The Oregon Medical Board (OMB or “Board”) held a regular quarterly meeting on Thursday and Friday, October 6-7, 2016, at the OMB offices, 1500 SW 1st Ave. Ste. 620, Portland. Chair Shirin R. Sukumar, MD, called the meeting to order at 8:00 a.m. A quorum was present, consisting of the following members:

<table>
<thead>
<tr>
<th>Shirin R. Sukumar, MD, Chair, West Linn</th>
<th>James K. Lace, MD, Salem</th>
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<tbody>
<tr>
<td>Donald E. Girard, MD, Vice Chair, Portland</td>
<td>Lisa M. Lipe, DPM, Lake Oswego</td>
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<tr>
<td>Robert M. Cahn, MD, Portland</td>
<td>Jennifer L. Lyons, MD, Portland</td>
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<tr>
<td>Paul Chavin, MD, Eugene</td>
<td>Michael J. Mastrangelo, Jr., MD, Bend</td>
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<tr>
<td>Katherine L. Fisher, DO, Happy Valley</td>
<td>Charlene A. McGee*</td>
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<tr>
<td>K. Dean Gubler, DO, Portland</td>
<td>Melissa Peng, PA-C, Portland</td>
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<tr>
<td>Rebecca Hernandez, PhD*</td>
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*Public Member

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

<table>
<thead>
<tr>
<th>Kathleen Haley, JD, Executive Director</th>
<th>Mark Levy, Senior Software and Systems Administrator</th>
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<tr>
<td>Joseph Thaler, MD, Medical Director</td>
<td>David Lilly, Investigator</td>
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<tr>
<td>Carol Brandt, Business Manager</td>
<td>Laura Mazzucco, Executive Support Specialist</td>
</tr>
<tr>
<td>Eric Brown, Chief Investigator</td>
<td>Netia N. Miles, Licensing Manager</td>
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<tr>
<td>Alexander Burt, MD, Psychiatric Consultant (Thursday only)</td>
<td>Shayne Nylund, Acupuncture Licensing Specialist &amp; EMS Advisory Committee Coordinator</td>
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<tr>
<td>Warren Foote, JD, Senior Assistant Attorney General (Thursday only)</td>
<td>Jenette Ramsey, Administrative Affairs Committee Coordinator</td>
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<tr>
<td>Susan Hall, Licensing Assistant</td>
<td>Michael Seidel, Investigator</td>
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<tr>
<td>Kristina Kallen, Executive Assistant</td>
<td>Michele Sherwood, Investigations Coordinator</td>
</tr>
<tr>
<td>Nicole Krishnaswami, JD, Operations &amp; Policy Analyst</td>
<td>Stephanie Vorderlandwehr, Procurement Specialist</td>
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<tr>
<td>Theresa Lee, Investigative Assistant</td>
<td>Shane Wright, Investigator</td>
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**OMB Committee members and guests present:**

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<tr>
<th>Kara Kohfield, EMS Advisory Committee Chair</th>
<th>Christoffer Poulson, DO, EMS Advisory Committee Member</th>
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<tr>
<td>Katy McCue, Donation and Family Advocate Lead, Pacific Northwest Transplant Bank</td>
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*Updated November 17, 2016*
Thursday, October 6, 2016

8:00 a.m. – CALL TO ORDER
Shirin R. Sukumar, MD; Chair of the Board

ANNOUNCEMENT OF EXECUTIVE SESSION – Shirin Sukumar, MD, 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 January 6, 2017.

Updated November 17, 2016
Dr. Sukumar took roll call. Drs. Fisher and Gubler and Ms. Mc Gee were absent by prior notice.

Dr. Sukumar shared her thoughts about the International Medical Regulation Association (IAMRA) conference in Melbourne, Australia. Dr. Sukumar thanked Kristina Kallen and Theresa Lee for all of the travel arrangements.

Dr. Sukumar also acknowledged all the wonderful work that Terry Lewis, Investigations Compliance Officer, had done throughout his career with the Oregon Medical Board.

Ms. Mc Gee joined the meeting at 8:03 a.m.

Swearing in of New Board Members

Dr. Sukumar swore in the newest Board members, Robert Cahn, MD, and public members Dr. Rebecca Hernandez, PhD, and Ms. Charlene McGee.

EXECUTIVE SESSION

BERNARDO, Peter A., MD

Dr. Mastrangelo recused himself and left the room. Dr. Girard reviewed the case.

BOARD ACTION: Dr. Girard moved that in the matter of Peter A. Bernardo, MD, the Board terminate Licensee’s 2014 Stipulated Order and terminate Terms 4.3 through 4.6 in the 2014 order. Dr. Lipe seconded the motion. The motion passed 8-0-2-1-2. Dr. Hernandez, PhD, and Ms. McGee abstained. Drs. Fisher and Gubler were absent by prior notice.

BLITMAN, Maury N., MD

Dr. Girard reviewed the case.

BOARD ACTION: Dr. Girard moved that in the matter of Maury N. Blitman, MD, the Board issue a Complaint and 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. Lace seconded the motion. The motion passed 11-0-0-0-2. Drs. Fisher and Gubler were absent by prior notice.

BURMAN, Malika, MD

Dr. Lipe reviewed the case.

BOARD ACTION: Dr. Lipe moved that in the matter of Malika Burman, MD, the Board approve the Corrective Action Agreement signed by Licensee on August 1, 2016. Dr. Girard seconded the motion. The motion passed 9-0-2-0-2. Dr. Hernandez, PhD, and Ms. McGee abstained. Drs. Fisher and Gubler were absent by prior notice.

Updated November 17, 2016
Dr. Gubler joined the meeting at 8:35 a.m.

DENKER, John T., MD

Supervision TL DG

Dr. Girard reviewed the case.

BOARD ACTION: Dr. Girard moved that in the matter of John T. Denker, MD, the Board modify Licensee’s 2014 Stipulated Order. Dr. Mastrangelo seconded the motion. The motion passed 9-0-3-0-1. Dr. Cahn, Dr. Hernandez, PhD, and Ms. McGee abstained. Dr. Fisher was absent by prior notice.

DOSSEY, Brian L., MD

# WF SS

Dr. Sukumar reviewed the case.

BOARD ACTION: Dr. Girard moved that in the matter of Brian L. Dossey, MD, the Board approve the Stipulated Order signed by Licensee on August 25, 2016. Dr. Mastrangelo seconded the motion. The motion passed 12-0-0-0-1. Dr. Fisher was absent by prior notice.

ELLINGSSEN, Megan B., MD

# TL KDG

Dr. Mastrangelo recused himself and left the room. Dr. Gubler reviewed the case.

BOARD ACTION: Dr. Gubler moved that in the matter of Megan B. Ellingsen, MD, the Board approve the Corrective Action Agreement signed by Licensee on September 14, 2016. Dr. Lipe seconded the motion. The motion passed 10-0-1-1-1. Ms. McGee abstained. Dr. Fisher was absent by prior notice.

FALK, Gregory A., DO

# TL KDG

Dr. Gubler reviewed the case.

BOARD ACTION: Dr. Gubler moved that in the matter of Gregory A. Falk, DO, the Board approve the Stipulated Order signed by Licensee on September 2, 2016. Dr. Lipe seconded the motion. The motion passed 12-0-0-0-1. Dr. Fisher was absent by prior notice.

GALLANT, James D., MD

# TL DG

Dr. Girard reviewed the case.

BOARD ACTION: Dr. Girard moved that in the matter of James D. Gallant, MD, the Board approve the Stipulated Order signed by Licensee on September 2, 2016. Ms. Peng seconded the motion. The motion passed 12-0-2-0-1. Dr. Hernandez, PhD, and Ms. McGee abstained. Dr. Fisher was absent by prior notice.
Approved by the Board on January 6, 2017.

**GOERING, Edward K., DO**  Supervision  TL  SS
Dr. Sukumar reviewed the case.

**BOARD ACTION:** Dr. Girard moved that in the matter of Edward K. Goering, DO, the Board modify Licensee’s 2013 Stipulated Order to remove terms 5.1 and 5.2. Dr. Chavin seconded the motion. The motion failed 6-4-2-0-1. Dr. Cahn, Dr. Gubler, Dr. Lipe and Ms. Peng voted nay. Dr. Hernandez, PhD, and Ms. McGee abstained. Dr. Fisher was absent by prior notice.

**GREGORY, Winn H., MD**  Supervision  TL  KDG
Dr. Gubler reviewed the case.

**BOARD ACTION:** Dr. Gubler moved that in the matter of Winn H. Gregory, MD, the Board terminate Licensee’s 2014 Corrective Action Agreement. Dr. Girard seconded the motion. The motion passed 12-0-0-0-1. Dr. Fisher was absent by prior notice.

**HAMILTON, Anthony M., PA**  #  MS  LL
Dr. Gubler recused himself and left the room. Dr. Lipe reviewed the case.

**BOARD ACTION:** Dr. Lipe moved that in the matter of Anthony M. Hamilton, PA, the Board approve the Stipulated Order signed by Licensee on July 27, 2016. Dr. Girard seconded the motion. The motion passed 11-0-0-1-1. Dr. Fisher was absent by prior notice.

**HARALABATOS, Susan S., MD**  #  WF  LL
Dr. Lipe reviewed the case.

**BOARD ACTION:** Dr. Lipe moved that in the matter of Susan S. Haralabatos, MD, the Board issue a Complaint and 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. Girard seconded the motion. The motion passed 10-0-2-0-1. Dr. Hernandez, PhD, and Ms. McGee abstained. Dr. Fisher was absent by prior notice.

**HUCKE, Heyden M., MD**  #  WF  DG
Dr. Girard reviewed the case.

**BOARD ACTION:** Dr. Girard moved that in the matter of Heyden M. Hucke, MD, the Board approve the Applicant’s request to withdraw her license application with report to the FSMB. Dr. Lipe seconded the motion. The motion passed 12-0-0-0-1. Dr. Fisher was absent by prior notice.

*Dr. Fisher joined the meeting at 9:45 a.m.*

*Updated November 17, 2016*
HUDSON, Peter C., MD  
Dr. Lipe reviewed the case.

BOARD ACTION: Dr. Lipe moved that in the matter of Peter C. Hudson, MD, the Board approve the Stipulated Order signed by Licensee on September 19, 2016. Dr. Gubler seconded the motion. The motion passed 13-0-0-0-0.

BOARD ACTION: Dr. Lipe moved that in the matter of Peter C. Hudson, MD, the Board terminate Licensee’s 2007 Stipulated Order. Dr. Girard seconded the motion. The motion passed 13-0-0-0-0.

PUBLIC SESSION
Public Comment  
No public comment was presented.

EXECUTIVE SESSION
GOLDSMITH, Victoria, MD  
Dr. Fisher reviewed the case.

BOARD ACTION: Dr. Fisher moved that in the matter of Victoria Goldsmith, MD, the Board approve Applicant’s request to withdraw her license application with report to the FSMB. Dr. Girard seconded the motion. The motion passed 12-0-0-0-1. Dr. Mastrangelo was absent.

Kenny, Rose J., MD  
Dr. Sukumar reviewed the case.

BOARD ACTION: Dr. Girard moved that in the matter of Rose J. Kenny, MD, the Board approve the Stipulated Order signed by Licensee on August 19, 2016. Ms. Peng seconded the motion. The motion passed 12-0-0-0-1. Dr. Mastrangelo was absent.

Kuo, Wie-Peng, MD  
Dr. Gubler reviewed the case.

BOARD ACTION: Dr. Gubler moved that in the matter of Wie-Peng Kuo, MD, the Board approve the Corrective Action Agreement signed by Licensee on September 13, 2016. Dr. Lipe seconded the motion. The motion passed 13-0-0-0-0.
LE, Christian T., MD
Dr. Girard reviewed the case.

**BOARD ACTION:** Dr. Girard moved that in the matter of Christian T. Le, MD, the Board amend Licensee’s April 7, 2016, Complaint and Notice of Proposed Disciplinary Action. Dr. Lipe seconded the motion. The motion passed 13-0-0-0-0.

LEWIS, Sue A., MD
Dr. Girard recused himself and left the room. Dr. Sukumar reviewed the case.

**BOARD ACTION:** Dr. Mastrangelo moved that in the matter of Sue A. Lewis, MD, the Board approve the Stipulated Order signed by Licensee on September 15, 2016. Dr. Lipe seconded the motion. The motion passed 12-0-0-1-0.

Name Redacted
Dr. Lipe reviewed the case.

**BOARD ACTION:** Dr. Lipe moved that in the matter of Name Redacted, the Board close the investigation. Dr. Gubler seconded the motion. The motion passed 13-0-0-0-0.

MAYS, Maureen E., MD
Dr. Sukumar reviewed the case.

**BOARD ACTION:** Dr. Girard moved that in the matter of Maureen E. Mays, MD, the Board terminate Licensee’s 2014 Stipulated Order. Dr. Sukumar seconded the motion. The motion passed 13-0-0-0-0.

MCMANAMA, Gerald P., III, MD
Dr. Gubler reviewed the case.

**BOARD ACTION:** Dr. Gubler moved that in the matter of Gerald P. McManama, III, MD, the Board issue a Complaint and 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. Girard seconded the motion. The motion passed 13-0-0-0-0.

MCNABB, Earl D., DPM
Dr. Girard reviewed the case.

**BOARD ACTION:** Dr. Girard moved that in the matter of Earl D. McNabb, DPM, the Board issue a Complaint and 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(8), and ORS 677.190(17). Dr. Gubler seconded the motion. The motion passed 13-0-0-0-0.

*Updated November 17, 2016*
Approved by the Board on January 6, 2017.

**MEIER, Douglas L., MD**

Dr. Sukumar reviewed the case.

**BOARD ACTION:** Dr. Girard moved that in the matter of Douglas L. Meier, MD, the Board issue a Complaint and 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(17). Dr. Chavin seconded the motion. The motion passed 12-0-1-0-0. Dr. Hernandez, PhD, abstained.

**MERIN, Jan M., MD**

Dr. Sukumar reviewed the case.

**BOARD ACTION:** Dr. Girard moved that in the matter of Jan M. Merin, MD, the Board approve the Corrective Action Agreement signed by Licensee on September 13, 2016. Dr. Lipe seconded the motion. The motion passed 12-0-1-0-0. Ms. McGee abstained.

**MISRA, Sounak, MD**

Dr. Sukumar reviewed the case.

**BOARD ACTION:** Dr. Girard moved that in the matter of Sounak Misra, MD, the Board approve the Stipulated Order signed by Licensee on September 20, 2016. Dr. Sukumar seconded the motion. The motion passed 13-0-0-0-0.

**MONJI, Zena I., MD**

Dr. Chavin recused himself and left the room. Dr. Lipe reviewed the case.

**BOARD ACTION:** Dr. Lipe moved that in the matter of Zena I. Monji, MD, the Board approve the Corrective Action Agreement signed by Licensee on August 3, 2016. Dr. Girard seconded the motion. The motion passed 12-0-0-1-0.

**PIVCEVICH, Carey A., LAc**

Dr. Lipe reviewed the case.

**BOARD ACTION:** Dr. Lipe moved that in the matter of Carey A. Pivcevich, LAc, the Board approve the Stipulated Order signed by Licensee on July 17, 2016. Dr. Gubler seconded the motion. The motion passed 13-0-0-0-0.

**RUSSELL, Jill R., DO**

Dr. Sukumar reviewed the case.

**BOARD ACTION:** Dr. Girard moved that in the matter of Jill R. Russell, DO, the Board approve the Corrective Action Agreement signed by Licensee on August 22, 2016. Dr. Sukumar seconded the motion. The motion passed 13-0-0-0-0.

Updated November 17, 2016
Approved by the Board on January 6, 2017.

<table>
<thead>
<tr>
<th>SOLDEVILLA, Francisco X., MD</th>
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<td>Dr. Gubler recused himself and left the room. Dr. Girard reviewed the case.</td>
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**BOARD ACTION:** Dr. Girard moved that in the matter of Francisco X. Soldevilla, MD, the Board approve the Corrective Action Agreement signed by Licensee on September 20, 2016. Dr. Lipe seconded the motion. The motion passed 12-0-0-1-0.

<table>
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<tr>
<th>STRAUSS, Mitchell J., MD</th>
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<tr>
<td>Dr. Gubler reviewed the case.</td>
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**BOARD ACTION:** Dr. Gubler moved that in the matter of Mitchell J. Strauss, MD, the Board approve the Voluntary Limitation signed by Licensee on August 23, 2016. Dr. Girard seconded the motion. The motion passed 13-0-0-0-0.

<table>
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<tr>
<th>TANGREDDI, Raymond P., MD</th>
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<tr>
<td>Ms. Peng recused herself and left the room. Dr. Mastrangelo reviewed the case.</td>
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**BOARD ACTION:** Dr. Mastrangelo moved that in the matter of Raymond P. Tangredi, MD, the Board approve the Stipulated Order signed by Licensee on August 19, 2016. Dr. Girard seconded the motion. The motion passed 12-0-0-1-0.

**PUBLIC SESSION**

**Organ Donation in Oregon: Hospital Systems and Physician Partners – Pacific Northwest Transplant Bank**

Katy McCue, Donation and Family Advocate Lead from the Pacific Northwest Transplant Bank, presented to the Board (*See Attachment I*).

Dr. Girard introduced Ms. McCue. Ms. McCue gave a PowerPoint presentation on organ transplants.

The Pacific Northwest Transplant Bank (PNTB) has the opportunity to work in all hospitals where they are guests but also care providers. The PNTB hopes to be regarded as team members and partners by the hospitals within the state of Oregon.

There are over 123,000 people nationally waiting for a transplant of some kind, of which 81 percent are waiting for a kidney. In Oregon there are just under 1,000 people who need a transplant. The average wait time in Oregon for a kidney is about two years. In Los Angeles, the average wait time for a kidney is approximately eight years. Most people waiting for a transplant are between the ages of 18 and 64. Very few people waiting are pediatric, and very few people are over the age of 64. Every 12 minutes another name is added to the list, and on average, about 18 to 22 people die every day while waiting for an organ.

Each patient who has said yes via the Oregon Department of Motor Vehicles (DMV) donor program can save the lives of up to eight people and impact up to 50 others, perhaps more depending on the donor’s health prior to his/her death, through eye and tissue donation. For the

*Updated November 17, 2016*
purposes of this presentation, Ms. McCue focused solely on organ donation. Over the last 10 to 11 years, not much has changed in terms of organ donation. There are about the same number of patients donating and are good candidates while the number of recipients is increasing. There is a very large gap that is continuing to increase.

In the PNTB service area, there are roughly 80 hospitals. The vast majority of these hospitals could potentially support an organ donor, but the injured patients are usually sent to other larger hospitals in the area due to the nature of their injuries. PNTB serves the entire state of Oregon and is one of six organ procurement organizations that falls under a hospital umbrella, which means they are affiliated with a hospital. The PNTB works with all hospitals in the state of Oregon, SW Washington, and Western Idaho. About 20 of the hospitals have regular potential for organ donation.

The PNTB focuses all its efforts and education on hospitals where there is the most potential. However, about 40 percent of donors come from the very small hospitals. There are two Level I Trauma Centers in Portland that have the most donation potential and are the most familiar with the donation process. Even these two large Trauma Centers average only about two donors per month in a busy year. Education is a big focus for the PNTB team. They are working now to reach out to hospital staff in order to fill the gap. This year has been a record-breaking year, following last year’s busiest ever in the agency with 120 organ donors. This year, however, the PNTB is on track to exceed the number of cases from last year, with 375 organs recovered for transplant.

There is a very common misconception about organ donation in this country. Most people think that the “D” on their driver’s license means they are an organ donor; however, less than 1 percent of patients who die in the hospital are candidates for organ donation. The rules of donation are the patient must die in a hospital and be on a ventilator in order to be an organ donor.

Ms. Haley asked why there was a bump up in donors in 2015. Ms. McCue said she was not sure. The PNTB has expanded its acceptance criteria so patients who previously would not have been candidates for organ donation are now candidates.

Dr. Hernandez, PhD, asked if the organs procured in Oregon stay here. Ms. McCue said yes, for the most part. There are many criteria to match organs to the best match possible, but for the most part they stay locally. There is very little time from when organs are recovered to when they need to be transplanted. Hearts and lungs have four to six hours from the time they are recovered to the time they need to be transplanted and breathing or beating in the recipient.

The PNTB is regulated by the United Network for Organ Sharing (UNOS). That is the federal agency that is designated to oversee the organ donation process. All hospitals in this country are required to participate with their local organ procurement organization (OPO). Hospitals are required to report all deaths or imminent deaths, all hospitals must advise families of their right to donate through a designated requestor, and hospitals are required to partner with an OPO to maintain a potential donor patient while all the necessary testing takes place in order to place potential organs. Hospitals are required to have a clinical trigger, and dying on a ventilator is the most widely adopted nationwide trigger.
The PNTB would **never ever** ask that something be done for a patient that would be good for donation but not good if the patient was going to survive. The PNTB supports standard critical care practices. This also means declaring brain death or cardiac death depending on the circumstances. Partnership between the PNTB system and hospitals, physicians, and nurses is critical in order to execute this seamlessly. Physicians should be caring for a donor patient just as they would care for any other patient they have and ideally not mention donation.

Once death has been declared, the PNTB staff takes over the medical management of the patient. The PNTB does not manage patients prior to their death.

After death has been declared, the focus shifts from saving a patient’s life to optimizing organ perfusion to save the lives of as many as eight other people. From the time that death is declared to the time organs are being recovered is minimally about 24 to 48 hours. The physician, as well as the bedside nurse, is involved throughout the entire process. Their assistance and willingness to partner with PNTB is necessary.

Common challenges in our state that could possibly be alleviated through statewide standardization are hospital policies, supporting patients and their families before death is declared, making the referral, declaring brain death, and finally, supporting patients and their families after death is declared.

Senior Assistant Attorney General Foote asked how immediately the donor recipient must be at the hospital to receive the donated organs. Ms. McCue said the recipient is usually notified 12+ hours before the PNTB goes to the operating room to recover the organs from the donor.

Dr. Hernandez, PhD, asked about the myth around the cost to the family of organ donation. Ms. McCue said all expenses are covered by the PNTB from the moment the patient is declared deceased and the family authorizes donation, or if the patient has a “D” on his/her driver’s license, the PNTB covers all expenses. Dr. Hernandez, PhD, further asked if all hospitals are separating the costs of organ donation from the original patient care bill. Ms. McCue said yes, the hospitals do separate the entire bill to ensure organ donation is completely covered. Generally speaking, the patient has been discharged once they have been declared dead at which time the PNTB will readmit the patient to proceed with the donation process.

Dr. Hernandez, PhD, inquired if the “D” on the driver’s license trumped the family’s wishes. Ms. McCue said technically and legally yes, but the PNTB believes strongly in supporting families so the approach PNTB will take changes a bit. Communication is provided to ensure the family understands the process and billing separation before moving forward with the donation. If the family adamantly opposes organ donation, the PNTB will not move forward with the donation.

Dr. Lipe asked if all the patient’s organs are donated to multiple recipients, and Ms. McCue said yes. Dr. Lipe further asked about whole-body specimens for anatomy classes. Ms. McCue said whole-body specimens have nothing to do with the PNTB, but anatomical donation for transplant takes priority over cadaveric donation.
Another question arose about whether PNTB gets involved with the recipient’s family, and Ms. McCue said they do not. While there is an after-care communication program between recipients and the donor family, PNTB does not often speak with any recipients.

The question of US citizenship and organ donation arose, and Ms. McCue said that a donor does not have to be a US citizen.

Dr. Fisher asked if the “D” on the driver’s license is an opt-in or an opt-out system. Ms. McCue said here in the US, the system is an opt-in only, although in some countries organ donation is an opt-out system where organs are automatically retrieved unless otherwise stated.

Dr. Mastrangelo asked about sending organs outside of the state as well as if the PNTB would sell skin or organs for money. Ms. McCue said no, the PNTB does not sell organs. In the US it is illegal to buy or sell organs. All donation organizations are nonprofits so nothing is ever being bought and sold. Regarding PNTB sending organs out of state and the receiving of “credits,” there is a “payback” program in that if the PNTB has recently sent a liver to Seattle, when Seattle receives a liver, a recipient within the state of Oregon will move to the top of the list.

Dr. Sukumar thanked Ms. McCue for her very well done and informative presentation.

**EXECUTIVE SESSION**

**TEXIDOR, Cesareo, Jr., PA**

Dr. Sukumar reviewed the case.

**BOARD ACTION:** Dr. Girard moved that in the matter of Cesareo Texidor, Jr., PA, the Board issue a Complaint and 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. Sukumar seconded the motion. The motion passed 13-0-0-0-0.

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<thead>
<tr>
<th>Name Redacted</th>
<th>14-0583</th>
<th>#3</th>
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<tr>
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<td>14-0718</td>
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Dr. Sukumar reviewed the case.

**BOARD ACTION:** Dr. Girard moved that in the matter of cases 14-0583 and 14-0718, the Board issue an Order for Evaluation. Dr. Lipe seconded the motion. The motion passed 13-0-0-0-0.

| Name Redacted | 15-0761 | #2 | MS | LL |

**BOARD ACTION:** Dr. Lipe moved to rescind the previous vote in the matter of Name Redacted. Dr. Girard seconded the motion. The motion passed 13-0-0-0-0.
Approved by the Board on January 6, 2017.

BOARD ACTION: Dr. Lipe moved that in the matter of case 15-0761, the Board accept the Licensee’s Administrative Retirement of License and close the investigative case. Dr. Girard seconded the motion. The motion passed 13-0-0-0-0.

THOMASHEFSKY, Allen J., MD

Dr. Sukumar reviewed the case.

BOARD ACTION: Dr. Girard moved that in the matter of Allen J. Thomashefsky, MD, the Board approve the Stipulated Order signed by Licensee on September 20, 2016. Dr. Sukumar seconded the motion. The motion passed 13-0-0-0-0.

TOMPKIN, Jane E., MD

Dr. Lyons recused herself and left the room. Dr. Lace reviewed the case.

BOARD ACTION: Dr. Lace moved that in the matter of Jane E. Tompkin, MD, the Board approve the Stipulated Order signed by Licensee on July 1, 2016. Dr. Girard seconded the motion. The motion passed 12-0-0-1-0.

WILLIAMS, Ryan E., DO

Dr. Sukumar reviewed the case.

BOARD ACTION: Dr. Girard moved that in the matter of Ryan E. Williams, DO, the Board terminate Licensee’s 2015 Corrective Action Agreement. Dr. Sukumar seconded the motion. The motion passed 13-0-0-0-0.

WONG, Charles M., MD

Dr. Sukumar reviewed the case.

BOARD ACTION: Dr. Girard moved that in the matter of Charles M. Wong, MD, the Board approve the Licensee’s request to terminate his 2014 Stipulated Order. Dr. Sukumar seconded the motion. The motion passed 12-0-1-0-0. Dr. Hernandez, PhD, abstained.

YAMANE, Robert Y., MD

Dr. Sukumar reviewed the case.

BOARD ACTION: Dr. Girard moved that in the matter of Robert Y. Yamane, MD, the Board approve the Correction Action Agreement signed by Licensee on September 12, 2016. Dr. Mastrangelo seconded the motion. The motion passed 13-0-0-0-0.

Investigative Committee Consent Agendas

The Board reviewed the following Consent Agendas: February 4, 2016, August 4, 2016, and September 1, 2016.

Updated November 17, 2016
Approved by the Board on January 6, 2017.

**BOARD ACTION:** Dr. Sukumar moved that the Board approve the February 4, 2016, August 4, 2016, and September 1, 2016, Investigative Committee Consent Agendas. Dr. Girard seconded the motion. The motion carried with a voice vote. Dr. Girard is recused on cases 15-0591 and 15-0489; Dr. Sukumar is recused on cases 15-0683, 15-0339, and 15-0534; Dr. Lipe is recused on cases 15-0762 and 16-0333.

**Investigative Committee Meeting Minutes**

The Board reviewed the Investigative Committee meeting minutes of August 4, 2016.

**BOARD ACTION:** Dr. Girard moved that the Board approve the August 4, 2016, Investigative Committee meeting minutes. Dr. Sukumar seconded the motion. The motion passed by a voice vote.

**COLORITO, Anthony L., MD**

Dr. Sukumar recused herself and left the room. Dr. Girard reviewed the case.

**BOARD ACTION:** Dr. Mastrangelo moved in the matter of Anthony L, Colorito, MD, the Board approve Applicant’s request to withdraw his license request with report to FSMB. Dr. Fisher seconded the motion. The motion passed 12-0-0-1-0.

**Name Redacted**

Dr. Sukumar reviewed the case.

The Board referred the case to the Investigative Committee.

**Name Redacted**

Dr. Chavin reviewed the case.

The Board referred the case to the Investigative Committee.

**Name Redacted**

Dr. Chavin reviewed the case.

The Board referred the case to the Investigative Committee.

**ROSEN, Mary H., PA**

Ms. Peng reviewed the case.

**BOARD ACTION:** Ms. Peng moved that in matter of Mary H. Rosen, PA, the Board grant Applicant an unlimited license. Dr. Girard seconded the motion. The motion passed 13-0-0-0-0.

*Updated November 17, 2016*
WAY, Nathan A., MD

Dr. Fisher reviewed the case.

**BOARD ACTION:** Dr. Fisher moved that in the matter of Nathan A. Way, MD, the Board grant Applicant an unlimited license. Dr. Girard seconded the motion. The motion passed 12-0-0-1-0. Dr. Cahn abstained.

**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>
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<tbody>
<tr>
<td>Dr. Mastrangelo</td>
<td>Name Redacted</td>
<td>1</td>
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<tr>
<td>Observer: Ms. McGee</td>
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<tr>
<td>Dr. Lipe</td>
<td>Name Redacted</td>
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<tr>
<td>Observers: Dr. Hernandez, PhD, and Dr. Lyons</td>
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<tr>
<td>Dr. Gubler</td>
<td>Name Redacted</td>
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<tr>
<td>Observer: Dr. Cahn</td>
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<tr>
<td>Dr. Girard</td>
<td>Name Redacted</td>
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<tr>
<td>Observer: Dr. Chavin</td>
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**Probationer Interview Reports**

The Board members reported on probationer interviews.

*The Board adjourned at 4:26 p.m.*

**Board Recessed until 8 a.m. Friday, October 7**

*6:00 p.m. – Working Board Dinner*
Friday, October 7, 2016

8:00 a.m. – CALL TO ORDER
Shirin Sukumar, MD; Chair of the Board

ANNOUNCEMENT OF EXECUTIVE SESSION – Shirin Sukumar, MD, 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.
PUBLIC SESSION
Dr. Sukumar took roll call. Dr. Hernandez, PhD, and Dr. Lyons were absent by prior notice.

Dr. Sukumar welcomed Kara Kohfield, Paramedic, Emergency Medical Services (EMS) Advisory Committee Chair, and Christoffer E. Poulsen, DO, to the meeting. Dr. Sukumar thanked them both for being at the meeting in person and expressed appreciation for the input Ms. Kohfield and Dr. Poulsen provide the Board.

Ms. Kohfield reported at the August 19, 2016, meeting of the EMS Advisory Committee, there was discussion regarding OAR 847-035-0011, the requirement for physician members of the EMS Committee to have at least two years’ experience actively practicing as Oregon EMS Supervising Physicians. Ms. Kohfield invited Dr. Poulsen to deliver the reasoning behind the requirement of a physician with two years’ experience as an EMS physician.

Dr. Poulsen drew the Board’s attention to a letter from the National Association of Emergency Medical Services Physicians (NAEMSP), Oregon Chapter, that each Board member was given. Dr. Poulsen explained it was the fairly strong opinion of the members of Oregon Chapter of NAEMSP that the two-year requirement was an appropriate requirement and should be a minimal requirement in the progress of EMS and EMS medical direction throughout the state. Dr. Poulsen further stated that requirement would not obstruct obtaining interested qualified candidates, as there was now board certification in EMS as a subspecialty certification (of which he has been certified) for emergency medicine by the American Board of Emergency Medicine. NAEMSP thought a board-certification requirement would be too limiting.

Dr. Sukumar thanked Dr. Poulsen for his presentation.

Dr. Gubler said the EMS Advisory Committee needed an experienced EMS provider who has a different perspective than an emergency room physician and people who were more active in the field. Dr. Gubler explained hospital admitting physicians had a perspective of the immediate care of the patient following transport, the intermediate care of that patient, and importantly, the long-term outcomes. He believed this was lost on emergency room physicians as well as the EMS transport personnel and there should be someone with these perspectives on the Committee. Dr. Gubler suggested having two physicians: One an active supervisor actively practicing medicine, and the second specifically not be an emergency room physician but a physician who has devoted his/her practice to the immediate care, intermediate care, and long-term care of patients.

Dr. Lyons joined the meeting at 8:07 a.m.

Dr. Poulsen said NAEMSP was trying to further the idea that EMS medicine was truly a specialty, and the knowledge of such was quite unique. Dr. Poulsen said the current idea that people would be practicing only EMS as a supervising physician and not actively involved in medical care is just not the case. He said almost anywhere in the United States, particularly here in Oregon, all of the supervising physicians, including himself, have a very minimal part of income and daily activity as simply EMS supervising physicians. Dr. Poulsen said all the
physicians were working full time in the role of emergency medicine. NAEMSP’s perspective was there is so much specialized to EMS that other physicians do not understand that role. NAEMSP wanted to ensure patients receive the proper type of care.

Dr. Girard said there needed to be a bridge between expertise in the field by an emergency physician as well as expertise within the patient-care setting, such as a hospital. Dr. Girard suggested changing the language to *in addition to expertise within the emergency medicine hospital system in which emergency medicine doctors are employed.*

Dr. Poulsen thanked Dr. Girard for his input and asked Dr. Girard if he was suggesting adding that the physician would still be actively practicing as a clinician instead of simply as an EMS supervising physician. Dr. Girard said yes, within the system which would allow for bridging.

Dr. Gubler said he was advocating for collaborative broader representation, and Dr. Poulsen was advocating for more limited representation. He said in his very small group, there are two people who have gone through extra training as EMS providers, have taken the exams, and one has been chair of the EMS committee in this state as well as in the state of Maryland. Dr. Gubler said there are people out there who are overly qualified for these types of positions, and they have a unique position. Dr. Gubler asked Dr. Poulsen why there was resistance to bringing to the table someone with a perspective that is broader than simply the EMS medical director.

Dr. Poulsen said he thought one of the perspectives was that Dr. Gubler certainly had the expertise that he does not have, nor did his EMS physician colleagues have in the Surgical Intensive Care Unit (SICU) or the operating suite; however, EMS physicians have devoted an enormous part of their careers to that subspecialty. Dr. Poulsen said he and EMS physicians truly believe EMS medicine is unique, and that was the only reason for resistance.

Dr. Mastrangelo said he thought both Dr. Gubler and Dr. Poulsen were making the same framework of an argument but just from different perspectives. Dr. Mastrangelo said all parties needed to ensure the physician on the Committee understands what happens in the Emergency Room and the Intensive Care Unit, on the floor, and when the patient goes home afterwards. Dr. Mastrangelo said there may be a great EMS crew that gets the patients to the hospital real quickly, but some components of the care may cause complications down the line. Dr. Mastrangelo gave the example of insertion of Foley catheters, which seemed very simple, but patients died of urosepsis and/or had urologic complications. Dr. Mastrangelo shared there was a urologist, Dr. McKimmy, on the Oregon Medical Board who had elucidated some of these issues. Dr. Mastrangelo said he totally supported Dr. Gubler and Dr. Girard. While Dr. Mastrangelo did agree with Dr. Poulsen, he said there needed to be someone who understood what was going on in the field, the acute setting, and in the post setting as well.

Dr. Lipe asked whether Dr. Poulsen could add a third physician member, possibly with trauma surgery expertise, to have the required experience on the physician panel.

Dr. Poulsen said the EMS Committee simply brings things forward to the Board for review and final decision making. The formation of the EMS Committee was supposed to be specifically for
emergency medical services, and that was why the EMS Committee was holding strongly to its opinion.

Dr. Girard said Dr. Poulsen had done a wonderful job of presenting this topic on behalf of the EMS Committee.

Dr. Sukumar acknowledged Dr. Poulsen’s very valuable role as an EMS supervising physician. Dr. Sukumar stated many of these situations were in rural settings, and there may not have been the backup of tertiary care settings. Dr. Sukumar asked whether in addition to having an EMS supervising physician or two on the Advisory Committee, was there an opinion about having an emergency room physician or a physician in the hospital who might be a part of the EMS Committee.

Ms. Kohfield said there had not been a specific discussion about that. Dr. Sukumar asked the Board, Dr. Poulsen and Ms. Kohfield to table the discussion for the day. Dr. Sukumar asked Dr. Poulsen to bring back to the Board information about broadening the scope to include members with expertise in the emergency room or the critical care setting.

Ms. Kohfield said at the EMS Advisory Meeting, regarding OAR 847-035-0030 Scope of Practice, the proposed rule amendment broadened the EMT Scope of Practice allowing the blind insertion of a supraglottic airway. The OAR 847-035-0030(9)(c) currently reads: *Insert a cuffed pharyngeal airway device in the practice of airway maintenance, a cuffed airway device is: (A) A single-lumen airway device designed for blind insertion into the esophagus providing airway protection where the cuffed tube prevents gastric contents from entering the pharyngeal space; or (B) A multi-lumen airway device designed to function either as the single-lumen device when placed in the esophagus, or by insertion into the trachea where the distal cuff creates an endotracheal seal around the ventilatory tube preventing aspiration of gastric contents.*

Ms. Kohfield proposed the revision to OAR 847-035-0030(9)(c) to read: *Insert a supraglottic airway device to facilitate ventilation through the glottic opening by displacing the tissue and sealing of the laryngeal area.* Ms. Kohfield explained the language change broadened the airway maintenance as new equipment was introduced while remaining under the Scope of Practice.

Dr. Mastrangelo asked if EMS providers were currently using Laryngeal Mask Airways (LMAs). Discussion ensued between Dr. Poulsen, Ms. Kohfield, and the Board regarding changing the language of the OAR for consistency in the currently used devices.

Dr. Mastrangelo said the change was sensible and asked how to ensure competency on new devices as well as decision making regarding which new devices to place on which emergency vehicles. Ms. Kohfield said essentially it was always the supervising physician who provides training on them.

Dr. Gubler asked about the vetting process for any of the new devices and whether there was uniformity amongst agencies. Dr. Gubler stated he was not opposed to changing the language, but he wanted to clarify the vetting process.

*Updated November 17, 2016*
Dr. Poulson said he thought there would be commonality across the state. Sometimes EMS providers brought information on new devices to the supervising physician to review, while other times the supervising physician brought something to the EMS providers. If the literature supported the device’s use and the EMS agency supported it, then there was training on the device. After the training sessions, the device goes into use.

Dr. Gubler asked how the hospital learned about the new device. Ms. Kohfield said from her perspective, the hospital knew immediately because they were a hospital-based ambulance. Therefore, in her case, her team essentially trained the emergency department staff on what was currently being used. Ms. Kohfield stated that in many instances, EMS was the trendsetter for the hospital on the newest greatest devices in use. In that case, Ms. Kohfield said, EMS personnel trained the hospital staff on proper use of the device.

Dr. Poulson said an alternative perspective would be the monthly Medical Control Board meeting, after which the physician groups or the emergency department’s personnel introduce a new device to the staff.

Dr. Mastrangelo asked if the device had to go through the Medical Control Board, and if there was a formal process for approval similar to the hospitals’ Value Analysis Committees (VAC) that looks at new products from all perspectives, financial to quality of care issues. He asked Dr. Poulsen who would take the responsibility for the new product or device and whether there was a generalized process.

Dr. Poulson said in the part of the state which he serves, there was uniformity in decision making. However, Dr. Poulsen stated, there was not an obligation for an individual agency or supervising physician to be consistent, but usually physicians come to an agreement as a group. Dr. Poulsen said in more rural parts of the state, there was not the luxury of the Medical Control Board with multiple board-certified positions to discuss things. He said there was more variability in different parts of the state.

Dr. Mastrangelo asked Ms. Kohfield if there were national guidelines on new products from EMS national societies. Dr. Poulsen answered not that he was aware of. Dr. Mastrangelo said he thought a set of formal guidelines with backing from a national organization would give the process more credibility. Dr. Poulsen said that is the constant goal and was why EMS was trying to move forward, including now having EMS board certification.

Dr. Sukumar asked why the language changed from maintain mechanical ventilation to initiate and maintain mechanical ventilation. Dr. Sukumar inquired about the training that staff would be receiving on ventilators.

Dr. Poulson said there was a detailed discussion regarding the change in language because there was an effort to be very careful. He said the initiate component of the language was important. Depending upon the EMS providers and training level in the agency, they may be actually endotracheally intubating a patient and placing the patient on a ventilator. EMS personnel could have also been simply a transporting agency that arrived to one hospital, transporting a patient already on a ventilator, and then the patient was being transported to Location B. Dr. Poulsen
said in that case, EMS personnel were maintaining the mechanical ventilation previously begun. He said the language change was not an attempt to increase the scope or change the Scope of Practice, but to have the language appropriately represent what already happens, which was to initiate mechanical ventilation. Dr. Poulsen said mechanical ventilation was far superior to manual ventilation by a provider. Therefore, this language change was an attempt to provide a much higher level of care to patients.

Dr. Sukumar thanked Dr. Poulsen and asked about the language, if trained on the particular equipment. Dr. Sukumar asked Dr. Poulsen about a training tracking system on devices as well as supervising physicians overseeing that training. Dr. Poulsensaid EMS providers believed proper training was critical for patient safety.

Ms. Kohfield said the Committee reviewed OAR 847-035-0030(9)(d) and the language change regarding performing tracheobronchial tube suctioning. The Committee was further investigating chart maintenance and readability.

The Committee further discussed the Scope of Practice change regarding advanced emergency medical technician (AEMT) establishing intravenous access via intraosseous (IO) infusion in adult patients just as they are currently only allowed to do in pediatric patients. Ms. Kohfield explained from a frontier aspect, lifesaving measures allowable in pediatric patients should be allowable in adult patients as well. Ms. Kohfield acknowledged the cost of training on the adult procedure versus solely training on the pediatric procedure.

Dr. Poulson said the situation was presented to him by a provider on the NW coast. He stated intraosseous devices were more and more commonly used with great efficacy. The use of lidocaine in both pediatric and adult patients during intraosseous infusion would also be a topic of discussion. The EMS Committee will be discussing this again and will be bringing this issue before the Board in the future.

Dr. Mastrangelo asked for clarification on EMS licensure and the Interstate Compact, allowing personnel to work across state lines. Dr. Poulsensaid the Committee discussed the intent, purpose, and language clarifying that it was meant for primarily emergency situations such as disasters. Currently emergency personnel cross state lines for wildland fire fighting for two-week periods of time and legally participate in care. Dr. Poulsensaid other states throughout the country have enacted policies.

Dr. Sukumar thanked Ms. Kohfield and Dr. Poulsen for their time and wished them well. Dr. Mastrangelo thanked Dr. Poulsen and Ms. Kohfield and said their presentation was very nicely done.

Dr. Sukumar recapped OAR 847-035-0011 and asked the EMS Committee to have further discussion regarding the Board’s concerns and stated the rule will stay at the first review stage.

Regarding OAR 847-035-0030, Scope of Practice on ventilation, Dr. Mastrangelo said the draft in which the Board was of receipt, originally read: Maintain mechanical ventilation. The Committee requested to amend the rule to read: Initiate and maintain mechanical ventilation.
Approved by the Board on January 6, 2017.

during transport if trained on the particular equipment. Dr. Mastrangelo asked for and received consensus that the amendment as stated would move forward.

**BOARD ACTION:** Dr. Girard moved that the Board approve the EMS Advisory Committee meeting minutes of August 19, 2016. Dr. Mastrangelo seconded the motion. The motion passed with a voice vote. Dr. Hernandez, PhD, was absent by prior notice.

<table>
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<tr>
<th>Agency Head Transactions</th>
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<tr>
<td>Dr. Girard explained the transactions before the Board for approval. The two items presented were travel reimbursement and bank credit card payments. Dr. Girard introduced Carol Brandt, Business Manager.</td>
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Dr. Girard asked Ms. Brandt the reason behind switching from Wells Fargo Bank to US Bank. Ms. Brandt explained the state-issued Small Procurement (SPOT) card saves money and provides rebates while the private credit card does not.

Dr. Girard reported these documents reflected the careful attention to the use of both money as well as leave time by the Board’s Executive Director, which sets the tone for the entire Board. Dr. Girard complimented the entire Board and OMB staff. Ms. Brandt said she agreed.

Dr. Sukumar thanked Ms. Brandt and stated she agreed with Dr. Girard’s previous comments. She appreciates Ms. Haley’s style of dedicated service. Ms. Haley thanked Dr. Sukumar and credited the team effort and Ms. Brandt as the business manager.

**BOARD ACTION:** Dr. Girard moved that the Board approve Agency Head Transactions from July 1, 2015, to June 30, 2016. Dr. Mastrangelo seconded the motion. The motion passed by a voice vote. Dr. Hernandez, PhD, was absent by prior notice.

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<tr>
<th>Annual Performance Program Report</th>
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<tr>
<td>Ms. Brandt said she was pleased to report that the Oregon Medical Board did meet all of its targets, and in some cases, exceeded the targets for the 2016 fiscal year. She said overall customer satisfaction increased by five percentage points. Although renewals were still within the target range, Ms. Brandt said the amount of time taken for renewals increased from the previous year due to unforeseen staff shortages such as retirements, deaths, etc. This issue has now been resolved.</td>
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Ms. Haley congratulated Netia Miles, Licensing Manager, and her staff on working tirelessly during the renewal period with the staff shortage. Ms. Haley shared that Ms. Miles and her team worked weekends throughout the entire period to ensure licensees received excellent service.

Dr. Sukumar and Dr. Girard thanked Ms. Miles.

Dr. Mastrangelo congratulated Ms. Brandt on her excellent report. He shared a thought about the Oregon Medical Board providing renewal licensees with a timeframe for the average wait time when licensees talk to the Call Center. Dr. Mastrangelo remarked that the Oregon Medical Board did his renewal in six hours last year.
Ms. Brandt added that the Oregon Medical Board was continually reviewing the customer satisfaction results and had recently overhauled the customer satisfaction survey.

**BOARD ACTION:** Dr. Girard moved that the Board approve the Annual Performance Program Report from July 1, 2015, to June 30, 2016. Dr. Mastrangelo seconded the motion. The motion passed by a voice vote. Dr. Hernandez, PhD, was absent by prior notice.

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<th>Oregon Medical Board Licensure Count</th>
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<td>Ms. Peng presented that between May and August, 2016, there were a total of 518 licenses issued. Ms. Peng stated that number of licenses for the quarter represented the hard work of the Oregon Medical Board staff. This count was also included in the last newsletter.</td>
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The Board took no official action.

<table>
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<tr>
<th>OAR 847-003-0200: Board Member Compensation</th>
<th>FIRST REVIEW</th>
<th>MP</th>
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<td>Ms. Peng stated the proposed rule amendment of OAR 847-003-0200 increases Board Member Compensation by $100. When investigating historical information, Ms. Peng found the last time there was an increase was in 1999, and prior to 1999, it had been several years. The fiscal impact on the Board was found to be minimal.</td>
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The Board discussed the increase in compensation and questioned the funding source. Ms. Haley explained the increase would be part of a budget package that was $18,400 per biennium. Ms. Haley reported the Governor’s analyst had denied the compensation increase so Ms. Haley will be visiting Salem to appeal the denial.

Dr. Sukumar stated Board compensation was discussed at the AAC, and some comparisons were made against the other regulatory boards. The AAC found several other boards had compensation for preparatory time in addition to meeting time.

The Board took no official action.

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<tr>
<th>OAR 847-010-0066: Visiting Physician Requirements</th>
<th>FIRST REVIEW</th>
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<tr>
<td>The proposed rule amendment specifies that physicians who are actively licensed and in good standing in another state or country may be approved as a visiting physician for the purpose of acting as an expert witness for up to 30 days per year. Physicians who serve as an expert witness for more than 30 days in Oregon in a year will not act under the supervision of an actively licensed Oregon physician in good standing and must apply for a full active license or locum tenens license. Ms. Peng asked the Board to draw its attention to OAR-847-010-0066(c) which</td>
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*Updated November 17, 2016*
Offer an opinion on a person’s diagnosis or treatment as an expert witness in Oregon’s civil or criminal case for a period up to 30 days per year. A physician approved under this subsection may perform physical or mental examinations, order radiologic or laboratory testing, and make referrals to other healthcare providers under the supervision of an actively licensed Oregon physician who is in good standing without disciplinary action. A physician approved under this subsection may not prescribe, administer, or dispense controlled substances.

Dr. Chavin invited Ms. Krishnaswami to comment on this.

Ms. Krishnaswami answered that a physician approved under this section may not prescribe, administer, or dispense. This rule would allow physicians to have courtesy privileges which means that visiting physicians must be practicing under the supervision of a currently licensed Oregon physician. They would be allowed to do this in a limited capacity for up to 30 days within a year. If the visiting physician wanted to go beyond this privilege to practice for more than 30 days, or if they do not want to have a supervising physician, the visiting physician would need a full license from the Oregon Medical Board which means either a full active license or a locum tenens license.

Ms. Krishnaswami said medical boards are seeing physicians acting as defense counsel or prosecution experts around the country. These expert physicians may want to order follow-up studies. Ms. Krishnaswami explained that under the Board’s provision, supervising physicians working with out-of-state physicians would be ordering the follow-up tests.

Dr. Gubler raised the question of whether these tests being ordered benefitted the patient or benefitted the legal system. Dr. Gubler stated the patient should always be the most important. Dr. Chavin asked if the out-of-state physician ordered an invasive study or test and then the patient encountered complications, who assumed care for that patient.

Dr. Mastrangelo said he had similar concerns regarding secondary findings on follow-up studies that may be ordered. He questioned who would inform the patient if a malignancy or important clinical finding was found secondary to what the ordering physician was looking for. Dr. Mastrangelo asked that there be a clear reporting process of results to the patient. He also raised the question of calculating the 30 days in respect to physicians who may be practicing routinely and operating a clinic here in Oregon but possibly only physically coming to Oregon one or two days a week. Dr. Mastrangelo stated he was not in support of this rule in its current form. He thanked Ms. Krishnaswami for her hard work and acknowledged her expertise and attention to detail.

Dr. Lyons asked about the origin of this rule. Ms. Krishnaswami said thus far physicians are only coming to Oregon to testify or to provide an opinion.

Dr. Mastrangelo asked about a patient dying due to anaphylaxis as a result of a CT scan with IV contrast; in that case, who has jurisdiction over the physician who ordered this test. Ms. Krishnaswami said if the visiting physician were granted courtesy privileges, the Oregon Medical Board has jurisdiction.
Approved by the Board on January 6, 2017.

Ms. Haley added that Oregon has had this visiting physician requirement for over a decade, with physicians coming to Oregon to complete training or provide training. Ms. Haley reported there had never been a problem with this provision.

Ms. Krishnaswami said she had spoken with Senior Assistant Attorney General, Warren Foote, and he was in agreement with the proposal for this intermediate step. Licensing was in agreement as well. Ms. Krishnaswami reiterated she was open to discussion regarding changing or modifying the rule.

Dr. Lyons questioned whether this rule had been reviewed by malpractice attorneys. According to Ms. Krishnaswami it had not, but she said that was certainly a possibility.

Dr. Sukumar thanked Ms. Krishnaswami and stated the Board will bring back the rule for review at the next Board meeting. Ms. Krishnaswami thanked Dr. Sukumar and the Board.

The Board took no official action.

OAR 847-001-0024; 847-001-0045; 847-008-0003; 847-020-0183; 847-050-0043; 847070-0045; 847-080-0021: Consent Agreements for Re-entry to Practice

The Board reviewed the AAC’s recommendation to approve the rule as written.

The proposed rulemaking on consent agreements for reentry to practice is a nondisciplinary rule but does allow for a series of actions to be taken to ensure that the licensee meets the bar the Board has set in terms of practice capability. This rule clarifies this is not disciplinary and will help the licensee meet the set requirements.

BOARD ACTION: Dr. Girard moved that the Board adopt OAR 847-001-0024; 847-001-0045; 847-008-0003; 847-020-0183; 847-050-0043; 847-070-0045; 847-080-0021: Consent Agreements for Re-entry to Practice, as written. Dr. Mastrangelo seconded the motion. The motion passed 12-0-0-1. Dr. Hernandez, PhD, was absent by prior notice.

OAR 847-002-0000; 847-002-0005; 847-002-0010; 847-002-0015; 847-002-0020; 847-002-0025; 847-002-0030; 847-002-0035; 847-002-0040; 847-002-0045: Criminal Background Checks [For Employees]

The Board reviewed the AAC’s recommendation to repeal and amend the rule as written.

The proposed rulemaking repeals existing procedural rules on criminal background checks of employees, volunteers and applicants and amends one rule to refer to new statewide rules and specifies the individuals subject to the rule. This rulemaking was required by House Bill 3168 (2013) and House Bill 2250 (2015), which gave the Department of Administrative Services the authority to adopt statewide administrative rules for criminal records checks and required other agencies to repeal or amend existing rules. There was no change to the existing process.

Updated November 17, 2016
Dr. Chavin asked if when a licensee was relicensing or renewing a license, would a criminal background check be performed. Ms. Haley said that while the Oregon Medical Board does not perform criminal background checks at the time of renewal, they do perform criminal background checks at the time of the initial issuance of the license and when Complaint and Notice will be issued. Discussion ensued regarding the cost and effectiveness of performing criminal background checks on licensees during each renewal cycle as well as the nuisance factor to licensees with no probable cause.

**BOARD ACTION:** Dr. Fisher moved that the Board adopt OAR 847-002-0000; 847-002-0005; 847-002-0010; 847-002-0015; 847-002-0020; 847-002-0025; 847-002-0030; 847-002-0035; 847-002-0040; 847-002-0045: Criminal Background Checks [For Employees], as written. Dr. Gubler seconded the motion. The motion passed 12-0-0-0-1. Dr. Hernandez, PhD, was absent by prior notice.

OAR 847-008-0068: State and Nationwide Criminal Records Checks, Fitness Determinations [For Applicants and Licensees]  
**FINAL REVIEW**  
KF

The Board reviewed the AAC’s recommendation to move the rule forward as written.

**BOARD ACTION:** Dr. Fisher moved that the Board adopt OAR 847-008-0068: State and Nationwide Criminal Records Checks, Fitness Determinations [For Applicants and Licensees], as written. Dr. Girard seconded the motion. The motion passed 12-0-0-0-1. Dr. Hernandez, PhD, was absent by prior notice.

OAR 847-005-0005: Fees  
**FINAL REVIEW**  
PC

The Board reviewed the AAC’s recommendation to move the rule forward as written.

The proposed rule amendment specifies that the one-time application fee for supervising physicians of physician assistants be reduced to $50 for physicians volunteering in free clinics or nonprofit organizations. It reduces the workforce data fee assessed to licensees on behalf of the Oregon Health Authority’s Office of Health Policy Analytics which recently reduced the fee from $5 per licensing period to $2 per year and corrects references to the criminal records, checks statutes, and the prescription monitoring program which were recently renumbered.

**BOARD ACTION:** Dr. Chavin moved that the Board adopt OAR 847-005-0005: Fees, as written. Ms. Peng seconded the motion. The motion passed 12-0-0-0-1. Dr. Hernandez, PhD, was absent by prior notice.

OAR 847-008-0055: Reactivation Requirements  
**FINAL REVIEW**  
DG

The Board reviewed the AAC’s recommendation to move the rule forward as written.

This amendment corrects the grammar only of the sentence which is under Reactivation Requirements OAR 847-008-0055(3)(a), (b), (c), and (4).

*Updated November 17, 2016*
BOARD ACTION: Dr. Girard moved that the Board adopt OAR 847-008-0055: Reactivation Requirements, as written. Dr. Chavin seconded the motion. The motion passed 12-0-0-0-1. Dr. Hernandez, PhD, was absent by prior notice.

<table>
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<tr>
<th>OAR 847-020-0150; 847-023-0010; 847-026-0015; 847-050-0025; 847-070-0019; 847-080-0013: Medical Practice Act Exams</th>
<th>FINAL REVIEW</th>
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The Board reviewed the AAC’s recommendation to move the rule forward as written.

The proposed rule amendment removes references to the Drug Enforcement Agency (DEA) exam. The most important prescription drug questions have now been incorporated into the Medical Practice Act exam. The rule clearly states that if an applicant fails the open book exam three times, then applicant must attend an informal meeting and also includes the option of meeting with the Oregon Medical Board Executive Director before licensee will be given a fourth and final attempt. The rule also relates to documents to be submitted for the expedited endorsement process, and these have been updated, and to allow for electronic fingerprint submission through the new FieldPrint program. There was no fiscal impact from this rule amendment.

Ms. Haley said that Dr. Thaler and Ms. Krishnaswami really did an incredible job updating and consolidating the exams.

Dr. Sukumar acknowledged the questions were excellent, pertinent, and addressed topics of which the licensee should be aware.

BOARD ACTION: Dr. Girard moved that the Board adopt OAR 847-020-0150; 847-023-0010; 847-026-0015; 847-050-0025; 847-070-0019; 847-080-0013: Medical Practice Act Exams, as written. Dr. Chavin seconded the motion. The motion passed 12-0-0-0-1. Dr. Hernandez, PhD, was absent by prior notice.

Oregon Medical Board Strategic Plan

Dr. Sukumar reported that the Oregon Medical Board’s Strategic Plan was very impressive, thoughtful, and insightful. The Board had been developing and implementing a Strategic Plan since 1999 with goals and core values. The Strategic Plan was reviewed by the AAC and has recommended the Board approve it. This year’s four core values have been identified: Integrity, Accountability, Excellence, and Customer Service. The seven goals for this year’s Strategic Plan are:

Goal 1: Streamlining Agency Operations & Implementing Cost Efficiencies;
Goal 2: Improving Access to Quality Care through Efficiently Managing Licensure and Renewal of Licensure;
Goal 3: Coordinated Outreach & Education to the Public & Licensees;
Goal 4: Investigating Complaints against Licensees & Applicants; Ensuring Appropriate Action Based on the Facts of the Case;
Goal 5: Remediating Licensees to Safe, Active, Useful Service to Oregon’s Citizens;

Updated November 17, 2016
Goal 7: Recruiting & Retaining the Highest Qualified Board Members.

BOARD ACTION: Dr. Girard moved that the Board approve the updated Oregon Medical Board Strategic Plan. Dr. Sukumar seconded the motion. The motion passed 12-0-0-0-1. Dr. Hernandez, PhD, was absent by prior notice.

There was a demonstration of the online reactivation system by Ms. Krishnaswami and Ms. Miles. The Board members thanked Jennifer Lannigan, PhD, and Randall Wagenmann for their software engineering expertise and success.

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<tr>
<th>Administrative Medicine License for Physician Assistants</th>
<th>MP</th>
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<td>Ms. Peng reported that the issue of physician assistants as administrators arose due to a physician sending a letter because a Physician Assistant (PA) was an administrator at the physician’s practice. Ms. Peng said PAs with an administrative license doing administrative duties that required a PA license but with no hands-on patient care would have more employment opportunities.</td>
<td></td>
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</table>

Dr. Girard explained at the AAC meeting, a number of options were discussed. Dr. Girard stated that people who were recruiting for jobs want the individual to have credentials commensurate with the candidate’s best abilities to carry out the roles of oversight. Ms. Peng said it was not uncommon for PAs to have advanced degrees in some sort of healthcare such as public health or health administration.

Dr. Sukumar thanked Ms. Krishnaswami for her memo outlining the statute with the definition of a Physician Assistant along with the 2011 legislation explicitly removing the need to have a supervising physician and employment from the qualification for licensure. Dr. Sukumar asked Ms. Krishnaswami for clarification regarding PAs who did not have supervising physicians must become inactive. Ms. Krishnaswami said that was correct, the PA would be inactive and would have an inactive license. The 2011 legislation separated the two processes so the Board could give PAs six months to find employment.

Dr. Sukumar questioned the checks and balances in a system in which a PA was an administrator involved in physician oversight or physician peer review which required clinical judgment, but the PA was still connected to a supervising physician. She questioned if PAs without an MBA or higher level degree received administrative training to support this position. The Board further raised the question of MBAs being able to sign off on clinical guidelines versus a physician assistant.

Dr. Girard stated this was a very difficult issue because if a CEO is a physician assistant and has to have a supervising physician, that creates mayhem in terms of conflict of interest and who can do what. On the other hand, if the physician assistant title is removed, the potential value of leadership which is not then tied to expertise in patient care was greatly diminished.
Dr. Gubler discussed a PA who is a CEO who was signing off on practice guidelines; he stated this situation would put the PA in the role of a supervising physician without their own supervising physician.

Dr. Lipe asked if other states were pursing PAs as administrators.

Dr. Fisher asked about the licensure of a Nurse Practitioner.

Ms. Peng said nurse practitioners are independent practitioners who can be CEOs, CMOs, etc., and physicians never question that because their license is different and not tied to a physician. An RN can be an administrator because RNs are independent practitioners, as are LPNs. Ms. Peng stated PAs needed employment options besides just practicing clinical medicine.

The Board took no official action.

**Eight-Hour On-Site Supervision Waiver Request**

Ms. Peng presented the background of the eight-hour on-site supervision waiver request involving Saint Alphonsus Hospital in Boise, Idaho in which physician assistants practice between that facility and a clinic in Eastern Oregon. The physicians at Saint Alphonsus had requested an exception to the eight-hour on-site supervision rule since the physicians were not actually onsite. Ms. Miles and Ms. Krishnaswami worked with Dr. Graff of Saint Alphonsus regarding physicians creating a supervising physician organization (SPO) with Oregon-licensed doctors. Ms. Krishnaswami reported Dr. Graff was very receptive to a SPO and would be taking this information to Saint Alphonsus’ administration for review.

The Board took no official action.

**Oregon Health Professionals’ Services Program (HPSP): Year Six Exit Interview, Annual Report and Satisfaction Survey**

Dr. Girard reported on the Health Professionals’ Services Program (HPSP) report written by the authors of the HPSP. This series of questions asked the licensees in the program, the monitors within the program, and its corollaries their opinions about the program itself. Dr. Girard said the report was quite positive, however, the respondent and data numbers were relatively small so may not warrant drawing a conclusion from them.

Dr. Sukumar said she found the HPSP was doing its best at this point given the role more as a monitoring system with no treatment involved. She was encouraged by the HPSP provider’s presentation to the Board. She believed they were trying to make this a high-quality program.

Dr. Girard inquired of Ms. Haley about the future of the HPSP. Ms. Haley said because the Oregon Health Authority (OHA) was administering the contract and charging the four Boards $300,000/biennium with only one vendor applying for the contract, the Boards have shifted administration to them with the Oregon Medical Board in the lead. Ms. Haley said now the Boards meet monthly and Stephanie Vorderlandwehr, OMB contract Specialist, was leading the
contract piece. The four Boards are collaboratively deciding on contract requirements. Ms. Haley shared that all the Boards agree they would like to see the participant numbers increase.

The Board took no official action.

### 2017 Legislative Concepts

Dr. Sukumar reported the Governor’s office has approved the first drafts of Legislative Concepts 652 and 653 which moves them forward to the final draft stage. Dr. Sukumar said Legislative Concept 652 related to administrative efficiencies which pertained to the designation of the OMB as a semi-independent state agency.

Legislative Concept 653 related to emeritus Board members, and the draft pertains to a selection of at least one emeritus member to serve on the Board as needed as directed by the Chair. At the request of Dr. Sukumar, Ms. Krishnaswami provided clarification that emeritus members would be required to have similar credentials to the Board member for which they are substituting, i.e., an MD needs an emeritus MD, a DPM needs an emeritus DPM, etc.

Regarding the previous Legislative Concept relating to the Interstate Medical Compact, Dr. Sukumar explained that concept was currently on hold until the Board receives further information.

Dr. Sukumar reported that the Governor’s office would be reviewing the final draft language of both these Legislative Concepts and would be deciding whether these concepts would be introduced as bills during the 2017 session.

Dr. Sukumar thanked Ms. Krishnaswami for her work in creating these Legislative Concept drafts.

The Board took no official action.

### Report of the Federation of State Medical Boards (FSMB) Workgroup on Innovation in State-Based Licensure

Dr. Sukumar explained that in 2014, the FSMB came up with a report on innovations and state-based licensure, and had recommended that states offer licenses for unique and special situations. These were temporary licenses and included such positions as a team physician coming for a sporting event for a limited time or a youth camp physician for a week.

The Board took no official action.

### Oregon Medical Board Peer Review Audit

Dr. Chavin said the Peer Review Audit was originally mandated by the 2009 Oregon Legislature to audit the health regulatory boards. This was actually the ninth audit, and Ms. Haley was interviewed on March 22, 2016, as well as reviewing licensing and disciplinary files, and interviewed persons who served on the Board as well as persons affiliated with professional associations whose members were licensed before the Board.

*Updated November 17, 2016*
Although the audit reported the Oregon Medical Board had 12 members throughout the document, Dr. Chavin corrected that the Oregon Medical Board has 13 members because there was now a physician assistant on the Board.

Dr. Chavin outlined the strengths, challenges, opportunities, etc., which Ms. Haley had submitted. Ms. Haley cited the due process requirements for disciplinary cases, difficulty in recruiting Board and staff given the workload demands, meeting the demands of our multiple stakeholders, and compensation parameters as some challenges.

Dr. Chavin pointed out the stakeholder interviews on Page 11,949 which found the Oregon Medical Board staff to work efficiently, to which Dr. Chavin agreed heartily.

According to Page 11,951, Dr. Chavin stated the Audit Team’s overall impression and conclusion was the Oregon Medical Board operates in a manner that was efficient and professional. Some specific observations were the Oregon Medical Board website provides relatively easy access to a wealth of information. The auditors also mentioned TechMed for case files which were found to be very well organized.

Dr. Chavin shared the suggestions by the auditors which were the Oregon Medical Board should continue to work on communication and collaboration with professional associations, increase the public’s awareness of the OMB’s role in protecting the public health, and to consider performing criminal background checks to help ascertain if licensees are noncompliant with the law. Dr. Chavin shared the fact that Ms. Haley, Dr. Thaler, Ms. Krishnaswami and Ms. Miles were already participating in community outreach events throughout the year.

A summary of the anatomy of a complaint was elucidated by Dr. Chavin for the benefit of the new Board members, as well as the types and status of licensure in Oregon.

Dr. Sukumar thanked Dr. Chavin for his excellent summary of the investigative process for our newer Board members.

Dr. Lipe inquired whether the peer review was a public document, and Ms. Haley reported that the document was posted publicly.

The Board took no official action.

**National Board of Osteopathic Medical Examiners (NBOME) National Center for Clinical Skills Testing**

Dr. Fisher reported she will be in Chicago on November 7, 2016, to tour the new National Board of Osteopathic Medical Examiners National Center for Clinical Skills Testing (NBOME) in Chicago. Previously the only other site in the country was located in Philadelphia.

The Board took no official action.
Dr. Girard updated the Board on the Wellness Coalition. He said the Wellness Coalition was a group of individuals who represent societies and various professional groups across the state who have come together over the past two years, with the help of the Oregon Medical Board and its leadership, to assemble here and to work toward having a uniform body who provides interventive and preventive services to healthcare professionals throughout our state to try to favorably impact the increasing burnout phenomenon that we are experiencing among healthcare professionals. Dr. Girard reported the Wellness Coalition has accomplished a lot through resources of the Oregon Medical Board provided by Ms. Haley and a consultant, Ann Witsil. The Coalition has formalized the agreement that the Coalition actually exists, and has tentative protocol both for how to set up a program and how to perform the series of operations to evaluate and help an individual licensee.

Dr. Girard shared there was currently an active program in Lane County through the efforts of the now emerita executive director there; in the Medical Society of Metropolitan Portland (MSMP), the old Multnomah County Medical Society, through the efforts of Amanda Borges and her Board; and through OHSU which has the longest-existing wellness program which involves both resident physicians and faculty physicians. According to Dr. Girard, collectively there were probably 125 individuals on the rolls.

Dr. Girard reported the goals for the Wellness Coalition now were to reach out to other larger communities within Oregon to help establish their programs as well as to develop a methodology to communicate to and provide services for those communities who have no realistic way to develop their own programs because of their remote locations and lack of fiscal resources.

Regarding the financial issues, Dr. Girard explained that The Foundation for Medical Excellence (TFME) with its new president, Tim Goldfarb, has accepted a fiduciary role for the Coalition to help generate money. Dr. Girard further stated through the efforts of Ms. Haley, colleagues, and the budgetary process, our current next biennial budget has money allowed for the implementation of a research program that looks at the data regarding the Coalition's growth, outreach, and outcomes of those who have been getting help.

A newly developed executive leadership committee will be working together between Coalition meetings to take those issues that were in some degree of being formulated, organized, and finalized, and do those processes to bring back to the Board for final approval or rejection. Dr. Girard said the hope was to move the whole process along in a faster manner.

Dr. Chavin asked if the Coalition would consider other healthcare providers like PAs, nurse practitioners, etc., be allowed in the Wellness Program.

Dr. Girard answered affirmatively and explained that the original intent of the Coalition program was for healthcare professional services that relate to physicians and physician assistants, but now it was his opinion, and he hoped the goal and the vision of the entire Coalition, to provide wellness services to all healthcare professionals.

The Board took no official action.
The Board reviewed the September 7, 2016, Administrative Affairs Committee meeting minutes.

**BOARD ACTION:** Dr. Girard moved that the Board approve the September 7, 2016, Administrative Affairs Committee meeting minutes, as written. Dr. Sukumar seconded the motion. The motion carried with a voice vote. Dr. Hernandez, PhD, was absent by prior notice.

The Board reviewed the July 6-7, 2016, Board meeting minutes.

**BOARD ACTION:** Dr. Girard moved that the Board approve the July 7-8, 2016, Board meeting minutes. Dr. Sukumar seconded the motion. The motion carried with a voice vote. Dr. Hernandez, PhD, was absent by prior notice.

No public comment was presented.

**EXECUTIVE SESSION**
The Board moved into exec session to discuss a specific investigative case.

**PUBLIC SESSION**

**Interim Stipulated Order (ISO) Acknowledgment**
The Board acknowledged the following Interim Stipulated Orders (ISO):

- Elisabeth L. Jappay, MD – *Effective August 2, 2016*
- Craig R. Laws, MD – *Effective August 19, 2016*
- Ashley R. Laird, MD – *Effective August 29, 2016*
- Kent F. Meckling, MD – *Effective September 9, 2016*
- Robert A. Read, MD – *Effective October 5, 2016*

*The Board adjourned at 11:52 am*

*Updated November 17, 2016*
Organ Donation in Oregon: Hospital Systems and Physician Partners
Pacific Northwest Transplant Bank

Objectives
• The Numbers... the critical need for organ donation and what is happening in PNTB’s service area
• Regulation and oversight of organ donation
• The donation process and the role of the Physician
• Most common challenges and pitfalls when working in host hospitals

What are the Issues?
• Over **123,000** patients are currently waiting for an organ transplant
  • 826 people are currently listed at transplant centers in OR
  • 81% are waiting for a kidney
  • 1.5% of patients waiting are under the age of 18
  • 76% of patients waiting are between the ages of 18 and 64
• Every **12** minutes a name is added to the list
• On average, **18** people die each day while on the waiting list
• Each organ donor can save up to **8** lives and enhance the lives of over **50** others

• Roughly ~80 hospitals
• Only about 20 hospitals have organ donation potential represented by:
  • ~ 9 hospital systems
  • ~ 5-8 hospitals w/o system affiliation

Oversight and Regulations Initiatives to Close the Gap

• Center for Medicare/Medicaid Services created (CMS) Conditions of Participation for Hospitals, effective 1998
  • Reporting all deaths or imminent deaths
  • Advise families of their right to donate through a designated requestor
  • Must partner with OPO to maintain potential donor while testing takes place

• Joint Commission & DNV
  • OPO and hospital contracts
  • Hospital specific policies

CMS Condition 1:
A hospital must report all deaths or “imminent” deaths

Identify and refer when a patient meets the Clinical Trigger:
Neurological condition requiring intubation/ventilation with one or more of the following:

– GCS of 5 or less
– Loss of one or more brain stem reflex: pupils, cough, gag, corneals, response to painful stimuli, no spontaneous respirations
– Plan for family care conference regarding: withdrawal of ventilator, end of life decisions

(Please CMS, call within 1 hour of patient meeting clinical trigger)
PNTB will determine medical suitability/registry status
CMS Condition 2:
A hospital must advise all families of medically suitable donors of their right (or legal authorization) to donate through a designated requestor

All Oregon hospital policies reflect that only agency representatives approach families about donation.
PNTB has a dedicated team trained in family support and requesting.
PNTB and hospital staff/MD’s collaborate on the timing of the donation discussion.

- Donation should not be included in a family conversation when grave prognosis/end of life decisions/comfort care/brain death declaration is discussed.

Process Overview & Physician Roles

- Patient arrives to ED with a severe neurological injury (no mention of donation).
- Patient is stabilized and admitted to the ICU (no mention of donation).
- Clinical trigger is recognized and referral is made to PNTB (no mention of donation).
- On-site visit from PNTB & Team Huddle (no mention of donation).
- Care team manages patient aggressively. Care goals continue to focus on optimal opportunity for recovery (no mention of donation).
- PNTB follows patient from afar, checking in daily (no mention of donation).
- Care Team continues to provide updates to family and reassess goals of treatment (no mention of donation).
- Patient’s condition improves or deteriorates (PNTB signs off or continues to follow) (no mention of donation).
- Care team supports patient through hemiation event and conducts brain death testing (no mention of donation).
- Brain death is formally declared and care team meets with family (no mention of donation).
- PNTB is introduced to the family as a hospital partner.

CMS Condition 3:
A hospital must work cooperatively with organ procurement organization (OPO) to maintain potential donor while necessary testing and placement of organs takes place

- Stabilize a patient hemodynamically and support a patient through a catastrophic brain injury with aggressive critical care.
- Declare brain death.
- Support and execute testing and orders requested by OPO to determine which organs can be recovered for transplant.

Process Overview & Physician Roles (Continued)

- PNTB assumes medical management of patient AFTER death is declared and authorization for organ donation has been obtained.
  - Focus in care shifts slightly from saving patient’s life, to optimizing organ perfusion to save the lives of others.
  - At the request of PNTB staff, physicians assist in donor management:
    - Putting in Central and Arterial lines.
    - Performing various procedures and tests at the bedside or cath lab.
    - Providing reports based on procedure findings.
    - At times talking with transplant surgeons to discuss clinical findings.
Common Challenges

- Hospital Policies
  - All different
    - “Patient free of sedating and/or paralyzing drugs for a minimum of 24 hours” vs. “Effects of drug intoxication from barbiturates, opiates or other sedatives is not present”
  - Specific brain death declaration policy may not exist
  - May or may not have order sets for organ donors

- Supporting patients and their families (before death is declared)
  - Unwillingness to support patients hemodynamically through herniation event
  - “Do you know if she has a “D” on her drivers license, because that is going to help guide how we care for her...”
  - Introducing the topic of donation to a family in a care conference:
    - “We don’t believe he has any opportunity for a meaningful recovery and would recommend withdrawing support. Or the other option for him is organ donation.”

Common Challenges

- Making the referral
  - “I don’t know why you’re here, this patient isn’t dead yet...”

- Declaring Brain Death
  - Lack of collaboration or notification to PNTB
  - “I will only declare brain death if the family is interested in donation...”
  - Willingness to perform clinical and apnea test, but unwilling to write the death note

- Supporting patients, families, and PNTB after death is declared
  - “This family is too overwhelmed and sad, talking to them about donation will only upset them more.”
  - “This is not the type of family that will want donation...”
  - “I’m too busy to help with ____, I’m taking care of living patients.”

Most Important Takeaways

- We want to partner and support hospital teams through this process

- Optimal patient care and organ donation are not competing priorities

- Patient and family care is ALWAYS the priority

Thank You!

www.donatelifenw.org