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KAPLAN, Gerald T., M.A., L.P. (J]W DfYg]XYbH	3	3/29/11 1/19
JAFRI, Irshad H., M.B., B.S., FACP fGYWYUfntL	2	10/15/12 1/19
EGGEN, Mark A., M.D.	4	4/27/09 1/17
ELLA, V. John, J.D.	5	3/09/10 1/18
JOHNSON, Kelli, Ph.D.	4	3/09/10 1/18
LINDHOLM, Patricia J., M.D., FAAFP	7	10/30/13 1/16
RASMUSSEN, Allen G., M.A.	8	9/29/14 1/18
SPAULDING, Kimberly W., M.D., M.P.H.	6	6/06/16 1/20
STATTON, Maria K., M.D., Ph.D.	8	10/15/12 1/17
THOMAS, Jon V., M.D., M.B.A.	At large	3/09/10 1/18
TOWNLEY, Patrick R., M.D., J.D.	5	6/06/16 1/20
WILLETT, Joseph R., D.O., FACOI	7	3/29/11 1/19

DATE: November 12, 2016

SUBJECT: Approve the Minutes of the
September 10, 2016, Board Meeting

SUBMITTED BY: Irshad H. Jafri, M.B., B.S., FACP, Secretary

REQUEST FOR BOARD ACTION
MINNESOTA BOARD OF MEDICAL PRACTICE

REQUESTED ACTION:

Approve the minutes of the September 10, 2016, Board Meeting as circulated.

MOTION BY: _____ SECOND: _____
 PASSED PASSED AMENDED LAYED OVER DEFEATED

BACKGROUND:

See attached Minutes.

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The Minnesota Board of Medical Practice met on September 10, 2016, at the Dan Abraham Healthy Living Center in Rochester, Minnesota.

The following Board members were present for both Public and Executive Sessions, unless otherwise indicated: Gerald T. Kaplan, M.A., L.P., Vice President; Irshad H. Jafri, M.B., B.S., FACP, Secretary; Keith H. Berge, M.D.; Mark A. Eggen, M.D.; V. John Ella, J.D.; Kelli Johnson, Ph.D.; Allen G. Rasmussen, M.A.; Jon V. Thomas, M.D., M.B.A.; Patrick R. Townley, M.D., J.D.; and Joseph R. Willett, D.O., FACOI.

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Agenda Item 1: Call to Order and Roll Call

The meeting was called to order by Board Vice President Gerald T. Kaplan, M.A., L.P., in the absence of Board President Subbarao Inampudi, M.B., B.S., FACR. Roll call was taken by Board staff.

Agenda Item 2: Minutes of the July 9, 2016, Board Meeting

The minutes of the July 9, 2016, Board meeting were received and approved as circulated.

Agenda Item 3: Presentation on Physician Burnout by Colin P. West, M.D., Ph.D.

Colin P. West, M.D., Ph.D, Professor of Medicine, Medical Education and Biostatistics, Division of General Internal Medicine, Division of Biomedical Statistics and Informatics at Mayo Clinic, provided a presentation on Physician Burnout: Why We Should Care and What We Can Do About It.

A question and answer session followed. The Board gave a round of applause.

Dr. West agreed to share his presentation materials with Board members, which will be distributed via e-mail. Board members thanked Dr. West.

The Board took a ten minute break.

Acknowledgments

Mr. Kaplan acknowledged public Board member Kelli Johnson for completing her Ph.D. Ms. Johnson earned her Ph.D., degree in organizational leadership, policy and development - evaluation studies from the University of Minnesota. The Board congratulated Ms. Johnson and gave a round of applause. Ms. Johnson thanked the Board for the recognition.

Mr. Kaplan also acknowledged attendance at the Board meeting of Chief Administrative Law Judge Tammy L. Pust. Chief Pust thanked the Board for inviting her to the September Board meeting and expressed her gratitude for the opportunity to see how the Board functions as she prepares to present to medical board executives at the upcoming Administrators in Medicine Executive Directors Workshop, and Certified Member Board Executive Training at the end of October. Chief Pust summarized the contested case process at the Office of Administrative Hearings (OAH), her role as Chief Administrative Law Judge, and the roles of other Administrative Law Judges at OAH. The Board thanked Chief Pust for attending the meeting and gave a round of applause.

Agenda Item 4: Licensure and Registration

On recommendation of the Licensure Committee, physician applicants 1 – 278 of the agenda were approved for licensure subject to the receipt of verification documents.

On recommendation of the Licensure Committee, physician applicants 279 - 280 of the agenda were approved for Emeritus registration.

On recommendation of the Acupuncture Advisory Council, acupuncturist applicants 281 - 284 of the agenda were approved for licensure subject to the receipt of verification documents.

On recommendation of the Athletic Trainers Advisory Council, athletic trainer applicants 285 - 314 of the agenda were approved for registration subject to the receipt of verification documents.

On recommendation of the Physician Assistant Advisory Council, physician assistant applicants 315 - 389 of the agenda were approved for licensure subject to the receipt of verification documents.

On recommendation of the Respiratory Therapist Advisory Council, respiratory therapist applicants 390 – 443 of the agenda were approved for licensure subject to the receipt of verification documents.

On recommendation of the Naturopathic Advisory Council, naturopathic doctor applicants 444 - 445 of the agenda were approved for licensure subject to receipt of verification documents.

On recommendation of the Midwifery Advisory Council, midwifery applicant 446 of the agenda was approved for licensure subject to receipt of verification documents.

Agenda Item 5: Licensure Committee Report

- Agenda Item 6a: Minutes of the August 18, 2016, Licensure Committee
In the absence of Licensure Committee Chair Patricia Lindholm, M.D., FAAFP, Licensure Committee member Allen G. Rasmussen, M.A., presented the minutes of the August 18, 2016, Licensure Committee Meeting.

Mr. Rasmussen summarized the Licensure Committee's actions and discussions.

Agenda Item 6: Licensure Update

- Molly Schwanz provided updates on the following:
 - a. Medical Faculty Licensure
The Medical Faculty Licensure application is now available on-line along with the authorizing section of statute. Ms. Schwanz thanked Mayo for their help in the process.
 - b. License Issued by Board Staff
At the May 14, 2016, Board meeting, the Board unanimously passed a motion to delegate authority to Board staff to issue credentials to applicants who satisfactorily demonstrate that they have met all minimum requirements for licensure/registration and have no adverse or questionable conduct to consider. On August 1, 2016, Board staff issued a license for an osteopathic physician who met requirements for licensure that became effective on August 1, 2016.
 - c. Licensure Processes
Board staff will issue credentials incrementally in batches to assure that any computer glitches are worked out. Temporary permits will ultimately be phased out as credentials are issued in real time. The Board agenda will include an informational report of licenses/registrations issued by staff.

Board members briefly discussed whether to include a notation of licenses issued through the Interstate Medical Licensure Compact (Compact) process. Board staff will internally track the number of licenses issued through the Compact process. The anticipated date of issuing licenses through the Compact process is January 2017. Ms. Martinez suggested a

presentation to the Board at a future meeting on the infrastructure and process of implementation of the Compact.

Ms. Martinez noted that she and Jon Thomas, M.D., M.B.A., were interviewed for an article on the Compact to be published in the October issue of Minnesota Medicine.

Agenda Item 6b: Acupuncture Advisory Council Appointment

The Licensure Committee's motion to appoint Patricia Casello-Maddox, D.C., LAc., Diplomate AC (NCCAOM), MBA, MOM, as the Chiropractor/NCCAOM Certified Member to the Acupuncture Advisory Council passed unanimously.

Agenda Item 7: Policy & Planning Committee Report

Chair of the Policy & Planning Committee V. John Ella, J.D., provided a report of the August 10, 2016, Policy & Planning Committee meeting.

- a. Federal Legislation, Senate Version, Sec. 705, Enhancement of use of Telehealth Services in Military Health System:

The Committee considered whether to recommend that the Board take a formal position on this federal legislation. The Senate version includes in Sec. 705, Enhancement of use of Telehealth services in Military Health System, language that places care where the provider is located, rather than where the patient is located. The Committee concluded that the language of the Senate bill nullifies a state's capability to respond appropriately to patient complaints. The Committee recommends that the Board oppose the language of S 2943, Sec. 705 that places patient care where the provider is located. The Committee authorized Board staff to draft and send letters to Congressional conferees and Minnesota's Congressional representatives stating the Policy & Planning Committee's recommendation, rationale, and intent to bring the Committee's recommendation to the full Board on September 10, 2016. A motion was made and passed unanimously to instruct Executive Director Ruth Martinez, MA, to send letters to Congressional Conferees and Minnesota's Congressional representatives reflecting the Committee's recommendation.

- b. Recommendation and Motion to Endorse Provider Orders for Life Sustaining Treatment (POLST): MN Medical Association (MMA) Policy Counsel Teresa Knoedler, JD, presented a proposal for Board endorsement of the MMA's updated POLST statement. Ms. Knoedler noted that MMA endorsed the POLST statement on July 16, 2016, and the Emergency Medical Services Regulatory Board endorsed the POLST statement in July 2016. She further noted requirements by CMS for use of POLST in long-term care facilities, incorporation of POLST into some health care systems' electronic medical record, and plans for national data gathering and initiatives in support of POLST. The Committee was asked to consider that the advance health care directive prevails and that use of POLST is not binding, but informs care, and that endorsement by the Board would recognize and acknowledge what many would consider an important tool that can be used to effectuate a patient's wishes. A motion was made and passed for the Policy & Planning Committee to recommend to the Board that it endorse the revised POLST statement as a positive contribution to patient safety. Dr. Townley opposed.

Ms. Martinez informed the Board that Ms. Knoedler requested that the motion regarding POLST be deferred to the November 12, 2016, Board meeting, at which time Victor Sandler, M.D., would be present to answer any questions. A motion was made and unanimously passed to table the POLST motion until the November 12, 2016, Board meeting. The Board had a brief discussion on what the Board's role should be in endorsing statements.

- c. Board Outreach:

The Committee considered an invitation to exhibit at the MN Medical Association Annual Meeting which will be held in St. Louis Park on September 23 – 24, 2016. The Committee authorized Board staff to begin the process for securing space and preparing materials for distribution. Ms.

Martinez stated that the exhibit table will be open for twelve hours, 7 am to 7 pm on Friday, September 24, 2016, and asked physician members to volunteer to join staff in the exhibit hall throughout the day. Board staff has ordered tote bags and will fill them with pertinent information of interest. Ms. Martinez invited Board members interested in volunteering at the exhibit table to contact her. Board staff will send out further communication to Board members.

- d. 2017 State Legislation, The Committee recommended the following:
- 1) Title Protection under Minn. Stat. § 147.081, Subd. 3(6), specific to use of the title of “physician”. After Board discussion, a motion was made and passed unanimously for the Policy & Planning Committee to develop language that would strengthen protection of the use of physician titles.
 - 2) Modification of grounds for disciplinary action, specifically Minn. Stat. § 147.091, Subd. 1(g), (k) and (l).
Currently, under Minn. Stat. § 147.091, Subd. 1(g) (unethical conduct), (k) (unprofessional conduct) and (l) (Illness) categories of disciplinary actions are combined in a summary paragraph and the Committee feels it would be helpful to break them into subdivisions. After discussion, a motion was made and passed unanimously that Board staff and the Policy & Planning Committee should develop language to modify grounds in § 147.091, Subd. 1(g), (k) and (l) and bring forward language to the November 12, 2016, Board meeting.
 - 3) Establishment of a public at large seat on the Board, either as an additional Board seat or as a conversion of an existing seat. The Committee decided to table discussion of any changes to the composition of the Board at this time.

The next meeting of the Policy & Planning Committee is scheduled for October 12, 2016. All Board members are welcome to attend and contribute to discussion of policy issues at the Policy & Planning Committee meetings.

Agenda Item 8: Updated Draft Opiate Antagonist Protocol

Included in the Board agenda was the Draft Opiate Antagonist Protocol prepared by the Board of Pharmacy pursuant to 2016 legislation. The Protocol will be finalized by the end of September, 2016. The Board of Medical Practice is specifically authorized by the legislation to consult and provide feedback on the protocol. The enclosed draft reflects feedback from other entities, to date. The protocol will be finalized in late September. It includes comments that explain which organization or agency suggested each change. Board members were asked to determine what, if any, feedback they wish to offer. The Board had a brief discussion and didn't have any feedback to offer.

Agenda Item 9: August 9, 2016, HPSP Program Committee Report

Allen G. Rasmussen, M.A., the Board's representative and Chair of the Health Professionals Services Program (HPSP) Program Committee presented his report summarizing the August 9, 2016, HPSP Program Committee meeting.

The HPSP Governance Subcommittee met and recommended keeping the present governance structure intact for the time being and having a subgroup of the Program Committee review the Committee's oversight responsibilities and functions and make future recommendations about potential governance, duties, structure, and statutory changes. The meeting of the subgroup will meet on September 28, 2016. Mr. Rasmussen will keep the Board updated.

Agenda Item 10: Executive Director's Report

Ruth M. Martinez, M.A., provided a summary of the Executive Director's Report.

The Board continues its active engagement in external groups. Relationships developed through these groups have proven to be significantly helpful to the Board in a variety of circumstances. The Board continues to participate in the following external work groups:

- State Opioid Oversight Project (SOOP)
- Opioid Prescribing Work Group (OPWG)

- National Governors' Association (NGA) Health Care Workforce Technical Assistance Program
- Immigrant International Medical (IMG) Graduate Stakeholder Advisory Group & subgroups:
 - Licensure Study work group
 - Alternate Pathways work group
- Drug Diversion Coalition through the MN Department of Health
- One Health MN Antibiotic Stewardship
- Community Dialogue on Diagnostic Error
- MN Alliance for Patient Safety
- Interstate Collaboration in Healthcare

Meetings were held with professional association representatives and other external stakeholders, including the MN Medical Association, MN Hospital Association, MN Academy of Physician Assistants, MN Athletic Trainers Association and MN Medical Insurance Company to discuss licensing and complaint review processes, collaboration, recent and planned legislation, and anticipated initiatives for 2017. The Board has also been invited to attend future meetings with stakeholders, including the MN Association of Medical Staff Services, and hospital chief medical officers and credentialers.

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On August 30, 2016, the core team convened with multiple stakeholders in a full day facilitated discussion of a tool for presenting scope of practice bills at the legislature. The core team met for several hours on August 31, 2016 to debrief the previous day's discussion and revise the tool, which may be available for use during the 2017 legislative session.

5 Xa]b]g]fUrcfg']b' A YX]W]bY (AIM) will hold its Executive Directors Workshop and Certified Member Board Executive training in Minneapolis in October 2016. Board staff facilitated the planning committee in securing presenters, including Chief Administrative Law Judge Tammy Pust, former Board member Sarah Evenson, JD, MBA, and MN Alliance for Patient Safety Executive Director Marie Dotseth, JD. Ms. Martinez is extremely grateful that Chief Administrative Law Judge Tammy Pust agreed to present at the Certified Member Board Executive Training.

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Board staff is researching converting the renewal cycle for all of the allied health professions to a birth month cycle to align with the current physician renewal cycle and spread renewals across the calendar year. There are now 7 allied professions under the Board's jurisdiction and it is challenging for Licensure Unit staff to process the simultaneous renewals of allied professions by June 30, 2016, which is also the peak application processing period. Some practice acts may require legislative modification to enable the change. A motion was made and passed unanimously to authorize Executive Director Ruth Martinez, M.A., to pursue such changes during the 2017 legislative session and to begin implementing the cycle change for allied professions that do not require statute changes.

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On August 16, 2016, Licensure Unit Supervisor Molly Schwanz participated in the MDH X-ray Unit Listening Session, which addressed the following:

- X-ray Unit, Minn. Rules Chapter 4732, regulating the use of ionizing producing equipment
- Process for rules
- Survey results
- Questions/Concerns/Feedback

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On August 24, 2016, the IMLC Commission held its fifth meeting, by conference call. IMLC committees continue work toward a target date of January 2017 for issuance of licenses. The Bylaws and Rules Committee has drafted a proposed Licensing Rule, which has undergone a comment period and which will be presented for Commission approval at its next meeting on October 3, 2016 in Kansas City, Kansas. Minnesota continues to work with the Council of State Governments, MN Criminal Background Checks Program, National Crime Prevention and Privacy Compact Council, and the IMLC Executive Committee to address an FBI determination (in three states, including Minnesota) that the IMLC statutory

language for criminal background checks does not comply with federal requirements for receipt of FBI data.

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On August 3 and 24, 2016, the MN Department of Corrections (DOC) conducted tours of the Stillwater and Oak Park Heights prisons for Board members, medical coordinators, and staff. Fourteen people participated in the tours. Attendees were very impressed with the DOC healthcare system and high level of security at the prisons.

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- Medical Practice Act modifications
- Physician Assistant Practice Act modifications
- Traditional Midwifery Practice Act modifications
- MN Prescription Monitoring Program Changes
- Implementation of Medical Faculty License
- Implementation of Genetic Counselor License

On August 1, 2016, health licensing policy legislation became effective, as outlined above. Health licensing board executive directors convened to discuss and plan for processes relating to legislation impacting multiple health licensing boards. Board of Medical Practice management staff continue their work to update and develop forms, establish internal processes, identify needs for technical support, and develop necessary human resources.

Budget planning for the next biennium is underway, as is preparation of the current Biennial Report, which will be presented at the November Board meeting. Ms. Martinez plans to expand Board staff with the addition of two professional positions that have not been filled in two years. Ms. Martinez is optimistic the appropriations will pass.

Agenda Item 11: Tri-Regulatory Symposium Survey Results

The June 1, 2016, Tri-Regulatory Symposium (Symposium) survey results were included in the Board agenda for review. Ms. Martinez noted that the survey results reflect that the Symposium was a success. Executive Directors of the Boards of Medical Practice, Nursing and Pharmacy met to discuss the survey results and discuss plans for future symposia. They suggest following the model of the National tri-regulator symposia which are held every other year. Perhaps the next Minnesota tri-regulatory symposium should be conducted similarly to a Board meeting to discuss topics of mutual interest. Ms. Martinez suggested the next symposium be held in two years and asked the Board for feedback. Mr. Kaplan agreed that it is a good idea.

Agenda Item 12: Appointment of a Nominating Committee

Three names were submitted for the Nominating Committee:

- Kelli Johnson, Ph.D.
- Kimberly W. Spaulding, M.D.
- Subbarao Inampudi, M.B., B.S., FACR

A motion was made and unanimously passed to accept the appointment of Ms. Johnson, Dr. Spaulding, and Dr. Inampudi to the Board's Nominating Committee.

Agenda Item 13: Proposed 2017 Meeting Dates

A motion was made and passed unanimously to establish the following meeting dates for 2017:

Regular Board Meetings

January 14
March 11
May 13
July 8

Contested Case Hearings

February 11
April 8
June 10
August 12

September 9
November 11

October 14
December 9

Agenda Item 14: New Business

Following the Supreme Court ruling regarding the Federal Trade Commission (FTC) North Carolina Dentistry case, Board members requested an opinion from the Attorney General's Office regarding indemnification of a Board member who may be sued by the FTC for anti-competitive behavior. Assistant Attorney General Brian Williams distributed a written opinion prior to the Board meeting regarding whether indemnification exists for Board members should the Board or individual members be sued for violations of Federal Anti-Trust Law. Mr. Williams reported that Board Members would likely be covered by the indemnification provisions of the Tort Claims Act if the Board member was acting within the scope of his or her employment and the member's actions did not involve malfeasant, willful or wanton actions, or neglect of duty. Until allegations are set forth in a complaint, the Attorney General's Office is not in a position to make any conclusions. In a typical situation, however, most of the actions that are taken by the Board or individual members are within the scope of their employment. It would be a rare exception that it would not be the case. The hope is that anything that would come close or remotely bordering on an antitrust violation would have been vetted by the AGO prior to the Board or any members taking action.

Mr. Kaplan acknowledged that it is Dr. Berge's last Board meeting. Mr. Kaplan expressed his appreciation for Dr. Berge's collegiality and involvement with the Board and its Committees. Mr. Kaplan thanked Dr. Berge and his wife Johanna for hosting Board members and staff on September 9, 2016, for a wonderful barbeque dinner at their home. The Board gave a round of applause. Dr. Berge thanked the Board.

Mr. Kaplan congratulated Dr. Thomas and Ms. Martinez for being listed in the article, "Top 100 influential Minnesota Health Care Leaders," published by *Minnesota Physician*. Ms. Martinez noted that Chief Administrative Law Judge Tammy Pust was also listed. The Board gave a round of applause.

Agenda Item 15: Corrective and Other Actions

The Corrective and other actions were presented for Board information only.

Mr. Kaplan adjourned the public session of the Board.

The following Board members were present for both Public and Executive Sessions, unless otherwise indicated: Gerald T. Kaplan, M.A., L.P., Vice President; Irshad H. Jafri, M.B., B.S., FACP, Secretary; Keith H. Berge, M.D.; Mark A. Eggen, M.D.; V. John Ella, J.D.; Kelli Johnson, Ph.D.; Allen G. Rasmussen, M.A.; Jon V. Thomas, M.D., M.B.A.; Patrick R. Townley, M.D., J.D.; and Joseph R. Willett, D.O., FACOI

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On recommendation of the Complaint Review Committee, the Board approved the Stipulation and Order for voluntary surrender of license signed by Dr. Johnson.

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On recommendation of the Complaint Review Committee, the Board approved the Stipulation and Order for reprimand signed by Dr. Lewis.

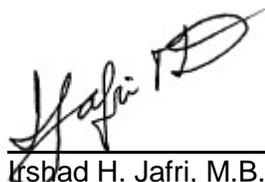
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On recommendation of the Complaint Review Committee, the Board approved the Stipulation and Order for reprimand, conditioned and restricted license signed by Dr. Roig.

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On recommendation of the Complaint Review Committee, the Board approved the Stipulation and Order for reprimand and conditioned license signed by Dr. Rosenbaum.

There being no further business, the meeting was adjourned.



Irshad H. Jafri, M.B., B.S., FACP
Secretary
MN Board of Medical Practice

November 3, 2016
Date

DATE: November 12, 2016

SUBJECT: Policy & Planning Committee Report
October 12, 2016

SUBMITTED BY: Policy & Planning Committee

REQUEST FOR BOARD ACTION
MINNESOTA BOARD OF MEDICAL PRACTICE

REQUESTED ACTION:

Approve the actions of the Policy & Planning Committee.

MOTION BY: _____ SECOND: _____
 PASSED PASSED AMENDED LAYED OVER DEFEATED

BACKGROUND:

Policy & Planning Committee Report:

- a. October 12, 2016, Policy & Planning Committee Meeting Minutes
- b. Recommendation and Motion to Endorse, Provide Orders for Life Sustaining Treatment (POLST): Victor Sandler, M.D., will present on POLST.
- c. Athletic Trainers Practice Act: Troy Hoehn, A.T., will present on proposed changes to Minn. Statute § 148.7801 – 148.7815, the practice act for registered athletic trainers.
- d. Naturopathic Doctors Practice Act: Sara Jean Barrett, N.D., and Benjamin Olson, J.D., will present on proposed changes to Minn. Statute § 147E, the practice act for registered naturopathic doctors.
- e. International Medical Graduate Assistance Program Stakeholder Advisory Group: Yende Anderson and Mark Schoenbaum from the Minnesota Department of Health will present on the work of the International Medical Graduate Stakeholder Advisory Group during the past year, including the work of the Licensing Subcommittee to consider whether to recommend changes to physician licensing requirements for international medical graduates. A report and recommendations from the Commissioner of Health is due to the Legislature in December 2016.
- f. Please refer to the October 12, 2016, Policy & Planning Committee materials, included in the Board agenda.

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(DRAFT)**

The Committee, chaired by V. John Ella, J.D., and attended by Patrick Townley, M.D., J.D., Allen Rasmussen, M.A., and Gerald Kaplan, M.A., L.P., met at 4:30 p.m. at the Board offices. Also in attendance was Board member Jon Thomas, M.D., M.B.A., and members of the public. The Committee was assisted by Board staff, Ruth Martinez, Elizabeth Huntley and Molly Schwanz. The Committee considered the following items:

1. **h Y a UHYf 'cZ&\$%' GHUY' @ [jg`U]cb.** Executive Director Ruth Martinez provided an update on proposed housekeeping changes to Board statutes. Draft language will be provided for review at a future meeting.
2. **h Y a UHYf 'cZdfcdcgYX'gWtdY'cZdfUWjW'W Ub [Yg'fY [UFX]b ['6 cUX'fY [i `UHYX' dfcZygg]cbg.**
 - A. Athletic Trainers practice act: Troy Hoehn, A.T. Amy Bruegge, A.T., and Patrick Sexton, A.T., presented on proposed changes to Minn. Statute § 148.7801 – 148.7815, the practice act for registered athletic trainers.
 - B. Naturopathic Doctors practice act: Sara Jean Barrett, N.D., Serina Aubrecht, N.D., and Benjamin Olson, J.D., presented on proposed changes to Minn. Statute § 147E, the practice act for registered naturopathic doctors.

The Committee declined to recommend a position on the proposed scope of practice changes for either profession. Both groups will be scheduled to present to the full Board on November 12, 2016.

1. **h Y a UHYf 'cZ h Y hYfbU]cbU 'A YX]WU'; fUXi UY'5 gg]ghUbW' Dfc [fUa ' GHU_Y c`XYf '5 Xj]gcfm; fci d'.** Yende Anderson and Mark Schoenbaum from the Minnesota Department of Health presented on the work of the International Medical Graduate Stakeholder Advisory Group during the past year, including the work of the Licensing Subcommittee to consider whether to recommend changes to physician licensing requirements for international medical graduates. A report and recommendations from the Commissioner of Health is due to the Legislature in December 2016.

No action was recommended by the Committee. A presentation on the IMG Assistance Program and Stakeholder Advisory Group's activities will be scheduled for the November 12, 2016.Board meeting.

There being no other business, a motion was made and unanimously passed to adjourn the meeting.

DATE: November 12, 2016

SUBJECT: Provider Orders for Life Sustaining Treatment (POLST)

SUBMITTED BY: Policy & Planning Committee

REQUEST FOR BOARD ACTION
MINNESOTA BOARD OF MEDICAL PRACTICE

REQUESTED ACTION:

The Policy & Planning Committee recommends that the Board endorse the revised POLST statement. Request a motion to endorse the revised POLST statement.

MOTION BY: _____ SECOND: _____
 PASSED PASSED AMENDED LAYED OVER DEFEATED

BACKGROUND:

Victor Sandler, M.D., will present on the revised Provider Orders for Life Sustaining Treatment (POLST) Statement.

The Policy & Planning Committee met on August 10, 2016, and reviewed and discussed the revised POLST statement.

- Recommendation from the August 10, 2016, Policy and Planning Committee Meeting: In the matter of proposed Provider Orders for Life Sustaining Treatment (POLST): Teresa Knoedler, Minnesota Medical Association (MMA) Policy Counsel, presented a proposal for Board endorsement of the MMA's updated POLST statement. The Committee considered endorsement of the POLST statement by MMA on July 16, 2016, endorsement by the Emergency Medical Services Regulatory Board in July 2016, requirements by CMS for use of POLST in long-term care facilities, incorporation of POLST into some health care systems' electronic medical record, and plans for national data gathering and initiatives in support of POLST. The Committee also considered that the advanced health care directive prevails and that use of POLST is not binding, but informs care, and that endorsement by the Board would recognize and acknowledge what many would consider an important tool that can be used to effectuate a patient's wishes.

A motion was made and passed for the Policy & Planning Committee to recommend to the Board that it endorse POLST as a positive contribution to patient safety. Dr. Townley voted against the motion.

At the September 10, 2016, Board meeting, the POLST Statement discussion was deferred to the November 12, 2016, Board meeting to allow Victor Sandler, M.D., to present to the Board.

The Committee recommends that the Board endorse the revised POLST statement. Request a motion to endorse the revised POLST statement.

POLST: Provider Orders for Life Sustaining Treatment POLST

HIPAA PERMITS DISCLOSURE OF POLST TO OTHER HEALTH CARE PROVIDERS AS NECESSARY

PROVIDER ORDERS FOR LIFE-SUSTAINING TREATMENT (POLST)

FIRST follow these orders, **THEN** contact the patient's provider. This is a provider order sheet based on the patient's medical condition and wishes. POLST translates an advance directive into provider orders. Any section not completed implies the most aggressive treatment for that section. Patients should always be treated with dignity and respect.

Last Name

First/Middle Initial

Date of Birth

Primary Care Provider/Phone

A CARDIOPULMONARY RESUSCITATION (CPR):

Check One Patient has no pulse and is not breathing.

CPR/ATTEMPT RESUSCITATION

DNR/DO NOT ATTEMPT RESUSCITATION (Allow Natural Death)

When not in cardiopulmonary arrest, follow orders in B and C. | An automatic external defibrillator (AED) should not be used for a patient who has chosen "Do Not Attempt Resuscitation."

B GOALS OF TREATMENT:

Check One Goal Patient has pulse and/or is breathing. See Section A regarding CPR if pulse is lost.

COMFORT CARE — Do not intubate but use medication, oxygen, oral suction, and manual clearing of airways, etc. as needed for immediate comfort.

Check all that apply:

In an emergency, call _____ (e.g. hospice)

If possible, do not transport to ER (when patient can be made comfortable at residence)

If possible, do not admit to the hospital from the ER (e.g. when patient can be made comfortable at residence)

LIMIT INTERVENTIONS AND TREAT REVERSIBLE CONDITIONS — Provide interventions aimed at treatment of new or reversible illness / injury or non-life threatening chronic conditions. Duration of invasive or uncomfortable interventions should generally be limited. (Transport to ER presumed)

Check one:

Do not intubate

Trial of intubation (e.g. _____ days) or other instructions: _____

PROVIDE LIFE SUSTAINING TREATMENT

Intubate, cardiovert, and provide medically necessary care to sustain life. (Transport to ER presumed)

Additional Orders (e.g. dialysis, etc.)

C INTERVENTIONS AND TREATMENT

Check All That Apply

ANTIBIOTICS (*check one*):

No Antibiotics (Use other methods to relieve symptoms whenever possible.)

Oral Antibiotics Only (No IV/IM)

Use IV/IM Antibiotic Treatment

NUTRITION/HYDRATION (*check all that apply*):

Offer food and liquids by mouth (Oral fluids and nutrition must always be offered if medically feasible)

Tube feeding through mouth or nose

Tube feeding directly into GI tract

IV fluid administration

Other: _____

Additional Orders:

Provider Name (MD/DO/APRN/PA when delegated, are acceptable)

Provider Signature

Date

FXED COPIES AND PHOTOCOPIES OF THIS FORM ARE VALID.

TO VOID THIS FORM, DRAW A LINE ACROSS SECTIONS A - D AND WRITE "VOID" IN LARGE LETTERS.

POLST

D SUMMARY OF GOALS

Check All That Apply

DISCUSSED WITH:

- PATIENT
- PARENT(S) OF MINOR
- HEALTH CARE AGENT: _____
- COURT-APPOINTED GUARDIAN
- NONE OTHER: _____

THE BASIS FOR THESE ORDERS IS PATIENT'S (check all that apply):

- REQUEST
- BEST INTEREST
- KNOWN PREFERENCE
- OTHER: _____
- HEALTH CARE DIRECTIVE/ LIVING WILL

Name of Health Care Professional Preparing Form	Preparer Title	Phone Number	Date Prepared
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E SIGNATURE OF PATIENT OR HEALTH CARE AGENT / GUARDIAN / SURROGATE
THESE ORDERS REFLECT THE PATIENT'S TREATMENT WISHES

Name	Date
Relationship to Patient	Phone Number
Signature*	

DIRECTIONS FOR HEALTH CARE PROFESSIONALS

COMPLETING POLST

- Must be completed by a health care professional based on patient preferences and medical indications.
 - If the goal is to support quality of life in last phases of life, then DNR must be selected in Section A.
 - If the goal is to maintain function and quality of life, then either CPR or DNR may be selected in Section A.
 - If the goal is to live as long as possible, then CPR must be designated in Section A.
- POLST must be signed by a physician, advance practice registered nurse, Doctor of Osteopathy, or Physician Assistant (when delegated). * The signature of the patient or health care agent/ guardian/surrogate is strongly encouraged.

USING POLST

- Any section of POLST not completed implies most aggressive treatment for that section.
- An automatic external defibrillator (AED) should not be used for a patient who has chosen "Do Not Attempt Resuscitation."
- Oral fluids and nutrition must always be offered if medically feasible.
- When comfort cannot be achieved in the current setting, the patient, including someone with "Comfort Measures Only," should be transferred to a setting able to provide comfort.
- An IV medication to enhance comfort may be appropriate for a patient who has chosen "Comfort Measures Only".
- Artificially-administered hydration is a measure which may prolong life or create complications. Careful consideration should be made when considering this treatment option.

- A patient with capacity or the surrogate (if patient lacks capacity) can revoke the POLST at any time and request alternative treatment.
- **Comfort care only:** At this level, provide only palliative measures to enhance comfort, minimize pain, relieve distress, avoid invasive and perhaps futile medical procedures, all while preserving the patients' dignity and wishes during their last moments of life. This patient must be designated DNAR status in section A for this choice to be applicable in section B.
- **Limit Interventions and Treat Reversible Conditions:** The goal at this level is to provide limited additional interventions aimed at the treatment of new and reversible illness or injury or management of non life-threatening chronic conditions. Treatments may be tried and discontinued if not effective.
- **Provide Life-Sustaining Care:** The goal at this level is to preserve life by providing all available medical care and advanced life support measures when reasonable and indicated. For patient's designated DNR status in section A above, medical care should be discontinued at the point of cardio and respiratory arrest.

REVIEWING POLST

This POLST should be reviewed periodically and a new POLST completed if necessary when:

1. The patient is transferred from one care setting or level to another, or
2. There is a substantial change in the patient's health status.
3. A new POLST should be completed when the patient's treatment preferences change.

MINNESOTA

Provider Orders for Life-Sustaining Treatment (POLST)

Follow these orders until orders change. These medical orders are based on the patient's current medical condition and preferences. Any section not completed does not invalidate the form and implies full treatment for that section. With significant change of condition new orders may need to be written. Patients should always be treated with dignity and respect.

LAST NAME	FIRST NAME	MIDDLE INITIAL
DATE OF BIRTH		
PRIMARY MEDICAL CARE PROVIDER NAME		PRIMARY MEDICAL CARE PROVIDER PHONE (WITH AREA CODE)

A

CHECK ONE

CARDIOPULMONARY RESUSCITATION (CPR) *Patient has no pulse and is not breathing.*

- Attempt Resuscitation / CPR (Note: selecting this requires selecting "Full Treatment" in Section B).
- Do Not Attempt Resuscitation / DNR (Allow Natural Death).

When not in cardiopulmonary arrest, follow orders in B.

B

CHECK ONE
(NOTE REQUIREMENTS)

MEDICAL TREATMENTS *Patient has pulse and/or is breathing.*

- Full Treatment.** Use intubation, advanced airway interventions, and mechanical ventilation as indicated. Transfer to hospital and/or intensive care unit if indicated. All patients will receive comfort-focused treatments.
TREATMENT PLAN: Full treatment including life support measures in the intensive care unit.
- Selective Treatment.** Use medical treatment, antibiotics, IV fluids and cardiac monitor as indicated. No intubation, advanced airway interventions, or mechanical ventilation. May consider less invasive airway support (e.g. CPAP, BiPAP). Transfer to hospital if indicated. Generally avoid the intensive care unit. All patients will receive comfort-focused treatments.
TREATMENT PLAN: Provide basic medical treatments aimed at treating new or reversible illness.
- Comfort-Focused Treatment (Allow Natural Death).** Relieve pain and suffering through the use of any medication by any route, positioning, wound care and other measures. Use oxygen, suction and manual treatment of airway obstruction as needed for comfort. Patient prefers no transfer to hospital for life-sustaining treatments. Transfer if comfort needs cannot be met in current location.
TREATMENT PLAN: Maximize comfort through symptom management.

C

CHECK ALL THAT APPLY

DOCUMENTATION OF DISCUSSION

- | | | |
|---|---|--|
| <input type="checkbox"/> Patient (Patient has capacity) | <input type="checkbox"/> Court-Appointed Guardian | <input type="checkbox"/> Other Surrogate |
| <input type="checkbox"/> Parent of Minor | <input type="checkbox"/> Health Care Agent | <input type="checkbox"/> Health Care Directive |

SIGNATURE OF PATIENT OR SURROGATE

SIGNATURE (STRONGLY RECOMMENDED) _____ NAME (PRINT) _____

RELATIONSHIP (IF YOU ARE THE PATIENT, WRITE "SELF") _____ PHONE (WITH AREA CODE) _____

Signature acknowledges that these orders reflect the patient's treatment wishes. Absence of signature does not negate the above orders.

D

SIGNATURE OF PHYSICIAN / APRN / PA

My signature below indicates to the best of my knowledge that these orders are consistent with the patient's current medical condition and preferences.

NAME (PRINT) (REQUIRED) _____ LICENSE TYPE (REQUIRED) _____ PHONE (WITH AREA CODE) _____

SIGNATURE (REQUIRED) _____ DATE (REQUIRED) _____

SEND FORM WITH PATIENT WHENEVER TRANSFERRED OR DISCHARGED. (2010) PROVIDER USE ONLY. ORIGINAL SIGNATURES OF THIS FORM ARE REQUIRED.

Definitions of "Endorsement":

1. Simple Definition of ENDORSEMENT:
a public or official statement of support or approval
Source: Merriam-Webster's Learner's Dictionary
2. US /ɪnˈdɔːsmənt/
endorsementnoun
the act of making a public statement of your support for something or someone:
Source: Cambridge Academic Content Dictionary © Cambridge University Press
3. endorsement - definition NOUN/ɪnˈdɔːsmənt
an occasion when someone gives official or public support to a particular person or thing
Source: <http://www.macmillandictionary.com/us/dictionary/american/endorsement>

IMG Assistance Program—Stakeholder Advisory Group
Licensure Group
Potential Recommendations

Decision Making Criteria:

- Does recommendation require statutory changes?
- Is the recommendation controversial?
- Does it require new resources? Funding? Personnel? Etc.
- How much progress would it produce?
- What is the impact on health equity?

Timeline:

August: Work group meeting

September: Work group meeting, Finalize recommendations

October: Present recommendations to the stakeholder group

Present recommendations to BMP

Policy/Planning Committee (October 12, 4:30pm)

November: Presentation to BMP

Draft of Report which will include recommendations
to legislators.

January: final report due

General note: There were statements in licensure group meetings that immigrant physicians are a special interest group that should be required to meet all licensing requirements in current law. Related statements were made that if new paths to licensure are provided to immigrant physicians, inquiries and expectations will increase from others requesting variances from the current process, and that this will increase the workload of the Board of Medical Practice.

In response it was noted that immigrant physicians have a unique potential to contribute to improving health equity in Minnesota, and that this potential is a central basis of Minnesota Statutes section 144.1911, the International Medical Graduates Assistance Program, which was established "to address barriers to practice and facilitate pathways to assist immigrant international medical graduates to integrate into the Minnesota health care delivery system, with the goal of increasing access to primary care in rural and underserved areas of the state." Among other provisions, M.S. 144.1911 requires the Commissioner of Health to study, in consultation with the Board of Medical Practice and other stakeholders, changes necessary in health professional licensure and regulation to ensure full utilization of immigrant international medical graduates in the Minnesota health care delivery system, and to make recommendations to the legislature.

It was agreed that the need for new funds to cover any increased workload should be included in recommendations.

There was also discussion that negative consequences that may occur if changes are made to licensing requirements without explicitly addressing all potential contingencies, and that changes should not be recommended until provisions for preventing all potential consequences are identified and included in recommendations.

In response it was noted that current law does not address all potential aspects of the supervision and practice of residents and physicians, which are the responsibility of training sites and employers.

Proposals for consideration

Proposal	Pros/Cons
<p>A. IMG Primary Care Integration License</p> <ol style="list-style-type: none"> 1. IMG registers with MDH 2. IMG demonstrates that s/he has a minimum of 7 years of prior medical practice including residency and fellowships. Observerships do not qualify. 3. IMG passes USMLE step 1, 2 and 3 within 3 attempts; becomes ECFMG certified 4. IMG participates in clinical assessment at U of M; participates in 6 months of clinical experience; undergoes post assessment with an established assessment service provider similar to PACE or CPEP – receives a certificate of clinical readiness to <u>practice medicine</u> (Meets level 5 of the 4 selected general milestones of the next accreditation system) 5. IMG obtains employer sponsorship. Employer must provide supervision and mentorship outlined in a supervision agreement. Employer must be in “rural” or “underserved” community as defined by Minn Stat. 144.1911. Scope of practice limited to primary care as described in Minn Stat. 144.1911. 6. Once sponsorship is obtained, IMG applies for an IMG integration License – a restrictive license renewable annually with recommendation to renew from employer. 7. Participant can apply for an unrestricted license after 4 years of successful renewals (5 years total of effective practice) 	<p>Pros:</p> <ul style="list-style-type: none"> • Fast. Gets objectively qualified physicians into the system quickly. • Does not require residency positions. • Very cost effective. May need money for clinical post assessment and clinical experience. • Increases state revenue from new doctors paying taxes. • Helps with health disparities and primary care shortages <p>Cons:</p> <ul style="list-style-type: none"> • May require new level of effort for Board of Medical Practice and new revenue. • Doctors with this restricted license may get paid less than other doctors with a traditional unrestricted license. • #5, 6, 7. MAPA objected to these components prior to the passing

<p>8. The Board shall take disciplinary action against a licensee and supervisor for violations of the limitations on the license.</p>	<p>of the 2015 legislation. Those objections and concerns are unchanged by the current writing.</p> <ul style="list-style-type: none"> • MAPA's position is that creating a "sponsored or supervised" restricted IMG integration license for IMG physicians will create professional role confusion for healthcare systems and patients, specifically with regards to how they would be similar to or vary from the PA profession. • Unless clearly defined, this could create confusion for who can supervise a PA during the restricted licensure periods and potentially after unrestricted license is obtained regarding proper PA/ Physician relationships. • Such a program will create potential challenges to full licensure by other professions as well. • Reimbursement and the ability to obtain liability coverage are unknowns. These issues have been identified in similar programs that sought to create alternative licensing categories— such as Missouri's Assistant Physician program. • Other physicians who would not meet minimum requirements will view this as arbitrary and preferential, and will demand equal opportunity under the law.
<p>B. Amend 147.037 to include Exemption for primary care in a rural or underserved area. The board may exempt any requirement for more than one year of approved graduate medical education, as set forth in the Physicians Practice Act, if the applicant has served at least one year of graduate medical education approved by the board and if the following conditions are met:</p> <p>(a) The applicants meets all other qualifications for a medical license</p> <p>(i) The applicants submits satisfactory proof that issuance of a license based on the waiver requirement of more than one year of approved graduate medical education will not jeopardize the health, safety, and welfare of the citizens of this state.</p> <p>Satisfactory proof would include participation in clinical assessment at U of M;</p>	<p>Pros: Similar to pros listed above</p> <p>Cons: B(b)(i) This sections has similar concerns to the above regarding clarity of licensure title and potential supervision of other professions such as nursing ,PAs Etc.</p>

participation in 6 months of clinical experience and post assessment with an established assessment service provider similar to PACE or CPEP – receipt of certificate of clinical readiness to practice medicine (Meets level 5 of the 4 selected general milestones of the next accreditation system); and

- (b) The applicant submits proof – such as an employment contract – that he or she will enter into the practice of medicine in primary care in a rural or underserved community as defined by Minn stat. 144.1911 immediately upon obtaining a license to practice medicine based upon a waiver of the requirement for more than one year of graduate medical education.

(i) A license issued on the basis of this exemption shall be subject to the limitation that the licensee continue to practice primary care in a rural or underserved community as defined by Minn stat. 144.1911 and such other limitations, if any, deemed appropriate under the circumstances, which may include, but shall not be limited to, supervision by a medical practitioner, training, education, and scope of practice. After two years of practice under a limited license issued on the basis of a waiver of the requirement of more than one year of graduate medical education, a licensee may apply to the Board for removal of the limitations. The Board may grant or deny such application or may continue the license with limitations.

(ii) The Board shall take disciplinary action against a license granted on the basis of this exemption of the requirement of more than one year of graduate medical education for violation of the limitations on the license.

Policy & Planning Committee
October 12, 2016
4:30 p.m.
5th Floor Board of Medical Practice
Conference Room
Agenda

1. Update on 2017 housekeeping changes to the Medical Practice Act.
2. Presentation on proposed changes to the Registered Athletic Trainers Practice Act.
 - Enclosed copy of current practice act, Minn. Stat. § 148.7801 – 148.7808.
 - Draft legislation.
 - Athletic Trainers Modification Act.
 - Athletic Trainers Act Modification, Abstract.
3. Presentation on proposed changes to the Registered Naturopathic Doctors Practice Act.
 - Enclosed copy of current practice act, Minn. Stat. § 147E.
 - Draft legislation.
 - Frequently Asked Questions about Naturopathic Medicine in the USA, by Serina Aubrecht, Immediate Past Chair, Naturopathic Doctor Advisory Board.
 - Naturopathic Formulary Laws by State.
 - 10 Reasons Naturopathic Medicine Lowers Healthcare Costs.
 - Naturopathic Medicine: Cost Saving Disease Prevention and Health Improvement.
4. Presentation on proposals for modifying licensure requirements for Immigrant International Medical Graduates.
 - Proposals discussed by the International Medical Graduate (IMG) Licensure Study Work Group.
 - Proposal(s) for potential recommendation and incorporation into the IMG Stakeholder Group report to the 2017 Legislature.
 - Task Force on Foreign-Trained Physicians, Minnesota Department of Health Report to the Minnesota Legislature 2015 (January 2015) – <http://www.health.state.mn.us/divs/orhpc/workforce/iimg/finalrpt.pdf>.
 - Chapter 71 - S.F. No. 1458, Section 17. [144.1911] International Medical Graduates Assistance Program.
 - IMG Program – www.health.state.mn.us/divs/orhpc/img/.
 - IMG Assistance Program: Report to the Minnesota Legislature 2016 (January 2016) – <http://www.health.state.mn.us/divs/orhpc/img/documents/img2016.pdf>.
 - Continuum of Services – Years 1-2 of IMG Assistance Program.
 - *The New England Journal of Medicine*, Special Report, “The Next GME Accreditation System – Rationale and Benefits” by Thomas J. Nasca, M.D., M.A.C.P., Ingrid Philibert, Ph.D., M.B.A., Timothy Brigham, Ph.D., M.Div., and Timothy C. Flynn, M.D.

148.7801 CITATION.

Sections 148.7801 to 148.7815 may be cited as the "Minnesota Athletic Trainers Act."

History: *1993 c 232 s 2*

148.7802 DEFINITIONS.

Subdivision 1. **Applicability.** The definitions in this section apply to this chapter.

Subd. 2. **Approved continuing education program.** "Approved continuing education program" means a continuing education program that meets the continuing education requirements in section 148.7812 and is approved by the board.

Subd. 3. **Approved education program.** "Approved education program" means a university, college, or other postsecondary education program of athletic training that, at the time the student completes the program, is approved or accredited by a nationally recognized accreditation agency for athletic training education programs approved by the board.

Subd. 4. **Athlete.** "Athlete" means a person participating in exercises, sports, games, or recreation requiring physical strength, agility, flexibility, range of motion, speed, or stamina.

Subd. 5. **Athletic injury.** "Athletic injury" means an injury sustained by a person as a result of the person's participation in exercises, sports, games, or recreation requiring physical strength, agility, flexibility, range of motion, speed, or stamina.

Subd. 6. **Athletic trainer.** "Athletic trainer" means a person who engages in athletic training under section 148.7806 and is registered under section 148.7808.

Subd. 7. **Board.** "Board" means the Board of Medical Practice.

Subd. 8. **Credential.** "Credential" means a license, permit, certification, registration, or other evidence of qualification or authorization to practice as an athletic trainer in this state or any other state.

Subd. 9. **Credentialing examination.** "Credentialing examination" means an examination administered by the Board of Certification, or the board's recognized successor, for credentialing as an athletic trainer, or an examination for credentialing offered by a national testing service that is approved by the board.

Subd. 10. **Primary employment site.** "Primary employment site" means the institution, organization, corporation, or sports team where the athletic trainer is employed for the practice of athletic training.

Subd. 11. **Primary physician.** "Primary physician" means a licensed medical physician who serves as a medical consultant to an athletic trainer.

History: 1993 c 232 s 3; 2014 c 291 art 4 s 14,15

148.7803 DESIGNATION OF ATHLETIC TRAINER.

Subdivision 1. **Designation.** A person shall not use in connection with the person's name the words or letters registered athletic trainer; licensed athletic trainer; Minnesota registered athletic trainer; athletic trainer; AT; ATR; or any words, letters, abbreviations, or insignia indicating or implying that the person is an athletic trainer, without a certificate of registration as an athletic trainer issued under sections 148.7808 to 148.7810. A student attending a college or university athletic training program must be identified as an "athletic training student."

Subd. 2. **Penalty.** A person who violates this section is guilty of a misdemeanor and subject to section 214.11.

History: 1993 c 232 s 4; 2014 c 291 art 4 s 16

148.7804 POWERS OF THE BOARD.

The board, acting under the advice of the Athletic Trainers Advisory Council, shall issue all registrations and shall exercise the following powers and duties:

- (1) adopt rules necessary to implement sections 148.7801 to 148.7815;
- (2) prescribe registration application forms, certificate of registration forms, protocol forms, and other necessary forms;
- (3) approve a registration examination;
- (4) keep a complete record of registered athletic trainers, prepare a current official listing of the names and addresses of registered athletic trainers, and make a copy of the list available to any person requesting it upon payment of a copying fee established by the board;
- (5) keep a permanent record of all its proceedings; and
- (6) establish the duties of, and employ, clerical personnel.

History: 1993 c 232 s 5

148.7805 ATHLETIC TRAINERS ADVISORY COUNCIL.

Subdivision 1. **Membership.** The Athletic Trainers Advisory Council is created and is composed of eight members appointed by the board. The advisory council consists of:

- (1) two public members as defined in section 214.02;
- (2) three members who are registered athletic trainers, one being both a licensed physical therapist and registered athletic trainer as submitted by the Minnesota American Physical Therapy Association;
- (3) two members who are medical physicians licensed by the state and have experience with athletic training and sports medicine; and
- (4) one member who is a doctor of chiropractic licensed by the state and has experience with athletic training and sports injuries.

Subd. 2. **Administration.** The advisory council is established and administered under section 15.059.

Subd. 3. **Duties.** The advisory council shall:

- (1) advise the board regarding standards for athletic trainers;
- (2) distribute information regarding athletic trainer standards;
- (3) advise the board on enforcement of sections 148.7801 to 148.7815;
- (4) review registration and registration renewal applications and make recommendations to the board;
- (5) review complaints in accordance with sections 214.10 and 214.13, subdivision 6;
- (6) review investigation reports of complaints and recommend to the board whether disciplinary action should be taken;
- (7) advise the board regarding evaluation and treatment protocols;
- (8) advise the board regarding approval of continuing education programs; and
- (9) perform other duties authorized for advisory councils under chapter 214, as directed by the board.

History: 1993 c 232 s 6; 2000 c 260 s 25; 2014 c 286 art 8 s 20; 2014 c 291 art 4 s 17

148.7806 ATHLETIC TRAINING.

Athletic training by a registered athletic trainer under section 148.7808 includes the activities described in paragraphs (a) to (e).

(a) An athletic trainer shall:

- (1) prevent, recognize, and evaluate athletic injuries;
- (2) give emergency care and first aid;
- (3) manage and treat athletic injuries; and
- (4) rehabilitate and physically recondition athletic injuries.

The athletic trainer may use modalities such as cold, heat, light, sound, electricity, exercise, and mechanical devices for treatment and rehabilitation of athletic injuries to athletes in the primary employment site.

(b) The primary physician shall establish evaluation and treatment protocols to be used by the athletic trainer. The primary physician shall record the protocols on a form prescribed by the board. The protocol form must be updated yearly at the athletic trainer's registration renewal time and kept on file by the athletic trainer.

(c) At the primary employment site, except in a corporate setting, an athletic trainer may evaluate and treat an athlete for an athletic injury not previously diagnosed for not more than 30 days, or a period of time as designated by the primary physician on the protocol form, from the date of the initial evaluation and treatment. Preventative care after resolution of the injury is not considered treatment. This paragraph does not apply to a person who is referred for treatment by a person licensed in this state to practice medicine as defined in section 147.081, to practice chiropractic as defined in section 148.01, to practice podiatry as defined in section 153.01, or to practice dentistry as defined in section 150A.05 and whose license is in good standing.

(d) An athletic trainer may:

(1) organize and administer an athletic training program including, but not limited to, educating and counseling athletes;

(2) monitor the signs, symptoms, general behavior, and general physical response of an athlete to treatment and rehabilitation including, but not limited to, whether the signs, symptoms, reactions, behavior, or general response show abnormal characteristics; and

(3) make suggestions to the primary physician or other treating provider for a modification in the treatment and rehabilitation of an injured athlete based on the indicators in clause (2).

(e) In a clinical, corporate, and physical therapy setting, when the service provided is, or is represented as being, physical therapy, an athletic trainer may work only under the direct supervision of a physical therapist as defined in section 148.65.

History: 1993 c 232 s 7

148.7807 LIMITATIONS ON PRACTICE.

If an athletic trainer determines that a patient's medical condition is beyond the scope of practice of that athletic trainer, the athletic trainer must refer the patient to a person licensed in this state to practice medicine as defined in section 147.081, to practice chiropractic as defined in section 148.01, to practice podiatry as defined in section 153.01, or to practice dentistry as defined in section 150A.05 and whose license is in good standing and in accordance with established evaluation and treatment protocols. An athletic trainer shall modify or terminate treatment of a patient that is not beneficial to the patient, or that is not tolerated by the patient.

History: 1993 c 232 s 8

148.7808 REGISTRATION; REQUIREMENTS.

Subdivision 1. **Registration.** The board may issue a certificate of registration as an athletic trainer to applicants who meet the requirements under this section. An applicant for registration as an athletic trainer shall pay a fee under section 148.7815 and file a written application on a form, provided by the board, that includes:

- (1) the applicant's name, Social Security number, home address and telephone number, business address and telephone number, and business setting;
- (2) evidence satisfactory to the board of the successful completion of an education program approved by the board;
- (3) educational background;
- (4) proof of a baccalaureate or master's degree from an accredited college or university;
- (5) credentials held in other jurisdictions;
- (6) a description of any other jurisdiction's refusal to credential the applicant;
- (7) a description of all professional disciplinary actions initiated against the applicant in any other jurisdiction;
- (8) any history of drug or alcohol abuse, and any misdemeanor or felony conviction;
- (9) evidence satisfactory to the board of a qualifying score on a credentialing examination;
- (10) additional information as requested by the board;
- (11) the applicant's signature on a statement that the information in the application is true and correct to the best of the applicant's knowledge and belief; and
- (12) the applicant's signature on a waiver authorizing the board to obtain access to the applicant's records in this state or any other state in which the applicant has completed an education program approved by the board or engaged in the practice of athletic training.

Subd. 2. [Repealed, 2014 c 291 art 4 s 59]

Subd. 3. **Registration by reciprocity.** (a) The board may register by reciprocity an applicant who:

- (1) submits the application materials and fees required under subdivision 1, clauses (1) to (8) and (10) to (12);
- (2) provides a verified copy of a current and unrestricted credential for the practice of athletic training in another jurisdiction that has credentialing requirements equivalent to or more stringent than the requirements under subdivision 1; and
- (3) provides letters of verification from the credentialing body in each jurisdiction in which the applicant holds a credential. Each letter must include the applicant's name, date of birth, credential number, date of issuance of the credential, a statement regarding disciplinary actions taken against the applicant, and the terms under which the credential was issued.

(b) An applicant for registration by reciprocity who has applied for registration under subdivision 1 and meets the requirements of paragraph (a), clause (1), may apply to the board for temporary registration under subdivision 4.

Subd. 4. Temporary registration. (a) The board may issue a temporary registration as an athletic trainer to qualified applicants. A temporary registration is issued for 120 days. An athletic trainer with a temporary registration may qualify for full registration after submission of verified documentation that the athletic trainer has achieved a qualifying score on a credentialing examination within 120 days after the date of the temporary registration. A temporary registration may not be renewed.

(b) Except as provided in subdivision 3, paragraph (a), clause (1), an applicant for a temporary registration must submit the application materials and fees for registration required under subdivision 1, clauses (1) to (8) and (10) to (12).

(c) An athletic trainer with a temporary registration shall work only under the direct supervision of an athletic trainer registered under this section. No more than two athletic trainers with temporary registrations shall work under the direction of a registered athletic trainer.

Subd. 5. Temporary permit. The board may issue a temporary permit to practice as an athletic trainer to an applicant eligible for registration under this section if the application for registration is complete, all applicable requirements in this section have been met, and a nonrefundable fee set by the board has been paid. The permit remains valid only until the meeting of the board at which a decision is made on the athletic trainer's application for registration.

History: 1993 c 232 s 9; 1999 c 33 s 7,8; 2014 c 291 art 4 s 18,19

MINNESOTA STATUTES

148.7802 DEFINITIONS

Subdivision 1. **Applicability.** The definitions in this section apply to this chapter.

Subd. 2. **Approved continuing education program.** “Approved continuing education program” means a continuing education program that meets the continuing education requirements in section 148.7812 and is approved by the board.

Subd. 3. **Approved education program.** “Approved education program” means a university, college, or other postsecondary education program of athletic training that, at the time the student completes the program, is approved or accredited by a nationally recognized accreditation agency for athletic training education programs approved by the board.

Subd. 4. ~~**Athlete.** “Athlete” means a person participating in exercises, sports, games, or recreation requiring physical strength, agility, flexibility, range of motion, speed, or stamina.~~

~~Subd. 5. **Athletic injury.** “Athletic injury” means an injury sustained by a person as a result of the person’s participation in exercises, sports, games, or recreation requiring physical strength, agility, flexibility, range of motion, speed, or stamina.~~

Subd. 6. **Athletic trainer.** “Athletic trainer” means a person who engages in athletic training under section 148.7802 and 148.7806 and is ~~licensed~~ **registered** under section 148.7808.

Subd. 6a. **Athletic training.** “Athletic training” means the provision of care for the prevention, recognition, evaluation, management, rehabilitation, and reconditioning of human ailments sustained or exacerbated by physical activity, or that limits the patient’s or client’s full return to functional physical activities and wellness. Athletic training does not include the practice of medicine as defined in section 147.081, or the practice of chiropractic as defined in section 148.01, or the practice of podiatric medicine as defined in section 153.01.

Subd. 7. **Board.** “Board” means the Board of Medical Practice.

Subd. 8. **Credential.** “Credential” means a license, permit, certification, registration, or other evidence of qualification or authorization to practice as an athletic trainer in this state or any other state.

Subd. 9. **Credentialing examination.** “Credentialing examination” means an examination administered by the Board of Certification, or the board’s recognized successor, for credentialing as an athletic trainer, or an examination for credentialing offered by a national testing service that is approved by the board.

~~Subd. 10. **Primary employment site.** “Primary employment site” means the institution, organization, corporation, or sports team where the athletic trainer is employed for the practice of athletic training.~~

~~Subd. 11. **Primary physician.** “Primary physician” means a licensed medical physician who serves as a medical consultant to an athletic trainer.~~

History: 1993 c 232 s 3; 2014 c 291 art 4 s 14, 15

148.7803 DESIGNATION OF ATHLETIC TRAINER.

Subdivision 1. **Designation.** A person shall not use in connection with the person's name the words or letters registered athletic trainer; licensed athletic trainer; Minnesota ~~licensed registered~~ athletic trainer; athletic trainer; AT; ATR; ~~ATC; LAT;~~ or any words, letters, abbreviations, or insignia indicating or implying that the person is an athletic trainer, without a ~~license certificate of registration~~ as an athletic trainer issued under sections 148.7808 to 148.7810. A student attending a college or university athletic training program must be identified as an "athletic training student."

Subd. 2. **Penalty.** A person who violates this section is guilty of a misdemeanor and subject to section 214.11.

History: 1993 c 232 s 4; 2014 c 291 art 4 s 16

148.7804 POWERS OF THE BOARD.

The board, acting under the advice of the Athletic Trainers Advisory Council, shall issue all ~~licenses registrations~~ and shall exercise the following powers and duties:

- (1) adopt rules necessary to implement sections 148.7801 to 148.7815;
- (2) prescribe ~~license registration~~ application forms, certificate of ~~license registration~~ forms, ~~protocol forms,~~ and other necessary forms;
- (3) approve a ~~licensure registration~~ examination;
- (4) keep a complete record of ~~licensed registered~~ athletic trainers, prepare a current official listing of the names and addresses of ~~licensed registered~~ athletic trainers, and make a copy of the list available to any person requesting it upon payment of a copying fee established by the board;
- (5) keep a permanent record of all its proceedings; and
- (6) establish the duties of, and employ, clerical personnel.

History: 1993 c 232 s 5

148.7805 ATHLETIC TRAINERS ADVISORY COUNCIL.

Subdivision 1. **Membership.** The Athletic Trainers Advisory Council is created and is composed of eight members by the board. The advisory council consists of:

- (1) two public members as defined in section 214.02;
- (2) three members who are ~~licensed~~ ~~registered~~ athletic trainers; one being both a licensed physical therapist and ~~licensed~~ ~~registered~~ athletic trainer as submitted by the Minnesota American Physical Therapy Association; and two as submitted by the Minnesota Athletic Trainers' Association;
- (3) two members who are medical physicians licensed by the state and have experience with athletic training and sports medicine; and
- (4) one member who is a doctor of chiropractic licensed by the state and has experience with athletic training and sports injuries.

Subd. 2. **Administration.** The advisory council is established and administered under section 15.059.

Subd. 3. **Duties.** The advisory council shall:

- (1) advise the board regarding standards for athletic trainers;
- (2) distribute information regarding athletic trainer standards;
- (3) advise the board on enforcement of sections 148.7801 to 148.7815;
- (4) review ~~licensing~~ ~~registration~~ and ~~license~~ ~~registration~~ renewal applications and makes recommendation to the board;
- (5) review complaints in accordance with sections 214.10 and 214.13, subdivision 6;
- (6) review investigation reports of complaints and recommend to the board whether disciplinary action should be taken;
- (7) advise the board regarding evaluation and treatment protocols;
- (8) advise the board regarding approval of continuing education programs; and
- (9) perform other duties authorized for advisory councils under chapter 214, as directed by the board.

History: 1993 c 232 s 6; 2000 c 260 s 25; 2014 c 286 art 8 s 20; 2014 c 291 art 4 s 17

148.7806 ATHLETIC TRAINING.

- (a) Athletic training by a licensed ~~registered~~-athletic trainer under section 148.7808 includes the activities described in paragraphs (a) to (c) ~~(e)~~.
- (b) An athletic trainer shall perform athletic training on the direction of or in collaboration with a person:
 - (1) Licensed in the state to practice:
 - (i) medicine as defined in section 147.081;
 - (ii) as an advanced practice nurse as defined in section 148.171;
 - (iii) chiropractic as defined in section 148.01;
 - (iv) podiatric medicine as defined in section 153.01;
 - (v) as a physician assistant as defined in section 147A.01;
 - (vi) dentistry as defined in section 150A.05;
 - (vii) physical therapy as defined in section 148.65; and

(2) whose license is in good standing.

- ~~(1) prevent, recognize, and evaluate athletic injuries;~~
- ~~(2) give emergency care and first aid;~~
- ~~(3) manage and treat athletic injuries; and~~
- ~~(4) rehabilitate and physically recondition athletic injuries.~~

~~The athletic trainer may use modalities such as cold, heat, light, sound, electricity, exercise, and mechanical devices for treatment and rehabilitation of athletic injuries to athletes in primary employment site.~~

~~(c) The primary physician shall establish evaluation and treatment protocols to be used by the athletic trainer. The primary physician shall record the protocols on a form prescribed by the board. The protocol form must be updated yearly at the athletic trainer's registration renewal time and kept on file by the athletic trainer.~~

~~(d) At the primary employment site,~~ (c) except in a corporate setting, an athletic trainer may evaluate and treat an individual athlete for an athletic injury not previously diagnosed for not more than 30 days, ~~or a period of time as designated by the primary physician on the protocol form~~, from the date of the initial evaluation and treatment. Prevention, wellness, education, or exercise ~~Preventative care after resolution of the injury~~ is not considered treatment. This paragraph does not apply to a person who is referred for a treatment by a person (1) licensed in this state to practice medicine as defined in section 147.081, to practice chiropractic as defined in section 148.01, to practice podiatric medicine as defined in section 153.01, or to practice dentistry as defined in section 150A.05 and (2) whose license is in good standing.

~~(e) And athletic trainer may:~~

~~(1) organize and administer an athletic training program including, but not limited to, educating and counseling athletes;~~

~~(2) monitor the signs, symptoms, general behavior, and general physical response of an athlete to treatment and rehabilitation including, but not limited to, whether the signs, symptoms, reactions, behavior, or general response show abnormal characteristics; and~~

~~(3) make suggestions to the primary physician or other treating provider for a modification in the treatment and rehabilitation of an injured athlete based on the indicators in clause (2).~~

~~(e) (c)~~ In a clinical, corporate, and physical therapy setting, when the service provided is, or is represented as being, physical therapy, an athletic trainer may work only under the direct supervision of a physical therapist as defined in section 148.65.

History: 1933 c 232 s 7

148.7807 LIMITATIONS ON PRACTICE.

If an athletic trainer determines that a patient's medical condition is beyond the scope of practice of that athletic trainer, the athletic trainer must refer the patient to a person licensed in this state to practice medicine as defined in section 147.081, to practice chiropractic as defined in section 148.01, to practice podiatry as defined in section 153.01, or to practice dentistry as defined in section 150A.05 and whose license is in good standing and in accordance with established evaluation and treatment protocols. An athletic trainer shall modify or terminate treatment of a patient that is not beneficial to the patient, or that is not tolerated by the patient.

History: 1993 c 232 s 8

148.7808 LICENSE REGISTRATION; REQUIREMENTS.

Subdivision 1. **Licensure Registration.** The board may issue a **license certificate of registration** as an athletic trainer to applicants who meet the requirements under this section. An applicant for a **license registration** as an athletic trainer shall pay a fee under section 148.7815 and file a written application on a form, provided by the board that includes:

(1) the applicant's name, Social Security number, home address and telephone number, business address and telephone number, and business setting;

(2) evidence satisfactory to the board of the successful completion of an education program approved by the board;

(3) educational background;

- (4) proof of a baccalaureate or master's degree from an accredited college or university;
- (5) credentials held in other jurisdictions;
- (6) a description of any other jurisdiction's refusal to credential the applicant;
- (7) a description of all professional disciplinary actions initiated against the applicant in any other jurisdictions;
- (8) any history of drug or alcohol abuse, and any misdemeanor or felony conviction;
- (9) evidence satisfactory to the board of a qualifying score on a credentialing examination;
- (10) additional information as requested by the board;
- (11) the applicant's signature on a statement that the information in the application is true and correct to the best of the applicant's knowledge and belief; and
- (12) the applicant's signature on a waiver authorizing the board to obtain access to the applicant's records in this state or any other state in which the applicant has completed an education program approved by the board or engaged in the practice of athletic training.

Subd. 2. [Repealed, 2014 c 291 art 4 s 59]

Subd. 3. **License Registration by reciprocity.** (a) the board may **license register** by reciprocity an applicant who:

(1) submits the application materials and fees required under subdivision 1, clauses (1) to (8) and (10) to (12);

(2) provides a verified copy of a current and unrestricted credential for the practice of athletic training in another jurisdiction that has credentialing requirements equivalent to or more stringent than the requirements under subdivision 1; and

(3) provides letters of verification from the credentialing body in each jurisdiction in which the applicant holds a credential. Each letter must include the applicant's name, date of birth, credential number, date of issuance of the credential, a statement regarding disciplinary actions taken against the applicant, and the terms under which the credential was issued.

(b) An applicant for **a license registration** by reciprocity who has applied for **a license registration** under subdivision 1 and meets the requirements of paragraph (a), clause (1) may apply to the board for temporary **license registration** under subdivision 4.

Subd. 4. **Temporary registration.** ~~(a) The board may issue a temporary registration as an athletic trainer to a qualified applicants. A temporary registration is issued for 120 days. An athletic trainer with a temporary registration may qualify for full registration after submission of verified documentation that the athletic trainer has achieved a qualifying score on a credentialing examination within 120 days after the date of the temporary registration. A temporary registration may not be renewed.~~

~~(b) Except as provided in subdivision 3, paragraph (a), clause (1), an applicant for a temporary registration must submit the application materials and fees for registration required under subdivision 1, clauses (1) to (8) and (10) to (12).~~

~~(c) An athletic trainer with a temporary registration shall work only under the direct supervision of an athletic trainer registered under this section. No more than two athletic trainers with temporary registration shall work under the direction of a registered athletic trainer.~~

Subd. 5 Temporary license permit. The board may issue a temporary **license permit** to practice as an athletic trainer to an applicant eligible for **license registration** under this section if the application for a **license registration** is complete, all applicable requirements in this section have been met, and a nonrefundable fee set by the board has been paid. The **license permit** remains valid only until the meeting of the board at which a decision is made on the athletic trainer's application for a **license registration**.

History: 1993 c 232 s 9; 1999 c 33 s 7,8; 2014 c 291 art 4 s 18,19

148.7809 **LICENSE REGISTRATION RENEWAL.**

Subdivision 1. **Requirements for license registration renewal.** A **licensed registered** athletic trainer shall apply to the board for a one-year extension of **license registration** by paying a fee under section 148.7815 and filing an application on a form provided by the board that includes:

- (1) the athletic trainer's name, Minnesota athletic trainer **license registration** number, home address and telephone number, business address and telephone number, and business setting;
- (2) work history for the past year, including the average number of hours worked per week;
- (3) a report of any change in status since initial registration or previous **license registration** renewal;
- (4) evidence satisfactory to the board of **national Board of Certification (or recognized successor) current certification and** having met the continuing education requirements of section 148.7812;

- (5) ~~the athletic trainer's signature on a statement that a current copy of the protocol form is on file at the athletic trainer's primary employment site; and~~
- (6) additional information as requested by the board.

Subd. 2. **License Registration renewal notice.** Before June 1 of each year, the board shall send out a renewal notice to an athletic trainer's last known address on file with the board. The notice shall include an application for **license registration** renewal and notice of the fees required for renewal. An athletic trainer who does not receive a renewal notice must still meet the requirements for **license registration** renewal under this section.

Subd. 3. **Renewal deadline.** (a) An application for **license** renewal ~~of registration~~ must be postmarked on or before July 1 of each year. If the postmark is illegible, the application is considered timely if received in the board office by the third working day after July 1.

(b) An application for **license** renewal ~~of registration~~ submitted after the deadline date must include a late fee under section 148.7815.

Subd. 4. **Lapse of license registration status.** (a) Except as provided in paragraph (b), an athletic trainer whose **license registration** has lapsed must:

- (1) apply for **license registration** renewal under this section; and
 - (2) submit evidence satisfactory to the board from a licensed medical physician verifying employment in athletic training for eight weeks every three years during the time of the lapse in **license registration**.
- (b) The board shall not renew, reissue, reinstate, or restore a **license registration** that has lapsed after June 30, 1999, and has not been renewed within two annual renewal cycles starting in July 1, 2001. An athletic trainer whose **license registration** is cancelled for nonrenewal must obtain a new **license registration** by applying for a **license registration** and fulfilling all requirements then in existence for an initial **license registration**.

History: 1993 c 232 s10; 2001 c 31 s 2

148.7810 BOARD ACTION ON APPLICATIONS.

Subdivision 1. **Verification of application information.** The board or advisory council, with the approval of the board, may verify information provided by an applicant for **license registration** under section 148.7808 and **license registration** renewal undersection 148.7809 to determine whether the information is accurate and complete.

Subd. 2. **Notification of board action.** Within 120 days of receipt of the application, the board shall notify each applicant in writing of the action taken on the application.

Subd. 3. **Request for hearing by applicant denied licensed registration.** An applicant denied a **license registration** shall be notified of the determination, and the grounds for it, and may request a hearing on the determination under Minnesota Rules, part 5615.0300, by filing a written statement of issues with the board within 20 days after receipt of the notice from the board. After the hearing, the board shall notify the applicant in writing of its decision.

History: 1993 c 232 s 11

148.7812 CONTINUING EDUCATIONR EQUIREMENTS.

Subdivision 1. **Number of contact hours required.** An athletic trainer shall complete during every three-year period at least the equivalent of 60 contact hours of continuing professional postdegree education in programs approved by the board. **The board may accept recertification by the Board of Certification, or the board's recognized successor, in lieu of compliance with the continuing education requirement during the cycle in which recertification is granted.**

Subd. 2. **Approved programs.** The board shall approve a continuing education program that has been approved for continuing education credit by the Board of Certification, or the board's recognized successor.

Subd. 3. **Approval of continuing education programs.** A continuing education program that has not been approved under subdivision 2 shall be approved by the board if:

- (1) the program content directly relates to the practice of athletic training or sports medicine;
- (2) each member of the program faculty shows expertise in the subject matter by holding a degree from an accreditation education program, having verifiable experience in the field of athletic training or sports medicine, having special training in the subject area, or having experience teaching in the subject area;
- (3) the program lasts at least one contact hour;
- (4) there are specific written objectives describing the goals of the program for the participants; and
- (5) the program sponsor maintains attendance records for four years.

Subd. 4. **Verification of continuing education credits.** The board shall periodically select a random sample of athletic trainers and require the athletic trainers to show evidence to the board of having completed the continuing education requirements attested to by the athletic trainer. Either the athletic trainer or state or national organizations that maintain continuing education records may provide to the board documentation of attendance at a continuing education program.

Subd. 5. **Restriction on continuing education topics.** To meet the continuing education requirement in subdivision 1, an athletic trainer may have no more than ten hours of continuing education in the areas of management, risk management, personal growth, and educational techniques in a three-year reporting period.

History: *1993 c 232 s 13; 2014 c 291 art 4 s 20*

148.7813 DISCIPLINARY PROCESS.

Subdivision 1. [Repealed, 2014 c 291 art 4 s 59]

Subd. 2. [Repealed, 2014 c 291 art 4 s 59]

Subd. 3. [Repealed, 2014 c 291 art 4 s 59]

Subd. 4. [Repealed, 2014 c 291 art 4 s 59]

Subd. 5. **Discipline; reporting.** For the purposes of this chapter, **licensed** ~~registered~~ athletic trainers and applicants are subject to sections 147.091 to 147.162.

History: *1993 c 232 s 14; 2014 c 291 art 4 s 21*

148.7814 APPLICABILITY.

Sections 148.7801 to 148.7815 do not apply to persons who are certified as athletic trainers by the Board of Certification or the board's recognized successor and come into Minnesota for a specific athletic event or series of athletic events with an individual or group.

History: *1993 c 232 s 15; 2014 c 291 art 4 s 22*

148.7815 FEES.

Subdivision 1. **Fees.** The board shall establish fees as follows:

(1) application fee, \$50;

(2) annual license registration fee, \$100;

~~(3) temporary license registration fee, \$100; and~~

~~(4) temporary permit, \$50.~~

Subd. 2. **Proration of fees.** The board may prorate the initial annual license fee ~~for registration~~ under section 148.7808. Athletic trainers licensed ~~registered~~ under section 148.7808 are required to pay the full fee upon license registration renewal.

Subd. 3. **Penalty for a late application for license registration renewal.** The penalty for late submission of a license registration renewal application under section 148.7809 is \$15.

Subd. 4. **Nonrefundable fees.** The fees in this section are nonrefundable.

History: 1993 c 232 s 16; 1999 c 33 s 9, 10



Athletic Trainers Modification Act

Minnesota Board of Medical Practice

Policy & Planning Committee

October 12, 2016

Presented by the [Minnesota Athletic Trainers' Association](#)

What is an Athletic Trainer?

“An AT is a healthcare professional who renders service or treatment, under the direction of or in collaboration with a physician, in accordance with their education and training and the states’ statutes, rules and regulations. As a part of the healthcare team, services provided by ATs comprise, but are not limited to, prevention and education, emergent care, clinical diagnosis, therapeutic intervention and rehabilitation of injuries and medical conditions.” ([BOC Standards of Professional Practice](#))

Recognized as an allied health care profession by:

American Medical Association (AMA)

Health Resources Services Administration (HRSA)

Department of Health and Human Services (HHS)



Practice Settings

- Orthopedics/Sports Medicine practices
- Rehabilitation clinics
- ED & Urgent Care
- Occupational health
- Military
- College/University athletics & health services
- Performing arts
- Olympics & Paralympics
- Professional sports
- Secondary schools
- Industrial/Manufacturing
- Fitness & Wellness



National Agencies

- Board of Certification, Inc. (BOC)
 - Administers credentialing exam & recertification through continuing education requirements for ATs
 - Qualifying exam score is required for registration in MN §148.7808 Subd. 1
- Commission on Accreditation of Athletic Training Education (CAATE)
 - Recognized by the Council for Higher Education Accreditation (CHEA)
 - Defines education standards nationally
 - Measures & accredits AT education programs
 - Approximately 360 accredited programs worldwide
- National Athletic Trainers' Association (NATA)
 - Professional association with over 49,000 members
 - Collaborates with BOC & CAATE through a formal Strategic Alliance





Demographics

	1993	2016
NATA Members	≈ 7,500	> 49,000
Registered ATs in MN	170	966
Disciplinary or Corrective Actions	N/A	3
Accredited AT Education Programs	1	8*

*Two are post-baccalaureate degree programs

Bureau of Labor Statistics predicts an overall increase of **21.1%** in athletic trainer employment by 2024, with estimated **46.9%** growth in the ambulatory care sector

Education Changes Since 1993

- The past 20 years has seen significant advancement in professional preparation of athletic trainers
 - Program type & degree level
 - Heightened accreditation standards & outcome measures
 - Increased clinical experiences across practice settings
- By 2022 *all* entry-level education will be at the Master's degree level

	1993	2005	2016	2022
Program type	Internship	Accredited	Accredited	Accredited
Degree level	Bachelor's	Bachelor's	Bachelor's or Master's	Master's
Education Competencies	2nd Edition	3rd Edition	5th Edition	6 th Edition or beyond



Educational Content – 5th Edition Competencies

- Evidence-based practice
- Prevention & health promotion
- Clinical examination & diagnosis
- Acute care of injury & illness
- Therapeutic interventions
- Psychosocial strategies & referral
- Health care administration
- Professional development & responsibility



Athletic Trainers Modification Act



- Transition from registration to licensure
- Intended to update the scope of practice for athletic trainers in MN
 - Minnesota Athletic Trainers Act was first enacted 1993
 - Minor housekeeping revision since; no definition or scope adjustments despite significant advancement in the professional preparation of ATs
- Further restrict temporary credentialing to only allow for applicants who have successfully completed the BOC credentialing exam

Proposed Revisions – Credential Level



- From Registration to Licensure

*“In MN, as in other jurisdictions, registration is a less restrictive form of credentialing. In order to be a registered health care professional, an individual must meet certain educational, training and examination requirements that he or she is qualified to practice and use the appropriate title to the profession, but **other individuals may engage in the practice without the use of the title.***

Minnesota law provides that registration is the appropriate level of credentialing for athletic trainers and naturopathic doctors.” (Minnesota Board of Medical Practice)

- Given the advancement in AT education, registration is no longer the appropriate level of credentialing & does not mirror the rest of the nation.

Proposed Revisions – Scope of Practice



Create a formal definition of “athletic training” in §148.7802 that reads:

"Athletic training" means the provision of care for the prevention, recognition, evaluation, management, rehabilitation, and reconditioning human ailments sustained or exacerbated by physical activity, or that limits the patient's or client's full return to functional physical activities and wellness. Athletic training does not include the practice of medicine as defined in section 147.081, the practice of chiropractic as defined in section 148.01, or the practice of podiatric medicine as defined in section 153.01"

Proposed Revisions – Scope of Practice

- Adjusts §148.7806 to identify the patient or client population from only “athletes” to “individuals”
- Asserts that “prevention, wellness, education, or exercise is not considered treatment” which matches the existing exclusion clause in [item a\(8\) of §148.75](#) in the Physical Therapy Practice Act in regards to preventative care.



Proposed Revisions – Scope of Practice



Assert in §148.7806 that:

“An athletic trainer shall perform athletic training on the direction or in collaboration with a person: 1). licensed in the state to practice: (i) medicine as defined in section 147.081; (ii) as an advanced practice registered nurse defined in section 148.171; (iii) chiropractic as defined in section 148.01; (iv) podiatric medicine as defined in section 153.01; (v) as a physician assistant as defined in section 147A.01; (vi) dentistry as defined in section 150A.05; (vii) physical therapy as defined in section 148.65; and 2). whose license is in good standing.”

Proposed Revisions – Scope of Practice

- Removes the protocol form signed only by a MD or DO as required in §148.7806 in order to allow for collaboration with the other licensed health professionals previously mentioned.
- The [Changes in Healthcare Professions' Scope of Practice: Legislative Considerations](#) white paper asserts that “collaboration between healthcare providers should be the professional norm”, especially at a time when the Institute of Medicine considers the development of interdisciplinary care teams as a core competency for all health professions.
- Only 6 other states require a signed protocol form in its regulation of athletic trainers

Proposed Revisions – Temporary Credential

- Repeals the temporary practice provision ([§148.7808 Subd. 2](#)) that allows individuals who have not yet successfully completed the national examination from the Board of Certification, Inc. to practice under the supervision of a registered athletic trainer for 120 days.
- Seeking to further restrict new applicants/individuals to the athletic training profession to better protect the public.



Questions & Discussion



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Athletic Trainers Act Modification
90th Legislative Session

ABSTRACT

Statutes 148.7801 – 148.7815, the Minnesota Athletic Trainers' Act was originally enacted in 1993 and has not received any updates to definitional language or scope of practice since that time. The Athletic Trainers Modification Act seek to modify these statutes to bring definitional language around scope of practice in line with professional practice and mirror the evolution of this health care profession over the past 23 years.

Amy Brugge, EdD, ATR, ATC
Chair, Governmental Affairs Committee
Minnesota Athletic Trainers' Association

October 1, 2016

Introduction

The Minnesota Athletic Trainers Act ([Minn Stat §148.7801 – 148.7815](#))¹ was enacted in 1993 to regulate athletic trainers in their professional practice in the state. Athletic trainers across Minnesota have been working to update definitional language around athletic training services for over a decade. In 2014, minor housekeeping revisions were made to update the statutes to reflect current credentialing bodies and educational routes, as the 1993 language had been rendered ineffective in regards to education expectations due to the evolution of athletic training as a health care profession. There was a committee hearing on scope of practice updates once in the Minnesota House of Representatives in 2008, and prior to this legislative session there has never been a committee hearing in the Minnesota Senate related to scope. This report serves to provide background around the history of this profession, describe the registration of athletic trainers in Minnesota, delineate the proposed statute revisions in Athletic Trainers Modification Act, and detail why such action is necessary to improve patients' access to athletic trainers, further protect the public, and better serve the citizens of Minnesota.

Background

When the Minnesota Athletic Trainers' Act was in enacted in 1993 there were approximately 170 credentialed athletic trainers in Minnesota² and roughly 7,500 athletic trainers nationwide.³ At the time, the minimum education expectation for athletic trainers was completion of a National Athletic Trainers Association (NATA)-approved bachelor's curriculum or a bachelor's degree in a related field with an associated internship, in order to be eligible for the national credentialing examination offered through the Board of Certification, Inc. Today there are 966 athletic trainers registered in Minnesota⁴ and more than 49,000 athletic trainers across the United States.⁵ The minimum education required⁶ to be eligible for the Board of Certification, Inc. examination is a bachelor's or master's degree from an accredited program, including at least two years of clinical education, and all accredited programs must transition to the master's degree level by 2022.⁷ As this evolution in professional preparation has occurred, states have moved athletic trainers to the licensure level⁸ and modified scope of practice accordingly, except in Minnesota where athletic trainers are registered, not licensed, and have not had any definitional or scope of practice updates to the laws that regulate them. Like occupational therapists, who no longer prepare patients for only work-related tasks, athletic trainers no longer care only for "athletes", but instead provide care to physically active patients across the lifespan. Although a change in nomenclature for this provider group may be appropriate, the National Athletic Trainers' Association has elected to retain the original name of "athletic trainer" after two serious investigations in the 2000s⁹, as updating practice acts across the nation would be a multi-million dollar endeavor.

¹ Minn Stat §148.7801-148.7815

² Minnesota Board of Medical Practice

³ Board of Certification, Inc.

⁴ Minnesota Board of Medical Practice – data current as of 9/2016

⁵ Board of Certification, Inc.

⁶ National Athletic Trainers' Association – [Athletic Training Education Overview](#)

⁷ [Commission on Accreditation of Athletic Training Education](#)

⁸ [National Athletic Trainers' Association \(NATA\) – State Regulatory Boards](#)

⁹ National Athletic Trainers' Association Nomenclature Task Force [2004](#) & [2012](#)

Athletic Trainer Registration in Minnesota

The 1993 statutes for athletic trainer registration do not define “athletic training”, but instead delineate what an athletic trainer shall do in §148.7806. These statutes detail the process by which athletic trainers register in the state, define the composition of the Athletic Trainers Advisory Council under the Board of Medical Practice, designate the credential, set continuing education requirements, and explicate that athletic trainers evaluate “athletes” and treat “athletic injuries”. It is this definition around “athletes” and “athletic injuries” that does not fully encompass the health care services provided by athletic trainers to patients/clients, nor mirrors the conditions athletic trainers are professionally prepared to evaluate, manage, and/or refer given the evolution of athletic training education competencies¹⁰ and accredited education programs¹¹ since 1993. Further, the Revisor’s office feels that “athletic training” is a term that should be defined alongside all other definitions in the Minnesota Athletic Trainers Act in §148.7802.

Proposed Statute Revision

The Athletic Trainers Modification Act seeks to:

1. Create a formal definition of “athletic training” in §148.7802 that reads:

"Athletic training" means the provision of care for the prevention, recognition, evaluation, management, rehabilitation, and reconditioning human ailments sustained or exacerbated by physical activity, or that limits the patient's or client's full return to functional physical activities and wellness. Athletic training does not include the practice of medicine as defined in section 147.081, the practice of chiropractic as defined in section 148.01, or the practice of podiatric medicine as defined in section 153.01"

2. Asserts in §148.7806 that

“An athletic trainer shall perform athletic training on the direction or in collaboration with a person: 1). licensed in the state to practice: (i) medicine as defined in section 147.081; (ii) as an advanced practice registered nurse defined in section 148.171; (iii) chiropractic as defined in section 148.01; (iv) podiatric medicine as defined in section 153.01; (v) as a physician assistant as defined in section 147A.01; (vi) dentistry as defined in section 150A.05; (vii) physical therapy as defined in section 148.65; and 2). whose license is in good standing.”

3. Repeals the temporary practice provision ([§148.7808 Subd. 2](#)) that allows individuals who have not yet successfully completed the national examination from the Board of Certification, Inc. to practice under the supervision of a registered athletic trainer for 120 days. This change seeks to further restrict individuals in the athletic training profession to better protect the public.
4. Removes the protocol form¹² signed only by a MD or DO as required in §148.7806 in order to allow for collaboration with the other licensed health professionals previously mentioned. The

¹⁰ [Athletic Training Education Competencies, 5th Edition](#)

¹¹ Commission on Accreditation of Athletic Training Education ([CAATE](#))– recognized by the Council for Higher Education Accreditation ([CHEA](#))

¹² Minnesota Board of Medical Practice – [Athletic Trainer Registration Protocol Form](#)

[Changes in Healthcare Professions' Scope of Practice: Legislative Considerations](#) white paper¹³ asserts that “collaboration between healthcare providers should be the professional norm”, especially at a time when the Institute of Medicine¹⁴ considers the development of interdisciplinary care teams as a core competency for all health professions.

5. Adjusts §148.7806 to identify the patient or client population from only “athletes” to “individuals” and asserts that “[prevention, wellness, education, or exercise is not considered treatment](#)” which matches the existing exclusion clause in [item a\(8\) of §148.75](#) in the Physical Therapy Practice Act in regards to preventative care.
6. Makes no alteration to item (e) in §148.7806 that states “[when the service provided is, or is represented as being, physical therapy, an athletic trainer may work only under the direct supervision of a physical therapist as defined in section 148.65](#)” so as not to conflict with the business interests of the physical therapists who utilize athletic trainers in the provision of physical therapy, and not to contest the legal precedent set via the *Toni Lee v. Fairview Health System* case of 2004.

The Rationale for Practice Act Revision

The rationale for the proposed revisions is multi-faceted, yet predicated on the overall need to align the Minnesota Athletic Trainers Act of 1993 with current educational preparation and professional practice. Like all health professions, the practice of athletic training has advanced over the decades, demonstrates professional overlap with other peer provider groups, and requires prerequisite knowledge, skills, and abilities from entry-level education, formal post-professional education, and required continuing education. First, it is necessary to define “athletic training” in state statutes.

The proposed definition of athletic training seeks to succinctly summarize what previously existed outside the definition section in §148.7802 of the Minnesota Athletic Trainers Act, and appropriately encompasses all that athletic trainers are prepared to do either with “patients” or with “clients”. It identifies “human ailments” in the scope language, identical to item [a\(1\) of §148.75](#) in the physical therapy statutes, and addresses the physically active population athletic trainers regularly engage with in professional practice. In particular, it describes an athletic trainer’s ability to return physically active individuals back to a level of function beyond that of normal activities of daily living to promote and maintain overall health and wellness, and therefore prevent future health care expenditures.

The language “on the direction of or in collaboration with” speaks to the interdisciplinary care team that athletic trainers commonly function within, is inclusive of the variety of licensed providers who may seek to incorporate athletic trainers in their private practice, allows athletic trainers to accept referrals from providers beyond a supervising MD or DO, and yet allows individual healthcare organizations to determine if the athletic trainers should perform care “on the direction” of a specific provider. This language is not unique, as it mirrors the language defining the practice of athletic training in the *Board of Certification’s Standards of Professional Practice*¹⁵ and corresponds with the National Athletic

¹³ [Changes in Healthcare Professions' Scope of Practice: Legislative Considerations](#)

¹⁴ [Institute of Medicine – Core Competencies](#)

¹⁵ [BOC Standards of Professional Practice](#)

Trainers' Association definition of athletic trainers.¹⁶ The proposed revision removes the existing protocol form signed by a MD or DO licensed in Minnesota, which is not collected by the Board of Medical Practice as part of the registration process, as this form limits other provider groups' ability to employ an athletic trainer and forces the MD or DO to accept liability for the provision of care by the athletic trainer who may not be directly under their employment. Given that the Bureau of Labor Statistics¹⁷ predicts an overall increase of 21.1% in athletic trainer employment by 2024, with estimated 46.9% growth in the ambulatory care sector, it is prudent that non-physicians also be able to incorporate athletic trainers into their private practice and further increase rural access to athletic training services. Although this protocol form may have been more common in 1993, today only 6 states besides Minnesota retain such a protocol form in their athletic training practice acts. Two additional states require a physician to complete a checkbox form in which they accept liability for the athletic trainer, but overall a protocol form is not the standard in states' regulation of athletic trainers. Removing the protocol form will make the athletic trainer fully liable for the provision of care and may increase liability insurance premiums for athletic trainers in Minnesota, although this has not been the case in other states where athletic trainers are licensed and do not have a protocol form. However, this is something the state's athletic trainers are willing to accept in order to have greater participation in collaborative interdisciplinary practice in their employment settings. In regards to public safety, the Board of Medical Practice received eight complaints against seven athletic trainers during the last biennium and there have been three disciplinary or corrective actions taken by the Board of Medical Practice since the profession became regulated in Minnesota.¹⁸

Despite this record of safe practice among Minnesota's athletic trainers, repealing the temporary registration provision for individuals who have not yet successfully completed the national credentialing examination is one way to better protect the public and regulate the profession. Currently, a non-certified athletic trainer may work under the supervision of a registered athletic trainer (who functions under the liability of the associated MD/DO) for up to 120 days. As part of the elimination of the protocol form, it is best practice to also eliminate this temporary permitting of individuals who have not yet passed the national examination for athletic trainers. This is stricter than other provider groups. For instance, an applicant for a physical therapy license who has qualified to be eligible for examination may practice under the supervision of a licensed physical therapist for up to 90 days after the next examination ([Minn Stat §148.71](#)¹⁹), and occupational therapists allow for a similar process for up to six months ([Minn Stat §148.6418](#)²⁰). Repealing [§148.7808 Subd. 2](#) from the Minnesota Athletic Trainers Act will ensure that all temporary registrants have already successfully completed the national examination prior to interacting with patients and clients in Minnesota.

It is also necessary to exclude "prevention, wellness, education, or exercise as treatment" in the current 30-day patient access period, as the current version of §148.7806 only states that "preventative care *after resolution of the injury* is not considered treatment" (emphasis added). The difference between these sentences is simple, as the proposed language ensures that athletic trainers are able to provide preventative care, patient/client education, and wellness and fitness activities prior to the development of an ailment without having to refer this otherwise healthy individual into the healthcare

¹⁶ [National Athletic Trainers' Association Definition of Athletic Trainers](#)

¹⁸ [Bureau of Labor Statistics – Athletic Trainers Job Outlook](#)

¹⁸ Email correspondence (09/2016) with Ruth Martinez, Executive Director Board of Medical Practice

¹⁹ [Minn Stat §148.71](#)

²⁰ [Minn Stat §148.6418](#)

system at the 30-day mark. The goal is to keep healthy clients healthy and not be held to a referral when the “client” has not yet become a “patient”.

Summary

The evolution of the athletic training profession since 1993 is inherently equal to that of other provider groups whose education and professional preparation has expanded, yet athletic trainers in Minnesota have not been granted any scope of practice progression in the 23 years since the Minnesota Athletic Trainers Act was written into law. Today in Minnesota, newly credentialed professionals are held to an outdated definition of their field via a law that was enacted prior to their birth, despite considerable evolution of the athletic training profession in the previous two decades. The Athletic Trainers Modification Act seeks to make these appropriate modifications and update existing statutes to mirror current educational competencies in athletic training and the professional practice of athletic trainers with a physically active population.

CHAPTER 147E

REGISTERED NATUROPATHIC DOCTORS

147E.01	DEFINITIONS.	147E.20	BOARD ACTION ON APPLICATIONS FOR REGISTRATION.
147E.05	SCOPE OF PRACTICE.	147E.25	CONTINUING EDUCATION REQUIREMENT.
147E.06	PROFESSIONAL CONDUCT.	147E.30	DISCIPLINE; REPORTING.
147E.10	PROTECTED TITLES.	147E.35	REGISTERED NATUROPATHIC DOCTOR ADVISORY COUNCIL.
147E.15	REGISTRATION REQUIREMENTS.	147E.40	FEES.

147E.01 DEFINITIONS.

Subdivision 1. **Applicability.** The definitions in this section apply to this chapter.

Subd. 2. **Advisory council.** "Advisory council" means the Registered Naturopathic Doctor Advisory Council established under section 147E.35.

Subd. 3. **Approved naturopathic medical education program.** "Approved naturopathic medical education program" means a naturopathic medical education program in the United States or Canada and meets the requirements for accreditation by the Council on Naturopathic Medical Education (CNME) or an equivalent federally recognized accrediting body for the naturopathic medical profession recognized by the board. This program must offer graduate-level full-time didactic and supervised clinical training leading to the degree of Doctor of Naturopathy or Doctor of Naturopathic Medicine. The program must be an institution, or part of an institution, of higher education that at the time the student completes the program is:

(1) either accredited or is a candidate for accreditation by a regional institution accrediting agency recognized by the United States Secretary of Education; or

(2) a degree granting college or university that prior to the existence of CNME offered a full-time structured curriculum in basic sciences and supervised patient care comprising a doctoral naturopathic medical education that is at least 132 weeks in duration, must be completed in at least 35 months, and is reputable and in good standing in the judgment of the board.

Subd. 4. **Board.** "Board" means the Board of Medical Practice or its designee.

Subd. 5. **Contact hour.** "Contact hour" means an instructional session of 50 consecutive minutes, excluding coffee breaks, registration, meals without a speaker, and social activities.

Subd. 6. **Homeopathic preparations.** "Homeopathic preparations" means medicines prepared according to the Homeopathic Pharmacopoeia of the United States.

Subd. 7. **Registered naturopathic doctor.** "Registered naturopathic doctor" means an individual registered under this chapter.

Subd. 8. **Minor office procedures.** "Minor office procedures" means the use of operative, electrical, or other methods for the repair and care incidental to superficial lacerations and abrasions, superficial lesions, and the removal of foreign bodies located in the superficial tissues and the use of antiseptics and local topical anesthetics in connection with such methods.

Subd. 9. **Naturopathic licensing examination.** "Naturopathic licensing examination" means the Naturopathic Physicians Licensing Examination or its successor administered by the North American Board of Naturopathic Examiners or its successor as recognized by the board.

Subd. 10. **Naturopathic medicine.** "Naturopathic medicine" means a system of primary health care for the prevention, assessment, and treatment of human health conditions, injuries, and diseases that uses:

- (1) services, procedures, and treatments as described in section 147E.05; and
- (2) natural health procedures and treatments in section 146A.01, subdivision 4.

Subd. 11. **Naturopathic physical medicine.** "Naturopathic physical medicine" includes, but is not limited to, the therapeutic use of the physical agents of air, water, heat, cold, sound, light, and electromagnetic nonionizing radiation and the physical modalities of electrotherapy, diathermy, ultraviolet light, hydrotherapy, massage, stretching, colon hydrotherapy, frequency specific microcurrent, electrical muscle stimulation, transcutaneous electrical nerve stimulation, and therapeutic exercise.

History: 2008 c 348 s 1

147E.05 SCOPE OF PRACTICE.

Subdivision 1. **Practice parameters.** (a) The practice of naturopathic medicine includes, but is not limited to, the following services:

(1) ordering, administering, prescribing, or dispensing for preventive and therapeutic purposes: food, extracts of food, nutraceuticals, vitamins, minerals, amino acids, enzymes, botanicals and their extracts, botanical medicines, herbal remedies, homeopathic medicines, dietary supplements and nonprescription drugs as defined by the Federal Food, Drug, and Cosmetic Act, glandulars, protomorphogens, lifestyle counseling, hypnotherapy, biofeedback, dietary therapy, electrotherapy, galvanic therapy, oxygen, therapeutic devices, barrier devices for contraception, and minor office procedures, including obtaining specimens to assess and treat disease;

(2) performing or ordering physical examinations and physiological function tests;

(3) ordering clinical laboratory tests and performing waived tests as defined by the United States Food and Drug Administration Clinical Laboratory Improvement Amendments of 1988 (CLIA);

(4) referring a patient for diagnostic imaging including x-ray, CT scan, MRI, ultrasound, mammogram, and bone densitometry to an appropriately licensed health care professional to conduct the test and interpret the results;

(5) prescribing nonprescription medications and therapeutic devices or ordering noninvasive diagnostic procedures commonly used by physicians in general practice; and

(6) prescribing or performing naturopathic physical medicine.

(b) A registered naturopathic doctor may admit patients to a hospital if the naturopathic doctor meets the hospital's governing body requirements regarding credentialing and privileging process.

Subd. 2. **Prohibitions on practice.** (a) The practice of naturopathic medicine does not include:

- (1) administering therapeutic ionizing radiation or radioactive substances;

(2) administering general or spinal anesthesia;

(3) prescribing, dispensing, or administering legend drugs or controlled substances including chemotherapeutic substances; or

(4) performing or inducing abortions.

(b) A naturopathic doctor registered under this chapter shall not perform surgical procedures using a laser device or perform surgical procedures beyond superficial tissue.

(c) A naturopathic doctor shall not practice or claim to practice as a medical doctor, surgeon, osteopath, dentist, podiatrist, optometrist, psychologist, advanced practice professional nurse, physician assistant, chiropractor, physical therapist, acupuncturist, dietician, nutritionist, or any other health care professional, unless the naturopathic physician also holds the appropriate license or registration for the health care practice profession.

History: 2008 c 348 s 2

147E.06 PROFESSIONAL CONDUCT.

Subdivision 1. **Informed consent.** (a) The registered naturopathic doctor shall obtain a signed informed consent from the patient prior to initiating treatment and after advising the patient of the naturopathic doctor's qualifications including education and registration information; and outlining of the scope of practice of registered naturopathic doctors in Minnesota. This information must be supplied to the patient in writing before or at the time of the initial visit. The registrant shall present treatment facts and options accurately to the patient or to the individual responsible for the patient's care and make treatment recommendations according to standards of good naturopathic medical practice.

(b) Upon request, the registered naturopathic doctor must provide a copy of the informed consent form to the board.

Subd. 2. **Patient records.** (a) A registered naturopathic doctor shall maintain a record for seven years for each patient treated, including:

(1) a copy of the informed consent;

(2) evidence of a patient interview concerning the patient's medical history and current physical condition;

(3) evidence of an examination and assessment;

(4) record of the treatment provided to the patient; and

(5) evidence of evaluation and instructions given to the patient, including acknowledgment by the patient in writing that, if deemed necessary by the registered naturopathic doctor, the patient has been advised to consult with another health care provider.

(b) A registered naturopathic doctor shall maintain the records of minor patients for seven years or until the minor's 19th birthday, whichever is longer.

Subd. 3. **Data practices.** All records maintained on a naturopathic patient by a registered naturopathic doctor are subject to sections 144.291 to 144.298.

Subd. 4. **State and municipal public health regulations.** A registered naturopathic doctor shall comply with all applicable state and municipal requirements regarding public health.

History: 2008 c 348 s 3

147E.10 PROTECTED TITLES.

Subdivision 1. **Designation.** (a) No individual may use the title "registered naturopathic doctor," "naturopathic doctor," "doctor of naturopathic medicine," or use, in connection with the individual's name, the letters "R.N.D." or "N.M.D.," or any other titles, words, letters, abbreviations, or insignia indicating or implying that the individual is a registered naturopathic doctor unless the individual has been registered as a registered naturopathic doctor according to this chapter.

(b) After July 1, 2009, individuals who are registered under this chapter and who represent themselves as practicing naturopathic medicine by use of a term in paragraph (a) shall conspicuously display the registration in the place of practice.

Subd. 2. **Other health care practitioners.** Nothing in this chapter may be construed to prohibit or to restrict:

(1) the practice of a profession by individuals who are licensed, certified, or registered under other laws of this state and are performing services within their authorized scope of practice;

(2) the provision of the complementary and alternative healing methods and treatments, including naturopathy, as described in chapter 146A;

(3) the practice of naturopathic medicine by an individual licensed, registered, or certified in another state and employed by the government of the United States while the individual is engaged in the performance of duties prescribed by the laws and regulations of the United States;

(4) the practice by a naturopathic doctor duly licensed, registered, or certified in another state, territory, or the District of Columbia when incidentally called into this state for consultation with a Minnesota licensed physician or Minnesota registered naturopathic doctor; or

(5) individuals not registered by this chapter from the use of individual modalities which comprise the practice of naturopathic medicine.

Subd. 3. **Penalty.** A person violating subdivision 1 is guilty of a misdemeanor.

History: 2008 c 348 s 4

147E.15 REGISTRATION REQUIREMENTS.

Subdivision 1. **General requirements for registration.** To be eligible for registration, an applicant must:

(1) submit a completed application on forms provided by the board along with all fees required under section 147E.40 that includes:

- (i) the applicant's name, Social Security number, home address and telephone number, and business address and telephone number;
 - (ii) the name and location of the naturopathic medical program the applicant completed;
 - (iii) a list of degrees received from other educational institutions;
 - (iv) a description of the applicant's professional training;
 - (v) a list of registrations, certifications, and licenses held in other jurisdictions;
 - (vi) a description of any other jurisdiction's refusal to credential the applicant;
 - (vii) a description of all professional disciplinary actions initiated against the applicant in any jurisdiction; and
 - (viii) any history of drug or alcohol abuse, and any misdemeanor or felony conviction;
- (2) submit a copy of a diploma from an approved naturopathic medical education program;
- (3) have successfully passed the Naturopathic Physicians Licensing Examination, a competency-based national naturopathic licensing examination administered by the North American Board of Naturopathic Examiners or successor agency as recognized by the board; passing scores are determined by the Naturopathic Physicians Licensing Examination;
- (4) submit additional information as requested by the board, including providing any additional information necessary to ensure that the applicant is able to practice with reasonable skill and safety to the public;
- (5) sign a statement that the information in the application is true and correct to the best of the applicant's knowledge and belief; and
- (6) sign a waiver authorizing the board to obtain access to the applicant's records in this or any other state in which the applicant has completed an approved naturopathic medical program or engaged in the practice of naturopathic medicine.

Subd. 2. Registration by endorsement; reciprocity. (a) To be eligible for registration by endorsement or reciprocity, the applicant must hold a current naturopathic license, registration, or certification in another state, Canadian province, the District of Columbia, or territory of the United States, whose standards for licensure, registration, or certification are at least equivalent to those of Minnesota, and must:

- (1) submit the application materials and fees as required by subdivision 1, clauses (1), (2), and (4) to (6);
- (2) have successfully passed either:
 - (i) the Naturopathic Physicians Licensing Examination; or
 - (ii) if prior to 1986, the state or provincial naturopathic board licensing examination required by that regulating state or province;
- (3) provide a verified copy from the appropriate government body of a current license, registration, or certification for the practice of naturopathic medicine in another jurisdiction that has initial licensing, registration, or certification requirements equivalent to or higher than the requirements in subdivision 1; and

(4) provide letters of verification from the appropriate government body in each jurisdiction in which the applicant holds a license, registration, or certification. Each letter must state the applicant's name, date of birth, license, registration, or certification number, date of issuance, a statement regarding disciplinary actions, if any, taken against the applicant, and the terms under which the license, registration, or certification was issued.

(b) An applicant applying for license, registration, or certification by endorsement must be licensed, registered, or certified in another state or Canadian province prior to January 1, 2005, and have completed a 60-hour course and examination in pharmacotherapeutics.

Subd. 3. **Temporary registration.** The board may issue a temporary registration to practice as a registered naturopathic doctor to an applicant who is licensed, registered, or certified in another state or Canadian province and is eligible for registration under this section, if the application for registration is complete, all applicable requirements in this section have been met, and a nonrefundable fee has been paid. The temporary registration remains valid only until the meeting of the board at which time a decision is made on the registered naturopathic doctor's application for registration.

Subd. 4. **Registration expiration.** Registrations issued under this chapter expire annually.

Subd. 5. **Renewal.** To be eligible for registration renewal a registrant must:

(1) annually, or as determined by the board, complete a renewal application on a form provided by the board;

(2) submit the renewal fee;

(3) provide evidence of a total of 25 hours of continuing education approved by the board as described in section 147E.25; and

(4) submit any additional information requested by the board to clarify information presented in the renewal application. The information must be submitted within 30 days after the board's request, or the renewal request is nullified.

Subd. 6. **Change of address.** A registrant who changes addresses must inform the board within 30 days, in writing, of the change of address. All notices or other correspondence mailed to or served on a registrant by the board are considered as having been received by the registrant.

Subd. 7. **Registration renewal notice.** At least 45 days before the registration renewal date, the board shall send out a renewal notice to the last known address of the registrant on file. The notice must include a renewal application and a notice of fees required for renewal or instructions for online renewal. It must also inform the registrant that registration will expire without further action by the board if an application for registration renewal is not received before the deadline for renewal. The registrant's failure to receive this notice does not relieve the registrant of the obligation to meet the deadline and other requirements for registration renewal. Failure to receive this notice is not grounds for challenging expiration of registration status.

Subd. 8. **Renewal deadline.** The renewal application and fee must be postmarked on or before December 31 of the year of renewal. If the postmark is illegible, the application is considered timely if received by the third working day after the deadline.

Subd. 9. **Inactive status and return to active status.** (a) A registrant may be placed in inactive status upon application to the board by the registrant and upon payment of an inactive status fee.

(b) Registrants seeking restoration to active from inactive status must pay the current renewal fees and all unpaid back inactive fees. They must meet the criteria for renewal specified in subdivision 5, including continuing education hours.

(c) Registrants whose inactive status period has been five years or longer must additionally have a period of no less than eight weeks of advisory council-approved supervision by another registered naturopathic doctor.

Subd. 10. **Registration following lapse of registration status for two years or less.** For any individual whose registration status has lapsed for two years or less, to regain registration status, the individual must:

(1) apply for registration renewal according to subdivision 5;

(2) document compliance with the continuing education requirements of section 147E.25 since the registrant's initial registration or last renewal; and

(3) submit the fees required under section 147E.40 for the period not registered, including the fee for late renewal.

Subd. 11. **Cancellation due to nonrenewal.** The board shall not renew, reissue, reinstate, or restore a registration that has lapsed and has not been renewed within two annual registration renewal cycles starting January 2009. A registrant whose registration is canceled for nonrenewal must obtain a new registration by applying for registration and fulfilling all requirements then in existence for initial registration as a registered naturopathic doctor.

Subd. 12. **Cancellation of registration in good standing.** (a) A registrant holding an active registration as a registered naturopathic doctor in the state may, upon approval of the board, be granted registration cancellation if the board is not investigating the person as a result of a complaint or information received or if the board has not begun disciplinary proceedings against the registrant. Such action by the board must be reported as a cancellation of registration in good standing.

(b) A registrant who receives board approval for registration cancellation is not entitled to a refund of any registration fees paid for the registration year in which cancellation of the registration occurred.

(c) To obtain registration after cancellation, a registrant must obtain a new registration by applying for registration and fulfilling the requirements then in existence for obtaining initial registration as a registered naturopathic doctor.

Subd. 13. **Emeritus status of registration.** A registrant may change the status of the registration to "emeritus" by filing the appropriate forms and paying the onetime fee of \$50 to the board. This status allows the registrant to retain the title of registered naturopathic doctor but restricts the registrant from actively seeing patients.

History: 2008 c 348 s 5

147E.20 BOARD ACTION ON APPLICATIONS FOR REGISTRATION.

(a) The board shall act on each application for registration according to paragraphs (b) to (d).

(b) The board shall determine if the applicant meets the requirements for registration under section 147E.15. The board or advisory council may investigate information provided by an applicant to determine whether the information is accurate and complete.

(c) The board shall notify each applicant in writing of action taken on the application, the grounds for denying registration if registration is denied, and the applicant's right to review under paragraph (d).

(d) Applicants denied registration may make a written request to the board, within 30 days of the board's notice, to appear before the advisory council or the board and for the advisory council to review the board's decision to deny the applicant's registration. After reviewing the denial, the advisory council shall make a recommendation to the board as to whether the denial shall be affirmed. Each applicant is allowed only one request for review each yearly registration period.

History: 2008 c 348 s 6

147E.25 CONTINUING EDUCATION REQUIREMENT.

Subdivision 1. **Number of required contact hours.** (a) A registrant applying for registration renewal must complete a minimum of 25 contact hours of board-approved continuing education in the year preceding registration renewal, with the exception of the registrant's first incomplete year, and attest to completion of continuing education requirements by reporting to the board.

(b) Of the 25 contact hours of continuing education requirement in paragraph (a), at least five hours of continuing education must be in pharmacotherapeutics.

Subd. 2. **Approved programs.** The board shall approve continuing education programs that have been approved for continuing education credit by the American Association of Naturopathic Physicians or any of its constituent state associations, the American Chiropractic Association or any of its constituent state associations, the American Osteopathic Association Bureau of Professional Education, the American Pharmacists Association or any of its constituent state associations, or an organization approved by the Accreditation Council for Continuing Medical Education.

Subd. 3. **Approval of continuing education programs.** The board shall also approve continuing education programs that do not meet the requirements of subdivision 2 but meet the following criteria:

- (1) the program content directly relates to the practice of naturopathic medicine;
- (2) each member of the program faculty is knowledgeable in the subject matter as demonstrated by a degree from an accredited education program, verifiable experience in the field of naturopathic medicine, special training in the subject matter, or experience teaching in the subject area;
- (3) the program lasts at least 50 minutes per contact hour;
- (4) there are specific, measurable, written objectives, consistent with the program, describing the expected outcomes for the participants; and
- (5) the program sponsor has a mechanism to verify participation and maintains attendance records for three years.

Subd. 4. **Accumulation of contact hours.** A registrant may not apply contact hours acquired in one one-year reporting period to a future continuing education reporting period.

Subd. 5. **Verification of continuing education credits.** The board shall periodically select a random sample of registrants and require those registrants to supply the board with evidence of having completed the continuing education to which they attested. Documentation may come directly from the registrants from state or national organizations that maintain continuing education records.

Subd. 6. **Continuing education topics.** Continuing education program topics may include, but are not limited to, naturopathic medical theory and techniques including diagnostic techniques, nutrition, botanical medicine, homeopathic medicine, physical medicine, lifestyle modification counseling, anatomy, physiology, biochemistry, pharmacology, pharmacognosy, microbiology, medical ethics, psychology, history of medicine, and medical terminology or coding.

Subd. 7. **Restriction on continuing education topics.** (a) A registrant may apply no more than five hours of practice management to a one-year reporting period.

(b) A registrant may apply no more than 15 hours to any single subject area.

Subd. 8. **Continuing education exemptions.** The board may exempt any person holding a registration under this chapter from the requirements of subdivision 1 upon application showing evidence satisfactory to the board of inability to comply with the requirements because of physical or mental condition or because of other unusual or extenuating circumstances. However, no person may be exempted from the requirements of subdivision 1 more than once in any five-year period.

History: 2008 c 348 s 7

147E.30 DISCIPLINE; REPORTING.

For purposes of this chapter, registered naturopathic doctors and applicants are subject to sections 147.091 to 147.162.

History: 2008 c 348 s 8

147E.35 REGISTERED NATUROPATHIC DOCTOR ADVISORY COUNCIL.

Subdivision 1. **Membership.** The board shall appoint a seven-member Registered Naturopathic Doctor Advisory Council consisting of one public member as defined in section 214.02, five registered naturopathic doctors who are residents of the state, and one licensed physician or osteopath with expertise in natural medicine.

Subd. 2. **Organization.** The advisory council shall be organized and administered under section 15.059. Section 15.059, subdivision 2, does not apply to this section. Members shall serve two-year terms, and shall serve until their successors have been appointed. The council shall select a chair from its membership.

Subd. 3. **Duties.** The advisory council shall:

- (1) advise the board regarding standards for registered naturopathic doctors;
- (2) provide for distribution of information regarding registered naturopathic doctors standards;
- (3) advise the board on enforcement of sections 147.091 to 147.162;
- (4) review applications and recommend granting or denying registration or registration renewal;

(5) advise the board on issues related to receiving and investigating complaints, conducting hearings, and imposing disciplinary action in relation to complaints against registered naturopathic doctors;

(6) advise the board regarding approval of continuing education programs using the criteria in section 147E.25, subdivision 3; and

(7) perform other duties authorized for advisory councils by chapter 214, as directed by the board.

Subd. 4. [Repealed, 2014 c 286 art 8 s 40]

History: 2008 c 348 s 9

147E.40 FEES.

Subdivision 1. **Fees.** Fees are as follows:

(1) registration application fee, \$200;

(2) renewal fee, \$150;

(3) late fee, \$75;

(4) inactive status fee, \$50; and

(5) temporary permit fee, \$25.

Subd. 2. **Proration of fees.** The board may prorate the initial annual registration fee. All registrants are required to pay the full fee upon registration renewal.

Subd. 3. **Penalty fee for late renewals.** An application for registration renewal submitted after the deadline must be accompanied by a late fee in addition to the required fees.

Subd. 4. **Nonrefundable fees.** All of the fees in subdivision 1 are nonrefundable.

History: 2008 c 348 s 10

1.1 A bill for an act
1.2 relating to health professions; requiring licensure of naturopathic physicians;
1.3 modifying scope of practice; amending Minnesota Statutes 2014, sections 147E.01;
1.4 147E.05; 147E.06; 147E.10; 147E.15; 147E.20; 147E.25; 147E.30; 147E.35;
1.5 147E.40.

1.6 BE IT ENACTED BY THE LEGISLATURE OF THE STATE OF MINNESOTA:

1.7 Section 1. Minnesota Statutes 2014, section 147E.01, is amended to read:

1.8 **147E.01 DEFINITIONS.**

1.9 Subdivision 1. **Applicability.** The definitions in this section apply to this chapter.

1.10 Subd. 2. **Advisory council.** "Advisory council" means the ~~Registered~~ Naturopathic
1.11 ~~Doctor~~ Physician Advisory Council established under section 147E.35.

1.12 Subd. 3. **Approved naturopathic medical education program.** "Approved naturopathic
1.13 medical education program" means a naturopathic medical education program in the United
1.14 States or Canada and meets the requirements for accreditation by the Council on Naturopathic
1.15 Medical Education (CNME) or an equivalent federally recognized accrediting body for the
1.16 naturopathic medical profession recognized by the board. This program must offer
1.17 graduate-level full-time didactic and supervised clinical training leading to the degree of
1.18 Doctor of Naturopathy or Doctor of Naturopathic Medicine. The program must be an
1.19 institution, or part of an institution, of higher education that at the time the student completes
1.20 the program is:

1.21 (1) either accredited or is a candidate for accreditation by a regional institution accrediting
1.22 agency recognized by the United States Secretary of Education; or

2.1 (2) a degree granting college or university that prior to the existence of CNME offered
2.2 a full-time structured curriculum in basic sciences and supervised patient care comprising
2.3 a doctoral naturopathic medical education that is at least 132 weeks in duration, must be
2.4 completed in at least 35 months, and is reputable and in good standing in the judgment of
2.5 the board.

2.6 Subd. 4. **Board.** "Board" means the Board of Medical Practice or its designee.

2.7 Subd. 5. **Contact hour.** "Contact hour" means an instructional session of 50 consecutive
2.8 minutes, excluding coffee breaks, registration, meals without a speaker, and social activities.

2.9 Subd. 6. **Homeopathic preparations.** "Homeopathic preparations" means medicines
2.10 prepared according to the Homeopathic Pharmacopoeia of the United States.

2.11 Subd. 7. ~~Registered Naturopathic doctor~~ **physician.** "~~Registered Naturopathic doctor~~
2.12 physician" means an individual ~~registered~~ licensed under this chapter.

2.13 Subd. 8. **Minor office procedures.** "Minor office procedures" means the use of operative,
2.14 electrical, or other methods for the repair and care incidental to superficial lacerations and
2.15 abrasions, superficial lesions, and the removal of foreign bodies located in the superficial
2.16 tissues and the use of antiseptics and local topical or injectable anesthetics in connection
2.17 with such methods.

2.18 Subd. 9. **Naturopathic licensing examination.** "Naturopathic licensing examination"
2.19 means the Naturopathic Physicians Licensing Examination or its successor administered
2.20 by the North American Board of Naturopathic Examiners or its successor as recognized by
2.21 the board.

2.22 Subd. 10. **Naturopathic medicine.** "Naturopathic medicine" means a system of primary
2.23 health care for the prevention, assessment, and treatment of human health conditions, injuries,
2.24 and diseases that uses:

2.25 (1) services, procedures, and treatments as described in section 147E.05; and

2.26 (2) natural health procedures and treatments in section 146A.01, subdivision 4.

2.27 Subd. 11. **Naturopathic physical medicine.** "Naturopathic physical medicine" includes,
2.28 but is not limited to, the therapeutic use of the physical agents of air, water, heat, cold,
2.29 sound, light, and electromagnetic nonionizing radiation and the physical modalities of
2.30 electrotherapy, diathermy, ultraviolet light, hydrotherapy, massage, stretching, colon
2.31 hydrotherapy, frequency specific microcurrent, electrical muscle stimulation, transcutaneous
2.32 electrical nerve stimulation, manipulation, and therapeutic exercise.

3.1 Sec. 2. Minnesota Statutes 2014, section 147E.05, is amended to read:

3.2 **147E.05 SCOPE OF PRACTICE.**

3.3 Subdivision 1. **Practice parameters.** (a) The practice of naturopathic medicine includes,
3.4 but is not limited to, the following services:

3.5 (1) ordering, administering, prescribing, or dispensing for preventive and therapeutic
3.6 purposes: food, extracts of food, nutraceuticals, vitamins, minerals, amino acids, enzymes,
3.7 botanicals and their extracts, botanical medicines, herbal remedies, homeopathic medicines,
3.8 dietary supplements and nonprescription drugs as defined by the Federal Food, Drug, and
3.9 Cosmetic Act, glandulars, protomorphogens, lifestyle counseling, hypnotherapy, biofeedback,
3.10 dietary therapy, electrotherapy, galvanic therapy, oxygen, therapeutic devices, and barrier
3.11 devices for contraception, and minor office procedures, including obtaining specimens to
3.12 assess and treat disease;

3.13 (2) minor office procedures, including obtaining specimens to assess, diagnose, and treat
3.14 disease;

3.15 ~~(2)~~ (3) performing or ordering physical examinations, including but not limited to and
3.16 physiological function tests, speculum examinations, orificial examinations, and phlebotomy;

3.17 ~~(3)~~ (4) ordering clinical laboratory tests and performing waived tests as defined by the
3.18 United States Food and Drug Administration Clinical Laboratory Improvement Amendments
3.19 of 1988 (CLIA);

3.20 ~~(4)~~ (5) referring a patient for diagnostic imaging including x-ray, CT scan, MRI,
3.21 ultrasound, mammogram, and bone densitometry to an appropriately licensed health care
3.22 professional to conduct the test and interpret the results;

3.23 ~~(5)~~ (6) prescribing nonprescription medications and therapeutic devices or ordering
3.24 noninvasive diagnostic procedures commonly used by physicians in general practice; and

3.25 (7) prescribing pharmacological therapies including schedule III, IV, and V legend drugs
3.26 and controlled substances;

3.27 (8) administering vaccinations;

3.28 (9) administering intravenous therapies; and

3.29 ~~(6)~~ (10) prescribing or performing naturopathic physical medicine.

3.30 (b) A ~~registered naturopathic doctor~~ physician may admit patients to a hospital if the
3.31 naturopathic doctor physician meets the hospital's governing body requirements regarding
3.32 credentialing and privileging process.

4.1 Subd. 2. **Prohibitions on practice.** (a) The practice of naturopathic medicine does not
4.2 include:

4.3 (1) administering therapeutic ionizing radiation or radioactive substances;

4.4 (2) administering general or spinal anesthesia; or

4.5 (3) ~~prescribing, dispensing, or administering legend drugs or controlled substances~~
4.6 ~~including chemotherapeutic substances; or~~

4.7 ~~(4) performing or inducing abortions.~~

4.8 (b) A naturopathic ~~doctor~~ registered physician licensed under this chapter shall not
4.9 perform surgical procedures using a laser device or perform surgical procedures beyond
4.10 superficial tissue the repair of superficial lacerations and abrasions, superficial lesions, and
4.11 the removal of foreign bodies located in superficial tissues.

4.12 (c) A naturopathic ~~doctor~~ physician shall not practice or claim to practice as a medical
4.13 doctor, surgeon, osteopath, dentist, podiatrist, optometrist, psychologist, advanced practice
4.14 professional nurse, physician assistant, chiropractor, physical therapist, acupuncturist,
4.15 ~~dietician~~ dietitian, nutritionist, or any other health care professional, unless the naturopathic
4.16 physician also holds the appropriate license or registration for the health care practice
4.17 profession.

4.18 Sec. 3. Minnesota Statutes 2014, section 147E.06, is amended to read:

4.19 **147E.06 PROFESSIONAL CONDUCT.**

4.20 Subdivision 1. **Informed consent.** (a) The naturopathic physician shall present treatment
4.21 facts and options accurately to the patient or to the individual responsible for the patient's
4.22 care and make treatment recommendations according to standards of good naturopathic
4.23 medical practice. The ~~registered naturopathic doctor~~ physician shall obtain a signed informed
4.24 consent from the patient prior to initiating treatment ~~and after advising the patient of the~~
4.25 ~~naturopathic doctor's qualifications including education and registration information; and~~
4.26 ~~outlining of the scope of practice of registered naturopathic doctors in Minnesota. This~~
4.27 ~~information must be supplied to the patient in writing before or at the time of the initial~~
4.28 ~~visit. The registrant shall present treatment facts and options accurately to the patient or to~~
4.29 ~~the individual responsible for the patient's care and make treatment recommendations~~
4.30 ~~according to standards of good naturopathic medical practice.~~

4.31 (b) Upon request, the ~~registered naturopathic doctor~~ physician must provide a copy of
4.32 the informed consent form to the board.

5.1 Subd. 2. **Patient records.** (a) A ~~registered~~ naturopathic ~~doctor~~ physician shall maintain
5.2 a record for seven years for each patient treated, including:

5.3 (1) a copy of the signed informed consent;

5.4 (2) evidence of a patient interview concerning the patient's medical history and current
5.5 physical condition;

5.6 (3) evidence of an examination and assessment;

5.7 (4) record of the treatment provided to the patient; and

5.8 (5) evidence of evaluation and instructions given to the patient, including acknowledgment
5.9 by the patient in writing that, if deemed necessary by the ~~registered~~ naturopathic ~~doctor~~
5.10 physician, the patient has been advised to consult with another health care provider.

5.11 (b) A ~~registered~~ naturopathic ~~doctor~~ physician shall maintain the records of minor patients
5.12 for seven years or until the minor's 19th birthday, whichever is longer.

5.13 Subd. 3. **Data practices.** All records maintained on a naturopathic patient by a ~~registered~~
5.14 naturopathic ~~doctor~~ physician are subject to sections 144.291 to 144.298.

5.15 Subd. 4. **State and municipal public health regulations.** A ~~registered~~ naturopathic
5.16 ~~doctor~~ physician shall comply with all applicable state and municipal requirements regarding
5.17 public health.

5.18 Sec. 4. Minnesota Statutes 2014, section 147E.10, is amended to read:

5.19 **147E.10 PROTECTED TITLES.**

5.20 Subdivision 1. **Designation.** (a) No individual may use the title "~~registered naturopathic~~
5.21 ~~doctor~~," "naturopathic doctor," "doctor of naturopathic medicine," "naturopathic medical
5.22 doctor," "naturopathic physician" or use, in connection with the individual's name, the letters
5.23 "~~R.N.D.~~" "N.D.," or "N.M.D.," or any other titles, words, letters, abbreviations, or insignia
5.24 indicating or implying that the individual is a ~~registered~~ licensed naturopathic ~~doctor~~
5.25 physician unless the individual has been ~~registered~~ licensed as a ~~registered~~ naturopathic
5.26 ~~doctor~~ physician according to this chapter.

5.27 (b) After July 1, 2009, individuals who are ~~registered~~ licensed under this chapter and
5.28 who represent themselves as practicing naturopathic medicine by use of a term in paragraph
5.29 (a) shall conspicuously display the ~~registration~~ license in the place of practice.

5.30 Subd. 2. **Other health care practitioners.** Nothing in this chapter may be construed to
5.31 prohibit or to restrict:

6.1 (1) the practice of a profession by individuals who are licensed, certified, or registered
 6.2 under other laws of this state and are performing services within their authorized scope of
 6.3 practice;

6.4 (2) the provision of the complementary and alternative healing methods and treatments,
 6.5 including naturopathy, as described in chapter 146A;

6.6 (3) the practice of naturopathic medicine by an individual licensed, registered, or certified
 6.7 in another state and employed by the government of the United States while the individual
 6.8 is engaged in the performance of duties prescribed by the laws and regulations of the United
 6.9 States;

6.10 (4) the practice by a naturopathic ~~doctor~~ physician duly licensed, registered, or certified
 6.11 in another state, territory, or the District of Columbia when incidentally called into this state
 6.12 for consultation with a Minnesota licensed physician or Minnesota ~~registered~~ licensed
 6.13 naturopathic ~~doctor~~ physician; or

6.14 (5) individuals not ~~registered~~ licensed by this chapter from the use of individual modalities
 6.15 which comprise the practice of naturopathic medicine.

6.16 Subd. 3. **Penalty.** A person violating subdivision 1 is guilty of a misdemeanor.

6.17 Sec. 5. Minnesota Statutes 2014, section 147E.15, is amended to read:

6.18 **147E.15 ~~REGISTRATION~~ LICENSURE REQUIREMENTS.**

6.19 Subdivision 1. **General requirements ~~for registration~~ for licensure.** To be eligible
 6.20 for ~~registration~~ licensure as a naturopathic physician, an applicant must:

6.21 (1) submit a completed application on forms provided by the board along with all fees
 6.22 required under section 147E.40 that includes:

6.23 (i) the applicant's name, Social Security number, home address and telephone number,
 6.24 and business address and telephone number;

6.25 (ii) the name and location of the naturopathic medical program the applicant completed;

6.26 (iii) a list of degrees received from other educational institutions;

6.27 (iv) a description of the applicant's professional training;

6.28 (v) a list of registrations, certifications, and licenses held in other jurisdictions;

6.29 (vi) a description of any other jurisdiction's refusal to credential the applicant;

7.1 (vii) a description of all professional disciplinary actions initiated against the applicant
7.2 in any jurisdiction; and

7.3 (viii) any history of drug or alcohol abuse, and any misdemeanor or felony conviction;

7.4 (2) submit a copy of a diploma from an approved naturopathic medical education
7.5 program;

7.6 (3) have successfully passed the Naturopathic Physicians Licensing Examination, a
7.7 competency-based national naturopathic licensing examination administered by the North
7.8 American Board of Naturopathic Examiners or successor agency as recognized by the board;
7.9 passing scores are determined by the Naturopathic Physicians Licensing Examination;

7.10 (4) submit additional information as requested by the board, including providing any
7.11 additional information necessary to ensure that the applicant is able to practice with
7.12 reasonable skill and safety to the public;

7.13 (5) sign a statement that the information in the application is true and correct to the best
7.14 of the applicant's knowledge and belief; and

7.15 (6) sign a waiver authorizing the board to obtain access to the applicant's records in this
7.16 or any other state in which the applicant has completed an approved naturopathic medical
7.17 program or engaged in the practice of naturopathic medicine.

7.18 **Subd. 1a. Transition from registration to licensure.** (a) An individual registered as
7.19 naturopathic doctor on or after July 1, 2009, may be granted a license as a naturopathic
7.20 physician if the individual:

7.21 (1) holds a current, valid registration as a naturopathic doctor that has been issued by
7.22 the Minnesota Board of Medical Practice; and

7.23 (2) is in good standing with the board.

7.24 (b) For purposes of this subdivision, "good standing" means that the registered
7.25 naturopathic doctor is not currently under investigation by the board or advisory council as
7.26 the result of a complaint, or subject to disciplinary proceedings by the board.

7.27 **Subd. 2. ~~Registration~~ Licensure by endorsement; reciprocity.** ~~(a)~~ To be eligible for
7.28 ~~registration~~ licensure by endorsement or reciprocity, the applicant must hold a current
7.29 naturopathic license, registration, or certification in another state, Canadian province, the
7.30 District of Columbia, or territory of the United States, whose standards for licensure,
7.31 registration, or certification are at least equivalent to those of Minnesota, and must:

8.1 (1) submit the application materials and fees as required by subdivision 1, clauses (1),
8.2 (2), and (4) to (6);

8.3 (2) have successfully passed either:

8.4 (i) the Naturopathic Physicians Licensing Examination; or

8.5 (ii) if prior to 1986, the state or provincial naturopathic board licensing examination
8.6 required by that regulating state or province;

8.7 (3) provide a verified copy from the appropriate government body of a current license,
8.8 registration, or certification for the practice of naturopathic medicine in another jurisdiction
8.9 that has initial licensing, registration, or certification requirements equivalent to or higher
8.10 than the requirements in subdivision 1; and

8.11 (4) provide letters of verification from the appropriate government body in each
8.12 jurisdiction in which the applicant holds a license, registration, or certification. Each letter
8.13 must state the applicant's name, date of birth, license, registration, or certification number,
8.14 date of issuance, a statement regarding disciplinary actions, if any, taken against the applicant,
8.15 and the terms under which the license, registration, or certification was issued.

8.16 ~~(b) An applicant applying for license, registration, or certification by endorsement must~~
8.17 ~~be licensed, registered, or certified in another state or Canadian province prior to January~~
8.18 ~~1, 2005, and have completed a 60-hour course and examination in pharmacotherapeutics.~~

8.19 Subd. 3. **Temporary ~~registration~~ licensure.** The board may issue a temporary
8.20 ~~registration~~ license to practice as a ~~registered naturopathic doctor~~ physician to an applicant
8.21 who is ~~licensed, registered, or certified~~ :

8.22 (1) holds a current naturopathic license, registration, or certification in another state or
8.23 Canadian province, the District of Columbia, or territory of the United States, whose
8.24 standards for licensure, registration, or certification are at least equivalent to those of
8.25 Minnesota;

8.26 and (2) is eligible for ~~registration~~ licensure under this section;

8.27 ~~if the application for registration is complete, (3) meets all applicable requirements in~~
8.28 ~~this section have been met, and a nonrefundable fee has been paid.~~

8.29 (4) completes an application for licensure; and

8.30 (5) pays the nonrefundable licensure fee.

9.1 The temporary ~~registration~~ license remains valid only until the meeting of the board at which
9.2 time a decision is made on the ~~registered naturopathic doctor's physician's~~ application for
9.3 ~~registration~~ licensure.

9.4 Subd. 4. **Registration License expiration.** ~~Registrations~~ Licenses issued under this
9.5 chapter expire annually.

9.6 Subd. 5. **Renewal.** To be eligible for ~~registration~~ license renewal a ~~registrant~~ licensee
9.7 must:

9.8 (1) annually, or as determined by the board, complete a renewal application on a form
9.9 provided by the board;

9.10 (2) submit the renewal fee;

9.11 (3) provide evidence of a total of ~~25~~ 30 hours of continuing education approved by the
9.12 board as described in section 147E.25; and

9.13 (4) submit any additional information requested by the board to clarify information
9.14 presented in the renewal application. The information must be submitted within 30 days
9.15 after the board's request, or the renewal request is nullified.

9.16 Subd. 6. **Change of address.** A ~~registrant~~ licensee who changes addresses must inform
9.17 the board within 30 days, in writing, of the change of address. All notices or other
9.18 correspondence mailed to or served on a ~~registrant~~ licensee by the board are considered as
9.19 having been received by the ~~registrant~~ licensee.

9.20 Subd. 7. **Registration License renewal notice.** At least 45 days before the ~~registration~~
9.21 license renewal date, the board shall send out a renewal notice to the last known address of
9.22 the ~~registrant~~ licensee on file. The notice must include a renewal application and a notice
9.23 of fees required for renewal or instructions for online renewal. It must also inform the
9.24 ~~registrant~~ licensee that ~~registration~~ the license will expire without further action by the board
9.25 if an application for ~~registration~~ license renewal is not received before the deadline for
9.26 renewal. The ~~registrant's~~ licensee's failure to receive this notice does not relieve the ~~registrant~~
9.27 licensee of the obligation to meet the deadline and other requirements for ~~registration~~ license
9.28 renewal. Failure to receive this notice is not grounds for challenging expiration of ~~registration~~
9.29 licensure status.

9.30 Subd. 8. **Renewal deadline.** The renewal application and fee must be postmarked on or
9.31 before ~~December 31 of the year of renewal~~ the deadline established by the board. If the
9.32 postmark is illegible, the application is considered timely if received by the third working
9.33 day after the deadline.

10.1 Subd. 9. **Inactive status and return to active status.** (a) A ~~registrant~~ licensee may be
10.2 placed in inactive status upon application to the board by the ~~registrant~~ licensee and upon
10.3 payment of an inactive status fee.

10.4 (b) ~~Registrants~~ Licensees seeking restoration to active from inactive status must pay the
10.5 current renewal fees and all unpaid back inactive fees. They must meet the criteria for
10.6 renewal specified in subdivision 5, including continuing education hours.

10.7 (c) ~~Registrants~~ Licensees whose inactive status period has been five years or longer must
10.8 additionally have a period of no less than eight weeks of advisory council-approved
10.9 supervision by another ~~registered~~ licensed naturopathic doctor physician.

10.10 Subd. 10. **Registration Licensure following lapse of ~~registration~~ licensure status for**
10.11 **two years or less.** For any individual whose ~~registration~~ licensure status has lapsed for two
10.12 years or less, to regain ~~registration status~~ a license, the individual must:

10.13 (1) apply for ~~registration~~ license renewal according to subdivision 5;

10.14 (2) document compliance with the continuing education requirements of section 147E.25
10.15 since the ~~registrant's~~ licensee's initial ~~registration~~ licensure or last renewal; and

10.16 (3) submit the fees required under section 147E.40 for the period not ~~registered~~ licensed,
10.17 including the fee for late renewal.

10.18 Subd. 11. **Cancellation due to nonrenewal.** The board shall not renew, reissue, reinstate,
10.19 or restore a ~~registration~~ license that has lapsed and has not been renewed within two annual
10.20 ~~registration~~ renewal cycles starting January 2009. A ~~registrant~~ licensee whose ~~registration~~
10.21 license is canceled for nonrenewal must obtain a new ~~registration~~ license by applying for
10.22 ~~registration~~ licensure and fulfilling all requirements then in existence for initial ~~registration~~
10.23 licensure as a ~~registered~~ naturopathic ~~doctor~~ physician.

10.24 Subd. 12. **Cancellation of ~~registration~~ licensure in good standing.** (a) A ~~registrant~~
10.25 licensee holding an active ~~registration~~ license as a ~~registered~~ naturopathic ~~doctor~~ physician
10.26 in the state may, upon approval of the board, be granted ~~registration~~ license cancellation if
10.27 the board is not investigating the person as a result of a complaint or information received
10.28 or if the board has not begun disciplinary proceedings against the ~~registrant~~ licensee. Such
10.29 action by the board must be reported as a cancellation of ~~registration~~ licensure in good
10.30 standing.

10.31 (b) A ~~registrant~~ licensee who receives board approval for ~~registration~~ licensure
10.32 cancellation is not entitled to a refund of any ~~registration~~ fees paid for the ~~registration~~
10.33 licensure year in which cancellation of ~~the registration~~ occurred.

11.1 (c) To obtain ~~registration~~ licensure after cancellation, a ~~registrant~~ licensee must obtain
 11.2 a new ~~registration~~ license by ~~applying for registration~~ submitting an application and fulfilling
 11.3 the requirements then in existence for obtaining initial ~~registration~~ licensure as a ~~registered~~
 11.4 ~~naturopathic doctor~~ physician.

11.5 Subd. 13. **Emeritus status of registration.** A ~~registrant~~ licensee may change the status
 11.6 of the ~~registration~~ license to "emeritus" by filing the appropriate forms and paying the
 11.7 onetime fee of \$50 to the board. This status allows the ~~registrant~~ licensee to retain the title
 11.8 of ~~registered~~ naturopathic doctor physician but restricts the ~~registrant~~ licensee from actively
 11.9 seeing patients.

11.10 Sec. 6. Minnesota Statutes 2014, section 147E.20, is amended to read:

11.11 **147E.20 BOARD ACTION ON APPLICATIONS FOR REGISTRATION**
 11.12 **LICENSURE.**

11.13 (a) The board shall act on each application for ~~registration~~ licensure according to
 11.14 paragraphs (b) to (d).

11.15 (b) The board shall determine if the applicant meets the requirements for ~~registration~~
 11.16 licensure under section 147E.15. The board or advisory council may investigate information
 11.17 provided by an applicant to determine whether the information is accurate and complete.

11.18 (c) The board shall notify each applicant in writing of action taken on the application,
 11.19 the grounds for denying ~~registration~~ licensure if ~~registration~~ licensure is denied, and the
 11.20 applicant's right to review under paragraph (d).

11.21 (d) Applicants denied ~~registration~~ licensure may make a written request to the board,
 11.22 within 30 days of the board's notice, to appear before the advisory council or the board and
 11.23 for the advisory council to review the board's decision to deny the applicant's ~~registration~~
 11.24 licensure. After reviewing the denial, the advisory council shall make a recommendation
 11.25 to the board as to whether the denial shall be affirmed. Each applicant is allowed only one
 11.26 request for review each yearly ~~registration~~ licensure period.

11.27 Sec. 7. Minnesota Statutes 2014, section 147E.25, is amended to read:

11.28 **147E.25 CONTINUING EDUCATION REQUIREMENT.**

11.29 Subdivision 1. **Number of required contact hours.** (a) A ~~registrant~~ licensee applying
 11.30 for ~~registration~~ license renewal must complete a minimum of ~~25~~ 30 contact hours of
 11.31 board-approved continuing education in the year preceding ~~registration~~ license renewal,

12.1 with the exception of the ~~registrant's~~ licensee's first incomplete year, and attest to completion
12.2 of continuing education requirements by reporting to the board.

12.3 (b) Of the ~~25~~ 30 contact hours of continuing education requirement in paragraph (a), at
12.4 least ~~five~~ 10 hours of continuing education must be in pharmacotherapeutics.

12.5 Subd. 2. **Approved programs.** The board shall approve continuing education programs
12.6 that have been approved for continuing education credit by the American Association of
12.7 Naturopathic Physicians or any of its constituent state associations, the American Chiropractic
12.8 Association or any of its constituent state associations, the American Osteopathic Association
12.9 Bureau of Professional Education, the American Pharmacists Association or any of its
12.10 constituent state associations, or an organization approved by the Accreditation Council for
12.11 Continuing Medical Education.

12.12 Subd. 3. **Approval of continuing education programs.** The board shall also approve
12.13 continuing education programs that do not meet the requirements of subdivision 2 but meet
12.14 the following criteria:

12.15 (1) the program content directly relates to the practice of naturopathic medicine;

12.16 (2) each member of the program faculty is knowledgeable in the subject matter as
12.17 demonstrated by a degree from an accredited education program, verifiable experience in
12.18 the field of naturopathic medicine, special training in the subject matter, or experience
12.19 teaching in the subject area;

12.20 (3) the program lasts at least 50 minutes per contact hour;

12.21 (4) there are specific, measurable, written objectives, consistent with the program,
12.22 describing the expected outcomes for the participants; and

12.23 (5) the program sponsor has a mechanism to verify participation and maintains attendance
12.24 records for three years.

12.25 Subd. 4. **Accumulation of contact hours.** A ~~registrant~~ licensee may not apply contact
12.26 hours acquired in one one-year reporting period to a future continuing education reporting
12.27 period.

12.28 Subd. 5. **Verification of continuing education credits.** The board shall periodically
12.29 select a random sample of ~~registrants~~ licensees and require those ~~registrants~~ licensees to
12.30 supply the board with evidence of having completed the continuing education to which they
12.31 attested. Documentation may come directly from the ~~registrants~~ licensees from state or
12.32 national organizations that maintain continuing education records.

13.1 Subd. 6. **Continuing education topics.** Continuing education program topics may
 13.2 include, but are not limited to, naturopathic medical theory and techniques including
 13.3 diagnostic techniques, nutrition, botanical medicine, homeopathic medicine, physical
 13.4 medicine, lifestyle modification counseling, anatomy, physiology, biochemistry,
 13.5 pharmacology, pharmacognosy, microbiology, medical ethics, psychology, history of
 13.6 medicine, and medical terminology or coding.

13.7 Subd. 7. **Restriction on continuing education topics.** (a) A ~~registrant~~ licensee may
 13.8 apply no more than five hours of practice management to a one-year reporting period.

13.9 (b) A ~~registrant~~ licensee may apply no more than 15 hours to any single subject area.

13.10 Subd. 8. **Continuing education exemptions.** The board may exempt any person holding
 13.11 a ~~registration~~ license under this chapter from the requirements of subdivision 1 upon
 13.12 application showing evidence satisfactory to the board of inability to comply with the
 13.13 requirements because of physical or mental condition or because of other unusual or
 13.14 extenuating circumstances. However, no person may be exempted from the requirements
 13.15 of subdivision 1 more than once in any five-year period.

13.16 Sec. 8. Minnesota Statutes 2014, section 147E.30, is amended to read:

13.17 **147E.30 DISCIPLINE; REPORTING.**

13.18 For purposes of this chapter, ~~registered naturopathic doctors~~ physicians and applicants
 13.19 are subject to sections 147.091 to 147.162.

13.20 Sec. 9. Minnesota Statutes 2014, section 147E.35, is amended to read:

13.21 **147E.35 ~~REGISTERED NATUROPATHIC DOCTOR~~ PHYSICIAN ADVISORY**
 13.22 **COUNCIL.**

13.23 Subdivision 1. **Membership.** The board shall appoint a seven-member ~~Registered~~
 13.24 ~~Naturopathic Doctor~~ Physician Advisory Council consisting of one public member as defined
 13.25 in section 214.02, five ~~registered~~ licensed naturopathic ~~doctors~~ physicians who are residents
 13.26 of the state, and one licensed physician or osteopath with expertise in natural medicine.

13.27 Subd. 2. **Organization.** The advisory council shall be organized and administered under
 13.28 section 15.059. Section 15.059, subdivision 2, does not apply to this section. Members shall
 13.29 serve two-year terms, and shall serve until their successors have been appointed. The council
 13.30 shall select a chair from its membership.

13.31 Subd. 3. **Duties.** The advisory council shall:

14.1 (1) advise the board regarding standards for ~~registered~~ licensed naturopathic ~~doctors~~
14.2 physicians;

14.3 (2) provide for distribution of information regarding ~~registered~~ licensed naturopathic
14.4 ~~doctors~~ physician standards;

14.5 (3) advise the board on enforcement of sections 147.091 to 147.162;

14.6 (4) review applications and recommend granting or denying ~~registration~~ licensure or
14.7 ~~registration~~ license renewal;

14.8 (5) advise the board on issues related to receiving and investigating complaints,
14.9 conducting hearings, and imposing disciplinary action in relation to complaints against
14.10 ~~registered~~ naturopathic ~~doctors~~ physicians;

14.11 (6) advise the board regarding approval of continuing education programs using the
14.12 criteria in section 147E.25, subdivision 3; and

14.13 (7) perform other duties authorized for advisory councils by chapter 214, as directed by
14.14 the board.

14.15 Sec. 10. Minnesota Statutes 2014, section 147E.40, is amended to read:

14.16 **147E.40 FEES.**

14.17 Subdivision 1. **Fees.** Fees are as follows:

14.18 (1) ~~registration~~ license application fee, \$200;

14.19 (2) renewal fee, \$150;

14.20 (3) late fee, \$75;

14.21 (4) inactive status fee, \$50; and

14.22 (5) temporary permit fee, \$25.

14.23 Subd. 2. **Proration of fees.** The board may prorate the initial annual ~~registration~~license
14.24 fee. All ~~registrants~~ licensees are required to pay the full fee upon ~~registration~~ license renewal.

14.25 Subd. 3. **Penalty fee for late renewals.** An application for ~~registration~~ license renewal
14.26 submitted after the deadline must be accompanied by a late fee in addition to the required
14.27 fees.

14.28 Subd. 4. **Nonrefundable fees.** All of the fees in subdivision 1 are nonrefundable.

**FREQUENTLY ASKED
QUESTIONS
ABOUT
NATUROPATHIC MEDICINE
IN THE USA**

*Prepared for the
American Medical Student Association*

*by Serina Aubrecht
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Naturopathic Medicine

WHAT IS NATUROPATHIC MEDICINE?¹

Naturopathic medicine is a distinct branch of medicine that encompasses modern, traditional, scientific, and empirical methods of diagnosis, treatment, and prevention; is based on the principles of *primum non nocere* (first do no harm), *vis medicatrix naturae* (the healing power of nature), *tolle causam* (treat the whole cause) *tolle totum* (treat the whole person), *docere* (doctor as teacher), *praevenire* (prevention), and *salus* (wellness); and emphasizes the inherent self-healing capacity of each person. Naturopathic medicine is a medical specialty.

WHAT IS A BRIEF HISTORY OF NATUROPATHIC MEDICINE IN THE USA, INCLUDING ITS RELATION TO OTHER AREAS OF MEDICINE?⁴⁴

In 1765, John Morgan, MD, founded the first allopathic medical school in the USA in Philadelphia, Pennsylvania, associated with the “College, Academy, and Charity School of Philadelphia” (known today as the “University of Pennsylvania”) – “Medical School”. It is still open today as the oldest allopathic medical school in the USA and is known as the “Perelman School of Medicine at the University of Pennsylvania”. Initially, the school offered a Bachelor of Medicine (MB) degree and a Doctor of Medicine (MD) degree. In 1768, on June 21, ten medical students received MB degrees. In 1771, four of the ten inaugural MB students received MD degrees. In 1792, on March 1, the MB degree was abolished.

In 1844, the “American Institute of Homeopathy” (“AIH”) was formed. It is still in existence today as the oldest national physicians’ organization in the USA.

In 1847, on the evening of May 7, delegates at the national medical convention at the Academy of Natural Sciences in Philadelphia, Pennsylvania approved a resolution to establish the “American Medical Association” (“AMA”). At the meeting, the first code of medical ethics was adopted and the first nationwide standards for preliminary medical education and the degree of “MD” were established.

In 1874, Andrew Taylor Still, MD, developed osteopathic philosophy. Dr. Still is known as the founder of osteopathic medicine and referred to as the “Father of Osteopathy”.

In 1892, Andrew Taylor Still, MD, founded the first osteopathic medical school in the USA in Kirksville, Missouri – the “American School of Osteopathy” (“ASO”). The school offered a Doctor of Osteopathy (DO) degree. It is still open today as the oldest osteopathic medical school in the USA and is known as “A.T. Still University” (“ATSU”). Today, the school offers a Doctor of Osteopathic Medicine (DO) degree.

In 1895, John H. Scheel developed the term “naturopathy”.

In 1896, Vermont became the first state to license osteopathic physicians to practice osteopathy.

In 1897, the “American Association for the Advancement of Osteopathy” was established.

In 1901, the “American Association for the Advancement of Osteopathy” changed its name to the “American Osteopathic Association” (“AOA”).

In 1901, Benedict Lust, MD, DO, DC, founded the first naturopathic medical school in the USA in New York – the “American School of Naturopathy”. Dr. Lust is known as the founder of naturopathic medicine and referred to as the “Father of Naturopathy”. The school offered a Doctor of Naturopathy (ND) degree.

In 1947, on September 17, the “World Medical Association” (“WMA”) was established.

In 1956, the naturopathic medical school “National College of Naturopathic Medicine” (“NCNM”) was founded. The school offered a Doctor of Naturopathy (ND) degree. It is still open today as the oldest naturopathic medical school in the USA and is known as “National University of Natural Medicine” (“NUNM”). Today, the school offers a Doctor of Naturopathic Medicine (NMD) degree.

In 1985, the “American Association of Naturopathic Physicians” (“AANP”) was established.

In 1989, Nebraska passed legislation that licensed osteopathic physicians to practice osteopathic medicine to the full scope of their training. With the passing of the legislation in Nebraska, the practice of osteopathic medicine was recognized as equivalent to the practice of allopathic medicine in all 50 states in the USA.

In 2004, in December, the “Osteopathic International Alliance” (“OIA”) was established.

In 2014, the “World Naturopathic Federation” (“WNF”) was established.

Scope of Training & Practice

WHAT DIAGNOSTIC AND TREATMENT MODALITIES ARE NATUROPATHIC PHYSICIANS TRAINED IN?²

Naturopathic physicians are trained in conventional, holistic, complementary, integrative, and alternative diagnostic and therapeutic treatment modalities, including nutritional medicine; botanical medicine; homeopathic medicine; pharmaceutical medicine; physical medicine, including osseous and soft tissue manipulative therapy and hydrotherapy; mind-body medicine, including counseling; environmental medicine; lifestyle medicine, including hygiene and diet; minor surgery; phlebotomy; intravenous and injection therapy;

traditional Asian medicine, including acupuncture; public health; imaging; and naturopathic obstetrics. The use of physical medicine treatment modalities by a naturopathic physician is sometimes referred to as “naturopathic physical medicine” and osseous and soft tissue manipulative therapy is sometimes referred to as “naturopathic manipulative medicine” (“NMM”).

Like with all health care professions, as scientific discoveries and developments, such as pharmaceutical medications, have advanced and enhanced the practice of medicine, the scope of training and, thus, the scope of practice of the naturopathic medical profession has changed to reflect the discoveries and developments to protect the safety and the health of the public.

HOW MANY YEARS OF TRAINING IN MEDICAL SCHOOL DO NATUROPATHIC PHYSICIANS RECEIVE?⁵

Naturopathic physicians receive 4 years of training in naturopathic medical school.

WHAT ARE NATUROPATHIC PHYSICIANS WELL-KNOWN FOR?⁴

Naturopathic physicians are known as experts in drug-herb-nutrient interactions and for emphasizing prevention of disease and overall wellness.

ARE NATUROPATHIC PHYSICIANS TRAINED TO PRACTICE EVIDENCE-BASED MEDICINE?³¹

Yes, naturopathic physicians are trained to practice evidence-based medicine.

ARE NATUROPATHIC PHYSICIANS TRAINED TO PRACTICE “STANDARDS OF CARE”?³²

Yes, naturopathic physicians are trained to practice “standards of care”. A naturopathic physician can be held liable for medical malpractice, just like an allopathic or osteopathic physician, if standards of care are not adhered to.

ARE NATUROPATHIC PHYSICIANS TRAINED TO PRACTICE INDEPENDENTLY?⁴²

Yes, naturopathic physicians are trained to practice independently, with out oversight by another health care provider.

ARE NATUROPATHIC PHYSICIANS TRAINED TO WORK WITH AND REFER TO OTHER HEALTH CARE PROVIDERS?⁵⁰

Yes, naturopathic physicians are trained to work with and refer to other health care providers.

WHAT PHARMACEUTICAL MEDICATIONS DO NATUROPATHIC PHYSICIANS LEARN AND NEED TO KNOW?⁴⁶

Naturopathic physicians learn and need to know over-the-counter (OTC) drugs, legend drugs, and scheduled drugs (pharmaceutical medications containing controlled substances). Pharmacology is an integral and critical part of naturopathic medical education and, like allopathic and osteopathic physicians, to ensure patient safety, naturopathic physicians need to know how to appropriately prescribe pharmaceutical medications, check for medication interactions, and put patients onto and take patients off of medications. Additionally, since naturopathic physicians also study botany and nutrition, to be able to accurately prescribe botanical medications and nutritional medications, naturopathic physicians learn and need to know drug-herb-nutrient interactions.

ARE NATUROPATHIC PHYSICIANS TRAINED IN VACCINE ADMINISTRATION?³

Yes, naturopathic physicians are trained in vaccine administration as part of their training in pharmaceutical medicine, injection therapy, and public health. Like allopathic and osteopathic physicians, they learn the Centers for Disease Control and Prevention (CDC) immunization recommendations and schedules.

DO NATUROPATHIC PHYSICIANS NEED NPI AND DEA NUMBERS?⁴⁷

Yes, naturopathic physicians need U.S. Department of Health & Human Services (HHS) Centers for Medicare & Medicaid Services (CMS) National Plan and Provider Enumeration System (NPPES) National Provider Identifier (NPI) and U.S. Department of Justice U.S. Drug Enforcement Administration (DEA) numbers in order to prescribe pharmaceutical medications.

In some states with regulation of naturopathic medicine and licensure of naturopathic physicians, state law does not yet accurately reflect scope of training of naturopathic physicians and naturopathic physicians are allowed to prescribe pharmaceutical medications classified as legend drugs, but not those classified as scheduled drugs. In those states, to prescribe legend drugs, naturopathic physicians need only an NPI number. A DEA number is needed only if scheduled drugs are prescribed.

WHAT PHARMACEUTICAL MEDICATIONS CAN NATUROPATHIC PHYSICIANS PRESCRIBE?⁴⁸

The pharmaceutical medications that naturopathic physicians are able to prescribe completely varies from state to state, depending on how the state legislation was written. The variation in legislation is mainly due to a lack of public education and understanding on the scope of training of naturopathic physicians.

In the state of Washington, *Cannabis* (marijuana), although federally classified as a Schedule I drug, is legal for recreational use and medical use. Naturopathic physicians, along with allopathic physicians, osteopathic physicians, physician assistants, osteopathic physician assistants, and nurse practitioners are allowed to authorize the medical use of marijuana to patients.

In the state of Arizona, *Cannabis* (marijuana) is legal for medical use. Naturopathic physicians, along with allopathic and osteopathic physicians, are allowed to authorize the medical use of marijuana to patients.

WHAT IS THE IMPORTANCE OF PHARMACEUTICAL PRESCRIBING RIGHTS FOR NATUROPATHIC PHYSICIANS THAT ACCURATELY REFLECT THE SCOPE OF TRAINING OF NATUROPATHIC PHYSICIANS?⁴⁹

Public safety and health are the most important aspects of pharmaceutical prescribing rights for naturopathic physicians that accurately reflect the scope of training of naturopathic physicians. Since patients may choose to see a naturopathic physician for any symptom or complaint, without pharmaceutical prescribing rights that accurately reflecting scope of training, naturopathic physicians may be unable to prescribe antibiotics for conditions such as strep throat, vaccines for vaccine-preventable diseases, epinephrine injectors for patients with risk of anaphylaxis due to allergic reaction, hormonal contraception, or emergency oxygen for life-threatening hypoxic (low oxygen) situations. It is important that the scope of training of naturopathic physicians is understood so that the scope of practice of naturopathic physicians in each state is consistent and accurately reflects the scope of training.

WHAT LEVEL OF CPR ARE NATUROPATHIC MEDICAL STUDENTS AND PHYSICIANS REQUIRED TO KNOW?³³

Naturopathic medical students and physicians are required to know Basic Life Support (BLS) cardiopulmonary resuscitation (CPR). Depending on the facility where a naturopathic physician works (for example, in a hospital), a naturopathic physician may also be required to know more advanced CPR procedures, such as Advanced Cardiovascular Life Support (ACLS) and Pediatric Advanced Life Support (PALS).

WHAT ARE THE DIFFERENCES IN TRAINING BETWEEN NATUROPATHIC PHYSICIANS, ALLOPATHIC PHYSICIANS, AND OSTEOPATHIC PHYSICIANS?⁶

Naturopathic physicians are trained in outpatient family medicine and primary care medicine, with an emphasis on prevention and wellness, through the use of naturopathic treatment modalities. Pharmaceutical medicine and minor surgery are naturopathic treatment modalities.

Comparatively, where allopathic and osteopathic physicians spend time learning in-patient (hospital) medicine, including the treatment modalities of major and minor surgery (and, in the case of osteopathic physicians, osteopathic manipulative medicine [OMM] and osteopathic manipulative treatment [OMT], in preparation for rotations in osteopathic manipulative therapy [OMTh]), naturopathic physicians spend time learning the treatment modalities of nutritional medicine; botanical medicine; homeopathic medicine; pharmaceutical medicine; physical medicine, including osseous and soft tissue manipulative therapy and hydrotherapy; mind-body medicine, including counseling; lifestyle medicine, including hygiene and diet; minor surgery; phlebotomy; intravenous and injection therapy; traditional Asian medicine, including acupuncture; and naturopathic obstetrics. Allopathic, osteopathic, and naturopathic physicians all learn outpatient family medicine and primary care medicine. Thus, for better understanding of the training of naturopathic physicians, as a comparison to specialty areas of the allopathic and osteopathic medical professions, naturopathic physicians can be thought of as outpatient integrative family medicine physicians with an emphasis on natural medical treatment modalities.

What is the difference between an MD, DO, & NMD/ND?			
	MD	DO	NMD/ND
Years 1-2	<ul style="list-style-type: none"> • Basic Biomedical Sciences • Pharmaceutical Medicine 	<ul style="list-style-type: none"> • Basic Biomedical Sciences • Pharmaceutical Medicine • Physical Medicine <ul style="list-style-type: none"> ▪ OMM 	<ul style="list-style-type: none"> • Basic Biomedical Sciences • Pharmaceutical Medicine • Physical Medicine <ul style="list-style-type: none"> ▪ NMM ▪ Hydrotherapy • Nutritional Medicine • Botanical Medicine • Homeopathic Medicine • Mind-Body Medicine <ul style="list-style-type: none"> ▪ Counseling • Lifestyle Medicine • Environmental Medicine • Minor Surgery • Acupuncture
Years 3-4	<u>Outpatient & Inpatient Rotations</u> <ul style="list-style-type: none"> • Internal Medicine • Family Medicine • Pediatrics • Neurology • Psychiatry • Obstetrics/Gynecology • General Surgery 	<u>Outpatient & Inpatient Rotations</u> <ul style="list-style-type: none"> • Internal Medicine • Family Medicine • Pediatrics • Neurology • Psychiatry • Obstetrics/Gynecology • General Surgery • OMT 	<u>Outpatient Rotations</u> <ul style="list-style-type: none"> • Naturopathic Medicine <ul style="list-style-type: none"> ▪ naturopathic treatment modalities in the context of family medicine and primary care medicine

WHAT ICD-10 CODES DO NATUROPATHIC PHYSICIANS USE FOR OSSEOUS AND SOFT TISSUE MANIPULATIVE MEDICINE AND THERAPY?³⁴

For osseous and soft tissue manipulative medicine and therapy, naturopathic physicians use the same ICD-10 codes that osteopathic physicians use for osteopathic manipulative treatment (OMT). Insurance companies will reject a claim if a chiropractic ICD-10 code is used.

Educational & Professional Titles – NMD versus ND

WHAT IS THE DIFFERENCE BETWEEN AN “NMD” AND AN “ND” EDUCATIONAL DEGREE AND TITLE?²²

Naturopathic medical schools that are accredited or provisionally accredited by the Council on Naturopathic Medical Education (CNME) offer a doctorate degree in naturopathic medicine and grant the educational doctorate degree title as either “Doctor of Naturopathic Medicine” (abbreviated “NMD”) or “Doctor of Naturopathy” (abbreviated “ND”).

Allopathic medical schools that are accredited or provisionally accredited by the Liaison Committee on Medical Education (LCME) offer a doctorate degree in allopathic medicine and grant the educational degree title as “Doctor of Medicine” (abbreviated “MD”).

Osteopathic medical schools that are accredited or provisionally accredited by the American Osteopathic Association (AOA) Commission on Osteopathic College Accreditation (COCA) offer a doctorate degree in osteopathic medicine and grant the educational doctorate degree title as either “Doctor of Osteopathic Medicine” (abbreviated “DO”) or “Doctor of Osteopathy” (abbreviated “DO”).

WHAT IS THE DIFFERENCE BETWEEN AN “NMD” AND AN “ND” PROFESSIONAL TITLE?²³

The protected professional title of a naturopathic physician may be “NMD” (Naturopathic Medical Doctor/Physician) or “ND” (Naturopathic Doctor/Physician), depending on state law, and is independent of the educational degree title of a naturopathic physician. For example, a naturopathic physician may earn an NMD degree and represent her or his education with that title (“Firstname Lastname, NMD”), however, state law may require that the naturopathic physician use the protected professional title of “ND” (“Firstname Lastname, ND”) in the context of communicating to the public that the naturopathic physician is licensed to practice naturopathic medicine. In most states with licensure of naturopathic physicians, professionally using “NMD” and “ND” are restricted to only those who have earned a “Doctor of Naturopathic Medicine” or “Doctor of Naturopathy” degree from a CNME-accredited or CNME-provisionally accredited school.

An example of this in the context of another healthcare profession is that of a physician assistant (PA). A PA may earn a Master of Science (MS) degree in Physician Assistant Studies and thus have an educational degree title that looks like "Firstname Lastname, MS". Once the PA takes the Physician Assistant National Certifying Exam (PANCE) and passes, the PA can then obtain licensure and use the professional title that looks like, "Firstname Lastname, PA-C". Thus, a PA can put either "MS" or "PA-C" after the PA's name, depending on if the PA wants to communicate educational degree title (MS) or protected professional title (PA-C).

Another example of this is that of an acupuncturist. An acupuncturist may earn a Master of Science (MS) degree in Acupuncture and thus have an educational degree title that looks like "Firstname Lastname, MS". Once the acupuncturist takes the necessary National Certification Commission for Acupuncture and Oriental Medicine (NCCAOM) examinations and passes, the acupuncturist can then obtain licensure and use the professional title that looks like, "Firstname Lastname, LAc". Thus, an acupuncturist can put either "MS" or "LAc" after the acupuncturist's name, depending on if the acupuncturist wants to communicate educational degree title (MS) or protected professional title (LAc).

An allopathic physician earns an "MD" educational degree and the protected professional title in all states is "MD". There is no difference between the educational degree title and the protected professional title of an allopathic physician.

An osteopathic physician earns a "DO" educational degree and the protected professional title in all states is "DO". There is no difference between the educational degree title and the protected professional title of an osteopathic physician.

WHAT ARE PROTECTED PROFESSIONAL TITLES OF NATUROPATHIC PHYSICIANS?²⁴

Depending on the state and how legislation regarding naturopathic physicians was written, the following are all protected professional titles that are used to refer to naturopathic physicians:

- Naturopathic Physician
- Naturopathic Medical Doctor
- Naturopathic Doctor
- Doctor of Naturopathic Medicine
- Doctor of Naturopathy
- Registered Naturopathic Doctor
- N.M.D. or NMD
- N.D. or ND
- R.N.D. or RND
- Naturopath

The variations in the title of a naturopathic physician from state to state can be seen in the legislation for each state that either licenses or registers naturopathic physicians.

HOW DOES THE US DEPARTMENT OF LABOR DEFINE NATUROPATHIC PHYSICIANS?²⁵

The US Department of Labor defines naturopathic physicians in the following way:

29-1199.04 – Naturopathic Physicians

Diagnose, treat, and help prevent diseases using a system of practice that is based on the natural healing capacity of individuals. May use physiological, psychological or mechanical methods. May also use natural medicines, prescription or legend drugs, foods, herbs, or other natural remedies.

The sample of reported job titles include:

Doctor (Dr), Doctor of Naturopathic Medicine, Naturopathic Doctor, Naturopathic Physician, Physician

Licensing

WHAT LICENSING EXAMINATION DO NATUROPATHIC PHYSICIANS TAKE?⁷

Naturopathic physicians (NMDs/NDs) take the Naturopathic Physicians Licensing Examinations (NPLEX), which consists of two parts – Part I and Part II. NPLEX Part I is the Biomedical Science Examination (BSE) and is administered after the second year of naturopathic medical school. NPLEX Part II is the Core Clinical Science Examination (CCSE) and is administered after the fourth year of naturopathic medical school.

Allopathic physicians (MDs) take the United States Medical Licensing Examination (USMLE), which consists of three steps – Step 1, Step 2 (CK & CS), and Step 3. USMLE Step 1 is administered at the end of the second year of allopathic medical school. USMLE Step 2 CK (Clinical Knowledge) and Step 2 CS (Clinical Skills) is administered during either the third or fourth year of allopathic medical school. USMLE Step 3 is administered during residency.

Osteopathic physicians (DOs) take the Comprehensive Osteopathic Medical Licensing Examination (COMLEX-USA), which consists of three levels – Level 1, Level 2, and Level 3. COMLEX Level 1 is administered at the end of the second year of osteopathic medical school. COMLEX Level 2-CE (Cognitive Evaluation) is administered during either the third or fourth year of osteopathic medical school. COMLEX Level 3 is administered during residency. Osteopathic physicians are eligible to take the USMLE.

WHO ADMINISTERS THE LICENSING EXAMINATION (NPLEX)?⁸

The North American Board of Naturopathic Examiners (NABNE) administers the NPLEX to each naturopathic medical student (NMS) and naturopathic physician (NMD/ND).

The National Board of Medical Examiners (NBME) and the Federation of State Medical Boards (FSMB) co-sponsor administration of the USMLE to each allopathic medical student (MS) and allopathic physician (MD).

The National Board of Osteopathic Medical Examiners (NBOME) administers the COMLEX-USA to each osteopathic medical student (OMS) and osteopathic physician (DO).

WHO IS ELIGIBLE TO TAKE THE LICENSING EXAMINATION (NPLEX)?⁹

Naturopathic medical students who successfully complete their biomedical science coursework during their first two years are eligible to take the NPLEX Part I BSE.

Naturopathic medical students who successfully complete their clinical science coursework and clinical rotations during their second two years and who passed the NPLEX Part I BSE are eligible to take the NPLEX Part II CCSE.

DO NATUROPATHIC PHYSICIANS HAVE BOARD CERTIFICATIONS THAT THEY CAN OBTAIN?¹⁰

Yes, naturopathic physicians have 2 board certifications that they can obtain. Board certification is not required to practice naturopathic medicine, but may be required by individual employers. There currently is no national board certification organization that oversees naturopathic medical board certifications in specialties and subspecialties.

Fellow of the American Board of Naturopathic Oncology (FABNO)

A naturopathic physician can become board-certified in naturopathic oncology by taking the American Board of Naturopathic Oncology Board of Medical Examiners (ABNOBOMEx) examination, passing it, and meeting all requirements for board certification in naturopathic oncology. Once board certification is attained, a naturopathic physician earns the title “Fellow of the American Board of Naturopathic Oncology” (“FABNO”).

Diplomate of the Homeopathic Academy of Naturopathic Physicians (DHANP)

A naturopathic physician can become board-certified in homeopathy by taking the Homeopathic Board Certification Exam (HBCE), passing it, and meeting all requirements for board certification in homeopathy. Once board certification is attained, a naturopathic physician earns the title “Diplomate of the Homeopathic Academy of Naturopathic Physicians” (“DHANP”).

Osteopathic physicians have 29 primary specialty and 77 subspecialty board certifications that they can obtain from 18 different Specialty Certifying Boards that are overseen by the American Osteopathic Association (AOA) Bureau of Osteopathic Specialists (BOS). Board certification is not required to practice osteopathic medicine in the USA, but may be required by individual employers. The process of board certification for osteopathic physicians is administered by the AOA's Department of Certifying Board Services.

Allopathic physicians have many specialty and subspecialty board certifications they can obtain from 2 different national board certification organizations – the American Board of Medical Specialties (ABMS) and the American Board of Physician Specialists (ABPS). The ABMS was established in 1933, is not overseen by a medical association, has 24 specialty Member Boards, and is the largest national board certification organization, offering the most specialty and subspecialty board certifications. The ABPS administers board certifications for the American Association of Physician Specialists (AAPS), offering 18 specialty board certifications between 12 Member Boards. Board certification is not required to practice allopathic medicine in the USA, but may be required by individual employers. Osteopathic physicians are able to obtain board certifications from the ABMS and the ABPS.

ARE NATUROPATHIC PHYSICIANS CURRENTLY LICENSED IN EVERY STATE?¹¹

No, naturopathic physicians are not currently licensed in every state. Currently, naturopathic physicians are licensed or registered in 17 USA states; Washington, DC; and the USA territories of Puerto Rico and the Virgin Islands.

ARE LICENSURE REQUIREMENTS CURRENTLY STANDARDIZED IN ALL USA STATES AND TERRITORIES?¹²

No, licensure requirements are not currently standardized in all USA states and territories. In addition to the NPLEX, some states and territories have jurisprudence examinations that must be passed in order for licensure to be granted. Utah is currently the only state that requires completion of at least 1 year of a naturopathic residency program in order to be eligible for licensure.

IS COMPLETION OF A RESIDENCY PROGRAM REQUIRED FOR LICENSURE?¹³

At this time, completion of a residency program is not required for licensure, except in the state of Utah, where completion of at least 1 year of a residency program is required.

WHY IS COMPLETION OF A RESIDENCY PROGRAM NOT REQUIRED FOR LICENSURE?¹⁴

Completion of a residency program is not currently required for licensure, other than in Utah, because of how the legislation has been written and passed in states that license or register naturopathic physicians. A current barrier to requirement of completion of a residency program, other than in Utah, is that naturopathic residencies are privately funded and there are more graduating naturopathic physicians each year than there are available naturopathic residencies.

Allopathic and osteopathic residency programs are currently federally - and state-funded, mostly through Medicare, Medicaid, and the Veterans Administration (VA), which is why there are more programs and completion of a residency is able to be required for licensure.

WHAT IS THE IMPORTANCE OF LICENSURE OF NATUROPATHIC PHYSICIANS AND REGULATION OF NATUROPATHIC MEDICINE IN EVERY STATE?¹⁵

Public safety is the most important aspect of licensure of naturopathic physicians and regulation of naturopathic medicine in every state. Not understanding the difference between naturopathic physicians (NMDs/NDs) who have attended CNME-accredited or provisionally-accredited four-year naturopathic medical schools to specialize in naturopathic medicine, including the practice of naturopathy, and earned a Doctor of Naturopathic Medicine (NMD) or Doctor of Naturopathy (ND) doctoral degree to become licensed naturopathic physicians and lay naturopaths who have earned a diploma, distance-learning diploma, or distance-learning degree in naturopathy from a non-accredited institution can be very confusing to the public. It is critical to the safety of the public that the public is educated on the difference between a naturopathic physician versus a lay naturopath.

Lay naturopaths are not licensed in any USA state or territory to practice naturopathic medicine, as it is not a part of their in-person or online diploma, distance-learning diploma, or distance-learning degree in naturopathy from a non-accredited institution program, however, they have founded their own organizations of which the titles imply that they are trained to do so, which is misleading and dangerous to the public. The American Naturopathic Medical Association (ANMA), the American Naturopathic Medical Accreditation Board (ANMAB), the American Naturopathic Medical Certification Board (ANMCB), American Naturopathic Certification Board (ANCB), and the National Registry of Naturopathic Practitioners (NRNP) are all organizations for lay naturopaths who do not have training in naturopathic medicine. This is very important for the public to understand, as it can be confusing to patients who do not have the education and resources available to them to distinguish between a naturopathic physician and a lay naturopath, but want to see a naturopathic physician (within permissible capacity of state laws) in a state that does not yet have licensure for naturopathic physicians and regulation of naturopathic medicine.

In states without licensure of naturopathic physicians and regulation of naturopathic medicine, there is no educational degree title protection nor are there protected professional titles of naturopathic physicians. This means that, in those states, a naturopathic physician who earned a “Doctor of Naturopathy” (“ND”) doctoral degree from a CNME-accredited naturopathic medical school and a lay naturopath who earned a “Doctor of Naturopathy” online diploma from a non-accredited institution, which includes no medical training, can both use “ND” as initials after their name to signify their education, since there is no regulation of those initials in those states. In many states with licensure of naturopathic physicians and regulation of naturopathic medicine, using “NMD” or “ND” after a person’s name to signify their education is restricted to naturopathic physicians who have earned an NMD or ND degree from a CNME-accredited naturopathic medical school, as those states only recognize the degree from CNME-accredited naturopathic medical schools.

Due to lack of available information, education, and resources, many people do not understand the difference between an educational degree title and a protected professional title. Without licensure of naturopathic physicians and without regulation of naturopathic medicine, a person may see a lay naturopath using the initials “ND”, instead of a naturopathic physician, and not understand the difference in level of education and training.

Additionally, the ANMCB issues certification titles to lay naturopaths, who have taken and passed a “national exam” that has no name, including, “Board Certified Naturopathic Physician” (“BCNP”) and “Board Certified Naturopathic Doctor” (“BCND”), which are used by lay naturopaths without training in naturopathic medicine in states without licensure for naturopathic physicians and regulation of naturopathic medicine. This is confusing, misleading, and dangerous to patients, as they may think they are seeing a naturopathic physician, but may be actually seeing a lay naturopath. It is important to know that, currently, the only two board certifications available to naturopathic physicians who have graduated from a CNME-accredited naturopathic medical school are in naturopathic oncology (FABNO) and homeopathy (DHANP). If a person is using the title “Board Certified Naturopathic Physician” or “Board Certified Naturopathic Doctor,” that person is a lay naturopath without any medical training, not a naturopathic physician with training in naturopathic medicine.

It is crucial that education and resources are made available to the public to help patients understand the educational background and difference between naturopathic physicians, with training in naturopathic medicine, and lay naturopaths.

WHAT IS THE IMPORTANCE OF CONSISTENT SCOPE OF PRACTICE IN EACH STATE THAT ACCURATELY REFLECTS THE SCOPE OF TRAINING OF NATUROPATHIC PHYSICIANS?⁵¹

Public safety and health are the most important aspects of consistent scope of practice in each state that accurately reflects the scope of training of naturopathic physicians. Like all

health care providers, having proper scope of practice that accurately reflects scope of training allows for safe and effective medical care to be delivered. If proper scope of practice is not in place, for example, if in a state naturopathic physicians do not have pharmaceutical prescribing rights that accurately reflect their scope of training, since patients may choose to see a naturopathic physician for any symptom or complaint, naturopathic physicians may be unable to prescribe antibiotics for conditions such as strep throat, vaccines for vaccine-preventable diseases, epinephrine injectors for patients with risk of anaphylaxis due to allergic reaction, hormonal contraception, or emergency oxygen for life-threatening hypoxic (low oxygen) situations. In emergency situations, deliverance of epinephrine or oxygen may be crucial to saving the life of a patient while emergency medical services (EMS) are on their way. It is important that the scope of training of naturopathic physicians is understood so that the scope of practice of naturopathic physicians in each state is consistent and accurately reflects the scope of training.

DO NATUROPATHIC PHYSICIANS HAVE THE SAME PUBLIC HEALTH DUTIES AS ALLOPATHIC AND OSTEOPATHIC PHYSICIANS?³⁵

Yes, like allopathic and osteopathic physicians, naturopathic physicians are held liable for reporting diseases and conditions to a state department of health that are considered to be mandatory reportable diseases.

CAN NATUROPATHIC PHYSICIANS LOSE THEIR LICENSE TO PRACTICE NATUROPATHIC MEDICINE?³⁶

Yes, naturopathic physicians can lose their licenses to practice naturopathic medicine, just like allopathic and osteopathic physicians can lose their licenses to practice medicine.

Naturopathic Residency Programs

WHO ACCREDITS NATUROPATHIC RESIDENCY PROGRAMS?¹⁶

The Council on Naturopathic Medical Education (CNME) accredits naturopathic residency programs.

The Accreditation Council for Graduate Medical Education (ACGME) accredits allopathic and osteopathic residency programs.

The American Osteopathic Association (AOA) Osteopathic Graduate Medical Education (OGME) Development Initiative is transitioning accreditation and matching of osteopathic residency programs to the ACGME and the NRMP.

WHO OVERSEES THE NATUROPATHIC RESIDENCY MATCH PROGRAM?¹⁷

The Naturopathic Post-Graduate Association (NPGA) oversees the matching process for naturopathic physicians applying to CNME-approved naturopathic residency programs. Applications require submission of the “Universal Application for CNME-Approved Naturopathic Residencies” to the directors responsible for processing applications of each sponsoring school of the residencies being applied for.

The National Resident Matching Program (NRMP), also known as “The Match,” oversees the matching process for allopathic and osteopathic physicians (who submit AAMC USMLE scores) applying to ACGME-approved allopathic and osteopathic residency programs. Applicants must submit their applications using the Association of American Medical Colleges (AAMC) Electronic Residency Application Service (ERAS).

The American Osteopathic Association (AOA) sponsors the AOA Intern/Resident Registration program, also known as the “Match” or the “AOA Match,” and oversees the matching process, administered by National Matching Services Inc. on behalf of the AOA, for osteopathic physicians applying to AOA-approved osteopathic residency programs. Applicants must submit their applications using the Association of American Medical Colleges (AAMC) Electronic Residency Application Service (ERAS). Osteopathic physicians have the options of applying to residency programs in the AOA Match only, applying to residency programs in the NRMP only, or applying to residency programs in both the AOA Match and the NRMP.

IS COMPLETION OF A RESIDENCY PROGRAM REQUIRED FOR LICENSURE?¹³

At this time, completion of a residency program is not required for licensure, except in the state of Utah, where completion of at least 1 year of a residency program is required.

WHY IS COMPLETION OF A RESIDENCY PROGRAM NOT REQUIRED FOR LICENSURE?¹⁴

Completion of a residency program is not currently required for licensure, other than in Utah, because of how the legislation has been written and passed in states that license or register naturopathic physicians. A current barrier to requirement of completion of a residency program, other than in Utah, is that naturopathic residencies are privately funded and there are more graduating naturopathic physicians each year than there are available naturopathic residencies.

Allopathic and osteopathic residency programs are currently federally - and state-funded, mostly through Medicare, Medicaid, and the Veterans Administration (VA), which is why there are more programs and completion of a residency is able to be required for licensure.

Naturopathic Medical School Accreditation

WHICH US DEPARTMENT OF EDUCATION SPECIALIZED ACCREDITING AGENCY ACCREDITS NATUROPATHIC MEDICINE DEGREE PROGRAMS?¹⁸

The Council on Naturopathic Medical Education (CNME) accredits naturopathic medicine (NMD/ND) degree programs in the USA, Canada, and Puerto Rico.

The Liaison Committee on Medical Education (LCME) accredits allopathic medicine (MD) degree programs in the USA.

The American Osteopathic Association (AOA) Commission on Osteopathic College Accreditation (COCA) accredits osteopathic medicine (DO) degree programs in the USA.

WHAT SCHOOLS CURRENTLY HAVE CNME-ACCREDITED OR CNME-PROVISIONALLY ACCREDITED PROGRAMS THAT OFFER A DOCTORATE DEGREE IN NATUROPATHIC MEDICINE?¹⁹

The CNME-accredited schools that offer a doctorate degree in naturopathic medicine are:

- Bastyr University (BU) – Kenmore, Washington, USA
- Bastyr University California (BUC) – San Diego, California, USA
- Boucher Institute of Naturopathic Medicine (BINM) – New Westminster, British Columbia, Canada
- Canadian College of Naturopathic Medicine (CCNM) – Toronto, Ontario, Canada
- National University of Health Sciences (NUHS) – Lombard, Illinois, USA
- National University of Natural Medicine (NUNM) – Portland, Oregon, USA
- Southwest College of Naturopathic Medicine & Health Sciences (SCNM) – Tempe, Arizona, USA
- University of Bridgeport (UB) – Bridgeport, Connecticut, USA

The CNME-provisionally accredited school that offers a doctorate degree in naturopathic medicine is:

- Sistema Universitario Ana G. Méndez (SUAGM) Universidad del Turabo (UT) – Gurabo, Puerto Rico

WHAT DOES IT MEAN IF A NATUROPATHIC MEDICAL PROGRAM IS CNME-PROVISIONALLY ACCREDITED?²⁰

If a naturopathic medical program is CNME-provisionally accredited, it means that the school has applied for and met accreditation candidacy requirements with the CNME and that the program has had full-time naturopathic medical students enrolled for at least 1 academic year, but that the school has not yet graduated its first class of students in the program.

WHICH US DEPARTMENT OF EDUCATION REGIONAL ACCREDITING AGENCIES ACCREDIT SCHOOLS WITH NATUROPATHIC MEDICINE DEGREE PROGRAMS IN THE USA?⁴³

The US Department of Education regional accrediting agencies that accredit schools with naturopathic medicine degree programs in the USA are:

- Northwest Commission on Colleges and Universities
 - Bastyr University (BU) – Kenmore, Washington, USA
 - Bastyr University California (BUC) – San Diego, California, USA
 - National University of Natural Medicine (NUNM) – Portland, Oregon, USA
- North Central Association of Colleges and Schools, The Higher Learning Commission
 - National University of Health Sciences (NUHS) – Lombard, Illinois, USA
 - Southwest College of Naturopathic Medicine & Health Sciences (SCNM) – Tempe, Arizona, USA
- New England Association of Schools and Colleges, The Higher Learning Commission
 - University of Bridgeport (UB) – Bridgeport, Connecticut, USA
- Middle States Commission on Higher Education
 - Sistema Universitario Ana G. Méndez (SUAGM) Universidad del Turabo (UT) – Gurabo, Puerto Rico

DO NATUROPATHIC MEDICAL SCHOOLS HAVE A REQUIRED ENTRANCE EXAMINATION THAT IS THE SAME BETWEEN ALL OF THE SCHOOLS?²¹

No, there is not currently a required entrance examination, such as the Medical College Admission Test (MCAT), that is the same between all of the naturopathic medical schools. The Association of Accredited Naturopathic Medical Colleges (AANMC) has not developed its own examination for entrance into naturopathic medical schools.

The MCAT was developed and is administered by the Association of American Medical Colleges (AAMC) for entrance into allopathic medical schools.

The American Association of Colleges of Osteopathic Medicine (AACOM) has not developed its own examination for entrance into osteopathic medical schools. Applicants take and submit AAMC MCAT scores.

Most allopathic and osteopathic medical schools in the USA require submission of AAMC MCAT scores as a part of the application and admission process.

WHAT IS THE CENTRAL APPLICATION SERVICE FOR APPLYING TO NATUROPATHIC MEDICAL SCHOOLS?³⁷

The Doctor of Naturopathic Medicine Centralized Application Service (NDCAS) is the central application service for applying to naturopathic medical schools.

The American Medical College Application Service (AMCAS) is the central application service for applying to allopathic medical schools.

The American Association of Colleges of Osteopathic Medicine Application Service (AACOMAS) is the central application service for applying to osteopathic medical schools.

Naturopathic Medical Organizations

WHAT ORGANIZATION FURTHERS EDUCATIONAL INITIATIVES OF THE NATUROPATHIC MEDICAL PROFESSION?²⁶

The Association of Accredited Naturopathic Medical Colleges (AANMC) furthers educational initiatives of the naturopathic medical profession.

The Association of American Medical Colleges (AAMC) furthers educational initiatives of the allopathic medical profession.

The American Association of Colleges of Osteopathic Medicine (AACOM) furthers educational initiatives of the osteopathic medical profession.

WHAT ORGANIZATION FURTHERS PROFESSIONAL INITIATIVES OF THE NATUROPATHIC MEDICAL PROFESSION?²⁷

The American Association of Naturopathic Physicians (AANP) furthers professional initiatives of the naturopathic medical profession.

The American Medical Association (AMA) furthers professional initiatives of the allopathic medical profession.

The American Osteopathic Association (AOA) furthers professional initiatives of the osteopathic medical profession.

WHAT ORGANIZATION FURTHERS STUDENT INITIATIVES OF THE NATUROPATHIC MEDICAL PROFESSION?²⁸

The Naturopathic Medical Student Association (NMSA) furthers student initiatives of the naturopathic medical profession.

The American Medical Student Association (AMSA) furthers student initiatives of the allopathic and osteopathic medical professions.

The Student Osteopathic Medical Association (SOMA) furthers student initiatives of the osteopathic medical profession.

WHAT ORGANIZATION FURTHERS GLOBAL HEALTH INITIATIVES OF THE NATUROPATHIC MEDICAL PROFESSION?⁴⁵

The World Naturopathic Federation (WNF) furthers global health initiatives of the naturopathic medical profession.

The World Medical Association (WMA) furthers global health initiatives of the allopathic medical profession.

The Osteopathic International Alliance (OIA) furthers global health initiatives of the osteopathic medical profession.

WHAT ORGANIZATION FURTHERS RESEARCH INITIATIVES OF THE NATUROPATHIC MEDICAL PROFESSION?²⁹

The Naturopathic Physicians Research Institute (NPRI) furthers research initiatives of the naturopathic medical profession.

Naturopathic medical research in the USA is also furthered by:

- Bastyr University Research Institute
- National University of Natural Medicine Helfgott Research Institute
- U.S. Department of Health and Human Services (HHS) National Institutes of Health (NIH) National Center for Complementary and Integrative Health

WHAT ORGANIZATIONS FURTHER CLINICAL LITERATURE INITIATIVES OF THE NATUROPATHIC MEDICAL PROFESSION?³⁰

Naturopathic Doctor News and Review (NDNR) furthers clinical literature initiatives of the naturopathic medical profession.

The Natural Medicine Journal (NMJ) is the official journal of the American Association of Naturopathic Physicians (AANP).

The Journal of the American Medical Association (JAMA) is the official journal of the American Medical Association (AMA). JAMA has affiliated journal publications specific to areas of medicine, including cardiology, dermatology, facial plastic surgery, internal medicine, neurology, oncology, ophthalmology, otolaryngology, pediatrics, psychiatry, and surgery.

The Journal of the American Osteopathic Association (JAOA) is the official journal of the American Osteopathic Association (AOA).

Insurance Coverage

HOW ARE NATUROPATHIC PHYSICIANS CREDENTIALLED?³⁸

Naturopathic physicians are specialized in naturopathic medicine and are trained in outpatient family medicine and primary care medicine, with an emphasis on prevention and wellness through the use of naturopathic treatment modalities. Thus, just like allopathic and osteopathic physicians, naturopathic physicians can be credentialed as either specialists or primary care providers, depending on whether the focus of their practice is specialty care or primary care.

In some states, state laws mandate that naturopathic physicians are credentialed as specialists, whereas, in other states, state laws mandate that naturopathic physicians are credentialed as primary care providers.

DO NATUROPATHIC PHYSICIANS USE CPT CODES?³⁹

Yes, naturopathic physicians use the same Current Procedural Terminology (CPT) codes as allopathic and osteopathic physicians.

DO NATUROPATHIC PHYSICIANS USE ICD CODES?⁴⁰

Yes, naturopathic physicians use the same World Health Organization (WHO) International Classification of Diseases (ICD) codes as allopathic and osteopathic physicians. The current ICD codes being used are from the International Statistical Classification of Diseases and Health Related Problems 10th Revision and are known as ICD-10 codes.

WHAT ICD-10 CODES DO NATUROPATHIC PHYSICIANS USE FOR OSSEOUS AND SOFT TISSUE MANIPULATIVE MEDICINE AND THERAPY?³⁴

For osseous and soft tissue manipulative medicine and therapy, naturopathic physicians use the same ICD-10 codes that osteopathic physicians use for osteopathic manipulative treatment (OMT). Insurance companies will reject a claim if a chiropractic ICD-10 code is used.

DO NATUROPATHIC PHYSICIANS PROVIDE “ESSENTIAL HEALTH BENEFITS” SERVICES SPECIFIED IN THE PPACA?⁴¹

Yes, naturopathic physicians provide “Essential Health Benefits” services specified in Section 1302(b)(1) of the Patient Protection and Affordable Care Act (PPACA), including services in the categories of “Ambulatory patient services,” “Maternity and newborn care,”

“Mental health and substance use disorder services, including behavioral health treatment,” “Prescription drugs,” “Rehabilitative and habilitative services and devices,” “Laboratory services,” “Preventative and wellness services and chronic disease management,” and “Pediatric services, including oral and vision care.” Like allopathic and osteopathic physicians, naturopathic physicians perform ambulatory care services, such as taking routine physical examinations and thorough health histories; perform cardiovascular screenings and Pap smears; and order laboratory tests, imaging procedures, colonoscopies, mammograms, and other diagnostic tests.

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NATUROPATHIC FORMULARY LAWS BY STATE

As the scope of practice for NDs varies from state to state, so do the laws and regulations regarding prescribing. Ten of the 16 states that license NDs allow NDs to prescribe independently, without any MD/DO supervision or protocol.

STATES WITH LICENSURE OF NATUROPATHIC DOCTORS & PRESCRIPTIVE AUTHORITY, UPDATED 2011

State	ND Licensure Enacted	# of Current Active NDs	Prescriptive Authority	MD/DO Supervision Required
Alaska	1986	40	No	No
Arizona	1935	750	Yes	No
California	2005	450	Yes	Yes ¹
Connecticut	1920	260	No	No
District of Columbia	2007	28	Yes	No
Hawaii	1925	85	Yes	No
Idaho	2005	8	Yes	No
Kansas ²	2003	12	Yes	Yes
Maine	1995	28	Yes	1 year
Minnesota	2008	12	No	No
Montana	1991	67	Yes	No
New Hampshire	1994	57	No	No
North Dakota ³	2011	pending	No	No
Oregon	1927	715	Yes	No
Utah	1997	25	Yes	No
Vermont	1995	117	Yes	No
Washington	1919	802	Yes	No

¹ In the State of California, the MD/DO need not be in the same office or need to sign the ND's charts or prescriptions. A written agreement must be signed for NDs to be able to furnish all drugs with the exception of schedule I-II controlled substances.

² Kansas and Minnesota have registration for Naturopathic Doctors and are regulated under State Board of Healing Arts and the Medical Board's Registered Naturopathic Doctor Advisory Council, respectively.

³ The bill for licensure of NDs in North Dakota just passed this year and therefore, licenses have not yet been issued.

**CATEGORIES OF PRESCRIPTIVE MEDICATIONS
WITHIN NATUROPATHIC DOCTORS' SCOPE OF PRACTICE BY STATE**

Prescription	A K	AZ	CA	C T	D C	HI	I D	KS	ME	M N	MT	NH	N D	OR	UT	VT	WA
Epinephrine		✓	✓		✓	✓		*	✓			✓		✓	?	✓	✓
Hormones		✓	✓		✓	✓			✓		✓	✓		✓	✓	✓	✓
Antibiotics/ Anti-microbials		✓	*		✓	✓			✓		✓	✓		✓	✓	✓	✓
IV/IM (nutrients)		✓	*					*	✓		✓	✓		✓	?	✓	✓
Non-opiate pain control		✓	*			✓						✓		✓	✓	✓	✓
Dermatologicals/ Topicals		✓	*			✓			✓		✓	✓		✓	✓	✓	✓
Ophthalmic agents		✓	*			✓								✓			✓
Otic agents		✓	*			✓								✓			✓
Respiratory Expectorants/ mucolytics		✓	*			✓					✓	✓		✓		✓	✓
Gastrointestinal		✓	*			✓						✓		✓	✓	✓	✓
Cardiovascular		✓	*			✓						✓		✓	✓	✓	✓
Renal and GU		✓	*			✓						✓		✓	✓	✓	✓
Psychotherapeutic		✓	*			✓						✓		✓	✓	✓	✓
Endocrine/ Metabolic		✓	*			✓						✓		✓	✓	✓	✓
Vaccine/ Immunization		✓	*			✓			✓			✓		✓	✓	✓	✓
CNS		✓	*			✓						✓		✓		✓	✓
Chelating substances		✓	*			✓		*			✓	✓		✓		✓	✓
Childbirth prep		✓	*								✓					✓	
Chemotherapeutics																	
Psychotropics																	
Schedule I																	
Schedule II																	

All checks indicate independent prescriptive authority and asterick(*) indicates with MD/DO supervision.

Arizona has the broadest formulary in the nation, and able to prescribe all classes of prescription drugs with 4 exceptions: IV medications (except vitamins, chelation therapy, and drugs used in emergency resuscitation and stabilization, which are allowed), controlled substances listed as Schedule I or II (except morphine is allowed), cancer chemotherapeutics classified as legend drugs, and antipsychotics.

Kansas is the only state, other than California, which requires physician supervision for prescribing.

Maine requires one year of a collaborative relationship with an MD/DO.

WEBSITE LINKS TO FORMULARY BY STATE

ARIZONA

<http://www.npbomex.az.gov/notice.asp>

CALIFORNIA

<http://www.naturopathic.ca.gov/laws/regulations.shtml#article6>

HAWAII

http://hawaii.gov/dcca/pvl/news-releases/naturopathy_announcements/NaturopathicFormulary010110.pdf

KANSAS

<http://www.ksbha.org/regulations/article72.html>

MAINE

www.maine.gov/sos/cec/rules/02/502/502c006.doc

MONTANA

<http://www.mtrules.org/gateway/RuleNo.asp?RN=24.111.511>

NEW HAMPSHIRE

<http://www.nh.gov/pharmacy/documents/naturo-form.pdf>

OREGON

http://www.oregon.gov/OBNM/rules/850-060-0225_1.pdf

UTAH

<http://www.rules.utah.gov/publicat/code/r156/r156-71.htm#T5>

VERMONT

<http://vtprofessionals.org/opr1/naturopaths/>

WASHINGTON

<http://apps.leg.wa.gov/WAC/default.aspx?cite=246-836-210>



10 Reasons Naturopathic Medicine Lowers Healthcare Costs

1. Offers more treatment options.

Naturopathic physicians provide consumers with a broader range of safe, cost effective care.

2. Offers less expensive treatment.

Naturopathic treatments are inherently less expensive than those in conventional medicine and many naturopathic treatments incur no cost whatsoever.

3. Reduces need for expensive surgical procedures.

Naturopathic physicians offer non-surgical options to patients, while referring for surgery when it is indicated.

4. Decreases prescription drug costs.

Naturopathic physicians typically prescribe less expensive botanical or nutritional supplements to effectively care for medical problems.

5. Decreases in costs associated with drug prescriptions.

About two percent of drug prescriptions result in hospital admission. Adverse drug reactions may add as much as \$5 billion annually to health care costs and are considered the 5th leading cause of death in the U.S. 100,000 people died in 2003 of adverse reactions from correctly prescribed pharmaceuticals.

6. Reduces the incidence of iatrogenic (doctor-induced) illnesses.

As many as one-third of patients admitted to hospitals contract another illness while there, resulting in longer stays. Fatal pharmaceutical adverse reactions combined with iatrogenic fatalities are the 3rd leading cause of death in the U.S.

7. Lowers malpractice rates, resulting in reduced patient costs.

Malpractice insurance rates are much lower for naturopathic physicians than they are for conventional doctors. Patients of naturopathic physicians do not have to absorb high malpractice costs.

8. Addresses the cause of illness thus eliminating expensive ongoing care.

By addressing and treating the cause of disease, the need for repeated, expensive and often ineffective symptomatic treatment is eliminated. Naturopathic physicians use state-of-the-art diagnostic testing, through history and complete physical examinations to diagnose underlying causes of disease.

9. Offers true disease prevention.

Naturopathic physicians emphasize health-building practices, reducing the high future cost of preventable degenerative diseases.

10. Reduces insurance costs.

Naturopathic medical billing is far lower per patient than conventional medical billing.

Naturopathic Medicine: Cost Saving Disease Prevention and Health Improvement

Naturopathic Medicine Works

Improved Medical Outcomes

- Several clinical trials have demonstrated how naturopathic care produces health improvement and risk factor reduction:
- **Menopausal symptoms:** patients smoked less and exercised more. These patients were *seven times* more likely to report improvement in insomnia and increased energy.¹
- **Anxiety:** improvements in anxiety, fatigue, and quality-of-life.²
- **Low Back Pain:** less pain, more weight loss, less days off work.³
- **Heart Disease:** fewer medications, better blood pressure and cholesterol, better mood.⁴
- **Diabetes:** improvements in blood sugar, mood, and self-care.⁵
- **Multiple Cardiovascular risk factors:** Reduction in Hypertension, High Cholesterol, Obesity, Smoking, Inactivity and Excessive Stress.⁶

Improved Community Health Outcomes

- Patients receiving CAM services were significantly more likely to have obtained commonly used preventive services, including blood pressure and cholesterol testing, complete physical exams, and breast cancer screening.⁷

Improved Patient Satisfaction

- Patient satisfaction with services: 92% CAM vs. 44% conventional services.⁸
- Bastyr Center for Natural Health – the teaching clinic of the naturopathic medical school in Seattle –ranked in the top 3 among 46 Seattle-area primary care clinics for overall patient satisfaction.⁹

Naturopathic Medicine Saves Money

Naturopathic Care Reduces need for more-costly Conventional Medical care

- 55% of CAM users report a slight to substantial reduction of their use of conventional medical care⁸
- 61% of CAM users report a slight to substantial reduction in their use of prescription drugs.⁸
- The Diabetes Prevention Trial demonstrated that diet and lifestyle treatments to prevent type 2 diabetes were more effective (and cost effective) than early drug therapy in high-risk patients.¹⁰
- Williamson et al. recently recommended increased incorporation of diet and lifestyle therapy into the health system in their review of health policy for diabetes prevention.¹¹
- Blue Shield’s internal study found that a naturopathic-centered managed care program could cut the costs of chronic and stress related illness by up to 40%, and lower costs of specialist utilization by 30%.¹²
- Naturopathic care to treat diabetics led to improvements in blood sugar, mood, and patient self care.⁵

Naturopathic Care Reduces Employee Sick Days and Cost, while Improving Productivity

- Employees of the Canadian Postal Service receiving naturopathic care for low back pain or heart disease showed reductions in lost work days and improvements in productivity while at work.^{4,13}
- These improvements in workplace productivity actually made naturopathic medicine a **COST-SAVINGS** approach. In other words, adding naturopathic care for employees showed an actual return-on-investment.
- Vermont Auto Dealers Association use of naturopathic care for employees saved \$2.10 in medical costs for every dollar spent, and \$8.20 in total costs per employee for every dollar spent.⁶

Naturopathic Medicine is not an “add-on,” but Primary Care

- 67.7% patients in Washington State who receive Naturopathic care do not receive concurrent care from an MD/DO for their RFV (reason for visit). In most cases Naturopathic care is not “add-on” care.¹⁴

Naturopathic care has negligible cost

- A 2004 analysis of payers found that in WA State CAM services cost approximately \$0.20-\$0.19 per member per month in HMO and PPO plans respectively. ¹⁵
- A 2006 analysis attempting to quantify the impact of the WA State “Every Category of Provider” law found that the impact on insurance premiums was “modest,” representing about 2.9% of total expenditures. ¹⁶
- According to Lafferty et al. in 2004, approximately 7.6% of cancer patient records sampled had claims for naturopathic services amounting to <2% of overall medical bills for cancer care for over 7,000 patients. The average amount billed per cancer patient for Naturopathic services was \$413.00; the average amount billed for conventional care for the same patients was \$40,728. ¹⁷

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INTERNATIONAL MEDICAL GRADUATE (IMG) ASSISTANCE PROGRAM

BMP – Policy and Planning Committee

October 12, 2016

Background

The challenge of integrating IMGs into the workforce is complex and longstanding. In the Minnesota, the issue has gained urgency as policy makers seek to address several major issues facing the state:

- Shortages in the supply of physicians
- An aging and diversifying population
- Persistent health disparities
- Rising health care costs.

2014 Task Force

- Charge: To develop **strategies** to integrate refugee, asylee and other immigrant physicians into the Minnesota health care delivery system and make **recommendations** to the Commissioner of Health and Legislature.

- Composition



Chair
E. Bogonko, MD



Members

Immigrant Physicians; University of MN, Mayo Clinic, MN Medical Association; Women's Initiative for Self-Empowerment; New Americans Alliance for Development; Workforce Development Inc.; Federal Reserve Bank of Mpls; Essentia Health

Primary barriers identified

- Lack of recognized clinical experience, lack of opportunities to obtain it, and lack of faculty references/connections.
- “Recency” of graduation: Common requirement that graduation from medical school occurred within 3-5 years of application to residency.
- Fierce competition for limited residency spots.
- Access to test prep courses, materials and time to study.
- Unfamiliarity with U.S. medical culture, vocabulary, treatment methods, and technology.

2015 IMG legislation

- International Medical Graduate Assistance Program

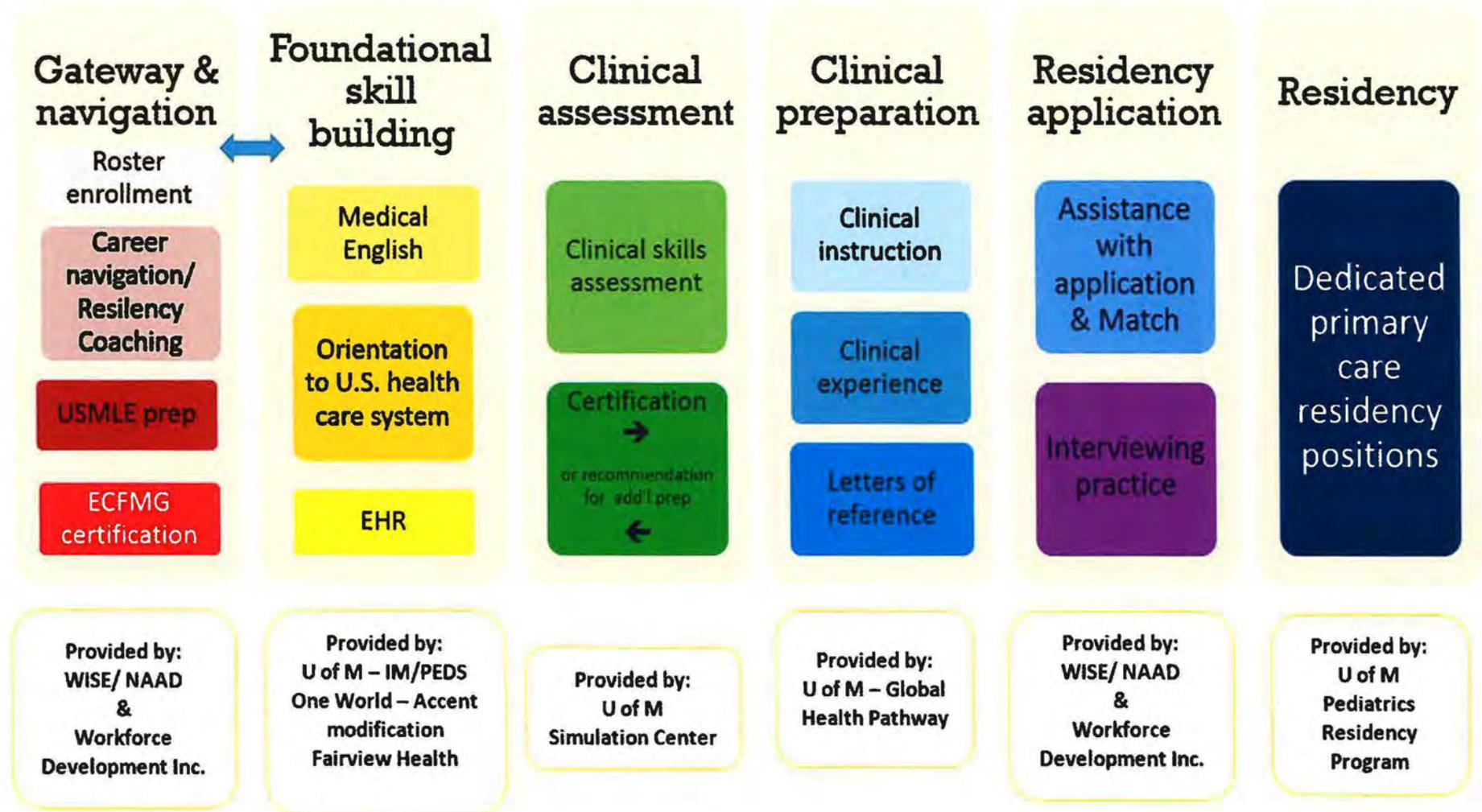


IMG Assistance program

The program addresses barriers to practice for IMGs by:

1. Providing **career guidance and support** such as license test preparation, skill building to use electronic health records and guidance to consider alternative occupations.
2. Providing an **assessment process** and certificate to document immigrant physicians' qualification to enter residency.
3. Providing **clinical experience**.
4. Establishing a revolving fund that will support 3-5 **residency positions** with state funds each year and accept private grants and contributions for additional slots

CONTINUUM of SERVICES – Years 1-2 of IMG Assistance Program



Additional program requirements

The law also requires that MDH:

- Work in collaboration with a stakeholder advisory group
- Maintain a roster of immigrant physicians in Minnesota.
- Work with training programs to address barriers to securing residency and explore pathways to non-physician careers.
- Study possible licensing and regulatory changes needed for full utilization of immigrant physicians in Minnesota.

Recommended Proposals

- Recommendation # 1 – IMG Primary Care Integration License
- Recommendation #2 Exemption for primary care in a rural or underserved area

Discussion and Feedback



For more information:

- Immigrant IMGs (International Medical Graduates) website:

<http://www.health.state.mn.us/divs/orhpc/img/index.html>

- MDH staff: Yende Anderson,
yende.anderson@state.mn.us, 651-201-5988.

IMG Assistance Program –Stakeholder Advisory Group
Licensure Group
Potential Recommendations

Decision Making Criteria:

- Does recommendation require statutory changes?
- Is the recommendation controversial?
- Does it require new resources? Funding? Personnel? Etc.
- How much progress would it produce?
- What is the impact on health equity?

Timeline:

August: Work group meeting

September: Work group meeting, Finalize recommendations

October: Present recommendations to the stakeholder group

Present recommendations to BMP

Policy/Planning Committee (October 12, 4:30pm)

November: Presentation to BMP

Draft of Report which will include recommendations to legislators.

January: final report due

General note: There were statements in licensure group meetings that immigrant physicians are a special interest group that should be required to meet all licensing requirements in current law. Related statements were made that if new paths to licensure are provided to immigrant physicians, inquiries and expectations will increase from others requesting variances from the current process, and that this will increase the workload of the Board of Medical Practice.

In response it was noted that immigrant physicians have a unique potential to contribute to improving health equity in Minnesota, and that this potential is a central basis of Minnesota Statutes section 144.1911, the International Medical Graduates Assistance Program, which was established “to address barriers to practice and facilitate pathways to assist immigrant international medical graduates to integrate into the Minnesota health care delivery system, with the goal of increasing access to primary care in rural and underserved areas of the state.” Among other provisions, M.S. 144.1911 requires the Commissioner of Health to study, in consultation with the Board of Medical Practice and other stakeholders, changes necessary in health professional licensure and regulation to ensure full utilization of immigrant international medical graduates in the Minnesota health care delivery system, and to make recommendations to the legislature.

It was agreed that the need for new funds to cover any increased workload should be included in recommendations.

There was also discussion that negative consequences that may occur if changes are made to licensing requirements without explicitly addressing all potential contingencies, and that changes should not be recommended until provisions for preventing all potential consequences are identified and included in recommendations.

In response it was noted that current law does not address all potential aspects of the supervision and practice of residents and physicians, which are the responsibility of training sites and employers.

Proposals for consideration

Proposal	Pros/Cons
<p>A. IMG Primary Care Integration License</p> <ol style="list-style-type: none"> 1. IMG registers with MDH 2. IMG demonstrates that s/he has a minimum of 7 years of prior medical practice including residency and fellowships. Observerships do not qualify. 3. IMG passes USMLE step 1, 2 and 3 within 3 attempts; becomes ECFMG certified 4. IMG participates in clinical assessment at U of M; participates in 6 months of clinical experience; undergoes post assessment with an established assessment service provider similar to PACE or CPEP – receives a certificate of clinical readiness to <u>practice medicine</u> (Meets level 5 of the 4 selected general milestones of the next accreditation system) 5. IMG obtains employer sponsorship. Employer must provide supervision and mentorship outlined in a supervision agreement. Employer must be in “rural” or “underserved” community as defined by Minn Stat. 144.1911. Scope of practice limited to primary care as described in Minn Stat. 144.1911. 6. Once sponsorship is obtained, IMG applies for an IMG integration License – a restrictive license renewable annually with recommendation to renew from employer. 7. Participant can apply for an unrestricted license after 4 years of successful renewals (5 years total of effective practice) 	<p>Pros:</p> <ul style="list-style-type: none"> • Fast. Gets objectively qualified physicians into the system quickly. • Does not require residency positions. • Very cost effective. May need money for clinical post assessment and clinical experience. • Increases state revenue from new doctors paying taxes. • Helps with health disparities and primary care shortages <p>Cons:</p> <ul style="list-style-type: none"> • May require new level of effort for Board of Medical Practice and new revenue. • Doctors with this restricted license may get paid less than other doctors with a traditional unrestricted license. • #5, 6, 7. MAPA objected to these components prior to the passing

<p>8. The Board shall take disciplinary action against a licensee and supervisor for violations of the limitations on the license.</p>	<p>of the 2015 legislation. Those objections and concerns are unchanged by the current writing.</p> <ul style="list-style-type: none"> • MAPA’s position is that creating a “sponsored or supervised” restricted IMG integration license for IMG physicians will create professional role confusion for healthcare systems and patients, specifically with regards to how they would be similar to or vary from the PA profession. • Unless clearly defined, this could create confusion for who can supervise a PA during the restricted licensure periods and potentially after unrestricted license is obtained regarding proper PA/ Physician relationships. • Such a program will create potential challenges to full licensure by other professions as well. • Reimbursement and the ability to obtain liability coverage are unknowns. These issues have been identified in similar programs that sought to create alternative licensing categories– such as Missouri’s Assistant Physician program. • Other physicians who would not meet minimum requirements will view this as arbitrary and preferential, and will demand equal opportunity under the law.
<p>B. Amend 147.037 to include Waiver for primary care in a rural or underserved area. The board may waive any requirement for more than one year of approved graduate medical education, as set forth in the Physicians Practice Act, if the applicant has served at least one year of graduate medical education approved by the board and if the following conditions are met:</p> <p>(a) The applicants meets all other qualifications for a medical license</p> <p>(i) The applicants submits satisfactory proof that issuance of a license based on the waiver requirement of more than one year of approved graduate medical education will not jeopardize the health, safety, and welfare of the citizens of this state. Satisfactory proof would include participation in clinical assessment at U of M;</p>	<p>Pros: Similar to pros listed above</p> <p>Cons: B(b)(i) This sections has similar concerns to the above regarding clarity of licensure title and potential supervision of other professions such as nursing ,PAs Etc.</p>

participation in 6 months of clinical experience and post assessment with an established assessment service provider similar to PACE or CPEP – receipt of certificate of clinical readiness to practice medicine (Meets level 5 of the 4 selected general milestones of the next accreditation system); and

(b) The applicant submits proof – such as an employment contract - that he or she will enter into the practice of medicine in primary care in a rural or underserved community as defined by Minn stat. 144.1911 immediately upon obtaining a license to practice medicine based upon a waiver of the requirement for more than one year of graduate medical education.

(i) A license issued on the basis of such a waiver shall be subject to the limitation that the licensee continue to practice primary care in a rural or underserved community as defined by Minn stat. 144.1911 and such other limitations, if any, deemed appropriate under the circumstances, which may include, but shall not be limited to, supervision by a medical practitioner, training, education, and scope of practice. After two years of practice under a limited license issued on the basis of a waiver of the requirement of more than one year of graduate medical education, a licensee may apply to the Board for removal of the limitations. The Board may grant or deny such application or may continue the license with limitations.

(ii) The Board shall take disciplinary action against a license granted on the basis of a waiver of the requirement of more than one year of graduate medical education for violation of the limitations on the license.



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Task Force on Foreign-Trained Physicians

Minnesota Department of Health
Report to the Minnesota Legislature 2015

January 2015

Task Force on Foreign-Trained Physicians: Report to the Minnesota Legislature

January 2015

For more information, contact:

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As requested by Minnesota Statute 3.197: This report cost approximately \$35,500 to prepare, including staff time, printing and mailing expenses.

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Protecting, maintaining and improving the health of all Minnesotans

January 23, 2015

The Honorable Matt Dean
Chair, Health and Human Services Finance
401 State Office Building
100 Rev. Dr. Martin Luther King Jr. Blvd.
St. Paul, MN 55155

The Honorable Tara Mack
Chair, Health and Human Services Reform
545 State Office Building
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The Honorable Tony Lourey
Chair, Health and Human Services Finance
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The Honorable Kathy Sheran
Chair, Health, Human Services and Housing
Capitol, Room G-12
75 Rev. Dr. Martin Luther King Jr. Blvd.
St. Paul, MN 55155

Honorable Chairs:

I am pleased to present this report from the Task Force on Foreign-Trained Physicians, offering its recommended strategies for integrating refugee, asylee and other immigrant physicians into the Minnesota health care delivery system, as authorized by 2014 Minnesota Session Laws, Chapter 228, Article 5, Section 12.

At its first meeting six months ago, I urged Task Force members to think boldly and creatively about how the state could tap the talents of these clinicians. I likened the possibilities to the innovation that created the dental therapist profession in Minnesota: a situation where our state thought beyond the limits of the existing system to meet the health needs of its citizens and make the most of its talented workforce. In these recommendations, the Task Force has risen to that challenge, bringing us thoughtful, feasible and groundbreaking strategies that could fortify our physician workforce for years to come.

Once again, Minnesota could lead the nation in health care innovation. We have both an opportunity and an obligation to address this issue, as much for these professionals so eager to serve their state as for the thousands of citizens who would benefit from their care and the disparities and costs this diverse workforce could help reduce.

I urge you to consider these recommendations in the next legislative session, and welcome your questions and thoughts on how we can work together to strengthen Minnesota's health workforce.

Sincerely,

A handwritten signature in black ink, appearing to read "Edward P. Ehlinger".

Edward P. Ehlinger, M.D., M.S.P.H.
Commissioner
P.O. Box 64975
St. Paul, MN 55164-0975

Acknowledgements

MDH staff would like to thank the members and chair of the Task Force on Foreign-Trained Physicians for their dedication and collaboration over the past six months. So many gave so much, all on a volunteer basis and all in the spirit of helping our state break new ground in expanding health access and health equity. Many others deserve recognition and thanks, too, including our colleagues at the Board of Medical Practice and the Department of Employment and Economic Development, the Refugee Health Program at MDH, New Americans Alliance for Development and Women's Initiative for Self Empowerment staff and volunteers, and the representatives from health care associations, hospitals, insurers and providers who followed the work of the Task Force and offered suggestions. We would also like to express special thanks to the numerous immigrant physicians who attended Task Force meetings, participated in the Task Force survey, and shared their stories.

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Executive Summary

Background

Pursuant to [2014 Minnesota Session Laws, Chapter 228, Article 5, Section 12](#), in July 2014 the commissioner of health convened an advisory task force to develop strategies to integrate refugee, asylee and other immigrant physicians into the Minnesota health care delivery system.

The challenge of integrating foreign-trained physicians is complex and long-standing. In Minnesota, the issue has recently gained urgency as policy makers seek to address several major issues facing the state:

- Shortages in the supply of physicians.
- An aging and diversifying population.
- Persistent health disparities.
- Rising health care costs.

Integrating more immigrant physicians into Minnesota's health workforce could help address each of these issues.

Findings

The Task Force completed the following tasks assigned by the Legislature:

- 1. Comparison of the licensed physician workforce to the population overall.**
 - The licensed physician workforce is older than Minnesota's population.
 - The physician workforce does not mirror the state's racial and ethnic composition.
 - Licensed foreign-trained physicians represent 16 percent of the physician workforce, but most of Minnesota's largest immigrant and refugee communities are underrepresented.
- 2. Identification of immigrant physicians seeking to enter the health workforce.**
 - Minnesota is currently home to an estimated 250-400 unlicensed immigrant physicians.
 - In a survey of the state's immigrant physicians, 87 percent of respondents were interested in entering medical practice or other health careers in Minnesota.
 - Among the survey respondents, 37 countries were represented and over 30 languages.
 - Just over half of the survey respondents were eligible to apply for medical residency, but only a small minority (17 percent) has been accepted into a residency program.
- 3. Identification of barriers to practice.** Immigrant physicians face a range of barriers, with the following most significant:
 - *Growing competition for limited residency spots:* While 95 percent of seniors in U.S. medical schools get into medical residency, most immigrant physicians do not. This competition will get even tougher with the "residency bottleneck": increasing numbers of medical graduates competing for a capped number of residency slots.

- *“Recency” of graduation from medical school:* Most U.S. residency programs consider only those who have recently graduated from medical school (within 3-5 years). Consequently, many of the most highly qualified immigrant physicians – those who have practiced extensively since medical school – are essentially disqualified at this point in the path to licensure.
 - *Lack of recognized clinical experience:* Most American residency programs prefer or even require that applicants have clinical experience acquired in the U.S., but such hands-on experience is nearly impossible to obtain outside of medical school or residency.
 - *Complexity and costs of testing and other steps needed to qualify for residency:* Foreign-trained physicians often need assistance in English proficiency, exam preparation and navigating the path to licensure. Assistance programs are crucial, but will continue to have only limited success if other structural barriers go unaddressed.
4. **Exploration of alternative professions.** Most immigrant physicians would prefer to practice as physicians, but 64 percent of respondents to the Task Force survey said they would also be interested in exploring other health professions. The physician assistant profession is likely the best alternative for most considering non-physician occupations. Barriers and costs should be removed or diminished, however, so these physicians can appropriately meet physician assistant education and licensure standards more quickly and cost effectively.
5. **Identification of costs and possible funding sources.** It currently costs \$7,500-\$15,000 for a foreign-trained physician to get as far as applying to residency programs, and even then, most fail to secure a residency and therefore never become licensed to practice. **The strategies recommended by the Task Force would entail greater initial investments – from \$10,000-\$60,000 per immigrant physician depending on his/her skills and readiness for residency – but are expected to bring significantly more physicians into the workforce and therefore a greater return on investment.**

Possible funding sources include (1) new State funding; (2) private funding and (3) philanthropic support.

Recommendations

The Task Force recommends the following strategies, which it concludes will produce a larger and more diverse primary care workforce capable of reducing both health disparities and health costs in Minnesota:

- Create a **statewide council** on immigrant physician integration.
- Provide **gateway and foundational support** to immigrant physicians.
- Develop a standardized and rigorous **assessment process** to evaluate the readiness of immigrant physicians.
- Create a **Minnesota certificate of clinical readiness**.
- Develop a **clinical preparation program** for those needing it.
- Create **dedicated Minnesota primary care residency positions** for immigrant physicians willing to serve in rural or underserved areas of the state.

- Encourage or require Minnesota medical residency programs to revise their graduation “**recency**” **guidelines** to take into account other measures of readiness.
- Develop a structured **apprenticeship program** for highly experienced immigrant physicians willing to serve in rural or underserved areas.
- Develop **new licensing options** for immigrant physicians.
- Explore and facilitate more streamlined pathways for **non-physician professions**, including the physician assistant role.

Background

Charge

Pursuant to [2014 Minnesota Session Laws, Chapter 228, Article 5, Section 12](#) (Appendix A), in July 2014 the commissioner of health convened an advisory task force to develop strategies to integrate refugee, asylee and other immigrant physicians into the Minnesota health care delivery system.

Within this overall charge, the Task Force undertook the following tasks, as outlined in the law:

1. Analyze demographics of current medical providers compared to the population of the state.
2. Identify, to the extent possible, foreign-trained physicians living in Minnesota who are refugees or asylees and interested in meeting the requirements to enter medical practice or other health careers.
3. Identify costs and barriers associated with integrating foreign-trained physicians into the state workforce.
4. Explore alternative roles and professions for foreign trained physicians who are unable to practice as physicians in the Minnesota health care system.
5. Identify possible funding sources to integrate foreign-trained physicians into the state workforce as physicians or other health professionals.

The Task Force included representatives from health care, higher education, community-based organizations, workforce development, finance and government, as well as foreign-trained physicians themselves (see Appendix B). The Minnesota Department of Health (MDH) provided staff support, with additional support from the Board of Medical Practice (BMP) and the Department of Employment and Economic Development (DEED).

Between July and December 2014, the Task Force met monthly. It also held an open forum attended by over 50 immigrant physicians, and additional discussions with the Legislative Health Care Workforce Commission; the Minnesota delegation to the Health Care Workforce Policy Academy of the National Governors Association; immigrant community leaders; and the University of Minnesota's Graduate Medical Education Committee.

In addition, the Task Force convened four working groups that met between monthly meetings, including a group that examined strategies already in place to integrate immigrant physicians in Minnesota, in other states in the U.S., and in other countries, including Canada, Germany and Australia. The group investigated the nature and outcomes of these programs and pathways, distilled those most applicable to the Minnesota context, and used these findings as the basis from which to develop recommended strategies. A summary of these is provided in Appendix F, "Promising programs and pathways."

Detailed materials from the Task Force meetings are also available on the [Task Force website](#).

Definitions

At its first meeting in July 2014, the Task Force moved to use the terms "Immigrant International Medical Graduate (IIMG)" or "immigrant physician" rather than "foreign-trained physician" to describe more precisely the population of physicians referred to in the session law. Foreign-trained physicians, also known as International Medical Graduates (IMGs), are defined as individuals who obtained their basic medical degree outside the U.S. and Canada.¹ IMGs in the U.S. include several distinct subsets: (1) U.S.-born citizens who obtained their medical degree overseas (most commonly in the Caribbean or Central America); (2) IMGs who are foreign-born and reside in the U.S. on non-immigrant visas (such as J-1, O-1 or H1-B visas) and (3) IMGs who are immigrants to the U.S. classified as either permanent residents ("green card" holders), U.S. citizens, asylees or refugees.

Pursuant to the law authorizing it, the task focused specifically on category (3) - referred to in this report as immigrant physicians² - and specifically immigrant physicians not licensed to practice medicine in the U.S.

Current Pathway to Licensure

To practice in the U.S., foreign-trained physicians must complete an intensive process that takes an average of 3-5 years (sometimes as long as 10 years) and costs roughly \$7,500-15,000.³

Figure 1 depicts the steps an immigrant physician currently must complete to practice in Minnesota. The four overall stages are as follows:

A. Certification from the Educational Commission for Foreign Medical Graduates (ECFMG).

The ECFMG is a U.S. nonprofit formed in 1956 to certify foreign-trained physicians as ready to enter American residency or fellowship programs. To be certified, a foreign-trained physician must (a) obtain "primary source" verification of their diploma and transcripts from their medical school, which must be included in the International Medical Education Directory; and (b) pass two of three "steps" in the United States Medical Licensing Exams (USMLEs). Becoming ECFMG certified takes an average of four years for foreign-trained physicians generally, but can take much longer for immigrant physicians specifically.⁴

B. Completion of at least two years of graduate clinical medical training (most commonly, a medical residency) in the U.S. or Canada.

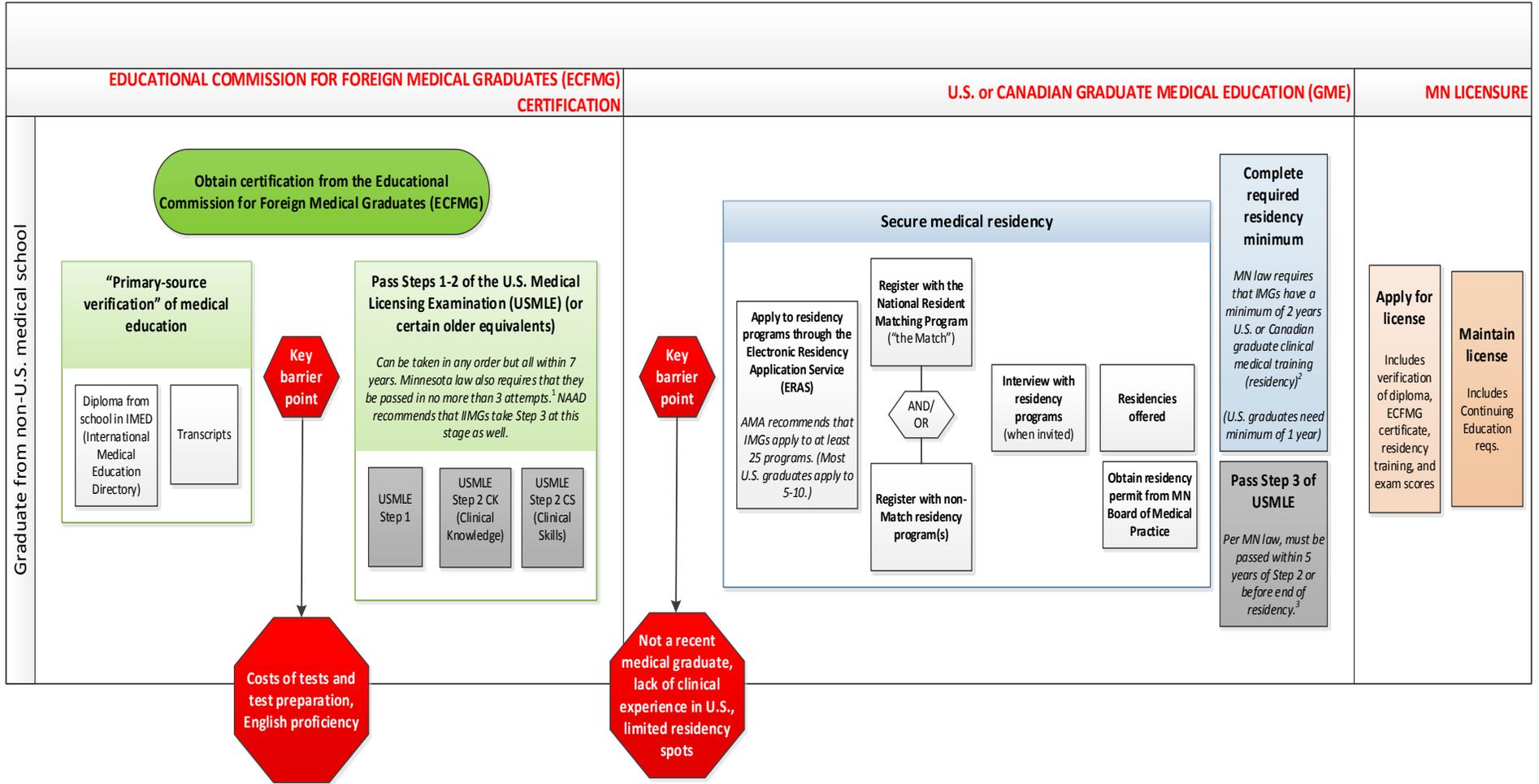
This includes securing a medical residency permit from the Board of Medical Practice if the residency program is in Minnesota. Most U.S. residency programs require applicants to be recent graduates of medical school, typically defined as graduation within 3-5 years of applying for residency.

C. Passing Step 3 of the United States Medical Licensing Exams.

D. Application for a Minnesota license.

Minnesota statutes require completion of all the steps above before a foreign-trained physician can apply for licensure.

Figure 1. Pathway requirements for an immigrant physician to obtain a physician license in Minnesota.



¹ Some exceptions for physicians who are licensed in other states and are board certified (they are allowed four attempts in any one step of the USLME).

² Does not apply to an applicant admitted as an immigrant under certain conditions on or before October 1, 1991 as "a person of exceptional ability in the sciences or as an outstanding professor or research." Also does not apply to applicants licensed in other states under certain conditions. Minnesota Statutes Section 147.037, subdivision 1, paragraph (d).

³ Combinations of FLEX, National Board, and USMLE may be accepted only if approved by the Board of Medical Practice as comparable to existing exam sequences, and all exams are completed prior to the year 2000. Minnesota Statutes Section 147.02, subdivision 1, paragraph (c).

Immigrant physicians face a range of challenges along this pathway, which at key points can disqualify even those with extensive graduate medical training overseas (what is known in the U.S. as residency) and those who have practiced for many years internationally.

These challenges will be discussed in more detail under Findings.

Policy Drivers

The challenge of integrating foreign-trained physicians into the health care system is complex and long-standing. The number of foreign-trained physicians in the U.S. has ebbed and flowed over the past 70 years, largely in response to demographic shifts, workforce needs and immigration policies, and has been intertwined in many ways with the evolution of American graduate medical education.⁵ Since 2005, various efforts at both state and national levels have sought to facilitate integration of foreign-trained physicians into the health workforce, including a similar task force in Massachusetts that issued recommendations toward this goal in December 2014.⁶

To date, such efforts have fallen into two main categories: (1) support services for immigrant physicians as they navigate the many steps and costs toward licensure, and (2) educational programs, including pre-residency preparation programs. As discussed in more detail under Findings, these initiatives have had limited success in integrating immigrant physicians.

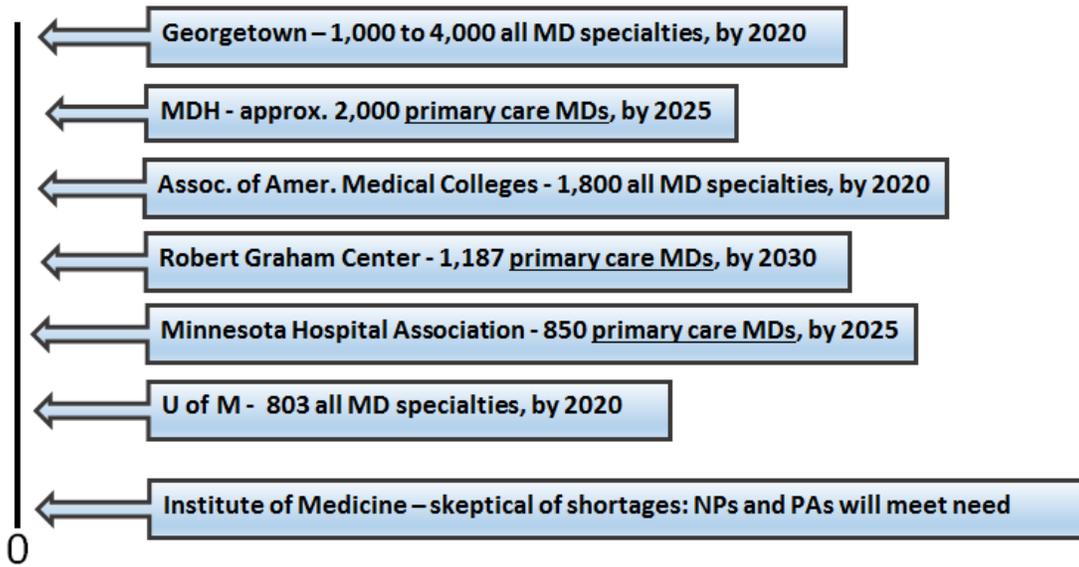
In Minnesota, the issue has gained urgency as policy makers seek to address several major, interconnected issues facing the state:

- Shortages in the supply of physicians.
- An aging and diversifying state population.
- Persistent health disparities.
- Rising health care costs.

Physician shortage

Various academic, government, professional and industry organizations have projected shortages of physicians in Minnesota over the next 5-15 years, as summarized in Figure 2.

Figure 2. Physician shortage projections for Minnesota⁷



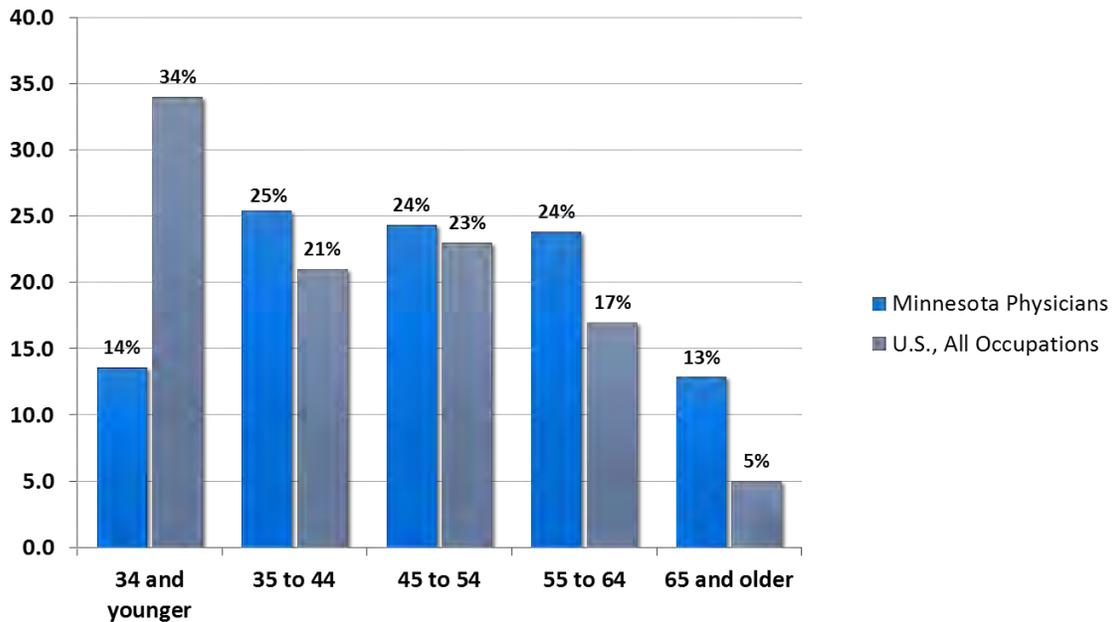
Analysts base these projections on variables such as medical school and residency cohort sizes, changing or growing demand for physician services, and changing work hour preferences by younger physicians.

The most important factor in the impending physician shortage is the aging of the U.S. population, which is expected to affect both demand (as a population with more seniors uses more health services) and supply (as a greater proportion of physicians age out of the workforce than will be replaced through the existing pipeline).

As Minnesota's state demographer has recently noted, this aging of the Baby Boomer generation will slow the labor force growth rate considerably, not only here in Minnesota but across the U.S. and in most developed countries. As a result, **“there will be heightened international competition for labor, particularly talented workers that can take on the mantle of highly skilled and complex job functions.** ... Immigrant workers will be increasingly necessary to supply the labor force in Minnesota with ready hands and talented minds.”⁸

This may be especially true in the physician workforce. In Minnesota, more than one-third (37 percent) of licensed physicians are 55 or older, and roughly 40 percent of primary care physicians say they intend to practice only 10 years or less into the future.⁹ This is high relative to U.S. occupations overall, where only 21 percent are 55 or older (Figure 3), and higher than the overall state population (of which 26 percent of Minnesotans are 55 or older).

Figure 3. Age of Minnesota physicians vs. U.S. workforce overall



Sources: Minnesota Board of Medical Practice, May 2014 and Current Population Survey, Employed Persons by Detailed Occupation and Age, 2013 (http://www.bls.gov/cps/occupation_age.htm).

Beyond any future deficits, Minnesota already has physician shortages in many parts of the state, particularly in rural areas. A common indicator of geographic availability is the federal government’s Health Professional Shortage Area designation. Substantial areas of Greater Minnesota are designated shortage areas in the fields of primary care, dentistry and mental health, as shown in the maps in Appendix C.

If key barriers can be addressed, integrating more immigrant physicians into Minnesota’s health workforce could help fill the most pressing of these shortages in a relatively short period of time. Foreign-trained physicians are more likely than U.S. medical graduates to provide primary care and to work in underserved and rural areas, including in very isolated rural communities and Critical Access Hospitals.¹⁰ In 2002, over half of the nation’s Critical Access Hospitals employed at least one foreign-trained physician on their medical staff, including 62 percent of CAHs located in “persistent poverty” rural counties.¹¹

Minnesota has a shortage of doctors coming. We can solve that. There are hundreds of immigrant medical graduates ready for residency here to contribute to their full capacity and serve Minnesota. We can be a solution to Minnesota’s medical problems.

Immigrant physician at community meeting hosted by the Task Force

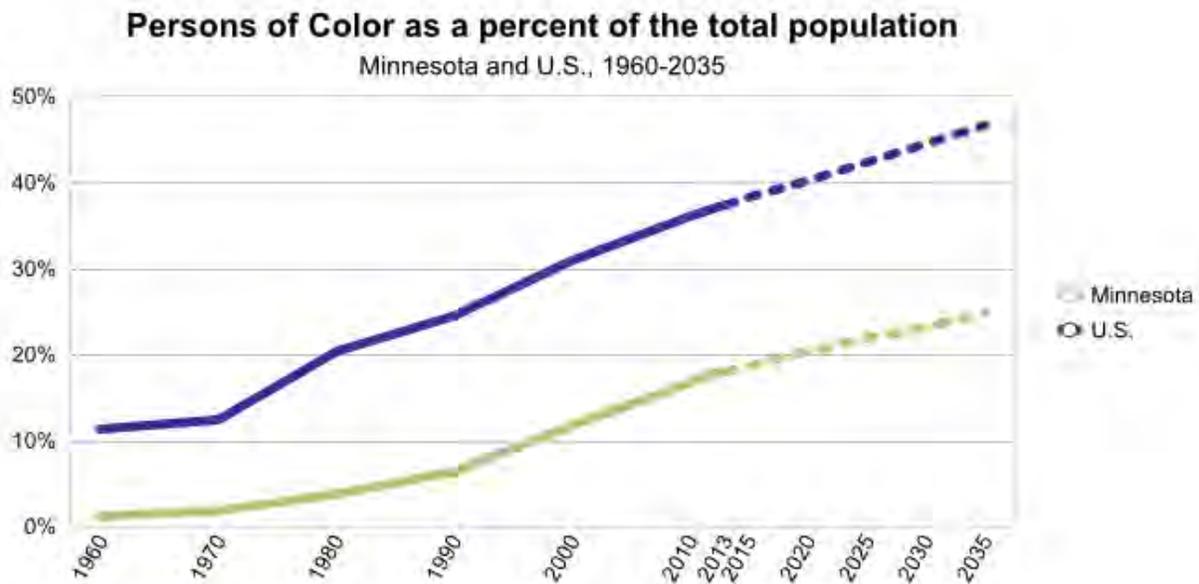
Demographic shifts

Minnesota's population is undergoing major shifts, and will continue to do so over the next 15-20 years. As noted above, the state's aging population is growing rapidly, with the number of adults age 65+ expected to nearly double between 2010 and 2030, and to surpass the school-age population of the state for the first time.¹²

This will have enormous implications for the state's health care system. Not only will it affect the health workforce supply as described above, it will create unprecedented demand for health care services, particularly primary care. On average, seniors need and use health care services much more than those younger than 55; health care spending on Americans between the ages of 65 and 74 averages \$9,017 per year compared to \$2,747 for those between 25 and 34.¹³ The number of people with chronic conditions will also increase dramatically, as discussed in more detail under Costs. Overall, as Minnesota's senior population grows, the burden on the state's health care system – including its publicly supported health care programs – will balloon, just as its physician workforce is shrinking.

At the same time, Minnesota's population is growing increasingly diverse (Figure 4).

Figure 4.

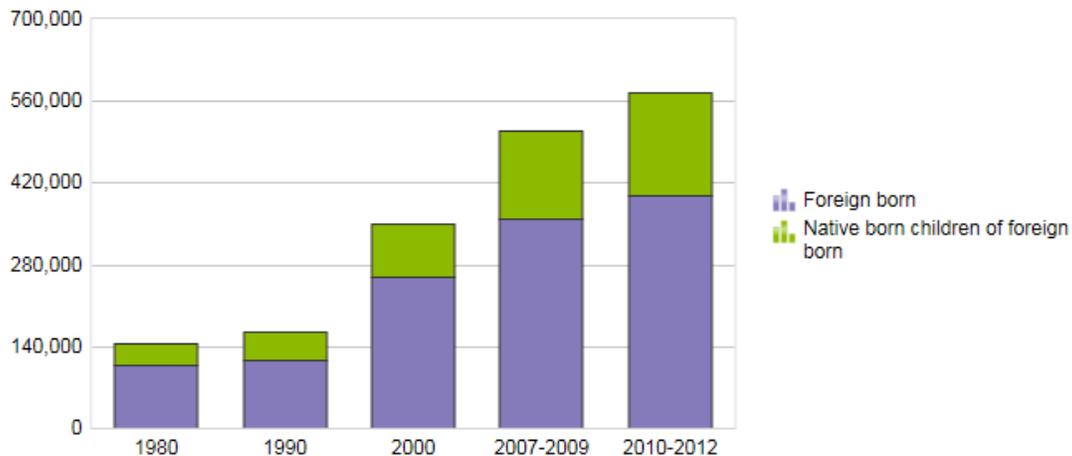


Source: Minnesota State Demographic Center and U.S. Census Bureau, Decennial Census and Population Estimates, as compiled by [Minnesota Compass](#).

The state's immigrant and refugee population is growing especially quickly (Figure 5):

- **Minnesota's foreign-born population is increasing faster than the national average.** Since 1990, the foreign-born population has doubled nationally but tripled in Minnesota.¹⁴
- Among the state's youngest children (0-4), nearly one in every five is a child of an immigrant.¹⁵
- Minnesota has one of the largest African-born populations in the U.S., including the largest Somali and Liberian communities in the country.¹⁶
- The state is home to 33,000 refugees, representing 8.9 percent of Minnesota's immigrants, a far greater portion than the national average of 1.7 percent.¹⁷
- Last year, Minnesota was 13th in the nation for the number of refugees resettled, and 1st for secondary refugee resettlement (secondary refugees are refugees who originally resettled to another state before moving to Minnesota).¹⁸

Figure 5. Foreign-born population and their children, Minnesota, 1980-2012



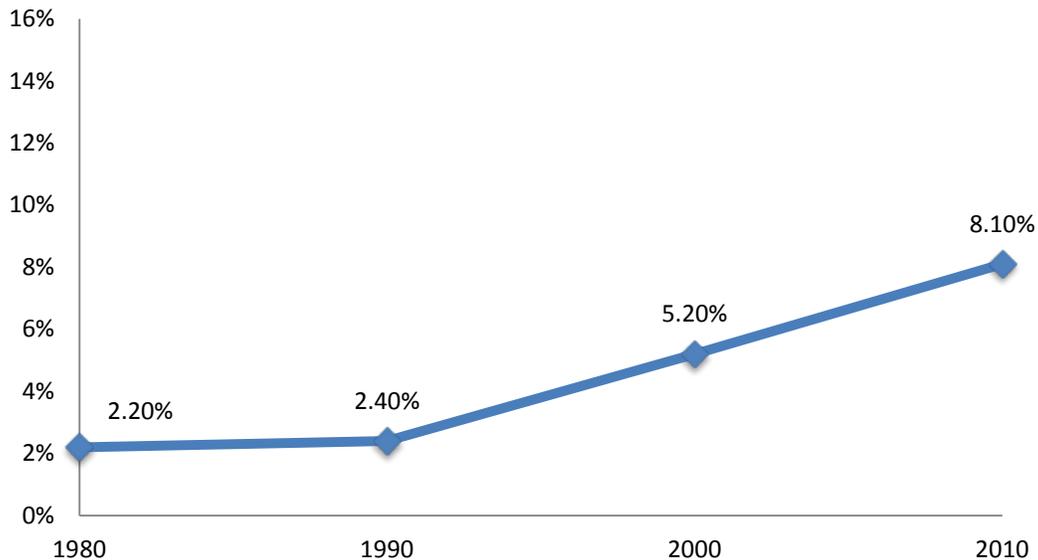
Source: Integrated Public Use Microdata Series from the U.S. Census Bureau, American Community Survey, as compiled by [Minnesota Compass](#).

Minnesota is different from other states in that it has a lot of immigrants and refugees. These immigrants really need doctors who can represent and help them. A lot of messes come from using only interpreters, and this creates significant disparities.

Survey respondent originally from Ethiopia

This influx of immigrants has shaped Minnesota's labor force as well. According to the state demographer, **it is only because of new international arrivals that Minnesota experiences positive total migration of workers each year.** The state loses 12,000 residents between the ages of 16 and 64 annually due to domestic migration, but because of 20,000 international immigrants, gains about 8,000 working-age people overall.¹⁹ These immigrants tend to be younger, too: 60 percent of Minnesota's foreign-born population is in the prime working years of 25-54, compared to 40 percent of its U.S.-born population.²⁰

Figure 6. Foreign-born as a percentage of Minnesota’s workforce, 1980-2010



Source: Migration Policy Institute Data Hub; American Community Survey 2007-2011, as compiled in Corrie B, and Radosevich S, “The Economic Contributions of Immigrants in Minnesota.” Minnesota Chamber of Commerce, Sept. 2013. Available at: http://cdn2.hubspot.net/hub/172912/file-371412567-pdf/Economic_Contributions_of_Immigrants_in_Minnesota_2013.pdf

The immigrant workforce tends to be concentrated at two ends of the spectrum, in low- and high-skill industries, and in occupations and geographies that have difficulty attracting sufficient numbers of qualified native-born residents.²¹ In 2013, roughly one-third of Minnesota’s immigrants held a four-year college degree or higher, a similar proportion as the overall population.²² Overall, Minnesota immigrants contribute an estimated \$793 million in state and local taxes and bring a purchasing power of \$5 billion to the state.²³

Despite this growing diversity and high-skilled immigrant workforce, however, Minnesota’s current physician workforce does not mirror the racial and ethnic composition of the state’s population, in some part because immigrant physicians have struggled to join the physician workforce. **Currently only 14 percent of the state’s physicians are individuals of color,²⁴ and certain racial and ethnic groups are especially underrepresented, including most of Minnesota’s largest refugee and immigrant communities.** This imbalance is discussed in greater detail under Findings.

Health disparities

Despite Minnesota’s relatively high ranking in key health measures,²⁵ significant racial disparities persist. For some populations of color, rates of certain chronic diseases, sexually transmitted infections, and health risk behaviors can be as much as five times worse as those for the population groups with the best rates.

Examples of these disparities include the following:

- African American and American Indian babies die in the first year of life at twice the rate of white babies in Minnesota. While infant mortality rates for all groups have declined, the disparity in rates has existed for over 20 years.
- The rate of HIV/AIDS among African-born persons is nearly 16 times higher than among white, non-Hispanic Minnesotans.
- American Indian, Hispanic/Latino and African American youth have the highest rates of obesity.
- African American and Hispanic/Latino women in Minnesota are more likely to be diagnosed with later-stage breast cancer.²⁶
- Nationally, foreign-born individuals are significantly less likely to receive cancer screening and other preventive health services.²⁷ Minnesota-specific studies have found Somali immigrants experience disparities in diabetes management²⁸ and have significantly lower rates of colorectal cancer screening, mammography, pap smears and influenza vaccination than non-Somali patients.²⁹

These disparities have been stubbornly persistent. As a recent report to the Legislature on health equity in Minnesota put it: “Multiple efforts have been made to try to close the significant gaps in health outcomes across populations, but essentially we have been running in place.”³⁰

Adding more immigrant physicians to the Minnesota health workforce offers an opportunity to tackle these disparities in more effective ways. Research suggests that greater diversity in the health workforce, particularly better racial and cultural “concordance,” or similarity between health care providers and the patients they serve, can improve clinical outcomes for racial minorities.

Evidence suggests this can happen in two ways. First, there is ample evidence that minority physicians are more likely to be accessible to diverse or underserved communities. Minority physicians are more likely than their white counterparts to practice primary care.³¹ And while communities of color (Black and Hispanic communities, for example) are far more likely to face physician shortages,³² physicians of color are more likely to locate their practice in areas of ethnic and racial diversity, and to serve patients not only of their own race but of other populations of color as well.³³ One study indicates that race is a stronger predictor than even socioeconomic status of the share of Medicaid or uninsured patients a physician treats.³⁴

The second way a diverse physician workforce leads to better health outcomes is through patient-practitioner “concordance.” That is, physicians who are “like” their patients in certain key ways can be better positioned to provide culturally competent, patient-centered care. There is a large and growing body of work studying the relationship between cultural similarities and health care access, quality and outcomes. **This literature supports an association between racial concordance and health care quality and outcomes,³⁵ and an even stronger association between language concordance and health care access/utilization, quality and outcomes.** A provider speaking the same language as his/her patient can lead to better outcomes through increased trust and better comprehension of care instructions.³⁶

I am available and eager to contribute with my knowledge and skills to the U.S. health system. For all Hispanic/Latino groups, linguistic isolation can pose barriers

to access the health system. Having invested many years in health services in Venezuela and worked many years as clinical researcher in Mayo Clinic, I am passionately committed to helping patients in my community who would benefit most from my expertise. I trust that the Minnesota health system could help foreign-trained physicians get into the system.

Survey respondent originally from Venezuela

This research has prompted many, including the Association of American Medical Colleges (AAMC), to recommend increasing the racial and ethnic diversity of the physician workforce as a way of addressing health disparities.³⁷ The Institute of Medicine specifically recommends increasing the diversity of language ability, background and experience, and notes that increasing health care provider diversity improves the cultural competence of health professionals and health systems both directly and indirectly: not only through the care delivered by providers of diverse backgrounds, but through the educational experiences those providers make possible for their colleagues.³⁸

Integrating more of Minnesota’s diverse immigrant physicians offers a direct way to diversify the physician workforce and thereby help address the state’s long-standing goal of reducing health disparities. As the Sullivan Commission, a bipartisan initiative that examined diversity in the U.S. health workforce, put it 10 years ago: “The fact that the nation’s health professions have not kept pace with changing demographics may be an even greater cause of disparities in health access and outcomes than the persistent lack of health insurance for tens of millions of Americans.”³⁹

Right now we can’t give back to the community. We have a lot to offer. We are Minnesota residents willing to do what we can to solve the problems of disparities and inequity.

Immigrant physician at community meeting hosted by the Task Force

Rising health care costs

Health care is increasingly expensive, both in the costs of its services and in the training required of its providers. **Greater integration of immigrant physicians could have an impact in these realms as well.**

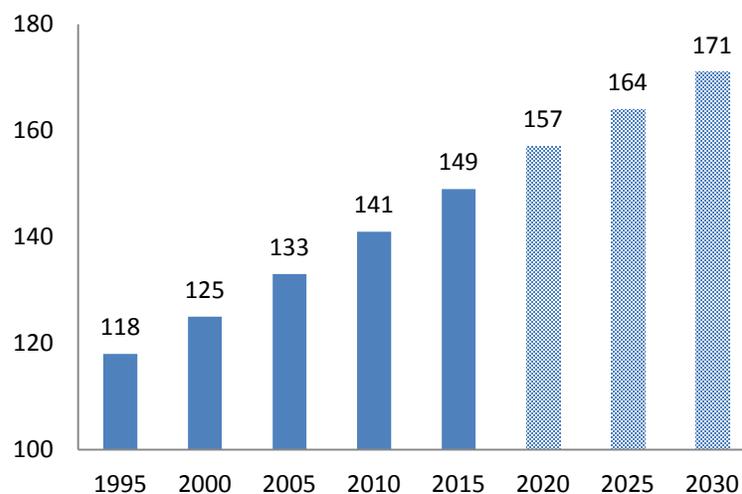
Health care costs. In 2011, health care spending in Minnesota grew to \$38.3 billion, accounting for 13.6 percent of the state’s economy, and is projected to more than double over the next decade if no changes occur in the drivers of health care spending or reforms to curb spending growth.⁴⁰

A significant portion of these costs come from potentially preventable hospitalizations – those caused by deficits in timely access to high quality care in primary care settings, patient education and/or compliance with provider recommendations. The Agency for Healthcare Research and Quality has stated that “reducing preventable hospitalization rates is crucial to controlling health care costs.”⁴¹ In Minnesota, such cases resulted in roughly 53,000 potentially avoidable

hospitalizations in 2007 alone, at a cost of about \$400 million, or 8 percent of inpatient cost for Minnesota adults.⁴²

A related, but even more substantial, portion of U.S. health care costs are associated with chronic medical conditions. A majority of adult and youth populations in Minnesota exhibit at least one risk factor for chronic diseases, and obesity is rising in Minnesota as it is nationwide, as are rates of diabetes.⁴³ Such conditions account for 85 percent of the nation's health care costs overall,⁴⁴ including half (51 percent) of the potentially preventable hospitalizations in Minnesota noted above.⁴⁵ Treatment costs for chronic disease in Minnesota are estimated at \$5 billion annually.⁴⁶ A higher priority on prevention and preventive care is widely seen as critical to controlling these costs, particularly since the number of Americans with such conditions is expected to grow dramatically (Figure 7).⁴⁷

Figure 7. Number of people with chronic conditions in U.S., 1995-2030 (in millions)



Source: Wu, Shin-Yi and Green, Anthony. Projection of Chronic Illness Prevalence and Cost Inflation. RAND Corporation, October 2000.

Immigrant physicians could play a powerful role in reducing costs in both of these areas – preventable hospitalizations and chronic disease care – particularly since the rates of such hospitalizations are higher among patients of color and low-income individuals, and patients of color with chronic conditions are more likely to receive conflicting advice, duplicate tests or conflicting prescriptions, **all issues that can be exacerbated by language barriers and cultural factors.**⁴⁸

Immigrant physicians could also improve health care access and outcomes more broadly, particularly in Minnesota's sizeable immigrant and refugee communities, where the ability to provide care in the same language could lead to better patient follow-through, diminished complications and fewer visits to health care facilities. While many health care settings use interpreters to accommodate non-English speaking patients, the presence of an interpreter is not as effective as direct communication between patient and provider. A 2004 study, for example, found that language concordance for Hispanic individuals improved physician-patient agreement

with regard to physician-recommended changes in patient-health behavior.⁴⁹ In another, Asian patients in visits with interpreters avoided asking questions more often than patients in visits where the patient and the doctor spoke the same language.⁵⁰

Apart from the efficacy of care provided, one study concluded that simply by integrating more foreign-trained physicians to address existing physician shortages in areas designated as underserved, Minnesota could save \$62.56 million.⁵¹

Training costs. For the Class of 2013, the median in-state four-year cost of medical school in the U.S. (including tuition, fees and living expenses) was \$228,200. The median debt upon graduation was \$170,000, with 86 percent of graduates carrying some level of debt.⁵² A medical graduate must then complete a clinical residency, which in Minnesota in 2012 averaged roughly \$153,000 per trainee (costs borne by the training site, which pays each resident a salary plus benefits, and incurs additional costs for their training and supervision).⁵³

These high costs are often cited as one of the main reasons for the decline in the number of primary care physicians.⁵⁴ Primary care specialties pay less than other medical specialties, yet medical students considering practicing primary care shoulder the same student debt levels as all other medical students.⁵⁵

Immigrant physicians, in contrast, enter the U.S. health workforce pipeline with a medical degree already completed, and many wish to practice primary care. The cost of preparing them for licensed practice is limited to the expense of becoming certified by the Educational Commission for Foreign Medical Graduates (which includes taking the first two steps of the United States Medical Licensing Exams); any related test preparation, coaching and support; and medical residency application fees. Currently, these expenses come to \$7,5000-15,000 for an individual physician. They must then complete at least two years of medical residency, costs also required for U.S. medical graduates (USMGs), although in Minnesota, foreign-trained physicians are required to have at least two years of graduate clinical medical training while USMGs technically need only one.⁵⁶

With new, more efficient pathways to licensure, these training costs could be further reduced. These options are discussed in more detail under Findings and Recommendations.

This could be a big win. A win for the Minnesota medical community, a win for Minnesotans needing culturally appropriate health care, a win for immigrant physicians, and a win for all taxpayers.

Immigrant physician at community meeting hosted by the Task Force

Findings

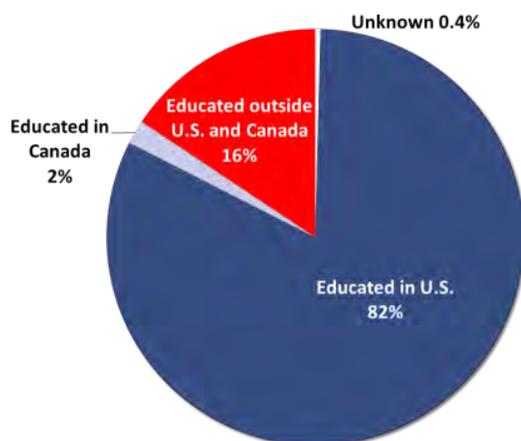
In developing its recommendations, the Task Force completed the following specific tasks assigned by the Legislature:

Demographic Analysis

As context to the issue of unlicensed foreign-trained physicians, the Legislature requested that the Task Force also examine the demographics of the physicians who *are* licensed and compare those to the state’s population. The Task Force examined data from a variety of sources to conduct this analysis, including licensing data from the Minnesota Board of Medical Practice (BMP), physician workforce surveys MDH conducts in partnership with the BMP, U.S. Census and refugee resettlement data, and immigrant community estimates.

Overall, foreign-trained physicians represent 16 percent of the state’s licensed physician workforce (this includes all foreign-trained physicians, including U.S.-born physicians who went to medical school overseas and foreign-trained physicians who came to the U.S. on a visitor visa for their residency) (Figure 8). This is somewhat low compared to the U.S. overall, where foreign-trained physicians represent approximately 25 percent of the overall licensed physician workforce. It is also important to note that few of the licensed doctors are the immigrant physicians who are the subject of this report and who often arrive unexpectedly in the U.S. due to hardship (the category of physicians educated outside the U.S. and Canada also includes American-born citizens who went to foreign medical schools, and international medical graduates who come to the U.S. on non-immigrant visas, such as J-1, O-1 or H1-B visas).

Figure 8. Share of Minnesota-licensed physicians educated outside U.S./Canada, 2014.



Source: May 2014 licensing data from the Minnesota Board of Medical Practice. The chart includes 21,669 Minnesota-licensed physicians, 90 of whom did not report a country of education.

As discussed under Background, **the state’s physician workforce is older than the state’s population overall**: Over one-third (37 percent) of Minnesota’s licensed physicians are age 55 or older (Figure 3), compared to a quarter (26 percent) of the state’s population.⁵⁷

The Task Force also compared race and ethnicity data. **Overall, the state’s licensed physician workforce does not mirror the racial and ethnic composition of its population**. This is true even though the total proportion of licensed Minnesota physicians of color is roughly equal to the state’s populations of color overall (14 percent of licensed physicians vs. 14.7 percent of the state population).

As in the case of the state’s health disparities, it is in looking more closely – at specific racial and ethnic groups – that imbalances emerge. Two major racial groups are underrepresented in the current (licensed) physician workforce: African-Americans (2 percent of physicians vs. 5 percent of the population) and Latinos (2.4 percent of physicians vs. 5 percent of the population).

A similar dynamic is true in the case of the foreign-born population. Overall, foreign-born licensed physicians appear to over represent the state’s foreign-born population: 14 percent of licensed physicians were born outside the U.S., compared to 8 percent of the Minnesota population. However, **most of Minnesota’s largest immigrant and refugee communities are significantly underrepresented** (Table 2).

It is important to note that population estimates based on U.S. census data likely undercount immigrant and refugee communities. As the state demographer cautions: “These estimates ... likely underestimate the size of our immigrant populations because trust and language issues depress response rates to Census surveys.”⁵⁸ For this reason, estimates from community-based sources were included as well (Table 2). Data from additional countries from which immigrants come to Minnesota, and the number of currently licensed physicians from those countries, are provided in Appendix D.

Table 2. Minnesota immigrant populations compared to Minnesota licensed physicians¹

Country	Estimated foreign-born populations in Minnesota, 2010-2012	Number of MN-licensed physicians <u>educated</u> in these countries ⁷	Number of MN-licensed physicians <u>born</u> in these countries ⁷
Mexico	70,988 ¹	87 ⁸	43
Laos	24,408 ¹ -66,200 ²	0	19
Somalia	21,227 ¹ -77,000 ²	7	28
Vietnam	18,548 ¹	3	64
Thailand	15,014 ¹	27	35
Liberia	12,216 ¹ -35,000 ³	2	8
Ethiopia	12,503 ¹ -45,000 ⁴	20	35
Burma (Myanmar)	4,183 ¹ -8,200 ⁵	10 ⁹	15 ⁹
El Salvador	7,233 ¹	1	4
Honduras	4,534 ¹	0	1
Cambodia (Kampuchea)	3,045 ¹ -8,000 ⁶	0	1

The Task Force concludes that the imbalances between Minnesota’s population and its physician workforce are significant and warrant new and innovative action.

¹Sources for table:

¹ Population estimates from the [Minnesota Compass Project](http://usa.ipums.org/usa/), citing Steven Ruggles, J. Trent Alexander, Katie Genadek, Ronald Goeken, Matthew B. Schroeder, and Matthew Sobek. Integrated Public Use Microdata Series: Version 5.0 [Machine-readable database]. Minneapolis: University of Minnesota, 2010. Available from: <http://usa.ipums.org/usa/>.

² Population estimates cited by Arrive Ministries, a refugee resettlement agency and affiliate of World Relief (U.S.), on its website: <http://arriveministries.org/who-we-serve/refugee-populations/somalis/>. Estimate for Laotian community in Minnesota includes Laotian Hmong refugees.

³ Population estimate from the Organization of Liberians in Minnesota, cited by Stratis Health, Liberians in Minnesota. Culture Care Connection series. Available at: <http://www.culturecareconnection.org/matters/diversity/liberian.html>

⁴ Population estimate from the Ethiopian Community in Minnesota (ECM), correspondence from Mesfin Negia, Vice President and Board Member, December 23, 2014. Another source has estimated the Minnesota Oromo community alone (an ethnic group that makes up an estimated 34-40 percent of the population in Ethiopia) at 40,000, cited by Hirsi, I., in MinnPost, “Killings in Ethiopia outrage Minnesota’s Oromo community.” May 8, 2014. Available at: <http://www.minnpost.com/community-sketchbook/2014/05/killings-ethiopia-outrage-minnesota-s-oromo-community>

⁵ Population estimate from the Karen Organization of Minnesota, cited in personal correspondence from Mimi Oo, December 23, 2014. Estimate includes all ethnicities from Burma, including Karen refugees living in Minnesota.

⁶ Minnesota State Demographic Center, cited by Stratis Health, Cambodians in Minnesota. Culture Care Connection series. Available at: <http://www.culturecareconnection.org/matters/diversity/cambodian.html>

⁷ Number of Minnesota licensed physicians comes from Minnesota Board of Medical Practice licensing data, October 2014. Note these totals may overstate the number of physicians from each country currently in active practice in Minnesota. Some physicians choose to maintain a Minnesota license even if they now practice in another state, have retired or are in a medical residency or fellowship program.

⁸ Includes a significant number of non-Mexican individuals (including U.S. citizens) who attended medical school in Mexico.

⁹ Experts on the Minnesota Burmese community report only eight physicians from Burma are currently practicing in Minnesota. Personal correspondence from Mimi Oo, December 23, 2014.

Identification of Foreign-Trained Physicians Living in Minnesota

The Task Force estimates that Minnesota is currently home to between 250 and 400 immigrant physicians who are not able to practice because of barriers to licensure. New Americans Alliance for Development (NAAD), in partnership with the Women’s Initiative for Self-Empowerment (WISE), two community-based nonprofits with extensive experience serving immigrant physicians in Minnesota since 2005, estimates that of the 300,000 refugees and immigrants who have made Minnesota their home since 1990, an estimated 300 are trained physicians who practiced in their home countries and of these, only about 20 have been able to practice as licensed physicians in Minnesota (leaving approximately 280 unlicensed).⁵⁹ A 2006 report estimated that 80 percent of African immigrants with medical training are “relegated to entry-level medical positions such as nursing aides – or, worse, unskilled jobs such as taxi drivers or parking attendants – simply because they lack the necessary licensing required for professional medical employment.”⁶⁰

Another important source of information on Minnesota immigrant physicians is the Foreign-Trained Health Care Professionals program administered by the Department of Employment and Economic Development (DEED). This program currently funds two sets of organizations – one in the Twin Cities (WISE in partnership with NAAD) and one in Rochester (Workforce Development Inc.) – to assist foreign-trained physicians and other health care professionals in obtaining licenses and certifications. As of December 2014, 146 immigrant physicians were enrolled in these programs. This total, however, does not include immigrant physicians who have previously participated in these programs (the two organizations have worked with over 300 physicians since 2006) or the many immigrant physicians who have never contacted the organizations, either because they are recent arrivals to Minnesota or because they arrived in the state before the programs were established and have been working in other occupations.

The Task Force is confident in its estimate of the number of unlicensed immigrant physicians living in the state. However, because there is currently no official, ongoing count of the total number of unlicensed immigrant physicians living in the state, the Task Force is recommending that a central roster be created (see Recommendations).

The Task Force also conducted a statewide survey of immigrant physicians between August and December 2014 to obtain deeper qualitative information about this population. A total of 69 immigrant physicians participated in the survey (out of 275 invited). Of these, **87 percent (60 individuals) indicated an interest in “meeting the requirements to enter medical practice or other health careers” in Minnesota.**

Just over half of the survey respondents have been certified by the Educational Commission for Foreign Medical Graduates (ECFMG), and are therefore eligible to apply for medical residency training. **The great majority (83 percent), however, have not been accepted into a residency program.** This is the most common and often impenetrable barrier for immigrant physicians, as will be discussed in more depth below under Barriers.

The survey also demonstrated the great diversity of skills and experience that Minnesota’s immigrant physicians bring to the state. **Among the survey respondents, 37 countries are represented and over 30 languages spoken** (Figures 9 and 10). Nearly half (43 percent) of the immigrant physicians surveyed speak more than three or more languages.

Figure 9. Countries of birth, Task Force survey respondents, by count

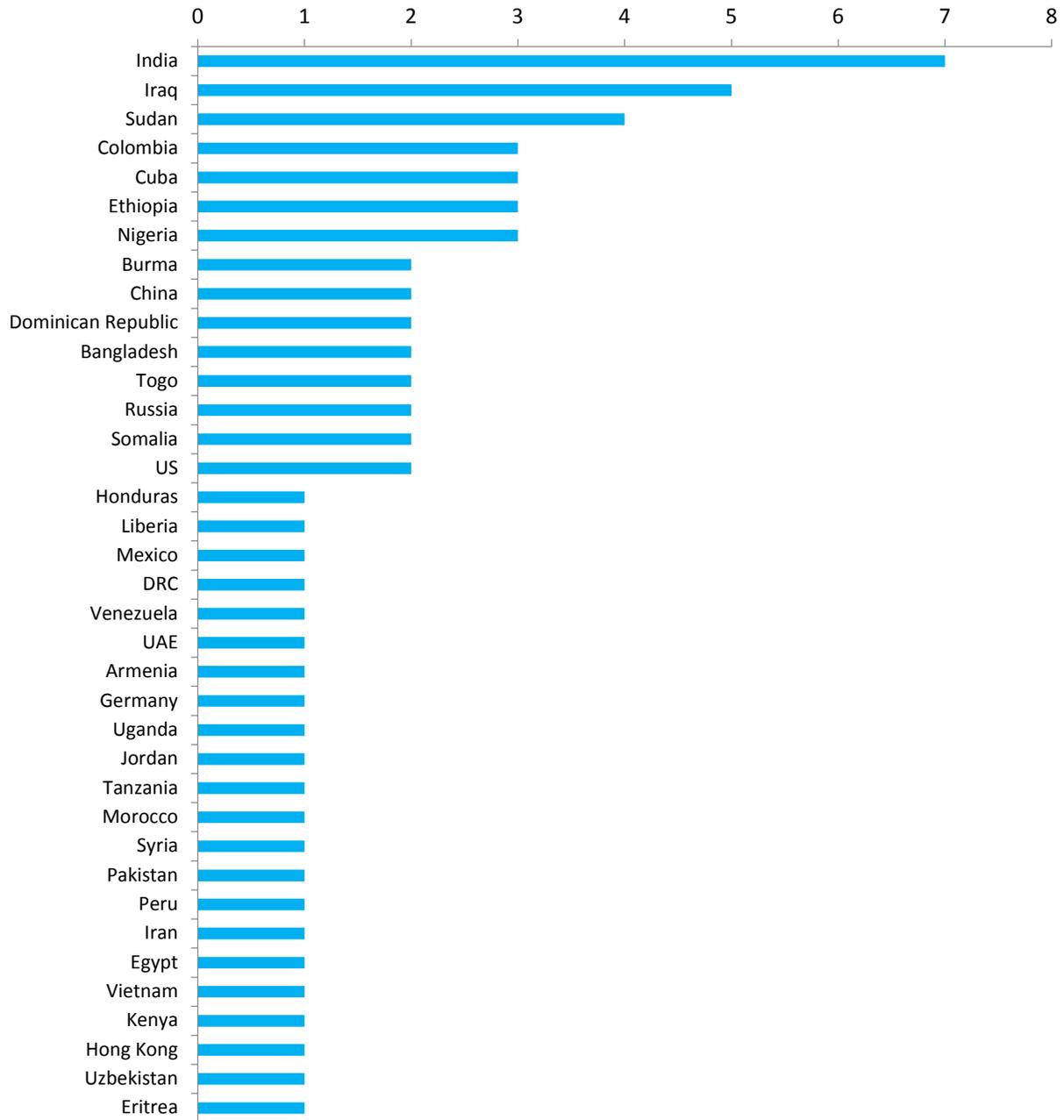
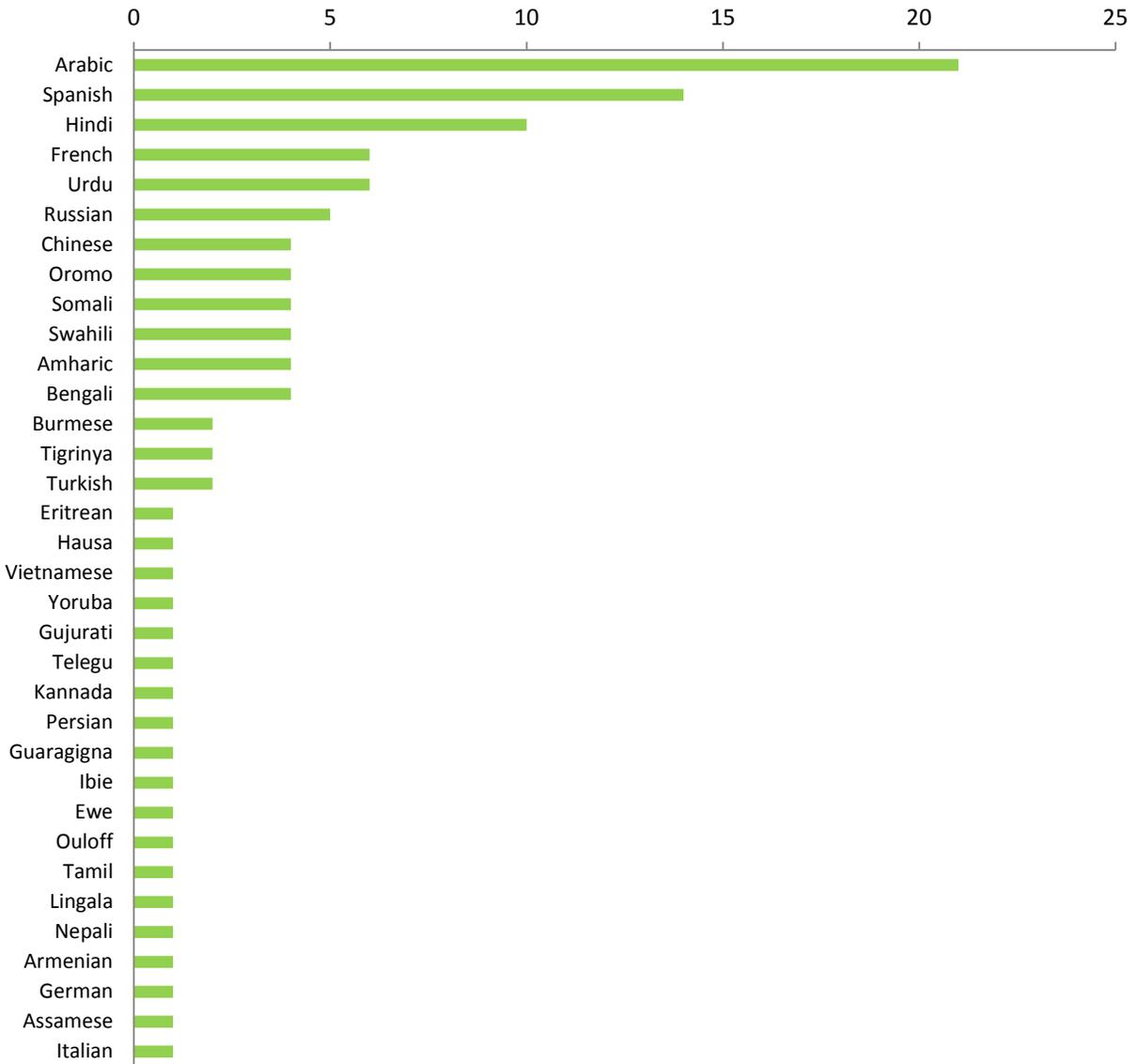
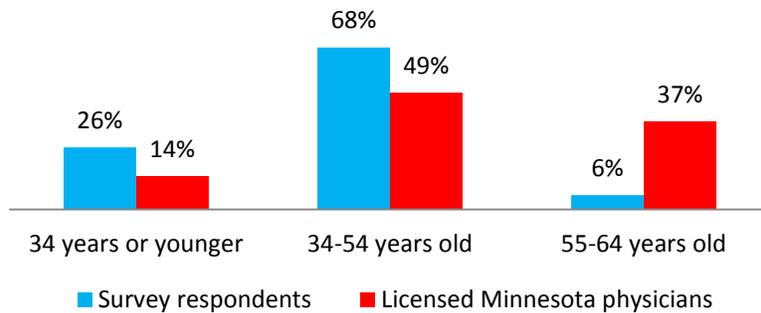


Figure 10. Languages spoken, Task Force survey respondents, by count



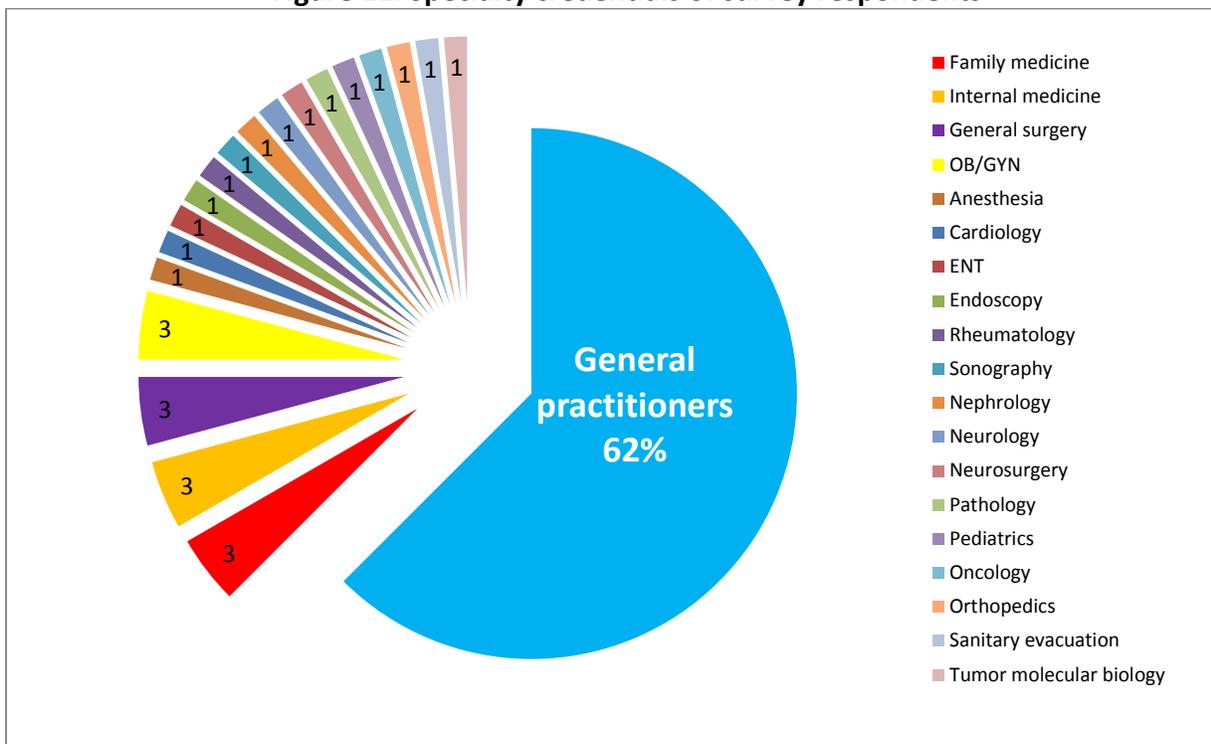
The immigrant physicians responding to the survey on the whole are younger than the current population of licensed physicians in Minnesota, with only 6 percent over 55 (Figure 11).

Figure 11. Age of Task Force survey respondents vs. licensed MDs in MN



Most survey respondents are trained as general practitioners, though over a third have credentials in specialties as well, and these span a large range of practice areas (Figure 12).

Figure 11. Specialty credentials of survey respondents



More survey results are discussed below and in Appendix E.

Foreign-trained physicians also shared their experiences at each Task Force meeting, and the Task Force held one evening and one weekend public forum to hear from foreign physicians. The information collected at these meetings is consistent with the survey results.

America is home. We have the education and have been struggling to stay within the health care industry so we can make a difference. Help us get back to doing what we love most: being a doctor.

Survey respondent originally from Tanzania

Barriers to Integrating Foreign-Trained Physicians

The Task Force identified a range of barriers faced by immigrant physicians seeking to practice. It then analyzed these barriers according to where they obstruct the pathway to licensure and at what level they might be addressed: at the individual level, within the higher education system, within state policy, or at the federal or national level. The following table summarizes these findings.

Table 3. Barriers along pathway to licensure

<p style="text-align: center;">EDUCATIONAL COMMISSION FOR FOREIGN MEDICAL GRADUATES (ECFMG) CERTIFICATION</p>	<p style="text-align: center;">U.S. or CANADIAN GRADUATE MEDICAL EDUCATION (GME)</p>	<p style="text-align: center;">MN LICENSURE</p>	
<div style="display: flex; justify-content: space-around; align-items: center;"> <div style="border: 1px solid black; padding: 5px; width: 150px; text-align: center;"> <p>“Primary-source verification” of medical education</p> <div style="display: flex; justify-content: space-between; margin-top: 10px;"> <div style="border: 1px solid black; padding: 2px; font-size: 8px;">Diploma from school in IMED (International Medical Education Directory)</div> <div style="border: 1px solid black; padding: 2px; font-size: 8px;">Transcripts</div> </div> </div> <div style="border: 1px solid black; padding: 5px; width: 200px; text-align: center;"> <p>Pass Steps 1-2 of the U.S. Medical Licensing Examination (USMLE) (or certain older equivalents)</p> <p style="font-size: 8px;"><i>Can be taken in any order but all within 7 years. Minnesota law also requires that they be passed in no more than 3 attempts.¹ NAAD recommends that IMGs take Step 3 at this stage as well.</i></p> <div style="display: flex; justify-content: space-around; margin-top: 10px;"> <div style="border: 1px solid black; padding: 2px; font-size: 8px;">USMLE Step 1</div> <div style="border: 1px solid black; padding: 2px; font-size: 8px;">USMLE Step 2 CK (Clinical Knowledge)</div> <div style="border: 1px solid black; padding: 2px; font-size: 8px;">USMLE Step 2 CS (Clinical Skills)</div> </div> </div> </div>	<div style="border: 1px solid black; padding: 10px; text-align: center;"> <p>Secure medical residency</p> <div style="display: flex; justify-content: space-between; align-items: center; margin-top: 10px;"> <div style="border: 1px solid black; padding: 5px; font-size: 8px;"> <p>Apply to residency programs through the Electronic Residency Application Service (ERAS)</p> <p style="font-size: 7px;"><i>AMA recommends that IMGs apply to at least 25 programs. (Most U.S. graduates apply to 5-10.)</i></p> </div> <div style="border: 1px solid black; padding: 5px; font-size: 8px;"> <p>Register with the National Resident Matching Program (“the Match”)</p> </div> <div style="border: 1px solid black; padding: 5px; font-size: 8px;"> <p>Interview with residency programs (when invited)</p> </div> <div style="border: 1px solid black; padding: 5px; font-size: 8px;"> <p>Residencies offered</p> </div> </div> <div style="display: flex; justify-content: center; margin: 10px 0;"> <div style="border: 1px solid black; padding: 5px; font-size: 8px;">AND/OR</div> </div> <div style="display: flex; justify-content: space-between; align-items: center; margin-top: 10px;"> <div style="border: 1px solid black; padding: 5px; font-size: 8px;"> <p>Register with non-Match residency program(s)</p> </div> <div style="border: 1px solid black; padding: 5px; font-size: 8px;"> <p>Obtain residency permit from MN Board of Medical Practice</p> </div> </div> </div>	<div style="border: 1px solid black; padding: 5px; text-align: center; margin: 10px auto; width: 100px;"> <p>Apply for license</p> <p style="font-size: 8px;">Includes verification of diploma, ECFMG certificate, residency training, and exam scores</p> </div>	
<p>BARRIERS – Faced at individual level</p>	<ul style="list-style-type: none"> ● Expense of obtaining and translating credentials. ● Difficulties accessing home country medical school transcripts/credentials. ● Cost of test preparation courses/materials and test fees (including any repeat tests needed), and cost of registering with ECFMG. ● Loss of income while preparing for and taking tests, and other financial stresses (e.g., lack of other employment, and past debt), often exacerbated when IIMGs have family obligations and arrive impoverished. ● Limited English proficiency (and fees + time needed for classes). ● Need to refresh clinical knowledge if didn’t graduate or practice recently. ● Unfamiliarity with U.S. medical culture, vocabulary, treatment methods, protocols and technology. ● Need for social and emotional support amid stress of extended personal and professional dislocation. 	<ul style="list-style-type: none"> ● Lack of recognized clinical experience (often have extensive experience in home country but not in U.S.), and lack of opportunities to obtain it. ● Lack of faculty references and course/performance evaluations like those available to USMGs, and/or lack of current professional references. ● Language difficulties during application process (e.g., writing effective personal statement and responding to interview questions). ● Costs of applying to residencies (IIMGs are encouraged to apply to many). ● Difficulty navigating complex application and selection process. 	<ul style="list-style-type: none"> ● Cost of license application and renewal fees. ● Costs associated with certifications and assessments.

	EDUCATIONAL COMMISSION FOR FOREIGN MEDICAL GRADUATES (ECFMG) CERTIFICATION	U.S. or CANADIAN GRADUATE MEDICAL EDUCATION (GME)	MN LICENSURE
	<ul style="list-style-type: none"> • Lack of mentors/coaches and professional networks. • Difficulty navigating complex certification and testing process. • Other practical barriers: Lack of computer skills, transportation. • Time limit (7 years) on completing all certification steps. 		
BARRIERS – Within higher education system		<ul style="list-style-type: none"> • “Recency” of graduation: Many residency programs require graduation from medical school within 3-5 years (many IIMGs have been out far longer). • Fierce competition for limited residency spots; the worsening “residency bottleneck.” • Reported preference given to USMGs and other IMGs, and/or bias against IIMGs. • Lack of recognition for prior clinical experience (often have extensive experience in home country but not in U.S.), and lack of opportunities to obtain experience that will carry weight in applications. • Confusion/lack of transparency over application and selection process, including lack of info on Match and ranking criteria, and non-Match options. 	
BARRIERS – State policy	<ul style="list-style-type: none"> • Minnesota requirement that USMLEs be passed in more than 3 attempts. 	<ul style="list-style-type: none"> • Regulatory issues limiting hands-on clinical experience prior to residency. 	
BARRIERS – National & federal policy	<ul style="list-style-type: none"> • Home country medical school not included in IMED. 	<ul style="list-style-type: none"> • Time limit (7 years) on completing all certification steps. 	<ul style="list-style-type: none"> • Limited residency spots with Medicare cap; the worsening “residency bottleneck.”

Among these barriers, the following are the most significant:

- Growing competition for limited residency spots.
- “Recency” of graduation from medical school.
- Lack of recognized clinical experience.
- Complexity and costs of testing and other steps needed to qualify for residency.

Growing competition for limited residency spots

As discussed under Background, a key requirement for medical licensure in Minnesota is graduate clinical medical training in a U.S. or Canadian program accredited by a national accrediting organization approved by the state Board of Medical Practice. **With rare exceptions, immigrant physicians are required to complete at least two years of such training, typically in a residency program, regardless of whether they completed similar clinical training outside the U.S.**⁶¹

Obtaining such a position, however, is a difficult feat for a variety of reasons. One is the sheer number of medical graduates vying for an essentially static number of residency positions. Medicare funding for residency training (which covers about 25 percent of GME costs in the U.S.) has been capped at the number of slots that existed in 1997, and funding by Medicare is less than what it costs to provide care and training, according to the Metro Minnesota Council on Graduate Medical Education. Even as the number of slots remains capped, however, the number of medical school graduates is increasing as many schools expand enrollments in anticipation of the physician shortages. Sometimes referred to as the “residency bottleneck,” this is a major reason cited by both the University of Minnesota and Mayo medical schools for why they do not plan to expand their medical school class sizes.⁶²

Foreign-trained physicians who immigrate to the U.S. following medical school or international practice do not generally fare well in this competition. **The Task Force found that most immigrant physicians repeatedly fail to be accepted into a medical residency program through the National Resident Matching Program (“the Match”), while nearly all (95 percent) of seniors in U.S. medical schools find a “match.”**[†]

Foreign-trained physicians often get screened out even before the interview or “ranking” phases of the Match.⁶³ Nearly all (99 percent) of residency program directors in 2014 reported interviewing and ranking U.S. medical seniors, but only half said they typically do so for foreign-trained physicians.⁶⁴

[†] Foreign students graduating from international medical schools frequently apply to U.S. residency programs and, if admitted, come to the U.S. on a visitor, or “J-1” visa. These physician trainees must return to their home country upon finishing their studies. Some of these foreign physicians are allowed to remain in the U.S. for three years on a “J-1 visa waiver” if they practice in underserved areas. The residency match data for medical students applying while residing in their home countries shows that 50 percent of these applicants are accepted into residency.

The immigrant foreign-trained physicians who are the subject of this report are those who did not have the opportunity to pursue medical careers through this prearranged route, but who arrived in the U.S. due to hardship without access to the J-1 visa career path.

The odds of a foreign-trained physician getting into a U.S. residency program, even if he or she has high USMLE scores and has become a U.S. citizen, are poor enough that the American Medical Association recommends that foreign-trained physicians apply to a minimum of 25 residency programs (U.S. medical graduates typically apply to 5-10).⁶⁵

Being an International Medical Graduate instantly puts you into a different category regardless of your own attributes.

Survey respondent originally from Nigeria

The University of California-San Francisco echoes many schools when it explains that foreign-trained physicians are at a disadvantage “partly because of large variation in the formal training and clinical experiences offered by foreign medical schools, when compared to the relatively uniform curriculum and clinical requirements offered by U.S. medical schools.”⁶⁶

Representatives from the University of Minnesota Medical School described similar challenges to the Task Force, explaining the difficulties program directors face in choosing a relatively small number of residents from a very large pool. Their goal is to choose applicants who will successfully complete residency, and because they are not as familiar with non-U.S. systems, they feel unequipped to judge whether an immigrant physician’s education and training have prepared them adequately. In contrast, they know the relatively standard U.S. medical education system well.

The Task Force found that policies and processes within the current graduate medical education system – even those created with the best intentions to be as fair and objective as possible – have unintended consequences that advantage U.S. medical graduates and create structural inequities for immigrant physicians. For example, residency programs receive up to 100 applications for each residency position, which can mean 2,000 applications for a 20-resident program, and need efficient approaches to screen out all but the most competitive candidates for interview invitations. Residency programs often set a preference for recent medical school graduates, for example, as a screening criteria (more on this below). The effect of this screening is that the experience of immigrant physicians may be automatically excluded from consideration, and immigrant physician applicants don’t have the opportunity to communicate their unique abilities to admissions personnel.

There are also reports of preference given to USMGs and non-immigrant IMGs (such as those who arrive in the U.S. on a J-1 visitor visa) in the residency selection process, and associated biases against immigrant physicians based on assumptions about the quality of their medical education or other factors. These findings⁶⁷ and related concerns prompted the American Medical Association (AMA) to create a policy encouraging medical school admissions officers and residency program directors to “select applicants on the basis of merit, without considering an ethnic name as a negative factor.”⁶⁸

The Task Force concluded that developing a way to assess and certify an immigrant physician’s readiness for clinical training and practice is critical for an immigrant physician integration effort to be successful, and its recommendations include a system that

would make Minnesota a national leader in addressing this major barrier (see Recommendations).

I am a foreign graduate, and the obstacle is to get a residency position. Programs should not look only at fresh graduates. Rather, they should consider the year of the USMLE Step 3 exam because this is a reflection of current clinical knowledge.

Survey respondent originally from Bangladesh

“Recency” of graduation

One of the main reasons immigrant physicians struggle to secure a medical residency is one out of their control: Most U.S. residency programs consider only “recent” graduates from medical school, typically requiring graduation within 3-5 years of application to residency.

As a result, some of the most highly qualified immigrant physicians – those who have practiced extensively since medical school – are essentially disqualified at this point in the pathway to licensure. The Task Force learned that the primary rationale for this guideline is the need for residents to be as up-to-date as possible on medical knowledge, treatment methods and protocols, and technology, particularly given how swiftly the health care field is changing.

As will be discussed under Recommendations, **the Task Force concludes that these valid concerns could be addressed in new, more effective ways that would benefit residency programs and immigrant physicians alike.** These innovations alone could go a long way toward integrating more immigrant physicians into the health workforce.

The program directors put the criterion [requiring applicants to be recent medical school graduates] which is beyond any human being, as I am unable to change my age. The war and economic factors made me an old graduate involuntarily. Unfortunately, they do not take into consideration my naturalized American citizenship and being integrated within the American community for many years.

Minnesota immigrant physician from Iraq

Lack of recognized clinical experience

Another major reason immigrant physicians are not accepted into residency programs, and also one largely out of their control given the current system, is a lack of hands-on clinical experience in the U.S.

Most American residency programs give preference to applicants with clinical experience acquired in the U.S. or Canada. However, **such hands-on experience with patients is nearly impossible to obtain outside of U.S. medical school or residency**, particularly since patient privacy and security regulations were strengthened under the 1996 Health Insurance Portability and Accountability Act (HIPAA).

Because of these barriers, immigrant physicians are generally limited to other ways of attempting to demonstrate clinical experience, such as volunteering in medical settings as volunteers,

working as researchers or interpreters, or participating in observership rotations (programs in which medical graduates observe licensed physicians as they diagnose and treat patients, but do not examine patients or provide any care themselves). The AMA specifically recommends that foreign-trained physicians participate in observerships before application to residency,⁶⁹ but many residency programs specifically state that these do not qualify as clinical experience.⁷⁰

The lack of U.S.-based clinical experience weakens another key part of immigrant physicians' applications to residency: letters of recommendations. Unable to obtain letters from U.S.-based supervisors with first-hand knowledge of their clinical skills, they must rely on recommendations either from individuals who know them only in non-clinical situations or from physicians who directed their clinical work overseas. The latter are often based on older experience (as immigrant physicians typically have lived in the U.S. for at least two years before being able to apply for residency), which in turn makes them less competitive to residency program directors, who prefer letters that measure an applicant's most current knowledge and skills.⁷¹

The Task Force concludes that opportunities for hands-on clinical experience for immigrant physicians should be developed to address this major barrier toward licensure.

As further discussed under Recommendations, the Task Force proposes that a clinical preparation program be developed based in part on the past experience of the Preparation for Residency Program at the University of Minnesota, which provided seven months of orientation and clinical experience for immigrant physicians from 2010-2012, and similar programs at the University of California-Los Angeles and elsewhere (see Appendix F, "Promising Practices and Pathways").

The biggest barrier for me has been a lack of accredited clinical experience – not being able to get any experience in any capacity except as an interpreter or a medical assistant.

Survey respondent originally from India

Complexity and costs of testing and other steps needed to qualify for residency

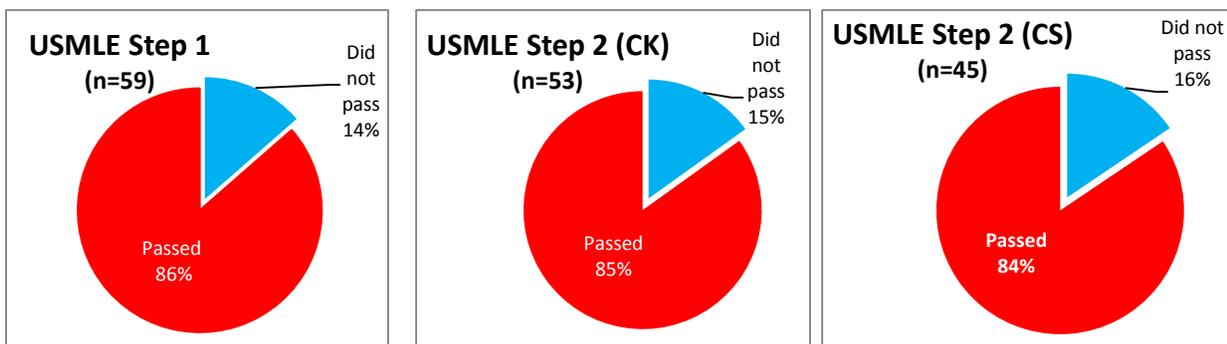
Practicing medicine in the U.S. requires a wide range of skills and knowledge, some specific to the rapidly changing and highly complex American health care system. Even immigrant physicians with extensive clinical skills and experience overseas have much to learn in order to qualify for residency and practice effectively in the U.S. In addition to passing the rigorous and highly technical USMLE licensing exams required for ECFMG certification, they must demonstrate to residency programs that their English proficiency, technological skills and understanding of U.S. medical culture make them qualified to train successfully in a graduate clinical setting and beyond.

The Foreign-Trained Health Care Professionals program administered by the Department of Employment and Economic Development (DEED) currently provides many Minnesota immigrant physicians with support for these foundational skills and the many steps needed to qualify for residency, particularly assistance with English language proficiency, preparation for the USMLEs, and help navigating the ECFMG certification and residency application processes,

as well as important social and peer support during the often grueling and lengthy experience of pursuing a residency. This program was funded with a one-time state appropriation for fiscal years 2014 and 2015, and will end on June 30, 2015.⁷²

The Task Force investigated the impact of such programs – here in Minnesota and elsewhere around the world – and found they are very successful in helping immigrant physicians pass the USMLEs and become ECFMG certified (see Appendix F, “Promising Practices and Pathways”). This finding was supported by the Task Force’s statewide survey, in which the majority of respondents – most of whom have worked with the current DEED grantees – have passed these tests successfully (see Figures 13-15).

Figures 13-15. Share of immigrant physician survey respondents passing USMLE steps 1-2.

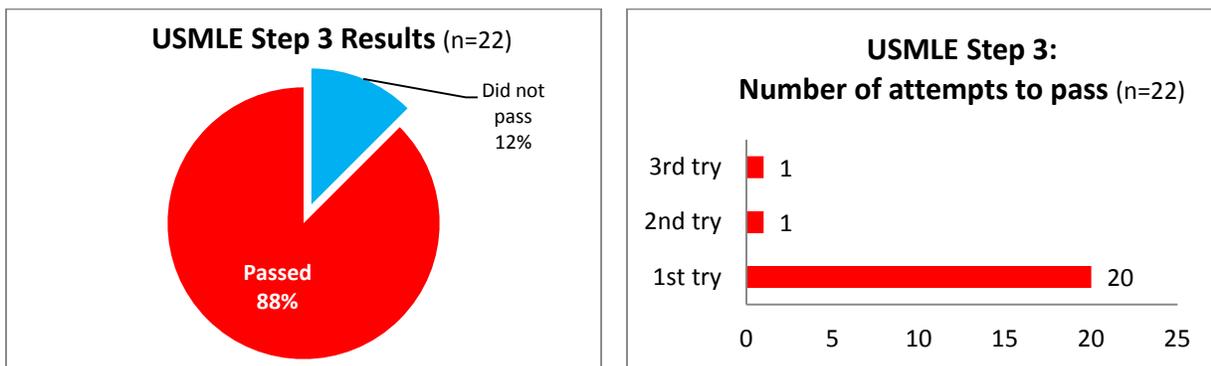


Just over half (55 percent, or 38 immigrant physicians) of those surveyed are fully certified through the ECFMG. Many have also gone on to pass Step 3 of the USMLEs, which is technically not required for ECFMG certification and is usually taken during residency, and most did so on their first try (Figure 16-17).

I had to work at minimum wage jobs at Walmart in order to support myself but I passed all the exams, thankfully.

Survey respondent originally from Bulgaria

Figures 16-17. Share of immigrant physician survey respondents passing USMLE step 3.



Few graduates of these programs are actually then admitted to residency, however, due to the barriers to residency described above. One of the Minnesota nonprofit organizations in the Foreign-Trained Health Care Professionals program reports that of the 275 Minnesota immigrant physicians it has worked with since 2006, only about 35 (13 percent) have been able to obtain residency positions.⁷³ This is consistent with other, similar programs in the U.S., such as the Welcome Back Initiative program now operating in 10 states.⁷⁴ (See Appendix F, “Promising Practices and Pathways,” for more detail on these and other programs the Task Force consulted).

It is not about passing the USMLE exams. The problem is after you pass, you have to compete with recent graduates to get a residency program space. It is very difficult to get a spot.

Survey respondent originally from Honduras

The Task Force concludes that such programs are a key component of integrating immigrant physicians into the health workforce, but will have only limited success unless there are changes elsewhere in the medical education system. **Evidence suggests that such programs will have a far greater impact if they work in concert with other key partners (including the medical education system, health care providers and employers, and regulatory bodies) and if key barriers on the pathway can be addressed (including opportunities for clinical experience and mechanisms for assessing clinical readiness)** (see Appendix F). The Task Force’s recommendations therefore propose continuing support for these foundational programs but doing so within a coordinated statewide system, along with exploring new pathways to licensure.

I am double certified in surgery and oncology and I am considered among the top surgeons in my home country. I am able to speak fluently in five languages. I have passed the USMLE Step 1 and 2 exams. Now I am looking for a residency. I know I have the knowledge, skills and ability to be a good doctor in any country plus I have the drive and determination.

Minnesota immigrant physician originally from Russia

Alternative Roles and Professions for Foreign-Trained Physicians

The Task Force heard repeatedly that most immigrant physicians would prefer to practice the profession they spent years training to perform: physician. Some feel this preference quite strongly, such as the immigrant physician from Morocco who wrote: “I worked hard to become a pediatrician and would like to achieve my dream.”

Still, **64 percent of the immigrant physician survey respondents said they would be interested in exploring other health professions.** Of these, the largest group responded they would be interested in exploring the physician assistant (PA) role, with others indicating interest in serving as a nurse practitioner or registered nurse, or working in research, public health or medical counseling.

Based on these findings, and acknowledging that additional immigrant physicians may need or prefer an alternative profession in which to contribute their skills and experience, the Task Force studied the opportunities for some to become physician assistants, nurse practitioners or other advanced practice registered nurses in Minnesota.

The Task Force noted that nursing and medicine are two different yet complementary disciplines. Before becoming a nurse practitioner, candidates must first be or become a registered nurse; requirements for entrance into physician assistant programs tend to be much more flexible, with a range of degrees accepted. Currently, no expedited pathways into the advanced practice nursing field exist in Minnesota for foreign-trained physicians, and if they start at the beginning of this path, it will take longer than the 27-31 months of traditional physician assistant education. In addition, nursing's focus on helping individuals manage their health in the context of their environment, family and community is different than the medical focus on diagnosing and treating disease, with which immigrant physicians and all physicians are most familiar. The physician assistant curriculum and approach are based on and similar to medical education and practice, offering a potentially better alignment with the expertise of immigrant physicians.

The Task Force concluded that the physician assistant profession would be the best alternative profession for most immigrant physicians considering non-physician occupations, if current barriers to entry can be removed or diminished so these physicians can appropriately meet physician assistant education and licensure standards as quickly and cost effectively as possible.

Both Task Force members and immigrant physicians who contributed to this project concluded that assisting interested immigrant physicians to become physician assistants should be the initial alternative pathways strategy for those immigrant physicians who will not be pursuing physician practice (see Recommendations).

Costs and Possible Funding Sources to Integrate Foreign-Trained Physicians

The Task Force was charged with identifying both the costs and possible funding sources for integrating foreign-trained physicians into the health workforce. In doing so, it sought to paint as complete a picture as possible of what would be needed to bring a *significant* number of such clinicians fully into the Minnesota workforce. It concluded that such a system will need to be comprehensive and coordinated, and as such will require greater investment and innovation than past efforts. But it also concluded that such action is worth taking. **The Task Force believes the potential return on investment will far outstrip the initial costs, and will come in the form not just of financial benefits but also better health outcomes and greater health equity in the state. It also concludes that this return will be greatest if public and private entities join forces to coordinate and fund the new system.**

Costs and return on investment

As discussed under Barriers, integrating immigrant physicians into the health workforce does entail initial costs. Some of these expenses – such as those required to prepare for the U.S.-

specific licensing exams (the USMLEs) or to improve English language skills to clinical-level proficiency – will likely be necessary regardless of the integration strategies implemented. Others – such as the expense of repeatedly applying to numerous residency programs or the costs of public assistance to support unemployed or underemployed physicians unable to practice – could be reduced or potentially even eliminated depending on the pathways developed.

As noted above, it currently costs \$7,500-\$15,000 for a foreign-trained physician to get as far as applying to residency programs, and even after making such expenditures, most fail to secure a residency position and therefore cannot become licensed to practice, as discussed under Barriers. **Clearly the current system is only working for a relatively small number of physicians – a lost opportunity at a time when Minnesota cannot afford to limit its physician workforce, particularly when that untapped pool is uniquely qualified to serve the fastest growing segments of the state’s population and is willing to serve in its rural and underserved communities.**

The strategies recommended by the Task Force would entail greater initial investments – from \$10,000-\$60,000 per immigrant physician depending on his/her skills and readiness for residency – but are expected to produce a much higher return on investment. That is, by investing in more effective, coordinated strategies, rather than the piecemeal efforts that have allowed relatively few immigrant physicians into practice, Minnesota could produce a significant increase in and diversification of its physician workforce, particularly in primary care.

It is also worth noting that some of these integration costs could be further reduced with more fundamental changes to the physician licensure pathway, which the Task Force is also recommending be explored (see Recommendations). Even at the levels required under the current pathway, however, the proposed investments would still be far less than the average expense of \$228,000 to train a U.S. undergraduate to the same point (up to residency). While those U.S. medical school costs are largely paid by graduates themselves and other private sources, there is still a significant level of public subsidy involved, including state and federal funding of medical schools, publicly funded scholarships, and public student loans.

The investments proposed by the Task Force are expected to bring significant benefits to Minnesota. Two analyses of existing programs reviewed by the Task Force illustrate the impact foreign physician integration efforts can have. The Welcome Back Initiative, now operating in 10 states and providing educational case management and other support services to foreign-trained health care professionals who are unemployed or underemployed, found that internationally trained nurses experienced a six-fold increase in earnings after graduating from their program.⁷⁵ Locally, Wilder Research estimated that the Foreign Trained Health Professionals Program (FTHP) of the Women’s Initiative for Self Empowerment (WISE), operated in partnership with NAAD (formerly known as the African American Friendship Association for Cooperation and Development of Minnesota or AAFACD), generated \$358,003 in net benefits and **a prospective return of \$2.56 per every dollar invested in the program should a physician successfully become fully licensed.**⁷⁶

As discussed under Policy Drivers, licensed immigrant physicians can also bring a variety of cost savings to Minnesota’s overall health care system, including its government-funded health care programs, by providing a more culturally adept and better distributed physician workforce

capable of helping reduce the costly hospitalizations and health disparities that have persisted for so long.

In addition, employing immigrant physicians to their full abilities would allow the state to take fuller advantage of the tremendous resources – both human and economic – that remain untapped in Minnesota’s immigrant communities and are increasingly needed throughout the state. An estimated 21 percent of Minnesota’s college-educated, foreign-born population is currently underutilized in the labor force, meaning they are either unemployed or underemployed in unskilled “survival jobs,” a phenomenon also sometimes referred to as “brain waste” within the workforce.⁷⁷

In contrast to such “brain waste,” **developing better pathways for immigrant physicians to practice their profession would bring the state the many economic and social benefits known to come when highly skilled immigrants are successfully employed and well-integrated into their professions.**⁷⁸ A 1997 study found that highly educated immigrants in the U.S. averaged a net per capita benefit of \$198,000 to society, and subsequent studies have confirmed that such immigrants confer a significant net benefit to the U.S.⁷⁹ One Minnesota-specific analysis estimated that the state’s 2007 population of 40,638 immigrants with graduate or professional degrees would generate lifetime earnings of \$134 billion.⁸⁰

We are immigrant International Medical Graduates who are American citizens and permanent residents of Minnesota. We are taxpayers.

Immigrant physician at community meeting hosted by the Task Force

Possible funding sources

The Task Force explored a variety of possible funding sources for its recommended strategies. It concluded that the most effective approach will be a public-private partnership, at both the governance and funding levels. State support and funding will be necessary, but the Task Force also believes it is important that the private sector also contribute to its operations, as well as immigrant physicians themselves.

1. Current Federal (Medicare) and State (MERC) Graduate Medical Education funding

The Task Force finds that current federal (Medicare) and state (MERC) Graduate Medical Education funding is not a realistic source of support for activities recommended in this report. Current funding does not fully support the current level of physician training, and redirecting it would reduce rather than expand the training capacity needed to meet growing demand. Financial resources to support additional primary care clinical training capacity for candidates such as immigrant physicians is already limited for clinics and other ambulatory settings best suited for primary care training because, among other reasons, the majority of Graduate Medical Education funds flow to hospital-based training.

2. New state funding

The Task Force believes additional State investments should be considered to implement its recommendations and achieve the goal to integrate immigrant physicians into the state's workforce as physicians or other health professionals. Successfully integrating foreign-trained physicians into the state's workforce will yield public benefit by better meeting the health care needs of citizens, contributing to state goals for health system improvement and contributing to economic development by more fully employing this group of underemployed professionals.

3. Private funding

Physician employers such as hospitals, clinics and health systems are working to add culturally competent providers to better serve their increasingly diverse patient populations. Though some health care employers may be experiencing financial stress, the Task Force believes it is in the interest of health care employers to invest through public-private partnerships in the type of cost-effective workforce diversity strategies offered in this report.

Immigrant physicians themselves could also be an important source of support. The Task Force heard from many physicians willing and even eager to “pay back” into a system that would allow them to practice their profession. Several of the strategies recommended therefore include both return-of-service obligations (in which participating physicians would commit to practicing in a rural or underserved area for a certain length of time, similar to obligations now built into loan forgiveness and repayment programs for U.S. medical graduates) and reimbursement obligations (in which the physicians would contribute to the costs of a given program, typically by receiving a graduated salary that increases with each year of service, though other reimbursement arrangements such as a revolving loan program may be feasible as well).

4. Philanthropic support

Several Minnesota private foundations have provided support to advance the goal of integrating foreign-trained physicians into the state workforce as physicians or other health professionals. The Task Force sees potential for further private and corporate foundation investment in implementing activities needed to implement this goal.

One specific effort already under way: In 2014, the Bush Foundation awarded a two-year Community Innovation Grant for a collaborative of Minnesota nonprofits and other health care stakeholders, led by the Women's Initiative for Self-Empowerment (WISE) and New Americans Alliance for Development (NAAD), to develop a public-private partnership initiative to fund additional medical residency opportunities for immigrant physicians. This group intends to use the Task Force's recommendations as a basis for its partnership development, and its work will leverage any public funding with additional private investment from Minnesota health care institutions, businesses and philanthropy.

We are ready to work in the health care system. Working as a health care provider is my only American dream. I bring passion, integrity and a pledge to work hard to bring my dream to reality.

Survey respondent originally from India

Recommendations

The Task Force concludes that Minnesota has a valuable and underused resource in its population of immigrant physicians, many of whom stand willing and qualified to serve as primary care providers in rural and underserved communities of the state. These physicians currently face multiple barriers to practice, but these obstacles could be addressed effectively with strategic, coordinated, public-private action. **When implemented, these strategies could produce a larger and more diverse primary care workforce capable of reducing both health disparities and health costs in Minnesota.**

Guiding Principles

In developing these recommendations, based on its findings, the Task Force adopted a set of guiding principles:

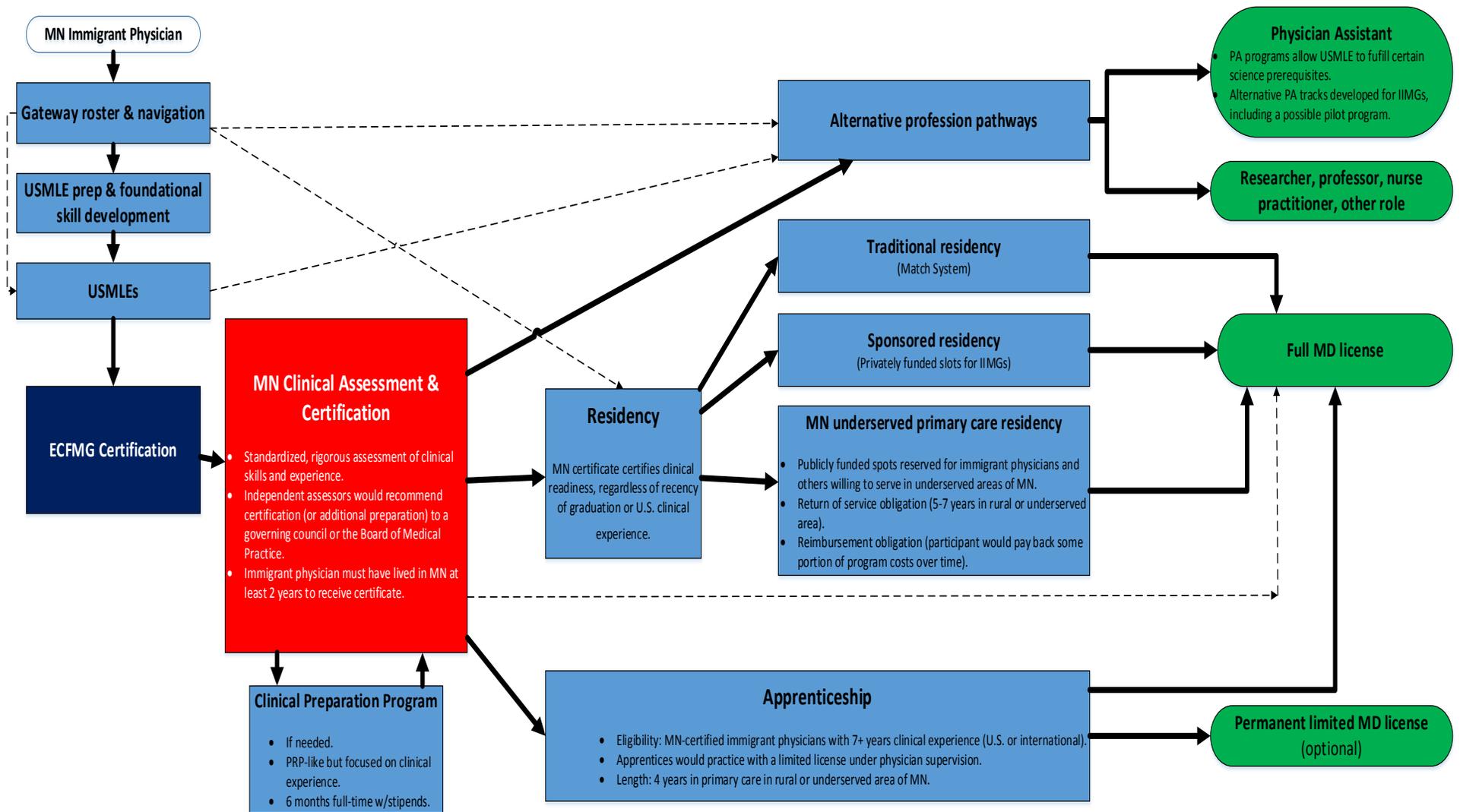
- Programs must be comprehensive (providing career direction, academic experiential and related activities and support) and provide multiple pathways to appropriate licensing and employment.
- Ideal programs will be collaborations between public and private entities.
- Admission procedures and criteria for services and programs should fully and objectively capture the knowledge, skills and experience of applicants.
- Programs should be affordable to participants.
- Participants who meet specified outcomes must have a reasonable assurance that they will be able to continue toward their goal of working as a physician, physician assistant or similar health professional, within the limits of the resources available for support services and programs.
- Programs and policies should include competency assurances comparable to Minnesota physician licensing requirements.
- Priority should be given to immigrant physicians who have lived in Minnesota at least 2 years and limited to those legally able to work.
- Programs should include return-of-service requirements, through which participants who succeed in becoming practicing physicians or similar professionals are obligated to work in an underserved area and/or contribute to funding ongoing services.

Specifically, the Task Force recommends the following set of strategies, which would work in concert as depicted in Figure 16. **The recommendations are presented as a comprehensive system of linked strategies, rather than isolated tactics, to address the key barriers in a cohesive, cost-effective way, and to allow multiple pathways into the workforce depending on a physician's qualifications, interests and level of readiness to practice.**

Importantly, key stakeholders in the state's health care system have been actively involved in developing these innovative solutions and have expressed interest in implementing them. The chair of the Task Force, Dr. Edwin N. Bogonko of St. Francis Regional Medical Center, represented the Minnesota Medical Association, and the medical schools of both the University of Minnesota and Mayo Clinic were active Task Force and work group members. Essentia

Health, a major hospital and clinic system with many facilities in rural Minnesota, served on the Task Force from the perspective of a rural health care employer already facing challenges finding physicians and other health care providers to fill vacancies within its system. Mayo, Hennepin County Medical Center, Fairview Health Services, North Memorial Health Care and other providers have also expressed interest in participating in the proposed clinical preparation program, and the Minnesota Hospital Association is interested in convening other member hospitals to facilitate their participation as well.

Figure 18. Proposed Minnesota immigrant physician system



Note: Any funding amounts provided are general figures only, not formal state government fiscal notes, and are provided so as to be scalable, allowing the adjustment of program sizes and funding amounts as needed.

Strategy 1: Statewide coordinating council

The Task Force recommends the Legislature authorize the creation of a statewide Council on International Medical Graduates to provide overall coordination for the planning, implementation and evaluation of a comprehensive system to integrate immigrant physicians into the Minnesota health care system. The Council would be charged with addressing the barriers faced by immigrant physicians and facilitating pathways for their integration into the Minnesota health care delivery system. **Specifically, the Council would be responsible for implementing and evaluating the outcomes of Strategies 2-10 below, with an overall goal of increasing access to primary care in rural and underserved areas of the state.**

As part of its duties, the Task Force also recommends that the Council develop and maintain, in partnership with the Board of Medical Practice and community organizations working with immigrant physicians, a centralized, voluntary roster of those interested in entering the Minnesota health workforce. This would equip the Council with better and more consistent information about the pool of immigrant physicians in the state and their qualifications and interests, which could in turn guide Council planning and program administration for maximum impact.

The Council should include members from key stakeholders, including the following:

- State agencies (including MDH, the Board of Medical Practice, the Office of Higher Education, and the Department of Employment and Economic Development).
- Representatives from the health care industry (including a health care employer from a rural or underserved area and a health insurer).
- Community-based organizations, including those serving immigrant and refugee communities, such as the partnership between New Americans Alliance for Development and the Women's Initiative for Self-Empowerment.
- Higher education (including the University of Minnesota, the Mayo Clinic School of Health Professions and/or Medical School, a graduate medical education program not located at the University of Minnesota or Mayo, and a physician assistant education program).
- Immigrant physicians.

Recommended action: *Authorize the Commissioner of Health to develop a statewide council, in collaboration with the Board of Medical Practice and key stakeholders, to design, implement and coordinate a comprehensive system for the integration of immigrant physicians into the Minnesota health care system. The authorization should include appropriation of funding for the programs and operations of the council (see Recommendations 2-10).*

Strategy 2: Gateway and foundational support

The Task Force recommends that a state grant program be established to maintain and expand career guidance and support services for immigrant physicians, building on the current Foreign-Trained Health Care Professionals program administered by the Department of Employment and Economic Development (DEED). The program should seek to accomplish the following:

- Maintain and expand career guidance and support for immigrant physicians, including information on training and licensing requirements for physician and non-physician health care professions, and guidance in determining which pathway is best suited for an individual foreign-trained physician based on his/her skills, experience, resources and interests.
- Provide support to build foundational skills needed to practice in the U.S., including English health care terminology and information technology proficiency.
- Provide support for USMLE test preparation and expenses.
- Provide support for immigrant physicians interested in pursuing alternative professions, including a clearinghouse on pathway options and educational programs available.
- Register all participating immigrant physicians in the Council's Minnesota Immigrant Physician roster.

Recommended action: *Allocation of \$500,000/year for grant(s) to Minnesota nonprofit(s) to serve 50 immigrant physicians per year (at an average of \$10,000 per immigrant physician served), coordinated through the proposed Council on International Medical Graduates, with the initial round of grants distributed by December 2015. This amount does not include administrative costs for the grant program. The Task Force bases this funding recommendation on costs of similar programs (particularly the existing Foreign-Trained Health Care Professionals program), but recommends providing additional funding to allow for more intensive, coordinated support services than is currently available.*

Strategies 3 and 4: Clinical assessment & certification

The Task Force recommends that Minnesota develop a standardized assessment and certification program that would assess the clinical readiness of immigrant physicians. Key features should include the following:

- Standardized and rigorous assessment of clinical skills.
- Prerequisite that immigrant physicians first be certified by the ECFMG.
- Prerequisite that immigrant physicians have lived in Minnesota for at least two years.
- Upon successfully passing the assessment, physicians would receive Minnesota certification of clinical readiness for either residency or apprenticeship.
- The Council should further explore whether the assessment program could be extended to assess clinical readiness to practice medicine (assessment toward full licensure without the requirement of medical residency experience or an apprenticeship) (see also Recommendation 9).

Recommended action: *Authorize the proposed Council on International Medical Graduates to work with the Commissioner of Health and the Board of Medical Practice, in consultation with*

key stakeholders and experts, to develop a plan by December 31, 2015 for implementing an assessment and certification system, including proposed legislation, a proposed budget, and an implementation schedule that allows for assessment and certification of immigrant physicians by June 2016.

Strategy 5: Clinical preparation program

The Task Force recommends that a state grant program be established to support clinical training sites in providing hands-on experience and other preparation for Minnesota immigrant physicians needing additional clinical preparation or experience to become certified as ready for residency or apprenticeship. The grant program should include the following:

- Development of training curricula and associated policies and procedures for clinical training sites.
- Monthly stipends for participating physicians.
- Prerequisite that eligible participating physicians must have lived in Minnesota for at least two years and be certified by the ECFMG.
- Successful completion of the program would lead to Minnesota certification of clinical readiness for either residency or an apprenticeship (based on clinical assessment following program completion).
- Priority should be given to primary care sites in rural or underserved areas of the state, and participating physicians should have to commit to serving at least five years in a rural or underserved community of the state.

Importantly, several Minnesota hospitals, clinics and medical education programs have expressed preliminary interest in participating in such a program, including the following who have stepped forward to date:

- Fairview Health Services
- Hennepin County Medical Center
- Mayo Clinic College of Medicine
- Minnesota Department of Human Services (DHS) – Direct Care and Treatment (State Operated Services)
- North Memorial Health Care
- University of Minnesota Medical School, Department of Family Medicine and Community Health

The Minnesota Hospital Association has also expressed interest in working with its member hospitals, particularly those in rural and underserved areas of the state, to facilitate their participation in the program.

Recommended action: *Authorize the proposed Council on International Medical Graduates to develop policies and procedures for a clinical preparation program by December 2015, including an implementation schedule that allows for grants to clinical preparation programs beginning in June 2016. Allocate \$750,000/year for grants to training programs to serve and provide stipends to 15 immigrant physicians/year (two 6-month cohorts/year, at an average cost of \$50,000 per participant). This amount does not include administrative costs for the grant*

program. The Task Force bases this funding recommendation on historic costs and testimony provided by the administrators of the previous Preparation for Residency Program at the University of Minnesota, and the cost-per-physician experience of the similar University of California-Los Angeles International Medical Graduate program. The Task Force estimates that the average cost per immigrant physician would be \$50,000, which would include a total stipend amount of \$12,000 to the participant (\$2,000/per month for six months) plus program costs (including expenses incurred by the clinical site for the training provided) totaling \$38,000.

Strategy 6: Dedicated residency positions

The Task Force recommends that dedicated Minnesota primary care residency positions be created for immigrant physicians who are Minnesota residents and are willing to serve in rural or underserved areas of the state. These positions should be developed with the following key features:

- Prerequisite that participating physicians must have lived in Minnesota for at least two years and be certified by both the ECFMG and the Minnesota Council on International Medical Graduates.
- Participating physicians would commit to providing primary care for at least five years in a rural or underserved area of Minnesota.
- In addition to this return-of-service obligation, the residencies would also include some level of reimbursement obligation (with the participating physician committing to pay back a portion of program costs).
- Ideally, these new residency positions would be funded through a combination of public and private funding, including the following:
 - a. Sponsored (privately supported) primary care residency spots dedicated for immigrant physicians.
 - b. State-funded primary care residency spots reserved for immigrant physicians and others willing to serve in rural or underserved areas.

Recommended action: Allocation of \$2.25 million/year for 15 primary care residency positions dedicated to immigrant physicians living in Minnesota, for implementation beginning in June 2016, and the development of sponsored (privately funded) residency slots. The Task Force bases this funding recommendation on the average cost of residency training in Minnesota, which according to the Metro Minnesota Council on Graduate Medical Education is currently \$150,000 per resident (which includes \$50,000 annual salary and benefits for the resident). This amount does not include administrative costs for the grant program.

Strategy 7: Changing “recency” guidelines

The Task Force recommends that Minnesota residency programs be encouraged or required to revise their graduation recency guidelines to take into account other measures of readiness. Specifically, instead of looking only at the recency of graduation from medical school, residency programs should consider:

- When an immigrant physician passed the USMLEs and/or became certified by the ECFMG.

- When an immigrant physician has been certified through the proposed Minnesota clinical assessment and certification program.

Recommended action: Charge the proposed Council on International Medical Graduates to work with Minnesota residency programs to accept the Minnesota immigrant physician certification and/or ECFMG certification as a measure of readiness for residency, regardless of recency of graduation or U.S. clinical experience.

Strategy 8: Apprenticeship program

The Task Force recommends that Minnesota develop a structured apprenticeship program for highly experienced immigrant physicians willing to serve in rural or underserved areas. The program should include the following features:

- Prerequisite that participating physicians have lived in Minnesota for at least two years and are certified by both the ECFMG and the Minnesota Council on International Medical Graduates.
- Prerequisite that eligible participating physicians would have at least seven years of clinical experience, in the U.S. or internationally.
- Development of a time-limited apprenticeship licensure by the Board of Medical Practice to allow an apprentice to practice under supervision of a licensed physician (see also Strategy 9).
- Apprentices would serve four years under physician supervision.
- In addition to this return-of-service obligation, apprenticeships would include a reimbursement obligation (with apprentices to receiving graduated salaries over the four-year period, with their salaries increasing with each year of service).
- Training sites would be part of a network of primary care clinics in rural and underserved areas and would receive \$20,000/year per apprentice for their costs.
- Upon successful completion, participating physicians could choose to apply for (1) a full medical license, or (2) a permanent limited license, for practice under supervision of another physician.
- Participating physicians would commit to providing primary care for at least five years in a rural or underserved area of Minnesota.

Recommended action: Authorize the proposed Council on International Medical Graduates to develop and administer, in consultation with the Board of Medical Practice and other partners, an apprenticeship program for qualified immigrant physicians. The Council should work with the Board to develop policies and procedures for the program, including any additional admissions criteria, and proposed legislation for licensing changes needed, a proposed budget, and an implementation schedule that allows for the enrollment of eligible immigrant physicians as apprentices by June 2017. Allocate \$100,000/year for the program to apprentice five immigrant physicians each year (providing for \$20,000 grants annually to each of the five participating clinical sites). These grants would support the sites' costs of supervision and staffing (including salary and benefits for the apprentice, whose salary amount would gradually

increase with each year of service as part of their reimbursement obligation to the program). This amount does not include administrative costs for the program.

Strategy 9: New licensure options

The Task Force recommends that Minnesota develop new licensing options for immigrant physicians, in coordination with new programs and pathways developed by the Council on International Medical Graduates and key stakeholders. These new licensing options would not require completion of medical residency experience. Specific licensing options that should be explored include the following:

- Time-limited apprenticeship licensure, to practice under supervision in the apprenticeship program recommended under Strategy 8.
- Permanent limited licensure to practice under supervision, for those physicians choosing this option following the apprenticeship program described under Strategy 8.
- Full licensure following successful completion of the apprenticeship program.
- If deemed feasible by the Board of Medical Practice and the Council based on more in-depth study, the development of a full licensure option based on a clinical assessment process recommended under Strategy 3 (with the certificate of clinical readiness serving in whole or part as evidence a candidate is clinically qualified to practice medicine).
- In all cases, the participating physicians must be certified by both the ECFMG and the Minnesota Council on International Medical Graduates, pass all USMLE tests and be clinically qualified to practice medicine.

Recommended action: *Authorize the Board of Medical Practice to work with the proposed Council on International Medical Graduates and other key stakeholders to develop and propose legislation to grant qualified immigrant physicians time-limited apprenticeship licensure, limited licensure to practice under supervision, and full licensure. The legislation need not require that candidates obtain United States medical residency experience. The Council and Board should submit recommendations and proposed legislation by December 15, 2016.*

Strategy 10: Streamline paths to alternative professions

The Task Force recommends that Minnesota explore and facilitate more streamlined pathways for immigrant physicians to serve in non-physician professions in the Minnesota health workforce. Specifically, it recommends the following:

- Strengthening career counseling resources for alternative health professions for foreign-trained physicians, particularly through the community organizations providing the gateway and foundational skill support in Strategy 2.
- Working with physician assistant training programs in Minnesota to explore alternatives for admission requirements for foreign-trained physicians, including allowing a foreign-trained physicians scores on the United States Medical Licensing Exams to fulfill basic and higher science prerequisites in physician assistant program admissions.
- Working with at least one interested physician assistant education program in Minnesota, in partnership with the Board of Medical Practice and national physician

assistant accreditation and certification bodies, to create a program track that meets the existing professional standards for physician assistants, but is designed to meet the unique needs of the immigrant physician who wishes to practice as a physician assistant, including expedited training and specially designed clinical rotations.

Recommended action: *Authorize the proposed Council on International Medical Graduates to work with physician assistant programs on alternatives for admission requirements for foreign-trained physicians, and to work with at least one interested physician assistant program based in Minnesota to develop a new or pilot FTP-to-PA track to include expedited training during the academic phase and specifically designed clinical rotations. Allocate \$450,000 to support program development and accreditation of the new program track over two years, developing a program design by July 1, 2017 and any needed legislation for the program proposed by December 31, 2016, with an enrollment target of September 2017. This funding recommendation is based on a two-year development period requiring two full-time faculty (one to develop the didactic curriculum and one to secure clinical placements) plus one full-time administrative support person, and is based on historic costs and time required to develop Physician Assistant programs and secure accreditation from the appropriate national accreditation and certification bodies. This amount does not include administrative costs for the grant program.*

A summary of these recommendations follows.

Summary of Recommended Strategies

Strategy	Recommended action	Funding ³ and timetable
Strategy 1: Statewide coordinating council	Authorize the Commissioner of Health to develop a statewide council, in collaboration with the Board of Medical Practice and key stakeholders, to design, implement and coordinate a comprehensive system for the integration of immigrant physicians into the health care workforce.	Funding for the operations of the council beginning in June 2015.
Strategy 2: Gateway & foundational support	Establish a state grant program to maintain and expand career guidance and support services for immigrant physicians, building on the current Foreign-Trained Health Care Professionals program administered by the Department of Employment and Economic Development (DEED).	\$500,000/year for grants to nonprofits to serve 50 immigrant physicians/year, with initial grants distributed by December 2015.
Strategies 3 and 4: Clinical assessment & certification	Develop a standardized assessment and certification program that would assess the clinical readiness of immigrant physicians.	Develop a plan by December 31, 2015, including proposed legislation, a proposed budget, and an implementation schedule that allows for assessment and certification of immigrant physicians by June 2016.
Strategy 5: Clinical preparation program	Establish a state grant program to support clinical training sites in providing hands-on experience and other preparation to Minnesota immigrant physicians needing additional clinical preparation or experience to qualify for residency or apprenticeship.	Develop policies and procedures by December 2015, including an implementation schedule that allows for grants to programs beginning in June 2016, allocating \$750,000/year for grants to train 15 immigrant physicians/year.
Strategy 6: Dedicated residency positions	Develop dedicated residency positions for immigrant physicians, through both state and private funding.	\$2.25 million/year for 15 primary care residency positions dedicated to immigrant physicians, for implementation beginning in June 2016, and the development of sponsored (privately funded) residency slots.
Strategy 7: Changing “recency” requirements	Encourage or require Minnesota medical residency programs to revise their graduation recency requirements to accept the Minnesota immigrant physician certification and/or ECFMG certification as a	Council will report progress on this and other activities in its annual report, due December 31, 2015.

³ Funding amounts provided are general figures only, not formal state government fiscal notes, and are provided so as to be scalable, allowing the adjustment of program sizes and funding amounts as needed. Amounts do not include grant program and other administrative costs.

Strategy	Recommended action	Funding ³ and timetable
	measure of readiness for residency, regardless of recency of graduation or U.S. clinical experience.	
Strategy 8: Apprenticeship program	Authorize the Council to develop and administer, in consultation with the Board of Medical Practice and other partners, a structured apprenticeship program for highly experienced immigrant physicians willing to serve in rural or underserved areas.	<p>Develop policies and procedures for the program, including admissions criteria, and proposed legislation for licensing changes needed, a proposed budget, and an implementation schedule that allows for the enrollment of eligible immigrant physicians by June 2017.</p> <p>\$100,000/year for the program to apprentice five immigrant physicians each year beginning in 2017.</p>
Strategy 9: New licensure options	Develop new licensing options for immigrant physicians -- including a time-limited apprenticeship licensure, limited licensure to practice under supervision, and full licensure – that does not require U.S. medical residency experience.	Submit recommendations and proposed legislation by December 15, 2016.
Strategy 10: Streamline paths to alternative professions	<p>Authorize the Council on International Medical Graduates to explore and facilitate more streamlined pathways for immigrant physicians to serve in non-physician professions in the Minnesota health workforce, including:</p> <ul style="list-style-type: none"> • Alternatives for foreign-trained physicians in admission requirements for physician assistant (PA) programs. • A new (or pilot) immigrant physician-to-PA track to include expedited training during the academic phase and specially designed clinical rotations. 	<p>Work with PA programs on alternatives for admission requirements for foreign-trained physicians, and include progress in annual report due December 31, 2015.</p> <p>\$450,000 to support program development and accreditation of a new PA program track over two years, developing a program design by July 1, 2017 and any needed legislation for the program proposed by December 31, 2016, with an enrollment target of September 2017.</p>

Appendices

- A. Task Force session law
- B. Task Force membership
- C. Minnesota health professional shortage areas
- D. Demographic analysis, additional detail
- E. Survey findings, additional detail
- F. Promising practices and pathways

Appendix A: Task Force Charge

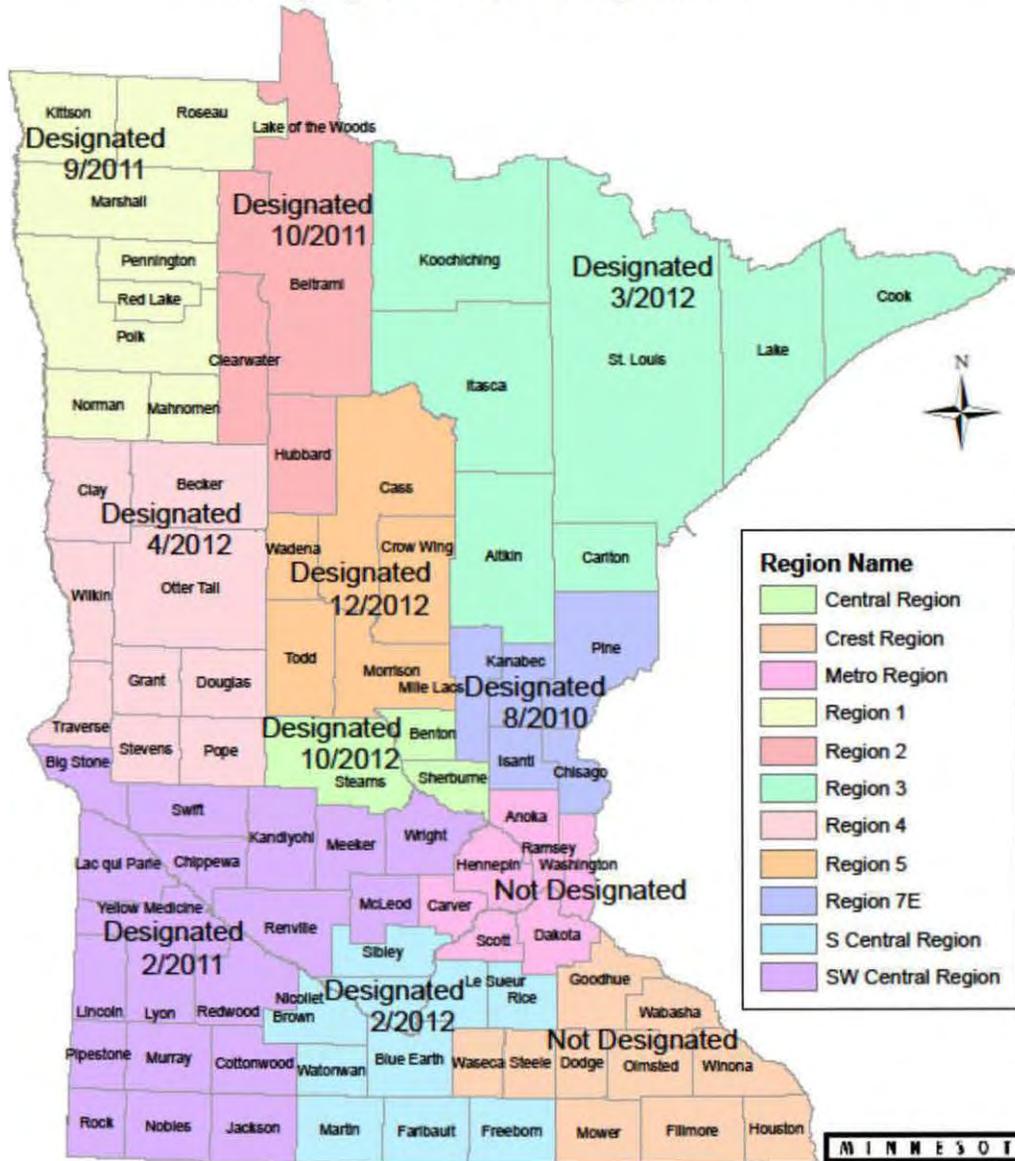
2014 Minnesota Session Laws, Chapter 228, Article 5, Section 12

- (1) The commissioner of health shall appoint members to an advisory task force by July 1, 2014 to develop strategies to integrate refugee and asylee physicians into the Minnesota health care delivery system. The task force shall:
 - (a) analyze demographic information of current medical providers compared to the population of the state;
 - (b) identify, to the extent possible, foreign-trained physicians living in Minnesota who are refugees or asylees and interested in meeting the requirements to enter medical practice or other health careers;
 - (c) identify costs and barriers associated with integrating foreign-trained physicians into the state workforce;
 - (d) explore alternative roles and professions for foreign trained physicians who are unable to practice as physicians in the Minnesota health care system;
 - (e) identify possible funding sources to integrate foreign-trained physicians into the state workforce as physicians or other health professionals.
- (2) The commissioner shall provide assistance to the task force, within available resources.
- (3) **By January 15, 2015, the task force must submit recommendations** to the commissioner of health. The commissioner shall report findings and recommendations to the legislative committees with jurisdiction over health care by January 15, 2015.

Appendix B: Task Force Members

<p>Yende Anderson Executive Director and Co-Founder New Americans Alliance for Development</p>	<p>Edwin Bogonko, Chair Physician St. Francis Regional Medical Center Representative for the MN Medical Association</p>
<p>Donna DeGracia Curriculum Director/Academic Coordinator Master of Physician Assistant (PA) Studies Program St. Catherine University School of Health</p>	<p>Sue Field Nursing Accreditation Consultant HealthForce Minnesota</p>
<p>Jane Graupman Executive Director International Institute of Minnesota</p>	<p>Michael Grover Assistant Vice President Federal Reserve Bank of Minneapolis</p>
<p>Wilhelmina Holder International Medical Graduate Executive Director, Women's Initiative for Self- Empowerment, Inc. Co-Founder, New Americans Alliance for Development</p>	<p>Barbara L. Jordan Administrator Mayo Clinic College of Medicine Office for Diversity</p>
<p>Tedla Kefene International Medical Graduate Board Member, New Americans Alliance for Development</p>	<p>Christine Mueller Professor & Assoc. Dean for Academic Programs University of Minnesota, School of Nursing</p>
<p>Kris Olson Vice President, Physician and Professional Services Essentia Health</p>	<p>Mimi Oo International Medical Graduate Program Director/Coordinator New Americans Alliance for Development, Foreign- Trained Health Care Professionals Program</p>
<p>James Pacala Associate Department Head University of Minnesota Family Medicine & Community Health</p>	<p>Jinny Rietmann Program Coordinator Foreign-Trained Healthcare Professionals Workforce Development Inc.</p>
<p>Michael Scandrett Minnesota Safety Net Coalition</p>	

MN Rational Service Areas - Mental Health Geographic HPSA Designations

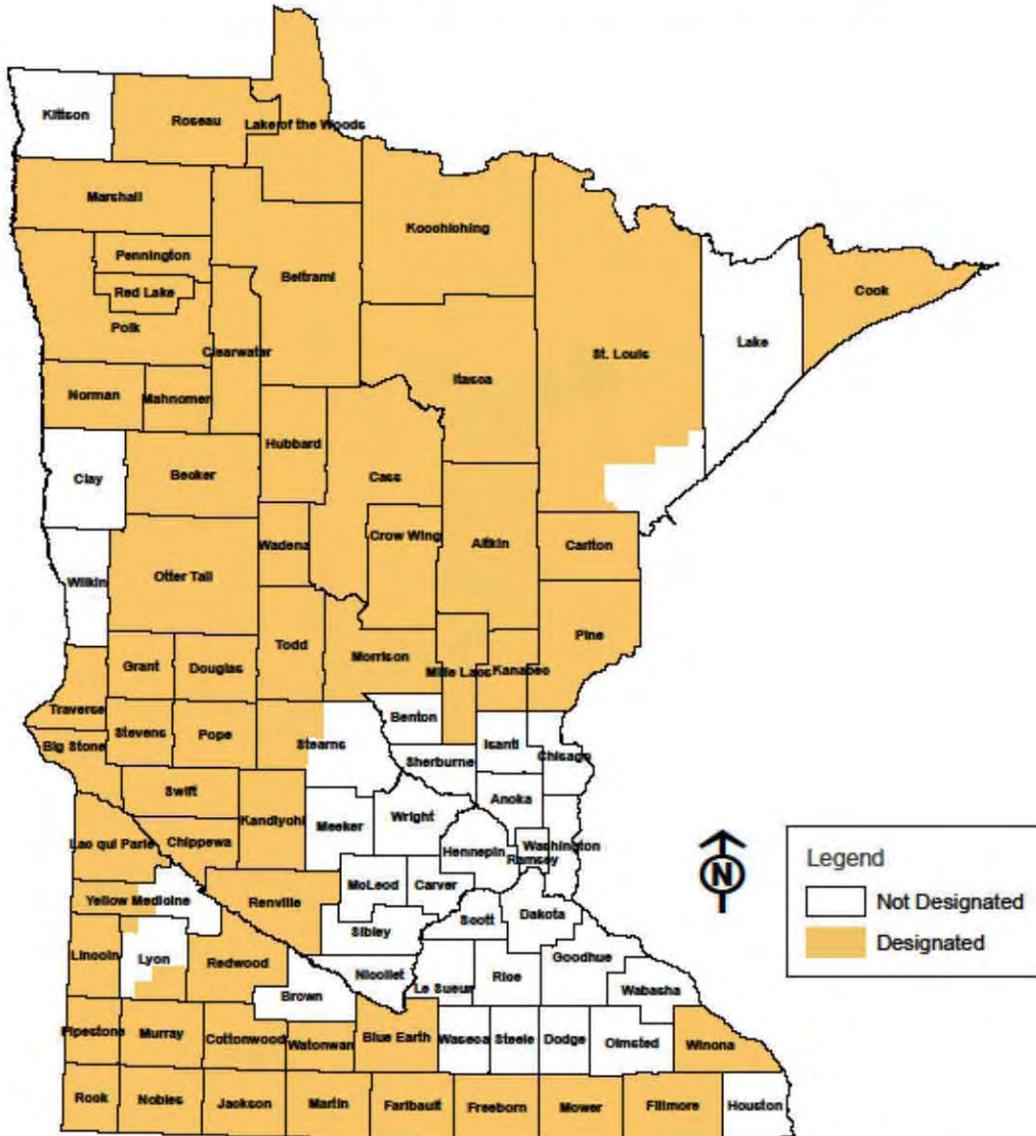


Source: Minnesota Department of Health
Office of Rural Health, June 2014
HPSA designations 6_2014.mxd



Health Professional Shortage Areas

Low Income Dental HPSA Designations



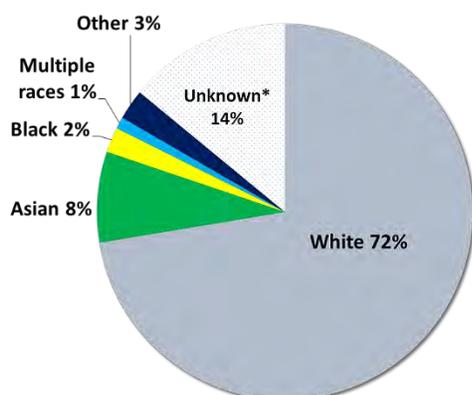
Data Source:
 Minnesota Department of Health
 Office of Rural Health and Primary Care
 State DD HPSA Nov 2014



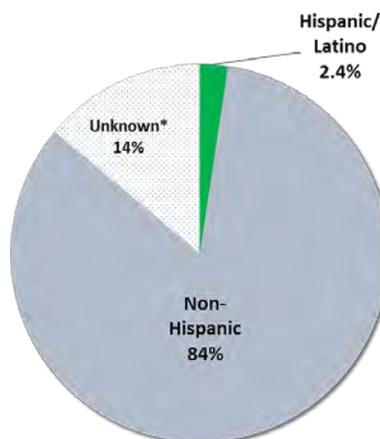
Appendix D: Demographic analysis, additional detail

Race and ethnicity of licensed physicians in Minnesota

Race



Ethnicity



Source: **2013 MDH Physician Workforce Survey**. Respondents may choose not to answer certain questions on the survey. 1,399 out of 10,809 (14 percent) did not answer the survey question about race. 1,388 (13.9 percent) of respondents did not answer the survey question about ethnicity.

Race of licensed physicians vs. population, by region

Economic Development Region	Share of physicians of color in the region*	Share of persons of color in region's population, 2010 Census	Total number of licensed physicians in region†
Central	11%	6%	1,070
Northeast	7%	7%	917
Northwest	15%	8%	724
7-County Minneapolis/St. Paul metro	14%	21%	8,632
Southeast	12%	9%	3,064
Southwest	23%	7%	570
Statewide	14%	14.7%	14,977

* Source: **2013 MDH Physician Survey**. 1,399 out of 10,809 (14 percent) did not answer the survey question about race. "Physicians of color" include American Indian, Asian, Black, Native Hawaiian physicians who identify as multiple races, and "other" races. † Source: May 2014 licensing data from the **Minnesota Board of Medical Practice**. The data in this column includes only those physicians who provided a business address in Minnesota (excludes physicians working out of state and who did not provide a business address to the Board.)

Foreign-trained licensed physicians by Minnesota region

Economic Development Region	Number of U.S. or Canadian-trained physicians in region	Number of foreign-trained physicians in region	Total number of licensed physicians in region	Share of foreign-trained physicians in region
Central	943	124	1,070	12%
Northeast	844	69	917	8%
Northwest	606	112	724	15%
Seven County Minneapolis/St. Paul	7,75	1,116	8,632	13%
Southeast	2,473	585	3,064	19%
Southwest	432	135	570	24%
Statewide	12,773	2,141	14,977	14%

Source: May 2014 licensing data from the Minnesota Board of Medical Practice. Not all licensed physicians are working as physicians. This chart includes only those physicians who provided a business address that was in Minnesota (excludes 6,692 physicians who were working out of state and/or who did not provide a business address to the Board).

Minnesota physicians by rural-urban location

	U.S-trained Physicians (n= 12,541)*	Foreign-trained physicians (n=2,141)*	Share of Population in Area**
Metropolitan	87%	87%	70%
Micropolitan/Large Rural	8%	8%	13%
Small Town/Small Rural	4%	3%	7%
Rural/Isolated	1%	1%	10%
Total	100%	100%	100%

Note: Rural-urban categories are based on Rural-Urban Commuting Areas (RUCAs). See [Defining Rural, Urban and Underserved Areas in Minnesota](#).

Sources:

*Minnesota Board of Medical Practice licensing data, current through May 2014. A total of 2,445 physicians did not provide a business address.

**U.S. Census.

Currently licensed physicians vs. Minnesota immigrant communities, by region of the world

The population estimates in this section are all from [Minnesota Compass](#), which in turn used data from Steven Ruggles, J. Trent Alexander, Katie Genadek, Ronald Goeken, Matthew B. Schroeder, and Matthew Sobek. Integrated Public Use Microdata Series from the U.S. Census Bureau, American Community Survey: Version 5.0 [Machine-readable database]. Minneapolis: University of Minnesota, 2010. Available from: <http://usa.ipums.org/usa/>. The number of Minnesota-licensed physicians by education country and birth country comes from the MN Board of Medical Practice licensing data from May and October 2014, respectively.

Note: The population estimates here are based on U.S. Census estimates only. It is important to note that such estimates **likely undercount** immigrant and refugee communities. As the state demographer cautions: “These estimates ... likely underestimate the size of our immigrant populations because trust and language issues depress response rates to Census surveys.”⁸¹ *For community-based estimates of some of the largest immigrant and refugee communities in Minnesota in addition to these census-based data, see Table 2 on Page 19.*

Africa

	Estimated Foreign-Born Population in Minnesota, 2010-2012	Number of MN Licensed Physicians <u>Educated in this Country</u>	Number of MN Licensed Physicians <u>Born</u> in this Country
Somalia	21,227	7	28
Ethiopia	12,503	20	35
Liberia	12,216	2	8
Kenya	7,295	14	37
Sudan	3,327	14	15
Cameroon	1,303	3	7
Eritrea	1,197	0	5
Tanzania	1,028	4	12
Sierra Leone	772	0	2

Southeast Asia

	Estimated Foreign-Born Population in Minnesota, 2010-2012	Number of MN Licensed Physicians <u>Educated</u> in this Country	Number of MN Licensed Physicians <u>Born</u> in this Country
Laos	24,408	0	19
Vietnam	18,548	3	64
Thailand	15,014	27	35
Philippines	6,346	146	158
Burma (Myanmar)	4,183	10	15
Cambodia (Kampuchea)	3,045	0	1
Indonesia	N/A*	3	9

*A value of N/A indicates that the number of people sampled in a given year was too small to provide a reliable estimate.

South Asia

	Estimated Foreign-Born Population in Minnesota, 2010-2012	Number of MN Licensed Physicians <u>Educated</u> in this Country	Number of MN Licensed Physicians <u>Born</u> in this Country
India	26,273	783	914
Pakistan	1,556	256	248
Sri Lanka (Ceylon)	1,038	13	24
Bangladesh	897	15	16
Nepal	812	34	37

East Asia

	Estimated Foreign-Born Population in Minnesota, 2010-2012	Number of MN Licensed Physicians <u>Educated</u> in this Country	Number of MN Licensed Physicians <u>Born</u> in this Country
China	13,634	90	155
Korea	13,419	39	138
Other Asia*	5,335	98	64
Taiwan	2,994	12	66
Japan	1,983	17	42
Hong Kong	1,361	1	19
Malaysia	714	1	18

*Includes all other Asian countries, not just those in East Asia.

Latin America

	Estimated Foreign-Born Population in Minnesota, 2010-2012	Number of MN Licensed Physicians <u>Educated</u> in this Country	Number of MN Licensed Physicians <u>Born</u> in this Country
Mexico	70,988	87	43
El Salvador	7,233	1	4
Colombia	5,116	43	56
Guatemala	4,594	9	7
Honduras	4,534	0	1
Ecuador	4,080	15	20
Guyana/British Guiana	2,447	0	6
Haiti	1,358	4	11
Trinidad and Tobago	423	0	9

Middle East

Country	Estimated Foreign-Born Population in Minnesota, 2010-2012	Number of MN Licensed Physicians <u>Educated</u> in this Country	Number of MN Licensed Physicians <u>Born</u> in this Country
Iran	1,711	44	112
Egypt/United Arab Republic	1,122	60	69
Turkey	940	49	41
Iraq	665	13	21
Lebanon	582	55	63
Israel/Palestine	N/A*	38	34
Jordan	N/A*	25	20
Kuwait	N/A*	1	8
Syria	N/A*	68	70
Afghanistan	N/A*	2	3

*A value of N/A indicates that the number of people sampled in a given year was too small to provide a reliable estimate.

Eastern Europe

	Estimated Foreign-Born Population in Minnesota, 2010-2012	Number of MN Licensed Physicians <u>Educated</u> in this Country	Number of MN Licensed Physicians <u>Born</u> in this Country
Russia/Other Former USSR	6,710	26	83
Ukraine	3,766	14	26
Byelorussia/Belarus	2,737	3	10
Poland	1,898	52	63
Bosnia	1,624	7	6
Romania	1,385	41	52
Latvia	567	0	5
Hungary	531	24	16

Western Europe

Country	Estimated Foreign-Born Population in Minnesota, 2010-2012	Number of MN Licensed Physicians <u>Educated</u> in this Country	Number of MN Licensed Physicians <u>Born</u> in this Country
Germany	7,617	83	155
England	4,161	59	68
Sweden	1,141	5	9
Italy	1,063	27	31
Norway	1,057	1	13
Netherlands	824	21	11
Finland	691	3	3
Denmark	602	5	8
Ireland	579	79	54
Greece	519	29	32
Scotland	424	7	14
Spain	N/A*	14	18
Portugal	N/A*	2	3

*A value of N/A indicates that the number of people sampled in a given year was too small to provide a reliable estimate.

Oceania

Country	Estimated Foreign-Born Population in Minnesota, 2010-2012	Number of MN Licensed Physicians <u>Educated</u> in this Country	Number of MN Licensed Physicians <u>Born</u> in this Country
New Zealand	627	9	7
Australia	913	21	21

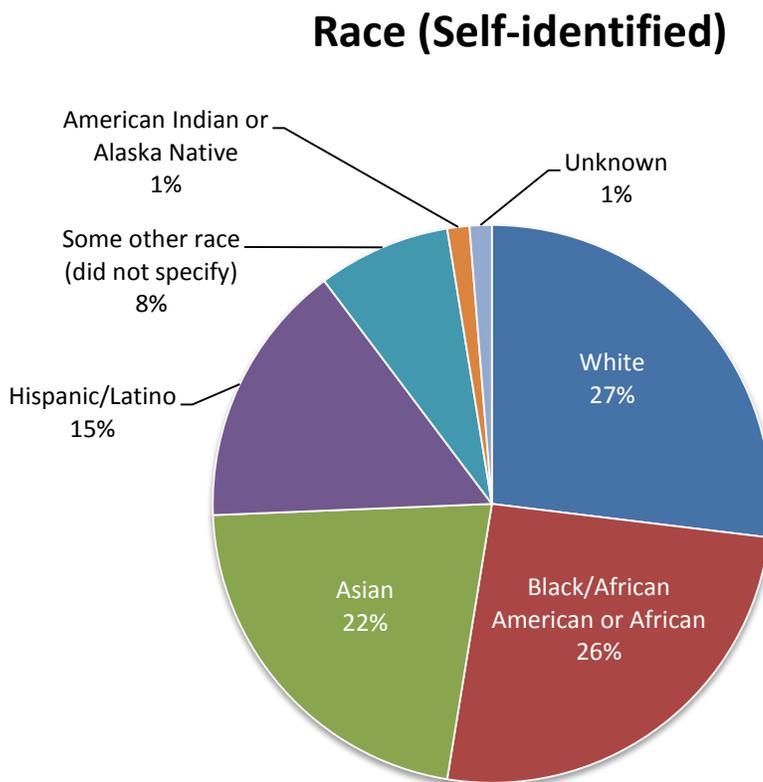
Appendix E: Survey findings

From August-December 2014, the Task Force conducted a statewide survey of foreign-trained physicians with the goal of obtaining a better understanding of the immigrant physician population and their needs. MDH reached out to 275 immigrant physicians during the four months with a 25 percent survey completion rate.

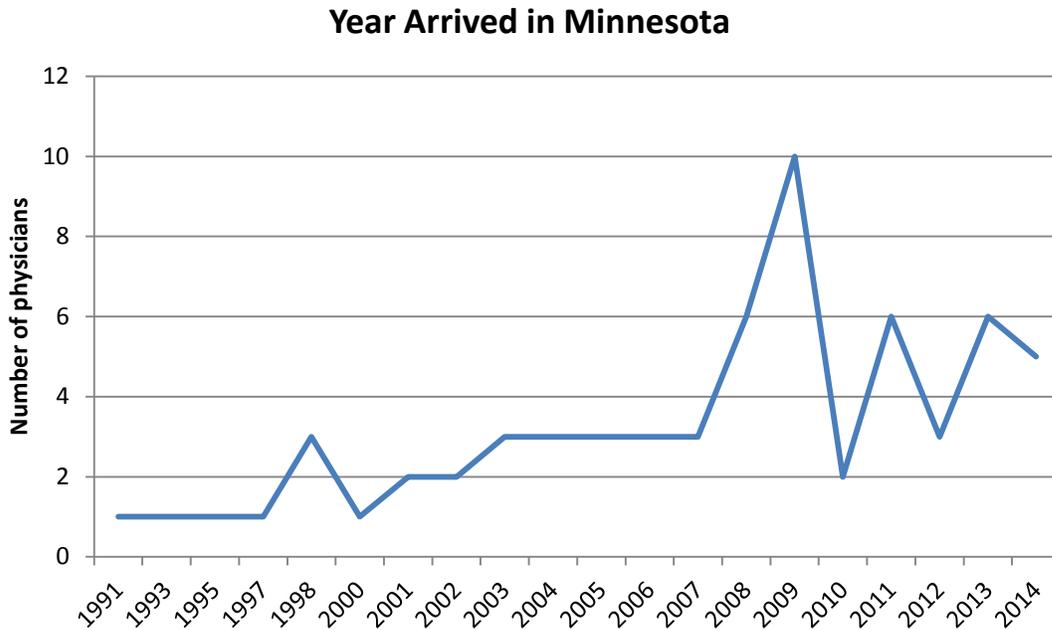
Demographics

Survey respondents came from 37 different countries. Sixty-eight (68) percent of respondents were 35-54 years old, and the gender makeup was almost 50/50. Fifteen (15) percent of survey respondents identified as refugees or asylees.

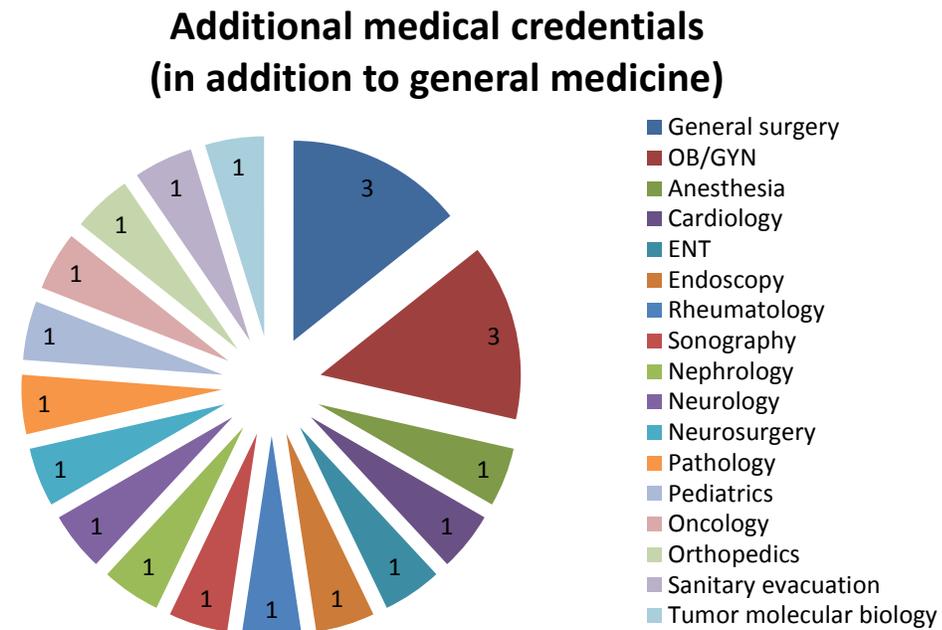
The figure below shows the racial diversity of the respondents.



The trend of immigrant physician arrivals in Minnesota is difficult to discern, but appears relatively stable. Based on the survey responses, there was a notable spike in 2009 of 10 immigrant physicians.

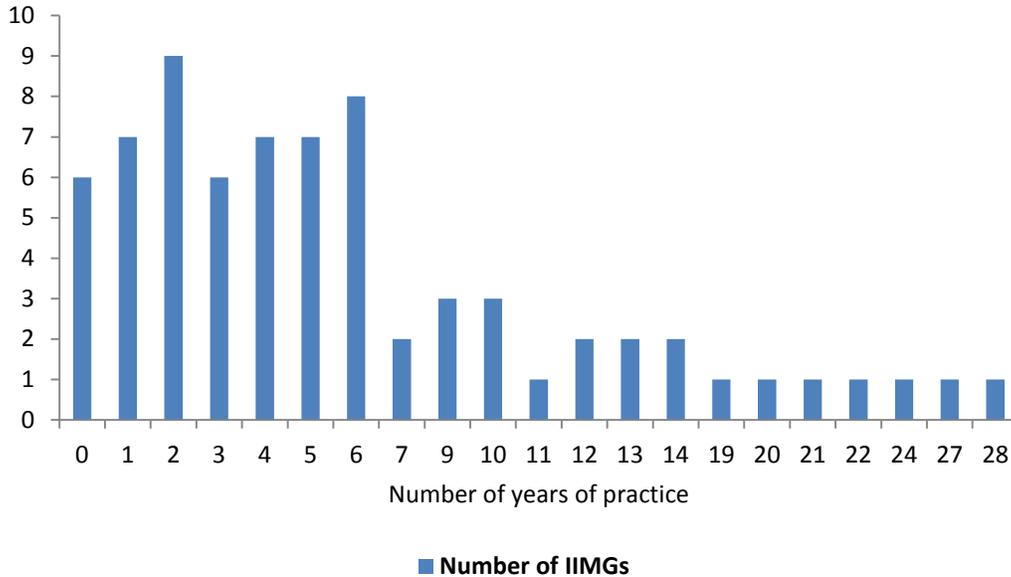


The majority (71 percent of respondents, or 51 individuals) are trained as general practitioners and do not hold any additional medical credentials. The variety amongst those who do is seen below.



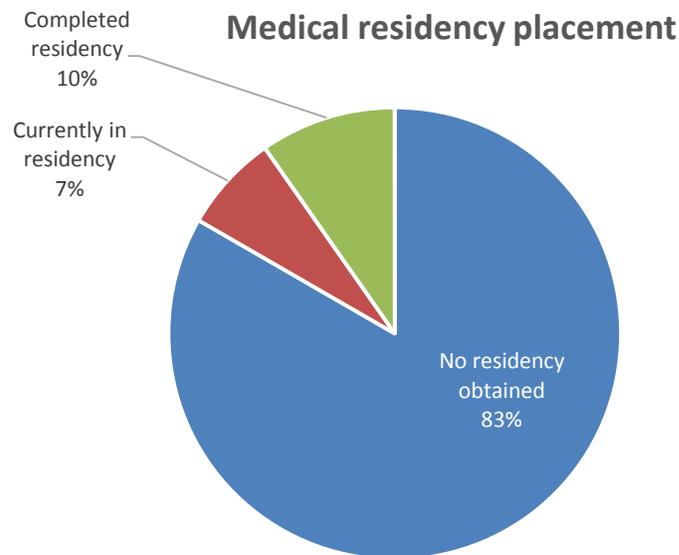
Respondents have a wide breadth of clinical experience outside of the U.S., from 0-28 years.

Number of years practiced outside the U.S.



Medical residency

While there is an overwhelming interest in “meeting the requirements to enter medical practice or other health careers” in Minnesota (87 percent), the majority of respondents have not been accepted into a residency program (83 percent).

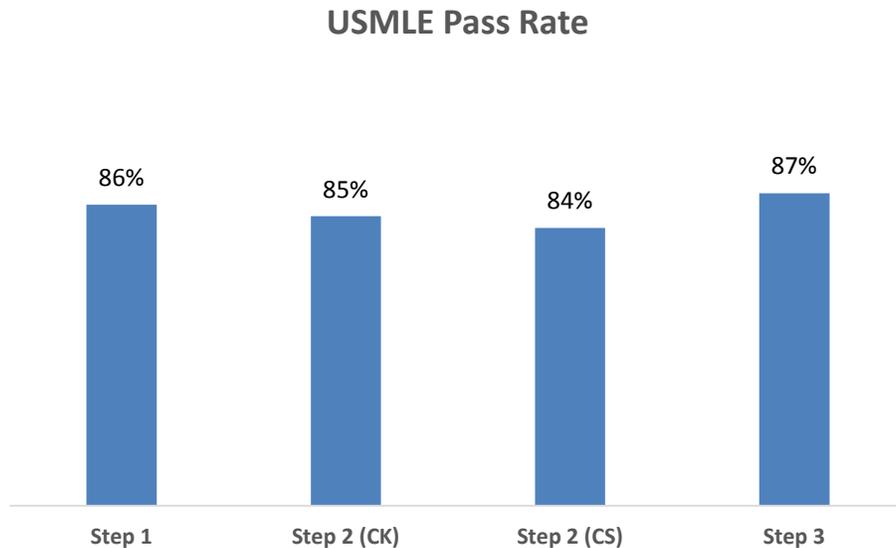


Of the seven respondents who have completed residency, five have a license to practice in Minnesota.

Of those who have not completed residency, 32 percent have spent less than a year looking for residency programs. The average search time has been 1.5 years, although two immigrant physicians have spent over 5 years trying. Respondents who have completed or are currently in residency programs stated that the most helpful factors throughout the application process were: (1) U.S. clinical experience and (2) having connections with people who can attest to your clinical skill set.

Licensing Exams

The majority of respondents who attempted any or all of the three United States Medical Licensing Exams (USMLE) steps passed, usually on their first attempt.



Respondents cited the following challenges in preparing for the licensing exams (challenges listed by order of frequency of response).

- A. Money/financial barriers
- B. Lack of resources, including but not limited to: preparation materials, government, institutional, and social support
- C. Working and studying at the same time
- D. Exam and exam prep fees
- E. Language barriers
- F. Lack of time
- G. Residency barriers, including a lack of US clinical experience and residency requirements
- H. Household problems
- I. Exam rigor
- J. Studying and taking care of children at the same time
- K. Settlement issues, including legal barriers

L. Isolation

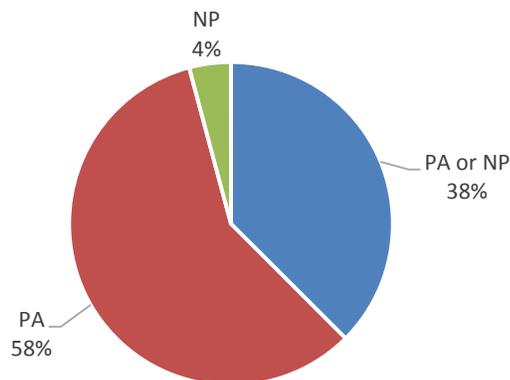
M. Political climate in home country

Only four respondents explicitly stated that there were no barriers to testing. The top three resources utilized were the USMLE website/Qbank (34 percent), Kaplan prep materials (19 percent), and New Americans Alliance for Development (NAAD) (9 percent).

Alternative Professions

Just over one-third (35 percent of respondents or 24 individuals) were not interested in pursuing alternative medical professions. Of those 24 respondents, 15 explicitly stated they were determined to go down the physician route. Among the 65 percent interested in exploring alternative professions, just over half (58 percent) expressed interest in the physician assistant role.

Interest in Alternative Professions



Most (37 out of 45 respondents) are currently employed in the health field (excluding the physician profession). These positions include researcher (8), medical interpreter (6), medical assistant (4), and health service manager/administrator (4).

Suggested Solutions

44 respondents suggested possible solutions:

- 15 suggested creating training programs (like the former Preparation for Residency Program at the University of Minnesota).
- 11 suggested clinical spots/opportunities for hands-on experience.
- 7 mentioned willingness to work in rural communities.
- 7 expressed interest in entering the PA/NP profession with limited to no extra training.
- 6 asked for support services (including financial).
- 5 explicitly asked for access to residency slots.
- 2 wanted to waive or lower recency requirements.
- 2 felt licensing/certification requirements overall needed to be changed.
- 2 wanted appropriate committees to count education and experience abroad.
- 2 voiced concerns about opportunities for the utilization of appropriate skills.

Appendix F: Promising practices and pathways

	KEY FEATURES	OUTCOMES	LEAD ORG.	IMPLEMENTATION ISSUES – WHAT WOULD BE NEEDED?
PROGRAMS				
U.S.				
Welcome Back Initiatives (various sites)	<ul style="list-style-type: none"> Educational and professional assessment and guidance. Courses and workshops to address key barriers. Group activities and support. 	<ul style="list-style-type: none"> Good success in validating credentials (27%) and passing Board exams (16%). Low success rate in securing residencies (2.5% of the 4,022 physicians assisted between 2001 and 2011 at all Welcome Back sites, and 7-8% at the original site in San Francisco). Another 20% have pursued other health care professions. 	Nonprofits (with government and other grant funding)	<ul style="list-style-type: none"> Most successful sites have strong relationships with community colleges, incl. for ESL classes and intro-to-U.S.-health-care classes. Partnerships with medical schools have been more difficult to establish.
NAAD + Workforce Development Inc. (Minnesota)	<ul style="list-style-type: none"> Career counseling and pathway navigation. Social and financial support. Test preparation support. English proficiency support, and other workshops/learning sessions. Group activities and support. 	<ul style="list-style-type: none"> Good success in IMGs passing USLMEs and becoming ECFMG certified. Fairly low success rates in securing residencies (13%). 	Nonprofits (with state grant and other grant funding)	<ul style="list-style-type: none"> Funding to serve more IMGs and provide more comprehensive support. Closer ties to residency programs. More opportunities for IIMGs to gain clinical experience and demonstrate competence.
UCLA IMG Program (California)	<ul style="list-style-type: none"> 9-21 month program. Prep for Steps 1-3. Clinical observership and hands-on clerkship. Specialized courses in English. Stipends. Counseling and prep for FM residencies in California, incl. 2 letters of recommendation Limited to Spanish speakers. 	<ul style="list-style-type: none"> High success rate in placing graduates in residency (75-95%). 	University (with funding from foundations, health systems and corporations), possibly also state Medicaid reform funding.	<ul style="list-style-type: none"> Costs \$52,000-54,000 per student, with over 40% of that for stipends. Relies on private donations. May also receive support from the state’s Medicaid reform program.

	KEY FEATURES	OUTCOMES	LEAD ORG.	IMPLEMENTATION ISSUES – WHAT WOULD BE NEEDED?
	<ul style="list-style-type: none"> After residency, IMGs commit to practicing for 2-3 years in a Calif. Medically Underserved Area. 			
Prep for Residency (PRP) (Univ of Minnesota)	<ul style="list-style-type: none"> Orientation to the U.S. medical education system and Family Medicine (FM) 6 months of clinical experiences. English language enhancement. Simulation Lab training and residency-level workshops. Most instruction at individual or small group levels. \$1,000/month stipends. 	<ul style="list-style-type: none"> High success rate in participants securing residency (nearly 100%). Low # of applicants and participants. 	University (with state grant and/or internal funding)	<ul style="list-style-type: none"> Funding (original program required \$150,000+/year to support 3-4 participants; U's "ideal" PRP estimated at \$550K for 4 participants, not including costs to hospitals/clinics that participate). Ways of finding and assessing qualified candidates. Support for English and typing skills. Issue of limited residency slots, competition w/ better-known USMGs.
Tufts University School of Medicine – sponsored residency positions	<ul style="list-style-type: none"> Residency positions for IMGs "sponsored" (funded) by their home countries. Example: Saudi Arabian government pays all travel and living expenses for their medical graduates in residency (amount unclear, though each resident costs a hospital around \$60,000 a year, including a monthly stipend and benefits). 	International Affairs office in School of Medicine generally places 20 foreign residents among a network of 10 affiliated hospitals.	University (with "sponsorships" funded by other countries)	<ul style="list-style-type: none"> Funding/sponsorships for the residency slots. Partnership with medical school(s) to add designated residency positions.
CANADA				
Alberta IMG Program	<ul style="list-style-type: none"> Competitive application process. Pre-residency clinical assessment. Residency positions reserved for IMGs in the program and aligned with provincial physician needs. Residency positions are in a variety of disciplines, with half in family medicine and 	Each year, 40 participants placed in designated IMG residency positions (20 at the University of Alberta and 20 at the University of Calgary).	University (with funding from the Alberta government)	<ul style="list-style-type: none"> Funding. Partnership with medical school(s) to do pre-residency clinical assessments and add designated residency positions.

	KEY FEATURES	OUTCOMES	LEAD ORG.	IMPLEMENTATION ISSUES – WHAT WOULD BE NEEDED?
	most of balance in other primary care fields (IM, peds, etc.).			
University of British Columbia	<ul style="list-style-type: none"> ▪ Competitive application process. ▪ Pre-residency clinical assessment over 8 week period. ▪ Residency positions reserved for IMGs in the program. ▪ Participants can do just the clinical assessment and then compete in the overall match, or apply for the residencies reserved for IMGs. ▪ Return-of-service obligation (1 year of service for every year of residency, up to 3 years). 	<ul style="list-style-type: none"> ▪ Serves 60 IMGs each year. ▪ In 2014, 50% of the IMGs matched into a Canadian residency slot went through this clinical assessment program. 	University (with funding from the British Columbia govt)	<ul style="list-style-type: none"> ▪ Funding (British Columbia govt pays the University of British Columbia \$108,000 CAD per year per IMG residency slot). ▪ Partnership with medical school(s) to do pre-residency clinical assessments and add designated residency positions.
PATHWAYS				
CANADA				
College Des Mediciens Du Quebec (CMQ) – Restrictive Permit	<ul style="list-style-type: none"> ▪ IMGs <u>register</u> with the RSQ at the Quebec health ministry, which serves as the “portal of entry” for IMGs who wish to practice. ▪ IMG undergoes a <u>3-month clinical assessment</u> in a University-based or other approved site. Also must pass <u>language test</u> and a <u>3-hr class</u> on Quebec health care system. ▪ RSQ helps the IMG find facility in underserved region willing to <u>sponsor</u> the IMG. ▪ Once an employer sponsorship is obtained, the IMG applies to the CMQ for <u>restrictive permit</u>. ▪ IMG issued restrictive permit for one year, which <u>may be renewed each year or converted to a regular permit</u> (after 1 year after passing an exam, or after 5 years with no exam). 	<ul style="list-style-type: none"> ▪ About 60 restrictive permits have been issued each year since 2010, with about 13% of these in Family Medicine, though this number has been increasing (21% in 2013). 	<p>Govt agencies -- regulatory agency and health ministry</p> <p>Universities and other clinical sites (for assessments)</p> <p>Employers</p> <p>ECFMG (for verification of credentials)</p>	<ul style="list-style-type: none"> ▪ Mechanism for registry and matching to underserved sites. ▪ Partnerships with universities and other clinical sites for clinical assessments. ▪ Changes in licensing system – creation of new restrictive permit/licensing option.

	KEY FEATURES	OUTCOMES	LEAD ORG.	IMPLEMENTATION ISSUES – WHAT WOULD BE NEEDED?
AUSTRALIA				
Standard pathway – AMC Exams	<ul style="list-style-type: none"> • IMG must have proof of <u>English proficiency</u> and medical education verified by ECFMG. • IMG takes <u>two tests</u> via the Australian Medical Council (AMC): (1) clinical knowledge test; and (2) in-person clinical skills assessment. If passed, receives <u>AMC certificate</u>. • IMG secures <u>employment offer</u> and then applies to Medical Board of Australia (MBA) for <u>provisional registration</u> to practice. • With provisional registration, completes a <u>12-month period of supervised practice</u>. • After successful 12 months of supervised practice, can apply for <u>general registration</u>. 	<ul style="list-style-type: none"> • Many IMGs need to take the in-person clinical skills exam twice, paying \$4,000 each time and often having to wait 18-24 months to resit for the exam -- this is one of the reasons Australia is piloting the workplace-based assessment pathway (below). 	<p>Medical Board of Australia (MBA) (for permits)</p> <p>Australian Medical Council (AMC) (for assessment)</p> <p>Employers (for supervision)</p> <p>ECFMG (for credentials)</p>	<ul style="list-style-type: none"> • Mechanism for testing and clinical assessment. • Partnerships with employers for supervised practice. • Changes in licensing system – creation of new restrictive permit/licensing option.
Standard pathway – Workplace-based assessments	<ul style="list-style-type: none"> • Similar to Standard Pathway above, but the <u>clinical assessment is done in a workplace setting</u> after clinical knowledge test is passed. 	Only in pilot stage now, at limited sites.	Same as above but employer plays greater role (for assessment)	Same as above, with more intensive role for employers (to conduct assessment).
Competent Authority Pathway	<ul style="list-style-type: none"> • For IMGs <u>deemed eligible to practice by entities in particular countries</u> (the UK, the US, Canada, Ireland and New Zealand). • The IMG must secure an offer of employment and obtain verification of degree via the ECFMG. • The IMG applies for a provisional registration with the Board. The IMG may need to take a pre-employment structural interview (PESCI) if the Board determines it necessary. • After satisfactory completion of a 12-month period of supervised practice, the 		<p>MBA</p> <p>ECFMG (for verification of credentials)</p> <p>Employers (for supervised practice)</p>	<ul style="list-style-type: none"> • Mechanism for identifying “competent authorities.” • Partnerships with employers for supervised practice. • Changes in licensing system – creation of new restrictive permit/licensing option.

	KEY FEATURES	OUTCOMES	LEAD ORG.	IMPLEMENTATION ISSUES – WHAT WOULD BE NEEDED?
	<p>IMG is eligible to apply for general registration.</p> <ul style="list-style-type: none"> Process was streamlined as of July 2014 (previously the Australian Medical Council did assessment and issued a certificate at the end of the 12 months of supervised practice). 			
Specialist Pathway – Specialist recognition	<ul style="list-style-type: none"> After <u>verification of medical credentials</u>, the IMG applies to a relevant specialist medical college, which <u>assesses</u> whether the IMG is (a) not comparable to Australian-trained specialists in that field; (b) substantially comparable; or (c) partially comparable. If deemed not comparable, the IMG can take Standard Pathway or Competent Authority Pathway. If deemed partially or substantially comparable, the IMG secures an employment offer and applies for <u>limited or provisional registration</u>. Depending on the specifics of the college’s assessment, the IMG may need to undertake a period of peer review (oversight), which may involve a workplace-based assessment, or a period of supervised practice and further training. After completing the steps identified by the college, awarded a college fellowship or advised by college as eligible for fellowship. Applies to MBA for <u>specialist registration</u>. 		<p>AMC + ECFMG (for verification of creds)</p> <p>MBA (for registration)</p> <p>Specialist medical colleges (for assessment)</p>	<ul style="list-style-type: none"> Assessment fees vary by specialist college, but seem to average about \$5,000-6,000 (USD). Additional fees for AMC/MBA steps. Partnerships with specialist programs to conduct assessments. Mechanisms for follow-up assessments, training, etc. Changes in licensing system – creation of new restrictive permit/licensing option.
Specialist Pathway – Area of Need	<ul style="list-style-type: none"> An employer <u>IDs a specialist position</u> needed and works with a specialist college to prepare the job description and criteria. 		AMC (for verification of creds)	Same as specialist pathway above.

	KEY FEATURES	OUTCOMES	LEAD ORG.	IMPLEMENTATION ISSUES – WHAT WOULD BE NEEDED?
	<ul style="list-style-type: none"> The employer works with the state or territory health authority to <u>have the position declared an area-of-need position</u>. The IMG secures an <u>employment offer</u> for the position. The IMG obtains <u>verification</u> of medical credentials and applies to the relevant specialist medical college. The <u>college assesses the IMG’s qualifications</u> and experience against the requirements of the specific position. If deemed qualified, the IMG applies for <u>limited registration</u> to practice. This pathway does not necessarily lead to specialist recognition. To obtain that, the IMG must complete the requirements for that recognition (see above). Alternatively, they can pursue the Standard Pathway. 		<p>MBA (for registration)</p> <p>Specialist medical colleges (for assessment)</p> <p>Employer (to develop position)</p> <p>State or territory health authority (to authorize area of need position)</p>	<p>Mechanism for approving/declaring positions in “areas of need” (could be similar to current designations under National Health Service Corps).</p>
GERMANY				
Pathway to licensure (approbation)	<ul style="list-style-type: none"> Citizens of the European Union (EU) (with the exception of Bulgaria and Romania), the European Economic Area (EEA) and Switzerland are automatically recognized and allowed to practice. An IMG trained in another country (outside the EU, EEA or Switzerland) may apply for an <u>equivalency review</u>. The state (regional) health authority evaluates whether the basic medical training and qualifications are equivalent to training in Germany. Significant differences in qualifications can be offset by relevant professional experience. If deemed equivalent and other requirements are met (such as German 	<p>This is a relatively new system – a product of the 2012 German Recognition Act (an “Act to improve the assessment and recognition of foreign professional qualifications”). Before then it was more difficult for IMGs to become licensed in Germany.</p>	<p>State health authorities (for assessment, testing and licensing)</p> <p>State chambers of physicians (for specialty assessment)</p>	<ul style="list-style-type: none"> Mechanism for equivalency review and testing. Changes in licensing system – creation of new licensing option based on equivalency review and testing.

	KEY FEATURES	OUTCOMES	LEAD ORG.	IMPLEMENTATION ISSUES – WHAT WOULD BE NEEDED?
	<p>language proficiency), the IMG is granted an <u>Approbation (license)</u>.</p> <ul style="list-style-type: none"> • If the health authority finds substantial differences between the IMG’s qualifications and Germany’s, the IMG may take an <u>assessment test</u> (a 60-90 minute clinical-practical test with patient presentation) to prove the equivalence of his/her professional knowledge. If they pass, they are granted a license (Approbation). Until the test is passed and a license is obtained, the IMG may obtain a provisional license for up to 2 years to work under supervision. • <u>Other requirements:</u> <ul style="list-style-type: none"> ○ Proof of spoken and written German. Some states require a “Medical German” test be passed as well. ○ A certificate stating they are entitled to work as a doctor in their country. ○ Documents proving they intend to practice in Germany – including confirmation of employment by a hospital or clinical employer. • <u>Specialists</u> are assessed by specialty associations. They assess whether the content and duration of the IMG’s training complies with German training regulations for that specialty. Specialists must also complete at least 12 months of specialty training in Germany. 			

Notes

¹ Educational Commission for Foreign Medical Graduates [Internet]. *Definition of an IMG*. Available from: <http://www.ecfmg.org/certification/definition-img.html>. As the ECFMG notes, it is the location of the medical school that determines whether the physician is an IMG. Hence, if a non-U.S. citizen obtains their degree in the U.S., s/he is not considered an IMG.

² For the purposes of this report, “physician” refers to an individual with a medical degree from any part of the world, regardless of whether s/he is licensed to practice in Minnesota. It should be noted, however, that the designation “physician” has a specific, protected meaning under the Minnesota Medical Practice Act (Minnesota Statutes section 147.081, subdivision 3, Available from: <https://www.revisor.mn.gov/statutes/?id=147.081>).

³ Includes total cost of professional examinations, residency application-related costs and licensing fees as calculated in Massachusetts. Costs for immigrant physicians in other states (including Minnesota) are similar, as the exam, certification and residency application fees apply nationally. Millona A, Erwin S, Krame B. *Tapping the Potential of Foreign-Trained Engineering and Health Care Professionals in Massachusetts*. Appendix B: Medical License Requirements. Boston (MA): The New Americans Integration Institute [Internet]; 2014. Available from: http://www.miracoalition.org/images/stories/pdf/tapping%20the%20potential_final_appendices.pdf.

⁴ Rabben L. *Credential Recognition in the United States for Foreign Professionals*. Washington D.C.: Migration Policy Institute [Internet]; 2013. Available from: <http://www.migrationpolicy.org/research/credential-recognition-united-states-foreign-professionals>. Educational Commission for Foreign Medical Graduates. *2013 Annual Report*. Philadelphia (PA): Educational Commission for Foreign Medical Graduates [Internet]; 2014. Available from: <http://www.ecfmg.org/resources/ECFMG-2013-annual-report.pdf>.

⁵ For more on IMG history in the U.S., see American Medical Association-IMG Section Governing Council [Internet]. *International Medical Graduates in American Medicine: Contemporary Challenges and Opportunities*. Chicago (IL): American Medical Association; January 2013. Available from: <http://www.ama-assn.org/ama/pub/about-ama/our-people/member-groups-sections/international-medical-graduates.page>. The AMA report in turn draws on Ludmerer KM. *Learning to heal: the development of American medical education*. Baltimore (MD): Johns Hopkins University Press; 1996 and Ludmerer KM. *Time to Heal: American Medical Education from the Turn of the Century to the Era of Managed Care*. New York (NY): Oxford University Press; 1999.

⁶ Governor’s Advisory Council for Refugees and Immigrants [Internet]. *RX for Strengthening Massachusetts’ Economy and Healthcare System: A Report by The Governor’s Advisory Council for Refugees and Immigrants Task Force on Immigrant Healthcare Professionals in Massachusetts*. Boston (MA): The Commonwealth of Massachusetts; December 2014. Available from: http://miracoalition.org/images/stories/pdf/gac_task_force_report_final-12.18.14.pdf

⁷ Carnevale AP, Smith N, Gulish A, Beach BH. *Healthcare*. Washington DC: Georgetown University Center on Education and the Workforce; 2012. Georgetown's Center for Education and the Workforce has not conducted physician shortage analyses at the national or the state level. Their publication, *Healthcare*, only examines growth in physician employment from 2010 and 2020 (personal communication, A. Gulish, November 13, 2014).

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Minnesota Hospital Association [Internet]. *Registered nurses and primary care physicians: How will Minnesota fare in the next 10 years?* St. Paul (MN): Minnesota Hospital Association; July 2014. Available from: <http://www.mnhospitals.org/Portals/0/Documents/news/RNPCPWorkforceFinal.pdf>.

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supply in 2020 by the Georgetown Center for Education and the Workforce. Eden J, Berwick D, Wilensky G. (Eds). *Graduate medical education that meets the nation's health needs*. National Academies Press; 2014.

⁸ Minnesota State Demographic Center. *The Time for Talent: Why the Development, Recruitment, and Retention of Talent Is Key to a Prosperous Future for Minnesota*. St. Paul (MN): Minnesota State Demographic Center [Internet]; March 13, 2013. Available from: <http://mn.gov/admin/images/the-time-for-talent-msdc-march2013.pdf>.

⁹ Minnesota Department of Health. *Minnesota's Primary Care Workforce, 2011-2012*. St. Paul (MN): MDH [Internet]; September 2013. Available from: <http://www.health.state.mn.us/divs/orhpc/pubs/workforce/primary.pdf>.

¹⁰ Rabben L. Credential Recognition in the United States for Foreign Professionals. Washington D.C.: Migration Policy Institute [Internet]; 2013. Available from: <http://www.migrationpolicy.org/research/credential-recognition-united-states-foreign-professionals>. Jolly P, Erikson C, Garrison G, U.S. Graduate Medical Education and Physician Specialty Choice. *Academic Medicine*. 2013;88(4):468-474. Available from:

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¹¹ Hagopian A, Thompson MJ, Kaltenbach E, Hart LG. The role of international medical graduates in America's small rural critical access hospitals. *J Rural Health*. 2004;20:52-8. Baer LD, Konrad TR, Miller JS. The need of community health centers for international medical graduates. *Am J Public Health*. 1999;98:1570-4.

¹² Minnesota State Demographic Center and U.S. Census Bureau, Decennial Census and Population Estimates. Available from: <http://mn.gov/admin/demography/data-by-topic/aging/>

¹³ Minnesota State Demographic Center, *The Long Run Has Become the Short Run: Budget Implications of Demographic Change*. St. Paul (MN): Minnesota State Demographic Center; February 2011. Available from: <http://mn.gov/admin/images/long-run-has-become-the-short-run-msdc-feb2011.pdf>

¹⁴ Minnesota Compass. *Immigration – Overview*. Available from: <http://www.mncompass.org/immigration/overview>.

¹⁵ Ibid.

¹⁶ Gambino CP, Trevelyan EN, Fitzwater JT. *The Foreign-Born Population From Africa: 2008-2012*. American Community Survey Briefs. Washington DC: US Census Bureau [Internet]; October 2014. Available from: <http://www.census.gov/content/dam/Census/library/publications/2014/acs/acsbr12-16.pdf>

¹⁷ Chicago Council on Global Affairs, Immigration Task Force. *Minnesota Demographic Characteristics, 2012*. Chicago (IL): The Chicago Council on Global Affairs [Internet]. Available from <http://midwestimmigration.org/in-your-state/overview/state/minnesota> cited in Corrie B and Radosevich S. *The Economic Contributions of Immigrants in Minnesota*. St. Paul (MN): Minnesota Chamber of Commerce [Internet]; September 2013. Available from: http://cdn2.hubspot.net/hub/172912/file-371412567-pdf/Economic_Contributions_of_Immigrants_in_Minnesota_2013.pdf

¹⁸ U.S. Office of Refugee Resettlement:

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CHAPTER 71--S.F.No. 1458**Sec. 17. [144.1911] INTERNATIONAL MEDICAL GRADUATES ASSISTANCE PROGRAM.**

Subdivision 1. **Establishment.** The international medical graduates assistance program is established to address barriers to practice and facilitate pathways to assist immigrant international medical graduates to integrate into the Minnesota health care delivery system, with the goal of increasing access to primary care in rural and underserved areas of the state.

Subd. 2. **Definitions.** (a) For the purposes of this section, the following terms have the meanings given.

(b) "Commissioner" means the commissioner of health.

(c) "Immigrant international medical graduate" means an international medical graduate who was born outside the United States, now resides permanently in the United States, and who did not enter the United States on a J1 or similar nonimmigrant visa following acceptance into a United States medical residency or fellowship program.

(d) "International medical graduate" means a physician who received a basic medical degree or qualification from a medical school located outside the United States and Canada.

(e) "Minnesota immigrant international medical graduate" means an immigrant international medical graduate who has lived in Minnesota for at least two years.

(f) "Rural community" means a statutory and home rule charter city or township that is outside the seven-county metropolitan area as defined in section 473.121, subdivision 2, excluding the cities of Duluth, Mankato, Moorhead, Rochester, and St. Cloud.

(g) "Underserved community" means a Minnesota area or population included in the list of designated primary medical care health professional shortage areas, medically underserved areas, or medically underserved populations (MUPs) maintained and updated by the United States Department of Health and Human Services.

Subd. 3. **Program administration.** In administering the international medical graduates assistance program, the commissioner shall:

(1) provide overall coordination for the planning, development, and implementation of a comprehensive system for integrating qualified immigrant international medical graduates into the Minnesota health care delivery system, particularly those willing to serve in rural or underserved communities of the state;

(2) develop and maintain, in partnership with community organizations working with international medical graduates, a voluntary roster of immigrant international medical graduates interested in entering the Minnesota health workforce to assist in planning and program administration, including making available summary reports that show the aggregate number and distribution, by geography and specialty, of immigrant international medical graduates in Minnesota;

(3) work with graduate clinical medical training programs to address barriers faced by immigrant international medical graduates in securing residency positions in Minnesota, including the requirement that applicants for residency positions be recent graduates of medical school. The annual report required in subdivision 10 shall include any progress in addressing these barriers;

(4) develop a system to assess and certify the clinical readiness of eligible immigrant international medical graduates to serve in a residency program. The system shall include assessment methods, an operating plan, and a budget. Initially, the commissioner may develop assessments for clinical readiness for practice of one or more primary care specialties, and shall add additional assessments as resources are available. The commissioner may contract with an independent entity or another state agency to conduct the assessments. In order to be assessed for clinical readiness for residency, an eligible international medical graduate must have obtained a certification from the Educational Commission of Foreign Medical Graduates. The commissioner shall issue a Minnesota certificate of clinical readiness for residency to those who pass the assessment;

(5) explore and facilitate more streamlined pathways for immigrant international medical graduates to serve in nonphysician professions in the Minnesota workforce; and

(6) study, in consultation with the Board of Medical Practice and other stakeholders, changes necessary in health professional licensure and regulation to ensure full utilization of immigrant international medical graduates in the Minnesota health care delivery system. The commissioner shall include recommendations in the annual report required under subdivision 10, due January 15, 2017.

Subd. 4. **Career guidance and support services.** (a) The commissioner shall award grants to eligible nonprofit organizations to provide career guidance and support services to immigrant international medical graduates seeking to enter the Minnesota health workforce. Eligible grant activities include the following:

(1) educational and career navigation, including information on training and licensing requirements for physician and nonphysician health care professions, and guidance in determining which pathway is best suited for an individual international medical graduate based on the graduate's skills, experience, resources, and interests;

(2) support in becoming proficient in medical English;

(3) support in becoming proficient in the use of information technology, including computer skills and use of electronic health record technology;

(4) support for increasing knowledge of and familiarity with the United States health care system;

(5) support for other foundational skills identified by the commissioner;

(6) support for immigrant international medical graduates in becoming certified by the Educational Commission on Foreign Medical Graduates, including help with preparation for required licensing examinations and financial assistance for fees; and

(7) assistance to international medical graduates in registering with the program's Minnesota international medical graduate roster.

(b) The commissioner shall award the initial grants under this subdivision by December 31, 2015.

Subd. 5. **Clinical preparation.** (a) The commissioner shall award grants to support clinical preparation for Minnesota international medical graduates needing additional clinical preparation or experience to qualify for residency. The grant program shall include:

(1) proposed training curricula;

(2) associated policies and procedures for clinical training sites, which must be part of existing clinical medical education programs in Minnesota; and

(3) monthly stipends for international medical graduate participants. Priority shall be given to primary care sites in rural or underserved areas of the state, and international medical graduate participants must commit to serving at least five years in a rural or underserved community of the state.

(b) The policies and procedures for the clinical preparation grants must be developed by December 31, 2015, including an implementation schedule that begins awarding grants to clinical preparation programs beginning in June of 2016.

Subd. 6. **International medical graduate primary care residency grant program and revolving account.** (a) The commissioner shall award grants to support primary care residency positions designated for Minnesota immigrant physicians who are willing to serve in rural or underserved areas of the state. No grant shall exceed \$150,000 per residency position per year. Eligible primary care residency grant recipients include accredited family medicine, internal medicine, obstetrics and gynecology, psychiatry, and pediatric residency programs. Eligible primary care residency programs shall apply to the commissioner. Applications must include the number of anticipated residents to be funded using grant funds and a budget. Notwithstanding any law to the contrary, funds awarded to grantees in a grant agreement do not lapse until the grant agreement expires. Before any funds are distributed, a grant recipient shall provide the commissioner with the following:

(1) a copy of the signed contract between the primary care residency program and the participating international medical graduate;

(2) certification that the participating international medical graduate has lived in Minnesota for at least two years and is certified by the Educational Commission on Foreign Medical Graduates. Residency programs may also require that participating international medical graduates hold a Minnesota certificate of clinical readiness for residency, once the certificates become available; and

(3) verification that the participating international medical graduate has executed a participant agreement pursuant to paragraph (b).

(b) Upon acceptance by a participating residency program, international medical graduates shall enter into an agreement with the commissioner to provide primary care for at least five years in a rural or underserved area of Minnesota after graduating from the residency program and make payments to the revolving international medical graduate residency account for five years beginning in their second year of postresidency employment. Participants shall pay \$15,000 or ten percent of their annual compensation each year, whichever is less.

(c) A revolving international medical graduate residency account is established as an account in the special revenue fund in the state treasury. The commissioner of management and budget shall credit to the account appropriations, payments, and transfers to the account. Earnings, such as interest, dividends, and any other earnings arising from fund assets, must be credited to the account. Funds in the account are appropriated annually to the commissioner to award grants and administer the grant program established in paragraph (a). Notwithstanding any law to the contrary, any funds deposited in the account do not expire. The commissioner may accept contributions to the account from private sector entities subject to the following provisions:

(1) the contributing entity may not specify the recipient or recipients of any grant issued under this subdivision;

(2) the commissioner shall make public the identity of any private contributor to the account, as well as the amount of the contribution provided; and

(3) a contributing entity may not specify that the recipient or recipients of any funds use specific products or services, nor may the contributing entity imply that a contribution is an endorsement of any specific product or service.

Subd. 7. Voluntary hospital programs. A hospital may establish residency programs for foreign-trained physicians to become candidates for licensure to practice medicine in the state of Minnesota. A hospital may partner with organizations, such as the New Americans Alliance for Development, to screen for and identify foreign-trained physicians eligible for a hospital's particular residency program.

Subd. 8. Board of Medical Practice. Nothing in this section alters the authority of the Board of Medical Practice to regulate the practice of medicine.

Subd. 9. Consultation with stakeholders. The commissioner shall administer the international medical graduates assistance program, including the grant programs described under subdivisions 4, 5, and 6, in consultation with representatives of the following sectors:

(1) state agencies:

(i) Board of Medical Practice;

(ii) Office of Higher Education; and

(iii) Department of Employment and Economic Development;

(2) health care industry:

(i) a health care employer in a rural or underserved area of Minnesota;

(ii) a health plan company;

(iii) the Minnesota Medical Association;

(iv) licensed physicians experienced in working with international medical graduates; and

(v) the Minnesota Academy of Physician Assistants;

(3) community-based organizations:

- (i) organizations serving immigrant and refugee communities of Minnesota;
- (ii) organizations serving the international medical graduate community, such as the New Americans Alliance for Development and Women's Initiative for Self Empowerment; and
- (iii) the Minnesota Association of Community Health Centers;
- (4) higher education:
 - (i) University of Minnesota;
 - (ii) Mayo Clinic School of Health Professions;
 - (iii) graduate medical education programs not located at the University of Minnesota or Mayo Clinic School of Health Professions; and
 - (iv) Minnesota physician assistant education program; and
- (5) two international medical graduates.

Subd. 10. Report. The commissioner shall submit an annual report to the chairs and ranking minority members of the legislative committees with jurisdiction over health care and higher education on the progress of the integration of international medical graduates into the Minnesota health care delivery system. The report shall include recommendations on actions needed for continued progress integrating international medical graduates. The report shall be submitted by January 15 each year, beginning January 15, 2016.

From appropriations rider:

International Medical Graduate Assistance Program. (a) \$500,000 in fiscal year 2016 and \$500,000 in fiscal year 2017 are from the health care access fund for the grant programs and necessary contracts under Minnesota Statutes, section 144.1911, subdivisions 3, paragraph (a), clause (4), and 4 and 5. The commissioner may use up to \$133,000 per year of the appropriation for international medical graduate assistance program administration duties in Minnesota Statutes, section 144.1911, subdivisions 3, 9, and 10, and for administering the grant programs under Minnesota Statutes, section 144.1911, subdivisions 4, 5, and 6. The commissioner shall develop recommendations for any additional funding required for initiatives needed to achieve the objectives of Minnesota Statutes, section 144.1911. The commissioner shall report the funding recommendations to the legislature by January 15, 2016, in the report required under Minnesota Statutes, section 144.1911, subdivision 10. The base for this purpose is \$1,000,000 in fiscal years 2018 and 2019.

(b) \$500,000 in fiscal year 2016 and \$500,000 in fiscal year 2017 are from the health care access fund for transfer to the revolving international medical graduate residency account established in Minnesota Statutes, section 144.1911, subdivision 6. This is a onetime appropriation.

International Medical Graduate (IMG) Program

The Minnesota Department of Health is supporting the integration of international medical graduates (IMG) through the implementation of the International Medical Graduate Assistance Program. The Minnesota Legislature established this program, in 2015 Minnesota Session Laws, [Chapter 71](#), Article 8, Section 17, to address barriers to practice and facilitate pathways to assist immigrant international medical graduates (IIMG) to integrate into the Minnesota health care delivery system, with the goal of increasing access to primary care in rural and underserved areas of the state.

Read the [International Medical Graduate Assistance Program: Report to the Minnesota Legislature, January 2016 \(PDF\)](#)

This comprehensive approach to IIMG integration into the Minnesota health care delivery system requires MDH to:

Develop and maintain a **voluntary roster** of IIMGs interested in entering the Minnesota Health workforce.

Develop **clinical readiness assessment** of eligible IIMGs to serve in a residency program.

Award grants to nonprofit organizations to provide **career guidance and support services** to IIMGs seeking to enter the Minnesota health workforce

Award grants to support **clinical preparation** for Minnesota IIMGs needing additional clinical preparation or experience to qualify for residency.

Award grants to support **primary care residency positions** designated for Minnesota IIMGs who are willing to serve in rural or underserved areas of the state.

Collaborate with graduate clinical medical training programs to address barriers faced by IIMGs in securing residency positions in Minnesota

Explore and facilitate more streamlined pathways for IIMG to serve in non-physician professions in the Minnesota Workforce.

Study in consultation with the Board of Medical Practice and other stakeholders, changes necessary in health professional licensure and regulation to ensure full utilization of IIMG in the Minnesota health care delivery system

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International Medical Graduate Assistance Program: Report to the Minnesota Legislature

JANUARY 2016

International Medical Graduate Assistance Program: Report to the Minnesota Legislature

January 2016

Minnesota Department of Health
Division of Health Policy
Office of Rural Health & Primary Care



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Minnesota
Department
of Health

PROTECTING, MAINTAINING AND IMPROVING THE HEALTH OF ALL MINNESOTANS

March 9, 2016

The Honorable Matt Dean
Chair, Health and Human Services Finance
401 State Office Building
100 Rev. Dr. Martin Luther King Jr. Blvd.
St. Paul, MN 55155

The Honorable Tara Mack
Chair, Health and Human Services Reform
545 State Office Building
100 Rev. Dr. Martin Luther King Jr. Blvd.
Saint Paul, MN 55155

The Honorable Tony Lourey
Chair, Health and Human Services Finance
2105 Minnesota Senate Building
95 University Avenue West
St. Paul, MN 55155

The Honorable Kathy Sheran
Chair, Health, Human Services and Housing
2103 Minnesota Senate Building
95 University Ave West
St. Paul, MN 55155

Honorable Chairs:

I am pleased to present this report of the International Medical Graduate (IMG) Assistance Program, as authorized by 2015 Minnesota Statutes, Section 144.1911.

In the last few months, MDH and stakeholders have made great strides in establishing a strong foundation for the IMG Assistance program by engaging additional stakeholders, working across state agencies, issuing grants, and developing programmatic policies and procedures.

Once again, Minnesota is leading the nation in health care innovation as the first state to implement a comprehensive program to integrate immigrant medical graduates into the physician workforce, taking an important first step to realize the potential of these uniquely qualified professionals to address pressing issues like healthcare disparities, workforce shortages and rising health care costs. This program is an important strategy to improve health equity in Minnesota.

I thank you for your commitment to Minnesota and all who live here. I welcome your questions and thoughts on how we can work together to strengthen Minnesota's health workforce and improve health equity for new Americans and the entire population.

Sincerely,

A handwritten signature in black ink, appearing to read "Edward P. Ehlinger", with a horizontal line extending from the end of the signature.

Edward P. Ehlinger, M.D., M.S.P.H.
Commissioner
P.O. Box 64975
St. Paul, MN 55164-0975

Acknowledgements

MDH staff would like to thank the members and chair of the IMG Assistance Program Stakeholder Group and other key partners for their dedication and collaboration. So many continue to give so much, all on a volunteer basis and all in the spirit of helping our state break new ground in expanding health access and health equity. For a full list of Members of the Stakeholder Group, see Appendix C on pages 28-30.

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Executive Summary

Background

While Minnesota's population is growing and becoming increasingly diverse, the state's primary care workforce is not keeping pace. Currently, 19% of Minnesota's population is comprised of minority and immigrant communities, but just 13% of the primary care workforce is from minority and immigrant communities. At the same time, Minnesota is projected to experience a shortage of primary care providers in the next decade.

In addition, Minnesota has among the worst health disparities in the nation, with minority and immigrant populations experiencing poorer health outcomes and poorer general health than their white counterparts.

Studies suggest that greater diversity in the health workforce, specifically increased cultural and linguistic competency, leads to improved clinical outcomes for racial minorities and immigrant populations.¹ One strategy to increase both the number and diversity of primary care providers is to integrate people trained as physicians in other countries into medical practice or an alternate health profession in Minnesota.

In response to these issues, the 2014 Legislature created a task force on foreign trained physicians, whose report documented the significant and longstanding barriers immigrant physicians face in securing medical residency and becoming licensed physicians. The task force also made recommendations to integrate these physicians into the health care workforce, which became the basis for the 2015 Legislature's creation of the International Medical Graduate (IMG) Assistance Program.

The IMG Assistance Program makes a powerful statement about the value that these individuals can provide in terms of both expanding access to care and diversifying Minnesota's health care workforce. It is also an innovative complement to other health care workforce development programs in Minnesota, which can address barriers to practice and facilitate pathways to assist the integration of IMGs into the Minnesota health care delivery system, with the goal of increasing access to primary care in rural and underserved areas of the state and decreasing health disparities.

¹ Joiner, J. Racial Concordance as a Method to Decrease Healthcare Disparities. [Internet] Available from: http://www.cwru.edu/med/epidbio/mphp439/Racial_Concordance.pdf

Activities to Date

In the initial six months since the IMG Assistance Program was created by the Legislature, MDH has implemented the following program elements:

Program Administration

The program is being implemented in consultation with a stakeholder group including representatives from state agencies (the Board of Medical Practice, the Office of Higher Education, Minnesota Department of Employment and Economic Development), the health care industry, provider associations including the Minnesota Academy of Physician Assistants, community-based organizations, higher education, and the Immigrant International Medical Graduate (IIMG) community. The stakeholder group has met twice to date.

Program Components

- 1) Roster:** With the help of community organizations, the new IMG program has developed an initial list of 99 immigrant physicians currently interested in entering the Minnesota healthcare workforce. As the program becomes more established, the number of IMG on the list is expected to grow. (It is estimated that there are approximated 250-400 IMGs living in Minnesota.)
- 2) Collaboration to address barriers to residency:** A major barrier to residency is the recency of the year of graduation from medical school. Stakeholders have surveyed primary care residency program directors at the University of Minnesota and all reported that they would be willing to relax the requirement relating to the year of graduation if the applicant demonstrated that they passed a rigorous clinical assessment and participated in an in-depth clinical experience in the US.
- 3) Clinical Assessment:** Statute directs MDH to establish a process to assess and certify the clinical readiness of eligible immigrant international medical graduates to serve in a residency program. MDH has conducted the background research and as of January 2016 is beginning the process to contract with a qualified entity to develop the Minnesota IIMG Clinical Assessment.
- 4) Career Guidance and Support:** This component of the program includes information on training and licensing requirements for physician and nonphysician health care professions, and guidance in determining which pathway is best suited for an individual international medical graduate based on the graduate's skills, experience, resources, and interests; support in becoming proficient in medical English; support in becoming proficient in the use of information technology, including computer skills and use of electronic health record technology; and support for increasing knowledge of and familiarity with the United States health care system and preparation for the licensing exams.

The MN Department of Employment and Economic Development (DEED) and MDH executed an interagency agreement which will supplement funds at MDH for these activities. MDH will invite eligible nonprofits to submit proposals for the 2016 IMG Career Guidance and Support Grant Program in January 2016.

- 5) **Clinical Preparation and Experience:** MDH and stakeholders have developed the policies and procedures for the clinical preparation and experience. The prerequisite to participation is completing the clinical assessment, which will determine the length of the clinical experience. IMGs will then participate in a post assessment which will lead to a certificate of clinical readiness.
- 6) **Dedicated Residency Positions:** The University of Minnesota Pediatric Residency Program was selected as the first recipient of funding from the International Medical Graduate Primary Care Residency Grant Program and is in the process of selecting a resident. The resident will begin in March 2016.

Conclusion

Minnesota is the first state in the nation to implement a comprehensive program to integrate immigrant medical graduates into the physician workforce, taking an important and innovative first step to realize the potential of these uniquely qualified professionals to address pressing issues like healthcare disparities and workforce shortages.

In the last few months, MDH and stakeholders have made great strides in establishing a strong foundation for the IMG Assistance program by engaging additional partners, working across state agencies, issuing grants, and developing policies and procedures.

This program is positioned to have great impact, both for the individual immigrant medical graduates who participate in it and for the future patients that they may serve. However, MDH and stakeholders also realize that its reach may be limited, given the number of IMGs in Minnesota and those likely to arrive in the future. MDH and stakeholders look forward to implementing the next steps, including developing strategies to leverage additional funding sources and continuing to explore changes necessary in health professional licensure and regulation to ensure full utilization of immigrant international medical graduates in the Minnesota health care delivery system.

Introduction

While Minnesota's population is growing and becoming increasingly diverse, the state's primary care workforce is not keeping pace. Currently, 19% of Minnesota's population is comprised of minority and immigrant communities, but just 13% of the primary care workforce is from minority and immigrant communities. At the same time, Minnesota is projected to experience a shortage of primary care providers in the next decade.

In addition, Minnesota has among the worst health disparities in the nation, with minority and immigrant populations experiencing poorer health outcomes and poorer general health than their white counterparts.

Studies suggest that greater diversity in the health workforce, specifically increased cultural and linguistic competency, leads to improved clinical outcomes for racial minorities and immigrant populations.² One strategy to increase both the number and diversity of primary care providers is to integrate people trained as physicians in other countries into medical practice or an alternate health profession in Minnesota.

In response to these issues, the 2014 Legislature created a task force on foreign trained physicians, whose report documented the significant and longstanding barriers immigrant physicians face in securing medical residency, which is required to become a Minnesota licensed physician. The task force also made recommendations to integrate these physicians into the health care workforce, which became the basis for the 2015 Legislature's creation of the International Medical Graduate (IMG) Assistance Program.

The International Medical Graduate (IMG) Assistance Program ([2015 Minnesota Statutes, Section 144.1911](https://www.revisor.mn.gov/statutes/?id=144.1911) <https://www.revisor.mn.gov/statutes/?id=144.1911>) is designed to address barriers to practice and facilitate pathways to assist immigrant IMGs to integrate into the Minnesota health care delivery system, with the goal of increasing access to primary care in rural and underserved areas of the state.

Pursuant to subdivision 10 of that law, this report represents the Department's annual report on the progress of IMG integration activities, including recommendations on actions needed for continued progress integrating IMGs.

² Id.

In collaboration with a multidisciplinary stakeholder group, community-based grantees, contractors, medical schools and medical residency programs, the IMG Assistance Program works to provide the following services (see Appendix B for the continuum of services):

- Gateway and Navigation (roster enrollment, career navigation, United States Medical Licensing Exam (USMLE) prep and ECFMG certification)
- Foundational Skill Building (medical English training, orientation to U.S. health care system, IT/typing skills training)
- Clinical Assessment
- Clinical Preparation (clinical instruction, clinical experience, letters of reference)
- Clinical Certification
- Residency Application Assistance
- Residency positions

Detailed information about the IMG Assistance Program is available on the [IMG Assistance Program website](http://www.health.state.mn.us/divs/orhpc/img/index.html) (<http://www.health.state.mn.us/divs/orhpc/img/index.html>).

This legislation reflected many of the recommendations presented in the [Task Force on Foreign-Trained Physicians Report to the Minnesota Legislature in January 2015](http://www.health.state.mn.us/divs/orhpc/workforce/iimg/finalrpt.pdf) (<http://www.health.state.mn.us/divs/orhpc/workforce/iimg/finalrpt.pdf>). (See Appendix C for a summary of the recommendations and how those compare to the final law). The Task Force report provides rich background on the rationale, policy drivers and potential of the new program. Additional background information is available on the [Task Force website](http://www.health.state.mn.us/divs/orhpc/workforce/iimg/meetings.html) (<http://www.health.state.mn.us/divs/orhpc/workforce/iimg/meetings.html>).

Background

The challenge of integrating foreign-trained physicians is complex and long-standing. In Minnesota, the issue has recently gained urgency as policy makers seek to address several major issues facing the state:

- Shortages in the supply of physicians
- An aging and diversifying population
- Persistent health disparities
- Rising health care costs

The Task Force concluded that integrating more immigrant physicians into Minnesota's health workforce could help address each of these issues, based on the following findings:

1. **Comparison of the licensed physician workforce to the population overall**
 - The licensed physician workforce is older than Minnesota's population.
 - The physician workforce does not mirror the state's racial and ethnic composition.
 - Licensed foreign-trained physicians represent 16 percent of the physician workforce, but most of Minnesota's largest immigrant and refugee communities are underrepresented.
2. **Identification of immigrant physicians seeking to enter the health workforce**
 - Minnesota is currently home to an estimated 250-400 unlicensed immigrant physicians.
 - In a survey of the state's immigrant physicians, 87 percent of respondents were interested in entering medical practice or other health careers in Minnesota.
 - Among the survey respondents, 37 countries were represented and over 30 languages.
 - Just over half of the survey respondents were eligible to apply for medical residency, but only a small minority (17 percent) has been accepted into a residency program.
3. **Identification of barriers to practice.** Immigrant physicians face a range of barriers, with the following most significant:
 - *Growing competition for limited residency spots:* While 95 percent of seniors in U.S. medical schools get into medical residency, most immigrant physicians do not. This competition will get even tougher with the "residency bottleneck:" increasing numbers of medical graduates competing for a capped number of residency slots,
 - *"Recency" of graduation from medical school:* Most U.S. residency programs consider only those who have graduated from medical school within three to five years. Consequently, many of the most highly qualified immigrant physicians – those

who have practiced extensively since medical school – are essentially disqualified at this point in the path to licensure.

- *Lack of recognized clinical experience:* Most American residency programs prefer or even require that applicants have clinical experience acquired in the U.S., but such hands-on experience is nearly impossible to obtain outside of medical school or residency.
- *Complexity and costs of testing and other steps needed to qualify for residency:* Foreign-trained physicians often need assistance in English proficiency, exam preparation and navigating the path to licensure. Assistance programs are crucial, but will continue to have only limited success if other structural barriers go unaddressed.

The Task Force concluded that Minnesota has a valuable and underused resource in its population of immigrant physicians, many of whom stand willing and qualified to serve as primary care providers in rural and underserved communities of the state. It also concluded that Minnesota could effectively address the obstacles faced by those physicians if it undertook strategic, coordinated, public-private action. When implemented, these strategies could produce a larger and more diverse primary care workforce capable of reducing both health disparities and health costs in Minnesota. These findings are discussed in greater detail in the 2014 Task Force report, available at:

<http://www.health.state.mn.us/divs/orhpc/workforce/iimg/finalrpt.pdf>

Definitions

International Medical Graduates (IMGs) are defined as individuals who obtained their basic medical degree outside the U.S. and Canada.³ IMGs in the U.S. include several distinct subsets: (1) U.S.-born citizens who obtained their medical degree overseas (most commonly in the Caribbean or Central America); (2) foreign-born individuals who reside in the U.S. on non-immigrant visas (such as J-1, O-1 or H1-B visas) and (3) immigrants to the U.S. classified as either permanent residents (“green card” holders), U.S. citizens, asylees or refugees.

Pursuant to the law authorizing it, **the IMG Assistance Program focuses specifically on category (3), herein referred to as Immigrant IMGs (IIMGs), and specifically IIMGs not licensed to practice medicine in the U.S.**

³ Educational Commission for Foreign Medical Graduates. Definition of an IMG. Available from: <http://www.ecfm.org/certification/definition-img.html>. As the ECFMG notes, it is the location of the medical school that determines whether the physician is an IMG. Hence, if a non-U.S. citizen obtains their degree in the U.S., s/he is not considered an IMG.

Activities to Date

The International Medical Graduate (IMG) Assistance Program is the first multi-component state program in the U.S. to assist immigrant international medical graduates (IIMGs) with integrating into the health care delivery system. As such, much of its start-up work in the first year, particularly establishing an administrative foundation and developing program elements with an eye to maximum long-term impact and value for the state of Minnesota, has had few or no existing models to draw from. Despite the challenges of scaling the program to available funds and designing a first-of-its-kind program from scratch, the program has accomplished much in its first seven months and is well-positioned to help integrate growing numbers of IIMGs in their quest to serve in Minnesota's health care system.

Program Administration

Funding for the program became available in July 2015 and a coordinator was hired in September 2015.

The program is being implemented in consultation with a variety of stakeholders, guided by a highly engaged stakeholder group that builds on the success of the 2014 Task Force, which brought together an unprecedented combination of individuals and organizations. The membership of the stakeholder group includes representatives from state agencies including the Board of Medical Practice and the Office of Higher Education, the health care industry, provider associations including the Minnesota Academy of Physician Assistants, community-based organizations, higher education, and the IIMG community. (See Appendix D: Roster of stakeholder group). The IIMG Assistance Program Stakeholder group meets quarterly and has subgroups or workgroups which meet in between the quarterly meetings. The workgroups are:

- Clinical Assessment and Experience
- Nonphysician Professions
- Licensing
- Financial Aid

These work groups include additional stakeholders beyond those serving on the overall stakeholder group, and include additional representatives from the Minnesota Medical Association and Board of Medical Practice.

Program Components

1. Roster

Legislative charge: [D]evelop and maintain, in partnership with community organizations working with international medical graduates, a voluntary roster of immigrant international medical graduates interested in entering the Minnesota health workforce to assist in planning and program administration, including making available summary reports that show the aggregate number and distribution, by geography and specialty, of immigrant international medical graduates in Minnesota. (M.S. 144.1911, subd. 3, clause (2))

Last year's Task Force estimated that Minnesota is home to approximately 250-400 immigrant physicians who are not able to practice here because of barriers to licensure. This estimate was made without the benefit of any official, ongoing count of the total number of unlicensed immigrant physicians living in the state. This led to the recommendation that a centralized, voluntary roster of those interested in entering the Minnesota health workforce be created to provide better and more consistent information about the pool of immigrant physicians in the state and their qualifications and interests. This would, in turn, guide planning and program administration for maximum impact.

Progress to Date

With the help of community organizations, the new IMG program has developed an initial database of 99 immigrant physicians currently interested in entering Minnesota health care workforce. This initial database is simply the starting point and will be used to build the full IMG Roster, which will collect the following information:

- Name
- Home Country
- Country of Medical Education
- Date of Medical School Graduation
- Specialty / Area of Practice
- Date of Entry into the US
- Date of Entry into Minnesota
- Minnesota County of Residency
- Current Employment
- Languages Spoken
- Desire to pursue US Medical Licensure (Y/N)
- USMLE tests taken and scores
- ECFMG Certified (Y/N)
- Have you applied for Residency
- If so, how many times? Any interviews? Did you secure a residency position (Y/N)
- If you secured a residency position, what was the specialty area of practice?

- Have you completed residency in the US? If so what is your current area of practice? Is it in a rural or underserved area?

The program is currently reviewing the technology options available to build and host the IMG Roster. The current options are minimal, static and do not allow for continual interaction and updates. The ability to interact and update the data will not only help identify IMGs in Minnesota but will help the program track their progress of integration into the health care system and will offer a recruitment pool for medical residency programs and other alternative professional opportunities, such as internships for the expansion of the public health workforce.

The next step is to continue populating the current database as we invite more IMGs to participate through outreach and recruitment with our partners and through the application and intake process of the grant programs. We will also explore funding options to build a more robust, interactive IMG Roster that could include features such as an initial self-assessment to quickly direct people to next steps. An enhanced Roster could also be an official source of information on health professionals who have unique skills such as competency in particular cultures, specific language skills, etc., that would be available to potential pre-residency employers, residency and Physician Assistant programs. It could also serve as a platform for identifying and working with immigrants in other health occupations.

2. Collaboration to address barriers to residency

Legislative charge: [W]ork with graduate clinical medical training programs to address barriers faced by immigrant international medical graduates in securing residency positions in Minnesota, including the requirement that applicants for residency positions be recent graduates of medical school. (M.S. 144.1911, subd. 3, clause (3)).

One of the main reasons immigrant physicians struggle to secure a medical residency is out of their control: most U.S. residency programs consider only “recent” graduates from medical school, typically requiring graduation within three to five years of application to residency. As a result, some of the most highly qualified immigrant physicians – those who have practiced extensively since medical school – are essentially disqualified at this point in the pathway to licensure.

The primary rationale for these “recency” guidelines is the need for residents to be as up-to-date as possible on medical knowledge, treatment methods and protocols, and technology, particularly given how swiftly the health care field is changing. The 2014 Task Force concluded these valid concerns could be addressed in new, more effective ways that would benefit residency programs and immigrant physicians alike, and that these innovations alone could go a long way toward integrating more immigrant physicians into the health workforce.

Progress to Date

As indicated earlier, one of the workgroups of the Stakeholder group is Clinical Assessment and Clinical Preparation. Collaborating with clinical medical training programs to address the recency issue falls within the purview of this workgroup.

As an initial step, the work group conducted a survey of the six primary care residency program directors at the University of Minnesota and asked:

- a) Does your program eligibility include:
 - Graduation for medical school within five years of date of program application and;
 - U.S. clinical experience?
- b) Under what circumstances are you willing to relax those requirements?

The responses confirmed that a majority of the programs require applicants to have graduated from medical school within the last five years. One program requires applicants to have graduated from medical school within the last five years *or* practiced medicine within the last three years. Two programs evaluate the year of graduation on a case-by-case basis. However, they reported that the applications of those who graduated from medical school more than five years ago are under increased scrutiny.

All program directors reported that they would be willing to relax the requirement relating to the year of graduation if the applicant demonstrated that they had passed a rigorous clinical assessment and participated in an in-depth clinical experience in the United States.

We also learned that all program directors value IMGs and the cultural competencies IMGs add to the practice of medicine in Minnesota. Many work with IMGs. However, they generally work with IMGs who are on J-1 or H1-B visas⁴ and not IMGs who have immigrated to Minnesota (the focus of this program).

To address this opportunity, the program will next work to finalize the clinical assessment and clinical experience program (described below) and work with the program directors to ensure that its components meet the requirements of being rigorous and in-depth. Our partners at the University of Minnesota are also conducting a review of past IIMG applications to residency programs to identify the impact of the recency issue in obtaining a residency position and to identify ways in which IIMGs can highlight their competencies and be more competitive in the residency application process.

⁴ J-1 visa is a non-immigrant visa issued by the United States to scholars, professionals or others to participate in cultural exchange in the US, including obtaining medical training. H1-B visa is also a nonimmigrant visa issued by the United States to high skilled workers. It allows US employers to temporarily employ foreign workers to specialty occupations. Both visas require a sponsor and are costly to obtain.

3. Clinical Assessment

Legislative Charge: [D]evelop a system to assess and certify the clinical readiness of eligible immigrant international medical graduates to serve in a residency program. (M.S. 144.1911, subd. 3, clause (4))

The current system of certification from the Educational Commission on Foreign Medical Graduates (ECFMG), needed for admission to residency and for licensure, requires that IMGs pass a part of the United States Medical Licensing Exam (USMLE) that assesses a medical graduate's clinical skills. However, the 2014 Task Force heard repeatedly – including from residency program directors directly – that ECFMG certification alone does not give them enough information about a candidate's clinical aptitude to know if they will succeed in a U.S. medical residency program. The Task Force therefore recommended, and the IMG Program Assistance program provides, that Minnesota develop a standardized assessment and certification program that would assess the clinical readiness of immigrant physicians, and therefore allow IIMGs to compete more fully with U.S. medical graduates for limited residency spots.

Progress to Date

As noted above, one of the workgroups of the Stakeholder group is the Clinical Assessment and Clinical Preparation group. In designing this component of the IMG program staff worked with the Interprofessional Education and Resource Center (IERC) and Academic Health Center (AHC) Simulation Center at the University of Minnesota. Staff there conduct simulations designed to meet assessment needs for professional accreditation as well as develop and promote interprofessional education and collaborative practice, and foster the development of clinical skills and patient communication. (<http://www.simulation.umn.edu/about>) Staff also has past experience conducting assessments for IMG's in collaboration with the University of Minnesota's Preparation for Residency Program which ended in [year].

The Simulation Center has provided concepts for building and implementing an assessment which will be presented to the Stakeholder Group in early 2016 for review and direction regarding contracting and implementation. MDH will then solicit bids and contract with a qualified entity to develop a Minnesota IIMG Assessment.

4. Career Guidance and Support

Legislative Charge:

(a) The commissioner shall award grants to eligible nonprofits organizations to provide career guidance and support services to immigrant international medical graduates seeking to enter the Minnesota health workforce.

(b) The commissioner shall award the initial grants under this subdivision by December 31, 2015. (M.S. 144.1911, subd. 4)

Practicing medicine in the U.S. requires a wide range of skills and knowledge, some specific to the rapidly changing and highly complex American health care system. Even immigrant physicians with extensive clinical skills and experience overseas have much to learn in order to qualify for residency and practice effectively in the U.S. In addition to passing the rigorous and highly technical USMLE licensing exams required for ECFMG certification, they must demonstrate to residency programs that their English proficiency, technological skills and understanding of U.S. medical culture make them qualified to train successfully in a graduate clinical setting and beyond.

The Task Force examined existing programs, including the Foreign-Trained Health Care Professionals program funded by the legislature in three of the last ten years and administered by the Minnesota Department of Employment and Economic Development (DEED), that seek to support IMGs with career navigation, language assistance and test preparation. It concluded that such programs are a key component of integrating immigrant physicians into the health workforce, but will have a far greater impact if they work in concert with other key partners (including the medical education system, health care providers and employers, and regulatory bodies) and if key barriers on the pathway can be addressed (including opportunities for clinical experience and mechanisms for assessing clinical readiness).

The Task Force's recommendations therefore proposed, and the new program provides, for continuing support for these foundational programs, but doing so within a coordinated statewide system.

Progress to Date

In the interests of interagency coordination, DEED and MDH executed an interagency agreement that will transfer from DEED to MDH most of the \$200,000 DEED was allocated by the 2015 Legislature for its Foreign-Trained Health Care Professionals program. This will supplement funds at MDH for these activities.

Staff and work group members also concluded that the program should expand traditional career guidance and support to also include trauma support and coaching. Many of the immigrant IMGs did not plan to leave their countries of origin but rather have uprooted their families, lost their physical belongings, professions and a sense of self-worth due to political persecution, civil unrest or war. As a result, they have experienced significant trauma. This is further compounded by the disappointment of loss of the ability to use their skills and talents in their new home. Many have tried for years to enter the health workforce and are experiencing failure to reach goals for the first time in their lives. Many hold on at all cost to the dream of practicing medicine. While this is an option for some, others could add value to the health workforce in MN by considering other alternatives including working in public health or in the Physician Assistant (PA) profession. Part of the problem is that they are not fully aware of these opportunities and what they entail. Combining trauma support and coaching including information on alternative pathways would be essential in helping IMGs deal with past trauma

and providing the necessary information and tools to help them make informed professional decisions.

The next step in developing these services is to issue a request for proposals from non-profit organizations to provide the necessary career guidance and support.

5. Clinical Preparation and Experience

Legislative Charge

(a) The commissioner shall award grants to support clinical preparation for Minnesota international medical graduates needing additional clinical preparation or experience to qualify for residency.

(b) The policies and procedures for the clinical preparation grants must be developed by December 31, 2015, including an implementation schedule that begins awarding grants to clinical preparation programs beginning in June of 2016. (M.S. 144.1911, subd. 5)

The 2014 Task Force concluded another major reason immigrant physicians are not accepted into residency programs is a lack of hands-on clinical experience in the U.S. Most American residency programs give preference to applicants with clinical experience acquired in the U.S. or Canada. However, such hands-on experience with patients is nearly impossible to obtain outside of U.S. medical school or residency, particularly since patient privacy and security regulations were strengthened under the 1996 Health Insurance Portability and Accountability Act (HIPAA). This led to the recommendation, and resulting law, calling for a state grant program to support clinical training sites in providing hands-on experience and other preparation for Minnesota immigrant physicians needing additional clinical preparation or experience to become certified as ready for residency.

Progress to Date

The Clinical Assessment and Clinical Preparation work group has been working to develop the policies, procedures, evaluation and outcomes for a grant program to support clinical preparation.

The group studied two basic types of clinical preparation: [UCLA International Medical Graduate Program](http://fm.mednet.ucla.edu/IMG/img_program.asp) http://fm.mednet.ucla.edu/IMG/img_program.asp) and the former University of Minnesota Preparation for Residency Program (PRP). The program at UCLA is narrowly tailored to serve only Spanish speaking IMGs -not all IIMGs - who graduated from an international medical institution within the last four years. The PRP program was a broader program.

Based on its study of those programs, the work group has developed the following recommendations, which it will present to the overall Advisory stakeholder group in January 2016:

- a) The Clinical Preparation should serve a broad range of IIMGs and should not be limited to specific languages, ethnicities or year of graduation for medical school.

- b) A prerequisite for the clinical preparation should be the new Minnesota clinical assessment.
- c) The length of the clinical preparation should be based on the outcome of the clinical assessment. Standard preparation time is six months. A high pass on the assessment should result in a shorter preparation time and a low pass, a longer preparation time. Individuals who fail the assessment will be counseled on possible alternative opportunities.
- d) After the clinical preparation, an IIMG will be required to participate in a post-assessment conducted by an assessment preceptor.
- e) Passing the post-assessment will result in a certificate of clinical readiness.

The next step is to finalize the policies and procedures for the program and prepare a Request for Proposals for clinical preparation programs.

6. Dedicated Residency Positions

Legislative Charge: The commissioner shall award grants to support primary care residency positions designated for Minnesota immigrant physicians who are willing to serve in rural or underserved areas of the state. (M.S. 144.1911, subd. 6)

A key requirement for medical licensure in Minnesota is graduate clinical medical training in a U.S. or Canadian program accredited by a national accrediting organization approved by the state Board of Medical Practice. With rare exceptions, immigrant physicians are required to complete at least two years of such training, typically in a residency program, regardless of whether they completed similar clinical training outside the U.S.

Obtaining such a position, however, is a difficult feat for a variety of reasons. One is the sheer number of medical graduates vying for an essentially static number of residency positions. Medicare funding for residency training (which covers about 25 percent of GME costs in the U.S.) has been capped at the number of slots that existed in 1997, and funding by Medicare is less than what it costs to provide care and training, according to the Metro Minnesota Council on Graduate Medical Education. Even as the number of slots remains capped, however, the number of medical school graduates is increasing as many schools expand enrollments in anticipation of the physician shortages. Sometimes referred to as the “residency bottleneck,” this is a major reason cited by both the University of Minnesota and Mayo medical schools for why they do not plan to expand their medical school class sizes.

Given this need for additional residency spots and the unique qualifications many IIMGs bring to serve the fastest growing segments of the state’s population and their willingness to serve in rural and underserved communities, the IMG Program includes grants to establish new residency slots dedicated specifically to immigrant physicians. The enabling legislation also established a revolving international medical graduate residency account to accept funds from the public and private sectors to sustain grants for dedicated residency positions. In addition to the commitment to serve in a rural or underserved community for at least five years, an IIMG

accepted into a residency position funded by this grant program is required to pay the lesser of \$15,000 or ten percent of their annual compensation into the revolving account for five years, beginning in the second year of post residency employment.

Progress to Date

In September, MDH invited Minnesota primary care residency programs to apply for such grant funding through the 2016 Immigrant International Medical Graduate Primary Care Residency Grant Program.

The University of Minnesota facilitated two informational meetings with primary care program directors to review the grant, answer any questions, and brainstorm on how to implement this grant and remain in compliance with the policies of post graduate medical education.

One program, the University of Minnesota Pediatric Residency Program, responded with an application for funding. The application was approved for funding and will include:

- a) An assessment-based recruitment process.
- b) Preliminary preparation period with more targeted and mentored orientation.
- c) A training program with additional retention and career preparation activities through mentorship. We are in the process of finalizing the contract with the University of Minnesota Pediatric Residency Program.

In December, 2015, the University of Minnesota Pediatric Residency Program issued a call for applications for this new IMG residency. As of the time of this report, they had received 26 applications. One individual will be selected to fill the residency position, for training between 2016 and 2019. The individual should begin serving in a rural or underserved community in July 2019 and will start making payments into the revolving fund in July 2020.

Conclusion

The creation of the IMG Assistance Program was an important milestone. Minnesota is now the first state in the nation to implement a comprehensive program to integrate immigrant medical graduates into the physician workforce, taking an important and innovative first step to realize the potential of these uniquely qualified professionals to address pressing issues like healthcare disparities, access to healthcare and workforce shortages.

In the last few months, MDH and stakeholders have made great strides in establishing a strong foundation for the IMG Assistance program by engaging additional stakeholders, working across state agencies, issuing grants, and developing programmatic policies and procedures. This program is positioned to have great impact in lowering healthcare cost by increasing the use of primary care; eliminating healthcare disparities through diversifying the healthcare workforce with culturally and linguistically appropriate care; and increasing the number of physicians in rural and underserved areas of the state.

However, as implementation begins and the program's resources are committed, MDH also realizes the limited reach the program may have, given the number of IIMGs in Minnesota and those likely to arrive in the future. MDH and stakeholders look forward to implementing the next steps detailed above, including developing strategies to leverage existing resources and continuing to explore changes necessary in health professional licensure and regulation to ensure full utilization of immigrant international medical graduates in the Minnesota health care delivery system.

Minnesota law establishing the program requires the commissioner to develop and report recommendations for additional funding needed to achieve the objectives of this program. Although specific funding amounts needed have not yet been identified and reviewed by the program's stakeholder group, current funding is only sufficient to successfully serve 60 - 85 of the 250 – 400 immigrant physicians in Minnesota, and the short term funding appropriated will only support dedicated residency positions for two or three immigrant physicians.

Appendices

- A. IMG Assistance Program Legislation
- B. Continuum of Services
- C. Stakeholder Group Membership

Appendix A: IMG Assistance Program Legislation

2015 Minnesota Session Laws, Chapter 71, Article 8, Section 17

144.1911 INTERNATIONAL MEDICAL GRADUATES ASSISTANCE PROGRAM.

Subdivision 1. Establishment.

The international medical graduate assistance program is established to address barriers to practice and facilitate pathways to assist immigrant international medical graduates to integrate into the Minnesota health care delivery system, with the goal of increasing access to primary care in rural and underserved areas of the state.

Subd. 2. Definitions.

- (a) For the purposes of this section, the following terms have the meanings given.
- (b) "Commissioner" means the commissioner of health.
- (c) "Immigrant international medical graduate" means an international medical graduate who was born outside the United States, now resides permanently in the United States, and who did not enter the United States on a J1 or similar nonimmigrant visa following acceptance into a United States medical residency or fellowship program.
- (d) "International medical graduate" means a physician who received a basic medical degree or qualification from a medical school located outside the United States and Canada.
- (e) "Minnesota immigrant international medical graduate" means an immigrant international medical graduate who has lived in Minnesota for at least two years.
- (f) "Rural community" means a statutory and home rule charter city or township that is outside the seven-county metropolitan area as defined in section [473.121, subdivision 2](#), excluding the cities of Duluth, Mankato, Moorhead, Rochester, and St. Cloud.
- (g) "Underserved community" means a Minnesota area or population included in the list of designated primary medical care health professional shortage areas, medically underserved areas, or medically underserved populations (MUPs) maintained and updated by the United States Department of Health and Human Services.

Subd. 3. Program administration.

In administering the international medical graduate assistance program, the commissioner shall:

- (1) provide overall coordination for the planning, development, and implementation of a comprehensive system for integrating qualified immigrant international medical graduates into the Minnesota health care delivery system, particularly those willing to serve in rural or underserved communities of the state;
- (2) develop and maintain, in partnership with community organizations working with international medical graduates, a voluntary roster of immigrant international medical graduates interested in entering the Minnesota health workforce to assist in planning

and program administration, including making available summary reports that show the aggregate number and distribution, by geography and specialty, of immigrant international medical graduates in Minnesota;

(3) work with graduate clinical medical training programs to address barriers faced by immigrant international medical graduates in securing residency positions in Minnesota, including the requirement that applicants for residency positions be recent graduates of medical school. The annual report required in subdivision 10 shall include any progress in addressing these barriers;

(4) develop a system to assess and certify the clinical readiness of eligible immigrant international medical graduates to serve in a residency program. The system shall include assessment methods, an operating plan, and a budget. Initially, the commissioner may develop assessments for clinical readiness for practice of one or more primary care specialties, and shall add additional assessments as resources are available. The commissioner may contract with an independent entity or another state agency to conduct the assessments. In order to be assessed for clinical readiness for residency, an eligible international medical graduate must have obtained a certification from the Educational Commission of Foreign Medical Graduates. The commissioner shall issue a Minnesota certificate of clinical readiness for residency to those who pass the assessment;

(5) explore and facilitate more streamlined pathways for immigrant international medical graduates to serve in nonphysician professions in the Minnesota workforce; and

(6) study, in consultation with the Board of Medical Practice and other stakeholders, changes necessary in health professional licensure and regulation to ensure full utilization of immigrant international medical graduates in the Minnesota health care delivery system. The commissioner shall include recommendations in the annual report required under subdivision 10, due January 15, 2017.

Subd. 4. Career guidance and support services.

(a) The commissioner shall award grants to eligible nonprofit organizations to provide career guidance and support services to immigrant international medical graduates seeking to enter the Minnesota health workforce. Eligible grant activities include the following:

(1) educational and career navigation, including information on training and licensing requirements for physician and nonphysician health care professions, and guidance in determining which pathway is best suited for an individual international medical graduate based on the graduate's skills, experience, resources, and interests;

(2) support in becoming proficient in medical English;

(3) support in becoming proficient in the use of information technology, including computer skills and use of electronic health record technology;

(4) support for increasing knowledge of and familiarity with the United States health care system;

(5) support for other foundational skills identified by the commissioner;

- (6) support for immigrant international medical graduates in becoming certified by the Educational Commission on Foreign Medical Graduates, including help with preparation for required licensing examinations and financial assistance for fees; and
 - (7) assistance to international medical graduates in registering with the program's Minnesota international medical graduate roster.
- (b) The commissioner shall award the initial grants under this subdivision by December 31, 2015.

Subd. 5. Clinical preparation.

- (a) The commissioner shall award grants to support clinical preparation for Minnesota international medical graduates needing additional clinical preparation or experience to qualify for residency. The grant program shall include:
- (1) proposed training curricula;
 - (2) Associated policies and procedures for clinical training sites, which must be part of existing clinical medical education programs in Minnesota; and
 - (3) Monthly stipends for international medical graduate participants. Priority shall be given to primary care sites in rural or underserved areas of the state, and international medical graduate participants must commit to serving at least five years in a rural or underserved community of the state.
- (b) The policies and procedures for the clinical preparation grants must be developed by December 31, 2015, including an implementation schedule that begins awarding grants to clinical preparation programs beginning in June of 2016.

Subd. 6. International medical graduate primary care residency grant program and revolving account.

- (a) The commissioner shall award grants to support primary care residency positions designated for Minnesota immigrant physicians who are willing to serve in rural or underserved areas of the state. No grant shall exceed \$150,000 per residency position per year. Eligible primary care residency grant recipients include accredited family medicine, internal medicine, obstetrics and gynecology, psychiatry, and pediatric residency programs. Eligible primary care residency programs shall apply to the commissioner. Applications must include the number of anticipated residents to be funded using grant funds and a budget. Notwithstanding any law to the contrary, funds awarded to grantees in a grant agreement do not lapse until the grant agreement expires. Before any funds are distributed, a grant recipient shall provide the commissioner with the following:
- (1) a copy of the signed contract between the primary care residency program and the participating international medical graduate;
 - (2) certification that the participating international medical graduate has lived in Minnesota for at least two years and is certified by the Educational Commission on Foreign Medical Graduates. Residency programs may also require that

participating international medical graduates hold a Minnesota certificate of clinical readiness for residency, once the certificates become available; and (3) verification that the participating international medical graduate has executed a participant agreement pursuant to paragraph (b).

(b) Upon acceptance by a participating residency program, international medical graduates shall enter into an agreement with the commissioner to provide primary care for at least five years in a rural or underserved area of Minnesota after graduating from the residency program and make payments to the revolving international medical graduate residency account for five years beginning in their second year of post residency employment. Participants shall pay \$15,000 or ten percent of their annual compensation each year, whichever is less.

(c) A revolving international medical graduate residency account is established as an account in the special revenue fund in the state treasury. The commissioner of management and budget shall credit to the account appropriations, payments, and transfers to the account. Earnings, such as interest, dividends, and any other earnings arising from fund assets, must be credited to the account. Funds in the account are appropriated annually to the commissioner to award grants and administer the grant program established in paragraph (a). Notwithstanding any law to the contrary, any funds deposited in the account do not expire. The commissioner may accept contributions to the account from private sector entities subject to the following provisions:

- (1) the contributing entity may not specify the recipient or recipients of any grant issued under this subdivision;
- (2) the commissioner shall make public the identity of any private contributor to the account, as well as the amount of the contribution provided; and
- (3) a contributing entity may not specify that the recipient or recipients of any funds use specific products or services, nor may the contributing entity imply that a contribution is an endorsement of any specific product or service.

Subd. 7. Voluntary hospital programs.

A hospital may establish residency programs for foreign-trained physicians to become candidates for licensure to practice medicine in the state of Minnesota. A hospital may partner with organizations, such as the New Americans Alliance for Development, to screen for and identify foreign-trained physicians eligible for a hospital's particular residency program.

Subd. 8. Board of Medical Practice.

Nothing in this section alters the authority of the Board of Medical Practice to regulate the practice of medicine.

Subd. 9. Consultation with stakeholders.

The commissioner shall administer the international medical graduates assistance program, including the grant programs described under subdivisions 4, 5, and 6, in consultation with representatives of the following sectors:

- (1) state agencies:
 - (i) Board of Medical Practice;
 - (ii) Office of Higher Education; and
 - (iii) Department of Employment and Economic Development;
- (2) health care industry:
 - (i) a health care employer in a rural or underserved area of Minnesota;
 - (ii) a health plan company;
 - (iii) the Minnesota Medical Association;
 - (iv) licensed physicians experienced in working with international medical graduates; and
 - (v) the Minnesota Academy of Physician Assistants;
- (3) community-based organizations:
 - (i) organizations serving immigrant and refugee communities of Minnesota;
 - (ii) organizations serving the international medical graduate community, such as the New Americans Alliance for Development and Women's Initiative for Self Empowerment; and
 - (iii) the Minnesota Association of Community Health Centers;
- (4) higher education:
 - (i) University of Minnesota;
 - (ii) Mayo Clinic School of Health Professions;
 - (iii) graduate medical education programs not located at the University of Minnesota or Mayo Clinic School of Health Professions; and
 - (iv) Minnesota physician assistant education programs; and
- (5) two international medical graduates.

Subd. 10. Report.

The commissioner shall submit an annual report to the chairs and ranking minority members of the legislative committees with jurisdiction over health care and higher education on the progress of the integration of international medical graduates into the Minnesota health care delivery system. The report shall include recommendations on actions needed for continued progress integrating international medical graduates. The report shall be submitted by January 15 each year, beginning January 15, 2016.

Appendix B: Continuum of Services

Continuum of Services – Years 1-2 of IMG Assistance Program

Gateway & navigation	Foundational skill building	Clinical assessment	Clinical preparation	Residency application	Residency
<p>List of services:</p> <ul style="list-style-type: none"> • Roster enrollment • Career navigation • USMLE prep • ECFMG certification 	<p>List of Services:</p> <ul style="list-style-type: none"> • Medical English • Orientation to U.S. health care system • IT/typing 	<p>List of Services:</p> <ul style="list-style-type: none"> • Clinical skills assessment 	<p>List of Services:</p> <ul style="list-style-type: none"> • Clinical instruction • Clinical experience • Certification of clinical readiness • Letters of reference 	<p>List of Services:</p> <ul style="list-style-type: none"> • Assistance with application & match • Interviewing practice 	<p>List of Services:</p> <ul style="list-style-type: none"> • Dedicated primary care residency positions
<p>Provided by: Community-based grantees</p>	<p>Provided by: Community-based grantees</p>	<p>Provided by: Contractor</p>	<p>Provided by: Medical schools and/or residency programs</p>	<p>Provided by: Community-based grantees</p>	<p>Provided by: Residency programs</p>

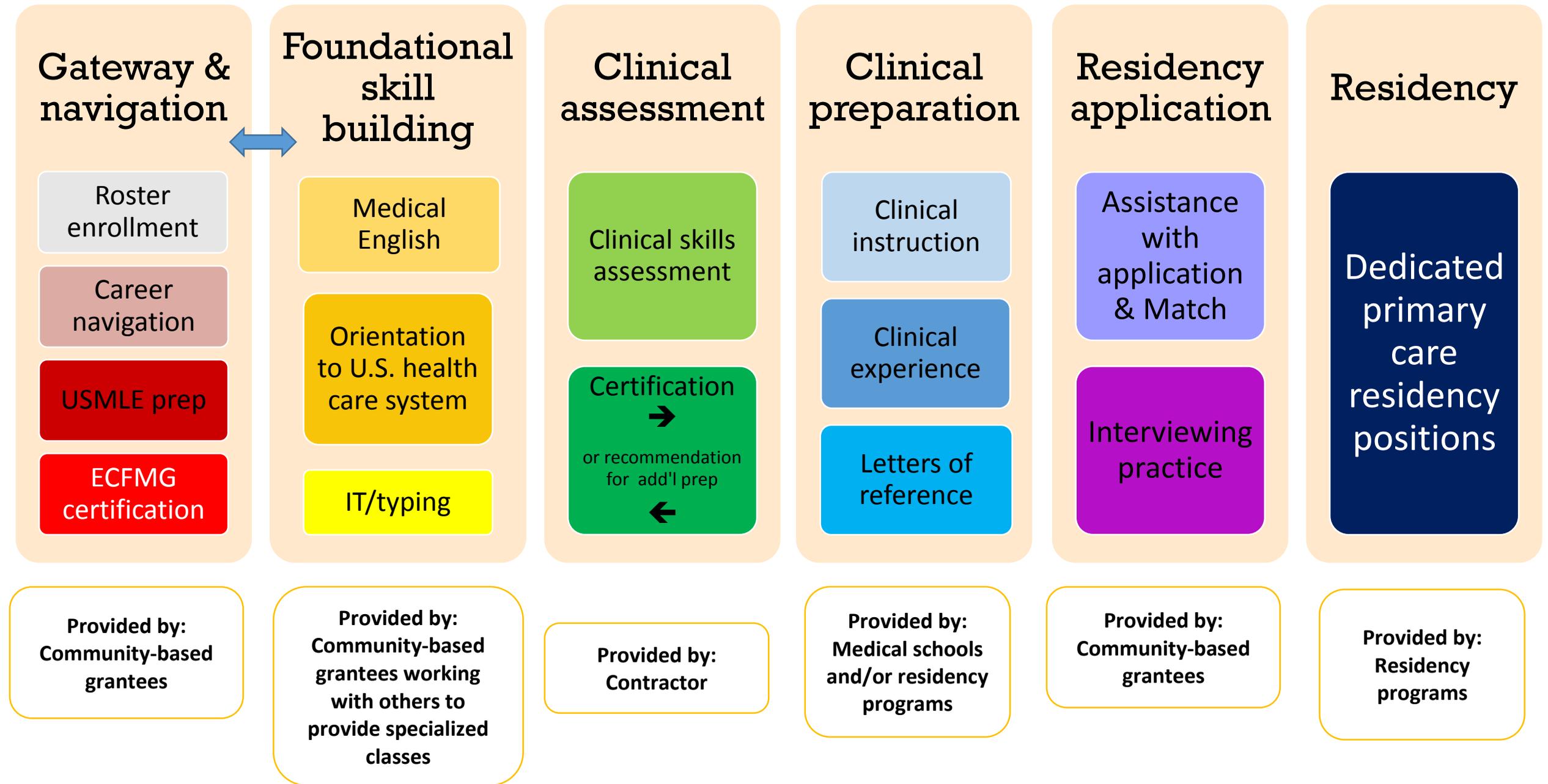
Appendix C: Stakeholder Group

Stakeholder Group	Member
Board of Medical Practice	<p>Ruth Martinez Executive Director Board of Medical Practice</p> <p>Molly Shwanz Supervisor, Licensure Unit Board of Medical Practice</p>
Office of Higher Education	<p>Diane O'Connor Deputy Commissioner Office of Higher Education</p>
Dept of Employment and Economic Dev	<p>Annie Welch Senior Planner MN Department of Employment and Economic Development</p> <p>Sarah Sinderbrand Planner MN Department of Employment and Economic Development</p>
Health care employer in rural or underserved area	<p>James Volk, MD Chief Medical Officer Sanford Health</p>
Health plan	<p>Julie Cole GME Health Partners</p>
MN Medical Association (MMA)	<p>Armit Singh, MD MN Medical Association</p>
MN Academy of Physician Assistants (MAPA)	<p>Leslie Milteer President Minnesota Academy of Physician Assistants (MAPA)</p>

Stakeholder Group	Member
Licensed physicians experienced in working with IMGs	<p>Edwin Bogonko, MD, Chair Physician St. Francis Regional Medical Center Representative for the MN Medical Association</p>
Organizations serving the IMG community, such as NAAD and WISE	<p>Wilhelmina Holder Executive Director Women’s Initiative for Self Empowerment (“WISE”)</p> <p>Mimi Oo Program Director/Coordinator New Americans Alliance for Development (“NAAD”)</p> <p>Jinny Rietmann Program Coordinator Foreign-Trained Healthcare Professionals Workforce Development Inc.</p> <p>Jane Graupmann Executive Director International Institute of Minnesota</p>
MN Assoc of Community Health Centers (MNACHC)	<p>Christopher Reif, MD Director of Clinical Services Community University Health Care Clinic</p>
University of MN	<p>James Pacala, MD Associate Department Head University of Minnesota, Family Medicine & Community Health</p>
Mayo School of Health Sciences	<p>Barbara Jordan Administrator Mayo Clinic College of Medicine Office for Diversity</p>
GME programs not at U or Mayo	<p>Meghan Walsh, MD Chief Medical Education Officer Associate Medical Director Hennepin County Medical Center</p>
PA education program	<p>Donna DeGracia Curriculum Director/Academic Coordinator</p>

Stakeholder Group	Member
	Master of PA Studies Program St. Catherine University, School of Health
Two IMGs	Tedla Kefene International Medical Graduate Nadia Rini International Medical Graduate

CONTINUUM of SERVICES – Years 1-2 of IMG Assistance Program



SPECIAL REPORT

The Next GME Accreditation System — Rationale and Benefits

Thomas J. Nasca, M.D., M.A.C.P., Ingrid Philibert, Ph.D., M.B.A., Timothy Brigham, Ph.D., M.Div., and Timothy C. Flynn, M.D.

In 1999, the Accreditation Council for Graduate Medical Education (ACGME) introduced the six domains of clinical competency to the profession,¹ and in 2009, it began a multiyear process of restructuring its accreditation system to be based on educational outcomes in these competencies. The result of this effort is the Next Accreditation System (NAS), scheduled for phased implementation beginning in July 2013. The aims of the NAS are threefold: to enhance the ability of the peer-review system to prepare physicians for practice in the 21st century, to accelerate the ACGME's movement toward accreditation on the basis of educational outcomes, and to reduce the burden associated with the current structure and process-based approach.

Self-regulation is a fundamental professional responsibility, and the system for educating physicians answers to the public for the graduates it produces.² As the accreditor for graduate medical education (GME), the ACGME serves this public trust by setting and enforcing standards that govern the specialty education of the next generation of physicians. In this article, we discuss the NAS, including elements and attributes of interest to stakeholders (program directors, leaders of sponsoring institutions, ACGME's partner organizations, residents, and the public). The ACGME's public stakeholders have heightened expectations of physicians. No longer accepting them as independent actors, they expect physicians to function as leaders and participants in team-oriented care. Patients, payers, and the public demand information-technology literacy, sensitivity to cost-effectiveness, the ability to involve patients in their own care, and the use of health information technology to improve care for individuals and populations; they also expect that GME will help to develop practitioners who possess these skills along with the requisite clinical and professional attributes.³⁻⁷

LIMITATIONS OF THE CURRENT SYSTEM

When the ACGME was established in 1981, the GME environment was facing two major stresses: variability in the quality of resident education⁸ and the emerging formalization of subspecialty education. In response, the ACGME's approach emphasized program structure, increased the amount and quality of formal teaching, fostered a balance between service and education, promoted resident evaluation and feedback, and required financial and benefit support for trainees. These dimensions were incorporated into program requirements that became increasingly more specific during the next 30 years.

The results have been largely salutary. Performance on certifying examinations has improved, residents are prepared to deal with the dramatically increasing volume and complexity of information in their specialty, and graduates and academic institutions have contributed to clinical advances and innovation that the public enjoys today.^{9,10} In addition, the role of the program director has been established as an educational career path, and the formal teaching and assessment of residents and fellows have improved substantially.

Yet success has come at a cost. Program requirements have become prescriptive, and opportunities for innovation have progressively disappeared. As administrative burdens have grown, program directors have been forced to manage programs rather than mentor residents, with a recent study reporting administrative tasks related to compliance as a factor in burnout among directors of anesthesiology programs.¹¹ Finally, educational standards often lag behind delivery-system changes. The introduction of innovation through accreditation is limited and is often viewed as an unfunded mandate.

THE NEXT ACCREDITATION SYSTEM

In July 2013, the NAS will be implemented by 7 of the 26 ACGME-accredited core specialties (emergency medicine, internal medicine, neurologic surgery, orthopedic surgery, pediatrics, diagnostic radiology, and urology). In the remaining specialties and the transitional year (a year of preparatory education for specialties such as ophthalmology and radiology that accept residents at the second postgraduate year), the NAS will be implemented in July 2014. Educational milestones (developmentally based, specialty-specific achievements that residents are expected to demonstrate at established intervals as they progress through training) have been completed or nearly completed for the seven specialties in the first phase of implementation. The residency review committees in these specialties will be in an excellent position to begin to collect milestone data during the 2012–2013 academic year to create a baseline data set for the NAS.

The NAS moves the ACGME from an episodic “biopsy” model (in which compliance is assessed every 4 to 5 years for most programs) to annual data collection. Each review committee will perform an annual evaluation of trends in key performance measurements and will extend the period between scheduled accreditation visits to 10 years. In addition to the milestones, other data elements for annual surveillance include the ACGME resident and faculty surveys and operative and case-log data. The NAS will eliminate the program information form, which is currently prepared before a site visit to describe compliance with the requirements. Programs will conduct a self-study before the 10-year site visit, similar to what is done by other educational accreditors. It is envisioned that these self-studies will go beyond a static description of a program by offering opportunities for meaningful discussion of what is important to stakeholders and showcasing of achievements in key program elements and learning outcomes.

Ongoing data collection and trend analysis will base accreditation in part on the educational outcomes of programs while enhancing ongoing oversight to ensure that programs meet standards for high-quality education and a safe and effective learning environment. Programs that demonstrate high-quality outcomes will be freed to innovate by relaxing detailed process standards that specify elements of residents’ formal

learning experiences (e.g., hours of lectures and bedside teaching), leaving them free to innovate in these areas while continuing to offer guidance to new programs and those that do not achieve good educational outcomes.

THE EDUCATIONAL MILESTONES

A key element of the NAS is the measurement and reporting of outcomes through the educational milestones, which is a natural progression of the work on the six competencies. Starting more than 10 years ago, the ACGME, in concert with the American Board of Medical Specialties (ABMS), established the conceptual framework and language of the six domains of clinical competency and introduced them into the profession’s lexicon, mirroring the move toward outcomes and learner-centered approaches in other domains of education.¹²

In each specialty, the milestones result from a close collaboration among the ABMS certifying boards, the review committees, medical-specialty organizations, program-director associations, and residents. The earliest efforts involved internal medicine, pediatrics, and surgery,^{13–15} and by late 2011, milestones were being developed in all specialties. The aim is to create a logical trajectory of professional development in essential elements of competency and meet criteria for effective assessment, including feasibility, demonstration of beneficial effect on learning, and acceptability in the community.¹⁶

Programs in the NAS will submit composite milestone data on their residents every 6 months, synchronized with residents’ semiannual evaluations. Although the internal collection of milestone data may be more comprehensive, the data submitted to the ACGME will consist of 30 to 36 dimensions that represent the consensus of the assessment committee on the educational achievements of residents, informed by evaluations the program has performed. Table 1 shows a sample of generic milestones for professionalism, interpersonal and communication skills, practice-based learning and improvement, and systems-based practice. The milestones are based on the published literature on these competencies^{17–22} and were developed by an expert panel with representation from the specialties in the early phase for use in milestone development.

At the completion of training, the final milestones will provide meaningful data on the per-

Table 1. Four Selected General Milestones in the Next Accreditation System.*

Milestone	Level 1	Level 2	Level 3	Level 4	Level 5
Professionalism	Recognizes the importance and priority of patient care, with an emphasis on the care that the patient wants and needs; demonstrates a commitment to this value Is aware of basic bioethical principles and is able to identify ethical issues in clinical situations	Is consistently able to recognize and identify own beliefs and values and their impact on practice of medicine; recognizes internal and external barriers that interfere with patient care Consistently recognizes ethical issues in practice and is able to discuss, analyze, and manage such issues in common and frequent clinical situations	Demonstrates awareness of own values and beliefs and how they affect perspective on ethical issues; is able to effectively manage personal beliefs to avoid any negative effect on patient care Is able to effectively analyze and manage ethical issues in complicated and challenging clinical situations	Develops and applies a consistent and appropriate approach to evaluating care, possible barriers, and strategies to intervene that consistently prioritizes the patient's best interest in all relationships and situations Consistently considers and manages ethical issues in practice and develops and applies a systematic and appropriate approach to analyzing and managing ethical issues when providing medical care	Is knowledgeable about, consistently uses, and effectively manages ethical principles of medicine in general and as related to specialty care Demonstrates leadership and mentorship on understanding and applying bioethical principles clinically, particularly responsiveness to patients above self-interest and self-monitoring Develops institutional and organizational strategies to protect and maintain these principles
Interpersonal and communication skills	Identifies team-based care as the optimal approach and is able to describe and appreciate the expertise of each team member, including the patient and family	Actively participates in team-based care; supports activities of other team members, communicates their value to the patient and family	Facilitates or leads team-based patient care activities Actively participates in meetings not directly related to patient care	NA	Seeks leadership opportunities within professional organizations Facilitates or leads meetings within the organization or system
Practice-based learning and improvement	Describes basic concepts in clinical epidemiology, biostatistics, and clinical reasoning Categorizes the study design of a research study	Ranks study designs according to their ability to minimize threats to validity and to generalize to larger populations Identifies critical threats to study validity when reading a research paper or study synopsis Distinguishes research outcomes that directly affect patient care from other outcomes Formulates a searchable question from a clinical question (e.g., using the PICO format)	Applies a set of critical appraisal criteria to different types of research, including synopses of original research findings, systematic reviews and meta-analyses, and clinical-practice guidelines Critically evaluates information from others: colleagues, experts, pharmaceutical representatives, and patient-delivered information	Demonstrates a clinical practice that incorporates principles and basic practices of evidence-based practice and information mastery	Independently teaches and assesses evidence-based medicine and information-mastery techniques Can cite evidence supporting several common practices
Systems-based practice	Can describe systems theory and the characteristics of high-reliability organizations Understands the epidemiology of medical errors and the differences between medical errors, near misses, and sentinel events Can define human-factors engineering	Reports problematic devices, architecture, and processes (including errors and near misses) to supervisor, institution, or program, as appropriate Illustrates with examples how human-factors engineering promotes patient safety (e.g., Stroop effect, perceptual illusions, easily confused medications)	Analyzes the causes of adverse events through root-cause analysis Demonstrates basic usability testing and critique design of devices, architecture, and processes on the basis of principles of human-factor engineering	Can compare and contrast failure modes and effects analysis with root-cause analysis as a patient-safety tool in health care Develops content for and facilitates a morbidity-and-mortality presentation or conference focusing on systems-based errors in patient care	Recommends and justifies characteristics of high-reliability organizations (e.g., reporting adverse events, root-cause analysis, and failure modes and effects analysis) to organizational leadership to promote patient safety Develops and works with multidisciplinary teams (e.g., human-factors engineers, reference librarians, and cognitive and social scientists) to find solutions to patient-safety problems

* The four listed milestones, which were developed by an ACGME expert panel, reflect the following expected levels of performance: level 1, typical graduating medical student; levels 2 and 3, resident during the program; level 4, graduating resident; and level 5, advanced, specialist resident or practicing physician. NA denotes not applicable, and PICO patient, population, or problem; intervention; comparison (alternative to intervention); and outcome.

formance that graduates must achieve before entering unsupervised practice. This process moves the competencies “out of the realm of the abstract and grounds them in a way that makes them meaningful to both learners and faculty.”¹³ The final milestones also create the entry point into the maintenance of certification and licensure phase of lifelong learning. The initial milestones for entering residents will add a performance-based vocabulary to conversations with medical schools about graduates’ preparedness for supervised practice.²³ Over time, the milestones will reach into undergraduate medical education to follow the adoption of the competencies by many medical schools. This will contribute to a more seamless transition across the medical-education continuum.

Another key element of the NAS is emphasis on the responsibility of the sponsoring institutions for the quality and safety of the environment for learning and patient care, a key dimension of the 2011 common program requirements.²⁴ This will be accomplished through periodic site visits to assess the learning environment. Institutions will see their results, and the first visit will establish a baseline for self-comparison over time. The process will generate national data on program and institutional attributes that have a salutary effect on quality and safety in settings where residents learn and on the quality of care rendered after graduation.²⁵

BENEFITS AND LIMITATIONS

The visits to sponsoring institutions will ensure that residents are exposed to an appropriate learning environment, and the milestones will ensure that they demonstrate readiness for independent practice and possess the attributes that the public deems to be important in physicians. As future competencies emerge, the milestones will enhance the ability of the ACGME to ensure their successful incorporation into the physician’s armamentarium. The NAS will enhance education focused on physician competencies that are deemed to be relevant to the health of individuals and populations. Through this, the NAS will benefit employers of new graduates and the public by enhancing the competence of future physicians in areas that are relevant to a well-per-

forming, efficient, and cost-effective health care system and that have been recommended by experts and stakeholder groups.³⁻⁷

In the context of our aspirations for the NAS, it is important to note the limits of accreditation. Much has been written about the constrained environment for GME, including threatened reductions in support for physician training and increased productivity pressures on academic institutions and their faculties. The development of the NAS is sensitive to these factors, since they are characteristics of the environment in which GME programs, sponsoring institutions, and the ACGME operate. At the same time, accreditation is not a panacea, and no accreditation model by itself can effectively compensate for the overuse of resources, inefficiencies, and disparities that characterize aspects of the nation’s health care system. It would be presumptuous to expect accreditation to effectively resolve these problems. Rather, its roles are to arm the next generation of physicians with knowledge, skills, and attributes that will enhance care in the future and to expand the traditional role of residents in the care of underserved populations to an enhanced understanding of the problem of health disparities and how to eradicate them.²⁶

Finally, although accreditation must be sensitive to the burden it creates on programs, institutions, and individuals, it would be dangerous to expect accreditation to reduce its expectations to accommodate the host of other pressures on the system of physician training. Any move to create a reductionist model of accreditation to avoid burdening the system may further erode public support for physician education and public trust in the physicians the system produces. Constrained finances and future threats of reductions make it even more important for accreditation to ensure that learners are not unduly burdened with service obligations that do not meaningfully contribute to their education²⁷ and that education and patient care proceed in an environment that complies with requirements for duty hours, supervision, and other elements important to the safety of patients and residents.²⁸ This makes the visits to sponsoring institutions a critical component of the NAS in the untoward event of serious cuts in support for GME.

CONCLUSIONS

Key benefits of the NAS include the creation of a national framework for assessment that includes comparison data, reduction in the burden associated with the current process-based accreditation system, the opportunity for residents to learn in innovative programs, and enhanced resident education in quality, patient safety, and the new competencies. Over time, we envision that the NAS will allow the ACGME to create an accreditation system that focuses less on the identification of problems and more on the success of programs and institutions in addressing them.

Although the ACGME has not piloted the NAS in its entirety, pivotal elements of the system have been tested successfully in the Educational Innovation Project in internal medicine and in a multiyear pilot in emergency medicine. Besides testing annual data collection, the Educational Innovation Project provided the ACGME with insight into standards that could be relaxed for high-performing programs (i.e., a 40% reduction in requirements for the internal medicine program, which went into effect in July 2009²⁹). Knowledge about acquisition of data elements around the milestones is being gained from the ACGME's international accreditation effort in Singapore and will benefit the implementation of the NAS. Finally, the learning gained from the first phase of the NAS will benefit the specialties that will implement the NAS in the second phase.

Much work remains to be done. The next step in moving toward the NAS will involve informing the GME community about the NAS, with a particular focus on the milestones. This work will continue in close collaboration with program-director organizations, the ABMS boards, the specialty colleges, and related academic organizations. The ACGME will continue its role in educating program directors, faculty, and others by building on its annual conference, with a focus on faculty development that is sensitive to time and financial constraints for many faculty members.

The NAS will support the education of physicians to provide care for Americans into the middle of the century. This requires an enduring system that takes the best of the current

system and enhances it with a more explicit focus on attributes of the learning environment that carry over into a lifetime of practice in a clinical specialty. By encouraging high-performing programs to innovate, the system will open the quality ceiling and produce new learning. Simultaneously, an ongoing process-based approach for programs with less-than-optimal performance will continue to raise the floor for all programs.

Disclosure forms provided by the authors are available with the full text of this article at NEJM.org.

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From the Accreditation Council for Graduate Medical Education, Chicago (T.J.N., I.P., T.B., T.C.F.); Jefferson Medical College of Thomas Jefferson University, Philadelphia (T.J.N., T.B.); and the University of Florida College of Medicine, Gainesville (T.C.F.).

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DATE: November 12, 2016

SUBJECT: Report of Licenses Issued

SUBMITTED BY: Licensure Staff

REQUEST FOR BOARD ACTION
MINNESOTA BOARD OF MEDICAL PRACTICE

REQUESTED ACTION:

For Informational purposes only.

MOTION BY: _____ SECOND: _____
 PASSED PASSED AMENDED LAYED OVER DEFEATED

BACKGROUND:

For information only, attached is a listing of licenses issued from September 20 through November 3, 2016.

**Minnesota Board of Medical Practice
New Credential Summary for 09/20/2016**

<u>Name</u>	<u>License #</u>	<u>Expire Date</u>	<u>Seq #</u>
License Type: Physician and Surgeon			
MapelLentz , James Emerson M.D.	61246	08/31/2017	1

**Minnesota Board of Medical Practice
New Credential Summary for 10/19/2016**

<u>Name</u>	<u>License #</u>	<u>Expire Date</u>	<u>Seq #</u>
License Type: Medical Faculty Physician			
Ruano , Rodrigo M.D., Ph.D.	1001	03/31/2018	1

**Minnesota Board of Medical Practice
New Credential Summary for 10/22/2016**

<u>Name</u>	<u>License #</u>	<u>Expire Date</u>	<u>Seq #</u>
License Type: Physician and Surgeon			
Exposito Cespedes , Jesus M.D.	61247	01/31/2018	1
Hughes , Jason Andrew M.D.	34845	06/30/2017	2
Bromen , Kenneth Alcuin M.D. (Emeritus)	18138	09/30/2016	3
Dahlgren , David Charles M.D. (Emeritus)	17810	09/30/2016	4
Grimm , Terrence Earl M.D. (Emeritus)	29858	10/31/2016	5
Kinney , William N M.D. (Emeritus)	15336	09/30/2016	6
Odegard , Elizabeth Allen M.D. (Emeritus)	32714	08/31/2016	7
Peterson , Christian Mark M.D. (Emeritus)	27365	09/30/2016	8

**Minnesota Board of Medical Practice
New Credential Summary for 10/27/2016**

<u>Name</u>	<u>License #</u>	<u>Expire Date</u>	<u>Seq #</u>
License Type: Physician and Surgeon			
Ache , Robyn Michele D.O.	61248	04/30/2017	1
Ahmad , Omair M.D.	61249	01/31/2018	2
Al Sharif , Muhammad Muhammad Anwar D.O.	61250	02/28/2018	3
Alsumrain , Mohammad Hassan Mahmoud M.B., B.S.	61251	06/30/2017	4
Anangur Ganesan , Chitra Devi M.B., B.S.	61252	04/30/2017	5
Anderson , Caitlin Victoria M.D.	61253	09/30/2017	6
Anderson , Danielle Nicole M.D.	61254	11/30/2017	7
Anwer , Bilal M.D.	61255	05/31/2017	8
Arnaout , Majd Mahmoud M.D.	61256	01/31/2018	9
Bala , Kamalesh Kumar M.B., B.S.	61257	10/31/2017	10
Balaram , Manjunath M.B., B.S.	61258	07/31/2017	11
Barron , David Angelo M.D.	61259	12/31/2017	12
Belle Isle , Richard Mark	61260	08/31/2017	13
Bhat , Samrat Vithaldas M.B., B.S.	61261	10/31/2017	14
Blacher , Eric Samuel M.D.	61262	04/30/2017	15
Brown , Nicholas Michael M.D.	61263	04/30/2017	16
Cappelle , Quintin Mark M.D.	61264	10/31/2017	17
Carlston , Cory Vernon M.D.	61265	04/30/2017	18
Cathcart , Peter Lars M.D.	61266	05/31/2017	19
Chauhan , Ravi Dinesh M.D.	61267	03/31/2017	20
Cherkasky , Alan Hugh M.D.	61268	08/31/2017	21
Choi , Woo Joeong M.D.	61269	04/30/2017	22
Choudhery , Sadia Amanullah M.D.	61270	05/31/2017	23
Cochrane , Christopher James D.O.	61271	09/30/2017	24
Conniff , James Francis M.D.	61272	07/31/2017	25
Coyne , Kimberly Michelle M.D.	61273	12/31/2017	26
Cross , Jennette Lynnell M.D.	61274	06/30/2017	27
Cruz , Victor Damaso M.D.	61275	02/28/2018	28
Cunningham , Brian Patrick M.D.	61276	09/30/2017	29
Davis , Glen Anthony M.D.	61277	03/31/2017	30
DeMare , Jeffrey Scott M.D.	61278	02/28/2018	31
DuBosque , Kari Kristiane	61279	07/31/2017	32
EL-Amin , Suliman Salahuddin M.D.	61280	05/31/2017	33
Enrico , Michael Robert M.D.	61281	05/31/2017	34
Esco , Miechia Ashawn M.D.	61282	06/30/2017	35
Federly , Tara Jacquelyn M.D.	61283	10/31/2017	36
FitzSimmons , John Michael M.D.	61284	09/30/2017	37
Flory , Amanda Renae D.O.	61285	07/31/2017	38
Foster , Robert Campbell M.D.	61286	10/31/2017	39
Fulbright , Renee Annette M.D.	61287	01/31/2018	40
Gunderson , Elizabeth Michelle M.D.	61288	09/30/2017	41
Hall , David Justin M.D.	53017	09/30/2017	42
Hanson , Kristin R.	61289	02/28/2018	43
Her , Cheng M.D.	61290	03/31/2017	44
Hess , Ryan William M.D.	61291	04/30/2017	45
Hester , Zina Renee M.D.	61292	09/30/2017	46
Hill , Caitlin Claire Darley M.D.	61293	01/31/2018	47
Horna , Pedro	61294	08/31/2017	48
Janssen , Christopher James M.D.	61295	07/31/2017	49
Kannon , Bodhi Kikue M.D.	61296	08/31/2017	50

Minnesota Board of Medical Practice New Credential Summary for 10/27/2016

Name	License #	Expire Date	Seq #
License Type: Physician and Surgeon			
Keglovits , LaToya Guinn M.D.	61297	11/30/2017	51
Kevan , Emily Nelson M.D.	61298	03/31/2017	52
Khalife , Tarek M.B., B.Ch.	61299	08/31/2017	53
Kizy , Scott Salam M.D.	61300	10/31/2017	54
Klein , Jonathan Tzvi M.D.	61301	06/30/2017	55
Knoper , Ryan Christopher M.D.	61302	06/30/2017	56
Knuttinen , Martha Gracia M.D.	61303	02/28/2018	57
Kobe , Christopher Michael M.D.	61304	08/31/2017	58
Kok , Susan Nell M.D.	61305	06/30/2017	59
Kolstoe , John Dennis M.D.	29139	09/30/2017	60
Kotiso , Florence Fikre	61306	03/31/2017	61
Laroche , Roger Renan M.D.	32177	07/31/2017	62
Latycheva , Ekaterina M.D.	61307	02/28/2018	63
LeTourneau , Peter Robert M.D.	61308	11/30/2017	64
Li , Debbie M.D.	61309	10/31/2017	65
Lyons , Jacob Allen M.D.	61310	08/31/2017	66
MacGregor , Jay Martin M.D.	61311	03/31/2017	67
Manrique Mogollon , Oscar Javier	61312	10/31/2017	68
Martin , Peter Andrew M.D.	61313	06/30/2017	69
Mashaqi , Saif Arsan Abdellatif M.B., B.S.	61314	09/30/2017	70
Mays , Ashley Ann M.D.	61315	07/31/2017	71
McAnally , Kelsey Michele Bowden D.O.	61316	02/28/2018	72
McCarthy , Mark Andrew M.D.	61317	10/31/2017	73
McCollister , Keith Bruce M.D.	61318	03/31/2017	74
McNeeley , Michael Fielden M.D.	61319	03/31/2017	75
Megits , Lyuba M.D.	61320	01/31/2018	76
Merriman , Lindsay Marie M.D.	61321	07/31/2017	77
Meyers , Peter Jensen M.D.	61322	07/31/2017	78
Michaud , Anthony Lane M.D.	61323	05/31/2017	79
Millis , Andrew Arthur M.D.	61324	05/31/2017	80
Mintz , Ariel David M.D.	61325	10/31/2017	81
Mortland , Leslie Jean M.D.	53414	06/30/2017	82
Mullings , Kadir Owen M.B., B.S.	61326	06/30/2017	83
Muradov , Pavel Igorevich M.D.	61327	04/30/2017	84
Muzic , John Gregory M.D.	61328	04/30/2017	85
Naqvi , Tasneem Zehra M.B., B.S.	61329	01/31/2018	86
Nelson , Nan Elaine M.D.	61330	11/30/2017	87
Ngo , Tan Duy M.D.	61331	03/31/2017	88
Nordberg , Jerrod Douglas M.D.	61332	09/30/2017	89
Nwaokolo , Maureen Onyinyechukwu M.B., B.S.	57020	05/31/2017	90
Olszewski , Gregory Michael M.D.	61333	07/31/2017	91
Page , Alexander Roy M.D.	61334	09/30/2017	92
Palacio , Ryan Joshua M.D.	61335	02/28/2018	93
Patel , Priyesh Rashiklal M.D.	61336	07/31/2017	94
Pessanha , Breno Santiago da Silva	61337	01/31/2018	95
Pinkhasov , Genri M.D.	61338	12/31/2017	96
Ponton , Lilia C M.D.	61339	01/31/2018	97
Purdy , Justin Joseph M.D.	61340	05/31/2017	98
Qamar , Asma M.B., B.S.	61341	08/31/2017	99
Raman , Dileep M.B., B.S.	61342	01/31/2018	100

**Minnesota Board of Medical Practice
New Credential Summary for 10/27/2016**

<u>Name</u>	<u>License #</u>	<u>Expire Date</u>	<u>Seq #</u>
License Type: Physician and Surgeon			
Ravella , Shalini M.D.	61343	05/31/2017	101
Rehman , Abdul M.B., B.S.	61344	04/30/2017	102
Reiner , Bruce Ian M.D.	61345	08/31/2017	103
Rick , Brianna Jean M.D.	61346	01/31/2018	104
Roh , Michael Howard M.D.	61347	11/30/2017	105
Rosenkvist , Jessica Christine Oetting M.D.	61348	08/31/2017	106
Ruades Ninfea , Jose Ignacio	61349	07/31/2017	107
Saha , Indrani M.D.	61350	07/31/2017	108
Saleh , Bilal Ahmad M M.D.	61351	07/31/2017	109
Sams , Paige Ann D.O.	61352	01/31/2018	110
Santino , Steven George M.D.	61353	12/31/2017	111
Schaefer , Stephanie McLeish M.D.	61354	06/30/2017	112
Schat , Robben Andrew D.O.	61355	08/31/2017	113
Schomer , Amy Rounds M.D.	61356	05/31/2017	114
Schultz , Brittney Jean M.D.	61357	11/30/2017	115
Schwartz , Matthew Stander M.D.	61358	07/31/2017	116
Shah , Ishan Kamlesh M.B., B.S.	61359	05/31/2017	117
Shen , Joanne Fang M.D.	61360	03/31/2017	118
Shicker , Louis M.D.	61361	07/31/2017	119
Smith , Nicholas Alexander D.O.	61362	03/31/2017	120
Spak , Cedric Wojciech M.D.	61363	04/30/2017	121
Sugar , Jerome Orry M.D.	61364	09/30/2017	122
Sugarbaker , Rena Jeannette M.D.	61365	10/31/2017	123
Swancoat , Steven Shepherd D.O.	61366	11/30/2017	124
Tauriac , Ashley Nicole M.D.	61367	11/30/2017	125
Tazuke , Salli Ikuko M.D.	61368	07/31/2017	126
Timp , Matthew James D.O.	61369	07/31/2017	127
Torok , Haruka Matsubara	61370	04/30/2017	128
Tsai , Amy Chu M.D.	61371	10/31/2017	129
Tuladhar , Tsewang Namgyal M.B., B.S.	61372	06/30/2017	130
Tungpalan-Grondolsky , Lori-Anne Noelani M.D.	44120	03/31/2017	131
Uselman , Ryan Robert M.D.	61373	08/31/2017	132
Ussher , Christopher Neville M.B., Ch.B.	61374	02/28/2018	133
Valencia , Elizabeth Marie M.D.	61375	02/28/2018	134
Vinogradov , Sophia M.D.	61376	05/31/2017	135
VonDerHaar , Jonathan Newton M.D.	61377	04/30/2017	136
Vukelich , John Lee M.D.	61378	05/31/2017	137
Wang , Joseph Ming-Lian M.D.	61379	05/31/2017	138
Wang , Yingchun	61380	11/30/2017	139
Wecker , Amy Beth M.D.	61381	06/30/2017	140
White , Cheryl Lynn M.D.	61382	07/31/2017	141
Wickre , Mark Curtis M.D.	61383	06/30/2017	142
Williams , Stephanie Ann M.D.	61384	09/30/2017	143
Zgherea , Daniela	61385	11/30/2017	144
Zgherea , Yuriy	61386	07/31/2017	145
Ziebarth , Stephanie Ann M.D.	61387	11/30/2017	146
Zorko , Nicholas Alexander M.D.	61388	12/31/2017	147
Holger , Joel Stanford M.D. (Emeritus)	24793	09/30/2016	148

**Minnesota Board of Medical Practice
New Credential Summary for 11/03/2016**

<u>Name</u>	<u>License #</u>	<u>Expire Date</u>	<u>Seq #</u>
License Type: Physician and Surgeon			
Abidi , Syed Kashan Ali Haider M.B., B.S.	61389	07/31/2017	1
Allred , Jeremy Russell M.D.	61390	06/30/2017	2
Anghel-Filip , Anemona M.D.	61391	05/31/2017	3
Armstrong , Michele Elizabeth M.D.	61392	12/31/2017	4
Bindra , Sanjay Madanlal M.B., B.S.	61393	11/30/2017	5
Bloemke , Adam Douglas M.D.	49284	09/30/2017	6
Bradley , Steven Michael M.D.	61394	01/31/2018	7
Chhabra , Arun Singh M.D.	61395	04/30/2017	8
Chiou , Victoria M.D.	61396	06/30/2017	9
Choi , Gwen M.D.	61397	11/30/2017	10
Chu , Bradford Jan M.D.	61398	05/31/2017	11
Contag , Stephen Arthur	45694	04/30/2017	12
Elliott , Laura Lynn M.D.	61399	10/31/2017	13
Emani , Madhu Kumar M.B., B.S.	61400	04/30/2017	14
Hayes , Ellen Carol M.D.	61401	01/31/2018	15
Inbarasu , Jennifer Jean M.D.	61402	05/31/2017	16
Khvilivitzky , Katherine M.D.	61403	06/30/2017	17
Leal , Janette Coelho M.D.	61404	10/31/2017	18
Melzer , Anne Catherine M.D.	61405	08/31/2017	19
Merchant , Amina Ibrahim M.D.	61406	01/31/2018	20
Moncrief , Sara Buckley M.D.	61407	12/31/2017	21
Pansegrau , Morgan Leigh M.D.	61408	06/30/2017	22
Perry , Melissa Ann M.D.	61409	03/31/2018	23
Rice , Sarah Nicole D.O.	61410	04/30/2017	24
Stanley , Jeffrey Peterson M.D.	61411	08/31/2017	25
Sundberg , Jacob Eugene M.D.	61412	11/30/2017	26
Tunney , Carol Madeleine MB, BCh, BAO	55488	11/30/2017	27
Williams , Anthony Darnell M.D.	61413	07/31/2017	28

DATE: 11/12/2016

SUBMITTED BY: Licensure Committee

SUBJECT: Physician Licensure

REQUEST FOR BOARD ACTION
MINNESOTA BOARD OF MEDICAL PRACTICE

REQUESTED ACTION:

The following physician applicants for licensure be approved subject to receipt of all verification documents.

1 - 84 of agenda

MOTION BY:

SECOND:

Passed Amended Layed Over Defeated

BACKGROUND:

See # 1 - 84 for each applicants credentials

COMB = COMBINATION of NBME,FLEX,USMLE
COMLEX = COMPREHENSIVE OSTEOPATHIC MLE
FLEX = FED. OF STATE MEDICAL BOARDS
LMCC = LICENTIATE MED CNCL OF CANADA
NBME = NATIONAL BRD OF MED. EXAMINERS
NBOME = NAT. BD OF OSTEOPATHIC EXAM.
STATE = LICENSED BY OTHER STATE
USMLE = UNITED STATES MED LIC EXAM

NO	NAME AND ADDRESS	PLACE and DATE of BIRTH	UNIVERSITY and DATE of DEGREE	US/CANADIAN TRAINING	EXAM-ID # DATES EXAM/COMB. SCORES
1		Benin, NIGERIA 02/23/1986	U OF BENIN Benin, Nigeria M.B., B.S. 11/25/2010	Hennepin County Medical Center Minneapolis, MN, USA 06/17/2014 to 06/30/2017 AMA FREIDA Online	08635112 06/24/2013 08/27/2013 06/09/2014 USMLE1 USMLE2 USMLE3 223 231 214 ECFMG 0-863-511-2
2		Riyadh, SAUDI ARABIA 08/25/1985	KING SAUD U/RIYADH Riyadh, SAUDI ARABIA M.B., B.S. 07/01/2009	Mayo Clinic Rochester, MN, USA 07/01/2014 to 06/30/2020 AMA FREIDA Online	08125163 03/31/2011 07/10/2011 04/28/2015 USMLE1 USMLE2 USMLE3 215 218 190 ECFMG 0-812-516-3
3		Portland, OR, USA 01/27/1984	BOWMAN GRAY SCHL OF MED Winston-Salem, NC USA M.D. 05/17/2010	University of Washington Seattle, WA, USA 07/01/2010 to 06/30/2015 DARP PG 422, 2010/11	42154721 04/02/2008 05/23/2009 10/05/2010 USMLE1 USMLE2 USMLE3 236 265 235
4		Amman, JORDAN 11/21/1981	U OF JORDAN Amman, Jordan M.B., B.S. 06/27/2005	University of Arizona Tucson, AZ, USA 07/01/2008 to 06/30/2012 DARP PG 379, 2008/09	06910806 02/07/2007 03/28/2007 09/25/2010 USMLE1 USMLE2 USMLE3 218 227 231 ECFMG 0-691-080-6
5		Minneapolis, MN, USA 04/24/1983	CHICAGO COL OF OSTEO MED Downers Grove, IL USA D.O. 05/27/2011	Henry Ford Macomb Hospital Clinton Township, MI, USA 07/01/2011 to 06/30/2016 AOA Website	904137 06/01/2009 07/01/2010 03/19/2012 COMLEX1 COMLEX2 COMLEX3 552 616 531

NO	NAME AND ADDRESS	PLACE and DATE of BIRTH	UNIVERSITY and DATE of DEGREE	US/CANADIAN TRAINING	EXAM-ID # DATES EXAM/COMB. SCORES
6		Lahore, PAKISTAN 01/25/1986	U OF SOUTH FLORIDA Tampa, FL USA M.D. 05/04/2012	Baylor College of Medicine Houston, TX, USA 06/24/2012 to 06/30/2015 DARP PG 201, 2012/13	52428307 05/10/2010 06/27/2011 10/28/2013 USMLE1 USMLE2 USMLE3 237 247 222
7		San Francisco, CA, USA 07/05/1962	VANDERBILT U Nashville, TN USA M.D. 05/14/1999	Berkshire Medical Center Pittsfield, MA, USA 07/01/2000 to 06/30/2001 DARP PG 605, 2000/01	50307677 06/10/1997 03/02/1999 11/27/2000 USMLE1 USMLE2 USMLE3 234 222 205 ABMS Anesthesiology- Anesthesiology 04/15/2005-12/31/2025-Time Limited
8		Cuddalore, INDIA 12/13/1986	PONDICHERRY UNIVERSITY Puducherry, India M.B., B.S. 08/23/2010	Marshfield Clinic Marshfield, WI, USA 07/01/2014 to 06/30/2017 AMA FREIDA Online	08186777 08/26/2011 07/27/2012 03/06/2013 USMLE1 USMLE2 USMLE3 213 230 207 ECFMG 0-818-677-7
9		Logan, UT, USA 03/18/1978	MIDWESTERN U AZ COL OSTE Glendale, AZ USA D.O. 06/01/2007	Mercy St Vincent Medical Center Toledo, OH, USA 07/01/2007 to 06/30/2010 AOA Website	762142 06/07/2005 12/18/2006 03/28/2008 COMPLEX1 COMPLEX2 COMPLEX3 612 737 720

NO	NAME AND ADDRESS	PLACE and DATE of BIRTH	UNIVERSITY and DATE of DEGREE	US/CANADIAN TRAINING	EXAM-ID # DATES EXAM/COMB. SCORES
10		Lake Preston, SD, USA 12/26/1973	DES MOINES U COLLEGE OF OSTEO MED Des Moines, IA USA D.O. 05/23/2015	University of Minnesota Mankato, MN, USA 07/01/2015 to 06/30/2017 AOA Website	501251 06/26/2013 07/28/2014 11/21/2015 COMLEX1 COMLEX2 COMLEX3 594 557 524
11		New Brunswick, NJ, USA 01/02/1970	PENN STATE U Hershey, PA USA M.D. 05/21/1995	Abington Memorial Hospital Jenkintown, PA, USA 06/23/1995 to 06/30/1998 DARP PG 400, 1995/96	40168122 06/08/1993 08/31/1994 12/05/1995 USMLE1 USMLE2 USMLE3 196 190 215 ABMS Family Medicine- Family Medicine 04/02/2015-12/31/2025-MOC
12		Manhattan, NY, USA 04/14/1985	MED. U. OF THE AMERICAS Charlestown, Nevis M.D. 03/15/2013	Hennepin County Medical Center Minneapolis, MN, USA 06/14/2014 to 06/30/2017 AMA FREIDA Online	08095655 03/25/2011 08/21/2012 07/27/2013 USMLE1 USMLE2 USMLE3 204 216 212 ECFMG 080-956-5
13		Iowa City, IA, USA 01/05/1987	U OF IOWA/COL OF MED Iowa City, IA USA M.D. 05/16/2014	University of Minnesota Minneapolis, MN, USA 06/09/2014 to 06/30/2016 AMA FREIDA Online	52810652 06/06/2012 07/27/2013 06/13/2015 USMLE1 USMLE2 USMLE3 238 258 236

NO	NAME AND ADDRESS	PLACE and DATE of BIRTH	UNIVERSITY and DATE of DEGREE	US/CANADIAN TRAINING	EXAM-ID # DATES EXAM/COMB. SCORES
14		Jackson, MS, USA 09/27/1951	U OF MISSISSIPPI Jackson, MS USA M.D. 04/30/1978	University of Texas-Hermann Hosp Houston, TX, USA 01/01/1979 to 06/30/1982 DARP PG 185, 1977/78	20146965 06/13/1978 FLEX 78.60 MS ABMS OB & GY- Obstetrics & Gynecology 12/07/1984--Lifetime
15		Longview, TX, USA 03/30/1977	U OF TEXAS/HOUSTON Houston, TX USA M.D. 06/07/2003	Loyola University Medical Center Maywood, IL, USA 07/01/2004 to 08/10/2007 DARP PG# 490, 2004/05	50931476 06/13/2001 11/25/2002 02/13/2006 USMLE1 USMLE2 USMLE3 191 224 213 SPEX 50931476 08/16/2016 88
16		Cleveland, OH, USA 06/01/1965	BOWMAN GRAY SCHL OF MED Winston-Salem, NC USA M.D. 05/18/1998	Boston Medical Center Boston, MA, USA 07/01/1998 to 06/30/1999 DARP PG 899, 1998/99	50069012 06/11/1996 08/26/1997 05/24/2000 USMLE1 USMLE2 USMLE3 222 216 189 ABMS Otolaryngology- Otolaryngology 06/01/2015-06/30/2025-Time Limited
17		Minneapolis, MN, USA 07/30/1985	CREIGHTON U Omaha, NE USA M.D. 05/14/2011	William Beaumont Hospital Royal Oak, MI, USA 07/01/2011 to 06/30/2016 DARP PG 481, 2011/12	52208204 06/03/2009 07/28/2010 05/22/2012 USMLE1 USMLE2 USMLE3 231 250 224

NO	NAME AND ADDRESS	PLACE and DATE of BIRTH	UNIVERSITY and DATE of DEGREE	US/CANADIAN TRAINING	EXAM-ID # DATES EXAM/COMB. SCORES
18		Edina, MN, USA 06/21/1988	MEDICAL COLLEGE OF WISCONSIN Milwaukee, WI USA M.D. 05/16/2014	University of Minnesota Minneapolis, MN, USA 06/11/2014 to 06/30/2017 AMA FREIDA Online	52799400 06/09/2012 09/21/2013 11/10/2014 USMLE1 USMLE2 USMLE3 224 240 218
19		Erzurum, TURKEY 05/08/1973	HACETEPPE U Ankara, Turkey M.D. 06/30/1997	University of Minnesota Minneapolis, MN, USA 09/01/2007 to 06/30/2009 DARP PG 222, 2007/08 University of Minnesota Minneapolis, MN, USA 05/09/2016 to 08/08/2016 AMA FREIDA Online	06456966 03/22/2004 08/09/2004 12/26/2015 USMLE1 USMLE2 USMLE3 232 241 224 ECFMG 0-645-696-6
20		Scranton, PA, USA 06/21/1983	DREXEL U COLLEGE OF MEDICINE Philadelphia, PA USA M.D. 05/18/2012	Thomas Jefferson University Philadelphia, PA, USA 06/30/2012 to 06/30/2016 DARP PG 472, 2012/13	52404415 06/14/2010 06/30/2011 02/25/2013 USMLE1 USMLE2 USMLE3 202 208 194
21		Guatemala City, GU, GUATEMALA 12/03/1978	U FRANCISCO MARROQUIN Guatemala City, Guatemala 05/10/2006	Saint Lukes Hospital Bethlehem, PA, USA 07/01/2009 to 06/30/2013 DARP PG 499, 2009/10	07161409 05/31/2007 09/04/2008 02/19/2009 USMLE1 USMLE2 USMLE3 229 236 211 ECFMG 0-716-140-9

NO	NAME AND ADDRESS	PLACE and DATE of BIRTH	UNIVERSITY and DATE of DEGREE	US/CANADIAN TRAINING	EXAM-ID # DATES EXAM/COMB. SCORES
22		Hawthorne, CA, USA 06/09/1971	U OF TEXAS/GALVESTON Galveston, TX USA M.D. 05/25/2002	Scottsdale Healthcare Scottsdale, AZ, USA 07/01/2002 to 06/30/2005 DARP PG 516, 2002/03	50804830 06/05/2000 09/19/2001 11/20/2003 USMLE1 USMLE2 USMLE3 224 228 230 ABMS Family Medicine- Family Medicine 07/21/2005-11/16/2015-MOC
23		Hong Kong, CHINA 11/01/1971	YALE U New Haven, CT USA M.D. 05/25/1998	Johns Hopkins Hospital Baltimore, MD, USA 07/01/1998 to 06/30/2001 DARP PG 574, 1998/99	40512576 06/14/1995 08/27/1996 03/31/2000 USMLE1 USMLE2 USMLE3 193 203 225 ABMS IM (Sub) - Clinical Cardiac Electrophysiology 11/07/2007-12/31/2017-MOC
24		Anchorage, AK, USA 06/03/1967	THOMAS JEFFERSON U Philadelphia, PA USA M.D. 06/05/1992	Jackson Memorial Hospital Miami, FL, USA 07/01/1992 to 06/30/1996 DARP PG 481, 1991/92	3-416-913-6 06/12/1990 09/25/1991 03/03/1993 NBME1 NBME2 NBME3 86 87 83 ABMS Radiology- Diagnostic Radiology 06/11/1997--Lifetime

NO	NAME AND ADDRESS	PLACE and DATE of BIRTH	UNIVERSITY and DATE of DEGREE	US/CANADIAN TRAINING	EXAM-ID # DATES EXAM/COMB. SCORES
25		Delta, UT, USA 10/25/1969	NY MED COL/VALHALLA Valhalla, NY USA M.D. 05/14/1999	University of Illinois Peoria, IL, USA 07/01/1999 to 06/30/2002 DARP PG 465, 1999/00	50297688 06/10/1997 08/25/1998 11/01/2001 USMLE1 USMLE2 USMLE3 205 211 219 ABMS Emergency Medicine- Emergency Medicine 05/25/2005-12/31/2025-Time Limited
26		St. Paul, MN, USA 06/15/1968	U OF MINNESOTA Minneapolis, MN USA M.D. 06/08/1996	University of Maryland Baltimore, MD, USA 07/01/1996 to 06/30/2000 DARP PG 620, 1996/97	40481665 06/08/1994 03/05/1996 12/03/1996 USMLE1 USMLE2 USMLE3 207 221 208 ABMS OB & GY- Obstetrics & Gynecology 01/17/2003-12/31/2016-MOC
27		Chicago, IL, USA 12/13/1978	U OF TEXAS/GALVESTON Galveston, TX USA M.D. 06/01/2013	University of Utah Salt Lake City, UT, USA 06/01/2013 to 06/30/2014 AMA FREIDA Online	52706959 06/17/2011 09/27/2012 05/13/2014 USMLE1 USMLE2 USMLE3 198 210 205
28		Baltimore, MD, USA 12/27/1965	VANDERBILT U Nashville, TN USA M.D. 05/13/1994	University of Pittsburgh Pittsburgh, PA, USA 06/24/1994 to 06/30/1997 DARP PG 306, 1994/95	40030454 06/09/1992 03/30/1994 12/06/1994 USMLE1 USMLE2 USMLE3 189 201 210 ABMS Emergency Medicine- Emergency Medicine 01/01/2008-12/31/2018-Time Limited

NO	NAME AND ADDRESS	PLACE and DATE of BIRTH	UNIVERSITY and DATE of DEGREE	US/CANADIAN TRAINING	EXAM-ID # DATES EXAM/COMB. SCORES
29		San Fernando, PHILIPPINES 09/01/1985	A.T. STILL U SCH OF OSTEO MEDICINE Mesa, AZ USA D.O. 06/03/2011	St Joseph Hospital Chicago, IL, USA 07/02/2012 to 07/01/2014 AOA Website	926681 07/13/2009 07/17/2010 10/30/2012 COMLEX1 COMLEX2 COMLEX3 520 435 585
30		Owatonna, MN, USA 07/23/1986	DES MOINES U COLLEGE OF OSTEO MED Des Moines, IA USA D.O. 05/23/2015	U of MN Mankato Mankato, MN, USA 07/01/2015 to 08/22/2017 AOA Website	501549 07/01/2013 09/05/2014 12/18/2015 COMLEX1 COMLEX2 COMLEX3 548 540 556
31		La Habana, CUBA 02/24/1983	PONCE SCHL OF MED Ponce, PR USA M.D. 05/28/2011	University of Puerto Rico San Juan, PR, USA 07/01/2012 to 06/30/2017 AMA FREIDA Online	52220571 06/23/2009 08/23/2010 06/18/2014 USMLE1 USMLE2 USMLE3 215 232 203
32		Hyderabad, INDIA 09/25/1987	ST. JAMES SCHOOL OF MEDICINE Kingstown, Saint Vincent and the Grenadines M.D. 05/23/2014	Hennepin County Medical Center Minneapolis, MN, USA 06/17/2014 to 06/30/2017 AMA FREIDA Online	08750416 03/31/2012 08/13/2013 03/26/2015 USMLE1 USMLE2 USMLE3 214 217 210 ECFMG 0-875-041-6
33		St. Paul, MN, USA 08/26/1982	U OF MINNESOTA Minneapolis, MN USA M.D. 05/07/2011	University of Arizona Tucson, AZ, USA 07/01/2011 to 06/30/2014 DARP PG 108, 2011/12	52182326 07/29/2009 09/08/2010 03/15/2013 USMLE1 USMLE2 USMLE3 215 259 240

NO	NAME AND ADDRESS	PLACE and DATE of BIRTH	UNIVERSITY and DATE of DEGREE	US/CANADIAN TRAINING	EXAM-ID # DATES EXAM/COMB. SCORES
34		Mankato, MN, USA 09/26/1986	U OF MINNESOTA Minneapolis, MN USA M.D. 01/03/2015	UMN/St. Cloud Hospital St. Cloud, MN, USA 07/01/2015 to 06/30/2017 AMA FREIDA Online	52864923 06/11/2012 10/30/2014 08/08/2016 USMLE1 USMLE2 USMLE3 201 237 219
35		Seoul, SOUTH KOREA 04/14/1969	DARTMOUTH COL MED SCHOOL Hanover, NH USA M.D. 06/09/1996	Mount Auburn Hospital Cambridge, MA, USA 06/23/1996 to 06/30/1999 DARP PG 532, 1996/97	40348237 06/08/1994 03/05/1996 05/13/1997 USMLE1 USMLE2 USMLE3 203 190 204 ABMS IM Internal Medicine 08/24/1999-12/31/2019-Time Limited
36		Fairfield, CA, USA 04/28/1982	CASE WESTERN RESERVE U Cleveland, OH USA M.D. 05/16/2010	Cleveland Clinic Cleveland, OH, USA 07/01/2011 to 06/30/2016 DARP PG 484, 2011/12	5-172-123-1 07/07/2006 02/05/2010 05/02/2011 USMLE1 USMLE2 USMLE3 237 216 2002
37		La Grange, IL, USA 06/21/1973	MIDWESTERN U AZ COL OSTE Glendale, AZ USA D.O. 06/16/2006	Valley Hospital Medical Center Las Vegas, NV, USA 07/01/2006 to 06/30/2009 AOA Website	740838 06/08/2004 03/22/2006 01/18/2008 COMLEX1 COMLEX2 COMLEX3 575 590 619 AOABPE IM Internal Medicine 09/16/2010-12/31/2020-MOC

NO	NAME AND ADDRESS	PLACE and DATE of BIRTH	UNIVERSITY and DATE of DEGREE	US/CANADIAN TRAINING	EXAM-ID # DATES EXAM/COMB. SCORES
38		Pleasanton, CA, USA 02/22/1958	WRIGHT STATE U Dayton, OH USA M.D. 06/13/1987	Latrobe Area Hospital Latrobe, PA, USA 07/01/1989 to 06/30/1991 DARP PG 168, 1988/89	3-349-133-3 09/04/1985 09/23/1986 03/02/1988 NBME1 NBME2 NBME3 75 75 79.7 ABMS Family Medicine- Family Medicine 06/01/1991-04/17/2023-MOC
39		Kasganj, INDIA 11/30/1980	MED. U. OF THE AMERICAS Nevis, West Indies M.D. 05/16/2014	Hennepin County Medical Center Minneapolis, MN, USA 06/17/2014 to 06/30/2018 AMA FREIDA Online	0-852-992-7 07/20/2012 08/16/2013 06/04/2015 USMLE1 USMLE2 USMLE3 206 228 199 ECFMG 0-852-992-7
40		Youngstown, OH, USA 11/20/1960	HOWARD U Washington, DC USA M.D. 07/25/1987	Georgetown University Hospital Washington, DC, USA 07/29/1987 to 12/31/1991 DARP PG 118, 1987/88	3-340-018-5 09/04/1985 09/23/1986 03/01/1989 NBME1 NBME2 NBME3 76 79 77 ABMS Anesthesiology- Anesthesiology 10/29/1993--Lifetime
41		Grand Forks, ND, USA 05/20/1987	U OF KANSAS SCHL OF MED Kansas City, KS USA M.D. 05/18/2014	U of MN Med Ctr Minneapolis, MN, USA 06/24/2014 to 06/30/2017 AMA FREIDA Online	52854437 06/07/2012 07/22/2013 12/02/2015 USMLE1 USMLE2 USMLE3 235 234 232

NO	NAME AND ADDRESS	PLACE and DATE of BIRTH	UNIVERSITY and DATE of DEGREE	US/CANADIAN TRAINING	EXAM-ID # DATES EXAM/COMB. SCORES
42		Gangapur, INDIA 07/15/1980	SMS MED COL/RAJASTHAN U Jaipur, India M.B., B.S. 08/26/2005	University at Buffalo Buffalo, NY, USA 06/21/2010 to 06/30/2011 DARP PG 193, 2010/11 University at Buffalo Buffalo, NY, USA 07/01/2011 to 06/30/2014 DARP PG 401, 2011/12	06884019 03/02/2006 02/14/2007 02/22/2011 USMLE1 USMLE2 USMLE3 223 213 208 ECFMG 0-688-401-9
43		Kanpur, INDIA 11/25/1983	GSVM MED COL/KANPUR U Kanpur, India M.B., B.S. 02/16/2007	Children's Hospital of Michigan Detroit, MI, USA 07/01/2009 to 06/30/2016 DARP PG 617, 2009/10	07081219 12/14/2006 09/07/2007 02/17/2009 USMLE1 USMLE2 USMLE3 236 234 210 ECFMG 0-708-121-9
44		Bethlehem, PA, USA 02/28/1981	PENN STATE U Hershey, PA USA M.D. 05/20/2007	University of Rochester Rochester, NY, USA 06/13/2007 to 06/25/2010 DARP PG# 431, 2007/08	51552735 06/13/2005 08/03/2006 02/18/2009 USMLE1 USMLE2 USMLE3 219 243 245
45		Seattle, WA, USA 02/25/1981	U OF MINNESOTA Minneapolis, MN USA M.D. 05/05/2012	U of MN Masonic Children's Minneapolis, MN, USA 06/14/2012 to 02/27/2017 AMA FREIDA Online	52364585 06/07/2010 10/06/2011 09/08/2014 USMLE1 USMLE2 USMLE3 238 250 225
46		Wynnewood, PA, USA 10/06/1983	DREXEL U COLLEGE OF MEDICINE Philadelphia, PA USA M.D. 05/17/2013	Drexel University Philadelphia, PA, USA 06/23/2013 to 06/30/2016 AMA FREIDA Online	52604469 06/01/2011 06/28/2012 01/28/2014 USMLE1 USMLE2 USMLE3 245 250 242

NO	NAME AND ADDRESS	PLACE and DATE of BIRTH	UNIVERSITY and DATE of DEGREE	US/CANADIAN TRAINING	EXAM-ID # DATES EXAM/COMB. SCORES
47		Independence, MO, USA 12/19/1953	WAYNE STATE U Detroit, MI USA M.D. 06/03/1979	MidMichigan Medical Center Midland, MI, USA 07/01/1979 to 06/30/1982 DARP PG# 131, 1979/80	3-214-156-6 06/14/1977 09/26/1978 03/05/1980 NBME1 NBME2 NBME3 79 82 81.9 ABMS Family Medicine- Family Medicine 07/09/1982-12/31/2017-Time Limited
48		Uniontown, PA, USA 06/22/1966	WEST VIRGINIA U Morgantown, WV USA M.D. 05/12/1991	Mt Sinai Medical Center Cleveland, OH, USA 07/01/1991 to 06/30/1995 DARP PG# 183, 1991/92	3-407-379-1 06/11/1991 09/25/1990 03/04/1992 NBME1 NBME2 NBME3 78 78 76 ABMS Radiology- Diagnostic Radiology 11/04/1996--Lifetime
49		St. Louis Park, MN, USA 11/04/1987	U OF MINNESOTA Minneapolis, MN USA M.D. 05/09/2015	HCMC Minneapolis, MN, USA 07/01/2015 to 06/30/2016 AMA FREIDA Online	53035614 06/14/2013 11/14/2014 04/20/2016 USMLE1 USMLE2 USMLE3 227 217 224
50		Columbus, OH, USA 07/14/1977	STANFORD U Stanford, CA USA M.D. 06/15/2008	Stanford Hospital and Clinics Stanford, CA, USA 06/21/2008 to 06/30/2016 DARP PG# 706, 2008/09	51493120 06/10/2005 03/25/2008 12/19/2008 USMLE1 USMLE2 USMLE3 232 240 218

NO	NAME AND ADDRESS	PLACE and DATE of BIRTH	UNIVERSITY and DATE of DEGREE	US/CANADIAN TRAINING	EXAM-ID # DATES EXAM/COMB. SCORES
51		Maraghe, IRAN 10/25/1983	S.V. U MED SCH/TIRUPATI Tirupati, INDIA M.B., B.S. 08/10/2007	Medical College of Georgia Augusta, GA, USA 07/01/2009 to 06/30/2013 DARP PG# 391, 2009/10	07551583 05/12/2008 08/12/2008 12/27/2008 USMLE1 USMLE2 USMLE3 250 236 206 ECFMG 0-755-158-3
52		Quezon City, PHILIPPINES 07/29/1982	U OF SANTO TOMAS Manila, PHILIPPINES M.D. 04/15/2010	SUNY Upstate Medical University Syracuse, NY, USA 07/01/2013 to 06/30/2017 AMA FREIDA Online	08283665 01/31/2012 06/29/2012 03/11/2013 USMLE1 USMLE2 USMLE3 254 258 250 ECFMG 0-828-366-5
53		Kishinev, MOLDOVA 06/23/1986	DES MOINES U COLLEGE OF OSTEO MED Des Moines, IA USA D.O. 05/23/2015	U of MN St Cloud Hospital St. Cloud, MN, USA 07/01/2015 to 06/30/2017 AMA FREIDA Online	502278 07/08/2013 09/05/2014 02/09/2016 COMLEX1 COMLEX2 COMLEX3 559 566 740
54		Memphis, TN, USA 08/17/1986	AMER U OF THE CARIBBEAN Plymouth, WEST INDIES M.D. 08/31/2013	HCMC Minneapolis, MN, USA 06/17/2014 to 06/30/2017 AMA FREIDA Online	08177479 06/27/2011 12/22/2012 12/13/2014 USMLE1 USMLE2 USMLE3 213 225 207 ECFMG 0-817-747-9
55		Newton, MA, USA 10/08/1982	TOURO U. COLL OF OSTEO. Vallejo, CA USA D.O. 11/09/2012	Garden City Hospital Garden City, MI, USA 07/01/2013 to 06/30/2016 AMA FREIDA Online	928153 02/12/2010 04/23/2012 12/24/2014 COMLEX1 COMLEX2 COMLEX3 425 433 408

NO	NAME AND ADDRESS	PLACE and DATE of BIRTH	UNIVERSITY and DATE of DEGREE	US/CANADIAN TRAINING	EXAM-ID # DATES EXAM/COMB. SCORES
56		Cincinnati, OH, USA 10/28/1979	U OF WISCONSINMADISON Madison, WI USA M.D. 05/14/2006	University of Wisconsin Madison, WI, USA 06/24/2006 to 06/30/2009 DARP PG# 375, 2006/07	51382174 06/14/2004 11/17/2005 12/11/2007 USMLE1 USMLE2 USMLE3 202 234 229
57		Fairbanks, AK, USA 06/26/1985	LOMA LINDA U Loma Linda, CA USA M.D. 05/29/2011	Loma Linda University Medical Cen Loma Linda, CA, USA 06/30/2011 to 10/31/2014 AMA FREIDA Online	52189610 06/17/2009 07/30/2010 09/14/2011 USMLE1 USMLE2 USMLE3 241 242 221
58		New York, NY, USA 12/01/1986	AMERICA U OF THE CARIBBEAN, ST MAARTEN Cupecoy, Netherlands Antilles M.D. 12/29/2012	UND Medical Education Center Fargo, ND, USA 07/29/2013 to 06/30/2016 AMA FREIDA Online	08082158 11/09/2010 06/18/2012 11/25/2013 USMLE1 USMLE2 USMLE3 211 235 207 ECFMG 0-808-215-8
59		Rochester, MN, USA 03/30/1987	MED COL WI/MARQUETTE U Milwaukee, WI USA M.D. 05/16/2014	University of Minnesota Minneapolis, MN, USA 06/10/2014 to 06/30/2017 AMA FREIDA Online	52798626 06/07/2012 07/22/2013 04/08/2015 USMLE1 USMLE2 USMLE3 225 232 230
60		Roanoke, VA, USA 07/06/1984	MED COL OF VIRGINIA Richmond, VA USA M.D. 05/20/2010	University of Maryland Baltimore, MD, USA 06/24/2010 to 06/23/2011 DARP PG# 188, 2010/11	52030038 07/02/2008 08/27/2009 04/22/2013 USMLE1 USMLE2 USMLE3 234 263 233

NO	NAME AND ADDRESS	PLACE and DATE of BIRTH	UNIVERSITY and DATE of DEGREE	US/CANADIAN TRAINING	EXAM-ID # DATES EXAM/COMB. SCORES
61		St. Paul, MN, USA 04/22/1974	U OF NORTH DAKOTA Grand Forks, ND USA M.D. 05/10/2003	Penn State Milton S Hershey Hershey, PA, USA 07/01/2003 to 06/30/2006 DARP PG# 651, 2003/04	50948785 06/18/2001 12/20/2002 03/01/2005 USMLE1 USMLE2 USMLE3 223 229 226 ABMS IM Internal Medicine 08/28/2006-12/31/2016-Time Limited
62		Mumbai, INDIA 08/01/1984	TOPIWAA NAT'L MED COLLEGE, U OF MUMBAI Mumbai, INDIA M.B., B.S. 05/15/2008	University of Virginia Health Charlottesville, VA, USA 07/01/2009 to 06/30/2012 DARP PG# 657, 2009/10	07316706 11/19/2007 06/02/2008 06/01/2010 USMLE1 USMLE2 USMLE3 222 209 201 ECFMG 0-731-670-6
63		Bucuresti, ROMANIA 09/14/1977	U MEDICINA SI FARMACIE Bucuresti, ROMANIA 10/23/2002	Overlook Hospital Summit, NJ, USA 07/01/2005 to 06/30/2008 DARP PG# 669, 2005/06	06378426 07/29/2002 03/26/2003 02/25/2004 USMLE1 USMLE2 USMLE3 227 196 212 ECFMG 0-637-842-6 ABMS Family Medicine- Family Medicine 12/03/2008-12/31/2018-Time Limited

NO	NAME AND ADDRESS	PLACE and DATE of BIRTH	UNIVERSITY and DATE of DEGREE	US/CANADIAN TRAINING	EXAM-ID # DATES EXAM/COMB. SCORES
64		Newport Beach, CA, USA 06/14/1969	ST GEORGES U St. George's, GRENADA 05/15/1998	University of Southern California Los Angeles, CA, USA 07/01/1999 to 06/30/2002 DARP PG# 463, 1999/00	05539002 06/11/1996 08/26/1997 05/11/1999 USMLE1 USMLE2 USMLE3 241 239 233 ECFMG 0-553-900-2 ABMS Emergency Medicine- Emergency Medicine 11/07/2003-12/31/2023-Time Limited
65		Corpus Christi, TX, USA 12/14/1952	TEXAS TECH U Lubbock, TX USA M.D. 06/05/1983	University of Texas San Antonio, TX, USA 07/01/1983 to 06/01/1986 DARP PG 238, 1982/83	21278692 06/14/1983 FLEX 77 TX ABMS Physical Med. & Rehab.- Physical Medicine & Rehabil05/17/1987--Lifetime
66		Mumbai, INDIA 12/02/1974	U OF CA/LOS ANGELES Los Angeles, CA USA M.D. 06/01/2001	Saint John Hospital and Medical Cli Detroit, MI, USA 07/01/2001 to 07/01/2002 DARP PG 996, 2001/02	5-030-807-1 07/31/1999 02/23/2001 11/15/2003 USMLE1 USMLE2 USMLE3 209 197 205 ABMS Family Medicine- Family Medicine 08/01/2009-12/31/2018-MOC
67		Sunsari, NEPAL 01/06/1988	B.J. MEDICAL COLLEGE, UNIV OF PUNE Pune, INDIA M.B., B.S. 12/31/2010	Gundersen Lutheran La Crosse, WI, USA 06/30/2014 to 06/29/2017 AMA FREIDA Online	08346942 02/28/2013 09/24/2013 05/26/2015 USMLE1 USMLE2 USMLE3 250 253 239 ECFMG 08346942

NO	NAME AND ADDRESS	PLACE and DATE of BIRTH	UNIVERSITY and DATE of DEGREE	US/CANADIAN TRAINING	EXAM-ID # DATES EXAM/COMB. SCORES
68		Barmer, INDIA 11/24/1984	DR SN MED COL/RAJASTHAN Jodhpur, INDIA M.B., B.S. 09/05/2008	University of Missouri Columbia, MN, USA 07/01/2009 to 06/30/2012 DARP PG 398, 2009/10	07389927 05/13/2008 11/28/2007 02/18/2009 USMLE1 USMLE2 USMLE3 263 255 220 ECFMG 07389927
69		Gapan, PHILIPPINES 09/02/1974	U OF EAST/MAGSAYSAY COL Quezon City, PHILLIPINES M.D. 04/14/1999	University of Minnesota Minneapolis, MN, USA 07/01/2014 to 07/18/2017 AMA FREIDA Online	07450661 04/30/2010 02/22/2011 01/09/2015 USMLE1 USMLE2 USMLE3 218 235 214 ECFMG 07450661
70		Poughkeepsie, NY, USA 06/29/1955	MOUNT SINAI/CITY U OF NY New York, NY USA M.D. 05/29/1981	Emory University Atlanta, GA, USA 07/01/1982 to 06/30/1984 DARP PG 120, 1984/85	32467219 06/12/1979 09/23/1980 03/10/1982 NBME1 NBME2 NBME3 485 500 460 ABMS Emergency Medicine- Emergency Medicine 01/01/2016-12/31/2025-Time Limited
71		New Delhi, INDIA 03/02/1985	ALL INDIA INST MED SCI New Delhi, INDIA M.B., B.S. 08/27/2009	Good Samaritan Hospital Baltimore, MD, USA 07/01/2012 to 06/30/2013 DARP PG 189, 2012/13 Temple University Hospital Philadelphia, PA, USA 07/01/2013 to 06/30/2016 AMA FREIDA Online	07525280 02/26/2009 12/14/2009 06/22/2011 USMLE1 USMLE2 USMLE3 247 227 208 ECFMG 07525280

NO	NAME AND ADDRESS	PLACE and DATE of BIRTH	UNIVERSITY and DATE of DEGREE	US/CANADIAN TRAINING	EXAM-ID # DATES EXAM/COMB. SCORES
72		Indianapolis, IN, USA 05/23/1961	U OF IOWA/COL OF MED Iowa City, IA USA M.D. 05/14/1988	Maricopa County Medical Center Phoenix, AZ, USA 06/19/1988 to 06/27/1989 DARP PG 480, 1988/89	22235709 06/14/1988 06/14/1988 FLEX FLEX2 77 77 IA IA ABMS Preventive Med. - Public Health & General Medicine 01/01/2008-01/31/2018-Time Limited
73		Rangely, CO, USA 11/02/1961	MAYO MED SCH Rochester, MN USA M.D. 05/21/1988	Naval Hospital- Camp Pendleton Camp Pendleton, CA, USA 07/01/1988 to 06/30/1989 DARP PG 155, 1988/89	33640780 06/10/1986 04/12/1988 05/17/1989 NBME1 NBME2 NBME3 510 630 665 ABMS Family Medicine- Family Medicine 04/04/2016-MOC
74		Philadelphia, PA, USA 05/18/1946	PHILADELPHIA COL OSTEO Philadelphia, PA USA D.O. 06/02/1974	Michigan Osteopathic Medical Cent Detroit, MI, USA 07/01/1974 to 06/30/1975 AOA Website	049553 05/10/1972 03/14/1974 01/15/1975 COMPLEX1 COMPLEX2 COMPLEX3 79 81 80 ABMS Physical Med. & Rehab.- Physical Medicine & Rehabil05/30/1981--Lifetime
75		Winnipeg, MB, CANADA 01/31/1986	U OF DUBLIN/TRINITY COLLEGE Dublin, IRELAND MB, BCh, BAO 05/13/2014	Cedar Rapids Medical Education Fc Cedar Rapids, IA, USA 06/23/2014 to 06/30/2017 AMA FREIDA Online	08383317 08/21/2012 09/05/2013 04/29/2015 USMLE1 USMLE2 USMLE3 206 210 232 ECFMG 08383317

NO	NAME AND ADDRESS	PLACE and DATE of BIRTH	UNIVERSITY and DATE of DEGREE	US/CANADIAN TRAINING	EXAM-ID # DATES EXAM/COMB. SCORES
76		Buffalo, MN, USA 10/24/1971	JOHNS HOPKINS U Baltimore, MD USA M.D. 05/21/1998	University of Cincinnati Cincinnati, OH, USA 07/01/1998 to 06/30/2001 DARP PG 484, 1998/99	50115989 10/15/1996 03/03/1998 05/11/1999 USMLE1 USMLE2 USMLE3 223 220 222 ABMS Family Medicine- Family Medicine 07/26/2008-12/31/2018-Time Limited
77		Rhineland, WI, USA 12/02/1951	U OF MINNESOTA Minneapolis, MN USA M.D. 06/05/1985	University of Minnesota Minneapolis, MN, USA 09/01/1985 to 09/01/1986 DARP PG 263, 1985/86	33037375 09/09/1982 04/02/1985 05/21/1986 NBME1 NBME2 NBME3 540 430 355 ABMS Family Medicine- Family Medicine 04/14/2014-MOC
78		Tochigi, JAPAN 04/25/1978	U OF MINNESOTA Minneapolis, MN USA M.D. 05/05/2007	Spectrum Health Butterworth Grand Rapids, MI, USA 07/01/2007 to 06/30/2011 DARP PG 466, 2007/08	51621951 07/07/2005 11/06/2006 10/16/2008 USMLE1 USMLE2 USMLE3 190 198 192
79		Bangkok, THAILAND 10/12/1981	FAC OF MED MAHIDOL U, SIRIRAJ HOSPITAL Bangkok, THAILAND M.D. 03/14/2006	Texas Tech University Lubbock, TX, USA 07/01/2013 to 06/30/2017 AMA FREIDA Online	07530199 07/08/2008 01/30/2009 08/20/2013 USMLE1 USMLE2 USMLE3 224 253 205 ECFMG 07530199

NO	NAME AND ADDRESS	PLACE and DATE of BIRTH	UNIVERSITY and DATE of DEGREE	US/CANADIAN TRAINING	EXAM-ID # DATES EXAM/COMB. SCORES
80		Fargo, ND, USA 08/05/1964	U OF NORTH DAKOTA Grand Forks, ND USA M.D. 05/12/1990	Altru Hospital Grand Forks, ND, USA 07/01/1990 to 06/30/1995 DARP PG 498, 1990/91	33926163 06/14/1988 04/03/1990 03/06/1991 NBME1 NBME2 NBME3 440 470 420 ABMS Surgery- Surgery 12/15/2005-12/31/2016-Time Limited
81		Kavali, Andhra Pradesh, INDIA 09/07/1983	S.V. U MED SCH/TIRUPATI Tirupati, INDIA M.B., B.S. 08/01/2008	HCMC Minneapolis, MN, USA 06/17/2014 to 06/30/2017 AMA FREIDA Online	08762866 08/30/2011 06/28/2012 01/26/2015 USMLE1 USMLE2 USMLE3 231 238 203 ECFMG 08762866
82		Trivandrum, INDIA 12/18/1971	U OF HLTH SCI COLL OF OSTEOPATHIC MED Kansas City, MO USA D.O. 05/17/1998	Capital Region Medical Center Jefferson City, MO, USA 06/24/1998 to 06/23/1999 AOIA Report	396125 06/04/1996 03/24/1998 02/09/1999 COMPLEX1 COMPLEX2 COMPLEX3 489 460 471 ABMS Psy. & Neur.- Psychiatry 06/08/2007-12/31/2017-Time Limited
83		Pittsburgh, PA, USA 03/10/1988	STATE U OF NY/BROOKLYN Brooklyn, NY USA M.D. 05/31/2014	University of Minnesota Minneapolis, MN, USA 06/16/2014 to 06/11/2021 AMA FREIDA Online	52891884 06/16/2012 07/12/2013 10/22/2015 USMLE1 USMLE2 USMLE3 253 254 233

11/12/2016

Physician Licensure

NO	NAME AND ADDRESS	PLACE and DATE of BIRTH	UNIVERSITY and DATE of DEGREE	US/CANADIAN TRAINING	EXAM-ID # DATES EXAM/COMB. SCORES
84		Baghdad, IRAQ 08/31/1981	WAYNE STATE U Detroit, MI USA M.D. 06/02/2009	Crittenton Hospital Rochester, MI, USA 07/01/2009 to 06/30/2012 DARP PG 307, 2009/10	51707289 06/22/2007 07/31/2008 04/28/2010 USMLE1 USMLE2 USMLE3 227 224 220

DATE: 11/12/2016

SUBMITTED BY: AP Advisory Council

SUBJECT: Acupuncture Licensure

REQUEST FOR BOARD ACTION
MINNESOTA BOARD OF MEDICAL PRACTICE

REQUESTED ACTION:

The following acupuncture applicants for licensure be approved subject to receipt of all verification documents.

85 - 87 of agenda

MOTION BY:

SECOND:

Passed Amended Layed Over Defeated

BACKGROUND:

See # 85 - 87 for each applicants credentials

GENAP = GENERAL REGISTRATION
RECIAP = RECIPROCITY REGISTRATION
RANAP = TRANSITIONAL REGISTRATION

11/12/2016

Acupuncture Licensure

NO	NAME AND ADDRESS	PLACE and DATE of BIRTH	UNIVERSITY and DATE of DEGREE	BASIS	CERTIFICATE NO
85		Devils Lake, IA, USA 09/30/1985	MN College of AP & OM Bloomington, MN USA M.AC 12/18/2010	APRE	128278
86		Minneapolis, MN, USA 06/02/1975	Pacific Coll of OM Chicago, IL USA M.OM 12/11/2011	APRE	137775
87		Fargo, ND, USA 08/29/1980	MCOM at Northwestern Health Bloomington, MN USA M.AC 04/16/2016	APGR	163348

DATE: 11/12/2016

SUBMITTED BY: AT Advisory Council

SUBJECT: Athletic Trainer Registration

REQUEST FOR BOARD ACTION
MINNESOTA BOARD OF MEDICAL PRACTICE

REQUESTED ACTION:

The following athletic trainer applicants be approved subject to receipt of all verification documents.

88 - 130 of agenda

MOTION BY:

SECOND:

Passed Amended Layed Over Defeated

BACKGROUND:

See # 88 - 130 for each applicants credentials

NATAEQ = EQUIVALENCY REGISTRATION
NATAGR = GENERAL REGISTRATION
NATARE = RECIPROCITY REGISTRATION
NATATR = TRANSITIONAL REGISTRATION
CATAEQ = CANADIAN EXAM

11/12/2016

Athletic Trainer Registration

NO	NAME AND ADDRESS	PLACE and DATE of BIRTH	UNIVERSITY and DATE of DEGREE	BASIS	CERTIFICATE NO
88		St. Louis Park, MN, USA 04/01/1992	Coll of St. Scholastica Duluth, MN USA NATA Approved NATA Approved 05/14/2016	NATAGR	2000024337
89		Grand Forks, ND, USA 08/29/1987	North Dakota State U Fargo, ND USA NATA Approved NATA Approved 05/16/2014	NATARE	2000017385
90		Windom, MN, USA 11/29/1993	MN State U/Mankato Mankato, MN USA NATA Approved NATA Approved 05/07/2016	NATAGR	2000026186
91		Minneapolis, MN, USA 09/09/1992	St. Cloud State U St. Cloud, MN USA NATA Approved NATA Approved 05/06/2016	NATAGR	2000025807
92		Edina, MN, USA 01/13/1994	Bethel University St. Paul, MN USA NATA Approved NATA Approved 05/21/2016	NATAGR	2000025888
93		Rochester, MN, USA 03/27/1994	U Of Wisconsin La Crosse, WI USA NATA Approved NATA Approved 05/14/2016	NATAGR	2000025043
94		Saint Croix Falls, WI, USA 07/30/1991	Coll of St. Scholastica Duluth, MN USA NATA Approved NATA Approved 05/14/2016	NATAGR	2000025044
95		Duluth, MN, USA 04/14/1987	Coll of St. Scholastica Duluth, MN USA NATA Approved NATA Approved 05/14/2016	NATAGR	20000263626

11/12/2016

Athletic Trainer Registration

NO	NAME AND ADDRESS	PLACE and DATE of BIRTH	UNIVERSITY and DATE of DEGREE	BASIS	CERTIFICATE NO
96		Minneapolis, MN, USA 12/03/1981	U Of Wisconsin La Crosse, WI USA NATA Approved NATA Approved 05/15/2004	NATARE	060402475
97		Madison, MN, USA 05/23/1992	U Of Wisconsin La Crosse, WI USA NATA Approved NATA Approved 05/11/2014	NATAGR	2000017697
98		MN, USA 10/02/1993	Bethel University St. Paul, MN USA NATA Approved NATA Approved 05/21/2016	NATAGR	2000025376
99		Minneapolis, MN, USA 08/23/1992	Coll of St. Scholastica Duluth, MN USA NATA Approved NATA Approved 05/14/2016	NATAGR	2000024512
100		Anchorage, AK, USA 03/31/1993	U Of North Dakota Grand Forks, ND USA NATA Approved NATA Approved 05/14/2016	NATAGR	2000024989
101		Crystal City, MO, USA 03/05/1993	LINDENWOOD UNIVERSITY Belleville, IL USA NATA Approved NATA Approved 05/30/2016	NATAGR	2000024751
102		Fargo, ND, USA 11/01/1991	U Of Minnesota/Duluth Duluth, MN USA NATA Approved NATA Approved 05/15/2015	NATAGR	2000021254
103		Shakopee, MN, USA 04/30/1993	MSU-Mankato Mankato, MN USA NATA Approved NATA Approved 05/06/2016	NATAGR	2000023769

11/12/2016

Athletic Trainer Registration

NO	NAME AND ADDRESS	PLACE and DATE of BIRTH	UNIVERSITY and DATE of DEGREE	BASIS	CERTIFICATE NO
104		Denver, CO, USA 05/22/1992	SD State U Brookings, SD USA NATA Approved NATA Approved 05/09/2014	NATARE	2000017593
105		Huron, SD, USA 01/30/1990	Augustana College Sioux Falls, SD USA NATA Approved NATA Approved 05/19/2012	NATARE	2000011309
106		Britt, IA, USA 10/08/1991	Central College Pella, IA USA NATA Approved NATA Approved 05/17/2014	NATARE	2000017735
107		Marshfield, WI, USA 09/17/1992	UW Eau Claire Eau Claire, WI USA NATA Approved NATA Approved 05/25/2015	NATAGR	2000020813
108		St. Cloud, MN, USA 11/04/1993	St. Cloud State U St. Cloud, MN USA NATA Approved NATA Approved 05/06/2016	NATAGR	2000026349
109		Richmond, VA, USA 11/18/1989	Coll of St. Scholastica Duluth, USA NATA Approved NATA Approved 05/14/2016	NATAGR	2000024689
110		Libertyville, IL, USA 01/19/1994	IL State U Normal, IL USA NATA Approved NATA Approved 05/07/2016	NATAGR	2000025096
111		Sandstone, MN, USA 03/08/1985	St. Cloud State U St. Cloud, MN USA NATA Approved NATA Approved 05/06/2016	NATAGR	2000023619

11/12/2016

Athletic Trainer Registration

NO	NAME AND ADDRESS	PLACE and DATE of BIRTH	UNIVERSITY and DATE of DEGREE	BASIS	CERTIFICATE NO
112		Alexandria, MN, USA 07/29/1993	North Dakota State U Fargo, ND USA NATA Approved NATA Approved 05/13/2016	NATAGR	2000025351
113		Calgary, Canada 10/07/1994	Valley City State U Valley City, ND USA NATA Approved NATA Approved 05/14/2016	NATAGR	2000025626
114		Lake Forest, IL, USA 01/23/1987	U Of Wisconsin/Stevens Point Stevens Point, IL USA NATA Approved NATA Approved 08/15/2011	NATARE	2000001017
115		Waseca, MN, USA 07/07/1994	Winona State U Winona, MN USA NATA Approved NATA Approved 05/06/2016	NATAGR	2000024666
116		Coon Rapids, ME, USA 07/09/1993	St. Cloud State U St. Cloud, MN USA NATA Approved NATA Approved 05/06/2016	NATAGR	2000023448
117		Seoul, South Korea 07/27/1994	Winona State U Winona, WI USA NATA Approved NATA Approved 05/06/2016	NATAGR	2000023764
118		Canby, MN, USA 10/04/1989	SD State U Brookings, SD USA NATA Approved NATA Approved 05/11/2013	NATAGR	2000014579
119		Faribault, MN, USA 05/03/1991	St. Cloud State U St. Cloud, MN USA NATA Approved NATA Intern 05/06/2016	NATAGR	2000025632

11/12/2016

Athletic Trainer Registration

NO	NAME AND ADDRESS	PLACE and DATE of BIRTH	UNIVERSITY and DATE of DEGREE	BASIS	CERTIFICATE NO
120		Valley City, ND, USA 06/02/1989	MN State U/Moorhead Moorhead, MN USA NATA Approved NATA Approved 05/11/2012	NATARE	2000009617
121		Madison, WI, USA 08/10/1994	Luther College Decorah, IA USA NATA Approved NATA Approved 05/22/2016	NATAGR	2000025161
122		Burnsville, MN, USA 12/28/1990	CHATTANOOGA Chattanooga, TN USA NATA Approved NATA Approved 05/02/2015	NATARE	2000019573
123		Eau Claire, WI, USA 10/16/1991	U Of Wisconsin/Eau Claire Eau Claire, WI USA NATA Approved NATA Approved 05/23/2016	NATARE	2000021245
124		Green Bay, WI, USA 01/02/1993	MN State U Mankato Mankato, MN USA NATA Approved NATA Approved 05/01/2015	NATARE	2000021064
125		Ashland, WI, USA 09/21/1994	Gustavus Adolphus St. Peter, MN USA NATA Approved NATA Approved 05/29/2016	NATAGR	2000025334
126		Fargo, ND, USA 10/30/1993	Gustavus Adolphus St. Peter, MN USA NATA Approved NATA Approved 05/29/2016	NATAGR	200024948
127		Scottsdale, AZ, USA 03/20/1990	Augustana College Sioux Falls, SD USA NATA Approved NATA Approved 05/19/2012	NATARE	2000012006

11/12/2016

Athletic Trainer Registration

NO	NAME AND ADDRESS	PLACE and DATE of BIRTH	UNIVERSITY and DATE of DEGREE	BASIS	CERTIFICATE NO
128		Olean, NY, USA 09/19/1987	DAEMEN COLLEGE Amherst, NY USA NATA Approved NATA Approved 05/19/2012	NATARE	2000010833
129		St. Paul, MN, USA 03/22/1994	U. of KS Lawrence, KS USA NATA Approved NATA Approved 05/15/2016	NATAGR	2000025715
130		Bismarck, ND, USA 05/20/1991	MN State U Mankato Mankato, MN USA NATA Approved NATA Approved 05/06/2016	NATAGR	200002521

DATE: 11/12/2016

SUBMITTED BY: PA Advisory Council

SUBJECT: Physician Assistant Licensure

REQUEST FOR BOARD ACTION
MINNESOTA BOARD OF MEDICAL PRACTICE

REQUESTED ACTION:

The following physician assistant applicants for licensure be approved subject to receipt of all verification documents.

131 - 196 of agenda

MOTION BY:

SECOND:

 Passed Amended Layed Over Defeated

BACKGROUND:

See # 131 - 196 for each applicants credentials

NCCPA = NATL COMMISSION ON THE CERTIFICATION OF PA
OTHERPA = OTHER

11/12/2016

Physician Assistant Licensure

NO	NAME AND ADDRESS	PLACE and DATE of BIRTH	UNIVERSITY and DATE of DEGREE	BASIS	CERTIFICATE NO
131		Vallejo, CA, USA 04/09/1987	TOURO UNIVERSITY Vallejo, CA USA MSPA 06/03/2016	NCCPA	1133980
132		St. Paul, MN, USA 06/20/1986	TOURO UNIVERSITY Vallejo, CA USA MSPA 06/03/2016	NCCPA	1133981
133		Duluth, MN, USA 06/23/1990	Bethel University St. Paul, MN USA MSPA 08/13/2016	NCCPA	1136807
134		Tyler, TX, USA 05/08/1982	Wake Forest U Winston Salem, NC USA MSPA 05/16/2011	NCCPA	1097566
135		Fargo, ND, USA 04/04/1989	Bethel University St. Paul, MN USA MSPA 08/13/2016	NCCPA	1136808
136		Robbinsdale, MN, USA 09/04/1990	CONCORDIA Mequon, WI USA MSPA 07/15/2016	NCCPA	1135933
137		Marshall, MN, USA 08/16/1990	U Of South Dakota Vermillion, SD USA MSPA 07/29/2016	NCCPA	1136283
138		Coon Rapids, MN, USA 09/27/1985	U Of Wisconsin Madison, WI USA MSPA 05/15/2016	NCCPA	1133871
139		La Crosse, WI, USA 05/06/1991	Bethel University St. Paul, MN USA MSPA 08/13/2016	NCCPA	1136809
140		Burnsville, MN, USA 02/10/1992	Philadelphia U. Philadelphia, PA USA MSPA 08/12/2016	NCCPA	1133394

11/12/2016

Physician Assistant Licensure

NO	NAME AND ADDRESS	PLACE and DATE of BIRTH	UNIVERSITY and DATE of DEGREE	BASIS	CERTIFICATE NO
141		Missoula, MT, USA 08/23/1989	Bethel University St. Paul, MN USA MSPA 08/13/2016	NCCPA	1168103
142		Brainerd, MN, USA 05/22/1990	U. of New England Portland, ME USA MSPA 05/21/2016	NCCPA	1134769
143		St. Louis Park, MN, USA 04/03/1991	Bethel University St. Paul, MN USA 08/13/2016	NCCPA	1136813
144		Iowa City, IA, USA 09/09/1988	Western U Of Hlth Sci Pomona, CA USA MSPA 07/31/2015	NCCPA	1128419
145		Grand Rapids, MN, USA 12/24/1989	NOVA Southeast U Fort Myers, FL USA MSPA 08/31/2016	NCCPA	1138270
146		St. Louis Park, MN, USA 07/09/1989	Midwestern U. Downers Grove, IL USA MSPA 08/26/2016	NCCPA	1137757
147		Vermillion, SD, USA 01/17/1989	U Of South Dakota Vermillion, SD USA MSPA 07/29/2016	NCCPA	1136287
148		Glendive, MT, USA 08/13/1976	University of Colorado Aurora, CO USA MSPA 05/28/2010	NCCPA	1090502
149		Lexington, KY, USA 11/18/1992	SETON HILL UNIVERSITY Greensburg, PA USA MSPA 05/14/2016	NCCPA	1134906

11/12/2016

Physician Assistant Licensure

NO	NAME AND ADDRESS	PLACE and DATE of BIRTH	UNIVERSITY and DATE of DEGREE	BASIS	CERTIFICATE NO
150		Rocky Mount, NC, USA 06/21/1970	Duke U Durham, NC USA MSPA 08/26/2005	NCCPA	1068912
151		Rock Valley, IA, USA 12/05/1988	THOMAS JEFFERSON UNIVERSITY Philadelphia, PA USA MSPA 08/31/2016	NCCPA	1138034
152		Fridley, MN, USA 02/26/1991	Midwestern U. Downers Grove, IL USA MSPA 08/26/2016	NCCPA	1137876
153		St. Paul, MN, USA 05/27/1988	Augsburg College Minneapolis, MN USA MSPA 12/18/2015	NCCPA	1132608
154		Reno, NV, USA 12/10/1986	Bethel University St. Paul, MN USA MSPA 08/13/2016	NCCPA	1136817
155		Maplewood, MN, USA 02/16/1990	Rocky Mountain College Billings, MT USA MSPA 08/20/2014	NCCPA	1138763
156		St. Louis, MO, USA 02/07/1991	Midwestern U. Downers Grove, IL USA MSPA 08/26/2016	NCCPA	1137783
157		Minneapolis, MN, USA 06/03/1992	Bethel University St. Paul, MN USA MSPA 08/13/2016	NCCPA	1136820
158		St. Louis Park, MN, USA 02/19/1991	Bethel University St. Paul, MN USA MSPA 08/13/2016	NCCPA	1136815
159		Robbinsdale, MN, USA 06/02/1988	Bethel University St. Paul, MN USA MSPA 08/13/2016	NCCPA	1136822

11/12/2016

Physician Assistant Licensure

NO	NAME AND ADDRESS	PLACE and DATE of BIRTH	UNIVERSITY and DATE of DEGREE	BASIS	CERTIFICATE NO
160		Red Wing, MN, USA 03/15/1984	Rosalind Franklin U of M&S North Chicago, IL USA MSPA 06/06/2008	NCCPA	1083074
161		Edina, MN, USA 01/13/1987	University of Colorado Aurora, CO USA MSPA 05/27/2016	NCCPA	1133453
162		Tuzla 07/10/1986	U Of Wisconsin Madison, WI USA MSPA 05/13/2016	NCCPA	1133900
163		Buffalo, MN, USA 02/23/1990	Bethel University St. Paul, MN USA MSPA 08/13/2016	NCCPA	1136824
164		Charleston, SC, USA 09/04/1988	Wake Forest U Winston-Salem, NC USA MSPA 05/19/2014	NCCPA	1118713
165		Oconomowoc, WI, USA 04/06/1987	U Of Wisconsin/La Crosse La Crosse, WI USA MSPA 06/01/2013	NCCPA	1110319
166		Pipestone, MN, USA 12/28/1974	Augsburg College Minneapolis, MN USA MSPA 05/05/2016	NCCPA	1104113
167		Minneapolis, MN, USA 04/08/1984	U. of New England Portland, OR USA MSPA 05/21/2016	NCCPA	1134794
168		Waconia, MN, USA 02/27/1989	Rosalind Franklin U of M&S North Chicago, IL USA MSPA 06/03/2016	NCCPA	1135136

11/12/2016

Physician Assistant Licensure

NO	NAME AND ADDRESS	PLACE and DATE of BIRTH	UNIVERSITY and DATE of DEGREE	BASIS	CERTIFICATE NO
169		Coon Rapids, MN, USA 10/19/1990	Bethel University St. Paul, MN USA MSPA 08/13/2016	NCCPA	1136826
170		Toledo, OH, USA 08/08/1991	DESALES UNIVERSITY Center Valley, PA USA MSPA 09/01/2016	NCCPA	1124593
171		Robbinsdale, MN, USA 06/20/1990	Duke U Durham, NC USA MSPA 08/05/2016	NCCPA	1136254
172		Northfield, MN, USA 08/30/1990	U Of Florida Gainesville, FL USA MSPA 06/18/2016	NCCPA	1135347
173		Minneapolis, MN, USA 10/18/1983	U Of Wisconsin Madison, WI USA MSPA 07/13/2016	NCCPA	1133927
174		Fort Lauderdale, FL, USA 04/13/1984	Carroll U Waukesha, WI USA MSPA 05/12/2013	NCCPA	1111536
175		Northfield, MN, USA 09/01/1990	Central MI U. Mt. Pleasant, MI USA MSPA 08/10/2016	NCCPA	1137617
176		Milwaukee, WI, USA 02/20/1989	CONCORDIA Mequon, WI USA MSPA 07/15/2016	NCCPA	1135961
177		Madison, MN, USA 02/11/1990	Bethel University St. Paul, MN USA MSPA 08/13/2016	NCCPA	1136829
178		Winfield, IL, USA 04/03/1987	Marquette U Milwaukee, WI USA MSPA 05/20/2012	NCCPA	1101113

11/12/2016

Physician Assistant Licensure

NO	NAME AND ADDRESS	PLACE and DATE of BIRTH	UNIVERSITY and DATE of DEGREE	BASIS	CERTIFICATE NO
179		Indianapolis, IN, USA 01/26/1987	Butler U Indianapolis, IN USA MSPA 05/11/2013	NCCPA	1111511
180		Rochester, MN, USA 06/05/1990	Midwestern U Az Col Oste Glendale, AZ USA B.S. 08/21/2014	NCCPA	1122795
181		Cedar Rapids, IA, USA 09/04/1991	Bethel University St. Paul, MN USA MSPA 08/13/2016	NCCPA	1136830
182		Baker, OR, USA 08/19/1974	Pacific U Forest Grove, OR USA MSPA 08/11/2001	NCCPA	1053094
183		Edina, MN, USA 04/01/1983	Bethel University St. Paul, MN USA MSPA 08/13/2016	NCCPA	1136831
184		Fort Dodge, IA, USA 07/10/1992	U Of South Dakota Vermillion, SD USA MSPA 07/29/2016	NCCPA	1136301
185		Burlington, WI, USA 07/21/1973	A.T. Still U Mesa, AZ USA MSPA 08/21/1999	NCCPA	1043973
186		Winona, MN, USA 10/21/1989	Des Moines U Des Moines, IA USA MSPA 05/28/2016	NCCPA	1135404
187		Baldwin, WI, USA 02/28/1988	Rosalind Franklin U of M&S North Chicago, IL USA MSPA 06/03/2016	NCCPA	1135152
188		Brookings, SD, USA 05/20/1985	U Of South Dakota Vermillion, SD USA MSPA 05/08/2013	NCCPA	1109161

11/12/2016

Physician Assistant Licensure

NO	NAME AND ADDRESS	PLACE and DATE of BIRTH	UNIVERSITY and DATE of DEGREE	BASIS	CERTIFICATE NO
189		Buffalo, MN, USA 06/08/1990	Carroll U Waukesha, WI USA MSPA 05/08/2016	NCCPA	1126431
190		Lincoln, NE, USA 11/07/1991	Bethel University St. Paul, MN USA MSPA 08/13/2016	NCCPA	1136832
191		Mankato, MN, USA 01/19/1992	U Of South Dakota Vermillion, SD USA MSPA 07/29/2016	NCCPA	1136302
192		Minneapolis, MN, USA 04/09/1989	Western U Of Hlth Sci Pomona, CA USA MSPA 07/31/2016	NCCPA	1136926
193		Evansville, IN, USA 05/10/1992	Rosalind Franklin U of M&S North Chicago, IL USA MSPA 06/03/2016	NCCPA	1135155
194		Plantation, FL, USA 05/19/1986	Ft. Lauderdale, FL Fort Lauderdale, FL USA MSPA 12/15/2012	NCCPA	1103723
195		Landstuhl, Germany 06/27/1990	Bethel University St. Paul, MN USA MSPA 08/13/2016	NCCPA	113833
196		Pretoria, South Africa 10/23/1989	Bethel University St. Paul, MN USA MSPA 08/13/2016	NCCPA	1136834

DATE: 11/12/2016

SUBMITTED BY: RT Advisory Council

SUBJECT: Respiratory Therapist Licensure

REQUEST FOR BOARD ACTION
MINNESOTA BOARD OF MEDICAL PRACTICE

REQUESTED ACTION:

The following respiratory therapist applicants for licensure be approved subject to receipt of all verification documents.

197 - 234 of agenda

MOTION BY:

SECOND:

Passed Amended Layed Over Defeated

BACKGROUND:

See # 197 - 234 for each applicants credentials

NBRCGR = GENERAL REGISTRATION
NBRCRE = RECIPROCITY REGISTRATION

NO	NAME AND ADDRESS	PLACE and DATE of BIRTH	UNIVERSITY and DATE of DEGREE	BASIS	CERTIFICATE NO
197		Dire Dawa, Ethiopia 02/06/1995	St. Paul College St. Paul, MN USA AAS 07/22/2016	NBRCGR	1935
198		Minneapolis, MN, USA 08/07/1992	St. Paul College St. Paul, MN USA AAS 07/22/2016	NBRCGR	2669
199		Mogadisho, Somalia 01/01/1987	St. Paul College St. Paul, MN USA AAS 07/22/2016	NBRCGR	6843
200		Tema, Ghana 06/13/1984	St. Paul College St. Paul, MN USA AAS 07/22/2016	NBRCGR	1209
201		Willmar, MN, USA 11/11/1993	U Of Minnesota/Rochester, Rochester, USA Rochester, MN USA BS 05/15/2016	NBRCGR	0699
202		Fargo, ND, USA 01/17/1977	St. Paul College St. Paul, MN USA AAS 07/22/2016	NBRCGR	4666
203		Roseau, MN, USA 09/16/1993	Lake Superior College Duluth, MN USA AAS 05/16/2016	NBRCGR	6456
204		Addis Ababa, ETHIOPIA 11/19/1965	Malcolm X College Chicago, USA AAS 12/16/2006	NBRCRE	3548
205		Maple Grove, MN, USA 06/13/1992	U Of Mary Bismarck, ND USA BS 05/02/2014	NBRCGR	142270
206		Wiesbaden, Germany 09/15/1971	St. Paul College St. Paul, MN USA AAS 07/22/2016	NBRCGR	0639

11/12/2016

Respiratory Therapist Licensure

NO	NAME AND ADDRESS	PLACE and DATE of BIRTH	UNIVERSITY and DATE of DEGREE	BASIS	CERTIFICATE NO
207		Edina, MN, USA 07/05/1976	HUDSON VALLEY COMMUNITY Troy, NY USA AAS 05/01/2016	NBRCGR	129472
208		Maplewood, MN, USA 12/12/1995	Lake Superior College Duluth, MN USA AAS 05/16/2016	NBRCGR	2377
209		Mogadishu, Somalia 08/07/1985	St. Paul College St. Paul, MN USA AAS 07/22/2016	NBRCGR	5544
210		Minneapolis, MN, USA 11/18/1984	St. Paul College St. Paul, MN USA AAS 07/22/2016	NBRCGR	1165
211		Mankato, MN, USA 10/15/1985	American Career College-Anaheim Ontario, CA USA AS 08/27/2013	NBRCRE	9011
212		Lansing, MI, USA 03/04/1980	St. Paul College St. Paul, MN USA AAS 07/22/2016	NBRCGR	7377
213		Omaha, NE, USA 05/19/1985	Metropolitan Comm Col Omaha, NE USA AAS 05/26/2010	NBRCRE	118294
214		Wausau, WI, USA 08/13/1982	St. Paul College St. Paul, MN USA AAS 07/22/2016	NBRCGR	7927
215		St. Paul, MN, USA 11/13/1992	North Dakota State U Fargo, ND USA BS 08/07/2016	NBRCRE	152557

11/12/2016

Respiratory Therapist Licensure

NO	NAME AND ADDRESS	PLACE and DATE of BIRTH	UNIVERSITY and DATE of DEGREE	BASIS	CERTIFICATE NO
216		Edina, MN, USA 05/23/1991	UNIVERSITY OF ST. THOMAS St. Paul, MN USA BS 05/20/2016	NBRCGR	7777
217		Mogadishu, Somalia 03/03/1991	St. Paul College St. Paul, MN USA AAS 07/22/2016	NBRCGR	5101
218		Waterbury, CT, USA 05/03/1980	Kennebec Valley Community Col Fairfield, ME USA AAS 06/20/2012	NBRCRE	131600
219		St. Paul, MN, USA 11/07/1992	St. Catherine University St. Paul, MN USA BS 05/22/2016	NBRCGR	8032
220		Ely, MN, USA 07/17/1983	Lake Superior College Duluth, MN USA AAS 05/16/2016	NBRCGR	2773
221		St. Paul, MN, USA 08/12/1994	St. Paul College St. Paul, MN USA AAS 07/22/2016	NBRCGR	4533
222		Cambridge, MN, USA 07/26/1987	St. Paul College St. Paul, MN USA AAS 07/22/2016	NBRCGR	0378
223		St. Paul, MN, USA 03/14/1993	St. Catherine University St. Paul, MN USA BS 05/22/2016	NBRCGR	157986
224		De Moines, IA, USA 05/13/1988	Des Moines Area Com Col Ankeny, IA USA AAS 08/06/2009	NBRCRE	113011
225		Binh Minh, Vietnam 02/10/1988	St. Paul College St. Paul, MN USA AAS 07/22/2016	NBRCGR	7001

NO	NAME AND ADDRESS	PLACE and DATE of BIRTH	UNIVERSITY and DATE of DEGREE	BASIS	CERTIFICATE NO
226		Masno, Ethiopia 01/01/1986	St. Paul College St. Paul, MN USA AAS 07/22/2016	NBRCGR	2447
227		Burnsville, MN, USA 04/07/1987	St. Paul College St. Paul, MN USA AAS 07/22/2016	NBRCGR	0538
228		Willmar, MN, USA 03/05/1993	North Dakota State Univ/Sanford Health Fargo, ND USA BS 12/18/2015	NBRCGR	155153
229		Landstuhl, Germany 05/22/1983	Pueblo Comm College Pueblo, CO USA AAS 05/01/2010	NBRCRE	117657
230		Nashua, NH, USA 02/07/1963	RIVER VALLEY COMMUNITY COLLEGE Claremont, NH USA AAS 05/20/2016	NBRCRE	6754
231		Brainerd, MN, USA 11/01/1993	Lake Superior College Duluth, MN USA AAS 05/16/2016	NBRCGR	158131
232		Murfreesboro, TN, USA 08/27/1988	Volunteer State Comm College Gallatin, TN USA AS 12/01/2010	NBRCRE	120403
233		Rapid City, SD, USA 01/23/1987	St. Paul College St. Paul, MN USA AAS 07/22/2016	NBRCGR	7040
234		St. Paul, MN, USA 10/27/1988	St. Catherine University St. Paul, MN USA BS 05/22/2016	NBRCGR	4308

DATE: 11/12/2016

SUBMITTED BY: ND Advisory Council

SUBJECT: Naturopathic Registration

REQUEST FOR BOARD ACTION
MINNESOTA BOARD OF MEDICAL PRACTICE

REQUESTED ACTION:

The following naturopathic doctor applicant for licensure be approved
subject to receipt of all verification documents,

235 - 235 of agenda

MOTION BY:

SECOND:

Passed Amended Layed Over Defeated

BACKGROUND:

See # 235 - 235 for each applicants credentials

NPLEXGR = GENERAL REGISTRATION
NPLEXER = RECIPROCITY REGISTRATION
ST/PROV = STATE/PROVINCIAL REGISTRATION

11/12/2016

Naturopathic Registration

NO	NAME AND ADDRESS	PLACE and DATE of BIRTH	UNIVERSITY and DATE of DEGREE	BASIS	EXAM SCORES
235		Minneapolis, MN, USA 01/03/1988	Bastyr University Kenmore, WA USA ND 06/18/2016	NPLEXGR	NPLEX1; 02/01/2015; Pass; WA NPLEX2; 08/01/2016; Pass; WA

DATE: 11/12/2016

SUBMITTED BY: MW Advisory Council

SUBJECT: Midwifery Licensure

REQUEST FOR BOARD ACTION
MINNESOTA BOARD OF MEDICAL PRACTICE

REQUESTED ACTION:

The following midwifery applicants for licensure be approved subject to receipt of all verification documents.

236 - 238 of agenda

MOTION BY:

SECOND:

Passed Amended Layed Over Defeated

BACKGROUND:

See # 236 - 238 for each applicants credentials

11/12/2016

Midwifery Licensure

NO	NAME AND ADDRESS	PLACE and DATE of BIRTH	UNIVERSITY and DATE of DEGREE	BASIS	CERTIFICATE NO
236		Two Harbors, MN, USA 05/14/1980	Birthingway College of Midwifery Portland, OR USA Degree 12/15/2014	NARMGR	14120018
237		Augusta, GA, USA 09/24/1987		NARMGR	16080005
238		Pittsburg, KS, USA 11/17/1961		NARMGR	16040008

DATE: November 12, 2016

SUBJECT: Licensure Committee Meeting Minutes

SUBMITTED BY: Licensure Committee

REQUEST FOR BOARD ACTION
MINNESOTA BOARD OF MEDICAL PRACTICE

REQUESTED ACTION:

Approve the actions of the Licensure Committee.

MOTION BY: _____

SECOND: _____

PASSED PASSED AMENDED LAYED OVER DEFEATED

BACKGROUND:

See attached October 12, 2016, Licensure Committee Meeting Minutes.

LICENSURE COMMITTEE MEETING
Minnesota Board of Medical Practice
University Park Plaza, 2829 University Avenue SE, Suite 500
Minneapolis, MN 55414-3246

October 20, 2016

FINAL MINUTES

Of a meeting of the Licensure Committee (“Committee”) of the Board of Medical Practice held Thursday, October 20, 2016 at 5:30 p.m. in the fifth floor conference room.

Committee Members Present: Patricia J. Lindholm, M.D., FAAFP; Mark A. Eggen, M.D.; and Kimberly W. Spaulding, M.D., M.P.H.

Others Present: Molly Schwanz; Elizabeth Larson; Paul Luecke; and Ruth Martinez, Board staff; and Greg Schaefer, Assistant Attorney General

ADMINISTRATIVE ISSUES:

- **Meeting Dates:**

The final meeting date for 2016 is:

- December 15, 2016

Meeting dates for 2017, scheduled at 1:00 p.m. are:

- February 9
- April 13
- June 8
- August 10
- October 12
- December 14

- **Physicians Requesting Resigned/Inactive Status:** The Committee approved the list of 38 requests for resignation/inactive status.
- **Respiratory Therapists Requesting Resigned/Inactive Status:** The Committee approved the list of 10 requests for resignation/inactive status.

APPEARANCE/APPLICATION REVIEWS:

- **REDACTED:** The Committee met with REDACTED to discuss REDACTED practice plans and approved issuance of a license.

- **REDACTED:** The Committee reviewed REDACTED application and approved issuance of a license.
- **REDACTED:** The Committee reviewed REDACTED application and agreed to offer REDACTED an opportunity to withdraw from further consideration.

DATE: November 12, 2016

SUBJECT: Executive Director's Report

SUBMITTED BY: Ruth M. Martinez, M.A., Executive Director

REQUEST FOR BOARD ACTION
MINNESOTA BOARD OF MEDICAL PRACTICE

REQUESTED ACTION:

For information only.

MOTION BY: _____ SECOND: _____

PASSED PASSED AMENDED LAYED OVER DEFEATED

BACKGROUND:

Attached is the Executive Director's Report of activities since the last board meeting.

EXECUTIVE DIRECTOR'S REPORT November 12, 2016

External Stakeholder Groups/Conferences and Meetings/Outreach

The Board continues its active engagement in the following external work groups:

- State Opioid Oversight Project (SOOP)
- Opioid Prescribing Work Group (OPWG)
- National Governors' Association (NGA) Health Care Workforce Technical Assistance Program
- Immigrant International Medical (IMG) Graduate Stakeholder Advisory Group & subgroups:
 - Licensure Study work group
 - Alternate Pathways work group
- Drug Diversion Coalition through the MN Department of Health
- One Health MN Antibiotic Stewardship
- Community Dialogue on Diagnostic Error
- MN Alliance for Patient Safety
- Interstate Collaboration in Healthcare

Board staff also met with leadership from the respiratory therapy profession to discuss practice issues and Board processes.

Office of Medical Cannabis: On September 15, 2016, executive directors of the tri-regulatory Boards of Medical Practice, Nursing and Pharmacy met with representatives of the Minnesota Department of Health Office of Medical Cannabis (OMC) to discuss regulation as it relates to medical cannabis. The meeting was productive and the group will continue to convene regularly to discuss developments and evolving issues.

Acupuncture: On September 20, 2016, several of the health licensing board executive directors met with representatives from the acupuncture professional association to discuss the benefits of non-opioid modalities such as acupuncture for pain management.

Minnesota Medical Association (MMA) Annual Meeting: On September 23, 2016, the Board exhibited at the MMA Annual Meeting in St. Louis Park. The Board interacted with attendees and gave away Board of Medical Practice tote bags that included copies of Board of Medical Practice information, tri-regulatory (Board of Medical Practice, Nursing and Pharmacy) information, and Minnesota Prescription Monitoring Program (PMP) material. Many attendees visited the exhibit table to ask questions, offer comments and obtain information. It was a very positive experience, overall. Costs to exhibit were minimal, as follows:

• Exhibit fee	\$ 920.00
• Tote Bags	\$ 480.00
• Copying costs	<u>\$3,279.45</u>
Total	\$4,679.45

We would like to thank MMA Policy Counsel Teresa Knoedler, J.D., and MMA Sponsorship Manager Scott Wilson for their kind assistance with exhibit preparations and placement in the exhibit hall.

Special thanks to Board staff Cheryl Johnston and Lois Kauppila, and to PMP Director Barb Carter, for their assistance with preparation of exhibit materials.

If invited, the Board should consider whether it is worthwhile to exhibit at the 2017 MMA Annual Meeting.

Administrators in Medicine (AIM) Executive Directors Meetings: The professional association of state medical board executive directors convened its annual orientation, workshop and training at the Commons Hotel in Minneapolis from October 24 – 27, 2016.

- Oct. 24, 2016: AIM Executive Academy oriented new executive directors.
- Oct. 25, 2016: AIM Executive Directors Workshop offered a series of open discussions on challenges in licensing, discipline, operations, and management. Jacqueline Byrd, PhD, provided an outstanding presentation on creativity and innovation in leadership. The day wrapped up with an executive directors' roundtable.
- Oct. 26 – 27, 2016: AIM Certified Member Board Executive Institute provided training and certification for executive directors who met application and participation requirements. Executive directors submitted and presented papers on topics describing management of specific challenges. Seasoned executive directors presented on such topics as management, leadership, communication, transparency, legislation and advocacy. Additional presenters included former Minnesota Public Board Member Sarah Evenson, JD (*Understanding and Engaging the Public Member*), Minnesota Alliance for Patient Safety Executive Director Marie Dotseth, JD (*Engaging Patients, Providers, and the Community for Safe Care*), Minnesota Chief Administrative Law Judge Tammy Pust (*Leadership in Public Service*), and FSMB Chief Advocacy Officer Lisa Robin (*Legislation and Advocacy Issues*). Ruth Martinez was issued CMBE certification following the training.

A handout, *A Call to Serve: Quotes on Public Service*, distributed by Chief Judge Pust, is enclosed for your reference and enjoyment!

Minnesota Alliance for Patient Safety (MAPS) Conference: On October 26 – 27, 2016, MAPS held its biannual conference, *Safe Care. Everywhere*, in Brooklyn Park, MN. Presenters included Mark Graber, MD, Dorothy Sisneros and Barbara Balik. In addition, there were multiple break-out sessions on topics including but not limited to evidence-based care delivery, patient and family engagement, and addressing the opioid crisis through evidence-based pain assessment and management.

Interstate Medical Licensure Compact (IMLC) Commission Meeting

On October 3, 2016, the IMLC Commission met in Kansas City, Kansas, and by teleconference on November 7, 2016, to continue its work toward its target date of January 2017 to begin issuing licenses through the compact process. Minnesota continues to work with the Council of State Governments, Minnesota Criminal Background Checks Program, National Crime Prevention and Privacy Compact Council, and the IMLC Executive Committee to address the FBI determination (in three states, including Minnesota) that the IMLC statutory language for criminal background checks does not comply with federal requirements for receipt of FBI CHRI data.

On October 26, 2016, Pennsylvania became the 18th state to join the IMLC.

Please refer to the Board's website or to the FSMB's license portability website for meeting agendas and minutes, committee reports, Bylaws and Rules, and other relevant information.

<https://mn.gov/boards/medical-practice/applicants/imlc/>

<http://www.licenseportability.org/>

Biennial Report

The draft Biennial Report of the Board of Medical Practice for the period of July 1, 2014 – June 30, 2016 is attached for your reference. In addition to the required statistical information included in the attachment, the Board also took 157 licensing actions during the biennium. The report will be filed with Minnesota Management and Budget in December 2016.

[See attached report]

Biennial Budget Proposal and Policy Change Items

- The Board will seek an increased biennial budget appropriation from the Legislature to cover increased technology costs through MN.iT and to create permanent funding for additional staff

positions/salaries. The increased appropriation will not require an increase in licensing/registration fees.

- The Board will seek a budget line item to accept service fees related to the Interstate Medical Licensure Compact.
- Policy Change Items
 - Medical Practice Act modifications to grounds for discipline
 - Medical Practice Act modification to title protection of term “physician”
 - Practice act modifications for allied professions to remove renewal dates and enable implementation of birth month renewal cycles for all professions

National Governors’ Association (NGA) Health Care Workforce Technical Assistance Program

On November 14, 2017, the Legislative Health Care Workforce Commission, co-chaired by Senator Greg Clausen and Representative Tara Mack, will convene to review a draft framework for scope of practice legislative proposals. The Commission will also hear presentations on scope of practice bills by representatives of the Minnesota Athletic Trainers Association and the Minnesota Association of Naturopathic Physicians and, possibly, other groups. The Board of Medical Practice is represented on the NGA core team of stakeholders that developed the framework. If adopted by the Legislature, groups proposing scope of practice bills could begin using the framework during the 2017 legislative session, which convenes on January 3, 2017.

Other Activities

Minnesota Secretary of State Website for Appointments: In November 2016, the Secretary of State’s office plans to launch a new website for posting vacancies and accepting applications for appointments to Minnesota state boards and advisory councils. In September 2016, Executive Assistant Cheryl Johnston, Licensure Unit Supervisor Molly Schwanz, and Executive Director Ruth Martinez participated in training on the new appointment process, which will decentralize the posting of vacancies. The Board currently has two vacancies for physician appointees and one vacancy for a public member.

Institute for Clinical Systems Improvement (ICSI) Guidelines: At the May 14, 2016 Board meeting, Dr. Charles Reznikoff presented on opioid addiction and the recently published CDC Guidelines on opioid prescribing. Dr. Reznikoff noted that ICSI was in the process of preparing its own set of guidelines on pain management and opioid prescribing, of which he is a contributor.

On October 26, 2016, ICSI published its guidelines on *Pain: Assessment, Non-Opioid Treatment Approaches and Opioid Management*. Please link to the PDF of the full set of guidelines at <https://www.icsi.org/asset/f8rj09/Pain.pdf>.

Opiate Antagonist Protocol: Enclosed is the final draft of the Protocol prepared by the Minnesota Board of Pharmacy in consultation with the Board of Medical Practice (which chose not to offer feedback), the Minnesota Medical Association and other stakeholders.

[See attachment]

Implementation of new licensing processes:

- As authorized by the Board at its May 14, 2016 meeting, Licensure Unit staff began real-time issuance of licenses in August 2016 for individuals with complete applications who meet all minimum requirements for licensure/registration. Licenses are currently processed in a weekly batch. Staff will continue to implement real-time issuance of licenses/registrations across all professions over the next several months.
- On October 19, 2016, the Board issued its first medical faculty physician license, pursuant to Minn. Statute § 147.0375, which went into effect on August 1, 2016. Mayo Clinic or other

entities may lobby during the 2017 legislative session for removal of the July 1, 2018 sunset provision that is currently included in the statute.

Staffing:

- Sean McCarthy, JD, has been hired as a Legal Analyst, following the retirement of Polly Hoyer in August. Sean will begin his employment with the Board in mid-November. Sean comes to the Board from his position as Director of the Minnesota Criminal Background Check Program for the health licensing boards.
- Medical Regulations Analyst Helen Patrikus has announced her retirement from the Board, effective December 6, 2016, after 25 years. The Board hired Arielle (Ari) Bowhay, JD, to fill the position. Ari began her employment with the Board on November 3, 2016.
- The Board is also seeking to fill a vacancy and add positions to the Licensure Unit.

Biennial requirements

214.07, Subd. 1b

Subdivision 1b. Health-related licensing board reports.

Subd. 1b. Health-related licensing board reports.

Each health-related licensing board must prepare a report by October 15 of each even-numbered year. The report must be submitted to the administrative services unit serving the boards. The report must contain the following information for the two-year period ending the previous June 30: (1) the number and type of credentials issued or renewed; (2) the number of complaints received; (3) the number and age of complaints open at the end of the period; (4) receipts, disbursements, and major fees; and (5) such other information that the interests of health occupation regulation require. The report must also contain information showing historical trends. The reports must use a common format and consistent terminology and data (emphasis added).

Subd. 2. Administrative services report.

The administrative services unit serving the boards shall prepare a report by December 15 of each even-numbered year. One copy of the administrative services report must be delivered to each of the following: the governor, the commissioner of health, and the chairs of the house of representatives and senate policy and appropriations committees with jurisdiction over health-related licensing boards. The report must be delivered to the Legislative Reference Library as provided by section [3.195](#). The administrative services report must contain the following information:

- (1) a summary of the information contained in the reports submitted by the health-related licensing boards pursuant to subdivision 1b;
- (2) a description of the health-related licensing boards' cooperative activities during the two-year period ending the previous June 30;
- (3) a description of emerging issues relating to health occupation regulation that affect more than one board or more than one occupation; and
- (4) a copy of each health-related licensing board report submitted to the administrative services unit pursuant to subdivision 1b.

Number of persons licensed / registered

Board Name	Total Number of persons licensed or registered as of June 30, 2016
Board of Medical Practice	30,365

Board Name	License Type	Total Number of persons licensed or registered as of June 30, 2016 by license type (Number in this column needs to = Total Number of persons licensed or registered as of June 30, 2016 in box above)	Total Number of persons licensed or registered as of June 30, 2014 by license type	Total Number of persons licensed or registered as of June 30, 2012 by license type	Total Number of persons licensed or registered as of June 30, 2010 by license type	Total Number of persons licensed or registered as of June 30, 2008 by license type
Board of Medical Practice	Acupuncturist	595	490	470	415	349
	Athletic Trainer	992	884	738	652	611
	Traditional Midwife	32	28	17	13	14
	Naturopathic Doctor	58	50	33	21	NA
	Physician Assistant	2522	2230	1941	1814	1746
	Physician	22593	21993	20405	19661	18797
	Respiratory Therapist	1976	1941	1814	1746	1669
	Telemedicine	653	639	448	317	223
	Resident Permit	944	661	833	781	857
	TOTAL OF ALL LICENSE TYPES	30365	28916	26699	25420	24266

NA = Not Available

Number and Type of Credentials Issued or Renewed July 1, 2014 – June 30, 2016

Board Name	Type of License / Credential (list all)	Number of Licenses Issued or Renewed July 1, 2014 through ending June 30, 2016 by license type		Number of Credentials Renewed Online (# and per cent) during biennium ending June 30, 2016*
Board of Medical Practice		New MN License	Renewed License	Online Renewal License
		Column A	Column B	Column C
	Acupuncturist	95	1058	1020 (96.41%)
	Athletic Trainer	245	1706	1670 (97.89%)
	Traditional Midwife	13	42	42 (100%)
	Naturopathic Doctor	13	102	101 (99.02%)
	Physician Assistant	566	4444	4411 (99.26%)
	Physician	2787	42410	41428 (97.68%)
	Respiratory Therapist	1429	3640	3568 (98.02%)
	Telemedicine	221	1083	1078 (99.54%)
	Resident Permit	1429	NA	NA
	TOTAL	6,798	54,485	53,318 (97.86%)

Number and Type of Credentials Issued or Renewed July 1, 2012 – June 30, 2014

Board Name	Type of License / Credential (list all)	Number of Licenses Issued or Renewed July 1, 2012 through ending June 30, 2014 by license type		Number of Credentials Renewed Online (# and per cent) during biennium ending June 30, 2014*
Board of Medical Practice		New MN License	Renewed License	Online Renewed License
		Column A	Column B	Column C
	Acupuncturist	102	1075	896 (83.35%)
	Athletic Trainer	216	1730	1400 (80.92%)
	Traditional Midwife	11	55	35 (63.64%)
	Naturopathic Doctor	19	92	39 (42.39%)
	Physician Assistant	465	4293	3755 (87.48%)
	Physician	2849	43336	40481 (93.41%)
	Respiratory Therapist	258	3816	3430 (89.88%)
	Telemedicine	274	1184	855 (72.21%)
	Resident Permit	1533	NA	NA
	TOTAL	5,727	55,581	50,891(91.56%)

Number and Type of Credentials Issued or Renewed July 1, 2010 – June 30, 2012

Board Name	Type of License / Credential (list all)	Number of Licenses Issued or Renewed July 1, 2010 through ending June 30, 2012 by license type		Number of Credentials Renewed Online (# and per cent) during biennium ending June 30, 2012*
Board of Medical Practice		New MN License	Renewed License	Online Renewed License
		Column A	Column B	Column C
	Acupuncturist	88	993	623 (62.74%)
	Athletic Trainer	175	1509	993 (65.81%)
	Traditional Midwife	5	33	NA
	Naturopathic Doctor	16	62	NA
	Physician Assistant	387	3609	2553 (70.74%)
	Physician	2346	41134	34559 (84.02%)
	Respiratory Therapist	198	3628	2768 (76.30%)
	Telemedicine	197	869	201 (23.13%)
	Resident Permit	1717	NA	NA
	TOTAL	5,129	51,837	41,697 (80.44%)

Number and Type of Credentials Issued or Renewed July 1, 2008 – June 30, 2010

Board Name	Type of License / Credential (list all)	Number of Licenses Issued or Renewed July 1, 2008 through ending June 30, 2010 by license type		Number of Credentials Renewed Online (# and per cent) during biennium ending June 30, 2010*
Board of Medical Practice		New MN License	Renewed License	Online Renewed License
		Column A	Column B	Column C
	Acupuncturist	95	823	640 (77.76%)
	Athletic Trainer	134	1299	1045 (80.45%)
	Traditional Midwife	3	26	NA
	Naturopathic Doctor	21	21	NA
	Physician Assistant	321	3026	2598 (85.86%)
	Physician	2233	39560	32436 (81.99%)
	Respiratory Therapist	202	3547	3167 (89.29%)
	Telemedicine	165	575	201 (34.96%)
	Resident Permit	1650	NA	NA
	TOTAL	4,824	48,816	40,087 (82.12%)

Number of Complaints Received July 1, 2014 – June 30, 2016

Board Name	Total Number of Complaints Received July 1, 2014 through June 30, 2016	Total Number of Complaints Closed July 1, 2014 through June 30, 2016*
Board of Medical Practice	1,562	1,872

NOTE: Do not break down by year; include all complaints submitted for the time period July 1, 2014 through June 30, 2016.

*Not required by statute, but helpful reference; if information is unavailable, insert “NA”

Board Name	Total Number of Complaints Received July 1, 2012 through June 30, 2014	Total Number of Complaints Closed July 1, 2012 through June 30, 2014*
Board of Medical Practice	1,514	1,718

Board Name	Total Number of Complaints Received July 1, 2010 through June 30, 2012	Total Number of Complaints Closed July 1, 2010 through June 30, 2012*
Board of Medical Practice	1,614	1,603

Board Name	Total Number of Complaints Received July 1, 2008 through June 30, 2010	Total Number of Complaints Closed July 1, 2008 through June 30, 2010*
Board of Medical Practice	1,707	1,936

Number and age of complaints open at the end of the period June 30, 2016

Board Name	Number of Complaints Open as of June 30, 2016	Age of Complaints Open as of June 30, 2016
Board of Medical Practice	389	< one year: 311 > One year: 78

*Some complaints are subject to lengthier investigations, settlement negotiations or contested case hearing processes that may increase the timeframe for resolution.

Types of Complaints received from June 30, 2014 through June 30, 2016

Board Name	Type of complaints received from July 1, 2014 – June 30, 2016	Number of complaints alleging this basis from July 1, 2014 – June 30, 2016*
Board of Medical Practice		
	Actions by another jurisdiction	60
	Incompetency / unethical conduct	1200
	Unprofessional conduct	1187
	Illness	95
	Non-jurisdictional	58
	Medical records management	122
	Becoming addicted or habituated	63
	Prescribing	469
	Sexual misconduct	40
	Other	140

*Some complaints allege more than one basis

Receipts, disbursements, and major fees

Biennium	Total Receipts (Do not break down by each year; include combined receipts for the entire biennium)	Total Disbursements (Do not break down by each year; include combined disbursements for the entire biennium)
July 1, 2014 – June 30, 2016	\$11,445,514	\$7,962,117
July 1, 2012 – June 30, 2014	\$10,847,180	\$7,796,647
July 1, 2010 – June 30, 2012	\$10,181,278*	\$7,449,684
July 1, 2008 – June 30, 2010	\$9,335,076	\$7,770,120
July 1, 2006 – June 30, 2008	\$9,084,669	\$7,310,960

*Including 10% license / application fees for Minnesota Office of Enterprise Technology e-licensing surcharge

Fees by Type

Type of fee	Fee
Acupuncture Annual License	\$150.00
Acupuncture applications	150.00
Acupuncture Certification Fees	25.00
Acupuncture Late Fees	50.00
Acupuncture Temporary Permit	60.00
Acupuncture Inactive Status Fee	50.00
Athletic Trainer Annual Registration	\$100.00
Athletic Trainer Application	50.00
Athletic Trainer Temp Permit	50.00
Athletic Trainer Certification	25.00
Athletic Trainer Late Fee	15.00
Athletic Trainer Temp Registration	100.00
Midwifery Certification Fee	\$25.00
Midwifery Late Fee	75.00

Midwifery Temporary Permit Fee	75.00
Midwifery Licensure & Renewal Fee	100.00
Midwifery Inactive Status Fee	50.00
Midwifery Application Fee	100.00
Physician Annual License	\$192.00
Physician Application Fee	200.00
Physician Temporary License	60.00
MD Endorsement Fees	40.00
MD Certification Fees	25.00
MD Late Fees	60.00
Residency Permit	20.00 / 15.00
Emeritus Registration	50.00
Naturopathic Certification Fee	\$25.00
Naturopathic Application Fee	200.00
Naturopathic Registration Renewal Fee	150.00
Naturopathic Late Fee	75.00
Naturopathic Inactive Status	50.00
Naturopathic Temporary Permit	25.00
Naturopathic Emeritus	50.00
Physicians Assistant (PA) Annual License with Prescribing	\$135.00
PA Application Fees	120.00
PA Certification Fee	25.00
PA Lase Fees	50.00
PA Annual License Without Pres.	115.00
PA Temporary License	60.00
Respiratory Therapists (RTS) License	\$90.00
RTS Application Fee	100.00
RTS Certification Fee	25.00
RTS Temporary Permit	60.00
Respiratory Therapists Late Fee	50.00
RTS Inactive Status	50.00
Telemedicine Application Fee	\$100.00
Telemedicine Registration Fee	75.00
Telemedicine Certification Fee	25.00
Civil Penalties	Various
Miscellaneous Service Charges, Copies	Various
Duplicate Extension Ltr / License Requests	\$20.00
Education / Training Program Approval	1000.00
Competitive Athletic Event Registration	50.00
Medical Corp Annual Reg	25.00
Corporation Application	100.00
Report Generation (per hour)	60.00
Primary Source Verification	25.00

During the 2014-2016 biennium, the health-related licensing boards faced a number of common emerging issues, described below.

Staffing / funding issues. As a result of state requirements regarding budgets and expenditures, as well as increasing costs, such as legal fees, a number of the boards are facing salary constraints and possible budgetary shortfalls that affect staffing levels and service delivery, including the ability to investigate complaints and process contested cases for disciplinary issues.

The Boards continue to make technology / communication improvements, refinements, and to expand services through technology. The Boards are strongly committed to providing efficient and timely access to public data and to license renewal and verification. The Boards continue to make their web sites increasingly interactive.

Applicants and the general population are becoming increasingly diverse, including cultural and language diversity. The boards continue to examine matters pertaining to possible barriers in licensure, as well as issues surrounding clients and patients from diverse populations. The Boards are facing increased costs of disciplinary actions, due to increased legal costs, as well as increased complexity of complaints that require additional legal involvement, and a trend toward increased, and more substantial, and extended involvement by licensees' legal representatives.

The Boards are moving toward a standardized system of criminal background checks for licensees, and are working with state and federal agencies to ensure that such background checks are in compliance with all applicable statutes and regulations.

Newly regulated professions were authorized under the jurisdiction of health related licensing boards. As regulatory processes are implemented, staffing and technology may be impacted. It is anticipated that additional professions may seek regulation during the next biennium that may further impact the boards.

Board Members Who Served During the Period 7/1/2014 – 6/30/2016

Keith H. Berge, MD, Rochester, MN
Professional Member
Appt Date: 09/08; Reappt: 06/12; Exp Date: 1/1/2016

Mark Eggen, MD, Shoreview, MN
Professional Member
Appt Date: 04/09; Reappt: 06/13; Exp Date: 1/1/2017

V. John Ella, JD, Robbinsdale, MN
Public Member
Appt Date: 03/10; Reappt: 06/14; Exp Date: 1/1/2018

Sarah Evenson, JD, MBA, Maple Grove, MN
Public Member
Appt Date: 04/09; Reappt: 7/12; Exp Date: 1/1/2016

Dr. Eduardo T. Fernandes, Minneapolis, MN
Professional Member
Appt Date: 06/14; Exp Date: 1/1/2018 Exp Date: 1/1/2018

Rebecca J. Hafner-Fogarty, MD, MBA, Avon, MN
Professional Member
Appt Date: 06/12; Exp Date: 1/1/2016

Subbarao Inampudi, MBBS, FACR, Minnetonka, MN
Professional Member
Appt Date; 04/09; Reappt: 06/13; Exp Date: 1/1/2017

Irshad H. Jafri, MBBS, FACP, Minneapolis, MN
Professional Member
Appt Date: 10/12; Reappt: 05/15; Exp Date: 1/1/2019

Kelli Johnson, PhD, St. Paul, MN
Public Member
Appt Date: 03/10; Reappt: 06/14; Exp Date: 1/1/2018

Gerald T. Kaplan, MA, LP, Minneapolis, MN
Public Member
Appt Date: 03/11; Reappt: 06/15; Exp Date: 1/1/2019

Patricia J. Lindholm, MMD, FAAFP, Fergus Falls, MN
Professional Member
Appt Date: 10/13; Reappt: 06/16; Exp Date: 1/1/2020

Charles F. Moldow, MD, Minneapolis, MN
Professional Member
Appt Date: 06/12; Exp Date: 1/1/2016

Allen G. Rasmussen, MA, International Falls, MN
Public Member
Appt Date: 9/14; Exp Date: 1/1/2018

Kimberly W. Spaulding, MD, MPH, Kimball, MN
Professional Member
Appt Date: 6/16; Exp Date: 1/1/2020

Maria K. Statton, MD, PhD, Bemidji, MN
Professional Member
Appt Date: 6/13; Exp Date 1/1/2017

Jon V. Thomas, MD, MBA, Vadnais Heights, MN
Professional Member
Appt Date: 3/10; Reappt: 6/14; Exp Date: 1/1/2018

Patrick R. Townley, MD, JD, Minneapolis
Professional Member
Appt Date: 6/16; Exp Date: 1/1/2020

Joseph R. Willett, DO, FACOI, Marshall, MN
Professional Member
Appt Date: 3/11; Reappt: 6/15; Exp Date: 1/1/2019

Current Board Members

Mark Eggen, MD, Shoreview, MN
Professional Member
Appt Date: 04/09; Reappt: 06/13; Exp Date: 1/1/2017

V. John Ella, JD, Robbinsdale, MN
Public Member
Appt Date: 03/10; Reappt: 06/14; Exp Date: 1/1/2018

Subbarao Inampudi, MBBS, FACR, Minnetonka, MN
Professional Member
Appt Date; 04/09; Reappt: 06/13; Exp Date: 1/1/2017

Irshad H. Jafri, MBBS, FACP, Minneapolis, MN
Professional Member
Appt Date: 10/12; Reappt: 05/15; Exp Date: 1/1/2019

Kelli Johnson, PhD, St. Paul, MN
Public Member
Appt Date: 03/10; Reappt: 06/14; Exp Date: 1/1/2018

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Appt Date: 03/11; Reappt: 06/15; Exp Date: 1/1/2019

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Appt Date: 10/13; Reappt: 06/16; Exp Date: 1/1/2020

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Appt Date: 06/12; Exp Date: 1/1/2016

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Appt Date: 9/14; Exp Date: 1/1/2018

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Appt Date: 06/16; Exp Date 1/1/2020

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Appt Date: 6/13; Exp Date 1/1/2017

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Professional Member
Appt Date: 3/10; Reappt: 6/14; Exp Date: 1/1/2018

Patrick R. Townley, MD, JD, Minneapolis, MN
Professional Member
Appt Date: 06/16; Exp Date: 1/1/2020

Joseph R. Willett, DO, FACOI, Marshall, MN
Professional Member
Appt Date: 3/11; Reappt: 6/15; Exp Date: 1/1/2019

Staff Members Who Served During the Period 7/1/2014 – 6/30/2016

Hanan Ahmad, Licensure Specialist, Office & Administrative Specialist Int.
Wendy Boswell, Licensure Specialist, Office & Administrative Specialist Int.
Vicki Chelgren, Licensure Specialist, Office & Administrative Specialist
Mary Delahunt, Licensure Specialist, Office & Administrative Specialist Int.
Barb Dressel, Receptionist, Office & Administrative Specialist
Mary Erickson, Senior Medical Regulations Analyst, Investigator Sr.
Pat Hayes, Licensure Coordinator, Office & Administrative Specialist Principal
Matthew Heffron, Senior Medical Regulations Analyst, Investigator Sr.
Polly Hoye, Legal Analyst
Elizabeth Huntley, Licensure Unit Supervisor, Management Analyst Supervisor;
Complaint Review Unit Supervisor, Investigator Supervisor
Cheryl Johnston, ED Admin. Assistant, Office & Administrative Specialist Principal
Lois Kauppila, Office Manager, Office Services Supervisor
Roselynn Kowalczyk, Complaint Review Unit Assistant, Office & Administrative Specialist
Elizabeth Larson, Licensure Specialist, Office & Administrative Specialist Int.
Robert Leach, Executive Director
Maura LeClair, Medical Regulations Analyst, Investigator
Paul Luecke, Licensure Specialist, Office & Administrative Specialist;
Licensure Coordinator, Office & Administrative Specialist Principal
Ruth Martinez, Complaint Review Unit Supervisor, Investigator Supervisor;
Executive Director
Debbie Milla, Accounting Officer
Helen Patrikus, Medical Regulations Analyst, Investigator
Rachel Prokop, Licensure Specialist, Office & Administrative Specialist Int.
Molly Schwanz, Licensure Unit Supervisor, Management Analyst Supervisor
Karen Stuart, Complaint Review Unit Assistant, Office & Administrative Specialist
Tama Trinkka, Senior Medical Regulations Analyst, Investigator Sr.
Anthony Wijesinha, Medical Regulations Analyst, Investigator

Current Staff Members

Wendy Boswell, Licensure Specialist, Office & Administrative Specialist Int.
Arielle Bowhay, Medical Regulations Analyst, Investigator
Mary Delahunt, Licensure Specialist, Office & Administrative Specialist Int.
Barb Dressel, Receptionist, Office & Administrative Specialist
Mary Erickson, Senior Medical Regulations Analyst, Investigator Sr.
Elizabeth Huntley, Complaint Review Unit Supervisor, Investigator Supervisor
Cheryl Johnston, ED Admin. Assistant, Office & Administrative Specialist Principal
Lois Kauppila, Office Manager, Office Services Supervisor
Roselynn Kowalczyk, Complaint Review Unit Assistant, Office & Administrative Specialist
Elizabeth Larson, Licensure Specialist, Office & Administrative Specialist Int.
Maura LeClair, Medical Regulations Analyst, Investigator
Paul Luecke, Licensure Coordinator, Office & Administrative Specialist Principal
Ruth Martinez, Executive Director
Sean McCarthy, Legal Analyst
Helen Patrikus, Medical Regulations Analyst, Investigator
Molly Schwanz, Licensure Unit Supervisor, Management Analyst Supervisor
Tama Trinkka, Senior Medical Regulations Analyst, Investigator Sr.

Board of Medical Practice Functions

- Setting and administering educational and examination standards for initial and continuing licensure or registration for each health profession regulated by the Board
- Pursuing educational or disciplinary action with licensees as deemed necessary based upon results of investigations conducted in response to complaints/reports
- Providing information and education about licensure requirements and procedures and standards of practice to the public, the health care community, and other interested clientele
- Responding to inquiries, complaints and reports from the public and other health care regulators regarding licensure and conduct of applicants, permit holders, licensees and unlicensed practitioners
- Pursuing educational or disciplinary action with licensees as deemed necessary based upon results of investigations conducted in response to complaints/reports

BMP Major Activities during the Biennium

Interstate Medical Licensure Compact

In May 2014, Alabama and Minnesota joined Idaho, Montana, South Dakota, Utah, West Virginia, and Wyoming as states that formally enacted the Interstate Medical Licensure Compact (IMLC). The IMLC creates a streamlined process for medical licensure for physicians interested in practicing medicine in multiple states. In October 2015, the Interstate Commission, comprised of two appointed representatives from each of the member states, began the work of implementing the IMLC. Governor Dayton appointed Board Member Jon V. Thomas, MD, and Board Executive Director Ruth M. Martinez, MA, to serve as Minnesota's commissioners. The IMLC has grown to 17 member states, with pending legislation in additional states. The Interstate Commission met six times between October 2015 and October 2016 to establish policies, develop technological infrastructure, and approve rules for licensing processes. The Interstate Commission hopes to begin issuing licenses through the IMLC in January 2017. For more information about the Interstate Medical Licensure Compact, visit: <http://licenseportability.org/>

Legislation

Several additional pieces of legislation passed during the biennium that impacted the Board including:

- Medical Practice Act modifications relating to osteopathic physicians
- Physician Assistant Practice Act modifications
- Traditional Midwifery Practice Act modifications
- MN Prescription Monitoring Program Changes
- Modification of procedures related to temporary suspension of credentials
- Implementation of Medical Faculty License
- Implementation of Genetic Counselor License

Educational Outreach

The Board was invited to present to several organizations including professional associations and societies, the MN Department of Corrections, and malpractice insurers. Board members and staff attended educational conferences and seminars on the topics of patient safety, opioid prescribing and abuse, mental health and other topics of interest. Engagement with credentialing committees and hospital personnel were instrumental in the Board's evaluation of how it could improve and

streamline processes and procedures to better serve clientele. In efforts to further engage with stakeholders, the Board held off-site Board meetings at the University of Minnesota campus in Minneapolis, Hamline University campus in St. Paul, and Mayo Clinic in Rochester. The Board also exhibited at the 2016 Minnesota Medical Association annual meeting. The Board also participated on a number of initiatives, including but not limited to:

- State Opioid Oversight Project
- National Governors' Association policy academy
- Interstate Collaboration in Healthcare
- Immigrant International Medical Graduate stakeholder advisory group
- One Health MN Antibiotic Stewardship work group
- Community Dialogue on Diagnostic Error
- MN Alliance for Patient Safety
- MN Controlled Substance Diversion coalition
- MN Prescription Monitoring Program advisory task force
- Health Professionals Services Program strategic planning groups

Collaborative Initiatives

Members and staff of the Minnesota Boards of Medical Practice, Nursing and Pharmacy attended the national Tri-Regulatory Symposium in Washington, DC in October 2015 and, subsequently, hosted the inaugural Minnesota Tri-Regulatory Symposium in Minneapolis on June 1, 2016. The Minnesota Tri-Regulatory Symposium was a great success, with participation by the CEOs of the three national regulatory organizations, and nationally recognized speakers on the topics of medical cannabis and interprofessional practice. The tri-regulatory boards developed and endorsed joint guidance statements, contributed joint articles to publications, and were invited to present on Minnesota's collaborative initiatives at the 2016 Federation of State Medical Boards annual meeting in San Diego, California. The executive directors of Minnesota's tri-regulatory boards continue to meet regularly to consider issues of common interest related to regulation, legislation and patient safety, and to collaborate on activities.

National Leadership

The Minnesota Board of Medical Practice continues to provide leadership at the national level. Board member Mark Eggen, MD, served on the FSMB Board of Directors, and also served on the FSMB Awards Committee, Minimal Data Set Advisory Group, Ethics & Professionalism Committee, Workgroup on Board Education Service & Training, and Workgroup on Telemedicine Consultations. Board Member and FSMB immediate past-chair Jon Thomas, MD, MBA, served as the FSMB representative to the American Board of Medical Specialties and National Board of Medical Examiners, and also served on the FSMB Awards Committee, Compensation Committee, Nominating Committee, Minimal Data Set Advisory Group, Ethics & Professionalism Committee, Interstate Compact Taskforce, Executive Committee, Investment Committee, Maintenance of Licensure Committee, Special Committee on Strategic Positioning, Workgroup on International Collaboration and USMLE Composite Committee. Board Member Kelli Johnson, PhD, served on the FSMB Nomination Committee. Board Member Rebecca Hafner-Fogarty, MD, MBA, served on the FSMB Editorial Committee. Board Member Gerald Kaplan, MA, LP, served on the FSMB Ethics & Professionalism Committee. Board Member Sarah Evenson, JD, MBA, served on the FSMB Finance Committee. Former Board member Gregory Snyder, MD, DABR, is the 2016 chair-elect of the Federation of State Medical Boards (FSMB) and served on the Audit Committee, Workgroup on Telemedicine Consultations, Governance Committee, Workgroup on Marijuana & Medical Regulation, Workgroup on International Collaboration and Advisory Panel to the USMLE.

Goals for 2017-2018

As the Board goes experiences staffing and legislative changes, it recognizes opportunities for growth. To better serve its clientele, the Board plans to update its database, streamline processes, improve the quality of reporting, enhance technological features, expand on-line services and update practice acts under the Board's jurisdiction.

Ruth M. Martinez, MA
Executive Director
Minnesota Board of Medical Practice
(612) 548-2150
Ruth.martinez@state.mn.us

Mission:

The mission of the Minnesota Board of Medical Practice is to protect the public's health and safety by assuring that the people who practice medicine or as an allied health professional are competent, ethical practitioners with the necessary knowledge and skills appropriate to their title and role.

Contact information for the Board:

Minnesota Board of Medical Practice
University Park Plaza Building
2829 University Avenue SE, Suite 500
Minneapolis, MN 55414

Phone: 612-617-2130

FAX: 612-617-2166

Email: medical.board@state.mn.us

Website: <https://mn.gov/boards/medical-practice/>



MINNESOTA BOARD OF PHARMACY

Opiate Antagonist Protocol

Background

This protocol has been prepared as required by Minnesota Session Laws, 2016 Regular Session, [Chapter 124](#). This protocol was developed for the use of the Commissioner of Health to distribute to the medical consultants of community health boards or to be used by Minnesota Department of Health practitioners designated by the Commissioner. Pharmacists may also use this protocol when working in collaboration with other practitioners. Pharmacists are **not** required to use this protocol in order to be involved in the prescribing of opiate antagonists. Instead, they can work with a physician, advanced practice registered nurse (APRN) or physician assistant (PA) to develop a different protocol as allowed by Minn. Stats. §151.01, subd. 27(6).

Protocol

1. General considerations

- a. Pharmacists who enter into this protocol with a physician, APRN nurse, or PA are authorized to issue prescriptions for naloxone, in accordance with the provisions of this protocol. The physician, APRN or PA is considered to be the prescriber of record.
- b. Pharmacists who enter into this protocol must keep a written copy of it at each location from which they issue prescriptions or dispense naloxone. They must make a copy of the protocol available upon the request of a representative of the Board of Pharmacy. This protocol must list the name and contact information for the responsible practitioner and

each pharmacist working under the protocol. To the extent that a practitioner agrees to allow all pharmacists that work for a pharmacy, a chain of pharmacies or a health care system to participate in the protocol, the individual pharmacists do not need to be named.

c. While not required by law, the responsible practitioner and pharmacists should strongly consider completing appropriate training related to opioid overdoses and the use of naloxone, unless they have already done so. Examples of such training are:

- i. Pharmacist Letter:
<https://pharmacistsletter.therapeuticresearch.com/logon.aspx?bu=/ce/course.aspx?pc=16-242> (requires account)
- ii. Boston College and SAMHSA Program:
http://www.opioidprescribing.com/naloxone_module_1-landing
- iii. College of Psychiatric & Neurologic Pharmacists:
<https://cpnp.org/guideline/naloxone> (requires account)
- iv. California Society of Addiction Medicine:
<http://www.csam-asam.org/naloxone-resources>
- v. Prescribe to Prevent Videos for Pharmacists, Prescribers and Patients:
<http://prescribetoprevent.org/video/>
- vi. Substance Abuse and Mental Health Service Administration SAMSHA:
<http://store.samhsa.gov/product/Opioid-Overdose-Prevention-Toolkit-Updated-2016/SMA16-4742>
- vii. Emergency Medical Service Training
<http://steверummlerhopefoundation.org/emergency-medical-service-training/>

2. Procedure

a. When an individual requests naloxone (or other opioid antagonist), or when a pharmacist in his or her professional judgement decides to advise an individual of the availability of naloxone (or other opioid antagonist), the pharmacist shall complete the following steps:

- 1) Screen for the following (in the primary spoken language of the recipient, upon request and when possible):
 - a) Does the recipient understand that opioid antagonists can only be used for opioid overdoses and cannot be used for other drug overdoses?

- b) Does the person to whom the naloxone would be administered have a known hypersensitivity to naloxone (if yes, do not furnish)?
- b. Provide training in opioid overdose prevention and recognition, the administration of naloxone (or other opioid antagonist), and in the appropriate response to an opioid overdose, including the need to pursue immediate, follow-up treatment (e.g., calling 911).
- c. When naloxone (or other opioid antagonist) is dispensed:
 - 1) The pharmacist shall provide the individual to whom naloxone (or other opioid antagonist) is dispensed (“recipient”) with appropriate written information and with counseling on the product dispensed, including information concerning administration, effectiveness, adverse effects, storage conditions, shelf-life, safety, and any other information deemed necessary in the professional judgment of the pharmacist. A pharmacist dispensing naloxone (or other opioid antagonist) pursuant to this protocol shall not permit the recipient to waive the provision of the written information or the counseling required by this protocol. Whenever possible, the pharmacist should provide information, whether written or oral, to the recipient in the primary language of the recipient.
 - 2) The pharmacist shall provide the recipient with information about and/or referrals to substance abuse treatment resources if the recipient indicates interest in substance abuse treatment or recovery services.
 - 3) The pharmacist shall provide the recipient with information and appropriate resources concerning proper disposal of medications and needles/syringes.
 - 4) The pharmacist shall answer all questions the recipient may have regarding the naloxone (or other opioid antagonist) that is dispensed.

3. Authorized drugs.

- a. The issuance of prescriptions and the dispensing done pursuant to this protocol is limited to naloxone (or other appropriate opiate antagonist that may be developed). A pharmacist may supply naloxone hydrochloride as an intramuscular injection, intranasal spray, autoinjector or any other FDA- approved product. A pharmacist may not dispense a compounded version of naloxone. A pharmacist may also recommend optional items when appropriate, such as alcohol pads, rescue breathing masks, and protective gloves.
- b. In selecting a product for which a prescription will be generated, the pharmacist shall obtain sufficient information from the recipient to make a decision that is based on: products available; how well the product can be administered by the individuals likely to be involved in administering the product; and any other pertinent factor.

4. Records. The pharmacist must generate a written or electronic prescription for any naloxone dispensed. If a written prescription is prepared, it shall be signed in the following format: *[signature of pharmacist], R.Ph. per naloxone protocol with [name of practitioner], [credential – i.e. MD, DO, APRN, PA]*. The prescription must be processed in the same manner that any other prescription is processed, pursuant to the applicable statutes and rules for the dispensing of prescription drugs. The prescription shall be kept on file and maintained for a minimum of two years, as required by the rules of the Minnesota Board of Pharmacy. Pharmacists are reminded that prescriptions paid for by Medicare and Medicaid must be kept on file for even longer periods of time.

5. Notification. If the recipient is the potential individual to whom the naloxone will be administered, the recipient is considered to be the patient. In that case, with patient consent, the pharmacist shall notify the patient's primary care provider of any drug or device dispensed. If the patient does not have a primary care provider, or does not consent to have the primary care provider notified, then

the pharmacist shall provide the recipient with a written record of the drug or device dispensed and advise the patient to consult an appropriate health care provider of the patient's choice.

Names and Contact Information of Responsible Practitioner and Pharmacists (enter below)

(Note: to the extent that a practitioner agrees to allow all pharmacists that work for a pharmacy, a chain of pharmacies or a health care system to participate in the protocol, the individual pharmacists do not need to be named. However, a statement indicating that all pharmacists may participate should be included).

A Call to Serve



Quotes on Public Service

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Compiled by:

Marc Holzer, Mahako Etta, Yetunde A. Odugbesan

A Call to Serve



Quotes on Public Service

Inside Cover
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School of Public Affairs and Administration
Rutgers University – Newark Campus
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❧ Introduction ❧

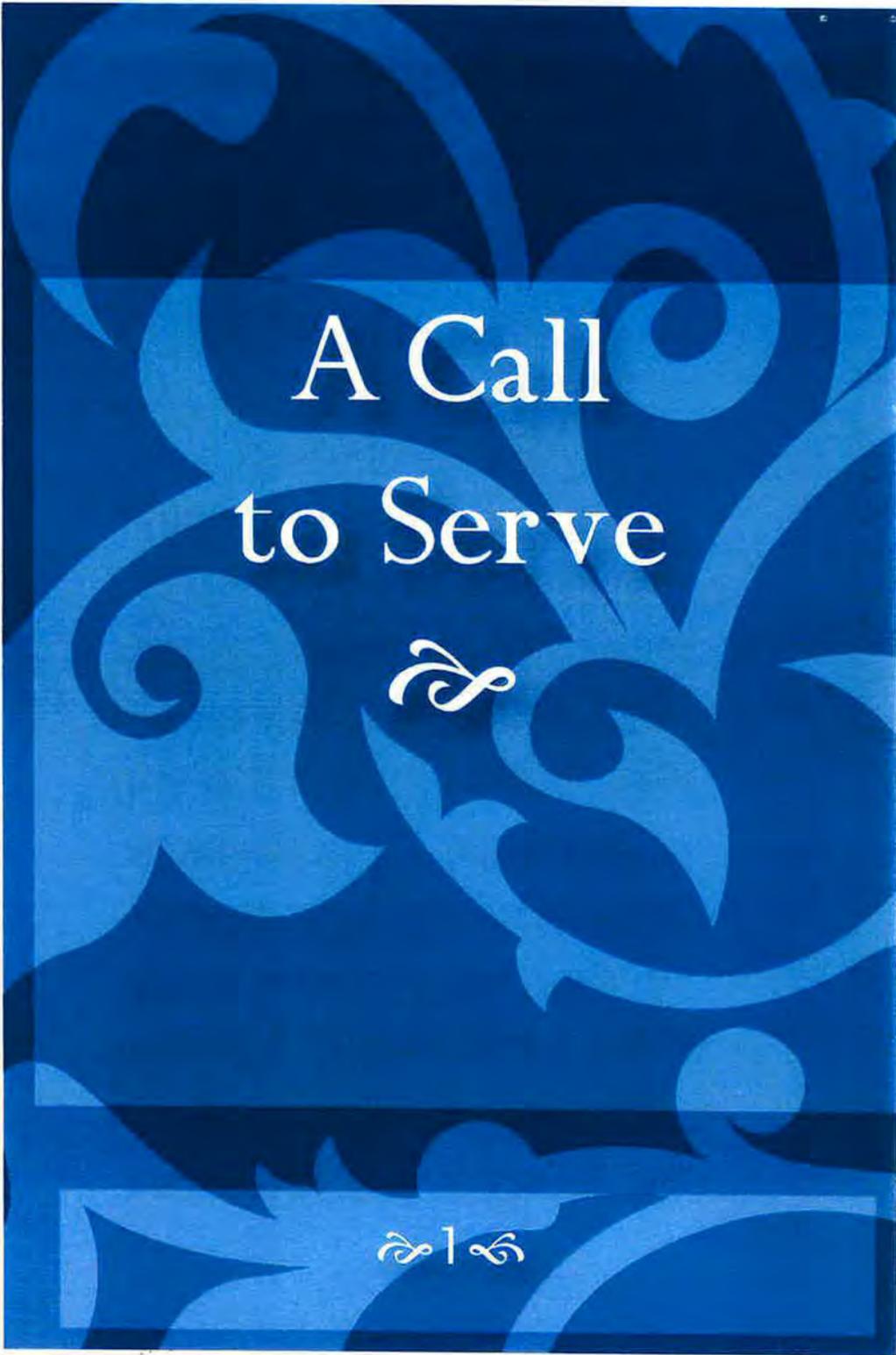
We are all public servants at some point in our lives: employees of government and not-for-profits, elected officials, members of boards and community organizations, volunteers, philanthropists, etc. The purpose of this book is to emphasize the concepts of civic engagement and the common good, to foster an understanding of the spirit of service already evident among many citizens, and to suggest a broad array of pathways to public service.

Public service attracts a special kind of individual and is often based on a sense

of duty or an intense inner commitment to a cause that extends beyond the pressures of the moment. Public servants achieve internal satisfaction by making a contribution to a society as opposed to a commitment to achieving only personal goals. Those who enter public service do so out of a desire to serve the public interest and link themselves to the larger community.

Public Service embodies the ethical principles of the common good, service to others and social equity. Public Service is important because the essential components of our society are largely carried out

in the public sphere: public education, public health, justice and security, environmental protection, museums and the arts, etc. We hope the quotes contained in this volume inspire, encourage and draw more of our fellow citizens to public service.



A Call to Serve



And so, my fellow Americans,
ask not what your country
can do for you; ask what you
can do for your country.

JOHN F. KENNEDY
35th President of the United States



Never doubt that a small group
of thoughtful committed citizens
can change the world; indeed,
it's the only thing that ever has.

MARGARET MEAD
American Cultural Anthropologist

I can assure you, public service
is a stimulating, proud and lively
enterprise. It is not just a way of
life, it is a way to live fully. Its
greatest attraction is the sheer
challenge of it – struggling to
find solutions to the great issues
of the day. It can fulfill your
highest aspirations. The call to
service is one of the highest
callings you will hear and your
country can make.

LEE H. HAMILTON
Chairman of 9/11 Commission

Service to others is the payment
you make for your space
here on earth.

MOHAMMAD ALI
World Champion Boxer



We are all called to serve
as long as we call ourselves free.

TOM RIDGE
Former Governor of Pennsylvania



We are here to add what we can to,
not to get what we can from, life.

SIR WILLIAM OSLER

I shall pass through this world
but once. Any good therefore
that I can do or any kindness
that I can show to any human
being, let me do it now. Let me
not defer or neglect it, for I
shall not pass this way again.

MAHATMA GANDHI
Global Humanitarian



The vocation of every man and
woman is to serve other people.

LEO TOLSTOY
(1828-1910) *What Is To Be Done*

This is man's highest end, to others'
service, all his powers to bend.

SOPHOCLES
Greek Playwright



There is no greater calling
than to serve your fellow men.
There is no greater contribution
than to help the weak. There is
no greater satisfaction than
to have done it well.

WALTER REUTHER
American Labor Union Leader

Citizen service is the very
American idea that we meet
our challenges not as isolated
individuals but as members of
a true community, with all of us
working together. Our mission
is nothing less than to spark
a renewed sense of obligation,
a new sense of duty, a new
season of service.

BILL CLINTON
42nd President of the United States

I was taught that the world
had a lot of problems;
that I could struggle and change
them; that intellectual and material
gifts brought the privilege and
responsibility of sharing with
others less fortunate; and that
service is the rent each of us
pays for living, the very purpose
of life and not something you
do in your spare time or after you
have reached your personal goals.

MARIAN WRIGHT EDELMAN
Founder and President of
the Children's Defense Fund

What made you choose this
career is what made me go into
politics – a chance to serve,
to make a difference. It is not
just a job. It is a vocation.

TONY BLAIR
Former Prime Minister of United Kingdom



Do nothing – Or, take history
into our own hands and like
few generations are given
the chance, bend it, bend it,
in the service of a better day.

VICE PRESIDENT JOE BIDEN
at Syracuse University

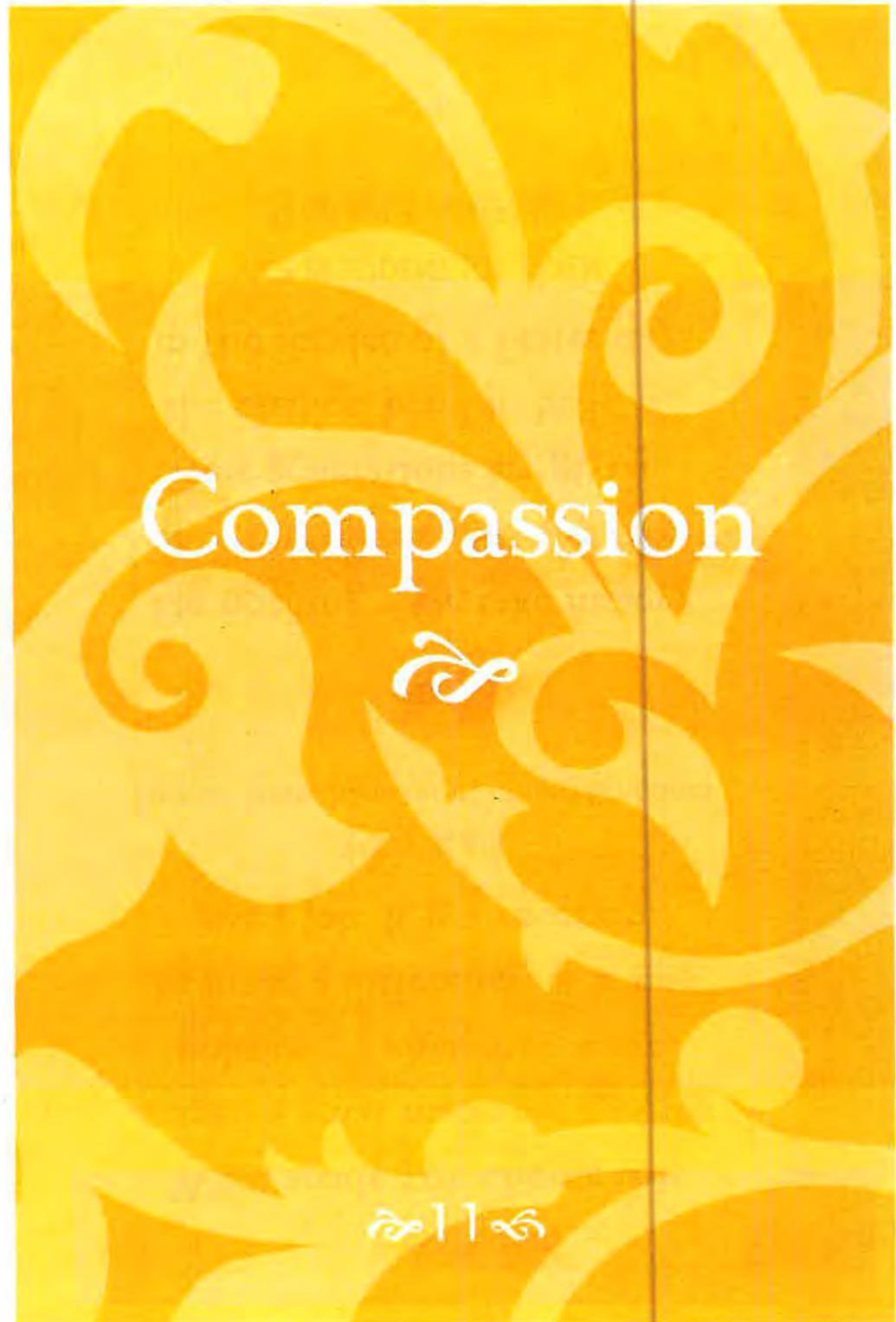
The service we render to others
is really the rent we pay for our
room on this earth. It is obvious
that man is himself a traveler;
that the purpose of the world
is not 'to have and to hold'
but 'to give and to serve.'

SIR WILFRED T. GRENFELL
Medical Missionary
to Newfoundland and Labrador



Every life speaks to the power
of what can be done.

OPRAH WINFREY
Talk Show Host



The moral test of a society
is how that society treats
those who are in the dawn of life.
the children; those who are in the
twilight of life. the elderly;
and those who are in the shadow
of life; the sick, the needy
and the handicapped.

HUBERT HUMPHREY

38th Vice President of the United States



What do we live for if not to make
life less difficult for each other?

GEORGE ELIOT

English Novelist

Let us not be satisfied with
just giving money. Money is not
enough. Money can be got,
but others need your heart to
love them. So, spread love
everywhere you go.

MOTHER TERESA

Global Humanitarian



The miracle is this – the more
we share, the more we have.

LEONARD NIMOY

Actor, "Star Trek" series

Those who bring sunshine
to the lives of others cannot
keep it from themselves.

SIR JAMES M. BARRIE
Scottish Author and Dramatist



Volunteers are the only
human beings on the face
of the earth who reflect this
nation's compassion,
unselfish caring, patience, and
just plain love for one another.

ERMA BOMBECK
Novelist, Columnist

How far you go in life depends
on your being tender with
the young, compassionate
with the aged, sympathetic with
the striving and tolerant of the
weak and strong.

GEORGE WASHINGTON CARVER
American Scientist, Educator and Inventor



It is important to engage those
we serve, but often we do an
adequate job of ministering to
the poor, but not with the poor.

ANONYMOUS

I have been the recipient of love and service; therefore I can love and serve. There is great satisfaction in service to others, in seeing people and their conditions change.

CLARENCE E. HODGES

Former US Commissioner for the Administration of Children, Youth, and Families



Living is the art of loving. Loving is the art of caring. Caring is the art of sharing. Sharing is the art of living. If you want to lift yourself up, lift up someone else.

BOOKER T. WASHINGTON

American Educator, Orator,
and Author *Up from Slavery*

Motivation to Serve



Act as if what you do
makes a difference. It does.

WILLIAM JAMES

American Psychologist and Philosopher



Everyone can be great because
anyone can serve. You don't have
to have a college degree to
serve. You don't even have to
make your subject and your verb
agree to serve... You only need a
heart full of grace. A soul
generated by love...

DR. MARTIN LUTHER KING, JR.

African American Civil Rights Leader;
Pastor, Ebenezer Baptist Church

The only thing necessary for
the triumph of evil is for
good men to do nothing.

EDMUND BURKE

British Statesman and Orator



I don't know what your destiny
will be, but one thing I know:
the only ones among you
who will be really happy are
those who have sought and
found how to serve.

ALBERT SCHWEITZER

Author and Journalist
The Ethics of Reverence for Life

The world will little note,
nor long remember what
we say here, but it can never
forget what they did here. It is
for us the living, rather, to be
dedicated here to the unfinished
work which they who fought
here have thus far so nobly
advanced. It is rather for us to
be here dedicated to the great task
remaining before us – that from
these honored dead we take
increased devotion to that cause
for which they gave the last full
measure of devotion – that we

here highly resolve that
these dead shall not have died
in vain – that this nation, under
God, shall have a new birth of
freedom – and that government
of the people, by the people,
for the people, shall not
perish from the earth.

ABRAHAM LINCOLN

16th President of the United States



The highest of distinctions
is service to others.

KING GEORGE VI

Insist that we support the sciences
and the arts, especially the arts.
They have nothing to do with
the defense of the country;
they just make the country
worth defending.

KEN BURNS
Documentary Filmmaker



It is better to light one small candle
than to curse the darkness.

CONFUCIUS
Chinese Thinker and Social Philosopher

I was having a better time at
my job than were those of
my peers who had opted for
private practice. Life as a public
servant was more interesting.
The work was more challenging.
The encouragement and guidance
from good mentors was more
genuine. And the opportunities
to take initiative and to see real
results were more frequent.

SANDRA DAY O'CONNOR
Supreme Court Justice

Yes, our greatness as a nation has depended on individual initiative, on a belief in the free market. But it has also depended on our sense of mutual regard for each other, of mutual responsibility. The idea that everybody has a stake in the country, that we're all in it together and everybody's got a shot at opportunity. Americans know this. We know that government can't solve all our problems – and we don't want it to. But we also know that

there are some things we can't do on our own. We know that there are some things we do better together.

BARACK OBAMA

44th President of the United States of America



The best way to find yourself is to lose yourself in the service of others.

RALPH WALDO EMERSON

American Essayist, Philosopher, and Poet

I am of the opinion that my life
belongs to the community, and
as long as I live it is my privilege
to do for it whatever I can.

GEORGE BERNARD SHAW

Irish Playwright



The time is always right to do right.

DR. MARTIN LUTHER KING, JR.

African American Civil Rights Leader;
Pastor, Ebenezer Baptist Church

I always wondered why somebody
didn't do something about that.
Then I realized I was somebody.

LILY TOMLIN

American Actress, Comedian, Writer



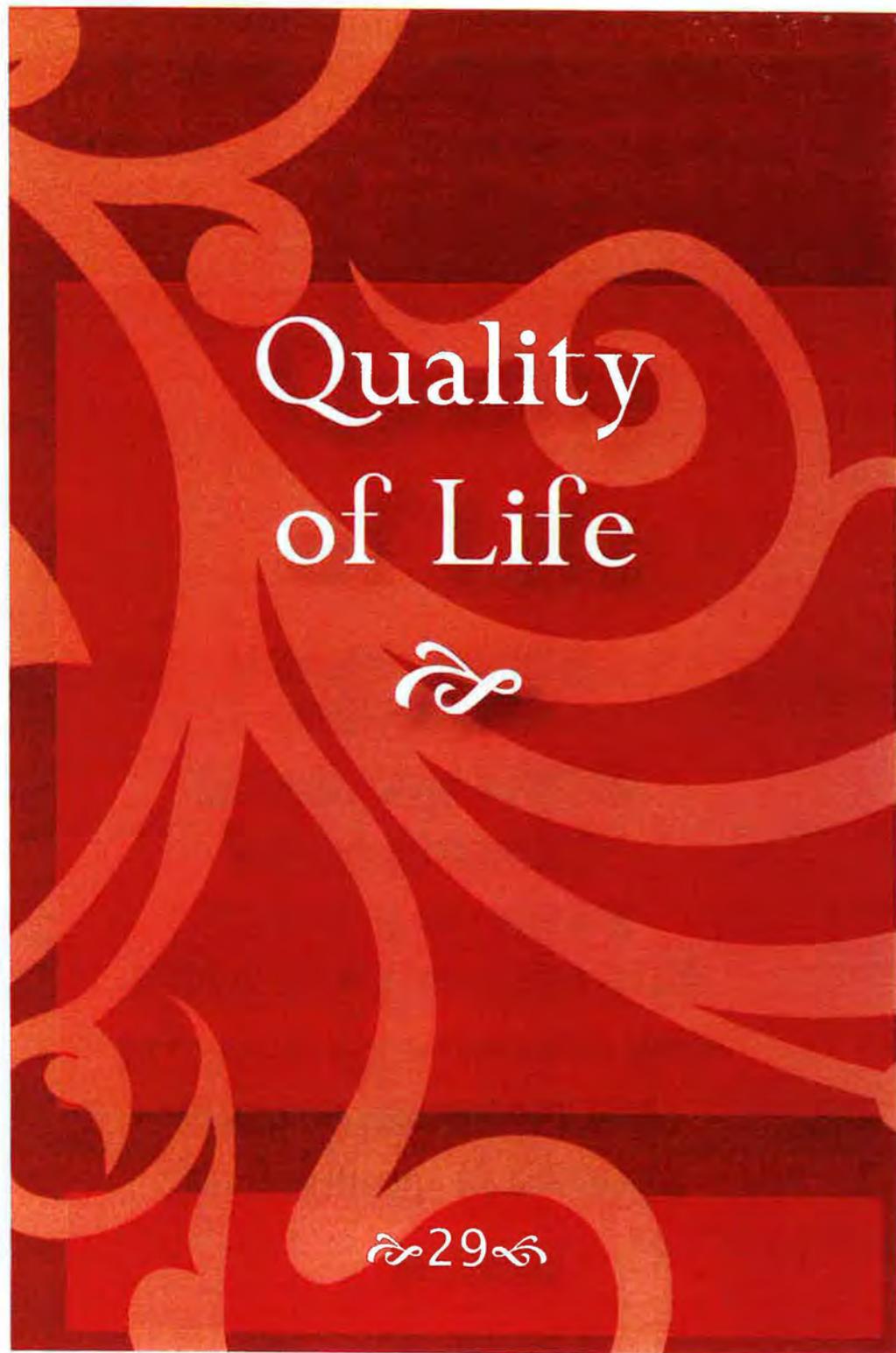
Let the public service be
a proud and lively career.

JOHN F. KENNEDY

35th President of the United States

Careers focused on lifting up our communities – whether it's helping transform troubled schools or creating afterschool programs or training workers for green jobs. These careers are not always obvious, but today they are necessary.

FIRST LADY MICHELLE OBAMA



Without community service,
we would not have a strong
quality of life. It's important to the
person who serves as well as the
recipient. It's the way in which we
ourselves grow and develop.

DR. DOROTHY I. HEIGHT

President and CEO of the National Council
of Negro Women



The care of human life and
happiness is the first and only
legitimate objective
of good government.

THOMAS JEFFERSON

3rd President of the United States

The magnitude of our social
problems will require that
all citizens and institutions make
a commitment to volunteering
as a way of life and as a
primary opportunity
to create needed change.

GEORGE ROMNEY

Former Michigan Governor

Never before has man had such a great capacity to control his own environment, to end hunger, poverty and disease, to banish illiteracy and human misery. We have the power to make the best generation of mankind in the history of the world.

JOHN F. KENNEDY

35th President of the United States

I think the events of September 11th remind us that there are issues larger and more transcendent than the issues we thought they were before September 11th, things we took for granted before September 11th – the idea of progress and prosperity, the sense of our security – are now very much at risk. And as they come to be very much at risk, the imperative of service to society becomes all the more important.

LAWRENCE H. SUMMERS

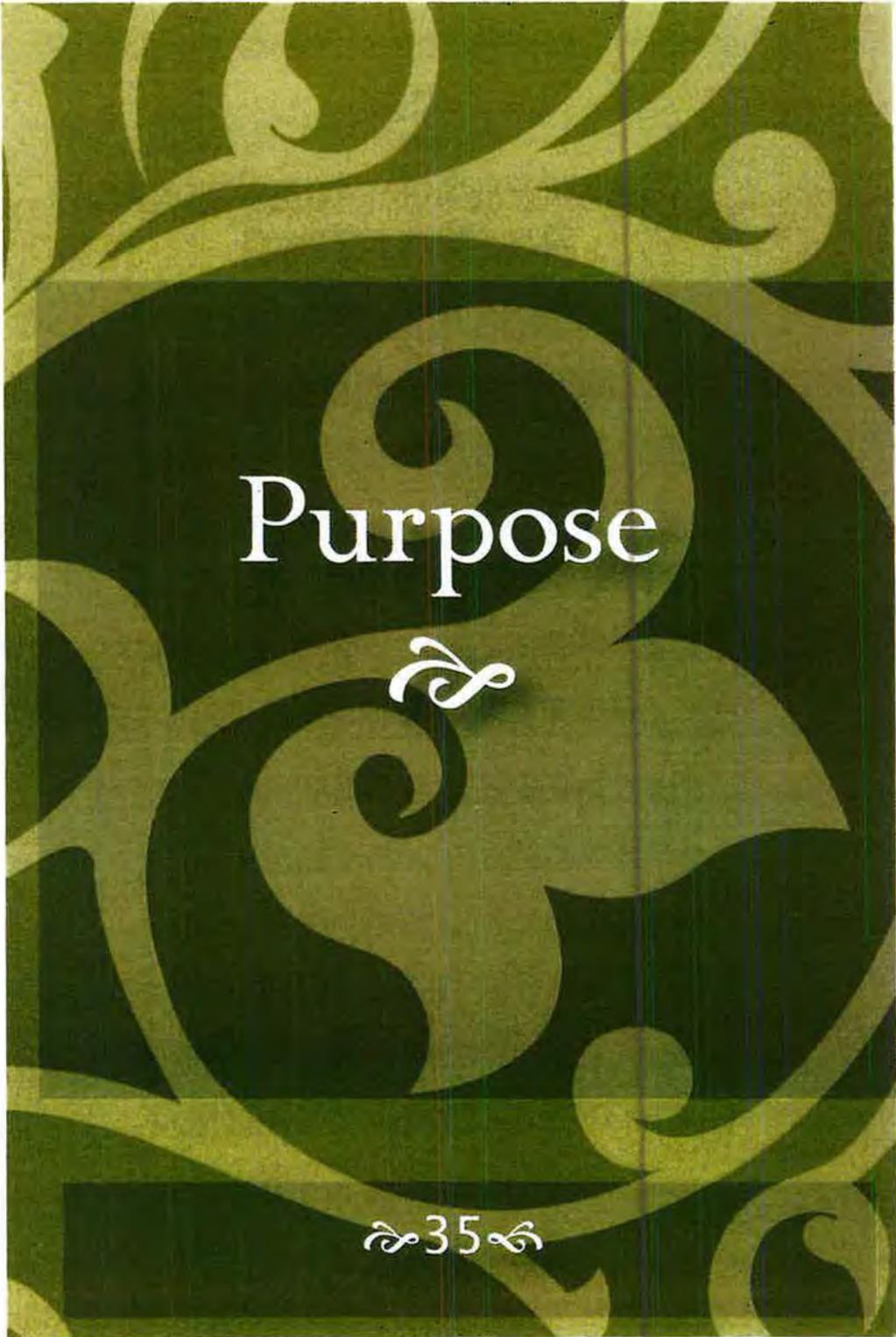
Former President of Harvard University



I must study politics and war
that my sons may have liberty
to study mathematics and
philosophy. My sons ought
to study mathematics and
philosophy, geography, natural
history, naval architecture,
navigation, commerce and
agriculture in order to give their
children a right to study
painting, poetry, music,
architecture, statuary,
tapestry, and porcelain.

JOHN ADAMS

2nd President of the United States



Purpose



Giving kids clothes and food
is one thing, but it's much more
important to teach them that
other people besides themselves
are important, and that the
best thing they can do with
their lives is to use them
in the service of other people.

DOLORES HUERTA

Co-founder and First Vice President Emeritus
of the United Farm Workers of America

How can we expect our children
to know and experience the joy
of giving unless we teach them
that the greater pleasure in life
lies in the art of giving
rather than receiving.

JAMES CASH PENNEY

Businessman and Entrepreneur;
Founder J.C. Penney stores



Treat people as if they were
what they ought to be, and
help them become what they
are capable of being.

GOETHE

German Writer

It is one of the most beautiful
compensations of this life that
no man can sincerely try to
help another without
helping himself.

RALPH WALDO EMERSON
American Essayist, Philosopher, and Poet



If I am not for myself, who
will be for me? If I am not
for others, who am I for?
And if not now, when?

RABBI HILLEL
Jewish Religious Leader

Never forget that the purpose
for which a man lives is the
improvement of the man himself,
so that he may go out of
this world having, in his great
sphere or his small one, done
some little good for his fellow
creatures and labored a little
to diminish the sin and
sorrow that are in the world.

WILLIAM E. GLADSTONE
Former Prime Minister of the United Kingdom

When you cease to make a
contribution, you begin to die.

ELEANOR ROOSEVELT
First Lady of the United States



Doing nothing for others
is the undoing of ourselves.

BENJAMIN FRANKLIN
A Founding Father of the
United States of America

I've met many people across
the public sector who are as
efficient and entrepreneurial
as anyone in the private sector,
but also have a sense of public
duty that is awe-inspiring.

TONY BLAIR
Former British Prime Minister



No act of kindness, no matter
how small, is ever wasted.

AESOP
Greek Slave and Writer

It is not the critic who counts,
not the man who points out
how the strong man stumbled,
or where the doer of deeds could
have done better. The credit
belongs to the man who is actually
in the arena, whose face is
marred by dust and sweat and
blood, who strives valiantly,
who errs and comes short again
and again, who knows the great
enthusiasms, the great devotions,
and spends himself in a worthy
cause, who at best knows
achievement and who at

the worst if he fails at least fails
while daring greatly so that his
place shall never be with those
cold and timid souls who
know neither victory nor defeat.

THEODORE ROOSEVELT
26th President of the United States

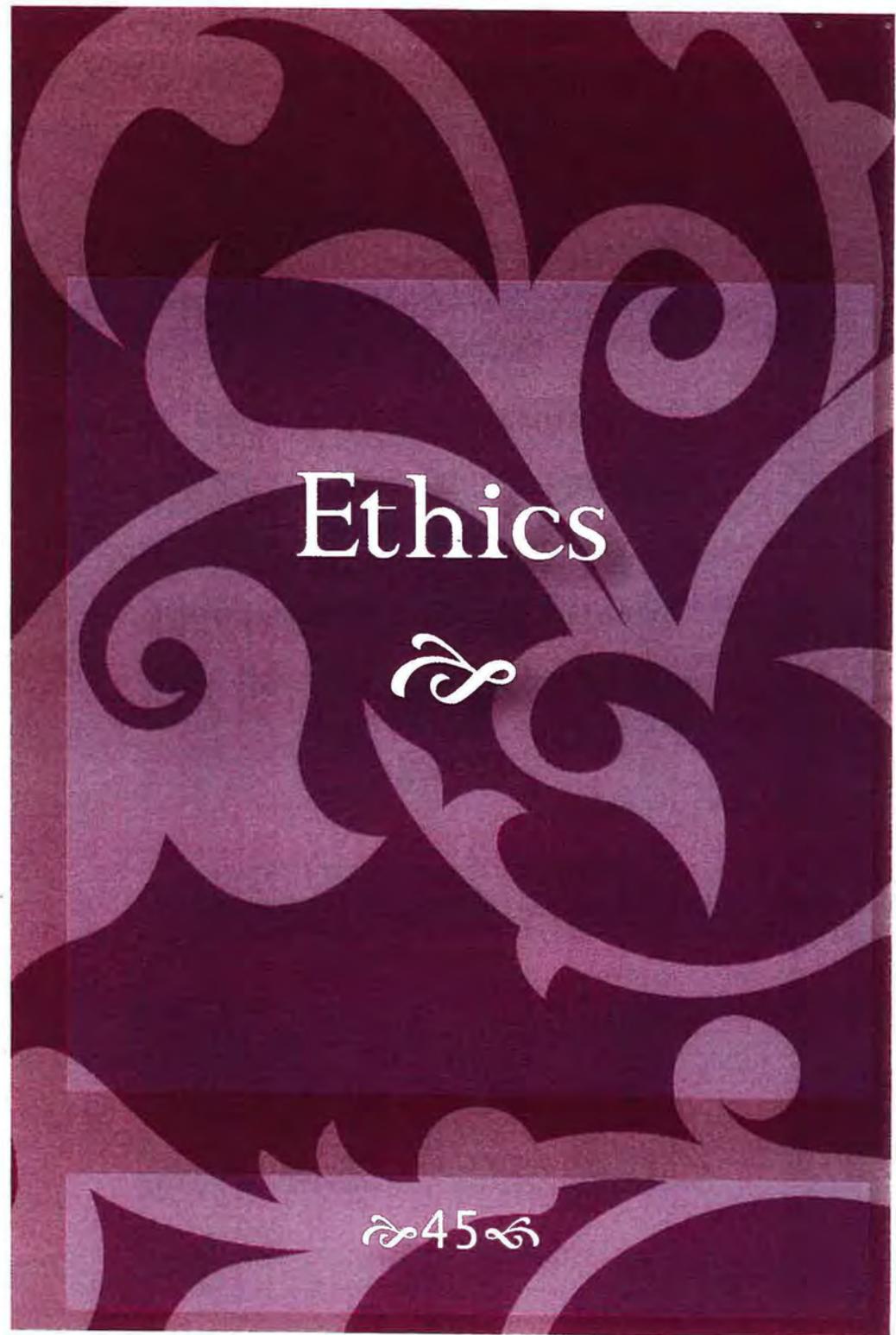


We make a living by what we do,
but we make a life by what we give.

WINSTON CHURCHILL
Former Prime Minister of the United Kingdom

Focusing your life solely
on making a buck shows
a poverty of ambition. It asks
too little of yourself. And it
will leave you unfulfilled.

PRESIDENT BARACK OBAMA
44th President of the United States



Try not to become a man
of success but rather try
to become a man of value.

ALBERT EINSTEIN
Theoretical Physicist



A man is truly ethical only when
he obeys the compulsion
to help all life which he is able
to assist, and shrinks from
injuring anything that lives.

ALBERT SCHWEITZER
German-French Theologian, Musician,
Philosopher, and Physician

Nobody made a greater mistake
than he who did nothing
because he could do only a little.

EDMUND BURKE
Anglo-Irish Statesman, Author,
Orator, and Political Theorist



I have the consolation of having
added nothing to my private
fortune during my public service,
and of retiring with hands
clean as they are empty.

THOMAS JEFFERSON
3rd President of the United States

Being good is commendable,
but only when it is combined
with doing good is it useful.

AUTHOR UNKNOWN



The citizen can bring our
political and governmental
institutions back to life, make
them responsive and accountable,
and keep them honest.

No one else can.

JOHN GARDNER

Secretary of Health, Education,
and Welfare under Former President
Lyndon Johnson

My creed is that public service
must be more than doing a
job efficiently and honestly.
It must be a complete dedication
to the people and to the nation
with full recognition that
every human being is entitled
to courtesy and consideration,
that constructive criticism is not
only to be expected but sought,
that smears are not only to be
expected but fought, that
honor is to be earned, not bought.

MARGARET CHASE SMITH

Former Maine Senator

As soon as public service ceases
to be the chief business of the
citizens, and they would rather
serve with their money than
with their persons, the State
is not far from its fall.

JEAN JACQUES ROUSSEAU
Major Philosopher, Writer, and Composer



When will our consciences
grow so tender that we will
act to prevent human misery
rather than avenge it?

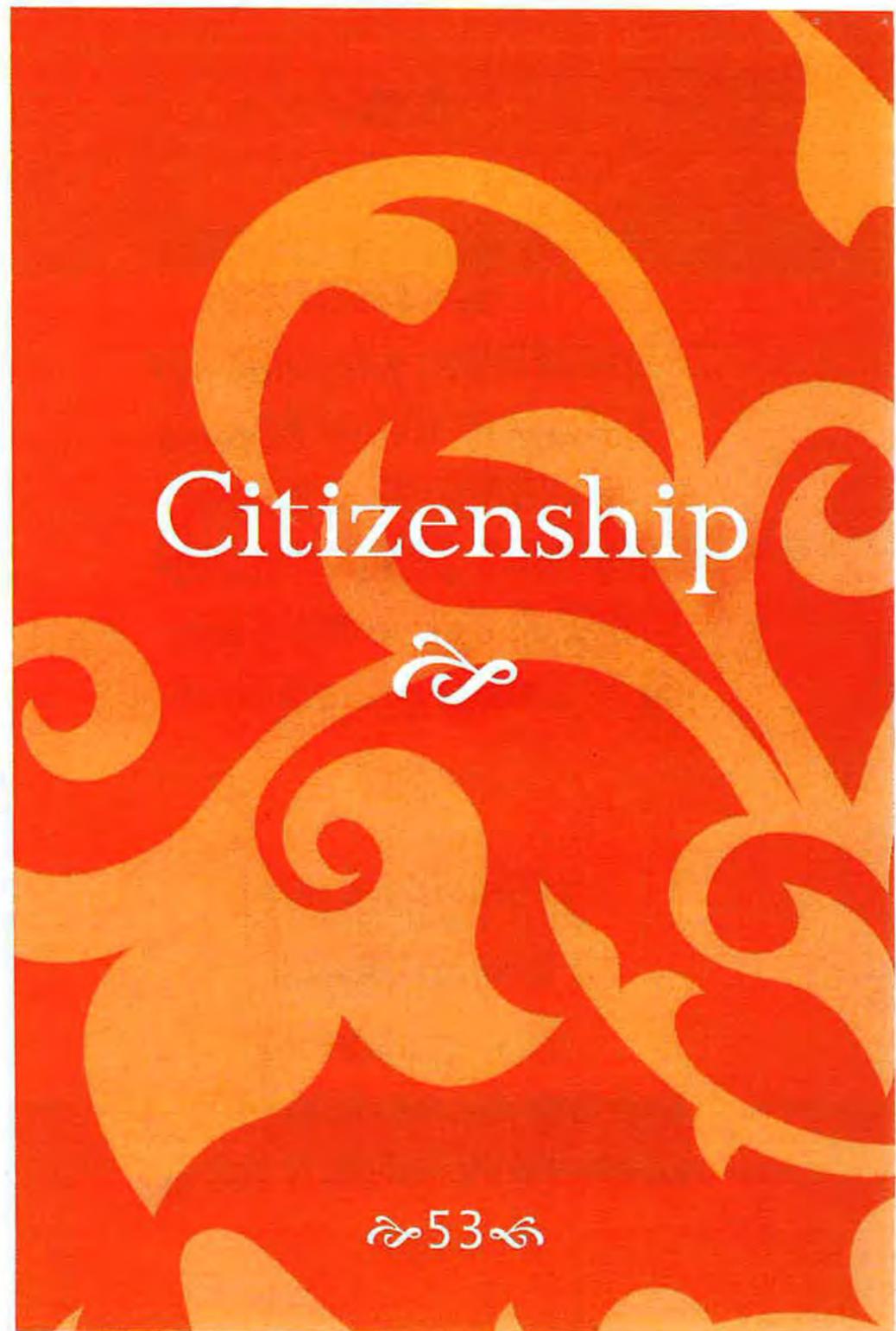
ELEANOR ROOSEVELT
Former First Lady of the United States

And I say to you that it is the
work of public employees – it is
the work of those who work
in the public sector – to hope,
to be optimistic, and to
build a better, safer, fairer,
more just society.

LAURENCE H. SUMMERS
Former President of Harvard University

Where is the man who owes nothing to the land in which he lives? Whatever that land may be, he owes to it the most precious thing possessed by man, the morality of his actions and the love of virtue.

JEAN JACQUES ROUSSEAU
Philosopher, Writer, and Composer



We seldom stop to think
how many people's lives are
entwined with our own. It is a
form of selfishness to imagine
that every individual can
operate on his own or can
pull out of the general stream
and not be missed.

IVY BAKER PRIEST
Former United States Treasurer



You must be the change
you wish to see in the world.

MAHATMA GANDHI
Global Humanitarian

No one is useless in this world
who lightens the burden of it
for someone else.

BENJAMIN FRANKLIN
A Founding Father of the
United States of America



Your nation will succeed or fail
to the degree that all of us
citizens and businesses alike
are active participants in
building strong, sustainable
and enriching communities.

ARNOLD HIATT
Former CEO of the Stride Rite Corp

We ourselves feel that what
we are doing is just a drop in the
ocean, but the ocean would be less
because of that missing drop.
We can do no great things, only
small things with great love.

MOTHER TERESA
Global Humanitarian



How wonderful it is that
nobody need wait a single
moment before starting
to improve the world.

ANNE FRANK
Author The Diary of a Young Girl

Everything that lives, lives not
alone, not for itself.

WILLIAM BLAKE
English Poet, Painter, and Printmaker



One reason not to wait to address
the world's biggest problems is that
they need your attention before
you accept the status quo, before
you are plagued by the knowledge
of what is impossible.

WENDY KOPP
Teach for America Founder

If I can stop one heart
from breaking,
I shall not live in vain.
If I can ease one life the aching,
Or cool one pain,
Or help one fainting robin
Unto his nest again,
I shall not live in vain.

EMILY DICKINSON
Poet

It is possible to eradicate
hunger. How can we live
and sleep comfortably knowing
that millions of our sisters and
brothers go to bed hungry?

ARCHBISHOP DESMOND TUTU

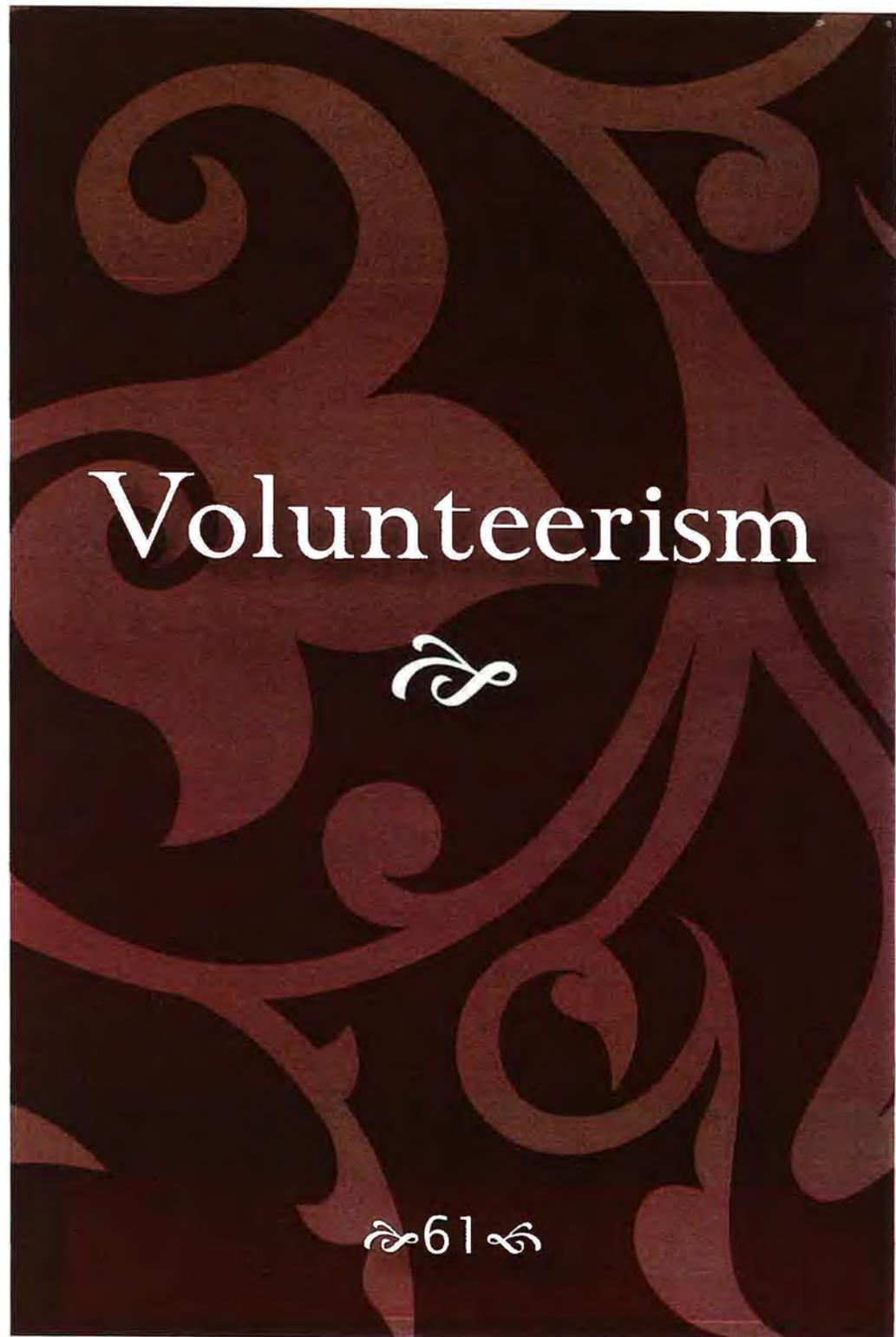


If you can't feed a hundred people,
then feed just one.

MOTHER TERESA
Global Humanitarian

Be the special envoy of
your ideals. Be citizen-ambassadors,
using your personal and
professional lives to forge
global partnerships built on a
common commitment to solve
our planet's common problems.

HILLARY CLINTON
Secretary of State



Volunteerism



Throughout my life, I've seen the difference that volunteering efforts can make in people's lives. I know the personal value of service as a local volunteer.

JIMMY CARTER

39th President of the United States



I urge young people to consider public service, whether they do it now by volunteering in their community or prepare for public service as an adult.

JOHN WALTERS

Director of the White House
Office of National Drug Control Policy

Volunteering can be an exciting, growing, enjoyable experience. It is truly gratifying to serve a cause, practice one's ideals, work with people, solve problems, see benefits, and know one had a hand in them.

HARRIET NAYLOR

National Director of the
Office of Volunteer Development

A volunteer is a person who is a light to others, giving witness in a mixed-up age, doing well and willingly the tasks at hand-namely, being aware of another's needs and doing something about it.

A volunteer is a person who remembers to do the thing to make other people happy, who takes the loneliness out of the alone by talking to them, who is concerned when others are unconcerned, who has the courage to be a prophet and to say the things that have to be said for the good of all.

A volunteer is a person whose charity is fidelity, who is faithful in an unfaithful world, grateful in an ungrateful world, giving when all about are grasping, listening when others need to tell about their fears and problems.

THE BEACON

Newsletter of Birthrite, South Africa



Opportunity + Preparedness = Success. Volunteer to help others be prepared for the opportunities afforded them.

ANONYMOUS

A volunteer is a person who can see what others cannot see; who can feel what most do not feel. Often, such gifted persons do not think of themselves as volunteers, but as citizens – citizens in the fullest sense: partners in civilization.

GEORGE H. W. BUSH
41st President of the United States

There is something enormously fulfilling about being engaged in something bigger than you yourself. It imparts a satisfying sense of purpose which, in my experience, is not attained in any other way.

GENERAL BRENT SCOWCROFT
United States National Security Advisor

Though government has an important role to play in meeting the many challenges that remain before us, we are coming to understand that no organization, including government, will fully succeed without the active participation of each of us. Volunteers are vital to enabling this country to live up to the true promise of its heritage.

BILL CLINTON

42nd President of the United States

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default/files/RuralCommunities.pdf](http://www.pointsoflight.org/sites/default/files/RuralCommunities.pdf)

<http://www.energizeinc.com>

Marc Holzer, PhD, is the Dean of the School of Public Affairs and Administration at Rutgers University in Newark, New Jersey.

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Inside Back Cover
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DATE: November 12, 2016

SUBJECT: Federation of State Medical Boards'
(FSMB) Annual Meeting Issues

SUBMITTED BY: Subbarao Inampudi, M.B., B.S. FACR, Board President

REQUEST FOR BOARD ACTION
MINNESOTA BOARD OF MEDICAL PRACTICE

REQUESTED ACTION:

For discussion.

MOTION BY: _____ SECOND: _____
 PASSED PASSED AMENDED LAYED OVER DEFEATED

BACKGROUND:

Discussion of the following FSMB Issues:

1. Call for resolutions;
2. Call for committee appointment recommendations;
3. Call for nominations; and
4. Minnesota Welcome Reception

**Federation of State Medical Boards
House of Delegates Meeting
April 30, 2016**

Subject: Task Force to Study the Need for State Board Regulation of Physician Compounding

Introduced by: North Carolina Medical Board

Approved: January 2016

Whereas, In 2012, a meningitis outbreak resulted from contaminated steroid injections produced at the New England Compounding Center (NECC) in Massachusetts, a compounding pharmacy; and

Whereas, In the aftermath of the NECC incident, pharmacy boards around the country increased the level of inspection and regulation of such compounding pharmacists; and

Whereas, Historically, physicians have also compounded medications for the use of their patients;

Therefore, be it hereby

Resolved, That the Federation of State Medical Boards (FSMB) will establish a task force to review: (1) current federal regulations; (2) the degree to which physicians are currently compounding medicines; and (3) current state laws governing physician compounding; and be it further

Resolved, That the FSMB task force will work with the Food and Drug Administration and National Association of Boards of Pharmacy to evaluate the current regulatory environment pertaining to physician compounding; and be it further

Resolved, That the FSMB task force will develop recommendations for those states that permit physician compounding.

House of Delegates Policy Development Process

Federation of State Medical Boards

Reference Committees

One or more Reference Committee hearings are scheduled prior to the House of Delegates annual business meeting. An agenda for the items to be heard by each Committee is distributed with the Annual Meeting materials and posted on the FSMB website.

All interested Annual Meeting participants may attend Reference Committee hearings and make statements on items being considered. Agenda items can include resolutions, Board reports, Bylaws amendments or other proposals that require a vote by the House of Delegates. All items heard in Reference Committee hearings will be voted upon by the full House of Delegates at the annual business meeting. Reference Committees are not empowered to take any action on items of business. Their role is to make recommendations to the House of Delegates. Only those items acted upon by the House of Delegates are considered official.

Each Reference Committee will be appointed by the Chair of the FSMB and will be composed of three to five members. However, the Chair may appoint additional members as needed. The Chairs of the Reference Committees introduce each item of business, open the floor for comment and recognize individuals from the floor. While the purpose of the Reference Committees is to hear as much testimony as necessary for a full discussion of each item, the Committee Chairs may, at their discretion, set time limits on the testimony.

Members of the FSMB's Board of Directors, standing committees, special committees and staff are present at Reference Committee hearings to provide any requested resources or information. The Reference Committees are to listen and, if necessary, seek out any appropriate information and/or viewpoints on each item under discussion. Members of the Reference Committees are not allowed to engage in debate or express their own opinions during the hearings, and they are not empowered to entertain motions or make decisions on items of business.

At the close of the hearings, Reference Committee members meet to formulate their recommendations on each item. These recommendations are based on what is in the best interest of the FSMB, and not on the amount of testimony for or against a particular proposal.

At the House of Delegates business meeting, the Chair of each Reference Committee presents the Committee's report. Reference Committees may recommend that a proposal be adopted, rejected, amended or otherwise disposed of, and give reasons

therefore. They may also recommend amendments to proposals that have been referred and/or make substitute proposals of their own. Reference Committees must forward a recommendation to the House of Delegates on each item of business, and the House must take action on these recommendations. Any “whereas” portions or preambles of resolutions before the Committees are informational and explanatory, and only the “resolve” portions are considered by the House of Delegates. Recommendations of Reference Committees are advisory, and it is important that the House of Delegates has the opportunity to consider all proposals submitted to it and make the final decision on each.

The use of Reference Committee hearings allows for a more detailed and thorough discussion of items of business to come before the House of Delegates, thereby facilitating the progress of the annual House of Delegates business meeting.

Setting Policy

A simple majority vote of the House is required for most items of business. Some actions, such as changes to the Bylaws, require a two-thirds majority vote.

The House of Delegates may act on items before it in one of the following ways:

- The House may **adopt** the recommendations of reports and resolves of resolutions or **not adopt** if a majority of the House votes against them.
- The House may **amend and then adopt** the amended recommendations of reports and resolves of resolutions.
- The House may **propose amendments by substitution and then adopt** the substitute amendments to recommendations of reports and resolves of resolutions.
- The House may **refer the items back to the Board** (or through the Board to the appropriate committee) **for further review**. If an item is referred for further study, then all pending information (i.e., amendments) relating to that item is referred as well. A specific time for reporting back to the House should be indicated.
- The House may **refer the items back to the Board for decision**, which gives the Board the authority and responsibility for making a determination on the matter.
- The House may **file an informational report** (acknowledging that a report has been received and considered, but that no action has been necessary or taken).
- The House may **table** a recommendation, which sets aside the recommendation for the current meeting unless the House votes to resume its consideration. A tabled recommendation is postponed to an undetermined time and may be proposed again as a new recommendation at any future meeting; however, if a recommendation is tabled as a means of closing debate indefinitely, it would require a two-thirds majority vote.

**The Federation of State Medical Boards
Public Policy Compendium 2016**

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CONTINUING MEDICAL EDUCATION

100.1 Formation of Accreditation Council for Continuing Medical Education (ACCME)

The FSMB Board of Directors approved the formation of [ACCME](#), its budget, [Essentials](#) and [bylaws](#).
BD, October 1980

100.2 Mandating Continuing Medical Education

The FSMB believes mandatory continuing medical education is a matter reserved for the individual state jurisdictions.

HD, April 1980

100.3 Post-residency Skills and Procedures-based Retraining

The FSMB will assist state medical boards in identifying and developing—in conjunction with other organizations—new post-residency skills and procedures retraining programs in specialties dependent on skills and procedures competencies.

HD, April 1996

100.4 Point of Care Learning

The FSMB recommends that continuing medical education credits be given for point of care learning, described as practice-based learning that takes place in support of specific patient care and that publishes and; vendors of information resources be encouraged to incorporate time-keeping or automated use-recording into their products.

HD, May 2005

100.5 Participation in ABMS MOC and AOA BOS OCC Programs to Meet CME Requirements for License Renewal

The Federation of State Medical Boards (FSMB) supports the use of, and encourages state boards to recognize, a licensee's participation in an ABMS MOC and/or AOA BOS OCC program as an acceptable means of meeting CME requirements for license renewal.

HD, April 2012

MEDICAL EDUCATION

110.1 Medical School Curriculum

The FSMB opposes attempts by legislative bodies to mandate specific details of the curriculum of accredited medical schools in the United States and Canada. This should remain the responsibility of the faculties of these schools and the accrediting body, to permit and encourage adaptation of medical student education to the future challenges medical students will face as physicians in the rapidly changing practice of medicine.

HD, April 1985

110.2 Medical Students Attending Board Meetings

The FSMB recommends that medical students enrolled in an approved medical school be encouraged to attend either their state medical board meeting or a meeting sponsored by their state medical board for the purpose of educating medical students regarding the responsibilities as a licensed physician and the specific ramifications of violating medical regulations

HD, April 2000

110.3 Report on Licensure of Physicians Enrolled in Postgraduate Training Programs

The FSMB approves as policy the recommendations contained in the report, [Licensure of Physicians Enrolled in Postgraduate Training Programs](#), developed by the FSMB's Legislative and Legal Advisory Committee.

HD, April 1996

110.4 Education of Medical Students, Interns, Residents and Related Faculty on Licensure and Attendant Good Conduct Requirements

The FSMB shall continue to provide access to new and existing presentation materials for boards to use to educate medical students, interns, residents and appropriate faculty on medical licensure and regulation. The FSMB shall seek funding for the development of educational modules to be used in medical schools and residency programs.

HD, April 2003

110.5 Report of the Special Committee on the Evaluation of Undergraduate Medical Education The FSMB adopts as policy the recommendations contained in the report, [Special Committee for the Evaluation of Undergraduate Medical Education](#).
HD, April 2006

110.6 Medical Education in Substance Abuse
The FSMB will develop methods and/or modules of information to be used to educate medical students, residents and practicing physicians regarding the identification of substance use disorders, intervention and the proper prescribing of controlled substances.
HD, May 2007

110.7 Shortening Undergraduate Medical Education
The FSMB will work in collaboration with the AAMC, AACOM, AMA and the AOA to study the value of shortening the duration of undergraduate medical education from four years to three years and its impact collectively on access to care, patient outcomes, patient safety and medical student indebtedness.
HD, 2013

EXAMINATIONS

120.1 English Administration of Licensing Exams
The FSMB reaffirms its policy that licensing examinations for U.S. jurisdictions be administered in English only. BD, May 1979
BD, October 1995, Revised

120.2 Special Purpose Examination (SPEX) Use Statement
The FSMB accepts as policy the following statement for SPEX use:
SPEX is a cognitive examination to assist licensing jurisdictions in their assessment of current competence requisite for general, specialty-undifferentiated medical practice by physicians who hold or have held a valid unrestricted license in a United States or Canadian jurisdiction.
BD, April 1987

120.3 Release of SPEX Score Reports
The FSMB endorses the release of SPEX score performance profile information, including information regarding limitations of the performance information, to the examinee and the sponsoring state medical boards.
HD, April 1998

120.4 Clinical Skills Assessment as Part of Licensure Process
The FSMB supports and encourages the development and use of an evaluation of clinical skills as a component of the physician licensure process for all medical students.
BD, October 1987

120.5 Single Examination for Medical Licensure
The FSMB reaffirms its commitment to establish a single examination for medical licensure in collaboration with other concerned organizations and adopts as an official FSMB position paper the document A Proposal for a Single Examination for Medical Licensure.
HD, April 1989

The FSMB reaffirms its policy that USMLE be the single pathway to licensure for all U.S. allopathic physicians.
HD, April 1999
HD, April 2012, Revised

120.6 Enhancement of the USMLE
The FSMB endorses the Strategic Plan for Enhancement of the USMLE adopted by the USMLE Composite Committee.
HD, April 1995

120.7 Hybrid Examination Combinations
The FSMB approves the following guidelines relevant to FLEX 1 and 2:
1. Candidates, who passed FLEX Component 1 before 1994 and pass the USMLE Step 3 within seven

years of the original FLEX pass, will be recommended as having met acceptable licensing examination requirements.

2. Candidates (likely only international medical graduates) who have passed NBME Part I or USMLE Step 1 and NBME Part II or USMLE Step 2 before 1994, and who pass FLEX Component 2 before 1994, will be recommended as having met acceptable licensing examination requirements.

BD, February 1992

120.8 Examination History

The FSMB receives a request from any state for examination history; the FSMB will attach a Board Action Data Bank report to all transcripts that contain a disciplinary history.

In reporting the results from all queries of the FSMB Data Bank, the board action history report will include licensing history as a standard informational element on all reports, in addition to any reportable disciplinary history when it exists for an individual physician.

HD, April 1984

HD, May 2009, revised

120.9 Common Examination System

The FSMB recognizes the [USMLE](#) and [COMLEX-USA](#) as valid exams for their intended purposes. To assure the public that all physicians are meeting a uniform standard for purposes of medical licensure, the FSMB may collaborate with interested parties to develop a common licensing examination system that advances both osteopathic and allopathic medical licensure while maintaining the distinctiveness of both professions.

HD, April 2001

HD, May 2008, Revised

120.10 Inclusion of Pain, Pain Assessment and Pain Management Questions on National Standardized Licensure Examinations

The FSMB will encourage the [NBME](#), the [NBOME](#) and other appropriate organizations to ensure that questions related to pain mechanisms, pain assessment, and pain management be included in all standardized medical licensing examinations, emphasizing the importance of appropriate pain management in quality medical care.

HD, April 2002

120.11 Evaluation of Licensure Examinations

The FSMB will develop a mechanism for continuous evaluation of the evidence developed by the [USMLE](#) and [COMLEX-USA](#) programs to support the validity of decisions being made by state medical boards on the basis of test scores, and that reports regarding the outcomes of such evaluation be provided to the membership on a regular basis.

HD, May 2004

120.12 Report of Committee to Evaluate the USMLE Program (CEUP) (HD)

The member boards of the Federation of State Medical Boards resolve:

1. To adopt the Final Report and Recommendations of CEUP as a conceptual framework for the continued improvements in the USMLE examination program;
2. To make a clear commitment to incorporate into the USMLE program the following enhancements (described in CEUP Recommendations 1, 2, and 3) at such point when models and methodologies have been developed and tested and the results of this testing indicate that such enhancements will provide assessments that meet reasonable standards of validity, reliability, and practicality;

Enhancement 1: The USMLE program shall be a series of assessments that are specifically intended to support decisions about a physician's readiness to provide patient care at each of two patient-centered points: at the interface between undergraduate and graduate medical education (supervised practice), at the beginning of independent (unsupervised) practice.

Enhancement 2: USMLE shall adopt a general competencies schema (such as the six general competencies identified by the Accreditation Council on Graduate Medical Education) for the overall design, development, and scoring of USMLE, using a model consistent with national standards. Further, as the USMLE program evolves, it should foster a research agenda that explores new ways to measure those general competencies important to medical practice and licensure which are difficult to assess using current methodologies.

Enhancement 3: USMLE shall emphasize the importance of the scientific foundations of medicine in all components of the assessment process. The assessment of these foundations should occur within a clinical context or framework, to the greatest extent possible.

3. To make a clear commitment to support the development of methodologies and instruments to enhance testing methods to assess clinical skills, as reflected in CEUP Recommendation #4, and to consider approaches for design and implementation of a testing format to assess an examinee's ability to recognize and define a clinical problem, to access appropriate reference resources in order to find the scientific and clinical information needed to address the problem, and to interpret and apply that information in an effective manner, consistent with CEUP Recommendation #5;
4. To delegate monitoring and final approval of such enhancements to the Composite Committee and the Board of Directors of the Federation of State Medical Boards in concert with the Executive Board of the National Board of Medical Examiners; and
5. To affirm the principle that the parents recognize that such enhancements will require shared investment of financial resources and that this investment will be recovered via revenues generated by the USMLE program over time.

HD, May 2009

SPECIALTY BOARD CERTIFICATIONS

130.1 Licensure by Specialty
The FSMB opposes licensure by specialty.
HD, April 1982

130.2 License Restriction/Board Certification

It is the position of the FSMB that a physician who has a restricted license and is allowed to practice clinical medicine under board supervision and is complying with all the terms and conditions of his/her license restriction, should be allowed to be a candidate for specialty board certification, re-certification or main enhancement of certification

HD, April 1992

HD, May 2005, Revised

130.3 License Restrictions and Specialty Board Certification

The FSMB shall establish an ongoing dialogue with allopathic and osteopathic specialty boards regarding restrictions on medical licenses due to a mental or physical disability and specialty board certification. The primary purpose would be to develop mechanisms allowing physicians with physical or mental disabilities to obtain and maintain specialty board certification without compromising public protection.

HD, April 1998

The FSMB will continue discussions with the [American Board of Medical Specialties](#) and the [American Osteopathic Association](#) regarding the issue of eligibility for specialty recertification of physicians with licensure restrictions. The FSMB will explore the possibility of developing alternate mechanisms which would allow physicians to be eligible for specialty recertification while preserving medical board oversight of their recovery program.

HD, April 1999

TELEMEDICINE and LICENSE PORTABILITY

140.1 Report of the Special Committee on License Portability

The FSMB adopts as policy the recommendations contained in the [Report of the Special Committee on License Portability](#).

HD, April 2002

140.2 Disaster Preparedness and Licensing

The FSMB will cooperate with federal and state legislators, agencies, and organizations in facilitating the movement of properly licensed physicians among FSMB member licensing jurisdictions in support of necessary emergency medical response

HD, April 2002

140.3 License Portability During a Public Health Emergency

Resolved that state medical boards cooperate and support each other to further license portability in the event of a public health emergency and assist FSMB in verifying licensure and qualifications by regularly providing FSMB with licensure and contact information on all licensees; and that the FSMB study issues relative to license portability during an emergency including, but, not limited to, joining with other organizations or entities to determine the best manner to provide necessary medical care and maintain licensure autonomy for the individual states.

HD, April 2006

140.4 Interstate Mobility of Physicians

Resolved, that the Federation of State Medical Boards takes steps to assist its member boards to evaluate their own statutes, rules and regulations and where necessary and appropriate modify those statutes, rules and regulations to provide for the rapid research, training or unique clinical care.

140.5 Definition of Telemedicine

“Telemedicine” is the practice of medicine using electronic communication, information technology or other means between a physician in one location and a patient in another location with or without an intervening health care provider. The policy was adopted to supersede the Telemedicine Model Policy (HD, 2007)

HD, May 2009

140.6 Development of an Interstate Compact to Expedite Medical Licensure and Facilitate Multi-State Practice

The FSMB will convene representatives from state medical boards and special experts as needed to aggressively study the development of an Interstate Compact model to facilitate license portability hereinafter known as the Medical License Portability Interstate Compact model and be it further that the this be initiated no later than July 2013.

HD, April 2013

140.7 Model Policy for the Appropriate Use of Telemedicine Technologies in the Practice of Medicine

The FSMB adopts as policy the Model Policy for the Appropriate Use of Telemedicine Technologies in the Practice of Medicine.

HD, April 2014

LICENSURE REQUIREMENTS

150.1 Requirements Unrelated to the Practice of Medicine

The FSMB opposes enactment by any jurisdiction of requirements for initial physician licensure not reasonably related to the qualifications and fitness of individuals or practice medicine, and, instead, have in view the implementation of social, economic or political policies of the jurisdiction at a particular moment, however well-intentioned or justified those policies may appear.

HD, April 1987

HD, April 1997, Revised

150.2 Report of the Ad Hoc Committee on Licensure by Endorsement

The FSMB adopts as policy the recommendations contained in the report, [Licensure by Endorsement](#).

HD, April 1995

150.3 Criminal Record Check

The FSMB reaffirms its policy that all state medical boards conduct criminal record checks as part of the licensure application process. The FSMB encourages all state medical boards to require any applicant with a criminal history report to appear before the board for questioning to evaluate the applicant’s degree of risk to the public in determining fitness or licensure. The FSMB will develop legislative or administrative approaches that will assist member boards who wish to have the authority to require criminal background checks for applicants for professional licensure.

HD, April 2001

150.4 Setting Higher Standards for Unrestricted Licensure

The FSMB will, in collaboration with other stakeholders, examine the benefits as well as the potential harms and unintended consequences that could occur as a result of requiring all applicants for licensure to have completed 36 months of progressive postgraduate medical training.
HD, April 2013

150.5 Sports Team Physicians

The FSMB adopts as policy the recommendation contained in the Report of the Workgroup on Innovations in State-based Licensure that sports team physicians are held exempt from the state licensure requirement, as follows:

A physician licensed in another state, territory, or jurisdiction of the United States is exempt from the licensure requirements in (name of state) if the physician is employed or formally designated as the team physician by an athletic team visiting (name of state) for a specific sporting event and the physician limits the practice of medicine in (name of state) to medical treatment of the members, coaches and staff of the sports entity that employs (or has designated) the physician.

HD, April 2014

OTHER

160.1 Military/Government Employed Physicians

All physicians, other than those in training, be required to have a full and unrestricted license in at least one state and that exemptions not be made for physicians in the armed forces, Public Health Service or other governmental agencies.

BD, December 1977

BD, July 1996, Revised

160.2 Liability Insurance

Professional liability insurance is an economic issue, not to be linked with medical licensure.

HD, April 1995

160.3 Verifying Credentials of Physicians in Postgraduate Training Programs

The FSMB urges its member boards to bring reasonable procedures and rules into effect or encourage enactment of laws which would ensure thorough verification and authentication of the credentials of all medical school graduates in training programs and who do not hold a full and unrestricted license to practice medicine.

The FSMB recommends that, in those jurisdictions that provide for credentials verification, the directors of medical education of the training institutions, deans of the medical schools, hospital administrators, or other responsible individuals involved with medical school graduates, such verification be certified by the state medical board or, where the state medical board has no authority, to an appropriate state agency.

HD, April 1985

160.4 Federation Credentials Verification Se vice (FCVS) and Educational Commission on Foreign Medical Graduated (ECFMG) to Expedite Licensure

The FSMB, through the [FCVS](#), pursue cooperative efforts with the [ECFMG](#) to reduce duplication of efforts and redundancy in primary source verification

HD, April 2003

160.5 Credentials Verification or International Medical Graduates

The FSMB shall continue to monitor and encourage the progress of the FCVS/ECFMG initiative, and for the FSMB and its member boards to strongly recommend that International Medical Graduates establish an FCVS profile or the purpose of securing and protecting their medical school credentials for a lifetime of license portability and practice.

HD, April 2006

160.6 Framework on Professionalism in the Adoption and Use of Electronic Health Records

The FSMB adopts as policy the Framework on Professionalism in the Adoption and Use of Electronic Health Records.

HD, April 2014

160.7 Framework for a Minimal Physician Data Set

The FSMB adopts as policy the Framework for a Minimal Physician Data Set to supersede the Policy on Physician Demographics (HD, 2011)
HD, April 2013

160.8 Advocacy Efforts in Response to Antitrust Concerns of State Medical Boards

The FSMB adopted a resolution by the Wyoming Board of Medicine calling for advocacy against the expanded application of antitrust principles that may compromise patient safety, and for the FSMB to assist state boards facing litigation alleging antitrust violations.

IMPAIRED PHYSICIANS

170.1 AMA Report on the Use of Alcohol by Physicians

The FSMB supports the guidelines established by the American Medical Association (AMA) regarding physicians' ingestion of alcohol and patient care (H-30.960 Physician Ingestion of Alcohol and Patient Care).
HD, April 1993
HD, April 2012, Revised

170.2 Addressing Sexual Boundaries: Guidelines for State Medical Boards

The FSMB adopts as policy: [Addressing Sexual Boundaries: Guidelines for State Medical Boards](#), superceding the Report on Sexual Boundary Issues.
HD, April 1996
HD, April 2006, Revised

170.3 Credit Against License Suspensions or Restrictions

The FSMB recommends to all member boards that, for cases of license suspension or restriction, any time during which a disciplined physician practices in another jurisdiction without comparable restriction should not be credited as part of the period of suspension or restriction.
HD, April 1993

170.4 Policy on Physician Impairment

The [Policy on Physician Impairment](#) was adopted to supersede *The Report on Physician Impairment* (HOD 1995).
HD, April 2011

170.5 Report of the Special Committee on Reentry for the Ill Physician

The FSMB adopts as policy the recommendations contained in the Report of the Special Committee on Reentry for the Ill Physician.
HD, April 2013

NATIONAL DATA BANKS

180.1 Centralized Database of Licensing Profile

The FSMB recognizes the need for a centralized database displaying the licensing profile of all practicing physicians and the need of the individual state medical boards for ready access to such a file, as well as the value of such a centralized database for analysis of practice trends, especially designation and distribution of physicians and the dynamics of geographical distributional changes of physicians.

The FSMB endorses efforts in conjunction with the NBME to obtain appropriate funding to design and engage in a process leading to the development and implementation of a computerized national tracking system containing longitudinal data relevant to the licensure status of all physicians within the licensing jurisdictions of the United States.

Representatives of the constituent medical boards of the FSMB endorse the concept of the centralized computerized database and express their intent to participate in the implementation of the process by the individual state medical boards.

HD, April 1980

180.2 Reporting to the Board Action Data Bank (BADB)

The FSMB encourages all state medical boards to report all board actions to the FSMB's Board Action Data Bank, including denials and/or withdrawals for cause, as quickly as possible but no later than 30 days after actions are taken.

HD, April 1996

The FSMB encourages all member boards to include disclosure language in all board orders.

BD, October 1997

All state licensing boards report all formal board actions to BADB, including non-prejudicial actions.

BD, January 1980

The FSMB will expand its database to include all licensed physicians.

BD, October 1997

The FSMB encourages all state medical boards enacting emergency actions to immediately contact the FSMB Physician Data Center to provide information on individuals who are subject to these actions. The FSMB encourages state medical boards taking emergency action to immediately transmit a copy of the emergency order to the FSMB Physician Data Center so that notification can be immediately transmitted to all other states wherein the physician is licensed, applying for licensure, or in post-graduate training and/or residency.

The FSMB Physician Data Center will provide timely notification to member boards of disciplinary actions taken by other state medical boards through a Disciplinary Alert Report. The FSMB encourages all state medical boards to provide data files and timely updates to the FSMB Physician Data Center, so that there will exist a national database comprised of current and complete information which can be accessed by all states in which a physician is licensed or seeking licensure. The FSMB encourages the executive directors of all medical boards in states enacting emergency actions to immediately determine all other states of licensure for individuals subject to such emergency actions. The director of the board enacting the emergency action shall then immediately advise those directors of other boards where the licensee is known to hold another medical license about the emergency action. This contact should occur as close to the same day of the board action as is possible. This will ensure optimal public protection and the most timely notification possible while processes for drafting, serving and disseminating legal orders for the emergency action take place.

HD, April 2001

180.3 National Practitioner Data Bank (NPDB)

The FSMB supports continued monitoring of the progress and development of the National Practitioner Data Bank (NPDB) and continued dialogue with the Health Resources Services Administration staff regarding potential future modifications in the NPDB.

BD, April 1991

180.4 Public Access

The FSMB approves an initiative to develop a means to provide public access to national physician data base information.

BD, February 1998

CONDUCT AND ETHICS

190.1 Report of the Special Committee on Professional Conduct and Ethics

The FSMB adopts as policy the recommendations contained in the [Report of the Special Committee on Professional Conduct and Ethics](#).

HD, April 2000

190.2 Model Guidelines for the Appropriate Use of the Internet in Medical Practice

The FSMB adopts as policy the [Model Guidelines for the Appropriate Use of the Internet in Medical Practice](#).

HD, April 2002

190.3 Best Practices in the Use of Social Media by Medical and Osteopathic Boards

At its 2016 Annual Meeting, the FSMB shall present information on current uses of social media by regulatory agencies and collect and disseminate information on best practices for regulatory agencies to follow in using social media and other forms of communication to publicize Board news and information, including public disciplinary actions.

HD, April 2015

190.4 Position Statement on Practice Draft

The FSMB adopts as policy the position contained in the [Position Statement on Practice Draft](#).

HD, April 2016

190.5 Position Statement on Duty to Report

The FSMB adopts as policy the position contained in the [Position Statement on Duty to Report](#).
HD, April 2016

190.6 Position Statement on Sale of Goods by Physicians and Physician Advertising

The FSMB adopts as policy the position contained in the [Position Statement on Sale of Goods by Physicians and Physician Advertising](#).

HD, April 2016

INTERNATIONAL MEDICAL REGULATION

200.1 Clinical Clerkships for Foreign Medical Graduates

The FSMB encourages all member boards to bring rules into effect or to encourage enactment of laws authorizing the respective state boards of medical examiners or appropriate state agency to regulate the clinical clerkships of those students from medical schools not approved by the Liaison Committee on Medical Education or the American Osteopathic Association, where such rules or laws are not already in effect.

HD, April 1985

200.2 International Association of Medical Regulatory Authorities (IAMRA)

The FSMB and its representatives to the [IAMRA](#) be encouraged to seek opportunities to share information with the international community on matters related to education, training and licensure for both osteopathic and allopathic physicians in the United States. At the time that a formal membership structure is established, the IAMRA Office of the Secretariat forward information regarding associate membership to the [AMA](#), [AOA](#), [ACGME](#), [LCME](#), [ABMS](#) and other appropriate organizations.

HD, April 2001

SCOPE OF PRACTICE

210.1 National Commission on Certification of Physician Assistants (NCCPA) Examination

The FSMB urges state boards that regulate physician assistants to formulate rules and regulations that would permit acceptance of the examination of the [NCCPA](#) in the authorization of physician assistants in their respective states.

BD, February 1976

210.2 Participation in the NCCPA

The FSMB supports continued participation on the [NCCPA](#) Board of Directors and encourages and supports the [NCCPA](#).

BD, October 1990

210.3 Non-physician Duties and Scope of Practice

A non-physician should be permitted to provide medical services delegated to him or her by a supervising physician consistent with state law, as long as those medical services are within his or her training and experience, form a usual component of the supervising physician's practice of medicine, and are provided under the direction of the supervising physician.

BD, July 1998

210.4 Scope of Practice Information for Non-Physician Health Care Professionals

The FSMB will maintain information on scopes of practice of licensed non-physician health care professionals and make the information available to member medical boards.

HD, April 2000

HD, April 2012 Revised

210.5 Delegation of Medical Functions to Unlicensed Individuals

The FSMB will maintain new and existing legislation/regulations and other information on the delegation of medical functions and make the information available to member medical boards and other interested parties.

HD, April 2003

210.6 Use of "Doctor" Title in Clinical Settings

1. The FSMB work with the Scope of Practice Partnership and other stakeholders, including associations of health professional regulatory boards and patient advocacy groups, in supporting state legislation to provide transparency for patients seeking a health care professional;
2. The FSMB, through its advocacy network, support the Healthcare Truth and Transparency Act of 2010 or similar federal legislation designed to assure patients receive accurate information about the qualifications and licensure of health care professionals; and,
3. Adopted the following policy statement: Health care practitioners who provide health services to consumers and are legally authorized to use the term "doctor" or "physician" or any abbreviation thereof, should be required to simultaneously and clearly disclose and identify which branch of the healing arts for which they are licensed. Such disclosure should apply to written advertisements, identification badges, and any other form of practitioner/patient communications.

HD, May 2009

HD, April 2011

MEDICAL BOARDS: STRUCTURE AND FUNCTION

220.1 Elements of a State Medical and Osteopathic Board

The FSMB adopts as policy the fourth edition of the [Elements of a State Medical and Osteopathic Board](#).
BD, October 1989
HD, May 1998, Revised
HD, April 2006, Revised
HD, May 2009, Revised
HD, April 2012, Revised

220.2 Essentials of a State Medical and Osteopathic Practice Act

The FSMB adopts as policy the thirteenth edition of the [Essentials of a State Medical and Osteopathic Practice Act](#).
BD, February 1956
BD, February 1970, Revised
BD, February 1977, Revised
BD, February 1985, Revised
BD, October 1987, Revised
BD, February 1991, Revised
BD, February 1994, Revised
HD, April 1997, Revised
HD, April 2000, Revised
HD, April 2003, Revised
HD, April 2006, Revised
HD, May 2009, Revised
HD, April 2010, Revised
HD, April 2012, Revised

220.3 Maintaining State-based Medical Licensure and Discipline: A Blueprint for Uniform and Effective Regulation of the Medical Profession

The FSMB adopts as policy the recommendations contained in [Maintaining State-based Medical Licensure and Discipline: A Blueprint for Uniform and Effective Regulation of the Medical Profession](#) from the Special Committee on Uniform Standards and Procedures.
HD, April 1998

220.4 Funding

The FSMB urges state legislatures to provide their state medical licensing boards adequate resources to properly discharge their responsibilities and duties.
BD, January 1980

220.5 Report of the Special Committee on Physician Profiling

The FSMB adopts as policy the recommendations contained in the [Report of the Special Committee on Physician Profiling](#).
HD, April 2000
HD, April 2002, Revised

220.6 Information Exchange Between Boards

The FSMB policy adopted in 1998 and reaffirmed in the [Report of the Special Committee on License Portability](#) encourages member boards to share investigative information at the early stages of a complaint investigation in order to reduce the likelihood that a licensee may become licensed in one state while under investigation in another state. The FSMB will collaborate with other interested organizations and agencies in addressing communication barriers resulting from variances in state confidentiality. The FSMB will maintain and distribute information related to state confidentiality to its member medical boards.
HD, April 2002

220.7 Reporting Withdrawals of Licensure Applications to the FSMB

The FSMB will undertake, at the earliest possible opportunity, a thorough review of the reporting of withdrawals by each member board and draft a policy to ensure consistent reporting of these or any level of withdrawals by each member board that will advise member boards of a physician's history of withdrawals in other states.
HD, May 2009

220.8 Report of the Workgroup to Examine Composite Action Index (CAI) and Board Metrics

The FSMB adopts as policy the recommendations contained in the Report of the Workgroup to Examine Composite Action Index (CAI) and Board Metrics.
HD, April 2012

220.9 Report of the Workgroup to Define A Minimal Data Set

The FSMB adopts as policy the framework for a minimal physician data set as recommended in the [Report of the Workgroup to Define a Minimal Data](#).
HD, April 2012

220.10 Reporting of Drug Diversion by Healthcare Employers

The FSMB will cooperate with other stakeholders, including similar associations of health professional regulatory boards, to study the feasibility of drafting model legislation addressing the duty of all healthcare workplace employers to report any discipline based on such diversion to health licensing boards and be it further that the FSMB support state medical boards in the study and development of legislation addressing the duty of healthcare workplace employers to report such diversion by healthcare licensees to the respective HLBS.
HD, April 2013

220.11 Collateral Consequences of Board Actions

The FSMB will continue to communicate with credentialing bodies, and other entities that use public board action reports as a basis for their actions to explore ways to accomplish their missions while taking measured, appropriate and proportionate action in response to public board actions involving a physician.
HD, April 2014

STATE MEDICAL BOARDS: RELATIONSHIPS WITH OTHER AGENCIES

230.1 Drug Enforcement Agency (DEA)

The FSMB strongly urges the [DEA](#) to promptly report all violations by physicians to the Board(s) of Medical Examiners of the state in which the physician practices and to the FSMB's Board Action Data Bank.
BD, February 1965
BD, October 1995, Revised

230.2 Quality Improvement Organizations

The FSMB encourages state boards to cooperate with state quality improvement organizations on issues of medical discipline.
BD, February 1990
BD, April 2012, Revised

230.3 Federal Facilities

The FSMB encourages the federal government to have federal facilities use state boards of medical examiners in the states in which such facilities are located to ensure that fraudulent or incompetent physicians are not allowed to practice at those facilities; encourages states to require federally-employed physicians to possess a current active license in a state or territory, and recommends that within each state or territorial possession in which a federal facility exists, a liaison committee be established consisting of a representative of the federal facility and the state licensing board.
HD, April 1988

230.4 Memorandum of Understanding for Sharing Information Between the Department of Defense Medical System and State Medical Boards (HD)

The Federation of State Medical Boards (FSMB) shall initiate dialogue and pursue a Memorandum of Understanding or other means with the Department of Defense Medical System and other uniformed health services to facilitate the sharing of information necessary to state medical and osteopathic boards in fulfilling their regulatory responsibilities.

HD, April 2011

230.5 JMR to Key State Decision Makers

The FSMB encourages each state medical and osteopathic board to assess their budgets to consider sending the JMR (at a reduced rate subscription) to their respective legislators and Governor.

HD, April 2014

QUALITY OF CARE and COMPETENCY

240.1 Report of the AMA and the FSMB : Ethics and Quality of Care

The FSMB adopts as policy the recommendations contained in the [Report of the American Medical Association and the FSMB: Ethics and Quality of Care](#).

HD, April 1995

240.2 Report of the Special Committee on Quality of Care and Maintenance of Physician Competence

The FSMB adopts as policy the recommendations contained in the [Report of the Special Committee on Quality of Care and Maintenance of Physician Competence](#).

HD, April 1998

HD, April 1999, Revised

240.3 Remedial Education

The FSMB will identify available remedial educational resources and [publish a comprehensive directory](#) of such resources for its member boards; foster regional expansion of assessment centers throughout the country in support of member boards' efforts; and encourage development of centers capable of assessing specialty practice performance.

HD, April 1999

240.4 Post-Licensure Assessment System

When physician competence is called into question, state medical regulatory boards should consider using the [Post-Licensure Assessment System \(PLAS\)](#) established by the FSMB and National Board of Medical Examiners. State medical regulatory boards should work with relevant medical organizations in their states to encourage development of educational programs designed to address physicians' learning needs as identified through assessment programs. The FSMB, when requested, will assist and support any member board in its effort to utilize PLAS, including, but not limited to, providing informational resources, research studies and suggested policies on identifying and referring physicians for assessment, evaluating assessment programs, stimulating development of need-based educational programs and continuing improvement of the post-licensure assessment and education effort.

HD, April 1999

240.5 Review of FSMB Model Guidelines for the Use of Controlled Substances for the Treatment of Pain

The FSMB will develop a process for review of its policy, [Model Guidelines for the Use of Controlled Substances for the Treatment of Pain](#), and consider whether it might be strengthened in the light of new medical insights during the past five years, particularly focusing in issues surrounding the undertreatment of pain.

HD, April 2003

240.6 Model Policy for the Use of Controlled Substances for the Treatment of Pain

The FSMB adopts as policy the, [Model Policy for the Use of Controlled Substances for the Treatment of Pain](#), superceding the Model Policy for the Use of Controlled Substances for the Treatment of Pain.

HD, April 1998

HD, May 2004, Revised

240.7 Prevention of HIV/HBV Transmission to Patients

The State medical and osteopathic practice acts, other appropriate statutes and/or the rules of the state medical or osteopathic board should include provisions dealing with preventing the transmission of human immunodeficiency virus (HIV), hepatitis B virus (HBV) and hepatitis C virus (HVC) to patients. These statutes or rules should be consistent with the following recommendations:

- A. Persons under the jurisdiction of the Board should comply with the guidelines established by the Centers for Disease Control and Prevention for preventing the transmission of human immunodeficiency virus (HIV), hepatitis B virus (HBV) and hepatitis C virus (HVC) to patients.

- B. State medical boards should have the powers and responsibilities
1. to encourage physicians and other health care providers to know their HIV and HBV status;
 2. to require reporting to the state board and/or the state public health department of HIV- and HBV-infected healthcare workers who perform invasive procedures;
 3. to ensure confidentiality of those reports received by the state board and/or state public health department under (2) above;
 4. to establish practice guidelines for HIV- and HBV-infected practitioners; and
 5. to monitor or to assist the state public health department to monitor the practices and health of HIV and HBV-infected practitioners who perform invasive procedures.
- C. The state board should be authorized to discipline all persons under its jurisdiction who violate the statute(s) or rule(s) establishing or otherwise implementing requirements related to preventing transmission of HIV and HBV to patients.

HD, April 1992

HD, April 1996, Revised

HD, April 2012, Revised

240.8 Report of the Special Committee on Questionable and Deceptive Health Care Practices

The FSMB adopts as policy the recommendations contained in the Report of the Special Committee on Questionable and Deceptive Health Care Practices, previously published as the Report on Health Care Fraud.

HD, April 1997

HD, April 1999, Revised

240.9 Model Guidelines for the Use of Complementary and Alternative Therapies in Medical Practice

The FSMB adopts as policy the [Model Guidelines for the Use of Complementary and Alternative Therapies in Medical Practice](#).

HD, April 2002

240.10 Report of the Special Committee on Managed Care

The FSMB adopts as policy the recommendations contained in the [Report of the Special Committee on Managed Care](#).

HD, April 1998

The FSMB reaffirms its recommendation, as stated in the “Report of the Special Committee on Managed Care,” to encourage state medical boards to communicate with state agencies responsible for regulating managed care organizations on issues relating to quality of care.

HD, April 2001

240.11 Model Policy on DATA 2000 and Treatment of Opioid Addiction in the Medical Office

The FSMB adopts as policy the Model Policy on DATA 2000 and Treatment of Opioid Addiction in the Medical Office

HD, April 2002

HD, April 2013, Revised

240.12 Model Policy on the Use of Opioid Analgesics in the Treatment of Chronic Pain

The FSMB adopts as policy the Model Policy on the Use of Opioid Analgesics in the Treatment of Chronic Pain.

HD, April 2013

240.13 Communication Between Physicians and Patients

The FSMB supports continued and improved effective means of communication between patients and physicians. The FSMB will develop an inventory of resources that promotes effective communication to provide to patients and professional communities.

HD, May 2009

240.14 Report of the Special Committee on Reentry to Practice

The FSMB adopts as policy the twelve recommendations contained in the [Report of the Special Committee on Reentry to Practice](#).

HD, April 2012

240.15 **Incorporating Quality Improvement Principles into Disciplinary Actions**

The FSMB investigates ways in which medical boards can incorporate quality improvement principles into disciplinary actions when appropriate to do so, as part of their mission to protect the public and improve patient care in the [Report of the MOL Workgroup on Clinically Inactive Physicians](#).

HD, April 2013

240.16 **Model Guidelines for the Recommendation of Marijuana in Patient Care**

The FSMB adopts as policy the recommendations contained in [Model Guidelines for the Recommendation of Marijuana in Patient Care](#).

HD, April 2016

240.17 **Physicians' Use of Marijuana**

Given the lack of data supporting clinical efficacy and difficulty evaluating impairment, the FSMB adopted a resolution that state medical and osteopathic boards advise their licensees to abstain from the use of marijuana, for medical or recreational purposes, while actively engaged in the practice of medicine.

HD, April 2016

Maintenance of Licensure

250.1 **Continued Competence**

State medical boards have a responsibility to the public to ensure the ongoing competence of physicians seeking re-licensure.

HD, May 2008 Guiding principles for future activities related to Maintenance of Licensure:

250.2

- Maintenance of licensure should support physicians' commitment to lifelong learning and facilitate improvement in physician practice.
- Maintenance of licensure systems should be administratively feasible and should be developed in collaboration with other stakeholders. The authority for establishing maintenance of licensure requirements should remain within the purview of state medical boards.
- Maintenance of licensure should not compromise patient care or create barriers to physician practice.
- The infrastructure to support physician compliance with maintenance of licensure requirements must be flexible and offer a choice of options for meeting requirements.
- Maintenance of licensure processes should balance transparency with privacy protections.

HD, May 2008

HD, April 2010, Revised

250.3 **Dissemination of Maintenance of Licensure Information**

The FSMB through its Board of Directors and staff should be instructed by the House of Delegates to continue to more broadly, openly, regularly and in a timely manner disseminate all information to and seek input from all concerned parties including state medical boards, executive directors of state medical boards, the public, all national and state medical and osteopathic medical societies and associations, and other interested parties regarding any proceedings, deliberations and actions of the FSMB's House of Delegates, Board of Directors, special committees and any ad hoc committees that relate to the MOL concept.

HD, May 2009

250.4 **Maintenance of Licensure**

The FSMB adopts as policy the following maintenance of licensure framework and recommendations as stated in the Report of the Advisory Group on Continued Competence of Licensed Physicians.

The FSMB adopts the following maintenance of licensure framework and recommendations as proposed by the Advisory Group on Continued Competence of Licensed Physicians as policy.

Maintenance of Licensure Framework

As a condition of license renewal, physicians should provide evidence of participating in a program of professional development and lifelong learning that is based on the general competencies model:

- medical knowledge
- patient care
- interpersonal and communication skills
- practice based learning
- professionalism
- systems based practice

1. Reflective Self Assessment (What improvements can I make?)

The following requirements reflect the three major components of what is known about effective lifelong learning in medicine.

Physicians must participate in an ongoing process of reflective self-evaluation, self-assessment and practice assessment, with subsequent successful completion of appropriate educational or improvement activities.

2. Assessment of Knowledge and Skills (What do I need to know and be able to do?)

Physicians must demonstrate the knowledge, skills and abilities necessary to provide safe, effective patient care within the framework of the six general competencies as they apply to their individual practice.

3. Performance in Practice (How am I doing?)

Physicians must demonstrate accountability for performance in their practice using a variety of methods that incorporate reference data to assess their performance in practice and guide improvement.

Recommendations

Documentation

Licensees should be expected to provide documented evidence of compliance with the state medical board's maintenance of licensure requirements. State medical boards should provide guidance to licensees as to the types of evidence deemed acceptable and not acceptable for purposes of meeting maintenance of licensure requirements.

Licensed Physicians not in Active Clinical Practice

Physicians not in active clinical practice who wish to maintain an active license should be expected to comply with all maintenance of licensure requirements adopted by the state medical board.

Physicians with Inactive Licenses

Physicians whose licenses are inactive or have lapsed should be expected to meet maintenance of licensure requirements upon reentering active clinical practice.

Practice Profile Data

State medical boards should require licensees to report information about their practice as part of the license renewal process. Such information may include: area of current practice, type of practice (to include location, supervisory responsibilities), status (e.g., full-time, part-time, number of hours worked per week), whether they are actively seeing patients, specialty board certification or recertification status, and what activities they are engaged in if they are not engaged in clinical practice (e.g., research, administration, non-medical work, retired, etc.). Licensees should keep the board apprised of their practice status by reporting any subsequent changes to the board within a specified timeframe as determined by the board.

Practice Performance Data

Practice performance data collected and used by physicians to comply with maintenance of licensure requirements should not be reported to state medical boards. Third party attestation of collection and use of such data (as part of a professional development program) will satisfy reporting requirements.

Research

The Federation of State Medical Boards and its member state medical boards should work with other stakeholder organizations to develop research aimed at assessing the impact of maintenance of licensure programs on physician practice and patient care.

Assessment Resources

Assessment tools used to meet maintenance of licensure requirements should be:

- valid, reliable, and feasible
- credible with the public and the profession
- provide adequate feedback to the licensee to facilitate practice improvement

Professional Development Activities

Individual learning plans should address any identified needs and should include educational and improvement activities that are shown to improve performance and include plans to assess the impact of the educational and improvement activities on each physician's practice.

Board Certification in the Context of MOL

Maintenance of licensure is separate and distinct from Maintenance of Certification (MOC) and Osteopathic Continuous Certification (OCC). However, state medical boards at their discretion may determine that participation in MOC and OCC represents substantial compliance with maintenance of licensure requirements. Physicians who are not participating in the maintenance of certification/osteopathic continuous certification possesses may meet maintenance of licensure requirements by providing evidence of participation in available MOC or OCC activities or by participating in other approved maintenance of licensure requirements.
 HD, April 2010

250.5 Report of the MOL Workgroup on Clinically Inactive Physicians

The FSMB adopts as policy the recommendations contained in the report, [Report of the MOL Workgroup on Clinically Inactive Physicians](#).
 HD, April 2013

FSMB Role

260.1 State Medical Board Representation

The FSMB reaffirms FSMB as the organization representing state medical boards in the legislative, policy development and spokesperson arenas.
 BD, February 1998

260.2 Policy Comment Period

The FSMB shall include a comment period on draft reports of special committees, as feasible, so that the comments received from member medical boards and other interested parties may be taken into consideration prior to submission to the Board of Directors for approval and recommendation to the House of Delegates.
 HD, April 2001

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DATE: November 12, 2016

SUBJECT: Election of Board Officers
for Calendar Year 2017

SUBMITTED BY: Subbarao Inampudi, M.B., B.S., FACR, Board President

REQUEST FOR BOARD ACTION
MINNESOTA BOARD OF MEDICAL PRACTICE

REQUESTED ACTION:

Elect the following persons to the offices listed below for calendar year 2017:

President:	<u>Gerald T. Kaplan, M.A., L.P.</u>
Vice President:	<u>Patricia J. Lindholm, M.D., FAAFP</u>
Secretary:	<u>Kelli Johnson, Ph.D.</u>
Voting Delegate to the Federation:	<u>Joseph R. Willett, D.O., FACOI</u>

MOTION BY: _____ SECOND: _____
 PASSED PASSED AMENDED LAYED OVER DEFEATED

BACKGROUND:

The Nominating Committee, consisting of Subbarao Inampudi, M.B., B.S., FACR, Kelli Johnson, Ph.D., and Kimberly W. Spaulding, M.D., M.P.H., met by teleconference on November 1, 2016, at 1:00 P.M. Ms. Johnson recused from the nominating discussion regarding the Board Secretary.

The Committee nominates the following persons to the offices listed below:

President:	Gerald T. Kaplan, M.A., L.P.
Vice President:	Patricia J. Lindholm, M.D., FAAFP
Secretary:	Kelli Johnson, Ph.D.
Voting Delegate to the Federation:	Joseph R. Willett, D.O., FACOI

DATE: November 12, 2016

SUBJECT: New Business

SUBMITTED BY: Subbarao Inampudi, M.D., B.S., FACR, Board President

REQUEST FOR BOARD ACTION
MINNESOTA BOARD OF MEDICAL PRACTICE

REQUESTED ACTION:

MOTION BY: _____

SECOND: _____

PASSED PASSED AMENDED LAYED OVER DEFEATED

BACKGROUND:

Any other new business to be discussed?

DATE: November 12, 2016

SUBJECT: Corrective or other Actions

SUBMITTED BY: Complaint Review Committees

REQUEST FOR BOARD ACTION
MINNESOTA BOARD OF MEDICAL PRACTICE

REQUESTED ACTION:

MOTION BY:

SECOND:

PASSED PASSED AMENDED LAYED OVER DEFEATED

BACKGROUND:

For your information only, attached are copies of Corrective or other Actions that were implemented between September 1, 2016, and October 31, 2016.

TRUE AND EXACT COPY OF ORIGINAL

BEFORE THE MINNESOTA BOARD OF MEDICAL PRACTICE COMPLAINT REVIEW COMMITTEE

In the Matter of the
Medical License of
Gregory J. Frane, M.D.
Year of Birth: 1965
License Number: 41,168

AGREEMENT FOR CORRECTIVE ACTION

This Agreement is entered into by and between Gregory J. Frane, M.D. ("Respondent"), and the Complaint Review Committee ("Committee") of the Minnesota Board of Medical Practice ("Board") pursuant to the authority of Minn. Stat. § 214.103, subd. 6(a) (2016). Respondent has been advised by Board representatives that Respondent may choose to be represented by legal counsel in this matter. Respondent has chosen to be represented by Bryon G. Ascherman, Burke & Thomas, 3900 Northwoods Drive, Suite 200, Saint Paul, Minnesota 55112, telephone (651) 490-1808. The Board was represented by Brian L. Williams, Assistant Attorney General, 1400 Bremer Tower, 445 Minnesota Street, St. Paul, Minnesota 55101, (651) 296-7575. Respondent and the Committee hereby agree as follows:

FACTS

- I. This Agreement is based upon the following facts:
 - a. Respondent was licensed by the Board to practice medicine and surgery in the State of Minnesota on November 14, 1998. Respondent is board-certified in family medicine.
 - b. In August 2014, the Board received a complaint alleging that Respondent failed to appropriately prescribe controlled substances for a patient with a known history of chemical abuse. The complaint further alleged Respondent was informed of the patient's misuse

and abuse of her medications, but Respondent continued to prescribe large quantities of habit-forming medications to the patient.

c. The Board initiated an investigation, including an audit of Respondent's practice, which revealed concerns regarding Respondent's patient care, documentation, and prescribing practices and procedures.

2. On August 15, 2016, Respondent met with the Complaint Review Committee to discuss the information set forth in paragraph 1 above. Based on the discussion, the Committee views Respondent's conduct as inappropriate under Minn. Stat. § 147.091, subd. 1(k) (departure from the minimum standards of practice), (o) (improper management of medical records), and (s) (inappropriate prescribing practices) (2016), and Respondent agrees that the conduct cited above constitutes a reasonable basis in law and fact to justify corrective action under these statutes.

CORRECTIVE ACTION

3. Respondent agrees to address the concerns referred to in paragraph 1 by taking the following corrective action:

a. Respondent shall successfully complete the following coursework, approved in advance by the Complaint Review Committee or its designee, within one year of the date of this Agreement:

- 1) Chemical dependency awareness.
- 2) Chronic pain management.
- 3) Professional boundaries.
- 4) Medical records management.

Successful completion shall be determined by the Board or its designee.

b. Respondent shall read the "Model Policy on the Use of Opioid Analgesics in the Treatment of Chronic Pain," adopted as policy by the Executive Committee of the Federation of State Medical Boards of the United States, Inc. (FSMB), July 2013. Respondent shall also read *Responsible Opioid Prescribing, A Clinician's Guide, Second Edition, Revised*, by Scott M. Fishman, M.D., published by Waterford Life Sciences, Washington D.C., 2014. Respondent shall also read the Guideline for Prescribing Opioids for Chronic Pain, published by the Centers for Disease Control and Prevention (CDC) – United States, 2016.

c. Upon successful completion of the above-referenced coursework and readings, and within one year of the date of this Agreement, Respondent shall write and submit a paper, for review and approval by the Committee or its designee, discussing what he has learned from the above-referenced coursework and readings, reflecting on what he might have done differently with the patients discussed at his meeting with the Committee, and how he will incorporate the knowledge into his practice.

4. This Agreement shall become effective upon execution by the Committee and shall remain in effect until Respondent successfully completes the terms of the Agreement. Successful completion shall be determined by the Committee.

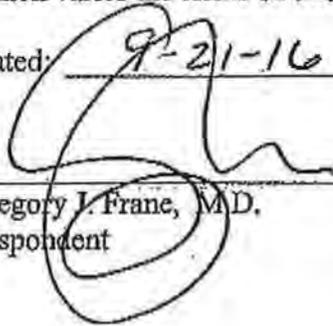
5. Upon Respondent's satisfactory completion of the Agreement for Corrective Action, the Committee agrees to issue a letter of satisfaction to Respondent and dismiss the complaint referred to in paragraph 1. Respondent agrees that the Committee shall determine satisfactory completion. Respondent understands and further agrees that if, after dismissal, the Committee receives additional complaints similar to the information in paragraph 1, the Committee may reopen the dismissed complaint.

6. If Respondent fails to complete the corrective action satisfactorily or if the Committee receives additional complaints similar to the allegations described in paragraph 1, the Committee may, in its discretion, reopen the investigation and proceed according to Minn. Stat. chs. 147, 214, and 14. Failure to complete corrective action satisfactorily constitutes failure to cooperate under Minnesota Statutes section 147.131. In any subsequent proceeding, the Committee may use as proof of the allegations of paragraphs 1 and 2 Respondent's agreements herein.

7. Respondent understands that this Agreement does not constitute disciplinary action. Respondent further understands and acknowledges that this Agreement and any letter of satisfaction are classified as public data.

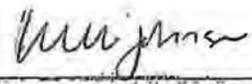
8. Respondent hereby acknowledges having read and understood this Agreement and having voluntarily entered into it. This Agreement contains the entire agreement between the Committee and Respondent, there being no other agreement of any kind, verbal or otherwise, which varies the terms of this Agreement.

Dated: 9-21-16



 Gregory J. Franc, M.D.
 Respondent

Dated: 9-26-16



 FOR THE COMMITTEE

AFFIDAVIT OF SERVICE BY U.S. MAIL

**Re: In the Matter of the Medical License of Gregory J. Frane, M.D.
License No. 41,168**

STATE OF MINNESOTA)
) ss.
COUNTY OF RAMSEY)

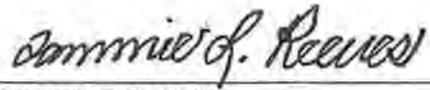
SANDRA SYLVESTER, being first duly sworn, deposes and says:

That at the City of St. Paul, County of Ramsey and State of Minnesota, on September 27, 2016, she caused to be served the attached AGREEMENT FOR CORRECTIVE ACTION, by depositing the same in the United States mail at said city and state, a true and correct copy thereof, properly enveloped with prepaid first class postage, and addressed to:

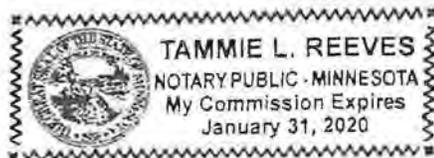
Bryon G. Ascheman, Esq.
Burke & Thomas
3900 Northwoods Drive, Suite 200
St. Paul, MN 55112


SANDRA SYLVESTER

Subscribed and sworn to before me on
September 27, 2016.



NOTARY PUBLIC



BEFORE THE MINNESOTA

BOARD OF MEDICAL PRACTICE

In the Matter of the
Medical License of
Jonathan Christopher Haas, M.D.
Year of Birth: 1967
License Number: 41,628

ORDER FOR REINSTATEMENT

1. The Minnesota Board of Medical Practice ("Board") is authorized pursuant to Minn. Stat. §§ 147.001 through 147.381 (2016) to license, regulate, and discipline persons who apply for, petition, or hold licenses to practice medicine and surgery in the State of Minnesota and is further authorized pursuant to Minn. Stat. §§ 214.10 and 214.103 (2016) to review complaints against physicians, to investigate such complaints, and to initiate appropriate disciplinary action.

2. Jonathan Christopher Haas, M.D. ("Respondent") has been and now is subject to the jurisdiction of the Board from which he holds a license to practice medicine and surgery in the State of Minnesota.

3. Pursuant to Minn. Stat. § 147.091, subd. 2(a) (2016), the license of a physician is automatically suspended if, "...the licensee is committed by order of a court pursuant to chapter 253B. The licensee remains suspended until the licensee is restored to capacity by a court and, upon petition by the licensee, the suspension is terminated by the board after a hearing."

4. On January 6, 2016, a district court judge, in Kandiyohi County, issued a Findings and Order Revoking Order of Stayed Commitment ("Court Order") concerning Respondent. The Court Order revoked Respondent's stay of commitment and committed Respondent to the

custody of the Commissioner of Human Services as a mentally ill person pursuant to Minnesota Statutes Chapter 253B for an initial period not to exceed six months.

5. On January 8, 2016, the Board issued an Order for Suspension ("Board Order") and served it on Respondent, as required by Minn. Stat. § 147.091, subd. 2(a) (2016). The Board Order suspended Respondent's license and required Respondent to submit a petition for the reinstatement of his license after his January 6, 2016, Court Order expired.

6. By letter dated July 15, 2016, Kandiyohi County Health and Human Services confirmed that Respondent's Court Order expired on July 15, 2016.

7. On July 28, 2016, the Board received Respondent's written petition for the reinstatement of his license.

8. On September 29, 2016, Respondent met with the Board's Complaint Review Committee to discuss his petition. Following that meeting, the Complaint Review Committee authorized the reinstatement of Respondent's license.

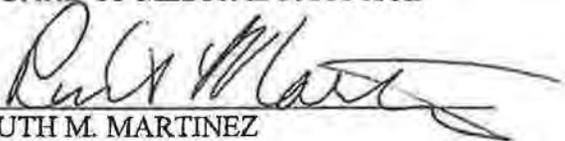
9. The authority to sign automatic suspension orders and orders suspending licenses and subsequent reinstatement orders has been delegated by the Board to its Executive Director.

ORDER

IT IS HEREBY ORDERED that Respondent's license to practice medicine and surgery in the State of Minnesota is **REINSTATED**, effective on October 12, 2016.

Dated: Oct. 12, 2016

STATE OF MINNESOTA
BOARD OF MEDICAL PRACTICE


RUTH M. MARTINEZ
Executive Director

AFFIDAVIT OF SERVICE BY U.S. MAIL

**Re: In the Matter of Jonathan Christopher Haas, M.D.
License No. 41,628**

STATE OF MINNESOTA)
) ss.
COUNTY OF RAMSEY)

DONNA ACKERMAN, being first duly sworn, deposes and says:

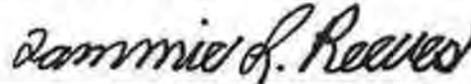
That at the City of St. Paul, County of Ramsey and State of Minnesota, on the 20th day of October 2016, she served the attached **ORDER FOR REINSTATEMENT**, upon licensee's counsel by depositing the same in the United States mail at said city and state, a true and correct copy thereof, properly enveloped with prepaid first class postage, and addressed to:

PERSONAL AND CONFIDENTIAL

John M. Degnan
Briggs and Morgan, PA
80 South Eighth Street, Suite 2200
Minneapolis, MN 55402-2157


DONNA ACKERMAN

Subscribed and sworn to before me on
this 20th day of October 2016.


NOTARY PUBLIC

