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.

AGENDA FOR
THE MINNESOTA BOARD OF MEDICAL PRACTICE
BOARD MEETING
JANUARY 11, 2025, 9:00 AM

THE BOARD WILL MEET IN PERSON AT:
335 RANDOLPH AVENUE
BOARD ROOM 104
SAINT PAUL, MN 55102
AND ELECTRONICALLY BY WEBEX:
Go To: https://minnesota.webex.com/minnesota/j.php?MTID=m531de42d76cf42e1b8a9fa44c2d32716
Meeting Number (access code): 2485 721 0626
Meeting Password: Csxj6JPRh47

Join by Phone
Tap to call in from a mobile device (attendees only)
+1-415-655-0003 United States Toll
1-855-282-6330 United States Toll Free

Join from a video system or application
Dial 24857210626@minnesota.webex.com
You can also dial 173.243.2.68 and enter your meeting number.

Need Help? Go to http://help.webex.com

President: Pamela Gigi Chawla, M.D.

1. Call to Order & Roll Call
2. Announcements & Introduction of Board Officers
3. Approve
   a) Minutes of the November 9, 2024, Board Meeting
   b) January 11, 2025, Board Agenda
4. 2025 Board Committee Assignments
5. Report of New Credentials, November 2, 2024 through January 3, 2025
6. Policy & Planning Committee: Updates and Motions from October 14 and November 25, 2024 and January 6, 2025
   a) October 14, 2024, Agenda and Final Minutes
      i) submitted on behalf of the Board on December 2, 2024
   b) November 25, 2024, Agenda and Final Minutes
   c) January 6, 2025, Agenda
      i) ACGME Common Program Requirements (Residency) (Not Included in Committee Meeting Materials)
7. Campaign Finance & Public Disclosure Form Completion Requirement
8. Health Related Licensing Boards Biennial Report 2024
9. Federation of State Medical Boards Update
   a) Annual Meeting: April 24 – 26, 2025, Seattle, WA
   b) FSMB Annual Meeting Voting Delegate
   c) Call for Resolutions: Due by February 21, 2025
10. United States Medical Licensing Examination (USMLE) Reports
    a) 2024 Annual Report
    b) 2024 USMLE Primer for State Boards
11. Executive Director's Report
12. New Business
13. Corrective or Other Actions

Executive Session – Closed to Public

A) Review Proposed Disciplinary Actions
B) Board Member Training

Minnesota Board of Medical Practice

ROLL CALL
JANUARY 11, 2025
BOARD MEETING

NAME	CONGRESSIONAL DISTRICT	APPOINTMENT FROM	TO
CHAWLA, Pamela Gigi, M.D., M.H.A. (**President)**	5	06/29/20	1/28
ANAND, Chaitanya, M.B.B.S. **(Vice President)**	2	03/03/21	1/27
THULLNER, Karen, M.F.A. **(Secretary)**	4	06/22/22	1/26
ANDERSON, Bruce	6	03/14/23	1/27
BAILEY, Cheryl L., M.D.	4	09/19/18	1/25
CARTER, Sarah, M.D.	6	06/19/24	1/28
EMIRU, Tenbit, M.D., Ph.D., M.B.A.	At Large	03/03/21	1/25
HENRY, Peter, M.D.	8	06/22/22	1/26
KROHN, Kristina, M., M.D.	At Large	06/22/22	1/26
MANAHAN, John M. (Jake), J.D.	3	09/19/18	1/26
PAZDERNIK, Julie A., M.D.	7	09/25/24	1/29
RASMUSSEN, Allen, M.A.	8	06/19/24	1/28
SUTOR, Bruce, M.D.	1	06/22/22	1/25
TURNER, Averi M.	5	06/22/22	1/26
WILLETT, Jane, D.O.	7	03/14/23	1/26
ZACHARY, Cherie Y., M.D., ABAI	3	01/05/21	1/25

DATE: January 11, 2025 SUBJECT: Announcement & Introduction of Board Officers

SUBMITTED BY: **Pamela Gigi Chawla, M.D., M.H.A. Board President**

REQUEST FOR BOARD ACTION
MINNESOTA BOARD OF MEDICAL PRACTICE

REQUESTED ACTION:

For Information Only

MOTION BY: SECOND:

( ) PASSED ( ) PASSED AMENDED ( ) LAYED OVER ( ) DEFEATED

BACKGROUND:

President: **Pamela Gigi Chawla, M.D., M.H.A.**

Vice President: **Chaitanya Anand, M.B.B.S.**

Secretary: **Karen Thullner, M.F.A.**

DATE: January 11, 2025 SUBJECT: Approve the Minutes of the November 9, 2024, Board Meeting

SUBMITTED BY: **Pamela Gigi Chawla, M.D., M.H.A. Board President**

REQUEST FOR BOARD ACTION
MINNESOTA BOARD OF MEDICAL PRACTICE

REQUESTED ACTION:

Approve the minutes of the November 9, 2024, Board Meeting as Circulated

MOTION BY: SECOND:

( ) PASSED ( ) PASSED AMENDED ( ) LAYED OVER ( ) DEFEATED

BACKGROUND:

See Attached Minutes

Minnesota Board of Medical Practice
Board Meeting
In Person and Via WebEx
335 Randolph Avenue, Suite 140
St. Paul, MN 55102
November 9, 2024 * 9:00 a.m.

The Minnesota Board of Medical Practice met in person and via Webex at 335 Randolph Avenue, Board Room 104, St. Paul, MN, 55102, on November 9, 2024. The public portion of the meeting was accessible to public attendees both in-person and via WebEx.

The following Board members were present for both Public and Executive Sessions, unless otherwise indicated: Cheryl Bailey, M.D., (President); Pamela Gigi Chawla, M.D., M.H.A., (Vice President); Tenbit Emiru, M.D., Ph.D., M.B.A., (Secretary) Chaitanya Anand, M.B.B.S.; Bruce Anderson; Sarah Carter, M.D.; Kristina Krohn, M.D.; John M. (Jake) Manahan, J.D.; Julie Pazdernik, M.D.; Allen Rasmussen, M.A.; Bruce Sutor, M.D.; Karen Thullner, M.F.A.; Averi Turner; Jane Willett, D.O., and Cherie Zachary, M.D., ABAI.

Peter Henry. M.D. was absent from both the Public and Executive Sessions.

Public Session

Agenda Item 1: Call to Order and Roll Call

The meeting was called to order by Board President, Cheryl Bailey, M.D.

Unanimous votes will be recorded as unanimous consent and will document all members present. If the vote is not unanimous, a roll call vote will be taken and recorded.

Dr. Bailey conducted a roll call and asked each Board Member to introduce themselves.

Board member, Peter Henry, M.D., was absent from roll call.

Agenda Item 2:

A) Approve the Minutes of the September 14, 2024, Board Meeting

A motion to approve the minutes from the September 14, 2024, Board meeting was made, a second to the motion was offered and the motion was passed with unanimous consent by the following Board members:

Cheryl Bailey, M.D., (President); Pamela Gigi Chawla, M.D., M.H.A., (Vice President); Tenbit Emiru, M.D., Ph.D., M.B.A., (Secretary) Chaitanya Anand, M.B.B.S.; Bruce Anderson; Sarah Carter, M.D.; Kristina Krohn, M.D.; John M. (Jake) Manahan, J.D.; Julie Pazdernik, M.D.; Allen Rasmussen, M.A.; Bruce Sutor, M.D.; Karen Thullner, M.F.A.; Averi Turner; Jane Willett, D.O., and Cherie Zachary, M.D., ABAI.

B) Approve the November 9, 2024, Board Agenda

A motion to approve the agenda for the November 9, 2024, Board meeting was made, a second to the motion was offered and the motion was passed with unanimous consent by the following Board members:

Cheryl Bailey, M.D., (President); Pamela Gigi Chawla, M.D., M.H.A., (Vice President); Tenbit Emiru, M.D., Ph.D., M.B.A., (Secretary) Chaitanya Anand, M.B.B.S.; Bruce Anderson; Sarah Carter, M.D.; Kristina Krohn, M.D.; John M. (Jake) Manahan, J.D.; Julie Pazdernik, M.D.; Allen Rasmussen, M.A.; Bruce Sutor, M.D.; Karen Thullner, M.F.A.; Averi Turner; Jane Willett, D.O., and Cherie Zachary, M.D., ABAI.

Agenda Item 3: Introduction of new Board member, Julie Pazdernik, M.D.

Dr. Bailey welcomed Dr. Julie Pazdernik. Dr. Pazdernik was appointed as a physician member to the Board, effective September 25, 2024. Dr. Pazdernik represents Minnesota's 7th Congressional District and replaces Cybill Oragwu, M.D., who resigned her seat when she relocated to another state.

Agenda Item 4: Presentation by Rick Hodsdon, JD, Legal Counsel for the Minnesota Sheriffs Association, on Extreme Risk Protection Orders

Dr. Bailey introduced Rick Hodsdon, JD, Legal Counsel for the Minnesota Sheriff's Association, and thanked him for presenting to the Board on Extreme Risk Protection Orders.

Mr. Hodsdon has been General Counsel of the Minnesota Sheriff's Association since 1987. Mr. Hodsdon spent over 33 years as an Assistant County Attorney in the Washington County Attorney's Office, a year in private practice doing civil rights defense work, and eight years with the Minnesota Attorney General's Office.

Following the presentation, Mr. Hodsdon answered several questions asked by Board members regarding Extreme Risk Protection Orders.

Mr. Hodsdon thanked the Board for their time and engagement on the topic of Extreme Rick Protection Orders and agreed to share with Board members the PowerPoint presentation he uses to train law enforcement and attorneys. Eden Young will coordinate the sharing of that presentation.

Agenda Item 5: Report of New Credentials, September 2, 2024, to November 1, 2024

An informational report was included in the Board Agenda of licenses issued between September 2, 2024, and November 1, 2024. Dr. Bailey noted 542 new credentials were issued during this time and both Drs. Bailey and Zachary acknowledged the incredible work of the Board's licensure staff.

Agenda Item 6: Federation of State Medical Board News

Coalition for Physician Accountability – Mr. Manahan was nominated by the Federation of State Medical Boards (FSMB) to become a public member of the Coalition for Physician Accountability. Mr. Manahan shared with Board members what the Coalition's mission is and described the forum that is used allowing the "House of Medicine" to meet twice a year to collaborate and share their experience from various perspectives.

Leadership Positions - Ms. Huntley encouraged Board members who are interested in or curious about leadership positions with the Federation of State Medical Boards to submit their application by the deadline of December 15, 2024.

Agenda Item 7: Interstate Medical Licensure Compact (IMLC Reports)

Ms. Huntley shared that the Interstate Medical Licensure Compact Reports included in the agenda are for informational purposes only. It was noted that in 2023, 27% of physician licenses issued in Minnesota were through the IMLC pathway.

Agenda Item 8: Policy & Planning Committee Report: October 14, 2024, and Motion

Dr. Krohn shared her Policy & Planning Committee Report.

Dr. Krohn informed the Board that the Minnesota Academy of Physician Assistants ("MAPA") presented proposed language changes to Minn. Stat. §147A.02(c), recognizing the required 2080 hours of post-graduate training can be done outside of Minnesota. MAPA will present this legislative change to the Board on January 11, 2025, and the Committee's motion will be presented at that meeting as well.

Dr. Krohn walked through each of the nine recommendations from the Advisory Commission on Additional Licensing Models through the FSMB and offered insight and feedback for each recommendation. Several Board members had questions and additional feedback, in particular regarding what, if any role, the Board would have in making equivalency determinations.

Dr. Krohn moved the Committee's motion that the Board support submission of public commentary based on the draft comments that were provided in the agenda. If any Board members have additional feedback they would like to add, to please e-mail those thoughts or ideas to Dr. Krohn who will work with Dr. Bailey and Ms. Huntley to include the additional comments in the public comment that will be submitted on behalf of the Board.

The motion passed with unanimous consent by the following Board Members:

Cheryl Bailey, M.D., (President); Pamela Gigi Chawla, M.D., M.H.A., (Vice President); Tenbit Emiru, M.D., Ph.D., M.B.A., (Secretary) Chaitanya Anand, M.B.B.S.; Bruce Anderson; Sarah Carter, M.D.; Kristina Krohn, M.D.; John M. (Jake) Manahan, J.D.; Julie Pazdernik, M.D.; Allen Rasmussen, M.A.; Bruce Sutor, M.D.; Karen Thullner, M.F.A.; Averi Turner; Jane Willett, D.O., and Cherie Zachary, M.D., ABAI.

Agenda Item 9: Election of Board Officers for Calendar Year 2025

The Nominating Committee of Cheryl Bailey, M.D., Bruce Sutor, M.D., Averi Turner, and Jane Willett, D.O., met on October 21, 2024, and moves the following slate of candidates for elected office for 2025:

- President: Pamela Gigi Chawla, M.D., M.H.A.
- Vice President: Chaitanya Anand, M.B.B.S.
- Secretary: Karen Thullner, M.F.A.

The motion passed with unanimous consent to nominate Dr. Chawla as the Board's President for 2025 by the following Board Members:

Cheryl Bailey, M.D., (President); Tenbit Emiru, M.D., Ph.D., M.B.A., (Secretary) Chaitanya Anand, M.B.B.S.; Bruce Anderson; Sarah Carter, M.D.; Kristina Krohn, M.D.; John M. (Jake) Manahan, J.D.; Julie Pazdernik, M.D.; Allen Rasmussen, M.A.; Bruce Sutor, M.D.; Karen Thullner, M.F.A.; Averi Turner; Jane Willett, D.O., and Cherie Zachary, M.D., ABAI.

The motion passed with unanimous consent to nominate Dr. Anand as the Board's Vice President for 2025 by the following Board Members:

Cheryl Bailey, M.D., (President); Pamela Gigi Chawla, M.D., M.H.A., (Vice President); Tenbit Emiru, M.D., Ph.D., M.B.A., (Secretary); Bruce Anderson; Sarah Carter, M.D.; Kristina Krohn, M.D.; John M. (Jake) Manahan, J.D.; Julie Pazdernik, M.D.; Allen Rasmussen, M.A.; Bruce Sutor, M.D.; Karen Thullner, M.F.A.; Averi Turner; Jane Willett, D.O., and Cherie Zachary, M.D., ABAI.

The motion passed with unanimous consent to nominate Ms. Thullner as the Board's Secretary for 2025 by the following Board Members:

Cheryl Bailey, M.D., (President); Pamela Gigi Chawla, M.D., M.H.A., (Vice President); Tenbit Emiru, M.D., Ph.D., M.B.A., (Secretary) Chaitanya Anand, M.B.B.S.; Bruce Anderson; Sarah Carter, M.D.; Kristina Krohn, M.D.; John M. (Jake) Manahan, J.D.; Julie Pazdernik, M.D.; Allen Rasmussen, M.A.; Bruce Sutor, M.D.; Averi Turner; Jane Willett, D.O., and Cherie Zachary, M.D., ABAI.

Agenda Item 10: Campaign Finance & Public Disclosure Form Completion Requirement

Board members are required to complete a Campaign Finance and Public Disclosure form online between January 1 and January 31, 2025. Board members will receive a notice from the Campaign Finance and Public Disclosure Board prior to January 2025. Failure to complete the form could result in a fine.

Agenda Item 11: President's Report

Dr. Bailey presented her President's Report.

Dr. Bailey thanked Kathryn Van Etta-Olson and MNIT staff for their work on the new Board of Medical Practice website. Dr. Bailey also suggested that Board members should consider creating a blog or e-mail blast that can be sent to all licenses with information on what the Board is doing, what the Board's role is, what other professions the Board licenses and what those health-care providers do in their professions, to name a few.

Dr. Willett thanked Dr. Bailey for role as President of the Board of Medical Practice.

Agenda Item 12: Executive Director's Report

Ms. Huntley also thanked Dr. Bailey for her service as Board President. Ms. Huntley thanked Dr. Krohn for her leadership and efforts on the Policy & Planning Committee.

Ms. Huntley presented her Executive Director's Report.

Legislative Updates – Ms. Huntley is working with the revisor's office on a bill to do some technical and grammatical cleanup throughout the medical practice act as well as the various practice acts for the allied professions under the Board's regulation.

Federation of State Medical Boards (FSMB) – Ms. Huntley recently completed the annual Federation of State Medical Boards Survey. It's a very comprehensive survey that asks about a variety of things, everything from policy and operational challenges to the role of consultants or peer reviewers. Other topics included authority when considering an application from someone who has had misconduct on a medical licensing exam to how reentry for the practice of medicine Is considered.

Ms. Huntley, Kathryn Van Etta-Olson, and Erin Dupey the Board Attorney Workshop sponsored by the FSMB that was held in Reno, Nevada. Ms. Huntley was once again on the Planning Committee for the Workshop.

Ms. Huntley and Kim Navarre, Program Director for the Health Professionals Services Program (HPSP), were on a panel presenting about the relationships that medical boards have with their Physician Health Programs. Ms. Huntley and Ms. Navarre were joined on the panel by their colleagues from Texas and North Carolina.

Previously, Ms. Huntley mentioned a three-part module that the FSMB launched this fall for new Board member training. The sessions were held in August, September, and October. The goal of the program was to help new members to medical boards gain a better understanding of the landscape of medical regulation and the crucial role of medical board members. Ms. Huntley was on faculty for the first module presenting on the history of medical regulation, and as previously mentioned, the FSMB is continuing to explore avenues to have those modules more available to people who were not able to attend the sessions.

Interstate Medical Licensure Compact (IMLC) –

The annual commissioner meeting is being held November 18 – 19 in Scottsdale, Arizona. Ms. Huntley and Mr. Manahan will be attending that meeting. Mr. Manahan is currently the Vice-Chair of the IMLCC, and one of the agenda items at the meeting is to elect new officers. Mr. Manahan is being considered for the Chair of the IMLCC.

Ms. Huntley will stay in Scottsdale to attend the Administrators in Medicine (AIM) conference. AIM is the national organization of state medical and osteopathic board executives.

Other Business –

In collaboration with HPSP, Dr. Sutor and the Mayo School of Medicine, Ms. Huntley will be presenting to the fourth-year medical students at the Mayo School of Medicine in February. This presentation will be similar, but in a different format, to the one given to the students at the University of Minnesota earlier this year.

There will be a few changes in Board Committees. Mr. Rasmussen has joined a Complaint Review Committee and Mr. Manahan will be joining the Policy & Planning Committee. Starting in January, Dr. Bailey will join the Licensure Committee and Dr. Sutor will be joining a Complaint Review Committee.

Ms. Huntley concluded her Executive Director's Report and opened the floor for questions from Board members.

Agenda Item 13: Establish 2025 Board Meeting & Contested Case Dates

REGULAR BOARD MEETINGS

January 11
March 8
May 10
July 12
September 13

November 8

CONTESTED CASE/HEARING DATES (reserved)

February 8
April 12
June 14
August 9
October 11
December 13

A motion to approve the 2025 Board Meeting & Contested Case/Hearing dates was made, a second to the motion was offered and the motion was passed with unanimous consent by the following Board members:

Cheryl Bailey, M.D., (President); Pamela Gigi Chawla, M.D., M.H.A., (Vice President); Tenbit Emiru, M.D., Ph.D., M.B.A., (Secretary) Chaitanya Anand, M.B.B.S.; Bruce Anderson; Sarah Carter, M.D.; Kristina Krohn, M.D.; John M. (Jake) Manahan, J.D.; Julie Pazdernik, M.D.; Allen Rasmussen, M.A.; Bruce Sutor, M.D.; Karen Thullner, M.F.A.; Averi Turner; Jane Willett, D.O., and Cherie Zachary, M.D., ABAI.

Agenda Item 14: New Business

Ms. Huntley asked if Board members have suggestions for educational sessions at future Board meetings to please e-mail her those ideas.

No other new business was discussed.

Agenda Item 15: Corrective or Other Actions

Corrective and other actions since the last Board meeting were presented for Board Information only.

Mr. Manahan adjourned the public session.

The Board will reconvene in a closed session to consider proposed disciplinary actions.

The following Board members were present for the Executive Session, unless otherwise indicated.

Cheryl Bailey, M.D., (President); Pamela Gigi Chawla, M.D., M.H.A., (Vice President); Tenbit Emiru, M.D., Ph.D., M.B.A., (Secretary) Chaitanya Anand, M.B.B.S.; Bruce Anderson; Sarah Carter, M.D.; Kristina Krohn, M.D.; John M. (Jake) Manahan, J.D.; Julie Pazdernik, M.D.; Allen Rasmussen, M.A.; Bruce Sutor, M.D.; Karen Thullner, M.F.A.; Averi Turner; Jane Willett, D.O., and Cherie Zachary, M.D., ABAI.

Peter Henry. M.D. was absent from the Executive Sessions.

Lian S. Chang, M.D.:

On recommendation of the Complaint Review Committee, the Board approved the Order of Unconditional License. Ms. Turner opposed.

La Tania M. Akers-White, M.D.:

On recommendation of the Complaint Review Committee, the Board approved the Stipulation and Order for Voluntary Surrender signed by Dr. Akers-White.

Merlin E. Brown, M.D.:

On recommendation of the Complaint Review Committee, the Board approved the Order of Unconditional License.

Neeraj B. Chepuri, M.D.:

On recommendation of the Complaint Review Committee, the Board approved the Stipulation and Order for Voluntary Surrender signed by Dr. Chepuri. Dr. Chawla recused.

Evan M. Dewald, A.T.:

On recommendation of the Complaint Review Committee, the Board approved the Stipulation and Order for reprimand and a civil penalty signed by Mr. Dewald.

Milind S. Gadgil, M.D.:

On recommendation of the Complaint Review Committee, the Board approved the Stipulation and Order for Voluntary Surrender signed by Dr. Gadgil.

Aisha Z. Rush, M.D.:

On recommendation of the Complaint Review Committee, the Board approved the Order of Unconditional License. Ms. Turned opposed.

Jay E.L. Sather, M.D.:

On recommendation of the Complaint Review Committee, the Board approved the Order of Unconditional License. Dr. Willett opposed.

Heather J. Sieben Bell, M.D.:

On recommendation of the Complaint Review Committee, the Board approved the Order of Unconditional License. Dr. Carter recused.

Daniel A.P. Smith, M.D.:

On recommendation of the Complaint Review Committee, the Board approved the Stipulation and Order for Voluntary Surrender signed by Dr. Smith. Dr. Sutor recused.

Tenbit Emiru, M.D., Ph.D., M.B.
Secretary
Minnesota Board of Medical Practice

Date: 01/06/2025

DATE: January 11, 2025 SUBJECT: Approve the January 11, 2025, Board Agenda

SUBMITTED BY: **Pamela Gigi Chawla, M.D., M.H.A. Board President**

REQUEST FOR BOARD ACTION
MINNESOTA BOARD OF MEDICAL PRACTICE

REQUESTED ACTION:

Approve the Agenda of the January 11, 2025, Board Meeting

MOTION BY: SECOND:

( ) PASSED ( ) PASSED AMENDED ( ) LAYED OVER ( ) DEFEATED

BACKGROUND:

See Attached Minutes

DATE: January 11, 2025 SUBJECT: 2025 Board Committee Assignments

SUBMITTED BY: **Pamela Gigi Chawla, M.D., M.H.A. Board President**

REQUEST FOR BOARD ACTION
MINNESOTA BOARD OF MEDICAL PRACTICE

REQUESTED ACTION:

For Information Only

MOTION BY: SECOND:

( ) PASSED ( ) PASSED AMENDED ( ) LAYED OVER ( ) DEFEATED

BACKGROUND:

Listed below are the 2025 Committee Assignments:

CRC #1
Dr. Pamela Gigi Chawla (Chair)
Dr. Chaitanya Anand
Mr. Rasmussen

CRC #2
Dr. Peter Henry (Chair)
Dr. Bruce Sutor
Ms. Thullner

Licensure Committee
Dr. Cherie Zachary (Chair)
Mr. Bruce Anderson
Dr. Cheryl Bailey
Dr. Sarah Carter
Dr. Tenbit Emiru

Policy & Planning Committee
Dr. Kristina Krohn (Chair)
Mr. John (Jake) Manahan
Dr. Julie Pazdernik
Miss Averi Turner
Dr. Jane Willett

DATE: January 11, 2025 SUBJECT: Report of New Credentials

SUBMITTED BY: **Licensure Committee**

REQUEST FOR BOARD ACTION
MINNESOTA BOARD OF MEDICAL PRACTICE

REQUESTED ACTION:

For Informational Purposes Only

MOTION BY: SECOND:

( ) PASSED ( ) PASSED AMENDED ( ) LAYED OVER ( ) DEFEATED

BACKGROUND:

Attached are the listings of new credentials issued from November 2, 2024, to January 3, 2025.

Board of Medical Practice

New Licensee List - 11/02/2024 to 01/03/2025

License Type	Count
Acupuncturist	9
Athletic Trainer	8
Genetic Counselor	10
Naturopathic Doctor	1
Physician and Surgeon	146
Physician and Surgeon - IMLC	173
Physician Assistant	40
Respiratory Therapist	8
Telemedicine	11
Traditional Midwife	1
TOTAL	**407**

License Type	Name	License Number	Grant Date	Expire Date
Acupuncturist	Anderson, Claire Terese	2096	11/26/2024	11/30/2025
Acupuncturist	Bergquist, Hannah Christine	2098	12/10/2024	05/31/2026
Acupuncturist	Dunaisky, Emily Anne	2094	11/21/2024	04/30/2026
Acupuncturist	Goldammer, Lindsey Dawn	1632	11/21/2024	07/31/2025
Acupuncturist	Kessler, Abbey Marie	2099	12/13/2024	06/30/2025
Acupuncturist	Krohn, Nathan Phillip	2097	12/05/2024	12/31/2025
Acupuncturist	Overby, Jacquelyn Danielle	2095	11/26/2024	04/30/2026
Acupuncturist	Peiffer, Aniela Muriel	2100	12/20/2024	10/31/2025
Acupuncturist	Thao, Bhao Nhiang	2101	12/20/2024	08/31/2025
Athletic Trainer	Gray, Caitlin Elaine	3842	12/03/2024	06/30/2025
Athletic Trainer	Grunke, Christopher Elliot	3844	12/09/2024	06/30/2025
Athletic Trainer	Hobson, Matthew Allen	3840	11/06/2024	06/30/2025
Athletic Trainer	Latronica, Alexi M	3847	12/16/2024	06/30/2025
Athletic Trainer	Nix , Abigail Josephine	3843	12/03/2024	06/30/2025
Athletic Trainer	Ortiz, Stacey Lynn	3841	11/20/2024	06/30/2025
Athletic Trainer	Palmer, Elisabeth Margaret	3846	12/13/2024	06/30/2025
Athletic Trainer	Willeford, Kristin Marie	3845	12/13/2024	06/30/2025
Genetic Counselor	Bailey, Samuel Stephen	1694	12/03/2024	05/31/2026
Genetic Counselor	Chen, Anthony Alvin	1693	11/21/2024	12/31/2025
Genetic Counselor	Hanauer, Kathlyn Watson	1696	12/18/2024	11/30/2025
Genetic Counselor	Huismann, Darcy Jane-O'Rourke	1698	12/30/2024	04/30/2026
Genetic Counselor	Makaram, Aditi Ramanujan	1690	11/15/2024	07/31/2025
Genetic Counselor	Palaia, Cedar Lee	1691	11/19/2024	12/31/2025
Genetic Counselor	Shrewsbery, Kathryn Terese	1697	12/20/2024	01/31/2026
Genetic Counselor	Thies, Jenny Marie	1689	11/07/2024	12/31/2025
Genetic Counselor	Williams, Sabrina Renee	1692	11/19/2024	11/30/2025
Genetic Counselor	Young, Kristen Elizabeth	1695	12/13/2024	06/30/2025
Naturopathic Doctor	Vechini Miranda, Jessica	1151	11/15/2024	04/30/2026
Physician and Surgeon	Abdel-Karim, Tasneem Riyad B.M., B.S.	78432	11/14/2024	10/31/2025
Physician and Surgeon	Acosta, Jonathan Ryan M.D.	78665	12/30/2024	06/30/2025
Physician and Surgeon	Acosta, Michael Anthony M.D.	78655	12/26/2024	08/31/2025
Physician and Surgeon	Aders, Graig Alan M.D.	78498	11/26/2024	12/31/2025
Physician and Surgeon	Adhami, Faisal M.D.	78602	12/13/2024	04/30/2026
Physician and Surgeon	Affeldt, Zachary Stephen M.D.	78509	11/27/2024	08/31/2025
Physician and Surgeon	Ahmed, Alwiya Mukhtar M.D.	78619	12/18/2024	12/31/2025
Physician and Surgeon	Aispur, Carlos Eduardo D.O.	78603	12/13/2024	10/31/2025
Physician and Surgeon	Alrifai, Nada Mahmoud Sha'Ban M.D.	78504	11/26/2024	11/30/2025
Physician and Surgeon	Arce Espasas, Julian Pablo M.D.	78467	11/20/2024	03/31/2026
Physician and Surgeon	Asatryan, Babken M.D.	78575	12/10/2024	06/30/2025
Physician and Surgeon	Azeez, Abiodun Luqman M.B., B.S.	78446	11/15/2024	11/30/2025
Physician and Surgeon	Bach, Sarah Elizabeth M.D.	78604	12/13/2024	04/30/2026
Physician and Surgeon	Berry, Todd Matthew M.D.	78531	12/03/2024	10/31/2025
Physician and Surgeon	Bhunia, Kaushik B.M., B.S.	78417	11/12/2024	11/30/2025
Physician and Surgeon	Blaskowsky, Justin Ross D.O.	78652	12/24/2024	09/30/2025
Physician and Surgeon	Briseno Kenney, Lara Anne M.D.	78549	12/05/2024	06/30/2025
Physician and Surgeon	Britton, Elisabeth Marie M.D.	78621	12/19/2024	11/30/2025
Physician and Surgeon	Brower, Charles Higgins M.D.	78641	12/23/2024	07/31/2025
Physician and Surgeon	Brucker, Jason Jeffrey M.D.	78572	12/10/2024	04/30/2026
Physician and Surgeon	Brusko, Gregory D.O.	78408	11/07/2024	01/31/2026
Physician and Surgeon	Carter, Alexandra Lewis M.D.	78402	11/06/2024	01/31/2026
Physician and Surgeon	Chang, Jonathan Chun-Hsiang M.D.	78680	12/31/2024	06/30/2025
Physician and Surgeon	Christensen, Diana Marie M.D.	78606	12/16/2024	12/31/2025
Physician and Surgeon	Clabbers, Kim Marie M.D.	78499	11/26/2024	07/31/2025
Physician and Surgeon	COHEN, INBAL M.D.	78529	12/03/2024	03/31/2026
Physician and Surgeon	Colef, Robert Gabriel D.O.	78550	12/06/2024	08/31/2025
Physician and Surgeon	Dajani, Salah Dean M.D.	78500	11/26/2024	12/31/2025
Physician and Surgeon	Das, John Anupam	78457	11/19/2024	11/30/2025
Physician and Surgeon	Das, John Anupam M.D.	78457	11/19/2024	11/30/2025
Physician and Surgeon	De Silva, Neelantha Menaka M.D.	78681	12/31/2024	10/31/2025
Physician and Surgeon	Deeb, Andrew-Paul M.D.	78659	12/27/2024	12/31/2025
Physician and Surgeon	Dickson, Nicholas Alexander D.O.	78422	11/12/2024	09/30/2025

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Physician and Surgeon	Dunning, Richard Michael D.O.	78501	11/26/2024	12/31/2025
Physician and Surgeon	Duque Ramirez, Alejandra M.D.	78656	12/26/2024	10/31/2025
Physician and Surgeon	Eoff, Aundria Nichelle M.D.	78573	12/10/2024	12/31/2025
Physician and Surgeon	Esmaeili, Mansour M.D.	78403	11/06/2024	03/31/2026
Physician and Surgeon	Farhi, Shai Ben Shoshan M.D.	78657	12/26/2024	03/31/2026
Physician and Surgeon	Fernandez, Edgar Serge M.D.	78562	12/09/2024	06/30/2025
Physician and Surgeon	Finke, Michael Thomas D.O.	78563	12/09/2024	12/31/2025
Physician and Surgeon	Fogelson, Bernard Gerald M.D.	78445	11/15/2024	07/31/2025
Physician and Surgeon	Frimpong, Kwame Bediako M.B., Ch.B.	78660	12/27/2024	12/31/2025
Physician and Surgeon	Gendreau, Julian Lassiter M.D.	78447	11/15/2024	12/31/2025
Physician and Surgeon	Glidden, Ian Thomas Peter M.D.	78510	11/27/2024	07/31/2025
Physician and Surgeon	Goder-Reiser, Max Nicholas M.D.	78418	11/12/2024	07/31/2025
Physician and Surgeon	Goodwin, Meredith Rumon M.D.	78526	12/02/2024	08/31/2025
Physician and Surgeon	Greenwell, Kathriena LoreAnna M.D.	78511	11/27/2024	11/30/2025
Physician and Surgeon	Hadden, William Jackson M.D.	78485	11/22/2024	03/31/2026
Physician and Surgeon	Hager, Kirsten Dlonra M.D.	78647	12/23/2024	02/28/2026
Physician and Surgeon	Harb, Christine Yasmine-Widad D.O.	78395	11/06/2024	03/31/2026
Physician and Surgeon	Hatch, Daniel Joe M.D.	78456	11/19/2024	07/31/2025
Physician and Surgeon	Hautala, Gavin Santini M.D.	78687	01/02/2025	12/31/2025
Physician and Surgeon	Hohle, Rae Dane M.D.	78688	01/02/2025	11/30/2025
Physician and Surgeon	Hoppe, Roberta Lynn M.D.	47516	11/22/2024	03/31/2026
Physician and Surgeon	Huang, Chi-Cheng M.D.	78448	11/18/2024	12/31/2025
Physician and Surgeon	Jensen, Donna Christine D.O.	78633	12/23/2024	04/30/2026
Physician and Surgeon	Jibril, Abdi Sufiyan	78682	12/31/2024	01/31/2026
Physician and Surgeon	Jibril, Abdi Sufiyan M.D.	78682	12/31/2024	01/31/2026
Physician and Surgeon	Kalra, Rishi D.O.	78468	11/20/2024	12/31/2025
Physician and Surgeon	Kennedy, Neil M.D.	78505	11/26/2024	10/31/2025
Physician and Surgeon	Khan, Mujtaba Ali M.B., B.S.	49167	12/23/2024	09/30/2025
Physician and Surgeon	Kilen, Christopher Lee D.O.	78594	12/13/2024	01/31/2026
Physician and Surgeon	Kirzeder, Daniel James M.D.	78470	11/20/2024	01/31/2026
Physician and Surgeon	Ko Ko, Nway Le B.M., B.S.	78406	11/07/2024	04/30/2026
Physician and Surgeon	Koo, Elliot Yuk-Gai M.D.	78441	11/15/2024	01/31/2026
Physician and Surgeon	Krebs, Erin Elizabeth M.D.	44453	12/11/2024	11/30/2025
Physician and Surgeon	Krinochkin, Olexandr Sergeyevich M.D.	78649	12/23/2024	01/31/2026
Physician and Surgeon	Kumka, Joseph E. M.D.	78658	12/26/2024	06/30/2025
Physician and Surgeon	Lager, Steven Andrew D.O.	78407	11/07/2024	03/31/2026
Physician and Surgeon	Lee, Junggu Joseph M.D.	78541	12/04/2024	05/31/2026
Physician and Surgeon	Lehman Wiens, Ruth Mary M.D.	78595	12/13/2024	12/31/2025
Physician and Surgeon	Lennon, Michael James M.D.	78442	11/15/2024	07/31/2025
Physician and Surgeon	Lewis, Wesley Luke D.O.	78449	11/18/2024	08/31/2025
Physician and Surgeon	Li, Darren Ye M.D.	78539	12/04/2024	04/30/2026
Physician and Surgeon	London, Sean Spencer M.D.	78622	12/19/2024	08/31/2025
Physician and Surgeon	Loud, Zachery Soren D.O.	78443	11/15/2024	12/31/2025
Physician and Surgeon	Loudas, Nicholas Basil M.D.	78623	12/19/2024	01/31/2026
Physician and Surgeon	Lussenhop, Carolyn Elaine M.D.	78444	11/15/2024	04/30/2026
Physician and Surgeon	Luu, Lydia An M.D.	78540	12/04/2024	04/30/2026
Physician and Surgeon	Madson, Joel Adam M.D.	78538	12/04/2024	09/30/2025
Physician and Surgeon	Makki, Kassem Michael D.O.	78469	11/20/2024	10/31/2025
Physician and Surgeon	Mamo, Theodros M.D.	78683	12/31/2024	12/31/2025
Physician and Surgeon	Marek, Tomas M.D.	78553	12/06/2024	01/31/2026
Physician and Surgeon	Massoll, Nicole Ann M.D.	78596	12/13/2024	01/31/2026
Physician and Surgeon	Meisenheimer, John M.D.	78421	11/12/2024	01/31/2026
Physician and Surgeon	Miller, Barrie Robyn Lois M.D.	78512	11/27/2024	12/31/2025
Physician and Surgeon	Mohammadzadeh, Gelareh M.D.	78632	12/23/2024	10/31/2025
Physician and Surgeon	Moring, Nikolas Alan M.D.	78634	12/23/2024	08/31/2025
Physician and Surgeon	Morrison, Zachary Tyler M.D.	78597	12/13/2024	10/31/2025
Physician and Surgeon	Mukherjee, Shubhra Shirley M.D.	78646	12/23/2024	03/31/2026
Physician and Surgeon	Mundt, Daniel Patrick M.D.	78532	12/03/2024	04/30/2026
Physician and Surgeon	Murray, Anika Shani M.D.	78544	12/04/2024	11/30/2025
Physician and Surgeon	Nchanji, Comfort Lumyedang M.D.	78513	11/27/2024	02/28/2026
Physician and Surgeon	Nelson, Connor Michael D.O.	78684	12/31/2024	11/30/2025
Physician and Surgeon	Nguyen, Dao Kim Hoang D.O.	78685	12/31/2024	09/30/2025
Physician and Surgeon	Odetola, Oluwatobi Ezekiel B.M., B.S.	78648	12/23/2024	12/31/2025
Physician and Surgeon	Oeverli, Elisabeth M.D.	78426	11/13/2024	04/30/2026
Physician and Surgeon	Patel, Dharmik Suresh M.D.	78689	01/02/2025	09/30/2025
Physician and Surgeon	Patel, Rajiv Nanu M.D.	78488	11/25/2024	07/31/2025
Physician and Surgeon	Paulson, Marissa Lee M.D.	78506	11/27/2024	01/31/2026
Physician and Surgeon	Pedreira Vaz, Igor M.D.	78507	11/27/2024	01/31/2026
Physician and Surgeon	Peer, Syed Murfad M.B., B.S.	61172	11/20/2024	12/31/2025
Physician and Surgeon	Peliska, Michael Dean M.D.	78459	11/20/2024	12/31/2025
Physician and Surgeon	Phillips, Julie Katherine M.D.	78624	12/19/2024	01/31/2026
Physician and Surgeon	Polavarapu, Soumya Lakshmi D.O.	78396	11/06/2024	07/31/2025
Physician and Surgeon	Poonam, Poonam M.D.	78661	12/27/2024	09/30/2025
Physician and Surgeon	Pope, Kai Rae M.D.	78527	12/02/2024	02/28/2026
Physician and Surgeon	Posch, Marie-Louise M.D.	78489	11/25/2024	07/31/2025
Physician and Surgeon	Przybylinski, John Paul M.D.	78427	11/13/2024	12/31/2025
Physician and Surgeon	Pugely, James Michael M.D.	78666	12/30/2024	05/31/2026

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Physician and Surgeon	Qiu, Lisa D.O.	78398	11/06/2024	02/28/2026
Physician and Surgeon	Quinn, Kevin Leo M.D.	78490	11/25/2024	02/28/2026
Physician and Surgeon	Ree, Chloe Jacqueline M.D.	78399	11/06/2024	10/31/2025
Physician and Surgeon	Riggs, Jennifer Rosslyn M.D.	78672	12/30/2024	05/31/2026
Physician and Surgeon	Sandrow, Cherisa D.O.	78389	11/04/2024	07/31/2025
Physician and Surgeon	Sayler, Daniel James M.D.	78686	12/31/2024	02/28/2026
Physician and Surgeon	Sayler, Zoe Ellen M.D.	78460	11/20/2024	03/31/2026
Physician and Surgeon	Schaenzer, Sara Marie Robinette M.D.	78461	11/20/2024	05/31/2025
Physician and Surgeon	Schuette, Hayden Bryant D.O.	78662	12/27/2024	10/31/2025
Physician and Surgeon	Sell, Jordan James M.D.	78428	11/13/2024	07/31/2025
Physician and Surgeon	Smestad, Logan Erik M.D.	78663	12/27/2024	09/30/2025
Physician and Surgeon	Smith, Phoebe Louise M.D.	78508	11/27/2024	04/30/2026
Physician and Surgeon	Solano, Maria Del Pilar M.D.	78651	12/23/2024	05/31/2026
Physician and Surgeon	Sonnenberg, Jill Marie M.D.	78528	12/02/2024	03/31/2026
Physician and Surgeon	Spencer, Celina D.O.	78625	12/19/2024	05/31/2026
Physician and Surgeon	Spencer, Daniel Bonneson M.D.	78462	11/20/2024	12/31/2025
Physician and Surgeon	Stec, Eugene Eric M.D.	78626	12/19/2024	11/30/2025
Physician and Surgeon	Stevens, Quin Treacy M.D.	78514	11/27/2024	03/31/2026
Physician and Surgeon	Stime, Katrina Jene M.D.	78429	11/13/2024	10/31/2025
Physician and Surgeon	Sukharan, Jessica Eliza M.D.	78400	11/06/2024	02/28/2026
Physician and Surgeon	Sun, Wenzhu M.D.	78627	12/19/2024	10/31/2025
Physician and Surgeon	Sweet, Rachel Kelsey M.D.	78390	11/04/2024	08/31/2025
Physician and Surgeon	Taylor, Myiesha Draon Nancy M.D.	78401	11/06/2024	02/28/2026
Physician and Surgeon	Theuerkauf, Andre Robert M.D.	78667	12/30/2024	08/31/2025
Physician and Surgeon	Titan, Ashley Lauren M.D.	78491	11/25/2024	07/31/2025
Physician and Surgeon	Todo, Akira M.D.	78492	11/25/2024	06/30/2025
Physician and Surgeon	Tow, Fred Mitchell M.D.	78635	12/23/2024	05/31/2026
Physician and Surgeon	Tuburan, Smyrna Perez M.D.	78493	11/25/2024	09/30/2025
Physician and Surgeon	Tucker, Laura Anne M.D.	78650	12/23/2024	11/30/2025
Physician and Surgeon	Vang, Tony Kong M.D.	78463	11/20/2024	07/31/2025
Physician and Surgeon	Vann, Vincent Raul M.D.	78671	12/30/2024	01/31/2026
Physician and Surgeon	Vecellio, Alison Ann M.D.	78397	11/06/2024	03/31/2026
Physician and Surgeon	Vora, Maulin Upendra M.B., B.S.	78502	11/26/2024	08/31/2025
Physician and Surgeon	Weagley, Amy Gallop M.D.	78503	11/26/2024	04/30/2026
Physician and Surgeon	Werner, Heidi Racquel M.D.	78430	11/13/2024	10/31/2025
Physician and Surgeon	Zaenger, David William M.D.	78464	11/20/2024	10/31/2025
Physician and Surgeon - IMLC	Abd Elazim, Ahmed Alaa Eldin Fathy M.B., B.Ch.	78690	01/02/2025	08/31/2025
Physician and Surgeon - IMLC	Abou Merhi Saifeddine, Mohamad	78465	11/20/2024	03/31/2026
Physician and Surgeon - IMLC	Ader, John D.O.	78394	11/06/2024	02/28/2026
Physician and Surgeon - IMLC	Agyako-Wiredu, David M.B., Ch.B.	78587	12/13/2024	09/30/2025
Physician and Surgeon - IMLC	Akers, Ted Joseph M.D.	28077	11/21/2024	12/31/2025
Physician and Surgeon - IMLC	Albers, Lauren M.D.	78482	11/21/2024	10/31/2025
Physician and Surgeon - IMLC	Alleyne, Ron M.D.	78586	12/13/2024	05/31/2026
Physician and Surgeon - IMLC	Babaa, Nidal Nabhan M.D.	78416	11/09/2024	10/31/2025
Physician and Surgeon - IMLC	Beatty, Timothy Buel D.O.	78533	12/03/2024	07/31/2025
Physician and Surgeon - IMLC	Betler, Michael Paul D.O.	78547	12/05/2024	03/31/2026
Physician and Surgeon - IMLC	Bevelaqua, Anna-Christina M.D.	78433	11/14/2024	09/30/2025
Physician and Surgeon - IMLC	Bigelow, Elizabeth Remus M.D.	78607	12/16/2024	11/30/2025
Physician and Surgeon - IMLC	Boyd, Michael Joseph M.D.	78496	11/25/2024	02/28/2026
Physician and Surgeon - IMLC	Branach, Casey M.D.	78593	12/13/2024	08/31/2025
Physician and Surgeon - IMLC	Brandman, Deleys Ann M.D.	78552	12/06/2024	03/31/2026
Physician and Surgeon - IMLC	Braunreiter, Chi L M.D.	78580	12/12/2024	10/31/2025
Physician and Surgeon - IMLC	Brightbill, Todd Carlin M.D.	78570	12/10/2024	06/30/2025
Physician and Surgeon - IMLC	Brimmo-Longe, Olufunke Louise M.B., B.S.	78475	11/21/2024	12/31/2025
Physician and Surgeon - IMLC	Brittain, Eric Stewart M.D.	78534	12/03/2024	06/30/2025
Physician and Surgeon - IMLC	Bulian, Brady Patrick D.O.	78546	12/05/2024	03/31/2026
Physician and Surgeon - IMLC	Cade, Craig Bryan D.O.	78435	11/15/2024	02/28/2026
Physician and Surgeon - IMLC	Carstensen, Christine Ruth M.D.	78616	12/17/2024	08/31/2025
Physician and Surgeon - IMLC	Carter, Jacqueline M.D.	78525	12/02/2024	07/31/2025
Physician and Surgeon - IMLC	Chen, Elizabeth Ph M.D.	78486	11/22/2024	07/31/2025
Physician and Surgeon - IMLC	Close, Kenneth Raymond M.D.	78631	12/20/2024	07/31/2025
Physician and Surgeon - IMLC	Cole, Stephen M.D.	78440	11/15/2024	07/31/2025
Physician and Surgeon - IMLC	Collins, Gretchen M.D.	78608	12/16/2024	04/30/2026
Physician and Surgeon - IMLC	Contreras, Francisco Jose M.D.	78439	11/15/2024	12/31/2025
Physician and Surgeon - IMLC	Cooper, Kathrine Amanda M.D.	78590	12/13/2024	09/30/2025
Physician and Surgeon - IMLC	Crain, Dominique Juanita M.D.	78559	12/09/2024	03/31/2026
Physician and Surgeon - IMLC	Cranmer, Thomas Van Der Weg M.D.	78574	12/10/2024	10/31/2025
Physician and Surgeon - IMLC	De Leon, Mary Jeanne Soberano M.D.	78654	12/24/2024	05/31/2026
Physician and Surgeon - IMLC	DeMaio, Kristine Diana M.D.	78425	11/13/2024	11/30/2025
Physician and Surgeon - IMLC	Dickie, Sara Rath M.D.	78519	12/02/2024	05/31/2026
Physician and Surgeon - IMLC	Douglas, Jason M.D.	78693	01/03/2025	05/31/2026
Physician and Surgeon - IMLC	Durojaiye, Victoria Temitope M.D.	78542	12/04/2024	10/31/2025
Physician and Surgeon - IMLC	Edling, Jason Eric M.D.	78669	12/30/2024	02/28/2026
Physician and Surgeon - IMLC	Edwards, Megan M.D.	78536	12/03/2024	10/31/2025
Physician and Surgeon - IMLC	Essling, Carla Marie M.D.	78644	12/23/2024	04/30/2026
Physician and Surgeon - IMLC	Faircloth, John Clifton D.O.	78582	12/12/2024	06/30/2025
Physician and Surgeon - IMLC	Farooq, Muhammad Anas M.B., B.S.	78692	01/02/2025	07/31/2025

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Physician and Surgeon - IMLC	Fazio, Michael Gregory D.O.	78643	12/23/2024	04/30/2026
Physician and Surgeon - IMLC	Fitzgerald, Susan Mumm M.D.	78481	11/21/2024	07/31/2025
Physician and Surgeon - IMLC	Forcier, Michelle Marie M.D.	78411	11/08/2024	07/31/2025
Physician and Surgeon - IMLC	Friedlander, Joshua Alan M.D.	78476	11/21/2024	06/30/2025
Physician and Surgeon - IMLC	Gaffney, Brody Jacob M.D.	78473	11/21/2024	10/31/2025
Physician and Surgeon - IMLC	Gatchell, Gregory Ryan D.O.	78636	12/23/2024	12/31/2025
Physician and Surgeon - IMLC	Geyer, Charissa Lateesha M.D.	78453	11/19/2024	08/31/2025
Physician and Surgeon - IMLC	Gharwan, Helen	78524	12/02/2024	09/30/2025
Physician and Surgeon - IMLC	Gibbons, Sarah Kathryn D.O.	78458	11/20/2024	09/30/2025
Physician and Surgeon - IMLC	Gogia, Rajendra S M.B., B.S.	78600	12/13/2024	02/28/2026
Physician and Surgeon - IMLC	Goldman, Stephen Jamie D.O.	78637	12/23/2024	05/31/2026
Physician and Surgeon - IMLC	Gordon, Katrina M.D.	78640	12/23/2024	07/31/2025
Physician and Surgeon - IMLC	Gray, Geoffrey Milton M.D.	78551	12/06/2024	09/30/2025
Physician and Surgeon - IMLC	Grossett, Robert Todd M.D.	51586	12/02/2024	10/31/2025
Physician and Surgeon - IMLC	Gru, Alejandro Ariel	78628	12/19/2024	05/31/2026
Physician and Surgeon - IMLC	Hammond, Alexis Shea M.D.	78664	12/30/2024	06/30/2025
Physician and Surgeon - IMLC	Hardy, Constance Alexis M.D.	78579	12/11/2024	05/31/2026
Physician and Surgeon - IMLC	Hasan, Tasneem Fatema M.B., B.S.	78436	11/15/2024	03/31/2026
Physician and Surgeon - IMLC	Hewlett, Nathan Ross M.D.	78495	11/25/2024	03/31/2026
Physician and Surgeon - IMLC	Hoerst, Karen Anne M.D.	78474	11/21/2024	10/31/2025
Physician and Surgeon - IMLC	Hoffman, Benjamin Haskell M.D.	78413	11/08/2024	03/31/2026
Physician and Surgeon - IMLC	Hoffman, Ian Patrick M.D.	78437	11/15/2024	01/31/2026
Physician and Surgeon - IMLC	Howton, Marica Jean M.D.	78583	12/12/2024	01/31/2026
Physician and Surgeon - IMLC	Huan, Lawrence Mark M.D.	78691	01/02/2025	10/31/2025
Physician and Surgeon - IMLC	Huang, Yuan Yu M.D.	78609	12/16/2024	03/31/2026
Physician and Surgeon - IMLC	Hurtubise, Amanda M.D.	78617	12/17/2024	05/31/2026
Physician and Surgeon - IMLC	Husain, Abid M.D.	78565	12/10/2024	12/31/2025
Physician and Surgeon - IMLC	Ibanez, Jamie M.D.	78581	12/12/2024	03/31/2026
Physician and Surgeon - IMLC	Ilyas, Kamran M.B., B.S.	78613	12/16/2024	12/31/2025
Physician and Surgeon - IMLC	Irwin, Anna Isakov M.D.	78564	12/10/2024	07/31/2025
Physician and Surgeon - IMLC	James, George C M.B., B.S.	78535	12/03/2024	11/30/2025
Physician and Surgeon - IMLC	Jones, Stephen M.D.	78584	12/12/2024	07/31/2025
Physician and Surgeon - IMLC	Julian, Scott Earl M.D.	34613	11/15/2024	08/31/2025
Physician and Surgeon - IMLC	Kahn, Yosef M.D.	78391	11/04/2024	04/30/2026
Physician and Surgeon - IMLC	Kaluza, Vesna M.D.	78405	11/07/2024	08/31/2025
Physician and Surgeon - IMLC	Khiani, Monika A M.D.	78629	12/19/2024	10/31/2025
Physician and Surgeon - IMLC	Kiernan, Julia M.D.	78675	12/30/2024	11/30/2025
Physician and Surgeon - IMLC	Kiltz, Robert J M.D.	78598	12/13/2024	03/31/2026
Physician and Surgeon - IMLC	Kim, Sion Lee M.D.	78639	12/23/2024	04/30/2026
Physician and Surgeon - IMLC	Kluger, Carrie Irene Zwerdling M.D.	78618	12/17/2024	05/31/2026
Physician and Surgeon - IMLC	Koehn, Monica Anne M.D.	38391	12/04/2024	05/31/2026
Physician and Surgeon - IMLC	Koti, Madhava Rao M.B., B.S.	78393	11/04/2024	09/30/2025
Physician and Surgeon - IMLC	Kurtzer, Traci Armer M.D.	78466	11/20/2024	12/31/2025
Physician and Surgeon - IMLC	Lake, Mikhailia M.D.	78674	12/30/2024	08/31/2025
Physician and Surgeon - IMLC	Lam, Christopher Kin-Wah M.D.	78415	11/09/2024	06/30/2025
Physician and Surgeon - IMLC	Lans, Joel Isidore M.D.	78517	12/02/2024	08/31/2025
Physician and Surgeon - IMLC	Lopez, William Manuel M.D.	78420	11/12/2024	10/31/2025
Physician and Surgeon - IMLC	Mahmood, Syed Abid M.B., B.S.	78548	12/05/2024	03/31/2026
Physician and Surgeon - IMLC	Manmohan, Rajan M.D.	78592	12/13/2024	10/31/2025
Physician and Surgeon - IMLC	Manon Matos, Yorell M.D.	78642	12/23/2024	08/31/2025
Physician and Surgeon - IMLC	Marshall, Jonathan Terry D.O.	78630	12/20/2024	09/30/2025
Physician and Surgeon - IMLC	Martin, Robert Ambrose M.D.	78392	11/04/2024	06/30/2025
Physician and Surgeon - IMLC	Masood, Faraz M.B., B.S.	78472	11/20/2024	04/30/2026
Physician and Surgeon - IMLC	Mather, Jon Seth M.D.	78452	11/19/2024	02/28/2026
Physician and Surgeon - IMLC	Matz, Paul Gregory M.D.	78545	12/04/2024	07/31/2025
Physician and Surgeon - IMLC	Means, Alexander David M.D.	78530	12/03/2024	11/30/2025
Physician and Surgeon - IMLC	Mendes, Marisa Dias M.D.	78554	12/09/2024	03/31/2026
Physician and Surgeon - IMLC	Meyer, Tamera Kim M.D.	78677	12/31/2024	08/31/2025
Physician and Surgeon - IMLC	Miller, Kristie Lee M.D.	78571	12/10/2024	02/28/2026
Physician and Surgeon - IMLC	Mitchell, Joseph Lee M.D.	78480	11/21/2024	05/31/2025
Physician and Surgeon - IMLC	Mixon, Joel Ashby M.D.	78568	12/10/2024	09/30/2025
Physician and Surgeon - IMLC	Modi, Sanjiv S M.B., B.S.	73755	11/13/2024	12/31/2025
Physician and Surgeon - IMLC	Morris, Julia Hyland M.D.	78576	12/11/2024	06/30/2025
Physician and Surgeon - IMLC	Murphy, Michael David M.D.	78610	12/16/2024	11/30/2025
Physician and Surgeon - IMLC	Mylvaganam, Ruben Joseph M.D.	78434	11/14/2024	06/30/2025
Physician and Surgeon - IMLC	Nadel, Jennifer Lee M.D.	78556	12/09/2024	05/31/2026
Physician and Surgeon - IMLC	Nader, Mathieu M.D.	78451	11/19/2024	01/31/2026
Physician and Surgeon - IMLC	Nahar, Tamanna M.B., B.S.	78455	11/19/2024	09/30/2025
Physician and Surgeon - IMLC	Nass, Scott Edward M.D.	78438	11/15/2024	09/30/2025
Physician and Surgeon - IMLC	Neziri, Leart M.D.	78497	11/25/2024	09/30/2025
Physician and Surgeon - IMLC	Nguyen, Minh Thi Xuan M.D.	78423	11/13/2024	07/31/2025
Physician and Surgeon - IMLC	Okoh, Emuejevoke Orpheus Joseph M.D.	78558	12/09/2024	04/30/2026
Physician and Surgeon - IMLC	Oyewole, Oghenevwairhe M.D.	78410	11/08/2024	04/30/2026
Physician and Surgeon - IMLC	Padla, Dennis M.D.	78478	11/21/2024	04/30/2026
Physician and Surgeon - IMLC	Pandravada, Sasirekha D.O.	78404	11/07/2024	09/30/2025
Physician and Surgeon - IMLC	Pardilla, Richard Tan Lim M.D.	78412	11/08/2024	10/31/2025
Physician and Surgeon - IMLC	Park, Pierce Chang-Whan M.D.	78523	12/02/2024	02/28/2026

Board of Medical Practice

New Licensee List - 11/02/2024 to 01/03/2025

Physician and Surgeon - IMLC	Paschos, Jennifer Anne M.D.	78557	12/09/2024	04/30/2026
Physician and Surgeon - IMLC	Pasteur, Nicholas Allan M.D.	78431	11/13/2024	03/31/2026
Physician and Surgeon - IMLC	Pate, Meagan Joy M.D.	78477	11/21/2024	07/31/2025
Physician and Surgeon - IMLC	Patras, Theodosios Peter M.D.	78653	12/24/2024	03/31/2026
Physician and Surgeon - IMLC	Policastro, Michael Anthony M.D.	78588	12/13/2024	01/31/2026
Physician and Surgeon - IMLC	Porter, Kristin Kelly M.D.	78577	12/11/2024	01/31/2026
Physician and Surgeon - IMLC	Pyko, Maximilian D.O.	78561	12/09/2024	12/31/2025
Physician and Surgeon - IMLC	Qureshi, Mariam Rabya M.D.	78673	12/30/2024	10/31/2025
Physician and Surgeon - IMLC	Rao, Amitha M.D.	78409	11/08/2024	01/31/2026
Physician and Surgeon - IMLC	Riley, Lyrad Kelly M.D.	78589	12/13/2024	08/31/2025
Physician and Surgeon - IMLC	Roach, Patrick Erin M.D.	78424	11/13/2024	06/30/2025
Physician and Surgeon - IMLC	Rodas, Anthony Gerard M.D.	78615	12/17/2024	02/28/2026
Physician and Surgeon - IMLC	Rosenthal, Harry Benjamin M.D.	78578	12/11/2024	08/31/2025
Physician and Surgeon - IMLC	Salazar, Susan M M.D.	78518	12/02/2024	06/30/2025
Physician and Surgeon - IMLC	Samindla, Kiran M.B., B.S.	78522	12/02/2024	08/31/2025
Physician and Surgeon - IMLC	Sarangi, Shamit M.D.	78494	11/25/2024	12/31/2025
Physician and Surgeon - IMLC	Schaffer, Wendy M.D.	78560	12/09/2024	03/31/2026
Physician and Surgeon - IMLC	Schefter, Tracey M.D.	78567	12/10/2024	06/30/2025
Physician and Surgeon - IMLC	Schwartz, Michael Alan M.D.	78566	12/10/2024	06/30/2025
Physician and Surgeon - IMLC	Sharma, Ayushman M.D.	58213	11/19/2024	02/28/2026
Physician and Surgeon - IMLC	Sharma, Neetu M.B., B.S.	78585	12/12/2024	07/31/2025
Physician and Surgeon - IMLC	Sherer, Joseph Houston D.O.	78521	12/02/2024	02/28/2026
Physician and Surgeon - IMLC	Simmons, Garrett Lane M.D.	78612	12/16/2024	08/31/2025
Physician and Surgeon - IMLC	Singh, Abhishek M.B., B.S.	78483	11/22/2024	11/30/2025
Physician and Surgeon - IMLC	Smith, Christopher Mitchell M.D.	78679	12/31/2024	08/31/2025
Physician and Surgeon - IMLC	Stephens, Kevin Ulysse M.D.	78454	11/19/2024	02/28/2026
Physician and Surgeon - IMLC	Stewart, Colin Carter M.D.	78569	12/10/2024	10/31/2025
Physician and Surgeon - IMLC	Strange, Cedric Carl Warren M.D.	78645	12/23/2024	06/30/2025
Physician and Surgeon - IMLC	Stumpf, Amanda Laura D.O.	78611	12/16/2024	05/31/2026
Physician and Surgeon - IMLC	Sturtevant, Linda Ruth M.D.	78668	12/30/2024	06/30/2025
Physician and Surgeon - IMLC	Sullivan, Christopher Andrew M.D.	78591	12/13/2024	12/31/2025
Physician and Surgeon - IMLC	Swartz, Jordan Louis M.D.	78670	12/30/2024	01/31/2026
Physician and Surgeon - IMLC	Tadros, Mina Ehab M.D.	78450	11/19/2024	04/30/2026
Physician and Surgeon - IMLC	Talug, Can M.D.	78537	12/04/2024	11/30/2025
Physician and Surgeon - IMLC	Tapryal, Neel M.B., B.S.	78555	12/09/2024	02/28/2026
Physician and Surgeon - IMLC	Taylor, Melba Margaret M.D.	78516	12/02/2024	08/31/2025
Physician and Surgeon - IMLC	Tenbrink, Kelly James M.D.	78614	12/16/2024	10/31/2025
Physician and Surgeon - IMLC	Thomas, Joel Richard M.D.	57118	12/16/2024	10/31/2025
Physician and Surgeon - IMLC	Thompson, Carolyn Crump M.D.	78515	12/02/2024	07/31/2025
Physician and Surgeon - IMLC	Thrasher, Tony Walton D.O.	78678	12/31/2024	01/31/2026
Physician and Surgeon - IMLC	Torres, Luis Edgardo M.D.	78601	12/13/2024	12/31/2025
Physician and Surgeon - IMLC	Tran, Carol M.D.	78599	12/13/2024	12/31/2025
Physician and Surgeon - IMLC	Ugoeke, Nene M.D.	78471	11/20/2024	12/31/2025
Physician and Surgeon - IMLC	Ulmer, April Lee M.D.	78484	11/22/2024	04/30/2026
Physician and Surgeon - IMLC	Vaca, Carlos Andres M.D.	78419	11/12/2024	04/30/2026
Physician and Surgeon - IMLC	VanWyk, Jill Renae M.D.	78479	11/21/2024	05/31/2025
Physician and Surgeon - IMLC	Virani, Haider Ali M.D.	78605	12/16/2024	04/30/2026
Physician and Surgeon - IMLC	Viyuoh, Nicholas Ghowi M.D.	78543	12/04/2024	06/30/2025
Physician and Surgeon - IMLC	Waskin, Randolph Benjamin M.D.	78620	12/19/2024	01/31/2026
Physician and Surgeon - IMLC	Wells, Tabatha Selina M.D.	78676	12/31/2024	10/31/2025
Physician and Surgeon - IMLC	Witt, Gary John M.D.	78487	11/25/2024	06/30/2025
Physician and Surgeon - IMLC	Worley, Melanie Faith D.O.	78414	11/08/2024	08/31/2025
Physician and Surgeon - IMLC	Yaeger, Jackie Lynn M.D.	52639	11/13/2024	02/28/2026
Physician and Surgeon - IMLC	Yao, Lei	78638	12/23/2024	11/30/2025
Physician and Surgeon - IMLC	Zwiener, Jessica Erin M.D.	78520	12/02/2024	07/31/2025
Physician Assistant	Adams, Amy Elizabeth	15188	12/03/2024	03/31/2026
Physician Assistant	Ahmed, Yasin Ali	15176	11/20/2024	07/31/2025
Physician Assistant	Amador, Gerardo	15204	12/24/2024	07/31/2025
Physician Assistant	Bakeman, Cassandra Lynn	15186	12/02/2024	12/31/2025
Physician Assistant	Broadnax , Tasheena La Teshea	15206	12/26/2024	04/30/2026
Physician Assistant	Bukolt, Samantha Rose	15200	12/16/2024	03/31/2026
Physician Assistant	Campos, Maribel Diaz	15201	12/18/2024	04/30/2026
Physician Assistant	Cleppe, Amanda Marie	15189	12/03/2024	04/30/2026
Physician Assistant	Costello, Colleen Marie	15199	12/16/2024	09/30/2025
Physician Assistant	Crowley, Elizabeth Jean	15203	12/20/2024	10/31/2025
Physician Assistant	Dale, Mary Peeples	15198	12/16/2024	11/30/2025
Physician Assistant	Gamoke, Adam Francis	15183	11/27/2024	07/31/2025
Physician Assistant	Haan, Jenni Marie	15173	11/13/2024	01/31/2026
Physician Assistant	Hehre, Amy Elizabeth	15205	12/26/2024	03/31/2026
Physician Assistant	Hurley, Vincent Anthony	15184	11/27/2024	03/31/2026
Physician Assistant	Kaplan, Danielle Marissa	15191	12/09/2024	06/30/2025
Physician Assistant	Kaseman, Joanne Fay	15172	11/05/2024	09/30/2025
Physician Assistant	Kempf, Robyn Rachelle	15208	12/31/2024	03/31/2026
Physician Assistant	Kennedy, Erika Denise	15175	11/15/2024	08/31/2025
Physician Assistant	Kent, Siobhan Mairead	15178	11/21/2024	11/30/2025
Physician Assistant	Koopman, Tori Lynn	15194	12/13/2024	10/31/2025
Physician Assistant	Kusilek, Mackenzie Lea	15180	11/26/2024	07/31/2025

Board of Medical Practice

New Licensee List - 11/02/2024 to 01/03/2025

Physician Assistant	Marchenko, Ivana Yourievna	15179	11/21/2024	01/31/2026
Physician Assistant	Medo, Zachary Ryan	15190	12/04/2024	09/30/2025
Physician Assistant	Mohamed, Hassan Abdisalam	15171	11/05/2024	01/31/2026
Physician Assistant	Monette, Marc Nathaniel	15185	11/27/2024	08/31/2025
Physician Assistant	Moravchik, Lindsey Marie	10377	12/20/2024	07/31/2025
Physician Assistant	Nutter, Madison June	15181	11/26/2024	09/30/2025
Physician Assistant	Nykamp, Emma Grace	15196	12/13/2024	03/31/2026
Physician Assistant	Pham, Quynh Quoc	15193	12/13/2024	02/28/2026
Physician Assistant	Stenzel, Madeleine Ann	15177	11/21/2024	12/31/2025
Physician Assistant	Strain, Thomas Scott	15182	11/26/2024	09/30/2025
Physician Assistant	Street, Tami Jo LaRayne	15192	12/13/2024	03/31/2026
Physician Assistant	Tang, Sabrina Jia	15202	12/18/2024	11/30/2025
Physician Assistant	Thomas, Jessica Elizabeth	15174	11/13/2024	03/31/2026
Physician Assistant	Van Gilder, Ellie Marie	15207	12/26/2024	03/31/2026
Physician Assistant	Vieira, Lauren Elizabeth	15209	12/31/2024	12/31/2025
Physician Assistant	Wagner, Alexandra Wilson	15197	12/13/2024	10/31/2025
Physician Assistant	Wanzek, Brittany Nicole	15187	12/02/2024	07/31/2025
Physician Assistant	Wright, Renee Tiffani	15195	12/13/2024	08/31/2025
Respiratory Therapist	Anderson, April Esther	5742	12/31/2024	10/31/2025
Respiratory Therapist	Galvin-Siebenaler, Tekakawitha Antonia	2185	11/26/2024	11/30/2025
Respiratory Therapist	Kotecki, Cortnie Danielle	5739	12/19/2024	03/31/2026
Respiratory Therapist	Mahamud, Fatima Abdi	5740	12/19/2024	01/31/2026
Respiratory Therapist	Rankins, Vilai	5741	12/23/2024	03/31/2026
Respiratory Therapist	Regan, Ashley Ann	4648	12/04/2024	06/30/2025
Respiratory Therapist	Roberts, Shedrick	5738	12/16/2024	03/31/2026
Respiratory Therapist	Storevik, Ryan Jared	5737	12/04/2024	10/31/2025
Telemedicine	Ali, Ali Abdelmonem	3091	11/12/2024	12/31/2025
Telemedicine	Alvarado, Maritza	3093	11/20/2024	12/31/2025
Telemedicine	Bakshi, Neeru Verma	3100	12/23/2024	12/31/2025
Telemedicine	Catoera, Ireneo Hiso	3096	11/27/2024	12/31/2025
Telemedicine	Hirsch, Sharon L	3099	12/16/2024	12/31/2025
Telemedicine	Hopkins, Thomas Ruff	3090	11/06/2024	12/31/2025
Telemedicine	Luke, Micah James	3097	11/27/2024	12/31/2025
Telemedicine	McDowell, Karen Ann	3095	11/22/2024	12/31/2025
Telemedicine	Nagel, James Sherman	3098	12/11/2024	12/31/2025
Telemedicine	Shah, Shahid Saleem	3094	11/20/2024	12/31/2025
Telemedicine	Yang, Mike Je	3092	11/20/2024	12/31/2025
Traditional Midwife	Breakfield, Carisa May	1109	12/04/2024	06/30/2025
TOTAL		**407**		

DATE: January 11, 2025 SUBJECT: Policy & Planning Committee: Updates and Motions from October 14 and November 25, 2024, and January 6, 2025

SUBMITTED BY: **Kristina Krohn, M.D.**

REQUEST FOR BOARD ACTION
MINNESOTA BOARD OF MEDICAL PRACTICE

REQUESTED ACTION:

For information Only

MOTION BY: SECOND:

( ) PASSED ( ) PASSED AMENDED ( ) LAYED OVER ( ) DEFEATED

BACKGROUND:

Attached are the agendas from the Policy and Planning Committee meetings from October 14 and November 25, 2024 and January 6, 2025. The Policy and Planning Committee makes the following motions:

Motion 1, from the October 14, 2024, Committee Meeting:
Support the language change to Minn. Stat. §147A.02(c) as presented and discussed to allow the required 2,080 collaborative hours to be with a physician licensed in any United States state of territory.

Motion 2, from the November 25, 2024, Committee Meeting:
Take a neutral position on the changes to the Minnesota Athletic Trainers Act, Minn. Stat. §148.7801 - .7815, as presented and discussed.

Motion 3, from the January 6, 2025, Committee Meeting:
Support Dr. Krohn, Ms. Huntley and Lindsey Franklin, Legislative Liaison, Minnesota Health Professionals Regulatory Boards, to continued discussions with Sen. Mann as the bill moves forward and the preliminary guidance for formal consideration is released by the Advisory Commission on Additional Licensing Models.

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 POLICY & PLANNING COMMITTEE WILL MEET ELECTRONICALLY BY WEBEX:
To join the meeting, go to:
https://minnesota.webex.com/minnesota/j.php?MTID=m6fdd6ff92b123225ea8d6756c5679c34
Meeting number (access code): 2485 021 1134
Meeting password: Am9aKV6Ug5s

Join by phone:
Tap to call in from a mobile device (attendees only)
+1-415-655-0003 United States Toll
1-855-282-6330 United States Toll Free

Join from a video system or application
Dial 24850211134@minnesota.webex.com
You can also dial 173.243.2.68 and enter your meeting number

Need help? Go to http://help.webex.com

AGENDA FOR
THE MINNESOTA BOARD OF MEDICAL PRACTICE
POLICY & PLANNING COMMITTEE
OCTOBER 14, 2024
12:00 P.M. – CST

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1. Roll Call of Policy & Planning Committee members

2. Presentation by the Minnesota Academy of Physician Assistants: *proposed* changes to Minn. Stat. §147A.02(c)
    a. Proposed language attached

3. Review and Discuss the DRAFT GUIDANCE DOCUMENT from the Advisory Commission on Additional Licensing Models ("Advisory Commission")
    a. DRAFT GUIDANCE DOCUMENT
    b. Legislation introduced in Minnesota during the 2024 Legislative Session

    The Advisory Commission is accepting public comment through December 6, 2024, at which time it will review the feedback and release its preliminary guidance for formal consideration in early 2025.

4. Other business

5. REMAINING Meeting Dates for 2024: November 25 and December 9, 2024 at 12 noon

2080 Hours Bill

MN Stat. 147A.02(c)

(c) A physician assistant who qualifies for licensure must practice for at least 2,080 hours, within the context of a collaborative agreement, within a hospital or integrated clinical setting where physician assistants and physicians work together to provide patient care. The physician assistant shall submit written evidence to the board with the application, or upon completion of the required collaborative practice experience. For purposes of this paragraph, a collaborative agreement is a mutually agreed upon plan for the overall working relationship ~~and collaborative arrangement~~ between a physician assistant, and one or more physicians licensed under chapter 147 OR IN ANOTHER STATE OR UNITED STATES TERRITORY, that designates the scope of ~~services that can be provided~~ COLLABORATION NECESSARY to manage the care of patients. The physician assistant and one of the collaborative physicians must have experience in providing care to patients with the same or similar medical conditions. The collaborating physician is not required to be physically present so long as the collaborating physician and physician assistant are or can be easily in contact with each other by radio, telephone, or other telecommunication device.

Advisory Commission on Additional Licensing Models
DRAFT GUIDANCE DOCUMENT

There are currently two primary pathways by which internationally trained physicians may become eligible for medical licensure from a state medical board in the United States and its territories:

1. Completion of one to three years, depending on the state or territory,[1] of U.S.-based graduate medical education (GME) accredited by the Accreditation Council for Graduate Medical Education (ACGME), accompanied by certification by ECFMG®, a division of Intealth™, and successful passage of all three Steps of the United States Medical Licensing Examination® (USMLE®), is the most common current pathway to medical licensure for international medical graduates (IMGs) in the United States. In addition to expanding a physician's knowledge and skills in one or more medical or surgical specialties, U.S.-based GME affords time for participants to acclimate to the U.S. health care system, culture and social norms, and the medical illnesses and conditions that are most prevalent (e.g., heart disease, cancer, accidents) among those residing in the United States.
2. "Eminence" pathways (usually sought by prominent mid-career physicians from abroad) have long existed in many states and typically do not require ECFMG Certification or successful passage of any Step of the USMLE. It is likely that such pathways will continue to be an option for highly qualified and fully trained internationally trained physicians. These pathways are most often used for those deemed to have "extraordinary ability," and include "eminent specialist" or "university faculty" pathways for physicians pursuing academic or research activities, and they typically align with the O-1 (extraordinary ability) visa issued by the U.S. State Department.[2] Of note, most state medical boards also have existing statutes or regulations allowing the licensing of IMGs at their discretion, though in practice these are not easy to achieve or available commonly. A few medical boards explicitly allow postgraduate training (PGT) – also known as postgraduate medical education (PGME) – outside of the United States or Canada, from countries such as England, Scotland, Ireland, Australia, New Zealand and the Philippines.

Beginning in 2023, eight (8) states have enacted legislation creating additional licensing pathways for internationally trained physicians that does <u>not</u> require completion of ACGME-accredited GME training in the United States.

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[1] International Medical Graduates GME Requirements, Board-by-Board Overview, FSMB
[2] https://www.uscis.gov/working-in-the-united-states/temporary-workers/o-1-visa-individuals-with-extraordinary-ability-or-achievement

These newly established additional licensing pathways are designed principally for internationally-trained and internationally-practicing physicians who wish to enter the U.S. health care workforce. A primary goal of these pathways in many jurisdictions, according to testimony and statements by sponsors and supporters, is to address U.S. health care workforce shortages, especially in rural and underserved areas.

It must be noted that U.S. federal immigration and visa requirements will impact the practical ability of those who are not U.S. citizens or permanent U.S. residents (green card holders) to utilize any additional pathway. Additionally, the ubiquity of specialty-board certification as a key factor in employment and privileging decisions is likely to impact the efficacy of non-traditional licensing pathways. States may, therefore, wish to consider other health care workforce levers, such as advocating for increased state and Medicare/Medicaid funding to expand U.S. GME training slots, offering some means of transition assistance to IMGs, and expanding the availability and utilization of enduring immigration programs like the Conrad 30 waiver program, Health and Human Services (HHS) waivers, regional commission waivers, and the United States Citizenship and Immigration Service (USCIS) Physician National Interest Waiver.

While the additional pathway legislation introduced and enacted since 2023 varies from state to state, this consensus-based guidance highlights areas of similarities among them and suggests considerations and resources related to each, where such may exist. Areas of concordance among most, if not all, state laws advancing additional licensure pathways – as addressed in more detail later in this document – include the following:

1. **Rulemaking authority should be delegated, and resources allocated, to the state medical board for implementing additional licensure pathways**
2. **An offer of employment prior to application for an additional pathway**
3. **ECFMG Certification and graduation from a recognized medical school**
4. **Completion of post-graduate training (PGT) outside the United States**
5. **Possession of a license/registration/authorization to practice medicine in another country or jurisdiction and medical practice experience**
6. **A limit on "time out of practice" before becoming eligible to apply for an additional pathway**
7. **A requirement for a period of temporary provisional licensure prior to eligibility to apply for a full and unrestricted license to practice medicine**
8. **Eligibility for a full and unrestricted license to practice medicine**
9. **Standard data collection requirements**

The Advisory Commission on Additional Licensing Models, established in December 2023 and convened on four separate occasions in 2024, would like to offer the following set of initial recommendations for consideration by state medical boards, state legislators, policymakers, and other relevant stakeholders, specific to the above nine areas of concordance. The purpose of these recommendations is to support alignment of policies, regulations and statutes, where possible, and to add clarity and specificity to statutory and

procedural language to better protect the public – the principal mission of all state medical boards – and to advance the delivery of quality health care to all citizens and residents of the United States.

These initial recommendations focus on eligibility requirements and related considerations for entry into an additional licensure pathway. To ensure that physicians entering these pathways are prepared to safely practice in the United States, these pathways should optimally include assessment and supervisory components for which additional guidance is under development by the advisory commission and will be forthcoming in 2025.

1. **Rulemaking authority should be delegated, and resources allocated, to the state medical board for implementing additional licensure pathways.**

Many states that have enacted additional pathway legislation have explicitly included state medical boards in the implementation process to assure the ability of the state to support safe medical practice.

Additional licensure pathways will likely incur increased processes, time and resources for state medical boards. State legislatures should consider additional funding and resources that may need to be allocated through state appropriations to fully implement, operationalize, and evaluate an additional new pathway for medical licensure.

States evaluating how to proceed may wish to consider first authorizing their state medical boards to establish a smaller pilot program with primary care specialties that typically require a shorter period of post-graduate training, which may be more comparable internationally, and which may serve to increase access to care in rural and underserved areas. This may enable state medical boards and private partners to build the necessary infrastructure and trust for adoption of additional licensure pathways and evaluate the programs before a substantial increase in applicants or expansion to other specialties is welcomed.

***Recommendation 1a*: States should empower their medical boards to promulgate rules and regulations should they choose to enact additional licensure pathway requirements for qualified, internationally trained physicians.**

***Recommendation 1b:* State legislatures should ensure state medical boards have the necessary resources to fully implement, operationalize, and evaluate any new, additional licensure pathways including the ability to hire or assign staff with knowledge and understanding of licensing international medical graduates.**

2. **An offer of employment prior to application for an additional pathway.**

Internationally trained physicians applying for a license to practice medicine under these new additional licensure pathways have typically required in statute to have an offer of employment from a medical facility that can assure supervision and assessment of the IMG's proficiency. All states that have enacted additional pathway legislation at the time of this document's publication have included such a requirement, whether it is employment with an associated ACGME-accredited program, a Federally Qualified Health Center (FQHC), a Community Health Center (CHC), a Rural Health Clinic (RHC), or other state-licensed medical facility that has capacity and experience with medical education and assessment. The employer should be an entity with sufficient infrastructure that allows for supportive education and training resources for the IMG, as well as supervisory and assessment resources, including peer-review.

Recommendation 2a: **States should require internationally trained physicians applying under an additional licensure pathway to have an offer of employment from a medical facility, as defined by the state medical board.**

Recommendation 2b: **State medical boards should have the authority to determine which medical facilities are able to supervise and assess the IMG's proficiency and capabilities (e.g., an ACGME-accredited program, an FQHC, a CHC, an RHC or other state-licensed medical facility that has capacity and experience with medical education and assessment).**

3. **ECFMG Certification and graduation from a recognized medical school.**

Internationally trained physicians applying under an additional licensure pathway should be graduates of a recognized medical school. All states that have enacted pathway legislation at the time of this document's publication have included this requirement.

Recognition or inclusion in directories from organizations such as the World Health Organization (WHO) or the *World Directory of Medical Schools* (*World Directory*)[3] may serve as a helpful proxy for this requirement. The latter directory is the product of a collaboration between the World Federation for Medical Education (WFME) and FAIMER®, a division of Intealth.

Traditionally, IMGs have been required to obtain ECFMG Certification, a qualification that includes verification of their graduation from a *World Directory* recognized medical school, passage of USMLE Steps 1 and 2, and demonstration of English language proficiency via the Occupational English Test (OET) Medicine.

[3] https://www.wdoms.org/

Recommendation 3: **States should require ECFMG Certification for internationally trained physicians to enter an additional licensure pathway**.

State medical boards may also wish to require IMGs to provide additional supporting materials of the medical education they have undertaken outside the United States. In such instances, primary source verification and review of credentials that utilizes resources such as Intealth's Electronic Portfolio of International Credentials (EPIC℠)[4] may be useful.

4. Completion of post-graduate training (PGT) outside the United States.

States that have introduced or enacted additional pathway legislation have generally included a requirement that applicants should have completed PGT that is "substantially similar" to a residency program accredited by the ACGME in the United States.

There is significant variability, however, in the structure and quality of international PGT. The degree of clinical exposure may be uncertain and inconsistent across programs. Too, there is not currently an established and accepted accreditation system or authority that is able to deem international PGT programs to be "substantially similar" to ACGME-accredited PGT programs available in the United States, nor do many state medical boards have the capacity, resources, or expertise to assess international programs for this purpose on their own. Until such a formal accreditation system exists, the term "substantially similar" may need to be defined and determined by the state medical board.[5] Arriving at definitions and determinations of substantial similarity will have significant implications for state medical boards to plan for and obtain additional resources and support, and expertise to evaluate international training programs that have significant variability in structure, content and quality.

Recommendation 4a: **Completion of formal, accredited PGT outside the United States should be a requirement for entry into an additional licensure pathway.**

Formal postgraduate training and accreditation is not available in all countries and jurisdictions. In its absence, medical boards may be inclined to consider alternative forms of training on a case-by-case basis. These circumstances and experiences – including apprenticeship, clerkship, or observership models – may differ widely in objective measures of quality that do not involve fellowship training or involve quasi-residency arrangements that may or may not support an international physician's education and experience for additional pathway eligibility.

[4] https://www.ecfmg.org/psv/

[5] Development of a program for recognition of international systems of accreditation of PGT is currently being led by the Word Federation for Medical Education, with anticipated launch in mid-2025.

Recommendation 4b: **State medical boards may make use of a variety of existing proxies for determining that a PGT program completed outside the United States is "substantively similar" for purposes of additional licensure pathway eligibility for internationally trained physicians, including whether the IMG's program has been accredited by ACGME International (ACGME-I) and/or whether the IMG has completed an ACGME-accredited fellowship training program in the United States. Boards may also wish to ask the IMG to produce their training program's curriculum (and case requirements, for surgical specialties) for review.**

A "number of years in-practice" threshold in a given specialty in place of formal PGT may also be used on a case-by-case basis by the state medical board as an alternative metric, as long as it also includes additional requirements, such as ECFMG Certification and passage of all three Steps of the USMLE program. Where boards have access to, or can partner with, organizations with relevant experience and expertise, they may seek to determine the nature of such practice, including degree of clinical exposure, interaction with patients and performance of procedures; where applicable, this information is likely to be valuable in making determinations of competency and practice readiness.

5. **Possession of a license/registration/authorization to practice medicine in another country or jurisdiction and medical practice experience.**

Most states that have enacted additional pathway legislation have included a requirement that applicants be licensed or authorized to practice medicine in another country. Practice experience requirements in current statutes vary from three to five years. Additional pathway legislation commonly also includes a requirement that the license obtained overseas be "in good standing" and that attempt be made to verify the physician's discipline and criminal background history. State medical boards should consider primary source verification of any documentation from applicants related to licensure, employment and practice history.

Recommendation 5: **States should require internationally trained physicians applying for a license under an additional licensure pathway to be fully licensed, registered, or authorized to practice medicine in another country or jurisdiction and to provide evidence of medical practice experience of at least three years.**

6. **A limit on "time out of practice" before becoming eligible to apply for an additional licensure pathway.**

An international physician's time out of active practice before applying for an additional licensing pathway is typically and explicitly limited in currently enacted legislation, in line with extant guidelines required for medical licensure renewal of most physicians licensed in the United States. Time out of practice is a major challenge and concern for state medical boards in terms of assuring patient safety and public protection, regardless of where the training or initial licensure occurred, given that the practice of medicine changes

so rapidly. Many state medical boards, and this is often included in their respective Medical Practice Acts, already recommend a formal re-entry process when a licensed physician has been out of practice for more than a certain number of years (the most often cited period of time in most statutes is two years).[6]

Recommendation 6: **States should consider limits on time out of practice for physicians entering additional licensing pathways that are consistent with re-entry to practice guidelines for other physician applicants within their jurisdiction.**

States that have enacted additional licensing pathway legislation have listed varying ranges for the number of years of IMG practice, from continuous practice preceding application to within the preceding five years. States should be cognizant that requiring continuous practice may be difficult for many applicants to manage and/or demonstrate, especially if they have to navigate the U.S. immigration system, adjust to displacement, or face any number of non-immigration barriers faced by domestic physicians that require time away from active practice, including, but not limited to, sickness, caregiving or raising children.

7. **A requirement for a period of temporary provisional licensure prior to eligibility to apply for a full and unrestricted license to practice medicine.**

All states that have enacted additional pathway legislation as of the date of publication of this guidance have explicitly included a provision that applicants for additional pathways to a full and unrestricted medical license first begin with a temporary provisional license to practice medicine.

"Supervision" is mentioned as a part of this provision by some states in their enacted legislation. For example, a few states have enacted legislation that allows internationally trained physicians to practice under the "supervision of a licensed physician for two years" as part of their pathway. Supervision and support for internationally trained physicians are crucial to navigate and bridge cultural and boundary differences, and to enable qualified internationally trained physicians to learn the technical and operational side of the U.S. health care system, including the process of billing and the use of electronic health records. Such supervision and support are also essential for public protection. Examples of supervisory structures that could be helpful include a collaborative practice arrangement, preceptorships and/or more formalized training models that include opportunities for progressive assessment of the international physician's caseload and practice. States may also choose to require a "declaration of fitness" made by supervising physicians or verification of compliance with a state's continuing medical education (CME) requirements in order to progress to full and unrestricted licensure.[7]

[6] board-requirements-on-re-entry-to-practice.pdf (fsmb.org)
[7] Continuing Medical Education, Board-by-Board Overview, FSMB

The Advisory Commission on Additional Licensing Models is exploring resources available to assist state medical boards with the potential structure of an assessment program and provisional supervised licensure, and anticipates proposing recommendations on this matter sometime in 2025.

***Recommendation 7a*: States should require a period of temporary provisional licensure for qualified internationally trained physicians under an additional licensure pathway before they become eligible to apply for a full and unrestricted license.**

***Recommendation 7b*: During their period of temporary provisional licensure, applicants should be supervised by licensed physicians within the same specialty as the applicant's intended practice.**

***Recommendation 7c*: During this period of temporary provisional licensure, applicants should receive progressive assessment (as defined by the state medical boards and suggested in this section) and adequate support by the employer to help the international physician navigate and bridge cultural and boundary differences, including understanding billing, coding and electronic health records.**

States have taken a variety of approaches in specifying the duration of provisional licensure, with two or three years being the most common time periods cited in legislation. However, there have been some legislative proposals for a two-step progression, by which an IMG first becomes eligible for a restricted or limited license after at least two years of provisional licensure, but still practices in areas or specialties with the greatest medical need, with or without ongoing supervision; provisional, restricted, and limited licensees under this arrangement are *required* in order to practice at these facilities for the entire duration of their time prior to full licensure.

8. Eligibility for a full and unrestricted license to practice medicine.

All states that have enacted additional pathway legislation have included a provision that at the conclusion of the provisional or restricted licensure period, the qualified international physician should become eligible to apply for a full and unrestricted license to practice medicine. There is a small but meaningful linguistic divergence in enacted legislation thus far, however, with wording indicating that state medical boards *may* or *shall* grant a full and unrestricted license to the IMG applicant.

State medical boards ordinarily and typically retain the authority to make licensure decisions for all licensees, even after a period of provisional licensure. Automatic transition to full and unrestricted licensure, by contrast, is neither ordinary nor typical. State medical boards may wish to consider working with their legislatures to retain the ability to exercise their due diligence and assess each applicant on their merits before determining whether they meet the state's criteria for full licensure.

States may also consider explicit requirements for provisional licensees before being granted eligibility for full licensure, such as passing USMLE Step 3 (already a requirement for all other IMGs for licensure), passing the employer's (or facility's) assessment and evaluation program, and having neither any disciplinary actions nor investigations pending over the course of their provisional licensure. Most states that have enacted pathway legislation have required a combination of these steps and there have been some proposals to include a letter of recommendation from the applicant's supervising physician as well.

***Recommendation 8a*: State medical boards in states that have enacted legislation to create additional licensing pathways for internationally trained physicians should work with their legislatures, where permitted, to retain their historic and statutory ability to exercise their due diligence and assess each applicant on their merits before they progress from provisional to full and unrestricted licensure.**

***Recommendation 8b:* State medical boards should add a requirement for passing USMLE Step 3 (as already required of all IMGs) for a full and unrestricted license and a proviso that the applicant not have any disciplinary actions or investigations pending from their provisional licensure period.**

9. Standard data collection requirements.

Data collection and dissemination is critical for state medical boards, state legislators, and state medical boards to better understand the impact of these types of additional licensure pathways. Significant questions remain about the efficacy of these additional pathways to address U.S. health care workforce shortages. Much of the legislation introduced thus far does not address what will likely be significant barriers to employment and the ability to practice with a full license in many states. These questions include whether physicians entering a pathway will be eligible for board certification, whether malpractice insurers will cover their practice, and whether payors will reimburse for the services provided by these physicians.

***Recommendation 9*: State medical boards, assisted by partner organizations as may be necessary, should collect information that will facilitate evaluation of these additional licensure pathways to make sure they are meeting their intended purpose. This information should include:**

- **the number of applicants**
- **the number of internationally trained physicians receiving provisional licensure under the pathway and the number denied provisional licensure under the pathway**
- **the number of individuals achieving full and unrestricted licensure,**
- **the percentage of individuals that stay and practice in their specialty of training and in rural or underserved areas**

- **the number of complaints received and disciplinary actions taken (if any)**
- **the practice setting and specialty of applicants**
- **the number of IMGs licensed through additional licensure pathways who ultimately remain in the United States versus returning to their home countries**
- **the number of individuals achieving specialty board certification**
- **the costs to the board of operating an additional licensing pathway**

ARTICLE 10
BOARD OF MEDICAL PRACTICE

Section 1. Minnesota Statutes 2023 Supplement, section 144.99, subdivision 1, is amended to read:

Subdivision 1. **Remedies available.** The provisions of chapters 103I and 157 and sections 115.71 to 115.77; 144.12, subdivision 1, paragraphs (1), (2), (5), (6), (10), (12), (13), (14), and (15); 144.1201 to 144.1204; 144.121; 144.1215; 144.1222; 144.35; 144.381 to 144.385; 144.411 to 144.417; 144.495; 144.71 to 144.74; 144.9501 to 144.9512; 144.97 to 144.98; 144.992; 147.037, subdivision 1b, paragraph (c); 326.70 to 326.785; 327.10 to 327.131; and 327.14 to 327.28 and all rules, orders, stipulation agreements, settlements, compliance agreements, licenses, registrations, certificates, and permits adopted or issued by the department or under any other law now in force or later enacted for the preservation of public health may, in addition to provisions in other statutes, be enforced under this section.

EFFECTIVE DATE. This section is effective January 1, 2025.

Sec. 2. Minnesota Statutes 2022, section 147.037, is amended by adding a subdivision to read:

Subd. 1b. **Limited license.** (a) The board must issue a limited license to any person who satisfies the requirements of subdivision 1, paragraphs (a) to (c) and (e) to (g), and who:

(1) pursuant to a license or other authorization to practice, has practiced medicine, as defined in section 147.081, subdivision 3, clauses (2) to (4), for at least 60 months in the previous ten years outside of the United States;

(2) submits sufficient evidence of an offer to practice within the context of a collaborative agreement within a hospital or clinical setting where the limited license holder and physicians work together to provide patient care;

(3) provides services in a designated rural area or underserved urban community as defined in section 144.1501; and

(4) submits two letters of recommendation in support of a limited license, which must include one letter from a physician with whom the applicant previously worked and one letter from an administrator of the hospital or clinical setting in which the applicant previously worked. The letters of recommendation must attest to the applicant's good medical standing.

(b) A person issued a limited license under this subdivision must not be required to present evidence satisfactory to the board of the completion of one year of graduate clinical

medical training in a program accredited by a national accrediting organization approved by the board.

(c) An employer of a limited license holder must pay the limited license holder at least an amount equivalent to a medical resident in a comparable field. The employer must carry medical malpractice insurance covering a limited license holder for the duration of the employment. The commissioner of health may issue a correction order under section 144.99, subdivision 3, requiring an employer to comply with this paragraph. An employer must not retaliate against or discipline an employee for raising a complaint or pursuing enforcement relating to this paragraph.

(d) The board must issue a full and unrestricted license to practice medicine to a person who holds a limited license issued pursuant to paragraph (a) and who has:

(1) held the limited license for two years and is in good standing to practice medicine in this state;

(2) practiced for a minimum of 1,692 hours per year for each of the previous two years; and

(3) submitted a letter of recommendation in support of a full and unrestricted license from any physician who participated in the collaborative agreement.

(e) A limited license holder must submit to the board, every six months or upon request, a statement certifying whether the person is still employed as a physician in this state and whether the person has been subjected to professional discipline as a result of the person's practice. The board may suspend or revoke a limited license if a majority of the board determines that the licensee is no longer employed as a physician in this state by an employer. The licensee must be granted an opportunity to be heard prior to the board's determination. A licensee may change employers during the duration of the limited license if the licensee has another offer of employment. In the event that a change of employment occurs, the licensee must still work the number of hours required under paragraph (d), clause (2), to be eligible for a full and unrestricted license to practice medicine.

(f) For purposes of this subdivision, "collaborative agreement" means a mutually agreed upon plan for the overall working relationship and collaborative arrangement between a holder of a limited license and one or more physicians licensed under this chapter that designates the scope of services that can be provided to manage the care of patients. The limited license holder and one of the collaborating physicians must have experience in providing care to patients with the same or similar medical conditions. The collaborating physician is not required to be physically present, but the limited license holder must have

one-on-one practice reviews provided in person or through eye-to-eye electronic media while maintaining visual contact with each collaborating physician for at least two hours per month, and the collaborating physician and limited license holder can easily contact each other by radio, telephone, or other telecommunication device.

(g) The board must not grant a license under this section unless the applicant possesses federal immigration status that allows the applicant to practice as a physician in the United States.

EFFECTIVE DATE. This section is effective January 1, 2025.

MINNESOTA BOARD OF MEDICAL PRACTICE
POLICY & PLANNING COMMITTEE MINUTES
October 14, 2024 * 12:00 noon

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's Policy and Planning Committee of Kristina Krohn, M.D., Chairperson, Sarah Carter, M.D., John (Jake) Manahan, J.D., Averi Turner, and Jane Willett, D.O., met at 12:00 p.m. via WebEx. Also in attendance was the Board's Executive Director, Elizabeth Huntley and Board staff, Kita Nelson and Eden Young. Board members Cheryl Bailey, M.D., Bruce Anderson, and Allen Rasmussen, M.A., were also present along with several members of the public. The Committee considered the following items:

Introductions: Committee, staff, and members of the public introduced themselves.

Presentation from the Minnesota Academy of Physician Associates ("MAPA"): Leslie Clayton DMSc, PA-C, gave a presentation about legislation MAPA will bring in the 2025 legislative session specific to the qualification rule for licensure in Minn. Stat. §147A.02(c). This statute requires that a physician assistant practice for at least 2,080 hours, within the context of a collaborative agreement with a Minnesota licensed physician and the proposed change would allow the 2,080 collaborative hours to be with a physician licensed by any United States state or territory.

Mr. Manahan made a motion to support the language change to Minn. Stat. §147A.02(c) as presented and discussed. Dr. Willett made a second to the motion and the motion passed with three votes. Drs. Krohn and Pazdernik abstained on the vote.

Ms. Clayton offered a courtesy notice that the professional association will be moving forward with an effort for title change from physician assistant to physician associate in accordance with national and international changes to the physician assistant profession.

Review and Discussion of the DRAFT GUIDANCE DOCUMENT from the Advisory Commission on Additional Licensing Models: Dr. Krohn thoroughly walked through the recommendations of the Advisory Commission and facilitated questions and comments from Board members. Following the discussion, Mr. Manahan made a motion to support the recommendations as suggested with additional impute from Dr. Krohn specific to ensuring quality in assessment at the end of the provisional licensure time and consideration of the impact for underserved communities. Dr. Pazdernik made a second to the motion and it passed by unanimous consent. Ms. Turner was absent for the vote.

Other business. No other business was noted.

Remaining meeting dates for 2024: It was noted the remaining meeting dates for this calendar year are November 25 and December 9, 2024.

Dear FSMB Advisory Commission on Alternative Licensing Models

The Minnesota Board of Medical Practice strongly supports the FSMB Advisory Commission's recommendations for any proposed legislation to create alternative pathways for physician licensure.

We greatly appreciate and fully support the following recommendations:

- Start with a small pilot program – rural/underserved – family medicine/primary care.
- Ensure the necessary resources are delegated or allocated for medical boards to hire staff with the necessary training, knowledge and understanding of licensing international medical graduates to be able to properly vet an application for an additional pathway to licensure.
- Provide the medical board with final approval of medical facilities who offer employment under these provisional licenses.
- Require ECFMG Certification and graduation from a recognized medical school.
- Ensure that facilities provide the provisional licensee the necessary and appropriate support, education, and assessment.
- Appropriate monitoring of provisional licensees by facilities and medical boards.
- Appropriate data collection and monitoring of the alternate pathway to ensure that provisional licensees are providing safe care, and facilities are providing appropriate support.
- After a temporary period on a provisional license, allowing provisional licensees to apply for a full unrestricted medical license, with the decision to be granted a full medical license remaining with the medical board and contingent on the applicant submitting appropriate assessments from during the provisional licensing time period.

We wish to further ensure the following concerns are noted by the FSMB Advisory Commission on Alternative Licensing Models:

- We would like to stress that the recommendations are drafted from FSMB's members' experience implementing licensure to ensure public protection. The individual state boards will be unable to enforce or implement the above recommendations without appropriate support in personnel, equipment, data monitoring, time for appropriate supervision and assessment. If the boards are not supported in a manner that allows them to safely implement licensure, then they will not be able to offer the license as described.

- If medical boards are to be responsible for the final determination of if a given medical facility has the ability to appropriately supervise and assess an internationally trained physician's proficiency and capabilities, then boards need to have the necessary support to be able to appropriately assess the supervision and assessment and/or facilities must provide sufficient documentation and explanation of their capabilities. Facilities should be responsible for compiling and providing this information. In addition, we would presume that boards would view facilities more favorably if they also ensured that those hired into these positions are hired in transparent manners that ensure their ability to utilize the license if it is granted, such as ensuring malpractice coverage and ability to practice as an individual physician, (for example availability of board certification). Medical boards may feel more inclined to approve facilities if they know that the licenses approved would be utilized.

- The high variability in medical training and medical practice around the world makes evaluating post graduate programs difficult. The variety makes it difficult for programs to know the quality of the applicants before the program starts. In the United States, the Accreditation Council for Graduate Medical Education (ACGME) is responsible for ensuring the quality of the post graduate programs, not the medical boards. To our knowledge, proposed legislation has not required an accreditation body to oversee either the post graduate training outside of the United State or the training/assessment provided during the provisional licensing time period. Our medical board, and others, are not staffed nor trained in determining the quality of education or assessment. We rely on others' expertise, specifically ACGME, in this area. Therefore, legislation should ensure the following:

    - Appropriate measures for evaluating the quality of the post graduate training outside of the United States, including support for time, personnel, and necessary training.

- In discussions with medical educators in Minnesota, it noted that it is easier to predict which students will need additional assistance as residents when those students come from known programs than when students come from unknown programs, especially programs outside of the United States. Our board also has significant concerns about any one facilities ability to self-monitor its support and assessments for a provisional licensee. Therefore, legislation should ensure the following:

    - Appropriate measures for evaluating the quality of the supervision, training, and assessment at any medical facility.
    - Appropriate support for an alternative body (whether a medical board or other agency) to separately assess a medical facility's supervision, training, and assessment of a provisional licensee.

- The Minnesota Medical Board had robust discussions regarding attempts to increase the number of providers who work in underserved areas. In general, we support efforts to increase the number of providers in underserved areas. We also have hesitations about programs that require certain types of doctors to work only in certain areas. Our concerns include an actual or perceived difference in quality of the clinician. We do not have specific additional recommendations here; however, we would appreciate efforts that ensure adequate support for any physician placed in a low resourced area.

Without all of the above concerns being addressed, in particular with the necessary financial support to hire appropriate personnel and collect appropriate data, it would be difficulty for the Minnesota Board of Medical Practice to support such legislation within our jurisdiction.

Sincerely,
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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 POLICY & PLANNING COMMITTEE OF THE MINNESOTA BOARD OF MEDICAL PRACTICE WILL MEET ELECTRONICALLY BY WEBEX:
To join the meeting, go to:
https://minnesota.webex.com/minnesota/j.php?MTID=m01f26b1c52c1b7bbaa491a7a3b6cc098
Meeting number (access code): 2495 025 1702
Meeting password: yNCQXVba387

Join by phone:
Tap to call in from a mobile device (attendees only)
+1-415-655-0003 United States Toll
1-855-282-6330 United States Toll Free

Join from a video system or application
Dial 24950251702@minnesota.webex.com
You can also dial 173.243.2.68 and enter your meeting number

Need help? Go to http://help.webex.com

AGENDA FOR
THE MINNESOTA BOARD OF MEDICAL PRACTICE
POLICY & PLANNING COMMITTEE
NOVEMBER 25, 2024
12:00 P.M. – CST

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1. Roll Call of Policy & Planning Committee members

2. Approval of minutes from October 14, 2024 meeting

3. Presentation by the Minnesota Athletic Trainers' Association: *proposed* changes to Minn. Stat. §148

    a. PowerPoint Presentation
    b. Proposed language changes

4. Select meeting dates for 2025. Following is a proposed list of meeting dates for the first quarter of 2025:

    - Monday, January 6, 2025 @ 12 noon
    - Tuesday, February 18, 2025 @ 12 noon
    - Monday, March 3, 2024 @ 12 noon
    - Monday, April 7, 2025 @ 12 noon

5. Other business

6. Final meeting date for 2024: December 9, 2024 @ 12 noon

MINNESOTA BOARD OF MEDICAL PRACTICE
POLICY & PLANNING COMMITTEE MINUTES
October 14, 2024 * 12:00 noon

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Other business. No other business was noted.

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Athletic Training

148.7802 DEFINITIONS

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

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

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

Subd. 6a. Athletic training. (a) For the purpose of emergent, acute, and chronic injuries and non-orthopedic conditions, “athletic training” means: within the training and experience of the athletic trainer as required in 148.7806 sub(c). “Athletic training” means:

(1) Prevention and wellness promotion:
(2) Risk management;
(3) Immediate and emergency care;
(4) Examination, assessment, and diagnosis of a condition for which treatment is included in the training and experience of the athletic trainer as required in 148.7806 sub(c); and
(5) Therapeutic interventions, rehabilitation, and reconditioning.

(b) Athletic training also includes making clinical decisions to determine if a consultation or referral is necessary, health care administration, and maintaining professional responsibility.

148.7806 ATHLETIC TRAINING.

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

(a) An athletic trainer shall: perform athletic training, as defined under section 148.7802, subdivision 6a, under the direction of, on the prescription of, or in collaboration with a primary physician who is licensed in the state to practice medicine as defined in section 147.081 and whose license is in good standing.
~~(1) Prevent, recognize, and evaluate athletic injuries;~~
~~(2) Give emergency care and first aid;~~
~~(3) Manage and treat athletic injuries; and~~
~~(4) Rehabilitate and physically recondition athletic injuries.~~

~~The~~ (b) An athletic trainer may use ~~modalities such as cold, heat, light, sound, electricity, exercise, and mechanical devices~~ therapeutic interventions within the training and experience of the athletic trainer as required in sub(c) for treatment and rehabilitation of ~~athletic injuries to athletes in the primary employment site~~ a patient.

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

~~(c)~~ (d) At the primary employment site, ~~except in a corporate setting,~~ an athletic trainer may evaluate and treat ~~an athlete for an athletic injury~~ a patient not previously diagnosed for not more than 30 days, ~~or a period of time as designated by the primary physician on the protocol form,~~ from the date of the initial evaluation and treatment. ~~Preventative care after resolution of the injury is~~ Prevention, wellness, education, exercise, and reconditioning are not considered treatment. This paragraph does not apply to a person who is referred for treatment by a person licensed in this state to practice medicine as defined in section 147.081, to practice chiropractic as defined in section 148.01, to practice podiatry as defined in section 153.01, to practice physical therapy as defined in section 148.65, except as provided under paragraph (g); or to practice dentistry as defined in section 150A.05 and whose license is in good standing.

~~(d)~~ (e) An athletic trainer may:

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

(2) monitor the signs, symptoms, general behavior, and general physical response of ~~an athlete~~ a patient to treatment and rehabilitation including, but not limited to, whether the signs, symptoms, reactions, behavior, or general response show abnormal characteristics requiring a change in the plan of care or referral; and

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

(f) An athletic trainer must not practice or claim to practice medicine as defined in section 147.081; chiropractic as defined in section 148.01; podiatric medicine as defined in section 153.01; occupational therapy as defined in section 148.6404; physical therapy as defined in section 148.65, except as provided under paragraph (g); acupuncture as defined in section 147B.01; or any other licensed or registered health care professional unless the athletic trainer also holds the appropriate license or registration to practice that profession.

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

148.7807 LIMITATIONS ON PRACTICE.

If an athletic trainer determines that a patient's medical condition is ~~beyond~~ outside the scope of practice of that athletic trainer, the athletic trainer must refer the patient to a person licensed in this state to practice medicine as defined in section 147.081, to practice chiropractic as defined in section 148.01, to practice podiatry as defined in section 153.01,

to practice physical therapy as defined in section 148.65, except as provided under paragraph (g); or to practice dentistry as defined in section 150A.05 and whose license is in good standing and in accordance with established evaluation and treatment protocols. An athletic trainer shall modify or terminate treatment of a patient that is not beneficial to the patient, or that is not tolerated by the patient.

148.7814 APPLICABILITY.

Sections 148.7801 to 148.7815 do not apply to ~~persons who are certified as athletic trainers~~ an athletic trainer who is in this state temporarily with an individual or group that is participating in a specific athletic event or series of athletic events if the athletic trainer is licensed, certified, registered by another state or country or certified as an athletic trainer by the Board of Certification or the board's recognized successor ~~and come into Minnesota for a specific athletic event or series of athletic events with an individual or group.~~

MINNESOTA BOARD OF MEDICAL PRACTICE
POLICY & PLANNING COMMITTEE MINUTES
November 25, 2024 * 12:00 noon

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's Policy and Planning Committee of Kristina Krohn, M.D., Chairperson, John (Jake) Manahan, J.D., Julie Pazdernik, M.D., Averi Turner, and Jane Willett, D.O., met on November 25, 2024, at 12:00 p.m. via Webex. Also in attendance was the Board's Executive Director, Elizabeth Huntley and Board staff, Kita Nelson, Kate Van Etta-Olson and Eden Young. The Committee considered the following items:

Introductions: Committee, staff, and members of the public introduced themselves.

Minute Approval: The Committee of Dr. Krohn, Mr. Manahan, Dr. Pazdernik and Dr. Willett approved the minutes from the October 14, 2024, Policy & Planning Committee meeting. Ms. Turner was absent for this vote.

Presentation from the Minnesota Athletic Trainers' Association ("MATA"): Kate Taber, M.Ed., LAT, ATC, MATA GAD Chair, and Josh Pinkney, MS, LAT, ATC – MATA President, presented on several proposed changes to the Minnesota Athletic Trainers Act, Minn. Stat. §148.7801 - .7815, including, but not limited to modernizing definitional language to include the addition of a new section defining athletic training; adjusting language to update the population receiving care from athletes to patients; and an update to the applicability clause to be inclusive of athletic trainer's temporarily in Minnesota with an individual or group participating in a specific athletic event or series of events. Ms. Taber added they want to be certain that none of the proposed changes impact the Board's regulatory authority for athletic trainers.

Ms. Taber and Mr. Pinkney answered questions from Committee members regarding the education, role and work of athletic trainers and how legislative efforts have been received in previous years.

Mr. Manahan made a motion to take a neutral position on the changes to the Minnesota Athletic Trainers Act, Minn. Stat. §148.7801 - .7815, as presented and discussed. Dr. Willett made a second to the motion and the motion passed with unanimous consent.

Other business. No other business was noted.

Remaining meeting dates scheduled for 2024: February 18, March 3 and April 7, all at 12 noon meeting virtually via Webex.

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 POLICY & PLANNING COMMITTEE OF THE MINNESOTA BOARD OF MEDICAL PRACTICE WILL MEET ELECTRONICALLY BY WEBEX:
To join the meeting, go to:
https://minnesota.webex.com/minnesota/j.php?MTID=m931349bf327ea9067954d0c60c02adf3
Meeting number (access code): 2491 325 4593
Meeting password: 3mbVxDT8vB3

Join by phone:
Tap to call in from a mobile device (attendees only)
+1-415-655-0003 United States Toll
1-855-282-6330 United States Toll Free

Join from a video system or application
Dial 24913254593@minnesota.webex.com
You can also dial 173.243.2.68 and enter your meeting number

Need help? Go to http://help.webex.com

AGENDA FOR
THE MINNESOTA BOARD OF MEDICAL PRACTICE
POLICY & PLANNING COMMITTEE
JANUARY 6, 2025
12:00 P.M. – CST

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1. Roll Call of Policy & Planning Committee members

2. Approval of minutes from November 25, 2024 meeting

3. Review and Discuss DRAFT legislation regarding an additional pathway to licensure for internationally trained physicians

4. Remaining scheduled meeting dates for the first quarter of 2025:

   - Tuesday, February 18, 2025 @ 12 noon
   - Monday, March 3, 2024 @ 12 noon
   - Monday, April 7, 2025 @ 12 noon

5. Other business

MINNESOTA BOARD OF MEDICAL PRACTICE
POLICY & PLANNING COMMITTEE MINUTES
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Other business. No other business was noted.

Remaining meeting dates scheduled for 2025: February 18, March 3 and April 7, all at 12 noon meeting virtually via Webex.

A bill for an act

relating to health; amending licensing requirements for graduates of foreign medical schools; authorizing the commissioner of health to remedy certain violations by employers of limited license holders; requiring employers of limited license holders to carry medical malpractice insurance; requiring limited license holders to provide periodic certification to the medical board; amending Minnesota Statutes 2024, sections 144.99, subdivision 1; 147.037, by adding a subdivision.

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

Section 1. Minnesota Statutes 2024, section 144.99, subdivision 1, is amended to read:

Subdivision 1. **Remedies available.** The provisions of chapters 103I and 157 and sections 115.71 to 115.77; 144.12, subdivision 1, paragraphs (1), (2), (5), (6), (10), (12), (13), (14), and (15); 144.1201 to 144.1204; 144.121; 144.1215; 144.1222; 144.35; 144.381 to 144.385; 144.411 to 144.417; 144.495; 144.71 to 144.74; 144.9501 to 144.9512; 144.97 to 144.98; 144.992; 147.037, subdivision 1b, paragraph (c); 326.70 to 326.785; 327.10 to 327.131; and 327.14 to 327.28 and all rules, orders, stipulation agreements, settlements, compliance agreements, licenses, registrations, certificates, and permits adopted or issued by the department or under any other law now in force or later enacted for the preservation of public health may, in addition to provisions in other statutes, be enforced under this section.

EFFECTIVE DATE. This section is effective January 1, 2026.

Sec. 2. Minnesota Statutes 2024, section 147.037, is amended by adding a subdivision to read:

Subd. 1b. **Limited license.** (a) The board must issue a limited license to any person who satisfies the requirements of subdivision 1, paragraphs (a) to (c) and (e) to (g), and who:

(1) pursuant to a license or other authorization to practice, has practiced medicine, as defined in section 147.081, subdivision 3, clauses (2) to (4), for at least 60 months in the previous ten years outside of the United States;

(2) submits sufficient evidence of an offer to practice within the context of a collaborative agreement within a hospital or clinical setting where the limited license holder and physicians work together to provide patient care;

(3) provides services in a designated rural area or underserved urban community as defined in section 144.1501; and

(4) submits two letters of recommendation in support of a limited license, which must include one letter from a physician with whom the applicant previously worked and one letter from an administrator of the hospital or clinical setting in which the applicant previously worked. The letters of recommendation must attest to the applicant's good medical standing.

For purposes of this subdivision, a person has satisfied the requirements of subdivision 1, paragraph (e), if the person has passed steps or levels one and two of the USMLE or the COMLEX-USA with passing scores as recommended by the USMLE program or National Board of Osteopathic Medical Examiners within three attempts.

(b) A person issued a limited license under this subdivision must not be required to present evidence satisfactory to the board of the completion of one year of graduate clinical medical training in a program accredited by a national accrediting organization approved by the board.

(c) An employer of a limited license holder must pay the limited license holder at least an amount equivalent to a medical resident in a comparable field. The employer must carry medical malpractice insurance covering a limited license holder for the duration of the employment. The commissioner of health may issue a correction order under section 144.99, subdivision 3, requiring an employer to comply with this paragraph. An employer must not retaliate against or discipline an employee for raising a complaint or pursuing enforcement relating to this paragraph.

(d) The board must issue a full and unrestricted license to practice medicine to a person who holds a limited license issued pursuant to paragraph (a) and who has:

(1) held the limited license for two years and is in good standing to practice medicine in this state;

(2) practiced for a minimum of 1,692 hours per year for each of the previous two years;

(3) submitted a letter of recommendation in support of a full and unrestricted license from any physician who participated in the collaborative agreement, which letter must include all attestations required under paragraph (g); and

(4) has passed steps or levels one, two, and three of the USMLE or COMLEX-USA with passing scores as recommended by the USMLE program or National Board of Osteopathic Medical Examiners within three attempts.

(e) A limited license holder must submit to the board, every six months or upon request, a statement certifying whether the person is still employed as a physician in this state and whether the person has been subjected to professional discipline as a result of the person's practice. The board may suspend or revoke a limited license if a majority of the board determines that the licensee is no longer employed as a physician in this state by an employer. The licensee must be granted an opportunity to be heard prior to the board's determination. A licensee may change employers during the duration of the limited license if the licensee has another offer of employment. In the event that a change of employment occurs, the licensee must still work the number of hours required under paragraph (d), clause (2), to be eligible for a full and unrestricted license to practice medicine.

(f) For purposes of this subdivision, "collaborative agreement" means a mutually agreed upon plan for the overall working relationship and collaborative arrangement between a holder of a limited license and one or more physicians licensed under this chapter that designates the scope of services that can be provided to manage the care of patients. The limited license holder and one of the collaborating physicians must have experience in providing care to patients with the same or similar medical conditions. A limited license holder may practice medicine without a collaborating physician physically present, but the limited license holder and collaborating physicians must be able to easily contact each other by radio, telephone, or other telecommunication device while the limited license holder practices medicine. The limited license holder must have one-on-one practice reviews with each collaborating physician, provided in person or through eye-to-eye electronic media while maintaining visual contact, for at least two hours per week.

(g) At least one collaborating physician must submit a letter to the board, after the limited license holder has practiced under the license for 12 months, attesting to the following:

(1) that the limited license holder has a basic understanding of federal and state laws regarding the provision of health care, including but not limited to:

(i) medical licensing obligations and standards; and

(ii) the Health Insurance Portability and Accountability Act, Public Law 104-191;

(2) that the limited license holder has a basic understanding of documentation standards;

(3) that the limited license holder has a thorough understanding of which medications are available and unavailable in the United States;

(4) that the limited license holder has a thorough understanding of American medical standards of care;

(5) that the limited license holder has demonstrated mastery of each of the following:

(i) gather a history and perform a physical exam;

(ii) develop and prioritize a differential diagnosis following a clinical encounter and select a working diagnosis;

(iii) recommend and interpret common diagnostic and screening tests;

(iv) enter and discuss orders and prescriptions;

(v) provide an oral presentation of a clinical encounter;

(vi) give a patient handover to transition care responsibly;

(vii) recognize a patient requiring urgent care, and initiate an evaluation; and

(viii) obtain informed consent for tests, procedures, and treatments; and

(6) that the limited license holder is providing appropriate medical care.

(h) The board must not grant a license under this section unless the applicant possesses federal immigration status that allows the applicant to practice as a physician in the United States.

EFFECTIVE DATE. This section is effective January 1, 2026.

ACGME
Common Program Requirements (Residency)

Revision Information
ACGME-approved modification: September 30, 2024; effective July 1, 2025 - removed “or Canada” from III.A.1.a) and III.A.1.b)
ACGME-approved interim revision: September 17, 2022; effective July 1, 2023

Definitions
For more information, see the ACGME Glossary of Terms.

Core Requirements: Statements that define structure, resource, or process elements essential to every graduate medical educational program.

Detail Requirements: Statements that describe a specific structure, resource, or process, for achieving compliance with a Core Requirement. Programs and sponsoring institutions in substantial compliance with the Outcome Requirements may utilize alternative or innovative approaches to meet Core Requirements.

Outcome Requirements: Statements that specify expected measurable or observable attributes (knowledge, abilities, skills, or attitudes) of residents or fellows at key stages of their graduate medical education.

Osteopathic Recognition
For programs with or applying for Osteopathic Recognition, the Osteopathic Recognition Requirements also apply (www.acgme.org/OsteopathicRecognition).

Common Program Requirements (Residency) Contents

Where applicable, text in italics describes the underlying philosophy of the requirements in that section. These philosophic statements are not program requirements and are therefore not citable.

Note: Review Committees may further specify only where indicated by "The Review Committee may/must further specify."

Introduction

Int.A. Definition of Graduate Medical Education

Graduate medical education is the crucial step of professional development between medical school and autonomous clinical practice. It is in this vital phase of the continuum of medical education that residents learn to provide optimal patient care under the supervision of faculty members who not only instruct, but serve as role models of excellence, compassion, cultural sensitivity, professionalism, and scholarship.

Graduate medical education transforms medical students into physician scholars who care for the patient, patient's family, and a diverse community; create and integrate new knowledge into practice; and educate future generations of physicians to serve the public. Practice patterns established during graduate medical education persist many years later.

Graduate medical education has as a core tenet the graded authority and responsibility for patient care. The care of patients is undertaken with appropriate faculty supervision and conditional independence, allowing residents to attain the knowledge, skills, attitudes, judgment, and empathy required for autonomous practice. Graduate medical education develops physicians who focus on excellence in delivery of safe, equitable, affordable, quality care; and the health of the populations they serve. Graduate medical education values the strength that a diverse group of physicians brings to medical care, and the importance of inclusive and psychologically safe learning environments.

Graduate medical education occurs in clinical settings that establish the foundation for practice-based and lifelong learning. The professional development of the physician, begun in medical school, continues through faculty modeling of the effacement of self-interest in a humanistic environment that emphasizes joy in curiosity, problem-solving, academic rigor, and discovery. This transformation is often physically, emotionally, and intellectually demanding and occurs in a variety of clinical learning environments committed to graduate medical education and the well-being of patients, residents, fellows, faculty members, students, and all members of the health care team.

Int.B. Definition of Specialty

[The Review Committee must further specify]

Int.C. Length of Educational Program

[The Review Committee must further specify]

I. Oversight

I.A. Sponsoring Institution

The Sponsoring Institution is the organization or entity that assumes the ultimate financial and academic responsibility for a program of graduate medical education, consistent with the ACGME Institutional Requirements.

When the Sponsoring Institution is not a rotation site for the program, the most commonly utilized site of clinical activity for the program is the primary clinical site.

Background and Intent: Participating sites will reflect the health care needs of the community and the educational needs of the residents. A wide variety of organizations may provide a robust educational experience and, thus, Sponsoring Institutions and participating sites may encompass inpatient and outpatient settings including, but not limited to a university, a medical school, a teaching hospital, a nursing home, a school of public health, a health department, a public health agency, an organized health care delivery system, a medical examiner's office, an educational consortium, a teaching health center, a physician group practice, federally qualified health center, or an educational foundation.

I.A.1. The program must be sponsored by one ACGME-accredited Sponsoring Institution. (Core)

I.B. Participating Sites

A participating site is an organization providing educational experiences or educational assignments/rotations for residents.

I.B.1. The program, with approval of its Sponsoring Institution, must designate a primary clinical site. (Core)
[The Review Committee may specify which other specialties/programs must be present at the primary clinical site]

I.B.2. There must be a program letter of agreement (PLA) between the program and each participating site that governs the relationship between the program and the participating site providing a required assignment. (Core)

I.B.2.a) The PLA must:

I.B.2.a).(1) be renewed at least every 10 years; and, (Core)

I.B.2.a).(2) be approved by the designated institutional official (DIO). (Core)

I.B.3. The program must monitor the clinical learning and working environment at all participating sites. (Core)

I.B.3.a) **At each participating site there must be one faculty member, designated by the program director as the site director, who is accountable for resident education at that site, in collaboration with the program director.** (Core)

Background and Intent: While all residency programs must be sponsored by a single ACGME-accredited Sponsoring Institution, many programs will utilize other clinical settings to provide required or elective training experiences. At times it is appropriate to utilize community sites that are not owned by or affiliated with the Sponsoring Institution. Some of these sites may be remote for geographic, transportation, or communication issues. When utilizing such sites, the program must ensure the quality of the educational experience.

Suggested elements to be considered in PLAs will be found in the Guide to the Common Program Requirements. These include:

- **Identifying the faculty members who will assume educational and supervisory responsibility for residents**
- **Specifying the responsibilities for teaching, supervision, and formal evaluation of residents**
- **Specifying the duration and content of the educational experience**
- **Stating the policies and procedures that will govern resident education during the assignment**

I.B.4. **The program director must submit any additions or deletions of participating sites routinely providing an educational experience, required for all residents, of one month full time equivalent (FTE) or more through the ACGME's Accreditation Data System (ADS).** (Core) **[The Review Committee may further specify]**

I.C. **Workforce Recruitment and Retention**

The program, in partnership with its Sponsoring Institution, must engage in practices that focus on mission-driven, ongoing, systematic recruitment and retention of a diverse and inclusive workforce of residents, fellows (if present), faculty members, senior administrative GME staff members, and other relevant members of its academic community. (Core)

Background and Intent: It is expected that the Sponsoring Institution has, and programs implement, policies and procedures related to recruitment and retention of individuals underrepresented in medicine and medical leadership in accordance with the Sponsoring Institution's mission and aims.

I.D. **Resources**

I.D.1. **The program, in partnership with its Sponsoring Institution, must ensure the availability of adequate resources for resident education.** (Core)

[The Review Committee must further specify]

I.D.2. **The program, in partnership with its Sponsoring Institution, must ensure healthy and safe learning and working environments that promote resident well-being and provide for:**

I.D.2.a) **access to food while on duty; (Core)**

I.D.2.b) **safe, quiet, clean, and private sleep/rest facilities available and accessible for residents with proximity appropriate for safe patient care; (Core)**

Background and Intent: Care of patients within a hospital or health system occurs continually through the day and night. Such care requires that residents function at their peak abilities, which requires the work environment to provide them with the ability to meet their basic needs within proximity of their clinical responsibilities. Access to food and rest are examples of these basic needs, which must be met while residents are working. Residents should have access to refrigeration where food may be stored. Food should be available when residents are required to be in the hospital overnight. Rest facilities are necessary, even when overnight call is not required, to accommodate the fatigued resident.

I.D.2.c) **clean and private facilities for lactation that have refrigeration capabilities, with proximity appropriate for safe patient care; (Core)**

Background and Intent: Sites must provide private and clean locations where residents may lactate and store the milk within a refrigerator. These locations should be in close proximity to clinical responsibilities. It would be helpful to have additional support within these locations that may assist the resident with the continued care of patients, such as a computer and a phone. While space is important, the time required for lactation is also critical for the well-being of the resident and the resident's family, as outlined in VI.C.1.c).(1)

I.D.2.d) **security and safety measures appropriate to the participating site; and, (Core)**

I.D.2.e) **accommodations for residents with disabilities consistent with the Sponsoring Institution's policy. (Core)**

I.D.3. **Residents must have ready access to specialty-specific and other appropriate reference material in print or electronic format. This must include access to electronic medical literature databases with full text capabilities. (Core)**

I.E. **Other Learners and Health Care Personnel**

The presence of other learners and other health care personnel, including, but not limited to residents from other programs, subspecialty fellows, and advanced practice providers, must not negatively impact the appointed residents' education. (Core)

[The Review Committee may further specify]

Background and Intent: The clinical learning environment has become increasingly complex and often includes care providers, students, and post-graduate residents and fellows from multiple disciplines. The presence of these practitioners and their learners enriches the learning environment. Programs have a responsibility to monitor the learning environment to ensure that residents' education is not compromised by the presence of other providers and learners.

II. Personnel

II.A. Program Director

II.A.1. There must be one faculty member appointed as program director with authority and accountability for the overall program, including compliance with all applicable program requirements. (Core)

II.A.1.a) The Sponsoring Institution's GMEC must approve a change in program director and must verify the program director's licensure and clinical appointment. (Core)

II.A.1.a).(1) Final approval of the program director resides with the Review Committee. (Core)
[For specialties that require Review Committee approval of the program director, the Review Committee may further specify. This requirement will be deleted for those specialties that do not require Review Committee approval of the program director.]

Background and Intent: While the ACGME recognizes the value of input from numerous individuals in the management of a residency, a single individual must be designated as program director and have overall responsibility for the program. The program director's nomination is reviewed and approved by the GMEC.

II.A.1.b) The program must demonstrate retention of the program director for a length of time adequate to maintain continuity of leadership and program stability. (Core)
[The Review Committee may further specify]

Background and Intent: The success of residency programs is generally enhanced by continuity in the program director position. The professional activities required of a program director are unique and complex and take time to master. All programs are encouraged to undertake succession planning to facilitate program stability when there is necessary turnover in the program director position.

II.A.2. The program director and, as applicable, the program's leadership team, must be provided with support adequate for administration of the program based upon its size and configuration. (Core)
[The Review Committee must further specify minimum dedicated time for program administration, and will determine whether

program leadership refers to the program director or both the program director and associate/assistant program director(s).]

Background and Intent: To achieve successful graduate medical education, individuals serving as education and administrative leaders of residency programs, as well as those significantly engaged in the education, supervision, evaluation, and mentoring of residents, must have sufficient dedicated professional time to perform the vital activities required to sustain an accredited program.

The ultimate outcome of graduate medical education is excellence in resident education and patient care.

The program director and, as applicable, the program leadership team, devote a portion of their professional effort to the oversight and management of the residency program, as defined in II.A.4.-II.A.4.a).(16). Both provision of support for the time required for the leadership effort and flexibility regarding how this support is provided are important. Programs, in partnership with their Sponsoring Institutions, may provide support for this time in a variety of ways. Examples of support may include, but are not limited to, salary support, supplemental compensation, educational value units, or relief of time from other professional duties.

Program directors and, as applicable, members of the program leadership team, who are new to the role may need to devote additional time to program oversight and management initially as they learn and become proficient in administering the program. It is suggested that during this initial period the support described above be increased as needed.

In addition, it is important to remember that the dedicated time and support requirement for ACGME activities is a *minimum*, recognizing that, depending on the unique needs of the program, additional support may be warranted. The need to ensure adequate resources, including adequate support and dedicated time for the program director, is also addressed in Institutional Requirement II.B.1. The amount of support and dedicated time needed for individual programs will vary based on a number of factors and may exceed the minimum specified in the applicable specialty/subspecialty-specific Program Requirements. It is expected that the Sponsoring Institution, in partnership with its accredited programs, will ensure support for program directors to fulfill their program responsibilities effectively.

II.A.3. Qualifications of the program director:

II.A.3.a) must include specialty expertise and at least three years of documented educational and/or administrative experience, or qualifications acceptable to the Review Committee; (Core)

Background and Intent: Leading a program requires knowledge and skills that are established during residency and subsequently further developed. The time period from completion of residency until assuming the role of program director allows the individual to cultivate leadership abilities while becoming professionally established. The three-year period is intended for the individual's professional maturation.

The broad allowance for educational and/or administrative experience recognizes that strong leaders arise through diverse pathways. These areas of expertise are important when identifying and appointing a program director. The choice of a program director should be informed by the mission of the program and the needs of the community.

In certain circumstances, the program and Sponsoring Institution may propose and the Review Committee may accept a candidate for program director who fulfills these goals but does not meet the three-year minimum.

II.A.3.b) **must include current certification in the specialty for which they are the program director by the American Board of _____ or by the American Osteopathic Board of _____, or specialty qualifications that are acceptable to the Review Committee; and,** (Core)
[The Review Committee may further specify acceptable specialty qualifications or that only ABMS and AOA certification will be considered acceptable]

II.A.3.c) **must include ongoing clinical activity.** (Core)

Background and Intent: A program director is a role model for faculty members and residents. The program director must participate in clinical activity consistent with the specialty. This activity will allow the program director to role model the Core Competencies for the faculty members and residents.

[The Review Committee may further specify additional program director qualifications]

II.A.4. **Program Director Responsibilities**

The program director must have responsibility, authority, and accountability for: administration and operations; teaching and scholarly activity; resident recruitment and selection, evaluation, and promotion of residents, and disciplinary action; supervision of residents; and resident education in the context of patient care. (Core)

II.A.4.a) **The program director must:**

II.A.4.a).(1) **be a role model of professionalism;** (Core)

Background and Intent: The program director, as the leader of the program, must serve as a role model to residents in addition to fulfilling the technical aspects of the role. As residents are expected to demonstrate compassion, integrity, and respect for others, they must be able to look to the program director as an exemplar. It is of utmost importance, therefore, that the program director model outstanding professionalism, high quality patient care, educational excellence, and a scholarly approach to work. The program director creates an environment where respectful discussion is welcome, with the goal of continued improvement of the educational experience.

II.A.4.a).(2) **design and conduct the program in a fashion consistent with the needs of the community, the mission(s) of the Sponsoring Institution, and the mission(s) of the program; (Core)**

Background and Intent: The mission of institutions participating in graduate medical education is to improve the health of the public. Each community has health needs that vary based upon location and demographics. Programs must understand the structural and social determinants of health of the populations they serve and incorporate them in the design and implementation of the program curriculum, with the ultimate goal of addressing these needs and eliminating health disparities.

II.A.4.a).(3) **administer and maintain a learning environment conducive to educating the residents in each of the ACGME Competency domains; (Core)**

Background and Intent: The program director may establish a leadership team to assist in the accomplishment of program goals. Residency programs can be highly complex. In a complex organization, the leader typically has the ability to delegate authority to others, yet remains accountable. The leadership team may include physician and non-physician personnel with varying levels of education, training, and experience.

II.A.4.a).(4) **have the authority to approve or remove physicians and non-physicians as faculty members at all participating sites, including the designation of core faculty members, and must develop and oversee a process to evaluate candidates prior to approval; (Core)**

Background and Intent: The provision of optimal and safe patient care requires a team approach. The education of residents by non-physician educators may enable the resident to better manage patient care and provides valuable advancement of the residents' knowledge. Furthermore, other individuals contribute to the education of residents in the basic science of the specialty or in research methodology. If the program director determines that the contribution of a non-physician individual is significant to the education of the residents, the program director may designate the individual as a program faculty member or a program core faculty member.

II.A.4.a).(5) **have the authority to remove residents from supervising interactions and/or learning environments that do not meet the standards of the program; (Core)**

Background and Intent: The program director has the responsibility to ensure that all who educate residents effectively role model the Core Competencies. Working with a resident is a privilege that is earned through effective teaching and professional role modeling. This privilege may be removed by the program director when the standards of the clinical learning environment are not met.

There may be faculty in a department who are not part of the educational program, and the program director controls who is teaching the residents.

II.A.4.a).(6) **submit accurate and complete information required and requested by the DIO, GMEC, and ACGME; (Core)**

Background and Intent: This includes providing information in the form and format requested by the ACGME and obtaining requisite sign-off by the DIO.

II.A.4.a).(7) **provide a learning and working environment in which residents have the opportunity to raise concerns, report mistreatment, and provide feedback in a confidential manner as appropriate, without fear of intimidation or retaliation; (Core)**

II.A.4.a).(8) **ensure the program's compliance with the Sponsoring Institution's policies and procedures related to grievances and due process, including when action is taken to suspend or dismiss, or not to promote or renew the appointment of a resident; (Core)**

Background and Intent: A program does not operate independently of its Sponsoring Institution. It is expected that the program director will be aware of the Sponsoring Institution's policies and procedures, and will ensure they are followed by the program's leadership, faculty members, support personnel, and residents.

II.A.4.a).(9) **ensure the program's compliance with the Sponsoring Institution's policies and procedures on employment and non-discrimination; (Core)**

II.A.4.a).(9).(a) **Residents must not be required to sign a non-competition guarantee or restrictive covenant. (Core)**

II.A.4.a).(10) **document verification of education for all residents within 30 days of completion of or departure from the program; and, (Core)**

II.A.4.a).(11) **provide verification of an individual resident's education upon the resident's request, within 30 days; and (Core)**

Background and Intent: Primary verification of graduate medical education is important to credentialing of physicians for further training and practice. Such verification must be accurate and timely. Sponsoring Institution and program policies for record retention are important to facilitate timely documentation of residents who have previously completed the program. Residents who leave the program prior to completion also require timely documentation of their summative evaluation.

II.A.4.a).(12) **provide applicants who are offered an interview with information related to the applicant's eligibility for the relevant specialty board examination(s). (Core)**
[This requirement may be omitted at the discretion of the Review Committee]

II.B. Faculty

Faculty members are a foundational element of graduate medical education – faculty members teach residents how to care for patients. Faculty members provide an important bridge allowing residents to grow and become practice-ready, ensuring that patients receive the highest quality of care. They are role models for future generations of physicians by demonstrating compassion, commitment to excellence in teaching and patient care, professionalism, and a dedication to lifelong learning. Faculty members experience the pride and joy of fostering the growth and development of future colleagues. The care they provide is enhanced by the opportunity to teach and model exemplary behavior. By employing a scholarly approach to patient care, faculty members, through the graduate medical education system, improve the health of the individual and the population.

Faculty members ensure that patients receive the level of care expected from a specialist in the field. They recognize and respond to the needs of the patients, residents, community, and institution. Faculty members provide appropriate levels of supervision to promote patient safety. Faculty members create an effective learning environment by acting in a professional manner and attending to the well-being of the residents and themselves.

Background and Intent: "Faculty" refers to the entire teaching force responsible for educating residents. The term "faculty," including "core faculty," does not imply or require an academic appointment.

II.B.1. **There must be a sufficient number of faculty members with competence to instruct and supervise all residents. (Core)**
[The Review Committee may further specify]

II.B.2. **Faculty members must:**

II.B.2.a) **be role models of professionalism; (Core)**

II.B.2.b) **demonstrate commitment to the delivery of safe, equitable, high-quality, cost-effective, patient-centered care; (Core)**

Background and Intent: Patients have the right to expect quality, cost-effective care with patient safety at its core. The foundation for meeting this expectation is formed during residency and fellowship. Faculty members model these goals and continually strive for improvement in care and cost, embracing a commitment to the patient and the community they serve.

II.B.2.c) demonstrate a strong interest in the education of residents, including devoting sufficient time to the educational program to fulfill their supervisory and teaching responsibilities; (Core)

II.B.2.d) administer and maintain an educational environment conducive to educating residents; (Core)

II.B.2.e) regularly participate in organized clinical discussions, rounds, journal clubs, and conferences; and, (Core)

II.B.2.f) pursue faculty development designed to enhance their skills at least annually: (Core)

Background and Intent: Faculty development is intended to describe structured programming developed for the purpose of enhancing transference of knowledge, skill, and behavior from the educator to the learner. Faculty development may occur in a variety of configurations (lecture, workshop, etc.) using internal and/or external resources. Programming is typically needs-based (individual or group) and may be specific to the institution or the program. Faculty development programming is to be reported for the residency program faculty in the aggregate.

II.B.2.f).(1) as educators and evaluators; (Detail)

II.B.2.f).(2) in quality improvement, eliminating health inequities, and patient safety; (Detail)

II.B.2.f).(3) in fostering their own and their residents' well-being; and, (Detail)

II.B.2.f).(4) in patient care based on their practice-based learning and improvement efforts. (Detail)

Background and Intent: Practice-based learning serves as the foundation for the practice of medicine. Through a systematic analysis of one's practice and review of the literature, one is able to make adjustments that improve patient outcomes and care. Thoughtful consideration to practice-based analysis improves quality of care, as well as patient safety. This allows faculty members to serve as role models for residents in practice-based learning.

[The Review Committee may further specify additional faculty responsibilities]

II.B.3. Faculty Qualifications

II.B.3.a) Faculty members must have appropriate qualifications in their field and hold appropriate institutional appointments. (Core)

[The Review Committee may further specify]

II.B.3.b) Physician faculty members must:

II.B.3.b).(1) **have current certification in the specialty by the American Board of _____ or the American Osteopathic Board of _____, or possess qualifications judged acceptable to the Review Committee.** (Core)

[The Review Committee may further specify additional qualifications and/or requirements regarding non-physician faculty members]

II.B.4. **Core Faculty**

Core faculty members must have a significant role in the education and supervision of residents and must devote a significant portion of their entire effort to resident education and/or administration, and must, as a component of their activities, teach, evaluate, and provide formative feedback to residents. (Core)

Background and Intent: Core faculty members are critical to the success of resident education. They support the program leadership in developing, implementing, and assessing curriculum, mentoring residents, and assessing residents' progress toward achievement of competence in and the autonomous practice of the specialty. Core faculty members should be selected for their broad knowledge of and involvement in the program, permitting them to effectively evaluate the program. Core faculty members may also be selected for their specific expertise and unique contribution to the program. Core faculty members are engaged in a broad range of activities, which may vary across programs and specialties. Core faculty members provide clinical teaching and supervision of residents, and also participate in non-clinical activities related to resident education and program administration. Examples of these non-clinical activities include, but are not limited to, interviewing and selecting resident applicants, providing didactic instruction, mentoring residents, simulation exercises, completing the annual ACGME Faculty Survey, and participating on the program's Clinical Competency Committee, Program Evaluation Committee, and other GME committees.

II.B.4.a) **Core faculty members must complete the annual ACGME Faculty Survey.** (Core)

[The Review Committee must specify the minimum number of core faculty and/or the core faculty-resident ratio]

[The Review Committee may further specify either:

(1) requirements regarding dedicated time and support for core faculty members' non-clinical responsibilities related to resident education and/or administration of the program, or

(2) requirements regarding the role and responsibilities of core faculty members, inclusive of both clinical and non-clinical activities, and the corresponding time commitment required to meet those responsibilities.]

If the Review Committee adds requirements as described in number (1) above, the Review Committee may choose to include background and intent as follows:

Background and Intent: Provision of support for the time required for the core faculty members' responsibilities related to resident education and/or administration of the program, as well as flexibility regarding how this support is provided, are important. Programs, in partnership with their Sponsoring Institutions, may provide support for this time in a variety of ways. Examples of support may include, but are not limited to, salary support, supplemental compensation, educational value units, or relief of time from other professional duties.

It is important to remember that the dedicated time and support requirement is a *minimum*, recognizing that, depending on the unique needs of the program, additional support may be warranted. The need to ensure adequate resources, including adequate support and dedicated time for the core faculty members, is also addressed in Institutional Requirement II.B.2. The amount of support and dedicated time needed for individual programs will vary based on a number of factors and may exceed the minimum specified in the applicable specialty-/ subspecialty-specific Program Requirements.

If the Review Committee adds requirements as described in number (2) above, the following Background and Intent must be included:

Background and Intent: The core faculty time requirements address the role and responsibilities of core faculty members, inclusive of both clinical and non-clinical activities, and the corresponding time to meet those responsibilities. The requirements do not address how this is accomplished, and do not mandate dedicated or protected time for these activities. Programs, in partnership with their Sponsoring Institutions, will determine how compliance with the requirements is achieved.

[The Review Committee may specify requirements specific to associate program director(s)]

II.C. Program Coordinator

II.C.1. There must be a program coordinator. (Core)

II.C.2. The program coordinator must be provided with dedicated time and support adequate for administration of the program based upon its size and configuration. (Core)
[The Review Committee must further specify minimum dedicated time for the program coordinator]

Background and Intent: The requirement does not address the source of funding required to provide the specified salary support.

Each program requires a lead administrative person, frequently referred to as a program coordinator, administrator, or as otherwise titled by the institution. This person will frequently manage the day-to-day operations of the program and serve as

an important liaison and facilitator between the learners, faculty and other staff members, and the ACGME. Individuals serving in this role are recognized as program coordinators by the ACGME.

The program coordinator is a key member of the leadership team and is critical to the success of the program. As such, the program coordinator must possess skills in leadership and personnel management appropriate to the complexity of the program. Program coordinators are expected to develop in-depth knowledge of the ACGME and Program Requirements, including policies and procedures. Program coordinators assist the program director in meeting accreditation requirements, educational programming, and support of residents.

Programs, in partnership with their Sponsoring Institutions, should encourage the professional development of their program coordinators and avail them of opportunities for both professional and personal growth. Programs with fewer residents may not require a full-time coordinator; one coordinator may support more than one program.

The minimum required dedicated time and support specified in II.C.2.a) is inclusive of activities directly related to administration of the accredited program. It is understood that coordinators often have additional responsibilities, beyond those directly related to program administration, including, but not limited to, departmental administrative responsibilities, medical school clerkships, planning lectures that are not solely intended for the accredited program, and mandatory reporting for entities other than the ACGME. Assignment of these other responsibilities will necessitate consideration of allocation of additional support so as not to preclude the coordinator from devoting the time specified above solely to administrative activities that support the accredited program.

In addition, it is important to remember that the dedicated time and support requirement for ACGME activities is a minimum, recognizing that, depending on the unique needs of the program, additional support may be warranted. The need to ensure adequate resources, including adequate support and dedicated time for the program coordinator, is also addressed in Institutional Requirement II.B.4. The amount of support and dedicated time needed for individual programs will vary based on a number of factors and may exceed the minimum specified in the applicable specialty/subspecialty-specific Program Requirements. It is expected that the Sponsoring Institution, in partnership with its accredited programs, will ensure support for program coordinators to fulfill their program responsibilities effectively.

II.D. Other Program Personnel

The program, in partnership with its Sponsoring Institution, must jointly ensure the availability of necessary personnel for the effective administration of the program. (Core)
[The Review Committee may further specify]

Background and Intent: Multiple personnel may be required to effectively administer a program. These may include staff members with clerical skills, project managers, education experts, and staff members to maintain electronic communication for the

program. These personnel may support more than one program in more than one discipline.

III. Resident Appointments

III.A. Eligibility Requirements

III.A.1. An applicant must meet one of the following qualifications to be eligible for appointment to an ACGME-accredited program: (Core)

III.A.1.a) graduation from a medical school in the United States, accredited by the Liaison Committee on Medical Education (LCME) or graduation from a college of osteopathic medicine in the United States, accredited by the American Osteopathic Association Commission on Osteopathic College Accreditation (AOACOCA); or, (Core)

III.A.1.b) graduation from a medical school outside of the United States, and meeting one of the following additional qualifications: (Core)

III.A.1.b).(1) holding a currently valid certificate from the Educational Commission for Foreign Medical Graduates (ECFMG) prior to appointment; or, (Core)

III.A.1.b).(2) holding a full and unrestricted license to practice medicine in the United States licensing jurisdiction in which the ACGME-accredited program is located. (Core)

III.A.2. All prerequisite post-graduate clinical education required for initial entry or transfer into ACGME-accredited residency programs must be completed in ACGME-accredited residency programs, AOA-approved residency programs, Royal College of Physicians and Surgeons of Canada (RCPSC)-accredited or College of Family Physicians of Canada (CFPC)-accredited residency programs located in Canada, or in residency programs with ACGME International (ACGME-I) Advanced Specialty Accreditation. (Core)

III.A.2.a) Residency programs must receive verification of each resident's level of competency in the required clinical field using ACGME, CanMEDS, or ACGME-I Milestones evaluations from the prior training program upon matriculation. (Core)
[The Review Committee may further specify prerequisite postgraduate clinical education]

Background and Intent: Programs with ACGME-I Foundational Accreditation or from institutions with ACGME-I accreditation do not qualify unless the program has also achieved ACGME-I Advanced Specialty Accreditation. To ensure entrants into ACGME-accredited programs from ACGME-I programs have attained the prerequisite milestones for this training, they must be from programs that have ACGME-I Advanced Specialty Accreditation.

III.A.3. Resident Eligibility Exception

The Review Committee for _____ will allow the following exception to the resident eligibility requirements: (Core)
[Note: A Review Committee may permit the eligibility exception if the specialty requires completion of a prerequisite residency program prior to admission. If the specialty-specific Program Requirements define multiple program formats, the Review Committee may permit the exception only for the format(s) that require completion of a prerequisite residency program prior to admission. If this language is not applicable, this section will not appear in the specialty-specific requirements.]

III.A.3.a) An ACGME-accredited residency program may accept an exceptionally qualified international graduate applicant who does not satisfy the eligibility requirements listed in III.A.1.-III.A.2., but who does meet all of the following additional qualifications and conditions: (Core)

III.A.3.a).(1) evaluation by the program director and residency selection committee of the applicant's suitability to enter the program, based on prior training and review of the summative evaluations of this training; and, (Core)

III.A.3.a).(2) review and approval of the applicant's exceptional qualifications by the GMEC; and, (Core)

III.A.3.a).(3) verification of Educational Commission for Foreign Medical Graduates (ECFMG) certification. (Core)

III.A.3.b) Applicants accepted through this exception must have an evaluation of their performance by the Clinical Competency Committee within 12 weeks of matriculation. (Core)

III.B. Resident Complement

The program director must not appoint more residents than approved by the Review Committee. (Core)
[The Review Committee may further specify minimum complement numbers]

Background and Intent: Programs are required to request approval of all complement changes, whether temporary or permanent, by the Review Committee through ADS. Permanent increases require prior approval from the Review Committee and temporary increases may also require approval. Specialty-specific instructions for requesting a complement increase are found in the "Documents and Resources" page of the applicable specialty section of the ACGME website.

III.C. Resident Transfers

The program must obtain verification of previous educational experiences and a summative competency-based performance evaluation prior to acceptance of a transferring resident, and Milestones evaluations upon matriculation. (Core)
[The Review Committee may further specify]

IV. Educational Program

The ACGME accreditation system is designed to encourage excellence and innovation in graduate medical education regardless of the organizational affiliation, size, or location of the program.

The educational program must support the development of knowledgeable, skillful physicians who provide compassionate care.

It is recognized programs may place different emphasis on research, leadership, public health, etc. It is expected that the program aims will reflect the nuanced program-specific goals for it and its graduates; for example, it is expected that a program aiming to prepare physician-scientists will have a different curriculum from one focusing on community health.

IV.A. Educational Components

The curriculum must contain the following educational components:

IV.A.1. **a set of program aims consistent with the Sponsoring Institution's mission, the needs of the community it serves, and the desired distinctive capabilities of its graduates, which must be made available to program applicants, residents, and faculty members;** (Core)

IV.A.2. **competency-based goals and objectives for each educational experience designed to promote progress on a trajectory to autonomous practice. These must be distributed, reviewed, and available to residents and faculty members;** (Core)

Background and Intent: The trajectory to autonomous practice is documented by Milestones evaluations. Milestones are considered formative and should be used to identify learning needs. Milestones data may lead to focused or general curricular revision in any given program or to individualized learning plans for any specific resident.

IV.A.3. **delineation of resident responsibilities for patient care, progressive responsibility for patient management, and graded supervision;** (Core)

Background and Intent: These responsibilities may generally be described by PGY level and specifically by Milestones progress as determined by the Clinical Competency Committee. This approach encourages the transition to competency-based education. An advanced learner may be granted more responsibility independent of PGY level and a learner needing more time to accomplish a certain task may do so in a focused rather than global manner.

IV.A.4. **a broad range of structured didactic activities; and, (Core)**

IV.A.4.a) **Residents must be provided with protected time to participate in core didactic activities. (Core)**

Background and Intent: It is intended that residents will participate in structured didactic activities. It is recognized that there may be circumstances in which this is not possible. Programs should define core didactic activities for which time is protected and the circumstances in which residents may be excused from these didactic activities. Didactic activities may include, but are not limited to, lectures, conferences, courses, labs, asynchronous learning, simulations, drills, case discussions, grand rounds, didactic teaching, and education in critical appraisal of medical evidence.

IV.A.5. **formal educational activities that promote patient safety-related goals, tools, and techniques. (Core)**

IV.B. **ACGME Competencies**

Background and Intent: The Competencies provide a conceptual framework describing the required domains for a trusted physician to enter autonomous practice. These Competencies are core to the practice of all physicians, although the specifics are further defined by each specialty. The developmental trajectories in each of the Competencies are articulated through the Milestones for each specialty.

IV.B.1. **The program must integrate the following ACGME Competencies into the curriculum:**

IV.B.1.a) **Professionalism**

Residents must demonstrate a commitment to professionalism and an adherence to ethical principles. (Core)

IV.B.1.a).(1) **Residents must demonstrate competence in:**

IV.B.1.a).(1).(a) **compassion, integrity, and respect for others; (Core)**

IV.B.1.a).(1).(b) **responsiveness to patient needs that supersedes self-interest; (Core)**

IV.B.1.a).(1).(c) **cultural humility; (Core)**

IV.B.1.a).(1).(d) **respect for patient privacy and autonomy; (Core)**

IV.B.1.a).(1).(e) **accountability to patients, society, and the profession; (Core)**

IV.B.1.a).(1).(f) **respect and responsiveness to diverse patient populations, including but not limited to**

diversity in gender, age, culture, race, religion, disabilities, national origin, socioeconomic status, and sexual orientation; (Core)

IV.B.1.a).(1).(g) **ability to recognize and develop a plan for one's own personal and professional well-being; and, (Core)**

IV.B.1.a).(1).(h) **appropriately disclosing and addressing conflict or duality of interest. (Core)**

Background and Intent: This includes the recognition that under certain circumstances, the interests of the patient may be best served by transitioning care to another practitioner. Examples include fatigue, conflict or duality of interest, not connecting well with a patient, or when another physician would be better for the situation based on skill set or knowledge base.

IV.B.1.b) **Patient Care and Procedural Skills**

Background and Intent: Quality patient care is safe, effective, timely, efficient, patient-centered, equitable, and designed to improve population health, while reducing per capita costs. In addition, there should be a focus on improving the clinician's well-being as a means to improve patient care and reduce burnout among residents, fellows, and practicing physicians.

IV.B.1.b).(1) **Residents must be able to provide patient care that is patient- and family-centered, compassionate, equitable, appropriate, and effective for the treatment of health problems and the promotion of health. (Core)**
[The Review Committee must further specify]

IV.B.1.b).(2) **Residents must be able to perform all medical, diagnostic, and surgical procedures considered essential for the area of practice. (Core)**
[The Review Committee may further specify]

IV.B.1.c) **Medical Knowledge**

Residents must demonstrate knowledge of established and evolving biomedical, clinical, epidemiological, and social-behavioral sciences, including scientific inquiry, as well as the application of this knowledge to patient care. (Core)
[The Review Committee must further specify]

IV.B.1.d) **Practice-based Learning and Improvement**

Residents must demonstrate the ability to investigate and evaluate their care of patients, to appraise and assimilate scientific evidence, and to continuously improve patient care based on constant self-evaluation and lifelong learning. (Core)

IV.B.1.d).(1) **Residents must demonstrate competence in:**

IV.B.1.d).(1).(a) **identifying strengths, deficiencies, and limits in one's knowledge and expertise; (Core)**

IV.B.1.d).(1).(b) **setting learning and improvement goals; (Core)**

IV.B.1.d).(1).(c) **identifying and performing appropriate learning activities; (Core)**

IV.B.1.d).(1).(d) **systematically analyzing practice using quality improvement methods, including activities aimed at reducing health care disparities, and implementing changes with the goal of practice improvement; (Core)**

IV.B.1.d).(1).(e) **incorporating feedback and formative evaluation into daily practice; and, (Core)**

IV.B.1.d).(1).(f) **locating, appraising, and assimilating evidence from scientific studies related to their patients' health problems. (Core)**

[The Review Committee may further specify by adding to the list of sub-competencies]

IV.B.1.e) **Interpersonal and Communication Skills**

Residents must demonstrate interpersonal and communication skills that result in the effective exchange of information and collaboration with patients, their families, and health professionals. (Core)

IV.B.1.e).(1) **Residents must demonstrate competence in:**

IV.B.1.e).(1).(a) **communicating effectively with patients and patients' families, as appropriate, across a broad range of socioeconomic circumstances, cultural backgrounds, and language capabilities, learning to engage interpretive services as required to provide appropriate care to each patient; (Core)**

IV.B.1.e).(1).(b) **communicating effectively with physicians, other health professionals, and health-related agencies; (Core)**

IV.B.1.e).(1).(c) **working effectively as a member or leader of a health care team or other professional group; (Core)**

IV.B.1.e).(1).(d) **educating patients, patients' families, students, other residents, and other health professionals; (Core)**

IV.B.1.e).(1).(e) **acting in a consultative role to other physicians and health professionals; (Core)**

IV.B.1.e).(1).(f) **maintaining comprehensive, timely, and legible health care records, if applicable. (Core)**

IV.B.1.e).(2) **Residents must learn to communicate with patients and patients' families to partner with them to assess their care goals, including, when appropriate, end-of-life goals. (Core)**

[The Review Committee may further specify by adding to the list of sub-competencies]

IV.B.1.f) **Systems-based Practice**

Residents must demonstrate an awareness of and responsiveness to the larger context and system of health care, including the structural and social determinants of health, as well as the ability to call effectively on other resources to provide optimal health care. (Core)

Background and Intent: Medical practice occurs in the context of an increasingly complex clinical care environment where optimal patient care requires attention to compliance with external and internal administrative and regulatory requirements.

IV.B.1.f).(1) **Residents must demonstrate competence in:**

IV.B.1.f).(1).(a) **working effectively in various health care delivery settings and systems relevant to their clinical specialty; (Core)**

IV.B.1.f).(1).(b) **coordinating patient care across the health care continuum and beyond as relevant to their clinical specialty; (Core)**

Background and Intent: Every patient deserves to be treated as a whole person. Therefore it is recognized that any one component of the health care system does not meet the totality of the patient's needs. An appropriate transition plan requires coordination and forethought by an interdisciplinary team. The patient benefits from proper care and the system benefits from proper use of resources.

IV.B.1.f).(1).(c) **advocating for quality patient care and optimal patient care systems; (Core)**

IV.B.1.f).(1).(d) participating in identifying system errors and implementing potential systems solutions; (Core)

IV.B.1.f).(1).(e) incorporating considerations of value, equity, cost awareness, delivery and payment, and risk-benefit analysis in patient and/or population-based care as appropriate;(Core)

IV.B.1.f).(1).(f) understanding health care finances and its impact on individual patients' health decisions; and, (Core)

IV.B.1.f).(1).(g) using tools and techniques that promote patient safety and disclosure of patient safety events (real or simulated). (Detail)

IV.B.1.f).(2) Residents must learn to advocate for patients within the health care system to achieve the patient's and patient's family's care goals, including, when appropriate, end-of-life goals. (Core)

[The Review Committee may further specify by adding to the list of sub-competencies]

IV.C. Curriculum Organization and Resident Experiences

IV.C.1. The curriculum must be structured to optimize resident educational experiences, the length of the experiences, and the supervisory continuity. These educational experiences include an appropriate blend of supervised patient care responsibilities, clinical teaching, and didactic educational events. (Core)
[The Review Committee must further specify]

Background and Intent: In some specialties, frequent rotational transitions, inadequate continuity of faculty member supervision, and dispersed patient locations within the hospital have adversely affected optimal resident education and effective team-based care. The need for patient care continuity varies from specialty to specialty and by clinical situation, and may be addressed by the individual Review Committee.

IV.C.2. The program must provide instruction and experience in pain management if applicable for the specialty, including recognition of the signs of substance use disorder. (Core)
[The Review Committee may further specify]

[The Review Committee may specify required didactic and clinical experiences]

IV.D. Scholarship

Medicine is both an art and a science. The physician is a humanistic scientist who cares for patients. This requires the ability to think critically, evaluate the literature, appropriately assimilate new knowledge, and practice lifelong learning. The program and faculty must create an environment that fosters the acquisition of such skills through resident participation in scholarly activities. Scholarly activities may include discovery, integration, application, and teaching.

The ACGME recognizes the diversity of residencies and anticipates that programs prepare physicians for a variety of roles, including clinicians, scientists, and educators. It is expected that the program's scholarship will reflect its mission(s) and aims, and the needs of the community it serves. For example, some programs may concentrate their scholarly activity on quality improvement, population health, and/or teaching, while other programs might choose to utilize more classic forms of biomedical research as the focus for scholarship.

IV.D.1. Program Responsibilities

IV.D.1.a) The program must demonstrate evidence of scholarly activities consistent with its mission(s) and aims. (Core)

IV.D.1.b) The program, in partnership with its Sponsoring Institution, must allocate adequate resources to facilitate resident and faculty involvement in scholarly activities. (Core)
[The Review Committee may further specify]

IV.D.1.c) The program must advance residents' knowledge and practice of the scholarly approach to evidence-based patient care. (Core)

IV.D.2. Faculty Scholarly Activity

IV.D.2.a) Among their scholarly activity, programs must demonstrate accomplishments in at least three of the following domains: (Core)

- **Research in basic science, education, translational science, patient care, or population health**
- **Peer-reviewed grants**
- **Quality improvement and/or patient safety initiatives**
- **Systematic reviews, meta-analyses, review articles, chapters in medical textbooks, or case reports**
- **Creation of curricula, evaluation tools, didactic educational activities, or electronic educational materials**
- **Contribution to professional committees, educational organizations, or editorial boards**
- **Innovations in education**

IV.D.2.b) **The program must demonstrate dissemination of scholarly activity within and external to the program by the following methods:**
[Review Committee will choose to require either IV.D.2.b).(1) or both IV.D.2.b).(1) and IV.D.2.b).(2)]

Background and Intent: For the purposes of education, metrics of scholarly activity represent one of the surrogates for the program's effectiveness in the creation of an environment of inquiry that advances the residents' scholarly approach to patient care. The Review Committee will evaluate the dissemination of scholarship for the program as a whole, not for individual faculty members, for a five-year interval, for both core and non-core faculty members, with the goal of assessing the effectiveness of the creation of such an environment. The ACGME recognizes that there may be differences in scholarship requirements between different specialties and between residencies and fellowships in the same specialty.

IV.D.2.b).(1) **faculty participation in grand rounds, posters, workshops, quality improvement presentations, podium presentations, grant leadership, non-peer-reviewed print/electronic resources, articles or publications, book chapters, textbooks, webinars, service on professional committees, or serving as a journal reviewer, journal editorial board member, or editor; (Outcome)**

IV.D.2.b).(2) **peer-reviewed publication. (Outcome)**

IV.D.3. **Resident Scholarly Activity**

IV.D.3.a) **Residents must participate in scholarship. (Core)**
[The Review Committee may further specify]

V. Evaluation

V.A. Resident Evaluation

V.A.1. Feedback and Evaluation

Background and Intent: Feedback is ongoing information provided regarding aspects of one's performance, knowledge, or understanding. The faculty empower residents to provide much of that feedback themselves in a spirit of continuous learning and self-reflection. Feedback from faculty members in the context of routine clinical care should be frequent, and need not always be formally documented.

Formative and summative evaluation have distinct definitions. Formative evaluation is *monitoring resident learning* and providing ongoing feedback that can be used by residents to improve their learning in the context of provision of patient care or other educational opportunities. More specifically, formative evaluations help:

- **residents identify their strengths and weaknesses and target areas that need work**

- **program directors and faculty members recognize where residents are struggling and address problems immediately**

Summative evaluation is *evaluating a resident's learning* by comparing the residents against the goals and objectives of the rotation and program, respectively. Summative evaluation is utilized to make decisions about promotion to the next level of training, or program completion.

End-of-rotation and end-of-year evaluations have both summative and formative components. Information from a summative evaluation can be used formatively when residents or faculty members use it to guide their efforts and activities in subsequent rotations and to successfully complete the residency program.

Feedback, formative evaluation, and summative evaluation compare intentions with accomplishments, enabling the transformation of a neophyte physician to one with growing expertise.

V.A.1.a) **Faculty members must directly observe, evaluate, and frequently provide feedback on resident performance during each rotation or similar educational assignment. (Core)**

Background and Intent: Faculty members should provide feedback frequently throughout the course of each rotation. Residents require feedback from faculty members to reinforce well-performed duties and tasks, as well as to correct deficiencies. This feedback will allow for the development of the learner as they strive to achieve the Milestones. More frequent feedback is strongly encouraged for residents who have deficiencies that may result in a poor final rotation evaluation.

V.A.1.b) **Evaluation must be documented at the completion of the assignment. (Core)**

V.A.1.b).(1) **For block rotations of greater than three months in duration, evaluation must be documented at least every three months. (Core)**

V.A.1.b).(2) **Longitudinal experiences, such as continuity clinic in the context of other clinical responsibilities, must be evaluated at least every three months and at completion. (Core)**

V.A.1.c) **The program must provide an objective performance evaluation based on the Competencies and the specialty-specific Milestones, and must: (Core)**

V.A.1.c).(1) **use multiple evaluators (e.g., faculty members, peers, patients, self, and other professional staff members); and, (Core)**

V.A.1.c).(2) **provide that information to the Clinical Competency Committee for its synthesis of progressive resident**

performance and improvement toward unsupervised practice. (Core)

V.A.1.d) **The program director or their designee, with input from the Clinical Competency Committee, must:**

V.A.1.d).(1) **meet with and review with each resident their documented semi-annual evaluation of performance, including progress along the specialty-specific Milestones;** (Core)

V.A.1.d).(2) **assist residents in developing individualized learning plans to capitalize on their strengths and identify areas for growth; and,** (Core)

V.A.1.d).(3) **develop plans for residents failing to progress, following institutional policies and procedures.** (Core)

Background and Intent: Learning is an active process that requires effort from the teacher and the learner. Faculty members evaluate a resident's performance at least at the end of each rotation. The program director or their designee will review those evaluations, including their progress on the Milestones, at a minimum of every six months. Residents should be encouraged to reflect upon the evaluation, using the information to reinforce well-performed tasks or knowledge or to modify deficiencies in knowledge or practice. Working together with the faculty members, residents should develop an individualized learning plan.

Residents who are experiencing difficulties with achieving progress along the Milestones may require intervention to address specific deficiencies. Such intervention, documented in an individual remediation plan developed by the program director or a faculty mentor and the resident, will take a variety of forms based on the specific learning needs of the resident. However, the ACGME recognizes that there are situations which require more significant intervention that may alter the time course of resident progression. To ensure due process, it is essential that the program director follow institutional policies and procedures.

V.A.1.e) **At least annually, there must be a summative evaluation of each resident that includes their readiness to progress to the next year of the program, if applicable.** (Core)

V.A.1.f) **The evaluations of a resident's performance must be accessible for review by the resident.** (Core)

[The Review Committee may further specify under any requirement in V.A.1.-V.A.1.f)]

V.A.2. **Final Evaluation**

V.A.2.a) **The program director must provide a final evaluation for each resident upon completion of the program.** (Core)

V.A.2.a).(1) **The specialty-specific Milestones, and when applicable the specialty-specific Case Logs, must be used as tools to ensure residents are able to engage in autonomous practice upon completion of the program.** (Core)

V.A.2.a).(2) **The final evaluation must:**

V.A.2.a).(2).(a) **become part of the resident's permanent record maintained by the institution, and must be accessible for review by the resident in accordance with institutional policy;** (Core)

V.A.2.a).(2).(b) **verify that the resident has demonstrated the knowledge, skills, and behaviors necessary to enter autonomous practice; and,** (Core)

V.A.2.a).(2).(c) **be shared with the resident upon completion of the program.** (Core)

V.A.3. **A Clinical Competency Committee must be appointed by the program director.** (Core)

V.A.3.a) **At a minimum, the Clinical Competency Committee must include three members of the program faculty, at least one of whom is a core faculty member.** (Core)

V.A.3.a).(1) **Additional members must be faculty members from the same program or other programs, or other health professionals who have extensive contact and experience with the program's residents.** (Core)

Background and Intent: The requirements regarding the Clinical Competency Committee do not preclude or limit a program director's participation on the Clinical Competency Committee. The intent is to leave flexibility for each program to decide the best structure for its own circumstances, but a program should consider: its program director's other roles as resident advocate, advisor, and confidante; the impact of the program director's presence on the other Clinical Competency Committee members' discussions and decisions; the size of the program faculty; and other program-relevant factors. Inclusivity is an important consideration in the appointment of Clinical Competency Committee members, allowing for diverse participation to ensure fair evaluation. The program director has final responsibility for resident evaluation and promotion decisions.

Program faculty may include more than the physician faculty members, such as other physicians and non-physicians who teach and evaluate the program's residents. There may be additional members of the Clinical Competency Committee. Chief residents who have completed core residency programs in their specialty may be members of the Clinical Competency Committee.

V.A.3.b) **The Clinical Competency Committee must:**

V.A.3.b).(1) review all resident evaluations at least semi-annually; (Core)

V.A.3.b).(2) determine each resident's progress on achievement of the specialty-specific Milestones; and, (Core)

V.A.3.b).(3) meet prior to the residents' semi-annual evaluations and advise the program director regarding each resident's progress. (Core)

V.B. Faculty Evaluation

V.B.1. The program must have a process to evaluate each faculty member's performance as it relates to the educational program at least annually. (Core)

Background and Intent: The program director is responsible for the educational program and all educators. While the term "faculty" may be applied to physicians within a given institution for other reasons, it is applied to residency program faculty members only through approval by a program director. The development of the faculty improves the education, clinical, and research aspects of a program. Faculty members have a strong commitment to the resident and desire to provide optimal education and work opportunities. Faculty members must be provided feedback on their contribution to the mission of the program. All faculty members who interact with residents desire feedback on their education, clinical care, and research. If a faculty member does not interact with residents, feedback is not required. With regard to the diverse operating environments and configurations, the residency program director may need to work with others to determine the effectiveness of the program's faculty performance with regard to their role in the educational program. All teaching faculty members should have their educational efforts evaluated by the residents in a confidential and anonymous manner. Other aspects for the feedback may include research or clinical productivity, review of patient outcomes, or peer review of scholarly activity. The process should reflect the local environment and identify the necessary information. The feedback from the various sources should be summarized and provided to the faculty on an annual basis by a member of the leadership team of the program.

V.B.1.a) This evaluation must include a review of the faculty member's clinical teaching abilities, engagement with the educational program, participation in faculty development related to their skills as an educator, clinical performance, professionalism, and scholarly activities. (Core)

V.B.1.b) This evaluation must include written, anonymous, and confidential evaluations by the residents. (Core)

V.B.2. Faculty members must receive feedback on their evaluations at least annually. (Core)

V.B.3. Results of the faculty educational evaluations should be incorporated into program-wide faculty development plans. (Core)

Background and Intent: The quality of the faculty's teaching and clinical care is a determinant of the quality of the program and the quality of the residents' future clinical care. Therefore, the program has the responsibility to evaluate and improve the program faculty members' teaching, scholarship, professionalism, and quality care. This section mandates annual review of the program's faculty members for this purpose, and can be used as input into the Annual Program Evaluation.

V.C. Program Evaluation and Improvement

V.C.1. The program director must appoint the Program Evaluation Committee to conduct and document the Annual Program Evaluation as part of the program's continuous improvement process. (Core)

V.C.1.a) The Program Evaluation Committee must be composed of at least two program faculty members, at least one of whom is a core faculty member, and at least one resident. (Core)

V.C.1.b) Program Evaluation Committee responsibilities must include:

V.C.1.b).(1) review of the program's self-determined goals and progress toward meeting them; (Core)

V.C.1.b).(2) guiding ongoing program improvement, including development of new goals, based upon outcomes; and, (Core)

V.C.1.b).(3) review of the current operating environment to identify strengths, challenges, opportunities, and threats as related to the program's mission and aims. (Core)

Background and Intent: To achieve its mission and educate and train quality physicians, a program must evaluate its performance and plan for improvement in the Annual Program Evaluation. Performance of residents and faculty members is a reflection of program quality, and can use metrics that reflect the goals that a program has set for itself. The Program Evaluation Committee utilizes outcome parameters and other data to assess the program's progress toward achievement of its goals and aims. The Program Evaluation Committee advises the program director through program oversight.

V.C.1.c) The Program Evaluation Committee should consider the outcomes from prior Annual Program Evaluation(s), aggregate resident and faculty written evaluations of the program, and other relevant data in its assessment of the program. (Core)

Background and Intent: Other data to be considered for assessment include:
- **Curriculum**

- **ACGME letters of notification, including citations, Areas for Improvement, and comments**
- **Quality and safety of patient care**
- **Aggregate resident and faculty well-being; recruitment and retention; workforce diversity, including graduate medical education staff and other relevant academic community members; engagement in quality improvement and patient safety; and scholarly activity**
- **ACGME Resident and Faculty Survey results**
- **Aggregate resident Milestones evaluations, and achievement on in-training examinations (where applicable), board pass and certification rates, and graduate performance.**
- **Aggregate faculty evaluation and professional development**

V.C.1.d) **The Program Evaluation Committee must evaluate the program's mission and aims, strengths, areas for improvement, and threats.** (Core)

V.C.1.e) **The Annual Program Evaluation, including the action plan, must be distributed to and discussed with the residents and the members of the teaching faculty, and be submitted to the DIO.** (Core)

V.C.2. **The program must complete a Self-Study and submit it to the DIO.** (Core)

Background and Intent: Outcomes of the documented Annual Program Evaluation can be integrated into the Accreditation Self-Study process. The Self-Study is an objective, comprehensive evaluation of the residency program, with the aim of improving it. Underlying the Accreditation Self-Study is this longitudinal evaluation of the program and its learning environment, facilitated through sequential Annual Program Evaluations that focus on the required components, with an emphasis on program strengths and self-identified areas for improvement. Details regarding the timing and expectations for the Accreditation Self-Study are provided in the *ACGME Manual of Policies and Procedures*. Additionally, a description of the Self-Study process is available on the ACGME website.

V.C.3. ***One goal of ACGME-accredited education is to educate physicians who seek and achieve board certification. One measure of the effectiveness of the educational program is the ultimate pass rate.***

The program director should encourage all eligible program graduates to take the certifying examination offered by the applicable American Board of Medical Specialties (ABMS) member board or American Osteopathic Association (AOA) certifying board. **[If certification in the specialty is not offered by the ABMS and/or the AOA, V.C.3.a)-V.C.3.f) will be omitted.]**

V.C.3.a) **For specialties in which the ABMS member board and/or AOA certifying board offer(s) an annual written exam, in the preceding three years, the program's aggregate pass rate of**

those taking the examination for the first time must be higher than the bottom fifth percentile of programs in that specialty. (Outcome)

V.C.3.b) **For specialties in which the ABMS member board and/or AOA certifying board offer(s) a biennial written exam, in the preceding six years, the program's aggregate pass rate of those taking the examination for the first time must be higher than the bottom fifth percentile of programs in that specialty.** (Outcome)

V.C.3.c) **For specialties in which the ABMS member board and/or AOA certifying board offer(s) an annual oral exam, in the preceding three years, the program's aggregate pass rate of those taking the examination for the first time must be higher than the bottom fifth percentile of programs in that specialty.** (Outcome)

V.C.3.d) **For specialties in which the ABMS member board and/or AOA certifying board offer(s) a biennial oral exam, in the preceding six years, the program's aggregate pass rate of those taking the examination for the first time must be higher than the bottom fifth percentile of programs in that specialty.** (Outcome)

V.C.3.e) **For each of the exams referenced in V.C.3.a)-d), any program whose graduates over the time period specified in the requirement have achieved an 80 percent pass rate will have met this requirement, no matter the percentile rank of the program for pass rate in that specialty.** (Outcome)

Background and Intent: Setting a single standard for pass rate that works across specialties is not supportable based on the heterogeneity of the psychometrics of different examinations. By using a percentile rank, the performance of the lower five percent (fifth percentile) of programs can be identified and set on a path to curricular and test preparation reform.

There are specialties where there is a very high board pass rate that could leave successful programs in the bottom five percent (fifth percentile) despite admirable performance. These high-performing programs should not be cited, and V.C.3.e) is designed to address this.

V.C.3.f) **Programs must report, in ADS, board certification status annually for the cohort of board-eligible residents that graduated seven years earlier.** (Core)

Background and Intent: It is essential that residency programs demonstrate knowledge and skill transfer to their residents. One measure of that is the qualifying or initial certification exam pass rate. Another important parameter of the success of the program is the ultimate board certification rate of its graduates. Graduates are eligible for up to seven years from residency graduation for initial certification. The ACGME

will calculate a rolling three-year average of the ultimate board certification rate at seven years post-graduation, and the Review Committees will monitor it.

The Review Committees will track the rolling seven-year certification rate as an indicator of program quality. Programs are encouraged to monitor their graduates' performance on board certification examinations.

In the future, the ACGME may establish parameters related to ultimate board certification rates.

VI. The Learning and Working Environment

Residency education must occur in the context of a learning and working environment that emphasizes the following principles:

- ***Excellence in the safety and quality of care rendered to patients by residents today***
- ***Excellence in the safety and quality of care rendered to patients by today's residents in their future practice***
- ***Excellence in professionalism***
- ***Appreciation for the privilege of caring for patients***
- ***Commitment to the well-being of the students, residents, faculty members, and all members of the health care team***

VI.A. Patient Safety, Quality Improvement, Supervision, and Accountability

VI.A.1. Patient Safety and Quality Improvement

VI.A.1.a) Patient Safety

VI.A.1.a).(1) Culture of Safety

A culture of safety requires continuous identification of vulnerabilities and a willingness to transparently deal with them. An effective organization has formal mechanisms to assess the knowledge, skills, and attitudes of its personnel toward safety in order to identify areas for improvement.

VI.A.1.a).(1).(a) **The program, its faculty, residents, and fellows must actively participate in patient safety systems and contribute to a culture of safety.** **(Core)**

VI.A.1.a).(2) Patient Safety Events

Reporting, investigation, and follow-up of safety events, near misses, and unsafe conditions are pivotal mechanisms for improving patient safety, and are essential for the success of any patient safety program. Feedback and experiential learning are essential to developing true competence in the ability to identify causes and institute sustainable systems-based changes to ameliorate patient safety vulnerabilities.

VI.A.1.a).(2).(a) **Residents, fellows, faculty members, and other clinical staff members must:**

VI.A.1.a).(2).(a).(i) **know their responsibilities in reporting patient safety events and unsafe conditions at the clinical site, including how to report such events; and, (Core)**

VI.A.1.a).(2).(a).(ii) **be provided with summary information of their institution's patient safety reports. (Core)**

VI.A.1.a).(2).(b) **Residents must participate as team members in real and/or simulated interprofessional clinical patient safety and quality improvement activities, such as root cause analyses or other activities that include analysis, as well as formulation and implementation of actions. (Core)**

VI.A.1.a).(3) **Quality Metrics**

Access to data is essential to prioritizing activities for care improvement and evaluating success of improvement efforts.

VI.A.1.a).(3).(a) **Residents and faculty members must receive data on quality metrics and benchmarks related to their patient populations. (Core)**
[The Review Committee may further specify]

VI.A.2. **Supervision and Accountability**

VI.A.2.a) ***Although the attending physician is ultimately responsible for the care of the patient, every physician shares in the responsibility and accountability for their efforts in the provision of care. Effective programs, in partnership with their Sponsoring Institutions, define, widely communicate, and monitor a structured chain of responsibility and accountability as it relates to the supervision of all patient care.***

Supervision in the setting of graduate medical education provides safe and effective care to patients; ensures each resident's development of the skills, knowledge, and attitudes required to enter the unsupervised practice of medicine; and establishes a foundation for continued professional growth.

VI.A.2.a).(1) **Residents and faculty members must inform each patient of their respective roles in that patient's care when providing direct patient care.** (Core)

VI.A.2.a).(1).(a) **This information must be available to residents, faculty members, other members of the health care team, and patients.** (Core)

Background and Intent: Each patient will have an identifiable and appropriately credentialed and privileged attending physician (or licensed independent practitioner as specified by the applicable Review Committee) who is responsible and accountable for the patient's care.

VI.A.2.a).(2) **The program must demonstrate that the appropriate level of supervision in place for all residents is based on each resident's level of training and ability, as well as patient complexity and acuity. Supervision may be exercised through a variety of methods, as appropriate to the situation.** (Core)
[The Review Committee may specify which activities require different levels of supervision.]

Background and Intent: Appropriate supervision is essential for patient safety and high-quality teaching. Supervision is also contextual. There is tremendous diversity of resident-patient interactions, training locations, and resident skills and abilities, even at the same level of the educational program. The degree of supervision for a resident is expected to evolve progressively as the resident gains more experience, even with the same patient condition or procedure. The level of supervision for each resident is commensurate with that resident's level of independence in practice; this level of supervision may be enhanced based on factors such as patient safety, complexity, acuity, urgency, risk of serious safety events, or other pertinent variables.

VI.A.2.b) **Levels of Supervision**

To promote appropriate resident supervision while providing for graded authority and responsibility, the program must use the following classification of supervision:

VI.A.2.b).(1) **Direct Supervision:**

VI.A.2.b).(1).(a) **the supervising physician is physically present with the resident during the key portions of the patient interaction; or,**
[The Review Committee may further specify]

VI.A.2.b).(1).(a).(i) **PGY-1 residents must initially be supervised directly, only as described in VI.A.2.c).(1).(a). (Core)**
[The Review Committee may describe the conditions under which PGY-1 residents progress to be supervised indirectly]

VI.A.2.b).(1).(b) **the supervising physician and/or patient is not physically present with the resident and the supervising physician is concurrently monitoring the patient care through appropriate telecommunication technology.**
[The RC may choose not to permit this requirement. The Review Committee may further specify]

VI.A.2.b).(2) **Indirect Supervision: the supervising physician is not providing physical or concurrent visual or audio supervision but is immediately available to the resident for guidance and is available to provide appropriate direct supervision.**

VI.A.2.b).(3) **Oversight – the supervising physician is available to provide review of procedures/encounters with feedback provided after care is delivered.**

VI.A.2.c) **The program must define when physical presence of a supervising physician is required. (Core)**

VI.A.2.d) **The privilege of progressive authority and responsibility, conditional independence, and a supervisory role in patient care delegated to each resident must be assigned by the program director and faculty members. (Core)**

VI.A.2.d).(1) **The program director must evaluate each resident's abilities based on specific criteria, guided by the Milestones. (Core)**

VI.A.2.d).(2) **Faculty members functioning as supervising physicians must delegate portions of care to residents based on the needs of the patient and the skills of each resident. (Core)**

VI.A.2.d).(3) **Senior residents or fellows should serve in a supervisory role to junior residents in recognition of their progress toward independence, based on the needs of each patient and the skills of the individual resident or fellow. (Detail)**

VI.A.2.e) **Programs must set guidelines for circumstances and events in which residents must communicate with the supervising faculty member(s).** (Core)

VI.A.2.e).(1) **Each resident must know the limits of their scope of authority, and the circumstances under which the resident is permitted to act with conditional independence.** (Outcome)

Background and Intent: The ACGME Glossary of Terms defines conditional independence as: Graded, progressive responsibility for patient care with defined oversight.

VI.A.2.f) **Faculty supervision assignments must be of sufficient duration to assess the knowledge and skills of each resident and to delegate to the resident the appropriate level of patient care authority and responsibility.** (Core)

VI.B. Professionalism

VI.B.1. **Programs, in partnership with their Sponsoring Institutions, must educate residents and faculty members concerning the professional and ethical responsibilities of physicians, including but not limited to their obligation to be appropriately rested and fit to provide the care required by their patients.** (Core)

Background and Intent: This requirement emphasizes the professional responsibility of residents and faculty members to arrive for work adequately rested and ready to care for patients. It is also the responsibility of residents, faculty members, and other members of the care team to be observant, to intervene, and/or to escalate their concern about resident and faculty member fitness for work, depending on the situation, and in accordance with institutional policies. This includes recognition of impairment, including from illness, fatigue, and substance use, in themselves, their peers, and other members of the health care team, and the recognition that under certain circumstances, the best interests of the patient may be served by transitioning that patient's care to another qualified and rested practitioner.

VI.B.2. **The learning objectives of the program must:**

VI.B.2.a) **be accomplished without excessive reliance on residents to fulfill non-physician obligations;** (Core)

Background and Intent: Routine reliance on residents to fulfill non-physician obligations increases work compression for residents and does not provide an optimal educational experience. Non-physician obligations are those duties which in most institutions are performed by nursing and allied health professionals, transport services, or clerical staff. Examples of such obligations include transport of patients from the wards or units for procedures elsewhere in the hospital; routine blood drawing for laboratory tests; routine monitoring of patients when off the ward; and clerical duties, such as

scheduling. While it is understood that residents may be expected to do any of these things on occasion when the need arises, these activities should not be performed by residents routinely and must be kept to a minimum to optimize resident education.

VI.B.2.b) **ensure manageable patient care responsibilities; and, (Core) [The Review Committee may further specify]**

Background and Intent: The Common Program Requirements do not define "manageable patient care responsibilities" as this is variable by specialty and PGY level. Review Committees will provide further detail regarding patient care responsibilities in the applicable specialty-specific Program Requirements and accompanying FAQs. However, all programs, regardless of specialty, should carefully assess how the assignment of patient care responsibilities can affect work compression, especially at the PGY-1 level.

VI.B.2.c) **include efforts to enhance the meaning that each resident finds in the experience of being a physician, including protecting time with patients, providing administrative support, promoting progressive independence and flexibility, and enhancing professional relationships. (Core)**

VI.B.3. **The program director, in partnership with the Sponsoring Institution, must provide a culture of professionalism that supports patient safety and personal responsibility. (Core)**

Background and Intent: The accurate reporting of clinical and educational work hours, patient outcomes, and clinical experience data are the responsibility of the program leadership, residents, and faculty.

VI.B.4. **Residents and faculty members must demonstrate an understanding of their personal role in the safety and welfare of patients entrusted to their care, including the ability to report unsafe conditions and safety events. (Core)**

VI.B.5. **Programs, in partnership with their Sponsoring Institutions, must provide a professional, equitable, respectful, and civil environment that is psychologically safe and that is free from discrimination, sexual and other forms of harassment, mistreatment, abuse, or coercion of students, residents, faculty, and staff. (Core)**

Background and Intent: Psychological safety is defined as an environment of trust and respect that allows individuals to feel able to ask for help, admit mistakes, raise concerns, suggest ideas, and challenge ways of working and the ideas of others on the team, including the ideas of those in authority, without fear of humiliation, and the knowledge that mistakes will be handled justly and fairly.

The ACGME is unable to adjudicate disputes between individuals, including residents, faculty members, and staff members. However, information that suggests a pattern of behavior that violates the requirement above will trigger a careful review and, if

deemed appropriate, action by the Review Committee and/or ACGME, in accordance with ACGME Policies and Procedures.

VI.B.6. **Programs, in partnership with their Sponsoring Institutions, should have a process for education of residents and faculty regarding unprofessional behavior and a confidential process for reporting, investigating, and addressing such concerns.** (Core)

VI.C. **Well-Being**

Psychological, emotional, and physical well-being are critical in the development of the competent, caring, and resilient physician and require proactive attention to life inside and outside of medicine. Well-being requires that physicians retain the joy in medicine while managing their own real-life stresses. Self-care and responsibility to support other members of the health care team are important components of professionalism; they are also skills that must be modeled, learned, and nurtured in the context of other aspects of residency training.

Residents and faculty members are at risk for burnout and depression. Programs, in partnership with their Sponsoring Institutions, have the same responsibility to address well-being as other aspects of resident competence. Physicians and all members of the health care team share responsibility for the well-being of each other. A positive culture in a clinical learning environment models constructive behaviors, and prepares residents with the skills and attitudes needed to thrive throughout their careers.

VI.C.1. **The responsibility of the program, in partnership with the Sponsoring Institution, must include:**

VI.C.1.a) **attention to scheduling, work intensity, and work compression that impacts resident well-being;** (Core)

VI.C.1.b) **evaluating workplace safety data and addressing the safety of residents and faculty members;** (Core)

Background and Intent: This requirement emphasizes the responsibility shared by the Sponsoring Institution and its programs to gather information and utilize systems that monitor and enhance resident and faculty member safety, including physical safety. Issues to be addressed include, but are not limited to, monitoring of workplace injuries, physical or emotional violence, vehicle collisions, and emotional well-being after safety events.

VI.C.1.c) **policies and programs that encourage optimal resident and faculty member well-being; and,** (Core)

Background and Intent: Well-being includes having time away from work to engage with family and friends, as well as to attend to personal needs and to one's own health, including adequate rest, healthy diet, and regular exercise. The intent of this

requirement is to ensure that residents have the opportunity to access medical and dental care, including mental health care, at times that are appropriate to their individual circumstances. Residents must be provided with time away from the program as needed to access care, including appointments scheduled during their working hours.

VI.C.1.c).(1) **Residents must be given the opportunity to attend medical, mental health, and dental care appointments, including those scheduled during their working hours.** (Core)

VI.C.1.d) **education of residents and faculty members in:**

VI.C.1.d).(1) **identification of the symptoms of burnout, depression, and substance use disorders, suicidal ideation, or potential for violence, including means to assist those who experience these conditions;** (Core)

VI.C.1.d).(2) **recognition of these symptoms in themselves and how to seek appropriate care; and,** (Core)

VI.C.1.d).(3) **access to appropriate tools for self-screening.** (Core)

Background and Intent: Programs and Sponsoring Institutions are encouraged to review materials to create systems for identification of burnout, depression, and substance use disorders. Materials and more information are available in Learn at ACGME (https://dl.acgme.org/pages/well-being-tools-resources).

Individuals experiencing burnout, depression, a substance use disorder, and/or suicidal ideation are often reluctant to reach out for help due to the stigma associated with these conditions and may be concerned that seeking help may have a negative impact on their career. Recognizing that physicians are at increased risk in these areas, it is essential that residents and faculty members are able to report their concerns when another resident or faculty member displays signs of any of these conditions, so that the program director or other designated personnel, such as the department chair, may assess the situation and intervene as necessary to facilitate access to appropriate care. Residents and faculty members must know which personnel, in addition to the program director, have been designated with this responsibility; those personnel and the program director should be familiar with the institution's impaired physician policy and any employee health, employee assistance, and/or wellness/well-being programs within the institution. In cases of physician impairment, the program director or designated personnel should follow the policies of their institution for reporting.

VI.C.1.e) **providing access to confidential, affordable mental health assessment, counseling, and treatment, including access to urgent and emergent care 24 hours a day, seven days a week.** (Core)

Background and Intent: The intent of this requirement is to ensure that residents have immediate access at all times to a mental health professional (psychiatrist,

psychologist, Licensed Clinical Social Worker, Primary Mental Health Nurse Practitioner, or Licensed Professional Counselor) for urgent or emergent mental health issues. In-person, telemedicine, or telephonic means may be utilized to satisfy this requirement. Care in the Emergency Department may be necessary in some cases, but not as the primary or sole means to meet the requirement.

The reference to affordable counseling is intended to require that financial cost not be a barrier to obtaining care.

VI.C.2. **There are circumstances in which residents may be unable to attend work, including but not limited to fatigue, illness, family emergencies, and medical, parental, or caregiver leave. Each program must allow an appropriate length of absence for residents unable to perform their patient care responsibilities.** (Core)

VI.C.2.a) **The program must have policies and procedures in place to ensure coverage of patient care and ensure continuity of patient care.** (Core)

VI.C.2.b) **These policies must be implemented without fear of negative consequences for the resident who is or was unable to provide the clinical work.** (Core)

Background and Intent: Residents may need to extend their length of training depending on length of absence and specialty board eligibility requirements. Teammates should assist colleagues in need and equitably reintegrate them upon return.

VI.D. **Fatigue Mitigation**

VI.D.1. **Programs must educate all residents and faculty members in recognition of the signs of fatigue and sleep deprivation, alertness management, and fatigue mitigation processes.** (Detail)

Background and Intent: Providing medical care to patients is physically and mentally demanding. Night shifts, even for those who have had enough rest, cause fatigue. Experiencing fatigue in a supervised environment during training prepares residents for managing fatigue in practice. It is expected that programs adopt fatigue mitigation processes and ensure that there are no negative consequences and/or stigma for using fatigue mitigation strategies.

Strategies that may be used include but are not limited to strategic napping; the judicious use of caffeine; availability of other caregivers; time management to maximize sleep off-duty; learning to recognize the signs of fatigue, and self-monitoring performance and/or asking others to monitor performance; remaining active to promote alertness; maintaining a healthy diet; using relaxation techniques to fall asleep; maintaining a consistent sleep routine; exercising regularly; increasing sleep time before and after call; and ensuring sufficient sleep recovery periods.

VI.D.2. **The program, in partnership with its Sponsoring Institution, must ensure adequate sleep facilities and safe transportation options for residents who may be too fatigued to safely return home.** (Core)

VI.E. Clinical Responsibilities, Teamwork, and Transitions of Care

VI.E.1. Clinical Responsibilities

The clinical responsibilities for each resident must be based on PGY level, patient safety, resident ability, severity and complexity of patient illness/condition, and available support services. (Core)
[Optimal clinical workload may be further specified by each Review Committee]

Background and Intent: The changing clinical care environment of medicine has meant that work compression due to high complexity has increased stress on residents. Faculty members and program directors need to make sure residents function in an environment that has safe patient care and a sense of resident well-being. It is an essential responsibility of the program director to monitor resident workload. Workload should be distributed among the resident team and interdisciplinary teams to minimize work compression.

VI.E.2. Teamwork

Residents must care for patients in an environment that maximizes communication and promotes safe, interprofessional, team-based care in the specialty and larger health system. (Core)
[The Review Committee may further specify]

Background and Intent: Effective programs will have a structure that promotes safe, interprofessional, team-based care. Optimal patient safety occurs in the setting of a coordinated interprofessional learning and working environment.

VI.E.3. Transitions of Care

VI.E.3.a) **Programs must design clinical assignments to optimize transitions in patient care, including their safety, frequency, and structure.** (Core)

VI.E.3.b) **Programs, in partnership with their Sponsoring Institutions, must ensure and monitor effective, structured hand-off processes to facilitate both continuity of care and patient safety.** (Core)

VI.E.3.c) **Programs must ensure that residents are competent in communicating with team members in the hand-off process.** (Outcome)

VI.F. Clinical Experience and Education

Programs, in partnership with their Sponsoring Institutions, must design an effective program structure that is configured to provide residents with educational and clinical experience opportunities, as well as reasonable opportunities for rest and personal activities.

Background and Intent: The terms "clinical experience and education," "clinical and educational work," and "clinical and educational work hours" replace the terms "duty hours," "duty periods," and "duty." These terms are used in response to concerns that the previous use of the term "duty" in reference to number of hours worked may have led some to conclude that residents' duty to "clock out" on time superseded their duty to their patients.

VI.F.1. Maximum Hours of Clinical and Educational Work per Week

Clinical and educational work hours must be limited to no more than 80 hours per week, averaged over a four-week period, inclusive of all in-house clinical and educational activities, clinical work done from home, and all moonlighting. (Core)

Background and Intent: Programs and residents have a shared responsibility to ensure that the 80-hour maximum weekly limit is not exceeded. While the requirement has been written with the intent of allowing residents to remain beyond their scheduled work periods to care for a patient or participate in an educational activity, these additional hours must be accounted for in the allocated 80 hours when averaged over four weeks.

Work from Home

While the requirement specifies that clinical work done from home must be counted toward the 80-hour maximum weekly limit, the expectation remains that scheduling be structured so that residents are able to complete most work on site during scheduled clinical work hours without requiring them to take work home. The requirements acknowledge the changing landscape of medicine, including electronic health records, and the resulting increase in the amount of work residents choose to do from home. The requirement provides flexibility for residents to do this while ensuring that the time spent by residents completing clinical work from home is accomplished within the 80-hour weekly maximum. Types of work from home that must be counted include using an electronic health record and taking calls from home. Reading done in preparation for the following day's cases, studying, and research done from home do not count toward the 80 hours. Resident decisions to leave the hospital before their clinical work has been completed and to finish that work later from home should be made in consultation with the resident's supervisor. In such circumstances, residents should be mindful of their professional responsibility to complete work in a timely manner and to maintain patient confidentiality.

Residents are to track the time they spend on clinical work from home and to report that time to the program. Decisions regarding whether to report infrequent phone calls of very short duration will be left to the individual resident. Programs will need to factor in time residents are spending on clinical work at home when schedules are developed to ensure that residents are not working in excess of 80 hours per week, averaged over four weeks. There is no requirement that programs assume responsibility for documenting this time. Rather, the program's responsibility is ensuring that residents

report their time from home and that schedules are structured to ensure that residents are not working in excess of 80 hours per week, averaged over four weeks.

VI.F.2. Mandatory Time Free of Clinical Work and Education

VI.F.2.a) Residents should have eight hours off between scheduled clinical work and education periods. (Detail)

Background and Intent: There may be circumstances when residents choose to stay to care for their patients or return to the hospital with fewer than eight hours free of clinical experience and education. This occurs within the context of the 80-hour and the one-day-off-in-seven requirements. While it is expected that resident schedules will be structured to ensure that residents are provided with a minimum of eight hours off between scheduled work periods, it is recognized that residents may choose to remain beyond their scheduled time, or return to the clinical site during this time-off period, to care for a patient. The requirement preserves the flexibility for residents to make those choices. It is also noted that the 80-hour weekly limit (averaged over four weeks) is a deterrent for scheduling fewer than eight hours off between clinical and education work periods, as it would be difficult for a program to design a schedule that provides fewer than eight hours off without violating the 80-hour rule.

VI.F.2.b) Residents must have at least 14 hours free of clinical work and education after 24 hours of in-house call. (Core)

Background and Intent: Residents have a responsibility to return to work rested, and thus are expected to use this time away from work to get adequate rest. In support of this goal, residents are encouraged to prioritize sleep over other discretionary activities.

VI.F.2.c) Residents must be scheduled for a minimum of one day in seven free of clinical work and required education (when averaged over four weeks). At-home call cannot be assigned on these free days. (Core)

Background and Intent: The requirement provides flexibility for programs to distribute days off in a manner that meets program and resident needs. It is strongly recommended that residents' preference regarding how their days off are distributed be considered as schedules are developed. It is desirable that days off be distributed throughout the month, but some residents may prefer to group their days off to have a "golden weekend," meaning a consecutive Saturday and Sunday free from work. The requirement for one free day in seven should not be interpreted as precluding a golden weekend. Where feasible, schedules may be designed to provide residents with a weekend, or two consecutive days, free of work. The applicable Review Committee will evaluate the number of consecutive days of work and determine whether they meet educational objectives. Programs are encouraged to distribute days off in a fashion that optimizes resident well-being, and educational and personal goals. It is noted that a day off is defined in the ACGME Glossary of Terms as "one (1) continuous 24-hour period free from all administrative, clinical, and educational activities."

VI.F.3. Maximum Clinical Work and Education Period Length

VI.F.3.a) **Clinical and educational work periods for residents must not exceed 24 hours of continuous scheduled clinical assignments.** (Core)

VI.F.3.a).(1) **Up to four hours of additional time may be used for activities related to patient safety, such as providing effective transitions of care, and/or resident education. Additional patient care responsibilities must not be assigned to a resident during this time.** (Core)

Background and Intent: The additional time referenced in VI.F.3.a).(1) should not be used for the care of new patients. It is essential that the resident continue to function as a member of the team in an environment where other members of the team can assess resident fatigue, and that supervision for post-call residents is provided. This 24 hours and up to an additional four hours must occur within the context of 80-hour weekly limit, averaged over four weeks.

VI.F.4. **Clinical and Educational Work Hour Exceptions**

VI.F.4.a) **In rare circumstances, after handing off all other responsibilities, a resident, on their own initiative, may elect to remain or return to the clinical site in the following circumstances: to continue to provide care to a single severely ill or unstable patient; to give humanistic attention to the needs of a patient or patient's family; or to attend unique educational events.** (Detail)

VI.F.4.b) **These additional hours of care or education must be counted toward the 80-hour weekly limit.** (Detail)

Background and Intent: This requirement is intended to provide residents with some control over their schedules by providing the flexibility to voluntarily remain beyond the scheduled responsibilities under the circumstances described above. It is important to note that a resident may remain to attend a conference, or return for a conference later in the day, only if the decision is made voluntarily. Residents must not be required to stay. Programs allowing residents to remain or return beyond the scheduled work and clinical education period must ensure that the decision to remain is initiated by the resident and that residents are not coerced. This additional time must be counted toward the 80-hour maximum weekly limit.

VI.F.4.c) **A Review Committee may grant rotation-specific exceptions for up to 10 percent or a maximum of 88 clinical and educational work hours to individual programs based on a sound educational rationale.**

VI.F.4.c).(1) **In preparing a request for an exception, the program director must follow the clinical and educational work hour exception policy from the *ACGME Manual of Policies and Procedures*.** (Detail)

Background and Intent: Exceptions may be granted for specific rotations if the program can justify the increase based on criteria specified by the Review Committee. Review Committees may opt not to permit exceptions. The underlying philosophy for this requirement is that while it is expected that all residents should be able to train within an 80-hour work week, it is recognized that some programs may include rotations with alternate structures based on the nature of the specialty. DIO/GMEC approval is required before the request will be considered by the Review Committee.

VI.F.5. Moonlighting

VI.F.5.a) **Moonlighting must not interfere with the ability of the resident to achieve the goals and objectives of the educational program, and must not interfere with the resident's fitness for work nor compromise patient safety. (Core)**

VI.F.5.b) **Time spent by residents in internal and external moonlighting (as defined in the ACGME Glossary of Terms) must be counted toward the 80-hour maximum weekly limit. (Core)**

VI.F.5.c) **PGY-1 residents are not permitted to moonlight. (Core)**

Background and Intent: For additional clarification of the expectations related to moonlighting, please refer to the Common Program Requirement FAQs (available at http://www.acgme.org/What-We-Do/Accreditation/Common-Program-Requirements).

VI.F.6. In-House Night Float

Night float must occur within the context of the 80-hour and one-day-off-in-seven requirements. (Core)
[The maximum number of consecutive weeks of night float, and maximum number of months of night float per year may be further specified by the Review Committee.]

VI.F.7. Maximum In-House On-Call Frequency

Residents must be scheduled for in-house call no more frequently than every third night (when averaged over a four-week period). (Core)

VI.F.8. At-Home Call

VI.F.8.a) **Time spent on patient care activities by residents on at-home call must count toward the 80-hour maximum weekly limit. The frequency of at-home call is not subject to the every-third-night limitation, but must satisfy the requirement for one day in seven free of clinical work and education, when averaged over four weeks. (Core)**

VI.F.8.a).(1) **At-home call must not be so frequent or taxing as to preclude rest or reasonable personal time for each resident.** (Core)

[The Review Committee may further specify under any requirement in VI.F.]

Background and Intent: As noted in VI.F.1., clinical work done from home when a resident is taking at-home call must count toward the 80-hour maximum weekly limit. This acknowledges the often significant amount of time residents devote to clinical activities when taking at-home call, and ensures that taking at-home call does not result in residents routinely working more than 80 hours per week. At-home call activities that must be counted include responding to phone calls and other forms of communication, as well as documentation, such as entering notes in an electronic health record. Activities such as reading about the next day's case, studying, or research activities do not count toward the 80-hour weekly limit.

In their evaluation of residency/fellowship programs, Review Committees will look at the overall impact of at-home call on resident/fellow rest and personal time.

DATE: January 11, 2025 SUBJECT: Campaign Finance & Public Disclosure Form Completion Requirement

SUBMITTED BY: **Elizabeth A. Huntley, JD, CMBE, Executive Director**

REQUEST FOR BOARD ACTION
MINNESOTA BOARD OF MEDICAL PRACTICE

REQUESTED ACTION:

For Informational Purposes Only

MOTION BY: SECOND:

( ) PASSED ( ) PASSED AMENDED ( ) LAYED OVER ( ) DEFEATED

BACKGROUND:

Board members are required to complete a Campaign Finance and Public Disclosure form, available online, before January 27, 2025, Board members should have received a notice regarding the certification of statement of economic interest from the Campaign Finance and Public Disclosure Board in the last couple of weeks. Failure to complete the form could result in a fine.

DATE: January 11, 2025 SUBJECT: Health Related Licensing Boards Biennial Report 2024

SUBMITTED BY: **Elizabeth A. Huntley, JD, CMBE, Executive Director**

REQUEST FOR BOARD ACTION
MINNESOTA BOARD OF MEDICAL PRACTICE

REQUESTED ACTION:

For Informational Purposes Only

MOTION BY: SECOND:

( ) PASSED ( ) PASSED AMENDED ( ) LAYED OVER ( ) DEFEATED

BACKGROUND:

See attached Biennial Report.

MINNESOTA
HEALTH RELATED
LICENSING BOARDS

Biennial Report

July 1, 2022 to June 30, 2024

MINNESOTA

Table of Contents

EXECUTIVE SUMMARY

REPORTING REQUIREMENTS

The Minnesota Health Licensing Boards ("HLB") individual biennial reports for 2022-2024 are submitted in accordance with Minn. Stat. §214.07, subd. 1b, which states:

> **214.07 REPORTS**
> **Subd. 1b. Health-related licensing board reports.**
> Each health-related licensing board must prepare a report by October 15 of each even-numbered year. The report must be submitted to the administrative services unit serving the boards. The report must contain the following information for the two-year period ending the previous June 30:
> (1) the number and type of credentials issued or renewed;
> (2) the number of complaints received;
> (3) the number and age of complaints open at the end of the period;
> (4) receipts, disbursements, and major fees; and,
> (5) such other information that the interests of health occupation regulation require. The report must also contain information showing historical trends. The reports must use a common format and consistent terminology and data.

The combined Minnesota HLB Biennial Report, 2022-2024, is submitted in accordance with Minn. Stat. §214.07, subd. 2, which states:

> **214.07 REPORTS.**
> **Subd. 2. Administrative services report.**
> The administrative services unit serving the boards shall prepare a report by December 15 of each even-numbered year. One copy of the administrative services report must be delivered to each of the following: the governor, the commissioner of health, and the chairs of the house of representatives and senate policy and appropriations committees with jurisdiction over health-related licensing boards. The report must be delivered to the Legislative Reference Library as provided by section 3.195. The administrative services report must contain the following information:
> (1) a summary of the information contained in the reports submitted by the health-related licensing boards pursuant to subdivision 1b;
> (2) a description of the health-related licensing boards' cooperative activities during the two-year period ending the previous June 30;
> (3) a description of emerging issues relating to health occupation regulation that affect more than one board or more than one occupation; and
> (4) a copy of each health-related licensing board report submitted to the administrative services unit pursuant to subdivision 1b.

Total cost of report preparation: $1,856

SUMMARY OF BOARD DATA – MINN. STAT. §214.07, SUBD. 2(1)

Number of Credentials Issued or Renewed and Total Persons Licensed or Registered

Board	Number of credentials issued or renewed during biennium ending June 30, 2024	Total number of persons licensed or registered as of June 30, 2024
Behavioral Health and Therapy	14,225	9,443
Chiropractic Examiners	10,339	5,103
Dentistry	17,213	18,346
Dietetics and Nutrition Practice	5,483	2,477
Executives for Long Term Services and Supports	3,579	3,176
Marriage and Family Therapy	6,577	3,186
Medical Practice	80,237	40,709
Nursing	198,409	192,113
Occupational Therapy	7,718	5,866
Optometry	2,697	1,280
Pharmacy	52,191	21,019
Physical Therapy	17,089	8,360
Podiatric Medicine	641	620
Psychology	3,665	3,676
Social Work	18,161	18,178
Veterinary Medicine	3,815	3,747
TOTAL	442,039	337,299

Number of Complaints Received and Closed in Biennium

Board	Number of complaints received	Number of complaints closed
Behavioral Health and Therapy	407	580
Chiropractic Examiners	175	155
Dentistry	448	405
Dietetics and Nutrition Practice	8	6
Executives for Long Term Services and Supports	582	557
Marriage and Family Therapy	192	136
Medical Practice	2,188	1,973
Nursing	1,956	2,141
Occupational Therapy	24	22
Optometry	62	62
Pharmacy	368	400
Physical Therapy	79	67
Podiatric Medicine	19	22
Psychology	207	136
Social Work	900	1187
Veterinary Medicine	214	204
TOTAL	7,829	8,053

Number of and Age of Complaints Open at the End of the Period

Board	Number of complaints open less than 1 year	Number of complaints open more than 1 year
Behavioral Health and Therapy	103	96
Chiropractic Examiners	21	2
Dentistry	54	9
Dietetics and Nutrition Practice	3	0
Executives for Long Term Services and Supports	59	4
Marriage and Family Therapy	44	41
Medical Practice	750	303
Nursing	780	91
Occupational Therapy	2	0
Optometry	0	0
Pharmacy	50	64
Physical Therapy	2	0
Podiatric Medicine	6	0
Psychology	70	16
Social Work	91	48
Veterinary Medicine	8	2
TOTAL	2,043	676

Receipts and Disbursements

Board	Receipts received during biennium ending June 30, 2024	Disbursements made during biennium ending June 30, 2024
Behavioral Health and Therapy	$4,048,418	$3,004,754
Chiropractic Examiners	$1,633,550	1,780,602
Dentistry	$3,931,627	$3,576,721
Dietetics and Nutrition Practice	$501,373	$340,168
Executives for Long Term Services and Supports	$1,699,553	$1,377,017
Marriage and Family Therapy	$1,104,479	$1,021,458
Medical Practice	$15,403,943	$11,251,691
Nursing	$17,530,707	$15,135,182
Occupational Therapy	$1,111,508	$1,042,761
Optometry	$498,148	$534,072
Pharmacy	$9,077,179	$8,174,283
Physical Therapy	$1,653,734	$1,384,114
Podiatric Medicine	$426,313	$434,529
Psychology	$2,201,575	$2,221,101
Social Work	$4,788,113	$4,011,625
Veterinary Medicine	$853,752	$883,587
TOTAL	$66,463,972	$56,173,665

COOPERATIVE ACTIVITIES – MINN. STAT. §214.07, SUBD. 2(2)

Council of Health Boards

As required by statute since 2001, the Health Licensing Boards ("HLBs") established the Council of Health Boards consisting of representatives of all the HLBs. *See* Minn. Stat. §214.025 (2024). When the council reviews legislation or legislative proposals that relate to the regulation of health occupations not licensed by the HLBs, the council includes the Commissioner of Health or designee and the director of the Office of Emergency Medical Services or designee. *See also* Minn. Stat. §214.01 (2024).

Executive Directors Forum

The executive directors of each HLB meet monthly in an Executive Director Forum ("Forum") to collaborate on issues common to the boards, to share best practices, and to address issues of shared concern, including policy development, legislation, and technological improvements. The Forum has established committees, including the policy committee, the management committee, and the information technology governance committee, to study issues and provide recommendations to the Forum as a whole. The goals of the Forum, in addition to collaboration, are to ensure fiscal efficiency, to eliminate duplication when possible, and to promote cooperation among the HLBs.

Health Professionals Services Program

In 1994, the Minnesota legislature authorized the establishment of the Health Professional Services Program ("HPSP"), which provides monitoring services for "regulated professionals who are unable to practice with reasonable skill and safety by reason of illness, use of alcohol, drugs, chemicals, or any other materials, or as a result of any mental, physical, or psychological condition." Minn. Stat. §214.32 (2024). All of the HLBs participate in the HPSP and use it as a monitoring program for regulated persons who meet the HPSP criteria. Each participating Board has a designated representative who serves on the HPSP Program Committee, which oversees administration of the program, sets the program budget, and allocates a pro rata share of the program expenses to each participating board. Id. at subd. 1(a). Effective July 1, 2023, the administering board for HPSP changed from the Board of Medical Practice to the Board of Psychology.

Administrative Services Unit and SmART

The Administrative Services Unit ("ASU") is a statutorily created entity "established for the health-related licensing boards….to perform administrative, financial, and management functions common to all boards in a manner that streamlines services, reduces expenditures, targets the use of state resources, and meets the mission of public protection." Minn. Stat. §214.107, subd. 1 (2024). ASU acts as an agent of the HLBs collectively and individually and is funded by an allocation of resources from each HLB. Id. at subd. 3. ASU provides fiscal oversight to the HLB's statutorily authorized Criminal Background Check Program and manages the Volunteer Health Care Provider Program, which provides malpractice coverage for health care providers serving in a volunteer capacity at charitable organizations. ASU's annual budget is determined by the Forum, and the oversight of ASU is assigned on a rotating basis to one of the HLBs.

In 2019, ASU initiated an interagency agreement with the Department of Administration, Small Agency Resource Team (SmART) to provide financial and human resources services to the Boards. ASU staff was reduced from seven to two. In 2023, a legislative liaison position was created to provide legislative

support and coordination to the HLBs, bringing total staff to 3 full-time equivalents. Additionally, ASU continues to process deposits, reconcile banking discrepancies, maintain fixed assets, manage shared projects, coordinate facility management, and support the Continuity of Operations Planning for the HLBs.

Criminal Background Check Program

The HLB's Criminal Background Check Program (CBCP) was established following the enactment of Minn. Stat. §214.075 in 2013. The CBCP facilitates criminal background checks on behalf of all of the HLB's. The background checks are run through the Bureau of Criminal Apprehension and the Federal Bureau of Investigation. See Minn. Stat. §214.075 (2024). From April 2022 to January 2023, criminal background check volume temporarily increased by 55 percent due to two Nursing strikes. A total of 31,974 criminal background checks were completed in FY 2023. A more normal volume occurred in FY 2024 with 21,772 checks completed. The baseline for CBCP staffing is 4 full-time equivalents. Program costs are allocated based on a base fee and background check volume by board.

EMERGING ISSUES – MINN. STAT. §214.07, SUBD. 2(3)

License Portability

As state and national boundaries become increasingly fluid and populations grow more mobile, there is a rising demand for alternative pathways to support individuals entering Minnesota's healthcare workforce efficiently. These measures also aim to address healthcare shortages in Greater Minnesota and provider diversity gaps, particularly in the Twin Cities Metro. Nationally, progress in portability laws and compact development is advancing across numerous professions.

- Interstate Medical Licensure Compact: In 2015, the Legislature authorized the Board of Medical Practice to join this compact, which currently includes 37 states, the District of Columbia, and Guam.
- Psychology Interjurisdictional Compact (PSYPACT): In 2021, legislation was passed allowing the Board of Psychology to join this compact, which is currently effective in 33 states.
- Interstate Counseling Compact: In 2024, legislation was passed authorizing Minnesota to join this compact. Licensed Professional Clinical Counselors regulated by the Board of Behavioral Health and Therapy will be eligible to apply when the compact begins accepting applications, anticipated in 2025 or 2026.
- Interstate Occupational Therapy Compact: In 2024, legislation was passed authorizing Minnesota to join this compact. Licensed Occupational Therapists regulated by the Board of Occupational Therapy will be eligible to apply when the compact begins accepting applications, anticipated in 2025 or 2026.
- Interstate Dental and Dental Hygienist Compact: In 2024, legislation was passed authorizing Minnesota to join this compact. Licensed Dentists and Dental Hygienists regulated by the Board of Dentistry will be eligible to apply when the compact begins accepting applications, anticipated in 2026 or 2027.
- Interstate Social Work Compact: In 2024, legislation was passed authorizing Minnesota to join this compact. Licensed Independent Clinical Social Workers, Licensed Independent Social Workers, Licensed Graduate Social Workers, and Licensed Social Workers regulated by the Board of Social Work will be eligible to apply when the compact begins accepting applications, anticipated in 2026 or 2027.
- Interstate Physician Assistant Compact: In 2024, legislation was passed authorizing Minnesota to join this compact. Licensed Physician Assistants regulated by the Board of Medical Practice will be eligible to apply when the compact begins accepting applications, anticipated in 2026 or 2027.
- Physical Therapy Compact: In 2024, legislation was passed authorizing Minnesota to join this compact. However, due to language changes made by the Legislature related to liability immunity for PT Compact Commission employees, the Commission rejected Minnesota’s eligibility for the compact.
- Guest Licensure for Marriage and Family Therapy: The Board of Marriage and Family Therapy introduced and passed legislation for a new guest license, allowing out-of-state practitioners to treat patients in Minnesota for up to five months annually.
- Social Work Provisional License Expansion: The Board of Social Work passed legislation broadening access to the Provisional License. Prior to October 1, 2024, eligibility for provisional licensure was restricted to applicants born outside the United States, whose first language was not English, and who had attempted but not passed the national exam. The amended statute expands provisional license eligibility to all applicants and no longer requires an applicant to attempt the national exam.

New and Potentially New Regulated Persons

Veterinary Technician Licensure: After being proposed for at least two decades, legislation establishing a Veterinary Technician license was passed following a three-year informational campaign led by the Minnesota Veterinary Medical Association and the Minnesota Association of Veterinary Technicians, with support from the Board. The legislation authorizes the Board to establish licensure and related practice requirements for Licensed Veterinary Technicians (LVTs).

The rules will become effective on July 1, 2026, when applications will open. To qualify as an LVT, individuals must graduate from a program accredited by the AVMA Committee on Veterinary Technology Education and Activities (CVTEA), pass the Veterinary Technician National Examination (VTNE), and complete the Minnesota Veterinary Technician Jurisprudence Examination.

Additionally, a provision allows individuals who do not meet these criteria—but have worked as veterinary technicians for approximately 2.5 years full-time within the last five years—to apply for LVT licensure by July 1, 2031.

Behavior Analyst Licensure: Several boards collaborated on a Council of Health Boards study regarding licensure for Behavior Analysts, culminating in a March 2020 report recommending that the Board of Psychology regulate and license Behavior Analysts. Legislation was initially introduced in 2021 but did not advance. Reintroduced in 2023, the bill was passed into law in 2024. The Board began accepting applications for licensure in September 2024.

Licensure for International Medical Graduates (IMGs): In 2024, a legislative proposal was introduced to create a pathway for licensing certain International Medical Graduates. Under current Minnesota law, IMGs must complete at least one year of graduate clinical medical training in an accredited program, typically a U.S. residency, which many IMGs are unable to secure.

The proposed legislation sought to establish a limited license for IMGs who have “performed the duties of a physician” in another country for at least five years among other requirements. The bill failed to pass in 2024 and it is anticipated that it will be brought forward in a future session.

Certified Midwife Licensure: In 2024, a bill was introduced that provide non-nurses a pathway to licensure as a Certified Midwife. The bill would allow those with a bachelor’s degree in a non-nursing field to complete specified academic pre-requisites prior to enrolling in an educational program to train to become a certified midwife. Legislation is anticipated to be reintroduced in a future session.

Others: Other professions considering a move to licensure within the HLB structure include art therapists, music therapists, massage therapists and Asian bodywork therapists.

Legislative Initiatives and Challenges

Expanded Pharmacist Role in Vaccination and Changes to Prescription Label Accessibility: In response to the COVID-19 pandemic, the 2024 legislature passed a provision allowing licensed pharmacists to initiate, order, and administer “influenza and COVID-19 or SARS-CoV-2” to children three years or older and initiate, order, and administer other approved vaccines to children six years or older. Under certain circumstances, the licensed pharmacist may delegate these functions to a pharmacy technician or intern.

Additionally, effective January 1, 2026, statute will allow licensed pharmacists to prescribe, dispense, and administer drugs for preventing the acquisition of human immunodeficiency virus and to order, conduct, and interpret laboratory tests necessary for preventing the acquisition of HIV.

The legislature also addressed prescription labeling in 2024, requiring pharmacies to provide audible or braille labels upon request. This legislation, effective January 1, 2026, also requires a survey to identify pharmacies that currently offer accessible labels.

Finally, the legislature passed a provision that requires the Board of Pharmacy to engage in rulemaking to allow specific changes to prescription labels.

Physician Wellness Program: In the 2024 session, legislation passed and went into effect August 1, 2024 to support clinicians' well-being and offer resources for career fatigue, wellness, and burnout. The program, SafeHaven, runs independently from the State's Health Professional Services Program and will serve as an additional resource to physicians experiencing stressors from work.

Expanded Scope for Optometrists: In 2023, the Minnesota Optometric Association introduced legislation to expand the scope of practice for optometrists in the state. It did not pass but future legislation is anticipated.

Cannabis Management: During the 2022 Session, legislation was passed legalizing tetrahydrocannabinol (THC) edible gummies as outlined in MN Stat. 151.72 (2022) within the Pharmacy Practice Act. With support from the Board, legislation was passed during the 2023 session removing the statute from the Pharmacy Practice Act and establishing the Office of Cannabis Management to oversee all cannabis products.

Increasing Operational Costs: In 2025, multiple Boards will be seeking increases in base appropriations and fee increases to cover all operating expenses. Operational costs have increased steadily with significant increases in information technology including cybersecurity, and workforce costs. The Boards are self-funded through revenue collected and do not receive general fund appropriations.

Health Licensing Boards Name Change

At the end of the 2022 Legislative session, the Boards submitted a technical change request to the Revisors office to modify the overarching name, Health Related Licensing Boards, to Health Professionals Regulatory Boards. The new name better represents the broad scope of the Boards as regulatory entities ensuring protection of the public through not only licensing but regulation of the licensed professionals as well. The name change bill was not reintroduced in the 2023-2024 biennium, but future legislation related to this technical change is expected.

Post-COVID Hybrid Environment

While State office buildings re-opened to the public April 22, 2022, health threats from COVID variants have continued to warrant caution. The HLBs have successfully integrated tele-working, virtual meetings, and other workflow processes to meet the needs of constituents, board members and employees.

BOARD OF BEHAVIORAL HEALTH AND THERAPY

The mission of the Board of Behavioral Health and Therapy is to protect the public through effective licensure and enforcement of the statutes and rules governing its licensees to ensure a standard of competent and ethical practice.

Report of the Executive Director

July 1, 2022 – June 30, 2024

The Board of Behavioral Health and Therapy exists to regulate the practices of alcohol and drug counseling, professional counseling, and professional clinical counseling in the State of Minnesota. Regulation of these professions is necessary to protect the health, safety, and welfare of Minnesota citizens when they receive mental health and substance use disorder counseling services. The Board has 13 members appointed by the Governor: 5 Licensed Alcohol and Drug Counselors (LADCs), 5 Licensed Professional Counselors/Licensed Professional Clinical Counselors (LPC/LPCCs), and 3 public members. The full Board convenes 4 times per year and conducts special board meetings when necessary. Several smaller committees of the Board meet regularly throughout the year, including the Board's Complaint Resolution Committees; Legislative Committee; Application and Licensure Committee; and Diversity, Equity, and Inclusion Committee.

In 2019, the Board's Policy and Rules Committee initiated the rule writing process to update the rules that govern professional counseling practice (Minnesota Rules Chapter 2150). The Board sought to revise its rules to incorporate LPCCs, make technical changes that reflect the Board's processes and procedures, and to expand opportunities for coursework and continuing education for licensees. The rules were adopted on February 10, 2023, and effective on April 10, 2023.

During the 2024 session, legislation passed establishing an interstate licensure compact for licensed professional counselors. The Counseling Compact ("Compact") allows professional counselors to apply for a privilege to practice in any state that is a member of the Compact. The Counseling Compact will improve access to mental health services by allowing more professional counselors to provide services to Minnesota residents through telehealth, will ensure continuity of care when licensees or clients relocate to other states permanently or temporarily, and will make it easier for military personnel and their family members to practice professional counseling in Minnesota. The Counseling Compact hopes to begin issuing privileges to practice in 2025.

The Board is currently in the process of updating its website and paper forms to make them easier to understand and accessible. The Board is also working to expand the services that can be completed online (initial applications, continuing education applications, etc.) which will improve access and make these streamline these processes for licensees, applicants, and the public.

Each year, the Board's total number of licensees increases. Between June 30, 2014, and June 30, 2024, the number of regulated persons more than doubled, going from approximately 4,000 licensees to approximately 9,400 licensees. In turn, the number of applications, complaints, and general inquiries to the Board continues to increase.

Samantha Strehlo, Executive Director
Board of Behavioral Health and Therapy
Telephone: 651.201.2758
Email address: samantha.strehlo@state.mn.us

BOARD MEMBERS SERVING DURING THE PERIOD 7/1/2022 – 6/30/2024

Name	Location	Appointment Status	Appointment Date	Reappointment Date	Term Expiration
Bharati Acharya	Minneapolis	LPCC Professional Member	5/6/2020	5/29/2024	1/3/2028
Christopher Anderson	Elbow Lake	LPCC Professional Member	4/5/2023	NA	1/4/2027
Randy Anderson	Golden Valley	LADC Professional Member	4/5/2023	NA	1/4/2027
Jacqueline Bluem	Lakeville	LADC Professional Member	7/1/2018	4/5/2023	1/4/2027
Sandra Clark	Andover	LPCC Professional Member	5/29/2024	NA	1/4/2027
Marlae Cox-Kolek	Mankato	LADC Professional Member	3/16/2009	12/1/2019	4/4/2023
Derrick Crim	Brooklyn Park	LADC Professional Member	4/16/2018	6/22/2022	1/5/2026
Rachel Dame	Minneapolis	Public Member	7/6/2021	NA	2/17/2023
Amy Dols	Minneapolis	LPCC Professional Member	5/6/2020	2/3/2021	1/6/2025
Sarah Sirianni Driever	Minneapolis	Public Member	5/29/2024	NA	1/6/2025
Dean Gilbertson	Mankato	LADC Professional Member	2/3/2021	NA	1/6/2025
Corey Harland	New Brighton	Public Member	1/5/2021	6/5/2022	1/5/2026
Jae Hyun Shim	Minneapolis	Public Member	6/29/2016	5/6/2020	2/14/2023
Roy Kammer	Kasota	LADC Professional Member	4/16/2018	5/29/2024	1/2/2028
Rebecca Lund	St. Louis Park	LPCC Professional Member	10/4/2014	12/1/2019	3/2/2023
Landyn Prescott-Miles	Royalton	LPCC Professional Member	6/5/2022	NA	1/5/2026
Randy Stillday	Red Lake	Public Member	4/5/2023	1/17/2024	1/3/2028
Marjorie (DeDe) Van Slyke	St. Louis Park	LPCC Professional Member	6/30/2011	4/5/2023	5/8/2023

Board Staff and Office Location

1 Executive Director
1 Office Manager
1 LADC Program Administrator
1 LADC Administrative Specialist
1 LPC/LPCC Program Administrator
1 LPC/LPCC Administrative Specialist
1 Complaints and Compliance Director
1 Student Worker

Minnesota Board of Behavioral Health and Therapy
Randolph Square Building
335 Randolph Avenue, Suite 290
St. Paul, MN 55102
Phone: 651.201.2756
FAX: 651.797.1374
Email: bbht.board@state.mn.us
Website: http://mn.gov/boards/behavioral-health/

CREDENTIALS ISSUED OR RENEWED – MINN. STAT. § 214.07, SUBD. 1B(1)

Total number of persons licensed or registered as of June 30, 2024: 9,443

Number and Type of Credentials Issued or Renewed

License Type	Licensed or registered as of June 30, 2024	Licensed or registered as of June 30, 2022	Licensed or registered as of June 30, 2020	Licensed or registered as of June 30, 2018	Licensed or registered as of June 30, 2016	Licensed or registered as of June 30, 2014
Licensed Alcohol and Drug Counselor (LADC)	4436	3915	3595	3484	2990	2647
Temporary Permit (ADC Temp)	290	285	268	229	184	185
Licensed Professional Counselor (LPC)	564	479	440	511	463	480
Licensed Professional Clinical Counselor (LPCC)	4153	3108	2210	1753	1177	755
TOTAL	**9443**	**7787**	**6513**	**5977**	**4814**	**4067**

Historical Renewal Data by Biennium

July 1, 2022 – June 30, 2024

Type of License/Credential	Number of New Licenses	Number of Renewed Licenses	Number and Percent Renewed Online
Licensed Alcohol and Drug Counselor (LADC)	662	3830	3536 (92%)
Temporary Permit (ADC Temp)	280	410	387 (94%)
Licensed Professional Counselor (LPC)	300	875	817(93%)
Licensed Professional Clinical Counselor (LPCC)	1072	6796	6615(97%)
TOTAL	2314	11911	11355 (95%)

July 1, 2020 – June 30, 2022

Type of License/Credential	Number of New Licenses	Number of Renewed Licenses	Number and Percent Renewed Online
Licensed Alcohol and Drug Counselor (LADC)	666	4118	3183 (77%)
Temporary Permit (ADC Temp)	279	657	329 (50%)
Licensed Professional Counselor (LPC)	282	1086	752 (70%)
Licensed Professional Clinical Counselor (LPCC)	873	5918	4811 (81%)
TOTAL	2100	11779	9075 (77%)

July 1, 2018 – June 30, 2020

Type of License/Credential	Number of New Licenses	Number of Renewed Licenses	Number and Percent Renewed Online
Licensed Alcohol and Drug Counselor (LADC)	589	3166	2847 (90%)
Temporary Permit (ADC Temp)	239	327	257 (79%)
Licensed Professional Counselor (LPC)	256	851	765 (90%)
Licensed Professional Clinical Counselor (LPCC)	687	3739	3380 (90%)
TOTAL	1771	8083	7249 (90%)

July 1, 2016 – June 30, 2018

Type of License/Credential	Number of New Licenses	Number of Renewed Licenses	Number and Percent Renewed Online
Licensed Alcohol and Drug Counselor (LADC)	643	2854	2437 (85.4%)
Temporary Permit (ADC Temp)	237	268	200 (74.6%)
Licensed Professional Counselor (LPC)	302	818	729 (89.1%)
Licensed Professional Clinical Counselor (LPCC)	584	2675	2423 (93.9%)
TOTAL	1766	6615	5789 (87.5%)

July 1, 2014 – June 30, 2016

Type of License/Credential	Number of New Licenses	Number of Renewed Licenses	Number and Percent Renewed Online
Licensed Alcohol and Drug Counselor (LADC)	644	2460	Not Available*
Temporary Permit (ADC Temp)	198	213	Not Available*
Licensed Professional Counselor (LPC)	349	768	Not Available*
Licensed Professional Clinical Counselor (LPCC)	458	1766	Not Available*
TOTAL	1649	5207	Not Available*

*Database online renewal report not functioning during this biennium.

July 1, 2012 – June 30, 2014

Type of License/Credential	Number of New Licenses	Number of Renewed Licenses	Number and Percent Renewed Online
Licensed Alcohol and Drug Counselor (LADC)	533	2171	Not Available*
Temporary Permit (ADC Temp)	261	177	Not Available*
Licensed Professional Counselor (LPC)	304	770	Not Available*
Licensed Professional Clinical Counselor (LPCC)	302	1074	Not Available*
TOTAL	1400	4192	Not Available*

*Database online renewal report not functioning during this biennium.

COMPLAINT ACTIVITY – MINN. STAT. §214.07, SUBDS. 1B (2), (3)

Complaints Received and Closed by Biennium

Biennium	Total Number of Complaints Received	Total Number of Complaints Closed
July 1, 2022 – June 30, 2024	407	580
July 1, 2020 – June 30, 2022	378	252
July 1, 2018 – June 30, 2020	368	304
July 1, 2016 – June 30, 2018	359	127
July 1, 2014 – June 30, 2016	255	215
July 1, 2012 – June 30, 2014	210	248

Number of and Age of Complaints Open at the End of the Period

Total Number of Complaints Open as of June 30, 2024	**199**
Complaints open less than one year as of June 30, 2024	103
Complaints open greater than one year as of June 30, 2024	96

Complaints may be open for more than one year for any number of reasons, including the complexity of the issues to resolve, the necessity for extensive investigation by the Attorney General's Office, and contested case proceedings at the Office of Administrative Hearings.

Types of Complaints Received by Biennium

Basis for complaints*	Number alleging this basis in 2022-2024	Number alleging this basis in 2020-2022	Number alleging this basis in 2018-2020
Misrepresentation of Credential	11	10	8
Practice without a License	11	6	10
Practice After License Expired	4	3	5
Mental/Physical Illness	27	17	6
Substance Use	65	42	56
Discipline in Other Jurisdiction	9	2	6
Violated Board Order	6	1	6
Non-compliance with Board Order	3	0	1
Recordkeeping	32	16	16
Fraudulent Billing	12	19	7
Sexual Conduct	56	68	54
Boundaries Issues	66	53	43
Criminal Charges/Conviction	35	19	21
Failure to Report Charges/Convictions	0	1	1
Unprofessional Conduct	229	153	198
Failure to Maintain Confidentiality	31	19	23
Fraud in Licensure Process	0	1	1
Disregard for Health, Welfare, and Safety	0	0	2
Competence	24	21	24
Aiding/Abetting Unlicensed Practice	0	4	1
Misrepresentation of Facts on Application	2	1	0
Failure to Make Mandatory Report	0	2	1
Failure to Cooperate with Board Investigation	0	2	0

*Some complaints may allege more than one basis.

RECEIPTS, DISBURSEMENTS & MAJOR FEES – MINN. STAT §214.07, 1B(4)

Total Receipts and Disbursements by Biennium

Biennium	Total Receipts	Total Disbursements
July 1, 2022 – June 30, 2024	$4,048,418	$3,004,754
July 1, 2020 – June 30, 2022	$3,401,980	$1,433,997
July 1, 2018 – June 30, 2020	$2,561,554	$2,149,366
July 1, 2016 – June 30, 2018	$2,408,944	$1,501,061
July 1, 2014 – June 30, 2016	$1,970,876	$1,298,503
July 1, 2012 – June 30, 2014	$1,697,100	$907,365

Fees by Type

LADC Fees	Fee
LADC Application for Licensure Fee	$295
LADC Biennial Renewal Fee (Active)	$295
LADC Biennial Renewal Fee (Inactive)	$150
LADC Biennial Renewal Active Late Fee	$74
LADC Biennial Renewal Inactive Late Fee	$37
Temporary Permit Application Fee	$100
Temporary Permit Annual Renewal Fee	$150
Temporary Permit Annual Renewal Late Fee	$37
License Verification Fee	$25
CE Sponsor Application Fee	$60
Board Order Copy Fee	$10
Duplicate Certificate/License Fee	$25
Supervisor Application Fee	$30

LPC and LPCC Fees	Fee
LPC and LPCC License Application Fee	$150
LPC and LPCC Initial License Fee	$250
Temporary License for Members of the Military	$250
LPC and LPCC Annual Renewal Fee (Active)	$250
LPC and LPCC Annual Renewal Fee (Inactive)	$125
LPC/LPCC Renewal Late Fee	$100 per month or portion thereof
Board Order Copy Fee	$10
License Verification Fee	$25
Duplicate Certificate/License Fee	$25
CE Sponsor Application Fee	$60
Supervisor Application Fee	$30
Professional Firm Renewal Fee	$25
Initial Registration Fee	$50
Annual Registration Renewal Fee	$25

BOARD OF CHIROPRACTIC EXAMINERS

The mission of the Minnesota Board of Chiropractic Examiners (MBCE) is to protect the public through effective licensure and enforcement of the statutes and rules governing the practice of chiropractic to ensure a standard of competent and ethical practice in the profession.

Report of the Executive Director

July 1, 2022 – June 30, 2024

The Minnesota Board of Chiropractic Examiners (MBCE) was established by legislative act on March 13, 1919. Minnesota Statutes sections 148.01-148.108 and Minnesota Rules Chapter 2500 give the board authority to regulate, license by examination and renewal, and investigate complaints.

Licensing/Credentialing Services

The purpose of regulation through licensing is to set and enforce standards of competence and ethical practice and to ensure that persons licensed as Doctors of Chiropractic meet educational, examination, and continuing education standards. Staff process applications, verify compliance with statutory requirements, provide assistance and information to a variety of customers, and work in collaboration with other agencies at the state, federal, and national levels.

To meet these functions, the MBCE operates under five key service strategies:

- maintain an integrated database of licensee information, registrations, discipline, and complaints;
- publish information on the web, including licensure data, disciplinary orders, and rulemaking efforts;
- conduct regular board meetings where citizens may have input into the review of operations and rulemaking efforts;
- respond to public requests for information on chiropractors, continuing education sponsors, and licensee's status; and,
- manage funds soundly.

The Board accomplishes its core public safety and regulatory mission of Doctors of Chiropractic by:

- ensuring minimum entry-level competency through primary source verification of education and examination for initial licensure as a Doctor of Chiropractic and administering requirements and processes for renewal of licensure;
- enforcing standards of ethical practice and responding to inquiries, complaints and or reports regarding applicants or licensees;
- investigating complaints of alleged violations of statutes, holding educational and disciplinary conferences, and taking legal action when appropriate against licensees who are in violation of statutory standards of practice or who may otherwise pose a harm to the public as a result of improper or unethical practice;
- approving continuing education providers and auditing licensees' continuing education compliance; and,
- providing information about licensure and standards of practice through professional education outreach efforts, the Board's website, online license verification services, and telephone, mail, or email inquiry.

The Board provides core public safety services through the regulatory oversight of Doctors of Chiropractic, as noted in the strategies listed above, to ensure both high standards of chiropractic practice and excellent customer service. The Board provides services to the general public, consumers of chiropractic services, applicants and licensees, students and faculty in chiropractic academic programs, other state and local agencies, state and national professional chiropractic associations, and the national testing organization as well as the Federation of Chiropractic Licensing Boards.

Discipline/Complaint Resolution Services

Staff, Board Members, and the Office of the Attorney General work collaboratively to review, investigate, and take action, as appropriate, in alleged violations against licensed Doctors of Chiropractic. When a licensee is determined to have engaged in conduct that is a violation of the statutes or rules the Board is empowered to enforce, an appearance before Board Members may occur. Licensees may enter into an agreement for corrective action with the Board's complaint panel or may become subject to disciplinary action, with such final action determined by the full Board. Either of these two remedies is public once completed. In addition, staff provides informational services to a variety of customers regarding the Board's statutory requirements and standards of practice, including how to file a complaint and the complaint resolution process. The Board also works with the Health Professionals Services Program (HPSP), the state's diversion program for regulated professionals who are impaired, as an additional method to ensure public protection.

Online Services

The Board maintains a robust website that includes the following: information on Board structure, meetings, and policies; licensing information, application forms, and online applications including renewals for nearly all licenses/registrations; information on continuing education programs and sponsors; access to specific statutes and rules directly impacting the profession; information on current emerging issues impacting the profession; information on access to the HPSP; and links to other related sites. The Board renews in excess of 5000 licenses and registrations every fiscal year. Since 2022, the Board has implemented 100% online renewals and is nearing 100% online new applications.

Key Activity Goals and Measures

The MBCE works to meet the Minnesota milestone of access to government information 24x7x365 through its self-service website. The MBCE works to protect the public from impaired or unethical practitioners by prompt investigation of complaints and resolution of disciplinary matters through educational conferences, corrective action agreements, board orders and/or contested case proceedings. The MBCE collaborates with other licensing boards and state agencies to create an efficient state government.

Ridge M. Pidde, DC
Executive Director
Board of Chiropractic Examiners
651-201-2850
Ridge.Pidde@state.mn.us

GENERAL INFORMATION – MINN. STAT. § 214.07, SUBD. 1B(5)

Board Members Serving During the Period 7/1/2022 – 6/30/2024

Name	Location	Appointment Status	Appointment Date	Reappointment Date	Term Expiration Date
Robert Daschner, DC	Faribault	Professional Member #1	4/22/2008	6/30/2012 6/27/2016 2/3/2021	1/6/2025
Derek Doty, DC	Shoreview	Professional Member #2	7/2/2019	5/3/2023	1/4/2027
Ridge Pidde, DC	Bloomington	Professional Member #3	9/13/2015	6/27/2016 6/29/2020	9/3/2022
Noel Fredericksen, DC	Forest Lake	Professional Member #3	5/3/2023	5/22/2024	1/3/2028
Richard Ottomeyer, DC	Forest Lake	Professional Member #4	2/16/2022	NA	1/5/2026
Nicole Zaret, DC	Golden Valley	Professional Member #5	6/29/2020	NA	2/21/2024
Cody Rodewald, DC	Lakeville	Professional Member #5	5/22/2024	NA	1/3/2028
Kim Hill	Woodbury	Public Member #1	7/2/2019	5/3/2023	1/4/2027
Nestor Riano	Roseville	Public Member #2	6/20/2015	7/2/2019	5/3/2023
Mary Syfax Noble	Shoreview	Public Member #2	5/3/2023	NA	1/4/2027

Board Staff and Office Location

1 Executive Director
1 Compliance Specialist
1 Administrative Specialist / Office Manager
1 Licensing Coordinator
1 Continuing Education Coordinator
1 General Support
1 Long-term Temporary Position (employed 2022-2023)

Minnesota Board of Chiropractic Examiners
Randolph Square Building
335 Randolph Avenue, Suite 280
St. Paul, MN 55102
Phone: 651-201-2850
Email: chiropractic.board@state.mn.us
Website: https://mn.gov/boards/chiropractic-examiners

CREDENTIALS ISSUED OR RENEWED – MINN/ STAT/ § 214/07, SUBD/ 1B(1)

Total number of persons licensed or registered as of June 30, 2024: **5103**

Number and Type of Credentials Issued or Renewed

License Type	Licensed or registered as of June 30, 2024	Licensed or registered as of June 30, 2022	Licensed or registered as of June 30, 2020	Licensed or registered as of June 30, 2018	Licensed or registered as of June 30, 2016	Licensed or registered as of June 30, 2014
Doctor of Chiropractic (DC)	3339	3388	3179	3286	3182	3069
Acupuncture Registration	690	667	667	658	649	668
Animal Chiropractic Registration	62	55	48	42	39	33
Independent Examiner Registration	32	38	41	45	48	51
Professional Firm Registration	950	940	966	938	936	901
Graduate Preceptor Registration	30	27	24	18	16	15
TOTAL	**5103**	**5115**	**4925**	**4969**	**4870**	**4737**

Historical Renewal Data by Biennium

July 1, 2022 – June 30, 2024

Type of License/Credential	Number of New Licenses	Number of Renewed Licenses	Number and Percent Renewed Online
Doctor of Chiropractic (DC)	252	6548	6545 (99%)
Acupuncture Registration	44	1326	1326 (100%)
Animal Chiropractic Registration	9	116	116 (100%)
Independent Examiner Registration	2	67	67 (100%)
Professional Firm Registration	89	1880	1873 (99%)
Graduate Preceptor Registration	NA	NA	NA
TOTAL	396	9943	9927 (99%)

July 1, 2020 – June 30, 2022

Type of License/Credential	Number of New Licenses	Number of Renewed Licenses	Number and Percent Renewed Online
Doctor of Chiropractic (DC)	253	6637	6570 (99%)
Acupuncture Registration	43	1331	1331 (100%)
Animal Chiropractic Registration	13	103	97 (94%)
Independent Examiner Registration	2	75	75 (100%)
Professional Firm Registration	69	1885	1810 (96%)
Graduate Preceptor Registration	24	NA	NA
TOTAL	404	10031	9883 (98/5%)

July 1, 2018 – June 30, 2020

Type of License/Credential	Number of New Licenses	Number of Renewed Licenses	Number and Percent Renewed Online
Doctor of Chiropractic (DC)	229	6496	6308 (97%)
Acupuncture Registration	32	1331	1289 (97%)
Animal Chiropractic Registration	5	87	87 (100%)
Independent Examiner Registration	2	73	68 (93%)
Professional Firm Registration	95	1865	1827 (98%)
Graduate Preceptor Registration	27	NA	NA
TOTAL	390	9190	8941 (97%)

July 1, 2016 – June 30, 2018

Type of License/Credential	Number of New Licenses	Number of Renewed Licenses	Number and Percent Renewed Online
Doctor of Chiropractic (DC)	281	6421	6096 (95%)
Acupuncture Registration	35	1319	1259 (95%)
Animal Chiropractic Registration	7	85	84 (99%)
Independent Examiner Registration	10	80	76 (95%)
Professional Firm Registration	96	1847	1776 (96%)
Graduate Preceptor Registration	37	NA	NA
TOTAL	466	9752	9291 (95%)

July 1, 2014 – June 30, 2016

Type of License/Credential	Number of New Licenses	Number of New Licenses	Number and Percent Renewed Online
Doctor of Chiropractic (DC)	287	6193	5818 (94%)
Acupuncture Registration	38	1315	1243 (95%)
Animal Chiropractic Registration	8	72	70 (97%)
Independent Examiner Registration	11	92	88 (96%)
Professional Firm Registration	143	1814	1712 (94%)
Graduate Preceptor Registration	41	NA	NA
TOTAL	528	9486	8931 (94%)

July 1, 2012 – June 30, 2014

Type of License/Credential	Number of New Licenses	Number of Renewed Licenses	Number and Percent Renewed Online
Doctor of Chiropractic (DC)	259	5887	5254 (89%)
Acupuncture Registration	33	1316	1194 (91%)
Animal Chiropractic Registration	10	52	NA
Independent Examiner Registration	9	103	90 (87%)
Professional Firm Registration	237	1512	1387 (92%)
Graduate Preceptor Registration	26	NA	NA
TOTAL	574	8870	7925 (89%)

COMPLAINT ACTIVITY – MINN/ STAT/ §214/07, SUBDS/ 1B(2), (3)

Complaints Received and Closed by Biennium

Biennium	Total Number of Complaints Received	Open from Prior Biennium	Total Number of Complaints Closed
July 1, 2022 – June 30, 2024	175	0	155
July 1, 2020 – June 30, 2022	152	41	180
July 1, 2018 – June 30, 2020	269	not tracked	237
July 1, 2016 – June 30, 2018	248	not tracked	239
July 1, 2014 – June 30, 2016	289	not tracked	309
July 1, 2012 – June 30, 2014	402	not tracked	362

Number of and Age of Complaints Open at the End of the Period

Total Number of Complaints Open as of June 30, 2024	**23**
Complaints open less than one year as of June 30, 2024	21
Complaints open greater than one year as of June 30, 2024	2

With regard to complaints more than one year old, the MBCE had several cases proceeding to contested case hearing, some of which are still pending at this time. The MBCE has other cases pending that will likely be contested. In several cases, the allegations and number of patients involved required an extensive review of multiple patient files. The Board has also had several cases referred to the Attorney General's Office for investigation, which, due to the complexity of the allegations, took many months to complete and some are still under investigation.

Types of Complaints Received by Biennium

Basis for complaints*	Number alleging this basis in 2022-2024	Number alleging this basis in 2020-2022	Number alleging this basis in 2018-2020
Actions in Other Jurisdiction	3	5	8
Acupuncture Violations	2	0	1
Advertising	25	5	14
Animal Chiropractic	1	4	0
Application	37	51	50
Billing	17	14	29
Chemical Dependency	1	11	13
Conviction / Crime	7	9	2
Exploiting Patient for Financial Gain	11	1	6
Fee Splitting	2	0	2
Impairment Mental / Physical / Chemical	42	8	11
Independent Examiner Registration	0	0	2
Malpractice	1	1	1
Miscellaneous / Other	27	9	5
Petitions	0	5	7
Practicing Without a License	5	4	13
Professional Firms Violation	3	0	2
Recordkeeping - False / Inadequate / etc.	51	12	17
Unprofessional Conduct (UC)	121	79	76
Violation of a Board Order	7	3	11

**Some complaints may allege more than one basis.*

Due to the number and variation in types of unprofessional conduct, these complaints are further broken down in the table below.

Breakdown of Unprofessional Conduct (UC) complaints*	Number alleging this basis in 2022-2024	Number alleging this basis in 2020-2022	Number alleging this basis in 2018-2020
Advertising No-Out-Of-Pocket Expenses	2	4	11
Dishonest / Threatening / Misleading Fee	14	3	2
Fraud	5	5	6
Gross Ignorance / Incompetence	27	32	15
Sexual Misconduct	26	21	25
Unconscionable Fees / Services Not Rendered	9	2	3
Unethical, Deceptive	35	8	8
Unnecessary Services	3	4	6
Total	121	79	76

**Some complaints may allege more than one basis.*

RECEIPTS, DISBURSEMENTS & MAJOR FEES – MINN/ STAT §214/07, 1B(4)

Total Receipts and Disbursements by Biennium

Biennium	Total Receipts	Total Disbursements
July 1, 2022 – June 30, 2024	$1,633,549.75	$1,780,602.46
July 1, 2020 – June 30, 2022	$1,630,207.75	$1,159,051.80
July 1, 2018 – June 30, 2020	$1,633,229.14	$859,640.79
July 1, 2016 – June 30, 2018	$1,608,683.52	$1,528,267.16
July 1, 2014 – June 30, 2016	*$1,600,291.48	$1,349,570.89
July 1, 2012 – June 30, 2014	*$1,760,987.96	$1,312,419.76

**Does not include 10% e-licensing surcharge collected from licensees but paid to MN.IT or fees for credit card transactions collected in part from licensees but paid to US Bank.*

Fees by Type

Type of Fee	Fee
Acupuncture Initial Application	$100
Acupuncture Renewal – Active	$50
Acupuncture Renewal – Inactive	$25
Acupuncture Reinstatement – Active	$100
Acupuncture Reinstatement – Inactive	$50
Animal Chiropractic Initial Application	$125
Animal Chiropractic Renewal – Active	$75
Animal Chiropractic Renewal – Inactive	$25
Civil Penalty	Up to $10,000 per violation
Criminal Background Check	$33.25
Copies	$0.25 per page
Continuing Education Annual Sponsorship	$500
Continuing Education Audit Penalty	Up to $900 per failure
Continuing Education Individual Sponsorship	$100
Doctor of Chiropractic Initial Application	$250
Doctor of Chiropractic Renewal – Active	$200
Doctor of Chiropractic Renewal – Inactive	$150
Doctor of Chiropractic Renewal – Late Penalty	$150 per month up to $900
Doctor of Chiropractic Reinstatement – Inactive	$100
Doctor of Chiropractic Reinstatement – Voluntarily Retired	$100
Doctor of Chiropractic Reinstatement – Prior Year Renewal	$200 per year
Doctor of Chiropractic Reinstatement – Prior Year Penalty	$150 per month up to $900
Duplicate License	$10
Graduate Preceptor Initial Application	$100
Independent Examiner Initial Application	$150
Independent Examiner Renewal	$100
Labels (partial or complete)	$15 or $150
License Verification	$10
Lists (partial or complete)	$10 or $100
NSF Service Charge	$25
Professional Firm Initial Application	$100
Professional Firm Renewal	$25
Professional Firm Renewal – Late Penalty	$5 per month
Professional Firm Reinstatement – Prior Year Penalty	$5 per month

BOARD OF DENTISTRY

The mission of the Minnesota Board of Dentistry is to promote and protect public health and safety; and ensure that every licensed dental professional practicing in the state meets the requirements for safe, competent and ethical practice.

Report of the Executive Director

July 1, 2022 – June 30, 2024

We are proud to announce more "firsts" for the Minnesota Board of Dentistry. We have worked with legislators to have the Dentist and Dental Hygienist Compact enacted in Minnesota, making us one the first states to enact the compact and allow us to have an active role in the development of the DDH Compact Commission. The compact increases collaboration between states, increases access to more providers while preserving qualifications and standards, reduces administrative duplicity, retains state jurisdiction while expanding cooperation on investigations, and enhances public safety with shared data systems. The goal is to begin issuing compact privileges in early 2026.

We also completed a rulemaking project that includes provisions on the administration of local anesthesia by licensed dental assistants that obtain additional training and certification. We are the first state in the nation to develop the training criteria, testing, and certification process for dental assistants that choose to pursue this new delegated duty in practice.

We continue to improve our license by credential pathways for dentists, dental hygienists, and dental assistants by incorporating a holistic approach to evaluation of competency that includes work experience, education, and third-party testing methods. We have also established a pathway for license by credential for dental therapists, as more states have enacted dental therapy legislation.

We have worked on several rule and legislative changes that align with our mission without creating unnecessary barriers to access to dental care in Minnesota. We have completed a rulemaking project that clarifies and promotes safety in our sedation and anesthesia requirements, including continuing education requirements for anesthesia certificate holders and pediatric anesthesia training and facility requirements. We have also made additions and clarifications regarding duties allowed for dental assistants and unlicensed dental assistants.

Last biennium, we implemented changes to a limited radiology registration for interested individuals that want to perform this duty in practice. This was met with enthusiasm in the dental community and has gained further traction this biennium. This position in a dental practice can add to clinical efficiency and provide expansion of access to care for patients, while maintaining a balanced level of safety and competency. We now have 172 limited radiology registrants (see historical data in table) and more candidates that continue to enroll in training. In addition, we have evaluated and approved additional training courses for dental radiology.

We are still working on implementation of a new database to manage applications, licensure, professional development, complaints, and discipline. We will be using a new system that can be supported on the local level by a specialized MNIT team. This will allow for a closer relationship with our IT team and better support for staff and other system users.

We have a robust social media presence to engage stakeholders with board activities and policy

considerations. We send routine newsletters to our subscriber list, which includes over 20,000 subscribers. We monitor all engagement with the board including phone stats, website, social media, and Gov Delivery campaigns. We truly believe that a well-informed licensee and stakeholder population allows for increased understanding and overall compliance, thus increasing patient health and safety.

We continue to challenge ourselves with evaluating process improvements to aid in the efficiency of our service delivery and continue to seek ways to improve internal controls. We continue to seek cost savings, when possible, to further perform our fiduciary duties in a responsible manner.

In the Service of Health,

Bridgett Anderson LDA, MBA
Executive Director
Minnesota Board of Dentistry
612-548-2127
bridgett.anderson@state.mn.us

GENERAL INFORMATION – MINN. STAT. §214.07, SUBD. 1B(5)

Board Members Serving During the Period 7/1/2022 – 6/30/2024

Name	Location	Appointment Status	Appointment Date	Reappointment Date	Term Expiration Date
Ruth Dahl	Northfield	Public Member	July 2017	2020	June 2024
Hassan Ismail	Medina	Dentist	July 2018	2022	June 2026
Heidi Donnelly	Crosby	Dental Assistant	July 2018	2022	January 2026
P. (Angela) Rake	Elko	Dentist	January 2018	2021	January 2025
Terry Klampe	Rochester	Dentist	June 2019	NA	June 2023
Frederick Nolting	Rochester	Dentist	March 2023	NA	January 2027
Ashley Johnson	Brooklyn Park	Dentist	June 2020	June 2024	June 2028
Rainer Adarve	Rosemount	Dentist	June 2019	NA	June 2023
Peter Cannon	Stillwater	Dentist	March 2023	NA	January 2027
Connie Bye	Hugo	Public Member	June 2020	NA	June 2024
Linda Gustafson	Minnetonka	Public Member	June 2023	NA	January 2027
Trina Courtright	Isanti	Dental Hygienist	May 2022	NA	June 2024
Samuel Ankrah	Woodbury	Public Member	January 2024	NA	January 2028

Board Staff and Office Location

1 Executive Director
1 Office Manager
3 Administrative Assistants
1 Assistant Director, Practitioner Review
1 Legal Analyst
2 Investigators
1 Complaint Analyst, Practitioner Review
1 Assistant Director, Licensing and Credentialing
1 Licensing Analyst

Minnesota Board of Dentistry
Randolph Square Building
335 Randolph Avenue, Suite 250
St. Paul, MN 55102
Phone: 612-617-2250
FAX: 651-797-1373
Email: dental.board@state.mn.us
Website: http://mn.gov/boards/dentistry

CREDENTIALS ISSUED OR RENEWED – MINN. STAT. §214.07, SUBD. 1B(1)

Total number of persons licensed or registered as of June 30, 2024: 18,346

Number and Type of Credentials Issued or Renewed

License Type	Licensed or registered as of June 30, 2024	Licensed or registered as of June 30, 2022	Licensed or registered as of June 30, 2020	Licensed or registered as of June 30, 2018	Licensed or registered as of June 30, 2016	Licensed or registered as of June 30, 2014
Dentists	4,041	4,033	4,078	4,093	4,038	4,033
Hygienists	5,834	5,748	5,770	5,756	5,668	5,542
Dental Assistants	7,614	7,369	7,374	7,323	7,331	7,176
Specialty Dentists	157	124	109	99	79	46
Dental Therapists	149	130	113	89	63	39
Guest Dentists	10	13	15	21	26	50
Guest Dental Assistants	1	2	2	5	2	4
Guest Dental Hygienists	1	1	1	2	3	5
Resident Dentists	49	49	63	67	73	100
Resident Provider Dental Therapist	18	10	1	5	0	NA
Resident Provider Dental Hygienist	3	1	1	NA	NA	NA
Full Faculty Dentists	19	20	24	20	24	22
Limited Faculty Dentists	12	9	9	5	6	22
Limited Assistants	172	9	5	4	4	4
Limited General Dentist	4	2	2	4	2	5
Limited Radiology (Registrations)	172	4	NA	NA	NA	NA
Dental Lab (Registrations)	90	112	127	126	149	NA
Total	**18,346**	**17,636**	**17,694**	**17,624**	**17,468**	**17,048**

Historical Renewal Data by Biennium

July 1, 2022 – June 30, 2024

Type of License/Credential	Number of New Licenses	Number of Renewed Licenses	Number and Percent Renewed Online*
Dentists	293	3,550	3,525 (99%)
Hygienists	333	5,271	5,222 (99%)
Dental Assistants	519	6,650	6,566 (99%)
Specialty Dentists	27	114	NA
Dental Therapists	17	117	117 (100%)
Resident Dentists	22	25	NA
Full Faculty Dentists	4	16	NA
Limited Faculty Dentists	1	21	NA
Limited Assistants	116	19	NA
Limited General Dentist	4	4	3 (75%)
Limited Radiology (Registrations)	168	4	4 (100%)
Dental Lab (Registrations)	8	82	81 (99%)
TOTAL	1,344	15,869	15,514 (98%)

July 1, 2020 – June 30, 2022

Type of License/Credential	Number of New Licenses	Number of Renewed Licenses	Number and Percent Renewed Online*
Dentists	328	3,589	NA
Hygienists	419	5,218	NA
Dental Assistants	465	6,740	NA
Specialty Dentists	24	95	NA
Dental Therapists	35	98	NA
Resident Dentists	23	1	NA
Full Faculty Dentists	4	15	NA
Limited Faculty Dentists	2	7	NA
Limited Assistants	4	2	NA
Limited General Dentist	2	0	NA
Limited Radiology (Registrations)	4	0	NA
Dental Lab (Registrations)	16	109	NA
TOTAL	1,322	15,874	99%*

* Out of every renewal, very few renewed via paper (1%)

July 1, 2018 – June 30, 2020

Type of License/Credential	Number of New Licenses	Number of Renewed Licenses	Number and Percent Renewed Online*
Dentists	258	3,495	NA
Hygienists	300	5,106	NA
Dental Assistants	422	6,550	NA
Specialty Dentists	20	76	NA
Dental Therapists	15	61	NA
Resident Dentists	25	38	NA
Full Faculty Dentists	9	14	NA
Limited Faculty Dentists	4	8	NA
Limited Assistants	2	3	NA
Limited General Dentist	0	2	NA
Dental Lab (Registrations)	19	104	NA
TOTAL	1,074	15,457	98%*

* Out of every renewal, only 365 licensees renewed by paper in this reporting period (2%).

July 1, 2016 – June 30, 2018

Type of License/Credential	Number of New Licenses	Number of Renewed Licenses	Number and Percent Renewed Online*
Dentists	287	4,093	3,888 (95%)
Hygienists	389	5,217	5,008 (96%)
Dental Assistants	403	6,720	6,250 (93%)
Specialty Dentists	24	99	NA
Dental Therapists	21	91	85 (94%)
Guest Dentists	5	21	NA
Guest Dental Assistants	0	5	NA
Guest Dental Hygienists	0	2	NA
Resident Dentists	20	67	NA
Resident Provider Dental Therapist	5	5	NA
Full Faculty Dentists	2	20	NA
Limited Faculty Dentists	0	5	NA
Limited Assistants	0	4	NA
Limited General Dentist	0	4	NA
Dental Lab (Registrations)	0	126	126 (100%)
TOTAL	1,156	16,479	16,121 (98%)

July 1, 2014 – June 30, 2016

Type of License/Credential	Number of New Licenses	Number of Renewed Licenses	Number and Percent Renewed Online*
Dentists	270	3,703	3,258 (88%)
Hygienists	406	5,188	4,664 (90%)
Dental Assistants	548	6,750	5,825 (86%)
Specialty Dentists	28	48	NA
Dental Therapists	23	37	34 (92%)
Guest Dentists	9	45	NA
Guest Dental Assistants	3	3	NA
Guest Dental Hygienists	1	5	NA
Resident Dentists	59	43	NA
Resident Provider Dental Therapist	NA	NA	NA
Full Faculty Dentists	7	18	NA
Limited Faculty Dentists	3	11	NA
Limited Assistants	0	4	NA
Limited General Dentist	2	1	NA
Dental Lab (Registrations)	NA	NA	NA
TOTAL	1,362	15,856	14,128 (89%)

July 1, 2012 – June 30, 2014

Type of License/Credential	Number of New Licenses	Number of Renewed Licenses	Number and Percent Renewed Online*
Dentists	298	3,735	3,147 (84%)
Hygienists	453	5,089	4,506 (86%)
Dental Assistants	555	6,621	5,523 (83%)
Specialty Dentists	7	39	NA
Dental Therapists	25	14	0
Guest Dentists	8	42	NA
Guest Dental Assistants	3	1	NA
Guest Dental Hygienists	2	3	NA
Resident Dentists	66	34	NA
Resident Provider Dental Therapist	NA	NA	NA
Full Faculty Dentists	6	16	NA
Limited Faculty Dentists	9	13	NA
Limited Assistants	0	4	NA
Limited General Dentist	2	3	NA
Dental Lab (Registrations)	NA	NA	NA
TOTAL	1,434	15,614	13,176 (84%)

COMPLAINT ACTIVITY – MINN. STAT. ß214.07, SUBDS. 1B(2), (3)

Complaints Received and Closed by Biennium

Biennium	Total Number of Complaints Received	Total Number of Complaints Closed
July 1, 2022 – June 30, 2024	448	405*
July 1, 2020 – June 30, 2022	392	415
July 1, 2018 – June 30, 2020	534	486
July 1, 2016 – June 30, 2018	362	318
July 1, 2014 – June 30, 2016	515	382
July 1, 2012 – June 30, 2014	517	524

* This number includes corrective actions and unconditional license actions taken during the period that "close" the open complaint matter.

Number of and Age of Complaints Open at the End of the Period

Number of Complaints Open as of June 30, 2024	**63**
Complaints open less than one year as of June 30, 2024	54
Complaints open greater than one year as of June 30, 2024	9

Types of Complaints Received by Biennium

Basis for complaints	Number alleging this basis in 2022-2024	Number alleging this basis in 2020-2022	Number alleging this basis in 2018-2020
Action by another jurisdiction	2	0	0
Incompetency/unethical conduct (substandard care)	237	189	226
Unprofessional Conduct	127	103	109
Illness	2		0
Non-jurisdictional	NA	NA	NA
Medical Records	NA	NA	NA
Substance Use Disorder	5	5	Combined with prescribing
Prescribing	12	19	30
Sexual Misconduct	2	2	5
Other/Miscellaneous	61	74	164
TOTAL	448	392	534

RECEIPTS, DISBURSEMENTS & MAJOR FEES – MINN. STAT §214.07, 1B(4)

Total Receipts and Disbursements by Biennium

Biennium	Total Receipts	Total Disbursements
July 1, 2022 – June 30, 2024	$3,931,627	$3,576,721
July 1, 2020 – June 30, 2022	$3,875,461	$3,219,488
July 1, 2018 – June 30, 2020	$3,872,863	$3,554,177
July 1, 2016 – June 30, 2018	$3,954,747	$3,082,545
July 1, 2014 – June 30, 2016	$3,456,577	$3,188,210
July 1, 2012 – June 30, 2014	$3,112,539	$3,144,060

Fees by Type

Application Fees - Initial	Current Fee	Criminal Background Check Fee	Initial License Fee	Total
Dentist	$140	$33.25	$168.00	$341.25
Dental Therapist	$100	$33.25	$120.00	$253.25
Dental Hygienist	$55	$33.25	$60.00	$148.55
Licensed Dental Assistant	$55	$33.25	$36.00	$124.25
Limited Dental Assistant	$15	$33.25	$12.00	$60.25
Full Faculty	$140	$33.25	$168.00	$341.25
Limited Faculty	$140	$33.25	NA	$173.25
Resident Dentist	$55	$33.25	NA	$88.25
Limited General Dentist	$140	$33.25	$155.00	$328.25
Resident Provider Dental Therapist	$55	$33.25	NA	$88.25
Resident Provider Dental Hygienist	$55	$33.25	NA	$88.25
Guest Dentist/ Hygienist/Assistant	$50	$33.25	NA	$83.25

Licensure by Credential Fees	Current Fee	Criminal Background Check Fee	Initial License Fee	Total
Dentist	$725	$33.25	$168.00	$926.25
Specialist	$725	$33.25	$168.00	$926.25
Hygienist	$175	$33.25	$60.00	$268.25

Reinstatement Fees	Current Fee	Criminal Background Check Fee	Biennial Renewal Fee	Total
Dentist	$140	$33.25	$425	$598.25
Dental Therapist	$85	$33.25	$200	$318.25
Dental Hygienist	$55	$33.25	$150	$238.25
Licensed Dental Assistant	$35	$33.25	$110	$178.25

Renewal Fees-Biennial	Current Fee	Late Fee = 25% of Renewal Fee	Total
Dentist	$425	$106.25	$531.25
Dental Therapist	$200	$50.00	$250.00
Hygienist	$150	$37.50	$187.50
Dental Assistant	$110	$27.50	$137.50
Limited Dental Assistant	$24	$6.00	$30.00
Full Faculty	$425	$106.25	$531.25

Renewal Fees-Annual	Current Fee	Late Fee = 50% of Renewal Fee	Total
Limited Faculty	$168	$84.00	$252.00
Resident Dentist	$75	$37.50	$112.50
Limited General Dentist	$155	$77.50	$232.50
Resident Provider Dental Therapist	$75	$37.50	$112.50
Resident Provider Dental Hygienist	$75	$37.50	$112.50
Guest Dentist/ Hygienist/Assistant	$50	$25.00	$75.00

Certification Fees – Initial Application	Current Fee	Total
General anesthesia (GA)	$325	$325
Conscious sedation (CS)	$325	$325
Contracted sedation (CSS)	$325	$325
Advanced Dental Therapy	$100	$100

Certification Fees – Biennial Renewal	Current Fee	Late Fee = 50% of Renewal Fee	Total
General anesthesia (GA)	$325	$162.50	$487.50
Conscious sedation (CS)	$325	$162.50	$487.50
Contracted sedation (CSS)	$325	$162.50	$487.50

Corporation Fees	Current Fee	Late Fee	Total
Initial	$100	NA	$100
Renewal (Annual)	$25	$15	$40

Dental Lab Fees	Current Fee	Total
Initial	$50	$50
Renewal (Biennial)	$50	$50

Miscellaneous Fees	Current Fee
Duplicate License	$35
Duplicate Certificate	$10
License Verification (fee for paper verification, no fee for on-line verification) – **NOT for State Board Verifications, see Affidavits**	$5
NSF Fee	$20

BOARD OF DIETETICS AND NUTRITION PRACTICE

The mission of the Minnesota Board of Dietetics and Nutrition Practice is to promote public interest in receiving quality dietetic and nutrition services from competent licensed dietitians and nutritionists; protect the public by ensuring that all licensed dietitians and nutritionists meet the educational and practical requirements specified in law; and protect the public by setting standards for quality dietetic and nutrition services.

Report of the Executive Director

July 1, 2022 – June 30, 2024

Currently there are 2,477 licensed Dietitians and Nutritionists in Minnesota, an increase of 22 percent in just the past two years. We had 770 applicants in this biennium compared to 530 in the previous one, a 45 percent increase. We expect this trend to continue with the increased growth for services in dietitian and nutritionist demands across the State of Minnesota, especially in long-term care facilities, hospitals, schools and food service programs, and telehealth.

Although the number of licensees has increased significantly, complaints have not seen the same trend, pointing to an effective Complaint Review Process and educational component to licensure.

We are committed to the advancement of offering more and improved online services to licensees. In Fiscal Year 2024, we offered online license verifications with 100 percent completed online. Technological improvements continue to allow us to accommodate the increased workload with minimal staffing.

Board members continue to support policies that result in high quality, customer focused, efficient, and cost-effective services. They are to be commended for their exceptional dedication and time commitment required to serve on the Board. They are strongly committed to providing efficient and timely access to public data, license renewals and verifications. The Board continues to make its website increasingly interactive.

Ruth Grendahl
Executive Director
Board of Dietetics and Nutrition Practice
651-201-2764
ruth.grendahl@state.mn.us

GENERAL INFORMATION – MINN. STAT. §214.07, SUBD. 1B(5)

Board Members Serving During the Period 7/1/2022 – 6/30/2024

Name	Location	Appointment Status	Appointment Date	Reappointment Date	Term Expiration Date
Donna Gjesvold, Chair	St. Michael	Dietitian	11/19/2019	8/26/2024	8/1/2027
Marge Humbert	Champlin	Dietitian	2/8/2022	8/26/2024	8/1/2028
Marcie Vaske	Victoria	Nutritionist	8/1/2018	12/1/2022	8/1/2026
Corey Schuler	Cottage Grove	Nutritionist	4/5/2022	NA	8/1/2025
Samuel Ankrah	Woodbury	Public Member	11/19/2019	NA	8/25/2024
Christine Rice	Woodbury	Public Member	8/26/2024	NA	8/1/2027
Susan Landwehr Marshall	St. Louis Park	Public Member	12/21/2022	NA	8/1/2026
Sue Estes	Minneapolis	Public Member	2/8/2022	NA	8/1/2025

Board staff and office location

1 Executive Director

Minnesota Board of Dietetics and Nutrition Practice
Randolph Square Building
335 Randolph Avenue, Suite 210
St. Paul, MN 55102
Phone: 651-201-2764
Email: board.dietetics-nutrition@state.mn.us
Website: https://mn.gov/boards/dietetics-and-nutrition/

CREDENTIALS ISSUED OR RENEWED – MINN. STAT. §214.07, SUBD. 1B(1)

Total Number of persons licensed as of June 30, 2024: 2,477

Number and Type of Credentials Issued or Renewed

License Type	Licensed or registered as of June 30, 2024	Licensed or registered as of June 30, 2022	Licensed or registered as of June 30, 2020	Licensed or registered as of June 30, 2018	Licensed or registered as of June 30, 2016	Licensed or registered as of June 30, 2014
Dietitians	2,404	2,066	1,958	1,841	1,752	1,493
Nutritionists	73	64	73	69	65	71
TOTAL	**2,477**	**2,130**	**2,031**	**1,910**	**1,817**	**1,564**

Historical Renewal Data by Biennium

July 1, 2022 – June 30, 2024

Type of License/Credential	Number of New Licenses	Number of Renewed Licenses	Number and Percent Renewed Online
Dietitians	561	4,767	4,767 (100%)
Nutritionists	13	142	142 (100%)
TOTAL	574	4,909	4,909 (100%)

July 1, 2020 – June 30, 2022

Type of License/Credential	Number of New Licenses	Number of Renewed Licenses	Number and Percent Renewed Online
Dietitians	402	4,169	4,169 (100%)
Nutritionists	5	136	136 (100%)
TOTAL	407	4,305	4,305 (100%)

July 1, 2018 – June 30, 2020

Type of License/Credential	Number of New Licenses	Number of Renewed Licenses	Number and Percent Renewed Online
Dietitians	351		
Nutritionists	13		
TOTAL	364	3,642	3,606 (99%)

July 1, 2016 – June 30, 2018

Type of License/Credential	Number of New Licenses	Number of Renewed Licenses	Number and Percent Renewed Online
Dietitians	294	3,687	3,339 (90%
Nutritionists	8	134	115 (86%)
TOTAL	302	3,821	3,454 (90%)

July 1, 2014 – June 30, 2016

Type of License/Credential	Number of New Licenses	Number of Renewed Licenses	Number and Percent Renewed Online
Dietitians/Nutritionists	319	3246	2,792 (78%)

July 1, 2012 – June 30, 2014

Type of License/Credential	Number of New Licenses	Number of Renewed Licenses	Number and Percent Renewed Online
Dietitians/Nutritionists	151	2985	2116 (71%)

COMPLAINT ACTIVITY – MINN. STAT. §214.07, SUBDS. 1B(2), (3)

Complaints Received and Closed by Biennium

Biennium	Total Number of Complaints Received	Total Number of Complaints Closed
July 1, 2022-June 30, 2024	8	6
July 1, 2020-June 30, 2022	6	6
July 1, 2018-June 30, 2020	12	11
July 1, 2016-June 30, 2018	10	11
July 1, 2014-June 30, 2016	9	8
July 1, 2012-June 30, 2014	6	6
July 1, 2010-June 30, 2012	12	11

Number of and Age of Complaints Open at the End of the Period

Number of Complaints Open as of June 30, 2024	**3**
Complaints open less than one year as of June 30, 2024	3
Complaints open greater than one year as of June 30, 2024	0

RECEIPTS, DISBURSEMENTS & MAJOR FEES – MINN. STAT §214.07, 1B(4)

Total Receipts and Disbursements by Biennium

Biennium	Total Receipts	Total Disbursements
July 1, 2022 – June 30, 2024	$501,373	$340,168
July 1, 2020 – June 30, 2022	$435,083	$292,199
July 1, 2018 – June 30, 2020	$373,825	$281,785
July 1, 2016 – June 30, 2018	$351,200	$307,163
July 1, 2014 – June 30, 2016	$324,698	$246,936
July 1, 2012 – June 30, 2014	$210,872	$209,218

Fees by Type

Fee Type	Fee
Application for Nutritionist	$175
Application for Dietitian with RD	$100
Licensing Fee	$150
Reinstatement	$92.50
Renewal Fee	$75
License Verification	$20

BOARD OF EXECUTIVES FOR LONG TERM SERVICES AND SUPPORTS

The mission of the Board of Executives for Long Term Services and Supports is to promote the public's interest in quality care, effective services and supports for consumers of nursing homes and assisted living communities by ensuring that licensed executives are qualified to perform their administrative duties.

Report of the Executive Director

July 1, 2022 – June 30, 2024

This biennial period included the first license renewal of a new license class of Assisted Living Director. In the prior biennium, the Board of Executives for Long Terms Services and Supports (BELTSS) added additional licensing categories for Health Services Executive (HSE) and Assisted Living Director (ALD) to the existing Nursing Home Administrator (NHA) license category. The 2022-2024 biennium resulted in modification of process, continued system build-out, and specific refinement of education needs for the new implemented license class of ALD and HSE. The first renewals of HSE licensures occurred in FY 2022. The first renewals of ALDs were conducted in October 2022.

The Board spent much of this biennium attempting to improve oversite, educate, and enhance public and licensee facing platforms. The new licensees, who many had never not held a professional license, required frequent education on enforcement of rules. We have seen a significant increase and time commitment to compliance enforcement, expense, and disciplinary action.

Digital system build-out that allows for real-time oversite and monitoring continues into this biennium. With Odessey funds getting implemented in March 2024, it is expected that system improvements will continue even into the 2024-2026 biennium. Updates to the board's website and ALIMS licensing database are ongoing. Rulemaking was reopened in 2024 to bring standardization in language and concepts. BELTSS is hoping to have this complete by June 2025.

The Board continued to work on the remaining objectives in the 2022-2025 strategic plan. The Board also continued to work and strengthen the relationship with the National Board of Long-Term Care Administrators (NAB). This important partnership continued with active participation from two Board members and two BELTSS staff that served on various national committees, including the preparation of the national examination and the new practice analysis.

The Board continues to work collectively with NAB on national licensure standards. Minnesota is one of four states that were early implementers of educational programs to create a Health Services Executive license. The Board continues to support NAB-approved educational programs. Currently there are four Minnesota Schools with programs certified by NAB. The board is dedicated to recognizing educators and college programs in creating leaders for new models of elder care throughout the upper Midwest and nationally.

Stephen Jobe
Executive Director
Minnesota Board of Executives for Long Term Services and Supports
651-201-2730

GENERAL INFORMATION – MINN. STAT. §214.07, SUBD. 1B(5)

Board Members Serving During the Period 7/1/2022 – 6/30/2024

Name	Location	Appointment Status	Appointment Date	Reappointment Date	Term Expiration Date
Steven Chies, LNHA Secretary	Coon Rapids	• Proprietary Manager/Owners • Licensure/Education • Executive Committee	6/28/2016	1/1/2020	1/3/2028
Katie Davis, LNHA	Albert Lea	• Proprietary Managers/Owners • Board Chair • Executive Committee • Exam Committee • Standards of Practice Committee	1/1/2015	1/1/2019	1/4/2027
Frederick "Fred" Dawe	Minneapolis	• Public • Rules	2019	NA	1/7/2025
Drew Hood	Mankato	• Assisted Living Director • Exam committee • Rules Committee	2022	NA	1/5/2026
Amanda Johnson, RN	Morris	• Registered Nurse – Nursing Home • Standards of Practice Committee • Licensure Education Committee • Executive Committee	1/7/2019	NA	1/4/2027
Jonathan Lundberg	Edina	• Manager/Owner Non-Profit • Exam Committee	2022	NA	1/5/2026
Natalie Morland, RN	Chaska	• RN Assisted Living • Standards of Practice Committee	1/1/2020		1/3/2028
Jane C. Pederson, M.D., M.S.	Woodbury	• Doctor • Rules Committee, Chair	1/1/1997	1/7/2017	1/6/2025
Deb Stock	Maple Grove	• Public Member • License Education	2022	NA	1/1/2028
H. Michael Tripple	St. Paul	• Public • Standards of Practice Committee • Rules Committee • Licensure Education Committee	1/1/2015	1/1/2019	1/4/2027
Valerie Cooke	St. Paul	• Ex-officio • Rules Committee • Exam Committee	2019	NA	NA
Lindsey Krueger, RN	St. Paul	• Ex-officio • Exam Committee	2019	NA	NA
Alex Mountain, AAG	St. Paul	• Assistant Attorney General • Standards of Practice Committee • Rules Committee	NA	NA	NA

The following are appointed by the Commissioners of Health and of Human Services and serve as non-voting designees of those commissioners:

- Lindsey Krueger, MN Department of Health, 7/1/2020 to 6/30/2024
- Valerie Cooke, MN Department of Human Services, 7/1/2020 to 6/30/2024

Board Staff and Office Location

1 Executive Director
1 Director of Assisted Living and Education
2 Office and Administrative Specialist

Minnesota Board of Executives for Long Term Services and Supports
Randolph Square Building
335 Randolph Avenue, Suite 210-B
St. Paul, MN 55102
Phone: 651-201-2730
FAX: 651-797-1376
Email: beltss.hlb@state.mn.us
Website: https://mn.gov/boards/beltss/

CREDENTIALS ISSUED OR RENEWED – MINN. STAT. §214.07, SUBD. 1B(1)

Total Number of persons licensed or registered as of June 30, 2024: 3,176

Number and Type of Credentials Issued or Renewed

License Type	Licensed or registered as of June 30, 2024	Licensed or registered as of June 30, 2022	Licensed or registered as of June 30, 2020	Licensed or registered as of June 30, 2018	Licensed or registered as of June 30, 2016	Licensed or registered as of June 30, 2014
Nursing Home Administrator	804	830	925	928	894	852
Health Services Executive	106	101	Not established	Not established	Not established	Not established
Assisted Living Director	2,266	2493	Not established	Not established	Not established	Not established
TOTAL	**3,176**	**3424**	**925**	**928**	**894**	**852**

Total number of persons licensed or registered by fiscal year

Fiscal Year	NHA	HSE	ALD
2023	712	97	2093
2024	796	106	2266

Historical Renewal Data by Biennium

July 1, 2022 – June 30, 2024

Type of License	Number of New Licenses*	Number of Renewed Licenses*	Number and Percent Renewed Online
NHA	111	1,696	1,696 (100%)
HSE	10	221	221(100%)
ALD	292	4,651	4,651 (100%)
TOTAL	413	3,166	3,166 (100%)

*Does not include shared licenses or permits.

July 1, 2020 – June 30, 2022

Type of License	Number of New Licenses*	Number of Renewed Licenses*	Number and Percent Renewed Online
NHA	124	1542	1542 (100%)
HSE	110	101	101 (100%)
ALD	2493	No renewals in this biennium	NA
TOTAL	2727	1643	1643 (100%)

*Does not include shared licenses or permits.

July 1, 2018 – June 30, 2020

Type of License	Number of New Licenses	Number of Renewed Licenses	Number and Percent Renewed Online
NHA	132	1709	1640 (96%)

July 1, 2016 – June 30, 2018

Type of License	Number of New Licenses	Number of Renewed Licenses	Number and Percent Renewed Online
NHA	160	1709	1658 (97%)

July 1, 2014 – June 30, 2016

Type of License	Number of New Licenses	Number of Renewed Licenses	Number and Percent Renewed Online
NHA	130	894	822 (92%)

July 1, 2012 – June 30, 2014

Type of License	Number of New Licenses	Number of Renewed Licenses	Number and Percent Renewed Online
NHA	103	1709	1555 (91%)

COMPLAINT ACTIVITY – MINN. STAT. §214.07, SUBDS. 1B(2), (3)

Complaints Received and Closed by Biennium

Biennium	Total Number of Complaints Received	Total Number of Complaints Closed
July 1, 2022 – June 30, 2024	582	557
July 1, 2020 – June 30, 2022	248	295
July 1, 2018 – June 30, 2020	641	577
July 1, 2016 – June 30, 2018	436	406
July 1, 2014 – June 30, 2016	95	91
July 1, 2012 – June 30, 2014	96	89

Number of and Age of Complaints Open at the End of the Period

Number of Complaints Open as of June 30, 2024	**63**
Complaints open less than one year as of June 30, 2024	59
Complaints open greater than one year as of June 30, 2024	4

Types of Complaints Received by Biennium

Basis of Complaint*	Number alleging this basis in 2022-2024	Number alleging this basis in 2020-2022	Number alleging this basis in 2018-2020
Neglect of Care	14	7	48
Financial	3	2	10
Physical Abuse	0	0	22
Administration	39	5	10
Grievances	27	8	0
Verbal/Mental	1	2	10
Quality of Care (MDH Survey)	475	158	74
Resident Rights	7	0	0
HPSP	2	2	0
Practice without a License	2	0	0
Sexual Abuse	0	0	4
Background Check Issues	149	64	Not tracked

*Some complaints allege more than one basis

RECEIPTS, DISBURSEMENTS & MAJOR FEES – MINN. STAT §214.07, 1B(4)

Total Receipts and Disbursements by Biennium

Biennium	Total Receipts	Total Disbursements
July 1, 2022 – June 30, 2024	$1,699,553	$1,377,017
July 1, 2020 – June 30, 2022	$737,316	$476,319
July 1, 2018 – June 30, 2020	$478,196	$512,040
July 1, 2016 – June 30, 2018	$442,516	$401,533
July 1, 2014 – June 30, 2016	$445,515	$298,868
July 1, 2012 – June 30, 2014	$423,482	$304,405

Fees by Type

Type of Fee	Fee
NHA Application	$150
ALD Application	$200
HSE Application	$250
NHA Original License (until 4/30/24)	$225
NHA Original License (as of 5/1/24)	$250
ALD Original License	$200
HSE Original License	$250
NHA Annual Renewal	$225
ALD Annual Renewal	$200
HSE Annual Renewal	$250
State Exam NHA, ALD and HSE	$100
Acting Administrator Permit	$250
Director in Residence	$250
Assisted Living Director in Residence	$250

BOARD OF MARRIAGE AND FAMILY THERAPY

The mission of the Minnesota Board of Marriage and Family Therapy is to protect the public through effective licensure and enforcement of the statutes and rules governing the practice of marriage and family therapists to ensure a standard of competent and ethical practice.

Report of the Executive Director

July 1, 2022 – June 30, 2024

The Board of Marriage and Family Therapy's mission is to protect the public and ensure a standard of competent and ethical care through effective licensure and enforcement of the statues and rules governing the practice of marriage and family therapy.

To accomplish the Board's mission, we:

- Set standards for initial licensure, including a review of each applicant's education and training;
- Conduct an examination of each applicant's knowledge of the laws and rules governing the practice of marriage and family therapy in Minnesota prior to issuing marriage and family therapy license;
- Annually review qualifications and renew licenses of current, qualified licensees;
- Investigate complaints made against licensees and applicants, and allegations of unlicensed practice of marriage and family therapy;
- Take disciplinary or corrective action against a licensee or applicant when warranted by conduct and necessary to protect the public;
- Review and approve continuing education programs used by licensees to meet continuing education requirements for license renewal;
- Monitor and enforce continuing education requirements for license renewal;
- Maintain mandated and educational information available to the public via the Board's website;
- Work collaboratively with academic institutions and national and state marriage and family therapy professional associations to identify, discuss and address issues involving the education, licensure and practice of marriage and family therapists;
- Provide information about licensure and standards of practice to citizens and other business entities;
- Regularly collaborate with other governmental and non-governmental entities to keep Minnesotans safe.

The last biennium (FY2023 and FY2024) saw the Board continue to function smoothly in the post-COVID environment with two Board staff working in a hybrid environment and one staff regularly in the office full-time. All public Board meetings are available in-person and online to those wishing to attend. Having rebounded to near-normal levels following 2020, Licensed Marriage and Family Therapist (LMFT) and Licensed Associate Marriage and Family Therapist (LAMFT) application and licensure activity decreased in calendar year 2023 (1/1/2023-12/31/2023). It is unknown whether the decrease is a one-time occurrence or reflects a new data trend. The Board saw its largest number of LMFTs retire from practice at the end of calendar year 2023. While Minnesota continues to maintain a strong LMFT professional base to meet Minnesotans' mental health needs, the closure of the MFT Master's program at St. Cloud State University and the decision by Minnesota State University Mankato to focus on its licensed professional clinical counselor graduate program (and not its MFT graduate track), means that Minnesota does not have a graduate MFT program at a public college or university for the first time since the LMFT license's creation.

The Board continues to work on a comprehensive rule review which will include changes to address licensure portability, increased access to supervision for licensure, electronic therapy and electronic licensure supervision. The Board was successful in passing a guest license statute in the 2024 legislative session allowing for limited MFT practice in Minnesota by qualified LMFT professionals licensed in another U.S. jurisdiction. Board members continue to show great dedication to maintaining the high level of training and professionalism denoted by Minnesota MFTs. Board staff continue to provide efficient and accountable government services in support of the Board's work to keep Minnesotans safe.

Jennifer L. Mohlenhoff, Executive Director
Minnesota Board of Marriage and Family Therapy
Telephone Number: (612) 617-2220
Email address: jennifer.mohlenhoff@state.mn.us

GENERAL INFORMATION – MINN. STAT. §214.07, SUBD. 1B(5)

Board Members Serving During the Period 7/1/2022 – 6/30/2024

Name	Location	Appointment Status	Appointment Date	Reappointment Date (if applicable)	Term Expiration Date
Adam Arnold	St. Paul	LMFT	07/05/2022	NA	01/05/2026
Chilah Brown	Isle	Public Member	03/29/2023	NA	01/04/2027
Anna Clavin	St. Cloud	LMFT	06/12/2024	NA	01/03/2028
Shonda Craft	Minneapolis	Higher Education	05/16/2012	05/21/2016 05/17/2020 06/12/2024	01/03/2028
Ukasha Dakane	Minneapolis	Public Member	09/19/2018	07/02/2019	01/02/2023
Jessie Everts	White Bear Lake	LMFT	09/19/2018	07/02/2019 03/29/2023	01/04/2027
Kathryn Graves	Minneapolis	Public Member	06/16/2014	02/26/2018 07/05/2022	01/05/2026
Andrea Hendel	Albertville	LMFT	05/21/2016	05/17/2020	01/01/2024
Thad Shunkwiler	Mankato	LMFT	07/05/2022	NA	01/05/2026

Board Staff and Office Location

The Board has three (3) full time staff:
Executive Director
Office and Administrative Specialist Principle
Office and Administrative Specialist Intermediate

Minnesota Board of Marriage and Family Therapy
Randolph Square Building
335 Randolph Avenue, Suite 260
St. Paul, MN 55102
Phone: 612-617-2220
Email: mft.board@state.mn.us
Website: mn.gov/boards/marriage-and-family/

CREDENTIALS ISSUED OR RENEWED – MINN. STAT §214.07, SUBD. 1B(1)

Total Number of persons licensed or registered as of June 30, 2024: 3186

Number and Type of Credentials Issued or Renewed

License Type	Licensed or registered as of June 30, 2024	Licensed or registered as of June 30, 2022	Licensed or registered as of June 30, 2020	Licensed or registered as of June 30, 2018	Licensed or registered as of June 30, 2016	Licensed or registered as of June 30, 2014
LMFT	2951	2776	2551	2364	2054	1801
LAMFT	235	247	308	318	316	306
TOTAL	**3186**	**3023**	**2859**	**2,682**	**2370**	**2107**

Historical Renewal Data by Biennium

July 1, 2022 – June 30, 2024

Type of License	Number of New Licenses	Number of Renewed Licenses	Number and Percent Renewed Online
LMFT	297	5662	5601 (99%)
LAMFT	238	380	378 (99%)
TOTAL	535	6042	5979 (99%)

July 1, 2020 – June 30, 2022

Type of License	Number of New Licenses	Number of Renewed Licenses	Number and Percent Renewed Online
LMFT	350	5306	5224 (98%)
LAMFT	254	391	390 (100%)
TOTAL	604	5697	5614 (99%)

July 1, 2018 – June 30, 2020

Type of License	Number of New Licenses	Number of Renewed Licenses	Number and Percent Renewed Online
LMFT	314	4901	4843 (99%)
LAMFT	232	455	454 (100%)
TOTAL	546	5356	5297 (99%)

July 1, 2016 – June 30, 2018

Type of License	Number of New Licenses	Number of Renewed Licenses	Number and Percent Renewed Online
LMFT	412	4395	4275 (97%)
LAMFT	301	472	468 (99%)
TOTAL	713	4867	4743 (97%)

July 1, 2014 – June 30, 2016

Type of License	Number of New Licenses	Number of Renewed Licenses	Number and Percent Renewed Online
LMFT	350	3798	3454 (92%)
LAMFT	324	528	512 (97%)
TOTAL	674	4326	3966 (92%)

July 1, 2012 – June 30, 2014

Type of License	Number of New Licenses	Number of Renewed Licenses	Number and Percent Renewed Online
LMFT	342	3284	2857 (87%)
LAMFT	333	504	453 (90%)
TOTAL	675	3788	4463 (89%)

COMPLAINT ACTIVITY – MINN. STAT. §214.07, SUBD. 1B(2), (3)

Complaints Received and Closed by Biennium

Biennium	Total Number of Complaints Received	Total Number of Complaints Closed
July 1, 2022 – June 30, 2024	192	136
July 1, 2020 – June 30, 2022	155	91
July 1, 2018 – June 30, 2020	147	142
July 1, 2016 – June 30, 2018	145	72
July 1, 2014 – June 30, 2016	156	81
July 1, 2012 – June 30, 2014	130	89

Number of and Age of Complaints Open at the End of the Period

Number of Complaints Open as of June 30, 2024	**85**
Complaints open less than one year as of June 30, 2024	44
Complaints open greater than one year as of June 30, 2024	41

Types of Complaints received from June 30, 2022 through June 30, 2024

The general categories of complaints most commonly received include (1) lack of professional competence/unprofessional conduct; (2) violation of client confidentiality; (3) boundary violation; (4) inappropriate sexual behavior or contact; (5) unlicensed or unsupervised practice; and (6) other violation of administrative rule (such as billing impropriety, impairment, dual/multiple relationship). Many complaints contain more than one allegation of illegal, unprofessional, or unethical conduct.

RECEIPTS, DISBURSEMENTS & MAJOR FEES – MINN. STAT §214.07, 1B(4)

Total Receipts and Disbursements by Biennium

Biennium	Total Receipts	Total Disbursements
July 1, 2022 – June 30, 2024	$ 1,104,479	$ 1,021,458
July 1, 2020 – June 30, 2022	$ 883,079	$ 883,910
July 1, 2018 – June 30, 2020	$ 833,224	$ 892,697
July 1, 2016 – June 30, 2018	$ 798,429	$ 696,934
July 1, 2014 – June 30, 2016	$ 707,410	$ 662,262
July 1, 2012 – June 30, 2014	$ 652,142	$ 530,647

Fees by Type

Type of Fee	Fee
Application for National Examination	$150
Application for LMFT Licensure	$150
Initial LMFT Annual License Fee	Prorated; not to exceed $225
Annual LMFT Renewal fee	$225
Late fee for annual LMFT Renewal	$100
Application for LMFT Licensure by Reciprocity	$300
Application for LAMFT Licensure	$100
Annual LAMFT Renewal Fee	$100
Late fee for annual LAMFT Renewal	$50
Application for LMFT Emeritus License Status	$225
License Reinstatement	$150
Application for Temporary License (for Military)	$100
LMFT Guest License	$150
Continue Education – Program Sponsor Application	$60
Mailing List purchase	$60
Duplicate License Certificate	$25
Duplicate Renewal Card	$10
Written License Verification	$10
Professional Firm Initial Filing	$100
Professional Firm Annual Renewal	$25

In the 2023 legislative session, the Board was successful in obtaining a fee increase for application, licensure, and renewal fees to ensure sufficient revenues are received to cover all operational expenses.

BOARD OF MEDICAL PRACTICE

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.

Report of the Executive Director

July 1, 2022 – June 30, 2024

The Minnesota Board of Medical Practice (Board) is charged with protecting the public. The Board ensures that physicians, and the seven allied healthcare professionals under its regulation, including acupuncturists, athletic trainers, genetic counselors, naturopathic doctors, physician assistants, respiratory care therapists, and traditional midwives meet the minimum education and training requirements to obtain a credential to practice in Minnesota. The Board also receives, investigates, and resolves complaints against the healthcare providers under its regulation.

The Board hired a new Executive Director in January 2023 and has provided incredible and continuous support for this transition of new leadership. The Board's staff have settled into their new workspace (move in September 2021) and are continuing to embrace the flexibility offered of a hybrid work schedule. The Board continues to benefit from being co-located with several of the other health professionals regulatory boards along with two cooperative programs.

This biennium began with the launch of online applications for physicians and several allied professionals and has welcomed the intermittent addition of more applications throughout the two-year period. A website redesign effort was initiated, and the release of the new website is scheduled for fiscal year 2025. Minnesota was one of thirteen states to pass the model legislation in 2024 to join the Physician Assistant Licensure Compact.

Several Board members have been appointed to leadership positions through local and national organizations committed to the work of state medical boards and the nation's comprehensive healthcare environment. The Board remains committed to expanding its outreach and providing opportunities for people to learn about the work and mission of the Board.

Elizabeth A. Huntley JD, CMBE
Executive Director
Minnesota Board of Medical Practice
612-548-2168
Elizabeth.Huntley@state.mn.us
Website: https://mn.gov/boards/medical-practice/

GENERAL INFORMATION – MINN. STAT. §214.07, SUBD. 1B(5)

Board Members Serving During the Period 7/1/2022 – 6/30/2024

Name	Location	Appointment Status	Appointment Date	Reappointment Date	Term Expiration Date
Bruce Sutor, M.D.	Rochester	Physician Congressional District 1	6/22/2022	NA	1/6/2025
Chaitanya Anand, M.B., B.S.	Eagan	Physician Congressional District 2	3/3/2021	3/24/2023	1/4/2027
Cherie Zachary, M.D.	Bloomington	Physician Congressional District 3	1/5/2021	NA	1/6/2025
Cheryl L. Bailey, M.D.	St. Paul	Physician Congressional District 4	9/19/2018	1/05/2021	1/6/2025
Pamela Gigi Chawla, M.D.	Minneapolis	Physician Congressional District 5	6/29/2020	6/19/2024	1/4/2028
Sarah Carter, M.D.	St. Cloud	Physician Congressional District 6	6/19/2024	NA	1/3/2028
Kimberly W. Spaulding, M.D. (inactive)	South Haven	Physician Congressional District 6	6/6/2016	6/29/2020	1/1/2024
Cybill E. Oragwu, M.D. (inactive)	Sauk Center	Physician Congressional District 7	12/13/2022	NA	1/6/2025
Peter J. Henry, M.D.	Baxter	Physician Congressional District 8	6/22/2022	NA	1/5/2026
Jane Willett, D.O.	Spicer	Doctor of Osteopathy	3/14/2023	NA	1/4/2027
Jennifer Y. Kendall Thomas, D.O. (inactive)	Blaine	Doctor of Osteopathy	6/29/2020	NA	1/4/2023
Kristina M. Krohn, M.D.	Roseville	Physician Member at Large	6/22/2022	NA	1/5/2026
Tenbit Emiru, M.D.	Plymouth	Physician Member at Large	3/3/2021	NA	1/6/2025
Averi M. Turner	Minneapolis	Public Member 1	6/22/2022	NA	1/5/2026
Bruce Anderson	St. Cloud	Public Member 2	3/14/2023	NA	1/4/2027
Allen Rasmussen, J.D.	International Falls	Public Member 3	6/19/2024	NA	1/3/2028
John M. Manahan, J.D.	Bloomington	Public Member 4	9/19/2018	6/22/2022	1/5/2026
Karen Thullner, M.F.A.	Vadnais Heights	Public Member 5	6/22/2022	NA	1/5/2026
Stephanie Bumgardner, M.S.W. (inactive)	LaPorte	Public Member	7/5/2022	NA	1/1/2024
Shaunequa B. James, M.S.W. (inactive)	Ramsey	Public Member	6/29/2020	NA	1/2/2023

Board Staff and Office Location

Administration:

1 Executive Director
1 Deputy Director
1 Executive Assistant
1 Office and Administration Manager
1 Office Operations Specialist

Licensing:

1 Licensing Unit Manager
1 Licensing Coordinator
1 Licensing Case Manager
4 Licensing Specialists

Complaint Review:

1 Complaint Review Unit Manager
1 Legal Analyst
2 Senior Medical Regulation Analysts
5 Medical Regulation Analysts
2 Complaint Review Unit Assistants

MN.IT:

1 Database Administrator

Minnesota Board of Medical Practice
Randolph Square Building
335 Randolph Avenue, Suite 140
St. Paul, MN 55102
Phone: 612-617-2130
FAX: 612-617-2166
Email: medical.board@state.mn.us
Website: https://mn.gov/boards/medical-practice/

CREDENTIALS ISSUED OR RENEWED – MINN. STAT. §214.07, SUBD 1B(1)

Total Number of persons licensed or registered as of June 30, 2024: 40,709

Number and Type of Credentials Issued or Renewed

License Type	Licensed or registered as of June 30, 2024	Licensed or registered as of June 30, 2022	Licensed or registered as of June 30, 2020	Licensed or registered as of June 30, 2018	Licensed or registered as of June 30, 2016	Licensed or registered as of June 30, 2014
Acupuncturist	658	661	652	615	595	490
Athletic Trainer	1,343	1,341	1,271	1,181	992	884
Genetic Counselor	544	480	351	180	NA	NA
Traditional Midwife	58	55	50	42	32	28
Naturopathic Doctor	109	98	88	78	58	50
Physician Assistant	4,552	3,932	3,515	1,972	2,522	2,230
Physician	28,958	26,937	25,532	24,080	22,593	21,993
Respiratory Therapist	2,309	2,227	2,176	2,084	1,976	1,941
Telemedicine	826	812	727	711	653	639
Residency Permit	1,352	1,977	1,837	1,503	944	661
TOTAL	**40,709**	**38,520**	**36,199**	**32,446**	**30,365**	**28,916**

Historical Renewal Data by Biennium

July 1, 2022 – June 30, 2024

Type of License/Credential	Number of New Licenses	Number of Renewed Licenses	Number and Percent Renewed Online
Acupuncturist	70	1,253	1,245 (99.4%)
Athletic Trainer	205	2,391	2,391 (100%)
Genetic Counselor	139	937	937 (100%)
Traditional Midwife	14	100	100 (100%)
Naturopathic Doctor	23	194	192 (99.0%)
Physician Assistant	878	8,088	8,805 (99.9%)
Physician	5,730	51,813	51,296 (99.0%)
Respiratory Therapist	440	4,209	4,202 (99.8%)
Telemedicine	232	1,424	1,402 (99.7%)
Residency Permit	1,741	NA	NA
TOTAL	9,747	70,490	69,868 (99.2%)

July 1, 2020 – June 30, 2022

Type of License/Credential	Number of New Licenses	Number of Renewed Licenses	Number and Percent Renewed Online
Acupuncturist	68	1,121	1,114 (99.4%)
Athletic Trainer	266	2,391	2,387 (99.8%)
Genetic Counselor	167	739	736 (99.6%)
Traditional Midwife	12	88	87 (98.9%)
Naturopathic Doctor	13	173	172 (99.4%)
Physician Assistant	708	6,106	6,095 (99.8%)
Physician	4,332	47,550	47,301 (99.5%)
Respiratory Therapist	382	3,677	3,658 (99.5%)
Telemedicine	278	1,404	1,401 (99.8%)
Residency Permit	1,697	N/A	N/A
TOTAL	7,923	63,249	62,951 (99.5%)

July 1, 2018 – June 30, 2020

Type of License/Credential	Number of New Licenses	Number of Renewed Licenses	Number and Percent Renewed Online
Acupuncturist	88	1,183	1,170 (98.90%)
Athletic Trainer	242	2,222	2,216 (99.73%)
Genetic Counselor	181	470	464 (98.72%)
Traditional Midwife	14	84	84 (100%)
Naturopathic Doctor	19	158	160 (98.75%)
Physician Assistant	697	6,264	6,252 (99.83%)
Physician	3,760	46,432	46,083 (99.25%)
Respiratory Therapist	279	3,986	3,964 (99.45%)
Telemedicine	189	1,260	1,252 (99.36%)
Residency Permit	1,729	N/A	N/A
TOTAL	7,198	62,059	61,645 (99.33%)

July 1, 2016 – June 30, 2018

Type of License/Credential	Number of New Licenses	Number of Renewed Licenses	Number and Percent Renewed Online
Acupuncturist	61	1,168	1,150 (98.5%)
Athletic Trainer	320	2,026	2.020 (99.7%)
Genetic Counselor	180	51	N/A
Traditional Midwife	16	76	76 (100%)
Naturopathic Doctor	25	118	118 (100%)
Physician Assistant	626	5,336	5,317 (99.64%)
Physician	3,528	44,673	44,151 (98.8%)
Respiratory Therapist	298	3,854	3,811 (98.9%)
Telemedicine	221		
Residency Permit	1,571	N/A	N/A
TOTAL	6,839	58,518	57,857 (98.9%)

July 1, 2014 – June 30, 2016

Type of License/Credential	Number of New Licenses	Number of Renewed Licenses	Number and Percent Renewed Online
Acupuncturist	95	1,058	1,020 (96%)
Athletic Trainer	245	1,706	1,670 (98%)
Traditional Midwife	13	42	42 (100%)
Naturopathic Doctor	13	102	101 (99%)
Physician Assistant	566	4,444	4,411 99%)
Physician	2,787	42,410	41,428 (98%)
Respiratory Therapist	1,429	3,640	3,568 (98%)
Telemedicine	221	1,083	1,078 (100%)
Residency Permit	1,429	N/A	N/A
TOTAL	6,798	54,485	53,318 (98%)

July 1, 2012 – June 30, 2014

Type of License/Credential	Number of New Licenses	Number of Renewed Licenses	Number and Percent Renewed Online
Acupuncturist	102	1,075	896 (83%)
Athletic Trainer	216	1,730	1,400 (81%)
Traditional Midwife	11	55	35 (64%)
Naturopathic Doctor	19	92	39 (42%)
Physician Assistant	465	4,293	3,755 (87%)
Physician	2,849	43,336	40,481 (93%)
Respiratory Therapist	258	3,816	3,430 (90%)
Telemedicine	274	1,184	855 (72%)
Residency Permit	1,533	N/A	N/A
TOTAL	5,727	55,581	50,891 (92%)

COMPLAINT ACTIVITY – MINN. STAT. §214.07, SUBD. 1B(2), (3)

Complaints Received and Closed by Biennium

Biennium	Total Number of Complaints Received	Total Number of Complaints Closed
July 1, 2022 – June 30, 2024	2,188	1,973
July 1, 2020 – June 30, 2022	1,771	1,684
July 1, 2018 – June 30, 2020	1,835	1,731
July 1, 2016 – June 30, 2018	1,930	1,726
July 1, 2014 – June 30, 2016	1,562	1,872
July 1, 2012 – June 30, 2014	1,514	1,718

Number of and Age of Complaints Open at the End of the Period

Number of Complaints Open as of June 30, 2024	**1,053**
Complaints open less than one year as of June 30, 2024	750
Complaints open greater than one year as of June 30, 2024	303

Types of Complaints Received by Biennium

Basis of complaints*	Number alleging this basis in 2022-2024	Number alleging this basis in 2020-2022	Number alleging this basis in 2018-2020
Actions by another jurisdiction	486	302	207
Incompetency / unethical conduct	1,447	1,211	1,119
Unprofessional conduct	1,277	1,061	1,049
Illness	140	137	73
Non-jurisdictional	136	75	88
Medical records management	228	232	218
Becoming addicted or habituated	104	160	94
Prescribing	617	479	386
Sexual misconduct	49	42	64
Other	431	526	454

*Some complaints allege more than one basis.

RECEIPTS, DISBURSEMENTS & MAJOR FEES – MINN. STAT §214.07, 1B(4)

Total Receipts and Disbursements by Biennium

Biennium	Total Receipts	Total Disbursements
July 1, 2022 – June 30, 2024	$15,403,943	$11,251,691
July 1, 2020 – June 30, 2022	$13,669,779	$10,640,999
July 1, 2018 – June 30, 2020	$13,084,970	$8,425,468
July 1, 2016 – June 30, 2018	$18,057,981	$11,719,220
July 1, 2014 – June 30, 2016	$11,445,514	$7,962,117
July 1, 2012 – June 30, 2014	$10,847,180	$7,796,647

Fees by Type

Type of fee	Fee
Acupuncture Application	150.00
Acupuncture Annual Renewal	150.00
Acupuncture Verification	25.00
Acupuncture Late	50.00
Acupuncture Certification Letter	25.00
Acupuncture Inactive Status	50.00
Athletic Trainer Application	50.00
Athletic Trainer Annual License	100.00
Athletic Trainer Verification	25.00
Athletic Trainer Certification	25.00
Athletic Trainer Late	15.00
Genetic Counselor Application	200.00
Genetic Counselor Annual Renewal	150.00
Genetic Counselor Certification	25.00
Genetic Counselor Verification	25.00
Genetic Counselor Late	75.00
Midwifery Application	100.00
Midwifery Annual Renewal	100.00
Midwifery Certification and Certification Letter	25.00
Midwifery Verification	25.00
Midwifery Late	75.00
Midwifery Inactive Status	50.00
Physician Application	200.00
Physician Annual Renewal	192.00
Physician Certification Letter	25.00
Physician Endorsement	40.00
Physician Verification	25.00
Physician Late	60.00
Residency Permit / Extension	20.00 / 15.00
Physician Emeritus Registration	50.00
Medical Faculty Application	200.00
Medical Faculty Renewal	192.00
Naturopathic Application	200.00
Naturopathic Annual Registration Renewal	150.00
Naturopathic Verification	25.00
Naturopathic Late	75.00
Naturopathic Inactive Status	50.00
Naturopathic Certification	25.00
Naturopathic Emeritus Registration	50.00
Physician Assistant Application	120.00
Physician Assistant Annual License Renewal	115.00
Physician Assistant Verification	25.00
Physician Assistant Late	50.00
Physician Assistant Certification Letter	25.00
Respiratory Therapists Application	100.00
Respiratory Therapists Annual Renewal	90.00
Respiratory Therapists Certification Letter	25.00
Respiratory Therapists Verification	25.00

Type of fee	Fee
Respiratory Therapists Late	50.00
Respiratory Therapists Inactive Status	50.00
Telemedicine Application	100.00
Telemedicine Annual Renewal	75.00
Professional Firm Application	100.00
Professional Firm Annual Renewal	25.00
Civil Penalties	Various
Miscellaneous Service Charges, Copies	Various
Duplicate Extension Letter / License Request	20.00
Education / Training Program Approval	100.00
Competitive Athletic Event Registration	50.00
Report Generation (per hour)	60.00

BOARD OF NURSING

The mission of the Minnesota Board of Nursing is to protect the public's health and safety through regulation of nursing education, licensure and practice.

Report of the Executive Director

July 1, 2022 – June 30, 2024

The 2022-2024 biennial report for the Board of Nursing reflects the emergence from the COVID-19 pandemic and the threat of a widespread nursing strike and a return to more typical business activities of the Board.

The COVID-19 pandemic was a challenge for all healthcare workers and the nursing workforce was no exception. During the 2022-2024 biennium, the Board monitored issues affecting the nursing workforce in Minnesota, including increased attrition, staffing shortages, and the increased use of telehealth options.

The composition of the nursing workforce in Minnesota also continued to change during this period. Minnesota experienced a continued gradual decrease in LPN licensure and an increase in both RN and APRN licensure and certification.

Another change for nursing education and licensure was implemented in April of 2023 when the National Council of State Boards of Nursing introduced the Next Generation NCLEX. The NCLEX, the examination for nurse licensure, was revised to focus more on clinical judgement and decision-making based on over a decade of research. Although Next Generation represented a significant change to the exam, it is too soon to say what effect it will have on pass rates.

Caren Gaytko, MA, BSN, RN
Executive Director
Minnesota Board of Nursing

GENERAL INFORMATION – MINN. STAT. §214.07, SUBD. 1B(5)

Board Members Serving During the Period 7/1/2022 – 6/30/2024

Name	Location	Appointment Status	Appointment Date	Reappointment Date	Term Expiration Date
Sandra Anderson	Wyoming	RN	1/17/2024		1/3/2028
Katlynn Berntson	Bagley	LPN	9/1/2022	1/2/2023	1/4/2027
Kaleeca Bible	Minneapolis	RN	12/8/2020		1/2/2023 End: 3/7/2023
Laura Elseth	Eden Prairie	LPN	7/1/2020	7/5/2022	1/5/2026
Summer Hagy	Sartell	Public Member	3/8/2023		1/5/2026
Lynette How	Cohasset	RN	6/23/2021	2/16/2022	1/5/2026
Shaunequa James	Ramsey	Public Member	4/5/2023		1/4/2027
David Jiang	Rochester	Public Member	6/23/2021	2/16/2022	1/5/2026 Resigned: 8/4/2022
Rhonda Johnson	Tyler	LPN	7/1/2020	1/1/2024	1/3/2028
Latasha Lee	Robbinsdale	RN	9/28/2020	1/17/2024	1/3/2028
Jacqueline Lloyd Cunningham	Minneapolis	Public member	7/5/2022		1/6/2025
Katherine Lynch	Roseville	LPN	7/23/2021		1/6/2025
Jessica Miehe	White Bear Lake	RN	3/8/2023		1/6/2025
Joseph Owen	Litchfield	APRN	3/8/2023	1/17/2024	1/3/2028
Cindy Petty	Hugo	RN	1/17/2024		1/4/2027
Rui Pina	Minneapolis	RN	6/27/2017	6/1/2021	1/6/2025 Resigned: 12/8/2023
Sarah Simons	Richfield	RN	7/1/2020		1/1/2024 End: 1/16/2024
Tracy Sonterre-Rieger	Duluth	RN	9/20/2023		1/4/2027
Jane Teipel	Farmington	RN	3/8/2023		1/4/2027 Resigned: 7/27/2023
Maria Tran	Minneapolis	Public Member	3/14/2023		1/4/2027

The Board held twelve board meetings during the 2022-2024 biennium and spent approximately 2,434 board member hours on meetings and other Board activities.

Board Staff and Office Location

The Board of Nursing has 45 employees and conducts business through four major service areas: Licensure, Education, Nursing Practice and Complaint Resolution, and Compliance.

Administration
- 1 Executive Director
- 1 Executive Assistant

Licensing/Credentialing
- 1 Director of Licensing and Operations
- 1 Licensing Supervisor
- 2 Operations Program Assistants
- 12 Licensure Specialists

Education
- 1 Director for Education
- 1 Nursing Education Specialist
- 1 Education Program Assistant
- 2 Continuing Education/APRN Specialists

Nursing Practice/Complaint Resolution
- 8 Nursing Practice Specialists
- 4 Legal Analysts
- 2 Paralegals
- 4 Administrative Assistants
- 1 Director of Research and Public Relations
- 1 Director of Practice and Compliance

Compliance
- 1 Nursing Regulations Analyst

Data Management
- 1 Data Systems Manager (MNIT)

Minnesota Board of Nursing
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Mendota Heights, MN 55120
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FAX: 651-688-1841
Email: Nursing.Board@state.mn.us
Website: https://mn.gov/boards/nursing/

CREDENTIALS ISSUED OR RENEWED – MINN. STAT. §214.07, SUBD. 1B(1)

Total Number of persons licensed or registered as of June 30, 2024: 192,113

Number and Type of Credentials Issued or Renewed

License Type	Licensed or registered as of June 30, 2024	Licensed or registered as of June 30, 2022	Licensed or registered as of June 30, 2020	Licensed or registered as of June 30, 2018	Licensed or registered as of June 30, 2016	Licensed or registered as of June 30, 2014
RN	134,648	122,247	116,220	109,251	101,531	93,872
LPN	17,887	19,105	20,580	21,512	22,694	23,603
PHN Certificates	26,347	23,743	21,506	18,616	16,467	15,028
APRN, CNP	9,872	7,944	6,768	5,596	4,478	3,864
APRN, CRNA	2,313	2,217	2,184	2,068	1,887	1,794
APRN, CNS	456	451	479	514	493	548
APRN, CNM	466	407	374	343	297	282
Border State Registrants	124	102	123	139	182	191
TOTAL	192,113	176,216	168,234	158,039	148,029	139,182

Historical Renewal Data by Biennium

July 1, 2022 – June 30, 2024

Type of License/Credential	Number of New Licenses	Number of Renewed Licenses	Number and Percent Renewed Online
RN	27,004	114,599	112,593 (98.2%)
LPN	2,084	15,773	15,152 (96.1%)
RN Permit	21,912	N/A	N/A
LPN Permit	690	N/A	N/A
PHN Certificates	2,604	N/A	N/A
APRN, CNP	2,477	7,967	7,938 (99.6%)
APRN, CRNA	272	2,102	2,093 (99.6%)
APRN, CNS	53	399	394 (98.7%)
APRN, CNM	84	389	387 (99.5%)
TOTAL	57,180	141,229	138,557 (98.1%)

July 1, 2020 – June 30, 2022

Type of License/Credential	Number of New Licenses	Number of Renewed Licenses	Number and Percent Renewed Online
RN	17,474	106,619	105,006 (98.4%)
LPN	2,258	16,911	16,264 (96.2%)
RN Permit	12,888	N/A	N/A
LPN Permit	680	N/A	N/A
PHN Certificates	2,507	N/A	N/A
APRN, CNP	1,756	6,613	6,591 (99.7%)
APRN, CRNA	237	2,015	2,006 (99.6%)
APRN, CNS	25	429	421 (98.1%)
APRN, CNM	67	355	351 (98.9%)
TOTAL	37,892	132,942	130,639 (98.3%)

July 1, 2018 – June 30, 2020

Type of License/Credential	Number of New Licenses	Number of Renewed Licenses	Number and Percent Renewed Online
RN	16,980	101,842	99,542 (98%)
LPN	2,541	18,256	17,298 (95%)
RN Permit	8,482	N/A	N/A
LPN Permit	685	N/A	N/A
PHN Certificates	2,632	N/A	N/A
APRN, CNP	1,586	5,585	5,541 (99%)
APRN, CRNA	267	1,988	1,972 (99%)
APRN, CNS	34	453	440 (97%)
APRN, CNM	66	327	322 (98%)
TOTAL	33,273	128,451	125,115 (97%)

July 1, 2016 – June 30, 2018

Type of License/Credential	Number of New Licenses	Number of Renewed Licenses	Number and Percent Renewed Online
RN	17,694	95,040	91,787 (97%)
LPN	2,662	18,896	17,756 (94%)
RN Permit	6,222	N/A	N/A
LPN Permit	486	N/A	N/A
PHN Certificates	2,419	N/A	N/A
APRN, CNP*	1,334	4,705	4,466 (95%)
APRN, CRNA*	285	1,845	1,766 (96%)
APRN, CNS*	44	483	428 (89%)
APRN, CNM*	61	303	280 (92%)
TOTAL	31,207	121,272	116,483 (96%)

*2016-2018 First Biennium APRN Renewal Data Available.

July 1, 2014 – June 30, 2016

Type of License/Credential	Number of New Licenses	Number of Renewed Licenses	Number and Percent Renewed Online
RN	15,849	87,633	83,260 (95%)
LPN	3173	19,693	18,247 (93%)
RN Permit	4820	N/A	N/A
LPN Permit	394	N/A	N/A
PHN Certificates	2184	N/A	N/A
APRN, CNP	4478	2258	N/A
APRN, CRNA	1887	960	N/A
APRN, CNS	493	259	N/A
APRN, CNM	297	150	N/A
TOTAL	33,575	110,953	101,507 (94%)

COMPLAINT ACTIVITY – MINN. STAT. §214.07, SUBDS. 1B(2), (3)

Complaints Received and Closed by Biennium

Biennium	Total Number of Complaints Received	Total Number of Complaints Closed
July 1, 2022 – June 30, 2024	1,956	2,141
July 1, 2020 – June 30, 2022	1,892	1,573
July 1, 2018 – June 30, 2020	2,599	2,270
July 1, 2016 – June 30, 2018	2,807	2,857
July 1, 2014 – June 30, 2016	2,146	2,423
July 1, 2012 – June 30, 2014	3,291	3,709

Number of and age of complaints open at the end of the period:

Number of Complaints Open as of June 30, 2024	**871**
Complaints open less than one year as of June 30, 2024	780
Complaints open greater than one year as of June 30, 2024	91

The number of complaints received by the Board in the 2022-2024 biennium was similar to the previous biennium. However, the Board did close significantly more complaints this biennium. The average time to resolve a complaint during this period was 306 days.

Types of Complaints Received by Biennium (New System)

The Board implemented a new complaint tracking database in late 2022 which uses new categories for the basis of complaints received. The types of complaints have remained relatively consistent with some variation due to the transition to a new data management system.

Basis of complaints received	Number alleging this basis in 2022-2024
Failure to demonstrate qualifications for license	23
Violation of federal law, state law, Board rule, or Board order	355
Board action in another state	58
Failure to practice with skill and safety	387
Practice issues related to substance use, mental health, or physical health	262
Unprofessional or unethical conduct	255
Historical conversion	12
Non-jurisdictional	88

Types of Complaints Received by Biennium (Old Tracking System)

Basis of complaints received*	Number alleging this basis in 2020-2022	Number alleging this basis in 2018-2020	Number alleging this basis in 2016-2018
Failure to practice with reasonable skill and safety	502	670	683
Actual or potential inability to practice nursing safely due to the use of substances or mental or physical health condition	364	492	525
Action in another jurisdiction	71	112	256
Failure to demonstrate qualification for licensure or fraud/deceit in obtaining a license	18	147	137
Unauthorized practice, including practicing without current registration, without informing the board of APRN certification and practicing without a license	10	57	54
Unprofessional conduct	241	164	171
Violation of a board order	61	58	83
Failure to practice Advanced Practice nursing with reasonable skill and safety	85	102	134
Failure to successfully complete the Health Professionals Services Program	54	104	68
Criminal conviction	39	155	90
Tax delinquency	21	22	127
Unethical conduct, including use of undue influence to the benefit of the nurse	150	174	80
Improper management of patient records or privacy violations	29	35	36
Sexual Misconduct	22	15	23
All others	250	292	257

*Some complaints allege more than one basis.

GENERAL PROGRAM INFORMATION – MINN. STAT. §214.07, SUBD. 1B(5)

Nursing Education Program

The Board promotes excellence in nursing education programs by monitoring program graduate success rates on the national nurse licensure examination; providing consultation to nursing education programs regarding national nurse licensure examination (NCLEX®) pass rates; and providing technical assistance to programs on nursing education standards. The Board has established requirements for initial and continuing approval of pre-licensure preparing nursing programs including practical nursing, professional nursing, and advanced practice nursing.

Approved Licensure-Preparing Programs

Type and Number of Nursing Programs	As of June, 2024	As of June, 2022	As of June, 2020
Practical	23	24	25
Professional – Associate	25	26	25
Professional – Baccalaureate	22	22	20
Professional – Master's	4	4	3
Advanced Practice Registered Nurse	15	14	12
TOTAL	89	90	85

Graduates of Licensure Programs

Number of Graduates	FY 2023	FY 2022	FY 2021	FY 2020	FY 2019	FY 2018	FY 2017	FY 2016
Practical	750	808	1017	1067	1101	1146	1180	1260
Professional – Associate	2199	2413	2307	2286	2308	2245	2347	2389
Professional – Baccalaureate	1588	1357	1440	1320	1209	1107	1060	1101
Professional – Master's	149	159	136	137	134	135	125	119
Advanced Practice	4209	4257	3563	3650	3009	4754	2108	n/a
TOTAL	8,895	8,994	8,463	8,460	7,761	9,387	6,820	4,869

Initial Program Approval of Licensure-Preparing Nursing Programs

Programs	FY 2022 – FY 2023	FY 2020 – FY 2021	FY 2019 – FY 2020	FY 2018 – FY 2019	FY 2017 – FY 2018	FY 2016 – FY 2017
Practical	0	0	0	0	0	0
Professional – Associate	0	0	1	0	0	0
Professional– Baccalaureate	0	1	1	0	0	2
Professional – Master's	0	1	0	0	0	0
Advanced Practice	1	0	2	0	0	12
TOTAL	1	2	4	0	0	14

Continuing Program Approval of Approved Licensure-Preparing Nursing Programs

Programs	FY 2022 – FY 2023	FY 2020 – FY 2021	FY 2019 – FY 2020	FY 2018 – FY 2019	FY 2017 – FY 2018	FY 2016 – FY 2017
Practical	6	1	4	15	18*	1
Professional	16	8	5	11	16*	7
Advanced Practice	7	3	4	0	0	0
Total	29	12	13	26	34	8

* Number includes 17 practical and 12 professional programs granted continued approval on 6/7/18 in accordance to program approval rules for those programs achieving accreditation candidacy status.

On-site surveys, collection and review of annual reports, review of improvement plans submitted by programs, decisions of national nursing accreditation bodies, and analysis of the National Council Licensure Examination (NCLEX®) data were used to evaluate each nursing education programs' compliance with statutes and rules. Analysis of all available data provides a basis for the education reports submitted to the Board for decision-making.

The Board performs additional oversight of programs that have first-time licensure examination (NCLEX®) success rates at 75% or below for a calendar year. During calendar years 2022 and 2023, 21 nursing programs were below the minimum standard for 1, 2 or 3 years. The following table presents a comparison of programs below minimum standard for the prior six calendar years.

Programs Below Minimum Standard by Calendar Year

Year(s) below minimum standard	2023	2022	2021	2020	2019	2018
1 year	3 (PN)	15 (2 PN, 5 ADN, 8 BSN)	9 (6 PN, 2 ADN, 1 BSN)	8 (2 PN, 2 ADN, 4 BSN)	4 (1 PN, 2 ADN, 1 Baccalaureate)	5 (2 PN, 2 ADN, 1 Baccalaureate)
2 consecutive years	3 (1 PN, 2 ADN)	3 (2 PN, 1 ADN)	2 (2 ADN)	2 (2 ADN)	1 (Baccalaureate)	3 (1 PN, 1 ADN, 1 Baccalaureate)
3 consecutive years	1 (PN)	0	2 (2 ADN)	1 (1 PN)	2 (1 PN, 1 Baccalaureate)	1 (PN)
Total	7	18	13	11	7	9

All programs with first-time NCLEX® candidate success rates of 75 percent or less within a calendar year submitted plans of corrective action, as required by rule. For programs below minimum standard for two consecutive calendar years, the Board conducted an on-site survey to determine progress on the previously submitted plan. Following the survey, revised plans of corrective action were submitted as required by rule. An on-site survey for compliance with all applicable rules and for the implementation of the revised plan of corrective action was required for the program below minimum standard for three consecutive calendar years.

RECEIPTS, DISBURSEMENTS & MAJOR FEES – MINN. STAT §214.07, 1B(4)

Total Receipts and Disbursements by Biennium

Biennium	Total Receipts	Total Disbursements
July 1, 2022 – June 30, 2024	$17,530,707	$15,135,182
July 1, 2020 – June 30, 2022	$17,203,522	$9,039,989
July 1, 2018 – June 30, 2020	$17,979,016	$12,658,104
July 1, 2016 – June 30, 2018	$13,285,603	$11,029,345
July 1, 2014 – June 30, 2016	$13,260.405	$10,358,110
July 1, 2012 – June 30, 2014	$11,552,309	$9,374,288

Fees by Type

Type of Fee	Fee
APRN Initial Licensure	$105
Border State Registry- Notice of Employment Change to remain or be reinstated on the registry	$50
RN, LPN Licensure by Examination	$105
RN, LPN Re-Examination	$60
RN, LPN Licensure by Endorsement	$105
RN, LPN, APRN Registration Renewal	$85
RN, LPN, APRN Re-Registration	$105
RN, LPN Border State Registry	$50
Public Health Nurse Registration	$30
Replacement License Certificate	$20
Replacement Public Health Nurse Registration Certificate	$20
Verification of Licensure Status other than through Nursys	$20
Verification of Examination Scores	$20
Copy of Microfilmed Licensure Application Materials	$20
Nursing Business Registration Initial Application	$100
Nursing Business Registration Annual Application	$25
Practicing without current RN and LPN registration	Two times the current registration renewal fee ($85) for any part of the first calendar month, plus the current registration renewal fee ($85) for any part of any subsequent month, up to 24 months.
Practicing without current APRN license and certification or recertification	$200 for the first month or part of a month and an additional $100 for each subsequent month or parts of months of practice, up to 24 months.
Auto Verification Service Subscription Note: A subscription lasts for one year from the date that the subscription payment is received by the Board of Nursing. During the year, subscribers can add and delete licensees from the subscription. The maximum number of licensees in a subscription is the number of licensees tracked at any one time.	$100 1-100 Licenses $225 101-500 Licenses $350 501-1000 Licenses $475 1001-2000 Licenses $600 2001-3000 Licenses $725 3001-4000 Licenses $850 4001-5000 Licenses $1000 5000+ Licenses
Data Requests, Public Data – up to 100 pages, black and white, letter- or legal-size paper. Note: Charged only if fees exceed $15.00.	25 cents per page copied
Data Requests, Public Data – over 100 paper copies, copies of photographs, audiotapes, data on CD, DVD, or data stored electronically. Note: Charged only if fees exceed $15.00.	Actual costs incurred in searching for, retrieving, and providing the data including costs of labor ($24.22/hr.), materials, and delivery; cost paid for third-party assistance, if applicable. Material costs may include costs for paper, CDs, DVDs, audiotapes, etc.
Data Requests- Summary Data	Actual costs as noted above plus costs incurred in creating the data, either by Board staff or a third party.
Data Requests- Private Data Note: No charge for searching for and retrieving the data.	Actual costs for making paper copies or printing electronically stored data.

BOARD OF OCCUPATIONAL THERAPY PRACTICE

The mission of the Board of Occupational Therapy is to protect the public through effective licensure and enforcement of the statutes and rules governing the practice of occupational therapy to reasonably ensure a standard of competent and ethical practice.

Report of the Executive Director

July 1, 2022 – June 30, 2024

The Minnesota Board of Occupational Therapy Practice (Board) was created by the legislature effective January 1, 2018. The Board exists to protect the health and welfare of the public by ensuring a standard of competent and ethical care provided by occupational therapy practitioners in the State of Minnesota.

The Board and its staff strive to ensure it fulfills its mission through:

- Implementation of statutory license application requirements, ensuring a thorough review of applicant qualifications;
- Timely initial license processing for occupational therapist (OT), occupational therapy assistant (OTA), and temporary license applicants;
- Timely biennial renewal of licenses for OT's and OTAs;
- Thorough and timely review, response, and action on complaints;
- Accurate, timely, information dissemination to licensees, applicants, and other interested persons and agencies;
- Excellent customer service, ensuring correspondence is responded to accurately, efficiently and in a positive manner; and
- Educating licensees about statutory obligations and changes to ensure safe, ethical practice that falls within the Occupational Therapy Practice Act.

The bulk of this biennium included a transition to a new normal for Board operations. New office norms include two staff working in hybrid roles with a third staff in the office daily. Staffing levels continue to meet the needs of the public and the board and effectively and efficiently manage the services provided to applicants, licensees, stakeholders, and the public.

The MN Occupational Therapy Association brought legislation allowing Minnesota to join the Occupational Therapy Interstate Licensure Compact (Compact). The Compact passed with Board support in the 2024 session. Board operations are pivoting to incorporate the development work required for implementation. The Board expects significant staff and data base development costs in order to integrate with the Compact. The Board has appointed its Compact Commissioner representing Minnesota interests in the Compact Commission.

The Board has undertaken a thorough, comprehensive statutory review and is in the process of language revision for the Occupational Therapy Practice Act. These changes will incorporate items related to the Compact along with updates and clarification of existing language. The proposed changes will be brought forward for introduction in the 2025 legislative session.

Operationally, the Board continues 100% online routine license applications and renewals. Paper processes are minimal and primarily related to late license renewal applications (those more than 364 days expired). Board staff continue to strive to ensure their work is efficient, transparent, and in alignment with

Board and State of Minnesota expectations.

Board members continue to demonstrate tremendous commitment and service to the people of the State of Minnesota. The Board of Occupational Therapy Practice strives to always meet its foremost obligation of protection of the public.

Christina Bourland, MHA, OTR/L
Executive Director
Minnesota Board of Occupational Therapy Practice
612-548-2179
https://mn.gov/boards/occupational-therapy/

GENERAL INFORMATION – MINN. STAT. §214.07, SUBD. 1B(5)

Board Members Serving During the Period 7/1/2022 – 6/30/2024

Name	Employment Location*	Appointment Status	Appointment Date	Reappointment Date	Term Expiration Date
Mary Bartzen	Wayzata	Occupational Therapist	1/1/2018	7/3/2019; 1/2/2023	1/4/2027
Lynnette Buckley	Bloomington	Occupational Therapy Assistant	1/1/2018	1/3/2019	1/2/2023
Donna Coughlin	Rochester	Occupational Therapy Assistant	1/1/2018	5/20/2020; 4/3/2024	1/3/2028
Chris Harbaugh	Big Lake	Occupational Therapist	1/1/2018	7/5/2022	1/5/2026
Samantha Olsen	Cleveland	Occupational Therapist	1/1/2018	3/8/2021	1/6/2025
Erin Staum	Oakdale	Occupational Therapy Assistant	1/1/2018	3/8/2021	1/6/2025
Jessica Engman	White Bear Lake	Occupational Therapist	7/3/2019	4/19/2023	1/4/2027
Jeffrey Malikowski	Saint Cloud	Public Member	7/3/2019	NA	1/2/2023
Stephen Jobe	Brainerd	Public Member	7/3/2019	NA	1/2/2023
Stephanie Smith	Ham Lake	Occupational Therapist	6/16/2020	4/3/2024	1/3/2028
Gregg Schaeppi	Minneapolis	Public Member	6/24/2020	NA	1/1/2024
Karoline Pierson	St. Louis Park	Public Member	4/19/2023	NA	1/4/2027
Katelyn Bills	St. Cloud	Public Member	4/19/2023	NA	5/1/2024
Barbara Kloetzke	Anoka	Occupational Therapy Assistant	4/19/2023	NA	1/4/2027
Chad Kinart	Maple Grove	Public Member	4/3/2024	NA	1/3/2028
Vacant, Other Licensed Health Professional	(vacant)	Public Member	(vacant)	(vacant)	(vacant

*Employment Location reflects home address if retired or unemployed.

Board membership is comprised of the following Governor appointed members: five licensed occupational therapists, three licensed occupational therapy assistants, one public member who is a licensed health care provider, and two public members who have received or have a family member who has received occupational therapy services. The occupational therapy practitioners must represent various practice

areas, settings, and parts of the state. Two must be employed outside the Twin Cities area. The full Board meets four times per year. The Board currently has four standing committees: The Executive Committee, Compliance Committee, Legislative Committee and Complaint Resolution Committee.

Board Staff and Office Location

Executive Director
Assistant Executive Director
Licensing and Administrative Specialist

Minnesota Board of Occupational Therapy Practice
Randolph Square Building
335 Randolph Avenue, Suite 240
St. Paul, MN 55102
Phone: 612-548-2179
Email: occupational.therapy@state.mn.us
https://mn.gov/boards/occupational-therapy/

CREDENTIALS ISSUED OR RENEWED – MINN. STAT. §214.07, SUBD. 1B(1)

Total Number of persons licensed or registered as of June 30, 2024: 5,866

Number and Type of Credentials Issued or Renewed

License Type	Licensed or registered as of June 30, 2024	Licensed or registered as of June 30, 2022	Licensed or registered as of June 30, 2020	Licensed or registered as of June 30, 2018*	Licensed or registered as of June 30, 2016	Licensed or registered as of June 30, 2014
Occupational Therapist	4,669	4,802	4,204	3,913	NA	NA
Occupational Therapist Assistant	1,168	1,232	1,247	1,236	NA	NA
Temporary Occupational Therapist	17	14	163	21	NA	NA
Temporary Occupational Therapy Assistant	12	9	63	14	NA	NA
TOTAL	**5,866**	**6,057**	**5,677**	**5,184**	**NA**	**NA**

* Reported numbers include information provided by the Minnesota Department of Health (MDH), Health Occupations Program and transferred to the Board April 13, 2018. Historical data is with MDH.

Historical Renewal Data by Biennium

July 1, 2022 – June 30, 2024

Type of License/Credential	Number of New Licenses	Number of Renewed Licenses*	Percent** Renewed Online
Occupational Therapist	649	5,238	100%
Occupational Therapy Assistant	163	1,461	100%
Occupational Therapist Temporary License	158	NA	NA
Occupational Therapy Assistant Temporary License	49	NA	NA
TOTAL	1,019	6,699	

* Higher renewal numbers reflect ongoing transition to birth month renewal and individuals that may have completed a prorated renewal more than once in a two-year period.
**A very small number of renewals that occur more than 364 days after license expiration occur through paper processing. All others occur through an online process.

July 1, 2020 – June 30, 2022

Type of License/Credential	Number of New Licenses	Number of Renewed Licenses	Percent* Renewed Online
Occupational Therapist	642	4,802	100%
Occupational Therapy Assistant	165	1,232	100%
Occupational Therapist Temporary License	151	NA	NA
Occupational Therapy Assistant Temporary License	63	NA	NA
TOTAL	1,021	6,036	

*A very small number of renewals that occur more than 90 days after license expiration occur through paper processing. All others occur through an online process.

July 1, 2018 – June 30, 2020

Type of License/Credential	Number of New Licenses	Number of Renewed Licenses	Percent* Renewed Online
Occupational Therapist	564	4204	100%
Occupational Therapy Assistant	182	1247	100%
Occupational Therapist Temporary License	153	10	0**
Occupational Therapy Assistant Temporary License	52	11	0**
TOTAL	951	5,451	100%

* All renewals that are on time or within 90 days of the license expiration date occur through an online process.
**Temporary license renewals must occur on paper. August 2020 statute changes removed the temporary license renewal option.

COMPLAINT ACTIVITY – MINN. STAT. §214.07, SUBDS. 1B(2), (3)

Complaints Received and Closed by Biennium

Biennium	Total Number of Complaints Received	Total Number of Complaints Closed
July 1, 2022 – June 30, 2024	24	22
July 1, 2020 – June 30, 2022	16	14
July 1, 2018 – June 30, 2020	17	17
July 1, 2016 – June 30, 2018	1*	5*

*This number reflects cases transferred from MDH that were closed by the Board AND cases opened and closed by the Board.

Number of and Age of Complaints Open at the End of the Period

Number of Complaints Open as of June 30, 2024	**2**
Complaints open less than one year as of June 30, 2024	2
Complaints open greater than one year as of June 30, 2024	0

Types of Complaints Received by Biennium

Basis of complaints received*	Number alleging this basis in 2022-2024	Number alleging this basis in 2020-2022	Number alleging this basis in 2018-2020
Incompetence/services below the community standard of care	15	8	11
Unethical/Unprofessional conduct	15	8	13
Disregard health, welfare, safety	2	-	-
Action by another jurisdiction	0	-	-
Billing improprieties	11	3	5
Failure to respond to the Board or participate in an investigation as required	8	7	10
Fraudulent or inaccurate representation	16	3	-
Sexual misconduct/boundaries	0	0	0
Miscellaneous	7	2	0

*Some rows may be blank due to recategorization of complaints based upon data. Some complaints included more than one allegation.

RECEIPTS, DISBURSEMENTS & MAJOR FEES – MINN. STAT §214.07, 1B(4)

Total Receipts and Disbursements by Biennium

Biennium	Total Receipts	Total Disbursements**
July 1, 2022 – June 30, 2024	$1,111,508	$1,042,761
July 1, 2020 – June 30, 2022	$1,131,430	$887,427
July 1, 2018 – June 30, 2020	$940,327*	$735,263
April 19, 2018 – June 30, 2018*	$100,898	$221,909

*Total Receipts and Total Disbursements reflects ONLY activity conducted by the Board from the end of the interagency agreement 4/19/18-6/30/18 and does not reflect MDH data. Includes $64,782.21 transferred from the Department of Health to the Board in November of 2018.
**Total disbursements include all direct and indirect costs/expenditures to the board.

Fees by Type

Type of fee	Fee
Initial License- OT	$185
Initial License-OTA	$105
Biennial Renewal- OT	$185
Biennial Renewal-OTA	$105
Duplicate License	$30
Temporary License	$75
Verification to institutions	$10
Verification to Another State	$25
Course Approval after lapse of Licensure	$100
Limited License	$100
Penalty Fees	Varies

BOARD OF OPTOMETRY

The mission of the Minnesota Board of Optometry is promoting public interest in receiving quality optometric health care from competent licensed optometrists; protecting the public by ensuring that all licensed optometrists meet the educational and practical requirements specified in law; and protecting the public by setting standards for quality optometric health care.

Report of the Executive Director

July 1, 2022 – June 30, 2024

The mission of the Board of Optometry (aka Board) is public protection by striving to ensure Minnesota citizens receive quality optometric care from competent optometrists. Public protection through licensure and regulation underlies every activity and all functions of the Board.

The Board website (https://mn.gov/boards/optometry/) provides access to online Annual License Renewals, online address/phone change, online reporting of continuing education, information about the status of individual licensees, complaint forms, and optometry statutes and rules. In the past year the Board has also added information about continuing education opportunities on the website.

The Board continues to be well represented at a national level with one licensed optometrist representing Minnesota with of the Association of Regulatory Boards (ARBO), serving in an elected position.

In the 2024 legislative session, there was substantial activity regarding optometrists and their scope of practice. Despite a bipartisan bill, no changes were adopted. This topic will likely return in the future.

The Board requires all licensees to complete 40 hours of continuing education in a two-year timeframe. Credits may be obtained in person or online, with 15 of the hours allowed for prerecorded events. Since implementing the use of a national database tracker for credits, the Board has been able to audit 100 percent of our licensees' credits.

The Board staff consists of 1.5 FTE employees split between the positions of Executive Director and Office Administrative Specialist. In the fall of 2022, a new Office Administrative Specialist joined the Board. The Board continues to provide responsive, customer focused, efficient, and cost-effective services. Board members are commended for exceptional dedication, rarely missing a meeting. Board members are valued partners to meet the increasing demands of optometric/consumer education.

Britt Heglund
Executive Director
Minnesota Board of Optometry
651-201-2762

GENERAL INFORMATION – MINN. STAT. §214.07, SUBD. 1B(5)

Board Members Serving During the Period 7/1/2022 – 6/30/2024

Name	Location	Appointment Status	Appointment Date	Reappointment Date	Term Expiration Date
Fernando Alvarado	Willmar	Public	6/2021	NA	1/2025
Eric Bailey	St. Cloud	Optometrist	3/2017	7/2021	1/2025
George Bruehl	Stillwater	Public	5/2024	NA	1/2028
Leah Colby	Rogers	Optometrist	7/2022	NA	1/2026
Georgiann Jensen Bohn	Cambridge	Optometrist	9/2022	1/2023	1/2027
Shari Koll	Springfield	Public	7/2019	NA	1/2024
Tina McCarty	Maple Grove	Optometrist	7/2020	1/2023	1/2028
Sam Villella	Blaine	Optometrist	7/2019	1/2023	1/2027

Board Staff and Office Location

Executive Director, Effective 9/1/2021
Office and Administrative Specialist, Senior, Effective 8/27/2022

Minnesota Board of Optometry
Randolph Square Building
335 Randolph Avenue, Suite 210
St. Paul, MN 55102
Phone: 651-201-2762
FAX: 612-201-2763
Email: optometry.board@state.mn.us
Website: www.mn.gov/boards/optometry/

CREDENTIALS ISSUED OR RENEWED – MINN. STAT. §214.07, SUBD. 1B(1)

Total Number of persons licensed or registered as of June 30, 2024: 1,280

Number and Type of Credentials Issued or Renewed

License Type	Licensed or registered as of June 30, 2024	Licensed or registered as of June 30, 2022	Licensed or registered as of June 30, 2020	Licensed or registered as of June 30, 2018	Licensed or registered as of June 30, 2016	Licensed or registered as of June 30, 2014
Optometrist	1,280	1,210	1,164	unavailable	1,097	1,085
TOTAL	1,280	1,210	1,164	unavailable	1,097	1,085

Historical Renewal Data by Biennium

July 1, 2022 – June 30, 2024

Type of License/Credential	Number of New Licenses	Number of Renewed Licenses	Percent Renewed Online
Optometrist	152	2545	100%

July 1, 2020 – June 30, 2022

Type of License/Credential	Number of New Licenses	Number of Renewed Licenses	Percent Renewed Online
Optometrist	115	2616	100%

July 1, 2018 – June 30, 2020

Type of License/Credential	Number of New Licenses	Number of Renewed Licenses	Percent Renewed Online
Optometrist	119	2402	99.8%

July 1, 2016 – June 30, 2018

Type of License/Credential	Number of New Licenses	Number of Renewed Licenses	Percent Renewed Online
Optometrist	94	2250	95%

July 1, 2014 – June 30, 2016

Type of License/Credential	Number of New Licenses	Number of Renewed Licenses	Percent Renewed Online
Optometrist	86	2194	90%

July 1, 2012 – June 30, 2014

Type of License/Credential	Number of New Licenses	Number of Renewed Licenses	Percent Renewed Online
Optometrist	95	2063	89%

COMPLAINT ACTIVITY – MINN. STAT. §214.07, SUBDS. 1B(2), (3)

Complaints Received and Closed by Biennium

Biennium	Total Number of Complaints Received	Total Number of Complaints Closed
July 1, 2022 – June 30, 2024	62	62
July 1, 2020 – June 30, 2022	35	39
July 1, 2018 – June 30, 2020	69	65
July 1, 2016 – June 30, 2018	33	30
July 1, 2014 – June 30, 2016	28	18

Number of and Age of Complaints Open at the End of the Period

Number of Complaints Open as of June 30, 2024	**0**
Complaints open less than one year as of June 30, 2024	0
Complaints open greater than one year as of June 30, 2024	0

Types of Complaints by Biennium

Basis of complaint*	Number alleging this basis in 2022-2024	Number alleging this basis in 2020-2022	Number alleging this basis in 2018-2020	Number alleging this basis in 2016–2018
Unprofessional conduct	23	6	13	10
Non-jurisdictional	29	17	13	8
Medical Records	0	0	7	15
Sexual Misconduct	2	0	0	0
Miscellaneous	8	12	23	0

*Some complaints allege more than one basis

RECEIPTS, DISBURSEMENTS & MAJOR FEES – MINN. STAT §214.07, 1B(4)

Total Receipts and Disbursements by Biennium

Biennium	Total Receipts	Total Disbursements
July 1, 2022 – June 30, 2024	$ 498,148	$ 534,072
July 1, 2020 – June 30, 2022	$ 498,660	$ 411,696
July 1, 2018 – June 30, 2020	$ 441,664	$ 441 076
July 1, 2016 – June 30, 2018	$ 312,142	$ 412,488
July 1, 2014 – June 30, 2016	$ 289,146	$ 300,353
July 1, 2012 – June 30, 2014	$ 253,311	$ 228,686

Fees by Type

Type of Fee	Fee
Professional Corporation	$ 100 initial report $ 25 annual report
Licensure Application	$ 160
Annual License Renewal	$ 160
Late Penalty Fee	$ 75
Duplicate/Replacement card	$ 10
CE Provider Application	$ 45
Emeritus Registration	$ 10
Endorsement Application	$ 160
Reinstatement Application	$ 160
Replacement of Initial License Certificate	$ 12

BOARD OF PHARMACY

The Minnesota Board of Pharmacy exists to promote, preserve, and protect the public health, safety, and welfare by fostering the safe distribution of pharmaceuticals and the provision of quality pharmaceutical care to the citizens of Minnesota.

Report of the Executive Director

July 1, 2022 – June 30, 2024

The Board accomplishes its core public safety and regulatory mission of the practice of pharmacy and distribution of pharmaceuticals by:

- Licensing pharmacies and pharmacists and registering pharmacist interns, pharmacy technicians, and controlled substance researchers.
- Licensing drug manufacturers, drug wholesalers, 503B outsourcers, medical gas manufacturers, wholesalers, and distributors, and third-party logistics providers (e.g., UPS and FedEx).
- Conducting inspections of all in-state pharmacies, drug wholesalers, legend medical gas distributors, and controlled substance researchers. Additionally, we review inspection reports for out-of-state pharmacy licensure approval.
- Responding to public and agency inquiries, complaints, and reports regarding licensure and conduct of applicants, registrants, and licensees.
- Investigating all jurisdictional complaints received by the Board.
- Setting standards of practice and conduct for licensees and pursuing educational or disciplinary action with licensees, to ensure that standards are met.
- Providing technical assistance to elected public officials, other state agencies, federal agencies and units of local government.
- Administering the State's Prescription Monitoring Program (PMP).
- Administering the State's Opioid Product Registration Fee Program.
- Administering the Minnesota Insulin Safety Net Program (along with MNsure).

Emerging issues regarding the regulation of the practice of pharmacy:

- Manufacturers and software developers continue to develop new devices and programs that automate pharmacy dispensing processes. These devices continue to change how pharmacy is practiced and how drugs are dispensed to patients. The Board devotes a significant amount of resources to evaluating this new technology to ensure that it does not pose a threat to patients.
- Pharmacies continue to expand their offering of services such as immunizations, medication therapy management, and prescribing authority for select categories of drugs. Specifically, legislation was enacted that allows pharmacists to follow protocols and directly prescribe nicotine-replacement therapy products, naloxone, self-administered hormonal contraceptives, and human immunodeficiency virus (HIV) testing and treatment. This trend should result in improved public health by increasing the number of individuals who are immunized against various diseases and

by helping to reduce adverse drug reactions and other medication-related problems. However, if these services are performed incorrectly, there can be a detrimental impact on patients.

- Since the last reporting period, the Board has initiated a complete rules package revision project needed to stay current with the continual changes in the professional practice of pharmacy. The last time the Board engaged in significant rulemaking changes was in 2011.

Operational Efficiency and Improvements

- An exciting and pivotal moment occurred during the biennium for board staff and its more than 26,000 licensees/registrants. The Board migrated from an onerous, paper-based licensing system to one that supports online renewals, applications, and other services. On October 2, 2023, the Board migrated to and went "live" with ALIMS, a licensing system employed by 14 other Minnesota Health Licensing Boards. The Board's transition has consisted of key milestones and benchmarks. Highlights include:
    - Converted and mapped data fields from previous system to ALIMS
    - Established online renewals for the following:
        - Pharmacy technicians
        - Pharmacists
        - Pharmacies
        - Manufacturers
        - Wholesale distributors
    - Enabled ACH payments for facility renewals
    - Established an online payment system to support the intricacies of Minnesota Statute §151.065 (e.g., first facility fee for medical gas manufacturers or wholesalers; $55,000 fee for the first opiate facility)
    - Established online applications for the following:
        - Pharmacists by exam
        - Pharmacists by reciprocity
        - Pharmacy technicians
        - Interns
    - Established registration codes to move existing Facility Licensees online and further grant access to pharmacist-in-charge or others utilizing a token system
    - Established an electronic workflow for processing variance requests and created a variance report for Board members
    - Established workflow for paperless processing
        - Provide online upload capability
        - Display informative checklist items online
        - Provide workflow queues for staff to monitor and proactively process
    - Automated Continuing Education (CE) Submission
        - CE Certification/Attestation
        - CE Late Audit
        - CE Random Audit

- Additional highlights include, but are not limited to, utilizing standard features and online services enjoyed by other Health Licensing Boards
  - Online username and password reset for Board's clientele
  - ALIMS Complaint and Action features
  - ALIMS financial management features

Jill Phillips, MPH, RPh
Executive Director
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651-201-2825

GENERAL INFORMATION – MINN. STAT. §214.07, SUBD. 1B(5)

Board Members Serving During the Period 7/1/2022—6/30/2024

Name	Location	Appointment Status	Appointment Date	Reappointment Date(s)	Term Expiration Date
Ronda Chakolis	Minneapolis	Pharmacist	06/2022	NA	01/2026
Michael Haag	Blaine	Pharmacist	04/2023	01/2024	01/2028
Ben Maisenbach	Rosemount	Pharmacist	06/2021	NA	01/2025
Kendra Metz	Moose Lake	Pharmacist	06/2020	05/2024	01/2028
Rabih Nahas	Orono	Pharmacist	02/2013	06/2021	01/2025
Amy Paradis	Fairmont	Pharmacist	06/2019	04/2023	04/2027
James Bialke	Minneapolis	Public member	01/2016	01/2022	01/2026
Barbara Droher Kline	Le Sueur	Public member	06/2023	NA	01/2027
John Zwier	St Paul	Public member	06/2023	NA	01/2027
Stuart Williams (inactive)	St. Louis Park	Public member	07/2011	06/2019	01/2023
Samantha Schirmer (inactive)	Andover	Public member	01/2016	06/2019	01/2023

Board Staff and Office Location

Administration:
1 Executive Director
1 Deputy Director
1 Executive Assistant

Compliance:
7 Pharmacy Surveyors

Licensing:
1 Licensing Supervisor
6 Licensing Specialists

Enforcement:
1 Associate Director
1 Legal Analyst

Controlled Substance and Reporting:
1 Director
1 Program Administrator
1 Data Analyst
1 Program Coordinator

Minnesota Board of Pharmacy
Randolph Square Building
335 Randolph Avenue, Suite 230
St. Paul, MN 55102
Phone: 651-201-2825
FAX: 651-215-0951
Email: Pharmacy.board@state.mn.us
Website: https://mn.gov/boards/pharmacy

CREDENTIALS ISSUED OR RENEWED – MINN. STAT. §214,07, SUBD. 1B(1)

Total number of persons licensed or registered as of June 30, 2024: 21,019
Total number of facilities licensed or registered as of June 30, 2024: 3,959
Total number of PMP users registered as of June 30, 2024: 36,766

Number and Type of Credentials Issued or Renewed

License Type	Licensed or registered as of June 30, 2024	Licensed or registered as of June 30, 2022	Licensed or registered as of June 30, 2020	Licensed or registered as of June 30, 2018	Licensed or registered as of June 30, 2016	Licensed or registered as of June 30, 2014
Active Pharmacists	9,597	9,354	9,176	8,911	8,620	8,057
Inactive Pharmacists	93	230	197	118	96	139
Emeritus Pharmacists	594	564	393	117	98	159
Pharmacy Technicians	10,507	9,324	9,262	9,874	10,760	9,887
Pharmacy	1,980	2,091	1,980	1,996	2,176	2,062
Wholesalers	686	930	676	1,406	1,234	1,274
Manufacturers	986	998	791	790	614	533
3rd Party Logistics Providers	193	126	119	0	0	0
Medical Gas Dispensers	114	104	87	116	119	100
Controlled Substance Researchers	5	10	16	15	17	15
Interns	915	1,236	1,296	1,228	1,680	1,792
Preceptors	1,518	1,839	1,808	1,888	2,003	1,824
Prescription Monitoring Program Users	36,766	25,402	11,882**	21,427	21,536*	14,072
TOTAL	**63,954**	**52,208**	**37,819**	**47,886**	**48,953**	**39,914**

* Data up to 2016 includes inactive registrations. Starting in 2017, only active registrations are counted.
** Reflects a significant decrease in program users due to a data migration that occurred in 2019. Users were given 12 months to re-enroll; however, many did not re-enroll within that timeframe.

Historical Renewal Data by Biennium

July 1, 2022 – June 30, 2024

Type of License/Credential	Number of New Licenses	Number of Renewed Licenses	Number and Percent Renewed Online
Pharmacists	874	19,009	18,813 (99%)
Pharmacy Technicians	4,686	18,141	16,991 (93.7%)
Pharmacies	324	4,041	2005 (49.6%)*
Wholesalers	112	1,630	670 (40.0%)*
Manufacturers	268	1,974	981 (46.2%)*
Medical Gas Distributors	20	242	0**
Controlled Substance Researchers	5	17	0
3rd Party Logistics Providers*	44	222	0**
Interns	582	NA	NA
TOTAL	6,915	45,276	39,460 (87.2%)

*Percentage calculated from FY23 and FY24 totals, although online renewals were first made available in FY24.

**Online renewals for 3rd Party Logistics Providers and medical gas dispensers were first made available 9/1/2024 and 10/1/2024, respectively.

July 1, 2020 – June 30, 2022

Type of License/Credential	Number of New Licenses	Number of Renewed Licenses*	Number and Percent Renewed Online
Pharmacists	836	8518	8050 (94.5%)
Pharmacy Technicians	2931	6393	5243 (82%)
Pharmacies	386	1705	0
Wholesalers	247	683	0
Manufacturers	350	648	0
Medical Gas Distributors	41	63	0
Controlled Substance Researchers	2	8	0
3rd Party Logistics Providers	61	65	0
Interns	883	Not applicable	Not applicable
TOTAL	5,737	18,083	13,293 (73.5%)

*Board of Pharmacy licenses and registrations are renewed annually. These numbers are for FY 2022 only.

July 1, 2018 – June 30, 2020

Type of License/Credential	Number of New Licenses	Number of Renewed Licenses*	Number and Percent Renewed Online
Pharmacists	868	8,814	8330 (94.5%)
Pharmacy Technicians	3,606	7,912	6488 (82%)
Pharmacies	394	1,940	0
Wholesalers	441	691	0
Manufacturers	313	733	0
Medical Gas Distributors	26	86	0
Controlled Substance Researchers	1	15	0
3rd Party Logistics Providers	119	0	0
Interns	789	Not applicable	Not applicable
TOTAL	6,557	20,191	14,818 (73.4%)

*Board of Pharmacy licenses and registrations are renewed annually. These numbers are for FY 2020 only.

July 1, 2016 – June 30, 2018

Type of License/Credential	Number of New Licenses	Number of Renewed Licenses*	Number and Percent Renewed Online
Pharmacists	954	8,929	8,393 (94%)
Pharmacy Technicians	5,135	8,465	6,772 (80%)
Pharmacies	993	2,082	0
Wholesalers	962	1,667	0
Manufacturers	309	912	0
Medical Gas Distributors	13	116	0
Controlled Substance Researchers	0	15	0
Interns	880	Not applicable	Not applicable
TOTAL	9,246	22,186	15,165 (68.4%)

*Board of Pharmacy licenses and registrations are renewed annually. These numbers are for FY 2018 only.

July 1, 2014 – June 30, 2016

Type of License/Credential	Number of New Licenses	Number of Renewed Licenses*	Number and Percent Renewed Online
Pharmacists	1044	8581	7987 (93%)
Pharmacy Technicians	5041	8676	6845 (78%)
Pharmacies	511	2166	0
Wholesalers	269	1171	0
Manufacturers	201	592	0
Medical Gas Distributors	42	109	0
Controlled Substance Researchers	9	15	0
Interns	NA	NA	0
TOTAL	7117	21,310	17,063 (80%)

*Board of Pharmacy licenses and registrations are renewed annually. These numbers are for FY 2016 only.

July 1, 2012 – June 30, 2014

Type of License/Credential	Number of New Licenses	Number of Renewed Licenses*	Number and Percent Renewed Online
Pharmacists	869	8544	7177 (84%)
Pharmacy Technicians	4395	10,531	7582 (72%)
Pharmacies	NA	2331	0
Wholesalers	NA	1436	0
Manufacturers	NA	649	0
Medical Gas Distributors	NA	107	0
Controlled Substance Researchers	NA	19	0
Interns	NA	NA	0
TOTAL	NA	23,617	14,759 (63%)

*Board of Pharmacy licenses and registrations are renewed annually. These numbers are for FY 2014.

COMPLAINT ACTIVITY – MINN. STAT. 214.07, SUBDS. 1B(2), (3)

Complaints Received and Closed by Biennium

Biennium	Total Number of Complaints Received	Total Number of Complaints Closed
July 1, 2022 – June 30, 2024	368	400
July 1, 2020 – June 30, 2022	318	235
July 1, 2018 – June 30, 2020	262	255
July 1, 2016 – June 30, 2018	318	324
July 1, 2014 – June 30, 2016	410	423
July 1, 2012 – June 30, 2014	366	253

Number of and Age of Complaints Open at the End of the Period

Number of Complaints Open as of June 30, 2024	**114**
Complaints open less than one year as of June 30, 2024	50
Complaints open greater than one year as of June 30, 2024	64

Complaints open for over one year are either complicated cases that are still being investigated or cases for which the Board is engaged in the due process procedures required to take disciplinary action.

Types of Complaints by Biennium

Basis for complaints*	Number alleging this basis in 2022-2024	Number alleging this basis in 2020-2022	Number alleging this basis in 2018-2020	Number alleging this basis in 2016-2018
Billing Issues/Fraudulent Billing	2	0	0	5
Chemical Dependency/Diversion	22	39	33	29
Child Support	0	0	0	0
Dispensing Error	44	15	29	46
Dispensing Outdated Drugs	1	0	0	1
Dispensing Without Authorization	0	0	0	3
Failure to Counsel	1	0	0	2
Failure to Maintain Patient Confidentiality	0	0	5	4
Failure to Renew Registration on Time	0	0	0	0
Kickbacks	0	0	5	2
Other	7	6	3	29
Physical/Mental Impairment	1	1	1	1
Practicing without a license	15	10	10	23
Unprofessional Conduct	275	342	173	173
Welfare Fraud	0	0	0	0

*Some complaints allege more than one basis.

RECEIPTS, DISBURSEMENTS & MAJOR FEES – MINN. STAT §214.07, 1B(4)

Total Receipts and Disbursements by Biennium

Biennium	Total Receipts	Total Disbursements
July 1, 2022 – June 30, 2024	$9,077,179	$8,174,283
July 1, 2020 – June 30, 2022	$7,282,203	$6,968,858
July 1, 2018 – June 30, 2020	$6,531,899	$5,487,682
July 1, 2016 – June 30, 2018	$6,381,234	$6,367,383
July 1, 2014 – June 30, 2016	$5,525,140	$5,476,855
July 1, 2012 – June 30, 2014	$4,819,355	$4,605,139

Receipts and disbursements represented in this section are specific to general operations. Not included are federal grant funds received to support a portion of Prescription Monitoring Program costs and fees from opiate manufacturers that are collected and transferred into the Opiate Epidemic response account.

Fees by Type

Application fees	**Fee**
Pharmacist licensed by examination	$225
Pharmacist licensed by reciprocity	$300
Pharmacy intern	$75
Pharmacy technician	$60
Pharmacy	$450
Drug wholesaler - legend drugs only	$5,500
Drug wholesaler - legend and non-legend drugs	$5,500
Drug wholesaler - non-legend drugs, veterinary legend drugs, or both	$5,500
Drug wholesaler - medical gases	$5,500 for the first facility and $500 for each additional facility
Third-party logistics provider	$300
Drug manufacturer - non-opiate legend drugs only	$5,500
Drug manufacturer - non-opiate legend and non-legend drugs	$5,500
Drug manufacturer - non-legend or veterinary legend drugs	$5,500
Drug manufacturer - medical gases	$5,500 for the first facility and $500 for each additional facility
Drug manufacturer also licensed as a pharmacy in Minnesota	$5,500
Drug manufacturer of opiate-containing controlled substances	$55,500
Medical gas dispenser	$400
Controlled substance researcher	$150
Pharmacy professional corporation	$150

Annual renewal fees	Fee
Pharmacist	$225
Pharmacy technician	$60
Pharmacy	$450
Drug wholesaler - legend drugs only	$5,500
Drug wholesaler - legend and non-legend drugs	$5,500
Drug wholesaler - non-legend drugs, veterinary legend drugs, or both	$5,500
Drug wholesaler - medical gases	$5,500 for the first facility and $500 for each additional facility
Third-party logistics provider	$300
Drug manufacturer - non-opiate legend drugs only	$5,500
Drug manufacturer - non-opiate legend and non-legend drugs	$5,500
Drug manufacturer - non-legend or veterinary legend drugs	$5,500
Drug manufacturer - medical gases	$5,500 for the first facility and $500 for each additional facility
Drug manufacturer also licensed as a pharmacy in Minnesota	$5,500
Drug manufacturer of opiate-containing controlled substances	$55,500
Medical gas dispenser	$400
Controlled substance researcher	$150
Pharmacy professional corporation	$150

Late fees
All late fees are 50% of the original fee

BOARD OF PHYSICAL THERAPY

The mission of the Board of Physical Therapy is to ensure that Minnesota citizens receive appropriate physical therapy services from competent physical therapists and physical therapist assistants.

Report of the Executive Director

July 1, 2022 – June 30, 2024

The mission of the Board is to provide public protection by striving to ensure Minnesota citizens receive quality physical therapy services from competent physical therapists PT) and physical therapist assistants (PTA). Public protection through licensure and regulation underlies every activity and all functions of the Board. The major functions of the Board are to ensure that applicants meet the standards for licensure; ensure that licensees meet the standards for license renewal; identify licensees who fail to maintain minimum standards for the provision of safe and quality care, and, when warranted, provide appropriate disciplinary or corrective action; and provide information and education to the public.

The number of licensees and complexity of complaint cases and investigations have continued to steadily increase. New graduate applicants continue to test on four fixed dates each year, changing the workflow for staff and board members. The Board continues to develop a comprehensive database, which streamlines online processes for initial licensure, renewals and criminal background checks, jurisprudence exam and continuing education audits. We are committed to the advancement of offering better online services to licensees and the public with 99 percent of licensure applications and renewals completed online in this biennium.

Additional highlights for the past two years include continued investment and active participation with the Federation State Boards of Physical Therapy (FSBPT). The Minnesota Board of Physical Therapy was awarded the Excellence in Regulation Award. The Excellence in Regulation Award was created to recognize jurisdictions that have made significant accomplishments towards increasing public protection for their consumers of physical therapy services. Minnesota was recognized for our work in successful rules changes, implementation of the jurisprudence licensure process, website redesign to decrease the burden of a public complaint, using grant funding for a project to embrace technology and initiate automation between the FSBPT Electronic, Licensure Discipline Database (ELDD) platform and the Minnesota Board's ALIMS (automated licensure information management system).

The Board consistently provides high quality, customer focused, efficient, and cost-effective services. Board members and staff are to be commended for their exceptional dedication and hard work to meet the increasing demands while continuing to provide public protection and service excellence.

Erin DeTomaso
Executive Director
Minnesota Board of Physical Therapy
612-627-5406

GENERAL INFORMATION – MINN. STAT. §214.07, SUBD. 1B(5)

Board Members Serving During the Period 7/1/2022 – 6/30/2024

Name	Location	Appointment Status	Appointment Date	Reappointment Date	Term Expiration Date
Sara Conrad, PTA	Minneapolis	Professional Member	4/2/2020	2/22/2023	1/4/2027
Linda Gustafson, PT	Minnetonka	Professional Member	3/5/2009	6/20/2011; 6/24/2015; 7/3/2019	1/2/2023
Maura Kelly, PT	Maple Grove	Professional Member	2/22/2023	1/17/2024	1/3/2028
Julia McDonald, PTA	Otsego	Professional Member	3/26/2014	6/18/2018 7/5/2022	1/5/2026
Samantha Mohn-Johnsen, PT	Duluth	Professional Member	6/24/2015	7/3/2019 2/22/2023	1/4/2027
Debra Newel	St. Paul	Public Member	10/19/2009	6/20/2011; 6/24/2015	1/7/2023
Pamela Peters	Savage	Public Member	5/5/2021	2/22/2023	1/4/2027
Kathy Polhamus	North St. Paul	Public Member	9/4/2007	5/5/2010; 3/26/2014; 6/18/2018 7/5/2022	1/5/2026
Allen Rasmussen	International Falls	Public Member	5/5/2021	2/22/2023	1/4/2027
Steven Scherger, PT	Andover	Professional Member	6/24/2015	7/3/2019 2/22/2023	1/4/2027
Debra Sellheim, PT	Maplewood	Professional Member	5/5/2010	3/26/2014; 6/18/2018	9/3/2022
Neel Shah, MD	Rochester	Professional Member	6/24/2017	5/5/2021	1/6/2025
Tanya Terman, PT	Rochester	Professional Member	5/5/2021	NA	1/6/2025
Adam Urick, PT	Eagan	Professional Member	10/1/2022	NA	1/5/2026

Board Staff and Office Location

The Board has four (4) full time staff:

- Executive Director
- Office Specialist
- Office Administrative and Licensing Specialist
- Administrative Support Staff

Minnesota Board of Physical Therapy
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CREDENTIALS ISSUED OR RENEWED – MINN. STAT. §214.07, SUBD. 1B(1)

Total Number of persons licensed or registered as of June 30, 2024: 8,360

Number and Type of Credentials Issued or Renewed

License Type	Licensed or registered as of June 30, 2024	Licensed or registered as of June 30, 2022	Licensed or registered as of June 30, 2020	Licensed or registered as of June 30, 2018	Licensed or registered as of June 30, 2016	Licensed or registered as of June 30, 2014
Physical Therapist	6,585	6,238	5,915	5,613	5,145	4,715
Physical Therapist Assistant	1,775	1,660	1,850	1,824	1,698	1,585
TOTAL	8,360	7,898	7,765	7,437	6,843	6,300

Historical Renewal Data by Biennium

July 1, 2022 – June 30, 2024

Type of License/Credential	Number of New Licenses	Number of Renewed Licenses	Percent Renewed Online
Physical Therapist	847	12,538	see total
Physical Therapist Assistant	205	3,499	see total
TOTAL	1,052	16,037	99%

July 1, 2020 – June 30, 2022

Type of License/Credential	Number of New Licenses	Number of Renewed Licenses	Percent Renewed Online
Physical Therapist	862	11,797	see total
Physical Therapist Assistant	236	3,532	see total
TOTAL	1,098	15,329	99%

July 1, 2018 – June 30, 2020

Type of License/Credential	Number of New Licenses	Number of Renewed Licenses	Percent Renewed Online
Physical Therapist	792	11,590	see total
Physical Therapist Assistant	237	3,712	see total
TOTAL	1,029	15,302	99%

July 1, 2016 – June 30, 2018

Type of License/Credential	Number of New Licenses	Number of Renewed Licenses	Percent Renewed Online
Physical Therapist	872	11,472	see total
Physical Therapist Assistant	285	3,815	see total
TOTAL	1,157	15,287	98.8%

July 1, 2014 – June 30, 2016

Type of License/Credential	Number of New Licenses	Number of Renewed Licenses	Percent Renewed Online
Physical Therapist	747	9772	see total
Physical Therapist Assistant	251	3265	see total
TOTAL	998	13,037	94%

July 1, 2012 – June 30, 2014

Type of License/Credential	Number of New Licenses	Number of Renewed Licenses	Percent Renewed Online
Physical Therapist	655	NA	NA
Physical Therapist Assistant	242	NA	NA
TOTAL	897	12,417	NA

COMPLAINT ACTIVITY – MINN. STAT. §214.07, SUBDS. 1B(2), (3)

Complaints Received and Closed by Biennium

Biennium	Total Number of Complaints Received	Total Number of Complaints Closed
July 1, 2022 – June 30, 2024	79	67
July 1, 2020 – June 30, 2022	85	90
July 1, 2018 – June 30, 2020	70	61
July 1, 2016 – June 30, 2018	92	85
July 1, 2014 – June 30, 2016	101	88
July 1, 2012 – June 30, 2014	80	77

Number of and Age of Complaints Open at the End of the Period

Number of Complaints Open as of June 30, 2024	**2**
Complaints open less than one year as of June 30, 2024	2
Complaints open greater than one year as of June 30, 2024	0

Types of Complaints Received by Biennium

Basis of complaints*	Number alleging this basis in 2022-2024	Number alleging this basis in 2020-2022	Number alleging this basis in 2018-2020	Number alleging this basis in 2016-2018
Actions by another jurisdiction	1	2	1	2
Incompetency / unethical conduct	5	6	10	15
Unprofessional conduct	36	33	16	11
Impairment (Including Conviction of DUI/DWI/OUI/OWI)	17	18	15	24
Protected Terms	3	7	4	10
Failure to comply with CE requirement	0	1	0	3
Conviction of a felony/fraud element	18	15	4	12
Practice after license expired	11	15	7	8
Sexual misconduct/boundaries	5	11	5	2
Miscellaneous	4	9	8	3

*Some complaints allege more than one basis.

RECEIPTS, DISBURSEMENTS & MAJOR FEES – MINN. STAT §214.07, 1B(4)

Total Receipts and Disbursements by Biennium

Biennium	Total Receipts	Total Disbursements
July 1, 2022 – June 30, 2024	$1,653,734	$1,384,114
July 1, 2020 – June 30, 2022	$1,570,643	$913,202
July 1, 2018 – June 30, 2020	$1,412,839	$960,628
July 1, 2016 – June 30, 2018	$1,353,929	$867,222
July 1, 2014 – June 30, 2016	$1,230,305	$973,881
July 1, 2012 – June 30, 2014	$1,095,715	$880,670

Fees by Type

Type of fee	Fee
PT and PTA Annual License Renewal	$60.00
PT and PTA Late Fee for Annual Renewal	$20.00
PT and PTA Initial Application	$100.00
PT and PTA Examination	$50.00
PT and PTA Temporary Permit Fee	$25.00
PT and PTA Duplicate License	$20.00
PT and PTA Certification of Licensure	$25.00
Continuing Education Course Review	$100.00

BOARD OF PODIATRIC MEDICINE

The mission of the Board of Podiatric Medicine is to protect the public by extending the privilege to practice to qualified applicants and investigating complaints relating to the competency or behavior of individual licensees or registrants.

Report of the Executive Director

July 1, 2022—June 30, 2024

There are currently 309 licensed Doctors of Podiatric Medicine (DPM) in Minnesota, which includes 22 temporary permits. Temporary permits are issued to DPMs participating in one of the four Minnesota residency programs being offered. Increasingly, a number of our new licensees complete their residency program in Minnesota and choose to practice here afterward.

The Board received new administrative responsibilities from the legislature for licensure of the following professions in 2018 - prosthetists, orthotists, pedorthists, prosthetist orthotists, assistants, and fitters. Currently there are 123 prosthetist orthotists, 23 prosthetists, 84 orthotists, 42 pedorthists, 18 fitters, 15 orthotist assistants and 6 prosthetist assistants licensed by our Board.

COVID-19 presented the Board with many unique challenges, but our offices have transitioned to normal operations. The Board encourages its licensees to know and comply with their own facility's specific protocols, policies and procedures that have been developed in response to the COVID 19 pandemic.

From 2020 to 2022, the Board experienced a reduction in the number of total licensees across all professions due to many licensees choosing to retire or leave the workforce during the COVID-19 pandemic. The rate of new applications has returned to normal, and the number of active licensees has recovered to pre-pandemic levels.

DPM Licenses expired on June 30th, so extensions were provided for licensees that were unable to complete their CME's due to travel restrictions or illness.

We are always committed to the advancement of offering more and better online services to licensees and the public. The Board completed 2,214 license verifications in FY23/FY24, with 100% of them completed online.

The Board members continue to provide high quality, efficient, customer-focused, and cost-effective services. They are to be commended for their exceptional dedication, time commitment, and hard work that is required to serve on a State Board.

Paul D.R. Bakken
Executive Director
Board of Podiatric Medicine
paul.d.r.bakken@state.mn.us

GENERAL INFORMATION – MINN. STAT. §214.07, SUBD. 1B(5)

Board Members Serving During the Period 7/1/2022 – 6/30/2024

Name	Location	Appointment Status	Appointment Date	Reappointment Date	Term Expiration Date
Nicole Bauerly, DPM	Brooklyn Park	DPM	10/29/2012	6/23/2021	1/6/2025
Kimberly Bobbitt, DPM	St. Paul	DPM	4/13/2015	5/31/2023	6/4/2027
Lois McCray	Oakdale	Public	7/5/2022	NA	1/5/2026
Ryan Peterson	Minneapolis	Public	6/23/2021	NA	1/6/2025
Jackie Pham, DPM	Savage	DPM	6/29/2020	NA	1/1/2024
Naomi Schmid, DPM	Fergus Falls	DPM	7/1/2018	6/5/2022	1/5/2026
Allison Willkom, DPM	Minneapolis	DPM	5/31/2023	NA	1/4/2027

Board Staff and Office Location

Paul D.R. Bakken, Executive Director

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Randolph Square Building
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Email: podiatric.medicine@state.mn.us
Website: https://mn.gov/boards/podiatric-medicine/

CREDENTIALS ISSUED OR RENEWED – MINN. STAT. §214.07, SUBD. 1B(1)

Total Number of persons licensed or registered as of June 30, 2024: 620

Number and Type of Credential Issued or Renewed

License Type	Licensed or registered as of June 30, 2024	Licensed or registered as of June 30, 2022	Licensed or registered as of June 30, 2020	Licensed or registered as of June 30, 2018	Licensed or registered as of June 30, 2016	Licensed or registered as of June 30, 2014
DPM—Doctor of Podiatric Medicine	287	276	270	254	246	238
DPM Temporary Permits	22	23	20	18	17	21
Orthotists	84	84	105	97	NA	NA
Prosthetists	23	27	39	35	NA	NA
Prosthetist Orthotists	123	101	98	73	NA	NA
Pedorthists	42	42	49	49	NA	NA
Fitters	18	19	29	26	NA	NA
Prosthetist Assistants	6	6	5	4	NA	NA
Orthotist Assistants	15	10	9	9	NA	NA
TOTAL	620	588	624	565	263	259

Historical Renewal Data by Biennium

Temporary permits are the only credential renewed on an annual basis. All other licenses are renewed every two years.

July 1, 2022 – June 30, 2024

Type of License/Credential	Number of New Licenses	Number of Renewed Licenses	Number and Percent Renewed Online
DPM – Doctor of Podiatric Medicine	41	246	245 (99%)
DPM Temporary Permits	22	21	21 (100%)
Orthotists	10	74	74 (100%)
Prosthetists	1	22	22 (100%)
Prosthetist Orthotists	31	92	92 (100%)
Pedorthists	5	37	37 (100%)
Fitters	8	10	10 (100%)
Prosthetist Assistants	1	5	5 (100%)
Orthotist Assistants	7	8	8 (100%)
TOTAL	126	515	514 (99%)

July 1, 2020 – June 30, 2022

Type of License/Credential	Number of New Licenses	Number of Renewed Licenses	Number and Percent Renewed Online
DPM – Doctor of Podiatric Medicine	25	227	225 (99%)
DPM Temporary Permits	23	18	0 (0%)
Orthotists	6	69	65 (94%)
Prosthetists	3	20	20 (100%)
Prosthetist Orthotists	24	69	67 (97%)
Pedorthists	2	33	32 (97%)
Fitters	5	5	5 (100%)
Prosthetist Assistants	2	4	4 (100%)
Orthotist Assistants	2	4	4 (100%)
TOTAL	92	449	422 (94%)

July 1, 2018 – June 30, 2020

Type of License/Credential	Number of New Licenses	Number of Renewed Licenses	Number and Percent Renewed Online
DPM – Doctor of Podiatric Medicine	38	249	198 (80%)
DPM Temporary Permits	28	43	0 (0%)
Orthotists	8	85	59 (70%)
Prosthetists	5	26	22 (85%)
Prosthetist Orthotists	27	80	60 (75%)
Pedorthists	6	48	28 (58%)
Fitters	12	25	12 (48%)
Prosthetist Assistants	2	6	5 (83%)
Orthotist Assistants	3	10	4 (40%)
TOTAL	129	572	388 (68%)

July 1, 2016 – June 30, 2018

Type of License/Credential	Number of New Licenses	Number of Renewed Licenses	Number and Percent Renewed Online
DPM – Doctor of Podiatric Medicine	26	242	87 (36%)
DPM Temporary Permits	14	18	8 (45%)
Orthotists	97	NA	NA
Prosthetists	35	NA	NA
Prosthetist Orthotists	73	NA	NA
Pedorthists	49	NA	NA
Fitters	26	NA	NA
Prosthetist Assistants	4	NA	NA
Orthotist Assistants	9	NA	NA
TOTAL	333	260	95 (37%)

July 1, 2014 – June 30, 2016

Type of License/Credential	Number of New Licenses	Number of Renewed Licenses	Number and Percent Renewed Online*
DPM – Doctor of Podiatric Medicine	21	239	50 (21%)
DPM Temporary Permits	14	20	7 (35%)
TOTAL	35	259	57 (22%)

*FY16 was the first year that online renewals were available.

July 1, 2012 – June 30, 2014

Type of License/Credential	Number of New Licenses	Number of Renewed Licenses	Number and Percent Renewed Online
DPM – Doctor of Podiatric Medicine	29	231	not available
Temporary Permits	16	20	not available
TOTAL	45	251	not available

COMPLAINT ACTIVITY – MINN. STAT. §214.07, SUBDS. 1B(2), (3)

Complaints Received and Closed by Biennium

Biennium	Total Number of Complaints Received	Total Number of Complaints Closed
July 1, 2022 – June 30, 2024	19	22
July 1, 2020 – June 30, 2022	13	14
July 1, 2018 – June 30, 2020	21	18
July 1, 2016 – June 30, 2018	11	12
July 1, 2014 – June 30, 2016	10	6
July 1, 2012 – June 30, 2014	13	30

Number of and Age of Complaints Open at the End of the Period

Number of Complaints Open as of June 30, 2024	**6**
Complaints open less than one year as of June 30, 2024	6
Complaints open greater than one year as of June 30, 2024	0

Types of Complaints Received by Biennium

Basis for Complaint*	Number alleging this basis in 2022-2024	Number alleging this basis in 2020-2022	Number alleging this basis in 2018-2020	Number alleging this basis in 2016-2018
153.19 (7) (11) (12) (14) (16)	11	12	9	6
Violation of Professional Firms Act	0	0	0	1
153B.70 (8) (9)	0	0	7	0
Malpractice Reports	7	1	4	3
Billing Issue	1	0	1	1

*Some complaints may allege more than one basis.

RECEIPTS, DISBURSEMENTS & MAJOR FEES – MINN. STAT §214.07, 1B(4)

Total Receipts and Disbursements by Biennium

Biennium	Total Receipts	Total Disbursements
July 1, 2022 – June 30, 2024	$ 426,313	$ 434,529
July 1, 2020 – June 30, 2022	$ 418,674	$ 245,380
July 1, 2018 – June 30, 2020	$ 402,710	$ 266,900
July 1, 2016 – June 30, 2018	$ 380,486	$ 230,626
July 1, 2014 – June 30, 2016	$ 222,170	$ 186,535
July 1, 2012 – June 30, 2014	$ 207,640	$ 181,393

Fees by Type

Type of fee	Fee
License Application	$ 600
License Renewal	$ 600
Temporary Permit - Annual	$ 250
Reinstatement	$ 650
License Verification	$ 30
Professional Firms – Annual	$ 25
Miscellaneous	$ 25
2nd License	$ 100

BOARD OF PSYCHOLOGY

The mission of the Board of Psychology is to protect the public through licensure, regulation, and education to promote access to safe, competent, and ethical psychology service.

Report of the Executive Director

July 1, 2022 – June 30, 2024

The Board focused on fulfilling its mission to "protect the public through licensure, regulation, and education to promote access to safe, competent, and ethical psychological services" in a fiscally responsible manner. The Board continues to focus on technology to streamline licensing and complaint review processes. The Board continued to refine online services for all applications and agency processes. During the last biennium, more than 98% of licensees renewed their license online and almost 100% of initial license applications are completed online, reducing the need for storage space, paper usage, and resources spent scanning and disposing of documents.

The Board meets ten times per year. On alternating months, one of the Board's two Complaint Resolution Committees meets to manage complaints, investigations, and discipline with the assistance of staff and the Attorney General's Office. The Board began the biennium meeting in an online format for both Board meetings and committee meetings. Mid-point of the biennium, the Board continued to offer a hybrid meeting format with an increase of in-person attendance. The opportunity for in-person attendance augmented by online meetings helped the Board continue to meet its duties to the community regarding licensing, regulating, and educating licensees and the public.

The Board has eliminated Board fees charged to applicants who retake required licensing examinations. It also initiated a program to help support applicants to the Board having trouble passing the national licensing exam. The Board is also granting additional time to applicants who do not speak English as their first language.

In the context of providing services to the public in an online and hybrid format, the Board engaged stakeholders and the public through its outreach programs including continuing education conferences, presentations to the public, as well as presentations to psychology programs in Minnesota.

As the Board advances public protection through licensure, regulation, and education for the benefit of the public, we invite you to join us by sharing feedback, attending a meeting, or participating in our open public processes as we work to make access to safe, competent, and ethical psychological services a reality for all Minnesota citizens.

Samuel S. Sands
Executive Director
Minnesota Board of Psychology
612-548-2100

GENERAL INFORMATION – MINN. STAT. §214.07, SUBD. 1B(5)

Board Members Serving During the Period 7/1/2022 – 6/30/2024

Name	Location	Appointment Status	Appointment Date	Reappointment Date	Term Expiration Date
Nancy Cameron	Minneapolis	Public Member	6/6/2021	5/9/2023	1/4/2027
Jill Idrizow	Stillwater	Public Member	3/6/2018	1/3/2022	1/3/2026
Michelle Zhao, J.D.	Minneapolis	Public Member	6/16/2021	NA	1/6/2025
Daniel Hurley, Ph.D., LP	St. Paul	Training Program Member	2/28/2024	NA	1/3/2028
Salina Renninger, Ph.D., LP	Falcon Heights	Training Program Member	3/6/2018	1/3/2022	1/3/2026
Joel Bakken, MS, LP	Moorhead	Master's Member	4/2/2020	5/10/2023	1/4/2027
Pamela Freske, Ph.D., LP	St. Paul	Doctoral Member	2/28/2024	NA	1/3/2028
Cesar Gonzalez PhD, LP, ABPP	Rochester	Doctoral Member	6/30/2022	NA	1/3/2026
Sonal Markanda, Ph.D., LP	Minneapolis	Doctoral Member	5/6/2020	2/28/2024	1/3/2028
Sebastian Rilen, Psy.D., LP	St. Paul	Doctoral Member	5/10/2023	NA	1/4/2027
Michael Thompson Psy.D., LP		Doctoral Member	5/10/2023	NA	1/4/2027
Michael Brunner, Ph.D., LP (inactive)	St. Paul	Doctoral Member	3/6/2018	7/2/2019	1/7/2023
Jessica Gourneau, Ph.D., LP (inactive)	St. Paul	Doctoral Member	3/28/2017	7/2/2019	1/2/2023
Jack Rusinoff, MA, LP (inactive)	St. Paul	Masters Member	6/28/2016	4/2/2020	1/1/2024
Robin McLeod, Ph.D., LP (inactive)	Woodbury	Training Program Member	3/28/2017	4/2/2020	1/1/2024

Board Staff and Office Location

The Board is supported by 8 full-time staff:

- Executive Director
- Assistant Executive Director
- Compliance Director, Investigator Senior
- Investigator
- Continuing Education and Renewals Administrator
- Licensure Lead
- Licensure Specialist
- Front Desk Support Specialist

Minnesota Board of Psychology
Randolph Square Building
335 Randolph Avenue, Suite 270
St. Paul, MN 55102
Phone: 612-617-2230
Email: psychology.board@state.mn.us
Website: https://mn.gov/boards/psychology/

CREDENTIALS ISSUED OR RENEWED – MINN. STAT. §214.07, SUBD. 1B(1)

Total Number of persons licensed or registered as of June 30, 2024: 3,676

Number and Type of Credentials Issued or Renewed

License Type	Licensed or registered as of June 30, 2024	Licensed or registered as of June 30, 2022	Licensed or registered as of June 30, 2020	Licensed or registered as of June 30, 2018	Licensed or registered as of June 30, 2016	Licensed or registered as of June 30, 2014
Psychologist	3,676	3,597	3,754	3,783	3,835	3,768
TOTAL	**3,676**	**3,597**	**3,754**	**3,783**	**3,835**	**3,768**

Historical Renewal Data by Biennium

July 1, 2022 – June 30, 2024

Type of License/Credential	Number of New Licenses	Number of Renewed Licenses	Number and Percent Renewed Online
Psychologist	309	3356	3,346 (98%)
TOTAL	309	3356	

July 1, 2020 – June 30, 2022

Type of License/Credential	Number of New Licenses	Number of Renewed Licenses	Number and Percent Renewed Online
Psychologist	293	3,407	3,391 (99%)
TOTAL	293	3,407	

July 1, 2018 – June 30, 2020

Type of License/Credential	Number of New Licenses	Number of Renewed Licenses	Number and Percent Renewed Online
Psychologist	288	3,453	3,389 (98%)
TOTAL	288	3,453	

July 1, 2016 – June 30, 2018

Type of License/Credential	Number of New Licenses	Number of Renewed Licenses	Number and Percent Renewed Online
Psychologist	265	3,364	3248 (97%)
TOTAL	265	3,364	

July 1, 2014 – June 30, 2016

Type of License/Credential	Number of New Licenses	Number of Renewed Licenses	Number and Percent Renewed Online
Psychologist	233	3,564	1537 (*67%)
TOTAL	233	3,564	

*Online renewals did not start until July 1, 2015

July 1, 2012 – June 30, 2014

Type of License/Credential	Number of New Licenses	Number of Renewed Licenses	Number and Percent Renewed Online
Psychologist	272	3595	0
TOTAL	272	3595	0

COMPLAINT ACTIVITY – MINN. STAT. §214.07, SUBDS. 1B(2), (3)

Complaints Received and Closed by Biennium

Biennium	Total Number of Complaints Received	Total Number of Complaints Closed
July 1, 2022 – June 30, 2024	207	136
July 1, 2020 – June 30, 2022	331	303
July 1, 2018 – June 30, 2020	271	251
July 1, 2016 – June 30, 2018	296	306
July 1, 2014 – June 30, 2016	444	308
July 1, 2012 – June 30, 2014	249	208

Number of and Age of Complaints Open at the End of the Period

Number of Complaints Open as of June 30, 2024	**86**
Complaints open less than one year as of June 30, 2024	70
Complaints open greater than one year as of June 30, 2024	16

Types of Complaints Received by Biennium

Basis for Complaint*	Number alleging this basis in 2022-2024	Number alleging this basis in 2020-2022	Number alleging this basis in 2018-2020	Number alleging this basis in 2016-2018
Engaged in unprofessional conduct	160	202	186	186
Failure to limit practice areas to areas of competence	20	14	29	37
Conclusions and reports violations including failure to base assessments on procedures sufficient to substantiate conclusions, to include information required in a report, to properly administer and/or interpret psychological reports	38	55	49	42
Violated a statute or rule, or order the board is empowered to enforce relating to the practice of psychology including reporting the abuse of minors/vulnerable adults, professional firms, CE audit, discipline in another jurisdiction, licensure and renewal	207	190	203	38
Exploited the professional relationship with a current client	4	15	14	9
Provided psychological services while in a multiple relationship	6	3	15	13
Engaged in conduct likely to deceive or defraud the public or the board including public statements of a false or misleading nature or misrepresenting the nature of services	7	9	71	53
Failure to safeguard private client information	11	10	14	20
Failure to properly maintain and provide access to client records including failure to provide the client bill of rights and failure to obtain informed consent	7	25	25	33
Failure to provide qualifying supervision or failure to practice psychology under qualifying supervision	6	3	4	42

Basis for Complaint (continued)	Number alleging this basis in 2022-2024	Number alleging this basis in 2020-2022	Number alleging this basis in 2018-2020	Number alleging this basis in 2016-2018
Engaged in misconduct with a supervisee including exploitation or misuse of the professional relationship, sexual behavior, or failure to protect the welfare of a supervisee	6	1	5	8
Provided psychological services with impaired objectivity or bias	23	15	29	19
Engaged in the practice of psychology without a license	4	9	6	29
Engaged in sexual behavior with a client or former client (reasonably interpreted or sexual contact)	10	14	19	13
Inability to offer psychological services with reasonable skill and safety due to a mental or physical impairment	4	20	22	14
Other (failure to make clear the prescriber, failure to coordinate care, failure to resolve organizational conflicts, failure to terminate a client in a manner that minimizes harm)	1	50	77	11

*Some complaints allege more than one basis.

RECEIPTS, DISBURSEMENTS & MAJOR FEES – MINN. STAT §214.07, 1B(4)

Total Receipts and Disbursements by Biennium

Biennium	Total Receipts	Total Disbursements
July 1, 2022 – June 30, 2024	$2,201,575	$2,221,101
July 1, 2020 – June 30, 2022	$2,248,466	$2,339,780
July 1, 2018 – June 30, 2020	$2,295,585	$1,777,977
July 1, 2016 – June 30, 2018	$2,325,992	$2,153,429
July 1, 2014 – June 30, 2016	$2,333,818	$1,578,771
July 1, 2012 – June 30, 2014	$2,228,169	$1,589,309

Fees by Type

Type of Fee	Fee
Licensed Psychologist Renewal	$500
Licensed Psychologist Renewal Late Fee	$250
Professional Responsibility Examination	$150
Examination for the Professional Practice of Psychology	$150
Licensed Psychologist for Licensure	$500
Convert Master's to Doctoral LP Licensure	$150
Guest Licensure	$150
Verification of Licensure	$20
Professional Firm — Registration	$100
Professional Firm — Annual Report	$25
Pre-Approval of supervisor	$50
Continuing Education Sponsor	$80
Emeritus Registration	$150
Licensed Psychologist Re-licensure	$500

BOARD OF SOCIAL WORK

The mission of the Minnesota Board of Social Work is protecting the public through licensing and regulation of the social work profession.

Report of the Executive Director

July 1, 2022 – June 30, 2024

The Board of Social Work's public safety mission creates the foundation for the Board's work. Fifteen volunteer Board Members, including five public members, provide oversight to make certain we meet the needs of all citizens and promote a diverse, inclusive, and qualified workforce. Currently, the Board has a staff of 13.6 FTEs serving over 18,000 licensees, and providing services daily to citizens, licensees, applicants, employers, educators, and others. The demand for our services has grown due to significant increases in the number of applicants, licensees, and complaints. Core services provided include: 1) licensing qualified social workers; 2) investigating and resolving complaints when services do not meet standards; and 3) providing outreach and education.

The following priorities serve to highlight results and current initiatives:

- The BOSW Board and Staff continues its commitment to diversity, equity, inclusion and belonging (DEIB) in our work as regulators, demonstrated by active training and utilizing the DEIB mission and value statement in consideration for change. The Board sponsored several DEIB trainings for Board Members and staff. The Board utilized the DEIB framework to guide discussion regarding policy changes and the impact on social workers and the community it serves.
- In the 2024 legislative session, BOSW sponsored two licensing legislations, and both successfully passed. One legislation is to join the Social Work Interstate Compact. BOSW will be part of the new established compact commission and will start to integrate the compact requirements in preparation for implementation and issuing multistate license. The second legislation was recodification of the provisional license statute. Changes to the provisional license creates a pathway for all individuals with a social work education to obtain a social work license without the national exam. The Board successfully implemented the legislative changes and continues to accept provisional applications.
- The BOSW implemented the Jurisprudence Online Learning Module. It is designed to provide licensed social workers the opportunity to be informed about social work licensing requirements and the Board's standards of practice. Licensees can earn one hour of independent learning continuing education with a passing score. In addition, BOSW upgraded ALIMS license database to improve the functionality for applicants and licensees accessing online services.

Thanks to Board Members for their countless hours of volunteer service, expertise, leadership, and passion, and to our extremely competent Board Staff, who are committed to carrying out the Board's mission of protecting the public and serving the residents of Minnesota.

Youa Yang, LICSW
Executive Director
Minnesota Board of Social Work
612-617-2110

GENERAL INFORMATION – MINN. STAT. §214.07, SUBD. 1B(5)

Board Members Serving During the Period 7/1/2022 – 6/30/2024

Name	Location	Appointment Status	Appointment Date	Reappointment Date	Term Expiration Date
Christopher Anderson	Elbow Lake	Public Member	6/2021	NA	1/2025
Thomas Brooks	Brooklyn Park	Public Member	11/2016	7/2019	1/2027
Angie DeLille, LICSW	Minneapolis	Professional Member	4/2008	6/2011, 6/2015, 7/2019, 1/2023	1/2027
Dieu Do	St. Paul	Public Member	6/2021	NA	1/2025
Katherine Driskell, LICSW	Rochester	Professional Member	6/2024	NA	1/2025
Jolene Engelking, LISW	Minnetonka	Professional Member	7/2018	6/2021	1/2025
Donna Ennis, LSW	Superior, WI	Professional Member	6/2013	6/2017, 6/2021	10/2023
Kate Goodman, LGSW	Minneapolis	Professional Member	1/2020	6/2024	1/2027
Linda Gustafson	Minnetonka	Public Member	3/2023	NA	1/2027
Heidi Holmes, LGSW	Mankato	Professional Member	6/2021	NA	1/2025
Stephanie Jacobson, LSW	Richfield	Professional Member	7/2018	6/2021	1/2025
Joanne Kronstedt	Duluth	Public Member	6/2024	NA	1/2025
Kenneth Middlebrooks	Plymouth	Public Member	7/2003	8/2007, 6/2011, 6/2015, 7/2019	1/2023
Martera Nelson, LSW	Red Lake	Professional Member	6/2022	NA	1/2026
Yolonda Rogers, LICSW	Plymouth	Professional Member	6/2022	NA	1/2026
Lori Thompson, LSW	Brainerd	Professional Member	6/2016	6/2020, 6/2024	8/2024
Pa Der Vang, LICSW	Maplewood	Professional Member	7/2018	6/2020, 6/2024	1/2027
Mary Weaver	Underwood	Public Member	10/2014	6/2017, 6/2021	12/2023

Board Staff and Office Location

The Board of Social Work has 13.6 employees and provides the services in licensing social workers, investigating and resolving complaints, outreach and education services.

Administration:

1 Executive Director

Licensing:

1 Assistant Director
1 Licensing Coordinator
1 Licensing Application Coordinator
2 Licensing Specialists

Compliance Unit:

1 Compliance Manager
1 Compliance Investigator
1 Compliance Coordinator

Operations:

1 Office Manager
1 Customer Service Representative
1.6 Administrative Specialist

Communication:

1 Communication and Executive Services Coordinator

Minnesota Board of Social Work
335 Randolph Avenue, Suite 245
Phone: 612-617-2100
Fax: 651-215-0956
Email: social.work@state.mn.us
Website: https://mn.gov/boards/social-work/

CREDENTIALS ISSUED OR RENEWED – MINN. STAT. §214.07, SUBD. 1B(1)

Total Number of persons licensed or registered as of June 30, 2024: 18,178

Number and Type of Credentials Issued or Renewed

License Type	Licensed as of June 30, 2024	Licensed as of June 30, 2022	Licensed as of June 30, 2020	Licensed as of June 30, 2018	Licensed as of June 30, 2016	Licensed as of June 30, 2014
Licensed Social Worker (LSW)	5,553	5,797	5,989	6,192	6,110	5,814
Licensed Graduate Social Worker (LGSW)	3,506	3,245	2,934	2,747	2,339	2,000
Licensed Independent Social Worker (LISW)	644	686	732	766	782	787
Licensed Independent Clinical Social Worker (LICSW)	8,475	7,353	6,279	5,661	5,198	4,746
TOTAL	18,178	17,081	15,934	15,366	14,429	13,347

Historical Renewal Data by Biennium

July 1, 2022 – June 30, 2024

Type of License	Number of New Licenses	Number of Renewed Licenses	Number and Percent Renewed Online
LSW	725	4546	4417 (97%)
LGSW	1576	2546	2510 (99%)
LISW	24	483	461 (95%)
LICSW	1538	6723	6598 (98%)
TOTAL	3863	14298	13986 (98%)

July 1, 2020 – June 30, 2022

Type of License	Number of New Licenses	Number of Renewed Licenses	Number and Percent Renewed Online
LSW	753	4964	4718 (95%)
LGSW	1476	2433	2355 (97%)
LISW	44	546	517 (95%)
LICSW	1377	5917	5684 (96%)
TOTAL	3650	13860	13274 (96%)

July 1, 2018 – June 30, 2020

Type of License	Number of New Licenses	Number of Renewed Licenses	Number and Percent Renewed Online
LSW	724	5060	4547 (90%)
LGSW	1178	2341	2157 (92%)
LISW	49	560	510 (91%)
LICSW	906	5113	4706 (92%)
TOTAL	2857	13,074	11,920 (91%)

July 1, 2016 – June 30, 2018

Type of License	Number of New Licenses	Number of Renewed Licenses	Number and Percent Renewed Online
LSW	973	4927	4399 (89%)
LGSW	1260	1978	1787 (90%)
LISW	47	566	493 (87%)
LICSW	746	4607	4196 (91%)
TOTAL	3026	12,078	10,875 (90%)

July 1, 2014 – June 30, 2016

Type of License	Number of New Licenses	Number of Renewed Licenses	Number and Percent Renewed Online*
LSW	1164	4643	-
LGSW	1143	1643	-
LISW	85	591	-
LICSW	693	4243	-
TOTAL	3085	11,120	9674 (87%)

*Data by license type unavailable for this period

July 1, 2012 – June 30, 2014

Type of License	Number of New Licenses	Number of Renewed Licenses	Number and Percent Renewed Online*
LSW	920	4443	-
LGSW	971	1337	-
LISW	89	577	-
LICSW	529	3926	-
TOTAL	2509	10,283	8124 (79%)

*Data by license type unavailable for this period

COMPLAINT ACTIVITY – MINN. STAT. §214.07, SUBD. 1B(2), (3)

Complaints Received and Closed by Biennium

Biennium	Total Number of Complaints Received	Total Number of Complaints Closed
July 1, 2022 – June 30, 2024	900	1187
July 1, 2020 – June 30, 2022	821	767
July 1, 2018 – June 30, 2020	575	395
July 1, 2016 – June 30, 2018	773	737
July 1, 2014 – June 30, 2016	775	673
July 1, 2012 – June 30, 2014	298	339

Number of and Age of Complaints Open at the End of the Period

Total Number of Complaints Open as of June 30, 2024	**139**
Complaints open less than one year as of June 30, 2024	91
Complaints open greater than one year as of June 30, 2024	48

Types of Complaints Received by Biennium

Basis for Complaints*	Number alleging this basis in 2022-2024	Number alleging this basis in 2020-2022	Number alleging this basis in 2018-2020
Boundaries	87	84	73
Competence/Harmful Conduct	85	94	37
Confidentiality	69	39	42
Criminal Conviction	21	27	52
Failure to Report	25	10	10
Fee/Payment Issue/Fraudulent Billing	17	23	15
Fraudulent Application	2	0	0
Human Services/Revenue Violation	1	0	6
Impairment	85	98	82
Improper Termination	16	8	10
Non-compliance with Licensing Requirements	119	143	56
Non-Jurisdictional	275	NA	NA
Other	70	150	92
Recordkeeping	21	28	23
Sexual Conduct or Harassment	37	24	19
Unlicensed Practice/Misrepresentation	89	81	59
Unprofessional Conduct	523	315	133
Violation of Board Order	5	4	16

* Some complaints may allege more than one basis.

RECEIPTS, DISBURSEMENTS & MAJOR FEES – MINN. STAT §214.07, 1B(4)

Total Receipts and Disbursements by Biennium

Biennium	Total Receipts	Total Disbursements
July 1, 2022 – June 30, 2024	$4,788,113	$4,011,625
July 1, 2020 – June 30, 2022	$4,215,263	$3,571,765
July 1, 2018 – June 30, 2020	$3,308,299	$3,239,689
July 1, 2016 – June 30, 2018	$2,758,415	$2,931,578
July 1, 2014 – June 30, 2016	$2,559,693	$2,593,148
July 1, 2012 – June 30, 2014	$2,324,527	$2,363,353

Fees by Type

Type of fee	7/9/2019 to 7/14/2023	7/15/2023 to Present
Licensure by Endorsement Application	$100.00	$115.00
LSW, LGSW, LISW, LICSW Application	$60.00	$75.00
Temporary License	$50.00	$50.00
LSW License	$93.50 (24-month fee)	$103.50 (24-month fee)
LSW Renewal and Temporary Leave	$110.00 (24-month fee)	$115.00 (24-month fee)
LGSW License	$167.75 (24-month fee)	$189.00 (24-month fee)
LGSW Renewal and Temporary Leave	$195.00 (24-month fee)	$210.00 (24-month fee)
LISW License, Renewal and Temporary Leave	$295.00 (24-month fee)	$305.00 (24-month fee)
LICSW License, Renewal and Temporary Leave	$325.00 (24-month fee)	$335.00 (24-month fee)
Late Renewal Fee	1/4 Renewal Fee	1/4 Renewal Fee
Emeritus Active License	1/2 Renewal Fee	1/2 Renewal Fee
Emeritus Inactive License	$50.00	$65.00
Duplicate License Certificate	$30.00	$30.00
Duplicate License Card	$10.00	$10.00
License Verification	$20.00	$20.00

BOARD OF VETERINARY MEDICINE

The mission of the Minnesota Board of Veterinary Medicine is to promote, preserve, and protect the health, safety, and welfare of the public and animals through the effective control and regulation of the practice of veterinary medicine.

Report of the Executive Director

July 1, 2022 – June 30, 2024

The Board of Veterinary Medicine exists to regulate the practice of veterinary medicine in the State of Minnesota. Regulation is necessary to protect the health, safety, and welfare of Minnesota's animals and citizens. The Board has 7 members appointed by the Governor: 5 veterinarians and 2 public members. The full Board meets 3 times per year and convenes special board meetings when required. The Board has 5 Complaint Review Committees, each comprised of two Board members. A Board member may serve on more than one Committee. These include 2 Small Animal Complaint Review Committees, a Large Animal Complaint Review Committee, an Impaired Veterinarian Complaint Review Committee and a Continuing Education Review and Audit Failure Committee. The Committees function primarily through secure communication means, including State e-mail and SharePoint sites, and meet as needed for conferences with licensees.

Board Regulatory and Outreach Activities:

- Setting educational and examination requirements for initial licensure for veterinarians
- Issuing veterinary licenses and permits to qualified individuals
- Setting requirements for license renewals and administering the renewal process
- Registering veterinary professional firms and monitoring changes in professional firms via annual reports
- Setting minimum standards of veterinary practice in Board statutes and rules
- Responding to inquiries, complaints and reports regarding applicants and licensees
- Investigating complaints of alleged violations of statutes and rules including unlicensed practice of veterinary medicine and taking action when appropriate
- Holding educational and disciplinary conferences with licensees and applicants, taking disciplinary or corrective action when appropriate against practitioners who fail to meet minimum standards of practice, and reporting public actions to national databanks
- Maintaining a website that provides information to the public about license status, complaints and discipline, including a list of disciplinary and corrective actions taken by the Board
- Offering online services from the Board's website, including downloadable forms for complaints, continuing education program approval requests, professional firm registration and reports, license application, verification, and renewal as well as links to the full text of public disciplinary and corrective orders the Board has adopted against licensed professionals and unlicensed practitioners of veterinary medicine
- Reviewing and approving continuing education activities
- Distributing an e-newsletter with timely regulatory updates for licensees and the public and posting the newsletters on the Board's website
- Communicating Board variances and recommendations pertaining to the COVID-19 pandemic's impact on veterinarians
- Providing information about licensure requirements and standards of practice to applicants,

licensees, and other interested parties. Board staff gave virtual yearly licensure presentations to applicants.

- Actively engaging with the Minnesota Veterinary Medical Association (MVMA) to address questions pertaining to Statutes and Rules of the Board of Veterinary Medicine and the Board of Pharmacy.
- Supplying information to the MVMA to estimate the fiscal impact of licensing veterinary technicians and feedback on proposed statutory changes
- Presenting regulatory insights via staff participation in the Minnesota Veterinary Medical Association's Annual Conference on multiple topics, including strategies to diminish the risk of using animals to illicitly obtain controlled substances from veterinarians, telemedicine, drug compounding, non-profit veterinary professional firms and other topics based on frequently asked questions.
- Collaborating with other regulatory agencies, including the Minnesota Board of Animal Health, Minnesota Board of Pharmacy, Minnesota Prescription Monitoring Program Advisory Task Force, Minnesota Racing Commission, USDA-APHIS, and Drug Enforcement Administration in resolution of issues with overlapping areas of regulatory oversight
- Actively participating in Minnesota's One Health Antibiotic Stewardship Collaborative
- Actively participating in the American Association of Veterinary State Boards' annual meeting and committees

Legislative Activities:

The Board of Veterinary Medicine supported legislation to create a new license category for veterinary technicians. The bill passed and promulgated rules are scheduled to become effective July 1, 2026. Applications for licensure will open at that time.

Staffing:

The Board is staffed with two full-time equivalent employees: an executive director and a state program administrator. Long-time Executive Director Dr. Julia Wilson retired from State service effective June 2024. Thanks to Board Members for their countless hours of volunteer service, expertise, leadership, and commitment to carrying out the Board's mission.

Pamela A. Johnson, DVM, MPH
Diplomate, American College of Veterinary Internal Medicine
Executive Director
Minnesota Board of Veterinary Medicine
651-201-2844

GENERAL INFORMATION – MINN. STAT. § 214.07, SUBD. 1B(5)

Board Members Serving During the Period 7/1/2022 – 6/30/2024

Name	Location	Appointment Status	Appointment Date	Reappointment Date	Term Expiration Date
Mahlon Bauman	Buffalo	Public Member	4/6/2021	NA	1/1/2025
Julie Dahlke, DVM	St. Paul	Professional Member	7/3/2019	1/17/2023	1/1/2027
Jody Grote	Richfield	Public Member	5/4/2016	1/1/2024	1/1/2028
John How, DVM	Grand Rapids	Professional Member	1/17/2023	NA	1/1/2027
Kathleen Jost, DVM	Benson	Professional Member	3/18/2024	NA	1/1/2028
Steven Shadwick, DVM	Stillwater	Professional Member	6/29/2018	6/5/2022	1/1/2026
Raye Taylor, DVM	Centerville	Professional Member	6/5/2022	NA	1/1/2026

Board Staff and Office Location

1 Executive Director
1 State Program Administrator

Minnesota Board of Veterinary Medicine
Randolph Square Building
335 Randolph Avenue, Suite 215
St. Paul, MN 55102
Phone: 651-201-2844
FAX: 651-201-2842
Email: vet.med@state.mn.us
Website: https://mn.gov/boards/veterinary-medicine/

CREDENTIALS ISSUED OR RENEWED – MINN. STAT. §214.07, SUBD. 1B(1)

Total Number of persons licensed or registered as of June 30, 2024: 3,747

Number and Type of Credentials Issued or Renewed

License Type	Licensed as of June 30, 2024	Licensed as of June 30, 2022	Licensed as of June 30, 2020	Licensed as of June 30, 2018	Licensed as of June 30, 2016	Licensed as of June 30, 2014
Veterinarian	3,747	3,616	3,562	3,413	3,330	3,249
Total	**3,747**	**3,616**	**3,562**	**3,413**	**3,330**	**3,249**

Historical Renewal Data by Biennium

July 1, 2022 – June 30, 2024

Type of License	Number of New Licenses	Number of Renewed Licenses	Number and Percent Renewed Online
Veterinarian	414	3,401	2881 (85%)
TOTAL	414	3,401	2881 (85%)

July 1, 2020 – June 30, 2022

Type of License	Number of New Licenses	Number of Renewed Licenses	Number and Percent Renewed Online
Veterinarian	352	3330	2882 (87%)
TOTAL	352	3330	2882 (87%)

July 1, 2018 – June 30, 2020

Type of License	Number of New Licenses	Number of Renewed Licenses	Number and Percent Renewed Online
Veterinarian	356	3579	2638
TOTAL	356	3579	2638 (78%)

July 1, 2016 – June 30, 2018

Type of License	Number of New Licenses	Number of Renewed Licenses	Number and Percent Renewed Online
Veterinarian	365	3,471	2,812
TOTAL	365	3,471	2,812 (81%)

July 1, 2014 – June 30, 2016

Type of License	Number of New Licenses	Number of Renewed Licenses	Number and Percent Renewed Online
Veterinarian	346	3212	2687
TOTAL	346	3212	2687 (84%)

July 1, 2012 – June 30, 2014

Type of License	Number of New Licenses	Number of Renewed Licenses	Number and Percent Renewed Online
Veterinarian	330	3121	2705
TOTAL	330	3121	2705 (87%)

COMPLAINT ACTIVITY – MINN. STAT. §214.07, SUBDS. 1B(2), (3)

Complaints Received and Closed by Biennium

Biennium	Total Number of Complaints Received	Open from Prior Biennium	Total Number of Complaints Closed
July 1, 2022 – June 30, 2024	214	10	204
July 1, 2020 – June 30, 2022	202	15	194
July 1, 2018 – June 30, 2020	190	not tracked	175
July 1, 2016 – June 30, 2018	197	not tracked	169
July 1, 2014 – June 30, 2016	175	not tracked	143
July 1, 2012 – June 30, 2014	148	not tracked	114
July 1, 2010 – June 30, 2012	145	not tracked	132

Number of and Age of Complaints Open at the End of the Period

Total Number of Complaints Open as of June 30, 2024	**10**
Complaints open less than one year as of June 30, 2024	8
Complaints open greater than one year as of June 30, 2024	2

Types of Complaints Received by Biennium

Basis for complaints*	Number alleging this basis in 2022-2024	Number alleging this basis in 2020-2022	Number alleging this basis in 2018-2020	Number alleging this basis in 2016-2018
Incompetence	54	133	110	83
Unprofessional Conduct	33	156	124	68
Criminal Conviction	2	6	8	11
Unlicensed Practice	29	13	16	20
Disregard Health, Wellness, or Safety	79	156	7	14
Mental Health	7	6	8	0
Sanitation	3	5	25	7
Inadequate Continuing Education Hours	10	12	26	18

*Some complaints allege more than one basis.

RECEIPTS, DISBURSEMENTS & MAJOR FEES – MINN. STAT §214.07, 1B(4)

Total Receipts and Disbursements by Biennium

Biennium	Total Receipts	Total Disbursements
July 1, 2022 – June 30, 2024	$853,752	$883,587
July 1, 2020 – June 30, 2022	$826,996	$740,432
July 1, 2018 – June 30, 2020	$871,498	$772,614
July 1, 2016 – June 30, 2018	$400,004	$352,392
July 1, 2014 – June 30, 2016	$374,573	$227,482
July 1, 2012 – June 30, 2014	$353,399	$199,451

Fees by Type

Type of Fee	Fee
Jurisprudence Examination	$50
Application	$50
Initial License	$200
Biennial Active License Renewal	$200
Biennial Inactive License Renewal	$100
Temporary Permit	$50
Late fee (Inactive renewal)	$50
Late fee (Active renewal)	$100
Professional Firm Registration	$100
Professional Firm Annual Report	$25
Duplicate License	$10
Mailing List	$100
CE Sponsor Approval	$50
License Verification	$25

OFFICE OF COMPLEMENTARY AND ALTERNATIVE HEALTH CARE

The mission of the Minnesota Department of Health (MDH) is to protect, maintain, and improve the health of all Minnesotans.

Program Structure

The Office of Unlicensed Complementary and Alternative Health Care Practices (OCAP) exists within the Minnesota Department of Health. The Office is administered by the Health Occupations Program (HOP) within the Health Regulation Division (HRD). HOP evaluators, administrative staff, and management share OCAP responsibilities and balance them with the other occupational programs HOP administers.

OCAP advances MDH's mission by protecting consumers and prospective consumers of complementary and alternative health care practices (CAP). It accomplishes this by investigating complaints and taking disciplinary actions against practitioners of complementary and alternative health, providing information to the public about CAP, and informing practitioners about their obligations under the law.

OCAP Staff and Office Location

Daphne Ponds, Executive Operations Manager
Robert Dehler, Manager
Debbie Thao, Supervisor
Ah Her, Evaluator
Peter Meuwissen, Evaluator

Minnesota Department of Health
85 East Seventh Street
Suite 220
P.O. Box 64882
St. Paul, Minnesota 55164-0882
Telephone: 651 201-3731
Email: Health.HOP@state.mn.us
Website: www.health.state.mn.us/facilities/providers/compalt/

Scope

Complementary and alternative health practices (CAP) encompass a broad domain of healing, methods, and treatments. Massage therapy is the practice about which OCAP receives the most complaints. However, CAP also include practices that are less common but well known, such as aromatherapy and homeopathy, as well as lesser-known practices, such as nondiagnostic iridology (examining the iris of the human eye to determine information about systemic health). CAP also encompasses folk practices and practices associated with specific cultures, such as ayurveda and traditional Asian practices. Minnesota Statutes, Section 146A.01, Subdivision 4(a) provides a nonexclusive list of healing methods and treatments included within CAP.

Budget

CAP practitioners are not licensed; instead, the Department regulates this activity by investigating complaints against practitioners and imposing discipline, when appropriate. As such, there are no licensure fees collected to fund the program. Operating funds are supplied by the General Fund.

EXPENDITURES	FY 2024	FY 2023	FY 2022	FY 2021	FY 2020	FY 2019
Salaries/Fringe	49,248	50,953	66,359	72,322	61,266	73,667
Supplies	0	0	269	0	63	96
Attorney General Costs	0	0	0	0	333	0
Other Non-Payroll	2,426	1,061	641	4,283	5,320	5,910
TOTAL EXPENDITURES	**51,674**	**52,014**	**67,269**	**76,605**	**66,982**	**79,673**

Activities

OCAP's activities include operating as a clearinghouse to provide information to the public and practitioners and investigating and acting on complaints against CAP practitioners. Inquiries are documented contacts rather than complaints. Because CAP practitioners are unlicensed, the number of practitioners of any complementary or alternative modality is not known.

Complaints, Investigations, Enforcement

OCAP conducts investigations and takes disciplinary action on a practitioner's right to practice when appropriate. OCAP disciplinary actions may be referred to the Attorney General's Office if a practitioner requests a contested case hearing in response to a proposed disciplinary action. The initial question for any investigation is whether OCAP has jurisdiction. The answer to this question is often less obvious for CAP practitioners than for other regulated individuals. Licensed practitioners often incorporate CAP into their licensed practice activities. In those instances, the licensing board has jurisdiction over the practitioner.

Practices that span disciplines and/or regulatory agencies can also pose difficulties. OCAP encounters inquiries and complaints about activities taking place in Medi-spas (hybrid day spa and medical clinic). For each of these, OCAP must determine whether the practice is purely cosmetic or also undertaken to improve health, in which case it would fall under the jurisdiction of MDH. Some of these cases involve the use of medical devices, a complex area of law governed by the federal Food and Drug Administration. If a procedure is undertaken for reasons of health, OCAP staff will research, analyze, and apply federal regulations relating to medical devices.

Complaints Received and Closed by Biennium

Biennium	Total Number of Complaints Received	Total Number of Complaints Closed
July 1, 2022 – June 30, 2024	7	14
July 1, 2020 – June 30, 2022	17	10
July 1, 2018 – June 30, 2020	16	11
July 1, 2016 – June 30, 2018	15	37
July 1, 2014 – June 30, 2016	23	29
July 1, 2012 – June 30, 2014	14	2

For the biennium ending in FY 2024, OCAP received 7 complaints, resulting in one open investigation pending additional evidence to determine investigation and 6 closed complaint investigations. Given the

very small number of complaints in this program area, it is difficult to analyze trends or to draw valid conclusions from the scant data.

While CAP practitioners are not required to register with MDH, and MDH does not have data on the number of CAP practitioners, based on the best information available, massage therapists constitute the largest single group of CAP practitioners and, therefore, are the most likely subjects of complaints and disciplinary actions.

Number of and Age of Complaints Open at the End of the Period

Number of Complaints Open as of June 30, 2024	**6**
Number of complaints open less than 1 year	5
Number of complaints open greater than 1 year	1

As of the close of FY 2024, OCAP has six open investigations. In the 18 months prior to this report, HOP employed two evaluators which improved the timeliness of complaint investigations resulting in a higher number of complaints closing at the end of the fiscal year. The number of complaints in OCAP has remained relatively stable over the last biennium; it is unclear whether this is a trend that will continue or merely a short-term variance.

OCAP staff takes its mission to protect the public seriously and is always considering methods to improve efficiency and outcomes. As the data is analyzed and significant trends or changes in data are noted, the OCAP will continue to evaluate its processes and strive for excellence in producing results that benefit public safety and consumers of the complementary and alternative practices.

Types of Complaints Received

The majority of OCAP complaints are related to the practice of massage therapy, specifically, physical contact with a client. For the 2022-2024 biennium, complaints were related to inappropriate touch: sexual contact with a client, misrepresentation, and fraud.

Basis for complaints*	Number alleging this basis in 2022-2024	Number alleging this basis in 2020-2022	Number alleging this basis in 2018-2020
Sexual contact, conduct reasonably interpreted by client as sexual, verbal behavior that is seductive or sexually demeaning	5	2	4
False, fraudulent, deceptive or misleading advertisement	2	3	1
Conduct likely to deceive, defraud, or harm the public. Careless disregard for health welfare or safety of a client	0	2	2
Inappropriate touching, non-sexual	0	3	0
Nutritional supplements	0	2	0
Unprofessional conduct/failure to protect	0	2	0
Unlicensed establishment	0	1	0

*Some complaints allege more than one basis.

DATE: January 11, 2025 SUBJECT: Federation of State Medical Boards Update – Annual Meeting: April 24 – 26, 2025, Seattle, WA

SUBMITTED BY: **Elizabeth A. Huntley, JD, CMBE, Executive Director**

REQUEST FOR BOARD ACTION
MINNESOTA BOARD OF MEDICAL PRACTICE

REQUESTED ACTION:

For Informational Purposes Only

MOTION BY: SECOND:

( ) PASSED ( ) PASSED AMENDED ( ) LAYED OVER ( ) DEFEATED

BACKGROUND:

Join hundreds of your colleagues in medical licensure, regulation, and discipline at the FSMB Annual Meeting from April 24 - 26, 2025, at
the Hyatt Regency in Seattle, WA. During this three-day intensive program, we will bring together state medical board leaders and health care industry professionals to foster collaboration and dialogue on pivotal issues facing the medical regulatory community.

Eden Young will get everyone who wishes to attend registered. She will also send you a link to book your hotel stay at the Hyatt Regency.

Eden will also send you contact information from Travel Leaders to book your airfare.

Please make sure to keep all receipts for reimbursement once the trip concludes.

Please reach to Eden if you have additional questions.

DATE: January 11, 2025 SUBJECT: FSMB Annual Meeting Voting Delegate

SUBMITTED BY: **Elizabeth A. Huntley, JD, CMBE, Executive Director**

REQUEST FOR BOARD ACTION
MINNESOTA BOARD OF MEDICAL PRACTICE

REQUESTED ACTION:

For Informational Purposes Only

MOTION BY: SECOND:

( ) PASSED ( ) PASSED AMENDED ( ) LAYED OVER ( ) DEFEATED

BACKGROUND:

Determine who will be the FSMB Annual Meeting Voting Delegate.

DATE: January 11, 2025 SUBJECT: Federation of State Medical Boards Update – Call for Resolutions: Due by February 21, 2025

SUBMITTED BY: **Elizabeth A. Huntley, JD, CMBE, Executive Director**

REQUEST FOR BOARD ACTION
MINNESOTA BOARD OF MEDICAL PRACTICE

REQUESTED ACTION:

FSMB Call for Resolutions

MOTION BY: SECOND:

( ) PASSED ( ) PASSED AMENDED ( ) LAYED OVER ( ) DEFEATED

BACKGROUND:

The submission deadline is February 21, 2025, for resolutions to be considered at the Annual Meeting in April.

See attached to learn more about the FSMB's policy-making process and to view a sample resolution.

CALL FOR RESOLUTIONS
2024-2025

Member Medical Boards wishing to submit resolutions for consideration at the FSMB's April 26, 2025 House of Delegates annual business meeting are requested to forward all proposed resolutions to the FSMB.

Resolution Deadline

Member Medical Boards wishing to submit a resolution(s) for consideration by the 2025 House of Delegates must do so no later than **February 21, 2025.**

Drafting of Resolutions

When drafting resolutions for submission, please give close attention to the following:

- As stated in the FSMB Bylaws, "…the right to introduce resolutions is restricted to Member Medical Boards and the Board of Directors and the procedure for submission of such resolutions shall be in accordance with FSMB Policy."
- The title of the resolution should appropriately and concisely reflect the action for which it calls.
- The date on which the resolution was approved by the Member Medical Board should appear beneath the title.
- Information contained in the resolution should be checked for accuracy.
- The "resolved" portions should stand alone, since the House adopts only the "resolved" portions and the "whereas" portions are not subject to adoption.

A sample resolution can be found on pages 2-3.

Some Useful Information

The FSMB's Public Policy Compendium that includes the policies adopted by the House of Delegates in previous years is attached following the sample resolution.

Resolution Submission

Resolutions will need to be submitted **electronically to Lauren Mitchell, Manager, Board of Directors Liaison and Governance Support at lmitchell@fsmb.org. If submitting more than one resolution, please do so in one email.**

A confirmation acknowledging receipt of the document(s) will be sent within two business days. If you do not receive a confirmation, or for questions, please contact Ms. Mitchell by email or at 817-868-4060.

Resolution 24-3

Federation of State Medical Boards
House of Delegates Meeting
April 20, 2024

Subject: Medical Directors of Health Insurers Making Medical Necessity Determinations

Introduced by: Oregon Medical Board

Approved: February 16, 2024

Whereas, State medical boards are responsible for protecting the health, safety, and wellbeing of patients within their states by ensuring they have equitable access to quality care; and

Whereas, An estimated one-third of Americans have medical debt, and communities of color and families below the poverty level are disproportionately impacted by medical debt; and

Whereas, Patients may delay or defer care due to the inability to pay for medical services, which disproportionately affects disadvantaged communities and can exacerbate disparities in health outcomes; and

Whereas, More than 65% of Americans have private health insurance according to the U.S. Census Bureau's Report, "Health Insurance Coverage in the United States: 2022;" and

Whereas, Health insurers employ medical directors to make medical necessity determinations; and

Whereas, A medical director's medical necessity determinations are *de facto* determinations of whether patients will have access to needed treatments and medical services; and

Whereas, A medical director's role is not clearly within the definition of "practicing medicine" in state Medical Practice Acts, and state medical boards may not have authority to review their decision making in medical necessity determinations; and

Whereas, Medical directors are not required to meet standard qualifications or criteria by a particular government or regulatory authority, and medical directors are not required to specialize in the type of care they review; and

Whereas, There is a lack of transparency regarding each medical director's education, training, experience, and standing; and

Whereas, Medical directors may have a history of discipline by a state medical board, employer, or government agency or other malpractice or conduct reported to the National Practitioner Data Bank; and

Whereas, Peer-to-peer discussions between the treating physician and the medical director are administratively burdensome and contribute to physician burnout; and

Whereas, State medical boards aim to reduce causes of burnout in order support and retain a thriving workforce who can provide quality medical care for patients;

Therefore, be it hereby

Resolved: that the FSMB will research the current regulatory oversight for Medical Directors of health insurance companies; and be it further

Resolved: that the FSMB will publish a report articulating the impact of health insurance Medical Directors on patient care and providing recommendations to improve the quality of medical necessity determinations.

Federation of State Medical Boards
Public Policy Compendium
2024-25

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BOARD STRUCTURE AND FUNCTION

100.1 **Guidelines for the Structure and Function of a State Medical and Osteopathic Board**

The FSMB adopts as policy the Guidelines for the Structure and Function of a State Medical and Osteopathic Board, superseding the previous edition.
HD, April 2024

100.2 **Emergency Preparedness and Response**

The FSMB adopts as policy the recommendations contained in the Report of the FSMB Workgroup on Emergency Preparedness and Response.
HD, April 2022

100.3 **Report of the FSMB Workgroup on Emergency Preparedness and Response**

The FSMB adopts as policy the recommendations contained in the Report of the FSMB Workgroup on Emergency Preparedness and Response.
HD, May 2021

100.4 **Regulatory Strategies for Achieving Greater Cooperation and Collaboration Among Health Professional Boards**

The FSMB adopts as policy Regulatory Strategies for Achieving Greater Cooperation and Collaboration Among Health Professional Boards.
HD, April 2017

100.5 **Innovations in State Based Licensure**

The FSMB adopts as policy the recommendation contained in the Report of the Workgroup on Innovations in State-based Licensure that sports team physicians are held exempt from the state licensure requirement.
HD, April 2014

100.6 **Collateral Consequences of Board Actions**

The FSMB will continue to communicate with credentialing bodies, and other entities that use public board action reports as a basis for their actions to explore ways to accomplish their missions while taking measured, appropriate and proportionate action in response to public board actions involving a physician.
HD, April 2014

100.7 **Reporting of Drug Diversion by Healthcare Employers**

The FSMB will cooperate with other stakeholders, including similar associations of health professional regulatory boards, to study the feasibility of drafting model legislation addressing the duty of all healthcare workplace employers to report any discipline based on such diversion to health licensing boards and be it further that the FSMB support state medical boards in the study and development of legislation addressing the duty of healthcare workplace employers to report such diversion by healthcare licensees to the respective HLBS.
HD, April 2013

100.8 **Report of the Workgroup to Define a Minimal Data Set**

The FSMB adopts as policy the framework for a minimal physician data set as recommended in the Report of the Workgroup to Define a Minimal Data Set.
HD, April 2012

100.9 **Report of the Workgroup to Examine Composite Action Index (CAI) and Board Metrics**

The FSMB adopts as policy the recommendations contained in the Report of the Workgroup to Examine Composite Action Index (CAI) and Board Metrics.
HD, April 2012

100.10 **Reporting Withdrawals of Licensure Applications to the FSMB**

The FSMB will undertake, at the earliest possible opportunity, a thorough review of the reporting of withdrawals by each member board and draft a policy to ensure consistent reporting of these or any level of withdrawals by each member board that will advise member boards of a physician's history of withdrawals in other states.
HD, May 2009

100.11 **Information Exchange Between Boards**

The FSMB policy adopted in 1998 and reaffirmed in the Report of the Special Committee on License Portability encourages member boards to share investigative information at the early stages of a complaint investigation in order to reduce the likelihood that a licensee may become licensed in one state while under investigation in another state. The FSMB will collaborate with other interested organizations and agencies in addressing communication barriers resulting from variances in state confidentiality laws. The FSMB will maintain and distribute information related to state confidentiality laws to its member medical boards.
HD, April 2002

100.12 **Report of the Special Committee on Physician Profiling**

The FSMB adopts as policy the recommendations contained in the Report of the Special Committee on Physician Profiling.
HD, April 2000
HD, April 2002, Revised

100.13 **Policy Comment Period**

The FSMB shall include a comment period on draft reports of special committees, as feasible, so that the comments received from member medical boards and other interested parties may be taken into consideration prior to submission to the Board of Directors for approval and recommendation to the House of Delegates.
HD, April 2001

100.14 **State Medical Board Representation**
The FSMB reaffirms FSMB as the organization representing state medical boards in the legislative, policy development and spokesperson arenas.
BD, February 1998

100.15 **Maintaining State-based Medical Licensure and Discipline: A Blueprint for Uniform and Effective Regulation of the Medical Profession**
The FSMB adopts as policy the recommendations contained in Maintaining State-based Medical Licensure and Discipline: A Blueprint for Uniform and Effective Regulation of the Medical Profession from the Special Committee on Uniform Standards and Procedures.
HD, April 1998 (Archived, available upon request by contacting dcarlson@fsmb.org)

100.16 **Funding**
The FSMB urges state legislatures to provide their state medical licensing boards adequate resources to properly discharge their responsibilities and duties.
BD, January 1980

CONDUCT AND ETHICS

110.1 **Navigating the Responsible and Ethical Incorporation of Artificial Intelligence into Clinical Practice**
The FSMB adopts as policy the principles and recommendations in Navigating the Responsible and Ethical Incorporation of Artificial Intelligence into Clinical Practice.
HD, April 2024

110.2 **Report of the FSMB Ethics and Professionalism Committee: Considerations for Identifying Standards of Care**
The FSMB adopts as policy the recommendations contained in the Report of the FSMB Ethics and Professionalism Committee: Considerations for Identifying Standards of Care.
HD, May 2023

110.3 **Professional Expectations Regarding Medical Misinformation and Disinformation**
The FSMB adopts as policy the recommendations contained in the Report of the FSMB Ethics and Professionalism Committee.
HD, April 2022

110.4 **Position Statement on Treatment of Self, Family Members and Close Relations** (HD)
The FSMB adopts as policy the position contained in the Treatment of Self, Family Members and Close Relations.
HD, May 2021

110.5 **Report and Recommendations of the FSMB Workgroup on Physician Sexual Misconduct**
The FSMB adopts as policy the Report and Recommendations of the FSMB Workgroup on Physician Sexual Misconduct, superseding the policy Addressing Sexual Boundaries: Guidelines for State Medical Boards (2006).
HD, April 1996
HD, April 2006, Revised
HD, May 2020, Revised

110.6 **Report of the Ethics and Professionalism Committee: Social Media and Electronic Communications**
The FSMB adopts as policy the guidelines and recommendations contained in the Report of the Ethics and Professionalism Committee: Social Media and Electronic Communications, superseding the Model Guidelines for the Appropriate Use of Social Media and Social Networking in Medical Practice (2012).
HD, April 2012
HD, April 2019, Revised

110.7 **Position Statement on Practice Dr**ift
The FSMB adopts as policy the Position Statement on Practice Drift.

HD, April 2016

110.8 **Position Statement on Duty to Report**
The FSMB adopts as policy the Position Statement on Duty to Report.
HD, April 2016

110.9 **Position Statement on Sale of Goods by Physicians and Physician Advertising**
The FSMB adopts as policy the Position Statement on Sale of Goods by Physicians and Physician Advertising.
HD, April 2016

110.10 **Best Practices in the Use of Social Media by Medical and Osteopathic Boards**
At its 2016 Annual Meeting, the FSMB shall present information on current uses of social media by regulatory agencies and collect and disseminate information on best practices for regulatory agencies to follow in using social media and other forms of communication to publicize Board news and information, including public disciplinary actions.
HD, April 2015

110.11 **Report of the Special Committee on Professional Conduct and Ethics**
The FSMB adopts as policy the recommendations contained in the Report of the Special Committee on Conduct and Ethics.
HD, April 2000

CONTINUING MEDICAL EDUCATION

120.1 **Interprofessional Continuing Education (IPCE)**
The FSMB adopts a resolution supporting and recognizing Interprofessional Continuing Education for physicians that is identified by IPCE credit and is accredited by the Joint Accreditation system launched by the Accreditation Council for Continuing Medical Education, the Accreditation Council for Pharmacy Education and the American Nurses Credentialing Center, as an additional means of satisfying continuing medical education requirements for medical license renewal.
HD, April 2018

120.2 **Participation in ABMS MOC and AOA BOS OCC Programs to Meet CME Requirements for License Renewal**
The Federation of State Medical Boards (FSMB) supports the use of, and encourages state boards to recognize, a licensee's participation in an ABMS MOC and/or AOA BOS OCC program as an acceptable means of meeting CME requirements for license renewal.
HD, April 2012

120.3 **Point of Care Learning**
The FSMB recommends that continuing medical education credits be given for point of care learning, described as practice-based learning that takes place in support of specific patient care and that publishers and vendors of information resources be encouraged to incorporate time-keeping or automated use-recording into their products.
HD, May 2005

120.4 **Post-residency Skills and Procedures-based Retraining**
The FSMB will assist state medical boards in identifying and developing—in conjunction with other organizations—new post-residency skills and procedures retraining programs in specialties dependent on skills and procedures competencies.
HD, April 1996

120.5 **Formation of Accreditation Council for Continuing Medical Education (ACCME)**
The FSMB Board of Directors approved the formation of the ACCME, its budget, Essentials, and bylaws.
BD, October 1980

120.6 Mandating Continuing Medical Education

The FSMB believes mandatory continuing medical education is a matter reserved for the individual state jurisdictions.
HD, April 1980

ELECTRONIC HEALTH RECORDS

130.1 Framework on Professionalism in the Adoption and Use of Electronic Health Records

The FSMB adopts as policy the Framework on Professionalism in the Adoption and Use of Electronic Health Records as contained in the Report of the Committee on Ethics and Professionalism in the Adoption and Use of Electronic Health Records.
HD, April 2014
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EXAMINATIONS

140.1 Single Examination for Medical Licensure

The FSMB reaffirms its commitment to establish a single examination for medical licensure in collaboration with other concerned organizations and adopts as an official FSMB position paper the document, A Proposal for a Single Examination for Medical Licensure.
HD, April 1989

The FSMB reaffirms its policy that USMLE be the single pathway to licensure for all U.S. allopathic physicians.
HD, April 1999
HD, April 2012, Revised

140.2 Report of Committee to Evaluate the USMLE Program (CEUP) (HD)

The member boards of the Federation of State Medical Boards resolve:

- To adopt the Final Report and Recommendations of CEUP as a conceptual framework for the continued improvements in the USMLE examination program;
- To make a clear commitment to incorporate into the USMLE program the following enhancements (described in CEUP Recommendations 1, 2, and 3) at such point when models and methodologies have been developed and tested and the results of this testing indicate that such enhancements will provide assessments that meet reasonable standards of validity, reliability, and practicality;

Enhancement 1: The USMLE program shall be a series of assessments that are specifically intended to support decisions about a physician's readiness to provide patient care at each of two patient-centered points: a) at the interface between undergraduate and graduate medical education (supervised practice), b) at the beginning of independent (unsupervised) practice.
Enhancement 2: USMLE shall adopt a general competencies schema (such as the six general competencies identified by the Accreditation Council on Graduate Medical Education) for the overall design, development, and scoring of USMLE, using a model consistent with national standards. Further, as the USMLE program evolves, it should foster a research agenda that explores new ways to measure those general competencies important to medical practice and licensure which are difficult to assess using current methodologies.
Enhancement 3: USMLE shall emphasize the importance of the scientific foundations of medicine in all components of the assessment process. The assessment of these foundations should occur within a clinical context or framework, to the greatest extent possible.

- To make a clear commitment to support the development of methodologies and instruments to enhance testing methods to assess clinical skills, as reflected in CEUP Recommendation #4, and to consider approaches to for design and implementation of a testing format to assess an examinee's ability to recognize and define a clinical problem, to access appropriate reference resources in order to find the scientific and clinical information needed to address the problem ,and to interpret and apply that information in an effective manner, consistent with CEUP Recommendation #5;
- To delegate monitoring and final approval of such enhancements to the Composite Committee and the Board of Directors of the Federation of State Medical Boards in concert with the Executive Board of the National Board of Medical Examiners; and

To affirm the principle that the parents recognize that such enhancements will require shared investment of financial resources and that this investment will be recovered via revenues generated by the USMLE program over time.

HD, May 2009

140.3 Examination History

The FSMB receives a request from any state for examination history; the FSMB will attach a Physician Data Center (formally Board Action Data Bank) report to all transcripts that contain a disciplinary history.

In reporting the results from all queries of the FSMB Data Bank, the board action history report will include licensing history as a standard informational element on all reports, in addition to any reportable disciplinary history when it exists for an individual physician.

HD, April 1984

HD, May 2009, revised

140.4 Common Examination System

The FSMB recognizes the USMLE and COMLEX-USA as valid exams for their intended purposes. To assure the public that all physicians are meeting a uniform standard for purposes of medical licensure, the FSMB may collaborate with interested parties to develop a common licensing examination system that advances both osteopathic and allopathic medical licensure while maintaining the distinctiveness of both professions.

HD, April 2001

HD, May 2008, Revised

140.5 Evaluation of Licensure Examinations

The FSMB will develop a mechanism for continuous evaluation of the evidence developed by the USMLE and COMLEX-USA programs to support the validity of decisions being made by state medical boards on the basis of test scores, and that reports regarding the outcomes of such evaluation be provided to the membership on a regular basis.

HD, May 2004

140.6 Inclusion of Pain, Pain Assessment and Pain Management Questions on National Standardized Licensure Examinations

The FSMB will encourage the NBME, the NBOME and other appropriate organizations to ensure that questions related to pain mechanisms, pain assessment, and pain management be included in all standardized medical licensing examinations, emphasizing the importance of appropriate pain management in quality medical care.

HD, April 2002

140.7 Release of SPEX Score Reports

The FSMB endorses the release of SPEX score performance profile information, including information regarding limitations of the performance information, to the examinee and the sponsoring state medical boards.

HD, April 1998

140.8 English Administration of Licensing Exams

The FSMB reaffirms its policy that licensing examinations for U.S. jurisdictions be administered in English only.

BD, May 1979

BD, October 1995, Revised

140.9 Enhancement of the USMLE

The FSMB endorses the Strategic Plan for Enhancement of the USMLE adopted by the USMLE Composite Committee.

HD, April 1995

140.10 **Hybrid Examination Combinations**

The FSMB approves the following guidelines relevant to FLEX 1 and 2:

Candidates, who passed FLEX Component 1 before 1994 and pass the USMLE Step 3 within seven years of the original FLEX pass, will be recommended as having met acceptable licensing examination requirements.

Candidates (likely only international medical graduates) who have passed NBME Part I or USMLE Step 1 and NBME Part II or USMLE Step 2 before 1994, and who pass FLEX Component 2 before 1994, will be recommended as having met acceptable licensing examination requirements.

BD, February 1992

140.11 **Clinical Skills Assessment as Part of Licensure Process**

The FSMB supports and encourages the development and use of an evaluation of clinical skills as a component of the physician licensure process for all medical students.

BD, October 1987

140.12 **Special Purpose Examination (SPEX) Use Statement**

The FSMB accepts as policy the following statement for SPEX use:

"SPEX is a cognitive examination to assist licensing jurisdictions in their assessment of current competence requisite for general, specialty-undifferentiated medical practice by physicians who hold or have held a valid unrestricted license in a United States or Canadian jurisdiction."

BD, April 1987

IMPAIRMENT

150.1 **Policy on Physician Illness and Impairment: Towards a Model that Optimizes Patient Safety and Physician Health** (HD)

The FSMB adopts the Policy on Physician Illness and Impairment: Towards a Model that Optimizes Patient Safety and Physician Health, superseding the Policy on Physician Impairment (HOD 2011).

HD, May 2021

150.2 **Report of the Workgroup on Physician Wellness and Burnout**

The FSMB adopts as policy the recommendations contained in the Report of the Workgroup on Physician Wellness and Burnout.

HD, April 2018

150.3 **AMA Report on the Use of Alcohol by Physicians**

The FSMB supports the guidelines established by the American Medical Association (AMA) regarding physicians' ingestion of alcohol and patient care (H-30.960 Physician Ingestion of Alcohol and Patient Care).

HD, April 1993

HD, April 2012, Revised

150.4 **Policy on Physician Impairment**

The FSMB adopts the Policy on Physician Impairment, superseding the Report on Physician Impairment (HOD 1995).

HD, April 2011 (Archived, available upon request by contacting dcarlson@fsmb.org)

150.5 **Credit Against License Suspensions or Restrictions**

The FSMB recommends to all member boards that, for cases of license suspension or restriction, any time during which a disciplined physician practices in another jurisdiction without comparable restriction should not be credited as part of the period of suspension or restriction.

HD, April 1993

LICENSURE REQUIREMENTS

160.1 **Setting Higher Standards for Unrestricted Licensure**

The FSMB will, in collaboration with other stakeholders, examine the benefits as well as the potential harms and unintended

consequences that could occur because of requiring all applicants for licensure to have completed 36 months of progressive postgraduate medical training.
HD, April 2013

160.2 Federation Credentials Verification Service (FCVS) and Educational Commission for Foreign Medical Graduates (ECFMG) to Expedite Licensure

The FSMB, through the FCVS, pursue cooperative efforts with the ECFMG to reduce duplication of efforts and redundancy in primary source verification.
HD, April 2003

160.3 Criminal Record Check

The FSMB reaffirms its policy that all state medical boards conduct criminal record checks as part of the licensure application process. The FSMB encourages all state medical boards to require any applicant with a criminal history report to appear before the board for questioning to evaluate the applicant's degree of risk to the public in determining fitness for licensure. The FSMB will develop legislative or administrative approaches that will assist member boards who wish to have the authority to require criminal background checks for applicants for professional licensure.
HD, April 2001

160.4 Requirements Unrelated to the Practice of Medicine

The FSMB opposes enactment by any jurisdiction of requirements for initial physician licensure not reasonably related to the qualifications and fitness of individuals to practice medicine, and, instead, have in view the implementation of social, economic or political policies of the jurisdiction at a particular moment, however well-intentioned or justified those policies may appear.
HD, April 1987
HD, April 1997, Revised

160.5 Military/Government Employed Physicians

All physicians, other than those in training, be required to have a full and unrestricted license in at least one state and that exemptions not be made for physicians in the armed forces, Public Health Service or other governmental agencies.
BD, December 1977
BD, July 1996, Revised

160.6 Liability Insurance

Professional liability insurance is an economic issue, not to be linked with medical licensure.
HD, April 1995

160.7 Report of the Ad Hoc Committee on Licensure by Endorsement

The FSMB adopts as policy the recommendations contained in the report Licensure by Endorsement, developed by the Ad Hoc Committee on Licensure by Endorsement.
HD, April 1995 (Archived, available upon request by contacting dcarlson@fsmb.org)

MEDICAL EDUCATION

170.1 Regulation of Physicians in Training

The FSMB adopts as policy the recommendations contained in Regulation of Physicians in Training.
HD, April 2024
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170.2 Shortening Undergraduate Medical Education

The FSMB will work in collaboration with the AAMC, AACOM, AMA and the AOA to study the value of shortening the duration of undergraduate medical education from four years to three years and its impact collectively on access to care, patient outcomes, patient safety and medical student indebtedness.
HD, 2013

170.3 Medical Education in Substance Abuse

The FSMB will develop methods and/or modules of information to be used to educate medical students, residents and practicing physicians regarding the identification of substance use disorders, intervention and the proper prescribing of controlled substances.
HD, May 2007

170.4 Report of the Special Committee on the Evaluation of Undergraduate Medical Education

The FSMB adopts as policy the recommendations contained in the Report of the Special Committee on the Evaluation of Undergraduate Medical Education.
HD, April 2006

170.5 Credentials Verification for International Medical Graduates

The FSMB shall continue to monitor and encourage the progress of the FCVS/ECFMG initiative, and for the FSMB and its member boards to strongly recommend that International Medical Graduates establish an FCVS profile for securing and protecting their medical school credentials for a lifetime of license portability and practice.
HD, April 2006

170.6 Education of Medical Students, Interns, Residents and Related Faculty on Licensure and Attendant Good Conduct Requirements

The FSMB shall continue to provide access to new and existing presentation materials for boards to use to educate medical students, interns, residents and appropriate faculty on medical licensure and regulation. The FSMB shall seek funding for the development of educational modules to be used in medical schools and residency programs.
HD, April 2003

170.7 International Association of Medical Regulatory Authorities (IAMRA)

The FSMB and its representatives to the IAMRA are encouraged to seek opportunities to share information with the international community on matters related to education, training and licensure for both osteopathic and allopathic physicians in the United States. At the time that a formal membership structure is established, the IAMRA Office of the Secretariat forward information regarding associate membership to the AMA, AOA, ACGME, LCME, ABMS and other appropriate organizations.
HD, April 2001

170.8 Medical Students Attending Board Meetings

The FSMB recommends that medical students enrolled in an approved medical school be encouraged to attend either their state medical board meeting or a meeting sponsored by their state medical board for educating medical students regarding the responsibilities as a licensed physician and the specific ramifications of violating medical regulations.
HD, April 2000

170.9 Position in Support of Postgraduate Training and Licensure Standards

The FSMB adopts as policy the position in support of postgraduate training and licensure standards.
HD, 1998 (Archived, available upon request)

170.10 Report on Licensure of Physicians Enrolled in Postgraduate Training Programs

The FSMB approves as policy the recommendations contained in the Report on Licensure of Physicians Enrolled in Postgraduate Training Programs, developed by the FSMB's Legislative and Legal Advisory Committee.
HD, April 1996 (Archived, available upon request by contacting dcarlson@fsmb.org)

170.11 Medical School Curriculum

The FSMB opposes attempts by legislative bodies to mandate specific details of the curriculum of accredited medical schools in the United States and Canada. This should remain the responsibility of the faculties of these schools and the accrediting body,

to permit and encourage adaptation of medical student education to the future challenges medical students will face as physicians in the rapidly changing practice of medicine.
HD, April 1985

170.12 **Clinical Clerkships for Foreign Medical Graduates**
The FSMB encourages all member boards to bring rules into effect or to encourage enactment of laws authorizing the respective state boards of medical examiners or appropriate state agency to regulate the clinical clerkships of those students from medical schools not approved by the Liaison Committee on Medical Education or the American Osteopathic Association, where such rules or laws are not already in effect.
HD, April 1985

170.13 **Verifying Credentials of Physicians in Postgraduate Training Programs**
The FSMB urges its member boards to bring reasonable procedures and rules into effect or encourage enactment of laws which would ensure thorough verification and authentication of the credentials of all medical school graduates in training programs and who do not hold a full and unrestricted license to practice medicine.

The FSMB recommends that, in those jurisdictions that provide for credentials verification by the directors of medical education of the training institutions, deans of the medical schools, hospital administrators, or other responsible individuals involved with medical school graduates, such verification be certified to the state medical board or, where the state medical board has no authority, to an appropriate state agency.
HD, April 1985

NATIONAL DATA BANKS

180.1 **Reporting to the Physician Data Center (formally Board Action Data Bank)**
The FSMB encourages all state medical boards to report all board actions to the FSMB's Physician Data Center (formally Board Action Data Bank), including denials and/or withdrawals for cause, as quickly as possible but no later than 30 days after actions are taken.
HD, April 1996

The FSMB encourages all member boards to include disclosure language in all board orders.
BD, October 1997

All state licensing boards report all formal board actions to Physician Data Center, including non-prejudicial actions.
BD, January 1980

The FSMB will expand its database to include all licensed physicians.
BD, October 1997

The FSMB encourages all state medical boards enacting emergency actions to immediately contact the FSMB Physician Data Center to provide information on individuals who are subject to these actions. The FSMB encourages state medical boards taking emergency action to immediately transmit a copy of the emergency order to the FSMB Physician Data Center so that notification can be immediately transmitted to all other states wherein the physician is licensed, applying for licensure, or in post-graduate training and/or residency.

The FSMB Physician Data Center will provide timely notification to member boards of disciplinary actions taken by other state medical boards through a Disciplinary Alert Report. The FSMB encourages all state medical boards to provide data files and timely updates to the FSMB Physician Data Center, so that there will exist a national database comprised of current and complete information which can be accessed by all states in which a physician is licensed or seeking licensure. The FSMB encourages the executive directors of all medical boards in states enacting emergency actions to immediately determine all other states of licensure for individuals subject to such emergency actions. The director of the board enacting the emergency

action shall then immediately advise those directors of other boards where the licensee is known to hold another medical license about the emergency action. This contact should occur as close to the same day of the board action as is possible. This will ensure optimal public protection and the most timely notification possible while processes for drafting, serving and disseminating legal orders for the emergency action take place.
HD, April 2001

180.2 **Public Access**
The FSMB approves an initiative to develop a means to provide public access to national physician data base information.
BD, February 1998

180.3 **National Practitioner Data Bank (NPDB)**
The FSMB supports continued monitoring of the progress and development of the National Practitioner Data Bank (NPDB) and continued dialogue with the Health Resources Services Administration staff regarding potential future modifications in the NPDB.
BD, April 1991

180.4 **Centralized Database of Licensing Profiles**
The FSMB recognizes the need for a centralized database displaying the licensing profile of all practicing physicians and the need of the individual state medical boards for ready access to such a file, as well as the value of such a centralized database for analysis of practice trends, especially designation and distribution of physicians and the dynamics of geographical distributional changes of physicians.

The FSMB endorses efforts in conjunction with the NBME to obtain appropriate funding to design and engage in a process leading to the development and implementation of a computerized national tracking system containing longitudinal data relevant to the licensure status of all physicians within the licensing jurisdictions of the United States.

Representatives of the constituent medical boards of the FSMB endorse the concept of the centralized computerized database and express their intent to participate in the implementation of the process by the individual state medical boards.
HD, April 1980

QUALITY OF CARE

190.1 **Strategies for Prescribing Opioids for the Management of Pain**
The FSMB adopts as policy Strategies for Prescribing Opioids for the Management of Pain, superseding Guidelines for the Chronic Use of Opioid Analgesics (2017).
HD, April 1998, Revised
HD, April 2004, Revised
HD, April 2013, Revised
HD, April 2017, Revised
HD, April 2024

190.2 **Position Statement on Access to Evidence-Based Treatment for Opioid Use Disorder**
The FSMB adopts as policy the Position Statement on Access to Evidence-Based Treatment for Opioid Use Disorder, superseding Model Policy on the DATA 2000 and Addiction Treatment in the Medical Office (2013).
HD, 2013, Revised
HD, April 2024

190.3 **Diversity, Equity and Inclusion in Medical Regulation and Patient Care**
The FSMB adopts as policy the recommendations included in the Interim Report of the FSMB Workgroup on Diversity, Equity and Inclusion in Medical Regulation and Patient Care.
HD, April 2022

190.4 **Acute Opioid Prescribing Workgroup and Guidelines**
The FSMB will perform a comprehensive review of acute opioid prescribing patterns, practices, federal laws and guidance (including Centers for Disease Control and Prevention guidelines), state rules and laws across the United States, available data, and present a report to the House of Delegates at the Annual Meeting in 2019.
HD, April 2018

190.5 **Report of the Workgroup on Prescription Drug Monitoring Programs (PDMPs)**
The FSMB adopts as policy the recommendations contained in the Report of the Workgroup on Prescription Drug Monitoring Programs (PDMPs).
HD, April 2018

190.6 **Report of the Workgroup to Study Regenerative and Stem Cell Therapy Practices**
The FSMB adopts as policy the recommendations contained in the Report of the Workgroup to Study Regenerative and Stem Cell Therapy Practices.
HD, April 2018

190.7 **Model Guidelines for the Recommendation of Marijuana in Patient Care** (HD)
The FSMB adopts as policy the recommendations contained in Model Guidelines for the Recommendation of Marijuana in Patient Care.
HD, April 2016

190.8 **Physicians Use of Marijuana**
Given the lack of data supporting clinical efficacy and the difficulty of evaluating impairment, the FSMB adopted a resolution that state medical boards advise their licensees to abstain from the use of marijuana, for medical or recreational purposes, while actively engaged in the practice of medicine.
HD, April 2016

190.9 **Incorporating Quality Improvement Principles into Disciplinary Actions**
The FSMB will investigate ways in which medical boards can incorporate quality improvement principles into disciplinary actions when appropriate to do so, as part of their mission to protect the public and improve patient care.
HD, April 2013

190.10 **Report of the Maintenance of Licensure (MOL) Workgroup on Clinically Inactive Physicians**
The FSMB adopts as policy the recommendations contained in the Report of the MOL Workgroup on Clinically Inactive Physicians.
HD, April 2013 (Additional policies related to Maintenance of Licensure are archived and available by contacting dcarlson@fsmb.org)

190.11 **Prevention of HIV/HBV Transmission to Patients**
The state medical and osteopathic practice acts, other appropriate statutes and/or the rules of the state medical or osteopathic board should include provisions dealing with preventing the transmission of human immunodeficiency virus (HIV), hepatitis B virus (HBV) and hepatitis C virus (HVC) to patients. These statutes or rules should be consistent with the following recommendations:

A. Persons under the jurisdiction of the Board should comply with the guidelines established by the Centers for Disease Control and Prevention for preventing the transmission of human immunodeficiency virus (HIV), hepatitis B virus (HBV) and hepatitis C virus (HVC) to patients.
B. State medical boards should have the powers and responsibilities:
    1. to encourage physicians and other health care providers to know their HIV and HBV status;
    2. to require reporting to the state board and/or the state public health department of HIV- and HBV -infected healthcare workers who perform invasive procedures;

3. to ensure confidentiality of those reports received by the state board and/or state public health
4. department under (2) above;
5. to establish practice guidelines for HIV- and HBV–infected practitioners; and
6. to monitor or to assist the state public health department to monitor the practices and health of HIV and HBV - infected practitioners who perform invasive procedures.

C. The state board should be authorized to discipline all persons under its jurisdiction who violate the statue(s) or rule(s) establishing or otherwise implementing requirements related to preventing transmission of HIV and HBV to patients.

HD, April 1992
HD, April 1996, Revised
HD, April 2012, Revised

190.12 **Communication Between Physicians and Patients**

The FSMB supports continued and improved effective means of communication between patients and physicians. The FSMB will develop an inventory of resources that promotes effective communication to provide to patients and professional communities.
HD, May 2009

190.13 **Continued Competence**

State medical boards have a responsibility to the public to ensure the ongoing competence of physicians seeking relicensure.
HD, May 2004

190.14 **Review of FSMB Model Guidelines for the Use of Controlled Substances for the Treatment of Pain**

The FSMB will develop a process for review of its policy Model Guidelines for the Use of Controlled Substances for the Treatment of Pain and consider whether it might be strengthened in the light of new medical insights during the past five years, particularly focusing on issues surrounding the undertreatment of pain.
HD, April 2003

190.15 **Report of the Special Committee on Outpatient (Office-based) Surgery**

The FSMB adopts as policy the Report of the Special Committee on Outpatient (Office-based) Surgery.
HD, April 2002

190.16 **Model Guidelines for the Use of Complementary and Alternative Therapies in Medical Practice**

The FSMB adopts as policy the Model Guidelines for the Use of Complementary and Alternative Therapies in Medical Practice.
HD, April 2002

The FSMB reaffirms its recommendation, as stated in the "Report of the Special Committee on Managed Care," to encourage state medical boards to communicate with state agencies responsible for regulating managed care organizations on issues relating to quality of care.
HD, April 2001

190.17 **Report of the Special Committee on Quality of Care and Maintenance of Physician Competence**

The FSMB adopts as policy the recommendations contained in the Report of the Special Committee on Quality of Care and Maintenance of Physician Competence.
HD, April 1998
HD, April 1999, Revised

190.18 **Remedial Education**

The FSMB will identify available remedial educational resources and publish a comprehensive directory of such resources for its

member boards; foster regional expansion of assessment centers throughout the country in support of member boards' efforts; and encourage development of centers capable of assessing specialty practice performance.
HD, April 1999

190.19 **Post-Licensure Assessment System**
When physician competence is called into question, state medical regulatory boards should consider using the Post-Licensure Assessment System (PLAS) established by the FSMB and National Board of Medical Examiners. State medical regulatory boards should work with relevant medical organizations in their states to encourage development of educational programs designed to address physicians' learning needs as identified through assessment programs. The FSMB, when requested, will assist and support any member board in its effort to utilize PLAS, including, but not limited to, providing informational resources, research studies and suggested policies on identifying and referring physicians for assessment, evaluating assessment programs, stimulating development of need-based educational programs and continuing improvement of the post-licensure assessment and education effort.
HD, April 1999

190.20 **Report of the Special Committee on Managed Care**
The FSMB adopts as policy the recommendations contained in the Report of the Special Committee on Managed Care.
HD, April 1998 (Archived, available upon request by contacting dcarlson@fsmb.org)

190.21 **Report of the Special Committee on Questionable and Deceptive Health Care Practices**
The FSMB adopts as policy the recommendations contained in the Report of the Special Committee on Questionable and Deceptive Health Care Practices, previously published as the Report on Health Care Fraud.
HD, April 1997
HD, April 1999, Revised

190.22 **Position in Support of Adoption of Pain Management Guidelines**
The FSMB adopts as policy the position in support of adoption of pain management guidelines.
HD, 1998 (Archived, available upon request by contacting dcarlson@fsmb.org)

190.23 **Position on Partial Birth Abortion Ban Acts**
The FSMB adopts as policy the position on partial-birth abortion ban acts.
HD, 1997 (Archived, available upon request by contacting dcarlson@fsmb.org)

190.24 **Report of the AMA and the FSMB: Ethics and Quality of Care**
The FSMB adopts as policy the recommendations contained in Ethics and Quality of Care: Report of the American Medical Association and the Federation of State Medical Boards.
HD, April 1995 (Archived, available upon request by contacting dcarlson@fsmb.org)

REENTRY

200.1 **Report of the Special Committee on Reentry for the Ill Physician**
The FSMB adopts as policy the five recommendations contained in the Report of the Special Committee on Reentry for the Ill Physician.
HD, April 2013

200.2 **Report of the Special Committee on Reentry to Practice**
The FSMB adopts as policy the 12 recommendations contained in the Report of the Special Committee on Reentry to Practice.
HD, April 2012

SCOPE OF PRACTICE

210.1 **Advocacy Efforts in Response to Antitrust Concerns of State Medical Boards**
The FSMB adopts a resolution calling for advocacy against the expanded application of antitrust principles that may

compromise patient safety, and for FSMB to assist state boards facing litigation alleging antitrust violations.
HD, April 2016

210.2 Scope of Practice Information for Non-Physician Health Care Professionals

The FSMB will maintain information on scopes of practice of licensed non-physician health care professionals and make the information available to member medical boards.
HD, April 2000
HD, April 2012, Revised

210.3 Use of "Doctor" Title in Clinical Settings

The FSMB work with the Scope of Practice Partnership and other stakeholders, including associations of health professional regulatory boards and patient advocacy groups, in supporting state legislation to provide transparency for patients seeking a health care professional;

The FSMB, through its advocacy network, support the Healthcare Truth and Transparency Act of 2010 or similar federal legislation designed to assure patients receive accurate information about the qualifications and licensure of health care professionals; and,

Adopted the following policy statement: Health care practitioners who provide health services to consumers and are legally authorized to use the term "doctor" or "physician" or any abbreviation thereof, should be required to simultaneously and clearly disclose and identify which branch of the healing arts for which they are licensed. Such disclosure should apply to written advertisements, identification badges, and any other form of practitioner/patient communications.
HD, May 2009
HD, April 2011

210.4 Assessing Scope of Practice in Health Care Delivery: Critical Questions in Assuring Public Access and Safety

The FSMB adopts the policy Assessing Scope of Practice in Health Care Delivery: Critical Questions in Assuring Public Access and Safety.
HD, April 2005

210.5 Delegation of Medical Functions to Unlicensed Individuals

The FSMB will maintain new and existing legislation/regulations and other information on the delegation of medical functions and make the information available to member medical boards and other interested parties.
HD, April 2003

210.6 Participation in the National Commission on Certification of Physician Assistants (NCCPA)

The FSMB supports continued participation on the NCCPA Board of Directors and encourages and supports the NCCPA.
BD, October 1990

210.7 Non-physician Duties and Scope of Practice

A non-physician should be permitted to provide medical services delegated to him or her by a supervising physician consistent with state law, as long as those medical services are within his or her training and experience, form a usual component of the supervising physician's practice of medicine, and are provided under the direction of the supervising physician.
BD, July 1998

210.8 National Commission on Certification of Physician Assistants (NCCPA) Examination

The FSMB urges state boards that regulate physician assistants to formulate rules and regulations that would permit acceptance of the examination of the NCCPA in the authorization of physician assistants in their respective states.
BD, February 1976

SPECIALTY BOARD CERTIFICATIONS

220.1 License Restriction/Board Certification

It is the position of the FSMB that a physician who has a restricted license and is allowed to practice clinical medicine under board supervision and is complying with all the terms and conditions of his/her license restriction, should be allowed to be a candidate for specialty board certification, re-certification or Maintenance of Certification.
HD, April 1992
HD, May 2005, Revised

220.2 License Restrictions and Specialty Board Certification

The FSMB shall establish an ongoing dialogue with allopathic and osteopathic specialty boards regarding restrictions on medical licenses due to a mental or physical disability and specialty board certification. The primary purpose would be to develop mechanisms allowing physicians with physical or mental disabilities to obtain and maintain specialty board certification without compromising public protection.
HD, April 1998

The FSMB will continue discussions with the American Board of Medical Specialties and the American Osteopathic Association regarding the issue of eligibility for specialty recertification of physicians with licensure restrictions. The FSMB will explore the possibility of developing alternate mechanisms which would allow physicians to be eligible for specialty recertification while preserving medical board oversight of their recovery program.
HD, April 1999

220.3 Licensure by Specialty

The FSMB opposes licensure by specialty.
HD, April 1982

STATE MEDICAL BOARDS: RELATIONSHIPS WITH OTHER AGENCIES

230.1 Journal of Medical Regulation (JMR) to Key State Decision Makers

The FSMB encourages each state medical and osteopathic board to assess their budgets to consider sending the JMR (at a reduced rate subscription) to their respective legislators and Governor.
HD, April 2014

230.2 Quality Improvement Organizations

The FSMB encourages state boards to cooperate with state quality improvement organizations on issues of medical discipline.
BD, February 1990
BD, April 2012, Revised

230.3 Memorandum of Understanding for Sharing Information Between the Department of Defense Medical System and State Medical Boards (HD)

The Federation of State Medical Boards (FSMB) shall initiate dialogue and pursue a Memorandum of Understanding or other means with the Department of Defense Medical System and other uniformed health services to facilitate the sharing of information necessary to state medical and osteopathic boards in fulfilling their regulatory responsibilities.
HD, April 2011

230.4 Drug Enforcement Agency (DEA)

The FSMB strongly urges the DEA to promptly report all violations by physicians to the Board(s) of Medical Examiners of the state in which the physician practices and to the FSMB's Physician Data Center (formally Board Action Data Bank).
BD, February 1965
BD, October 1995, Revised

230.5 Federal Facilities

The FSMB encourages the federal government to have federal facilities use state boards of medical examiners in the states in

which such facilities are located to ensure that fraudulent or incompetent physicians are not allowed to practice at those facilities; encourages states to require federally-employed physicians to possess a current active license in a state or territory; and recommends that within each state or territorial possession in which a federal facility exists, a liaison committee be established consisting of a representative of the federal facility and the state licensing board.
HD, April 1988

TELEMEDICINE and LICENSE PORTABILTY

240.1 **The Appropriate Use of Telemedicine Technologies in the Practice of Medicine**
The FSMB adopts as policy the Report of the FSMB Workgroup on Telemedicine, superseding the Model Policy for the Appropriate Use of Telemedicine Technologies in the Practice of Medicine (2014).
HD, April 2022

240.2 **Model Policy for the Appropriate Use of Telemedicine Technologies in the Practice of Medicine**
The FSMB adopts as policy the Model Policy for the Appropriate Use of Telemedicine Technologies in the Practice of Medicine, superseding the Model Guidelines for the Appropriate use of the Internet in Medical Practice (HD, 2002).
HD, April 2014

240.3 **Development of an Interstate Compact to Expedite Medical Licensure and Facilitate Multi-State Practice**
The FSMB will convene representatives from state medical boards and special experts as needed to aggressively study the development of an Interstate Compact model to facilitate license portability, hereinafter known as the Medical License Portability Interstate Compact model, and be it further that this be initiated no later than July 2013.
HD, April 2013

240.4 **Definition of Telemedicine**
"Telemedicine" is the practice of medicine using electronic communication, information technology or other means between a physician in one location and a patient in another location with or without an intervening health care provider.
HD, May 2009

240.5 **License Portability During a Public Health Emergency**
Resolved that state medical boards cooperate and support each other to further license portability in the event of a public health emergency and assist FSMB in verifying licensure and qualifications by regularly providing FSMB with licensure and contact information on all licensees; and that the FSMB study issues relative to license portability during an emergency including, but not limited to, joining with other organizations or entities to determine the best manner to provide necessary medical care and maintain licensure autonomy for the individual states.
HD, April 2006

240.6 **Report of the Special Committee on License Portability**
The FSMB adopts as policy the recommendations contained in the Report of the Special Committee on License Portability.
HD, April 2002 (Archived, available upon request by contacting dcarlson@fsmb.org)

240.7 **Disaster Preparedness and Licensing**
The FSMB will cooperate with federal and state legislators, agencies, and organizations in facilitating the movement of properly licensed physicians among FSMB member licensing jurisdictions in support of necessary emergency medical response.
HD, April 2002

240.8 **Interstate Mobility of Physicians**
Resolved, that the Federation of State Medical Boards take steps to assist its member boards in evaluating their own statutes, rules and regulations and where necessary and appropriate modify those statutes, rules and regulations to provide for the rapid research, training or unique clinical care.

240.9 **Report of the Ad Hoc Committee on Telemedicine**

The FSMB adopts as policy the Report of the Ad Hoc Committee on Telemedicine HD, April 1996 (Archived, available upon request by contacting dcarlson@fsmb.org)

DATE: January 11, 2025 SUBJECT: United States Medical Licensing Examination (USMLE) Reports – 2024 Annual Report

SUBMITTED BY: **Elizabeth A. Huntley, JD, CMBE, Executive Director**

REQUEST FOR BOARD ACTION
MINNESOTA BOARD OF MEDICAL PRACTICE

REQUESTED ACTION:

For Informational Purposes Only

MOTION BY: SECOND:

( ) PASSED ( ) PASSED AMENDED ( ) LAYED OVER ( ) DEFEATED

BACKGROUND:

See attached report.

2024

Annual Report on the United States Medical Licensing Examination® (USMLE)

Prepared for Medical Licensing Authorities in the United States by the Federation of State Medical Boards of the United States and the National Board of Medical Examiners®

Table of Contents

Executive Summary

The United States Medical Licensing Examination® (USMLE®) is a three-step examination sequence for medical licensure in the United States. The USMLE is composed of three complementary Steps: Step 1, Step 2 Clinical Knowledge (CK) and Step 3. The program administers approximately 100,000 Step examinations annually, with more than 3 million total tests administered since implementation in 1992.

Medical licensing authorities and their representatives continue to be key stakeholders and contributors to the USMLE program. In 2024, 44 individuals from 26 state medical and osteopathic boards across the United States participated in USMLE in some capacity. Since implementation of the USMLE in 1992, 360 members and staff from 65 state medical and osteopathic boards have participated in the USMLE program in some capacity.

As of 2023, approximately 63% of the 1,062,460 physicians licensed in the United States have taken all or part of the USMLE sequence; 58% have taken all Steps (1, 2 and 3). This represents a 2% increase in both measures since 2022.

The *Annual Report on the United States Medical Licensing Examination (USMLE)* provides state medical boards with an overview of the USMLE, a jointly owned program of the Federation of State Medical Boards (FSMB) and the National Board of Medical Examiners (NBME). In addition to general information about the examination, the report provides updates on topics of specific interest to the boards and a summary of state medical boards' interactions with the USMLE program. State medical boards participate in USMLE in a variety of capacities, including writing and reviewing test items; serving on governing committees; and participating in standard-setting surveys and on advisory panels. Links to key USMLE resources, articles, research and publications are also provided.

Introduction and Program Overview

The United States Medical Licensing Examination® (USMLE®) was the result of "A Proposal for a Single Examination for Medical Licensure" presented by a Task Force to Study Pathways to Licensure in 1989. A jointly owned program of the Federation of State Medical Boards of the United States, Inc., (FSMB) and the National Board of Medical Examiners® (NBME®), the USMLE instituted a single examination for use by all physicians seeking licensure in the United States.

Before USMLE, multiple examinations (the NBME Parts examination and the Federation Licensing Examination [FLEX]) offered paths to medical licensure. It was desirable to create one examination system accepted in every state, to ensure that all licensed allopathic physicians (MDs) had passed the same assessment standards – no matter in which school or which country they had trained.

Today, all state medical boards utilize a national examination – USMLE for allopathic physicians, COMLEX-USA for osteopathic physicians. Predecessor licensing examinations –FLEX and the NBME Parts – were gradually phased out and replaced with the USMLE in 1992-1994.

The USMLE is a unified examination program for initial medical licensure comprised of three complementary Steps: Step 1, Step 2 Clinical Knowledge (CK) and Step 3. The USMLE Step 2 Clinical Skills, or Step 2 CS, was implemented in 2004 and officially discontinued in January 2021.

Although the USMLE is typically completed over the course of several years in the career of a prospective physician, it constitutes a unitary examination program. Each of the three Steps complements the others; no Step can stand alone in the assessment of readiness for medical licensure, nor can other assessments be substituted to replace one of the Steps.

The USMLE program administers approximately 130,000 Step examinations annually, with more than three million test administrations since implementation of USMLE began in 1992.

As of 2023, approximately 63% of the 1,062,460 physicians licensed in the United States have taken all or part of the USMLE sequence; 58% have taken all Steps (1, 2 and 3). This represents a 2% increase in both measures since 2022.

Breakdown of this data by medical degree and medical education show:

- 67% of licensed MDs have taken part or all of the USMLE; 64% have taken all three Steps.
- 37% of licensed DOs have taken part or all of the USMLE; 1% have taken all three Steps.
- 61% of licensed domestic medical graduates (i.e., graduates of medical schools accredited by the Liaison Committee on Medical Education or LCME) have taken part or all of the USMLE; 54% have taken all three Steps.
- 73% of licensed international medical graduates (i.e., graduates of non-LCME accredited medical schools) have taken part or all of the USMLE; 71% have taken all three Steps.

Mission

The USMLE supports U.S. medical licensing authorities through its leadership in the development, delivery and continual improvement of high-quality assessments across the continuum of physicians' preparation for practice.

The program's goals are:

- To provide to licensing authorities meaningful information from assessments of physician characteristics—including medical knowledge, skills, values, and attitudes—that are important to the provision of safe and effective patient care.
- To engage medical educators and their institutions, licensing authority members, and practicing clinicians in the design and development of these assessments.
- To assure fairness and equity to physicians through the highest professional testing standards.
- To continue to develop and improve assessments for licensure with the intent of assessing physicians more accurately and comprehensively.

The results of the USMLE are reported to medical licensing authorities for use in the decision to grant a provisional license to practice in a post-graduate training program and the decision to grant an initial license for the independent practice of medicine. The USMLE is recognized and utilized by all state medical boards for licensing allopathic physicians and graduates of international medical schools. Many of the osteopathic licensing boards also recognize USMLE for licensing graduates holding the D.O. degree.

Governance

The USMLE is owned by FSMB and NBME. However, USMLE is governed by the USMLE Composite Committee, which consists of representatives from FSMB, NBME, the Educational Commission for Foreign Medical Graduates (ECFMG™) – a Division of Intealth, and the public. The Composite Committee is responsible for the overall direction of the program, identifying and approving procedures for scoring and determining the pass/fail standard, and all significant policies and procedures. The membership of the Composite Committee routinely includes current or former members of state medical boards. **Members from the Florida-Medical, Hawaii, Missouri, Montana and North Carolina boards served on the USMLE Composite Committee in 2024.**

The three USMLE Step examinations are overseen by a Management Committee composed of physicians and scientists from the licensing, practice and medical education communities, and members of the public. **Current and former members of the District of Columbia, Iowa, Missouri, North Carolina and Vermont-Medical boards served on the USMLE Management Committee in 2024.**

Medical Licensing Authorities and the USMLE

USMLE Services to State Medical Boards

In 2023, FSMB registered over 38,000 applicants for the USMLE Step 3, the final examination in the USMLE sequence. Step 1 and Step 2 registration services are provided by NBME for students and graduates of U.S. and Canadian medical and osteopathic schools and by ECFMG for students and graduates of international medical schools.

FSMB also produced and delivered over 108,000 USMLE transcripts in 2023, including nearly 52,000 transcripts produced as part of the Federation Credentials Verification System (FCVS) profile sent to state medical boards for physicians seeking licensure.

The USMLE makes a wide range of informational materials about the program available to medical licensing authorities. FSMB provides a quarterly electronic update on USMLE to all state medical boards, and research and informational articles on USMLE have appeared in FSMB's *Journal of Medical Regulation* (https://meridian.allenpress.com/jmr).

FSMB also hosts web seminars on USMLE-related topics, such as USMLE attempt, time limit, and retake policies; USMLE scoring (such as the transition to pass/fail reporting for Step 1); and USMLE transcripts and irregular behavior. Copies of these presentations are available upon request from FSMB.

State Medical Boards' Participation in USMLE

State medical board members and staff have a long history of involvement with the USMLE program. Since implementation of the USMLE in 1992, 360 members and staff from state medical boards have participated in the USMLE program in some capacity. These individuals represent 65 different medical and osteopathic licensing boards throughout the United States. In 2024, 44 individuals from 26 state medical and osteopathic boards across the United States participated in USMLE in some capacity.

Annual USMLE Orientation for State Board Members and Staff

Since 2007, FSMB and NBME have hosted an annual USMLE Orientation workshop for state board members and staff with an interest in learning about and/or participating in the program. The 2024 workshop was held October 2 at FSMB offices in Euless, Texas. **A total of 21 individuals from 12 different boards – Alabama-Commission, Hawaii, Illinois, Maine-Medical, Indiana, Minnesota, Mississippi, New Hampshire, New Jersey, Texas, Washington-Medical and Washington-Osteopathic – attended the Orientation.**

To date, 229 individuals from 61 medical and osteopathic boards have participated in an orientation workshop. Sixty-six (66) past participants (representing 35 boards) have served subsequently with the USMLE program. This includes participation on standard setting panels and advisory panels, as well as

serving on the USMLE Management Committee, the USMLE Composite Committee, and/or item writing and item review committees. Physician and public members of state medical and osteopathic boards interested in attending this workshop should contact FSMB for more information.

State Board Advisory Panel to the USMLE

In 2011, the USMLE program established the State Board Advisory Panel to the USMLE to bring together board members and staff from state medical and osteopathic boards for in-depth discussions between the primary intended users of USMLE scores - state medical boards - and USMLE program staff. For more than a decade this panel has convened annually as a reactor panel and sounding board offering feedback, advice and input from the medical licensing community on all aspects of the USMLE program.

The State Board Advisory Panel to the USMLE met in person on November 13, 2024, at FSMB offices in Euless, Texas. During the meeting, the panel discussed recent and ongoing USMLE program updates and work and provided updates about issues occurring in their states. Specific topics discussed included examination security; impact of the USMLE attempt limit change; impact of moving Step 1 to pass/fail outcome reporting; impact of the discontinuation of Step 2 Clinical Skills (CS); program updates (research, performance data, new item formats); ECFMG Certification expiration and USMLE eligibility requirements; and impact of the impending 2025 change in accreditation of Canadian medical schools on USMLE eligibility requirements.

Current panel members include staff and board members from the Alabama-Medical Licensure Commission, Idaho, Illinois, Michigan-Medical, New York-Licensure, Pennsylvania-Medical, Texas, Vermont-Medical and West Virginia-Medical boards.

USMLE Policy Exceptions Allowed at the Request of a State Medical Board

There are two USMLE eligibility policies that a state medical board may request an exception to on behalf of an individual examinee - 1) the 4-attempt limit and 2) retake of a previously passed Step. How and why a state medical board may want or need to sponsor an individual for either is detailed below.

USMLE Attempt Limit

The USMLE program imposes a limit of no more than four attempts to pass each of Step. Examinees who have attempted any USMLE Step four or more times (including the discontinued USMLE Step 2 Clinical Skills, or Step 2 CS) and have not passed are ineligible to apply for any USMLE Steps.

The only exception to this policy identified by the USMLE Composite Committee (the governing body of the USMLE program) involves state medical boards. The policy includes a provision to allow examinees who have four or more attempts at a Step to have a single additional attempt if requested by a state medical board that is fully informed of the individual's prior examination history.

This policy exception recognizes that USMLE is intended to support state medical boards' licensing decisions. Therefore, the program will accept a request from a medical licensing authority to allow one

additional attempt for an individual who would be eligible to become licensed in that jurisdiction if they passed that Step after more than four attempts and go on to meet all other licensure requirements. As part of this process, the examinee must request that FSMB send an official USMLE transcript to the medical board.

Examinees are required to pass the state board sponsored attempt at the exam to maintain eligibility to continue with the USMLE exam sequence (i.e., to apply for and take additional Steps).

An official petition form - Petition for Exception to USMLE 4-Attempt Limit Policy - for use by state medical boards to request an exception to the USMLE attempt limit policy was provided to all state medical boards via email. If you need the form resent to your board, please contact FSMB staff (see Contacts toward the end of this report) or email the Office of the USMLE Secretariat (usmlesec@nbme.org).

Retaking a Previously Passed Step

Once an individual passes a USMLE Step, it may not be retaken, except to comply with a time limit imposed by a state medical board for completion of all Steps for licensure purposes or by another authority recognized by the USMLE program. The physician may apply to retake the necessary Step only after the applicable time limit has expired. Individuals who have not yet passed Step 3 and need to retake a previously passed Step 1 or Step 2 CK examination are informed that, if they fail a retake, they will no longer be eligible to take Step 3.

Both the physician (examinee) and the sponsoring state medical board must fill out a form in order for a retake to be considered and granted by the USMLE program. The sponsorship form that state medical boards must complete - the USMLE Retake Sponsorship Form - was distributed to all state medical boards via email. If you need the form resent to your board, please contact FSMB staff (see Contacts toward the end of this report) or email the Office of the USMLE Secretariat (usmlesec@nbme.org).

A new sponsorship form is required for each retake and must be emailed directly from the medical board to the physician's USMLE registration entity.

USMLE and Medical Licensure Requirements

USMLE Recommended Time Limit for Completing USMLE

The USMLE recommends that state medical boards require the dates of passing Step 1, Step 2 CK, and Step 3 to occur within a seven-year period. However, the program recognizes that the recommended seven-year time limit may pose problems for medical licensure for some candidates with a combined degree (i.e., MD/PhD, DO/PhD). For this reason, the USMLE program recommends to licensing jurisdictions that they consider allowing exceptions to the seven-year limit for MD/PhD candidates who meet the following requirements:

1. The candidate has obtained both degrees from an institution or program accredited by the LCME and a regional university accrediting body.
2. The PhD should reflect an area of study which ensures the candidate a continuous involvement with medicine and/or issues related, or applicable to, medicine.

3. A candidate seeking an exception to the seven-year rule should be required to present a verifiable and rational explanation for the fact that he or she was unable to meet the seven-year limit. These explanations will vary and each licensing jurisdiction will need to decide on its own which explanation justifies an exception. Students who pursue both degrees should understand that while many states' regulations provide specific exceptions to the seven-year rule for dual-degree candidates, others do not. Students pursuing a dual degree are advised to check the state-specific requirements for licensure listed by FSMB.

These recommendations are provided on the USMLE website at: https://www.usmle.org/common-questions/general.

State Medical Boards' Time and Attempt Limits for Completing USMLE

Most state medical boards impose both time and attempt limits on the USMLE as part of their requirements for obtaining an initial medical license. Currently, 42 state boards impose some limit on the number of attempts at the USMLE, while 47 state boards impose a time limitation for the completion of the USMLE sequence.

A snapshot of the individual state medical boards' time and attempt limits are available on the FSMB website at: http://www.fsmb.org/step-3/state-licensure/. Board staff are encouraged to review this information and to provide updates to FSMB staff as needed.

Data about each board's composition, governance structure, funding basis, and other procedural and operational details are also available on the FSMB website at: https://www.fsmb.org/u.s.-medical-regulatory-trends-and-actions/state-medical-board-data/

Strategic Communication and Outreach

Below is a summary of communication work undertaken by the USMLE program in 2024, for examinees, medical regulators, medical educators and the public.

Medical Licensing Authorities

Quarterly FSMB Update on USMLE

Since March 2020, FSMB has emailed a Quarterly FSMB Update on USMLE® to all state medical and osteopathic boards' executive directors. The update covers key USMLE developments, policies and meetings, and highlights state board representatives that participate in the USMLE program. Copies of the 2024 updates are provided as **Appendix A**.

Examinees

USMLE Medical Student and Resident Advisory Panel

The USMLE program implemented a Medical Student & Resident Advisory Panel in 2018 to provide a consultative role to the USMLE program. The panel is charged to 1) assist staff in working through operational issues directly impacting the examinee experience of the exam, 2) serve as an additional voice and resource to inform more substantive policy questions from or before the USMLE Management and Composite Committees and (3) serve as informal ambassadors of the USMLE program. The panel consists of 15 members: 14 medical students and residents (MD, DO, MD/PhD and IMG) drawn from all regions of the country, and 1 public member.

A public member from the Minnesota board serves as the public representative on the panel.

Social Media

USMLE also uses Facebook, LinkedIn, and X (formerly known as Twitter) to more directly, efficiently and quickly communicate with applicants and examinees.

USMLE Facebook: https://www.facebook.com/usmle/

USMLE LinkedIn: https://www.linkedin.com/company/usmle/

USMLE X: https://x.com/TheUSMLE

General

Program News

The USMLE website (www.usmle.org) serves as the official communication channel for the USMLE program, providing regular updates and news to examinees and other interested parties. News items

and announcements posted on the USMLE website (www.usmle.org/announcements/) from 2023-2024 are provided in **Appendix B**.

Eligibility for the USMLE Steps

Eligibility Requirements

USMLE is intended to be taken by students and graduates of medical school programs leading to the MD, DO, or equivalent degree (e.g., MBBS degree held by many IMGs).

To be eligible for Step 1 and Step 2 CK, the examinee must be in one of the following categories at the time of application and on test day:

- a medical student officially enrolled in, or a graduate of, a U.S. or Canadian medical school program leading to the MD degree that is accredited by the Liaison Committee on Medical Education (LCME), **OR**
- a medical student officially enrolled in, or a graduate of, a U.S. medical school leading to the DO degree that is accredited by the Commission on Osteopathic College Accreditation (COCA), **OR**
- a medical student officially enrolled in, or a graduate of, a medical school that is outside the U.S. and Canada, listed in the World Directory of Medical Schools as meeting ECFMG eligibility requirements, and that meets other eligibility criteria of the ECFMG.

Step 3 applicants must meet the following eligibility requirements:

- Passing scores on Step 1 and Step 2 Clinical Knowledge; **AND**
- An MD degree or DO degree from an LCME- or COCA-accredited U.S. or Canadian medical school, **OR** the equivalent of the MD degree from a medical school outside the U.S. and Canada that is listed in the World Directory of Medical Schools as meeting ECFMG eligibility requirements, and obtain ECFMG Certification which is valid and unexpired at the time of application and testing; **AND**
- All other eligibility criteria as listed in the USMLE *Bulletin of Information*.

The USMLE program recommends (but does not require) that, for Step 3 eligibility, applicants should have completed, or be near completion of, at least one postgraduate training (PGT) year in an accredited U.S. graduate medical education (GME) program that meets state board licensing requirements.

Impact of Change to Accreditation Body for Medical Schools in Canada Effective in July 2025

Currently, medical education programs in Canada leading to the MD degree are accredited by both the Liaison Committee on Medical Education and the Committee on Accreditation of Canadian Medical Schools (CACMS). Effective July 1, 2025, CACMS will become the sole accrediting body for medical education programs in Canada.

Accreditation by LCME establishes eligibility to take the USMLE and to enter U.S. residency programs accredited by the Accreditation Council for Graduate Medical Education (ACGME). In the absence of

LCME accreditation for Canadian medical education programs, Canadian medical school graduates will establish their eligibility for USMLE and ACGME-accredited residency programs through ECFMG Certification.

This means that individuals who graduate from Canadian medical schools on or after July 1, 2025 will be considered international medical graduates for the purpose of entry into graduate medical education programs in the United States, and, in order for these graduates to enter ACGME-accredited residency programs, the ACGME will require that they either obtain ECFMG Certification or hold a full and unrestricted license to practice medicine in the U.S. licensing jurisdiction in which the ACGME-accredited program is located.

ECFMG Certification is the standard for evaluating the qualifications of IMGs entering the U.S. health care system and includes requirements for medical schools, examination requirements (which include USMLE Step 1 and Step 2 CK among other requirements), and verification of medical education credentials directly with the issuing institution.

Individuals who will graduate from Canadian medical schools on or after July 1, 2025, will be able to apply for ECFMG Certification beginning in late spring 2025, prior to the start of the 2026 residency application cycle in the United States.

Individuals who will graduate from medical schools in Canada on or after July 1, 2025, and who plan to pursue U.S. GME should monitor the ECFMG and USMLE websites for detailed information on applying for ECFMG Certification and USMLE.

Eligibility Policies

In addition to the requirements outlined above, all USMLE examinees must meet the following USMLE eligibility policies.

Sequencing of Steps

Step 1 and Step 2 CK can be taken in any sequence. Step 3 can be taken only after passing Step 1 and Step 2 CK.

Retakes

Examinees may not take the same Step more than three times within a 12-month period. A fourth attempt on any Step must be at least 12 months after the first attempt at that Step and at least six months after the most recent attempt at that Step. This includes incomplete attempts.

Attempt Limit

The total number of attempts allowed per Step is four (4). Examinees who have attempted any USMLE Step four or more times and have not passed are ineligible to apply for any USMLE Steps. Attempts at the formerly administered Step 2 CS count toward the limit. All attempts at a Step are counted toward the limit, regardless of when the examinations were taken. The only exception to this policy identified by the USMLE Composite Committee (the governing body of the USMLE program) involves state medical boards. The policy includes a provision to allow examinees who have four or more attempts at a Step to have a single additional attempt if requested by a state medical board that is fully informed

of the individual's prior examination history. Examinees are required to pass the state board sponsored attempt at the exam to maintain eligibility to continue with the USMLE exam sequence.

Retaking a Previously Passed Step

Once an individual passes a USMLE Step, it may not be retaken, except to comply with a time limit imposed by a U.S. physician licensing authority for completion of all Steps or by another authority recognized by the USMLE program. Individuals who have not yet passed Step 3 and need to retake a previously passed Step 1 or Step 2 CK examination are informed that, if they fail a retake, they will no longer be eligible to take Step 3. To meet the examination requirements for Step 3 eligibility, individuals must have achieved a passing performance on the most recent administration of Step 1 and Step 2 CK.

Physicians Who are Already Licensed in the United States

Individuals who have already been granted a physician license by a US medical licensing authority based on other licensure examinations, including but not limited to the Federation Licensing Examination (FLEX), Medical Council of Canada Qualifying Examination (MCCQE), NBME certifying examinations (NBME Parts), National Board of Osteopathic Medical Examiners (NBOME) Parts or Comprehensive Osteopathic Medical Licensing Examination of the United States (COMLEX-USA), or by exception, may not be eligible to take the USMLE.

Content and Administration

Content Development

Content for the USMLE is prepared by examination committees broadly representing the medical profession. Members of USMLE test committees include biomedical scientists, educators, and clinicians from every region of the United States. Virtually all LCME-accredited medical schools in the United States have been represented on USMLE test committees. USMLE test committee members represent a "national faculty of medicine" drawn from medical schools, state medical boards, and clinical practice settings across the United States. A directory of USMLE test committees and task forces is available at: https://www.usmle.org/about-usmle.

At least two of these committees critically appraise each test item or case before it is used as live (i.e., scored) material on the USMLE. These committees may revise or discard materials for any of several reasons, e.g., inadequate clinical relevance, outdated content, failure to meet acceptable statistical performance criteria, etc.

For a more detailed explanation of content development, contact FSMB for a copy of the 2009 Journal of Medical Licensure and Discipline article, "Developing Test Content for the USMLE". State board members and staff are also invited to attend an annual USMLE Orientation session to learn more about how USMLE is developed.

Step Content and Structure

Step 1 assesses whether a candidate understands and can apply important concepts of the sciences basic to the practice of medicine, with special emphasis on principles and mechanisms underlying health, disease and modes of therapy. It ensures mastery of not only the sciences that provide a foundation for the safe and competent practice of medicine in the present, but also the scientific principles required for maintenance of competence through lifelong learning. Step 1 is constructed according to an integrated content outline that organizes basic science material along two dimensions: system and process.

Step 2 CK assesses an examinee's ability to apply medical knowledge, skills, and understanding of clinical science essential for the provision of patient care under supervision and includes emphasis on health promotion and disease prevention. Step 2 CK ensures that due attention is devoted to principles of clinical sciences and basic patient-centered skills that provide the foundation for the safe and competent practice of medicine under supervision.

Step 3 assesses whether the candidate can apply medical knowledge and understanding of biomedical and clinical science essential for the unsupervised practice of medicine, with emphasis on patient management in ambulatory settings. Step 3 content reflects a data-based model of generalist medical practice in the United States. The test items and cases reflect the clinical situations that a general, as-yet undifferentiated, physician might encounter within the context of a specific setting. It is the final examination in the USMLE sequence leading to a license to practice medicine without supervision. As

such, it provides a final assessment of physicians assuming independent responsibility for delivering general medical care.

Table 1 details the structure and exam day(s) for each USMLE Step.

Table 1: Exam Structure by Step

Exam	Number of Exam Days	Item Format	Total Testing Time	Testing Blocks	Maximum Number of Total Items
Step 1	1	Multiple-choice questions (MCQs)	8 hours	Seven 60-minute blocks	280
Step 2 CK	1	MCQs, including patient scenario format and abstract format	9 hours	Eight 60-minute blocks	318
Step 3	2 Day One: Foundations of Independent Practice (FIP)	Day One: MCQs, including patient scenario format, abstract format, and pharmaceutical advertisement (drug ad) format	Day One: 7 hours	Day One: Six 60-min. blocks	Day One: MCQs: 232
	Day Two: Advanced Clinical Medicine (ACM)	Day Two: MCQs & Computer-based Case Simulations (CCS)	Day Two: 9 hours	Day Two: MCQs: Six 45-min. blocks CCS: Max. 10 or 20 min. of real time (each)	Day Two: MCQs: 180 CCS: 13

Test Administration

Steps 1, 2 CK and 3 are administered by computer at Prometric Test Centers (PTCs). Step 1 and Step 2 CK are given at PTCs around the world. Step 3 is only given at PTCs in the United States and its territories.

All USMLE examinations are proctored and videotaped. Strict guidelines are followed for proper identification of examinees. Efforts are made to reduce the overlap of test content from examinee to examinee and from test administration to test administration when examinees need to retake a Step.

Any significant breaches in security can result in the cancellation of scores/results, suspension of an individual from USMLE, and/or annotation of score reports and official USMLE transcripts.

All Step exams include an optional survey at the end of the final exam day, which can be completed if time allows.

Test Accommodations

Reasonable and appropriate accommodations are provided in accordance with the Americans with Disabilities Act (ADA) for individuals with documented disabilities. The purpose of test accommodations is to provide access to the examination program. While presumably the use of accommodations will enable the individual to better demonstrate his/her knowledge or skill, accommodations are not a guarantee of improved performance, test completion, or a particular outcome. Examinees are informed of the availability of test accommodations via the USMLE *Bulletin of Information*, the USMLE website, and the individual Step applications.

The ADA defines disability as a physical or mental impairment that substantially limits one or more major life activities as compared to most people in the general population. Examples of major life activities include, but are not limited to, walking, seeing, hearing, and learning. Determination of whether an individual is substantially limited in functioning as compared to most people is based on an individualized assessment of the current impact of the identified impairment.

Requests for test accommodations are reviewed by NBME staff trained in clinical and school psychology at the doctoral level or by medical professionals, depending on the basis of the request. Further review of the request and supporting documentation may be provided by external experts in the respective fields of disability with whom NBME consults regarding the presence of a disability and appropriate accommodations. NBME makes decisions regarding appropriate test accommodations for all USMLE Steps.

Examinees with disabilities may be provided with a variety of accommodations, including but not limited to assistance with keyboard tasks, audio rendition, extended testing time and additional break time. Efforts are made to match accommodations to the individual's functional limitations. For example, audio-recorded versions of the computer-based Step examinations are available for candidates with visual or visual processing disabilities. Special tactile versions of visual material for a Step examination may be provided for examinees with severely impaired vision. Items with an audio component may include a visual representation of the sound for hearing impaired examinees.

Scores

Minimum Passing Scores

The USMLE Management Committee establishes a recommended passing standard for all Step examinations (an overview of the standard setting process USMLE uses is provided in the Psychometrics section of this report). Recommended performance standards for the USMLE are based on a specified level of proficiency. As a result, no predetermined percentage of examinees will pass or fail the examination.

In alignment with best practices for licensing and certification exams, a comprehensive review and analysis of the passing standard for each Step exam typically occurs every three to four years but can occur at any time. Periodic review ensures that the passing score is consistent with expectations of the level of content mastery of the knowledge and skills needed to support effective medical practice and licensure. Notice of such review and any adjustments are posted on the USMLE website. More information about the passing score process is provided in the "Standard Setting" section of this report.

A statistical procedure ensures that the performance required to pass each test form is equivalent to that needed to pass other forms; this process also places scores from different forms on a common scale (the three-digit score scale).

Although 2-digit scores are not reported, test results reported as passing would represent an exam score of 75 or higher if a two-digit score were reported.

Current minimum passing scores for each Step are provided in **Table 2** below.

Score Reporting

When examinees take Step 1, Step 2 CK, or Step 3, the computer records their responses, which are then transmitted to NBME for scoring.

Results for Step 1 taken on or after January 26, 2022, are reported as pass/fail only. Results for Step 1 exams taken prior to January 26, 2022, and for all Step 2 CK and Step 3 exams, are reported on a 3-digit scale; reported scores range from 1 to 300.

Table 2 presents performance data for first-time examinees from LCME-accredited medical schools in the United States and Canada who tested in the 2023 calendar year for Step 1 and Step 3, and the 2022-2023 academic year for Step 2 CK. Additional performance data is provided in **Appendix C**.

Table 2. USMLE 2023 Calendar Year Performance for First-Time Examinees from LCME-accredited Medical Schools

Exam	Most Scores Fall Between	Minimum Passing Score	Mean and (Standard Deviation)	Pass Rate
Step 1*	N/A *(reported as pass/fail only)*	194: For exams taken on or before January 25, 2022 196: For exams taken on or after January 26, 2022	Reported as pass/fail only	92%
Step 2 CK	200-275	209: For exams taken on or before June 30, 2022 214: For exams taken on or after July 1, 2022 (to be reviewed in March 2025)	248 (15)	98%
Step 3	185 - 260	198: For exams taken on or before December 31, 2023 200: For exams taken on or after January 1, 2024	227 (15)	97%

*Because of the transition to reporting only a pass/fail outcome, future reviews of the Step 1 passing standard will not be reported in terms of a three-digit score.

Under most circumstances, to receive a score on Step 1, Step 2 CK, and Step 3, an examinee must begin every block of the test. If an examinee does not begin every block and no results are reported, an "incomplete" annotation may appear on the USMLE transcript. If an examinee registers for but does not begin an examination, no record of the test will appear on the examinee's transcript.

Some unscored items and cases may also be included in the Step examinations for research purposes.

Annual performance data for all Step examinations, as well as Score Interpretation Guidelines, are available on the USMLE website at https://www.usmle.org/usmle-updates-research.

Important Notes about the Step 1 Summary Performance

Results indicate a higher fail rate on the Step 1 exam for examinees after the pass/fail transition. It is important to note that factors not present in previous years introduce complexities when comparing this examinee group to previous years. These differences should be considered when interpreting reported data. The factors include:

- Increased passing standard for Step 1
    - The Step 1 pass/fail transition beginning on January 26, 2022, coincided with an increase in the exam's minimum passing standard from 194 to 196. The increase in passing standard accounts for some increases observed in the fail rates.
- Shift in examinee scheduling patterns and volumes
    - The USMLE program has observed shifts in the timing of when examinees tested, particularly around the pass/fail transition date. These changes in test timing patterns suggest that those who tested during this period may not be representative of the typical group that tested during these times in the past. We have also seen changes in the composition of the examinee group. Overall, the volume of Step 1 test takers has increased over time, with a considerable increase in international medical graduates and Osteopathic graduates relative to previous years. These differences complicate comparisons to past performance data.

Conversely, the following factors did not change and should also be considered when interpreting the data:

- Consistency in the construction of USMLE Step examinations
    - Within each Step examination, USMLE creates various forms that are similar in difficulty and content. Each USMLE Step examination includes multiple forms that are similar in difficulty and content for the respective Step. Scores on individual examination forms are made comparable through equating, a psychometric process that adjusts scores based on the difficulty of the questions. This process ensures examinees who take different forms are held to the same passing standard.
- No significant changes to exam specifications for Step 1
    - All USMLE examinations are constructed from an integrated content outline, which organizes content according to general principles and individual organ systems. While not all topics listed in the content outline are included in each Step exam, overall content coverage is comparable among the various examination forms that different examinees of each Step will take. Although foundational science content was recategorized into existing content areas, the test specifications used to construct USMLE Step 1 examinations have not changed substantively since the exam transitioned to pass/fail reporting.
- Consistent style and difficulty for Step 1 exam questions
    - No changes were made to the style and targeted difficulty of the Step 1 exam. USMLE collaborates with a network of medical school faculty and clinicians that come from a variety of educational backgrounds and specialties and throughout the United States to create test items, or questions and cases, that make up the USMLE Step exams. Each year, this network draws on their own experience and expertise to develop high-quality test items with NBME staff that address the topics and challenges that they encounter in their own classrooms and practice based on years of lessons and learned best practices. Participating physicians maintained the standard USMLE item writing approach for the Step 1 exam.

Score Reports and Transcripts

USMLE score reports and transcripts show scores (for Step 1 exams taken prior to January 26, 2022; Step 2 CK; and Step 3) and an indication of whether an examinee passed or failed (for all examinations, including the previously administered Step 2 CS).

If an examinee is found to have engaged in irregular behavior, an annotation to that effect is recorded on the score report or transcript, as well as a copy of the letter to the examinee regarding the finding of irregular behavior. Upon examinee authorization for release of an official USMLE transcript, the same information (i.e., annotation on the transcript, determination letter regarding a finding of irregular behavior, and a report from the FSMB Physician Data Center if applicable) is sent to all transcript recipients, including to medical licensing authorities, for use in making licensure decisions.

Official USMLE transcripts are only provided to individual state medical boards from the FSMB and only upon request of the physician (examinee).

Official USMLE transcripts include the following information/fields:

- All USMLE Steps taken by the physician/examinee, including:
    - Test date
    - Indication of whether an examinee passed or failed (for all examinations, including the previously administered Step 2 CS).
    - Score (only applies to Step 1 exams taken prior to January 26, 2022; Step 2 CK; and Step 3)
    - Minimum passing score in effect on the test date (only applies to Step 1 exams taken prior to January 26, 2022; Step 2 CK; and Step 3)
- Comments
    - If an examinee is found to have engaged in irregular behavior, an annotation to that effect is recorded under Comments on the transcript. A short description of the irregular behavior is included (e.g., security violation) as part of the comment. Additionally, a copy of the determination letter to the examinee regarding the finding of irregular behavior is provided with the transcript. If the irregular behavior finding was reported to the FSMB Physician Data Center (PDC), a report from the FSMB Physician Data Center is also provided.
- Notes
    - All transcripts include a Note regarding the results of the search of the FSMB's Physician Data Center at the time the transcript was requested. If the search reveals that information has been reported to the PDC, the note will state that information was found and a report from the PDC will be provided with the transcript. If no information has been reported to the PDC, the Note will state no reported information has been found for the examinee.
    - Irregular Behavior annotations may also appear under Notes - either alone or in conjunction with an Irregular Behavior annotation under Comments as described above. A short description of the irregular behavior is included (e.g., security violation) as part of the note. Additionally, a copy of the determination letter to the examinee regarding the finding of irregular behavior is provided with the transcript. If the irregular behavior

finding was reported to the FSMB Physician Data Center (PDC), a report from the FSMB Physician Data Center is also provided.

Psychometrics

Score Reliability and Precision

All standardized examinations include some degree of measurement imprecision. Like all high-quality assessments, USMLE utilizes several psychometric measures to monitor and minimize such imprecision. Reliability refers to a score's expected consistency. Candidates' test scores are reliable to the extent that an administration of a different random sample of items from the same content domain would result in little or no change in each candidate's rank order among a group of candidates. In general, long examinations of very similar items administered to a diverse group of examinees yield high reliabilities.

One of the ways that reliability is measured is through metrics of precision that indicate how scores may fluctuate. The standard error of measurement (SEM) provides a general indication of how much a score might vary across repeated testing using different sets of items covering similar content. As a general rule of thumb, chances are about two out of three that the reported score is within one SEM, plus or minus, of the score that truly reflects the examinee's ability (i.e., of the score that would be obtained if the examination were perfectly reliable). Currently, the SEM is approximately 6 points for Step 2 CK and 5 points for Step 3.

The standard error of difference (SED) in scores is an index used to assess whether the difference between two scores is statistically meaningful. If the scores received by two examinees differ by two or more SEDs, it is likely that the examinees are different in their proficiency. Currently, the SED is approximately 8 points for Step 2 CK and 7 points for Step 3.

The standard error of the estimate (SEE) is an additional index of the amount of uncertainty in the scores used to gauge the likelihood of performing similarly on a repeat attempt. If an examinee tested repeatedly on a different set of items covering the same content, without learning or forgetting, their score would fall within one SEE of their current score two-thirds of the time. Currently, the SEE is approximately 8 points for Step 2 CK and 7 points for Step 3.

Decision Consistency

Decision consistency reflects the probability an examinee would be classified in the same category (e.g., pass or fail) on a repeat administration without change in their underlying knowledge. In the context of USMLE, the index quantifies how consistently the respective Step examination categorizes examinees as passing or failing. The index ranges from 0 to 1, where higher values indicate the assessment yields more stable classifications. Decision consistency is generally higher with longer exams – because of the increased reliability – and when most students score far from the passing standard. The most recent decision consistency value is .95 for Step 1, .97 for Step 2 CK, and .97 for Step 3. The high values indicate examinees would almost assuredly receive the same outcome if taking an administration of a different random sample of items from the same content domain without a change in content knowledge.

See **Table 3** for decision consistency, SEM, SED and SEE information for all Steps.

Table 3. Current USMLE Score Precision and Decision Consistency

Exam	Standard error of measurement (SEM)	Standard error of difference (SED)	Standard error of the estimate (SEE)	Decision Consistency
Step 1	Not reported	Not reported	Not reported	.95
Step 2 CK	6 points	8 points	8 points	.97
Step 3	5 points	7 points	7 points	.97

Score Validity

Score validity refers to the extent to which existing evidence supports the appropriateness of the interpretation of test outcomes. The public and state medical boards can reliably conclude that an individual who has passed all examinations in the USMLE sequence has demonstrated the fundamental knowledge and skills for safe and effective patient care.

The best way to support a proposed score interpretation is through accumulation of developmental documentation and research on all components of the test design, delivery, and scoring processes, and through tracking the relationship of examination outcomes with later measures of the individual's ability. The USMLE program has a fairly extensive history of such activity.

A searchable list of NBME and USMLE research published after 2017 can be found at: https://www.nbme.org/research-library.

A list of research citations for studies published from 2009 to 2017, as well as descriptions of many of the USMLE processes, is available on the USMLE website at: https://www.usmle.org/usmle-updates-research.

A recent USMLE-related article published in Academic Medicine - The Associations Between United States Medical Licensing Examination Performance and Outcomes of Patient Care - co-authored by USMLE Vice President Dr. Alex Mechaber shows higher performance on the USMLE exam series was associated with lower in-hospital mortality and shorter length of stay for patients in the Pennsylvania hospital system. In demonstrating higher USMLE performance correlates with improved patient outcomes, this article study further strengthens the evidence that USMLE assesses competencies essential to safe and effective patient care.

Standard Setting

USMLE General Procedures for Standard Setting

The USMLE system for setting standards is established by the USMLE Composite Committee, which includes representatives of the ECFMG, FSMB, NBME and the public. The system specifies the kinds of data to be gathered and how the data are to be gathered, the frequency of reviewing the standards and adjusting them, and assigns the judgment task to the Management Committee. The Management Committee, jointly appointed by the FSMB and NBME, must use the procedures defined by the Composite Committee, but is free to set the standard and revise the standard as it deems necessary. The decision of the Management Committee is final; no superior governing committee is authorized to

alter its decision. The Management Committee includes those with educational, licensing, and clinical practice perspectives, as well as a representative from the public.

Current policy requires that the Management Committee review the effectiveness of Step standards at least annually. A comprehensive review and possible adjustment of the standard must be undertaken approximately every four years. In addition, when there are any major changes to the design or format of the Step examination, the Management Committee is asked to establish new passing requirements for the redesigned components. USMLE believes that there must be an opportunity for review and adjustment of standards in order to reflect the realities of change in the content of medicine, the nature of the test, the characteristics of examinees, and the expectations of stakeholders. Such review of the standard is essential to assure that the judgment inherent in defining the standard reflects current conditions, not those that were pertinent in the past.

Mandated Data Sources Informing the Judgment Process

USMLE policy mandates the use of four categories of data in making judgments about standards. These are:

- Content-referenced judgments of experts. Content experts provide their opinions, based upon review of content and examinee performance, on the appropriate requirements for passing the examination.
- Survey of stakeholders. Expectations of stakeholders for the percent of examinees that should pass the examination.
- Cohort performance trends. Trends in examinee performance over a long period of time and the effect of repeated attempts at the examinations on the failure rate in a defined cohort of examinees.
- Score precision in the region of the cut-score. Estimates of numbers of misclassified examinees based on historical distributions of examinee performance and the measurement error in the scale area under consideration for the cut-score.

Setting the Standard

The Management Committee meets to consider the collected data. As part of this process the committee reviews all of the data collection processes and considers the combined data. Typically, the question posed of the committee is whether the externally collected data, performance trends, and score reliability data suggest that the current standard for a particular Step exam needs to be changed. The committee can allow the standard to remain the same or can vote to make a change. If the latter occurs, the committee identifies the new performance requirements.

Information regarding the timing of the standard setting process and final decisions is posted on the USMLE website.

Data and Research

Aggregate Performance Data

The USMLE program publishes aggregate performance data for all Steps on the USMLE website at www.usmle.org/performance-data.

These data include examinee volume and passing percentages categorized by:

- first-taker and repeater examinees,
- U.S./Canadian and international students/graduates, and
- allopathic and osteopathic examinees.

Passing rates and examinee counts for 2022-2023 for each Step are provided in **Appendix C**.

Research Agenda

Each year, the USMLE program coordinates an operational research agenda to strengthen the evidence supporting USMLE as a tool for medical licensure and guide future program enhancements. Key themes for the 2023 research agenda included:

- Enhancing USMLE security procedures;
- Exploring the association of scores and pass/fail outcomes with patient outcomes;
- Investigating the pass/fail transition's effect on examinee performance, preparation, and scheduling behaviors;
- Understanding how artificial intelligence can be leveraged to improve USMLE through automated scoring of complex item types and item development support; and
- Developing and researching innovative items to enhance clinical skills coverage.

Publications

A listing of recent (2022-2024) USMLE-related publications is available as **Appendix D**.

A list of research citations for studies published from 2009 to 2017, as well as descriptions of many of the USMLE processes, is available on the USMLE website at: https://www.usmle.org/usmle-updates-research.

A searchable list of NBME and USMLE research published after 2017 can be found at: https://www.nbme.org/research-library.

Resources

Websites

- USMLE website (www.usmle.org) provides the most current information on the program.
- FSMB website (www.fsmb.org) contains information specific to USMLE Step 3.
- NBME website (www.nbme.org) contains information specific to registering for USMLE Step 1 and Step 2 CK for students and graduates of U.S. and Canadian medical schools.
- ECFMG website (www.ecfmg.org) provides information on ECFMG certification and registering for USMLE Step 1 and Step 2 CK for students and graduates of international medical schools seeking information.

Written Materials

- USMLE *Bulletin of Information* – provides USMLE policies and procedures and can be accessed from the main page of the USMLE website (www.usmle.org).
- *Journal of Medical Regulation* (previously the *Journal of Medical Licensure and Discipline*) – published by the FSMB, the Journal occasionally provides informational articles summarizing major aspects of the USMLE program. Topics covered include Step 2 Clinical Skills, the development of multiple-choice questions for test content, research, and processes for maintaining program security (see citations below). Past issues are available on the JMR website at https://meridian.allenpress.com/jmr or upon request from the FSMB:
    - "Characteristics and Outcomes of Individuals Engaging in USMLE Irregular Behavior, 2006–2015." Journal of Medical Regulation. Vol. 106, No. 4, 2020.
    - "Implementing Strategic Changes to the USMLE." Journal of Medical Regulation. Vol. 100, No. 3, 2014.
    - "An Assessment of USMLE Examinees Found to Have Engaged in Irregular Behavior, 1992-2006." Journal of Medical Regulation. Vol. 95, No. 4, 2010.
    - "Developing Content for the United States Medical Licensing Examination." Journal of Medical Licensure and Discipline. Vol. 95, No. 2, 2009.
    - "Maintaining the Integrity of the United States Medical Licensing Examination." Journal of Medical Licensure and Discipline. Vol. 92, No. 3, 2006.
    - "The Introduction of Clinical Skills Assessment into the United States Medical Licensing Examination (USMLE): A Description of the USMLE Step 2 Clinical Skills (CS)." Journal of Medical Licensure and Discipline. Vol. 91, No. 3, 2005.
    - "The United States Licensing Examination." The Journal of Medical Licensure and Discipline. Vol. 91, No. 1, 2005.

Key Contacts

The following individuals are key contacts for state medical boards on matters involving the USMLE.

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APPENDIX A
2024 Quarterly FSMB Updates on USMLE

Quarterly FSMB Update on USMLE®

March 2024, Vol.5, No.1

USMLE Score Invalidation

The USMLE program regularly monitors and analyzes examinees' test performances for unusual score patterns or variations, and other information that could raise questions about the validity of an examinee's results. As part of an ongoing investigation, the USMLE program has identified a pattern of anomalous exam performance associated with Nepal, which challenges the validity of test results for a group of examinees. Highly irregular patterns can be indicative of prior unauthorized access to secure exam content. Examinees with results in question are being notified by the USMLE Secretariat's Office that their previous Step score(s) have been invalidated and that they will be required to take a validation exam(s). The USMLE program is working to notify examinees who need to schedule validation exam(s) and to support state medical boards and other score users and stakeholders impacted by the validation exam requirements.

If you or your board have any questions or need additional information, please contact David Johnson, FSMB's Chief Assessment Officer, at djohnson@fsmb.org.

USMLE Standard Setting

The USMLE program is inviting state medical boards to participate in a USMLE standard setting survey. An email was recently sent out to all state board executive directors and chairs/presidents about the survey. Individuals who are interested in participating should complete and submit the survey within the next month.

Change in Step 3 Passing Standard

The USMLE Management Committee met on December 12-13, 2023, and conducted a review of the passing standard – used to determine a Pass or Fail outcome – for USMLE Step 3. As part of the USMLE program's operational procedures and in alignment with best practices for licensing and certification exams, a comprehensive review and analysis of the passing standard for each Step exam typically occurs every three to four years. This ensures that the passing standard is consistent with expectations of the level of content mastery of the knowledge and skills needed to support effective medical practice and licensure.

For the Step 3 review, information from multiple sources was considered, including:

- Recommendations from independent groups of physicians unaffiliated with the USMLE participating in content-based standard-setting panels in September and October 2023;
- Results of surveys of various groups (e.g., state medical board representatives, residency program directors, medical school faculty, examinees) concerning the appropriateness of current passing standards for the Step 3 examination;
- Data on trends in examinee performance; and
- Score precision and its effect on the pass/fail outcome.

The Committee decided that a two-point increase in the passing standard will apply to Step 3 examinees testing on or after January 1, 2024. On the three-digit score scale, the passing standard changed from 198 to 200.

2024 USMLE Meetings Calendar

Budget Committee - April 24

Committee for Individualized Review - May 7-8

Composite Committee - June 7-9

Resources

USMLE.org

Bulletin of Information

FAQs

Contact

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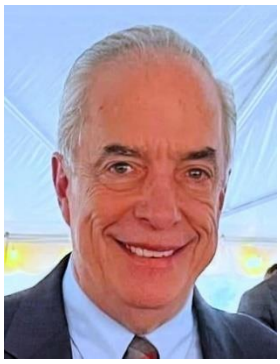
Quarterly FSMB Update on USMLE®

June 2024, Vol. 5, No. 2

USMLE Volunteer Spotlight



Gerard (Gerry) Dillon, PhD
Public Member
Pennsylvania State Board of Medicine

I have been a public member of the Pennsylvania State Board of Medicine for four years. Being a member of a state board has allowed me the opportunity to work with FSMB in several ways. I have represented my board as a delegate to FSMB's annual meeting, am on the Editorial Board for the Journal of Medical Regulation and am currently on the FSMB Ethics and Professionalism Committee.

Prior to joining the board of medicine, I worked at NBME for more than forty years, spending nearly all that time helping to develop examinations to be used in the medical licensing process. I was witness to the hard work and dedication of members of the national faculty of content experts (many of whom were and are members of state medical boards) who develop test materials, set testing standards and provide direction for the USMLE program. I was also witness to the excellence of the testing professionals who strove to make the examinations as reliable and valid as possible. The stated goal was always to provide the best possible assessment tool for the state medical boards to use in the licensing process.

My opportunity to be a USMLE volunteer started with my appointment to the State Board Advisory Panel to the USMLE program. The panel is made up of approximately 10 individuals who are members of state boards from around the country. The panel meets annually and has an opportunity to interact with USMLE program members (including ECFMG, FSMB and NBME staff). USMLE uses the panel as a sounding board for the direction that the program takes in terms of policies, test design, standard setting, score reporting and other issues. The USMLE staff also seeks input from the member states about the pressing issues they encounter locally and how those might impact or be impacted by the examination system. It is also a wonderful opportunity to "compare notes" with colleagues from sister boards on the issues that impact all regulators. This dialogue between and among examination developers and users is enormously important, and I consider myself fortunate to be a part of it.

Finally, one of the many things I have become aware of since becoming a member of a state medical board is how trusting we are of all the excellent partner organizations that contribute to the regulatory process in this country. The USMLE program and its parents, FSMB and NBME, are among some of the most important of these organizations. It is an honor to be a small contributor to this process, and I would encourage my state board colleagues to consider how they might become part of this program.

USMLE Orientation for State Board Members and Staff

Since 2007, FSMB and NBME have hosted an annual USMLE Orientation workshop for state board members and staff with an interest in learning about and/or participating in the program. To date, 209 individuals from 60 medical and osteopathic boards have participated in an orientation workshop. Sixty-five past participants (representing 35 boards) have served subsequently with the USMLE program. This includes participation on standard setting panels and advisory panels, as well as serving on the USMLE Management Committee, the USMLE Composite Committee and/or item writing and item review committees.

If you or any of your board members or staff are interested in attending the Orientation, please contact Frances Cain, FSMB's Director of Assessment Services, at fcain@fsmb.org.

USMLE Composite Committee Update

At the June 2024 USMLE Composite Committee meeting, the committee elected Cheryl Walker-McGill, MD, MBA, (North Carolina) as Chair for a two-year term. Congratulations, **Dr. Walker-McGill**!

The committee met over two days and discussed a revision to the committee's rules of operation, appeals stemming from decisions of the Committee for Individualized Review, appointment of new members, organizational updates, an update on USMLE Management Committee activities, discussions of form design and exam security and a review of plans for an ongoing transformation of the USMLE exam.

Other members of the committee include representatives of FSMB who serve or have served on state medical boards - FSMB Past Chair Jeffrey Carter, MD, (Missouri); FSMB Past Chair Sarvam TerKonda, MD, (Florida-Medical); Kristin Spanjian, MD, (Montana); and Danny Takanishi, Jr., MD, (Hawaii).

2023 USMLE Aggregate Performance Data

2023 performance data are now available for all USMLE Steps. These data include examinee volume and passing percentages categorized by:

- first-taker and repeater examinees
- U.S./Canadian and international students/graduates
- allopathic and osteopathic examinees

Performance data for USMLE administrations dating back to 2013, as well as Score Interpretation Guidelines, are also available on the USMLE website.

Score Reporting Timeline

The USMLE program will no longer implement dedicated score delay periods for the Step examinations. Most exam scores will continue to be reported within four weeks after an examinee completes their test. However, in rare cases, various factors may delay score reporting. Examinees are advised to allow at least eight weeks to receive their score reports.

USMLE Content Outline Updated

To help ensure the relevancy of content on the USMLE, the USMLE program has released an updated content outline. In this update, topics in the previous "General Principles of Foundational Science" category, which focused on foundational science content, have been redistributed into respective organ system categories or included in a new category titled "Human Development."
Learn more about the update with this infographic.

What's the purpose of this update?
The USMLE is created to be clinically relevant by a diverse national faculty of medicine drawn from medical schools, state licensing boards and clinical practice settings from every region of the United States. As practice guidelines evolve or are introduced, the content on the USMLE is reviewed and modified by these experts as needed. All USMLE examinations are constructed from two classification schemes: (1) an integrated content outline, which organizes content according to individual organ systems and (2) a physician tasks and competencies outline. To ensure that foundational science principles are tested in a clinically relevant manner, this latest modification to the content

outline aims to better incorporate these topics into individual organ systems without changing the proportion of foundational science covered within the exams.

What's the impact of this change?
Foundational science knowledge is a critical building block for future physicians to develop clinical skills and reasoning. The foundational science topics included in the updated content outline are not being removed, just recategorized. Additionally, the weighting or proportion of foundational science content included in the Step exams will not change.

How will this influence examinee preparation for Step exams?
Examinees preparing for Step exams should use the updated content outline available on USMLE.org. The content outline provides a common organization of content across all three Step examinations. However, no single examination includes questions on all listed topics.

Follow USMLE on social media

We encourage state board staff to follow USMLE on social media for timely USMLE news and updates!

Facebook LinkedIn X *(formerly Twitter)*

2024 USMLE Meetings Calendar

Patient Characteristics Advisory Panel - May 22
Management Committee - June 4, August 5-7
Composite Committee - June 7-9
Committee for Individualized Review - July 16-17

Contact

Frances Cain, MPA
Director, Assessment Services
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October 2024, Vol. 5, No. 3

USMLE Orientation for State Board Members and Staff

Pictured (L-R): *Erica Lamy, Freda Pace, Tiffany Seamon, Camille Lindsay, Dr. Kenneth Cleveland, Rebecca Robbins, Christopher Palazola*

On October 2, 2024, the FSMB and NBME hosted 21 members and staff from 12 state medical boards at FSMB's offices in Euless, Texas, and virtually for the 18th annual USMLE Orientation for State Board Members and Staff.

The orientation, first held in 2007, provides members and staff from state medical and osteopathic boards with an opportunity to learn about the USMLE program and engage directly with program staff. The goals of the workshop remain: (1) to inform and educate the medical board/regulatory community on the USMLE program, including new developments and key issues; (2) to create and facilitate relationships with USMLE program staff to ensure that state boards have an immediate resource for any USMLE-related questions; and (3) to share opportunities for state board members and staff to participate directly with the USMLE program.

This year's meeting included a brief history of medical licensing examinations, which spotlighted two key principles upholding the value of the medical licensing examination: (1) acting as an independent audit of the medical education/training system and (2) providing a common national standard for the assessment of physicians for purposes of initial medical licensure. The meeting also provided an overview of the USMLE program, research, examination security and how state board members and staff can participate.

Attendees (in-person and virtual) included:

- Rebecca Robbins, Alabama (Commission)
- Tiffany Seamon, Alabama (Commission)
- Randy Ho, Hawaii
- Camile Lindsay, Illinois
- Lynne Weinstein, Maine-Medical
- Valerie Hunt, Maine-Medical
- Rebecca Mueller, MD, Indiana
- Kiko Dixon, Indiana
- Elizabeth Huntley, JD, CMBE, Minnesota
- Kita Nelson, Minnesota
- Kenneth Cleveland, MD, Mississippi
- Erica Lamy, New Hampshire
- Antonia Winstead, New Jersey
- Lawrence Muka, New Jersey
- Christopher Palazola, Texas
- Mandy Moreno, Texas
- Abigail Revuelta, Texas
- Becky McElhiney, Washington-Osteopathic
- Danielle Dooley, Washington-Osteopathic
- Freda Pace, Washington-Medical
- Kyle Karinen, Washington-Medical

Since the creation of USMLE in 1992, more than 209 individuals from 60 medical and osteopathic boards have participated in the USMLE orientation. Sixty-five past participants (representing 35 boards) have served subsequently with the USMLE program. This includes participation on standard setting panels and advisory panels, as well as serving on the USMLE Management Committee, the USMLE Composite Committee, and/or item writing and item review committees.

The USMLE program sincerely thanks all current and past state board volunteers for their participation, which is integral to the success of the program!

Physicians and public members of state medical and osteopathic boards interested in attending the next orientation should contact Frances Cain, MPA, Director of Assessment Services at FSMB, at fcain@fsmb.org.

USMLE Committee Member Social Media Campaign

The USMLE program is launching a social media campaign to feature USMLE committee members. These posts will help to humanize the program by showcasing the many medical educators and regulators who contribute behind the scenes to the success of the USMLE program. Participating is as easy as sharing a headshot and completing a quick questionnaire. The Marketing & Communications team will use these materials to create social media posts. If you're a USMLE committee member, or served previously in this capacity, and are interested in participating in this campaign, please contact Alyssa Yeroshefsky, Communications Manager of the USMLE Program, at ayeroshefsky@fsmb.org.

Anomalous Performance on USMLE Step Examinations

The USMLE program is committed to protecting the integrity of the exam sequence and continues to evaluate and enhance exam security policies and initiatives. Routine analyses are performed as part of the scoring process to detect unusual examinee response behavior. As part of an ongoing investigation, the USMLE program recently took action to invalidate exam scores based on a pattern of anomalous performance detected that indicates prior knowledge of secure examination content. Invalidated scores appear on transcripts as "Score Not Available".

The USMLE program also revised policies applicable to performance data for failing outcomes that raise concerns about an examinees' readiness or motivation to pass the exam. Examinees who meet such criteria may be contacted by the USMLE program and required to allow a twelve (12) month period to pass before attempting USMLE again. The mandatory twelve (12) month bar on access to the exam cannot be appealed and is intended to encourage adequate study time and to pace exam content exposure for individuals who are not performing at a level predictive of passing on the next attempt without additional preparation.

Should an examinee reach out to your board about appealing any USMLE decision, please feel free to contact Frances Cain, MPA, Director of Assessment Services at FSMB, at fcain@fsmb.org to gain clarification.

ECFMG Update Regarding Change to Accreditation Body for Medical Schools in Canada Effective in 2025

According to a recent update from the Educational Commission for Foreign Medical Graduates (ECFMG), a member of Intealth™, individuals who graduate from Canadian medical schools on or after July 1, 2025, will be considered international medical graduates for the purpose of entry into GME programs in the United States. In order for these graduates to enter ACGME-accredited residency programs, the ACGME will require that they either obtain ECFMG Certification or hold a full and unrestricted license to practice medicine in the U.S. licensing jurisdiction in which the ACGME-accredited program is located.

More detailed information is available in this ECFMG update.

2024 USMLE Meetings Calendar

Composite Committee - October 21

State Board Advisory Panel - November 13

Patient Characteristics Advisory Panel - November 22

Management Committee - December 3-4

Committee for Individualized Review - December 3-4

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Quarterly FSMB Update on USMLE®

December 2024, Vol. 5, No. 4

Reflecting on 2024

As December draws to a close, we want to express our appreciation to the many volunteers from the medical licensing community who devoted their time and effort to support the USMLE program this past year. In particular, we would like to thank those who served on the USMLE Composite and Management Committees in 2024: Andrea Anderson, MD (DC); Jeffrey Carter, MD (MO); Sarvam TerKonda, MD (FL); Danny Takanishi, MD (HI); Nicole Gilg, MD (IA); Jade James-Halbert, MD (MO); Kristin Spanjian, MD (MT); Bryant Murphy, MD (NC); Cheryl Walker-McGill, MD (NC); and Patricia Hunter (VT). We thank these individuals and the many additional volunteers from the state board community who served on other USMLE committees and panels. Their contributions and perspectives are invaluable.

The USMLE program benefited immensely this year from the input of key stakeholders such as our State Board Advisory Panel and Medical Student & Resident Advisory Panel. The same can be said for the participants at our annual USMLE workshop for state medical board members and staff. Their insight and thoughtful input on program activities will continue to help shape our efforts going forward.

We enjoyed the opportunity to inform and update many of you on the USMLE this past summer through the program created and conducted jointly by FSMB and Administrators in Medicine (AIM) for licensing specialists. We are already looking forward to working with the next cohort of licensing specialists registered for the 2025 session.

This year included unique challenges to USMLE governance and staff charged with protecting the security of the USMLE. The enhancements and changes already implemented have further safeguarded the integrity of the USMLE, helping to inform your licensing decisions.

Looking ahead, we remain committed to strengthening USMLE's ability to assess key physician competencies valued by the licensing community. Accordingly, we will keep you apprised of ongoing pilot work on testing formats that can further enhance USMLE assessment of key competencies, e.g., clinical reasoning and communication. At the same time, we will continue exploring new and enhanced ways to keep you informed on USMLE activities.

Finally, we wish all the staff and members at the state medical and osteopathic boards a happy and healthy holiday season.

David Johnson
FSMB Chief Assessment Officer

Alex Mechaber, MD
NBME Vice President of USMLE

USMLE State Board Advisory Panel

The USMLE State Board Advisory Panel met at FSMB's Texas offices on November 13, 2024. The panel brings together board members and staff from state medical and osteopathic boards for in-depth discussions between the licensing community and USMLE program staff. For more than a decade this panel has convened annually as a reactor panel and sounding board offering feedback, advice and input from the medical licensing community on all aspects of the USMLE program.

Current members include the following board staff and members (pictured left to right in the photo above):

- Mustafa Hamed, MD, Michigan-Medical
- Gerard Dillon, PhD, Pennsylvania-Medical
- Maria Laporta, MD, Illinois
- Shami Goyal, MD, Illinois
- Rebecca Robbins, Alabama (Licensure Commission)
- David Herlihy, Esq, Vermont-Medical
- Stephen Boese, New York (Licensure)
- Guillermo Guzman, MD, Idaho
- Stephen Brint Carlton, JD, Texas (not pictured; participated virtually)
- Mark Spangler, MA, CMBE, West Virginia-Medical (not pictured; participated virtually)

Topics discussed during the meeting included examination security; impact of recent USMLE changes, specifically, the attempt limit change, Step 1 pass/fail outcome reporting and discontinuation of Step 2 Clinical Skills (CS); program updates (research, performance data, new item formats); ECFMG Certification expiration and USMLE eligibility requirements; and impact of the impending 2025 change in accreditation of Canadian medical schools on USMLE eligibility requirements.

Annual USMLE Report

The 2024 *Annual Report on the United States Medical Licensing Examination* is now available and has been provided along with this newsletter. The report is distributed via email to all state medical boards and provides a timely snapshot into major developments within USMLE, as well as foundational information explaining the program.

As of 2023, approximately 63% of the 1,062,460 physicians licensed in the U.S. have taken all or part of the USMLE sequence; 58% have taken all Steps (1, 2 and 3). This represents a 2% increase in both measures since 2022. *(Note: Physicians with a partial USMLE sequence include those who took a combination of USMLE and either the previously administered NBME Parts examination or the FLEX examination.)*

Medical licensing authorities and their representatives continue to be key stakeholders and contributors to the USMLE program. In 2024, 44 individuals from 26 state medical and osteopathic boards across the U.S. participated in USMLE in some capacity. Since implementation of the USMLE in 1992, 360 members and staff from state medical boards have participated in the USMLE program in some capacity. These individuals represent 65 different medical and osteopathic licensing boards throughout the country. More detailed information about state boards' involvement with USMLE is provided in the "State Medical Boards Participation in USMLE" section of the report.

State board members and staff who are interested in learning more about USMLE or serving on a USMLE committee, panel or task force can contact Frances Cain, fcain@fsmb.org, for information about participating in the annual USMLE Orientation.

USMLE Meetings Calendar

Management Committee
December 3-4, 2024

Committee for Individualized Review
December 3-4, 2024

Composite Committee
February 11, 2025

Committee for Individualized Review
March 5-6, 2025

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fcain@fsmb.org
(817) 868-4402

APPENDIX B
USMLE Program News 2023 – 2024

Below are excerpts from key USMLE announcements in 2023 - 2024. The full archive of announcements is available on the USMLE website at https://www.usmle.org/announcements

Early Release of USMLE Step 1 2022 Summary Performance (posted February 2023)

In response to requests from LCME schools following the recent policy transition of Step 1 to pass/fail reporting only, USMLE has released Step 1 summary performance data to provide score users with important outcome data earlier than scheduled. The data provides information regarding the performance of all examinees and examinees from LCME-accredited schools.

More information is available at:

https://www.usmle.org/early-release-usmle-step-1-2022-summary-performance

USMLE Program Discusses ChatGPT (posted February 2023)

With the advent of ChatGPT, a large language model developed by OpenAI, there have been growing conversations about the advancements of artificial intelligence (AI) programs and their intersectionality with medicine and medical education. Several studies have been conducted on the use of AI to answer multiple-choice test questions on medical knowledge. Some conversations about these studies seem to suggest that AI tools are correctly answering USMLE test questions and we wanted to provide some additional context.

A review of the MedQA-USMLE database revealed that the study used test preparation materials from a third party unaffiliated with USMLE. Another study examined the results of ChatGPT using practice questions available at USMLE.org. It's not surprising that ChatGPT was successful in answering these questions, as the input material is largely representative of medical knowledge available from online sources.

However, it's important to note that the practice questions used by ChatGPT are not representative of the entire depth and breadth of USMLE exam content as experienced by examinees. For example, certain question types were not included in the studies, such as those using pictures, heart sounds, and computer-based clinical skill simulations. This means that other critical test constructs are not being represented in their entirety in the studies.

Although there is insufficient evidence to support the current claims that AI can pass the USMLE Step exams, we would not be surprised to see AI models improve their performance dramatically as the technology evolves. If utilized correctly, these tools can have a positive impact on how assessments are built and how students learn.

The USMLE co-sponsors (NBME and Federation of State Medical Boards) recognize the importance of these studies and their findings. In the future, we would be very interested in examining the questions that ChatGPT answered incorrectly and the implications of these results. As the technology advances, we will continue to look for ways to enhance the assessment of skills and behavior so that we may evolve in tandem with medical education and potential changes to the practice of medicine. While we are optimistic, we remain mindful of the risks that large language models bring in terms of potential for misinformation and perpetuating harmful biases.

2022 USMLE Performance Data Available Now (posted March 2023)

The USMLE program has released the 2022 examinee performance data for each of its three Step exams. The performance tables show the passing rates for each Step by various examinee groups and are available at: https://www.usmle.org/performance-data.

USMLE Brand Refresh (posted April 2023)

USMLE has refreshed its branding with a new, modernized look and feel that better reflects its relevance to the practice of medicine today.

The new logo features three distinct segments that represent the Step exams that medical school students and graduates take on their journey to medical licensure. It also references a common symbol for health care and medicine – the cross – which represents protection and help at hand.

New Study: USMLE Performance Tied to Better Patient Outcomes (posted November 2023)

A recent article published in *Academic Medicine* explores the correlation between examinee performance on the United States Medical Licensing Examination® (USMLE®) and improved patient outcomes. This new research provides additional support for the validity and importance of USMLE's role in the medical licensure process and the connection between examinee performance and providing safe and effective health care for patients.

The authors conducted a retrospective analysis of nearly 200,000 hospitalizations (with five common inpatient diagnoses) in Pennsylvania over a three-year period with more than 1,750 family physicians and general internists, connecting their USMLE scores with outcomes of in-hospital mortality and

length of stay. Results showed that better physician USMLE performance across the series of exams was associated with lower mortality and shorter length of stay.

Prior studies have documented the link between performance on licensing exams and the number of test attempts with other markers of physician competence – demonstrating associations between USMLE and specialty board exam performance, clinical performance evaluations, and ensuing disciplinary actions by state medical boards. In showing higher USMLE performance connects with improved patient outcomes, this study strengthens the evidence that USMLE assesses competencies essential to patient care.

"The USMLE is designed to ensure that licensed physicians have the necessary knowledge and skills to provide safe and effective patient care," said Alex Mechaber, MD, Vice President, USMLE, NBME. "This latest research further demonstrates the positive correlations between USMLE scores and improved patient outcomes of care,"

For further information about the important and continuing role of independent standardized assessments for medical regulation and the conclusions about trainee/physician performance, read the full paper "The Associations Between United States Medical Licensing Examination Performance and Outcomes of Patient Care" in Academic Medicine.

Change to Step 3 Passing Standard Begins January 1, 2024 (posted December 2023)

At its December 2023 meeting, the USMLE Management Committee, representing a national group of physicians in licensure, medical education, and current practice, and two public members, conducted a review of the USMLE Step 3 passing standard. It was decided that a two-point increase in the passing standard – used to determine a Pass or Fail outcome – will apply to Step 3 examinees testing on or after January 1, 2024. **On the three-digit score scale, the passing standard will change from 198 to 200.**

As part of the USMLE program's operational procedures and in alignment with best practices for licensing and certification exams, a scheduled comprehensive review and analysis of the passing standard for each Step exam typically occurs every three to four years. This ensures that the passing score reflects current expectations concerning knowledge and skills needed to support effective medical practice and patient care.

The Management Committee determined this adjustment to the passing standard through the careful and thorough consideration of information from multiple sources, including:

- Recommendations from independent groups of physicians unaffiliated with the USMLE who participated in content-based standard-setting panels in September and October 2023;
- Results of surveys of various groups (e.g., residency program directors, medical school faculty, state licensing representatives, examinees) concerning the appropriateness of the current passing standard for the Step 3 examination;
- Data on trends in examinee performance; and
- Score precision and its effect on the pass/fail outcome.

The USMLE program provides advanced notice of Step exam passing standard reviews and any adjustments on the USMLE website. Details about the review process also appear in the USMLE *Bulletin of Information.*

The USMLE program updates content outlines for all Step exams (posted January 2024)

To help ensure the relevancy of content on the United States Medical Licensing Examination® (USMLE®), the USMLE program has released an updated content outline for its assessments**.** In this update, topics in the previous "General Principles of Foundational Science" category, which focused on foundational science content, have been redistributed into respective organ system categories or included in a new category titled "Human Development." Learn more about the update with our infographic.

What's the purpose of this update?
The USMLE is created to be clinically relevant by a diverse national faculty of medicine drawn from medical schools, state licensing boards and clinical practice settings from every region of the United States. As practice guidelines evolve or are introduced, the content on the USMLE is reviewed and modified by these experts as needed.

All USMLE examinations are constructed from two classification schemes: (1) an integrated content outline, which organizes content according to individual organ systems, and (2) a physician tasks and competencies outline. To ensure that foundational science principles are tested in a clinically relevant manner, this latest modification to the content outline aims to better incorporate these topics into individual organ systems without changing the proportion of foundational science covered within the exams.

What's the impact of this change?
Foundational science knowledge is a critical building block for future physicians to develop clinical skills and reasoning.

The foundational science topics included in the updated content outline are not being removed, just recategorized. Additionally, the weighting or proportion of foundational science content included in the Step exams will not change.

How will this influence examinee preparation for Step exams?
Examinees preparing for Step exams should use the updated content outline available on USMLE.org. The content outline provides a common organization of content across all three Step examinations. However, no single examination includes questions on all listed topics.

Examinees should continue to study Foundational Science content while preparing for the Step examinations.

When preparing for a Step examination, use the links below for details on which parts of the content outline are emphasized and specific weighting for topics for each Step.
Review Step 1 Exam Specifications
Review Step 2 CK Exam Specifications
Review Step 3 Exam Specifications

USMLE Program Statement on Notification of Invalidated Exam Scores (posted January 2024)

For more than 30 years, the United States Medical Licensing Examination (USMLE) has helped to ensure that physicians licensed to practice medicine in the United States have the knowledge and clinical skills necessary to care for patients safely and effectively. Consequently, ensuring the integrity and validity of the USMLE is paramount. Examinees who take the USMLE agree to uphold the integrity of the testing process, and security measures are in place to detect exam practices or performances that may raise questions of score validity.

The USMLE program regularly monitors and analyzes examinees' test performances for unusual score patterns or variations, and other information that could raise questions about the validity of an examinee's results. As part of an ongoing investigation, the USMLE program has identified a pattern of anomalous exam performance associated with Nepal, which challenges the validity of test results for a group of examinees. Highly irregular patterns can be indicative of prior unauthorized access to secure exam content. Examinees with results in question are being notified by the USMLE Secretariat's Office that their previous Step scores have been invalidated and that they will be required to take a validation exam(s). The USMLE program is working to notify examinees who need to schedule validation exam(s) and to support score users and other stakeholders impacted by the validation exam requirements.

USMLE score reporting timeline update (posted March 2024)

The USMLE program will no longer implement dedicated score delay periods for the Step examinations. Most exam scores will continue to be reported within four weeks after an examinee completes their test. However, in rare cases, various factors may delay score reporting. When selecting your test date and inquiring about results, you should allow at least eight weeks to receive notification that your score report is available.

Important Update: Change in Process for Requesting USMLE Transcripts (posted August 2024)

Effective August 21, 2024, the processing of all United States Medical Licensing Examination® (USMLE®) transcript requests from international medical students and graduates (IMGs) will transition from ECFMG®, a division of Intealth™, to the Federation of State Medical Boards (FSMB), a co-sponsor of the USMLE program. ECFMG will process complete transcript requests received through August 20, 2024. IMGs who wish to request USMLE transcripts after this date must submit their requests and payment to FSMB following the instructions on FSMB's website.

This change does not affect transcripts requested and sent via ERAS. IMGs participating in ERAS 2025 should continue to follow instructions from ERAS for sending their USMLE transcripts to U.S. training programs.

This change streamlines the transcript request process by centralizing all transcript requests (except for ERAS transcripts) with FSMB, which already processes transcript requests from U.S. and Canadian

medical school students and graduates and from certain IMGs (for example, IMGs who want to send a transcript to a U.S. state medical licensing authority).

For more information, please refer to the Important Dates or common questions below.

Important Dates:
August 20, 2024: Deadline for receipt of IMG transcript requests by ECFMG.
August 21, 2024: FSMB begins processing transcript requests for IMGs.

FAQs:

- What's the deadline for an IMG to request a transcript from ECFMG?
    - To help ensure that ECFMG can process your transcript request, the request form and payment must be received by ECFMG no later than August 20, 2024 (U.S. Eastern Time).
- What's the first date to submit a transcript request to FSMB?
    - FSMB will begin accepting transcript requests on August 21, 2024. Please visit FSMB's website and follow the instructions to submit your request and payment.
- I'm an IMG participating in ERAS 2025. Does this change affect electronic transcripts sent to programs via ERAS?
    - No. Electronic transcripts sent to programs for ERAS 2025 are not affected by this change.
- I just submitted a transcript request to ECFMG. Will my transcript be sent? Or do I need to submit a new request?
    - If ECFMG receives your completed transcript request and payment on or before August 20, 2024, your request will be processed, and your transcript will be sent. Please allow several business days for ECFMG to process your request.
    - If your request is received by ECFMG after August 20, 2024, it will not be processed, and you will need to submit a new request and payment to FSMB. To request a refund of transcript fees sent to ECFMG, please contact finance@ecfmg.org.
- How can international medical schools make an institutional request for transcripts for their students and graduates after this change?
    - Institutional requests for transcripts will no longer be offered after August 20, 2024. However, medical students and graduates can still request and pay for their transcripts to be sent directly to their medical school.
- I'm an IMG and will need to request a transcript in September. Where can I find more info on how to do that?
    - To request a transcript after August 20, please visit FSMB's website and follow the instructions to submit your request and payment.
- What is the reason for this change?
    - Currently, multiple organizations receive and process paper transcripts for the USMLE program. This change streamlines the transcript request process by centralizing all transcript requests, except for residency application transcripts (including ERAS), with USMLE co-sponsor FSMB. This change will also allow recipients to receive transcripts more quickly because transcripts will now be delivered electronically via email instead of by mail in paper format.
- Will transcripts still be delivered by mail in paper format?
    - No, after August 20, all transcripts will be delivered electronically via email.

USMLE Fee Assistance Program to Help Learners with Financial Need (posted August 2024)

The United States Medical Licensing Examination® (USMLE®) co-sponsor, NBME, is introducing a new fee assistance program for students with demonstrated financial need who meet the required criteria to use towards the registration cost of the USMLE Step exams. This program will provide aid to approximately 1,300 medical students to cover their fees for USMLE Step 1 or Step 2 Clinical Knowledge (CK) examinations.

Applications for the fee assistance program are open until October 16, 2024. Examinees can learn more at NBME.org.

Scheduled Review of USMLE Step 1 Passing Standard (posted October 2024)

The USMLE Management Committee is scheduled to conduct a review of the passing standard for USMLE Step 1 at its December 2024 meeting.

As part of the USMLE program's operational procedures and in alignment with best practices for licensing and certification exams, a comprehensive review and analysis of the passing standard for each Step exam typically occurs every three to four years. This process ensures that the passing standard aligns with the expected level of content mastery needed to support effective medical practice and licensure.

For the 2024 Step 1 review, information from multiple sources will be considered, including:

- Recommendations from independent groups of physicians and educators unaffiliated with the USMLE participating in content-based standard-setting panels in September and October 2024;
- Survey results of various groups (e.g., state licensing representatives, residency program directors, medical school faculty, examinees) concerning the appropriateness of the current passing standard for the Step 1 examination;
- Data on trends in examinee performance; and
- Score precision and its effect on the pass/fail outcome.

The USMLE program provides advanced notice of Step exam reviews and any adjustments on the USMLE website. The review process also appears in the USMLE *Bulletin of Information*.

If the Committee determines that a change to the passing standard is appropriate, the new recommended passing standard will become effective for all examinees who take the Step 1 examination on or after January 1, 2025. As more information becomes available, updates and the final decision will appear on the USMLE website.

Expiration of ECFMG Certificates and Impact on USMLE Eligibility (posted October 2024)

The USMLE program requires unexpired ECFMG Certification to be eligible for USMLE Step 3. If you have an ECFMG Certificate that is subject to expiration and wish to take Step 3, you must meet the following eligibility requirements:

- Passing scores on Step 1 and Step 2 CK, AND

- An MD degree or the DO degree from an LCME- or COCA-accredited US or Canadian medical school, OR the equivalent of the MD degree from a medical school outside the US and Canada that is listed in the World Directory of Medical Schools as meeting ECFMG eligibility requirements and AND **obtain ECFMG Certification which is valid and unexpired at the time of application and testing,**
- Meet all other eligibility criteria as listed in the USMLE Bulletin of Information.

If you have questions about your eligibility to take Step 3, please contact the FSMB at +1 (817) 868-4041 or usmle@fsmb.org.

If you have any questions regarding the status of your ECFMG Certification, please contact ECFMG at +1 (215) 386-5900 or info@ecfmg.org.

Policy re non-expired ECFMG Certificates and Step 3 eligibility FAQs

1. Am I eligible to apply for and take USMLE Step 3 if my ECFMG Certificate has expired?
   No, applicants must have a valid and unexpired ECFMG Certificate at the time of application and on the testing dates for USMLE Step 3.

2. Can I select an eligibility period that includes dates beyond the date my ECFMG Certificate expires?
   No, applicants must have a valid and unexpired ECFMG Certificate at the time of application and on the testing dates for USMLE Step 3. Therefore, examinees must select an eligibility period with an end date before the expiration date of their ECFMG Certificate.

3. Can I extend my eligibility period beyond the date my ECFMG Certificate expires?
   No, applicants must have a valid and unexpired ECFMG Certificate at the time of application and on the testing dates for USMLE Step 3. Therefore, examinees cannot extend their eligibility period beyond the expiration date of their ECFMG Certificate.

4. I have questions about my ECFMG Certificate expiration and/or renewal process. Who should I contact?
   Please contact ECFMG at info@ecfmg.org with any questions about ECFMG Certification.

Change in Provision of USMLE Service Functions

The co-sponsors of the United States Medical Licensing Examination® (USMLE®), the Federation of State Medical Boards (FSMB) and NBME, are developing plans to centralize all USMLE service functions. As part of these plans, USMLE services currently provided to international medical students and graduates (IMGs) by ECFMG®, a division of Intealth™, will transition to the USMLE co-sponsors.

This change will consolidate all USMLE examinee services, including exam registration, score report delivery, and USMLE customer service, with the USMLE co-sponsors. The goal of this change is to streamline the examinee journey and to create a more consistent and efficient examinee experience.

The transition of USMLE services is expected to take place no earlier than mid-2025. Until then, ECFMG will continue to provide USMLE services to IMGs.

Please note that this change does not affect the requirements for ECFMG Certification. After the transition of services takes effect, ECFMG will continue to determine whether IMGs are eligible for ECFMG Certification, and eligibility for Certification will continue to be a core requirement for IMGs to take USMLE. ECFMG will share information on Certification eligibility with the USMLE co-sponsors for the purposes of registration. Step 1 and Step 2 Clinical Knowledge (CK) will continue to be required by ECFMG to meet the medical science examination requirement for Certification.

The USMLE program will release additional information, including more details on the timing of this transition and other related developments, in the first quarter of 2025. Please continue to monitor USMLE.org for program updates.

APPENDIX C
USMLE Aggregate Performance Data 2022-2023

The data tables below are extracted from the performance data provided on the USMLE website at https://www.usmle.org/performance-data. Performance data for USMLE administrations dating back to 2012 are also available on the website.

Table 1.C

2023 STEP 1 ADMINISTRATIONS *
Number Tested and Percent Passing

	# Tested	% Passing
Examinees from US/Canadian Schools that Grant:		
MD Degree	25,146	90%
1st Takers	23,100	92%
Repeaters**	2,046	70%
DO Degree	4,913	86%
1st Takers	4,798	87%
Repeaters**	115	60%
Total US/Canadian	30,059	90%
Examinees from Non-US/Canadian Schools		
1st Takers	22,611	72%
Repeaters**	3,530	47%
Total non-US/Canadian	26,141	68%

*Represents data for examinees that tested in 2023 whose scores were reported through February 21, 2024.
**Repeaters represents examinations given, not number of examinees.

Table 2.C

2022-2023 STEP 2 CK ADMINISTRATIONS *
Number Tested and Percent Passing

	# Tested	% Passing
Examinees from US/Canadian Schools that Grant:		
MD Degree	23,500	98%
1st Takers	23,018	98%
Repeaters**	482	71%
DO Degree	4,712	96%
1st Takers	4,666	96%
Repeaters**	46	61%
Total US/Canadian	28,212	97%
Examinees from Non-US/Canadian Schools		
1st Takers	14,395	88%
Repeaters**	1,411	60%
Total non-US/Canadian	15,806	86%

*Data for Step 2 CK are provided for examinees that tested during the period of July 1, 2022, to June 30, 2023 whose scores were reported through November 8, 2023.
**Repeaters represents examinations given, not number of examinees.

Table 3.C

2023 STEP 3 ADMINISTRATIONS *
Number Tested and Percent Passing

	# Tested	% Passing
Examinees from US/Canadian Schools that Grant:		
MD Degree	22,405	97%
1st Takers	21,703	97%
Repeaters**	702	77%
DO Degree	104	95%
1st Takers	100	95%
Repeaters**	4	†
Total US/Canadian	22,509	97%
Examinees from Non-US/Canadian Schools		
1st Takers	11,500	92%
Repeaters**	1,264	64%
Total non-US/Canadian	12,764	89%

*Represents data for examinees that tested in 2023 whose scores were reported through March 13, 2024.
**Repeaters represents examinations given, not number of examinees.
†Performance data not reported for categories containing fewer than 5 examinees.

APPENDIX D
Program-related Publications by USMLE Staff in 2022-2024

Andriole DA, Grbic D, Jurich DP, Mechaber AJ, Roskovensky L, Young GH. US Medical School Graduates' Placement in Graduate Medical Education: A National Study. *Acad Med*. 2023:10.1097.

Baldwin P, Clauser BE. Historical perspectives on score comparability issues raised by innovations in testing. *J Educ Meas*. 2022;59(2):140-160.

Baldwin P, Mee J, Yaneva V, et al. A Natural-Language-Processing-Based Procedure for Generating Distractors for Multiple-Choice Questions. *Eval Health Prof*. Dec 2022;45(4):327-340. doi:10.1177/01632787211046981

Barone MA, Bienstock JL, Lovell E, et al. How the Quadruple Aim Widens the Lens on the Transition to Residency. *J Grad Med Educ*. 2022;14(6):634-638.

Clauser BE, Yaneva V, Baldwin P, An Ha L, Mee J. Automated Scoring of Short-Answer Questions: A Progress Report. *Appl Meas Educ*. 2024;37(3):209-224.

Cuddy, M. M., Liu, C., Ouyang, W., Barone, M. A., Young, A., & Johnson, D. A. An Examination of the Associations Among USMLE Step 3 Scores and Likelihood of Disciplinary Action in Practice. Academic Medicine. *Acad Med*. Oct 2022;97(10):1504-1510. doi: 10.1097/ACM.0000000000004775

Fan F, O'Donnell F, Morrison C, Durand L, Barone M. Revisiting the Utility of the National Board of Medical Examiners Comprehensive Basic Science Self-Assessment to Gauge Readiness for USMLE Step 1. *Med Sci Educ*. 2024:1-7.

Gierl M, Swygert K, Matovinovic D, Kulesher A, Lai H. Three Sources of Validation Evidence Needed to Evaluate the Quality of Generated Test Items for Medical Licensure. *Teach Learn Med*. Jan-Mar 2024;36(1):72-82. doi:10.1080/10401334.2022.2119569

Harik P, Mee J, Runyon C, Clauser BE. Assessment of clinical skills: a case study in constructing an NLP-based scoring system for patient notes. *Advancing Natural Language Processing in Educational Assessment*. Routledge; 2023:58-73.

Hauer KE, Williams PM, Byerley JS, Swails JL, Barone MA. Blue Skies With Clouds: Envisioning the Future Ideal State and Identifying Ongoing Tensions in the UME-GME Transition. *Acad Med*. Feb 1 2023;98(2):162-170. doi:10.1097/ACM.0000000000004920

Jurich DP, Liu C, Clauser A. To the Editor: Limitations and alternative solutions to a USMLE COMLEX-USA concordance. Journal of Graduate Medical Education. 2022;353-354.

Mee J, Pandian R, Wolczynski J, et al. An experimental comparison of multiple-choice and short-answer questions on a high-stakes test for medical students. *Adv Health Sci Educ Theory Pract*. Jul 2024;29(3):783-801. doi:10.1007/s10459-023-10266-3

Norcini J, Grabovsky I, Barone MA, Anderson MB, Pandian RS, Mechaber AJ. The associations between United States medical licensing examination performance and outcomes of patient care. *Acad Med*. 2024;99(3):325-330.

Rashid H, Runyon C, Burk-Rafel J, et al. Medical Student Well-Being While Studying for the USMLE Step 1: The Impact of a Goal Score. *Acad Med*. 2022;97(11S):S176.

Rubright JD, Jodoin M, Woodward S, Barone MA. Differential Item Functioning Analysis of United States Medical Licensing Examination Step 1 Items. *Acad Med*. May 1 2022;97(5):718-722. doi:10.1097/ACM.0000000000004567

Rubright JD, Ong TQ, Jodoin MG, Johnson DA, Barone MA. Revisiting Retake Policy: Analyzing the Success Rates of Examinees With Multiple Attempts on the United States Medical Licensing Examination. *Acad Med*. Aug 1 2022;97(8):1219-1225. doi:10.1097/ACM.0000000000004713

Runyon CR, Harik P, Barone MA. "Cephalgia" or "migraine"? Solving the headache of assessing clinical reasoning using natural language processing. *Diagnosis (Berl)*. Feb 1 2023;10(1):54-60. doi:10.1515/dx-2022-0047

Swails JL, Angus S, Barone MA, et al. The undergraduate to graduate medical education transition as a systems problem: a root cause analysis. *Acad Med*. 2023;98(2):180-187

Yaneva V, Baldwin P, Jurich DP, Swygert K, Clauser BE. Examining ChatGPT Performance on USMLE Sample Items and Implications for Assessment. *Acad Med*. Feb 1 2024;99(2):192-197. doi:10.1097/ACM.0000000000005549

Yaneva V, Baldwin P, Runyon C. Extracting Linguistic Signal From Item Text and Its Application to Modeling Item Characteristics. *Advancing Natural Language Processing in Educational Assessment*. Routledge; 2023:167-182.

Yaneva V, Clauser BE, Morales A, Paniagua M. Assessing the validity of test scores using response process data from an eye-tracking study: a new approach. *Adv Health Sci Educ Theory Pract*. Dec 2022;27(5):1401-1422. doi:10.1007/s10459-022-10107-9

Yaneva, V., Mee, J., Ha, L. A., Harik, P., Jodoin, M., & Mechaber, A. (2022, July). The USMLE® Step 2 clinical skills patient note corpus. Association for Computational Linguistics.

Yaneva V, North K, Baldwin P, et al. Findings from the first shared task on automated prediction of difficulty and response time for multiple-choice questions. In: *Proceedings of the 19th Workshop on Innovative Use of NLP for Building Educational Applications*. Association for Computational Linguistics; 2024:470-482.

Yaneva V, Suen KY, Mee J, Quranda M, Harik P. Automated scoring of clinical patient notes: findings from the Kaggle competition and their translation into practice. In: *Proceedings of the 19th Workshop on Innovative Use of NLP for Building Educational Applications*; 2024:87-98.

USMLE℠

DATE: January 11, 2025 SUBJECT: United States Medical Licensing Examination (USMLE) Reports – 2024 USMLE Primer for State Boards

SUBMITTED BY: **Elizabeth A. Huntley, JD, CMBE, Executive Director**

REQUEST FOR BOARD ACTION
MINNESOTA BOARD OF MEDICAL PRACTICE

REQUESTED ACTION:

For Informational Purposes Only

MOTION BY: SECOND:

( ) PASSED ( ) PASSED AMENDED ( ) LAYED OVER ( ) DEFEATED

BACKGROUND:

See attached report.

An Informational Overview from the Federation of State Medical Boards & National Board of Medical Examiners

December 2024

Topics

- What is USMLE?
- Why is USMLE important?
- How is USMLE governed?
- How is the exam developed?
- How is the pass/fail standard determined?
- What enhancements to USMLE are being explored?
- How can I get more information or data?

USMLE℠

What is USMLE?

USMLE℠

United States Medical Licensing Examination (USMLE)

- The USMLE is a jointly sponsored program of
  - Federation of State Medical Boards (FSMB)
  - National Board of Medical Examiners (NBME)

- ECFMG/Intealth is a key collaborator

USMLE℠

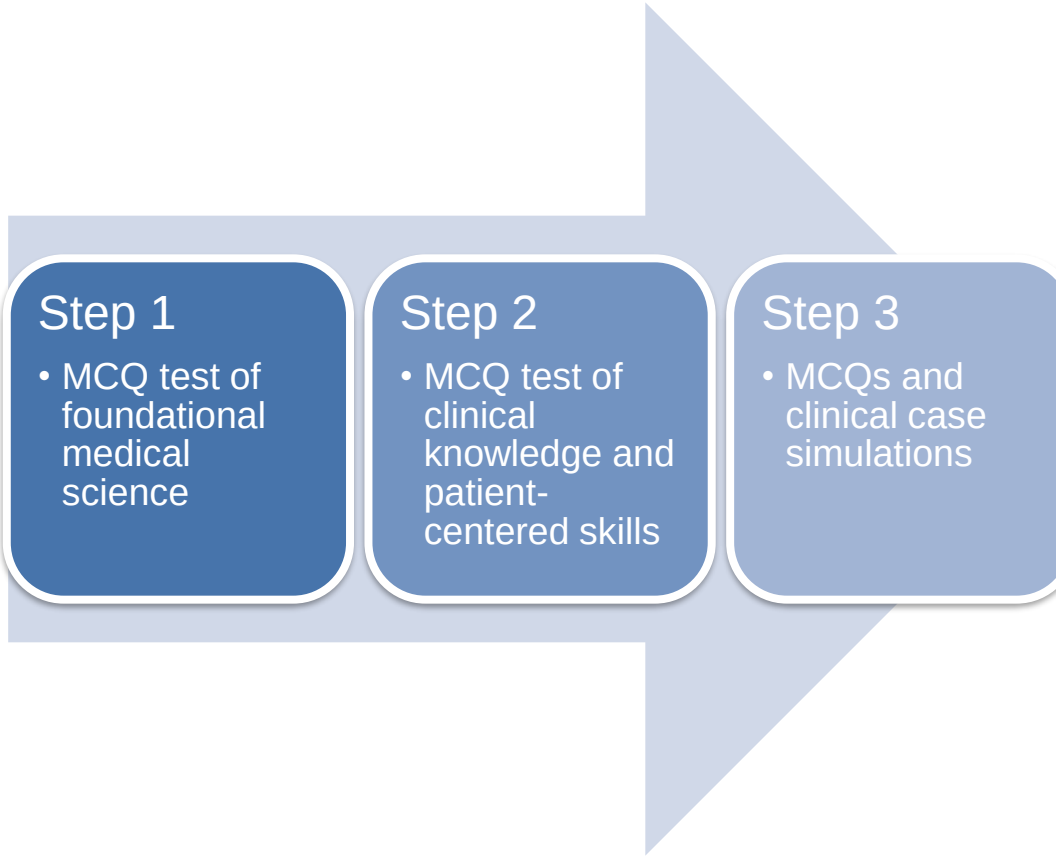
Introduction to USMLE

- Established in 1991… over 3 million test administered to date
- Single exam composed of 3 “Steps”
- Provides state boards with assessment of physician knowledge, clinical and communication skills
- As of 2023, 63% of all licensed physicians in the US have taken all or part of the USMLE sequence
  - 58% have taken all Steps (1, 2 and 3)
  - This is a 2% increase in both measures since 2022
- A required examination for graduates of accredited US medical schools granting MD degree, and all graduates of international medical schools
  - Open to students and graduates of accredited osteopathic medical schools granting DO degree

USMLE℠

USMLE:
A single three Step examination for initial medical licensure

- Assesses physician cognitive, clinical and communication skills
- Provides a national standard
- Assists medical boards in their public protection mission
- Facilitates license portability



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Comparison of USMLE Components

		Step 1	Step 2		Step 3
			CK	CS*	
Eligibility requirements		Medical student/graduate			• MD or DO • Pass Steps 1 & 2 • GME**
Test administration		• Offered year-round • 4 attempt limit per Step • Limited to 3 attempts within a 12-month period • 4th attempt must be 12 months after first attempt & six months from most recent attempt			
Test length (days)		1	1	1	2
Format	MCQ items***	280	318		412
	SP stations			12	
	CCS cases				13

* Discontinued January 2021; attempts and results still reported on official USMLE transcripts

** GME recommended but not required

*** Approximate

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Why is USMLE important?

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Users and Uses of USMLE Results

User	Step 1	Step 2	Step 3
Licensing Jurisdictions	Protecting the health of the public Training and unrestricted licenses		
ECFMG (International graduates only)	ECFMG Certification Entry into GME in the U.S.		
Medical Schools	Promotion & graduation decisions Curriculum evaluation		
Residency Programs	Screening for interviews Ranking of applicants		
LCME	Accreditation (aggregated results)		
Examinees	(all of the above)		

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How is USMLE governed?

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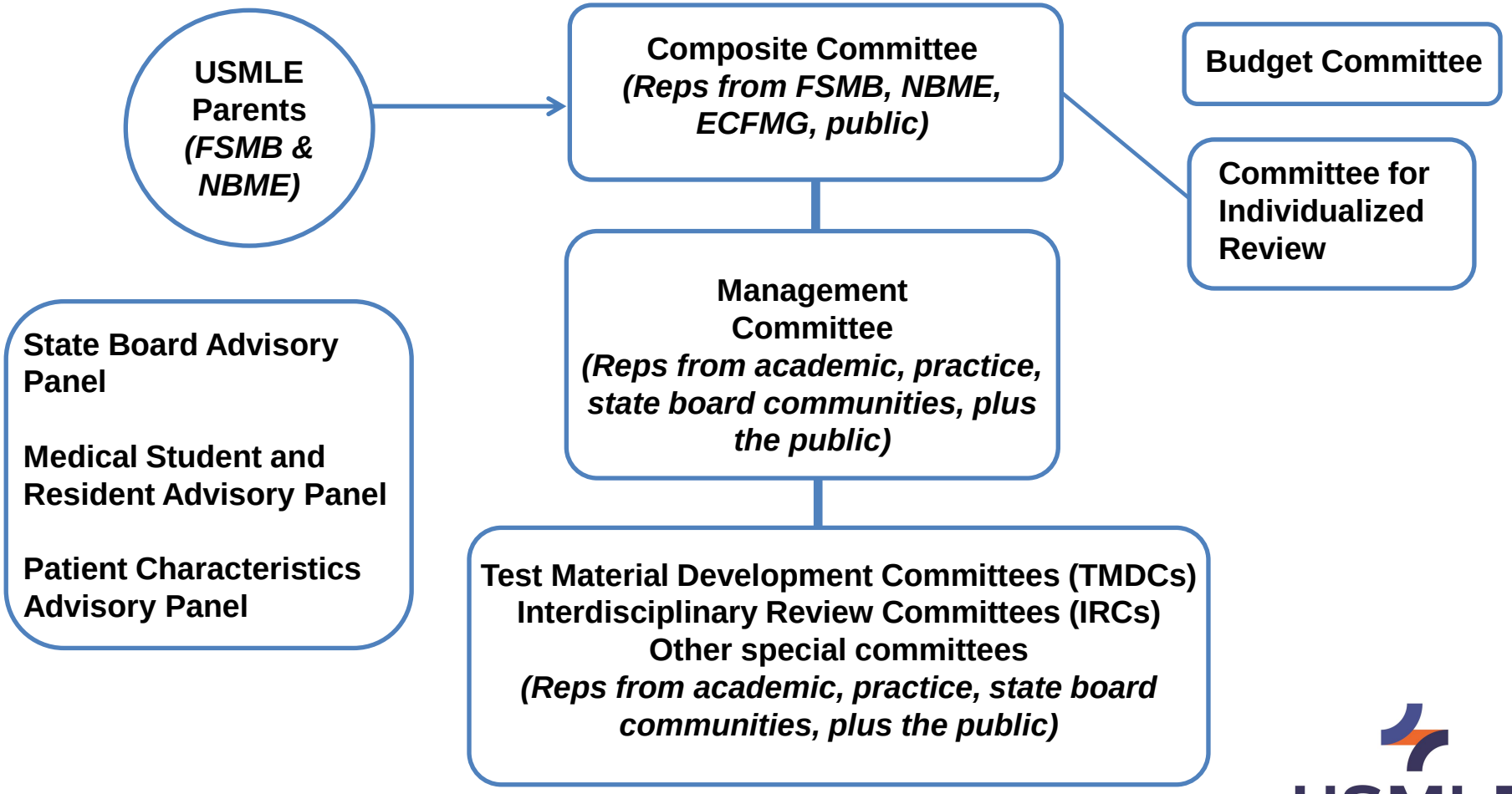
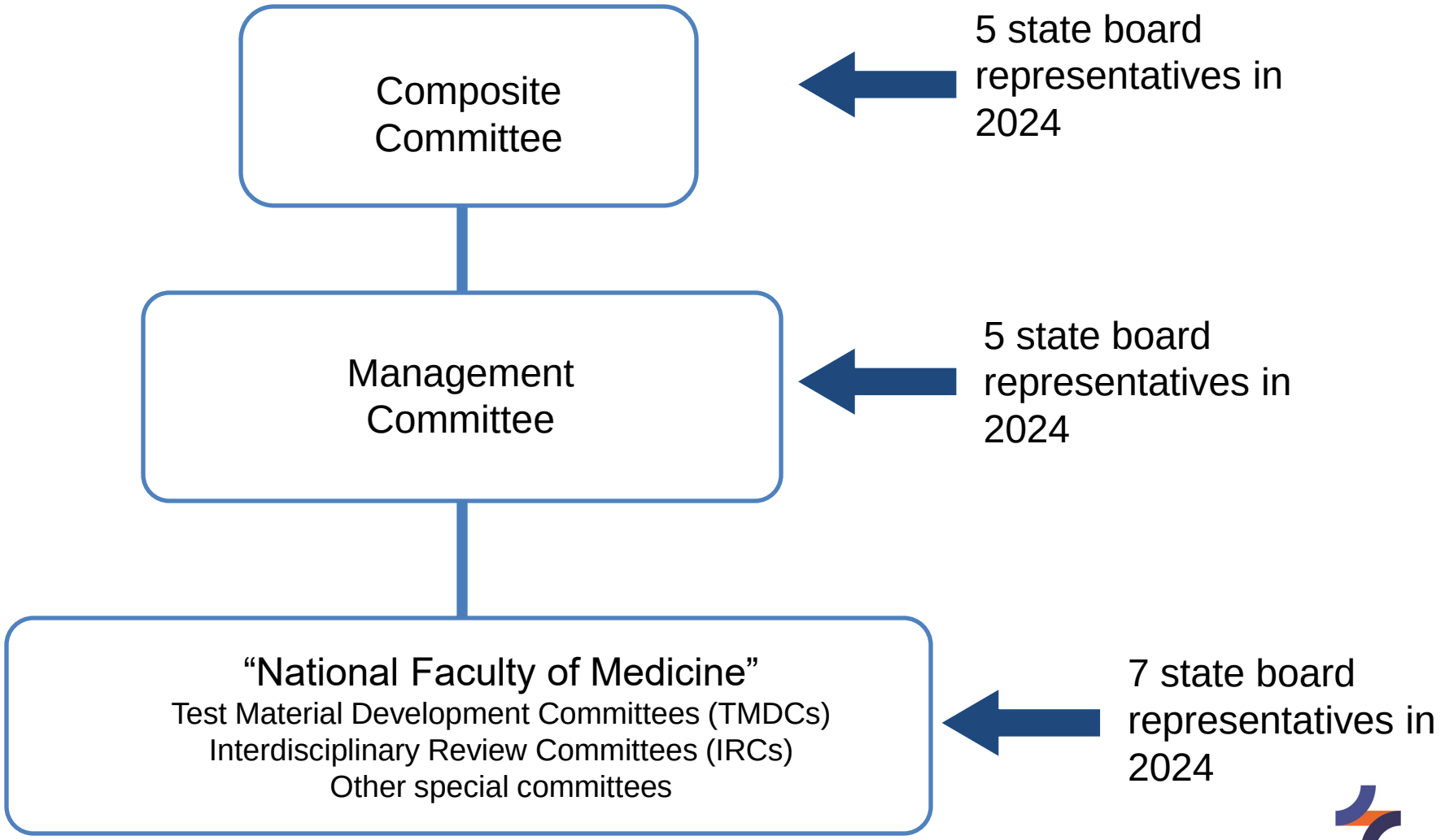
USMLE Committee Structure



USMLE℠

USMLE Committee Structure



How is the exam developed?

USMLE℠

Developing Content for USMLE

- Content is developed by a “national faculty” of physicians and scientists…
  - All volunteers
  - Drawn from the academic, licensing and practice communities
  - 400+ physicians representing specialties and expertise from across the country

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USMLE Test Development

- All items and cases…
  - Are developed and reviewed by content experts
  - Pass through multiple levels of review
  - Are pre-tested prior to use as live (scored) material
- Each Step…
  - Uses multiple test forms
  - Has thousands of items (or hundreds of cases) in the test pool

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How is the pass/fail standard determined?

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Standard Setting
(minimum passing score)

- USMLE uses an “absolute” standard
  - A minimum level of demonstrated proficiency for examinees is established in advance; there is no ‘curve’ applied
- Set by the USMLE Management Committee
- Reviewed approximately every 4 years

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Standard Setting (cont'd)

- Management Committee reviews information & data from variety of sources
  - Results from standard setting exercises involving panels of physician experts unaffiliated with USMLE
  - Survey input from state boards, deans, faculty, students
  - Trends in examinee performance
  - Data on reliability of scores

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How can I get more information or data?

USMLE℠

USMLE Website

https://www.usmle.org/usmle-updates-research

- Performance Data
- Score Interpretation Guidelines
- Research & USMLE-related publications

https://www.usmle.org/what-to-know/exam-security-fairness

- Irregular Behavior

https://www.usmle.org/common-questions

- FAQs

USMLE℠

Other Informational Resources

- Quarterly FSMB Update on USMLE
- Extensive research on USMLE has been published in professional, peer-review journals such as *Academic Medicine*
- FSMB webinars on topics such as.….
  - USMLE scoring
  - Annotating for irregular behavior
  - Communication with state boards
- FSMB publications
  - *Journal of Medical Regulation* (pictured), *eNews, NewsLine*

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USMLE on Social Media

- linkedin.com/company/usmle
- facebook.com/usmle/
- x.com/theusmle

Key Contacts

Office of the USMLE Secretariat
(215) 590-9877
USMLESec@nbme.org

David Johnson, M.A.
FSMB Chief Assessment Officer
djohnson@fsmb.org

Alex Mechaber, M.D., FACP
NBME Vice President, USMLE
amechaber@nbme.org

DATE: January 11, 2025 SUBJECT: Executive Director's Report

SUBMITTED BY: **Elizabeth A. Huntley, JD, CMBE, Executive Director**

REQUEST FOR BOARD ACTION
MINNESOTA BOARD OF MEDICAL PRACTICE

REQUESTED ACTION:

For Informational Purposes Only

MOTION BY: SECOND:

( ) PASSED ( ) PASSED AMENDED ( ) LAYED OVER ( ) DEFEATED

BACKGROUND:

Attached is the Executive Director's Report of activities since the last Board meeting.

EXECUTIVE DIRECTOR'S REPORT

January 11, 2025

LEGISLATIVE UPDATES

Minnesota's 94th legislative session convenes starting next week and I will continue working closely with our trusted partners to monitor and respond to legislation that impacts the work of the Board of Medical Practice.

INTERSTATE MEDICAL LICENSURE COMPACT (IMLC)

The Interstate Medical Licensure Compact Commission held its annual in-person meeting in November 2024. One order of business was the election of officers and Minnesota's Commissioner Manahan was unanimously elected Chair of the Interstate Medical Licensure Compact Commission and assumed that role following the meeting.

OTHER BUSINESS

The Physician Assistant Compact Commission continues its work to operationalize the compact in partnership of the American Academy of Physician Assistants, the Federation of State Medical Boards, the National Commission on Certification of Physician Assistants, and The Council of State Governments.

DATE: January 11, 2025 SUBJECT: New Business

SUBMITTED BY: **Pamela Gigi Chawla, M.D., M.H.A. Board President**

REQUEST FOR BOARD ACTION
MINNESOTA BOARD OF MEDICAL PRACTICE

REQUESTED ACTION:

For Informational Purposes Only.

MOTION BY: SECOND:

( ) PASSED ( ) PASSED AMENDED ( ) LAYED OVER ( ) DEFEATED

BACKGROUND:

DATE: January 11, 2025 SUBJECT: Corrective or Other Actions

SUBMITTED BY: **Complaint Review Committees**

REQUEST FOR BOARD ACTION
MINNESOTA BOARD OF MEDICAL PRACTICE

REQUESTED ACTION:

For Informational Purposes Only

MOTION BY: SECOND:

( ) PASSED ( ) PASSED AMENDED ( ) LAYED OVER ( ) DEFEATED

BACKGROUND:

Attached are copies of the Corrective or Other Actions that were implemented since the November 9, 2024, Board Meeting.

BEFORE THE MINNESOTA

BOARD OF MEDICAL PRACTICE

In the Matter of the
Medical License of
Frederick S. Dattel, M.D.
Year of Birth: 1965
License Number: 61770

ORDER FOR AUTOMATIC SUSPENSION

1. The Minnesota Board of Medical Practice ("Board") is authorized pursuant to Minn. Stat. §§ 147.001 through 147.381 (2023) to license, regulate, and discipline persons who apply for, petition, or hold licenses to practice medicine and surgery in the State of Minnesota and is further authorized pursuant to Minn. Stat. §§ 214.10 and 214.103 (2023) to review complaints against physicians, to investigate such complaints, and to initiate appropriate disciplinary action.

2. Frederick Scott Dattel, M.D. ("Respondent") has been and now is subject to the jurisdiction of the Board from which he holds a license to practice medicine and surgery in the State of Minnesota.

3. Respondent was licensed by the Board to practice medicine and surgery in the State of Minnesota on February 9, 2017.

4. The Board received a report that Respondent pled guilty to Medicare fraud in federal court on November 10, 2022. The report further stated Respondent "caus[ed] fraudulent Medicare claims to be submitted for more than 1,000 beneficiaries for medications and equipment they didn't need, which was part of a larger nationwide scheme to defraud Medicare."

5. On February 29, 2024, Respondent was sentenced on one count of False Statement Relating to Health Care in violation of 18 U.S.C.§§ 1035 (a) 2. Respondent was ordered to complete three years of probation and pay restitution.

STATUTES

1. Pursuant to Minn. Stat. § 147.091, subdivision 2(b), the credentials of a regulated person shall be automatically suspended by the board upon notice to the board of a judgment of, or a plea of guilty to, a felony reasonably related to the practice of patient care.

ORDER

1. IT IS HEREBY ORDERED that Respondent's license to practice medicine and surgery in the State of Minnesota is **SUSPENDED** pursuant to Minn. Stat. § 147.091, subd. 2(b) (2023), **effective November** 15**, 2024**. During the period of suspension, Respondent shall not engage in the practice of medicine, as defined by Minn. Stat. § 147.081 (2023), in the State of Minnesota.

2. IT IS FURTHER ORDERED that Respondent's license to practice medicine and surgery in the State of Minnesota shall remain suspended until Respondent petitions for reinstatement, and after a hearing, the Board takes further action.

Dated: Nov. 15, 2024

MINNESOTA BOARD OF
MEDICAL PRACTICE

ELIZABETH A. HUNTLEY
Executive Director

BEFORE THE MINNESOTA

BOARD OF MEDICAL PRACTICE

In the Matter of the
Medical License of
Sophie Dojacques, M.D.
Year of Birth: 1964
License Number: 54678

AGREEMENT FOR CORRECTIVE ACTION

This Agreement for Corrective Action ("Agreement") is entered into by and between Sophie Dojacques, M.D. ("Respondent"), and the Complaint Review Committee of the Minnesota Board of Medical Practice ("Committee") pursuant to the authority of Minnesota Statutes section 214.103, subdivision 6(a) (2023). Respondent is represented by Chad Staul, Quinlivan & Hughes, P.A., 1740 West St. Germain Street, Saint Cloud, Minnesota 56302. The Committee was represented by Daniel Schueppert, Assistant Attorney General, 445 Minnesota Street, Suite 1400, St. Paul, Minnesota 55101. Respondent and the Committee hereby agree as follows:

FACTS

1. For the purpose of this Agreement, the Board may consider the following facts as true:

a. Respondent was licensed by the Board to practice medicine and surgery in the State of Minnesota on November 12, 2011. Respondent is board certified in obstetrics and gynecology.

b. Through her June 2023 license renewal, Respondent answered affirmatively to the question inquiring about malpractice actions. Respondent reported there was a malpractice settlement made for care she provided to a patient in another state in 2018. Specifically, Respondent's use of Pitocin in an elective induction.

c. In response to the allegations, Respondent stated the patient underwent an elective induction and had an uneventful delivery, although the baby required respiratory resuscitation. The Board initiated an investigation into Respondent's care of the patient, which revealed concerns about Respondent's management of the patient's labor and delivery.

d. On July 1, 2024, Respondent appeared before the Committee to discuss the allegations. During the conference and in her written submissions, Respondent reviewed and discussed the fetal heart tracings, identifying concerning or problematic readings. Respondent indicated that there was no central monitoring made available to Respondent in the facilities. Respondent relied upon verbal reports instead of reviewing the tracings herself.

2. Based on the discussion, the Committee views Respondent's conduct as inappropriate under Minnesota Statutes section 147.091, subdivision 1 (k) (conduct that departs from or fails to conform to the minimal standards of acceptable and prevailing medical practice in which case proof of actual injury need not be established) (2023), and Respondent agrees that the conduct cited above constitutes a reasonable basis in law and fact to justify corrective action under these statutes.

CORRECTIVE ACTION

3. Respondent agrees to address the concerns referred to in paragraphs 1 and 2 by taking the following corrective action:

a. Within six months of the date of the Agreement, Respondent shall successfully complete a pre-approved course in Team Leadership and Communication;

b. Within three months of successful completion of the above-referenced coursework, she shall write and submit a paper, for review and approval by the Committee, discussing what she has learned from the coursework and how she has implemented this knowledge into her practice; and

c. This Agreement shall be satisfied upon Respondent's successful completion of the terms of the Agreement.

4. This Agreement shall become effective upon execution by the Committee and shall remain in effect until Respondent successfully completes the terms of the Agreement. Successful completion shall be determined by the Committee. Upon Respondent's signature and the Committee's execution of this Agreement, the Committee agrees to close the complaints resulting in the information referred to in paragraphs 1 and 2. Respondent understands and further agrees that if, after the matter has been closed, the Committee receives additional complaints similar to the information in paragraphs 1 and 2, the Committee may reopen the closed complaint.

5. If Respondent fails to satisfy the terms of the Agreement the Committee may, in its discretion, reopen the investigation and proceed according to Minnesota Statutes chapters 14, 147, and 214. Failure to satisfy the terms of the Agreement constitutes failure to cooperate under Minnesota Statutes section 147.091, subdivision 1(u). In any subsequent proceeding, the Committee may use this Agreement as proof that Respondent's conduct, cited in the Facts above, justified action under these statutes.

6. Respondent understands that this Agreement does not constitute disciplinary action. Respondent further understands and acknowledges that this Agreement and any letter of

satisfaction are classified as public data for purposes of Minnesota Statutes sections 13.02, subdivision 15, and 13.41, subdivision 5 (2023). Data regarding this Agreement may be provided to data banks as required by federal law or consistent with Board policy.

7. Respondent acknowledges reading and understanding this Agreement and entering into it voluntarily. This Agreement contains the entire agreement between the Committee and Respondent, there being no other agreement of any kind, verbal or otherwise, which varies the terms of this Agreement.

Dated: December 3, 2024

SOPHIE DOJACQUES, M.D.
Respondent

Dated: 12/4/24

FOR THE COMMITTEE

BEFORE THE MINNESOTA

BOARD OF MEDICAL PRACTICE

In the Matter of the
Medical License of
Jeffrey P. Sanderson, M.D.
Year of Birth: 1970
License Number: 44481

STIPULATION TO CEASE PRACTICING MEDICINE

WHEREAS, the Minnesota Board of Medical Practice ("Board") received a report related to alleged activities that would affect the license to practice medicine and surgery of Jeffrey Paul Sanderson, M.D. ("Respondent");

WHEREAS, Respondent was licensed by the Board to practice medicine and surgery in the State of Minnesota on March 9, 2002;

WHEREAS, the report alleged Respondent engaged in any unethical or improper conduct, including, but not limited to: conduct likely to deceive or defraud the public; conduct likely to harm the public; conduct that demonstrates a willful or careless disregard for the health, welfare, or safety of a patient; medical practice that is professionally incompetent; and conduct that may create unnecessary danger to any patient's life, health, or safety in any of which cases, proof of actual injury need not be established;

WHEREAS, the report alleged Respondent's conduct departs from or fails to conform to the minimal standards of acceptable and prevailing medical practice in which case proof of actual injury need not be established;

WHEREAS, the report alleged that Respondent's inability to practice medicine with reasonable skill and safety to patients by reason of the following, including but not limited to: (1) illness; (2) intoxication; (3) use of drugs, narcotics, chemicals, or any other type of substance;

(4) mental condition; (5) physical condition; (6) diminished cognitive ability; (7) loss of motor skills; or (8) deterioration through the aging process;

WHEREAS, the report alleged Respondent became addicted or habituated to a drug or intoxicant;

WHEREAS, the report alleged Respondent violated the terms of the health professionals services program participation agreement or leaves the program except upon fulfilling the terms of successful completion of the program as set forth in the participation agreement;

WHEREAS, the report alleged that Respondent has engaged in conduct that is in violation of Minnesota Statutes sections 147.091, subdivision 1 (g), (k), (l), and (r) and 214.355 (2023); and

WHEREAS, the Board initiated an investigation relating to alleged activities that could affect the license of Respondent to practice medicine and surgery.

NOW, THEREFORE, IT IS HEREBY STIPULATED AND AGREED, by and between Respondent and the Board that:

1. During all times herein, Respondent has been and now is subject to the jurisdiction of the Board from which he holds a license to practice medicine and surgery in the State of Minnesota.

2. Respondent agrees to refrain from practicing medicine in any manner in the State of Minnesota and shall neither offer nor provide any medical services of any nature within the State until such time as the Board has resolved any allegations pending against him.

3. This Stipulation shall be in effect until: (a) the Board issues a final order, which may occur after a contested case proceeding held pursuant to Minnesota Statutes chapter 14; (b) the Board adopts a final stipulation between the parties; or (c) the Board dismisses the proceedings against Respondent or determines that disciplinary action is not warranted.

4. Respondent agrees to notify the Board in writing within five (5) days of the resolution of any criminal proceeding naming him as a defendant that is related to his medical practice or the report received by the Board.

5. Respondent's violation of this Stipulation shall be considered a violation of Minnesota Statutes Chapter 147 and constitute independent grounds for disciplinary action.

6. Respondent agrees that should he violate the terms of this Stipulation, the following actions may be taken:

a. The Board may, pursuant to Minnesota Statutes Chapter 14 (2023) and Minnesota Rules 1400.5100 to 1400.8400 (2023), refer any alleged violation of this Stipulation to the Office of Administrative Hearings.

b. Should a violation be alleged, Respondent agrees that the issue before the administrative law judge may be limited as to whether a violation did in fact occur and whether there was sufficient or reasonable cause to excuse such violation. If the administrative law judge finds that there has been a violation and there is not sufficient or reasonable cause to excuse such, he or she may make a recommendation of discipline.

c. Respondent agrees that in the event the Board receives findings of the administrative law judge that there has been a violation of this Stipulation, the Board may order a suspension or revocation of Respondent's license to practice medicine or such lesser action or remedy as the Board deems appropriate.

d. Upon application of the Board, any appropriate court may enter a decree enforcing the terms of this Stipulation and prohibiting Respondent's practice of medicine until and unless the conditions of this Stipulation are fulfilled.

7. This Stipulation shall be classified as public data for purposes of Minnesota Statutes sections 13.02, subdivision 15, and 13.41, subdivision 5 (2023). Data regarding this Stipulation may be provided to data banks as required by federal law or consistent with Board policy.

8. Respondent is represented in this matter by Teresa Knoedler, Sage Health Law, 5775 Wayzata Blvd., Suite 700-9112, St. Louis Park, Minnesota 55416.

9. This Stipulation contains the entire agreement between the Board and Respondent, there being no agreement of any kind, verbal or otherwise, which varies this Stipulation.

MINNESOTA BOARD OF
MEDICAL PRACTICE

Jeffrey P. Sanderson

Jeffrey P. Sanderson, M.D.

Elizabeth A. Huntley
Executive Director

Dated: 11/21/2024, 2024

Dated: 11-26, 2024

BEFORE THE MINNESOTA

BOARD OF MEDICAL PRACTICE

In the Matter of the
Medical License of
Dr. Omar I. Massoud
Year of Birth: 1956
License Number: 51194

ORDER FOR AUTOMATIC REVOCATION

1. The Minnesota Board of Medical Practice ("Board") is authorized pursuant to Minn. Stat. §§ 147.001 through 147.381 (2024) to license, regulate, and discipline persons who apply for, petition, or hold licenses to practice medicine and surgery in the State of Minnesota and is further authorized pursuant to Minn. Stat. §§ 214.10 and 214.103 (2024) to review complaints against physicians, to investigate such complaints, and to initiate appropriate disciplinary action.

2. Dr. Omar I. Massoud ("Respondent"), who was licensed by the Board to practice medicine and surgery in the State of Minnesota on September 13, 2008, has been and now is subject to the jurisdiction of the Board from which he holds a license to practice medicine and surgery in the State of Minnesota.

3. On June 11, 2024, Respondent was sentenced to serve 12 months in prison, after pleading guilty to three counts of Gross Sexual Imposition, all felony offenses, in violation of Ohio R.C. 2907.05 A(1).

4. Pursuant to Minn. Stat. § 147.091, subd. 1a. (b) and (d) (2024), a license to practice medicine is automatically revoked if the licensee is convicted of a felony-level criminal sexual conduct offense in Minnesota or a similar statute in another jurisdiction. Respondent's conviction is similar.

5. NOW THEREFORE, pursuant to the above recitals, the Board issues the following:

ORDER

1. IT IS HEREBY ORDERED that Respondent's license to practice medicine and surgery in the State of Minnesota shall be **REVOKED** pursuant to Minn. Stat. §§ 147.091, subd. 1a. (b) and 2a. (2024), **effective December 19th, 2024**.

Dated: December 18, 2024

MINNESOTA BOARD OF
MEDICAL PRACTICE

ELIZABETH A. HUNTLEY
Executive Director

BEFORE THE MINNESOTA

BOARD OF MEDICAL PRACTICE

In the Matter of the
Medical License of
Aman K. Patel, D.O.
Year of Birth: 1981
License Number: 71356

**ORDER FOR
AUTOMATIC SUSPENSION**

1. The Minnesota Board of Medical Practice ("Board") is authorized pursuant to Minn. Stat. §§ 147.001 through 147.381 (2024) to license, regulate, and discipline persons who apply for, petition, or hold licenses to practice medicine and surgery in the State of Minnesota and is further authorized pursuant to Minn. Stat. §§ 214.10 and 214.103 (2024) to review complaints against physicians, to investigate such complaints, and to initiate appropriate disciplinary action.

2. Aman Kanti Patel, D.O. ("Respondent") has been and now is subject to the jurisdiction of the Board from which he holds a license to practice medicine and surgery in the State of Minnesota through the Interstate Medical Licensure Compact ("IMLC").

3. Respondent was licensed by the Board to practice medicine and surgery in the State of Minnesota on April 13, 2022.

4. In October 2024, the Board received a report that Respondent's medical license was summarily suspended by the Maryland Board of Physicians ("Maryland Board"), which found Respondent engaged in a pattern of sexual harassment of at least four female staff members at a facility where he worked, leading to his termination in May 2024.

5. Since the suspension of Respondent's medical license by the Maryland Board, multiple other licensing boards have taken action against Respondent's license, including North

Dakota, Alabama, Texas, New Hampshire, Iowa, West Virginia, Guam, Delaware, and Nevada. Texas is Respondent's state of principal license.

STATUTES

1. In accordance with the Interstate Medical Licensure Compact and pursuant to Minn. Stat. § 147.38, Art. 10 (b), if a license granted to a physician by the member board in the state of principal license is revoked, surrendered, relinquished in lieu of discipline, or suspended, then all licenses issued to the physician by member boards shall automatically be placed, without further action necessary by any member board, on the same status.

ORDER

1. IT IS HEREBY ORDERED that Respondent's license to practice medicine and surgery in the State of Minnesota is **SUSPENDED** pursuant to Minn. Stat. § 147.38, art. 10, paragraph (b) (2024), **effective January 8, 2025**. During the period of suspension, Respondent shall not engage in the practice of medicine, as defined by Minn. Stat. § 147.081 (2024), in the State of Minnesota.

2. IT IS FURTHER ORDERED that Respondent's license to practice medicine and surgery in the State of Minnesota shall remain suspended until Respondent petitions for reinstatement, and after a hearing, the Board takes further action.

Dated: Jan. 06, 2025

MINNESOTA BOARD OF
MEDICAL PRACTICE

ELIZABETH A. HUNTLEY
Executive Director