AGENDA FOR
THE MINNESOTA BOARD OF MEDICAL PRACTICE
BOARD MEETING THAT WILL BE HELD ON:
MARCH 10, 2018, 9:00 AM
AT:
2829 UNIVERSITY AVENUE
FOURTH FLOOR, CONFERENCE ROOM A
MINNEAPOLIS, MN  55414-3246

PUBLIC SESSION

President: Patricia J. Lindholm, M.D., FAAFP, Board President

1. Call to Order and Roll Call 2

2. Minutes of the January 13, 2018, Board Meeting 3 - 13

3. Health Professionals Service Program (HPSP) Annual Report to the Board by Program Manager Monica Feider 14 - 18

4. HPSP Program Committee Report 19 -123


6. February 8, 2018, Licensure Committee Report 167
   a) Meeting Minutes 168
   b) Acupuncture Advisory Council Appointments 169-175

7. February 6, 2018, Policy & Planning Committee Report 176
   a) Meeting Minutes 177
   b) Meeting Agenda 178-204

8. Federation of State Medical Boards 2018 Annual Meeting 205
   a) Report of the Bylaws Committee 206-264
   b) Board Reports 265-380
   c) Resolutions 381-392
   d) Revised 2018 Report of the Nominating Committee 393-395

9. Executive Director’s Report and Legislative Update 396-400

10. New Business 401

11. Corrective or Other Actions 402-405
MINNESOTA BOARD OF MEDICAL PRACTICE

ROLL CALL
MARCH 10, 2018
BOARD MEETING

<table>
<thead>
<tr>
<th>NAME</th>
<th>CONGRESSIONAL DISTRICT</th>
<th>APPOINTMENT FROM</th>
<th>TO</th>
</tr>
</thead>
<tbody>
<tr>
<td>LINDHOLM, Patricia J., M.D., FAAFP (President)</td>
<td>7</td>
<td>10/30/13</td>
<td>1/20</td>
</tr>
<tr>
<td>RASMUSSEN, Allen G., M.A. (Vice President)</td>
<td>8</td>
<td>9/29/14</td>
<td>1/18</td>
</tr>
<tr>
<td>TOWNLEY, Patrick R., M.D., J.D. (Secretary)</td>
<td>5</td>
<td>6/06/16</td>
<td>1/20</td>
</tr>
<tr>
<td>BURKLE, Christopher, M.D., J.D., FCLM</td>
<td>1</td>
<td>3/11/17</td>
<td>1/21</td>
</tr>
<tr>
<td>JAFRI, Irshad H., M.B., B.S., FACP</td>
<td>2</td>
<td>10/15/12</td>
<td>1/19</td>
</tr>
<tr>
<td>JOHNSON, Kelli, Ph.D.</td>
<td>4</td>
<td>3/09/10</td>
<td>1/18</td>
</tr>
<tr>
<td>KAPLAN, Gerald T., M.A., L.P.</td>
<td>3</td>
<td>3/29/11</td>
<td>1/19</td>
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<tr>
<td>LOMBARDO, Kathryn, M.D.</td>
<td>At large</td>
<td>3/11/17</td>
<td>1/18</td>
</tr>
<tr>
<td>PARHAM, III, William, M.D., FACP, FCCP</td>
<td>3</td>
<td>3/11/17</td>
<td>1/21</td>
</tr>
<tr>
<td>SPAULDING, Kimberly W., M.D., M.P.H.</td>
<td>6</td>
<td>6/06/16</td>
<td>1/20</td>
</tr>
<tr>
<td>STATTON, Maria K., M.D., Ph.D.</td>
<td>8</td>
<td>10/15/12</td>
<td>1/21</td>
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<td>At large</td>
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<td>1/18</td>
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<tr>
<td>WILLET, Joseph R., D.O., FACOI</td>
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<td>3/29/11</td>
<td>1/19</td>
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REQUEST FOR BOARD ACTION
MINNESOTA BOARD OF MEDICAL PRACTICE

REQUESTED ACTION:

Approve the minutes of the January 13, 2018, Board Meeting as circulated.

MOTION BY: ____________________  SECOND: _______________________
(  ) PASSED  (  ) PASSED AMENDED  (  ) LAYED OVER  (  ) DEFEATED

BACKGROUND:

See attached Minutes.
The Minnesota Board of Medical Practice met on January 13, 2018, at its offices in Minneapolis, Minnesota.

The following Board members were present for both Public and Executive Sessions, unless otherwise indicated: Patricia J. Lindholm, M.D., FAAFP, President; Allen G. Rasmussen, M.A., Vice President; Patrick R. Townley, M.D., J.D, Secretary; Christopher Burkle, M.D., J.D., FCLM; Kelli Johnson, Ph.D.; Gerald T. Kaplan, M.A., L.P.; Kathryn D. Lombardo, M.D.; William Parham, III, M.D., FACP, FCCP; and Maria K. Statton, M.D., Ph.D.

PUBLIC SESSION

Agenda Item 1: Call to Order and Roll Call
The meeting was called to order by Board President Patricia J. Lindholm, M.D., FAAFP. Roll call was taken by Board staff.

Agenda Item 2: Minutes of the November 11, 2017, Board Meeting
A meeting attendee addressed the Board stating the November 11, 2017, Board meeting minutes regarding his public comments were not accurate. After discussion and comment from Board Secretary Kelli Johnson, Ph.D., the Board decided the minutes related to the public comment are accurate, as written. A friendly amendment was offered and accepted by Ms. Johnson to correct a reference in the minutes to Ms. Becca Branum.

A motion passed unanimously to accept the minutes of the November 11, 2017, Board meeting, as amended.

Agenda Item 3: Prescription Monitoring Program Mandatory Registration Presentation
Prescription Monitoring Program (PMP) Manager Barbara Carter presented to the Board on PMP use, mandatory registration and planned program enhancements.

In December 2016, APPRISS purchased RxSentry Solution from Health Information Designs, LLC, the current PMP vendor. APPRISS will be retiring the RxSentry Solution and a new and enhanced Solution, “PMP AWARxE”, will be implemented in the fall of 2018.

Ms. Carter provided a demonstration of NarxCare, which can be accessed directly from the PMP AWARxE, or via electronic health records and pharmacy operations systems. NarxCare offers a more comprehensive approach to addressing substance use disorder. NarxCare aggregates and analyzes prescription information from providers and pharmacies and presents interactive, visual representation of information, as well as advanced analytic insights and complex risk scores, which facilitates improved patient safety and outcomes.

PMP InterConnect is the solution currently used to access data across state lines and via the PMP Gateway system, which is used by many health care entities and pharmacies to access PMP data via electronic health records and pharmacy operations systems. Allowing for integration into electronic health records and clinical workflow is the next step to increase utilization of the PMP. It is intended to provide the data at the point of care, with little effort by the prescriber or pharmacist.

A question and answer session followed the presentation.
Dr. Parham asked how the algorithms have been developed and validated in the Appriss system. Ms. Carter will contact the vendor and provide additional information.

Ms. Carter noted that other states that have launched the NarxCare system have completed mandatory training modules. Mandatory training may not be necessary, but having training modules available is helpful.

The PMP has received a grant from the Department of Human Services to train prescribers on the use and value of PMP data. Continuing education units will be available for the training, which will be free.

The administrative cost for the PMP is currently shared by the Health Licensing Boards which regulate prescribers. There will be an additional cost of approximately $300,000.00 per year for the NarxCare enhancement. The PMP is currently working on legislative funding initiatives to support statewide integration of NarxCare. It currently takes about 3.5 minutes to access the PMP and get a report. Enhancements will reduce access time to approximately 20 seconds.

Ms. Carter noted that support for legislative funding initiatives by the Board, professional associations, and individual practitioners is important to implement PMP enhancements and integration. An opioid stewardship bill will include some aspects of the funding initiatives.

Dr. Lindholm suggested that the Board should communicate its support for legislative funding for the PMP enhancements and thanked Ms. Carter for her presentation.

Agenda Item 4: Prescription Monitoring Program Advisory Task Force Representative
Former Board member Mark A. Eggen, M.D., previously served as the Board’s representative on the Prescription Monitoring Program (PMP) Advisory Task Force. Allen Rasmussen, M.A., serves as the alternate. Because Dr. Eggen has completed his term on the Board, a new representative should be selected.

Ms. Carter provided a brief overview of the Prescription Monitoring Program (PMP) Advisory Task Force. The purpose of the Task Force is to advise the Minnesota Board of Pharmacy on the development and operation of the PMP.

Dr. Lindholm asked if any members are interested in serving as the Board’s representative. Kathryn D. Lombardo, M.D., expressed interest and Mr. Rasmussen expressed interest in continuing to serve as the alternate representative.

A motion was made and passed unanimously to nominate Dr. Lombardo as the Board’s representative and Mr. Rasmussen as the alternate representative to the PMP Advisory Task Force.

Agenda Item 5: Federation of State Medical Boards (FSMB) Presentation by Gregory B. Snyder, M.D., DABR
Former Board member and Chair of the Federation of State Medical Boards (FSMB) Board of Directors Gregory B. Snyder, M.D., DABR, provided a brief background of the history of implementation of the PMP in Minnesota. Dr. Snyder noted that the Minnesota Board of Medical Practice recently submitted a resolution to the FSMB requesting that the FSMB review mandatory use of the PMP. Dr. Snyder stated that, since thirty-six states already have some form of mandatory PMP use, the taskforce will instead study best practices for use of PMPs.

Dr. Snyder, as Chair of the FSMB Board of Directors and Liaison Director, provided an overview of the FSMB and the services offered to member Boards. He then presented his initiative to modify the FSMB’s bylaws to enhance the role of state medical Board executive directors in FSMB governance. Dr. Snyder stated that one of the most important actions he’d like to accomplish as FSMB Chair is to enhance and recognize the pivotal role that executive directors play in all of the regulatory activities. Executive directors are currently considered Associate Members. Associate Membership includes the following:
A member medical Board may designate one or more employees or staff members to be an Associate Member of the FSMB.

No Associate Member shall continue in that capacity upon termination of employment by or service to the member medical Board. This designation limits the FSMB’s ability to involve and benefit from the expertise of the member Boards’ executive directors.

Staff members of medical Boards are currently eligible to serve as Associate Members. Dr. Snyder proposes a new role for executive directors as Staff Fellows. The proposed new category of membership for executive directors would include the following:

- Staff Fellows have the same rights and responsibilities as any other Federation member.
- Staff Fellows may serve on committees and work groups which were previously limited.
- Staff Fellow engagement increases the FSMB’s influence by increasing its advocates.
- Staff Fellows may serve for two years and are eligible for reappointment for one additional term.
- A spot will be created on the FSMB Executive Committee for a Staff Fellow to serve.

The FSMB Bylaws Committee met on January 9, 2018, to consider comments received by member medical Boards on the bylaws draft proposal. Dr. Snyder stated that feedback from state medical Boards was overwhelming supportive of Staff Fellow membership. The recommendations of the Bylaws Committee and the full text of proposed amendments will be sent to each member medical Board no later than February 26, 2018. The proposed amendments will be presented to the House of Delegates for action at the FSMB Annual Meeting. Dr. Snyder asked the Board for its support.

Dr. Snyder regrets that members of the Minnesota Board of Medical Practice are unable to attend the FSMB Annual Meeting, due to Governor Dayton’s travel restriction to North Carolina. The FSMB has requested that the Governor allow the Minnesota Board to attend.

The Board took a ten minute break.

Agenda Item 8: December 13, 2017 and January 9, 2018, Policy & Planning Committee Report

Agenda item 8 was heard prior to agenda item 6 to accommodate members from the Minnesota Athletic Trainers’ Association (MATA), Troy Hoehn, A.T.R., and Amy Brugge, A.T.R.

Ms. Brugge and Mr. Hoehn requested feedback to technical changes in draft legislation modifying the athletic trainer practice act, Minn. Stat. § 148.7801 – 7815. The draft bill proposes to move athletic trainers from registration to licensure, modernize language and streamline processes.

Licensure Unit Supervisor Molly Schwanz summarized comments from the December 13, 2017, MATA presentation to the Board’s Policy & Planning Committee

A brief Board discussion ensued regarding the substantive difference between athletic trainer registration versus licensure, including:

- There are 43 states that license athletic trainers. Minnesota is one of the few remaining states that registers athletic trainers.
- Licensure provides greater title protection.
- In Minnesota, new applicants for licensure are subject to a criminal background check while applicants for registration are not.

No scope of practice changes are included in the proposed legislation.

The Board previously took a neutral position on the proposed change from registration to licensure. Following discussion, a motion was made and passed unanimously to take a position in support of the proposed changes to the Athletic Trainer Practice Act.

The Board thanked Ms. Brugge and Mr. Hoehn for working with the Board on the proposed changes. Ms. Brugge thanked the Board for its support.
Allen G. Rasmussen, M.A., Chair of the Board’s Policy & Planning Committee, provided a report of the December 13, 2017, and January 9, 2018, Policy & Planning Committee meetings.

On December 13, 2018, the Policy & Planning Committee considered a request from the FSMB as a founding member of the Professional Licensing Coalition (PLC) (comprised of more than a dozen organizations representing state licensing Boards), to support the PLC in sponsoring federal legislation that would limit antitrust liability for state licensing Boards. The PLC is currently seeking authors and the bill language has not been finalized. The Committee agreed to draft a letter stating that it will recommend that the Board should support federal antitrust legislation, in concept, contingent upon review of the actual language of the bill. A copy of the letter sent to Minnesota Senator Amy Klobuchar on January 2, 2018, was included in the Board agenda.

Mr. Rasmussen and Ms. Martinez met with Senator Michelle Benson, Chair of the Senate Health and Human Services Finance and Policy Committee, to discuss access to healthcare in outstate communities and removal of barriers to licensure for foreign medical graduates. Mr. Rasmussen and Ms. Martinez will seek authors for the Board’s housekeeping bills and set up meetings with legislators to educate and answer questions about proposed legislation.

Ms. Martinez updated the Board on the criminal background check (CBC) authority for the purpose of the Interstate Medical Licensure Compact and other proposed changes to Minn. Stat.§ 214. Board staff is working with the CBC Oversight Committee and the MN Bureau of Criminal Apprehension on language.

At the January 9, 2018, Policy & Planning Committee meeting, the Committee continued to discuss modifications to reduce barriers to licensure for foreign medical graduates.

Regarding statutory requirements related to temporary suspension of licensure, the Committee discussed draft language to modify Minn. § 214.077 to increase the timeframe from 30 to 60 days between receipt of the Administrative Law Judge’s report and a hearing before the Board on final action.

Ms. Martinez provided an overview of a Board housekeeping bill, including:

- Conversion to birth month renewal cycles across all of the Board’s regulated professions.
- Repealing language relating to temporary permits. The Board issues licenses on a weekly basis so there is no longer a need for temporary permits.
- Recapturing in statute common fees.

The Policy & Planning Committee will continue to meet monthly throughout the legislative session, which is scheduled to end in May. Following the legislative session, the Committee will meet on the second Tuesday of even months at 1:00 pm, if there is business to discuss.

Agenda Item 6: Report of New Credentials, November 1 to December 31, 2017

An informational report was provided of licenses issued on a weekly basis by Board staff between November 1, 2017 and December 31, 2017.

Agenda Item 7: December 14, 2017, Licensure Committee Report

- a. Minutes
  Licensure Committee member Christopher Burkle, M.D., J.D., FCLM, presented the December 14, 2017, Licensure Committee meeting minutes. Dr. Burkle summarized the Licensure Committee’s actions and discussions.

Agenda Item 9: Health Professionals Services Program (HPSP) Program Committee Report

Mr. Rasmussen, Chair of the Health Professionals Services Program (HPSP) Program Committee, provided a report of the November 14, 2017, HPSP Program Committee meeting.
Jennifer Mohlenhoff, Executive Director of the Board of Marriage and Family Therapy and Chair of the Executive Directors’ Forum (ED Forum), provided a summary of the ED Forum meetings since the HPSP Program Committee last met on August 8, 2017.

Dr. Tom Arneson from the Minnesota Department of Health, Office of Medical Cannabis, presented an overview of the medical cannabis program. Mr. Rasmussen noted that this may be a good presentation for the Board.

The next HPSP Program Committee meeting is scheduled for February 13, 2018. Dr. Charles Reznikoff, an addiction medicine physician at Hennepin County Medical Center will provide a presentation on marijuana and medication assisted recovery. Mr. Rasmussen invited Board members to attend the HPSP Program Committee meeting. Dr. Lindholm expressed interest in attending the presentation by Dr. Reznikoff. Ms. Martinez noted that Dr. Reznikoff has agreed to present at the Tri-Regulatory Symposium scheduled for June 6, 2018.

Agenda Item 10: Federation of State Medical Boards (FSMB) 2018 Annual Meeting
Ms. Martinez reiterated that the Minnesota Board of Medical Practice is unable to attend the FSMB Annual meeting because Governor Dayton has imposed a travel restriction to North Carolina based on its “Public Facilities Privacy and Security Act.” Ms. Martinez informed the Board that the FSMB has offered assurance that Minnesota’s Voting Delegate to the FSMB Annual Meeting, Joseph Willett, D.O., FACOI, will be able to vote remotely on formal business at the meeting. Minnesota is one of 14 states that are not able to attend the FSMB Annual Meeting.

Dr. Willett obtained the Board’s endorsement of his candidacy for the FSMB Board of Directors. A letter of nomination was submitted to the FSMB on December 20, 2017. Dr. Willett will be interviewed by the FSMB within the next week. Dr. Willett may have an opportunity to remotely present to the Candidate’s Forum.

The Board also nominated Jon V. Thomas, M.D., M.B.A., for the FSMB Distinguished Service Award.

Board and staff members are invited to convene at the Board office for webcast portions of the FSMB Annual Meeting, so that they may discuss information presented. The webcast will likely include presentations by keynote speakers and, possibly, the awards ceremony.

Ms. Martinez encouraged Board members who are interested in appointment to a FSMB committees or workgroups to contact her, Executive Assistant Cheryl Johnston, or the FSMB. The travel ban to North Carolina and Mississippi will not affect Board members from participating on committees or workgroups.

At its November 11, 2017 meeting, the Board passed a motion to submit a resolution to the FSMB to evaluate the need for testing under time constraints as a necessary and explicit component of the United States Medical Licensing Examination. The resolution will be submitted next week.

Agenda Item 11: Federation of State Medical Boards (FSMB) Request for Comments
Dr. Lindholm stated that the FSMB is seeking comments on its draft Guidelines for the Structure and Function of a State Medical and Osteopathic Board. The Board was asked if it would like to submit comments on the draft Guidelines (included in the Board agenda). No comments were offered. Board members may individually submit comments to Shiri Hickman, FSMB Director of State Policy and Legal Services at shickman@fsmb.org. The deadline for comments is Wednesday, January 31, 2018.

Agenda Item 12: Executive Director’s Report
Ms. Martinez summarized the Executive Director’s Report.

Other Business
- Ms. Martinez reminded Board members to complete the Campaign Finance and Public Disclosure form online. It is not optional and is required to be completed between January 1 – 31, 2018. All
Board members should have or will receive a notice from Campaign Finance and Public Disclosure Board. Failure to complete the form could result in a fine.

- Ms. Martinez informed the Board that there may be changes in paperless technology. MNiT Central advised the Boards that it will no longer provide support for the iPads or Surface Pros. Ms. Martinez is exploring alternate technology.

- Ms. Martinez discourages personal cell phones at meetings and invited Board members to participate in cell phone free Board and Committee meetings.

- Ms. Martinez gave Dr. Lindholm a piece of unsolicited mail as an example of the kind of mail received at the Board office that may not be directed to Board members. When mail arrives at the Board office, it is reviewed by staff to determine whether it should be directed into a Board process or how to appropriately respond.

INITIATIVES

- **Board Presentation on the Minnesota Department of Health (MDH) Opioid Dashboard**
  As the Board recalls, Kate Erickson, MSW, provided a presentation on the Minnesota Department of Health (MDH) opioid dashboard at the November 11, 2017, Board meeting. The dashboard continues to be regularly updated.

- **State Opioid Oversight Project (SOOP)**
  The Board participates in the State Opioid Oversight Project (SOOP). The SOOP group contributed to a report to Governor Dayton on opioid initiatives.

- **Opioid Prescribing Work Group (OPWG)**
  The Health Licensing Boards (HLBs) and the Board of Medical Practice’s Policy and Planning Committee considered whether to submit comments on the draft *Opioid Prescribing Guidelines* distributed for comment by the Minnesota Department of Human Services on December 5, 2017. Board members received the request for comments. The complete proposed recommendations are enclosed in the Board agenda under Policy & Planning Committee agenda materials. As noted in the December 13, 2017, meeting minutes, the Policy & Planning Committee declined to recommend comments. The HLBs also declined to offer comments, collectively, but individual Boards did submit comments, including the Boards of Dentistry and Pharmacy. The Board of Pharmacy is concerned about mandated PMP use. Ms. Martinez noted that the Board’s resolution to the FSMB asks for a study of mandated PMP use.

**Attorney General’s Office**
The Board continues to be listed as a supporter on Attorney General Lori Swanson’s Dose of Reality website.

- **APPRISS**
PMP Program Director Barb Carter provided an excellent overview regarding APPRISS and PMP enhancements. The prospect of implementing the PMP into the electronic health record is exciting.

  Ms. Martinez visited with Ms. Carter during the break about how the Board can support funding initiatives. Ms. Carter stated that Board of Pharmacy bill includes a controlled substance registration fee by prescribers that would cover the costs of implementation. When the bill is available, it will be presented to the Policy & Planning Committee. All Board members are welcome to attend Policy & Planning Committee meetings.

  If legislative funding is not approved, the increased cost of implementation could be assessed to the HLBs that regulate prescribers.
• Tri-Regulatory Initiatives
  The tri-regulatory Boards of Medical Practice, Nursing and Pharmacy are continuing with plans for a second Minnesota Tri-Regulatory Symposium, tentatively scheduled for June 6, 2018.

IMPLEMENTATION OF CRIMINAL BACKGROUND CHECKS FOR NEW APPLICANTS
On December 1, 2017, the Board of Medical Practice successfully implemented criminal background checks (CBCs) for all new applicants for licensure. Ms. Martinez offered special thanks to Mark Chu, Molly Schwanz and the entire Licensure Unit for facilitating implementation of CBCs. Ms. Martinez also expressed the Boards gratitude to the professional associations which assisted in posting notice of the implementation schedule to professional members.

Ms. Martinez was asked if the CBC slows down the issuing of licenses. Ms. Martinez doesn’t really know yet because the process is so new. Ms. Martinez urged applicants to submit their application form and fee as soon as they know they need a license. The CBC is triggered when the Board receives an application and fee.

Ms. Martinez was asked if there is a way to track how many applicants are not truthful on the application. Ms. Martinez stated that the Board of Dentistry has been processing CBCs for quite a while and the number of positive criminal background checks that they receive when someone has not disclosed on the application is very low.

IMPLEMENTATION OF GENETIC COUNSELOR LICENSURE
As of January 1, 2018, all genetic counselors practicing in the State of Minnesota are required to be licensed. The Board has issued approximately 128 genetic counselor licenses.

INTERSTATE MEDICAL LICENSURE COMPACT (IMLC)
Ms. Martinez thanked the Governor’s Office for the timely appointment of IMLC Commissioners, for terms beginning in January 2018. Ms. Martinez welcomed Dr. Townley as Minnesota’s Commissioner to the IMLC. Dr. Townley joined Ms. Martinez on the IMLCC Bylaws and Rules Committee, which Ms. Martinez chairs. Dr Townley participated in an orientation with former IMLC Commissioner Dr. Thomas and Ms. Martinez. The IMLC has its own website and has hired an executive director.

ENGAGEMENT/OUTREACH/CONFERENCES/EVENTS
The Board continues its engagement with internal and external stakeholder groups.

Interstate Collaboration in Healthcare Conference Call, October 6 and November 3, 2017
The Board continues to participate in monthly conference call with the Interstate Collaboration in Healthcare. Calls routinely include updates on interstate compacts for health professionals, as well as things telemedicine initiatives. If Board members are interested in joining the group, Ms. Martinez can arrange to add their contact information to the distribution list for the notices.

Ms. Martinez noted expressed appreciation for strong relationships with the Minnesota Medical Association and the Minnesota Academy of Physician Assistants. The Associations and the Board apprise one another on topics of mutual interest.

ALIMS DATABASE UPDATE PROJECT
Progress continues on the Board’s project to update its ALIMS database.

Other Business
The Board is in the process of updating statute books. The updated compilation will include practice acts for all Board regulated professions, as well as other relevant sections of statutes and rules. Once finalized, the statute books will be made available to Board members, advisory council members, medical coordinators, and AGO and BMP staff. Office Manager Laurie Hanrahan is overseeing the project. Ms. Martinez will check to see if the statute book will be available electronically.
Board members asked about the status of appointments to the Board by the Governor. Appointments for posted vacancies have not yet been announced.

Ms. Martinez was asked if calculating a quorum of the Board is based on the number of actual Board members or based on the full membership of 16. Ms. Martinez stated that the Board is required to convene a quorum of sitting Board members.

Public Comment:
A member of the public/regulated physician expressed that he would like his interactions with the executive director to be included in the executive director’s report. Dr. Lindholm expressed that it is not appropriate to include the interactions of individuals in a public report.

Ms. Martinez stated that she interacts with many of the Board’s licensees and members of the public. She doesn’t incorporate any of those communications into her executive director’s report, nor does she intend to include them in future reports.

Dr. Lindholm stated that the Board will not invite or accept input outside of the Board regarding the contents of its reports. Dr. Lindholm advised that, if a regulated individual would like to discuss his or her interactions with the Board in a forum outside of a public meeting, he or she is welcome to do so. While an individual may waive his or her confidentiality, the Board cannot openly discuss confidential or private information.

A public member may speak to an agenda item or topic presented. However, it is not appropriate to discuss nonpublic matters at a public meeting.

Dr. Lindholm declined to allow public discussion of a piece of correspondence between the Board and a licensee.

Agenda Item 13: Educational Sessions for 2018 Board Meetings
Dr. Lindholm noted that the Board previously suggested inviting Dr. Arneson from the Office of Medical Cannabis and Dr. Reznikoff, an addiction medicine physician, to present at future Board meetings. Dr. Lindholm asked Board members for any other suggestions or ideas.

Suggested presentations:
- Telemedicine.
- Duty to report and the consequences of reporting vulnerable adults and children in Minnesota.

Presentations previously requested:
- Presentations by Minnesota chapters of specialty boards, particularly the American Board of Family Practice and the American Board of Psychiatry and Neurology.
- Presentations by representatives of professional associations regarding the roles and relationships between the Board and professional associations, and the value of relationships between the Board and professional organizations.
- Presentation about the medical model in a large health care system; what it looks like, and how healthcare is currently delivered in Minnesota.
- Privately owned and operated clinics, especially clinics that have both licensed and unlicensed providers. What does a model clinic look like?

Monica Feider, MSW, LICSW, the Health Professionals Services Program (HPSP) Program Manager, has been invited to present at the March 10, 2018, Board meeting.

It was noted that the Attorney General’s Office (AGO) provides an annual presentation to the Board. Ms. Martinez invited suggestions for topics of particular interest.
Ms. Johnson was contacted by an individual from the University of Minnesota who is involved in a program in the Health Career Center called Global Ambassadors for Patient Safety. Ms. Johnson suggested that Ms. Martinez may want to look into it. She will follow-up with more information. Apparently there are medical missions that take undergraduates, in pre-health careers, on missions where they are practicing medicine in foreign countries. There is growing concern about this. This topic may not pertain to the Board’s regulatory activities, although it is a very interesting issue.

**Agenda Item 14: Board Committee Appointments for Year 2018**
Dr. Lindholm presented the 2018 Board Committee Appointments.

The Licensure Committee will select a new Chair to replace Dr. Lindholm. Dr. Thomas and Ms. Johnson have both agreed to serve until their replacements are appointed by the Governor. V. John Ella, J.D, will attend the January 18, 2018, Complaint Review Committee meeting after which he will complete his term on the Board. Gerald T. Kaplan, M.A., L.P., will replace Mr. Ella on the Complaint Review Committee. Changes will be made on the Licensure and Policy & Planning Committees as new Board members are appointed.

**Public Comment**
A member of the public/regulated physician commented that he submitted a suggestion for appointment of an ad hoc Complaint Review Committee. Dr. Lindholm responded that the suggestion does not pertain to the Board agenda item. Ms. Martinez confirmed that an ad hoc Complaint Review Committee has not been appointed.

**Agenda Item 15: New Business**
There wasn’t any new business.

**Agenda Item 16: Corrective or Other Actions**
Corrective and other actions were presented for Board information only.

Dr. Lindholm adjourned the public session of the Board meeting.
The following Board members were present for both Public and Executive Sessions, unless otherwise indicated: Patricia J. Lindholm, M.D., FAAFP, President; Allen G. Rasmussen, M.A., Vice President; Patrick R. Townley, M.D., J.D, Secretary; Christopher Burkle, M.D., J.D., FCLM; Kelli Johnson, Ph.D.; Gerald T. Kaplan, M.A., L.P.; Kathryn D. Lombardo, M.D.; William Parham, III, M.D., FACP, FCCP; and Maria K. Statton, M.D., Ph.D.

ROXANEE E. PIERRE, M.D.
On recommendation of the Complaint Review Committee, the Board approved the Order of Unconditional License.

JANE R. WILKENS, M.D.
On recommendation of the Complaint Review Committee, the Board approved the Order of Unconditional License.

There being no further business, the meeting was adjourned.

Date: March 2, 2018

Patrick R. Townley, M.D., J.D.
Secretary
MN Board of Medical Practice
DATE:    March 10, 2018    SUBJECT:    Health Professional Services Program Annual Report

SUBMITTED BY: Patricia J. Lindholm, M.D., FAAFP, 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:

Monica Feider, MSW, LICSW, Program Manager for the Health Professionals Services Program (HPSP), will provide HPSP’s annual report to the Board.
Referrals by First Referral Source and Fiscal Year – **BMP SPECIFIC**

The following chart shows the number of persons regulated by the Board of Medical Practice referred to HPSP by fiscal year by *first referral source* over the past six years. *First referral source* represents the initial source of the licensee’s referral to HPSP during an admission. For example, one may self-refer to the program and later be referred by their board. In such an instance, the first referral source would be a self-referral.

<table>
<thead>
<tr>
<th>Fiscal Year</th>
<th>FY12</th>
<th>FY13</th>
<th>FY14</th>
<th>FY15</th>
<th>FY16</th>
<th>FY17</th>
<th>SUM</th>
</tr>
</thead>
<tbody>
<tr>
<td>Board Voluntary</td>
<td>20</td>
<td>11</td>
<td>12</td>
<td>12</td>
<td>9</td>
<td>13</td>
<td>77  (22%)</td>
</tr>
<tr>
<td>Board Discipline</td>
<td>1</td>
<td>5</td>
<td>2</td>
<td>5</td>
<td>1</td>
<td>1</td>
<td>15  (4%)</td>
</tr>
<tr>
<td>Self</td>
<td>40</td>
<td>47</td>
<td>30</td>
<td>21</td>
<td>33</td>
<td>20</td>
<td>191 (55%)</td>
</tr>
<tr>
<td>Third Party</td>
<td>13</td>
<td>9</td>
<td>10</td>
<td>12</td>
<td>10</td>
<td>10</td>
<td>64  (18%)</td>
</tr>
<tr>
<td><strong>SUM</strong></td>
<td>74</td>
<td>72</td>
<td>54</td>
<td>50</td>
<td>53</td>
<td>44</td>
<td>347</td>
</tr>
</tbody>
</table>

Discharges by Discharge Category and Fiscal Year – **BMP SPECIFIC**

Over the past six fiscal years, 365 person regulated by the Board of Medical Practice have been discharged from HPSP; 251 (69%) engaged in Monitoring. Of those that engaged in monitoring 76% successfully completed the conditions of their Participation Agreements. The table below shows discharges by discharge category and fiscal year.

<table>
<thead>
<tr>
<th>Fiscal Year</th>
<th>FY12</th>
<th>FY13</th>
<th>FY14</th>
<th>FY15</th>
<th>FY16</th>
<th>FY17</th>
<th>SUM</th>
</tr>
</thead>
<tbody>
<tr>
<td>Completion</td>
<td>28</td>
<td>34</td>
<td>34</td>
<td>41</td>
<td>27</td>
<td>26</td>
<td>190  (76%)</td>
</tr>
<tr>
<td>Voluntary Withdraw</td>
<td>4</td>
<td>1</td>
<td>5</td>
<td>1</td>
<td>2</td>
<td>0</td>
<td>13</td>
</tr>
<tr>
<td>Non-Compliance</td>
<td>1</td>
<td>0</td>
<td>1</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>2</td>
</tr>
<tr>
<td>Deceased</td>
<td>0</td>
<td>0</td>
<td>1</td>
<td>0</td>
<td>1</td>
<td>1</td>
<td>3</td>
</tr>
<tr>
<td>Ineligible Monitored</td>
<td>4</td>
<td>11</td>
<td>11</td>
<td>6</td>
<td>6</td>
<td>5</td>
<td>43</td>
</tr>
<tr>
<td><strong>SUM Monitored</strong></td>
<td>37</td>
<td>46</td>
<td>52</td>
<td>48</td>
<td>36</td>
<td>32</td>
<td>251</td>
</tr>
<tr>
<td>Ineligible Not Monitored</td>
<td>5</td>
<td>1</td>
<td>4</td>
<td>0</td>
<td>1</td>
<td>3</td>
<td>14</td>
</tr>
<tr>
<td>No Contact</td>
<td>3</td>
<td>1</td>
<td>1</td>
<td>3</td>
<td>2</td>
<td>3</td>
<td>13</td>
</tr>
<tr>
<td>Non Cooperation</td>
<td>3</td>
<td>6</td>
<td>2</td>
<td>4</td>
<td>1</td>
<td>2</td>
<td>18</td>
</tr>
<tr>
<td>Non-Jurisdictional</td>
<td>14</td>
<td>14</td>
<td>11</td>
<td>11</td>
<td>9</td>
<td>10</td>
<td>69</td>
</tr>
<tr>
<td><strong>SUM Not Monitored</strong></td>
<td>25</td>
<td>22</td>
<td>18</td>
<td>18</td>
<td>13</td>
<td>18</td>
<td>114</td>
</tr>
<tr>
<td><strong>SUM Total</strong></td>
<td>62</td>
<td>68</td>
<td>70</td>
<td>66</td>
<td>49</td>
<td>50</td>
<td>365</td>
</tr>
</tbody>
</table>
**Definitions of Referral Sources**

HPSP’s intake process is consistent, regardless of how practitioners are referred for monitoring. The program is responsible for evaluating the practitioner's eligibility for services and whether an illness is present that warrants monitoring. If it is determined that a practitioner has an illness that warrants monitoring, a Participation Agreement is developed and monitoring is initiated. Practitioners can be referred to HPSP in the following ways:

1. **Self-Referral:** Practitioner contacts the program directly.
2. **Third-Party Referral:** The most common referrals from third parties are from employers and treatment providers. The identity of all third party reporters is confidential.
3. **Board Referrals:** Participating boards have three options for referring practitioners to HPSP:
   a. **Determine Eligibility** (Board Voluntary): The boards refer because there appears to be an illness to be monitored but a diagnosis is not known.
   b. **Follow-up to Diagnosis and Treatment** (Board Voluntary): The board has determined that the practitioner has an illness and refers the licensee to HPSP for monitoring of the illness.
   c. **Action** (Board Discipline): The board has determined that there is an illness to monitor and refers the practitioner to HPSP as part of a disciplinary action (i.e.: Stipulation and Order). The Board Order may also dictate specific monitoring requirements.

**Definitions of Discharge Categories**

1. **Completion:** Program completion occurs when the practitioner satisfactorily completes the terms of the Participation Agreement.
2. **Non-Compliance:** Participant violates the terms their Participation Agreement; case manager closes case and files a report with practitioner's board.*
3. **Voluntary Withdrawal:** Participant chooses to withdraw from monitoring prior to completion of the Participation Agreement; case manager closes case and files a report with the practitioner's board.*
4. **Ineligible Monitored:** During the course of monitoring, it is determined that practitioner is not eligible for program services as listed in statute (i.e. license is suspended, revoked or went inactive, violation of practice act, illness too severe); case manager files report with practitioner's board. *
5. **Ineligible Not Monitored:** At time of intake, it is determined that practitioner is not eligible for program services as listed in statute; case manager files report with practitioner's board. *
6. **No Contact:** Initial report received by third party or board; practitioner fails to contact HPSP; case manager closes case and files a report with practitioner's board.*
7. **Non-Cooperation:** Practitioner cooperates initially, may sign Enrollment Form and/or releases, but then ceases to cooperate before the Participation Agreement is signed; case manager closes case and files a report with practitioner's board.*
8. **Non-Jurisdictional:** No diagnostic eligibility established; the case is closed. The board is notified if they were the source of the referral.

*Discharge results in a report to the regulatory board and provision of the practitioner's file, including pre-monitoring and monitoring data.
GENERAL HPSP INFORMATION

Mission and Goals
Mission: Minnesota’s Health Professionals Services Program protects the public by providing monitoring services to regulated health professionals whose illnesses may impact their ability to practice safely. The goals of HPSP are to promote early intervention, diagnosis and treatment for health professionals with illnesses, and to provide monitoring services as an alternative to board discipline. Early intervention enhances the likelihood of successful treatment, before clinical skills or public safety are compromised.

Services
HPSP provides monitoring services by Participation Agreements, which establish illness and practice related provisions that assist participants in documenting appropriate illness management. An agreement may include the participant’s agreement to comply with continuing care recommendations, practice restrictions, random drug screening, and support group participation.

Functions
Provide health professionals with services to determine if they have an illness that warrants monitoring:
- Evaluate symptoms, treatment needs, immediate safety and potential risk to patients
- Obtain substance, psychiatric, and medical histories along with social, and occupational data
- Determine practice limitations, if necessary
- Secure records consistent with state and federal data practice regulations
- Collaborate with medical consultants and community providers concerning treatment

Create and implement monitoring contracts:
- Specify requirements for appropriate treatment and continuing care
- Determine illness-specific and practice-related limitations or conditions

Monitor the continuing care and compliance of health program participants:
- Communicate monitoring procedures to treatment providers, supervisors and other collaborative parties
- Review records and reports from treatment providers, supervisors and other sources regarding the health professional’s level of functioning and compliance with monitoring
- Coordinate toxicology screening process
- Intervene, as necessary, for non-compliance, inappropriate treatment, or symptom exacerbation

Act as a resource for licensees, licensing boards, health employers, practitioners, and medical communities

Unique Characteristics
While health professional monitoring programs are found throughout the United States, HPSP is unique in the following ways:
- Offers a single point of contact for all regulated health professionals, providers, and employers
- Eliminates the duplication of services among boards
- Serves health professionals with substance, psychiatric, and other medical disorders
Benefits

- HPSP legislation enables health professionals to report their illness to HPSP in lieu of their licensing board
- HPSP legislation provides permission, confidentiality and immunity for others reporting impaired health professionals
- Protects the public by monitoring and/or restricting the practice of impaired health professionals
- Provides health professionals with a proactive and structured method to document appropriate illness management
- Ensures licensees are receiving the appropriate level of care

Examples of How HPSP Protects the Public:

Employers report practitioners to HPSP for:
- Stealing narcotics
- Being intoxicated
- Being manic or psychotic
- Being unable to function due to brain damage

Health professionals call HPSP when they are:
- Terminated or put on leave due to symptoms of mania, psychosis, dementia or other medical disorders
- Terminated for diverting drugs or showing up to work intoxicated
- Seeking treatment for a substance use disorder

How HPSP responds:
HPSP intervenes immediately. For example, HPSP may request that practitioners refrain from practice if their illness is active (i.e.: not sober, hasn’t been assessed or treated). HPSP requests that practitioners obtain assessments (substance, psychiatric and/or medical) to determine the appropriate level of care needed and whether they are safe to return to practice. After the assessments are completed, HPSP implements monitoring contracts and reviews the practitioners’ compliance with the monitoring contract.

Legislation
HPSP is governed by Minn. Stat. 214.29 to 214.36.

Funding
HPSP is funded almost entirely (99%) by the health-licensing boards, whose income is generated through licensing fees. Each board pays an annual participation fee of $1,000 and a pro rata share of program expenses based upon number of licensees enrolled. The average annual cost per HPSP participant is approximately $1,000, which is charged to the licensing board. There is no cost to the participant except for the costs associated with treatment and toxicology screens, if required. HPSP consistently spends within its budget.
SUBMITTED BY: Allen G. Rasmussen, M.A.

REQUESTED ACTION: For information only.

MOTION BY: SECOND: ( ) PASSED ( ) PASSED AMENDED ( ) LAYED OVER ( ) DEFEATED

BACKGROUND:

Mr. Rasmussen is the Board’s representative and Chair of the Health Professionals Services Program (HPSP) Program Committee. Attached is his report of the February 13, 2018, HPSP Program Committee meeting.
The Health Professional Services Program (HPSP) Program Committee met on February 13, 2018, at 2:00 p.m. 13 of the 17 Minnesota Health Related Licensing Boards were in attendance (meeting minutes attached).

Dr. Charles Reznikoff, an addiction medicine physician at Hennepin County Medical Center, gave a presentation about medical cannabis (presentation attached).

HPSP Program Director Monica Feider provided an overview of HPSP’s Fiscal Year 18 Mid-Year Report (report attached).

Executive Director of the Board of Marriage and Family Therapy and the Chairperson of the Executive Directors’ Forum, Jennifer Mohlenhoff, provided an update of the Forum meetings since the HPSP Program Committee’s November 14, 2017, meeting (included in the meeting minutes).

The next HPSP Program Committee meeting is scheduled for May 8, 2018, at 10:00 a.m. A presentation from the Minnesota Prescription Monitoring Program is planned.

The meeting was adjourned at 3:45 p.m.

Respectfully Submitted,

Allen Rasmussen
HPSP Program Committee Chair
MEMBERS IN ATTENDANCE:

<table>
<thead>
<tr>
<th>P.C. Member</th>
<th>Board</th>
<th>Present</th>
</tr>
</thead>
<tbody>
<tr>
<td>Yvonne Hunshamer</td>
<td>Behavioral Health</td>
<td>X</td>
</tr>
<tr>
<td>Nestor Riano</td>
<td>Chiropractic Examiners</td>
<td>X</td>
</tr>
<tr>
<td>Ruth Dahl</td>
<td>Dentistry</td>
<td>X</td>
</tr>
<tr>
<td>Barb Damchik-Dykes</td>
<td>Dept. Health</td>
<td>X</td>
</tr>
<tr>
<td>Margaret Schreiner</td>
<td>Dietetics and Nutrition</td>
<td>X</td>
</tr>
<tr>
<td>Matt Simpson</td>
<td>Emergency Services</td>
<td>X</td>
</tr>
<tr>
<td>Jennifer Mohlenhoff</td>
<td>Marriage and Family</td>
<td>X</td>
</tr>
<tr>
<td>Allen Rasmussen</td>
<td>Medical Practice</td>
<td>X</td>
</tr>
<tr>
<td>Christine Norton</td>
<td>Nursing</td>
<td>X</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>P.C. Member</th>
<th>Board</th>
<th>Present</th>
</tr>
</thead>
<tbody>
<tr>
<td>Randy Snyder</td>
<td>Nursing Home Administ.</td>
<td>X</td>
</tr>
<tr>
<td>Randy Snyder</td>
<td>Optometry</td>
<td>X</td>
</tr>
<tr>
<td>James Bailey</td>
<td>Pharmacy</td>
<td>X</td>
</tr>
<tr>
<td>Kathy Polhamus (Vice Chair)</td>
<td>Physical Therapy</td>
<td>X</td>
</tr>
<tr>
<td>Margaret Schreiner</td>
<td>Podiatric Medicine</td>
<td>X</td>
</tr>
<tr>
<td>Samuel Sands</td>
<td>Psychology</td>
<td></td>
</tr>
<tr>
<td>Laura McGrath</td>
<td>Social Work</td>
<td></td>
</tr>
<tr>
<td>Julia Wilson &amp; Jody Grote</td>
<td>Veterinary Medicine</td>
<td>X</td>
</tr>
</tbody>
</table>

OTHERS IN ATTENDANCE: Monica Feider, Tracy Erfourth, Bettina Oppenheimer, Marilyn Miller, Kurt Roberts (HPSP), Kimberly Zillmer, Char Duke (HPSP staff), Shirley Brekken and Judy Reeve (Board of Nursing), Ruth Martinez, Elizabeth Huntley, Dr. Patty Lindholm (Board of Medical Practice), and Dr. Chales Reznikoff, MD (Addiction Medicine Physician, Hennepin County Medical Center).

AGENDA:

I. Convene and Introductions: Allen Rasmussen convened the meeting at 2:04 pm. Introductions were made.

II. Review of Minutes: The minutes from the November 14, 2017 Program Committee meeting were accepted.

III. Review of Agenda: The agenda for this meeting was accepted.

IV. Recognition: Ruth Martinez and Allen Rasmussen recognized Monica Feider for her 20 years of service at HPSP.

I. Medication Cannabis and Medication Assisted Treatment: Dr. Charles Reznikoff, an addiction medicine physician from Hennepin County Medical Center, provided the Committee with information about medical cannabis. He reported that there are two main properties of cannabis; THC (the mood altering and medicinal property) and cannabidiol (reported to be not intoxicating with medicinal properties poorly understood but hopeful). He reported that laws related to medical cannabis were developed as part of a political process, not a medical process. He reported that the Minnesota law is much better than laws in other states. He reported that in general, there is little conventional research to support the use of medical cannabis, with the exception of treatment for persons with HIV/AIDS, children with seizure disorders, multiple sclerosis with muscle spasms and end of life cancer care. He described promise in cannabinoids but cautioned that research needs to take place, as they contain many properties and there is a lot that is unknown. In general, he does not support persons working in the medical field or other safety sensitive positions when their medical cannabis product contains more THC than cannabidiol. If an exception were made in this opinion, it would be only after careful consideration and communication with the provider. The typical physician has not been well trained in cannabis or medical cannabis.

II. HPSP Mid-Year Report: Monica Feider provided a brief overview of HPSP’s mid-year report. The report will not be outlined here, as it was provided to members.

III. Executive Directors Forum: Jennifer Mohlenhoff provided an overview of the Executive Directors Forum:
   A. Meetings held December 5, January 9, February 6
   B. Policy Committee: Drafting proposed changes to Minn. Stat. 214 re: criminal background checks, temp. suspension actions. Also reviewing possible legislative changes to HLB budgeting processes.
   C. CBC: Fully implemented across HLBs. Increase in demand has resulted in increased staffing and space needs for CBC Office. Have noted slightly slower turnaround times for reports received back from FBI/BCA.
D. ASU: Assisting all HLBs in compiling proposed policy and/or fiscal change items for 2018 legislative session; will assist with review of space/leasing needs as HLB lease ends January 2021.

E. HR: Assisting with start-up of new Board of Occupational Therapy. New Program Committee member from Board of OT in 2018.

F. Management Committee: Reviewing current ASU and MN.IT staffing needs as part of early preparatory work for 2020-2021 budgeting process (beginning Summer 2018).

G. MN.IT: Rollout of new IT Project Management system to better gather information on all IT-related projects across the HLBS and assist with prioritization of limited IT resources.

H. MN Attorney General’s Office: Continuation of work assisting HLBs with Minn. Stat. 319B interpretation/enforcement. Discussion of protection of attorney/client privilege when providing information to other govt. entities.

IV. **Adjourn** – Meeting adjourned at 3:45pm.

*Thank you for your participation on the Program Committee. Minutes respectfully submitted by the staff of the HPSP.*
Medical Cannabis (In MN)

Fall 2017

Charlie Reznikoff

Charlie.reznikoff@hcmed.org
Colorado Legalizes Medicinal Fireworks
Science Seeks to Unlock Marijuana’s Secrets

As the once-vilified drug becomes more accepted, researchers around the world are trying to understand how it works and how it might fight disease.
For years the landscape of marijuana use has been rapidly shifting as more and more states are legalizing cannabis for the treatment of medical conditions and recreational use," said Marie McCormick, chair of the committee, the Sumner and Esther Feldberg Professor of Maternal and Child Health, department of social and behavioral sciences, Harvard T.H. Chan School of Public Health; and professor of pediatrics, Harvard Medical School, Cambridge, Mass. "This growing acceptance, accessibility, and use of cannabis and its derivatives have raised important public health concerns. Moreover, the lack of
Management of substance abuse

Cannabis

Terminology
Cannabis is a generic term used to denote the several psychoactive preparations of the plant Cannabis sativa. The major psychoactive constituent in cannabis is Δ⁹-tetrahydrocannabinol (THC). Compounds which are structurally similar to THC are referred to as cannabinoids. In addition, a number of recently identified compounds that differ structurally from cannabinoids nevertheless share many of their pharmacological properties. The Mexican term ‘marijuana’ is frequently used in referring to cannabis leaves or other crude plant material in many countries. The unpollinated female plants are called hashish. Cannabis oil (hashish oil) is a concentrate of cannabinoids obtained by solvent extraction of the crude plant material or of the resin.

Epidemiology
Cannabis is by far the most widely cultivated, trafficked and abused illicit drug. Half of all drug seizures worldwide are cannabis seizures. The geographical spread of those seizures is also global, covering practically every country of the world. About 147 million people, 2.5% of the world population, consume cannabis (annual prevalence) compared with 0.2% consuming cocaine and 0.2% consuming opiates. In the present decade, cannabis abuse has grown more rapidly than cocaine and opiate abuse. The most rapid growth in cannabis abuse since the 1960s has been in
Cannabinoids for Medical Use
A Systematic Review and Meta-analysis

Penny F. Whiting, PhD; Robert F. Wolff, MD; Sohan Deshpande, MSc; Marcello Di Nisio, PhD; Steven Duffy, Pgd; Adrian V. Hernandez, MD, PhD; J. Christiaan Keurentjes, MD, PhD; Shona Lang, PhD; Kate Misso, MSc; Steve Ryder, MSc; Simone Schmidtkofer, MSc; Marie Westwood, PhD; Jos Kleijnen, MD, PhD

IMPORTANCE Cannabis and cannabinoid drugs are widely used to treat disease or alleviate symptoms, but their efficacy for specific indications is not clear.

OBJECTIVE To conduct a systematic review of the benefits and adverse events (AEs) of cannabinoids.

DATA SOURCES Twenty-eight databases from inception to April 2015.

STUDY SELECTION Randomized clinical trials of cannabinoids for the following indications: nausea and vomiting due to chemotherapy, appetite stimulation in HIV/AIDS, chronic pain, spasticity due to multiple sclerosis or paraplegia, depression, anxiety disorder, sleep disorder, psychosis, glaucoma, or Tourette syndrome.

DATA EXTRACTION AND SYNTHESIS Study quality was assessed using the Cochrane risk of bias tool. All review stages were conducted independently by 2 reviewers. Where possible, data were pooled using random-effects meta-analysis.

MAIN OUTCOMES AND MEASURES Patient-relevant/disease-specific outcomes, activities of daily living, quality of life, global impression of change, and AEs.

RESULTS A total of 79 trials (6462 participants) were included; 4 were judged at low risk of bias. Most trials showed improvement in symptoms associated with cannabinoids but these associations did not reach statistical significance in all trials. Compared with placebo, cannabinoids were associated with a greater average number of patients showing a complete nausea and vomiting response (47% vs 20%; odds ratio [OR], 3.82 [95% CI, 1.55-9.42]; 7 trials), reduction in pain (23% vs 3%; OR, 1.41 [95% CI, 0.99-2.02], 8 trials), and...
Local database of cannabis articles

www.health.state.mn.us/topics/cannabis/practitioners/clinicalinfo.html
DEA Announces Actions Related to Marijuana and Industrial Hemp

AUG 11 (WASHINGTON) - The Drug Enforcement Administration (DEA) announced several marijuana-related actions, including actions regarding scientific research and scheduling of marijuana, as well as principles on the cultivation of industrial hemp under the Agricultural Act of 2014.

DEA Publishes Responses to Two Pending Petitions to Reschedule Marijuana
DEA has denied two petitions to reschedule marijuana under the Controlled Substances Act (CSA). In response to the petitions, DEA requested a scientific and medical evaluation and scheduling recommendation from the Department of Health and Human Services (HHS), which was conducted by the U.S. Food and Drug Administration (FDA) in consultation with the National Institute on Drug Abuse (NIDA). Based on the legal standards in the CSA, marijuana remains a schedule I controlled substance because it does not meet the criteria for currently accepted medical use in treatment in the United States, there is a lack of accepted safety for its use under medical supervision, and it has a high potential for abuse.

In his letter to the petitioners, DEA Acting Administrator Chuck Rosenberg offered a detailed response outlining the factual and legal basis for the denial of the petitions.

The full responses to the petitions can be found in the Federal Register. Response 1 AND Response 2

The DEA and the FDA continue to believe that scientifically valid and well-controlled clinical trials conducted under investigational new drug (IND) applications are the most appropriate way to conduct research on the medicinal uses of marijuana. Furthermore, DEA and FDA believe that the drug approval process is the most appropriate way to assess whether a product derived from marijuana or its constituents is safe and effective and has an accepted medical use. This pathway allows the FDA the important ability to determine whether a product meets the FDA criteria for safety and effectiveness for approval.

Increasing the Number of Authorized Marijuana Manufacturers Supplying Researchers
DEA announced a policy change designed to foster research by expanding the number of DEA-registered marijuana manufacturers. This change should provide researchers with a more varied and robust supply of marijuana. At present, there is only one entity authorized to produce marijuana to supply researchers in the United States: the University of Mississippi.
Dronabinol (marinol), pure THC
Federal Medical Cannabis
Schedule 3 controlled substance
“Medical” Edibles in Colorado
Cannabis Clinic in California
Medical Cannabis in Minnesota

Tinctures & Oils
Tinctures and oils are liquids made of cannabis-derived medicine that can be placed in the mouth and either swallowed or absorbed to some degree in the mouth itself. It can take up to 2-3 hours for these medicines to take full effect, so you should wait three hours before taking another dose. Too often, patients do not believe the first dose is working due to the delay in effect. Be aware that these doses add up over time so please wait the recommended amount so as not to over-dose.

Vaporizers
Vaporizers gently heat the oils in the cannabis-derived medicine until they evaporate and can be inhaled. It is important with your first use that you take a very short "puff" from the vaporizer. You should then wait at least 10 minutes to feel the effects. At that point you can again take another slightly longer "puff". Remember to wait a sufficient time after each inhalation to be certain you do not take too much.

Capsules
These types of medicine, like the liquids, take a long time to enter your system and take effect. They also last for a long time. As a general rule, patients should wait at least 3 hours before taking another dose.
"Medical" cannabis part of a wider cannabis legalization effort?

Marijuana Legalization Status

- Medical marijuana legalized
- Marijuana legalized for recreational use
- No laws legalizing marijuana
DENVER — More Americans than ever are smoking, eating and drinking marijuana, and they now overwhelmingly support full legalization of the long-banned plant, a new study and poll show.

A Gallup poll released Wednesday shows 58% of American adults think marijuana should be legal, up from 51% a year ago, with just 40% believing it should remain illegal.

And the number of adults who said they’ve used marijuana sometime in the past year has doubled in the past decade, with 9.5% of adults in 2013 saying they’d used marijuana sometime in the past year, compared to 4.1% in 2001. Notable increases came among women, African-Americans, the middle-aged, and those living in the South, the study published in JAMA Psychiatry found.

The trends appear to be reinforcing each other, say experts who caution that broader marijuana use brings the potential for abuse. Young people in particular are
Federal/State discrepancies unresolved: enforcement at the discretion of the attn. gen.
(see "Cole memo" for holder/lynch approach)

Sessions' Fight Against Marijuana

Tim Marcin
International Business Times December 5, 2016

The likely next attorney general could reverse most of the U.S.' efforts to legalize pot.
Justice Department Issues Memo on Marijuana Enforcement

The Department of Justice today issued a memo on federal marijuana enforcement policy announcing a return to the rule of law and the rescission of previous guidance documents. Since the passage of the Controlled Substances Act (CSA) in 1970, Congress has generally prohibited the cultivation, distribution, and possession of marijuana.

In the memorandum, Attorney General Jeff Sessions directs all U.S. Attorneys to enforce the laws enacted by Congress and to follow well-established principles when pursuing prosecutions related to marijuana activities. This return to the rule of law is also a return of trust and local control to federal prosecutors who now where and how to deploy Justice Department resources most effectively to reduce violent crime, stem the tide of the drug crisis, and dismantle criminal gangs.

"It is the mission of the Department of Justice to enforce the laws of the United States, and the previous issuance of guidance undermined the rule of law and the ability of our local, state, tribal, and federal law enforcement partners to carry out this mission," said Attorney General Jeff Sessions. "Therefore, today's memo on federal marijuana enforcement simply directs all U.S. Attorneys to use previously established prosecutorial principles that provide them all the necessary tools to disrupt criminal organizations, tackle the growing drug crisis, and thwart violent crime across our country."

Attachment(s):
Download Marijuana Enforcement 1.4.18

Component(s):
Office of the Attorney General

Press Release Number:
18-8

Updated January 4, 2018
Viewpoint

August 9, 2016

Medical Board Expectations for Physicians Recommending Marijuana

Humayun J. Chaudhry, DO, MS1; Arthur S. Hengerer, MD2; Gregory B. Snyder, MD1

>> Author Affiliations


Heightened public interest in marijuana and marijuana-infused products for medicinal and recreational purposes led the nation’s state medical and osteopathic boards recently to issue recommendations about marijuana in patient care and a cautionary note advising actively licensed physicians to abstain from using marijuana while practicing medicine.1 This is the first time that the dispensing or use of products derived from the Cannabis sativa plant have been highlighted in a policy recommendation of the Federation of State Medical Boards (FSMB), whose members include 70 state and territorial medical licensing boards of the United States. We examine the dilemma of physicians caught between increasingly permissive local statutes and prohibitive federal regulations and summarize 10 recommendations about marijuana for patient care from the agencies authorized by statute to protect the health and welfare of the public through the licensure and discipline of physicians and other health care professionals.
Medical Cannabis:

- Popular support
- Scant medical evidence
- Barriers to proper research
- Nonmedical production/distribution
  - Regulated by local authorities
  - Variable state by state
- Federal enforcement concerns
- Can fit within a professional practice
Ben

Stress Disorder

Annals of Internal Medicine

Cannabis for Pain and Posttraumatic Stress Disorder: More Consensus Than Controversy or Vice Versa?

The scientific evidence for the effectiveness and safety of cannabis and cannabinoids in treating medical and psychiatric disease has recently come under substantial scrutiny. This surge in methodologically rigorous analysis of the evidence supporting cannabis-based therapeutics is driven in part by recent, dramatic, and ongoing changes in the accessibility of cannabis caused by U.S. state-level antiprohibition movements. In this context, clinicians, policymakers, and the public are increasingly interested in understanding the scientific evidence base underlying potential indications for medical cannabis use. This issue of Annals of Internal Medicine includes 2 such analyses. 1 looking at pain and the other on posttraumatic stress disorder (PTSD). The systematic reviews highlight an ongoing lack of high-quality data from which to draw conclusions from discussions about the efficacy of cannabis for these conditions, for which cannabis is both sanctioned and commonly used.

Nugent and colleagues (1) systematically reviewed data on the effects of cannabis for several types of pain and found only limited, low-strength evidence that cannabis alleviates neuropathic pain and insufficient evidence for other types of pain. Of importance, their conclusions were heavily based on studies using cannabinoids (an oral mixture of tetrahydrocannabinol and cannabidiol) rather than smoked cannabis products (2). In addition, the authors comment that most available studies are small, have methodological pitfalls, and are of relatively short duration. These conclusions seem at odds with the fact that pain is one of the most common medical conditions for which cannabis is used and approved in many states (3). So why the discrepancy? One simple reason could be that most of the studies used lower doses of tetrahydrocannabinol or cannabinoids than those commonly used in dispensary settings, and the all-or-none characteristic of cannabis on pain could be dose-dependent. Also, persons using medical cannabis for pain relief are likely to be a highly self-selecting group not always captives of the clinical trials. In the largest clinical trial reviewed, only 28% of participants showed a clinical response to nabilomix compared with 16% to placebo; thus, most participants in the intervention group did not have clinically meaningful benefit. As Nugent and colleagues note, patient characteristics associated with clinical response to cannabis products are unknown. Another, more controlled study might pursue high-quality studies and disseminate the results to clinicians and the public. In this context, these reviews are must-reads for all physicians, especially those practicing in states where medical cannabis is legal.

Sachin Patel, MD, PhD
Burlington Hospital
MN Qualifying Conditions

- HIV/AIDS
- Cancer (pain, nausea, cachexia)
- Severe muscle spasm (typical of MS)
- ALS
- End of life, <1 year expectancy (pain, nausea, cachexia)
- Crohn’s
- Seizure disorder
- Glaucoma
- Tourette’s syndrome
- Intractable pain*
- PTSD**
- Autism***
- Apnea***
MDH website: helpful

Medical Cannabis

For Patients
Find out which conditions qualify, how to get certified, where to get medical cannabis and the costs.

For Parents/Legal Guardians and Caregivers
Find out how you can assist the patient to get medical cannabis.

For Health Care Practitioners
Register yourself and certify your patients.

For Public Safety
Information for law enforcement.

Laws and Rules
Information about laws, rules and policies related to Minnesota medical cannabis.

Registry Login/Create Account
For health care practitioners, certified patients and certified caregivers.

News
News releases about the Medical Cannabis program.

Print Materials and Forms
Repository for forms and documents.

About the Medical Cannabis Program
Manufacturer and laboratory selection, rulemaking, task force, and other details about Minnesota's unique medical cannabis program.

Spotlight
- Medical Cannabis Registry
- Statistics
- Intractable Pain - Including Opportunities for Public Comment
- MDH Office of Medical Cannabis to hold community sessions around state
Two medical cannabis manufacturers:
Law prohibits recommending one

LeafLine Labs provides relief through medical cannabis to suffering Minnesotans who deserve a better quality of life.

Do you qualify?
THC in appropriate amounts has many therapeutic effects such as appetite stimulation and pain relief. This benefit comes without the risk of respiratory depression and narcotic addiction that current prescription pain pills do.

**Available in:**
- Oral suspension, *unflavored and flavored* *(creamsicle)*
- Oils for vaporization
- Sublingual spray, *flavored* *(vanilla mint)*
- Tincture, *flavored* *(vanilla)*

Commonly used for painful muscle spasm disorders. Combining THC and CBD in similar amounts diminishes the sedating effect possible with higher THC concentrations while increasing the overall targeted therapeutic effect of the medication.

**Available in:**
- Oral suspension, *unflavored and flavored* *(creamsicle)*
- Oils for vaporization
- Sublingual spray, *flavored* *(vanilla mint)*

CBD is generally accepted as less sedating and is often utilized to treat epilepsy and other seizure disorders. It also has potent anti-inflammatory properties as well.

**Available in:**
- Oral suspension, *unflavored*
commonly experienced by users of THC. In our spectrum of cannabis derivatives, a small CBD percentage will be incorporated into the THC-dominate products to minimize side effects.

**THC Dominant**

Yellow THC:CBD (4:1) Cannabis Product

**Balanced THC:CBD**

Green THC:CBD (1:1) Cannabis Product

**CBD Dominant**

Indigo CBD Only Cannabis Product

Violet

**THC** = Δ9-tetrahydrocannabinol

This chemical produces the mental effects of cannabis, commonly referred to as “high”. In the past, THC was the most desired chemical within the cannabis plant, and strains have been bred to maximize THC content ranging from 4-35%.

**CBD** = cannabidiol

This compound produces medicinal effects without psychoactivity. Historically, this less-desired chemical was nearly nonexistent within popular cannabis strains, but more recently its medical potential has brought CBD to the forefront of cannabis research.
Tinctures & Oils

Tinctures and oils are liquids made of cannabis-derived medicine that can be placed in the mouth and either swallowed or absorbed to some degree in the mouth itself. It can take up to 2-3 hours for these medicines to take full effect, so you should wait three hours before taking another dose. Too often, patients do not believe the first dose is working due to the delay in effect. Be aware that these doses add up over time so please wait the recommended amount so as not to over-dose.

Vaporizers

Vaporizers gently heat the oils in the cannabis-derived medicine until they evaporate and can be inhaled. It is important with your first use that you take a very short “puff” from the vaporizer. You should then wait at least 10 minutes to feel the effects. At that point you can again take another slightly longer “puff”. Remember to wait a sufficient time after each inhalation to be certain you do not take too much.

Capsules

These types of medicine, like the liquids, take a long time to enter your system and take effect. They also last for a long time. As a general rule, patients should wait at least 3 hours before taking another dose.
Never whole plant
Never smoked
Always ratios of thc and cbd
No focus on strains of cannabis
(indica vs sativa)
Cost is High

- Insurance does not cover medical cannabis
- Patient state registration fee $50-$200
  - Medical assistance patients get a discount
- Monthly cost of medication is variable
  - $100 to $500 per month depending on product and dose
Age of enrollees

- 4% <18 years
- 18% age 18-35
- 24% age 36-49
- 36% age 50-64
- 18% 65+
Male:Female = 52:48
With the current nationwide epidemic of opioid abuse, dependence, and fatalities, clinicians are being asked by federal agencies and professional societies to control their prescribing of narcotic medications for pain. Federal guidelines emphasize tapering, discontinuing, and limiting initiation of these drugs except in provision of end-of-life care. Reducing reliance on opioids, however, is a massive task. According to one estimate, more than 650 000 opioid prescriptions are dispensed each day in the United States. Unless the nation develops an
Legalization of Medical Marijuana and Incidence of Opioid Mortality

Marie J. Hayes, PhD; Mark S. Brown, MD

The rapid acceleration of prescription opioid-related overdose deaths in the United States is correlated with the availability of stronger opioid medications, as well as a change in medical practice from withholding opioid medication because of dependence risk to treating patients with chronic pain with opioids. Subsequently, the pendulum of concern has swung again, driven by the public health crisis of rising opioid analgesic addiction, overdose, and death. Opioid medications are problematic as a treatment for chronic pain. Opioid pharmaceuticals cause other adverse effects when used for long periods, such as tolerance, hyperalgesia, and gastrointestinal complications, making this class of drugs a poor choice for long-term use. As is well known, prescription opioids also have great abuse potential due to their influence on stress and reward circuits in the brain, promoting nonmedical use and abuse and diversion of prescription medications.

In this issue, Bachhuber et al examine the link between medical marijuana laws and unintentional opioid mortality in which an opioid analgesic was identified. Using Centers for Disease Control and Prevention data, states with and without medical marijuana laws were contrasted for age-adjusted, opioid-related mortality. Overall, the incidence of opioid analgesic–associated mortality rose dramatically across the study period (1999-2010). States with medical marijuana laws had higher overdose rates than did those without such laws when population-adjusted mortality was analyzed across years, although the rise in deaths over the study period was similar for both groups. In contrast, a convincing protective effect of medical marijuana laws was found in a covariate-adjusted, time-series model in which opioid analgesic mortality declined steadily based on years since medical marijuana laws were enacted, termed implementation. The model included an analysis of the impact of critical policies for prescription opioid regulatory efforts: prescription monitoring programs, pharmacist collection of patient information, state and oversight of pain management clinics, as well as state unemployment rates. In states with medical marijuana laws, age-
Legalizing medical marijuana does not increase use among adolescents

Date: June 15, 2015
Source: The Lancet

Summary: A nationwide study analyzing 24 years of data (1991 to 2014) from over one million American adolescents in the 48 contiguous states has found no evidence that legalizing the use of marijuana for medical purposes leads to increased use among teenagers.

A new study showed no significant difference in adolescent marijuana use in 21 states with medical marijuana laws before or after implementation of these laws.
Use
% who used daily

Risk
% seeing "great risk" in using regularly

YEAR

PERCENT

YEAR

PERCENT

8th Grade
10th Grade
12th Grade
Disapproval
% disapproving of using regularly

Availability
% saying "fairly easy" or "very easy" to get
Prevalence of Marijuana Use Disorders in the United States Between 2001-2002 and 2012-2013

Deborah S. Hasin, PhD1,2; Tulehi D. Saha, PhD3; Bradley T. Kolliege, PhD4; Risë B. Goldseien, PhD, MPH4; S. Patricie Chieu, PhD1; Hailio Zhang, PhD4; Jeesun Jung, PhD4; Roger P. Pickering, MD4; W. June Ruan, MA4; Sharon M. Smith, PhD4; Boji Huang, MD, PhD4; Bridge1 F. Grant, PhD, PhD4

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JAMA Psychiatry. Published online October 21, 2015. doi:10.1001/jamapsychiatry.2015.1855

ABSTRACT

ABSTRACT | INTRODUCTION | METHODS | RESULTS | DISCUSSION | CONCLUSIONS | ARTICLE INFORMATION | REFERENCES

Importance Laws and attitudes toward marijuana in the United States are becoming more permissive but little is known about whether the prevalence rates of marijuana use and marijuana use disorders have changed in the 21st century.

Objective To present nationally representative information on the past-year prevalence rates of marijuana use, marijuana use disorder, and marijuana use disorder among marijuana users in the US adult general population and whether this has changed between 2001-2002 and 2012-2013.

Design, Setting, and Participants Face-to-face interviews conducted in surveys of 2 nationally representative samples of US adults: the National Epidemiologic Survey on Alcohol and Related Conditions (data collected April 2001-April 2002; N = 43,093) and the National Epidemiologic Survey on Alcohol and Related Conditions-III (data collected April 2012-June 2013; N = 36,309). Data were analyzed March through May 2015.

Main Outcomes and Measures Past-year marijuana use and DSM-IV marijuana use disorder (abuse or dependence).

Results The past-year prevalence of marijuana use was 4.1% (SE, 0.13) in 2001-2002 and 9.5% (SE, 0.27) in 2012-2013, a significant increase (P < .05). Significant increases were also found across demographic subgroups (sex, age, race/ethnicity, education, marital status, income, urban/rural, and region). The past-year prevalence of DSM-IV marijuana use disorder was 1.5% (SE, 0.08) in 2001-2002 and 2.9% (SE, 0.13) in 2012-2013 (P < .05). With few exceptions, increases in the prevalence of marijuana use disorder between 2001-2002 and 2012-2013 were also statistically significant (P < .05) across demographic subgroups. However, the prevalence of marijuana use disorder among marijuana users decreased significantly from 2001-2002 (35.6%; SE, 1.37) to 2012-2013 (32.6%; SE, 1.04).

Conclusions and Relevance The prevalence of marijuana use more than doubled between 2001-2002 and 2012-2013, and there was a large increase in marijuana use disorders during that time. While not all marijuana users experience problems, nearly 3 of 10 marijuana users manifested a marijuana use disorder in 2012-2013. More research is needed on how marijuana use disorders impact health.
**Table 1. Past-Year Prevalence of Marijuana Use by Sociodemographic Characteristics, 2001-2013**

<table>
<thead>
<tr>
<th>Sociodemographic Characteristics</th>
<th>NESARC Wave 1, 2001-2002</th>
<th>NESARC-Wave III, 2012-2013</th>
</tr>
</thead>
<tbody>
<tr>
<td>Total</td>
<td>4.1 (0.15)</td>
<td>9.5 (0.27)</td>
</tr>
<tr>
<td>Sex</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Male</td>
<td>5.6 (0.24)</td>
<td>12.3 (0.40)</td>
</tr>
<tr>
<td>Female</td>
<td>2.6 (0.15)</td>
<td>6.9 (0.29)</td>
</tr>
<tr>
<td>Age, y</td>
<td></td>
<td></td>
</tr>
<tr>
<td>18-29</td>
<td>10.5 (0.47)</td>
<td>21.2 (0.67)</td>
</tr>
<tr>
<td>30-34</td>
<td>4.1 (0.24)</td>
<td>10.1 (0.41)</td>
</tr>
<tr>
<td>45-64</td>
<td>1.6 (0.15)</td>
<td>5.9 (0.28)</td>
</tr>
<tr>
<td>≥65</td>
<td>0.0 (0.02)</td>
<td>1.3 (0.22)</td>
</tr>
<tr>
<td>Race/ethnicity</td>
<td></td>
<td></td>
</tr>
<tr>
<td>White</td>
<td>4.1 (0.17)</td>
<td>9.4 (0.34)</td>
</tr>
<tr>
<td>Black</td>
<td>4.7 (0.35)</td>
<td>12.7 (0.64)</td>
</tr>
<tr>
<td>Native American</td>
<td>7.0 (1.15)</td>
<td>17.1 (2.32)</td>
</tr>
<tr>
<td>Asian</td>
<td>3.1 (0.54)</td>
<td>5.0 (0.59)</td>
</tr>
<tr>
<td>Hispanic</td>
<td>3.3 (0.31)</td>
<td>8.4 (0.50)</td>
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<tr>
<td>Education</td>
<td></td>
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<tr>
<td>&lt;High school</td>
<td>4.5 (0.38)</td>
<td>9.7 (0.51)</td>
</tr>
<tr>
<td>High school</td>
<td>4.0 (0.26)</td>
<td>10.4 (0.43)</td>
</tr>
<tr>
<td>Some college</td>
<td>4.0 (0.17)</td>
<td>9.1 (0.32)</td>
</tr>
<tr>
<td>Marital status</td>
<td></td>
<td></td>
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<tr>
<td>Married</td>
<td>2.1 (0.13)</td>
<td>5.5 (0.24)</td>
</tr>
<tr>
<td>Widowed/separated</td>
<td>3.4 (0.30)</td>
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<tr>
<td>Income, $</td>
<td></td>
<td></td>
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<tr>
<td>0-19 999</td>
<td>6.3 (0.34)</td>
<td>15.6 (0.61)</td>
</tr>
<tr>
<td>20 000-34 999</td>
<td>4.2 (0.28)</td>
<td>9.8 (0.47)</td>
</tr>
<tr>
<td>35 000-69 999</td>
<td>3.4 (0.23)</td>
<td>8.4 (0.33)</td>
</tr>
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**Table 2. Past-Year Prevalence of DSM-IV Marijuana Use Disorder (Abuse or Dependence) by Sociodemographic Characteristics, 2001-2013**

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<td>2.2 (0.14)</td>
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</tr>
<tr>
<td>Female</td>
<td>0.8 (0.07)</td>
<td>1.7 (0.13)</td>
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<td>Race/ethnicity</td>
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<td>1.4 (0.10)</td>
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<td>1.8 (0.22)</td>
<td>4.6 (0.39)</td>
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Marijuana devastated Colorado, don’t nationally

Jeff Hunt, Opinion contributor  Published 7:00 a.m. ET Aug. 7, 2017 | Updated 2:06 p.m. ET Aug. 7, 2017

The proposed Marijuana Justice Act would remove marijuana from the Controlled Substances Act. Video provided by Newsy Newslook

Arrests are up. We still have a black market. And people are in danger.

Last week, Senator Cory Booker introduced the Marijuana Justice Act in an effort to legalize marijuana across the nation and penalize local communities that want nothing to do with this dangerous drug. This is the furthest reaching marijuana legislation effort to date and makes pot the second most popular drug in our nation’s
Endocannabinoids and cannabis receptors

CB-1 and CB-2 Receptors

CB1 (○) and CB2 (●)
Cannabis receptor ligands

- Endocannabinoids
  - Anandamide, *et c.*
- Phytocannabinoids
  - THC, CBD, *et c.*
- Synthetic cannabinoids
  - K2, spice
Cannabinoids are inhibitory retrograde inhibitors
CB1 receptor distribution: limbic system, hippocampus, cerebellum
CB2 receptor distribution: Immune cells, bone marrow
## Endocannabinoid System

<table>
<thead>
<tr>
<th>Endocannabinoids</th>
<th>Phytocannabinoids</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Dampen tonic nerve and immune signals locally</td>
<td>• Dampen tonic nerve and immune signals globally</td>
</tr>
<tr>
<td>• Rapidly broken down in the body at the site of action by enzymes (FAAH, COX)</td>
<td>• Metabolized by the liver, not the site of action. Large volume of distribution</td>
</tr>
<tr>
<td>• Endocannabinoid signals are quick and localized</td>
<td>• Cannabinoids have sustained and global</td>
</tr>
</tbody>
</table>
Raphael Mechoulam:
Described THC in 1963, later Anandamide
Andrew Weill described its behavioral effects
"Active Placebo"- Set & Setting
THC vs CBD

both naturally occurring phytocannabinoids

THC- agonist for CB1 And CB2 receptors

CBD- nonagonist for CB receptors
Tetrahydrocannabinol (THC)

- CB1 and CB2 agonist
- Provides many of the classic effects (good and bad) of marijuana
  - Intoxication
  - Anxiety/paranoia
  - Pain relief
  - Nausea relief
  - Appetite stimulation
Cannabidiol (CBD)

- Indirect antagonist of CB receptor ligands
- Not impairing or intoxicating
- Not much is known clinically, maybe:
  - Antiseizure
  - Antipsychotic
  - Anti-addictive
  - Offsets thc effects
Many other (85+) cannabinoids...
“Entouragé Effect”
“Entourage Effect”

Only by combining multiple cannabinoids in a medicine can you achieve maximal benefit and minimal adverse effects.
First pass metabolism 85%

Fig. 1: Figure shows the time course of the acute behavioral effects of Δ-9-THC (feeling high) as a function of route of administration (intravenous, inhaled and oral).

The acute effects of cannabinoids on memory in humans: a review.

Psychopharmacology, Nov 2006, Vol. 188 Issue 4, p425-444, 20p, 1 chart, 3
Self reported symptoms of cannabis withdrawal

Budney et al, J of Abnl Psyche 2003 vol 112 #3 p393
Cannabis withdrawal:
Mild, not life threatening, irritability, poor sleep, poor appetite, restlessness
Requires no treatment, only education and reassurance
Commonest emergency caused by marijuana ingestion?
Commonest emergency caused by marijuana ingestion?

Panic Attack
Is marijuana and/or medical cannabis addictive?
Is Marijuana Addictive?

Estimated percentage of people in a national survey who used a substance at least once and became dependent:

- Tobacco: 32%
- Heroin: 23%
- Cocaine: 17%
- Alcohol: 15%
- Stimulants (other than cocaine): 11%
- Anxiolytic sedative/hypnotic drugs: 9%
- Marijuana: 9%
- Analgesic drugs: 8%
- Psychedelic drugs: 5%
- Inhalant drugs: 4%

Source: The National Comorbidity Survey, which included 8,092 participants and was supported by the National Institute on Drug Abuse; results published in Experimental and Clinical Psychopharmacology, 1994.

If <18 years, risk of addiction increased to 17%.

www.drugabuse.gov/publications/research-reports/marijuana/marijuana-addictive
Cannabis ranked against other drugs of abuse

Lancet 2007, 369, p1047-1053
Primary Substance at Admission to SUD Treatment Services for Adults CY1995 - CY2015

Source: Minnesota Department of Human Services, ADAD, DAANES (5/10/2016)
Is marijuana a "gateway drug"?
Figure 2. Use of Substances Other Than Marijuana, by Frequency of Marijuana Use: 2003

- Past Month Cigarette Use: 74.1%
  - Daily Marijuana Users: 40.6%
  - Less Than Daily Marijuana Users: 20.3%
  - Nonusers: 28%

- Past Month Heavy Alcohol Use: 21.2%
  - Daily Marijuana Users: 63.3%
  - Less Than Daily Marijuana Users: 40.6%
  - Nonusers: 3.9%

- Past Year Use of Any Illicit Drug Other Than Marijuana: 59.3%
  - Daily Marijuana Users: 38.8%
  - Less Than Daily Marijuana Users: 24.9%
  - Nonusers: 4.6%

- Past Year Nonmedical Use of Pain Relievers: 10%
  - Daily Marijuana Users: 20.3%
  - Less Than Daily Marijuana Users: 20.3%
  - Nonusers: 2.8%
Cannabis is a vasodilator
Figure 4. Change of blood pressure (systolic, diastolic, and mean arterial) after exposure to the highest dose (23.12% THC, 69.4 mg/joint), for participant 20. For this individual, the mean arterial blood pressure decreases with more than 30 mmHg during smoking.
RESEARCH

Acute cannabis consumption and motor vehicle collision risk: systematic review of observational studies and meta-analysis

BMJ 2012: 344 doi: http://dx.doi.org/10.1136/bmj.e536 (Published 9 February 2012)

<table>
<thead>
<tr>
<th>Study</th>
<th>No of events/Total</th>
<th>Odds ratio (95% CI)</th>
<th>Weight (%)</th>
<th>Odds ratio (95% CI)</th>
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<tbody>
<tr>
<td></td>
<td>Case</td>
<td>Control</td>
<td></td>
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<tr>
<td>Bedard 2007</td>
<td>1106/19511</td>
<td>541/13032</td>
<td>18.0</td>
<td>1.39 (1.25 to 1.54)</td>
</tr>
<tr>
<td>Blows 2005</td>
<td>32/552</td>
<td>5/587</td>
<td>7.9</td>
<td>7.16 (2.77 to 18.52)</td>
</tr>
<tr>
<td>Drummer 2004</td>
<td>51/1214</td>
<td>5/376</td>
<td>8.1</td>
<td>3.25 (1.29 to 8.21)</td>
</tr>
<tr>
<td>Laumon 2005</td>
<td>322/3972</td>
<td>100/2793</td>
<td>17.0</td>
<td>2.38 (1.89 to 2.99)</td>
</tr>
<tr>
<td>Longo 2000</td>
<td>21/1038</td>
<td>23/937</td>
<td>12.0</td>
<td>0.82 (0.45 to 1.49)</td>
</tr>
<tr>
<td>Mathijssen 2005</td>
<td>6/108</td>
<td>148/3571</td>
<td>9.0</td>
<td>1.36 (0.59 to 3.15)</td>
</tr>
<tr>
<td>Mura 2003</td>
<td>49/321</td>
<td>21/310</td>
<td>12.8</td>
<td>2.48 (1.45 to 4.24)</td>
</tr>
<tr>
<td>Terhune 1982</td>
<td>13/129</td>
<td>4/161</td>
<td>6.2</td>
<td>4.40 (1.40 to 13.84)</td>
</tr>
<tr>
<td>Terhune 1992</td>
<td>16/541</td>
<td>9/258</td>
<td>9.1</td>
<td>0.84 (0.37 to 1.93)</td>
</tr>
<tr>
<td>Total (95% CI)</td>
<td>1616/27286</td>
<td>856/22025</td>
<td>100.0</td>
<td>1.92 (1.35 to 2.73)</td>
</tr>
</tbody>
</table>

Test for heterogeneity: $\chi^2=0.18$, $\chi^2=42.74$, df=8, $P<0.001$, I²=81%
Test for overall effect: $z=3.63$, $P<0.001$

Collision risk lower with tetrahydrocannabinol
Collision risk higher with tetrahydrocannabinol
More Colorado drivers in fatal crashes positive for pot, study says

By John Ingold

The Denver Post

POSTED 05/15/2014 04:02:14 PM MDT | UPDATED: ABOUT A YEAR AGO

Two new University of Colorado studies paint an ominous picture of the direction of the state since marijuana commercialization, but neither provides conclusive evidence that legal pot is causing harm.

One study shows more drivers involved in fatal car accidents in Colorado are testing positive for marijuana — and that Colorado has a higher percentage of such drivers testing positive for pot than other states even when controlled for several variables. But the data the researchers use does not reveal whether those drivers were impaired at the time of the crash or whether they were at fault.

"The primary result of this study may simply reflect a general increase in marijuana use during this ... time period in Colorado," the study's authors write.

The other study shows that perceptions of marijuana's risk have decreased across all age groups with the boom in marijuana businesses in the state. The study also finds that near-daily marijuana use among adults increased significantly starting in 2009, relative to states without medical marijuana laws. But the study's authors acknowledge that they cannot show Colorado's marijuana laws are the reason for the shifts in attitudes and use.
Study: Fatal Car Crashes Involving Marijuana Have Tripled

February 4, 2014 9:14 PM

 According to a recent study, fatal car crashes involving pot use have tripled in the U.S.

"Currently, one of nine drivers involved in fatal crashes would test positive for marijuana," Dr. Guohua Li, director of the Center for Injury Epidemiology and Prevention at Columbia, and co-author of the study told HealthDay News.

Researchers from Columbia University's Mailman School of Public Health gathered data from six states – California, Hawaii, Illinois, New Hampshire, Rhode Island, and West Virginia – that perform toxicology tests on drivers involved in fatal car accidents. This data included over 23,500 drivers that died within one hour of a crash between 1999 and 2010.
Work place accidents associated with cannabis use

New Zealand Dunedin Study

>1000 cohort studied over 38 years

• Updated summer 2012
• Neuropsychiatric declines across the board in MJ users

• Age and dose dependent
  – Mental health
  – Verbal IQ
  – Academic achievement and job satisfaction
A new study provides credible evidence that marijuana legalization will lead to decreased academic success. (Elaine Thompson/AP)

The most rigorous study yet of the effects of marijuana legalization has identified a disturbing result: College students with access to recreational cannabis on average earn worse grades and fail classes at a higher rate.

Economists Olivier Marie and Ulf Zölitz took advantage of a decision by Maastricht, a city in the Netherlands, to change the rules for “cannabis cafes.” which legally sell recreational marijuana. Because Maastricht is
Marijuana use doubles in anxiety disorders and depression

- Adolescent marijuana use may cause anxiety disorders
  - Panic, depression, general anxiety

- Marijuana is also anxiety relieving
  - Social anxiety and PTSD

J. Of American Academy of Child and adol psych 46(3) 2007
Marijuana and Psychosis

- Worsening of preexisting schizophrenia
  - Increased psychiatric hospitalizations
- Acute reversible psychotic reaction
  - Increased likelihood of eventual schizophrenia
- Acute irreversible psychotic reaction
  - Psychotic break, Schizophrenia

Zammit brit journal of psyche nov 2008 193 (5) p357
D'souza, int. review of neurobiology 2007 (78) p289
Moore et al. LANCET July 28, 2007 P.319
Cannabis and psychosis

• 24% new psychosis cases linked to THC consumption

• BBC news 16, Feb 2015
Cannabinoid Hyperemesis Syndrome: Cyclic Vomiting, Chronic Cannabis Use, and Compulsive Bathing

by Vikram Budhraja, Tarun Narang, Sulaiman Azeez

Marijuana is an illicit, but frequently used drug. Recently, a syndrome characterized by chronic marijuana use, cyclic vomiting, and compulsive bathing has been described in the literature. We report the third case of Cannabinoid Hyperemesis in the United States and its complete symptomatic resolution following abstinence from marijuana. This case represents the first reported case of Cannabinoid Hyperemesis in the Hispanic population. The case reported also demonstrates the earliest development of symptoms following habitual marijuana use and suggests a need to clearly define the characteristics of newly emerging diagnosis.

INTRODUCTION

Marijuana is one of the most frequently abused illicit substances in the United States (U.S.) (1). Cannabinoid Hyperemesis Syndrome was first reported recently in the literature with a series of patients exhibiting a triad of symptoms: cyclic vomiting, chronic marijuana use, and compulsive bathing.

CASE REPORT

A 19-year-old Hispanic man presented to the emergency department with nausea and vomiting for three days, and daily marijuana use for the last 18 months. He was admitted for intractable nausea, non-bilious non-bloody vomiting 10–12 times per day, and epigastric pain. Nausea was relieved by hot showers, and he reported taking
Medical cannabis warnings

- Cannabis addiction and withdrawal is real!
- Cannabinoids are vasodilators
- Cannabinoids are associated with increased mental health symptoms, and mental health emergencies
- It is unsafe to drive on cannabinoids
- Heavy use in adolescence affect cognitive development
- Hyperemesis syndrome increasingly recognized
Thank you!
Questions?
To Certify a Patient (1):

- You must be a board certified doc, NP, or PA
- You must register with the state \textit{(very easy)}
- Determine that the patient has a qualifying condition
- \textbf{You} must be treating the patient for their qualifying condition
- Review one year of the medical history of the qualifying condition
- Do a medical interview and appropriate exam
To Certify a Patient (2):

• Determine that medical cannabis is appropriate
  - You can say “no” at this point!
• Certify through the state website that this patient has a qualifying condition (*very easy*)
• Plan a follow up: provider judgment
• Document you visit
Common incorrect concerns....

“Only subspecialists treat these conditions so only they can certify them, by law.”
Common incorrect concerns....

"Only subspecialists treat these conditions so only they can certify them, by law."

Primary providers who might treat nausea associated with chemo or neuropathy associated with HIV, for example, can certify medical cannabis for those conditions
Common incorrect concerns....

“My job is only to certify the condition. It is not my job to weigh risks and benefits.”
Common incorrect concerns....

“My job is only to certify the condition. It is not my job to weigh risks and benefits.”

Certifying docs have a confusingly defined role. But there are clear legal requirements that require proper medical decision making, documentation and follow up, not just rubber-stamping conditions.

*It is true that a lot of the work will be done for you by the state and the manufacturers*
Common incorrect concerns....

"I am obligated by law to certify conditions if I am a registered doctor, and if the patient I’m seeing has the condition.... Therefore I will not register with the state"
Common incorrect concerns....

“I am obligated by law to certify conditions if I am a registered doctor, and the patient I’m seeing has the condition.... Therefore I will not register with the state”

The law explicitly states you can say “no” if you believe that the patient would not benefit despite having a qualifying condition
When you certify a patient

- You certify the patient for one year

- Once you certify, you cannot "revoke" the certification

- You can and should report adverse events to the state and they can revoke the certification (rare)

- You can log in to the state database and see the products and quantities dispensed
Medical cannabis will not be on the prescription monitoring program
Designated Caregivers

- If the patient is unable to self-administer or possess medical cannabis (spinal cord injury or a child)
- A designated caregiver can be vetted and authorized by the state

- Possession of medical cannabis by an "undesignated caregiver" is treated like marijuana possession
Physician concerns

- Practicing medicine outside the evidence base
- Unconventional production, regulation, dispensing
- Recreating the opioid-for-pain epidemic
- Challenging conversations, demanding patients
- Paperwork
- Time and energy to learn something new
- Personal opinions about marijuana
STATE OF MINNESOTA

Health Professionals Services Program
HPSP, 1380 Energy Lane Suite 202, St. Paul, MN 55108 – Phone: 651.643.2120 – Fax: 651.643.2163 - www.hpsp.state.mn.us

FISCAL YEAR 2018
MID-YEAR REPORT

REPORT SUBMITTED TO THE
HEALTH LICENSING BOARDS AND THE
HEALTH PROFESSIONALS SERVICES PROGRAM’S
PROGRAM AND ADVISORY COMMITTEES
BY MONICA FEIDER, MSW, LICSW, PROGRAM MANAGER
AND HPSP STAFF
FEBRUARY 2018
REPORT CONTENT

INTRODUCTION .................................................................................................................. 1
MISSION AND GOALS .......................................................................................................... 1
MISSION ................................................................................................................................ 1
GOALS .................................................................................................................................. 1
PROGRAM PARTICIPATION .................................................................................................. 1
DEFINITIONS OF REFERRAL SOURCES .............................................................................. 1
REFERRALS BY FIRST REFERRAL SOURCE AND BOARD ................................................... 2
REFERRALS BY FIRST REFERRAL SOURCE ......................................................................... 2
REFERRALS BY SECOND REFERRAL SOURCE ....................................................................... 3
DEFINITIONS OF DISCHARGE CATEGORIES ......................................................................... 4
DISCHARGES BY DISCHARGE CATEGORY AND BOARD ....................................................... 5
DISCHARGES OF THOSE MONITORED .................................................................................. 6
UNSATISFACTORY DISCHARGE DETAIL ............................................................................. 6
DISCHARGES BY REFERRAL SOURCE ................................................................................... 6
ACTIVE CASES .................................................................................................................... 7
UPDATES ............................................................................................................................... 8
STRATEGIC PLANNING .......................................................................................................... 8
BUDGET .................................................................................................................................. 9
COMMITTEE MEMBERS AND STAFF .................................................................................. 10
INTRODUCTION
The Health Professionals Services Program (HPSP) is pleased to provide our mid-year report to the Health Licensing Boards, the HPSP Program Committee and Advisory Committees, legislators and the citizens of Minnesota. The document provides readers with information about program participation and activities that took place in the first half of fiscal year 2018 (July 1, 2017 to December 31, 2017).

MISSION AND GOALS

MISSION
Minnesota's Health Professionals Services Program protects the public by providing monitoring services to regulated health care professionals whose illnesses may impact their ability to practice safely.

GOALS
The goals of HPSP are to promote early intervention, diagnosis, and treatment for health professionals with illnesses, and to provide monitoring services as an alternative to board discipline or when pursuant to board discipline. Early intervention enhances the likelihood of successful treatment, before clinical skills or public safety are compromised.

PROGRAM PARTICIPATION

DEFINITIONS OF REFERRAL SOURCES
HPSP's intake process is consistent, regardless of how practitioners are referred for monitoring. The program is responsible for evaluating the practitioner's eligibility for services and whether an illness is present that warrants monitoring. If it is determined that a practitioner has an illness that warrants monitoring, a Participation Agreement is developed and monitoring is initiated. Practitioners can be referred to HPSP in the following ways:

- **Self-Referrals:** Practitioners contact the program directly.
- **Third-Party Referrals:** The most common referrals from third parties are from employers and treatment providers. The identity of all third party reporters is confidential.
- **Board Referrals:** Participating boards have three options for referring practitioners to HPSP:
  - **Determine Eligibility** (Board Voluntary): The boards refer because there appears to be an illness to be monitored, but a diagnosis is not known.
  - **Follow-up to Diagnosis and Treatment** (Board Voluntary): The board has determined that the practitioner has an illness and refers the licensee to HPSP to determine whether the illness needs to be monitored.
  - **Action** (Board Discipline): The board has determined that there is an illness to monitor and refers the practitioner to HPSP as part of a disciplinary action (i.e.: Stipulation and Order). The Board Action may also dictate specific monitoring requirements.
REFERRALS BY FIRST REFERRAL SOURCE AND BOARD

The table below compares the number of practitioners referred to HPSP in the first halves of fiscal years 2017 and 2018:

<table>
<thead>
<tr>
<th>Referral Source</th>
<th>Nursing Admin.</th>
<th>Behavioral Health &amp; Therapy</th>
<th>Chiropractic Examiners</th>
<th>Dentistry</th>
<th>Department of Health</th>
<th>Dietetics &amp; Nutrition</th>
<th>Emergency Services</th>
<th>Marriage &amp; Family Therapy</th>
<th>Medical Practice</th>
</tr>
</thead>
<tbody>
<tr>
<td>Fiscal Year</td>
<td>17 18 17 18 17 18 17 18 17 18 17 18 17 18 17 18</td>
<td></td>
<td></td>
<td></td>
<td></td>
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<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Board Voluntary</td>
<td>0 1 6 5 9 5 15 11 0 0 3 9 0 0 8 4</td>
<td></td>
<td></td>
<td></td>
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<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Board Discipline</td>
<td>0 0 0 0 0 1 2 4 1 0 0 0 0 1 0 1 1</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Self</td>
<td>0 0 3 3 1 0 2 3 1 2 0 0 6 2 3 1 7 18</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
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</tr>
<tr>
<td>Third Party</td>
<td>0 0 1 6 0 0 0 1 0 0 0 0 0 1 1 1 3 4</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
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<tr>
<td>Sum</td>
<td>0 1 10 14 10 5 19 19 2 2 0 0 9 12 5 2 19 27</td>
<td></td>
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<td></td>
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</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Referral Source</th>
<th>Nursing</th>
<th>Optometry</th>
<th>Pharmacy</th>
<th>Physical Therapy</th>
<th>Podiatric Medicine</th>
<th>Psychology</th>
<th>Social Work</th>
<th>Veterinary Medicine</th>
<th>Sum</th>
</tr>
</thead>
<tbody>
<tr>
<td>Fiscal Year</td>
<td>17 18 17 18 17 18 17 18 17 18 17 18 17 18</td>
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<td></td>
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<td></td>
</tr>
<tr>
<td>Board Voluntary</td>
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<td></td>
<td></td>
<td></td>
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<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Board Discipline</td>
<td>21 15 0 0 1 1 0 0 0 0 0 0 0 2 0 0</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Self</td>
<td>52 35 0 0 1 3 2 0 1 0 1 1 4 3 0 0</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Third Party</td>
<td>25 20 0 0 0 1 0 0 0 0 0 2 2 4 0 0</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Sum</td>
<td>127 86 0 0 2 9 8 2 1 2 2 4 9 9 0 2</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
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</tr>
</tbody>
</table>

REFERRALS BY FIRST REFERRAL SOURCE

HPSP received a total of 197 referrals in the first half of fiscal year 2018. These referrals represent the number of cases opened during the first half of the fiscal year. The referrals represent practitioners new to HPSP or who returned to HPSP. The chart on the right shows the percent of referrals by First Referral Source, as explained under “Referrals by Second Referral Source” on page on page 3.
REFERRALS BY SECOND REFERRAL SOURCE

It is not uncommon for health professionals to be referred to HPSP by more than one source. The first referral source refers to how HPSP initially learned about the practitioner during enrollment. This should not be confused with practitioners who were referred and discharged and later referred again (these are two separate cases for the same practitioner). For example, we often see self-referrals followed almost immediately by third party referrals or vice versa. Whichever referral came first is considered the first referral source.

Of the 198 referrals in the first half of fiscal year 2018:
- 1 person who was initially board referred without discipline, was later referred pursuant to discipline;
- 4 persons who initially self-referred, were later board referred without discipline;
- 7 persons who initially self-referred, were later referred by a third party; and
- 1 person who was referred by a third party was later board referred pursuant to discipline.

RE-REFERRALS TO HPSP

July 1, 2017 to December 31, 2017
In the first half of fiscal year 2018, 76 of the 197 (39%) persons referred to HPSP had previously been referred and discharged. The following provides more detailed information:

- 29 of 61 (48%) persons board referred without discipline had previously been referred to HPSP
- 17 of 24 (71%) persons board referred with discipline had previously been referred to HPSP
- 21 of 71 (30%) persons who self-referred had previously been referred to HPSP
- 9 of 40 (23%) persons who were referred by a third party had previously been referred

Of the 21 persons who self-referred to HPSP in the first half of fiscal year 2018 and had previously been referred, 19 had successfully completed monitoring. Of these, the shortest timeframe from completion to re-referral was two months and the longest was 203 months (>16 years), with an average of 81 months (>6 years).

August 1, 1994 through December 31, 2017,
HPSP has received 8,750 referrals representing 6,495 health care practitioners; 26% had more than one referral episode. Of these, the shortest timeframe from discharge to re-referral was zero days, the longest was more than 22 years (268 months) and the average was just shy of four years (47 months).

The following shows the number of times persons have been referred to HPSP:
- 4,821 (74%) were referred once
- 1,211 (19%) were referred twice
- 317 (5%) were referred three times
- 99 (1%) were referred four times
- 22 (<1%) were referred five times
- 6 (<1%) were referred six times
- 2 (<1%) were referred seven times
DEFINITIONS OF DISCHARGE CATEGORIES

- **Completion**
  Program completion occurs when the practitioner satisfactorily completes the terms of the Participation Agreement.

- **Non-Compliance**
  - Participant violates the conditions of his or her Participation Agreement; case manager closes case and files a report with practitioner's board. Sub-categories of this include:
    - Non-Compliance - Diversion
    - Non-Compliance - Monitoring
    - Non-Compliance - Positive Screen
    - Non-Compliance - Problem Screens
    - Non-Compliance - Treatment

- **Voluntary Withdrawal**
  Participant chooses to withdraw from monitoring prior to completion of the Participation Agreement; case manager closes case and files a report with the practitioner's board.

- **Ineligible Monitored**
  - During the course of monitoring, it is determined that practitioner is not eligible for program services as listed in statute; case manager files report with practitioner's board. Sub-categories of this include:
    - Ineligible Monitored - Illness too severe
    - Ineligible Monitored - License suspended/revoked
    - Ineligible Monitored - License inactive
    - Ineligible Monitored - License surrendered
    - Ineligible Monitored - Violation of practice act

- **Ineligible Not Monitored**
  - At time of intake, it is determined that practitioner is not eligible for program services as listed in statute; case manager files report with practitioner's board. Subcategories of this include:
    - Ineligible Not Monitored - Illness too severe
    - Ineligible Not Monitored - License suspended/revoked
    - Ineligible Not Monitored - License inactive
    - Ineligible Not Monitored - No active Minnesota license
    - Ineligible Not Monitored - Violation of practice act
    - Ineligible Not Monitored - Previously discharged to the board

- **No Contact**
  Initial report received by third party or board; practitioner fails to contact HPSP; case manager closes case and files a report with practitioner's board.

- **Non-Cooperation**
  Practitioner cooperates initially, may sign Enrollment Form and/or releases, but then ceases to cooperate before the Participation Agreement is signed; case manager closes case and files a report with practitioner's board.

- **Non-Jurisdictional**
  No diagnostic eligibility established; the case is closed.

*Represents discharges that result in a report to the licensing board.*
DISCHARGES BY DISCHARGE CATEGORY AND BOARD

The following table compares the number of practitioners discharged from HPSP in the first half of fiscal years 2017 and 2018 by Board.

<table>
<thead>
<tr>
<th>Discharge Category</th>
<th>Nursing</th>
<th>Optometry</th>
<th>Pharmacy</th>
<th>Physical Therapy</th>
<th>Podiatric Medicine</th>
<th>Psychology</th>
<th>Social Work</th>
<th>Veterinary Medicine</th>
<th>Sum</th>
</tr>
</thead>
<tbody>
<tr>
<td>Fiscal Year</td>
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<td>18</td>
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<td>18</td>
<td>17</td>
<td>18</td>
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<tr>
<td>Completion</td>
<td>1</td>
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<td>2</td>
<td>0</td>
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<tr>
<td>Withdraw*</td>
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<td>9</td>
<td>4</td>
<td>17</td>
<td>21</td>
<td>2</td>
</tr>
</tbody>
</table>

*Represents discharges that result in a report to the licensing Board.
DISCHARGES OF THOSE MONITORED

The chart on the right represents the percent of practitioners who engaged in monitoring and were discharged in the first half of fiscal year 2018 by discharge category.

UNSATISFACTORY DISCHARGE DETAIL

The table below shows detailed information about practitioners who, in the first half of fiscal year 2018, engaged in monitoring and were discharged due to either non-compliance, choosing to voluntarily withdraw from monitoring, or a determination of being ineligible for continued participation:

<table>
<thead>
<tr>
<th>Discharge Category</th>
<th>Number</th>
</tr>
</thead>
<tbody>
<tr>
<td>Non-Compliance - Problem Screens</td>
<td>19</td>
</tr>
<tr>
<td>Non-Compliance with Participation Agreement*</td>
<td>6</td>
</tr>
<tr>
<td>Non-Compliance - Diversion</td>
<td>3</td>
</tr>
<tr>
<td>Non-Compliance - Positive Screen</td>
<td>3</td>
</tr>
<tr>
<td>Non-Compliance - Treatment</td>
<td>3</td>
</tr>
<tr>
<td>Ineligible Monitored - License Suspended/Revoked/Inactive</td>
<td>18</td>
</tr>
<tr>
<td>Ineligible Monitored - Illness Too Severe</td>
<td>3</td>
</tr>
<tr>
<td>Voluntarily Withdrew from Monitoring</td>
<td>14</td>
</tr>
<tr>
<td>Total Number Monitored &amp; Discharged Unsatisfactorily</td>
<td>69</td>
</tr>
</tbody>
</table>

*The discharge category of Non-compliance with Participation Agreement includes persons who refuse to sign authorizations, worked without informing HPSP, used alcohol or other controlled substances, or other forms of non-compliance with the terms of their Participation Agreement.

DISCHARGES BY REFERRAL SOURCE

The following table shows the number of practitioners discharged from HPSP in the first half of fiscal year 2018 by first referral source and discharge category:

<table>
<thead>
<tr>
<th>Discharge Category</th>
<th>Referral Source</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Board Voluntary</td>
</tr>
<tr>
<td>Completion</td>
<td>15 (45%)</td>
</tr>
<tr>
<td>Voluntary Withdrew</td>
<td>2</td>
</tr>
<tr>
<td>Non-Compliance</td>
<td>14</td>
</tr>
<tr>
<td>Deceased</td>
<td>0</td>
</tr>
<tr>
<td>Ineligible-Monitored</td>
<td>2</td>
</tr>
<tr>
<td>Ineligible-Not Monitored</td>
<td>0</td>
</tr>
<tr>
<td>No Contact</td>
<td>6</td>
</tr>
<tr>
<td>Non-Cooperation</td>
<td>9</td>
</tr>
<tr>
<td>Non-Jurisdictional</td>
<td>24</td>
</tr>
<tr>
<td>Sum</td>
<td>72</td>
</tr>
</tbody>
</table>

Of the 230 discharges in the first half of fiscal year 2018, 147 (64%) represent persons who signed Participation Agreements and engaged in monitoring. The percentage listed after the “Completion” number represent the percent of persons who completed monitoring based on referral source. *Represents the total number of persons who were referred by specified referral source.
REFERRAL AND DISCHARGE TRENDS

The chart below shows the number of referrals and discharges in the first half of each fiscal year since 2009. The number of referrals was lower than in the past nine fiscal years whereas the number of discharges has remained fairly consistent.

![Chart showing referrals and discharges]

ACTIVE CASES

A total of 533 health professionals were active with HPSP on January 2, 2018. The term active refers to persons in the intake process as well as those being monitored. The table below provides the number and percent of active cases by Board on January 2, 2018.

<table>
<thead>
<tr>
<th>Board</th>
<th>Number</th>
<th>Percent</th>
</tr>
</thead>
<tbody>
<tr>
<td>Behavioral Health and Therapy</td>
<td>21</td>
<td>3.93%</td>
</tr>
<tr>
<td>Nursing Home Administrators</td>
<td>1</td>
<td>0.18%</td>
</tr>
<tr>
<td>Chiropractic Examiners</td>
<td>7</td>
<td>1.31%</td>
</tr>
<tr>
<td>Dentistry</td>
<td>22</td>
<td>4.12%</td>
</tr>
<tr>
<td>Department of Health</td>
<td>6</td>
<td>1.12%</td>
</tr>
<tr>
<td>Dietetics and Nutrition</td>
<td>2</td>
<td>0.37%</td>
</tr>
<tr>
<td>EMS</td>
<td>17</td>
<td>3.18%</td>
</tr>
<tr>
<td>Marriage and Family Therapy</td>
<td>3</td>
<td>0.56%</td>
</tr>
<tr>
<td>Medical Practice</td>
<td>91</td>
<td>17.07%</td>
</tr>
<tr>
<td>Nursing</td>
<td>302</td>
<td>56.66%</td>
</tr>
<tr>
<td>Pharmacy</td>
<td>16</td>
<td>3.00%</td>
</tr>
<tr>
<td>Physical Therapy</td>
<td>9</td>
<td>1.68%</td>
</tr>
<tr>
<td>Podiatric Medicine</td>
<td>2</td>
<td>0.37%</td>
</tr>
<tr>
<td>Psychology</td>
<td>5</td>
<td>0.93%</td>
</tr>
<tr>
<td>Social Work</td>
<td>23</td>
<td>4.31%</td>
</tr>
<tr>
<td>Veterinary Medicine</td>
<td>3</td>
<td>0.56%</td>
</tr>
<tr>
<td><strong>Sum</strong></td>
<td><strong>530</strong></td>
<td></td>
</tr>
</tbody>
</table>
UPDATES

STRATEGIC PLANNING

Background
In 2014, HPSP staff identified the need for comprehensive strategic planning for the program. HPSP contracted with Management, Analysis and Development (MAD), which is part of the Department of Management and Budget, to facilitate the initial phases of the process. MAD conducted situational analyses of the Program Committee, Advisory Committee, Executive Directors, HPSP staff, and the HPSP Program Manager. A Strategic Planning team was established consisting of four health licensing board executive directors and HPSP staff. A three to five year vision was created for the program along with one to two year strategies. HPSP staff was then assigned to lead seven strategic goals.

Summary
The following is a summary of each strategic goal:

1. **Measure program effectiveness**
   Surveys evaluating program effectiveness were implemented and provided valuable data about improving communication regarding toxicology screening. HPSP subsequently created an online video regarding the toxicology screening process for participants to review.

2. **Best practices drive the program**
   HPSP reviewed its processes in relation to those of the Federation of State Medical Boards and the National Council of State Boards of Nursing. HPSP's terms of monitoring meet those of both groups. HPSP will continue to review new science and national norms to ensure the program is operating consistent with best practices.

3. **Develop governance that supports the program**
   HPSP's governance structure was reviewed and it was determined that it is effective.

4. **Strengthen Board and HPSP staff relationship and understanding of roles**
   HPSP staff implemented strategies to improve relationships with board staff. Greater emphasis is being placed on quality of quarterly meetings with board staff. Additionally, both HPSP and staff from specific boards have met to address questions and provide clarity regarding processes.

5. **Develop, strengthen and maintain efficient processes**
   Since the strategic planning process began, nearly every template letter HPSP uses has been updated. Participation Agreements were improved and authorizations and participant forms were revised to include plain language. HPSP continues to explore methods to improve program processes and make the program more user-friendly.

6. **Promote staff well-being and professional growth**
   HPSP staff completed a survey about employee engagement and decided to read "Commitment to Co-Workers" before every team meeting. This has been an effective method of setting the tone for team meetings.

7. **Enhance program outreach**
   HPSP staff expanded outreach to more professional associations. Despite this, the program is seeing fewer referrals. Staff are committed to doing additional outreach to connect with professions showing the lowest program utilization rate.

The strategic planning undertaken in 2014 has been implemented and/or completed, with the exception of ongoing assessments of program effectiveness, efficiency, and outreach. HPSP is invested in continuing to review these areas and implement improvements as the program continues to mature.
BUDGET

HPSP's base budget for fiscal years 2018 and 2019 is $924,000 ($1,848,000 for the biennium). HPSP's appropriation for fiscal year 2018 is $955,000 and $964,000 in fiscal year 2019. The additional appropriations were specifically granted to make technological improvements.

HPSP experienced some salary savings in the first half of this fiscal year. Aside from salaries, rent is the next greatest cost to the program. Eleven percent of the budget is directed to all other program operations, including but not limited to phone, email, computing services, copy machine rental, printing, attorney general fees, medical consultation costs, supplies and equipment.

In December 2017, the Department of Administration extended HPSP's lease agreement. The new rates are listed in the chart below:

<table>
<thead>
<tr>
<th>Timeframe</th>
<th>Cost</th>
</tr>
</thead>
<tbody>
<tr>
<td>FY 2018 (2/1/18 to 6/30/18)</td>
<td>$16,265.00</td>
</tr>
<tr>
<td>FY 2019 (7/1/18 to 6/30/19)</td>
<td>$39,961.20</td>
</tr>
<tr>
<td>FY 2020 (7/19 to 6/30/20)</td>
<td>$40,043.78</td>
</tr>
<tr>
<td>FY 2021 (7/1/20 to 6/30/21)</td>
<td>$40,779.38</td>
</tr>
<tr>
<td>FY 2022 (7/1/20 to 6/30/22)</td>
<td>$41,524.33</td>
</tr>
<tr>
<td>FY 2023 (7/1/22 to 1/31/23)</td>
<td>$24,480.33</td>
</tr>
</tbody>
</table>

The HPSP Program Manager, Monica Fieder and the Executive Director of HPSP's Administering Board, Ruth Martinez, meet on a regular basis with the health licensing boards' chief financial officer to review HPSP's spending and budgetary needs. Additionally, the Administrative Services Unit (ASU) sends monthly reports to HPSP for reconciliation of bills paid and the current encumbrances. ASU audits accounts payable, accounts receivable, payroll and timesheets.
COMMITTEE MEMBERS AND STAFF

PROGRAM COMMITTEE MEMBERS

The Program Committee consists of one member from each participating board. By law, the Program Committee provides HPSP with guidance to ensure that the direction of HPSP is in accordance with its statutory authority. In 1997 the Program Committee established the following five goals to meet this responsibility:

1. The public is protected;
2. Individual clients are treated with respect;
3. The program is well-managed;
4. The program is financially secure; and
5. The program is operating consistently within its statutory authority.

<table>
<thead>
<tr>
<th>Board</th>
<th>Member Name</th>
<th>Term</th>
</tr>
</thead>
<tbody>
<tr>
<td>Behavioral Health and Therapy</td>
<td>Yvonne Hundshamer</td>
<td>1/1/18 to 12/31/18</td>
</tr>
<tr>
<td>Chiropractic Examiners</td>
<td>Nestor Riano</td>
<td>1/1/18 to 12/31/18</td>
</tr>
<tr>
<td>Dentistry</td>
<td>Ruth Dahl</td>
<td>1/1/18 to 12/31/18</td>
</tr>
<tr>
<td>Department of Health</td>
<td>Barbara Damchik-Dykes</td>
<td>1/1/18 to 12/31/18</td>
</tr>
<tr>
<td>Dietetics and Nutritionists</td>
<td>Margaret Schreiner</td>
<td>1/1/18 to 12/31/18</td>
</tr>
<tr>
<td>Emergency Medical Services</td>
<td>Matthew Simpson</td>
<td>1/1/18 to 12/31/18</td>
</tr>
<tr>
<td>Marriage and Family Therapy</td>
<td>Jennifer Mohlenhoff</td>
<td>1/1/18 to 12/31/18</td>
</tr>
<tr>
<td>Medical Practice</td>
<td>Allen Rasmussen, Chair</td>
<td>1/1/18 to 12/31/18</td>
</tr>
<tr>
<td>Nursing</td>
<td>Christine Norton (Alt: Steven Strand)</td>
<td>1/1/18 to 12/31/18</td>
</tr>
<tr>
<td>Nursing Home Administrators</td>
<td>Randy Snyder</td>
<td>1/1/18 to 12/31/18</td>
</tr>
<tr>
<td>Optometry</td>
<td>Randy Snyder</td>
<td>1/1/18 to 12/31/18</td>
</tr>
<tr>
<td>Pharmacy</td>
<td>James Bialke</td>
<td>1/1/18 to 12/31/18</td>
</tr>
<tr>
<td>Physical Therapy</td>
<td>Kathy Polhamus, Vice Chair</td>
<td>1/1/18 to 12/31/18</td>
</tr>
<tr>
<td>Podiatric Medicine</td>
<td>Margaret Schreiner</td>
<td>1/1/18 to 12/31/18</td>
</tr>
<tr>
<td>Psychology</td>
<td>Samuel Sands</td>
<td>1/1/18 to 12/31/18</td>
</tr>
<tr>
<td>Social Work</td>
<td>Laura McGrath</td>
<td>1/1/18 to 12/31/18</td>
</tr>
<tr>
<td>Veterinary Medicine</td>
<td>Jody Grote</td>
<td>1/1/18 to 12/31/18</td>
</tr>
</tbody>
</table>

ADMINISTERING BOARD

The Board of Medical Practice, under the leadership of Ruth Martinez, Executive Director, serves as the HPSP Administering Board.
ADVISORY COMMITTEE MEMBERS

The Advisory Committee consists of one person appointed by various health-related professional associations and two public members appointed by the Governor. The Advisory Committee established the following goals:

1. Promote early intervention, diagnosis, treatment and monitoring for potentially impaired health professionals;
2. Provide expertise to HPSP staff and Program Committee; and
3. Act as a liaison with membership.

<table>
<thead>
<tr>
<th>Association</th>
<th>Member Name</th>
<th>Term</th>
</tr>
</thead>
<tbody>
<tr>
<td>MN Academy of Nutrition and Dietetics</td>
<td>Andrew Pfath</td>
<td>1/15/18 to 1/14/20</td>
</tr>
<tr>
<td>MN Academy of Physician Assist.</td>
<td>Tracy Keizer</td>
<td>1/15/18 to 1/14/20</td>
</tr>
<tr>
<td>MN Ambulance Assoc.</td>
<td>Megan Hartigan (Alt: Debbie Gillquist)</td>
<td>1/15/18 to 1/14/20</td>
</tr>
<tr>
<td>MN Assoc. of Marriage &amp; Family Therapy</td>
<td>Eric Hansen</td>
<td>1/15/18 to 1/14/20</td>
</tr>
<tr>
<td>MN Assoc. of Social Workers</td>
<td>Lois Bosch</td>
<td>1/15/18 to 1/14/20</td>
</tr>
<tr>
<td>MN Chiropractic Assoc.</td>
<td>Vacant</td>
<td>1/15/18 to 1/14/20</td>
</tr>
<tr>
<td>MN Dental Assoc.</td>
<td>Stephen Gulbrandsen (Vice Chair)</td>
<td>1/15/18 to 1/14/20</td>
</tr>
<tr>
<td>MN Health Systems Pharmacists</td>
<td>S. Bruce Benson</td>
<td>1/15/18 to 1/14/20</td>
</tr>
<tr>
<td>MN LPNA/AFSCME</td>
<td>Lisa Weed</td>
<td>1/15/18 to 1/14/20</td>
</tr>
<tr>
<td>MN Medical Assoc.</td>
<td>Becca Branum</td>
<td>1/15/18 to 1/14/20</td>
</tr>
<tr>
<td>MN Nurse Peer Support Network</td>
<td>Linda Hakon</td>
<td>1/15/18 to 1/14/20</td>
</tr>
<tr>
<td>MN Nurses Assoc.</td>
<td>Jody Haggy</td>
<td>1/15/18 to 1/14/20</td>
</tr>
<tr>
<td>MN Occupational Therapy Assoc.</td>
<td>Karen Sames (Chair)</td>
<td>1/15/18 to 1/14/20</td>
</tr>
<tr>
<td>MN Organization of Registered Nurses</td>
<td>Joseph Twitchell (Alt: Tonjia Reed)</td>
<td>1/15/18 to 1/14/20</td>
</tr>
<tr>
<td>MN Pharmacists Assoc.</td>
<td>Jim Alexander</td>
<td>1/15/18 to 1/14/20</td>
</tr>
<tr>
<td>MN Psychological Assoc.</td>
<td>Lois Cochrane-Schlueter</td>
<td>1/15/18 to 1/14/20</td>
</tr>
<tr>
<td>MN Veterinary Assoc.</td>
<td>Marcia Brower</td>
<td>1/15/18 to 1/14/20</td>
</tr>
<tr>
<td>Physicians Serving Physicians</td>
<td>Jeff Morgan</td>
<td>1/15/18 to 1/14/20</td>
</tr>
<tr>
<td>Ad Hoc Member</td>
<td>Rose Nelson</td>
<td>1/15/18 to 1/14/20</td>
</tr>
<tr>
<td>Public Member</td>
<td>Vacant</td>
<td></td>
</tr>
</tbody>
</table>

HPSP STAFF

- Monica Feider: Program Manager
- Tracy Erfourth: Case Manager
- Marilyn Miller: Case Manager
- Bettina Oppenheimer: Case Manager
- Kurt Roberts: Case Manager
- Kimberly Zillmer: Case Manager
- Char Duke: Case Management Assistant
- Alicia Gonzales: Student Worker

Questions about the content of this report should be directed to Monica Feider at 612-317-3060 or monica.felder@state.mn.us. HPSP staff, Ruth Martinez and Elizabeth Huntley from the Board of Medical Practice and Mark Chu from MN.IT were instrumental in the development of this report. Thank you.
DATE: March 10, 2018
SUBJECT: Report of New Credentials

SUBMITTED BY: Licensure Staff

REQUEST FOR BOARD ACTION
MINNESOTA BOARD OF MEDICAL PRACTICE

REQUESTED ACTION:

- For informational purposes only.

MOTION BY: SECOND:
( ) PASSED ( ) PASSED AMENDED ( ) LAYED OVER ( ) DEFEATED

BACKGROUND:

For information only, attached are listings of new credentials issued from January 1, 2018 to February 28, 2018.
**Minnesota Board of Medical Practice**  
**New Credential Summary in January and February 2018**

<table>
<thead>
<tr>
<th>Name</th>
<th>License #</th>
<th>Application Date</th>
<th>Grant Date</th>
<th>Expire Date</th>
<th>SPL</th>
</tr>
</thead>
<tbody>
<tr>
<td>Temple, Brian A W M.D.</td>
<td>63220</td>
<td>1/2/2018</td>
<td>1/3/2018</td>
<td>10/31/2018</td>
<td>WI</td>
</tr>
<tr>
<td>Jain, Vikas M.D.</td>
<td>63219</td>
<td>1/2/2018</td>
<td>1/3/2018</td>
<td>8/31/2018</td>
<td>IL</td>
</tr>
<tr>
<td>LaFollette, Martin Jones D.O.</td>
<td>63228</td>
<td>1/9/2018</td>
<td>1/10/2018</td>
<td>2/28/2019</td>
<td>AZ</td>
</tr>
<tr>
<td>Colber, Melissa Marie M.D.</td>
<td>63229</td>
<td>12/21/2017</td>
<td>1/10/2018</td>
<td>1/31/2019</td>
<td>KS</td>
</tr>
<tr>
<td>Byerly, Robert Roland M.D.</td>
<td>63241</td>
<td>1/10/2018</td>
<td>1/11/2018</td>
<td>9/30/2018</td>
<td>AZ</td>
</tr>
<tr>
<td>Fields, Jonathon Michael M.D.</td>
<td>63255</td>
<td>1/19/2018</td>
<td>1/19/2018</td>
<td>10/31/2018</td>
<td>IA</td>
</tr>
<tr>
<td>Lwin, Kiki Yu Hu M.B., B.S.</td>
<td>63256</td>
<td>1/17/2018</td>
<td>1/19/2018</td>
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<td>AZ</td>
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<tr>
<td>Serra, Alexander Duane M.D.</td>
<td>45118</td>
<td>12/28/2017</td>
<td>1/22/2018</td>
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<td>NE</td>
</tr>
<tr>
<td>Gonzalez, Keith Orlando M.D.</td>
<td>63273</td>
<td>1/26/2018</td>
<td>1/26/2018</td>
<td>10/31/2018</td>
<td>AZ</td>
</tr>
<tr>
<td>Reddy, Deepak Kolagatla D.O.</td>
<td>63274</td>
<td>1/26/2018</td>
<td>1/31/2018</td>
<td>10/31/2018</td>
<td>AL</td>
</tr>
<tr>
<td>Kumar, Madhuresh M.D.</td>
<td>63310</td>
<td>2/8/2018</td>
<td>2/8/2018</td>
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<td>NE</td>
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<tr>
<td>Mehr, Samuel Harry</td>
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<td>2/14/2018</td>
<td>11/30/2018</td>
<td>NE</td>
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<tr>
<td>Schuchman, Mark Charles M.D.</td>
<td>63342</td>
<td>2/15/2018</td>
<td>2/21/2018</td>
<td>10/31/2018</td>
<td>KS</td>
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<tr>
<td>Schumacher, Abram James M.D.</td>
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<td>Name</td>
<td>License #</td>
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<td>-------</td>
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<tr>
<td>Anderson, Andrew Jon D.O.</td>
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<td>Bennett, Cole Austin M.D.</td>
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<td>02/28/2019</td>
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<td>Goswami, Aarti M.B., B.S.</td>
<td>63223</td>
<td>09/30/2018</td>
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<td>Haas, Thomas Stewart D.O.</td>
<td>33363</td>
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<td>Papapetrou, Peter M.D.</td>
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<td>Perez-Lauterbach, David Robert M.D.</td>
<td>63225</td>
<td>11/30/2018</td>
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<tr>
<td>Sand, Jordan Paul M.D.</td>
<td>63226</td>
<td>11/30/2018</td>
<td>7</td>
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<tr>
<td>Ward, Christina Marie M.D.</td>
<td>63227</td>
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<td></td>
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<tr>
<td>Name</td>
<td>License #</td>
<td>Expire Date</td>
<td>Seq #</td>
<td></td>
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<td>-----------------------</td>
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</tr>
<tr>
<td>Rasmussen, Julie Kay</td>
<td>9690</td>
<td>06/30/2018</td>
<td>9</td>
<td></td>
<td></td>
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Minnesota Board of Medical Practice  
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# Minnesota Board of Medical Practice

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## Minnesota Board of Medical Practice
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Minnesota Board of Medical Practice  
New Credential Summary for 02/22/2018

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## New Credential Summary for 02/22/2018

### License Type: Athletic Trainer

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REQUEST FOR BOARD ACTION
MINNESOTA BOARD OF MEDICAL PRACTICE

REQUESTED ACTION:

Approve the actions of the Licensure Committee.

MOTION BY: ____________________  SECOND: ________________________
(  ) PASSED     (  ) PASSED AMENDED     (  ) LAYED OVER     (  ) DEFEATED

BACKGROUND:

See attached February 8, 2018, Licensure Committee Meeting Minutes.
Licensure Committee Minutes
February 8, 2018

A ballot vote was acted on by the Licensure Committee (“Committee”) relating to one new business matter required for the February 8, 2018 scheduled Committee meeting. There being no other business, the in-person meeting was cancelled.

Committee Members Providing a Quorum for Ballot Vote: Christopher Burkle, M.D., J.D., FCLM; Kathryn Lombardo, M.D.; and Allen Rasmussen, M.A.

Additional Meeting Dates for 2018, Scheduled at 1:00 p.m., are:
- April 12
- June 14
- August 9
- October 11
- *December 6

*December 6, 2018 LC alt. due to CRC and HOL

Advisory Council Appointments:

Advisory Council Appointments: The Committee agreed to recommend the following applications to the Board in March, 2018:
- Michael Green, M.D.
- Debra Renee Weiss, L.Ac., RN, Dipl.Ac., M. OM
REQUEST FOR BOARD ACTION
MINNESOTA BOARD OF MEDICAL PRACTICE

REQUESTED ACTION:

Appoint each of the following persons to a three-year term on the Acupuncture Advisory Council with term ending January, 2021:

Physician Member
- Michael Green, M.D.

Acupuncture Practitioner
- Debra Weiss, L.Ac.

MOTION BY: SECOND:
( ) PASSED ( ) PASSED AMENDED ( ) LAYED OVER ( ) DEFEATED

BACKGROUND:

Acupuncture Advisory Council members are appointed to three year-terms (Minn. Stat. §147B.05). The Board shall appoint a replacement to fill the vacancy created when the Council member’s terms expire. The following Council member’s terms expired in January, 2018:

<table>
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<th>Council Member</th>
<th>Position</th>
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<tr>
<td>Dr. Michael Green</td>
<td>Physician Member</td>
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<tr>
<td>Debra Weiss</td>
<td>Acupuncture Practitioner</td>
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One application has been received for the acupuncture practitioner member and four for the acupuncture practitioner member positions. Applications have been received from the following:

- Mary Elizabeth Kraker Denison, L.Ac.
- Justin Michael Heesakker, L.Ac.
- *Michael Green, M.D.
- Korina Kay St. John, L.Ac.
- *Debra Renee Weiss, L.Ac.
The Licensure Committee is recommending Dr. Michael Green and Debra Weiss for reappointment, and Kathy Allen for appointment to the Council.

See attached applications.

*Current Council Member
Application for the position Acupuncture Practitioner

Part I: Position Sought

Agency Name: Acupuncture Advisory Council
Position: Acupuncture Practitioner

Part II: Applicant Information

Name: Ms Mary EK Denison
Phone:
Mailing Address:
Email:
County: Hennepin
Felony Conviction: No
Mn House District: 63B
US House District: 5
Recommended by the Appointing Authority: False

Part III: Appending Documentation

Cover Letter and Resume

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Part IV: Optional Statistical Information

Gender: Female
Disability: No
Age: 
Political Affiliation: No Answer
Ethnicity: White or Caucasian
Hispanic, Latino or Spanish origin: No

Part V: Signature

Signature: Mary EK Denison, L. Ac.
Date: 12/28/2017 11:56:52 AM
Application Details

Application for the position Acupuncture Practitioner

Part I: Position Sought

Agency Name: Acupuncture Advisory Council
Position: Acupuncture Practitioner

Part II: Applicant Information

Name: Justin Heesakker
Phone:
Mailing Address:
Email:
County: Ramsey
Felony Conviction: No
Mn House District: 64B
US House District: 4
Recommended by the Appointing Authority: False

Part III: Appending Documentation

Cover Letter and Resume
Type | File Type
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Resume | application/pdf

Additional Documents (.doc, .docx, .pdf, .txt)
Type | File Name
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Curriculum Vitae | OCT 2017 MN.pdf

Part IV: Optional Statistical Information

Gender: No Answer
Disability: No Answer
Age: 
Political Affiliation: No Answer
Ethnicity: No Answer
Hispanic, Latino or Spanish origin: No Answer

Part V: Signature

Signature: Justin Heesakker
Date: 11/3/2017 10:11:56 AM
Application for the position Physician Member

Part I: Position Sought

Agency Name: Acupuncture Advisory Council
Position: Physician Member

Part II: Applicant Information

Name: Michael Green
Phone: 
Mailing Address: 
Email: 
County: Hennepin
Felony Conviction: No
Mn House District: 62B
US House District: 5
Recommended by the Appointing Authority: False

Part III: Appending Documentation

Cover Letter and Resume
Type Resume
File Type application/pdf

Additional Documents (.doc, .docx, .pdf, .txt)
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Part IV: Optional Statistical Information

Gender: Male
Disability: No
Age: 
Political Affiliation: Other
Ethnicity: White or Caucasian
Hispanic, Latino or Spanish origin: No Answer

Part V: Signature

Signature: Michael Green
Date: 12/29/2017 4:31:42 PM
Application for the position Acupuncture Practitioner

Part I: Position Sought

Agency Name: Acupuncture Advisory Council
Position: Acupuncture Practitioner

Part II: Applicant Information

Name: Dr Korina St John Rongitsch
Phone:
Mailing Address:
Email:
County: Polk
Felony Conviction: No
Mn House District: 01B
US House District: 7
Recommended by the Appointing Authority: False

Part III: Appending Documentation

Cover Letter and Resume

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Age:
Political Affiliation: No Answer
Ethnicity: White or Caucasian
Hispanic, Latino or Spanish origin: No Answer

Part V: Signature

Signature: Korina St John
Date: 1/17/2018 11:49:30 AM
Application for the position Acupuncture Practitioner

Part I: Position Sought

Agency Name: Acupuncture Advisory Council
Position: Acupuncture Practitioner

Part II: Applicant Information

Name: Debra Weiss
Phone:
Mailing Address:
Email:
County: Washington
Felony Conviction: No
Mn House District: 43B
US House District: 4
Recommended by the Appointing Authority: True

Part III: Appending Documentation

Cover Letter and Resume

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Disability: No Answer
Age:
Political Affiliation: No Party Preference
Ethnicity: White or Caucasian
Hispanic, Latino or Spanish origin: No Answer

Part V: Signature

Signature: Debra Rene Weiss LAc.
Date: 1/10/2018 1:02:07 PM

AGENCY DETAILS

https://commissionsandappointments.sos.state.mn.us/ApplicationAdditionalDocument/ApplicationFinal/13407
REQUEST FOR BOARD ACTION
MINNESOTA BOARD OF MEDICAL PRACTICE

REQUESTED ACTION:

Approve the actions of the Policy & Planning Committee.

MOTION BY:_____________________SECOND:______________________________

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

BACKGROUND:

February 6, 2018, Policy & Planning Committee Report:
   a. Meeting Minutes
   b. Meeting Agenda
The Committee, chaired by Allen Rasmussen, M.A, and attended by Patrick Townley, M.D., J.D., met at 1:00 p.m. at the Board offices, 4th floor conference room A. Board President Patricia J. Lindholm, M.D., was also in attendance. The Committee was assisted by Board staff Ruth Martinez, Molly Schwanz and Kate Van Etta-Olson. Members of the public also attended. The Committee considered the following items:

1. In the matter of legislative updates: Board staff provided an update on meetings scheduled with legislators to discuss proposed legislation for the coming session.

   Executive Director Martinez and Policy and Planning Chair Allen Rasmussen met with Senator Ron Latz on February 5, 2018 to discuss the proposed revision to the temporary suspension of license language in Minn. Stat. § 214.077. Other meetings with legislators are scheduled.

   Board staff provided an update on proposed changes to chapter 214 of Minnesota statutes related to authority to conduct criminal background (CBC) checks and the Health-Licensing Boards Executive Directors approved the proposed changes at their meeting on February 6, 2018.

   Board staff provided an update that the Health-Licensing Boards are pursuing repealing Minn. Stat. §§ 214.17-214.25 and changing the monitoring requirements for licensees with HIV, HBV, and HCV. The change would likely involve monitoring of the health condition through the Health Professionals Services Program.

   No action was required.

2. In the matter of SF 1151-5A Clinical Lactation Care Services – Licensure under the authority of the Board of Medical Practice: Board staff informed the Committee of a new proposed bill related to licensure of clinical lactation consultants under the Board of Medical Practice. Board staff was made aware of the bill when the Board was required to submit a Fiscal Note related to the budget impact of licensure.

   The proposed bill has not been reviewed by the Council of Health Boards pursuant to Minn. Stat. § 214.002.

   The Committee discussed whether or not regulation to protect the public was needed in the field of lactation care services.

   No action was required.

3. In the matter of federal legislation update: Board staff provided an update on federal legislative initiatives.

   No action was required.

4. Other Business: The Legislature is seeking a source of dedicated funding for the Prescription Monitoring Program (PMP) going forward. The PMP is currently funded by the Boards that regulate prescribers.

   There being no other business, the meeting was adjourned.
Policy & Planning Committee
February 6, 2018
1:00 p.m.,
Conference Room A
Agenda

1. Legislative Updates

2. SF 1151 – 5A Clinical Lactation Care Services – Licensure under the authority of the Board of Medical Practice

3. Federal Legislation Updates

4. Other Business
Senator .................... moves to amend S.F. No. 1151 as follows:

Delete everything after the enacting clause and insert:

"Section 1. [147G.01] DEFINITIONS.

Subdivision 1. Application. For purposes of this chapter, the following terms have the meanings given.

Subd. 2. Board. "Board" means the Board of Medical Practice.

Subd. 3. Breastfeeding education, counseling, and support services. "Breastfeeding education, counseling, and support services" refers to services such as educating women, families, health professionals, and the community about the impact of breastfeeding and human lactation on health and what to expect in the normal course of breastfeeding; facilitating the development of policies that protect, promote, and support breastfeeding; acting as an advocate for breastfeeding as the child-feeding norm; providing holistic breastfeeding support, encouragement, and care from preconception to weaning in order to help women and their families meet their breastfeeding goals; using principles of adult education when teaching parents, health care providers, and others in the community; and identifying and referring high-risk mothers and babies and those requiring clinical treatment to licensed providers.

Subd. 4. Certified lactation counselor. "Certified lactation counselor" means an individual who provides lactation education, counseling, and support services and who possesses certification from the Academy of Lactation Policy and Practice of the Healthy Children Project, Inc., as accredited by the American National Standards Institute.

Subd. 5. Clinical lactation services. "Clinical lactation services" refers to the clinical application of evidence-based practices for evaluation, problem identification, treatment, education, and consultation in providing lactation care and services to childbearing families. Clinical lactation services involves one or more of the following activities: lactation assessment through the systematic collection of data; analysis of data; creation of lactation care plans; and the implementation of lactation care plans, including but not limited to providing demonstration and instruction to clients; communicating with a client's primary health care provider; evaluating outcomes; and recommending the use of assistive devices when appropriate.

Subd. 6. Credential. "Credential" means a license, permit, certification, registration, or other evidence of qualification or authorization to engage in the practice of clinical lactation care services issued by any authority.
Sec. 2. [147G.02] LICENSURE; PROTECTED TITLES AND RESTRICTIONS ON USE; EXEMPT PERSONS.

Subdivision 1. Unlicensed practice prohibited. (a) Effective July 1, 2019, no individual shall engage in the practice of clinical lactation services unless the individual is a licensed international board certified lactation consultant under this chapter.

(b) Nothing in this chapter shall prohibit any individual, including, but not limited to, a certified lactation counselor from providing breastfeeding education, counseling, and support services, or require an individual to be licensed under this chapter in order to provide breastfeeding education, counseling, and support services.

Subd. 2. Protected titles and restrictions on use. The terms or phrases "licensed international board certified lactation consultant" or "licensed lactation consultant" alone or in combination shall only be used by an individual who meets the requirements under this chapter and is a licensed international board certified lactation consultant.

Subd. 3. Exempt persons. (a) This section does not apply to:

(1) an individual employed as a lactation consultant by the government of the United States or any agency of it;

(2) a student participating in supervised fieldwork or supervised coursework that is necessary to meet the certification requirements under this chapter;

(3) an individual visiting and then leaving the state and performing clinical lactation services while in the state if the services are performed no more than 30 days in a calendar year as part of a professional activity that is limited in scope and duration and is in association with an international board certified lactation consultant licensed under this chapter, and the individual:

(i) is credentialed under the law of another state which has credentialing requirements at least as stringent as the requirements of this chapter; or

(ii) meets the requirements for certification as an international board certified lactation consultant established by the International Board of Lactation Consultant Examiners as accredited by the National Commission for Certifying Agencies:
(4) an individual licensed to practice as a dentist under chapter 150A, physician or osteopath under chapter 147, nurse under sections 148.171 to 148.285, physician assistant under chapter 147A, dietitian under sections 148.621 to 148.634, or midwife under chapter 147D, when providing clinical lactation services incidental to the practice of the individual's profession;

(5) an employee of a department, agency, or division of state, county, or local government, when providing clinical lactation services within the discharge of the employee's official duties including, but not limited to, peer counselors in the Special Supplemental Nutrition Program for Women, Infants, and Children; or

(6) a volunteer providing clinical lactation services, if the volunteer:

(i) does not use the protected titles under subdivision 2 or represents to the public that the volunteer is licensed or has the clinical skills and abilities associated with licensure;

(ii) is performing services for free, with no fee or payment charged to the individual or group served; and

(iii) receives no compensation, monetary or otherwise, from the individual or group being served except for administrative expenses including, but not limited to, mileage.

(b) No individual identified under paragraph (a) shall use one of the protected titles under subdivision 2 while providing clinical lactation services unless licensed under this chapter.

Subd. 4. Exemption. Nothing in this chapter shall prohibit the practice of any profession or occupation, licensed or registered by the state, by any individual duly licensed or registered to practice the profession or occupation or to perform any act that falls within the scope of practice of the licensed or registered profession or occupation.

Sec. 3. [147G.03] APPLICATION REQUIREMENTS; PROCEDURE.

Subdivision 1. Requirements for licensure. (a) An applicant for licensure as a licensed international board certified lactation consultant must:

(1) have a current certification from the International Board of Lactation Consultant Examiners as accredited by the National Commission for Certifying Agencies; and

(2) submit an application in accordance with subdivision 2.

(b) An applicant is responsible for providing verified documentation with the applicant's application submitted to the board that the applicant is currently credentialed as required under this subdivision. The applicant must also sign a waiver authorizing the board access.
4.1 to the applicant's records maintained by the International Board of Lactation Consultant Examiners.

Subd. 2. Application. An applicant for licensure must:

4.2 (1) submit a completed application on forms provided by the board and supply the information requested on the application, including:

4.3 (i) the applicant's name, business address, business telephone number, business setting, and daytime telephone number;

4.4 (ii) a description of the applicant's education and training, including a list of degrees received from educational institutions;

4.5 (iii) the applicant's work history for the six years preceding the application, including the number of hours worked;

4.6 (iv) a list of all lactation consulting credentials currently and previously held in Minnesota and other jurisdictions;

4.7 (v) a description of any jurisdiction's refusal to credential the applicant;

4.8 (vi) a description of all professional disciplinary actions initiated against the applicant in any jurisdiction;

4.9 (vii) information on any physical or mental condition or chemical dependency that impairs the applicant's ability to provide lactation education, counseling, and support services or clinical lactation services with reasonable judgment or safety;

4.10 (viii) a description of any misdemeanor, gross misdemeanor, or felony conviction that is reasonably related to providing lactation education, counseling, and support services or clinical lactation services; and

4.11 (ix) a description of any state or federal court order, including a conciliation court order or a disciplinary order, related to the individual providing lactation education, counseling, and support services or clinical lactation services;

4.12 (2) submit with the application all fees required by section 147G.07;

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

4.14 (4) sign a waiver authorizing the board access to the applicant's records in this or any other state in which the applicant holds or previously held a credential for the practice of lactation education, counseling, and support services or clinical lactation services.
an occupation, completed a clinical lactation services education program, or engaged in
lactation education, counseling, and support services or clinical lactation services; and

(5) within 30 days of a request, submit additional information as requested by the board
to clarify information in the application.

Subd. 3. Licensure by reciprocity. (a) An applicant who holds a current credential as
a lactation consultant, lactation care provider, or lactation counselor or substantially
equivalent title in the District of Columbia or a state or territory of the United States whose
standards for credentialing are determined by the board to be equivalent to or exceed the
requirements for licensure under this section, may be eligible for licensure by reciprocity
as a licensed international board certified lactation consultant under this subdivision.

(b) Applicants under this subdivision must provide the information required in subdivision
2 and must request that the appropriate government body in each jurisdiction in which the
applicant holds or held credentials as a lactation care provider or substantially similar title
send a letter to the board verifying the applicant's credentials. A license shall not be issued
by the board until the board receives a letter verifying each of the applicant's credentials.
Each letter must include the applicant's name and date of birth; credential number date of
issuance and date of expiration; a statement regarding investigations pending and disciplinary
actions taken or pending against the applicant; current status of the credential; and the terms
under which the credential was issued.

Subd. 4. Action on applications for licensure. (a) The board shall act on an application
for licensure according to paragraphs (b) to (d).

(b) The board shall determine if the applicant meets the requirements for licensure under
this section. The board may investigate information provided by an applicant to determine
whether the information is accurate and complete.

(c) The board shall approve, approve with conditions, or deny licensure. The board shall
notify an applicant of action taken on the application and, if licensure is denied or approved
with conditions, the grounds for the board's determination.

(d) An applicant denied licensure or granted licensure with conditions may make a
written request to the board, within 30 days of the date of the board's determination, for
reconsideration of the board's determination. Individuals requesting reconsideration may
submit information which the applicant wants considered in the reconsideration. After
reconsideration of the board's determination to deny licensure or grant licensure with
conditions, the board shall determine whether the original determination should be affirmed
or modified. An applicant is allowed no more than one request in any one biennial licensure
6.1 period for reconsideration of the board's determination to deny licensure or approve licensure
with conditions.

6.3 Sec. 4. [147G.04] LICENSURE RENEWAL.

6.4 Subdivision 1. Renewal requirements. To be eligible for licensure renewal, a licensee
must:

6.5 (1) submit a completed and signed application for licensure renewal on forms provided
by the board;

6.6 (2) submit the renewal fee required under section 147G.07;

6.7 (3) submit proof that the licensee is currently credentialed by the International Board of
Lactation Consultant Examiners as accredited by the National Commission for Certifying
Agencies, or another jurisdiction as described in section 147G.03; and

6.8 (4) submit additional information as requested by the board to clarify information
presented in the renewal application. The information must be submitted within 30 days
from the date of the board's request.

6.15 Subd. 2. Renewal deadline. (a) Licenses must be renewed every two years. Licensees
must comply with the procedures in paragraphs (b) to (d).

6.16 (b) An application for licensure renewal must be received by the board or postmarked
at least 30 calendar days before the expiration date.

6.17 (c) An application for licensure renewal not received within the time required under
paragraph (b), but received on or before the expiration date, must be accompanied by a late
fee in addition to the renewal fee specified in section 147G.07.

6.18 (d) Licensure renewals received after the expiration date shall not be accepted and
individuals seeking licensed status must comply with the requirements of section 147G.03.

6.24 Subd. 3. Licensure renewal notice. Each license must state an expiration date. At least
60 calendar days before the license expiration date, the board shall notify the licensee at
the licensee's last known address on file with the board. The notice must include an
application for licensure renewal and notice of fees required for renewal. The licensee's
failure to receive notice does not relieve the licensee of the obligation to meet the renewal
deadline and other requirements for licensure renewal.

6.30 Subd. 4. Licensure renewal after expiration date. An individual whose application
for licensure renewal is received after the licensure expiration date must submit the following:
(1) a completed and signed application for licensure following lapse in licensed status on forms provided by the board;

(2) the renewal fee and the late fee required under section 147G.07;

(3) proof that the licensee is currently credentialed by the International Board of Lactation Consultant Examiners or another jurisdiction as described in section 147G.03; and

(4) additional information as requested by the board to clarify information in the application, including information to determine whether the individual has engaged in conduct warranting disciplinary action as set forth in section 147G.08. This information must be submitted within 30 days of the board's request.

Sec. 5. [147G.05] CHANGE OF NAME, ADDRESS, OR EMPLOYMENT.

A licensee who changes a name, address, or employment must inform the board, in writing, of the change of name, address, employment, business address, or business telephone number within 30 days. A change in name must be accompanied by a copy of a marriage certificate or court order. All notices or other correspondence mailed to or served on a licensee by the board at the licensee's address on file with the board shall be considered as having been received by the licensee.

Sec. 6. [147G.06] CLIENT NOTIFICATION.

Subdivision 1. Required notification. (a) In the absence of a physician referral or prior authorization approval, and before providing clinical lactation services to a client, a licensed international board certified lactation consultant must provide to the client or the client's parent or guardian if the client is a minor, the following written notification in all capital letters of 12-point or larger boldface type: "Your health care provider, insurer, or health plan may require a physician referral or prior authorization before providing payment for any clinical lactation services rendered and you may be obligated for partial or full payment for any clinical lactation services rendered,"

(b) Information other than this notification may be included as long as the notification remains conspicuous on the face of the document.

(c) A nonwritten disclosure format may be used to satisfy the recipient notification requirement when necessary to accommodate the physical condition of a client or client's guardian.
Subd. 2. **Evidence of recipient notification.** Upon request, the licensed international board certified lactation consultant is responsible for providing evidence of compliance with the client notification requirement of this section.

Sec. 7. *[147G.07] FEES.*

Subdivision 1. **Initial licensure fee.** The initial licensure fee is $80. The board shall prorate fees based on the number of quarters remaining in the biennial licensure period.

Subd. 2. **Licensure renewal fee.** The biennial licensure renewal fee is $80.

Subd. 3. **Duplicate license fee.** The fee for a duplicate license is $25.

Subd. 4. **Late fee.** The fee for late submission of a renewal application is $25.

Subd. 5. **Verification to other states.** The fee for verification of licensure to other states is $25.

Subd. 6. **Use of fees.** All fees are nonrefundable. Fees collected under this section shall be deposited in the state treasury and credited to the state government special revenue fund.

Subd. 7. **Penalty fee.** (a) The penalty for using one of the protected titles under section 147G.02 without a current license after the credential has expired and before it is renewed is the amount of the license renewal fee for any part of the first month, plus the license renewal fee for any part of any subsequent month up to 36 months.

(b) The penalty for applicants who use one of the protected titles under section 147G.02 before being issued a license is the amount of the license application fee for any part of the first month, plus the license application fee for any part of any subsequent month up to 36 months.

(c) For conduct described in paragraph (a) or (b) exceeding six months, payment of a penalty does not preclude any disciplinary action reasonably justified by the individual case.

Sec. 8. *[147G.08] GROUNDS FOR DISCIPLINE OR DENIAL OF LICENSURE; INVESTIGATION PROCEDURES; DISCIPLINARY ACTIONS.*

Subdivision 1. **Grounds for discipline or denial of licensure.** The board may deny an application for licensure, may approve licensure with conditions, or may discipline a licensee using any disciplinary action listed in subdivision 3 on proof that the individual has:

1) intentionally submitted false or misleading information to the board;
(2) failed, within 30 days, to provide information in response to a written request by the board;

(3) performed services of a licensed international board certified lactation consultant in an incompetent manner, in a manner that is outside of the provider's scope of practice, or in a manner that falls below the community standard of care;

(4) violated a provision of this chapter;

(5) aided or abetted another person in violating a provision of this chapter;

(6) failed to perform services with reasonable judgment, skill, or safety due to the use of alcohol or drugs, or other physical or mental impairment;

(7) been convicted of violating any state or federal law, rule, or regulation which directly relates to providing clinical lactation services;

(8) been disciplined for conduct in the practice of an occupation by the state of Minnesota, another jurisdiction, or a national professional association, if any of the grounds for discipline are the same or substantially equivalent to those in this chapter;

(9) not cooperated with the board in an investigation conducted according to subdivision 2;

(10) advertised in a manner that is false or misleading;

(11) engaged in dishonest, unethical, or unprofessional conduct in connection with providing clinical lactation services that is likely to deceive, defraud, or harm the public;

(12) demonstrated a willful or careless disregard for the health, welfare, or safety of a client;

(13) performed medical diagnosis or provided treatment without being licensed to do so under the laws of this state;

(14) paid or promised to pay a commission or part of a fee to any person who contacts the licensed international board certified lactation consultant for consultation or sends patients to the licensee for treatment;

(15) engaged in abusive or fraudulent billing practices, including violations of federal Medicare and Medicaid laws, Food and Drug Administration regulations, or state medical assistance laws;

(16) obtained money, property, or services from a consumer through the use of undue influence, high-pressure sales tactics, harassment, duress, deception, or fraud;
(17) performed services for a client who had no possibility of benefiting from the services;

(18) failed to refer a client for medical evaluation when appropriate or when a client indicated symptoms associated with diseases that could be medically or surgically treated;

(19) engaged in conduct with a client that is sexual, or may reasonably be interpreted by the client as sexual, or in any verbal behavior that is seductive or sexually demeaning to a client;

(20) violated a federal or state court order, including a conciliation court judgment, or a disciplinary order issued by the board, related to the individual's clinical lactation services practice; or

(21) any other just cause related to the practice of clinical lactation services.

Subd. 2. Discipline; reporting. For purposes of this chapter, licensed international board certified lactation consultants and applicants are subject to the provisions of sections 147.091 to 147.162.

Sec. 9. EFFECTIVE DATE.

Sections 1 to 8 are effective July 1, 2018."

Delete the title and insert:

"A bill for an act relating to health; creating licensing for the practice of clinical lactation services; establishing fees; requiring a report; proposing coding for new law as Minnesota Statutes, chapter 147G."
State of Arizona
Senate
Fifty-third Legislature
Second Regular Session
2018

SB 1184

Introduced by
Senator Kavanagh

AN ACT

AMENDING TITLE 41, ARIZONA REVISED STATUTES, BY ADDING CHAPTER 55:
RELATING TO PROFESSIONAL LICENSES.

(TEXT OF BILL BEGINS ON NEXT PAGE)
Be it enacted by the Legislature of the State of Arizona:

Section 1. Title 41, Arizona Revised Statutes, is amended by adding chapter 55, to read:

CHAPTER 55
TEMPORARY LICENSURE OF PROFESSIONALS

ARTICLE 1. GENERAL PROVISIONS

41-5601. Temporary licensure of professionals compact

THE INTERSTATE COMPACT FOR THE TEMPORARY LICENSURE OF PROFESSIONALS IS ADOPTED AND ENACTED AS FOLLOWS:

SECTION I. PURPOSE

THE PURPOSE OF THIS COMPACT IS TO:
1. ALLOW MEMBER STATES TO EXPEDIENTLY GRANT A TEMPORARY LICENSE TO ELIGIBLE LICENSEES MOVING TO THEIR STATE.
2. ALLOW ELIGIBLE LICENSEES MOVING TO A MEMBER STATE TIME TO MEET THE LICENSURE REQUIREMENTS OF THE DESTINATION STATE WHILE PRACTICING THEIR OCCUPATION.
3. INCREASE THE MOBILITY OF PROFESSIONAL LICENSES, SAFEGUARD THE HEALTH AND SAFETY OF THE PUBLIC, AND ENHANCE THE WORKFORCE IN MEMBER STATES.

SECTION II. DEFINITIONS

IN THIS COMPACT:
1. "APPLICANT" MEANS A NATURAL PERSON WHO HAS SUBMITTED AN APPLICATION TO A MEMBER STATE FOR A TEMPORARY LICENSE.
2. "BACKGROUND CHECK" INCLUDES A CRIMINAL BACKGROUND INVESTIGATION AND A NATIONAL CRIMINAL HISTORY RECORDS CHECK.
3. "DESTINATION STATE" MEANS THE MEMBER STATE IN WHICH A TEMPORARY LICENSE IS SOUGHT.
4. "MEMBER STATE" MEANS A STATE THAT HAS ENACTED THE COMPACT.
5. "MILITARY SPOUSE" MEANS A PERSON WHOSE SPOUSE IS A MEMBER OF THE UNITED STATES ARMED FORCES AND IS ON ACTIVE DUTY AND STATIONED IN THE DESTINATION STATE.
6. "PROFESSIONAL LICENSE" OR "LICENSE" MEANS ANY STATE ISSUED CREDENTIAL THAT AUTHORIZES A NATURAL PERSON TO WORK IN A GIVEN PROFESSION, WHICH WOULD BE UNLAWFUL WITHOUT THE AUTHORIZATION OF A STATE LICENSING AUTHORITY.
7. "STATE" MEANS ANY STATE, COMMONWEALTH, DISTRICT OR TERRITORY OF THE UNITED STATES.
8. "TEMPORARY LICENSE" MEANS AN UNRESTRICTED LICENSE GRANTED BY A MEMBER STATE TO AN ELIGIBLE PROFESSIONAL THROUGH THE PROCESS SET FORTH IN THE COMPACT.
9. "UNRESTRICTED LICENSE" MEANS A LICENSE THAT IS NOT CONDITIONED ON THAT PARTICULAR LICENSEE'S AGREEMENT TO LIMIT THE SCOPE OF THE LICENSEE'S PROFESSIONAL WORK OR TO ENGAGE IN ADDITIONAL REQUIREMENTS OR PROTOCOLS SPECIFIC TO THAT LICENSEE.
SECTION III: CONTENTS OF APPLICATION AND FEES
A. AN APPLICATION FOR A TEMPORARY LICENSE SHALL INCLUDE ALL OF THE FOLLOWING:
   1. THE APPLICANT’S FULL NAME.
   2. A LIST OF ALL STATES IN WHICH THE APPLICANT HOLDS A PROFESSIONAL LICENSE.
   3. A STATEMENT BY THE APPLICANT THAT THE APPLICANT:
      (a) HOLDS A VALID, FULL AND UNRESTRICTED LICENSE IN A MEMBER STATE.
      (b) IS IN GOOD STANDING, AS SET FORTH IN SECTION IV, WITH EVERY OTHER STATE IN WHICH THE INDIVIDUAL IS LICENSED.
B. THE LICENSING AUTHORITY MAY REQUEST IDENTIFYING INFORMATION SUCH AS AN APPLICANT’S DATE OF BIRTH, SOCIAL SECURITY NUMBER OR STATE LICENSE NUMBER. THE DESTINATION STATE’S LICENSING AUTHORITY MAY CHARGE FEES COMPARABLE TO OTHER FEES CHARGED BY THAT LICENSING AUTHORITY.

SECTION IV: ISSUANCE OR NONISSUANCE OF TEMPORARY LICENSE
A. AN APPLICANT SEEKING A TEMPORARY LICENSE SHALL SUBMIT A COMPLETE APPLICATION TO THE LICENSING AUTHORITY OF THE DESTINATION STATE. THE LICENSING AUTHORITY OF THE DESTINATION STATE, OR ITS AGENT, SHALL ISSUE THE TEMPORARY LICENSE WITHIN THIRTY DAYS OF RECEIPT OF A COMPLETE APPLICATION UNLESS IT DETERMINES THAT THE APPLICANT:
   1. DOES NOT POSSESS A VALID, FULL AND UNRESTRICTED LICENSE ISSUED BY A MEMBER STATE.
   2. IS NOT IN GOOD STANDING IN ALL STATES IN WHICH THE APPLICANT IS LICENSED.
   3. IS INELIGIBLE DUE TO A DISQUALIFYING RECORD IDENTIFIED DURING A BACKGROUND CHECK.
B. AN APPLICANT IS CONSIDERED TO BE IN GOOD STANDING WITH A STATE LICENSING AUTHORITY IF THE LICENSEE IS NOT UNDER ACTIVE INVESTIGATION, HAS NOT BEEN THE SUBJECT OF AN UNFAVORABLE DETERMINATION IN A DISCIPLINARY ACTION TWO YEARS BEFORE THE DATE OF THE APPLICATION AND HAS NO PENDING DISCIPLINARY ACTIONS BEFORE THE AUTHORITY.
C. A LICENSING AUTHORITY MAY ONLY CONDUCT A BACKGROUND CHECK IF IT IS OTHERWISE AUTHORIZED TO DO SO. BASED ON THE RESULTS OF A BACKGROUND CHECK, A LICENSING AUTHORITY MAY FIND AN APPLICANT INELIGIBLE FOR A TEMPORARY LICENSE ONLY IF IT WOULD SIMILARLY FIND AN APPLICANT FOR A REGULAR LICENSE INELIGIBLE. AN APPLICANT WHO FAILS TO MEET THE NECESSARY REQUIREMENTS SHALL BE ISSUED A PROMPT INELIGIBILITY LETTER FROM THE LICENSING AUTHORITY OF THE DESTINATION STATE OR ITS AGENT. ANY APPLICANT FOUND TO BE INELIGIBLE MAY APPEAL THE DETERMINATION PURSUANT TO CHAPTER 6, ARTICLE 10 OF THIS TITLE.

SECTION V: DUTIES OF MEMBER STATES
A. ON REQUEST, EACH MEMBER STATE SHALL PROVIDE ANOTHER MEMBER STATE WITH THE FOLLOWING INFORMATION WITHIN TEN DAYS:
   1. WHETHER A LICENSEE POSSESSES A VALID, FULL AND UNRESTRICTED LICENSE.
2. WHETHER A LICENSEE IS IN GOOD STANDING AS SET FORTH IN SECTION IV.

B. A DESTINATION STATE MAY NOTIFY A MEMBER STATE WHEN THE DESTINATION STATE GRANTS A TEMPORARY LICENSE BASED ON AN INDIVIDUAL’S LICENSURE WITHIN THAT MEMBER STATE. IF SO NOTIFIED, THE MEMBER STATE SHALL PROMPTLY INFORM THE DESTINATION STATE IF IT TAKES ADVERSE ACTION AGAINST SUCH LICENSEE.

SECTION VI: OPT OUT

ANY MEMBER STATE MAY DECLINE TO AFFORD RECIPROCITY TO ACTIVE LICENSEES FROM ANOTHER MEMBER STATE FOR A PARTICULAR OCCUPATION BY ENACTING LEGISLATION FINDING THAT THE REQUIREMENTS FOR SUCH LICENSES IN THE RELEVANT MEMBER STATE ARE INADEQUATE TO PROTECT THE PUBLIC HEALTH AND SAFETY.

SECTION VII: TERMS OF TEMPORARY LICENSE

THE TEMPORARY LICENSE SHALL BE FOR A TERM OF EIGHTEEN MONTHS UNLESS THE APPLICANT IS A MILITARY SPOUSE. IF THE APPLICANT IS A MILITARY SPOUSE THE TEMPORARY LICENSE SHALL BE FOR A TERM OF TWO YEARS. A TEMPORARY LICENSE IS NONRENEWABLE EXCEPT THAT ANY MEMBER STATE MAY DECIDE TO MAKE TEMPORARY LICENSES FOR ANY OR ALL OCCUPATIONS RENEWABLE BY STATUTE. AN INDIVIDUAL HOLDING A TEMPORARY LICENSE IS AUTHORIZED TO WORK AS A LICENSED PROFESSIONAL IN THE DESTINATION STATE CONSISTENT WITH ALL APPLICABLE LAWS AND REGULATIONS OF THE DESTINATION STATE AND THE LICENSURE AUTHORITY THAT ISSUED THE TEMPORARY LICENSE.

SECTION VIII: JURISDICTION OVER LICENSES

AN INDIVIDUAL WHO IS ISSUED A TEMPORARY LICENSE BY A DESTINATION STATE AUTOMATICALLY SUBMITS TO THE JURISDICTION OF THE LICENSING AUTHORITY OF THE DESTINATION STATE. OTHER MEMBER STATES, HOWEVER, RETAIN JURISDICTION TO IMPOSE ADVERSE ACTION AGAINST THEIR OWN LICENSEES.

SECTION IX: STATE LAW SUPERSEDED

ALL MEMBER STATES’ LAWS, EXCEPT FOR STATE CONSTITUTIONS, ARE SUPERSEDED BY THE INTERSTATE COMPACT FOR THE TEMPORARY LICENSURE OF PROFESSIONALS TO THE EXTENT OF A CONFLICT. THE OPTION OF TEMPORARY LICENSURE THAT THIS COMPACT CREATES IS INTENDED TO COEXIST WITH THE OPTION OF PERMANENT LICENSURE THAT MAY BE CREATED BY OTHER INTERSTATE LICENSING COMPACTS SPECIFIC TO A PROFESSION, AND WHENEVER POSSIBLE THIS COMPACT SHOULD BE INTERPRETED SO AS TO IMPLY NO CONFLICT BETWEEN IT AND ANY OTHER LICENSING COMPACT. NOTHING IN THIS COMPACT SHALL BE CONSTRUED TO LIMIT THE ABILITY OF A LICENSING AUTHORITY TO ISSUE A LICENSE PURSUANT TO A STATE OR FEDERAL LAW THAT ALLOWS FOR ISSUANCE OF LICENSES IN A MORE EXPEDITED MANNER.

SECTION X: EFFECTIVE DATE

ANY STATE IS ELIGIBLE TO BECOME A MEMBER STATE. THE COMPACT SHALL BECOME EFFECTIVE AND BINDING ON LEGISLATIVE ENACTMENT OF THE COMPACT INTO LAW BY NO LESS THAN TWO STATES. THE INITIAL EFFECTIVE DATE SHALL BE THE LATER OF JULY 1, 2018, OR ON THE DATE THE LAW IS ENACTED IN THE SECOND
JURISDICTION TO JOIN THE COMPACT. THEREAFTER IT SHALL BECOME EFFECTIVE AND BINDING AS TO ANY OTHER MEMBER STATE ON THE DATE THE LAW BECOMES ENACTED IN THAT STATE.

SECTION XI: WITHDRAWAL

ANY MEMBER STATE MAY WITHDRAW FROM THIS COMPACT BY SPECIFICALLY REPEALING THE STATUTE THAT ENACTED THE COMPACT INTO LAW. THE EFFECTIVE DATE OF THE WITHDRAWAL IS THE EFFECTIVE DATE OF THE REPEAL. TEMPORARY LICENSES ISSUED BY THE MEMBER STATE BEFORE THE WITHDRAWAL DATE SHALL NOT BE AFFECTED BY WITHDRAWAL.

SECTION XII: INSUBSTANTIAL DIFFERENCES

THE VALIDITY OF THIS COMPACT SHALL NOT BE AFFECTED BY ANY INSUBSTANTIAL DIFFERENCES IN ITS FORM OR LANGUAGE AS ADOPTED BY ANY MEMBER STATE.
Need a license to do your job? That may be excessive

Congress should curb this costly scheme that imposes barriers.

By Morris M. Kleiner  JANUARY 17, 2018 — 6:52PM

Occupational licensure, a legal process that establishes qualifications to practice a trade or profession for pay, has become one of the most significant labor market regulations in the United States.

While only about 5 percent of the workforce needed a license to work in the 1950s, it is now required for about 25 percent of American workers. As a regulatory scheme, occupational licensing dwarfs both the minimum wage and unionization in terms of its coverage of the American workforce.

When many people think of occupational licensing, they think of doctors, lawyers, dentists. There are important arguments that many professions require licensing due to health and safety concerns. But today licensing can extend to jobs such as being a florist, upholsterer or interior designer. The practical impact of extending licensing to such professions is to decrease the number of people in those jobs — because before people can work, they must get costly training, pass tests and pay licensing fees.

Excessive licensing has other costs. First, licensing works as a barrier to entry for low-income workers who lack the resources or time to take costly courses and enter apprenticeship programs. This limits their ability to move into higher-paying occupations.

Second, licensing limits the mobility of workers. For example, teachers and electricians have difficulty moving across state lines to seek new opportunities without taking new tests and additional classes. This is a special problem for military spouses, who have little control over where they will live.

Third, licensing makes it far more difficult for ex-offenders to get a new start, as they are often shut out of many occupations, ranging from emergency medical technicians to cosmetology.

Policy analysis estimates suggest that the costs in higher prices to consumers and reduced economic growth are as much as $203 billion annually.

Despite the best efforts by many policymakers and academics, we hear little about the problems of excessive occupational licensing. Part of the reason is that most licensing statutes are enacted at the state or local level, not in Washington. However, given the growth of occupational licensing and its influence on the economy and jobs, these are national issues, and Congress should get involved.

A 2015 decision by the U.S. Supreme Court has provided an important opening for Congress to begin to address occupational licensing and its economic and labor market costs. In the landmark decision of North Carolina Board of Dental Examiners vs. Federal Trade Commission, the court held that the state dental board unlawfully restricted trade by not allowing nondentists to offer teeth-whitening services. The court reasoned that the dentists who served on that licensing board had a conflict of interest and that they were trying to use their regulatory position to protect themselves against competition from a lower-wage provider.

As a result of this Supreme Court decision, members of state licensing boards that engage in anticompetitive practices can be sued under the antitrust laws. That has had a negative effect on some state licensing boards. Sarah Oxenham Allen, the senior assistant attorney general of Virginia, said in a statement before Congress: "Private individuals already have begun expressing hesitation to serve on state boards because of the treble damages risk, and many state constitutions inhibit the ability of states to indemnify board members from treble damage liability." In Florida, the chair of the state Podiatry Board stepped down because of potential lawsuits due to anticompetitive practices.

The efficient functioning of these boards is in many cases necessary for health and safety reasons, and we would want people with expertise about the profession and its services serving on them.

Dentistry is one of the professions that requires occupational licensure for health and safety reasons.
Given the problems with licensing, plus the new antitrust liability issues, Congress is looking to curb the former and limit the latter. The Restoring Board Immunity Act (RBI) has been introduced in both the U.S. House and Senate. It would establish that individuals who serve on occupational boards are not subject to antitrust liability provided that their state has implemented clear occupational licensing reforms.

States would be required to actively supervise occupational boards to ensure that they are protecting the public interest instead of advancing private economic interests such as restricting the supply of practitioners or expanding the scope of work over which the regulated occupation has a monopoly. Equally important, states would be required to examine licensing laws through, for example, periodic cost-benefit reviews to ensure that the licensing of an occupation is still serving a public purpose.

If states take these steps, then licensing boards would have immunity from antitrust liability.

This proposal addresses two problems. It ensures that state licensing boards will have high-quality professionals serving without fear of lawsuits, and it reduces excessive regulations promoted by the licensed occupations, which are interested in the maintaining of high salaries by limiting access to the professions. The nonpartisan approach to these issues is one where consumers, advocates of economic growth, and more efficient and equitable labor markets gain.

Morris M. Kleiner is professor and AFL-CIO Chair in Labor Policy at the Humphrey School of Public Affairs at the University of Minnesota.
Statement for the Record
The United States House of Representatives
Judiciary Subcommittee on Regulatory Reform, Commercial and Antitrust Law

Hearing - Occupational Licensing Regulation and Competition
September 12, 2017

The undersigned associations of state licensing boards and the organizations representing those licensed professionals serving on these boards have a direct interest in the issues being considered by this Committee. Our shared mission is to work together with state governments to ensure the quality, safety, and integrity of the knowledge-based professions by promoting high standards for licensure and practice, and to effectuate the state’s primary goal of protecting public health, safety, and welfare. The public is best served when state regulatory boards, duly constituted under state law, are free to make decisions on issues of public health, safety, and welfare, decisions which involve a balancing of multiple values—including the effect on the economic health of the marketplace—without heightened subjugation to federal antitrust law and other federal mandates which would force states to create additional levels of bureaucracy and oversight.

To that end, our organizations collectively voice concern that the injection of federal procedural mandates into areas of traditional state law and regulations will limit the ability of state and local officials from taking good faith actions which are reasonably believed to be in the best interests of the welfare of its citizens, thereby further eroding the constitutional balance of state and federal powers. We urge the Committee to contemplate the unique role of state licensing bodies in the system of state government and their mandate to protect the consuming public from harm. We respectfully suggest that regulation of certain licensed professional services requires deference to the preferences of the state regarding the structure, composition, and powers provided to their duly appointed boards and acknowledge that in performing its duties, a state regulatory body exercises judgment that focuses on many factors, including competition.

The Role of Licensing Boards in a Free Market

Professional licensure exists within a system of federalism in which, under the Tenth Amendment, the federal government displays respect for the sovereign decisions made by the states to oversee professionals providing services within their boundaries. State licensing boards limit the ability of unqualified professionals from entering the market and restrict or remove professionals
when they do not adhere to the professional standards set by the state or they endanger members of the consuming public. Through promulgation and enforcement of standards of practice, state licensing boards ensure that the skilled professional is acting for the benefit of the consumer, and not at the expense of the consumer.

It is important to underscore the great, pro-competitive strides that states and state licensing boards have made in recent years to facilitate and encourage licensed professionals to engage in the delivery of regulated services in a variety of U.S. jurisdictions. These strides have been in the form of interstate compacts, mutual recognition agreements, increased reciprocity, and, in some instances, the mobility model of no notice and no fee when practicing in a jurisdiction that is substantially equivalent to the individual licensee’s state of licensure. In addition, many learned professions have developed and vigorously implemented their professions’ model practice acts, thereby aligning and conforming state law in an attempt to streamline licensing and increase consistency, all while ensuring public protection. These efforts have been coupled with efforts to reduce licensing burdens for veterans and their spouses. Procompetitive steps being taken by states and their licensing boards, especially when they help to reduce barriers to crossing state lines, have been and should continue to be an area where there is cooperation between federal competition enforcers and state licensing regulators.

State licensing boards also serve an important role in the function of a free market by creating trust between the public consumer of a service and the professional that provides it within a state’s borders. Although boards vary in structure and form, the legislatively mandated purview of any state licensing board is to determine whether other societal values, such as reduction of physical harm or avoidance of deception, outweigh the benefits of unrestricted competition. In comments at the July 2017 FTC Economic Liberty Taskforce Roundtable, Acting Chairman Maureen Ohlhausen recognized that licensing serves important consumer protection functions, especially in situations where consumers may be vulnerable because they lack sufficient information to evaluate the quality of service providers.

The broad generalizations relied upon by critics of state licensing boards assume that consumers can unilaterally discern the qualifications necessary to provide a service, and characterize the role of licensing boards as superfluous in a modern marketplace. However, it is difficult for a consumer to properly value a market good that is based upon the provision of advanced knowledge. Knowledge-based market goods lack the purely transparent character that allows a consumer to discern the quality of the goods much in the same way they would discern the quality of basic retail
goods such as food or clothing. This understanding is implicit in the decision of a state to license a profession and should be reflected in federal competition preferences.

The uncertainty and risk created by unclear antitrust standards and federal legislation creating additional levels of state bureaucracy limit the ability of state licensing boards to act expeditiously and with certainty, thereby weakening public protection. State licensing boards understand the concerns about professional licensure and will continue to work proactively with interested parties at the state and federal level to find solutions that meet the needs of the modern market, but also protect the public health, safety, and welfare.

North Carolina Dental and Its Results

For more than 70 years, state licensing boards were presumed to be immune from federal antitrust laws as long as their actions were clearly authorized by state statutes. However, the Supreme Court's 2015 holding in North Carolina State Board of Dental Examiners v. Federal Trade Commission now requires that state licensing boards comprised of a controlling number of active market participants also be “actively supervised” by a neutral state entity in order to enjoy state action immunity from federal antitrust law. The decision in North Carolina Dental fails to recognize the capacity (and in many cases, an ethical duty under state law) of an individual, often appointed by a governor or approved by the state legislature, to put self-interest aside and act in the public interest during his or her service on a state board.

The Supreme Court's decision also left open questions concerning the extent of the decision's application to the various situations where a professional licensing board could act in a manner that impacts the market. For example, the Court did not detail how many licensee board members would constitute a controlling interest on the board or whether their particular area of practice would be a factor, leading to speculation as to whether traditional state oversight of licensing boards, along with the potential for court review of enforcement actions, would be sufficient supervision to ensure antitrust immunity.

In October 2015, the FTC released staff guidance that addressed the lingering questions left by North Carolina Dental. The guidance does implicitly recognize that states will not cede the expertise and contributions of active market participants. However, the guidance urges states to create another level of review which, in practice, will delay decisions and jeopardize expeditious actions made to protect the public. In a rehashing of the Court's four constants of a context-dependent review, the supervisor must take a fresh look at the decision and issue a written
explanation as to why he or she agrees with the board's determination. The guidance also states that the participation of disinterested state actors, such as staff of the attorney general, should not be considered state supervision. Moreover, neither does a decision reached in compliance with the administrative procedures act and other state transparency laws. One way to make the market more efficient, no matter if the goal is time, money, or any other value, is not to add another layer of bureaucratic review.

Despite the FTC's assertion to the contrary, federal policy makers should acknowledge that state regulatory boards and their members are subject to procedures that ensure that any action is undertaken in a manner that reflects state policy, rather than implementing private preferences of market participants. There are checks and balances inherent in the state political process that federal policy should acknowledge and respect. Active supervision starts at the appointment process, as a governor is responsible for appointing members capable of acting in a manner that ensures decisions of the regulatory board reflect state policy, rather than simply the private preferences of market participants. Additionally, all rules that a regulatory board wishes to promulgate must go through a notice-and-comment process under state administrative procedure acts, subjecting board actions to public scrutiny and review. On top of the various forms of political oversight and public accountability set forth above, many state regulatory boards are already subject to periodic, comprehensive review by the legislature. These reviews, so-called “sunset reviews,” identify the mission, goals, and objectives of the state board and analyze the extent to which they have been achieved. All of these options are less burdensome on the regulatory process than the creation of a new oversight body that would operate to overturn decisions made transparently by politically accountable actors.

What constitutes active supervision is far from clear, particularly where state statutes grant boards substantial authority and independence in carrying out their duties. Thus, over the last two years, the actions of boards and their members and employees have been placed under a cloud of uncertainty, including the prospect of antitrust treble damages as they attempt to carry out their duties under their existing governance structures. Just as importantly, this threat of treble damage liability has led several states to adopt regulatory or legislative changes to board governance mechanisms without assurance that antitrust courts might find, over the course of years of litigation, that these changes meet the active supervision requirement. Nonetheless, absent clarity on this issue, states have incurred costs to defend against these claims in court.
To date, at least twenty-seven antitrust cases have been filed against state licensing boards in the wake of the Supreme Court’s 2015 decision. The majority of those have been dismissed on Eleventh Amendment and sovereign immunity grounds, or have been found to be insufficient grounds to uphold a claim under federal antitrust law, as the action challenged related to issues of individual discipline. Indeed, ministerial acts and licensee discipline actions present very low antitrust risk and do not necessarily require active supervision scrutiny, a fact that was acknowledged by the majority in the *North Carolina Dental* decision and the FTC guidance on active supervision.

More troubling, however, is the potential use of antitrust litigation to compel a state licensing board to rescind its disciplinary inquiries against a licensee. Sadly, this is less fantasy and more reality. In June 2017, the Kansas Board of Healing Arts received a strongly worded letter from an attorney representing the subject of a disciplinary inquiry. In this letter, the attorney demanded that the board “cease and desist” its investigation of his client, lest it be subject to the filing of a federal antitrust lawsuit. This threat was punctuated by the statement that the plaintiff would seek personal damages from board members. Clearly, threats of litigation to avoid discipline were never intended to be the aim of federal antitrust laws, nor did subsequent guidance envision the use of threats of litigation as a shield from discipline, but such threats are the result of the *North Carolina Dental* decision that weakens the state regulatory systems and may allow bad actors to continue to provide services in the marketplace.

States will continue to incur costs to defend against antitrust claims for the foreseeable future. Subjecting individual decisions regarding issuance or denial of a license, or standard disciplinary decisions to a bureaucratic review process has created an unnecessary hurdle that represents a waste of government resources for marginal, if any, market improvement. The requirement that such actions be reviewed unduly burdens the regulatory board and other components of state government, not to mention compromises public safety during the interim period before the board’s action becomes final.

**Restoring Board Immunity (RBI) Act**

Some state models for active supervision and the review of occupational licensing boards already exist or are being developed. With regard to rulemaking, the rules of many state boards are already subject to review by an executive or legislative branch commission or agency charged with rules review oversight. Whether or not a state’s rules review mechanism is sufficient to meet the requirements for active supervision will likely depend upon whether there is a substantive review of the promulgating entity’s statutory authority to propose such a rule and whether the disinterested
reviewer has the power to modify or veto the proposed rule. Despite variations within these models of supervision, it is right and proper for states to continue to perfect their own regulatory structures in a manner that is free from federal interference and in a manner that accounts for a broader range of local considerations, rather than merely the value of competition, when matters of the public welfare of its citizens are at issue.

We recognize that the recently-introduced Restoring Board Immunity Act (RBI Act) aims to achieve both deregulation and active supervision goals. The RBI Act appears to use the *North Carolina Dental* decision as an opportunity to mandate state deregulation efforts under the guise of antitrust compliance. In doing so, the RBI Act would have states establish an Office of Supervision of Occupational Boards to oversee the activities undertaken by licensing boards. Of additional concern, the RBI Act specifically sets out federal mandates for the staff structure of a state agency, directing the state on the minimum number of attorneys that must staff the agency and further restricting the state from using its own employees as the state sees fit. Creating more state bureaucracy, processes, and red tape is not the answer.

Moreover, the active supervision that is required under the RBI Act goes far beyond the supervision parameters set by the Supreme Court in *North Carolina Dental* and in the decades of jurisprudence since the first decision establishing the active state supervision standard was issued by the Supreme Court in 1980. The RBI Act proposes an active supervision regime that implicitly targets state legislative mandates, not actions undertaken by state boards. It requires the newly-developed bureaucratic office to determine whether a state licensing board has utilized the “least restrictive means” to regulate within a particular profession or occupation. However, under the powers vested in it through the Tenth Amendment, it is the prerogative of a state legislature to determine what means it wants to employ to regulate a given profession or occupation. The legislature has already defined the least restrictive means for most of its learned professions—a state licensure regime. Thereafter, the legislature has set forth the requirements for licensure, typically addressing areas such as examination, education, and experience. If deregulating certain occupations is the aim, the RBI Act is not the most effective way to address such aim.

The practical application of such systems is not without its limitations. The institution of such reforms does not guarantee that the regulatory process will improve, but it will guarantee a less efficient process. An unforeseen consequence of creating a new agency tasked with reviewing a regulatory board’s actions through an antitrust lens is that the potential for regulatory capture has not been ameliorated, but shifted to another entity within government. The decisions of the
reviewing entity are not subject to the same transparency demanded of state regulatory boards during the rulemaking process. The decision to veto or modify a board's decision is not subject to the same scrutiny as the process which created the rule under review. By forcing states to bend to federal preferences, federal law would attempt to prevent regulatory capture but, quite possibly, would ultimately encourage it by shifting unlimited veto powers to another state agency.

Of note, in this past legislative session, several states have considered state legislation that mirrors much of the language contained in the RBI Act. The rationale for these proposals included the establishment of statewide policy for the regulation of professions and occupations specifying criteria for government regulation with the objective of increasing opportunities, promotion of competition, encouragement of innovation, protecting consumers, and compliance with applicable federal antitrust laws. These state legislative proposals would have established a process for the active supervision of state regulatory boards, including the establishment of a bureaucratic oversight body responsible for the active supervision of regulatory boards and which is to review all state licensure on a hierarchy similar to that proposed in the RBI Act.

Beyond issues of practicality, of concern were the issues of additional costs that would be imposed upon states. Fiscal analysis of the costs of legislation proposed in 2017 for the creation of agencies similar to that which has been proposed in the RBI Act are significant.

- Maryland — HB 1471
  - Fiscal Year 2018: $1,100,000
- Nebraska — LB299
  - Fiscal Year 2017-18: $642,000
  - Fiscal Year 2018-2019: $1,207,400
- Virginia — HB1566
  - Fiscal Year 2018: $1,240,362
- West Virginia — HB2984
  - Fiscal Year 2017-18: $855,000

None of these bills have been enacted. If state legislators believed that the creation of a new oversight board to review occupational licensure on a continuum of restraint was a cost-effective, efficient, and practical approach to occupational licensure and antitrust immunity, surely this legislation would have been more successful at the state level.
The lack of passage of these proposals by state legislatures begs the question of whether the federal legislature should use the antitrust laws to supplant the choices of a state on how it spends its money and how it structures its governmental functions. Additionally, this Committee should question whether it is appropriate for federal policy to offer states immunity by way of an unfunded mandate that requires creation of a new state agency and additional layers of red tape and bureaucracy.

**A Better Way Forward**

In the wake of *North Carolina Dental*, there is an opportunity for federal legislation to help states navigate the Supreme Court's decision without creating an immunity that is neither practical, productive, nor consistent with universal application of competition law across all sectors of the economy. Alternative legislation should seek a balanced approach that protects the public against potential antitrust violations without disrupting the good faith functioning of state government or threatening public treasuries with significant damage awards.

A substitute approach for consideration by this Committee would not create immunity, but rather shield state professional and occupational licensing boards and their staff members from damage awards by removing treble damages from the available remedies for actions brought against state regulatory boards. Elimination of monetary damages for antitrust violations by state regulatory boards found guilty under the federal antitrust laws would leave intact the injunctive relief to remedy potentially anticompetitive acts of a state regulatory board. Limiting the available remedy to only injunctive relief (including attorneys' fees) will ensure that antitrust laws are not used to bring frivolous claims against state regulatory boards for the purpose of monetary gain. It would also address the type of threats made against board members as illustrated in the Kansas example and deter the filing of meritless antitrust lawsuits in disciplinary matters.

Additionally, it better aligns with the rationale of subjecting regulatory boards to active supervision, serving as a check against regulatory activity that conflicts with competition goals. By retaining state board liability under federal antitrust laws, and retaining both public and private enforcement, free and open market competition will be preserved. But at the same time, the unique role of state licensing boards governing the learned professions is acknowledged and state government retains the unfettered authority to structure and supervise their regulatory boards in a manner of their choosing.
Moreover, the removal of treble damages ensures that state boards will continue to be populated and staffed by well-meaning and civic-minded professionals. For regulatory functions of the state to work for the public’s welfare, officials who are required to exercise their discretion in the public interest must receive assurance that their exercise of official authority will not subject them to joint and several antitrust treble damages. Potential antitrust liability has already caused some to reconsider service. In 2016, the chair of the Florida Board of Accountancy wrote Governor Rick Scott and expressed concern that his reappointment to the board, absent the state’s ability to indemnify his actions while on the board, would expose him to personal antitrust liability. In some states, board members are barred by constitutional provisions from indemnification and in other states risk managers have refused to extend the coverage of insurance. Removal of treble damages in federal law addresses these issues while respecting the sovereignty of state regulatory affairs.

Conclusion

We appreciate the House Judiciary Committee’s attention to this issue, and respectfully urge the Committee to consider devising appropriate policies that balance underlying concerns of competition, efficiency, and innovation with the principles of federalism and the good public policy of state regulatory boards as the protector of the health and safety of the public. We would be pleased to meet with the Committee to discuss these issues further. Thank you.

Sincerely,

American Association of Veterinary State Boards (AAVSB)
American Physical Therapy Association (APTA)
American Psychological Association Practice Organization
American Society of Civil Engineers (ASCE)
American Society of Landscape Architects (ASLA)
Association of Social Work Boards (ASWB)
Association of State and Provincial Psychology Boards (ASPPB)
Council of Landscape Architectural Registration Boards (CLARB)
Federation of Associations of Regulatory Boards (FARB)
Federation of Podiatric Medical Boards (FPMB)
Federation of State Boards of Physical Therapy (FSBPT)
Federation of State Medical Boards (FSMB)
National Association of REALTORS®
National Association of State Boards of Accountancy (NASBA)
National Council of Architectural Registration Boards (NCARB)
National Society of Professional Engineers (NSPE)
SUBMITTED BY: Ruth M. Martinez, M.A., Executive Director

REQUESTED ACTION:

For information only.

MOTION BY: ___________________ SECOND: ______________________
(  ) PASSED (  ) PASSED AMENDED (  ) LAYED OVER (  ) DEFATED

BACKGROUND:

Ms. Martinez will update the Board on the April 26-28, 2018, Federation of State Medical Boards’ (FSMB) Annual Meeting.

The Minnesota Board of Medical Practice is unable to attend the April 26-28, 2018, FSMB Annual Meeting, in person, because of a travel restriction. Board members will have some electronic access to portions of the meeting.
REPORT OF THE BYLAWS COMMITTEE

SUBJECT: PROPOSED AMENDMENTS TO THE FEDERATION BYLAWS

REFERRED TO: REFERENCE COMMITTEE

The Bylaws Committee, chaired by Jerry G. Landau, JD, met on September 27-28, 2017 in Washington, D.C. and extended its discussion on January 9 and February 21, 2018 via videoconference to consider the current Bylaws and proposed amendments thereto and make recommendations for any necessary changes. In keeping with its charge, the Committee also discussed the FSMB Articles of Incorporation as they relate to the Bylaws. Members of the Committee include: Charles A. Castle, MD; Erich W. Garland, MD; Eric R. Groce, DO; W. Reeves Johnson, Jr., MD; and Ian Marquand. Ex officio members include FSMB Chair Gregory B. Snyder, MD; FSMB Chair-elect Patricia A. King, MD, PhD; and FSMB President-CEO Humayun J. Chaudhry, DO.

The Bylaws Committee is presenting twenty-five (25) proposed amendments for consideration. Proposed amendments #1-7 are contained in Bylaws Proposal #1; proposed amendments #8-23 are contained in Bylaws Proposal #2; proposed amendment #24 is contained in Bylaws Proposal #3; and proposed amendment #25 is contained in Bylaws Proposal #4. Each Bylaws Proposal will be addressed separately.

The Bylaws may be amended at any annual meeting of the House of Delegates by two-thirds of those present and voting.

BYLAWS PROPOSAL #1/ PROPOSED AMENDMENTS #1-7 (PROPOSED BY THE FSMB BOARD OF DIRECTORS)

In July 2017, the FSMB Board of Directors approved a resolution directing the Bylaws Committee to explore changes to the Bylaws that would enhance the role of state medical board executive directors in FSMB governance. The catalyst prompting the resolution was the FSMB’s commitment to enhancing its effectiveness in supporting its state medical and osteopathic boards (SMBs) and its awareness that the institutional knowledge, historical perspective and political savvy of SMB executive directors are invaluable to the creation of FSMB work products and positions statements.

The Board of Directors acknowledges that since the inception of the FSMB there has been ongoing review and periodic revisions to the bylaws to allow for appropriate evolution of the organization. In its current form, executive directors as ‘Associate Members’ cannot be utilized to their full potential to benefit the organization.
After extensive discussion and careful consideration, the concept of creating a new category of Fellow was advanced which would allow for both appropriate recognition of the significant contribution that executive directors provide to medical regulation as well as allow the organization to more fully benefit from their expertise on our various committees, work groups and task forces.

In September 2017, the Bylaws Committee met to develop a draft Bylaws proposal for the Board’s consideration, as well as to consider other potential amendments to the Bylaws. At this time, the Bylaws Committee determined that potential amendments designed to create a new category of Fellow could be drafted within the structure of the Bylaws and were feasible to consider. The Committee began to draft recommended revisions. In furtherance of this effort, the Bylaws Committee also sought input from Administrators in Medicine (AIM). In December 2017, the Bylaws Committee distributed proposed revisions to the FSMB Member Medical Boards for comment.

In January 2018, the Bylaws Committee discussed the feedback received from the Member Medical Boards and AIM, all of which was favorable, and the draft proposal was then forwarded, with no additional changes, to the Board of Directors for final review at its February 2018 meeting. On February 21, the Bylaws Committee discussed the Board’s feedback and finalized its position on the proposal.

Bylaws Proposal #1 can be found in its entirety behind Attachment 1 and contains seven (7) proposed amendments (#1-7) within Article II. Classes of Membership, Election and Membership Rights; Article III. Officers: Election and Duties; and Article IV. Board of Directors. The Bylaws Committee recommends the House of Delegates ADOPT proposed Amendments #1-7 as follows:

PROPOSED AMENDMENT #1

Article II. Classes of Membership, Election and Membership Rights
Section B. Fellows

There shall be two categories of Fellow of the FSMB:

1. Board Member Fellow. A Board Member Fellow is an individual member who as a result of appointment or confirmation is designated to be a member of a Member Medical Board. A Board Member Fellow shall be a Fellow of the FSMB during the member’s period of service on a Member Medical Board, and for a period of 36 months thereafter, and

2. Staff Fellow. A Staff Fellow is an individual hired or appointed and who is responsible for the day-to-day supervision and performance of the administrative duties and functions for which a medical board is responsible. Each member board may denote only one individual to serve as a Staff Fellow of the FSMB. No individual shall...
continue as a Staff Fellow upon termination of employment by or service to the Member Medical Board.

PROPOSED AMENDMENT #2
Article II. Classes of Membership, Election and Membership Rights
Section C. Honorary Fellows

Thirty-six months after completion of service on a Member Medical Board, a Board Member Fellow as defined in section B, paragraph 1 shall become an Honorary Fellow of the FSMB thirty-six months after completion of service on a Member Medical Board. A Staff Fellow as defined in Section B, paragraph 2 shall become an Honorary Fellow of the FSMB upon termination of employment by or service to the Member Medical Board. An Honorary Fellow of the FSMB may be appointed by the Chair to serve as a member of any committee or in any other appointive capacity.

PROPOSED AMENDMENT #3
Article II. Classes of Membership, Election and Membership Rights
Section D. Associate Members

A Member Medical Board may designate one or more employees or staff members, other than an individual designated as a Staff Fellow, to be an Associate Member of the FSMB. No Associate Member individual shall continue in that capacity as an Associate Member upon termination of employment by or service to the Member Medical Board.

PROPOSED AMENDMENT #4
Article III. Officers: Election and Duties
Section A. Officers of the FSMB

1. OFFICERS. The officers of the FSMB shall be that of Chair, Chair-elect, Treasurer and Secretary.
2. Only an individual who is a Fellow as defined in Article II, Section B, Paragraph 1 at the time of the individual’s election or appointment shall be eligible for election or appointment as an Officer of the FSMB, except for the position of Secretary.
3. The position of Secretary shall be an ex-officio office, without vote, and the President of the FSMB shall serve as Secretary.

PROPOSED AMENDMENT #5
Article IV. Board of Directors
Section A. Membership and Terms

1. MEMBERSHIP: The Board of Directors shall be composed of the Officers, the Immediate Past Chair, nine Directors-at-Large and two Associate Members Staff Fellows. At least
two members of the Board, who are not Associate Members Staff Fellows, shall be non-physicians, at least one of whom shall be a public/consumer member.

2. NOMINATION OF ASSOCIATE MEMBERS STAFF FELLOWS: Nominations for Associate Member Staff Fellow positions shall be accepted from Member Boards, the Board of Directors and the Administrators in Medicine (AIM). Associate Members Staff Fellows shall be elected appointed by the Board of Directors in staggered terms in accordance with policies and procedures established by the Board of Directors.

3. TERMS: Directors-at-Large shall each serve for a term of three years and shall be eligible to be reelected to one additional term. Staff Fellows shall serve for a term of two years and shall be eligible to be reappointed to one additional term. A partial term totaling one-and-a-half years or more shall count as a full term. Associate Members shall each serve for a term of two years. Associate Members shall not be eligible to serve consecutive terms.

PROPOSED AMENDMENT #6
Article IV. Board of Directors
Section F. Vacancies

1. DIRECTORS-AT-LARGE: In the event of a vacancy in the membership of the Directors-at-Large, the Board of Directors may appoint a Fellow who meets the qualifications for the position to serve until the next Annual Meeting of the House of Delegates, at which time an individual shall be nominated and, if elected, shall serve for the remainder of the unexpired term. In the event a Director-at-Large is elected to the office of Treasurer or Chair-elect, that vacancy shall be filled by an election at the same Annual Meeting of the House of Delegates.

2. ASSOCIATE MEMBERS STAFF FELLOWS: In the event of a vacancy of an Associate Member a Staff Fellow, the Board of Directors may appoint a substitute to complete the Associate Member’s Staff Fellow’s term in accordance with the policies established by the Board of Directors.

PROPOSED AMENDMENT #7
Article IV. Board of Directors
Section G. Executive Committee of the Board

1. MEMBERSHIP: The Board of Directors shall establish an Executive Committee of the Board, which shall consist of the Chair as Chair, Chair-elect, Treasurer, Immediate Past Chair and two three Directors-at-Large. The Directors-at-Large shall be elected for a one-year term by majority vote of the Directors-at-Large and the Associate Members of Staff Fellows serving on the Board of Directors at the first regular meeting of the Board following the annual meeting of the House of Delegates. In the event of a vacancy in a Director-at-Large position, the Directors-at-Large and the Associate Members of Staff Fellows serving on the Board, by majority vote, shall choose another Director-at-Large to serve the remainder of the one-year term. A Staff Fellow may serve in one of the
Director-at-Large positions. No more than one Staff Fellow may serve on the Executive Committee at any one time. In the event of vacancy in the position of Immediate Past Chair, this position shall remain vacant until the next Annual Meeting of the House of Delegates.

**Bylaws Proposal #2/ Proposed Amendments #8-23 (Proposed by the Bylaws Committee)**

Bylaws Proposal #2 can be found in its entirety behind Attachment 2 and contains sixteen (16) proposed amendments (#8-24) within Article II. Classes of Membership, Election and Membership Rights; Article III. Officers: Election and Duties; Article IV. Board of Directors; Article V. Nomination by Petition for Board of Directors and Nominating Committee; and Article VII. Meetings. For discussion purposes, these proposed amendments are divided into three sections.

1) Proposed Amendments #8-13 to Articles III and IV address the Bylaws Committee’s recommendation that the Bylaws be changed so that the FSMB Immediate Past Chair is considered an Officer of the corporation given that when a Fellow is elected Chair-elect, the individual is expected to serve for three years: one year as Chair-elect; one year as Chair: and one year as Immediate Past Chair. The individual is also a standing member of the Executive Committee during those three years.

Accordingly, the Bylaws Committee recommends the House of Delegates **ADOPT proposed Amendments #8-13 as follows:**

**Proposed Amendment #8**

Article III. Officers: Election and Duties

Section A. Officers of the FSMB

1. Officers. The officers of the FSMB shall be that of Chair, Chair-elect, **Immediate Past Chair**, Treasurer and Secretary.

**Proposed Amendment #9**

Article III. Officers: Election and Duties

Section B. Election of Officers

1. The Chair-elect shall ascend to the position of Chair at the Annual Meeting following the meeting in which the Chair-elect was elected.

2. The Chair-elect shall be elected at each Annual Meeting of the House of Delegates.

3. **The Immediate Past Chair assumes that position upon the Chair-elect ascending to the position of Chair.**
The Treasurer shall be elected every third year at the Annual Meeting of the House of Delegates.

Officers shall be elected by a majority of the members of the House of Delegates present and voting.

In any election, should no candidate receive a majority of the votes cast, a runoff election shall be held between the two candidates who receive the most votes for that office on the first ballot. Up to two additional runoff elections shall be held.

Prior to each election, the presiding officer shall cast a sealed vote that shall be counted only to resolve a tie that cannot be decided by the process set forth in this section.

**PROPOSED AMENDMENT #10**

Article III. Officers: Election and Duties
Section C. Duties of Officers

3. The duties of the Immediate Past Chair shall be as follows:
   a. Assist the Chair in the transition from Chair-elect to Chair;
   b. Serve as chair of the Nominating Committee; and
   c. Perform such other duties and responsibilities as the Chair shall determine.

34. The duties of the Treasurer shall be as follows:
   a. Perform the duties customary to that office;
   b. Perform such other duties as the Bylaws and custom and parliamentary usage may require or as the Board of Directors shall deem appropriate;
   c. Serve as an ex officio member of the Audit Committee; and
   d. Serve as chair of the Finance Committee.

45. The duties of the Secretary shall be as follows:
   a. Administer the affairs of the FSMB; and
   b. Such duties and responsibilities as the FSMB and the Board of Directors shall determine.

**PROPOSED AMENDMENT #11**

Article III. Officers: Election and Duties
Section D. Terms of Office and Succession

1. The Chair and Chair-elect shall serve for single terms of one year or until their successors assume office.

2. **The Immediate Past Chair shall serve until a successor to the current Chair assumes office.**

23. The Treasurer shall serve for a single term of three years or until the Treasurer’s successor assumes the office.

34. Officers shall assume office upon final adjournment of the Annual Meeting of the House of Delegates at which they were elected.

45. The term of the Secretary is co-terminus with that of the President.
PROPOSED AMENDMENT #12

Article III. Officers: Election and Duties
Section E. Vacancies

3. In the event of a vacancy in the office of Immediate Past Chair, the office shall remain open until a new Chair assumes the office.

34. In the event of a vacancy in the office of the Treasurer, the Board of Directors shall elect one of the Directors-at-Large to serve as Treasurer, with one vote on the Board of Directors and one vote on the Executive Committee, until the next year’s Annual Meeting of the House of Delegates, at which time a Treasurer shall be elected.

PROPOSED AMENDMENT #13

Article IV. Board of Directors
Section A. Membership and Terms

1. MEMBERSHIP: The Board of Directors shall be composed of the Officers, the Immediate Past Chair, nine Directors-at-Large and two Associate Members. At least two members of the Board, who are not Associate Members, shall be non-physicians, at least one of whom shall be a public/consumer member.

2) Proposed Amendment #14 to Article IV addresses the Bylaws Committee’s recommendation that the Bylaws be changed to offer greater clarity about the process for removing an individual from the Board of Directors. Accordingly, the Bylaws Committee recommends the House of Delegates ADOPT proposed Amendment #14 as follows:

PROPOSED AMENDMENT #14

Article IV. Board of Directors
Section E. Removal from Office

1. REMOVAL: Any officer or member of the Board of Directors may be removed for any cause deemed sufficient by an affirmative vote of two-thirds of the total members of the Board of Directors entitled to vote and who are not subject to removal from office.

2. PROCEDURE: The procedure for removal shall be as follows:
   a. The Board shall file with the Secretary of the Board and deliver a written statement of the cause for removal to the officer or board member in sufficient detail as to state the grounds for the removal. Delivery to the officer or board member shall be by certified mail, return receipt requested, to the last address known to the Board and is effective upon mailing.
   b. The officer or board member shall deliver a sworn written response to the Board, no later than thirty calendar days after the written statement of the cause for removal is delivered to the officer or board member in question. Delivery to the Board shall be by certified mail, return receipt requested,
directed to the Secretary of the Board at the FSMB corporate office. **Delivery is effective upon mailing.**

c. At the **next** Board meeting **following the date the response is due,** the Board shall determine whether or not to proceed with removal. Notice of the Board’s action shall be delivered to the officer or Board member by certified mail, return receipt requested. If the officer or board member **did does** not file a written response the Board shall proceed with a determination. **Delivery is effective upon mailing.**

d. If the Board votes to proceed with removal of the officer or Board member, at a Board meeting **held no less than thirty days after delivery of the notice,** the Board member shall be afforded the opportunity to address the Board on the merits of the allegations and produce any relevant information to the Board after which the Board shall make a determination. **The Board meeting at which the officer or board member has the opportunity to address the Board shall be held no less than thirty days after delivery of the notice of removal.**

3. **APPEAL:** Any officer or member of the Board of Directors removed by the Board of Directors may appeal to the House of Delegates at its next business meeting. The officer or member may be reinstated by a two-thirds vote of the House of Delegates.

4. **DELIVERY:** For the purposes of this section, “**Delivery**” is effective upon mailing.

3) **Proposed Amendments #15-24** to Articles II, IV, V and VII address the Bylaws Committee’s recommendation that the Bylaws be changed to reflect an increase in the Executive Committee from two to three Directors-at-Large, minor editorial improvements. Accordingly, the Bylaws Committee recommends the House of Delegates **ADOPT proposed Amendments #15-24 as follows:**

**PROPOSED AMENDMENT #15**

Article II. Classes of Membership, Election and Membership Rights

Section B. Fellows

An individual member who as a result of appointment or confirmation is designated to be a member of a Member Medical Board shall be a Fellow of the FSMB during the member’s period of service on a Member Medical Board, and for a period of **36 thirty-six** months thereafter.

**PROPOSED AMENDMENT #16**

Article IV. Board of Directors

Section B. Nominations

2. The Nominating Committee shall mail its roster of candidates to Member Boards not fewer than **60 sixty** days prior to the Annual Meeting of the House of Delegates.
PROPOSED AMENDMENT #17
Article IV. Board of Directors
Section D. Duties of the Board of Directors

2. The Board of Directors shall carry out the mandates of the FSMB as established by the House of Delegates, and it shall have full and complete power and authority to perform all acts and to transact all business for and on behalf of the FSMB.

PROPOSED AMENDMENT #18
Article IV. Board of Directors
Section F. Vacancies

1. DIRECTORS-AT-LARGE: In the event of a vacancy in the membership of the Directors-at-Large, the Board of Directors may appoint a Fellow who meets the qualifications for the position to serve until the next Annual Meeting of the House of Delegates, at which time an individual a Fellow shall be nominated and, if elected, and shall serve for the remainder of the unexpired term. In the event a Director-at-Large is elected to the office of Treasurer or Chair-elect, that vacancy shall be filled by an election at the same Annual Meeting of the House of Delegates.

PROPOSED AMENDMENT #19
Article IV. Board of Directors
Section G. Executive Committee of the Board

1. MEMBERSHIP: The Board of Directors shall establish an Executive Committee of the Board, which shall consist of the Chair as Chair, Chair-elect, Treasurer, Immediate Past Chair and two three Directors-at-Large. The Directors-at-Large shall be elected for a one-year term by majority vote of the Directors-at-Large and the Associate Members of the Board of Directors at the first regular meeting of the Board following the Annual Meeting of the House of Delegates. In the event of a vacancy in a Director-at-Large position, the Directors-at-Large and the Associate Members of the Board, by majority vote, shall choose another Director-at-Large to serve the remainder of the one-year term. In the event of vacancy in the position of Immediate Past Chair, this position shall remain vacant until the next Annual Meeting of the House of Delegates.

PROPOSED AMENDMENT #20
Article V. Nomination by Petition for Board of Directors and Nominating Committee
Section A. Submission of a Petition

3. The deadline to submit petitions to the Administrative Staff is 21 twenty-one days prior to the Annual Meeting.
PROPOSED AMENDMENT #21
Article V. Nomination by Petition for Board of Directors and Nominating Committee
Section B. Validation and Placement on Ballot

3. The names of those seeking to run by petition whose petitions are deemed valid shall be
distributed to the Voting Delegates not fewer than 14 fourteen days prior to the Annual
Meeting.

PROPOSED AMENDMENT #22
Article VII. Meetings
Section A. Annual Meeting of the House of Delegates

The annual meeting of the House of Delegates of the FSMB, which shall be called the House
of Delegates, shall be held at such time and place as may be fixed by the Board of Directors.
Written notice of the time and place of the meeting shall be given to all Member Medical
Boards by mail not fewer than 90 ninety days prior to the date of the meeting. Notice is
effective upon mailing.

PROPOSED AMENDMENT #23
Article VII. Meetings
Section B. Special Meetings of the House of Delegates

Special meetings of the House of Delegates may be called at any time by the Chair, on the
written request of ten Member Medical Boards or by action of the Board of Directors.
Written notice of the time and place of such meetings shall be given to all Member Medical
Boards by mail not fewer than 30 thirty days prior to the date of the meeting. Notice is
effective upon mailing.

PROPOSED AMENDMENT #24
Article XIV. Adoption and Amendment of Bylaws, Effective Date
Section A. Amendment

These Bylaws may be amended at any annual meeting of the House of Delegates by two-
thirds of those present and voting. Bylaws changes may be proposed only by the Board of
Directors, Member Medical Boards or the Bylaws Committee and its members. All such
proposals must be submitted in writing to the Bylaws Committee, in care of the Secretary of
the FSMB. The Bylaws Committee shall inform the Member Medical Boards of its meeting
dates not fewer than 60 sixty days in advance of the meeting. The recommendations of the
Bylaws Committee and the full texts of all proposed amendments recommended to the
Committee shall be sent to each Member Medical Board not fewer than 60 sixty days prior to
the Annual Meeting of the House of Delegates at which they are to be considered.
BYLAWS PROPOSAL #3/ PROPOSED AMENDMENT #25 (PROPOSED BY THE BYLAWS COMMITTEE)

Bylaws Proposal #3 can be found in its entirety behind Attachment 3 and contains one (1) proposed amendment (#25) within Article VIII. Standing and Special Committees.

The Bylaws Committee proposes that Article VIII be changed to allow the FSMB Chair an opportunity to appoint an Associate Member to the Editorial Committee should the Chair so choose. Accordingly, the Bylaws Committee recommends the House of Delegates ADOPT proposed Amendment #25 as follows:

PROPOSED AMENDMENT #25

Article VIII. Standing and Special Committees
Section D. Editorial Committee

1. An Editorial Committee, not to exceed twelve Fellows and three non-member subject matter experts non-Fellows, at least two of whom shall be subject matter experts, shall advise the Editor-in-Chief on editorial policy for the FSMB’s official publication, and shall serve as the editorial board of that publication and otherwise assist the Editor-in-Chief in the performance of duties as appropriate and necessary. No officer or member of the Board of Directors shall serve on this Committee.

BYLAWS PROPOSAL #4/ PROPOSED AMENDMENT #26 (PROPOSED BY THE TENNESSEE BOARD OF MEDICAL EXAMINERS)

Bylaws Proposal #4 can be found in its entirety behind Attachment 4 and contains one (1) proposed amendment (#26) within Article IV. Board of Directors.

The Tennessee Board of Medical Examiners proposes that Article IV be changed to allow the inclusion of two (2) public/consumer members, who are not Associate Members, to serve on the Board of Directors as follows:

PROPOSED AMENDMENT #26

Article IV. Board of Directors
Section A. Membership and Terms

1. MEMBERSHIP: The Board of Directors shall be composed of the Officers, the Immediate Past Chair, nine Directors-at-Large and two Associate Members. At least two members of the Board, who are not Associate Members, shall be non-physicians, at least one of whom shall be a public/consumer member.

The Tennessee Board suggests that this modification to the Bylaws makes clear that the public/consumer members’ participation and perspective on the Board is valued and aligned with
the Member Medical Boards of the FSMB, and notes that non-physician members can still be
elected to the Board if they are Fellows of the FSMB.

The Bylaws Committee considered the Tennessee Board’s position and discussed the current
process for electing Fellows to the Board of Directors, which begins with the election of the
requisite number of non-physicians and public/consumer members and a ballot that only includes
the non-physician and public/consumer member candidates. After those positions are filled, any
non-physician or public/consumer member candidate not elected at that time is included on the
next ballot with the physician candidates.

The Bylaws Committee opined that while it is true that the Tennessee Board’s proposed change
to the Bylaws would still provide an opportunity for non-physicians (who are not
public/consumer members because of their nexus to healthcare) to be elected to the Board, they
would not have the added benefit of being considered independently of physicians, which might
discourage a non-physician, such as a physician assistant, from running for election because of a
perception that voting delegates would likely favor the physicians.

Given the importance of this issue, the Bylaws Committee agreed that additional discussion is
needed to consider all of the possible ramifications of this proposed change as well as how it
might affect the rest of the Bylaws. The Committee also concurred that because of the
significance of the changes being presented to the House of Delegates in Proposal 1, it would be
best to act on Proposal 4 in 2019. Therefore, the Bylaws Committee recommends the House of
Delegates TABLE proposed Amendment #26 until the Bylaws Committee can make its final
recommendation to the House in 2019.
ARTICLE I. NAME

The corporation shall be known as the Federation of State Medical Boards of the United States, Inc. (“FSMB”).

ARTICLE II. CLASSES OF MEMBERSHIP, ELECTION AND MEMBERSHIP RIGHTS

SECTION A. MEMBER MEDICAL BOARDS

The term “Member Medical Board” as used in the Articles of Incorporation and in these Bylaws shall refer to any board, committee or other group in any state, territory, the District of Columbia or possession of the United States of America that is empowered by law to pass on the qualifications of applicants for licensure to practice allopathic or osteopathic medicine or to discipline such licensees. If a state or other jurisdiction has more than one such entity and if each is an independent agency unrelated to the others, each is eligible for membership. Any eligible Medical Board may become a Member Medical Board upon approval of its application by the Board of Directors.

SECTION B. FELLOWS

There shall be two categories of Fellow of the FSMB:

1. Board Member Fellow. A Board Member Fellow is an individual member who as a result of appointment or confirmation is designated to be a member of a Member Medical Board. A Board Member Fellow shall be a Fellow of the FSMB during the member’s period of service on a Member Medical Board, and for a period of 36 months thereafter, and

2. Staff Fellow. A Staff Fellow is an individual hired or appointed and who is responsible for the day-to-day supervision and performance of the administrative duties and functions for which a medical board is responsible. Each member board may denote only one individual to serve as a Staff Fellow of the FSMB. No individual shall continue as a Staff Fellow upon termination of employment by or service to the Member Medical Board.
SECTION C. HONORARY FELLOWS

Thirty-six months after completion of service on a Member Medical Board, a Member Fellow as defined in section B, paragraph 1 shall become an Honorary Fellow of the FSMB thirty-six months after completion of service on a Member Medical Board. A Staff Fellow as defined in Section B, paragraph 2 shall become an Honorary Fellow of the FSMB upon termination of employment by or service to the Member Medical Board. An Honorary Fellow of the FSMB and may be appointed by the Chair to serve as a member of any committee or in any other appointive capacity.

SECTION D. ASSOCIATE MEMBERS

A Member Medical Board may designate one or more employees or staff members, other than an individual designated as a Staff Fellow, to be an Associate Member of the FSMB. No Associate Member individual shall continue in that capacity as an Associate Member upon termination of employment by or service to the Member Medical Board.

SECTION E. COURTESY MEMBERS

Any physician or physician assistant licensed by a Member Medical Board or an Affiliate Member Board and not eligible for any other type of membership may become a Courtesy Member of the FSMB upon approval of the candidate’s application. A Courtesy Member may serve as a member of a committee and in any other capacity upon appointment by the Chair.

SECTION F. AFFILIATE MEMBERS BOARDS

A board or authority that is not otherwise eligible for membership may become an Affiliate Member Board of the FSMB upon approval of its application by the Board of Directors if the board or authority licenses either:

1. Allopathic or osteopathic physicians or physician assistants in the United States; or
2. Allopathic or osteopathic physicians if the board or authority is located in another country.

SECTION G. OFFICIAL OBSERVERS

An organization may apply for Official Observer status at meetings of the House of Delegates. The Board of Directors shall prescribe rules and procedures to govern the application for, the granting of and the exercise of Official Observer status.
SECTION H. RIGHTS OF MEMBERS

Except as otherwise provided in these Bylaws, rights, duties, privileges and obligations of a member of the FSMB may be exercised only by a Member Medical Board.

SECTION I. METHODS OF NOMINATION TO ELECTED OFFICE

Nomination by the Nominating Committee or Nomination by Petition pursuant to Articles III, IV, V and VIII shall be the sole methods of nomination to an elected office of the FSMB. A candidate who runs for and is not elected to an elected office shall be ineligible to be nominated for any other elected office during the same election cycle.

ARTICLE III. OFFICERS: ELECTION AND DUTIES

SECTION A. OFFICERS OF THE FSMB

1. OFFICERS. The officers of the FSMB shall be that of Chair, Chair-elect, Treasurer and Secretary.

2. Only an individual who is a Fellow as defined in Article II, Section B, Paragraph 1 at the time of the individual's election or appointment shall be eligible for election or appointment as an Officer of the FSMB, except for the position of Secretary.

3. The position of Secretary shall be an ex-officio office, without vote, and the President of the FSMB shall serve as Secretary.

SECTION B. ELECTION OF OFFICERS

1. The Chair-elect shall ascend to the position of Chair at the Annual Meeting following the meeting in which the Chair-elect was elected.

2. The Chair-elect shall be elected at each Annual Meeting of the House of Delegates.

3. The Treasurer shall be elected every third year at the Annual Meeting of the House of Delegates.

4. Officers shall be elected by a majority of the members of the House of Delegates present and voting.

5. In any election, should no candidate receive a majority of the votes cast, a runoff election shall be held between the two candidates who receive the most votes for that office on the first ballot. Up to two additional runoff elections shall be held.
6. Prior to each election, the presiding officer shall cast a sealed vote that shall be counted only to resolve a tie that cannot be decided by the process set forth in this section.

**SECTION C. DUTIES OF OFFICERS**

1. The duties of the Chair shall be as follows:
   a. Preside at all meetings and sessions of the House of Delegates and the Board of Directors;
   b. Perform the duties customary to the office of the Chair;
   c. Make appointments to committees and define duties of committee members in accordance with these Bylaws, except as otherwise provided herein;
   d. Serve, ex officio, on all committees except as otherwise provided herein; and
   e. Exercise such other rights and customs as the Bylaws and parliamentary usage may require or as the FSMB or the Board of Directors shall deem appropriate.

2. The duties of the Chair-elect shall be as follows:
   a. Assist the Chair in the discharge of the Chair’s duties; and
   b. Perform the duties of the Chair at the Chair’s request or, in the event of the Chair’s temporary absence or incapacitation, at the request of the Board of Directors.

3. The duties of the Treasurer shall be as follows:
   a. Perform the duties customary to that office;
   b. Perform such other duties as the Bylaws and custom and parliamentary usage may require or as the Board of Directors shall deem appropriate;
   c. Serve as an ex officio member of the Audit Committee; and
   d. Serve as chair of the Finance Committee.

4. The duties of the Secretary shall be as follows:
   a. Administer the affairs of the FSMB; and
   b. Such duties and responsibilities as the FSMB and the Board of Directors shall determine.
SECTION D. TERMS OF OFFICE AND SUCCESSION

1. The Chair and Chair-elect shall serve for single terms of one year or until their successors assume office.

2. The Treasurer shall serve for a single term of three years or until the Treasurer’s successor assumes the office.

3. Officers shall assume office upon final adjournment of the Annual Meeting of the House of Delegates at which they were elected.

4. The term of the Secretary is co-terminus with that of the President.

SECTION E. VACANCIES

1. In the event of a vacancy in the office of the Chair, the Chair-elect shall assume the position of Chair for the remainder of the unexpired term, and shall then serve a full one-year term as Chair.

2. In the event of a vacancy in the office of the Chair-elect, the Board of Directors shall appoint a Director-at-Large to assume the duties, but not the office, of Chair-elect for the remainder of the unexpired term. At the next Annual Meeting of the House of Delegates, both a Chair and a Chair-elect shall be elected in accordance with the provisions in Section B of this Article.

3. In the event of a vacancy in the office of the Treasurer, the Board of Directors shall elect one of the Directors-at-Large to serve as Treasurer, with one vote on the Board of Directors and one vote on the Executive Committee, until the next year’s Annual Meeting of the House of Delegates, at which time a Treasurer shall be elected.

ARTICLE IV. BOARD OF DIRECTORS

SECTION A. MEMBERSHIP AND TERMS

1. MEMBERSHIP: The Board of Directors shall be composed of the Officers, the Immediate Past Chair, nine Directors-at-Large and two Associate Members Staff Fellows. At least two members of the Board, who are not Associate Members Staff Fellows, shall be non-physicians, at least one of whom shall be a public/consumer member.

2. NOMINATION OF ASSOCIATE MEMBERS STAFF FELLOWS: Nominations for Associate Member Staff Fellow positions shall be accepted from Member Boards, the Board of Directors and the Administrators in Medicine (AIM). Associate Members Staff Fellows shall be elected
appointed by the Board of Directors in staggered terms in accordance with policies and procedures established by the Board of Directors.

3. ** TERMS:** Directors-at-Large shall each serve for a term of three years and shall be eligible to be reelected to one additional term. **Staff Fellows shall serve for a term of two years and shall be eligible to be reappointed to one additional term.** A partial term totaling one-and-a-half years or more shall count as a full term. **Associate Members shall each serve for a term of two years. Associate Members shall not be eligible to serve consecutive terms.**

**SECTION B. NOMINATIONS**

1. The Nominating Committee shall submit a roster of one or more candidates for each of the offices and positions to be filled by election at the Annual Meeting of the House of Delegates.

2. The Nominating Committee shall mail its roster of candidates to Member Boards not fewer than 60 days prior to the Annual Meeting of the House of Delegates.

**SECTION C. ELECTION OF DIRECTORS-AT-LARGE**

1. At least three of the Directors-at-Large shall be elected each year at the Annual Meeting of the House of Delegates by a majority of the votes cast.

2. If no candidate receives a majority of the votes on the first ballot, and one seat is to be filled, a runoff election shall be held between the two candidates who received the most votes on the first ballot.

3. If more than one seat is to be filled from a single list of candidates, and if one or more seats are not filled by majority vote on the first ballot, a runoff election shall be held, with the ballot listing candidates equal in number to twice the number of seats remaining to be filled. These candidates shall be those remaining who received the most votes on the first ballot. The same procedure shall be used for any required subsequent runoff elections. In the event of a tie vote in a runoff election up to two additional runoff elections shall be held.

4. Prior to the election, the presiding officer shall cast a sealed vote, ranking each candidate in a list. The presiding officer’s vote is counted for the candidate in the runoff election who is highest on the list. The presiding officer’s vote is counted only to resolve a tie that cannot be decided by the process set forth in this section.

5. Directors shall assume office upon final adjournment of the Annual Meeting of the House of Delegates at which they were elected.
6. Only an individual who is a Fellow at the time of the individual’s election shall be eligible for
election as a Director of the FSMB.

SECTION D. DUTIES OF THE BOARD OF DIRECTORS

1. The control and administration of the FSMB is vested in the Board of Directors and it shall act
for the FSMB between Annual Meetings.

2. The Board of Directors shall carry out the mandates of the FSMB as established by the House
of Delegates, and it shall have full and complete power and authority to perform all acts and to
transact all business for and on behalf of the FSMB.

3. The Board of Directors shall conduct and manage all property, affairs, work and activities of
the FSMB, subject only to the provisions of the Articles of Incorporation and these Bylaws and
to resolutions and enactments of the House of Delegates.

4. The Board of Directors shall be the fiscal agent of the FSMB.

5. The Board of Directors shall establish rules for its operations and meetings.

6. The FSMB shall indemnify Directors, Officers and other individuals acting on behalf of the
FSMB if such indemnification is in accordance with the laws of the State of Nebraska and the
operational policies and procedures of the Board of Directors, as adopted. The Board shall
report to the membership of the FSMB at the Annual Meeting of the House of Delegates.

7. The Board of Directors shall establish a strategic plan for the FSMB that states the FSMB
mission and objectives and shall submit that plan to the House of Delegates for ratification,
modification or rejection. The Board shall review the current strategic plan annually and
propose any amendments to the Annual Meeting of the House of Delegates for ratification,
modification or rejection. The President shall report to the Annual Meeting of the House of
Delegates on the extent to which the FSMB’s stated objectives have been accomplished in the
preceding year.

SECTION E. REMOVAL FROM OFFICE

1. REMOVAL: Any officer or member of the Board of Directors may be removed for any cause
deemed sufficient by an affirmative vote of two-thirds of the total members of the Board of
Directors entitled to vote and who are not subject to removal from office.

2. PROCEDURE: The procedure for removal shall be as follows:
a. The Board shall file with the Secretary of the Board and deliver a written statement of the cause for removal to the officer or board member in sufficient detail as to state the grounds for the removal. Delivery to the officer or member shall be by certified mail, return receipt requested, to the last address known to the Board and is effective upon mailing.

b. The officer or board member shall deliver a sworn written response to the Board no later than thirty calendar days after the written statement is filed with the Secretary of the Board. Delivery to the Board shall be by certified mail, return receipt requested, directed to the Secretary of the Board at the FSMB corporate office. Delivery is effective upon mailing.

c. At the next Board meeting, the Board shall determine whether or not to proceed with removal. Notice of the Board’s action shall be delivered to the officer or Board member by certified mail, return receipt requested. If the officer or board member did not file a written response the Board shall proceed with a determination. Delivery is effective upon mailing.

d. If the Board votes to proceed with removal of the officer or Board member, at a Board meeting held no less than thirty days after delivery of the notice, the Board member shall be afforded the opportunity to address the Board on the merits of the allegations and produce any relevant information to the Board after which the Board shall make a determination.

3. APPEAL: Any officer or member of the Board of Directors removed by the Board of Directors may appeal to the House of Delegates at its next business meeting. The officer or member may be reinstated by a two-thirds vote of the House of Delegates.

SECTION F. VACANCIES

1. DIRECTORS-AT-LARGE: In the event of a vacancy in the membership of the Directors-at-Large, the Board of Directors may appoint a Fellow who meets the qualifications for the position to serve until the next Annual Meeting of the House of Delegates, at which time an individual shall be nominated and, if elected, shall serve for the remainder of the unexpired term. In the event a Director-at-Large is elected to the office of Treasurer or Chair-elect, that vacancy shall be filled by an election at the same Annual Meeting of the House of Delegates.

2. ASSOCIATE MEMBER'S STAFF FELLOWS: In the event of a vacancy of an Associate Member a Staff Fellow, the Board of Directors may appoint a substitute to complete the Associate Member’s Staff Fellow’s term in accordance with the policies established by the Board of Directors.
**SECTION G. EXECUTIVE COMMITTEE OF THE BOARD**

1. **MEMBERSHIP:** The Board of Directors shall establish an Executive Committee of the Board, which shall consist of the Chair as Chair, Chair-elect, Treasurer, Immediate Past Chair and two three Directors-at-Large. The Directors-at-Large shall be elected for a one-year term by majority vote of the Directors-at-Large and the Associate Members of Staff Fellows serving on the Board of Directors at the first regular meeting of the Board following the annual meeting of the House of Delegates. In the event of a vacancy in a Director-at-large position, the Directors-at-Large and the Associate Members of Staff Fellows serving on the Board, by majority vote, shall choose another Director-at-Large to serve the remainder of the one-year term. A Staff Fellow may serve in one of the Director-at-Large positions. No more than one Staff Fellow may serve on the Executive Committee at any one time. In the event of a vacancy in the position of Immediate Past Chair, this position shall remain vacant until the next Annual Meeting of the House of Delegates.

2. **DUTIES:** In intervals between Board meetings, the Executive Committee shall act for and on behalf of the Board in any matters that require prompt attention. It shall not modify actions previously taken by the Board unless additional information or a change of circumstances is presented and warrants additional action.

3. **MEETINGS:** The Executive Committee may meet as often as it deems necessary or appropriate, either in person, telephonically, electronically or by unanimous written consent, and at such times and places and manner as the Chair may determine. Minutes must be kept of all meetings.

4. **REPORTING:** The Executive Committee shall report in writing all formal actions taken by it to the Board of Directors within five working days of taking those actions. At each meeting of the Board, the Executive Committee shall present to the Board a written report of all its formal actions since the previous meeting of the Board.

**SECTION H. PUBLIC POLICY STATEMENTS**

A “public policy” is defined as the official public position of the FSMB on a matter that may be reasonably expected to affect Member Boards when dealing with their licensees, other health care providers, health-related special interest groups, governmental bodies or the public. The House of Delegates is the official public policy-making body of the FSMB. When the interests of the FSMB require more immediate action, the Board of Directors, or the President in consultation with the
Chair, if feasible, is authorized to issue statements on matters of public policy between Annual Meetings.

**ARTICLE V. NOMINATION BY PETITION FOR BOARD OF DIRECTORS AND NOMINATING COMMITTEE**

**SECTION A. SUBMISSION OF A PETITION**

1. At the time the Nominating Committee’s roster of candidates is distributed to the Member Boards, the Boards will be informed that a Fellow who is qualified for nomination, but not otherwise nominated by the Nominating Committee, may seek to run for a position on the Board of Directors as an Officer or Director-at-Large, or for a position on the Nominating Committee.

2. In order to be placed on the ballot, the Fellow seeking nomination is required to present a petition to Administrative Staff that is signed by at least one Fellow from at least four Member Boards as well as a fellow from the Board of the member seeking nomination.

3. The deadline to submit petitions to the Administrative Staff is 21 days prior to the Annual Meeting.

**SECTION B. VALIDATION AND PLACEMENT ON BALLOT**

1. The Administrative Staff shall verify that all signatures on the petition are valid. “Valid” is defined as the person who is seeking nomination and the persons who signed the petition are Fellows as defined in the FSMB Bylaws.

2. Once verified, the petitions are deemed valid and the candidate is placed on the ballot.

3. The names of those seeking to run by petition whose petitions are deemed valid shall be distributed to the Voting Delegates not fewer than 14 days prior to the Annual Meeting.

4. Once a candidate seeking to run by petition is added to the ballot, the candidate shall be afforded the same privileges and be bound by the same rules in the campaign process as candidates who were nominated by the Nominating Committee.

**ARTICLE VI. PRESIDENT**

The Board of Directors may, by a two-thirds majority vote of the full Board, appoint a President of the FSMB, who shall be a physician, to serve without term. The President shall administer the affairs of the FSMB and shall have such duties and responsibilities as the Board of Directors and
the FSMB shall direct. The President shall serve as Secretary of the FSMB and shall be an ex-
officio member, without vote, of the Board of Directors.

**ARTICLE VII. MEETINGS**

**SECTION A. ANNUAL MEETING OF THE HOUSE OF DELEGATES**

The annual meeting of the House of Delegates of the FSMB, which shall be called the House of
Delegates, shall be held at such time and place as may be fixed by the Board of Directors. Written
notice of the time and place of the meeting shall be given to all Member Medical Boards by mail
not fewer than 90 days prior to the date of the meeting.

**SECTION B. SPECIAL MEETINGS OF THE HOUSE OF DELEGATES**

Special meetings of the House of Delegates may be called at any time by the Chair, on the written
request of ten Member Medical Boards or by action of the Board of Directors. Written notice of the
time and place of such meetings shall be given to all Member Medical Boards by mail not fewer
than 30 days prior to the date of the meeting.

**SECTION C. RIGHT TO VOTE**

1. The right to vote at meetings of the House of Delegates is vested in, and restricted to, Member
Medical Boards. Each Member Medical Board is entitled to one vote, said vote to be cast by
the delegate of the Member Board. The delegate shall be the president of the Member Medical
Board or the President’s designated alternate. In order for a delegate to be permitted to vote,
the delegate shall present a letter of appointment to the Secretary of the Board of Directors.

2. All classes of membership shall have the right of the floor at meetings of the House upon
request of a delegate and approval of the presiding officer; however, 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.

**SECTION D. QUORUM**

A majority of Member Medical Boards shall constitute a quorum at any meeting of the House of
Delegates. A majority of the voting members of the Board of Directors or any committee or other
constituted group shall constitute a quorum of the Board, committee or group.
SECTION E. RULES OF ORDER

Meetings of the House of Delegates, Board of Directors and all committees shall be conducted in accordance with the American Institute of Parliamentarians Standard Code of Parliamentary Procedure, current edition, except when in conflict with the Articles of Incorporation or these Bylaws, in which case the Articles of Incorporation or these Bylaws shall prevail.

ARTICLE VIII. STANDING AND SPECIAL COMMITTEES

SECTION A. STANDING COMMITTEES

1. The Standing Committees of the FSMB shall be:
   a. Audit Committee
   b. Bylaws Committee
   c. Editorial Committee
   d. Education Committee
   e. Ethics and Professionalism Committee
   f. Finance Committee
   g. Nominating Committee

2. ADDITIONAL STANDING COMMITTEES. Additional standing committees may be created by resolution of the FSMB and/or amendment to the Bylaws. Chairs and members of all standing committees, with the exception of the Nominating Committee, shall be appointed by the Chair, with the approval of the Board of Directors, for a term of one year, unless otherwise provided for in these Bylaws. Reappointment, unless specifically prohibited, is permissible.

3. MEMBERSHIP. Honorary Fellows, Associate Members and Courtesy Members may be appointed by the Chair to serve on a standing committee in addition to the number of committee members called for in the following sections of this chapter. No more than one Honorary Fellow, Associate or Courtesy Member or non-member subject matter expert may be appointed by the Chair to serve in such a capacity on any standing committee unless otherwise provided for in these Bylaws. All committee members shall serve with vote. Honorary Fellows, Associate or Courtesy Members, and non-members appointed to standing committees by the Chair shall serve for a term concurrent with the term of the Chair. No individual shall serve on more than one standing committee except as specified in the Bylaws. With the exception of the Nominating Committee and the Editorial Committee, the Chair and the Chair-elect shall serve, ex-officio, on all committees.
4. **VACANCIES.** In the event a vacancy occurs in an elected position on a standing committee, the Chair, with the approval of the Board of Directors, shall appoint a Fellow to serve on the committee until the next meeting of the House of Delegates, at which time an election will be held to fill the vacant position for the remainder of the unexpired term. In the event a vacancy occurs in an appointed position on a standing committee, the Chair, with the approval of the Board of Directors, shall appoint a Fellow to serve on the committee for the remainder of the unexpired term. In the event the Chairmanship of the Nominating Committee becomes vacant, the FSMB Chair, with the approval of the FSMB Board of Directors, shall appoint a Past Chair of the FSMB Board of Directors to serve in that capacity for the remainder of the unexpired term.

**SECTION B. AUDIT COMMITTEE**

The Audit Committee shall:

1. Be composed of five Fellows, three of whom shall be members of the Board of Directors. The Treasurer of the FSMB shall serve ex-officio without vote. The Chair of the FSMB shall appoint the Chair of the Audit Committee from one of the three sitting Board Members.

2. Ensure that an annual audit of the financial accounts and records of the FSMB is performed by an independent Certified Public Accounting firm.

3. Recommend to the Board of Directors the appointment, retention or termination of an independent auditor or auditors and develop a schedule for periodic solicitation of audit firms consistent with Board policies and best practices.

4. Oversee the independent auditors. The independent auditors shall report directly to the Committee.

5. Review the audit of the FSMB. Submit such audit and Committee’s report to the Board of Directors.

6. Report any suggestions to the Board of Directors on fiscal policy to ensure the continuing financial strength of the FSMB.

7. When the finalized committee report to the Board of Directors is made, suggestions and feedback will be forwarded to the Finance Committee.
SECTION C. BYLAWS COMMITTEE

The Bylaws Committee, composed of five Fellows, shall continually assess the Articles of Incorporation and the Bylaws and shall receive all proposals for amendments thereto. It shall, from time to time, make recommendations to the House of Delegates for changes, deletions, modifications and interpretations thereto.

SECTION D. EDITORIAL COMMITTEE

1. An Editorial Committee, not to exceed twelve Fellows and three non-member subject matter experts, shall advise the Editor-in-Chief on editorial policy for the FSMB’s official publication, and shall serve as the editorial board of that publication and otherwise assist the Editor-in-Chief in the performance of duties as appropriate and necessary. No officer or member of the Board of Directors shall serve on this Committee.

2. Service on the Editorial Committee is by nomination and appointment by the FSMB Chair, subject to approval of the Board of Directors, immediately following the Annual Meeting of the House of Delegates. Candidates are allowed to express their interest in serving on the Committee through self-nomination. Committee members shall serve staggered three-year terms and shall be limited to two full terms.

3. The Editor-in-Chief shall be elected by the Editorial Committee to a three-year term beginning on the date of the annual Editorial Committee meeting, with the Editor-in-Chief’s term on the Editorial Committee being automatically extended to allow the Editor-in-chief to serve for three years. A member of the Editorial Committee whose term is expiring shall continue to serve until the member’s replacement meets at the next annual Editorial Committee meeting.

4. The Editorial Committee will elect its Chair, who will serve as the Editor-in-Chief of the Journal of Medical Regulation. The Editor-in-Chief will serve without compensation and will coordinate decisions on the Journal content, among other duties to be determined by the Bylaws Committee.

SECTION E. EDUCATION COMMITTEE

The Education Committee shall be composed of eight Fellows, to include the Chair as chair, the Immediate Past Chair and the Chair-elect. The Committee shall be responsible for assisting in the development of educational programs for the FSMB.
SECTION F. ETHICS AND PROFESSIONALISM COMMITTEE

The Ethics and Professionalism Committee shall be composed of up to five Fellows and up to two subject matter experts. The Ethics and Professionalism Committee shall address ethical and professional issues pertinent to medical regulation.

SECTION G. FINANCE COMMITTEE

The Finance Committee shall be composed of five Fellows, to include the Treasurer as Chair. The Finance Committee shall review the financial condition of the FSMB, review and evaluate the costs of the activities and programs to be undertaken in the forthcoming year, present a budget for the FSMB to the Board of Directors for its recommendation to the House of Delegates at the Annual Meeting and perform such other duties as are assigned to it by the Board of Directors. Except for the Treasurer, no Fellow shall serve on both the Audit and Finance Committees.

SECTION H. NOMINATING COMMITTEE: PROCESS FOR ELECTION

1. MEMBERSHIP: The Nominating Committee shall be composed of six Fellows and the Immediate Past Chair, who shall chair the Committee and serve without vote except in the event of a tie. At least one elected member of the Nominating Committee shall be a public member. With the exception of the Immediate Past Chair, no two Committee members shall be from the same member board and no officer or member of the Board of Directors shall serve on the Committee. A member of the Nominating Committee may not serve consecutive terms.

2. ELECTION: At least three Fellows shall be elected at each Annual Meeting of the House of Delegates by a plurality of votes cast, each to serve for a term of two years. Only an individual who is a Fellow at the time of the individual’s election shall be eligible for election as a member of the Nominating Committee. In the event of a tie vote in a runoff election, up to two additional runoff elections shall be held. Prior to the election, the presiding officer shall cast a sealed vote, ranking each candidate in a list. The presiding officer’s vote is counted for the candidate in the runoff election who is highest on the list. The presiding officer’s vote is counted only to resolve a tie that cannot be decided by the process set forth in this section.

3. Members of the Nominating Committee are not eligible for inclusion on the roster of candidates for offices and positions to be filled by election at the Annual Meeting of the House of Delegates.
SECTION I. SPECIAL COMMITTEES
Special committees may be appointed by the Chair, from time to time, as may be necessary for a specific purpose.

SECTION J. REPRESENTATIVES TO OTHER ORGANIZATIONS AND ENTITIES
Appointment of all representatives of the FSMB to other official organizations or entities shall be made or nominated by the Chair, with the approval of the Board of Directors, as applicable, and shall serve for a term of three years unless the other organization shall specify some other term of appointment. Representatives to these organizations shall be Fellows, Honorary Fellows, Associate Members or Courtesy Members at the time of their appointment or nomination.

ARTICLE IX. UNITED STATES MEDICAL LICENSING EXAMINATION (USMLE)
SECTION A. Except as otherwise set forth in this Article, the composition of committees and subcommittees for the USMLE are subject to agreements with and the advice and consent of the National Board of Medical Examiners (NBME) and/or the USMLE Composite Committee. The Chair, with the approval of the Board of Directors, shall make appointments to the following USMLE committees in appropriate numbers and at appropriate times as required by the FSMB/NBME Agreement establishing the USMLE and by other agreements as may apply:

1. USMLE Composite Committee, which shall be responsible for the development, operation and maintenance of policies governing the three-step USMLE. The President shall be one of the FSMB’s representatives on this Committee.

2. USMLE Budget Committee, which shall be responsible for the development and monitoring of USMLE revenues and expenses, including the establishment of fees. FSMB representatives on the Committee will be the Chair, Chair-elect, Treasurer, President and the senior FSMB financial staff member.

3. The USMLE Management Committee shall be responsible for overseeing the design, development, scoring and standard setting for the USMLE Step examinations, subject to policies established by and reporting to the USMLE Composite Committee. Appointments to the Management Committee shall be made consistent with the FSMB/NBME Agreement Establishing the USMLE.
SECTION B. The President shall provide FSMB advice and consent to the NBME for NBME’s appointments to the USMLE Management Committee and/or any appointments made jointly under the FSMB/NBME Agreement Establishing the USMLE.

ARTICLE X. POST-LICENSURE ASSESSMENT SYSTEM

The Post-Licensure Assessment Governing Committee shall be responsible for the development, operation and maintenance of policies governing the Post-Licensure Assessment System (PLAS) established by joint agreement between FSMB and NBME. The Chair, with the approval of the Board of Directors, shall make appointments to the Post-Licensure Assessment Governing Committee and its program committees in appropriate numbers and at appropriate times as required by the FSMB/NBME joint agreement establishing the Post-Licensure Assessment System and by other agreements as may apply.

ARTICLE XI. FINANCES AND DUES

SECTION A. SOURCES OF FUNDS

Funds necessary for the conduct of the affairs of the FSMB shall be derived from but not be limited to:

1. Annual dues imposed on the Member Medical Boards, Affiliate Members, Courtesy Members and Official Observers;
2. Special assessments established by the House of Delegates;
3. Voluntary contributions, devices, bequests and other gifts;
4. Fees charged for examination services, data base services, credentials verification services and publications.

SECTION B. ANNUAL DUES, ELIGIBILITY TO SERVE AS A DELEGATE

The annual dues for Member Medical Boards shall be established, from time to time, by a majority vote of the House of Delegates.

1. Annual dues for Member Medical Boards shall be the same for all Members regardless of their physician populations. Annual dues are due and payable not later than January 1.
2. Any Member Medical Board whose dues are in default at the time of the Annual Meeting of the House of Delegates shall be ineligible to have a seated delegate.
ARTICLE XII. DISCIPLINARY ACTION

SECTION A. MEMBER

For the purposes of this Article, a member shall be defined as a Member Medical Board, a Fellow, an Honorary Fellow, an Associate Member, an Affiliate Member, Courtesy Member or Official Observer.

SECTION B. AUTHORIZATION

The Board of Directors, on behalf of the House of Delegates, may enforce disciplinary measures, including expulsion, suspension, censure and reprimand, and impose terms and conditions of probation or such sanctions as it may deem appropriate, for any of the following reasons:

1. Failure of the member to comply or act in accordance with these Bylaws, the Articles of Incorporation of the FSMB, or other duly adopted rules or regulations of the FSMB;

2. Failure of the member to comply with any contract or agreement between the FSMB and such member or with any contract or agreement of the FSMB that binds such member;

3. Failure of the member to maintain confidentiality or security, or the permitting of conditions that allow a breach of confidentiality or security, in any manner dealing with the licensing examination process or the confidentiality of FSMB records, including the storage, administration, grading or reporting of examinations and information relating to the examination process; or

4. The imposition of a sanction, judgment, disciplinary penalty or other similar action by a Member Medical Board that licenses the member or by a state or federal court, or other competent tribunal, whether or not related to the practice of medicine and including conduct as a member of a Member Medical Board.

SECTION C. PROCEDURE

Any member alleged to have acted in such manner as to be subject to disciplinary action shall be accorded, at a minimum, the procedural protection set forth in the Manual for Disciplinary Procedures, which is available from the FSMB upon the written request of any member.

SECTION D. REINSTATEMENT

In the event a member is suspended or expelled from the FSMB, the member may apply to the President for reinstatement after one year following final action on expulsion. The President shall review the application and the reason for the suspension or expulsion and forward a report to the
Board. The Board may accept application for reinstatement under such terms and conditions as it may deem appropriate, reject the application or request further information from the President. The Board’s decision to accept or reject an application is final.

**ARTICLE XIII. CORPORATE SEAL**

The Board of Directors shall adopt a corporate seal that meets the requirements of the state in which the FSMB is incorporated.

**ARTICLE XIV. ADOPTION AND AMENDMENT OF BYLAWS, EFFECTIVE DATE**

**SECTION A. AMENDMENT**

These Bylaws may be amended at any annual meeting of the House of Delegates by two-thirds of those present and voting. Bylaws changes may be proposed only by the Board of Directors, Member Medical Boards or the Bylaws Committee. All such proposals must be submitted in writing to the Bylaws Committee, in care of the Secretary of the FSMB. The Bylaws Committee shall inform the Member Medical Boards of its meeting dates not fewer than 60 days in advance of the meeting. The recommendations of the Bylaws Committee and the full texts of all proposed amendments recommended to the Committee shall be sent to each Member Medical Board not fewer than 60 days prior to the Annual Meeting of the House of Delegates at which they are to be considered.

**SECTION B. EFFECTIVE DATE**

These Bylaws and any other subsequent amendments thereto, shall become effective upon their adoption, except as otherwise provided herein.

Bylaws last amended in April 2017
ARTICLE I. NAME
The corporation shall be known as the Federation of State Medical Boards of the United States, Inc. (“FSMB”).

ARTICLE II. CLASSES OF MEMBERSHIP, ELECTION AND MEMBERSHIP RIGHTS

SECTION A. MEMBER MEDICAL BOARDS
The term “Member Medical Board” as used in the Articles of Incorporation and in these Bylaws shall refer to any board, committee or other group in any state, territory, the District of Columbia or possession of the United States of America that is empowered by law to pass on the qualifications of applicants for licensure to practice allopathic or osteopathic medicine or to discipline such licensees. If a state or other jurisdiction has more than one such entity and if each is an independent agency unrelated to the others, each is eligible for membership. Any eligible Medical Board may become a Member Medical Board upon approval of its application by the Board of Directors.

SECTION B. FELLOWS
An individual member who as a result of appointment or confirmation is designated to be a member of a Member Medical Board shall be a Fellow of the FSMB during the member's period of service on a Member Medical Board, and for a period of 36 thirty-six months thereafter.

SECTION C. HONORARY FELLOWS
Thirty-six months after completion of service on a Member Medical Board, a Fellow shall become an Honorary Fellow of the FSMB and may be appointed by the Chair to serve as a member of any committee or in any other appointive capacity.

SECTION D. ASSOCIATE MEMBERS
A Member Medical Board may designate one or more employees or staff members to be an Associate Member of the FSMB. No Associate Member shall continue in that capacity upon termination of employment by or service to the Member Medical Board.
FSMB 2018 Bylaws Page 2

SECTION E. COURTESY MEMBERS

Any physician or physician assistant licensed by a Member Medical Board or an Affiliate Member Board and not eligible for any other type of membership may become a Courtesy Member of the FSMB upon approval of the candidate’s application. A Courtesy Member may serve as a member of a committee and in any other capacity upon appointment by the Chair.

SECTION F. AFFILIATE MEMBERS BOARDS

A board or authority that is not otherwise eligible for membership may become an Affiliate Member Board of the FSMB upon approval of its application by the Board of Directors if the board or authority licenses either:

1. Allopathic or osteopathic physicians or physician assistants in the United States; or
2. Allopathic or osteopathic physicians if the board or authority is located in another country.

SECTION G. OFFICIAL OBSERVERS

An organization may apply for Official Observer status at meetings of the House of Delegates. The Board of Directors shall prescribe rules and procedures to govern the application for, the granting of and the exercise of Official Observer status.

SECTION H. RIGHTS OF MEMBERS

Except as otherwise provided in these Bylaws, rights, duties, privileges and obligations of a member of the FSMB may be exercised only by a Member Medical Board.

SECTION I. METHODS OF NOMINATION TO ELECTED OFFICE

Nomination by the Nominating Committee or Nomination by Petition pursuant to Articles III, IV, V and VIII shall be the sole methods of nomination to an elected office of the FSMB. A candidate who runs for and is not elected to an elected office shall be ineligible to be nominated for any other elected office during the same election cycle.

ARTICLE III. OFFICERS: ELECTION AND DUTIES

SECTION A. OFFICERS OF THE FSMB

1. OFFICERS. The officers of the FSMB shall be that of Chair, Chair-elect, Immediate Past Chair, Treasurer and Secretary.
2. Only an individual who is a Fellow at the time of the individual’s election or appointment shall be eligible for election or appointment as an Officer of the FSMB, except for the position of Secretary.

3. The position of Secretary shall be an ex-officio office, without vote, and the President of the FSMB shall serve as Secretary.

SECTION B. ELECTION OF OFFICERS

1. The Chair-elect shall ascend to the position of Chair at the Annual Meeting following the meeting in which the Chair-elect was elected.

2. The Chair-elect shall be elected at each Annual Meeting of the House of Delegates.

3. The Immediate Past Chair assumes that position upon the Chair-elect ascending to the position of Chair.

4. The Treasurer shall be elected every third year at the Annual Meeting of the House of Delegates.

5. Officers shall be elected by a majority of the members of the House of Delegates present and voting.

6. In any election, should no candidate receive a majority of the votes cast, a runoff election shall be held between the two candidates who receive the most votes for that office on the first ballot. Up to two additional runoff elections shall be held.

7. Prior to each election, the presiding officer shall cast a sealed vote that shall be counted only to resolve a tie that cannot be decided by the process set forth in this section.

SECTION C. DUTIES OF OFFICERS

1. The duties of the Chair shall be as follows:
   a. Preside at all meetings and sessions of the House of Delegates and the Board of Directors;
   b. Perform the duties customary to the office of the Chair;
   c. Make appointments to committees and define duties of committee members in accordance with these Bylaws, except as otherwise provided herein;
   d. Serve, ex officio, on all committees except as otherwise provided herein; and
3. The duties of the Immediate Past Chair shall be as follows:

a. Assist the Chair in the transition from Chair-elect to Chair;

b. Serve as chair of the Nominating Committee; and

c. Perform such other duties and responsibilities as the Chair shall determine.

4. The duties of the Treasurer shall be as follows:

a. Perform the duties customary to that office;

b. Perform such other duties as the Bylaws and custom and parliamentary usage may require or as the Board of Directors shall deem appropriate;

c. Serve as an ex officio member of the Audit Committee; and

d. Serve as chair of the Finance Committee.

SECTION D. TERMS OF OFFICE AND SUCCESSION

1. The Chair and Chair-elect shall serve for single terms of one year or until their successors assume office.

2. The Immediate Past Chair shall serve until a successor to the current Chair assumes office.

3. The Treasurer shall serve for a single term of three years or until the Treasurer’s successor assumes the office.
3.4. Officers shall assume office upon final adjournment of the Annual Meeting of the House of Delegates at which they were elected.

4.5. The term of the Secretary is co-terminus with that of the President.

SECTION E. VACANCIES

1. In the event of a vacancy in the office of the Chair, the Chair-elect shall assume the position of Chair for the remainder of the unexpired term, and shall then serve a full one-year term as Chair.

2. In the event of a vacancy in the office of the Chair-elect, the Board of Directors shall appoint a Director-at-Large to assume the duties, but not the office, of Chair-elect for the remainder of the unexpired term. At the next Annual Meeting of the House of Delegates, both a Chair and a Chair-elect shall be elected in accordance with the provisions in Section B of this Article.

3. In the event of a vacancy in the office of Immediate Past Chair, the office shall remain open until a new Chair assumes the office.

3.4. In the event of a vacancy in the office of the Treasurer, the Board of Directors shall elect one of the Directors-at-Large to serve as Treasurer, with one vote on the Board of Directors and one vote on the Executive Committee, until the next year’s Annual Meeting of the House of Delegates, at which time a Treasurer shall be elected.

ARTICLE IV. BOARD OF DIRECTORS

SECTION A. MEMBERSHIP AND TERMS

1. MEMBERSHIP: The Board of Directors shall be composed of the Officers, the Immediate Past Chair, nine Directors-at-Large and two Associate Members. At least two members of the Board, who are not Associate Members, shall be non-physicians, at least one of whom shall be a public/consumer member.

2. NOMINATION OF ASSOCIATE MEMBERS: Nominations for Associate Member positions shall be accepted from Member Boards, the Board of Directors and Administrators in Medicine (AIM). Associate Members shall be elected by the Board of Directors in staggered terms in accordance with policies and procedures established by the Board of Directors.
3. **TERMS:** Directors-at-Large shall each serve for a term of three years and shall be eligible to be reelected to one additional term. A partial term totaling one-and-a-half years or more shall count as a full term. Associate Members shall each serve for a term of two years. Associate Members shall not be eligible to serve consecutive terms.

**SECTION B. NOMINATIONS**

1. The Nominating Committee shall submit a roster of one or more candidates for each of the offices and positions to be filled by election at the Annual Meeting of the House of Delegates.

2. The Nominating Committee shall mail its roster of candidates to Member Boards not fewer than **60 sixty** days prior to the Annual Meeting of the House of Delegates.

**SECTION C. ELECTION OF DIRECTORS-AT-LARGE**

1. At least three of the Directors-at-Large shall be elected each year at the Annual Meeting of the House of Delegates by a majority of the votes cast.

2. If no candidate receives a majority of the votes on the first ballot, and one seat is to be filled, a runoff election shall be held between the two candidates who received the most votes on the first ballot.

3. If more than one seat is to be filled from a single list of candidates, and if one or more seats are not filled by majority vote on the first ballot, a runoff election shall be held, with the ballot listing candidates equal in number to twice the number of seats remaining to be filled. These candidates shall be those remaining who received the most votes on the first ballot. The same procedure shall be used for any required subsequent runoff elections. In the event of a tie vote in a runoff election up to two additional runoff elections shall be held.

4. Prior to the election, the presiding officer shall cast a sealed vote, ranking each candidate in a list. The presiding officer’s vote is counted for the candidate in the runoff election who is highest on the list. The presiding officer’s vote is counted only to resolve a tie that cannot be decided by the process set forth in this section.

5. Directors shall assume office upon final adjournment of the Annual Meeting of the House of Delegates at which they were elected.

6. Only an individual who is a Fellow at the time of the individual’s election shall be eligible for election as a Director of the FSMB.
SECTION D. DUTIES OF THE BOARD OF DIRECTORS

1. The control and administration of the FSMB is vested in the Board of Directors and it shall act for the FSMB between Annual Meetings.

2. The Board of Directors shall carry out the mandates of the FSMB as established by the House of Delegates, and it shall have full and complete power and authority to perform all acts and to transact all business for and on behalf of the FSMB.

3. The Board of Directors shall conduct and manage all property, affairs, work and activities of the FSMB, subject only to the provisions of the Articles of Incorporation and these Bylaws, and to resolutions and enactments of the House of Delegates.

4. The Board of Directors shall be the fiscal agent of the FSMB.

5. The Board of Directors shall establish rules for its operations and meetings.

6. The FSMB shall indemnify Directors, Officers and other individuals acting on behalf of the FSMB if such indemnification is in accordance with the laws of the State of Nebraska and the operational policies and procedures of the Board of Directors, as adopted. The Board shall report to the membership of the FSMB at the Annual Meeting of the House of Delegates.

7. The Board of Directors shall establish a strategic plan for the FSMB that states the FSMB mission and objectives and shall submit that plan to the House of Delegates for ratification, modification or rejection. The Board shall review the current strategic plan annually and propose any amendments to the Annual Meeting of the House of Delegates for ratification, modification or rejection. The President shall report to the Annual Meeting of the House of Delegates on the extent to which the FSMB's stated objectives have been accomplished in the preceding year.

SECTION E. REMOVAL FROM OFFICE

1. REMOVAL: Any officer or member of the Board of Directors may be removed for any cause deemed sufficient by an affirmative vote of two-thirds of the total members of the Board of Directors entitled to vote and who are not subject to removal from office.

2. PROCEDURE: The procedure for removal shall be as follows:
   a. The Board shall file with the Secretary of the Board and deliver a written statement of the cause for removal to the officer or board member in sufficient detail as to state the grounds
for the removal. Delivery to the officer or board member shall be by certified mail, return receipt requested, to the last address known to the Board and is effective upon mailing.

b. The officer or board member shall deliver a sworn written response to the Board, no later than thirty calendar days after the written statement of the cause for removal is filed with the Secretary of the Board delivered to the officer or board member in question. Delivery to the Board shall be by certified mail, return receipt requested, directed to the Secretary of the Board at the FSMB corporate office. Delivery is effective upon mailing.

c. At the next Board meeting following the date the response is due, the Board shall determine whether or not to proceed with removal. Notice of the Board’s action shall be delivered to the officer or board member by certified mail, return receipt requested. If the officer or board member did not file a written response the Board shall proceed with a determination. Delivery is effective upon mailing.

d. If the Board votes to proceed with removal of the officer or board member, at a Board meeting held no less than thirty days after delivery of the notice, the board member shall be afforded the opportunity to address the Board on the merits of the allegations and produce any relevant information to the Board. Delivery of the notice of removal.

3. APPEAL: Any officer or member of the Board of Directors removed by the Board of Directors may appeal to the House of Delegates at its next business meeting. The officer or member may be reinstated by a two-thirds vote of the House of Delegates.

4. Delivery. For the purposes of this section, “Delivery” is effective upon mailing.

SECTION F. VACANCIES

1. DIRECTORS-AT-LARGE: In the event of a vacancy in the membership of the Directors-at-Large, the Board of Directors may appoint a Fellow who meets the qualifications for the position to serve until the next Annual Meeting of the House of Delegates, at which time an individual a Fellow shall be nominated and, if elected, shall serve for the remainder of the unexpired term. In the event a Director-at-Large is elected to the office of Treasurer or Chair-elect, that vacancy shall be filled by an election at the same Annual Meeting of the House of Delegates.
2. ASSOCIATE MEMBERS: In the event of a vacancy of an Associate Member, the Board of Directors may appoint a substitute to complete the Associate Member’s term in accordance with the policies established by the Board of Directors.

SECTION G. EXECUTIVE COMMITTEE OF THE BOARD

1. MEMBERSHIP: The Board of Directors shall establish an Executive Committee of the Board, which shall consist of the Chair as Chair, Chair-elect, Treasurer, Immediate Past Chair and two (2) Directors-at-Large. The Directors-at-Large shall be elected for a one-year term by majority vote of the Directors-at-Large and the Associate Members of the Board of Directors at the first regular meeting of the Board following the Annual Meeting of the House of Delegates. In the event of a vacancy in a Director-at-Large position, the Directors-at-Large and the Associate Members of the Board, by majority vote, shall choose another Director-at-Large to serve the remainder of the one-year term. In the event of vacancy in the position of Immediate Past Chair, this position shall remain vacant until the next Annual Meeting of the House of Delegates.

2. DUTIES: In intervals between Board meetings, the Executive Committee shall act for and on behalf of the Board in any matters that require prompt attention. It shall not modify actions previously taken by the Board unless additional information or a change of circumstances is presented and warrants additional action.

3. MEETINGS: The Executive Committee may meet as often as it deems necessary or appropriate, either in person, telephonically, electronically or by unanimous written consent, and at such times and places and manner as the Chair may determine. Minutes must be kept of all meetings.

4. REPORTING: The Executive Committee shall report in writing all formal actions taken by it to the Board of Directors within five working days of taking those actions. At each meeting of the Board, the Executive Committee shall present to the Board a written report of all its formal actions since the previous meeting of the Board.

SECTION H. PUBLIC POLICY STATEMENTS

A “public policy” is defined as the official public position of the FSMB on a matter that may be reasonably expected to affect Member Boards when dealing with their licensees, other health care providers, health-related special interest groups, governmental bodies or the public.
of Delegates is the official public policy-making body of the FSMB. When the interests of the FSMB require more immediate action, the Board of Directors, or the President in consultation with the Chair, if feasible, is authorized to issue statements on matters of public policy between Annual Meetings.

ARTICLE V. NOMINATION BY PETITION FOR BOARD OF DIRECTORS AND NOMINATING COMMITTEE

SECTION A. SUBMISSION OF A PETITION

1. At the time the Nominating Committee’s roster of candidates is distributed to the Member Boards, the Boards will be informed that a Fellow who is qualified for nomination, but not otherwise nominated by the Nominating Committee, may seek to run for a position on the Board of Directors as an Officer or Director-at-Large, or for a position on the Nominating Committee.

2. In order to be placed on the ballot, the Fellow seeking nomination is required to present a petition to Administrative Staff that is signed by at least one Fellow from at least four Member Boards as well as a fellow from the Board of the member seeking nomination.

3. The deadline to submit petitions to the Administrative Staff is 21 days prior to the Annual Meeting.

SECTION B. VALIDATION AND PLACEMENT ON BALLOT

1. The Administrative Staff shall verify that all signatures on the petition are valid. “Valid” is defined as the person who is seeking nomination and the persons who signed the petition are Fellows as defined in the FSMB Bylaws.

2. Once verified, the petitions are deemed valid and the candidate is placed on the ballot.

3. The names of those seeking to run by petition whose petitions are deemed valid shall be distributed to the Voting Delegates not fewer than 14 days prior to the Annual Meeting.

4. Once a candidate seeking to run by petition is added to the ballot, the candidate shall be afforded the same privileges and be bound by the same rules in the campaign process as candidates who were nominated by the Nominating Committee.
ARTICLE VI. PRESIDENT

The Board of Directors may, by a two-thirds majority vote of the full Board, appoint a President of the FSMB, who shall be a physician, to serve without term. The President shall administer the affairs of the FSMB and shall have such duties and responsibilities as the Board of Directors and the FSMB shall direct. The President shall serve as Secretary of the FSMB and shall be an ex-officio member, without vote, of the Board of Directors.

ARTICLE VII. MEETINGS

SECTION A. ANNUAL MEETING OF THE HOUSE OF DELEGATES

The annual meeting of the House of Delegates of the FSMB, which shall be called the House of Delegates, shall be held at such time and place as may be fixed by the Board of Directors. Written notice of the time and place of the meeting shall be given to all Member Medical Boards by mail not fewer than 90 ninety days prior to the date of the meeting. Notice is effective upon mailing.

SECTION B. SPECIAL MEETINGS OF THE HOUSE OF DELEGATES

Special meetings of the House of Delegates may be called at any time by the Chair, on the written request of ten Member Medical Boards or by action of the Board of Directors. Written notice of the time and place of such meetings shall be given to all Member Medical Boards by mail not fewer than 30 thirty days prior to the date of the meeting. Notice is effective upon mailing.

SECTION C. RIGHT TO VOTE

1. The right to vote at meetings of the House of Delegates is vested in, and restricted to, Member Medical Boards. Each Member Medical Board is entitled to one vote, said vote to be cast by the delegate of the Member Board. The delegate shall be the president of the Member Medical Board or the President’s designated alternate. In order for a delegate to be permitted to vote, the delegate shall present a letter of appointment to the Secretary of the Board of Directors.

2. All classes of membership shall have the right of the floor at meetings of the House upon request of a delegate and approval of the presiding officer; however, 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.
SECTION D. QUORUM

A majority of Member Medical Boards shall constitute a quorum at any meeting of the House of Delegates. A majority of the voting members of the Board of Directors or any committee or other constituted group shall constitute a quorum of the Board, committee or group.

SECTION E. RULES OF ORDER

Meetings of the House of Delegates, Board of Directors and all committees shall be conducted in accordance with the *American Institute of Parliamentarians Standard Code of Parliamentary Procedure*, current edition, except when in conflict with the Articles of Incorporation or these Bylaws, in which case the Articles of Incorporation or these Bylaws shall prevail.

ARTICLE VIII. STANDING AND SPECIAL COMMITTEES

SECTION A. STANDING COMMITTEES

1. The Standing Committees of the FSMB shall be:
   a. Audit Committee
   b. Bylaws Committee
   c. Editorial Committee
   d. Education Committee
   e. Ethics and Professionalism Committee
   f. Finance Committee
   g. Nominating Committee

2. ADDITIONAL STANDING COMMITTEES. Additional standing committees may be created by resolution of the FSMB and/or amendment to the Bylaws. Chairs and members of all standing committees, with the exception of the Nominating Committee, shall be appointed by the Chair, with the approval of the Board of Directors, for a term of one year, unless otherwise provided for in these Bylaws. Reappointment, unless specifically prohibited, is permissible.

3. MEMBERSHIP. Honorary Fellows, Associate Members and Courtesy Members may be appointed by the Chair to serve on a standing committee in addition to the number of committee members called for in the following sections of this chapter. No more than one Honorary Fellow, Associate or Courtesy Member or non-member subject matter expert may be appointed by the Chair to serve in such a capacity on any standing committee unless otherwise
provided for in these Bylaws. All committee members shall serve with vote. Honorary Fellows, Associate or Courtesy Members, and non-members appointed to standing committees by the Chair shall serve for a term concurrent with the term of the Chair. No individual shall serve on more than one standing committee except as specified in the Bylaws. With the exception of the Nominating Committee and the Editorial Committee, the Chair and the Chair-elect shall serve, ex-officio, on all committees.

4. VACANCIES. In the event a vacancy occurs in an elected position on a standing committee, the Chair, with the approval of the Board of Directors, shall appoint a Fellow to serve on the committee until the next meeting of the House of Delegates, at which time an election will be held to fill the vacant position for the remainder of the unexpired term. In the event a vacancy occurs in an appointed position on a standing committee, the Chair, with the approval of the Board of Directors, shall appoint a Fellow to serve on the committee for the remainder of the unexpired term. In the event the Chairmanship of the Nominating Committee becomes vacant, the FSMB Chair, with the approval of the FSMB Board of Directors, shall appoint a Past Chair of the FSMB Board of Directors to serve in that capacity for the remainder of the unexpired term.

SECTION B. AUDIT COMMITTEE

The Audit Committee shall:

1. Be composed of five Fellows, three of whom shall be members of the Board of Directors. The Treasurer of the FSMB shall serve ex-officio without vote. The Chair of the FSMB shall appoint the Chair of the Audit Committee from one of the three sitting Board Members.

2. Ensure that an annual audit of the financial accounts and records of the FSMB is performed by an independent Certified Public Accounting firm.

3. Recommend to the Board of Directors the appointment, retention or termination of an independent auditor or auditors and develop a schedule for periodic solicitation of audit firms consistent with Board policies and best practices.

4. Oversee the independent auditors. The independent auditors shall report directly to the Committee.

5. Review the audit of the FSMB. Submit such audit and Committee’s report to the Board of Directors.
6. Report any suggestions to the Board of Directors on fiscal policy to ensure the continuing financial strength of the FSMB.

7. When the finalized committee report to the Board of Directors is made, suggestions and feedback will be forwarded to the Finance Committee.

SECTION C. BYLAWS COMMITTEE

The Bylaws Committee, composed of five Fellows, shall continually assess the Articles of Incorporation and the Bylaws and shall receive all proposals for amendments thereto. It shall, from time to time, make recommendations to the House of Delegates for changes, deletions, modifications and interpretations thereto.

SECTION D. EDITORIAL COMMITTEE

1. An Editorial Committee, not to exceed twelve Fellows and three non-member subject matter experts, shall advise the Editor-in-Chief on editorial policy for the FSMB’s official publication, and shall serve as the editorial board of that publication and otherwise assist the Editor-in-Chief in the performance of duties as appropriate and necessary. No officer or member of the Board of Directors shall serve on this Committee.

2. Service on the Editorial Committee is by nomination and appointment by the FSMB Chair, subject to approval of the Board of Directors, immediately following the Annual Meeting of the House of Delegates. Candidates are allowed to express their interest in serving on the Committee through self-nomination. Committee members shall serve staggered three-year terms and shall be limited to two full terms.

3. The Editor-in-Chief shall be elected by the Editorial Committee to a three-year term beginning on the date of the annual Editorial Committee meeting, with the Editor-in-Chief’s term on the Editorial Committee being automatically extended to allow the Editor-in-chief to serve for three years. A member of the Editorial Committee whose term is expiring shall continue to serve until the member’s replacement meets at the next annual Editorial Committee meeting.

4. The Editorial Committee will elect its Chair, who will serve as the Editor-in-Chief of the Journal of Medical Regulation. The Editor-in-Chief will serve without compensation and will coordinate decisions on the Journal content, among other duties to be determined by the Bylaws Committee.
SECTION E. EDUCATION COMMITTEE

The Education Committee shall be composed of eight Fellows, to include the Chair as chair, the Immediate Past Chair and the Chair-elect. The Committee shall be responsible for assisting in the development of educational programs for the FSMB.

SECTION F. ETHICS AND PROFESSIONALISM COMMITTEE

The Ethics and Professionalism Committee shall be composed of up to five Fellows and up to two subject matter experts. The Ethics and Professionalism Committee shall address ethical and professional issues pertinent to medical regulation.

SECTION G. FINANCE COMMITTEE

The Finance Committee shall be composed of five Fellows, to include the Treasurer as Chair. The Finance Committee shall review the financial condition of the FSMB, review and evaluate the costs of the activities and programs to be undertaken in the forthcoming year, present a budget for the FSMB to the Board of Directors for its recommendation to the House of Delegates at the Annual Meeting and perform such other duties as are assigned to it by the Board of Directors. Except for the Treasurer, no Fellow shall serve on both the Audit and Finance Committees.

SECTION H. NOMINATING COMMITTEE: PROCESS FOR ELECTION

1. MEMBERSHIP: The Nominating Committee shall be composed of six Fellows and the Immediate Past Chair, who shall chair the Committee and serve without vote except in the event of a tie. At least one elected member of the Nominating Committee shall be a public member. With the exception of the Immediate Past Chair, no two Committee members shall be from the same member board and no officer or member of the Board of Directors shall serve on the Committee. A member of the Nominating Committee may not serve consecutive terms.

2. ELECTION: At least three Fellows shall be elected at each Annual Meeting of the House of Delegates by a plurality of votes cast, each to serve for a term of two years. Only an individual who is a Fellow at the time of the individual’s election shall be eligible for election as a member of the Nominating Committee. In the event of a tie vote in a runoff election, up to two additional runoff elections shall be held. Prior to the election, the presiding officer shall cast a sealed vote, ranking each candidate in a list. The presiding officer's vote is counted for the candidate in the runoff election who is highest on the list. The presiding officer’s vote is counted only to resolve a tie that cannot be decided by the process set forth in this section.
3. Members of the Nominating Committee are not eligible for inclusion on the roster of candidates for offices and positions to be filled by election at the Annual Meeting of the House of Delegates.

SECTION I. SPECIAL COMMITTEES

Special committees may be appointed by the Chair, from time to time, as may be necessary for a specific purpose.

SECTION J. REPRESENTATIVES TO OTHER ORGANIZATIONS AND ENTITIES

Appointment of all representatives of the FSMB to other official organizations or entities shall be made or nominated by the Chair, with the approval of the Board of Directors, as applicable, and shall serve for a term of three years unless the other organization shall specify some other term of appointment. Representatives to these organizations shall be Fellows, Honorary Fellows, Associate Members or Courtesy Members at the time of their appointment or nomination.

ARTICLE IX. UNITED STATES MEDICAL LICENSING EXAMINATION (USMLE)

SECTION A. Except as otherwise set forth in this Article, the composition of committees and subcommittees for the USMLE are subject to agreements with and the advice and consent of the National Board of Medical Examiners (NBME) and/or the USMLE Composite Committee. The Chair, with the approval of the Board of Directors, shall make appointments to the following USMLE committees in appropriate numbers and at appropriate times as required by the FSMB/NBME Agreement establishing the USMLE and by other agreements as may apply:

1. USMLE Composite Committee, which shall be responsible for the development, operation and maintenance of policies governing the three-step USMLE. The President shall be one of the FSMB’s representatives on this Committee.

2. USMLE Budget Committee, which shall be responsible for the development and monitoring of USMLE revenues and expenses, including the establishment of fees. FSMB representatives on the Committee will be the Chair, Chair-elect, Treasurer, President and the senior FSMB financial staff member.

3. The USMLE Management Committee shall be responsible for overseeing the design, development, scoring and standard setting for the USMLE Step examinations, subject to policies established by and reporting to the USMLE Composite Committee. Appointments to
the Management Committee shall be made consistent with the FSMB/NBME Agreement Establishing the USMLE.

SECTION B. The President shall provide FSMB advice and consent to the NBME for NBME's appointments to the USMLE Management Committee and/or any appointments made jointly under the FSMB/NBME Agreement Establishing the USMLE.

ARTICLE X. POST-LICENSURE ASSESSMENT SYSTEM

The Post-Licensure Assessment Governing Committee shall be responsible for the development, operation and maintenance of policies governing the Post-Licensure Assessment System (PLAS) established by joint agreement between FSMB and NBME. The Chair, with the approval of the Board of Directors, shall make appointments to the Post-Licensure Assessment Governing Committee and its program committees in appropriate numbers and at appropriate times as required by the FSMB/NBME joint agreement establishing the Post-Licensure Assessment System and by other agreements as may apply.

ARTICLE XI. FINANCES AND DUES

SECTION A. SOURCES OF FUNDS

Funds necessary for the conduct of the affairs of the FSMB shall be derived from but not be limited to:

1. Annual dues imposed on the Member Medical Boards, Affiliate Members, Courtesy Members and Official Observers;
2. Special assessments established by the House of Delegates;
3. Voluntary contributions, devices, bequests and other gifts;
4. Fees charged for examination services, data base services, credentials verification services and publications.

SECTION B. ANNUAL DUES, ELIGIBILITY TO SERVE AS A DELEGATE

The annual dues for Member Medical Boards shall be established, from time to time, by a majority vote of the House of Delegates.
1. Annual dues for Member Medical Boards shall be the same for all Members regardless of their physician populations. Annual dues are due and payable not later than January 1.

2. Any Member Medical Board whose dues are in default at the time of the Annual Meeting of the House of Delegates shall be ineligible to have a seated delegate.

**ARTICLE XII. DISCIPLINARY ACTION**

**SECTION A. MEMBER**

For the purposes of this Article, a member shall be defined as a Member Medical Board, a Fellow, an Honorary Fellow, an Associate Member, an Affiliate Member, Courtesy Member or Official Observer.

**SECTION B. AUTHORIZATION**

The Board of Directors, on behalf of the House of Delegates, may enforce disciplinary measures, including expulsion, suspension, censure and reprimand, and impose terms and conditions of probation or such sanctions as it may deem appropriate, for any of the following reasons:

1. Failure of the member to comply or act in accordance with these Bylaws, the Articles of Incorporation of the FSMB, or other duly adopted rules or regulations of the FSMB;

2. Failure of the member to comply with any contract or agreement between the FSMB and such member or with any contract or agreement of the FSMB that binds such member;

3. Failure of the member to maintain confidentiality or security, or the permitting of conditions that allow a breach of confidentiality or security, in any manner dealing with the licensing examination process or the confidentiality of FSMB records, including the storage, administration, grading or reporting of examinations and information relating to the examination process; or

4. The imposition of a sanction, judgment, disciplinary penalty or other similar action by a Member Medical Board that licenses the member or by a state or federal court, or other competent tribunal, whether or not related to the practice of medicine and including conduct as a member of a Member Medical Board.
SECTION C. PROCEDURE

Any member alleged to have acted in such manner as to be subject to disciplinary action shall be accorded, at a minimum, the procedural protection set forth in the Manual for Disciplinary Procedures, which is available from the FSMB upon the written request of any member.

SECTION D. REINSTATEMENT

In the event a member is suspended or expelled from the FSMB, the member may apply to the President for reinstatement after one year following final action on expulsion. The President shall review the application and the reason for the suspension or expulsion and forward a report to the Board. The Board may accept application for reinstatement under such terms and conditions as it may deem appropriate, reject the application or request further information from the President. The Board’s decision to accept or reject an application is final.

ARTICLE XIII. CORPORATE SEAL

The Board of Directors shall adopt a corporate seal that meets the requirements of the state in which the FSMB is incorporated.

ARTICLE XIV. ADOPTION AND AMENDMENT OF BYLAWS, EFFECTIVE DATE

SECTION A. AMENDMENT

These Bylaws may be amended at any annual meeting of the House of Delegates by two-thirds of those present and voting. Bylaws changes may be proposed only by the Board of Directors, Member Medical Boards or the Bylaws Committee and its members. All such proposals must be submitted in writing to the Bylaws Committee, in care of the Secretary of the FSMB. The Bylaws Committee shall inform the Member Medical Boards of its meeting dates not fewer than 60 sixty days in advance of the meeting. The recommendations of the Bylaws Committee and the full texts of all proposed amendments recommended to the Committee shall be sent to each Member Medical Board not fewer than 60 sixty days prior to the Annual Meeting of the House of Delegates at which they are to be considered.

SECTION B. EFFECTIVE DATE

These Bylaws and any other subsequent amendments thereto, shall become effective upon their adoption, except as otherwise provided herein.
Attachment 3
ARTICLE VIII. STANDING AND SPECIAL COMMITTEES

SECTION A. STANDING COMMITTEES

1. The Standing Committees of the FSMB shall be:
   
   a. Audit Committee
   b. Bylaws Committee
   c. Editorial Committee
   d. Education Committee
   e. Ethics and Professionalism Committee
   f. Finance Committee
   g. Nominating Committee

2. ADDITIONAL STANDING COMMITTEES. Additional standing committees may be created by resolution of the FSMB and/or amendment to the Bylaws. Chairs and members of all standing committees, with the exception of the Nominating Committee, shall be appointed by the Chair, with the approval of the Board of Directors, for a term of one year, unless otherwise provided for in these Bylaws. Reappointment, unless specifically prohibited, is permissible.

3. MEMBERSHIP. Honorary Fellows, Associate Members and Courtesy Members may be appointed by the Chair to serve on a standing committee in addition to the number of committee members called for in the following sections of this chapter. No more than one Honorary Fellow, Associate or Courtesy Member or non-member subject matter expert may be appointed by the Chair to serve in such a capacity on any standing committee unless otherwise provided for in these Bylaws. All committee members shall serve with vote. Honorary Fellows, Associate or Courtesy Members, and non-members appointed to standing committees by the Chair shall serve for a term concurrent with the term of the Chair. No individual shall serve on more than one standing committee except as specified in the Bylaws. With the exception of the Nominating Committee and the Editorial Committee, the Chair and the Chair-elect shall serve, ex-officio, on all committees.

4. VACANCIES. In the event a vacancy occurs in an elected position on a standing committee, the Chair, with the approval of the Board of Directors, shall appoint a Fellow to serve on the committee until the next meeting of the House of Delegates, at which time an election will be held to fill the vacant position for the remainder of the unexpired term. In the event a vacancy occurs in an appointed position on a standing committee, the Chair, with the approval of the Board of Directors, shall appoint a Fellow to serve on the committee for the remainder of the unexpired term. In the event
the Chairmanship of the Nominating Committee becomes vacant, the FSMB Chair, with the approval of the FSMB Board of Directors, shall appoint a Past Chair of the FSMB Board of Directors to serve in that capacity for the remainder of the unexpired term.

SECTION B. AUDIT COMMITTEE

The Audit Committee shall:

1. Be composed of five Fellows, three of whom shall be members of the Board of Directors. The Treasurer of the FSMB shall serve ex-officio without vote. The Chair of the FSMB shall appoint the Chair of the Audit Committee from one of the three sitting Board Members.

2. Ensure that an annual audit of the financial accounts and records of the FSMB is performed by an independent Certified Public Accounting firm.

3. Recommend to the Board of Directors the appointment, retention or termination of an independent auditor or auditors and develop a schedule for periodic solicitation of audit firms consistent with Board policies and best practices.

4. Oversee the independent auditors. The independent auditors shall report directly to the Committee.

5. Review the audit of the FSMB. Submit such audit and Committee’s report to the Board of Directors.

6. Report any suggestions to the Board of Directors on fiscal policy to ensure the continuing financial strength of the FSMB.

7. When the finalized committee report to the Board of Directors is made, suggestions and feedback will be forwarded to the Finance Committee.

SECTION C. BYLAWS COMMITTEE

The Bylaws Committee, composed of five Fellows, shall continually assess the Articles of Incorporation and the Bylaws and shall receive all proposals for amendments thereto. It shall, from time to time, make recommendations to the House of Delegates for changes, deletions, modifications and interpretations thereto.

SECTION D. EDITORIAL COMMITTEE

1. An Editorial Committee, not to exceed twelve Fellows and three non-Fellows, at least two of whom shall be subject matter experts, shall advise the Editor-in-Chief on editorial policy for the FSMB’s official publication, and shall serve as the editorial board of that publication and otherwise assist the Editor-in-Chief in the performance of duties as appropriate and necessary. No officer or member of the Board of Directors shall serve on this Committee.

2. Service on the Editorial Committee is by nomination and appointment by the FSMB Chair, subject to approval of the Board of Directors, immediately following the Annual
Meeting of the House of Delegates. Candidates are allowed to express their interest in serving on the Committee through self-nomination. Committee members shall serve staggered three-year terms and shall be limited to two full terms.

3. The Editor-in-Chief shall be elected by the Editorial Committee to a three-year term beginning on the date of the annual Editorial Committee meeting, with the Editor-in-Chief’s term on the Editorial Committee being automatically extended to allow the Editor-in-chief to serve for three years. A member of the Editorial Committee whose term is expiring shall continue to serve until the member’s replacement meets at the next annual Editorial Committee meeting.

4. The Editorial Committee will elect its Chair, who will serve as the Editor-in-Chief of the *Journal of Medical Regulation*. The Editor-in-Chief will serve without compensation and will coordinate decisions on the *Journal* content, among other duties to be determined by the Bylaws Committee.

**SECTION E. EDUCATION COMMITTEE**

The Education Committee shall be composed of eight Fellows, to include the Chair as chair, the Immediate Past Chair and the Chair-elect. The Committee shall be responsible for assisting in the development of educational programs for the FSMB.

**SECTION F. ETHICS AND PROFESSIONALISM COMMITTEE**

The Ethics and Professionalism Committee shall be composed of up to five Fellows and up to two subject matter experts. The Ethics and Professionalism Committee shall address ethical and professional issues pertinent to medical regulation.

**SECTION G. FINANCE COMMITTEE**

The Finance Committee shall be composed of five Fellows, to include the Treasurer as Chair. The Finance Committee shall review the financial condition of the FSMB, review and evaluate the costs of the activities and programs to be undertaken in the forthcoming year, present a budget for the FSMB to the Board of Directors for its recommendation to the House of Delegates at the Annual Meeting and perform such other duties as are assigned to it by the Board of Directors. Except for the Treasurer, no Fellow shall serve on both the Audit and Finance Committees.

**SECTION H. NOMINATING COMMITTEE: PROCESS FOR ELECTION**

1. **MEMBERSHIP:** The Nominating Committee shall be composed of six Fellows and the Immediate Past Chair, who shall chair the Committee and serve without vote except in the event of a tie. At least one elected member of the Nominating Committee shall be a public member. With the exception of the Immediate Past Chair, no two Committee members shall be from the same member board and no officer or member of the Board of Directors shall serve on the Committee. A member of the Nominating Committee may not serve consecutive terms.
2. **ELECTION**: At least three Fellows shall be elected at each Annual Meeting of the House of Delegates by a plurality of votes cast, each to serve for a term of two years. Only an individual who is a Fellow at the time of the individual’s election shall be eligible for election as a member of the Nominating Committee. In the event of a tie vote in a runoff election, up to two additional runoff elections shall be held. Prior to the election, the presiding officer shall cast a sealed vote, ranking each candidate in a list. The presiding officer’s vote is counted for the candidate in the runoff election who is highest on the list. The presiding officer’s vote is counted only to resolve a tie that cannot be decided by the process set forth in this section.

3. Members of the Nominating Committee are not eligible for inclusion on the roster of candidates for offices and positions to be filled by election at the Annual Meeting of the House of Delegates.

**SECTION I. SPECIAL COMMITTEES**

Special committees may be appointed by the Chair, from time to time, as may be necessary for a specific purpose.

**SECTION J. REPRESENTATIVES TO OTHER ORGANIZATIONS AND ENTITIES**

Appointment of all representatives of the FSMB to other official organizations or entities shall be made or nominated by the Chair, with the approval of the Board of Directors, as applicable, and shall serve for a term of three years unless the other organization shall specify some other term of appointment. Representatives to these organizations shall be Fellows, Honorary Fellows, Associate Members or Courtesy Members at the time of their appointment or nomination.
ARTICLE IV. BOARD OF DIRECTORS

SECTION A. MEMBERSHIP AND TERMS

1. MEMBERSHIP: The Board of Directors shall be composed of the Officers, the Immediate Past Chair, nine Directors-at-Large and two Associate Members. At least two members of the Board, who are not Associate Members, shall be non-physicians, at least one of whom shall be a public/consumer member.

TN Board Comment:
This simple modification of the FSMB Bylaws makes clear that the Public/Consumer members' participation and perspective on the Board of Directors is valued and aligned with the member medical boards of the FSMB.

It should be noted that non-physician members can be elected to the Board of Directors if they are fellows of the FSMB. This proposed change to the Bylaws would not alter that status.

There are nine Directors-at-Large and two Associate Members on the FSMB Board of Directors in addition to the Officers of the Board of Directors and the Immediate Past Chair. The Secretary (President) of the Board of Directors is ex officio and does not vote.
REPORT OF THE BOARD OF DIRECTORS

Subject: Report of the FSMB Workgroup to Study Regenerative and Stem Cell Therapy Practices

Referred to: Reference Committee B

The Federation of State Medical Boards (FSMB) Workgroup to Study Regenerative and Stem Cell Therapy Practices was convened in May of 2017 by FSMB Chair Gregory B. Snyder, M.D., DABR, in response to a letter from U.S. Senator Lamar Alexander (R-TN), Chairman of the U.S. Senate Health, Education, Labor, and Pensions (HELP) Committee, urging the FSMB to develop best practices for state medical and osteopathic boards (hereinafter referred to as “state medical boards”) in regulating the promotion, communication, and practices of treatments received at stem cell clinics in the United States.

Members of the Workgroup are: Scott A. Steingard, DO, Chair (FSMB Director-at-Large, Past President, Arizona Board of Osteopathic Examiners in Medicine and Surgery); Debbie J. Boe (Former Public Member, Minnesota Board of Medical Practice); Sandra L. Coletta (Public Member, Rhode Island Board of Medical Licensure and Discipline); Sarah L. Evenson, JD, MBA (Former Public Member, Minnesota Board of Medical Practice); H. Joseph Falgout, MD (Chair, Alabama Board of Medical Examiners); Joseph E. Fojtik, MD, FACP (Deputy Medical Coordinator, Illinois Department of Financial & Professional Regulation); Gary R. Hill, DO (Member, Alabama Medical Licensure Commission); Howard R. Krauss, MD (Member, Medical Board of California). Subject matter experts included: Ronald E. Domen, MD, FACP, FCAP (Penn State College of Medicine); Zubin Master, PhD (Mayo Clinic); Douglas Oliver, MSW; and Bruce D. White, DO, JD (Alden March Bioethics Institute). Participating ex officio were Gregory B. Snyder, MD, DABR, FSMB Chair; Patricia A. King, MD, PhD, FACP, FSMB Chair-elect; and Humayun J. Chaudhry, DO, MS, MACP, MACOI, FSMB President and CEO.

The Workgroup was charged with: 1) evaluating the prevalence, promotional practices, and incidences of patient harm related to regenerative medicine and adult stem cell therapies in the U.S.; 2) evaluating current regulatory approaches that will protect the public, recognizing the potential for improved patient outcomes through health innovation and technology; 3) identifying best practices for state medical and osteopathic boards in investigating complaints of patient harm, fraud, and compliance with licensure requirements; and 4) issuing a report on the Workgroup’s findings from prevailing research and recommending best regulatory practices and guidelines related to physicians’ use of regenerative medicine and adult stem cell therapies in a manner consistent with safe and responsible medicine.

In completing its charge, the Workgroup drafted its report in the form of a guidance document, with recommendations that address the regulation of the provision of stem cell and regenerative therapies, as well as their promotion and communication to patients, and documentation of treatments provided. The recommendations do not address which uses are appropriate or for specific conditions or symptoms, as this area of medicine continues to be dynamic and subject to change. Rather, the recommendations focus on sensible and necessary principles of patient safety, autonomy, and non-exploitation.

A draft of the report was distributed to FSMB member boards and other key stakeholder organizations in December 2017 with comments due January 26, 2018. The draft report was distributed to the American Medical Association (AMA), American Osteopathic Association (AOA), Council of Medical Specialty Societies (CMSS), U.S. Food and Drug Administration (FDA), Office of U.S. Senator Lamar Alexander (R-TN), Association of Clinical Research Organizations (ACRO), and others for comment. Minimal comments were received, and all were generally positive.

The FSMB Board of Directors considered the draft Report of the FSMB Workgroup to Study Regenerative and Stem Cell Therapy Practices at its meeting on February 8, 2018 in Washington D.C. and discussed clarifications to the document.

ITEM FOR ACTION:

The Board of Directors recommends that:

Attachment 1
REPORT OF THE FSMB WORKGROUP TO STUDY REGENERATIVE AND STEM CELL THERAPY PRACTICES

Section One. Introduction and Charge:

The Federation of State Medical Boards (FSMB) Workgroup to Study Regenerative and Stem Cell Therapy Practices was convened in May of 2017 by FSMB Chair Gregory B. Snyder, M.D., DABR, in response to a letter (Attachment 1) from U.S. Senator Lamar Alexander (R-TN), Chairman of the U.S. Senate Health, Education, Labor, and Pensions (HELP) Committee, urging the FSMB to develop best practices for state medical and osteopathic boards (hereinafter referred to as “state medical boards”) in regulating the promotion, communication, and practices of treatments received at stem cell clinics in the United States.

In order to address Senator Alexander’s request, Dr. Snyder charged the Workgroup with:

1) Evaluating the prevalence, promotional practices, and incidences of patient harm related to regenerative medicine and adult stem cell therapies in the U.S.;

2) Evaluating current regulatory approaches that will protect the public, recognizing the potential for improved patient outcomes through health innovation and technology;

3) Identifying best practices for state medical and osteopathic boards in investigating complaints of patient harm, fraud, and compliance with licensure requirements; and

4) Issuing a report on the Workgroup’s findings from prevailing research and recommending best regulatory practices and guidelines related to physicians’ use of regenerative medicine and adult stem cell therapies in a manner consistent with safe and responsible medicine.

Stem cell and regenerative therapies offer opportunities for advancement in the practice of medicine and the possibility of an array of new treatment options for patients experiencing a variety of symptoms and conditions. Despite significant momentum in research and development, and the potential for such medical advancements, there is reasonable concern about a growing number of providers and clinics in the United States that are undermining the field. Such providers and clinics have been known to apply, prescribe or recommend therapies inappropriately, over-promise without sufficient data to support claims, and exploit patients who are often in desperate circumstances and willing to try any proposed therapy as a last resort, even if there is excessive cost or scant evidence of efficacy.

The following report aims to raise awareness about regenerative and stem cell therapy practices generally, outline their potential benefits and risks, and provide basic guidance for state medical boards and licensed physicians and physician assistants. Central to all of the
recommendations provided herein is a range of imperatives, including the importance of
protecting the public, respecting patient autonomy, preventing patient exploitation, obtaining
informed consent, and appropriately documenting care that is recommended and provided.

The Workgroup’s deliberations were aided by participants and subject matter experts who
brought varying perspectives. For example, Dr. Ronald Domen has expertise in stem cell
therapies, bioethics and humanities, and has served on numerous ethics committees at
institutional, state, and national levels. Dr. Zubin Master of the Mayo Clinic has extensive
training and education in cellular and molecular biology, bioethics and genetics, as well as
research and publications on stem cell therapies. Mr. Douglas Oliver became known to the
Workgroup through a recommendation by Senator Lamar Alexander of Tennessee, was a
recipient of stem cell therapies himself, and has a foundation that advocates for stem cell
therapies based on his own experiences and those of others like him. Dr. Bruce White has
educational backgrounds in medicine, law, pharmacy and ethics and currently serves as
Director of the Alden March Bioethics Institute at Albany Medical College and is Chair of
Medical Ethics at the College. The Workgroup also received written comments from several
external organizations. The sum of these perspectives aided the Workgroup in producing a
balanced report on this emerging issue of national importance.

Section Two. Definitions:

Homologous (Allogeneic) Use: the repair, reconstruction, replacement, or supplementation of a
recipient’s cells or tissues with a HCT/P (human cells, tissues, and cellular and tissue-based
product) that performs the same basic function or functions in the recipient as in the donor,
including when such cells or tissues are for autologous use.\(^1\)

According to the Food and Drug Administration’s (FDA) Regulatory Considerations for
Human Cell, Tissues, and Cellular and Tissue-Based Products: Minimal Manipulation and
Homologous Use / Guidance for Industry and Food and Drug Administration Staff
(November 2017), the FDA “generally considers an HCT/P to be for homologous use
when it is used to repair, reconstruct, replace, or supplement:
• Recipient cells or tissues that are identical (e.g., skin for skin) to the donor cells
  or tissues, and perform one or more of the same basic functions in the recipient
  as the cells or tissues performed in the donor; or
• Recipient cells or tissues that may not be identical to the donor’s cells or
tissues, but that perform one or more of the same basic functions in the
recipient as the cells or tissues performed in the donor.”\(^2\)

\(^1\) 21 CFR 1271.3(c)
\(^2\)U.S. Food and Drug Administration (November 2017). Regulatory Considerations for Human
Cells, Tissues, and Cellular and Tissue-Based Products: Minimal Manipulation and Homologous
Use Guidance for Industry and Food and Drug Administration Staff.
Autologous Use: the implantation, transplantation, infusion, or transfer of human cells or tissue back into the individual from whom the cells or tissue were recovered.  

Informed and Shared Decision Making: The process by which a physician discusses, in the context of the use of regenerative and stem cell therapies, the risks and benefits of such treatment with the patient. The patient is given an opportunity to express preferences and values before collaboratively evaluating and arriving at treatment decisions.

Informed Consent: Evidence documenting appropriate patient informed consent typically includes the following elements:
- Identification of the patient, the physician, and the physician’s credentials;
- Types of transmissions permitted using regenerative and stem cell therapies (e.g. prescription refills, appointment scheduling, patient education, etc.);
- Agreement from the patient with the physician’s determination about whether or not the condition being diagnosed and/or treated is appropriate for regenerative and stem cell therapy;
- Express patient consent to forward patient-identifiable information to a third party;
- An accurate description of the benefits and risks of treatment or intervention, based on scientific evidence, as well as an explanation of alternatives to treatment or an intervention, and the right to withdraw from treatment or an intervention without denial of standard of care to patients.

Minimal Manipulation: (minor processing including purification, centrifugation, washing, preservation, storage) – the Food and Drug Administration (FDA) argues that it has the authority to regulate anything beyond minimal manipulation and homologous use: “(1) For structural tissue, processing that does not alter the original relevant characteristics of the tissue relating to the tissue’s utility for reconstruction, repair, or replacement; and (2) For cells or nonstructural tissues, processing that does not alter the relevant biological characteristics of cells or tissues.”

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3 21 CFR 1271.3(a)
6 With respect to informed consent for the purposes of research studies involving human subjects, researchers should be aware of the basic elements of informed consent outlined in 21 CFR Part 50.25 “Protection of Human Subjects.”
7 Federation of State Medical Boards (2014). Model Policy for the Appropriate Use of Telemedicine Technologies in the Practice of Medicine.
8 21 CFR 1271.3(f)
Unproven Stem Cell Intervention: Stem cell therapy that lacks compelling evidence, based upon scientific studies, to validate its treatment efficacy.⁹

Section Three. Background, Prevalence and Marketing of Regenerative and Stem Cell Therapies:

Historically, many of the clinics providing unproven stem cell interventions fell under the definition of “stem cell tourism” because most patients seeking such interventions had to travel outside of North American jurisdictions to receive them. The landscape in the United States has evolved considerably over the last few years with hundreds of new clinics opening across the country and many more physicians willing to provide stem cell and regenerative therapies. A study identified 351 U.S. businesses with over 570 clinics engaged in direct-to-consumer (DTC) marketing of stem cell interventions.¹⁰ It has also been suggested that growth in this area of medicine, especially in terms of adult, amniotic, fat-derived and bone marrow stem cell therapies to treat a host of conditions and injuries, is accelerating, both in the U.S. and internationally, and, perhaps counterintuitively, such growth is noted to be most significant in jurisdictions with more stringent regulatory frameworks.¹¹

Stem cell clinics typically reach their patients through online DTC marketing, primarily through information provided on company websites. Data purportedly supporting unproven stem cell interventions commonly undermine information about risks and overemphasize information about benefits. Treatment options are described on such websites and are often accompanied by supporting information in the form of journal articles, patient testimonials, and accolades related either to the clinic itself or its affiliated physicians and researchers. Supporting information that accompanies marketing materials can appear to be legitimate, but can also overemphasize, exaggerate, inflate, or misrepresent information derived from legitimate (or even questionable) sources. A physician engaging in such practices of deceptive or false advertising can be in violation of a state’s Medical Practice Act. Information provided on clinic websites should be represented accurately and come from reputable peer-reviewed publications or respected external organizations.

Some clinics, however, that are engaged in the provision of treatment modalities that lack evidence – or an appropriate rationale for application of that modality to particular medical conditions – often use what have been described as “tokens of scientific legitimacy” to lend credence to treatments offered or the quality of a clinic and its associated professionals. Examples of such tokens of legitimacy include patient or celebrity testimonials and

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endorsements, clinician affiliations or memberships in academic or professional societies,
registrations in clinical trials, claims of various types of certifications or awards, and others.¹²
Further detail and explanations are provided in Table 1.

Physicians are ordinarily permitted to advertise themselves, their practice and services offered,
provided that such advertisements do not contain claims that may be deceptive or are
intentionally false or misleading. Further, physicians should be mindful of ways in which patient
testimonials, quality ratings, or other evaluative data is presented to prospective patients
through advertisements. In advertising stem cell treatments to potential patients, physicians
are responsible for ensuring that all information, especially in terms of risks, benefits and
efficacy, is presented in an objective manner. Physicians must not deliberately misrepresent the
expected outcomes or results of treatments offered. Physicians should be prepared to support
any claims made about benefits of treatment(s) with documented evidence, for example with
studies published in peer-reviewed publications.¹³

Physicians must be accurate and not intentionally misleading in providing descriptions of their
training, skills, or treatments they are able to competently offer to patients. This includes
descriptions of one’s specialization and any specialty board certifications.¹⁴

A recent study on the prevalence and marketing practices of businesses offering stem cell
treatments internationally noted the presence of the following elements in their marketing
practices:

- Mention of affiliations with a professional society or network
- Claims of partnerships with academic institutions
- Statements of receipt of FDA approval, or explicit mention of exemption from FDA
  oversight
- Mention of official endorsement from a local or other authority, or professional
  accreditation
- Listing of patents granted
- Statement that clinical trials of investigational stem cell-based interventions are being
  conducted¹⁵

The marketing practices and information found on a business’ website can be important
sources of data for state medical boards as they investigate complaints made against physicians

¹³ Federation of State Medical Boards (2016). Position Statement on Sale of Goods by Physicians
and Physician Advertising.
¹⁴ Ibid.
¹⁵ Berger, et al. (2016) Global Distribution of Businesses Marketing Stem Cell-Based
affiliated with businesses providing regenerative and stem cell treatments. Even where an appropriate informed consent process seems to be in place, deceptive or fraudulent information on clinic websites and other marketing materials could mislead patients into consenting to treatment, thereby invalidating the informed consent process.

Physicians must make accurate claims about the enrollment process of subjects, treatments, and products in clinical trials and are responsible for ensuring that any research conducted and described in marketing materials is carried out according to accepted research protocols and recognized standards. Physicians should consider consulting with Institutional Review Boards (IRBs) to clarify processes and must seek IRB approval, where necessary. The National Institutes of Health (NIH) provides helpful guidance on clinical trials and research methods. Physicians are also encouraged to consult the guidance contained in the International Conference on Harmonisation’s Harmonised Tripartite Guideline for Good Clinical Practice to support acceptability of clinical data by patients, state medical boards, and other regulatory authorities.

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<th>Table 1: Co-opted Tokens of Scientific Legitimacy</th>
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Section Four. Patient Perceptions:

In seeking treatment for any condition, patients desire safety and efficacy, but may overlook risks to their own safety or a lack of evidence of efficacy in favor of access to treatment, particularly in circumstances where traditional treatment options seem limited or have been exhausted. The power of hope also is known to play a significant role in how patients attempt to gain control over their illness and its potential treatments, thereby putting them in a position of increased vulnerability. This is especially the case when patients and their families have overcome various obstacles on the path to a treatment, including raising large sums of money to pay for it. This can lead to a psychological predisposition to anticipate and assume a positive outcome, regardless of the treatment in question or the availability of compelling evidence.

Given the vulnerable state of some patients who seek regenerative and stem cell therapies, perhaps without the requisite knowledge for making informed decisions, there is increased potential for patient exploitation. Physicians must therefore be mindful of the ways in which at-risk or susceptible patients may process information and arrive at decisions about their treatment options, expectations, and ultimately, the potential for success. A promising way of navigating such difficult circumstances, where treatment options are uncertain or complex, is through the use of shared decision making. This process, whereby the physician describes the risks and benefits of potential treatment options and the patient is given an opportunity to express preferences and values before collaboratively arriving at and evaluating treatment decisions, may help mitigate the risk of patient exploitation and ensure that consent to any treatment option has been provided in an informed manner.

The process of obtaining informed consent and engaging in shared decision making with patients involves conveying information about the reasonable effectiveness of a proposed treatment, as well as its risks and benefits. This can be particularly difficult with respect to regenerative and stem cell therapies, as this is an area of medicine that currently lacks

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substantive data on efficacy. Generation of relevant data and evidence has not occurred to a sufficient enough degree and this is often blamed on the difficulty involved in organizing large-scale, randomized controlled trials as part of the approval process for novel therapies. However, the FDA has recently argued that a statistically significant 100% improvement in an outcome measure ($\alpha = 0.05$, $\beta = 0.1$) may be detected with a randomized trial involving as few as 42 participants.\(^{21}\)

The lack of a formal mechanism for reporting outcomes of unproven stem cell interventions, both positive and negative, adds to the difficulty involved in generating data on the effectiveness of such interventions, as does the fact that there is neither a requirement, nor a mechanism, for reporting adverse events related to interventions administered outside of clinical trials and investigations. In the current environment, this increases the importance of appropriate documentation of treatment(s) and ongoing care in patients’ medical records. A centralized cell therapy registry for reporting treatment and outcomes may improve the current information available about the effectiveness of such therapies and interventions. It may also dissuade unscrupulous practitioners from engaging in the provision of unproven interventions without an adequate or appropriate basis in theory or peer-acknowledged practice, a prerequisite for the provision of any intervention, whether proven or not.\(^{22}\)

Section Five. Regulatory Landscape:

The current state of affairs for regulatory oversight on regenerative and stem cell therapies (including human cells and tissues), at both the federal and state level, is evolving and will continue to change in the coming years. In November 2017, the FDA released two guidance documents to explain the Agency’s current thinking on stem cell policy. However, this thinking, as well as the agency’s jurisdiction and authority, may evolve in the future.

Until recently, the regulatory landscape for stem cell and regenerative therapies has been at times restrictive, allowing patients to access stem cell interventions only under the Expanded Access to Investigational Drugs for Treatment Use program. Treatments are eligible under this program if they are undergoing testing in a clinical trial and are subject to approval by the FDA. Three-quarters of the states in the nation have passed “Right to Try” legislation, however, which allows terminally ill patients to receive experimental therapies that have passed phase 1 trials without seeking FDA approval.\(^{23}\) The U.S. Congress is also considering similarly proposed


\(^{23}\) Lancet Commission: Stem Cells and Regenerative Medicine. Published Online October 4, 2017 http://dx.doi.org/10.1016/S0140-6736(17)31366-1
legislation and in August of 2017, the U.S. Senate passed S. 204, Trickett Wendler, Frank Mongiello, Jordan McLinn, and Matthew Bellina Right to Try Act of 2017.

The 21st Century Cures Act (Public Law 114–255), signed into law in December of 2016, represents legislative efforts at the federal level to expand and accelerate patient access to treatment, in addition to promoting innovation in medical products and treatments. With respect to regenerative medicine, the Act amends Section 506 of the Federal Food, Drug, and Cosmetic Act (21 U.S.C. 356) by requiring expedited review for regenerative medicine therapies, including human cells and tissues, intended to treat, modify, reverse, or cure a serious or life-threatening disease or condition, where there is preliminary clinical evidence indicating that the drug has the potential to address unmet medical needs. There are also ongoing efforts at the federal level to ensure even greater access to treatments that are not subject to FDA approval prior to administration to patients.

Regulation in the regenerative and stem cell therapy arena is continuing to evolve. Human cells, tissues, and cellular or tissue-based products (HCT/Ps) are currently regulated under Sections 351 and 361 of the Public Health Service Act. However, a HCT/P can be regulated solely under Section 361 of the PHS Act if it is:

1. Minimally manipulated,
2. Intended for homologous use only,
3. Not combined with another article, and
4. Either:
   a. Does not have a systemic effect and is not dependent upon the metabolic activity of living cells for its primary function; or
   b. Has a systemic effect or is dependent upon the metabolic activity of living cells for its primary function, and is for autologous use, use in a first or second-degree blood relative, or reproductive use.

The difference between an HCT/P that is regulated under both sections of the Public Health Service Act, as opposed to solely under Section 361, is significant for providers of stem cell treatments since the requirements for pre-market authorization of a product are much more stringent under Section 351 and require conducting clinical investigations under an investigational new drug (IND) application and obtaining a biologics license through the FDA, whereas requirements under Section 361 focus only on the prevention of communicable diseases. This represents a lower regulatory threshold for HCT/Ps; their use and transplantation can be considered to fall under the practice of medicine and would, therefore, be regulated by state medical boards.

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24 The Public Health Service Act of 1944 outlines a policy framework for federal and state cooperation in health services and provides for the licensing of biological products.
25 21 CFR 1271.10(a)
26 United States Food and Drug Administration: Regulatory Considerations for Human Cell, Tissues, and Cellular and Tissue-Based Products: Minimal Manipulation and Homologous Use
In regulating this evolving area of medical practice, state medical boards will need to strive to achieve an appropriate balance between respecting the autonomy of patients as they seek viable and reasonable treatment options, and adequately safeguarding them against the risks presented by novel, but often unproven and potentially dangerous, interventions. Results from a 2017 survey of its member boards conducted by the FSMB indicate that a third (n = 17) of the 51 responding boards have investigated complaints against physicians related to regenerative medicine or stem cell therapy, and that eight of those boards have taken disciplinary action against physicians for issues relating to regenerative medicine or stem cell therapy.

In ensuring that physicians offer regenerative and stem cell therapies in a manner that is consistent with safe and responsible practices, state medical boards should ensure that any treatment offered to patients is informed by an appropriate history and physical examination; such informed consent is obtained after an explanation has been provided describing risks, benefits, alternative treatment options, expected convalescence, and expected treatment outcomes; that relevant information about the clinical encounter and ongoing care plans has been documented in the patient’s medical record; that the physician is appropriately trained in, and knowledgeable about the proposed treatment; and that the patient has not been coerced in any way into receiving treatment(s) or exploited through the charging of excessive fees.

In order to implement best practices for regenerative and stem cell therapies, physicians must understand the relevant clinical issues and should obtain sufficient targeted continuing education and training.\(^27\)

The recommendations in the final section of this report provide further detail on various requirements that apply to the provision of regenerative and stem cell therapies that state medical boards may wish to consider.

**Section Six. Recommendations:**

The recommendations that follow address the regulation of the provision of stem cell and regenerative therapies, as well as their promotion and communication to patients, and documentation of treatments provided. The recommendations do not address which uses are appropriate or not for specific conditions or symptoms, as this area of medicine continues to be dynamic and subject to change. Rather, they focus on sensible and necessary principles of patient safety, autonomy, and non-exploitation.

\(^{27}\) Federation of State Medical Boards (2017). *Guidelines for the Chronic Use of Opioid Analgesics.*
The FSMB recommends that:

1. Where evidence is unavailable for a particular treatment in the form of clinical trials or case studies, physicians must only proceed with an appropriate rationale for the proposed treatment, and justification of its use, in relation to the patient’s symptoms or condition. Novel, experimental, and unproven interventions should only be proposed when traditional or accepted proven treatment modalities have been exhausted. In such instances, there must still be a basis in theory or peer-acknowledged practice.28

2. State medical boards raise awareness among licensees of applicable federal and state legislation and guidelines regarding regenerative and stem cell therapies, including “right to try” legislation existing or pending at the state and federal levels. State medical boards should also keep their licensees and the public apprised of new developments and regulations in the field of regenerative and stem cell therapies. This may include educational resources, guidance documents, and appropriate industry and stakeholder information on a state medical board’s website. State medical boards should further provide information as to reporting procedures of adverse actions related to stem cell interventions.

3. State medical boards should examine their policies and rules addressing informed consent and consider expanding these to include a shared decision making framework that includes the following general elements at a minimum:
   - An explanation, discussion, and comparison of treatment options with the patient
   - An assessment of the patient’s values and preferences
   - Arrival at a decision in partnership with the patient
   - An evaluation of the patient’s decision in partnership with the patient

4. State medical boards should review professional marketing materials and claims, including any office/clinic and/or doctor websites, and information publicly available about an office/clinic or licensee on online blogs or social media, as information sources in the investigation of complaints made against physicians.

5. State medical boards should pro-actively monitor warning letters sent to licensees that are made publicly available on the FDA website in order to ascertain information, and consider opening an investigation, about licensees who may be engaged in other unscrupulous or unprofessional practices related to the provision of regenerative and stem cell therapy. State medical boards should investigate such practices, when appropriate, in conjunction with applicable state laws, policies, and procedures.29


29 The FDA’s warning letters are available at the following address: https://www.fda.gov/ICECI/EnforcementActions/WarningLetters/default.htm
6. Physicians must only offer treatments to patients for which they have a bona fide physician-patient relationship. Physicians must have received adequate and appropriate training, and be able to perform any proposed intervention safely and competently.  

7. Physicians should employ a “shared decision making” process when discussing treatment options with patients. Physicians must avoid any claims that may be deceptive or are intentionally or knowingly false or misleading, especially in terms of making promises about uncertain or unrealistic outcomes.

8. Physicians should not use gag orders (rulings that a case must not be discussed publicly) or disclaimers as a way to circumvent liability.

9. Physicians should be prepared to support any claims made about benefits of treatments or devices with documented evidence, for example with studies published in peer-reviewed publications.

10. Physicians should refrain from charging excessive fees for treatments provided. Further, physicians should not recommend, provide, or charge for unnecessary medical services, nor should they make intentional misrepresentations to increase the level of payment they receive.

11. Physicians should consult and educate patients about stem cell interventions and alert them to important resources available to the community. A list of selected resources is provided in Appendix A.

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30 Federation of State Medical Boards (2014). Model Policy for the Appropriate Use of Telemedicine Technologies in the Practice of Medicine.
31 American Medical Association, Code of Medical Ethics, Opinion 11.3.1.
APPENDIX A: SAMPLE LIST OF EDUCATIONAL RESOURCES ON REGENERATIVE AND STEM CELL THERAPY PRACTICES

The Australian Stem Cell Handbook 2015

Stem Cell Basics (National Institutes of Health)

Stem Cell Patient booklet (Albany Medical College)

A closer look at Stem Cells (International Society for Stem Cell Research)

Patient Handbook on Stem Cell Therapies (International Society for Stem Cell Research)

Stem Cell Tourism (California Institute for Regenerative Medicine)

The Power of Stem Cells (California Institute for Regenerative Medicine)

SCOPE: Learn About Stem Cells in Your Native Language (The Niche)
WORKGROUP TO STUDY REGENERATIVE AND STEM CELL THERAPY PRACTICES

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Past President, Arizona Board of Osteopathic Examiners in Medicine and Surgery

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Former Public Member, Minnesota Board of Medical Practice

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Mayo Clinic

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Patient Appointee

Founder and Executive Director, Regenerative Outcomes Foundation

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STAFF SUPPORT

Jonathan Jagoda, MPP
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REPORT OF THE BOARDS OF DIRECTORS

Subject: Prescription Drug Monitoring Programs (PDMPs), Report and Recommendations of the Workgroup on PDMPs

Referred to: Reference Committee B

In April 2017, the FSMB House of Delegates adopted Resolution 17-1, Mandatory Use of Prescription Drug Monitoring Programs which directed FSMB to –

- Establish a task force to study PDMP use in the U.S. and its territories;
- Evaluate whether mandatory PDMP use positively impacts patient outcomes and prescribing practices;
- Evaluate the feasibility of incorporating the PDMP into an electronic medical record system; and
- Develop recommendations regarding mandatory use of PDMP data by licensed prescribers and dispensers.

Accordingly, FSMB Chair Gregory B. Snyder, MD, DABR, appointed the Workgroup on Prescription Drug Monitoring Programs (PDMP) which was comprised of a diverse group of medical and policy stakeholders. Members of the Workgroup are: Anna Z. Hayden, DO, Chairman; J. Mark Bailey, DO, PhD (University of Alabama at Birmingham); Daniel Blaney-Koen, JD (American Medical Association); Mark E. Bowden, MPA, CMBE (IA); Shawn Brooks (U.S. Food and Drug Administration); Danna E. Droz, JD, RPh (National Association of Boards of Pharmacy); Robert P. Giacalone, JD, RPh (OH); Patrice A. Harris, MD, MA (American Medical Association); Robin N. Hunter Buskey, DHSc, PA-C (NC); William K. Hoser, MS, PA-C (VT-Medical); Christina A. Mikosz, MD, MPH (Centers for Disease Control); Rebecca Poston, MHL (Electronic-Florida Online Reporting of Controlled Substance Evaluation (E-FORCSE) Program); Louis J. Prues, DMin, MDiv, MBA (MI-Medical); Jean L. Rexford (CT); Thomas H. Ryan, JD, MPA (WI); Judy Staffa, PhD, RPh (U.S. Food and Drug Administration); and Joseph R. Willett, DO (MN). Participating ex officio were Gregory B. Snyder, MD, DABR; Patricia A. King, MD, PhD, FACP; and Humayun J. Chaudhry, DO, MACP, FSMB President/CEO.

The Workgroup was charged with evaluating the impact of mandatory PDMP query on patient outcomes and the prescribing of controlled substances; evaluating challenges to increasing PDMP utilization, including, but not limited to: a) authority to access; b) currency of data; c) Electronic Medical Record (EMR) integration; and d) interoperability; and developing recommendations to state medical and osteopathic boards (hereafter referred to as “state medical boards”) regarding physician utilization of PDMPs, including a recommendation regarding mandatory query.

To accomplish its charge, the Workgroup conducted a review of PDMP statutes, rules, and state medical board policies currently enacted across the United States, research reports and peer-reviewed articles in the medical literature and policy statements regarding the use of PDMP. The
The report is provided as a guidance document for state medical boards and other state agencies to maximize the effective use of PDMPs.

The Workgroup met in person and via web conference to develop its report, *Prescription Drug Monitoring Programs (Attachment 1)*. A draft of the report was distributed to FSMB member boards and other key stakeholder organizations for comment in December 2017 with comments due January 26, 2018. Comments were generally supportive and have been incorporated to the extent that they did not substantively conflict with the Workgroup’s recommendations. The FSMB Board of Directors considered the draft report at its meeting on February 8, 2018 in Washington D.C. and discussed clarifications to the document.

**ITEM FOR ACTION:**

The Board of Directors recommends that:

The House of Delegates ADOPT the recommendations in the report, *Prescription Drug Monitoring Programs*, and the remainder of the report be filed.
INTRODUCTION

In April 2017, the Federation of State Medical Boards (FSMB) Chair, Gregory B. Snyder, MD, DABR, appointed a Workgroup on Prescription Drug Monitoring Programs (PDMP) in accordance with FSMB Resolution 17-1: Mandatory Use of Prescription Drug Monitoring Programs, which was adopted by the FSMB’s House of Delegates and which directed the FSMB to establish a task force to study PDMP use in the United States and its territories. The Workgroup was charged with evaluating the impact of mandatory PDMP query on patient outcomes and the prescribing of controlled substances; evaluating challenges to increasing PDMP utilization, including, but not limited to: a) authority to access; b) currency of data; c) Electronic Medical Record (EMR) integration; and d) interoperability; and developing recommendations to state medical and osteopathic boards (hereafter referred to as “state medical boards”) regarding physician utilization of PDMPs, including a recommendation regarding mandatory query.

This document provides recommendations for state medical boards and other state agencies to maximize the effective use of PDMPs.

In developing the recommendations that follow, the Workgroup conducted a review of PDMP statutes, rules, and state medical board policies currently enacted across the United States, research reports and peer-reviewed articles in the medical literature and policy statements regarding the use of PDMP.
Section 1. Background

Overdose deaths from prescription opioids in the United States quintupled between 1999-2016, totaling more than 200,000 deaths during that time. In 2016, more than 46 people died every day from overdoses involving prescription opioids.1 This escalating public health epidemic has led to a wave of implementations and upgrades to states’ prescription drug monitoring programs over the past decade in an effort to curb substance use disorder.

State regulatory, administrative, and law enforcement agencies have long seen the need to establish systems to track and monitor the prescribing and dispensing of certain controlled substances, a recognition that dates to 1918.2 California has the oldest continuous program, created in 1939. Early PDMPs were paper-based and collected data on Schedule II prescribing and dispensing only. Collected data was typically reported into such systems within 30 days of the time from dispensing.

In 1990, a new era of electronic PDMPs broke ground when Oklahoma became the first state to require electronic transmission of such data, which helped reduce operational costs and increase accuracy and timely submissions. By 1992, 10 states had operational PDMPs and many other states were considering establishing their own. In 1995, Nevada became the first state to expand the type of drugs reported to the PDMP, expanding from Schedule II only to Schedules II-IV. At the same time, Nevada also became the first state to provide unsolicited reports back to prescribers. By 2000, 15 states had established PDMPs. Between 2000-2012, 34 additional states established such a program, bringing the total number to states with PDMPs to 49. In 2014, the District of Columbia established a PDMP, bringing the total of operational PDMPs to 49 states, plus D.C. and Guam. Puerto Rico has also enacted legislation creating a PDMP but it is not yet operational.

As of September 2017, Missouri remains the only state without a statewide, operational PDMP. To work around this obstacle, St. Louis County established its own PDMP in March 2016 and, since then, this PDMP has gone live (as of April 2017) and more than 50 counties in the state and several individual cities have joined as participants, representing more than 70 percent of Missouri’s population and 91 percent of its prescribers.3 Separately, in July 2017, the Missouri governor issued an executive order to create a statewide PDMP that allows the Missouri Department of Health and Senior Services to analyze and identify inappropriate prescribing, dispensing, and obtaining of controlled substances, and to address these actions by making

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1 Centers for Disease Control, Opioid Data Analysis. https://www.cdc.gov/drugoverdose/data/analysis.html
referrals to appropriate government officials, including law enforcement and professional licensing boards.\(^5\)

While the common goal of PDMPs is to provide prescribers and other health care professionals with accurate information about the prescriptions that patients have obtained, a state’s decision to apply comprehensive mandates varies widely. The differences between states relate to the types of drugs monitored and the types of prescribers who are mandated to query, as well as to the circumstances which necessitate querying the PDMP, among other differences.\(^6\) For instance, some PDMPs monitor Schedules II-IV controlled substances, while others monitor Schedules II-V or certain non-controlled substances.\(^8\) Thirty-six states and the District of Columbia mandate PDMP query under certain circumstances. Of those, 27 states require querying the PDMP during the initial prescribing of a designated substance, while nine states require querying the PDMP before each prescription of a designated substance. Twelve states mandate querying the PDMP when prescribing for the treatment of pain and 14 states require it when prescribing for drug addiction. Among those states requiring a prescriber to query the PDMP prior to the initial prescription of a designated substance, some only require it if it is a Schedule II or III opioid, while others require it only if the initial opioid prescription surpasses a seven-day supply.\(^9\)

This report aims to provide guidance to state medical boards about effective PDMP use, one of many strategies being recommended to address the growing prescription opioid epidemic.

Section 2. Definitions

**Mandatory Registration** – A state’s requirement that prescribers of controlled substances must register with the state’s PDMP.

**Prescription Drug Monitoring Program** – A patient safety tool designed to facilitate the collection, analysis, and reporting of information about the prescribing and dispensing of controlled substances.\(^10\)

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\(^9\) “Mandated Use of State Prescription Drug Monitoring Programs: Highlights of Key State Requirements.” National Alliance for Model State Drug Laws, June 2017. [http://www.namsdl.org/library/6735895A-CA6C-1D6B-B8064211764D65D0](http://www.namsdl.org/library/6735895A-CA6C-1D6B-B8064211764D65D0/)

Universal Use – A state’s requirement that prescribers must query the patient’s PDMP history before initially prescribing opioid pain relievers and benzodiazepines, and at certain intervals thereafter.\[11\]

Unsolicited Reports – Proactive communications from the PDMP to prescribers, dispensers, law enforcement, and/or regulators to provide information about patient prescriptions and/or the prescribing activity of a health care professional based upon PDMP data.\[12\]

3. Mandatory Registration

Studies show that between 2010-2012, states with operational PDMPs saw an average registration rate of 35 percent among licensed prescribers who prescribed at least one controlled substance during that period.\[13\] In 2014, a national survey found that 53 percent of primary care physicians used their state’s PDMP at least once, but many were not using the PDMP on a routine basis.\[14\] Although there have been extensive educational campaigns to recruit prescribers to participate in their state’s PDMP, results have not always been successful.\[15\] At the same time, however, PDMP registration has increased significantly, increasing from approximately 471,000 to more than 1.3 million from 2014 to 2016. During the same time period, queries by physicians and other health care professionals increased from approximately 61 million to more than 136 million.\[16\]

States are seeing success in increasing prescriber PDMP registration rates through other methods, such as mandatory registration. Massachusetts took a staggered, low resource-intensive approach by linking PDMP enrollment to the renewal of state controlled substance registration, where renewals are required every three years for practitioners. The process established by Massachusetts allowed for a continuous workflow for PDMP staff, rather than a surge in applications immediately after the enactment of mandatory PDMP registration legislation. As a result, the state first saw a gradual increase in registration, followed by a more dramatic increase, between 2011-2016. In 2011 and 2012, only 1 percent and 2 percent of prescribers were registered with the PDMP, respectively. By the end of 2014, however, nearly 66 percent of prescribers were enrolled. By September 2015, that percentage increased to 83 percent, and by January 2016, more than 90 percent had enrolled.\[17\]

4. Universal Use

\[11\] CDC Prevention Status Report, [https://wwwn.cdc.gov/psr/NationalSummary/NSPDO.aspx](https://wwwn.cdc.gov/psr/NationalSummary/NSPDO.aspx)


\[14\] Ibid.

\[15\] Ibid.


Research shows that between 2011-2014, 85 percent of states that implemented some form of a PDMP universal use mandate were based upon legislation that was of limited scope and strength. Due to the weakness of the mandates in these cases, it is unlikely that they will prove effective in improving opioid prescribing practices. Efforts to strengthen universal use mandates are supported by President Donald Trump’s Commission on Combating Drug Addiction and the Opioid Crisis, which recommends that federal agencies mandate PDMP querying.

States that have established an effective PDMP, in part or in whole, employ certain evidence-based practices. These practices include delegated authority, unsolicited reports, data timeliness, streamlined enrollment, educational initiatives, integration and data sharing, enhanced user interfaces, and proper funding, with delegated authority, data timeliness, and integration and data sharing being critical elements.

Delegated Authority

Prescription Drug Monitoring Programs can serve as valuable tools to help inform prescribers’ decision making and identify potential substance use disorder, but a significant barrier to increasing prescriber use of them is the time typically needed to query the system. To decrease the time spent by prescribers reviewing patient records, many states authorize registered users to delegate non-prescriber employees the ability to access the system using sub-accounts. States vary, however, in whether a delegate has to be a licensed individual or not, as well as in the number of prescriber delegates permissible. Currently, 47 states and the District of Columbia authorize prescribers to delegate such authority, with 36 states actively doing so. Some states only permit two delegates per prescriber, while others impose no limits.

In Kentucky, the state’s PDMP, known as the Kentucky All Schedule Prescription Electronic Reporting Program (KASPER), does not restrict the number of subaccounts to licensed staff. Prescribers also have no limit on the number of designated delegates, who are also permitted to serve as a delegate for multiple prescribers. For prescribers sharing multiple delegates, delegates are able to select the prescriber from a dropdown list to accurately record for which prescriber a

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The report is being queried. The prescriber is responsible for deactivating accounts of delegates who leave the practice or otherwise warrant discontinuance of PDMP access. Delegates are permitted to conduct queries and provide reports for prescriber review, but are prohibited from conducting the clinical review of data that the state’s mandate requires. As a result of allowing such delegated authority, during the fourth quarter of 2015 delegates requested nearly 64 percent of in-state prescriber reports, despite accounting for 42 percent of combined delegate and prescriber master accounts by the end of that year. 

**Unsolicited Reports**

PDMPs provide prescription history reports to authorized users upon request (these are also known as “solicited” reports), but when these reports are not requested useful information can go unseen or unused by prescribers. In an effort to increase utilization, many PDMPs proactively send “unsolicited” (and, therefore, unrequested) reports to specific prescribers, dispensers, state licensing boards, and law enforcement agencies that contain data suggestive, or indicative, of multiple provider episodes or inappropriate prescribing and dispensing.

In 2005, Maine began sending prescribers quarterly threshold notification reports via U.S. mail, but in 2013 moved to monthly emailed alerts. Originally, these alerts were sent to registered PDMP users only when one of three criteria was met by a patient: 1) exceeds a certain number of prescribers and pharmacies in a three-month period; 2) exceeds a specified average daily dose of acetaminophen coming from prescriptions of opioid-acetaminophen combination drugs; or 3) is prescribed buprenorphine and another opioid in a 30-day period. In 2015, however, the state’s legislature added two new criteria to initiate alerts: 1) multiple overlapping prescriptions for medications containing opioids; and 2) prescriptions for more than 300 morphine milligram equivalents daily for more than 45 consecutive days within a 90 day period. Alert recipients must log into their PDMP account to review the patient’s prescription history, which includes the other providers who prescribed to the patient, the pharmacies that dispensed to the patient, drugs and quantities and other details of prescriptions dispensed for the past three months. Additionally, the state recently enabled prescribers to request reports based on their own set thresholds. It is believed that unsolicited reports may have affected prescriber behavior from 2010 to 2014 when the state saw a steady decline in the rate of multiple provider episodes.

Additionally, in Indiana, a prescriber who believes a patient’s PDMP data suggests questionable activity has the option to send email alerts to other prescribers and dispensers of the patient. These “user-led unsolicited report” email alerts do not contain a patient’s name or any conclusions, but rather contains a hyperlink to a patient’s prescription history report that registered users can review after logging into the PDMP, thus ensuring Health Insurance Portability and Accountability Act (HIPAA) compliance. These alerts serve to notify prescribers and dispensers that a patient may be using unnecessary prescription drugs, may be receiving controlled substances from multiple providers, or may be involved in controlled substance

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24 Ibid.
26 Ibid.
diversion. Indiana first launched its user-led unsolicited reports in March 2012. After the first three months of the program, 140 practitioners had sent 2,284 alerts on 214 unique patients, at virtually no cost to the program.\(^{27}\)

**Data timeliness**

A prescriber’s ability to effectively use PDMP data to assess a patient’s prescription history can only be as complete as the data that is transmitted into the system by a dispenser. If a PDMP report does not contain information about the most recently dispensed controlled substances, a prescriber may lack valuable data to determine the best course of treatment. Because of this, it is imperative to minimize the pharmacy reporting interval. States are increasingly moving away from weekly reporting towards daily PDMP data reporting. In 2015, 24 states required daily data submissions. As of July 2017, 40 states and the District of Columbia required data to be reported within 24 hours or one business day. Oklahoma is the only state currently requiring real-time reporting,\(^ {28}\) but the transition from daily reporting to real-time required two years and involved intensive effort and overtime for the PDMP, as well as redesign for pharmacy data systems and workflow procedures.\(^ {29}\)

**Streamlined Enrollment**

In order to access PDMP data, prescribers must typically establish online accounts with a state’s PDMP system. This process requires the prescriber to submit, and the PDMP to verify, identifying information, such as name, date of birth, state controlled substance prescribing or medical practice license number, DEA registration number, driver’s license number, place of employment, medical specialty, and contact information. Once the prescriber’s state controlled substance prescribing or medical practice license number and a DEA registration number is verified, the prescriber may create an account and begin to query patients’ controlled substance prescription history. Unfortunately for many prescribers, the process can be time consuming to complete registration applications as some states require paper applications and notarization.\(^ {30}\)

To expedite PDMP registration, and to transition away from paper applications, some states began migrating to an online registration system, in addition to automatic prescriber enrollment, during initial medical licensure and licensure renewal.

In 2012, the Tennessee Legislature enacted legislation mandating that prescribers use the state’s PDMP and dispensers register. The comprehensive mandate required DEA-registered prescribers and dispensers to register with the PDMP within the first eight months after the law’s enactment. New licensees are required to register with the PDMP within 30 days. The universal use mandate went into effect four months after prescribers and dispensers were required to register. In an

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\(^{28}\) National Alliance for Model State Drug Laws, “Frequency of Prescription Drug Monitoring Program Data,” 30 June 2017. [http://www.namsdl.org/library/03B95893-0EE2-3766-EABAD212B5C8E8D3/](http://www.namsdl.org/library/03B95893-0EE2-3766-EABAD212B5C8E8D3/)


effort to handle the influx of registrations, Tennessee adopted an online registration system. This system automatically attempts to validate a prescriber’s information using electronic databases for the state’s professional health care licenses, driver’s licenses, and DEA prescriber registration. For prescribers who do not have health care licenses or DEA numbers, such as medical residents in hospitals in some states, PDMP registration is still processed manually. As a result of the streamlined online registration system for licensed prescribers and dispensers, the number of registered prescribers has increased 127 percent between 2011 (a year before the mandate went into effect) and 2014. Additionally, average queries per month have increased 203 percent during that same time period.\(^{31}\)

**Educational Initiatives**

Many state medical boards require physicians to complete continuing medical education (CME) in specific content areas, such as pain management and controlled substance prescribing practices. Thirty-two of the 50 states, and the District of Columbia, mandate at least one content-specific CME course. Of those 32 states, 29 states require CME focused on either pain management or controlled substance prescribing practices, or in some circumstances both. In 26 out of those 29 states, the CME requirements are for both allopathic and osteopathic physicians. In two states, Oklahoma and Nevada, only osteopathic physicians are required to complete CME on pain management/controlled substance prescribing practices, while in Vermont only allopathic physicians are required to complete such CME. Additionally, 12 of the 29 states require CME on pain management/controlled substance prescribing practices for all physicians, while the other 17 states only require a subset of physicians to complete such requirements, such as controlled substance providers or certain providers who work in pain clinics.\(^{32}\)

In order to assist prescribers in completing CME requirements, as well as educate prescribers who are not required to complete content-specific CME, the federal government promotes certain educational initiatives. The U.S. Department of Health and Human Service’s (HHS) Substance Abuse and Mental Health Services Administration (SAMHSA) and the Health Resources and Services Administration (HRSA) jointly developed the “Substance Use Trainings” webpage as an online educational resource that provides one-time and ongoing training activities dedicated to pain management and controlled substance prescribing practices. HHS’s Office of Disease Prevention and Health Promotion also developed an online education resource, *Pathways to Safer Opioid Use*, while the U.S. Food and Drug Administration’s (FDA) Risk Evaluation and Mitigation Strategy (REMS) for extended release/long-acting opioids requires CME to be offered by opioid manufacturers.\(^{33}\) As part of REMS, the FDA released the *FDA Blueprint for Prescriber Education for Extended-Release and Long-Acting Opioid Analgesics*, which contains core educational messages for the development of continuing...


\(^{33}\) Ibid.
education activities focused on safe prescribing. The Centers for Disease Control (CDC) also provides educational materials, such as Applying CDC’s Guideline for Prescribing Opioids: An Online Training Series for Providers and What Healthcare Providers Need to Know About PDMPs. While a majority of states require physicians to complete certain content-specific CME, FSMB policy states that, “the FSMB believes mandatory continuing medical education is a matter reserved for the individual state jurisdictions.”

Integration and Data Sharing

The value of PDMP data is based in part on whether such data is readily available and accessible. Although PDMPs collect controlled substance prescription information in a central repository, the adoption and utilization of a PDMP by prescribers is slowed when such data is not integrated into health information technology (HIT) systems, specifically electronic health records (EHR).

There have been several efforts and initiatives to spur the pace at which PDMP data is integrated, such as SAMHSA’s PDMP Electronic Health Records Integration and Interoperability Expansion (PEHRIIE) program, which funded projects in nine states from 2012-2016. The goal of this program was to increase prescriber utilization by integrating PDMP data into HITs. The program also sought to increase the comprehensiveness of PDMP data by increasing interstate PDMP data sharing.

Programs such as PEHRIIE demonstrate the effectiveness of integrating PDMP data into HITs. During the fourth quarter of 2014, the state of Washington became interoperable with OneHealthPort, a statewide HIE, enabling integration with the Emergency Department Information Exchange (EDIE), a hub connecting hospital emergency departments. In 2015, the first full calendar year after integration, the PDMP provided 2,222,446 solicited reports to prescribers, compared to 2014, when 26,546 solicited reports were provided to prescribers. Significant increases in solicited reports were also experienced in Kansas after PDMP data was integrated with the Via Christi Health Network, the largest healthcare provider in Kansas, in late 2013. After integration, solicited reports provided to Via Christi prescribers increased from 31,156 reports in 2013 to 223,000 reports in 2015. Compared to other prescribers in Kansas, the number of solicited reports increased significantly less, from 23,171 in 2013 to 65,242 in 2015.

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36 Centers for Disease Control, What Healthcare Providers Need to Know About PDMPs. https://www.cdc.gov/drugoverdose/pdmp/providers.html
37 Federation of State Medical Boards (FSMB), FSMB Policy 100.2, Mandating Continuing Medical Education, Washington, DC: The Federation, 1980.
39 Ibid.
Several states also announced efforts to integrate prescription drug information into EHRs and other HITs. In August 2017, Indiana announced that it would integrate PDMP data into EHRs at hospitals and physician practices across the state at no cost to the facility or individual practitioner. The phased-in integration is scheduled to be completed by 2020.40 Michigan also announced in June 2017 that state and federal funds will be invested over a two year period to integrate the state’s PDMP, Michigan Automated Prescription System, into EHRs and pharmacy dispensation systems.41 Additionally, Arizona, Kansas, Massachusetts, Ohio, Pennsylvania, and Virginia are supporting integration into EHRs, HITs, and pharmacy dispensing systems at no cost.

These recent state trends to integrate PDMP data are in line with recommendations being conveyed at the federal level, including the President’s Commission on Combating Drug Addiction and the Opioid Crisis, which recommended in November 2017 that “PDMP data integration with electronic health records, overdose episodes, and substance use disorder-related decision support tools for providers is necessary to increase effectiveness.”42

The ability for prescribers to view prescription drug history information across state lines can assist in identifying a potential substance use disorder. To facilitate interstate PDMP data sharing and integration, states have opted to connect to a data sharing hub. Forty-five states and the District of Columbia are currently engaged in some form of interstate data sharing, while three other states are in the process of implementing data sharing.43 Not all states, however, allow universal data sharing among states. Some states allow prescribers in any state to access PDMP data, while other states allow prescribers from specific states within a region. These are usually in-state policy decisions that often change to expand toward a goal of universal access.

The President’s Commission on Combating Drug Addiction and the Opioid Crisis also recommended supporting federal legislation mandating states that receive grant funds to comply with PDMP requirements, including data sharing, and establishing and maintaining a data-sharing hub.44

In an effort to reduce barriers to data sharing across state lines, there have been various data sharing hubs launched to facilitate data sharing in compliance with each state’s data access regulations. At the request of several PDMPs, the National Association of Boards of Pharmacy (NABP) created Prescription Monitoring Program (PMP) InterConnect in 2011. PMP InterConnect provides for encrypted data to be transmitted across state lines. To date, 45 states have executed a memorandum of understanding (MOU) with NABP to participate and 42 of

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those states are now live. Each month, PMP InterConnect processes more than 15 million requests.45

Separately, RxCheck is another data sharing hub that was created with support from the U.S. Bureau of Justice Assistance (BJA) and using the Prescription Monitoring Information Exchange (PMIX) National Architecture specifications. As of July 2017, there are four states that are engaged in interstate data sharing with RxCheck, while two states are currently implementing interstate data sharing and eight states have plans to connect to RxCheck.

Enhanced User Interfaces
While having access to PDMP data is integral for prescribers, it is equally important that prescribers are able to quickly analyze and use that data. As the amount of controlled substance prescription information available to prescribers has increased in recent years, prescribers have sought ways to quickly analyze the most important information for clinical decision making. To address this, states began exploring ways to better interpret the data. Some of these methods included adding an enhanced user interface to the PDMP system that includes, but is not limited to, a total morphine milligram equivalent (MME) calculation for each opioid prescription, a daily MME dose level, and flags or alerts if a patient’s MME surpasses a certain threshold.46

In 2016, the California PDMP, Controlled Substance Utilization Review and Evaluation System (CURES) underwent a redesign to help prescribers improve their clinical decision-making when evaluating whether to prescribe a controlled substance. The new updated program contains a dashboard that provides users patient alerts, including a list of patients who are prescribed more than 100 MME per day; have obtained prescriptions from six or more prescribers or pharmacies during the past 12 months; are prescribed more than 40 milligrams of methadone daily; have been prescribed opioids for more than 90 consecutive days; or are concurrently prescribed benzodiazepines and opioids.47

Enhanced user interfaces are a recent development and, as such, there is a paucity of evidence on its effectiveness in identifying a potential substance use disorder or coordinating care in the case of a multiple provider event.

Data Security/Patient Protections
As the use of PDMP increases nationwide and controlled substances prescription history is increasingly used by prescribers, patients are increasingly concerned about the security of their data and the possibility of law-enforcement scrutiny. Prescribers are also increasingly concerned

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that medical consultations are no longer a private affair and that staff access pose the potential for unscrupulous use and data leaking.\textsuperscript{48}

Substance use disorder is a multifaceted problem and often requires collaboration among various agencies and stakeholders. PDMPs are primarily used as a public health tool, but law enforcement agencies see PDMPs as a potential law enforcement tool. An increase in law enforcement scrutiny of PDMP data may significantly affect a prescriber’s clinical decision making and cause a prescriber to under prescribe.\textsuperscript{49}

A balanced approach between patient safety and data protection has been encouraged by various stakeholders. Both the American Medical Association (AMA) and the American Society of Addiction Medicine (ASAM) believe that PDMP data should be considered protected health information, and should not be released outside of the health care system unless there is authorization for release from the individual patient. The AMA also supports access to PDMP data via a warrant, as well as when the public safety demands in certain situations.\textsuperscript{50}

The United States District Court for the District of Oregon, Portland Division affirmed the limits of law enforcement access in February 2014 in \textit{Oregon Prescription Drug Monitoring Program v. United States Drug Enforcement Administration}. The Court found that federal drug investigators cannot access patients’ prescription information without proving probable cause and obtaining a warrant. The Court also found that administrative subpoenas are insufficient to demand information relevant to investigations into potential drug violations, such as a doctor who improperly prescribes drugs.\textsuperscript{51} In June 2017, the United States Court of Appeals for the Ninth Circuit reversed the ruling as it found that requiring a court order to enforce the subpoena on the DEA interfered with Congress’ intent to strengthen law enforcement tools against the traffic of illicit drugs. It recognized, however, that medical records require strong legal safeguards.\textsuperscript{52}

In Georgia, in addition to authorizing prescribers and dispensers, and their designated delegates, the Georgia Drugs and Narcotics Agency is authorized to provide requested prescription information collected to a patient, or the patient’s attorney; local or state law enforcement or


\textsuperscript{49} Ibid.


prosecutorial officials pursuant to the issuance of a search warrant from an appropriate court or official in the county in which the office of such law enforcement or prosecutorial officials are located or to federal law enforcement or prosecutorial officials pursuant to the issuance of a search warrant or a grand jury subpoena; to the Georgia Drugs and Narcotics Agency, the Georgia Composite Medical Board or any other state regulatory board governing prescribers or dispensers in this state, or the Department of Community Health for purposes of the state Medicaid program upon the issuance of a subpoena by such agency, board, or department pursuant to their existing subpoena power or to the federal Centers for Medicare and Medicaid Services upon the issuance of a subpoena by the federal government pursuant to its existing subpoena powers.  

Proper Funding

To continually maintain and update a state’s PDMP system often comes with a certain level of financial need. It is often difficult, however, for states to properly fund such operations and projects. In order to meet these demands, states use a wide variety of funding mechanisms, whether in whole or in part, including state appropriations, registration and licensing fees, and federal grants.

One source of funding for states has been legislative appropriations and state government funding. In October 2015, Ohio Governor John Kasich announced that the state would invest up to $1.5 million a year to integrate the Ohio Automated Rx Reporting System (OARRS) directly into electronic medical records and pharmacy dispensing systems across the state, allowing instant access for prescribers and pharmacists.  

In addition to licenses to practice medicine, several states require a controlled substance prescribing license that is separate from DEA registration. The registration fees from these state prescribing licenses frequently go to support the PDMP, whether in full or in part. This funding mechanism assesses a fee on a subset of providers while the more current thinking is that all licensed providers should have access to their patients’ PDMP data.  

Instead of allocating funds from a specific controlled substance prescribing license, some states allocate a certain percentage from all professional licensing fees to go towards the state’s PDMP. Although this avenue provides consistent funding, it is limited in dollar amount and increasing the allocated percentage may affect other operations of the Board.  

States often leverage federal grants to fund and maintain PDMP projects, as well. Since 2003, the U.S. Department of Justice’s Bureau of Justice Assistance has administered the Harold Rogers PDMP Grant Program to reduce opioid misuse and the number of overdose fatalities by

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54 Ga. Code § 16-13-30  
supporting the implementation, enhancement, and proactive use of state PDMPs. For Fiscal Year 2017, two-year grants were awarded to 10 states and Puerto Rico totaling $3,966,932.\textsuperscript{59} The CDC also provides funding opportunities to support states’ efforts to enhance and maximize PDMPs, including the Data Driven Prevention Initiative (DDPI) and Prevention for States (PfS) Funding Opportunity Announcements.\textsuperscript{60,61} Additionally, SAMHSA also provides a variety of funding opportunities for states to enhance their PDMPs.\textsuperscript{62}

5. Recommendations

1. Mandatory Registration –
States should require PDMP registration for prescribers of controlled substances. This registration should take place at the time of the prescriber’s initial medical licensure application or next renewal. In an effort to expedite the process, state PDMPs should facilitate online registration to meet the expected increase in applications.

2. Universal Use of PDMPs–
States should require universal use of PDMPs if the state’s PDMP contains certain characteristics. Ideally, all the characteristics listed below would be present within a state’s PDMP system but some are more critical than others to the functionality of the PDMP.

a. Group 1: Critical Characteristics Needed for an Effective PDMP
i. Delegation –
Each prescriber should be permitted to delegate authority to access the PDMP to any member of their health care team by creating subaccounts without limitations. Delegates should be able to be shared by multiple providers, such as a physician group or emergency department or similar setting. The prescriber must have the authority to deactivate a delegate’s subaccount for any reason, including, but not limited to, leaving the practice or no longer serving in that capacity.

In order to ensure delegate accountability, prescribers must be allowed to audit their delegates’ activity and use of the PDMP.

\textsuperscript{59} U.S. Department of Justice, Bureau of Justice Assistance, Harold Rogers PDMP Grant Program, \url{https://www.bja.gov/funding/Category-5-awards.pdf}
\textsuperscript{60} Centers for Disease Control, Data Driven Prevention Initiative. \url{https://www.cdc.gov/drugoverdose/foa/ddpi.html}
\textsuperscript{61} Centers for Disease Control, Prevention for States. \url{https://www.cdc.gov/drugoverdose/states/state_prevention.html}
\textsuperscript{62} Substance Abuse and Mental Health Services Administration. Grants Related to Prescription Drug Misuse and Abuse. \url{https://www.samhsa.gov/prescription-drug-misuse-abuse/grants}
ii. Data timeliness/accuracy –
State PDMPs should require daily reporting of controlled substance prescription. Although it may be ideal to have real-time reporting, there is a paucity of data at this time to support it.\(^6\)

In order to ensure data accuracy, prescribers should be able to review their prescribing history and provide corrections to it, if necessary.

iii. Integration and Data Sharing –
In order to minimize any workflow disruption, states should integrate their PDMP system with electronic health records and pharmacy systems. Ideally, this integration will provide near-instant and seamless access to critical prescription history information to both prescribers and pharmacists.

States should engage in interstate PDMP data sharing.

b. Group 2: Other Characteristics Needed for an Effective PDMP

i. Unsolicited reports –
In an effort to notify prescribers of a patient’s prescribing information, as well as the prescriber’s own prescribing history, PDMP systems should provide unsolicited reports. Examples of information in such reports may include multiple provider episodes, combinations of commonly misused drugs, or exceeding a designated threshold for an average daily dose of an opioid in morphine milligram equivalents.

To protect patients, prescribers should generate user-led unsolicited reports to send to other prescribers treating the same patient. These user-led unsolicited reports are sent at the discretion of the prescriber and serve as a judgment that the patient may be receiving a potentially harmful controlled substance or has experienced a situation, such as an overdose, that may increase the patient’s future risk of overdose or abuse.

When possible, these reports should be sent electronically and should not contain identifying patient information, but rather alert and direct the prescriber to query the PDMP to view the information.

ii. Educational initiatives –
A state medical board may choose to encourage or require prescribers to complete content-specific continuing medical education related to prescribing practices including, but not limited to, PDMP utilization.

iii. Enhanced user interface –

PDMP system tools to increase usability for prescribers should be considered. These components, as part of a PDMP’s interface, may include, but are not limited to, a summary of morphine milligram equivalent (MME) for each opioid prescription and a daily MME dose level, as well as any other “red” flags or alerts for a specific patient.

iv. Data Security/Patient Privacy —
States should grant PDMP data access to local, state, and federal law enforcement only when there is an issuance of warrant/judicial finding of probable cause.

States should grant PDMP data access to state medical boards when a licensee is under investigation by the board for inappropriate prescribing.

In order to protect the privacy of patient information and to ensure proper patient treatment, Medicare, Medicaid, state health insurance programs and/or health care payment benefit providers and insurers should not have access to a patient’s PDMP record unless a subpoena has been issued in accordance with existing subpoena powers.

v. Proper funding —
To meet the demands of updating and maintaining a PDMP, states should implement a sustainable funding mechanism, whether through state funding or federal grant programs.
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The Federation of State Medical Boards (FSMB) Workgroup on Physician Wellness and Burnout, chaired by Dr. Arthur S. Hengerer, M.D., has been tasked with examining the issues of physician wellness and burnout from a regulatory perspective, identifying key patient safety issues, and determining ways in which member boards can be supported.

The Workgroup’s charge includes identifying resources and strategies to address physician burnout. In accomplishing its charge, the Workgroup focused on: 1) educating state medical boards and physicians through the creation of a compendium of research and resources on identifying, managing and preventing physician burnout; 2) raising awareness about the prevalence of burnout among physicians and other health care professionals and thereby reducing stigma associated with seeking help for burnout symptoms; 3) evaluating current research on the impact of physician burnout on patient care; and 4) convening stakeholder organizations and experts to discuss physician wellness and recommend best practices for identifying, managing and preventing physician burnout throughout the career continuum.

Over the course of two years, the Workgroup examined the issue of physician burnout from a broad perspective, reviewing existing research, resources, and strategies for addressing it. The Workgroup has drafted a report that includes recommendations, most of which pertain to the licensing and license renewal processes of state medical boards, as well as suggestions for external organizations that aim to address physician burnout. Workgroup members include Mohammed A. Arsiwala, MD; Amy Feitelson, MD; Doris C. Gundersen, MD; Kathleen Haley, JD; Brian J. Miller, MD; Roger M. Oskvig, MD; Michael R. Privitera Jr., MD; Jean L. Rexford; Dana C. Shaffer, DO; Scott A. Steingard, DO; and Barbara E. Walker, DO.

A draft of the report was distributed to FSMB member boards in December 2017, as well as to several external organizations and individuals with a nexus to physician wellness and burnout. Comments received were generally positive and the Workgroup has revised its Report to address them, where appropriate. The FSMB Board of Directors considered the draft Report of the FSMB Workgroup on Physician Wellness and Burnout at its meeting on February 7, 2018 in Washington D.C. and discussed clarifications to the document.

ITEM FOR ACTION:

The Board of Directors recommends that:

The House of Delegates ADOPT the recommendations contained in the Report of the FSMB Workgroup on Physician Wellness and Burnout, and the remainder of the Report be filed.
Attachment 1
FSMB Workgroup on Physician Wellness and Burnout

Draft Report and Recommendations

Executive Summary:

The Federation of State Medical Boards (FSMB) Workgroup on Physician Wellness and Burnout was convened in April of 2016 by FSMB Chair Arthur S. Hengerer, M.D. to identify resources and strategies to address physician burnout.

While the Workgroup examined the issue of physician burnout from a broad perspective, reviewing as many facets of this complex issue as possible, including existing research, resources, and strategies for addressing it, the recommendations for state medical and osteopathic boards (hereinafter referred to collectively as “state medical boards”) found in this report focus first and foremost on the licensing process. The Workgroup also saw fit to include commentary and recommendations on several other aspects of physician wellness and burnout, though some of these areas may not be under the direct purview of the FSMB or its member boards. The FSMB recognizes the importance of collaboration for effectively supporting physicians and protecting patients in the face of circumstances that lead to burnout, which is ultimately a patient safety issue. A shared accountability model that includes responsibilities to be carried out by providers from all the health professions, including physicians and physician assistants, and with organizations from across the health care community is therefore recommended as the most promising course of action to address this important issue.

Recommendations for state medical boards related to the licensing process include considering whether it is necessary to include probing questions about a physician applicant’s mental health, addiction, or substance use on applications for medical licensure or their renewal, and whether the information these questions are designed to elicit, ostensibly in the interests of patient safety, may be better obtained through means less likely to discourage treatment-seeking among physician applicants.

Where member boards strongly feel that questions addressing the mental health of physician applicants must be included on medical licensing applications, several recommendations are included in this report for the appropriate phrasing of such questions, including focusing only on current impairment, which may be more meaningful in the context of a physician’s ability to provide safe care to patients in the immediate future.

State medical boards are also encouraged to approach physician wellness and burnout from a non-punitive perspective, avoiding public disclosure of any information about a physician’s diagnosis during licensing processes and offering “safe haven” non-reporting options (mentioned later in this report) to physicians
who are under treatment and in good standing with a recognized physician health program (PHP) or other appropriate care provider.

It is also recommended that boards take advantage of all opportunities available to them to discuss physician wellness, communicate regularly with licensees about relevant board policies and available resources, and make meaningful contributions to the ongoing national dialogue about burnout in order to advance a positive cultural change that reduces the stigma among and about physicians seeking treatment for mental, behavioral, physical or other medical needs of their own.

The Workgroup’s recommendations to external organizations and stakeholders focus on increasing the awareness and availability of information and resources for addressing physician burnout and improving wellness. The value of noting and listing the availability of accessible, private, confidential counselling resources is a particular point of emphasis in this report, as is dedicating efforts to ensuring that any new regulation, technology, or initiative is implemented with due consideration to any potential for negative impact on physician wellness.

This report, which follows two years of careful study, evaluation and discussion by Workgroup members, FSMB staff, and various stakeholders, is intended to support initial steps by the medical regulatory community to begin to address the issues associated with promotion of physician wellness and mitigation of burnout, to the extent that is possible. The information and recommendations contained herein are based on principles of fairness and transparency, and grounded in the primacy of patient safety. They emphasize a responsibility among state medical boards to work to ensure physician wellness as a component of their statutory right and duty to protect patients.

Background and Charge:

In 2014, the Ethics and Professionalism Committee of the Federation of State Medical Boards (FSMB) engaged in several discussions about the risks to patient safety that may result from disruptive physician behavior. As these discussions proceeded, it became apparent from a review of the literature and discussions with state medical boards that a link exists between many instances of disruptive behavior and symptoms of professional burnout experienced by so-called “disruptive physicians.” The Committee, chaired by Dr. Janelle A. Rhyne, M.D., MACP, determined that further research into physician health, self-care, and burnout should be conducted to identify resources that may be of value for state medical boards and physicians alike, and to outline possible roles for the FSMB and its partners to better promote patient safety and quality health care.

Given the complexity of the issue and the many factors contributing to physician burnout, in 2016, Dr. Arthur S. Hengerer, MD, (while serving as Chair of the FSMB), established the FSMB Workgroup on Physician Wellness and Burnout to study the
issue further. The Workgroup was specifically charged with identifying resources and strategies to address physician burnout. To accomplish its charge, the Workgroup reported that it would engage in a multi-part work program that would likely involve: 1) educating state medical boards and physicians through the creation of a compendium of research and resources on identifying, managing and preventing physician burnout; 2) raising awareness about the prevalence of burnout among physicians and other health care professionals, helping reduce the stigma sometimes associated with physicians seeking help for burnout symptoms; 3) evaluating current research on the impact of physician burnout on patient care; and 4) convening stakeholder organizations and experts to discuss physician wellness and to recommend best practices for promoting physician wellness and helping physicians identify, manage and prevent burnout throughout their career continuum (i.e. from medical school through residency training and throughout their years of licensed, unsupervised practice.)

The purpose of this report is to summarize the steps taken by the Workgroup in fulfilment of their charge, to share information gathered as part of this process, and to provide a series of recommendations for state medical boards and others to consider for addressing burnout and its symptoms. It should be noted that the Workgroup’s charge does not include tasks related to defining the phenomenon of burnout or performing further analysis into the concept itself, as it was felt there is a significant amount of valuable research that has already been done in these areas and is ongoing. Much of this research, including some that is inchoate, was reviewed by the Workgroup in fulfilment of the third component of its charge. This body of research is referenced herein and informs many of the recommendations contained in this report. While burnout is a phenomenon that may impact physicians at all stages of their career, it should be noted that the recommendations specific to state medical boards in this report focus primarily on the licensing process. The Workgroup feels it is also important, however, to share information in this report related to issues beyond the licensing process. Such additional information and guidance is provided for the benefit of relevant partner organizations and stakeholders responsible for undergraduate, graduate and continuing medical education; medical school, residency training and health facility accreditation; governance, information technology, health insurance, and other activities and functions that support the provision of health care to the nation’s citizens.

In developing the content and recommendations of this report, the Workgroup understands and endorses the importance of the “quadruple aim,” which added a call for improvements in the quality of work lives of physicians and other health care providers\(^1\) to the existing three aims of improving the health of populations, enhancing the patient experience of care, and reducing the per capita cost of health

As argued by proponents of the fourth aim, improved population health care cannot be achieved without ensuring the health and well-being of health care providers.

Several definitions have been applied to the phenomenon of physician burnout and, for the purposes of this report, it is considered a psychological response that may be experienced by doctors exposed to chronic situational stressors in the health care practice environment. This is characterized by overwhelming exhaustion, feelings of cynicism and detachment from work, and a sense of ineffectiveness and lack of accomplishment. While burnout's manifestations and consequences vary widely, they could result in significant harm to patients.

It has been widely reported for more than a decade that nearly 100,000 preventable medical errors occur in the United States each year. More recent findings suggest that between 210,000 and 400,000 deaths each year are associated with preventable harm. Many of these errors may be attributed to physician burnout and its drivers, such as excessive caseloads, negative workplace culture, poor work-life balance, or perceived lack of autonomy in one’s work. Burnout affects a significant proportion of the U.S. physician workforce. A 2012 study conducted by Shanafelt and colleagues showed that 45.5% of surveyed physicians demonstrated at least one symptom of burnout. When this study was repeated three years later with a different sample, the authors demonstrated that burnout and work-life dissatisfaction had increased by 9% over the three year period. In addition to obvious risks to patient safety, an alarming and extreme result of physician burnout has been the disproportionate (relative to the general population) levels of suicide.

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in recent years by physicians, medical residents and even medical students.\textsuperscript{9,10} One
is hard-pressed to find a phenomenon that negatively affects a broader array of
stakeholders in health care than burnout. It impacts providers from all health
professions. State medical boards’ duty to protect the public, in this regard, also
includes a responsibility to ensure the wellness of its licensees.

**Features and Consequences of Burnout:**

Physicians experiencing burnout, according to the medical literature, exhibit a wide
array of signs, symptoms and related conditions, including fatigue, loss of empathy,
detachment, depression, and suicidal ideation. The three principal components of
burnout are widely described in the medical literature as emotional exhaustion,
depersonalization, and diminished feelings of personal accomplishment.\textsuperscript{11} Many of
these symptoms are also said to be linked to low levels of career satisfaction.

Career satisfaction may be diminished by even a single influencing factor.
Unreasonable increases in workload, for example, may quickly lead to
dissatisfaction with one’s career. Loss of job satisfaction has been noted as both a
primary contributor to burnout as well as a contributor to its further progression.\textsuperscript{12}
Burnout has specifically been found to be the single greatest predictor of surgeons’
satisfaction with career and choice of specialty.\textsuperscript{13} It may also be a significant
contributor to increased rates of suicidal ideation among both physicians\textsuperscript{14} and
medical students.\textsuperscript{15}

\textsuperscript{9} Rubin R. (2014). Recent Suicides Highlight Need to Address Depression in Medical
\textsuperscript{10} Gold KJ, Sen A, Schwenk TL. (2013). Details on suicide among US physicians: data
\textsuperscript{11} Maslach C, Schaufeli WB, Leiter MP. (2001). Job burnout. \textit{Annual Review of
Psychology}, 52:397-422.
\textsuperscript{12} Mirvis DM, Graney MJ, Kilpatrick AO. (1999). Burnout among leaders of the
Department of Veterans Affairs medical centers: contributing factors as determined
stress among leaders of Department of Veterans Affairs medical centers. \textit{J Healthc
\textsuperscript{13} Shanafelt TD, et al. (2009). Burnout and Career Satisfaction among American
\textsuperscript{14} Shanafelt TD, Balch CM, Dyrbye LN, et al. (2011). Suicidal ideation among
\textsuperscript{15} Schwenk TL, Davis L, Wimsatt LA. (2010). Depression, stigma, and suicidal
Physicians experiencing manifestations of burnout are also reported to be more prone to engage in unprofessional behavior,\textsuperscript{16} commit surgical or diagnostic medical errors,\textsuperscript{17,18,19} and lose the trust\textsuperscript{20} of their patients, while also decreasing their satisfaction.\textsuperscript{21} At a time when there is compelling evidence of a shortage of qualified practicing physicians in many parts of the United States, losing additional physicians to early or unnecessary retirement would have a detrimental impact on patient access to care across the country. As the American Medical Association’s Policy on Physician Health and Wellness states, “When health or wellness is compromised, so may be the safety and effectiveness of the medical care provided.”\textsuperscript{22}

Factors Contributing to Burnout:

While a large proportion of physicians are said to experience burnout and its correlates, they do not always experience it in the same way or for the same reasons. Physicians may be predisposed to burnout because of personality traits that led them to pursue a medical career in the first place, such as perfectionism, self-denial, and compulsiveness. These are traits that are said to be common among practicing physicians. Predisposition to burnout may be stronger in instances where personal factors such as denial of personal vulnerability, tendencies to delay gratification, or excess feelings of guilt are layered onto these aforementioned personality traits. While burnout is a distinct phenomenon from mental illness and substance use disorders, the latter two issues can play a compounding role in a

physician’s struggle with burnout, making the identification and effective treatment of its symptoms or causes even more difficult.\textsuperscript{23}

It is a common misconception that physicians are more susceptible to suffering from burnout at later stages in their career, presumably from fatigue and aging. In fact, research has demonstrated that physicians in the middle of their careers are at the highest risk for burnout.\textsuperscript{24} Education and training also appear to be critical peak times for physicians, physicians-in-training or medical students to suffer from burnout.\textsuperscript{25,26}

The environment in which physicians work, including their choice of specialty, also plays a significant role in contributing to burnout. Shanafelt and colleagues have shown substantial differences in burnout rates by specialty, although changes in the highest and lowest rates were noted between 2011\textsuperscript{27} and 2014.\textsuperscript{28} The control, or lack thereof, that physicians have over their work environment plays a significant role in predisposition to burnout. This may explain why emergency medicine is frequently found at or near the top of the list of medical and surgical specialties with the highest proportion of physicians experiencing burnout. Emergency physicians often work in environments that are high-demand and low-control.\textsuperscript{29} While finding meaning in one’s work has long been claimed to be the antidote to burnout,\textsuperscript{30} it may be difficult to find such meaning absent an adequate degree of control over one’s work environment.

The movement towards maximal standardization of processes, often labeled a phenomenon of “deprofessionalization,” is also claimed to be a contributor to burnout among physicians. There is worry among some professionals, in medicine and other health care fields, that an expectation for rigid adherence to guidelines

\textsuperscript{27} Shanafelt TD, et al. (2012). Burnout and satisfaction with work-life balance among US physicians relative to the general US population. \textit{Archives of Internal Medicine}, 172(18):1377-1385.
\textsuperscript{29}https://www.medpagetoday.com/emergencymedicine/emergencymedicine/54916
\textsuperscript{30} Sotile W. (2002). \textit{The Resilient Physician}. 
will replace what were formerly considered the more elegant, artistic and satisfying aspects of medical practice.\textsuperscript{31} These movements need not be perceived as threats to physician autonomy or to the exercise of professional judgment. Rather, embracing evidence-based medicine, focusing on the value of care that is provided, and celebrating increasingly positive outcomes can contribute to great improvements in patient and population health. Professional judgment will continue to play an important role in realizing these improvements.

Frustrations have also been voiced in relation to the move in health care delivery away from paper-based records to electronic health records (EHRs). Many physicians have expressed dissatisfaction with the intrusiveness and complexity of EHR use and the limits this sometimes places on the ways in which they are able and capable of effectively documenting treatment decisions and provision of care.\textsuperscript{32} These frustrations exist in addition to those related to the often complex, redundant, or non-intuitive methods of data entry and other elements of medical record keeping associated with EHRs,\textsuperscript{33,34,35} as well as the fact that most systems are not yet fully interoperable. However, complaints made about particular aspects of an evolving or disruptive technology should not be interpreted as calls to abandon the important gains in patient safety, professional communication, and even efficiency that have been brought about by the introduction and implementation of EHR systems. Rather, they should be interpreted as important user feedback that may contribute to ongoing improvement of such technology.

The constantly changing and evolving nature of medicine, as well as the challenges faced by the American health care system itself, also appear to be affecting the way many physicians feel within their professional roles. A recent study reported that 65% of physicians who were surveyed predicted an ongoing deterioration in the quality of health care that they deliver, which in turn has been attributed, in part, to the erosion of physician autonomy.\textsuperscript{36} When evolving requirements are layered onto

\textsuperscript{32} Friedberg MW, et al. (2013). Factors Affecting Physician Professional Satisfaction and Their Implications for Patient Care, Health Systems, and Health Policy. RAND Corporation, \url{https://www.rand.org/pubs/research_reports/RR439.html}.
new expectations with regard to technology, quality reporting, increased clinical
volume, and numerous other initiatives required by payers, employers, and even
state medical boards, it may not be surprising that physicians are experiencing
burnout at alarming rates. While many of the initiatives that place additional
burdens on physicians are grounded in strong rationales related to patient safety
and quality care, the burnout resulting from their combined effect may actually
inhibit the success of the initiatives themselves. This should certainly bring pause
to those charged with implementing initiatives and requirements to carefully
evaluate their effectiveness, unintended consequences, and potential burden, but
also to communicate their goals and perceived value. The reaction of the profession
to the ongoing changes that are occurring may also indicate particular attitudes
within the culture of medicine that would benefit from further discussion, as would
support to integrate positive change into practice.

Burnout is not always related to stressors arising in a physician’s work environment
or to a physician’s character traits. Family issues, personal and professional
relationships, financial pressures, insufficient work-life balance, or other external
stressors may also contribute to burnout. Efforts aimed at the identification,
treatment, or prevention of burnout must, therefore, approach the issue from a
broad enough perspective to take all of these factors into account.

Challenges and Barriers to Addressing Burnout:

While there has been a promising rise in the number of peer-reviewed research
publications addressing the topic of physician burnout, in the academic medical
literature, popular media and so-called gray literature (e.g., white papers, position
statements, organizational reports), there seems to be a perceived lack of resources
available to identify and address the issue. This perception may be misguided,
however, since several academic institutions, health systems, medical specialty
societies, independent physicians, physician health programs, and state medical
boards make many useful, high-quality resources available (See Appendix A.). While
more resources would be beneficial to physicians, and ultimately their patients,
their development should be complemented with efforts aimed at highlighting best
practices. Research is also needed to identify how sources of burnout might differ
for male and female physicians in order that resources may be appropriately
tailored. A more coordinated effort to raise awareness not only about the issue of
physician burnout but also about resources for ameliorating related circumstances
may also serve to reduce stigma and facilitate identification and treatment. It may
also help improve systems issues that impact burnout by improving communication,
team building, and collaboration within and among health care professions. Broader

awareness may also better equip physicians in their capacity as leaders to improve circumstances for those with whom they work.\textsuperscript{38}

Many physicians are reluctant to seek help for burnout or any of its many underlying causes for fear that they will be perceived as weak or unfit to practice medicine by their colleagues or employers, or because they assume that seeking such care may have a detrimental effect on their ability to renew or retain their state medical license, arguably the most important credential a physician receives during their professional career.\textsuperscript{39,40,41,42,43} This stigma may be felt as early as medical school,\textsuperscript{44} a particularly dangerous cultural feature in a population where symptoms of anxiety and depression have been found to be more prevalent than in the general population.\textsuperscript{45} In a study by Dyrbye and colleagues, it was found that only a third of the medical students experiencing features of burnout sought help and that stigma was seen as a barrier for those who chose not to seek help.\textsuperscript{46} The same reluctance is seen with respect to help-seeking for other types of stigmatized suffering such as depression, substance use disorders, or suicidal ideation.\textsuperscript{47} Without adequate modeling of appropriate self-care behaviors among faculty mentors, progress at stigma reduction will likely be slow. Further, while there are laudable examples of programs at academic medical centers across the country which responsibly offer

\begin{itemize}
\item\textsuperscript{39} Chew-Graham CA, et al. (2003). 'I wouldn’t want it on my CV or their records': medical students’ experiences of help-seeking for mental health problems. \textit{Medical Education}, 37(10):873–880.
\item\textsuperscript{40} Federation of State Medical Boards. (2011). Policy on Physician Impairment.
\item\textsuperscript{42} Gold K, et al. (2016). "I would never want to have a mental health diagnosis on my record": A survey of female physicians on mental health diagnosis, treatment, and reporting. \textit{General Hospital Psychiatry}, 43:51–57.
\item\textsuperscript{46} Dyrbye LN, et al. (2015). The Impact of Stigma and Personal Experiences on the Help-Seeking Behaviors of Medical Students with Burnout. \textit{Academic Medicine}, 90(7):961-969.
\end{itemize}
accessible, complementary, private, and confidential counselling to medical students, these programs are by no means widely available.

Privacy and confidentiality of a physician’s health and treatment history is important to allow those in need of help to come forward without fear of punishment, disciplinary action, embarrassment or professional isolation. The use of confidential services whenever possible in lieu of regulatory awareness is preferred in order to mitigate fear of negative impacts on licensure, employment, or collegial relationships. When confidential services are not utilized, it is less likely licensees will receive early intervention and appropriate treatment, thereby foregoing opportunities for early detection of potentially impairing illness or recovery.

Funding for important programs and initiatives such as those identified above is often difficult to obtain. However, there is a growing body of research that identifies the cost savings for hospitals and employers associated with providing them, particularly when costs associated with medical errors and lower quality of care attributed to burnout are mitigated, as are high turnover rates, absenteeism, and loss of productivity.

Another challenge to identifying and addressing burnout is the fact that the associated stigma may reduce the degree to which the phenomenon itself is discussed. This impacts not only a physician’s own willingness to discuss or seek help for burnout, but also the willingness of fellow physicians to address or report instances of impairment among their colleagues, especially that which unduly risks the safety of patients. While the duty to report impairment or incompetence and the duty to encourage help-seeking may seem to conflict, in that a fear of being reported could cause a physician to conceal problems and avoid help, the duty to report is actually based on principles of patient safety and ethics. The duty to report also aims to assist physicians in seeking the help they need in order to continue practicing safely.

In addition to the cultural stigma associated with admitting experiences of burnout, recent research has shed light on the potential impact of licensure and license renewal processes of state medical boards that may discourage treatment-seeking

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48 Examples include the HEAR Program at UC San Diego (available to everyone at the UCSD Health System, not only medical students), the Henderson Student Counseling Center at Nova Southeastern University, the Wellness Resources offered at Oregon Health and Science University, and the Medical Student Counseling and Wellness Center at the Herbert Wertheim College of Medicine, Florida International University.

among physicians. State medical boards may inadvertently discriminate unfairly against physicians suffering from mental illness or substance use disorders, or against those who choose to take a leave of absence from practice to prevent or recover from burnout. The very presence of application questions for medical licensure or licensure renewal may stigmatize those suffering from mental and behavioral illnesses for which physicians might otherwise seek care. In fact, questions about substance abuse and mental illness on state medical licensure renewal applications have nearly doubled between 1996 and 2006. While information about a physician's health status (both mental and physical) may be essential to a state medical board's solemn duty to protect the public, the FSMB has previously noted that a history of mental illness or substance use does not reliably predict future risk to the public. It is also very important to recognize that court interpretations of the Americans with Disabilities Act (ADA) have suggested that state medical boards should focus on current functional impairment rather than a history of diagnoses or treatment of such illness.

In carrying out their duty to protect the public and ensure that only individuals who are fully qualified to practice medicine are granted licenses, state medical boards usually, and for good reasons, insist that they must have sufficient information with which to make medical licensure decisions. During the licensure granting process, state boards also work diligently to ensure that candidates for licensure (or renewal) provide a thorough assessment of their fitness to practice, balanced by protecting their rights as contained in ADA legislation. Fear among prospective and current licensees about potential limitations placed on their ability to practice medicine independently, however, or of their previous diagnoses or treatments somehow being made public despite HIPAA and other federal privacy and confidentiality laws, may cause some physicians to misrepresent personal information that is requested or not respond accurately at all to licensing application questions. In such instances, paradoxically, the efforts of state medical boards to get comprehensive information may not yield the accurate information

they seek about a physician’s practice risks to patients. They may also discourage
treatment-seeking among physicians, thereby increasing the degree of risk to
patients presented by physicians experiencing conditions that remain undiagnosed
or untreated.

**Recommendations:**

The majority of the recommendations that follow are designed for state medical
boards to consider and pertain mainly to the inclusion and phrasing of questions on
state medical licensing applications. Appropriately addressing the issue of physician
burnout provides a unique opportunity for state medical boards to declare, directly
or indirectly, that it is not only normal but anticipated and acceptable for a physician
to feel overwhelmed from time to time and to seek help when appropriate. This is
also an important opportunity for state medical boards to highlight and promote the
benefits of physician health, both mental and physical, to help reduce stigma, to
clarify related regulatory and reporting issues, promote patient safety and assure
the delivery of quality health care. Physicians should feel safe about reporting
burnout and be able to take appropriate measures to address it without fear of
having their licensure status placed in jeopardy.

Safeguarding physician wellness and mitigating damage caused by burnout cannot
be accomplished through isolated actions and initiatives by individual organizations
alone. Coordinated efforts and ongoing collaboration will be essential not only for
addressing the many systemic issues that contribute to burnout but also for
ensuring that appropriate tools, resources, and programs are continuously in place
and readily available to help physicians avoid and address burnout. As such, the
FSMB also offers suggestions and recommendations to its partner organizations,
many of which have been instrumental in furthering the FSMB’s current
understanding of burnout, its related features, and the role of the regulatory
community in addressing and safeguarding physician health.

Ultimately, the Workgroup and the FSMB believe that a shared accountability model
that includes several related responsibilities among regulatory, educational,
systemic, organizational, and administrative stakeholders provides a promising way
forward. The specific recommendations outlined below begin to address what such
responsibilities should entail.

The FSMB recognizes its responsibility to help address physician burnout, not only
through following its own recommendations and promoting the resources provided
in this report, but also by continuing its collaborative efforts with partner
organizations from across the wider health care community.
For State Medical Boards:

1. The FSMB recommends that state medical boards review their medical licensure (and renewal) applications and evaluate whether it is necessary to include probing questions about a physician applicant’s mental health, addiction, or substance use, and whether the information these questions are designed to elicit in the interests of patient safety may be obtained through means that are less likely to discourage treatment-seeking among physician applicants. For example, some boards subscribe to notification services such as the National Practitioner Data Bank’s “Continuous Query” service or other data services that provide information about arrests or convictions, including for driving under the influence, within their states which can serve as a proxy finding for physician impairment. The FSMB also recommends in its Essentials of a State Medical and Osteopathic Practice Act that boards require applicants to satisfactorily pass a criminal background check as a condition of licensure.56

2. Where state medical boards strongly feel that questions addressing the mental health of physician applicants must be included on medical licensing applications, they should carefully review their applications to ensure that appropriate differentiation is made between the illness with which a physician has been diagnosed and the impairments that may result. Application questions must focus only on current impairment and not on illness, diagnosis, or previous treatment in order to be compliant with the Americans with Disabilities Act (ADA).

3. The ADA requires licensure application questions to focus on the presence or absence of current impairments that are meaningful in the context of the physician’s practice, competence, and ability to provide safe medical treatment to patients. Applications must not seek information about impairment that may have occurred in the distant past and state medical boards should limit the time window for such historical questions to two years or less, though a focus on the presence or absence of current impairment is preferred.

Questions that address the mental health of the applicant should be posed in the same manner as questions about physical health, as there is no distinction between impairment that might result from physical and mental illness that would be meaningful in the context of the provision of safe treatment to patients.

Where boards wish to retain questions about the health of applicants on licensing applications, the FSMB recommends that they use the language

recommended by the American Psychiatric Association:

“Are you currently suffering from any condition that impairs your judgment or that would otherwise adversely affect your ability to practice medicine in a competent, ethical and professional manner? (Yes/No)”

4. The FSMB recommends that state medical boards consider offering the option of “safe haven non-reporting” to applicants for licensure who are receiving appropriate treatment for mental health or addiction. While it is up to boards to determine what constitutes appropriate treatment, the FSMB recommends that physicians who are monitored by, and in good standing with, the recommendations of a state or territorial Physician Health Program (PHP) be permitted to apply for medical licensure or license renewal without having to disclose their diagnosis or treatment to the board. The option of safe haven non-reporting should only be offered when treatment received is commensurate with the illness being treated and has a reasonable chance of avoiding any resultant impairment.

5. State medical boards should work with their state legislatures to ensure that the personal health information of licensees related to an illness or diagnosis is not publicly disclosed as part of a board’s processes. Information disclosed must relate only to impairment of professional abilities, medical malpractice, and professional misconduct.

6. State medical boards should emphasize the importance of physician health, self-care, and treatment-seeking for all health conditions by including a statement to this effect on medical licensing applications, state board websites, and other official board communications. Where appropriate, options for treatment and other resources should be made available, such as information about a state Physician Health Program (PHP), services offered through a county, state, or national medical society, and any other relevant programs. These means of communicating the importance of physician health and self-care are aimed at helping physicians with relevant information and resources but could also help raise awareness among patients of the importance of physician wellness and the threat of burnout to their doctors and their own care.

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58 The American Psychiatric Association (APA) passed an Action Paper in November 2017, resolving to query state medical boards and notify them about their compliance with APA policy and the ADA.

7. **State medical boards should clarify through communications, in print and online, that an investigation is not the same as a disciplinary undertaking.** Achieving an understanding of this distinction among licensees may help begin to dispel the stigma associated with reporting burnout and remove a barrier to physicians seeking help in times of need.

8. **State medical boards are encouraged to maintain or establish relationships with a PHP in their state and to support the use of data from these programs in a board's decision-making.**

9. **State medical boards should examine the policies and procedures currently in place for working with physicians who have been identified as impaired in a context that is meaningful for the provision of safe care to patients to ensure that these are fair, reasonable, and fit for the purpose of protecting patients. All such processes should be clearly explained and publicly available.**

10. **State medical boards should be aware of potential burdens placed on licensees by new or redundant regulatory requirements.** They should seek ways of facilitating compliance with existing requirements to support licensees and ensure that they are able to spend time with patients and in those areas of medicine which they find most meaningful. “Reducing the cumulative burden of rules and regulations may improve professional satisfaction and enhance physicians' ability to focus on patient care.”

Upon implementing some or all of the above changes to state medical board policy or processes that are meant to reduce the stigma associated with mental health issues and encourage treatment-seeking, the board should communicate these, and their rationale, to current and prospective licensees, as well as patients and the public. State medical boards should also raise the issue of physician burnout more often, emphasizing the importance of physician wellness, help-seeking, and the availability of accessible, confidential, and private counselling programs for physicians and all health professionals.

**For External Stakeholders and Partner Organizations:**

**Professional Medical Organizations and Societies:**

11. Professional medical societies at local, state, and national levels have a key role to play in encouraging physicians to seek treatment, both preventive

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and curative, for the physical and mental health issues they face, as well as for features of burnout. The FSMB recognizes the many exemplary programs and initiatives of professional medical societies and encourages their continued advocacy for physician wellness and the availability of support and treatment services.

12. The FSMB recommends a sustained focus in the medical profession on the importance of self-care with an aim to reduce the stigma attached with seeking treatment for health issues, particularly ones related to mental health.

13. The FSMB recommends that attempts be made to expand the availability of accessible, private, and confidential counseling for physicians through medical societies, such as those provided by organizations like the Lane County Medical Society (Oregon), which has a program with several features identified as best practices for physician wellness by the Workgroup. Counseling via telehealth could also enhance access and provide greater assurance of privacy to those seeking care.

14. Given the prevalence of burnout, all physicians need to be educated about the resources currently available regarding burnout, including those referenced in Appendix A, for self-awareness, and for identification and referral of peer professionals who may have burnout. Medical societies are encouraged to partner with other organizations identified in this report to improve awareness of resources and their dissemination.

15. The FSMB recommends that professional medical societies and organizations representing physicians, such as the American Medical Association, the American Osteopathic Association, and the Council of Medical Specialty Societies work with state medical boards to raise awareness among the public of the importance of physician wellness not only because of its inherent value to physicians themselves but also as a significant contributor to patient safety.

Centers for Medicaid and Medicare Services:

16. The FSMB recommends careful analysis of any new requirements placed on physicians to determine their potential impact on physician wellness. Any new requirements that could serve as a driver of burnout in physicians must be supported by evidence and accompanied by a strong rationale that is based in improving patient care to justify any new burdens imposed on physicians.
State Government, Health Departments, and Legislatures:

17. As state government, health departments, and legislatures make decisions that can impact physicians, the FSMB recommends that they weigh the potential value of proposed new regulations against potential risks to the health of physicians and other clinicians.

Vendors of Electronic Health Records (EHR) systems and standard setting organizations:

18. As a promising advancement in the provision and documentation of care, but also a key driver of frustration with medical practice, EHRs need to be improved in a way that takes the user experience into greater consideration than it does currently. This experience may be improved through facilitating greater ease of data entry into the system, as well as ease of access to data from the system. Vendors are encouraged to include end-user physicians on their builder teams to optimize input about operability and interoperability.

19. Efforts to reduce redundant or duplicative entry should be required by standard setting organizations, such as the Office of the National Coordinator for Health IT (ONC), and reflected in the EHR systems ultimately designed by vendors.

20. EHR vendors are encouraged to focus future improvements on facilitating and improving the provision of patient care. The primary purposes of an EHR relate to documentation of care received by a patient, retrieval of patient care related information and data, and patient communication.

Medical Schools and Residency Programs:

21. The FSMB encourages the Accreditation Council for Graduate Medical Education, the Association of American Medical Colleges, the American Association of Colleges of Osteopathic Medicine, the American Medical Association, the American Osteopathic Association and the institutions they represent, to continue their laudable efforts at improving the culture of medicine and facilitating open conversations about illness and wellness in order to promote positive change.

22. The FSMB recommends continued efforts to encourage medical students and residents to value self-care and understand the positive impacts that physician wellness can have on patient care.

23. The FSMB recommends that medical schools, residency programs, and their accrediting bodies consider ways of amplifying the medical student and
resident voice on systemically induced pressures and support trainees by providing means for raising issues related to medical student and resident health and well-being anonymously.

**Hospitals/Employers:**

24. The FSMB recommends that hospitals revise, where necessary and appropriate, their questions asked as part of their credentialing process according to the recommendations made above for the medical licensing community to ensure that these are not discouraging physicians or other health professionals from seeking needed treatment.

25. The FSMB recommends that hospitals and health systems assess physician health at regular intervals using a validated instrument and act upon the results. Employers should keep results of these assessments internal to the organization or health system in order to promote workplace change, while avoiding threatening or punitive cultures.

26. Hospitals, as well as the American Hospital Association and related organizations, are encouraged to officially adopt the “Quadruple Aim” to demonstrate the importance they place in the health and wellness of the physicians and all other health professionals they employ and recognize the impact of provider health on safe patient care.

27. Hospitals should ensure that their policies and procedures are adopted with consideration given to the impact they have on the health of the hospital workforce. Decisions impacting hospital the health of hospital and health system employees should be made with adequate input from individuals representing the impacted sectors of that workforce.

28. While acknowledging the need for hospitals to acknowledge all staff in their programmatic development, employers are encouraged to make resources and programs available to physicians, including time and physical space for making connections with colleagues and pursuing personal goals that add meaning to physicians’ work lives. Resources and programs should not always be developed and implemented in a “one size fits all” manner, but should incorporate consideration of the different stressors placed on male and female physicians, within and outside of the workplace, and be tailored appropriately. Resources related to EHR implementation and use should also be made available by employers, including training to optimize use and support for order-entry such as scribes or other technological solutions aimed at restoring time available to physicians.
29. Hospitals should ensure that mandatory reports related to physician competence and discipline are made available to state medical boards and other relevant authorities.

**Insurers:**

30. The FSMB recommends that insurance carriers revise, where necessary and appropriate, their questions on applications for professional liability insurance according to the recommendations made above for the medical licensing community to ensure that these are not discouraging physicians or other health professionals from seeking needed treatment.

31. In evaluating the quality of care provided by physicians, insurers should look beyond cost-saving measures and use metrics related to physician health and incentivize practice patterns that contribute to physician wellness.

**Accrediting Organizations:**

32. In its ongoing development of standards for the accreditation of undergraduate medical education programs, graduate medical education training programs, hospitals and healthcare facilities, the FSMB encourages those organizations charged with the accreditation of institutions and educational programs to include standards related to required resources and policies aimed at protecting medical student, medical resident and attending physician health.

**Physicians:**

33. Physician wellness is a complex issue, made up of system-wide and individual components. However, physicians have a responsibility to attend to their own health, well-being, and abilities in order to provide care of the highest standard. This involves a responsibility to continually self-assess for indicators of burnout, discuss and support the identification of health issues with peers, and seek help or treatment when necessary. Physicians are encouraged to make use of services of state Physician Health Programs, which, where available, can be accessed confidentially in instances where patient harm has not occurred.

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Physicians are encouraged to inform themselves about their ethical duty, oftentimes codified in state statutes, to report issues related to incompetence and unsafe care delivered by their peers. They are also encouraged to engage in open dialogue with peers about the importance of self-care, treatment-seeking, and the threats to themselves and their patients presented by burnout.

Physicians are also encouraged to seek an appropriate balance between time spent on practice and related work and activities external to work, particularly ones with restorative potential.

**Conclusion**

The duty of state medical boards to protect the public includes a responsibility to ensure physician wellness and to work to minimize the impact of policies and procedures that impact negatively on the wellness of licensees, both prospective and current. The rationale for this duty is based on the link between physician burnout and its intendant risks to patient safety, the fact that some regulatory processes employed by state medical boards can have negative impacts on the health and wellness of physicians themselves, and the potential for regulatory change to support physician wellness and help prevent further instances of burnout.

The information and recommendations in this Report of the FSMB’s Workgroup on Physician Wellness and Burnout are meant to support initial steps in the medical regulatory community and to contribute to ongoing conversation about patient safety and physician health.
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APPENDIX A: SAMPLE RESOURCE LIST

The following list is offered as a sample of resources available to support and facilitate the understanding, diagnosis, treatment, and prevention of symptoms of burnout or to maintain and improve physician wellness. The FSMB has not conducted an in-depth evaluation of individual resources, and inclusion herein does not indicate, nor is it to be interpreted as, an endorsement or guarantee of quality. Further, while some resources listed below are available free of charge, others are only accessible through purchase.

Federation of State Medical Boards, Policy on Physician Impairment, 2011.


The standard tool used to evaluate rates of burnout is the Maslach Burnout Inventory, developed in the 1980s by Christina Maslach, PhD, a psychologist at the University of California Berkeley.

The HappyMD.com – in particular, the burnout prevention matrix, 117 ways to prevent burnout

Accreditation Council for Graduate Medical Education – Physician Wellbeing Resources

American Academy of Family Physicians - Physician Burnout Resources Page:

American College of Emergency Physicians (ACEP) – ACEP Wellness Resource page

American College of Physicians – Resources on Physician Well-Being and Professional Satisfaction

American Medical Association Steps Forward website:

American Osteopathic Association – AOA Physician Wellness Strategy

Association of American Medical Colleges – Wellbeing in Academic Medicine

Federation of State Physician Health Programs

Mayo Physician Well-being Program:

National Academy of Medicine Action Collaborative on Clinician Well-Being and Resilience
Remembering the Heart of Medicine

Stress Management and Resiliency Training (SMART) program

SuperSmartHealth

The Studer Group

The Well-Being Index (Mayo Clinic)
REPORT OF THE BOARD OF DIRECTORS

Subject: Guidelines for the Structure and Function of a State Medical and Osteopathic Board

Referred to: Reference Committee A

Since 1988, the FSMB’s Guide to the Essentials of a Modern Medical Practice Act and Elements of a State Medical and Osteopathic Board have functioned as companion documents to provide state medical boards a useful blueprint for their structure and functions as stated in their medical practice act. These policies have served as a highly effective stimulus to medical boards and state legislatures for periodic review and revision of their statutes. The policies are revised every three years. The Advisory Council of Board Executives is charged with updating the policies to ensure currency and recommending the revisions to the Board of Directors. The 2017 Advisory Council includes Kimberly Kirchmeyer, Micah T. Matthews, MPA, Maegan Martin, JD, Frank B. Meyers, JD, Kathleen Selzler Lippert, JD, Kevin D. Bohnenblust, JD, Mark E. Bowden, MPA, Kathleen Haley, JD, and Ian Marquand.

The Advisory Council of Board Executives met on August 17, 2017 in Washington, DC, to revise the Elements and Essentials for consideration by the FSMB House of Delegates at its Annual Meeting in April 2018. At this meeting the Council considered a full agenda in meeting its charge to conduct a review and revision of the Essentials and Elements of a State Medical and Osteopathic Act. As part of its meeting, the Council conducted a thorough review of the licensure by endorsement provisions in accordance with Resolution 17-3, Review of Model Guidelines for State Medical Boards Granting Licensure by Endorsement and Assessment of the Standards of ACGME International.

As a result of in person discussions and in response to feedback from member state boards, the Council agreed to condense the Elements and Essentials into one document, Guidelines for the Structure and Function of a State Medical and Osteopathic Board (Attachment 1). The Council determined that a singular guidance document on state medical board structure would reduce redundancies inherent in the original two documents and allow for a more dynamic and user-friendly resource for member state boards. The Council recommended that existing FSMB policy regarding licensure by endorsement not be amended to include reference to ACGME-International.

Guidelines for the Structure and Function of a State Medical and Osteopathic Board incorporates the contents of prior Elements and Essentials, containing the principles of state medical board responsibility, duty, empowerment, and accountability that the initial documents outlined, as well as detailing the essential components for the structure and function of a state medical board. This
guidance document reflects not only relevant characteristics of effective modern medical boards, but also a number of innovative concepts not yet widely implemented. Though presented for consideration as an integrated whole, the guidelines offer significant approaches to a variety of issues that concern many boards, including: funding and budgeting, confidentiality, board authority, personnel and staffing, administration, emergency powers, training of board members, immunity and indemnity, standards of evidence, and the public’s right to know.

Recognizing the differences among jurisdictions, this document is designed with the flexibility to accommodate as many of those differences as possible, while maintaining the integrity of the overall concept. Some sections empower boards to adopt alternatives of their choice, provided they are in accord with other state statutes, while other sections are phrased loosely to allow boards necessary discretionary authority. These guidelines may thus be seen not as one proposal but as various proposals.

A draft of the Guidelines for the Structure and Function of a State Medical and Osteopathic Board was distributed to FSMB member boards and other key stakeholder organizations in December 2017 with comments due January 31, 2018. There were no suggestions for modification received. No comments were received. The FSMB Board of Directors considered the draft Guidelines for the Structure and Function of a State Medical and Osteopathic Board at its meeting on February 7, 2018 in Washington D.C. and discussed clarifications to the document.

ITEM FOR ACTION:

The Board of Directors recommends that:

The House of Delegates ADOPT Guidelines for the Structure and Function of a State Medical and Osteopathic Board, superseding Guide to the Essentials of a Modern Medical Practice Act (HOD 2015) and Elements of a State Medical and Osteopathic Board (HOD 2015).
Guidelines for the Structure and Function of a State Medical and Osteopathic Board

Introduction

As early as 1914, the Federation of State Medical Boards (FSMB), which now represents 70 state and territorial medical and osteopathic licensing and disciplinary boards (hereafter referred to as “state medical board(s)” or “Board(s)”), recognized the need for a guidance document supporting U.S. states and territories in their development, and updating as needed, of their medical practice acts, and the corresponding structures and functions of their medical boards.

Following extensive consultations with members and staff of state medical boards, and a review of emerging best practices, the FSMB first issued A Guide to the Essentials of a Modern Medical Practice Act in 1956. The stated purposes of this guidance document were:

1. To serve as a guide to those states that may adopt new medical practice acts or may amend existing laws; and
2. To encourage the development and use of consistent standards, language, definitions, and tools by boards responsible for physician and physician assistant regulation.

Over the years, dynamic changes in medical education, in the practice of medicine, and in the diverse responsibilities that face medical boards have necessitated frequent revision of a state or territory’s medical practice act. The Essentials has since undergone numerous revisions to respond to these changes and assist member boards to be consistent with best practices in the interests of public protection and patient safety.

In 1988, the Division of Medicine of the Bureau of Health Professions, Health Resources and Services Administration (HRSA), in the U.S. Department of Health and Human Services, requested proposals for the development of a parallel document on a state medical board’s structure and function. The FSMB proposed a new guidance document in response, called the Elements of a State Medical and Osteopathic Board. The Bureau of Health Profession and HRSA accepted the FSMB’s proposal, and the document was soon developed and made available for consideration by the public, state medical boards, medical organizations, and other relevant groups.

The primary focus of the Elements document was to develop a blueprint of the structure and function of a modern state medical board. It detailed the powers, duties, and protections that are basic to a state medical board’s structure and function. In that context, it reflected the understanding, concepts, opinions, knowledge and experience of the individuals comprising the work panel, which included members, attorneys and staff of state medical boards. The Elements presented a blueprint that was consistent with the principles expressed in the Essentials, and was offered as a stimulus for discussion of several issues vital to improving the regulation of the medical profession in the United States.

The Elements and Essentials have, since 1988, functioned as companion documents to provide state
medical boards a useful blueprint for their structure and functions as stated in their medical practice act. Revised by the FSMB’s Advisory Council of Board Executives every three years to remain current, the model policies have served as a highly effective stimulus to medical boards and state legislatures for periodic review and revision of their statutes.

In 2017, the Advisory Council met to revise the Elements and Essentials for consideration by the FSMB House of Delegates at its Annual Meeting in April 2018. At this meeting and in response to feedback from member state boards, the Advisory Council considered and agreed to condense the two model policies into one document. The Advisory Council determined that a singular guidance document on state medical board structure would reduce redundancies inherent in the original two documents and allow for a more dynamic and user-friendly resource for member state boards.

The guidance document that follows incorporates the contents of prior Elements and Essentials documents, containing the principles of state medical board responsibility, duty, empowerment, and accountability that the initial documents outlined, as well as detailing the essential components for the structure and function of a state medical board.

This guidance document reflects not only relevant characteristics of effective modern medical boards, but also a number of innovative concepts not yet widely implemented. The result is a document worthy of consideration for adaptation to the requirements of any state or territorial jurisdiction. Although it could hardly be expected that any one jurisdiction would accept every component of this model, it should lead every jurisdiction to assess its present board structure and function. Does the status quo provide maximum potential for protection of the public interest? Though presented for consideration as an integrated whole, the guidelines offer significant approaches to a variety of issues that concern many boards, including: funding and budgeting, confidentiality, board authority, personnel and staffing, administration, emergency powers, training of board members, immunity and indemnity, standards of evidence, and the public’s right to know.

Recognizing the differences among jurisdictions, this document is designed with the flexibility to accommodate as many of those differences as possible, while maintaining the integrity of the overall concept. Some sections empower boards to adopt alternatives of their choice, provided they are in accord with other state statutes, while other sections are phrased loosely to allow boards necessary discretionary authority. These guidelines may thus be seen not as one proposal but as various proposals. Each is applicable in one form or another to a diversity of settings, and all are aimed at increasing or refining the ability of state medical boards to better protect the health, safety and welfare of the public.

The Federation urges member boards to consider including any recommendations contained herein in their respective medical practice acts, rules, or their own guidance documents.

The following guidelines apply equally to boards that govern physicians who have acquired the M.D. or D.O. degree, and the terms used herein should be interpreted throughout with this understanding.
Table of Contents

69 Introduction .................................................................................................................................................. 1

70 Section I. Definitions ..................................................................................................................................... 6

71 Section II. The Medical Practice Act .............................................................................................................. 8

72 Statement of purpose ....................................................................................................................................... 8

73 Exemptions ............................................................................................................................................... 9

74 Unlawful Practice of Medicine ................................................................................................................ 10

75 Section III. State Medical Board Duty, Responsibility, and Power .............................................................. 10

76 Section IV. State Medical Board Membership ............................................................................................ 14

77 Composition and Size ........................................................................................................................................ 14

78 Qualifications .......................................................................................................................................... 15

79 Terms ...................................................................................................................................................... 15

80 Requirements .......................................................................................................................................... 16

81 Appointment ........................................................................................................................................... 16

82 Removal .................................................................................................................................................. 16

83 Compensation/Reimbursement ................................................................................................................ 17

84 Section V. State Medical Board Structure ................................................................................................... 17

85 Officers .................................................................................................................................................... 17

86 Committees ............................................................................................................................................. 17

87 Funding ................................................................................................................................................... 18

88 Revenues ................................................................................................................................................. 18

89 Budget ..................................................................................................................................................... 18

90 Setting Fees and Charges ........................................................................................................................ 18

91 Fiscal Year ............................................................................................................................................... 18

92 Section VI. Meetings of the Board and Committee of the Board ............................................................... 18

93 Location .................................................................................................................................................. 18

94 Frequency, Duration .................................................................................................................................... 19

95 Special Meetings, Conferences ............................................................................................................... 19

96 Notice ...................................................................................................................................................... 19

97 Quorum .................................................................................................................................................. 19
<table>
<thead>
<tr>
<th>Page</th>
<th>Section</th>
<th>Page</th>
</tr>
</thead>
<tbody>
<tr>
<td>130</td>
<td>Section XVI: Compulsory Reporting and Investigation</td>
<td>40</td>
</tr>
<tr>
<td>131</td>
<td>Section XVII. Impaired Physicians</td>
<td>41</td>
</tr>
<tr>
<td>132</td>
<td>Section XVIII: Dyscompetent and Incompetent Licensees</td>
<td>43</td>
</tr>
<tr>
<td>133</td>
<td>Section XIX: Physician Assistants</td>
<td>44</td>
</tr>
<tr>
<td>134</td>
<td>Administration</td>
<td>44</td>
</tr>
<tr>
<td>135</td>
<td>Licensing</td>
<td>44</td>
</tr>
<tr>
<td>136</td>
<td>Rules and Regulations</td>
<td>45</td>
</tr>
<tr>
<td>137</td>
<td>Disciplinary Actions</td>
<td>45</td>
</tr>
<tr>
<td>138</td>
<td>Duties and Scope of Practice</td>
<td>45</td>
</tr>
<tr>
<td>139</td>
<td>Responsibility of Supervising Physician</td>
<td>45</td>
</tr>
<tr>
<td>140</td>
<td>Renewal</td>
<td>45</td>
</tr>
</tbody>
</table>
Section I. Definitions
The following terms have the following meanings:

“Assessment Program” means a formal system to examine or evaluate a physician’s competence within the scope of the physician’s practice.

“Competence” means possessing the requisite abilities and qualities (cognitive, non-cognitive, and communicative) to perform effectively within the scope of the physician’s practice while adhering to professional ethical standards.

“Dyscompetence” means failing to maintain acceptable standards in one or more areas of professional physician practice. (HOD 1999)

“Impairment” means a physician’s inability to practice medicine with reasonable skill and safety due to:

1. Mental, psychological, or psychiatric illness, disease, or deficit;
2. Physical illness or condition, including, but not limited to, those illnesses or conditions that would adversely affect cognitive, motor, or perceptive skills; or
3. Habitual, excessive, or illegal use or abuse of drugs defined by law as controlled substances, illegal drugs, alcohol, or of other impairing substances.

“Incompetence” means lacking the requisite abilities and qualities (cognitive, non-cognitive, and communicative) to perform effectively in the scope of the physician’s practice.

“License” means any license, certificate, or other practice authorization granted by the Board pursuant to the medical practice act, or any other applicable statute.

“Licensee” means the holder of any license, certificate, or other practice authorization granted by the Board.

“Licensed physician” means a physician licensed to practice medicine in the jurisdiction.

“Medical Practice Act” means the statute that determines the structure and function of a state medical or osteopathic board. Section II below addresses categories that the medical practice act does not typically apply to.

“Physician assistant” means a skilled person who by training, scholarly achievements, submission of acceptable letters of recommendations, and satisfaction of other requirements of the Board has been licensed for the provision of patient services under the supervision and direction of a licensed physician who is responsible for the performance of that person.

“Physician Assistant Council” means a council appointed by the Board or other means that reviews matters relating to physician assistants, reports its findings to the Board, and makes recommendations for action.

“Practice of medicine” is consistent with the following:
1. Advertising, holding out to the public, or representing in any manner that one is authorized to practice medicine in the jurisdiction;
2. Offering or undertaking to prescribe, order, give, or administer any drug or medicine for the use of any other person;
3. Offering or undertaking to prevent or to diagnose, correct, and/or treat in any manner or by any means, methods, or devices any disease, illness, pain, wound, fracture, infirmity, defect, or abnormal physical or mental condition of any person, including the management of pregnancy and parturition;
4. Offering or undertaking to perform any surgical operation upon any person;
5. Rendering a written or otherwise documented medical opinion concerning the diagnosis or treatment of a patient or the actual rendering of treatment to a patient within a state by a physician located outside the state as a result of transmission of individual patient data by electronic or other means from within a state to such physician or the physician’s agent;
6. Rendering a determination of medical necessity or a decision affecting the diagnosis and/or treatment of a patient; and
7. Using the designation Doctor, Doctor of Medicine, Doctor of Osteopathic Medicine/Doctor of Osteopathy, Physician, Surgeon, Physician and Surgeon, Dr., M.D., D.O., or any combination thereof in the conduct of any occupation or profession pertaining to the prevention, diagnosis, or treatment of human disease or condition unless such a designation additionally contains the description of another branch of the healing arts for which one holds a valid license in the jurisdiction where the patient is located.

The definition of the practice of medicine may also include several exceptions, which exempt certain activities from the categorization of the practice of medicine.

The practice of medicine is determined to occur where the patient is located in order that the full resources of the state are available for the protection of that patient.

“Remediation” means the process whereby deficiencies in physician performance identified through an examination or assessment program are corrected, resulting in an acceptable state of physician competence.

“Supervising physician” means a licensed physician in good standing in the same jurisdiction as the physician assistant who the Board approved to supervise the services of a physician assistant, and who has in writing formally accepted the responsibility for such supervision.

“Telemedicine” means the practice of medicine using electronic communications, information technology, or other means between a licensee in one location, and a patient in another location, with or without an intervening healthcare provider. Generally, telemedicine is not an audio-only, telephone conversation, e-mail/instant messaging conversation, or fax. It typically involves the application of secure videoconferencing or store and forward technology to provide or support healthcare delivery by replicating the interaction of a traditional, encounter in person between a provider and a patient. (HOD 2014)
Section II. The Medical Practice Act

The structure and function of each of the 70 medical regulatory boards (allopathic, osteopathic and composite) within the United States and its territories are determined by a unique state statute (or group of statutes), usually referred to as a medical practice act. The differences among these statutes are related to the general administrative structure of each jurisdiction and to the needs of the public as they are perceived by each responsible legislative body.

The following section is not intended to encourage movement toward total uniformity among these statutes. Given the diversity of administrative structures and the variations in perceived needs, that would be a futile exercise. The existing differences do have a positive creative value, allowing the evolution and testing of a range of new approaches in a number of jurisdictions concurrently. Rather, it is intended to nurture that creativity by encouraging the public, state legislators, medical boards, medical societies, and others who have an interest in the regulation of the medical profession to reexamine existing practice acts as they relate to the composition, structure, functions, responsibilities, powers, and funding of medical boards.

The medical practice act should provide for a separate state medical board, acting as a governmental agency to regulate the practice of medicine, in order to protect the public from unlawful, incompetent, unqualified, impaired, or unprofessional practitioners of medicine, through licensure, regulation, and rehabilitation of the medical profession in the state.

Generally, the medical practice act should authorize Boards to promulgate rules and regulations to facilitate the enforcement of the act. Boards should be authorized to adopt and enforce rules and regulations to carry out the provisions of the medical practice act and to fulfill their duties under the act. Boards should adopt rules and regulations in accord with administrative procedures established in the respective jurisdiction.

Statement of purpose

The medical practice act should be introduced by a statement of policy specifying the purpose of the act. This statement should include language expressing the following concepts:

- The practice of medicine is a privilege granted by the people acting through their elected representatives.
- In the interests of public health, safety, and welfare, and to protect the public from the unprofessional, improper, incompetent, unlawful, fraudulent, and/or deceptive practice of medicine, it is necessary for the government to provide laws and regulations to govern the granting and subsequent use of the privilege to practice medicine.
- The primary responsibility and obligation of the state medical board is to act in the sovereign interests of the government by protecting the public through licensing, regulation and education as directed by the state government.

Sample Statement of Purpose:
As a matter of public policy, the practice of medicine is a privilege granted by the people of the State acting through their elected representatives by their adoption of the Medical Practice Act. It is not a natural right of individuals. Therefore, in the interests of public health, safety and welfare, and to protect the public from the unprofessional, improper, incompetent, unlawful, fraudulent, and/or deceptive practice of medicine, it is necessary to provide laws and regulations to govern the granting and subsequent use of the privilege to practice medicine and to ensure, as much as possible, that only qualified and fit persons hold that privilege. The Board’s primary responsibility and obligation is to protect the public, and any license, certificate or other practice authorization issued pursuant to this statute shall be a revocable privilege and no holder of such a privilege shall acquire thereby any irrevocable right.

Exemptions

The medical practice act should not apply to:

1. Students while engaged in training in a medical school approved or recognized by the state medical board, unless the board licenses the student;
2. Those providing service in cases of emergency where no fee or other consideration is contemplated, charged or received by the physician or anyone on behalf of the physician;
3. Commissioned medical officers of the armed forces of the United States and medical officers of the United States Public Health Service or the Veterans Administration of the United States in the discharge of their official duties and/or within federally controlled facilities, provided that such persons who hold medical licenses in the jurisdiction should be subject to the provisions of the act and provided that all such persons should be fully licensed to practice medicine in one or more jurisdictions of the United States. Further, the military physician should be subject to the Military Health System Clinical Quality Assurance (CQA) Program 10 U.S.C.A. § 1094; Regulation DOD 6025.13-R;
4. Those practicing dentistry, nursing, optometry, psychology, or any other of the healing arts in accord with and as provided by the laws of the jurisdiction;
5. Those practicing the tenets of a religion or ministering religious based medical procedures or ministering to the sick or suffering by mental or spiritual means in accord with such tenets;
6. Those administering a lawful domestic or family remedy to a member of one’s own family;
7. Those fully licensed to practice medicine in another jurisdiction of the United States who briefly render emergency medical treatment or briefly provide critical medical service at the specific lawful direction of a medical institution or federal agency that assumes full responsibility for that treatment or service and is approved by the state medical board; and
8. Those fully licensed to practice medicine in another jurisdiction of the United States who is employed or formally designated as the team physician by an athletic team visiting the jurisdiction for a specific sporting event, and the physician limits the practice of medicine in the jurisdiction to medical treatment of the members, coaches, and staff of the sports entity that employs (or has designated) the physician.
Unlawful Practice of Medicine

The medical practice act should provide a definition of the unlawful practice of medicine and penalties for such unlawful practice. These provisions of the act should implement or be consistent with the following:

1. It should be unlawful for any person, corporation, or association to perform any act constituting the practice of medicine as defined in the medical practice act without first obtaining a medical license in accord with that act and the rules and regulations of the Board. Other licensed health care professionals may provide medical services within the scope of their authorizing license.

2. The Board should be authorized to issue a cease-and-desist order and/or obtain injunctive relief against the unlawful practice of medicine by any person, corporation, or association.

3. It should be a felony for any person, corporation, or association that performs any act constituting the practice of medicine as defined in the medical practice act, or causing or aiding and abetting such actions.

4. A physician located in another state practicing within the state by electronic or other means without a license (full, special purpose or otherwise) issued by the Board should be deemed guilty of a felonious offense.

Section III. State Medical Board Duty, Responsibility, and Power

In some states, responsibility for licensing and disciplinary functions is divided between two separate Boards. In others, Boards are subject to supervision or, in some cases, complete control by larger administrative or umbrella agencies. In a few states, the Board is simply an advisory body. In most states, the Board regulates both allopathic and osteopathic physicians; in others, separate boards exist. And in some states, narrow constitutional restrictions inhibit effective Board funding. Clearly, the following section proposes a true working board with real and effective power and support, a proposal some states are much better prepared to implement than others. But it is also a reflection of those principles the authors consider to be basic to the operation of any accountable medical board, regardless of the administrative structure of the state, the size or distribution of the physician population being regulated, the form of legislation required for funding, or the title of the body to which responsibility and power for regulation have been entrusted. It may be drawn upon by both allopathic and osteopathic boards, making appropriate adaptations in the area of Board membership. Larger administrative agencies can use it to better assess their own structures and functions and to explore the broader roles their medical boards might play in meeting public expectations.

It is necessary that Boards have the responsibilities and powers necessary to fulfill the duties conferred on the Board by the medical practice act. These duties, responsibilities, and powers are to be liberally construed to protect the health, safety, and welfare of the people of the Board’s State. It is the duty of Boards to determine a physician’s initial and continuing qualification and fitness for the practice of medicine. Boards should be empowered to initiate proceedings against the unprofessional, improper,

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1 In light of the recent U.S. Supreme Court case, *North Carolina Board of Dental Examiners v. Federal Trade Commission*, it is currently unclear whether the reliance on cease-and-desist orders to regulate the unlicensed practice of medicine by state medical boards is a best practice.
incompetent, unlawful, fraudulent, deceptive, or unlicensed practice of medicine, and enforce the medical practice act and related rules. Boards should discharge these duties and responsibilities in accord with the medical practice act and other governing laws.

In addition to any other duty, responsibility, and power provided to the Board in the medical practice act, the Board, acting in accord with its medical practice act and the requirements of due process, should:

1. Enforce the provisions of the medical practice act;
2. Develop, adopt and enforce rules and regulations to affect the provisions of medical practice act and to fulfill the Boards duties there under;
3. Select and/or administer licensing examination(s);
4. Employ or contract with one or more organizations or agencies known to provide acceptable examinations for the preparation, administration, and scoring of required examinations;
5. Prepare, select, conduct, or direct the conduct of, set passing requirements for, assure security of, and impose conditions for (e.g., time or attempt limits) successful completion of the licensing and other required examinations;
6. Impose conditions, sanctions, deny licensure, levy fines, seek appropriate civil and/or criminal penalties, or any combination of these, against those who violate or attempt to violate examination security, those who obtain or attempt to obtain licensure by fraud or deception, and those who knowingly assist in such activities;
7. Acquire information about and evaluate medical education and training of applicants;
8. Determine which professional schools, colleges, universities, training institutions, and educational programs are acceptable relating to licensure under the medical practice act and are appropriately preparing physicians for the practice of medicine, and to accept the approval of such facilities and programs by Board-recognized accrediting bodies in the United States and Canada;
9. Develop and use applications and other necessary forms and related procedures it finds appropriate for purposes of the medical practice act;
10. Require supporting documentation or other acceptable verifying evidence of any information provided the Board by an applicant or licensee;
11. Require information on and evaluate an applicant’s or a licensee’s fitness, qualification, and previous professional record and performance from recognized data sources, including, but not limited to, the Federation of State Medical Boards’ Federation Physician Data Center, other national data repositories, licensing and disciplinary authorities of other jurisdictions, professional education and training institutions, liability insurers, health care institutions, and law enforcement agencies;
12. Issue, condition, or deny initial or endorsement licenses;
13. Maintain secure and complete records on individual licensees including, but not limited to license application, verified credentials, disciplinary information, and malpractice history;
14. Provide the public with a profile of all licensed physicians;
15. Process and approve or deny applications for license renewal and review of a licensee’s
activities for that time period;

16. Develop and implement methods to identify physicians who are in violation of the medical practice act;

17. Require the self-reporting by applicants or licensees of any information the Board determines may indicate possible deficiencies in practice, performance, fitness, or qualification.

18. Require all licensees, healthcare professionals, healthcare facilities, and medical societies and organizations to report to the Board information that appears to show another licensee is, or may be, professionally incompetent, guilty of unprofessional conduct, or mentally or physically unable to engage safely in licensed practice, and to report to the Board and/or to an agency designated by the Board a licensee’s possible dependence on alcohol or other addictive substances which have the potential to impair. Require licensees, malpractice insurance companies, attorneys, and healthcare facilities to report any payments on a demand, claim, settlement, arbitration award or judgment by or on behalf of a licensee;

19. Develop and implement methods to identify and rehabilitate, if appropriate, physicians with an alcohol, drug, and/or psychiatric illness;

20. When deemed appropriate by the Board to do so, require professional competency, physical, mental or chemical dependency examination, and evaluations of any applicant or licensee, including withdrawal and laboratory examination of bodily fluids;

21. Establish a mechanism, which at the Board’s discretion, may involve cooperation with and/or participation by one or more Board-approved professional organizations, for the identification and monitored treatment of licensees who are dependent on or abuse alcohol or other addictive substances which have the potential to impair;

22. Establish a mechanism by which licensees who believe they abuse or may be dependent on or addicted to alcohol or other addictive substances which have the potential to impair, and who have not been identified by the Board through other sources of information, will be encouraged to report themselves voluntarily to the Board and/or, at the Board’s discretion, to a professional organization approved by the Board to seek assistance and monitored treatment;

23. Receive, review, and investigate complaints and adverse information about licensees, including sua sponte complaints;

24. Review and investigate reports received from entities having information pertinent to the professional performance of licensees;

25. Act to halt the unlicensed or illegal practice of medicine; review, investigate, and take appropriate action to enjoin reports received concerning the unlicensed practice of medicine; and seek penalties against those engaged in such practices;

26. Adjudicate those matters that come before it for judgement under the medical practice act and issue final decisions on such matters;

27. Share investigative information at the early stages of a complaint investigation with other Boards;

28. Issue cease and desist orders and to obtain court orders and injunctions to halt unlicensed practice, violation of this statute or the rules of the Board;

29. Institute actions in its own name and enjoin violators of the medical practice act;

30. Act on its own motion in disciplinary matters, administer oaths, issue notices, issue subpoenas in
the name of the state including for patient records, receive testimony, conduct hearings, institute court proceedings for contempt to compel testimony or obedience to its orders and subpoenas, take evidentiary depositions, and perform such other acts as are reasonably necessary under the medical practice act or other laws to carry out its duties;

31. Issue subpoenas in the course of an investigation, including for *duces tecum* to compel production of documents or testimony to any party or entity that may possess relevant information regarding the subject of the investigation;

32. Institute proceedings in courts of competent jurisdiction to enforce its orders and the provisions of the medical practice act;

33. Use preponderance of the evidence as the standard of proof and to issue final decisions;

34. Present to the proper authorities information it believes indicates an applicant or licensee may be subject to criminal prosecution;

35. Discipline licensees found in violation of the medical practice act;

36. Issue conditioned, restricted, or otherwise circumscribed licenses as it determines necessary;

37. Take the following actions, in accord with applicable state statutes, alone or in combination, against those found in violation of the medical practice act:
   a. Revoke, suspend, condition, restrict, and/or otherwise limit the license;
   b. Place the licensee on probation with conditions;
   c. Levy fines and/or assess the costs of proceedings against the licensee;
   d. Censure, reprimand and/or otherwise admonish the licensee;
   e. Require the licensee to provide monetary redress to another party, and/or provide a period of free public or community service;
   f. Require the licensee to satisfactorily complete an educational, training, and/or treatment program or programs; and
   g. Require the licensee to successfully complete an examination, examinations, or evaluations designated by the Board; and

38. Summarily suspend a license when there is imminent risk of the public health and safety prior to hearing and final adjudication;

39. Enforce final disciplinary action against a licensee as deemed necessary to protect public health and safety;

40. Report all final disciplinary actions, non-administrative license withdrawals as defined by the Board, license denials, and voluntary license limitations or surrenders related to physicians, with any accompanying license limitations or surrenders related to physicians, with any accompanying Board orders, findings of fact and conclusions of law, to the Federation Physician Data Center of the Federation of State Medical Boards of the United States and to any other data repository required by law, and report all such actions, denials and limitations or surrenders related to other licensees, with the same supporting documentation, to the National Practitioner Data Bank as required by law;

41. Develop policies for disciplining or rehabilitating physicians who demonstrate inappropriate sexual behavior with patients or other professional boundaries violations;

42. Acknowledge receipt of complaints or other adverse information to persons or entities reporting to the Board and to the physician, and inform them of the final disposition of the matters
reported;

43. Develop and implement methods to identify dyscompetent physicians and physicians who fail to meet acceptable standards of care;

44. Develop or identify and implement methods to assess and improve physician practice;

45. Develop or identify and implement methods to ensure the ongoing competence of licensees;

46. Determine and direct the Board’s operating, administrative, personnel, and budget policies and procedures in accord with applicable state statutes;

47. Acquire real property or other capital for the administration and operation of the Board;

48. Set necessary fees and charges to ensure active and effective pursuit of all of its responsibilities, legal and otherwise;

49. Develop and adopt its budget;

50. Employ, direct, reimburse, evaluate, and dismiss when appropriate the Board’s executive director, in accord with the Board’s state’s procedures; Supervision of staff is the purview of the executive director.

51. Develop, recommend, and adopt rules, standards, policies, and guidelines related to qualifications of physicians and medical practice;

52. Engage in a full exchange of information with the licensing and disciplinary boards of other states and jurisdictions of the United States and foreign countries;

53. Direct the preparation and circulation of educational material, policies, and guidelines the Board determines is helpful and proper for licensees;

54. Develop educational programs to facilitate licensee awareness of provisions contained in the medical practice act and to facilitate public awareness of the role and function of state medical boards;

55. Delegate to the executive director the Board’s authority to discharge its duties as appropriate;

and

56. Recommend to the Legislature those changes in, or amendments to, the medical practice act that the Board determines would benefit the health, safety, and welfare of the public.

Section IV. State Medical Board Membership

Whatever the professional regulatory structure established by the government of the jurisdiction, the state medical board bears the primary responsibility for licensing and regulating the medical profession for the protection of the public. Every Board should include both physician and public members. All Board members should act to further the interest of the state, and not their personal interests.

Composition and Size

The Board should consist of enough members to appropriately discharge the duties of the Board, at least 25% of whom should be public members. The Board should consider several factors when determining the appropriate size and composition of a Board, including the size of a state’s physician population, the composition and functions of Board committees, adequate separation of prosecutorial and judicial powers, and the other work of the Board envisions throughout this document. The Board should be of sufficient size to allow for recusals due to conflicts of interest and other occasional member absences without concentrating final decisions in the hands of too few members or loss of quorum.
Qualifications

The membership of the Board should be drawn from as many different regions of the State, as many different specialties as possible, and should reflect the licensee population.

Members should be citizens of the United States who have attained the age of majority as defined in the statutes of the State.

Sex, race, national or ethnic origin, creed, religion, disability, or age above majority shall not be used as the sole reason for making an individual eligible or ineligible to serve on the Board.

All physician members of the Board should be in active practice\(^2\) (HOD 2012), hold full and unrestricted medical licenses in the jurisdiction, be persons of recognized professional ability and integrity, and should have resided or practiced in the jurisdiction long enough to have become familiar with the laws, policies, and practice in the jurisdiction (e.g., five years).

Public members of the Board should reside in the Board's respective jurisdiction and be persons of recognized ability and integrity; are not licensed physicians, providers of health care, or retired physicians or health care providers; have no past or current substantial personal or financial interests in the practice of medicine or with any organization regulated by the Board (except as a patient or care giver of a patient); and have no immediate familial relationships with individuals involved in the practice of medicine or any organization regulated by the Board.

Terms

Members of the Board, whether appointed or elected, should serve staggered terms to ensure continuity. All appointments and elections should be confirmed through the legislative branch of the jurisdiction. The length of terms on the Board should be set to permit development of effective skill and experience by members (e.g., three or four years). However, a limit should be set on consecutive terms of service (e.g., two or three consecutive terms).

The term of Board service shall be three to four years.

A person should not serve as a member of the Board for more than three consecutive full terms, but may be reappointed two years after completion of such service. A person who serves more than two

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\(^2\) FSMB Report of the Special Committee on Reentry to Practice (HOD 2012) defines the clinically active physician as one who, at the time of license renewal, is engaged in direct, consultative, or supervisory patient care, or as further defined by the states. Clinically inactive physician is defined as one who is not engaged in direct, consultative or supervisory patient care at the time of license renewal, but who, as a result of their professional activities, influences the care provided by clinically active practitioners.
years of an un-expired term should be considered to have served a full term.

Terms of service should be staggered, one fourth of the Board’s membership being appointed each year.

In order to ensure there is continual representation of public members, for Boards with up to four public members, the term of no more than one public member should expire in any one year. For Boards with more than four public members, the terms of no more than two public members should expire in any one year.

Requirements

Before assuming the duties of office, the following should be required of each member of the Board:

1. Take a constitutional oath or affirmation of office;
2. Swear or affirm that he/she is qualified to serve under all applicable statutes;
3. Sign a statement agreeing that he/she will disclose any potential conflicts of interest that may arise for that member in the conduct of Board business;
4. Sign a confidentiality and ethics statement agreeing to maintain the confidentiality of confidential Board business and patient identification and uphold high ethical standards in discharging Board duties.

The Board should also conduct, and new members should attend, a training program designed to familiarize new members with their duties and ethics of public service. The Board should hold an annual training program for new members.

Appointment

The members of the Board should be appointed by the Governor, who should make each appointment at least 30 calendar days prior to the beginning of the Board term being filled. The Governor should fill an unexpired term within 30 calendar days of the vacancy’s occurrence. The incumbent should serve until the Governor names a replacement. Should the Governor not act as such, the Board, by majority vote, should select a qualified person to serve in the interim until the Governor acts. Any individual, organization or group should be permitted to suggest potential Board appointees to the Governor.

Removal

A Board member should be automatically removed from the Board if the Board member:

1. Ceases to be qualified;
2. Submits written resignation to the Board Chair or to the Governor;
3. Is absent from the state for a period of more than six months;
4. Is found guilty of a felony or an unlawful act involving moral turpitude by a court of competent jurisdiction;
5. Is found guilty of malfeasance, misfeasance, or nonfeasance in relation to the Board member’s Board duties by a court of competent jurisdiction;
6. Is found to be mentally incompetent by a court of competent jurisdiction;
7. Fails to attend three successive Board meetings without just cause as determined by the Board,
or, if a new member, fails to attend the new members’ training program without just cause as determined by the Board;
8. Is found to be in violation of the medical practice act; or
9. Is found to be in violation of the conflict of interest/ethics law.

Compensation/Reimbursement
Members of the Board should receive appropriate compensation for services and reimbursement for expenses at the respective state’s current approved rate.

- Compensation: Service on the Board should not present an undue economic hardship. Board members should therefore receive compensation in an amount sufficient to allow full participation and not preclude qualified individuals from serving.
- Expenses: Each Board member’s travel and expenses necessarily and properly incurred for active Board service should be paid at the respective state’s current approved rate.
- Education/Training: Travel, expenses, and daily compensation should also be paid for each Board member’s attendance, in or out of the Board’s jurisdiction, for education or training purposes approved by the Board and directly related to Board duties.

Section V. State Medical Board Structure

Officers
The Board should elect annually from its members a president/chair, a vice president/vice-chair, a secretary-treasurer, and those other officers it determines are necessary to conduct its business. The officers shall serve for a one-year term.

- President/Chair: The president/chair should approve Board meeting agendas, preside at Board meetings, appoint Board committees and their chairs, and perform those other duties assigned by the Board and this statute.
- Vice President/Vice-Chair: The vice president/vice-chair should assist the president/chair in all duties as requested by the president/chair and should perform the duties of the president/chair in that officer’s absence.
- Secretary/Treasurer: The secretary-treasurer should ensure the maintenance of the minutes of all meetings of the Board and that the expenditure of funds complies with respective state law.

Committees
To effectively facilitate its work, fulfill its duties and exercise its powers, the Board should be authorized to appoint committees from its membership, establish standing committees, including, but not limited to, licensing, investigation, finance, administration, personnel, rules, legislative communications, and public information committees. The chair should also be empowered to name ad hoc committees as required. Changes in membership should not be deemed to affect or hinder the continuing business or activity of any committee.

Other committees created by the Board should have responsibilities, consistent with the medical
practice act, delegated to them by the Board.

**Funding**

The medical practice act should provide that Board fees be adequate to fund the Board’s ability to effectively regulate the practice of medicine under the act, and that those fees paid by licensees be used only for purposes related to licensee licensure, discipline, education and Board administration. A designated officer of the Board or employee, at the direction of the Board, should oversee the collection and disbursement of funds, and the State Auditor’s Office (or the equivalent State office) should routinely audit the financial records of the Board and report to the Board and the Legislature.

**Revenues**

The Board should be fully supported by the revenues generated from its activities, including fees, charges and reimbursed costs, which the Board should deposit in an appropriate account, and the Board should also receive all interest earned on the deposit of such revenues. Such funds should be appropriated continuously and used by the Board only for administration and enforcement of the medical practice act. All fines levied by the Board may be deposited in the State General Fund, unless otherwise allowed by law. All administrative, investigative and adjudicatory costs recoupment should be deposited in the Board’s account.

In the event the legislature imposes additional responsibilities on the Board beyond the Board’s statutory responsibilities for licensure and discipline, the legislature should appropriate additional funds to the Board sufficient to carry out such additional responsibilities.

**Budget**

The Board should develop and adopt its own budget reflecting revenues, including the interest thereon, and costs associated with each health care field regulated. Revenues and interest thereon, from each health care field regulated should fully support Board regulation of that field. The budget should include allocations for establishment and maintenance of a reasonable reserve fund.

**Setting Fees and Charges**

All Board fees and charges should be set by the Board pursuant to its proposed budget needs. The Board should provide reasonable notice to the regulated healthcare professional and the public of all increases or decreases in fees and charges.

**Fiscal Year**

The Board should operate on the same fiscal year as the State.

**Section VI. Meetings of the Board and Committee of the Board**

**Location**

The Board and its committees should meet in the Board’s offices, or other appropriate facilities in the same city as those offices. At their discretion, however, they may meet from time to time in other areas of the State to facilitate their work or to enhance communication with the public and members of the regulated professions.
Telephone or other telecommunication conference is an acceptable form of Board meeting if the president/chair alone or another officer and two Board members believe the Board’s business can be properly conducted by teleconference. The Board should be authorized to establish procedures by which its committees may meet by telephone or other telecommunication conference system.

**Frequency, Duration**

The Board should meet at least bimonthly for a period sufficient to complete the work before it at that time. One meeting per quarter may be sufficient for states with small physician populations. Committees should meet as directed by the Board.

**Special Meetings, Conferences**

Emergency meetings of the Board may be called at any time by the president/chair or at the request of an officer and two Board members if required to enforce the medical practice act. The Board may establish procedures by which its committees may call emergency meetings in accordance with the State’s open meeting laws.

Informal conferences of an investigation committee may be called by the chair of the committee for the purpose of holding discussions with licensees, accused or otherwise, who seek or agree to such conferences. Any disciplinary action taken as a result of such a conference and agreed to in writing by the Board and licensee should be binding and a matter of public record. The holding of an informal conference should be at an investigation committee’s discretion and should not preclude formal disciplinary investigation, proceedings, or action.

**Notice**

The Board should establish a system for giving all Board and committee members reasonable notice of all Board and committee meetings. The Board should comply with the State’s open meeting laws.

**Quorum**

A majority of members constitutes a quorum for the transaction of business by the Board or any committee of the Board. The business of the Board and its committees should be conducted in accord with the medical practice act and with rules of parliamentary procedure adopted by the Board.

**Conflict of Interest**

No member of the Board, acting in that capacity or as a member of any Board committee, shall participate in the deliberation, making of any decision, or the taking of any action affecting the Board member’s own personal, professional, or pecuniary interest, or that of a known relative or of a business or professional associate. With advice of legal counsel, the Board shall adopt and annually review a conflict of interest policy to enforce this section.

**Minutes**

Minutes of all Board and committee meetings and proceedings, and other Board and committee materials, shall be prepared and kept in accord with the Board’s adopted rules of parliamentary procedure and other applicable State laws.
Open Meetings

All meetings of the Board and its committees should be open to the public in accordance with the State’s Open Meeting laws, with the following exceptions:

1. Meetings or portions of meetings of the Board, acting in its capacity as a hearing or adjudicatory body, held to receive testimony or evidence the public disclosure of which the Board determines would constitute an unreasonable invasion of personal privacy, to consult with legal counsel, to deliberate issues, and to arrive at disciplinary judgments;
2. Meetings or portions of meetings regarding investigations;
3. Meetings or portions of meetings regarding license applications; and
4. Meetings or portions of meetings regarding personnel actions.

The Board should ratify all recommendations or decisions made in nonpublic meetings in public, which should be matters of public record.

Confidentiality

The minutes and all records of nonpublic meetings are privileged and confidential and should not be disclosed, except to the Board or its designees for the enforcement of the medical practice act, except that all licensing decisions made by the Board and all disciplinary orders, with the associated findings of fact and conclusions of law and order, issued by the Board should be matters of public record.

The following should be privileged and confidential:

1. Application and renewal forms and any evidence submitted in proof or support of an application to practice, except that the following items of information about each applicant or licensee included on such forms should be matters of public record:
   a. Full name;
   b. Date of birth;
   c. Name(s) and location(s) of professional schools attended;
   d. School awarding professional degree, date of award, and designation of degree;
   e. Site(s) and date(s) of graduate certification(s) held and date(s) granted;
   f. Specialty certifications;
   g. Year of initial licensure in the State;
   h. Other states in which licensed to practice; and
   i. Current office address and telephone number.
2. All investigations and records of investigations;
3. Any report from any source concerning the fitness of any person to receive or hold a license;
4. Any communication between or among the Board and/or its committees, staff, advisors, attorneys, employees, hearing officers, consultants, experts, investigators and panels occurring outside public meetings; and
5. A complaint and the identity of an individual or entity filing an initial complaint with the Board.

Notwithstanding the foregoing provisions, the Board may cooperate with and provide documentation to
other boards, agencies or law enforcement bodies of the State, other states, other jurisdictions, or the United States upon written official request by such entity(s). The Board should 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.

These provisions should not be construed as prohibiting a respondent or the respondent’s legal counsel from exercising the respondent’s right of due process under the law.

Section VII. Administration of the State Medical Board

Offices
The Board should maintain offices it determines are adequate in size, staff, and equipment to effectively carry out the provisions of the medical practice act. At its discretion, it may establish branch offices, staffed and equipped as it finds necessary, in as many areas of the State as it believes require such branch offices to facilitate the work of the Board.

Administration
The Board should set out the function, operation, and administration structure of its offices.

Staff, Special Personnel
To effectively perform its duties under the medical practice act, the Board should be empowered to determine its staff needs and to employ, fix compensation for, evaluate, discipline, and remove its own full-time, part-time and temporary staff in accord with the statutory requirements of the State. The Board should also be assigned adequate legal counsel by the office of the attorney general and/or be authorized to employ private counsel or its own full-time attorney. The Board should define the duties of and qualifications for the executive director. Staff benefits should be provided in accord with the statutes of the State.

The Board’s staff may include, but need not be limited to, the following:

- An executive director, who, among administrative and other delegated responsibilities, may assist, at the Board’s discretion, in the discharge of the duties of the secretary-treasurer and if one exists, the licensing committee, the investigation committee, and any other standing or ad hoc committee;
- One or more assistant executive directors;
- One or more medical consultants, who shall be licensed to practice medicine in the State without restriction;
- Office and clerical staff;
- One or more attorneys, who may be full-time employees of the Board, contractors of the Board, or assigned from the Office of the State Attorney General by agreement between the Board and that office, or in private practice; and/or
- One or more investigators, who shall be trained in and knowledgeable about the investigation of medical and related health care practice.
Special Support Personnel

The Board may enlist, at its discretion, the services of experts, advisors, consultants, and others who are not part of its staff to assist it in more effectively enforcing the medical practice act. Such persons may serve voluntarily, be reimbursed for expenses in accord with State law and policy, or be compensated at a level commensurate with services rendered in accord with state law and policy. When acting for or on behalf of the Board, such persons should benefit from the same immunity and indemnification protections afforded by this statute to the members and staff of the Board.

Section VIII. Immunity, Indemnity, Protected Communication

The medical practice act should provide legal protection for the members of the Board and its staff and for those providing information to the Board in good faith.

Immunity

There shall be no liability, monetary or otherwise, on the part of, and no cause of action for damages shall arise against any current or former member, officer, administrator, staff member, committee member, examiner, representative, agent, employee, consultant, witness, or any other person serving or having served the Board, either as a part of the Board’s operation or as an individual, as a result of any act, omission, proceeding, conduct, or decision related to the duties undertaken or performed in good faith and within the scope of the function of the Board.

Qualified Immunity and Indemnity

The medical practice act should provide the following:

1. There shall be no liability on the part of, and no action for damages against, any member of the Board, its agents, its employees, or any member of an examining committee of physicians appointed or designated by the Board, for any action undertaken or performed by such person within the scope of the duties, powers, and functions of the Board or such examining committee when such person is acting in good faith and in the reasonable belief that the action taken by such person is warranted.

2. If a current or former member, officer, administrator, staff member, committee member, examiner, representative, agent employee, consultant, or any other person serving or having served the Board requests the State to defend them against any claim or action arising out of any act, omission, proceeding, conduct, or decision related to their duties undertaken or performed in good faith in furtherance of the purposes of the medical practice act and within the scope of the function of the Board, and if such a request is made in writing at a reasonable time before trial, and if the person requesting defense cooperates in good faith in the defense of the claim or action, the State shall provide and pay for such defense and shall pay any resulting judgment, compromise, or settlement.

3. No person, committee, association, organization, firm, or corporation providing information to the Board in good faith and in the reasonable belief that such information is accurate and, whether as a witness or otherwise, shall be held, by reason of having provided such information, to be liable in damages under the law of the state or any political subdivision thereof.
4. In any suit brought against the Board, its employees or agents, any member of an examining committee appointed by the Board or any person, firm, or other entity providing information to the Board, when any such defendant substantially prevails in such suit, the court shall, at the conclusion of the action, award to any such substantially prevailing party defendant against any such claimant the cost of the suit attributable to such claim, including a reasonable attorney’s fee, if the claim was frivolous, unreasonable, without foundation, or in bad faith. For the purposes of this Section, a defendant shall not be considered to have substantially prevailed when the plaintiff obtains an award for damages or permanent injunctive or declaratory relief.

5. There shall be no liability on the part of and no action for damages against any corporation, foundation, or organization that enters into any agreement with the Board related to the operation of any committee or program to identify, investigate, counsel, monitor, or assist any licensed physician who suffers or may suffer from alcohol or substance abuse or a physical or mental condition which could compromise such physician’s fitness and ability to practice medicine with reasonable skill and safety to patients, for any investigation, action, report, recommendation, decision, or opinion undertaken, performed, or made in connection with or on behalf of such committee or program, in good faith, and in the reasonable belief that such investigation, action, report, recommendation, decision, or opinion was warranted.

6. There shall be no liability on the part of and no action for damages against any person who serves as a director, trustee, officer, employee, consultant, or attorney for or who otherwise works for or is associated with any corporation, foundation, or organization that enters into any agreement with the Board related to the operation of any committee or program to identify, investigate, counsel, monitor, or assist any licensed physician who suffers or may suffer from alcohol or substance abuse or a physical or mental condition which could compromise such physician’s fitness and ability to practice medicine with reasonable skill and safety to patients, for any investigation, action, report, recommendation, decision, or opinion undertaken, performed, or made in connection with or on behalf of such committee or program, in good faith and in the reasonable belief that such investigation, action, report, recommendation, decision, or opinion was warranted.

7. In any suit brought against any corporation, foundation, organization, or person described in Subsection 4 or 5 of this Section, when any such defendant substantially prevails in the suit, the court shall, at the conclusion of the action, award to any substantially prevailing party defendant against any claimant the cost of the suit attributable to such claim, including reasonable attorney fees, if the claim was frivolous or brought without a reasonable good faith basis. For purposes of this Subsection, a defendant shall not be considered to have substantially prevailed when the plaintiff obtains a judgment for damages, permanent injunction, or declaratory relief.

8. The state should defend a current or former member, officer, administrator, staff member, committee member, examiner, representative, agent, employee, consultant, witness, contractor, or any other person serving or having served the Board against any claim or action arising out of the medical practice act, omission, proceeding, conduct, or decision related to the person’s duties undertaken or performed in good faith and within the scope of the function of the Board. The State should provide and pay for such defense and should pay any resulting judgment, compromise, or settlement.
Protected Communication

Every communication made by or on behalf of any person, institution, agency, or organization to the Board or to any person designated by the Board, relating to an investigation or the initiation of an investigation, whether by way of report, complaint, or statement, should be privileged. No action or proceeding, civil or criminal, should be permitted against any such person, institution, agency, or organization by whom or on whose behalf such a communication was made in good faith.

The protections afforded in this provision should not be construed as prohibiting a respondent or the respondent’s legal counsel from exercising the respondent’s constitutional right of due process under the law.

Section IX. Reports of the Board

Annual Report

The Board should present to the Governor, the Legislature and the public, at the end of each fiscal year, a formal report summarizing its licensing and disciplinary activity for that year. The report should include, but not limited to, the following information about each of the Board’s regulated professions:

1. The total number of persons fully licensed by the State and the number of those licensees currently practicing in the State;
2. The number of licensees holding each form of limited license authorized by this statute;
3. The number of persons granted a full license by the State for the first time in the past year, the number of those licensees currently practicing in the State, and the number of full licenses denied in the past year;
4. The number of licensees currently practicing in-state about whom a complaint, a charge or an adverse item of information required by law was received in the past year;
5. The number and the source, by category, of complaints, charges and adverse items of information required by law received about licensees practicing in-state in the past year and the number of these found not to warrant action under this statute and the rules of the Board;
6. The number of disciplinary investigations conducted by the Board or its representatives concerning licensees practicing in-state in the past year;
7. The number of disciplinary actions, by category, taken by the Board in the past year against all licensees;
8. A ranking, by frequency, of primary causes for disciplinary action against all licensees in the past year;
9. A review of disciplinary activity related to holders of limited forms of license in the past year;
10. A review of the operations of the Board’s current mechanisms for dealing with a licensee dependent on or addicted to alcohol or other addictive substances which have the potential to impair;
11. A schedule of all current fees and charges;
12. A revenue and expenditure statement for the past year indicating the percentage of revenue from and expenditures for each regulated profession;
13. A summary of other Board activities and a schedule of days met by the Board and each of its...
committees during the year;
14. A summary of administrative and legislative activity in the past year;
15. A summary of the goals and objectives established by the Board for the coming fiscal year; and
16. A copy of the Board’s strategic plan.

Public Record, Action Reports
Each of the Board’s non-administrative license application withdrawals, license denials and final
disciplinary orders, including any associated findings of fact and conclusions of law, should be matters of
public record. Voluntary surrenders of or limitations on licenses shall also be matters of public record.
The Board should promptly report all denials, orders, surrenders, and limitations to the public, all health
care institutions in the State, appropriate State and federal agencies, related professional societies or
associations in the State, and any data repository. The Board should make the information readily
accessible to the public via the physician’s profile. The Board should update the profile at least annually
and offer the licensee an opportunity to correct erroneous information. A licensee’s profile shall
contain, but not be limited to:

1. Demographic Information: name and license number, gender, business or practice address, and
birth date.
2. Medical Education: medical school(s)’ name, address, year of graduation and degree, post-
graduate training program(s)’ name, address, years attended, and year completed.
3. License and Board Certification Information: license status, license type, original license date,
license renewal date, specialty and type of practice, and board certification by a certifying
authority recognized by the Board.
4. Criminal Convictions: a description of any conviction of a felony or a misdemeanor involving
moral turpitude within the last five years, including cases with a deferred adjudication or
expungement.
5. Malpractice History:
   a. The number of awards or judgments within the past 10 years;
   b. When the number exceeds 3, the number of demands, claims, and/or settlements paid
      by the licensee or on behalf of the licensee in the past 5 years; and
   c. A statement that malpractice payments do not necessarily demonstrate the quality of
      care provided by a physician, and that the Board independently investigates all reports
      of payment in malpractice cases, which will appear in the licensee’s disciplinary history if
      the Board completed the investigation and took disciplinary action.
6. Disciplinary History:
   a. All disciplinary actions taken by the Board;
   b. A brief description of the reason for a disciplinary action;
   c. All disciplinary actions taken by other state medical/osteopathic boards and a brief
description of the reason for discipline if available;
   d. All disciplinary actions taken by hospitals;
   e. An explanation of the types of discipline the Board takes and its effects on the licensee’s
      ability to practice; and
f. A statement that hospitals may take disciplinary actions for reasons that do not violate the governing statutes.

Section X. Examinations

The medical practice act should provide for the Board’s authority to approve an examination(s) of medical knowledge satisfactory to inform the Board’s decision to issue a full, unrestricted license to practice medicine and surgery in the jurisdiction.

In order to ensure a high quality, valid, and reliable examination of physician preparedness to practice medicine, the Board may delegate the responsibilities for examination development, administration, scoring, and security to a third party or nationally recognized testing entity. Such an examination should be consistent with recognized national standards for professional testing such as those reflected in Standards for Educational and Psychological Testing.

No person should receive a license to practice medicine in the jurisdiction unless he or she has successfully completed all components of an examination(s) identified as satisfactory to the Board:

- The currently administered United States Medical Licensing Examination (USMLE) Steps 1,2,3 or The Comprehensive Osteopathic Medical Licensing Examination of the United States (COMLEX-USA) Levels 1,2,3; or
- Previously administered examinations such as the Federation Licensing Examination (FLEX), National Board of Medical Examiners (NBME) Parts or National Board of Osteopathic Medical Examiners (NBOME) Parts; or
- A combination of these examinations identified as acceptable by the Board.

The examination(s) approved by the Board should be in the English language and designed to ascertain an individual’s fitness for an unrestricted license to practice medicine and surgery.

The Board may stipulate the numeric score or performance level required for passing the examination(s) or accept the recommended minimum passing score as determined by the developers of the examination.

The Board should be authorized to limit the number of times an examination may be taken, to require applicants to pass all examinations within a specified period, and to specify further medical education required for applicants unable to do so.

In order to support periodic or mandated reviews of its approved examination(s), the Board should be provided with reasonable access by the third party or testing entity in order to review the examination design, format, and content, as well as performance data and relevant procedures for test administration, security, and scoring.

Section XI. Requirements for Full Licensure

The medical practice act should provide minimum requirements for full licensure for the independent practice of medicine that bear a reasonable relationship to the qualifications and fitness necessary for...
such practice. These provisions of the act should implement or be consistent with the following:

1. The applicant should provide the Board, or its agent, and attest to, or provide the means to obtain and verify the following information and documentation in a manner required by the Board:
   a. The applicant’s full name and all aliases or other names ever used, current address, Social Security number, and date and place of birth;
   b. A signed photograph not more than two (2) years old and, at the Board’s discretion, other documentation of identity;
   c. Originals of all documents and credentials required by the Board, notarized photocopies, or other verification acceptable to the Board of such documents and credentials;
   d. A list of all jurisdictions, United States or foreign, in which the applicant is licensed or has ever applied for licensure to practice medicine or is authorized or has ever applied for authorization to practice medicine, including all jurisdictions in which any license application or authorization has been withdrawn;
   e. A list of all jurisdictions, United States or foreign, in which the applicant has been denied licensure or authorization to practice medicine or as any other health care professional or has voluntarily surrendered a license or an authorization to practice medicine or as any other health care professional;
   f. A list of all sanctions, judgments, awards, settlements, or convictions against the applicant in any jurisdiction, United States or foreign, that would constitute grounds for disciplinary action under the medical practice act or the Board’s rules and regulations;
   g. A detailed educational history, including places, institutions, dates, and program descriptions of all the applicant’s education including all college, pre-professional, professional, and professional postgraduate education;
   h. A detailed chronological life history, including places and dates of residence, employment, and military service (United States or foreign) including periods of absence from the active practice of medicine;
   i. All Web sites associated with the applicant’s practice and professional activities;
   j. A list and current status of all specialty certifications and the name of certifying organization; and
   k. Any other information or documentation the Board determines necessary.

2. The applicant should possess the degree of Doctor of Medicine or Doctor of Osteopathic Medicine/Doctor of Osteopathy from a medical college or school located in the United States, its territories or possessions, or Canada that was approved by the Board or by a private nonprofit accrediting body approved by the Board at the time the degree was conferred. No person who graduated from a medical school that was not approved at the time of graduation should be examined for licensure or be licensed in the jurisdiction based on credentials or documentation from that school nor should such a person be licensed by endorsement.

3. Should the applicant graduate from a medical school in a foreign country, other than Canada, the applicant should meet all the requirements established by the Board to determine the
4. The applicant should have satisfactorily completed at least thirty-six (36) months of progressive postgraduate medical training (also termed graduate medical education, or GME) accredited by the Board, the Accreditation Council for Graduate Medical Education (ACGME), or the American Osteopathic Association (AOA).

5. The applicant should have passed the USMLE Steps 1, 2, 3 or COMLEX Levels 1, 2, 3 or a predecessor examination (FLEX, NBME Parts, NBOME Parts) or a combination of these examinations identified as accredited by the Board.

6. The applicant should have demonstrated a familiarity with the statutes and regulations of the jurisdiction relating to the practice of medicine and the appropriate use of controlled or dangerous substances.

7. The applicant should be physically, mentally, and professionally capable of practicing medicine in a manner acceptable to the Board and should be required to submit to a physical, mental, professional competency, or chemical dependency examination(s) or evaluation(s) if deemed necessary by the Board.

8. The applicant should not have been found guilty by a competent authority, United States or foreign, of any conduct that would constitute grounds for disciplinary action under the regulations of the Board or the act. The Board may be authorized, at its discretion, to modify this restriction for cause, but it should be directed to use such discretionary authority in a consistent manner.

9. If the applicant’s license is denied or in accordance with Board policy, the applicant should be allowed a personal appearance before the Board or a representative thereof for interview, examination or review of credentials. At the discretion of the Board, the applicant should be required to present the applicant’s original medical education credentials for inspection at the time of personal appearance.

10. The applicant should be held responsible for verifying to the satisfaction of the Board the validity of all credentials required for the applicant’s medical licensure. The Board or its agent should verify medical licensure credentials directly from primary sources, and utilize recognized national physician information services (e.g., the Federation of State Medical Boards’ Physician Data Center (PDC), which includes its Board Action Data Bank, and Federation Credentials Verification Service (FCVS); the files of the American Medical Association and the American Osteopathic Association; and other national data banks and information resources.)

11. The applicant should have paid all fees and have completed and attested to the accuracy of all application and information forms required by the Board before the Board’s verification process begins. The Board should require the applicant to authorize the Board to investigate and/or verify any information provided to it on the licensure application.

12. Applicants should have satisfactorily passed a criminal background check.

13. Pay appropriate fees.

Graduates of Foreign Medical Schools

The medical practice act should provide minimum requirements, in addition to those otherwise established, for full licensure of applicants who are graduates of schools located outside the United States.
States, its territories or possessions, or Canada. These provisions of the act should implement or be consistent with the following:

1. Such applicants should possess the degree of Doctor of Medicine, Bachelor of Medicine, or a Board-approved equivalent based on satisfactory completion of educational programs acceptable to the Board.
2. Such applicants should be eligible by virtue of their medical education, training, and examination for unrestricted licensure or authorization to practice medicine in the country in which they received that education and training.
3. Such applicants should have passed an examination acceptable to the Board that adequately assesses the applicants’ medical knowledge.
4. Such applicants should be certified by the Educational Commission for Foreign Medical Graduates or its Board-approved successor(s), or by an equivalent Board-approved entity.
5. Such applicants should have a demonstrated command of the English language satisfactory to the Board.
6. Such applicants should have satisfactorily completed at least thirty-six (36) months of progressive post-graduate medical training accredited by the Board, the Accreditation Council for Graduate Medical Education (ACGME), or the American Osteopathic Association (AOA).
7. All credentials, diplomas, and other required documentation in a foreign language submitted to the Board by or on behalf of such applicants should be accompanied by certified English translations acceptable to the Board.
8. Such applicants should have satisfied all applicable requirements of the United States Immigration and Naturalization Service.

Section XII. Licensure by Endorsement, Expedited Licensure by Endorsement, and Temporary and Special Licensure

The medical practice act should provide for licensure by endorsement, expedited licensure by endorsement, and in certain clearly defined cases, for temporary and special licensure.

Endorsement for Licensed Applicants

The Board should be authorized, at its discretion, to issue a license by endorsement to an applicant who:

1. Has complied with all current medical licensing requirements save that for examination administered by the Board;
2. Has passed a medical licensing examination given in English by another state, the District of Columbia, or a territory or possession of the United States or Canada, provided the Board determines that examination was equivalent to its own current examination, or an independent testing agent designated by the Board; and
3. Has a valid current medical license in another state, the District of Columbia, or a territory or possession of the United States or Canada.
Expedited Licensure by Endorsement

The Board should be authorized, at its discretion, to issue an expedited license by endorsement to an applicant who provides documentation of:

1. Identity as required by the Board;
2. All jurisdictions in which the applicant holds a full and unrestricted license;
3. Graduation from an approved medical school:
   a. Liaison Committee on Medical Education (LCME) or Commission on Osteopathic College Accreditation (COCA) of the American Osteopathic Association (AOA) approved medical school;
   b. Fifth Pathway certificate; or
   c. Educational Commission for Foreign Medical Graduates (ECFMG) certificate.
4. Passing one or more of the following examinations acceptable for initial licensure within three attempts per step/level:
   a. United States Medical Licensing Examination (USMLE) Steps 1-3 or its predecessor examinations, the National Board of Medical Examiners (NBME) I-III or the Federation Licensing Examination (FLEX);
   b. Comprehensive Osteopathic Medical Licensure Examination (COMLEX-USA) Levels 1-3 or its predecessor examinations, the National Board of Osteopathic Medical Examiners Levels 1-3 or its predecessor examination(s); and/or
   c. Medical Council of Canada Qualifying Examinations (MCCQE) or its predecessor examination(s) offered by the Licentiate Medical Council of Canada.
5. Successful completion of the total examination sequence within seven (7) years, except when in combination with a Ph.D. program;
6. Successful completion of three (3) years of progressive postgraduate training in a program accredited by the Accreditation Council on Graduate Medical Education (ACGME) or the AOA; and/or
7. Certification or recertification by a medical specialty board recognized by the American Board of Medical Specialties (ABMS) or the AOA within the previous ten (10) years. Lifetime certificate holders who have not passed a written specialty recertification examination must demonstrate successful completion of the Special Purpose Examination (SPEX), Comprehensive Osteopathic Medical Variable Purpose Examination (COMVEX) or applicable specialty recertification examination.

Boards should obtain supplemental documentation including, but not limited to:

1. Criminal background check;
2. Absence of current/pending investigations in any jurisdiction where licensed;
3. Verification of specialty board certification; and
4. Professional experience.

Physicians desiring an expedited process for licensure may utilize the Federation Credentials Verification Service (FCVS), or credentials verification meeting equivalent standards for verification of core
credentials, or rely on the primary source verification of the state board of first licensure for:

1. Medical school diploma;
2. Medical school transcript;
3. Dean’s certificate;
4. Examination history;
5. Disciplinary history;
6. Identity (photograph and certified birth certificate or original passport);
7. ECFMG certificate, if applicable; and
8. Fifth Pathway certificate, if applicable, and postgraduate training verification.

Temporary Licensure
The Board should be authorized to establish regulations for issuance of a temporary medical license for the intervals between Board meetings. Such a license should:

1. Be granted only to an applicant demonstrably qualified for a full and unrestricted medical license under the requirements set by the medical practice act and the regulations of the Board; and
2. Automatically terminate within a period specified by the Board.

Special Licensure
The Board should be authorized to issue conditional, restricted, probationary, limited or otherwise circumscribed licenses as it determines necessary. It is up to the discretion of the state medical board to set the criteria for issuing special purpose licenses. This provision should include, but not be limited to, the ability to issue a special license for the following purposes:

1. To provide medical services to a traveling sports team, coaches, and staff for the duration of the sports event;
2. To provide volunteer medical services to under-insured/uninsured patients;
3. To provide medical services to youth camp enrollees, counselors, and staff for the duration of the youth camp; and
4. To engage in the limited practice of medicine in an institutional setting by a physician who is licensed in another jurisdiction in the United States.

Section XIII. Limited Licensure for Physicians in Postgraduate Training
The medical practice act should provide that all physicians in all postgraduate training in the state or jurisdiction who are not otherwise fully licensed to practice medicine should be licensed on a limited basis for educational purposes. These provisions of the act should implement or be consistent with the following:

1. To be eligible for limited licensure, the applicant should have completed all the requirements for full and unrestricted medical licensure except postgraduate training or specific examination
2. Issuance of a limited license specifically for postgraduate training should occur only after the applicant demonstrates that he/she is accepted in a residency program. The application for limited licensure should be made directly to the Board in the jurisdiction where the applicant’s postgraduate training is to take place.

3. The Board should establish by regulation restrictions for the limited license to assure that the holder will practice only under appropriate supervision and within the confines of the program within which the resident is enrolled.

4. The limited license should be renewable annually and upon the written recommendation of the supervising institution, including a written evaluation of performance, until the Board regulations require the achievement of full and unrestricted medical licensure.

5. The disciplinary provisions of the medical practice act should apply to the holders of the limited and postgraduate training license as if they held full and unrestricted medical licensure.

6. The issuance of a limited license should not be construed to imply that a full and unrestricted medical license would be issued at any future date.

Postgraduate Training Program Reporting Requirements

Program directors responsible for postgraduate training should be required annually to provide the Board a written report on the status of program participants having a limited license.

The report should inform the Board about program participants who have successfully completed the program, have departed from the program, have had unusual absences from the program, or have had problematic occurrences during the course of the program.

The report should include an explanation of any disciplinary action taken against a limited licensee for performance or behavioral reasons which, in the judgment of the program director, could be a threat to public health, safety, and welfare; unapproved or unexplained absences from the program; resignations from the program or nonrenewal of the program contract; dismissals from the program for performance or behavioral reasons; and referrals to substance abuse programs not approved by the Board.

Failure to submit the annual program director’s report shall be considered a violation of the mandatory reporting provisions of the medical practice act and shall be grounds to initiate such disciplinary action as the Board deems appropriate, including fines levied against the supervising institution and suspension of the program director’s medical license.

Section XIV: Periodic Renewal

The medical practice act should provide for the periodic renewal of medical licenses to permit the Board to review the qualifications of licensees on a regular basis. These provisions of the act should implement or be consistent with the following:

At the time of periodic renewal, the Board should require the licensee to demonstrate to its satisfaction the licensee’s continuing qualification for medical licensure. The Board should design the application for licensure renewal to require the licensee to update and/or add to the information in the Board’s file.
relating to the licensee and the licensee’s professional activity. It should also require the licensee to report to the Board the following information:

1. Any action taken for acts or conduct similar to acts or conduct described in the medical practice act as grounds for disciplinary action against a licensee by:
   a. Any jurisdiction or authority (United States or foreign) that licenses or authorizes the practice of medicine or participation in a payment or practice program;
   b. Any peer review body;
   c. Any specialty certification board;
   d. Any health care organization;
   e. Any professional medical society or association;
   f. Any law enforcement agency;
   g. Any health insurance company;
   h. Any malpractice insurance company;
   i. Any court; and
   j. Any governmental agency.

2. Any adverse judgment, settlement, or award against the licensee or payment by or on behalf of the licensee arising from a professional liability demand, claim, or case.

3. The licensee’s voluntary surrender of or voluntary limitation on any license or authorization to practice medicine in any jurisdiction, including military, public health, and foreign.

4. Any denial to the licensee of a license or authorization to practice medicine by any jurisdiction, including military, public health, and foreign.

5. The licensee’s voluntary resignation from the medical staff of any health care organization or voluntary limitation of the licensee’s staff privileges at such an organization if that action occurred while the licensee was under formal or informal investigation by the organization or a committee thereof for any reason related to possible medical incompetence, unprofessional conduct, or mental, physical, alcohol, or drug impairment.

6. The licensee’s voluntary resignation or withdrawal from a national, state, or county medical society, association, or organization if that action occurred while the licensee was under formal or informal investigation or review by that body for any reason related to possible medical incompetence, unprofessional conduct, mental, physical, alcohol, or drug impairment.

7. Whether the licensee is currently suffering from any condition that adversely affects or impairs the licensee’s practice of medicine.

8. The licensee’s completion of continuing medical education or other forms of professional maintenance and/or evaluation, including specialty board certification or recertification, within the renewal period.

The Board should be authorized, at its discretion, to require continuing medical education for license renewal and to require documentation of that education. The Board should have the authority to audit, randomly or specifically, licensees for compliance.

The Board should require the licensee to apply for license renewal in a manner prescribed by the board and attest to the accuracy and truthfulness of the information submitted. The Board should be
authorized to collect a fee for renewal of a license.

The Board should be directed to establish an effective system for reviewing renewal forms. It should also be authorized to initiate investigations and/or disciplinary proceedings based on information submitted by licensees for license renewal.

Failure to report fully and correctly as outlined above should be grounds for disciplinary action by the Board.

Section XV. Disciplinary Process

The medical practice act should provide for disciplinary and/or remedial action against licensees and the grounds on which such action may be taken. These provisions of the act should implement or be consistent with the following:

Range of Actions

A range of progressive disciplinary and remedial actions should be made available to the Board. The Board should be authorized, at its discretion, to take disciplinary, non-disciplinary, public or non-public actions, singly or in combination, as the nature of the violation requires and to promote public protection. These include, but are not limited to, the following:

1. Revocation of the medical license;
2. Suspension of the medical license;
3. Probation;
4. Stipulations, limitations, restrictions, probation, and conditions relating to practice;
5. Censure (including specific redress, if appropriate);
6. Reprimand;
7. Letters of concern and advisory letters:
   a. The Board should be authorized to issue a confidential (if allowed by state law), non-reportable, non-disciplinary letter of concern, or advisory letter to a licensee when evidence does not warrant formal discipline, but the Board has noted indications of possible errant conduct by the licensee that could lead to serious consequences and formal action if the conduct were to continue. In its letter of concern or advisory letter, the Board should also be authorized, at its discretion, to request clarifying information from the licensee.
8. Monetary redress to another party;
9. A period of free public service, either medical or non-medical;
10. Satisfactory completion of an educational, training and/or treatment program(s), or professional developmental plan:
   a. The Board should be authorized, at its discretion, to require professional competency, physical, mental, or chemical dependency examination(s) or evaluation(s) of any applicant or licensee, including withdrawal and laboratory examination of bodily fluids, tissues, hair, or nails.
11. Levy fines; and
1238 12. Payment of administrative and disciplinary costs.

Grounds for Action
The Board should be authorized to take disciplinary action for unprofessional or dishonorable conduct, which should be defined to mean, but not be limited to, the following:

1. Fraud or misrepresentation in applying for or procuring a medical license or in connection with applying for or procuring periodic renewal of a medical license;
2. Cheating on or attempting to subvert the medical licensing examination(s);
3. The commission or conviction or the entry of a guilty, nolo contendere plea, or deferred adjudication (without expungement) of:
   a. A misdemeanor related to the practice of medicine and any crime involving moral turpitude; or
   b. A felony related to the practice of medicine. The Board shall revoke a licensee’s license following conviction of a felony, unless a 2/3 majority vote of the board members present and voting determined by clear and convincing evidence that such licensee will not pose a threat to the public in such person’s capacity as a licensee and that such person has been sufficiently rehabilitated to warrant the public trust;
4. Conduct likely to deceive, defraud, or harm the public;
5. Disruptive behavior and/or interaction with physicians, hospital personnel, patients, family members, or others that interferes with patient care or could reasonably be expected to adversely impact the quality of care rendered to a patient;
6. Making a false or misleading statement regarding the licensee’s skill or the efficacy or value of the medicine, treatment, or remedy prescribed by the licensee or at the licensee’s direction in the treatment of any disease or other condition of the body or mind;
7. Representing to a patient that an incurable condition, sickness, disease, or injury can be cured;
8. Willfully or negligently violating the confidentiality between physician and patient except as required by law;
9. Professional incompetency as one or more instances involving failure to adhere to the applicable standard of care to a degree which constitutes negligence, as determined by the Board;
10. Being found mentally incompetent or of unsound mind by any court of competent jurisdiction;
11. Being physically or mentally unable to engage in the practice of medicine with reasonable skill and safety;
12. Practice or other behavior that demonstrates an incapacity or incompetence to practice medicine;
13. The use of any false, fraudulent, or deceptive statement in any document connected with the practice of medicine;
14. Giving false, fraudulent, or deceptive testimony while serving as an expert witness;
15. Practicing medicine under a false or assumed name;
16. Aiding or abetting the practice of medicine by an unlicensed, incompetent, or impaired person;
17. Allowing another person or organization to the licensee’s license to practice medicine;
18. Commission of any act of sexual misconduct, including sexual contact with patient surrogates or key third parties, which exploits the physician-patient relationship in a sexual way;

19. Habitual or excessive use or abuse of drugs, alcohol, or other substances that impair ability;

20. Failing or refusing to submit to an examination or any other examination that may detect the presence of alcohol or drugs upon Board order or any other form of impairment;

21. Prescribing, selling, administering, distributing, diverting, ordering or giving any drug legally classified as a controlled substance or recognized as an addictive or dangerous drug for other than medically accepted therapeutic purposes;

22. Knowingly prescribing, selling, administering, distributing, ordering, or giving to a habitual user or addict or any person previously drug dependent, any drug legally classified as a controlled substance or recognized as an addictive or dangerous drug, except as otherwise permitted by law or in compliance with rules, regulations, or guidelines for use of controlled substances and the management of pain as promulgated by the Board;

23. Prescribing, selling, administering, distributing, ordering, or giving any drug legally classified as a controlled substance or recognized as an addictive drug to a family member or to the licensee themselves;

24. Violating any state or federal law or regulation relating to controlled substances;

25. Signing a blank, undated, or predated prescription form;

26. Obtaining any fee by fraud, deceit, or misrepresentation;

27. Employing abusive, illegal, deceptive, or fraudulent billing practices;

28. Directly or indirectly giving or receiving any fee, commission, rebate, or other compensation for professional services not actually and personally rendered, though this prohibition should not preclude the legal functioning of lawful professional partnerships, corporations, or associations;

29. Disciplinary action of another state or federal jurisdiction against a license or other authorization to practice medicine or participate in a federal program (payment or treatment) based upon acts or conduct by the licensee similar to acts or conduct that would constitute grounds for action as defined in this section, a certified copy of the record of the action taken by the other state or jurisdiction being conclusive evidence thereof;

30. Failure to report to the Board any adverse action taken against oneself by another licensing jurisdiction (United States or foreign), by any peer review body, by any health care institution, by any professional or medical society or association, by any governmental agency, by any law enforcement agency, or by any court for acts or conduct similar to acts or conduct that would constitute grounds for action as defined in this section;

31. Failure to report or cause a report to be made to the Board of any physician upon whom a physician has evidence or information that appears to show that the physician is incompetent, guilty of negligence, guilty of a violation of this act, engaging in inappropriate relationships with patients, is mentally or physically unable to practice safely, or has an alcohol or drug abuse problem;

32. Failure of physician who is the chief executive officer, medical officer, or medical staff to report to the Board any adverse action taken by a health care institution or peer review body, in addition to the reporting requirement in 31. (Note: a report under 31 may need to wait until the peer review and due process procedures are completed, but the report under 30 must be
reported immediately without waiting for the final action of the health care institution and
applies to all physicians not just staff physicians);

33. Failure to report to the Board surrender of a license limitation or other authorization to practice
medicine in another state or jurisdiction, or surrender of membership on any medical staff or in
any medical or professional association or society has surrendered the authority to utilize
controlled substances issued by any state or federal agency, or has agreed to a limitation to or
restriction of privileges at any medical care facility while under investigation by any of those
authorities or bodies for acts or conduct similar to acts or conduct that would constitute
grounds for action as defined in this section;

34. Failure to report any adverse judgment, award, or settlement against the licensee resulting from
a medical liability claim related to acts or conduct similar to acts or conduct that would
constitute grounds for action as defined in this section;

35. Failure to report to the Board any adverse judgment, settlement, or award arising from a
medical liability claim related to acts or conduct similar to acts or conduct that would constitute
grounds for action as defined in this section;

36. Failure to provide pertinent and necessary medical records to another physician or patient in a
timely fashion when legally requested to do so by the subject patient or by a legally designated
representative of the subject patient regardless of whether the patient owes a fee for services;

37. Improper management of medical records, including failure to maintain timely, legible,
accurate, and complete medical records and to comply with the Standards for Privacy of
Individually Identifiable Health Information, 45 CFR Part 160 and 164, of the Health Insurance
Portability and Accountability Act of 1996;

38. Failure to furnish the Board, its investigators, or representatives information legally requested
by the Board or failure to comply with a Board subpoena or order;

39. Failure to cooperate with a lawful investigation conducted by the Board;

40. Violation of any provision(s) of the medical practice act or the rules and regulations of the Board
or of an action, stipulation, or agreement of the Board;

41. Engaging in conduct calculated to, or having the effect of, bringing the medical profession into
disrepute or conduct unbecoming of the medical profession, including but not limited to,
violation of any provision of a national code of ethics acknowledged by the Board and/or failing
to uphold the standards of the profession;

42. Failure to follow generally accepted infection control procedures;

43. Failure to comply with any state statute or board regulation regarding a licensee’s reporting
responsibility for HIV, HVB (hepatitis B virus), seropositive status or any other reportable
condition (including child abuse and vulnerable adult abuse) or disease;

44. Practicing medicine in another state or jurisdiction without appropriate licensure;

45. Conduct which violates patient trust, exploits the physician-patient relationship, or violates
professional boundaries, regardless of the medium;

46. Failure to offer appropriate procedures/studies, failure to protest inappropriate managed care
denials, failure to provide necessary service, or failure to refer to an appropriate provider within
such actions are taken for the sole purpose of positively influencing the physician’s or the plan’s
financial wellbeing;
47. Providing treatment or consultation recommendations, including issuing a prescription via
electronic or other means, unless the physician has obtained a history and physical evaluation of
the patient adequate to establish diagnosis and identify underlying conditions and/or
contraindications to the treatment recommended/provided;
48. Violating a Board formal order, condition of probation, consent agreement, or stipulation;
49. Representing, claiming, or causing the appearance that the physician possesses a particular
medical specialty certification by a Board recognized certifying organization (ABMS, AOA) if not
true;
50. Failing to obtain adequate patient informed consent;
51. Using experimental treatments without appropriate patient consent and adhering to all
necessary and required guidelines and constraints;
52. Any conduct that may be harmful to the patient or the public;
53. Failing to divulge to the Board upon legal demand the means, method, procedure, modality, or
medicine used in the treatment of an ailment, condition, or disease;
54. Conduct likely to deceive, defraud, or harm the public;
55. The use of any false, fraudulent, or deceptive statement in any document connected with the
practice of the healing arts including intentional falsifying or fraudulent altering of a patient or
medical care facility record;
56. Failure to keep written medical records which accurately describe the services rendered to the
patient, including patient histories, pertinent findings, examination results, and test results;
57. Delegating professional responsibilities to a person when the licensee knows or has reason to
know that such person is not qualified by training, experience, or license to perform them;
58. Using experimental forms of therapy without proper informed patient consent, without
conforming to generally accepted criteria or standard protocols, without keeping detailed
legible records, or without having periodic analysis of the study and results reviewed by a
committee or peers; and
59. Failing to properly supervise, direct, or delegate acts which constitute the healing arts to
persons who perform professional services pursuant to such licensee’s direction, supervision,
order, referral, delegation, or practice protocols.

Enforcement and Disciplinary Action Procedures
The medical practice act should provide for procedures that will permit the Board to take appropriate
enforcement and disciplinary action when and as required, while assuring fairness and due process to
licensees. These provisions of the act should implement or be consistent with the following:

Board Authority: The Board should be empowered to commence legal action to enforce the provisions
of the medical practice act and to exercise full discretion and authority with respect to disciplinary
actions. In the course of an investigation, the Board’s authority should include the ability to issue
subpoenas to licensees, health care organizations, complainants, patients, and witnesses to produce
documents or appear before the Board or staff to answer questions or be deposed. The Board should
have the power to enforce its subpoenas, including disciplining a non-compliant licensee, and it is
incumbent upon the subpoenaed party to seek a motion to quash the subpoena.
Administrative Procedures: The existing administrative procedures act or similar statute, in whole or in part, should either be applicable to or serve as the basis of the procedural provisions of the medical practice act. The procedural provisions should provide for Board investigation of complaints; notice of formal or informal charges or allegations to the licensee; a fair and impartial hearing for the licensee before the Board, an examining committee or hearing officer; an opportunity for representation of the licensee by counsel; the presentation of testimony, evidence and arguments; subpoena power and attendance of witnesses; a record of the proceedings; and judicial review by the courts in accordance with the standards established by the jurisdiction for such review. The Board should have subpoena authority to conduct comprehensive reviews of a licensee’s patient and office records and administrative authority to access otherwise protected peer review records. The Board should not need the patients’ consent to obtain copies of medical records, nor shall health care institutions’ peer-review privilege bar the Board from obtaining copies of peer review information. Once in the Board’s possession, the patient records and peer review records should have the same legal protection from disclosure as they have when in the possession of the licensee, the patient or the peer-review organization.

Standard of Proof: The Board should be authorized to use preponderance of the evidence as the standard of proof in its role as trier of fact for all levels of discipline.

Informal Conference: Should there be an open meeting law, an exemption to it should be authorized to permit the Board, at its discretion, to meet in informal conference with a licensee who seeks or agrees to such a conference. Disciplinary action taken against a licensee because of such an informal conference and agreed to in writing by the Board and the licensee should be binding and a matter of public record. However, license revocation and suspension should be held in open formal hearing, unless executive session is permitted by the State’s open meetings law. The holding of an informal conference should not preclude an open formal hearing if the Board determines such is necessary.

Summary Suspension: The Board should be authorized to summarily suspend or restrict a license prior to a formal hearing when it believes such action is required to protect the public from an imminent threat to public health and safety. The Board should be permitted to summarily suspend or restrict a license by means of a vote conducted by telephone conference call or other electronic means if appropriate Board officials believe such prompt action is required. Proceedings for a formal hearing should be instituted simultaneously with the summary suspension. The hearing should be set within a reasonable time of the date of the summary suspension. No court should be empowered to lift or otherwise interfere with such suspension while the Board proceeds in a timely fashion.

Cease and Desist Orders/Injunctions: The Board should be authorized to issue a cease-and-desist order and/or obtain an injunction to restrain any person or any corporation or association and its officers and directors from violating any provision of the medical practice act. Violation of an injunction should be punishable as contempt of court. No proof of actual damage to any person should be required for issuance of a cease-and-desist order and/or an injunction, nor should issuance of an injunction relieve those enjoined from criminal prosecution, civil action, or administrative process for violation of the medical practice act.
Board Action Reports: All the Board’s final disciplinary actions, non-administrative license withdrawals, and license denials, including related findings of fact and conclusions of law, should be matters of public record. The Board should report such actions and denials to the National Practitioner Data Bank and Board Action Data Bank of the Federation of State Medical Boards of the United States within 30 days of the action being taken, to any other data repository required by law, and to the media. Voluntary surrender of and voluntary limitation(s) on the medical license of any person should also be matters of public record and should also be reported to the Federation of State Medical Boards of the United States and to any other data repository by law. The Board should have the authority to keep confidential practice limitations and restrictions due to physical impairment when the licensee has not violated any provision in the medical practice act.

Tolling Periods of License Suspension or Restriction: The Board should provide, in cases of license suspension or restriction, that any time during which the disciplined licensee practices in another jurisdiction without comparable restriction shall not be credited as part of the period of suspension or restriction.

**Section XVI: Compulsory Reporting and Investigation**

The medical practice act should provide that certain persons and entities report to the Board any possible violation of the act or of the Board’s rules and regulations by a licensee. These provisions of the act should implement or be consistent with the following:

Any person should be permitted to report to the Board in a manner prescribed by the Board, any information he or she believes indicates a medical licensee is or may be dyscompetent, guilty of unprofessional conduct, or mentally or physically unable to engage safely in the practice of medicine.

The following should be required to report to the Board promptly and in writing any information that indicates a licensee is or may be dyscompetent, guilty of unprofessional conduct, or mentally or physically unable to engage safely in the practice of medicine; and any restriction, limitation, loss or denial of a licensee’s staff privileges or membership that involves patient care:

1. All licensees licensed under the act,
2. All licensed health care providers,
3. The state medical associations and its components,
4. All hospitals and other health care organizations in the state, to include hospitals, medical centers, long term care facilities, managed care organizations, ambulatory surgery centers, clinics, group practices, coroners, etc.,
5. All chiefs of staff, medical directors, department administrators, service directors, attending physicians, residency directors, etc.,
6. All liability insurance organizations,
7. All state agencies,
8. All law enforcement agencies in the state,
9. All courts in the state,
10. All federal agencies (e.g., Drug Enforcement Administration, Food and Drug Administration,
Centers for Medicare and Medicaid Services, Veterans Health Administration, and Department of Defense,

11. All peer review bodies in the state, and
12. All resident training program directors.

A licensee’s voluntary resignation from the staff of a health care organization or voluntary limitation of a licensee’s staff privileges at such an organization should be promptly reported to the Board by the organization if that action occurs while the licensee is under formal or informal investigation by the organization or a committee thereof for any reason related to possible medical incompetence, unprofessional conduct, or mental, physical, alcohol or drug impairment.

Malpractice insurance carriers, the licensee’s attorney, a hospital, a group practice, and the affected licensees should be required to file with the Board a report of each final judgment, settlement, arbitration award, or any form of payment by the licensee or on the licensee’s behalf by any source upon any demand, claim, or case alleging medical malpractice, battery, dyscompetence, incompetence, or failure of informed consent. Licensees not covered by malpractice insurance carriers should be required to file the same information with the Board regarding themselves. All such reports should be made to the Board promptly (e.g., within 30 days).

The Board should be permitted to investigate any evidence that appears to show a licensee is or may be medically incompetent, guilty of unprofessional conduct, or mentally or physically unable to engage safely in the practice of medicine.

Any person, institution, agency, or organization who reports in good faith and not made in bad faith, a licensee pursuant to paragraphs 2 and 3 of this section should not be subject to civil damages or criminal prosecution for so reporting. A bad faith report is grounds for disciplinary action under the medical practice act. There should be no monetary liability on the part of, and no cause of action for damages should arise against, any person, institution, agency, or organization for reporting in good faith.

To assure compliance with compulsory reporting requirements, specific civil penalties should be established for demonstrated failure to report (e.g., up to $10,000 per instance).

The Board should promptly acknowledge all reports received under this section. The Board should promptly notify persons or entities reporting under this section of the Board’s final disposition of the matters reported.

Section XVII. Impaired Physicians

The medical practice act should provide for the limitation, restriction, conditioning, suspension or revocation of the medical license of any licensee whose mental or physical ability to practice medicine with reasonable skill and safety is impaired.

The Board should have available to it a confidential impaired physician program approved by the Board and charged with the evaluation and treatment of licensees who are in need of rehabilitation. The Board may directly provide such programs or through a formalized contractual relationship with an
independent entity whose program meets standards set by the Board. The Board shall have the ability to monitor or audit the program to ensure the program meets the requirements of the Board.

The Board should be authorized, at its discretion, to require a licensee or applicant to submit to a mental or physical examination, body fluid, nail, or hair follicle test, or a chemical addiction, abuse, or dependency evaluation conducted by an independent evaluator designated or approved in advance by the Board. The results of the examination or evaluation should be admissible in any hearing before the Board or hearing officer, despite any claim of privilege under a contrary rule or statute. Every person who receives a license to practice medicine or who files an application for a license to practice medicine should be deemed to have given consent to submit to mental or physical examination or a chemical addition, abuse, or dependency evaluation, and to have waived all objections to the admissibility of the results in any hearing before the Board. If a licensee or applicant fails to submit to an examination or evaluation when properly directed to do so by the Board, the Board should be permitted to enter a final order upon proper notice, hearing, and proof of refusal.

If the Board finds, after an evaluation, examination or hearing, that a licensee is mentally, physically, or chemically impaired, it should be authorized to take one or more of the following actions:

1. Direct the licensee to submit to therapy, medical care, counseling, or treatment acceptable to the Board and comply with monitoring to ensure compliance;
2. Suspend, limit, restrict, or place conditions on the licensee’s medical license for the duration of the impairment and monitoring or treatment; and/or
3. Revoke the licensee’s medical license.

Any licensee or applicant who is prohibited from practicing medicine under this provision should be afforded, at reasonable intervals, an opportunity to demonstrate to the satisfaction of the Board that he or she can resume or begin the practice of medicine with reasonable skill and safety. A license should not be reinstated, however, without the payment of all applicable fees and the fulfillment of all requirements as if the applicant had not been prohibited from practicing medicine.

While all impaired licensees should be reported to the Board in accord with the mandatory reporting requirements of the medical practice act, unidentified and unreported impaired licensees should be encouraged to seek treatment. To this end, the Board should be authorized, at its discretion, to establish rules and regulations for the review and approval of a medically directed Physician Health Program (PHP). Those conducting a Board-approved PHP should be exempt from the mandatory reporting requirements relating to an impaired licensee who is participating satisfactorily in the program, or the Board should hold its report in confidence and without action, unless or until the impaired licensee ceases to participate satisfactorily in the program. The Board should require a PHP to report any impaired licensee whose participation is unsatisfactory to the Board as soon as that determination is made. Participation in an approved PHP should not protect an impaired licensee from Board action resulting from a report of licensee impairment from another source or resulting from an investigation of other medical practice violations. The Board should be the final authority for approval of a PHP, should conduct a review of its approved program(s) on a regular basis and should be permitted to withdraw or...
deny its approval at its discretion. The PHP should be required to report to the Board information
regarding any violation of the medical practice act by a PHP participant, other than the impairment,
even if the violation is unrelated to the licensee’s impairment.

Section XVIII: Dyscompetent and Incompetent Licensees
The medical practice act should provide for the restriction, conditioning, suspension, revocation, or
denial of the medical license of any licensee who the Board determines to be dyscompetent or
incompetent. These provisions of the act should implement or be consistent with the following:

The Board should be authorized to develop and implement methods to identify dyscompetent or
incompetent licensees and licensees who fail to provide the appropriate quality of care. The Board
should also be authorized to develop and implement methods to assess and improve licensee practices.

The Board should have access to a Board-approved assessment program charged with assessing
licensees’ clinical competency.

The Board should be authorized, at its discretion, to require a licensee or an applicant for licensure to
undergo a physician competency evaluation conducted by a Board-designated independent evaluator at
licensee’s own expense. The results of the assessment should be admissible in any hearing before the
Board or hearing officer, despite any claim of privilege under a contrary rule or statute. Every person
who receives a license to practice medicine or who files an application for a license to practice medicine
should be deemed to have given consent to submit to a physician competency evaluation, and to have
waived all objections to the admissibility of the results in any hearing before the Board or hearing
officer. If a licensee or applicant fails to submit to a competency assessment when properly directed to
do so by the Board, the Board should be permitted to enter a final order upon proper notice, hearing,
and proof of refusal to submit to such an evaluation.

If the Board finds, after evaluation by the assessment program, that a licensee or applicant for licensure
is unable to competently practice medicine, it should be authorized to take one or more of the following
actions:

1. Suspend, revoke, or deny the licensee’s medical license or application;
2. Restrict or limit the licensee’s practice to those areas of demonstrated competence and comply
   with monitoring to ensure compliance;
3. Place conditions on the licensee’s license; and/or
4. Direct the licensee to submit to a Board approved remediation program and comply with
   monitoring to ensure compliance to resolve any identified deficits in medical knowledge or
   clinical skills acceptable to the Board.

Any licensee or applicant for licensure who is prohibited from practicing medicine, or who has had
restrictions or conditions placed upon their license, under the above section, should be afforded, at
reasonable intervals, an opportunity to demonstrate to the satisfaction of the Board that he/she can
resume or begin the practice of medicine, or can practice without the restrictions or conditions, with
reasonable skill and safety. A license should not be reinstated, however, without the payment of all
applicable fees and the fulfillment of all requirements as if the applicant had not been previously
prohibited.

The Board should be authorized to require the assessment program to provide to the Board a written
report of the results of the assessment with recommendations for remediation of the identified
deficiencies.

The Board should have access to Board approved remedial medical education programs for referral of
licensees in need of remediation. Such programs shall incorporate and comply with standards set by the
Board. During remediation, the program shall provide, at Board determined intervals, written reports to
the Board on the licensee’s progress. Upon completion of the remediation program, the program shall
provide a written report to the Board addressing the remediation of the previously identified areas of
deficiency. The Board should be authorized to mandate that the licensee undergo post-remediation
assessment to identify areas of continued deficit. The licensee shall be responsible for all expenses
incurred as part of the assessment and the remediation.

Section XIX: Physician Assistants

The medical practice act should provide for the Board to license and regulate physician assistants.

Administration

The Board should administer and enforce these provisions of the medical practice act with the advice
and assistance of the Physician Assistant Council.

Licensing

No person should perform or attempt to practice as a physician assistant without first obtaining a
license from the Board and having a supervising physician.

An applicant for licensure as a physician assistant should complete all Board application forms and pay a
nonrefundable fee. The forms should request the applicant provide their name and address and such
additional information as the Board deems necessary. The Board may issue a license to a physician
assistant applicant who fulfills all board requirements for licensure. However, a licensed physician
assistant is prohibited from practicing until they have an agreement with a supervising physician(s).

Each licensed physician assistant should renew their license and file updated documentation stating
their name and current address and any additional information as required by the Board. A fee set by
the Board should accompany each renewal and filing of updated documentation.

The Board may require written notification by the supervising physician and the physician assistant if the
relationship is changed or severed for a reason that would have an adverse effect for patient care.

Persons not licensed by the Board who hold themselves out as physician assistants should be subject to
penalties applicable to the unlicensed practice of medicine.
Rules and Regulations
The Board should be empowered to adopt and enforce rules and regulations for:

1. Setting qualifications of education, skill, and experience for the licensing of a person as a physician assistant and providing forms and procedures for licensure and for renewal; and
2. Evaluating applicants for licensure as physician assistants.

Disciplinary Actions
The Board should be empowered to deny, revoke, or suspend any license, to limit or restrict the location of practice, to issue reprimands, to remove the authorization of a supervising physician, and to limit or restrict the practice of a physician assistant upon grounds and according to procedures similar to those for such disciplinary actions against licensed physicians. Such actions should be reported to the National Practitioner Databank and the Federation of State Medical Boards.

Duties and Scope of Practice
A physician assistant should be permitted to provide those medical services delegated to them by the supervising physician that are within their training and experience.

Responsibility of Supervising Physician
Every physician supervising or employing a physician assistant should be legally responsible for the delegation of health care tasks, the performance and the acts and omissions of the physician assistant. Nothing in these provisions, however, should be construed to relieve the physician assistant of any responsibility for any of their own acts and omissions. No physician should have under their supervision more staff, physician assistant, or otherwise than the physician can adequately supervise. In the event the supervising physician is absent, he or she must provide for appropriate supervision of the physician assistant by another licensed physician. Each and every relationship should adhere to all statutory requirements for licensure.

Renewal
The Board should be authorized, at its discretion, to require evidence of satisfactory completion of continuing medical education for license renewal.
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FSMB Staff Support:

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REPORT OF THE BOARD OF DIRECTORS

Subject: Report on Resolution 17-2: Advocacy for Professional Licensure of Emergency Medical Service Providers

Referred to: Reference Committee A

In April 2017, the Federation of State Medical Boards House of Delegates referred Resolution 17-2, Advocacy for Professional Licensure of Emergency Medical Service (EMS) Providers, to the Board of Directors for study. The Resolution, submitted by the Montana Board of Medical Examiners, states:

Resolved, that the Federation of State Medical Boards (FSMB) adopt a position supporting professional licensure of paramedics and other advanced life support EMS providers under the authority of state medical boards; and be it further

Resolved, that the FSMB coordinate and collaborate with individual state medical boards and other stakeholders to develop model statutory language for states to utilize in adopting a professional licensing process and standards for EMS providers.

The Board of Directors considered the Resolution and tasked the Advisory Council of Board Executives to evaluate the regulatory oversight of paramedics and make a recommendation as to the position of the FSMB. The Board noted that the Advisory Council of Board Executives would be reviewing and recommending revisions to the *Essentials of a State Medical and Osteopathic Medical Practice Act* and the *Elements of a State Medical and Osteopathic Board* and would therefore be well positioned to study this issue and draft model statutory language, if the resolution was to be recommended for adoption.

**Background**

Each state, territory and the District of Columbia has a lead EMS agency, according to the National Association of State Emergency Medical Services Officials (NASEMSO). These agencies are usually a part of the state health department, but in some states they are part of a multidisciplinary state public safety department, or are an independent state agency. State EMS agencies are responsible for the overall planning, coordination, and regulation of the EMS system within the state as well as licensing local EMS agencies and personnel.

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1. [https://www.nasemso.org/About/StateEMSAgencies/StateEMSAgencyListing.asp](https://www.nasemso.org/About/StateEMSAgencies/StateEMSAgencyListing.asp)
There is longstanding history of state regulation of EMS providers, with promulgation and execution of state laws and rules regarding EMS provider requirements for practice dating as far back as 1972. This includes accreditation of educational programs, use of a valid, reliable and legally defensible examination, criminal history checks, and ongoing competency maintenance requirements such as minimum continuing education credits and skill proficiency demonstration.

Additionally, recent developments in critical care transport and community paramedicine has served as a catalyst to the adoption of state laws and rules requiring physician oversight of EMS providers. These rules typically entail physician oversight and review of patient care, physician review of written patient care protocols, and when necessary, physician contact during patient care via radio or telephone.

**State Medical Boards**

Today only four state medical boards have oversight of EMS professionals: Alaska State Medical Board; Hawaii Medical Board; Commonwealth of the Northern Mariana Islands; and the Montana Board of Medical Examiners. According NASEMSO, the licensing and regulation of EMS personnel began in the 1970’s and has steadily migrated away from state boards of medicine to separate State EMS regulatory boards. These EMS boards are not only responsible for the licensing of EMS personnel, but also the nation’s 21,000 EMS agencies that respond to 911 emergencies and provide transport, including specialty care air medical transport, and ground transport. This regulatory scheme is similar to the boards of pharmacy that license not only the individual pharmacists but also pharmacies, distributors, manufactures, and wholesalers.

The number of non-physician health care providers that are under the purview of state medical boards varies significantly throughout the country, from athletic trainers to polysomnography techs. The FSMB has not heretofore taken a position on what professions should be regulated by the medical board, with the exception of physician assistants for whom the medical and osteopathic boards license the majority, and therefore a specific recommendation and practice act for EMS personnel would not be in keeping with current policy or practice. Additionally, state medical boards would require extra human and financial resources to take on the licensure and regulation of another health occupation, and boards have not indicated their desire to do so. However, it should be noted that state medical boards have an indirect role in the oversight of EMS personnel through the licensure and regulation of the EMS associated physician medical directors.

**Advisory Council of Board Executives**

The FSMB Advisory Council of Board Executives (Council) is made up of nine executive directors, including the two associate members of the FSMB Board of Directors and the

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The Council noted the limited resources of state medical boards and the capacity of boards to take on additional regulated professions. The Council recognized the authority and discretion of the state to delegate oversight of the health occupation to best protect the public within their individual state structures. The Advisory Council recommended the Board of Directors not pursue policy in favor of Resolution 17-2, primarily due to the additional responsibilities and resources that would be required for the licensing of EMS providers, investigation and adjudication of complaints, and standard enforcement. Additionally, the Council noted current political pressures and criticisms of state occupational licensure generally and were concerned policy proposals for additional layers of oversight would be ill advised.

As an alternative approach to Resolution 17-2, the recommendations contained in FSMB’s policy, *Regulatory Strategies for Achieving Greater Cooperation and Collaboration Among Health Professional Boards* (HOD 2017) may address the concerns expressed in Resolution 17-2. The policy recommends that state medical boards establish procedures for exchanging information with other boards, agencies, and departments responsible for regulating health-related occupations, facilities, and programs, and for coordinating investigations involving matters within the jurisdiction of more than one regulatory body. These procedures would apply to exchanging information between the state medical board and the state EMS agency to 1) conduct joint investigations; 2) share investigatory data; and create or develop processes to facilitate communication and collaboration between the board/agency.

Resolution 17-2 also speaks to the need for standardization of licensing and practice standards among the states. While there are variances in state licensure requirements for EMS personnel based on the needs and available resources in individual states, the majority require passage of a national examination and certification from the National Registry of Emergency Medical Technicians. Additionally, the NASEMSO, with support from the U.S. Department of Homeland Security, has initiated an interstate licensure compact that should further standardize licensing requirements among states. To participate in the compact, EMS personnel must have passed the National Registry of Emergency Medical Technicians (NREMT) examination for initial licensure and have an unrestricted license in his/her home state.
Conclusion

In conclusion, the Board of Directors concurs with the Advisory Council of Board Executives and does not recommend a policy change at this time regarding the licensure and regulation of EMS personnel. The Board further finds that the policy, *Regulatory Strategies for Achieving Greater Cooperation and Collaboration Among Health Professional Boards* (HOD 2017), applies and is a more feasible approach to Resolution 17-2.

ITEM FOR ACTION:

For information.
Whereas, long-term use of opioids frequently begins with the treatment of acute pain; and

Whereas, millions of Americans undergo surgical procedures and sustain painful injuries every year; and

Whereas, many, if not most, people have their first exposure to opioids in the acute medical and postoperative settings; and

Whereas, acute medical and postoperative prescribing varies widely by prescriber; and

Whereas, the duration, dosage, and formulation of opioids can have a dramatic impact on the likelihood of risk of acute medical and postoperative persistent opioid use; and

Whereas, prescriber awareness of risk factors for persistent opioid use could deter overprescribing of opioids, which could lead to a decreased incidence of long-term opioid use. This would lead to a decreased incidence of addiction, comorbidity, and diversion; and

Whereas, a number of states may be considering – or have already implemented – rules or laws limiting the permissible number of days, morphine equivalency and type of opioid to prescribe for acute conditions; and

Whereas, prescribers frequently practice in multiple states in which acute opioid prescribing laws and rules may vary significantly;

Therefore, be it hereby

Resolved, that the Federation of State Medical Boards (FSMB) perform a comprehensive review of acute opioid prescribing patterns, practices, federal laws and guidance (including Centers for Disease Control and Prevention guidelines), and state rules and laws across the United States; and

Resolved, that the FSMB perform a comprehensive review of data related to patient outcomes, comparing states with and without limitations on opioid prescribing for acute conditions; and
Resolved, that the FSMB establish a workgroup tasked to formulate acute opioid prescribing guidelines and best practices, and to present these guidelines and best practices to the House of Delegates at the FSMB annual meeting in 2019.
Federation of State Medical Boards  
House of Delegates Meeting  
April 28, 2018

Subject: Testing Under Time Constraints of the Necessary and Explicit Component of the United States Medical Licensure Examination (USMLE)

Introduced by: Minnesota Board of Medical Practice

Approved: November 2017

Whereas, the USMLE is an exam used for licensure by states; and

Whereas, the USMLE is used to determine the safety of physicians in the independent practice of medicine; and

Whereas, the practice of medicine is constrained by time; and

Whereas, the USMLE has been publicized as a test of knowledge; and

Whereas, testing under time constraint is not considered a component of the USMLE;

Therefore, be it hereby

Resolved, that the Federation of State Medical Boards study and consider the addition of testing time constraint as an explicit component of the USMLE examination.
Whereas, a recent study estimates that by 2025, the US will face a shortfall of between 61,000 and 94,000 physicians, a third of them in primary care; and

Whereas, many US citizens live in medically underserved areas and lack access to primary care; and

Whereas, the profession of physician assistant is rooted with physicians in the medical team-based model, with physician assistant choice, flexibility of practice area, and degree of practice independence considered a benefit of the profession; and

Whereas, numerous outcome studies show physician assistants provide affordable, high quality primary care to patients; and

Whereas, physician assistants play a vital role in easing the health care shortage and expanding access to primary care in underserved areas, but are limited by state laws; and

Whereas, permitting qualified physician assistants to conduct Optimal Team Practice up to the full scope of their education and training, subject to approval by their state medical board, is a natural and logical evolution of the profession and will help ease the physician shortage and improve access to primary care; and

Whereas, medical boards are better able to meet their mandate to ensure licensees are qualified, to discipline unethical or incompetent practitioners, and to set professional standards, when the boards include physician assistants as full members;

Therefore, be it hereby

Resolved, that the Federation of State Medical Boards (FSMB) shall adopt an advocacy position for the voluntary full Optimal Team Practice of physician assistants up to the full scope of their education and training; and be it further

Resolved, that the FSMB will revise the “Elements of a State Medical and Osteopathic Board” and the “Essentials of a State Medical and Osteopathic Practice Act,” to recommend that all medical boards integrate physician assistants as full members with proportional representation or other method deemed acceptable; and be it further
Resolved, that the FSMB will collaborate with national hospital, clinic, and credentialing employer groups to establish guidelines and best practices for on the job training programs for physician assistants that promote best clinical outcomes and the highest standards of practice; and be it further

Resolved, that the FSMB will provide support to fully integrate physician assistant regulatory bodies and their representatives into all relevant aspects of FSMB operations and offerings as full members; and be it further

Resolved, that the FSMB will create a dedicated physician assistant position on the Board of Directors, but shall not limit the physician assistant representation on the Board to that single position; and be it further

Resolved, that the FSMB will provide support, upon request, to state medical boards to amend their laws to permit the voluntary full and independent practice of physician assistants up to their education and training; and be it further

Resolved, that the FSMB will collaborate with the USMLE and its stakeholders to allow physician assistants to take the appropriate levels of the exam and satisfy requirements for licensing bodies in lieu of or in addition to other national exams; and be it further

Resolved, that the FSMB will advocate on the federal level to identify and address regulatory barriers which impede recognition of the voluntary full Optimal Team Practice of physician assistants in all federal institutions.
References

1. ARNPs and PAs as Usual Source of Care: [https://www.ncbi.nlm.nih.gov/pmc/articles/PMC2794129/](https://www.ncbi.nlm.nih.gov/pmc/articles/PMC2794129/)

2. PAs and ARNPs in Team Based Settings of Chronic Care Patients: [http://www.med.wisc.edu/news-events/study-supports-team-role-for-physician-assistants-and-nurse-practitioners-for-chronic-illness/42167](http://www.med.wisc.edu/news-events/study-supports-team-role-for-physician-assistants-and-nurse-practitioners-for-chronic-illness/42167)


5. Kaiser Family Literature Review comparing NPs and PAs: [https://kaiserfamilyfoundation.files.wordpress.com/2013/01/8167.pdf](https://kaiserfamilyfoundation.files.wordpress.com/2013/01/8167.pdf)
Subject: Permitting Out-of-State Practitioners to Provide Continuity of Care in Limited Situations

Introduced by: Washington State Medical Commission

Approved: January 2018

Whereas, state medical boards are responsible for protecting the citizens of their states by ensuring that physicians are qualified and competent; and

Whereas, state medical boards determine, within the context of their enabling statutes, under what circumstances a license is required for a physician to treat a patient in their states; and

Whereas, many states have license reciprocity and/or the Interstate Medical License Compact which establishes reliance on sister state licensing processes; and

Whereas, due to rapid changes in telemedicine technology, the practice of medicine is occurring more frequently across state lines; and

Whereas, telemedicine is a tool that has the potential to increase access, lower costs, and improve the quality of healthcare; and

Whereas, the historic practice of medicine has prioritized the continuity of care delivery to established patients over recognition of jurisdictional boundaries; and

Whereas, continuity of care is an essential element in consistently delivering high quality health care; and

Whereas, physicians can promote continuity of care by using telemedicine to provide follow-up care to established patients who travel outside the physician’s state of licensure. For example, a physician at a major academic medical center who treats a patient who then returns home, can maintain a connection with the patient by providing follow-up care, including having access to timely and accurate data from the patient; and

Whereas, permitting physicians who are duly licensed in another jurisdiction to provide follow-up care to established patients, and to engage in peer-to-peer consultations, will result in better outcomes and lower costs;

Therefore, be it hereby

Resolved, that the Federation of State Medical Boards (FSMB) will encourage state medical boards to interpret their licensing laws, or work to change their licensing laws if
necessary, to permit physicians duly licensed in another jurisdiction to provide infrequent and episodic continuity of care by providing follow-up care to established patients or a peer-to-peer consultation without the need to obtain a license in the state in which the patient is located at the time of the interaction.
Subject: Interprofessional Continuing Education (IPCE)

Introduced by: FSMB Board of Directors

Approved: February 2018

Whereas, a commitment to lifelong learning and continuing professional development is critical to a physician’s ability to keep up with advances in medicine and with changes in the delivery of care; and

Whereas, state medical and osteopathic boards require continuing medical education for license renewal as a means of assuring the public that licensed physicians are maintaining their competence; and

Whereas, insufficient communication and coordination of care between physicians and other health care professionals in team-based care settings is a patient safety issue; and

Whereas, interprofessional education and team-based care among physicians, nurses and pharmacists is a critical component of health care delivery and improvement; and

Whereas, the Federation of State Medical Boards (FSMB) works with the National Council of State Boards of Nursing (NCSBN) and the National Association of Boards of Pharmacy (NABP) to support collaborative educational opportunities, including regularly hosting Tri-Regulator Meetings for state and territorial licensing boards for medicine, nursing and pharmacy; and

Whereas, Interprofessional Continuing Education (IPCE) is defined as a process by which individuals from two or more professions learn with, from, and about each other to enable effective collaboration and improve health outcomes; and

Whereas, a Joint Accreditation system for Interprofessional Continuing Education was launched in 2009 that is a collaboration of the Accreditation Council for Continuing Medical Education (ACCME®), the Accreditation Council for Pharmacy Education (ACPE), and the American Nurses Credentialing Center (ANCC); and

Whereas, the Joint Accreditors have adopted a shared credit (IPCE credit) that designates an educational activity as having been planned by and for an interprofessional team;

Therefore, be it hereby

Resolved, that the Federation of State Medical Boards supports and recognizes 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.
Whereas, The Internet can gather large amounts of data from diverse sources that include but are not limited to electronic health records, digital images, and mobile apps; and

Whereas, Technology enables the compilation, storage, and processing of vast amounts of data to help identify clinically significant patterns and provide predictions; and

Whereas, Recent developments propel interest in healthcare AI, whether defined as “artificial intelligence,” the ability of a computer to complete tasks in a manner typically associated with a rational human being, or “augmented intelligence,” design that enhances human intelligence rather than replaces it; and

Whereas, Healthcare AI has been developed and applied to clinical decision support, treatment protocols, diagnostic recommendations, clinical prognostication, drug development, personalized medicine, patient monitoring, chronic care, and patient flow analytics; and

Whereas, Healthcare AI operates with variable levels of transparency, vetting, and oversight by experts and regulators; and

Whereas, Technology industry leaders and academic institutions have developed and implemented healthcare AI for radiology, pathology, oncology, ophthalmology, cardiology, and dermatology, and further applications are anticipated; and

Whereas, Modern machine learning technology in healthcare AI can readily re-identify data sources posing a challenge to confidentiality of protected health information; and

Whereas, Investment in healthcare AI is robust and a recent report from Markets and Markets pins the healthcare AI sector at nearly $8 billion in 2022, accelerating at a compound annual growth rate of 52.68 percent over the forecast period; and

Whereas, State medical boards should have an understanding of AI and its impact on medical practice;
Therefore, be it hereby

**Resolved,** That the Federation of State Medical Boards will convene a workgroup comprised of relevant stakeholders and subject matter experts including the American Medical Association to provide state medical boards with an understanding of AI and its potential impact on patient safety and quality of care in medical practice.


10 Yu KH, et al. Predicting non-small cell lung cancer prognosis by fully automated microscopic pathology image features. [https://www.nature.com/articles/ncomms12474](https://www.nature.com/articles/ncomms12474).


The Nominating Committee met on Friday, January 19, 2018 in Irving, Texas at 9:00 am CST. FSMB Immediate Past Chair Dr. Arthur Hengerer serves as Chair of the Committee. Other members of the Committee include Dr. Howard (Joey) Falgout, Dr. Jone Geimer-Flanders, Dr. Marilyn Heine, Dr. Stuart Mackler, Dr. Michelle Terry and Carmela Torrelli. Providing staff support were FSMB President and CEO Dr. Humayun Chaudhry, Director of Leadership Services Pat McCarty, and Governance Support Associate Pam Huffman.

Dr. Hengerer expressed his sincere appreciation for the Committee’s dedication and emphasized the importance of their work in selecting highly qualified candidates for the elected office positions.

The Committee reviewed all submitted nomination materials; considered the results of the one-on-one interviews between the Committee members and nominees; and discussed the importance of selecting candidates who fulfill the qualifications for FSMB leadership positions as outlined in the Committee’s charge. The Committee also shared ideas for strengthening the process of finding good candidates in the future. After thoughtful and careful deliberation throughout the vetting process, the Nominating Committee unanimously approved the following roster of candidates:

**Chair-elect** – 1 fellow, to be elected for three years; a one-year term as chair-elect; a one year term as chair; and a one-year term as immediate past chair

Assists the chair in the discharge of the chair’s duties; and performs the duties of the chair at the chair’s request or, in the event of the chair’s temporary absence or incapacitation, at the request of the Board of Directors.

**Scott A. Steingard, DO – Arizona Osteopathic**

With only one candidate for chair-elect, Dr. Steingard will be elected by acclamation; his current term on the FSMB Board of Directors does not expire until 2019, therefore his election as chair-elect will result in a partial term of one year to be filled.

**Treasurer** – 1 fellow, to be elected for a three-year term

The Treasurer shall perform the duties customary to that office and shall perform such other duties as the Bylaws and custom and parliamentary usage may require or as the Board of Directors shall deem appropriate; serves as chair of the Finance Committee and as an ex officio member of the Audit Committee.
Jerry G. Landau, JD – Arizona Osteopathic

With only one candidate for treasurer, Mr. Landau will be elected by acclamation; his current term as a director-at-large on the FSMB Board of Directors expires in May 2018 and is one of the full terms that will need to be filled.

Board of Directors – 4 fellows; three to be elected for a three-year term each; one to be elected for a one-year term.

Control and administration of the corporation is vested in the Board of Directors, which is the fiscal agent of the corporation; the Board acts for the FSMB between Annual Meetings.

Mohammed A. Arsiwala, MD – Michigan Medical
Anna Z. Hayden, DO – Florida Osteopathic
Shawn P. Parker, JD, MPA* – North Carolina
Anita M. Steinbergh, DO – Ohio
Sarvam P. TerKonda, MD – Florida Medical
Joseph R. Willett, DO - Minnesota

*In accordance with the FSMB bylaws, “At least two members of the Board, who are not Associate Members, shall be non-physicians, at least one of whom shall be a public/consumer member.” With Mr. Landau’s pending election as treasurer and the continued service of another public member on the Board, this bylaws requirement will be fulfilled. Therefore, there will be no need to address the public member candidacy separately. The public member and physician candidates will be included on the same slate.

One candidate will need to be elected to fill Mr. Landau’s expired term (a 3-year term). Dr. Hayden’s current term as director-at-large on the Board expires in May 2018 resulting in a 2nd full term to be filled. The term of another board member who is not eligible for re-election also expires in 2018 resulting in a 3rd full term to be filled. A fourth candidate will need to be elected to serve a partial term of 1 year due to Dr. Steingard’s pending election as chair-elect.

Nominating Committee – 3 fellows, each to be elected for a two-year term

Committee members select a roster of nominees for each of the elected positions to be filled at the annual business meeting of the House of Delegates.

Nathaniel B. Berg, MD – Guam [Dr. Berg has withdrawn his nomination]*
Ahmed D. Faheem, MD – West Virginia Medical
Robert P. Giacalone, RPh, JD – Ohio
Kenneth J. Walker, MD – Virginia
*In accordance with the FSMB bylaws, “At least one elected member of the Nominating Committee shall be a public member.” The term of the one public member currently on the Nominating Committee will expire in May 2018; therefore the 2018 House of Delegates will be required to elect at least one public member. With only three candidates for the Nominating Committee, including the requisite public member, the three candidates will be elected by acclamation.

No two Nominating Committee members are to be from the same member board. Continuing members of the Committee are from Alabama, Pennsylvania Medical and Washington Medical.

Respectfully submitted,

Arthur S. Hengerer, MD, FACS
Chair, Nominating Committee
REQUEST FOR BOARD ACTION
MINNESOTA BOARD OF MEDICAL PRACTICE

REQUESTED ACTION:

For information only.

MOTION BY: ___________________ SECOND: __________________________
(  ) PASSED      (  ) PASSED AMENDED     (  ) LAYED OVER     (  ) DEFEATED

BACKGROUND:

Attached is the Executive Director’s Report of activities since the last board meeting.
EXECUTIVE DIRECTOR’S REPORT
March 10, 2018

INTERSTATE MEDICAL LICENSURE COMPACT (IMLC)
The IMLC Commission (IMLCC) convened by conference call and webinar on February 16, 2018. New member states and commissioners were welcomed and committees reported on progress toward strategic goals. Minnesota’s Commissioners, Patrick Townley, MD, and Ruth Martinez, MA, serve on the IMLCC Bylaws and Rules Committee, which Ms. Martinez chairs.

Board staff continue to participate in monthly updates, debriefings and training sessions hosted by the IMLCC, held via teleconference and webinar.

Minnesota continues to issue licenses as a member state, but remains unable to participate as a state of principal license, pending further legislation. The Board worked with the Minnesota Bureau of Criminal Apprehension and the CBC Oversight Committee to draft language responsive to concerns raised by the Federal Bureau of Investigation.

The full IMLCC will convene by conference call and webinar in May 2018 and in person in November 2018. All IMLCC meetings are public. Please refer to the IMLC website for meeting dates, agendas and minutes, committee reports, bylaws and rules, and other relevant information. A link to the website follows:

https://imlcc.org/

ENGAGEMENT/OUTREACH/CONFERENCES/EVENTS
The Board continues its engagement with internal and external stakeholder groups.

Interstate Collaboration in Healthcare Conference Calls
Other professions are pursuing compacts, including nurses in Minnesota. Two nursing compacts have been introduced in the Minnesota legislature this session, an RN Compact and an APRN Compact.

Rotary Club Presentation
On January 22, 2018, Ms. Martinez presented an overview of the Board of Medical Practice to the Bloomington Rotary Club. Ms. Martinez was invited by former Board member Peter Smyth, MD., who participated in the presentation. The audience was very receptive and the presentation was recorded.

The video is posted on the Bloomington Noon Rotary YouTube Channel; Minnesota Board of Medical Practice
https://youtu.be/l-0h3CAxoQM

It also aired on Bloomington TV Ch. 14/859 HD - Comcast here in Bloomington
Bloomington Rotary: Minnesota Board of Medical Practice
2/19 at 11:00 PM
2/20 at 5:00 AM, 11:00 AM, 5:00 PM
2/24 at 7:00:00 PM
2/25 at 1:00 AM, 7:00 AM, 1:00 PM

Tim Sasse
Municipal Cable TV Coordinator
City of Bloomington
1800 W. Old Shakopee Rd
Bloomington, MN  55431
TSasse@BloomingtonMN.gov
952 563-8788
Minnesota Association of Medical Staff Services (MAMSS)
As previously noted, Ms. Martinez will present at the annual meeting of MAMSS in April 2018.

2018 Tri-Regulatory Symposium
As noted, plans continue for the second Minnesota Tri-Regulator Symposium, tentatively scheduled for June 13, 2018, at a site and time TBD.

ALIMS DATABASE UPDATE PROJECT
Progress continues on the Board’s project to update its ALIMS database.

Other Business
- Updated statute books
- Updated logo and business cards

LEGISLATIVE UPDATE
On November 16, 2017, Senator Fischbach instructed the Revisor of Statutes to cease or reduce all work creating legislation for the Executive Branch, of which the Health Licensing Boards (HLBs) are members. The instruction followed Governor Dayton’s veto of funding for the Minnesota House of Representatives and Senate.

On February 20, 2018, the Minnesota Legislature convened for the 2018 session and took up the legislative funding issue. On February 27, 2018, with the passage of House File 399, the funding issue was resolved and the Legislative Coordinating Commission directed the Revisor of Statutes to resume the important work of drafting bills for state agencies.

House and Senate leadership established the following legislative committee deadlines:

1st deadline – March 22, 2018 at midnight: The first deadline is for committees to act favorably on bills in the house of origin.

2nd deadline – March 29, 2018 at midnight: The second deadline is for committees to act favorably on bills, or companions of bills, that met the first deadline in the other house.

3rd deadline – April 20, 2018 at midnight: The third deadline is for committees to act favorably on major appropriation and finance bills.

Because this is a short session and with a very short window of time between the resumption of authority to draft bills and the first deadline for bills to pass through a committee, the HLBs have been working diligently with legislative staff and authors to prepare bills for committee consideration. Some Boards, including the Board of Medical Practice, have bills specific to their regulatory authority. The Boards have also collaborated on bills that impact all or several HLBs.

Board of Medical Practice Legislation

H.F. 822/S.F. 614
Modifying the Minnesota Athletic Trainers Practice Act, M.S. § 148.7801 – 7815
- Moves registration to licensure
- Updates language

On March 8, 2018, the Senate Health and Human Services Reform and Policy Committee passed an amendment to the bill to remove scope of practice changes and moved the bill to the Senate floor.

H.F. 2753/SF 2310
Modifying licensing requirements for foreign medical graduates, M.S. § 147.037
• Proposes a supervised apprenticeship model in an outstate or underserved setting to create a pathway to licensure for foreign medical graduates lacking the required accredited clinical training

On March 5, 2018, Senator Jim Abeler, the Senate bill’s chief author, accepted an amendment proposed by the Board of Medical Practice to eliminate the apprenticeship model and insert a reduction in the accredited clinical training requirement for foreign medical graduates from two years to one year and allowing the Board to consider expanding the clinical training programs it deems acceptable to satisfy the clinical training requirement.

On March 8, 2018, the Senate Health and Human Services Reform and Policy Committee passed the amendment and moved the bill to the Senate floor.

H.F. 3536/S.F. 2865
Eliminating term limits for Physician Assistant Advisory Council members

• The Physician Assistant (PA) Advisory Council is one of seven advisory councils to the Board of Medical Practice, providing expertise for allied professions regulated by the Board
• The PA Advisory Council is the only council that has term limits for its members

On March 8, 2018, the Senate Health and Human Services Reform and Policy Committee passed an amendment to the bill to delete an effective date and moved the bill to the Senate floor. In the absence of a stated effective date, all policy bills become effective on August 1.

Bill Number Pending
Establishing birth month renewal cycles for allied professions regulated by the Board; recapturing fees; and adding genetic counselors as an allied profession under the authority of the Board

• Six allied professions, with the exception of athletic trainers, will move to a birth month renewal cycle, beginning in 2019 – M.S. § 147A - G
• Fees are moved from rule to the individual practice acts for each of the Board’s regulated professions – because no fees are added or increased, there is no fiscal impact
• Genetic counselors are added to M.S. § 147.012 authorizing Board oversight of allied professions

The bill was jacketed on March 8 and signatures will be secured by March 13.

Health Licensing Board Legislation

Bill Number Pending
Modifying sections of M.S. § 214 related to criminal background checks (CBCs), data sharing and temporary suspension; and modifying M.S. § 364 related to exceptions to the criminal rehabilitation act

• Under the criminal background section:
  - eliminate implementation language, since all HLBs implemented CBC as of January 1, 2018
  - Clarify validity of CBC for one year
  - Create exemption from CBC for an individual applying for a second license type with the same HLB within one year of completing a CBC for another license within the same Board
  - Remove 90-day time period for refusal to consent or submit fingerprints
  - Establish consistent reference to national criminal history records checks
  - Authorize alternative method of CBC after applicant has submitted two, rather than three, sets of unreadable fingerprints
• Under M.S. § 214.10 Subd. 8(d), add language to explicitly prohibit sharing of criminal history record information
• Under M.S. § 214.077, increase the maximum timeline from 30 – 60 days between receipt of the Administrative Law Judge’s report and the Board’s hearing on final action, following a temporary suspension of license and completion of an administrative hearing

The bill was signed by the authors and dropped for assignment of bill numbers on March 7, 2018.
**Bills Being Monitored**
The Board is tracking a number of bills, including but not limited to the following:

**H.F. 95/S.F. 623**
Mandatory opioid continuing education for health professionals and reimbursement for acupuncture services

**H.F. 1134/S.F. 752**
Limiting the time to fill prescriptions for opioid drugs to 30 days after issuance of the prescription

**H.F. 1219/S.F. 843**
MN PMP restrictions on a prescriber’s authority to prescribe controlled substances

**H.F. 1413/S.F. 1151**
Clinical lactation service licensing created, fees established; amended to establish authority under Board of Medical Practice

**H.F. 3023/S.F. 2957**
Mandatory opioid CE for physicians
(Senate HHS Reform and Policy hearing scheduled for March 13)

**H.F. 3060/S.F. 3218**
Healthcare providers required to obtain a direct secure messaging address

**H.F. 3061/S.F. 2886**
Primary care residency programs grants expansion

**H.F. 3396/S.F. 3033**
Health care providers and plans required to provide price transparency to patients and enrollees

**H.F. 3401/S.F. 3107**
Opiate prescriptions limited to a seven-day supply

**H.F. 3449**
Providers required to provide patients with written estimates of charges

**H.F. 3507/S.F. 3004**
SOS directed to collect data on veteran status from applications for appointment to state agencies, boards, councils, commissions and task forces

**H.F. 3534**
Opioid reduction pilot program established and money appropriated

**H.F. 3568**
Medical cannabis manufacturer registration and patient registry program provisions modified
DATE: March 10, 2018  SUBJECT: New Business

SUBMITTED BY: Patricia J. Lindholm, M.D., FAAFP, Board President

REQUEST FOR BOARD ACTION
MINNESOTA BOARD OF MEDICAL PRACTICE

REQUESTED ACTION:

MOTION BY: ____________________  SECOND: ____________________
(  ) PASSED   (  ) PASSED AMENDED   (  ) LAYED OVER   (  ) DEFEATED

BACKGROUND:

Any other new business to be discussed.
DATE: March 10, 2018
SUBJECT: Corrective or Other Actions

SUBMITTED BY: Complaint Review Committees

REQUEST FOR BOARD ACTION
MINNESOTA BOARD OF MEDICAL PRACTICE

REQUESTED ACTION:

MOTION BY: SECOND:
( ) PASSED ( ) PASSED AMENDED ( ) LAYED OVER ( ) DEFEATED

BACKGROUND:
For information only, attached are copies of Corrective or Other Actions that were implemented between January 4 and March 1, 2018.
PUBLIC DOCUMENT

January 18, 2018

Sim Gesundheit, M.D.
11928 St Albans Hollow Dr
Minnetonka, MN 55305-3983

RE: Agreement for Corrective Action, Dated November 28, 2017

Dear Dr. Gesundheit:

The Complaint Review Committee of the Minnesota Board of Medical Practice has reviewed your Agreement for Corrective Action and documentation in support of satisfaction of the terms contained therein. The Committee concluded that the Agreement has been satisfied.

Thank you for your cooperation.

Sincerely,

Ruth M. Martinez
Executive Director
February 15, 2018

Taryn Marie McEvoy, M.D.
Oakdale OB/GYN
9825 Hospital Drive
#205
Maple Grove, MN  55369

RE: Agreement for Corrective Action, Dated September 1, 2017

Dear Dr. McEvoy:

The Complaint Review Committee of the Minnesota Board of Medical Practice has reviewed your Agreement for Corrective Action and documentation in support of satisfaction of the terms contained therein. The Committee concluded that the Agreement has been satisfied.

Thank you for your cooperation.

Sincerely,

Ruth M. Martinez
Executive Director
February 15, 2018

Beth Renee Keegstra, M.D.
800 Medical Center Drive
Fairmont, MN 56031

RE: Agreement for Corrective Action, Dated February 27, 2017

Dear Dr. Keegstra:

The Complaint Review Committee of the Minnesota Board of Medical Practice has reviewed your Agreement for Corrective Action and documentation in support of satisfaction of the terms contained therein. The Committee concluded that the Agreement has been satisfied.

Thank you for your cooperation.

Sincerely,

[Signature]

Ruth M. Martinez
Executive Director