in leadership team projects in Quality Improvement and implementation of Healthcare Reform. She provides clinical primary care services one day per week.

In response to many inquiries, Dr. Rupert provided a post on the Public Health Insider blog about "What it means if your doctor is A D.O." at http://publichealthinsider.com/2015/04/24/what-does-it-mean-if-your-doctor-is-a-do-our-new-medical-director-explains/.

Proposed Bylaws Amendments

At its meeting on March 21, 2015 the WOMA Board of Governors voted to recommend adoption of the following bylaws amendments to the membership at the annual meeting in June (old language crossed out, new language underlined.):

Article II - Membership and Dues

Section 1: There shall be ~~twelve~~ thirteen categories of memberships: Active, Post-Graduate Trainee, Associate, Student, Probationary, Retired, ~~Semi-Retired~~ Part-Time, Life, Distinguished Life, Honorary, Institutional, Inactive and Allied. Dues for each category shall be determined by the membership of the association and may be changed by the membership at the annual meeting.

Section 2: Active Membership. Eligibility for membership in this Association shall include all osteopathic physicians and/or surgeons who are licensed to practice and residing and/or practicing in the State of Washington and who are graduates of schools approved by the American Osteopathic Association at the time of their graduation. All applications for Active Membership must be approved by members of the Membership Committee from the applicant's respective district before being presented to the Board of Governors for approval. Active members shall have the privilege of voting and holding office and pay dues at a rate approved by the membership at the annual meeting.

Section 4: Associate Membership. a) Associate membership may be granted by the Board of Governors to those osteopathic physicians and/or surgeons, who are graduates of schools approved by the American Osteopathic Association at the time of their graduation and who at the time of acceptance for membership, are practicing outside of Washington State or in active military status. Associate membership shall not have the privilege of voting or holding office in the Association and pay dues at a rate approved by the membership at the annual meeting.

Section 5: Student Membership may be granted to any person enrolled in a school of osteopathic medicine accredited by the American Osteopathic Association. (There are no dues for Student Members). A Student Member may not hold office or vote on association business, except for the one student member of the Board of Governors.

Section 7: ~~Semi-Retired~~ Part-time Membership. ~~Semi-retired~~ Part-time membership may be granted by the Board of Governors to active members whose practice is reduced to a part time basis of less than 50% of the usual because of ~~age or disability~~ life circumstances. Application must be in writing. A ~~Semi-retired~~ Part-time member may vote but not hold office and pay dues at a rate approved by the membership at the annual meeting.

Section 8: Retired Membership. Retired membership shall be granted to those osteopathic physicians ~~and/or surgeons~~ who are graduates of schools approved by the American Osteopathic Association at the time of their graduation and who at the time of acceptance for retired membership ~~must not be in active practice and~~ must be a member of this Association in good standing ~~at the time of retirement~~. Written application for retired members must be made to the Board of Governors and will include an attestation that no patients are seen for a fee. ~~the following certification: "I———, D.O. hereby certify that I do not maintain an office or use an office space on a rental or any other basis and I see no patients for a fee."~~ The Board of Governors shall grant such membership on the merits of each application. A retired member shall not vote or hold office and pay dues at a rate approved by the membership at the annual meeting. Retired membership in this association may be granted to retired members in good standing of other AOA state divisional societies upon change of residence to Washington State, or, to osteopathic physicians who were Active members in good standing of their AOA state divisional society immediately before retiring and moving to Washington State.

Section 11: Institutional Membership. Institutional Membership is available to any AOA accredited osteopathic medical school or osteopathic or mixed-staff hospital in the state which is accredited by a recognized legal accrediting authority. One institutional member shall be elected by the Board of Governors from nominees submitted by the institutional members. Each institution is entitled to submit one nominee to the WOMA nominating committee. Each such institution shall have one vote at the annual membership meeting and pay dues at a rate approved by the membership at the annual meeting.

Section ~~14~~ 13 (renumbered)

Section 14: Inactive Membership. Inactive membership may be granted to former active members who are not retired, but not in active practice and maintain their Washington license. Inactive members shall have such privileges as may be extended to them by the association at the discretion of the Board of Governors. Inactive members may not vote or hold office and pay dues at a rate approved by the membership at the annual meeting.

Subsequent sections are renumbered accordingly.

If approved, the Semi-Retired Membership will change to Part-Time membership defined as less than 50% of the usual time practiced due to life circumstances, not just age or disability. A new category of Inactive Membership is created for active members want to maintain their membership but have chosen to temporarily stop practicing for a while, are not retired and maintain their Washington license. All other changes are housekeeping measures.

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Naloxone Bill on Governor's Desk

HB 1671 will put life-saving heroin overdose medication in the hands of first responders, community providers, and family members and friends of users.

Opioid antagonists like naloxone — commonly known as brand name Narcan — save lives by reversing the effects of a heroin overdose. But under current law, access to heroin overdose drugs like Narcan is restricted to licensed health care professionals and those with prescriptions.

A health care practitioner who is authorized to prescribe legend drugs may prescribe, dispense, distribute, and deliver an opioid overdose medication: (1) directly to a person at risk of experiencing an opioid-related overdose; or (2) by collaborative drug therapy agreement, standing order, or protocol to a first responder, family member, or other person in a position to assist a person at risk of experiencing an opioid-related overdose. At the time of prescribing, dispensing, distributing, or delivering the opioid overdose medication, the practitioner must inform the recipient that as soon as possible after administration, the person at risk of experiencing an overdose should be transported to a hospital or a first responder should be summoned. A prescription or protocol order issued under these circumstances is issued for a legitimate medical purpose in the usual course of professional practice. Any person or entity may lawfully possess, store, deliver, distribute, or administer an opioid overdose medication pursuant to a practitioner's prescription or order.

A pharmacist may dispense an opioid overdose medication pursuant to such a prescription and may administer an opioid overdose medication to a person at risk of experiencing an overdose. At the time of dispensing the medication, the pharmacist must provide written instructions on the proper response to an opioid-related overdose, including instructions for seeking immediate medical attention. The instructions to seek immediate medical attention must be conspicuously displayed.

The following individuals are not subject to civil or criminal liability or disciplinary action under the Uniform Disciplinary Act (UDA) for their authorized actions related to opioid overdose medication or the outcomes of their authorized actions if they act in good faith and with reasonable care: practitioners who prescribe, dispense, distribute, or deliver an opioid overdose medication; pharmacists who dispense an opioid overdose medication; and persons who possess, store, distribute, or administer an opioid overdose medication. The provision in the UDA related to naloxone is repealed.

The bill has been delivered to Governor Jay Inslee for a final signature.

Annual Auction Benefits Washington Osteopathic Foundation

Whether or not you plan to attend the WOMA Annual Convention, please consider supporting the Washington Osteopathic Foundation (WOF) annual philanthropic event to fund WOF projects, scholarships and low-interest loans. The event takes place on Saturday evening, June 27th at the Semiahmoo Resort in Blaine. A no-host reception and silent auction start at 6:00 p.m. This is followed by a delicious dinner and awards ceremony and ends with a spirited live auction with an amazing variety of items for which to raise those paddles. Auctioneer Scott Fannin, DO is up for the challenge to increase the WOF resources.

Donations of items for the silent and live auctions are greatly appreciated and tax-deductible at their fair market value. This year we have an exciting helicopter ride for two donated by Peregrine Air LLC. The successful bidder will have a choice of 30-45 minute tour of the 2016 Skagit Valley tulip fields or a flight to beautiful Roche Harbor for lunch. The helicopter leaves from Skagit Regional Airport in Burlington and is piloted by an experienced licensed commercial pilot. For the kids in your life, we have a Big Hero 6 backpack full of Big Hero 6 items.

If you would like to help with an auction or cash donation, please complete the form on the last page of this newsletter and mail, fax or scan and email to the WOMA office. The address is PO Box 16486, Seattle, WA 98116-046. The fax is 206-933-6529 and the email is kitter@woma.org. And, if you have experience in auction set-up, displaying, cashiering, etc. and would like to help please call Kathie Itter at 206-937-5358.

You can be the suddessful bidder on a great helicopter ride donated by Kevin Ware, DO and Peregrine Air, LLC. Dr. Ware and his wife, Kari, are pictured with the helicopter, a Robinson R44, which due to its safety recorde has become the most commonly manufactured helicopter in the world.

Rule-Making for Osteopathic Board

On March 31, 2015, the Board of Osteopathic Medicine and Surgery (board) officially filed a CR-102 (WSR # 15-08-086) with the Office of the Code Reviser proposing revisions to chapter 246-853 WAC—Osteopathic medicine and surgery.

Re-entry to Practice

The board is proposing rules to establish standards to ensure that physicians returning to practice meet certain requirements to ensure patient safety. The proposed rule establishes the process that an osteopathic physician who has been out of practice for five years must follow to reactivate his or her license. It is the board's mandate to ensure that those who practice osteopathic medicine and surgery in Washington State are properly trained and safe to provide care to patients. Competency must be demonstrated through passage of a board approved exam, a board approved competency evaluation, a board approved retraining program, or a board approved monitoring program. The benefit of the new proposed rule is that it ensures that osteopathic physicians who have been out of practice are competent before providing care. There are potential costs to the physician returning to practice associated with taking an exam, undergoing a competency evaluation, or completing a retraining or monitoring program.

Retired Active Credential

The proposed rule establishes the process that an osteopathic physician must follow to obtain a retired active license at a reduced license fee. The purpose for adding this proposed new section is to allow physicians to obtain a retired active license in order to update and modernize current rules regulating physicians. Adding a retired active license status for osteopathic physicians, which is authorized under RCW 18.130.250, is consistent with other health care professions that are moving to adopt retired active status for members of their professions. The retired active license allows the osteopathic physician to work for limited periods each year or during emergencies, and may not charge fees for services. The licensee must complete continuing medical education every year to maintain a retired active license.

LLRP Delegation

The current rule stipulates that an osteopathic physician may delegate the operation of LLRP devices to a properly trained health care professional licensed under the authorization of RCW 18.130.040, whose scope of practice allows the use of a prescriptive LLRP device. The current rule does not allow an osteopathic physician to delegate the operation of these devices to professionals who are not licensed by the department. The proposed rule states that the use of these devices may be delegated to "a properly trained and licensed professional, whose licensure and scope of practice allow the use of an LLRP device…" This proposed language allows an osteopathic physician to delegate use of LLRP devices to professionals not licensed by the department, such as a master esthetician licensed by the Department of Licensing. The current allopathic rules include this language for allopathic physicians under WAC 246-919-605 and this proposal will further align the osteopathic physician and allopathic physician chapters of rule. The proposed rule will increase the number of professionals to whom an osteopathic physician can delegate the use of LLRP devices

Finally, the proposed rules make general housekeeping changes to ensure the chapter is current, relevant, and aligns with industry standards.

The board is accepting written comments for these rules on the Agency Rules Comment Page through May 13, 2015. A rules public hearing will be held at the Oxford Suites in Yakima, WA on May 15, 2015, at 9 a.m., and the board encourages your participation and comment.

Resolution Vote

Opposition to MOC as a Requirement for License Renewal

At the WOMA annual meeting on June 26th, the membership will be asked to approve a resolution to oppose maintenance of certification as a condition of license renewal. The resolution reads as follows:

WHEREAS, there is an education process (Continuing Medical Education) in place that has been effective for many years and the State Licensing and Disciplinary Boards have oversight that its physicians have fulfilled this requirement for licensure; and

WHEREAS, state licensing and disciplinary boards have mechanisms to identify and discipline osteopathic physicians who pose a threat to the public; and

WHEREAS, there is no body of documented evidence that proves that passing a written exam and recertification has any direct correlation on quality or protection of public safety above the established training and licensing program now, therefore be it

RESOLVED, that the AOA recognizes that the recertification requirements of maintenance of certification are costly, time consuming and disruptive of physician time for patient care, while lacking any proof of improving patient care; and BE IT FURTHER

RESOLVED, that the AOA opposes any efforts to mandate maintenance of certification as a condition for state licensure, hospital staff privileges, reimbursement from third party insurance parties, malpractice coverage and as a requirement for physician employment; and BE IT FURTHER

RESOLVED, that the AOA advocates that if a state licensure entity chooses maintenance of certification as an option for re-licensure, other requirements, such as CME, should remain an option for license renewal.

If approved, the resolution will be submitted to the AOA for consideration at the House of Delegates meeting in July.

Pertussis: DOH Key Messages for Providers

Pertussis is cyclical and peaks every 3-5 years as the numbers of susceptible persons in the population increases due to waning of immunity following both vaccination and disease. During the last peak year in Washington, 2012, pertussis activity was at epidemic levels with nearly 5,000 cases reported in the state. Now pertussis is definitely on the rise again. So far this year there have been 319 reported cases of pertussis compared to 49 during the same time last year; the burden of cases is among school-aged children and teens. However, those most at risk for severe disease are infants, and the rate in babies is also increasing. Vaccinations and good respiratory etiquette are the best tools we have for preventing pertussis and severe disease due to pertussis, especially among infants.

Recommend Tdap to all pregnant women with each pregnancy, preferably between 27 and 36 weeks gestation. Vaccination during each pregnancy reduces the risk of a mom with pertussis infecting the baby, and it can also provide passive protection for the baby in the first few months of life when they're most vulnerable and too young to be vaccinated. The timing of the dose is very important for optimal antibody transfer to the infant. Provide information on why the vaccine is beneficial and how it is safe for mother and infant. (Post-partum vaccination is acceptable for cocooning purposes if Tdap hadn't been given.)

If you do not stock Tdap in your office, make a "strong referral" to get a Tdap vaccination by taking the following steps: Provide specific information on where patients can get Tdap vaccine — examples may include a nearby pharmacy or your patient's primary care provider; Always write a patient-specific prescription in case it is required; Anticipate and be prepared to answer questions on why patients cannot get vaccinated in your office;
Emphasize the fact that just because you do not stock a specific vaccine in your office does not reduce the importance of vaccination or indicate that you have concerns about its safety; Have a plan in place to answer questions from other immunization providers who are concerned with vaccinating your pregnant patients.

Fully immunize all children against pertussis. Ensure that infants and children receive the primary DTaP series on-schedule; timely administration is essential for reducing severe disease in young infants and should not be delayed.

Give a single dose of Tdap to all adolescents and adults as recommended by national guidelines (see Table 1 for current recommendations). Recommend Tdap vaccination to household members and other close contacts of infants.

Consider the diagnosis of pertussis in the following situations, even if the patient has been immunized: Persistent or worsening cough with no fever or a low-grade fever in an infant <3 months, or in an older infant without other explanation; Persistent or paroxysmal cough with no fever or a low-grade fever in an infant <1 year and any of the following: apnea, cyanosis, post-tussive vomiting, seizure, pneumonia, non-purulent coryza, or inspiratory whoop; Cough illness >7 days that is paroxysmal, accompanied by gagging, post-tussive emesis, or inspiratory whoop in patients of any age; Cough illness of any duration and no alternative diagnosis in: 1) anyone with close contact with infants or pregnant women; 2) pregnant women in the third trimester; and, 3) patients who have had contact with someone known to have pertussis or with prolonged cough illness; Any cough illness >2 weeks duration with no alternative diagnosis in patients of any age.

To confirm pertussis, send a nasopharyngeal specimen for pertussis polymerase chain reaction (PCR) and/or culture. PCR is more sensitive and rapid than culture, but is more expensive and less specific. Testing is not necessary if the patient is a close contact of a lab-confirmed pertussis case.

Report pertussis cases within 24 hours to your local health jurisdiction.

Vaccination is the best tool we have for preventing pertussis. The most effective strategy to protect infants who are most at risk for severe pertussis disease is to vaccinate all pregnant women during each pregnancy, preferably between 27 and 36 weeks gestation. It is also important to vaccinate all children with the childhood DTaP series on-time and give a Tdap dose to adolescents and adults (see Table 1 below). Although most children have been vaccinated for pertussis, protection from the vaccine wanes over time, so some who are fully vaccinated may still become infected. In addition to vaccination, rapid identification of pertussis cases, appropriate treatment, isolation, and educating patients about good respiratory etiquette also help prevent ongoing transmission.

Vaccinated children and adults who get pertussis are likely to present with milder symptoms. Adults and school-aged children are now the major reservoir for pertussis in Washington.

Pertussis should be considered in anyone with a severe or persistent cough. Testing is appropriate until at least three weeks after the onset of paroxysmal coughing. After three weeks of coughing, infectiousness and test accuracy decrease significantly. Testing is most critical for symptomatic persons who are either high-risk or who may expose someone who is high-risk (see high-risk definition below).

If one member of a household tests positive, it is not necessary to test other family members who present with similar symptoms. If multiple members of a household present at the same time with symptoms, it is sufficient to test one, preferably the person with the most recent onset of symptoms.

If you have a high-risk patient whom you think should be tested but who is uninsured, contact your local health jurisdiction to talk about possible testing options.

Persons considered "high risk" from pertussis: Infants <1 year-old; Pregnant women (particularly those in their third trimester); Anyone who may expose infants <1 year-old or pregnant women (e.g., members of a household with infants or pregnant women, child care workers who take care of infants <1 year-old, health care workers with face-to-face contact with infants <1 year-old or pregnant women, childbirth educators)

If you strongly suspect pertussis:

1. Treat the patient whether or not you test. Do not wait for test results. Negative test results do not rule out pertussis.
2. Exclude the patient from work, school, or child care until the patient completes five full days of appropriate antibiotics. Consult with your local health jurisdiction if you have questions about exclusion.
3. Give preventive antibiotics to the entire household and to any high-risk close contacts (see high-risk definition above).

Report to your local health jurisdiction within 24 hours all patients with suspected or lab-confirmed pertussis.

For infant pertussis cases, include the mother's Tdap vaccination status, including date vaccine was given or reason not vaccinated, in the infant's medical record and in your report to your local health jurisdiction. This information is imperative to monitor the impact of the maternal Tdap vaccine recommendation.

Bear Droppings.....

by Loren H. Rex, D.O.

Well, here we go again. Easter season made me think of the small country churches in N.W. Missouri and my memories of them. My favorite Biblical writer is no doubt Saint Luke and in some ways these structures could be considered as theatres for Luke's writings. Basically, these churches functioned as a place, for unhappy children, to present a Christmas pageant, and serious eaters to attend an Easter Sunrise service, and the rest of the congregation to hold weddings and funerals. These churches were on the same basic model as the one room school we have all heard about and where my mother carried out her teaching career. A group of neighbors went together and built a school and another group, usually larger, built a church in the area. They were very much alike, upstairs was a Chapel with a pulpit and down stairs a kitchen with the rest of the room filled with tables for Sunday school or, depending on the mores of the group, playing cards.

My ex's father, a man named Homer, while not exactly God fearing, was at least sort of religion tolerant. Although he was not as simple as first appearance, he saw life in pretty simple terms. He was born on a Centennial farm which means the farm had been in the family for over a century and still is. He was from good Quaker stock and in a couple of places that caused a certain amount of friction. There were basically four things that guided his opinions and how he fit into life. The primary things he disliked were first, going to church and all of the things associated with the activity and the second was Fried Chicken. Concerning the primary matter, he figured he'd spent all the time in church he was ever going to spend in this life time. Remembering how I was raised, I had no problem understanding his position or, for that matter, agreeing with it. However, on the second matter, based on his up-bringing, he figured he had eaten all the fried chicken he would ever need to eat. I was inclined to take that a bit personal since it knocked me out of a lot of Sunday dinners based on fried chicken prepared by a fine cook. I wasn't anywhere close to my tolerance for fried chicken and I still am not. Now the secondary things that figured in, were first, playing music. He had played music all his life and was a fine musician. The second was probably, truth be known, Fox hunting with hounds. Not that effete nonsense with funny pants and red coats, the kind with back roads, pick-up trucks and listening to baying hounds. As in many activities, there is a by-product that can be involved: coyotes.

If I may digress for just a moment, there is some valuable information that needs to be imparted. While hounds may not be the smartest in the kennel, they may be the most dedicated. Hounds are scent dogs and don't go by sight i.e. they don't look up to follow their quarry. Another important part of the equation is the dew point defined as: the temperature at which the water vapor in a sample of air at constant barometric pressure condenses into liquid water at the same rate at which it evaporates. At temperatures below the dew point, water will leave the air. The condensed water is called dew when it forms on a solid surface. In other words, you need dew on the ground for the hounds to have something to smell and follow. This, of course, excites the hounds and they bay loudly (bark) as they follow the scent. The closer they get, the louder they bay. The dew point is best late at night or early in the morning.

And a fine Sunday morning it was, Easter to be exact. As anyone from the Midwest knows, it can be hot on Easter so, to get some air into the church, the windows and back doors had been opened and the minister was hitting his stride. In the distance, came a sound that not everyone could make out at first. It seems that at every gathering there will always be two older gentlemen whose ears have suffered the ravages of time and therefore tend to speak a bit loud. One turned to the other and queried "can you hear some hounds"? "Sure can" said the other again, loud enough to alert the dead. "I think they sound like Homer Smith's hounds to me." "Yep and they sound like they are coming closer." By now, of course, there was general agreement by the members of the congregation who had joined in, which, of course, included most everyone. All these little churches had a cemetery next to the church designed to be a place of final rest. It was toward this exact location that the Coyote was headed. The hounds, never having looked up since they were sniffing their way, and the Coyote who was running through the tombstones, were wondering the exact same thing: WHERE THE HELL AM I! This, of course resulted in the Coyote yipping loudly, the hounds braying at full volume and a congregation with snickers rapidly becoming full snorts and laughs and folks heading for the doors and windows. Soon the Coyote came to an opening in the tombstones and took in a Northerly direction with the hounds soon to be on his scent while never having looked up. Of course, by now, bedlam was afoot in the sanctuary and most everyone was up and milling around.

This was not the minister's first service and he quickly concluded that he would never get the crowd back. Besides, the way he saw it, the Savior may not have risen, but he certainly was awake and as any reasonably aware preacher would do, he ordered the singing of "Amazing Grace" and announced breakfast was served in the basement.

New Disabled Parking Permit Laws

Fraud and abuse has compromised Washington's special parking program for persons with disabilities. The state legislature recognized this during the 2013 session and again in 2014 by amending existing law to reduce the abuse of the program, among other things.

HB 2463 takes effect July 1, 2015, and will have a significant impact on the program's application and renewal process. At that time a person applying for parking privileges for persons with disabilities must include a written prescription from a health care provider. This requirement is in addition to completing the standard application. Healthcare providers without prescriptive authority may write an authorization on office letterhead.

Healthcare providers are advised to protect themselves and their patients who rely on this program by not prescribing special parking to those who do not meet the required criteria.

Disabled parking privilege criteria

Cannot walk two hundred feet without stopping to rest;

Is severely limited in ability to walk due to arthritic, neurological, or orthopedic condition;

Has such a severe disability that the person cannot walk without the use of or assistance from a brace, cane, another person, prosthetic device, wheelchair, or other assistive device;

Uses portable oxygen;

Is restricted by lung disease to an extent that forced expiratory respiratory volume, when measured by spirometry, is less than one liter per second or the arterial oxygen tension is less than sixty mm/hg on room air at rest;

Impairment by cardiovascular disease or cardiac condition to the extent that the person's functional limitations are classified as class III or IV under standards accepted by the American heart association;

Has a disability resulting from an acute sensitivity to automobile emissions that limits or impairs the ability to walk. The personal physician, advanced registered nurse practitioner, or physician assistant of the applicant shall document that the disability is comparable in severity to the others listed in this subsection;

Has limited mobility and has no vision or whose vision with corrective lenses is so limited that the person requires alternative methods or skills to do efficiently those things that are ordinarily done with sight by persons with normal vision;

Has an eye condition of a progressive nature that may lead to blindness; or

Is restricted by a form of porphyria to the extent that the applicant would significantly benefit from a decrease in exposure to light.

The changes in the law are, in part, the result of recommendations by the Disabled Parking Work Group. It was formed under the direction of the 2013 Legislature (SB 5024) to examine the use of placards and special license plates for persons with disabilities, and develop a plan to end program abuse. The work group included the Department of Licensing, the Department of Health, disabled citizen advocacy groups and local governments. It also accepted public input.

Other changes that are intended to help decrease abuse of the program include:

A new application will be required upon renewal;

Temporary parking placards are extended to up to 12 months;

Illegally obtaining a placard, license plate, tab, or identification card has been upgraded from a traffic infraction to a misdemeanor criminal offense.

New language on the application form includes a more detailed warning. It reminds applicants and healthcare providers that they are guilty of a gross misdemeanor if they knowingly providing false information during the application process. Healthcare providers may also be subject to sanctions under the Uniform Disciplinary Act.

More information is available at dol.wa.gov.

Allowable Copy Charge Increased

The Department of Health is required to adjust these amounts every two years according to the change in the Consumer Price Index. A public hearing will be held May 29, 2015 at 9:00 A.M. at the Department of Health, 111 Israel Road SE, Room 158, Tumwater, Washington, 98501.

If you would like to submit written comments, you may post them to the Department of Health Rules Comment Site at https://fortress.wa.gov/doh/policyreview/. You may also mail them to Sherry Thomas, Department of Health, PO Box 47850, Olympia, WA, 98504-7850. Comments are due June 5, 2013.

The fee limit to copy the first thirty pages is increased from $1.09 to $1.12 and no more than eighty-four cents (up from .82) for all other pages. The clerical fee is increased from $24.00 to $25.00 for searching and handling records. If the provider personally edits confidential information from the record, as required by statute, a basic office visit fee may be charged.

Exhibits Needed

We appreciate the support of the following who have signed up to exhibit at the 102nd NW Osteopathic Convention on June 25-27 at Semiahmoo: AbbVie, Amgen, Astra Zeneca, ATSU-SOMA, Health Evidence Resource for Washington State (HEAL-WA), Medical Protective, Pacific NW University of Health Sciences, Teva NeuroPsych, US Air Force Health Professions and Western U COMP-NW.

More exhibits are needed to help make the meeting a success. If you know of any firms that would like the opportunity to talk to a hundred osteopathic physicians you can direct them to the exhibit prospectus on the WOMA home page at www.woma.org or have them call the WOMA office at 206-937-5358.

This year the exhibit hall will have a new dimension. In an effort to encourage more research by DOs, we have invited PNWU member students and residents training in Washington osteopathic postgraduate programs to present research and case study posters in the exhibit hall.

2015 Legislative Session Report

by David Knutson, Lobbyist

On Friday, April 24, the Washington Legislature adjourned Sine Die, two days short of the regularly scheduled 105 day limit. Without a budget agreement, the legislature has now entered into Special Session, which began Wednesday, April 29. Pursuant to the state constitution, a special session can last no longer than 30 days. The legislature will likely focus on budget issues, but unless a joint resolution is adopted to limit issues for consideration, everything is "on the table."

Governor Inslee must act on all bills transmitted within the last 5 days of session by May 19; bills not acted upon will become effective without the Governor's signature. Bills will become effective 90 days after the close of the session (July 24, 2015) unless otherwise specified.

Budget Update: The House and Senate remain far apart on the biennial operating budget, with the House assuming an additional $1.5 billion in revenue and the Senate assuming no new revenue in their budget proposal. In addition to other tax increases, the House budget assumes a .3% increase in the B&O tax. WOMA, along with WSMA and other organizations have been actively opposing this potential tax increase. Also, the Legislature has not agreed on a Capital construction budget or a Transportation budget. The Special Session is limited to 30 days, beginning April 29th, and neither House nor Senate has shown movement toward a compromise.

ESSB 5084: All Payers Claims Database: Amends the APCD statutes by amending the definition of claims data to include billed, allowed and paid amounts. Enacts additional definitions, including "direct patient identifier" and "indirect patient identifier." Requires the database to systematically collect all medical claims and pharmacy claims from private and public payers, with data from all settings of care that permit the systematic analysis of health care delivery. Details procuremen process by which a lead organization must is selected. Requires lead organization to contract with a data vendor; outlines vendor's responsibilities. Sets data security requirements for lead organization and data vendor. Allow the director the discretion to expand the APCD data reporting requirements to supplemental plans. Sets requirements for requests for claims data and confidentiality of data collected. APCD legislation passed with strong bi-partisan support during the last week of session punctuated with the Senates concurrence in House amendments by a vote of 41-6. The bill now heads to the Governor for consideration, where coalition members are optimistic that he will provide signature.

E2SHB 1485: Family Practice Residencies: In an effort to increase medical residencies, this legislation re-establishes the Family Practice Education Advisory Board as the Family Medicine Education Advisory Board.

The committee is tasked with creating additional residency slots in rural and underserved areas of the State. The committee will have two permanent co-chairs, the Dean of UW Medical School and the Dean of PNWU. A member of WOMA will be a permanent member of the committee. Physicians, osteopathic physicians, physician assistants, and osteopathic physician assistants are required to provide information about their practices at the time of license renewal. The Governor is expected to take action on the bill within the next two weeks.

SSB5175: Telemedicine: Health insurance carriers, including health plans offered to state employees and Medicaid managed care plan enrollees, must reimburse a provider for a health care service delivered through telemedicine or store and forward technology if: 1) the plan provides coverage of the health care service when provided in person; 2) the health care service is medically necessary; and 3) the health care service is a service recognized as an essential health benefit under the ACA. The bill has been signed by the Governor.

SB 5010: Loan repayment: This legislation would restore funding to the health professional loan repayment and scholarship fund. The bill died but funding for this program and the creation of additional residencies is included in both House and Senate versions of the budget and is under ongoing negotiation.

SB 5269: An immediate family member, guardian, or conservator of a person may now petition Superior court for review of a DMHP decision to not detain a person for evaluation and treatment under the ITA, or to not take action within 48 hours of a request for investigation. Although we were unable to include treating physician as a petitioner, the legislation does allow anyone to submit a declaration in support of or in opposition to the DMHP's decision.

The **Medical Marijuana Act** provides that a registry will be established by the Department of Health and the cost of setting it up will be paid for out of the Health Professions Account. The estimated cost of establishing the registry is $2 million. The legislation includes a statement that the Health Professions Account will be repaid once the registry is established. (WOMA will be watching this closely so as not to affect our request for a license fee reduction.)

Neither House nor Senate budgets include funding to increase reimbursement rates for seeing Medicaid clients to the Medicare rate.

(*Editor's Note: This is the first of a two-year session. All bills introduced this session that did not make the cut-off may be back in January. Your support of Osteopac helps us maintain a presence in Olympia, support candidates friendly to our issues and fund DO Day in Olympia. Please contribute when asked.)*

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