

WSMA

REPORTS

MAR / APR 2020

A PUBLICATION FOR THE MEMBERS OF THE WASHINGTON STATE MEDICAL ASSOCIATION



**Partnering
to Solve the
Health Care
Puzzle**

Collaboration is key
to patient care



It's so nice to have one person throughout your entire claim, who knows your story -- your personal story -- and its impact on you throughout the process. It's amazing to be treated like this.

Angela Chien, MD
Obstetrics & Gynecology
Kirkland, WA

*Real People.
A Real Foundation.*



**Physicians
Insurance**
A MUTUAL COMPANY

www.phyins.com (800) 962-1399

CONTENTS

WSMA Reports
March/April 2020

Features



COVER STORY Solving the Health Care Puzzle / 8

Collaboration is key to patient care. BY RITA COLORITO

Training to Address the Region's Unmet Health Care Needs / 14

Washington state's PA education focuses on providing team-based medicine to rural, underserved populations. BY PAT CURRY

Guidance for the Use of Advanced Practice Providers / 18

Understanding compliance requirements will help you make the best use of these valuable team members. FROM PHYSICIANS INSURANCE

Vital Signs

Patient Care Depends Upon Partnerships / 2

Local delegation agreements would help optimize practices and maximize access to care for patients.

WSMA Huddle / 3

Meet WSMA members Tsering Lhewa, MD, FAAP; practice updates; members in the news; vintage WSMA; letter to the editors; and more.

By the Numbers

Our Demographic Destiny / 20

Washington state and the country as a whole are facing a growing mismatch between community health needs and physician supply.

Heartbeat

A Virtuous Cycle / 21

Adding physician assistants to a busy practice is good for the bottom line—both for patient care and practice revenue. BY NICHOLAS RAJACICH, MD



21

WSMA

WSMA Reports is published bimonthly as the official publication of the Washington State Medical Association.

SEATTLE OFFICE
2001 Sixth Avenue, Suite 2700
Seattle, WA 98121
206.441.9762 | Fax: 206.441.5863

OLYMPIA OFFICE
1800 Cooper Point Road SW,
Bldg 7, Suite A, Olympia, WA 98502
360.352.4848 | Fax: 360.352.4303

The style of WSMA Reports is to be gender inclusive, and uses preferred pronouns when requested.

EXECUTIVE DIRECTOR/CEO
Jennifer Hanscom

EDITORIAL DIRECTOR
Milana McLead

MANAGING EDITOR
Graham Short

SENIOR EDITOR
Pat Curry
patscurry@gmail.com
706.714.2808

ASSISTANT EDITOR
Katie Howard

ART DIRECTION AND DESIGN
Erin Foster

ADVERTISING
wsma@wsma.org
206.441.9762

WSMA EXECUTIVE COMMITTEE:
CHAIR
Tom Schaaf, MD

PRESIDENT
William K. Hirota, MD

PRESIDENT-ELECT
Nathan Schlicher, MD, JD

1ST VICE PRESIDENT
Mika Sinanan, MD, PhD

2ND VICE PRESIDENT
Katina Rue, DO

SECRETARY-TREASURER
Nariman Heshmati, MD

ASSISTANT SECRETARY-TREASURER
John Bramhall, MD, PhD

WSMA Reports, Volume 38, Issue 2 March/April 2020 (USPS #21920) is published bimonthly for \$100 per year by the Washington State Medical Association, 2001 Sixth Ave., Suite 2700, Seattle, WA 98121. Periodicals postage paid at Seattle, WA.

POSTMASTER: Send address changes to WSMA REPORTS, 2001 Sixth Ave., Suite 2700, Seattle, WA 98121.

To subscribe visit wsma.org.
© 2020 WSMA



Patient Care Depends Upon Partnerships

Even as early as the 1940s, educator and administrator Eugene A. Stead Jr., MD, had a vision. During his tenure as professor of medicine and chairman of the department of medicine at Duke University, he sought to meet the growing need for patient care by expanding the clinical decision-making skills of nurses. By 1965, his vision of a formal physician assistant program at Duke University was realized.

Having refined the idea for years, the program's launch came at a time when an expanding population demanded an expansion of access to care. By working closely with their supervising physicians, PAs became partners in optimizing medical practices and increasing access for patients.

Now, more than 50 years later, health care economics and the access mandate are more critical than ever, but the PA members of the WSMA, along with members of the Washington Academy of Physicians Assistants, point to emerging barriers to their employment. Linda Dale, PA-C notes (see article on page 12): "Washington state PAs reported that jobs were given to nurse practitioners because physicians were often hesitant to take on the liability and perceived extra work required to supervise a PA."

I have worked closely with PAs for my entire career, both in military and civilian practice, and I find PAs to be invaluable members of the health care team. Considering PAs are members of the WSMA, I wanted to more fully understand how physician/PA delegation agreements work and how the WSMA might advocate for change that benefits not only the health care team, but also our patients.

Your WSMA leadership—working closely with leaders from WAPA—spent many hours on listening tours with group practices, as well as individual clinicians and administrators, and reviewed WAPA membership survey data. We presented a report to WSMA's board of trustees and House of Delegates, which centered on modernizing the physician/PA delegation agreement. Our conclusions led us to support Senate Bill 6240 and House Bill 2378 during the 2020 state legislative session.

As introduced, these bills would modernize the PA practice by improving the flexibility of the delegation agreement between a PA and their supervising physician(s). This means moving the delegation agreement from the Washington Medical Commission to a local delegation agreement. The intent is to minimize the time it takes to get someone on board to start their work and to quickly respond to changes in local workflow demands or acute medical emergencies.

As I write this, both bills are making their way through the Legislature. Regardless of their fate, one thing is certain: For our partnership to thrive and evolve in the manner Dr. Stead envisioned, physicians and PAs will need to closely collaborate and build team practices that enhance workflow. It will also require physicians to step up and supervise PAs, so they can be employed and utilized to the full extent of their education, training, and experience.

It takes a lot of work, effort, and collaboration to make Washington state the best place to practice medicine and receive care. In the weeks and months to come, the WSMA will bring forward educational opportunities on the modernization of the PA practice. I hope you will take part, share your concerns, and offer your best solutions. The future of our profession—and patient care—will depend on it. ■

William K. Hirota, MD
WSMA President





HUDDLE

Touching base with need-to-know news for WSMA members

Member Profile

Tsering Lhewa, MD, FAAP

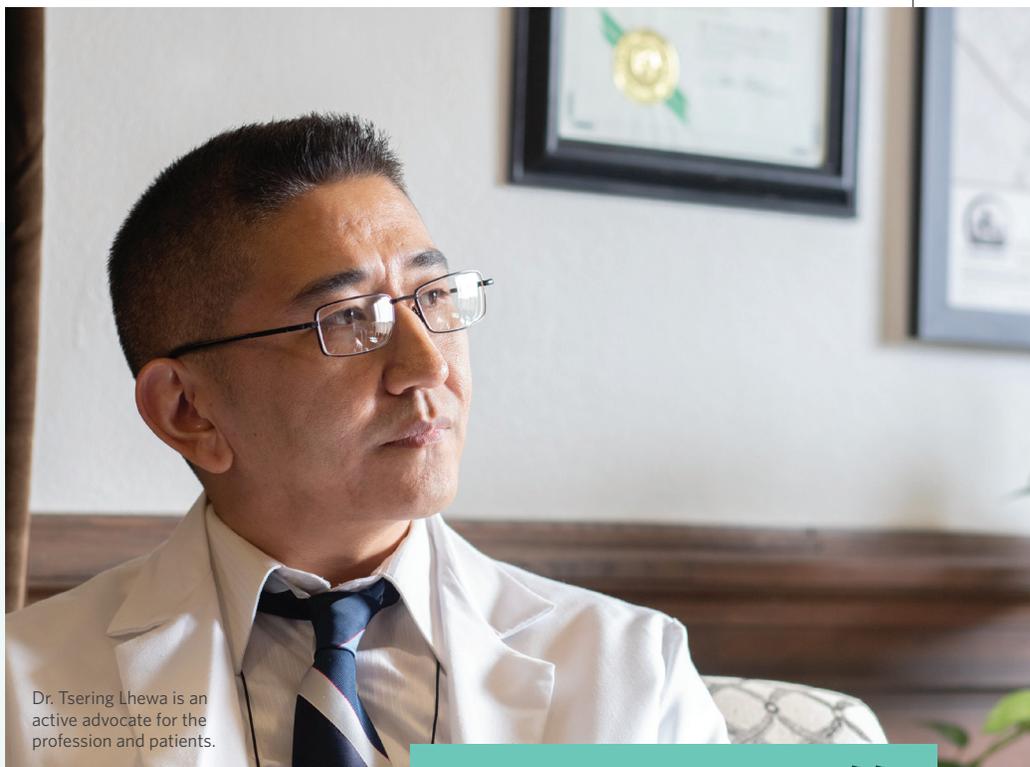
Works at: Child & Adolescent Clinic
in Vancouver

Specialty: Pediatrics

Why WSMA: The WSMA serves as a home for physicians from different specialties across our state to come together, learn from each other, and advocate for our patients and our profession. I have appreciated learning more effective leadership and management skills, quality improvement strategies, as well as some business savvy through the WSMA. I am chair of the Young Physician Section's governing council and enjoy partnering with young physicians, colleagues, state legislators, and other health care stakeholders on issues impacting the lives of Washington physicians and our patients.

Concerned about: Low Medicaid reimbursement that puts our most vulnerable patients at risk. Around half of all children in Washington state are insured by Medicaid and many have poor access to primary and preventive care. Many clinics have capped the number of Medicaid patients they see or stopped taking Medicaid patients, and some clinics have had to close due to lack of financial sustainability. Those children and families are left without a medical home, receive delayed care, and have more complications.

Proud moment: I appreciate being part of a team dedicated to serving all children in need. We serve more than 80% Medicaid patients at our two clinic locations and the lower reimbursement makes it financially challenging for us to serve an already



Dr. Tsering Lhewa is an active advocate for the profession and patients.

more medically and socially complex population. The resilience of the children and families we serve and our commitment to providing quality care when they need it most inspire me every day.

Best advice: As the social reformer John W. Gardner once said, "Life is full of golden opportunities carefully disguised as irresolvable problems." While being grateful for the gifts we have received, we can also appreciate the opportunities hidden inside every problem, as long as we can properly frame the situation and see its possibilities along with its constraints.

For fun: Traveling with my family (a recent highlight was a hike to Tiger's Nest Monastery in Bhutan), exploring state and national parks, going to the gym with my wife, watching Hindi movies, and listening to podcasts and music from different parts of the world.

“
The WSMA serves as a home for physicians from different specialties to come together, learn from each other, and advocate.”

Goals for 2020:

- Practice meditation and exercise on a more regular basis.
- Decrease my daily sugar consumption (I have a serious sweet tooth, and so do most of my clinic mates).
- Spend less time charting.

What others may not know about me:

English is my third language. I spent my early childhood in a Tibetan community in the Himalayan foothills of northern India before moving here to Washington state. I also speak Tibetan and Hindi. ▀



Members in the News



► **Mika Sinanan, MD, PhD**, of Brier has been elected as secretary of the American College of Surgeons Board of Governors. Dr. Sinanan, a surgeon at UW Medicine in Seattle, serves on WSMA's executive committee as 1st vice president.

► **Benjamin Starnes, MD**, of Mercer Island has been elected president of the Western Vascular Society for 2020. Dr. Starnes is a vascular surgeon at Harborview Medical Center in Seattle and Valley Medical Center in Renton and serves as chief of vascular surgery at UW Medicine in Seattle.



► **Erica Liebelt, MD**, of Seattle was awarded the American College of Medical Toxicology's 2020 Ellenhorn Award for her contributions to the field of toxicology. Dr. Liebelt is the executive/medical director for the Washington Poison Center and a clinical professor of

pediatrics and internal medicine at the University of Washington School of Medicine in Seattle.

► **Jeffrey Smith, MD**, of Tacoma received the Pierce County Medical Society's 2019 Community Service Award for his work at Community Health Care in Tacoma, where he is the chief medical officer and practices family medicine, obstetrics, and geriatrics.



► **Alex Mohit, MD**, has been appointed president of the Pierce County Medical Society for 2020. Dr. Mohit is a neurosurgeon specializing in complex spine surgery and practices at Harbor Spine and Joint Center in Gig Harbor. ▀



Letter to the Editors

Value-based care: A new label, an old concept

Articles in a recent edition of *WSMA Reports* on “value-based” health care left me with a mixed reaction. Lacking definitional clarity and consensus, can value-based care be constructively useful? This catchy term will ultimately rely on accurate data collection, statistically sound analysis, reporting standards, and validation (auditability). Close behind will be concerns about funding and process(es) of implementation.

To put it another way, can transparent, credible data management practices be implemented across all settings without alteration of what to date has remained largely hidden under the rubric of proprietary information?

While daunting, it seems hopeful that current initiatives of the WSMA can move the varied problematic aspects of the health care environment toward resolution, and with them the issues of “data quality.”

Perhaps it is not too far a reach to hope that “value-based” care as a new label—but not a new concept—can be a rallying point for leaders and members of all health care entities. It would appear, however, that a much-increased degree of collaboration among government agencies, commercial entities, and health care providers working individually and collectively is required—a goal that, for the most part, seems to be elusive.

In the needed exercise of stakeholder analysis, the ultimate stakeholders in—and beneficiaries of—these efforts must be patients. Hopefully, that is a statement on which we can all agree. —**Alfred S. Buck, MD, Lakewood**



What's on Your Mind?

Share your thoughts by writing to the editors at editors@wsma.org.

Hold the Date



MARCH 11 - National Patient Safety Awareness Week

MARCH 12 - End of regular legislative session

MARCH 16/20 - Match Week/Day

APRIL 13/16 - National Healthcare Decisions Week/Day

For a calendar of WSMA, state specialty, and county medical society events, visit wsma.org/calendar.



Healing Human Trafficking

Human trafficking is defined as the use of force, fraud, or coercion to compel a person into any form of work against their will. Like other forms of violence, trafficking is associated with physical and psychological harm, and is best understood—by victims and health care professionals alike—as a very serious health risk.

With its many ports of entry, an international border, and demand for both labor and sex workers, Washington is considered a high-risk state for trafficking. Many Washington physicians and providers, particularly those providing primary or emergency care services, may have had contact with trafficking victims without realizing it. These instances represent an opportunity for health care professionals to identify victims—and to intervene.

The following resources, easily found with a quick online search, can help you and your care teams identify trafficking

victims and respond appropriately in your care setting, find local resources available to victims, and stay up to date on the state response to human trafficking.

SOAR to Health and Wellness Training

The U.S. Department of Health & Human Services' SOAR training equips health professionals with skills to identify, treat, and respond appropriately to human trafficking.

i:CARE Health Care Provider's Guide

A resource designed to improve identification



and response to victims of sex trafficking within various health care settings.

watraffickinghelp.org

The Washington Trafficking Help website provides a centralized hub for services available to human trafficking victims.

The Washington State Clearinghouse on Human Trafficking

Washington State Department of Commerce Office of Crime Victims Advocacy maintains a human trafficking information portal, with information on statewide task force reports, a comprehensive resource directory for trafficking victims, and more.

If you suspect a case of human trafficking, either sex or labor, call the National Human Trafficking Hotline at 888.373.7888. If someone is in immediate danger, call 911. ▀

Practice News

The Washington State Health Care Authority has completed its multi-year effort to integrate physical and mental health and substance use disorder treatment services into one system for Washington's 2 million Apple Health (Medicaid) patients. The final three (of nine) regions integrating are Thurston-Mason, Great Rivers, and Salish.

For 2020's top areas of focus for your practice, review MGMA's "Medical Practice Leader's Guide to 2020" at bit.ly/2NeI3OQ.

Comagine Health (formerly Qualis Health), can provide free technical assistance to practices wishing to integrate the state's prescription monitoring program into their EHR system. Email WAPMP@comagine.org to get started.

The deadline for MIPS-eligible clinicians to submit their 2019 performance data is 5 p.m. PDT, March 31. If you're unsure of your eligibility, use the Medicare Quality Payment Program lookup tool at bit.ly/36Ijplg.

Prepare now to earn a positive payment adjustment in 2022 for your 2020 performance. Use the QPP lookup tool at bit.ly/36Ijplg to check on your initial 2020 MIPS eligibility.

For calendar year 2020, the application fee is \$595 for institutional physicians and providers who are initially

enrolling in Medicare, Medicaid, or the Children's Health Insurance Program; revalidating their Medicare, Medicaid, or CHIP enrollment; or adding a new Medicare practice location. More at go.cms.gov/37VunPo.

TRICARE now covers annual 3D mammography screenings through its provisional coverage program. Because this is a provisional benefit, prior authorization is required regardless of TRICARE plan type.

Use the new National Center for Health Statistics ICD-10-CM Browser Tool to search for ICD-10-CM codes, understand how to use the codes, and access multiple fiscal year version sets with comprehensive results. Find the tool at icd10cmtool.cdc.gov.

The AMA advises practices to prepare now for major changes to Medicare outpatient payments coming in 2021. Begin your practice's transition here: bit.ly/2CJXzLV.

The American Board of Internal Medicine anticipates launching a longitudinal assessment option for its maintenance of certification program in 2022. Learn more at bit.ly/2QE0o74.

The Washington State Medical Group Management Association's annual conference is April 26-28 in Stevenson, Wash. Register online at bit.ly/2UyWxMZ.

For more practice support and news, visit wsma.org. ▀



Vintage WSMA

The year was 1971, when then Gov. Dan Evans picked up his gubernatorial pen and signed enabling legislation that would allow trained physician assistants to practice medicine. Senate Bill 182 specified “each physician’s (sic) assistant shall practice medicine under the supervision and control of a physician licensed in this state, but supervision and control shall not be construed to necessarily require the personal presence of the supervising physician at a place where services are rendered.” Physician leaders within the WSMA provided crucial support of the legislation, eloquently and convincingly arguing for its necessity within and outside of the Legislature. Today, PAs are members of the WSMA along with physicians. In addition, they are now not only practicing in the United States, but also around the globe in Europe, Australia, New Zealand, and some countries in Africa. ▀

LEFT: Gov. Dan Evans signs Senate Bill 182. MEDEX Founder Richard Smith, MD, stands to the governor’s right.



National Healthcare Decisions Day is April 16

The WSMA is joining other national, state, and community organizations to help bring attention to National Healthcare Decisions Day on April 16.

The fact remains that only a small minority of Americans have documented their wishes for care in the event of a medical crisis. The WSMA and its clinical education arm, the WSMA Foundation for Health Care Improvement, are working year-round to change this through community outreach, clinical training, and patient resources designed to help physicians and patients have important conversations about care at the end of life.

Make the most of this National Healthcare Decisions Day by making sure you and your care teams are up to date with all that the WSMA has to offer for your advance care planning and end-of-life care efforts.

Honoring Choices® Pacific Northwest – Jointly sponsored by the WSMA Foundation and the Washington State Hospital Association, HCPNW offers an advance care planning program, community engagement initiatives, physician and advanced practitioner education, advocacy, and more.

“Who Will Decide If You Can’t?” – WSMA’s popular advance directive patient brochure contains both the health care directive and durable power of attorney for health care.

POLST – Intended for individuals with serious illness, the Physician Orders for Life-Sustaining Treatment form represents a way of translating an individual’s wishes—often expressed in their advance directives—into actual medical orders.

Join the WSMA and thousands of other health organizations this April 16 as we help raise awareness about the importance of advance care planning. Visit wsma.org for more information on these resources and more. ▀



Here’s to You on Doctors’ Day

We’re grateful every day for all you do, but it’s nice to have a day dedicated to saying thanks. This March 30, the WSMA thanks you for standing on the front lines of care in our communities. We are all patients and have personally experienced your dedication to serving the suffering, easing our pain, and making us whole. When the hours are long and you grow weary, we hope you will remember that we are grateful for your healing hands, your caring hearts, and your unwavering dedication. (And to our physician assistant members, mark your calendars for #PAweek, Oct. 6-12.) ▀ —THE EDITORS

Docs Making a Difference

Hope Wechkin, MD



Driving practitioner discussions around life-prolonging measures.

Groundbreaking. Thought-provoking. Insightful. These were the words most frequently used by attendees when asked to describe the two-day conference *At the End of Life: Agency, Role, and Responsibilities of the Physician/Advanced Practitioner*. A continuing education event for health professionals, the conference featured complex case presentations from multidisciplinary teams of clinician experts, and engaging, sometimes emotionally frank discussions with, and among, the clinicians in the standing-room-only audience.

While the September conference at the University of Washington required the efforts of many—including the WSMA—to pull off, the idea for it came from one person: Hope Wechkin, MD, the medical director of EvergreenHealth’s hospice and palliative care programs and a member of the steering committee of the Washington End-of-Life Coalition (sponsored by the WSMA Foundation). *WSMA Reports* sat down with Dr. Wechkin to discuss the event, why she felt it was needed, and why she thinks it struck a chord among so many.

WSMA Reports: What was the genesis for the event?

Dr. Wechkin: Two things have been growing in prominence in end-of-life care in recent years. Machines are keeping people alive longer, and patients and their families are requesting more control in determining their courses at the end of life. Physicians and advanced practitioners often find themselves navigating competing demands: First, to do no harm; and second, to respect patient autonomy. This inherent tension—which

has clinical, ethical, and legal dimensions, but which also raises psychological, sociocultural, and spiritual questions—is often navigated by medical providers in isolation. We wanted to illuminate these issues, to try to understand them better, and to decrease the isolation that many of us feel when confronting these matters.

Why do you think the event struck a chord with so many?

This conference focused on the experience of the medical provider in these complex situations. Of course, the patient and family experience are critically important. But there’s also a need among physicians, advanced practitioners, and many others on the front lines of health care to consider these issues—from stopping machines to prescribing lethal doses of medication—from the perspective of the health care provider who has agency and certain responsibilities. The case-based structure also helped us to focus on the stories that are at the heart of what we do. There are no right answers in many of these situations, but there’s definitely a need for the stories to be told and heard.

The event was designed to appeal across specialties. Why is that important?

A lot of energy is appropriately devoted

within specialty groups to defining when and how life-prolonging measures are implemented. For example, there are consensus guidelines regarding the initiation of cardiac devices, dialysis, chemotherapies, ventilator support, and so on. But there’s been less focus on developing consensus regarding how and when such measures should be discontinued when they’re no longer desired or indicated. There’s also been less discussion about how the eventual discontinuation of many of these life-prolonging measures might influence informed consent. Until these issues are addressed in both primary and specialty care, patients, families, and health care providers will continue to feel isolated and even blindsided when confronted with the reality that none of these life-prolonging measures are effective indefinitely.

What was one takeaway for you personally from the event?

Many physicians/advanced practitioners feel isolated when confronting these questions on their own. We’re hungry for the chance to discuss these issues with our colleagues, and discussion of these complex cases actually works to build community among us. ▀

—GRAHAM SHORT



SEBASTIEN GABRIEL ON UNSPLASH



Partnering to Solve the Health Care Puzzle

Patients benefit when physicians and physician assistants collaborate. BY RITA COLORITO

Residents of rural Grays Harbor County know what it means to wait for health care. The coastal southwestern Washington community has one primary care physician for every 2,980 residents, compared to the statewide ratio of one physician for every 1,220 residents, according to a 2019 analysis by the Robert Wood Johnson Foundation. Lack of access, among other factors, has taken its toll: The county ranks 36th of out 39 for overall health outcomes.

Working in an environment that's chronically underserved requires a collaborative approach to health care, says Ken Dietrich, MD, chief medical officer for Summit Pacific Medical Center in Elma. That's where physician assistants come in. These practitioners are nationally certified and licensed

to prescribe medication and practice medicine in inpatient and outpatient settings in all 50 states and the District of Columbia.

Improving access to care

To improve patient access to care, Summit takes a team-based approach,



using non-physician practitioners such as physician assistants as primary care providers, or PCPs. Over the last decade, Summit has focused on recruiting PAs to fill the PCP gap. The use of these skilled and flexible practitioners, says Dr. Dietrich, is something medical centers and physician practices should consider.

“We tell patients we have all these PCPs; does it matter who they see?”

Quoted



Ken Dietrich, MD



Eileen Ravella, PA-C



Leah Yoke, PA-C, MCHS



Jeanne Poole, MD

“Often times, they say, ‘I just want to get in as soon as I can,’ so that’s really created an opportunity for us,” he says.

Two kinds of patients need access to care, says Dr. Dietrich: those who don’t have a primary care physician and those who do, but can’t get in to see them. To accommodate in-paneled patients, a PA runs Summit’s same-day clinic, serving as a conduit between the patient and their physician.

“Patients can get in when they need to and the PA communicates collaboratively with that patient’s physician, if necessary,” says Dr. Dietrich.

For rural communities such as Elma, PAs have proven to be an essential piece of the health care puzzle. They’re also invaluable in urgent care, where reducing wait times is paramount regardless of geographic location, says Eileen Ravella, a PA-C with 36 years’ experience who works in urgent care for Kaiser Permanente in Olympia.

“The flexibility of PAs helps with patient care and throughput,” says Ravella, who also serves as the president of the Washington Academy of Physician Assistants. “I’m seeing all levels of acuity I’m comfortable with. I may see a complicated patient and work with physicians to get the patient

admitted, do all the evaluations, and order tests. Or I may see the lesser acuity patients and the physicians may see the extremely complicated patients to help patient flow.”

What collaboration looks like

Physicians who work with PAs say they help practices see more patients and provide continuity of care. Collaboration is at the core of the PAs role in health care.

“The collaboration looks different depending on the context, the geographic location, and the complexity of the patient,” says Leah Yoke, PA-C, MCHS, who holds a joint appointment at the Seattle Cancer Care Alliance (SCCA) and Fred Hutchinson Cancer Research Center.

Yoke, who specializes in internal medicine and infectious disease, works in inpatient and outpatient settings in concert with oncologists and hematologists to diagnose, prevent, and treat infections in patients with cancer.

Cancer care centers also face a shortage of infectious disease physicians. Here, too, PAs can fill the gap, says Yoke, who promotes PA usage to cancer centers nationwide in her member ambassador role with the Infectious Diseases Society of America. For cancer patients, who often face a

“We’re not here to replace physicians. We can’t replace you. We are dependent practitioners.” —EILEEN RAVELLA, PA-C

cascade of treatments and a dizzying number of specialists, PAs provide a familiar presence, says Yoke, as they are often the only provider who sees them across multiple treatments and teams.

“Typically, we’re seeing really complex patients that have multiple comorbidities,” says Yoke. “Because we don’t have a ton of ID physicians, I’m able to see all the patients and help teams make decisions in a timely manner and provide some of that logistical legwork that we wouldn’t otherwise be able to do.”

“For the transplant service in particular, they’re really a major piece of how cancer patients are cared for,” says Steve Pergam, MD, MPH, an infectious disease faculty member and medical director of infection prevention at SCCA.

“We see patients together. We review cases together. But I think they’ve really allowed us to see more patients in our practice,” says Dr. Pergam. “Because they’re consistently on service whereas as doctors we’re coming on and off service all the time, they have the ability to provide additional context and continuity for patient care.”

At the top of everyone’s profession

PAs also allow physicians and other PCPs to work at the top of their license to focus their energies on their most complex cases.

“In academic environments where we’re often doing lots of things—research, teaching, and other responsibilities beyond just direct patient care—they are critical to our service. They communicate with teams directly and we often do a lot of shared decision-making, specifically for our complex patients,” says Dr. Pergam, an associate professor in the division of allergy and infectious diseases at the University of Washington School of Medicine in Seattle.

PAs practice in nearly every area of medicine, with approximately 50% providing primary care services. The next largest proportion, some 23%, focus on surgery or surgical subspecialties.

“The physician assistants I’ve been most familiar with definitely assist the entire team in being able to be more efficient in what we do,” says Jeanne Poole, MD, a professor of medicine in the division of cardiology at UWSOM.

PAs can do a fair amount of high-level work alongside surgeons and proceduralists, says Dr. Poole. “We train them to be able to specialize and do portions of procedures, like sutures and getting access to venous systems.”

Lyle Larson, PA-C, PhD, entered the field of cardiac electrophysiology in 1986 when it was a new subspecialty at the UW Medical Center in Seattle. Along with Dr. Poole, who was a new attending physician at the time, Larson helped build the practice into what it is today. In 2018, the two also co-edited the textbook “Surgical Implantation of Cardiac Rhythm Devices.”

“It has been a positive, collaborative experience,” says Larson. Because of his deep experience, Larson helps to teach electrophysiology fellows how to do the surgical aspects of pacemaker and defibrillator implantation. “When there are particularly difficult cases, the electrophysiologists expect and ask for me to be on their cases to assist them,” he says.

Dr. Poole says highly experienced PAs such as Larson are integral to the cardiac electrophysiology practice. In the operating room, a PA’s experience with complicated procedures, such as carefully implanting or removing cardiac rhythm devices and leads, makes the entire procedure safer, she says. “It’s also an educational opportunity for young physicians who may not have had that same degree of experience.”

The question of oversight

Despite the many positives, Ravella says PAs aren’t being used to their fullest potential as a result of ongoing misconceptions.

“We’re coming up against physicians who have real concerns about the perceived competition between

physicians and PAs, and there is none. We can’t practice without them. They are our team,” says Ravella. “We’re not here to replace physicians. We can’t replace you. We are dependent practitioners.”

Larson echoes that sentiment: “I’m certainly qualified to do procedures on my own, but that does not make me a surgeon. That does not make me an electrophysiologist. That makes me a very, very skilled PA who can function as a right-hand man for the physicians to take care of their patients.”

Another barrier to utilization: the idea that PAs require direct supervision. In reality, PAs need minimal supervision, says Ravella.

At Summit, physicians are available if a PA has a question or concern, but they don’t have to be there physically to provide oversight, says Dr. Dietrich. “Because we have such an integrative model, on a day-to-day basis, our PCPs are touching base with one another, connecting with patients, so there’s a lot of collaborative care.”

“Certainly, you don’t have to have a physician right next to a physician assistant if they are working within the scope of their training,” says Dr. Poole. “For procedures, that’s different because you are really working as a team—multiple hands trying to accomplish a certain procedure.”

PAs can and do serve as resources for others in the medical community. Larson and Yoke both work as teaching associates at the UW Medical Center. Dr. Dietrich says experienced PAs at Summit often serve as mentors for new doctors.

“Our PAs are highly expert, spending all of their time dealing with high-risk, immunocompromised patients,” says Dr. Pergam. “Because they are so knowledgeable, they can be a great first resource for the teams to ask questions directly. And then the PA will come to us with the more complex questions.”

Investing in the future

The approach to using PAs to their fullest credentialed potential needs to

WSMA and WAPA Collaboration Continues to Be Strong

BY LINDA M. DALE, PA-C, DHED

The relationship between the WSMA and Washington Academy of Physician Assistants has always been strong. In 1971, the WSMA offered crucial support to help pass legislation that allowed physician assistants to practice in Washington state. The WSMA invited PAs to join as members in 1982 (WSMA now has more than 700 PA members) and supported the addition of a PA to the Medical Quality Assurance Commission (now the Washington Medical Commission) in 1991. And today, WAPA and WSMA are working to modernize the PA practice laws in Washington state via legislation introduced during the 2020 state legislative session (for updates on this legislation, visit wsma.org).

Collaboration on these changes began nearly three years ago when our organizations formed a work group to investigate how to support PAs in providing health care. The work group consisted of WSMA leadership, William Hirota, MD, and Mika Sinanan, MD, as well as WAPA

leadership, PAs Lynn Storm, Eileen Ravella, Lyle Larson, Constance Daruthayan, and myself. The group's priority was to maintain the existing strong physician/PA relationship and the common goal of providing safe, effective, and timely patient care.

The work group discussed barriers many PAs face in finding jobs and providing health care. Washington state PAs reported that jobs were given to nurse practitioners because physicians were often hesitant to take on the liability and perceived extra work required to supervise a PA. The delegation

agreement required for PAs to work with a physician must be approved by the Washington Medical Commission, a burdensome and sometimes lengthy process that can take months to clear, delaying PAs from beginning their clinical position. Differing rules between PAs working with DOs and MDs can also cause confusion when the PA is working in a group setting. Updating these requirements, as well as removing restrictive rules for those PAs working in rural areas, are a priority for both of our organizations.

Getting to this point took three years of discussion, ne-

gotiation, and collaboration between two great organizations that have the health and welfare of the people of Washington state in mind. These organizations recognize that PAs have been valuable members of the health care team for nearly 50 years and agree that barriers must be removed so they can continue to provide health care for years to come. ▀

Linda M. Dale is the legislative and health policy chair of the Washington Academy of Physician Assistants as well as the WAPA representative to the WSMA advocacy council and the WSMA board of trustees.

be well thought out, says Dr. Dietrich. Summit has a flat hierarchical structure. All team members go through initial onboarding and an external yearly peer review. This makes for a more effective, integrative, and collaborative approach to care, he says.

Summit typically hires experienced PAs, but about three years ago, it began adding PAs directly out of training. For these PAs, Summit provides a year-long residency-style program. While there's a lot of initial oversight, as these PAs gain experience and confidence, they are given more responsibility and

eventually obtain their own panel of patients to manage.

"By investing in their training, you're investing in a resource who is hopefully going to stay with you," says Dr. Dietrich. "Can they see all complexity of patients? No. But they can see 75% of patients."

The investment has paid off. About 25% of Summit's PCPs are PAs. If a patient develops a complex diagnosis while under a PA's care, the PA consults with physicians or other PCPs, but they would continue to manage that patient's care, says Dr. Dietrich. "It's the right care by the right person at the right time."

It comes down to the breadth of skills PAs bring to a team, says Dr. Poole. "PAs are very well-educated individuals. Many have had some sort of prior experience, such as medic experience in the military, so their training is solid," she says. In her work, PAs have proven highly valuable members of the team. "They should be sought after and included as part of the allied professional team for anyone considering expanding their practice in that manner." ▀

Rita Colorito is a freelance journalist who specializes in writing about health care.



YOU'RE INVITED!



2020 WSMA Leadership Development Conference

May 15-16

Campbell's Lake Chelan Resort & Conference Center

Visit wsma.org/LDC to find out more and to register.

This event is one of the most popular WSMA gatherings, combining top-quality programming and speakers amid a spectacular resort setting. Don't miss this opportunity to invest in yourself, build skills in quality improvement and leadership, and be energized during this family-friendly event on the shores of Lake Chelan.



"No matter what your 'official' role or where you are in your career journey, this leadership conference is for you."

**William K. Hirota, MD
WSMA President**

Training to Address the Region's Unmet Health Care Needs

Washington's PA education focuses on providing team-based medicine to rural, underserved populations.

BY PAT CURRY



In 1968, 14 former medics or corpsmen enrolled in a new program jointly sponsored by the WSMA and the University of Washington School of Medicine and funded by the National Center for Health Services Research. The 18-month program, called the MEDEX Demonstration Project, would allow them to continue the training they had gained in the military and use it to begin careers in civilian health care as physician assistants.

The program, only the second of its kind in the nation, was created by Richard A. Smith, MD, to address a shortage of qualified medical professionals. By the time MEDEX Northwest celebrated the 50th anniversary of that first graduating

class in 2019, the program had graduated more than 2,600 physician assistants.

Over the years, the program expanded beyond accepting former military medics—it now accepts applicants with health care experience,

Quoted



*Terry Scott, PA-C,
MPA, DFAAPA*



*Tim Evans, MD,
PhD, FACP*



*Linda Dale, PA-C,
DHEd*



Joseph DiMeo, DO

including nurses, EMTs, Alaska community health aides, medical assistants, and athletic trainers. The original class of 14 is now 140 students training in four locations in Seattle, Spokane, Tacoma, and Anchorage, with a fifth location in Hawaii in the works.

Central to the mission at MEDEX Northwest is a commitment to educating “experienced health personnel from diverse backgrounds to practice medicine with physician supervision.”

“As one of the original programs in the country, our program was established on people with prior health care experience,” says Terry Scott, PA-C, MPA, DFAAPA, program director of MEDEX Northwest. “We still think that matters. When you walk into medicine after just two years of study, you need some experience with the health care field.”

A graduate of MEDEX, Scott trained and worked in both rural and urban communities in Washington, worked in HIV vaccine research, and provided primary care to HIV-positive patients. He joined the MEDEX faculty in 1996 and maintains a practice at the University of Washington Family Practice Residency in Seattle.

The PA program also has gotten longer; it is now a master’s degree with 27 months of training and a capstone project. The first year consists of didactic training, followed by a four-month family practice preceptorship and then six one-month clerkships in behavioral medicine, emergency medicine, surgery, inpatient, and underserved populations; and one elective. During that time, the students also work on an in-depth, clinically relevant capstone project.

“There’s been a maturing of the profession,” Scott says. “The complexity of the profession requires the education be extensive and exhaustive.”

Keeping the vision alive and moving forward

Senior Medical Director Tim Evans, MD, PhD, FACP, is one of the MEDEX faculty the students see in the classroom in their first year of training. Dr. Evans gives 250-300 hours of lectures a year; he says he has immense admiration for their commitment to medicine.

“Our students, year after year after year, are really terrific,” Dr. Evans says.

“They’re smart, they’re hardworking, they’re here for a reason. ... They’re making some very serious sacrifices. You have to honor that, and I do.”

With the MEDEX program residing in UW’s department of family medicine, the training PAs receive complements that of physicians in the same way PAs complement physicians in clinical practice.

“Medicine is a team sport,” Scott says. “You need to teach everyone how to get the highest level from their training. We want all of us out there making a difference in the lives of our patients, delivering care to the public.”

While much has changed over the last half century, Scott notes that one thing has stayed the same: the program remains committed to diversity and inclusion, equity and justice.

“We want to provide training and education to meet the nation’s health care needs,” he says. “That’s from Dr. Richard Smith. He had an idea of what he

second PA training program, currently is training its fifth class of PAs. Program Director Linda Dale, PA-C, DHEd, has been a PA since 1996 and taught for 10 years at MEDEX.

The mission of Heritage University’s program is to put its students in primary care in rural, underserved areas.

“We are in Toppenish,” she says. “We’re in the middle of the hop fields; we are a Hispanic-serving institution. I was born and raised in this area; it’s always been medically underserved. Most Washington counties are. Even in King County and Spokane County, there are pockets that are underserved. Our mission is to increase access to health care for those populations.”

“That’s an intense need,” says Medical Director Joseph DiMeo, DO. “I’m also a clinician in town. The deficits in patient access to care are acute.”

The school has “done pretty well so far” in addressing that mission, Dale

“Medicine is a team sport. You need to teach everyone how to get the highest level from their training. We want all of us out there making a difference in the lives of our patients, delivering care to the public.” —TERRY SCOTT, PA-C, MPA, DFAAPA

wanted this program to be; those values have remained. It’s in our DNA. We are the current caretakers of that vision.”

The message Scott would share with WSMA members is that MEDEX is a well-established program and that PAs are not technicians.

“We are health care providers trained to deliver high-quality health care in collaboration with physicians,” he says. “What doesn’t change is a team-based approach to medicine. We are still here determined to deliver high-quality health to the region and the country.”

A mission of rural service

Heritage University, Washington state’s

says. The national average for PAs working in rural areas is 12.5%; Heritage has 24% of its grads working in rural areas, she says. Nationally, 26.7% of PAs work in primary care; for Heritage grads, it’s 46%.

The focus of Heritage University’s training is primary care. It complements the training of physician students by following the medical model for training. On a weekly basis, students attend class with DO students at Pacific Northwest University.

“We are side-by-side with DO students doing case discussions and workshops where they’ll do sutures, splinting, casting,” she says. “It’s an

interprofessional education, not only with DO students but nursing, pharmD, and paramedic students, for some of our clinical case discussions.”

Heritage teaches in systems modules, such as the cardiovascular system. A module covers anatomy and physiology, how to do an exam, what it looks like in a child, an adult, an elderly patient, chronic conditions and how that presents in the ER, Dale says.

“In that same model, we’ll teach how to treat it, including pharmacology and lifestyle,” she says. “When complete, we test on it. Once that’s tested, we moved to the next system.”

The biggest difference from MEDEX’s curriculum comes in the clinical year, Dale says. Heritage places students in a clinical site for a full year, working there two days a week. For the rest of the week, they do their specialties—surgery, pediatrics, obstetrics and gynecology, inpatient, emergency medicine, and mental health—switching about every six weeks. Sites are primarily in Washington, Idaho, Montana, and Alaska.

“The beauty of that is that when they learn something in their specialty, they’ll bring it back to primary care,” she says. “It gives them a great handle on it and takes the fear away from having to know everything as a primary care provider. I think that is why we have



MEDEX Northwest students Ryan Nolan, Landya Alexandria, Melissa Mateo, and Phoebe Bryson-Cahn at the National Library of Medicine exhibit: "Physician Assistants: Collaboration & Care."

That focus is being coupled with more and more simulation, Dr. DiMeo says. The result is that students get a greater experience of hands-on integration with medical

“The impact on those patients’ lives is difficult to measure, but relieving the pressure on the other clinicians in the area cuts down on their stress and ultimately keeps them practicing in those areas longer,” she says.

To help address the workforce challenges physicians are facing, Heritage University works to get students ready to see patients as soon as they finish their clinical rotation, Dr. DiMeo says. “They’re not a draw against the number of patients the [physician] has to see in a day.”

“Over the course of their training and then when they go into clinical practice, their education needs to continue,” he says. “They need to fit into the practice; there needs to be a comfort level between what the PA thinks they can handle and what the physician thinks they can handle, communicating on a daily basis about any complicated things. That’s less and less over time.

... Even at times a physician will be challenged and call for a consult. That is the way medicine is practiced.”

Pat Curry is senior editor of WSMA Reports.

“[Physician assistants] relieving the pressure on other clinicians in the area cuts down on their stress and ultimately keeps them practicing in [underserved] areas longer.” —LINDA DALE, PA-C, DHED

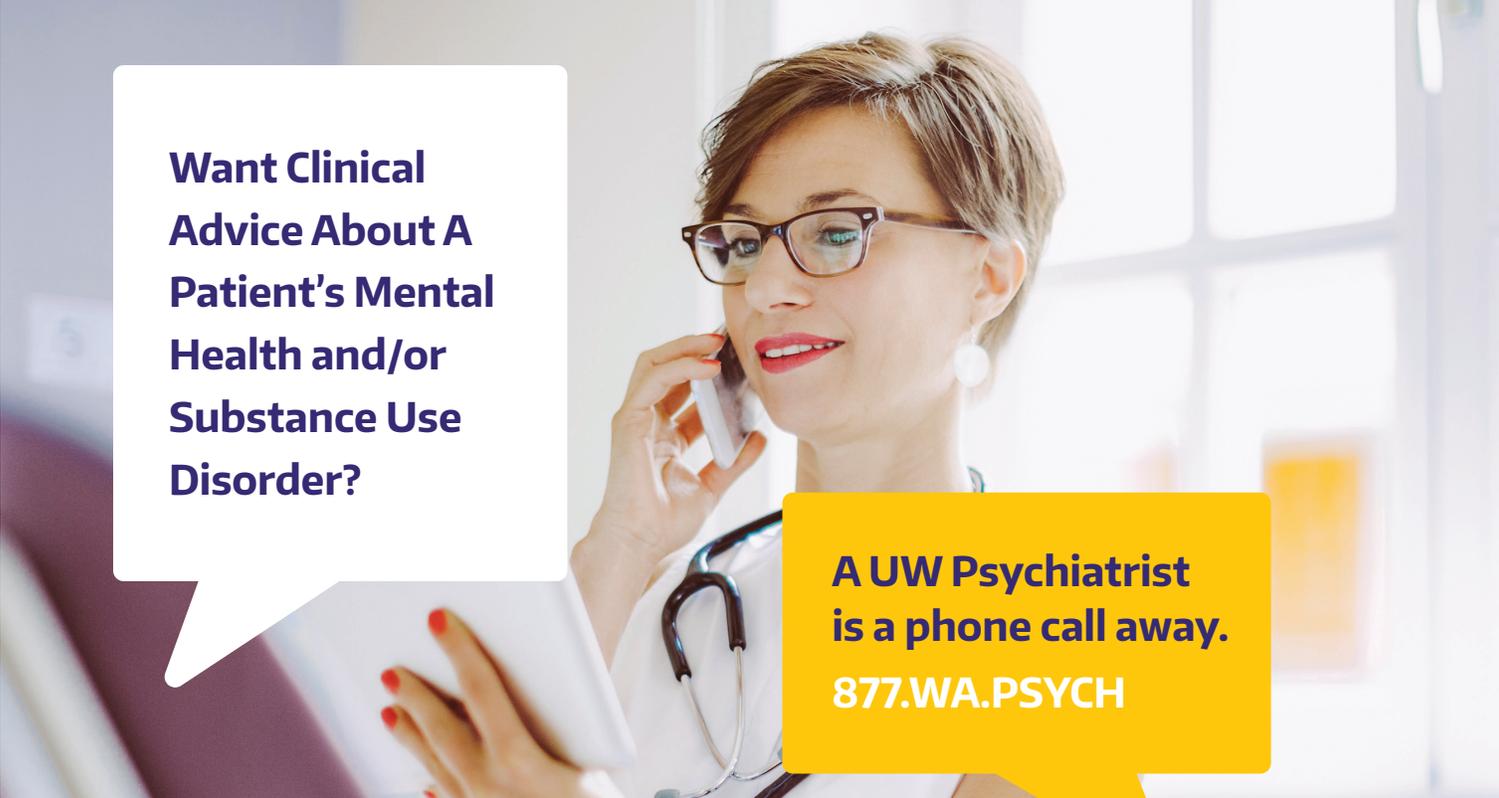
46% of our students in primary care; they’ve been in it for a full year.

“This training is what a family practice physician used to do in the old days,” she says. “Now with changes in their training, we’re seeing more and more physicians go to specialties. We’re trying to go back to the family medicine model. Sometimes, the old ways might be better.”

decision-making “so they can handle more difficult things in a safe environment before they go into clinical practice.”

Evidence of impact

Even with just four graduating classes under its belt, Heritage University already is seeing its efforts rewarded with increased access to health care in underserved areas.



**Want Clinical
Advice About A
Patient's Mental
Health and/or
Substance Use
Disorder?**

**A UW Psychiatrist
is a phone call away.
877.WA.PSYCH**

**The UW Psychiatry Consultation Line (PCL) provides
free, fast, on-demand consultations connecting
prescribing providers to psychiatrists at the
University of Washington.**



Callers receive

- Access to experienced psychiatrists versed in numerous clinical challenges
- Expert advice on assessment, diagnosis and treatment planning
- Consultation tailored to their unique setting of care
- Follow-up written recommendations

Available to prescribing providers from

- Primary care clinics
- Community hospitals
- Emergency departments
- Substance use treatment programs
- County and municipal correctional facilities

877.WA.PSYCH

(877-927-7924)

8 AM-5 PM weekdays

24/7 coverage begins July 1, 2020

→ **Learn more**

uwpsychiatry.org/pcl

PCLWA@UW.EDU

The UW Psychiatry Consultation Line is funded by the State of Washington.



Adding an Advanced Practice Provider to Your Practice

What you need to know.
FROM PHYSICIANS INSURANCE

There are numerous compliance considerations that accompany advanced practice provider employment, such as payer credentialing, billing, scope of practice, and physician supervision. Start off on the right course by establishing a compliant structure within which to onboard these professionals.

Contracting and credentialing

Some, but not all, payers have special requirements for enrolling and contracting with APPs. As part of your initial considerations, it is important to know what to review in order to understand any requirements to which you may be bound.

- Review current payer contracts, provider manuals, and bulletins for APP provisions. Contact your payers to inquire about their credentialing and contracting of APPs. Document the name of the person you spoke with, the date, and what was conveyed. Review hospital policies on utilization and credentialing limitations.
- Research relevant state scope-of-practice and licensure requirements; similarly to physician state licensure, payers expect you to follow state requirements.
- Note that some payers, such as many Medicaid payers, do not allow APPs to bill under a physician's provider number when performing independent services—the payer expects the practice to bill services under the APP.
- Credential APPs with payers that require credentialing; evaluate whether you should credential with payers where credentialing is optional, based on your ability to meet supervision, coverage, and clinical practice requirements combined with financial considerations. The best practice is to credential APPs with all payers allowing credentialing.

Scope of practice and licensure

States frequently oversee specific licensure and scope-of-practice requirements for physician assistants and nurse practitioners and they differ from state to state.

- Review the didactic and clinical training of both NPs and PAs to determine which is more in line with your needs and clinical philosophy. Different types of APPs have varying supervisory requirements, prescriptive authority, and rules for written protocols.
- Requirements for levels of autonomy and scope of practice vary, including physician supervision requirements (e.g., physical proximity and documentation review requirements). For more information on the requirements in Washington, visit the Physicians Insurance website at phyins.com/WA-APPresources, in addition to the Washington State Scope of Practice Policy at scopeofpracticepolicy.org/states/wa/ for more resources.
- Understand and operationalize any documentation requirements necessary to meet scope-of-practice and licensure regulations.

- Understand physician supervision requirements and evaluate how they will be met from an operational perspective.
- Draft and execute required collaborative agreements that govern the supervisory relationship.
- Provide documentation and coding training to new providers (new to medicine, and new to the practice/specialty). Oversight intensity may lessen as the clinical relationship matures and the physician grows comfortable with the APP's clinical approach, bedside manner, documentation adherence, etc.
- Communicate and provide clinical mentorship to develop the APP to become a strong provider. ■

Lori Foley, Valerie Rock, and Allison Wilson of PYA Consulting contributed to this article. A partner of Physicians Insurance, PYA Consulting is a professional services firm providing practice management consulting and other services to the health care industry.

Physician oversight

Physicians utilize APPs in different ways, in light of various goals and perspectives. State rules for PAs and NPs may influence your decision for the type of APP to select.

To read more about best practices for the use of APPs and payer billing guidelines, visit phyins.com/APPguidance.

CONCERNED ABOUT DISABILITY INSURANCE BENEFITS?

Don't go it alone!

An attorney's involvement can make all the difference

For years, I have advised medical professionals about long term disability insurance benefits.

Contact me to learn your options and plan accordingly.

All inquiries are confidential. *Phone appointments available.*



Deborah M. Nelson, Esq.

- Past President, Washington State Association for Justice
- Past Chair, Insurance Law Section, American Association for Justice
- Washington Super Lawyer since 2003



NELSON BOYD
ATTORNEYS

411 University St. • Suite 1200 • Seattle, WA 98101
(206) 971-7601 • nelsonboydlaw.com

Email me at: nelson@nelsonboydlaw.com



BY THE NUMBERS

Our Demographic Destiny

Washington state and the country as a whole are facing a growing mismatch between community health needs and physician supply. The demand is driven largely by demographics—in short, there will be more people, and more of them will be older.

Many doctors in Washington are already overburdened by heavy caseloads; without some relief in the form of additional physicians, burnout will only grow. More importantly, patient care across the state will suffer, particularly in rural areas. Even with new ways of delivering care, the shortage will be real and significant.

Bottom line? Maintaining the status quo is no longer an option.

55,200

Projected shortage of primary care physicians nationwide by 2032

46,900-121,900

The range of which demand for physicians will exceed supply nationwide by 2032

23,400

Projected shortage of physicians in surgical specialties nationwide by 2032

+1.8 million

Growth of Washington state population by 2040

20%

Percentage of Washingtonians age 65 or older by 2030 (compared with 1 in 7 today)

↑ Residencies
↓ Student debt

Add more physicians to the pipeline by increasing funding for residencies and health professional student loan repayment.

↑ Primary care \$

Strengthen our frontline physician workforce through increased investments in primary care, including increasing Medicaid reimbursement to Medicare levels.

↓ Administrative burden

Support a healthy practice environment for all physicians through administrative simplification.

For more, see the WSMA's 2019 workforce report at wsma.org.

Sources: Association of American Medical Colleges; Washington State Health Assessment



A Virtuous Cycle

Adding physician assistants to a busy practice is good for the bottom line—both for patient care and practice revenue. BY NICHOLAS RAJACICH, MD

I was surprised to hear a colleague express hesitation when I suggested that her practice, struggling with caseloads and administrative work, hire a physician assistant. After all, at my orthopedic practice, we were preparing to hire even more PAs (which will mean more than one PA per doctor).

For our practice, it's simple: PAs help us increase access to our services (more care for more people) and help manage many of our day-to-day tasks (fewer hours spent by our physician specialists on administrative work and less-complex procedures). Put even more simply, the bottom line is that our PAs are good for our practice's bottom line—both for patient care and practice revenue.

With most PAs trained in primary care, few come to us with experience or training in our surgical specialty. Some choose to do an additional year of specialized training, which we have found to be quite valuable. While it requires a significant commitment of time to train them both in the clinic and in the OR, the returns on this investment accrue rapidly.

For example: In the OR, our PAs prep the patients for surgery, handle the post-op orders, apply tourniquets during the operation and, in the case of a PA who's been around a while, close and dress incisions. Complicated patient discharges? Our PAs have us covered, arranging follow-up visits, DME prescriptions, and so on.

At our practice, the use of PAs has led to greater access to care, which, in turn, has led us to hire more PAs.

As their training moves along, and as the individual PA gains more experience, we give them expanded independence in our practice. With experience, we allow our PAs to see an independent panel of patients, saving the complex patients for our physicians.

And of course, a PA can do many of the tasks that doctors are being tasked with (more and more...and more) these days. With the development of EMRs and increasing regulatory requirements, there's a large burden of administrative material that a PA can help me with.

At this point, our investment in teaching these PAs has more than paid off. Our physicians are now freed up to practice at the highest level of our training and to see more new patients, which is a win-win for everyone.

We do at times allow PAs to run clinics offsite. In most situations when a PA is seeing patients in clinic, there is a physician available, either by phone (with the ability to review X-rays via PACs) or in person, to answer questions or provide advice as needed.

There are some relatively simple legal hurdles that one must address before hiring a PA, most of which can be navigated with the help of staff at the WSMA and the Washington Academy of Physician Assistants. Promising work is being done by those organizations at the state level to modernize the requirements around the PA delegation agreement—the document describing what training and supervision will be provided and what duties delegated to the PA. Ultimately, what's important is to clearly define and document the clinical partnership and to regularly revisit and revise as needed. This is key to building a successful physician-PA team and to ensure the highest quality of care for our patients.

At our practice, the use of PAs has led to greater access to care, which, in turn, has led us to hire more PAs (I envision a day when we may well have two PAs per doctor). It's a virtuous cycle if there ever was one, and one I'll continue to recommend to other physician colleagues. ▀

Nicholas Rajacich, MD, is a pediatric orthopedic surgeon at Mary Bridge Children's Orthopedic Clinic.

Are you passionate about this or another topic? Send us your story (less than 500 words) at editors@wsma.org.



Who will make health care decisions for you if you can't?

Advance care planning puts your voice at the center of your health care.

We can help!



Talk About It

Think about and tell the important people in your life what type of health care you would want if you were too sick to tell the doctor yourself.



Write It Down

Make sure your wishes are clearly written down so they can be followed.



Share It Around

Tell your loved ones and health care workers about your wishes, and make sure they have a copy of what you wrote down.

Find out more at honoringchoicespnw.org

© 2020 Honoring Choices Pacific Northwest. Privacy statement: The name Honoring Choices Pacific Northwest is used under license from Twin Cities Medical Society Foundation. All rights reserved.