The Oregon Medical Board (OMB or “Board”) held a regular quarterly meeting on Thursday and Friday, April 5-6, 2018, at the OMB offices, 1500 SW 1st Ave. Ste. 620, Portland. Chair K. Dean Gubler, DO, called the meeting to order at 8:00 a.m. A quorum was present, consisting of the following members:

| K. Dean Gubler, DO, Chair, Beaverton | James K. Lace, MD, Salem |
| Robert M. Cahn, MD, Portland | Charlotte Lin, MD, Bend |
| Paul Chavin, MD, Vice Chair, Eugene | Jennifer L. Lyons, MD, Portland |
| Katherine Fisher, DO, Happy Valley | Melissa Peng, PA-C, Secretary, Portland |
| Saurabh Gupta, MD, Portland | Chere Pereira, Public member, Corvallis |
| Kathleen Harder, MD, Salem | Andrew Schink, DPM, Eugene |

**Staff, consultants, and legal counsel present:**

| Kathleen Haley, JD, Executive Director | Nicole Krishnaswami, JD, Operations & Policy Analyst |
| Joseph Thaler, MD, Medical Director | Theresa Lee, HPSP & Compliance Coordinator |
| Carol Brandt, Business Manager | Mark Levy, Senior Software, and Systems Administrator |
| Eric Brown, Chief Investigator | David Lilly, Investigator |
| Alexander Burt, MD, Psychiatric Consultant (Thursday only) | Laura Mazzucco, Executive Support Specialist |
| Frank Clore, Licensing Assistant & EMS Advisory Committee Coordinator | Dante Messina, Investigator |
| Matt Donahue, Investigator | Netia Miles, Licensing Manager |
| Warren Foote, JD, Senior Assistant Attorney General (Thursday only) | Michael Seidel, Investigator |
| Walt Frazier, Assistant Chief Investigator | Michele Sherwood, Investigations Coordinator |
| Elizabeth Heckathorne, Investigator | Shane Wright, Investigator |

**OMB Committee members and guests present:**

| Robbie Bahl, MD, Reliant Behavioral Health (Thursday only) | George Koval, MD (Friday only) |
| Trevor Beltz, Oregon Medical Association (Friday only) | Breanna McGehee, Department of Administrative Services (Friday only) |
| Mark Bonanno, JD, Oregon Medical Association (Friday only) | Rachel Ostroy, Oregon Health Authority (Friday only) |
| Saje Davis-Risen, MS, PA-C, Oregon Society of Physician Assistants (Friday only) | Brandy Pestka, PA-C, Pacific University (Friday only) |
| Glenn Forister, OHSU (Friday only) | George Pitcher, JD (Thursday only) |
| Donald Girard, MD, Board member Emeritus (Thursday only) | Meg Reinhold, Legislative Fiscal Office (Friday only) |
| Christopher Hamilton, Ph.D., Reliant Behavioral Health (Thursday only) | Mary Vonn, Pacific University (Friday only) |
| Melissa Isavoran, Oregon Health Authority (Friday only) |
8:00 a.m. – CALL TO ORDER
K. Dean Gubler, DO; Chair of the Board

ANNOUNCEMENT OF EXECUTIVE SESSION – K. Dean Gubler, DO, Board Chair, announced that pursuant to ORS 192.660(2)(f) and (l), the Oregon Medical Board would convene in Executive Session to consider records that are exempt by law from public disclosure, including information received in confidence by the Board, information of a personal nature the disclosure of which would constitute an invasion of privacy, and records which are otherwise confidential under Oregon law.

EXECUTIVE AND CLOSED SESSIONS – Executive Sessions were conducted pursuant to ORS 192.660(1)(2)(a)(f)(k). Deliberations and Probationer Interviews took place in closed sessions, pursuant to ORS 441.055(9).

PUBLIC SESSIONS AND BOARD ACTIONS – The Board reconvened in Public Session prior to taking any formal, final action (shown in these minutes as BOARD ACTION). Unless otherwise indicated, all matters involving licensee or applicant cases include votes. Vote tallies are shown as follows: Ayes – Nays – Abstentions – Recusals – Absentees.

REcusals and abstentions – Where noted, Board members have recused themselves from discussion of any particular case or abstained from the final vote. To recuse means the Board member has actually left the room and not discussed or voted on the disposition of the case. To abstain means the Board member may have taken part in the discussion of the case, but chose to not cast a vote on its disposition.
Approved by the Board on July 13, 2018

PUBLIC SESSION
Dr. Gubler welcomed Board members and staff to the meeting.

Board members introduced themselves. Rebecca Hernandez, Ph.D., was absent by prior notice.

Swearing in New Board member
Dr. Gubler swore in new Board member, Charlotte Lin, MD, and welcomed her to the Board.

Introduction of Staff and Guests
Board members and staff introduced themselves.

Office Security
Eric Brown, Chief Investigator, discussed office security with the Board.

The Board moved into Executive Session to discuss specific licensees.

<table>
<thead>
<tr>
<th>Licensee</th>
<th>Case #</th>
<th>Complaint #</th>
<th>Investigator</th>
<th>Board Reviewer</th>
</tr>
</thead>
<tbody>
<tr>
<td>ABREU, Enrique A., DO</td>
<td>16-0006</td>
<td>#4</td>
<td>DL</td>
<td>KDG</td>
</tr>
</tbody>
</table>

Dr. Gubler reviewed the case.

BOARD ACTION:  Dr. Gubler moved that in the matter of Enrique A. Abreu, DO, the Board approve the Stipulated Order signed by Licensee on March 1, 2018. Dr. Cahn seconded the motion. The motion passed 12-0-0-1. Rebecca Hernandez, Ph.D., was absent by prior notice.

Warren Foote, JD, Senior AAG
Mr. Foote briefed that Board on the deliberation process.

CLOSED SESSION
Dr. Gubler recused himself and left the room.

RUSHTON, Michael J., DPM | 15-0239 | #3 | EB | PC |

George Pitcher, JD, presented on behalf of Dr. Rushton. The Board deliberated on the Administrative Law Judge’s Proposed Final Order and considered Dr. Rushton’s exceptions to the Order.

BOARD ACTION:  Dr. Cahn moved that in the matter of Michael J. Rushton, DPM, the Board adopt the Administrative Law Judge’s Proposed Final Order with a minor modification. Dr. Harder seconded the motion. The motion passed 10-0-1-1-1. Dr. Lin abstained and Rebecca Hernandez, Ph.D., was absent by prior notice.
EXECUTIVE SESSION

ASHORI, Mohammad, MD 17-0446 #1 MD CP
Ms. Pereira reviewed the case.

BOARD ACTION: Ms. Pereira moved that in the matter of Mohammad Ashori, MD, the Board issue a Complaint & Notice of Proposed Disciplinary Action based on a possible violation of the Medical Practice Act, ORS 677.190(1)(a), as defined in ORS 677.188(4)(a); and ORS 677.190(17). Dr. Gupta seconded the motion. The motion passed 12-0-0-0-1. Rebecca Hernandez, Ph.D., was absent by prior notice.

CHA, Michael J., MD 16-0203 #2 SW PC
Dr. Chavin reviewed the case.

BOARD ACTION: Dr. Chavin moved that in the matter of Michael J. Cha, MD, the Board approve the Stipulated Order signed by Licensee on February 27, 2018. Dr. Gubler seconded the motion. The motion passed 12-0-0-0-1. Rebecca Hernandez, Ph.D., was absent by prior notice.

FOUTZ, Steven R., MD 16-0621 #14 SW KDG
Dr. Gubler reviewed the case.

BOARD ACTION: Dr. Chavin moved that in the matter of Steven R. Foutz, MD, the Board approve the Stipulated Order signed by Licensee on January 2, 2018. Dr. Gubler seconded the motion. The motion passed 12-0-0-0-1. Rebecca Hernandez, Ph.D., was absent by prior notice.

BOARD ACTION: Dr. Chavin moved that in the matter of Steven R. Foutz, MD, the Board terminate Licensee’s April 20, 2017, Interim Stipulated Order. Dr. Gubler seconded the motion. The motion passed 12-0-0-0-1. Rebecca Hernandez, Ph.D., was absent by prior notice.

FRYE, Lindsay, DO 17-0269 #1 SW KMH
Dr. Harder reviewed the case.

BOARD ACTION: Dr. Harder moved that in the matter of Lindsay Frye, DO, the Board approve the Corrective Action Agreement signed by Licensee on March 19, 2018. Ms. Peng seconded the motion. The motion passed 12-0-0-0-1. Rebecca Hernandez, Ph.D., was absent by prior notice.

PUBLIC SESSION

Public Comment KDG
No public comment was presented.

EXECUTIVE SESSION

HARALABATOS, Susan S., MD 15-0039 #1 WF KDG
Dr. Gubler reviewed the case.

BOARD ACTION: Dr. Chavin moved that in the matter of Susan S. Haralabatos, MD, the Board approve the Stipulated Order signed by Licensee on February 2, 2018. Dr. Harder seconded the motion. The motion passed 12-0-0-0-1. Rebecca Hernandez, Ph.D., was absent by prior notice.
HOLUB, Ondria L., LAc | Supervision | SW | CP
Ms. Pereira reviewed the case.

BOARD ACTION: Ms. Pereira moved that in the matter of Ondria L. Holub, LAc, the Board terminate Licensee’s 2015 Stipulated Order. Dr. Chavin seconded the motion. The motion passed 12-0-0-0-1. Rebecca Hernandez, Ph.D., was absent by prior notice.

HUTSON, Daniel B., PA | Supervision | SW | PC
Dr. Chavin reviewed the case.

BOARD ACTION: Dr. Chavin moved that in the matter of Daniel B. Hutson, PA, the Board terminate Licensee’s 2013 Stipulated Order. Dr. Fisher seconded the motion. The motion passed 12-0-0-0-1. Rebecca Hernandez, Ph.D., was absent by prior notice.

JACOBSON, Lawrence E., MD | 16-0254 | #1 | MS | PC
Dr. Chavin reviewed the case.

BOARD ACTION: Dr. Chavin moved that in the matter of Lawrence E. Jacobson, MD, the Board issue a Complaint & Notice of Proposed Disciplinary Action based on a possible violation of the Medical Practice Act, ORS 677.190(1)(a), as defined in ORS 677.188(4)(a). Ms. Peng seconded the motion. The motion passed 12-0-0-0-1. Rebecca Hernandez, Ph.D., was absent by prior notice.

JEWETT, Stiles T., Jr., MD | Supervision | SW | JLL
Dr. Lyons reviewed the case.

BOARD ACTION: Dr. Lyons moved that in the matter of Stiles T. Jewett, Jr., MD, the Board terminate Licensee’s 2017 Consent Agreement for Re-entry to Practice. Dr. Fisher seconded the motion. The motion passed 12-0-0-0-1. Rebecca Hernandez, Ph.D., was absent by prior notice.

PUBLIC SESSION

Delegation of Authority for Consent Agreement for Re-entry to Practice | KDG

BOARD ACTION: Dr. Gupta moved that the Board delegate authority to the Board’s Executive Director and Medical Director to terminate Consent Agreements for Re-entry to Practice when the licensee has failed to complete the terms or secure a placement. Dr. Chavin seconded the motion. The motion passed with a voice vote. Rebecca Hernandez, Ph.D., was absent by prior notice.
EXECUTIVE SESSION

<table>
<thead>
<tr>
<th>JOYNER, Lisa C., MD</th>
<th>17-0108</th>
<th>#2</th>
<th>MD</th>
<th>PC</th>
</tr>
</thead>
</table>

Dr. Chavin reviewed the case.

**BOARD ACTION:** Dr. Chavin moved that in the matter of Lisa C. Joyner, MD, the Board issue a Complaint & Notice of Proposed Disciplinary Action based on a possible violation of the Medical Practice Act, ORS 677.190(1)(a), as defined in ORS 677.188(4)(a); ORS 677.190(13); and ORS 677.190(24). Dr. Harder seconded the motion. The motion passed 12-0-0-0-1. Rebecca Hernandez, Ph.D., was absent by prior notice.

<table>
<thead>
<tr>
<th>LEWIS, Wesley A., MD</th>
<th>15-0777</th>
<th>#7</th>
<th>MS</th>
<th>KDG</th>
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</thead>
</table>

Dr. Gubler reviewed the case.

**BOARD ACTION:** Dr. Chavin moved that in the matter of Wesley A. Lewis, MD, the Board rescind the Amended Complaint & Notice of Proposed Disciplinary Action dated October 30, 2017. Dr. Gubler seconded the motion. The motion passed 12-0-0-0-1. Rebecca Hernandez, Ph.D., was absent by prior notice.

<table>
<thead>
<tr>
<th>LIU, Helen, MD</th>
<th>17-0300</th>
<th>#2</th>
<th>MD</th>
<th>KDG</th>
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</thead>
</table>

Dr. Gubler reviewed the case.

**BOARD ACTION:** Dr. Chavin moved that in the matter of Helen Liu, MD, the Board issue a Complaint & Notice of Proposed Disciplinary Action based on a possible violation of the Medical Practice Act, ORS 677.190(1)(a), as defined in ORS 677.188(4)(a). Dr. Gubler seconded the motion. The motion passed 11-1-0-0-1. Dr. Gupta voted nay and Rebecca Hernandez, Ph.D., was absent by prior notice.

<table>
<thead>
<tr>
<th>MEAD, Richard J., MD</th>
<th>17-0475</th>
<th>#14</th>
<th>SW</th>
<th>KMH</th>
</tr>
</thead>
</table>

Dr. Harder reviewed the case.

**BOARD ACTION:** Dr. Harder moved that in the matter of Richard J. Mead, MD, the Board approve the Stipulated Order signed by Licensee on February 15, 2018. Dr. Chavin seconded the motion. The motion passed 12-0-0-0-1. Rebecca Hernandez, Ph.D., was absent by prior notice.

<table>
<thead>
<tr>
<th>MELLE, Francesca T., PA</th>
<th>17-0137</th>
<th>#1</th>
<th>MS</th>
<th>CP</th>
</tr>
</thead>
</table>

Ms. Pereira reviewed the case.

**BOARD ACTION:** Ms. Pereira moved that in the matter of Francesca T. Melle, PA, the Board approve the Stipulated Order signed by Licensee on November 27, 2017. Ms. Peng seconded the motion. The motion passed 12-0-0-0-1. Rebecca Hernandez, Ph.D., was absent by prior notice.

<table>
<thead>
<tr>
<th>Name Redacted</th>
<th>17-0602</th>
<th>#2</th>
<th>DM</th>
<th>KDG</th>
</tr>
</thead>
</table>

Dr. Gubler reviewed the case.

**BOARD ACTION:** Dr. Chavin moved that in the matter of case 17-0602, the Board close the case with no further action. Dr. Cahn seconded the motion. The motion passed 12-0-0-0-1. Rebecca Hernandez, Ph.D., was absent by prior notice.
Christopher Hamilton, Ph.D., HPSP Monitoring Programs Director and Robbie Bahl, MD, HPSP Monitoring Programs Medical Director, introduced themselves and presented to the Board (see Attachment I).

Dr. Hamilton, Ph.D. stated that four health profession regulatory boards currently participate in HPSP: Board of Dentistry (OSBD), Oregon Medical Board (OMB), Board of Nursing (OSBN), and Board of Pharmacy (OSBP). There is a total of 868 participants from the last eight years, of which 259 were from the OMB. 83% (215/259) of Medical Board licensees have completed or are on target to complete HPSP.

Dr. Hamilton, Ph.D. also provided an overview of HPSP’s Satisfaction Survey and Exit Interview results. Surveys are conducted every six months to the following groups of stakeholders: Licensees, Employers (Workplace Monitors), Treatment Providers, and Health Associations. The surveys sent out at the beginning of January 2018 had a Licensee response rate of 22.2%. Additional highlights from the survey are that 100% of treatment providers rate their experience working with HPSP as “excellent” or “above average” and 90% of licensees and workplace monitors rate their experience with HPSP positively (“excellent,” “above average” or “average.”). Results from the exit interviews indicated that licensees are most focused on individual meetings with monitoring consultant, group monitoring meetings, and participating in random toxicology testing, though only five participants took part in the exit interview process. Licensees also noted their concern about communication regarding toxicology reports and HPSP will discuss this at the next HPSP Advisory Committee. Additionally, enrollment has been removed from the exit interview and will be a separate survey presented to participants two to three months after their enrollment.

Dr. Bahl provided a toxicology update, noting that urine tests are the most common test provided to HPSP participants, but alternative testing provides greater deterrent and detection, such as PEth - blood test, which provides up to 21-day detection window for moderate to heavy alcohol consumption and hair and nail testing, which provides several months for multiple controlled substances. The mental health only licensees program requires weekly check-in with agreement monitor, monthly workplace reports, medication review, and communication with treatment providers, and only requires a toxicology plan if the OMB or a third party mandates it.

Dr. Hamilton, Ph.D. and Dr. Bahl thanked the Board and took questions.

Dr. Lace asked what was the extraction method for the blood test and was informed that HPSP uses venipuncture as standard practice and only uses a finger prick if directed to do so by the Board. Dr. Lace then asked if they are confident in the test results, to which Dr. Hamilton, Ph.D. and Dr. Bahl both answered yes. Dr. Lace also asked how far back can the test trace consumption and was told the test can detect moderate to severe consumption from approximately three weeks prior to testing.

Dr. Lyons asked about possibilities for false positives through use of mouthwash, hand sanitizer, and consumption of kombucha. Dr. Hamilton, Ph.D. and Dr. Bahl both spoke to her question noting that a urine test could possibly give a false positive, in very rare situations, but the licensee would be retested with a PEth test, which would be much more accurate and not give a false positive for the items in question. They also noted that licensees in the program are advised about the use of these items when on a toxicology plan.
Mr. Foote asked how alcohol can be detected so long after consumption at the rate in which it metabolizes. Dr. Bahl noted that they test for metabolite, the end product of metabolism, which lasts much longer in the system than the alcohol itself.

Dr. Chavin asked what the costs of the program are and was told that it is depends on what parts of the program the licensee is required to participate in. Intake can cost, on average, between $300 and $500 and up to $5,000 if inpatient evaluation is required. Self-referrals have an additional $1,500 fee, as they must be investigated. OMB investigates prior to referring licensees, so self-referrals would pay for the investigation themselves. The toxicology plan is approximately $2,500 for the first year, $1,700 for the second year, and $1,000 for the remaining years. The cost of the toxicology plan varies, depending on the panels used when testing. Group sessions are approximately $1,800 per year for the first two years and approximately $400 for the remaining years. Dr. Hamilton, Ph.D. and Dr. Bahl reiterated that the cost varies depending on the licensee’s specific situation; it can cost anywhere from a few thousand dollars to over ten thousand dollars. Dr. Chavin then asked if insurance covered any of it and was informed that most insurances do cover a portion of the program due to the behavioral health requirement.

Dr. Girard asked if participants are unwilling to use insurance due to possible traceability, to which Dr. Hamilton, Ph.D. noted that only two participants have mentioned an issue with using insurance in his four-year tenure with the program.

Dr. Lyons asked if self-referrals can drop out of the program. Dr. Hamilton, Ph.D. and Dr. Bahl informed her that if they drop out of the program, they will receive a noncompliance letter and the OMB would be notified. Dr. Lyons also inquired where healthcare providers who are not part of the four participating agencies go for help and was informed that while they are not a part of HPSP, Reliant Behavioral Health provides them with similar services.

Dr. Gubler asked Dr. Hamilton, Ph.D. and Dr. Bahl if they had any questions for the Board. They did not have any questions but did note that they would like help getting the word out about the program and are willing to give talks if anyone wanted to schedule one.

**EXECUTIVE SESSION**

| PARK, Sangkun, MD | 15-0645 | #9 | WF | KDG |

Dr. Gubler reviewed the case.

**BOARD ACTION:** Dr. Chavin moved that in the matter of Sangkun Park, MD, the Board approve the Stipulated Order signed by Licensee on March 14, 2018. Dr. Cahn seconded the motion. The motion passed 12-0-0-0-1. Rebecca Hernandez, Ph.D., was absent by prior notice.

| PATEL, Jitendra C., MD | 16-0400 | #7 | SW | PC |

Dr. Chavin reviewed the case.

**BOARD ACTION:** Dr. Chavin moved that in the matter of Jitendra Patel, MD, the Board issued a Complaint & Notice of Proposed Disciplinary Action based on a possible violation of the Medical Practice Act, ORS 677.190(1)(a), as defined in ORS 677.188(4)(a); and ORS 677.190(13). Dr. Gubler seconded the motion. The motion passed 12-0-0-0-1. Rebecca Hernandez, Ph.D., was absent by prior notice.
POPOWICH, Yale S., MD | 17-0129 | #2 | SW | PC

Dr. Chavin reviewed the case.

**BOARD ACTION**: Dr. Chavin moved that in the matter of Yale S. Popowich, MD, the Board issue a Complaint & Notice of Proposed Disciplinary Action based on a possible violation of the Medical Practice Act, ORS 677.190(1)(a), as defined in ORS 677.188(4)(a); ORS 677.190(13); ORS 677.190(17); and OAR 847-001-0024. Dr. Fisher seconded the motion. The motion passed 12-0-0-0-1. Rebecca Hernandez, Ph.D., was absent by prior notice.

POTTERJONES, Christine, MD | 17-0182 | #1 | MS | CP

Ms. Pereira reviewed the case.

**BOARD ACTION**: Ms. Pereira moved that in the matter of Christine Potterjones, MD, the Board grant Applicant an unlimited license. Dr. Fisher seconded the motion. The motion passed 11-1-0-0-1. Dr. Schink voted nay and Rebecca Hernandez, Ph.D., was absent by prior notice.

**Name Redacted** | 17-0456 | #7 | MD | PC

Dr. Chavin reviewed the case.

The Board provided direction to staff on possible sanctions.

REAVIS, David R., PA | Supervision | SW | SG

Dr. Gupta reviewed the case.

**BOARD ACTION**: Dr. Gupta moved that in the matter of David R. Reavis, PA, the Board terminate Licensee’s 2017 Consent Agreement for Re-entry to Practice because the Licensee has failed to complete the terms or secure a placement. Dr. Gubler seconded the motion. The motion passed 12-0-0-0-1. Rebecca Hernandez, Ph.D., was absent by prior notice.

RENDLEMAN, Neal J., MD | 17-0109 | #12 | SW | SG

Dr. Gupta reviewed the case.

**BOARD ACTION**: Dr. Gupta moved that in the matter of Neal J. Rendleman, MD, the Board approve the Stipulated Order signed by Licensee on March 14, 2018. Dr. Gubler seconded the motion. The motion passed 12-0-0-0-1. Rebecca Hernandez, Ph.D., was absent by prior notice.

SAMPSON, Robert A., DPM | 17-0060 | #3 | MS | PC

Dr. Chavin reviewed the case.

**BOARD ACTION**: Dr. Chavin moved that in the matter of Robert A. Sampson, DPM, the Board issue a Complaint & Notice of Proposed Disciplinary Action based on a possible violation of the Medical Practice Act, ORS 677.190(1)(a), as defined in ORS 677.188(4)(a); ORS 677.190(7); ORS 677.190(17); and ORS 677.190(22). Dr. Cahn seconded the motion. The motion passed 12-0-0-0-1. Rebecca Hernandez, Ph.D., was absent by prior notice.
Approved by the Board on July 13, 2018

SASSER, Sam M., MD  17-0024  #7  MS  PC
Dr. Chavin reviewed the case.

BOARD ACTION:  Dr. Chavin moved that in the matter of Sam M. Sasser, MD, the Board approve the Stipulated Order signed by Licensee on April 3, 2018. Dr. Harder seconded the motion. The motion passed 12-0-0-0-1. Rebecca Hernandez, Ph.D., was absent by prior notice.

STARK, Allen L., MD  16-0594  #2  SW  JLL
Dr. Lyons reviewed the case.

BOARD ACTION:  Dr. Lyons moved that in the matter of Allen L. Stark, MD, the Board approve the Stipulated Order signed by Licensee on March 20, 2018. Dr. Cahn seconded the motion. The motion passed 12-0-0-0-1. Rebecca Hernandez, Ph.D., was absent by prior notice.

Name Redacted  16-0020  #1  MS  KDG
Dr. Gubler reviewed the case.

The Board took no official action.

GIRI, Satyendra N., MD  15-0704  #2  WF  KDG
Dr. Gubler reviewed the case.

BOARD ACTION:  Dr. Chavin moved that in the matter of Satyendra Giri, MD, the Board approve the Stipulated Order signed by Licensee on April 1, 2018. Dr. Gubler seconded the motion. The motion passed 12-0-0-0-1. Rebecca Hernandez, Ph.D., was absent by prior notice.

REAGAN, Charles P., MD  17-0456  #7  MD  PC
Dr. Chavin reviewed the case.

BOARD ACTION:  Dr. Chavin moved that in the matter of Charles P. Reagan, MD, the Board amend Licensee’s existing Complaint & Notice of Proposed Disciplinary Action. Dr. Cahn seconded the motion. The motion passed 12-0-0-0-1. Rebecca Hernandez, Ph.D., was absent by prior notice.

KING, Julie A., MD  15-0735  #3  DL  KDG
Dr. Gubler reviewed the case.

BOARD ACTION:  Dr. Chavin moved that in the matter of Julie A. King, MD, the Board approve the Stipulated Order signed by Licensee on March 30, 2018. Dr. Fisher seconded the motion. The motion passed 12-0-0-0-1. Rebecca Hernandez, Ph.D., was absent by prior notice.
Ms. Peng reviewed the case.

The Board took no action.

**STURM, Anna C., PA**

Ms. Peng reviewed the case.

**BOARD ACTION**: Dr. Fisher moved that in the matter of Anna C. Sturm, PA, the Board grant Applicant an unlimited license. Ms. Peng seconded the motion. The motion passed with a voice vote. Rebecca Hernandez, Ph.D., was absent by prior notice.

Dr. Gubler reviewed the case.

The Board took no formal action.

Warren Foote, JD, Senior AAG, addressed the Board on the process of probationer interviews.

**CLOSED SESSION**

**Probationer Interviews**

The Board members conducted interviews of the following Board licensees/probationers:

<table>
<thead>
<tr>
<th>Board member</th>
<th>Licensee</th>
<th>Room No.</th>
</tr>
</thead>
<tbody>
<tr>
<td>Dr. Cahn &amp; Dr. Chavin</td>
<td>Name Redacted</td>
<td>1</td>
</tr>
<tr>
<td>Observer: Dr. Lin</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Ms. Peng &amp; Dr. Lace</td>
<td>Name Redacted</td>
<td>2</td>
</tr>
<tr>
<td>Observer: Dr. Schink</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Dr. Harder &amp; Dr. Fisher</td>
<td>Name Redacted</td>
<td>3</td>
</tr>
</tbody>
</table>

**Probationer Interview Reports**

The Board members reported on probationer interviews.
EXECUTIVE SESSION

Investigative Committee Consent Agenda

The Board reviewed the Consent Agendas from February 1, 2018, and March 1, 2018.

BOARD ACTION: Dr. Chavin moved that the Board approve the Consent Agendas from February 1, 2018, and March 1, 2018. Ms. Pereira seconded the motion. The motion passed with a voice vote. Rebecca Hernandez, Ph.D., was absent by prior notice.

STALLINGS, Ryan K., MD 17-0554 #1 SW SG

Dr. Gupta reviewed the case.

BOARD ACTION: Dr. Gupta moved that in the matter of Ryan K. Stallings, MD, the Board approve the Stipulated Order signed by Licensee on March 30, 2018. Dr. Fisher seconded the motion. The motion passed 12-0-0-0-1. Rebecca Hernandez, Ph.D., was absent by prior notice.

Board Recessed until 8 a.m. Friday, April 6, 2018
6:00 p.m. – Working Board Dinner
8:04 a.m. – CALL TO ORDER
K. Dean Gubler, DO; Chair of the Board

ANNOUNCEMENT OF EXECUTIVE SESSION – K. Dean Gubler, DO, Board Chair, announced that pursuant to ORS 192.660(2)(f) and (l) the Oregon Medical Board would convene in Executive Session to consider records that are exempt by law from public disclosure, including information received in confidence by the Board, information of a personal nature the disclosure of which would constitute an invasion of privacy, and records which are otherwise confidential under Oregon law.

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PUBLIC SESSIONS AND BOARD ACTIONS – The Board reconvened in Public Session prior to taking any formal, final action (shown in these minutes as BOARD ACTION). Unless otherwise indicated, all matters involving licensee or applicant cases include votes. Vote tallies are shown as follows: Ayes – Nays – Abstentions – Recusals – Absentees.

RECUASLS AND ABSTENTIONS – Where noted, Board members have recused themselves from discussion of any particular case or abstained from the final vote. To recuse means the Board member has actually left the room and not discussed or voted on the disposition of the case. To abstain means the Board member may have taken part in the discussion of the case but chose to not cast a vote on its disposition.
PUBLIC SESSION

Dr. Gubler took roll call. Dr. Gupta and Rebecca Hernandez, Ph.D., were absent by prior notice.

Dr. Gupta joined the meeting at 8:06 a.m.

PUBLIC SESSION

Emergency Medical Services (EMS) Advisory Committee

Dr. Gubler welcomed Christoffer Poulsen, DO, EMS Advisory Committee Chair. Dr. Poulsen reviewed the minutes of the February 16, 2018, EMS Committee meeting.

Dr. Poulsen noted the EMS Committee discussed, at length, the amendment to allow EMRs to administer epinephrine by subcutaneous or intramuscular injection. The OHA EMS Manager participated in the discussion. The main idea is to provide rural communities and first responders with a tool to give lifesaving medicine, in the event anaphylaxis is recognized. The concern is whether or not the most basic level of trained providers will be able to confidently administer this medicine.

The EMS committee decided not to bring back the scope of practice allowing EMRs to administer epinephrine by subcutaneous or intramuscular injection upon successful completion of an Oregon Health Authority approved course due to concern, on all levels, about safety of the patient.

Epinephrine auto-injectors are a good solution to this problem but are cost prohibitive for rural communities. OHA is researching ways to possibly find funding that would assist rural agencies with purchasing epinephrine auto-injectors. Another idea to reduce costs was to research the possible expiration extension from 1 year, to 2 years. There is currently literature stating this could be possible.

Dr. Poulsen answered questions from the Board.

Dr. Gupta asked how many epinephrine auto-injectors are needed and what are the concerns over liability of extending the expiration date. Dr. Poulsen noted that because oversite is set differently for responders, they cannot quantify the problem at the time. They only know how many auto-injectors transporting ambulances have, but transporting ambulances will always have someone highly trained and able to administer epinephrine by subcutaneous or intramuscular injection. As for liability, it will have to be based on data and research. There are papers on the subject.

Dr. Harder asked what questions OHA will answer at the next EMS Committee meeting and when the next meeting is. The next meeting is scheduled for May 18, 2018, at 9:00 am. Dr. Poulsen noted that OHA will have more precise data on the number of EMS agencies/ambulances, estimated costs for training, supplementary expense for rural agencies, and data gathered from other states on this issue.

Dr. Chavin asked if everyone, even highly training EMS, would be allowed to use epinephrine auto-injectors and who would pay for them? Dr. Poulsen answered that it would be an agency decision as to who would be allowed to use the auto-injectors and the costs are incurred at the local/regional level. Dr. Poulsen does not know of any state funding for the epinephrine auto-injectors at this time.
Dr. Fisher asked about the possibility of prefilled syringes and Dr. Poulsen noted that the issue would be liability as to who drew it and how stable it would be once it left the vial. Dr. Fisher then asked about prefilled syringes direct from the manufacturer. Dr. Poulsen and Dr. Gubler noted that those do exist, but not in the correct dosage, so that would provide room for error.

Ms. Peng asked about the use of generic to bring the cost down for epinephrine auto-injectors or central medicine buying/bulk buying. Dr. Poulsen noted that he believes all agencies are/would be using generic, but it is still expensive. He also noted that agencies purchase from a supplier so their discount would depend on quantity ordered and small agencies are not ordering enough to qualify for bulk discounts.

Dr. Poulsen also noted that the topic of EMS removal of stitches/staples was brought up and he believes it will continue to be brought up. There was a request for clarity as to whether or not EMS can remove skin/wound closure devices. The committee did not provide clarity at this time, as the issue is more complex than it seems.

**BOARD ACTION:** Dr. Schink moved that the Board approve the EMS Advisory Committee meeting minutes of February 16, 2018, as written. Dr. Cahn seconded the motion. The motion passed by voice vote. Rebecca Hernandez, Ph.D., was absent by prior notice.

**OAR 847-035-0030: Scope of Practice - FINAL REVIEW**

The rule amendment requires EMS providers to honor POLST orders executed according to the relevant statute, which now includes naturopathic physicians among the healthcare professionals who may sign POLST orders.

**BOARD ACTION:** Dr. Chavin moved that the Board amend OAR 847-035-0030: Scope of Practice, as proposed. Dr. Fisher seconded the motion. The motion passed 9-3-0-0-1. Dr. Cahn, Ms. Peng, and Dr. Schink voted Nay. Rebecca Hernandez, Ph.D., was absent by prior notice.

**Use of Tranexamic Acid (TXA)**

Dr. Gubler discussed the use of TXA in EMS. TXA used in prehospital community creates a potential risk, especially when used off-label, and there is a lot of data on these risks. Data for efficacy is mixed, but risks are recognized. TXA use was discussed at the February 2018 Western Trauma Association meeting, where a poll taken after the discussion noted that zero of the attendees would recommend the use of TXA in a prehospital environment.

Dr. Poulsen agreed that the continued review of medicine is very important and noted that EMS research and data is scant as the environment and lack of funding make it difficult to perform research. He believes agencies currently using TXA are doing so based on previous data and data in the Matters and Crash-2 trials. Dr. Gubler noted the discussion at the National Trauma Association was from the Matters research. Dr. Poulsen believes there could also be a misperception on the manner in which agencies are using the medication, as all of the agencies he has spoken with are using it in conjunction with trauma services in their area. Dr. Poulsen then asked that anyone with data points or literature on the subject, please email the information to him.

Dr. Gubler would like the TXA discussion to be on the next EMS Committee meeting agenda.
Public Comment

Saje Davis-Risen, President, Oregon Society of Physician Assistants - OAR 847-050-0060.
In favor in striking (2)(c) language, as OSPA does not believe it is required for PA preceptorship and believes it will create a hardship to the program.

Mary Vonn, Director, School of Physician Assistant Studies, Pacific University - OAR 847-050-0060.
In favor in striking (2)(c) language. She welcomes Board members to tour their facility.

J. Glenn Forister, Ph.D., PA-C, Director, Physician Assistant Program, OHSU - OAR 847-050-0060.
In favor in striking (2)(c) language. Thanked the Board and AAC for comprehensive review of this issue.

Mark Bonnano, JD, OMA General Council - OAR 847-050-0060.
In favor in striking (2)(c) language. Noted the OMA values the work of the Board.

OAR 847-050-0060: Physician Assistant Student (Preceptorships) – FIRST REVIEW

The Board reviewed the AAC’s recommendation to remove OAR 847-050-0060(2)(c) from the rule. Four of the five members of the AAC supported removing this language from the rule.

Dr. Fisher stated how difficult it is to find physicians to act as a preceptor. She is in support of striking (2)(c).

Dr. Gupta asked for further clarification on the need to strike (2)(c). Dr. Fisher noted that whether they are medical or PA students, they are not allowed to have real responsibility, whereas a real PA could kill someone. Dr. Gupta wonders if a trainee should be in a less restrictive or more restrictive environment? Ms. Peng noted that a training environment is more restrictive, as trainees are connected to the preceptor, but a PA is basically independent of the physician they are working with.

Dr. Gubler noted that (2)(c) makes the training of PAs much more restrictive than what we have for medical students. It allows preceptorship without having to get approval from the OMB; it allows that relationship to be established with the school.

Dr. Fisher noted the PA student can be in learning settings without the preceptor knowing what limitations are on the PA because the PA will not be allowed to do anything but observe.

Dr. Gupta believes this has more to do with how invested a preceptor is in training a trainee. If a physician cannot take the time to become Board approved, how invested are they really? Dr. Gubler noted that the liability is on the training institution to ensure its preceptors are appropriate for PAs, rather than on OMB. Eliminating (2)(c) just removes an additional obstacle that training institutions are already putting on the preceptors.

Dr. Schink does not believe that (2)(c) should cause that much of an issue. It tells a person what their responsibilities are.
Dr. Chavin believes this is redundant, as we trust the schools and the product that they put out. He trusts them to vet the process and believes the OMB does not need to do it over again. He supports the removal of (2)(c).

Dr. Cahn noted that we do not have these requirements for medical students, so why would we place these restrictions on PAs? He supports the removal of (2)(c).

Dr. Gupta asked if it has implications on schools from out of state? Dr. Fisher answered that it is up to the school to vet the preceptor but Dr. Gupta noted concern about schools outside of Oregon that might be poor schools.

Dr. Gubler noted this is the first reading, so the Board will reflect more on the issue.

Dr. Harder would like to see what guidelines the schools are currently using to vet potential preceptors.

**PA Workgroup Recommendation: Matrix to Evaluate Requests for Waiver of Monthly 8-Hours On-Site Supervision Requirement**

Dr. Koval, Board member Emeritus, addressed the Board. Dr. Koval noted, while previously working with the PA workgroup, requests for waiver of a rule that governs onsite supervision of PAs at place of practice had increased. The rule states 8 hours of onsite supervision by a physician is required each month. A panel was created to work on a system for review of waiver requests. The panel worked, with significant public input, to create a matrix for waiver requests.

Dr. Koval read over the proposed PA Workgroup Matrix *(see Attachment II)*. Essentially, a supervising physician would provide a request to the Board, with a letter attached, attesting to the competence and moral character of the PA. OMB staff would review the PA and supervising physician in the context of the checklist and if all the points were met, they would grant the waiver. Those that don’t meet these criteria would need to be reviewed by the AAC.

Dr. Lace inquired if this waiver was effective indefinitely. Ms. Peng said a new waiver would have to be submitted if the PA changes jobs, but if they stay at the same job, this would be indefinite. Ms. Peng noted that PAs would still have supervision, just not the 8-hour monthly requirement.

Dr. Fisher asked if there was discussion about continued medical practice, part-time/full-time, and is it specialty specific? Dr. Koval answered that it is not specialty specific and part-time was not addressed, but continued practice is required.

Dr. Lace asked if this will remove the barrier from hiring PAs as opposed to NPs? Dr. Koval noted that it could potentially expedite the process, as a new graduate would have to request a waiver which would take time, but a PA with experience could get a waiver much quicker through this process. Ms. Peng also noted that it would break down barriers in rural area clinics.

Dr. Lyons voiced her concern with PAs changing specialties and not having the supervising physician available. When it comes to changing specialties and rural areas, Dr. Lyons believes onsite supervision is important for public safety. She is also concerned about immediate care without the supervision. Dr. Koval shares Dr. Lyons concerns about changing specialties, but in most clinical contexts where a PA is being supervised, it will likely
be in a clinic environment, such as urgent care, so he does not believe that changing specialties is going to be as big an issue as it seems.

Dr. Lace and Dr. Lyons briefly discussed the issues caused by a lack of physicians. Dr. Gubler noted that he believes this waiver will make it easier for competent PAs to offer improved healthcare access.

Dr. Lin noted that the waiver requires a PA to have been in practice with this supervising physician for at least six months, so it seems as if a physician will likely be around after the waiver is signed. Dr. Koval noted that no one would be approved without this six-month supervision process.

Dr. Gubler noted that this is not changing the ability of the PA to request a waiver, but only changing the administrative way to review and grant/deny these requests in a consistent manner. It is streamlining the system, not changing it.

Dr. Gupta asked if there would be any minimum standards around the monthly contact. Dr. Koval noted that the PA Workgroup did not outline any specifics requirements. Dr. Gupta believes there should be requirements. He also asked if the expectation of the last bullet point is that the physical location would stay the same. Dr. Koval said that it is possible that the physical location could change. Dr. Lace noted that the doctor is still ultimately responsible for the PA. Dr. Gupta is concerned about the quality of care if a PA is allowed to basically go out on their own.

Dr. Gubler noted, again, that he believes this is a way to increase access to healthcare.

Dr. Koval noted that in all of the PA Workgroup’s extensive research into other states’ statutes, they found that most states currently do not require on-site supervision.

Dr. Harder agrees that the monthly meeting should have a minimum requirement, such as chart review. Dr. Koval noted that the agreement to supervise a PA has language about chart review. Dr. Harder also has concerns with the language “good moral character”.

Dr. Lyons would like the last two bullet points time to be increased. Ms. Peng says that data to support extending the time does not exist.

Dr. Thaler encouraged Board members who have concerns regarding the proposed matrix to attend the PA Workgroup meeting and assist in the process.

Dr. Gubler asked those with strong opposition to the matrix to submit questions/concerns in writing, and attend the meeting when this is next discussed. He reminded everyone that the purpose of this matrix is not to change the system, but to unburden the AAC and the Board from waiver review.

This discussion is referred back to the AAC for additional consideration.

Ms. Haley introduced the Board’s Budget Analysts, Breanna McGehee, DAS Budget and Management, and Meg Reinhold, with the Legislative Fiscal Office. Board members and staff introduced themselves.
Board’s Best Practices Survey Results

Carol Brandt, Business Manager, presented the results of the Annual Performance Progress Report. She noted the results will also be presented to the Legislature.

Dr. Gubler stated the results reflect how efficiently the Board runs its day to day business.

2019/2021 Board Budget

Carol Brandt, Business Manager, presented on the 2019/2021 policy packages being considered.

OMB is looking at a temporary fee reduction and/or possibly providing additional funding to the Oregon Wellness Program for healthcare providers. Additionally, repeat OMB request to add additional public member to the Board, possibly adding Public Affairs position to help with rule writing, additional security enhancements, and technology upgrades to help us work more efficiently. We would love to hear ideas or opinions from the Board.

Dr. Gubler said the cost-effectiveness is appreciated by licensees and thanked Ms. Brandt.

2019 Legislative Session

Dr. Lace presented on the 2019 Legislative Session. He noted that there are two items: go from annual to a biennial registration for the program limiting liability for donated medical services and third public member with an updated description of “Public member”.

This was followed by a brief discussion about a 2018 bill. Comments were made about mandatory reporting for all sexually active teenagers. Ms. Peng supports Dr. Lace’s concern. Nicole Krishnaswami noted that there is an OHA policy, issued by the reproductive health program, created to assist facilities providing reproductive health services in establishing their own policies as to when discretion is appropriate and mandatory reporting is necessary. It is not to cover all providers but it is to allow providers to adopt their own policies. DOJ has agreed with this stance, as does OMB. It should not warrant licensee discipline but there is a gray area and we expect this to come back next session for clarity.

Statement of Philosophy: Treating and Prescribing for Self or Family

The Board reviewed the AAC’s recommendation to adopt a Statement of Philosophy regarding treating and prescribing for self or family and friends.

Dr. Gubler noted that Ms. Krishnaswami has worked very hard on this Statement of Philosophy and he believes it is reasonable guidance for the treating and prescribing for self or family.

Dr. Lyons discussed physicians in her practice doing surgeries on their family members and prescribing glasses. It really is hard to determine what is fine and what is not. Dr. Thaler noted that it is not just an ophthalmologist issue, many physicians treat their family and friends. This is a general statement urging physicians to think about things before they do them.

Dr. Lin noted that it was very interesting that the statement touched on the fact that a family member or friend might actually want treatment from someone else but be reluctant to admit that. Dr. Gubler noted that
a Statement of Philosophy, like this one, can be very enlightening and can take burdens off people when there are expected behaviors. He believes that licensees and residents of Oregon need it.

Dr. Chavin noted that the Board has been acting like they already have this Statement of Philosophy.

Dr. Cahn asked if this would be added to the newsletter and was answered yes.

Dr. Lyons asked if there would be a mandatory reporting component, to which Dr. Gubler responded no; it is only a philosophy.

Dr. Gupta asked if a physician says take Tylenol for possible bruised ribs, is thinking they have bruised ribs or suggesting Tylenol treatment/prescribing? Dr. Chavin noted that there are exceptions noted, such as over the counter medicines.

Dr. Gupta asked if they need a philosophy independent from what national bodies have, such a AMA. Ms. Haley noted that there are statutes and rules, and each board comes up with their own way of handling guidance documents. A Statement of Philosophy is a guidance document. When it comes to disciplinary issues, the Board relies on the AMA code of ethics. This Statement of Philosophy provides guidance without being rigid or punitive. Dr. Gupta had concern that we are sending mixed messages. Ms. Haley recommended pulling a few cases for the Board to review to understand the disciplinary history regarding treating and prescribing for self or family.

Dr. Lyons would like to poll licensees on treating and prescribing for self or family. Dr. Gupta stated that he would not participate in that survey and doubts that anyone else would.

Dr. Gubler asked the Board to focus on what has been written. The nature of a philosophy indicates that there cannot be a checklist. We have to rely on our licensees to be reasonable and understand what we are trying to convey.

Dr. Gubler asked the Board if sending this to the AAC for a formal draft would be acceptable. Dr. Gupta would not like the OMB to have a treating and prescribing for self or family Statement of Philosophy because it would send a mixed message.

This discussion is referred back to the AAC.

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<th>2017 License Renewal: Law Enforcement Data System (LEDS) Results</th>
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<tr>
<td>Dr. Lace discussed 2017 License Renewal: Law Enforcement Data System (LEDS) Results. Staff audited licensees and found they were missing very little information. The recommendation is to only use LEDS during the initial review and not during renewal.</td>
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Dr. Lin felt like 6 was a lot. What about random audits? Ms. Haley noted that 3 of them are very old and of the remaining 3, we were processing 2 of them. The issue is not necessarily cost but would require licensees to get fingerprinted.

Dr. Chavin noted that in California, they are required to be fingerprinted and have a criminal background, to which Ms. Haley noted that happens in Oregon at the time of initial licensing. Ms. Haley also said that every
licensee, under investigation, goes through LEDS automatically. The cost is $48 to OMB and $12.50 to have the fingerprints actually taken.

Dr. Lyons asked how much the LEDS pilot project cost for Oregon only. Ms. Brandt noted that it was less than $300 paid to the OSBN for use of the program, which does not include staff time. Dr. Gupta noted that a national search could have come up with more information.

**BOARD ACTION:** Dr. Lace moved that the Board approve conducting routine background checks during initial licensure only. Dr. Harder seconded the motion. The motion passed 12-0-0-0-1. Rebecca Hernandez, Ph.D., was absent by prior notice.

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<th>2017 Grand Renewal Information</th>
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<td>Dr. Schink presented information regarding the 2017 grand renewal. He noted that the expected licensee renewal was 20,210, but only 18,423 actually renewed. The average renewal took only four days, though expectations were that it would take 15 days. Dr. Schink noted the Board should be proud of the efficiency of the licensure department. Ms. Haley noted that Netia Miles, Licensing Manager, and her entire team deserve kudos.</td>
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Dr. Gupta noted he had an excellent experience.

Dr. Gubler noted that when he submitted his application, he did not know how long the process would take before he would hear back. Ms. Miles noted that this issue came up in the postmortem process and licensing is currently working on an automated response informing the licensee that the renewal application has been received and they can expect further information within the next five business days.

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<th>Administrative Affairs Committee (AAC) Meeting Minutes</th>
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<td>The Board reviewed the AAC meeting minutes from March 7, 2018. There were no questions from the Board.</td>
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**BOARD ACTION:** Ms. Peng moved that the Board approve the AAC meeting minutes from March 7, 2018, as written. Dr. Cahn seconded the motion. The motion passed 11-0-0-0-2. Dr. Fisher and Rebecca Hernandez, Ph.D., were absent by prior notice.

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<th>Appointment of Emeritus members</th>
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<td>Dr. Gubler explained the current Emeritus members nominee process and noted that it does not require a formal vote from the Board, but he believes the Board should endorse the nominees. Dr. Gubler gave a brief description of the nominees. Dr. Chavin noted his support for these nominees. Ms. Haley noted that staff sent letters to everyone who would qualify and these physicians responded, which validates their interest in participating.</td>
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Dr. Fisher clarified that an Emeritus member could stand in for a current Board member if the current member was to be absent from a meeting and all other requirements for Emeritus member participation was met.

Donald Girard, MD, Roger McKimmy, MD, and George Koval, MD, were endorsed by the Board as Emeritus members.
Ms. Isavoran gave a brief history of the program, noting that it was a call to action by practitioners due to the administrative burdens of credentialing. This program is something that has been long coming; the state has had a common credentialing form since 2000. The Oregon Health Leadership Council had an Executive Committee on Administration Simplification that tried to create a centralized system for credentialing. They had trouble creating buy-in amongst the organizations on the council due to having to ensure that all their practitioners were in the system so it was useful to them and vice versa; all the practitioners did not want another system. They wanted to make sure that all the organizations were going to go to that one system to collect the information. In 2013, senators worked on legislation with the Medical Board to create a centralized program and database for the purpose of credentialing, recognizing that the Medical Board collected and verified at least 80% of the information necessary for credentialing. It was a great synergy however, the Medical Board only has a select number of licensees, so it was opened up to all Oregon healthcare practitioners. Because of this, OHA was assigned as the neutral entity to carry the project forward.

Over nearly five years, OHA has been working on implementation, with the majority of the issues and struggles based around procurement. Shortly after this was signed into law, Cover Oregon went live and had severe IT failure and this affected Common Credentialing. The Department of Administrative Services (DAS) decided the OHA needed a systems integrator to oversee the project, so OHA had to go through the procurement of a systems integrator. The OHA also had the new requirement that came down in 2015 to have a separately procured quality assurance vendor to oversee any IT projects over a million dollars. OHA was stuck in the procurement process for a while. OHA worked with healthcare regulatory boards through an advisory group, but Melissa met with them infrequently due to the slow progress.

The OHA created a data use agreement (DUA) draft for the OMB to allow them to share data. They would leverage the information from all the healthcare regulation boards. Because this started out as a Medical Board bill, the idea was that they would leverage the information that all the healthcare boards had on all Oregon practitioners. They intended on doing this by setting up a DUA and extracting data from them on a regular basis. This would give them the authoritative information on licensing and sanctions and other information they could leverage that practitioners had already put into those systems.

OHA drafted their first DUA and put it through the Department of Justice (DOJ) to ensure they had a standard agreement for all 15 healthcare regulatory boards. They received feedback but had slow progress while waiting on their implementation guide and the technical schematic that tells exactly what fields to put where in a document in order to transmit data. OHA had to wait on their implementation guide draft to bring to the healthcare regulatory boards and that was nearly a year later.

OHA acknowledged that this has taken some time and the slow progress created a disconnect between OHA and the healthcare regulatory boards. What OHA is trying to do now is ensure that there is an appropriate communication path on a regular basis. While they have had healthcare regulatory representation on their public advisory board, they did not regularly report their progress, but now they are. The Common Credentialing Advisory Group meets every two months. They, at a minimum, provide a high-level update to healthcare regulatory boards as to where the project is.
Ms. Isavoran asked for questions from the Board. Dr. Gupta asked what the mandate is and Ms. Isavoran answered that it is a mandate to create a centralized system for the collection and verification of practitioner information. Dr. Gupta asked what is the mandate to collect the data? Ms. Isavoran answered that it is the practitioners who are responsible for providing their data. The mandate for healthcare regulatory boards is to provide a set of data that they already collect and maintain. They are not being asked to provide anything in addition or to verify in a different way; they are mandated to provide information to the intent of the legislation. Dr. Gupta asked if all the boards must share their data, to which Ms. Isavoran answered yes. Dr. Lace asked if it was a statute; it is ORS 441.228. Ms. Haley noted the statute says it is in consultation with the boards.

Dr. Schink noted that Council for Affordable Quality Healthcare (CAQH) already has this information, so why do we need this? Ms. Isavoran noted that they could have bid to have this application except that CAQH does not validate the information so they cannot use it. Companies like CAQH will get their information from our system. Dr. Schink asked if this goes through, does that mean he will never have to fill out the CAQH again and the answer was that he would not unless he moved to a different state.

Dr. Gupta asked what the funding mechanism is for this? Ms. Isavoran noted that there is no state or federal funding for this program. It is all to be funded by user fees from credentialing organizations and practitioners. There has been a lot of discussion with stakeholders during the fee structure creation for this program. A onetime $150 fee to practitioners; no more fees ever. A tiered fee schedule has been created for credentialing agencies based on practitioner panel size. Tier 1, less than 100 practitioners, is $90/year/practitioner where the largest tier is tier 12, over 15,000 practitioners is $195,000/year.

Dr. Lace asked who owns it? We are divulging all this information but there is going to be another company managing it – do they own the information? Who actually owns the information? We want to be protected. OHA actually owns the information. Ultimately, the practitioner attests to the information in the system. Dr. Lace then specifically asked how the information is protected? Ms. Isavoran answered that OHA has to adhere to all of the state’s security standards from DAS and CIO. There was a security presentation made to the advisory group that they can provide to the Board. Ms. Ostroy added that Medversant Technologies has been in this business for many years and takes security very seriously.

Dr. Gupta asked if there is any intention to share data outside of credentialing organizations? Ms. Isavoran answered no; absolutely not. What is the expectation around public disclosure laws since OHA is a state entity? Ms. Isavoran noted OHA does not intend to sell or provide this data to external sources, but OHA does intend to provide directory related data only. This information is already public information about providers. This information will go to our statewide provider directory, which is a closed system, not a publically accessible system. Other public healthcare organizations can utilize it to validate their directories. The statute has a public inquiry protection on this information, except for public requests for directory related information, that is defined to be practitioner name, specialty, and practice city.

Dr. Lace asked who is going to go back and verify that what doctors submitted is actually accurate. Ms. Isavoran answered that what comes from the OMB has already been verified, but some information will have to be verified by the vendor. A mixture of leveraging information from the healthcare regulatory boards and verifying what they must through the vendor. Dr. Lace then asked about protected investigation information. Ms. Isavoran noted that they are working with OMB staff on what data they can and cannot extract from
OMB. What verifications are being done for licensure and sanctions are being published in the OMB newsletter already.

Dr. Lin asked if information on sanctions and malpractice will be published in the directory. Ms. Isavoran answered that sanctions will be but malpractice is different. They will ask for the malpractice information but will not be looking at the national practitioner data bank. They cannot house or share that information. That will still be on the organizations to do. Dr. Lin asked who would have access to that list of sanctions? Sanctions are not being provided to the directory; only credentialing organizations will have access to it, just as they currently have access. Practitioners have access to their own information, but not other practitioners.

Dr. Gubler, for clarification, verified that the only information the public can access will be practitioner name, specialty, and practice city. Ms. Isavoran reiterated that this was correct. Dr. Gubler also asked about data elements that the Board would be asked to provide. Ms. Isavoran noted that the OMB has 80% of the elements needed for credentialing. Provider directory: two things
First - statute says public requests are limited to directory related information
Second - The statewide directory is a separate system intended to federate a number of different sources of provider data into one system, common credentialing being the authoritative provider data source. The Health Information Task Force requested a statewide provider directory be created. It would also house MMIS practitioner data and basically federates those records and creates one true provider record. That can be more than practitioner name, specialty, and practice city. It would be name, licensure, license number, affiliations; so all the things you would see in an external facing directory. There is no protected personal information and protected health information in the directory. No sanction information or home address; nothing like that. Dr. Gubler asked who is going to hold that data? Ms. Isavoran answered that OHA is going to use some of the information collected for common credentialing for the statewide directory. Again, the statewide directory is a state system, it is a closed system. It is not available to the public. It will be used by healthcare entities vetted to ensure they have a necessity to use directory information.

Dr. Gubler asked if they have the data elements in a tabular form that can be shared with the Board? Yes. That can be provided. OHA will get that to Board members.

Ms. Isavoran continued her presentation by discussing that OHA is still working with OMB staff on exactly what data elements are going to be required for the credentialing program and which ones of those would be transferred over to the provider directory. She also noted that OHA is working with the DOJ on the issue of data ownership, recognizing that the OMB owns the data they push through the system. The practitioners end up seeing that data as a pre-population on the application. They would go in and verify/update. OHA is still working on what elements those will be and how to technically get them from OMB to OHA. It has been a challenge.

Ms. Isavoran noted that there is a DUA and an interagency agreement and these agreements need to be consistent. The interagency agreement acts as the overarching agreement that allows reimbursement to the boards for their time and money for setting this up. OHA is looking for not to exceed amounts, which can be figured out once they know which data elements they are going to need and how they are going to be collected. This would include board time as well.

Ms. Ostroy reiterated that the sharing of the information from OMB to the common credentialing system purpose is two-fold:
Approved by the Board on July 13, 2018

First - when the provider logs in for the first time to the common credentialing system, if there is data available, the system is prepopulated, so the provider may only have to complete 50 fields instead of 100, making it more efficient to complete the application.

Second - to not duplicate primary source verifying information that has already been primary source verified by the Board.

Dr. Cahn asked how much this has cost so far, what the projected cost is for the future, and who is paying for it? Ms. Ostroy noted that the cost up to this point is around 10 million dollars. As previously stated, the program is fee funded, but it is not only fee funded. The state has provided funding in the form of staffing and some Medicaid funding has been allocated to the program. The practitioner fees will cover a portion of the implementation cost and the operating costs will be covered by the credentialing organizations.

Dr. Harder noted they said that the data will be owned by the OHA, so do the regulatory boards relinquish ownership of the data? Ms. Ostroy answered that once the provider attests to the data, it becomes a part of the common credentialing system, which OHA is operating, therefore owns. Dr. Harder is still concerned about public disclosure laws and potential for some of that information to be unsafe. Ms. Isavoran noted that was why OHA defined what could be available via public disclosure. The statute protects everything else. Dr. Harder asked what would stop the OHA from amending the definition of “directory related” information. Ms. Isavoran responded that OHA cannot just change the rules. They have to go through the state process of amending rules. The OMA and OMB are involved in drafting rules. There are checks and balances. Dr. Harder noted that she is still concerned that if the OHA owns the data, they can do whatever they want with it. Ms. Isavoran noted that the statute calls out the term “directory related” so the OHA is governed by that statute and not able to just change their mind one day due to this limitation. There are legal arguments and case law that speak to “directory related” and it will not include protected personal information. Dr. Fisher asked if the state could go back and amend the statute? Absolutely they can. We have to trust that the Medical Associations and other lobbyists are there working to protect private personal information.

Dr. Gupta asked if anyone could opt-out? Ms. Isavoran noted that there is a waiver from the electronic process, but you would still have to fill out a paper application, which would then be entered into the system, so there really is no way to opt-out. Dr. Gupta also asked if a practitioner could ask for their information to be removed if they leave the state. Ms. Isavoran noted that they can, but there are record retention rules, so they would be inactive before they could be removed.

Dr. Lace asked if he only wanted to practice for cash money, would he have to register? Ms. Isavoran answered that he would not. This system is only for practitioners who are required to be credentialed.

Dr. Lin is still concerned that OHA has the ability to change the definition of “directory related” information. Ms. Isavoran reiterated that the statute says information in the system is protected from public disclosure, except for directory related data, which OHA defined as practitioner name, specialty, and practice city. In order to change a rule in the state of Oregon, the rule must go through a rules committee process and a hearing process. At the end of the day, OHA does have the authority to change rules, but it is still related to directory related information only, so there is protection in the statute for protected personal information and protected health information.

Ms. Isavoran reiterated that the purpose of this program is to reduce administrative burdens, not sell data on the black market. It is not intended to make money or be marketed. It is simply to help practitioners.
Ms. Isavoran explained that the statewide provider directory is another state data source. Data sources are defined in the DUA with the boards. That directory will also serve to reduce administrative burden in the healthcare system and on practitioners who are constantly having to update their information for provider directory purposes and credentialing purposes.

Ms. Isavoran asked if the delineation between public records requests and the statewide directory is clear now? Dr. Lin answered that it is clear, but her concern is that what OHA has defined can be changed at any time. Ms. Isavoran reiterated that it can, but it has to go through a public process and there is still a limitation on what directory related information can mean, even if OHA blew it up.

Dr. Schink asked who does get the information and if it is for credentialing, insurance does not need to know about sanctions so why does OHA need to have that in their system if it can’t be shared? Ms. Isavoran noted that they do need to know what sanctions have passed through the OMB. They don’t need to know the details, but they do need what sanctions have been placed against a licensee. The only thing OHA needs is what the OMB already publishes in their quarterly newsletter.

Ms. Peng asked who verifies the accuracy once the information is dumped to the new system? Ms. Isavoran answered that the practitioners have the ability to review their entire record, including the verifications. Are the practitioners going to be notified that this information has been dumped and they need to review it before it is sent out? Ms. Isavoran answered that the practitioners will be notified that all the verifications have been done and, practitioners would have the ability to verify their information in the system. Also, there is a file audit process that the vendor goes through to ensure that all the pieces match. A checks and balances. How is the OHA notifying practitioners that their information is going into this system before it is disbursed? Ms. Ostroy clarified that the practitioners control which credentialing organizations have access to their information. As a practitioner, you would log in and select whichever organizations you want to share your information with. Access granted can later be retracted. As a part of the mandate, the practitioner has to go in every 120 days to verify the information in their profile. Does OHA have a test scenario to run through the process because, conceptually, it is difficult to understand. Ms. Ostroy noted they do not have such a system and will not, but they will provide ample training through training material and webinars that will be distributed in advance of this going live. OHA is also doing a pilot phase. In July, OHA will open the system to a select group of people who are willing to go through the process for four months to help ensure that the system is working appropriately and that the training is going to be effective.

Dr. Cahn asked about personal history questions. Ms. Isavoran noted that items like DUIs, felonies, convictions, go into the system but are not publically available. Those items are only reported to credentialing organizations and are not part of the statewide directory. Those items are protected personal information.

Dr. Harder asked if everyone would have to log in and verify their information every 120 days or only practitioners in the process of releasing information. Ms. Ostroy noted that it is all practitioners. Dr. Harder commented that this does not seem to be reducing the administrative burden. Ms. Isavoran noted there is an exception and that is if a practitioner is credentialed to only one organization. This would apply to people like emergency room physicians and other hospital practitioners. The reason for this is because you would no longer have to do your reattestation application. If you are credentialed with numerous organizations, you are constantly being pushed a signature page that you have to sign and initial. With this system, you only have to do it every 120 days. This system also has a designee capability.
Dr. Harder asked what the appeals process is if the practitioner finds an error. Ms. Isavoran noted that it should be as easy as a helpdesk call to update the information and send the updated information out to all the organizations that have the data on that practitioner. Ms. Isavoran continued that the idea of a centralized solution is that if a practitioner has one centralized system, they have the opportunity to increase the accuracy of the data, whereas if a practitioner has data in multiple locations, it can be incorrect in multiple places and the practitioner may not even know. Who would man the helpdesk? The vendor, Medversant Technologies, and Conduent Services would control the helpdesk services. Dr. Harder pointed out that there is now a third party involved with the data; it just seems like data breach waiting to happen. Dr. Harder appreciates the intent of the statute to decrease administrative burden, but the risk seems apparent.

Ms. Isavoran noted that they anticipate over 55,000 practitioners and 330,000 organizations to use this system. What is happening today is the same thing Board members are worried about. Licensee information is going into credentialing systems that is then being pushed out to provider enrollment, provider directory, contracting, and every organization that you touch. By having OHA as a centralized hub, it has very strict security standards and contracting standards that they have to adhere to. Ms. Ostroy clarified that from the helpdesk perspective, they are very limited to what they can access. They are a triage point; they are not getting into files. If there are inaccuracies in a practitioners file, practitioners have the ability to correct those and that is the point of the 120 days revisiting of the file.

Dr. Cahn noted that perhaps this is a solution to a problem that does not exist. Ms. Isavoran noted that the problem does exist; practitioners are all credentialed independently by numerous organizations and a lot of times there are designees that do all of the paperwork, you may have delegate agreements setup that you don’t even know about. You may be credentialed with more organizations than you even know. Senator Steiner Hayward is credentialed with OHSU, but because she gets reimbursed from multiple plans, OHSU is sending all of her information to all of the plans. Most practitioners are not involved in this level of detail, but they are pushed again, for every plan, to sign that piece of paper and out goes your information. Office staff and practice managers are all screaming for this. This is the result of a survey to practice managers and practitioners who noted that this process is burdensome. This is not a process or program that OHA decided to do. OHA was appointed as a neutral entity to do this. Considering that we have a common form that has been in place since 2000, the Oregon Health Leadership Council tried to create a centralized system, and numerous other states are trying to create centralized systems in various ways, it is a problem.

OHA recognizes that this is not a “one size fits all” perfect solution. It is going to be iterative, just like most things in health information technology. They are steps in right directions. To the extent that OHA can make this successful, not onerous, and not incur security issues, that is what we are trying to do.

Dr. Gupta reiterated concern about the integrity of the data being shared. Ms. Isavoran said that he and all other credentialed practitioners are already sharing their data with multiple organizations. There will always be a concern about data breach. That is a reality of dealing with technology. OHA takes this very seriously and has had numerous conversations internally and externally about data security. OHA asked if it would be helpful if the OMB got more information on OHA’s security provisions and were able to go through it with their trusted IT advisors.

Dr. Lace noted that it would be so much easier if it were all centralized. Right now all credentialed practitioners have their information spread out of twenty-something organizations and each one of those organizations could be doing whatever they want with the information.
Ms. Haley asked to hear about an opt-out provision regarding Kaiser. Ms. Isavoran noted that was a provision in the statute that says prepaid health plans with 200,000 members or more could apply for a waiver to be excluded from this program. They would have to apply with the OHA Director and make a really good case as to why they should be excluded. Since most of their practitioners moonlight and practice elsewhere, they would still be required to be a part of the system.

Ms. Haley noted that when she first asked Medversant, in 2009, what primary source meant to them, they said: “web crawling”. She asked what they have done since then to update their verification process. Ms. Isavoran answered that OHA has a credentialing policy that will come out soon and there are some web crawls attached to that in a few different areas, like DEA. They will be checking against the AMA profile, different boards, going to hospitals, etc. Ms. Haley asked if they will have staff verifying the missing pieces. Ms. Isavoran noted that Medversant will have staff trained to perform the verification process. They will have the electronic process and they will use staff to acquire all the information, which is a lot, that is not available electronically. They will make calls and audit.

Ms. Krishnaswami noted that fields may be populated by Board information, but all the documents will have to be uploaded by the practitioners; pieces they may not have had to interact with in quite some time. Ms. Isavoran noted that is correct. Dr. Lace asked what if you have lost these documents? Ms. Isavoran answered that it will have to be primary source verified and noted that the document is lost. From there, the organization would decide if they will accept that. If the Board has verified your education and you have lost your degree, they can leverage that information from the Board. If the Board has already verified the practitioner, everything should be fine. There will be specific cases that will have to be dealt with as they come up. With the project, this is a very small piece of the administrative pie, but very foundational because there is a lot of liability attached to this and OHA has to be careful. There are numerous standards and a lot of details. As OHA pulls out the credentialing policy and people begin to ask specific questions, they are going to tease those items out. There is always going to be some other nuance that comes up.

Dr. Lace asked who will decide if something is good enough to be credentialed? Ms. Isavoran answered that the credentialing agency will decide that. OHA is only the collector and verifier of the information. If OHA cannot get a primary verification source, they are relying on the licensing board to be the authoritative source on that. If the OMB licensed a practitioner, OHA is trusting that. Dr. Lace is concerned about Ms. Isavoran’s previous use of the word “should”. Ms. Isavoran noted that they have to follow accrediting entity principles, but at the end of the day, OHA is not making the decision. OHA is just providing the collected and verified data. Accrediting bodies say that if a licensing board verifies education, that is golden. The only problem that could come up is that there are exclusions when you are an expedited practitioner. Since that rule was put in place, it explicitly tells an accrediting body that OHA did not verify education. In these cases, the practitioner could not be grandfathered in. OHA would put the information into the system but would have to note it was expedited and we can’t guarantee that the education was vetted. In that situation, the organization would have to decide to accept or reject the practitioner.

Dr. Gubler asked what the projected costs and timeframe was when this was initiated? Ms. Isavoran’s noted that the very initial cost was fifty thousand dollars and it went up to five hundred thousand dollars. We recognize that the system is costly. Dr. Gubler noted that the burden of this costs has not been equally placed. Ms. Isavoran responded that a medical group practice does not credential. There is a one-time $150 fee to practitioners; no more fees ever. Credentialing agencies with less than 100 practitioners, is $90/year/practitioner. Dr. Gubler is still concerned because if you are a private practice clinic, you are the credentialing entity. Ms. Isavoran answered that is not correct. A private practice is not going to credential
A credentialing organization is one that actually credentials practitioners. They generally have credentialing committees. Dr. Gubler asked when a clinic employs a physician, within their own organization, they go through their own verification (vetting of the practitioner), if they ask for the information from the common credentialing, would they have to pay? Ms. Isavoran answered yes; if they want it from common credentialing. Dr. Gubler noted that the private practice clinic would have to do their own primary source if they did not pay for common credentialing. Ms. Isavoran noted that OHA has not said that group practices cannot be a part of common credentialing. If they do and want the data, that would spread the costs more broadly. Right now, the costs are shared between 330 organizations, but if group practices and nursing facilities want to participate, that is thousands more entities to share in the cost. Essentially, group practices are not mandated or regulated by an accrediting body to credential.

Ms. Isavoran noted that the initial scope was that it would be great to have one place for every practitioner to enter all their information. Everyone could get it; one sole source. It was a grand idea.

Dr. Gubler thanked OHA for coming and Ms. Isavoran told the Board to feel free to email any questions to them. The website is healthit.oregon.gov and click on common credentialing.

Board Retreat
The Board will have a retreat from October 5 – 6, 2018.

Board Meeting Minutes
The Board reviewed the Board meeting minutes from January 11-12, 2018.

BOARD ACTION: Dr. Cahn moved that the Board approve the Board meeting minutes from January 11-12, 2018, as written. Dr. Chavin seconded the motion. The motion passed with a voice vote. Dr. Lin abstained, Dr. Lace and Rebecca Hernandez, Ph.D., were absent by prior notice.

Interim Stipulated Order (ISO) Acknowledgment
The Board acknowledged the following Interim Stipulated Order:
• Francisco X. Soldevilla, MD – Effective March 5, 2018

The meeting adjourned at 12:22 p.m.