Minnesota Board of Medical Practice

Report to the Legislature in Compliance with Minnesota Statutes Section 3D.06 (Sunset Review) 2012

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THE MINNESOTA BOARD OF MEDICAL PRACTICE
REPORT TO THE LEGISLATURE IN COMPLIANCE
WITH MINNESOTA STATUTES SECTION 3D.06
(SUNSET REVIEW)
2012

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INTRODUCTION

As Executive Director of the Minnesota Board of Medical Practice, I am submitting this report to the Legislature in compliance with Minnesota Statutes § 3D.06. That section requires the chief administrative officer of a State agency that is subject to sunset review to report to the Sunset Commission:

1. Information regarding the application to the agency of the criteria in section 3D.10;
2. A priority based budget for the agency;
3. An inventory of all boards, commissions, committees and other entities related to the agency; and
4. Any other information that the agency commissioner considers appropriate or that is requested by the commission.

This report contains all the required information, but not in the order listed above. Criteria (2) of Section 3D.10 will be addressed first along with background information and an inventory of the board, its committees and advisory councils. This will be followed by Criteria (1) and then the other criteria in order. The report will then conclude with information regarding the board's additional services and collaborative activities followed by a priority based budget, an Agency at a Glance section and an executive summary.

I. CRITERA 2

The mission, goals and objectives intended for the board and the problem or need that the board was intended to address and the extent to which the mission, goals and objectives has been achieved and the problem or need that has been addressed.

The Minnesota Board of Medical Examiners was established in 1883 with the purpose of developing licensure qualifications for medical doctors who wished to practice in Minnesota. The Board of Medical Examiners was Minnesota's first health licensing board.

In its first 100 years, the Board of Medical Examiners underwent many legislative changes. During this time, vast changes were also taking place in the medical profession as well as in the social, legal and economic environments in which medicine was practiced.

In the 1970's and 1980's, the nation was moving from individual state medical licensing examinations to a national exam, the United States Medical Licensing Examination. Shortly after the board ceased administering a state medical licensing examination, the agency's name was changed to the Board of Medical Practice.

In 1984, the current Minnesota Medical Practice Act (Minn. Stat. § 147) became law. This "modern" medical practice act not only continued the board's role in ensuring that medical doctors meet certain minimum qualifications before being granted the privilege to practice in the state, but also enhanced the board's ability to protect the public by expanding its authority to effectively deal with physician performance and competency to practice. The board enforces 27 separate grounds for disciplinary action, as set forth in the Medical Practice Act (Minn. Stat. § 147.091).

Beginning in 1986, a number of other allied health professions have been added to the board's jurisdiction. The board currently regulates the practice of physicians, physician assistants, respiratory therapists, athletic trainers, acupuncturists, naturopathic doctors and traditional midwives.

THE MINNESOTA MEDICAL PRACTICE ACT AND ALLIED HEALTH PROFESSIONALS PRACTICE ACTS

The authority of the Minnesota Board of Medical Practice to regulate physicians is found in the Minnesota Medical Practice Act, Minn. Stat. § 147.

The board's authority to regulate its allied health professions is found in the individual practice acts for each of these professions.

Minn. Stat. § 147A (physician assistants)
Minn. Stat. § 147C (respiratory therapists)

Minn. Stat. § 148.7801 (athletic trainers)
Minn. Stat. § 147B (acupuncturists)
Minn. Stat. § 147D (traditional midwives)
Minn. Stat. § 147E (naturopathic doctors)

The practice acts for the allied health professions are all based on the Minnesota Medical Practice Act.

MINNESOTA STATUTES § 214

In addition to the Minnesota Medical Practice Act, the Board of Medical Practice, as well as the other health licensing boards, is also governed by requirements in Minn. Stat. § 214.

INVENTORY OF BOARD, COMMITTEES AND ADVISORY COUNCILS:

BOARD MEMBERS

There are 16 members of the Minnesota Board of Medical Practice. There are 11 physician members and 5 public members. All board members are appointed by the Governor to four year terms and no member may serve longer than eight consecutive years. Physician members must come from each of Minnesota's eight congressional districts and must, as a whole, reflect the broad mix of expertise of physicians practicing in Minnesota. (Minn. Stat. § 147.01).

CURRENT BOARD MEMBERSHIP

Board Member Name	Residence	Occupation	Professional Member/Public Member
Alfred Anderson, MD, DC	Prior Lake	Medical Doctor	Physician
Keith Berge, MD	Rochester	Medical Doctor	Physician
Debbie Boe	Chaska	Administrator	Public member
Mark Eggen, MD	Shoreview	Medical Doctor	Physician
V. John Ella, JD	Robbinsdale	Attorney	Public member
Sarah Evenson, JD, MBA	Plymouth	Attorney	Public member

Board Member Name	Residence	Occupation	Professional Member/Public Member
Subbarao Inampudi, MD	Minnetonka	Medical Doctor	Physician
Bradley Johnson, MD	Woodbury	Medical Doctor	Physician
Kelli Johnson, MBA	St. Paul	Administrator	Public member
Gerald Kaplan, MA, LP	Minneapolis	Psychologist	Public member
Ernest Lampe, II, MD	Mankato	Medical Doctor	Physician
James Langland, MD	Thief River Falls	Medical Doctor	Physician
Gregory Snyder, MD	Minnetrista	Medical Doctor	Physician
Jon Thomas, MD, MBA	Vadnais Heights	Medical Doctor	Physician
Tracy Tomac, MD	Duluth	Medical Doctor	Physician
Joseph Willett, DO	Marshall	Doctor of Osteopathy	Physician

The full board meets at six regularly scheduled meetings annually to consider licensure, disciplinary and policy issues. Six additional meeting dates are scheduled for Contested Case Hearings if needed.

BOARD COMMITTEES

The majority of the work of the board is accomplished through a committee process with the recommendations of the various committees going to the full board for final approval.

The committees of the board are:

- Complaint Review Committee, #1 (Keith Berge, MD, Mark Eggen, MD, and Gerald Kaplan, MA, LP)
- Complaint Review Committee, #2 (Gregory Snyder, MD, DABR, Joseph Willett, DO, and Sarah Evenson, JD, MBA)
- Licensure Committee (Alfred V. Anderson, DC, MD, Subbarao Inampudi, MD, FACR, Bradley Johnson, MD, Jon Thomas, MD, MBA, and Kelli Johnson, MBA)
- Policy and Planning Committee (Ernest W. Lampe, II, MD, Tracy Tomac, MD, Debbie Boe, and V. John Ella, JD)

All board committees are structured to balance the need for professional expertise provided by the regulated practitioner members and the dispassionate judgment provided by the public members.

ADVISORY COUNCILS

Throughout the past twenty-five years, the legislature has given the board the regulatory responsibility for a number of allied health professions. Because none of these allied health professions are represented in membership on the board, the advisory council model is utilized by the board to assist it in making its regulatory decisions for those professions. Each advisory council for the allied health professions regulated by the board is made up of members of the regulated profession, a physician member and a public member.

Advisory councils review application materials and advise the Licensure Committee of the board on credentialing issues for the profession. The councils also review complaints against practicing professionals and advise the board's Complaint Review Committees on standard of practice issues.

The advisory councils provide board members with professional expertise for the professions and make recommendations only. The board members make decisions based on the recommendations of the councils. From 2002 – 2011, the board's advisory councils have reviewed 3,499 applications for credentials and provided professional expertise to the board on 434 complaint files (see Appendix 1, page 10).

- Acupuncture Advisory Council

  History

  The Minnesota Legislature enacted a law in 1995 establishing a licensure system for acupuncturists. The Board of Medical Practice enforces the requirements of the acupuncturist licensure system and provides information to consumers and other interested persons. The current Council members are:

  - Gary Steven Compton, LAc, acupuncture practitioner;
  - Michael Green, MD, physician who also practices acupuncture;
  - Jay Greenberg, LAc, DC, Chiropractor who is certified by the National Certification Commission for Acupuncture and Oriental Medicine (NCCAOM);
  - Peggy Miller, LAc acupuncture practitioner;
  - Emily Silkwood, LAc, acupuncture practitioner
  - Evelyn Staus, public member who has received acupuncture treatment as a primary therapy from a NCCAOM certified acupuncturist;
  - Debra R. Weiss, LAc, acupuncture practitioner.

Acupuncture Advisory Council Meetings

The Council has met six times per year during the last ten years. During that time, 403 applications and 18 complaints have been reviewed. As part of the complaint review process, council members may have participated in additional meetings with the Medical Coordinator or the Complaint Review Committee.

- Athletic Trainers Advisory Council

History

The Minnesota Legislature enacted a law in 1993 establishing a registration system for athletic trainers. The Board of Medical Practice enforces the requirements of the athletic trainer registration system and provides information to consumers and other interested persons. The current Council members are:

- Alexander Adams, public member;
- Jason Eggers, DC, chiropractor with experience in athletic training and sports injuries;
- Robert Johnson, MD, physician with expertise in athletic training and sports medicine;
- Thomas Kiff, ATR, athletic trainer;
- Jean Wang, public member;
- Paul Niemuth, ATR/PT, athletic trainer who is also a physical therapist;
- Kenji Sudoh, MD, physician with expertise in athletic training and sports medicine;
- Dean Wennerberg, ATR, athletic trainer.

Athletic Trainers Advisory Council Meetings

The Council has met six times per year during the last ten years. During that time, 694 applications and 18 complaints have been reviewed. As part of the complaint review process, council members may have participated in additional meetings with the Medical Coordinator or the Complaint Review Committee.

- Naturopathic Doctor Advisory Council

History

Minnesota legislators enacted a law in 2008 establishing a registration system for naturopathic doctors. The Board of Medical Practice enforces the requirements of the naturopathic doctor registration system and provides information to consumers and other interested persons. The current Council members are:

- Kristin Becker, ND, naturopathic doctor;

- Michael Green, MD, physician with expertise in natural medicine;
- Amy Johnson-Grass, ND, naturopathic doctor;
- Karen Thullner, public member;
- Dionne Reinhart, ND, naturopathic doctor;
- Helen Healy, ND, naturopathic doctor;
- Leslie Vilensky, ND, naturopathic doctor.

Registered Naturopathic Doctor Advisory Council Meetings

The Council came into being in 2009 and has met nine times. During that time, 29 applications and 0 complaints have been reviewed. As part of the complaint review process, council members may have participated in additional meetings with the Medical Coordinator or the Complaint Review Committee.

- Physician Assistant Advisory Council

History

Physician Assistants were initially registered in Minnesota in 1987 and governed by rules promulgated by the Minnesota Department of Health. Effective 1991, a new law allowed physicians to delegate prescribing authority (excluding controlled substances) to physician assistants who were currently certified by National Commission on Certification of Physician Assistants. In 1995, a law was enacted to replace the rules and thereby enabling the physician assistants to become statutorily legitimate. This law allowed physicians to extend their delegation of authority to controlled substances. The law also shifted more responsibility to the physicians and the physician assistants by eliminating the supervisory agreement protocol and instituting a system whereby a practice setting description is filed with the board annually along with the evidence of annual review of physician-physician assistant agreement.

A law became effective on August 1, 2009, changing:

- Registration to licensure;
- Eliminating temporary registration. Temporary licenses are still available to applicants who have passed the NCCPA exam;
- Increasing the number of physician assistants supervised from two to five;
- Practice Setting Description to Notice of Intent to Practice, and
- Supervisory Agreement/Delegation/Internal Protocol to Delegation Agreement.

Current Council members are:

- Tori Christiaansen, MD, physician;
- Richard Gebhart, MD, physician;
- Gay Lentfer, PA, physician assistant;
- Dawn Ludwig, PA, physician assistant;

- Jodi Nicholson, PA, physician assistant;
- Janice Rapheal, public member;
- Karen Thullner, public member.

Physician Assistant Advisory Council Meetings

The Council has met six times per year during the last ten years. During that time, 1,318 applications and 136 complaints have been reviewed. As part of the complaint review process, council members may have participated in additional meetings with the Medical Coordinator or the Complaint Review Committee.

- Respiratory Therapy Advisory Council

History

Respiratory care practitioners (RCPs) were initially registered in Minnesota in 1991 and governed by rules promulgated by the Minnesota Department of Health. Effective August 1, 1997, a law was enacted to replace the rules and thereby enabling the RCPs to become statutorily legitimate. A subsequent law took effect August 1, 2009 changing registration to licensure and RCPs to respiratory therapists (RTs). The Board of Medical Practice enforces the requirements of the respiratory therapist licensure regulations and provides information to consumers and other interested persons. The current Council members are:

- Alexander Adams, RT, respiratory therapist;
- Joseph Buhain, RT, respiratory therapist;
- Lois Chambers, public member;
- Amit Chandra, MD, physician with expertise in respiratory care;
- Kris Hammel, RT, respiratory therapist;
- Avi Nahum, MD, physician with expertise in respiratory care;
- Alan Uhl, public member.

Respiratory Therapy Advisory Council Meetings

The Council has met six times per year during the last ten years. During that time, 1,038 applications and 52 complaints have been reviewed.

- Advisory Council on Licensed Traditional Midwifery

History

The Minnesota Legislature enacted a law in 1999 establishing a licensure system for traditional midwives. The Board of Medical Practice is responsible for administering the law and providing information to consumers and other interested person. Current Council members are:

- Alyssa Folin, LTM, traditional midwife;
- Amy Johnson-Grass, LTM, traditional midwife;
- Jennifer Mason, homebirth parent;
- Joy Parker, LTM, traditional midwife;
- Annelise Swigert, MD, physician who has been or is currently consulting with licensed traditional midwives.

Advisory Council of Licensed Traditional Midwifery Meetings

The Council has met 19 times during the last ten years. During that time, 17 applications and 9 complaints have been reviewed. As part of the complaint review process, council members may have participated in additional meetings with the Medical Coordinator or the Complaint Review Committee.

Appendix 1
Issues, Applicants and Complaints Reviewed
by the Licensure Committee, PA, Athletic Trainer, Respiratory Care, Acupuncture Councils

	2002	2003	2004	2005	2006	2007	2008	2009	2010	2011
Licensure Committee										
Number of licensing issues	57	38	43	48	36	50	64	32	43	49
Total number of issues (Lic/ Admin)	74	56	62	88	62	81	94	62	65	69
Number of applicants denied	5	2	3	3	4	1	0	3	4	2
Number of re-entry applicants	0	0	0	1	3	4	11	6	4	4
Number of complaints reviewed										
PA Advisory Council										
Number of applicants reviewed	100			146	128	161	172	156	186	193
Number of re-entry applicants				0	2	2	10	3	1	1
Number of complaints reviewed	18			15	20	15	19	19	13	17
AT Advisory Council										
Number of applicants reviewed	68					86	67	60	69	73
Number of re-entry applicants	0					0	0	0	0	0
Number of complaints reviewed	7					8	3	0	0	37
RT Advisory Council										
Number of applicants reviewed	74	62	82	136	123	117	116	89	96	76
Number of re-entry applicants	0	0	0	0	2	1	1	0	1	3
Number of complaints reviewed	10	8	6	1	5	7	13	0	1	1
AP Advisory Council										
Number of applicants reviewed	12	7	41	30	40	40	42	56	38	38
Number of re-entry applicants	0	0	0	0	0	0	0	0	0	0
Number of complaints reviewed	1	2	0	0	7	1	5	2	1	3

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.

The board achieves this mission by assuring:

- Any applicant for a credential to practice meets all the minimum entrance to practice standards as established in statute;
- That continuing education for credentialed professionals is maintained;
- That any credentialed professional continues to practice with reasonable skill and safety to patients;
- And that disciplinary or corrective action will be implemented when health care professionals do not perform in compliance with the standards of care.

KEY FUNCTIONS

1. Licensure and registration;
2. Credential renewal (annual);
3. Credential verification;
4. Investigation of complaints;
5. Litigation of disciplinary matters;
6. Disciplinary compliance monitoring;
7. Educational and outreach activities that provide information to regulated professionals and the public; and
8. Administrative functions.

The licensure and registration functions of the board are necessary to protect the public from the harm of unlicensed and unqualified practice.

Annual credential renewal helps to promote the continued competency of the regulated health professionals.

The board's disciplinary processes, including investigation of complaints, litigation of disciplinary matters and compliance monitoring of board orders, are necessary to enforce the requirements of the Medical Practice Act and to protect the public.

Educational and outreach activities are necessary to provide the professions with information to enhance their ability to adhere to standards of practice and to provide the public with information needed to help make informed health care decisions.

Administrative functions are necessary to implement and support the regulatory functions of the board.

BOARD STAFF AND ATTORNEY GENERAL'S OFFICE

The Board of Medical Practice and Advisory Councils are supported in their role of public protection by a staff of twenty-three employees serving administrative, licensure and complaint review and compliance functions. Five medical coordinators, licensed physician consultants, assist the committees of the board in reviewing and assessing medical and credentialing information on applications for license/registration, or complaints against regulated professionals.

The board is also supported by the legal and investigative services of the Office of the Attorney General (Minn. Stat. § 214.103).

MEDICAL COORDINATORS

In order to assist board staff and the board's Licensure and Complaint Review Committees, the board utilizes the services of Medical Coordinators.

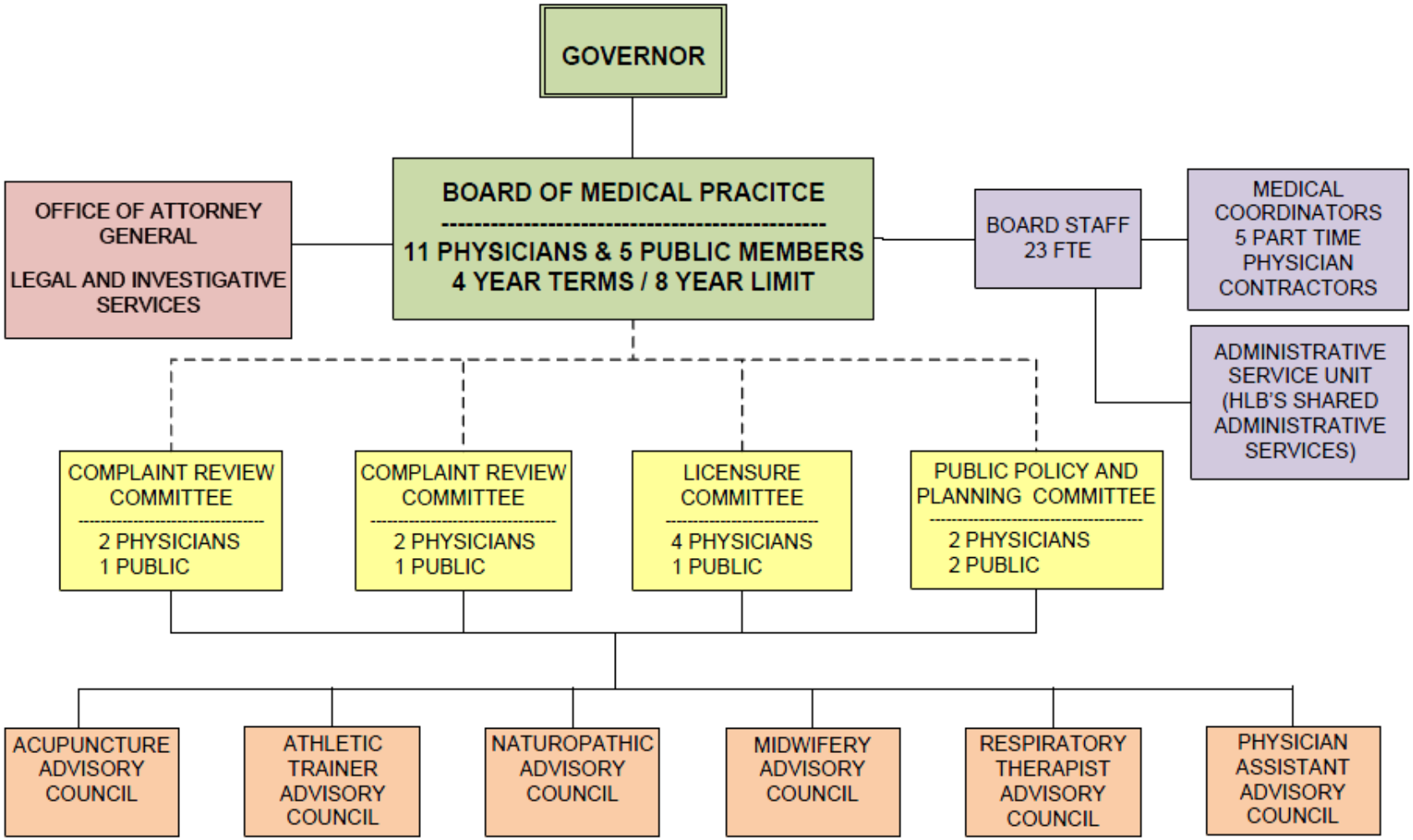
Medical Coordinators are licensed physicians who contract with the board to come into the board offices on a half-day a week basis to review licensure applications and supporting materials such as documents from post-graduate training programs to help staff identify any red flags that may indicate a denial of license or reasons to license under a board order.

In addition, the Medical Coordinators conduct medical record reviews on complaint files prior to their being submitted to the board's Complaint Review Committees. The Medical Coordinators will identify the need for and direct staff to obtain any information they feel the Complaint Review Committee will need in order to make an informed decision on complaints pending before the Committee. They will determine what medical records should be obtained, whether a full field investigation by the Office of the Attorney General is warranted and whether staff needs to obtain the services of an outside consultant in a particular specialty area of practice.

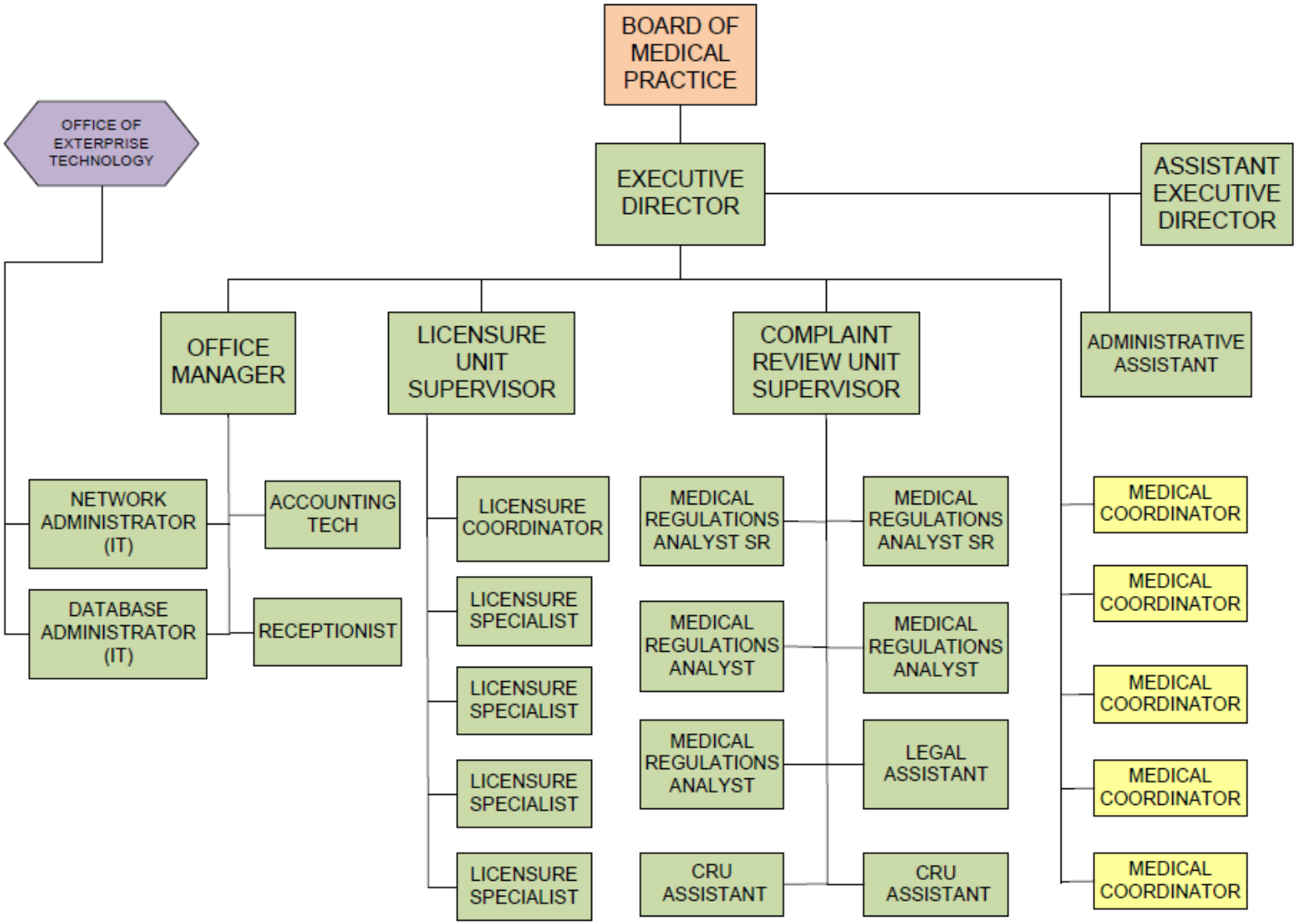
In addition, Medical Coordinators conduct educational conferences with licensees who have complaints before the board whose conduct, in the opinion of the Complaint Review Committee, has not risen to the level of warranting disciplinary or corrective action but has indicated questionable knowledge and/or judgement. If, after these conferences, the Medical Coordinator is satisfied that the individual has recognized and corrected the deficiency, the matter will be closed. If the Medical Coordinator is not satisfied, the matter will be referred back to the Complaint Review Committee for further board intervention.

Board's website: www.bmp.state.mn.us

Board of Medical Practice Organization Chart



Board of Medical Practice Staff Organization Chart (23 FTE)



BOARD OF MEDICAL PRACTICE
SIX YEAR FULL-TIME EMPLOYEE (FTE) STAFFING

2006 – 2011 FTE
Executive Director
Assistant Executive Director
Office Manager
Accounting Officer
Receptionist
Executive Assistant
Database Administrator
Network Administrator
Licensure Unit Supervisor
Licensure Coordinator
Licensure Specialist
Licensure Specialist
Licensure Specialist
Licensure Specialist
Complaint Review Unit Supervisor
Senior Medical Regulation Analyst
Senior Medical Regulation Analyst
Medical Regulation Analyst
Medical Regulations Analyst
Medical Regulations Analyst
Medical Regulations Analyst*
Legal Analyst
Complaint Unit Assistant
Complaint Unit Assistant

FTE 2006	**FTE 2007 – 2011**
24*	23

*One medical regulations analyst position was eliminated in May of 2006.

II. CRITERIA 1

The efficiency and effectiveness with which the agency or the advisory committee operates.

ADMINISTRATION

ADMINISTRATIVE SERVICES UNIT

Since 1998 the Minnesota Health Licensing Boards have worked together to implement and enhance administrative efficiencies. In 1995 the boards voluntarily and informally created the Administrative Services Unit which was statutorily formalized in 2011 (Minnesota Statutes § 214.07).

The Administrative Services Unit (ASU) is funded by all of the independent health licensing boards and consists of 7.12 FTE staff that perform shared administrative and business services for all the boards. This is far more efficient than if each board employed its own FTE's to perform these services.

ASU provides shared services to the boards in the areas of finance, budgeting, accounting, purchasing, reporting, banking, human resources, professional and technical contracts, information technology, policy development and payroll. ASU also facilitates the boards' cooperative policy and planning efforts, and coordinates the Voluntary Health Care Provider Program. This program provides malpractice insurance coverage for physicians, physician assistants, dentists, dental hygienists, and nurses who serve in a voluntary capacity at a charitable organization (Minnesota Statutes § 214.40).

ASU's annual budget is determined by the Executive Directors Forum of the health licensing boards, and the oversight of ASU is assigned on a rotating basis to one of the health licensing boards. The current oversight board is the Minnesota Board of Examiners for Nursing Home Administrators. ASU is managed through the Executive Director's Forum Management Committee.

The Health Licensing Boards are all located in the same office building and recently negotiated a new seven-year lease which reduced our rent by $2.42 per square foot for an annual savings of $121,990.

The Executive Directors of the Health Licensing Boards have created an Executive Director’s Forum which meets at least monthly to address issues of mutual concern. In addition, the forum has created a number of committees to address specific issues on behalf of the Forum.

PAPERLESS MEETINGS

In 2006, the Board of Medical Practice initiated paperless meetings. Previously, staff printed all documents for board member review and sent the materials to individual board members’ homes or work for their review. Paper based meetings posed several problems including the

security of the confidential documents, the transportation of the materials, and the paper and printing costs, as well as the total cost of doing business with hard-copied materials.

The board now utilizes iPads to reduce costs while further increasing security. With the iPad solution, data is secured via the hardware encryption on the device; the device is programmed to check into our system at regular intervals and data may be wiped remotely. The data is securely delivered in real time to the device when the user accesses it which enables us to send out agenda updates immediately and at no additional cost.

In addition to the cost savings, logistical benefits and increased data security, we also see soft benefits. Board members are able to quickly access specific portions of their material and navigate quickly to other topics within the material as needed.

	Fiscal Year 05	Fiscal Year 11
Deliveries (Fed Ex)	$ 8,366	$3,608
Copying (Allegra)	$48,161	$5,482
Envelopes (Heinrich)	$ 2,887	$1,492

Cost savings for the board is over $48,800 annually. The Total Cost of Ownership (TCO) switching over to paperless iPad was approximately $35,000 so the switch more than paid for itself in the first year.

LICENSURE

The Licensure Unit of the Board of Medical Practice consists of a Licensure Supervisor and five Licensure Specialists. The unit is responsible for processing applications for new credentials for physicians, physician assistants, acupuncturists, respiratory therapists, athletic trainers, naturopathic doctors and traditional midwives; the annual renewal of credentials and the monitoring of on-going continuing education requirements for these professions. In addition, the unit provides credential verification to health care facilities and to the public.

In fiscal year 2002, the licensure unit was responsible for processing 2,100 new credential applications and 19,162 annual credential renewals. Each year since has seen a steady growth in the number of applications processed as well as annual renewals. In fiscal year 2011, the unit processed 2,528 new applications and 25,000 annual credential renewals. (See Appendix 2A & 2B).

Despite this growth in applications and renewals, the Licensure Unit staff has remained at 6 FTE since 1987. Our ability to forestall growth of staff is due to the implementation of our Automated Licensure Information Management System (ALIMS) in November 2004, which allows for on-line credential renewal. In fiscal year 2005, ALIMS first operational year, 10,985 or 55% of credentials were renewed on-line. This number has steadily grown each year. In fiscal year 2011, 24,487 or 94.4% of all credentials were renewed on-line (See Appendix 2C)

In addition to on-line credential renewal, the implementation of ALIMS also allowed the board to provide public access to a physician/physician assistant profile feature. The physician profile gives public access to significant physician information to assist the public in making informed health care provider decisions. The physician profile also allows the public to search for physicians by name or by geographic area. If a member of the public is moving anywhere in the State, they may utilize the profile search engine to identify physicians in all specialty areas of practice located in that geographic area. The physician profile also provides license status information to health care credentialers, including the ability to view or download disciplinary and corrective actions against physicians/physician assistants.

In 2006, its first full year of operation, the physician profile was accessed 280,539 times for an average of 769 accesses per day. In 2011 those numbers had risen to 928,602 accesses annually for an average of 2,554 per day (See Appendix 2D).

In 2005, the Board of Medical Practice ALIMS system won the Minnesota Office of Enterprise Technology's Customer Service Award.

COMPLAINT REVIEW AND DISCIPLINE

The Complaint Review Unit (CRU) of the board processes an average of 840 complaints each year, through its two Complaint Review Committees. Each committee is comprised of two physicians and one public member of the board and meets monthly to review complaints, meet with respondent licensees, negotiate settlements, and resolve complaints or make recommendations for formal disciplinary or corrective action. See Section 7 for details regarding the complaint review and disciplinary processes.

In addition to complaint processing, the CRU monitors compliance with the terms of disciplinary and corrective actions. Staff compiles and analyzes compliance documentation to confirm compliance by respondent licensees. Instances of noncompliance may provide a basis for further disciplinary action and are processed through the board's Complaint Review Committees.

The addition of a full-time in-house legal assistant in 2006 improved the quality and efficiency of legal document drafting, even as the overall unit staff was reduced from 12 in 2004 to nine in 2009. Despite the reduction in staff, the CRU has continued to increase quality, while functioning efficiently and effectively.

Over the past decade, the CRU has increased its use of technology to improve its data management processes and overall efficiency. Paperless agendas reduce the board's overall costs while increasing efficiency. The board's state of the art information management database (ALIMS), enables the CRU to increase transparency and more efficiently provide public disciplinary information through on-line services, including on-line access to physician/physician assistant professional profiles and access to complete disciplinary and corrective actions.

Requests for non-public data, made pursuant to the Minnesota Data Practices Act, are processed by a delegated member of the CRU staff. Responses to data requests are processed within 48 hours, when possible. If a response requires significant redacting or involves records stored off-site, additional time may be required.

ELECTRONIC GOVERNMENT SERVICES

The Board of Medical Practice supports electronic technology to meet the efficient licensing process for physicians and allied health care professionals credentialed by the board and to provide the public with information to assist in making informed health care decisions.

As previously stated, the board's award winning ALIMS database now accounts for over 94% of all credential renewals annually. In addition to on-line credential renewal, ALIMS also provides the following benefits for its credentialed professionals:

- Downloadable forms and applications;
- Address changes;
- Credit card transactions for fee payment; and
- License verifications for other jurisdictions.

In addition to the physician profile feature, ALIMS also provides the following benefits to the public:

- Public orders and compliance history;
- License verification;
- Data requests;
- Automated license verification for large employers; and
- Automated licensure data for use by other state agencies.

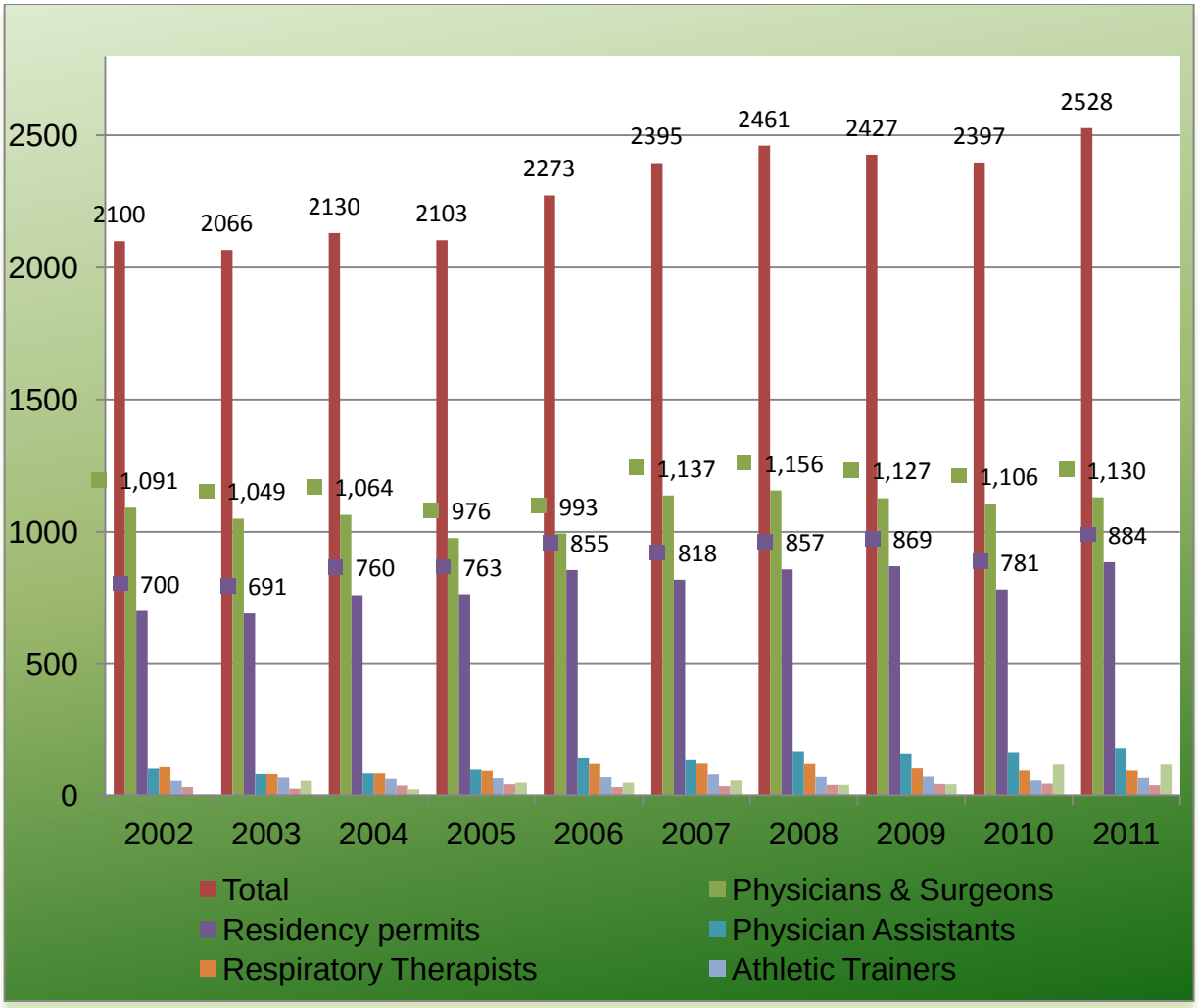
FEES

No credentialing fees for any profession have been raised in over ten years.

Appendix 2A
MN Board of Medical Practice - # New License/Registrations Issued

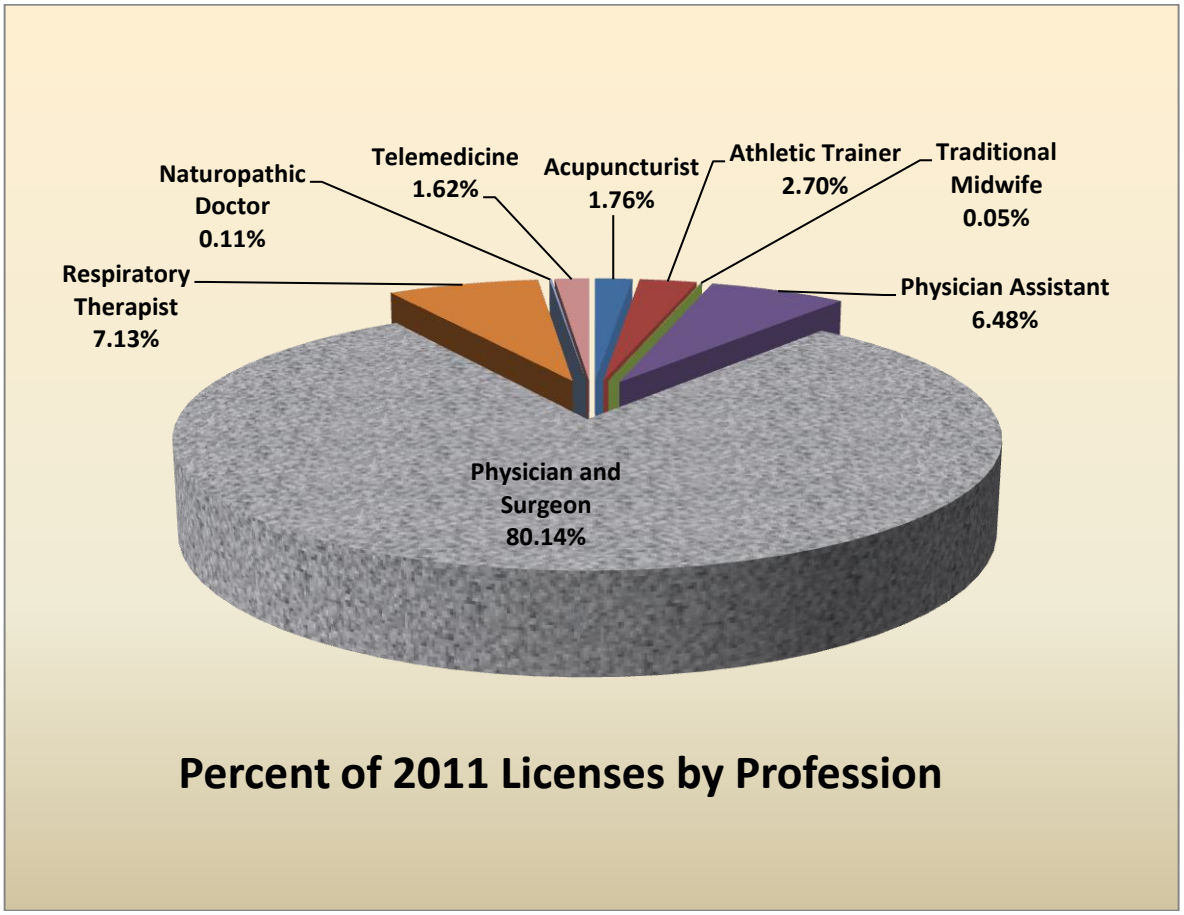
Fiscal Year	Physicians & Surgeons	Residency Permits	Physician Assistants	Respiratory Therapists	Athletic Trainers	Acupuncture Practitioners	Midwives	TM	ND*	TOTAL
2011	1,130	884	178	96	69	42	2	119	8	2528
2010	1,106	781	163	97	60	48	2	119	21	2397
2009	1,127	869	158	105	74	47	1	46		2427
2008	1,156	857	167	121	73	43	1	43		2461
2007	1,137	818	136	123	82	38	1	60		2395
2006	993	855	143	122	72	35	2	51		2273
2005	976	763	100	95	68	45	5	51		2103
2004	1,064	760	86	86	66	41	0	27		2130
2003	1,049	691	83	83	71	29	1	59		2066
2002	1,091	700	104	110	59	35	1			2100

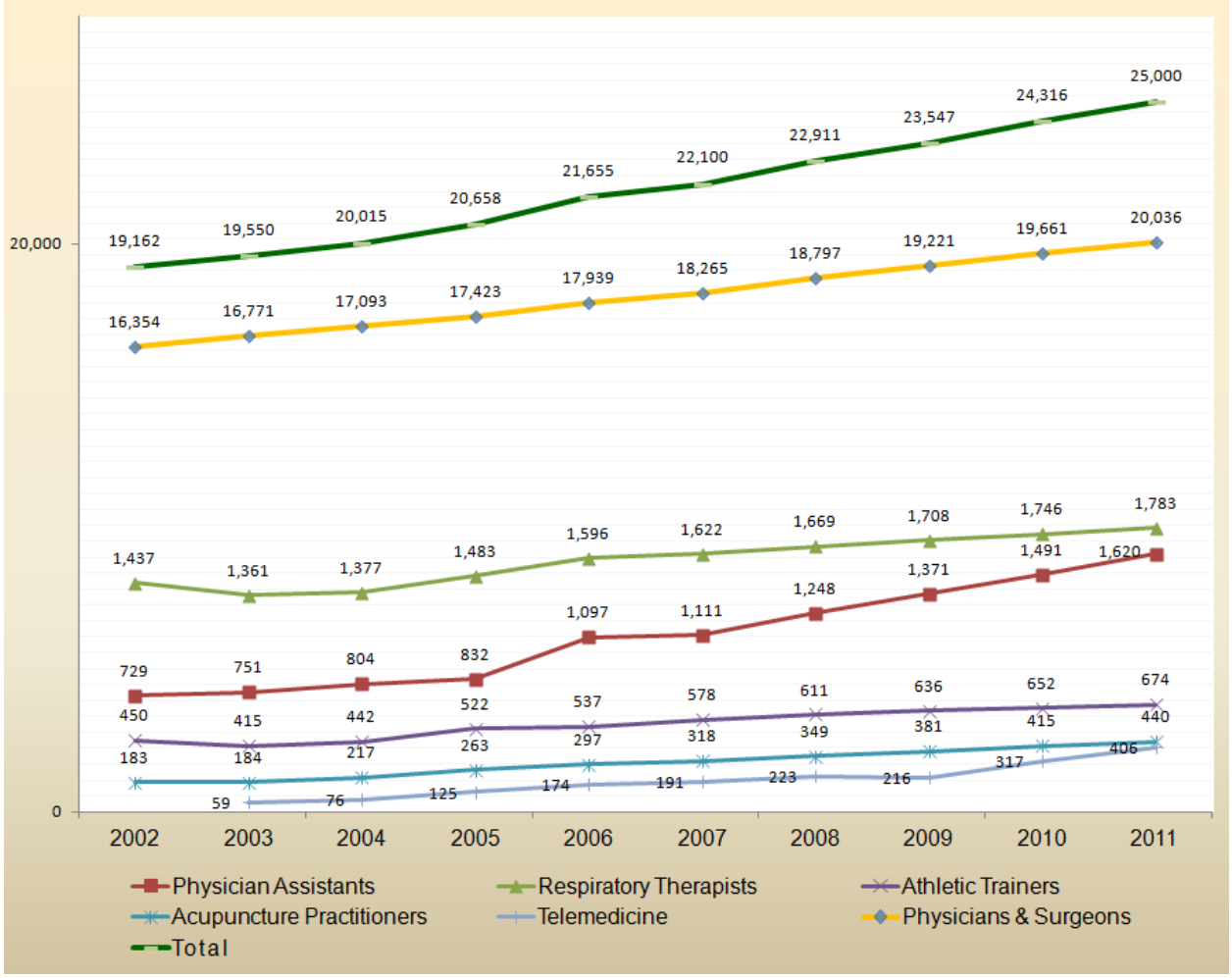
* ND: Naturopathic Doctor, TM: Telemedicine Registration



Appendix 2B
MN Board of Medical Practice - # Active Licenses/Registrations

Fiscal Year	Physicians & Surgeons	Physician Assistants	Respiratory Therapists	Athletic Trainers	Acupuncture Practitioners	Midwives	Telemedicine	Naturopaths	TOTAL
2011	20,036	1,620	1,783	674	440	13	406	28	25,000
2010	19,661	1,491	1,746	652	415	13	317	21	24,316
2009	19,221	1,371	1,708	636	381	14	216		23,547
2008	18,797	1,248	1,669	611	349	14	223		22,911
2007	18,265	1,111	1,622	578	318	15	191		22,100
2006	17,939	1,097	1,596	537	297	15	174		21,655
2005	17,423	832	1,483	522	263	10	125		20,658
2004	17,093	804	1,377	442	217	6	76		20,015
2003	16,771	751	1,361	415	184	9	59		19,550
2002	16,354	729	1,437	450	183	9			19,162





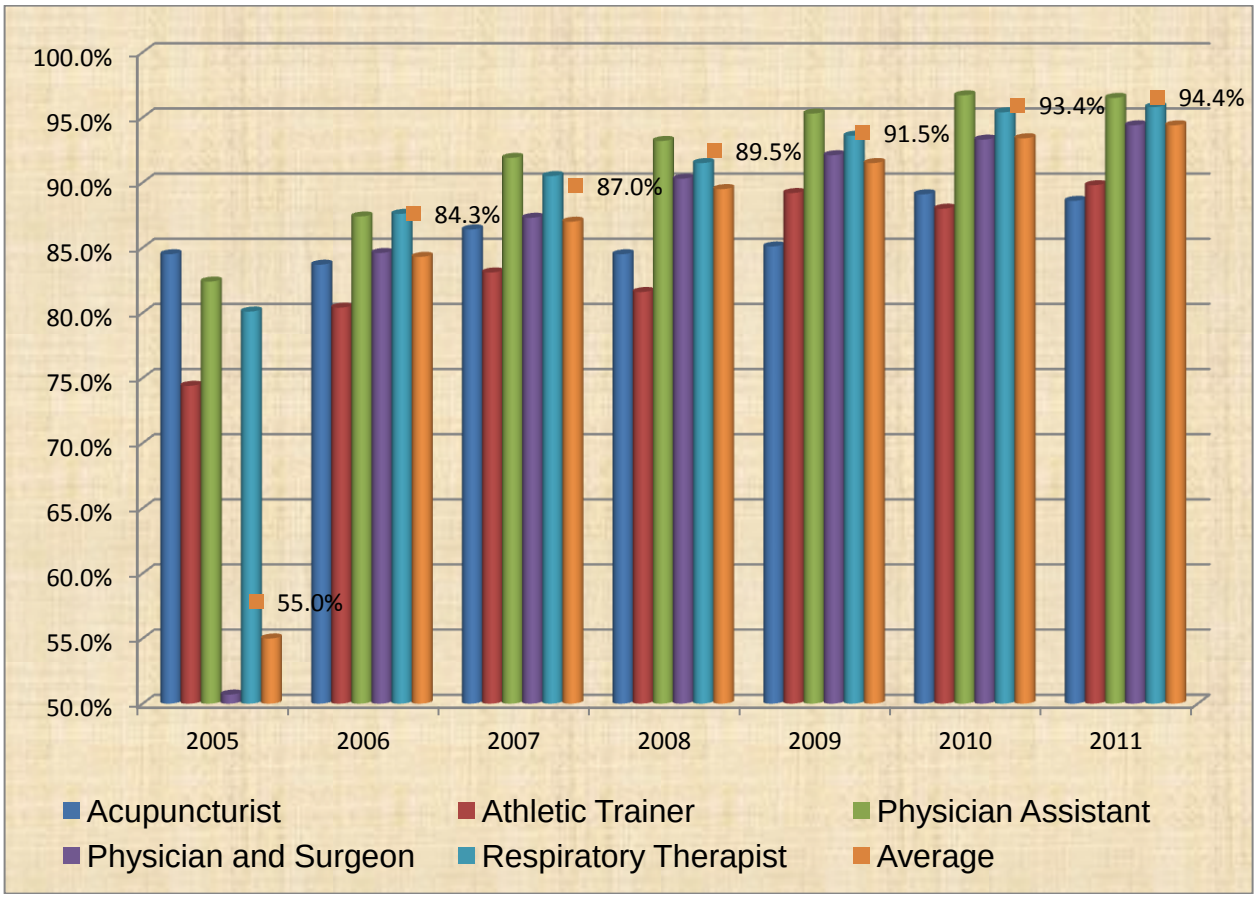
Growth Trend of Active Licenses/Registrations, from 2002 to 2011

Appendix 2C

Number and Percentage of Credential Online Renewals, from 2005 to 2011

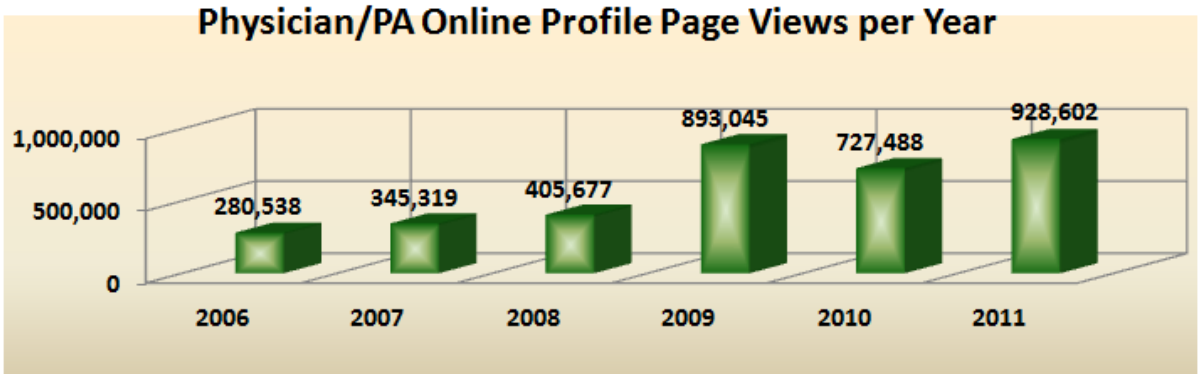
Fiscal Year	2011	2010	2009	2008	2007	2006	2005*
Acupuncturist	357 (88.6%)	310 (89.1%)	280 (85.1%)	257 (84.5%)	242 (86.4%)	206 (83.7%)	196 (84.5%)
Athletic Trainer	589 (89.8%)	426 (88.0%)	494 (89.2%)	412 (81.6%)	397 (83.1%)	340 (80.4%)	335 (74.4%)
Physician Assistant	1,477 (96.5%)	1,286 (96.7%)	1,205 (95.3%)	1,061 (93.2%)	958 (91.9%)	812 (87.4%)	709 (82.4%)
Physician and Surgeon	20,211 (94.4%)	17,514 (93.3%)	16,961 (92.1%)	16,172 (90.3%)	15,193 (87.3%)	14,281 (84.6%)	8,640 (50.7%*)
Respiratory Therapist	1,592 (95.8%)	1,473 (95.4%)	1,474 (93.6%)	1,373 (91.5%)	1,367 (90.5%)	1,208 (87.6%)	1,105 (80.1%)
Telemedicine	261 (88.8%)	201 (91.0%)					
Totals:	**24,487 (94.4%)**	**21,210 (93.4%)**	**20,414 (91.5%)**	**19,275 (89.5%)**	**18,157 (87.0%)**	**16,847 (84.3%)**	**10,985 (55.0%)**

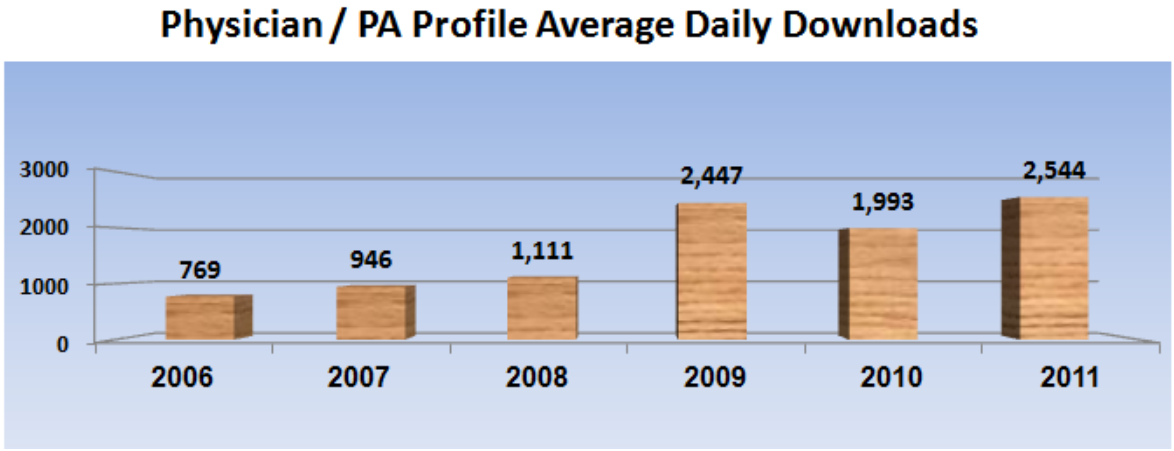
*: Online renewals started in November 2004.



Appendix 2D
Public Search on Physician / Physician Assistant Profile Online

Fiscal Year	2006	2007	2008	2009	2010	2011
Physician / PA Online Profile Page Views per Year	280,538	345,319	405,677	893,045	727,488	928,602
Average Daily Downloads	769	946	1,111	2,447	1,993	2,544

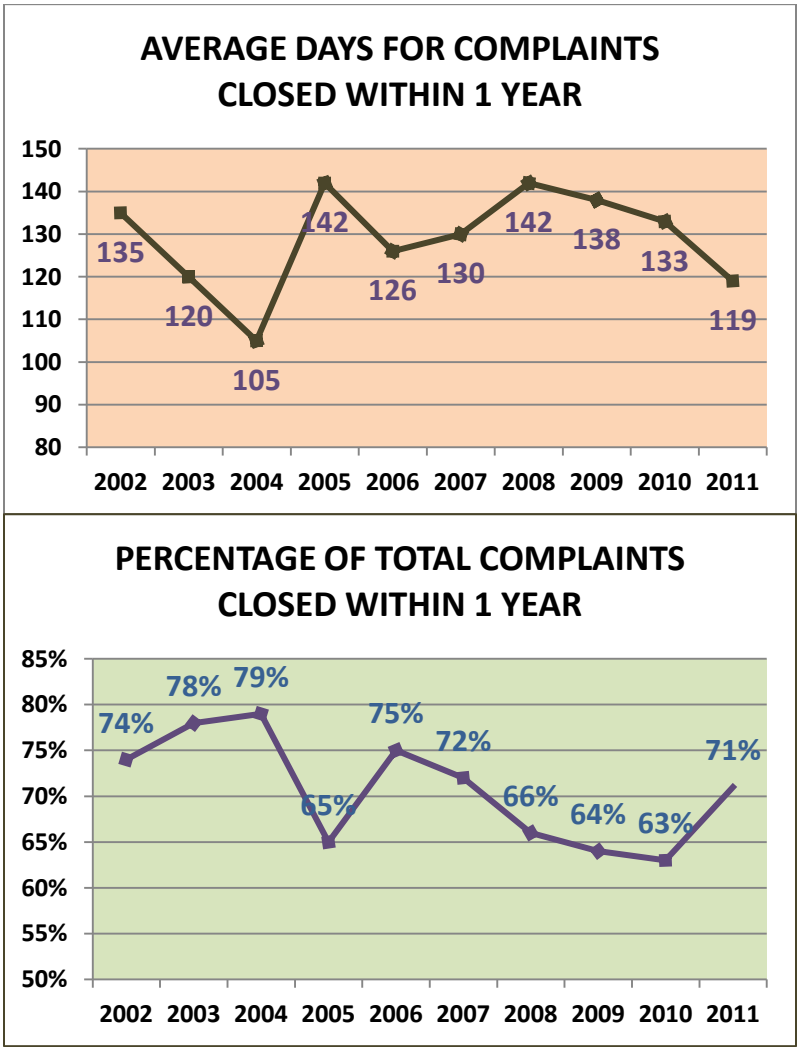




APENDIX 2E
AVERAGE DAYS & PERCENT TO CLOSE COMPLAINTS IN LESS THAN 365 DAYS

FISCAL YEAR	AVERAGE DAYS FOR COMPLAINTS CLOSED WITHIN 1 YEAR	PERCENTAGE OF TOTAL COMPLAINTS CLOSED WITHIN 1 YEAR
2002	135	74%
2003	120	78%
2004	105	79%
2005	142	65%
2006	126	75%
2007	130	72%
2008	142	66%
2009	138	64%
2010	133	63%
2011	119	71%

70% of complaints are closed within one year in an average of 130 days.



III. CRITERIA 3

An identification of any activities of the agency in addition to those granted by statute and of the authority for those activities and the extent to which those activities are needed.

In addition to the authority granted to the board in its enabling statutes, the board has been given these additional responsibilities:

- Provide all licensees' records to the Commissioner of the Department of Revenue for State tax clearance purposes. State tax delinquency results in automatic suspension of credential (Minn. Stat. § 270C.72).

- Provide physician credentials and specialty information to Minnesota Responds, which is a partnership which integrates local, regional, and statewide volunteer programs to assist public health and healthcare systems during times of disaster (United States Code, title 42, section 247d; Minn. Stat. § 145A.06, subd 6).

- Provide information, including license and registration status, name, address date of birth, sex, professional activity status, and educational background to the Commissioner of Health to assist the Commissioner in decision making pertaining to health personnel Minn. Stat. § 144.051 and Minn. Stat. § 144.102.

- Act in cooperation with the Minnesota Board of Pharmacy to implement the Prescription Monitoring Program (PMP) which promotes public health and welfare by detecting diversion, abuse, and misuse of prescription medications classified as controlled substances (Minn. Stat. § 152.126).

- Provide physician and physician assistant licensing information to the Department of Human Services to be used by Minnesota health care programs for processing provider's enrollment and credential verification.

- Minn. Stat. § 145.4132 requires the Commissioner of Health to prepare an abortion complication reporting form and requires the Board of Medical Practice to ensure the forms are delivered to current and newly licensed physicians. Every November, the board provides the Department of Health with a list of current mailing addresses for Minnesota licensed physicians in order for the forms to be distributed. The board distributes the forms to newly licensed physicians.

- Minn. Stat. § 145.4246 (Women's Right to Know Law) requires the Department of Health to prepare a reporting form for physicians to indicate the number of women who received information required by law and to ensure those forms are distributed to physicians. The board provides the Department of Health a list of current mailing addresses for physicians annually. The board also distributes the forms to newly licensed physicians.

IV. CRITERIA 4

An assessment of authority of the agency relating to fees, inspections, enforcement and penalties.

A. FEES

The authority of the board to charge license and registration fees to its credentialed practitioners is found in both statute and rule (See Appendix 4).

Licensure and registration fees support the operations of the board and are necessary because the board receives no appropriation from the State's general fund. All operations of the board are entirely fee funded. In addition, Minn. Stat. § 16A.1285 and Minn. Stat. § 214.06 require that the board only collect fees that will "as closely as possible equal anticipated expenditures during the fiscal biennium."

B. INSPECTIONS

The Board of Medical Practice has no authority to conduct inspections and this is not a part of its operations.

C. ENFORCEMENT

The Minnesota Medical Practice Act, as well as the Practice Acts of the allied health professionals regulated by the board, contains specific grounds for which the board may take disciplinary or corrective action on a practitioners credential. Since the allied health professionals practice acts are based on the Medical Practice Act, for brevity purposes only that law will be referenced.

The specific grounds for disciplinary action in the Medical Practice Act are found in Minn. Stat. § 147.091, subd. 1.

The specific forms of disciplinary action the board may take on a license are found in Minn. Stat. § 147.141. These actions are:

1. Revoke the license.
2. Suspend the license.
3. Revoke or suspend the registration to perform interstate telemedicine.
4. Impose limitations or conditions on the license.
5. Impose a civil penalty.
6. Order community service.
7. Censure or reprimand.

In any given board disciplinary action, one or a number of these actions may be imposed.

The board also has the authority to enter into a non-disciplinary Agreement for Corrective Action with a practitioner to remediate identified educational deficiencies in a case where no patient harm has occurred. The authority for the health licensing boards to utilize Agreements for Corrective Action is found in Minn. Stat. § 214.103, subd. 6 (2).

Disciplinary or corrective action is necessary to protect the public from those practitioners who have demonstrated an inability to meet the standard of care in certain areas of practice or who, because of a physical, mental or chemical impairment, are unsafe to continue in practice without some level of board intervention.

Other Enforcement related Statutes:

- Minn. Stat. §. 214.10, subd. 1. Receipt of Complaint; Notice.
- Minn. Stat. § 214.10, subd. 2. Investigation and Hearing.
- Minn. Stat. § 210.10, subd. 3. Discovery; Subpoenas.
- Minn. Stat. § 214.103. Health related licensing boards complaint, investigation and hearing.
- Minn. Sta. § 210.11. Injunctive relief for unauthorized practice or any threatened violation of a board law or rule.
- Minn. Stat. § 147.091, subd. 1a. Automatic revocation of license for conviction of felony level criminal sexual misconduct.
- Minn. Stat. § 147.091, subd. 2. Automatic suspension of License.

D. PENALTIES

The only authority of the board to collect penalties is found in Minn. Stat. § 147.141. Forms of Disciplinary Action. That law provides that the board may, "impose a civil penalty not exceeding $10,000 for each separate violation, the amount of the civil penalty to be fixed so as to deprive the physician of any economic advantage gained by reason of the violation charged or to reimburse the board for the cost of the investigation and proceeding."

APPENDIX 4
FEES, STATUTORY/RULE CITATION

Physicians		
Application	MR 5600.2500	$200
Annual	MR 5600.2500	192
Temporary license	MR 5600.2500	60
Late fee	MR 5600.2500	60
Endorsement	MR 5600.2500	40
Emeritus registration	MR 5600.2500	50
Residency permit	MS 147.0391 Subd. 1	20
Telemedicine app	MS 147.032 Subd. 1(a)(3)	100
Telemedicine annual	MS 147.032 Subd. 1(a)(3)	75
Competitive athletic event	MS 147.09(12)	50
Acupuncturists		
Application	MS 147B.08 Subd. 1	$150
Annual	MS 147B.08 Subd. 1	150
Temporary permit	MR 5600.2500	60
Inactive status	MR 5600.2500	50
Late fee	MS 147B.08 Subd. 2	50
Athletic Trainers		
Application	MS 148.7815 Subd 1	$50
Annual	MS 148.7815 Subd 1	100
Temporary registration	MS 148.7815 Subd 1	100
Temporary permit	MS 148.7815 Subd 1	50
Late fee	MS 148.7815 Subd 3	15
Naturopathic Doctors		
Application	MS 147E.40 Subd 1	$200
Annual	MS 147E.40 Subd 1	150
Temporary permit	MS 147E.40 Subd 1	25
Inactive status	MS 147E.40, Subd 1	50
Emeritus	MS 147E.15 Subd 13	50
Late fee	MS 147E.40 Subd 1	75
Physician Assistants		
Application	MR 5600.2500	$120
Annual w/o prescribing	MR 5600.2500	115
Annual w/prescribing	MR 5600.2500	135
Temporary permit	MR 5600.2500	60
Temporary registration	MR 5600.2500	115
Locum tenens permit	MR 5600.2500	25
Late fee	MR 5600.2500	50
Respiratory Therapists		
Application	MR 5600.2500	$100
Annual	MR 5600.2500	90
Temporary permit	MR 5600.2500	60
Temporary registration	MR 5600.2500	90
Late fee	MR 5600.2500	50
Inactive status	MR 5600.2500	50

<u>Traditional Midwives</u>		
Application	MS 147D.27 Subd 1	$100
Annual	MS 147D.27 Subd 1	100
Temporary permit	MS 147D.27 Subd 1	75
Inactive	MS 147D.27 Subd 1	50
Late fee	MS 147D.27 Subd 3	75
<u>Professional Firms</u>		
Application	MS 319B.11 Subd 3(3)	$100
Annual	MS 319B.11 Subd 4(b)	25
<u>Miscellaneous</u>		
Civil penalties	MS 147.141	various
Misc/service chg/copies	MS 147; MS 214	various
OET eLicensing surcharge	MS 16E.22	10% of initial application and renewal fees - July 2009 through June 2015
Duplicate license/registration	MR 5600.2500	$20
Certification letter	MR 5600.2500	$25
Verification of status	MR 5600.2500	$10
Education/training program approval fee	MR 5600.2500	$100
Report creation and generation, $60 per hour billed in quarter-hour increments with a quarter-hour minimum	MR 5600.2500	
Examination administrative fee:		
(1)half day, $50; and	MR 5600.2500	
(2)full day, $80.	MR 5600.2500	

MR = Minnesota Rule
MS = Minnesota Statute

V. CRITERIA 5

Whether less restrictive or alternative methods of performing any function that the agency performs could adequately protect or provide service to the public.

REGULATORY AUTHORITY

Licensure: Licensure is the most restrictive form of credentialing. Only those individuals who meet the rigorous educational, training and examination requirements set forth in State law may be granted a license to practice medicine or certain other allied health care professions in Minnesota. All jurisdictions in the United States require licensure for an individual to practice medicine. The unlicensed practice of medicine is against the law and may be subject to criminal prosecution.

In order to protect the health and safety of Minnesota patients, only the most highly qualified individuals should be granted the privilege to practice certain health care professions. Licensure ensures that individuals have met and continue to meet these standards.

The Board of Medical Practice and the legislature have determined that licensure is the appropriate level of credentialing for physicians, physician assistants, acupuncturists, respiratory therapists, and traditional midwives.

Registration: In Minnesota, 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 to ensure 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 use of the title. Use of the title of the profession is an assurance to the public that the individual has met the educational, training and examination requirements for the profession. Minnesota law provides that registration is the appropriate level of credentialing for athletic trainers and naturopathic doctors.

While all the states provide for the credentialing of these health care providers, there are differences among the states as to the appropriate level of credentialing. All states, however, provide that licensing is the appropriate level of credentialing for physicians.

Both licensure and registration assure the public that the credentialed individuals meet the annual continuing educational requirements set forth in statute. In addition, licensure and registration by a health licensing board enhances public protection by providing a credentialing authority and its attendant investigative and disciplinary powers to ensure that health care professionals continue to practice with reasonable skill and safety to patients.

ALTERNATIVES TO DISCIPLINARY ACTION

The board has identified several alternatives to formal discipline that serve to remediate and rehabilitate deficiencies while assuring public protection, including:

- Medical coordinator conferences, meetings between a respondent licensee and a physician for the purpose of offering education [see Appendix 5];
- Agreements for corrective action, public non-disciplinary agreements between a respondent licensee and a complaint review committee in which the licensee agrees to undertake specific education [see Appendix 5];
- Referral to the Health Professional Services program for confidential, non-disciplinary monitoring of a health condition.

FIDUCIARY OBLIGATION

Minnesota Statutes § 214.06 require the board to collect fees sufficient so that the total fees collected by the board will be based on anticipated expenditures. Fees collected are deposited to the health occupations licensing account in the State Government Special Revenue Fund and appropriated by the legislature. An alternative and less burdensome method would be for the board to have fiscal authority without this legislative appropriation. Fees established by the legislature and oversight by Minnesota Management and Budget would provide external and internal audit control mechanisms as assurance to the public of compliance with Minnesota law and best accounting practices while deleting a layer of bureaucracy

LEGAL SERVICES

Minnesota Statutes § 214.04, subd. 1 requires legal and investigative services to the boards be provided by the Attorney General's Office (AGO). The Minnesota Board of Medical Practice as well as the boards of Nursing and Dentistry have implemented a system in which board staff draft legal documents rather than the AGO. The AGO reviews the documents for accuracy and compliance with the law. This practice has resulted in a substantial decrease in the time from receipt of a complaint to a review before a board complaint committee or by the full board. There was no change in the cost to the board. A logical expansion of this practice would be for the health licensing boards to retain or employ legal counsel and investigative staff rather than using the AGO; thus eliminating a layer of involvement. Legal and investigative services would be shared among the health related licensing boards on a fee for use basis. Based on the experience with legal drafting, complaint resolution time would be reduced and public safety enhanced.

APPENDIX 5
Alternatives to Disciplinary Action

Fiscal year	2011	2010	2009	2008	2007	2006	2005	2004	2003	2002	Total
Corrective Actions	9	11	12	8	9	12	5	3	12	8	89
Medical Coordinator Conference	53	49	73	54	35	70	76	87	101	79	677

VI. CRITERIA 6

The extent to which the jurisdiction of the agency and the programs administered by the agency overlap or duplicate those of other agencies, the extent to which coordinates with those agencies, and the extent to which the programs administered by the agency can be consolidated with the programs with the programs of other State agencies.

THE MINNESOTA CREDENTIAL

There are no other Minnesota agencies responsible for the State credentialing and disciplining of physicians or the other allied health professionals regulated by the Board of Medical Practice.

With that said, there are circumstances where a physician may also be a licensed dentist, pharmacist, chiropractor, physical therapist or other credentialed health care profession regulated by another Minnesota health licensing board.

Number of physicians holding licenses issued by other health licensing boards:

Board	Number
Nursing	3
Pharmacy	10
Dentistry	20
Chiropractic	2
Cosmetology	1
Physical Therapy	6
Psychology	1
Dietetics and Nutrition Practice	1
EMSRB	1
Veterinary Medicine	4
Marriage & Family	1

Members of the allied health professions regulated by the Board of Medical Practice may also hold a credential issued by a different health licensing board. In those situations, the credential is granted by the professional board to which the individual is applying.

If there is a complaint against a dual credentialed individual, the board responsible for the professional credential under which the individual was practicing at the time of the incident will be responsible for the investigation and any subsequent action on the credential. In some cases, this line may not be clear and two or more boards would share in the investigation. In all cases, an individual board's investigative data may be shared with another board or any State agency (Minn. Stat. § 214.10, subd. 8 (d)).

OTHER STATE CREDENTIAL

All states provide for credentialing of health care professionals. An individual who holds a credential in Minnesota may also hold credentials in one or more states. A complaint against a credentialed health care professional is investigated by the State board in which the patient encounter occurred. Any resulting disciplinary action by the State board is reported to all other states in which a credential is held and, in most cases, those states would take similar disciplinary action on their state's credential. The law also provides for the sharing of investigative data between states (Minn. Stat. § 214.10, subd. 8 (e)).

VII. CRITERIA 7

The promptness and effectiveness with which the agency addresses complaints concerning entities or other persons affected by the agency, including an assessment of the agency's administrative hearings process;

As noted in Section 1, the board receives approximately 840 complaints against its regulated health care professionals each year. The number of annual complaints has remained relatively stable during the last decade [see Appendix 7A], reflecting a general public awareness of the board's role and mission to protect the public. Most complaints are filed by patients and family members, followed by reports of professional liability settlements and reports from other health care professionals [see Appendix 7B]. The basis for complaints is primarily substandard practice (unethical or unprofessional conduct, negligence, etc.), inappropriate prescribing, improper management of medical records, and impairment (mental, physical or chemical health issues) [see Appendix 7C]. The majority of complaints (70%) are resolved in less than one year and the average time to resolve those complaints is 130 days [see Appendix 7D].

The board has imposed an average of 79 formal disciplinary actions and eight non-disciplinary corrective actions, annually (see Appendix 7E). The conduct underlying board actions has primarily involved substandard practice and licensee illness or impairment (see Appendix 7F). The conduct underlying corrective actions has primarily related to inappropriate prescribing and documentation deficiencies.

CONTESTED CASE HEARING PROCESS

When the board has identified a need for restrictions on an individual's credential, it will try to settle the matter by agreement (Stipulations and Orders for disciplinary actions). These Stipulations and Orders for discipline will set forth a statement of the facts upon which the discipline is being imposed, a reference to the statutory violations upon which the order is based and a statement of the remedy which the board feels is appropriate in order to ensure public protection.

When the board is unable to resolve a case by settlement, it pursues action through a formal administrative hearing process. The Attorney General's Office will file a Notice of Hearing on behalf of the board with the Office of Administrative Hearings. An Administrative Law Judge will be assigned to hear the case and a separate Administrative Law Judge will be assigned to mediate the matter prior to thearing. If mediation is unsuccessful and a hearing is held, the Administrative Law Judge will issue a Findings of Fact, Conclusions of Law and Recommendation to the board. The board will then hold a hearing to determine if disciplinary action is appropriate based on the hearing record. The majority of cases scheduled for hearing are successfully mediated prior to hearing.

Since 2002, fifty-five cases have been scheduled for hearing before the Office of Administrative Hearings. Of these, thirty-four have been successfully mediated. Ten cases have gone to full hearing in that time and resulted in disciplinary action on the license. Five cases are currently pending and the remainder were disposed in some other way (physician death, resignation of license, etc.) (see Appendix 7G). The board has prevailed in all cases in which an appeal to District Court was filed.

Compliance with disciplinary and corrective actions is overseen by CRU staff who compile and analyze compliance data to determine whether the terms of board actions are being met. Noncompliance with a board action provides an independent basis for further disciplinary action.

Over the past decade, the CRU has expanded its use of technology to improve its data management processes and overall efficiency. The board's state of the art information management database (ALIMS), implemented in November 2004, enables the CRU to increase transparency and more efficiently provide public information regarding disciplinary and corrective actions through on-line services, including on-line access to view and download complete actions, as well as access to on-line professional profiles. Paperless agendas reduce the board's overall costs while increasing efficiency. The addition of a full-time in-house legal assistant in 2006 improved the quality and efficiency of legal document drafting, even as the overall unit staff was reduced from 12 in 2004 to nine in 2009. Use of technology and staffing changes have enabled the CRU to increase its quality and efficiency.

APPENDIX 7A

STATE OF MINNESOTA
BOARD OF MEDICAL PRACTICE

NUMBER OF COMPLAINTS RECEIVED EACH YEAR

Fiscal Year	Number of Complaints Received	Percent of Change From Previous Year
2011	789	(304)
2010	817	(8.9)
2009	890	2.5
2008	868	4.2
2007	832	8.2
2006	770	(1.3)
2005	780	(17)
2004	941	5.7
2003	890	6.5
2002	835	7

AVERAGE: 840 COMPLAINTS PER YEAR

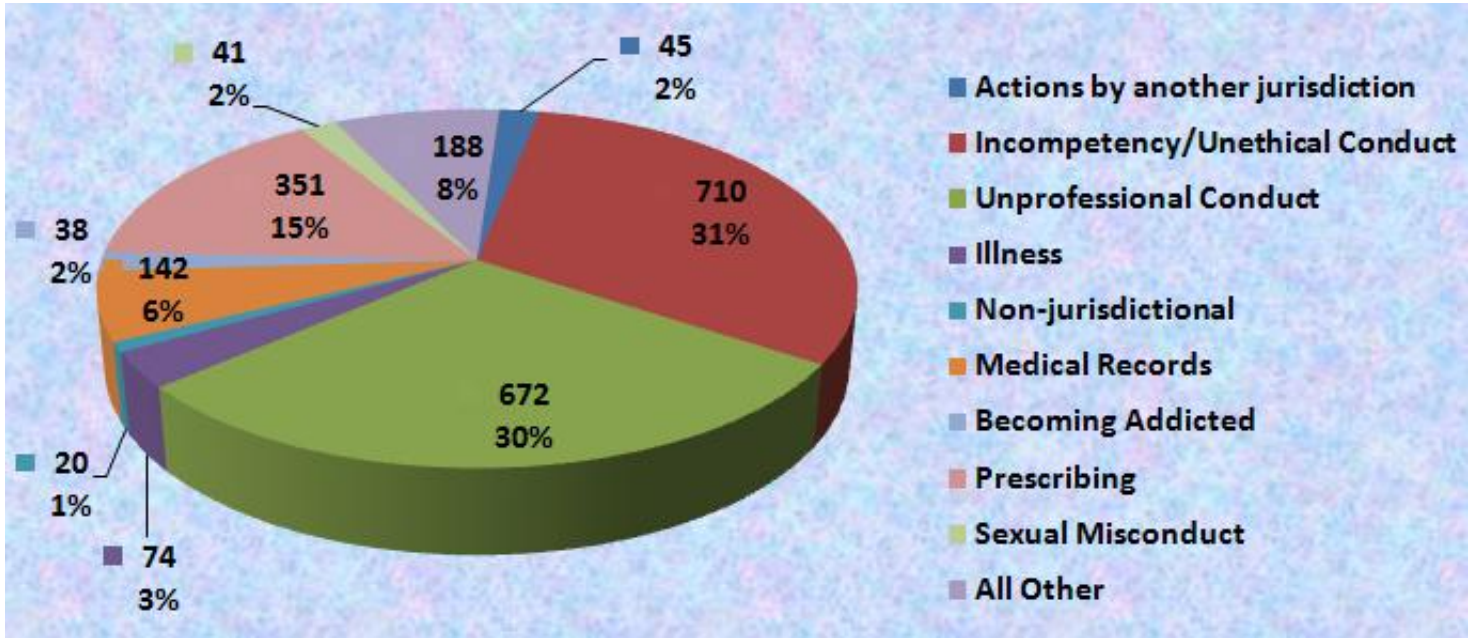
APPENDIX 7B
STATE OF MINNESOTA
BOARD OF MEDICAL PRACTICE

SUMMARY OF COMPLAINTS
BY SOURCE

COMPLAINT SOURCE	#OF COMPLAINTS FY 02	03	04	05	06	07	08	09	10	11
BMP License Renewal Form	42	39	32	18	41	43	73	48	47	8
BMP Application Form	2	0	0	1	0	1	0	0	0	0
BMP Staff; EX. Anonymous	61	40	60	34	54	24	40	42	47	54
BMP Non-Compliance with Order	3	0	0	2	1	2	2	3	1	4
Family Member	98	109	120	113	73	108	129	111	81	117
Patient	314	310	308	297	305	342	323	369	303	299
Third Party	15	28	23	35	26	23	35	13	30	27
Courts	0	0	0	0	1	1	2	0	0	4
Professional Liability Settlements	107	107	134	103	106	101	106	91	102	60
Enforcement Agency	0	0	2	1	6	4	2	3	3	4
AGO	0	2	6	1	0	0	0	0	0	0
Peer Review Organization	0	0	0	0	0	1	0	0	0	0
Pharmacists	1	3	10	6	3	6	1	6	6	11
Federal DHHS	1	2	0	0	0	1	0	5	0	0
Medical Examiner/Coroner	0	0	0	0	1	1	1	0	0	0
Department of Health	11	6	8	0	2	3	2	3	2	0
HPSP	31	26	43	37	28	32	45	49	44	40
MN Health Related Boards	0	1	5	0	0	7	4	2	0	4
Police/Sheriff Dept.	1	5	0	0	1	3	1	3	4	0
DHS	7	10	3	6	3	7	4	11	3	6
Drug Enforcement Agency	0	1	0	1	0	1	1	0	0	0
OHFC	20	51	6	19	12	13	7	11	2	7
Medical Board Other-Federation-AMA	13	15	16	2	31	12	14	11	3	15
Medical Societies	4	3	1	2	0	0	0	0	0	0
Other Enforcement Agency	7	20	18	13	4	5	3	0	3	4
Health Care Institution	41	33	23	25	28	30	30	37	40	39
Licensed Health Professional	56	71	127	72	41	60	52	65	103	99
PADS	0	0	0	0	0	0	0	0	0	0
Self-Report	8	9	8	5	13	23	15	32	35	27

APPENDIX 7C
STATE OF MINNESOTA BOARD OF MEDICAL PRACTICE

CONDUCT UNDERLYING COMPLAINTS		FY 02	03	04	05	06	07	08	09	10	11
D.	Actions by another jurisdiction	19	28	41	15	53	39	28	43	57	45
G	Incompetency/Unethical Conduct	278	597	662	579	638	709	752	747	668	710
K	Unprofessional Conduct	569	654	663	685	606	703	729	654	579	672
L	Illness	73	78	78	67	50	56	89	81	81	74
NJ	Non-jurisdictional	24	14	15	26	18	20	19	20	22	20
O	Medical Records	42	52	59	68	93	99	113	144	109	142
R	Becoming Addicted	16	15	17	27	30	34	33	27	52	38
S	Prescribing	55	61	120	194	182	288	280	362	300	351
T	Sexual Misconduct	42	40	43	41	26	37	45	40	33	41
All Other		182	158	270	276	167	146	235	167	157	188



APPENDIX 7D

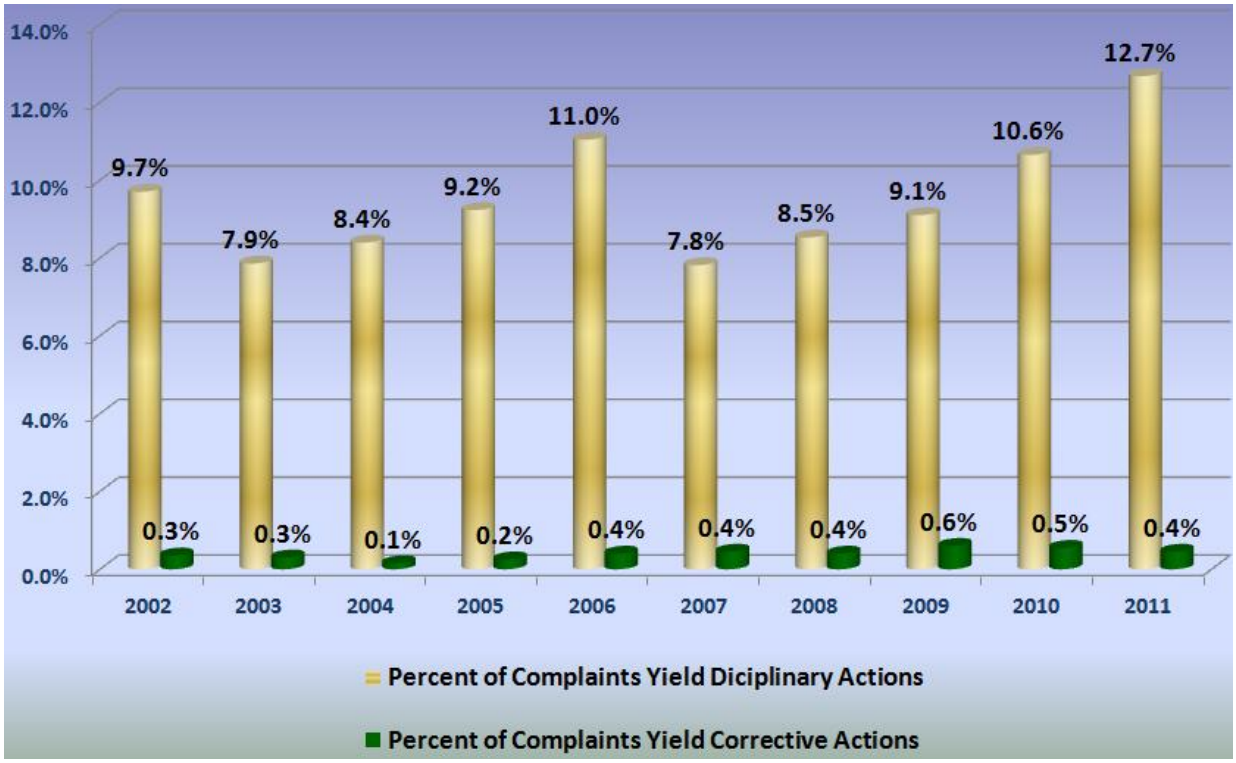
CONDUCT UNDERLYING COMPLAINTS IN FISCAL YEAR 2011

FISCAL YEAR	AVERAGE DAYS FOR COMPLAINTS CLOSED WITHIN 1 YEAR	PERCENTAGE OF TOTAL COMPLAINTS CLOSED WITHIN 1 YEAR
2002	135	74%
2003	120	78%
2004	105	79%
2005	142	65%
2006	126	75%
2007	130	72%
2008	142	66%
2009	138	64%
2010	133	63%
2011	119	71%

70% of complaints are closed within one year in an average of 130 days.

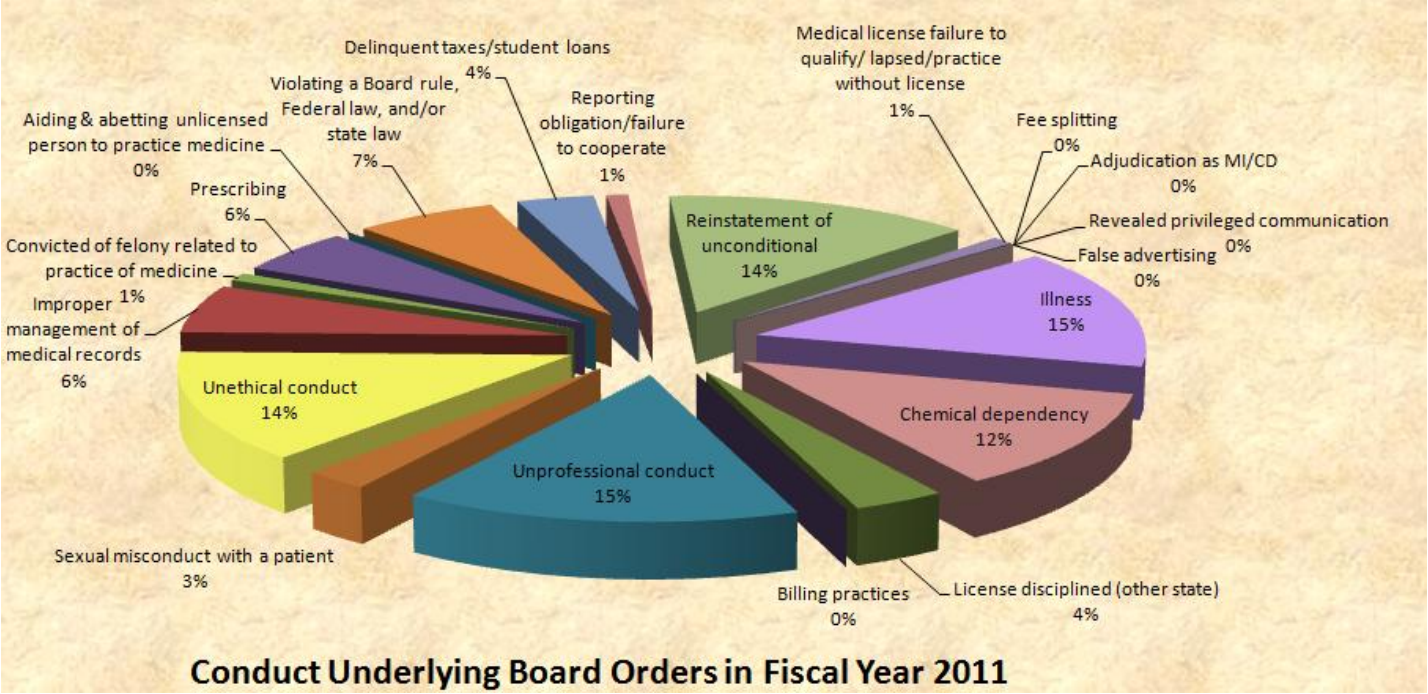
APPENDIX 7E
Complaint Statistics
Number of Complaints Received and Actions Taken

Fiscal Year	Complaints Received	Disciplinary Actions Taken	Corrective Actions Taken
2002	835	81	7
2003	891	70	6
2004	941	79	3
2005	780	72	5
2006	770	85	8
2007	832	65	9
2008	868	74	8
2009	890	81	12
2010	817	87	11
2011	789	100	9



APPENDIX 7F
STATE OF MINNESOTA BOARD OF MEDICAL PRACTICE

CONDUCT UNDERLYING BOARD ORDERS	FY 02	03	04	05	06	07	08	09	10	11
Illness	27	43	46	22	37	24	26	23	21	30
Chemical dependency	20	37	40	18	27	22	20	18	14	24
License disciplined (other state)	4	6	3	5	3	3	1	3	4	7
Billing practices	0	0	1	1	1	0	0	1	1	0
Unprofessional conduct	12	20	30	27	27	16	10	23	23	30
Sexual misconduct with a patient	3	3	4	9	9	1	2	5	2	5
Unethical conduct	13	21	28	26	28	14	10	16	21	27
Improper management of medical records	4	9	15	12	15	9	6	13	9	12
Convicted of felony related to practice of medicine	1	0	1	0	2	0	2	2	0	2
Prescribing	3	8	10	13	14	8	3	8	10	11
Aiding & abetting unlicensed person to practice medicine/failure to supervise	0	1	1	0	2	1	1	0	0	0
Violating a Board rule, Federal law, and/or state law related to the practice of medicine	3	9	10	3	4	9	11	9	3	13
Delinquent taxes/student loans	4	5	1	2	4	3	2	0	3	7
Reporting obligation/failure to cooperate	3	1	0	3	2	2	6	2	2	2
Reinstatement of unconditional	22	13	14	23	23	17	22	21	37	28
Medical license failure to qualify/ lapsed/practice without license	0	0	0	0	0	3	11	4	0	2
Fee splitting	0	0	0	0	0	0	0	1	0	0
Adjudication as MI/CD	0	0	0	0	0	0	0	1	0	0
Revealed privileged communication	0	1	0	2	0	0	0	0	0	0
False advertising	0	1	0	0	1	0	1	0	0	0



APPENDIX 7G
Complaint Statistics
Number of Contested Cases Authorized and Outcomes

Fiscal Year	Contested Cases Authorized	Mediated or Stipulated Settlements	Full Hearings	Outcomes	Appeals and Outcomes
2002	6	5	1	6 Disciplinary Actions	0
2003	5	4	1	1 Corrective Action 4 Disciplinary Actions	1 Appeal Dismissed as Untimely
2004	6	2	2	1 Deceased 1 Resigned 1 Dismissed 3 Disciplinary Actions	1 Appeal Board Action Upheld
2005	3	1	2	2 Dismissed 1 Disciplinary Action	0
2006	4	3	1	1 Corrective Action 3 Disciplinary Actions	1 Appeal Board Action Upheld
2007	3	3	0	1 Corrective Action 2 Disciplinary Actions	0
2008	8	4	3	1 Withdrawn 7 Disciplinary Actions	0
2009	6	6	1 (Summary Judgment)	1 Resigned 5 Disciplinary Actions	0
2010	7	4	1 Full Hearing 2 Pending	5 Disciplinary Actions 2 Pending	
2011	7	2	2 Full Hearings 3 Pending	1 Dismissed 3 Disciplinary Actions 3 Pending	1 Appeal Petition Denied

VIII. CRITERIA 8

An assessment of the agencies rulemaking process and the extent to which the agency has encouraged participation by the public in making its rules and decisions and the extent to which public participation has resulted in rules that benefit the public.

The Minnesota Board of Medical Practice has not written rules in over 10 years. In 1999, the board began a rule writing effort to raise physician annual license renewal fees from $168 annually to $192 annually. The reason for the fee increase was to address increased contested case expenses incurred in the board's disciplinary process and to build a new state-of-the-art IT system which would allow on-line credential renewal as well as a physician profiling system to assist health care consumers in making more informed decisions in choosing a physician.

Upon publication of the Intent to Adopt Rules and the Statement of Need and Reasonableness, the board received more than the required 25 requests for a hearing on the fee rule. The board went to a hearing on the fee rule and received a favorable decision from the Office of Administrative Hearings. This entire process took approximately 18 months to accomplish. The 2000 session of the legislature changed the requirement for fee adjustments and now allows that process to be accomplished through the legislative process (Minnesota Statutes § 16A.1283).

The original regulation of physician assistants and traditional midwives by the board, as created by the legislature, was via the use of administrative rules. As these professions developed, and as the health care market changed through time, it became necessary to update and modernize their regulatory framework. In working through the administrative rule making process, the board soon found this to be an enormously expensive, time consuming, and cumbersome process for all parties to the matter. The board also found the process to be lacking in true public involvement. Subsequently, the board has pursued all regulatory policy changes through legislative changes to appropriate statutes.

The board feels that taking these proposed changes through the public meetings of its Policy and Planning Committee to the public meeting of the board and finally through the legislative process is less costly and time consuming and provides more opportunity for public input.

The professions and the public are given notice of all board activity via its web site. All meetings of the board or committees of the board, whether open to the public or not, are posted on the website as well as posted at the board's office. The full agendas for upcoming board meetings are posted on the board's web site the same day as they are transmitted to board members. All minutes of previously held board meetings are also posted on the board's web site (http:/www.bmp.state.mn.us).

IX. CRITERIA 9

The extent to which the board has complied with federal and state laws and applicable rules regarding equality of employment opportunity and the rights and privacy of individuals, and state law and applicable rules of any state agency regarding purchasing guidelines and programs for historically underutilized businesses.

The board complies fully with federal and state laws regarding equality of employment opportunity, and the rights and privacy of individuals.

The Executive Director is entrusted with responsibility for ensuring that federal and state equal employment opportunity laws are fully complied with. This is achieved with the assistance of the board's designated Affirmative Action Officer, located in the Administrative Services Unit, which provides shared services to the health related licensing boards.

The board maintains and updates an Affirmative Action Plan on a biannual basis. Criteria for Affirmative Action Plans are established by State law, Minnesota Statutes § 43A.19 and 43A.191, and MMB Administrative Procedure 19.1. The Executive Director prepares and implements the Plan, and signs the Plan's Statement of Commitment. The current Affirmative Action Plan is posted on the board's website.

Likewise, the board fully complies with the Minnesota Human Rights Act and applicable federal equal opportunity laws. The board works cooperatively with the Administrative Services Unit, which provides expertise on equal opportunity issues.

This board has received no complaints of violation of equal employment opportunity laws.

All new employees are informed of equal employment opportunity policies and laws upon orientation, and a copy of the board's Affirmative Action Plan is reviewed with them, including equal opportunity provisions and the board's complaint process. This Affirmative Action Plan is provided to all new employees, and is posted on the employee bulletin board. Training on equal opportunity/affirmative action requirements is periodically provided to staff through in-person training sessions and on-line training. Equal opportunity/affirmative action matters are regularly reviewed at Executive Director meetings and Office Manager meetings.

The board conducts its hiring processes in accordance with all applicable collective agreements and state and federal law. This is accomplished through consultation with the board's affirmative action designee. The board uses the State's resume-base, skill-matching process. Resumes are evaluated against established minimum qualifications. Hiring processes are closely reviewed to insure compliance with equal employment opportunity. Interview questions are established based on knowledge, skills, and abilities required to perform the responsibilities of each position.

The board's home webpage has an affirmative action/equal opportunity statement, lists the phone number for hearing/speech relay, and provides an e-mail address for comments on the web page.

The board responds to all applicable State surveys regarding equal opportunity/affirmative action, including an annual ADA Survey.

Applicants and the general population are becoming increasingly diverse, including cultural and language diversity. The licensing boards continue to examine matters pertaining to possible barriers in licensure, as well as issues surrounding working with clients and patients from diverse populations.

PURCHASING AND CONTRACTING

The board complies with all purchasing requirements, including the State's Targeted Group/Economically Disadvantaged Small Business Program. Contractual guidance is provided by the Administrative Services Unit. The Administrative Services Unit also provides the services of a Buyer who has been trained in all State purchasing requirements, including Targeted Group/Economically Disadvantaged preferences in purchasing. The board is also strongly supportive of Minncor purchasing.

Applicable rules of any State agency regarding purchasing guidelines and programs for historically underutilized businesses.

The board is aware of State contracting requirements regarding accessibility for IT services over $25,000; assistance in these matter is provided by Administrative Services Unit IT and Contract staff. Training on these matters has been provided by the Department of Administration, Materials Management Division.

All departments and agencies making direct purchases in accordance with this authority, must follow the policies and procedures and instructions contained in this manual and all applicable laws and rules, including, but not limited to:

- Minnesota Statutes §§ 13, 16A, 16B, and 16C;
- Minnesota Statutes §§ 10A.07, 15.43, 43A.38, 609.43, and 609.456;
- Minnesota Rules § 1230; and
- Uniform Commercial Code (UCC) as adopted by Minnesota (see Minnesota Statutes § 336).

SECURITY PROFILES

Related to MAPS, SEMA4, SWIFT, Fiscal Notes, Budget, Payroll, HR, Warehouse Data.

Certified profile statute reports are viewed and are due to the Minnesota Department of Management and Budget every year. When profiles are added or changed, individual staff

profiles are viewed. Individual profiles are maintained and reviewed frequently to ensure compliance with statutes, rules, policies and procedures.

FINANCIAL POLICIES

The health related licensing boards follow statutes, rules, policies and procedures related to financial operations. The Minnesota Department of Management and Budget and the Minnesota Department of Administration provide policies and procedures and training related to financial activities that staff are required to maintain. The Administrative Services Unit provides policies and procedures for the health related licensing boards staff to follow. This ensures compliance with financial operations.

X. CRITERIA 10

The extent to which the board issues and enforces rules relating to potential conflicts of interest of its employees

The Executive Director of the board is responsible for enforcing rules relating to potential conflicts of interest of its employees.

The Executive Directors of all the health related licensing boards agreed to have each incumbent employee review the State Code of Conduct Provisions and to be recertified in the employee's understanding of the Code annually. All new board employees are also informed of the Code at employment orientation, and are instructed to certify understanding of their responsibilities under the Code. The State Code of Conduct (MMB Operating Policy & Procedure 01003-01) outlines the standards and expectations regarding employee honesty, integrity, and ethical behavior.

The Code of Ethics for State Employees [Executive Branch] with the State of Minnesota (Minnesota Statutes § 43A.38) is reviewed at orientation with all new employees, and is also discussed regularly at Office Managers meeting and Executive Directors meetings.

Questions regarding conflict of interest are directed to Administrative Services Unit staff, which seeks additional guidance as required from Minnesota Management and Budget.

Provisions regarding potential conflict of interest in regard to contracting are heavily regulated by Minnesota statutes. Provisions regarding institutional conflict of interest have been reviewed at meetings of Office Managers and of Executive Directors.

Board staff has received training from the Department of Administration, Materials Management Division, regarding appropriate contracting procedures, including conflict of interest. Adherence to State contracting statutes and regulations minimize the risk of conflict of interest.

New board members are advised of their responsibilities under the Conflict of Interest Laws (Minn. Stat. § 104.07 and Minn. Stat. § 43A.38) during their New Board Member Orientation. This is part of the New Board Member Orientation is conducted by a representative of the Office of the Attorney General.

Deposit process duties are separated among four staff members, per audit instructions. Entire deposit process cannot be completed by just one employee.

XI. CRITERIA 11

The extent to which the board complies lies with Chapter 13 and follows records management practices that enable the agency to respond efficiently to requests for public information.

The Board of Medical Practice strictly adheres to the legal requirements for managing its data as required by Minnesota Statutes § 13, the Data Practices Act.

Under the Data Practices Act, all data that is not made private or confidential by state or federal law is public data.

PUBLIC DATA

Under the law, the following data collected or retained by the board is available to the public:

- The name and address of all applicants for a credential;
- All application data which has been submitted by individuals who hold a credential to practice in Minnesota;
- All Orders for Contested Case Hearing before the Office of Administrative Hearings unless specifically exempt by statute;
- Findings of Fact, Conclusions of Law and Disciplinary Orders which have gone through Contested Case and board decision making.
- All Stipulation and Orders for disciplinary action;
- Disciplinary Orders and the record of disciplinary hearing if the hearing was public;
- Board staff and consultants;
    - Name;
    - Salary or contract fees;
    - Pension and benefits information;
    - Expense and other reimbursement paid;
    - Job title and description;
    - Education, training and work experience;
    - Dates of employment;
    - Existence and status of any complaints and final discipline;
    - Action, including reasons therefore; and
    - Payroll records, work phone number and designated address.

- Job Applicants:

    - Veteran status;
    - Test scores;
    - Eligibility ranking;
    - Job history;
    - Education and training; and
    - Names of job finalists.

PRIVATE DATA:

Accessible to the subject of the data, but not the public:

- Data submitted by credential applicants;
- Inactive investigative data;
- Name of Complainant when it appears in inactive investigative data;
- Information relating to unsubstantiated complaints;
- Patient names and patient records;
- Record of disciplinary proceeding except for items classified as public; -
- All other data on staff and consultants which is not public including unsubstantiated complaints, record of disciplinary proceeding, and non designated address; and
- Names of job applicants, except for finalists.

CONFIDENTIAL DATA:

Not accessible to data subject or public.

- Active investigative data.

THE PUBLIC'S ACCESS TO PUBLIC DATA:

Physician Profile

A great deal of public information on physicians is available to the public on the Physician Profile on the board's website. This information includes:

- Physicians name, age, address of record, practice locations, medical school, postgraduate training, specialty board certification criminal convictions, if any, and disciplinary or corrective action history.

- In addition, complete copies of any disciplinary orders or Agreements for Corrective Action are also available on the Profile.

- This same information is available on-line for physician assistants. For the other allied health professionals regulated by the board, requests can be made for public data in writing, by e-mail, fax or telephone or at the board's office. Almost all requests for public data are responded to immediately. Occasionally, the board receives requests for information which requires data mining which might result in a short delay.

DATA RETENTION:

Public Data:

- All public data is retained by the board indefinitely. No public data is destroyed or archived.

Private data:

- Closed complaint files are retained in the board office for six years following resolution of the complaint. After six years the files are archived to State archives where they can be retrieved if necessary. The only information removed from the closed complaint files upon archiving are copies of medical records and any other records which can be reproduced from another source if necessary.

- Private data on employees or consultants is retained indefinitely.

Tennessen Warnings:

- Every subject of a complaint who is requested to provide information to the board by board staff or a representative of the Attorney General's Office receives a Tennessen warning advising them of how that information may be used and how it may have an effect on the status of their credential.

XII. CRITERIA 12

EFFECT OF FEDERAL INTERVENTION AND FUNDING

The effect of federal intervention or loss of federal funds if the board is abolished.

The Board of Medical Practice is required to report its disciplinary actions to the National Practitioner Data Bank and the Healthcare Integrity and Protection Data Bank (collectively referred to as "The Data Bank"), within 30 days of the date of action. The Data Bank is a confidential information clearinghouse created by Congress to improve health care quality, protect the public, and reduce health care fraud and abuse in the U.S. There are significant consequences for failing to report to the Data Bank in a timely manner. The Secretary of Health and Human Services (HHS) publishes a public report that identifies those government agencies that have failed to report information on adverse actions as required.

The Data Bank at a Glance	
NPDB	**HIPDB**
Background	
The National Practitioner Data Bank was established under Title IV of Public Law 99-660, the *Health Care Quality Improvement Act of 1986,* and is expanded by Section 1921, as amended by section 5(b) of the *Medicare and Medicaid Patient and Program Protection Act of 1987,* and as amended by the *Omnibus Budget Reconciliation Act of 1990.* NPDB is an information clearinghouse to collect and release all licensure actions taken against all health care practitioners and health care entities, as well as any negative actions or finding taken against health care practitioners or organizations by Peer Review Organizations and Private Accreditation Organizations.	The Healthcare Integrity and Protection Data Bank was established under section 1128E of the *Social Security Act* as added by Section 221(A) of the *Health Insurance Portability and Accountability Act of 1996.* HIPDB was implemented to combat fraud and abuse in health insurance and health care delivery and to promote quality care. HIPDB alerts users that a more comprehensive review of past actions by a practitioner, provider or supplier may be prudent.
Who Reports?	
• Medical malpractice payers • State health care practitioner licensing and certification authorities (including medical and dental boards) • Hospitals • Other health care entities with	• Federal and State Government agencies • Health plans

formal peer review (HMOs, group practices, managed care organizations) • Professional societies with formal peer review • State entity licensing and certification authorities • Peer review organizations • Private accreditation organizations	
What Information is Available?	
• Medical malpractice payments (all health care practitioners) • Any adverse licensure actions (all practitioners or entities) ➢ Revocation, reprimand, censure, suspension, probation ➢ Any dismissal or closure of the proceedings by reason of the practitioner or entity surrendering the license or leaving the State or jurisdiction ➢ Any other loss of license • Adverse clinical privileging actions • Adverse professional society membership actions • Any negative action or finding by a State licensing or certification authority • Peer review organization negative actions or finding against a health care practitioner or entity • Private accreditation organization negative actions or findings against a health care practitioner or entity	• Licensing and certification actions ➢ Revocation, suspension, censure, reprimand, probation ➢ Any other loss of license – or right to apply for or renew – a license of the provider, supplier, or practitioner, whether by voluntary surrender, non-renewal, or otherwise ➢ Any negative action or finding by a Federal or State licensing and certification agency that is publicly available information • Civil judgments (health care-related) • Exclusions from Federal or State health care programs • Other adjudicated actions or decisions (formal or official actions, availability of due process mechanism and based on acts or omissions that affect or could affect the payment, provision, or delivery of a health care item or service

Source: http://www.npdb-hipdb.hrsa.gov/topNavigation/aboutUs.jsp, accessed October 25, 2011.

If the Board of Medical Practice was abolished and medical licensing was discontinued, a number of federal activities would be affected.

- Medicare Reimbursement
  Reimbursement for medical services can only be made for services provided by a credentialed health care professional.

- Military Service
  In order to serve in the United States military in a health care capacity, an individual must hold a credential to practice in one of the United States. Individuals who hold only a Minnesota credential would be ineligible to serve in the United States military once the credential expired.

- Veterans Administration(VA) Hospitals and Clinics
  Like the military, health care providers employed by the Veteran's Administration must hold a credential to practice in one of the United States. Individuals with only Minnesota credentials would be ineligible from practicing for the VA once the credential expired.

- Indian Health Services
  Federal law provides that individuals providing health care on reservations must hold a valid credential in one of the United States. Individuals who are credentialed only in Minnesota would be ineligible to provide medical care through the Indian Health Care Service once the credential expired.

- Abolition of state medical credentialing could lead to federal intervention in State health care and ultimately, federal health care licensing. This is a movement the Minnesota Board of Medical Practice has long opposed.

XIII. ADDITIONAL SERVICES AND COLLABORATION

A. EDUCATIONAL OUTREACH ACTIVITES

Through the years, the Board of Medical Practice has undertaken a number of educational outreach activities to both the medical profession and the public.

1. Professional Educational Outreach

   Through the years the board has undertaken a number of educational activities aimed at informing the practicing community of problems it was seeing in its complaint review process and providing practitioners with the information they need to meet the standard of care in certain areas of practice.

   a. Controlled Substance Prescribing 1992
   b. Boundaries and Communication 1994
   c. Controlled Substance Prescribing 2000
   d. Pain Management Prescribing 2010

2. Public Outreach

   Because the Board of Medical Practice realized that many citizens of Minnesota were unaware of the existence of the board and so unaware of a resource to turn to when they encountered a problem with a physician or other health care provider, the board initiated processes to help increase public awareness of the board and its role in medical regulation.

   a) Minnesota State Fair
   For six years, from 2000 to 2006, the board maintained a booth in the Education Building during the Minnesota State Fair. The booth was staffed for twelve hours a day for the twelve days of the fair by two board employees and board members who would hand-out brochures, familiarize people with the board's web site and answer questions.

   b) Minnesota Public Radio
   In 2006, the board felt that it had reached a saturation point at the Minnesota State Fair and decided to turn its resources in a different direction. For the next two years the board ran fifteen second public service announcements on Minnesota Public Radio inviting the public to visit the board's web site and giving the web site address.

B. NATIONAL INVOLVEMENT

1. Federation of State Medical Boards
   The Federation of State Medical Boards (FSMB) is the national organization for all state medical boards in the United States. The Federation is a strong voice in medical regulation, not only among the individual states but on a national level as well.

Minnesota has always maintained a strong presence at the Federation. Through the years many of our board members have been involved in various FSMB committees as well as on the Board of Directors. In fact, since the founding of the Federation in 1912, Minnesota has had six board members serve as Chair of the Board of Directors of the Federation. Only Minnesota and Texas have had so many board members serve in this national leadership role. The Minnesotans serving as Chair of the Federation have been:

- Thomas McDavitt, MD 1925-1926
- Julian DuBois, MD 1942-1943
- Howard L. Horns, MD 1974-1975
- William E. Jacott, MD 1986-1987
- Melvin E. Sigel, MD 1992-1993
- Doris C. Booker, MD 2004-2005

Most recently Doris Brooker MD, was elected the Chair of the Federation in 2004. The executive director of the board Robert Leach, JD, served on the Board of Directors that same year. Currently, Minnesota has one board member, Jon Thomas, MD, serving on the Board of Directors, one board member Gregory Snyder, MD, and one former board member, Tammy McGee, MBA serving on FSMB committees, and another board member, Mark Eggen MD, is serving on a task force of the FSMB which is charged with looking at the issue of Continuing Competency and Maintenance of Licensure.

From 2000-2004, the board's Executive Director, Robert Leach, JD, served on the Federation of State Medical Board's Advisory Council of Board Executives.

2. National Board of Medical Examiners
   The National Board of Medical Examiners is responsible for the continuing development and administration of the United States Medical Licensing Examination, the three part examination all applicants must pass in order to receive a medical license in any of the United States. From 2002 to 2010, the executive director of the Minnesota Board of Medical Practice, Robert Leach, JD, served on the NBME's Committee on Irregular Behavior and Score Validity. One former board member, Steven Altchuler, PhD, MD, serves on the National Board of Medical Examiners Composite Committee representing the Federation of State Medical Boards. This committee has the overall responsibility for the United States Medical Licensing Examination.

Dr. Altchuler also served on the Federation of State Medical Boards' Foundation Board of Directors from 2009 – 2011.

C. STATE INVOLVEMENT

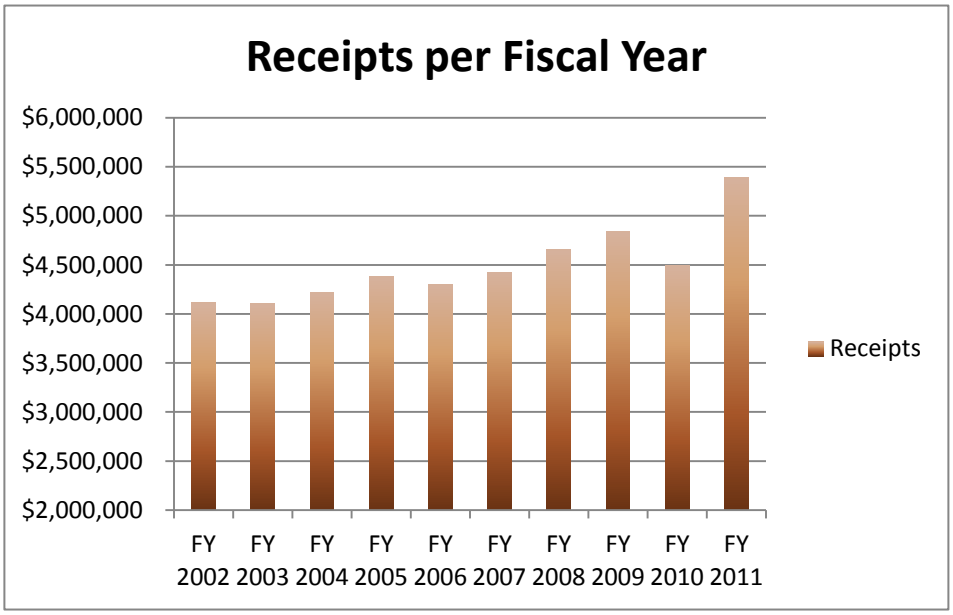
1. Minnesota Alliance for Patient Safety
   The Minnesota Alliance for Patient Safety was formed as a joint effort by the Minnesota Hospital Association, the Minnesota Medical Association and the Minnesota Department of Health to collaboratively address efforts toward improved patient safety. The board's Complaint Review Unit Supervisor, Ruth Martinez represents the board on that group.

2. Minnesota Hospital Association's Drug Diversion Coalition
   The Drug Diversion Coalition was formed to gather best practices and resources for health care organizations, professionals, and the public to prevent drug diversion, and to increase awareness and detection/surveillance if drug diversion occurs. Board member, Keith Berge, MD, and board Complaint Review Unit Supervisor, Ruth Martinez, represent the board on this workgroup.

3. Coalition of Health Care Providers
   This is a volunteer organization including representatives of various health care practitioners and professional associations who meet monthly to share information relating to clinical health care issues and economics. Richard Auld, PhD, the board's Assistant Executive Director monitors these meetings.

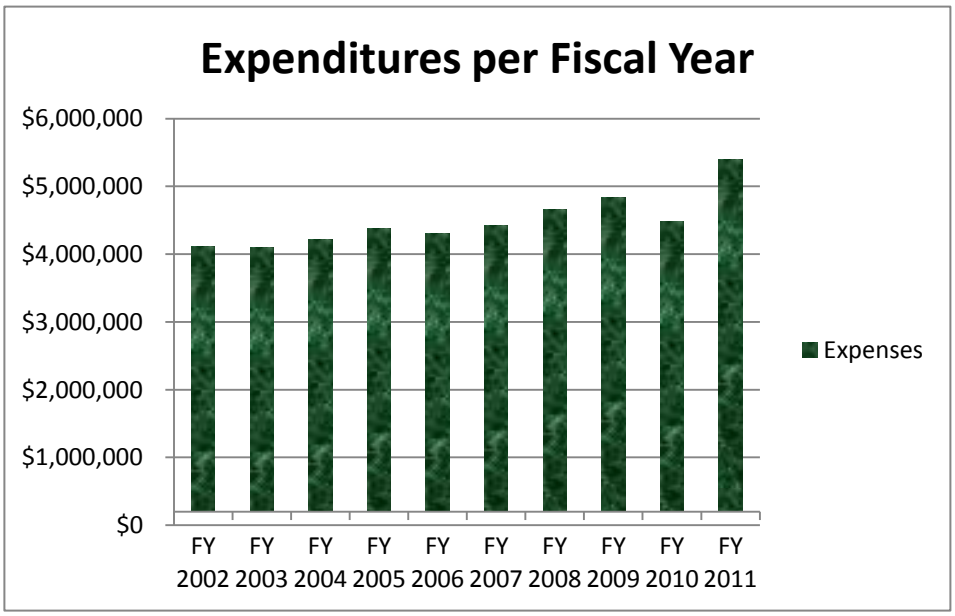
XIV. PRIORITY BASED

Revenues 2002 -2011

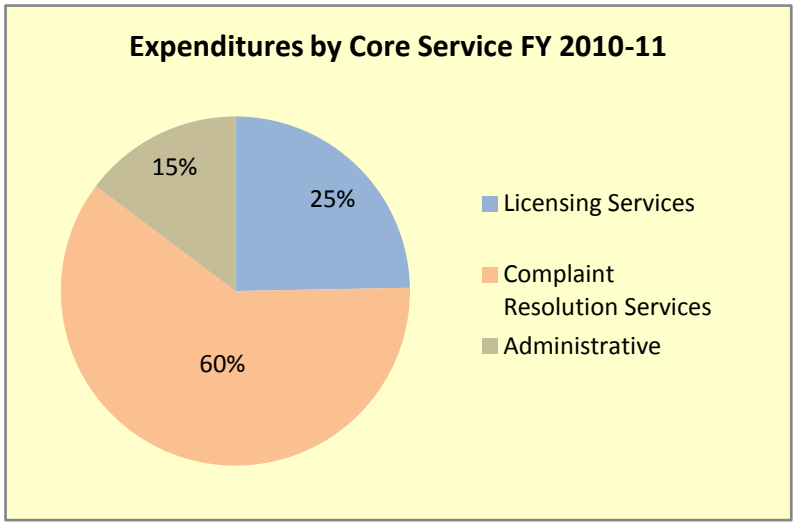


Fiscal Year	Receipts
FY 2002	$4,112,176
FY 2003	$4,105,064
FY 2004	$4,217,962
FY 2005	$4,383,653
FY 2006	$4,303,639
FY 2007	$4,427,542
FY 2008	$4,657,127
FY 2009	$4,843,566
FY 2010	$4,491,510
FY 2011	$5,392,934

Expenditures 2002 -2011



Fiscal Year	Expenses
FY 2002	$3,097,454
FY 2003	$4,749,117
FY 2004	$3,558,784
FY 2005	$3,950,965
FY 2006	$3,594,949
FY 2007	$4,029,415
FY 2008	$3,281,545
FY 2009	$4,392,310
FY 2010	$3,377,875
FY 2011	$3,908,341



Licensing Services	$1,781,419
Complaint Resolution Services	$4,366,543
Administrative	$1,063,412

XV. AGENCY AT A GLANCE

The Board of Medical Practice was established in 1887, and is statutorily mandated to protect the public from the unprofessional, improper, incompetent and unlawful practice of medicine. In fulfilling its mandate of public protection, it is necessary to provide laws and regulations to govern the granting and subsequent use of the license to practice medicine in Minnesota.

The board carries out its mission by granting qualified applicants the privilege to practice in Minnesota and by investigating complaints relating to the competency or behavior of individual licensees or registrants.

In addition to physicians, the board also regulates six other allied health professions; acupuncturists, athletic trainers, naturopathic doctors, physician assistants, respiratory therapists and traditional midwives.

KEY FACTS

Funding

The board is entirely supported by the fees it charges to its regulated health professionals. The board receives no General Fund dollars. The board is responsible for collecting sufficient revenue from fees to cover both direct and indirect expenditures. These fees are deposited into the State Government Special Revenue Fund. The board has not raised fees since 2000.

Staffing

The board has 16 volunteer Board members appointed by the Governor and 23 FTE staff members who serve over 25,000 licensees, the public, heath care providers and other customers. The staff to licensee ratio 1 staff to 1,104 licensees.

Licensing

The board licenses physicians, acupuncturists, physician assistants, respiratory therapists, and traditional midwives. The board registers athletic trainers and traditional midwives. Only those individuals who have met all the educational, training and examination requirements set forth in the law are granted the privilege to practice in Minnesota.

Complaint Review and Enforcement

In order to insure that those individuals who have been granted a credential to practice continue to practice with reasonable skill and safety to patients, the board investigates complaints against practitioners and takes appropriate disciplinary or corrective action when necessary. The board receives an average of 800 complaints per year

Advisory Councils

The board utilizes Advisory Councils for each of the allied health professions it regulates. The Advisory Councils are made up of members of the professions, physicians and public

provide the board’s committees with professional expertise in licensing and complaints for those professions.

On-Line Services

On line services were first implemented in 2005. The utilization rate for on line credential renewal has increased from 55% in 2005 to over 94% in 2011. The board's physician profile rate of access by the public and other customers has risen from an average of 769 accesses per day in 2006 to an average of 2,554 accesses per day in 2011.

XVI. MAJOR ACCOMPLISHMENTS

1883	Minnesota legislature creates Board of Medical Examiners.
1925	Board member Thomas McDavit, MD serves as Chair of the Federation of State Medical Boards (FSMB).
1942	Board member Julian DuBois, MD serves as Chair of the FSMB.
1974	Board member Howard Horns, MD serves as Chair of the FSMB.
1985	Board legislatively revises the Minnesota Medical Practice Act to add more enforcement authority to ensure standards of practice and public protection.
1986	Board member William Jacott, MD serves as Chair of the FSMB.
1987	Minnesota legislature gives the board regulatory authority over physician assistants.
1990	Board conducts series of educational seminars for physicians throughout the state on Controlled Substance Prescribing.
1991	The board's name was changed from the Board of Medical Examiners to the Board of Medical Practice.
1991	Minnesota legislature gives the board regulatory authority over respiratory care practitioners.
1992	Board forms Task Force on Physician Sexual Misconduct for recommendations on dealing with the issue of physician sexual misconduct with patients.
1992	Board member Melvin Sigel, MD serves as Chair of the FSMB.
1993	Board ceases administering examination for licensure
1993	Minnesota legislature gives the board regulatory authority over athletic trainers.
1994	Board conducts series of educational seminars for physicians throughout the State on Boundaries and Communication with Patients.
1995	Minnesota legislature gives the board regulatory authority over acupuncturists.
1995	Board of Medical Practice and 5 other health licensing boards create the Health Professional Services Program, a confidential, non disciplinary monitoring program for impaired health professionals.
1995	Health Licensing Boards informally create the Administrative Services Unit to create efficiencies and economy in the provision of administrative services to all the health licensing boards.
1997	Board forms a task force on Physician Impairment for recommendations on physician impairment issues.
1999	Minnesota legislature gives the board regulatory authority over traditional midwives.

2001	Board begins work on Automated Licensure Information Management System (ALIMS).
2001	Board conducts series of seminars for physicians throughout the State on Pain Management.
2002	Board forms Task Force on Physician Profiling to design form for physician profiling once ALIMS completed.
2004	Boards of Medical Practice, Nursing and Pharmacy issue Joint Statement on Controlled Substance Prescribing.
2004	Board member Doris Brooker, MD serves as Chair of the FSMB.
2005	ALIMS implemented. Fifty-five percent credentials renewed on line.
2007	Board forms Task Force on Continuing Competency and Maintenance of Licensure for recommendations on how the board can best assure the public that physicians are doing appropriate educational and clinical activities to maintain competency.
2008	Minnesota legislature gives the board regulatory authority over naturopathic doctors.
2010	Board conducts series of educational seminars for physicians throughout the state on Use of Controlled Substances in the Treatment of Chronic Pain.
2011	Health licensing boards' Administrative Services Unit formalized in statute
2011	ALIMS on line renewal exceeds 94%.

AWARDS FOR REGULATORY ACCOMPLISHMENTS

2000	Certificate of Commendation Semi-Finalist Cooperative Public Service Award: Presented by Governor Jesse Ventura.
2002	Administrators in Medicine (National Organization of Medical Board Executives) Best of Boards Award for Minnesota Board of Medical Practice use of task forces.
2005	Office of Enterprise Technology's Customer Service Award for Minnesota Board of Medical Practice's Automated Licensure Information Management System.
2006	Administrators in Medicine Best of Boards Award for Minnesota Board of Medical Practice's Automated Licensure Information Management System.
2000, 2004, and 2008	Minnesota Board of Medical Practice's Executive Director named one of Minnesota's top one-hundred Influential Health Care Leaders by Minnesota Physician Publication.

XVII. EXECUTIVE SUMMARY

The Minnesota Board of Medical Practice is statutorily charged with the protection of the public through the regulation of physicians and five other allied health professions. It is the board's responsibility to ensure that only qualified practitioners are granted a credential to practice and that anyone holding a credential to practice continues to practice with reasonable skill and safety to patients. The Minnesota Board of Medical Practice issues over 2,500 new credentials annually and regulates over 25,000 physicians and other allied health care professionals. The board's Complaint Review Unit processes approximately 800 complaints each year and the board issues an average of over 87 disciplinary and corrective actions annually.

The operations of the Board of Medical Practice are funded entirely by the fees collected from its regulated health care professionals. It is important to note that the board receives no general fund appropriations and has not raised fees in over 10 years. The fees collected by the board are sufficient to sustain the board's operations as well as to support a number of state health related initiatives created by the legislature and the board including the Volunteer Health Care Provider Program, the Health Professionals Services Program, the Department of Heath's HIV/HBV Monitoring Program and the Prescription Monitoring Program administered by the Board of Pharmacy.

The board staffing level has remained at 23 FTE for over 6 years despite the increasing numbers of new applications and the number of regulated professionals growing annually. The board has been able to maintain this staffing level primarily through the efficiencies it created with the development of its Automated Licensure Information Management System (ALIMS) which allows for credentials to be renewed annually on-line as well as for credential verifications by health care facilities and the public to also be accomplished on-line. Currently, over 94% of annual credential renewals are accomplished on line. ALIMS also incorporates a Physician Profile which allows the public access to physician qualification information and logistical data enhancing the public's ability to make informed health care decisions. The board's Automated Licensure Information Management System was presented with the Minnesota Office of Enterprise Technology's Customer Service Award at OET's Information Technology Symposium in 2005. ALIMS also won the Best of Boards Award from the national organization of medical board executive's organization, Administrators in Medicine at the organization's annual meeting in Boston, Massachusetts in 2006.

The eleven physicians and five public members who make up the board are all highly qualified and motivated professionals, resolute in their role of protecting the citizens of Minnesota from the unqualified and unprofessional practice of medicine. These individuals, who basically volunteer their time to the board's mission, assume their role in public protection and the enhancement of Minnesota's health care environment with utmost dedication. In addition to their work on behalf of the citizens of the state, many past and current board members have taken on the additional responsibility of representing the state of Minnesota on the national stage in service to the Federation of State Medical Boards on Federation committees as well as on the Board of Directors of the Federation. Only the

Texas medical board has had as many board members assume the Chair of this national organization. If the board's current candidate, Jon Thomas, MD wins the chair-elect seat at the House of Delegates election in April 2012, which is almost certain, Minnesota will take the lead in that regard.

The Minnesota Board of Medical Practice is confident that the Minnesota Sunset Commission will recognize the vital role of the board in ensuring public protection as well as the enhancement of the health care environment in our state. As the Executive Director of the board, I and my staff have found this sunset process to be a rewarding opportunity for reflection on our mission to protect the public, the work we have done in the past to achieve that mission in support of the board and, finally, as a foundation for what we may accomplish in the future.

Thank you for your consideration.

Robert A. Leach, JD
Executive Director
Minnesota Board of Medical Practice